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 25 March 2021
10.00 – 13.05

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 28 January 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 - Board & Committee Effectiveness Review 2021	Information	Chair	Verbal	10.10
7.	Chief Executive's Report	Information	Chief Executive	Enc.	10.15
KEY DISCUSSION TOPIC					
8.	Staff/ Patient Story Mike's Story: a personal experience	Discussion	Director of Nursing & Quality	Pres.	10.20
9.	Freedom to Speak Up Self-Review Tool	Discussion	Director of Corporate Governance	Enc.	10.40
10.	Renew and Recover Framework	Discussion	Chief Operating Officer	Enc.	10.55
11.	Integrated Performance Report	Discussion	Chief Executive	Enc.	11:15
12.	Staff Survey Report	Discussion	Director of People & Transformation	Enc.	11.35
BREAK *(15 mins)*					11.50
13.	Green Plan 2021/22	Approval	Director of Facilities, Estates and Capital Planning	Enc.	12.05
FINANCE					
14.	Finance Month 11 Report	Information	Chief Finance Officer	Enc.	12.15
GOVERNANCE & ASSURANCE					

No.	Item	Purpose	Lead	Paper	Time
15.	HSE inspection update – *to include summary of actions and progress against each (action from Jan 2021)*	Information	Director of Facilities, Estates and Capital Planning	Enc.	12.25
16.	Quality & Risk Management Committee Upward Report 16.1. Maternity Assurance Tool (Ockenden action) 16.2. Final Gynaecology inspection report & Action Plan 16.3. Terms of Reference	Information	NED Chair	Enc.	12.35
17.	People Committee Upward Report incl. safe staffing update	Information	NED Chair	Enc.	12.45
18.	Board Assurance Framework	Discussion	Director of Corporate Governance	Enc.	12.55
For information only – No discussion expected					
19.	Healthier Together update report	Information	Chief Executive	Enc.	
CLOSING BUSINESS					
	Any Other Business	Information	Chair	Verbal	13.00
	Questions from the Public in Relation to Agenda Items	Information	Chair	Verbal	13.05
	Date of Next Meeting: Thursday 29 April 2021, 10.00 a.m. Virtual				
	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	• Managing Director of Thames Water Utilities Ltd. • Vice President of The Institute of Customer Service. • 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 Evelyn Barker	Chief Executive	• Nothing to declare.
Ms Karen Brown	Chief Operating Officer	• Nothing to declare.
Dr Chris Burton	Medical Director and Deputy Chief Executive	• Wife works for NBT.
Ms Helen Blanchard	Director of Nursing and Quality	• Nothing to declare.

Name	Role	Interest Declared
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 Glyn Howells	Chief Finance Officer	• Governor and Vice Chair of Newbury College (voluntary).
Mr Simon Wood	Director of Estates, Facilities and Capital Planning (non-voting position)	• Member of Bristol City Council's Bristol One City Environmental Sustainability Board.

3

DRAFT Minutes of the Public Trust Board Meeting held virtually on Thursday 28 January 2021 at 10.00am

Present:

Michele Romaine	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	Catherine Phillips	Director of Finance
John Iredale	Non-Executive Director	Jacqui Marshall	Director of People & Transformation
		Simon Wood	Director of Estates, Facilities & Capital Planning

In Attendance:

Xavier Bell	Director of Corporate Governance & Trust Secretary	Pete Bramwell	Acting Director of Communications
Isobel Clements	Senior Corporate Governance Officer & Policy Manager	Glyn Howells	Director of Operational Finance, incoming Director of Finance

Presenters (present for minute item 08):

Juliette Hughes	Divisional Director of Nursing, ASCR Division	Su Monk	Deputy Director of Nursing & Quality
Morwenna (Mo) Maddock	Intensive Care Unit (ICU) Sister and wellbeing lead	Valentien Crook-Jones	Intensive Care Unit (ICU) Matron

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/21/01/01 Welcome and Apologies for Absence

Michele Romaine, Trust Chair, welcomed everyone to NBT's Trust Board meeting in public. Apologies had been received from Ade Williams and LaToyah Jones, both Associate NEDs.

TB/21/01/02 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/21/01/03 Minutes of the previous Public Trust Board Meeting

RESOLVED that the minutes of the public meeting held on 26 November 2020 be approved as a true and correct record subject to the following amendment:

- **On page 6, 'Pulse Auxiliary Service' is corrected to 'PULSE**

Oximetry Service'.

TB/21/01/04 Action Log and Matters Arising from the Previous Meeting

Regarding Action 19, a Staff/ Patient Story was scheduled for later in the meeting and for March's Board meeting. However, due to NBT's vacant Patient Experience Lead role, there was not yet a six-month forward work-plan for Staff/Patient Stories at Board.

Regarding Action 22, NED involvement in walk-arounds would be discussed at the next NED catch-up meeting.

No matters arising were raised.

RESOLVED that updates on the Action Log were noted.

TB/21/01/05 Chair's Business

Michele Romaine, Trust Chair, described visits to the following pressure points of the Trust during the previous week: Intensive Care Unit (ICU), Emergency Department (ED) and the Breast Care Centre.

Michele described conversations with staff across various professions including consultants, nurses and deep-clean teams. Michele's overarching perception was that of calm professionalism but with signs of staff distress from prolonged, intense pressure. This was particularly evident in international staff that had not seen family for over a year.

The Integrated Performance Report (IPR) - discussed in detail below- further evidenced the pressure on the above areas and the Trust. However, on the visit to the Breast Care Centre, Michele received significant assurance regarding how the Trust was managing two week wait referrals and long-waiters in cancer pathways by ensuring long waiters were clinically reviewed and did not fall through safety nets.

Michele further described conversations with the deep-clean teams who were under intense pressure to turn wards around. Simon Wood, Director of Estates and Facilities, quantified this pressure as an increase from 270 weekly deep-cleans pre-pandemic to 900 deep-cleans per week during the pandemic. Simon thanked Michele for the recognition and commended the Domestic team for their hard work.

RESOLVED that the Chair's briefing be noted.

TB/21/01/06 Chief Executive's Report

Evelyn Barker, Chief Executive, provided an update to the Board regarding the Trust's operational pressures which were expected to continue throughout January:

- NBT had taken a lead role in supporting the system and providing mutual aid further afield. The Trust had accepted patients from Weston General Hospital, surgical diverts, and regional transfer of ICU patients when required. This extended to cross-regional transfer as far as accepting patients from Kent, Swindon and Bath (total of 19 ICU patients to date);

- The current situation demanded an agile operational response given the need to manage both Covid-positive and non-Covid patients within the building. Teams were thanked for their collaborative working and thanks were also extended to military personnel on-site who were supporting NBT by carrying out mainly non-clinical duties;
- BNSSG had the highest infection rate in the South West region but ICU capacity had not been challenged enough to trigger use of the Nightingale Hospital Bristol (NHB);
- Exeter was using its Nightingale hospital as a step-down facility for Covid patients with 53 patients currently in situ;
- An NHSE/I letter had been received regarding reducing regulatory elements and reporting. This included suspension of all non-essential oversight meetings, flexible year-end submissions and a focus of resources and recovery on Covid-19;
- It was noted that NBT's Quality & Risk Management Committee (QRMC), Audit Committee, Charity Committee and Trust Board would continue to take place virtually but other committees would be stood-down this quarter and People Committee had been re-scheduled from February to March;
- Glyn Howells, Operational Finance Director, was introduced as the incoming Director of Finance who would start following Catherine Philips' departure in February.

Queries from the Board were as follows:

- Kelvin Blake, NED, noted that the majority of patients in NBT's ICU were out-of-area (19/27) and queried if this reflected that the South West region was doing better than elsewhere. Evelyn Barker responded that the region was doing better regarding the numbers of Covid patients in hospital (18% bed base Covid at NBT but in London this figure was much higher);
- Tim Gregory, NED, queried continuation of the transformation agenda and digital initiatives in light of NHSE/I endorsement to focus transformation resource on Covid-19. Neil Darvill, Director of IM&T, clarified that no IM&T work had been formally suspended. Digital transformation work continued as scheduled but with recognition that clinician-led elements had slowed due to clinicians returning to the front-line. Jacqui Marshall, Director of People & Transformation, reiterated that many workforce transformation projects continued as they did not affect the Trust's response to the pandemic. The People & Transformation team were working closely with divisions to establish priorities based on recovery for 2021/22.

RESOLVED that the Chief Executive's briefing be noted.

TB/21/01/07 Green Plan (2020/21)

Simon Wood, Director of Estates, Facilities and Capital Planning, presented the 2020/21 Green Plan for Board approval. It was explained that the Plan had a time lag as the normal presentation to Board in September had not been possible due the previous year's data having been unavailable. It was noted that in future the Board would receive the Green Plan for the financial year in March. Therefore, the 2021/22 Green Plan was expected at the next public Board meeting with a half-

year data update in September 2021 when data was available.

The Green Plan promoted sustainable thinking and behaviour in the Trust and activity regarding sustainability was ever increasing nation-wide. The expanded Sustainable Development Team would take forward the organisation's zero carbon aim route map.

During the ensuing discussion the following points were noted:

- John Everitt, NED, supported the report's aspirations but raised concern regarding resources required to achieve these as the report referred multiple times to issues being dealt with in the 'later business plan'. Simon Wood responded that the sustainability team (small but recently expanded) would coordinate the changes required but the rest of the Trust employees would have an active part in delivering aspirations such as carbon neutrality by 2030. Furthermore, each component of business planning now had a sustainability element. For example, business cases must complete a sustainable development assessment before being considered. Tenders had also been received for assistance with creating a carbon route map which would be presented with next year's 2021/22 plan. It was confirmed that sustainability plans would have a reasonable price tag in order to implement;
- Tim Gregory, NED, highlighted that the key way to make a difference regarding sustainability would be to change the Trust's procurement. Tim queried if there were currently sustainability experts within the procurement team and if a focus on sustainability was reflected in the procurement policy. Simon Wood confirmed that the head of procurement was involved and had bought-in to the Trust's sustainability journey with a number of his team interested in the topic. However, a specific sustainability procurement team was not currently in the Trust;
- Michele Romaine queried the impact of Covid-19 on the Trust's sustainability ambitions. Simon Wood confirmed Covid-19 had caused a move away from public transport to car use but an increase in cycling had also been seen (80 new cyclists signed up online and the try-before-you-buy scheme was over-subscribed). It was expected that data for 2020/21 would see a large increase in car use and waste which would move the Trust in the wrong direction regarding sustainability for a time but that momentum was there to move in the other direction following the pandemic.

RESOLVED that the Board commended the report, the sustainability team's work and the commitment the Trust had regarding sustainability. However, the Board recognised Covid-19 would negatively affect the sustainability targets for a period.

TB/21/01/08 Staff Story

The Board received a presentation from members of NBT's Intensive Care Unit (ICU) regarding various well-being initiatives within the team. Juliette Hughes, Divisional Director of Nursing for ASCR, introduced Morwenna (Mo) Maddock, ICU Sister and wellbeing lead, and Valentien Crook-Jones, ICU Matron, who were both involved in supporting staff and patient wellbeing prior to and during the pandemic.

The team described a video received by the ICU department from a patient and their family {*link on website}* where previous patient Anne-Marie sent her heartfelt thank-you to the ICU team. She described the compassion, care and clinical excellence NBT provided.

Key elements of ICU well-being support were then detailed as follows:

- After-care service for ICU patients with a Covid-19 specific follow-up clinic was important for patients to finish their recovery journey, but it was also important for staff to see patients recover. Videos such as above boosted staff morale and evidenced that their hard work and dedication pays off even in incredibly difficult times;
- The department has had a well-being offering in place for a number of years with emphasis on the Trauma Risk Management (TRiM) System. TRiM is a peer delivered risk assessment and ongoing support system, designed specifically to help in the management of traumatic events. It provides expert staff well-being and peer support and NBT now had a number of staff members trained to deliver TRiM-based support;
- NBT's ICU team had also worked alongside prominent psychologists specialising in designing support systems for teams;
- ICU staff were now actively engaged with well-being initiatives and offerings and it was reported that a tangible difference could be seen within the team. Visitors to the unit commented that ICU was positive despite the difficult nature of work and that staff maintained support for one another. Valentine agreed with this and highlighted that having only been in the Trust for 10 months, the team was positive, resilient and had a can-do attitude which allowed them to take difficult situations in their stride such as looking after colleagues with Covid-19;
- Juliette Hughes further thanked all those who had supported the ICU throughout the pandemic and noted the additional need to support those not normally exposed to the pressures of ICU to ensure their wellbeing was looked after.

During the ensuing discussion the following points were noted:

- Michele Romaine noted how impressed she was with the team's calmness and professionalism at her recent visit to ICU. She noted how proud the team should be and requested that the Board's sincere thanks be passed on to the whole team;
- Helen Blanchard, Director of Nursing and Quality, thanked the team for presenting to Board and for their work regarding Just Culture, well-being and quality of care improvements. Helen reiterated the challenges the department was under and commended the team for tackling them head-on. It was noted that support from staff across the Trust during the pandemic also reflected the team-spirit and supportive environment of NBT;
- Evelyn Barker also thanked the team personally and highlighted the extent of mutual aid provided by the Trust to those in and out of the region in addition to providing care for NBT's local population;

- John Iredale, NED, praised the teams' ability to flex in this unprecedented time and noted that NBT was held with great respect by partners in the system. On behalf of the University of Bristol and the Board John thanked the team. John also celebrated that mental health and moral support was addressed directly and queried if there was a way to share the team's wellbeing knowledge across the wider organisation to assist those who may be struggling;
- In response, Mo Maddock explained that she had attended the British Association of Critical Care Nurses meeting in Scotland to present the well-being changes made in the unit and positive effects on retention of staff from staff feeling valued. Mo also trained MDTs and worked frequently with the Trust's mega-teams created during the pandemic to ensure all staff felt cared for;
- Karen Brown commended the incredible support from staff Trust-wide to deploy the mega-teams and reduce the elective programme in order to continue to support the most vulnerable patients;
- Jacqui Marshall highlighted that a Trust-wide wellbeing update was included in the IPR and that NBT was acknowledged nationally for its wellbeing support; winning national NHS prizes. The Military had also stated that they were humbled by the emotional resilience of NBT staff and would use NBT's example for learning going forward.

RESOLVED that the Board:

- **Thanked the ICU team for their attendance and requested that the Board's sincere thanks to all staff was passed on;**
- **Acknowledged and thanked the wide-ranging staff who had supported ICU to ensure it was possible to continue to deliver quality care for all patients throughout Covid-19.**

TB/21/01/09 Annual EPRR Report/ EPRR assurance report

Karen Brown, Chief Operating Officer, presented the Emergency Preparedness Resilience and Response (EPRR) Annual Report 2019/20 required under the 2004 Civil Contingencies Act. Key elements of the highly relevant report were highlighted to the Board as follows:

- NBT was substantially compliant as indicated by the annual self-assessment that the Trust had completed;
- An issue to action was regarding the availability of loggists. A number of trained loggists had been used to support Silver and Gold Command during the pandemic but more trained loggists across the Trust were required;
- The biggest issue the Trust was experiencing was the gap in an EPRR manager lead. Three separate leads had been recruited but none had continued or started for a variety of reasons.

John Everitt highlighted that Care UK was non-compliant and queried if this was an issue for NBT to action. Karen Brown responded that Care UK provided a service to BNSSG rather than NBT alone so this would be picked up as an action under BNSSG's EPRR assurance rather than NBT's. In addition, NBT had been verbally informed that there were no

concerns within Care UK's more recent 2020 assessment.

RESOLVED that the Board noted that the Trust was 'substantially compliant' with the NHS Core Standards for Emergency Preparedness Resilience and Response (EPRR) for 2019/20.

TB/21/01/10 Integrated Performance Report

Evelyn Barker, Chief Executive, presented the Integrated Performance Report (IPR) for discussion. The data was not typical of the Trust's usual good performance which reflected Covid-19 and winter pressures experienced at NBT. Key points of the IPR were noted as follows:

- ED performance fell to 73% in December 2020 with 52 12-hour trolley waits. This indicated delays in off-loading ambulances due to getting patients into suitable Covid-19/ non-Covid-19 pathways;
- The Board were reassured that the Trust was not an outlier regarding the above figures and that the surrounding Trusts were reporting many more 12-hour trolley waits and ambulance waits;
- Elective recovery was working well especially compared to the South West region. MRI and CT activity reported good figures as teams had gone above and beyond to recover;
- Increased breast demand due to GPs not having face to face appointments had led to significant pressure at NBT though 31/62 day performance was improved due to NBT's prioritisation;
- Infection Prevention Control (IPC) was prevalent in everyone's minds and Su Monk, Deputy Director of Nursing and Quality, had led the IPC team well through the team's leadership vacancy;
- Lateral flow tests were being carried out twice weekly for all ward staff and majority of on-site staff;
- Staff turnover improved in December with extra staff allocated for recruitment during winter.

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

- NBT was in **Internal Critical Incident** and OPEL 4 for much of December due to flow of patients, ED and Covid-19 pathways;
- **Stranded patients** (129) was a significant pressure point, with quality and safety of patient care a priority for NBT;
- **Planned care h**ad been significantly reduced due to the Covid-19 response with no green wards in the organisation aside from Medirooms which was continuing an elective programme to deliver safe care to those in highest risk groups. Anaesthetists and the ASCR division were commended for managing this which had allowed the waiting list to remain static;
- **Cancer:** NBT was leading work to understand breast waits across the system. For NBT, the breast service was fragile in terms of radiology support. This was divisionally recognised and sickness had compounded the activity issues. The Board were reassured that the Trust's focus was on cancer support and delivery within the

organisation.

Helen Blanchard highlighted the key Quality elements of the IPR and Chris Burton, Medical Director, reported on the IPC elements of the IPR as follows:

- **Maternity services** had been a focus of QRMC and the IPR now included an additional slide regarding maternity indicators which was an action in response to the Ockenden Report. The maternity data slide presented was the first iteration which would be developed further to ensure the Board was fully sighted on maternity data and issues. John Iredale, NED, further noted that the Trust felt it was best practice to also present patient voice within the maternity data and that work to best capture this was ongoing;
- **Covid-19**: Page 28 of the IPR detailed hospital onset infections which were expected to be higher in January's IPC. The Board were reassured that a daily outbreak huddle was ongoing to manage outbreak events occurring in patients and staff. It was acknowledged that the Trust was having to increase pressure on an already pressured front door by closing wards when outbreaks occurred;
- Positively, Public Health England data showed very low levels of **influenza** this winter which meant significantly less pressure than there could have been on the hospital.

Key points discussed by the Board were as follows:

- After John Everitt's query regarding higher than trajectory C. difficile infection rates, Chris Burton noted this was a prime area of focus for the Executive Team and himself as Director of Infection Control (DIPC). After investigation of December's numbers, nothing unusual had been found about the cases but it was hypothesised that the increased C. diff infections may be due to Covid-19 patients requiring high levels of antibiotics which increased chances of infections. This would continue to be closely reviewed;
- Kelvin Blake noted the good complaint work and reduction in numbers of pressure injuries;
- Kelvin Blake also queried why numbers of stroke patients had fallen by up to 50%. Chris Burton responded that the answer to this was unknown but speculation was that people were not presenting to NBT's front door as they were frightened of attending hospitals during the pandemic. This reduction in demand was apparent nationally and it was likely people were coming to harm due to non-attendance. The Board noted this as a significant concern;
- Chris Burton further agreed that the significant backlogs of demand and non-attendance would lead to unaddressed need in the community which in turn would likely lead to significant greater need of acute care. The Trust would continue public messaging that emphasised hospitals were safe to attend if care was needed;
- Michele Romaine requested that the Board receive insight regarding Covid-19 impact on all services (such as District General Hospital services) as well as the currently reported effects on specialist services such as cancer. It was noted by the Board that this would be difficult to unpick but Chris Burton agreed to discuss with executive colleagues how this could be shown within the IPR;

- It was confirmed that a positive Lateral Flow test result had to be confirmed by a PCR test;
- Michele Romaine queried the effect of Covid-19 on diagnostics as prior to the pandemic diagnostics was already challenged. Karen Brown responded as follows: MRI capacity was currently being increased with use of BioBank to reduce the backlog; NBT was on-plan for MRI performance; concern remained regarding non-obstetric ultrasound with work ongoing to resolve this; pre-pandemic, endoscopy was challenged and system discussions were ongoing to stabilise this for the future as a system-wide solution was required to solve the deficiency in BNSSG's endoscopy services.

Jacqui Marshall highlighted the IPR's key People elements as follows:

- **Statistics:** Sickness was in-line with previous years due to low levels of 'normal' cold and flu viruses seen this year. Most sickness was Covid-19 related with approximately 250 staff members absent per day (an average 90 self-isolating, 70 shielding and the remaining with Covid-19). January's IPR would show significantly higher staff absence;
- **Resourcing:** Retention was at an all-time low and was a significant concern going forward. Work continued to retain a strong resourcing pipeline as large staff turnover was expected following the pandemic: Oversees nursing recruitment continued with 40 nurses having started at NBT between November and January, and 60 expected in spring and summer; monthly recruitment campaigns were ongoing with 25 Healthcare Assistants recruited each month; and over 400 staff had been recruited for the mass vaccination programme. The Trust also hoped to convert a number of the mass vaccination staff from temporary to substantial staff following completion of the programme;
- **Well-being:** Anxiety, trauma, burnout, emotional fatigue and the impact on staff and their lives from not being able to process or recover sufficiently was a key area of focus for the Trust and would be critical to tackle to ensure staff well-being and retention.

Key points discussed by the Board were as follows:

- Richard Gaunt, NED, queried if the Trust had a significant backlog of annual leave that would affect staffing post-pandemic. Jacqui Marshall responded that staff had been allowed to carry 10 days leave into 2021/22 though staff were encouraged to take all annual leave for their well-being. Up to November, 70% of leave had been taken which did not reflect a huge back-log of untaken leave;
- Tim Gregory expressed concern that exhaustion down-stream would affect the Trust's staffing levels. Tim suggested thought should be given to thinking long-term, and queried if the Trust would pay for incoming oversees staff to quarantine when this was compulsory;
- It was acknowledged that it was not only front-line staff who were experiencing exhaustion, but also staff across the wider Trust;
- Jacqui Marshall shared all the NED's concerns and reassured the Board that she was already working closely with Helen Blanchard regarding retention and resourcing. NHSI had also provided funding to support international recruitment and the Trust had pipelines into

the community (universities, schools etc.) and was one of five retention path finders in the UK. Jacqui emphasised that retention was critical and would be a key pillar of the Trust's 'Renew and Recover' plan;

- Michele Romaine noted that following a conversation with an ED sister, it was made clear that staff had no opportunity to decompress after a difficult shift at work as they could not socialise or spend time with family and friends under lockdown rules. This lack of decompression was using up staff's resilience across the organisation.

Catherine Phillips, Director of Finance, highlighted the key finance and annual planning elements of the IPR as follows:

- **Finance:** The half-year year-end deficit had reduced from £8.7m to £8.1m due to recovering more income than expected and delayed system mitigations. However, due to the current wave of the pandemic, predicted year-end deficit was likely to be greater than the predicted £24m;
- **Planning:** It had been confirmed that the current financial regime would be continued into Quarter 1 of the next financial year and a plan for Quarter 2, 3 and 4 was expected in June. Further discussion would be had at Private Board regarding intentions for next year and resources required for internal priorities.

RESOLVED that the Board:

- **Noted the contents of the Integrated Performance Report and discussion detailed above;**
- **Approved the Provider Licence Compliance Statements;**

TB/21/01/11 Quality & Risk Management Committee Upward Report

Professor John Iredale, NED and QRMC chair, presented the QRMC upward report which covered a lengthy and detailed meeting. A large proportion of the meeting had focussed on Women & Children's division (W&CH) where work was ongoing to assure the Board of excellent governance to match the excellent clinical outcomes and the Trust's response to the Ockenden report.

<u>During the ensuing discussion the following points were noted:</u>

- Michele Romaine noted the requirement of the Ockenden report to provide a data set to Board, but queried if there were further elements that required the Board's attention. In response, it was clarified that Kelly MacFarlane, NED lead for W&CH, and John Iredale would work together with lead clinicians and execs to continue work on visibility of the division's processes and governance that had already been set in motion prior to the Ockenden Report. QRMC would receive a quarterly maternity service update on behalf of the Board and patient voice, positive culture change and improvement would be top of the agenda;

- Helen Blanchard clarified that the next step in response to Ockenden would be to complete the Assurance Assessment Tool by mid-February to assess NBT's compliance with the seven immediate and essential actions, NICE guidance and CNST safety actions. This would be received at the next QRMC;
- Michele Romaine noted that she was struck by the Ockenden Report in that the Trust reviewed in the Report had a Board, NEDs and data and still issues and failures (described in the report) had occurred. Michele emphasised that NBT's Board and its members needed to challenge, be curious and continue asking difficult questions;
- Tim Gregory highlighted that challenge at Board meetings was even more pertinent due to NHSE/I's requested suspension of all other committees aside from Board and Quality. In addition, Tim requested that diagnostics be reviewed again at QRMC or Finance & Performance Committee if available;
- Helen Blanchard highlighted that the Local Maternity System (LMS) fed into regional and national teams and had an emphasis on oversight of quality and safety across maternity services in BNSSG.

RESOLVED that the Board:

- **Received the QRMC upward report for assurance and noted the activities QRMC had undertaken on behalf of the Board;**
- **Noted the initial letter detailing a positive CQC Inspection of Gynaecology with publication of the formal report expected in February;**
- **Approved the QRMC Terms of Reference;**
- **Requested that a deep-dive into diagnostics be carried out at FPC or QRMC;**
- **Agreed to a future Board presentation regarding the BNSSG Medical Examiner Service.**

KB/CB/JI/ JE

IC/XB

TB/21/01/12 Any Other Business

Evelyn Barker extended a huge thank you to Catherine Phillips, Director of Finance, at her last Board meeting before leaving NBT at the end of February. Catherine was thanked for her vast contribution to NBT over a number of years; she would be greatly missed but was wished all the best in her new role.

TB/21/01/13 Questions from the public – None received

TB/21/01/14 Date of Next Meeting

The next Board meeting in public is scheduled to take place on Thursday 25 March 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 11.40am

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	Patient Story / Staff Story	TBC/20/01/04	19	Patient story advance six month plan to be created for patient and staff stories with sufficient secondary options to ensure a staff/patient story is brought to the Board	**Helen Blanchard Director of Nursing & Quality**	Nov-20	Yes, regular item	**Open**	Story presented to Jan and one scheduled for March 2021. Six month forward plan not yet available due to the vacant Patient Experience Lead role.	28/01/2021
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	**Open**	NED involvement in walk-arounds would be discussed at the next NED catch up call.	28/01/2021
28/01/2020	Quality & Risk Management Committee Upward Report	TB/21/01/11	42	Schedule a Medical Examiner presentation update for future Board away-day when possible	**Isobel Clements, Corporate Governance Officer**	Jan-22	Yes	**Closed**	Scheduled January 2022	
28/01/2020	Quality & Risk Management Committee Upward Report	TB/21/01/11	43	Diagnostics deep-dive to be scheduled on QRMC forward work plan	**Chris Burton, Medical Director/ John Iredale, NED and QRMC chair**	May-21	QRMC	**Closed**	Agreed and underway - scheduled for May QRMC	05/03/2021

Report To:	Trust Board Meeting		
Date of Meeting:	25 March 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)	Evelyn Barker, Chief Executive		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
		X	
*If any boxes above ticked, paper may be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is asked to receive and note the content of the briefing.		
Report History:	The Chief Executive's briefing is a standing agenda item on all Board agendas.		
Next Steps:	Next steps in relation to any of the issues highlighted in the Report are shown in the body of the report.		

7

Executive Summary
The report sets out information on recent updates from our regulators, changes in senior leadership within the Trust, and other items of importance to the Board.

Strategic Theme/Corporate Objective Links	**Provider of high quality patient care** **1. Developing Healthcare for the future** **2. Employer of choice** **3. 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:	

1. Purpose

To present for information an update on local, regional and national issues impacting on the Trust.

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. Key Personnel Update

Maria Kane is joining the Trust on 19 April as Chief Executive, taking over from myself as Accountable Officer from 1 May. Maria is currently Chief Executive of North Middlesex University Hospital Trust.

Chris Burton has decided to step down as NBT's Medical Director after nearly ten years. Chris has provided outstanding clinical leadership for our organisation throughout many challenging times, not least the Covid-19 pandemic. An interim Medical Director will be appointed initially to ensure continuity whilst we recruit into the substantive position.

Glyn Howells has been appointed Chief Finance Officer following the departure of Catherine Phillips who had been with us for nearly eight years. Glyn has been with the Trust since 2019 as Director of Operational Finance.

Professor Marcus Drake (Professor of Physiological Urology, Bristol Medical School and Honorary Consultant Urological Surgeon, North Bristol NHS Trust) has been appointed to the new role of Associate Joint Director of Research for NBT and UHBW. Marcus will start his new role in April 2021.

4. Covid-19

The Trust is beginning to transition out of the Command and Control structure that has been in place throughout the Covid-19 pandemic and is restating its commitment to Service Line Management (SLM) and the clinically driven leadership of its services. A forward looking SLM development programme is being stood up for 2021/22 to support a resilient and effective workforce, as the Trust moves into "renew and recover" focusing on the resumption of elective activity.

The BNSSG Covid-19 vaccination programme is progressing well, with the only significant issue at this time, being the current amount of vaccine available while manufacturers scale up production. The vaccine is being offered to individuals in line with

the guidance published by the JCVI, with particular effort on reaching out to local communities and populations in refugee hotels and homeless centres.

5. White Paper

In February 2021 the Department of Health and Social Care (DHSC) published a White Paper, "Integration and Innovation: working together to improve health and social care for all – Department of Health and Social Care's legislative proposals for a Health and Care Bill". This White Paper sets out proposals for legislative change to create a framework for local partners to expand on existing partnerships as place and system level. This includes the establishment of statutory Integrated Care Systems (ICS), which will be responsible for developing plans to meet the health needs of their population, developing system-wide capital plans, and commissioning health services.

The Paper also encompasses a number of other proposals such as changes to procurement rules for health care services, a re-commitment to patient choice and a general shift from competition within the healthcare sector to an emphasis on collaboration, as well as changes to the structure of NHS Improvement and NHS England.

The clarity provided in the White Paper is welcomed; however there is still a great deal of detail to follow and the full implications of these proposed changes are being considered within the Bristol, North Somerset & South Gloucestershire (BNSSG) system, and being fed into the development of the BNSSG ICS.

6. NHS Genomics

I recently attended a national virtual meeting of the Chief Executives of all 7 Genomic Laboratory Hubs. The Covid-19 pandemic has impacted on the progress of the 500,000 Genomes Project, with patient recruitment, family blood sampling and consent constraints alongside complex data entry requirements. South West GLH had been on track until recently, with some issues in the peninsular; all have been asked to focus on ramping up activity, with recovery trajectories to be agreed between each GLH and NHSE/I.

7. EPR System C Contract Signature

Trust Board has previously approved a business case to upgrade the Trust's Electronic Patient Record System. There has been a delay in finalising the contract due to requirement for numerous regulatory approvals. However, the final approval was received at the end of February 2021. The contracts with the new provider, System C, will be signed following the Trust Board meeting. There will be further updates to Trust Board as the programme progresses.

8. Consultant Appointments

Since this report was last issued in January 2020 the Trust has appointed 36 new consultants across several key specialities:

Name	Speciality	Appointed From
Alexandros Grammatikos	Medicine – Immunology	January 2020
Shelley Barnes	Pain	February 2020

Douglas Kopcke	Radiology	February 2020
Noor Ali	Radiology	February 2020
Naomi Carson	Histopathology	February 2020
Sandeep Buddha	Stroke	March 2020
Amardeep Dastidar	Medicine – Cardiology	March 2020
Dominic Williamson	Medicine – E.D.	March 2020
Reuben Cooper	Medicine – E.D.	March 2020
Tim Godfrey	Medicine – E.D.	March 2020
Johannes Von Vopelius-Feldt	Medicine – E.D.	March 2020
Amy Crees	Medicine – Geriatrics	April 2020
Andrea Joughin	Medicine – Geriatrics	April 2020
Daniel Thornton	Medicine – Geriatrics	April 2020
Rahul Shrimanker	Medicine – Respiratory	May 2020
Margaret Presswood	Medicine – Palliative Care	August 2020
Natasha Lovell	Medicine – Palliative Care	August 2020
Isabel Baker	Core Clinical	August 2020
Cornelia Szecsei	Histopathology	September 2020
Claire Seller	Medicine – Respiratory	September 2020
Ben Ballisat	Anaesthetics	October 2020
Kate Nickell	Anaesthetics	October 2020
Andrew Smith	General Surgery	October 2020
David Minks	Radiology	November 2020
Libuse Pazderova	W&C	November 2020
Shigong Guo	NMSK	November 2020
Rina Adhikary	Acute Medicine	December 2020
Philip Harman	Rheumatology	January 2021
Luke Canham	Neurology	January 2021

Charles Roehr	NICU	February 2021
Anna Briggs	ICU	February 2021
Andrew Ray	ICU	February 2021
Christopher Williams	ICU	February 2021
Timothy Bates	Pathology	February 2021
Rachel Clancy	Plastic Surgery	March 2021
Delyth Badder	Pathology	March 2021

9. Use of the Trust Seal

Trust Board should note that the following contracts have been executed on behalf of the Trust under seal, in accordance with the Standing Orders and Scheme of Delegated Authority:

Contract	Date sealed
Retail Leases at Southmead Hospital (Licence for works)	22/01/2020
Lease for 35 Highmore Gardens, BS7	29/01/2020
Lease for 6B Derriford Business Park	30/01/2020
Frenchay Primary School Transfer	04/02/2020
Deed of Variation between NBT and The Hospital Co VE103	12/03/2020
Phase 5 of Frenchay Land Sale	18/03/2020
Frenchay Phase 2 Section 104 Agreement	26/03/2020
NEC3 ECC Contract for Nightingale Hospital Bristol	24/04/2020
Deed of Accord & Satisfaction	24/06/2020
Lease for Concord Medical Centre, Licence to Occupy, Licence Sign-off sheet	24/06/2020
Elgar shower room conversion	04/08/2020
Fetal Medicine, Malvern Ward – Capital Project	04/08/2020
Library Refurbishment Projects	24/09/2020
Retail Lease at Southmead Hospital (Amigo Retail Unit)	30/09/2020

Fire Integrity Project	27/10/2020
John James Charity Project (Phase 1)	27/10/2020
Beaufort House – Roof Replacement Works	27/10/2020
Contract for external structures at Nightingale	09/12/2020
Land Registry Transfer of Registered Title Phase 5 Transfer	17/12/2020
Additional Payment Deed with Redrow Homes Ltd	17/12/2020
Lease for residential accommodation for overseas nurses	20/01/2021
Lease for residential accommodation for overseas nurses	20/01/2020
Car Park Lease between NBT and Fertility Bristol Limited	16/02/2021
Deed of Novation for BIRU and Burden	16/02/2021
Licence for residential accommodation for overseas nurses	25/02/2021

10. Summary and Recommendations

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

NHS North Bristol NHS Trust

Report To:	Trust Board		
Date of Meeting:	25 March 2021		
Report Title:	Freedom to Speak Up Board Self-review & Update		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance Hilary Sawyer, Lead Freedom to Speak Up Guardian		
Executive/Non-executive Sponsor (presenting)	Xavier Bell, Director of Corporate Governance		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	None	None	None
*If any boxes above ticked, paper to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	
Recommendation:	That Trust Board: - Review, discuss and endorse the Trust Board FTSU self-review; - Note the ongoing work to refresh the Trust's FTSU vision, structure and network.		
Report History:	This self-review was discussed and endorsed by the Trust Management Team on 9 March 2021.		
Next Steps:	There will be a more detailed update on FTSU as part of the Trust's commitment to a Restorative Just Culture at the May meeting of Trust Board.		

Executive Summary

NHSI publishes guidance to help Trust boards reflect on their current position with regards to Speaking Up and the improvement needed to meet the expectations of its regulators (CQC, NHSE, NHSI) and the National Guardian's Office.

NBT has recently appointed a Lead FTSU Guardian, who has supported the Executive Team to complete the attached self-review tool (*Appendix 1*) on behalf of the Trust Board. The self-review tool is particularly focused on the Trust Board and the Executive Team as the group who will be held to account by regulators for the FTSU culture within the organisation; however, it has also been endorsed by the Trust Management Team.

Once comments and input from Trust Board is taken into account, this document will be used to inform the development of a refreshed FTSU vision, strategy and action plan. This will return to Trust Board in May alongside an update on the progress of the Trust's Just Culture work. The

aim is to make sure that the organisation's various patient safety initiatives, just culture work and freedom to speak up are all aligned and presented to staff in a manner that shows how closely linked and important they are to creating a culture focused on patient safety and empowered staff.

Appendix 2 sets out:

- a brief update on the work being undertaken by the Lead FTSU Guardian to refresh the Trust's network of FTSU Guardians and introduce the role of FTSU Champions, who will increase the reach and coverage of FTSU across the organisation; and
- a map showing next steps in the development and roll-out of FTSU across the Trust, including approval of the vision and action plan, ongoing proactive engagement and communications.

FTSU Board Self-review summary:

Expectation:	**Do we meet this now?**
Behave in a way that encourages workers to speak up	**Partially**
Demonstrate commitment to FTSU	**Partially**
Have a strategy to improve your FTSU culture	**Partially**
Support your FTSU Guardian	**Fully**
Be assured your FTSU culture is healthy and effective	**Partially**
Be open and transparent	**Fully**
Individual responsibilities	**Partially**

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. 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	National Guardian's Office (NGO) Guidance CQC Well-Led Key Lines of Enquiry
Financial implications	N/A
Other Resource Implications	N/A

Legal Implications	There are 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)	The Trust needs to improve the diversity and representation of all staff groups within the FTSU network. A proposed FTSU structure and action plan is under development and will be presented to TMT in May for endorsement, alongside a comprehensive Equality Impact Assessment.
Appendices:	Appendix 1: Trust Board FTSU Self-Assessment Appendix 2: FTSU Update & next steps

Freedom to Speak Up review tool for NHS trusts and foundation trusts

July 2019

How to use this tool

This is a tool for the boards of NHS trusts and foundation trusts to accompany the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with page numbers in the tool) *and the Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The executive lead should take updates to the board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the board's perception of itself. The board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net

NHSI are happy to support trusts on any aspect of the review process or the improvement work it reveals. Please get in touch with NHSI's Whistleblowing support team via rachel.clarke31@nhs.net.

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		February 2021	Insert review date		
Behave in a way that encourages workers to speak up					
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	~~Not~~ Partially ~~Fully~~	May '21	• Executive team are highly visible throughout the Trust, via informal walk-arounds and video communications • Chair provides regular video updates • Chief Executive regularly meets Staff Network leaders • Pulse survey's undertaken in 2020/21 • Board development programme 2019/20 allowed constructive challenge amongst Board members on behaviours and expectations • Executive team undertook "outward mindset" work via Arbinger Institute 2020, allowing constructive challenge and feedback	• Need to consider additional routes for testing our beliefs about our behaviours – e.g. 360 feedback, additional pulse surveys on culture and staff perceptions • Overt and clear commitment and Board pledges (including from NEDs) to FTSU/Restorative Just Culture (RJC). • Intolerance to bullying and harassment and incivility to be communicated in a variety of formats and forums. • New Trust Board/Executive Team development programme for 2021/22 • Development arrangements to be placed within wider programme across the Trust building culture of compassionate and inclusive leadership linked with Restorative Just Culture. Update to be presented to Board May 2021. • Trust to continue to invest in Health and Wellbeing programme and Recruitment and Retention programme, and support for building effective Teams.

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		February 2021	Insert review date		
					• Trust Leaders to complete new National Guardian Office/Health Education England FTSU training due in 2021 • New Lead FTSUG to develop baseline audit and follow-up Pulse surveys of Speaking Up awareness across the Trust, balanced with other surveys
Demonstrate commitment to FTSU					
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up • speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made	p6 Section 1 Section 2 Section 3	~~Not~~ Partially ~~Fully~~	May '21	• There are named Executive and Non-Executive leads for speaking up • Bi-annual FTSU report to Trust Board and to Trust Management Team • Board staff/patient stories at Trust Board (on hold due to Covid-19, but reinstated from November 2020) • Restorative Just Culture & Psychological Safety initiative at Trust Board August 2020 • Just Culture training rolled out in 2020 • Investment in leadership development (Peleton, NBT Leadership Programme etc.) • February 2020 assessment of FTSU model led to change in approach and adoption/investment in Lead Guardian model	• New Lead Guardian to develop a more detailed and proactive FTSU communications approach including re-iteration of responsibilities for staff (also cover in blog, induction training etc.) and including positive stories about speaking up at NBT • New Lead Guardian to work with Director of Corporate Governance on robust formal process for supporting individuals who have suffered detriment including review of claims by NED as per NHSI guidance for Boards • Evaluation of FTSU model to become an annual event • Staff speaking up experience to Board meeting (in person where possible) as per NHSI guidance – dedicate staff story session in May and November (when FTSU reports to Trust Board)

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		February 2021	Insert review date		
• the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.				• FTSU included in all Covid-19 daily operational updates • October focus on FTSU walk-arounds and awareness raising	
Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	P7 Section 4	~~Not~~ Partially ~~Fully~~	May '21	• Trust Board agreed an FTSU vision, strategy and action plan in August 2018 • Regular updates have been included in bi-annual FTSU reports, and agreed to include as an element in People Strategy • People Strategy launched in 2020 includes FTSU as part of its "Just Culture" and "Voice" focus within the "Great Place to Work theme • People Strategy involved wide engagement with stakeholders • FTSU reporting included as a measure of success in People Strategy	• New Lead Guardian and Director of Corporate Governance to develop refreshed FTSU vision and action plan Aligned to People Strategy, Trust Strategy and ED&I Strategy and RJC, to include engagement with stakeholders including staff & people/wellbeing team and present to Trust Board and Trust Management Team • Include diagnosis of the issues the Trust currently faces in relation to FTSU - audit of understanding and reach

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		February 2021	Insert review date		
Support your FTSU Guardian					
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non-executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes	p7 Section 1 Section 2 Section 5	~~Not~~ ~~Partially~~ Fully	May '21	• February 2020 board paper assessed suitability of current model. Trust Board agreed to move to Lead Guardian model with ring-fenced time • Lead Guardian employed at 0.6WTE from January 2020 • All existing Guardians have received appropriate NGO training. Quarterly meetings include review of case-studies from NGO • Quarterly Guardian meetings allow reflection on emotional aspects of role • Director of Corporate Governance and FTSU NED Lead meet with Guardians quarterly. Trust Chair attends meetings regularly • Director of Corporate Governance regularly meets with Chief Executive as FTSU Executive Lead • Executives have responded well when concerns raised within their Directorates, and supported the timely progression of cases • There is good access to patient safety and HR data (anonymised) for triangulation purposes (via wellbeing team)	• Induction, training & development plan in place for new Lead Guardian. Includes discussion with regional lead about mentor and emotional/wellbeing support • New Lead Guardian supported to attend quarterly Regional Guardian meetings and regular check-ins and has connected with local UHBW FTSUG • Monthly meetings planned with Lead NED and also with the Chair and CEO. Will also plan in with the Medical Director and Director of Nursing and Quality, and Chief Operating Officer • New Lead Guardian to attend Patient Safety Committee and Clinical Effectiveness & Audit Committee • Case-reviews to be incorporated into FTSU reports to Trust Board and TMT • Access to appropriate anonymised patient safety and employee relations data for triangulation to be arranged for Lead Guardian supported by Executive Lead

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		February 2021	Insert review date		
• the Guardian is enabled to develop external relationships and attend National Guardian related events				• FTSU Guardians in contact with regional colleagues and attend related events	
Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.	P8 Section 8 National policy	~~Not~~ ~~Partially~~ ~~Fully~~	May '21	• Current policy based on national template. • Has been reviewed with staff-side colleagues within last 12 months, and engagement across the organisation. Areas for update/amendment have been identified, but awaiting new national policy template before progressing	• Policy to be reviewed and updated as part of overall HR policy update process • Policy update also to be informed by feedback to be obtained from workers that have spoken up and following an audit using the NHSI policy section 8 on the effectiveness of all the speaking up channels as well as the whole speaking up culture.
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient	P8 Section 6	~~Not~~ ~~Partially~~ ~~Fully~~	May '21	• Bi-annual report includes triangulation with other data sources. This includes the staff survey, pulse surveys, happy app • Positive CQC feedback on format and content of reports • Feedback from individuals raising concerns is captured	• Future reports need to include more triangulation with specific patient safety data (e.g. Datix) • Case studies from NGO to be incorporated into Trust Board paper to provide additional assurance • Need to identify and support any workers who are unaware of the speaking up process or who find it

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		February 2021	Insert review date		
experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.				• Case studies are reviewed by Guardians on a quarterly basis	difficult to speak up through audit/pulse survey and in future from refreshed Guardian/Champion model
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	~~Not~~ ~~Partially~~ Fully	May '21	• Director of Corporate Governance (in capacity as FTSU Guardian) presents paper to Trust Board. Other Guardians invited to attend. • New Lead FTSU Guardian will present future papers	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	~~Not~~ ~~Partially~~ Fully	N/A	• Job description drafted with reference to national example JD, and in line with other FTSU Lead Guardian JDs in the NHS • Open, competitive recruitment process (internally advertised), multiple candidates interviewed	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		February 2021	Insert review date		
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	~~Not~~ ~~Partially~~ ~~Fully~~	May'21	• While Guardian network reviews NGO case studies on a quarterly basis, this is not currently covered in detail in Trust Board report	• Case studies from NGO (including gap analysis) to be incorporated into Trust Board paper to provide additional assurance • This updated review to be presented to Board in March as a gap analysis • 'Baseline' audit and pulse survey to be planned in next 12 months using elements of NHSI guidance
Be open and transparent					
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff	P9	~~Not~~ ~~Partially~~ Fully	May'21	• Plans to include additional detail in Annual Report for 2020/21 • Information and contact details on Intranet pages (regularly updated) • Discussions at Board on a 6-monthly basis • FTSU report published on website (as part of public Trust Board papers) • Engagement with other FTSU Guardians and the local and regional network • Advice and Guidance taken from Regional Lead on future FTSU structure arrangements • Best practice is shared locally between Guardians • Director of Corporate Governance (as FTSU Guardian) engages at regional events	• New Lead Guardian engaging at Regional level and will present any guidance to Board

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		February 2021	Insert review date		
Individual responsibilities					
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	Section 1	~~Not~~ Partially ~~Fully~~	May'21	• Covered as part of Director of Corporate Governance appraisal (as Exec Lead) • Covered in NED FTSU Lead's appraisal	• Plans to cover in more detail in future appraisals, with reference to NGO/NHSI guidance on specific roles • Roles and responsibilities for FTSU in NHSI/NGO guidance to be discussed by Lead Guardian as part of 1:1s with Executive Team members

NBT FTSU– March 2021

Open, Just Culture
Ambitious, Proactive
Safe, Trusted
Empowered, Inclusive
Resourced
Responsive, Effective

NHS
North Bristol
NHS Trust

Current FTSU work streams:

- Vision, strategy to May Board strongly aligned with Restorative Just Culture (RJC)
  – giving ALL staff a confident voice early-on

Communications refresh - new Lead Guardian

- Soft launch **March** (including HEE e-learning)
  - Further comms with RJC from June
- **Existing FTSU network arrangement review**
- **Board self-review tool/gap analysis**
- May Trust Board 6 monthly FTSU data report

NBT FTSU Guardian & Champion Network Model

NHS North Bristol NHS Trust

Current: Excellent team of experienced Guardians

Challenges:

- no ring-fenced time
- limited diversity of protected characteristics
- relatively senior staff
- All data not held centrally – minimals oversight, themes

Vision: Refresh

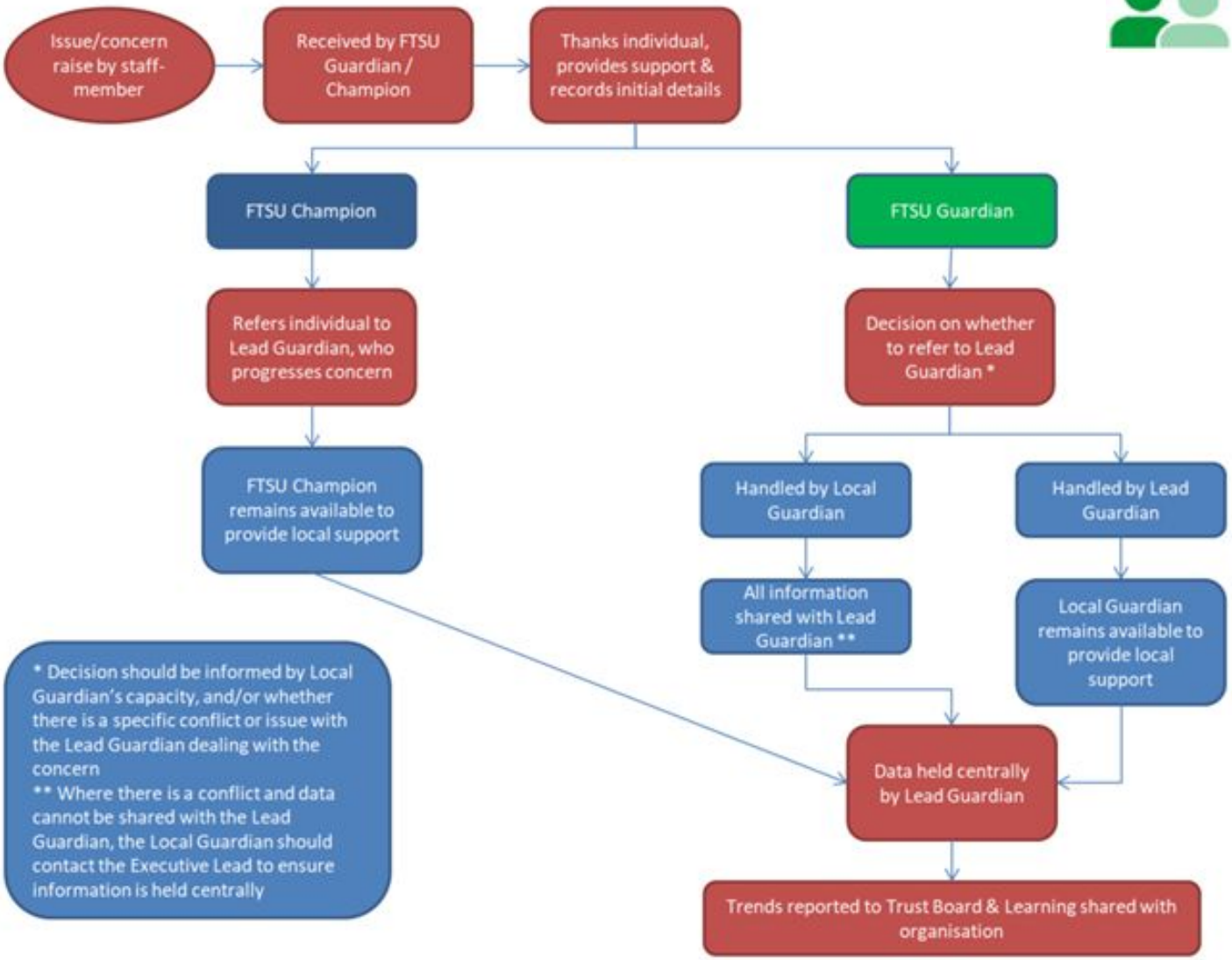
- Hilary as Lead – ring-fenced time
- Xavier stepping back as Guardian – remains Exec Lead
- Small number of fully-trained Guardians – continuing
- New Champions: To support, signpost, improve reach, representation – job roles, service, staff groups, diversity
- Data held centrally - oversight, transparency

NBT FTSU Champions

- To improve reach, representation – job roles, service, staff groups, diversity – ensure approachability, trust
- Raise awareness, signpost, support staff, give confidence
- Ensure satisfaction/no detriment down the line
- Welcome EOI through networks, staff groups, HR Partners, DMTs, etc.
- Champions network (support, training, quarterly meetings and CPD) - linked in with Guardians' network meetings
  - Potential future Guardians (succession)

Thoughts/Concerns -welcome

Proposed Process



NBT FTSU Work Plan Feb to May 2021

NHS North Bristol NHS Trust

PDSA

	Improve Understanding and Value of Speaking Up	Agree Vision and Strategy Aligned to RJC	Improve Visibility and Reach	Review data, learning and refresh
Activities	Clarify simple message	**Self-review and FTSU network proposal to Feb Exec team then March Board**	Comms plan for 2021 in place - will evolve	Review triangulated data and trends, discuss themes including EDI aspects
	Refreshed Comms plan- first phase - Poster, LINK page, Blogs, Video	**Align to RJC plan - strong Joint Vision**	Walkarounds with Chair/CEO/ED/NED/DMTs/Guardians - Board pledge to FTSU and RJC	Review number of concerns, and number anon concerns
	Introduce Lead FTSU position and link in with stakeholders and services	**Vision, strategy and action plan, self-review to May Board (with RJC)**	Issue EOI for Champions role and appoint	**6 monthy report to May Board meeting**
	Promote free e-learning for workers and line-managers	Agree local FTSU network SOP and Champions role outline	Update induction material	Case studies/staff stories to Board meeting and discuss how to operationalise learning
	Baseline audit of awareness of FTSU/Speaking Up	**Agree Vision and Strategy**	Listening events	Invite staff feedback on modelling from Board, Exec, Leaders, management
	Request strong message to commitment from Exec team and Board on SU in messaging	Ensure strong commitment/pledges and role-modelling from Board	Continue to engage with teams/dep'ts/ stakeholders/networks/workforce group	FTSU Pulse survey - reach, understanding, effectiveness
Outcomes	Staff clearly understand what Speaking Up is	Staff tangibly feel and see the Vision	Increased reach of awareness	Themes, trends and issues understood
	Staff aware of Lead FTSU Guardian, Guardian team and ED/NED	Staff start to feel culture building in every interaction and confidently engage in communicating and feeding back	Increased confidence that Trust actively wants to listen	Learning needed agreed
	Good communication with stakeholders/services	Line/middle managers confident in culture and value	Increased confidence in staff in process and value of speaking up	Value of speaking up understood and communicated
	e-learning communicated	Improve staff wellbeing	Increased understanding of issues, concerns and themes	Staff experience heard
	DMTs, managers aware and engaging	Constructive improvement and learning from SU and incidents	Increased reach across NBT and staff groups/job roles/Divisions	Improve in staff survey results - FTSU index score,

Report To:	Trust Board – Public Session		
Date of Meeting:	25 March 2021		
Report Title:	'Renew and Recover' Framework Update		
Report Author & Job Title	Lisa Whitlow, Associate Director of Performance Liz Perry, Director of People		
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 Jacqui Marshall, Director of People and Transformation		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is asked to note the contents of this report.		
Report History:	This report was received by the Trust Management Team on 9 March 2021.		
Next Steps:	Further work is to be undertaken with regards to the development of the 'Renew and Recover' framework, alongside the 2021/22 Operational Business Planning round.		

