Trust Board Meeting in Public

Thursday 25 July 2024, 10:00 – 13:10
Seminar Rooms 4 & 5, Learning & Research Building, Southmead Hospital

A G E N D A

No.	Item	Purpose	Lead	Paper	Time
OPENING BUSINESS					
1.	Welcomes and Apologies for Absence	Information	Chair	Verbal	10.00
2.	Declarations of Interest	Information	Chair	Enc.	-
3.	Patient Story	Discussion	Chief Nursing Officer	Enc.	10.01
4.	Questions from the public	Discussion	Chair	Verbal	10.25
STANDING ITEMS					
5.	Minutes: Public Board: 30 May 2024	Approval	Chair	Enc.	-
6.	Action Log	Approval	Trust Secretary	Verbal	-
7.	Matters Arising	Discussion	All	Verbal	-
8.	Chair's Briefing	Information	Chair	Enc.	10.35
9.	Chief Executive's Briefing	Information	Chief Executive	Enc.	10.45
STRATEGIC					
10.	Patient Experience Annual Report and Strategy Delivery Update	Discussion	Chief Nursing Officer	Enc.	11:00
BREAK (5 mins)					11.15
11.	Mental Health Strategy	Approval	Chief Nursing Officer	Enc.	11.20
12.	Equality, Diversity, and Inclusion Plan Progress Update	Discussion	Chief People Officer	Enc.	11.35
QUALITY					
13.	Quality Committee Upward Report	Information	NED Chair	Enc.	11.45
14.	Learning from Deaths Annual Report	Information	Chief Medical Officer	Enc.	11.50
15.	Patient & Carer Experience Committee Upward Report	Information	NED Chair	Enc.	11.55
BREAK (5 mins)					12.05
PEOPLE					
16.	People & EDI Committee Upward Report 16.1. Health & Safety Annual Report 16.2. Appraisal Rates	Information	NED Chair	Enc.	12.10
17.	Guardian of Safe Junior Doctor working hours	Discussion	Chief Medical Officer	Enc.	12.20
FINANCE, IM&T & PERFORMANCE					
18.	Integrated Performance Report	Discussion	Chief Operating Officer	Enc.	12.30

19.	Finance, Digital & Performance Committee Upward Report 19.1. Finance Report Month 3	Information	NED Chair	Enc.	12.50
CLOSING BUSINESS					
20.	Any Other Business	Information	Chair	Verbal	13.00
21.	Date of Next Meeting: 26 September 2024	Information	Chair	Verbal	-
22.	Exclusion of the Press and Public	Approval	Chair	Verbal	-
END					**13.05**

Lunch	**13.10 - 13:30**

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)
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 of the British Medical Association. • Member, Barts Charity Grants Committee. • Shareholder (more than 25% but less than 50%) Talking Health Limited.

Name	Role	Interest Declared
		Indirect Interests (ie through association of another individual eg close family member or relative) via Graham Rich who is: - Chair, Armada Topco Limited. - Director, Talking Health Ltd. - Chair, EHC Holdings Topco Limited.
Dr Jane Khawaja	Non-Executive Director	• Employee and Member of the Board of Trustees, University of Bristol. • Director of Gloucestershire Cricket Foundation. • 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 charity). • Visiting Professor to the University of the West of England (unremunerated).
Mr Steve Curry	Chief Operating Officer	• Nothing to declare.
Mr Tim Whittlestone	Chief Medical Officer	• Director of Bristol Urology Associates Ltd: undertakes occasional private practice (Urology Specialty) at company office, outside of NBT contracted hours. • Chair of the Wales and West Acute Transport for Children Service (WATCh). • Vice Chair of the South-West Genomic Medicine Service Alliance Board. • Wife is an employee of the Trust. • Director of 3RO Ltd (providing medical advice to international NGOs etc).

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.
Mr Neil Darvill	Chief Digital Information Officer (to NBT and UHBW) (non-voting position)	• Wife works as a senior manager for Avon and Wiltshire Partnership Mental Health Trust. • Stepbrother is an employee of the Trust, working in the Cancer Services Team.
Mr Peter Mitchell	Interim Chief People Officer (non-voting position)	• Nothing to declare.

NHS North Bristol NHS Trust

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Report To:	Public Trust Board			
Date of Meeting:	25 July 2024			
Report Title:	Patient Story			
Report Author:	Emily Ayling, Head of Patient Experience Marion Copeland, Infant Feeding Specialist Midwife			
Report Sponsor:	Steve Hams, Chief Nursing Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
	X	**X**		
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
		X	**X**	
Recommendations:	The Board is asked to reflect on Jada's story			
Report History:	None			
Next Steps:				

Executive Summary		
Jada's story is about her experience of feeding support from the midwifery staff on Quantock Ward, Transitional Care, Community Midwifery, Cossham team and the Infant Feeding Team. Jada's experience is a positive one and highlights the successes of the Maternity and NICU teams in this area and their ongoing work to go for gold standard in the UNICEF Baby Friendly Initiative re-assessment later this year.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	X
	High Quality Care – *Better by design*	X
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	X
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:		
Financial implications:	N/A	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No, the subject of the story to not likely to impact people from other groups.	
Appendices:	None	

DRAFT Minutes of the Public Trust Board Meeting held virtually and in Learning & Research Building, Seminar Room 4 on Thursday 30 May 2024 at 10.00am

Present:			
Michele Romaine	Trust Chair	**Maria Kane**	Chief Executive Officer
Kelly Macfarlane	Non-Executive Director	**Glyn Howells**	Chief Finance Officer
Richard Gaunt	Non-Executive Director	**Steven Hams**	Chief Nursing Officer
Jane Khawaja	Non-Executive Director	**Neil Darvill**	Chief Digital Information Officer
Shawn Smith	Non-Executive Director	**Steve Curry**	Deputy Chief Executive & Chief Operating Officer
Kelvin Blake	Non-Executive Director	**Dr Samir Patel**	Medical Director Workforce
Tim Whittlestone	Chief Medical Officer	**Jacqui Marshall**	Chief People Officer
		Peter Mitchell	Interim Chief People Officer
In Attendance:			
Xavier Bell	Director of Corporate Governance & Trust Secretary	**Elliot Nichols**	Director of Communications
Tomasz Pawlicki	Corporate Governance Officer (*minutes)*		
Presenters:			
Emily Ayling	Head of Patient Experience *(present for minute item TB/24/05/07)*	**Samir Patel**	Medical Director Workforce *(present for minute item TB/24/05/07)*
Benjamin Pope	*Head of Strategic Workforce Planning (present for minute item TB/24/05/11)*		

TB/24/05/01	**Welcome and Apologies for the Absence**	**Action**
	Michele Romaine, Trust Chair, welcomed everyone to the North Bristol Trust (NBT) Trust Board meeting in public. Apologies were noted from Sarah Purdy, Non-Executive Director.	
TB/24/05/02	**Declarations of Interest**	
	No Declarations of Interest were received relating to the agenda, nor were any updates required to the Trust Board register of interests as currently published on the NBT website and annexed to the Board papers.	
TB/24/05/03	**Minutes of the previous Public Trust Board Meeting**	
	Kelvin Blake, Non-Executive Director, requested that the minutes be corrected to confirm his attendance at the March meeting. **RESOLVED that subject to this amendment, the minutes of the Public Meeting held on 28 March 2024 were approved as a true and correct record of proceedings.**	
TB/24/05/04	**Action Log and Matters Arising from the Previous Meeting**	
	Xavier Bell, Director of Corporate Governance & Trust Secretary, presented the action log and noted that action. Action no. 87 Steve Hams, Chief Nursing Officer, noted actions taken by the Nursing teams and Safety Champions to visit the Community Midwife sites, ensuring that North Bristol Trust staff know the right escalation processes in case of safety issues.	

