North Bristol NHS Trust

Trust Board Meeting in Public

Thursday 28 November 2024, 10:00 – 13:45

Seminar Rooms 4 & 5, Learning & Research Building, Southmead Hospital

A G E N D A

No.	Item	Purpose	Lead	Paper	Time
OPENING BUSINESS					
1.	Welcomes and Apologies for Absence *Apologies: Steve Curry, Chief Operating Officer and Deputy Chief Executive*	Information	Joint Chair	Verbal	10.00
2.	Declarations of Interest	Information	Joint Chair	Enc.	10.01
3.	Patient Story	Discussion	Chief Nursing Officer	Enc.	10.02
4.	Questions from the Public	Discussion	Joint Chair	Verbal	10.25
STANDING ITEMS					
5.	Minutes: Public Board: 26 September 2024	Approval	Joint Chair	Enc.	10.35
6.	Action Log	Approval	Trust Secretary	Enc.	10.36
7.	Matters Arising	Discussion	All	Verbal	10.37
8.	Joint Chair's Report	Information	Joint Chair	Enc.	10.38
9.	Joint Chief Executive's Report	Information	Joint Chief Executive	Enc.	10.48
KEY DISCUSSION ITEMS					
10.	Freedom to Speak Up Bi-annual report	Discussion	Director of Corporate Governance	Enc.	11.15
BREAK (5 mins)					11.35
QUALITY					
11.	Quality Committee Upward Reports – • October 2024 • November 2024 11.1. Transplant Annual Report 11.2. Infection Control Annual Report 11.3. Tissue Viability Annual Report	Information	NED Chairs	Enc.	11.40
PEOPLE					
12.	Guardian of Junior Doctor Working Hours	Information	Chief Medical Officer	Enc.	12.00
13.	People & EDI Committee Upward Report	Information	NED Chair	Enc.	12.15

GOVERNANCE & ASSURANCE					
14.	Audit & Risk Committee Upward Report 14.1. Board Assurance Framework 14.2. Standing Orders, Standing Financial Instructions and Scheme of Delegation 14.3. Audit and Risk Committee Terms of Reference	Information /Approval	NED Chair	Enc.	12.25
15.	Joint Trust Modern Slavery Statement	Approval	Chief Finance Officer	Enc.	12.40
BREAK (5 mins)					12.50
FINANCE, IM&T & PERFORMANCE					
16.	Integrated Performance Report	Discussion	Chief Operating Officer	Enc.	12.55
17.	Finance, Digital & Performance Committee Upward Report 17.1. Finance Report Month 7 17.2. 2025/26 Business Planning Process Timeline	Information /Approval	NED Chair	Enc.	13.20
CLOSING BUSINESS					
18.	Any Other Business	Information	Chair	Verbal	13.30
19.	Date of Next Meeting: 30 January 2025	Information	Chair	Verbal	-
20.	Exclusion of the Press and Public	Approval	Chair	Verbal	-
END					**13.35**

North Bristol NHS Trust

TRUST BOARD DECLARATIONS OF INTEREST

Name	Role	Interest Declared
Ingrid Barker	Joint Chair	• Governor, University of Gloucestershire • Member of the Faculty of TPC Health – a coaching company working predominantly in the NHS and Social Care (since January 2024) • Deputy Lieutenant of Gloucestershire
Mr Kelvin Blake	Non-Executive Director	• Non-Executive Director of BRISDOC. • Chair and Trustee of Second Step. • Trustee of the SS Great Britain Trust. • Trustee of the Robins Foundation. • Member of the Labour Party • Elected Member of Bristol City Council.
Mr Richard Gaunt	Non-Executive Director	• Non-Executive Director of Alliance Homes, social housing provider.
Ms Kelly Macfarlane	Non-Executive Director	• Sister is Centre Leader of Genesiscare Bristol (Private Oncology). • Sister works for Pioneer Medical Group, Bristol. • Managing Director, HWM-Water (a Halma manufacturing company). • Director, Radcom Technologies Limited (dormant company). • Director of ASL Holdings Limited (a Halma company – IoT solutions). • Director of Invenio Systems Limited (water loss consultancy). • Non-Exec Director of Advanced Electronics Limited (a Halma fire safety company).
Professor Sarah Purdy	Non-Executive Director	• Professor Emeritus, University of Bristol. • Fellow of the Royal College of General Practitioners. • Fellow of the Royal College of Physicians. • Fellow of the Royal College of Physicians Edinburgh. • Member, Barts Charity Grants Committee. • Shareholder (more than 25% but less than 50%) Talking Health Limited.

		Indirect Interests (ie through association of another individual eg close family member or relative) via Graham Rich who is: - Chair, Armada Topco Limited. - Director, Talking Health Ltd. - Chair, EHC Holdings Topco Limited.
Dr Jane Khawaja	Non-Executive Director	• Employee and Member of the Board of Trustees, University of Bristol. • Director of Gloucestershire Cricket Foundation. • Commissioner, Bristol Commission on Race Equality.
Mr Shawn Smith	Non-Executive Director	• Bluebells Consultancy Ltd (sole shareholder). • Governor of City of Bristol College. • Trustee of Frank Water. • Elim Housing Association (Board member).
Ms Maria Kane	Chief Executive	• Advisory Group Member of CHKS, a provider of healthcare intelligence and quality improvement services (remuneration donated to Southmead Hospital Charity). • Visiting Professor to the University of the West of England (unremunerated). • Trustee of Help to Create Hope Charity.
Mr Steve Curry	Chief Operating Officer	• Nothing to declare.
Mr Tim Whittlestone	Chief Medical Officer	• Director of Bristol Urology Associates Ltd: undertakes occasional private practice (Urology Specialty) at company office, outside of NBT contracted hours. • Chair of the Wales and West Acute Transport for Children Service (WATCh). • Vice Chair of the South-West Genomic Medicine Service Alliance Board. • Wife is an employee of the Trust. • Director of 3RO Ltd (providing medical advice to international NGOs etc).

Name	Role	Interest Declared
Mr Glyn Howells	Chief Financial Officer	• Nothing to declare.
Professor Steve Hams	Chief Nursing Officer	• Visiting Professor, University of the West of England. • Director, Curhams Limited (dormant company). • Independent Trustee and Chair of the Infection Prevention Society. • Associate Non-Executive Director, Surrey Heartlands Integrated Care Board. • Husband is employed by Oxford University Hospitals NHS Foundation Trust. • Affiliate Member, Bristol and Avon St John Priory Group. • External Examiner – School of Nursing BPP University
Mr Neil Darvill	Chief Digital Information Officer (to NBT and UHBW) (non-voting position)	• Wife works as a senior manager for the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Board (ICB). • Stepbrother is an employee of the Trust, working in the Cancer Services Team.
Mr Peter Mitchell	Interim Chief People Officer (non-voting position)	• Nothing to declare.

Report To:	Public Trust Board		
Date of Meeting:	28 November 2024		
Report Title:	Patient Story		
Report Author:	Emily Ayling, Head of Patient Experience Dr Jack Galliford, Renal & Transplant Consultant Nephrologist and Transplant Lead Tim Whittlestone, Chief Medical Officer		
Report Sponsor:	Steve Hams, Chief Nursing Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
		X	
	The purpose of this item is to provide insight into the experience of a patient who underwent a kidney transplant at NBT last year. Alongside the Annual Transplant report, the story shines a light on the impact our transplant services have on patients and the importance of this service.		

Key Points to Note *(Including any previous decisions taken)*

- Neil's story relates to his experience of receiving a kidney transplant at NBT in early 2023.
- Neil lived with Chronic Kidney Disease (CKD) for 20 years.
- Neil's donation was from his partner Kate, and highlights that 1/3 of donations are from living donors.
- The story raises awareness about organ donation and the role of living donors.
- This accompanies item 11. Quality Committee Upward Reports- Transplant Annual Report.

Thank you to ITV for letting us share the story.

Strategic and Group Model Alignment

The item directly links to our Trust aim to provide outstanding patient experience by helping us to better understand and learn from the experience of our patients.

Risks and Opportunities

None identified.

Recommendation

This report is for discussion.

The Board is asked to discuss Neil's story which illustrates the importance of organ donation and the transplant service. Neil's story brings to life the impact of the service as described in the Annual Transplant report.

History of the paper (details of where paper has <u>previously</u> been received)	
Quality Committee (story not heard, Transplant Annual Report received)	12th November 2024
Appendices:	Neil's Patient Story to Board - November 2024

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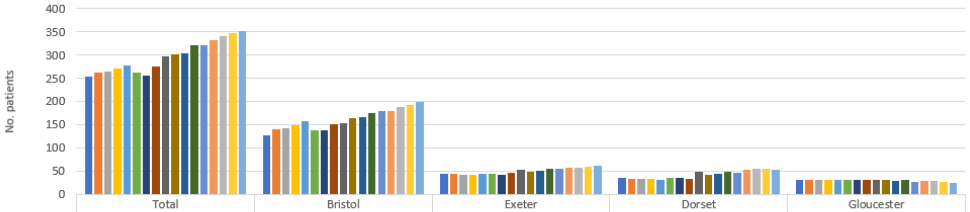
Neil's Story

Overview of the Transplant Service at NBT

- We are the **largest renal unit and transplant centre in the South West**. The other unit in the SW is Plymouth.
- We cover a geography as far north as Gloucester, down to parts of Cornwall and across to parts of Wiltshire and Dorset.
- We receive referrals from other renal centres such as Exeter, Dorchester and Gloucester.
- We have **grown our registrations/waiting list** with support from our referral partners. (To access a transplant patients must be on a waiting list, so growing the waiting list is positive)
- Transplants come from adult living donors (which can be influenced locally) or adult deceased donors (national responsibility)

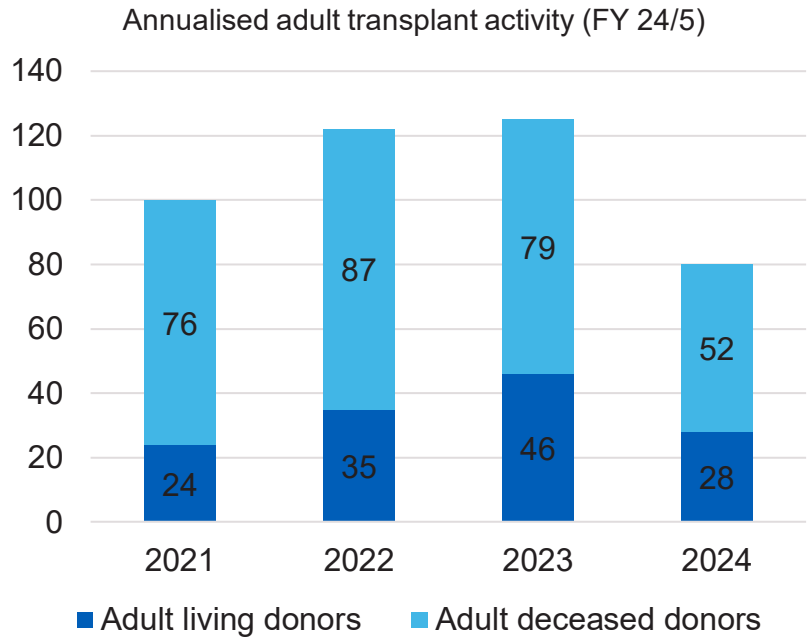
Transplant waiting list growth for NBT and referral partners



	Total	Bristol	Exeter	Dorset	Gloucester
Jan-22	255	128	46	36	31
Mar-22	263	140	46	34	31
May-22	266	143	43	35	33
Jul-22	271	149	42	35	32
Sep-22	278	159	46	32	31
Nov-22	262	139	44	36	31
Mar-23	257	138	42	36	31
May-23	275	151	47	35	33
Jul-23	297	153	53	49	31
Sep-23	301	165	50	43	32
Nov-23	304	166	51	45	30
Jan-24	322	176	55	49	31
Mar-24	321	180	56	48	28
May-24	333	181	58	54	30
Jul-24	341	188	58	55	30
Sep-24	347	194	60	56	27
Nov-24	351	200	63	54	26

Overview of the Transplant Service at NBT

- Over the past 7 years our rates of utilisation of organs from deceased donors have risen to be among the best in the country.
- We have also **grown our living donor renal transplant programe**. This has led to enhanced funding from the ICB.
- One of our key performance measures is adult living donor pre-emptive transplant rates. We are performing **above the UK average for this** (40% vs 36% UK average).
- There hasn't been a change in workforce despite the increase in activity for the team.
- Ambition is to be the best transplant centre in the country, to continue to develop team to facilitate kidney transplantation with commissioner support, whilst adhering to national targets, governance and DHSC recommendations



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Minutes of the Public Trust Board meeting held on
Thursday 26 September 2024 at 10.00am
in Seminar Room 4, Learning and Research Building, Southmead Hospital
and Microsoft Teams

Present: Trust Board members:

Ingrid Barker	Joint Chair and Non-Executive Director (NED)	Maria Kane	Joint Chief Executive
		Steve Curry	Chief Operating Officer and Deputy Chief Executive
Richard Gaunt	Non-Executive Director	Neil Darvill	Joint Chief Digital Information Officer
Jane Khawaja	Non-Executive Director	Dominique Duma	Deputy Chief Nursing Officer
Kelly Macfarlane	Non-Executive Director	Glyn Howells	Hospital Managing Director
Sarah Purdy	Non-Executive Director	Peter Mitchell	Interim Chief People Officer
		Elizabeth Poskitt	Deputy Chief Finance Officer
		Tim Whittlestone	Chief Medical Officer

Present: Others:

Xavier Bell	Director of Corporate Governance and Trust Secretary
Richard Gwinnell	Deputy Trust Secretary *(minutes)*
Elliot Nichols	Director of Communications
Emily Ayling	Head of Patient Experience (for agenda item 3, minute 03 below)
Rory Spanton	Divisional Director of Nursing, Medicine (for agenda item 3, minute 03 below)
Caroline Hartley	Associate Director, Culture, Leadership and Development (for agenda item 10)
John Kirby	General Manager, Endoscopy (for agenda item 23)
Fiona Rooke	Head of Imaging and Endoscopy Services (for agenda item 23)

TB/24/09/01 Welcomes and apologies for absence **ACTION**

Ingrid Barker, Joint Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol & Weston NHS Foundation Trust (UHBW), welcomed everyone to the meeting. Ingrid also welcomed members of the public and staff who were observing the meeting. She reminded everyone that the meeting would be recorded and the recording placed on the Trust's website for others to view, after the meeting.

Apologies for absence were received from Steve Hams, Chief Nursing Officer, Shawn Smith, Non-Executive Director and Kelvin Blake, Non-Executive Director.

TB/24/09/02 Declarations of Interest

No further interests (other than those listed in the meeting papers) were declared.

TB/24/09/03 Patient and Carer Story: Carl's story

Trust Board members watched a YouTube video in which Carl (a former nurse) talked (in May 2023) about his illnesses, his treatment on several wards and numerous occasions at NBT and his experiences as a patient at NBT. Carl praised staff for the "phenomenal" clinical and physical care they delivered in Accident and Emergency (A&E), the Minor Injuries Unit (MIU), the Medical Assessment Unit (MAU), the Acute Medical Unit (AMU) and the Medical Day Care Unit. However, he felt that, whilst technically the care delivered was very good, more could be done (on the MAU specifically) in delivering personal and

emotional care, including communication and conversation (for example, staff checking on patients more regularly, staff spending time talking to patients about how they feel, staff being quiet when patients were sleeping and so on). Carl had gone home feeling unsafe and had not wanted to return to hospital after his May 2023 experience. He was clear that he was not criticising individuals, but felt that staff needed to be supported, trained and educated better in communication at the bedside with patients, and with each other as a team, to improve overall quality.

Rory Spanton, Divisional Director of Nursing, Medicine, welcomed Carl's feedback. Rory commented on the significant pressures in AMU, where patients sometimes needed to be cared for in corridors due to the high demand and how, sometimes, patient safety considerations had to be prioritised over patient experience considerations. In May 2023, the Trust employed a large number of temporary staff, which may help explain the lack of "personal touch" Carl experienced at the time. Since then, the Trust had increased the number of permanent staff. A number of internationally educated nurses were also new starters in early 2023 but had since been trained and become established in their roles, leading to further improvements in communication. The Trust had also introduced a Nursing Standards document and additional training and was planning to show Carl's story as part of ongoing staff training sessions. Patient Conversations and other feedback showed that positive patient experience outweighed negative patient experience. Rory reported that Carl had recently come back to NBT as a patient and had reported that his experience in 2024 was vastly improved, compared to his experience in May 2023.

NED Board members commented or asked, in summary:

- that the story provided welcome opportunities for learning and improvement; ongoing conversations with patients were crucial
- whether NBT had spoken to other patients since Carl's story, and whether patients felt things had improved?
- whether leaders had time to observe staff and feed back to them on their communication skills?

Rory commented on Patient Conversations and ongoing patient surveys, and that most patients reported a positive experience. Patients were woken in the night and given medication and checked on, which some patients did not like, but this was often a necessary inconvenience. Having a trained, consistent workforce was crucial, and this was now the case. Team meetings were held regularly and ward sisters and matrons fed back to staff regularly.

Other Board members commented that AMU, A&E etc were at the sharp end of healthcare, where pressures were greatest, and staff may not have time to engage emotionally with patients. Managing expectations was important; in some cultures, touch and what some people may see as intrusion were not welcome.

The Chair welcomed Carl's insightful story and thanked Rory and all the teams involved for taking it on board and for all their hard work in bringing about such clear improvements over the last 18 months or so. She asked Rory to pass the Board's thanks back to the staff involved.

The Trust Board: welcomed the story and welcomed the positive improvements made across NBT since Carl's experience in May 2023.

Emily Ayling and Rory Spanton left the meeting.

TB/24/09/04 Questions from the Public

April Mackinnon commented on the Trust's ambitious Digital Strategy and asked for an update on whether sustainable technology was prioritised by the Trust.

Neil Darvill, Joint Chief Digital Information Officer replied that implementation of the Digital Strategy was progressing well, with a focus on patient safety and experience. Electronic Prescribing, Electronic Patient Records and electronic communication with patients were key implementation priorities and were on track over the next few months. The Digital Strategy prioritised sustainability and the Trust was progressing well with this; for example, the Trust used cloud technology where possible, reducing the need for physical infrastructure, buildings and carbon, it had replaced cooling systems in data centres and it was reducing its carbon footprint and investing in new "green" technologies wherever possible.

TB/24/09/05 Minutes - Private Trust Board – 25 July 2024

The Trust Board RESOLVED: that the minutes of the Public Trust Board meeting held on 25 July 2024 be approved as an accurate record.

TB/24/09/06 Action Log

The Trust Board noted the Action Log.

TB/24/09/07 Matters arising from the previous meeting

No matters were raised.

TB/24/09/08 Joint Chair's Update

Ingrid referred to her written report and highlighted:

- her ongoing visits to NBT service areas and her planned visit to Cardiology in the near future
- her increasing number of visits to and meetings with system partners
- the importance of working closely in partnership with others,
- good progress on developing the Hospital Group, with Board-to-Board, Joint Executive Group and other meetings taking place regularly, and
- her attendance at NHS Confederation Chairs' Group meetings.

The Trust Board noted the activities and key developments contained in the Joint Chair's Update.

TB/24/09/09 Joint Chief Executive's Report

Maria Kane, Joint Chief Executive, referred to her briefing paper and highlighted:

- the recent Lord Darzi Review of the NHS, and its key conclusions
- that a ten-year plan for the NHS was anticipated in Spring 2025; this would impact on timescales for planning for next year
- the NHS Leadership event she had attended in September, where Wes Streeting MP, Secretary of State for Health and Social Care, emphasised the inextricable links between health and social care
- national pay award updates including GP collective action
- the opening of the Community Diagnostic Centre and the vastly increased capacity to diagnose illnesses and therefore treat people earlier
- a University of Bristol Masterclass she had taken part in; she was impressed with the extent of healthcare research and innovation taking place and the need to adopt and spread the lessons learnt at scale

- the British Association of Physicians of Indian Origin Annual Conference she had attended recently; the UK had a lot to learn from India and its significant investment in healthcare infrastructure
- the recent visit of Baroness Merron, Parliamentary Under-Secretary of State for Patient Safety, Women's Health and Mental Health
- NBT's success in its CQC rating being upgraded to "Good" in the "Safe" Maternity domain
- performance challenges, with the highest number of attendances ever experienced recently and the hospital on Opel 4 escalation
- the number of people in the hospital with no criteria to reside remained high; discussions continued with the Integrated Care Board (ICB) on the need to increase community bed capacity
- the appointment of Glyn Howells as Hospital Managing Director for NBT, for one year from 1 September 2024.

The Board discussed Maria's update and Maria responded to questions.

The Trust Board noted the Joint Chief Executive's report.

Caroline Hartley joined the meeting.

TB/24/09/10 Gender Pay Gap and WRES/WDES Submission and Action Plan

Peter Mitchell, Interim Chief People Officer, introduced the report, commenting on the significant improvements in the EDI (equality, diversity and inclusion) data. The gender pay gap data reflected that many more women were employed than men, which was reflective of the gender balance of the healthcare workforce in general, and was not the same as equal pay (equal pay for work of equal value), on which NBT scored well. Peter also pointed out that the Trust was now using the terms "ethnic minorities" and "people from ethnic minority backgrounds" rather than "B.A.ME" as advised by the UK Government.

Caroline Hartley, Associate Director, Culture, Leadership and Development presented the report in detail, highlighting key points relating to the gender pay gap, the ethnicity pay gap and the Workforce Race Equality Standard (WRES) data and Workforce Disability Equality Standard (WDES) data as shown in the report. There had been many positive WRES and WDES improvements this year, with NBT performing above national averages in many areas and a small number of areas of continuing focus (e g. the disparity ratio).

NED and Executive Board members commented or asked:

- that the picture was very positive; staff were thanked for their hard work
- the People and EDI Committee had scrutinised the data very closely and was assured that appropriate actions were being taken
- NBT had several campaigns in place, to increase the number of disabled and ethnic minority staff employed and improve their experiences at work
- the data could change significantly from one year to the next, for example following the recruitment of groups of internationally educated nurses
- workforce gender and ethnicity pay gaps should not ideally exist, but they existed in every industry; the key was to take actions to address them appropriately and NBT was doing that
- on the importance of sharing the data with divisions and explaining it
- NBT had committed to be an anti-racist organisation and to various other specific EDI objectives and was working hard towards them

- the General Medical Council (GMC) had been discussing for at least 18 months the disproportionate rate of referrals nationally (of people from ethnic minority backgrounds under the Maintaining High Professional Standards (MHPS) process); these discussions were ongoing
- similarly, the Nursing and Midwifery Council (NMC) was aware of disparity in referrals, but discussions were less well developed at the NMC
- NBT managed MHPS referrals very carefully and kept robust EDI data
- what progress was being made on joint medical recruitment with UHBW?
- the Trust needed to focus on areas where it could make a real and positive impact (e.g. improving staff promotion and development opportunities); it could not do everything for everyone all the time.

Peter Mitchell responded that:

- the staff survey showed that ethnic minority staff rated their experience at work overall higher than white staff did
- there were always small anomalies in responses which required further exploration and where some responses seemed to conflict with others
- the staff survey for 2024 had been launched on 23 September
- the People and EDI Committee undertook deep-dives into the data and the People Team were absolutely focussed on EDI
- the Board last year had been keen to improve staff appraisals; this had resulted in extensive work and excellent results
- focus was needed on the key priorities, not trying to do everything.

Caroline Hartley added that:

- much work had been put into improving recruitment of non-medical staff; the good practice and lessons learnt needed to be applied to improving the recruitment of medical staff
- simple changes such as the wording of job adverts and job descriptions could often make a real difference
- the People Team were increasingly working in partnership with colleagues at UHBW.

Ingrid welcomed the clear improvements reported and referred to the difference this was making to local people and communities, given that NBT was one of the biggest employers in the region. She thanked the staff involved for their hard work and noted that there was always more work remaining to be done. In particular, she welcomed the clear progress towards NBT becoming an anti-racist organisation.

The Trust Board noted the report.

Caroline Hartley left the meeting.

The Board adjourned at this point for a brief comfort break.

TB/24/09/11 Revised Acute Provider Collaborative Arrangements

Xavier Bell outlined the report and the proposal to stand down the Acute Provider Collaborative Board (APCB) with UHBW, as other more inclusive governance mechanisms were now in place and working well. The UHBW Board had agreed already to stand down the APCB. Maria Kane commented that the “Strategic Minds Group” was now referred to as the “Future Designs Group”.

The Trust Board RESOLVED:

(1) to stand down its Acute Provider Collaborative Board with UHBW and
(2) to note that the ongoing work associated with developing the Hospital Group, including the ongoing delivery of the Joint Clinical Strategy, would be led by the Joint Executive Group, reporting into NBT's and UHBW's Boards via the Joint Chief Executive (the Accountable Officer).

TB/24/09/12 Quality Committee Upward Report

Sarah Purdy, NED Chair of the Quality Committee outlined the report, highlighting the Committee's consideration of:

- the safeguarding annual report (which was next on the Board's agenda)
- the David Fuller Inquiry report: this was an assurance report covering the findings of the first part of the David Fuller Inquiry. The Committee had welcomed the assurance provided but had decided to flag to the Board the delays with completing external building works to the mortuary, required by the Human Tissue Authority (HTA) and the issue of DBS checks for people working in the mortuary. The full assurance report was included in the private Board reading room but was not suitable for publication given the detail of security arrangements set out in the document
- the Perinatal Quality Surveillance Matrix (PQSM) report; the Committee received assurance that the increased rate of postpartum haemorrhage had been reviewed and there were no themes of concern
- the current national shortages of some medications.

Ingrid invited Glyn Howells, Hospital Managing Director and Xavier Bell, Director of Corporate Governance to comment on the items escalated in respect of the David Fuller Inquiry.

Glyn Howells reported that, as a result of the Grenfell Tower fire, plans for all works to buildings over nine metres high now had to be approved by the Health and Safety Executive (HSE) before commencement. This approval could only be obtained once RIBA stage 4 plans were submitted, and the current time for approval to be given was around four months. The planned works involved replacing a wooden structure with a brick structure, which would result in increased fire safety, but had been delayed awaiting HSE approval. This delay meant NBT was in breach of the statutory requirement imposed by the HTA, to undertake the works.

Tim Whittlestone, Chief Medical Officer reported that he had written to the HTA, as licence holder, and the HTA had noted the position.

Ingrid Barker expressed concern that NBT was in breach of statutory HTA requirements and asked that the Audit and Risk Committee seek further assurance on progress, actions and mitigations.

Xavier Bell explained that NBT had a clear policy on DBS checks for staff and there were strict legal rules around DBS checks that had to be complied with. However, he noted that, in the main, NHS staff were DBS-checked on appointment but not re-checked on a regular basis. NBT was not unusual in this regard, but a review of this position was warranted. Sarah Purdy asked for a further report to the appropriate Board Committee on this issue. It was confirmed that DBS checks were being refreshed for staff who worked in the mortuary.

The Trust Board:

(1) noted the report for assurance and noted the activities undertaken by the committee on its behalf

(2) delegated detailed oversight of the mortuary building works issue to the Audit and Risk Committee **TH/LV**
(3) agreed that a further report be submitted to the relevant Board Committee on the topic of DBS check renewal and **PM/SM**
(4) agreed that the Quality Committee receive confirmation (closing the loop), when both of the above reports had been completed.

TB/24/09/13 Annual Safeguarding Reports

Dominique Duma, Deputy Chief Nursing Officer, presented the report, which had been considered at the Quality Committee's recent meeting, highlighting (and answering questions from NEDs):

- the increasing demand for safeguarding support and complexity of cases
- the importance of working in collaboration with partners (including UHBW) to safeguard adults and children who may be at risk of abuse or neglect
- the ongoing effects of Covid-19, in terms of increased vulnerability in the community and heightened awareness of safeguarding issues
- the early intervention "Think Family" approach, and the impact of the pandemic on people's health, welfare and the development of children
- that NBT had a very strong approach to safeguarding, with designated leads in all divisions
- the increasing incidence of neglect, abuse, and youth and domestic violence in society.

Ingrid welcomed the report and the evident improvements, thanking the staff involved. She also commented on the increasing prevalence of vulnerability in the wider community and the importance of this work and collaboration with partners.

The Trust Board noted the report.

TB/24/09/14 Medical Revalidation and Appraisal Annual Report

Tim Whittlestone, Chief Medical Officer presented the report, highlighting:

- the statutory requirement to bring an annual report to the Board, to provide assurance that professional standards processes meet relevant statutory requirements and support quality improvement; this was the case at NBT
- the Good Medical Practice guidelines published by the GMC in 2024
- the introduction in the last year of a Responsible Officers Advisory Group at NBT to oversee the quality of appraisals and monitor compliance with appraisal and revalidation processes
- that NBT employed approximately 940 doctors on a permanent basis (with more in response to need when required) as well as trainees and associates
- doctors required an annual appraisal and to be re-validated every five years
- in very exceptional circumstances, a doctor may miss an annual appraisal, due to maternity or long-term sick leave for example
- the importance of managing these processes well
- NBT was a pilot site for the National Clinical Improvement Programme, which held data on all consultants, to help review their practice, support learning and development, and improve patient safety and clinical quality
- NBT had appointed a small number of "super-appraisers" in the last year, to assist with appraisal completion, and was sharing these with Sirona, to help Sirona and provide an external peer approach
- NBT was working closely with UHBW to ensure similar approaches were taken across the developing Hospital Group.

Ingrid thanked Tim for the comprehensive and assuring report, and the extensive work taking place.

The Trust Board RESOLVED:

(1) to note the report and
(2) to approve the Statement of Compliance with the Framework of Quality Assurance for Responsible Officers (appended to the report) and its signature by the Joint Chief Executive.

TB/24/09/15 People and EDI Committee Upward Report

Peter Mitchell, Interim Chief People Officer presented the report, highlighting the Committee's focus on the EDI data (discussed earlier in this meeting), the 2024 staff survey, how to build on the successes of the 2023 staff survey, and updates on workforce and health and safety.

Maria Kane referred to the need for more focus on violence and aggression at work issues, including sexual safety. Peter responded that these issues were on the work programme. Ingrid asked for relevant data to be presented to the People and EDI Committee in due course.

The Trust Board noted the report for assurance, noted the activities undertaken by the committee on its behalf and asked for more data to be presented to the People and EDI Committee on violence and aggression at work issues, including sexual safety. **PM**

TB/24/09/16 Patient and Carer Experience Committee Upward Report

The Trust Board noted the report for assurance and noted the activities undertaken by the committee on its behalf.

TB/24/09/17 Board Insight Visits

Xavier Bell presented the report, highlighting:

- that the feedback from visits was generally very positive
- a small number of issues had been raised, for example with regard to Badgernet, but these were already known about and being worked on
- the importance of Executives and NEDs being visible to staff
- the importance of triangulation of information gathered during Board Insight Visits with other information and feedback
- that aligning NBT's Board Insight Visits approach with UHBW's approach would be considered, alongside the Patient First "go and see" approach.

NED Board members commented or asked:

- that the Insight Visits were very helpful and the information enlightening; staff were thanked for their help on the visits
- that NEDs would appreciate being able to talk to more patients and staff during Insight Visits; staff should perhaps be informed better of the visits before they took place and the feedback forms amended to give space for patient feedback
- on the importance of NEDs speaking to patients (if they were well enough and if they were comfortable) and giving their feedback to the Board
- that feedback awaited following two visits had recently been submitted

- that staff were sometimes too busy to speak to; it was equally interesting for NEDs to stand back and watch what was happening on the wards
- that it was important to ensure all areas of the Trust were visited and no areas missed
- repeat visits were useful, to see what had changed since a previous visit
- whether feedback from Freedom to Speak Up (FTSU) visits could also be included in future reports?

Xavier responded in brief:

- that pre-visit communication and the feedback forms would be reviewed to take account of NEDs requests to speak to more patients, albeit there were downsides to too much preparation, insofar as the visits were designed for Executives and NEDs to see the situation as it really was **XB**
- the plan was to visit every area of the Trust over time and avoid too many repeat visits; NEDs and Executives were asked to identify areas where they wished to visit, or which may be helpful to visit
- NEDs could email him with any suggestions on future visit locations and
- that FTSU visit feedback could also be included in future reports.

Maria Kane commented on the good practice taking place at NBT, where feedback from Board Insight Visits was triangulated with many other forms of feedback and data, to help the Trust form an overall picture of operational performance, service quality and patient experience.

Ingrid welcomed the significant assurance given about the extent to which NBT was "joining the dots". She looked forward to Joint NED visits (with NEDs from UHBW) when appropriate in future.

The Trust Board noted the update and findings of recent Board Insight Visits.

TB/24/09/18 Audit and Risk Committee Upward Report

Glyn Howells, Hospital Managing Director presented the report, highlighting the Committee's focus on Women's and Children's Health Division retained estate risks and their mitigations, on which the Committee was assured, and on ongoing Grip and Control work.

The Trust Board noted the report for assurance and noted the activities undertaken by the committee on its behalf.

Ingrid Barker left the meeting and vacated the Chair at this point (as she had another important meeting to attend).

Sarah Purdy, NED, took the Chair for the remainder of the meeting.

TB/24/09/19 Developmental Well-Led Report - Action Plan Update

Xavier Bell presented the report, which updated the Board on actions taken following the Developmental Well-Led Review undertaken by AuditOne in Autumn 2023. Xavier explained that all actions had been completed or superseded by the work ongoing to develop the Hospital Group (e.g. Board development work). It was therefore proposed that the action plan be closed.

Sarah Purdy welcomed the huge amount of work undertaken and thanked everyone involved.

The Trust Board noted the update and agreed to close the action plan.

TB/24/09/20 Integrated Performance Report (IPR)

Steve Curry, Chief Operating Officer and Deputy Chief Executive, outlined the performance summary, commenting particularly and answering questions that:

- the Urgent and Emergency Care (UEC) position continued to be challenging, with significantly increased demand and reduced flow out of the hospital; demand was up by 5%, with 379 attendances on Monday this week (300 attendances was normally a very busy day)
- no criteria to reside (NC2R) remained a particular challenge, with 22% of people not needing to be in hospital but unable to go elsewhere
- more community beds had been promised but not yet materialised
- cancer waiting times performance had dipped in July but efforts remained focussed on 70% of patients waiting fewer than 62 days
- in diagnostics, performance continued to exceed targets
- NBT was currently the best Trust in the country in terms of diagnostics
- NBT was the main hospital for Stroke patients; it had 43 Stroke beds and recently had as many as 79 Stroke patients needing a bed
- the availability of step-down beds in the community was being discussed with the Integrated Care System (ICS) on a regular basis and a few more beds were coming onstream, but not quickly enough
- pathways in skin cancer (and other cancers) were also critical; activity in skin cancer had doubled but this did not result in improved performance as more demand led to more delays.

Dominique Duma outlined quality, safety, effectiveness and patient experience updates, commenting particularly that:

- quality, safety and effectiveness were very strong in maternity services
- no further action was expected in relation to the maternal death (at home, several months after birth) reported at the last Board meeting
- infections and pressure injuries remained at stable levels
- the rates of C-Difficile and MSSA remained low and below previous trends, with no cases of MRSA in August
- the number of falls had reduced further in August; two falls resulting in harm were being investigated
- patient experience results were very positive
- NBT had performed well in the recently published Adult Inpatient survey, with patients rating NBT 8.3 out of 10 overall (placing NBT 31st out of 131 Trusts in the UK and at the forefront of Trusts in the south west).

Tim Whittlestone outlined the extensive work done in medicines management, resulting in reduced errors in prescribing and dispensing (with the number of errors below the national average). He commented also on VTE risk assessments performance, which was the subject of focus and increased IT support, due to a recent reduction in compliance. In answer to questions, Tim explained that nine out of ten patients who needed a VTE risk assessment were being assessed.

Jane Khawaja, NED, congratulated everyone involved for NBT's recent success in being granted £1.2m by the Research Capability Fund (putting NBT 6th out of 248 NHS Trusts). Tim commented that NBT had a very good track record in terms of medical research and development and worked very closely with universities and other partners to align research portfolios. The future was very bright for medical research and development in Bristol.

Peter Mitchell, Interim Chief People Officer, outlined workforce highlights, commenting particularly that:

- workforce metrics were going in the right direction, with many positives, for example turnover rates continued to reduce, retention of healthcare support workers continued to improve, agency spend was down to 1.4% of the Trust's pay bill and vacancy and sickness rates continued to fall
- the disparity ratio had increased, as discussed earlier in the meeting; the People and EDI Committee was undertaking a deep-dive into the data
- all these efforts helped the Trust achieve savings, with agency spend in particular making a contribution of approximately £0.5 million in August
- there was some concern that reducing temporary staffing and slowing down recruitment as a result of the current financial pressures may have other negative consequences, including potentially a reduction in staff morale, as workloads increased; this was being monitored and may become apparent in the staff survey.

Board members questioned and discussed the reduction in temporary medical and nursing staffing numbers, and whether holding vacancies was sustainable. Peter commented that discussions about staffing and filling vacancies were held weekly at a senior level and that discussions at divisional performance reviews focussed on the level of bank or agency usage in different areas of the Trust.

Dominique Duma referred to the high level of scrutiny across the Trust of nursing staff numbers and unavailability rates. She emphasised that the overriding priority was always patient safety; some temporary staff would always be required.

Jane Khawaja referred to the reliance some people placed on being able to work on a temporary (e.g. agency) basis. Some people may have worked for many years for NBT on a temporary basis. If NBT reduced temporary staff use, this may result in those people losing money or going elsewhere for work, and a significant effect potentially on some communities. Jane also asked for consistency and clarity in the use of terminology, such as "challenged communities".

Elizabeth Poskitt, Deputy Chief Finance Officer stated that she would report on finance issues later in the meeting.

Xavier Bell reported that the NHS Provider Licence statements related to August were also applicable to September; regulatory compliance was good.

The Trust Board noted the Integrated Performance Report.

TB/24/09/21 Finance, Digital and Performance Committee (FD&PC) Upward Report

Kelly Macfarlane, NED, who chaired the September meeting of the FD&PC, presented the report, providing an update and assurance to the Board on the committee's work and an update on the key financial headlines. Kelly specifically highlighted:

- the year-to-date financial (revenue, capital, cash and CIP) position as detailed in the report
- that the Green Plan was commended to the Board and was very helpful in identifying how sustainability could be embedded into "business as usual" activity
- the very good and high-value work of the Energy Manager
- the ICS gap to net zero carbon by 2030 had been added to the Board Assurance Framework

- the Committee had reviewed digital programme priorities and was assured by the progress being made and lack of red-rated issues.

Finance Report, Month 5 (August 2024)

Elizabeth Poskitt, Deputy Chief Finance Officer presented the report, giving details of the Trust's current financial position, as shown in the report. Elizabeth emphasised that a breakeven position at year-end was currently at risk, given the current financial position and that actions were underway to reduce spend on temporary staffing and hold vacancies wherever possible, with extensive scrutiny of spending decisions taking place across the Trust.

The Trust Board noted the report for assurance, noted the activities undertaken by the committee on its behalf and noted the financial position at month 5.

TB/24/09/22 Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegated Authority (SoDA) - Amendments

Xavier Bell outlined the changes proposed to the SOs, SFIs and SoDA, to give effect and appropriate delegations to the role of the Hospital Managing Director. In answer to a question from Sarah Purdy, Xavier reported that UHBW were taking a similar approach to that of NBT.

The Trust Board RESOLVED: that the proposed changes to the SOs, SFIs and SoDA be approved.

TB/24/09/23 NBT Diagnostics Recovery and Performance Update

Fiona Rooke and John Kirby joined the meeting.

Steve Curry introduced Fiona and John, informing the Board of the real success story of Diagnostics and the hard work of the staff involved, to achieve the huge progress now being seen in giving patients earlier access to Diagnostics and hence earlier access to treatment when required.

Fiona Rooke, Head of Imaging and Endoscopy Services and John Kirby, General Manager, Endoscopy presented slides and answered questions, explaining:

- the critical contribution of Diagnostics to identifying cancers, early detection of Stroke or heart attacks and many other conditions affecting patients
- that the team now aimed for no more than 1% of patients waiting more than six weeks for Diagnostics, and no one at all waiting more than 13 weeks
- before Covid, around 10% of patients waited longer than six weeks
- during Covid, around 5,000 patients (around 50%) waited longer than 13 weeks, with 60% of those waiting longer than 26 weeks
- almost 8,000 patients waited longer than 13 weeks as at September 2022
- fewer than 100 patients now waited longer than 13 weeks
- the background to and causes of the backlogs, including multiple waves of Covid, lockdowns, and delays leading to increases in acuity and complexity
- subsequent causes of delays including national and local skills shortages, increased demand, complexity and acuity, high staff sickness and vacancy rates and extensive industrial action
- the actions taken by the team at NBT to reduce the backlog and turn the situation around, including increasing staff numbers and capacity in the bookings team, maximising appointments, improving recruitment and training, redesigning and reducing waste in pathways, improving guidance and triage and getting people working better together

- the importance of following and drilling down into the data and maximising digitisation to achieve success, including texting rather than writing letters to patients, to improve timely, two-way, communication and reduce missed appointments and cancellations
- NBT was the tenth worst Trust in the country for Diagnostics in September 2022
- NBT was now the best Trust in the country for Diagnostics
- patients were now seen much more quickly and staff felt back in control of their destiny and their work as a result
- staff had been tired after Covid; they were reluctant to go the extra mile
- many improvement initiatives were taken in 2022, but took time to result in actual and tangible success
- the key differences were improving the management of contracts, teams working in collaboration and managers engaging better with staff
- NBT staff wanted to be the best; one of the key changes was managers keeping staff up to date regularly on where performance stood and what was happening; staff wanted to know the detail
- once the situation started to improve, the staff wanted to work extra hours and do whatever it took to keep those improvements going
- the teams had massively improved the service for patients; making the change sustainable into the future was also about improving the situation for the staff; empowering them to make improvements and continuing to improve the culture; happy staff meant excellent service
- fulfilled staff were effective staff, who were less likely to go elsewhere.

Maria congratulated and thanked all the staff and teams involved. NBT was now being talked about on national stages as a result of its Diagnostics work. Other Board members also commented that:

- the turnaround was truly exceptional
- this was an example of operational excellence
- the staff involved should be very proud of their work
- thousands of patients had lost a lot of sleep about what might be wrong with them; this was no longer the case
- the team connected non-clinical and clinical staff to great effect
- managers fed back to staff every day about the difference their work was making to patients; this made all the difference.

The Trust Board: noted and welcomed the update and congratulated everyone involved.

John Kirby and Fiona Rooke left the meeting.

TB/24/09/24 Any Other Business

Glyn Howells reported that Board members may notice some disquiet in the next few weeks about staff car parking at the Southmead Hospital site, as a result of changes to NBT's car parking policy.

No other business was raised.

TB/24/09/25 Date of Next Meeting: Noted: Thursday 28 November 2024.

TB/24/09/26 Exclusion of the Press and Public

The Board RESOLVED: that representatives of the press and other members of the public be excluded from the Trust Board meeting, having regard to the confidential nature of the business to be transacted at the Private Board meeting

later in the day, publicity on which would be prejudicial to other public interest (section (2) Public Bodies (Admission to Meetings) Act 1960).

The meeting ended at 1.20pm

North Bristol NHS Trust

Trust Board - Public Committee Action Log

ACTION LOG

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

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
TB/24/09/12	91	The Board delegated detailed oversight of the mortuary building works issue to the Audit and Risk Committee	Tony Hudgell/Liz Varian	Not specified	No	Closed	On Audit and Risk agenda 7 November 2024	23/10/2024
TB/24/09/12	92	That a further report be submitted to the relevant Board committee on the topic of DBS check renewals	Sarah Margetts	Not specified	No	Closed	On People and EDI workplan for January 2025	21/11/2024
TB/24/09/12	93	That the Quality Committee receive confirmation (closing the loop) when both the above reports have been completed	Richard Gwinnell	Not specified	No	Open	Awaiting completion of the above two actions	23/10/2024
TB/24/09/15	94	That more data be presented to the People & EDI Committee on violence and aggression issues, including sexual safety at work	Peter Mitchell	Not specified	No	Open	To be scheduled for People & EDI Committee	23/10/2024
TB/24/09/17	95	That pre-visit communication and feedback forms be reviewed to take account of NED requests to speak to more patients and staff	Xavier Bell	Not specified	No	Open	Templates under review, and refreshed documents to be launched in January 2025	21/11/2024

Report To:	Public Trust Board		
Date of Meeting:	28 November 2024		
Report Title:	Joint Chair's Report		
Report Author:	Ingrid Barker, Joint Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) Rachel Bartlett, Senior Executive Personal Assistant to the Joint Chair Richard Gwinnell, Deputy Trust Secretary		
Report Sponsor:	Ingrid Barker, Joint Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)		
Purpose of the report:	**Approval**	**Discussion**	**Information**
		√	√
	To inform the Board of key items of interest to the Trust Board, including relevant activities of the Joint Chair during the period since the last Joint Chair's report, engagement with system partners and regulators, and the Joint Chair's visits and events.		
Key Points to Note *(Including any previous decisions taken)*			
The Joint Chair reports to every Public Trust Board meeting with updates relevant to the period in question.			
Strategic and Group Model Alignment			
The Joint Chair's report identifies her activities, along with key developments at the Trust and further afield, including those of a strategic nature.			
Risks and Opportunities			
Not applicable			
Recommendation			
This report is for discussion and information. The Board is asked to note the activities and key developments detailed by the Joint Chair.			
History of the paper (details of where paper has <u>previously</u> been received)			
Not applicable			
Appendices:	Not applicable		

1. Purpose

The report sets out information on key items of interest to the Trust Board, including the Joint Chair's attendance at events and visits as well as details of the Joint Chair's engagement with Trust colleagues, system partners, national partners and others during the reporting period.

2. Background

The Trust Board receives a report from the Joint Chair to each meeting of the Board, detailing relevant engagements she has undertaken and important changes or issues affecting NBT (and UHBW) and the external environment during the preceding months.

3. Appointment of Vice-Chairs

Sarah Purdy, Non-Executive Director, has been appointed to the position at NBT and Martin Sykes, Non-Executive Director, has been appointed to the position at UHBW. This is a further step forward and both Vice-Chairs will support me in the move to form a Hospital Group between the two organisations.

4. Connecting with our Trust Colleagues at North Bristol NHS Trust (NBT):

The Joint Chair undertook a variety of visits and meetings during September, October and November 2024, including:

- Chief Medical Officer's Senior Team, whilst hosting Hazel Busby-Earle, CMO at Leicester.
- Cardiology with Ella Chaudhuri and Jarrod Richards, Clinical Directors and supporting Medicine Division colleagues.
- Pharmacy visit with Matt Kaye, Director of Pharmacy.
- Annual Staff Awards celebration.
- NBT Health Fair and AGM in September.
- AHP Day, Shadowing physiotherapist in Rheumatology.
- Met with Freedom to Speak Up Champions from NBT/UHBW, alongside NED FTSU champions.
- Breast Care Centre visit supported by Jessica Smith, Admin lead, Michelle Mullan, Consultant and Siny Thankachan, Staff Nurse.
- Visit to Radiology Lab 3 to view new equipment purchased supported by Rebecca Warren.
- Closed Black History Month event.
- Monthly meeting with Non-Executive Directors.
- Monthly meeting with Vice-Chair.
- Visit to Neurology supported by Ellicia Sulway, Justin Pearson, Consultant, Mark Crossburn, Stroke Neurologist, Rachael Cromley, Clinical Matron and Harsha Gunawardena, Clinical Director.
- Visit to Burns and Plastics supported with George Wheble, Consultant and Christopher Wearn, Consultant.
- Visit to Bristol Centre of Enablement, celebrating its 10 year anniversary, supported by David Rowland, Assistant General Manager.
- Visit to Acute Oncology support by Alles Bartlett, Lead Acute Oncology & Haematology Lead Nurse.

5. Connecting with our Trust Colleagues at University Hospitals Bristol and Weston NHS Foundation Trust (UHBW):

The Joint Chair undertook a variety of visits and meetings during September, October and November 2024, including:

- Rev Rob Morgan, Chaplaincy Team leader from Spiritual and Pastoral Care.
- Jon Standing, Director of Pharmacy.
- Recruitment, Talent and Temporary Staffing teams, supported by Peter Russell. Russell, Head of Resourcing

- Celebrating Improvement Event and Prize Giving
- Finance Teams supported by Neil Kemsley, Chief Financial Officer.
- Met with Freedom to Speak Up Champions from UHBW and NBT
- Meeting with Lead Governor, Mo Phillips
- Governor/Non-Executive Director Engagement Session and Governor Development Seminar
- Monthly meeting with Non-Executive Directors
- Monthly meeting with Vice-Chair
- Reciprocal Tour with Non-Executive and Executive Directors at UHBW, locations included in the visit: BHOC, St Michael's, Bristol Heart Institute, Division of Surgery and Bristol Royal Hospital for Children.
- Council of Governors
- Chrissie Thirlwell, Head of Bristol Medical School and Prof of Cancer Genomics at University of Bristol.
- Visit to South Bristol Hospital with reps from Medicine, Surgery, W&CH and Sirona.
- Visit to Unity Sexual Health service.

6. Communications

The Communications teams of both Trusts have been very helpful in making the above visits more visible to all our colleagues and to UHBW Governors. For NBT this has been through a weekly 'round up' as part of 'Maria's Midweek Message' and for UHBW this has been through its platform Viva Connect and a newsletter to Governors. I would like to thank both teams for their support in this.

7. Connecting with our Partners

The Joint Chair undertook introductory and follow-up meetings with a number of partners during September, October and November as follows:

- Mike Bell, Leader of North Somerset Council, Cabinet members, and Jo Walker, Chief Executive, alongside our Joint CEO
- BNSSG Integrated Care Board Annual General Meeting
- Topping Out Ceremony for the main academic building of the new Temple Quarter Enterprise Campus (University of Bristol)
- Barbara Brown, Chair, Sirona
- Visit to South-West Ambulance Trust Bristol Operations Centre to meet the new SWAST Chair and CEO alongside ICB Chair and CEO.
- Sarah Weld, Director of Public Health for South Gloucestershire
- Hosted a visit to the Children's hospital by Peaches Golding, Lord Lieutenant
- David Smallacombe, Chief Executive, and Alethea Mizen, Deputy Chief Executive for Care and Support West
- Ian Boulton and Maggie Tyrrell Co-Leaders of South Gloucestershire Council and Dave Perry, Chief Executive I
- Monthly meetings with Chair BNSSG ICB, Jeff Farrar
- Interview Panel for Non-Executive Director recruitment for Sirona Care Health
- Claire Hazelgrove, MP for Filton and Bradley Stoke

- Visit by Karin Smyth, MP for Bristol South and Minister of State for Health to the Elective Centre under construction and to see robotic surgery. There followed a private meeting with the Minister alongside her constituency officer.
- Visit to Second Step to meet Aileen Edwards, CEO and Kelvin Blake, Chair.
- 4-way meeting with Chairs and Chief Executives – One Care and UHBW/NBT
- Attendance at the fortnightly City Partners Conference Call
- Leader of Bristol City Council, Tony Dyer, alongside our Joint CEO.
- Mayor Dan Norris, MP, West of England Combined Authority.
- BNSSG ICP Board, attended by Marc Griffiths.
- Planned date to meet with Darren Jones, MP on 29 November.

Further meetings with partners are planned.

8. National and Regional Engagement

The Joint Chair has also attended:

- Regular one to one 'touch points' with Elizabeth O'Mahony, NHS England Regional Director.
- The NHS Providers Chairs' and CEO Network group event in London in September.
- The monthly National NHS Confederation Chairs' Group.
- NHS Providers Annual Conference in Liverpool, hearing from Secretary of State Wes Streeting, NHS England CEO, Amanda Pritchard amongst others.

9. Summary and Recommendations

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

Report To:	Public Trust Board		
Date of Meeting:	28 November 2024		
Report Title:	Chief Executive Report		
Report Author:	Suzanne Priest, Executive Co-ordinator		
Report Sponsor:	Maria Kane, Joint Chief Executive		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events, and key staff appointments.		

Key Points to Note *(Including any previous decisions taken)*

The report seeks to highlight key issues not covered in other reports in the Board pack and which the Board should be aware of. These are structured into four sections:

- National Topics of Interest
- Integrated Care System Update
- Strategy and Culture
- Operational Delivery
- Engagement & Service Visits

Strategic Alignment

This report highlights work that aligns with the Trust's strategic priorities.

Risks and Opportunities

The risks associated with this report include:

- The potential impact of strikes on the availability of services and quality of care delivery.

Recommendation

This report is for Information. The Trust Board is asked to note the contents of this report.

History of the paper (details of where paper has <u>previously</u> been received)	
N/A	
Appendices:	N/A

Chief Executive's Report

Background

This report sets out briefing information for Board members on national and local topics of interest.

1. National Topics of Interest

1.1 Government's Autumn Budget

Chancellor Rachel Reeves delivered the new Government's first budget to Parliament on 30 October. The first phase of the budget will complete the Spending Review for 2025, which resets departmental budgets for 2024-25 and sets budgets for 2025-26.

The government is prioritising the NHS in Phase 1 of the Spending Review through extra investment and plans for reform to help put it on a sustainable footing and ensure it is fit for the future. This includes an additional £1.8 billion to support elective activity since July. The settlement will also support reform to patient care pathways to deliver better patient experience for lower cost, enhancing patient choice and embedding best practice right across the country.

A summary of key headlines for health is below:

- An additional £22.6 billion of resource spending for Health in 2025-26, compared to 2023-24 outturn, for DHSC. This will support the NHS in England to deliver an additional 40,000 elective appointments a week and make progress towards the commitment that patients should expect to wait no longer than 18 weeks from referral to consultant-led treatment.
- Increased capital investment in public services in 2025-26 including £1.5 billion to deliver capacity for more than 30,000 NHS procedures, over 1.25 million more diagnostic tests and new beds across the NHS estate, and £1 billion to reduce the backlog of critical NHS maintenance, repairs and upgrades (including RAAC).
- Will invest more than £2 billion in NHS technology and digital to run essential services and drive NHS productivity improvements.
- Strengthen the UK's pandemic preparedness and health protection with £460 million of investment to address the risk posed by future health emergencies and implement the lessons learnt from the pandemic.
- Provide £26 million to open new mental health crisis centres, reducing pressure on A&E services.
- Protect core R&D budgets with a real terms increase in funding for the NIHR.
- Support local authority services through a real terms increase in core local government spending power of around 3.2%, including at least £600 million of new grant funding to support social care.
- Appoint a Covid Corruption Commissioner, who will lead work to recover public funds from companies that took unfair advantage of the COVID-19 pandemic.
- A renewed focus on public sector productivity in Phase 1 of the Spending Review. The government has set departments a 2% productivity, efficiency and savings target for next year.

- Phase 2 of Spending Review will focus on reforming the public sector. On health, the 10-year plan, to be published in Spring 2025, will set out reforms transform the NHS from analogue to digital, move from models of sickness to prevention, and shift care from hospital to community.
- The government remains committed to delivering fair and timely pay awards for public sector workforces in 2025-26. Over the medium-term, above inflation pay awards are only affordable if they can be funded from improved productivity.

2. Integrated Care System Update

2.1 System Planning

The BNSSG System has launched the planning round for 2025-26 with a series of workshops to think about how partnership working and transparency is promoted across our system decision making processes, how we effectively and efficiently promote the progress of priority pathways within our resource limitations and how we actively shift from reactive to more preventative services.

UHBW and NBT colleagues have had strong and proactive engagement in the review of the Locality Partnerships over the past few weeks. This work will inform the Integrated Care Partnership about how we move forward and build on the strong platform that our locality arrangements and their leadership, within our distinct communities in BNSSG, provide.

2.2 Formal opening ceremony of North Bristol Community Diagnostic Centre

The official opening of the new permanent North Bristol Community Diagnostic Centre (CDC) took place this month. The centre which is housed next to the Asda at Cribbs Causeway, provides a number of different imaging tests for patients – these include-rays, CT and MRI scans, echocardiograms and endoscopy tests. Most of the centre opened in September, with endoscopy being fully open from the start of November.

This centre is run as a partnership between North Bristol NHS Trust (NBT) and independent healthcare provider InHealth and is their biggest CDC, and one of the largest in the country. There have been more than 11,000 appointments since the CDC opened to patients in April and is a fantastic facility for our patients.

2.3 Global Partnerships Workshop

UHBW and NBT have been offered a one-off workshop opportunity by **Healthcare UK,** a joint initiative of the Department of Health and Social Care, NHS England and the Department for Business and Trade, which champion the UK healthcare sector to foster opportunities and bolster international business growth. The workshop will be held in December jointly with UHBW and will give us the opportunity to consider our strengths as two organisations. It will help us think about the international work that we are already doing and how we could coordinate and grow this.

3. Strategy and Culture

3.1 Group Model Assurance

NHS England's regional South West office has conducted a desktop review of the developing Group Model for Bristol. This was done as part of a pilot in anticipation of the upcoming national assurance process for group models and shared services within provider collaboratives. This is expected to be launched later this year.

The findings of this review confirmed the substantial joint working efforts that have been taking place in advancing our Group Model – which is supported by a clear rationale and approach to its design and implementation. The outcome is that NHS England is fully supportive of this move towards a Group Model and looks forward to partnering with the Group and the ICB. There will be a follow up discussion scheduled in three months' time to review further progress.

3.2 Appointment of a Joint Green Champion for UHBW and NBT

Dr Sanjoy Shah has just been appointed as the very first Joint Green Champion. Sanjoy will support both Trusts to drive forward our respective Green Plan actions, particularly helping us to reach clinicians and create a stronger sustainable movement within the clinical workstreams.

3.3 HSJ Awards Ceremony

The Trust was successful in being shortlisted for two categories at this year's HSJ Awards – Trust of the Year, and the Towards Net Zero Award where our Green Operating Day was nominated. A mixed group of staff from the Trust attended the ceremony in London earlier this month.

4. Operational Delivery

4.1 Removal from Tiering for Elective Care

The NHS National Elective Recovery Programme has confirmed that the Trust has been removed fully from the tiering process for our elective work. They have recognised the work carried out by our clinical and operational teams to improve performance and have described this as impressive. The work of all members of staff from booking and admin through to senior clinicians has been noted. Thank you to all of our teams.

4.2 CQC published outcome of investigation following the death of Maddy Lawrence

CQC have this month published the outcome of the inspection visit which took place in January this year. The inspection was as a result of the inquest into the death of Maddy Lawrence and the CQC had been asked to assure that staff at the trust were appropriately trained in the safe care of a deteriorating patient. The Trust has acknowledged that there were a number of failings in the care of Ms Lawrence and have taken steps to ensure that all clinical staff are adequately trained in particularly in relations to NEWS2 and the deteriorating patient reporting.

The report which covers the assessment of two medical and surgical wards, and the Intensive Care Unit has rated the services as 'Good'. The CQC have written to assure the Trust that there will be no further action in relation to this matter. Link to report

4.3 NHSE Winter & H2 Priorities

On 16 September NHSE published the 2024-25 Winter & H2 priorities, confirming the operating assumptions for the remainder of the financial year. The letter outlines the steps that ICBs and providers should take to support delivery of safe, dignified and high-quality care throughout the winter months. These include, delivery of the Year 2 UEC recovery plan, with a focus on the move of activity away from acute providers to out of hospital settings through pro-active admission avoidance and discharge pathways; ensuring safe delivery of care across the 7-day week, both in and out of hours; and safe use of escalation capacity. A UHBW Winter Preparedness group maintains oversight of this work through to completion.

4.4 GP Collective Action

Following the non-statutory ballot held in July 2024, the BNSSG Local Medical Council met with General Practice contractors on the 10 September to agree which of the British Medical Association recommended actions would be implemented across the system. The output of this discussion has now been received, identifying seven actions that will be taken incrementally from October 2024, through to January 2025. The seven actions have potential to impact across both UEC and elective pathways, with the key impacts being seen from the action to reduce primary care appointments to 25 per day, and changes to referral practice. System partners continue to work together to maintain oversight of any changes to activity seen across all UEC points of access and providers, and ensure mitigations are in place.

4.5 Service Visits

I have been able to go and see a number of areas across the Trust over the past two months. These visits provide me with an opportunity to speak to frontline staff – clinical and non-clinical as well as our wonderful volunteers – and hear about their great ideas and of their challenges. Areas include:

- Pharmacy
- Ward 27a
- Community Discharge Centre

Recommendation
The Board is asked to note the report.

Maria Kane
Joint Chief Executive

Report To:	Public Trust Board		
Date of Meeting:	28 November 2024		
Report Title:	Freedom to Speak Up Bi-Annual Report November 2024		
Report Author:	Hilary Sawyer, Lead Freedom to Speak Up Guardian		
Report Sponsor:	Glyn Howells, Executive Lead for Freedom to Speak Up		
Purpose of the report:	**Approval**	**Discussion**	**Information**
		x	
	Update on: • Assessment of the last six months' FTSU data, themes and activity • Triangulation with other routes of speaking up and related improvement opportunities • Action taken and key next steps planned and advised to improve the organisational speaking up, listening up and following up continuous improvement cycle		

Key Points to Note *(Including any previous decisions taken)*

- The previously increased level of concerns raised to FTSU is sustained in the last six months
- A part-time (fixed term) Associate Freedom to Speak up Guardian started in role in late August 2024 to increase ring-fenced responsive time and capacity for strategic supportive actions
- Trust board and senior leaders are asked to role-model and disseminate the expectations of a healthy listening up and following up environment that reduces barriers to speaking up, which in itself provides vital information to the organisation
- An engagement session with Senior Leadership Group was conducted on 19/11/2024
- Senior leaders have been asked to support managers to complete the national e-learning 'Listening Up' module and provide a healthy listening up environment and ultimately reduce the level of concerns that are raised to the FTSU service. The Lead FTSU Guardian has drafted manager's guidance (to be rolled out through engagement sessions) and worked with the L&D trainers to weave training into HELM programme modules.
- Communication of the value, improvement and clear learning from speaking up by the organisation, leaders and managers is vital to increase trust in, and reduce futility around, speaking up
- Themes from the Triangulation Group are outlined in section 2
- An update to the high-level organisational self-review actions (previously presented in May 2024) will follow in the next 6 monthly report due in May 2025.

Strategic and Group Model Alignment

Speaking up and Listening up are key aspects of the organisation's Values and Behaviours Framework that underpin the Trust's strategic direction and aligns with Patient First ethos. The values include listening to understand, showing empathy and recognising a need to listen, taking time to listen, being open minded and curious, being honest with one another and speaking up,

improving together, and sharing challenges. These behaviours contribute to NBT's improvement priorities provide better high-quality care, improving, using limited resources and being proud to belong.

The FTSU Guardians at North Bristol NHS Trust and UHBW have always provided peer support and work to the same national guidance. Further consideration will be given to supportive working processes over the coming year. The two networks have met recently for the first time with the Joint Chair and the two respective Non-Executives for Freedom to Speak Up.

Risks and Opportunities

A healthy speaking up, listening up and following up environment is vital to a safe, effective and continuously improving organisation and aligns with Patient First aims.

It is a golden thread that runs through hearing and understanding issues of risk, safety, effectiveness, equity and inclusion, early and/or preventing issues arising.

Triangulation of issues from speaking up (broadly) through various routes supports key items raised on the risk register.

Recommendation

Trust Board is asked to:

- Review the update to FTSU data, themes and actions taken in the last six months (Q1 and Q2 2024/2025), and FTSU service actions taken and planned next key steps.
- Discuss how to support Senior Leaders to role-model and disseminate to managers an intentional and visible listening and following up environment to support routine speaking up for safety, learning and improvement
- Discuss how communication of the value to NBT of colleagues speaking up and the learning and changes made as a result can best be supported
- Consider the themes from the Triangulation Group

History of the paper (details of where paper has <u>previously</u> been received)	
This is a bi-annual report. Last report to Trust Board was May 2024	May 2024
Appendices:	Appendix A: Speak Up Month 2024 overview

1. Purpose

- The purpose of this report is to update the Trust Board on Freedom to Speak Up (FTSU) activity and themes of issues raised by colleagues at North Bristol NHS Trust (NBT) over the past 6 months for learning and to provide information on the work carried out to help workers speak up and feel valued for doing so.

2. Background

2.1 Freedom to Speak Up Guardians were introduced to NBT from November 2017. The number of volunteer Guardians has varied and is now four, with an increasing network of FTSU Champions being recruited to increase visibility, awareness, reach and diversity, and to support engagement and accessibility of FTSU. A substantive Lead Guardian role (0.6WTE) was introduced in mid-January 2021 since when awareness of speaking up and the FTSU Guardian role has increased and improved. The lead role was extended to 0.9WTE from April 2023 and an Associate Guardian started in role in mid-August 2024

(fixed-term, 0.6WTE role) to provide more ring-fenced time for responsive work, and support release of capacity for strategic and supportive work to leadership.

2.2 The Lead Guardian role brings ring-fenced time to support:

- NBT workers to be able to speak up (including awareness and response)
- a positive speaking up culture of continuous learning through listening and response
- the organisation in becoming a more open and transparent place to work, where staff speaking up is highly valued, influencing the organisation's improvement
- training and support for managers and leaders in 'listening up' and 'following up'
- identification of, and actions to address, any barriers to speaking up
- assessment of trends and responses to issues being raised

and hold Senior Leadership and the Board to account for taking appropriate action to create a positive speaking up culture across NBT.

3. Update of data, themes and activity

The report provides information as outlined in the NHSE FTSU guidelines:

- Part 1: Assessment of FTSU cases, data and themes
- Part 2: Actions taken to improve speaking up culture
- Part 3: Recommendations

4. Summary and Recommendations

Trust Board is asked to:

Discuss:

- The key take-home messages in the accompanying report and key messages from the Executive Lead communicated in Speak Up Month (links provided in Appendix A)
- Further ways to actively role-model and support senior leadership buy-in and actions for continued improvement of a routine speak up, listen up, follow up environment to ultimately break the level of approach to FTSU
- Active communication of the value to NBT of colleagues speaking up through whichever route and learning and change made as a result of speaking up

Consider: the themes from the People and Triangulation Group and related action required

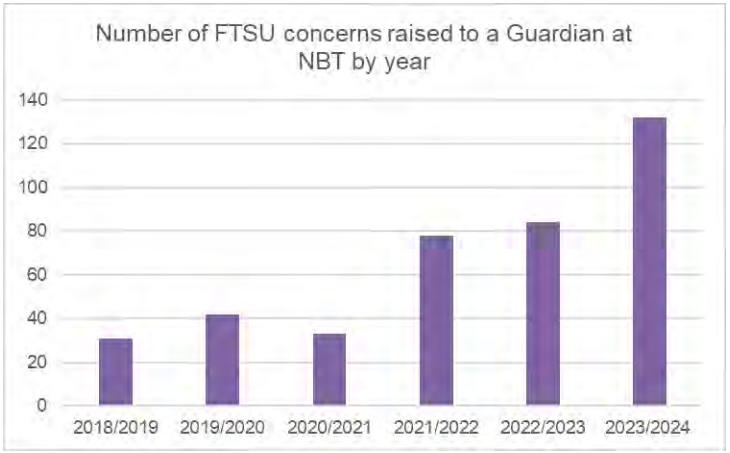
Note: actions taken by FTSU to improve speaking up culture (linking with key cultural work) and key FTSU function next steps

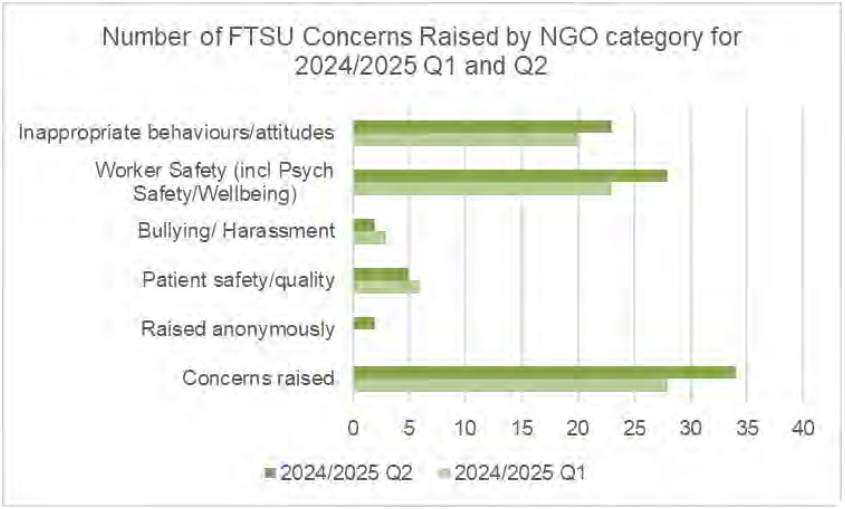
FTSU (Freedom to Speak Up) Board report November 2024

Key take-homes (report covers Q1 and Q2 2024/2025):

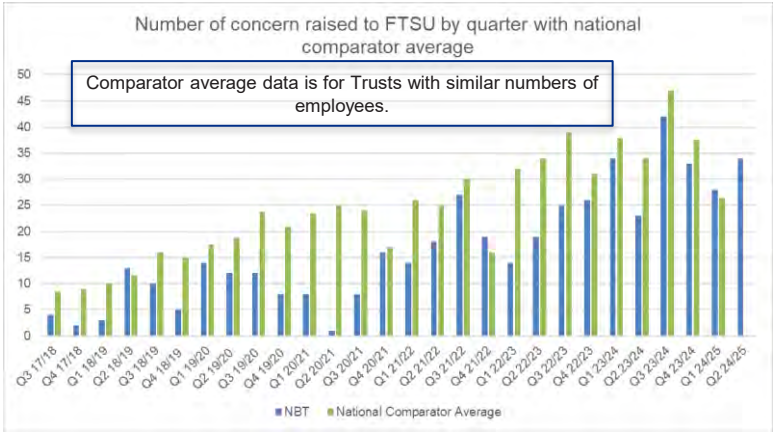
- **The increased level of speaking up brings a higher level of vital information to the organisation to act on:** for safety/quality, effectiveness, inclusion, improvement action and learning
- **The increase in FTSU concerns required additional capacity through the Associate FTSU Guardian role** (part-time, fixed-term role from late Q2) to be able to respond to concerns in a timely, quality way, provide resilience, support FTSU key actions including reporting into Divisions/Directorate/senior leaders, and provide time to profit from the intelligence gained from FTSU with strategic related work in partnership (e.g., reflections on patterns and work on barriers)
- **Ultimately there will be a need to break the cycle of workers feeling they need to approach FTSU** (FTSU Executive Lead's blog here); FTSU should become the safety valve for a smaller number of (likely the more complex) concerns
- **During October Speak Up month (nationally themed 'The Power of Listening') managers were encouraged to consider their role** (and the attributes needed) in listening and to complete the national 'Listen Up' e-learning module
- **Senior leaders have been encouraged to reflect and role-model proactive listening up behaviours**, take appropriate action and provide feedback (improving confidence and reducing barriers to speaking up locally).
- **Visibility of improvement change and communication to 'close the loop' will build confidence in the value of speaking up.** Senior leaders have been asked to proactively action a communications drumbeat aligned to the continuous improvement 'speak up, listen up, follow up' cycle to show action/response, and reduce futility around speaking up (e.g., local themes, actions from staff survey)
- **As an organisation we need to ensure that we can clearly state learning from colleagues speaking up,** no matter the route (FTSU or otherwise)
- **Staff speak up as they care and are passionate about NBT's services; they almost always quote NBT's CARES values as part of speaking up to FTSU**
- There has been increased focus and action as an organisation on areas that people may need to speak up about more broadly and hence more speaking up in the organisation generally: e.g., 'we do not accept', antiracism and sexual safety (which the Lead Guardian has supported)
- **Themes from the People and Quality Triangulation highlight continued aspects that require organisational action**

FTSU Board report November 2024: Part 1: Assessment of NBT FTSU 'cases'





NB:
NGO guidance:
- Concerns can be reported in more than one category.
- Focus is on the perceptions of the person raising the concern.



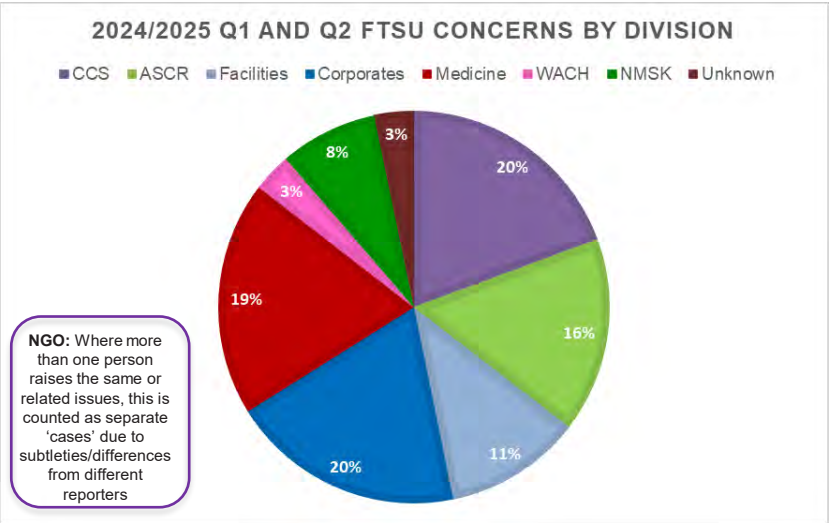
N.B. Nationally and at NBT Q3 concerns levels tend to be higher in Q3 due to Speak Up Month focus

What do the data tell us?

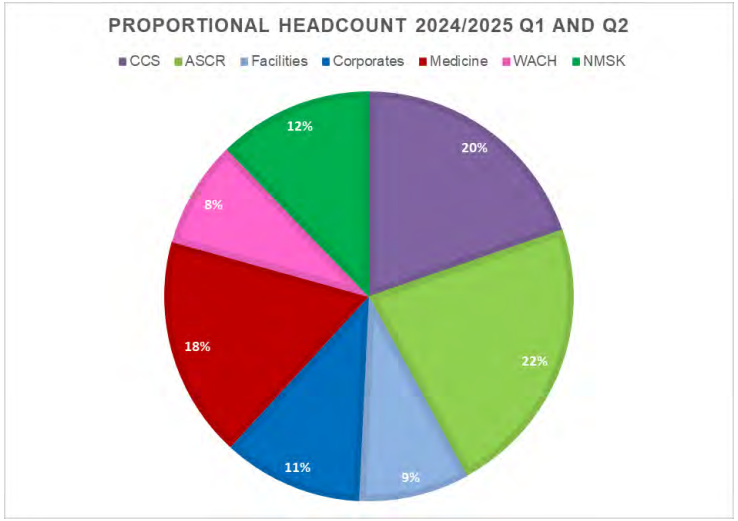
- The number of FTSU concerns raised per quarter averages ~ 32 from Q1 2023/2024
- Relatively few concerns are **directly** about patient safety or quality of care which is as expected given established mechanisms for raising safety concerns
- The highest number of concerns continues to fall into the category of 'inappropriate behaviours and attitudes' and also impact of issues on staff wellbeing
- This pattern is consistent in the last 2-3 years since the National Guardian Office (NGO) reporting categories were updated to include inappropriate behaviours or attitudes.
- This pattern appears to be consistent with national 2023/2024 reporting levels: see the NGO 2023/2024 Annual Speaking Up data report: 'Culture is a patient safety issue' where ~ 38.5% involved an element of inappropriate behaviours or attitudes and ~32% involved an element of worker wellbeing or safety
- Working environment/organisational culture ultimately affect quality of patient care and safety, ways of working, communication, engagement, inclusion and staff thriving to provide high level care/retention (two sides of the same coin: safety, risk and employee experience)

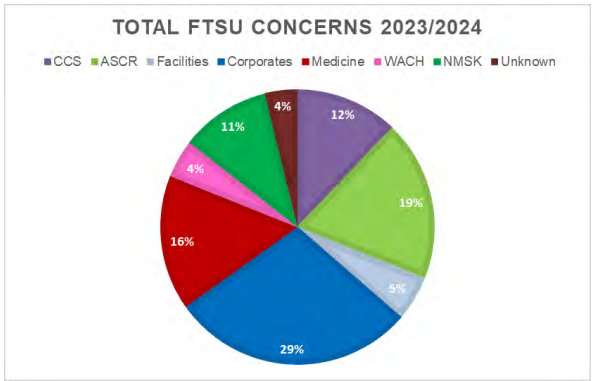
FTSU Board report November 2024: Part 1: Assessment of NBT FTSU 'cases'

2024/2025 Q1 and Q2 Concerns By Division



NGO: Where more than one person raises the same or related issues, this is counted as separate 'cases' due to subtleties/differences from different reporters





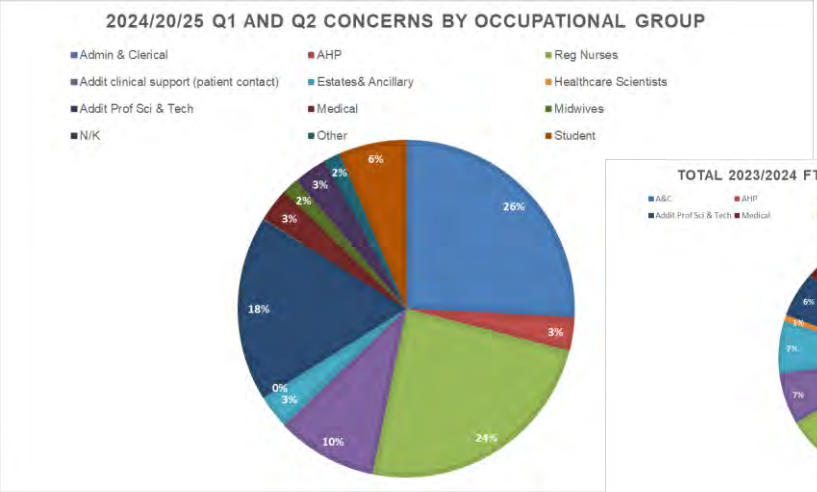
What do the data tell us?

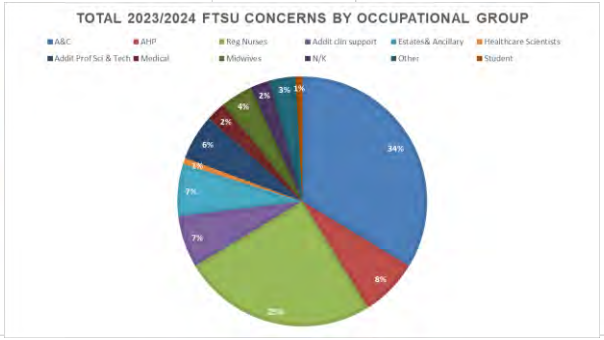
- Concerns have been raised across all Divisions and in Corporates
- Concern levels are higher in Corporates than is proportional to headcount
- There are a lower level of concerns raised in WACH and NMSK than is proportional to headcount (this is similar to previous patterns)
- The proportion of concerns for Q1 and Q2 were similar to the whole year in 2023/2024, with increases in CCS and NMSK, which is likely in part due to more than one person raising concerns in specific areas

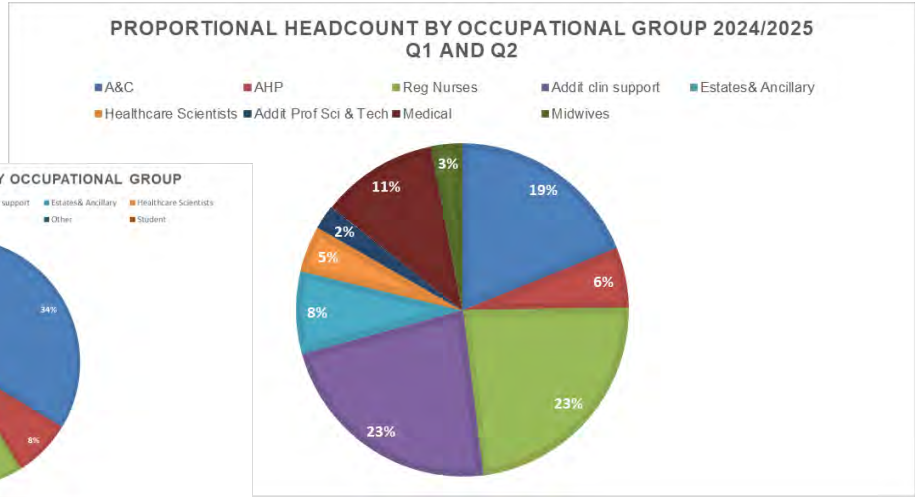
FTSU Board report Nov 2024: Part 1: Assessment of NBT FTSU 'cases' update

North Bristol NHS Trust

2024/2025 Q1 and Q2 Concerns By Worker Occupation







What do the data tell us?

Higher concerns levels:

- Admin & Clerical
- Registered Nurses

These are approximate to relative headcount

This aligns to national data/trends.

(N.B. A higher proportion in other worker groups is due to specific areas of collective concern)

Lower concerns level:

- Additional clinical support
- Medical
- Healthcare Scientists

This aligns to national data/trends also.