Executive Summary

This report provides an update on the plans to develop a 'Renew and Recover' framework with a particular focus on the resumption of elective activity quickly, efficiently and safely and ensuring equity of access across the BNSSG system, whilst recognising the immense commitment and effort given by staff through the pandemic and ensuring they are supported in their own personal and team recovery.

This work is being led by the Chief Operating Officer.

A key focus of the 'Renew and Recover' Framework is to support to staff in their health and wellbeing, recognition and professional fulfilment.

An Elective Recovery Programme Project Initiation Document (PID) is being produced to complement the Operational Business Plan for 2021/22 and future business planning rounds. This work is being led by the Divisional Operations Director for ASCR and NMSK and focusses on the recovery of Surgical/Theatres activity.

The purpose of the PID is to set out options available at a strategic level in recovering the elective position to pre-COVID-19 levels and beyond. Focus will initially be on options for the next 1-2 years with some reference to use of capacity and opportunities in years 3+.

As part of the 'Renew and Recover' approach, better supporting innovation will ensure the Trust captures and sustains the benefits of changes implemented through the pandemic response and

also fosters and encourages further innovation. A number of projects are currently in progress, with further discussions planned at the Trust's Operational Management Board (OMB) in April. To support the renewal and recovery of services, the de-escalation of command and control, and the move to formalise system working, the Trust will be harnessing the opportunity to promote dialogue as a way of empowering teams to feel control and ownership of their services again and feel positive about the future at NBT. A three month campaign of open conversation between staff, hand in hand with wraparound opportunities on health and wellbeing and innovation called "Reflect. Renew. Re-energise: The Big Conversation" will be launched.	
Strategic Theme/Corporate Objective Links	**1. Provider of high quality clinical care** a. Improve access to elective services b. Delivery of the quality priorities set through the Quality Account, the Quality Strategy and the NHS Patient Safety Strategy c. Deliver our financial plan **2. Developing Healthcare for the future** a. Use new technologies to deliver exceptional healthcare b. Mobilise capacity to deliver 'One NBT' transformation plan over the next four years **3. Employer of choice** a. Build teams that are inclusive and diverse. b. Improve the health, wellbeing and safety of our staff. c. Develop a resilient workforce.
Board Assurance Framework/Trust Risk Register Links	The report relates to the following BAF Risk: COV2: COVID-19 – residual risk score 3 x 5 = 15 SIR2: Workforce shortages – residual risk score 3 x 4 = 12 SIR14: Impact of sustained demand and acuity of patients on outcomes and patient safety/experience – residual risk score 3 x 4 = 12
Other Standard Reference	CQC Standards.
Financial implications	Not covered in this paper.
Other Resource Implications	Not covered in this paper.
Legal Implications including Equality, Diversity and Inclusion Assessment	Not applicable.
Appendices:	Appendix 1: Psychological Referrals into NBT Staff Psychology Team Appendix 2: Tiered Pathway of Psychological Support Appendix 3: Four Pillars of Recovery

1. Purpose

1.1 This report provides an update on the plans to develop a 'Renew and Recover' framework with a particular focus on the resumption of elective activity quickly, efficiently and safely and ensuring equity of access across the BNSSG system, whilst recognising the immense commitment and effort given by staff through the pandemic and ensuring they are supported in their own personal and team recovery. This work is being led by the Chief Operating Officer.

2. Background

2.1 The Trust has now responded to three waves of COVID-19 surges in hospital admissions, each of which have had an adverse impact on Elective capacity and activity.

2.2 In addition, it is recognised that staff have been significantly impacted by the sustained pressures of responding to the COVID-19 pandemic, maintaining services for non-COVID-19 patients, rapidly changing ways of working, alongside the challenges the pandemic has presented for individuals in their home lives.

3. 'Renew and Recover' Framework

3.1 The first meeting to discuss the development of the 'Renew and Recover' framework was held on 25 February 2021. The meeting was well attended by Senior Leaders from across the organisation including Executives, Clinical Divisions (both management and clinical staff) and Corporate Deputies.

3.2 The intention of these meetings is to ensure co-design of the 'Renew and Recover' framework.

3.3 Resources/literature from a range of national and international sources was shared in advance of the meeting to help shape and steer discussions.

3.4 Initial feedback from the group was across the following themes:

- Staff recognition: letters to staff; certificates; and job satisfaction.
- Hygiene factors - retaining and building on positive improvements/benefits of new ways of working: home working; agile working; time away from the workplace; access to food and drink; new employment offers; and working at pace with quick/streamlined decision-making.
- Need for wider engagement: through Pulse survey; at Divisional and Team levels; via specific focus groups; and using the rich data available in the staff survey (March/April).
- Returning to Service Line Management (SLM) way of working: empowerment; ownership; influence over service developments; professional development; and fulfilment and job satisfaction.

3.5 Feedback gained during the meeting will be used to set future agendas and the next steps in the development of the framework.

3.6 To complement this work, a Wave 2 and 3 of the COVID-19 pandemic response debrief was undertaken on 11 March 2021.

3.7 Alongside the 'Renew and Recover' framework, there is a need to remain agile in the response to the COVID-19 pandemic, as the Trust plans to continue to manage COVID-19 patients for the foreseeable future. This includes continued tracking of COVID-19 hospital admissions against predictive modelling and remodelling where necessary; a particular focus on 'hot spots' with limited capacity such as Maternity and ward 8b that cares for Renal dialysis patients; and maintaining access to 1 'blue' ward or zone within the ward to respond to COVID-19 demand.

3.8 The pandemic response plan will be refreshed to ensure clear documentation and the inclusion of COVID-19 surge triggers should there be a need to stand-up Command and Control structures again. This will be co-ordinated by the Emergency Preparedness, Resilience and Response (EPRR) Team.

3.9 In order to reinvigorate the SLM way of working a series of four 'Senior Leadership Community' masterclasses will be held across 2021/22. In addition, six Clinical Divisional specific, co-designed masterclasses will be held with each Division across the duration of 2021/22; targeted based on individual Divisional needs.

3.10 Clear links will be made to the Trust Strategy to ensure alignment with the overall Trust direction of travel and long-term plans.

4. Elective Care Recovery Programme

Theatres

4.1 An Elective Care Recovery Programme Project Initiation Document (PID) is being produced to complement the Operational Business Plan for 2021/22 and future business planning rounds. This work is being led by the Divisional Operations Director for ASCR and NMSK and focusses on the recovery of Surgical/Theatres activity.

4.2 The purpose of the PID is to set out options available at a strategic level in recovering the elective position to pre-COVID-19 levels and beyond. Focus will initially be on options for the next 1-2 years with some reference to use of capacity and opportunities in years 3+.

4.3 The PID will cover the following (this is not an exhaustive list):

- Core capacity;
- Efficiency/productivity opportunities and goals;
- Mitigations;
- Programme of waiting list validation including more in depth understanding of Removals Other Than Treatment (ROTT) rates;
- Options for the development of an Elective Care Centre;

- Impact on demand of commissioning policies and national guidance on Evidence-based Interventions (EBI), which has been expanded to include an additional 31 procedures of 'limited value';
- Clinical prioritisation of cases in line with Royal College of Surgeons guidance alongside the need to reduce the extended wait times for our longest waiting patients;
- Workforce requirements to support delivery; and
- Support to patients whilst they wait including Shared Decision Making conversations and access to online resources.

Outpatients

4.4 Discussions have commenced in the Outpatients Board in February with regards to the priorities for 2021/22 and transformation plans within the Trust and across BNSSG.

4.5 A huge amount of transformation has been delivered at pace in 2020/21 as a result of responding to the pandemic, for example, implementation of Attend Anywhere video consultations. Future transformation plans are extremely dependent on further digital solutions including the procurement of a digital patient platform.

4.6 Part of the 'Renew and Recover' framework needs to be taking stock of the changes made to date. To facilitate this, the Trust will be utilising a patient survey implemented by University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) to seek patients' opinions on the new ways of delivering services.

5. Looking after our people

5.1 A key aspect of the 'Renew and Recover' framework is looking after our people.

5.2 There is a need to balance the needs of both patients and staff ensuring operational delivery and recovery of the Elective programme and the wellbeing and recovery of staff. This recovery will be underpinned by innovation, empowerment and development opportunities.

5.3 Evidence shows us that the psychological impact of pandemic waves on mental health of healthcare workers and the consequent absence occurs after the wave has subsided, sometimes months or years later. This was seen within the Trust, with referrals to staff Psychology Services highest between June and October – i.e. between waves 1 and 2/3 (see **Appendix 1**). It is anticipated that there will be a further, larger wave of demand in the coming few months and lasting for months to come.

5.4 The evidence-led approach to supporting staff is to provide a tiered pathway of support that prioritises team, peer and manager support for staff, but also makes provision for acute support, e.g. PTSD (see **Appendix 2**). The Trust is

further bolstering this support with an additional £274k of psychologist resource for staff, funded by Southmead Hospital Charity in August 2020, and another £130k currently being bid for from NHS Charities together for further psychologist support. This team support is being delivered through a mixture of bespoke and standard team, manager and 1:1 sessions.

5.5 The wider wellbeing programme is also expanding with plans for enhanced financial wellbeing, support for physical wellness and lifestyle support, and the provision of 5 Calm Rooms (decompression spaces) within Brunel building funded by Southmead Hospital Charity in April, followed by further spaces across the retained estate over the coming months.

5.6 It is understood that staff are fatigued by the response to the pandemic and there are concerns that there are "pent-up leavers" across the BNSSG system, with turnover rates that have dropped during the pandemic being in part due to lack of opportunity to move. The average reduction in turnover for the Trust has been 2.2% less comparing March 2020-December 2020 to the same period in 2019.

5.7 In addition, there has been a reliance on staff who have returned to their profession, returned from retirement, volunteered, etc. who may not intend to stay working within the NHS, once the initial response to the pandemic is deemed to be over.

5.8 The Mass Vaccination campaign has opened up previously untapped talent pools. Over the next 3 months the Trust will explore opportunities for how some of these people can be brought into more permanent NHS career paths.

5.9 To further support the talent pipeline, the Trust will participate in targeted initiatives (e.g. Traineeships and Kickstart) aimed at supporting unemployed people from the local community into NHS Careers (national funding has already been secured for these initiatives).

5.10 Demonstrating commitment to personal development is also going to be important and the Trust is applying lessons learned over the last year as to how more blended learning events can be introduced that allow the Trust to make more efficient use of face-to-face delivery time.

5.11 The One NBT Leadership programme will be re-launched in April.

5.12 Workforce recovery has been described within four pillars of: Health and Wellbeing; Retention; Supply and Demand; and Leadership (see **Appendix 3**).

6. Supporting innovation

6.1 A significant amount of change and innovation took place during the pandemic response. As part of the 'Renew and Recover' approach, better supporting innovation will ensure the Trust captures and sustains the benefits of these changes. Innovation can be instrumental in empowering clinical teams, supporting staff to continuously develop, and provides a positive

legacy. The following projects are currently in progress, with further discussions planned at the Trust's Operational Management Board in April:

- An innovation competition 'Next Big Thing' to launch across the organisation in spring 2021.
- The Trust is in the final stage of application to be granted a Health Foundation Award to become an Innovation Hub to support front-line staff to adopt proven innovations.
- An Artificial Intelligence (AI) Framework is in development to better support teams who want to adopt AI technologies. Learning is being taken from recent NHSX pilot projects in ASCR and Medicine. The intention is to create a simple process for clinical innovators with support from the Trust's Transformation Team.
- Creating a network of innovators within the Trust with access to expertise from neighbouring organisations, the West of England Academic Health Science Network (WEAHSN) and the University of the West of England (UWE) Robotics Lab.

7. Enhancing dialogue

7.1 To support the renewal and recovery of services, the de-escalation of command and control, and the move to formalise system working, there is a big opportunity to promote dialogue as a way of empowering teams to feel control and ownership of their services again and feel positive about the future at NBT.

7.2 Labelled "Reflect. Renew. Re-energise: The Big Conversation", The People and Transformation Directorate are planning to facilitate a three month campaign of open conversation between staff, hand in hand with wraparound opportunities on health and wellbeing and innovation.

7.3 Launched in late March (**date to be confirmed**) marking the anniversary of when the first wave of the pandemic escalated and command and control stepped up, we are proposing a three phased approach:

- Reflect: taking stock of what we've experienced and achieved.
- Renew: assessing what we stop, start and do more of to get the best services for our patients.
- Re-energise: energising our strategic vision in NBT and BNSSG.

7.4 As much as possible, this will involve localised engagement such as informal Executive Team members going 'back to the floor', facilitated psychology and developmental sessions for teams, and toolkits and materials to empower local managers.

7.5 Sequenced after the publication of the 2020 staff survey results on 11 March, the Trust will also initiate a programme of fortnightly, centrally-coordinated Pulse surveys taking a temperature check on what people are thinking and feeling.

7.6 In an iterative process, each set of questions will be based on the results of the last so that the Trust is led by what staff tell us rather than purely what we corporately want to know. Using fixed scales covering staff engagement, experience and satisfaction, initial questions could include: How are you feeling today? How happy are you at work? Have you received meaningful recognition for doing good work over the past year? To what extent is my health and wellbeing a top priority for NBT?

8. Next Steps

8.1 Further work is to be undertaken with regards to the development of the 'Renew and Recover' framework, alongside the 2021/22 Operational Business Planning round.

8.2 Guidance and supporting frameworks for managers and teams are being developed as part of the 'Renew and Recover' framework against the three areas of staff support referenced above:

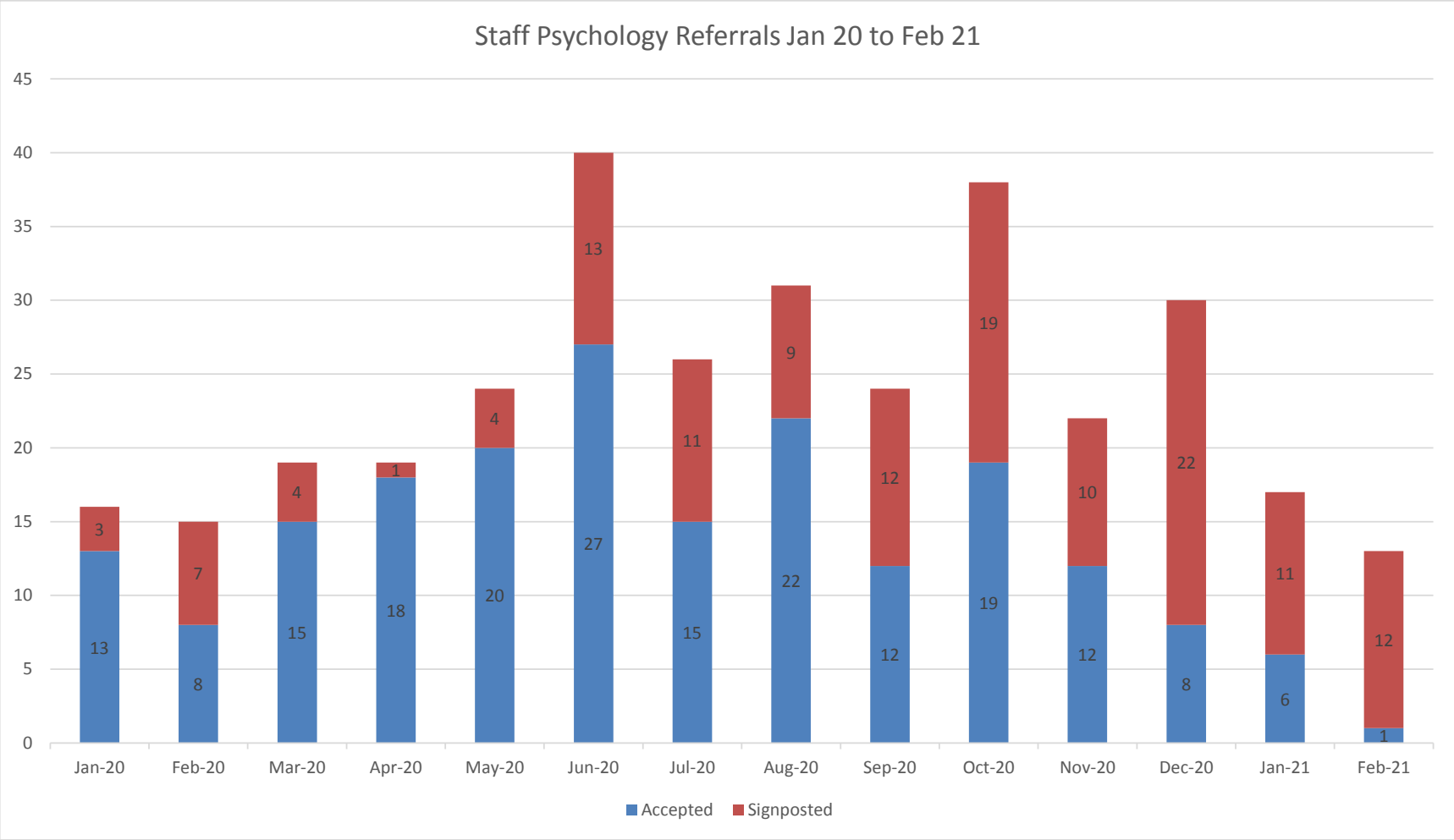
- Staff recognition;
- Hygiene factors; and
- SLM and professional fulfilment and development.

8.3 The detail will be created with key stakeholders to ensure inclusion of what is important to staff and will build in key enablers already in place e.g. the health and wellbeing programme.

9. Recommendations

9.1 The Trust Board is asked to note the contents of this report.

Appendix 1: Psychological Referrals into NBT Staff Psychology Team



Appendix 2: Tiered Pathway of Psychological Support

Appendix 3: Four Pillars of Recovery

Recovery Conversations

Recover – supporting people in whatever way is right for them
Re-connect – enabling home workers and staff under pressure to reconnect with colleagues
Re-new – learn from Covid to continue to build system working
Re-energise – a chance to move on with a clear focus

Health and Well Being

- Mental health hub and signposting
- Psychologists support
- PTSD support (national and local)
- Physical health eg physio and podiatry
- Yoga/meditation
- Financial/debt advice
- Dealing with impact on family
- Safe and compassionate, culturally sensitive space to heal

Retention

- "Itchy feet" offer to staff at risk of leaving
- Refreshing our flexible working options
- Recovery leave
- Career conversations
- Communication, engagement/ messaging of the offer to staff (EVP)
- Development opportunities and CPD

Supply and Demand

Demand:

- Annual leave – additional and accrued
- CPD and stat and man backlog
- Sickness - stress and long Covid
- "Pent-up" leavers
- Flexible working

Supply

- Mass Vacc workforce
- Support worker campaign
- International recruits

Leadership

- Clarity about the balance between operational delivery and recovery
- Materials and menu of options for managers
- Communication, engagement/ messaging
- Re-engaging with teams following remote working
- Awareness of disproportionate impact on some staff

Report To:	Trust Board		
Date of Meeting:	25 March 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

March 2021 (presenting February 2021 data)

CONTENTS

North Bristol Integrated Performance Report

Domain	Description	National Standard	Current Month Trajectory (RAG)	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-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%	79.90%	72.43%	80.16%	96.00%	95.47%	94.74%	93.47%	86.90%	87.76%	82.07%	77.95%	73.21%	68.51%	73.33%		77.01%	78/113	
	A&E 12 Hour Trolley Breaches	0	0	48	2	0	0	0	0	0	0	12	3	52	206	7		0 - 195	8/23	
	Ambulance Handover < 15 mins (%)	100%	95.30%	91.06%	95.41%	94.72%	97.38%	98.50%	98.07%	98.01%	76.69%	68.06%	67.67%	57.76%	54.95%	65.81%				
	Ambulance Handover < 30 mins (%)	100%	99.17%	98.15%	99.37%	99.53%	99.56%	99.96%	99.76%	99.83%	96.04%	93.49%	93.75%	88.43%	83.80%	93.37%				
	Ambulance Handover > 60 mins	0	0	2	1	0	0	0	0	0	4	33	26	82	180	57				
	Stranded Patients (>21 days) - month end			155	120	58	57	74	82	95	114	247	141	144	125	130				
	Bed Occupancy Rate		93.00%	98.87%	82.25%	50.84%	58.18%	77.11%	82.97%	87.51%	92.30%	94.19%	92.38%	95.10%	95.86%	92.74%				
	Diagnostic 6 Week Wait Performance	1.00%	20.97%	5.60%	10.25%	61.24%	65.94%	46.56%	28.98%	32.36%	29.58%	27.47%	26.73%	32.37%	33.04%	27.20%		33.34%	148/252	
	Diagnostic 13+ Week Breaches	0	0	113	114	402	2292	3161	1886	1979	1998	1697	1427	1487	1420	1358			128/211	
	Diagnostic Backlog Clearance Time (in weeks)			0.1	0.2	1.2	2.7	2.0	1.0	1.0	0.9	0.9	0.8	1.0	1.0	0.8				
	RTT Incomplete 18 Week Performance	92.00%	63.94%	82.95%	80.02%	71.82%	64.51%	58.20%	58.48%	63.96%	70.46%	74.00%	74.35%	73.18%	71.62%	70.65%		66.14%	188/390	
	RTT 52+ Week Breaches	0	2893	17	43	130	275	454	648	797	1001	1092	1249	1418	1817	2108		0 - 10663	167/274	
	Total Waiting List		34435	29552	28516	25877	25518	25265	27512	28814	29387	30214	29632	29611	29759	29716				
	RTT Backlog Clearance Time (in weeks)			3.0	3.2	4.4	6.9	10.3	9.5	7.6	6.4	5.4	4.8	4.9	5.1	5.7				
	Cancer 2 Week Wait	93.00%	91.26%	89.94%	91.25%	76.01%	93.23%	97.29%	88.11%	78.05%	76.30%	89.01%	78.65%	63.72%	60.03%	-		83.39%	129/133	
	Cancer 2 Week Wait - Breast Symptoms	93.00%	96.04%	89.63%	81.82%	81.25%	98.28%	96.62%	96.05%	75.18%	54.04%	87.76%	61.07%	33.77%	49.64%	-		62.67%	69/104	
	Cancer 31 Day First Treatment	96.00%	93.77%	95.36%	97.71%	92.96%	85.64%	95.35%	97.51%	95.78%	90.31%	92.68%	97.01%	95.47%	89.84%	-		94.01%	93/116	
	Cancer 31 Day Subsequent - Drug	98.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-		98.01%	1/52	
	Cancer 31 Day Subsequent - Surgery	94.00%	82.83%	70.89%	85.09%	75.76%	79.73%	86.96%	92.13%	89.86%	85.19%	87.76%	91.95%	92.22%	77.66%	-		86.33%	57/73	
	Cancer 62 Day Standard	85.00%	86.30%	61.31%	74.15%	73.53%	69.01%	70.12%	75.31%	73.10%	70.07%	72.87%	75.76%	77.39%	65.91%	-		71.18%	94/137	
	Cancer 62 Day Screening	90.00%	85.71%	67.27%	83.95%	85.07%	46.67%	28.57%	44.44%	66.67%	100.00%	77.14%	76.92%	86.36%	78.57%	-		79.78%	38/66	
	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%		83.22%	84.09%	84.07%	84.62%	85.89%	83.39%	82.78%	82.99%	84.18%	83.80%	82.98%	81.69%	84.17%				

North Bristol Integrated Performance Report

Domain	Description	National Standard	Current Month Trajectory (RAG)	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Trend
Quality Patient Safety & Effectiveness	5 minute apgar 7 rate at term		0.90%	0.7%	0.7%	1.3%	1.6%	1.0%	0.6%	0.2%	0.2%	0.6%	0.7%	0.7%	0.5%	0.5%	
	Caesarean Section Rate		28.00%	34.0%	33.4%	31.5%	33.9%	36.7%	34.6%	39.0%	35.0%	36.4%	31.2%	41.9%	35.1%	38.7%	
	Still Birth rate		0.40%	0.0%	0.4%	0.2%	0.0%	0.0%	0.4%	0.2%	0.4%	0.0%	0.2%	0.6%	0.5%	0.2%	
	Induction of Labour Rate		32.10%	41.4%	40.8%	40.6%	38.9%	34.9%	35.4%	38.6%	38.9%	36.6%	39.8%	37.6%	39.8%	33.8%	
	PPH 1000 ml rate		8.60%	9.2%	9.7%	8.7%	12.9%	11.5%	11.2%	10.7%	8.0%	10.4%	14.2%	8.9%	9.8%	11.6%	
	Never Event Occurance by month	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	
	Serious Incidents			9	10	2	2	4	7	5	4	5	6	4	3	2	
	Total Incidents			1118	853	597	679	833	948	1028	1056	1202	1049	1040	1007	663	
	Total Incidents (Rate per 1000 Bed Days)			45	39	45	43	46	47	49	47	50	49	48	41	31	
	WHO checklist completion		95%	99.30%	99.30%	99.50%	99.50%	99.60%	99.70%	99.70%	99.60%	99.60%	99.40%	99.95%	99.79%	99.94%	
	VTE Risk Assessment completion		95%	94.96%	95.35%	93.45%	93.89%	94.52%	95.40%	94.58%	94.64%	94.66%	94.02%	94.96%	94.48%	93.51%	
	Pressure Injuries Grade 2			17	29	24	16	13	8	14	13	28	17	17	17	27	
	Pressure Injuries Grade 3		0	1	1	0	0	0	0	0	1	1	0	0	0	0	
	Pressure Injuries Grade 4		0	0	0	0	0	0	0	0	0	0	0	0	1	0	
	Falls per 1,000 bed days			8.54	7.34	10.14	8.84	8.09	7.10	7.71	6.69	9.56	8.93	8.54	9.62	8.64	
	#NoF - Fragile Hip Best Practice Pass Rate			60.00%	70.91%	2.13%	10.20%	9.43%	47.46%	63.64%	54.17%	77.27%	75.61%	63.64%	35.56%	-	
	Admitted to Orthopaedic Ward within 4 Hours			54.72%	55.36%	85.11%	87.76%	83.02%	86.44%	66.67%	79.17%	67.44%	53.66%	57.14%	35.56%	-	
	Medically Fit to Have Surgery within 36 Hours			71.70%	83.93%	85.11%	67.35%	79.25%	74.58%	72.73%	68.75%	86.05%	80.49%	79.59%	55.56%	-	
	Assessed by Orthogeriatrician within 72 Hours			92.45%	100.00%	95.74%	97.96%	98.11%	98.31%	90.91%	87.50%	93.02%	95.12%	79.59%	75.56%	-	
	Stroke - Patients Admitted			72	97	71	72	79	84	63	83	86	79	80	70	61	
	Stroke - 90% Stay on Stroke Ward		90%	87.10%	86.67%	87.10%	81.50%	86.20%	80.00%	93.20%	88.00%	84.62%	81.97%	80.88%	58.18%	-	
	Stroke - Thrombolysed <1 Hour		60%	66.67%	66.67%	50.00%	Nil	85.70%	50.00%	60.00%	69.00%	72.73%	50.00%	33.33%	50.00%	-	
	Stroke - Directly Admitted to Stroke Unit <4 Hours		60%	54.84%	58.44%	74.19%	64.80%	88.10%	73.60%	63.30%	69.10%	61.73%	63.64%	47.83%	35.59%	-	
	Stroke - Seen by Stroke Consultant within 14 Hours		90%	80.60%	80.00%	79.41%	94.34%	94.00%	91.00%	89.00%	80.00%	86.00%	89.71%	85.92%	87.30%	-	
	MRSA	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	
	E. Coli		4	4	6	2	3	2	5	7	8	4	5	3	3	1	
	C. Difficile		5	2	2	1	4	2	4	3	5	7	5	7	4	9	
	MSSA		2	2	3	1	2	1	4	2	1	4	6	2	3	3	
Quality Caring & Experience	Friends & Family - Births - Proportion Very Good/Good			-	-	-	-	-	-	-	-	-	-	-	-	-	
	Friends & Family - IP - Proportion Very Good/Good			-	-	-	-	-	-	-	-	-	-	93.24%	94.06%	95.72%	
	Friends & Family - OP - Proportion Very Good/Good			-	-	-	-	-	-	-	-	-	-	95.60%	95.71%	95.29%	
	Friends & Family - ED - Proportion Very Good/Good			-	-	-	-	-	-	-	-	-	-	90.96%	87.49%	89.21%	
	PALS - Count of concerns			108	104	45	105	49	75	51	95	73	99	66	62	71	
	Complaints - % Overall Response Compliance		90%	88.57%	88.89%	88.46%	100.00%	98.30%	98.08%	97.06%	98.04%	94.44%	92.68%	94.64%	81.48%	84.38%	
	Complaints - Overdue			2	0	2	1	0	0	0	0	2	2	0	0	0	
	Complaints - Written complaints			51	26	24	27	40	59	53	46	48	39	23	37	43	
Well Led	Agency Expenditure ('000s)			869	1112	613	386	364	555	822	687	875	900	1043	1234	544	
	Month End Vacancy Factor			7.56%	6.76%	4.91%	4.93%	5.39%	6.05%	5.14%	3.82%	3.83%	3.38%	4.59%	3.80%	3.65%	
	Turnover (Rolling 12 Months)		13.60%	13.68%	13.25%	12.82%	12.53%	12.35%	13.10%	13.41%	13.25%	12.78%	12.74%	12.73%	12.89%	12.60%	
	Sickness Absence (Rolling 12 month -In arrears)		4.10%	4.46%	4.46%	4.53%	4.56%	4.53%	4.46%	4.46%	4.44%	4.41%	4.44%	4.38%	4.47%	-	
	Trust Mandatory Training Compliance			87.95%	87.95%	87.42%	87.23%	87.07%	85.24%	86.77%	86.26%	86.45%	86.07%	85.79%	85.90%	85.91%	

Urgent Care

Four-hour performance improved, but the Trust did not achieve the performance trajectory of 79.90% with performance of 73.33% in February. The Trust conceded 57 ambulance handover delays and seven 12-hour trolley breaches, which was an improvement on January's position. The improved position in February reflects the reduction in COVID-19 admissions, however, staffing pressures, segregated care and IPC measures continued to negatively impact flow, affecting performance and preventing achievement of trajectory. The Trust remains in the third quartile for ED performance when compared nationally. Performance is expected to improve in March.

Elective Care and Diagnostics

The RTT waiting list remained static in February with demand growth offsetting increasing clock stops. There were 2108 patients waiting greater than 52 weeks for their treatment in February against a revised trajectory of 2893. The continued increase in breaches is due predominately to reduced elective activity as part of the ongoing COVID-19 response and the impact of the application of the Royal College of Surgeons Clinical Prioritisation guidance. Nationally, the Trust positioning was static in January, remaining in the third quartile. Diagnostic performance improved in February with improvement reported for most test types in-month; Non Obstetric Ultrasound and Urodynamics reported the most significant improvement.

Cancer wait time standards

The TWW standard further deteriorated in January and continues to report under trajectory; the majority of breaches were in Breast, Colorectal, Upper GI and Skin. The 31-Day standard deteriorated more significantly, not achieving the recovery trajectory in January or the national standard and remains in the fourth quartile when compared nationally. The 62-Day standard failed both the recovery trajectory and the national standard, with the level of deterioration having moved the Trust from the second to the third quartile in January when compared nationally. It is anticipated that the Trust will continue to fail TWW in February largely due to breast capacity. The Trust is forecasting achievement of the 31-Day target, but there are continued performance problems with the remaining standards.

Quality

A revised Maternity data set is being developed, which will provide assurance across a range of areas and will provide more meaningful information as the data builds across following months. There have been no reported Grade 3 or 4 pressure injuries in February. C. difficile case numbers remain above trajectory with late sampling and documentation accounting for the majority of the lapses.

Workforce

The Trust turnover saw a small reduction in February to 10.95% (excluding the impact of staff temporarily employed during the COVID-19 response). The Trust vacancy factor decreased to 3.65% due to the ongoing enhanced HCA resourcing plan, which delivered a net gain of 23.70 WTE in this group. Temporary staffing demand decreased by 12% in February (equivalent to 136 WTE) in line the reduction in COVID-19 related staff absence. Annual sickness absence saw limited change in January; however the mix of absence continues to see a reduction in short-term sickness and an increase in long-term sickness, predominantly relating to COVID-19 sickness and our People Team continue to develop support resources for managers accordingly.

Finance

NHSI/E suspended the 2020/21 financial framework due to COVID-19 response preparations. The revised financial framework for months 1 to 6 required the Trust to breakeven against an NHSI/E calculated income level and to recover costs incurred in dealing with the COVID-19 pandemic in line with national guidance. From 1 October 2020 a new financial framework is now in place that requires the Trust to operate within a fixed financial envelope (plus a small number of specified "outside envelope" cost recoveries) and to deliver a deficit that is consistent with the financial forecast submitted on 22 October 2020.

RESPONSIVENESS
SRO: Chief Operating Officer
Overview

Urgent Care

The Trust reported a four-hour performance of 73.33% in February, not meeting the performance trajectory of 79.90%. There were seven, 12-hour trolley breaches, and Ambulance handover delays were reported in-month with 57 handovers exceeding one hour. Despite walk-in attendances reducing as a result of the national lockdown, attendances did increase to higher than expected towards the end of the month, whilst ambulance arrivals remained consistent with pre-pandemic levels. Bed occupancy improved, varying between 88.02% and 98.65% in February against the core bed base. Bed occupancy was positively impacted by a reduction in long stay patients towards the end of the month achieved through the BNSSG enhanced COVID-19 community capacity plan; supporting a reduction in ED wait for bed delays.

Planned Care

Referral to Treatment (RTT) - 18 week RTT performance reported a deterioration in February, but continues to achieve the trajectory of 63.94%. The number of patients exceeding 52 week waits in February was 2108 against a recovery trajectory of 2893; the majority of breaches (1256; 59.58%) being in Trauma and Orthopaedics. Reduced elective activity as a result of the ongoing COVID-19 response and the application of the Royal College of Surgeons Clinical Prioritisation guidance, leading to some of the longest waiting patients having further extended waits, has been a significant factor in the deterioration in the 52 week wait position and the 18 week RTT performance. In addition, 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.

Diagnostic Waiting Times – Diagnostic performance improved, though continued to fail the recovery trajectory with performance at 27.20% in February; reflective of the continued reduced activity resulting from the third wave of the pandemic. Improvement has been reported for Non-Obstetric Ultrasound resulting from additional Waiting List Initiative capacity, supporting backlog clearance. The number of patients waiting longer than 13 weeks improved, with a decrease of 3.17% reported in February. Compared nationally, 13 week performance deteriorated marginally in January and remains in the fourth quartile.

Cancer

The Trust achieved one of the Cancer Wating Time (CWT) standards (31-Day subsequent – chemotherapy treatment) and trajectories for January 2021. The Breast service continues to see an increase of TWW referrals above expected activity levels (34% increase vs. January 2020) and continues to have workforce constraints in both clinical and diagnostic support. Despite this, Breast have continued to perform well against the 28-Day diagnosis standard with 90% of patients meeting the timed target vs. a standard of 75%; with most patients offered a one stop appointment by day 18. Overall, the Trust achieved the 28-Day diagnosis standard and Urology achieved trajectory targets for all standards in January. For February the Trust will continue to fail TWW largely due to Breast capacity. Achievement of the 31-Day target is anticipated for February, but performance problems persist with the remaining CWT standards.

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 Minimum Data Set : A revised Maternity data set is being developed which will provide assurance across a range of areas and will provide more meaningful information as the data builds across following months. The Ockenden nationally required maternity assurance report was submitted as required to NHS England on 15 February 2021 and further assurance will be provided to the Quality & Risk Management Committee meeting on 18 March 2021. There have been no new HSIB referrals, or new completed reports in the past month relating to individual patient safety incidents.

Pressure Injuries: There have been no reported Grade 3 or 4 pressure injuries in February. The Trust wide Pressure Injury Review Group recommenced in March with plans to review specific themes from validated pressure injuries in February including medical devices and pressure injuries to heels.

Mortality Reviews / Medical Examiner service – The Trust continues to closely review deaths in hospital with a 95.1% completion rate. The Medical Examiner service, established across the BNSSG acute trust system is reviewing an increasing number of cases with clear signposting of any concerns into the Trust's governance systems.

Areas of Concern

Infection control: C. difficile case numbers remain above trajectory and the cases have been analysed, with late sampling and documentation accounting for the majority of the lapses. IPC are working with Divisional infection leads to reduce risks. One case of MRSA bacteraemia was identified on 8 February 2021 and is being investigated following required protocols.

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 factor decreased to 3.65% in February (from 3.80% in January 2020 (this excludes the impact of the COVID-19 vaccination workforce recruitment). The greatest net reduction in vacancies was in Additional Clinical Services (unregistered clinical staff) predominantly driven by the enhanced winter resourcing plan for HCAs. Nurse band 2 and 3 saw a net gain of 23.7 WTE.

Turnover
The Trust turnover is reported as 12.56% in February. Excluding the impact of staff leaving who were on temporary contracts during the COVID-19 response the Trust turnover is 10.95%, compared to 13.95% in February 2020. All staff groups saw fewer leavers than the same period last year with the most significant reduction being in clinical fellows, followed by administrative and clerical staff and registered nursing and midwifery.

Prioritise the wellbeing of our staff
The rolling 12 month sickness absence was 4.48% in January, an increase from December reflecting the spike in levels of COVID-19 related sickness. The level of short term sickness in January 2021 compared with January 2020 was the same with other non-COVID-19 related short term sickness reasons at lower levels. Long term sickness was 0.50% higher in January 2021 than the same period in the previous year. The Trust saw an 85% reduction in long term sickness driven by cough/cold/influenza but a 2300 % increase in long term sickness related to infectious diseases which reflects long term COVID-19 Sickness. Management guidance and support for staff off sick with Long COVID-19/Post-COVID 19 Syndrome has been implemented in response.

Continue to reduce reliance on agency and temporary staffing

Overall temporary staffing demand decreased in February (-12% equivalent to 136 WTE) in line with the significant reduction in COVID-19 related staff absence. Temporary staff requests for booking reason ‘COVID-19’ and ‘Sickness’ decreased by 26%. As a result bank fill increased and agency fill and unfilled shifts decreased.

Tier 4 agency use decreased from 7 WTE to 2 WTE in February with both band 5 Registered Nurses (RN) and band 5 Registered Mental Health Nurse (RMN) use reducing. ICU had the highest RN use in December and January and saw the greatest reduction with the emergency zone seeing the greatest reduction in RMN use and as a result overall agency expenditure decreased. Tier one agency use also decreased, 23 nursing teams saw a reduction vs 14 team seeing an increase. Wards and theatres remain the highest areas of tier one agency use, with Theatres Anaesthetics remaining the highest user at 10 WTE.

FINANCE
SRO: CFO
Overview

NHSI/E suspended the 2020/21 financial framework due to COVID-19 response preparations.

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

From 1 October 2020 a new financial framework is now in place that requires the trust to operate within a fixed financial envelope (plus a small number of specified “outside envelope” cost recoveries) and to deliver a deficit that is consistent with the financial forecast submitted on 22 October 2020.

Highlights:

The Forecast Trust deficit for February is £4.9m, while Actual deficit reported is £2.3m.
Cumulatively the Forecast Trust deficit to month 11 is £17.9m and the Actual deficit is £0.8m.

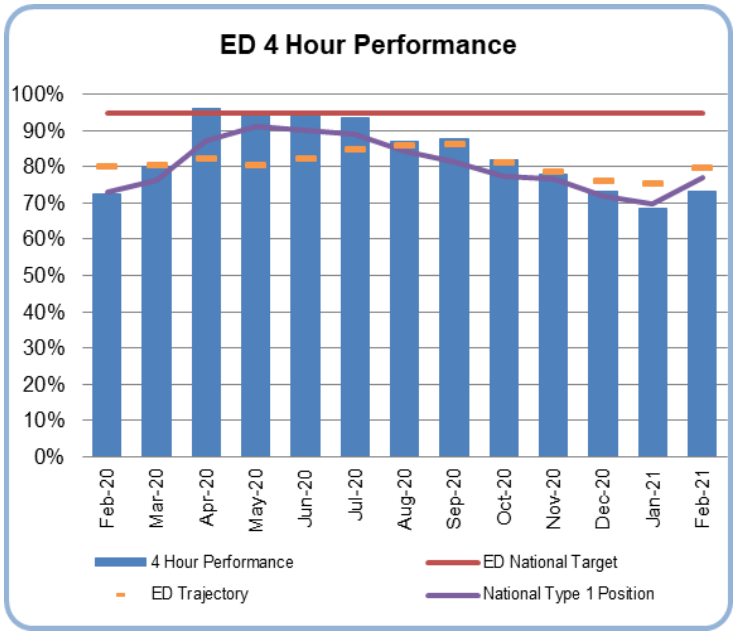
Cash balance at the end of February £146.6m which includes £55m of “month in hand” cash that was received in April 2020 and will be unwound in March.

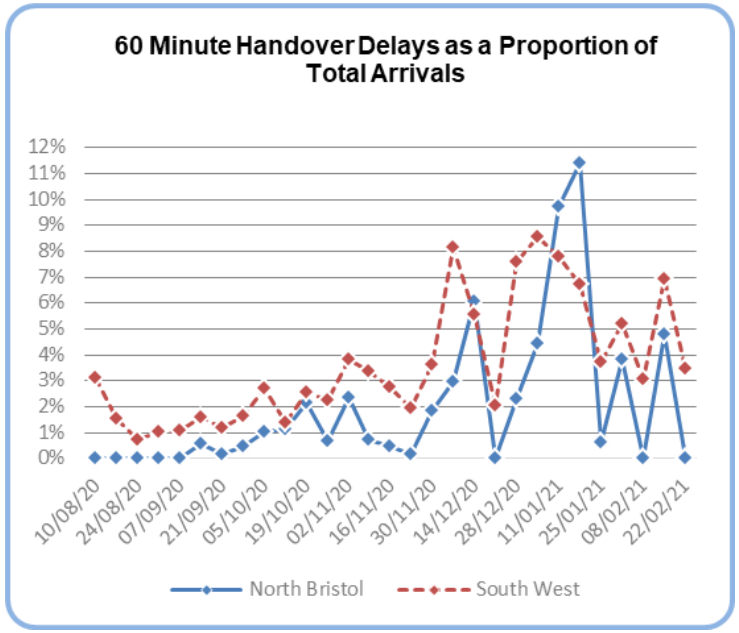
Capital spend for the year to date is £18.2m (plan is £24.6m) which includes £4.1m of COVID capital spend.

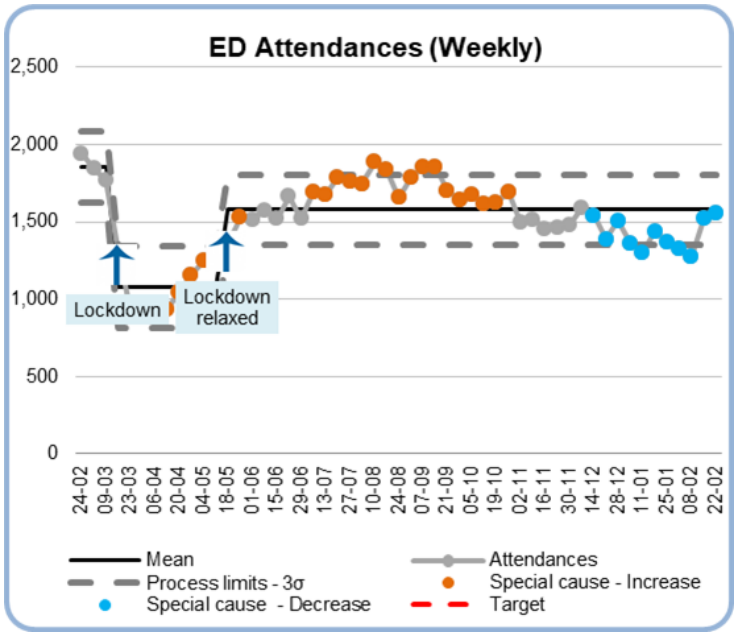
NHS North Bristol NHS Trust

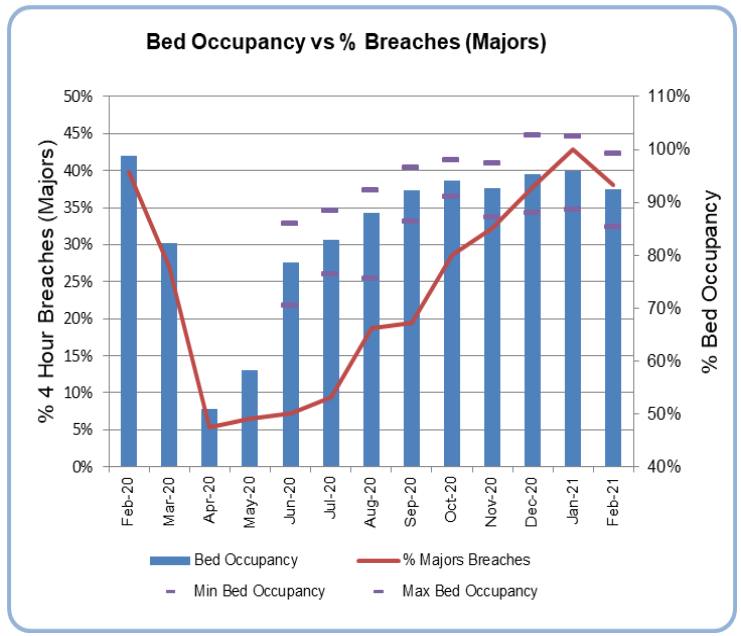
Responsiveness

Board Sponsor: Chief Operating Officer
Karen Brown









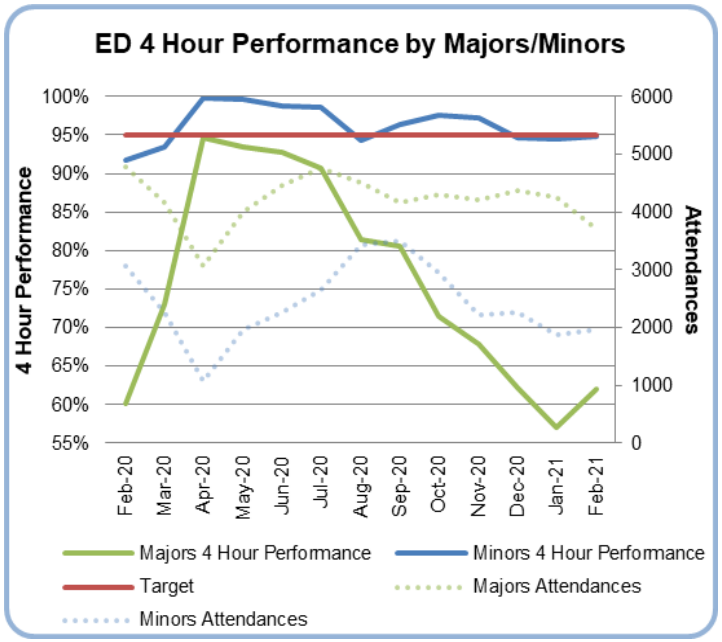
Urgent Care

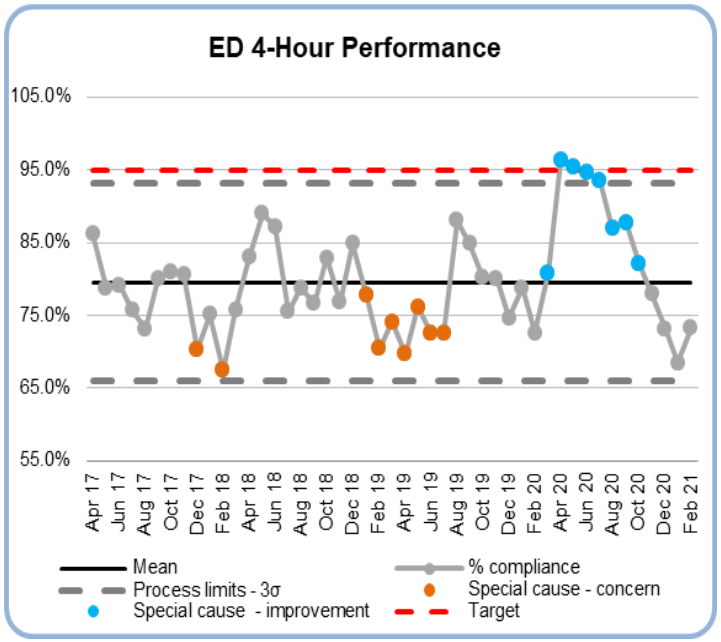
As anticipated, four-hour performance improved in February but the Trust did not achieve the trajectory of 79.90% with performance of 73.33%. Trust performance has reported below national performance for the second consecutive month.