	Glyn Howells, Chief Finance Officer, outlined that all the leases that the Trust have in the Community areas had been reviewed and noted work with the Women & Children's Health (W&CH) divisional leadership on ensuring clarity on responsibilities within those leases for security, access, etc. It was agreed that action no. 87 would remain open. Action no. 88: Steve noted that an update would be provided at the June 2024 Quality Committee meeting. **RESOLVED that the updates to the Action Log were noted and no matters arising were raised.**	
TB/24/05/05	**Chair's Business**	
	Michele Romaine provided an update on the Chair's Business and outlined her latest visits, including Infection Diseases Team, Rheumatology, Haematology and Same Day Emergency Clinic (SDEC). Michele highlighted the SDEC demands and that the majority of patients are diverted to the clinic from GP's. Michele noted her attendance at the National Improvement Conference in London and commented on the expansion of continuous improvement across the NHS. She also noted comments at the conference on the national Freedom To Speak Up (FTSU) arrangements. Michele highlighted the change in focus of FTSU, with it now bening used more for workforce and team-related concerns, and not the patient safety issues that it was originally set up to manage. **RESOLVED that the Chair's briefing was noted.**	
TB/24/05/06	**Chief Executive's Briefing**	
	Maria Kane, Chief Executive, presented the Chief Executive's Briefing. In addition to the content of the written report, the following was noted: • Performance - The ongoing high levels of activity within urgent and emergency care. Maria noted improved performance in cancer areas • The Industrial Action – British Medical Association (BMA) was balloting General Practitioners (GP) to vote for strike action following the recent GP contract 2024/25 changes. • The Mortuary Incident – The Trust received results of the review untaken by The Human Tissue Authority (HTA), actions and mitigations had been in place and the incident was now closed. • Publication of the Infected Blood Inquiry Report – Amanda Pritchard, Chief Executive Officer (CEO) of NHS England, had issued an apology on behalf of the NHS to all those affected. NHS Trusts had received an official guide with steps on responding to the Infected Blood Inquiry report. • Visits to Ward 27A (Cardiology) with Shawn Smith, Non-Executive Director, noting the positive engagement with Cardiology services at University Hospital Bristol & Weston (UHBW). Maria thanked Michele for her work as the Trust Chair, her dedication to NBT and her focus on visibility and working with the staff in the organisation. She congratulated Michele on her many achievements and positive work on many levels. *Emily Ayling, Samir Patel, Jake and his mother Jo joined the meeting* **RESOLVED that the Chief Executive's briefing be noted.**	
TB/24/05/07	**Patient Story**	

	Steve Hams, Chief Nursing Officer, introduced the Patient's Story and welcomed Emily Ayling, Head of Patient Experience, Samir Patel, Medical Director of Workforce, patient Jake and his mother Jo. After brief introductions, Samir presented the Patient's Story and Jake's pathway. Jake was admitted to Southmead Hospital in the early part of 2022 and was diagnosed with inflammatory disease. Jake required Intensive Care and was given plasma exchange treatment. Jo explained meeting the different teams at NBT and their support, highlighting the dedication that Samir and the various Teams had, along with staff on the ward and staff met throughout their stay. She explained how this had made their stay and treatments easier. Additionally, Jo mentioned the great communication with all the staff. Jo and Samir explained the treatment procedures Jake went through and the help he received from the Tissue Viability team and Physio while recovering after the operations. Jake and Jo highlighted the positive experience and the dedication that the staff presented towards helping Jake, they expressed thanks to every staff member they met in Jake's journey and particularly to Samir for his commitment. Michele thanked the family for the inspirational Patient Story and for coming to present it. Michele asked Jo if the team made her welcome as a support for her son and let her stay with him the whole time. Jo answered that there were no challenges with staying in the room, and highlighted as she was a nurse she had been able to support by changing the dressings and being with Jake the whole time. Kelvin Blake, Non-Executive Director, asked Jake if he had been offered any mental health support during and after his admission. Jake and Jo answered there had been several opportunities for Jake to see the Psychology Team. Maria Kane and Jake discussed his University experience and his future plans. Jake highlighted he was studying acting and expressed gratitude towards NBT staff without them he would not be able to continue his career. Sam noted that after intense investigations it was Covid was the cause of Jake's illnesses. *Emily Ayling, Samir Patel, Jake and Jo left the meeting.* **RESOLVED that the Board welcomed and noted the Patient's Story and thanked the team for an inspiring story.**	
TB/24/05/08	**Freedom To Speak Up (FTSU) Bi-Annual Report**	
	Hilary Sawyer, Lead Freedom to Speak Up Guardian, presented the FTSU report and highlighted that the report was written with the National Guidance and Standards. Hilary outlined the increased number of concerns and drew the Board's attention to the fact that there had been some concerns received from the W&CH division (unlike in previous reports). She noted no immediate patient safety concerns had been received. Hilary also flagged that there had been one allegation of disadvantageous treatment made by a member of staff, and that this would be investigated by a manager independent from the relevant area, and the FTSU Non-Executive Director kept informed. Hilary commented on the plan to employ an associate guardian which would help with the management of the number of concerns as well as more proactive work.	

	Peter Mitchell, Chief People Officer outlined the importance of creating an organisation where people feel free to come to their managers with their challenges and noted the great opportunity to improve this in NBT. Jane Khawaja, Non-Executive Director asked Hilary what support would be needed from the Trust Board. Hilary outlined that the connection of FTSU with the staff has improved and asked for executive support in walkarounds to promote FTSU visibility. Richard Gaunt, Non-Executive Director, queried how the responsibilities were distributed between guardians and champions. Hilary explained that as an FTSU Lead, she was managing most active cases as the other Guardians were volunteers and Champions are not involved in managing the concerns. Maria Kane noted the need to raise awareness of the FTSU reporting routes, particularly with the newly employed staff. Hilary confirmed that most staff who reached out to FTSU had already engaged with their managers. Following a discussion about the importance of triangulating data, Xavier provided reassurance that work of the People & Quality Triangulation Group would be formally reporting through to the People & EDI Committee and would also be covered in the bi-annual FTSU report. **RESOLVED the Board noted the FTSU Bi-Annual report and noted the updated progress on high-level actions from the organisational FTSU self-reflection review (from November 2023).**	
TB/24/05/09	**Quality Committee Upward Report**	
	Steve Hams, presented the Quality Committee Upward Report and highlighted key items: • Patient safety in Quarter four review • The Committee discussions on the use of Red Identification Bands: Visual Alert to Drug Allergy within the NHS, and whether NBT would adopt this approach • The Deteriorating Patient Update and ongoing work on identifying and escalating deteriorating patients • The update on ongoing work on psychological safety and health in theatres. • Women and Children's Health: Perinatal Quality Surveillance Matrix (PQSM) Quarter 4 report (including Perinatal Mortality Review Tool (PMRT) Q4 report and Avoiding Term Admissions into NICU (ATAIN) Q4 report) • The Quality and Safety Changes to Quality Governance Structures Steve highlighted the approval of the revised structure and terms of reference for the Patient Safety Group and noted that the Clinical Effectiveness and Outcomes Group (formerly the Clinical Effectiveness and Audit Committee) reviewed its terms in May 2024 and would present them to the Quality Committee for approval. Shawn Smith, Non-Executive Director, on behalf of Sarah Purdy, Non-Executive Director (Qualiy Committee Chair) updated the Board on great staff efforts in resolving and managing incidents which took place at the Bristol Royal Infirmary (BRI) on Friday 3 May and the impact, with the BRI's emergency department patients having to be diverted to Southmead Hospital.	