- Reduction in concerns proportionally by AHPs

These will remain areas of awareness when considering barriers to speaking up

NBT FTSU Themes 2024/2025 Q1 and Q2

(**Rider:** These reflect the perceptions of staff raising the issues. Concerns can be challenging to theme/group together and discuss in an informative/meaningful/sufficiently accurate manner while dealing with these sensitively and confidentially, and not creating unintended 'false narrative')

Patient safety/quality of care:

- Clinical practice in specific area
- Patient care related to professionalism/staff attitudes and behaviours
- Staffing levels or arrangements impacting quality of care
- Effectiveness of training and supervision
- Communication

Attitudes and behaviours:

- Incivility/culture and communication issues between colleagues and between professions
- Demeanour/attitudes and behaviours in interactions with junior colleagues
- Confidentiality around worker situations or health
- Attitudes around support on training

Process issues:

- Impact of handling of People processes
- Flexible working requests
- Impact of handling of safety incident and reporting – systems perspective vs individual 'error'
- Processes to respond to verbal abuse from patients
- Situations not changing in response to issues raised in services

Worker wellbeing

- Sexual safety at work
- Impact of abuse on staff
- Disempowerment in role/lack of support from manager to make improvement changes
- Ineffective handling of response to behaviours of colleagues
- Aspects of support for neurodivergent staff at work and their colleagues and managers
- Support for completion of training or effective mentoring

- Colleagues accessing FTSU often expressed wanting to be able to 'just get on with' the job that they love rather than experiencing the issues that brought them to contact FTSU.
- Typical drivers for approaching FTSU include feeling that issues were not fully heard previously, or that no change had been seen or assurance of action given, or that there are challenging dynamics in teams that are unresolved.
- Some colleagues come to FTSU expressing that they want some learning to be taken from their experience in the workplace, to prevent other people going through similar.
- Several colleagues have been in visible distress about their experiences (whether personal or team issues) or impact

FTSU Board report November 2024: Part 1: Assessment of NBT FTSU 'cases' (continued)

North Bristol NHS Trust

FTSU process timeframes (2024/2025 Q1 and Q2):

(To provide assurance that matters spoken up about are acknowledged, evaluated, escalated and responded to in a timely manner)

Q1 and Q2 data	Average	Range
Time taken for initial acknowledgement to a new concern by a FTSU Guardian	1 working day	1-2 working days; 100% within the specified 2 working days
Time to closure (calendar month)	1.5 months	<1 week to 5.5 months

- Number of cases remaining open as of 01/11/24: 13 from before Q3 (these are either relatively complex issues needing robust consideration and action by senior management, or where staff have been absent to resolve well. A further 8 new concerns raised from Q3 are open (currently being actioned)
- Factors in protracted length to closure: sick leave of worker, summer leave of staff member or manager, responsiveness of manager/leader, complexity of issue(s), Guardian capacity, FTSU workload balancing multiple cases, nuance, reflection and appropriate escalation/action/follow-up.
- Time from escalation to effective response by a manager that assures of appropriate action that issues are addressed (where appropriate): currently manual, improvement of analysis aimed for as part of new case management system development in future
- Typical actions taken by FTSU Guardians: Depending on the situation (following active listening), action can range from: supporting the staff member to speak up to a more senior or alternative manager themselves, or escalation on behalf of the staff member(s) to a manager/senior manager/senior leader, or logging the issue (after discussion) and informing themes and organisational triangulation action
- Learning from concerns in Q1 and Q2 has included: awareness of improvement required for various aspects of culture in various areas of the organisation (behaviours and working to NBT values) behaviours, communication, and inter-relationships, impact on wellbeing of processes, mentorship/supervision and training processes

Additional assurance: The Guardian(s) check in subsequently with those speaking up, to ensure that workers feel that they have not suffered any disadvantageous treatment, which also serves as opportunity to discuss whether they feel improvement has occurred, from worker perspective, as a result, and re-occurrence prevented.

FTSU Service User feedback included:

- I so appreciated being fully listened to and space to process my thoughts and experiences. I hope some good for others may come from raising the issues ultimately.
- The FTSU Guardian was very supportive, keeping in touch, despite a busy service. The whole process was great, very supportive, great listener. I value the FTSU service; it is a safe space to speak openly. The issue I reported on came to a better outcome than expected without very formal intervention.
- Thank you for escalating this issue in a way that reflected the supportive and positive intention of raising it, with patient care and staff wellbeing at the centre
- I really appreciated the support and efforts of the FTSU Guardian including the regular contact about progress and checking in.
- Thank you for the help; I have appreciated the time and efforts spent to work through this issue.
- I have been very grateful for the Guardian's support and contact while issues are gradually progressed.
- I was so grateful for the Guardian raising the issues and regular updates on progress
- Thank you for providing space to talk this through and consider an alternative option for me to raise the issues through myself that I had not thought of previously

Update to report of perception of disadvantageous treatment/detriment reported to the Lead FTSU Guardian in 2024:

- This was reviewed by an independent investigator (and that report subsequently reviewed by the FTSU NED for assurance); although the perception of detriment will remain as reported, the review found that the person was not treated differently as a result of speaking up. The report gave some recommendations however about possible learning about the approach used to consider the issues in the original concern, and assurance that appropriate action has been taken to address the issues raised.
- The FTSU policy has been updated (version 5; October 2024) to include information of the process to follow in response to communication of disadvantageous treatment

Triangulation

(NHSE guidance: *How speaking up matters fit into a wider patient safety and worker experience context to help build a broader picture of speaking up culture and opportunities to learn and improve. What has been learnt and what improvements have been made as a result of workers speaking up.)*

Trust-wide triangulation: (*Freedom to Speak Up, People/Workforce/Culture, Staff Psychology, Patient Safety, Patient Experience, Chief Nursing Office, Health and Safety, Risk)

The quarterly People and Quality Triangulation Group* shares respective high-level information around thematic concerns/issues, identified to ensure that Trust-wide joined up action is being taken to tackle and ultimately prevent these.

Over-arching themes from FTSU concerns aligned with intelligence presented from other areas:

- Relationships, interpersonal behaviours, communication, attitudes or differences in professional approach between teams/team factors, individuals and colleagues/managers, poor communication between colleagues, team dynamics and conflicts
- Bullying
- Challenges of cultural communication (with patients and colleagues), and need for culturally attuned approaches to People processes and disparities (and any performance expectation issues)
- Communication between teams and managers, including lack of feedback loops on issues raised.
- People feeling dismissed/unheard by managers when raising issues and futility around clear action and improvement after raising issues in teams
- Abuse, assaults, violence and aggression (from service users)
- Psychological support required around grievances/People processes
- Patient records and logging and communication of clinical decisions: hybrid digital and paper patient records and different recording mechanisms of different professionals
- Ability to be released or supported for training/progression
- Response to flexibility of working from managers (e.g., pattern or hybrid working) and return form maternity leave
- Issues around retained estates and impact on morale/wellbeing (which are also raised anecdotally on FTSU walkarounds)

These points have been taken by the relevant Directorate partner to progress in existing workstreams.

FTSU Board report November 2024: Part 2: Actions taken to improve speaking up culture:

(How speaking up matters fit into a wider patient safety and worker experience context to help build a broader picture of speaking up culture and opportunities to learn and improve.)

NHS North Bristol NHS Trust

Promotion of all speaking-up channels:

- Coverage of speaking up routes and FTSU at fortnightly corporate induction sessions and promotion of the **national e-learning module completion which is mandatory (Trust-wide compliance (commenced):** Speak Up module 61%, Listen Up module 38%, Follow Up module (all leaders 65% SLG 75%, Board 94%) – Manager's module focus in Speak Up Month (and will be a key area of future focus)
- Through supporting the 'We Do Not Accept' focus work; the Lead Guardian is part of NBT's sexual safety at work group and supported listening events
- Internal communications through the operational bulletin, social media, and Speak Up Month activity and communications; see Appendix

Engagement, training and service support:

- The Lead Guardian has worked with the NBT Leadership and Management Trainers to support weaving of training on supporting speaking up into HELM programme modules (e.g., Accountable leadership, High Performing Teams) and appropriate Bitesize management modules
- Promoted completion of the national e-learning modules (mandatory) and most recently completion of the Listen Up module for managers
- Regular tailored training sessions for new Student nurses and midwives, Trainee/Student Nurse Associates, (SLEC Raising Concerns Charter expectations covered) Preceptors, Internationally Educated Nurse 'Adapt' sessions, and GMC in-person sessions for International Medical Graduates, Accelerate programme.
- Team engagement: updates and discussion, e.g., Pharmacy, Finance, WACH Professional Forum, and Community Midwives, Charity
- Inclusion of material on FTSU through the Postgraduate Medical Education and support team; encouraged medical representation in the FTSU Champion team
- Supported work in Pharmacy on speaking up and the improvement environment by local leadership with the FTSU Champion and drafting of a Medicine Division 'Safe to Respond': ability to escalate patient safety concern competency assurance process/document

FTSU network visibility:

Walkarounds have involved the Executive Lead, or Non-Executive Lead, for FTSU, Lead, Associate, or volunteer FTSU Guardians; some have been supported by Chief Nursing Officer and Deputies.

These have included visits to: ED, IDS, Outpatients, Facilities, WACH services, other services in Retained Estates (Pre-op Centre, Elgar), Cossham, Corporate teams in Kendon, various wards (including very early morning to speak with night shift staff).
FTSU Champions also have individual profile posters for local services.

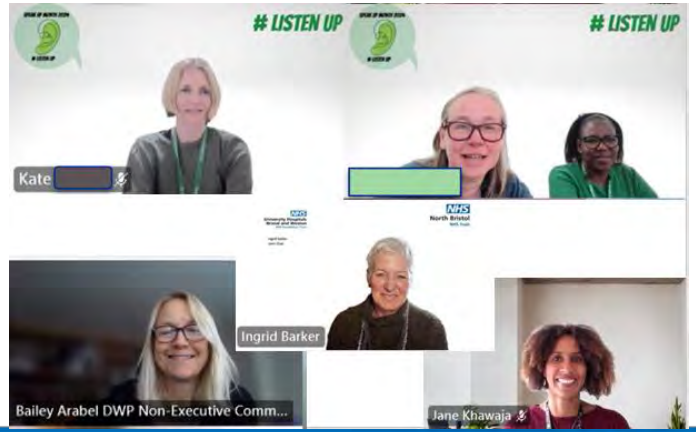
FTSU Board report November 2024: Part 2: Actions taken to improve speaking up culture (continued):

(How speaking up matters fit into a wider patient safety and worker experience context to help build a broader picture of speaking up culture and opportunities to learn and improve.)

North Bristol NHS Trust

Assurance that FTSU arrangements are continually evaluated, and improvement identified:

- Organisational self-review (presented May 2024) high-level actions ongoing – update to come to Board in May 2025
- 'Barriers to speaking up' engagement work carried out by the Lead Guardian through training sessions, walk-arounds will inform next organisational actions in conjunction with further information from the UWE Masters (Human Resource Management) project
- Learning from further speak up reviews would be highlighted and actioned – the most recent review (2024) is of **'Speaking Up Experiences of Overseas-Trained Workers in the NHS'**; output is awaited
- Continuing to work with peer UHBW Guardian colleague and recently connected NBT and UHBW networks with the Joint Chair Ingrid and NBT and UHBW NED leads for FTSU as a first step to actual network communication
- A South-West FTSU network (Champions and Guardians) conference day is planned for February 2025 supporting the development of the network
- The Lead Guardian attends the annual NGO conference, NGO webinars, SW Guardian network meetings, contributes to focus groups (the new Associate Guardian will attend also)
- FTSU Guardians complete annual online refresher training – the focus for 2024 is Equality Diversity and Inclusion



FTSU Board report November 2024: Part 3: Recommendations: Next steps:

FTSU-specific next-steps include:

- Onboard the new FTSU Champions to evolve reach and diversity, reduce barriers to speaking up through various routes, and improve support and development for the network (so that NBT can hear more)
- Supporting managers around provision of a listening up environment and support safety culture conversations
- Reflect themes from engagement work on barriers to speaking up for improvement
- Reflect learning from FTSU: themes and contribute to learning on broad cultural or organisational system/environment/complexity aspects and consider impacts and restorative measures needed
- Further refine the FTSU specific plan aligned with NBT Values, Behaviours and broader cultural work
- Support further triangulation in the organisation and with Divisional leadership teams (through quarterly reporting)
- Continue to work alongside our UHBW FTSU colleagues and more closely as part of the Hospital Group

Trust Board members are requested to:

- **Consider further ways to role-model and support buy-in**, despite busy services, for continued improvement of the speak up, listen up, follow up environment for safety, inclusion, learning and improvement and reduce the need to approach FTSU (see related key messages from Executive Lead for FTSU here)
- **Support senior leaders and managers** to follow suit (including through shadowing, 'go and see visits', routine huddles, board rounds, 1:1s, service meetings or communication materials, Patient First improvement boards)
- **Encourage all colleagues to complete the respective National FTSU e-learning modules** (mandatory)
- **Support mechanisms for communication of the value, learning and change made through speaking up (all routes)**
- **Consider the themes** from the People and Triangulation Group and related actions required

FTSU Board report November 2024: Appendix A: Speak Up Month 2024

Speak Up Month 2024 - LINK

North Bristol NHS Trust

Summary of focus and activity for NBT Speak Up Month

The Role of Freedom To Speak Up

Freedom To Speak Up is here as a safety valve, to ensure everyone can feel heard and problems are addressed in an appropriate manner, but it should never be the default option.

Nationally every year in October Speak Up Month is celebrated – a month to focus on a listening up and speaking up culture becoming routine/business as usual for everyone, and the work that Freedom to Speak Up networks do to support this.

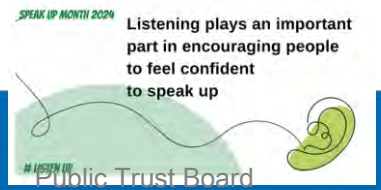
For 2024's October's Speak Up Month, the theme is '**The Power of Listening / Listen Up**', and the important part which listening plays in encouraging people to feel confident to speak up.

Confidence to speak up comes from knowing that if you speak up, you will be supportively listened to, and that appropriate action will be taken.

We all have a part to play in listening to one another with respect and compassion. This Speak Up Month is an opportunity for all of us to show that we are here to listen to one another and commitment to fostering a Speak Up, Listen Up, Follow Up learning and continuous improvement culture in our teams and throughout NBT.

Activity included:

- Executive Lead blog and video
- Walkarounds including encouraging expressions of interest (EOI) in the FTSU Champion role current round
- Drop-in session, and team training sessions
- Inviting and communicating Listen Up pledges from leaders and managers
- Issuing updated, new-look FTSU Guardian and Champion posters
- Draft of new manager guidance on providing a listening up environment – for engagement with managers before full launch
- Support from the Library Service to highlight books on the theme
- Supporting Black History Month events



North Bristol NHS Trust

Meeting of the Board on 28 November 2024 held in Public

Reporting Committee	**Quality Committee – 10 October 2024**
Chaired By	**Sarah Purdy, Non-Executive Director**
Executive Lead	**Steve Hams, Chief Nursing Officer** **Tim Whittlestone, Chief Medical Officer**

For Information

The Committee met on 10 October 2024 and received the following reports:

1. The Committee reviewed the Deteriorating Patient Group report which detailed the progress of the Group to date to work towards a safer hospital for acutely unwell patients.

   The Committee welcomed the update and were assured on the positive progress, particularly regarding the continued improvement in observation performance and the development of a 24/7 Acute Response Team.

   Discussion focused on:
   - the time taken to undertake an evidence based approach and to put in a place a robust service to do right by all patients,
   - the impact on patients and the metrics used to measure improvement,
   - the cultural element to the third element of Martha's Rule and the digital solutions being considered to help implement it.

2. The Committee were joined by the Divisional Operational Director for NMSK and a Stroke Consultant who presented the Stroke Deep Dive. A series of slides were presented which set out an overview of the impact to NBT stroke services of the stroke services reconfiguration that went live in May 2023.

   The Committee received assurance on the support measures for staff when rehabilitation units were unavailable and noted that the SNAP data reflected broader challenges with increased patient overflow. Discussion focused on the ongoing work with system partners to reduce the occupancy level of the acute stroke unit at NBT and to drive sustained improvements for the service. The Committee received reassurance that a system flow group had been established to explore bed utilisation and alternative pathway efficiency.

   The report provided assurance that QC understood the challenge and the adverse impact on patients. It was noted that this would continue to be monitored by the Board.

3. The Committee received the Radar Programme Delivery Assurance report which outlined the delivery of the Radar Programme to date and the current and future anticipated benefits.

   The Committee received assurance that:
   - the Radar Digital programme was being managed robustly, with effective governance and delivery of tangible benefits to date.
   - that challenges had been identified and were being actively worked upon to ensure the system was fully optimised.

- Future plans, within the context of strong partnership with the system supplier, were being shaped collaboratively with innovative aspiration and tangible deliverables.
- the Trust was not being charged for the change of controls as part of the partnership with the Trust.

4. The Committee reviewed the Perinatal Quality Surveillance Matrix (PQSM) report which detailed the perinatal safety intelligence for July 2024. The Committee received reassurance on the support provided to staff and the support provided to patients, noting that Duty of Candour was undertaken for every women with an adverse outcomes.

For Board Awareness, Action or Response (including risks)

5. The Committee received the Annual Human Tissue Authority (HTA) Compliance and Mortuary Assurance Report which set out information related to the Mortuary and linked to the recent recommendations from the Fuller Inquiry. The Committee were informed of the ongoing work by the Trust to prepare for unannounced HTA inspections and received assurance regarding the ongoing work with the security team to mitigate access risks with Mortuary services at UHBW. The Committee also received assurance regarding staff awareness training, noting that the offices and rooms were secured behind access-controlled swipe doors.

   The Committee raised concerns regarding the lack of Pathologists and regarding the delay to the completion of the required building works in the Mortuary external compound. The Committee discussed the risks, noting that it would have a significant impact on how the Trust used the Mortuary services.

6. The Committee noted the successful Baby Friendly Revalidation (BFI) revalidation. It was also recognised that the neonatal unit was due to be reaccredited in December.

Key Decisions and Actions

7. The Committee were joined by management teams within ASCR, IM&T and Patient Safety who presented the High Scoring Risk Review (as agreed following the discussion at September's QC meeting) which set out the context of the risks and the controls and mitigations in place.

   The Committee discussed each of the following risks in depth:

   - *The Patient Experience, Datix risk ID 1701, re the trier three weight management service and the challenges impacting the waiting list*.

     It was recognised that this was a regional issue, and that work was ongoing to mitigate the risk. The Committee received assurance on the mitigating actions in place and noted the next steps included clearing the backlog, the potential impact of the new medication (Semaglutide) on demand and the advocacy to reopen the service in June 2025. The Committee were reassured that once funding was secured the posts would be advertised, however it was acknowledged that the funding was difficult to agree as the

sums of money per patient were different due to the cost of the medication and was part of the reason the business case had not yet been approved.

It was agreed that the Executives would progress this with system colleagues to reduce the risk by implementing a long term solution and approval of the business case.

- *Patient Safety, Datix risk ID 1800, re the identification of patients allergy status and patient safety alerts.*

  The Committee discussed the digital and human factors contributing to the risk and received reassurance on the mitigating actions in place. The importance of a clinical pharmacist and the ongoing work with the education team to review opportunities to undertake simulation training and embed learning into practise was noted.

  It was agreed that it would be beneficial to clearly outline the process by which safe work systems address the human factors involved in the risk and identify data points which could be used to provide further assurance.

  The Committee agreed that an update would be brought back to QC in three months' time.

Additional Chair Comments
N/A

Date of next meeting:	Tuesday 12 November 2024.

North Bristol NHS Trust

Meeting of the Board on 28 November 2024 held in Public

Reporting Committee	**Quality Committee – 12 November 2024**
Chaired By	**Shawn Smith, Non-Executive Director**
Executive Lead	**Steve Hams, Chief Nursing Officer** **Tim Whittlestone, Chief Medical Officer**

For Information

The Committee met on 12 November 2024 and received the following reports:

1. **Kidney Transplant at NBT Annual Report** – providing an overview of NBT's kidney transplant activity, as the largest transplant centre in the South West. This report highlighted that over the last five years kidney transplant activity had been reducing at NBT, but that this had been turned around, with NBT growing its activity significantly in 2023 and 2024 particularly in the "living donor" category. The Committee noted that there was an ongoing risk around transplant surgical workforce capacity (on-call capacity in particular) but was reassured that the service was focused on consolidating the recent improvements and working with the Divisional leadership team to manage this risk. The report is included as **Appendix 1.**

2. **Infection Prevention Control & Tissue Viability Annual Reports** – these annual reports are included as **Appendix 2 and 3** and published on the Trust website. The Committee noted that the reports outlined positive ongoing improvement work and welcomed the ongoing focus on these important topics.

3. **Patient Safety Quarter Two Report** – this report highlighted the top incident categories reported in the trust as:
    - Medication,
    - Patient Falls,
    - Tissue Viability,
    - Admission/Discharge/Transfer/Transport,
    - Service provision.

   Positively, the Committee noted that tissue viability service provision was seeing a reduction in reported numbers since the start of 2024, and harm levels across all types of incidents were 'no harm'.

4. **CQC Assurance Report** – the Committee received an overview of CQC engagement over the preceding quarter and advised that the CQC report linked to Deteriorating Patient inspection would be published later in the week, and a copy would be shared with the Trust Board via the **Convene Reading Room**. This report recognised the actions that the Trust had taken in this area and did not highlight any areas of ongoing concern.

5. **Perinatal Quality Surveillance Matrix Report** – the Committee were assured that there were no themes of concern requiring escalation and noted that while the data was reported a month in arrears any immediate safety concerns would be presented to Divisional Quality Governance, Trust Board and the LMNS as appropriate. Positively, the Committee were advised that midwifery was currently recruited to vacancy and turnover.

6. **Maddy's Training** - Following the death of Maddy Lawrence at NBT in March 2022 due to unrecognised deterioration and sepsis the Trust has committed to continuous learning and an improvement journey. The Committee received an update on the new mandatory training package to educate front-line clinical staff recognition and responding to a deteriorating patient, sepsis, and acute kidney injury. It was agreed that a more detailed report would come to Trust Board in January 2025, providing further assurance on the new Rapid Response Service, training compliance, and the recent CQC report.

The Committee also received updates on:

- Quality Priorities 2024/25 – Quarter 2 Review – showing positive progress against the priorities.
- Quality and Patient Experience Trust Level Risks – a further deep-dive/snorkel into a number of key risks was agreed for a future meeting.
- Upward reports from the Drugs and Therapeutics Committee, Control of Infection Committee, Safeguarding Committee, and Clinical Effectiveness and Outcomes Group.

For Board Awareness, Action or Response (including risks)

Board should note the Annual Reports received by the Committee:

- Kidney Transplant Report (Appendix 1)
- Infection Prevention Control Report (Appendix 2)
- Tissue Viability Report (Appendix 3)

And should also note the CQC inspection Report (linked via the CEO report).

Key Decisions and Actions

The Committee has requested that a more detailed update and assurance report on Maddy's Training and the associated improvements and learning in the Trust be provided directly to Trust Board in public in January 2025.

Additional Chair Comments

The Quality Committee has adopted an approach of identifying high-scoring or long-term risks and commissioning a deep-dive/snorkel review, where the risk owner attends the Committee to provide a brief overview and update on the risk, ensuring that Committee members have the opportunity to ask questions and gain further insight and assurance on the risk. Other Committees may wish to consider this approach.

Date of next meeting:	Tuesday 14 January 2025

Report To:	Quality Committee		
Date of Meeting:	12 November 2024		
Report Title:	Annual Kidney Transplant report		
Report Author:	Jack Galliford; Consultant Nephrologist and physician lead for transplantation		
Report Sponsor:	Tim Whittlestone; Medical Director and Trust Executive lead for transplantation		
Purpose of the report:	**Approval**	**Discussion**	**Information**
		X	**X**
	An annual report to inform Trust Board as recommended in DHSC guidance as part of output from Steering Group for Organ Utilisation (ISOU) - Recommendation 10 of Organ Utilisation Report (Appendix 1).		

Key Points to Note *(Including any previous decisions taken)*

1. Over the course of the last few years, the directives for organ transplantation in the UK have moved from NHSE and NHS blood and transplant to DHSC.
2. This work was part of a national review, in which NBT participated (22nd March 2022) by the Organ Utilisation Group (OUG), which informed NHS MD to instruct the Secretary of State to Implement a Steering Group for Organ Utilisation (ISOU), to work to support organisations to best utilise life-saving and life-changing donor organs for transplant patients in Trusts.
3. Tim Whittlestone has been assigned as Trust Executive responsible for transplantation.
4. The aim of the ISOU is to drive the delivery of the 12 recommendations set out in the OUG report.
5. This is the first annual report of kidney transplantation at NBT.

Strategic and Group Model Alignment

Kidney Transplantation fulfils all aspects of the Trust strategy, using multi-disciplinary, multi-professional care across divisions within and without the Trust to enable access to this life-altering and enhancing treatment, for which there is no better economic or environmental model in healthcare. It lends itself perfectly to the formation of a Hospital Group. Many of the stakeholders are already in place informally.

Risks and Opportunities

Risks:

1) The surgical transplant workforce are currently at a Trust level risk (owned by ASCR divisional director Andrew Smith, Datix ID 487), based on on-call commitment to service/ activity and nos. working on rota (on-call and elective activity).
2) Repeated temporary closure of unit department to transplantation meaning imposition from NHS Blood and Transplant of measures to maintain NBT wait-listed patients access to transplantation.
3) Excessive delay in living donor transplantation within region (referral centres – Exeter, Dorchester and Gloucester, or from SW Operational Delivery Network (SWODN))

During period of report:

We have had official feedback and subsequent meetings from NHSBT MD and associate MD over perceived delays in listing patients for living donor transplantation within the UK live donor sharing scheme (May and June 2023).

We have received official feedback from SW ODN (October 2023) over perceived excessive delays in theatre date allocation for living donor transplantation.

FY 2024-current

Since the period covered in the report, the unit has been closed on 2 occasions due to lack of surgical availability on-call at weekends. 1 patient did not undergo transplantation consequently. These episodes are known to NHS Blood and Transplant, meaning, if this happens again, directives will be issued, mandating access to transplantation for part/all of NBT waiting list (essentially meaning transfer to an alternative transplant unit (patient choice and presumably temporary) causing operational and reputational damage.

Opportunities:

1) As the largest renal transplant unit in the South West, we can determine transplant policy for the South West within the SW Operational Delivery Network, important since this will be an important body in determining funding of transplantation from April 2025 through the ICB (assuming we can be part of these conversations) – as directed by NHSE Renal Clinical Reference Group.
2) This is particularly relevant to NBT given current overperformance in block contract for living donor transplantation which has secured in the region of £300,000 annually from the ICB.

Recommendation	
This report is for **Discussion and Information** The Committee is asked to note the current kidney transplant activity, both in terms of activity compared to NBT historical activity and in terms of national recommendations for the population served.	
History of the paper (details of where paper has <u>previously</u> been received)	
N/A	N/A
Appendices:	Appendix 1 Organ Donor Report Honouring the gift of donation: utilising organs for transplant - summary report of the Organ Utilisation Group - GOV.UK Appendix 2 Powerpoint presentation 'Annual Kidney Transplant report.ppt'

1. Purpose

An annual report to inform Trust Board as recommended (point 10) in DHSC guidance as part of output from Steering Group for Organ Utilisation (ISOU) - Recommendation 10 of Organ Utilisation Report.

2. Background

2.1 At a population level, the best treatment for kidney failure in terms of quality and quantity of life is kidney transplantation (when a patient is fit enough).

2.2 Living donor kidney transplantation provides the best outcomes accepting that not all patients have living donors.

2.3 Kidney transplantation undertaken pre-emptively, namely before dialysis is started, is the ideal time to have this surgical treatment.

2.4 North Bristol NHS Trust provide kidney transplantation for local patients (NBT) as well as receiving referrals from non-surgical kidney units at Exeter, Gloucester and Dorchester (appendix 2, slide 2).

2.5 In the last decade there has been a decline in the number of kidney transplants at NBT (Appendix 2, slide 3) and as such we as a region had fallen to a pmp rate (approx..10 pmp/year when removing Plymouth numbers) that was below the national recommendations.

2.6 These data were subject to publication in national reports and conferences (Appendix 2, slide 4 & 5) and in particular highlighted low adult living donor pre-emptive transplant rates at NBT (Appendix 2, slide 6)

2.7 Over the course of the last few years, the directives for organ transplantation in the UK have moved from NHSE and NHS blood and transplant to DHSC on the basis that Trust responsibility for organ transplantation is better for patients and change evolution than departmental responsibility.

2.8 On assuming leadership of transplantation post COVID, our aims (Galliford– nephrology /Turner – surgery – Joint Clinical Leads for Organ Utilisation) was to move us from adult unit undertaking 100-120 transplants a year to 150-160.

2.9 For our catchment population of approx. 2.8m, we aspired to undertake 50 Living donor kidney transplants annually.

3. Annual Report

3.1 It is an exciting time for Transplantation in Bristol. Between April 2023 and April 2024.

3.2 The waiting list for deceased donor transplantation is growing (Appendix 2, slide 7).

3.2.1 Transplant activity is increased (Appendix 2, slide 8 and 9) in both adult and paediatric patients. Summary: There were 134 kidney transplants performed across the City by our expert multidisciplinary team, including 125 adults at Southmead and 9 young people at Bristol Royal Hospital for Children.

3.3 Appendix 2, slides 13-15. We are unit C.

3.3.1 Over the past 7 years our rates of utilisation of organs from deceased donors have risen to be among the best in the country.

3.3.2 Our average waiting times for have fallen to lower than ever before, and given we are not a fast-track unit, considered to be an example of best practice in the UK and likely to be instrumental with national changes in fast track and organ allocation (appendix 2, slide 16).

3.3.3 Thanks to charitable funding from Bristol Kidney Patients Association we have recently acquired a state-of-the-art cold perfusion machine that will increase further the number of organs we are able to utilise for transplant.

4. Summary and Recommendations

4.1 Transplant activity at NBT is in keeping with national targets and local aspirations.

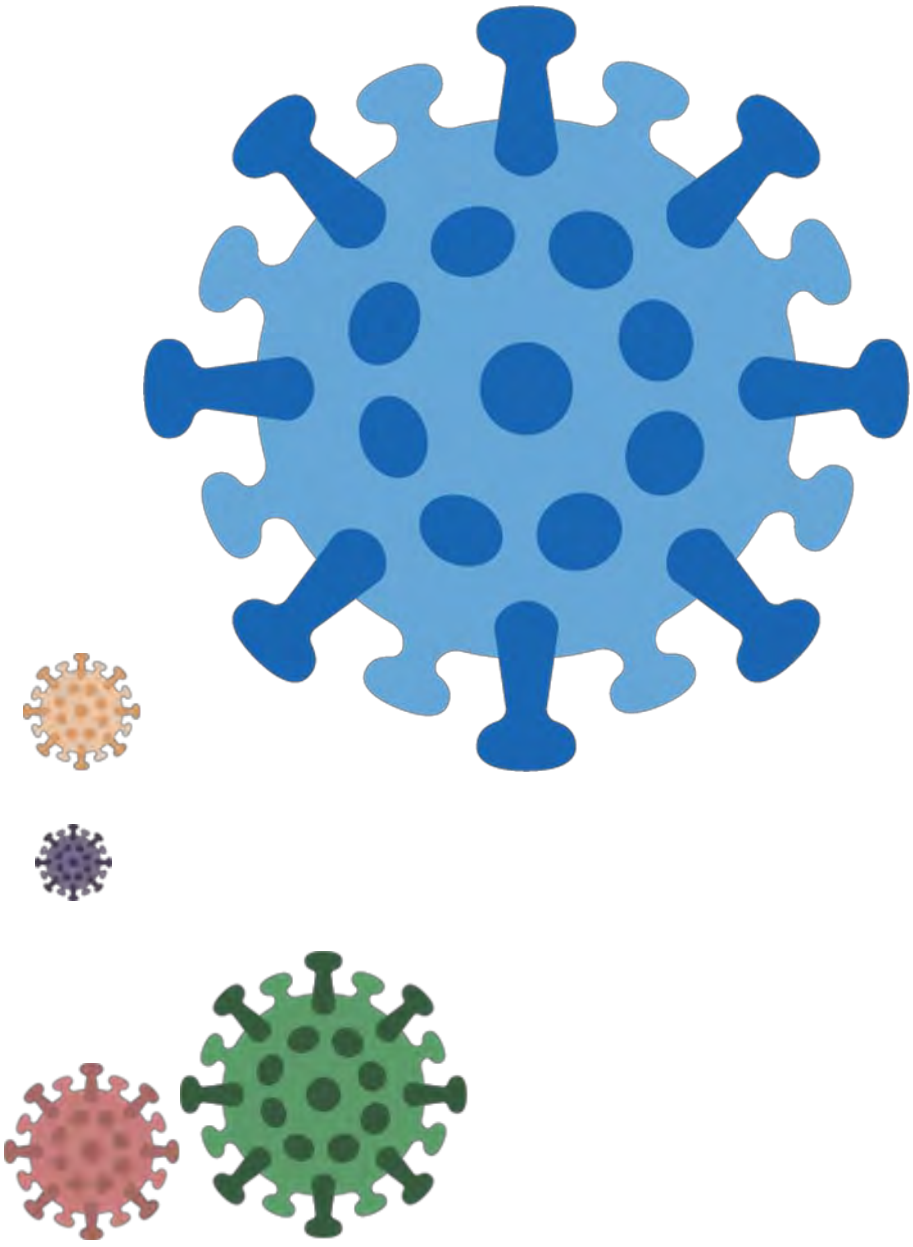
4.2 This annual report and our current organ utilisation strategy fits with the ISOU recommendations.

4.3 We shall continue to work with stakeholders and within the Trust to maintain and/or develop the service.

4.4 Closer links and formal meetings with the Organ Donation team at NBT will unify and allow documentation of an organ utilisation strategy (currently informal).

4.5 Recommendation is approval of local data and annual report to support development of kidney transplant team at NBT at Trust level.

Infection Prevention and Control
Annual Report 2023/24



Contents

Abbreviations

Abbreviations	Full Description
AAR	After Action Review
AMR	Anti-Microbial Resistance
ASG	Antimicrobial Stewardship Group
CCG	Clinical commissioning groups
C difficile	Clostridioides difficile
CDI	Clostridioides difficile infection
COHA	Community onset Hospital Acquired
COIC	Control of Infection Committee
SARS-COV-2	Coronavirus disease 2019
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Payment Framework
DH	Department of Health
DIPC	Director of Infection Prevention & Control
DON	Director of Nursing
E.coli	Escherichia coli
ESBL	Extended Spectrum Beta Lactamase
GDH	Glutamate dehydrogenase antigen of C. difficile
GRE	Glycopeptide Resistant Enterococcus
GP	General Practitioner
HCAI	Health Care Associated Infection
HOHA	Hospital Onset Hospital Acquired
IM&T	Information & Technology
ICS	Integrated Care System
IPC	Infection Prevention & Control
IPCN	Infection Prevention & Control Nurse
IPCT	Infection Prevention & Control Team
MGNB	Multi resistant gram-negative bacilli
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Methicillin Resistant staphylococcus aureus
MSSA	Methicillin Susceptible staphylococcus aureus
NBT	North Bristol NHS Trust
PCR	Polymerase Chain Reaction
PHE	Public Health England
PLACE	Patient-led assessments of the Care environment
PPE	Personal Protective Equipment
RAG	Red, Amber, Green
SSI	Surgical Site Infection
UKHSA	UK Health Security Agency
WACH	Women and Childrens Health

EXECUTIVE SUMMARY

The annual report provides a summary of the infection prevention and control (IPC) activity over the last year and status of the healthcare associated infections (HCAIs) for North Bristol NHS Trust. Infection Prevention and Control is the responsibility of everyone in healthcare and this is successful with strong leadership and collaborative working.

The Chief Nursing Officer is the accountable board member responsible for infection prevention and control and undertakes the role of the Director of Infection Prevention and Control.

The Infection Prevention and Control Committee (COIC) has a function to fulfil the requirements of the statutory Infection Prevention and Control obligations. It formally reports to the Quality Committee, providing assurance and progress via exception reports. All Trusts have a legal obligation to comply with the Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance, which was last updated in December 2022.

The yearly IPC plan, led and supported by the Infection Prevention and Control Head of service, Matron and Infection Prevention and Control Team (IPCT), sets clear IPC objectives for the organization to achieve, with strategies in place to meet the overall Trust strategic mission.

The IPC plan is developed closely with the completion of the new National Infection Prevention and Control Board Assurance Framework, which was launched in March 2023.

Overall, 2023- 2024 was another successful year, meeting some key standards and regulatory requirements for infection prevention and control, but also highlighting key areas for improvement and focus. Below documents highlights for the IPC year: -

- The Trust met the trajectories set for E-coli, Klebsiella and Pseudomonas blood stream organisms for 2023 - 2024.
- MRSA bacteremia cases have been investigated with a full after-action review and MSSA case increase has prompted a trust wide improvement plan with key objectives.
- Themes and trends for infections with *Clostridioides difficile* continued to be monitored and addressed at trust wide steering group, rates were slightly higher than in the previous year.
- We have implemented the IPC Patient Safety Incident Response Framework (PSIRF).
- The Trust continued to develop and adjust our response to the local and national requirements for SARS-COV-2, as we continued to move away from pandemic to endemic guidance ‘living with SARS-COV-2’ plan set out by the government.
- Trust Hand hygiene compliance has remained high and sustained at 97.8%.
- The trust continued to meet mandatory requirements for Surveillance of Surgical Site Infections (SSI) for fractured hip, spine, small and large bowel elective surgery and elective knee replacement.

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- Face to face IPC education and training has continued, combined with an IPC e-learning programme. We have regularly increased our face- to-face training within specific departments, especially when a requirement has been deemed necessary. We have maintained very good compliance with IPC mandatory training.
- Enhanced water monitoring continued to mitigate the risk of pseudomonas and legionella in tap water in high-risk areas.
- Outbreak and increased incident investigations have also been managed and investigated and detailed within this document.

The Trust continues to use ICNet for data management within Infection Prevention & Control.

INTRODUCTION

This Annual Report details the activities undertaken by the Infection Prevention and Control Team (IPCT) from 1st April 2023 to 31st March 2024. The Annual Report provides information on the Trust's progress on the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAIs). The purpose of the report is to provide assurance that the trust remains compliant with the Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance Department of Health, 2015).

The code sets out 10 criterion which are listed in the contents and the report uses these criterions as a guide to provide evidence and assurance.

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

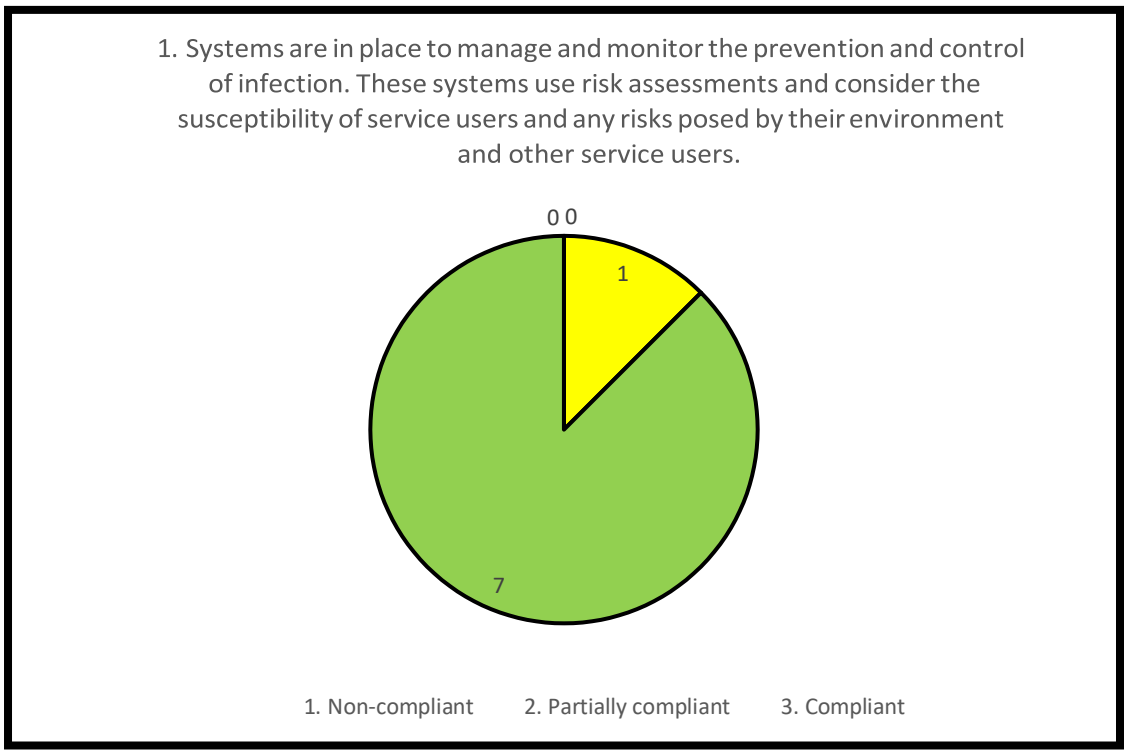
1. Providing advice on all aspects of infection prevention and control
2. Outbreak and incident management
3. Conducting programmes of education
4. Audits targeted on mandatory surveillance
5. Implementation of the National Infection Control Manual
6. Interpreting and implementing national guidance at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

Quality Improvement requires constant effort to seek, innovate and lead practice. The Infection Prevention and Control team epitomizes this quality improvement ethos, and they significantly contribute to achieving our strategic mission:
"Support, educate and empower staff to prevent hospital acquired infection through evidenced based practice and keeping a patient – centered and compassionate approach "
Their support for training and engaging with the clinical teams has been of the highest standard, reflective of the care provided and experience by our visiting public.

The Health and Social Care Act 2008: code of practice on the practice on the prevention and control of infections and related guidance sets out ten compliance criteria. This IPC Annual Report is divided into these criteria, which follow below individually, demonstrating the trust compliance and evidenced assurance in meeting the ten criteria. The IPC Head of Service has completed the IPC Board Assurance Framework, which was issued in March 2023 by NHS England, which enables organizations to respond to an evidenced-based approach to maintain the safety of patients, service users, staff, and others. It enables, supports, and provides an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National IPC Manual and the Health and Social Care act 2008. The IPC yearly IPC plan, within Appendix A, links closely with the IPC Board Assurance Framework, setting out a clear IPC workplan.

The framework enables clear compliance rating pie charts, which are evident within this report below for each criterion. Reduced compliance links with the IPC Plan (APPENDIX ONE).

CRITERION ONE:
Systems to manage and monitor the prevention and control of infections. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them.



Partially compliant 1.7: All staff receive the required training commensurate with their duties to minimise the risks of infection transmission. Tier three of the IPC education framework not rolled out following national guidance but mitigated by all staff receiving yearly IPC mandatory training. The IPC team plan to implement separate face to face training to cover this tier.

CONTROL OF INFECTION COMMITTEE (COIC)

COIC met 6 times during 2023- 2024. It is a requirement of *The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections,* that all registered providers: "*have in place an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks".*

COIC was chaired by the Chief Nursing Officer, Steve Hams, who is also the Director of Infection Prevention and Control (DIPC) or Juliette Hughes, Deputy Chief Nursing officer – Dep DIPC, with the responsibility for reporting to the sub-board Quality Committee for assurance.

DIPC REPORTS TO QUALITY COMMITTEE

The DIPC has presented the following items during 2023-2024:

- Monthly Gram-negative Bacteremia surveillance.
- Monthly *Clostridioides difficile* surveillance.
- Monthly MRSA/MSSA bloodstream infection.
- Outbreak and incident reports.
- IPC Escalation reports following bi-monthly IPC committee meetings.

INFECTION PREVENTION & CONTROL TEAM

Role	Band	WTE	WTE qtr. 4 review
Head of Service IPC / Tissue Viability	8b	1.0	1.0
Matron IPC	8a	1.0	1.0
Senior Nurse IPC	7	1.0	1.0
IPC Nurse	6	2.0 (x2 additional for winter 7 Day service)	3.6
Audit Practitioner	3	0.8	0.8
Team Administrator	4	0.8	0.8
IPC doctor (Medical Microbiology)	Consultant Medical Microbiologist	3.8 Pa	3.8 pa

The IPC team have delivered a service with increased staff numbers this year, due to winter plan investment (6 months), enabling the running of a 7-day-a-week service. This has been positively received by the trust and contributed to a 20% reduction in closed beds due to infections, in comparison with last winter.
The team have continued educational pathways with the Head of Service completing an MSc in infection control and the IPC Matron on a Pg Dip program, with other staff members also completing or studying Pg Dip / Cert in infection control.
The team have trained two new IPCNs this year to cover the 7 days-a-week service, although this resource is not substantive and linked to the winter plan. This is a resource that is hoped will become a substantive position in line with other trusts in the region.

The IPCT works within the structure of the newly developed IPC work plan, which has been developed alongside the ten criterions. (Appendix A)

IPC Implementation of Patient Safety Incident Response Framework (PSIRF)

We have changed the way we review healthcare acquired infections, in line with the Patient Safety Incident Response Framework (PSIRF). The PSIRF sets out the NHS' approach to developing and maintaining effective systems and processes for responding to patient safety incidents, for the purpose of learning and improving patient safety.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

PSIRF

• Advocates a coordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents.

• Embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

The Infection Prevention and Control Team launched the implementation of PSIRF in 2023/2024 and commenced reviewing Healthcare Associated Infections (HCAI) differently, working within the framework to identify learning, recurrent themes and improve patient safety. The below organisms are included in our internal PSIRF Programme;

- Clostridioides Difficile - (HOHA Hospital Onset Healthcare Associated)
- Gram-negative bloodstream infections – (*Klebsiella spp*., *Pseudomonas aeruginosa*, *E. coli* – HOHA cases)
- *Staph aureus* (MSSA and MRSA) bloodstream infections (HOHA cases)

We now hold 'hot debrief' meetings with the ward teams to identify immediate issues and learning. Multi-Disciplinary Team (MDT) and After-Action Review (AAR) meetings are then held to discuss each case that has identified wider learning following the initial IPCT/Consultant Microbiologist review. Other escalation of concerns occurs via COIC, PLACE based partnership meetings and Southwest regional meetings.

HEALTHCARE ASSOCIATED INFECTIONS

This year NHS England updated the trajectory figures for C*lostridioides difficile* and Gram-negative blood stream infections. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.).* The definition of a case is agreed as follows:

- HOHA – Hospital onset healthcare associated – cases detected within 48 hours after admission.
- COHA – Community onset healthcare associated – cases that occur in the community or within 48 hours of admission when the patients have been an inpatient in the Trust reporting the case in the previous 4 weeks.
- COIA – Community onset indeterminate association - cases that occur in the community with admission to the reporting Trust in the previous 12 weeks but not in the previous 4 weeks.
- COCA – Community onset community associated – cases that occur in the community with no admission to the reporting Trust ion the previous 12 weeks.

For the purposes of agreed trajectories HOHA and COHA are now combined in reporting.

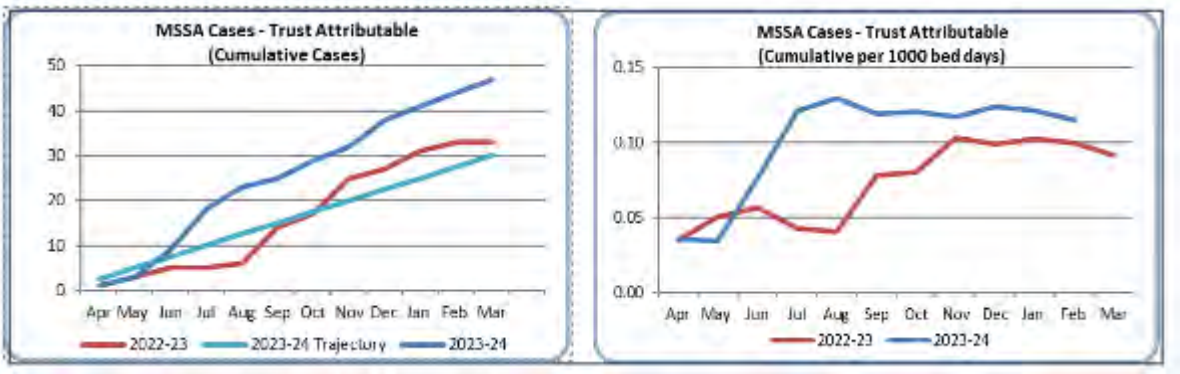
METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) BACTERAEMIA

There were four cases of MRSA bacteremia in 2023/24, this was the same number compared with the previous year.
National trajectory for these infections remains zero.
Each case prompted an individual action plan based upon the lessons learnt. This has been shared and reviewed by the trust and is shared both internally within divisions and externally to clinical commissioners.

METICILLIN *SENSITIVE STAPHYLOCOCCUS AUREUS (MSSA)* BACTERAEMIA

In 2023-2024 there were a total of 47 cases of MSSA bacteremia. No national trajectories have been set for this organism; our internal target was 30.

Increasing case numbers have been noted across the ICB system as well as nationally, prompting a number of workstreams. Amongst them was working with vascular access teams, the NBT IPC team have actively engaged with these.



Trust	12 month Rolling Rate per 100,000 bed days	Ranking
Dorset County Hospital NHS FT	15.7	123/135
Royal Devon University Healthcare NHS Foundation Trust	12.51	96/135
North Bristol NHS Trust	13.95	110/135
Torbay and South Devon NHS FT	9.45	60/135
University Hospitals Dorset FT	11.11	79/135
Great Western Hospitals NHS FT	5.75	15/135
University Hospital Bristol and Weston NHS FT	11.8	89/135
Somerset NHS FT	9.5	63/135
Gloucestershire Hospital NHS FT	7.71	38/135
Royal United Hospitals Bath NHS FT	10.98	77/135
University Hospital Plymouth NHS Trust	13.2	103/135
Royal Cornwall Hospital NHS Trust	8.35	47/135
Salisbury NHS FT	6.9	26/135

This increased rate compared with the previous year formed a specific targeted work programme to focus on a reduction plan, additionally an external audit was carried out by the Assistant Director of Nursing (NHSi) Infection Control lead, commissioned by NBT DIPC.
Recommendations from this report have been implemented as outlined in the MSSA reduction plan (see Appendix two). Depiction of data per 1000 bed days has been added to show the acuity of the trust, as well as supporting the vascular access service and their business case to increase PICC placement provision and promoting right device for intra-venous medication and duration of course.

All Hospital Onset Healthcare Associated MSSA infections have had a PSIRF review, with the results and learning feedback to the steering group and senior leaders within the trust. Quality improvement projects are then driven following these conclusions.

GRAM NEGATIVE BLOOD STREAM INFECTIONS

Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram–negative BSIs by 25% in March 2021 (PHE 2017) and 50% in March 2024 (PHE 2019). In February 2019 it was announced that the date for achieving this reduction has been changed to 2024/2025. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.).*

Mandatory data collection has been in place for many years for *E. coli*. In addition, from April 2017 additional mandatory data collection and surveillance has been in place for *Klebsiella spp. and Pseudomonas aeruginosa. 2023-2024 formal trajectories for gram-negative blood* stream infections were set by NHSE/I.

In 2023-2024 there were a total of 65 positive BSI samples for *E. coli,* which were attributed to the Trust – HOHA & COHA. Noting a slight increase from 2022-2023. A full data collection process is carried out in accordance with UKHSA guidance.

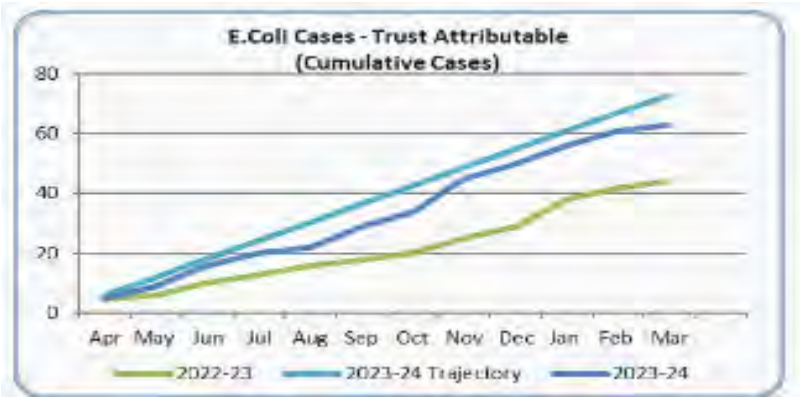
In 2023-2024 there were a total of 16 positive BSI samples for *Klebsiella spp*, which were attributed to the Trust – HOHA & COHA. Noting a slight increase from 2022-2023 data but improvement from 2021-2022 data. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

Key learning from these cases -

- Catheter passport refresh being undertaken by the Continence group
- Introduction of decaffeinated drinks and hydration project work working with new nutrition support workers

The continence group is led by an unfunded resource and has been supported by funds from Continued Professional Development, this will be at risk if not funded with an impact on quality in this area, this is particularly important as NBT are a regional urological centre.

Vaccine trials in Autumn 2023 (Embrace study), exploring the prevention of blood stream infections caused by *E. coli* bacteraemia, has shown some interesting results with a further study expected for autumn/ winter 2024.



In 2023-2024 there were a total of 10 positive BSI samples for *Pseudomonas aeruginosa*, which were attributed to the Trust. Noting a sustained position in cases over the last three years. A full data collection process is carried out in accordance with UKHSA guidance.

CLOSTRIDIOIDES DIFFICILE INFECTION (CDI)

In 2023-2024 *Clostridioides difficile* infection formal trajectories were set by NHSE/I at 75. In total the Trust reported 82 cases detected, of these cases 21 were identified as preventable and learning was implemented trust wide. This data represents an increase in cases from last year, this being 70 cases with a trajectory set at 100.

Each case of *C difficile* identified as attributable to NBT follows a clear governance process, which considers the national guidance for reporting and learning from incidents.
A formal multi-disciplinary post infection review (PIR) is undertaken with peer review and actions from learning occurring at the *C difficile* Steering Group (CDSG), This group has the same strategy as the *Staph aureus* steering group and works as a shared learning experience to review cases, using a PSIRF approach as previously mentioned.

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

Broad spectrum antibiotics are more frequently associated with *C. difficile infection* and both primary and secondary care are meeting the nationally set targets to reduce prescribing of these agents. In primary care the target is to reduce prescribing of cephalosporins, quinolones and co-amoxiclav to less than 10% of all antibiotics prescribed. In secondary care the target is to reduce broad spectrum antibiotic use by 10% from a 2017 reduction. NBT has met this target with a reduction of 11.3%.

OUTBREAKS / INCREASED INCIDENCE OF INFECTION

SARS-CoV-2 (Covid 19) / Influenza

Cases of Covid – 19 have not resulted in any full ward closures in this year.
The infection control team monitor episodes of increased incidence, and contact trace all cases of exposure, advising on the operational opening of beds and moving patients at the earliest opportunity to maintain patient flow. This has become easier to manage with 7 days working with quick discussion making and risk assessment. The use of the HEPA air filtration in Elgar house has also been used to great effect to minimise nosocomial spread.

During winter of 2023-2024, cases of Influenza A and B remained steady in comparison to the previous year. The identification of these cases at point of admission into NBT has been greatly assisted by point of care testing available in our emergency department, which has enabled prompt isolation of patients attending for emergency care and subsequent admission, and therefore reducing transmission in hospital and the occurrence of outbreaks.

In preparation for 'seasonal flu' all Trust staff were offered the annual SARS-CoV-2 and flu vaccine. It is noted that uptake of both of these vaccines has slightly reduced but work is currently being undertaken to increase these levels as well as staff health monitoring and Fit Mask testing.

NOROVIRUS

There have been several episodes of increased incidence of Norovirus in the reporting year 2023-2024. This is against the backdrop of a large incidence of norovirus within the community across the country. All declared outbreaks follow the trust's procedural policy and the IPC lead always carries out a de-brief meeting afterwards with the senior ward leadership team and escalates learning via COIC.

Incident Management

Diphtheria – July 2023

1 case of infection with *C. diphtheriae* requiring contact management for both staff and patients, working with UKHSA and Occupational health. This case linked both NBT and UHBW as the patient had attended both trusts.

Invasive Group A Streptococcal infection (IGAS) -- December 2023

1 case from homeless shelter, MDT approach taken to case management with attendance from UKHSA

Measles preparedness – February 2024

In response to an increase of confirmed cases and outbreaks in the Midlands and London, the following was made ready -

- Clinical guideline for management of measles
- Staff vaccination programme for those who had not received MMR
- Human Normal Immunoglobulin (HNIG) for Measles post exposure prophylaxis

Pertussis – Whooping cough – March/ April 2024

Case management working alongside Occupational health teams investigating cases in WACH community midwife teams and ASCCR. These cases involved contact tracing for both patient and staff as well as post exposure antibiotics and advice not to attend work. These cases were consistent with a national rise of cases at this time, with UKHSA reporting a jump to 180 – 200 cases per week.

Tuberculosis – September 23 – November 24

Several cases requiring investigation, contact tracing and involvement with the Sirona TB team for on-going case management. These cases involved both patients and staff, the staff cases were linked to staff starting prior to completion of all occupational health risk assessments. This fits the national picture of increased cases seen and the requirement to investigate and manage.

CLINICAL AUDIT

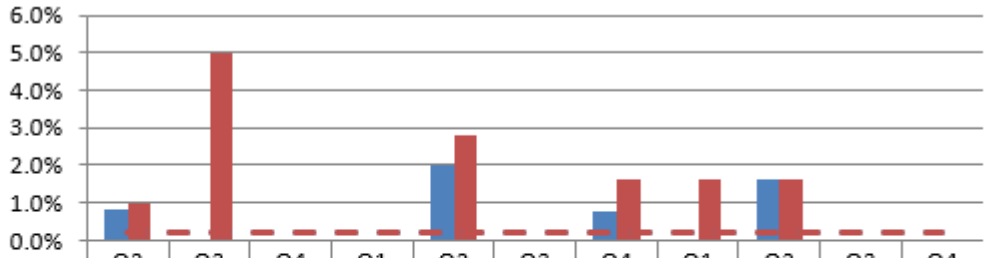
SURGICAL SITE SURVEILLANCE – Report from Maggie Alger and Laura Hughes (Spinal / orthopedic specialist nurse)

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

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

Fig.1

NBT Hip and knee Inpatient and readmission infections



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

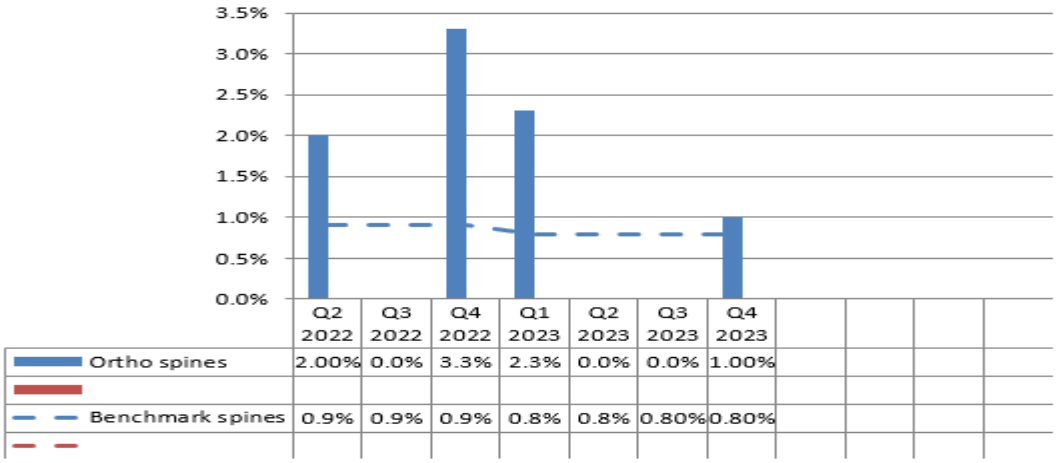
Elective surgical activity has been affected by COVID and most recently by Industrial action in the NHS. Ongoing monitoring of SSI has shown that knee replacement infections remain persistent but over the last 2 quarters have reduced. No hip or knee reportable infections since July 2023. At the time of this report we are still investigating quarter 1 of 2024 (January – March) so no updates as yet. All hip and knee infection cases are investigated by our RCA process based on NICE guidelines and reported to relevant infection leads, microbiology team and to the UK Health Security Agency (UKHSA). No specific patterns have been identified to date. NBT is compared against other hospitals on the readmission and inpatient infections predominantly, but all infection cases are investigated.

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

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

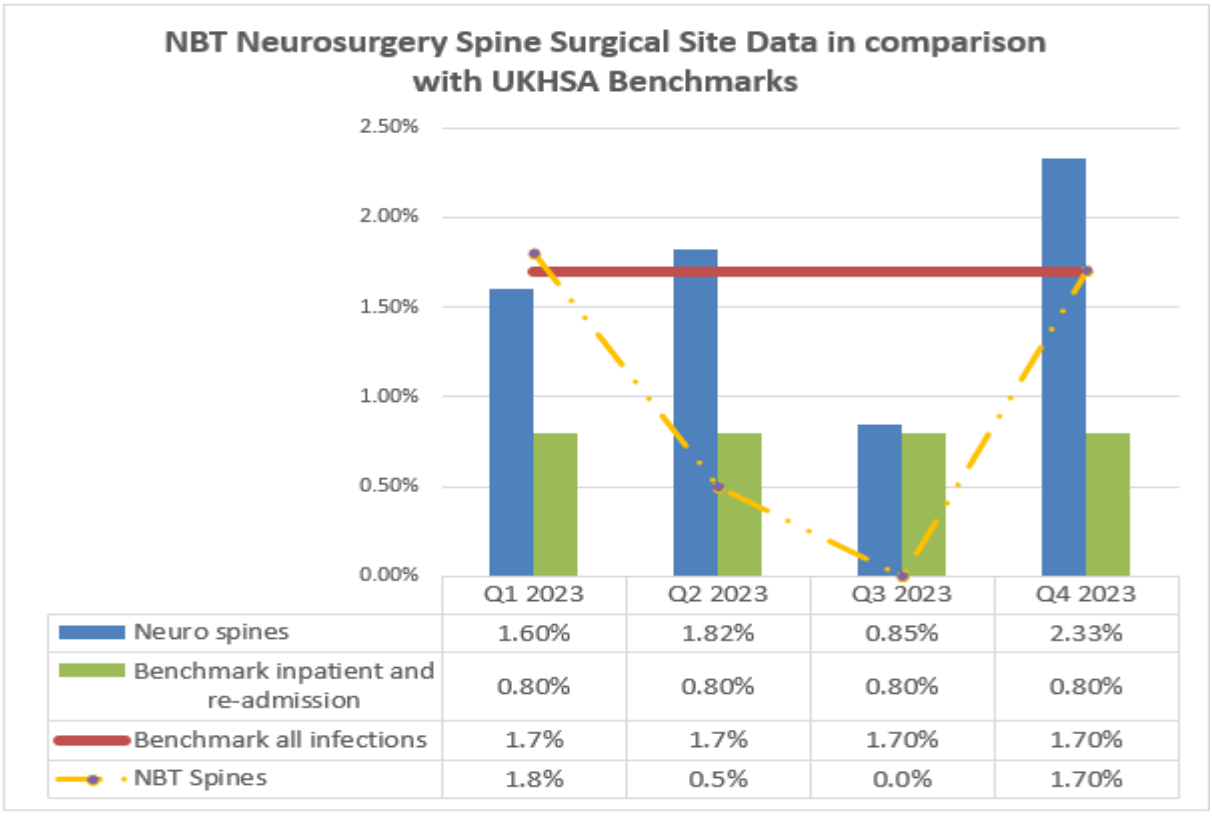
Fig. 2

Ortho Spinal inpatient and readmission infections.



	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Ortho spines	2.00%	0.0%	3.3%	2.3%	0.0%	0.0%	1.00%
Benchmark spines	0.9%	0.9%	0.9%	0.8%	0.8%	0.80%	0.80%

Neurosurgery Infection Data January – December 2023



	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Neuro spines	1.60%	1.82%	0.85%	2.33%
Benchmark inpatient and re-admission	0.80%	0.80%	0.80%	0.80%
Benchmark all infections	1.7%	1.7%	1.70%	1.70%
NBT Spines	1.8%	0.5%	0.0%	1.70%

The total number of neurosurgery spine surgeries included in this surveillance period 2023 equates to 536 procedures, of these there were 8 infections reported. 7 infections were reported as inpatient or re-admissions and 1 infection was patient reported, cared for by their General Practice team. Quarter 3 was not reported to UKHSA due to lack of admin support therefore no data for collective Ortho and Neuro 'NBT Spine' depicted in above chart as zero.

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

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

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

PERIPHERAL VENOUS CANNULA (PVC) AUDIT

PVCs are devices commonly used in acute hospitals, for the administration of intravenous fluids and medication. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The evidence presented in the national guidance suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident or when the PVC is no longer required. Regular monthly auditing to check that all PVCs have visual infusion phlebitis (VIP) score checks completed, has continued this year and remains ongoing.

COMPLIANCE WITH URINARY CATHETER POLICY

Insertion of a urinary catheter is known to be a significant risk factor in the development of urinary tract infections and the risk increases with the duration of catheter insertion. It is therefore important to ensure there is a comprehensive process in place to ensure that the risk of urinary tract infection is considered prior to insertion of the urinary catheter and there is a continuous process for review.

Compliance was measured against the requirement to accurately document indwelling urinary catheter insertion on Careflow as indwelling devices, the audit results are a good starting position with room for improvement as this audit progresses.

CARBAPENEMASE PRODUCING ENTEROBACTERIACEAE AUDIT (CPE)

Carbapenem antibiotics are a powerful group of β-lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been the antibiotics that doctors could always rely upon (when other antibiotics failed) to treat infections caused by Gram-negative bacteria.

In the UK we have seen a rapid increase in the incidence of infection and colonisation by multi-drug resistant Carbapenemase-producing organisms. A number of clusters and outbreaks have been reported in England during 2023 - 2024, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

UK Health Security Agency (UKHSA) recommends that as part of the routine admission procedure, all patients should be assessed on admission for Carbapenemase-producing Enterobacteriaceae status. UKHSA advice was updated in December 2019, and we have a dedicated policy for CPE. It remains that all patients admitted to the Trust must have a

screening risk assessment carried out on admission.

NBT receives repatriated patients from all over the world, but numbers of patients admitted with CPE organisms are relatively few, and proactive screening has enabled most to be identified at time of admission. NBT have worked with the Southwest Critical Care Network to establish core principles for infection prevention and control for hospital transfers and admissions.

Screening for CPE has risen year on year with travel and repatriation from other countries and health care providers. This has an impact on cleaning, as all suspected cases have a 'red clean' with some cases being discharged before a definite result is known. Additionally, with Yeovil Hospital experiencing an ongoing outbreak of CPE case numbers have risen.

Year	Number of CPE tests	Positive cases	Positives from Yeovil
2022/23	140	6	Not recorded
2023/24	250	30	75

NHS England and UKHSA guidance has continued to be reviewed and updated over 2023-2024, ensuring patient and staff safety remains at the forefront of providing healthcare services. The trust response continues to be led by the IPC leads and IPCT, and the trust follows the recommended national guidance.

SARSCoV2 (COVID 19)

Over the past 4 years the IPCT have continued to support the trust throughout the pandemic with updates to guidance in line with Public Health England/UKHSA. The IPCT have also continued to work closely with the BNSSG ICB to share best practice and learn from other trusts in the Southwest region and beyond.

We have declared no SARS-CoV-2 outbreaks between April 2023 and March 2024. This is excellent comparing outbreak figures for other inpatient settings in the Southwest region, especially considering the extremely transmissible nature of SARS-CoV-2 and increased prevalence in the community.

SARS-CoV-2 testing and monitoring and reporting continues to be carried out daily by the IPCT and prompt de-escalation of cases with support from the medical teams, supports our trust's isolation capacity.

INFECTION PREVENTION & CONTROL WEEK - OCTOBER 2023

To celebrate 'International Infection Prevention and Control week' on the 16th – 20th October 2023 the IPCT produced a short training video – "Simple ways you can help us prevent the spread of infection".

The overall aim was to improve staff knowledge and increase awareness of any IPC practice. We also provided a busy week's agenda, which included daily IPC clinics, rep visits and staff training. Many wards within the trust produced poster displays encompassing many different topic areas.

WORLD HAND HYGIENE DAY - May 2023

To celebrate world hand hygiene day, the IPCT visited all the clinical areas, supporting best hand hygiene practice, including reducing the use of gloves, bear below elbow and hand health, along with the addition of emollients on wards with new soap products and

the use of the correct hand washing technique. The IPCT carry out daily ward rounds during the week, and hand hygiene audits form part of this ongoing review process and continued staff engagement with regards to supporting IPC best practice.

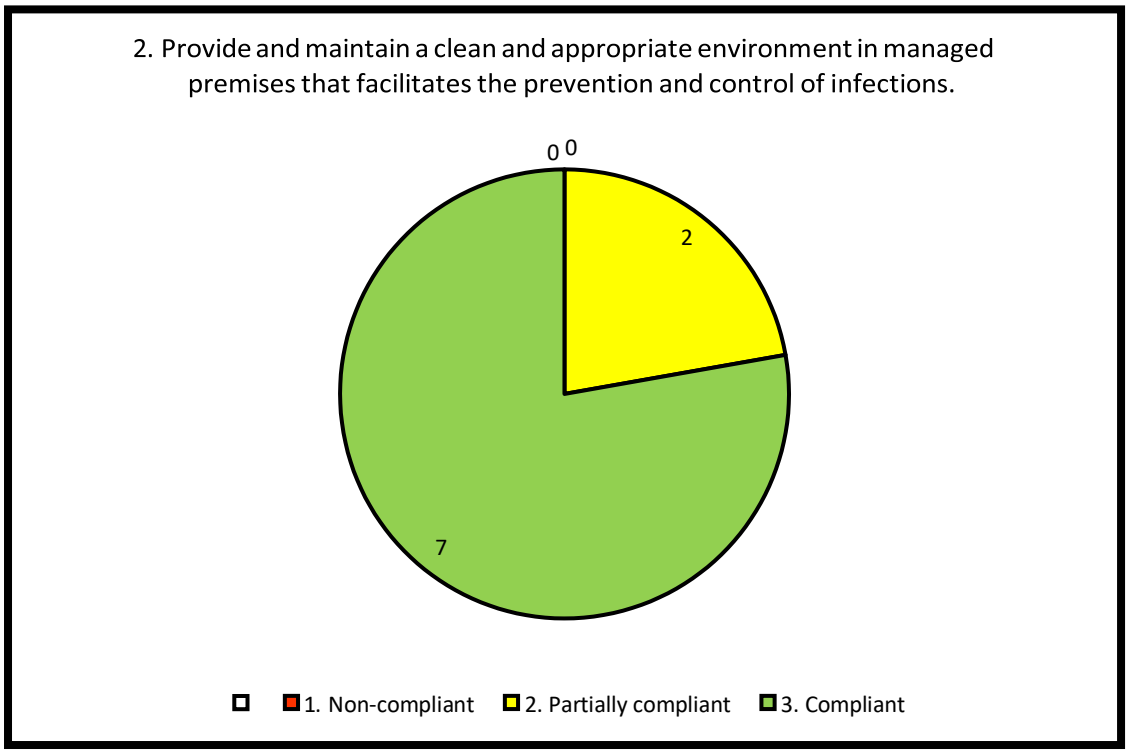
WORLD ANTIMICROBIAL AWARENESS WEEK 18-24 NOVEMBER 2023

IPC team assisted pharmacy colleagues with educational sessions to highlight issues related to the overuse of antibiotics. The stand also attracted members of the pubic in the main atrium.

WORLD SEPSIS DAY – 13TH SEPTEMBER 2023

IPCT worked with clinicians in the emergency zone and as part of NBT's deteriorating patient work, teaching and holding sessions to discuss early sepsis management.

CRITERION TWO:
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.



Partially compliant: 2.4 There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. Several ongoing risks exist in ventilation specifically in WACH. 2.4.2 Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.

ESTATES REPORT

WATER QUALITY- Daniel Perham (Maintenance Manager)

The Estates Team are responsible for maintaining the Trust's water systems, across the main hospital site and satellite properties, and reporting status to the Water Safety Group (WSG) and Control of Infection Committee. Provisions for water safety are independently audited with the trust's third party Authorised Expert for water safety – Alan Hanbridge.

Policy & Governance

The Water Safety Group meets and discusses the Brunel Building – monitored by Equans and the Retained Estate NBT facilities team.

Adhoc meetings are in place for adverse weather and connect to EPRR contingency plans.

Risks

There are currently no risks above a score of 12 for Water Management on the risk register.

- Level 6 (Gate 10A) Risk 1806 (score of 8) increased risk of Legionella due to domestic hot water temperature not being consistently kept above 55 degrees, Equans are working to determine the cause of the problem and resolve, additional flushing and monitoring are in place. A diagnosed replacement of return pipework to upgrade to 22mm pipework is being investigated. This has been ongoing for 8 months.
- Heat pump project connections completed; commissioning is nearing completion.

New Properties

The acquisition of additional properties and capital projects have presented some challenges. Measures to mitigate the various problems have been identified and are being implemented.

VENTILATION – Daniel Perham Maintenance Manager / Authorised Engineer

The Estates and Equans team continue to carry out routine inspections and maintenance on all ventilation systems and formal validations on all Theatre and Critical Areas in compliance with HTM 03-01 Part B and carry out remedial work where required.

Risks

There are currently 3 x Ventilation Trust Level Risks, (detailed in the table 1 below) which are reviewed regularly and discussed at Risk Management Group:

- 2 x risks scored at 20 (No 1418: CDS Theatres and risk 1587 specific to chiller provision to Path 1 and Path 2).
- 1 x risk scored at 16 (No 1420: NICU AHU).
- A working group has been set up to plan rebalancing works for the Cat 3 lab specific to the Pathology AHU 2a, 2b and 2c.
- Verification dates have been booked with Approved Air (specialist contractor) for Retained Estate AHU's.
- NICU – VSG discussing possible dates for access to update the inverters for the AHU's.

DECONTAMINATION SERVICES REPORT - **Robert Longstaff Quality Manager Decontamination Facilities**

STERILE SERVICES DEPARTMENT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN ISO 13485:2016. The department is also registered with the Medicines and Healthcare products Regulatory Agency (MHRA).

As a result of Brexit there are some ongoing changes in regulatory requirements. The Medical Device Directive has transferred to the Medical Device Regulation UK MDR 2002 (as amended); our Notified Body that was based in Sweden as an EU Representative has been transferred successfully after a transitional audit to a UK based competent. The Accreditation held by the service continues to give quality assurance on the products produced.

Services currently planning for Elective Care Centre planning to open Spring 2025

RISK

There is currently 1 x risk with a score of 12 for the decontamination service detailed on the risk register.

- Risk 1646: there is a service delivery issue as the theatre instrument washers have been utilised 24/7, which has expedited their lifecycle replacement programme. A plan to replace 5 x washers and 1 x Sterrad low temperature unit is being collated, with a funding stream identified.
- Risk 1705: (a score of 9) There is a risk of loss of sterilising function for equipment required for surgical procedures, due to Sterrad Low Temperature Steriliser machine reaching end of service life. (this is part of a life-cycle Capital replacement project)
- There have been No Major Non-Conformances reported for this period.
- The BSI audit carried out on the 18th of December 2023, detailed 11 x minor non-conformances. An action plan was created.

Facilities Cleaning Report – Sharon Andrews Operations Manager FM Operational Services

The Facilities Team (FM) continues to take a collaborative approach to ensure the healthcare setting is a clean and safe environment for everyone using its facilities. Working collaboratively with clinical teams and the Infection Prevention Control Team, FM continue to deliver a cleaning programme in line with National Standards of Healthcare Cleaning 2021, providing both in hours and out of hours cleaning support. Cleaning regimes are constantly reviewed and amended to ensure that areas are serviced in line with increased activity in today's dynamic environment.

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

Data below gives represents Red/Amber Cleans requested, all areas where known infection has been present.

	Apr 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
No of Red/Amber Requests	1480	1222	1564	1280	1666	1700	1474	1695	1679	1753	1652	1857

National Standards of Healthcare Cleanliness

A digital audit platform provides a detailed report on current cleanliness and supports education and driving improvement. Audits are made up of 3 areas of responsibility giving a combined overall score. All elements are reviewed, and clinical teams are invited by an FM auditor to join the audit.

Frequency of auditing is compliant with National Standards of Healthcare Cleanliness Functional Risk Categories. Each audit produces a star rating which is a combined score result from Domestic, Estates and Nursing. Maximum is 5 Star (Excellent) to 1 Star (Poor).
Monitoring these results continues to provide education and development, ensuring staff responsible for cleaning have the ability and support to maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections. A score of 3 star or below generates an Action Plan with all parties involved in the improvement plan.

Facilities Rapid Response Team continue to support weekly C-Diff reduction plan, ensuring sluices in wards where IPC confirm C-diff patients are located are red cleaned, and UV decontamination carried out to support and prevent cross contamination. This FM Team clean all areas where known infection has been present. In addition, FR1 Areas - ICU and Theatres, receive a 6 monthly UV Decontamination.

Standards of cleaning are monitored through the audit process, the frequency of which is determined through the functional risk category assigned in accordance with the national standards, in consultation with our IPC colleagues. The frequency can be changed, for example in a period of increased incidence of infection or when there are other concerns as to the standard in any area. These standards also set a timetable for the rectification of failures based on the risk category. Standards are further monitored through reports received from PALS, the environmental audit process and through PLACE. Feedback is given to staff on the areas from these audits, cleaning standards have been maintained with highlighted issues being remedied in acceptable timescales.

Internal Monitoring

The Facilities team monitor the cleaning standards through audits. The frequency of these audits is dependent on the new functional risk categories to which the area is assigned, and these vary between weekly and annually. The timescale for rectification, by the cleaning, estates, and nursing teams, of failures is also dictated by this categorization and by the potential IPC risk.

Star ratings are being assigned for display instead of the percentage of cleanliness

achieved, rated from 5 to 1 star. The percentage needed to achieve the five-star status is also linked to the functional risk category. Should an area receive 3 stars or less than a list of remedial actions is followed to ensure that the area is brought back up to and remains at standard.

Efficacy Audits

Facilities and the Infection Prevention and Control Team have devised the process for trust wide efficacy audits to be in line with the National Standards for Healthcare Cleanliness. The efficacy audit is a management tool to provide assurance that the correct cleaning procedures are consistently delivered to satisfy IPC and safety standards. These audits inform the healthcare organisation that correct training, IPC, health and safety, and safe systems of work are being used. We also identify any estates jobs that are required during the audit and monitor standards such as the general appearance of staff and hand hygiene. These audits also focus on the process of cleaning rather than its outcome to ensure that standards are maintained in the process and not just the outcome.

These audits are conducted by the IPCT, plus a representative from facilities and estates. All clinical areas have been risk stratified to provide assurance of our process for the schedule of our efficacy audits, but each clinical area is reviewed at least yearly or more frequently if concerns.

The results are fed back to the ward lead and matron to acknowledge good practice and address poor service and actions required to drive continuous improvement.

PLACE

We once again carried out a Patient Led Assessment of the Care Environment, (PLACE) in the autumn of 2023.

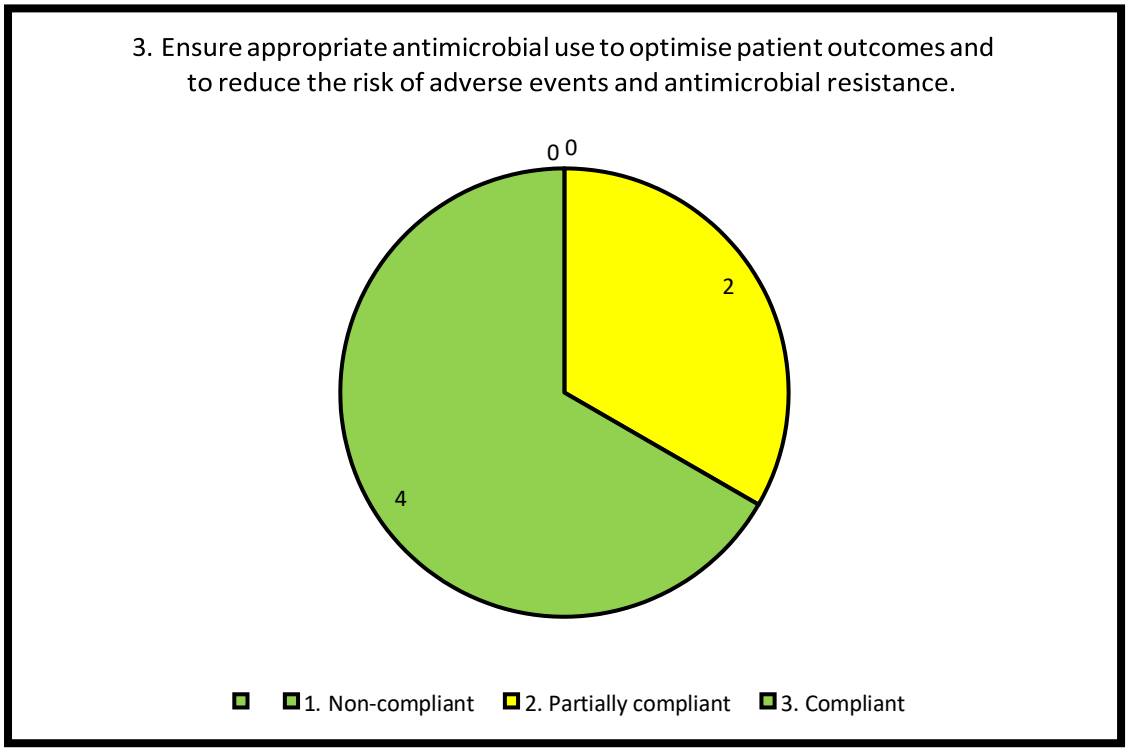
PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The questions are focused around 6 domains, the relevant ones for this report being the cleanliness and condition of the buildings.

It should be noted that the PLACE findings represent a snapshot of the areas as they were found on the day, and the good scores in these domain areas are a testament to the hard work of the facilities, housekeeping, and wider estates teams as they strive to maintain the environment with stretched resources.

Cleanliness – 96.13%

Condition – 96.76%

CRITERION THREE: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.