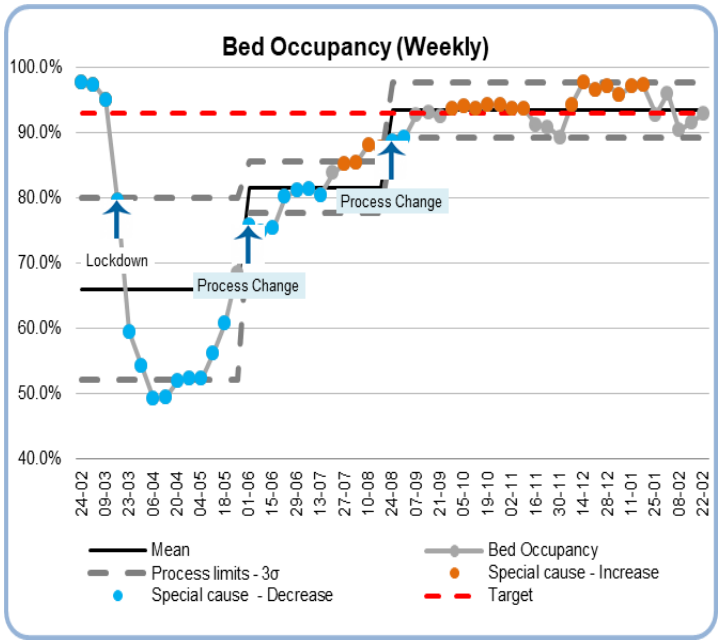
The Trust conceded 57 ambulance handovers exceeding one hour in February and seven 12-hour trolley breaches reflecting a significant improvement on January's position.

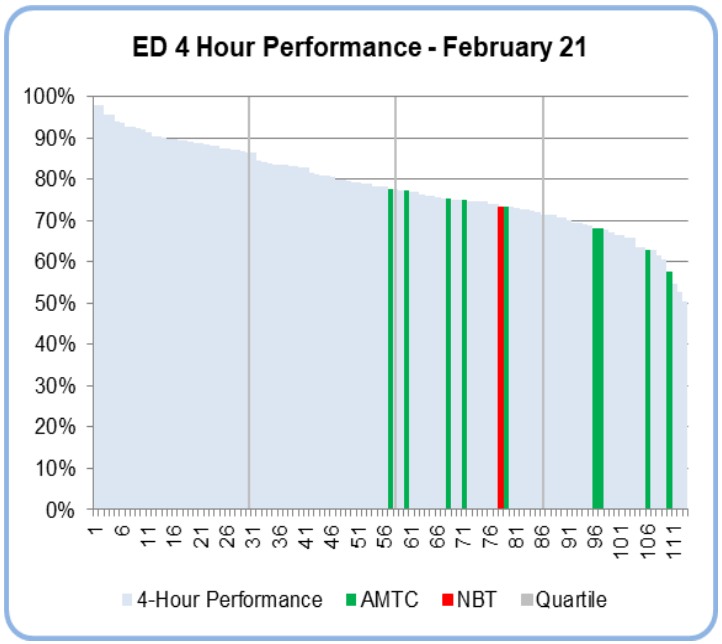
The improvement seen in ED performance for February reflects the continued reduction in COVID-19 admissions throughout the month, allowing for de-escalation in the number of Blue wards along with a reduction in the number of COVID-19 patients in ICU. However, staffing pressures, segregated care and enhanced IPC measures continued to negatively impact flow, affecting performance and preventing achievement of trajectory for February. Staffing pressures were more significant in the second half of the month where attendance levels increased and all Divisions saw emergency predictors reached or exceeded.

ED performance continues to improve throughout March, currently achieving trajectory with performance of 78.68%.









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

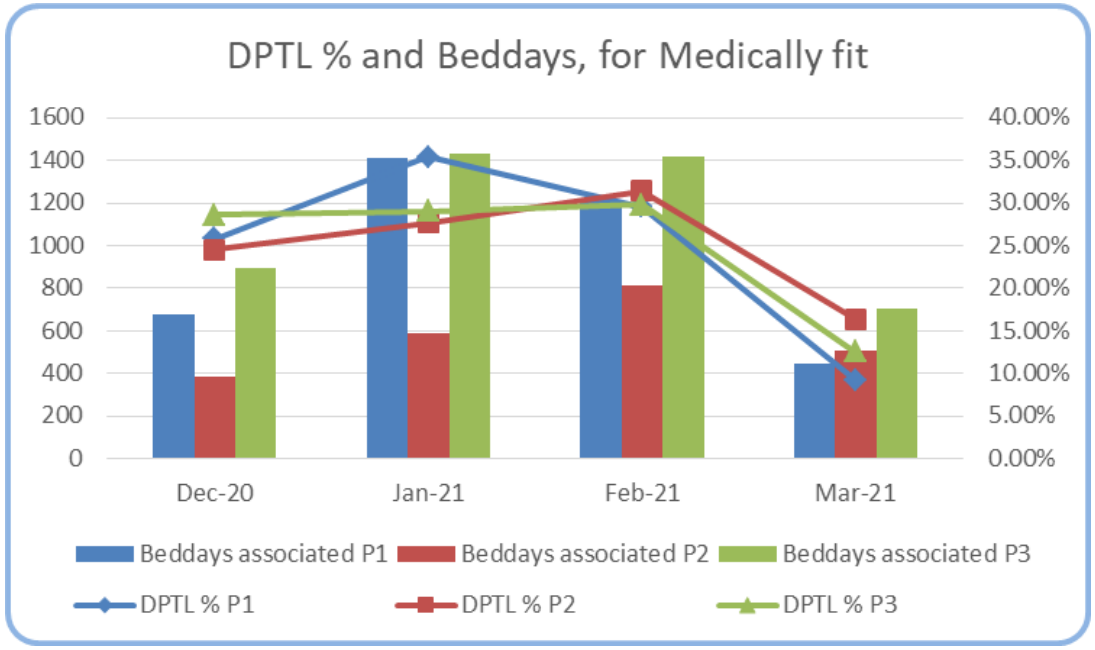
In February, Majors performance improved, though continued to be most notably impacted (61.98%), whilst Minors performance remained static at 94.80%.

Despite walk-in attendances reducing as a result of the national lockdown, attendances did increase to higher than expected towards the end of the month. In addition, ambulance arrivals remained consistent with pre-pandemic levels.

Of the breaches in ED in February, 46.66% were a result of waiting for a medical bed and 22.72% of delays resulted from waits for assessment. Despite being the predominant cause of breaches for the sixth consecutive month, Medicine bed capacity contributed to less than half of the breaches for the first time since September 2020, with a higher proportion of breaches in February being due to waits for assessment..

Bed occupancy improved, varying between 88.02% and 98.65% in February against the core bed base. Bed occupancy continues to be positively impacted by a reduction in long stay patients, supporting a reduction in ED delays. Across January and February the bed days for patients awaiting discharge once medically fit remained constant.

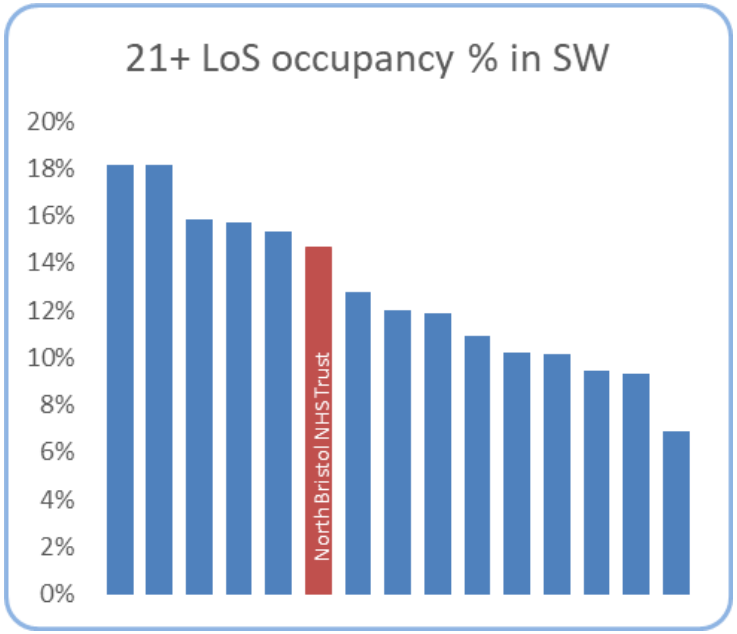
The Trust position has deteriorated for ED performance when compared nationally, though remains in the third quartile. ED performance for the NBT Footprint stands at 78.70% and the total STP performance was 79.31% for February.

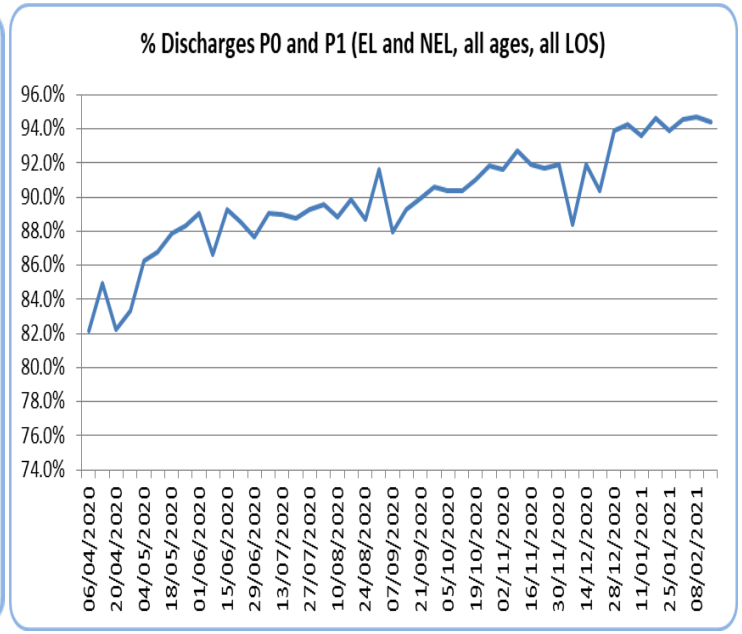


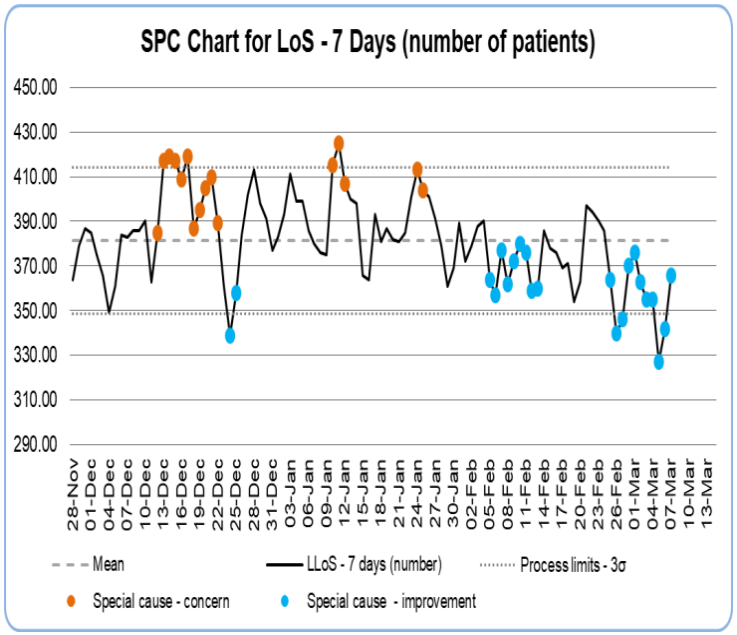
Right to Reside Report

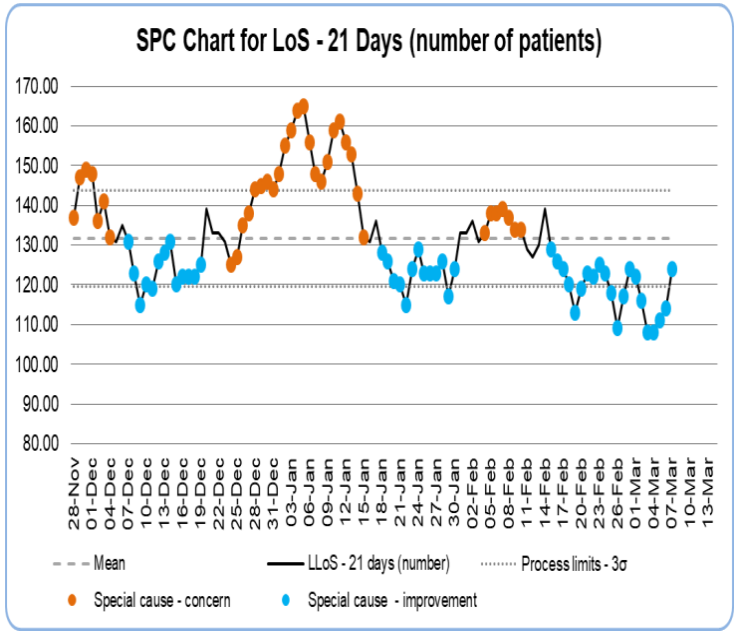
As of midnight 12/03/21(snapshot), 162 patients (22.3% of all patients) no longer meet the right to reside criteria, and under the Hospital Discharge Guidance model, should be discharged on the day they meet that criteria. Of the numbers that do not meet the right to reside, 88% are waiting for discharge to assess community capacity. Across January and February the bed days for patients awaiting discharge once medically fit remained constant.

There has been an improvement in flow for those waiting for pathway 2 as the beds have re-opened following COVID-19 outbreaks. However, there remain constraints in pathway 3 with the prolonged closure of the most complex dementia beds. In addition, whilst there has been a significant increase in the referral levels to pathway 1, the increased complexity of those referred requiring higher levels of care has increased the waiting time significantly and is currently identified as the pathway with the highest number waiting.









Stranded Reporting

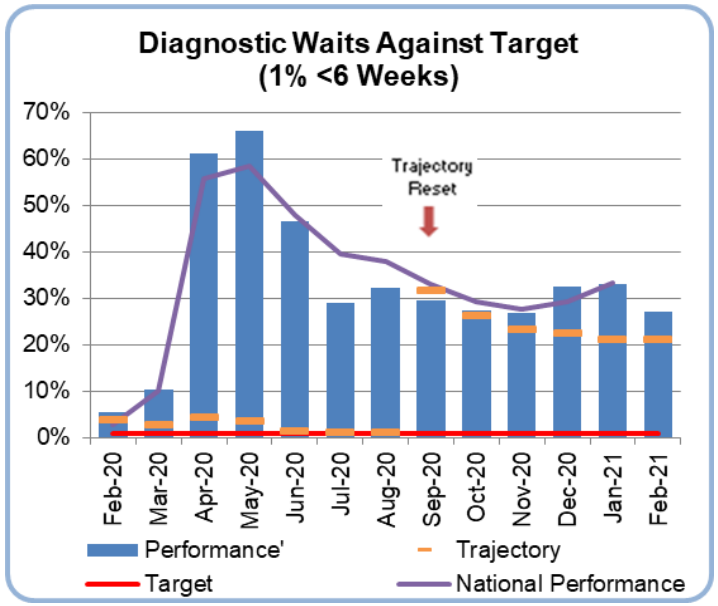
The reported levels for 7 days+ and 21 days+ are showing a reduction in patient numbers and this has remained a consistent trend. This has led to a percentage bed occupancy of 14.67% vs. 17.84% in January for patients waiting over 21 days, as measured against all Trusts in the South West.

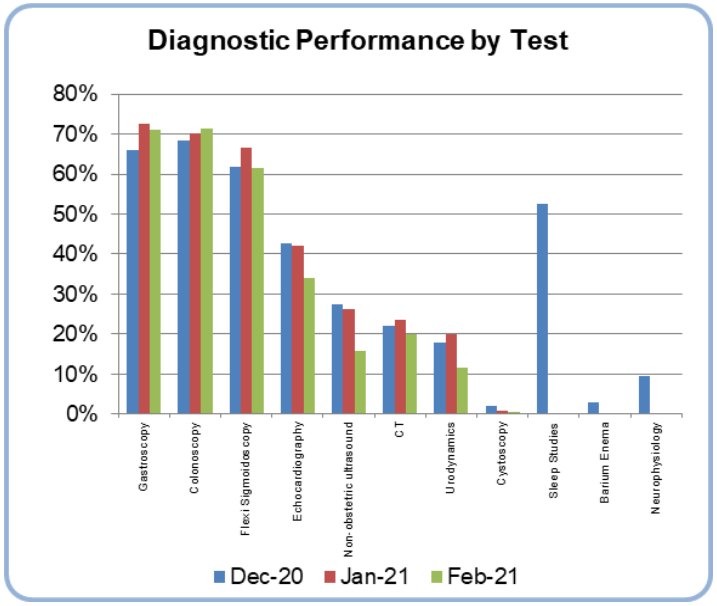
The level of people who are returning home on pathway 0 or pathway 1 has met the NHSE/I expectation of 95% across the month. This has continued to be supported by the Red Cross with telephone support for advice and signposting.

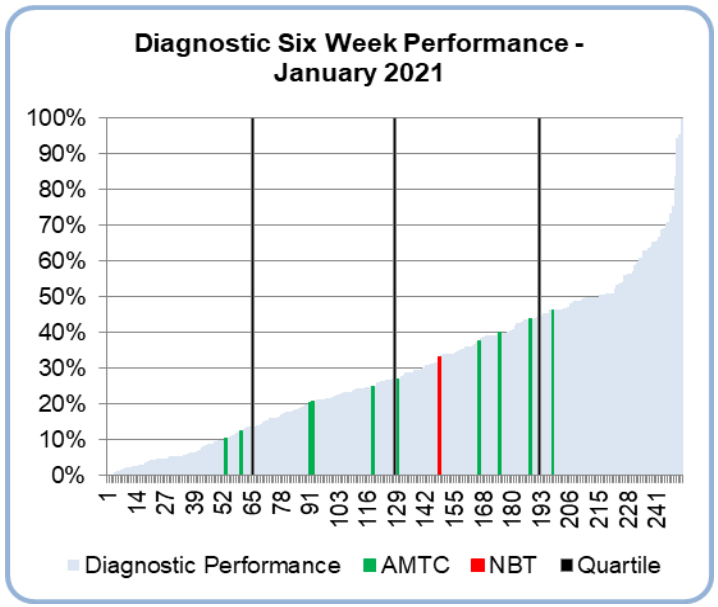
The Trust is committed to ensuring that we are completing the Single Referral Form and therefore the handover of care to the community, through a timely and effective process. Therefore, there will be a renewed review of the process for completion to ensure a referral is accepted first time.

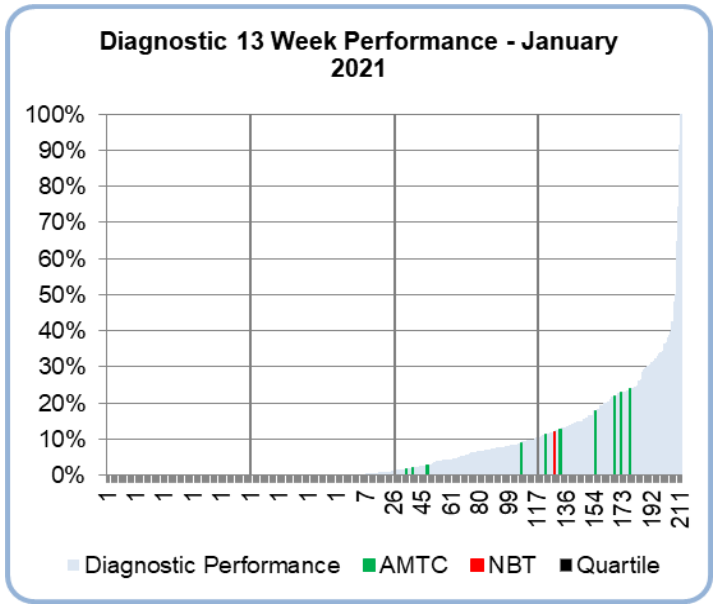
Current rejection rates for SRFs in February vary between 7.50% to 11.00%.

Data Source: South region NHSI UEC dashboard, w/e 7th March









Diagnostic Waiting Times
Diagnostic performance improved to 27.20% in February, but failed to achieve the trajectory of 20.97%. Improvement has been reported for most test types in month.

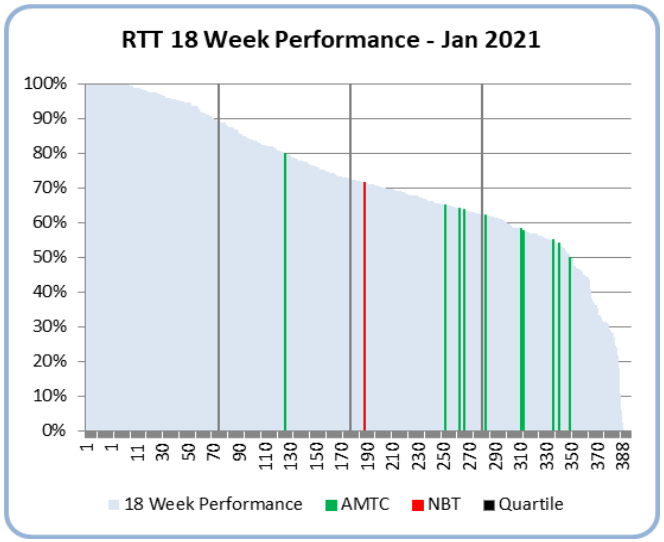
Endoscopy reported a further reduction in activity resulting predominantly from reduced IS capacity. Despite the activity reduction, increased demand coupled with a 2.09% reduction in the backlog improved performance marginally for February.

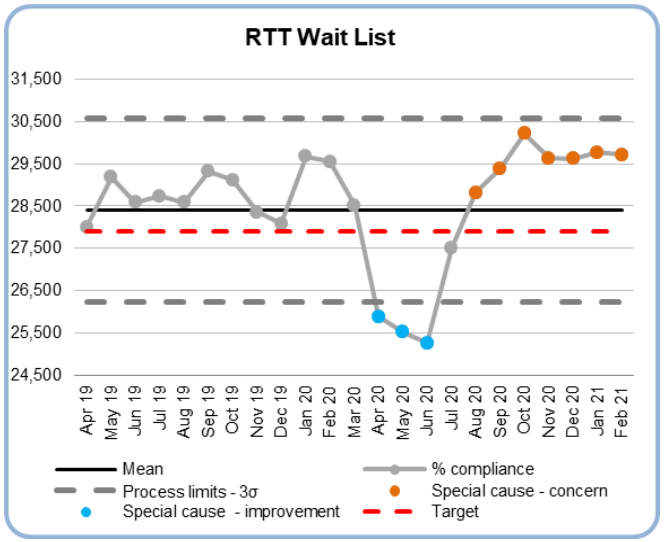
Non-Obstetric Ultrasound reports a significant improvement in month. The overall capacity shortfall arising from COVID-19 IPC measures has been mitigated by additional in-house weekend WLI (Waiting List Initiative) capacity supporting backlog clearance. Weekend activity has now been scheduled for most of the year to support further backlog clearance going forwards.

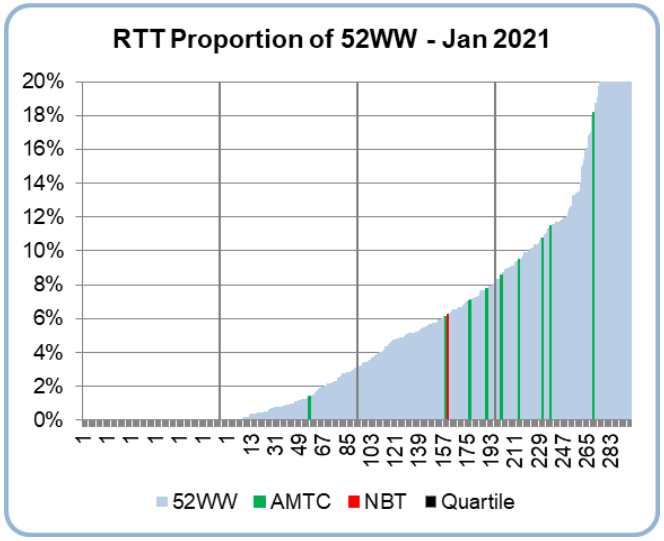
Urodynamics also reported improvement in-month due to an increase in demand and backlog reduction.

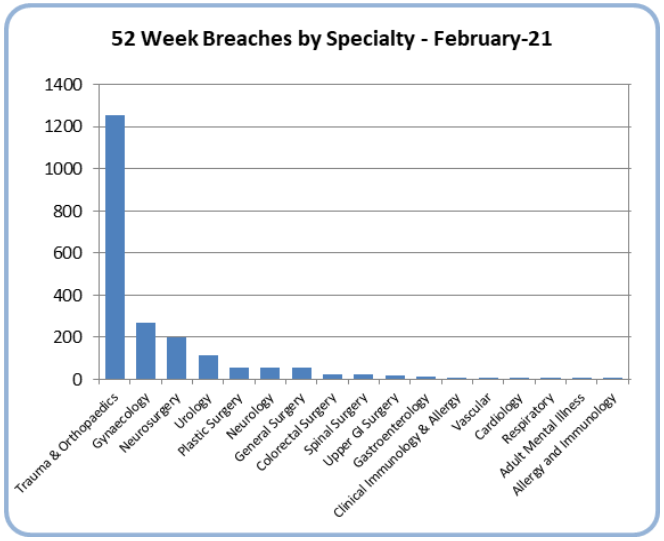
The number of patients waiting longer than 13 weeks improved, with a decrease of 3.17% reported in February. A high level review continues to be completed for patients exceeding 13 weeks to ensure no harm has resulted from the extended wait times.

Nationally, Trust positioning improved slightly for 6-Week performance, though remains in the third quartile. 13 Week performance deteriorated marginally, remaining in the fourth quartile.









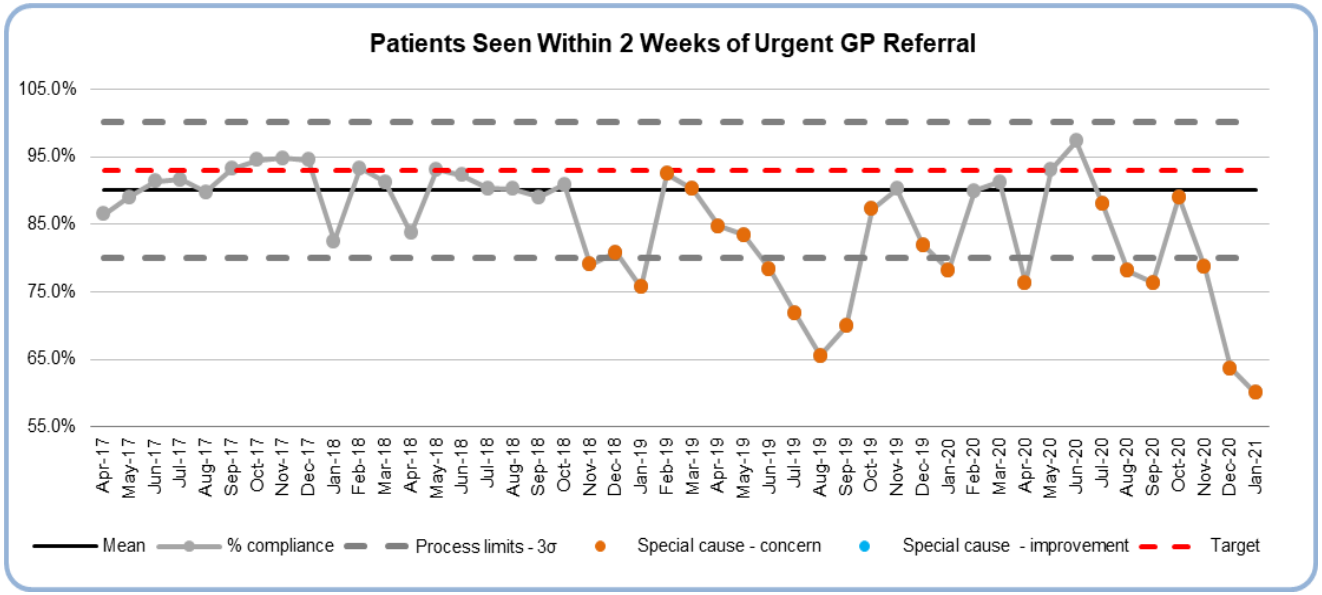
Referral to Treatment (RTT)
In February, the Trust reported RTT performance of 70.65%, exceeding the trajectory of 63.94%. The waiting list remained static at 29716 in February, reporting under the trajectory of 34435. Demand growth following the onset of the pandemic has been less than anticipated with elective activity delivering predominantly above plan, resulting in a lower waiting list than predicted.

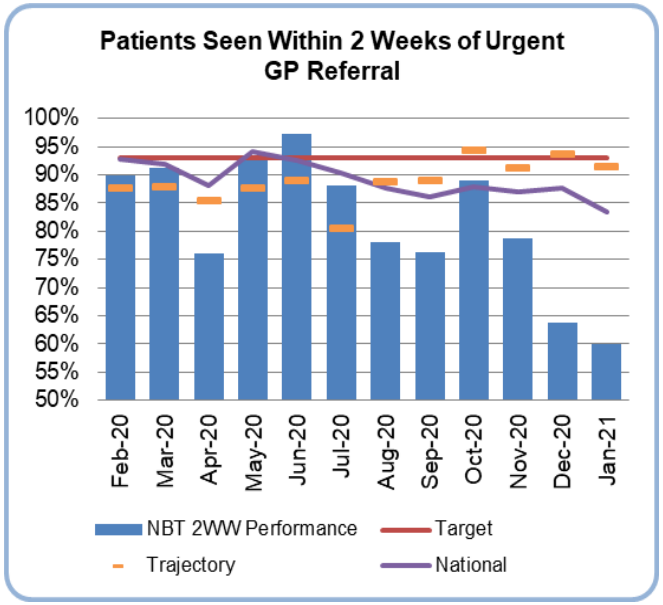
Overall, admitted and non-admitted clock stops increased to 85.91% of last year's activity in February, with a greater increase in admitted clock stops resulting from easing pandemic pressures. Increased activity was predominantly offset by increased demand in February resulting in a static wait list position.

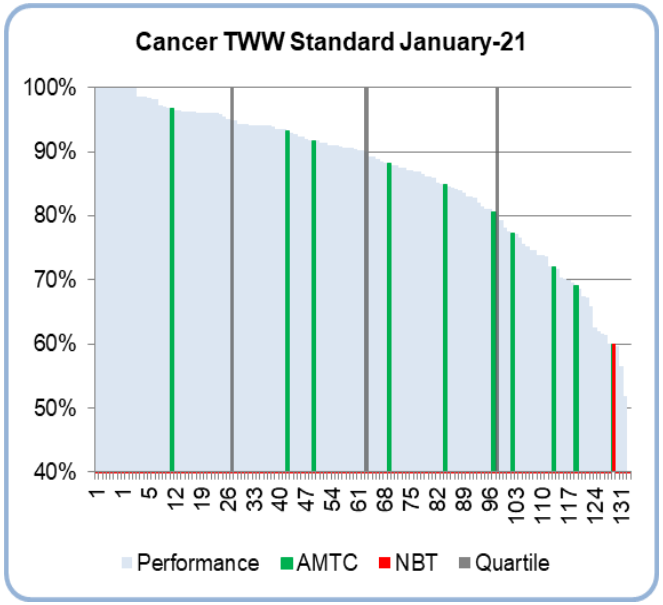
At month end, there were 2108 patients waiting greater than 52 weeks for their treatment against a trajectory of 2893; the majority of breaches (1256; 59.58%) being in Trauma and Orthopaedics. In February, there were 9 patients waiting more than 52 weeks that the Trust had accepted as late referrals from another Provider; the Trust is supporting equity of access to Clinical Immunology and Allergy services within the Region.

The continued increase in breaches is due predominately to reduced elective activity as part of the ongoing COVID-19 response and the impact of the application of the Royal College of Surgeons Clinical Prioritisation guidance. In addition, the Trust is still experiencing some patients choosing to defer their treatment due to concerns with regards to COVID-19.

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







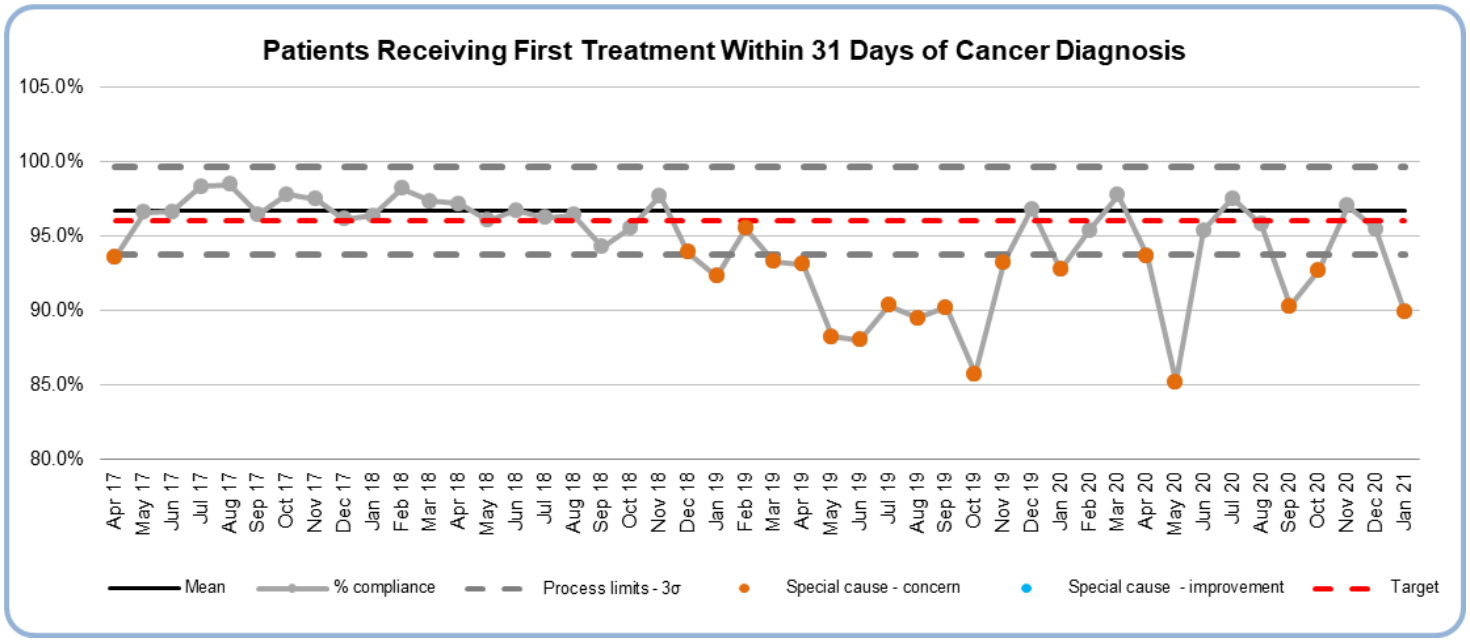
Cancer: Two Week Wait (TWW)
The Trust failed to achieve the recovery trajectory and the national TWW standard with performance of 60.03% in January. Across 2020, TWW breaches were largely due to Endoscopy capacity now it is largely due to Breast one stop capacity. The Trust saw 1779 TWW patients in January; 711 breached. The largest volume of breaches were in Breast, Colorectal, Upper GI and Skin.

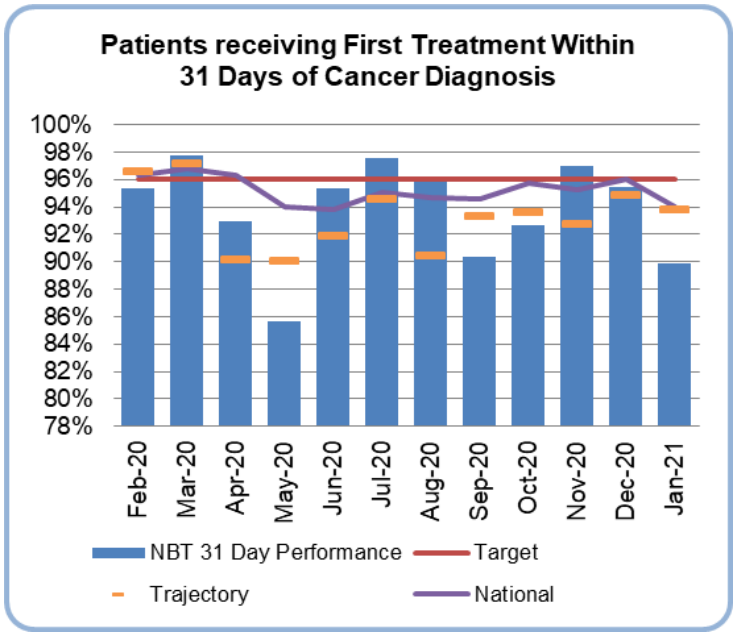
At times this led to TWW patients being seen outside of normal CWT standards; the deviation particularly in the Breast and Colorectal pathways have been agreed by the SWAG Clinical Group and NBT Clinicians.

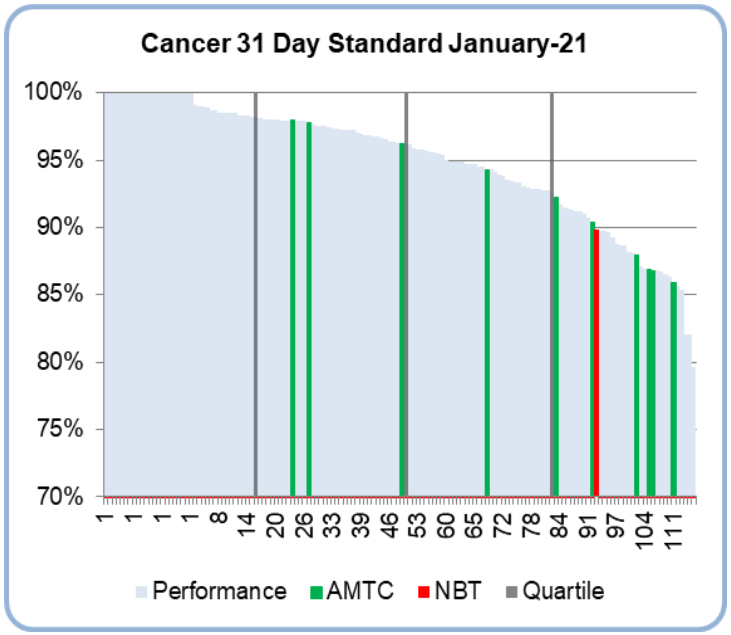
The January performance for Breast was 28.03%; a small increase in performance against their December position of 26.99%, mainly due to one stop clinic capacity short fall. Variations in referrals across all modalities and changes in how primary care deliver services especially in the reduction of face-to-face consultations have resulted in increased demand on TWW services.

In Breast this has resulted in an increase of 226 Breast referrals in January 2021 (877) vs. January 2020 (651); an increase of 34% particularly for Breast pain . The service were also subject to COVID-19 staffing impact to their Radiology team. However, the average day seen remains at 18 days and Breast achieved 90% of patients diagnosed by 28-Days in January. TWW performance in February is forecast to be 71.00%.

Although the TWW position is below target, the Trust is diagnosing 75% of patients within 28-Days.





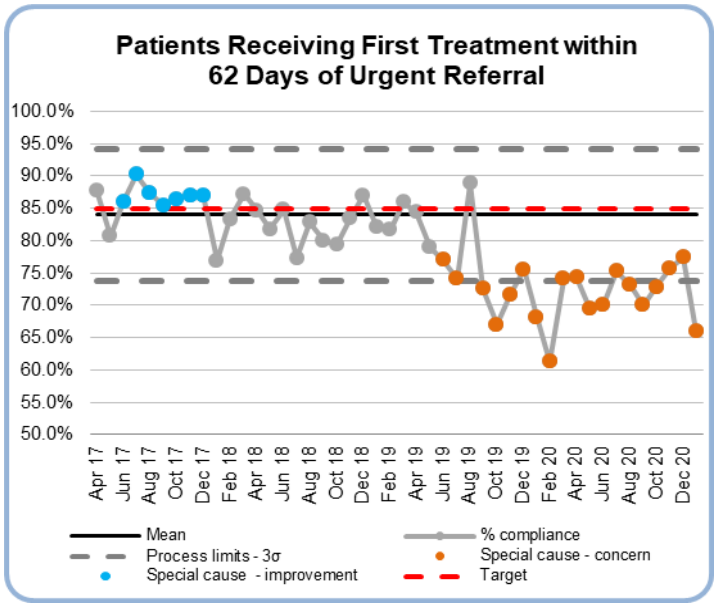


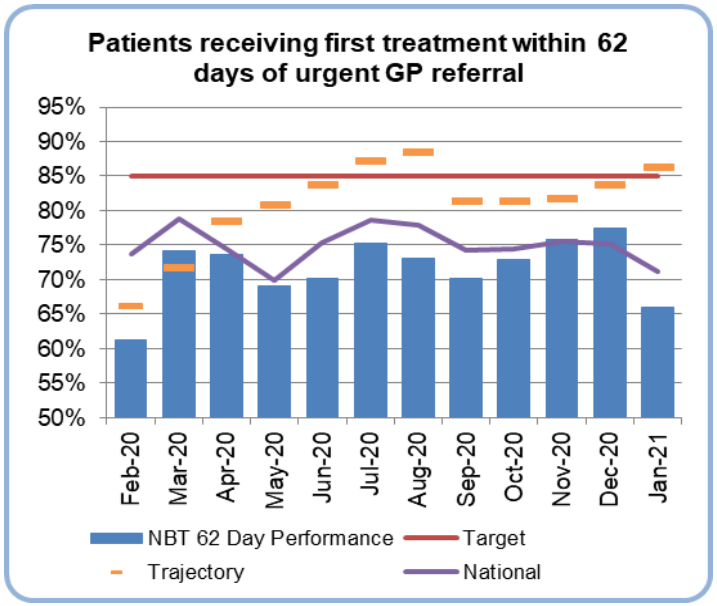
Cancer: 31-Day Standard
In January the Trust failed to achieve the standard with a performance of 89.84%. There were 187 completed pathways with 19 breaches; 9 in Skin; 4 in Urology; 2 in Colorectal; 3 in Breast; and 1 in Brain. 31-Day performance in February is forecast to be 96%.

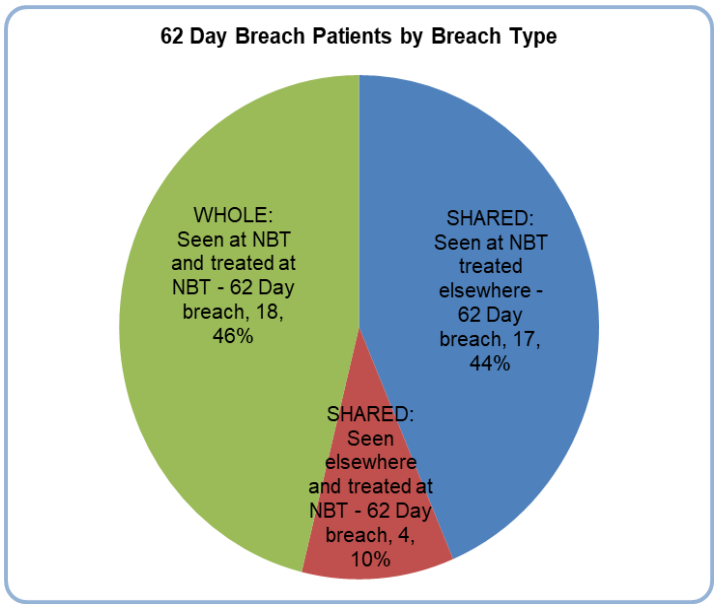
The specialties that achieved CWT target were Gynaecology, Haematology, Lung, Sarcoma, and Upper GI. Breast and Urology were very close to achieving the standard; Breast with performance of 93.33% and Urology with performance of 92.86%.

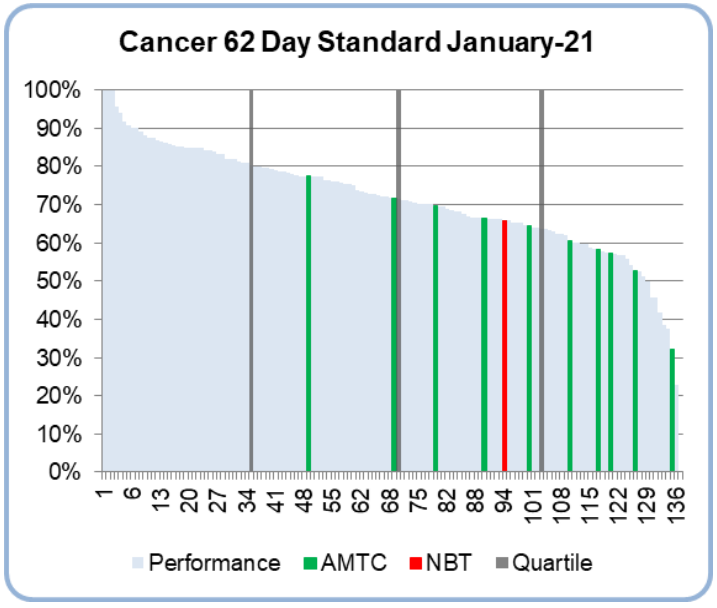
The Trust failed the 31-Day subsequent overall standard with a January position of 80.37%;107 patients were treated with 21 breaches. The Trust also failed the subsequent Surgery standard in January with a position of 77.66%; 82 patients were treated with 20 breaches. 18 of the 20 breaches were in Skin; 11 due to sentinel node biopsy capacity, which was reduced due to COVID-19 plans to redeploy theatre staff to ICU surge plans. This will continue into February.

COVID-19 impact on 104-Day remains low; in January there were 37 patients waiting longer than 104-Days. The biggest delay reason is due to patient choice related to COVID-19.









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 January is 65.71% with 110 treatments and 37.5 breaches. The Trust failed both the post COVID-19 recovery trajectory position of 86.10% and the CWT standard of 85.00%. February performance is predicted to be 72%.

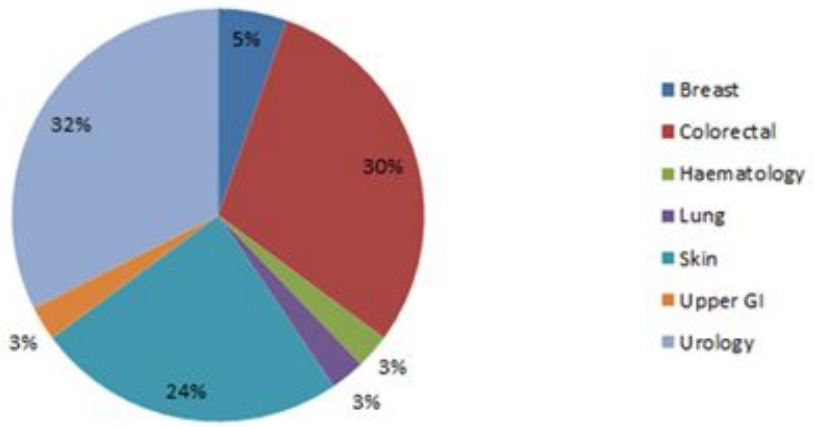
Skin and Upper GI were the only specialties that achieved 62-Day CWT standard in January; Skin with a performance of 92.31% and Upper GI of 100%.

Urology failed the 62-Day standard of 85.00% achieving 54.55% with 15 breaches. They achieved post COVID-19 revised trajectory of 52.00%. The majority of the 15 Urology breaches were due to provider delays, specifically turnaround times for template biopsy and Radiology.

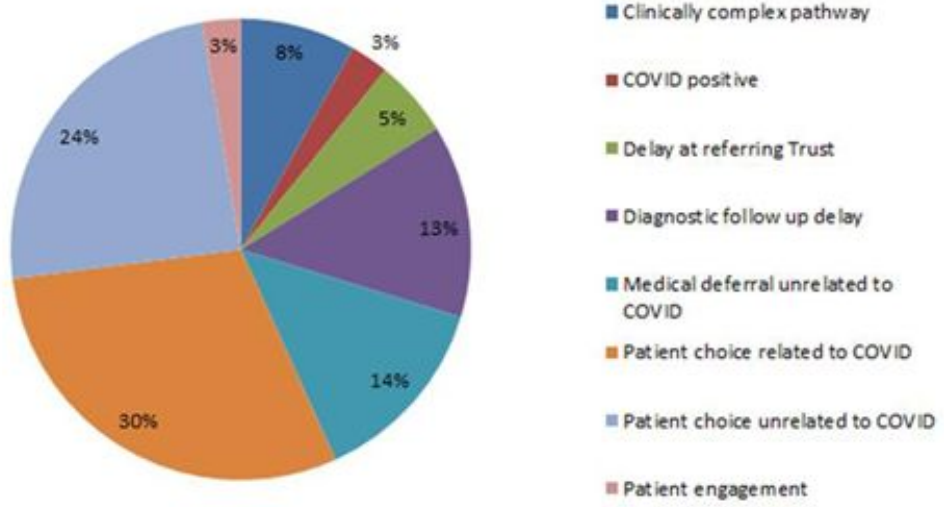
Colorectal failed to achieve the standard with 36.36%; this was an improvement on December's performance. They treated 11 patients with 7 breaches in January. The majority of this month's breaches were due to patient fitness and provider delay within the diagnostic and treatment planning stages to Endoscopy and deferral due to medical reasons.