	RESOLVED that the Board noted the Quality Committee Upward Report and the activities the Quality Committee has undertaken on behalf of the Board.	
TB/24/05/10	**People & EDI Committee Upward Report**	
	Kelvin Blake, NED and Committee Chair, presented the People & EDI Committee Upward Report and highlighted the following key areas that the Committee had covered: • Safe Staffing Nursing and Midwifery assurance reporting • Improvements in Operational Workforce metrics • Apprenticeship Centre Bi-Annual Report • Workforce Plan Update • Allied Healthcare Professional (AHP) Development Plan • NHS Staff Attitude Survey (NSS) Results – Key Follow-up Actions • EDI Action Plan and Staff Network Update • Draft Integrated Performance Report (IPR) format change for 2024/25 and the endorsement of the revised IPR structure. • Health & Safety Committee Upward Report Kelvin confirmed that the Committee had been generally assured with progress overall. Steve Hams highlighted positive engagement in nurse safer staffing, and highinghted that the Safer Nursing Care Tool (SNCT) had been updated by NHS England and noted the Committee acknowledged the clinical divisions' validation of their SNCT outputs using professional judgement. As a result, the need for an additional 22.28 Whole Time Equivalent (WTE) registered nurses had been identified, mainly for night shifts and ward safety. The Committee endorsed this request and noted that the Chief Nursing Officer was collaborating with the Chief Finance Officer to secure funding. Peter Mitchell highlighted that the Committee was asked to approve the revised IPR structure which was being aligned to the patient-first organisational priorities and with the work of the Divisional Performance Reviews (DPRs). Peter noted the endorsement from the Committee and outlined that the IPR data focused on workforce metrics, relation with staff and the disparity ratio, the percentage of staff employed residing in most challenged communities and the agency spending. Kelly Macfarlane, Non-Executive Director, noted the “We Do Not Accept” Campaign and positive engagement from staff in the organisation. *Benjamin Pope joined the meeting.* **RESOLVED that the Board noted the activities the People & EDI Committee undertaken on behalf of the Board. It was noted that the Board endorsed changes to the IPR and that the results will be feedback to the People team.** {Break}	
TB/24/05/11	**Long-Term Workforce Plan**	
	Benjamin Pope, Head of Strategic Workforce Planning presented the Long-Term Workforce Plan. Benjamin highlighted the update to the Long-Term Workforce Plan that was submitted to the Trust Board in October 2023 which focuses on the commitments made in the initial plan and highlights the next steps aligned with the NHS England Operational Planning processes. Benjamin highlighted the interventions and actions being taken across the following headings:	

	• Enhance Recruitment • Transform Teams • Grow Apprenticeships • Implement New & Extended Roles • Increase retention • Indicate Productivity Maria Kane queried the shortages of staff in some areas and asked if conversations with the divisional leads took place to address these challenges. Peter Mitchell provided reassurance on ongoing work with the divisions on the gaps in employment. Neil Darvill, Chief Digital Information Officer, commented on positive workforce planning processes and asked if the Long Term Plan had any collaborative objectives with UHBW. Benjamin explained that collaborative objectives were to be added to the Long Term Plan and provided reassurance on meetings in place and collaboration work with UHBW on aligning the focuses and the same sets of tools for both Trusts. Richard Gaunt queried Acute Collaborative apprenticeship work and management of apprenticeships in the future Hospital Group. Benjamin explained that plans were in place to see what changes needed to be implemented with collaborative work on apprenticeships and training. Michele commented on the ambition of the Long-Term Workforce Plan and the plan's positive direction. *Benjamin Pope left the meeting.* **RESOLVED that the Board noted the update on the progress against the actions described in the October 2023 Long-Term Workforce**	
TB/24/05/12	**Integrated Performance Report**	
	Steve Curry, Deputy Chief Executive & Chief Operating Officer, introduced the responsiveness section of the Integrated Performance Report (IPR), Steve outlined challenging ED attendance numbers, and the ongoing higher numbers of patients with no criteria to reside, as well as ongoing work on operational planning and Referral to Treatment (RTT) improvements. Steve Curry noted the challenges in Cancer services and the high demand, particularly in Skin cancer treatments and highlighted ongoing work on pathway revision. Steve positively noted improvements in diagnostics in outpatient areas and recruitment. <u>Quality, Safety and Effectiveness</u> Steve Hams highlighted no new Maternity and Newborn Safety Investigations (MNSI) cases during March 2024 and presented the data on the increases in pressure injuries and ongoing work to reduce the numbers of harm to patients, such as improvements in the ward's bathrooms. Steve noted the ongoing work on measles cases for adults treated in NBT and patient falls. Tim Whittlestone, Chief Medical Officer, highlighted ongoing work on the registration of medications on wards. <u>Patient Experience</u>	

	Steve Hams noted improvements in responses to complaints and positive response rates around outpatients. <u>Commissioning for Quality and Innovation (CQUIN)</u> Steve Hams highlighted positive work done on CQUIN and ongoing work to improve scheme CQUIN08 - Achievement of revascularisation standards Michele asked for updates on the staff vaccination hub. Tim Whittlestone highlighted positive engagement in the program but noted numerous staff members have their vaccinations done elsewhere such as their GP or pharmacies and there were limitations to how that data could be accessed and shared nationally. <u>Research and Innovation</u> Tim Whittlestone highlighted that NBT was now one of the top research active acute institutions in the country when looking at funding from the NIHR. <u>Workforce</u> Peter Mitchell highlighted the ongoing work on divisional reviews and filling the workforce gaps. Peter outlined the positive agency staff reduction numbers, positive mandatory training compliance and the new appraisal "Perform Online" system. Peter noted the ongoing rising numbers of appraisals and positive engagement from staff. It was agreed that data on appraisals will be provided at the next Trust Board meeting. <u>Finance</u> Glyn Howells noted a positive trajectory in the early year 2024/25 and was on a plan with CIP delivery with 5 million CIP by the end of quarter one. Glyn highlighted the ongoing reviews of the new finance set of rules and escalation processes. **RESOLVED that the Board noted the IPR report and agreed that data on appraisals will be provided at the next Trust Board meeting.**	PM/TP
TB/24/05/13	**Finance, Digital & Performance Committee Upward Report**	
	Richard Gaunt, Non-Executive Director and Committee Chair, presented the report and highlighted the key discussions: • The challenges the system faced delivering a financially balanced plan and the contingencies required to mitigate the risks to delivery. • The risk of delivering the 78% 4-hour standard and the commitment to achieve it on the conditionality of the system being able to meet 15% No Criteria to Reside (NC2R) and the Trust to maintain 92% bed occupancy. • The concerns regarding mental health and agency spending. • The importance of the narrative for productivity to focus on continuous improvement. Richard also highlighted that the Committee changed the name to Finance, Performance and Digital Committee to have more focus on digital processes and outlined the Financial performance for Month 1 2024/25. Richard outlined that the Committee received a Cancer Briefing presentation and provided assurance regarding the Trust's structure of cancer services. Richard highlighted Trust Level Risks, particularly in Urology services and Skin Cancer services and noted mitigations in place to love the risk rating.	