Partially compliant: 3.4 Antimicrobial stewardship systems and processes for effective antimicrobial medicine use or treat antibiotic responsibility, guidance and education – Mitigation - The current dedicated staffing resource for AMS in NBT falls substantially below that of local Trusts, the national average, and that recommended in national best practice standards. Additional AMS resource is needed to make effective and sustained improvements to AMS and support improvements in performance, patient safety and patient outcomes.

3.6 Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)

Mitigation: Antimicrobials: Summary report for Additional AMS resource is needed to make effective and sustained improvements to AMS and support improvements in performance, patient safety and patient outcomes. This risk has been added to the risk register and has been added to the Core Clinical cases for investment 2024/25 financial year 2023/24**.**

Christine Sluman (Lead Antimicrobial Pharmacist)

Overview

Antibiotic resistance is recognized as one of the major public health challenges. NBT's antibiotic stewardship programme is focused on implementing the recommendations in the Department of Health publication "Start Smart Then Focus: Antimicrobial Stewardship Kit for Inpatient Care Settings" (SSTF).

The NBT Antimicrobial Stewardship and Prescribing Policy provides standards for and informs all staff of their responsibilities in the safe, effective and appropriate prescribing of antimicrobials within the Trust, along with information on the Trust's Antimicrobial Stewardship management systems and reporting.

NBT complies with the following SSTF recommendations:

- An Antimicrobial Stewardship (AMS) committee
- Evidence-based antimicrobial prescribing guidelines
- Annual AMS action plan
- Monitoring documentation of indication and duration/review date
- Monitoring documentation of antimicrobial review at 48-72 hours
- Monitoring adherence to local antibiotic guidelines
- Monitoring antibiotic consumption trends
- Auditing adherence to SSTF principles at least annually in all clinical areas

NBT does not comply with the following recommendations in SSTF:

- A ward-focused AMS team which should include the AMS pharmacist and consultant microbiologist or ID specialist that report to the AMS committee or equivalent. The ward-focused team would be expected to review patients receiving antimicrobials at ward level as part of multi-disciplinary AMS ward rounds to ensure they are receiving the most appropriate care.
- Evidence of monitoring of the time between the onset of sepsis related hypotension and administration of appropriate antimicrobials.
- A multi-disciplinary QI or audit programme for AMS

All health and care workers involved in prescribing, dispensing and administration of antimicrobials receive induction and appropriate training in prudent antimicrobial use and the principles of AMS.

AMS staffing under-resourcing and lack of electronic prescribing present significant barriers to proactive antimicrobial stewardship interventions in NBT.

Trust-wide antimicrobial point prevalence audits were undertaken in May and November 2023. Results and key messages from the audits were discussed at the Antimicrobial Stewardship Group, and Drugs and Therapeutics Committee. Feedback was received that it would be helpful if results were available at specialty level as well as divisional to better target areas for improvement, and this has been actioned in the June 2024 audit.

These audits demonstrated poor documentation of stop dates on inpatient charts, which has been an ongoing theme since March 2020. An amendment was made to the antimicrobial section of the inpatient drug chart in 2023 to include a box for "review date" as well as "duration" to encourage documentation, however, this appears to have had little impact. The introduction of an Electronic Prescribing and Medicines Administration (EPMA) system in NBT provides an opportunity to address some areas of poor performance in these audits.

There has been a steady increase in restricted antibiotic approval which is very positive, as these are largely either those that are very broad spectrum and hence high risk for causing infection with *Clostridioides difficile,* or antimicrobial resistance, or are reserved to treat resistant infections.

		Jun 2024	Nov 2023	May 2023	Nov 2022	May 2022	Mar 2021	Mar 2020
Patients on antibiotics		32%	29%	34%	31%	31%	28%	32.9%
Number of antibiotic prescriptions		335	284	313	296	298	263	283
Route (PO/IV/Other)		48%/50%/ 2%	40%/59%/ 1%	41%/59%	43%/57%	40% / 60%	39% / 61%	43% / 57%
IV route still appropriate		91%	90%	90%	90%	95%	90%	
Duration stated on chart		69%	63%	68%	69%	65%	77%	84.5%
Indication stated on chart		88%	87%	86%	87%	87%	83%	88.7%
Compliance with guidelines		96%	94%	89%	90%	94%	91%	89.4%
Restricted antibiotics		28%	32%	34%	33%	29%	22%	17%
Restricted antibiotic approved		94%	93%	81%	79%	87%	81%	80%
Evidence of 72-hour review		85%	82%	89%	92%	83%	89%	94%
WHO AWaRe	Access	53%	53%	49%	46%	53%	46%	
	Watch	37%	38%	43%	47%	40%	47%	
	Reserve	4%	5%	6%	3%	4%	7%	

Contract and CQUIN performance.

The NHS standard contract for 2023/24 contained requirements for trusts in England to reduce use of broad-spectrum antibiotics (defined as the WHO “Watch” and “Reserve” categories) by 10% against 2017 calendar year baseline.
With no capacity to undertake proactive actions such as antimicrobial stewardship wards rounds and education, many actions taken in NBT were restrictive in nature.

The official performance data up to Q3 (rolling 4 quarters, includes Q4 23/24) shows NBT has demonstrated an 8.8% reduction against the 10% target.
For context, only 3 out of the 14 trusts in the Southwest, and 30 out of 131 Trusts in England, were achieving the target reduction in this data.

It is worth noting that NBT adopted a new Outpatient Parenteral Antimicrobial Therapy (OPAT) service in December 2021. This service has increased broad spectrum antibiotic usage but without being offset by admission days (denominator) as patients are outpatients. If OPAT antimicrobial usage is removed from the data to allow a fairer comparison with the 2017 baseline, this gives a locally calculated year end position of a 13.4% reduction. The expanding virtual ward services will impact on the ability of the Trust to deliver any future reductions based on a pre-virtual ward baseline.

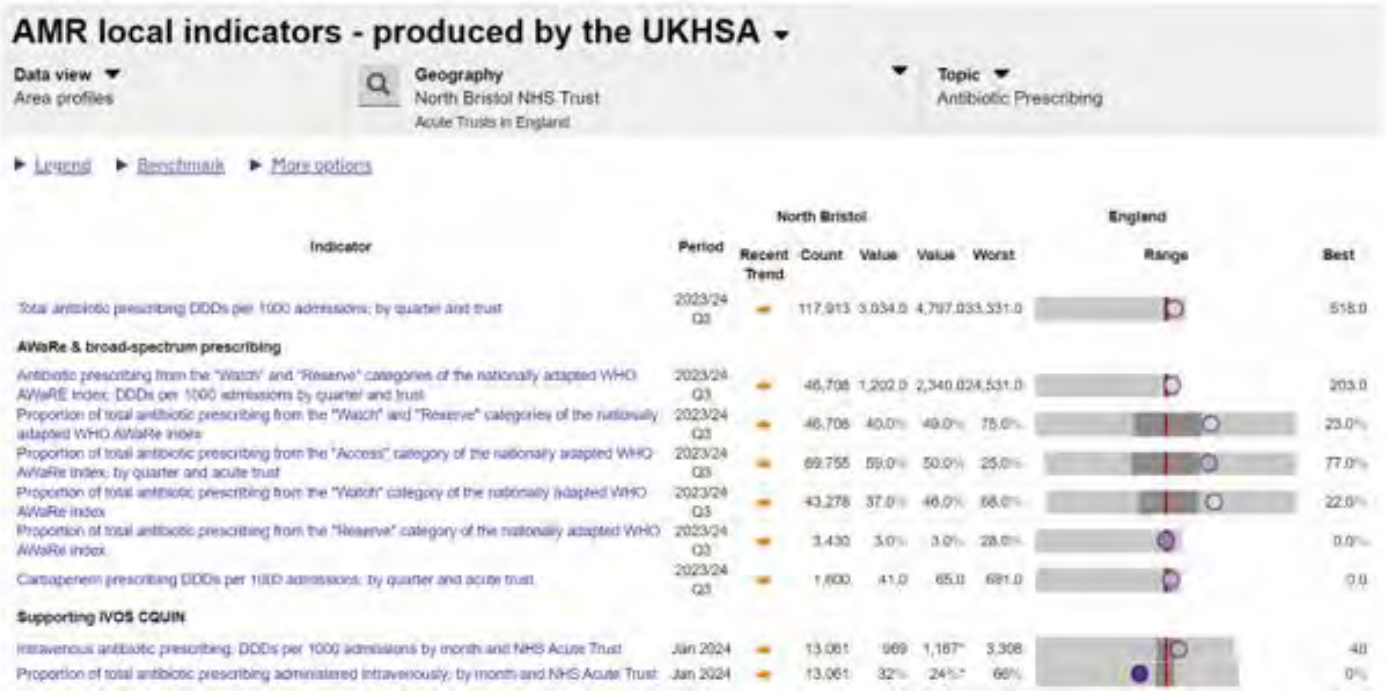
NBT adopted a CQUIN for 2023/24 looking at timely switching of patients from IV antibiotics to oral. The target was to achieve 60% or fewer patients still receiving IV antibiotics past the point at which they meet oral switching criteria. NBT performed extremely well, averaging 9% for the year. For official data up to Q3, NBT were 13th out of 117 English trusts.

Comparative data

Comparative information with other trusts is available on the Public Health England Fingertips website. For 2023/24 Q3, of all trusts in England, NBT had the fifth lowest total

antibiotic usage adjusted for admissions, and the lowest in the Southwest.

NBT benchmarks as the trust with the highest proportion of antibiotics administered intravenously (versus other routes) in the Southwest. However, when looking at the volume of IV antibiotics we use, adjusted for admissions, we sit towards the top of the 25th-75th percentile nationally.



AMR local indicators - produced by the UKHSA

Data view: Area profiles | Geography: North Bristol NHS Trust, Acute Trusts in England | Topic: Antibiotic Prescribing

▶ Legend ▶ Benchmark ▶ More options

Indicator	Period	Recent Trend	North Bristol Count	North Bristol Value	England Value	England Worst	England Range	England Best
Total antibiotic prescribing DDDs per 1000 admissions; by quarter and trust	2023/24 Q3		117,913	3,034.0	4,797,033,531.0			518.0
AWaRe & broad-spectrum prescribing								
Antibiotic prescribing from the "Watch" and "Reserve" categories of the nationally adapted WHO AWaRE Index; DDDs per 1000 admissions by quarter and trust	2023/24 Q3		46,708	1,202.0	2,340,024,531.0			203.0
Proportion of total antibiotic prescribing from the "Watch" and "Reserve" categories of the nationally adapted WHO AWaRe index	2023/24 Q3		46,708	40.0%	49.0%	75.0%		23.0%
Proportion of total antibiotic prescribing from the "Access" category of the nationally adapted WHO AWaRe index; by quarter and acute trust	2023/24 Q3		69,755	59.0%	50.0%	25.0%		77.0%
Proportion of total antibiotic prescribing from the "Watch" category of the nationally adapted WHO AWaRe index	2023/24 Q3		43,278	37.0%	46.0%	68.0%		22.0%
Proportion of total antibiotic prescribing from the "Reserve" category of the nationally adapted WHO AWaRe index	2023/24 Q3		3,430	3.0%	3.0%	28.0%		0.0%
Carbapenem prescribing DDDs per 1000 admissions; by quarter and acute trust	2023/24 Q3		1,600	41.0	65.0	681.0		0.0
Supporting IVOS CQUIN								
Intravenous antibiotic prescribing; DDDs per 1000 admissions by month and NHS Acute Trust	Jan 2024		13,061	969	1,167*	3,308		40
Proportion of total antibiotic prescribing administered intravenously; by month and NHS Acute Trust	Jan 2024		13,061	32%	24%*	66%		0%

In summary:

- Our volume of total antibiotic use is very low.
- Of our total antibiotic use, a large proportion of this is given IV.
- Our volume of IV antibiotic use adjusted for admissions is above average (positive position) nationally.
- Our CQUIN performance provides reassurance that, despite a high proportion of our total antibiotic use being IV, that this is appropriate.

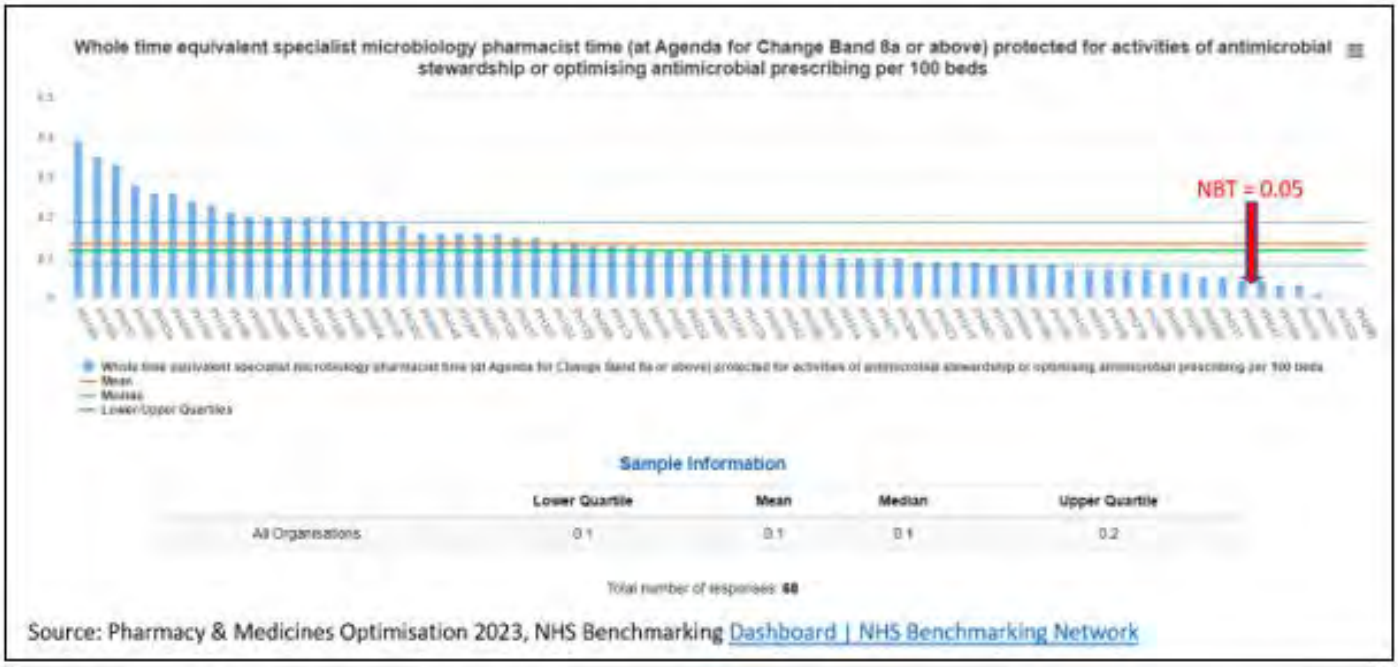
Other AMS activities.

- A review of the NBT antimicrobial formulary was completed in July 2023.
- Collaborative working with UHBW to start alignment of antimicrobial guidelines across organisations.
- Four Antimicrobial Stewardship Group meetings were held in 2023/24. Additional representation was secured from Urology and Infection Prevention and Control.
- Face-to-face education on AMS was delivered on F1 and F2 induction sessions.
- Participation in the thematic review on allergy incidents in NBT.
- Representation on the trust and ICB deteriorating patient groups.

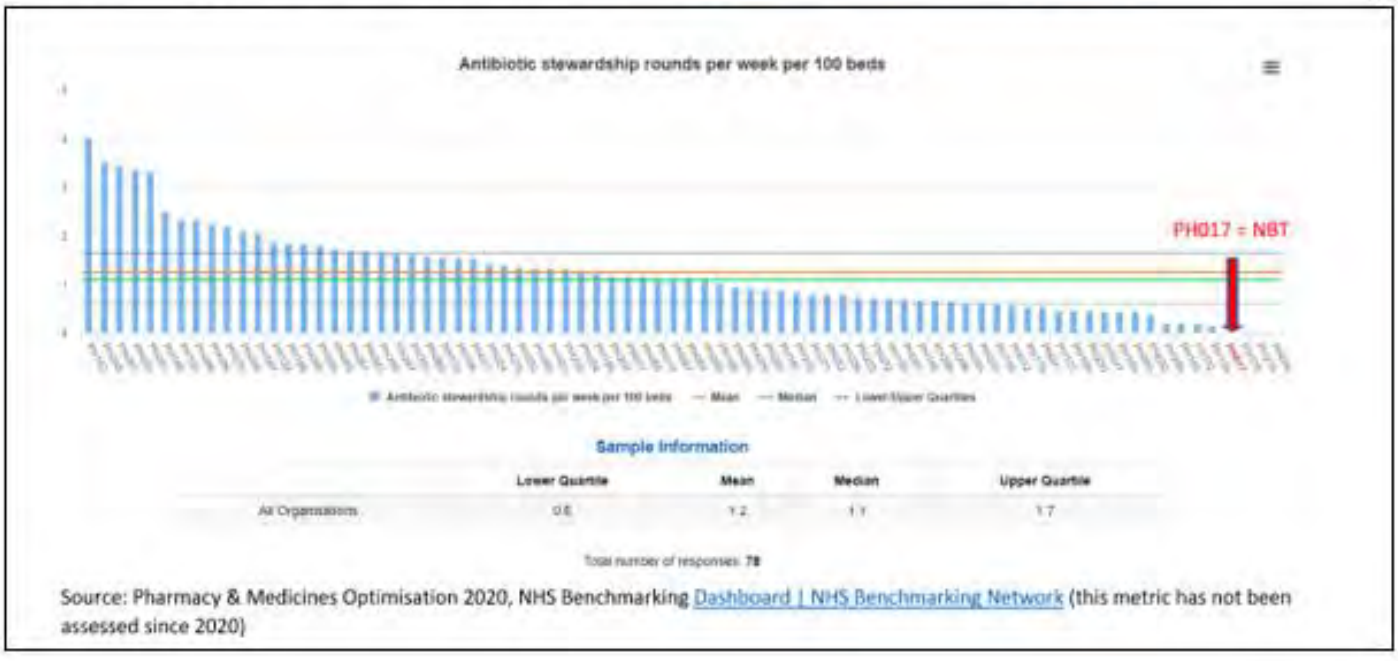
- Education sessions on beta-lactam allergy developed in conjunction with the allergy and immunology team and delivered on F1, F2 and NMP education sessions.
- Engagement with the EPMA build to optimise AMS opportunities.
- Development of stand-alone gentamicin and vancomycin prescribing charts supported by detailed protocols (pending ratification).
- Initiated a workstream to raise awareness on risks of gentamicin ototoxicity.

AMS resourcing

NHS benchmarking data shows protected antimicrobial pharmacist time in NBT for activities of antimicrobial stewardship to optimise antimicrobial prescribing (0.05WTE per 100 beds) to be significantly below the national average. This severely limits stewardship activities that can be undertaken, and challenges attainment of targets related to stewardship. A case for investment to expand resourcing for AMS in NBT was submitted in January 2024 – outcome awaited.



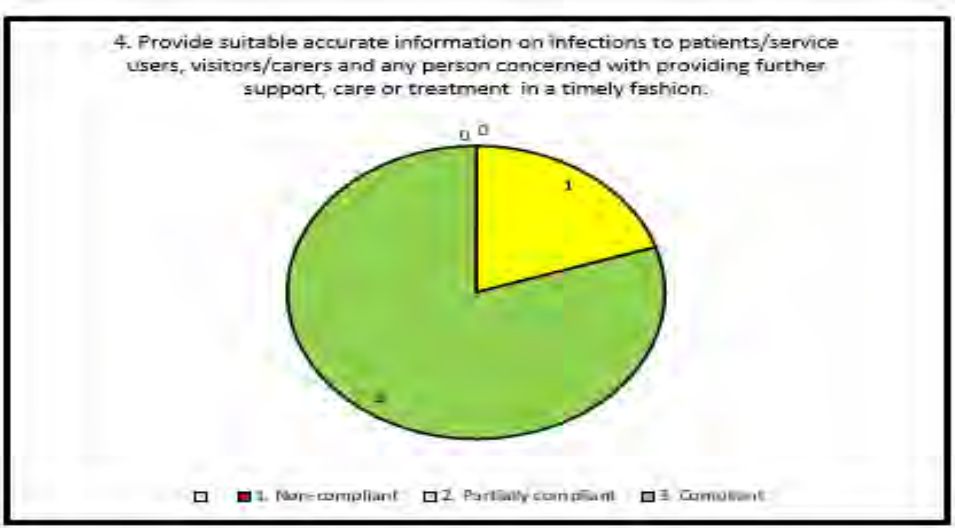
Source: Pharmacy & Medicines Optimisation 2023, NHS Benchmarking Dashboard | NHS Benchmarking Network



Source: Pharmacy & Medicines Optimisation 2020, NHS Benchmarking Dashboard | NHS Benchmarking Network (this metric has not been assessed since 2020)

Additional investment in AMS resourcing is essential for NBT to deliver the outcomes set out in the UK 5-year action plan for antimicrobial resistance 2024 to 2029.
In addition, whilst implementation of EPMA in NBT presents potential opportunities for AMS, realisation of this will require significant input from the AMS team. The team is also engaging with the AMS and EPMA teams in UHBW to align opportunities and processes across both organisations.

CRITERION FOUR: Provide suitable accurate information to patients/service users, visitors/carers and any person concerned with providing further support or nursing/medical care in a timely fashion.



Partially compliant – 4.2 Information is appropriate to the target audience, remains accurate and up to date, provided in a timely manner and easily accessible format.

Mitigation - Work being undertaken from a sustainability perspective in how we deliver patient information.

The IPC Team work closely with the clinical site managers, ward leads, ward staff and facilities services, and attend all bed meetings throughout the day to support patient placement and cleaning requirements. Infection control flags are added to CareFlow patient records as applicable to all newly identified infections.

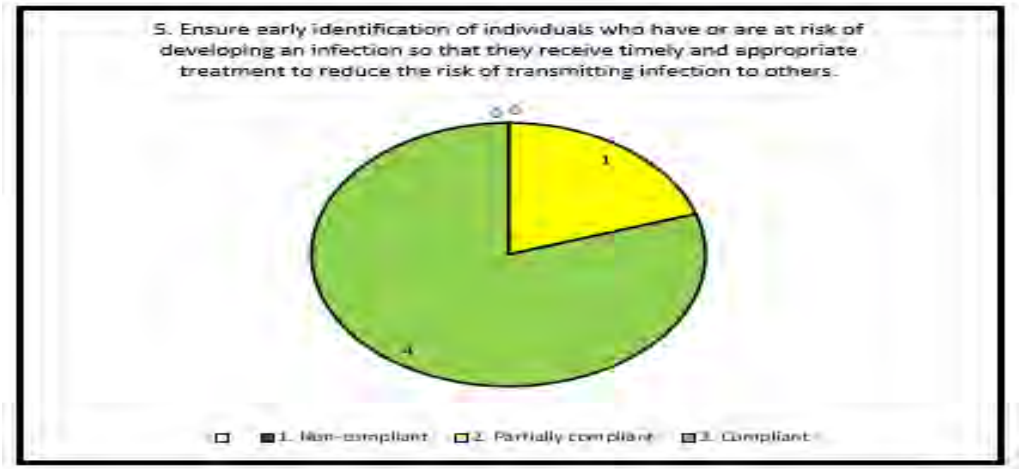
The IPC team visit in person all newly diagnosed patients with MRSA/ MSSA bacteraemia and CDI infections, providing the patient with an information leaflet, discuss the diagnosis and answer any questions.

The IPC Team work closely with the communications team and together we update staff via email and all staff bulletins when new guidance is implemented. Wealso have a dedicated IPC section on the trust intranet site, which is updated regularly, especially when any guidance changes are implemented. Additionally, we review the IPC information leaflets regularly and work towards a more sustainable way to deliver these messages.

The IPC team monitor all CDI and potential CDI infections daily and include an in-depth weekly review of patients, escalating concerns to medical teams, wards, and consultant microbiologists.

The IPCT work closely with the IPC ICS to identify the needs of the local population and develop strategies collaboratively to ensure joined up working. We also have Steering groups that act as a post infection review meeting to share learning and raise concerns.

CRITERION FIVE: Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infections to others.



Partially compliant 5.1 Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other.

Mitigation – ongoing work with Baxter the supplier of ICNet to ensure all components are delivered following new version upgrade.

The use of ICNET allows the IPC team and clinical site managers out of hours to be alerted to any new alert organisms or existing alert organisms. The IPC team are regularly reviewing these patients.

The Trust is able to demonstrate that responsibility for infection prevention and control is effectively devolved to all professional groups by means of inclusion in all job descriptions and mandatory inclusion in appraisal documentation, including for medical staff.

The IPC Team are involved in the management of outbreaks and periods of increased incidence. The IPC team monitors all alert organisms to identify trends and potential links between cases based on their location. If links are identified, a Period of Increased Incidence (PII) investigation is commenced and a weekly meeting to discuss potential cases is held as soon as possible. This task is greatly aided using ICNET.

Outbreak management.

In 2023/2024 - 0 outbreaks of *C Diff*, 4 Norovirus outbreaks and 0 SARS-COV-2 outbreaks were declared during this time frame. All outbreaks are discussed for the purpose of shared learning and service development.

For each outbreak, the IPC team produce a report, which is noted and discussed at ICMG / COIC, and the IPC lead specialist nurse conducts a de- brief following a Period of Increased Incidence or outbreak.

Recurring themes from these investigations are disseminated through the IPC Committee meetings. Action plans that are put in place by the ward manager and/or matron are supported and monitored by the IPC team for compliance.

CRITERION SIX: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Partially compliant: 6.2 The workforce is competent in IPC commensurate with roles and responsibilities.
Mitigation: Tier three of the IPC education framework, covered by mandatory training. The IPC team plan to implement separate face to face training to cover this tier.
6.4 Staff are trained in the selection of PPE.
Mitigation: PPE moving to a cooperate service rather than divisional – in the atrium.

EDUCATION

The Infection Prevention & Control Team continued to provide formal and informal face to face education training sessions for both clinical and non-clinical staff. IPCT have also been incorporated into the following teaching programs and all the nursing team were involved in delivering the sessions.

Mandatory IPC Training for clinical and non-clinical staff has been also offered via an online e-learning workbook. Overall compliance with mandatory IPC training over the year has remained very high for clinical staff. Compliance is part of the yearly appraisal review process for all members of staff. The Divisions are responsible to release staff to access their training.

The IPCT continue to provide extra training to specific groups of staff as and when necessary, this has included Allied Health Professionals, Porters, housekeeping staff etc. The team have also supported yearly training in areas that may be required to care for patients with a suspected or confirmed High Consequence Infectious Disease (HCID). This includes the correct PPE donning and doffing procedures to further protect themselves in their working environment.

The IPCT are currently working towards ensuring we are achieving the educational recommendations within the National IPC Educational Framework. This sets out a vision for the design and delivery of IPC education for staff that will support effective and safe care. The framework will support and enhance the skills and expertise in our existing workforce and deliver a positive impact for all learners, our people, educators, patients in our care and our populations. The learning outcomes are a minimum expectation and do not preclude additional outcomes being developed. There are

three tiers, which are incremental, building from tier 1 to tier 3.

We are currently fully achieving mandatory training for tier 1 and tier 2, and we are working on a new educational programme to achieve tier 3, suitable for staff who are responsible for an area of care. We plan that this tier will involve yearly face to face training and include a large antimicrobial stewardship (AMS) element.

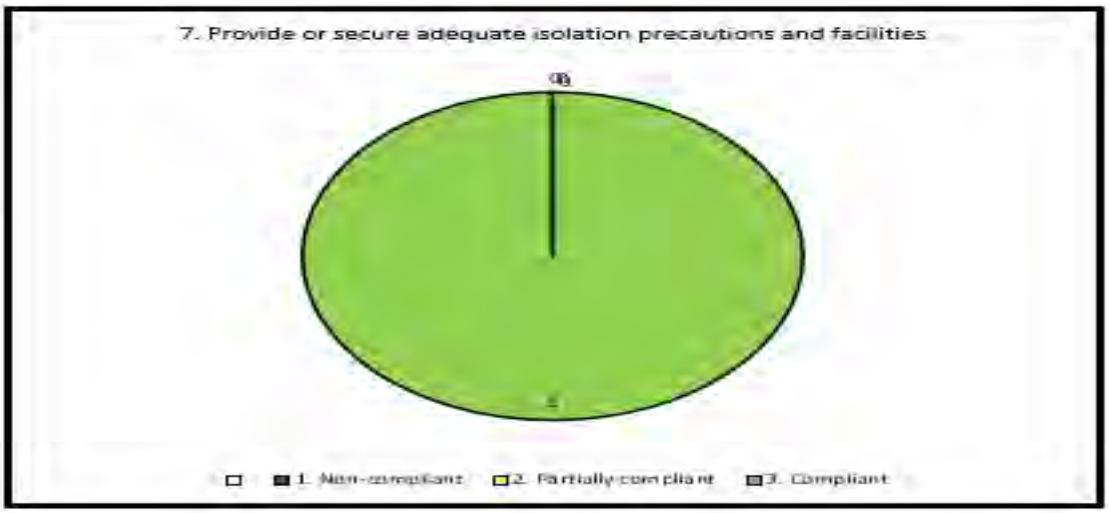
The IPC team continue to carry out daily ward rounds; during these ward rounds we support staff, monitor practice, provide advice, and provide continued IPC education.

FACE MASK FIT TESTING

Fit testing has declined in numbers over the past two years. After many clinics being added and offered to staff, the uptake has been minimal. It is a growing concern, now that the pandemic has eased, that staff are not making the effort to be fit tested even though it is a legal requirement.

The fit mask testing coordinator has escalated this via the IPC committee meeting and has been supported by divisional leads. The fit mask testing coordinator continues to improve fit mask testing compliance across the trust, particularly focusing on areas with higher risk as we move into 2023-2024. This is supported by the location in the atrium.

CRITERION SEVEN: Provide or secure isolation facilities.



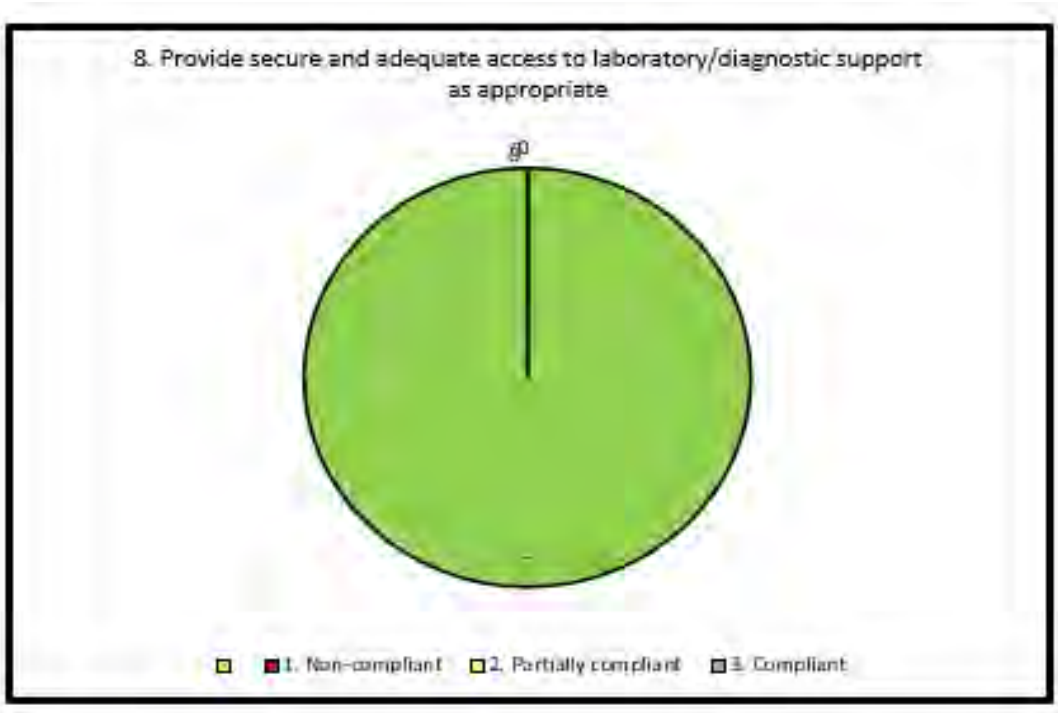
ISOLATION

NBT has 70% single bedrooms against the standard bed base. There are no recent statistics to compare this figure to the national average within acute trusts. This percentage does not impact the ability to isolate patients according to the national guidance, the National Infection Prevention and Control Manual for England 2024.

Multiple occupant risk assessments are used when placing patients in shared areas, with the concept of cohort nursing patients during high prevalence of certain infections such as Flu A, SARS-CoV-2, which the IPCT continue to suggest, support, and provide guidance on, when necessary.

Additionally negative pressure rooms are available in AMU, ID and ITU and will be used in by Infectious Diseases as part of establishing a new Respiratory HCID unit in 2024/2025.

CRITERION EIGHT: Secure adequate access to laboratory support as appropriate.



MICROBIOLOGY LABORATORY UPDATE

The laboratory services are located on site, there is a provision of seven-day laboratory working and 24-hour access to microbiology and virology advice, including 24-hour Point-Of-Care Testing in ED for COVID and influenza, with other POCT equipment on wards.

The IPC team have a close working relationship with the Microbiology Consultants, we have weekly hand over meetings and board review of Mandatory reportable HCAI twice per week.

The microbiology consultants are extremely busy, but still find time to assist the IPC team and we link closely together; there is a dedicated microbiology consultant as the IPC Doctor, and we have other members of the team specializing in AMS and Decontamination.

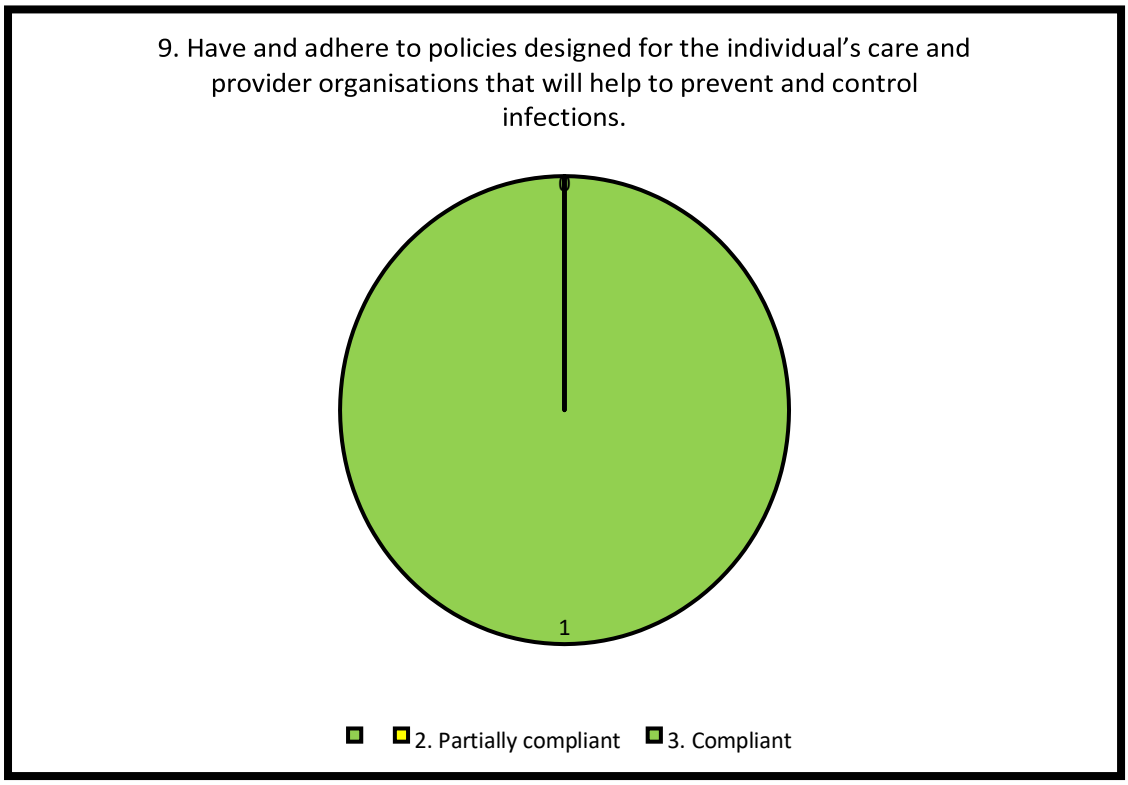
This year has seen the rise of two vaccine preventable diseases (Measles and Whooping Cough).

A significant amount of additional work has been seen in the lab through the public health testing aspects of Measles and Whooping Cough from within the hospital and across the areas of Bristol we serve.

Laboratory Team members have been working for some time with our Blood Culture System vendors and Pathology IT to be able to generate blood bottle volume data to drive optimal bottle fill volumes through feedback and education. The first data set in which we can identify the originating wards against average fill volumes has been encouraging and the picture across the Trust will become clearer as more culture bottle sets are received.

In the next year there will be some changes to enteric testing for stool samples and the management of C Diff.

CRITERION NINE: Have and adhere to policies designed for the individuals care and provider organisations that will help prevent and control infections.



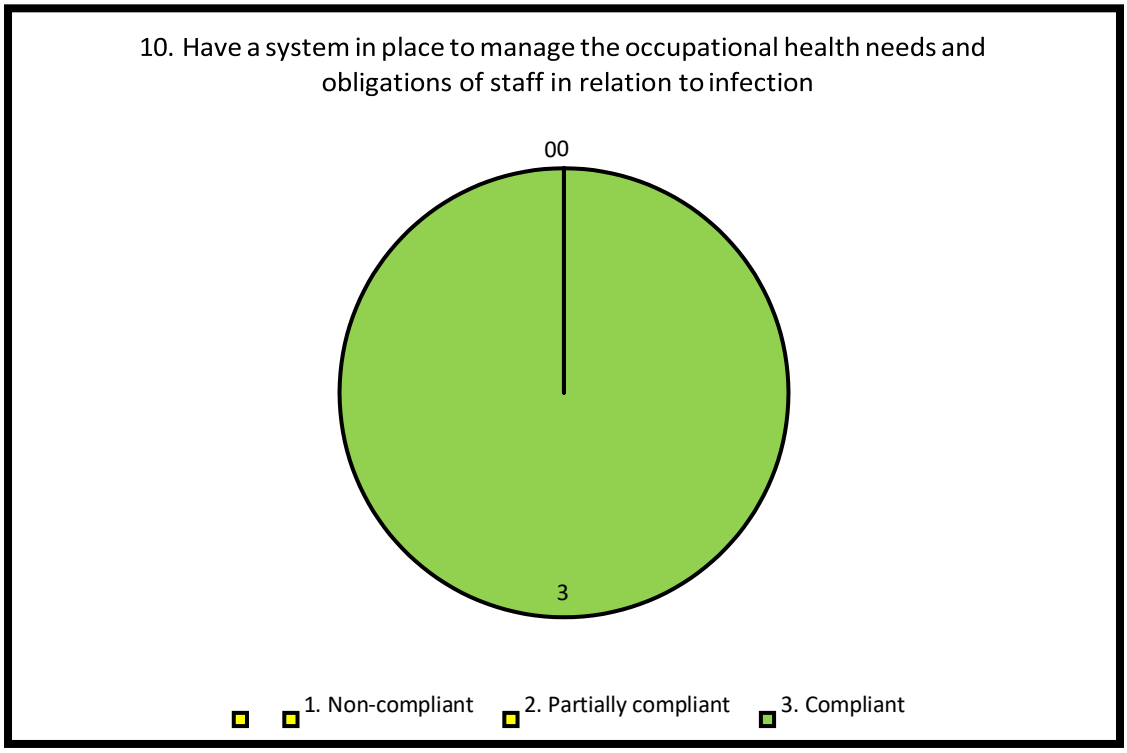
POLICY DEVELOPMENT/REVIEW

There is a comprehensive list of Infection Prevention and Control policies, procedures, and guidance on the trust intranet. These policies are reviewed by the IPCT and relevant specialties and link to the National Infection Control Manual. These documents are evidence based and reflect national guidance. Compliance is audited with key policies as detailed in Criterion one.

The following policies have been developed / reviewed / removed during the year 2023-2024:

Transmissible Spongiform Encephalopathies (CJD/vCJD)
Infection Prevention & Control Policy – Linked to National manual in conjunction with UHBW – IC01 Chapter 1 Governance Chapter 2 National Infection Prevention and Control Manual Chapter 3 A – Z of Clinical Guidelines Chapter 4 Outbreak Management
Avian Influenza - Infection Prevention and Control Advice for Management of Patients with Suspected
Clostridioides difficile Diarrhoea Policy
Carbapenemase Producing Enterobacteriaceae (CPE) - Policy for the Assessment and Management of Patients with
Norovirus and Infectious Diarrhoea Policy - Management of Standard Precautions – Infection Control
Measles

CRITERION TEN: Have a system in place to manage the Occupational health needs and obligations of staff in relation to infection.



OCCUPATIONAL HEALTH REPORT – Julie York / Karen Smith Lead OH Nurses

Occupational Health have worked with the IPC Team on a variety of cases that have required contact tracing, there has been a great development of some fast-track results in *Pertussis* cases, working with the UKHSA labs.

Contamination Injuries report

Occupational Health Service

Type of Injury (expanded Jan 2023)	2020	2021	2022	2023	2024
Bite	3	3	3	2	0
Blank/Incomplete	2	1	4	24	4
Hollow bore needle	199	187	204	111	16
Safety needle/cannula (hollow bore)					6
Razor Blade				0	0
Scalpel/blade				8	2
Solid needle				10	0
Scratch	10	21	6	17	3
No injury					1
Splash eye	27	32	28	27	4
Splash mouth				0	1
Splash skin				0	1
Stitch cutter				0	0
Surgical instrument (inc. dental)				17	1
Suture				18	7
Unknown from clinical waste				5	1
Total	**241**	**244**	**245**	**239**	**47**

Occupational health has been challenged by COIC to look at CI Reduction program and have been working with Health and Safety to pick up themes and trends to aim for reductions in 2024/25, these are likely to be driven by the implementation of Safe smart sharps system.

CONCLUSION

Last year has continued to be a challenging year for IPCT, as we continually strive to reduce healthcare associated infections, which has remained a priority for the trust; ensuring our patients, staff and the public are kept safe. The work of the IPC team remains unpredictable, and I would like to thank all the team for their hard work, dedication, and positive attitude throughout the year.
The team successfully implemented the IPC Patient Safety Incident Response framework, completed the IPC Board Assurance Framework, and linked our compliance with the Annual Plan.
We have seen a rise in MSSA blood stream infections and implemented a reduction plan linking both regionally and nationally.

This report demonstrates the continued commitment of the trust and demonstrates the success and service improvement through the leadership of a dedicated and committed IPC team. Infection Prevention and Control is the responsibility of all the Trust employees and the IPC team do not work in isolation. The successes over the last year have also only been possible due to the commitment to infection prevention and control of all NBT staff, ensuring IPC is high on everyone's agenda.

The annual IPC plan for 2023-2024 reflects a continuation of support and promotion of IPC. Looking forward to 2024-2025 we will strive to maintain high standards within IPC and continue to develop strong Antimicrobial Stewardship, ensuring our staff maintain a high level of compliance with IPC. A robust governance structured approach across the whole organization will remain crucial in the prevention of all healthcare associated infections.

Throughout 2024-2025 the IPC team will continue to strengthen and support close working relationships with the IPC Integrated Care System, Regional and National IPC groups, especially the continued work with sustainability.

The trust remains committed to preventing and reducing the incidence and risks associated with HCAIs and recognises that we can do even more by continually working collaboratively together with colleagues, patients, service users and carers to develop and implement a wide range of IPC strategies, quality improvement projects and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Sarah Wheatley
Head of Service IPC and TV

REFERENCES

Department of Health (2015) Health and Social care Act 2008, Code of practice on the prevention and control of infections and related guidance, Available at: Health and Social Care Act 2008: code of practice on the prevention and control of infections , Accessed 15.04.2023

National Infection Prevention and Control manual for England (2022), NHS England » National infection prevention and control

APPENDIX ONE

Infection Prevention and Control Annual Plan

April 2024 to March 2025

Sarah Wheatley, Head of Service Infection Prevention & Control and Tissue Viability

Written:

IPC Optimisation Programme 2023 to 2024

Introduction

The programme will be monitored through the Infection Prevention and Control Committee with an annual progress report presented to the Quality Committee and be incorporated within the annual report. Each work stream / action is RAG rated as follows:

Fully completed.

Partially completed with actions still to be completed, but due for completion with timescale.

Not completed, unlikely to be completed within timescale or significant risks to compliance.

The Key Objectives have been identified from the completion of the IPC Board assurance framework, which aims to demonstrate compliance with the Health and Social Act 2008 and the Ten Criteria outlined in the Act. The objectives have been identified as partially complaint and therefore an area for development or improvement.

Key Objectives

Objective 1: Education - This objective links to the new IPC education framework and compliance with Tier three of the IPC education framework. Tiers 1 & 2 are to be reviewed but expected to be already covered by the IPC mandatory training. The IPC team plan to implement separate face to face training to cover tier three, this is planned to be implemented with UHBW.

Linked to Criterion 1 IPC BAF – 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may post to them, specifically – 1.7 All staff receive the required training commensurate with their duties to minimise the risks of infection transmission and Criterion 6 IPC BAF Appendix 1 – Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection, Specifically, - 6.2 The workforce is competent in IPC commensurate with roles and responsibilities.

We will do this by:

- The IPCT reviewing the recommended learning outcomes for Tier 1 & 2, plan to use Skills for health package.
- The IPCT to review the recommendations of Tier 3 and plan an implementation training programme to encompass all the learning outcomes. This will be largely but not inclusively relevant for all staff who are responsible for an area of care.
- The IPCT will liaise with all ward leads and Matrons to ensure compliance with the IPC education framework.

Objective 2: Patient Safety - This objective links to the reset of IPC compliance following the SARS-CoV-2 pandemic, supporting leaders to find innovative ways to improve staff compliance with the National IPC Manual for England.

Linked to Criterion 1 IPC BAF – 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them, specifically – 1.4 – They implement, monitor, and report adherence to the NIPCM.

We will do this by:

- Developing a QI project to reset IPC practice and compliance in four key areas: Improve hand hygiene, all staff to have the confidence and ability to challenge poor practice, glove reduction, improve use of peripheral Venous catheters, in line with the continuation of MSSA improvement programme.

Objective 3: Compliance - The IPCT will liaise with specific departments to ensure robust governance structures are in place to ensure close links, demonstrating IPC assurance and departmental collaboration. This will feed into IPC Committee meetings, highlighting areas of concern and demonstrating clear escalation processes.

Linked to Criterion 2 IPC BAF – Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections, specifically IPC BAF sections 2.3 – There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleaning standards, 2.7 – The classification, segregation, storage etc. of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal, and 2.9 – Food hygiene training is commensurate with the duties of staff as per food hygiene regulations. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations, and Criterion 3 IPC BAF Appendix 1 – Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance, specifically IPC BAF sections 3.5 – Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including:

- Total antimicrobial prescribing
- Broad-spectrum prescribing
- Intravenous route prescribing
- Treatment course length, 3.6 – Resources are in place to support and measure adherence to good practice and improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)

We will do this by:

- The IPCT attending all relevant committee meetings and providing IPC support and guidance when relevant.

- The IPCT will request and remind departments for their reports for discussion and review, with recommendations and presentation at the bi-monthly COIC meetings.

- The IPCT will liaise with AMS trust lead and AMS microbiologist to support the role and support the planned QI improvement programme within this specialty.

Objective 4 – Patient Safety - The Implementation of PSRIF (Patient safety Incident Response Framework) within IPC and within the wider Integrated Care system (ICS) for BNSSG using this framework to review reportable infections whether they be COCA (Community Onset Community Associated), COIA (Community Onset Indeterminate Associated), COHA (Community Onset Healthcare Associated) or HOHA (Hospital Onset Healthcare Associated) cases.

Linked to Criterion 1 IPC BAF – 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users

and any risks their environment and other users may pose to them, specifically IPC BAF sections 1.3 – That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.

We will do this by:

- The IPC ICS team to work closely together with the aim of moving away from Post Infection reviews of all COHA & HOHA CDI and MSSA bloodstream infections, using a Hot Debrief strategy to get learning at ward level in a timely fashion.
- MRSA blood stream infection cases will be subject to a full review for this year due to a zero-trajectory.
- The new process will involve each division in the organization bringing cases to the monthly meetings for discussion and identifying any lesson learnt. Each division will carry out a comprehensive review of the patient's experience to include all healthcare interventions.

Objective 1 – Education							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
1.1 Ensure NBT achieves Tier 1 & 2 of the IPC education framework.	All Staff complaint with their IPC education framework	• IPCT to check IPC framework against trust IPC e- learning module.	• Monitor trust compliance with IPC mandatory training.	Sarah Wheatley / Jane Searle with UHBW IPC Leads	September 2024	IPC skills for health modules in place for Tier 1 and 2	G
		• IPCT to check IPC framework against trust IPC face to face training.	. Continue a teaching programme at divisional level, link ambassador level. Consultant updates and induction of new medical staff .	Sarah Wheatley / Jane Searle / Isabel Baker	September 2024	New programs in place with Housekeepers – Jane Searle Re-developed video for new medical teams – Sarah and Isabel	

Objective 1 – Education							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
1.2 Ensure NBT achieves Tier 3 of the IPC education framework	All Staff responsible for an area of care are complaint with their IPC education framework Tier 3	• IPCT to review the learning outcomes and devise a training plan appropriately.	• System in place.	Sarah Wheatley and Trevor Brooks (UHBW)	January 2025	Programme to be in place by early 2025	A
		• IPCT to review a behavior change approach, as suggested the COM-B model, and identify was to implement.	• Understand the model and implement with the training programme	Sarah Wheatley	January 2025	Programme to be in place by Early 2025	A
		• IPCT to link with other specialist teams to support the training programme.	• System in place and all leaders attend the training yearly.	Sarah Wheatley / Jane Searle	January 2025	Programme to be in place by Early 2025	A

Objective 2 – Patient Safety							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
2.1 Reset of IPC compliance, supporting leaders to find innovative ways to improve staff compliance with the National Manual for England.	IPC compliance improves across the trust.	• IPCT to develop ways to improve IPC compliance across the trust.	• IPCT re written policies, linking to the national manual with chapters for ease of reference. • RADAR, BadgerNet, BI data used to look at compliance and areas for improvement	Sarah Wheatley	September 2025	Completed and shared at COIC Augus 2025.	**G**

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
3.1 The IPCT will liaise with specific departments to ensure robust governance structures are in place to ensure close links with other key departments related to IPC, supporting IPC assurance and agreement.	IPCT support housekeeping with their compliance, with regards to national cleaning standards.	• IPCT to liaise closely with housekeeping teams and support Audits	• Efficacy audits • PLACE	Jane Searle	Ongoing Jan 2025	PLACE Ongoing and carried forward for 24-25	G
	IPCT supports the water safety, ventilation safety Group with IPC compliance.	• IPCT to liaise closely with Daniel Perham the Trusts Authorizing Officer • IPCT to attend the Water Safety Group meetings and link closely when concerns are raised. Emergency planning adverse weather plan	• Clear escalation plans • Close monitoring of water safety and these should feed into COIC / ICMG Additional Flushing in retained estate	Sarah Wheatley / Jane Searle Sarah Wheatley / Isabel Baker	April 2024	Reevaluation of The TORS escalation and risk register review Ongoing work	G

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
	IPCT supports the Ventilation safety Group with IPC compliance.	• IPCT to liaise closely the Trusts Ventilation Authorising Officer. • A ventilation update for all COIC meetings. • IPCT to attend the Ventilation Safety Group meetings and link closely when concerns are raised.	• Clear escalation plans • Close monitoring of Ventilation reports and these should feed into ICMG/ COIC	Sarah Wheatley / Isabel Baker	April 2024	Reevaluation of The TORS escalation and risk register review Ongoing work	G
	IPCT support an effective antimicrobial stewardship in accordance with local and national guidelines	• Antimicrobial Stewardship action plan to be written. • IPCT to support the National point Prevalence Survey of HCAI and Antimicrobial use in England.	• Action plan submitted to Antimicrobial Stewardship Committee	Sarah Wheatley / Christine Sluman / Roshina Gnanadurai	July 2024 – still ongoing	Antimicrobial stewardship Plan being created	G

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
	IPCT support the Decontamination Group with IPC compliance.	• IPCT to liaise closely with Decontamination Lead. • IPC to request a decontamination update for all COIC meetings. • IPCT to support the decontamination lead in their role	Quarterly meetings	Rob Longstaff	September 2024	Changes in senior staff in decon supported by IPC in 2024	G

Objective 4 – Patient Safety							
Issue	Desired Outcome	Action(s)	Evidence/Assurance	Lead(s)	Target Date	Update	**RAG**
4.1 The Implementation of PSIRF (Patient safety Incident Response Framework) within IPC and the wider Integrated Care system (ICS) for BNSSG	• NBT IPCT to review and develop strategy for PSIRF implementation.	• Lead IPC to compare NBT PSRIF IPC implementation vs other trusts for ideas and lessons learnt	• Attend workshops	Sarah Wheatley	September 2024		G
		• Develop a process for IPC to collaborate divisions to review HCAI infections in a steering group • Once PSIRF plan agreed – implement process and review progress	• Present a plan for the implementation of PSRIF. Review at Steering Group with feedback from Divisions	Sarah Wheatley Sarah Wheatley	September 2024 September 2024	IPC - PSIRF plan developed and shared across divisions	G G

	System wide process for the implementation of PSIRF and develop a new Post Infection review Process.	• PSIRF to be implemented systemwide during all PIR meetings.	• Close working with the wider BNSSG system and develop an implementation programme.	IPC ICS BNSSG system	April 2024	New process in place and under review for improvement. Including the use of ICNET results page to enable better initial reviews.	**G**

APPENDIX TWO

North Bristol NHS Trust

Staphylococcus aureus blood stream infection reduction plan – July 2024

NBT has seen an increase of cases of blood stream infections (BSI) with methicillin sensitive *Staphylococcus aureus* (MSSA) in 23/24. This is in line with increases that have been seen both regionally and nationally. As a result of the regional rising cases, NHSE Southwest developed an MSSA BSI improvement group, in which North Bristol NHS Trust Head of Infection Control and Tissue Viability have been an active member.
Staph aureus is a bacterium that commonly colonises human skin and mucosa without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or an invasive device.

If the bacteria enter the body, illnesses which range from mild to life-threatening may then develop. These include skin and wound infections, infected eczema, abscesses or joint infections, infections of the heart valves (endocarditis), pneumonia and bacteraemia (blood stream infection).

All cases of hospital acquired BSI undergo a detailed review, the outcome of these is reviewed in the multi-disciplinary Staph aureus Steering Group (SASG), overview of this sits with COIC (Control of Infection Committee).

An independent review conducted by Sally Matravers (Associate Director of Nursing – Infection Prevention and Control (IPC), NHS England Southwest) and Jenny Gray (IPC Lead, NHS Bristol, North Somerset, and South Gloucestershire ICB) was commissioned by Steve Hams (NBT Chief Nursing Officer) to review cases from May 2023 to August 2023.The following recommendations were made:

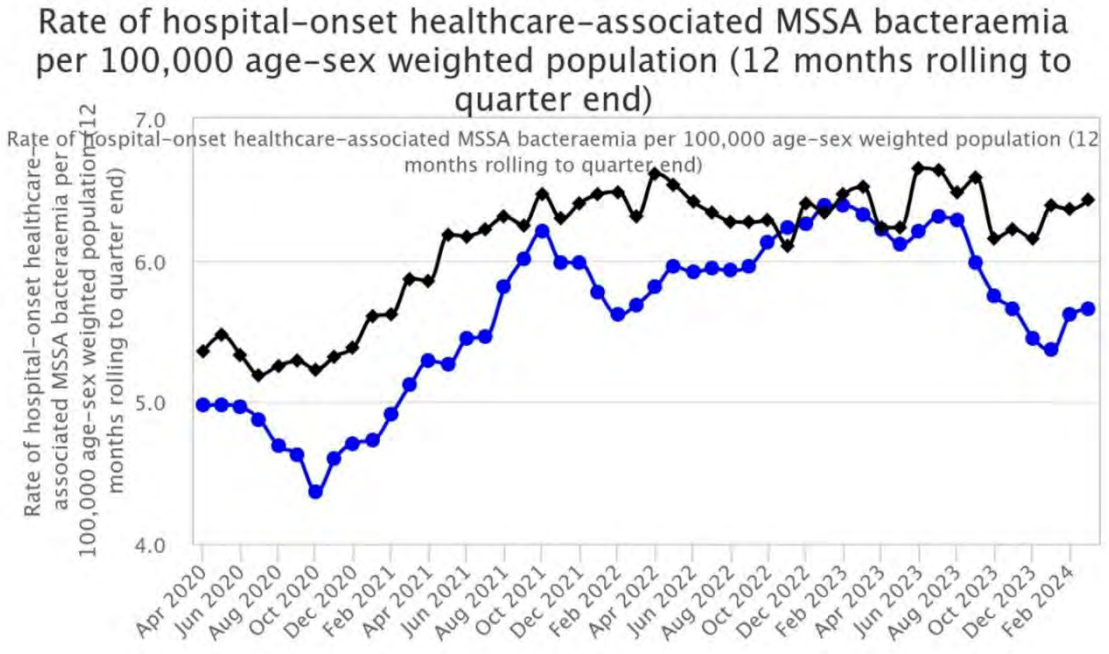
1. Continue with the current programme of work. The rolling rate per 100,00 bed days is showing a decline in the rate of MSSA bacteraemia's. It would be useful to use a quality improvement approach to the programme of work. It would be worth noting the acuity of patients as they may have a link to the case count.
2. Continue with the multidisciplinary approach. This is good practice and supports local ownership and local improvement.
3. Consider stopping identifying "lapses in care" as this can hinder learning.
4. Consider how the Vascular Access Service could support this improvement programme.
5. Ensure fundamentals of IPC practice are in place.

NBT Position 2023/24

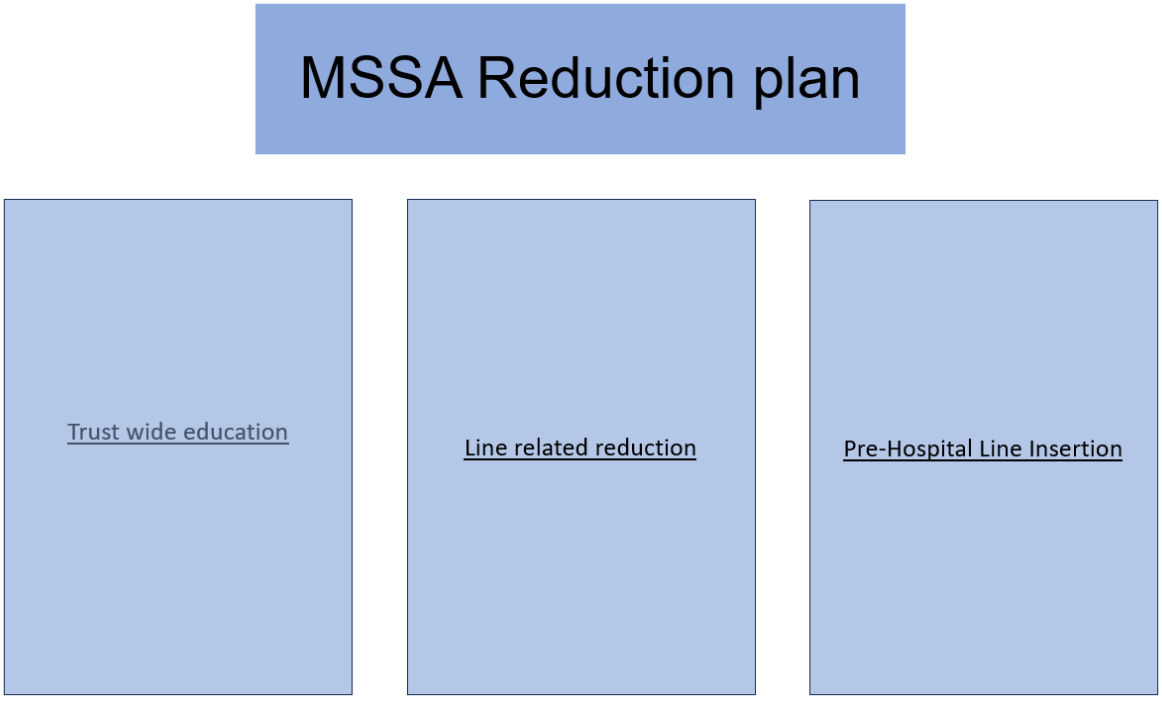
Trust	12 month Rolling Rate per 100,000 bed days	Ranking
Dorset County Hospital NHS FT	15.7	123/135
Royal Devon University Healthcare NHS Foundation Trust	12.51	96/135
North Bristol NHS Trust	13.95	110/135
Torbay and South Devon NHS FT	9.45	60/135
University Hospitals Dorset FT	11.11	79/135
Great Western Hospitals NHS FT	5.75	15/135
University Hospital Bristol and Weston NHS FT	11.8	89/135
Somerset NHS FT	9.5	63/135
Gloucestershire Hospital NHS FT	7.71	38/135
Royal United Hospitals Bath NHS FT	10.98	77/135
University Hospital Plymouth NHS Trust	13.2	103/135
Royal Cornwall Hospital NHS Trust	8.35	47/135
Salisbury NHS FT	6.9	26/135

Regional / National Position MSSA

Regional position shown in Blue, National in Black



Following this and continuous review at Infection Control Monitoring Group (ICMG), a reduction plan has been devised and implemented. This is based around three pillars as outlined below:



Education Plan – Delivery from IPC Team

Education delivered to clinical teams at the following forums. These sessions have focused on the current situation, prevention, and general awareness –

- Link ambassador sessions, increased in frequency, enabling links to teach in their own area and supported by IPCNs.
- Ward focused training- this is targeted based on learning from the outcome reviews at the Steering Group, these are also summarised in themes and trends.
- Trolley dashes linked to World Hand hygiene day, increasing awareness to all staff, focus on facilities around decreasing glove usage.
- Soap roll out and hand health education – TORK, this comes with an education package.
- Divisional COIC focus picking up on themes and trends, especially related to line, chest or wound infection.
- Ongoing delivery plan in place with *MSSA* BSI and *C Diff education*

Reduction of Line-Related Infections – Vascular Access Plan

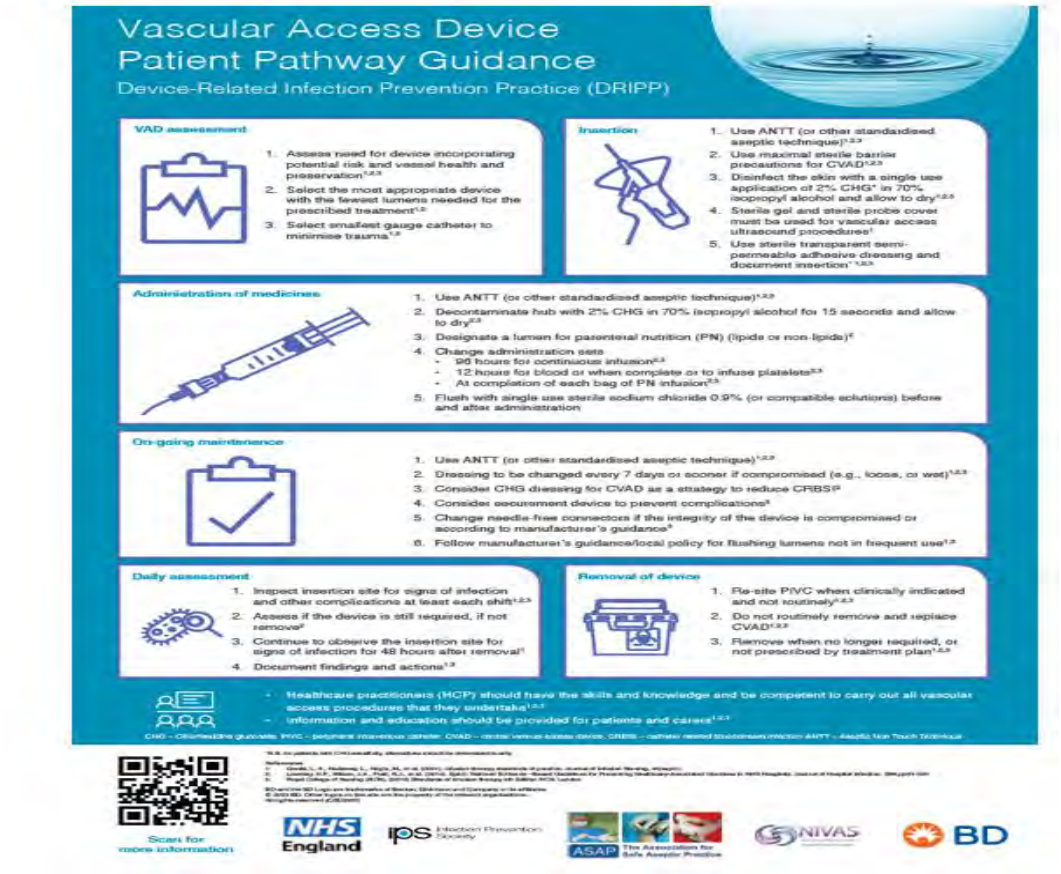
Objective: An all-inclusive multidisciplinary team approach to reduce Line-Related Infections through the standardisation of products, strengthening of education for all Healthcare Professionals. This is to include the implementation of best practice in infection prevention and control practices relating to vascular access device choice and post insertion care and management.

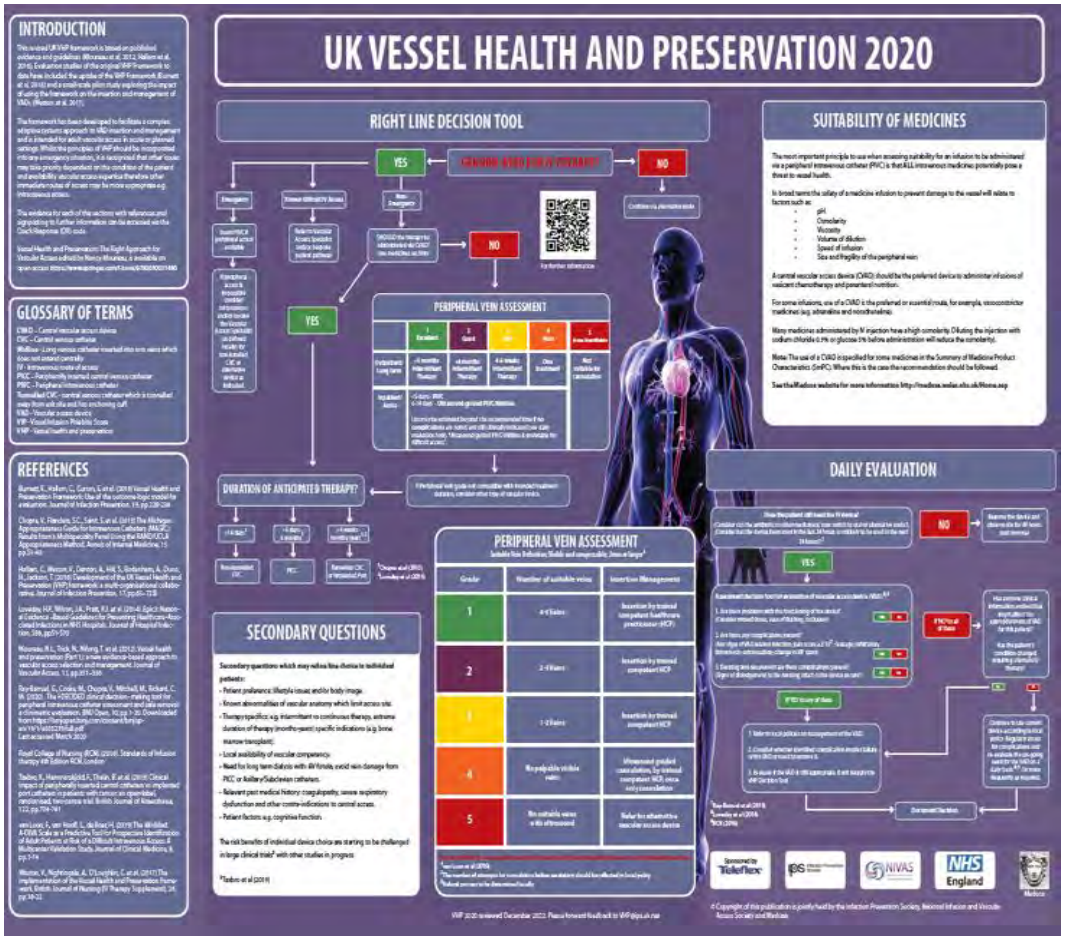
Strategies:

1. Standardisation of equipment and products. This will reduce errors and confusion amongst Healthcare Professionals and will be equally reassuring to our patients.
2. Strengthen education for Medical Staff on ANTT and the VHP algorithm. Working in collaboration with the Medical Education Team and supported by the CMO office.
3. Update IPC mandatory training to the "Skills for Health - IPC eLearn package" with a focus on Tier 3 education as a cross ICB approach.

https://www.england.nhs.uk/long-read/infection-prevention-and-control-education-framework/

4. Develop a multimodal vascular access training package.
5. Update the vascular access competency package following the rewrite of the policy.
6. Support the business case to increase the provision of the Vascular Access Service to allow for timely placements of the correct device and post-insertion support and surveillance.
7. Key stakeholders engagement through restarting the vascular access working group.
8. Conduct a review of skin preparation products.
9. Link with the Trust's Deteriorating Patient Group.
10. Utilise Qlik/Badger Net to monitor indwelling devices by Clinical area.
11. Ensure National tools such as DRIPP and UK Vessel Health and Preservation, (2020) (cited below) are embedded into practice to support device-related infection prevention practices.





Pre-Hospital Insertion – IPC Team

Working alongside South Western ambulance trust we have conducted a short audit to look at prehospital cannulation. This has the specific aim to identify cannulation that is performed for “Just in case “situations and cannulas that are in situ but are not being used.

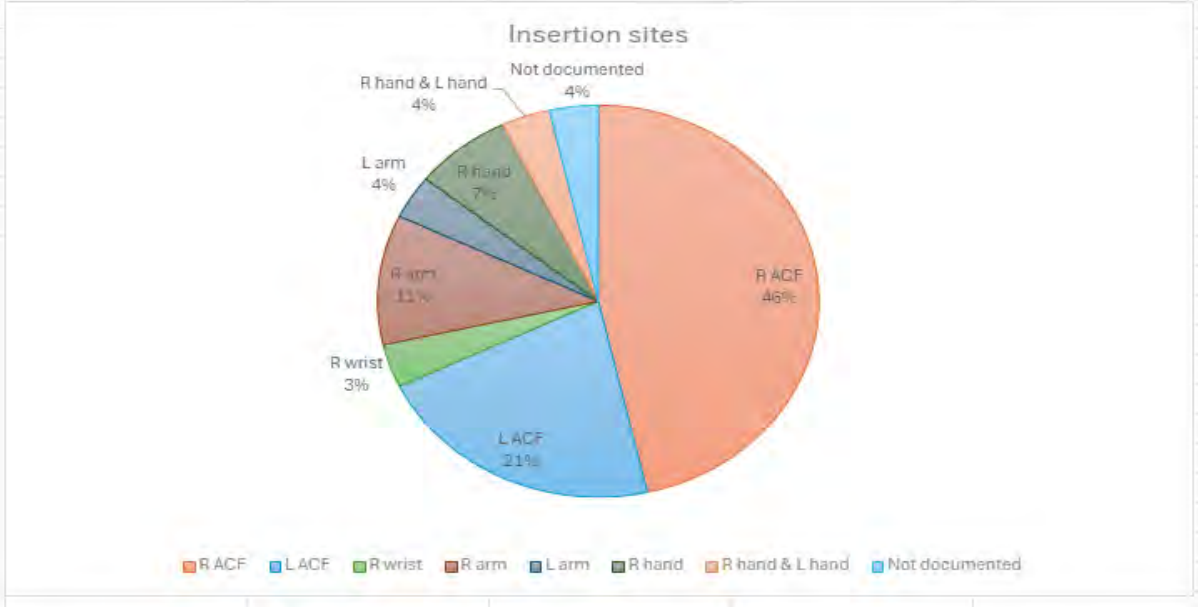
This also fits into work being conducted by SWAST looking at ANTT.

A snapshot audit was conducted with the following results these have been shared with SWAST – this shows that in this period a high proportion of cannulation was relevant and required.

We are feeding back our findings regarding ANTT insertion and would plan to re-audit this again to compare.

% of patients presenting to ED with a cannula in situ	% of these cannulas that were indicated	% of cannulas used	% of cannulas inserted aseptically
71.79%	92.86%	92.86%	82.14%

Number of patients presenting to ED with a cannula in situ	Number of these cannulas that were indicated	Number of cannulas used	Number of cannulas inserted aseptically	Total number of patients presenting via SWAST
28	26	26	23	39



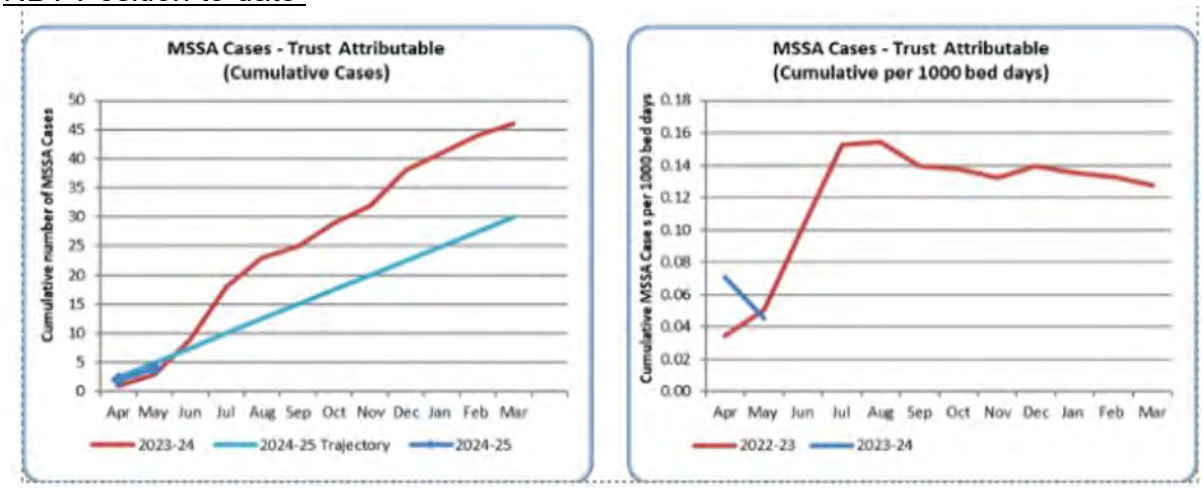
Position around hospital acquired MSSA BSI to date.

Cases at the end of March 23 were over trajectory (47 vs 30). A review of the internal trajectory based on 3- and 5-year mean data points towards this being an optimistic target so the trajectory for next year has been set at 36, however with a specific target of a10% reduction of line related infections.

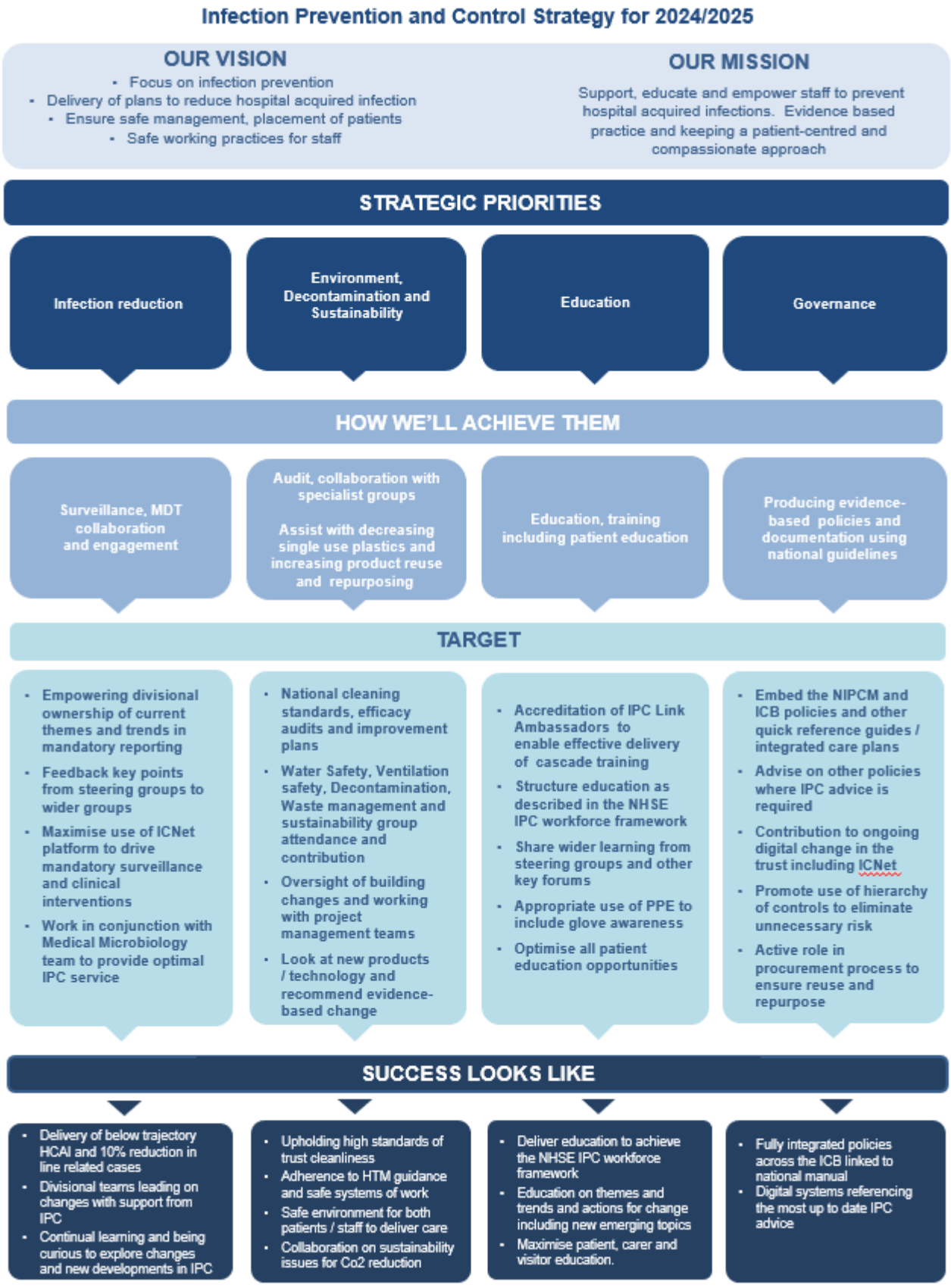
Cases are classified as line, chest or wound related so the appropriate actions can be put in place around prevention and education.

Data is now collected per case and per 1000 bed days as recommended.

NBT Position to date



APPENDIX THREE



NHS
North Bristol
NHS Trust

Tissue Viability
Annual Report 2023/24

Professor Steve Hams
Chief Nursing Officer

Contents

1.0 Executive summary

This is the annual report of the North Bristol NHS Trust (NBT) Tissue Viability Service (TVS) and summarises the work undertaken at the Trust to prevent and manage pressure ulcers during the period 1 April 2023 to 31 March 2024. The Trust continues to audit key performance indicators for pressure ulcer prevention on a weekly and monthly basis.

Achievements in 2023-2024

NBT achieved a reduction of pressure ulcers and patient harm.

- 15% reduction in the number of category 2s.
- 50% reduction in category 3s.
- 25% reduction in category 4s.

Hybrid Dynamic mattress rollout for inpatient's at NBT.

Implementation of Purpose-T Pressure Ulcer prevention risk assessment tool for NBT inpatients.

Pressure Ulcer prevention boarding card for inpatient bed spaces.

PSIRF process updated in collaboration with NBT patient safety team.

Safeguarding matrix and protocol created and implemented in collaboration with the NBT safeguarding team.

'Stop the Pressure' conference organised in conjunction with ICB.

Strategically evolving into a holistic wound care service within NBT.

Launch of the Collaborative Leg Ulcer Pathway at NBT and the Osteomyelitis Pathway

Management of NWPT across NBT

Safeguarding matrix for PU

The TVS works collaboratively within NBT and in a strategic partnership with the BNSSG ICB, Sirona CIC, UHBW to the protect and safeguard vulnerable patients from experiencing harm.

TVS will lead on strategies in 2024/25 to continue to have a reduction in pressure ulcer prevalence at NBT.

Prepared by: Kim Whitlock, Tissue Viability Matron

Tissue Viability Annual Report 2023/24

2.0. Introduction

The prevention of pressure ulcers remains an NBT priority and continues as one of the Trusts Patient Safety Priorities for 2023 / 2023. The TVS continues to develop to provide holistic wound management for complex wounds. The Tissue Viability Service (TVS) service at NBT strives to provide evidence based wound care from NICE guidelines and the National Wound Care Strategy Programme (NWCP) best practice statement recommendations.

3.0. Tissue Viability Service

This annual report highlights the initiatives undertaken by the TVS on improving the standard of tissue viability and wound care at NBT during 2023/24.

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

The Tissue Viability Team currently consists of a WTE Tissue Viability matron, 0.8 band 7 Tissue Viability Clinical Nurse Specialist, 2.0 WTE band 6 Tissue Viability Nurse and 1.0 seconded Tissue Viability Nurse which is due to end September 2024 (Figure 2024). The Tissue Viability Nurses (TVNs) are a daily visible presence on the wards and clinical departments. There is an active group of Tissue Viability Link Ambassadors (TVLA) across all wards and departments.