Breast 62-Day performance was 69.81%; treating 26.5 patients with 8 breaches. 5 breaches were due to complex pathways involving multiple diagnostics or complex bilateral cancers. The Breast pathway is introducing a pain referral triage process, which will have a positive impact on the 62-Day pathway going forward.

104 Day Without DTT



Delay Reasons - Without DTT



Cancer
104-Day Patients Live PTL Snapshot as of 2021

The Trust had 50 patients on the live cancer PTL as of 11 January waiting over 104-Days. The report is split into two sections; patients with or without a Decision to Treat (DTT) for cancer treatment.

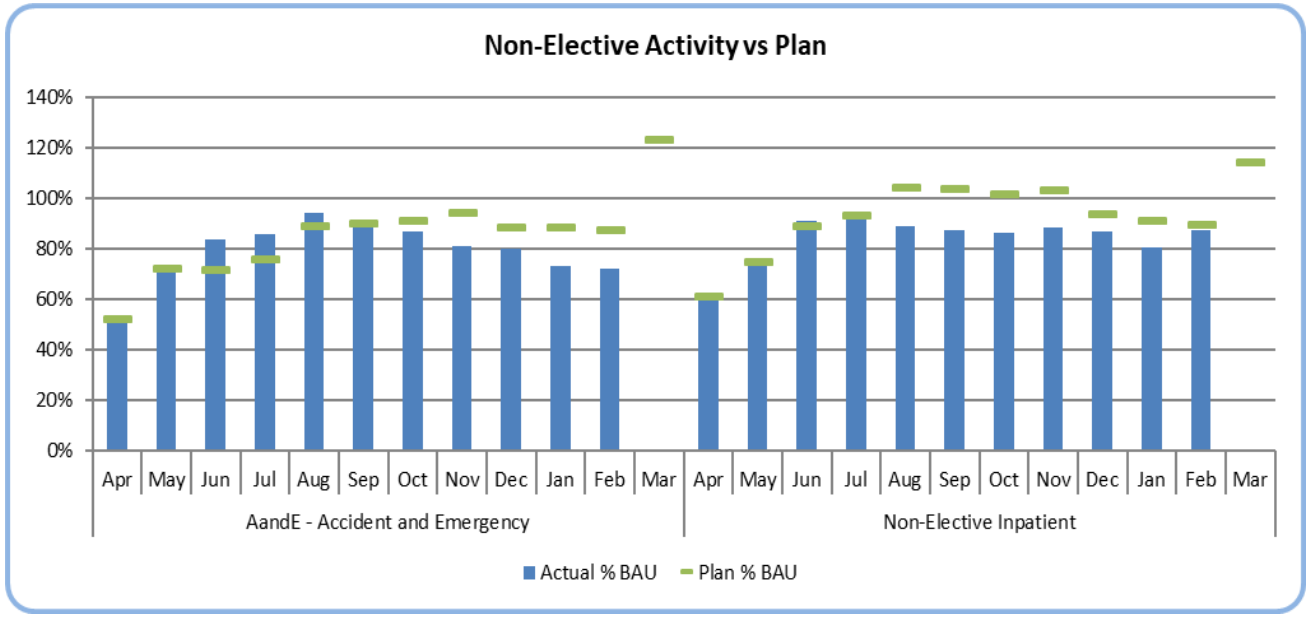
The Trust had 37 patients waiting >104-Days without a DTT: 2 in Breast; 11 in Colorectal; 9 in Skin; one each in Upper GI; Haematology; and Lung; and 12 in Urology.

The total number of patients currently over 104-Days on their pathway without a decision to treat has improved further since the January snapshot (43).

There were 13 patients with a DTT >104-Days with a confirmed cancer diagnosis: 3 in Breast; and 10 in Urology.

There has been a significant increase of Urology 104-Day waiters in this snapshot.

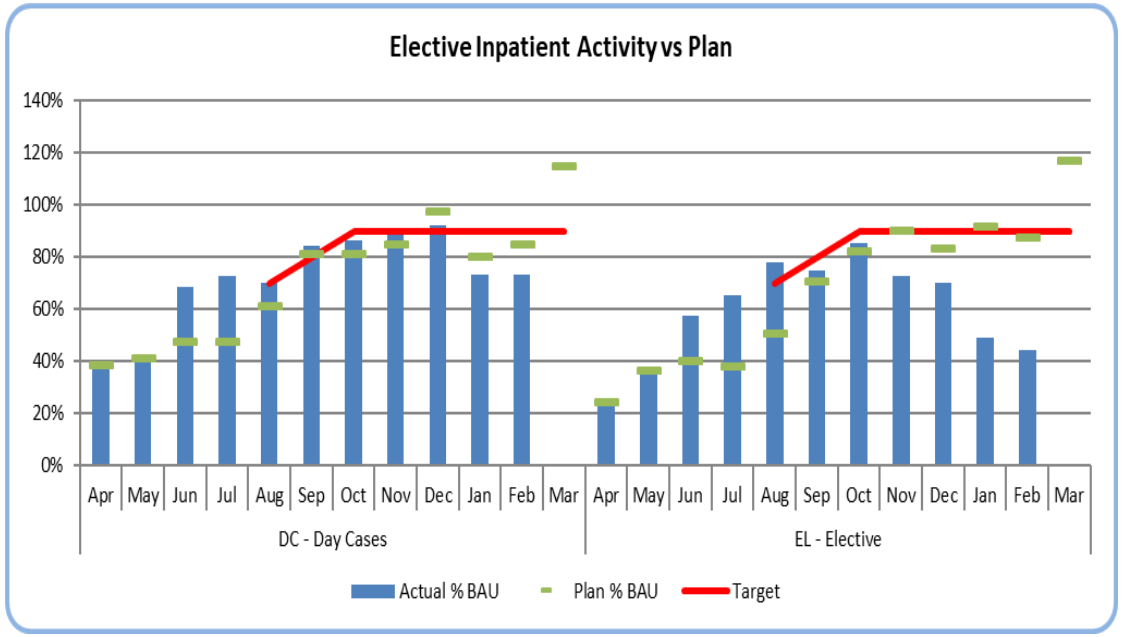
However when looking at the breakdown, 6 out of 10 patients were transferred to NBT late into their pathways from external Trusts, all past the 62-Day target. All have treatment plans in place.

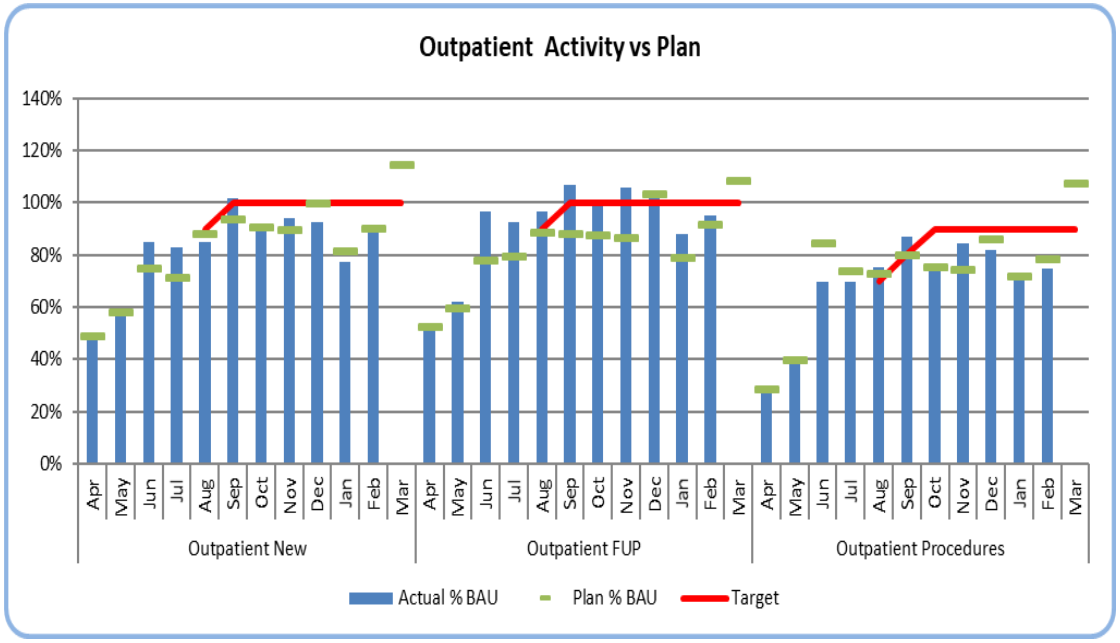


Non-Elective Activity vs Plan

- **ED attendances** have reported below plan since October 2020 in concordance with national lockdown rules and reduction in minors activity.
- **Non-Elective** activity for February has increased to near planned levels; the increase was predominantly for 0 LoS and direct admissions.

NB: March 2021 plan is above 100% due to March 2020 actuals being partially impacted by COVID-19. Activity vs Plan information includes only Specific Acute specialties.

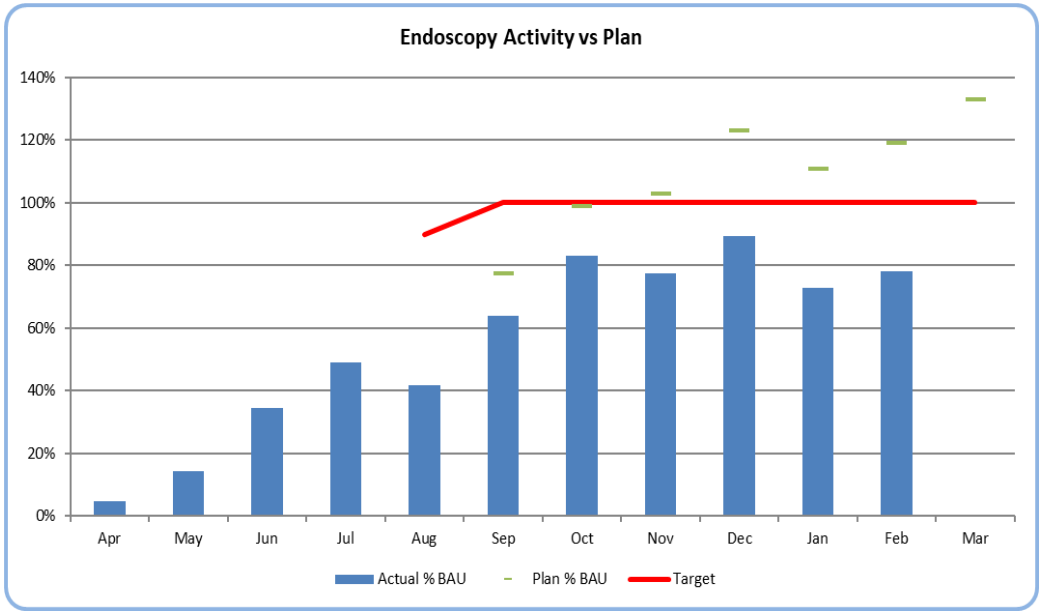


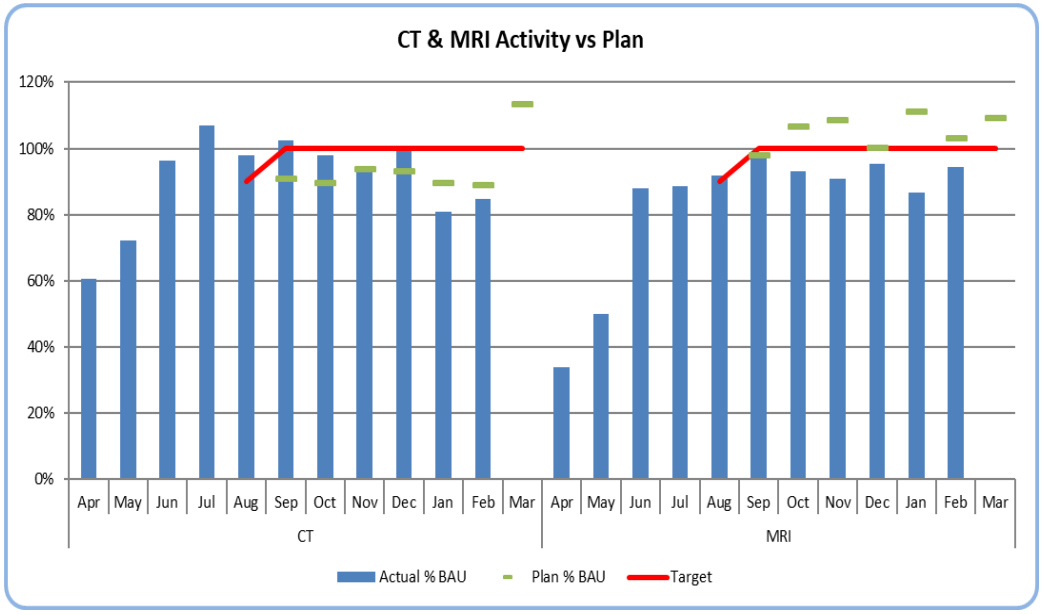


Elective Activity vs Plan

- **Day case** activity in January and February reduced more than planned resulting from the impact of the third wave of the pandemic.
- **Overnight admissions** have achieved plan in every period with the exception of Quarter three and four. The winter months have been particularly impacted by elective cancellations in response to the second and third wave of COVID-19.
- **Outpatient first attendances** have been above plan in most periods. January has been impacted by the third wave of the pandemic with activity increasing in February as services begin to recover.
- **Outpatient follow up** attendances have been above plan for every period.
- **Outpatient procedures** have been above plan in most periods. January has been impacted by elective cancellations due to the third wave of the pandemic.

NB: March 2021 plan is above 100% due to March 2020 actuals being partially impacted by COVID-19. Data includes activity undertaken in the Independent Sector on behalf of the Trust. Activity vs Plan information includes only Specific Acute specialties.





Diagnostic Activity vs Plan

- **Endoscopy activity** reports below plan and target from September. At test level, all Endoscopy test types reported below plan for February. This relates to the under-reporting of activity due to a coding lag.
- **CT activity** increased in February with a corresponding improvement in performance, but did not achieve plan.
- **MRI activity** did not achieve plan in February, but did achieve the national standard of 1% for 6-Week wait performance with performance at 0.50%.

NB: March 2021 plan is above 100% due to March 2020 actuals being partially impacted by COVID-19. Activity vs Plan information includes only Specific Acute specialties.

NHS North Bristol NHS Trust

Safety and Effectiveness

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

NBT Maternity Dashboard

	Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Total	Trend
Caesarean section rate (overall)	28.0%	34.0%	33.4%	31.5%	33.9%	36.8%	34.6%	39.0%	38.7%	36.4%	31.2%	41.9%	35.1%	38.7%	35.8%	
Elective CS rate (as % of all birth episodes)		14.4%	15.6%	12.0%	14.0%	15.4%	15.4%	16.8%	17.2%	16.1%	14.9%	16.8%	15.9%	16.1%	15.5%	
Emergency CS rate (as % of all birth episodes)		19.7%	17.8%	19.5%	19.9%	21.4%	19.2%	22.2%	21.4%	20.3%	16.3%	25.1%	19.2%	22.6%	20.4%	
Induction of labour rate	32.1%	41.4%	40.8%	40.6%	38.9%	34.8%	35.4%	38.6%	38.9%	36.6%	40.0%	37.6%	39.8%	33.8%	38.2%	
PPH >=1000 ml rate	8.6%	9.2%	9.7%	8.7%	12.9%	11.5%	11.2%	10.7%	8.0%	10.4%	14.2%	8.9%	9.8%	11.6%	10.5%	
PPH >=1500 ml rate	3.5%	3.7%	3.3%	2.8%	5.4%	3.8%	3.4%	3.9%	2.1%	3.4%	4.4%	2.8%	3.3%	3.9%	3.5%	
PPH >=2000 ml rate	1.5%	1.4%	0.9%	0.7%	1.9%	0.9%	1.6%	2.3%	0.8%	2.0%	1.6%	1.1%	1.4%	2.3%	1.5%	
5 minute apgar <7 rate at term	0.9%	0.7%	0.7%	1.3%	1.6%	1.0%	0.6%	0.2%	0.2%	0.6%	0.7%	0.7%	0.5%	0.5%	0.7%	
Stillbirth rate	0.4%	0.0%	0.4%	0.2%	0.0%	0.0%	0.4%	0.2%	0.4%	0.0%	0.2%	0.6%	0.5%	0.2%	0.2%	
Stillbirth rate at term		0.0%	0.0%	0.3%	0.0%	0.0%	0.2%	0.2%	0.0%	0.0%	0.0%	0.2%	0.3%	0.0%	0.1%	
Stillbirth rate <37 weeks		0.0%	4.8%	0.0%	0.0%	0.0%	2.6%	0.0%	5.3%	0.0%	5.3%	5.7%	2.7%	2.2%	2.1%	

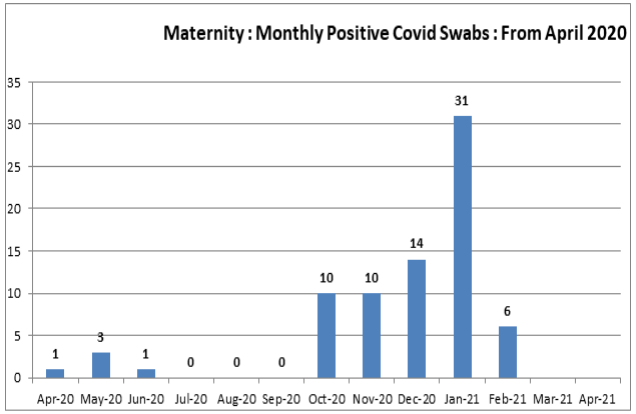
NBT Assurance Dashboard

	Jan-21	Feb-21	Year to date	Trend
Perinatal Morbidity and Mortality				
Total number of perinatal deaths	2	1	3	
Number of late fetal losses (22+0 to 23+6 weeks excl TOP)	0	0	0	
Number of stillbirths (>=24 weeks excl TOP)	2	1	3	
Number of neonatal deaths : 0-6 Days	0	2	2	
Number of neonatal deaths : 7-28 Days	1	0	1	
Suspected brain injuries in neonates (no structural abnormalities)	1	1	2	
Maternal Morbidity and Mortality				
Number of maternal deaths	0	0	0	
Rate of women requiring level 3 care	0.2%	0.2%		
Insight				
Number of datix incidents logged graded as moderate or above	3	1	4	
Datex incident moderate harm (not SI)	2	0	2	
Datex incident SI	1	1	2	
New HSIB referrals	0	0	0	
HSIB/NHSR/CQC or other organisation with a concern or request	0	0	0	
Coroner Reg 28 made directly to Trust	0	0	0	
Workforce				
Minimum safe staffing in maternity services: Obstetric cover	83	83	166	
Minimum safe staffing in maternity services: Obstetric middle	1	1	2	
Minimum safe staffing in maternity services: Obstetric	0	1	1	
Minimum safe staffing: midwife minimum safe staffing planned	14.52	10.52	0	
Datix related to workforce	5	12	17	
Number of times maternity unit on divert	0	1	1	
Involvement				
Service User Voice feedback: Number of Compliments	136	69	134	
Service User Voice feedback: Number of Complaints	24	15	24	
Staff feedback from frontline champions and walk-abouts	3	3	6	
Improvement				
Progress in achievement of CNST /10	7	8	15	
Training compliance in maternity emergencies and multi-	45%	40%		
Continuity of Carer (overall percentage)	17%	17%		

COVID-19 Maternity

Visiting arrangements within maternity were reviewed following national guidance on 14 December 2020 and this guidance will be reviewed to maintain safety of mothers, babies and staff within BNSSG. Partner visiting on postnatal wards has been reintroduced following the introduction of Lateral Flow Testing (LFT).

Incidence of COVID-19 amongst Maternity population reduced during February as shown below (-25 since Jan-21).



Perinatal Quality Surveillance Tool

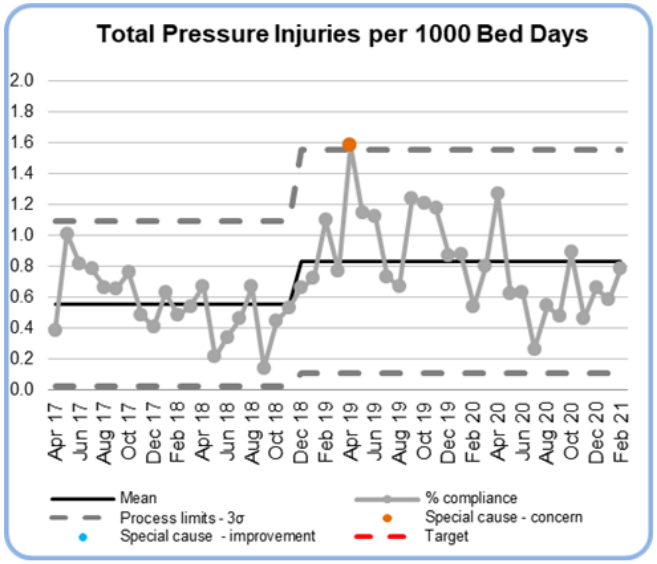
The information provided represents the recommended information from the Ockenden investigation report. NBT Maternity is further developing this dataset to ensure the Board is informed of safety metrics and indicators.

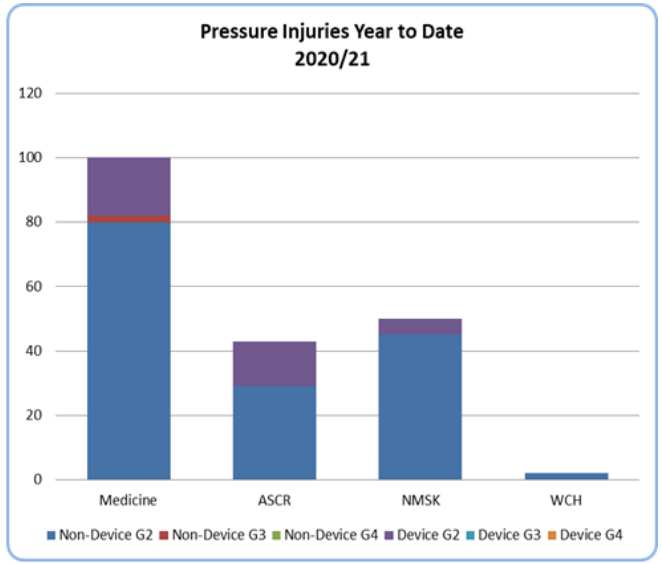
CNST deadline has been postponed until July 2021 and currently progress against CNST standards is 8/10.

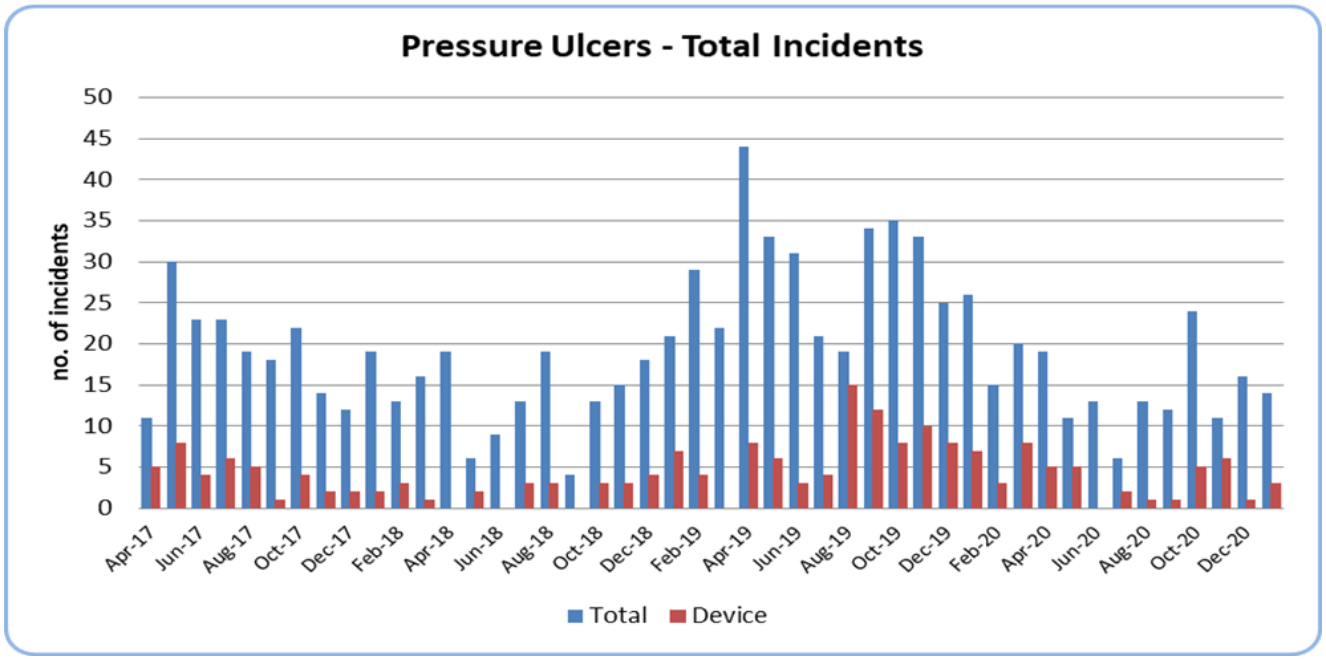
Serious Incidents:

QRMC receives a summary of each serious incident investigation, including themes and learning.

QP2







Pressure Injuries

The Trust ambition for 2020/21 is:

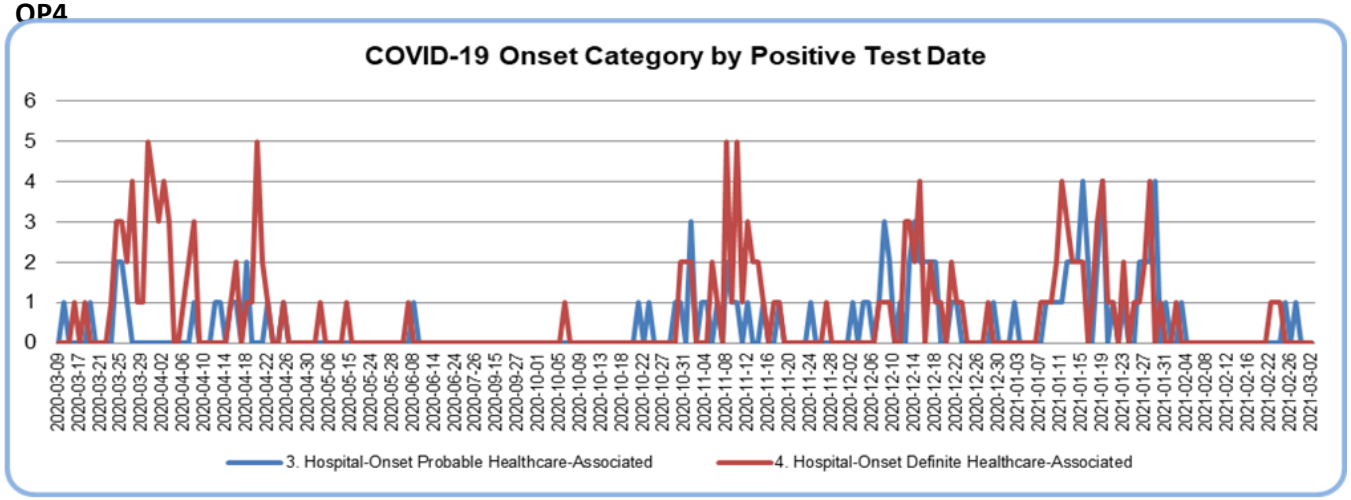
- Zero for both Grade 4 and 3 pressure injuries.
- 30% reduction of Grade 2 pressure injuries.
- 30% reduction of device related pressure injuries.

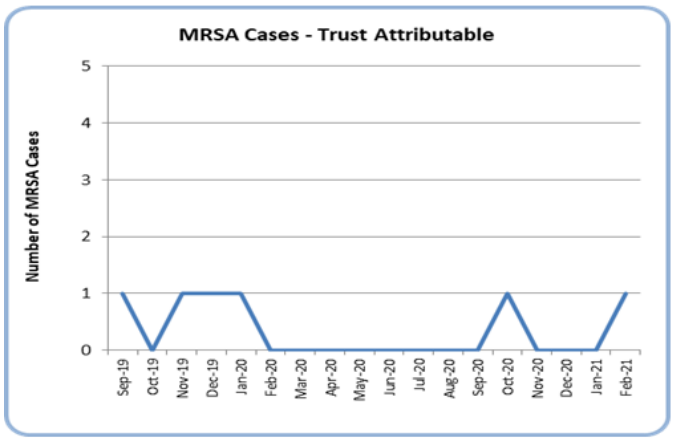
There have been no reported Grade 3 or 4 pressure injuries in February. 27 Grade 2 pressure injuries were reported of which 8 were related to a medical device.

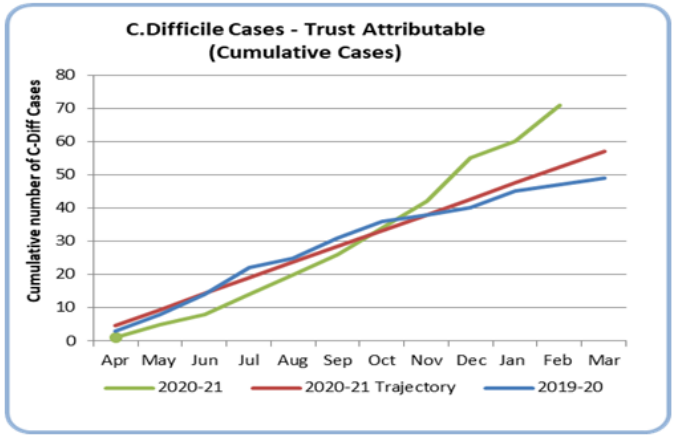
The incidence summary for the month is as follows:
Medical Devices: 30%
Heels: 37%
Buttock: 22%
Spine/ Coccyx/ Natal Cleft: 11%

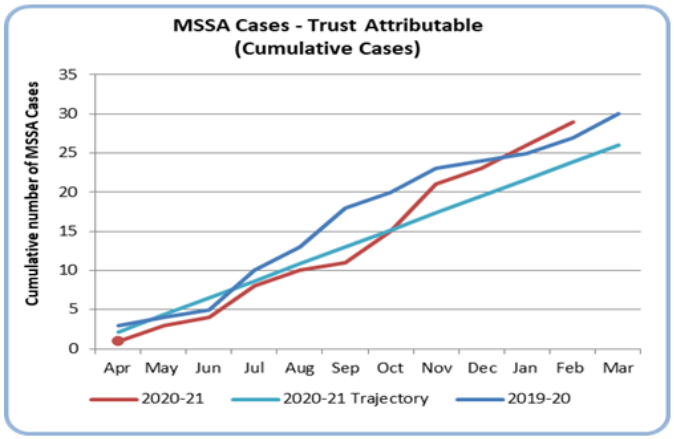
The Trust wide Pressure Injury Review Group recommenced in March with plans to review specific themes from validated pressure injuries in February including medical devices and pressure injuries to heels.

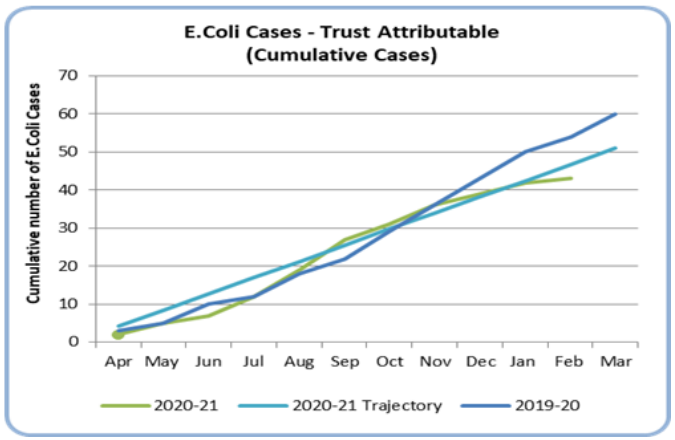
The Divisions continue to complete peer review audits. There are specific Quality Focus Meetings in Medicine to address themes from validated pressure injuries with identified actions to review and implement divisionally.











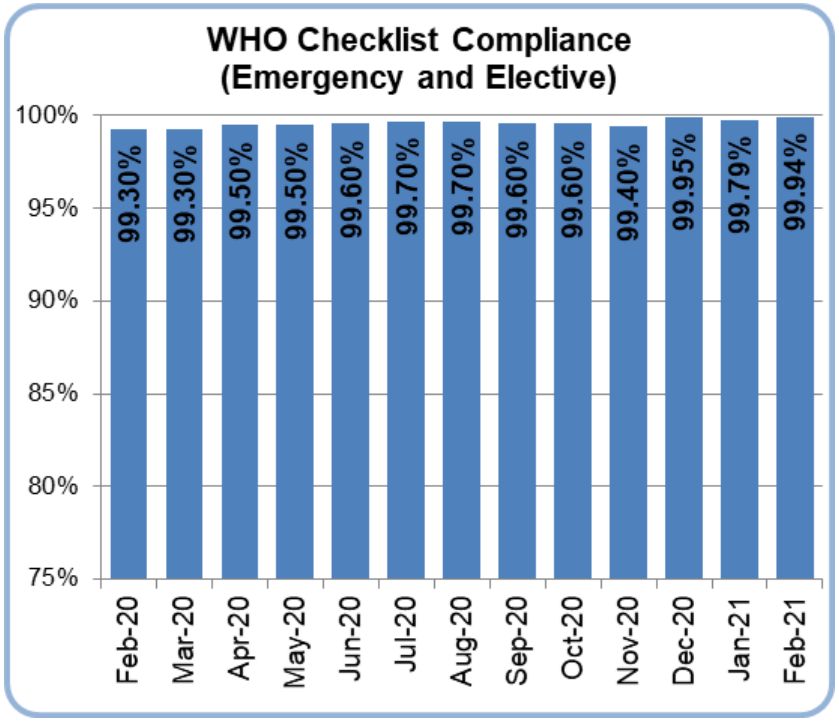
COVID-19 (Coronavirus)
The infection control effort and resources are focused on managing the COVID-19 pandemic and its impact on the Trust. In February there was a reduction in both staff and patient involvement in outbreaks resulting in fewer hospital onset cases.

All events are the subject of Outbreak meetings with appropriate PHE input. A daily infection control huddle led by the DIPC or deputy DIPC ensured appropriate actions were taken promptly. Staff across the Trust have been supported in good use of PPE and standard IPC precautions. Additional support has been given to increase uptake of Lateral Flow Testing (LFT) both as an early warning tool and also for outbreak management. The successful vaccination programme has contributed to reduction in hospital outbreaks.

MRSA
One MRSA bacteraemia within the renal service is being investigated.

C. difficile
The Trust will not achieve the trajectory for C. difficile cases this year following increased numbers in autumn 2020 that have continued in Quarter one 2021. Late sampling and poor documentation account for a number of cases and may be a consequence of the pandemic pressures. Divisional DoNs with increased support from IPC are working to return to best practice. Antibiotics given to patients with COVID-19 infection may also have contributed to additional cases.

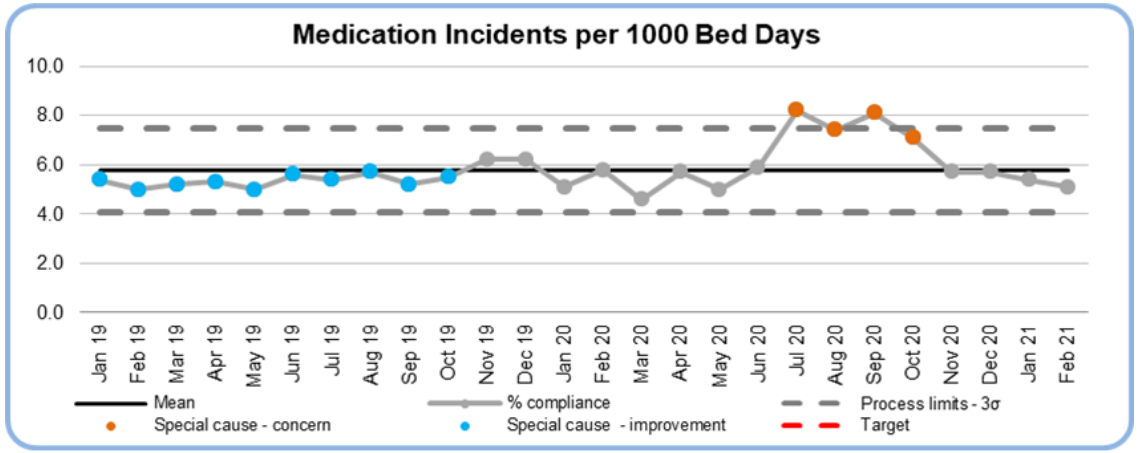
QP2

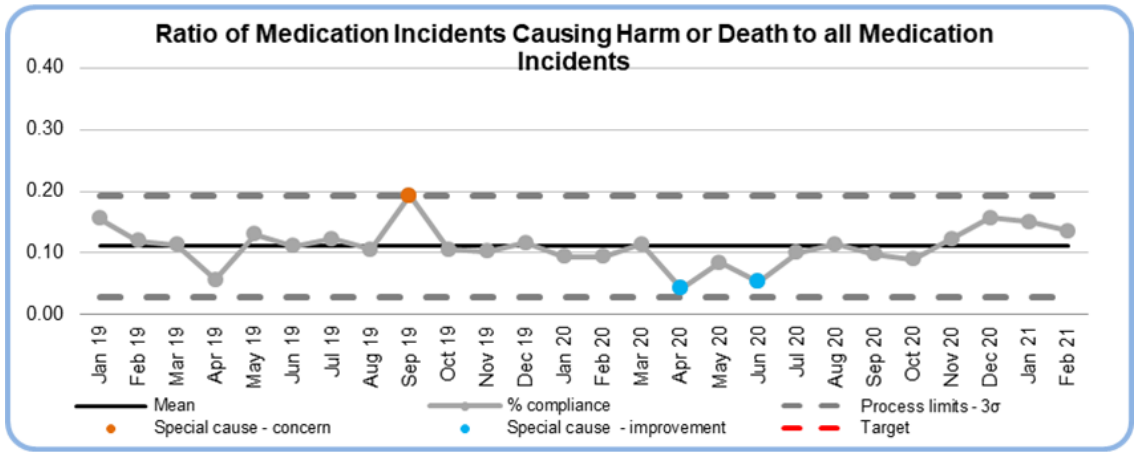


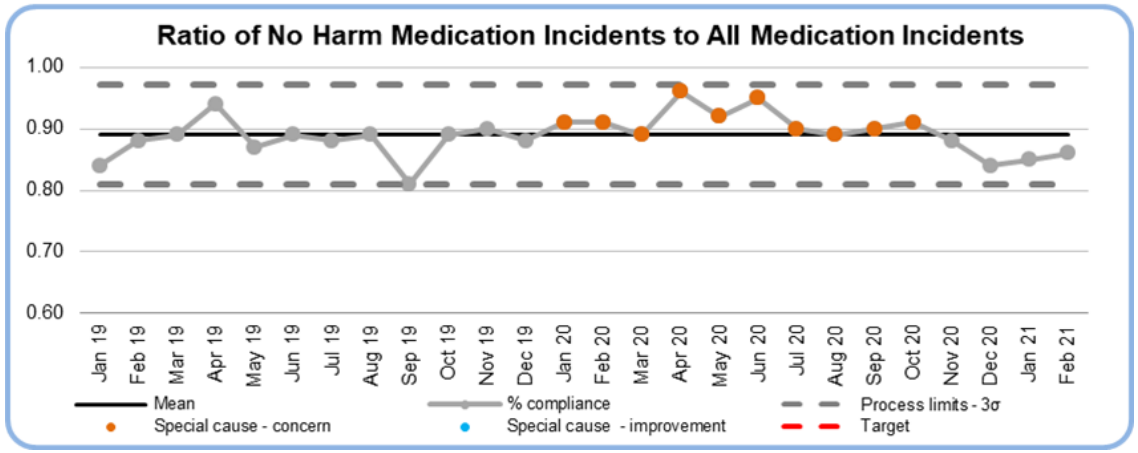
WHO Checklist Compliance

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.







Medicines Management

Medication Incident Rate per 1000 Bed Days

NBT had a rate of 5.1 medication incidents per 1000 bed days. Higher levels of reporting are considered an indicator of a strong safety culture. It is thought that rates of reporting fell during the last quarter due to pressures from the pandemic. The Trust will be working to increase reporting again in the months ahead.

Percentage of Medication incidents reported as causing Harm or Death

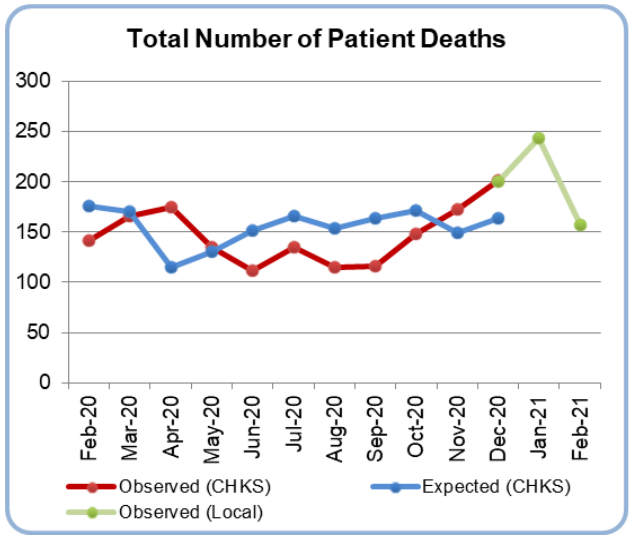
During February 2021, 13.5% of all medication incidents are reported to have caused a degree of harm. There has not been an increase in absolute number and the increased percentage is thought to be linked to the reduction in reporting of low level incidents discussed above**.**

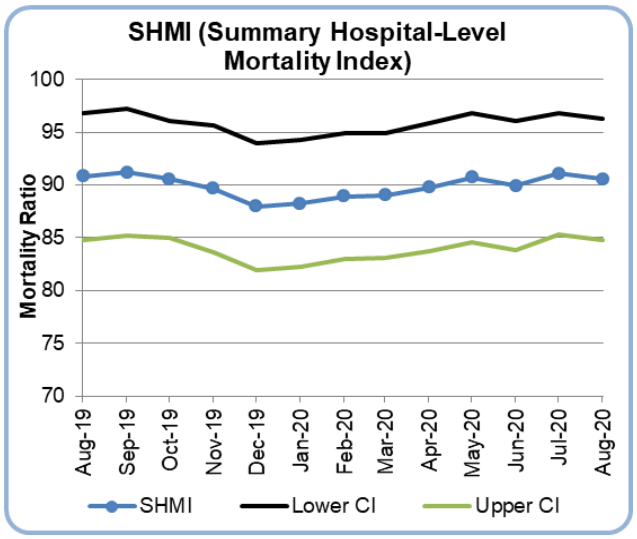
North Bristol Trust Medication Incident Reporting

Organisations where staff believe reporting incidents is worthwhile are likely to report a higher proportion of "no harm" incidents. During February 2021, “no harm“ incidents accounted for 86% of all NBT reported medication incidents.

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

Dec 19 – Nov 20[1]	Completed	Required	% Complete
Screened and excluded	1214*		
High priority cases	278		
Other cases reviewed	227		
Total reviewed cases	1719	1807	95.1%

Overall Score	1=very poor	2	3	4	5= Excellent
Care received	0.0%	3.8%	21.6%	49.0%	25.6%

Date of Death	Jun 20 – November 20
Scrutinised by Medical Examiner	195
Referral to Quality Governance team	5 (2.6%)

*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, with subsequent fall in February a reversal of this impact. The SHMI remains within the expected range but there is significant lag in reporting this number.

There are no current Mortality Outlier alerts for the trust.

Mortality Review Completion
Between 01 Dec 2019 and 30 Nov 2020, 95.1% of all deaths had a completed review, including through the Medical Examiner system.

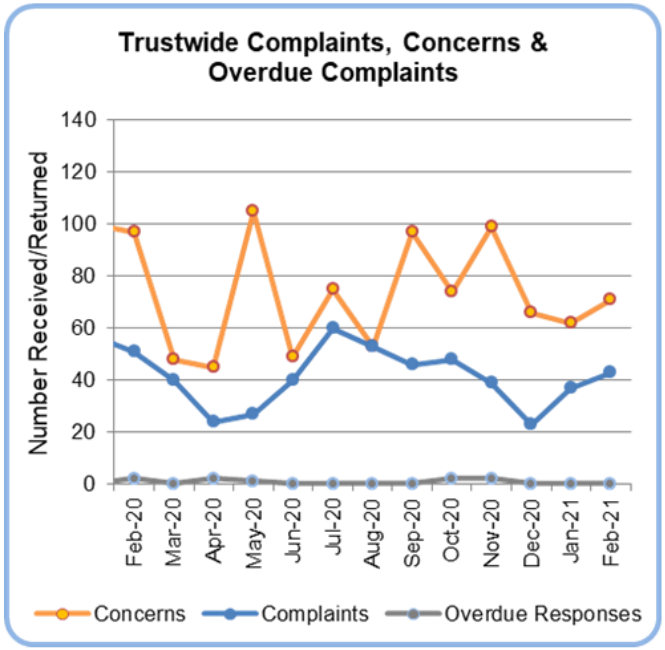
21 of the 21 deceased patients with Learning Disability and 33 of the 33 patients with Serious Mental Illness have had completed reviews.

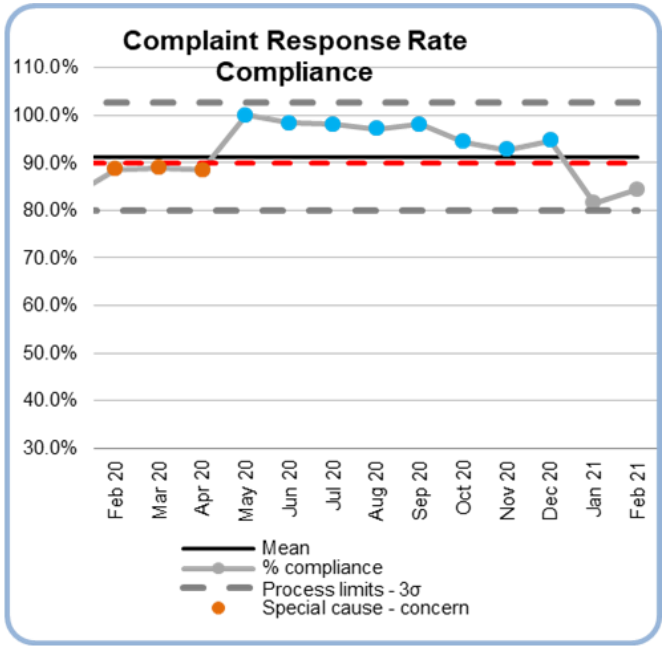
Mortality Review Outcomes
The percentage of cases reviewed by MCR with an Overall Care score of adequate, good or excellent is 96.2%. There have been 18 mortality reviews with a score indicating potentially poor, or very poor care which have undergone learning review through divisional governance processes. 1 case has been confirmed as SIRI (Feb 20).

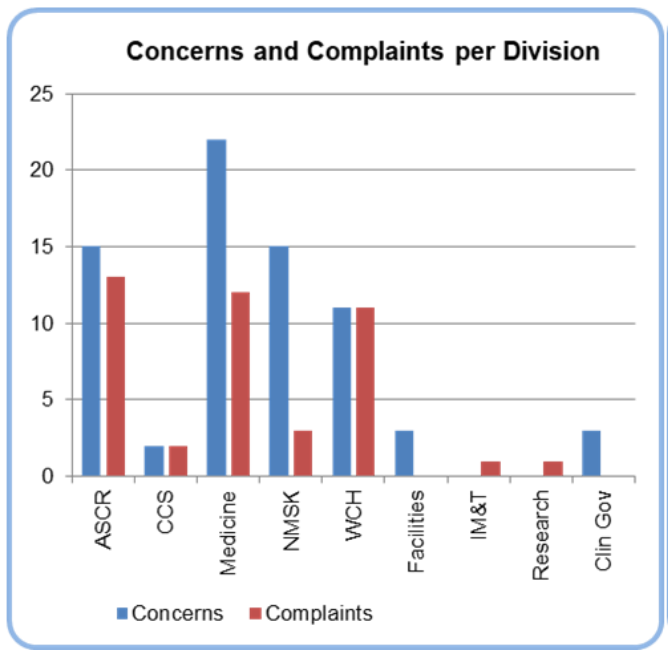
Pandemic 3rd Wave Process
As agreed with the Clinical Audit and Effectiveness Committee a revised review process is being instituted to manage a back log of reviews as a result of the pandemic.

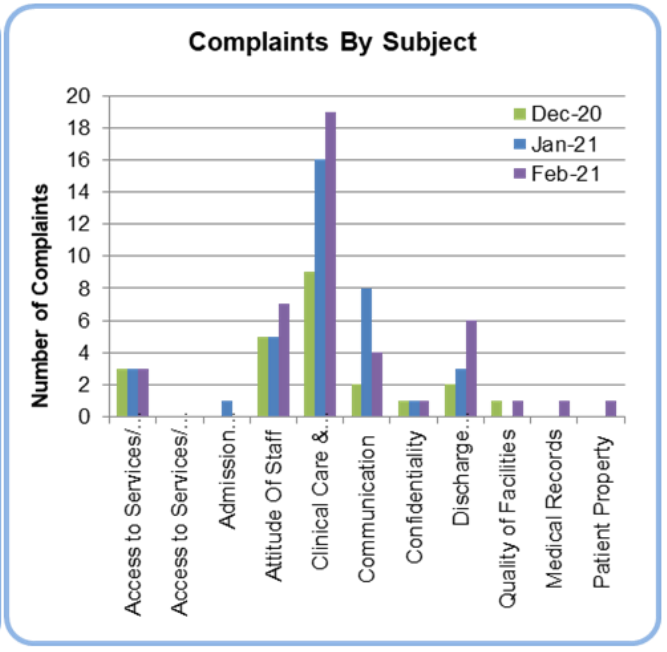
Patient Experience

Board Sponsor: Director of Nursing and Quality
Helen Blanchard









N.B. Feb-19 and Mar-19 data has been removed for complaints, concerns and overdue complaints owing to data quality issues. From June-19 Enquiries have **not** been included in the 'concerns' data.

Complaints and Concerns

In February 2021, the Trust received 43 formal complaints. This is a slight increase of the number received in January.

The most common subject for complaints remains 'Clinical Care and Treatment'. There has been a consistent increase in complaints regarding 'Attitude of Staff' over the past 3 months, and a notable increase in complaints regarding 'Discharge Arrangements' in February.