	Additionally, Richard noted the Committees support for the NBT Extended Digital Strategy 2023-2025. **RESOLVED that the Trust Board:** • **Received the report for assurance and note the activities Finance, Digital & Performance Committee has undertaken on behalf of the Board.** • **Note the key red-risk project which are unable to proceed due to lack of funding** • **Approval of the NBT Extended Digital Strategy 2023-2025 that the Committee requested.**	
TB/24/05/14	**Audit & Risk Committee Upward Report**	
	Shawn Smith, NED and Committee Chair, presented the Audit & Risk Committee Upward Report which outlined: - The ongoing External audit - The ongoing Internal audits, new regime and positive engagements from staff. - Cyber security updates and the risk in lack of funding to maintain strong cyber security in NBT Shawn requested the Trust Board approve the changes to the Standing Orders to reflect changes to the Charity approval and line management arrangements. Glyn Howells highlighted that the Trust received the draft Value for Money Order from Grant Thornton, which had five minor improvement opportunities and provided reassurance on ongoing work on these. **RESOLVED that the Trust Board:** • **Noted the report and the activities the Audit and Risk Committee has undertaken on behalf of the Board** • **Approve the changes to the Standing Orders and Standing Financial Instructions which were approved by the Committee (in relation to the line and budget management of the Southmead Hospital Charity).**	
TB/24/05/15	**Provider License Self-Certification**	
	Xavier Bell requested a sign-off of the Provider Licence Self-Certification. **RESOLVED that the Trust Board approved and signed off the Provider License Self-Certification**	
TB/24/05/16	**Any Other Business**	
	No business declared. Michele highlighted that Jane Khawaja took on the responsibility of acting as a champion for Schwartz rounds.	
TB/24/05/17	**Questions from the public**	
TB/24/05/18	**Date of Next Meeting**	
	The next Board meeting in public was scheduled to take place on Thursday 25 July 2024, at 10.00 a.m. Trust Board papers will be published on the website and interested members of the public are invited to submit questions in line with the Trust's normal processes.	

The meeting concluded at 12.52 pm

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

Trust Board - Public ACTION LOG

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

Meeting Date	Agenda Item	Minute Ref	Action No.	Agreed Action	Owner	Deadline for completion of action	Item for Future Board Meeting?	Status/ RAG	Info/ Update	Date action was closed/ updated
28/3/24	People & Equality, Diversity, and Inclusion (EDI) Committee Upward Report	TB/24/03/12	87	The Board agreed for update be brought back to the Board to provide assurance on the safety of community staff particularly regarding Midwifes given the recent incident.	Glyn Howells, Chief Finance Officer Steve Hams, Chief Nursing Officer.	May-24	Yes	Open	**21/05/24 -** A verbal update to be provided at the TB meeting on 30/05/2024 **30/05/2024 -** Steve Hams, Chief Nursing Officer, noted actions taken by the Nursing teams and Safety Champions to visit the Community Midwife sites, ensuring that North Bristol Trust staff know the right escalation processes in case of safety issues. Glyn Howells, Chief Finance Officer, outlined that all the leases that the Trust have in the Community areas had been reviewed and noted work with the Women & Children's Health (W&CH) divisional leadership on ensuring clarity on responsibilities within those leases for security, access, etc. It was agreed that action no. 87 would remain open. The update will be provided at the July Public Trust Board Meeting	30/05/2024
30/5/24	Integrated Performance Report	TB/24/05/12	90	Data on appraisals will be provided at the next Trust Board meeting.	Peter Mitchel, Interim Chief People officer/ Kelvin Blate, NED	Jul-24	Yes	Open	**09/07/2024** Update to be provided with the People & EDI Upward Report	15/07/2024

Report To:	Public Trust Board			
Date of Meeting:	25 July 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) and Rachel Bartlett, Senior Executive Personal Assistant to the Joint Chair			
Report Sponsor:	Ingrid Barker, Joint Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
		√		
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			√	
Recommendations:	The Trust Board is asked to receive and note the content of the briefing.			
Report History:	The Joint Chair's Briefing is a standing agenda item on all Board agendas.			
Next Steps:	Next steps in relation to any of the issues highlighted are shown in the body of the report.			

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Executive Summary		
The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events and visits.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	Not applicable	
Financial implications:	Not applicable	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No	
Appendices	N/A	

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 previous month.

3. Appointment of the Joint Chief Executive

Appointing the Joint Chief Executive across North Bristol Trust and University Hospitals Bristol and Weston Foundation Trust was the highest early priority for me as the new Joint Chair and I am delighted that Maria Kane's appointment has now been announced. This is a significant step forward in the move to form a Hospital Group between the two organisations. Maria's extensive experience as a Chief Executive and her track record in bringing about strategic change in partnership with others will be of huge benefit to us.

I would like to thank those colleagues and partners who played a part in this successful recruitment process. I know the Board will want to join me in congratulating Maria who will take up the role on 29th July.

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

The Joint Chair undertook a variety of visits during June 2024, in support of a planned induction programme, including:

- the Emergency Department, Acute Medical Unit and Same Day Emergency Care with Ella Chaudhuri, Clinical Director, Ben Hewlett, Divisional Operations Director, Annie Langford, Divisional Director of Nursing, and Anna Bell, ED Ward Manager
- the Research and Development team with Helen Lewis-White, Deputy Director of Research and Development
- the Transfer of Care Hub with Cathy Daffada, Associate Director for Integrated Discharge
- the Women's and Children's Health Division with Jane Mears, Clinical Director and Julie Northrop, Divisional Director of Midwifery and Nursing
- Ward 9b, Medical Division - Complex Care - with Lalu Abraham, Senior Sister and Shelley Panayiotou, Registered Nurse
- Cossham Estate Midwifery and Dialysis Unit with Joanna Karolewska, Community Midwife and Lisa Ford, Clinical Matron for Renal and Dialysis Services
- Pathology Labs with Dave Fisher, Director of Pathology
- Brunel Atrium with Volunteers and Move Makers, with Bwalya Treasure, Volunteer Service Manager and Jill Randall, Move Maker Volunteer Manager.

The Joint Chair undertook a variety of visits during July 2024, in continuation of this planned induction programme, including:

- Estates and Facilities teams with Tony Hudgell, Director of Operational Estates and Facilities, Matt Chick, Deputy Director of Estates and Facilities, Paul Jenkins, Associate Director of Estates and Facilities, Andy Kettle, Head of SOFT FM, Jeannette Baker, Senior FM Manager, Lisa Broderick, Senior Duty Manager for Domestics, Sharon Fortune, Senior Ops Manager, Craig Tolley, Head of Capital Projects.
- Hilary Sawyer, Freedom To Speak Up Lead.
- Sue Bourne, Joint Director of Safeguarding, Ashley Windebank-Brooks, Head of Patient Safety, Emily Ayling, Patient Experience and Complaints Team, Paul Cresswell, Director of Quality Governance.
- Fiona King, Union Representative and Shawn Fleming, Union Representative.
- IM&T walkaround, meeting a variety of staff hosted by Kath Kaboutian, Deputy Chief Digital Information Officer.
- Induction meetings with Executive Directors and Non-Executive Directors.