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

The Pressure Ulcer Steering Group (PUSG) provides an NBT strategic response to identified and emerging themes in PU reduction. The identified PU reduction themes are presented as a TVN Strategy on a Page.

The NBT TVS have established partnerships and networks within BNSSG and the wider region.

The TVS attend the BNSSG ICB System Pressure Ulcer Board (SPUG) and Formulary group with other stakeholders, such as community and acute providers across the region. These forums are used to provide peer support, discuss current themes and challenges, and formulate effective and responsive solutions across the BNSSG region.

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

NBT staff can make a clinical referral for a patient for the following categories:

- Pressure ulcers
- Surgical wounds and infected wounds
- Chronic leg ulcers
- Incontinence associated dermatitis (IAD) and Moisture Associated Skin Damage (MASD)
- Severe cellulitis
- Neonatal wounds
- Trauma wounds
- Wounds requiring Negative Wound Pressure Therapy (NWPT)
- Wounds requiring complex debridement, such as Tissue Viability Nurse Specialist led larval therapy, sharp debridement or NWPT Veraflow.

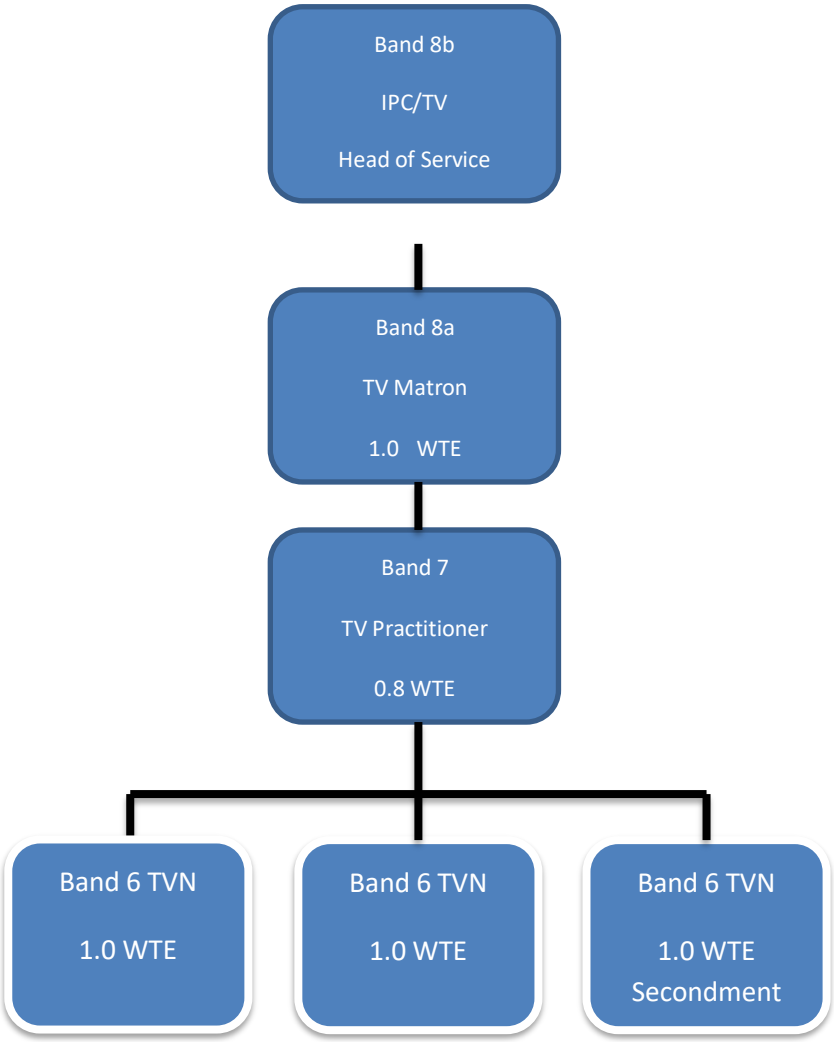


Figure 1: The WTE and structure for the Tissue Viability service.

4.0 Pressure ulcers

Pressure ulcers represent a challenge for patients who develop them, and a major burden of sickness and reduced quality of life for them, their carer's, and families (DOH, 2018, Fletcher 2022). Patients with a PU are at an increased risk of infection, depression, morbidity, and mortality (Borojeny et al 2020). The economic burden of PU to the healthcare service is an increase in financial cost from increased length of stay and ongoing care needs (Stephenson et al 2021). PU's are considered preventable patient harm (NICE 2014, NHS 2018), but in England remain in the top ten reported patient safety incidents (Fletcher 2022).

Pressure ulcers remains a challenge for the healthcare profession and a key indicator of the quality of nursing care and additional financial pressures (DOH, 2018).

In 2023/2024 at NBT there were:

- 167 grade 2 pressure ulcers, of which 27 grade 2 were caused by medical devices. 15 % decrease
- 4 grade 3 pressure ulcers: 50% decrease
- 3 grade 4 pressure ulcers: 25 % decrease
-

NBT Health Care Acquired Pressure Ulcer Figures 2022/2023

2023/2024	Quarter 1			Quarter 2			Quarter 3			Quarter 4				
	April	May	June	July	August	September	October	November	December	January	February	March	Totals	
Grade 2	18	15	8	25	15	15	12	17	11	15	8	12	171	
Grade2 (device)	1	4	6	4	1	3	2	2	0	1	1	1	26	197
Grade 3	0	1	1	0	0	0	2	2	1	0	0	1	8	
Grade 4	0	0	0	0	0	0	0	0	1	0	2	1	4	

NBT Health Care Acquired Pressure Ulcer Figures 2023/2024

2023/2024	Quarter 1			Quarter 2			Quarter 3			Quarter 4				
	April	May	June	July	August	September	October	November	December	January	February	March	Totals	
Grade 2	17	13	16	14	10	12	8	9	9	10	13	9	140	
Grade2 (device)	3	2	2	3	2	1	3	1	3	1	5	1	27	167
Grade 3	0	0	0	0	2	1	0	0	0	1	0	0	4	
Grade 4	0	0	0	0	1	0	0	1	0	0	1	0	3	

Figure 2 summaries the validated pressure ulcers at NBT for 2022/23 and 2022/23.

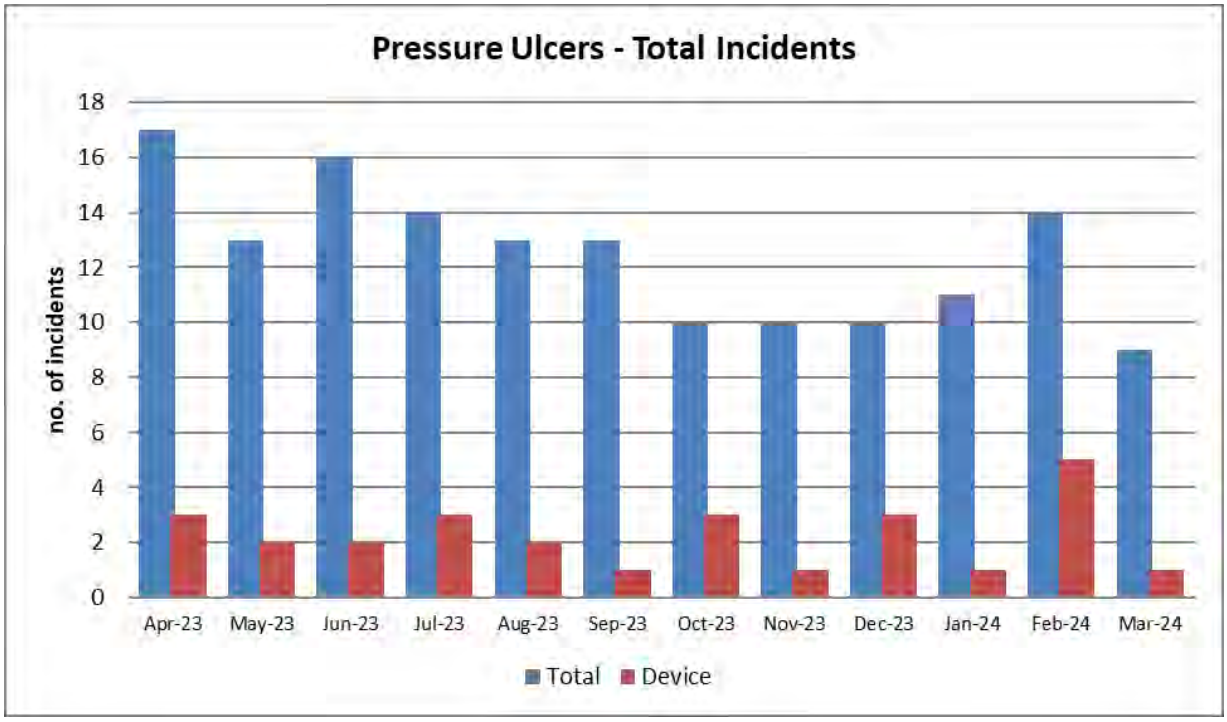


Figure 3 Total incidents of pressure ulcers.

Economic Cost of PU

The cost of treating patients with a PU is significant and imposes an economic burden to NBT and the wider healthcare system. The cost of PU to NBT in 2022/23 as per the NHS Pressure ulcers productivity calculator is:

Pressure ulcers by grade

How many pressure ulcers *of each grade* does your organisation treat?

Grade 1	0
Grade 2	167
Grade 3	4
Grade 4	3
Total	174

Section C: Results: Estimated cost of pressure ulcer care 2016/17
(rounded to the nearest thousand £s)

	Central estimate	Lower range	Higher range
Grade 1	-	-	-
Grade 2	1,131,000	916,000	1,368,000
Grade 3	45,000	36,000	54,000
Grade 4	49,000	39,000	59,000
Total	1,225,000	991,000	1,481,000

The 15% reduction of grade 2 PUs from the 2022/2023 figure had the potential saving to NBT of £184,000 (NHS England, 2018).

5.0 Medical Device Related Pressure Ulcers

During 2023/24, there were a total of 27 medical device related grade 2 pressure ulcers across the Trust. This is an increase of 1 incident from 26 in 2022/23.

The collaborative work between the orthopaedic ward and the plaster room has continued in 2023/24. The plaster of paris (POP) care plan was ratified and implemented on ward 25a, with an escalation pathway for any concerns. The ward team on 25a have created a LEARN package and a dedicated training room to educate staff on how to care for patients with a POP cast. The POP care plan and training is to be rolled out across NBT during 2024/2025.

Previously the TVS had worked closely with ICU to reduce medical device related pressure ulcers. This has recommenced in response to an emerging theme, that medical device related PUs is a particular challenge within ICU; given the acuity of the patients and the number of medical devices. A TVN with an ICU Band 7 has a visible present in the clinical areas. They will discuss any challenges or concerns, offer support and solutions on the unit regarding PU prevention management. There is bespoke education within the ICU teams, and a monthly ASCCR divisional pressure ulcer meeting where the senior nursing team review PU figures and strategies to reduce PU prevalence.

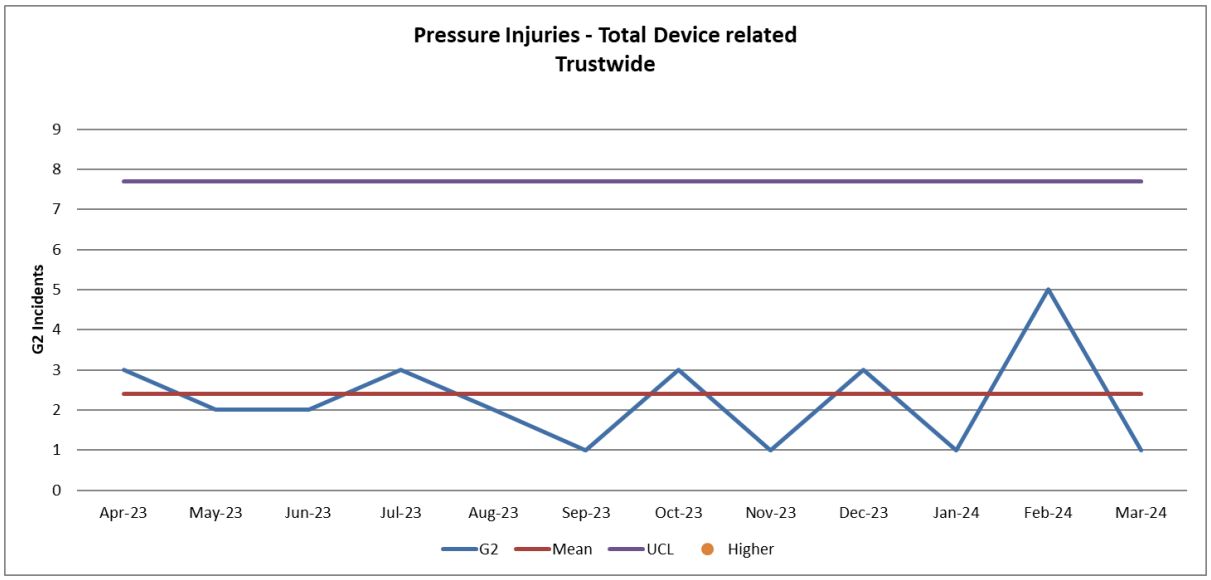


Figure 4 Numbers of NBT acquired device related pressure ulcers by number of incidents reported monthly from April 2023 – March 2024.

6.0 Rates of Pressure Ulcers at NBT per 1000 bed days

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

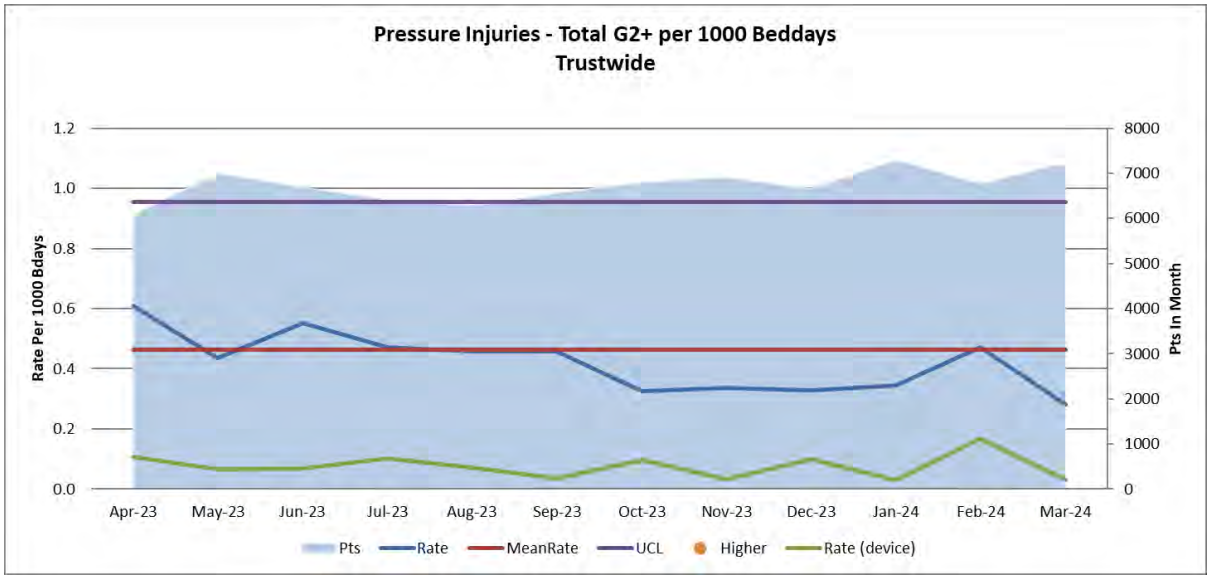


Figure 6 incidence of all NBT acquired hospital-acquired grade 2-4 pressure ulcers per 1000 bed days.

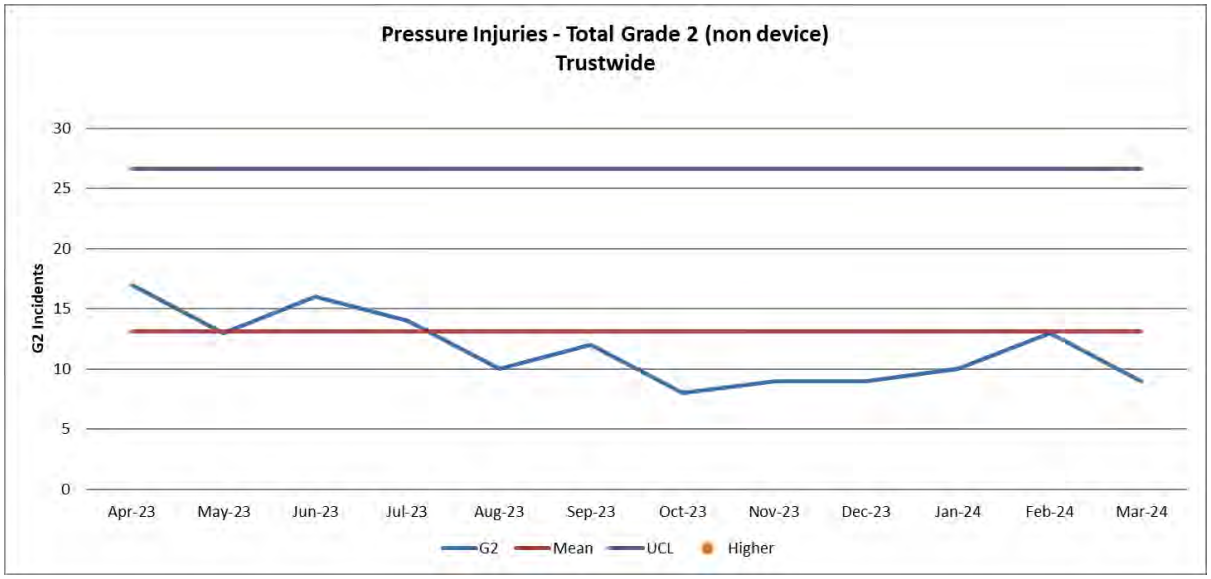


Figure 7: Grade 2 pressure ulcer trust wide on a bi-monthly basis, excluding medical device related.

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

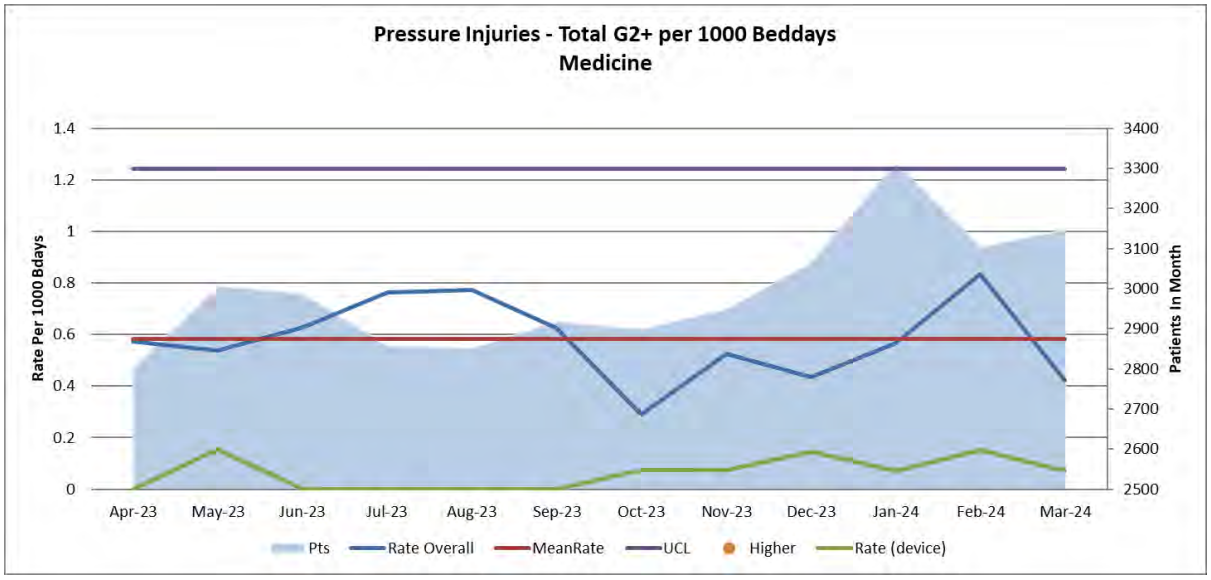


Figure 9: Medicine division validated NBT attributable pressure ulcers

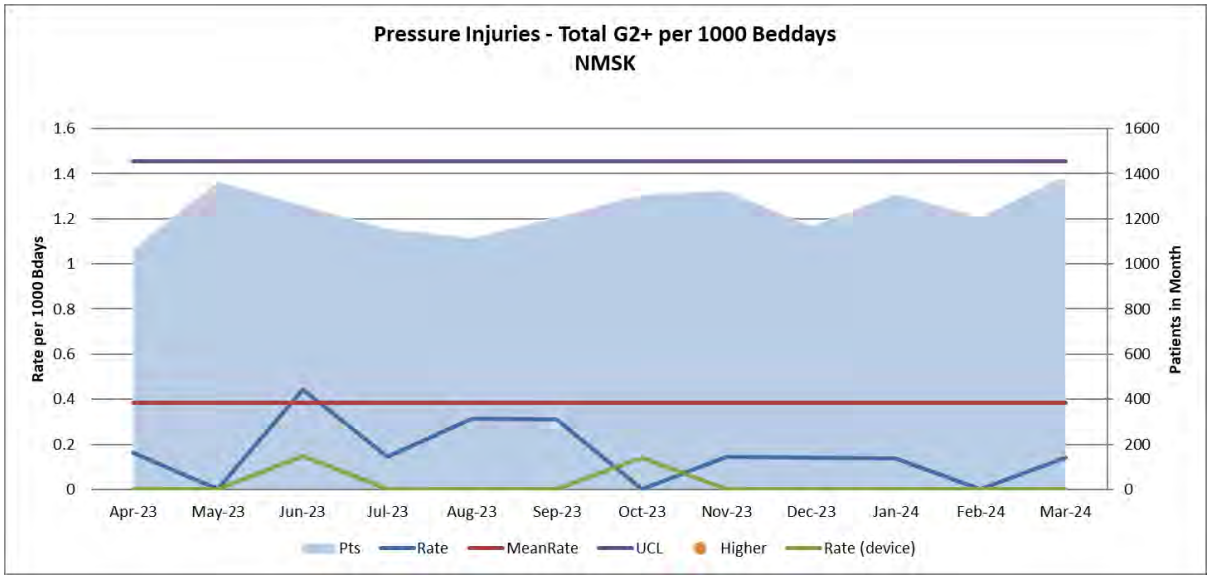


Figure 10: NMSK division validated NBT attributable pressure ulcers

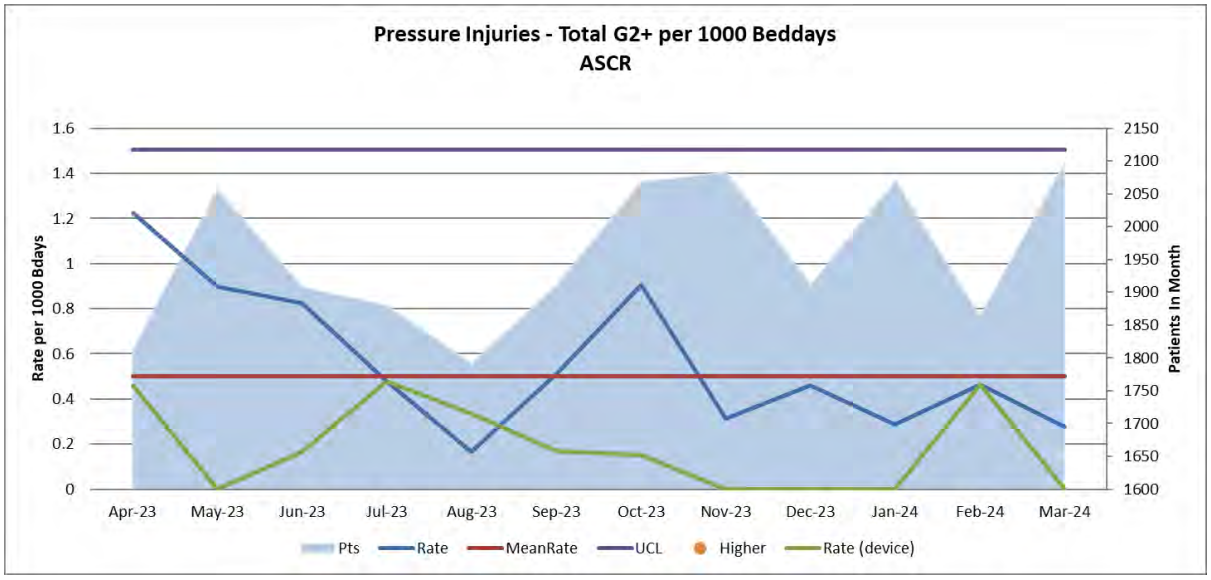


Figure 11: ASCR division validated NBT attributable pressure ulcers

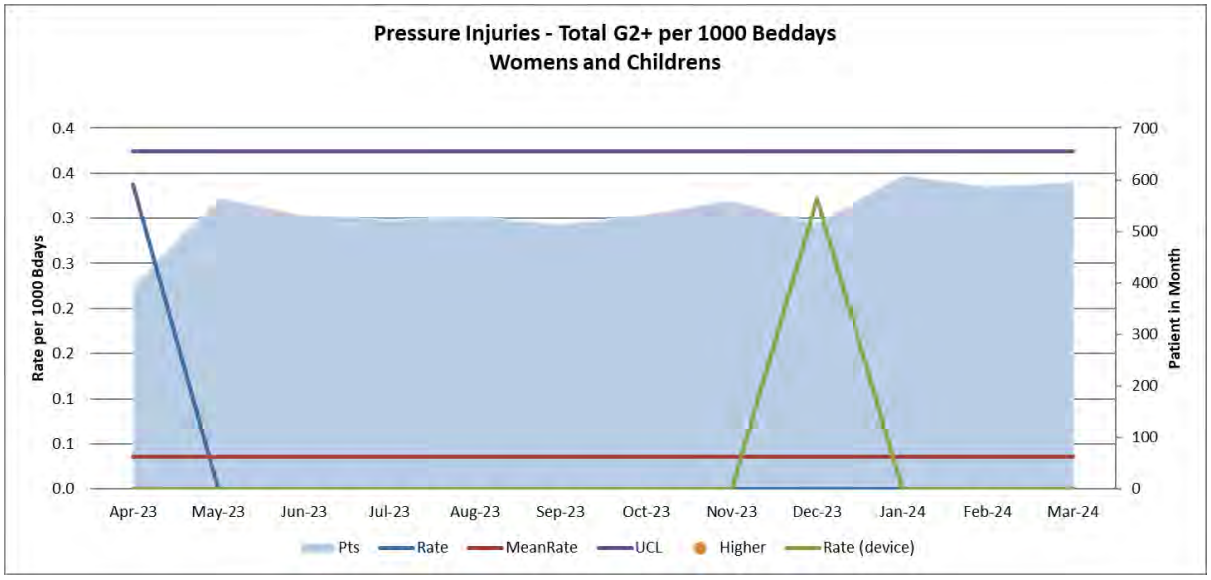


Figure 12: Women and Children's division validated NBT attributable pressure ulcers

7.0 Response to hospital acquired pressure ulcers

1645 present on admission pressure ulcers were reported via Datix, of which 282 were unstageable, grade 3 or 4.

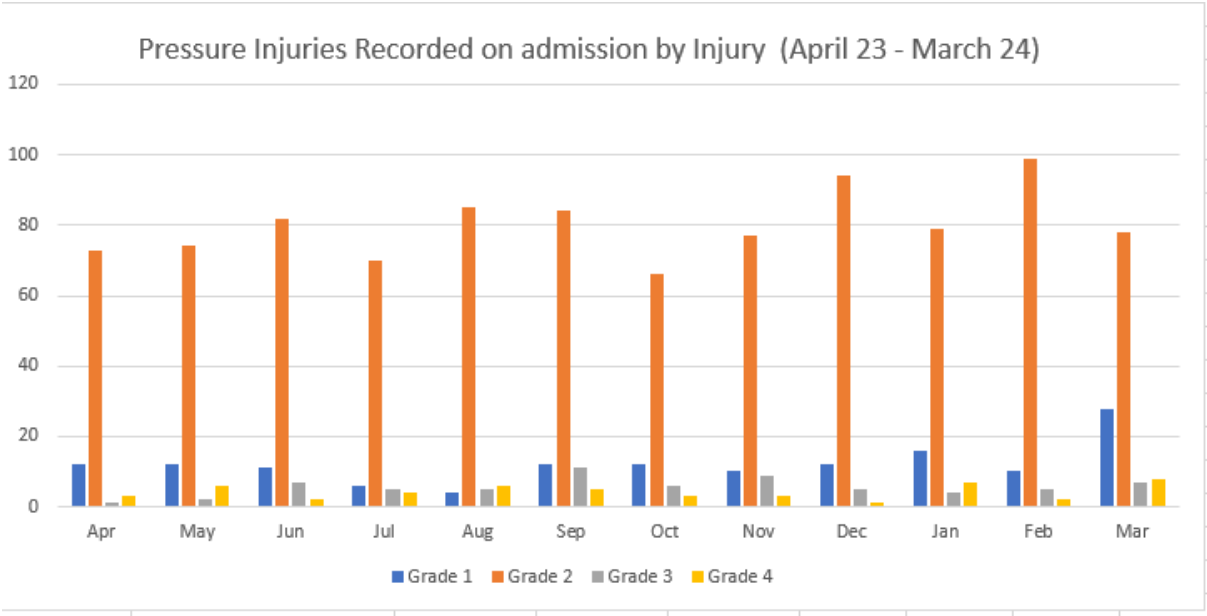


Figure 5 shows the number of patients admitted with present on admission pressure ulcers.

Guest et al (2020) report that pressure ulcers have increased by 32% from 2012/2013 to 0.4% of the UK adult population in 2017/2018. Stephenson et al (2021) conducted a National Audit of England and reported a higher PU prevalence rate of 9.04% of the patient population.

The Pressure Ulcer Steering Group (PUSG) was formed in early 2023 and is chaired by Juliette Hughes, Deputy Chief Nursing Officer and Sarah Wheatley, Head of Service for Infection Control and Tissue Viability. The PUSG membership includes representation of stakeholders at a strategic level across NBT to identify emerging themes of PU development. TVS have created a strategy for pressure ulcer reduction that outlines workstreams of identified themes to PU prevalence. The TVS have captured these on a TVN strategy on a page for 2023/2024 at NBT (Appendix 1), which has been updated to reflect delivered strategies and recognise new identified themes.

8.0 Investigation of pressure ulcers

The TVS team were early adopters of the Patient Safety Incident Response Framework (PSIRF) (NHS 2022). During 2023, it was recognised that a review was required as part of the continuation of implementing PSIRF to provide a transparent and proportionate response to hospital-acquired pressure ulcers. This review was undertaken in collaboration with the patient safety team, the divisions, and the governance teams. The governance teams now instigate, if appropriate, an investigation following the guidance on pressure ulcer investigation management.

9.0 NBT Reporting Process

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

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

The data is collated into a monthly report which is circulated across the Trust. This includes analysis, RAG rating and divisional breakdown. This is further scrutinised at the PUSG, identifying emerging themes of PU development and enables a focussed and targeted response.

The integrated performance report (IPR) is completed monthly and includes a quality narrative to provide context to the data. The Head of Service for Infection Control and Tissue Viability is responsible for providing quarterly reports to the Quality Board to provide assurance.

10.0 Audit

Audit compliance is reviewed by the Divisional Directors of Nursing within the Clinical Divisions. The PU prevention monthly audit was moved into a monthly quality audit on Radar during and results are from October 2023.

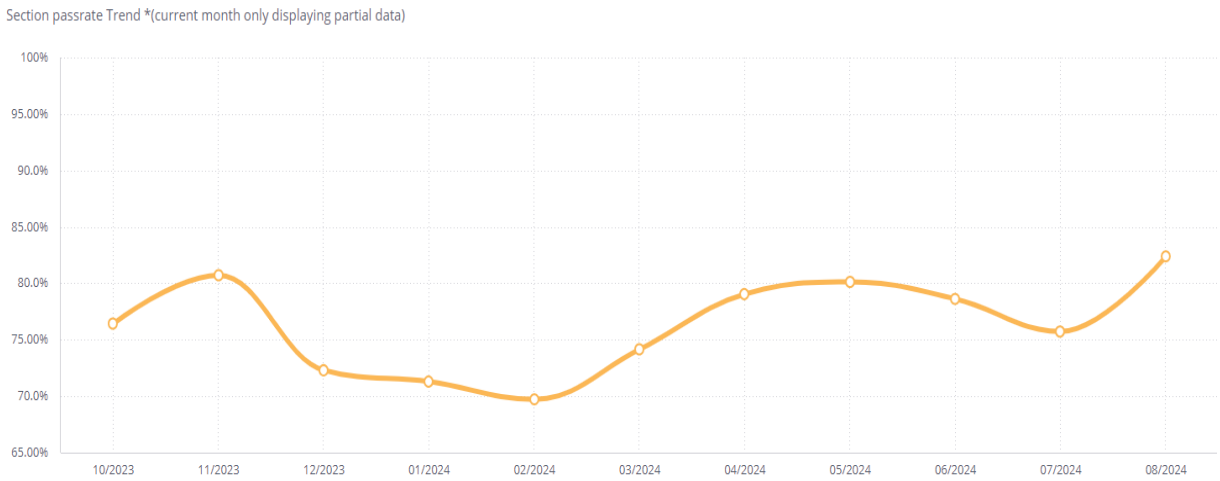


Figure 6 Pass rate trend per month for Pressure Injury Prevention Audit 2023-2024

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

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

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

12.0 Tissue Viability Education

The TVS team have delivered over 100 hours of education in the year 2023/2024. This has consisted of the face-to-face induction, tissue viability link ambassador days, healthcare education day, student nurse webinars, supporting MASD training, 'work with a TVN' and specific divisional and ward training needs.

The SSKIN eLearning package which includes competencies continues to support the staff, wards and divisions increase their awareness of PU prevention strategies and maintain an elevated level of staff compliancy. This will be reviewed during 2023/2024 and aligned to the National Wound Care Strategy competency framework and Skills for Health.

The TVS welcomed their first undergraduate nursing students in the September 2023, and again in March 2024. The students are on placement at the end of the 2nd year or the beginning of the 3rd year Adult Nursing programme at the University of West of England. The TVS have received positive feedback and look forward to facilitating further Adult Nursing students on placement.

The TVS team also offer shadow opportunities to medical, nursing and nursing associate students, as well as NBT clinical and healthcare staff.

The TVS held a successful 'Stop the Pressure' village in November 2023, to launch Purpose-T pressure ulcer risk assessment tool. This was supported with the digital team and webinars to raise awareness.

The TVS organised and led the working group to successfully deliver the 'Stop the Pressure' system wide conference held at BAWA. There were presentations, industry partners and 120 delegates from all care providers across BNSSG.

13.0 Tissue Viability Link Ambassadors (TVLA)

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

The TVS continue to facilitate quarterly TVLA meetings that offer an opportunity to discuss themes of PU prevention and management at NBT. This is managed via the LEARN booking portal and has update on the TVLA MS team channel.

TVS will also support TVLAs with a collaborative 'work with a TVN' in their clinical area or offer shadowing for a morning. This offers an opportunity to gain enhanced knowledge on PU prevention and management, and complex wound management.

14.0 BNSSG Region Activity

NBT TVS work strategically at reducing pressure ulcers across the region as an active member of the System Pressure Ulcer Board (SPUG). During late 2023 the SPUG membership voted to change to a System Wound Care Group (SWCG).

The membership of this group is being extended to include social care and private providers of health care from across the BNSSG system. This should optimise the collaborative working in line with the BNSSG Multi-Agency Strategy across the system. Wound care strategies adopted from the National Wound Care Strategy Programme recommendations and NICE evidence, are implemented strategically and then delivered across BNSSG to improve clinical outcomes.

15.0 Development of an NBT wound care service

A key objective for 2022/2023 was to expand the TVS service further to address the identified national crisis in wound care (Guest et al 2015). This has also been in response to a need from the divisions and wards to lead and manage complex wounds in certain clinical areas.

Through restructure of the current investigation process of pressure ulcers with the ownership sitting within the divisions the TVNs will be focussed on supporting the Trust in managing complex wounds. This has seen upskilling and clinical development of the current TVNs to include negative wound pressure therapy, veraflow negative wound therapy, sharp debridement and holistic leg ulcer assessment and leg ulcer clinic. This development will ensure that patients receive holistic wound care. This has involved work with the MDT and our community partners to ensure that patients have continuity of care.

- Development and implementation of a collaborative leg ulcer pathway. This involves maintaining or starting compression bandages for inpatients. NBT TVS has also mapped the leg ulcer pathway to Sirona to help seamless transition on discharge and reducing variations in care. This has been in collaboration with Urgo, an industry partner.

- Development of an osteomyelitis pathway, in collaboration with a microbiologist to optimise clinical outcomes.

- TVS utilising NWPT Veraflow for patients and avoiding surgical intervention.
- Collaboratively working with NHS@home for patients with a complex wound management plan, to enable discharge.
- Management of Activacs for NBT.
- Complex wound management
- Surgical debridement and bone biopsy.

16.0 Achievements 2022/2023

- PSIRF process updated with the clinical governance teams responsible for facilitating and ensuring that SWARMs and AARs are completed. TVS are not responsible, the ownership is with the to the division's governance and clinical teams.

- TVN strategy for pressure ulcer reduction created from identified pressure ulcer themes and discussed at patient safety group and the pressure ulcer steering group and dissemination to the governance teams and divisions.

- Hybrid dynamic mattress roll out across NBT from May 2023 to July 2023 in collaboration with the divisions, clinical equipment, and porters.

- The foam mattresses removed from NBT were recycled and reused as a sustainability project, this yielded:

  Recycled 46 and reused 340 mattresses that were otherwise being sent to landfill.

  Avoided 6.2 tonnes going to landfill, equivalent to an African Bush Elephant

  Avoided 2.88 tonnes CO_2e.

  Equivalent to ten passengers flying from Bristol to Barcelona

- Mattress selection guide updated in collaboration with Drive.

- NBT lead and delivered the regional BNSSG ICB National Stop the Pressure conference at BAWA November 2024.

- Purpose-T Pressure Ulcer prevention assessment rolled out across the Trust November 2023. This has involved mapping the assessment to the EPR system and working on care plans and a pressure ulcer prevention pathway to aid clinical decision making.

- Replacement of the Pressure Ulcer prevention patient leaflet to the Pressure Ulcer prevention boarding cards. The design is based on a pictorial airplane

information card following the SSKIN acronym on pressure prevention, with a QR code of a video of the TVNs.

- Development of a NICU pressure ulcer prevention bundle in collaboration with NICU.

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

- TVS provided training on Wound Care at the University of the West of England for student nurses.

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

- Working collaboratively with the Salisbury TVNs to support and prevent pressure ulcers to spinal cord ulcer patients. This work also involves the rehab teams at the Trust.

- Tissue Wound Interest Group (TWIG) sessions delivered during 2023/2024.

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

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

- Maintain communications with the community providers by including information in the discharge summary regarding pressure ulcers and wounds. Work with the ICB and BNSSG providers on developing tracking wounds across providers and providing cohesive joined up patient care. This has continued with the exploration of implementing Healthy IO for the TVS. This is a wound care app that would link directly with Sirona to reduce variations in care.

- Tissue Viability Link Ambassador quarterly education days delivered.

- Collaborative working on wound care across NBT with vascular outpatients, burns and plastic outpatients in relation to dressing formulary, supporting each other, and discussing challenges on delivering wound care across the system.

- Collaborative work with women and children division on wound care and providing 2 full study days.

- Display of Collaborative Leg Ulcer Pathway poster in the Brunel atrium for the Innovation to Improve event.

- Regional TVN meeting organised by NBT for the region in Bristol.

- TVN staff development with post graduate course training.

- TVS welcomed their first student nurses to the service in September 2023.

- Clinical sharp debridement to be offered by TVS to inpatients where appropriate to facilitate wound healing. New policy written by TVS and awaiting ratification.

- Band 6 TVN secondment retained to develop TVS and help with education to implement Purpose-T risk assessment for all inpatients.

17.0 Recommendations for 2023/24

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

- 30% reduction in NBT attributable Grade 2 pressure ulcer.
- Zero tolerance to NBT attributable Grade 3 and Grade 4 pressure ulcer with a 50% reduction from 2023/24.

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

- Development of an Osteomyelitis pathway.

- Development of a wound debridement pathway.

- SSI reduction – TVS continue to support post implementation of the Precission bundle to reduce SSI caesarean rates.

- Review of the SSKIN documentation to be mapped across to the Careflow EPR as per the Trust digitialisation programme.

- TVS will support the rollout of Purpose-T on the digital SHINE document at the NBT admission zones, with a specific focus on ED.

- NWPT pathway and referral to TVS to be updated. Referral process to external care providers to be ratified with the Pan Avon formulary.

- Collaborative leg ulcer pathway with Sirona Healthcare our community partners and the vascular outpatient clinic will continue to be imbedded.

- Doppler and ABPI leg ulcer assessment and management for inpatients by TVN with support from the vascular scientists. Compression bandaging to be applied if appropriate for inpatients.

- Real-time evaluation of leg ulcer pathway using the Healthy IO app to track wound management for patients and healing outcomes. This will be in conjunction with Healthy IO, Sirona, and Health Innovation Southwest.

- Adoption of a lower limb pathway as per national guidelines across the BNSSG and discussion with the ICB on funding a specialist lower limb service.

- Educational module to be created for delivery with UWE on wound healing at level 7.

- Wound care competencies for staff at NBT that are mapped to the National wound care strategy on wound care. This will involve education, development, and various levels for different health care practitioners.

- Redevelopment of the eLearning pressure ulcer modules and wound care modules utilising the eSkills for health modules. These will be tiered and mapped to job roles.

- Development of an Advanced Nurse Practitioner role in wound care at NBT, supporting the osteomyelitis pathway.

- TVS band 7 presenting at Wounds UK, and band 8 presenting a poster on the collaborative leg ulcer pathway.

- TVS band 8 contributing to a Wounds UK Best practice publication on cavity wound management.

- Standardisation of the dressing's cupboards at NBT, and update on dressing selection guide.

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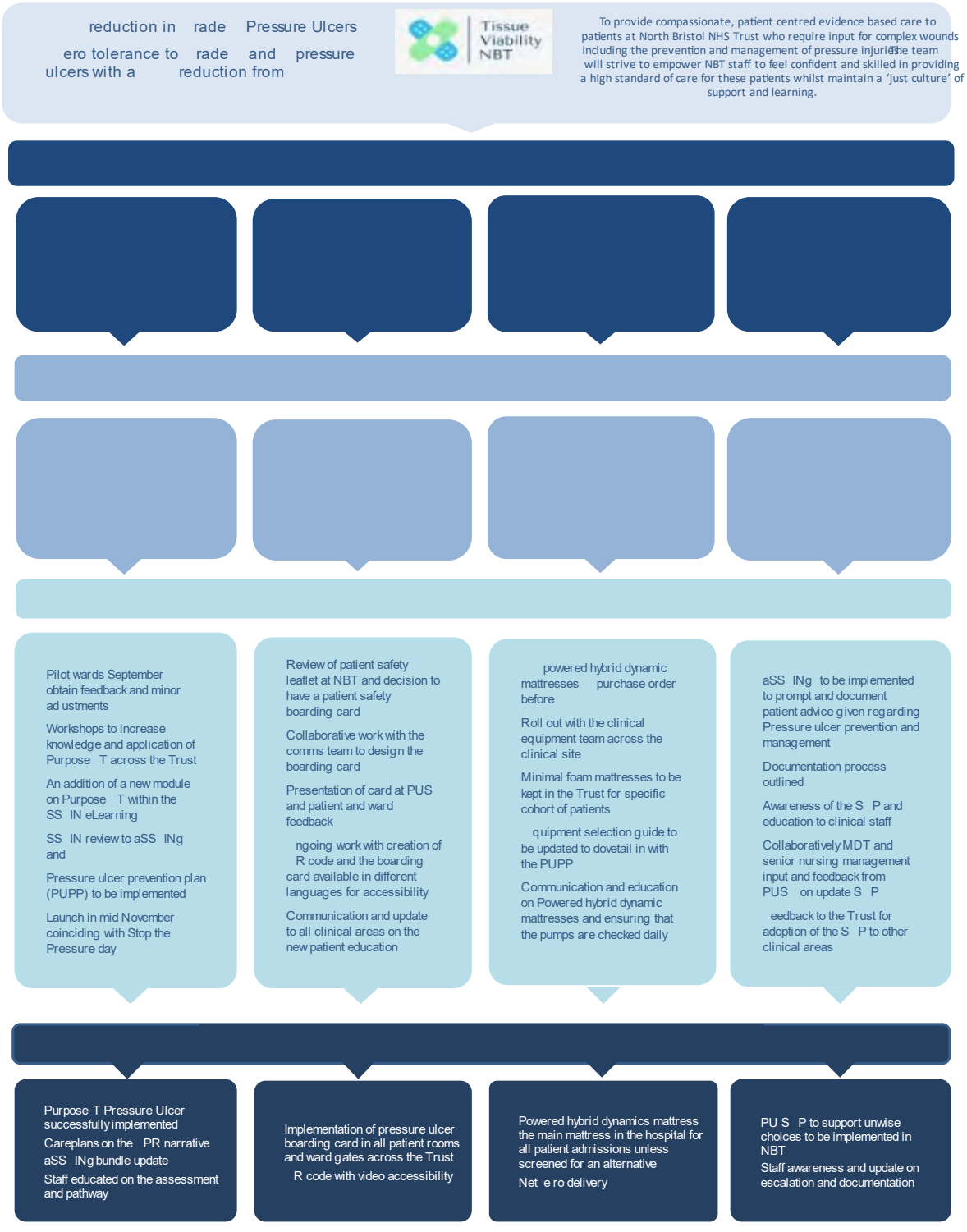
Appendix 1


reduction in rade Pressure Ulcers
ero tolerance to rade and pressure ulcers with a reduction from
Tissue Viability NBT
To provide compassionate, patient centred evidence based care to patients at North Bristol NHS Trust who require input for complex wounds including the prevention and management of pressure injuries The team will strive to empower NBT staff to feel confident and skilled in providing a high standard of care for these patients whilst maintain a 'just culture' of support and learning.
Pilot wards September obtain feedback and minor ad ustments
Workshops to increase knowledge and application of Purpose T across the Trust
An addition of a new module on Purpose T within the SS IN eLearning
SS IN review to aSS INg and
Pressure ulcer prevention plan (PUPP) to be implemented
Launch in mid November coinciding with Stop the Pressure day
Review of patient safety leaflet at NBT and decision to have a patient safety boarding card
Collaborative work with the comms team to design the boarding card
Presentation of card at PUS and patient and ward feedback
ngoing work with creation of R code and the boarding card available in different languages for accessibility
Communication and update to all clinical areas on the new patient education
powered hybrid dynamic mattresses purchase order before
Roll out with the clinical equipment team across the clinical site
Minimal foam mattresses to be kept in the Trust for specific cohort of patients
quipment selection guide to be updated to dovetail in with the PUPP
Communication and education on Powered hybrid dynamic mattresses and ensuring that the pumps are checked daily
aSS INg to be implemented to prompt and document patient advice given regarding Pressure ulcer prevention and management
Documentation process outlined
Awareness of the S P and education to clinical staff
Collaboratively MDT and senior nursing management input and feedback from PUS on update S P
eedback to the Trust for adoption of the S P to other clinical areas
Purpose T Pressure Ulcer successfully implemented
Careplans on the PR narrative
aSS INg bundle update
Staff educated on the assessment and pathway
Implementation of pressure ulcer boarding card in all patient rooms and ward gates across the Trust
R code with video accessibility
Powered hybrid dynamics mattress the main mattress in the hospital for all patient admissions unless screened for an alternative
Net e ro delivery
PU S P to support unwise choices to be implemented in NBT
Staff awareness and update on escalation and documentation

Report To:	Public Trust Board		
Date of Meeting:	28 November 2024		
Report Title:	Guardian of Safe Working Hours Report - covering Feb – May 2024		
Report Author:	Dr Lucy Kirkham, Trust Guardian for Safe Working Hours		
Report Sponsor:	Mr Tim Whittlestone, Chief Medical Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	This paper sets outs the background and context around the introduction of the Guardian of Safe Working as part of the 2016 T&Cs for Junior Doctors and implementation of that role in the Trust. It shows: • Gaps on rotas and plans to fill. • Locum data • Exception Report data • Guardian's actions		

Key Points to Note *(Including any previous decisions taken)*

Please note Doctors in Training (DiTS) and Locally Employed Doctors (LEDs, previously referred to as Clinical Fellows) are collectively known as Resident Doctors now.

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

Junior Doctor Contract Refresh - 2019

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

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

The NBT Trust Guardian for Safe Resident Doctor Working will:

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

2. There is a requirement in the NHSE document (published Apr 2024) 'Improving the working lives of doctors in training' that Trusts record DiT payroll errors, set out a time frame for acting on them and implement a governance framework of reporting on them.

   NHS England » Improving the working lives of doctors in training

   NBT payroll SLA in response is attached (appendix 1). The GOSW is not responsible for recording or resolving these payroll errors, but the GOSW report is the most appropriate place to inform the Board of the preceding 4 months of errors (appendix 2)

3. Ensure Exception Reporting by resident doctors for breaches of contract are acted upon. These comprise exceptions for:
   - Safety reasons
   - Excess hours – Leading to Time off in lieu (TOIL - the preference) or Payment where TOIL is not possible. Please note the contract for Locally Employed Doctors entitles them to TOIL for overtime only (though TOIL that is not taken due to proximity to the end of a rotation or critical staffing can be converted to payment by the GOSW)
   - Excess hours leading to work pattern reviews.
   - Missed scheduled education sessions.

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

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

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

Please note that there are 17 RD rotas in Trust that have average hours of >47. If overtime exceptions on these rotas are not able to be compensated with TOIL it is very likely that repeated overtime will result in a breach of the 48hr average and so a GOSW fine.

Next steps include: • Promote and support exception reporting system to consultants and trainees. • Continue to look at creative workforce and IT solutions to minimise gaps.
Strategic and Group Model Alignment
The report and its recommendations align with the Trust's strategic direction and, links back to the priorities and projects within Patient First, specifically High Quality Care – Better by design.
Risks and Opportunities
Risks include: • eRostering to alert contract breaches and enable leave booking for trainees. • Exception's alert ISCs
Recommendation
This report is for **Information.** The Board of Directors will discuss current Junior Doctor contract issues and as a public authority must, in the exercise of its functions, have due regard to the need to: • All contractual obligations in place • Be satisfied that the role of Trust Guardian is being fulfilled. • Exception Reports being acted upon • Gaps on Junior Rotas being filled as a priority. • Risks to Trust considered – Guardian fines; accountability; staffing
History of the paper
N/A

Appendices:	*N/A*

HIGH-LEVEL DATA:
NBT rota designs have continued to meet the refreshed 2016 junior doctor contract requirements according to rotas submitted to MHR that are then run through Allocate. There is some concern over self-rostering in ED leading to discrepancies in work carried out against the compliant work schedules issued by MHR.

A. ROTA GAPS
Vacancy is currently calculated by looking at funded establishment WTE and staff 'presumed' in post calculated via WTE we are paying.
Honorary posts paid for by other Trusts should be factored in by a 'recharge' calculation.
Associate Director for Workforce Planning, People Systems and Data and his team have determined that calculating vacancy based on NBT Electronic staff records (ESR) would give greater accuracy on vacancy. However, the ESR system currently is thought to contain many redundant records for individuals that no longer work at NBT.
The aspiration is to clean the ESR of 'deadwood' and potentially move to calculating vacancy via this method, this has yet to be realised so there are gross inaccuracies in the data below indicating gaps where there are none.

1a – Vacancy – OVER 4 MONTHS - June-Sept (excluding sickness, maternity)

	LED		Trainee	
Divisions	WTE	Vacancy WTE	WTE	Vacancy WTE
ASCR	367	-15	854	-59
Core Clinical	29	34	138	106
Medicine	270	-28	589	30
NMSK	241	-144	361	161
W&C	69	-64	179	11
Grand Total	**976**	**-217**	**2121**	**249**

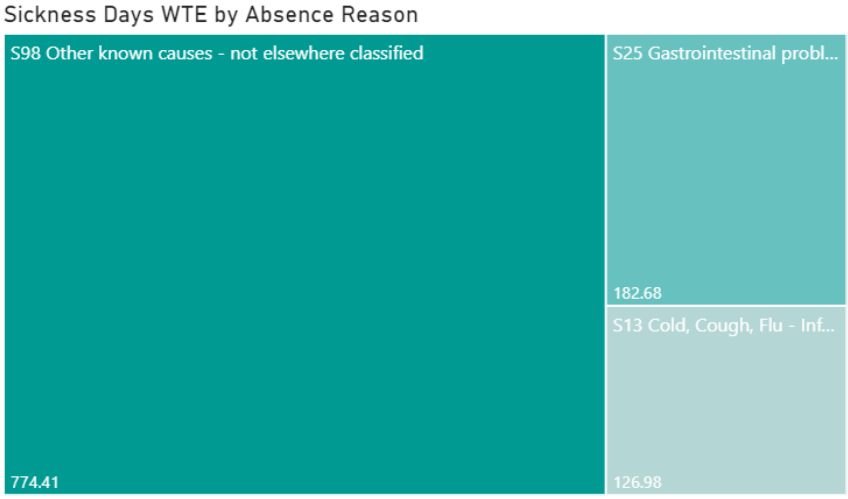
Table 1. Shows RD WTEs lost due to vacancy in each Division.

** VACANCY → Negative number indicates over establishment i.e., not a gap
Positive number is the actual deficit i.e., a gap.

1a – RD Sickness Absence
'NHS Digital' sickness data for RDs for same period 2022-2023 (lag in publication) in last column for benchmarking. NBT is below the National average for sickness rates.

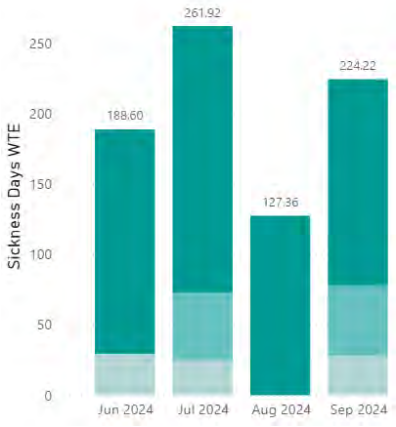
Month	ASCR	Core Clinical	Medicine	NMSK	W&C	NHS Digital June-Sept 2023
June	0.5%	1.4%	1.4%	1.3%	2.9%	1.8%
July	0.8%	1.5%	2.0%	0.8%	2.6%	1.9%
Aug	0.1%	1.3%	1.3%	0.5%	0.5%	1.2%
Sept	0.4%	1.7%	1.4%	1.1%	0.0%	1.8%
Grand Total	**0.5%**	**1.5%**	**1.5%**	**0.9%**	**1.5%**	**1.7%**

Table 1b – Sickness by absence reason June – Sept



1c – All sickness short term June – Sept

1d - WTE lost June-Sept



Large data hole as 2/3 of all sickness days lost are not classified/unknown.
BUT all NBT sickness days are classified as short term, and we are below national average so chasing the causes of the sickness would be of limited benefit.

B. GAP MANAGEMENT

There will always be gaps from short term sickness.
MHR are only informed of DiT names and LTFT status 12 weeks prior to the DiT commencing duties in Aug and Feb rotations. This leaves little time to recruit into rota gaps left by LTFT status. NBT should perhaps work toward predicting the trajectory percentage of DiT going LTFT to enable adequate financial planning of LED need. I have included in Appendix 3 some data on LTFT % in NBT at different grades and in different specialties as an example of tracking trends.

1. LED Adverts

- Recruitment into Locally employed Doctor gaps is continuous and on-going.
- 'Over recruitment' has occurred in areas that are large locum users e.g. Medicine cluster 1.

2. Optimising NBT locum reach

- RD Forum suggested 'Locums Nest' (LN) app – taken up by NBT.
- GRH, RUH, Great Western, and UHBW are now all signed up to the MOU to form the SwaG Collaboration

3. NBT is in a good position in the future (2024-2025) to potentially diversify and stabilise some parts of the RD workforce by expansion of Physicians Associate (PA) posts.

- An Extraordinary General Meeting took place on March 13th by the Royal College of Physicians to address national concerns regarding PA scope of practice, supervision, and regulation. An initial RCP PGD membership survey was shared indicating significantly more positive attitudes to PAs by those who have worked with them:
- GMC registration hopefully by end of 2024 – may lead to radiology requesting and prescribing rights.
- PAs currently work less hours than PGDs and do not cover on call.
- NBT trains ~20 PAs a year.
- Currently 19 PAs employed by NBT.
- Lead PA role appointed to in April 2023 – ……
- Roles to be rotational – help with role development and retention.

4. **Medical Workforce Resilience projects**

- Associate Director for Workforce Planning, People Systems and Data is leading on a large piece of work looking at the MDT with increased use of PAs, Aas and other allied health professionals.

5. **Could NBT more optimally use self-rostering to better use LTFT RDs clinical time and so minimise gaps and locum spend?**

- ED and Medicine have attempted to optimally engage with RLDatix Allocate rota solution.
- Self-rostering is a priority for the NHS in 2025-26 – to improve RD lives.
- Nationally, EDs are frontrunners in self-rostering with great RD qualitative feedback.
- Self-rostering a large LTFT work force is incredibly complicated. Our ED self-rosters RDs using a google doc to manage the process as Allocate has not been found suitable. One senior clinician manages this document during time they are not adequately re-numerated for, and it is then copied across by admin to Allocate. The google doc does not high-light rota breaches or count shifts or hours. MHR carried out a retrospective audit that indicated some discrepancies with shifts paid for and those worked by the end of the year.
- Annualised self-rostering is also a target for NBT Medicine Division; to improve qualitative experience and simplify rota construction but also potentially release another 10-12% of LTFT clinical activity (as they currently do not all work the full 60% or 80%, they are scheduled for due to fixed rolling shift patterns)
- Healthrota is an alternative platform to Allocate that is bespoke for self-rostering. I have spoken to a rota Fellow in the Northern Alliance who has realised 30K in saving in a short time within Medicine due to optimally using LTFT RDs time using Healthrota.
    i. Helathrota does not require a locked in contract and is paid per month per RD on the platform with the ability to withdraw at any time.
    ii. It can be run in one specialty within a Trust as a trial or permanently.

C. <u>LOCUM USAGE</u>

Locums Nest (LN) roll out for RD locum recruitment has been completed.

NBT Extra (doctors locums were booked and paid through this prior to LN full roll out) time sheets are still often used to retrospectively pay for shifts that are taken following a verbal/ email/ WhatsApp on the day urgent request.

This leads to variability in locum's payment for breaks within the Trust.

<u>A shift booked on LN does not pay for breaks</u> – the time sheet is set by NBT to preclude entering '0mins break' i.e. you should have had 60mins break in a 10hr shift so are paid for 9 hrs.

<u>Retrospective NBT Extra time sheets do pay for breaks</u> – they allow for having worked through your break and so getting paid for the whole shift including 'breaks'.

All payments, pro and retrospective can and should go through LN to give consistency in pay.

Payment for <u>locum breaks</u> is not mandated in the contract.

Doctors employed by the Trust on the 2016 contract are paid for breaks as it is acknowledged in the contract that it is unsafe to have a doctor uncontactable/bleep free for any part of their shift.

Shift Count				
Divisions	Jun 2024	Jul 2024	Aug 2024	Sep 2024
ASCR	223	381	123	77
Filled	195	328	113	74
Unfilled	28	53	10	3
Core Clinical	3	4	2	
Filled	3	4	2	
Medicine	709	1664	467	342
Filled	592	1243	396	306
Unfilled	117	421	71	36
NMSK	159	390	120	145
Filled	131	328	109	141
Unfilled	28	62	11	4

W&C	38	102	16	8
Filled	12	70	13	7
Unfilled	26	32	3	1
Grand Total shifts requested	**1132**	**2541**	**728**	**572**
Grand total requested in WTEs	**61**	**125**	**39**	**31**
Fill rate %	**82%**	**78%**	**87%**	**93%**

Fill rate target is 85%.

Medicine cluster 1: ED, Acute Medicine –

ED has been the biggest user of locums (preceding 4 months included for comparison)

	Feb	Mar	Apr	May	June	July	Aug	Sept
Total Shifts requested	385	505	422	458	450	1035	**320**	**211**
WTEs	20	25	20	22	23	45	17	12
Fill Rate %	**88%**	75%	80%	79%	**89%**	69%	**86%**	**92%**

Narrative from Medicine division lead clinicians on successful reduction in locum spend in ED since Aug:

1. July had an excess of gaps – RDs saving leave for the end, LEDs leaving their posts early etc.
2. Since August (new rotation) there are fewer gaps across the board
3. ED have made a very active effort to stop putting out locum shifts for RDs when there are more consultants / senior decision makers around.
4. We have re-evaluated the minimum shift numbers with a RAG rating and the consultant in charge is being supported to make more risk-based decisions in the context operational pressures/demand. This has reduced locum shifts considerably in ED.
5. We have overrecruited on LEDs for ED. They have started to become available since September but more coming online from now so hope to see sustained improvement.

D. EXCEPTION REPORTS

We have worked at removing some of the perceived 'barriers' to exception reporting that were highlighted in the Resident doctor and Consultant surveys we carried out in July 2024.

- Videos and posters show a QR code to Allocate exception reporting log in
- Instructions on saving the log in page to the phone home screen are in the videos and posters.
- Assurance on outcomes and instructions on access to consultants in videos
- Simplification or rota names; this is the first mandatory field in Allocate and not knowing the rota name leads to abandoning the report.
- We are seeing an increase in exception reporting – perhaps starting to reveal a truer picture of how our resident doctors are working.

Exception Reports (ER) over 4 months June – Sept		Number flagged as immediate safety concern (ISC)
Number relating to hours of working	141	
Number relating to pattern of work	0	
Number relating to educational opportunities	5	
Number relating to service support available	1	
TOTAL NUMBER OF EXCEPTION REPORTS	**147**	**0**

	EXCEPTIONS BY YEAR			
	2021	2022	2023	2024
JAN	37	29	56	28
FEB	33	28	64	45
MAR	16	27	28	42
APRIL	52	31	31	43
MAY	46	28	37	30
JUNE	61	24	40	**24**
JULY	51	44	48	**21**
AUG	27	89	54	**34**
SEPT	44	79	73	**68**
OCT	47	74	67	85
NOV	29	40	53	
DEC	21	52	30	

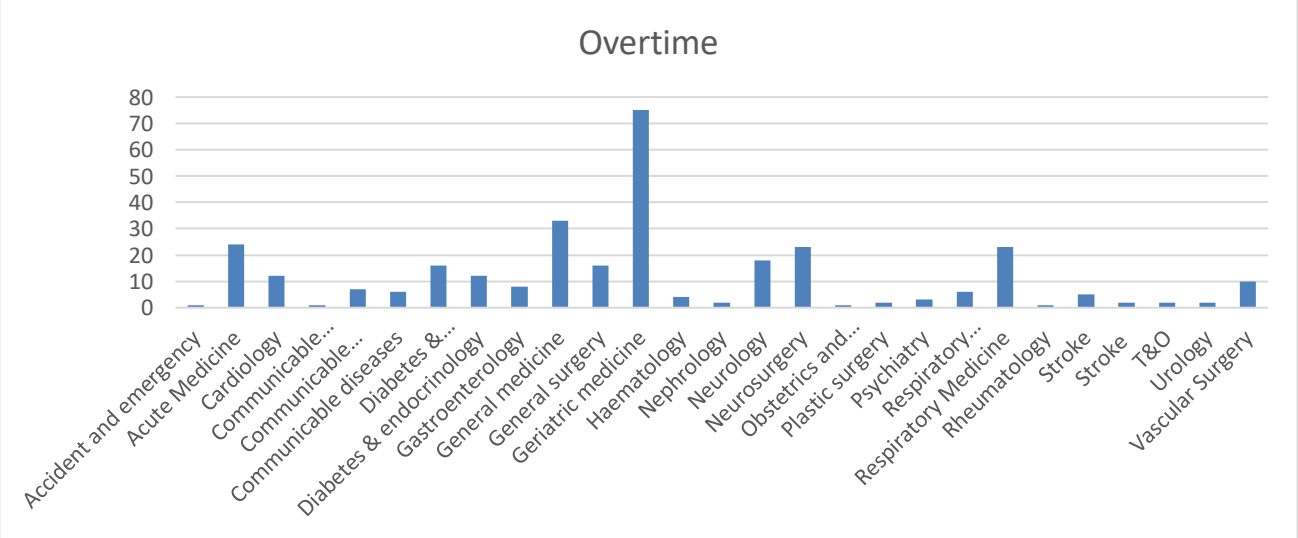
BREAKDOWN EDUCATIONAL REPORTS:

Number of exceptions	Rota	Issues
1	F1 nephrology	F1 teaching missed
1	F1 Geriatric Medicine	F1 teaching missed
1	F2 Acute medicine	F2 teaching missed
1	O&G ST3+	Missed 'pink session' admin/education for 2nd time as gap in gynae on-call.
1	F1 general medicine	F1 teaching missed

F1/F2 core teaching is mandatory and recorded so available if missed.

90% of all exception this year (as in previous years) are for hours.

'HOURS' EXCEPTION REPORTS BY SPECIALTY (June-Sept)



Geriatric medicine has one of the largest bed bases – 230 beds – so will be overrepresented.

The Clinical lead has discussed supporting exception reporting with the RDs and staff have been moved to support timely departure in geriatric medicine resulting in a decrease in overtime exceptions in Sept and Oct.

RESIDENT DOCTOR FORUM – Held in person and Teams every 2 months.

- Improved engagement asked for by Trust Board:
    - Achieved through posters and asking the lead Educational supervisors to promote the role.
    - Offer of £5 Vu voucher for all PDF attendees
    - Banner added to intranet and dates on LINK calendar.
    - GOSW videos for Induction and Educational Supervisors updated.
    - Continue to recruit new Reps via posters and monthly email.

- RDF useful outcomes:
    - **LTFT working group – very positively received by HR.**
    - **Survey recently carried out by a RD Rep to RDs and Consultants on views on and barriers to exception reporting – leading to amended videos with greater instructional element.**
    - App for locum contacts – Locums Nest
    - Re-think of Acute block 6-week structure - - due to for re-survey

Other issues arising:

1. **Self-rostering**

- NHSE have announced that self-rostering will be a major focus in 2025/26 to improve working lives of doctors in training. The lack of control DiTs have over their lives is reported as a major contributor to job dissatisfaction. NHS England » Improving the working lives of doctors in training
- As GOSW it is my role to report on how the Trust is endeavouring to minimise gaps and locum usage.
- In Dec, NBT is undertaking a review and myth busting exercise around RLDatix Allocate rostering solution.
- At this review I would ask that Allocate self-rostering capabilities are evaluated including end user feedback. This should be carried out alongside a review of the market leaders in self-rostering such as Healthrota. It may be that one rostering solution is not capable of meeting all NBTs needs to fully realise the potential of our LTFT RD workforce.

2. **LTFT schedules were late across the Trust in August 2024.**

- It is a contractual requirement that work schedules be issued 8 weeks prior to commencing duties and an accurate bespoke work rota be available to RDs at 6 weeks prior to commencing duties.
- Historic inaccuracies in RLDatix Allocate software were uncovered this year in relation to leave and salary calculations for LTFT doctors. A national update from NHSE and BMA working with RLDatix required that all work schedules and salaries be calculated based on individual's rota. This last-minute requirement led to delays in issuing the work schedules to ensure accuracy in salary calculations.
- MHR have been working closely with each specialty to try and ensure rota templates can be used for bespoke work schedules for individual doctors when we are notified of names and LTFT status. This is challenging for some specialties such as ITU, anaesthetics and ED due to the duration of the placements not fitting into rolling templates easily.

Networking

- The Guardian is in contact by WhatsApp and Zoom with national and regional groups.
- NHS-Employers remote meetings to network with them and other Guardians.
    - I am currently contributing to NHSE Guardian focus group that feeds into the ongoing 2016 contract re-negotiation in relation to exception reporting revision.
    - Webinar BMA GOSW conference attended in Sept

SUMMARY

NBT is compliant with:

- BMA contract rules regarding rota construction
- Electronic reporting system in place (Allocate)
- Resident Doctor Forum – meetings being held as required by New Contract
- Exception Reporting Policy
- NBT has met its locum fill rate target for the last 2 months and reduced its locum spend
- LNC involvement
- All national requirements as listed by NHS Employers

Concerns:

- Unfilled gaps on rotas
- LTFT – Medicine Divisional Leads have stated the current fixed rolling rota patterns means LTFT doctors often do not work the full 80 or 60% they are committed to working with a shortfall of 10-12%. This leads to gaps on rotas and increased locum spend. The NHSE/RLDatix requirement for bespoke LTFT schedules to precisely calculate hours worked and salaries means that some LTFT doctors have a shortfall of 10-12% of their salary that they did not budget for. The unrequested reduction in time at work by a further 10 -12% also means less opportunity to achieve training competencies.
- Timely issuing of schedules to LTFT RDs now needs bespoke individual rotas prior to release – time pressure – MHR have worked with the specialties to be ready for Feb
- Disparity on payment for locum breaks across the Trust – (At a previous Trust Board Chief Medical Officer stated that this may be reviewed with finance if the locum spend comes down)
- Inaccurate vacancy data due to recharge process

Recommendations:

1. The Board are asked to read and note this report from the Guardian of Safe Working
2. The Board are asked to seek further information on the adequacy of self-rostering platforms for doctors in relation to it's current and future IT commitments; to fully utilise NBT LTFT workforce and minimise RD gaps and locum spend.

North Bristol NHS Trust

Appendix 1: SLA- Board Governance Individual Payment Errors Framework.

This board governance framework is to oversee individual pay errors to enable Medical Workforce and Payroll to record and handle payroll queries swiftly and to monitor and report errors for all Postgraduate Junior Doctors and Clinical Fellows.

Please see the steps and timeframes below for how to resolve:

1. Urgent Error Notification

    a. All urgent errors must be investigated and resolved within 24 hours.
        i. The staff member in receipt of the error must notify Payroll and or Medical Workforce and log it on the Junior Doctor Pay Error spreadsheet.
        ii. Payroll and Medical Workforce will work together to verify the data on ESR and receive confirmation within the urgent/non-urgent time scale.
        iii. Payroll will rectify the error and update the Junior Doctor Pay Error spreadsheet upon resolution and email or call the member of staff with the rectified outcome within 24 hours.

2. Payroll Queries (non-urgent)

    a. non-urgent errors investigated and resolved within three working days.
        i. The staff member in receipt of the query must notify payroll and or Medical Workforce and log it on the Junior Doctor Pay Error spreadsheet.
        ii. Payroll will inform the Medical Workforce to verify the data on ESR and receive confirmation within the urgent/non-urgent time scale.
        iii. Payroll will rectify/explain and update the Junior Doctor Pay Error spreadsheet upon resolution and communicate with the member of staff with the rectified outcome within three working days.

3. Analysis
    a. Payroll and Medical Workforce will analyse error data monthly to identify recurring issues and use the analysis to develop new procedures and best practices.
    b. Payroll and Medical Workforce to submit findings and recommendations to the Guardian of Safe Working (GoSW).

2. Board Reporting
    a. GoSW will submit an error and mitigation report to the Board every quarter as part of their GOSW report.

Explanations

1. What is an Urgent Pay Error?

    iv. An urgent pay error refers to a significant and immediate issue in the payroll process that requires prompt attention and resolution. This type of error typically involves mistakes that directly affect staff.
    ability to meet their financial obligations, such as underpayment or non-payment of salary.

    b. Examples:
        i. They did not receive the correct amount of pay or were not paid on the scheduled pay date.
        ii. A significant underpayment.

2. What is a Pay Query?

v. A pay query is a general question or concern about payroll that staff raises. It does not necessarily indicate an urgent problem and might involve clarifications or minor adjustments that do not critically impact the staff's immediate financial situation.

b. Examples:

i. Questions about the calculation of deductions such as taxes or benefits.
ii. Clarifications regarding the breakdown of salary components.
iii. Minor discrepancies in the payroll amount, such as a small difference in the expected and received payment.
iv. Queries about changes in pay scales or scheduled increases.

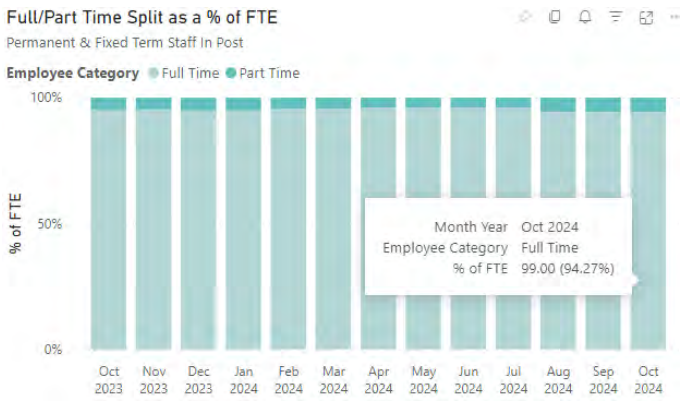
Appendix 2: Payroll errors since implementation on August 1st:

Division	Point of Error	Reason For Error	Date Raised	Further Info	Next Steps & Pay Correction/Resolution
W&C	Medical HR	Late CoC	03/09/2024	COC Form not done to move from ST2 grade to ST3 from 7th August, with payment not changed as a result	COC completed and sent to Payroll 04/09/24. MHR emailed back individual explain issue had been resolved.
W&C	Medical HR	Late Leaver form	03/09/2024	Leaver not entered onto August Dr's leaving spreadsheet – therefore overpaid	Leaver actioned by … M6, overpayment calculated waiting for retro to run to check figures
Medicine	Employments Services	Work Schedule	10/09/2024	Outdated F1 Medicine Work Schedule applied to … pay, causing slight underpayment.	COC completed and sent to Payroll 10/09/24. MHR emailed back individual explain issue had been resolved.
ASCR	Medical HR	Leaving date	06/09/2024	Leaver form submitted with wrong date (7th September rather than 7th October), causing Pay + IT to cease	Emailed to Payroll on 06/09/2024 but no response. Chased up on 11/09, resolved in Payroll and IT also have resolved today.
Medicine	Medical HR	Other	05/09/2024	Incorrect wording on C/o/C. – said new position number & no other additional changes instead of basic only and no additional hours to be paid	Emailed … and New c/o/c raised and actioned for September. Overpaid weekend and ARH from 6/8/24- 31/8/24 New change actioned for September's pay. Overpayment taken back in September and Dr informed.
Medicine	Payroll	Other	23/09/2024	Dr mess fees deduction taken in M6 in error.	Opt out and refund made M5 Supp. Resolution – Removed recurring element & refund fees M6 Supp. Emailed Dr with apology
Core Clinical	Employee	Other	23/09/2014	Thought Dr's Mess was still being deducted	Stopped and refunded in September.
W&C	Medical HR	Work Schedule	26/09/2024	Work Schedule was amended not forwarded to payroll	COC completed and sent to payroll on 27/09/2024. … emailed individual and explained now with payroll. Payroll to action COC – Payroll actioned
Medicine	Medical HR	Work Schedule	25/09/2024	Contact …	All COC Forms been done and sent to payroll. Doctors, department informed. Payroll to action.

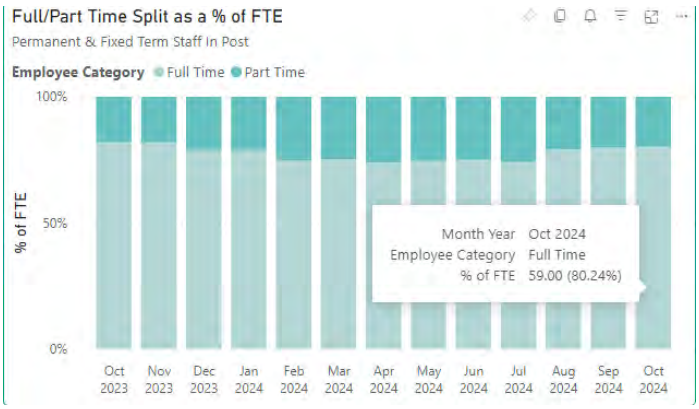
Appendix 3: LTFT prevalence at NBT for DiTs (excluding LEDs) by grade – highlighting some specialties to show the differences.

- LTFT proportion increases with seniority – explicable with child-care, ill health, other interests etc
- >ST3 DiT LTFT % leads to WTE deficit → poses largest challenge to safely staffing services.
- Fairly consistent % LTFT throughout 2024 in each specialty (no data from 2023 on BIHub to compare)
- LTFT % differs largely between specialties - related to gender, work intensity, burn out?
- Could be used to predict WTE need for LEDs in each specialty?

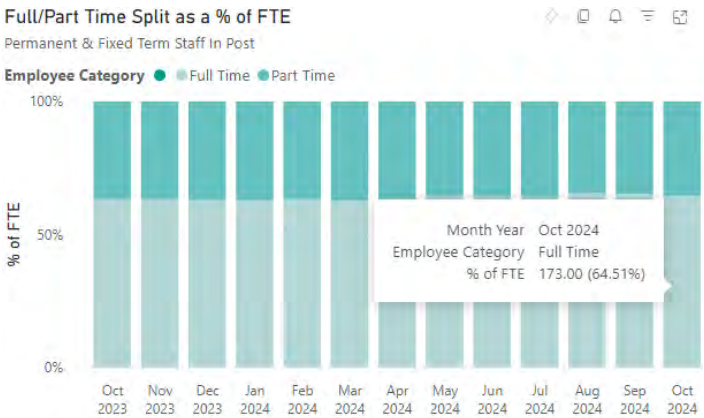
Foundation doctors: 6% LTFT



Core Trainees: 20% LTFT

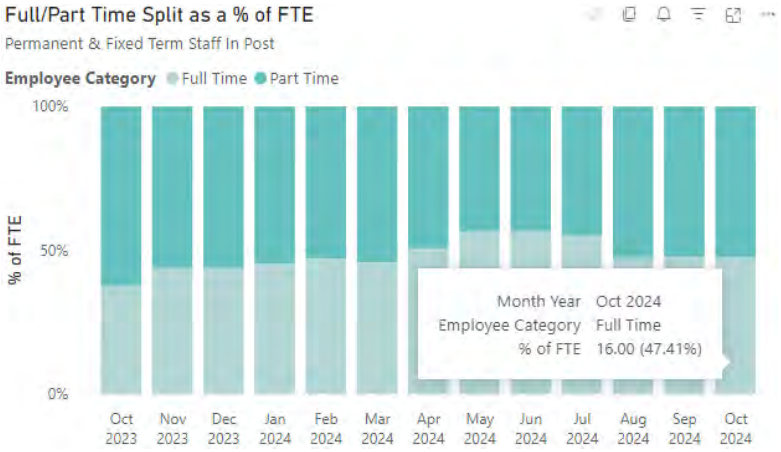


>ST3: 45% LTFT

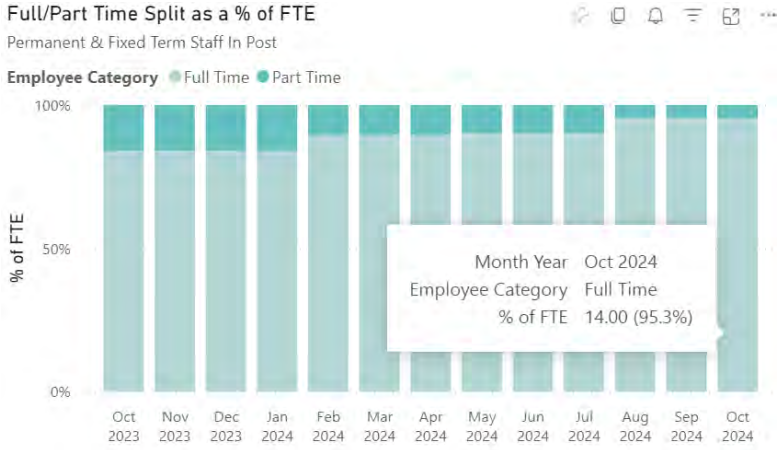


>ST3 different specialties:

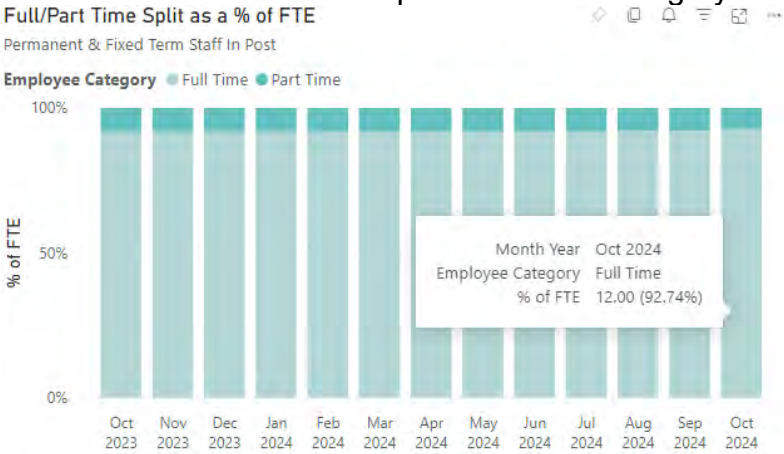
1. Anaesthesia and critical care: 53% LTFT



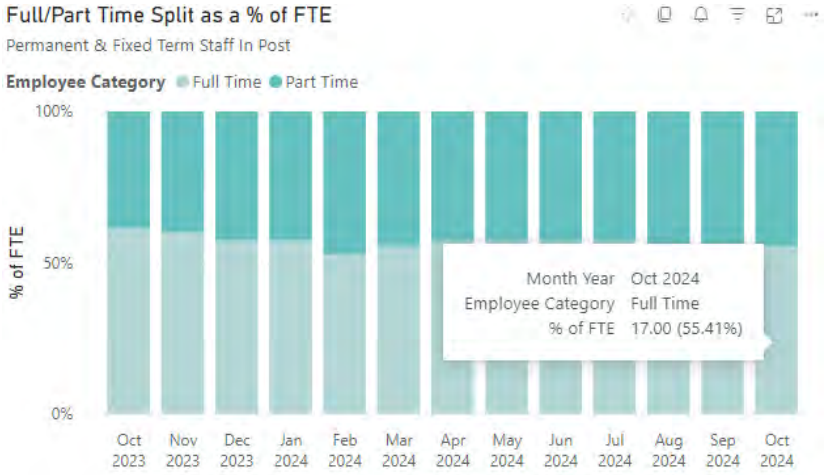
2. NMSK - cluster 2 – T&O – 5% LTFT



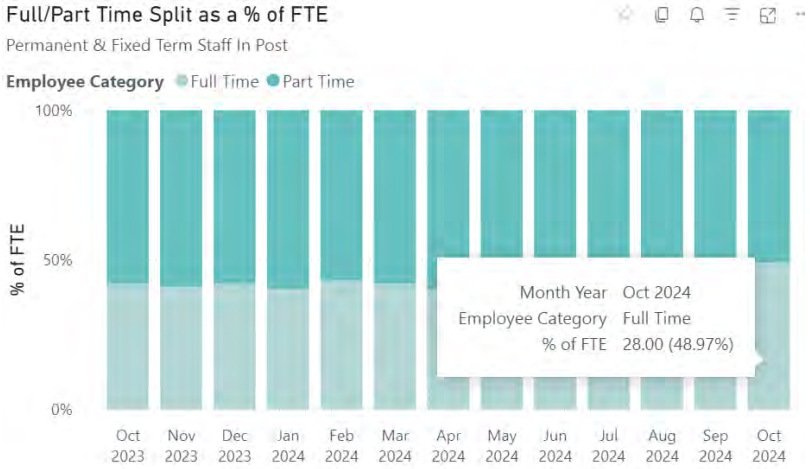
3. NMSK – cluster 1 - Spinal and Neurosurgery – 7% LTFT



4. W&C – 45% LTFT



5. Medicine Cluster 1 – ED and AMU – 51% LTFT



North Bristol NHS Trust

Meeting of the Board on 28 November 2024 held in Public

Reporting Committee	**People & EDI Committee**
Chaired By	**Kelvin Blake, Non-Executive Director**
Executive Lead	**Peter Mitchell, Interim Chief People Officer**

For Information

The Committee met on 14 November 2024 and received the following reports:

1. **Chief People Officer Update -** The Committee received a verbal update which focused on:
    - The positive workforce control audit that was received at November's Audit and Risk Committee.
    - The collaborative work across the People teams with UHBW and the appointment of a Joint Director of Education across both organisations.
    - An update on the Group model work, particularly regarding the structure, operating model and benefit realisation.
    - The positive progress toward achieving the staff survey target of a 62% completion rate, with a reported completion rate of 55% at the time of the meeting.
    - The implementation of the anti-racism training pilot, which has received favourable feedback.