The 43 formal complaints can be broken down by division: (the previous month total is shown in brackets)

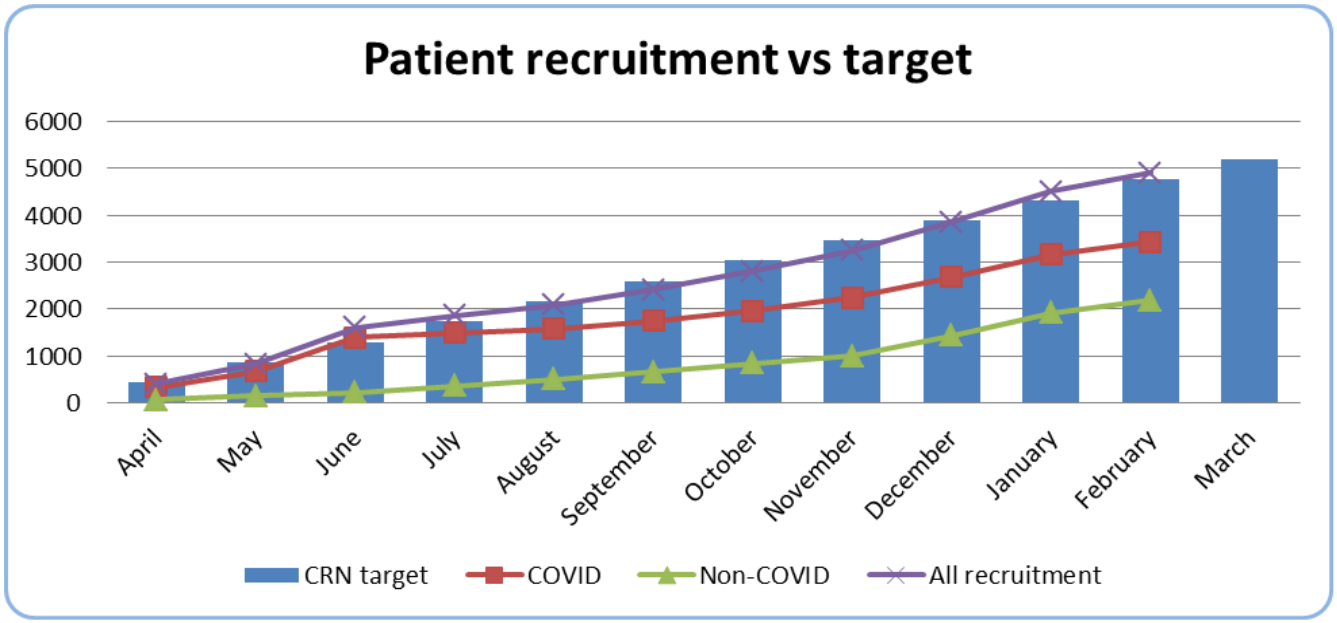
ASCR 13 (10) CCS 2 (1)
Medicine 12 (11) NMSK 3 (7)
WCH 11 (8) IM&T 1 (0)
Research 1 (0)

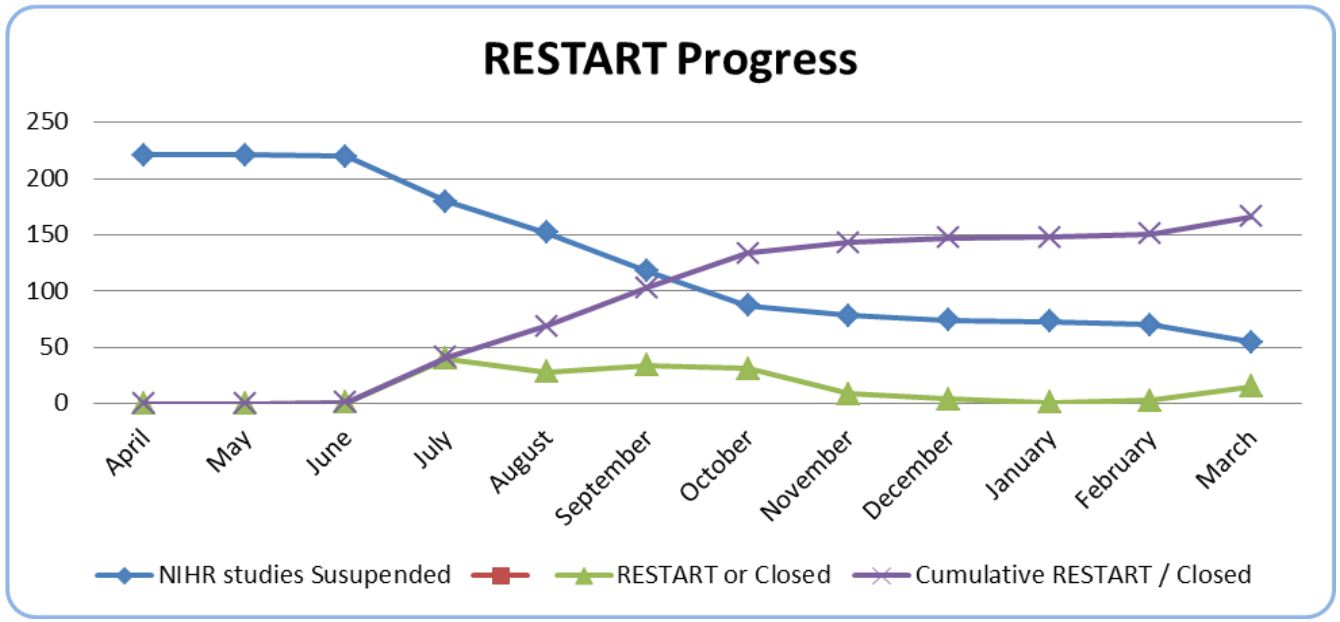
Enquiries and PALS concerns are recorded and reported separately. In February, a total of 65 enquiries were received by the Patient Experience Team and 71 PALS concerns were received. This is an increase of activity from January.

Complaint Response Rate Compliance
The chart demonstrates the % of complaints responded to within agreed timescales. In February there has been an improvement in compliance rate, from 81% in January to 84%. This is still below the Trust target of 90%.

Of the 32 complaints due to be closed in February, 27 were responded to on or before the due date. 5 complaints were delayed, 2 in WACH, 1 in Facilities, 1 in NMSK and 1 in ASCR.

Overdue complaints
There are no overdue complaints.





Research and Innovation

In addition to the 3442 participants recruited into COVID-19 studies, NBT researchers have also recruited 2195 patients into non-COVID-19 studies, achieving 104% of target.

NBT has also contributed a further 3865 patient data records to the Avon-Cap study (A Pan-Pandemic Respiratory Infection Surveillance Study), which is providing surveillance on the effectiveness of vaccines.

NBT suspended 221 studies during the epidemic and 166 studies have been re-started or closed. Due to the second wave, restart needed to slow during November and December 2020 but has resumed in February 2021.

NBT continues to work collaboratively with other Trusts to enable patients from Gloucester, Swindon, Bath and greater Bristol to participate in COVID-19 vaccine trials.

NBT currently leads 53 research grants (NIHR, charity, industry and other) to a total value of £20.3m, and is a partner on 50 grants to a total value of £6.3m.

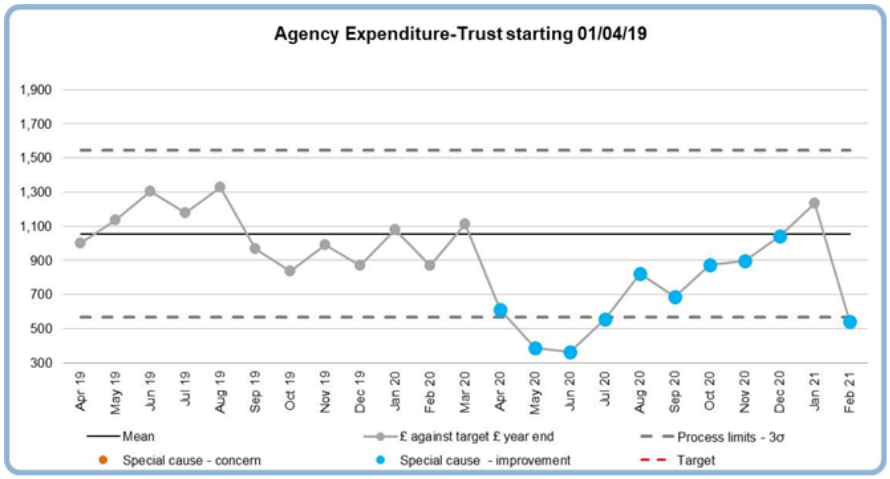
R&I has just opened a general call for applications to the SHC Research Fund (2020/21) and welcomes any NBT staff member wishing to undertake a research project (up to £20k) in any subject area to apply.

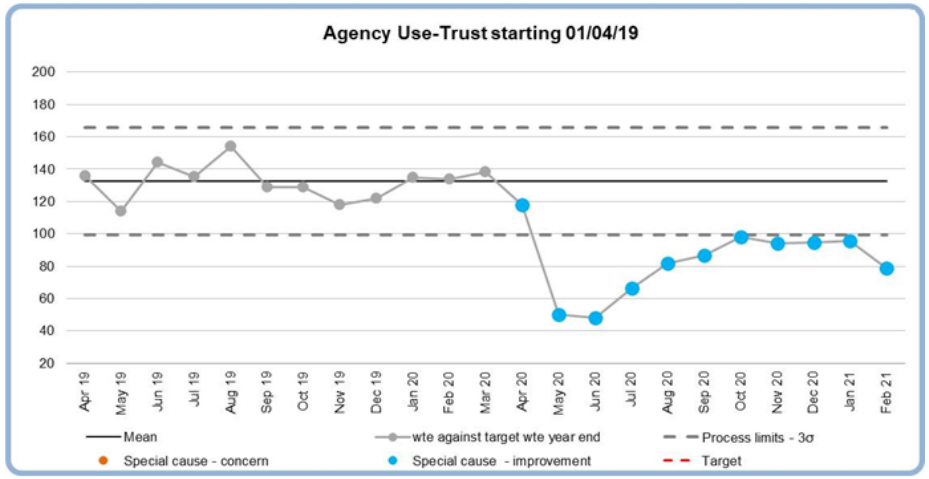
NHS North Bristol NHS Trust

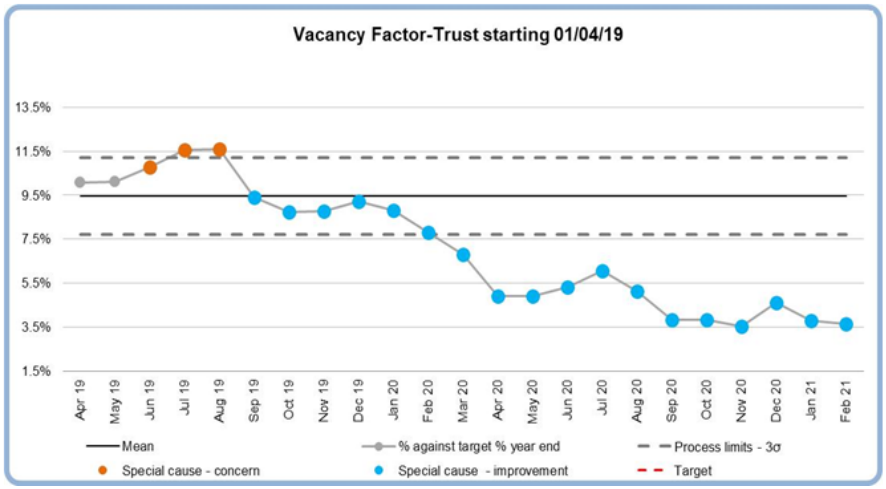
Well Led

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

Workforce







Resourcing

February 2021 saw a decrease in the demand on Temporary staffing, which resulted in significant reductions on the need for Tier 4 support and the resulting reduction in overall spend.

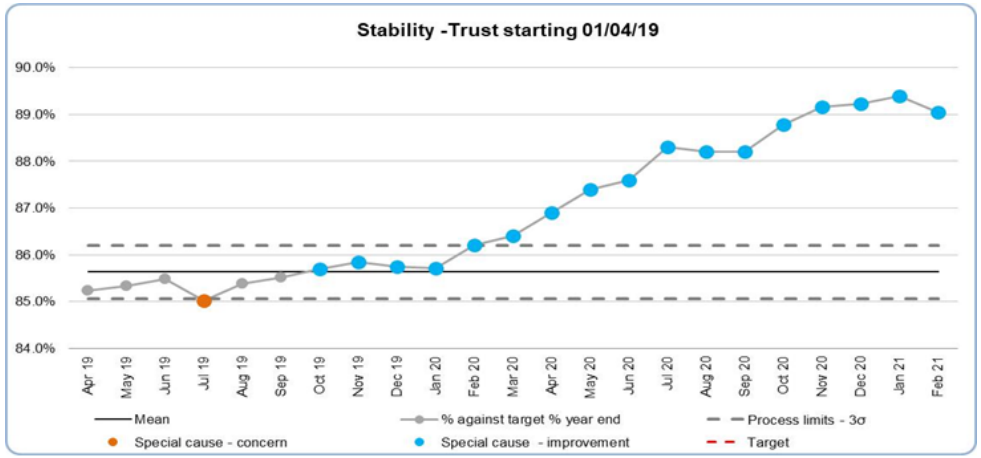
There is also a strong pipeline of Registered and Non Registered staff coming through the recruitment process.

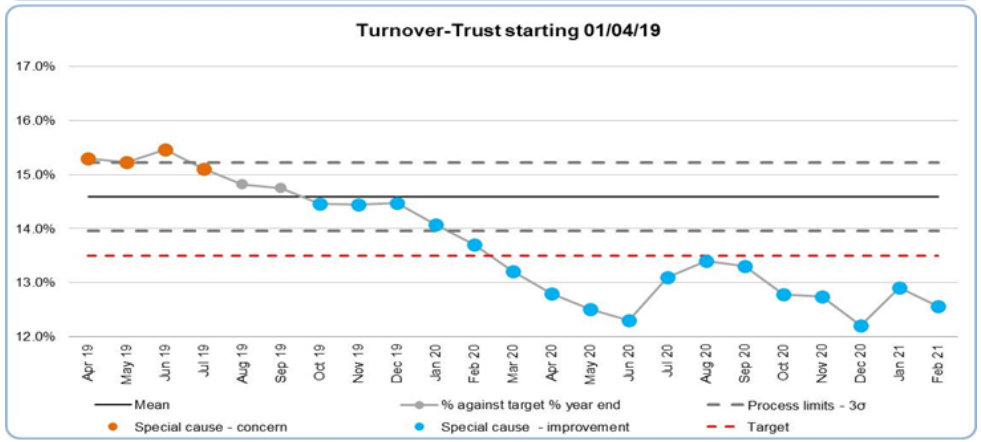
The NBT eXtra team continue to provide support for short term staffing needs for the BNSSG Mass Vaccination project. Demand from PCN's and Community Pharmacies are increasing and NBT eXtra have filled all 40 requests received so far.

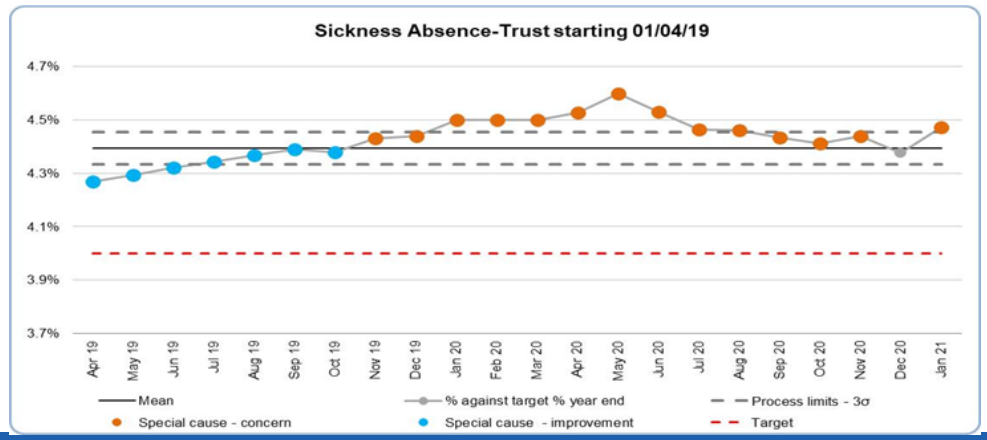
A Spring Nursing Careers digital event took place over 2 days. 50 candidates registered to attend on the day, and from 20 interviews, 14 offers were made. February saw a total of 32 offers made and 8 Band 5 Nurse starters, as well as 6 International Nurse arrivals.

HCA Recruitment saw 22 offers made to Healthcare Support workers in Band 2 and 3 in February and 25 starters. This took our HCA vacancies down to 42 WTE

Engagement and Wellbeing







Turnover and Stability

NBT, as well as being part of the Healthier Together Retention Task and Finish group (Pathfinder project), is also working at system level to address potential future increases in turnover due to the work impact on staff of COVID-19. We have developed the 'Four Pillars of Recovery'. One of these pillars is retention, and includes a system-wide focus on:

- 'Itchy feet' offer to staff at risk of leaving
- Refreshing our flexible working options
- Recovery leave
- Career conversations
- Communication, engagement/ messaging of the offer to staff (EVP)
- Development opportunities and CPD

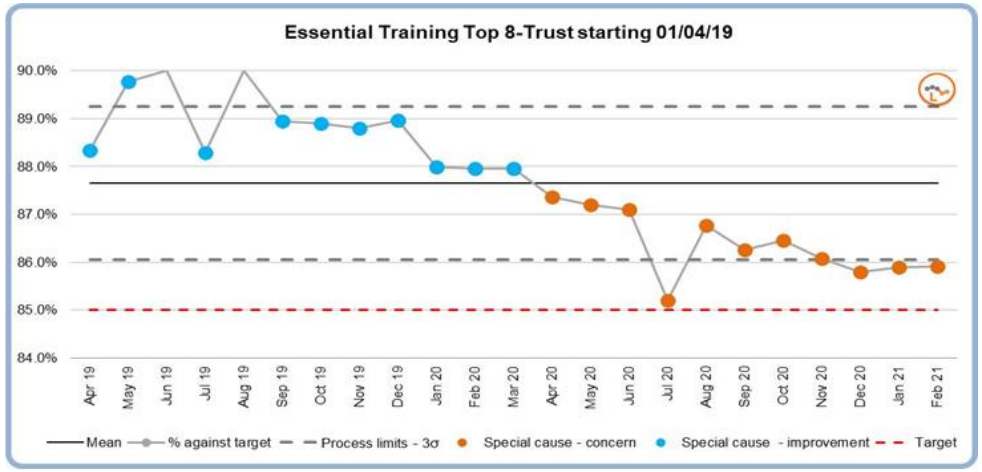
The 'Itchy Feet' campaign and 'Leaving the Trust' resources are currently being refreshed by the People Team within NBT. The Trust is also actively working on the development of a framework/guidance document for managers which will enable them to support staff wishing to take extended periods of leave to aid their recovery, stamina and well-being.

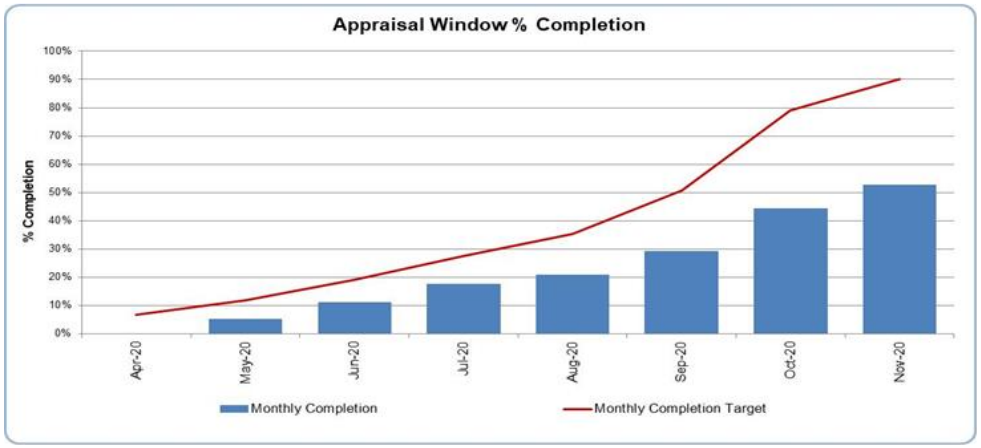
NBT's approach to retention is currently being audited by KPMG as part of their rolling programme of audits.

Sickness and Health and Wellbeing

Work undertaken to help improve sickness absence includes:

- Implementing the helpful feedback from KPMG's recent audit of the ER Case Tracker, particularly around the management of sickness cases;
- The development and implementation of management guidance and support for staff off sick with Long COVID-19/Post-COVID-19 Syndrome;
- Review and refresh of the Sickness Absence policy has now commenced;
- Continuation of high level case reviews for the 'top 30' LTS with People Business Partners and senior HR 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;





Training Topic	Variance	Jan-21	Feb-21
Child Protection	0.1%	85.9%	86.0%
Adult Protection	0.4%	87.4%	87.9%
Equality & Diversity	-0.2%	90.8%	90.6%
Fire Safety	-0.1%	85.7%	85.6%
Health &Safety	0.4%	87.4%	87.9%
Infection Control	0.5%	91.3%	91.8%
Information Governance	-0.2%	81.3%	81.1%
Manual Handling	-1.0%	75.6%	74.6%
Waste	0.1%	87.6%	87.7%
Total	**0.0%**	**85.90%**	**85.91%**

Essential Training

Despite challenging staffing conditions, compliance continues to remain inline with the 85% threshold, with eLearning being the main access route. 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

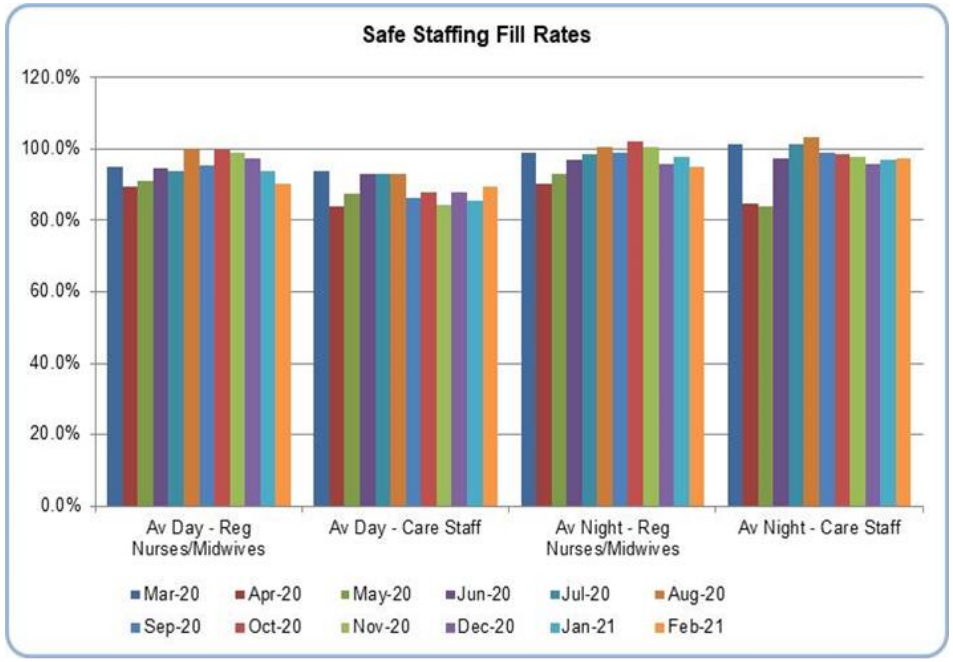
A reduced programme of offerings will be in place until April 2021 (although content directly related to staff wellbeing or use of eRostering is still available).

Apprenticeship Centre

Wherever feasible, Apprenticeship activity has continued the pandemic. Effective April 2021, the Trust will be providing extra support sessions to those ward based learners where it has not been possible to have Assessors in clinical environments.

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. Our next Trainees will join us in April and May 2021.



Feb-21	Day shift		Night Shift	
	RN/RM Fill rate	CA Fill rate	RN/RM Fill rate	CA Fill rate
Southmead	90.1%	89.3%	95.1%	97.5%

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

Percy Phillips Ward (78.6% Day/ 77.9% Night) unexpected absence, midwifery staff redeployed to support safe care from other services.

27b (73.5% Day) Registered staff vacancies

7a (60.1% Day / 54.1% Nights) This was a green ward which is intermittently running below full occupancy.

7b (79.4% Day) This was a green ward which is intermittently running below full occupancy.

Cotswold (53.8%) Reduced occupancy

ICU (73% day) Vacancies, Registered staff deployed from ICU Mega Team to support.

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 (47.7% day & 65.1% nights) : Reduction in HCSW required due to lower occupancy

8b: (71.7% night) Unregistered staff vacancies safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required

26a (79% day) Unregistered staff vacancies safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required

7a (52.1% day / 57.4% night) This was a green ward which is intermittently running below full occupancy

NICU (49.6% Days / 63.4% Nights) Unregistered staff vacancies, safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required. ,

34b (72.7% day) Ward closed for period of time in month.

ICU (41.1% day & 43.3% nights) safe staffing maintained through daily staffing monitoring and supplementing with ICU Mega Team

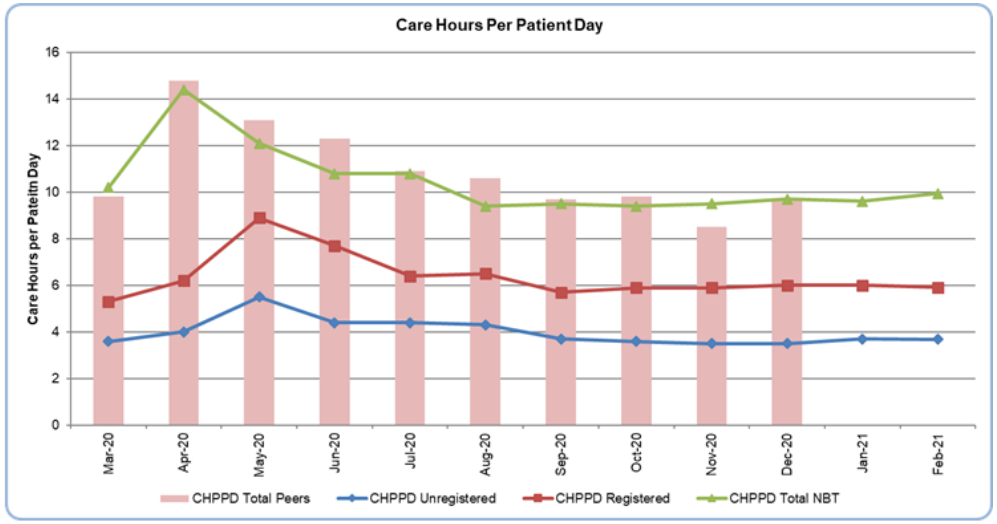
Quantock Ward (70.8% day) Unregistered staff vacancies

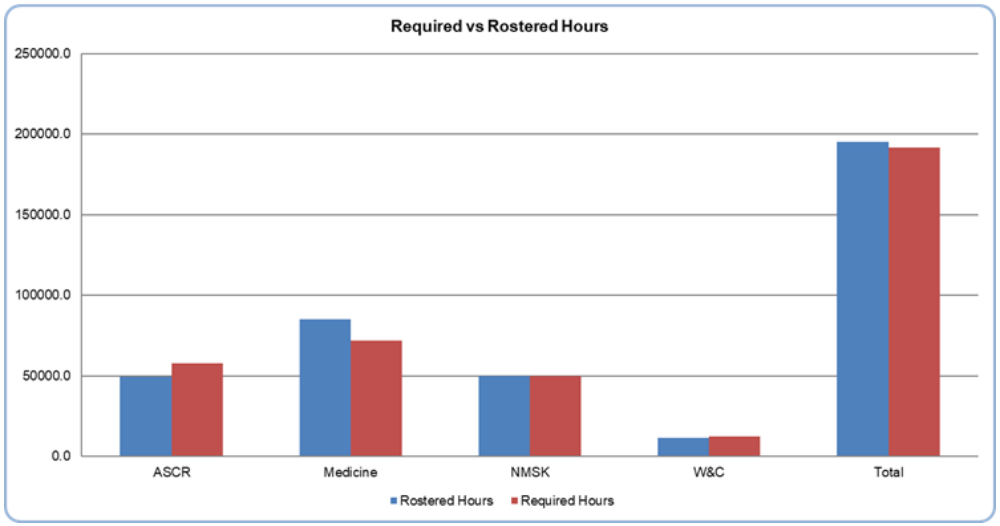
Wards over 150% fill rate:

33a (207.4% night) higher acuity and increased burns patients

6b (166.4% night) additional patients requiring enhanced care support with RMN and colocation of tracheostomy patients into this area.

Rosa Burden (178.3% 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.

NHS North Bristol NHS Trust

Finance

Board Sponsor: Chief Financial Officer
Glyn Howells

Position as at 28 February 2021

	Feb Forecast	Feb Actuals	Variance to Forecast	YTD Forecast	YTD Actuals	Variance to Forecast
	£m	£m	£m	£m	£m	£m
Contract Income	52.6	53.4	**0.8**	536.3	542	**5.7**
Other Income	4.4	8.7	**4.3**	104.9	117.8	**12.9**
Total Income	**57**	**62.1**	**5.1**	**641.2**	**659.8**	**18.6**
Pay	-36.3	-35.7	**0.6**	-385.2	-384.7	**0.5**
Non-Pay	-19.8	-20.3	**-0.5**	-209.2	-208.8	**0.5**
Financing	-5.8	-8.4	**-2.6**	-64.6	-67.1	**-2.5**
Total Expenditure	**-61.9**	**-64.4**	**-2.5**	**-659.1**	**-660.6**	**-1.5**
Surplus/ (Deficit)	**-4.9**	**-2.3**	**2.6**	**-17.9**	**-0.8**	**17.1**

Statement of Comprehensive Income

Assurances

The financial position at the end of February shows a year to date deficit of £0.8m compared to a forecast deficit of £17.9m

The trust achieved breakeven in months 1 to 6 under the cost recovery regime implemented to support service delivery under COVID-19 and a deficit of £0.8m when operating within the new financial envelope.

Income for the month includes a retrospective claim of £0.8m for Nightingale Hospital costs and a further £0.1m for mass vaccination services.

There are no further key issues to report.

Balance Sheet	19/20 M12 balance	20/21 M10 balance	20/21 M11 reported	In-month change	YTD change
Total Property plant and equipment	560.0	559.4	556.1	(3.3)	(3.9)
Intangible Assets	12.0	9.8	7.1	(2.7)	(4.8)
Non-current debtors	4.0	5.4	5.4	0.0	1.4
Total non-current assets	**576.0**	**574.6**	**568.7**	**(5.9)**	**(7.3)**
Inventory	13.1	12.1	12.2	0.1	(0.9)
Total NHS debtors	50.5	23.1	18.3	(4.8)	(32.2)
Total non-NHS debtors	22.2	24.5	22.5	(2.0)	0.3
Cash and cash equivalents	10.7	115.5	146.5	31.0	135.8
Total current assets	**96.4**	**175.3**	**199.5**	**24.2**	**103.1**
NHS creditors (accrued)	(6.5)	(5.4)	(5.0)	0.4	1.5
NHS creditors (invoiced)	(4.6)	(4.1)	(3.1)	1.0	1.5
Non-NHS creditors	(53.2)	(72.0)	(71.5)	0.5	(18.3)
Provisions current	(4.4)	(2.9)	(4.9)	(2.0)	(0.5)
Total deferred income	(3.7)	(68.1)	(89.4)	(21.3)	(85.7)
Total current borrowings	(189.1)	(17.6)	(17.6)	0.0	171.5
Total current liabilities	**(261.4)**	**(170.1)**	**(191.4)**	**(21.3)**	**70.0**
Total non-current provisions and deferred income	(7.2)	(8.7)	(8.7)	0.1	(1.5)
Total non-current borrowings	(388.5)	(374.8)	(373.9)	0.9	14.6
Total non-current liabilities	**(395.7)**	**(383.5)**	**(382.5)**	**1.0**	**13.2**
Total net assets	**15.3**	**196.3**	**194.3**	**(2.0)**	**179.0**
Public Dividend Capital	248.5	427.5	427.5	0.0	178.9
Revaluation reserve	149.1	150.2	150.2	0.0	1.0
In-year Income and Expenditure	(3.8)	2.0	0.0	(2.0)	3.8
Retained earnings	(378.5)	(383.4)	(383.4)	0.0	(4.8)
Total net assets	**15.3**	**196.3**	**194.3**	**(2.0)**	**179.0**

Statement of Financial Position

Assurances

The improved cash position of £146.6m (£m up since March) is a result of the current financial regime of advance payment arrangements presently in place for all NHS Trusts.

Key Issues

The level of payables is reflected in the Better Payment Practice Code (BPPC) performance for the year to date in 2020/21 of 86.6% by value compared to an average of 85.8% for financial year 2019/20.

Financial Risk Ratings , Capital Expenditure and Cash Forecast

Capital expenditure for the first 11 months of the year is £18.2m which compares to a year to date plan of £24.6m.

Financial Risk Rating

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

Rolling Cash forecast

The high level cash flow below is in line with NBT's element of the forecast submitted to NHSI on 22nd October. This shows that the Trust has will end the year with a circa. £85m cash balance after the unwinding of the month in hand advance payment in March 2021.

	Mar-21 (Forecast) £m
Cash Brought Forward	**146.6**
In Month Cash Movements	-62.4
Cumualtive Cash Balance	**84.2**

Regulatory

Board Sponsor: Chief Executive
Evelyn Barker

Monitor Provider Licence Compliance Statements at February 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, 31 February 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.

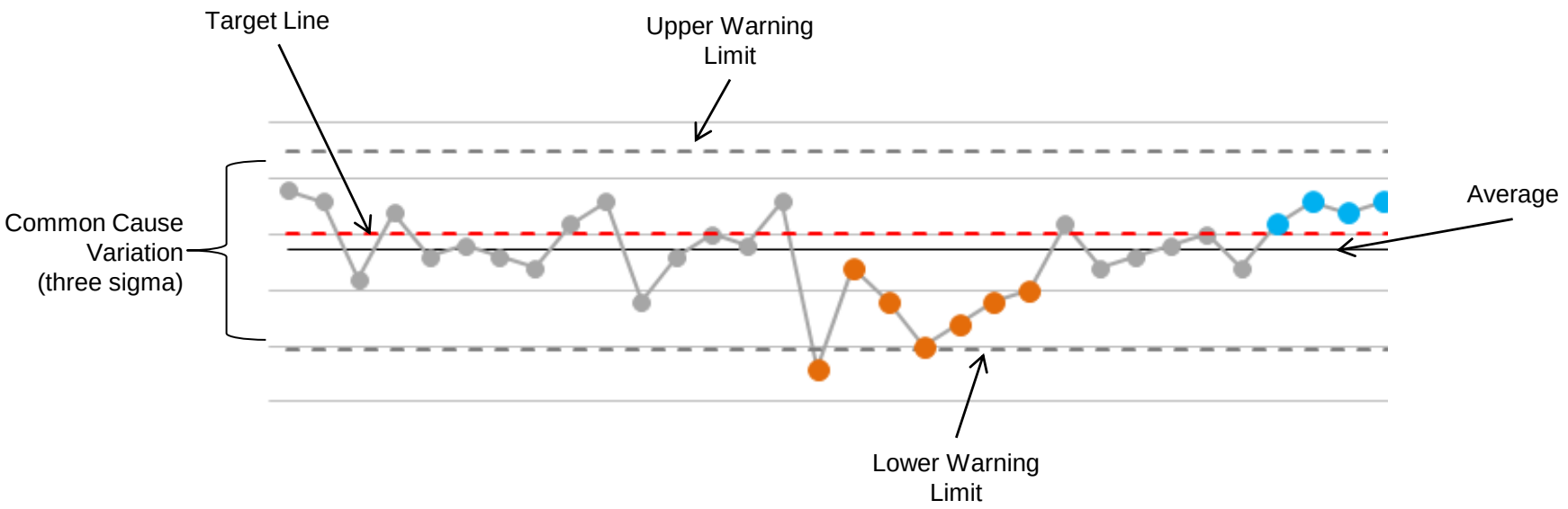
QP3 Ensuring excellence in our maternity services, delivering safer maternity care.

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

Report To:	Trust Board		
Date of Meeting:	25 March 2020		
Report Title:	Staff Survey 2020 Results Headlines		
Report Author & Job Title	Guy Dickson, Head of People Strategy		
Executive/Non-executive Sponsor (presenting)	Jacqui Marshall, Director of People & Transformation		
Does the paper contain	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	None	**None**	**None**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	
Recommendation:	• Discuss the key findings in this report. • Note / endorse the four 2021 themes for action.		
Report History:	• Previously shared with Execs 18/2/21 and People Committee 8/3/21		
Next Steps:	• Corporate and Divisional action planning		

Executive Summary

This paper shares the headline Staff Survey 2020 results with an analysis of key findings by trust, division, and job type; considers progress against last year's priority areas for action; and makes recommendations for priority action areas for 2021.

Overall, the 2020 results are very positive, we have consolidated the improvements seen over the last two years and further improved in many areas. We have improved our results in three of the five areas identified as themes for action last year.

More than half of our responses have improved since last year, and for the first time, overall the balance of our results are better than national acute average including staff engagement. Highlights and areas of concern are as follows:

• We are consistently better than acute trust average in the following areas: Patient Care; and NBT as a place to work.

• Our improvement was particularly strong in the following areas: Health and Wellbeing, bullying / violence, and workload / resources. • Areas where we are significantly below average or deteriorating are: management, quality of care, and inclusion The paper identifies 4 themes for action in 2020 as approved by the Executive Team: Staff Voice, Workload, Inclusion, and Management Development.	
Strategic Theme/Corporate Objective Links	**1. 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	Workforce Committee Risk Register: • Inability to ensure safe/sufficient staffing within clinical and corporate teams: score 12 • Inability for organisation to deliver necessary organisational change and business as usual performance within agreed resources: score 12
Other Standards Reference	CQC
Financial implications	Cost of running the staff survey is £8542, excluding NBT staff time.
Other Resource Implications	N/A
Legal Implications	EDS2 Objective: Representative and Supported Workforce
Equality, Diversity and Inclusion Assessment (EIA)	Process TBC
Appendices:	1. Summary of staff survey performance by division 2. Summary of staff survey performance by job category 3. Staff Survey Results Infographic

12

1. Purpose

1.1. Following the release of the embargoed summary staff survey results on 12/2/21, the purpose of this report is to:

- Inform the Trust Board of the full results of the 2020 Staff Attitude Survey;
- Update on progress against the corporate objectives and the themes for improvement agreed from the 2019 survey.
- Identify areas of strength and themes for action from the 2020 survey
- Identify key divisional differences and differences between job roles
- Identify the corporate themes for focus for 2021 as approved by the Executive team on 18/2/21.
- Identify next steps

1.1 On 12 February 2021 NBT received the results from the 2020 Staff Attitude Survey from the Staff Survey Coordination Centre. This is approximately a month later than in previous years.

1.2 All results were embargoed until 11 March 2021, when the full results will be published nationally (again, approximately one month later than in previous years).

1.3 The results at this stage are more detailed than in previous years, and do include the overall staff engagement score. They do not, however, include the "free text" comments which include responses questions about NBT's response to the Covid pandemic. These free text comments and an analysis of them are expected to be provided to us in April 2021.

1.4 In February 2020 the Executive team and People and Digital Committee reviewed the results of the 2019 Staff Survey and agreed 5 themes for action:

1. Staff Voice
2. Workload
3. Inclusion
4. Speaking Up
5. Management Development and Appraisals

Progress against each of these areas is assessed in 5.1 below.

12

2. Response Rates

2.1 4517 staff completed the survey in 2020, the highest number ever. The response rate for the Trust as a whole was 51%, the same as last year. It was significantly higher than the Acute Trust average of 45%, which fell from the previous year.

	2016	2017	2018	2019	2020
Response rate	32%	46%	41%	51%	51%
Total responses	401	3703	3362	4207	4517

3. Summary Results

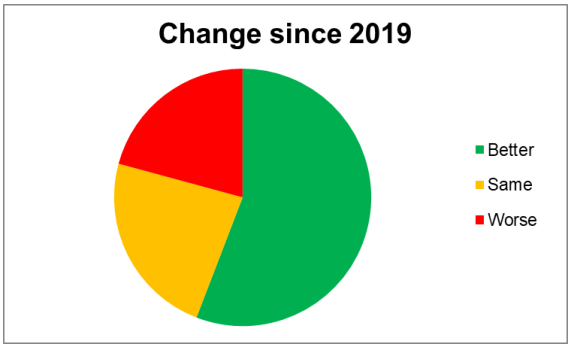
This paper shares the headline Staff Survey 2020 results with a brief analysis of key themes.

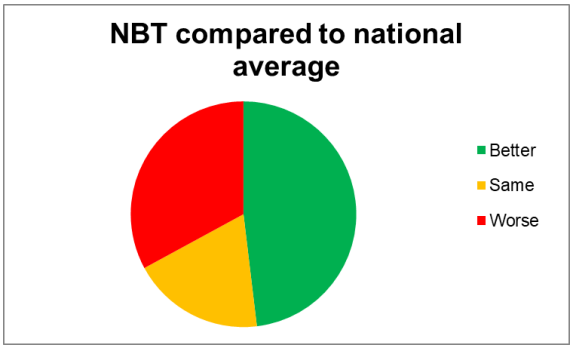
3.1 Overall, the 2020 results are very positive, we have consolidated the improvements seen over the last two years and further improved in many areas.

3.2 The single most important overall key measure is staff engagement, which tends to drive all other results. This year our staff engagement rating is 7.1, the same as last year, and higher than the national acute average of 7.0.

3.3 More than half of our responses have improved since last year, and overall the balance of our results are better than national acute average, as shown in the results below. In relation to other Trusts,

- In 2018 75% of results were below average
- In 2019 we were broadly in line with the average
- In 2020 48% of results are better than average, 18% the same, 33% worse





3.4 The staff survey coordination centre has provided an overview of performance by theme this year.

- NBT is **better** than average in the following themes: Morale, Bullying and Harassment, and Staff Engagement.
- NBT is **worse** than average in the following themes: Immediate Managers; Quality of Care; Violence, and Team Working.
- NBT has **improved** in the following themes since last year: Health and Wellbeing, Morale, Bullying and Harassment, Violence, Safety Culture.
- NBT has **deteriorated** in the following themes since last year: Equality, Diversity and Inclusion, Immediate Managers, Quality of Care, Team Working

In the published analysis provided by the National Staff Survey Coordination Centre, the overall analysis of the 10 themes between 2019 and 2020 on p69 shows that there are

no significant reductions, and there are 4 significant increases (Health and Wellbeing, Morale, Bullying and Harassment, Violence).

However it is important to also consider the response to individual questions as described in sections 6-9 below.

4. Progress Against Targets

4.1 The table below shows progress against the 5 thematic targets agreed in February 2020.

Priority	2020 Results	RAG
Workload and Resources	Of 4 relevant question responses: • 3 improved from 2019, 1 the same • 3 worse than national average, 1 better	Improved overall but remain below average
Leadership Development & Appraisals	No direct comparison on appraisal questions possible. Of 7 questions relating to management: • 2 improved from 2019, 1 the same, 4 got worse • 6 worse than national average, 1 the same	Deteriorated overall and falling behind average
Staff Voice	Of 4 relevant question responses: • 2 improved from 2019, 2 the same • 2 worse than national average, 1 the same, 1 better	Improved overall but remain slightly below average
Speaking Up & Violence	Of 14 relevant question responses: • 10 improved from 2019, 1 the same, 1 got worse, 2 new questions • 3 worse than national average, 1 the same, 10 better	Significantly improved and better than national average
Inclusion	Requires analysis by protected characteristic groups although staff survey report thematic summary indicates that we have got worse since last year but are in line with national average.	Deteriorated but around average

5. Areas of Strength Compared to Acute Trust Average

5.1 There are more questions than ever before where we score higher than Acute trust average. The key areas where we consistently score significantly above average as

illustrated below: patient care, health and wellbeing, and NBT as a place to work. These were also areas of strength last year.

Question	Positive Score 2020	Comparison to national average	Change from last year
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	83%	+8%	+3% (improved)
Does your organisation definitely take positive action on health and well-being?	38%	+5%	+7% (improved)
I would recommend my organisation as a place to work.	72%	+5%	+3% (improved)
Relationships at work are not strained.	51%	+5%	+2% (improved)

6. Areas of Improvement

We improved in most areas this year, however some areas saw particularly significant increases: workload and health and wellbeing.

Question	Positive Score 2020	Improvement from last year	Comparison to national average
In the last three months have you ever come to work despite not feeling well enough to perform your duties?	53%	+9%	0% (same)
Does your organisation take positive action on health and well-being? (yes, definitely)	38%	+7%	+5% (better)
There are enough staff at this organisation for me to do my job properly.	37%	+6%	-1% (worse)
I have adequate materials, supplies and equipment to do my work.	60%	+6%	+1% (better)

7. Areas where we underperform

7.1 There are a couple of themes where we are notably below Acute Trust average – management and delivery of care. Although we have not deteriorated significantly, the gap between us and the national average is widening.

Question	Positive Score 2020	Comparison to national average	Change from last year
My manager asks for my opinion before making decisions that affect my work.	51%	-4%	-1% (worse)

My manager gives me clear feedback on my work.	57%	-4%	-1% (worse)
I am able to deliver the care I aspire to.	66%	-4%	0% (same)

8. Areas where we are deteriorating

9.1 The areas where we have seen deteriorations since last year are common to other Trusts, and are likely to be deteriorations due to the Covid pressures.

Question	Positive Score 2020	Deterioration from last year	Comparison to national average
During the last 12 months have you felt unwell as a result of work related stress?	57%	-3%	+1% (better)
The team I work in often meets to discuss the team's effectiveness.	54%	-3%	-3% (worse)
I am enthusiastic about my job.	73%	-2%	0% (same)

In relation to inclusion and discrimination, whilst there has only been a minor deterioration in responses to these questions from all staff; more concerning is the experience of staff with protected characteristics as shown in 12.3 below.

10. Analysis by Division

10.1 Appendix 1 shows a high level analysis of the divisional performance in the staff survey, in terms of performance against trust average and how this year's results compare to last years'.

10.2 All divisions have again improved performance significantly this year. The most improved division is Facilities, who have improved in 75% of questions. The division with fewest improvements was NMSK who improved in 37% of questions – however this limited improvement was against an overall position of high performance. Medicine improved in improved in 49% of questions, in 2019 they improved in 87% of questions.

10.3 When comparing divisions to each other, broadly their performance ranks as last year. The highest performing division within the trust regarding the staff survey is NMSK, who are above trust average in 81% of questions. The division with most responses below trust average is ASCR (85% of responses below average).

10.4 A further more detailed analysis will now take place in partnership with key divisional stakeholders, the divisional People Partners and senior members of the People & Transformation team. A clear plan with timelines for doing so is under development.

10.5 This analysis will inform divisional level findings and areas to focus on, as well as communications and work with staff at a local level.

11. Analysis by Staff Group

11.1 A high level review of the staff survey scores by Job Category shows that there is a variety of staff experience dependent on the type of job. This is summarised in Appendix in a series of bar charts comparing responses for a given staff group to the NBT average.

11.2 This shows us the following:

- Additional Professional Scientific and Technical: Broadly show responses close to the average in most areas
- Additional Clinical Services: below average responses in most areas, particularly Health and Wellbeing. Above average response for Quality of Care.
- Administrative and Clerical: above average responses in most areas – particularly in bullying, harassment and violence.
- Allied Health Professionals: above average responses in most areas, notably immediate managers and team working.
- Estates and Ancillary: above average responses in bullying and harassment and health and wellbeing, below average responses in team working.
- Healthcare Scientists: above average responses in almost all areas, particularly bullying, harassment and violence.
- Medical and Dental: above average responses in almost every area, particularly Health and Wellbeing, Morale, and Team Working.
- Nursing and Midwifery: below average responses in most areas, particularly bullying, harassment, violence, and health and wellbeing.

11.3 A more detailed analysis of the data of staff with protected characteristics will be undertaken by the Head of Equality, Diversity and Inclusion. However, the data used in the WRES and WDES on p50 onwards in the Staff Survey Coordination Centre Analysis shows significantly worse experiences for BME staff than White staff; and for staff with a long term condition or illness than their colleagues without conditions:

- BME staff experience less harassment / bullying / abuse from patients / the public at NBT (25.1%) than White staff (26.3%) (whereas nationally BME staff experience more).
- Proportionally more BME staff experience harassment / bullying / abuse from other staff (25.7%) than White staff (21.9%). This difference is similar to the difference seen at a national level.

- 64.8% of BME staff think the organisation provides equal opportunities for career progression, compared to 88.2% of White staff. This NBT BME staff figure is significantly lower than the national average for BME staff (72.5%).
- A significantly higher proportion of BME staff at NBT experience discrimination from their manager or colleagues (17.6%) than White staff (5.9%). This difference has widened by around 5% since last year – this is similar to the national picture.
- Staff with a long term condition or illness have an average staff engagement score of 6.8 (out of 10) compared to 7.2 for those without.
- 38.6% of staff with a long term condition or illness feel that the organisation values their work compared with 49% of staff without conditions.
- There are similarly worse experiences for staff with conditions than their colleagues without conditions in the following areas: harassment / bullying abuse from colleagues, managers, patients and the public; career progression; and pressure from their manager to come to work when not feeling well enough.

12. Staff Survey Improvement Priorities 2020

12.1 Over the last three years we have seen a significant and continued increase in progress against our corporate themes for action. By focusing on a consistent few key areas over several years and supporting these with trust-wide initiatives, we have seen marked improvements. It is recommended that this approach continues.

12.2 Furthermore, we now have in place an agreed People Strategy which will embed the good practice and successes we have had in areas such as Health and Wellbeing; and seek to drive improvements in other areas identified as priorities in the staff survey such as Inclusion and Staff Voice.

12.3 The summary of progress against our themes shows that whilst we have made progress in Staff Voice, Workload, and Inclusion, there is still further work to do.

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

12.5 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.

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

1. Staff Voice
2. Workload
3. Inclusion
4. Management Development

12.7 These will be delivered through key corporate areas of work already underway, in particular through the People Strategy and the Transformation Strategy.

13. Staff Survey Narrative and Communications

13.1 A set of communications to feedback the results and how they relate to work we have done this year, and what we need to focus on next year was issued from 11 March 2021 including an intranet web page, video, and infographic summarising the results; announced via an all-staff email update.

13.2 This feedback gives a summary of results and links them to the priority areas set last year, confirming the key corporate work undertaken as a result.

13.3 It is important that we continue to feedback on these points throughout the year and link the corporate programmes of work back to staff survey results.