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

The Joint Chair undertook a variety of visits during May, before her employment contract started, and June 2024, in support of a planned induction programme, including:

- The Children's Hospital with Martin Gargan, Clinical Chair, Fiona Jones, Divisional Director, Rachel Hughes and Beth Shirt, Directors of Nursing;
- The Bristol Royal Infirmary Emergency Department and Same Day Emergency Care Unit with Rebecca Maxwell, Interim Chief Medical Officer, Clare Holmes, Clinical Chair, Lisa Galvani, Divisional Director and Angela Bezer, Director of Nursing (Division of Medicine);
- Hey Groves Theatres with Ashley Livesey, Divisional Director and Sarah Chalkley, Director of Nursing (Division of Surgery);
- Weston General Hospital, specifically the Emergency Department, SDEC, Seashore, Kewstoke and Hutton Wards, and OPAU;
- the Bristol Heart Institute, specifically Catheter Laboratories, Cardiac Critical Care Unit and Cardiac Surgery, with Rachel Protheroe, Clinical Chair, Owen Ainsley, Divisional Director, Jamie Cargill and Helen Bishop, Directors of Nursing (Division of Specialised Services);
- the Dental Hospital, with Ashley Livesey, Divisional Director, and Mark Stevens, Deputy Divisional Director (Division of Surgery);
- introduction and follow up meetings with Lead Governor, Mo Phillips;
- introduction meeting with Council of Governors;
- induction meetings with Executive Directors and Non-Executive Directors;
- UHBW Board Day where the Board of Directors came together to sign off the Annual Report and Accounts, as well as hold discussions on the Infected Blood Enquiry and a Digital update.

The Joint Chair undertook a variety of visits during July 2024, in continuation of a planned induction programme, including:

- Visit to Bristol Haematology and Oncology Centre with Rachel Protheroe, Clinical Chair, Owen Ainsley, Divisional Director, Jamie Cargill, Director of Nursing and Sophie Baugh, Deputy Divisional Director, Division of Specialised Services
- Visit to Neonatal Intensive Care Unit with Andy Jeanes, Director of Facilities and Estates
- Visit to Research and Development with Fergus Caskey and Diana Benton, Head of Research and Innovation
- Visit to St. Michael's Hospital with Martin Gargan, Clinical Chair, and Fiona Jones, Divisional Director, Division of Women's and Children's
- Visit to Laboratories and Radiology with Rachel Bennett, Clinical Chair, and Jenny Keeble, Divisional Director, Division of Diagnostics and Therapies
- Visit to Digital Services with Neil Darvill, Joint Chief Digital Information Officer, NBT and UHBW
- Introduction Meeting with Clare Haley, Workplace Wellbeing Manager
- Introduction Meeting with the Patient Safety Team and Anne Reader, Associate Director of Quality and Patient Safety
- Meet with UHBW Safeguarding Team with Sue Bourne, Director of Safeguarding, UHBW and NBT
- Introduction meeting with Staff Side
- Introduction to Patient First with Cathy Caple, Deputy Director of Innovation and Mel Jeffries, Continuous Improvement Programme Manager
- Induction meetings with Executive Directors and Non-Executive Directors.
- Meet with Valerie Clarke, Programme Director, Acute Provider Collaborative

5. Southmead Hospital Charity Event

The Joint Chair attended the Southmead Hospital Charity "Evening of Thanks" on 11 June 2024.

Attendees included Helen Lewis-White, Deputy Director of Research and Development, Sanjoy Shah, Deputy Chief Medical Officer, Donna Baber, Arts Programme Manager, Mario Teo, Consultant Neurosurgeon and Glyn Howells, Chief Finance Officer.

A wide variety of topics were discussed, including Charity-funded research, the Bristol ECMO Service, the Fresh Arts Programme and the Neurosurgery Robotic Microscope.

6. Clean Air Day Event

The Joint Chair attended the Clean Air Day event on 20 June 2024, with members of the Sustainability Team, led by Megan Murphy, Sustainability Manager.

7. Communications

The communications teams from both Trusts have been very helpful in making the above visits visible to our colleagues and to 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.

8. Connecting with our Partners

The Joint Chair undertook introductory meetings with a number of partners during June and July as follows:

- Jeff Farrar, Chair of Bristol, North Somerset and South Gloucestershire Integrated Care Board
- Dave Perry, Chief Executive Officer, South Gloucestershire Council
- Jo Walker, Chief Executive Officer, North Somerset Council
- Integrated Care Partnership Board Meeting

The Joint Chair undertook further introduction meetings with partners during July as follows:

- Ruth Hughes, Chief Executive Officer & Julia Ross, Chair, One Care.

Further meetings with partners are planned.

9. National and Regional Engagement

- Regular one to one ‘touch points’ with Elizabeth O’Mahony, NHS England Regional Director
- Meeting with Sir Ron Kerr, Chair of NHS Providers
- One to one meetings with four fellow ‘Group’ Joint Chairs to share experience and insight
- Attendance at the NHS Confederation National Chairs’ group meeting.

10. Summary and Recommendations

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

Report To:	Public Trust Board			
Date of Meeting:	25 July 2024			
Report Title:	Chief Executive's Briefing			
Report Author:	Suzanne Priest, Executive Co-ordinator			
Report Sponsor:	Maria Kane, Chief Executive			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			X	
Recommendations:	The Trust Board is asked to receive and note the content of the briefing.			
Report History:	The Chief Executive's briefing is a standing agenda item on all Board agendas.			
Next Steps:	Next steps in relation to any of the issues highlighted in the Report are shown in the body of the report.			

9

Executive Summary		
The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events, and key staff appointments.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	No	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No	
Appendices:	None	

1. Purpose

The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events, and key staff appointments during this month.

2. Background

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

3. Performance

In terms of urgent care, the Trust continues to have challenges in seeing some patients in our Emergency Department within the set four-hour target. Whilst July has seen an improvement against prior months this year, we are still working towards the target of 78%. A significant focus is on seeing all patients as quickly and as safely as possible. Through July we have seen an average of 23% of patients with no criteria to reside occupying our beds which heavily impacts our ability to manage flow through the hospital. Work continues in earnest with partners, focusing on facilitating discharge of patients who are medically fit to leave hospital.

Diagnostic performance continues to be above the national target across all modalities. Similarly, thanks to the extensive work of our clinical and operational colleagues, the Trust continues to make inroads into the cancer performance and elective recovery targets, working across the organisation, the system and beyond to help to ensure we can get patients treated as soon as possible.

There has been a significant rise in the number of cases of covid nationally and this is replicated in the hospital with numbers doubling from the end of June.

4. Industrial Action Update

The last round of junior doctor industrial action took place at the beginning of the month. Work was done by the operational teams to limit the impact of the strikes on our ability to continue to run services safely, but some activity had to be stepped down – although this was kept to a minimum to reduce the effects to our patients. There have not been any notices of further industrial action at this point.