    Discussion focused on staff parking and the possible implications the new policy may have had on the staff survey results. The Committee received reassurance that staff feedback and learning opportunities have been acknowledged and will be taken into account during the development of the next iteration of guidelines. It would also be used to help inform and refine the approach for future rollouts. The Committee were also pleased to note that the recent changes had helped to improve parking for staff members working twilight shift patterns.

2. **Operational Workforce Update -** The report provided assurance in relation to the delivery of operational workforce priorities. The following key areas were highlighted:
    - Staff turnover has seen a slight increase for September however, this does not represent a statistically significant trend, and overall performance remains strong. Work was ongoing with divisions to assess opportunities to reach individual targets, with a specific focus on Corporate and Facilities.
    - Sickness and absence data indicating a positive trend with reduced sickness absence among NBT staff compared to other partner organisations.
    - Commitment to our community including planned improvements in:
        - the disparity ratio - significant work is happening with the divisions to understand the metrics and a deep dive was scheduled for November's Senior Leadership Group meeting.
        - hiring staff from the 30 most socio-economically challenged communities – the metric was being reviewed and would be discussed at November's Patient First Steering Group. The benefits of the mentorship programme was positively noted.
    - Recruitment with a positive performance from September 2024 particularly with the Medical time to hire.

The Committee welcomed the report and the positive progress. Discussion focused on the importance of reviewing the reporting metrics and comparing it with UHBW.

3. **NBT Workforce Plan update -** The Committee received an update on the Long-Term Workforce Plan which detailed that the forecasting model would be paused as part of the Hospital Group's efforts to adopt a unified approach, aligning processes to target areas of greatest need and prioritising high-risk areas, with plans to reinvest in and enhance the modelling tool for future use in alignment with UHBW. It was noted that a further update would be brought to January's Trust Board meeting.

4. **Trust Health and Safety Committee Update -** The Committee received the report which provided assurance on the oversight and management of Health and Safety compliance in the organisation. An update was provided on:
    - Details of internal and external audits carried out across the Trust Estate.
    - Details of major incidents that have occurred over the past three months.
    - An update on health and safety risks and their management.
    - Recent RIDDOR Incidents

5. **Risk Report -** The Committee received an update on the Trust Level Risk (TLRs) across its areas of responsibility, including the Health and Safety and Workforce risks, and reviewed the related workforce Board Assurance Framework (BAF) risks. It was noted that SIR2 relating to "Workforce" has had its residual risk score reduced to 12 which reflected the significant improvements in workforce availability.
   The Committee were assured that the TLRs were being actively monitored, mitigations were in place and actions were being updated. The Committee also noted the ongoing work with divisions and the work with UHBW to improve the current Datix model and the reporting dashboard.

The Committee also received updates on:

- Apprenticeship Centre Biannual Report
- The EDI plan which had been formally reviewed and refreshed – the focus on the ongoing actions were noted, particularly regarding:
    - the anti-racism training,
    - sexual safety at work
    - formally adopting the social model of disability
    - inclusive recruitment practises
- Ethnicity Disparity in Casework - the Committee discussed the report and noted the analysis on the disparities in employee relations casework and the actions being taken to eliminate this.
- People Oversight Group Upward Report.

For Board Awareness, Action or Response (including risks)

Board should note the:

1. **Biannual Nursing, Midwifery and Allied Health Professionals Safe Staffing Report**
   The Committee received the report which provided assurance that that there was a clear validated process in place for monitoring and ensuring safe

staffing in line with current national recommendations.

It was noted that it was the second Safer Nursing Care Tool review undertaken using the new validated tool for areas where bed base is predominantly single patient rooms. Further work would be undertaken in collaboration with other organisations to review their outcomes and with the national team to gain insight into the methodology behind the tool's calculations. A full update would be presented to the Trust Board in due time.

The Committee discussed how staff were being supported in challenged areas and were reassured regarding the measures put in place. Discussion also highlighted the focus on resources, with an intention to request additional support in six months, despite the tool indicating an earlier need. The Committee were informed that investment priorities were being reviewed but that the support for off-the-job training was a main focal point. It was noted that the importance of recognising the growing annual demand, and the need to address the increasing patient volume across the hospital would help to inform the timing and allocation of resources. The positive recruitment strategies to transition bank staff into substantive roles were welcomed.

2. **Maternity Safer Staffing Report**
The Committee received the report and agreed that:
    - the midwifery staffing budget reflects the establishment as calculated in the North Bristol NHS Trust Birthrate Plus Report July 2022.
    - the Committee on behalf of the Trust Board has received the bi-annual midwifery staffing oversight report that covers staffing and safety issues (in line with NICE midwifery staffing guidance) during the Maternity Incentive Scheme (MIS) Year 6 reporting period.

The Committee also noted that the midwifery vacancy position as of July 2024 was -1.25% and that a Birthrate Plus review would be undertaken in 2025.

The Committee welcomed the report, acknowledging the improvements to staffing levels, and discussed the challenges regarding the Percy Phillips ward and the improvement initiatives to provide a better patient and staff experience.

The report is available in the Convene document library for Trust Board members to view.

Key Decisions and Actions

The Committee:

- agreed to receive an update operational planning process,
- requested that all policies and processes are reviewed and implemented through an anti-racism lense,
- requested that accessibility be considered when developing guidance.

Additional Chair Comments

N/A

Date of next meeting:	Thursday 16 January 2025

North Bristol NHS Trust

Meeting of the Board on 28 November 2024 held in Public

Reporting Committee	**Audit & Risk Committee**
Chaired By	**Shawn Smith, Non-Executive Director**
Executive Lead	**Elizabeth Poskitt, Interim Chief Finance Officer**

For Information

1. The Audit and Risk Committee met on 7 November 2024.

2. The Committee reviewed the following internal audit review reports:

   - **NHSE Workforce Controls Review**: While no formal assurance opinion rating was issued, Internal Audit had found that NBT was largely compliant with the workforce controls expected by NHS England, with no issues, risks or concerns of significance raised, and only minor improvements recommended.
   - **BadgerNet Maternity System Post-Implementation Review**: Internal Audit had issued a "significant" assurance opinion rating, again with no issues to raise.

3. The Committee received and reviewed the following additional reports:

   - **External Audit Progress Report** and Sector Update: this notified the Committee of timescales for next year's external audit and of developments in the wider NHS audit environment.
   - **Internal Audit Progress Report** and action tracker, along with monthly insight reports and updates on service-specific audits (see section 2 above). The Committee noted that progress on all internal audits and audit findings was very good, with only 6 low-to-moderate-risk target dates becoming overdue at the end of September, all for good reason and with short time extensions.
   - **Counter Fraud Progress Report** August to October 2024: this informed the Committee of proactive work (e.g. training, newsletters, alerts, and fraud prevention notices etc) and reactive work (e.g. investigations) currently ongoing. The Committee asked for more information in future on the estimated value of casework and a six-monthly report on key themes.
   - **Risk Management Report**, including updates on Trust Level Risks and the Board Assurance Framework (see BAF attached at **Appendix 1** and Trust Level Risks included in the **Convene Reading Room**). The Committee was informed of ongoing work to improve information on actions and mitigations, with timelines and more measurable actions, and of work planned to align risk appetite, risk policies, and processes with UHBW where appropriate.
   - **Cyber-Security Biannual Update**: this report informed the Committee of the wide-ranging and costly impact of cyber-attacks and of the extensive actions being taken to protect NBT (and UHBW and the wider ICS) from cyber security risks.
   - **Mortuary Building Works**: the Committee was informed that progress was being made with the building works, with the timescale for approval of the plans (by the Health and Safety Executive - HSE) outside NBT's control. This timescale could be in the region of 20 weeks. The Human Tissue Authority was however aware of this, in the context of NBT's licence, and there was perceived

to be no risk in this regard. The Committee accepted that everything possible was being done to meet the HTA requirements.

- **Bristol and Weston Procurement Consortium (BWPC) Update**: the Committee received the regular compliance dashboard, an update on the new Procurement Regulations (coming into force in February 2025) and an update on the rollout of the new SAP Ariba purchasing system. The Committee was informed of a reduction in the number and value of Single Tender Actions and non-compliant orders, and of reasons for those which existed. Progress was positive and welcomed. The Committee also asked for a post-implementation report at the appropriate time on the rollout of the SAP Ariba system.
- **Losses and Salary Overpayments**: these were noted.
- **Grip and Control Update**: the Committee was informed of the good progress being made to ensure all appropriate checks and balances were in place and working well at NBT. The Committee noted the positive results of the recent Peer Review (which evidenced NBT's good progress). This Peer Review report has been placed in the **Convene Reading Room** for Board members to peruse as they wish.
- **Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority** (SOs, SFIs and SoDA): the Committee agreed changes to (a) clarify who is responsible for appointing staff to posts and for deciding to increase departmental staffing establishments and (b) reflect the new NHSE strategic outline case value limit. The report on the amendments (which was submitted to the Committee) is attached as **Appendix 2** to this report. The amended SOs, SFIs and SoDA have been placed in the **Convene Reading Room** for Board members to peruse as they wish. The Committee was also informed of work planned to seek closer alignment in future with UHBW in terms of the SOs, SFIs and SoDA.
- **Committee Terms of Reference and Annual Committee Survey**: the Committee agreed amended terms of reference, aimed to help with cross-fertilisation of committee membership and improved triangulation of data and information across the Trust, and agreed these for approval by the Board. The amended terms of reference are attached as **Appendix 3** to this report. The Committee also agreed to defer its annual committee effectiveness survey for a year, while these changes took effect.

4. The Committee did not identify any specific areas requiring escalation to the Trust Board.

For Board Awareness, Action or Response (including risks)

In September, Trust Board asked the Audit and Risk Committee to seek additional assurance regarding the Mortuary Building Works, and compliance with Human Tissue Authority (HTA) expectations and requirements. Following its November meeting, the Committee is assured that work is progressing, and that the HTA is appraised of the delays linked to HSE approvals and has acknowledged and accepted the Trust's revised timescales.

As reflected below, approval is needed from the Board for the revised Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority and the revised Audit and Risk Committee Terms of Reference.

The Audit and Risk Committee Non-Executives also met separately as with the Interim Chief Finance Officer as the Auditor Panel, to review the arrangements for internal and external audit services at NBT. A verbal update will be provided in the Board meeting in private under AOB.

Key Decisions and Actions

The Committee recommends the following to Trust Board:

1. note this report for assurance purposes;
2. note the activities undertaken by the Audit and Risk Committee on behalf of the Board;
3. review and note the Board Assurance Framework attached as **Appendix 1** to this report;
4. approve the revised Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority proposed by the Committee which are referred to in **Appendix 2** to this report and contained (the Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority themselves) in the **Convene Reading Room**; and
5. approve the revised terms of reference for the Audit and Risk Committee attached as **Appendix 3** to this report.

Additional Chair Comments

It was particularly pleasing to receive the Internal Audit report on Badgernet as this has been a cause for some concern. The Chair has also discussed BadgerNet with members of the WACH team on a recent Board Insight visit, which was positive.

It was also good to see work had been completed on the risk register to update risks and in particular, to highlight overdue updates.

Date of next Audit and Risk Committee meeting:	Thursday 6 March 2025.

Board Assurance Framework (BAF)

Introduction

The following document is the Trust's Board Assurance Framework (BAF) for 2024/25. The Board Assurance Framework defines and assesses the principle strategic risks to the Trust's objectives. It provides the Trust Board with assurance that those risks are being proactively managed and mitigated.

The BAF is designed to provide the Trust Board with a simple but comprehensive method for the effective and focussed management of principal risks to its strategic and business objectives. The Board defines the principal risks and ensures that each is assigned to a lead director as well as to a lead committee:

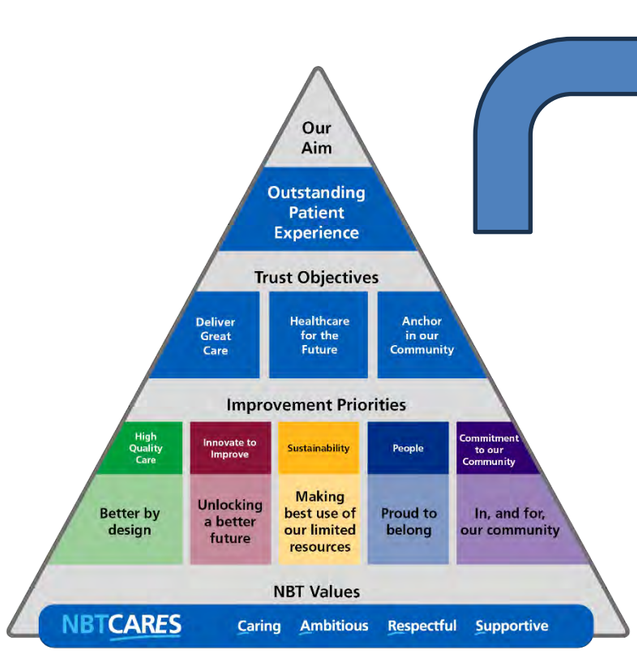
- The lead director is responsible for assessing any principal risks assigned to them by the Board and for providing assurance as to the effectiveness of primary risk controls to the lead committee;
- The role of the lead committee is to review the lead director's assessment of their principal risks, consider the range of assurances received as to the effectiveness of primary risk controls, and to recommend to the lead director any changes to the BAF to ensure that it continues to reflect the extent of risk exposure at that time;
- The Audit & Risk Committee is responsible for providing assurance to the Trust Board that the BAF continues to be an effective component of the Trust's control and assurance environment;
- The Trust Board reviews the whole BAF on a quarterly basis to ensure that the principal risks are appropriately rated and are being effectively managed; and to consider the inclusion within the BAF of additional risks that are of strategic significance.

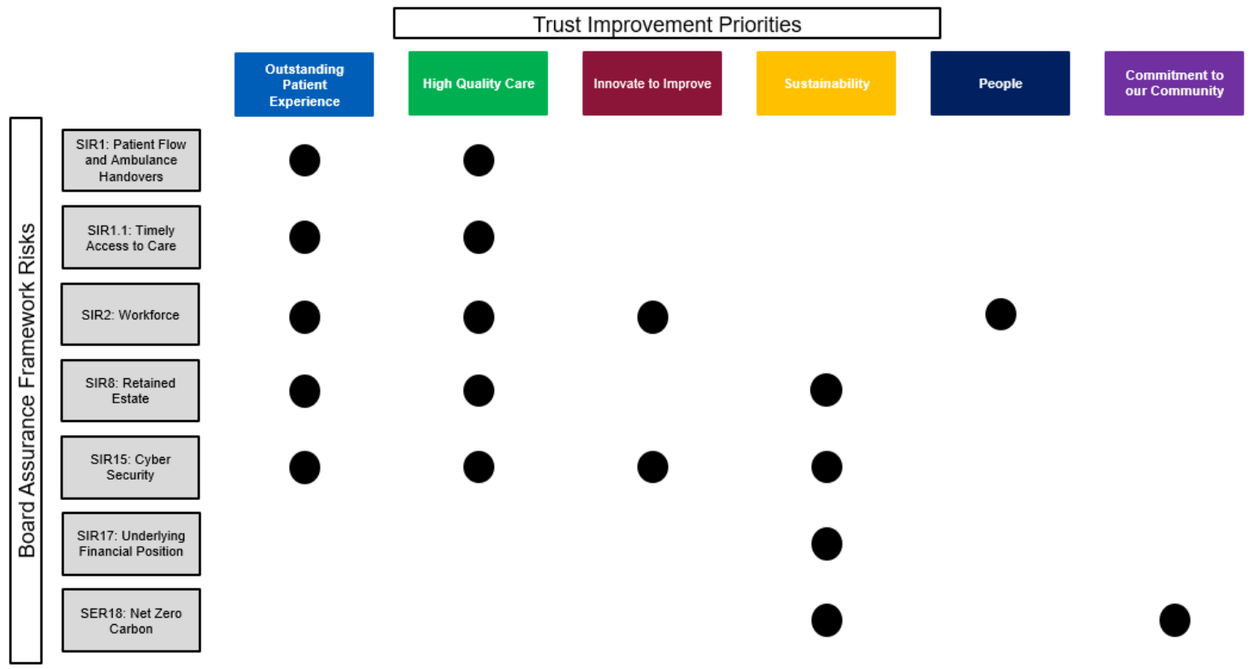
BAF Risks should be kept under review regularly, with a formal review and update mandated ahead of each meeting of the Audit & Risk Committee (meeting quarterly)

A guide to the criteria used to grade all risks within the Trust is provided in Appendix A.

BAF Risk alignment with Trust Strategic Objectives & Improvement Priorities:

This shows the primary alignment of our BAF risks with key organisational objectives and improvement priorities, noting that the risks have wide ranging implications which sit across all priority areas.





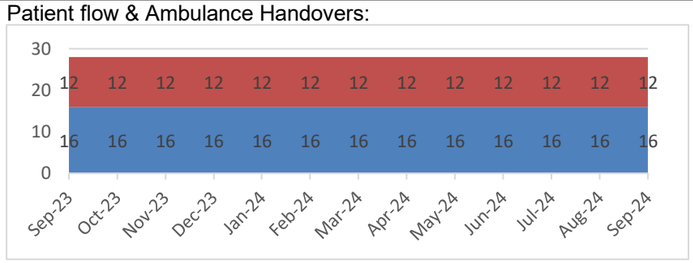
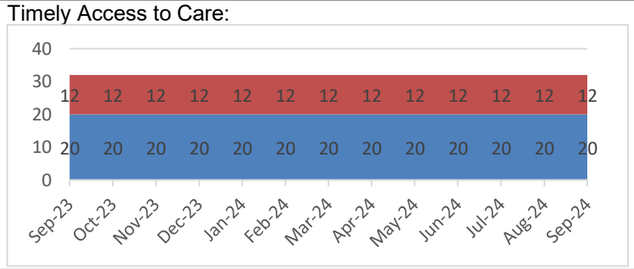
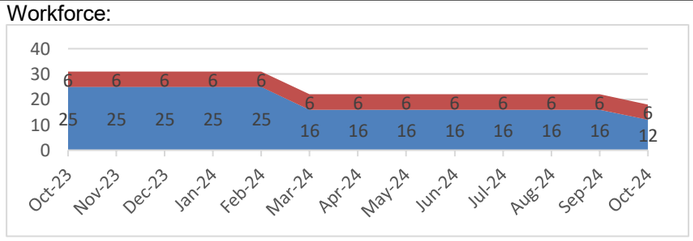
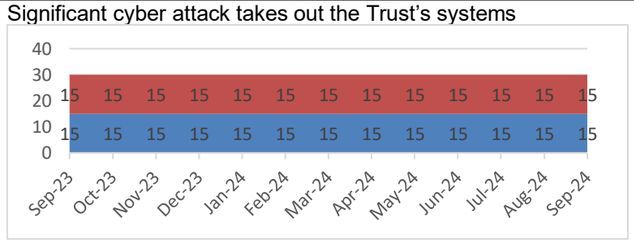
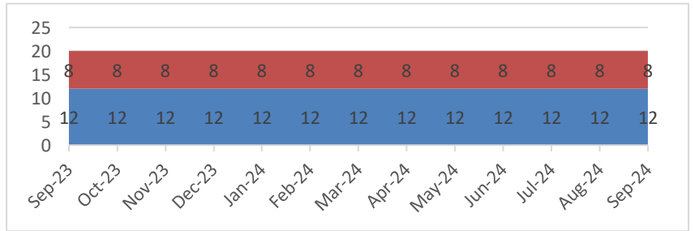
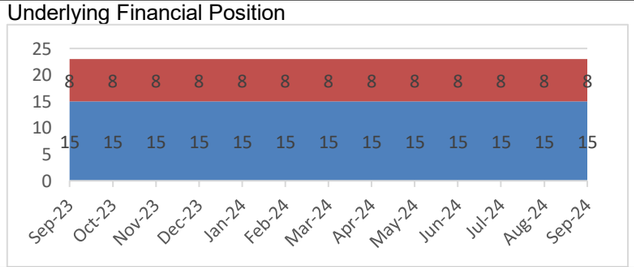
Board Assurance Framework (BAF)

Version Control (2023/24):

Version:	Summary of changes:	Reported to:
V1.0	Undertaking full BAF update for the beginning of 2023/24 – alignment to Patient First Trust Objectives and risk update	Audit Committee August 2024
V1.1	BAF now includes Carbon Neutral Risk, and alignment to key Trust Level Risks	Trust Board August 2024
V1.2	Quarterly update to BAF	Audit Committee November 2024

Board Assurance Framework (BAF)

Risk Score Trend and Trajectories

Risk	Current Residual Risk	Risk Summary and Trend	Forecast Trajectory (next 12 months)	Risk	Current Residual Risk	Risk Summary and Trend	Forecast Trajectory (next 12 months)
SIR1	**16**	Patient flow & Ambulance Handovers: 		**SIR 1.1**	**20**	Timely Access to Care: 	
SIR2	**25**	Workforce: 		**SIR15**	**15**	Significant cyber attack takes out the Trust's systems 	
SIR8	**12**	Retained Estate: 		**SIR17**	**15**	Underlying Financial Position 	
SIR 18	**12**	Net Zero Carbon **Trend TBC**					

Assurances set out for each risk in the Board Assurance Framework are categorised in line with the 'three lines of defence' model of risk management:

Key:

(1) **First line - Functions that own and manage risks**
(2) **Second line - Functions that oversee risks**
(3) **Third line - Functions that provide independent assurance**

Board Assurance Framework (BAF)

Impacting Trust Strategic Objectives:	Deliver Great Care; Healthcare for the Future	**Impacting Patient First Improvement Priorities:**	Outstanding Patient Experience; High Quality Care

Linked Trust Level Risks:

Datix 1940 – Performance Risk in Operations – Risk of poor patient flow

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 1	**Steve Curry, Chief Operating Officer** Last reviewed: 18/10/2024 Lead Committee: **Finance & Performance Committee** Also monitored by: **Quality Committee** Last reviewed: QC 10/09/2024 FPDC 19/09/2024 Risk added to BAF: **Pre-2019**	**<u>Patient flow & Ambulance Handovers:</u>** Due to a combination of factors, primarily high number of patients with no criteria to reside, but also including constrained community and primary care capacity and workforce pressures, the flow of patients across the hospital is constrained. This results in delays to key targets within the Emergency Zone, including the timely treatment of patients and delayed ambulance handovers. In turn this has the potential to result in patient harm, poor patient experience, and reputational damage to the Trust. Note: Elements of this risk are outside of the Trust's direct control – actions are focused on those areas that are within the organisation's influence. EXTERNALLY AND INTERNALLY DRIVEN RISK	Inherent likelihood: **5** **(Almost certain)** Inherent impact: **5** **(Catastrophic)** Inherent risk rating: **25** **(Extreme)**	**Internal:** FLOW boards (real-time bed state) Criteria to Reside data Integrated Discharge Service Repatriation Policy UEC Board and Improvement Plan OPEL/ICI Escalation & COVID-19 surge policies/procedures Accountability Framework Divisional Review assessment of and support to Divisions. Internal Professional Standards Clinically led dynamic risk assessed approach to pre-emptive transfers out of the emergency department Winter bed capacity contingency plans approved. Transfer of Care Hub **External:** Whole System Operational Group (WSOG – external) OPEL escalation process in system forums (Whole System Operational Group, OOH Delivery Group) Engagement with National UEC Improvement Team Discharge to Assess Winter pressure funding mechanisms UEC improvement plan	**Internal Assurance** Board rounds and site management processes (1) Integrated Performance Report (2) Patient flow metrics – daily control centre information (1) Executive Team review of dashboards (2) Performance report to Finance & Performance Committee (2) Finance & Performance Committee deep-dives into operational performance (ongoing 2024/25) (2) QC Deep dives into patient harm (2) Divisional Performance Reviews (2) UEC Board (2) **External Assurance** Urgent & Emergency Care Steering Group (external) (2) System Delivery & Operational Group (external) (2)	Residual likelihood: **4** **(Likely)** Residual impact: **4** **(Severe)** Residual risk rating: **16** **(Severe)** Previous residual risk rating: **3x5=15** **4x5=20** **5x4=20** Residual risk rating last changed: **22/10/2020** **09/03/2021** **08/07/2021** **13/07/2023** Forecast trajectory	Not yet seeing evidence that investment in "Discharge 2 Assess" initiative is delivering planned improvements to discharge numbers or reducing proportion of patients with no criteria to reside (led by BNSSG/Sirona). Other actions:	Working with ICS via the system Chief Executive group and the D2A Board to identify bridging strategies and short term mitigations to compensate for delayed D2A impact. (e.g., Transfer of care hub – see below) **Update:** D2A still not delivering as planned. Ongoing review via System-led D2A Board. Remains under regular review. **Owner: Various (COO & CEO)** **Delivery date: April 2025** Urgent and Emergency Care Improvement Plan actively overseen and sponsored by Executive Leads. This plan is being revised for 2024/25 and is focused on internal actions, including revised discharge/flow process management (process improvement). Appointed a Director of Urgent and Emergency Care who will lead the review and update. July 2024 Update: New Director of Urgent and Emergency Care embedded and internal UEC plan revised – linked to Winter Plan, presented at FP&C and Trust Board. **Owner: COO**	Target likelihood: **3** **(Possible)** Target impact: **4** **(Severe)** Target risk rating: **12** **(High)**

Board Assurance Framework (BAF)

				Same Day Emergency Care (SDEC) Model	CQC 2019 inspection – Urgent and Emergency Services rated Good [3]	(next 12 months): 		**Due date: various actions – aiming for improvement ahead of winter (Oct/Dec 2024)**	
							Lack of progress on system ambition to reduce NC2R levels to ≤15%	July 2024 Update: Initiated new work with analysis on capacity gaps in out of hospital services (including LAs). Agreed a revised NCTR percentage reduction at system level. Currently working through capacity funding options to service the new ambition. October 2024 Update: Ongoing discussions about resourcing demand and capacity gap. Some capacity released but does not yet match demand. **Owner:** COO & Chief Executive **Due Date:** Ahead of Winter 2024.	

Board Assurance Framework (BAF)

Impacting Trust Strategic Objectives:	Deliver Great Care; Healthcare for the Future	**Impacting Patient First Improvement Priorities:**	Outstanding Patient Experience; High Quality Care

Linked Trust Level Risks:

Datix 1436 – Performance Risk in ASCR – 65-week waits in Breast Plastic Surgery

Datix 1681 – Service Delivery Risk in CCS – Risk of end-of-life imaging equipment

Datix 988 – Performance Risk in Operations – Risk to timeliness of cancer care

Datix 523 – Patient Safety Risk in ASCR – Risk to timely follow-up appointments in Urology

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 1.1	**Steve Curry, Chief Operating Officer** Last reviewed: 18/10/2024 Lead Committee: **Finance & Performance Committee** Also monitored by: **Quality Committee** Last reviewed: QC 10/09/2024 FPDC 19/09/2024 Risk added to BAF: **January 2022**	**<u>Timely Access to Care</u>** **The impact of the Covid-19 pandemic, together with high numbers of patients with no criteria to reside, workforce/skills shortages, and complex clinical pathways, has resulted in a demand/capacity gap in cancer services, diagnostics, and planned care. This has the potential to result in long-waiting patients deteriorating and coming to harm, poor patient experience, and reputational damage to the Trust.** Note: drivers of this risk are outside of the organisation's direct control actions are focused on those areas that are within the organisation's influence. EXTERNALLY DRIVEN RISK	Inherent likelihood: **5** **(Almost certain)** Inherent impact: **5** **(Catastrophic)** Inherent risk rating: **25** **(Extreme)**	**Internal:** FLOW boards Integrated Discharge Service Repatriation Policy OPEL/ICI Escalation & COVID-19 surge policies/procedures Accountability Framework Internal Professional Standards Protected Elective Capacity. Use of WLI Use of independent sector Clinical Long-wait Harm Review Process (no wait related harm identified) Fortnightly Cancer Steering Group Cancer Improvement Plan Compliant Diagnostics Improvement Plan RTT Recovery Plan Agile and responsive IPC controls Well-rehearsed contingency process for managing immediate impacts of industrial action (i.e., safety heat-map, strike period booking avoidance etc.)	**Internal Assurance** Board rounds and site management processes (1) Integrated Performance Report (2) Patient flow metrics – daily control centre information (1) Executive Team weekly review of dashboards (2) Performance report to Finance & Performance Committee (2) Finance & Performance Committee deep-dives into operational performance ongoing in 2024/25(2) QC Deep dives into patient harm (2) Accurate Wating List Models (2) Divisional Performance Reviews (2) Trust Board presentations on Planned Care Trajectories, Cancer Performance 2022 (2) **External Assurance**	Residual likelihood: **5** **(Almost Certain)** Residual impact: **4** **(Severe)** Residual risk rating: **20** **(High)** Previous residual risk rating: Residual risk rating last changed: Forecast trajectory (next 12 months): ⇔	Not yet seeing evidence that investment in "Discharge 2 Assess" initiative is delivering planned improvements to discharge numbers (led by BNSSG/Sirona), to allow increased surgical activity.	**Update:** D2A still not delivering as planned. Ongoing review via System-led D2A Board. Remains under regular review. Longer term recovery relies on Community Diagnostics Centre and exploring opportunities for additional Elective Care Capacity in BNSSG via national Targeted Investment Fund (October 2024: the CDC is now online and will be moved to the "controls" section of this risk). Bristol Surgical Centre due to come online in May 2025. July 2024 Update: Bristol Surgical Centre Plans on track and activity transfer agreed with UHBW. October 2024: delay in build has pushed back go-live date to May 202 **Owner: COO** **Due Date: May 2025**	Target likelihood: **3** **(Possible)** Target impact: **4** **(Severe)** Target risk rating: **12** **(High)**

Board Assurance Framework (BAF)

				Ring-fenced surgical capacity since 2022 Community Diagnostics Centre Capacity Long-term workforce plans Well-developed and tested industrial action planning process. **External:** Whole System Operational Group (WSOG – external) OPEL escalation process in system forums (Whole System Operational Group, OOH Delivery Group) Elective Recovery Fund Access (system-wide) EPRR metallic structures to oversee Industrial action (meeting commensurate with strike action)	System Delivery & Operational Group (external) (2) National Tier 1 Cancer Escalation Status removed in December 2022 (3)		Issues that impact this risk, and which are being actively managed/mitigated: - junior doctor and consultant strikes have and will continue to significantly impact planned care - Ongoing workforce and skills shortages in key specialties	**Other actions:** Long-term workforce plan and model now in place and used for workforce planning. October 2024: Long-term workforce plan to be moved to “controls” section of the risk. Action closed. **Owner:** Chief People Officer **Due Date:** May 2024 then six-monthly thereafter.	

Board Assurance Framework (BAF)

Impacting Trust Strategic Objectives:	Deliver Great Care; Healthcare for the Future	**Impacting Patient First Improvement Priorities:**	Outstanding Patient Experience; High Quality Care; Innovate to Improve; People

Linked Trust Level Risks:

Datix 1979 – Workforce Risk (CSS/ASCR) – Shortage in certain specialist medical roles

Datix 1699 – Patient Safety (Medicine) – Absence of a Core24 Mental Health Service

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	**Peter Mitchell, Interim Chief People Officer** Last reviewed: 18/10/2024 **People Committee** Last reviewed: 12/09/2024 Risk added to BAF: **Pre-2019**	**<u>Workforce</u>** **Due to healthcare workforce shortages at a national level, exacerbated by the local high cost of living, workforce demand is outstripping supply in key areas, including nursing, midwifery, and specialist consultant roles. This gives rise to the risk of:** - **Increased workload intensity leading to staff turnover,** - **Uncontrolled spend on expensive agency/temporary staff,** - **Increase in recruitment activity and associated costs,** - **Poor staff morale, and** - **Poor patient safety & experience.** Elements of this risk are outside of the Trust's direct control (numbers of professionally registered medics and other specialists controlled via HEE national quotas and royal colleges) –	Inherent likelihood: **5 (Almost Certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	NBT Long Term Workforce Strategy & Plan (refreshed March 2024) People Oversight Group and sub-structure approved via People Committee and Trust Board in 2023. Retention interventions underpinned by Patient First Improvement Priority delivering a 1 and 5 year retention plan Long-term Retention Plan 2024 Award-winning, nationally recognised Staff Health & Wellbeing offering Staff experience initiatives including Buying & selling annual leave policy, expanded flexible working offer. EDI Plan and Anti-racism work Strong development and leadership offer (HELM) Increased opportunities through HELM Programme Staff Health Strategy – including staff health checks. Increased use of traineeship and apprenticeships. Collaborative recruitment and shared bank with UHBW including faster recruitment processes and system wide recruitment Financial wellbeing offering (overseen by Culture & Wellbeing working group).	**Internal Assurance** Integrated Performance Report – HR/Well-Led section (2) People Committee deep-dives and performance review (quarterly) (2) Staff survey results & action plans (2) Exit interview data (1) Pulse Surveys (1) Freedom to Speak Up Reports (2) Triangulation Group Reports (1) Trust Board People Deep-dive March 2023 (2) Trust Board Safe Staffing Deep-dive April 2023 (2) Six-monthly update on Long Term Workforce Plan to Trust Board (1) **External Assurance** Gender pay-gap report and WRES/WDES data (3) National Retention Data (3) Staff Survey Results (3) NHS England Workforce Plan 2023 (3)	Residual likelihood: **4 (Likely)** Residual impact: **3 (Possible)** Residual risk rating: **(High)** Previous residual risk rating: **4x3=12 4x4=16 3x4=12 5x4=20 5x5=25** Residual risk rating last changed: **24/10/2024 12/08/2020 05/10/2021 05/01/2023 23/04/2024**	There is potential competition between providers within the BNSSG ICS and the wider South West for the same staff, and there are identified differentials in grading between similar roles. There are insufficient trained staff in certain professions (including nursing, sonographers, histopathologists etc.) to meet ongoing and increasing needs.	Acute Provider Collaborative Workforce Programme, including shared bank and workforce arrangements. October 2024 update: Business case for year two of this programme is in train, to progress as part of operational planning for 2025/26. Updated business case for HELM programme also in train on similar timetable. **Owner: Chief People Officer** **Due date: March 2025** Talent acquisition team are providing targeted support to affected specialties with out of area recruitment campaigns planned for the next 3 months. **Delivery date: Feb 2025** **Owner: CPO**	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**

Board Assurance Framework (BAF)

		actions are focused on those areas that are within the organisation's influence.				Forecast trajectory (next 12 months): 			

Impacting Trust Strategic Objectives:	Deliver Great Care; Healthcare for the Future	**Impacting Patient First Improvement Priorities:**	Outstanding Patient Experience; High Quality Care; Sustainability

Board Assurance Framework (BAF)

Linked Trust Level Risks:

Datix 1587 – Service Delivery Risk in Facilities – Pathology Chiller Failure

Datix 1572 – Service Delivery Risk in Facilities – Pathology Air Handling Unit

Datix 1946 – Service Delivery Risk in WACH – Condition of WACH Estate

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	**Elizabeth Poskitt, Interim Chief Finance Officer** Last reviewed: 21/10/2024 **Finance & Performance Committee** Last reviewed: 19/09/2024 Risk added to BAF: **Pre-2019**	**<u>Retained Estate</u>** **Parts of the retained estates are aging and approaching the point where significant refurbishment is required. Without decant facilities or alternative provision this work cannot be undertaken in a proactive manner, exposing the Trust to the risk of unplanned service failure, and associated degradation of patient safety, operational performance, and patient/staff experience.** Note: The Trust has control over its internal capital spend. This risk is considered a controllable risk. INTERNALLY DRIVEN RISK	Inherent likelihood: **4** **(Likely)** Inherent impact: **5** **(Catastrophic)** Inherent risk rating: **20** **(Extreme)**	Capital Planning Group & sub-structure 10-year Estates Capital Plan (CRISP) Interim Estates Plan 2022 Health & Safety Committee & policies Preventative Maintenance Programme Facilities help-desk (to advise on any deterioration of estate) Executive and Board Insight walk-arounds Expected capital programme slippage used as a contingency for unexpected works in the retained estate Up-to-date Fire Safety Policy and Fire Safety Manager appointed (November 2022) 2023/24 Capital Plan approved prioritising significant fire and ventilation remediation spend Shared (jointly appointed) Strategic Estates Director between NBT and UHBW	**Internal Assurance** Capital Planning reports to Finance & Performance Committee (twice-yearly) (2) Health & Safety reports to People Committee (quarterly + annual report) (2) 2022 Fire Safety Audit Actions progress reported to People Committee (only one outstanding actions remain – October 2023) (3) Fire and ventilation risks are understood and recorded on a granular (building) level, with individual remediation plans. (3) Compliance Governance committees reviewing risks and incidents; COIC, Water Safety Group, Ventilation Safety Group, Electrical Safety Group, Fire Safety Group (2) ERIC Benchmarking confirms relative position to other Trusts backlog status (annual process) (2) Fire risk audits undertaken regularly across the site (1) Interim Estates Plan 2022 (1) Report to Finance & Performance Committee on Retained Estates Trust Level Risks and mitigations – September 2023. (1) Health & Safety Internal Audit Report – Green Amber Rating – provides	Residual likelihood: **3** **(Possible)** Residual impact: **4** **(Severe)** Residual risk rating: **12** **(High)** Previous residual risk rating: **N/A** Residual risk rating last changed: **N/A** Forecast trajectory (next 12 months): 	The Trust continues to ensure that there is regular capital investment in Critical Infrastructure towards compliant and appropriate clinical accommodation. However, this is limited by all other Trust-wide requirements therefore some programmes will be delivered over extended periods. It is assumed that major estates improvements will be specifically externally funded. There is a growing concern that due to the nature of the improvement works that are needed in the retained estate that there will be a need to decant buildings to facilitate this work namely, Elgar House, NICU, CDS and Gynae Theatres. These works are mainly related to fire improvement works and ventilation improvement works.	The majority of the fire works have been completed in September 2024 Following the completion of the first two phases, a review is being undertaken of further fire integrity works in line with the Fire Risk Assessment programme, and will feed into ongoing annual capital programme based on most effective risk reduction. A specific piece of work is being completed between the Estates and the W&C Divisional teams to detail the remaining risks that cannot be remediated within the available CDEL, understand the mitigation actions being undertaken and in recognition of the enhanced level of risk being accepted, detail the business continuity plans for services being delivered in these higher risk areas. **Due Date: 30/10/24** **Owner:** CFO/Director of Operational Estates and Facilities Elective Care Centre FBC approved nationally in September 2023. Go-live anticipated to be March 2025. While this will be focused on elective recovery, it will provide contingency in the event of catastrophic	Target likelihood: **2** **(Unlikely)** Target impact: **4** **(Severe)** Target risk rating: **8** **(High)**

Board Assurance Framework (BAF)

					assurance of robust oversight function. (3) **External Assurance** Six Facet Survey completed 2020 (3)		Revised System capital allocation and prioritisation processes had added complexity and delay to capital planning and resulted in reduced capital availability.	failure of other theatres and will ultimately be available for decant in year to come. **Due date:** March 2025 **Owner:** Chief Finance Officer	

Impacting Trust Strategic Objectives:	Deliver Great Care	Healthcare for the Future	**Impacting Patient First Improvement Priorities**	Outstanding Patient Experience / High Quality Care / Sustainability / Innovate to Improve

Board Assurance Framework (BAF)

Linked Trust Level Risks:

Datix 545 – Service Delivery Risk in IMT – Risk of overheating data centre

Various other sub-TLR (12+) risks reported to Finance & Performance Committee in line with Board Risk Appetite Statements.

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: 23/07/2024 **Finance & Performance Committee** Last reviewed: FPDC 18/07/2024 Risk added to BAF: **Pre-2019**	**Cyber Security** **A significant cyber-attack results in the loss of all Trust IT systems for an extended period leading to a failure of business continuity and the inability to treat patients.** Note: while this risk is externally driven, there are element of the risk that the trust can control through mitigations and additional back-up/protection. EXTERNALLT DRIVEN RISK	Inherent likelihood: **5 (Almost Certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	IT security measures such as password policies and information governance training Daily immutable system back-ups Business continuity and cyber incident recovery plans Timely server and software updates Continuous upgrades to supported versions of Windows and Microsoft 365 Ongoing assessments of software with removal or mitigations for outdated and unsupported products Ongoing monitoring and software upgrades (see further information under “gaps” and “planned actions”)** Microsoft 365 cloud-to-cloud backups for email and teams data Participants in NHS England cyber security alerting and briefing programme “CareCert” Server and Network vulnerability scanners Microsoft Defender Endpoint (antivirus) live across Microsoft Windows estate BNSSG Cyber Security Governance Group aligning organisational standards and ensuring best practice. NHS England South West Regional Cyber Security Group for direction and access to national solutions	**Internal Assurance** Data security protection toolkit return (“Standards Met” 2024) (1) Cyber security report (monthly to IM&T Divisional Board and Audit & Risk Committee) (2) Audit Committee Assurance Report (six monthly) (March 2023, August 2023, May 2024, scheduled November 2024) (1) **External Assurance** Information Commissioner Audit December 2019 (3) Data security protection toolkit return (minimum “Standards Met” 2024) (1) Penetration Tests and assessments, February 2024 (2) KPMG Data Security Protection Toolkit Audit 2024 “significant Assurance” (2)	Residual likelihood: **3 (Possible)** Residual impact: **5 (Catastrophic)** Residual risk rating: **15** **(Extreme)** Previous residual risk rating: **4x5=20** Residual risk rating last changed: **22/05/2020** Forecast trajectory (next 12 months): ⇔	**Significant work has been completed to reduce the likelihood of a cyber-security incident, through updating networks and migration to up-to-date operating systems. In 2023-2024 and 24-25: - Over 8000 end point devices upgraded to latest version of Windows 10 - Legacy Windows 2008 servers remain eradicated - Further 100 Windows 2012 servers eradicated leaving eight remaining all with paid for support - Deployment of log retention tool - Funding approved to refresh network and deploy micro-segmentation	Additional work is underway to implement software tools to proactively monitor network activity and quickly identify and respond to any changes to normal activity. **Owner: Phil Wade** **Due Date: see below** . Ongoing remediation work for areas highlighted by the vulnerability scanner. Target for change: persistent risk - ongoing The BNSSG Cyber Security Governance Group has been established with NBT leading its creation and operating as chair. The group is focusing on governance reporting across the ICS and considering converging Cyber Security toolsets. **Target April 2023 - Met.** Following the NHS Digital backup audit we are creating a business case for funding in 2024/25 to improve or replace the existing solution. **Target:** June 2024 for business case review. – part one of business case submitted to BCRG August 24. Network micro-segmentation project to block access and restrict spread cyber attacks: project in full flight with upgrades to outdate Wireless LAN controllers completed. . **Target project completion March 2024**, Remove or mitigate 146 Windows 2012 servers from the estate; currently 8 remain all of which have paid for support until March 2025. These servers	Target likelihood: **3 (Possible)** Target impact: **5 (Catastrophic)** Target risk rating: **15** **(High)**

Board Assurance Framework (BAF)

								support other services that have not yet completed migrations and we continue to assist with resolution. **Target completion March 2025.** New planned actions: - Increase risk and audit updates from annual to six monthly (now scheduled) Improve email filtering using additional tools **Business case submitted for consideration as part of 2024/25 business planning and is currently with Finance pending funding approval** Developing an assessment process with the Trust auditors to investigate cyber resilience of the supply chain with procurement. Report and action plan expected January 2025.	

Impacting Trust Strategic Objectives:	Deliver Great Care Healthcare for the Future	**Impacting Patient First Improvement Priorities**	Sustainability

Board Assurance Framework (BAF)

Linked Trust Level Risks:

Datix 1887 – Financial Risk – Risk to delivery of recurrent savings

Datix 1896 – Financial Risk – Risk of unfunded cost pressures

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 17	**Elizabeth Poskitt, Interim Chief Finance Officer** Last reviewed: 15/10//2024 **Finance & Performance Committee** Last reviewed: 19/09/2024 Risk added to BAF: October 2022	**<u>Underlying Financial Position</u>** There is a risk that if the Trust does not deliver its planned financial position sustainably, and reduce its underlying deficit, it will be subject to increased regulatory intervention. This may include a loss of decision-making autonomy, increased scrutiny, and increased reporting requirements.	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	**Internal:** Internal Planning Processes Divisional Reviews Business Case Review Group Financial Sustainability Reviews CIP Board oversight of plans Exceptions to Budgeted Establishment Group (EBE) Procurement controls (enhanced) Monthly Budget Monitoring "Grip & Control" reviews Financial Escalation procedures HELM Leadership Programme Engagement in regional procurement where appropriate **External:** ICS Directors of Finance (DoF) Group System Planning Processes Monthly Financial Returns and review with NHSE System Finance & Estates Group	Monthly Finance Report (Trust Board, FPC, Exec Management Team, Senior Leadership Group) (2) Divisional Reviews (2) Weekly CIP Monitoring Reports (1) Monthly consolidated System Finance Report (2) Annual Internal Audit Report – Financial Controls (3) External Audit – Value for Money Review (3) Model Hospital Benchmarking (3) National Cost Collection Submission (3) Financial Sustainability (CIP) Board meeting monthly. Breakeven plan submitted by NBT as part of System Breakeven plan submission.	Residual likelihood: **3 (Possible)** Residual impact: **5 (Catastrophic)** Residual risk rating: **15** **(High)** Previous residual risk rating: **4x5=20** Residual risk rating last changed: **01/03/2023** Forecast trajectory (next 12 months): ↑	2024/25 CIP and savings plans delayed in delivery. Being at or close to funded establishment means timely delivery of CIP becomes more important and reallocating resources to meet operational needs becomes a priority to avoid incurring additional temporary staffing costs.	40% of CIP schemes remain in pipeline (rather than planning or implementation) Divisions, Transformation and Trustwide teams need to develop plans to allow them to be delivered. **Delivery date:** 30 November 2024 **Owner:** CFO Additional controls are being put in place to manage both substantive recruitment and committing additional temporary staffing costs. In place from August 2024 and remaining under review through to January/February 2025. Delivery Date: Review Jan/Feb 2025 **Owner:** CFO	Target likelihood: **2 (Unlikely)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

Board Assurance Framework (BAF)

Impacting Trust Strategic Objectives:	Deliver Great Care Healthcare for the Future	**Impacting Patient First Improvement Priorities**	Sustainability
Linked Trust Level Risks: *Risk entries under review – likely to be linked to financial implications.*			

Board Assurance Framework (BAF)

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 18	**Elizabeth Poskitt, Interim Chief Finance Officer** Last reviewed: 11/10/2024 **Finance & Performance Committee** Last reviewed: 19/09/2024 Risk added to BAF: August 2024	**<u>Net Zero Carbon</u>** The Trust will not meet the goals set out in the ICS Green Plan to achieve net zero carbon by 2030 and biodiversity net gain, leading to ecosystem collapse, additional costs from carbon taxation and offset costs, reduced health outcomes resulting from air pollution and reputational damage. EXTERNALLY DRIVEN RISK	Inherent likelihood: **5** **(Almost Certain)** Inherent impact: **3** **(Moderate)** Inherent risk rating: **15** **(Extreme)**	**Internal:** Sustainability team in Estate & Facilities Dir. And close working relationship with UHBW team Sustainability impact assessment required in over £100k business cases. Carbon route map identifies Trust carbon emissions by emission sector & actions to reduce carbon emissions & increase biodiversity. Green Plan Delivery Plan defines work programme at Trust and partner level to reduce emissions and increase biodiversity. **External**: ICS Green Plan Steering Group (GPSG) monitors progress against Delivery Plan. ICS Green Plan Implementation Group (GPIG) drives actions set out in Delivery Plan. ICS Estates Steering Group allocates capital funding to support carbon reduction schemes. CQC Environmental Sustainability Quality Statement required. Task Force on Climate-Related Financial Disclosures	Monthly Green Plan Delivery Plan highlight report to GPSG. (1) Monthly workstream highlight reports to GPIG. (1) Regular updates to ICS Estates Steering Group. (1) Green Plan annual report to ICB Board and Trust Board. (1)	Residual likelihood: **4** **(Likely)** Residual impact: **3** **(Moderate)** Residual risk rating: **12** **(High)** Previous residual risk rating: **N/A** Residual risk rating last changed: **N/A** Forecast trajectory (next 12 months): ⬆	Insufficient capital funding to replace fossil fuel boilers and vehicles with NZC alternatives. Accounting rules are a barrier to using third party funding to decarbonise. Insufficient capacity in Trust teams to deliver change, in particular to procurement of goods which represent 54% (58k tCO2e) of our carbon emissions. Insufficient focus on cultural/behavioural change as sustainable behaviour needs to be embedded in all Trust activities where possible. Majority of Trust transport related emissions are associated with patients and visitors so reliance is on decarbonisation of public transport. Slow and costly to achieve sustainable change in PFI. NHS focus on in-year financial savings does not enable investment in sustainable practice that costs more upfront but will save money in the long term. No centralised process for capturing projects that contribute to the ICS Green Plan as well as deliver savings across multiple Trust priorities e.g. cost reduction, patient first, digitalisation, patient safety. Directorates and divisions are not held accountable for progress made against the ICS Green Plan.	Actively apply for all grant funding opportunities **Owner: Sustainability Team** **Due: Mar 2025** Engage with NHSE/DHSC on solutions to accounting barriers. **Owner: Sustainability Team** **Due: Mar 2025** Embed social value and carbon reduction into procurement processes. **Owner: Procurement Team** **Due: March 2025** Map Green Plan delivery actions to responsible owners and relevant oversight and decision-making forums. **Owner: Sustainability Team** **Due: December 2024** GPSG to focus on achievement of key deliverables in the Delivery Plan Maintain transparent dialogue with staff and citizens about what is achievable and barriers to delivery that are outside our control. Provide training to relevant staff in divisions, procurement, Patient First and finance teams to identify sustainability impacts of all projects and schemes that contribute to the ICS Green Plan **Owner: Sustainability Team** **Due: March 2025**	Target likelihood: **3** **(Possible)** Target impact: **3** **(Moderate)** Target risk rating: **9** **(High)**

Board Assurance Framework (BAF)

								Active engagement with THC/Equans to deliver carbon emission reductions. **Owner: Sustainability Team** **Due: March 2025** Forecast long-term carbon tax charges to NBT associated with the extent of NBT's removal of fossil fuels (complete) Build into business case financial analysis (revenue consequences of energy and carbon tax). **Owner: Finance team** **Due: January 2025** Embed sustainability in patient first, procurement and CIP projects or schemes using the SIA Set carbon and energy efficiency objectives for each division/directorate. Embed progress reporting into performance reviews. **Owner: Sustainability Team** **Due: March 2025**	

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

APPENDIX 2 – Audit & Risk Committee Upward Report (Nov 2024)

Report To:	Audit and Risk Committee (and subsequently Public Trust Board)		
Date of Meeting:	7 November 2024 (and Board on 28 November 2024)		
Report Title:	Standing Orders, Standing Financial Instructions, Scheme of Delegated Authority Amendments		
Report Author:	Richard Gwinnell, Deputy Trust Secretary		
Report Sponsor:	Xavier Bell, Trust Secretary Ingrid Barker, Joint Chair Maria Kane, Joint Chief Executive		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		
	This report sets out amendments to the Trust's Standing Orders, Standing Financial Instructions, and Scheme of Delegated Authorities (SO/SFI/SODA) to reflect additional staffing establishment controls and business case approval limits.		

Key Points to Note *(Including any previous decisions taken)*

Additional controls are required on staffing establishment limits, to provide clarity on who is responsible for appointing staff and deciding to increase departmental staffing establishments. The additions proposed ensure no appointments are made if they are not within the existing approved staffing establishment and that the existing establishment is only increased with the approval of the Chief Finance Officer or their nominated deputy.

In line with NHSE rule changes, a Strategic Outline Case (SOC) is now required, and needs to be approved by NHS England, for business cases valued at over £25 million (where previously one was required for business cases valued at over £15 million).

Strategic Alignment

Not applicable

Risks and Opportunities

N/A

Recommendation

This report is for **Approval.**

The Audit and Risk Committee, and subsequently the Trust Board, are asked to **approve** the proposed amendments to the SO/SFI/SODA outlined in this report and its attachments.

History of the paper (details of where paper has <u>previously</u> been received)	
N/A	N/A
Appendices:	*The full SO/SFI/SODA document is included in the Reading Room with tracked changes.*

North Bristol NHS Trust

Terms of Reference for the Audit & Risk Committee

Chair:	A Non-Executive Director (NED).
Other Members:	The Committee will be appointed by the Trust Board from amongst the non-executive directors (NEDs) of the Trust and shall consist of not less than three members. One of the members will be appointed Chair of the Committee by the Trust Board. At least one of the members of the Committee will have recent and relevant financial experience. To support triangulation and cross learning, the Committee should include a NED representative from each of the other Board Committees. The Chair of the Trust will not be a member of the Committee.
Other Attendance:	The Audit & Risk Committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair. In addition to members of the Audit & Risk Committee, the following shall normally attend all meetings and may contribute to discussions, but have no voting rights nor contribute to the quorum: • Chief Finance Officer or Interim Chief Finance Officer • Director of Operational Finance • Assistant Director of Finance (Financial Services) • Director of Corporate Governance/Trust Secretary • Deputy Trust Secretary • Head of Internal Audit • Senior management representatives from the appointed external auditors • Counter Fraud Specialist • Director of Procurement (for relevant agenda items only). The Accountable Officer should be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the annual governance statement. The Accountable Officer should also attend when the Committee considers the draft annual governance statement and the annual report and accounts. Other executive directors/managers should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager. Attendance at meetings is essential. In exceptional circumstances when an Executive Director cannot attend, they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Representatives from other organisations and other individuals may be invited to attend on occasion.

	The Trust Chair may be invited to attend meetings of the Committee in order that they can understand how the Committee works but will have no voting rights. The Head of Internal Audit, the representative of External Audit and the Counter Fraud Specialist have a right of direct access to the Chair of the Committee. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.
Quorum:	The quorum for the Audit & Risk Committee is at least two Non-Executive Director members.
Declaration of Interests	All members must declare any actual or potential conflicts of interest relevant to the work of the Audit & Risk Committee, which shall be recorded in the minutes accordingly. Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict.
Frequency of Meetings:	The Audit & Risk Committee will meet at least five times a year, timed in accordance with the discharge of its key responsibilities. At least once a year the Committee will meet privately with the external and internal auditors.
Notice of Meetings:	The Chair may call additional meetings where these are deemed necessary. The Trust Board, Accountable Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed and supporting papers, shall normally be forwarded to each member, and any other person required to attend, no later than five working days before the date of the meeting. Decisions may be taken by written resolution upon the agreement of the majority of members of the Committee in attendance, subject to the rules on quorum.
Inputs:	The Audit & Risk Committee will receive reports on issues within the remit of the meeting, so as to ensure timely discussion and decision-making. This will include: • Trust-Level Risks and BAF report

	• External Audit Progress Report • Internal Audit Progress Report & Recommendation Tracker • Counter Fraud Progress Report • Bi-Annual Conflict of Interest Report • Losses and Salary Overpayments • Single Tender Actions. Individual members may also raise concerns/risks/issues relevant to the meetings remit on an ad hoc basis but will do so with sufficient notice to ensure that meeting agenda can be set and managed effectively. The Audit & Risk Committee can request a report on any subject or issue relevant to its terms of reference.
Outputs:	The Audit & Risk Committee shall produce a set of minutes and a log of actions arising. The Committee shall issue an upward report to Trust Board following each meeting. The Committee will provide the Trust Board with an Annual Report, timed to support finalisation of the accounts and the Annual Governance Statement, summarising its conclusions from the work it has done during the year and including the following: • The fitness for purpose of the Trust's assurance framework. • The completeness and 'embeddedness' of risk management in the Trust. • The integration of the governance arrangements. • The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existences as a functioning business. • The robustness of the processes behind the quality accounts. • A description of how the Committee has fulfilled its terms of reference. • Give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.
Responsible for the following Strategies and Policies:	Strategies: • Risk Policies: • Finance • Standing Orders • Risk
Sub-Committees:	N/A
Committee Secretary:	The Corporate Governance Team is responsible for: • Agreement of agenda and collation of papers. • Taking the minutes and keeping a record of actions arising and issues to be carried forward.

	• Provision of a highlight report of the key business undertaken to the Trust Board following each meeting.

1. Purpose

1.1 The Audit & Risk Committee is established to be a sub-Committee of the Trust Board and is the Board assurance committee for risk management, internal audits, external audits and counter fraud.

2. Authority

2.1 The Audit & Risk Committee is a sub-group of the Trust Board from which it receives its authority. Its constitution and terms of reference shall be as set out in this document, subject to amendment.

3. Duties

3.1 The primary role and function of the Committee is as follows:

3.1.1 Integrated Governance, Risk Management and Internal Control

3.1.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

3.1.1.2 In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements, in particular the Annual Governance Statement attached to the Annual Report and Accounts, together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to submission to the Trust Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to counter fraud, bribery and corruption as set out in the NHS Standard Contract and as required by the NHS Counter Fraud Authority.

3.1.1.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.1.1.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

3.1.1.5 The Committee shall also ensure that the Trust has robust risk management systems and processes in place and shall receive a regular report setting out all Trust Level Risks and the Board Assurance Framework. The Committee will actively seek assurance that:

- an up-to-date risk register is maintained, and that relevant staff are able to access the risk register to raise concerns and know that concerns will be reviewed and addressed.
- act as the forum for risk to be discussed, and ensure that where serious concerns are raised, action is taken, and that action plans are carried through to completion, and the reporting loops closed. This may be progressed directly by the Committee or via delegation to other key committees (see below). In doing so, the Committee will ensure that there are robust links with clinical and non-clinical directorates to ensure a culture of effective risk management is present throughout the organisation.

3.1.1.6 As part of its integrated approach, the Committee will have effective relationships with other key committees - for example the five other committees of the Trust Board (Finance, Digital and Performance, People and EDI, Charity, Quality, and Patient and Carer Experience Committees) so that it understands processes and linkages. These other Committees must not usurp the Committee's role. The membership of the Audit and Risk Committee shall contain NED members of the Board's other assurance committees.

3.1.2 **Internal Audit**

3.1.2.1 The Committee will ensure that there is an effective internal audit function that meets the requirements of the Public Sector Internal Audit Standards 2017 and provides appropriate independent assurance to the Committee, Accountable Officer and the Trust Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.
- Review and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework and with reference to the risk register.
- Considering the major findings of internal audit work; and management's response to recommendations made.
- Ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Carrying out an annual review of the effectiveness of internal audit.
- Regular monitoring of key performance metrics aligned to the delivery of the service.

3.1.3 **External Audit**

3.1.3.1 The Committee will review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved through:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee.
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Trust Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring there is in place a clear policy for the engagement of external auditors to supply non-audit services.
- Regular monitoring of key performance metrics aligned to the delivery of the service.

3.1.4 **Counter Fraud**

3.1.4.1 The Committee will satisfy itself that the Trust has adequate arrangements in place for counter fraud, bribery and corruption that meet NHS Counter Fraud Authority's standards and will review the outcomes of work in these areas.

3.1.4.2 Specifically it will:

- Approve the Trust's Counter Fraud strategy and Local Counter Fraud Specialist annual work plan, including the resources allocated for the delivery of the strategy and work plan.
- Receive and review progress reports of the Local Counter Fraud Specialist against the four principles of the overall NHS Counter Fraud Strategy.
- Monitor the implementation of management actions arising from counter fraud reports.
- Receive and discuss reports arising from quality inspections by the counter fraud service.
- Make recommendations to the Trust Board as appropriate in respect of counter fraud at the Trust.
- Receive, review and approve the annual report of the Local Counter Fraud Specialist.

3.1.5 **Other Assurance Functions**

3.1.5.1 The Committee will review the findings of other significant assurance functions, both internal and external to the Trust; and consider the implications to the governance of the Trust.

3.1.5.2 These will include, but will not be limited to:

- Any reviews by Department of Health and Social Care arm's length bodies, or regulators and inspectors, - for example the Care Quality Commission, NHS Resolution etc.
- Professional bodies with responsibility for the performance of staff or functions – for example, Royal Colleges and accreditation bodies.

3.1.5.3 The Committee may review the work of other committees within the Trust, where their work can provide relevant assurance to the Audit and Risk Committee's own scope of work, appreciating that the triangulation of overall committee business is visible at the Trust Board via all committees' upward reports. In particular, this will include the five other committees of the Trust Board (Finance, Digital and Performance, People and EDI, Charity, Quality, and Patient and Carer Experience Committees).

3.1.5.4 In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit and Risk Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

3.1.5.5 The Committee will review and make recommendations to the Trust Board for any changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

3.1.5.6 The Committee will examine the circumstances associated with each occasion when Standing Orders are waived.

3.1.6 **Management**

3.1.6.1 The Committee will request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.1.6.2 The Committee may also request specific reports from individual functions within the Trust, for example, clinical audit, as may be appropriate to the understanding of the overall arrangements.

3.1.6.3 The Committee shall receive an annual Health and Safety Regulatory Compliance report.

3.1.6.4 If an internal audit report concludes with an assurance rating of less than green or green/amber, then the Executive Director with responsibility for the service shall attend the

Audit and Risk Committee meeting to present relevant findings and answer questions from the Committee.

3.1.6.5 If the Audit and Risk Committee asks another Board assurance committee to oversee the delivery of internal audit recommendations or requirements, then that Committee shall report back to the Audit and Risk Committee, when it is assured that the matter in question has been dealt with.

3.1.7 **Financial Reporting**

3.1.7.1 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

3.1.7.2 The Committee will ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review for completeness and accuracy of the information provided.

3.1.7.3 The Committee will review the Trust Annual Report and financial statements before submission to the Trust Board. It will focus on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of Representation.
- Explanations for significant variances.

4. Monitoring and Effectiveness

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

4.2 It will review its own performance, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

4.3 As per NHSE/I requirements the Committee will carry out an annual self-assessment to inform above review of its Terms of Reference.

Version:	1.5
Ratified by / responsible committee:	Version 1.4 approved by Audit and Risk Committee – 09 November 2023 and ratified by Trust Board on 30 November 2023. Version 1.5 proposed to Audit and Risk Committee on 7 November 2024 and to be ratified by the Trust Board on 28 November 2024.
Date ratified:	Trust Board –

Name of originator / author:	Trust Secretary
Lead:	Elizabeth Poskitt, , Interim Chief Finance Officer
Date issued:	November 2024
Review date:	November 2025

North Bristol NHS Trust

Terms of Reference for the Auditor Panel

Chair:	A Non-Executive Director (NED).
Other Members:	The auditor panel will comprise the entire membership of the Audit & Risk Committee with no additional appointees. This means that all members of the auditor panel are independent Non-Executive Directors. The Chair of the Audit & Risk Committee will be appointed Chair of the auditor panel by the Trust Board. The Chair of the Trust will not be a member of the auditor panel. The auditor panel Chair and/or members of the panel can be removed in line with rules agreed by the Trust Board.
Other Attendance:	The auditor panel's Chair may invite executive directors and others to attend depending on the requirement of each meeting's agenda. These invitees are not members of the auditor panel.
Quorum:	To be quorate, independent members of the auditor panel must be in the majority AND there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest.
Declaration of Interests	Conflicts of interest must be declared and recorded at the start of each meeting of the auditor panel. A register of panel members' interests must be maintained by the panel's Chair and submitted to the Trust Board in accordance with the Trust's existing conflicts of interest policy. If a conflict of interest arises, the Chair may require the affected panel member to withdraw at the relevant discussion or voting point.
Frequency of Meetings:	The auditor panel will consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the Audit & Risk Committee.
Notice of Meetings:	The Chair may call additional meetings where these are deemed necessary. The Trust Board, Accountable Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed and supporting papers, shall normally be forwarded to each member, and any other person required to attend, no later than five working days before the date of the meeting. Decisions may be taken by written resolution upon the agreement of the majority of members of the Committee in attendance, subject to the rules on quorum.

Inputs:	Auditor panel business will be identified clearly and separately on the agenda and audit committee members will deal with these matters as auditor panel members NOT as Audit & Risk Committee members. The panel's Chair shall formally state at the start of each meeting that the auditor panel is meeting in that capacity and NOT as the audit committee.
Outputs:	The Chair of the auditor panel must report to the Trust Board on how the auditor panel discharges its responsibilities. The minutes of the panel's meetings must be formally recorded and submitted to the Trust Board by the panel's Chair. The Chair of the auditor panel must draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board, or which require executive action.
Responsible for the following Strategies and Policies:	N/A
Sub-Committees:	N/A
Committee Secretary:	The Corporate Governance Team is responsible for: • Agreement of agenda and collation of papers. • Taking the minutes and keeping a record of actions arising and issues to be carried forward. • Provision of a highlight report of the key business undertaken to the Trust Board following each meeting

1. Purpose

1.1 The Trust Board hereby resolves to nominate its Audit Committee to act as its auditor panel in line with schedule 4, paragraph 1 of the *Local Audit and Accountability Act 2014*.

1.2 The auditor panel is a Non-Executive Committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Authority

2.1 The auditor panel is authorised by the Trust Board to carry out the functions specified below and can seek any information it requires from any employees/relevant third parties. All employees are directed to co-operate with any request made by the auditor panel.

2.2 The auditor panel is authorised by the Trust Board to obtain outside legal or other independent professional advice – for example, procurement specialists, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any 'outsider advice' must be obtained in line with the organisation's existing rules.

3. Duties

The auditor panel's functions are to:

3.1 Advise the Trust Board on the selection and appointment of the external auditor. This includes:

- Agreeing and overseeing a robust process for electing the external auditors in line with the organisation's normal procurement rules.
- Making a recommendation to the Trust Board as to who should be appointed.
- Ensuring that any conflicts of interest are dealt with effectively.

3.2 Advise the Trust Board on the maintenance of an independent relationship with the appointed auditor.

3.3 Advise (if asked) the Trust Board on whether or not any proposal form the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.

3.4 Advise on (and approve) the contents of the Trust's policy on the purchase of non-audit services from the appointed external auditor.

3.5 Advise the Trust Board on any decision about the removal or resignation of the external auditor.

4. Monitoring and Effectiveness

4.1 The terms of reference will be reviewed on an annual basis.

Version:	1.5
Ratified by / responsible committee:	Version 1.4 approved by Audit and Risk Committee – 09 November 2023 and ratified by Trust Board on 30 November 2023. Version 1.5 proposed to Audit and Risk Committee on 7 November 2024 and to be ratified by the Trust Board on 28 November 2024.
Date ratified:	Trust Board –
Name of originator / author:	Trust Secretary
Lead:	Elizabeth Poskitt, Interim Chief Finance Officer
Date issued:	November 2024
Review date:	November 2025

Report To:	Public Trust Board		
Date of Meeting:	28 November 2024		
Report Title:	Modern Slavery Statement 2023/24		
Report Author:	Philip Lewis, Director of Procurement BWPC		
Report Sponsor:	Elizabeth Poskitt, Chief Finance Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		
	To approve the publication of the Trust's Joint Modern Slavery Statement with UHBW.		

Key Points to Note *(Including any previous decisions taken)*

Update to the currently published 2022/23 Modern Slavery Statement for North Bristol NHS Trust, covering the period 2023/24. Previous approval covered a joint statement for NBT and UHBW.

Strategic and Group Model Alignment

The publication of a Modern Slavery Statement is a mandatory requirement. The publication of a joint statement supports the Group Model alignment and sends a single strong statement from the Trusts of its commitment to the removal of Modern Slavery from our supply chains.

Risks and Opportunities

The statement must comply with the minimum requirements as set out under Section 54 (Transparency in Supply Chains) of the Modern Slavery Act 2015.

Whilst there is no specific penalty for not publishing the statement, having a published Modern Slavery Statement is a requirement for commissioning contracts and is a requirement of all goods and service contracts let by BWPC on behalf of the two trusts.

Recommendation

This report is for **Approval**

Following the Transparency in Supply Chains consultation and public pressure the Government committed to extending Section 54 of the Modern Slavery Act 2015 to public bodies in England and Wales.

This requires the Trust to produce an annual Modern Slavery Statement setting out the steps taken over the course of the financial year to prevent modern slavery in their operations and supply chains.

Given that the bulk of the modern slavery risk sits within the Trust's supply chains, and procurement for the Trust is conducted through consortium arrangements with UHBW via

BWPC, it was agreed to create a joint Modern Slavery Statement. The creation of joint Modern Slavery Statements is encouraged where it is appropriate. There is a requirement to update the statement on an annual basis as a retrospective document detailing progress compared to the prior year. This paper proposes the Trust's update for a Modern Slavery Statement covering the 2023/24 time period.	
History of the paper (details of where paper has <u>previously</u> been received)	
n/a	n/a
Appendices:	Modern Slavery Statement 2023/24

1. Purpose

1.1 Request for approval of the 2023/24 Modern Slavery Statement for NBT, which as per the 2022/23 statement this is a joint statement with UHBW.

2. Background

2.1 Following the Transparency in Supply Chains consultation and public pressure the Government committed to extending Section 54 of the Modern Slavery Act 2015 to public bodies in England and Wales.

2.2 This requires the Trust to produce an annual Modern Slavery Statement setting out the steps taken over the course of the financial year to prevent modern slavery in their operations and supply chains.

3. Modern Slavery Statement requirements

3.1 To aid the Trust in reviewing the statement Government guidance on producing a modern slavery statement is that it should:

- Be transparent about instances or indicators of modern slavery found within the operations and supply chains as well as actions that have been undertaken in response.
- They should prioritise activity where the organisation can have most impact.
- Demonstrate progress by setting and reporting against clear targets.

3.2 The update from 2022/23 to 2023/24 focusses on providing details of the training within BWPC focussing on both Modern Slavery and wider Social Value.

4. Summary and Recommendations

4.1 The publication of a Modern Slavery Statement is a mandatory requirement. The publication of a joint statement supports the Group Model alignment and sends a single strong statement from The Group of its commitment to the removal of Modern Slavery from our supply chains.

4.2 It is recommended that the Modern Slavery Statement is approved for publication.

Appendix 1

Modern Slavery Statement 2023/24

Overview

Modern slavery is the removal of personal freedoms in order to exploit human beings for financial or personal gains. It can take many forms including forced labour, human trafficking and sexual exploitation. It is a complex issue with a global reach. There were an estimated 50 million people in modern slavery in 2021[1] and these numbers are increasing. We recognise that modern slavery will exist in our supply chain, and we are committed to do all we can to identify and manage the risks that our business and purchasing activities pose.

The Modern Slavery Act 2015 introduced changes in UK law, which focus on increasing transparency in supply chains. To support this, we have prepared and published this statement. We aim to be open and transparent about the work we are doing but also about the areas where we can do more. This statement provides a foundation upon which we can continually improve.

Our Statement

This Modern Slavery and Human Trafficking statement is for the financial year ending 31 March 2024. It outlines the shared commitment and actions that have been carried out by Bristol and Weston NHS Purchasing Consortium (BWPC), North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) over this time period. In the statement, terms such as ‘our’ and ‘we’ refer to all three organisations.

This is the first modern slavery statement that we have produced. It covers the following areas of our business activities;

1. The recruitment of both temporary and permanent employees
2. The working conditions and practices for our employees
3. The procurement of goods and services.

Organisation Structure and Supply Chains

Bristol and Weston Purchasing Consortium

BWPC provide a comprehensive range of purchasing services to support local Trust and Healthcare Providers.

BWPC staff are NHS employees, hosted by North Bristol NHS Trust and the services provided include all aspects of clinical and non-clinical purchasing and supply chain management. BWPC’s main clients include both NBT and UHBW and cover an annual spend of approximately £750m. BWPC work closely with both Trusts to support compliance with all purchase-to-pay procedures and deliver improved efficiencies.

North Bristol NHS Trust

NBT has over 12,000 staff delivering healthcare across main sites at Southmead Hospital Bristol, Cossham Hospital and Bristol Centre for Enablement and within the local community

[1] Global Slavery Index | Walk Free

of Bristol, North Somerset and South Gloucestershire. NBT is a regional centre for neurosciences, plastics, burns, orthopaedics and renal services. NBT's aim is to deliver an outstanding patient experience and its values of caring, ambitious, respectful and supportive underpin everything that we do.

University Hospitals Bristol and Weston NHS Foundation Trust

UHBW has a workforce of over 13,000 staff, delivering over 100 different clinical services across 10 different sites serving a core population of more than 500,000 people locally and from across the southwest.

With services from the neonatal intensive care unit to care of the elderly, UHBW provides care to the people of Bristol, Weston and the southwest from the very beginning of life to its later stages.

Our Supply Chain

Our supply chain is large, multi-tiered, global and complex. We procure a wide range of clinical and non-clinical goods, services and works. This includes medical equipment, personal protective equipment and uniforms, dressings, mattresses and bed linen, laptops, software, furniture and mechanical and electrical services to name but a few.

Many of our purchases are from sectors that are known to be high risk for modern slavery. Our approach to identifying and managing modern slavery risks must be embedded into any new procurement activity and within our existing contracts to be effective.

We let contracts over a range of timescales from medium to long term relationships to one-off purchases. As part of our procurement policy, we actively seek to utilise frameworks provided by public sector organisations such as NHS Supply Chain, Crown Commercial Services and NHS Shared Business Services. We have over 2,500 tier 1 suppliers and over 1,000 active contracts in place.

Policies in relation to slavery and human trafficking

A number of national regulations and mandates exist that allow for modern slavery to be prioritised as a topic for consideration in the purchases that we make.

The Health and Care Act 2022 allow for regulations to be set to eradicate modern slavery and human trafficking in NHS supply chains. NHS England has also adopted the mandatory inclusion of Net Zero and Social Value criteria in the evaluation of all tenders. This is also mandated for all NHS Trust procurements. Modern slavery can be a topic addressed under social value where it is proportionate and relevant to the contract.

We have created two policies that build on this national level focus to address to this issue. The BWPC procurement strategy 2022-25 is published online and is publicly available having been signed off and approved by the Trust Boards of both NBT and UHBW.

1. BWPC Procurement Strategy 2022-25.
   This document sets out our values and outlines the areas of focus for BWPC to ensure that we are maximising the value obtained from our external spend. There are 4 objectives within the strategy. The Anchor in the Community objective includes a clear commitment to remove modern slavery for our supply chain and to use our market leverage to drive an ethical supply chain. The aim is to ensure that our supply

chains and procurement processes are ethical, free from worker abuse and exploitation and provide safe working conditions. An away day was held with all BWPC staff to engage with and explore the strategy and what its aims mean in the short, medium and long term to the team.

2. Joint Ethical Procurement Strategy.
   This document will reflect our joint vision and aims to support the delivery of exceptional healthcare services in a sustainable manner. Included within the definition of 'sustainable' is ethical conduct and social value. We will document a specific commitment to ensure that our supply chain and procurement processes are ethical, free from worker abuse and exploitation and provide safe working conditions. This policy will be approved and be available publicly during 24/25.

Our existing recruitment policies set out the processes that cover the recruitment of both our temporary and permanent employees. The overall approach is governed by compliance with legislative and regulatory requirements and the maintenance and development of good practice in the fields of employment.

Our recruitment processes are robust and adhere to safe recruitment principles. We have a range of policies and procedures to protect staff from poor treatment and/or exploitation which comply with all respective laws and regulations. This includes policies on recruitment, pay and equality, diversity and inclusion.

In addition to this, we have clear systems and polices in place to encourage the reporting of concerns, speaking up and the protection of whistleblowers Our policies such as Safeguarding Adults and Children, Dignity at Work, Grievance procedure and Freedom to Speak Up policy provide additional platforms for our employees to raise concerns about poor and inappropriate working practices. We have a number of dedicated Freedom to Speak Up Guardians and Executive and Non-Executive Director leads for Freedom to Speak Up. Whilst these are not exclusively for the purpose of raising concerns for modern slavery and human trafficking, their remit covers any issues linked to this.

Risk Assessment and Management

A category level environmental, social and governance risk assessment has been carried out for our spend profile. This assessment included the identification of modern slavery risks across the lifecycle of goods and services purchased on criteria including the risk of forced labour, child labour, working conditions and discrimination.

The following purchasing categories were identified as high risk:

- Construction
- Information Technology (IT)
- Food and Catering
- Medical Equipment
- Textiles (clothing, bed linen etc)
- Waste Management
- Temporary Staff and Recruitment Services

Due Diligence Process

Our robust recruitment processes are in line with relevant employment legislation and adhere to safe recruitment principles. We follow strict pre-employment checks on all directly

employed staff, Bank Workers and others undertaking work within our organisation. These include identification, right to work, qualification, registration and reference checks. Our pre-employment checks are in line with the NHS employment check standards and our Resourcing functions oversee fair and equitable recruitment and selection practices.

We align to nationally negotiated NHS pay rates and terms and conditions of employment. We consult and negotiate with recognised Trade Unions on proposed changes to working arrangements, policies and contractual terms and conditions.

Only approved frameworks are used for the recruitment of temporary agency staff. All providers are audited to provide assurance that pre-employment clearance has been obtained in line with the NHS Employment Check Standards.

We also provide access to learning and development opportunities and provide a comprehensive staff benefits and health and wellbeing offer.

As part of our standard checks within our procurement process, bidders are checked (where relevant) for their compliance with the Modern Slavery Act (2015).

We have been engaging with our category leads and main suppliers within our IT category to raise awareness and understand the maturity levels of work across the sector in this area. We aim to replicate this approach for other high-risk categories. We will use this to inform the due diligence processes we need to implement.

We recognise that our current due diligence processes are not adjusted to reflect the risk associated with the purchase involved. We will develop our process over the coming year to ensure that our due diligence processes are proportionate to the risk posed by the purchase in question.

KPIs to measure effectiveness of steps being taken

We have a robust governance mechanism for monitoring the delivery of the commitments set out in our policies. The Sustainable Procurement Workstream as part of the ICS Green Plan Implementation Group is made up of representatives from all three organisations. It is responsible for driving the delivery of the commitments and reporting on their progress to the Green Plan Steering Group that sits above this and feeds into Executive and Board level activities at each organisation.

Training on Modern Slavery and Human Trafficking

We provide advice, training and support about modern slavery and human trafficking to all staff through our safeguarding children and adults mandatory training, our safeguarding policies and procedures and our safeguarding teams.

We also ensure that all staff receive a comprehensive induction programme which includes information on, and guidance regarding modern slavery and human trafficking.

Specifically, within our procurement function, all BWPC colleagues have access to the Government Commercial College training courses on

- Tackling modern slavery in supply chains
- Social Value Mandatory e-learning
- Social value seminar 1 – Social Value PPN 06/20

With completion mandatory for all BWPC colleagues.