13.4 Divisional engagement and action planning is now taking place in March / April 2021 after the embargo is lifted; with divisional actions being reported to Board and People Committee in May 2021, as below:

Date	Milestone	Notes
17/2/21	Trust wide survey report to Execs	Agree staff survey narrative and trust-wide priority actions Report submitted COP 16/2/21 for review 17/2/21? Including proposed top 3 areas of focus
22/2/21	Divisional / Detailed Data to BPs for onward share to Divisional Leads	Divisional data review and action planning begins
8/3/21	Trust wide survey report to People Committee	
11 March	Embargo Lifted	Date confirmed by NHS England. Results published nationally
	Communication of results and areas for action to staff	1 pager infographic plus video via Ops update
During April	Covid Question Feedback?	Co-ordination centre have not yet confirmed when we will receive this information
Feb / March	Divisional Engagement and Action planning with staff	Led by divisions with support from People Partners
31/3/21	Deadline for PP's to identify divisional priority actions	
7/4/21	Execs - Divisional Actions report	(also Covid Question Feedback if available)
13/4/21	TMT Papers Due	
20/4/21	TMT Meeting – Divisional Actions Report	(also Covid Question Feedback if available)
21/4/21	JCNC Staff Survey deep dive	

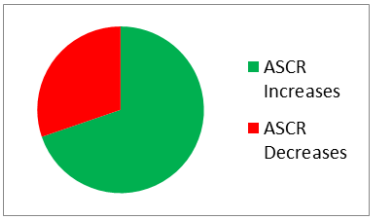
22/4/21	Divisional Actions report papers due for Board	
29/4/21	Board Meeting - Divisional Actions report	(also Covid Question Feedback)
19/5/21	Deadline for PP's to provide update on divisional actions progress	
26/5/21	Execs – Divisional Actions progress update report	(also Covid Question Feedback if not previously shared)
2/6/21	People Committee Papers Due	
8/6/21	People Committee - Divisional Actions progress update report	(also Covid Question Feedback)

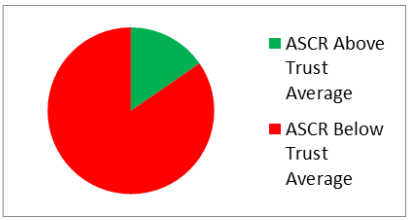
14. Recommendations

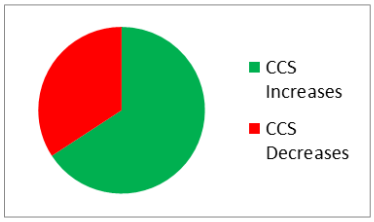
14.1 Discuss the key findings in this report.

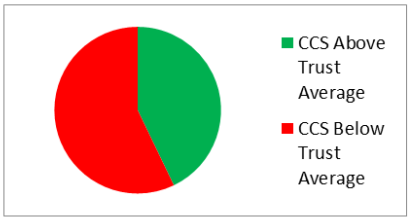
14.2 Note and endorse the four recommended areas of focus.

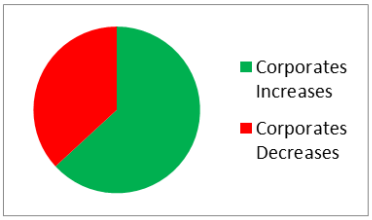
Appendix One Summary of Divisional Staff Survey Performance – Comparing to Trust Average and Previous Year's Performance:

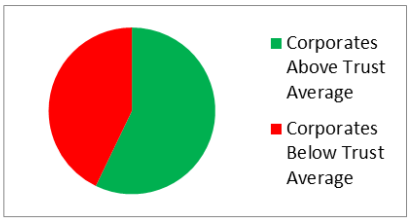


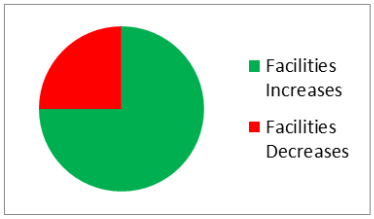


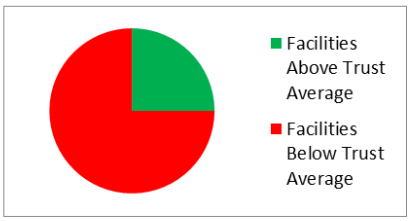


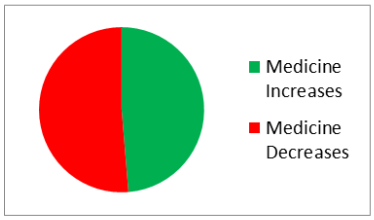


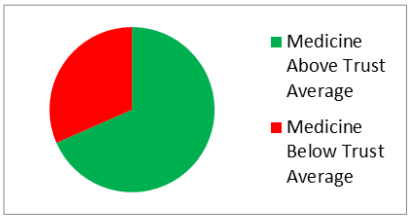


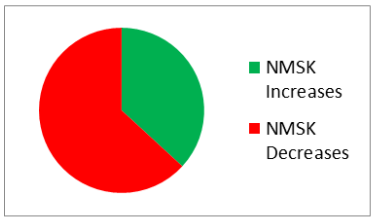


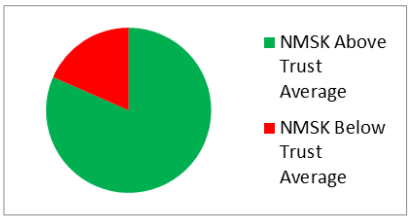


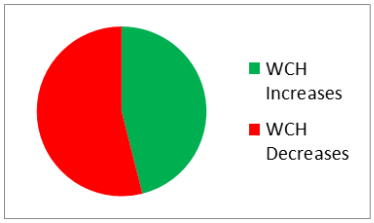


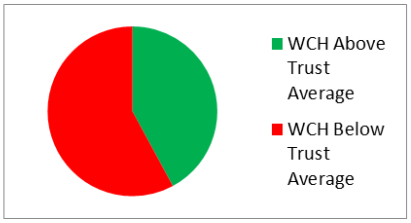






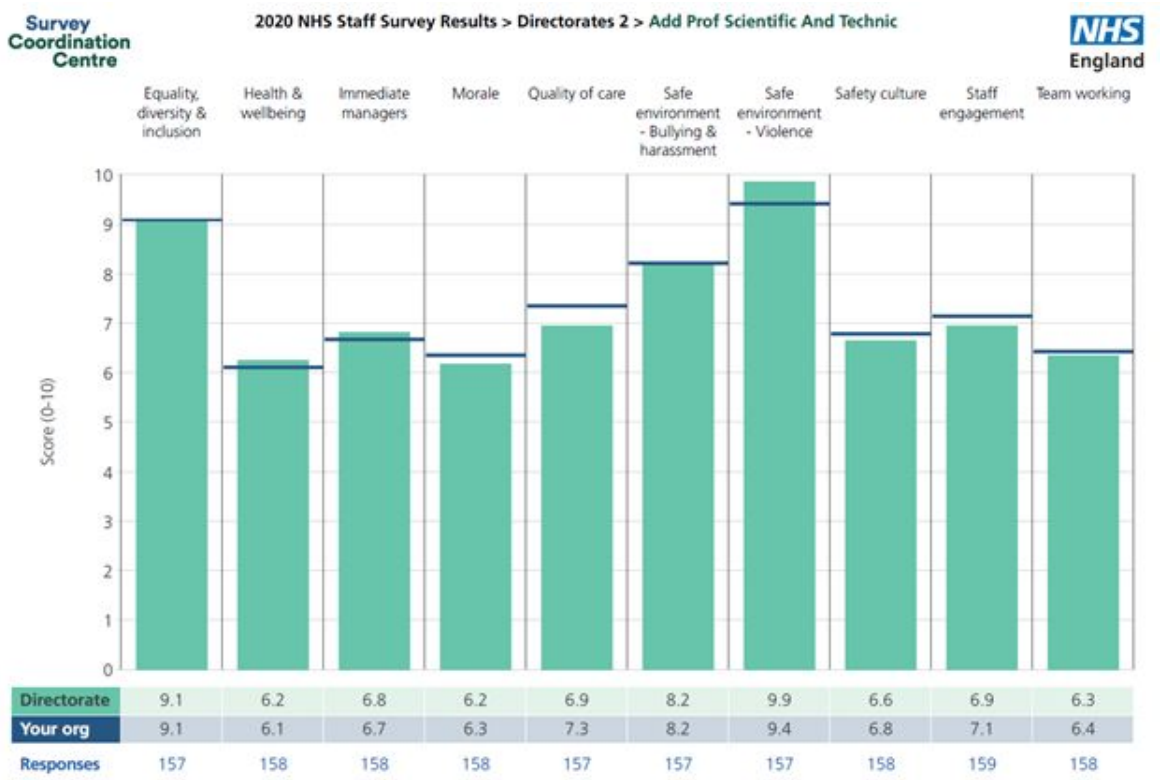


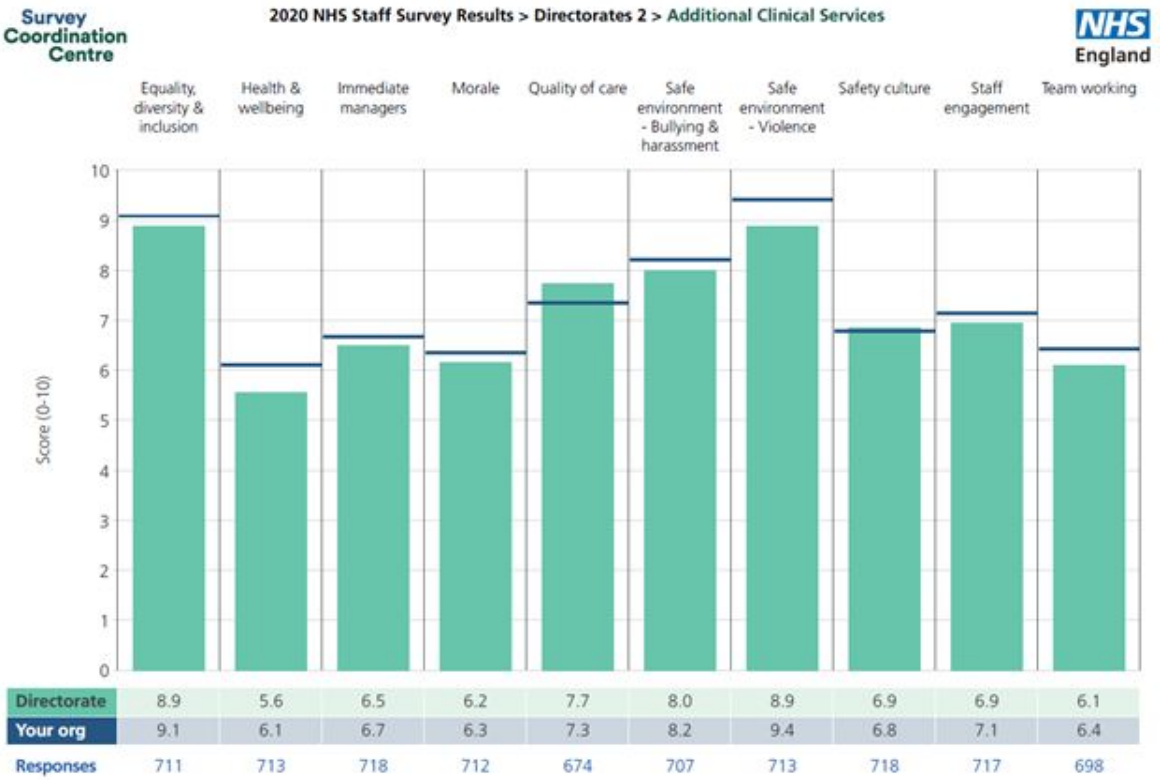




12

Appendix 2 Summary of Staff Survey Performance by Job Category – Comparing to NBT Average (Better than NBT Average or Worse):





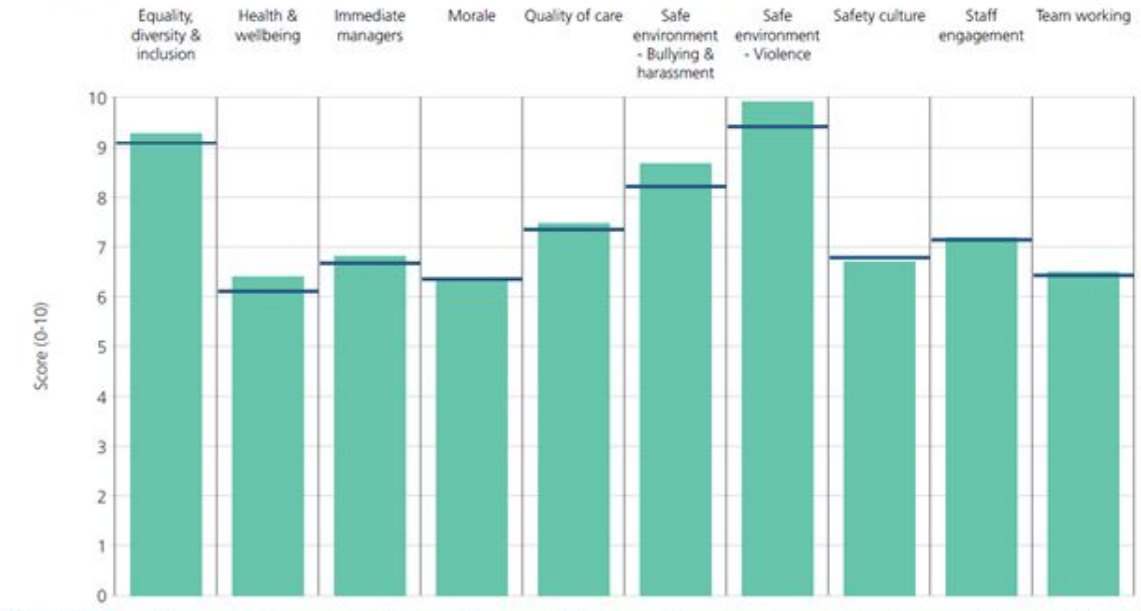
12

NHS North Bristol NHS Trust

Survey Coordination Centre

2020 NHS Staff Survey Results > Directorates 2 > Administrative And Clerical

NHS England

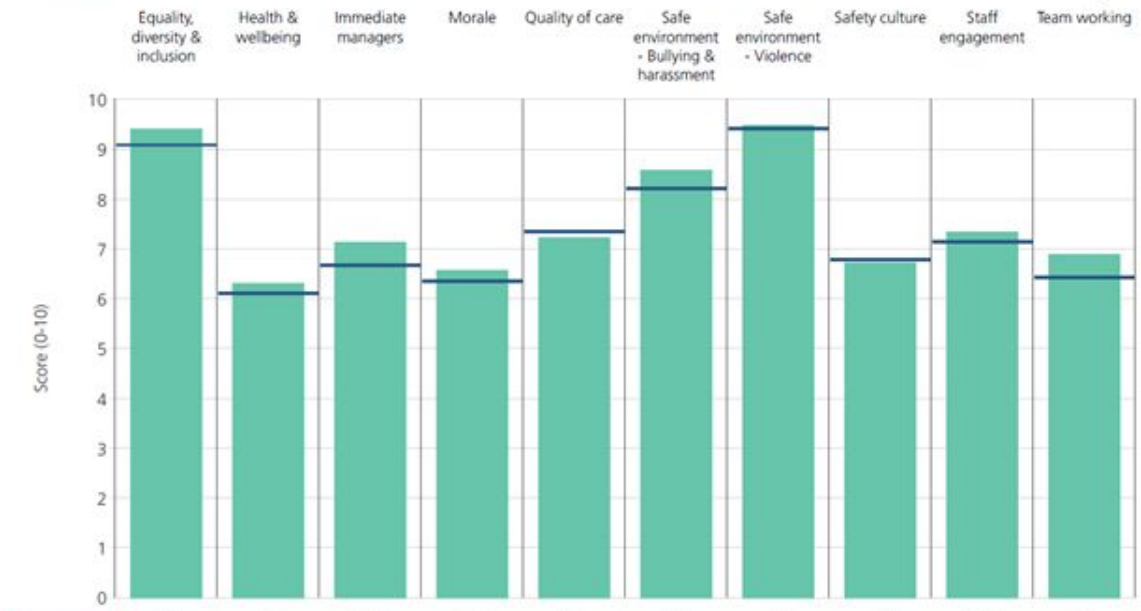


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Directorate	9.3	6.4	6.8	6.3	7.5	8.7	9.9	6.7	7.2	6.5
Your org	9.1	6.1	6.7	6.3	7.3	8.2	9.4	6.8	7.1	6.4
Responses	1149	1150	1147	1152	723	1140	1145	1139	1155	1128

Survey Coordination Centre

2020 NHS Staff Survey Results > Directorates 2 > Allied Health Professionals

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Directorate	9.4	6.3	7.1	6.6	7.2	8.6	9.5	6.7	7.3	6.9
Your org	9.1	6.1	6.7	6.3	7.3	8.2	9.4	6.8	7.1	6.4
Responses	303	306	307	307	306	306	308	307	308	301

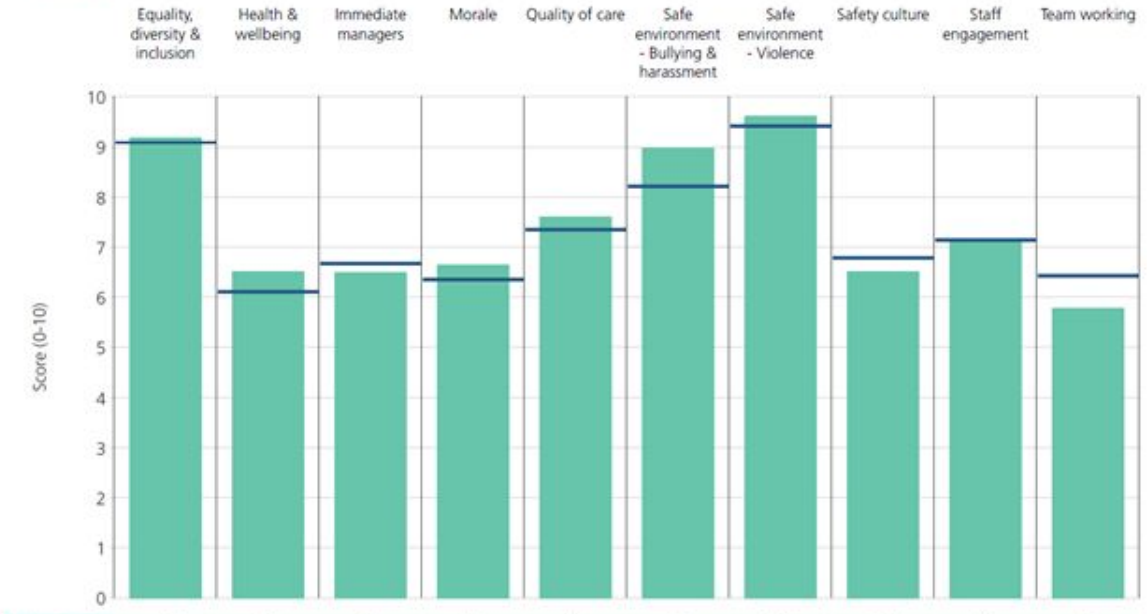
12

NHS North Bristol NHS Trust

Survey Coordination Centre

2020 NHS Staff Survey Results > Directorates 2 > Estates And Ancillary

NHS England

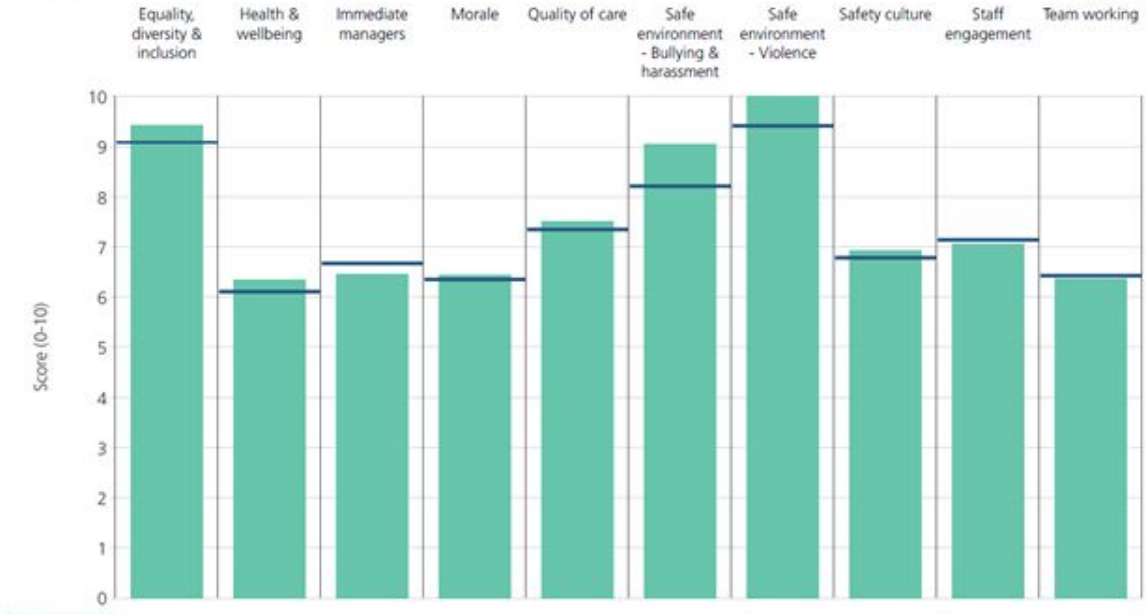


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Directorate	9.2	6.5	6.5	6.6	7.6	9.0	9.6	6.5	7.1	5.8
Your org	9.1	6.1	6.7	6.3	7.3	8.2	9.4	6.8	7.1	6.4
Responses	353	353	356	348	279	339	344	347	357	348

Survey Coordination Centre

2020 NHS Staff Survey Results > Directorates 2 > Healthcare Scientists

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Directorate	9.4	6.3	6.5	6.4	7.5	9.0	10.0	6.9	7.1	6.4
Your org	9.1	6.1	6.7	6.3	7.3	8.2	9.4	6.8	7.1	6.4
Responses	248	246	248	249	232	249	246	249	249	248

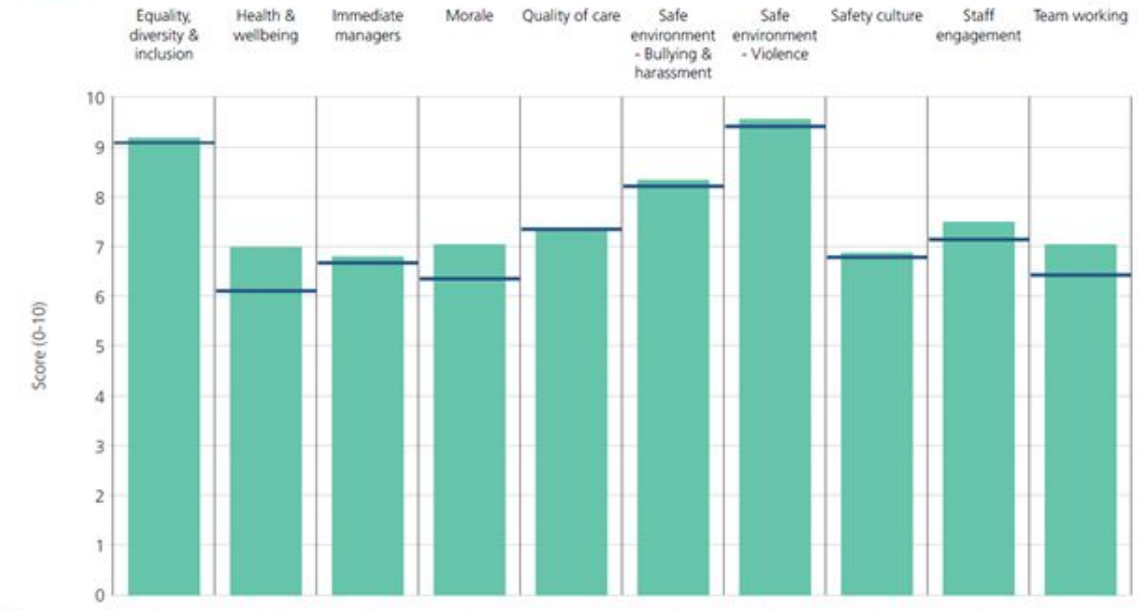
12

NHS North Bristol NHS Trust

Survey Coordination Centre

2020 NHS Staff Survey Results > Directorates 2 > Medical And Dental

NHS England

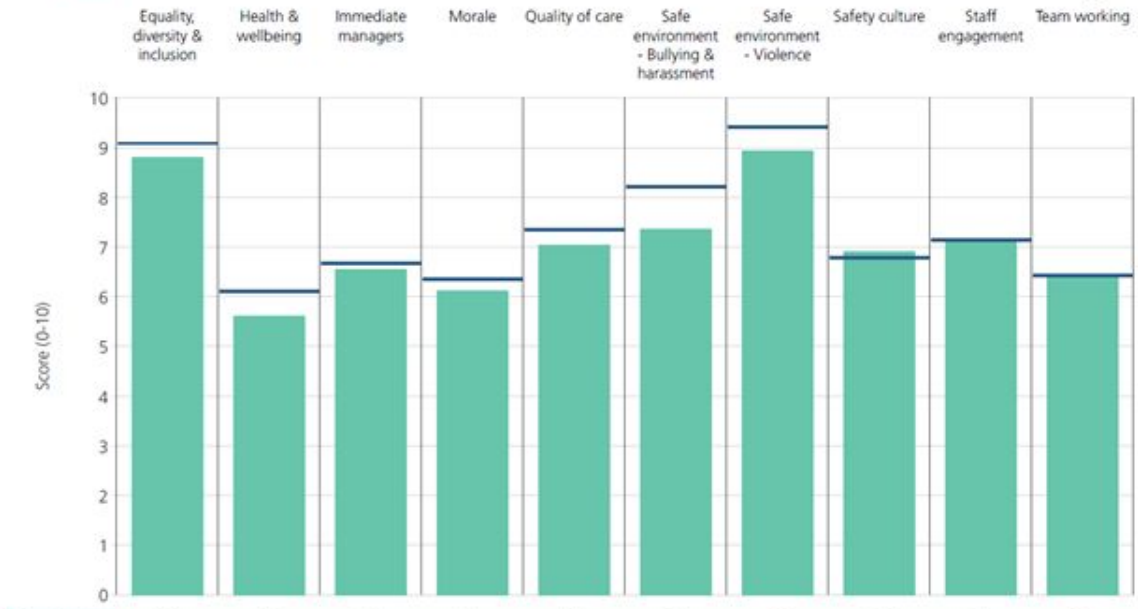


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Directorate	9.2	7.0	6.8	7.0	7.4	8.3	9.5	6.9	7.5	7.0
Your org	9.1	6.1	6.7	6.3	7.3	8.2	9.4	6.8	7.1	6.4
Responses	376	377	378	378	376	374	376	377	378	374

Survey Coordination Centre

2020 NHS Staff Survey Results > Directorates 2 > Nursing And Midwifery Registered

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Directorate	8.8	5.6	6.5	6.1	7.0	7.4	8.9	6.9	7.1	6.4
Your org	9.1	6.1	6.7	6.3	7.3	8.2	9.4	6.8	7.1	6.4
Responses	1178	1179	1183	1183	1169	1175	1171	1183	1185	1162

12

NHS North Bristol NHS Trust

Appendix 3 – Staff Survey Infographic

Staff Survey results 2020

Key Findings - Trust-wide

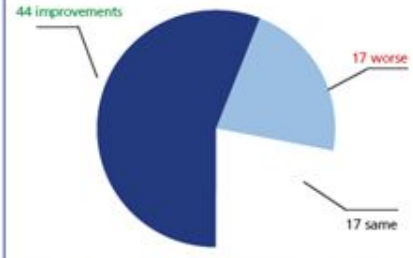
NHS North Bristol NHS Trust

Response rate **51%**
4,517 staff had their say
(above national average of 45%)

Engagement **7.1** / 10
(above national average of 7/10)

We are continuing on our journey of improvement.

Compared to 2019, of the 78 survey questions...



More than half of our responses have improved since last year, and for the first time, overall the balance of our results are better than national acute average including staff engagement.

Some highlights:

"I would recommend my organisation as a place to work"
72% (5% better than other trusts, increase of **3%** from 2019)

"If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation"
83% (8% better than other trusts, increase of **3%** from 2019)

"Does your organisation definitely take positive action on health and well-being?"
38% (5% better than other trusts, increase of **7%** from 2019)

Area for concern:

"My manager gives me clear feedback on my work"
57% (4% worse than other trusts, **1%** worse than 2019)

We have improved in most areas you told us were priorities last year...

2020 priority		2021 focus
Staff Voice	Improved overall but still slightly below national average	Staff Voice
Workload and Resources	Improved overall but still below national average	Workload and Resources
Inclusion	Deteriorated but around national average	Indusion
Speaking Up	Significantly improved and better than national average	Review our improvements and move towards business as usual
Management Development & Appraisals	Deteriorated overall and falling behind national average	Management Development

We have seen great progress across the Trust, but we know that we need to continue work on most of the key themes for action that we had in 2020. So our Trust-wide priority themes for action in 2021 are:

- Inclusion
- Management Development
- Staff Voice
- Workload & Resources

We expect to have the results for Q21a & Q21b relating to your COVID experience shortly. We look forward to sharing these with the Trust as well as using them to inform our renewal and recovery plans.

Report To:	Trust Board		
Date of Meeting:	25 March 2021		
Report Title:	Green Plan Work Areas 2021-22		
Report Author & Job Title	Esther Coffin-Smith, Sustainable Development Manager		
Executive/Non-executive Sponsor (presenting)	Simon Wood, Director of Facilities, Estates and Capital Planning		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	None	**None**	**None**
*If any boxes above ticked, paper may be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
	X		
Recommendation:	That the Green Plan work areas for 2021-22 be approved		
Report History:	The proposed work areas have been shared with the Sustainable Development Steering Group		
Next Steps:	• Distribution on website and to communication Trust-wide • Identify and utilise sustainability advocates from within divisions		

Executive Summary
A Board-approved Green Plan is an NHS Standard Contract requirement. The Plan must include actions to deliver the sustainable development-related NHS Long Term Plan commitments. In order to easily quantify improvements towards the Sustainable Development Assessment Tool (SDAT) mandated for use by all Trusts, the NBT Green Plan work areas reflect the SDAT categories. A large proportion of the Sustainable Development Unit's (SDU) resources over the next 12 months will be supporting the creation of the Carbon Route Map – a document which will set out the required journey to achieve our ambitious Carbon Neutral goal by 2030. However, with the team now back at full capacity, with new resource in place to deliver carbon reductions from energy projects, and with almost a year of slower progress due to COVID-19, the work plan for 2021-22 is appropriately ambitious. The SDU will bring a report of progress against this work plan to Trust management Team and Trust Board in September 2021.

Strategic Theme/Corporate	**1. Employer of choice** a. Support staff health & wellbeing

Objective Links	**2. An anchor in our community** a. Create a healthy & accessible environment b. Developing in a sustainable way
Board Assurance Framework/Trust Risk Register Links	Risk of non-compliance with the NHS Standard Contract which requires a Trust Board approved Green Plan.
Other Standards Reference	• Compliance with NHS Long Term Plan (2019-2029) • Compliance with the National Climate Change Adaptation Programme (2018-2023) • Compliance with Health Technical Memoranda 07 Environment and Sustainability • Compliance with NHS England and Improvement guidance on Green Plan reporting (2020)
Financial implications	This report is not seeking financial approval.
Other Resource Implications	The Sustainable Development Unit is resourced to manage the delivery of the Green Plan. Additional resources required for specific work programmes within the Green Plan will be addressed within separate business cases going forward.
Legal Implications	• Compliance with legal obligations which include but are not limited to; Climate Change Act (2008), Environmental Protection Act (1990), Civil Contingencies Act (2004) and Public Services (Social value) Act 2012.
Equality, Diversity and Inclusion Assessment (EIA)	Process TBC
Appendices:	Appendix 1 - Sustainability Advocate Role Description

1. Purpose

1.1 This report sets out recommended action for 2021-22 to continue improving our performance and meeting our sustainability obligations. It ensures progress with the NHS Long Term Plan requirements, most noticeably in the areas of: air quality (by reducing vehicle emissions), innovations to reduce waste, water and carbon, reducing single-use plastics and projects that reduce the carbon footprint of inhalers and anaesthetics.

2. Background

2.1 The Trust aspires to be a leader in the field of sustainable healthcare. This ambition has crystallised through recent declarations of both Climate and Ecological emergencies. Invitations last year to sit on both the national NHS Net Zero Leadership Discussion Sub-Group and NHS Sustainable Procurement Forum are indicative of the esteem placed on NBT for our efforts to improve the sustainability of the healthcare we deliver. Equally our position on the Bristol One City Environmental Strategy Board highlights our local partners' recognition of our contribution to the sustainability of the city in which we are anchored.

2.2 The NHS Net Zero Plan was published in late 2020 and sets out the NHS's progress to date and the work that lies ahead to achieve the country's climate goals. In line with the size of this ambition, the NHS has committed to be the world's first Net Zero national health service.

2.3 The NHS aims to provide health and high quality care for all, now and for future generations. This requires a resilient NHS, currently responding to the health emergency that COVID-19 brings, protecting patients, our staff and the public. The NHS also needs to respond to the health emergency that climate change brings, which will need to be embedded into everything we do now and in the future.

2.4 The following work areas are presented for approval and will lead to progress across all domains of the current NHS sustainable development assessment tool.

3. Proposed Green Plan Work Areas

3.1 Corporate Approach

We propose the following:

- Recruit the divisional Sustainability Advocates that were approved at the January Trust Board meeting (role description attached.)
- Update the business case template to make consideration of sustainability impacts more integral.
- Work with civic partners to play our part in the delivery of the Bristol One City Plan, including participation on the Environmental Strategy Board.
- Create a Sustainable Development Strategy informed by the Carbon Route Map.

13

3.2 Our People

We propose the following:

- Launch an OneNBT Leadership Programme module on sustainable development.
- Develop an enhanced staff engagement scheme including the use of an online/mobile app.

- Link NBT activity to the wider *For a Greener NHS* engagement scheme.

3.3 Climate Change Adaptation

We propose the following:

- Update the draft NBT Climate Change risk assessment and mitigation actions and consult with the Divisions.
- Work with STP partners to adopt the Healthier Together Climate Change Adaptation Plan.
- Create a Business Assurance Framework entry for the Trust's adaptation to Climate Change.

3.4 Sustainable Models of Care

We propose the following:

- Identify Sustainable Models of Care examples from the business planning Carbon Assessment Tool output and map carbon emissions improvements with at least one example per Division
- Increase the promotion of SusQI (sustainable quality improvement) projects and the identification of sustainability improvements as part of existing QI projects.

3.5 Sustainable Use of Resources

We propose the following:

Energy Consumption

- See *Capital Projects, Asset Management and* Utilities section further down.

Water Consumption

- Investigate toilet flush volumes and tap flow rates in the Science Quarter Buildings.

Waste and Recycling

- Reinstate the Trust-wide Waste Compliance Group.
- Commission a Waste Strategy.
- Continue to make progress with the NHS Plastics Pledge.

Anaesthetic Gases, Pharmaceuticals and Medical Devices

- Promote the use of the BNSSG *Environmental impacts of inhalers guide*
- Continued promotion of the use of TIVA where appropriate over volatile alternatives.

Fuel Consumption

- Implement the recommendations of the SDU's Fleet Review including introducing a minimum vehicle specification and replacing suitable vehicles with electric equivalents where possible.

Paper Consumption

We propose the following:

- Roll out further digital solutions including Office 365 and Teams, Electronic Patient Records, introduction of Bluespier and Electronic Observations.

3.6 Carbon Emissions

We propose the following:

- Engage a Carbon Route Map consultant, provide the required data, establish focus groups and communicate outcomes.

3.7 Travel and Logistics

We propose the following:

- Deliver year 3 of Travel Plan Action Plan including recruitment of a Fleet/Transport Manager, delivering sustainable travel awareness activities and increasing electric vehicle charging infrastructure.
- Introduce a staff Salary Sacrifice Scheme to encourage and enable the uptake of ultra-low emission vehicles.

3.8 Green Space and Biodiversity

We propose the following:

- Review and revise the Biodiversity Management Plan action plan.
- Host a Nature Recovery Ranger for 12 months.
- Develop and promote the allotment to staff and engage clinical areas in using the allotment and green gym for therapy.

3.9 Capital Projects, Asset Management and Utilities

We propose the following:

- Update and launch the Sustainable Design Guide
- Replace NICU, Gynae and Elgar air handling units (AHU) with a high efficiency alternative
- Replace A-Block gas boiler
- Upgrade Brunel stair cores, Brunel Multi Storey Car Park and Beaufort Multi Storey Car Park to efficient LED lighting.
- Install cavity wall insulation in the Christopher Hancock Building
- Install top up loft insulation in Christopher Hancock Building and Elgar House.
- Upgrade the Elgar House Building Management System (BMS) upgrade
- Conduct BMS optimisation of Learning and Research Centre, Pathology 1 and Pathology 2 buildings.

4. Summary and Recommendations

4.1 The Trust Board is asked to approve the proposed work areas. Progress against this work plan together with any further areas for consideration will be submitted as part of the Green Plan 2020-21 report in September 2021.

13

Appendix 1

Sustainability Advocate Role Description

The Trust has a well-established, award-winning Sustainable Development Unit and is seen as a Sustainability leader in the NHS. Using these foundations, the Trust aspires to maintain this position and decided, last year, to become Carbon Neutral by 2030, ahead of the NHS target of 2040. NBT has been successful, to date, due to the fantastic support of motivated individuals and teams throughout the Trust, engaging and taking action. NBT staff continue to demonstrate their commitment to environmental improvement and continue to be energised, making a difference.

However, to make our activity greener, reduce our carbon footprint and meet the 2030 challenge we have to step up and need a greater level of coordinated input and action from Divisional and Directorate teams. To this end we are seeking a network of Sustainability Advocates.

We hope this will be a positive opportunity for individuals to get involved in sustainability alongside their existing roles and be a part of what is clearly going to define our whole future modes of living and working.

We need Divisions and Directorates to adopt the concept and appoint individuals to be the single point of contact between the Trust's Sustainable Development Unit and their Divisions/Directorates. This link will be supporting all that is Sustainability, our Carbon Neutral 2030 goal and the Trust's Strategy core focus of being an Anchor in the Community. The role will not necessarily be responsible for completing tasks in each of the areas listed below but will co-ordinate the activity from within their respective areas.

The main areas of support required are with:

- Embedding sustainability within their area through:
    - Cascading information
    - Encouraging participation in the Trust's Sustainable Healthcare Staff Engagement Scheme
    - Encouraging participation in specific campaigns (e.g. Plastic Action Teams, Air Quality Champions etc.)
    - Encouraging the completion of Sustainability Impact Assessments for business cases
    - Identifying ways to deliver applicable Clean Air Hospital Framework criteria
    - Identifying potential and existing models of care/service delivery which could or already do reduce environmental impacts (e.g. waste, energy, water, reduced travel, pharmaceutical use, anaesthetic gas use etc.)

Appendix 1

- Supporting the completion of the Carbon Assessment Tool (CAT) as part of annual business planning process.
- Providing details of actions from the CAT that will deliver environmental improvements over the following financial year and performance against actions from the previous financial year to include in the Trust's Green Plan report.
- Collaborating on the completion of the Trust's Climate Change Risk Assessment.
- Presenting progress updates to the Sustainable Development Steering Group.
- Where applicable supporting the SDU with the completion of the annual Sustainable Development Assessment Tool (an online assessment tool to track progress.)

Those volunteering for this role will be provided with Sustainability training and given detailed background on the key areas mentioned above.

Report To:	Trust Board		
Date of Meeting:	25 March 2021		
Report Title:	Finance Report for February 2021		
Report Author & Job Title	Stuart Bird, Deputy Director of Finance – Financial Management		
Executive/Non-executive Sponsor (presenting)	Glyn Howells, Chief Financial Officer		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	None	**None**	**None**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is asked to note: • the revised financial framework that the Trust is operating in, • the spend and recovery for Covid-19 response and Nightingale in relation to the revised framework • the spend and income for Core Trust services in relation to both revised framework and annual plan • the cash position of the Trust.		
Report History:	Regular monthly report to TMT and Trust Board		
Next Steps:	As above		

Executive Summary

NHSI/E suspended the 2020/21 financial framework due to covid-19 response preparations.

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

From 1 October a new financial framework is now in place that requires the trust to operate within a fixed financial envelope (plus a small number of specified “outside envelope” cost recoveries) and to deliver a deficit that is consistent with the financial forecast submitted on October 22nd.

The forecast Trust deficit for February was £4.9m, while the actual deficit reported is £2.3m. Cumulatively the Forecast Trust deficit to month 11 is £17.9m and the Actual reported deficit is £0.8m.	
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 **Developing Healthcare for the future** e. Training, educating and developing out workforce f. Increase our capability to deliver research g. Support development & adoption of innovations h. Invest in digital technology **An anchor in our community** i. Create a health & accessible environment j. Expand charitable support & network of volunteers k. Developing in a sustainable way
Board Assurance Framework/Trust Risk Register Links	
Other Standards Reference	
Financial implications	If the risks laid out in section 9 cannot be mitigated there is a risk that the Trust will not be able to achieve its forecast deficit
Other Resource Implications	N/A
Legal Implications	Delivery of Trust statutory financial responsibilities
Equality, Diversity and Inclusion Assessment (EIA)	Process TBC
Appendices:	None

14

1. Purpose

1.1 This report is to inform and give an update to the Trust Board on:
- the revised financial framework that the Trust is operating in
- financial performance at the end of February 2021 and how this aligns with the forecast submitted on October 22nd

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 response preparations.

3.2 For the first half of the year the trust was funded to breakeven through a combination of block income and retrospective top ups.

3.3 For the second half of the year the trust has a forecast deficit of £24.6m (see section 7) which represents a shortfall in non-commissioned income compared to NHSI targets and a forecast increase in the annual leave provision at the end of the financial year as a result of accrued holiday entitlement that is not taken.

3.4 The position for the month of February shows a deficit of £2.3m compared to a forecast deficit of £4.9m.

3.5 Cumulatively to the end of February the position shows a deficit of £0.8m compared to a forecast deficit of £17.9m.

Position as at 28 February 2021

	Feb Forecast	Feb Actuals	Variance to Forecast	YTD Forecast	YTD Actuals	Variance to Forecast
	£m	£m	£m	£m	£m	£m
Contract Income	52.6	53.4	**0.8**	536.3	542.0	**5.7**
Other Income	4.4	8.7	**4.3**	104.9	117.8	**12.9**
Total Income	**57.0**	**62.1**	**5.1**	**641.2**	**659.8**	**18.6**
Pay	(36.3)	(35.7)	**0.6**	(385.2)	(384.7)	**0.5**
Non-Pay	(19.8)	(20.3)	**(0.5)**	(209.2)	(208.8)	**0.5**
Financing	(5.8)	(8.4)	**(2.6)**	(64.6)	(67.1)	**(2.5)**
Total Expenditure	**(61.9)**	**(64.4)**	**(2.5)**	**(659.1)**	**(660.6)**	**(1.5)**
Surplus/ (Deficit)	**(4.9)**	**(2.3)**	**2.6**	**(17.9)**	**(0.8)**	**17.1**

4. Financial Performance

The table below shows overall Trust income and expenditure for February split between Core Activities (including COVID-19) funded within the envelope, and activities outside envelope, such as Nightingale and Mass Vaccination, which are funded through mechanisms similar to retrospective top-up within M1 to M6.

NHS North Bristol NHS Trust

Position as at 28 February 2021

	WITHIN FUNDING ENVELOPE				OUTSIDE FUNDING ENVELOPE				Total	
	Covid-19		Core Trust		Mass Vaccination		Nightingale			
	M11 £m	YTD £m	M11 £m	YTD £m	M11 £m	YTD £m	M11 £m	YTD £m	M11 £m	YTD £m
Contract Income	0.0	0.0	53.4	542.0	0.0	0.0	0.0	0.0	53.4	542.0
Other Income	1.4	17.5	6.4	73.1	0.1	2.0	0.8	25.2	8.7	117.8
Total Income	**1.4**	**17.5**	**59.8**	**615.1**	**0.1**	**2.0**	**0.8**	**25.2**	**62.1**	**659.8**
Pay	(1.0)	(10.7)	(34.7)	(372.1)	0.0	(1.5)	(0.0)	(0.4)	(35.7)	(384.7)
Non-Pay	(0.4)	(6.8)	(19.0)	(176.7)	(0.1)	(0.5)	(0.8)	(24.8)	(20.3)	(208.8)
Financing	0.0	0.0	(8.4)	(67.1)	0.0	0.0	0.0	0.0	(8.4)	(67.1)
Total Expenditure	**(1.4)**	**(17.5)**	**(62.1)**	**(615.9)**	**(0.1)**	**(2.0)**	**(0.8)**	**(25.2)**	**(64.4)**	**(660.6)**
Surplus/ (Deficit)	**0.0**	**0.0**	**(2.3)**	**(0.8)**	**(0.0)**	**(0.0)**	**0.0**	**(0.0)**	**(2.3)**	**(0.8)**

4.1 Covid-19

The share of system funding being paid to the trust assumes direct Covid-19 costs will continue at the Month 1 to 6 level of £1.5m per month. During February the trust actually incurred £1.4m of additional I&E costs.

More detail is provided on this spend in section 6.

4.2 Core Trust

Due to Covid-19 response NHSI/E suspended the annual business planning processes so the Trust is not being monitored by NHSI/E against a plan, instead it submitted a financial forecast for months 7 to 12 which is being used for ongoing monitoring and performance management. The forecast is summarised at Section 7 of this report.

Section 6 details the costs incurred to date by the core Trust (excluding Nightingale and COVID spend).

4.3 Nightingale

The Trust is hosting Nightingale Bristol on behalf of multiple local Acute Trusts under an Agreement with National Specialised Commissioning.

During February 2021 the Trust reported an additional cost of £0.8m relating to running the Nightingale facility. The costs of running the Nightingale Hospital are treated as “pass-through costs” funded by NHSE in the similar mechanism as retrospective top-up in M1 to M6.

Section 5 details the costs incurred in February by the Trust as well as other costs incurred by Trusts that are **not** being recharged to NBT but are included to show a “memo” income and expenditure position for the Nightingale Hospital.

4.4 Mass Vaccination

During February 2021 the Trust has continued delivery of Mass COVID-19 Vaccinations, which resulted in additional cost £0.1m. The majority of costs incurred YTD are staff related as consumables and drugs costs are being met with nationally supplied push stock.

5. Nightingale Hospital Financial Position

5.1 The costs incurred by NBT in February 2021 are summarised below.

	Nightingale Core Costs as at 28 February 2021													
	April to January			February			YTD			Memo				Nightingale Total
	Setup costs	Running Costs	Total Costs	Setup costs	Running Costs	Total Costs	Setup costs	Running Costs	Total Costs	NBT	UHB	Other NHS	Total Memo	
Contract Income														
Other Income	15.6	8.7	24.3	(0.2)	1.0	0.8	15.4	9.7	25.2	0.0	0.0	0.0	0.0	**25.2**
Total Income	**15.6**	**8.7**	**24.3**	**(0.2)**	**1.0**	**0.8**	**15.4**	**9.7**	**25.2**	**0.0**	**0.0**	**0.0**	**0.0**	**25.2**
Clinical	0.0	0.1	0.1		0.0	0.0	0.0	0.1	0.1	0.1	0.0	0.1	0.2	**0.2**
Non-clinical	0.1	0.3	0.4		0.0	0.0	0.1	0.3	0.4	0.4	0.1	0.4	0.9	**1.3**
Total Pay	**0.1**	**0.3**	**0.4**	**0.0**	**0.0**	**0.0**	**0.1**	**0.3**	**0.4**	**0.5**	**0.2**	**0.4**	**1.1**	**1.5**
Building Costs	10.7	5.3	16.1	(0.1)	0.9	0.8	10.6	6.2	16.8	0.0	0.0	0.0	0.0	**16.8**
IT Costs	2.9	0.0	2.9	(0.1)	0.0	(0.1)	2.9	0.0	2.9	0.0	0.0	0.0	0.0	**2.9**
Medical and Surgical	0.7	0.1	0.8	(0.1)	0.0	(0.0)	0.7	0.1	0.8	0.0	0.0	0.0	0.0	**0.8**
Other non-pay	1.2	3.0	4.1	0.0	0.1	0.1	1.2	3.1	4.3	0.0	0.0	0.0	0.0	**4.3**
Total Non-pay	**15.5**	**8.4**	**23.9**	**(0.2)**	**1.0**	**0.8**	**15.3**	**9.4**	**24.7**	**0.0**	**0.0**	**0.0**	**0.0**	**24.7**
Total Expenditure	**15.6**	**8.7**	**24.3**	**(0.2)**	**1.0**	**0.8**	**15.4**	**9.7**	**25.2**	**0.5**	**0.2**	**0.4**	**1.1**	**26.2**
Surplus / (deficit)	**(0.0)**	**0.0**	**(0.0)**	**0.0**	**0.0**	**0.0**	**(0.0)**	**0.0**	**(0.0)**	**(0.5)**	**(0.2)**	**(0.4)**	**(1.1)**	**(1.1)**

5.2 The Donated figures above include costs incurred by other trusts who have loaned people to the Nightingale. NHSI/E guidance states that these Trusts should not recharge costs to NBT as they are funded for the costs either through their block contract or through their own Covid-19 cost recovery. This approach is being followed to reduce the numbers of recharges being done between NHS organisations. The costs shown as “memo” have been estimated based on payroll records and manual recording of work carried out by staff from each of the donating Trusts.

5.3 Separately, there are some costs that are being met by National Specialised Commissioning or the Army directly. NBT is not responsible for the payment or recording of these costs, has limited visibility of them and is not responsible for reporting them.

5.4 The cost arising in month of £0.8m compares to the approx. £1.0m expected by NHSI/E and is due to further updates to setup costs and VAT benefits. The detailed breakdown is presented below.

	Build	Running	Total
Forecast Submission (£m)		1.0	1.0
M11 Act (£'000)	(0.2)	1.0	0.8
Var (£'000)	**(0.2)**	**(0.0)**	**(0.2)**

Var (£'000)	**(0.2)**		**(0.2)**
Removal of accruals for costs no longer expected	(0.2)		(0.2)

5.5 Note that all items that would normally be accounted for through capital are being expensed as the facility is not expected to be used beyond the end of March 2021. Conversations are currently ongoing with in finance team and auditors regarding treatment of NHB assets within the NBT annual report if the facility is still in place at 31 March 2021.

6. Core Trust Financial Position

6.1 NHSI/E calculated the expected cost base of the Trust to generate a monthly block contract value payable by each of its main commissioners. In addition there was also an expectation that non contracted income would continue at the same level as in month 8 to 10 of financial year 19/20

6.2 Members of the Trust finance team are meeting regularly with NHSI/E to discuss a plan to close the gap on non-commissioned income and to improve the overall position of the trust.

6.3 For the month of February, Trust delivered a deficit of £2.3m on core activities (inclusive of Covid-19) and will recover £0.9m from NHSE for Nightingale and Mass Vaccination programme.

6.4 As the services are restored there will be increasing costs on core activity which will be compared to the forecast submitted on Oct 22nd for ongoing monitoring and assurance purposes.

The table below shows the February I&E for the Trust compared to the latest forecast.

The Contract Income figure shown in the table above reflects the Trust's block and variable contract value with its commissioners, together with relatively small value for Welsh income. The variance of £0.8m is related to additional funding allocated by NHSE of £0.5m (more details in Section 7) and variable elements of the contract of (Welsh and HCTED) which was above forecasted level by £0.3m.