5. Improving Quality in Allergy Services (IQAS) Accreditation

Following an inspection visit to the allergy service at NBT which took place in May, we have now received notice that we have been passed accreditation. This is a rigorous testing process which requires high standards to be demonstrated to be awarded the certificate.

6. Bristol Pride and the LBGTQIA+ Staff Network

Pride was celebrated again in Bristol over the last month with a number of our staff taking part in the Bristol Pride march in recognition of this annual festivity. I was able to meet with members of our own LGBQTIA+ staff network in the past couple of weeks to discuss

inclusion at NBT and hear first-hand about the experiences of LGBTQIA+ staff, volunteers, patients and visitors.

7. Commitment to Our Community Plan

We have launched our 'Commitment to Our Community' Plan which helps to identify how we will aim to build a workforce that truly reflects the vibrant diversity of our community. The plan focuses on increasing job opportunities in Bristol's most challenged areas, ensuring our workforce mirrors the local community's diversity. A key initiative is a pioneering community mentorship scheme which offers coaching, skills training, work shadowing, and apprenticeships.

8. Bristol Serious Youth Violence Board

I have been invited to sit on the newly convened Serious Youth Violence Board. This will meeting to consider the city's response to the continuing serious violence in Bristol. The Board has representatives from key partners in the city and include the Local Authority, Avon and Somerset Police, the Probation Service, NHS, Education Providers, Charities and Community Groups.

This work sits alongside the Trust's own meetings which have considered how we can help to reduce youth violence. Three working groups have been set up to direct the projects which have been identified by our roundtable attendees and are now delivering actionable work.

9. Engagement & Service Visits

I have had the pleasure of visiting colleagues in a number of areas this month:

- I was warmly welcomed at the Bristol Centre for Enablement where I was able to spend some time with the staff there that provide much needed supportive services for patients who need communication support, wheelchairs, prosthetics, and orthotics or assistive technology.
- I joined the Director of Operations for our ASCR Division and visited Park View Theatres which were brought on-site to allow essential maintenance work to take place in some of our Brunel theatres.
- I also met with volunteers from our very own move makers, ward support teams and the League of Friends staff that run the café on the ground floor of the Atrium.
- My consultant conversations continued this month with colleagues from Gastroenterology.

10. Summary and Recommendations

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

Report To:	Public Trust Board			
Date of Meeting:	25 July 2024			
Report Title:	Patient Experience Annual Report and Strategy Delivery Update			
Report Author:	Emily Ayling, Head of Patient Experience			
Report Sponsor:	Paul Cresswell, Director of Quality Governance Steve Hams, Chief Nursing Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
			X	**X**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
Recommendations:	The Board is asked to reflect on the activity of the Patient Experience team over the past twelve months and progress against the Patient and Carer Experience Strategy 2023-2026. The Board is asked to note the work plan for 2024/25.			
Report History:	The Patient Experience Annual Report and an update on Strategy Delivery was presented to the Patient and Carer Experience Committee in June 2024. The Annual Report has been published on our Trust website, staff intranet and shared internally. An accessible version has also been made available on our Trust website and staff intranet.			
Next Steps:	Continued delivery of plan for 2024-25 as outlined.			

Executive Summary
The report summarises the activity undertaken by the Patient Experience team to deliver year 1 of the Patient and Carer Experience Strategy 2023-2026. As the report details, thirteen objectives were set for year 1, and twelve were achieved. The only objective that was not achieved was 90% compliance for complaint response timeframes. Of the twelve objectives that were achieved there are several that we are particularly proud of including:

- The introduction of a real-time feedback programme – '*Patient Conversations'*
- Introduction of the Fresh Arts programme into the Patient Experience Team, which continues to demonstrate positive impact for patients, carers and staff.
- Successful implementation of a new quality governance system (Radar) for the management of complaints and PALS.
- Innovative work to understand the experience of seldom-heard voices in our local population and contribution to the Trustwide work on health inequalities
- Hosting of our first Faith Leaders Event.
- Introduction of two new volunteering roles in response to patient and volunteer feedback.
- Introduction of a Patient Experience Newsletter
- Successful embedding of a revised Patient Stories Framework, with impact at Board and sub committee level, aligned to strategic priorities.

In addition to all the new work, the patient experience team sustained its existing activity to a high standard.

The report sets out the plan for 2024/25 and objectives for delivery of year 2 of the Patient and Carer Strategy (see page 18 of the report).

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	X
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	X
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	X
Link to BAF or Trust Level Risks:	N/A	
Financial implications:	N/A	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No	
Appendices:	Appendix 1 - Patient and Carer Experience Annual Report 2023/24	

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NHS North Bristol NHS Trust

Patient and Carer Experience Annual Report 2023/2024

NHS North Bristol NHS Trust

Contents

1. Introduction

It has been an important year for Patient and Carer Experience at North Bristol NHS Trust (NBT). In August 2023 we launched our Patient and Carer Experience Strategy. This builds on our Trust Strategy aim to deliver 'Outstanding Patient Experience'.

The Patient and Carer Experience Strategy has allowed us to think ambitiously about how we can have the biggest impact on patient and carer experience.

The strategy focuses on four key commitments:

1. Listening to what patients tell us
2. Working together to support and value the individual and promote inclusion
3. Being responsive and striving for better
4. Putting the spotlight on patient and carer experience

Under each of these commitments are several objectives. These are broken down into sustain objectives (existing programmes of work where we're looking to continually improve) and stretch objectives (new programmes of work where we're looking to implement something innovative and different).

Alongside colleagues and our Patient and Carer Partners, we chose which of these objectives we wanted to prioritise for year 1. We devised a work plan to support the delivery of these objectives and will be sharing our progress on these through this report.

2. Listening to what patients tell us

Under this commitment, we will collaborate with patients to improve the patient experience by listening to and acting on what patients and their friends and family tell us would improve their experience. A key method for us to hear what patients are saying is through our survey programme which includes the Friends and Family Test, local surveys, and national surveys. As you will see below, however, there are limitations to the insight we can gain from these sources and this year we have challenged ourselves to think more creatively about how we can hear from patients and carers in different ways such as through a real-time feedback opportunity.

2.1 Friends and Family Test (FFT)

The FFT is a useful tool that allows people using our services to provide feedback on their experiences. We ask:

“Overall, how was your experience of our service?” and, “Please tell us why you gave your answer.”

Between 1st April 2023 to 31st March 2024, a total of 103,576 responses were received. This is an increase of 31% from last year. Our Trust-wide response rate has remained at 16% and we have improved our positive rating from 91.41% in 2022/23 to 92.67% in 2023/24. This is a significant achievement against the commitment ‘listening to what patients tell us’ and our objective to improve FFT scores.

The table below shows the positive score against each care domain. The arrow indicates whether this has improved, declined, or remained in line with the previous year.

2024/25	Response rate	Rating (positive)	Trajectory
Trust-wide	16%	92.67%	↑
Emergency Department	20%	80.03%	↑
Inpatients	22%	89.65%	↑
Outpatients	14%	95.08%	↑
Birth	27%	95.01%	↑
Day-case	21%	96.22%	↑

This year the top positive and negative themes for FFT remain unchanged. The top two negative themes, ‘Waiting time’ and ‘Communication’ align with the top themes we have heard through PALS concerns.