UHBW and NBT plan to develop education resources and make them available to their staff and, over the coming year, map the key stakeholders who are involved in the procurement and contract management process to focus engagement efforts and further drive our shared commitment to eradicate modern slavery and human trafficking from our supply chains.

Signed by

Next update due

North Bristol NHS Trust

Report To:	Public Trust Board		
Date of Meeting:	28 November 2024		
Report Title:	Integrated Performance Report		
Report Author:	Lisa Whitlow, Associate Director of Performance		
Report Sponsor:	Executive Team		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			✓
	To provide the Trust Board with the Integrated Performance Report for NBT.		
Key Points to Note *(Including any previous decisions taken)*			
The report is a standing item to the Trust Board Meeting.			
Strategic Alignment			
N/A			
Risks and Opportunities			
N/A			
Recommendation			
This report is for **Information** The Trust Board is asked to note the contents of the Integrated Performance Report.			
History of the paper (details of where paper has <u>previously</u> been received)			
Trust Board	Submitted every month for Trust Board.		
Appendices:	Slide deck - IPR November 2024		

North Bristol NHS Trust

North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

November 2024

(presenting October 2024 data)

Contents

North Bristol Integrated Performance Report

NHS North Bristol NHS Trust

Domain	Description	Regulatory	Trust Patient First Improvement Priority	National Standard	Current Month Trajectory (RAG)	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Trend	Benchmarking (in arrears except A&E & Cancer as per reporting month)	
																				Peer Performance	Rank
Responsiveness	A&E 4 Hour - Type 1 Performance	R		95.00%	70.73%	60.56%	63.37%	67.17%	63.30%	64.87%	63.77%	63.56%	61.83%	63.21%	69.31%	61.40%	58.25%	58.70%		54.07%	4/11
	A&E 12 Hour Trolley Breaches	R		0	-	223	213	269	318	168	260	324	217	252	125	83	396	419		18-2232	5/11
	Ambulance Handover < 15 mins (%)		PF	65.00%	-	25.78%	30.70%	28.97%	35.05%	39.35%	37.24%	39.99%	40.72%	42.19%	51.34%	41.75%	23.82%	26.55%			
	Ambulance Handover < 30 mins (%)	R	PF	95.00%	-	57.72%	66.27%	61.66%	64.52%	71.47%	68.13%	72.27%	75.47%	74.15%	82.25%	76.67%	55.01%	58.32%			
	Ambulance Handover > 60 mins		PF	0	-	627	455	554	534	329	366	274	210	240	165	182	516	552			
	Average No. patients not meeting Criteria to Reside				132	218	228	243	245	233	211	233	216	218	210	204	192	205			
	Bed Occupancy Rate			93.00%	-	97.12%	96.84%	96.28%	97.81%	97.40%	97.48%	97.86%	97.53%	97.37%	97.20%	97.22%	98.09%	98.17%			
	Diagnostic 6 Week Wait Performance			5.00%	0.98%	11.40%	9.81%	10.11%	12.28%	5.19%	4.22%	3.10%	2.47%	1.38%	0.85%	1.15%	0.81%	0.80%		24.59%	1/10
	Diagnostic 13+ Week Breaches			0	0	17	14	7	4	5	0	0	0	0	0	0	0	0		0-382	1/10
	RTT Incomplete 18 Week Performance			92.00%	-	61.52%	61.94%	60.14%	61.11%	61.58%	59.75%	60.36%	60.96%	61.97%	63.71%	63.94%	65.04%	66.33%		56.29%	8/10
	RTT 52+ Week Breaches	R		0	1043	2124	1858	1685	1393	1383	1498	1609	1632	1649	1305	1108	909	774		49-10976	2/10
	RTT 65+ Week Breaches				18	545	420	388	249	193	146	191	226	218	156	105	9	12		0-2525	2/10
	RTT 78+ Week Breaches	R			49	55	49	50	45	39	27	18	14	6	13	4	1	0		0-579	2/7
	Total Waiting List	R			47280	48595	47698	47245	46710	46394	46278	46441	46740	46252	45732	45478	45491	44755			
	Cancer 31 Day First Treatment			96.00%	87.76%	85.61%	88.14%	86.30%	77.12%	86.18%	83.07%	87.77%	84.83%	86.50%	80.45%	85.85%	80.97%	-		90.89%	9/10
	Cancer 62 Day Combined	R	PF	85.00%	66.88%	60.07%	61.59%	61.20%	53.33%	58.15%	59.14%	60.62%	59.32%	61.31%	58.16%	69.02%	60.70%	-		66.69%	8/10
	Cancer 28 Day Faster Diagnosis	R		75.00%	75.21%	59.46%	71.42%	74.89%	70.88%	74.80%	73.79%	57.28%	67.47%	78.05%	78.38%	79.04%	78.19%	-		72.83%	5/10
	Cancelled Operations Not Re-booked Within 28 Days			0	-	6	3	9	5	5	5	6	3	2	5	2	6	-			
	Urgent Operations Cancelled ≥2 times			0	-	0	1	0	0	0	0	0	0	0	0	0	0	-			

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North Bristol Integrated Performance Report

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Quality, Safety and Effectiveness	Trust Quality Metrics	Summary Hospital-Level Mortality Indicator (SHMI)					0.95	0.95	0.94	0.94	0.94	0.95	0.95	0.96	-	-	-	-	-	
		Never Event Occurrence by Month			0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
		Commissioned Patient Safety Incident Investigations					2	1	1	2	0	1	1	1	1	1	2	0	0	
		Maternity and Newborn Safety Investigations					2	0	0	0	1	0	1	0	0	0	2	0	0	
		Total Incidents					1470	1549	1208	1198	1329	1289	1125	1180	1131	1170	1077	1286	1270	
		Total Incidents (Rate per 1000 Bed Days)					48	52	40	38	45	40	37	38	37	38	36	43	40	
		WHO Checklist Completion				95.00%	99.08%	99.36%	99.43%	99.52%	99.82%	99.71%	99.89%	99.92%	99.73%	99.90%	99.37%	99.55%	98.72%	
		VTE Risk Assessment Completion	R			95.00%	93.48%	93.53%	93.06%	92.60%	91.51%	91.16%	91.01%	91.50%	90.22%	90.43%	90.48%	92.30%	-	
		Pressure Injuries Grade 2					11	10	12	11	18	10	14	11	4	11	4	5	10	
		Pressure Injuries Grade 3				0	0	0	1	1	0	0	0	0	0	0	0	0	0	
		Pressure Injuries Grade 4				0	0	1	0	0	1	0	0	0	0	0	0	0	0	
		Pressure Injuries rate per 1,000 bed days					0.26	0.34	0.33	0.35	0.47	0.28	0.36	0.35	0.10	0.36	0.13	0.10	0.25	
		Falls per 1,000 bed days					6.45	6.56	6.38	5.58	5.72	5.66	5.18	5.20	5.56	5.80	5.01	6.53	5.32	
		MRSA	R		0	0	1	1	0	0	0	0	1	0	0	1	0	1	1	
		E. Coli	R			4	5	11	5	6	5	2	6	10	4	6	4	4	12	
		C. Difficile	R			5	4	3	2	2	9	8	6	2	4	8	2	6	7	
		MSSA				2	4	3	6	3	3	2	2	2	3	3	2	2	5	
		Observations Complete					99.02%	98.83%	98.66%	98.73%	98.50%	98.60%	98.90%	98.93%	98.96%	98.90%	98.50%	98.48%	98.43%	
		Observations On Time					73.33%	75.00%	72.04%	72.85%	71.82%	72.94%	70.70%	71.10%	71.91%	73.81%	73.88%	72.98%	72.42%	
		Observations Not Breached					85.17%	88.39%	85.54%	85.57%	84.80%	84.52%	83.10%	83.96%	83.81%	86.04%	88.06%	87.05%	86.84%	
	Maternity	5 minute Apgar 7 rate at term				0.90%	0.68%	1.82%	0.78%	0.23%	1.22%	1.90%	1.00%	0.93%	0.93%	3.16%	0.98%	2.04%	1.56%	
		Caesarean Section Rate					42.89%	43.19%	41.26%	44.90%	47.50%	44.74%	45.88%	46.09%	46.07%	45.05%	46.40%	45.36%	48.44%	
		Still Birth Rate				0.40%	0.21%	0.21%	0.72%	0.43%	0.00%	0.22%	0.00%	0.22%	0.22%	0.00%	0.44%	0.42%	0.00%	
		Induction of Labour Rate				32.10%	34.31%	30.21%	36.65%	31.67%	31.36%	34.45%	32.71%	29.78%	29.91%	25.00%	28.83%	33.05%	30.98%	
		PPH 1500 ml rate				8.60%	3.97%	2.96%	2.42%	2.38%	4.04%	2.68%	3.52%	4.98%	4.78%	4.45%	4.94%	4.50%	3.51%	
	Fragile Hip	Fragile Hip Best Practice Pass Rate					79.17%	70.59%	61.40%	60.00%	67.92%	71.43%	68.57%	41.18%	59.57%	45.95%	65.63%	50.00%	-	
		Admitted to Orthopaedic Ward within 4 Hours					33.33%	25.49%	21.05%	28.57%	9.43%	14.29%	20.00%	19.61%	14.89%	32.43%	34.38%	16.67%	-	
		Medically Fit to Have Surgery within 36 Hours					81.25%	72.55%	68.42%	64.29%	71.70%	73.47%	68.57%	47.06%	65.95%	51.35%	75.00%	57.40%	-	
		Assessed by Orthogeriatrician within 72 Hours					97.92%	96.08%	91.23%	88.57%	90.57%	95.92%	91.43%	86.27%	91.48%	91.89%	100.00%	92.59%	-	
	Stroke	Stroke - Patients Admitted					155	164	157	184	163	152	174	135	154	160	159	156	-	
		Stroke - 90% Stay on Stroke Ward				90.00%	82.22%	71.95%	77.42%	75.22%	76.47%	78.13%	60.00%	70.73%	79.54%	51.32%	52.04%	64.29%	-	
		Stroke - Thrombolysed <1 Hour				60.00%	75.00%	56.25%	37.50%	85.71%	60.00%	78.13%	72.73%	60.00%	60.00%	62.50%	48.00%	56.00%	-	
		Stroke - Directly Admitted to Stroke Unit <4 Hours				60.00%	59.78%	61.45%	70.97%	58.62%	63.92%	61.54%	40.00%	60.61%	57.14%	38.16%	37.62%	43.43%	-	
		Stroke - Seen by Stroke Consultant within 14 Hours				90.00%	89.80%	85.71%	92.23%	86.47%	95.50%	84.21%	74.55%	81.37%	85.14%	84.71%	82.57%	84.48%	-	

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North Bristol Integrated Performance Report

NHS North Bristol NHS Trust

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Quality & Caring Patient Experience	Friends & Family Positive Responses - Maternity		PF			89.49%	89.29%	91.73%	92.73%	91.16%	93.93%	90.05%	93.37%	93.17%	89.47%	91.62%	88.69%	90.76%	
	Friends & Family Positive Responses - Emergency Department		PF			72.80%	79.33%	80.94%	81.44%	81.12%	73.99%	77.89%	74.65%	78.64%	81.05%	78.96%	71.71%	71.52%	
	Friends & Family Positive Responses - Inpatients		PF			91.96%	92.53%	91.30%	92.71%	91.98%	91.55%	92.73%	91.81%	93.80%	91.72%	90.81%	91.60%	91.81%	
	Friends & Family Positive Responses - Outpatients		PF			94.65%	95.45%	96.01%	95.31%	94.58%	95.12%	95.33%	95.06%	94.90%	95.00%	94.79%	94.24%	94.29%	
	PALS - Count of concerns					139	152	103	191	133	157	137	155	174	159	130	174	174	
	Complaints - % Overall Response Compliance				90.00%	65.00%	60.00%	73.00%	79.00%	71.00%	84.62%	86.11%	72.22%	84.09%	73.68%	79.19%	80.43%	84.00%	
	Complaints - Overdue					9	10	3	5	6	4	2	2	4	4	6	3	1	
	Complaints - Written complaints					60	49	36	44	40	39	36	47	45	59	59	63	62	
Workforce	Agency Expenditure ('000s)					2093	2184	1610	1507	1592	1368	891	1037	765	725	657	724	645	
	Month End Vacancy Factor					6.62%	6.42%	5.87%	4.87%	4.82%	5.02%	2.55%	3.46%	4.04%	4.26%	4.06%	4.17%	4.14%	
	Turnover (Rolling 12 Months)	R	PF		-	14.13%	13.74%	13.30%	13.09%	12.91%	12.32%	12.01%	11.88%	11.88%	11.75%	11.54%	11.92%	11.80%	
	Sickness Absence (Rolling 12 month)	R			-	4.89%	4.81%	4.70%	4.66%	4.67%	4.65%	4.62%	4.60%	4.61%	4.62%	4.58%	4.56%	4.56%	
	Trust Mandatory Training Compliance					89.39%	90.69%	91.06%	90.14%	89.44%	91.16%	91.50%	91.47%	92.02%	92.58%	92.71%	92.18%	92.33%	

RAG ratings (Red/Green) are against Current Month Trajectory. For metrics with no trajectory, RAG rating is according to comparison with previous month, except for Bed Occupancy, Diagnostic 6 Week Wait Performance and Urgent Operations Cancelled ≥ 2 times which are RAG rated against National Standard.

Executive Summary

Urgent Care

Four-hour performance reported at 58.70% in October. NBT again ranked fourth out of 11 AMTC providers. There was an increase in 12-hour trolley breaches compared to the previous month (419 in October from 396 in September), and an increase in ambulance handover delays over one-hour (541 in October from 515 in September). The UEC position continues to be driven by a combination of increasing demand and reduced patients flow out of the hospital. In the year-to-date, ED attendances are up by 3.5% which equates to over 2,100 additional presentations. At the same time, the average NC2R position has increased month on month. What is uncharacteristic, is the absence of any summer seasonal improvement this year. Once again, bed occupancy has reached a new high of 98.17% – higher than the peak winter months.

These circumstances are creating a challenging clinical, operational and performance environment. The System ambition to reduce the NC2R percentage within NBT to 15% remains unachieved. This ambition was central to the Trust being able to deliver the 78% ED 4-hour performance requirement for March 2025. As yet, there is no evidence this ambition will be realised. Community-led D2A programme remains central to ongoing improvement. Work also progresses around development of a “Transfer Of Care” Hub (TOC Hub) modelled on recommendations from the national UEC plan and aimed at reducing barriers to transfers of care through a single multi-disciplinary and multi-agency hub. In the meantime, internal hospital flow plans continue to be developed and implemented.

Elective Care

The Trust was successful in delivering its 65-week RTT commitments against the national September-2024 requirements. The final reported position for 65-week clearance in September showed the Trust as best performing in the South-West region, second best of its peers and seventh best performing nationally amongst 75 Trusts with waiting lists over 40,000. The overall waiting list is also now reducing, having decreased by approximately 10% over the last year. Having reached the milestone of reducing 52-week waits to below 1,000 in September, there has been another significant reduction during October, taking the position to just over 700. The Trust has now set its own ambition to reduce 52-week wait breach volumes to less than 1% by the end of this year. This ambition is beyond national target requirements and is on track to deliver.

Diagnostics

For a third month, the Trust’s diagnostic performance has achieved the national constitutional standard – going beyond the target of no more than 5% breaching six-week waits. The actual breach rate in October was less than 1%. Benchmarking against Trusts with similar waiting lists across England, NBT has ranked first for a third month. The Trust also remains compliant with the maximum 13-week wait. We continue to have no patients waiting beyond 13 weeks.

Executive Summary

Cancer Wait Time Standards

Having stabilised and achieved a reduction in the total >62-Day waiting list (the PTL) and having secured performance against the FDS, the remaining challenge is to deliver the overall 62-day breach position for the Trust i.e. 70% being fewer than 62-days wait by the end of the financial year. The work previously undertaken has been around improving systems and processes, and maximising performance in the high-volume tumour sites. To achieve the overall 62-Day breach standard this year, the Trust will now focus on improvements in some of the most challenging pathways/backlogs - including the high volume and high-complexity Urology pathway (in particular, robotic prostatectomy). Prostatectomy backlog work is now underway with the weekly activity increasing by up to 100%.

As reported in the previous Board report, the planned prostatectomy backlog activity the 62-Day position was expected to show a deterioration in overall 62-day performance in September, before recovering into October and November. This is shown in the reported position – as expected.
Performance stabilisation is forecast in October and improving significantly in November and December as the backlog clearance work concludes. At this point, plans for sustaining the position will be enacted which will require slightly lower levels of additional activity to be sustained. On this basis, the Trust is expecting to meet its commitments to secure its PTL, FDS and the 62-Day target by March 2025, as per the national requirement.

Quality

Within Maternity, the term admission rate to NICU was 3.6% against the national target of 5%. PMRT reviews saw three cases (four elements of care) graded as C or D in September. Improvement actions are described in the main report. There were no new cases referred to MNSI, or new Patient Safety Incident Investigations, with one moderate harm incident reported. During October 2024 NBT had a rate of 5.1 medication incidents per 1000 bed days, which is below the mean point of 6.2 for the past 6 months. The work of the 'Medicines Safety Forum' continues, now to meet monthly and with a renewed priority list to address the most significant risks. Infection control data for MSSA and E.coli remains below 2024-25 trajectory, however C-Difficile is increasingly above. Targeted plans are in place to address this trend. Covid-19 and flu numbers have seen a small increase but are being managed appropriately. There was one new MRSA case. NBT reported a rate of 5.32 falls incidents per 1000 bed days in October which is below the average of 6.32. A focus on individual cases continues, recognising the impact each one has. Continued improvement actions are outlined in the main report. The overall trend in Pressure Injury reduction continues, which includes those relating to devices, when benchmarked against 2023-24 figures for the same 6-month period there's a 45% reduction. VTE risk assessment compliance has fluctuated over the past 2 years, with a declining trend for some months. This has been arrested in the most recent month. Ongoing mitigating actions have been established, with the primary medium-term failsafe being implemented in Spring 2025 through the Digital Prescribing system (EPMA). Delivery of the Year 2 workplan for Patient & Carer Experience remains positive, with actions targeted to improve patient experience and aligned to the national patient surveys, which includes the Patient Conversations initiative which celebrated its one-year anniversary, as outlined in the report. 91.8% of patients gave the Trust a FFT positive rating, a decrease on the previous month but remaining within the overall expected statistical range of performance. Complaint volumes are static , but there has been a sizeable increase in PALS concerns, which is under review to understand through delving below the headline themes. The response rate compliance for complaints increased to 84%, sustaining the overall improved trend over the past 10 months. All complaints & PALS concerns are acknowledged within the agreed timeframes.

Executive Summary

Workforce

Turnover decreased from 11.92% for September to 11.80% in October, in line with the target set for 2024/25. We remain focussed on monitoring the impact of our actions from the one-year retention plan through delivery of our five-year retention plan, particularly the proportion of our Healthcare Support Workers leaving within the 1st 12 months of service; stability for this cohort has improved from 78.00% in September to 79.92% in October.

A deep dive into the Commitment to our Community metric, Disparity Ratio, took place in November and was the focus of the November Senior Leadership Group. We have enhanced our understanding of this metric, our top contributors to our position and most important started to design our action to positively impact on disparity. This work will continue to develop through our Commitment to our Community work programme in partnership with divisions. Our current disparity ration in October was 1.63.

Trust-wide agency spend decreased from 1.55% in September to 1.06% in October, below the Trust the 2024/25 target of 3.20%. Agency use has significantly reduced whilst bank use has remained stable, through the weekly focus of the Resourcing and Temporary Staffing Oversight group improvements have been seen in areas of focus, nursing and midwifery and resident doctors.

Our watch metrics (sickness absence and vacancy rate) have followed a trend of statistically significant improvement over the past 12 months.

Finance

This month the Trust has delivered a financial position above plan driven by non-recurrent commissioner funding recognised in month. The financial plan for 2024/25 in Month 7 (October) was to break even and in month the Trust has delivered a £0.3m surplus, which is £0.3m better than plan. Year to date, the position is a £3.5m adverse variance against a planned £2.5m deficit driven primarily by the impact of in year CIP delivery across pay and non-pay. The Trust cash position at Month 7 is £44.3m, a reduction of £18.4m from Month 12. This is driven by the underlying deficit, capital spend, and outstanding debt. The Trust has delivered £13.5m of completed cost improvement programme (CIP) schemes at month 7, an increase of £1.1m from month 6. There are a further £4.4m of schemes in implementation and planning that need to be developed, and £11.0m in the pipeline.

High Quality Care

NHS North Bristol NHS Trust

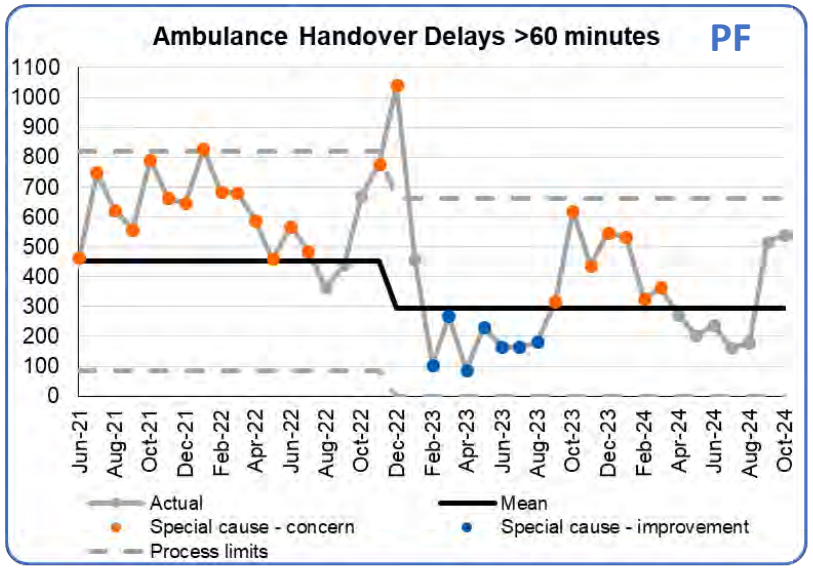
Responsiveness

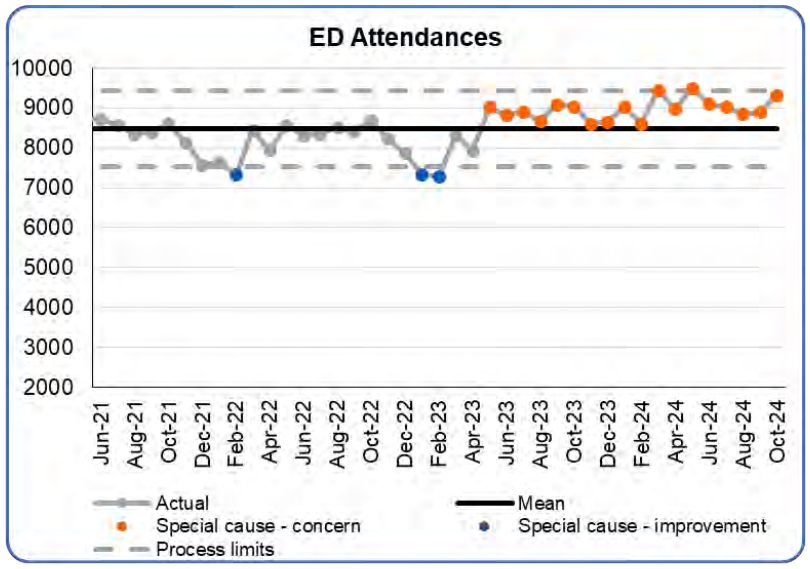
Board Sponsor: Chief Operating Officer
Steve Curry

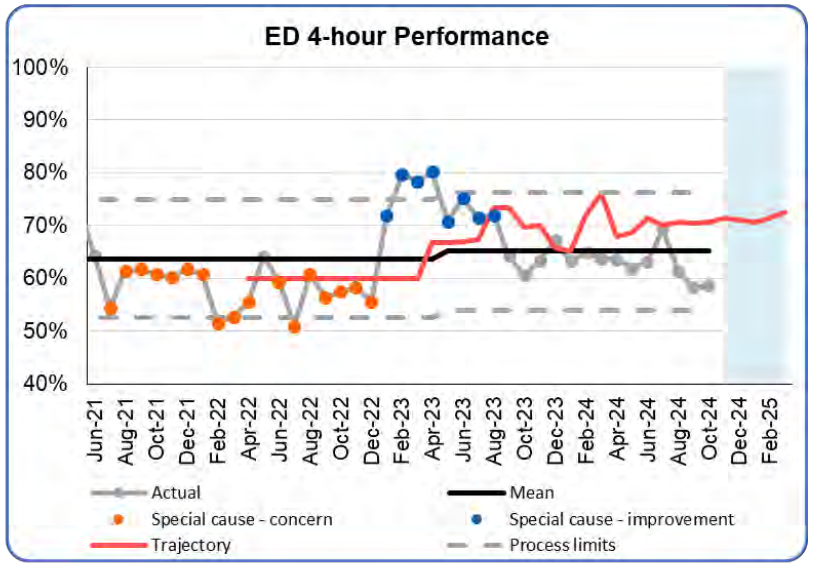
Responsiveness – Indicative Overview

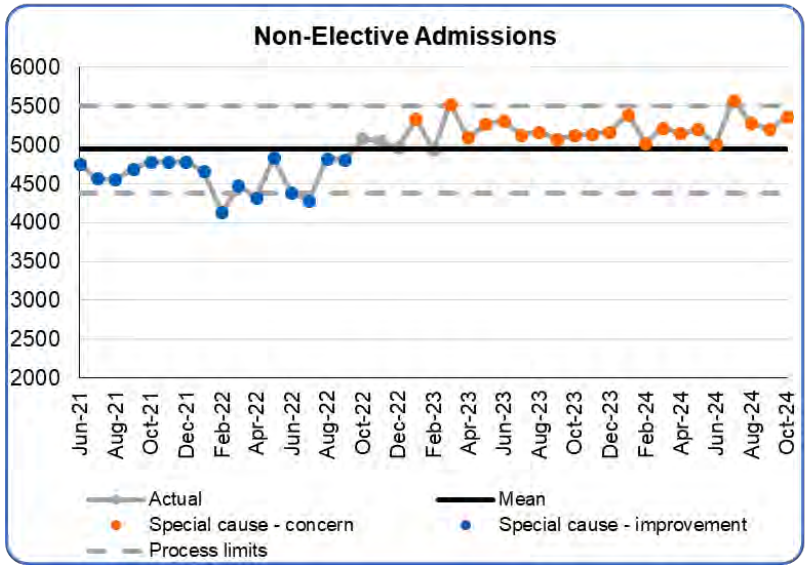
Delivery Theme	Delivery Indicator	Key Improvement /Delivery Action
Urgent & Emergency Care	UEC plan	Internal and partnership actions continue meanwhile, ED demand in the YTD is up 3.54%.
	NC2R/D2A	As yet, no evidence of progress with bed occupancy reaching its highest point for more than a year.
RTT	65-week wait	Delivered. Exceeded operational plan – final complex clearance underway and new internal ambition to reduce 52-week waits to less than 1% underway and on plan.
Diagnostics	5% 6-week target	Delivered. Exceeded national requirement. Now constitutional standard compliant.
	CDC	Delivered. Operational. Now including Endoscopy.
Cancer	28-day FDS Standard	Delivered. Now compliant for more than three months.
	62-Day Combined Standard	In-month dip in performance as expected, as breach backlog is being treated. This will not impact our ability to comply with the national in-year target as required.

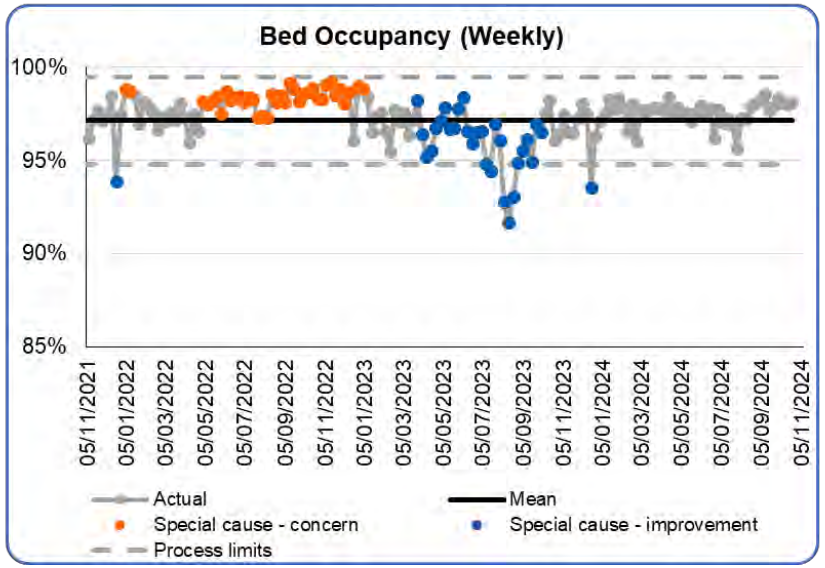
Urgent and Emergency Care

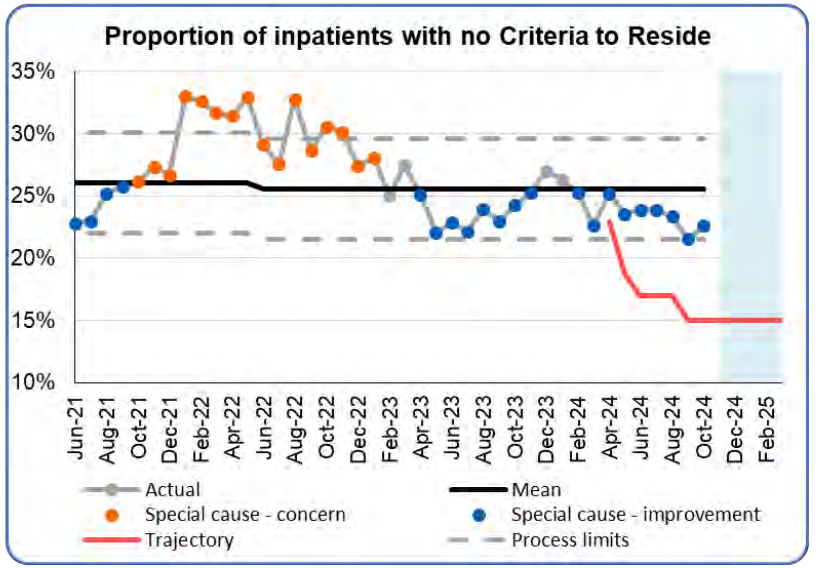












Urgent and Emergency Care

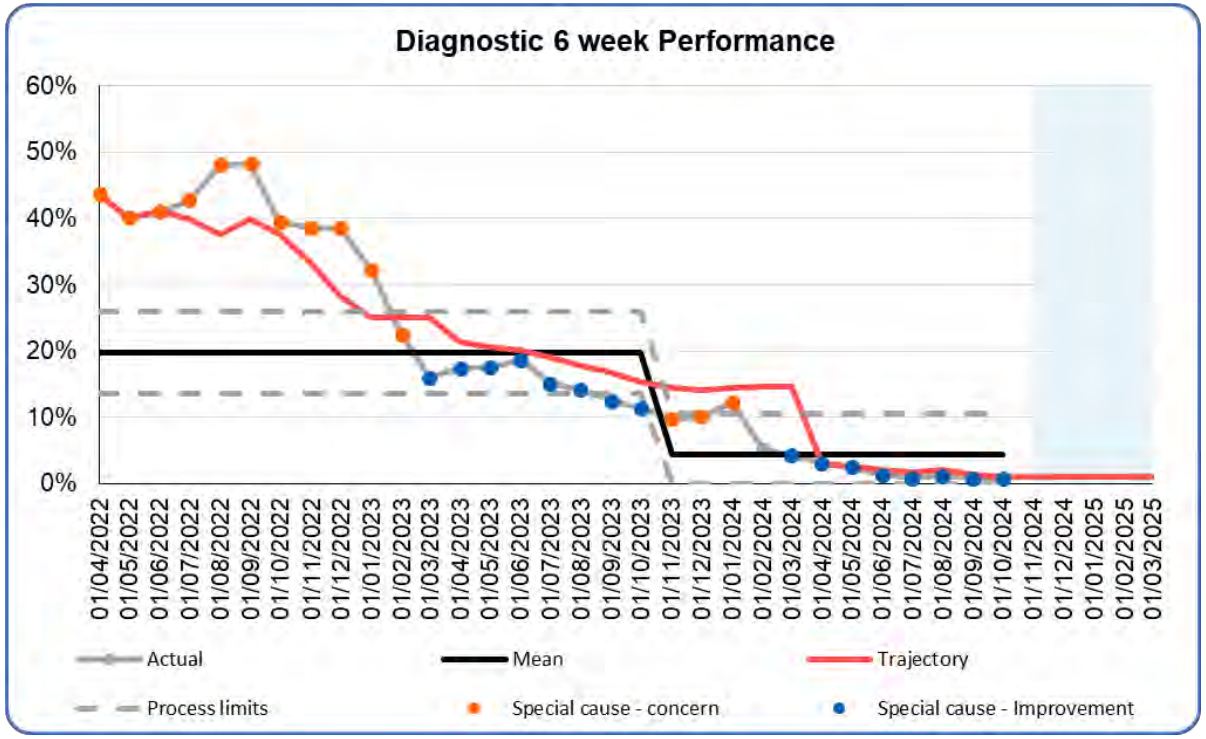
What are the main risks impacting performance?

- Year-on-year ED attendances have been increasing; October 2024 saw 3% more attendances than the same month last year.
- As yet, no significant progress in reducing NC2R problems against System ambition.
- Unusually, we have not seen any seasonal variation in NC2R numbers throughout the summer months.
- NC2R position contributing to the highest bed occupancy seen in over a year at 98.17%.

What actions are being taken to improve?

- Executive and CEO-level escalation regarding NC2R impact - commitment secured from system partners to focussed work with revised reduction ambition. Additional capacity requirements developed by COOs across the System with CEO funding agreement reached in the last week. Awaiting capacity provision.
- Ambulance handovers – significant year-on-year improvement in lost ambulance handover time – but previous months have proved more challenging. Internal UEC programme actions on handover processes, together with the 'continuous flow' model led by the Chief Nursing Officer has delivered further improvement.
- Ongoing introduction of the UEC plan for NBT; this includes key changes such as implementing a revised SDEC service, mapping patient flow processes to identify opportunities for improvement and implementing good practice ward level patient review and discharge processes (including actions recommended from the ECIST review).
- Development of a "Transfer Of Care" Hub (TOC Hub) modelled on recommendations from the national UEC plan and aimed at reducing barriers to transfers of care through a single multi-disciplinary and multi-agency hub.
- New demand and capacity work being undertaken by system partners to refresh D2A model to support NC2R reduction ambition – see first bullet point.
- COO escalating Stroke NC2R. Further escalation arranged with System partners. Two further BIRU beds secured in BIRU following the initial four already agreed.

Diagnostic Wait Times



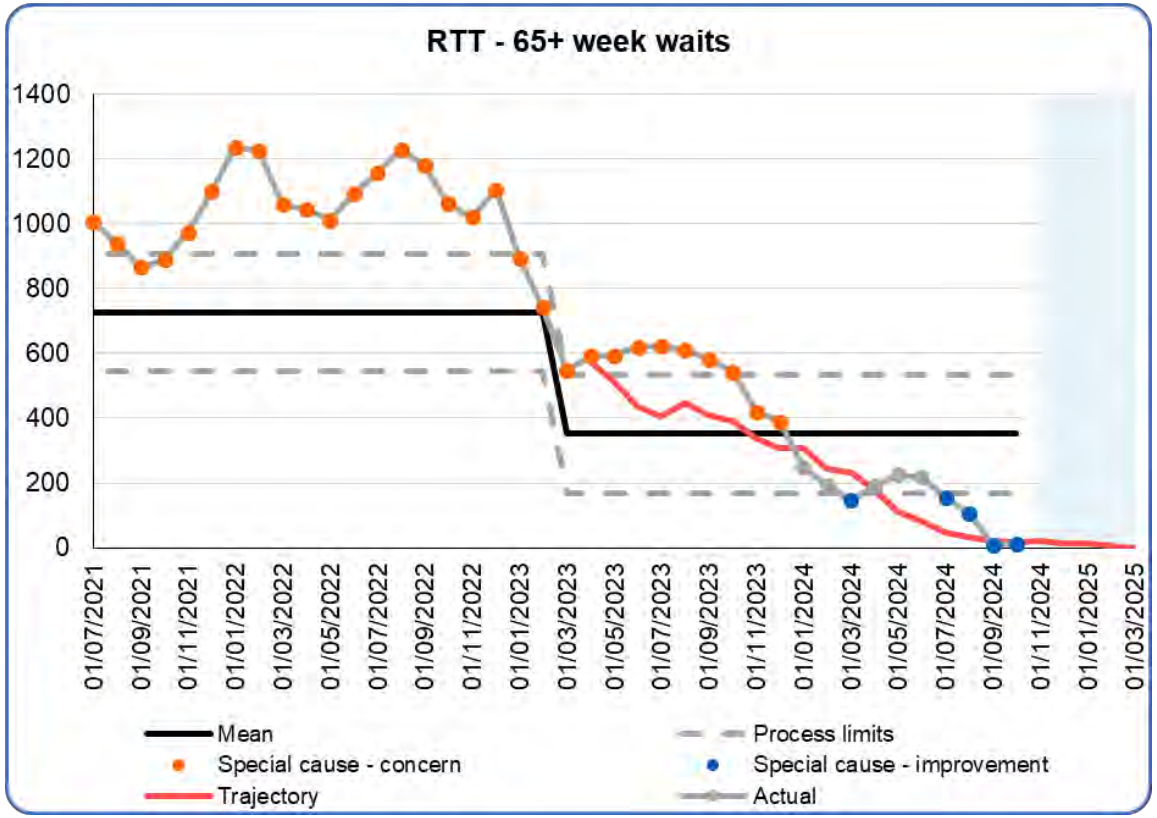
What are the main risks impacting performance?

- The Trust continues to exceed the target of no more than 5% patients waiting over 6-weeks, with performance reporting at 0.80% for October 2024.
- Cross-sectional imaging upgrades may result in some capacity losses in the next six weeks.
- Staffing gaps within the Sonography service and a surge in urgent demand means that the NOUS position remains vulnerable. Given the volume of this work, any deterioration can have a material impact on overall performance.
- Risks of imaging equipment downtime, staff absence and reliance on independent sector. Further industrial action remains the biggest risk to compliance.

What actions are being taken to improve?

- The Trust has committed to actions that deliver the national constitutional standard of 1% in 2024/25.
- The Trust is maintaining clearance of all >13-week breaches. NBT is the only trust in our region to have zero >13-week breaches.
- CDC is now operational.

Referral To Treatment (RTT)



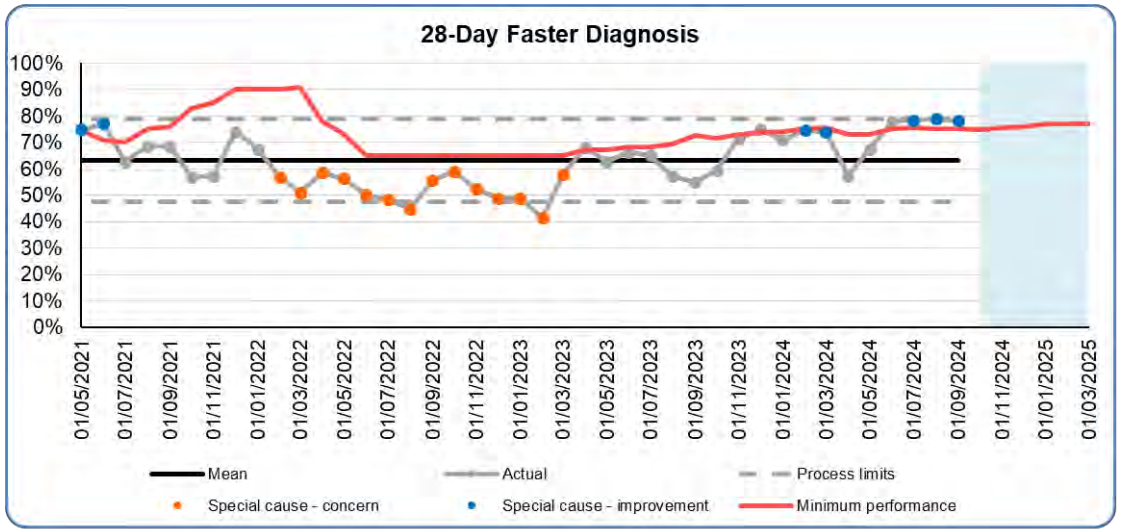
What are the main risks impacting performance?

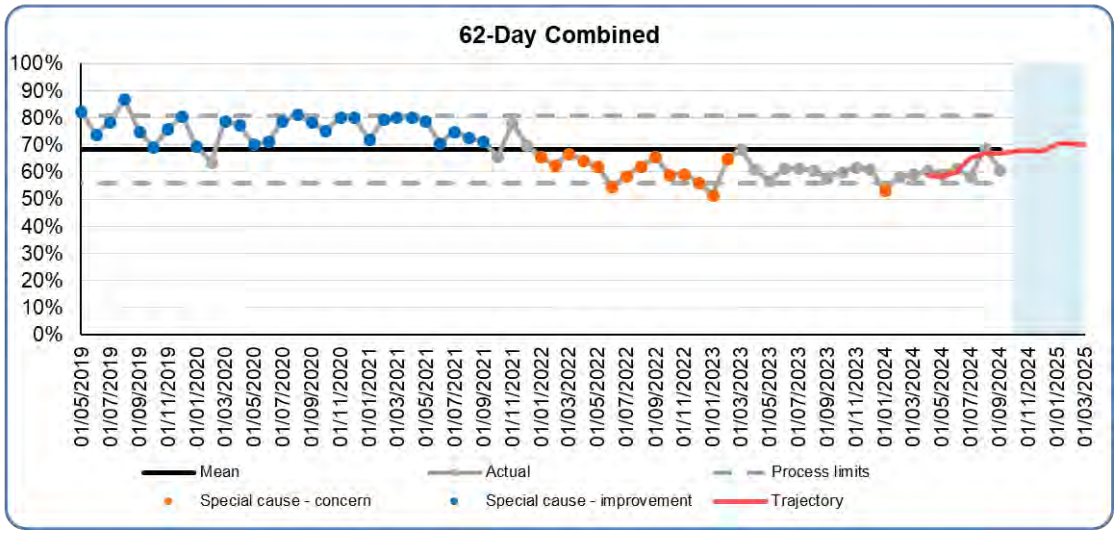
- Continued reliance on third party activity in a number of areas.
- The potential impact of UEC activity on elective care.
- Challenges remain in a small number of specialist procedures (DIEP).

What actions are being taken to improve?

- The Trust is committed to sustaining 65-week breach clearance.
- Work is underway to progress to a 52-week wait clearance.
- Speciality level trajectories have been developed with targeted plans to deliver required capacity in most challenged areas; including outsourcing to the IS for a range of General Surgery procedures and smoothing the waits in T&O between Consultants.
- Options for Independent Sector (IS) transfer are limited to patients meeting IS treatment criteria. The Trust has transferred all suitable patients into available capacity across local IS Providers.
- The Trust is actively engaged with the Getting It Right First Time (GIRFT) programme of work and working with specialists in theatre utilisation improvements to ensure use of available capacity is maximised.

Cancer Performance





What are the main risks impacting performance?

- Backlog clearance in Urology meaning headline performance will deteriorate before it improves.
- Ongoing clinical pathway work reliant on system actions remains outstanding.
- Reliance on non-core capacity.
- Increased demand is now a significant driver – Skin referrals, Gynaecology referrals and Endoscopy referrals.
- Volume and complexity of Urology pathway remains challenging.

What further actions are being taken to improve?

- Increased Urology activity through to the end of the calendar year to clear backlogs for robotic surgery.
- Recovery actions can only be made sustainable through wider system actions. The CMO is involved in System workshops looking to reform cancer referral processes at a primary care level.
- Focus remains on sustaining the absolute >62-Day Cancer PTL volume and the percentage of >62-Day breaches as a proportion of the overall wait list. This has been challenged by recent high volume activity losses (industrial action related) within areas such as Skin.
- Having secured a reduced PTL, and a FDS position compliant with trajectory, focus will now be on improving performance in the high-volume, high-complex area of Urology. Additional capacity is being secured and a new D&C model being developed.
- Moving from an operational improvement plan to a clinically-led pathway improvement plan for key tumour site pathways such as Skin and Urology (e.g. prostate pathway and implementation of Primary Care Tele-dermatology for the Skin care pathway).

Patient

Commitment to our Community

NHS North Bristol NHS Trust

Quality, Safety and Effectiveness

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

Maternity

Perinatal Quality Surveillance Monitoring (PQSM) Tool September 24 data

The term admission rate to NICU was 3.6% against a national target of 5%.

Perinatal services referred no new cases to MNSI in September. There were no new commissioned cases for Patient Safety Incident Investigations (PSII).

PMRT saw three cases being reviewed with four elements of care graded as C or D in September.

There was one moderate harm incident in September which related to the management of a post-partum haemorrhage

Midwifery is currently recruited to vacancy and turnover.

Perinatal services received nine formal complaints in September.

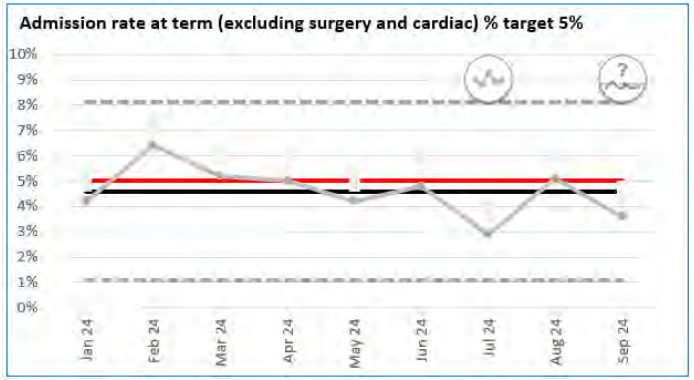
What actions are being taken to improve?

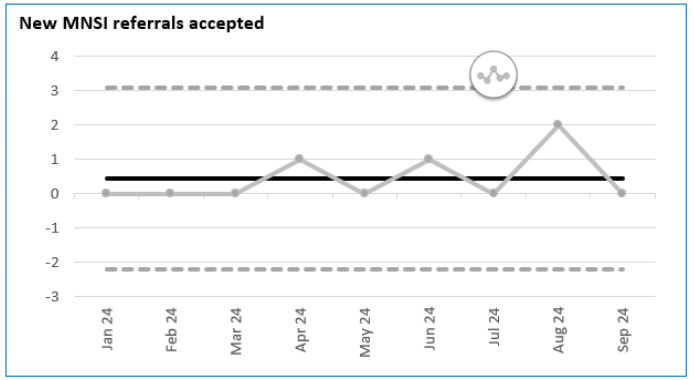
Following review of PMRT cases in September which found 2 missed opportunities for bereavement investigations following a stillbirth, the Bereavement team are leading a monthly educational hotspot for staff throughout November with a focus on appropriate investigations.

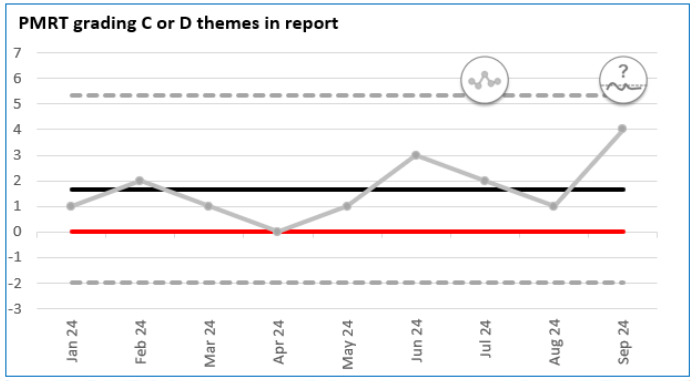
Future mandatory perinatal study days are being reviewed to ensure inclusion of the impact of bias on care following a stillbirth.

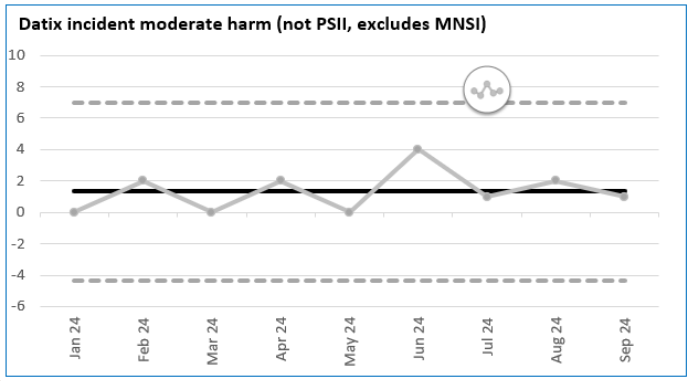
The moderate harm incident in September will be reviewed and actioned through the post-partum haemorrhage forum.

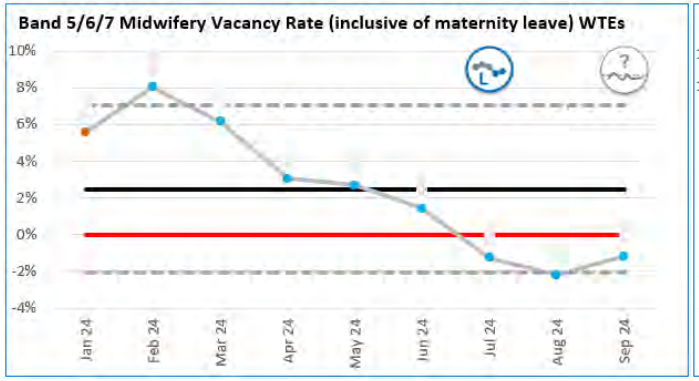
Ongoing work within the division surrounding providing compassionate care and communication in response to themes gained through complaints.

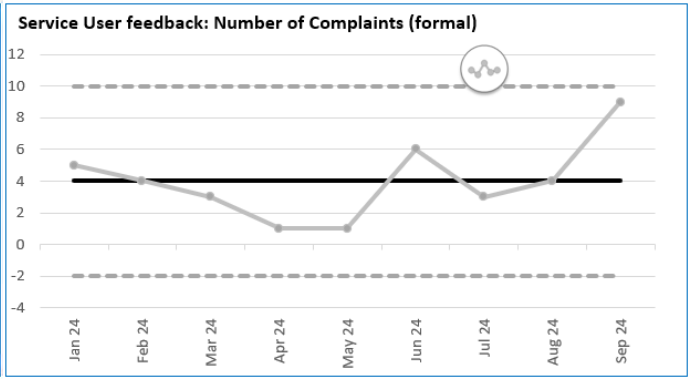


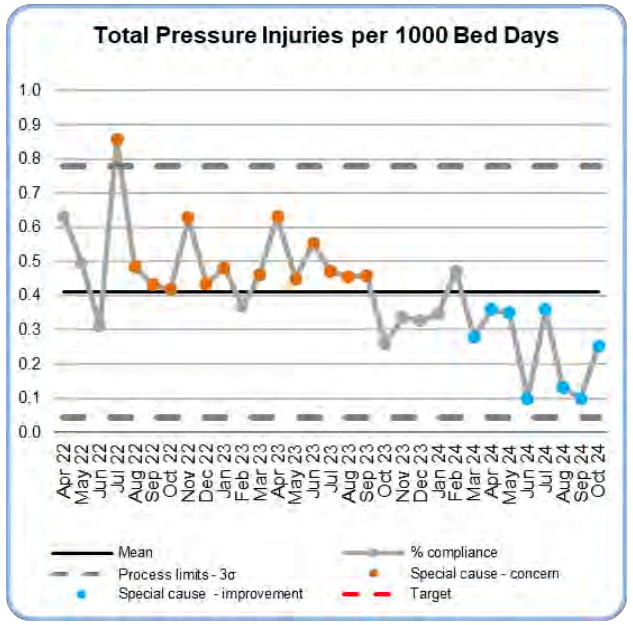


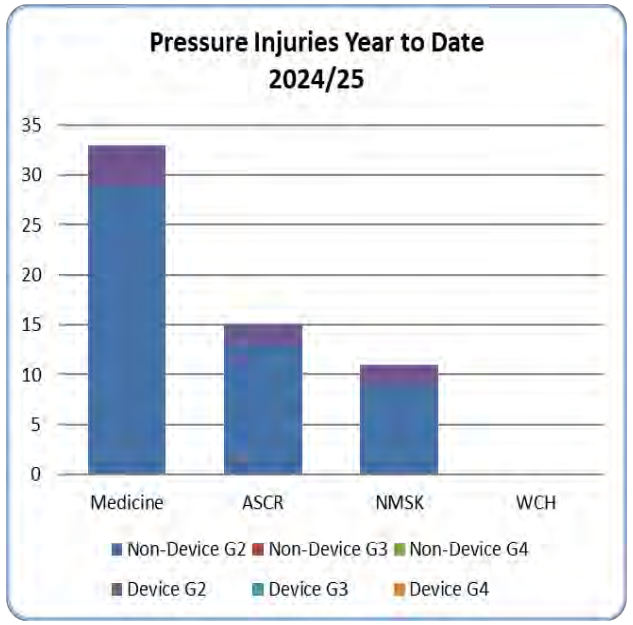


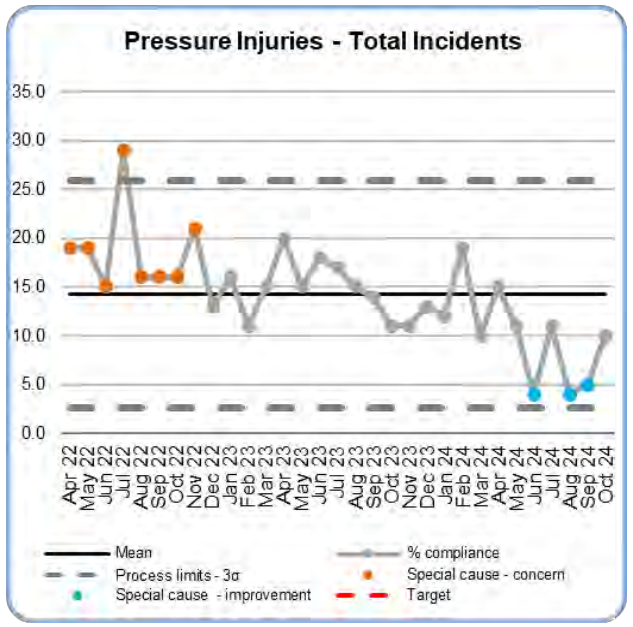


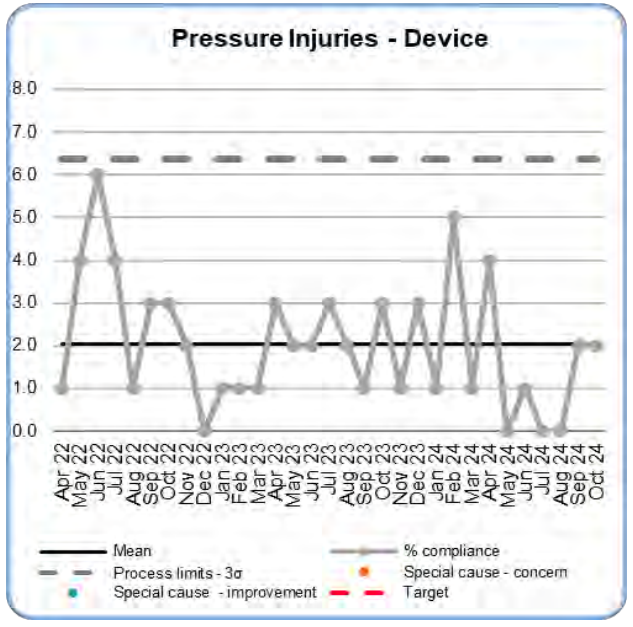












Pressure Injuries

What does the data tell us?

In October there were 11 x grade 2 pressure ulcers, of which 3 were attributable to medical devices.

In October there were 4 unstageable reported pressure ulcers reported. There were no grade 3 or 4 reported pressure ulcers.

When bench-marking grade 2 pressure ulcers against the figures from 2023-2024 for the same 7-month period, NBT is at a 45% reduction in grade 2 pressure ulcer prevalence. There are currently no reported grade 3 or 4 pressure ulcers for this period.

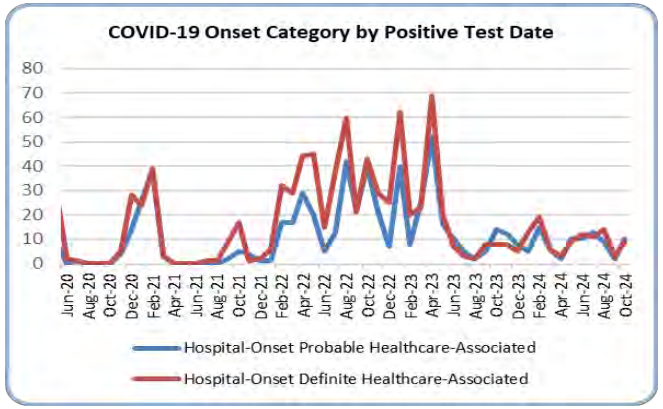
In October there was a decrease to 5 x DTIs reported. When benchmarked against the figures for 2023-2024 for the same 7-month period, NBT is at a 63% reduction in DTI prevalence.

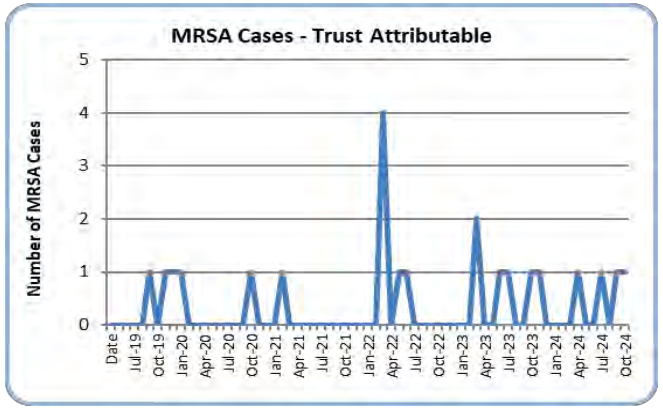
The target for pressure ulcer reduction will be a trajectory for the year based on the first-quarter figures. There will be zero tolerance for Grade 3 or 4 PUs, with a target for 50% reduction on last year's incidents.

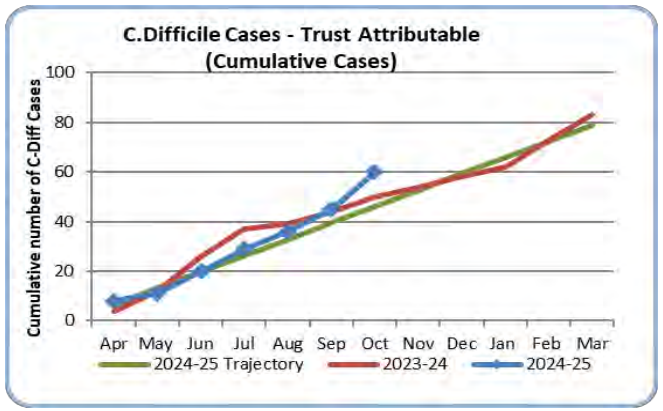
What actions are being taken to improve?

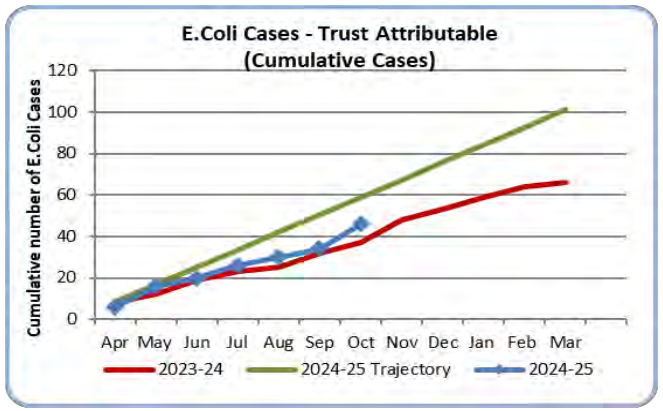
- The TVS attended the West of England regional tissue viability group to share best practice, initiatives, and challenges in providing PU prevention care. There was a discussion on the implementation on PSIRF across the region. NBT have fully implemented the PSIRF model and responding to emerging themes of PU incidents. TVN colleagues were eager to understand how we had implemented the model, and how it worked in practice.

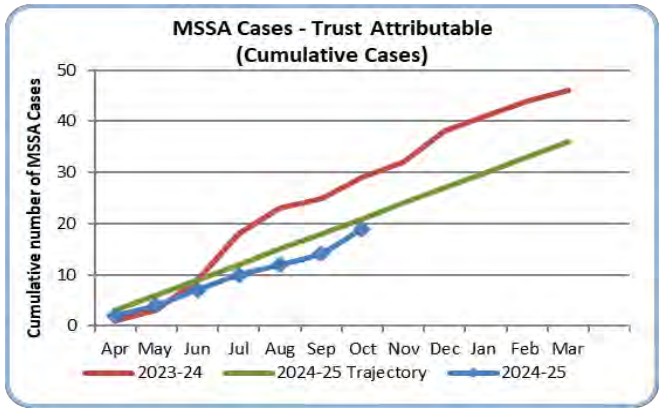
- The TVN team work in collaboration with patients, clinical teams and other stakeholders, to reduce patient harm and improve patient journeys and outcomes. The team provide a responsive, supportive and educational wound care service across NBT and work collaboratively and strategically within the ICB across the BNSSG system.

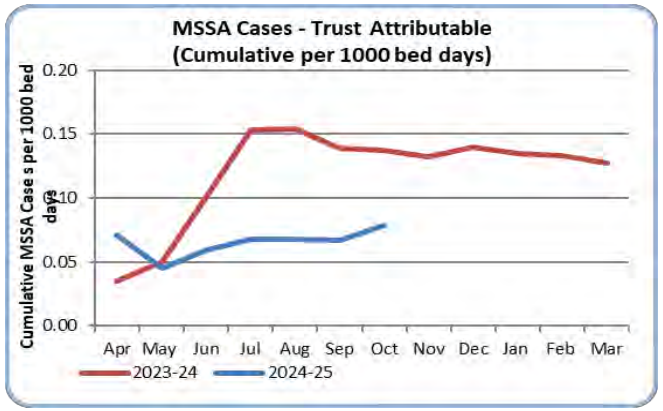












Infection Prevention and Control

What does the data tell us?

COVID-19 (Coronavirus) / Influenza - Small increase of cases seen but not enough to enact POCT testing influenza plan. All cases isolated and managed appropriately

MSSA – Case rates continue to trend lower than the trust trajectory. Training continues in all divisions with thematic analyse of all cases using a PSIRF approach at steering group . To date this remains a positive achievement of multi divisional work.

C. difficile – Cases have risen full reviews have taken place on each case with ward areas and divisions having targeted work plans , many of these cases having previous positives and complex histories.

Gram negative/ E.coli – Cases remain within trajectory, with ongoing work looking at catheter management and hydration

What actions are being taken to improve?.

- C Diff targeted plans in place in areas where positives have been seen. These look at training, cleaning, sampling as these remain the main issues.
- Patient hydration continues a focus to embed learning from regional/national programmes and initiatives. The continence group remains unfunded. Plans with BD medical to look at catheter audits.
- MSSA cases remain below trajectory, although improvements continue in wound management and Line care.

Other infections

Measles - Increased number of cases seen in locality requiring both staff ad patient contact tracing

Other projects

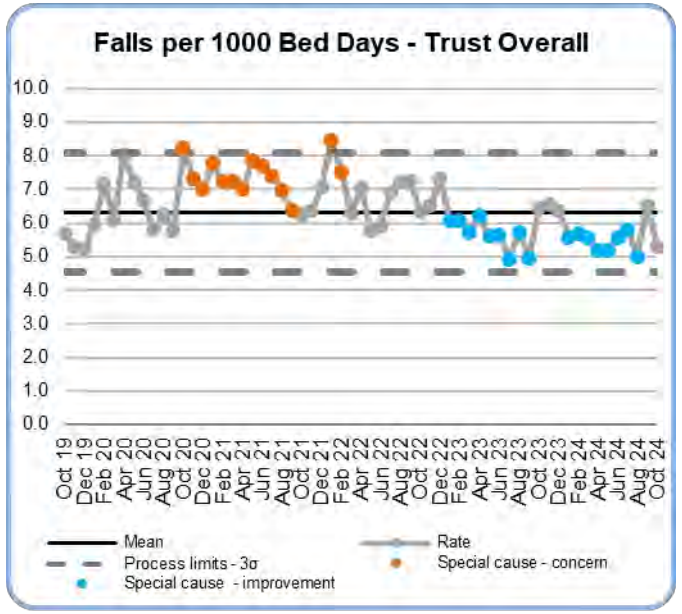
HCID – IPC working with Divisional teams to implement specifically supporting ventilation.

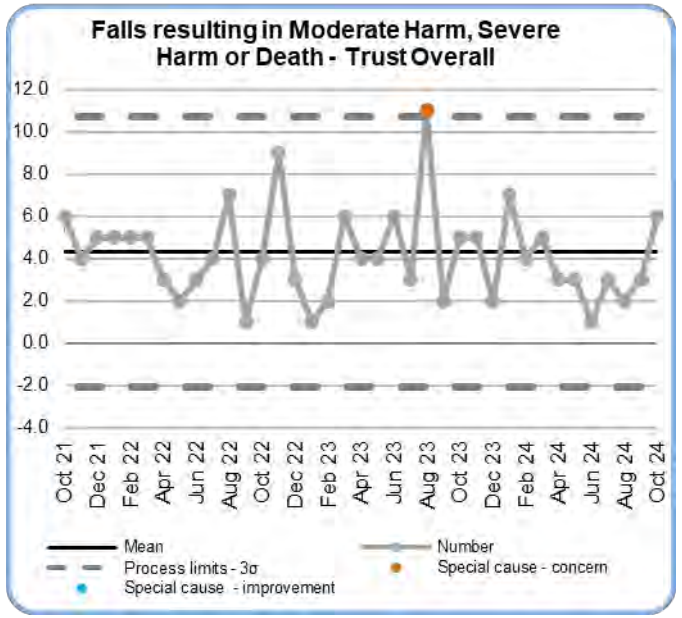
Alcohol free gel – Implementation of Spectrum X alcohol free gel that can be used with Norovirus and C Diff.

IPC winter training – Various sessions across all divisions as part of winter preparation

Mandatory IPC training – Tier 3 bespoke training collaborative work between NBT and UHBW continues.

Antimicrobial Awareness – IPC Teams supporting Pharmacy Teams in education awareness in the atrium and other sessions in the trust.





Falls

Falls incidents per 1000 bed days

NBT reported a rate of 5.32 falls incidents per 1000 bed days in October which is below the average of 6.32.
There were 168 falls reported in October. 6 moderate level physical harm incidents. No incidents had associated psychological harm.
An incident from July which has been under review has now been assigned a fatal harm rating.

5 of the harmful falls have resulted in fractures including 3 hip fractures. 1 harmful fall reported is for a case of an accidentally dropped baby. That incident is awaiting review and may have the harm level downgraded.

Medicine division: 91 falls reported. This is below the average for the first month following the spike in September.
NMSK division: 36 falls reported. This is around average.
ASCR: 35 falls reported. This is above the average for the second month.

Multiple falls accounted for 28% of falls this month which is around average of a quarter. 21 patients experienced more than 1 fall. With 4 patients having 3 or more falls. No patient experienced more than 4 falls this month.
Older patients continue to be the highest proportion of patients who fall, with 71% of reports in the over 65's.

What actions are being taken to improve?

The falls team staffing resource has now reduced to 0.9 WTE.

The Falls team have continued to be engaged with the stakeholder consultation for the new incident reporting system Radar.

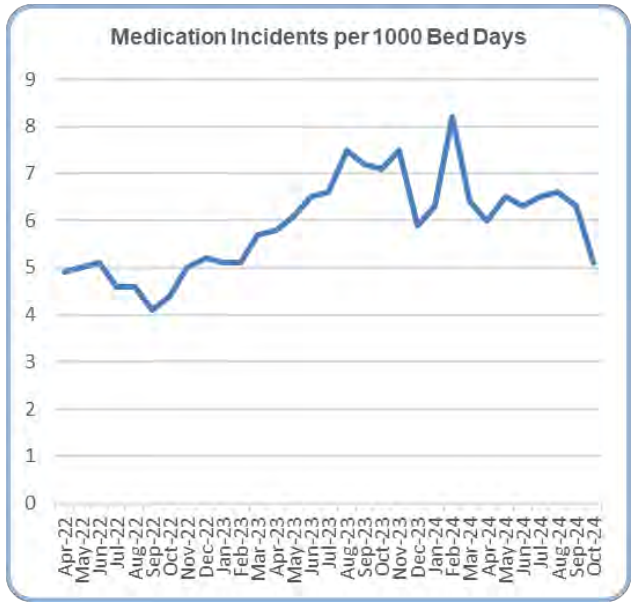
Review of actions taken to improve the time taken to gather a hoist and sling have shown to improve responsiveness to under 5 mins. This is a positive change to support staff to be able to access safe handling equipment to move patients following a fall. Further work is needed to sustain this change and to expand to ASCR. There is a working party to review the distribution and laundering processes around hoist slings.

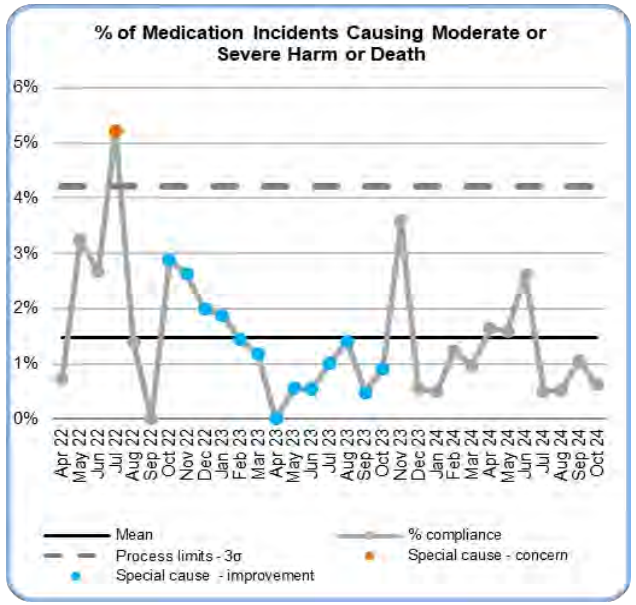
Senior staff within medicine division have been consulted and agreed a standardized approach to how to utilize the Vitals observations system to support the completion of neurological observations following a fall. This is due to be piloted on several wards and will then need supported roll out. The chosen features will help alert staff when observations are due at the higher frequency and support a full set of observations to be completed at each interval.

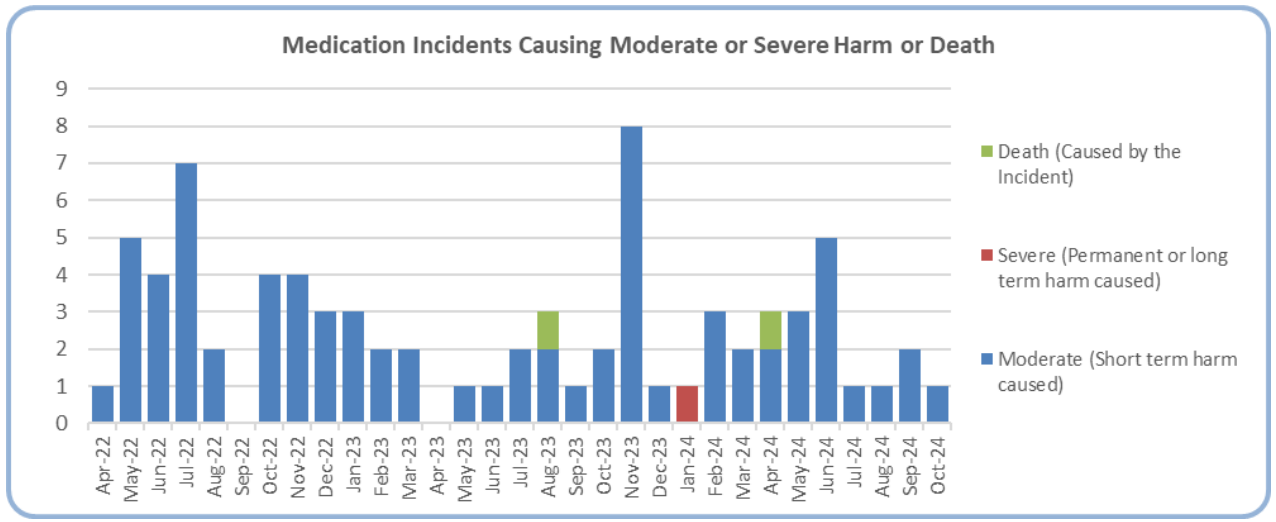
Training to junior doctors has commenced to outline the responsibilities and guidelines in place to support a patient following a fall in hospital. This will become an established aspect of the training schedule for future training programs.

N.B. The data presented only presents inpatient falls and does not include falls from hoist, stairs or in outpatient areas.

Medicines Management Report







What does the data tell us?

Medication Incidents per 1000 bed days

During October 24 NBT had a rate of 5.1 medication incidents per 1000 bed days, which is below the 6-month average of 6.2 for this measure.

Percentage of Medication Incidents Reported as Causing Moderate or Severe Harm or Death to all Medication incidents

The level of medication incidents causing moderate or severe harm or death was 0.6% this month with only 1 incident falling into this category..

Overall comment

The number of incidents per 1000 bed days has fallen quite considerably this month. This may in part be due to the fact that we are no longer duplicating records of Datix reports sent to us by the ICB on our system. There are usually approximately 10 such records each month. Work is ongoing to agree how best to manage the learning from these incidents in the future.

What actions are being taken to improve?

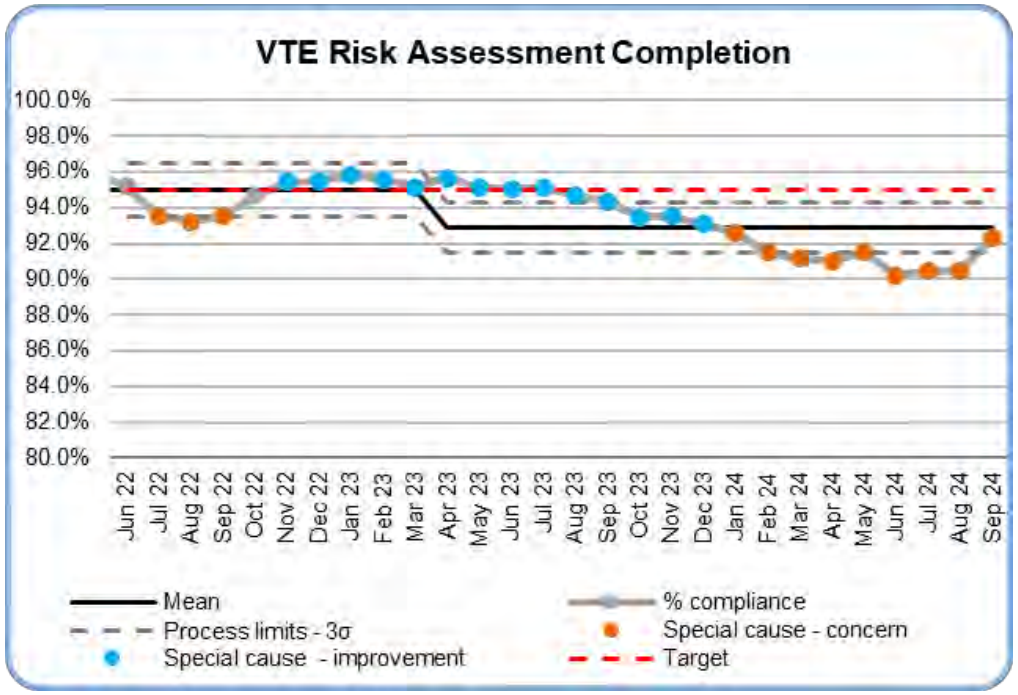
The work of the 'Medicines Safety Forum' continues – this is a multidisciplinary group whose aim is to focus on gaining a better understanding of medicines safety challenges and subsequently supporting staff to address these. This group meets monthly, with a high level of engagement with the groups and its activities from all Divisions and staff groups.

At the last meeting it was agreed that the group would initially focus on:

- Analysing practices around Controlled Drug management to assess whether any process changes could reduce workload for nursing staff and risk of errors
- Consideration of implementation of measures to reduce the task loading for nurses undertaking drug rounds.
- Reviewing the competence assessment process for nursing staff ensuring it is practical, fit for purpose and consistent.

A resource proposal detailing the Pharmacy staffing required to support medicines safety improvement work going forward will be discussed at the DTC in due course.

VTE Risk Assessment



Please Note: some VTE data is reported one month in arrears because the coding of the admission, and data collection for VTE RA, does not take place until after the patient is discharged.

What does the data tell us?

In June 2022 there was a noticeable dip in the VTE RA compliance (see graph) and action was taken to improve the situation
An audit of patient notes revealed VTE forms were not consistently completed.

Actions:

1. All clinicians were reminded of the importance of completing VTE RA for all patients, with regular audit and feedback to the teams.
2. In February 2023, a pilot of a **VTE digital assessment** took place; this was successful and thus rolled out across the Trust.:
    I. The digital form allows for real data collection
    II. There is a visual reminder of the patient's VTE RA status on the Ward Flow Board (VTE status is colour-coded)
3. Clinicians are reminded daily, at the Board Rounds, if the VTE RA form has not been completed
4. Reinstatement of face-to-face training for all HCPs in the Trust, at induction
5. Clinical leadership responsibilities agreed with direct oversight of the CMO and the Thrombosis Committee which reconvened to engage and drive actions across the Trust.

Reason for the initial drop in compliance :
Completing the digital VTE form is a manual deviation from the human ergonomic flow of clerking a patient, so it can be missed on admission. Much work has occurred with the clinicians to increase compliance and understand the barriers to completion. As can be seen from the graph this intervention appears to be paying dividends.

An additional improvement plan is in place this year:
In Spring 2025, completion of the VTE RA will become a **forcing measure** when the digital prescribing module is initiated, which will dramatically improve compliance

In the meantime, the VTE team are constantly reviewing the requirement for a VTE RA for individual patients, identifying cohorts of patients who do NOT require a VTE RA, and ensuring that the data collection is accurate.

Patient

NHS North Bristol NHS Trust

Patient Experience

Board Sponsor: Chief Nursing Officer
Steven Hams

Patient & Carer Experience – Strategy Delivery Overview October 2024

A	Amber - Progress on Track but known issues may impact on plan	C	Complete
G	Green - Progress on Track with no issues	R	Red - Progress is off Track and requires immediate action

NHS North Bristol NHS Trust

Patient & Carer Experience Strategy Commitment	Commitments	Progress Status
Listening to what patients tell us	We will continue to share patient experiences at Board and through other governance committees, to ensure the voice of the patient is heard.	Ongoing- a patient Story is scheduled for Trust Board in November and Patient and Carer Experience Committee in December.
	We will build on our existing methods to collect patient feedback ensuring these are accessible to all. We will explore the use of new technologies to support this including how we capture social listening (social media comments).	**This has been identified as a Quality Priority.** Patient Conversations year 1 evaluation has been completed (see details on next slide). We have begun our one-year feasibility study of PEP to review social listening and improve theming of our existing large narrative datasets. We will be focusing this work in key areas such as Cancer Services, Cardiology and BCE.
	We will continue to develop the Integrated Performance Report, so that the Board and other leaders can have oversight of the experience our patients receive.	Complete
Working together to support and value the individual and promote inclusion	We will aim to increase the diversity of our volunteer teams to reflect our local community and the patients we serve, with a particular focus on Outpatient areas.	New VS Strategic Plan is in development with a focus on this objective. First draft of the strategy has been shared for comment.
	We will meet the needs of patients with lived experience of Mental Health or Learning Disability and neurodivergent people in a person-centred way.	**This has been identified as a Quality Priority.** We have welcomed a new patient partner with lived experience of MH. We are also beginning a pilot of patient conversations targeted at LD patients.
	The voice and the involvement of carers will be respected and integral in all we do.	On 30th October we welcomed 5 young carers to do the 15 step challenge in ED.
	Personalised care in various services by using tools such as 'This is Me' developed for patients with dementia, 'Shared Decision Making' and "Supported Decision Making"	**This has been identified as a Quality Priority**. Focus on embedding SDM as BAU in 7 specialties where this is in place. Patient comms for 'Its ok to ask' has is being worked on.
	We will work together with health, care, and local authority partners to reduce health inequalities, by acting on the lived experiences of patients with a protected characteristic and/or who live in communities with a high health need.	Ongoing- we've worked closely alongside partners this month. We attended the South Asian Health Event, presented to BNSSG Quality Group on the findings of our Healthwatch commissioned report on waiting and attended the Community Insights Group.
Being responsive and striving for better	We will continue to sustain and grow our Complaints Lay Review Panel as part of our evaluation of the quality of our complaint investigations and responses	Ongoing- The panel are due to meet in November. We have welcomed a new panel member and have two further individuals interested in joining the panel.
	We will continue to undertake the annual Patient Led Assessments of the Care Environment (PLACE) audits and respond to areas of improvement.	PLACE assessments have taken place in November with involvement from patient partners, our physical access steering group and a patient partner with LD.
	We will involve the volunteer voice within feedback to shape future volunteer roles and patient engagement opportunities.	New VS Strategic Plan is in development with a focus on this objective. First draft of the strategy has been shared for comment.
Putting the spotlight on patient and carer experience	We will refresh the patient experience portal on our website and staff intranet	Completed
	We will develop a Patient Experience e-learning module to support the ongoing need of staff for easy access to busy frontline staff.	E-learning module scoped with L&D team through NHS Elect. The module is being tested.