Other Income is £3.2m higher than forecast, which is driven by multiple factors. The main driver is additional research income (£1.8m), which offset by non-pay increase in cost. The Trust has also managed to restore £1.4m of previously thought to be lost income streams (among others, external CEA funding, recharges to PHE and other NHS organisations, or additional funding from HEE) that would be included in the updated forecast.

	Position as at 28 February 2021								
	COVID-19			Core Trust			Total		
	Forecast	Actual	Variance	Forecast	Actual	Variance	Forecast	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Contract Income	0.0	0.0	0.0	52.6	53.4	0.8	**52.6**	**53.4**	**0.8**
Other Income	1.2	1.4	0.2	23.2	6.4	3.2	**4.4**	**7.8**	**3.4**
Total Income	**1.2**	**1.4**	**0.2**	**55.8**	**59.8**	**4.0**	**57.0**	**61.2**	**4.2**
Pay	(0.5)	(1.0)	(0.5)	(35.8)	(34.7)	1.1	**(36.3)**	**(35.7)**	**0.6**
Non-Pay	(0.7)	(0.4)	0.3	(19.1)	(19.0)	0.1	**(19.8)**	**(19.4)**	**0.4**
Financing	0.0	0.0	0.0	(5.8)	(8.4)	(2.6)	**(5.8)**	**(8.4)**	**(2.6)**
Total Expenditure	**(1.2)**	**(1.4)**	**(0.2)**	**(60.7)**	**(62.1)**	**(1.4)**	**(61.9)**	**(63.5)**	**(1.6)**
Surplus/ (Deficit)	**0.0**	**0.0**	**(0.3)**	**(4.9)**	**(2.3)**	**2.6**	**(4.9)**	**(2.3)**	**2.6**

Pay cost in February is £1.1m lower than forecast, which primarily driven by lower spend than planned on mitigations and winter pressures, which is linked with supply of temporary staffing.

The spend in month is £0.1m lower on non-pay than forecast. There is increase in non-pay charges linked with above mentioned income items (research costs) of £1.8m, which is offset by underspend on mitigations and clinical consumables due to lower elective activity (£1.9m). One of the main drivers of this variance is reduction in spent on Independent Sector that is funded either centrally or via CCG rather than directly funded by the Trust (£1.1m).

There is also £2.6m variance on capital charges, which is linked with accelerated depreciation offset by higher cash flow forecast and delays in capital programme (more details in Section 8).

6.5 Covid-19 costs incurred in February 2021 totalled £1.4m (January was £1.0m) and are summarised below.

- £0.5m was spent in additional pay costs as a result of staff who are self-isolating or shielding,
- £0.5m was incurred for COVID-specific staff cover, including Aspirant Nurses starting their placement in February
- £0.4m was spent on non-pay costs including additional clinical equipment, PPE and decontamination costs and other social distancing measures.

7. Full Year financial Forecast

7.1 In November the Trust was informed about an additional October to March allocation of £2.9m from NHSE which has now been transacted through BNSSG CCG. It is part recognition of underling baseline issues that the finance team have been discussing with commissioners and the NHSI regional team.

7.2 Further income of £22.4m was also passed to the trust during February to compensate for the other income shortfall in year that was reported in the October to March forecast submitted in September 2020. As reported each month, work has been ongoing to resolve the other income issues and therefore much of this money will be passed back to NHSI during March. As at the end of February the trust has deferred all of the £22.4m whilst work continues with system partners and regional team colleagues to conform that amount that will be retained.

7.3 Work is being co-ordinated within the BNSSG system to refresh the Trust-wide forecast with changes since October. The updates to the forecast will be confirmed after all organisations have reported their M11 position.

8. Cash and Balance Sheet

	19/20 M12 £m	20/21 M10 £m	20/21 M11 £m	In-month change £m	YTD Change £m
Non Current Assets					
Property, Plant and Equipment	560.0	559.4	556.1	(3.3)	(3.9)
Intangible Assets	12.0	9.8	7.1	(2.7)	(4.8)
Non-current receivables	4.0	5.4	5.4	0.0	1.4
Total non-current assets	**576.0**	**574.6**	**568.7**	**(5.9)**	**(7.3)**
Current Assets					
Inventories	13.1	12.1	12.2	0.1	(0.9)
Trade and other receivables NHS	50.5	23.1	18.3	(4.8)	(32.2)
Trade and other receivables Non-NHS	22.2	24.5	22.5	(2.0)	0.3
Cash and Cash equivalents	10.7	115.6	146.6	31.0	135.8
Total current assets	**96.4**	**175.3**	**199.5**	**24.2**	**103.1**
Current Liabilities (< 1 Year)					
Trade and Other payables - NHS	11.1	9.5	8.1	(1.4)	(3.0)
Trade and Other payables - Non-NHS	57.6	74.9	76.4	1.4	18.8
Deferred income	3.7	68.1	89.4	21.3	85.7
PFI liability	13.0	15.0	15.0	0.0	2.0
DHSC loans	173.6	0.0	0.0	0.0	(173.6)
Finance lease liabilities	2.4	2.6	2.6	(0.0)	0.2
Total current liabilities	**261.4**	**170.1**	**191.4**	**21.3**	**(70.0)**
Trade payables and deferred income	7.2	8.7	8.7	(0.1)	1.5
PFI liability	377.8	370.1	369.4	(0.7)	(8.4)
DHSC loans	5.4	0.0	0.0	0.0	(5.4)
Finance lease liabilities	5.3	4.7	4.5	(0.2)	(0.8)
Total Net Assets	**15.3**	**196.3**	**194.3**	**(2.0)**	**178.9**
Capital and Reserves					
Public Dividend Capital	248.5	427.5	427.5	0.0	178.9
Income and expenditure reserve	(382.3)	(383.4)	(383.4)	0.0	(1.0)
Income and expenditure account - current year	0.0	2.0	0.0	(2.0)	0.0
Revaluation reserve	149.1	150.2	150.2	0.0	1.0
Total Capital and Reserves	**15.3**	**196.3**	**194.3**	**(2.0)**	**178.9**

8.1 The significant year to date change to the balance sheet is that a number of Trust loans (totalling £178.5m in value) have been replaced by an injection of PDC capital. This was a planned change that was implemented as part of a national alignment programme to ensure that trust borrowings are at a consistent rate of 3.5%.

8.2 The year to date reduction in NHS debtors is a result of £14.8m PSF monies being received in year, along with collections of invoiced debt, most notably relating to UHBW and NHS England.

8.3 The cash balance increased by £31.0m in-month due to £24.4m of Other Income Reimbursements and other top-up payments received from NHSE&I, along with £6.6m payment of NBT's invoiced debtors.

8.4 Non-NHS creditors showed a year to date increase of £18.8m, of which £10m relates to payroll taxes, national insurance and pensions which were paid early during March 2020. Other increases include £5.9m of costs accrued in respect of the Nightingale Hospital Bristol, along with the impact of moving back to standard payment terms from the Cabinet Office mandated 7 day terms during Phase 1 of Covid-19, therefore resulting in an increase in invoiced payables.

8.5 Deferred income has increased in-month due to the receipt in February of £22.5m Other Income Reimbursement from NHSE&I.

8.6 A high level cash flow forecast has been developed which shows that the Trust is able to manage its affairs without any external support over the period for which the financial regime has been announced. The month's advance funding from commissioners which has been in place throughout the year will unwind in March leading to a reduction in cash during March of approximately £55m. £22.5m of top up funding to cover other income shortfalls was received during February; this is also expected to be reversed during March. £21.2m of PDC funding will be drawn down in March of which £10m is expected to be held as an accrual at year end. Together with other minor working capital movements, his leaves the expected year end cash balance at £84.2m

	Mar-21 (Forecast) £m
Cash Brought Forward	**146.6**
In Month Cash Movements	-62.4
Cumualtive Cash Balance	**84.2**

8.7 Whilst the cash balance of £146.6m is significantly higher than as at March 2020, it is in line with the intent of the new financial framework and will be considerably reduced before year end.

14

8.8 Total Capital spend to date is £18.2m, compared to a planned spend to date of £24.6m. This includes £4.1m of Covid-19 capital spend, against which the Trust has received NHSE&I approval for items totalling £5.5m. The year to date variance to plan is driven by the late notification and approval of nationally funded items but the Trust still expects to be able to deliver these schemes within the financial year. The Trust is currently forecasting to achieve its core capital plan and fully spend against the £21.7m of 2020/21 capital PDC funding.

8.9 The Better Payment Practice Code achievement of invoices paid within 30 days, by value, is 86.6% for the year to date in 2020/21, compared to an average of 85.8% for 2019/20.

9. Assumptions and risks

9.1 The Trust is assuming it will be able to retain underspends on mitigations and Covid-19 costs in its position.

9.2 There is a risk that £22.4m of other income funding will need to be retained by the Trust and will result in a significant surplus.

9.3 Capital expenditure required in March to deliver in line with plan involves a large increase in spend compare to previous months. There is a risk of underspend on capital of up to £2m, if schemes cannot be completed by 31st March 2021 as planned.

10. Cost Improvement Program

10.1 Actual CIP delivery reported for the year to date is £2.0m. Schemes are considered delivered when recurrent budget adjustments have been agreed and posted to the ledger, and EQIA completed.

10.2 Current forecast delivery if Amber (likely to deliver) is added to Green (delivered) is £2.2m compared to target of £5.4m.

11. Summary and Recommendation

11.1 The Trust Board is asked to note:

- the revised financial framework that the Trust is operating in,
- Financial performance compared to forecast
- the spend on Nightingale Hospital Bristol and Covid-19 expenditure areas in relation to both revised framework and annual plan
- The cash position of the Trust.
- Delivery of Cost Improvement Plan savings and how they compare with divisional targets.

NHS North Bristol NHS Trust

Report To:	Trust Board – Public Session		
Date of Meeting:	25 January 2021		
Report Title:	HSE Covid-19 Spot Check Inspection (2 Dec 20) – Update		
Report Author & Job Title	Patrick Cullen, Head of Health and Safety Services (HSS)		
Executive/Non-executive Sponsor (presenting)	Simon Wood, Director of Estates, Facilities and Capital Planning (H&S Lead)		
Does the paper contain	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	None	None	None
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Board are asked to note the actions taken against the HSE Notice of Contravention to the Trust and to receive the HSE report on the 17 hospitals inspected		
Report History:	• Post inspection verbal update in CEO briefing Private Board 17 December 2020 • HSE Post inspection update in CEO briefing Private Board 28 Jan 2021		
Next Steps:	Delivery and upkeep of the additional measures		

Executive Summary
The Health and Safety Executive (HSE) visited the Trust to carry out a Covid-19 spot-check inspection as one of 17 hospitals in a pilot. Two inspectors spent a day in the Trust on the 2 December 2020 following a schedule of areas proposed by them. These were predominantly non-clinical but included ED, Clinical Engineering and PPE Mask fit-testing. Their formal response represented their lowest level of advisory notice – Notification of Contravention but included areas of concern categorised by; Social Distancing; Cleaning and Hygiene; Risk Assessment and Management Arrangements.

Whilst they saw evidence of many good aspects of the Trusts response and management of Covid-19 they also witnessed behavioural and practice issues. An action plan of corrective actions was created to manage the issues and is presented here for the Boards assurance. The collated report on the 17 hospitals they eventually visited is attached at Appendix 3. Work and monitoring on all aspects continues, to maintain staff and patient safety.	
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. 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 **3. 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	BAF - Co2
Attachments:	Appendix 1 - Trust Action plan Appendix 2 – HSE Covering Letter Appendix 3 - HSE Summary of findings (17 hospitals)

NHS North Bristol NHS Trust

1. Purpose

1.1 The purpose of the paper is to present the action plan of corrective measures following the HSE Covid-19 spot check inspection letter (Dec 2020) and to enclose the HSE Summary of Findings report covering the 17 hospital visits programme

2. Background

2.1 The HSE visited the Trust to carry out a Covid-19 spot-check inspection as one of 18 hospitals in a pilot.

2.2 Two inspectors spent a day in the Trust on the 2 December following a schedule of areas proposed by them. These were predominantly non-clinical but included ED, Clinical Engineering and PPE Mask fit-testing.

2.3 Their formal response represented their lowest level of advisory notice – Notification of Contravention. They documented their findings by; Social Distancing; Cleaning and Hygiene; Risk Assessment and Management Arrangements.

2.4 The Trust responded as required and implemented a plan of action to address the issues identified

3. Update

3.1 A significant amount of work by Health & Safety, the Infection Prevention and Control and the Communications teams supported by Divisional and Directorate managers and staff has been undertaken.

3.2 The Action Plan (App 1) summarises those issues and actions as at 17 March

3.3 Whilst many of the requirements needed additional physical changes many are dynamic behavioural adjustments

3.4 There has been a coordinated communication campaign including life size manifestations of clinical and managerial staff posted around the Trust important reminders

3.5 There are existing formal reporting/audit systems in place for monitoring cleaning effectiveness and Covid-19-secure areas (Synbiotix). These are reported to Facilities Management and Health and Safety Services.

3.6 Other areas are reviewed and managed locally by Divisional/Directorate management teams

4. Monitoring and corrective actions

4.1 **For cleaning:** There is a continual process of cleaning audits with a dedicated audit team, in place for approximately 5 years. Audit scores and variances are routinely reviewed and a system for corrective actions is in place as required. Additional cleaning support and resources are available for hot spots and urgent and exceptional clinical cleaning requests

4.2 **For Covid-19-secure areas:** monitoring has recently been migrated from a paper-based process to using the same Synbiotix system as domestic and clinical cleaning audits

4.3 Each Covid-19-secure area is required to complete a weekly self-assessment and HSS audit each area monthly

4.4 Occupants in these areas input the self-assessment results into Synbiotix. These are reviewed directly by HSS and items of concern are routinely followed up. Corrective action is agreed with the occupants

4.5 A control process was agreed via Gold Command that If there is a further significant breach of the Covid-19-secure criteria, a 14 day suspension of Covid-19-secure status will be implemented. A 3rd breach would result in the secure status being permanently rescinded and occupants would need to return to wearing mask continually. There have been no instances of this.

4.6 However, there have been three areas where the layouts and essential working practices made implementation and Covid-19-security tricky. After trial periods and mutual agreement, they have returned to working in PPE

5. Summary and Recommendations

5.1 The Trust Board is asked to note the actions taken against the HSE Notice of Contravention to the Trust and to receive the HSE report on the 17 hospitals inspected.

Appendix 1

Health and Safety Executive - Covid spot-check Inspection (November 20)

Action plan update (March 2021)

Appendix 1

Action Required	Action Undertaken	Responsible	Complete/Incomplete	Monitoring
Social Distancing				
Review Procedures	*Reviewed and reaffirmed via Comms including additional signage, manifestations, resources*	H&SS and Central Comms	Complete	Ongoing/All
Review Provision of Rest Facilities	*Main areas (Vu/Pavilion reviewed).*	H&SS	Complete	Ongoing/All
"	*Clinical Break Out Areas reviewed and Risk Assessed*	ICP/HSS Team + Divisions	Complete	Managers of areas
"	*Additional spaces sought, identified and allocated*	Facilities/ICU	Complete	Managers of areas/HSS
Cleaning & Hygiene				
Develop Suitable Regime for Cleaning	*Evidence provided that this was in place to National Covid-specific standards*	Facilities	Complete	Process fully audited for compliance
Review Product availability for Self-help cleaning (contact points/shared items)	*Confirmed availability and suitability, communicated via Comms Updates*	Facilities, Domestics, Materials Management	Complete	Ongoing
Risk Assessment				
Produce RA for overlooked areas (Clinical Rest Areas, Changing Rooms)	*RA undertaken with Actions identified*	H&SS/IPC led	Largely Complete – limited capacity for implementation within Changing Areas (capacity, demand, flow and structure)	Ongoing
Management Arrangements				
Implement RA findings and controls	*Actions taken to further facilitate SD. Managers to pro-actively monitor and act on non-compliance*	All areas. HSS and local management joint reviews and agreement	Complete	Ongoing
"	*Further consolidation and audit of non-clinical Covid Secure areas*	Area leads and H&SS	Complete	Ongoing

15.1

Health and Safety Executive

EPD OPST

Harvey Wild

Birmingham - Advantage House
9 Quinton Business Park
Birmingham
WTM
B32 1AL

http://www.hse.gov.uk/

Acting Deputy Director
John Rowe

To: Chief Executives of all NHS acute trusts,
foundation trusts and health boards

2 March 2021

Dear colleagues

HSE COVID-19 SPOT CHECK INSPECTION – FINDINGS

I would like to take this opportunity to thank you and your teams for your on-going commitment and dedication to maintaining high quality healthcare services throughout these incredibly challenging times.

The health and safety of workers is a priority and, as Britain's regulator for workplace health and safety, HSE has been supporting the national effort to tackle coronavirus in a number of ways, including through a COVID-19 spot inspection programme.

As part of this programme, 17 acute hospitals were inspected across Great Britain during December and January. We carefully analysed the outcomes from the inspections so that we could use this opportunity to share learning and enable you to swiftly identify any common areas that may need improvement.

I have therefore enclosed a summary of our findings along with a number of recommendations in anticipation that you will use it in a constructive way alongside your other quality improvement approaches to ensure your COVID -19 arrangements are robust as they can be.

Whilst the inspections were carried out in acute hospitals the common themes we identified may also be applicable across a variety other health and social care settings and services.

Should you need to clarify any of the content please send your enquiry to Public.Services-Sector@hse.gov.uk.

Yours faithfully

Harvey Wild
Head of Transport and Public Services Unit
Engagement and Policy Division
Health and Safety Executive

15.2

SUMMARY OF FINDINGS

HOSPITAL SPOT CHECK INSPECTIONS – COVID-19

Background

HSE inspected 17 acute hospitals, in 13 NHS Trusts in England and 2 NHS Health Boards in Scotland and Wales respectively as part of the national HSE COVID–19 spot check inspection programme. The inspections were led by an HSE Occupational Health Inspector and were carried out between December 2020 and January 2021. Each one focused on 7 key areas to assess the arrangements in place to manage risk arising from COVID-19, but where other matters of evident health and safety concern were identified they were also dealt with.

Executive summary

Overview

The NHS Trusts and Boards had all invested significant time and effort to implement a variety of COVID control measures in the hospitals inspected.

We saw a range of compliance both in terms of comparing the hospitals with each other but also within individual hospitals. Five were highly compliant; four were given advice and 8 required letters to be sent formally requiring remedial action to be taken. The contraventions of health and safety law included in the letters were:

Risk Assessment	Management arrangements Specific to COVID	Social Distancing	Cleaning and hygiene measures	Ventilation	Dealing with suspected cases	PPE
8	6	8	6	5	0	5

A detailed summary is provided in Annex 1 setting out examples of where we saw good practice and where remedial action was required. The common themes were:

Leadership

- Higher levels of compliance were seen where the leadership team were visible to staff on the front line and the Infection Prevention and Control (IPC) leads worked alongside health and safety teams.
- Lower levels of compliance were generally found where there were limited or no monitoring arrangements in place to ensure the control measures identified in the risk assessments were implemented and/or maintained.

Clinical and Non-clinical areas

- Higher levels of compliance were seen in patient facing clinical areas across most of the 7 areas inspected.
- Lower levels of compliance were frequently found in in non-clinical areas, even when adjacent to clinical areas. Reasonably practicable control measures were often available but not utilised in a variety of locations.
- Arrangements for staff who are displaying COVID -19 symptoms were well established.

Matters of evident concern unrelated to COVID are detailed in Annex 2.

Recommended action:

We strongly recommend NHS Trusts and Boards review the detailed findings of the inspections in Annex 1 and take the following action to reassure themselves that adequate COVID control measures are in place and remain so during the pandemic:

1. Review their risk management arrangements to ensure they are adequately resourced.
2. Consider how well the various parts of the risk management system coordinate with each other, including the health and safety team, departmental managers, infection control and occupational health colleagues and whether they could be improved.
3. Ensure compliance with their legal obligations to consult with trade unions and employee representatives by ensuring they are engaged in the risk assessment process. Worker engagement in this process is critical to establishing workable control measures.
4. Review all non-patient facing areas to ensure a suitable and sufficient risk assessment has been carried out and the control measures identified have been implemented – in line with relevant guidance, including - Making your workplace COVID-secure during the coronavirus pandemic (hse.gov.uk). Consider how well the risk assessments for these areas have applied the hierarchy of control and have they:

    - Identified the maximum room occupancy numbers and the optimum layout and seating arrangements in all areas? For example, in libraries, the laundry, porters lodge, clinical records, rest rooms, toilets, locker rooms, post rooms, changing rooms, offices, canteens, training rooms, doctors' common rooms
    - Considered how ventilation could be improved in all areas? Could windows be unsealed to open, are doors left open, how are rooms with no windows or air conditioning being ventilated?
    - Implemented mitigating measures where it is not possible to maintain social 2m distancing? For example, by proving physical barriers (screens), one-way systems or rearranging /modifying layout.
    - Checked the adequacy of their cleaning regimes in non–clinical areas? Have they consistently considered high touch surfaces, for example printers, vending machines, kettles, photocopiers, door handles etc?

5. Review the provision of lockers and welfare facilities to ensure they can accommodate the number staff on shift in a COVID secure manner.
6. Establish routine monitoring and supervision arrangements to ensure control measures identified in the risk assessment are implemented and are being maintained.
7. Review your arrangements regularly to ensure they remain valid and act on any findings.

24 February 2021

Annex 1

INSPECTION FINDINGS

This is the detailed summary of the 17 hospital inspections undertaken. It is broken down in to the 7 key areas that were covered in order to assess the arrangements in place to manage risk arising from COVID -19.

1.Management Arrangements

Examples of good practice:

- High level leadership provided during the pandemic with establishment of Gold and Silver commands, frequent leadership meetings and briefings provided to staff through a variety of routes including webinars, blogs and social media.
- Board and senior leadership team engaged with staff on the front line thanking them for their hard work and listening to issues they may want to raise.
- Incident command center - staffed 24/7 by senior management.
- Strong links between infection control, health and safety and occupation health.
- Procedures in place for concerns to be raised.
- Departmental managers had access to expert support provided by health and safety team with NEBOSH professional qualifications.
- IPC Board Assurance Framework used to monitor progress and identify risks
- Trade Unions (TUs) engaged and actively encouraged to attend Health, Safety & Environmental committee chaired by head of Occupational Health.

Examples where improvement was required:

- Monitoring arrangements were not in place to ensure policies and procedures were read and were followed.
- Compliance with risk assessment control measures were not being audited resulting in the non-compliance issues contained in this report.
- Staff behaviour was not being challenged when non-compliance was seen by managerial staff.
- Departmental managers were not aware of their responsibilities for monitoring and maintaining COVID controls.
- Poor consultation with recognised Trade Union Safety Representatives and/or employee representatives during the completion of COVID related risk assessments.
- Sharing of good practice did not occur indicating lack of coordination within the system.

2.Risk assessment

Examples of good practice:

- Those carrying out risk assessments had been provided with appropriate risk assessment training and were supported by the health and safety team.
- Risk assessments were updated and reviewed by the Health and Safety Committee and Risk Management Committee comprising both senior leaders and frontline staff.
- Risk assessments disseminated to work force via multiple routes - local managers, through intranet/email systems and notice boards.

Examples where improvement was required:

- Risk assessments were not carried out for all areas and did not assess all the issues required, for example ventilation requirements and maximum occupancy were often omitted.
- Risk assessments not being reviewed after; lockdowns, events, such as outbreaks, when guidance changed, or when areas were repurposed e.g. from offices to rest areas.
- Staff had not received training to carry out risk assessments.
- Not all staff had access to the risk assessments, for example some hospitals used their intranet but not all staff have access to computers or were computer literate; there was a reliance on verbal cascade and colleague to colleague communication where English is not the first language.

3.Personal Protective Equipment (PPE)

Examples of good practice:

- Fit testing of close fitting FFP3 respirators was being carried out by in house trained fit testers or by contractors at all sites inspected.
- Non-clinical workers required to work in red-zones were fit tested, for example, domestics, engineers and chaplains.
- PPE stocks were in good supply, with a variety of respirators available.
- Staff entering red zones checked to ensure respiratory protective equipment (RPE) fit testing record was available for the respirator being worn.
- RPE/PPE Co-Ordinator nominated to monitor usage and stock levels.
- Staff received training in changing cartridges, decontaminating and storing their reusable RPE, and donning and doffing procedures.
- Separate donning and doffing areas were created, whilst maintaining one-way systems with adequate storage accommodation for reusable RPE.
- Contingency planning in place, for example the NHS Trust Alliance in the North West allows sourcing and swapping of PPE/RPE if needed.
- Daily monitoring of wearing of PPE.
- PPE panel were meeting twice a week to discuss stock levels and consider other PPE for introduction or replacement of items no longer available.

Examples where improvement was required:

- Records were not readily available to ensure the worker was provided with the correct respirator they had been fitted for. Face-fit information was not stored centrally on the person's personal file.
- A buddy/mirror was not always available to ensure a fit check was carried out correctly.
- Records were not readily available at the time of the inspection to demonstrate that additional training had been provided in addition to the suppliers' introductory session on using the PortaCount machine used for face-fit testing.
- Whilst pre-use checks were being carried out reusable RPE was not always being checked at suitable intervals to ensure that defective equipment was not being used.
- Reusable RPE was not always labelled with the individual's name and not stored in an appropriate manner e.g. seen to be stacked on top of one another in a variety of settings.
- RPE was not always located close to the place of use.

- Alternative FFP3 respirators being used without additional face fit testing, where it had not been clearly established from the PPE supplier or manufacturer that the respirators were compatible and could be used without a further face fit test.

4.Social Distancing:

Variety of areas across the hospital

Examples of good practice:

- One-way systems introduced with linear marking on the floor and signage on walls.
- Separate entrances/exits for staff and patients in wards where possible.
- Plastic curtains in wards between beds, instead of fabric curtains to allow easy cleaning and disposal.
- Hand sanitiser at all entrances/exits for staff visitors, and outpatients.
- Staff member stationed at entrances to hand out masks, ensure hand gel was used, control numbers entering and provide directions.

Examples where improvement was required:

Surgical masks:

- Surgical masks were being worn as a control measure in lieu of social distancing arrangements, contrary to IPC guidance that states ' Physical distancing of 2 metres is considered standard practice in all health and care settings, unless providing clinical or personal care and wearing appropriate PPE'.

- Some workers assumed if they were wearing surgical masks they did not need to be socially distanced from their colleagues. For example, staff were seen walking and chatting along corridors within close proximity to each other.

Changing areas/locker rooms/toilets (clinical and non–clinical staff)

- Maximum occupancy numbers and systems for maintaining social distancing not displayed on entry.
- Where maximum occupancy was identified no arrangements were in place to ensure compliance was possible. For example, no information was available to explain how to achieve the stated maximum occupancy of 10 for a changing/locker room when 120 workers were on duty.
- Sinks adjacent to each other had not been taken out of use/taped over and/or no perspex screens provided to ensure separation.
- Floor markings were not provided to identify social distancing, for example to signpost foot traffic though a large changing facility.
- Congestion caused by staff having to queue in the corridor and requiring colleagues to pass by in a narrow corridor space.
- Storage of personal clothing outside of lockers indicating insufficient number of lockers available.
- Changing facilities and lockers not close to the place of work.

Rest areas/common rooms/doctor's mess/patholgy

- Many were multi-purpose, used for breaks, eating, locker storage and working, with inadequate social distancing. For example, a workstation was being used whilst others were eating within 1m.
- Maximum occupancy numbers not being provided.

- Where maximum occupancy numbers provided the number of seats exceeded the limit allowed. On one occasion the maximum was 5 but 14 chairs were available and were positioned close together.
- Tables too small to allow 2m separation e.g. 4 workers were sat around a 1m diameter table facing each other.
- Areas repurposed for rest facilities but were too small to allow social distancing, which was compounded by lack of ventilation.
- Employees seen not social distancing on several occasions including eating within 1m of each other; 15 members of staff sitting in close proximity to each other, and 5 staff sitting at a table for 2.
- Areas were too small to accommodate the number of staff needing to use them at any one time.

Specific to the education department:

Examples of good practice:

- Virtual training was undertaken where practicable.
- Videos produced to minimise classroom time.
- Seats arranged on a marked floor to ensure separation.
- Rooms ventilated before and after use and at break times.
- Maximum occupancy sign in place.

Examples where improvement was required:

- Chairs closer than 2m as they had been moved from marked position.
- Chairs arranged close together and side by side.

Specific to Offices (including in clinical areas)/post rooms/medical records

Examples of good practice:

- Rotas introduced to minimise staff attendance when working from home is not an option.
- Screens provided at receptions to provide separation between patients and staff and in some offices to provide separation between desks.
- Layouts redesigned to avoid face to face working by staggering workstations.

Examples where improvement was required:

- Maximum occupancy was not known or communicated.
- Maximum occupancy identified but the room was too small to accommodate the numbers.
- Occupancy exceeded at busy times due to lack of sufficient computers/workstations on a ward.
- Desks and workstations were not organised to ensure social distancing. For example, excess seating and chairs were not removed, workers sat side by side or opposite facing each other when additional space was available (in one case 3 computer desks were side by side),
- Screens were not provided where reasonably practicable to do so.
- Screens were not provided despite being required in the risk assessment. For example: failure to provide a screen to separate officer workers from employees accessing the printer.

- Redesigning tasks not considered. For example: a drop off point for post could have been introduced, reducing the need for the worker to enter a small work area; in the reception area in a medical records library the receptionist was handing records through an open sliding window when an alternative method of transfer was possible that would avoid handing records between people.

Specific to Canteens/kitchens

Examples where improvement was required:

- Failing to supervise controls. For example: staff repositioned tables and chairs for socialising and breaking social distancing controls.
- Failing to address and manage busy times with congestion and breakdown of social distancing measures.
- No mitigation measures in food preparation areas where sinks were provided side by side. For example: no separation screens provided; or adjacent sinks not taped over to indicate they had been taken out of use.

Specific to Facilities/engineers/domestics/laundry/library

Examples of good practice:

- Plastic screens provided to separate workstations in engineering
- Good social distancing in place in porters lodge i.e. maximum occupancy identified and allocated seats marked out.
- Estates workshop benches socially distanced and with staff being allocated their own workstation.
- Facilities staff deliver to 'ultra-green' wards via lift to avoid the need to enter in person.
- Lunch breaks and shifts staggered in the engineering/domestic department to reduce traffic flow through the building and numbers using the changing and toilet facilities at any one time.

Examples where improvement was required:

- Poor furniture layout reducing the ability to social distance.
- Reliance on surgical masks where it was reasonably practicable to provide screens at some fixed workstations. For example: 5 employees working around a conveyor belt in the laundry ‘classification’ area when it was reasonably practicable to stagger them and provide separation screens.
- Floor markings not used to indicate direction of travel and separation distances. For example, walkways in the main library.
-

Specific to corridors and open waiting areas /lifts

Examples of good practice:

- Seats in waiting areas taped over to manage separation and overflow arrangement in place to avoid over-crowding.
- Informative safety posters and directional floor signs provided.
- Wardens deployed to monitor numbers and ensure face masks/coverings were being worn.
- Portacabins provided to increase waiting area capacity.

Examples where improvement was required:

- In staff only areas a walk on the left side was policy introduced but with no marking or signage and lack of supervision it was not being adhered to.
- Signage not provided in a lift to communicate maximum occupancy.

5. Hygiene and cleaning regimes

Examples of good practice:

- Additional cleaning machines purchased to remove the need for transfer between departments /wards.
- Dedicated cleaning teams provided to individual wards.
- Deep clean teams provided and overseen by IPC team.
- Clear instructions of what is cleaned by the cleaning team and nurses respectively
- Enhanced cleaning in education and libraries with laminated 'action' cards provided to explain cleaning system.
- Instructions for cleaning arrangements of frequent touch points or multi-user equipment clear and monitored to ensure implemented
- Internal hygiene audits carried out to assess compliance.
- Toolbox talks provided twice monthly and safety bulletins to remind staff of IPC procedures and update on changes.
- Cleaning supervisor monitors cleaning daily and in turn this was monitored by a manager.
- Laminated cards used to identify areas that had been used and required cleaning.

Examples where improvement was required:

- Cleaning schedules were not comprehensive, leading to areas being missed. For example, they did not always include rest rooms, porters lodge, staff toilets, changing rooms, doctor's mess, medical records and libraries. In those areas high touch points were not being cleaned in between use, for example telephones, printers, computers, photocopiers, vending machines, kettles, microwaves, equipment in engineering workshops.
- Local instructions for cleaning not available at point of use.
- Cleaning material not available for local point of use cleaning.
- Cleaning after use not occurring despite suitable wipes being provided.
- Insufficient monitoring being carried out to ensure high touch points were cleaned regularly.

Specific to canteens:

- Limited information on cleaning regime for those using the facility.
- Lack of supervision and monitoring. This resulted in tables not being routinely cleaned between use by cleaning staff or those eating at the tables, despite a card system being in place to identify used tables.
- Cleaning material not always available.
- Single wipe being used for multiple tables.
- Surgical masks being placed on tables.

6. Ventilation

Examples of good practice:

- Maxillofacial department in the outpatient's department engaged a competent ventilation contractor to assess air changes in each treatment room. They then implemented a system to ensure those rooms with greatest number of air changes were used for AGPs as their clearance time was shorter.
- Modifications carried out to ventilation system to increase air flow in theatres and ICU.
- Ventilation was checked regularly including velocity, dilution, and dwell times.
- Site wide survey of all mechanically ventilated wards and to identify any issues and rebalance the ventilation system.
- Implemented a schedule of cleaning and maintenance of all mechanical ventilation systems.
- Management regularly communicated to their teams about the need to open windows to introduce fresh air into areas without mechanical ventilation.

Examples where improvement was required:

- Ventilation was not considered when the risk assessment was carried out.
- A room was repurposed as a rest facility but there were no windows or other means of ventilation provided.
- In non-clinical areas rooms were identified with no forced/mechanical ventilation and the windows were secured shut and the risk assessment did not consider whether the windows could have been unsealed to allow opening for ventilation where this was a possibility.
- In areas where AGPs were carried out the clearance time was not available.
- Not all opportunities to open doors and windows were being taken.

7. Dealing with Suspected Cases

- Arrangements for staff who are displaying COVID -19 symptoms were well established.

Annex 2

Other health and safety issues requiring enforcement action

Improvement Notice

Machinery guarding

Engineering machinery such as lathes and pillar drills in a workshop were not adequately guarded to prevent access to dangerous parts that could cause injury.

Letters of contravention

Transport

Workers were not walking in the designated pedestrian walkways and using designated crossing points exposing them to the risk of being injured by a moving vehicle. Consideration of improving the precautions was required along with additional monitoring and supervision arrangements to manage the on-going risk.

Risk of falling from windows

A window opened for ventilation purposes in a non-clinical room was not provided with a restraint to prevent a person inadvertently falling though the opening.

Provision of changing facilities

Changing facilities were not provided for workers in a “Red” ICU. Workers were required to change at work into their scrubs. The only facilities available were two small toilets near to the Manager’s office. In addition, they were not provided with suitable storage for their personal clothing so they stored them in bags and stacked them in an adjacent room as lockers were not provided.

Machinery guarding

A horizontal sawing machine located in a workshop was not adequately guarded. The machine was immediately taken out of service and electrically isolated in order to be decommissioned.

A hired waste compactor was in operation in a publicly accessible area with an unlocked entry panel; this meant that there was direct access to the compaction chamber, which could result in serious injury or death if the machine was operated. Immediate action was taken to secure the access door.

Note: as immediate action was taken to repair these machines or remove them from further use the issuing of enforcement notices was not considered necessary. If the matters had not been resolved immediately enforcement notices would have been served.

Thorough examination and testing of local exhaust ventilation (LEV)

The local exhaust ventilation systems (LEV) provided to reduce substances hazardous to health, namely, exposure to wood dust and welding fume in the workshops, did not have the legally required current record of thoroughly examination and test.

Report To:	Trust Board - Public		
Date of Meeting:	25 March 2021		
Report Title:	Quality & Risk Management Committee Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary Isobel Clements, Corporate Governance Officer		
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
Recommendation:	The Trust Board should receive the report for assurance and note the activities QRMC has undertaken on behalf of the Board. It is requested that Trust Board: • Note the completed Maternity Assurance Assessment Tool which completes an Ockenden action and note the ongoing work regarding maternity services; • Note the final, positive, CQC Gynaecology inspection report; • Approve the QRMC Terms of Reference (following minor amendment to sub-committees).		
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 May 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 18 March 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 – Completed Maternity Assurance Tool (Ockenden action) Appendix 2 - Final Gynaecology inspection report & Action Plan Appendix 3 – Terms of Reference (slight amendment to sub-committees)

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 meetings held on 18 March 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 18 March 2020

2.2 Maternity

The Committee was joined by some of the Women and Children's Health divisional management team who presented the developing Maternity Assurance Dashboard .containing the minimum dataset as recommended by NHSE/I. The dashboard was developed

collaboratively alongside University Hospitals Bristol & Weston's Maternity service and will also be used to report into the Local Maternity System.

The Committee welcomed the progress made in capturing the minimum data set and other data the team felt were important. The Committee provided feedback on the dashboard; specifically raising the need to ensure that patient voice is reflected within this work and that appropriate summary/narrative arising from the dashboard is included. It was noted that the data set would be included in the Integrated Performance Report that is received monthly at Trust Board.

The Committee also reviewed the Trust's response to the Ockenden report actions and discussed the completed Maternity Services Assurance Assessment Tool (see Appendix 1). During discussion, it was requested that actions with a 'to be confirmed' completion date be provided with a date and lead name at the next Committee meeting. It was noted some actions were cross-city and would be decided at Local Maternity System level.

The Clinical Negligence Scheme for Trusts (CNST) and Perinatal Mortality Review Tool (PMRT) quarterly update reports were also provided to the Committee for review. The committee offered support to the Maternity Team to help progress compliance with elements of safety actions and noted the following:

- Changes to deadline dates for the CNST Maternity Incentive Scheme, Trust Board approval and sign off dates due to the Covid-19 pandemic (now mid-July 2021);
- Details of all eligible perinatal deaths had been reviewed and the consequent action plans. 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 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.

2.3 Patient Safety Programme 2021/2022

The Committee received an update on the thematic analysis across patient safety incidents, complaints, concerns, inquest outcomes and patient safety investigations. This forms a core part of preparing for and implementing the Patient Safety Incident Response Framework (PSIRF) which replaces the Serious Incident Framework. It also informs the patient safety programme for 2021-2023.

The Committee discussed the Trust's Patient Safety Priorities:

- Inpatient falls;
- Medications management;
- Responding well to clinically changing conditions;
- Discharge;
- Pressure injures;

And expressed enthusiastic support for the development of a continuous improvement model for each Patient Safety Priority. This will be presented to Trust Board for approval in due course.

2.4 Serious Incident: Care Home outbreak

The Committee received an update on the incident which took place in October 2020 where a patient with Covid-19 was discharged to a care home. The report set out the findings from the investigation and the safety recommendations arising from the investigation report.

The Committee were assured by the processes followed, the support provided to NBT staff, and the apology and ongoing communications with the organisation and families affected.

2.5 'Safe to Wait' – RTT, Diagnostics and Cancer Pathways – Update

The Committee received a follow up paper/presentation on the clinical safety net arrangements during Covid-19 and prioritisation/validation programme for patients on NBT waiting lists. The Clinical Directors for the ASCR and NMSK Divisions presented on the Trust's participation in the nationally mandated programme as well as the Trust's approach to managing "P2" status patients safely.

The Committee were assured that the Trust has robust processes in place and thanked the clinical leaders and other staff involved in these processes, for which the Trust had been nationally recognised.

2.6 CQC National Strategy Consultation & Assurance Programme 2021-22 including CQC insight summary

The Committee received an outline of the latest CQC Insight data and noted the data had a three month lag time.

The Associate Director of Quality Governance also presented to the Committee changes to CQC inspections including a move away from large-scale inspections and five criteria areas. Instead, the Trust's overall CQC rating would consist of one score focussed the 'well-led' aspect. Work was ongoing to prepare the Trust for the well-led focus; this would be brought to Trust Board in summer 2021.

The Committee were also informed of the positive, final, Gynaecology inspection (see Appendix 2).

2.7 Quality Governance Improvement Programme Update

The Committee supported the proposal to stand down the Quality Governance Improvement Programme Board, noting that the work previously overseen by that Board has now been incorporated into "business as usual" across the Trust, and no longer requires specific/separate oversight.

2.8 Forward work plan and Terms of Reference

The Committee approved the slightly amended Terms of Reference and commended it to Trust Board for final approval (see Appendix 3). A minor amendment to QRMC's sub-committees had been made to include Control of Infection Committee (CoIC) which will allow oversight of Infection Prevention Control issues at QRMC-level. The Committee would receive upward reports from CoIC in future.

2.9 Other items:

The Committee also received updates on:

- The Laparoscopic Ventral Mesh Rectopexy (LVMR) recall process;
- QRMC relevant BAF Risks;
- Risk Management Reports (including Covid-19, TLR, Nightingale Hospital Bristol and mass vaccination);
- Quality Performance Report;
- Sub-committee upward reports from Clinical Effectiveness & Audit Committee and Patient Safety & Clinical Risk Committee.

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.

It is requested that Trust Board:

- Note the completed Maternity Assurance Tool which completes an Ockenden action and note the ongoing work regarding maternity services;
- Note the final, positive, CQC Gynaecology inspection report;
- Approve the QRMC Terms of Reference (following minor amendment to sub-committees).

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

	Urgent Clinical Priority :	
What do we have in place currently to meet all requirements of IEA 1?	**UCP - a)**	In place currently: Principle 1 – Strengthening trust-level oversight for quality • Monthly review of maternity and neonatal safety using the tool in Appendix 2 (minimum data set). Clinical and quality governance dashboard reviewed and discussed at divisional and Trust level • All SI's (including HSIB) shared with Trust Board and CCG • Ongoing work with the LMS obstetric Lead and regional Chief Midwife to share best practice and trust level intelligence. • Appointment of a non-executive director maternity safety champion (December 2020)
	UCP - b)	Currently: • Weekly Executive Incident review group reviews and declares all SIs. • Patient Safety Committee receives and approves all SI investigation reports and has oversight of HSIB reports. • Monthly reports via Integrated Performance Reports to T rust Board – clinical dashboard, minimum data set and SI headlines and learning • Bimonthly reporting to QRMC
Describe how we are using this measurement and reporting to drive improvement?	**UCP – a)**	The new model will be used to identify and monitor trends and themes to drive improvement.
	UCP – b)	Learning shared at divisional and trust level.
How do we know that our improvement actions are effective and that we are learning at system and trust level?	**UCP – a)**	By drawing from safety intelligence from a range of qualitative and quantitative sources we will be able to provide a balanced view to our commitment to continuous improvement for our maternity services.
	UCP – b)	As part of Maternity Improvement Strategy and in line with the Trust's Quality Strategy Theme 2 – Safe and harm free care.

What further action do we need to take?	**UCP – a)**	Redesign floor to board reporting structure aligned with the Principles set out in the Perinatal clinical quality surveillance model Principle 1 – Strengthening trust-level oversight for quality • Ensure NBT representation at the newly formed LMS Learn and Support Group, to share best practice and trust level safety intelligence. • Participate in the national training for Board level Maternity Safety Champions Principle 2 – Strengthening LMS and ICS role in quality oversight. • To work with the LMS to ensure adequate meeting and NBT representation. • Share clinical dashboard and minimum data set with LMS. Principle 3 - Regional oversight for perinatal clinical quality. • Support regional oversight for perinatal clinical quality, ensuring adequate representation and sharing NBT data. Principle 4 – National oversight for perinatal clinical quality • No action for NBT, plans in relation to national safety intelligence Principle 5 – Identifying concerns, taking proportionate action and triggering escalation. • Action plans to be shared with Board level safety champions when concerns are raised by external or internal intelligence. These action plans will then be shared at LMS level at the newly formed LMS Learn and Support Group
	UCP – b)	Work with the newly formed LMS Learn and Support Group to share best practice and trust level safety intelligence. Develop a new reporting system.
Who and by when?	**UCP – a)**	By Executive and non-executive Safety Champions, supported by WACH Safety Champions and Maternity Quality Governance team. Plan to implement Principles 1,2,3 and 5 by March 2021
	UCP – b)	By Executive and non-executive Safety Champions and LMS Learn and Support Chair, supported by WACH Safety Champions and Maternity Quality Governance team. Plan to implement by March 2021
What resource or support do we need?	**UCP – a)**	This will be subject to further review.

	UCP – a)	This will be subject to further review
How will mitigate risk in the short term?	**UCP – b)**	Monitoring through divisional and Trust Quality Governance processes
	UCP – b)	Monitoring through divisional, Trust and LMS Quality Governance processes

Immediate and essential action 2: Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

	Urgent Clinical Priority :	
What do we have in place currently to meet all requirements of IEA 2?	**UCP – a)**	Currently we receive reports from Friends and Family Test, Maternity Picker Survey, Facebook, compliments and complaints which are shared monthly at Maternity Speciality Governance meeting to drive improvement. Active MVP within BNSSG. MVP chair now appointed Nov 2020 with meetings planned for 2021.
	UCP – b)	Named non-executive director in post since December 2020. Kelly Macfarlane. Named executive director. Helen Blanchard
How will we evidence that we are meeting the requirements?	**UCP – a)**	Service user feedback shared at Monthly Maternity Specialty Governance, monthly Maternity Safety Champion Meeting, Divisional Management Board and Patient and Carers Experience Group, using feedback to coproduce and improve local maternity services. Minutes of meetings where co-production has taken place with the outputs available i.e. service user information / involvement in guideline development etc. MVP chair shares themes from user feedback at LMS board monthly.
	UCP – b)	Meeting the minimum requirement as set out in the "Annex: Role descriptor for the non-exec board safety champion"
How do we know that these roles are effective?	**UCP – a) & b)**	Themes monitored and learning identified. Assess for the volume and quality of co-produced work.
What further action do we need to take?	**UCP – a) & b)**	Area of focus will be to work with the MVP to create a model which uses service user feedback insight to co-produce and improve local maternity services. Involve users in co-producing services through use of experience-based design process. NBT representation at MVP meetings.
Who and by when?	**UCP – a) & b)**	Safety Champions including non-executive director and MVP chair supported by Maternity Quality Governance Team – started January 2021.

What resource or support do we need?	**UCP – a) & b)**	This will be subject to review.
How will we mitigate risk in the short term?	**UCP – a) & b)**	To continue to use service user feedback from a range of sources and review regularly at Speciality, Divisional and Trust Level. Patient information group established to provide accessible information and communication for service users who don't have English as their first language. Service user feedback report will form part of the minimum data set which will be shared with Trust Board.

Immediate and essential action 3: Staff Training and Working Together

Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

	Urgent Clinical Priority:	
What do we have in place currently to meet all requirements of IEA 3?	**UCP – a)**	Consultant led ward rounds take place twice daily 7 days a week. Monday- Friday, 8am, 2pm and 8pm Saturday and Sunday, 8am and 3pm
	UCP – b)	MDT training schedule in place in line with CNST.
	UCP – c)	A statement of commitment is in place that year 3 (2021/2022) CNST maternity incentive scheme refunds will be ring-fenced for use within maternity services.
What are our monitoring mechanisms?	**UCP – a)**	Standard Operating Procedure for a minimum of twice daily consultant obstetrician labour ward rounds with supporting audit
	UCP – b)	Training is monitored as part of CNST compliance which is monitored monthly at Maternity Governance and Safety Champion meetings and Trust Board minimum data set.
Where will compliance with these requirements be reported?	**UCP – a)**	Added to Trust Audit programme. Compliance will be monitored at Maternity Specialty Governance.
	UCP – b)	Compliance reported at monthly Maternity Governance Meeting and Maternity Safety Champion Meeting and Trust Board as part of the minimum data set.
What further action do we need to take?	**UCP – a)**	To achieve full compliance with Consultant led MDT ward rounds requires the implementation of a dedicated Anaesthetic Review clinic, as this will release cover for the MDT ward round.
	UCP – b)	Up to date Maternity Services Department Multi-Disciplinary Training Needs Analysis to be agreed by the Division with HOM and Specialty Lead oversight. A training action plan is required to address the minimum requirements of the Core Competency Framework. Once a plan to meet requirements of the Core Competency Framework is agreed, compliance with each competency will need to be monitored using the minimum data set for Trust Board.
Who and by when?	**UCP – a)**	Anaesthetic Obstetric Lead and Maternity Business Manager by March 2021
	UCP – b)	Training Leads to complete training syllabus action plan by Jan 2021, new programme roll out to begin April 2021

What resource or support do we need?	**UCP – a) & b)**	Anaesthetic Obstetric lead and Maternity Business Manager to review resourcing.
How will we mitigate risk in the short term?	**UCP – a)**	Not applicable as Consultant led ward rounds in place.
	UCP – b)	Due to COVID 19 this training is now delivered online with interactive online sessions planned for 2021. Appointment of practice facilitator to support training compliance.

Immediate and essential action 4: Managing Complex Pregnancy

There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead

- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

	Urgent Clinical Priority:	
What do we have in place currently to meet all requirements of IEA 4?	**UCP – a)**	All women with complex pregnancy have a named consultant.
	UCP – b)	Expression of interest sent in 2019 for NBT to become maternal medicine specialist centre. Awaiting update from NHS England.
What are our monitoring mechanisms?	**UCP – a)**	Lorenzo/Care Flow Connect/Euroking IT systems are in use in Maternity services at NBT. Compliance monitored through audit.
	UCP – b)	Awaiting response from NHSE&I
Where is this reported?	**UCP – a)**	To be added to Trust Audit programme. To be reported at Maternity Specialty Governance
	UCP – b)	Progress updates reported to Maternity Specialty Governance.
What further action do we need to take?	**UCP – a)**	IT Lorenzo template improvement work required to ensure correct consultants are recorded and change of care provider occurs easily.
	UCP – b)	Await update from NHSE&I
Who and by when?	**UCP – a) & b)**	Quality Lead responsible for audit activity. Audit to start in February 2021 IT Lead Midwife responsible for Lorenzo template update , improvement work to commence February 2021
What resources or support do we need?	**UCP – a) & b)**	Nil identified at present, subject to review
How will we mitigate risk in the short term?	**UCP – a) & b)**	Spot check audits to be undertaken.

Immediate and essential action 5: Risk Assessment Throughout Pregnancy

Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

	Urgent Clinical Priority:
What do we have in place currently to meet all requirements of IEA 5?	Formal risk assessment at booking. Regular risk reviews throughout pregnancy. Further formal risk assessment at 36 weeks. (No national standardised risk assessment tool which is used throughout pregnancy).
What are our monitoring mechanisms and where are they reported?	Initial risk assessment documented on Euroking. Further risk assessments documented in hand held notes. Audit to monitor compliance.
Where is this reported?	To be added to Trust Audit programme. To be reported at Maternity Specialty Governance

What further action do we need to take?	• Implementation of Personalised Care and Support Plans across LMS • Design system to enable appropriate risk assessments • Hand held maternity notes across LMS to be redesigned to aid documentation of risk assessment at every contact. Consideration of new digital system of record keeping • Ensure risk assessments are performed on all patient contacts e.g. Antenatal Assessment Unit • Work with the LMS to develop a prompt tool for all staff to ensure risk assessments and place of birth is completed at every patient contact To set up an auditable process which will include ongoing review and discussion of intended place of birth and risk assessment
Who and by when?	LMS Obstetric and Midwife Lead with support from MVP and NBT Maternity Quality Governance Team. To commence implementation improvement work April 2021.
What resources or support do we need?	May require additional resources, subject to review. New digital system of record keeping to enable electronic risk assessments as per cross city digital plan for maternity records.
How will we mitigate risk in the short term?	Consider implementation of temporary risk assessment tool in the form of a sticker in the maternity hand held notes.