Aside from our objective to improve our FFT scores, we also had an objective to ensure that the FFT data given to front-line teams was reliable and reflective of their services. Since July 2023, we have not had any data quality issues with FFT. This means that we can confidently encourage staff to log in, review feedback and comments for their area of work and be assured

that this is accurate and reflective of their service. Whilst we are pleased to have made this progress, we still have much more work to do to ensure consistent use of FFT data by front-line teams so they can hear what patients are saying about their services and act on this.

2.2 Local Surveys

The Trust continues to use local surveys to collect more targeted feedback from patients and staff. These surveys help us to understand the experience of specific patients, the impact of changes or proposed changes on patients and to understand how we can improve our services. Currently, we have 112 active surveys. This is 21 more than last year.

Due to sickness within the team, we have been unable to develop this part of our programme as much as we would have liked. Next year we hope to complete some work to audit the outcomes of these surveys to ensure that, where we are asking patients to give us feedback, we are using this.

2.3 Patient Conversations

We know from our national inpatient survey results that only 8% of our patients say they are asked to give views on the quality of care during their stay. We wanted to improve this and offer an 'in the moment' opportunity to chat with our patients and hear about their experiences in their own words, reflecting on what matters most to them. With this in mind, we developed our 'patient conversations' framework.

This approach asks staff or volunteers to go to wards and chat with patients. They do not go with a set agenda or questions but instead will listen whilst the patient talks about their experience of being in our hospital. The volunteer will then share this feedback with the ward manager immediately, so opportunities for improvement can be implemented without delay.

We also consider overarching themes from the feedback with our other sources of patient experience data (e.g., Complaints, PALS, local surveys) and direct broader improvement work.

We launched patient conversations in October 2023, and to date, we have undertaken 17 patient conversations on wards or in departments. We have 15 staff and volunteers who have been involved, and we have spoken with over 50 patients. Whilst the feedback is predominantly good and we have used this to encourage staff, we have also made quick 'real-time' changes to support the patient whilst they are still with us. We have also looked at longer-term opportunities to improve patient experience. For example:

- Patients were confused about visiting rules on Percy Philips. The Trust's website has been updated to clarify that one birth partner may stay overnight with the patient.

- On one of the large bays in Elgar ward, only beds on one side of the ward had TVs, and not all patients had bedside tables. The ward is exploring possible charity funding to get TVs and bedside tables for all patients.

- A patient was sent incorrect information about their operation date in a letter and then received a call asking why they had not attended the operation. This was investigated with the support manager for the relevant area and identified a training and wellbeing issue with a member of the team who was making unintentional errors in their work.

- Suggestions from patients that it would be nice to have TVs in Cotswold Ward. This is being explored by the WaCH Service User Experience Team and the Gynaecology Matron.

2.4 National Survey Programme

The Trust continues to participate in the Care Quality Commission's National Patient Survey programme. This provides another opportunity to listen to what patients are saying about our services. In 2023/24 we received results for the Adult Inpatient Survey 2022, the Maternity Survey 2023 and, the Urgent and Emergency Care Survey 2022.

For each survey, a workshop was held with a range of staff and patient and carer partners to review the results and agree on an action plan for areas for improvement. The results and action plans were shared with the Trust Board for each of the surveys.

For the Adult Inpatient Survey 2022, patients scored their overall experience whilst in the hospital as 8.3 out of 10. This is the same score as last year and we are proud to have maintained a good overall experience for our patients despite significant pressures on our services. Our areas for improvement include discharge, access to drinks and asking patients to give feedback during their stay.

In the Maternity Survey 2023, women and birthing people felt they were treated with respect and dignity, kindness and compassion. Our scores in this area were top in the Southwest region and were also all above the national average, showing how caring and supportive our teams are of those in our care. Respondents to the survey said they had confidence and trust in staff during labour and birth, with our score of 9.5 above the national average of 8.7. Women and people in our care felt they were listened to by midwives during antenatal care (9.5, while the average was 9.1). Our lowest-scoring area was around partners being able to stay as long as they wanted after birth. We are aware that this has been a frustration for people using our maternity services since the COVID-19 pandemic. We reintroduced partners being able to stay overnight on our postnatal wards in April 2023 and hope this will reassure those giving birth with us and will be reflected in next year's survey.

In the Urgent and Emergency Care Survey, most of our patients felt listened to (8.9), had confidence and trust in the doctors and nurses who treated them (8.8) and felt they were given

enough privacy (9.1). The Trust also performed better than most other trusts in meeting the communication needs of our patients (7.4) and providing them with suitable food and drink while in the department (7.9).

2.5 Patient and Carer Partners

In October 2023 we celebrated the 20th anniversary of the Patient and Carer Partnership. We held a celebration event where we were able to reflect on the impact of the partnership over the past 20 years and thanked all our partners for their incredible contributions.

The Partnership continues to grow from strength to strength. As reflected in our objectives for this year we wanted to focus on developing wider representation within the group and gain insights from specific conditions or demographic backgrounds so we could listen to a wider range of patients and carers. We now have 17 Patient and Carer Partners, welcoming 6 new partners over the past 12 months. Within this, we have:

- Two partners with lived experience of cancer services.
- A partner under 30.
- Two partners who are members of the LGBTQ+ community.
- A partner with lived experience of mental health.

Our partners continue to share their lived experiences of our services and use their skills and expertise to help us think about how we improve for our patients and carers. Examples of some of the activities they have been doing include:

- Participating in the Patient Led Assessments of the Care Environment (PLACE)
- Participating in interview panels for new members of staff, clinical and non-clinical
- Reviewing leaflets, posters, and webpages
- Co-designing training
- Attendance at various groups and committees (Patient Safety Committee, Patient and Carer Experience Group, Clinical Effectiveness and Audit Committee to name a few)

3. Working together to support and value the individual and promote inclusion.

We have committed to valuing the individual by understanding what matters most to them and delivering on this. This means supporting personalised care approaches and understanding that people's experience goes beyond their physical treatment to include spiritual, religious, and pastoral care for example. Under this commitment, we are also seeking to hear from all our patients, particularly those from seldom-heard groups.

3.1 Patient Access and Inclusion

In our year 1 work plan we set ourselves the objective to understand what good patient experience means to all our patients, particularly those seldom-heard voices in our local community so we can act upon this. We successfully recruited a Patient Access and Inclusion Lead into the team to support this work.

We have begun engaging with two groups, those experiencing homelessness and the Gypsy, Roma and Traveller community. Working with the Voluntary, Community and Social Enterprise (VCSE) sector and partnering with colleagues in Sirona and UHBW, we have started building trusted relationships with these groups to understand better their experience of care and treatment in our services.

3.2 Working with community partners

We have continued to build on our well-established relationship with the Bristol Sight Loss Council (now West of England Sight Loss Council). The Sight Loss Council were awarded Team of the Year at the Rodney Powell Volunteer Awards, for the work they did collaborating with us to improve accessibility across healthcare settings and embed the Accessible Information Standard. We look forward to continuing our ongoing work together over the next year.

In February 2024 we hosted the Bristol Deaf Health Partnership for the first face-to-face meeting of the group since before COVID-19.

We have also welcomed Healthwatch on-site to run a monthly feedback stall from our hospital atrium and value the feedback they share with us. In December 2023, we commissioned Healthwatch to undertake a project for us, looking into the experiences of those waiting for surgery (specifically from areas of low deprivation, patients with learning disabilities & autism and other marginalised groups). We await the outcome of this report and actioning the findings in 2024/2025.