Patient & Carer Experience - Overview September 2024

Patient Conversations- Year 1 Evaluation

We are pleased to be able to report on the first year of Patient Conversations at North Bristol NHS Trust (NBT).

We launched Patient Conversations twelve months ago, at the start of November 2023 as our ‘real time’ feedback approach.

We wanted to chat with our patients whilst they are under our care and hear about their experiences in their own words, reflecting on what matters most to them

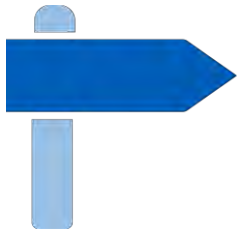
We have spoken with **204 patients**

Across **59 areas**.

We have had **25 volunteers** complete conversations with patients. These volunteers were a mix of staff, feedback volunteers and Patient and Carer Partners.

We have identified quick, immediate actions that could be taken by the ward at the time, and a number of overarching themes that came up across the Trust in most conversations.

Food, Staff Attitude, Environment and Facilities and Communication about discharge arrangements are the topics that came up most.

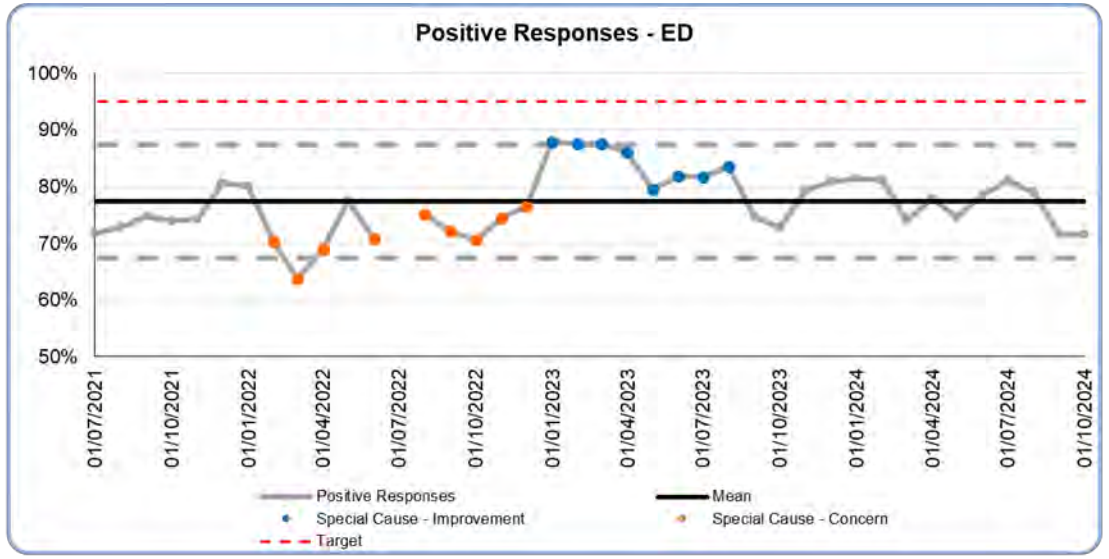


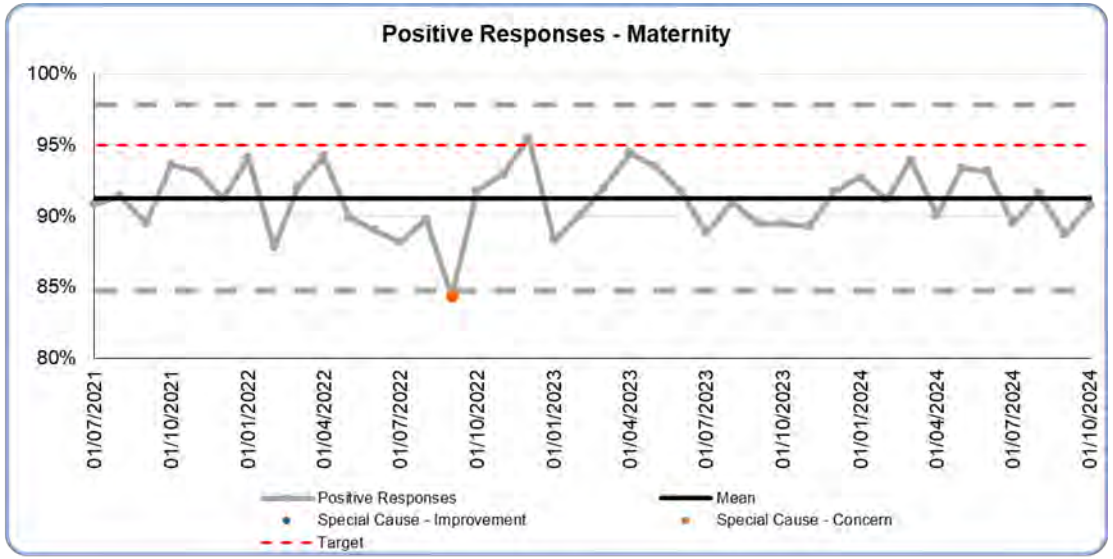
Most feedback was extremely positive providing a welcome morale boost to staff. Patients have enjoyed having someone to speak with, and volunteers report feeling “humbled” and like “it makes a difference”.

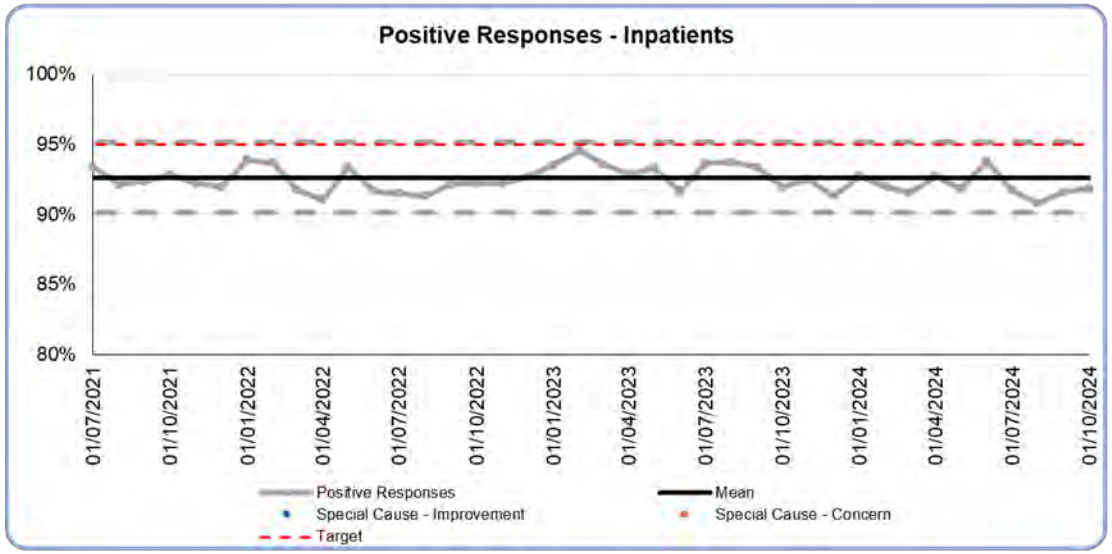
We’ve also seen an increase in the number of patients reporting they were asked to give views on the quality of care during their stay. This has increased from 8% to 31 in our National Inpatient Survey results.

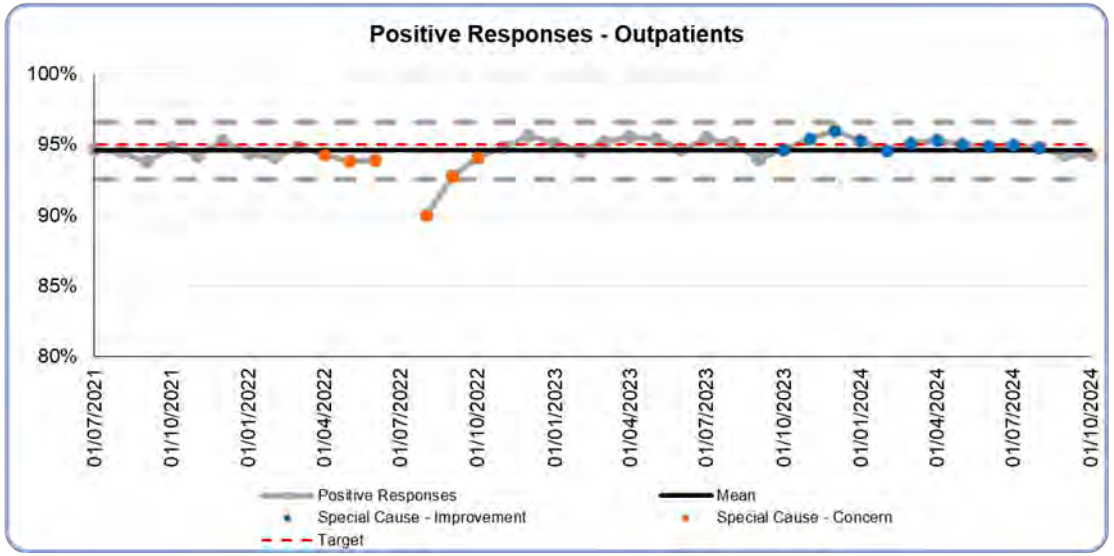
We’ve got ambitions to refine and grow the model over the coming year and build on this success.

Patient Experience









N.B. no data available for the month of July-22 for ED and Outpatients due to an issue with CareFlow implementation

Patient Experience

What does the data tell us – Trust wide?

- In October 9,596 patients responded to the Friends and Family Test question. 6,8686 patients chose to leave a comment with their rating.
- We had a Trust-wide response rate of 12.9%, which is slightly down on the previous month 13.2%.
- 92.3% of patients gave the Trust a positive rating. This was up on the previous month 91.8%.
- The top positive themes from comments remain: staff, waiting time and clinical treatment.
- The top negative themes from comments remain: waiting time, communication and staff.

What does this data tell us – Maternity?

- Positive responses across Maternity have increased 88.6% in September to 90.7% in October. Negative responses have decreased from 7% in September to 5.5% in October.
- The response rate across Maternity decreased from 17.5% in September to 14.7% in October.
- Top positive theme from comments remains staff.

Everyone who supported me and my family during birthing experience and post birth were absolutely amazing, caring and just very understanding and supportive. Thank you!!

What does the data tell us - Emergency Department?

- Positive responses have decreased from 71.7% in September to 71.5% in October. Negative responses have increased from 16.8% in September to 19.2% in October .
- The response rate for ED decreased from 19% in September to 17.5% in October.
- The top positive theme remains staff.
- The top negative theme remains waiting time.

The staff were lovely, i was there for 5 hours which was exhausting as most was spent in the waiting room

What does the data tell us - Inpatients?

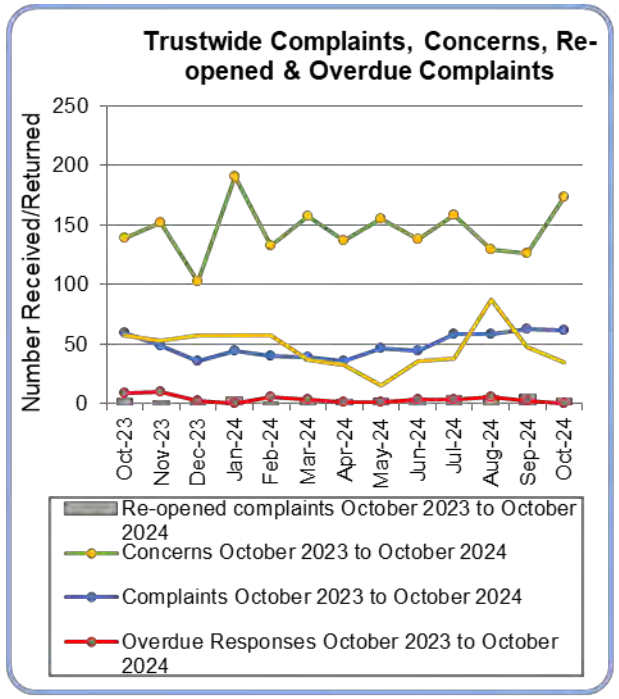
- Positive responses have increased from 91.6% in September to 91.8% in October. Negative responses have decreased from 6.3% in September to 5.3% in October.
- The response rate for inpatients has decreased from 21.6% in September to 20.8% in October.
- Top positive themes from comments are staff, clinical treatment, and waiting time.
- Negative themes from comments are communication, staff and clinical treatment .

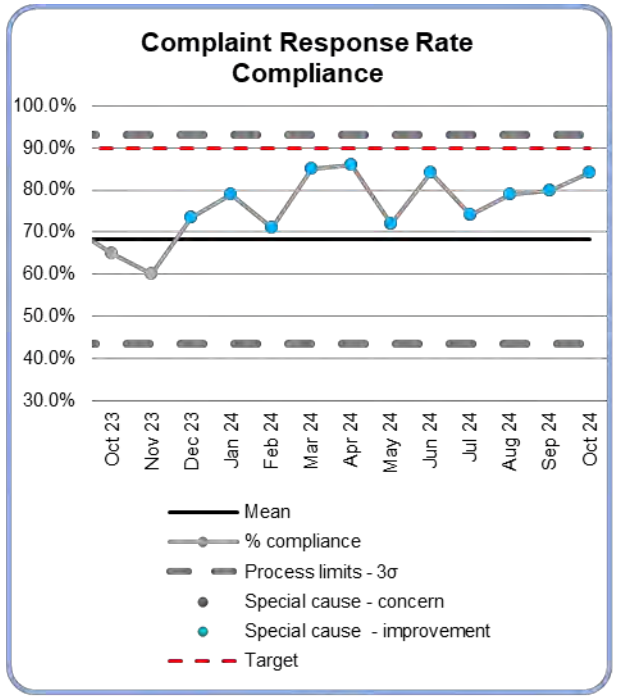
Our son was diagnosed and treated with the speed and care that his condition required. The staff were kind, even though they were clearly working under pressure.

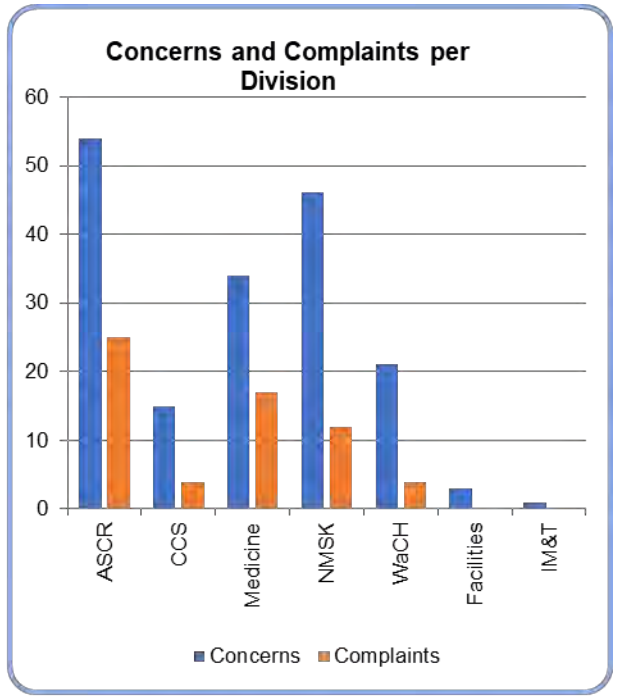
What does the data tell us – Outpatients?

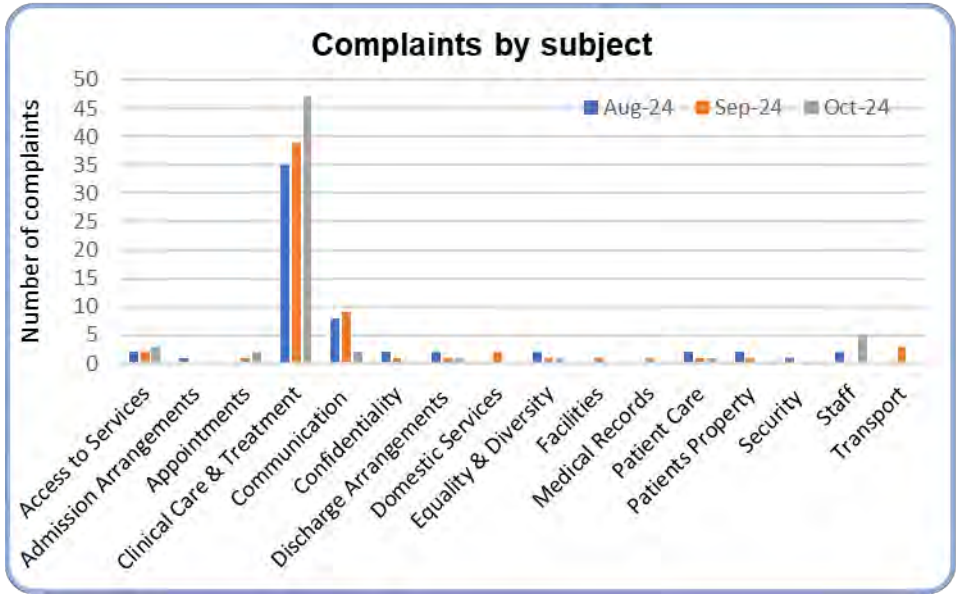
- Positive responses remain the same in October, 94.2%. Negative responses decreased from 2.6% in September to 2.4% in October.
- The response rate for outpatients stayed the same in October, 11.5%.
- Top positive themes from comments remain staff, waiting time and clinical treatment.
- Negative themes from comments remain waiting time, communication and clinical treatment.

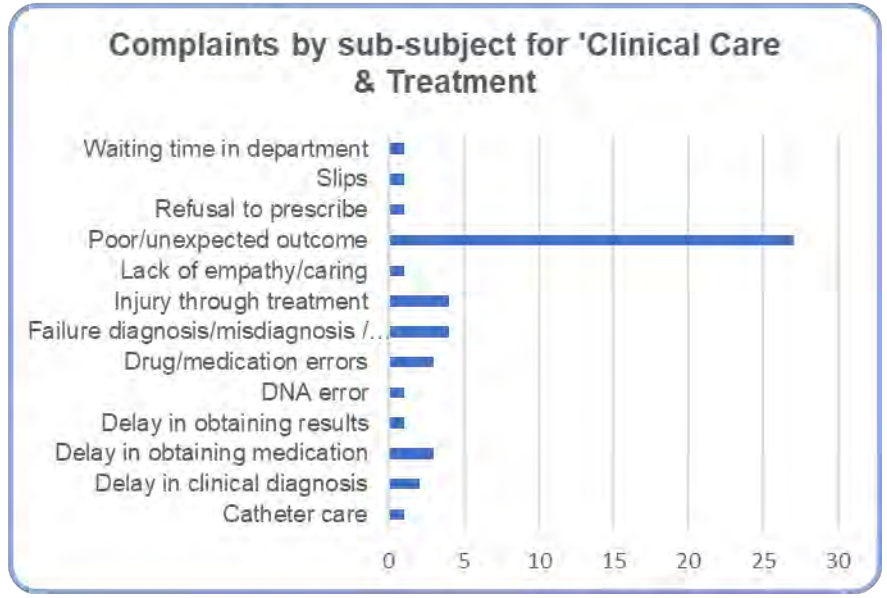
Staff were very polite. Appointment completed on time. Very efficient and understanding











Complaints and Concerns

What does the data tell us?

In October 2024, the Trust received 62 formal complaints. This is 1 less than the previous month and 4 more than the same period last year.

The most common subject for complaints is ‘Clinical Care and Treatment’ (47). A chart to break down the sub-subjects for ‘Clinical Care and Treatment’ is included.

Of the 62 complaints, the largest proportion was received by ASCR (25) followed by Medicine (17).

There were 4 re-opened complaints in September (2 ASCR, 1 CCS, 1 MED), which is 3 less than the previous month.

The number of overdue complaints at the time of reporting has decreased from 3 in September to 1 in October and is with WaCH.

The response rate compliance for complaints has increased slightly from in 80% in September to 84% in October. A breakdown of compliance by clinical division is shown below:

ASCR – 69% Medicine – 93%
NMSK - 80% WaCH –100%

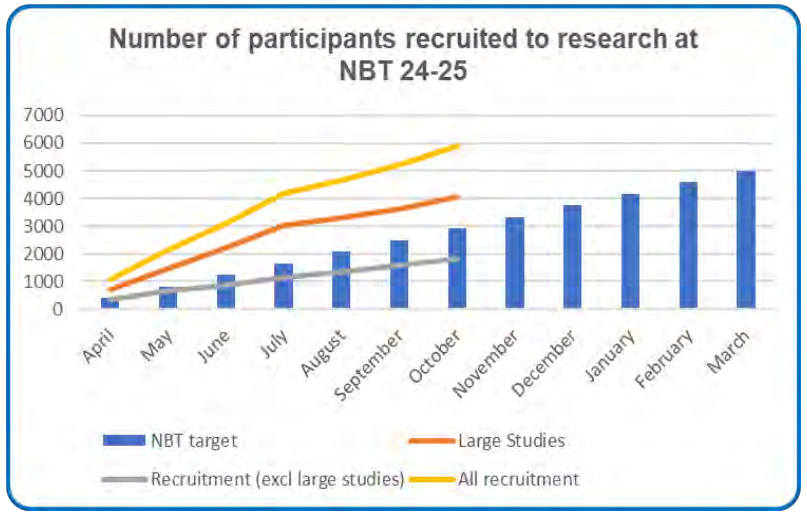
The number of PALS concerns received has significantly increased from 126 in September to 174 in October, which is 35 more than the same period last year.

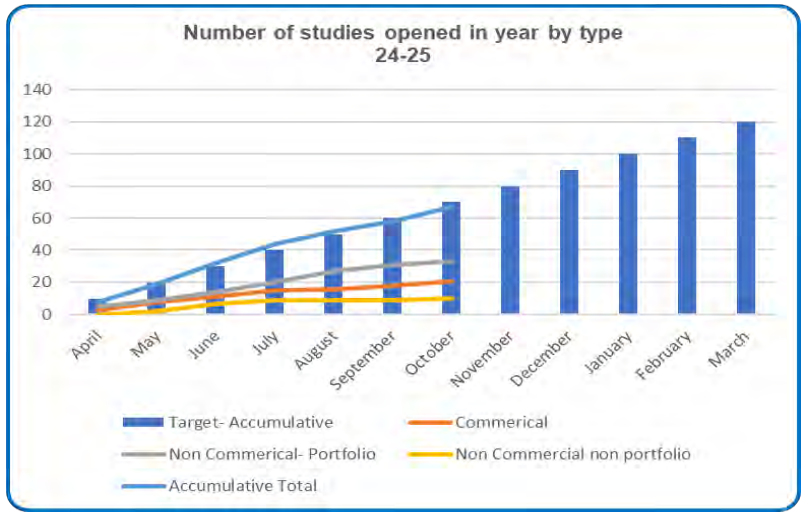
In October 100% of complaints were acknowledged within 3 working days and 100% of PALS concerns were acknowledged within 1 working day.

Research and Development

Board Sponsor: Chief Medical Officer
Tim Whittlestone

Research and Development





Our Research activity

We strive to offer a broad range of research opportunities to our NBT patients and local communities whilst delivering high-quality care combined with a positive research experience.

Graph 1 shows our activities in relation to research participation. Year to date 1832 participants have enrolled in research @NBT with an annual stretch target of 5000 (excluding our 2 large studies)- we are currently achieving 63% of the target. We are likely to see a lower number of participants recruited to research over the coming year as our portfolio becomes more complex .

The NBT research portfolio remains strong, we have 200 NIHR Portfolio studies open to recruitment . We have opened 67 new studies year to date, as shown in graph 2 against a target of 70. We are seeing a steady growth in the number of studies we are opening that are collaborations with commercial partners and a subsequent increase in recruitment to these studies; these collaborations enable us to offer our patients access to new clinical trial therapies and generate income to support reinvestment and growth in research across the trust. We are pleased to report that we have been able to secure some additional funding for Clinical Trials Pharmacy Capacity- From March 25 we are planning on opening 6 drug studies per month from our current position of 3.

Our grants

Congratulations to Sam Burr, Senior Research Fellow, Bristol Speech and Language Therapy Research Unit, who was recently awarded a prestigious NIHR Development and Skills Enhancement Award (£69.4k). The DSE is a post-doctoral level award aimed at supporting NIHR Academy Members to gain specific skills and experience to underpin the next phase of their research career
The active research grant portfolio at NBT has increased by almost £20m from Jan 2021 to a current total of £48m. NBT has been awarded £1.2m Research Capability Funding for 2024/25. This allocation puts NBT in 6th position, out of 248 NHS Trusts in England, our highest position to date. This is an amazing achievement and reflects the size of NBT's NIHR research grant portfolio; the level and quality of NIHR grants being submitted across NBT and the high success rates.
R&D has opened a trust-wide call for applications for Research Development Support Posts to help drive new pipelines of research in our clinical teams, departments and divisions, funded by RCF. The deadline for applications is 1st December, please contact ResearchGrants@nbt.nhs.uk if interested in applying to this call, where you will receive dedicated support from our research development team.
R&D has a focus on supporting non-medics, including nurses, midwives and allied health professionals to develop research ideas, projects and academic careers. R&D operates a rolling call for applications from non-medics to receive mentorship and funding for early-stage research. ResearchGrants@nbt.nhs.uk
NBT R&D was selected for NIHR Funding Review and Assurance (audit), due to the size of our NIHR grant portfolio. The audit reviewed R&D's processes for the financial management of NIHR grants as well as our organisational commitment to align with the principles of the Researcher Development Concordat. The full audit report has not yet been circulated, however the NIHR has informed NBT that three areas of non-compliance were found, for immediate remedial action: 1) NBT must have a Research Misconduct Policy, 2) NBT must a Research Ethics Policy, 3) The Trust's Fairness at Work, Safeguarding (Adults) and Safeguarding (Children) polices must be publicly accessible on NBT's website. These findings are being actioned.

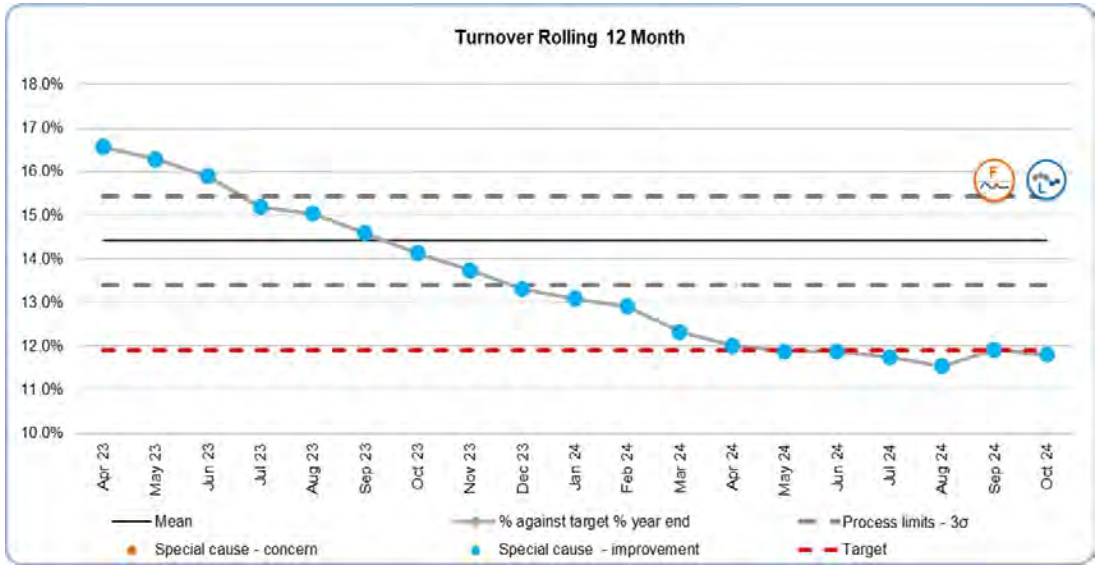
Innovate to Improve | People | Commitment to our Community

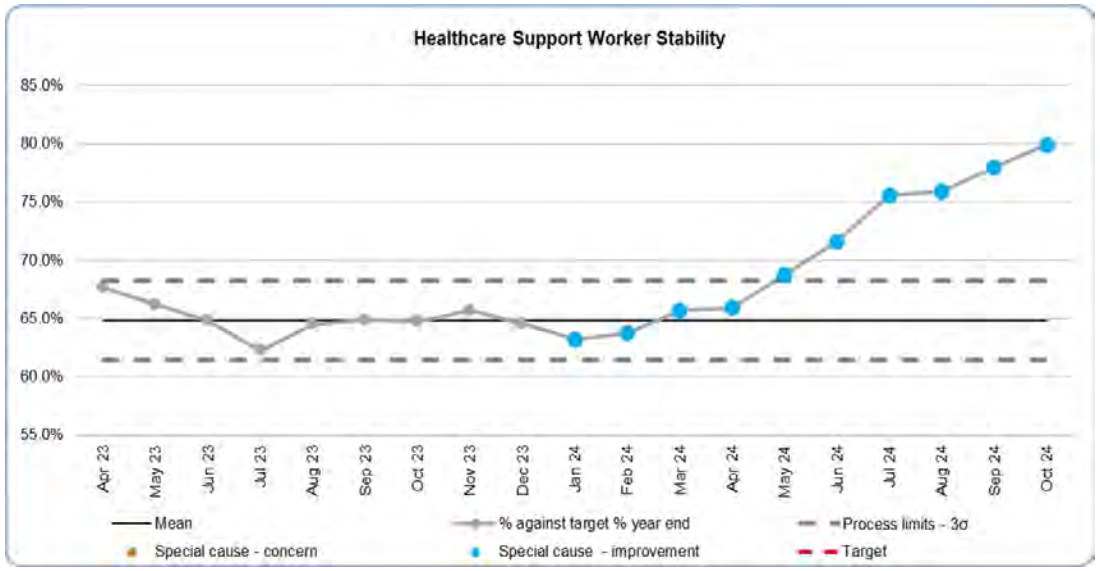
NHS North Bristol NHS Trust

Workforce

Board Sponsors: Chief Medical Officer, Chief People Officer
Tim Whittlestone and Peter Mitchell

Retention Patient First Priority People





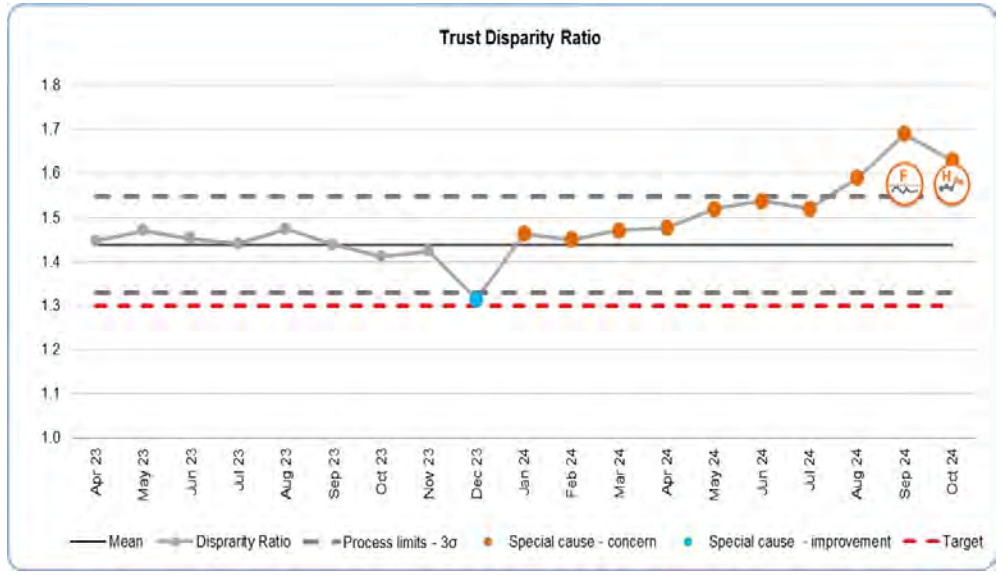
Turnover decreased from 11.92% for September to 11.80% in October, now below the target set for 2024/25. Following the review of retention data in the Patient First session at November's Senior Leadership Group a focus on turnover in non-clinical roles will begin, Estates and Ancillary staff turnover has increased and is higher now than at this point last year and Administrative and Clerical staff turnover is the highest of any staff group at 15.37%.

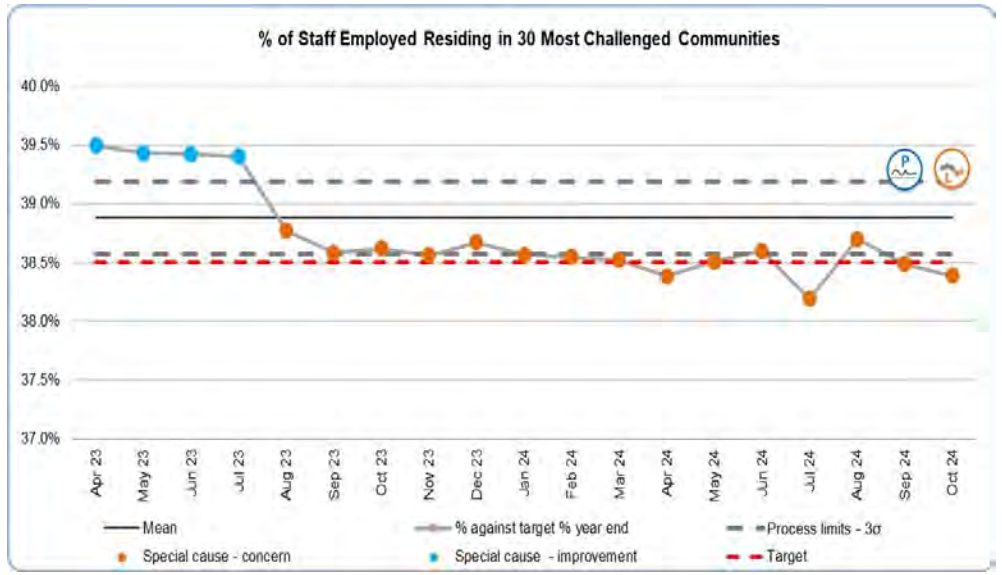
Healthcare Support Worker (HCSW) stability (% of staff in post with >12 months service) continues to follow a statistically significant improvement trend and is at 79.92% for October.

A Retention plan priority is 'Supporting New Starters' - specifically HCSWs where turnover in the first 12 months has been historically high. Enhanced Induction for these staff has been in place for 10 months and celebration events to recognise their achievements and progress within their first year, are occurring. This includes discussion and information about future career pathways as well as presentation of certificates. The Impact of actions to support them in their 1st year will continue to be monitored in 2024/25. The table below shows our immediate priority retention actions in the next 3 months:

Driver	Action and Impact	Owner	Due
Reward and recognition	Bespoke pension awareness sessions being run with a third party to increase awareness of the NHS pension as an attraction and retention tool.	People Promise Manager	Nov-24
Work Life Balance	Develop further guidance to support staff considering taking a sabbatical to reduce the number of leavers who leave us due to wishing to take a break.	People Promise Manager	Dec-24
Work Life Balance	Transition work life balance week learning and leader flexible working workshop to business as usual to support teams to work in flexible ways and reduce leaver rates for work life balance	People Promise Manager	Nov-24
Culture	Launch a Civility and Respect framework under 'Living Our Values' teams can use to improve their culture and reduce incidents of incivility.	Associate Director of Culture	Dec 24

Commitment to our Community Patient First Priority – Commitment to our Community





A deep dive into the Commitment to our Community metrics Disparity Ratio took place in November and was the focus of the November Senior Leadership Group (SLG).

Disparity Ratio – (likelihood of applicants from ethnic minority backgrounds being appointed over white applicants from shortlisting – Workforce Race Equality Standard metric). In November we worked with all clinical divisions and some corporate directorates (where high Disparity Ratios had been identified) to ensure there was a collective understanding of the metric and what the position looked like within their division/directorate, by staff group, cluster and band. At SLG divisions presented back their initial view of their data and intended actions and areas of focus ('top contributors'). Work will now take place to further enhance understanding of our data, develop actions and set realistic targets.

The October disparity ratio was 1.63 and the current target for the trust to achieve by March 2025 is 1.25.

% of Employed Staff from 30 Most Challenged Communities – November's Patient First Steering group approved the change in metric we will use to measure the success of our work to increase out recruitment pipelines from our 30 most challenged communities. We will now measure the proportion of our starters from those communities into the target roles highlighted in the Commitment to our Community plan. Work is in progress via the Commitment to our Community working group to determine our target for this new metric and this will be agreed through the Patient First Steering group and be reported via the Integrated Performance Report.

Activities

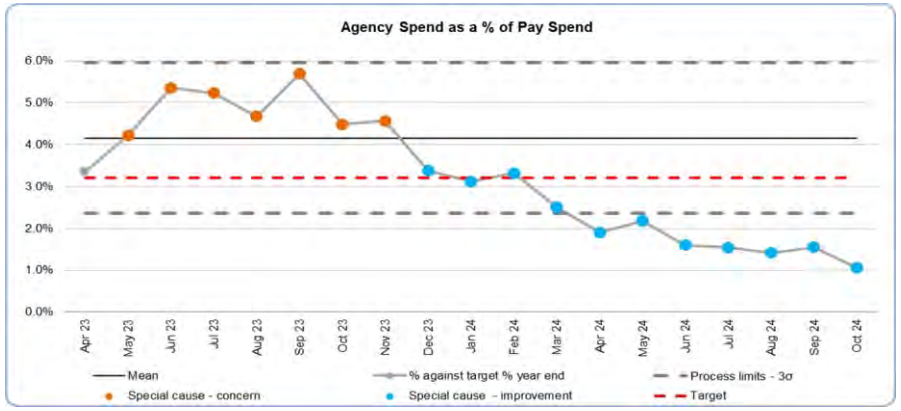
Community Outreach – Listening event booked for 21st Nov. Focus on creating long term connections with the community.

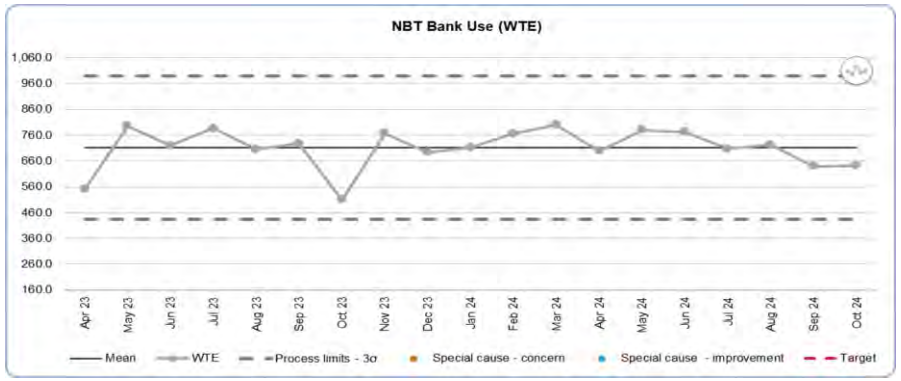
Mentoring Programme – Mentoring and support is being provided to around 110 people from our local area. Some are now seeing employment outcomes. Elective care centre is also on board to open these opportunities.

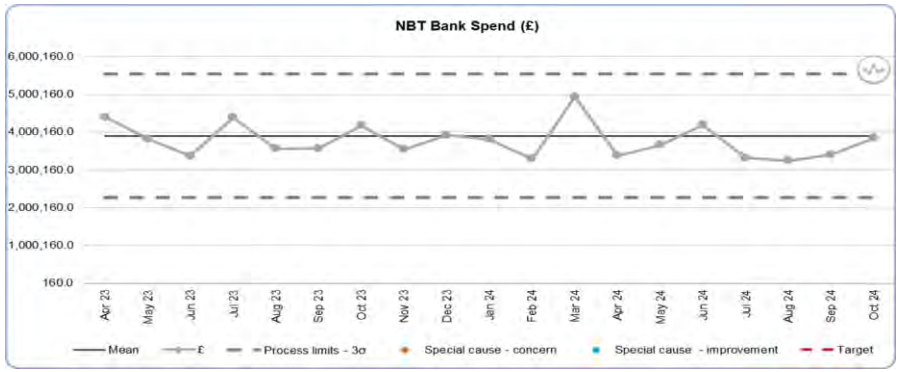
Work Experience – We have hosted 23 work placements this past 2 months for our community candidates. In some cases, this had led to employment, but has improved all participants' knowledge of the NHS, and given them vital learning to use for interviews.

Driver	Action and Impact	Owner	Due
Community Outreach	Five candidates have been offered roles in decontamination after the open day	Community Team	Mar 25
Community Outreach	Supported work experience has seen an uptake in placements, and we have 11 signups for November's course.	Community Team	Dec 24

Temporary Staffing





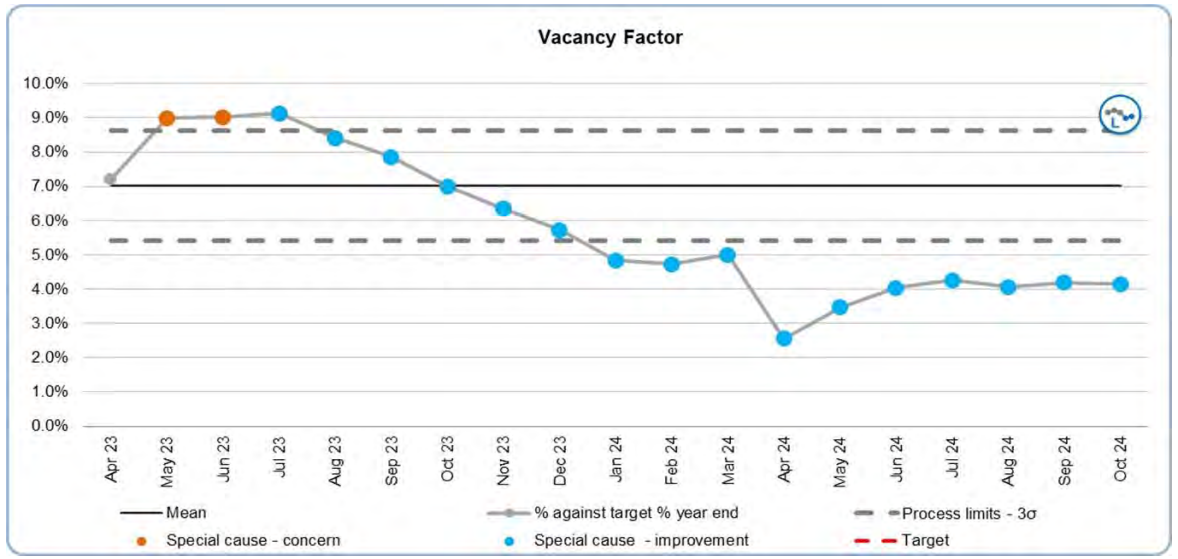


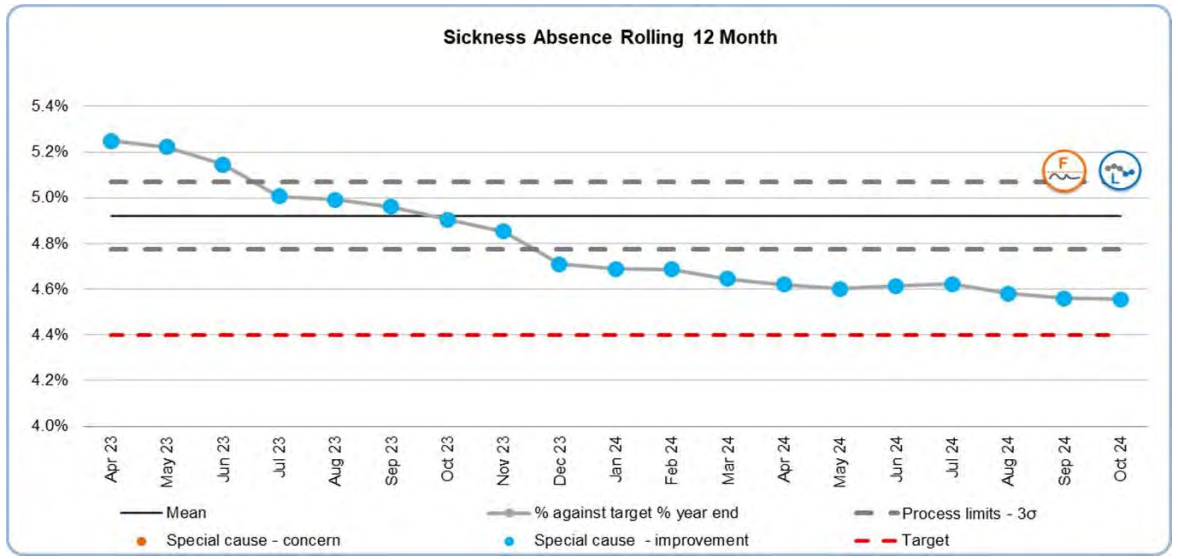
Agency use and spend continues to be significantly below the pay spend target of 3.2% of total pay spend at 1.06% in October.

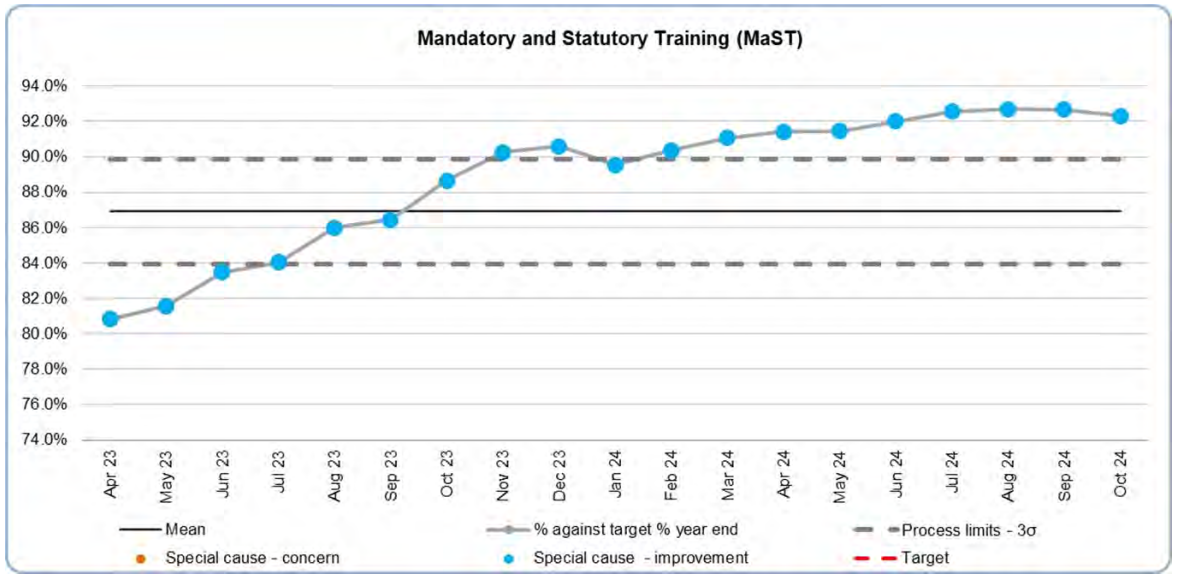
Bank use and spend has not shown any statistically significant deterioration or improvement compared to 2024/24 as a baseline, however reviewing weekly bank use and spend for in focus areas such as registered and unregistered nursing and resident doctor locums, there has been a positive step change in use in September and October.

Driver	Action and Impact	Owner	Due
Medical Staffing	Medical agency temp staffing reduction group now moved into the Recruitment and Temporary Staffing oversight Group (RaTSOG) – development of plans to convert long term agency workers to substantive, fixed term or Bank contracts are now monitored within this group.	Associate Director Medical Workforce	Ongoing
Medical Staffing	Pan-regional South-West Medical Agency rate card implementation begin on the 1st September for new and ad-hoc agency use with a flightpath to Aug 2025 for existing long-term agency use. Governance of rate reductions monitored within the new RaTSOG structure.	Associate Director Medical Workforce	Ongoing
Medical Staffing	Bank teams increasing engagement with agency suppliers to bring in line with SW rate cards, and further engagement required with departments to ensure all working towards rate reduction, or trajectory to reach agreed rate.	Head of Temporary Staffing Operations	Ongoing
All Staff Groups	The Agency Procurement Programme is entering its final stages of procurement and is on track to award the total temporary staffing (agency) Master Vendor contract in December 2024 ready to start April 2025	Associate Director Nursing Workforce Recovery	Dec 24
Nursing & Midwifery	Collaborative Bank: ongoing work with NICU/ICU/ED across UHBW & NBT to align skills and enable collaborative working. HCSW Go-live Collaborative Bank scheduled 11 December 2024.	APC Programme group / Head of Temporary Staffing	Dec-24
AHP / STT	SW Regional group scoping work to bring AHP & STT staffing groups to NHSE agency capped rate. Target date for first reduction 1st January 2025 with full compliance achievement June 2025	Associate Director Nursing Workforce Recovery and others	June 2025
AFC Staffing groups	Process now implemented for all other clinical and non-clinical staffing groups for requesting agency usage, and to ensure cap-compliance Ongoing communications and reinforcement of new process and supporting departments to transition agency workers to Bank positions as appropriate.	Head of Temporary Staffing Operations	Ongoing

Watch Measures (CPO)

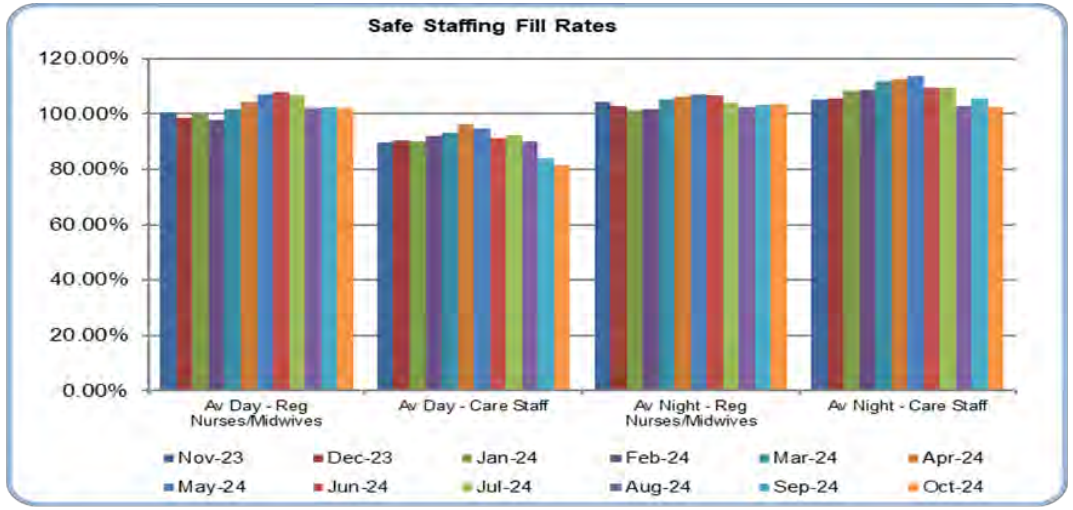






- The Trust **rolling 12-month sickness absence** rate continues to show statistically significant improvement over the last six months and is at 4.56% for October. However, sickness absence remains an ongoing focus improvement, summary actions:
  - Staff Health and Well-being Strategy Group has identified potential areas of focus for staff health & wellbeing linked to trust sickness absence data and current utilisation of wellbeing services. Discussion and further scoping of project workstreams planned for November.
  - Employee Assistance Program recommendation approved at POG 7th November to extend current contract to September 2025 to enable joint Hospital Group procurement process.
  - Staff Health and Wellbeing Strategy Group TOR's and project plan approved at POG 7th November.
  - Health and Wellbeing Plan being developed with clear strategic priorities for the next 3-5 years.
- The **Vacancy Factor** for NBT decreased slightly to 4.19% in September to 4.14% in October, continuing to follow an improvement trend since July'23.

Safe Staffing



Oct-24	Day shift		Night Shift	
	RN/RM Fill rate	CA Fill rate	RN/RM Fill rate	CA Fill rate
Southmead	102.17%	81.67%	103.41%	102.35%

Ward Name	Registered nurses/ midwives Day	Care staff day	Registered nurses/ midwives Night	Care staff Night
AMU 31 A&B 14031				
Cotswold Ward 01269				
Elgar Wards - Elgar 1 17003				
Theatre Medi-Rooms (Pre/Post Op Care)				
Ward 27B 14403				
Ward 28B 14520				
Ward 32A CAU 14103				
Ward 33A 14221				
Ward 33B 14222				
Ward 34A 14325				
Ward 7A 14302				
Ward 7B 14303				
Ward 8A 14410				
Ward 8B (Renal - 38 Bed) 14411				
Ward 9A 14503				
Ward 10a 14509				
		Below 80%		Over 120%

Safe Staffing Shift Fill Rates:
Ward staffing levels are determined as safe, if the shift fill rate falls between 80-120% , this is a National Quality Board (NQB) target.

What does the data tell us?
For October 2024, the combined shift fill rates for days for Registered Nurses (RN)s across the 28 wards was 102.17% and 103.41% respectively for days and nights for RNs. The combined shift fill for HCSWs was 81.67% for the day and 102.35% for the night. Therefore, the Trust as a collective set of wards is within the safe limits for October.

Current month *care staff* fill rates:
- 31.03% of wards had daytime fill rates of less than 80%
- 6.90% of wards had night-time fill rates of less than 80%
- 6.90% of wards had daytime fill rates of greater than 120%
- 17.24% of wards had night-time fill rates of greater than 120%

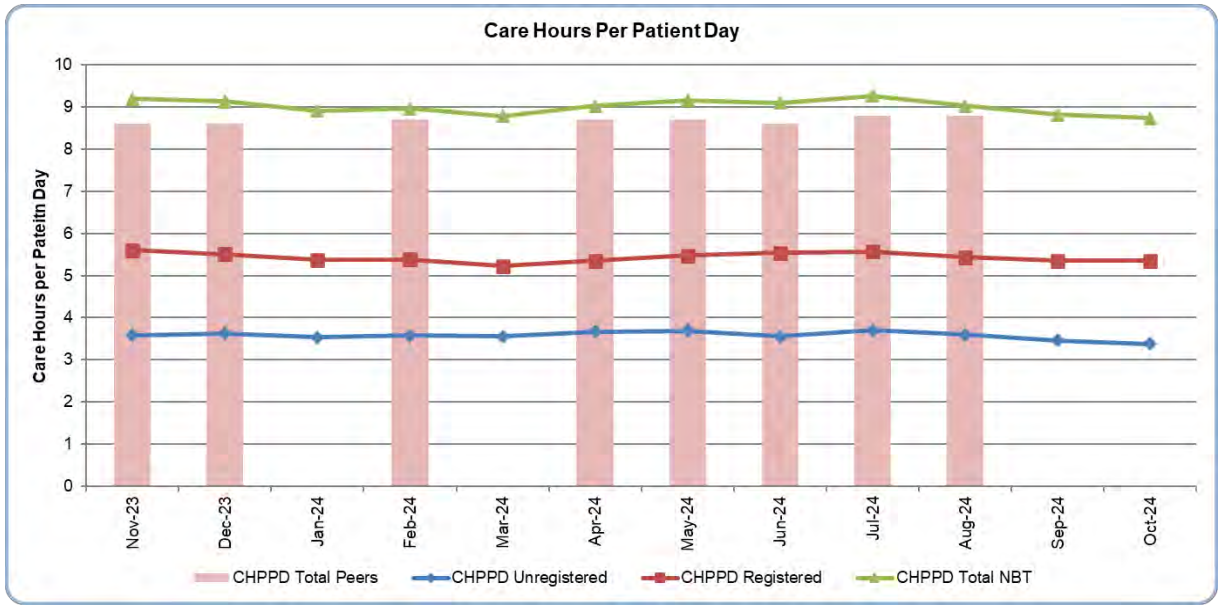
Current month *registered nursing* fill rates:
- 3.45% of wards had daytime fill rates of less than 80%
- 3.45% of wards had night-time fill rates of less than 80%
- 17.24% of wards had daytime fill rates of greater than 120%
- 17.24% of wards had night-time fill rates of greater than 120%

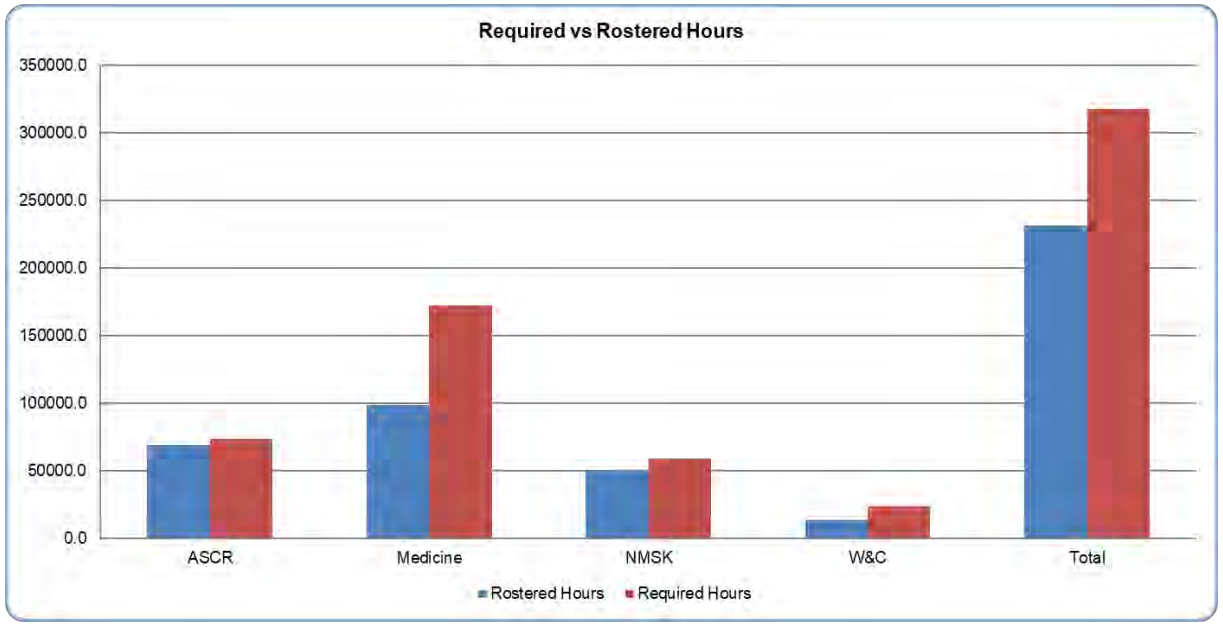
The “hot spots” as detailed on the heatmap which were less than 80% or greater than 120% fill rate for both RNs and HCSWs have been reviewed.

There are currently a higher proportion of HCSW vacancies and active recruitment is currently in progress.

Compliance:
The Safe Care Census regularity has been reduced to twice daily to more closely align with shift patterns. The average compliance for October has improved to 67.0% from 66.5% in September.

Care Hours





Care Hours per Patient Day (CHPPD)
The chart shows CHPPD for the Model Hospital peers (all data from Model Hospital). CHPPD data provides a picture of how staff are deployed and how productively. It provides a measure of total staff time spent on direct care and other activities such as preparing medications and patient records. This measure should be used alongside clinical quality and safety metrics to understand and reduce unwanted variation and support delivery of high quality and efficient patient care.

What does the data tell us?
Compared to national levels the acuity of patients at NBT has increased and exceeded the national position.

Required vs Roster Hours
The acuity of patients is measured three times daily at ward level. The Safe Care data is triangulated with numbers of staff on shift and professional judgement to determine whether the required hours available for safe care in a ward/unit aligns with the rostered hours available. Staff are redeployed between clinical areas and Divisions following daily staffing meetings involving all Divisions, to ensure safety is maintained in wards/areas where a significant shortfall in required hours is identified, to maintain patient safety.

What does the data tell us
The required hours have been augmented using the completion rate for SafeCare patient census data. Where the census completion was less than 100% the required hours have been supplemented by an assumption that for the census periods not completed the patient mix would have been the same on average. The data demonstrates that the total number of required hours has exceeded the available rostered hours.

Finance

Board Sponsor: Chief Financial Officer
Elizabeth Poskitt

Statement of Comprehensive Income at 31 October 2024

	Month 7			Year to date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Contract Income	81.4	84.3	2.9	492.5	501.8	9.3
Income	6.1	15.0	8.9	41.7	66.8	25.1
Pay	(58.9)	(62.3)	(3.4)	(335.6)	(349.3)	(13.8)
Non-pay	(28.6)	(36.6)	(8.0)	(201.1)	(225.2)	(24.1)
Surplus/(Deficit)	**0.0**	**0.3**	**0.3**	**(2.5)**	**(6.0)**	**(3.5)**

Assurances

This month the Trust has delivered a financial position £0.3m above plan. The financial position for October 2024 shows the Trust has delivered a £6.0m deficit against a £2.5m planned deficit which results in a £3.5m adverse variance year to date.

Contract income is £9.3m better than plan. This is driven by additional pass-through income of £7.3m, and genomics income of £0.8m.

Other income is £25.1m better than plan. The is due to new funding adjustments and pass through items (£20.5m fav). The remaining £4.6m favourable variance is driven by delays in investments (£0.5m fav) and increased divisional income (£3.0m fav).

Pay expenditure is £13.8m adverse to plan. New funding adjustments, offset in income, have caused a £13.9m adverse variance. Undelivered CIP is £5.3m adverse with overspends on medical and nursing pay £3.5m adverse. The pay award is causing a £1.6m adverse variance but is offset by recurrent funding received from the ICB. This is offset by delayed investments and service developments of £6.0m and vacancies £3.9m favourable.

Non-pay expenditure is £24.1m adverse to plan. Of which £13.3m relates to pass through items. This adverse position is driven primarily by increased medical and surgical consumable spend to deliver activity (£9.0m adverse), and multiple smaller non-pay variances. In year delivery CIP is £1.3m adverse to plan.

Statement of Financial Position at 31 October 2024

	23/24 Month 12 £m	24/25 Month 06 £m	24/25 Month 07 £m	In-Month Change £m	YTD Change £m
Non-Current Assets	**538.4**	**535.6**	**536.9**	**1.3**	**(1.4)**
Current Assets					
Inventories	11.7	12.0	11.8	(0.2)	0.1
Receivables	49.4	60.5	66.0	5.6	16.6
Cash and Cash Equivalents	62.7	35.0	44.3	9.3	(18.4)
Total Current Assets	**123.8**	**107.4**	**122.1**	**14.7**	**(1.7)**
Current Liabilities (< 1 Year)					
Trade and Other Payables	(99.9)	(81.3)	(89.9)	(8.6)	(10.0)
Deferred Income	(14.4)	(19.2)	(27.7)	(8.5)	13.3
Financial Current Liabilities	(23.6)	(23.6)	(23.6)	0.0	(0.0)
Total Current Liabilities	**(138.0)**	**(124.1)**	**(141.2)**	**(17.1)**	**3.2**
Non-Current Liabilities (> 1 Year)					
Trade Payables and Deferred Income	(6.2)	(6.6)	(6.6)	0.0	0.4
Financial Non-Current Liabilties	(571.8)	(588.3)	(586.6)	1.7	14.8
Total Non-Current Liabilities	**(578.0)**	**(594.9)**	**(593.2)**	**1.7**	**15.2**
Total Net Assets	**(53.7)**	**(76.0)**	**(75.3)**	**0.6**	**(21.6)**
Capital and Reserves					
Public Dividend Capital	485.2	492.5	492.5	0.0	7.3
Income and Expenditure Reserve	(541.8)	(610.8)	(610.8)	0.0	(69.0)
Income and Expenditure Account - Current Year	(69.0)	(29.5)	(28.9)	0.6	40.1
Revaluation Reserve	71.9	71.9	71.9	0.0	0.0
Total Capital and Reserves	**(53.7)**	**(76.0)**	**(75.3)**	**0.6**	**(21.6)**

Capital spend is £12.9m year-to-date (excluding leases). This is driven by spend on the Elective Centre, and is below the forecasted spend for Month 7.

Cash is £44.3m at 31 October 2024, a £18.4m decrease compared with M12. The decrease is driven by the I&E deficit, capital spend, and delays in payment of invoices related to 2023/24. It is expected the cash position will continue to reduce, resulting in the overall reduction of cash position to approximately £14m by Month 12.

Non-Current Liabilities have decreased by £1.7m in Month 7 as a result of the national implementation of IFRS 16 on the PFI. This has changed the accounting treatment for the contingent rent element of the unitary charge which must now be shown as a liability. This change also accounts for the £69m increase in the Income and Expenditure Reserve for the year.

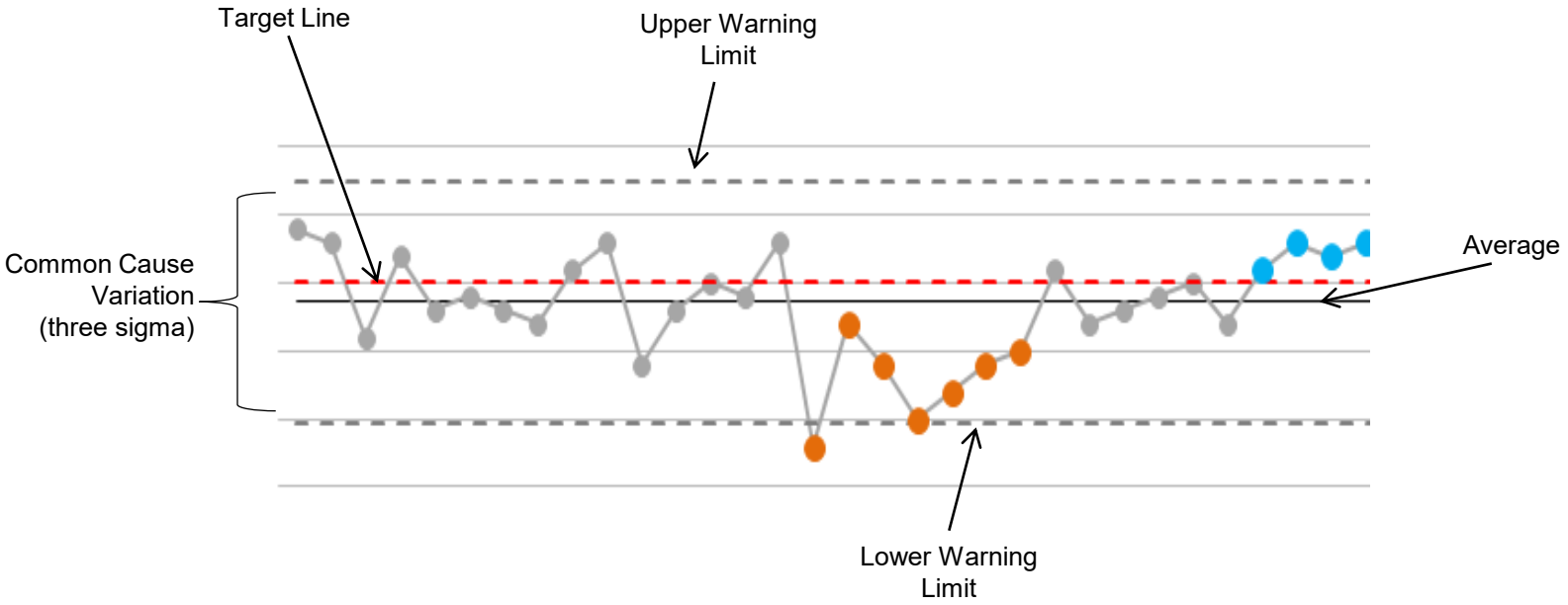
Regulatory

Board Sponsor: Chief Executive
Maria Kane

NHS Provider Licence Compliance Statements at September 2024 - Self-assessed, for submission to NHS

Ref	Criteria:	Comp (Y/N)	Comments where non complaint or at risk of non-compliance
G3	Fit and proper persons	Y	A Fit and Proper Persons Policy is in place. Annual checks have been undertaken and no areas of non-compliance have been identified.
G4	Having regard to NHS England Guidance	Y	Trust Board has regard to NHS England guidance where this is applicable.
G6	Registration with the CQC	Y	CQC registration is in place. The Quality Committee receives regular assurance on CQC compliance on behalf of the Board.
G7	Patient eligibility and selection criteria	Y	Trust Board has considered the assurances in place and considers them to be sufficient.
C1	Submission of costing information	Y	A rang od measures and controls are in place to provide internal assurance on data quality, including an annual internal audit assessment.
C2	Provision of costing and costing related information	Y	The Trust submits information nationally as required.
C3	Assuring the accuracy of pricing and costing information	Y	Scrutiny and oversight of assurance reports to regulators is provided by the Board's Committees as required.
P1	Compliance with NHS Payment Scheme	Y	NBT complies with national and local arrangements. It should be noted that NBT is currently receiving elements of income via a block arrangement in line with national financial arrangements.
P5	Constructive engagement concerning local tariff modifications	Y	NBT complies with national and local arrangements. It should be noted that NBT is currently receiving elements of income via a block arrangement in line with national financial arrangements.
IC1	Provision of Integrated Care	Y	The Trust is actively engaged in the ICS and within a provider collaborative.
IC2	Personalised Care and Patient Choice	Y	Trust Board has considered the assurances in place and considers them to be sufficient.
WS1	Cooperation	Y	The Trust is actively engaged in the ICS and within a provider collaborative.
NHS2	Governance Arrangements	Y	The Trust has robust governance arrangements in place, which have been reviewed annual as part of the licence self-certification process and tested via annual reporting and internal/external audit.

Appendix 1: General guidance and Statistical Process Charts (SPC)



Unless noted on each graph, all data shown is for period up to, and including, 31st of May 2024 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.

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

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

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

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

Appendix 2: NBT Strategy – Patient First

Patient First is the approach we are adopting to implement our Trust strategy.

The fundamental principles of the Patient First approach are to have a clear strategy that is easy to understand at all levels of NBT reduce our improvement expectation at NBT to a small number of critical priorities develop our leaders to know, run and improve their business become a Trust where everybody contributes to delivering improvements for our patients.

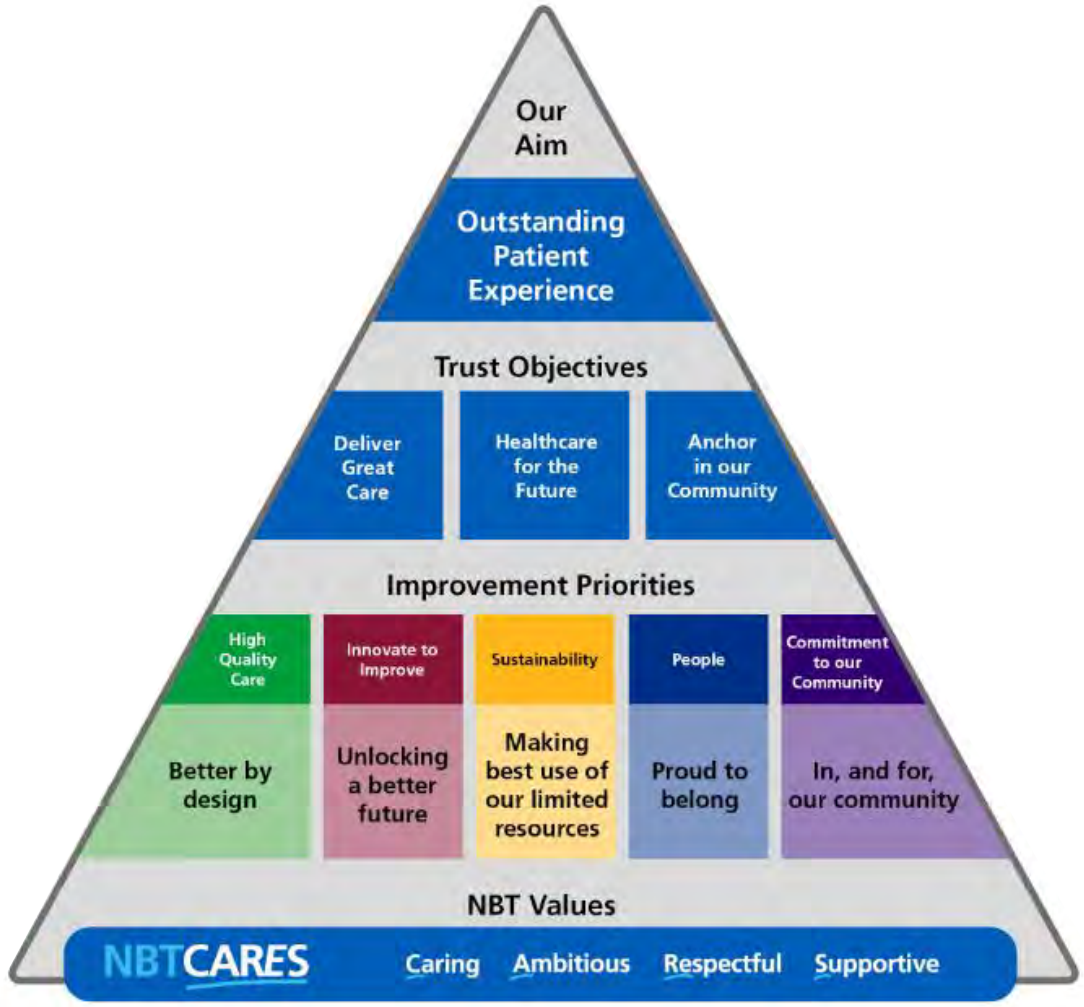
The Patient First approach is about what we do and how we do it and for it to be a success, we need you to join us on the journey.

Our reason for existing as an organisation is to put the patient first by delivering outstanding patient experience – and that's the focal point of our strategy, Our Aim. Everything else supports this aspiration.

Our Improvement Priorities which will help us to deliver our ultimate aim of delivering outstanding patient experience are:

1. **High quality care** – *we'll make our care better by design*
2. **Innovate to improve** – *we'll unlock a better future*
3. **Sustainability** – *we'll make best use of limited resources*
4. **People** – *you'll be proud to belong here*
5. **Commitment to our community** – *we'll be in our community, for our community.*

We have indicated areas of the IPR which are connected to the Trust Patient First improvement priorities with the icons below and initials **PF** on graphs.



Appendix 2: NBT Strategy – Patient First Improvement Priorities

Improvement Priorities	Descriptor	Vision	Strategic Goal	Current Target	Breakthrough Objective
PATIENT *Steve Hams*	Outstanding Patient experience	We consistently deliver person centred care & ensure we make every contact and interaction count. We get it right first time so that we reduce unwarranted variation in experience, whilst respecting the value of patient time	We have the highest % of patients recommending us as a place to be treated among non-specialist acute hospitals with a response rate of at least 10% in England	Upper decile performance against non-specialist acute hospitals with a response rate of at least 10% *(based on June 2022 baseline)*	Improving FFT 'positive' percentage
HIGH QUALITY CARE *Steve Curry*	Better by design	Our patients access timely, safe, and effective care with the aim of minimising patient harm or poor experience as a result	1. 62-day cancer compliance 2. >15 min ambulance handover compliance	85% of patients will receive treatment for cancer in 62 days Sustain/maintain <70 weekly hrs lost	70% of patients will receive treatment for cancer in 62 days Maintain best weekly delivered position between April 2021 and August 2022 – 141 hours (w/c 29th Aug 2022)
INNOVATE TO IMPROVE *Tim Whittlestone*	Unlocking a better future	We are driven by curiosity; undertake research and implement innovative solutions to improve patient care by enabling all our people and patients to make positive changes	Increase number of staff able to make improvements in their areas to 75% of respondents by 2028	Increase number of staff able to make improvements in their areas to 63% of respondents by 2026/2027	Increase number of staff able to make improvements in their areas to be 1% point above the benchmark average in 2024/25 (57% based on 2023 staff survey results)
SUSTAINABILITY *Glyn Howells*	Making best use of our limited resources	Through delivering outstanding healthcare sustainably we will release resources to invest in improving patient care.	To eliminate the underlying deficit by 2026/2027	To deliver at least 1% higher CIP than the national efficiency target	Deliver the planned levels of recurrent savings in 2024/25
PEOPLE *Interim CPO Peter Mitchell*	Proud to belong	Our exceptional people deliver outstanding patient care and experience	Staff turnover sustained at 10% or below by 2029	Staff Turnover sustained at 10.7% or below by Mar 2027	Staff Turnover Sustained at 11.9% or below
COMMITMENT TO OUR COMMUNITY *Interim CPO Peter Mitchell*	In, and for, our community	We will improve opportunities that help reduce inequalities and improve health outcomes	Increase NBT employment offers in our most deprived communities and amongst under-represented groups	Increase recruitment within NBT catchment to reflect the same proportion of our community in the most economically deprived wards – increase from 32% to 37% of starters equating to an additional 70 starters per year at current recruitment levels.	Reduce disparity ratio To 1.25 or better 38% employment from our most challenged communities

Appendix 3: Abbreviation Glossary

Abbreviation	Definition
AfC	Agenda for Change
AHP	Allied Health Professional
AMTC	Adult Major Trauma Centre
AMU	Acute medical unit
ASCR	Anaesthetics, Surgery, Critical Care and Renal
ASI	Appointment Slot Issue
AWP	Avon and Wiltshire Partnership
BA PM/QIS	British Association of Perinatal Medicine / Quality Indicators standards/service
BI	Business Intellligence
BIPAP	Bilevel positive airway pressure
BPPC	Better Payment Practice Code
BWPC	Bristol & Weston NHS Purchasing Consortium
CA	Care Assistant

Abbreviation	Definition
CCS	Core Clinical Services
CDC	Community Diagnostics Centre
CDS	Central Delivery Suite
CEO	Chief Executive
CHKS	Comparative Health Knowledge System
CHPPD	Care Hours Per Patient Day
CIP	Cost Improvement Programme
Clin Gov	Clinical Governance
CMO	Chief Medical Officer
CNST	Clinical Negligence Scheme for Trusts
COIC	Community-Oriented Integrated Care
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation

Abbreviation	Definition
CT	Computerised Tomography
CTR/NCTR	Criteria to Reside/No Criteria to Reside
D2A	Discharge to Assess
DivDoN	Deputy Director of Nursing
DoH	Department of Health
DPEG	Digital Public Engagement Group
DPIA	Data Protection Impact Assessment
DPR	Data for Planning and Research
DTI	Deep Tissue Injury
DTOC	Delayed Transfer of Care
ECIST	Emergency Care Intensive Support Team
EDI	Electronic Data Interchange
EEU	Elgar Enablement Unit

Appendix 3: Abbreviation Glossary

Abbreviation	Definition
EPR	Electronic Patient Record
ERF	Elective Recovery Fund
ERS	E-Referral System
ESW	Engagement Support Worker
FDS	Faster Diagnosis Standard
FE	Further education
FTSU	Freedom To Speak Up
GMC	General Medical Council
GP	General Practitioner
GRR	Governance Risk Rating
HCA	Health Care Assistant
HCSW	Health Care Support Worker
HIE	Hypoxic-ischaemic encephalopathy

Abbreviation	Definition
HoN	Head of Nursing
HSIB	Healthcare Safety Investigation Branch
HSIB	Healthcare Safety Investigation Branch
I&E	Income and expenditure
IA	Industrial Action
ICB	Integrated Care Board
ICS	Integrated Care System
ICS	Integrated Care System
ILM	Institute of Leadership & Management
IMandT	Information Management
IMC	Intermediate care
IPC	Infection, Prevention Control
ITU	Intensive Therapy Unit

Abbreviation	Definition
JCNC	Joint Consultation & Negotiating Committee
LoS	Length of Stay
MaST	Mandatory and Statutory Training
MBRRACE	Maternal and Babies-Reducing Risk through Audits and Confidential Enquiries
MDT	Multi-disciplinary Team
Med	Medicine
MIS	Management Information System
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Susceptible Staphylococcus Aureus
NC2R	Non-Criteria to Reside
NHSEI	NHS England Improvement
NHSi	NHS Improvement

Appendix 3: Abbreviation Glossary

Abbreviation	Definition
NHSR	NHS Resolution
NICU	Neonatal intensive care unit
NMPA	National Maternity and Perinatal Audit
NMSK	Neurosciences and Musculoskeletal
Non-Cons	Non-Consultant
NOUS	Non-Obstetric Ultrasound Survey
OOF	Out Of Funding
Ops	Operations
P&T	People and Transformation
PALS	Patient Advisory & Liaison Service
PCEG	Primary Care Executive Group
PDC	Public Dividend Capital
PE	Pulmonary Embolism
PI	Pressure Injuries
PMRT	Perinatal Morality Review Tool
PPG	Patient Participation Group
PPH	Post-Partum Haemorrhage
PROMPT	PRactical Obstetric Multi-Professional Training
PSII	Patient Safety Incident Investigation
PTL	Patient Tracking List
PUSG	Pressure Ulcer Sore Group
QC	Quality Care
qFIT	Faecal Immunochemical Test
QI	Quality improvement
RAP	Remedial Action Plan
RAS	Referral Assessment Service
RCA	Root Cause Analysis
RJC	Restorative Just Culture
RMN	Registered Mental Nurse
RTT	Referral To Treatment
SBLCBV2	Saving Babies Lives Care Bundle Version 2
SDEC	Same Day Emergency Care
SEM	Sport and Exercise Medicine
SI	Serious Incident
T&O	Trauma and Orthopaedic
TNA	Trainee Nursing Associates
TOP	Treatment Outcomes Profile
TVN	Tissue Viability Nurses
TWW	Two Week Wait

Appendix 3: Abbreviation Glossary

Abbreviation	Definition
UEC	Urgent and Emergency Care
UWE	University of West England
VSM	Very Senior Manager
VTE	Venous Thromboembolism
WCH	Women and Children's Health
WHO	World Health Organisation
WLIs	Waiting List Initiative
WTE	Whole Time Equivalent

Meeting of the Board on 28 November 2024 held in Public.