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies' lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place	**Urgent Clinical Priority:**

currently to meet all requirements of IEA 6?	Consultant Lead for Fetal Monitoring and Fetal Wellbeing, Dr Kate Collins. Overall Consultant lead for SBLCBv2, Dr Sonia Barnfield, Midwife Lead for Fetal Monitoring and Fetal Wellbeing, Susan Hughes and Kelly Hamilton Overall Midwife lead for SBLCBv2, Susan Hughes
How will we evidence that our leads are undertaking the role in full?	Progress shared of all 5 elements of SBLCBv2 at Monthly Maternity Governance meetings, Monthly Maternity Safety Champion Meetings with the completed South-West implementation survey quarterly.
What outcomes will we use to demonstrate that our processes are effective?	Review of our clinical dashboards Quarterly review of PMRT Regular audits of all 5 SBLCBv2 elements
What further action do we need to take?	To continue with implementation of SBLCBv2 To continue with monitoring progress and compliance with implementation of Saving Babies Lives Version 2. To embed the Maternity minimum data set in to divisional and Trust governance processes.
Who and by when?	Leads already in place
What resources or support do we need?	Subject to job plan review.
How will we mitigate risk in the short term?	Named Midwife and Obstetrician in already in post. Fortnightly fetal monitoring training sessions and cascade training in progress. Fetal monitoring updates provided to Maternity Specialty Governance meetings.

Immediate and essential action 7: Informed Consent

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	**Urgent Clinical Priority:** • Clear pathways of care described and available on Trust website and NBT Maternity App. • Women are involved in shared decision-making processes and make informed choices about their care
Where and how often do we report this?	All new national guidance is reviewed using a RAG rating at Specialty Governance meetings which is held monthly. Maternity website and App update report provided at Maternity Specialty Governance.
How do we know that our processes are effective?	• Rated Green, Birth Rights UK 2018. • Epidural waiting times regularly audited. • Maternal choice LSCS's and IOL's are offered as part of NBT's local guidelines

What further action do we need to take?	• Continue to maintain these standards, update Maternity App with videos/QR codes. • Continue to audit epidural waiting times • When i-DECIDE tool is released nationally to fully implement and embed in NBT • Roll out of personalised care plans across BNSSG
Who and by when?	Guideline midwife Lead to ensure Website/App information updated in line with national and local guidelines. LMS to lead on roll out personalised care plans
What resources or support do we need?	Potentially additional hours or new role to support NBT Maternity App and website, subject to review. Wider use of QR codes etc. May require additional hours to train on new i-DECIDE tool and electronic resources to implement (e.g. IPads/Wi-Fi etc.), subject to review
How will we mitigate risk in the short term?	Use hours from Guideline midwife to maintain App/Website in the short term.

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	BirthRate+® exercise completed October 2019. The Director of Midwifery reviewed the results of BirthRate+®, and triangulated the findings with professional judgement and her knowledge of the services provided at NBT. NBT assessment suggests that the ratio of midwives required to meet the patient acuity across all services is a ratio of 27 births to 1wte midwife. This is a clinical (not specialist midwife ratio) and based on births in the 2019 data collection and the Trust has since seen a reduction in births in 2020/21. A review taking account of the current birth rate is near completion and a business case is being prepared for investment in Midwifery staffing.
How have we assured that our plans are robust and realistic?	The business case is being developed by the senior clinical leads within the Women and Children's Division with business support and oversight from the Board level maternity safety champions. The case will be reviewed through NBT business case approval processes.
How will ensure oversight of progress against our plans going forwards?	Approval of business case through Trust Management Team / Trust Board. Safe staffing reviewed through Divisional Performance Reviews with the Executive Team and through the Board Assurance committee. Oversight by the LMS and Maternity Safety champions.
What further action do we need to take?	• Completion of business case for midwifery staffing in response to BirthRate+® and workforce assessment: due April 2021 • Maternity Staffing review as nationally recommended as part of Workforce Safeguards (NHSE/I) • Undertake a review of the plan and workforce necessary for implementation of the Continuity of Carer model of care.
Who and by when?	Deputy Director of Midwifery & Deputy Director of Nursing & Quality April 2021.

What resources or support do we need?	Approval of financial investment.
How will we mitigate risk in the short term?	Use of BirthRate+® daily to inform assessments of acuity and staffing requirements. Matrons have clear oversight and there is a process of escalation of any issues. Monitoring of outcomes, incidents and feedback from women.

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

The Deputy Director of Midwifery is currently the lead Midwife for the service with professional line management by the Deputy Director of Nursing and Quality.
The Trust is actively recruiting an interim Head of Midwifery for a 9 months fixed term contract, whilst the post of Director of Midwifery is vacant. This post holder will be professionally responsible and accountable to the executive Director of Nursing and quality.

The Deputy Director of Midwifery has been representing the Trust regionally and nationally. The DDOM has been attending the LMS Board, the Divisional Management Board and attends the regional Heads of Midwifery and Director of Midwifery bi-monthly meetings. The Deputy Director of Midwifery also has bi-monthly one-to-one contact with the Regional Chief Midwifery Officer.

There are a number of specialist Midwives, including; Perinatal Mental Health Specialist Midwife, Infant Feeding Specialist Midwives, Practice Development Midwives, Substance Misuse Midwife who also cares for teenagers and prisoners, Named Midwife for Safeguarding and Antenatal screening/fetal medicine specialist midwife. The Trust also has a team of research Midwives who are part of the internationally renowned Trust Research Department.

All Maternity Matrons are attending the Matrons' development programme - introduced at NBT following the launch of the new Matrons' handbook in 2020. Matrons are supported to complete Masters modules as appropriate to their roles. The Trust also has a leadership programme which Midwives have access to. The Deputy Director of Midwifery has been accepted to attend an accelerator course run by NHS England for future Heads of Midwifery.

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	
What process do we have in place currently?	Standing agenda item for Maternity Speciality Governance and Maternity Safety Champion Meeting to review any new national guidance/reports including NICE. All new national guidance is reviewed using a RAG rating at Specialty Governance meetings which is held monthly.
Where and how often do we report this?	Existing NICE guidelines to be reported at Maternity Specialty governance
What assurance do we have that all of our guidelines are clinically appropriate?	All NBT clinical guidelines are evidence based but will be reviewed to provide additional assurance. Guidelines related to are LMS cross city guidelines.
What further action do we need to take?	To implement a process for introduction and implementation all national guidance including NICE.
Who and by when?	Led by Guideline Lead Obstetrician and Midwife, improvement work to commence February 2021.
What resources or support do we need?	This will be subject to review.

How will we mitigate risk in the short term?	Any new national GL will be added to agenda for Maternity Safety Champion Meeting and Maternity Specialty Governance meeting and a RAGB rating will be completed highlighting areas of clinical need.

North Bristol NHS Trust

Southmead Hospital

Inspection report

Trust HQ
Bristol
BS10 5NB
Tel:
www.nbt.nhs.uk

Date of inspection visit: 10 December 2020
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Southmead Hospital

Inspected but not rated

North Bristol NHS Trust provides gynaecology services at Southmead Hospital and peripheral clinic locations.

We inspected but did not rate gynaecology services at Southmead Hospital and reviewed safe, effective, responsive and well-led key questions.

We inspected gynaecology services at Southmead Hospital to provide the public with information on the quality and safety of services. We were aware of improvements the trust had made and wanted to see if the trust's actions had been effective in improving the safety of the service.

We did not rate this service at this inspection as we did not inspect all key lines of enquiry. Gynaecology services were last comprehensively inspected as part of the maternity and gynaecology inspection published in February 2015 and was rated requires improvement for safe and responsive, and good for effective, caring and well-led. In April 2016 during a focused inspection, maternity and gynaecology services were rated good for safe and responsive. In June 2017 CQC separated the maternity and gynaecology core services.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk with was available. As this inspection took place during the Covid-19 pandemic we adapted our approach to minimise the risk of transmission to patients, staff and our inspection team. We limited the amount of time we spent at the service, followed the trust's local infection control policies and spoke with staff by video call rather than in person.

We reviewed all the information the trust had provided us with before the inspection.

During the inspection we spoke with 21 staff including managers of the women and children's health division and managers of the gynaecology service. We also spoke with the lead consultant for gynaecology, speciality lead for gynaecology, consultant lead for gynaecology oncology, gynaecology consultants, trainee doctors, the colposcopy coordinator, nurses and a healthcare assistant. We also spoke with the lead consultant for the gynaecology multidisciplinary team meeting based at the regional cancer centre.

We reviewed 15 records of women who had been referred to the gynaecology cancer service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Gynaecology

Inspected but not rated

Is the service safe?

Inspected but not rated

We inspected but did not rate the safe key question in relation to records and incidents.

Records

Staff kept detailed records of patients' care and treatment. Records were clear and up to date.

Patient notes were comprehensive and included the name and grade of the person recording the notes. We reviewed 15 records of women who had been referred to the gynaecology cancer service. Notes were mostly in an electronic system with written paper notes used in clinics. Test results were reported electronically so they could have a multidisciplinary review and be more easily audited. Records included women's full medical history including mental health conditions. Records we reviewed gave a full account of women's symptoms and showed women were involved in decision-making about their care. Discharge letters to GPs were sent in a timely way and included summaries of the treatment women had received and plans for ongoing treatment.

Incidents

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

Staff reported serious incidents in line with trust policy and managers shared learning with staff. Managers shared learning after significant event recommendation (LASER) posters with staff to share learning in an easy to understand, standardised format. A recent LASER poster we reviewed included learning points for pathology and gynaecology clinical teams. Managers also shared learning from incidents in the quarterly divisional newsletter and via email. While managers shared learning from incidents well within the gynaecology department, sharing learning with primary care could be improved.

Managers investigated incidents thoroughly. The trust had reviewed the serious investigation review process, including the templates, in line with the Health and Safety Investigation Branch and the NHS patient safety strategy. We reviewed a serious incident that had been investigated using this process and could see the quality of the investigation report had improved by using this approach.

There was evidence that changes had been made as a result of investigations of incidents. The trust had developed a guideline on the treatment of cervical ectropion (abnormal appearance of the cervix) in July 2018, following a clinical incident. The consultant lead for gynaecology oncology presented this guideline at a gynaecological departmental meeting and this was also discussed at a South West cervical screening programme meeting. The guideline was shared regionally and nationally as this was the first time the guideline had been produced.

Staff met to discuss the feedback and look at improvements to patient care. Staff attended monthly gynaecology governance meetings where incidents were discussed. Staff we spoke with were aware of changes made to ensure histopathology samples are correctly labelled following a recent incident.

Gynaecology

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. Patients and their families were involved in investigations. The service had improved teaching to clinical teams on the duty of candour as part of a quality improvement project on patient safety incident governance. The two most recent serious incident investigation reports we reviewed included details of how the patient and family had been informed and involved in the investigation in a timely way.

Is the service effective?

Inspected but not rated

We inspected but did not rate the effective key question in relation to competent staff and multidisciplinary working.

Competent staff

The service made sure staff were competent for their roles and provided support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Women who had been referred to the gynaecology cancer service were always seen by a consultant or speciality doctor (consultant level) clinic with junior doctors attending for training and experience. At following appointments, women were seen by a consultant or speciality doctor with junior doctors attending for training and experience. However, as only one out of twelve consultants had a specialist interest in gynae-oncology, the skill-mix of the consultant staff could be improved to provide better oversight of the gynaecology cancer service.

Managers made sure staff received any specialist training for their role. They identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Trainee doctors received specialist training in obstetrics and gynaecology as required by the Royal College of Obstetrics and Gynaecology, which included recognition and investigation of gynaecology cancers.

The trust had improved monthly teaching sessions, opportunities for quality improvement projects, research and other training opportunities. Trainee doctors we spoke with were positive about teaching sessions available to them. The trust's performance in the Royal College of Obstetricians and Gynaecologists teaching evaluation form had significantly improved. The trainee overall recommendation improved from a ranking of 110th (out of 180 nationally) in 2018, to 38th in 2019. Following the feedback from the evaluation, the service was working to improve workload and the balance of service provision to educational activities for trainee doctors.

Clinical educators supported the learning and development needs of staff. The service had a Royal College of Obstetrics and Gynaecology tutor and an undergraduate medical supervisor. In response to the coronavirus pandemic, weekly and monthly teaching sessions were now delivered by online webinars.

Managers supported medical staff to identify their personal development needs through regular, constructive clinical supervision of their work. The service had changed clinic templates and reduced the numbers of women seen in clinics since April 2019 to closer align with Royal College of Obstetrics and Gynaecology standards and to ensure consultants had enough time to support trainee doctors. Trainee doctors we spoke with confirmed they always had time to access support from a consultant.

Gynaecology

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The consultant lead for gynaecology and oncology attended weekly multidisciplinary meetings with the regional cancer centre. We saw evidence in the 15 records we reviewed of effective multidisciplinary working between primary care, diagnostics and the regional cancer centre. All staff we spoke with were positive about multidisciplinary working and told us there were clear lines of communication between departments and organisations involved in delivering care. Staff told us they got very quick responses from pathology and radiology staff if they had queries. The on-call consultant responded to queries from GPs about referrals and GPs could contact gynaecology consultants by phone or email for advice.

The service had developed a multidisciplinary complex pelvic pain service with input from two gynaecology consultants, a psychologist, pelvic health physiotherapist and endometriosis specialist nurse. The aim of the service was to improve patient care by developing emergency plans for these women so the gynaecology team could support them effectively.

Is the service responsive?

Inspected but not rated

We inspected but did not rate the responsive key question in relation to access and flow and learning from complaints and concerns.

Access and flow

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

Managers monitored waiting times and most patients could access services when needed. They mostly received treatment within agreed timeframes and national targets. We reviewed performance data on the two-week wait cancer referral pathway. We found the average performance between April 2018 and October 2020 was for 91% of patients to be seen within two weeks of referral. This was just below the national target of 93%. Managers acknowledged the two-week wait performance was quite variable due to fluctuations in demand for the service.

Managers monitored changes to demand and capacity regularly. In terms of long waits for non-urgent gynaecological treatment, between February and April 2020 there were no women waiting over 52 weeks for treatment. However, due to the coronavirus pandemic from May to October 2020, the number of women waiting over 52 weeks for non-urgent gynaecological treatment was steadily rising from fewer than ten women in May 2020 to just over 110 in October 2020. Managers monitored and discussed waiting times at the monthly gynaecology governance meeting. In November 2020 managers agreed to set up a prioritisation group, in addition to existing clinical reviews, where consultants could review women with more complex conditions listed for surgery and agree who needed treatment soonest.

The service had a choice of appointment options for women. Women could choose two-week-wait referral clinic slots available across the working week at both Southmead Hospital and peripheral clinics.

Gynaecology

Staff supported patients when they were referred or transferred between services. A nurse consultant led a dedicated postmenopausal bleeding clinic as part of the gynaecology service. Staff ensured women had support from Macmillan cancer nurses at the trust and cancer specialist nurses from the regional cancer centre if needed and the service had secured funding for a cancer specialist nurse for the service.

Learning from complaints and concerns

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

Managers investigated complaints and identified themes. We reviewed the last three complaints in gynaecology and found all aspects of complainants' concerns were addressed. The service responded fully to complaints within the trust target of 60 days in the complaints we reviewed. The service was responsive when complainants suggested ways care could be improved. In one complaint we reviewed, records showed the investigating manager called the complainant to discuss their concerns, offer a resolution meeting and explain the timescales of the investigation process. The division had created a form for ensuring these conversations were well-structured and supportive.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers discussed complaints at monthly divisional governance meetings. We reviewed the November 2020 women and children's health patient and experience report. This included a summary of the number of formal complaints and concerns and the status of the complaints, along with feedback from friends & family test results. The service was continuing to improve the patient experience and the way they used positive feedback to inform developments in the service.

Is the service well-led?

Inspected but not rated

We inspected but did not rate the well-led key question in relation to leadership, vision and strategy, culture, governance and management of risks, issues and performance.

Leadership

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

Gynaecology services were part of the women and children's health clinical division at North Bristol NHS Trust. The women and children's health clinical division was led by a clinical director, a divisional operational director and a divisional director of midwifery and nursing. Gynaecology services were led by a speciality lead, a general manager, a deputy head of nursing, a lead governance nurse, a consultant lead for governance, and an outpatient's matron. The service had a consultant lead for gynaecology oncology colposcopy and hysteroscopy who worked closely with the leads for pathology and radiology. The management team vision was based on patient-centred care and continuous improvement.

Leaders we spoke with were clear about the challenges the service faced. For example, the challenges of working across two sites during the coronavirus pandemic as the theatres in the main hospital building were used rather than the theatres next to Cotswold gynaecology ward. Leaders were managing the risk by ensuring that all consultants had fair access to theatres with long term plans to invest in additional theatre facilities.

Gynaecology

The gynaecology deputy director of nursing was working on succession planning for nurses by giving staff opportunities to go to national conferences and access to gynaecology training from Health Education England.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

Plans for the service included increasing specialist services and ambulatory care services, expanding the workforce, developing the estate and strengthening leadership.

The service used quality improvement methodology to make the service more efficient. For example, the hysteroscopy team reviewed the whole patient pathway to make improvements to the setup of the clinic. This enabled an additional patient to be seen at every clinic. The service was audited before and after the changes to ensure there was no negative impact on patient experience.

The service had secured funding from the hospital charity to appoint a cancer clinical nurse specialist for three years. After this time the funding will be covered by the clinical division on an ongoing basis. The cancer clinical nurse specialist would be a named point of contact for all women on the fast-track cancer pathway. The clinical nurse specialist would work to improve time from referral to diagnosis and provided support to women before and after diagnosis. The nurse specialist would work closely with the lead consultant and ensure a smooth transition to being cared for at the regional cancer centre.

Culture

Staff felt respected and supported. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns.

Staff we spoke with were consistently positive about the team approach and the way the views of all staff were listened to and respected. The service was patient-centred, and managers encouraged staff to report 'learning from excellence' examples so staff could be recognised and learning shared. In relation to behaviours experienced in the workplace, the trust performed well in the Royal College of Obstetrics and Gynaecology trainee evaluation form ranking 31st nationally out of 180 trusts. This result was mirrored in the General Medical Council survey, with the trust ranking in the top quartile for good workplace-based behaviours.

The service was working to improve safety culture in the department and reported to the trust's quality and risk management committee on these improvements. As part of work to improve safety culture the service completed a safety culture survey in 2019 which found the current overall safety attitude percentage was 65%. The service scored 73% for 'I am encouraged by my colleagues to report any patient safety concerns I may have.' Following this survey, the service had developed an action plan and planned to re-survey staff to see if actions had led to further improvements in safety culture. The service promoted the trust's freedom to speak up guardians. The governance lead nurse and another member of gynaecology staff were speak up ambassadors.

The service responded to feedback from staff. In response to the 2019 NHS staff survey, the service was improving arrangements for flexible working, increasing opportunities for staff to provide feedback, offering leadership training to staff and was involved in the trust wide 'red card to racism' campaign.

Gynaecology

The service was committed to improving staff wellbeing. The service had introduced 'calm pods' where staff could talk privately with another staff member across the department. Gynaecology staff were supporting the wellbeing of women who worked in the trust by running advice sessions on topics such as pelvic health, the menopause and the importance of cervical screening,

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff we spoke with were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had monthly gynaecology speciality governance meetings that reported to the monthly women and children's health divisional governance meeting. Updates on action plans following serious incidents were reported to the quality and risk management committee, a sub-committee of the trust board. A quarterly divisional newsletter included learning from incidents, updates on changes to clinical guidelines and patient safety reminders.

The trust had made improvements to governance processes. In the past year the service had started using a standardised agenda used across the trust. Terms of reference for the gynaecology speciality governance meeting were adopted in November 2020 which detailed roles and responsibilities of staff attending the meeting. We reviewed the last three gynaecology speciality governance meetings and found staffing, safeguarding, risk and incident review, quality improvement, clinical audit and effectiveness, patient feedback and sharing best practice were all discussed as part of a standardised agenda. Mortality and morbidity reviews were discussed as part of this meeting. Staff reviewed an action log as part of this meeting, and we saw from the October 2020 meeting minutes that actions were closed or followed up with actions for staff to progress.

The service reviewed clinical policies regularly and worked with the regional cancer centre to align policies and used clinical audits to measure compliance with guidelines. The consultant lead for gynaecology completed a quality assurance review in January 2020 of women diagnosed with cervical cancer between November 2014 and November 2019. The results of this review and an audit of the cervical guideline were presented at the gynaecology clinical governance meeting on 21 January 2020 and then at the trust's clinical effectiveness and audit committee in February 2020. The review provided reassurance to the trust and there were no improvement actions identified as a result of the audit as women had received appropriate treatment in line with the revised guidelines. The service had also completed a city-wide review of the diagnostic gynaecology cancer pathway.

Management of risk, issues and performance

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

Managers reviewed the risk register regularly at monthly gynaecology governance meetings. The gynaecology department risk register included four risks, of which one had been escalated to the trust-level risk register. The highest scoring risk related to split site working as due to the coronavirus pandemic theatres in the main hospital building were used rather than the theatres located next to Cotswold gynaecology ward. A business case was being written to appoint extra consultants to help with emergency gynaecology cover when consultants were on the main hospital site in theatres.

Gynaecology

Another risk related to lack of dedicated daytime gynaecology consultant cover. The consultant staffing risk was due to the service expanding to meet the needs of women using the service and continued rising demand. A business case to recruit two additional consultants was in progress at the time of inspection. The service was mitigating this risk by developing a business case for the recruitment of additional consultants and specialist nurses.

To reduce the risk of increased waiting times for treatment, a surgical prioritisation group that met every other week had been set up. The service used the Royal College of Obstetricians and Gynaecologists criteria for prioritisation to ensure patients were 'safe to wait.' Consultants reviewed waiting lists to see if there were women suitable to be offered novel outpatient treatments rather than inpatient procedures to help reduce waiting times. The service also reviewed waiting lists to check if women no longer required treatment due to having had treatment in another service.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

The trust SHOULD:

- Consider reviewing the structure of the consultant workforce to ensure there is oversight from a consultant who is a specialist in gynaecological cancer for clinics where women are referred to the gynaecological cancer service.
- Consider improving the way learning from incidents is shared with primary care services.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and a CQC inspection manager. The inspection team was overseen by Mandy Williams, Head of Hospital Inspection.

Quality and Risk Management Committee Terms of Reference

Date Approved and Adopted	21 January 2021
Frequency Review	Annual
Next Review	January 2022 or when self-assessment is completed
Terms of Reference Drafting	Trust Secretary
Review	Quality & Risk Management Committee
Approval and Adoption	Trust Board
Version Number	1.21

1. Constitution

1.1. The Trust Board hereby resolves to establish a Committee to be known as the Quality and Risk Management Committee.

1.2. The Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference shall be as set out below; and will be subject to amendments approved by the Trust Board.

2. Authority

2.1. The Committee is authorised to seek information it requires from any employee of the Trust. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain legal or other independent professional advice and to secure the attendance of advisors with such expertise that it considers necessary.

2.2. The Committee is authorised by the Board to make decisions within its terms of reference, including matters specifically referred to it by the Board.

3. Membership

3.1. The Committee shall comprise:

- Three Non-Executive Directors one of whom will chair the Committee.
- Director of Nursing and Quality
- Medical Director
- Chief Operating Officer

3.2. In the absence of the appointed Committee Chair, another Non-Executive Director will chair the meeting.

3.3. Attendance at meetings is essential. When an Executive Director member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf.

4. Attendance at Meetings

4.1. The following officers may also be required to attend meetings but are not members:

- Director of Facilities
- Director of People and Transformation
- Director of IM&T
- Associate Director of Quality Governance
- Director of Corporate Governance/Trust Secretary

4.2. These individuals are encouraged to send deputies in their stead where they feel this is appropriate.

4.3. The Committee can request the attendance of any other director or senior manager if an agenda item requires it.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be three members of whom two must be Non-Executive Directors (including the chair of the committee) and one of either the Medical Director or the Director of Nursing and Quality.

6. Frequency of Meetings and Conduct

6.1. The Committee will meet bi-monthly and will be set in advance as part of the planning of the Trust Board and Committee meetings annual calendar of business.

6.2. Further meetings can be called at the request of the Committee Chair.

6.3. An agenda of items to be discussed and supporting papers will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting.

6.4. Decisions may be taken by written resolution upon the agreement of the majority of members of the Committee in attendance, subject to the rules on quorum.

7. Responsibilities

The Committee shall hold the safety of patients, public and staff, as well as the reputation of the Trust, as a core value in assessing assurance, quality governance and risk.

The responsibilities of the Committee can be categorised as follows:

7.1. Assurance

The Committee shall ensure that the Trust Board is adequately assured in relation to all quality, clinical governance and research matters which will include, but is not limited to:

- Infection control
- Clinical outcomes by specialty and consultant, including review and response to national clinical audits, national registries etc.
- Mortality rates & Learning From Deaths
- Regulatory compliance
- Safeguarding Children's and Adults
- Quality assessment of CIP projects
- CQUIN delivery
- Incident reporting
- Risk management
- Medical records
- Clinical claims management

7.2. Quality Strategy and delivery of the quality agenda

7.2.1. The Committee shall maintain oversight of the business of the Quality Strategy Delivery Committee and any associated committee sub-structure through the receipt of regular update reports, and shall ensure that the Board is adequately assured in relation to the delivery of the Trust's quality strategy;

7.2.2. The Committee shall maintain oversight of the business of the Drugs and Therapeutics Committee, the Clinical Effectiveness & Audit Committee, the Patient Safety and Clinical Risk Committee and the Safeguarding Committee through the receipt of regular reports. This shall ensure that the Committee maintains oversight of:

- Management systems and structures to ensure that sufficient analysis of incidents, complaints, claims, clinical audits, service reviews etc. is undertaken to reflect, learn and make recommendations for required changes to improve quality of care provided to patients;

- Concerns raised by the Patient Safety & Clinical Risk Committee, in regard to issues of patient safety which require attention and resolution at Executive level;
- the quality work programme and the support required for quality improvement given by Quality & Patient Safety work streams, Clinical Audit, Learning and Development, and Information Management & Technology. This includes the quality improvements relating to national CQUINs.

7.3. Regulatory Compliance

7.3.1. The Committee shall assure itself that all regulatory requirements are complied with, with proven and demonstrable assurance, and immediate and effective action is taken where this is identified as deficient.

7.3.2. The Committee shall monitor and assure itself that it can with confidence, and evidence, assure the Trust Board, patients, public, and other stakeholders (e.g.: Care Quality Commission (CQC), NHS Improvement, Department of Health, commissioners) that the Trust is complying with its regulatory requirements and can evidence this. The Committee shall seek to embed the culture of compliance within the organisation, so that it happens as part of normal business, and not as a separate activity, contributing directly to a well-run organisation and the quality of patient care.

7.3.3. The Committee shall ensure compliance with the CQC registration requirements and standards and shall oversee the detailed work plan arising from inspections, alerts or other highlighted concerns raised by the CQC. The Committee shall also monitor key areas of compliance, such as NHS insurance (NHS Resolution General Risk Management Schemes and Clinical Negligence Scheme for Trusts), the NHS Constitution, and other key areas of compliance as they arise.

7.4. Risk Management

7.4.1. The Committee shall ensure the Trust has robust clinical and Health & Safety risk management systems and processes in place. Appropriate risk management systems and processes will remove, reduce, avoid, prevent or manage risks, whilst enabling innovation, to ensure the best possible patient care.

7.4.2. In particular, the Committee will:

- ensure that an up to date risk register is maintained, and that relevant staff are able to access the risk register to raise

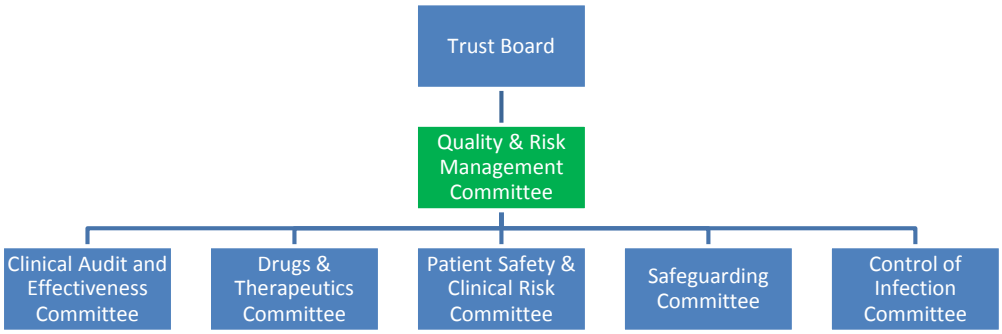
concerns and know that concerns will be reviewed and addressed.

- act as the forum for risk to be discussed, and ensure that where serious concerns are raised, action is taken, and that action plans are carried through to completion, and the reporting loops closed. In doing so, ensuring that there are robust links with clinical and non-clinical directorates to ensure a culture of quality and risk management is present throughout the organisation.
- Act in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

7.5. Sub-committees and Groups reporting to, or responsible to the Committee:

Comment [IC1]: Control of Infection Committee 'promoted' as QRMC sub-group rather than Safeguarding Committee sub-gro

Also removed Quality Strategy Delivery Committee



8. Reporting

8.1. Formal minutes of Committee meetings will be recorded.

8.2. Full minutes will be sent in confidence to all members of the Committee and shall be made available on request to NHS Improvement and the Trust's internal and external auditors.

8.3. The Committee shall report to the Trust Board on its proceedings after each meeting to provide assurance and to escalate issues as appropriate.

8.4. The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these terms of reference.

9. Monitoring and Effectiveness

9.1. The Committee shall have access to sufficient resources to carry out its duties, including access to company secretarial assistance as required.

9.2. It shall be provided with appropriate and timely training, both in the form of an induction programme for new members and an on-going basis for all members.

9.3. It will review its own performance, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

10. Administrative Support

10.1. Meetings will be supported by the Director of Corporate Governance/Trust Secretary's office, whose duties in this respect will include:

- Agreement of agendas with the Chair and Members.
- Collation and distribution of papers.
- Minute taking.
- Keeping a record of matters arising and issues to be carried forward within an action log.
- Advising the Committee on pertinent issues/areas.
- Provision of a highlight report of the key business undertaken to the Trust Board following each meeting.

North Bristol NHS Trust

Report To:	Trust Board		
Date of Meeting:	25 March 2021		
Report Title:	People 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)	Tim Gregory, Non-Executive Director and Chair of People & Digital Committee		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	None	**None**	**None**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X assurance	
Recommendation:	The Board is recommended to receive the upward report for assurance and note in particular: • the positive progress regarding the People Strategy, including; • the ongoing work to produce a People data dashboard to support managers understand the key people and culture issues in their own areas. • introduction of Just Culture • the overall positive staff survey results, building on last years focus of 5 key areas; and • The People focus within Trust's Recovery plan including well Being, workforce resilience and empowerment. • that Safe Staffing reports had been received which outlined the progress to date and further actions planned to ensure nurse staffing levels are safe to meet the needs of our patients.		
Report History:	The report is a standing item to each Trust Board meeting following a People Committee meeting		
Next Steps:	The next report to Trust Board will be to the June 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 People Committee Meeting held on the 8 March 2021.

Strategic Theme/Corporate Objective Links	**Developing Healthcare for the future** a. Training, educating and developing out workforce b. Increase our capability to deliver research c. Support development & adoption of innovations d. Invest in digital technology **Employer of choice** e. A great place to work that is diverse & inclusive f. Empowered clinically led teams g. Support our staff to continuously develop h. Support staff health & wellbeing
Board Assurance Framework/Trust Risk Register Links	Reports received support the mitigation of various BAF risks.
Other Standards Reference	Care Quality Commission Standards.
Financial implications	No financial implications as a consequence of this report.
Other Resource Implications	No other resource implications as a result of this report.
Legal Implications	No legal implications.
Equality, Diversity and Inclusion Assessment (EIA)	Full EIA page with EIA form to guide your assessment here: https://link.nbt.nhs.uk/Interact/Pages/Content/Document.aspx?id=9760 N/A
Appendices:	None

NHS
North Bristol
NHS Trust

1. Purpose

1.1. To provide a highlight of the key assurances, any escalations to the Board and identification of any new risks from the People Committee meeting held on 8 March 2021.

2. Background

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

2.2. This is the first meeting where 'People & Digital Committee' has become 'People Committee' and moved from bi-monthly meetings to quarterly. IM&T issues now feed into Finance & Performance Committee.

3. Key Assurances & matters for the attention of Trust Board

3.1. Deep dive: Restore & renew (including wellbeing and retention and update on E-Rostering and job planning)

The Committee received an update from the Director of People & Transformation on the workforce-focused restoration work being undertaken focusing on the impact of Covid-19. This update highlighted several key issues, including the analysis on staff resilience by looking at following factors:

- impact of sick-leave and shielding on the NHS;
- risk of burn-out and mental-health impacts on staff;
- risk of an exodus of staff from the NHS once Covid-19 pressures decrease;
- the weight of un-taken annual leave and CPD/study leave that has been built up over the last 12 months.

The Director of People & Transformation highlighted that there were four key pillars of recovery including: Health and Well Being; Retention interventions; Leadership and re-engaging of teams; and ensuring a proactive approach to Supply & Demand. These interventions will be supported by a series of 'Recovery Big Conversations' across the Trust. The new People dashboard to be launched early summer will be a data dashboard to help the Trust identify hotspots. It will provide an overall picture of the organisation's workforce position but also 'how' areas are performing. The dashboard will include staff sickness (including absence due to mental health/stress), supply and demand, retention and grievance/ case work data and an overall score for Voice data. The Committee requested that a regular top level overview of the dashboard should become a standing item at the People Committee.

3.2. Annual Case Work Review including update on Restorative Just Culture

The Committee received an update on the People Team's case work review work over the last 12 months, alongside the Restorative Just Culture work.

The Committee discussed the cultural shift required within the organisation to fully embrace the Restorative Just Culture approach within HR matters and noted the progress in this regard.

The overall reduction in HR case work and employment tribunal matters over the last 12-18 months was noted as encouraging. The Committee asked for ongoing updates, and to understand the lessons learned from the Restorative Just Culture approach and to receive assurance on the effectiveness and embeddedness of the approach.

3.3. Annual update on progress against People Strategy deliverables

The Committee received an update on the delivery of the People Strategy. Notwithstanding the impact of Covid-19, the Committee noted the extensive positive work of the People Team and significant progress against the Strategy. The People team were commended for the huge amount that has been delivered in this very challenging year and the strong alignment into both the BNSSG and National People Plans.

3.4. Voice Update

An update on the Trust's Voice project was provided, covering:

- Supporting managers to empower their teams through leadership and delegation;
- Direct mechanisms to allow insight into how staff are feeling and issues of important/interest in real time;
- Enhancing and expanding channels of communication; and
- Forming a better understanding of the differing parts of workforce and the audience it represents.

The Committee noted the progress and the need to monitor the outputs and outcomes of the Voice project over time. The Committee discussed how to best engage with "hard to reach" staff groups including those who do not have daily access to email.

3.5. Staff Survey 2020 Results Headlines

The Committee were provided with the headlines arising from the 2020 staff attitude survey results. This highlighted that:

- NBT is consistently better than the acute trust average in the following areas: Patient Care; and NBT as a place to work.
- NBT's improvement was particularly strong in the following areas: Health and Wellbeing, bullying / violence, and workload / resources.
- Areas where NBT are significantly below average or deteriorating are management, quality of care, and inclusion.

The Committee noted the significant improvements in areas where there has been a specific Trust focus. It was noted that there would be ongoing management focus on

Staff Voice, Workload, Inclusion and Management Development to ensure progress in the areas where NBT is below average or deteriorating.

Trust Board would receive a full Staff Survey Report at its April meeting.

3.6. Consultant Job Planning Internal Audit Report

The Committee reviewed an internal audit report on the Trust's approach to job planning. This review had identified "Partial Assurance with Improvements Required".

An update was received on the high priority action which related to evidence of approval of job plans. The Committee were advised that a new electronic job planning system was being rolled out which would deliver the required improvement, and generally strengthen the Trust's job planning arrangements and interactions with other areas of the Trust including payroll.

The Committee asked to receive a further update on the roll out of e-Job Planning at its next meeting and recommended that in 2022/23 there be a further internal audit review of e-Job Planning alongside e-Rostering.

3.7. Safe Staffing

The Committee received the nursing and maternity safer staffing reports and noted the actions and progress to ensure nurse staffing levels are safe to meet the needs of patients. It was noted that staff turnover had decreased but the committee requested that staffing levels be split by division to allow identification of hotspot areas.

A detailed report was received on the recommendations of the Birth Rate Plus requirements. It was noted that a business case was in development to ensure that the Trust was compliant in this area.

A further report would be received in June.

3.8. Guardian of Safe Junior Doctor Working (quarterly)

The Committee received the Guardian for Safe Junior Doctor Working Update Report, presented by Kathryn Holder. It was noted that the organisation had supported junior doctors throughout the pandemic and the Trust was in a positive position as all trainees were on the new junior doctor contract and there were only three rotation gaps in the Trust. In addition, a focus on timely release of rotas had meant February rotas had been distributed on time (which was not nationally the case). This was noted as hugely beneficial for junior doctors to manage their work-life balance.

Kathryn Holder was thanked for her excellent work as Guardian of Safe Junior Doctor Working as she would shortly be stepping down from the role.

3.9. Other items:

The Committee also received updates on:

- JCNC & LCNC Annual Update
- Health & Safety Committee Upward Report (Quarterly)

- Workforce Risk Register
- Board Assurance Framework – Workforce Risks
- People Committee 2021/22 Work-plan
- Workforce Transformation Programme Update

It was also noted that the Multi-Professional Clinical Workforce Committee and Medical Workforce Committee had been postponed due to the Trust's response to the pandemic.

4. Escalations to the Board/New Risks

4.1. No items for escalation were identified.

5. Summary and Recommendations

5.1. The Trust Board is asked to receive the upward report for assurance and note in particular:

- the positive progress regarding the People Strategy, including;
- the ongoing work to produce a People data dashboard to support managers understand the key people and culture issues in their own areas
- introduction of Just Culture
- the overall positive staff survey results, building on last year's focus of 5 key areas; and
- the People focus within Trust's Recovery plan including well Being, workforce resilience and empowerment
- that Safe Staffing reports had been received which outlined the progress to date and further actions planned to ensure nurse staffing levels are safe to meet the needs of our patients.

NHS North Bristol NHS Trust

NHS North Bristol NHS Trust

Report To:	Trust Board		
Date of Meeting:	17 December 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 Evelyn Barker, Chief Executive		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	
Recommendation:	The committee is requested to: • **Review and discuss** the Board Assurance Framework		
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.

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 **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	The Board Assurance Framework captures strategic risks identified at Board level and updated quarterly.
Other Standard Reference	N/A
Financial implications	Risks relating to financial areas are incorporated in routine risk management reports. The costs of risk management processes are not separately captured.
Other Resource Implications	N/A
Legal Implications including Equality, Diversity and Inclusion Assessment	N/A
Appendices:	Appendix 1: Board Assurance Framework

Board Assurance Framework (BAF)

Introduction

The following document is the Trust's Board Assurance Framework (BAF) for 2020/21. 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)

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

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: 09/03/2021 **Finance & Performance Committee** **Quality & Risk Management Committee** Last reviewed: QRMC 12/01/2021	**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	**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): 	National funding and planning guidance is anticipated in March/April to underpin recovery planning.	The Trust is engaged in internal Renew & Restoration planning and engaging with national/system planning initiatives. **Due Date: April 2021** **Owner: COO & DOF**	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Developing healthcare for the future Employer of choice Anchor in the community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
COV 2	**Karen Brown, Chief Operating Officer** Last reviewed: 09/03/2021 **Quality & Risk Management Committee** Last reviewed: 21/01/2021	**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: **4 (Likely)** Residual impact: **4 (Severe)** Residual risk rating: **16** **(Severe)** Previous residual risk rating: **3x5=15 5x5=25** Residual risk rating last changed: **15/01/2021 09/03/2021** 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: 02/03/2021 **People Committee** Last reviewed: Not yet reviewed: 09/12/2020	**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 **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. Retention of NHS workforce post-Covid-19 is increasingly an area of focus at a national and local level.	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** The NHS Recovery & Restoration plan will include a specific element on people and workforce. This is scheduled for a deep dive at NBT's People Committee in March 2021, with actions arising from that review. **Due Date: 31 March 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: 16/03/2021 **Finance & Performance Committee** Last reviewed: 10/12/2020	**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). Estates Masterplan signed off by Trust Board in August 2020 outlines options and opportunities. 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)** Trust Board agreed to first phase programme, to be delivered by Q4 2020/21 **Owner: Director of EFCP** **Due Date: April 2021** 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: 16/03/2021 **Finance & Performance Committee** Last reviewed: 10/12/2020	**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. **External Assurance** None.	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(Extreme)** Previous residual risk rating: **4x416** 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**	Target likelihood: **2 (Unlikely)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

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 Quality & Risk Management Committee 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 Quality & Risk Management Committee oversight and deep dive reviews e.g. long-wait patient harm, falls etc. Clinical audit outcomes and action plans - reported to Quality & RIsk Management Committee 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. **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 medical examiner model is being implemented in BNSSG. The Trust is still developing a Patient Safety Incident Response Framework to replace the Serious Incident Framework. Due to the high number of staff off sick/shielding, the Trust is increasingly reliant on agency to provide staffing. Many agency requests are not filling in a timely manner.	Good progress has been made in implementing the ME model, but there has been some impact as a result of Covid-19. Work is ongoing to transition fully to the new model by March 2021. **Due date: March 2021** **Owner: Medical Director** A plan is under development in response to the national patient safety strategy. This will be consulted on in March and April 2021 **Due date: June 2021/22** **Owner: Director of Nursing & Quality** The Director of Nursing & Quality has recommenced safer staffing reviews with clinical divisions. So that senior nursing staff have oversight of staffing across the hospital. This ensures that limited staffing resources are used in the most effective manner. **Review date: under regular review – national update on shielding staff guidance expected March/April 2021.** **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: 21/10/2020 **Finance & Performance Committee** Last reviewed: 21/10/2020	**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 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 Q4 2019/20 and Q1 2020/21 Updated Enterprise Network completed in Q4 2019/20	**Internal Assurance** Data security protection audit (draft presented to Feb 2019 People & Digital Committee) Cyber security report (monthly to IM&T Committee & P&D Committee) **External Assurance** Information Commissioner Audit December 2019	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** 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**	Target likelihood: **3 (Possible)** Target impact: **3 (Moderate)** Target risk rating: **9** **(Moderate)**

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: 16/03/2021 **Finance & Performance Committee** Last reviewed: 21/10/2020	**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.) Carbon Assessment Tool is not being completed by all Divisions/Directorates	Appointed a consultant to develop a Carbon 2030 Route-map (prioritised plan) to inform 2022/23 business planning. 6-9 month programme agreed, running from March 2021. **Owner: Sustainable Development Unit** **Due Date: December 2021** 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**	Target likelihood: **2 (Unlikely)** Target impact: **2 (Minor)** Target risk rating: **4** **(Moderate)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Developing healthcare of the future Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Areas of influence	Monitoring/assurance	Residual risk score	Gaps in influence or monitoring/assurance	Planned actions *(including owner and delivery date)*	Target risk score
SER 4	**Evelyn Barker, Chief Executive** **Xavier Bell, Director of Corporate Governance** Last reviewed: 17/02/2021 **Finance & Performance Committee** Last reviewed: 10/12/2020	**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	Residual likelihood: **4 (Likely)** Residual impact: **4 (Severe)** Residual risk rating: **16** **(Extreme)** Previous residual risk rating: **N/A** Residual risk rating last changed: **N/A** Forecast trajectory (next 12 months): ⇔	ICS development and formal governance structures (MOU/Financial framework etc.) are still under development	The Trust is participating fully in the development of the BNSSG ICS, with the Chair and Chief Executive representing NBT at the Partnership Board. Formal facilitated support has been procured at a system level to support the delivery of the "ICS Development Plan". **Due date: NBT facilitated session - April 2021** **Lead: NBT Chief Executive**	Target likelihood: **2 (Rare)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**
								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**	
							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.	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**	

NHS North Bristol NHS Trust

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

NHS North Bristol NHS Trust

19

Report To:	Trust Board		
Date of Meeting:	Thursday 25 March 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 Healthier Together monthly report to partner boards; this report has been seen at March Trust Management Team meeting.		
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: • Publication of the Government white paper: 'Integration and Innovation: working together to improve health and social care for all' • ICS designation and formalising how we will work together • Population health, prevention and inequalities workstream.

Strategic Theme/Corporate Objective Links	N/a
Board Assurance Framework/Trust Risk Register Links	N/a
Other Standards	N/a

Reference	
Financial implications	N/a
Other Resource Implications	N/a
Legal Implications	N/a
Equality, Diversity and Inclusion Assessment (EIA)	N/a
Appendices:	None

Healthier Together

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

Healthier Together Integrated Care System (ICS) monthly update

March 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:

- Publication of the Government white paper: 'Integration and Innovation: working together to improve health and social care for all'
- ICS designation and formalising how we will work together
- Population health, prevention and inequalities workstream

2. Publication of the Government white paper: 'Integration and Innovation: working together to improve health and social care for all'

On Thursday 11 February, the Department of Health and Social Care published a white paper detailing the legislative recommendations for Integrated Care Systems (ICSs). The paper, *'Integration and Innovation: working together to improve health and social care for all'*, sets out proposals for legislating for ICS. It reinforces the goal of joined up care for everyone and sets some key measures, including:

- Support for the NHS England and Improvement proposal to create statutory Integrated Care Systems.
- Scrapping mandatory competitive procurements by which NHS staff currently waste a significant amount of time on unnecessary tendering processes for healthcare services.
- Putting the Healthcare Safety Investigations Branch permanently into law as a Statutory Body so it can continue to reduce risk and improve safety. The Healthcare Safety Investigations Branch already investigates when things go wrong, so that mistakes can be learned from, and this strengthens its legal footing.
- Support for the NHS England and Improvement proposal to formally fold Monitor and the Trust Development Authority (i.e. NHS Improvement) into NHS England.
- A package of measures to deliver on specific needs in the social care sector. This will improve oversight and accountability in the delivery of services through new assurance and data sharing measures in social care, update the legal framework to enable person-centred models of hospital discharge, and improve powers for the Secretary of State to directly make payments to adult social care providers where required.
- The pandemic has shown the impact of inequalities on public health outcomes and the need for Government to act to help level up health across the country.

Legislation will help to support the introduction of new requirements about calorie labelling on food and drink packaging and the advertising of junk food before the 9pm watershed.

The paper builds on engagement that was undertaken by NHS England/Improvement in late 2020. As a system we jointly responded setting out our support for the principle of further developing ICSs, but recognised that questions relating to accountability would need to be addressed as the policy is further developed.

The white paper sets out a clear direction of travel that we have all been working towards for a number of years. One of its central aims is to remove outstanding barriers and fragmentation that exists in partnership working. While movement on this at a national level is crucial, we should not forget the amount of work we have already undertaken as a partnership locally, nor underestimate what else we have to do to help solidify our BNSSG Integrated Care Partnership further through 2021.

Further information regarding the white paper is set out in NHSE/I frequently asked questions and also a letter sent out from Amanda Pritchard, Chief Operating Officer at NHSE/I to system leaders.

3. ICS designation and formalising how we will work together

We established Healthier Together as a partnership in 2016 to work together across the NHS, local government and social care to improve health and wellbeing for the people of Bristol, North Somerset and South Gloucestershire (BNSSG).

In December 2020, our Partnership was recognised as a 'maturing' Integrated Care System (ICS) by NHS England. This is welcome recognition of the progress we have made in developing collaborative ways of working and integrating services to deliver better outcomes for BNSSG residents.

Yet we recognise there is more work to be done to change how we operate to make best use of resources within an integrated system. This is timely given the great strides that have been made in cooperation and partnership working from across the system in response to the Covid-19 pandemic, and to prepare for the legislative changes that will require further integration by April 2022.

As a Partnership we have agreed to formalise how we will work together in our next phase of development as an ICS through a Memorandum of Understanding (MoU). This will be a series of documents that we will develop together so that we can build shared ownership and commitment to collaborative ways of working. It covers a range of topics, including; communications and engagement, organisational development and financial frameworks.

Our Chief Executives started this work in January 2021. The next step that we are currently working through is engaging with the leadership of each of our constituent organisations.

A timeline of next steps is broadly as follows:

Date	Activity
February – March	Workshops to engage the leadership of each partner organisation to explore roles in the partnership and collect feedback
March – May	Functional experts develop and review key areas of agreement
July	Draft documents reviewed by the Partnership Board
September	MoU endorsed by the partners and signed off by the Partnership Board
Monthly	Touchpoints with CEOs through BNSSG Executive Group

4. Population health, prevention and inequalities workstream

As we develop as an Integrated Care System (ICS) our system leaders have agreed to have a *'shared ambition for the people of BNSSG via a collaborative approach to leadership that sees beyond and operates across organisational boundaries, holding the focus on the benefit and impact for the people we serve together; being person-centred and outcome oriented.'*

To achieve this ambition a focus on improved population health, prevention and reducing inequalities (PHPI) is required.

Population health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population. It is driven by the outcomes and experience that matter to the people we serve and so is shaped by population health management (data to help plan and deliver care for maximum impact), communications and engagement activities, value based health and care programmes and Building Healthier Communities (working with the voluntary and community sector).

The PHPI steering group has recently been expanded and includes representation from across the Partnership. It now reports directly into the Healthier Together Executive Group, which at its last meeting agreed the overarching strategic intent of the workstream:

1. To support and challenge partners across the system to embed a population health approach, share best practice and ensure that all programmes identify opportunities to prevent ill health, improve wellbeing and reduce inequalities in the delivery of their programmes;

2. To develop a work programme based on population need priorities and the achievement of population outcomes as agreed by the system in order to reduce inequalities and improve health;

3. To focus on the importance of place. This involves setting system-wide PHPI medium and long term objectives and outcomes whilst enabling place-based approaches to prioritisation and delivery, for example via Integrated Care Partnerships.

4. To focus on the impact of the wider determinants of health on outcomes; and enable system-wide focus and resource on tackling these to reduce inequalities across BNSSG and improve outcomes.

A recent example of work undertaken by the PHPI workstream is a high-level overview report of the health inequalities observed across the BNSSG population. It presents data from a range of sources, and mostly focuses on the part deprivation plays in health outcomes. The findings from this report will help to provide system oversight and further guide the priorities of our work programme.

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.