Reporting Committee	**Finance, Digital & Performance Committee**
Chaired By	**Richard Gaunt, Non-Executive Director**
Executive Lead	**Elizabeth Poskitt, Chief Finance Officer** **Steve Curry, Chief Operating Officer**

For Information

The Committee met on 21 November 2024 and received the following reports:

1. **Performance Report** - The Committee received an update on the latest Trust performance position against a range of key national metrics and discussed the most recent performance data:
   - With regards to Planned Care, the Trust was achieving the target for zero capacity breaches for patients waiting over 65-weeks for treatment, with the focus now on clearing the 52-week backlog.
   - With regards to Diagnostics, the Trust continued to deliver a zero >13-week breach backstop and was meeting the constitutional standard. Additionally, it was noted that the Community Diagnostic Centre was now fully operational.
   - With regards to Unscheduled Care, achieving the year-end target of 78% remained challenged, as a result of the continued increased Emergency Department attendances and challenges with the No Criteria To Reside (NC2R) position. It was noted that the NC2R position contributed to a >98% average bed occupancy. Discussion focused on the challenges and the ongoing work with the system to address the capacity issues.
   - With regards to Cancer performance, there had been continued improvement in the Faster Diagnosis Standard (FDS) compliance position and work was ongoing to focus on sustainable improvement for the 62 day Patient Tracking List (PTL).

   The Committee noted the continued impact of NC2R on stroke but received reassurance that there was no risk of increasing patient harm as the challenge was with discharge rather than admittance.

2. **Urology Deep Dive –** The Committee received the report which provided a deep dive into the Urology Cancer performance and identified the key areas for continued recovery and sustainability (including surgeon availability, access to the robotic equipment, clinical priority and patient choice). Discussion focused on investment into the additional robotic equipment (which was in the capital plan) and challenges regarding capital investments. The Committee were assured that the Trust was following the best practise referral pathway and agreed to continue to monitor the metric to ensure it continues on a positive trajectory.

3. **Infrastructure Strategy –** The Committee received the report which set out:
   - the content of the approved ICS Infrastructure Strategy 2024 including the system prioritised Top Ten capital schemes requiring investment.
   - how the completed NHS England (NHSE) capital allocation document aligns to NBT's 10-year capital programme.
   - the next steps in progressing the actions arising from the IS to drive system wide estates solutions, improve productivity and maximise opportunities.

Discussion focused on space utilisation and how the strategy linked to the Trust's high scoring estate risks. The Committee received assurance re the Trust's input into the prioritisation list and noted the challenges of a system level capital planning process.

4. **Finance Update -** The Committee received the Month 7 finance report which outlined:
   - The financial plan for 2024/25 in Month 7 was a breakeven position.
   - Year to date the Trust has delivered a £3.5m adverse overall variance. This has been driven by in year Cost Improvement Plan (CIP) non-delivery and overspends on temporary staffing from April to July.
   - The Month 7 CIP position showed £13.5m schemes fully completed with a further £4.4m in implementation and planning, and a further £11.0m of schemes identified in the pipeline.
   - Cash at Month 7 amounted to £44.3m, a reduction of £18.4m from Month 12 which was driven by the Trust underlying deficit and capital spend.

   The full report is appended (see **Appendix 1**).

5. **Business Planning 2025/26** - The Committee reviewed report the which set out the approach to the 2025/26 business planning process. It has incorporated lessons learnt and improvements via feedback received and will enable continued effective running of the hospital and to support delivery of the business plan from April 2025. It set out the aspiration to plan early in absence of clear guidance and sought approval of a high-level timeline that incorporated a structured approval route with indicative key milestones to be met ahead of a March 2025 Trust Board sign-off.

   The Committee endorsed the approach to the 2025/26 business planning process timeline for Trust Board approval (see **Appendix 2**).

6. **Productivity –** The Committee received the report which set out the productivity position for the Trust using the NHSE published waterfall positions published in July 2024. Discussion focused on enhancing the visibility of productivity efforts and the link between productivity and CIP.

7. **Digital Change Programme Delivery** - The Committee received an overall report on performance and priorities within the digital directorate. A detailed update on the status of each digital programme was provided, recognising areas of challenge and improvement. The Committee received reassurance regarding the digital risk mitigations, the financial position for the directorate and the controls in place for projects such as coding and SAP Ariba.

8. The Committee received and reviewed the following reports:
   - The risk report which included the Reputation, Performance, Finance, IM&T and Service Delivery Trust Level Risks (TLR) and Board Assurance Framework (BAF) risks within the Committee's purview. The Committee noted the longstanding high scoring risks and queried the mitigations in place.
   - CIP Review/Update which set out the CIP progress for 2024/25, how Non-Divisional schemes were being delivered and provided background and context about 2025/26 CIP planning. Discussion focused on CIP planning and the importance of identifying CIP through a continuous improvement lens.

- An update from the Business Case Review Group
- Quarter 2 Theatre Productivity Report which demonstrated the improvement that has been made over the last three months.

For Board Awareness, Action or Response (including risks)

Board should note:

- The Finance Report (Appendix 1).
- The concerns regarding the mitigations in place for TLRs.
- The challenges to secure additional bed capacity in the system to address the NC2R challenges and the resulting implications of the high bed occupancy levels.

Board are asked to approve the 2025/26 business planning process timeline (Appendix 2).

Key Decisions and Actions

The Committee has requested to receive:

- a deep dive at the next meeting into the Gynae Cancer performance,
- a quarterly report on the Urology Cancer performance,
- an update on the strategic estate work.

The Committee also identified the action to enhance the visibility of productivity efforts and requested to bring discussions on this topic from the finance sustainability forum to the Committee for further consideration.

Additional Chair Comments

N/A

Date of next meeting:	Thursday 23 January 2025.

Report To:	Public Trust Board		
Date of Meeting:	28 November 2024		
Report Title:	Finance Report for October 2024 (Month 7)		
Report Author:	Simon Jones, Assistant Director of Finance – Financial Management		
Report Sponsor:	Elizabeth Poskitt, Chief Financial Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			x
	The purpose of the report is to inform the Committee of the Month 5 financial report.		

Key Points to Note *(Including any previous decisions taken)*

The financial plan for 2024/25 in Month 7 (October) was a breakeven position. The Trust has delivered a £0.3m surplus. The in month improvement has been driven by non-recurrent commissioner funding recognised in month.

Year to date the Trust has seen a £3.5m adverse overall variance. This has been driven by in year CIP non-delivery and overspends on temporary staffing from April to July.

The Trust has delivered £13.5m of completed Cost Improvement Programme (CIP) schemes at Month 7. There are a further £4.4m of schemes in implementation and planning that need to be developed, and £11.0m in the pipeline. CIP non-delivery within the year to date position relates to the in-year impact of schemes delivering on a recurrent basis.

The Trust cash position at Month 7 is £44.3m, a reduction of £18.4m from Month 12. This is driven by the Trust underlying deficit and capital spend.

Strategic Alignment

This report aims for outstanding patient experience and links with priorities and projects within Patient First, particularly the improvement priority for Sustainability – making best use of our limited resources.

Risks and Opportunities

Key risks:

- At Month 7 the cash balance is £10.0m below planned levels. Assuming a breakeven position at year end, the Trust expects to end the year with a cash balance of £14.0m.
- In year, whilst pay costs year to date exceed plan, new controls introduced in August showed a promising reduction in bank spend from August to October.
- Continued under-delivery of CIP will put a break-even outturn at risk.
- Divisional non-pay costs are £6.0m adverse year to date, the non-pay run rate has increased in month and further actions to reduce in non-pay costs will be required.

Recommendation

This report is for Information. Trust Board are asked to note the report.

History of the paper (details of where paper has <u>previously</u> been received)	
Finance, Digital & Performance committee	21 November 2024
Appendices:	*Appendix 1 – Finance Report Month 7*

NHS North Bristol NHS Trust

Finance Performance Report

Trust Board: Month 7 2024/25

Author: Simon Jones (Assistant Director of Finance)

Sponsor: Elizabeth Poskitt (Chief Finance Officer)

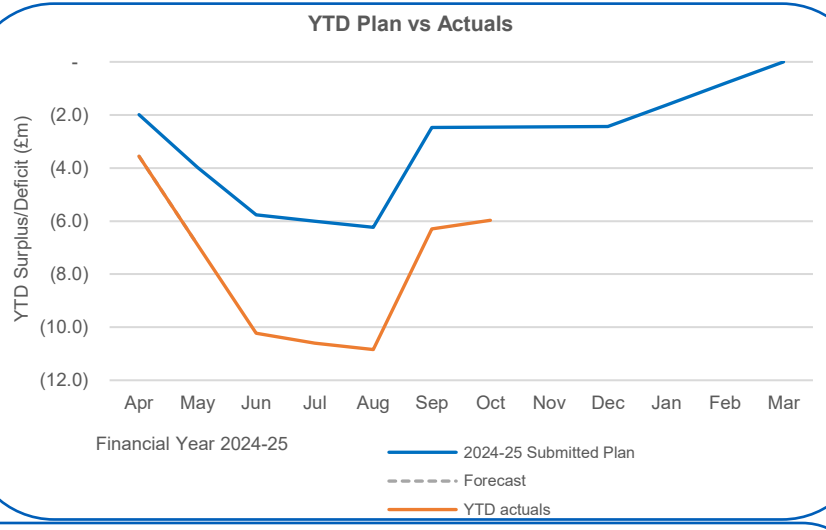
Finance Performance Report

Month 7 (October 2024)

NHS North Bristol NHS Trust

Finance Summary

	Month 7			Year to date		
	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	81.4	84.3	2.9	492.5	501.8	9.3
Income	6.1	15.0	8.9	41.7	66.8	25.1
Pay	(58.9)	(62.3)	(3.4)	(335.6)	(349.3)	(13.8)
Non-pay	(28.6)	(36.6)	(8.0)	(201.1)	(225.2)	(24.1)
Surplus/(Deficit)	**0.0**	**0.3**	**0.3**	**(2.5)**	**(6.0)**	**(3.5)**



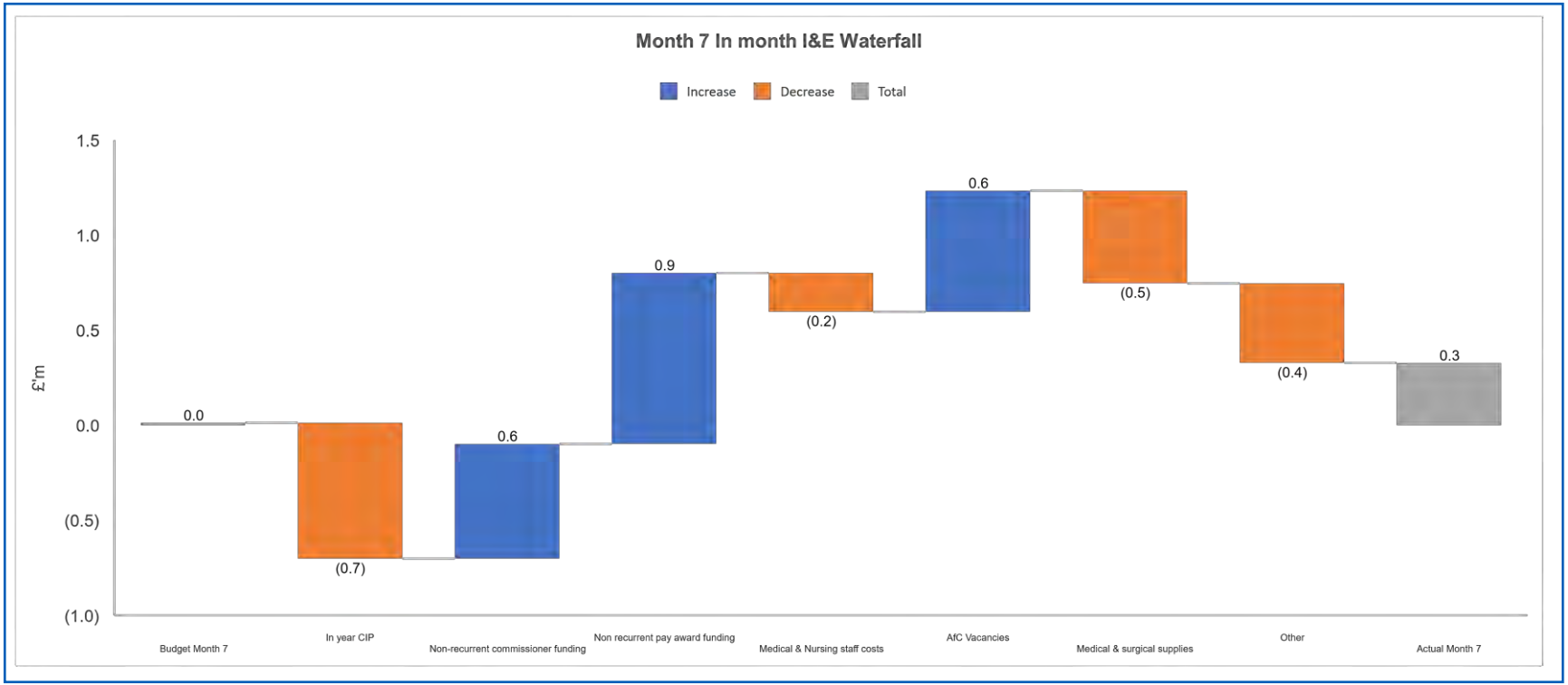
Key messages:

- The financial plan for 2024/25 in Month 7 (October) was a breakeven position. The Trust has delivered a £0.3m surplus. The improvement has been driven by non-recurrent commissioner funding recognised in month.
- Year to date the Trust has seen a £3.5m adverse overall variance. This has been driven by in year CIP non-delivery and overspends on temporary staffing from April to July.
- The Trust undertook a detailed update to the forecast outturn in October. Divisions have been provided with targets to achieve, and with additional non-recurrent mitigations the Trust is currently indicating a £6.6m deficit. Further work is being undertaken to deliver a breakeven position at year end.
- The Trust cash position at Month 7 is £44.3m, a reduction of £18.4m from Month 12. This is driven by the Trust underlying deficit and capital spend.
- The Trust has delivered £13.5m of completed Cost Improvement Programme (CIP) schemes at Month 7. There are a further £4.4m of schemes in implementation and planning that need to be developed, and £11.0m in the pipeline. CIP non-delivery within the year to date position relates to the in-year impact of schemes delivering on a recurrent basis.

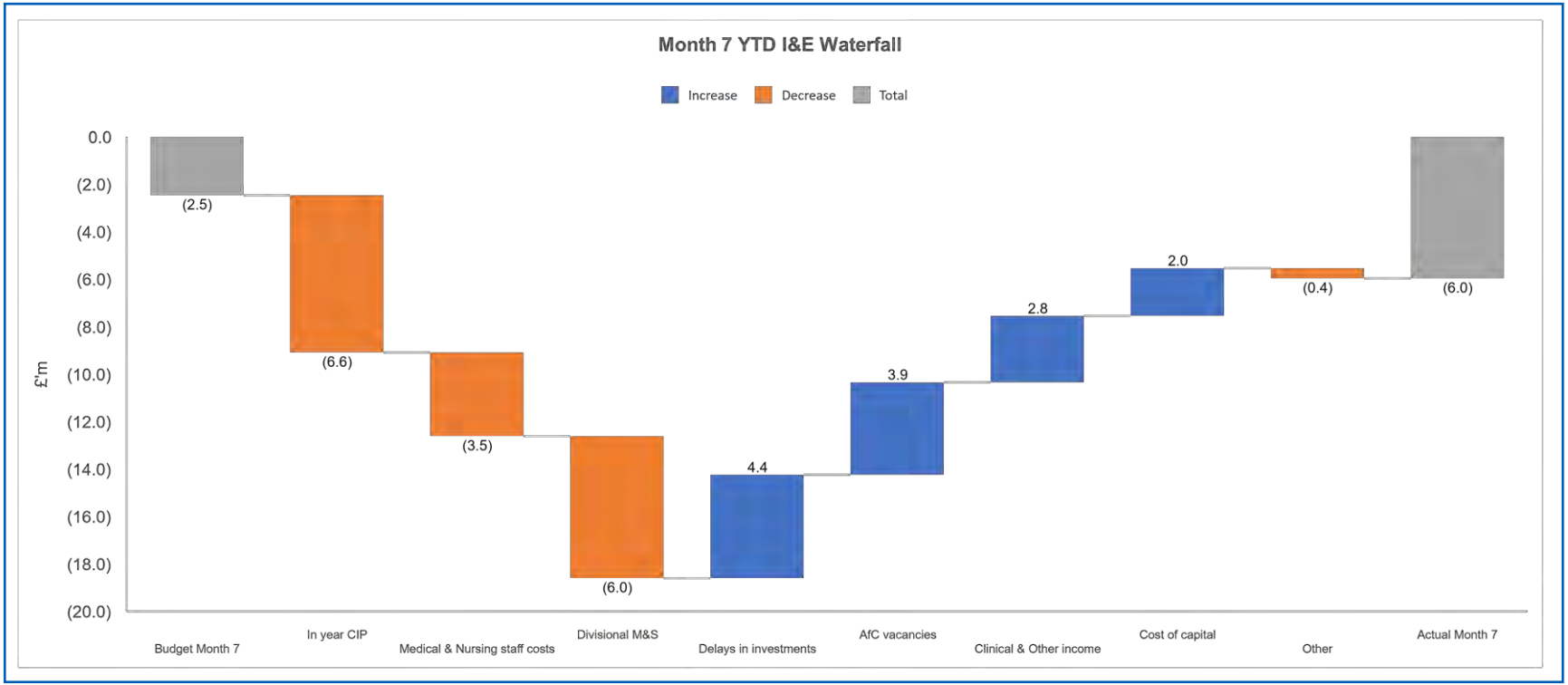
Key risks:

- At Month 7 the cash balance is £10.0m below planned levels. Assuming a breakeven position at year end, the Trust expects to end the year with a cash balance of £14.0m.
- In year, whilst pay costs year to date exceed plan, new controls introduced in August showed a promising reduction in bank spend from August to October.
- Continued under-delivery of CIP will put a breakeven outturn at risk.
- Divisional non-pay costs are £6.0m adverse year to date, the non-pay run rate has increased in month and further actions to reduce in non-pay costs will be required.

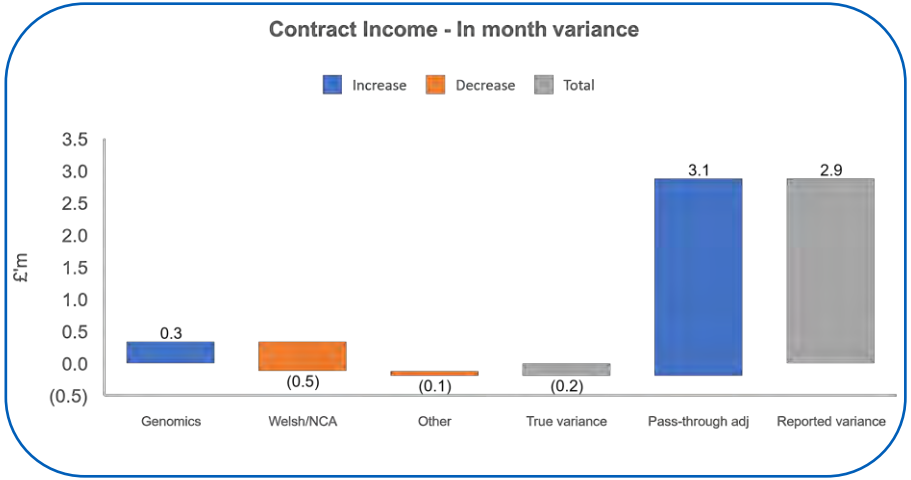
Income and Expenditure: In month I&E waterfall

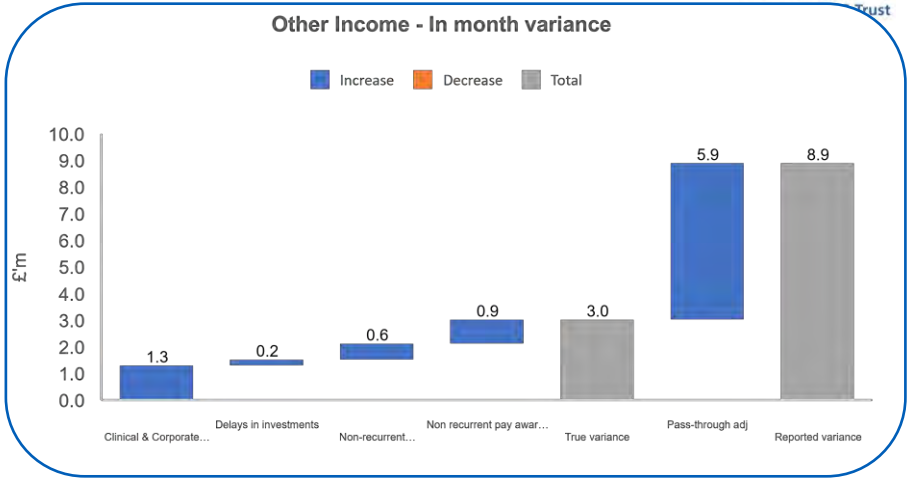


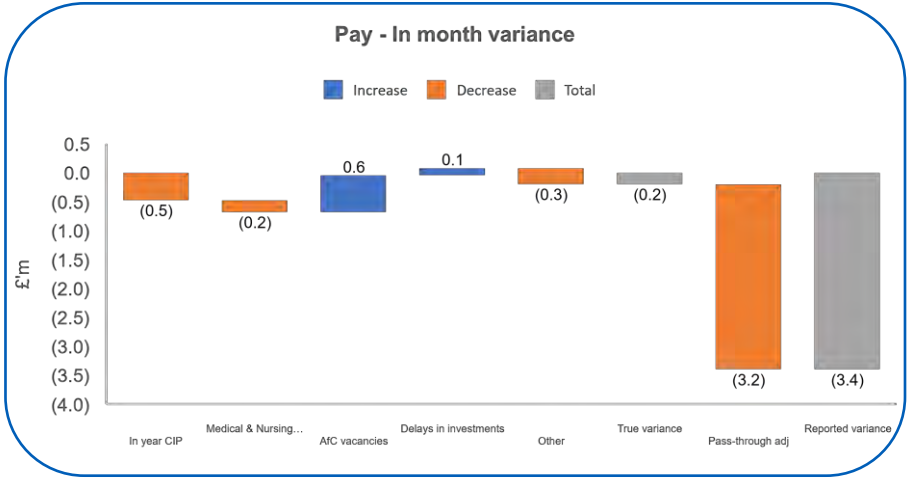
Income and Expenditure: Year to date I&E waterfall

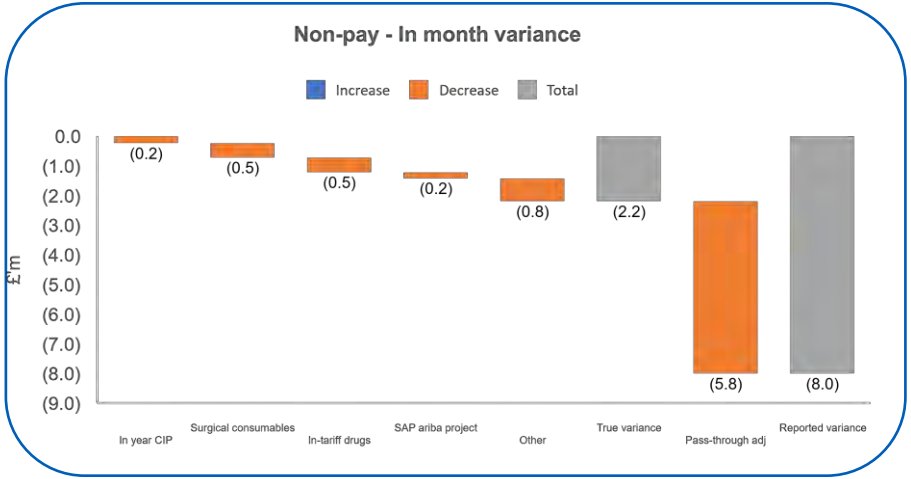


Finance Summary In Month



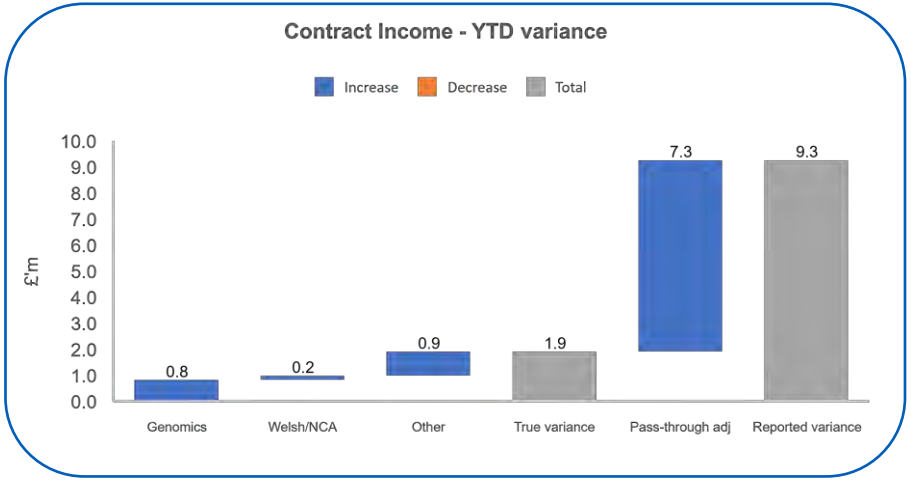


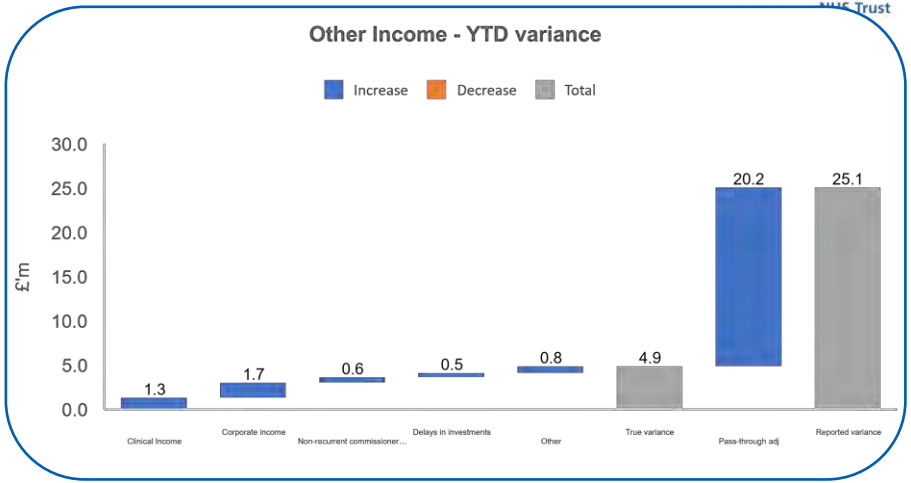


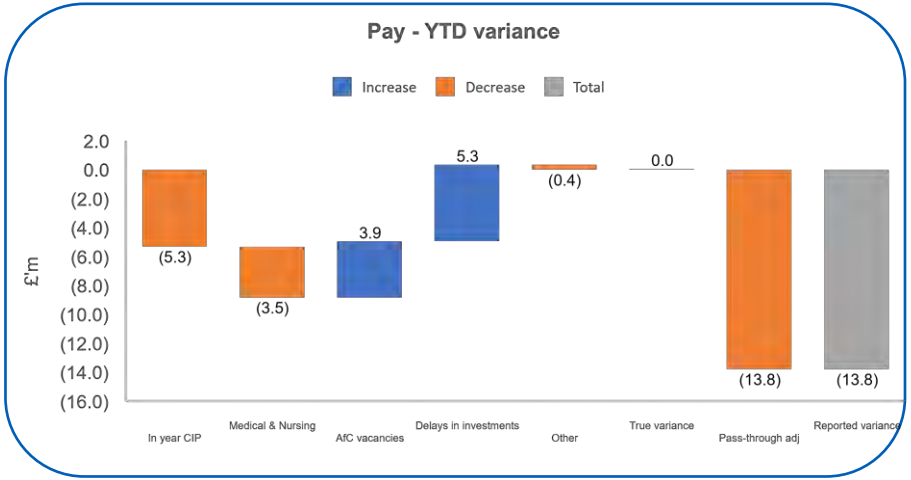


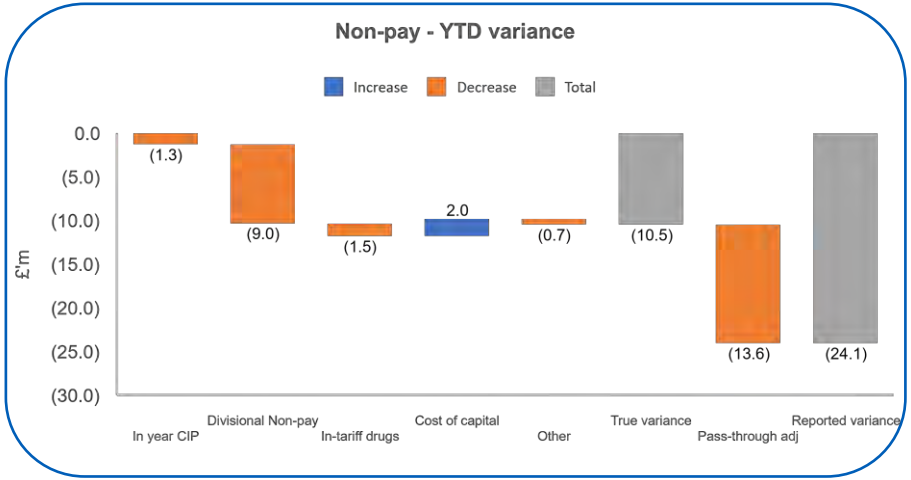
*Note: Further explanation of variances are provided on slides 8-11

Finance Summary Year to date









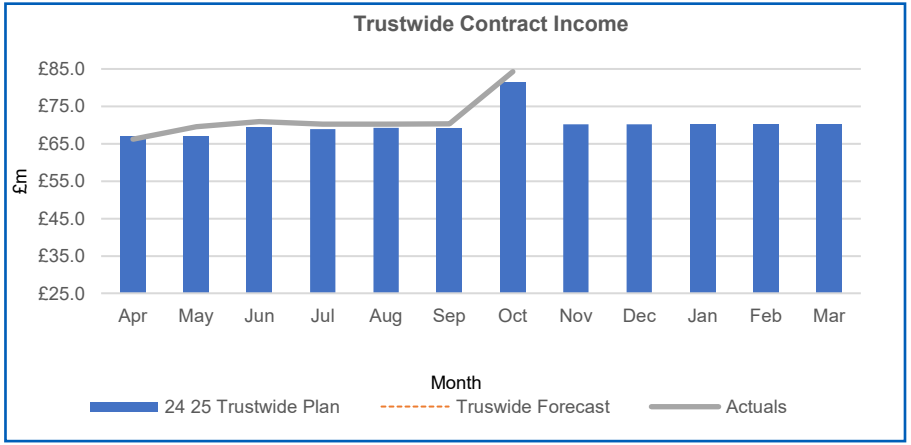
*Note: Further explanation of variances are provided on slides 8-11

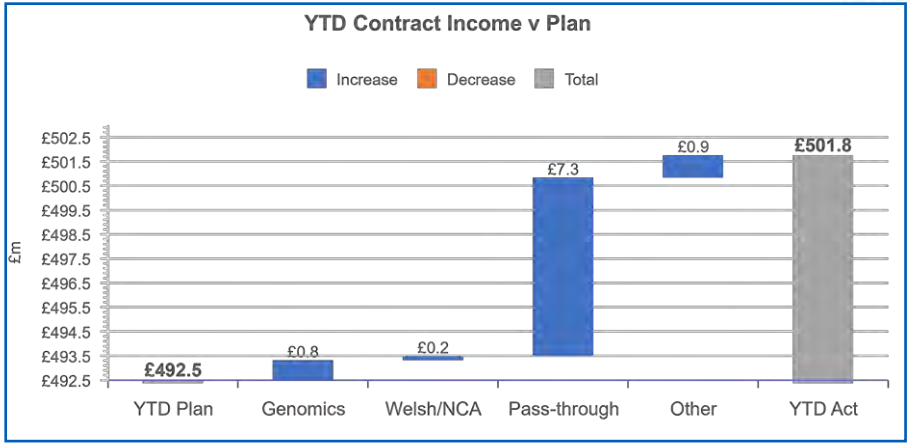
Finance Summary Pass through adjustments to reported variance

	In month					Year to date				
	Contract Income	Income	Pay	Non pay	Total	Contract Income	Income	Pay	Non pay	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Reported variance	**2.9**	**8.9**	**(3.4)**	**(8.0)**	**0.3**	**9.3**	**25.1**	**(13.8)**	**(24.1)**	**(3.5)**
Adjustments to remove:										
NHS Plan adjustments	0.0	2.7	(1.5)	(1.2)	(0.0)	0.0	17.5	(9.3)	(8.2)	0.0
Research & Education funding	0.0	0.4	0.0	(0.5)	0.0	0.0	(1.3)	0.1	1.2	0.0
High cost drugs	0.9	0.0	0.0	(0.9)	0.0	2.0	0.0	0.0	(2.0)	0.0
HCTED	0.6	0.0	0.0	(0.6)	0.0	1.1	0.0	0.0	(1.1)	0.0
Pay award	1.4	1.6	(3.0)	0.0	(0.0)	2.4	2.2	(4.6)	0.0	(0.0)
CIP adjustment	0.0	(0.6)	1.5	(0.9)	0.0	0.0	(0.6)	1.5	(0.9)	0.0
Other (<£0.5m)	0.2	1.7	(0.1)	(1.8)	(0.0)	1.8	2.4	(1.5)	(2.6)	0.1
True variance	**(0.2)**	**3.0**	**(0.2)**	**(2.2)**	**0.4**	**1.9**	**4.9**	**0.0**	**(10.5)**	**(3.7)**

- The tables above highlight items within the position that have an equal and offsetting impact within income and expenditure or are removed to make the explanation of the variances easier to understand.
- As these have minimal effect on the position they are removed when explaining the in month and year to date variances.
- These values reconcile to the 'pass-through' items on the waterfall graphs in the preceding two slides.

Contract Income Overview





Contract Income

In month: £2.9m fav

YTD: £9.3m fav

In month

- In month Trustwide Contract Income is £2.9m favourable to plan.
- This is driven by additional pass-through income of £3.1m (pay award and high-cost drugs and devices), partly offset by credits raised for prior year Welsh invoices.

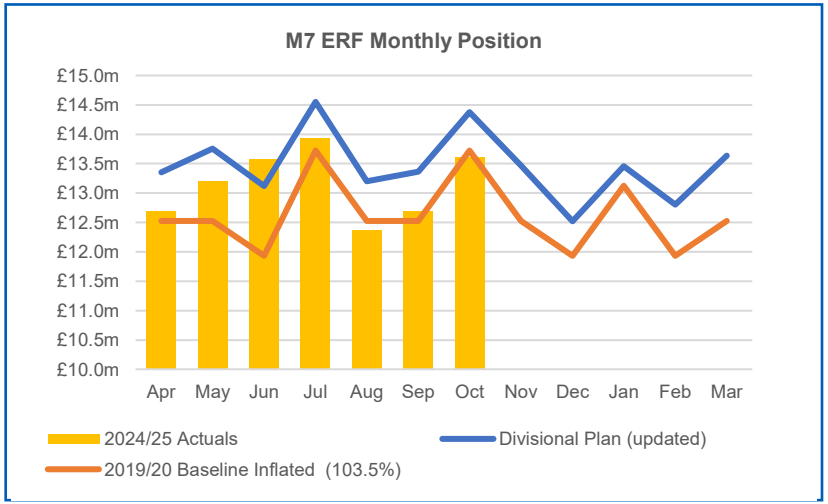
Year to date

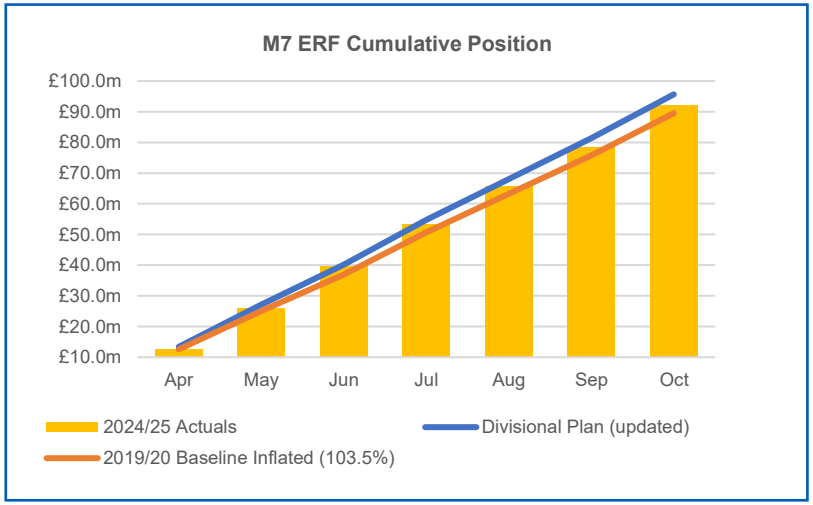
- Year to date the Trustwide Contract Income position is £9.3m favourable to plan.
- This is driven by additional pass-through income of £7.3m, which relates to pay award funding (backdated to April), high cost drugs and devices, and income for hosting SWAG. Other upsides include Genomics income of £0.8m not in plan.

Trend Analysis

The contract Income trend shows that month 7 is £14.0m favourable to prior month and £14.7m ahead of the YTD average. This positive variance is principally driven by the pay award funding (£13.3m) which has been recognised YTD within the month 7 position, along with additional pass-through devices activity (£1.0m).

Elective Recovery Fund Performance





Elective Recovery Funding

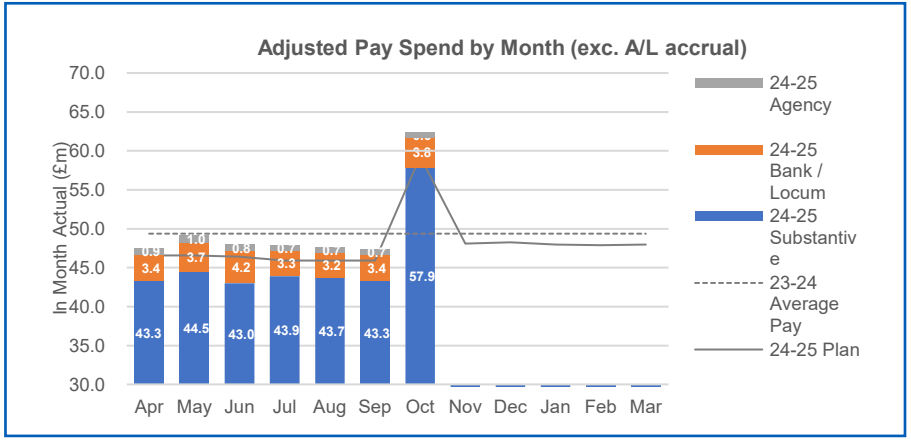
In month

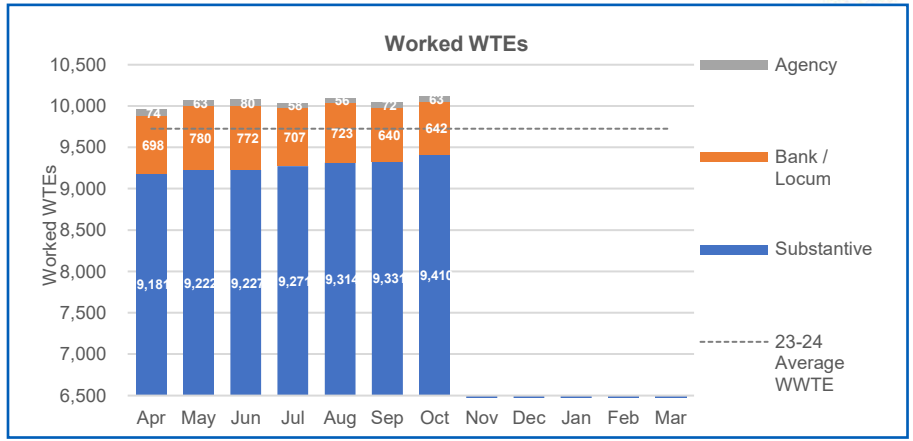
- ERF performance in October was 102.5% against 2019/20 activity.
- ERF is £0.1m less than the agreed baselines in month however this represents significant improvement on run rate over the last few months.
- In October, against divisional plans, the position underperformed by £0.8m.
- The main driver of the in month position is NMSK which continues to underperform in line with run rate. Recovery plans have been prepared which include alternative insourcing, additional lists and recruitment into to existing vacancies. Some of these have started to deliver in October.

Year to date

- Year to date ERF performance is 106.4%.
- Total ERF earned is £2.6m against agreed baselines year to date however is £4.0m below divisional plans.
- NMSK continue as the driver of under-delivery on divisional performance in T&O, Spinal Surgery and Neurosurgery, although there has been an improvement in October.

Pay Overview





*Note: Average 23-24 pay has been inflated for the pay awards recognised in this year and adjusted for one-offs throughout the year (pensions, non-consolidated pay award, annual leave accrual)

Pay

In month spend: £62.3m

In month: £3.4m adv

YTD: £13.8m adv

In month

- Trustwide pay spend is £62.3m driving a £3.4m adverse variance to plan. New funding adjustments, offset in income, are driving £3.2m of the variance (including the pay award), therefore, the revised pay variance is £0.2m adverse to plan. This is driven by unidentified CIP (£0.5m adverse) and medical and nursing overspends (£0.2m adverse) offset by staffing vacancies (£0.6m favourable).
- In month agency spend is £0.6m and bank/locum £3.8m. Slides 22 and 23 in the appendix have a more detailed breakdown.

Year to date

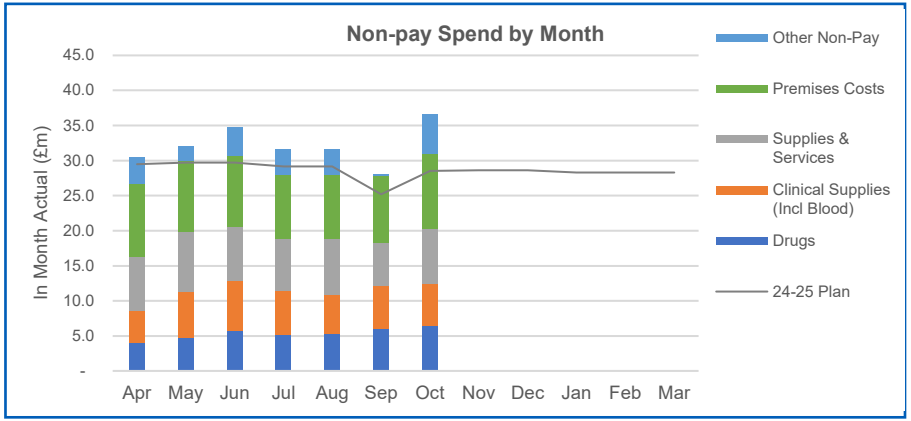
- Year to date Trust wide pay is £349.3m which is £13.8m adverse to plan. Excluding the adjustment for pass-through items, the revised position is £0.1m favourable to plan. Undelivered CIP is £5.3m adverse in addition to overspends on medical and nursing pay of £3.5m. The pay award is driving a £1.6m adverse variance year to date within pay, but is offset by non-recurrent funding received from the ICB. These are offset by delays in investments which are £6.0m favourable, other Agenda for Change vacancies which are £3.9m favourable, and other smaller favourable variances of £0.6m.

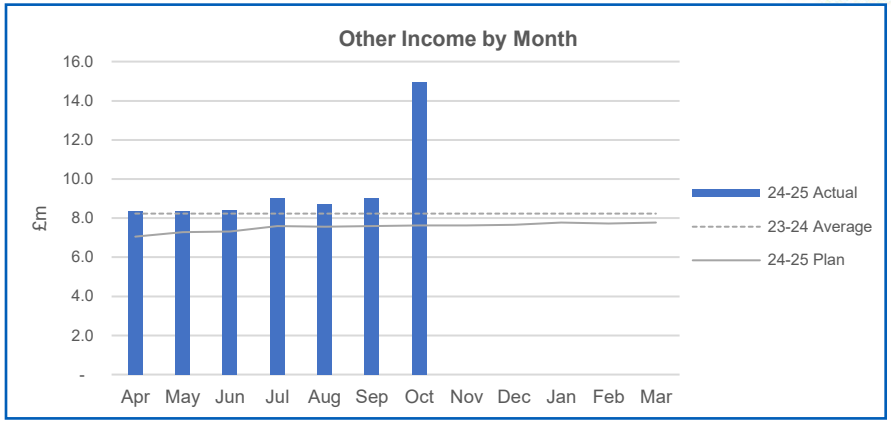
Trend Analysis

(further analysis shown in the Appendix)

- In October, pay spend was £62.3m. Excluding the pay award, pay is £46.0m which is a decrease of £1.4m in comparison to September. Bank usage has decreased by £0.5m in comparison to the year to date run-rate. WTE's in October were 10,115 compared to 10,042 in September (agency decreased by 9, bank/locum increased by 2 and substantive increased by 79). The decrease in bank is driven by less weekend working.

Non pay & Non commissioned Income Overview





*Note: Average 23-24 non-pay has been inflated by 0.8% for non-pay inflation, and adjusted for one-offs (Apprentice Levy and Stock)

Non pay

In month spend: £36.6m

In month: £8.0m adv

YTD: £24.1m adv

In month

- Trustwide non-pay spend was £8.0m adverse. Pass-through items are causing an adverse variance of £5.7m. The revised variance is therefore £2.3m adverse. This is driven by overspends on medical and surgical consumables (£0.5m adverse) and in-tariff drugs (£0.5m adverse) as well as overspend on the new procurement system project other one off overspends across a number of areas including general supplies, IT and premises.

Year to date

- Year to date Trustwide non-pay is £225.2m and £24.1m adverse to plan. Excluding pass-through items, the revised position is £10.8m adverse. This adverse position is driven primarily by medical and surgical consumable spend to deliver activity (£9.0m adverse) and CIP (£1.3m adverse).

Non NHS Income

In month income: £15.0m

In month: £8.9m fav

YTD: £25.1m fav

In month

- In month, non-commissioned income was £15.0m creating a £8.9m favourable variance. The favourable position was driven primarily by £6.8m new funding adjustments, including items relating to the pay award. The remaining £2.1m favourable variance is driven by additional activity in CCS and private patients, and educational funding.

Year to date

- Year to date non-commissioned income is £66.8m creating a £25.1m favourable variance. This is due to new funding in the year-to-date position since the final plan was signed off in May and pass through items (£20.5m). The remaining £4.6m favourable variance is driven by increased income across the divisions (£3.0m fav) and delays in investments (£0.5m fav) and other smaller items.

Savings

NHS North Bristol NHS Trust

Summary Division (£ m)	FYE Target	Completed Schemes	Schemes in Implementation	Schemes in Planning	Total FYE	Variance FYE	Schemes in Pipeline	Total FYE inc Pipeline
ASCR	5.8	2.2	0.0	1.0	3.2	(2.6)	1.7	4.9
CCS	4.8	2.8	0.0	0.4	3.2	(1.6)	0.2	3.4
MED	2.5	0.8	0.0	0.7	1.4	(1.0)	0.6	2.0
NMSK	4.1	1.9	0.0	0.8	2.7	(1.5)	0.2	2.8
WCH	3.7	1.4	0.0	0.5	1.9	(1.9)	1.3	3.2
FAC	1.6	0.8	0.0	0.4	1.2	(0.5)	0.4	1.5
Corp	1.8	1.4	0.0	0.0	1.4	(0.4)	0.4	1.8
Central	4.3	2.3	0.1	0.6	3.0	(1.4)	6.3	9.3
Total	**28.7**	**13.5**	**0.1**	**4.3**	**17.9**	**(10.8)**	**11.0**	**28.9**

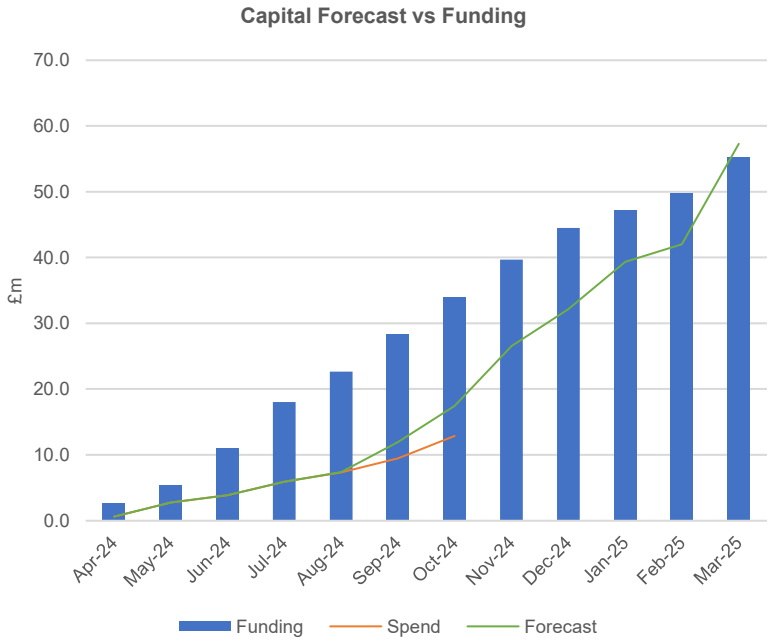
Saving Phasing £ m	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Plan phasing	1.5	1.5	1.7	2.5	2.5	2.5	2.5	2.5	2.5	3.0	3.0	3.0	28.7
Delivery	0.6	0.7	2.7	1.5	3.6	3.2	1.1						13.1
Cumulative Plan	1.5	3.0	4.7	7.2	9.7	12.2	14.7	17.2	19.7	22.7	25.7	28.7	28.7
Cumulative Delivery	0.6	1.3	4.0	5.5	9.1	12.3	13.5						13.1

- The CIP plan for 2024/25 is for savings of £28.7m with £14.7m planned to be delivered by Month 7.
- At Month 7 the Trust has £13.5m of completed schemes on the tracker. There are a further £4.4m of schemes in implementation and planning leaving a remaining £10.8m of schemes to be developed, against this we have £11.0m of schemes identified in the pipeline.
- The total identified CIP schemes on the tracker shows a positive variance of £0.2m with pipeline included, with further schemes currently being worked up.
- In the table above the Trust has reflected delivery of £13.5m of savings in 2024/25. This is the full year effect figure that will be delivered recurrently. Due to the start date of CIP schemes this creates a mis-match between the 2024/25 impact and the recurrent full year impact.
- At Month 7 the Trust is showing a £6.6m adverse variance for delays due to in year delivery of CIP, which reflects the fact that schemes delivered by month 7 are not currently impacting the year to date position. The I&E impact of this is being managed through vacancy factors in funded budgets and delays on implementing investments.

£ m	Plan	Delivery	Variance
Recurrent Impact	14.7	13.5	(1.6)
Year to Date Impact	14.7	8.1	(6.6)

Capital

Expenditure	FY Funding (£m)	FY Forecast (£m)	FY Forecast Variance (£m)	YTD Spend (£m)
Divisional Schemes	3.8	3.6	(0.2)	0.6
CRISP Schemes	3.7	5.1	1.4	1.0
IM&T Schemes	2.7	2.7	(0.0)	0.8
Medical Equipment	3.2	3.9	0.7	0.6
Sustainability Schemes	1.9	1.9	(0.0)	0.0
Core Spend	**15.3**	**17.1**	**1.8**	**2.9**
HCID Doors PDC	0.1	0.1	(0.0)	0.0
Digital Pathology PDC	1.0	1.0	0.0	0.0
Digital Imaging PDC	0.2	0.4	0.2	0.0
IR Lab 4 Replacement Bi Plane PDC	1.5	1.5	0.0	0.0
Subtotal	**18.0**	**20.0**	**2.0**	**2.9**
Elective Centre	37.3	37.3	0.0	10.0
Total	**55.3**	**57.3**	**2.0**	**12.9**
Charity & Grant Funded	0.5	0.5	0.0	0.3
Leases	10.9	10.9	0.0	0.1
PFI Lifecycle	1.5	1.5	0.0	0.1
Grand Total	**68.2**	**70.2**	**2.0**	**13.5**



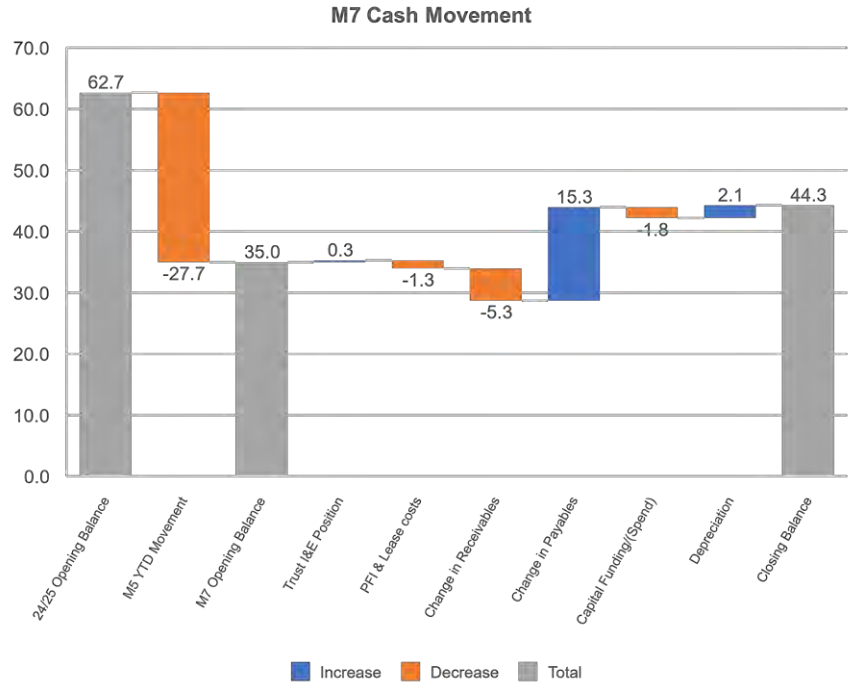
- The capital plan is currently over-programmed by £2.0m against projects funded within the Trust's core capital envelope and by national funding.
- While the capital plan is currently over-programmed, the Capital Planning Group is confident that it can be mitigated back to the funding envelope by the end of financial year.
- The spend year to date is driven by the Elective Centre project, £10.0m, with spend on Fire Integrity £0.8m, EPMA £0.5m, and Cyber Security £0.4m the other projects of note.
- Medical Equipment of £0.5m has been delivered so far this year, of which £0.4 relates to the Mobile Brain Lab equipment.
- The in-year variance to forecast is driven by reduced construction cost spend on the Elective Centre, for which mitigations are being requested from the supplier. Due to the profile of the project showing significant spend in the final quarter of the year, additional mitigations have been identified should they be required.
- Overall spend on the Elective Centre project is currently £20.5m, of which £16.3m relates to the main construction contract. Year to date spend is £10.0m, of which £9.3m is on the main construction contract.

Capital Large Project Update

Capital Project	£m					
	Approved Budget	Pre 24/25 Spend	Forecast 24/25 Spend	Forecast Future Year Spend	Forecast Total Project Spend	Variance
Southmead Elective Centre	49.9	10.5	37.3	2.1	49.9	0.0
CT Scanner	1.6	1.4	0.3	0.0	1.7	(0.1)
MRI Scanner	2.0	0.0	2.0	0.0	2.0	(0.0)
IR3 Biplane	1.8	1.5	0.3	0.0	1.8	(0.1)
Fire Integrity	3.3	2.9	1.4	0.0	4.3	(1.0)
Mortuary Extension	2.3	0.2	2.1	0.0	2.3	(0.0)
Level 0 CT Scanners	2.2	0.0	0.8	1.4	2.2	0.0
PSDS Wave 3c	8.3	0.0	1.0	7.3	8.3	0.0
SSD Washer Replacement	1.4	0.0	0.7	0.7	1.4	0.0
EPMA	2.6	0.4	1.8	0.5	2.7	(0.1)

- The above table presents the current capital projects with the budget of over £1.0m.
- The Trust has been approached by NHS England to ascertain whether we can use additional funding this year relating to the fire integrity project. CPG are looking into the feasibility of this and once a decision is reached a new case will be presented.
- Previous versions of the CT Scanner and IR3 Biplane Business Cases were based on provisional figures received from The Hospital Company. These figures have now been finalised and updated business cases are expected.
- The EPMA project has identified further cost pressures and are currently in the process of confirming forecast costs of equipment linked to the project. An updated case will be presented in Q4 if required.

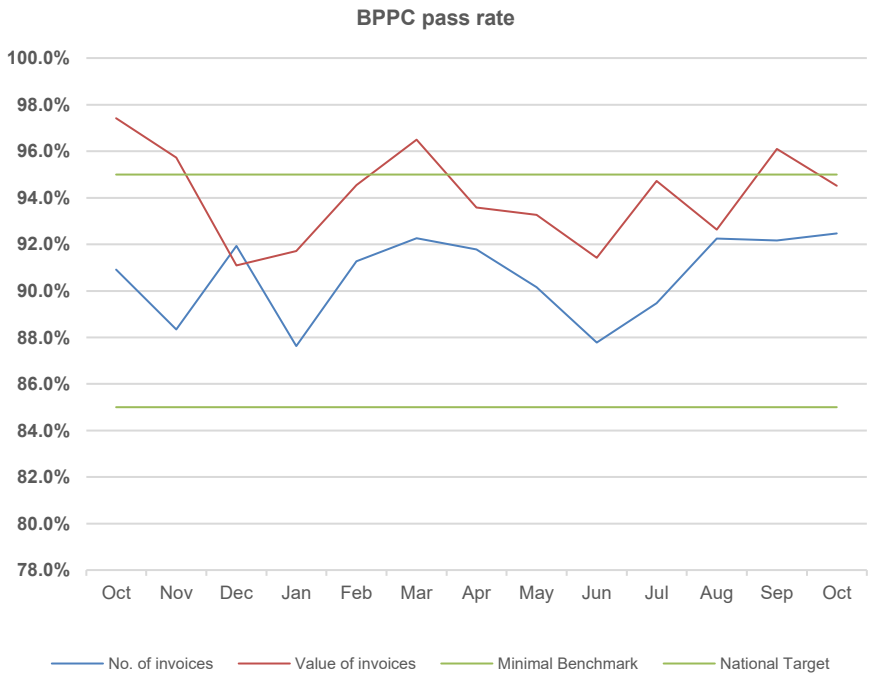
Cash Position

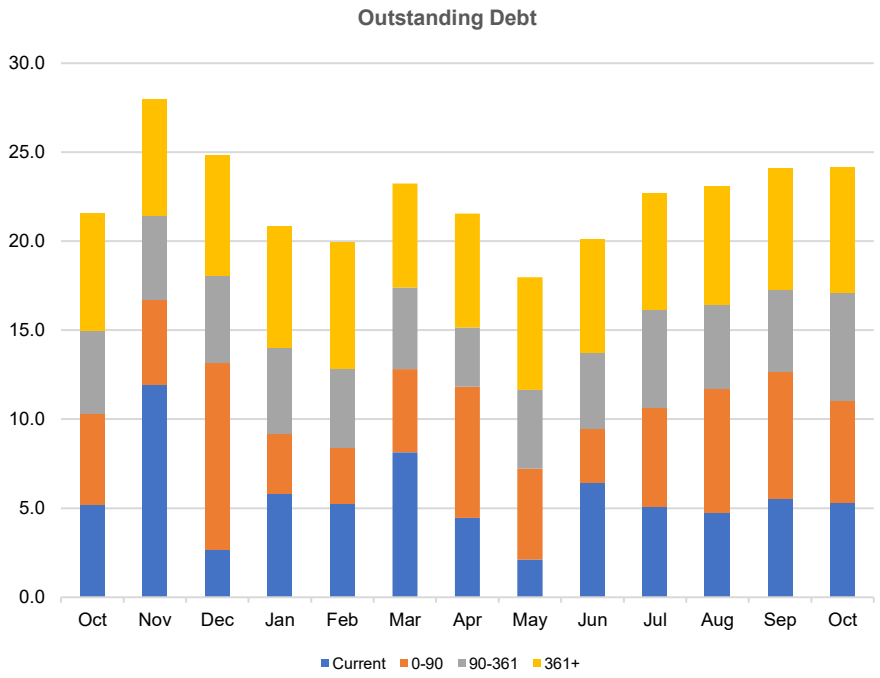


- In month cash is held at £44.3m, which is a £9.3m increase from Month 6 driven by Education income received in month.
- The cash balance has decreased by £18.4m year to date which is driven by the I&E deficit, capital expenditure and delays in payment of invoices relating to 2023/24.
- The cash position is forecast to reduce to approximately £14.0m. This is a reduction of £10.0m from plan due to the increased capital expenditure approved in July's CPG based on the additional non-cash backed funding allocation.

N.B. Change in payables includes deferred income but does not include change in capital payables as this is included in capital spend. Change in Receivables also includes movements in inventories.

BPPC and Debt position





- BPPC pass rates continues to outperform minimum benchmark of 85%. In September, the value performance increased above the national target of 95% due to the timely payment of large value invoices
- The increase in debt is a result of delays in payments from Welsh Commissioners.
- 53% of the debt over 361 days (£3.8m) relates to Overseas patients and is fully provided for.

Forecast

Forecast

- As a result of the adverse positions within the BNSSG acute providers in the first quarter of the year, the ICS has enacted the local forecast outturn protocol.
- In NBT, a detailed forecast was undertaken at Month 3, with further reviews at Month 4 and Month 5, indicating actions were required to reduce current run rates in order to achieve the breakeven plan.
- In accordance with the forecast outturn protocol, NBT has undertaken a series of actions to improve the forecast position in year:
    - **External Review**
        - External peer review completed in September.
        - Internal Audit of workforce controls completed in September – which reported to Audit and Risk Committee in October.
    - **Internal Review of Financial Controls**
        - Financial Sustainability Board continues to monitor progress against CIP targets and meet monthly.
        - Grip and Control checklist assessed and actions underway as reported to Audit and Risk Committee in August
    - **Internal escalation measures**
        - In June, two divisions were put into financial escalation (Medicine and ASCR); in July, a third was added (NMSK) and in September the Facilities division also went into escalation.
        - Recruitment controls have been implemented across the Trust with all recruitment reviewed at an Executive Director or Deputy Director level depending on banding.
- These actions have allowed the Trust to mitigate an initial forecast deficit of £28.8m in June to a forecast deficit of £11.1m in September. Further additional income mitigations identified through the ICS forecast review process would bring the forecast deficit down to £6.6m.
- Following Month 6 a detailed forecast was completed to ensure this reflected the anticipated £6.6m deficit. Initial review highlighted that the outturn reflected was £12.9m driven by pay and non-pay run rate reductions being less than anticipated. Divisions have been given additional targets to ensure the £6.6m is achievable. The Trust is monitoring Divisional performance on a monthly basis and further corrective actions will be implemented if any deterioration is seen.
- The Trust is currently reviewing other opportunities to further close the gap from £6.6m deficit to a breakeven position.
- A detailed review of organisations' forecast outturn positions was undertaken across the ICS during September indicating a System position of less than £10m deficit. A decision has been taken within the system that this is manageable, and we will continue to work together to find further mitigations to deliver a breakeven position. Therefore, no further escalation with NHSE will be required at this stage.
- Actions to further mitigate the deficit risk will be developed in coming months.

Forecast position	Month 3	Month 5	Month 6	Month 6 adjusted for additional income	Further mitigations
Deficit	(28.8)	(15.0)	(11.1)	(6.6)	0.0

Risks & Mitigations

NHS North Bristol NHS Trust

Issue	YTD Position £m	FOT £m	Risk	FOT £m	Mitigations	FOT £m	Actions
Under delivery of in year savings	-6.6	-9.6	Continued under delivery of CIP	-1.6	Delivery of pipeline items, with CIP Board holding divisions account.	1.6	Continued organisational focus on CIP identification and delivery
Non-recurrent Income (planning assumption	0.0	4.5	Trust unable to identify source of income	-2.0	Continued engagement with commissioners	2.0	Continued engagement with commissioners to identify additional income opportunities
In year surplus on pay	0.4	5.0	In year pressures continue	-3.6	Divisional pay targets introduced	3.6	Monitor the impact of controls
In year pressures on non-pay	-6.0	-12.9	In year pressures continue	-2.0	Divisional run-rate reduces	2.0	Monitor the impact of controls
Delays in investments	4.4	-1.7					
Contract and Other Income	2.8	3.2					
Non-recurrent mitigations	0.0	5.7					
Other	1.5	-0.8					
Further actions to be developed						6.6	
Total	**-3.5**	**-6.6**		**-9.2**		**15.8**	

- There is a risk that the cost pressures which have arisen or increased in 2023/24, and which have not been funded externally will risk the Trust's ability to breakeven in 2024/25 if action is not taken to reduce them. TLR 1896.
- There is a risk that the savings requirement of a 3.7% recurrent delivery is not achieved in 2024/25. This is due to an insufficient level of cost releasing and productivity savings being delivered. TLR 1887.
- There is a risk that the Trust will not receive the full £10m of non-recurrent income assumed in the 2024/25 plan, currently with unidentified sources. Risk ID 1924.
- The Trust is actively working to mitigate the risks to delivery of a breakeven position through the escalation process and the introduction of enhanced controls and will consider further actions where necessary.

- As noted in the previous slide the Trust has an expected £6.6m deficit position for 2024/25.
- The table above highlights that there are a further £9.2m of risks within this position which are currently offset by £15.8m of mitigations.
- Within this a further £6.6m of actions need to be identified.

Appendix – Financial Statements

Income and Expenditure: Main Heading

	Month 7			Year to Date		
	Budget	Actual	Variance	Budget	Actuals	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	81.4	84.3	2.9	492.5	501.8	9.3
Other Income	6.1	15.0	8.9	41.7	66.8	25.1
Total Income	**87.5**	**99.3**	**11.7**	**534.2**	**568.6**	**34.4**
AHP's and STT's	(8.7)	(8.7)	0.0	(51.5)	(50.0)	1.5
Medical	(20.4)	(20.9)	(0.5)	(101.9)	(106.1)	(4.2)
Nursing	(20.5)	(20.9)	(0.5)	(125.7)	(123.5)	2.1
Other Non Clinical Pay	(9.4)	(11.8)	(2.4)	(56.6)	(69.8)	(13.2)
Total Pay	**(58.9)**	**(62.3)**	**(3.4)**	**(335.6)**	**(349.3)**	**(13.8)**
Drugs	(4.8)	(6.5)	(1.6)	(34.7)	(37.7)	(3.1)
Clinical Supplies (Incl Blood)	(5.6)	(6.0)	(0.4)	(36.7)	(42.0)	(5.3)
Supplies & Services	(6.4)	(7.8)	(1.4)	(45.2)	(53.2)	(8.0)
Premises Costs	(9.2)	(10.8)	(1.6)	(65.6)	(69.1)	(3.4)
Other Non-Pay	(2.5)	(5.6)	(3.1)	(18.9)	(23.2)	(4.3)
Total Non-Pay Costs	**(28.6)**	**(36.6)**	**(8.0)**	**(201.1)**	**(225.2)**	**(24.1)**
Surplus/(Deficit)	**0.0**	**0.3**	**0.3**	**(2.5)**	**(6.0)**	**(3.5)**

- Detailed Trustwide month 6 and year to date position shown by key headings. This shows further detail from the table shown on slide 2.

Statement of Financial Position

	23/24 Month 12 £m	24/25 Month 06 £m	24/25 Month 07 £m	In Month Change £m	YTD Change £m
Non-Current Assets	**538.4**	**535.6**	**536.9**	**1.3**	**(1.4)**
Current Assets					
Inventories	11.7	12.0	11.8	(0.2)	0.1
Receivables	49.4	60.5	66.0	5.6	16.6
Cash and Cash Equivalents	62.7	35.0	44.3	9.3	(18.4)
Total Current Assets	**123.8**	**107.4**	**122.1**	**14.7**	**(1.7)**
Current Liabilities (< 1 Year)					
Trade and Other Payables	(99.9)	(81.3)	(89.9)	(8.6)	(10.0)
Deferred Income	(14.4)	(19.2)	(27.7)	(8.5)	13.3
Financial Current Liabilities	(23.6)	(23.6)	(23.6)	0.0	(0.0)
Total Current Liabilities	**(138.0)**	**(124.1)**	**(141.2)**	**(17.1)**	**3.2**
Non-Current Liabilities (> 1 Year)					
Trade Payables and Deferred Income	(6.2)	(6.6)	(6.6)	0.0	0.4
Financial Non-Current Liabilties	(571.8)	(588.3)	(586.6)	1.7	14.8
Total Non-Current Liabilities	**(578.0)**	**(594.9)**	**(593.2)**	**1.7**	**15.2**
Total Net Assets	**(53.7)**	**(76.0)**	**(75.3)**	**0.6**	**(21.6)**
Capital and Reserves					
Public Dividend Capital	485.2	492.5	492.5	0.0	7.3
Income and Expenditure Reserve	(541.8)	(610.8)	(610.8)	0.0	(69.0)
Income and Expenditure Account - Current Year	(69.0)	(29.5)	(28.9)	0.6	40.1
Revaluation Reserve	71.9	71.9	71.9	0.0	0.0
Total Capital and Reserves	**(53.7)**	**(76.0)**	**(75.3)**	**0.6**	**(21.6)**

Items to note:

Non Current Assets: Movements driven by capital expenditure are offset by in-year depreciation and amortisation.

Inventories: Minimal year-to-date movement driven by Pharmacy.

Receivables: The year-to-date movement is driven by the prepayment of large value invoices for Clinical Negligence Scheme contribution and the maintenance contracts, which are expected to reduce over the year.

Cash and Cash equivalents: Please refer to the detailed analysis of key movements on Slide 16.

Trade and Other Payables: The year-to-date movement is driven by paying major year-end balances, such as business rates and capital project invoices.

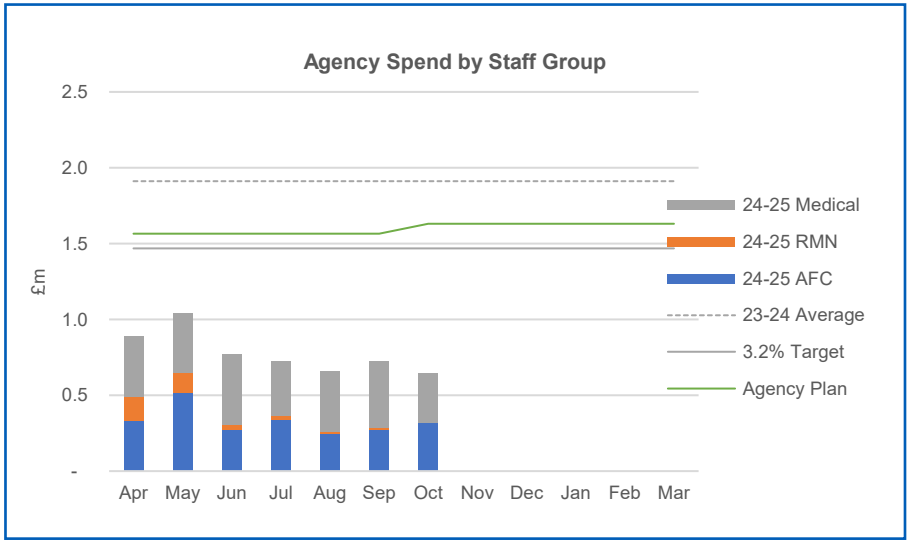
Deferred income: The year-to-date and in-month movements follow a regular cycle of payments in advance from Health Education England, Research Grants and Commissioners.

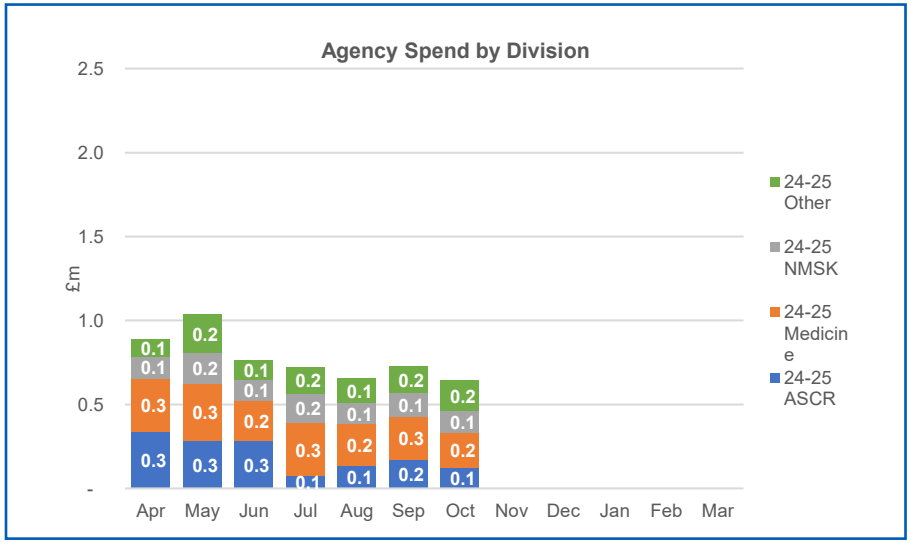
Financial Liabilities: The year-to-date movement relates to recognition of annual PFI liability remeasurement of £26m based on the applicable inflation rate offset by the year-to-date repayments.

Income and expenditure reserve: The year-to-date movement represents a rollover of the final I&E balance from the prior year.

Income and expenditure account - current year: The year-to-date movement represents the cumulative year-to-date I&E position including below control total items, such as annual PFI liability remeasurement of £26m.

Pay: Temporary Staffing Agency





Note: 3.2% target is calculated based on 2024-25 budgeted pay expenditure. The final figure is based on 3.2% of 2024-25 outturn, which will not be known until Month 12.

Agency analysis

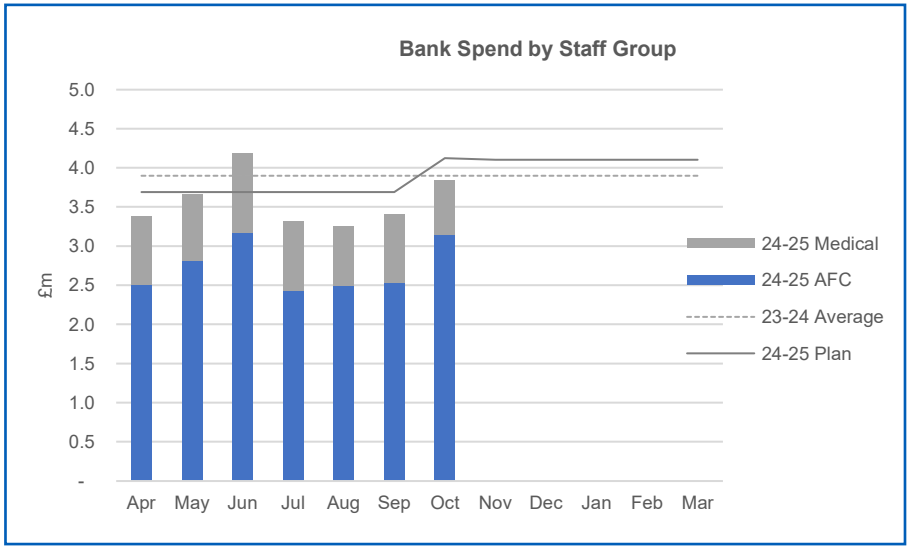
Monthly Trend

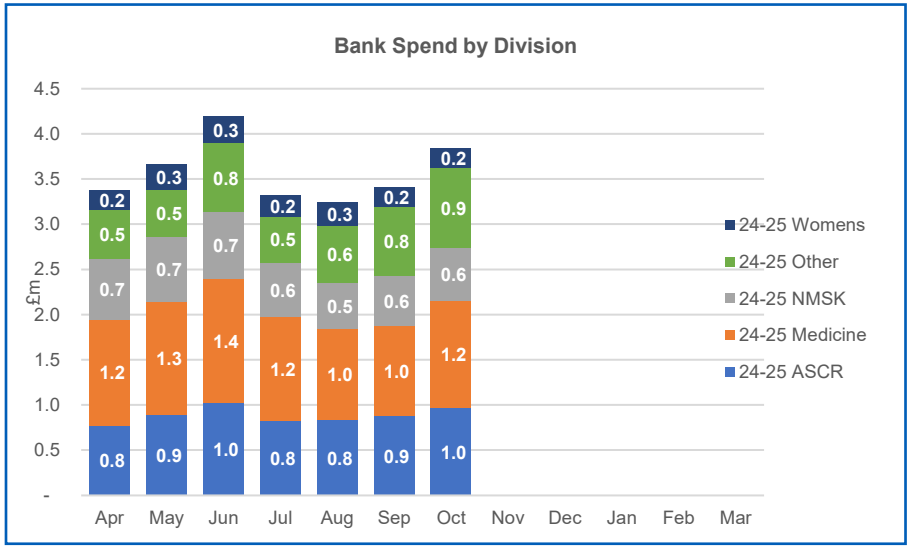
- Agency spend in October has remained in line with the reduction seen in the last few months, driven by the additional controls put in place.
- Against the 3.2% Agency target the Trust is at 1.0% in month and cumulatively the Trust is at 1.6%
- Overall spend in month is driven by consultant agency usage in NMSK, ASCR, and Medicine covering vacancies.

In Month vs Prior Year

- Trustwide agency spend in October is significantly below 2023/24 spend. This is due to increased controls being implemented across divisions as well as the introduction of the agency rate card across the region.

Pay: Temporary Staffing Bank





Bank analysis

Monthly Trend

- In October, the 2024/25 Pay Award was applied retrospectively to Bank pay in the year to a value of £0.8m. Excluding this bank spend would have continued to show a reduction against trend in line with the implementation of additional Trustwide controls (£3.1m). This has been seen across ASCR, Medicine and NMSK. Whilst bank spend in nursing and HCA has shown an improvement, this has been offset by increased escalation across the Trust in October.
- Included in Other is the impact of Locums Nest arrangements (£0.1m), where the Trust's doctors work shifts for other local providers. These costs are recharged and so do not represent additional cost to the Trust.

In Month vs Prior Year

- Bank spend in month is lower than 2023/24 spend. This is driven by decreases in escalation across the clinical divisions, and the application of additional Trustwide controls.

NHS North Bristol NHS Trust

Appendix 2 - 2025/26 System Planning High-Level Timeline

System Timeline
NBT Timeline

	Q2	Q3			Q4		
	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Update Medium Term Financial Plan							
Agree System Capital prioritisation process							
Draft long term workforce plan							
Contract Stocktake							
Stand up weekly Planning Huddle							
Meet with DODs/FBPs on approach							
EMT Approval of Business Planning Process		16-Oct					
System 'Launch' Workshop		22-Oct					
Establish baseline for 25/26 plans based on current position							
Undertake System capital prioritisation process							
Agree system planning assumptions, parameters & objectives							
Develop plan for incorporating delegation of Spec Comm							
Draft Major updates to Joint Forward Plan							
NBT 'Launch' Session			11-Nov				
Focus workshops, as required							
Agree Planning assumptions, parameters & objectives							
Planning Day 1 - Updated JFP content, Op Plan assumptions, risks							
Confirm budgets to HCIG/directorate level, incl savings targets							
National Guidance Published (Estimated)							
Triangulation Process							
Capital Plan				Agreed System Plan			

NHS North Bristol NHS Trust

	Q2	Q3			Q4		
	Sept	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
SOFP and Cash						Final position	
Patient First		Trust Executives to agree / revise breakthrough objectives	Identify their improvement priorities	Project Filter prioritisation	incorporate into divisional business plans	Final Plans agreed	
Workforce Plan			Refresh Model, cross cutting assumptions development	Divisional Workshops – review model and agree adjustments	Final assumptions, adjustment - People & EDI Committee / People Oversight Group	Final refresh and long term plan	
GooRoo Model	Focus on top 5 services	integrate improvements		Develop Keep up with Demand Model	Check Challenge	Conversion to National Format	
Activity Model		ED and NEL Plan discussion		Baseline Position	Sense Check	Build in Agreed position	
CIP Plan		Presentation of CIP target to FS Board 9-Oct	Presentation of CIP reporting structure to FS Board on the 13-Nov	Initial Plans to be submitted via Divisional Finance Review meetings	Presentation of Initial Plans to FS Board	Final Plans agreed and all loaded to Tracker.	
Finance Plan (Cost Pressure)				Submission by Div	Approved CP		
Finance Plan (Growth)					Submission by Div	Approved	
Finance Plan (I&E/Budget Rollover)						Culmination of above	
Divisional Planning Session 1				Initial draft - discussion			
Planning commences for Cancer Alliance							
Planning Drop–in sessions							
Assimilate guidance – gap analysis							
Joint Forward Plan sign off							

	Q2	Q3			Q4		
	Sept	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Confirm and approve System Capital Prioritisation Plan							
Independent Sector Plans							
Finalise Contracts							
EMT update					15-Jan		
FPC & Board latest position (Approve delegated authority proposal to allow CFO/COO for any final changes)					National guidance/latest position FPC 23rd Jan TB 30th Jan - delegated authority		
Divisional Planning Session 2					Jan Monthly Finance Meetings - Opportunity to Check/Challenge		
System Plan Submitted to ICB							
Divisional sign off						Draft Plan sign off – late February	
Trust Board sign off – with any late changes to be delegated to CFO/COO.							March Sign off
Final Planning Day - Review system plan							
Sign off Final system plan							
Submit Final system plan to NHSE							
Joint Forward Plan published							