In January 2024, we welcomed five young carers to undertake the 15-step- challenge in three of our inpatient ward areas. This marks the start of our work with the Carers Support Centre and Young Carers Group to better understand their experience of accessing our services with the person they care for. We have been able to use their feedback to draw up an action plan which we will work through in the next year, asking the group to check and challenge our progress. We have also been an early supporter of the 'Young Carers Covenant' and were one of four organisations noted as having pledged commitment to the Covenant at the time of its launch in March 2024.

3.3 SPaRC

Within our Patient and Carer Experience Strategy, we set ourselves an objective to continue to provide an inclusive person-centred holistic, spiritual, pastoral, and religious care (SPaRC) service. In July 2023, we launched a new Spiritual, Pastoral, and Religious Care (SPaRC) Strategic Plan. The strategic plan supports the delivery of the Patient and Carer Experience Strategy and has four key objective areas:

- Develop person-centred holistic, spiritual, pastoral, and religious care.
- Develop the Spiritual, Pastoral, and Religious Care Team.
- Develop faith community partnership and collaboration.
- Develop spiritual, pastoral, and religious well-being support for all NBT staff.

Despite significant staffing challenges, good progress was made against each of these objectives supporting the delivery of an inclusive, person-centred holistic, SPaRC service. Below is a summary of some of the key achievements of this service over the past 12 months.

Activity levels have increased. From April 2023 to March 2024, we carried out 2566 significant visits to 1518 adult patients. This is almost double what we achieved in the previous year. In the same period, we were able to support 272 patients who were Purple Butterfly (at end of life) and 174 who were receiving palliative care. We also supported 167 people at the End of Life. This shows awareness of the SPaRC service by patients, family, carers, staff, and faith communities has improved with more people accessing the service.

The new website was launched and improved resources for staff were uploaded on the intranet. New patient and staff information leaflets and resources covering a range of SPaRC needs have been developed.

Move to using CareFlow with new Chaplaincy Narrative Forms. This benefits patients as it promotes holistic care and is shared with other appropriate staff in real-time.

A new holistic SPaRC assessment tool was produced.

There has been an overhaul of processes, administration, funerals, and chaplaincy support following a baby loss. From April 2023 to March 2024, the team conducted 77 baby funerals including 13 communal (batch) cremations. This is up from 58 baby funerals in the previous year. In addition, chaplains were involved in supporting 18 families who made their own funeral arrangements and 5 Muslim baby deaths. Supporting parents and families, arranging, and conducting baby funerals and being adaptive to the needs of each situation takes time, skill, and compassionate care so improving the processes has been of huge benefit.

We hosted our first Faith Communities Event and established stronger community links (picture to the left).

We have provided training in recognising and responding to people's spiritual, pastoral, and religious needs to over 120 staff in eight training sessions and SPaRC is featured in every staff induction. We have produced PowerPoint presentations to support this training, and these are all available as a staff resource on LINK.

Reflective Practice and Supervision has been introduced for Chaplains. Chaplains provide a wide range of emotional, psychological, spiritual, pastoral, and religious support to people in highly complex and distressing circumstances. High levels of sickness absences have impacted the team. In response, this year we increased the wellbeing and pastoral support offered to the team. We arranged several new reflective practice sessions enabling the chaplaincy team to reflect on areas of practice. We also put in place arrangements for chaplains to begin receiving external pastoral supervision to support their wellbeing and practice. Supervision began in April 2024.

3.4 Fresh Arts

We were pleased to be able to welcome Fresh Arts to the Patient Experience Team in February 2024. The Fresh Arts service exists to enhance patient, visitor and staff experience of our hospitals and services through a high-quality and engaging arts programme. Fresh Arts has a standalone Strategic Plan to underpin its work. This directly supports the vision and aims of the Patient and Carer Experience Strategy, how we support and value the individual. Every day, we see and experience extraordinary moments with our patients when they reconnect with who they are through the power of the arts.

A summary of some of the key achievements over the past 12 months are noted below:

We presented a programme of exhibitions across NBT's sites with 16 different exhibitions shown during the year. Exhibitions related to themes like LGBTQI+ History Month, Parkinson's Awareness Month, Greener NHS, Black History Month, and Mental Health Awareness Week. In response to feedback from patients and staff we created new exhibition spaces in Women's &Children's Division and Pathology enabling us to tour exhibitions across the site so more people can enjoy the arts. Our partnership with the University of Bristol research project Sensing Spaces of Healthcare, enabled us to create our first exhibition in W&CH and they gifted several artworks to us to add to our permanent art collection.

A group of brilliant, brave and inspiring patients (being cared for by the Drug & Alcohol Care Recovery Team) joined us for an Arts on Referral programme and unveiled a triptych of three collaborative artworks they made at the entrance to Gate 8A. Talk about Patient First!



On Monday afternoons Dance for Dementia has taken place on the Elgar Enablement Unit. During the year, 1154 patients, visitors and staff danced, sang, wiggled, jived and crooned for 2 hours every week. That's 74 hours of patient activity evidenced by increases in fluid intake, increased appetites, better sleep, and some very hearty laughter.

Our music programme has provided 135 hours of live music featuring 34 professional musicians across the Southmead Hospital site with a total audience of over 4200 people including over 1200 patients, 1600 staff and 1200 visitors. At Cossham we delivered 85 hours of live music featuring 8 professional musicians to a total audience of more than 500.

We handed out 6942 resources for patients on wards, in clinics and in waiting areas to help pass their time in the hospital. This included 5000 Boredom Buster magazines, 600 colouring books and pens and 1300 hand-knitted blankets, teddies, Twiddle Muffs and cannula sleeves created by an amazing army of volunteer knitters.

During the year we offered 9 opportunities for 4 different patient groups to see if engaging in creative activity could help them to better manage a long-term chronic condition. 58 patients took up the challenge and joined us on Zoom and in the Community Arts Room. Our Creative Writing Follow-On Group for patients living with cancer benefited 46 patients. Overall, we delivered 152 hours of Arts on Referral programmes with 479 patient attendances with around 70% of patients continuing their creative journey in their local communities.

We supported placements for 8 UWE Music Therapy Masters Students in EEU and Rosa Burden and offered work experience for 3 young people.

3.5 Volunteer Services

The Volunteer Services are key to helping us deliver individualised care and to supporting staff to understand and meet the individual needs of our patients.

This year our amazing volunteers donated over 39,257 hours of their time. This is nearly 5,000 hours more than the previous year.

This year we have increased our active volunteer numbers by 100. We currently have 470 active volunteers across our sites, carrying out 35 different volunteering roles.

We are incredibly grateful to all our amazing volunteers for their immense commitment.

This year we developed two new roles, the Patient Feedback role and the Appointment Buddy role. The Appointment Buddy role was developed following a complaint made to the Trust about a lack of support for individuals coming in on their own to outpatient appointments. The Patient Feedback role has been developed with our volunteers who have helped evolve the role into a wider remit, with a greater impact. Developing roles in response to patient feedback and in collaboration with our volunteers has been a proud achievement.

4. Being responsive and striving for better.

Under this commitment we pledged to be responsive to the feedback we receive, ensuring that we are using it to drive improvements.

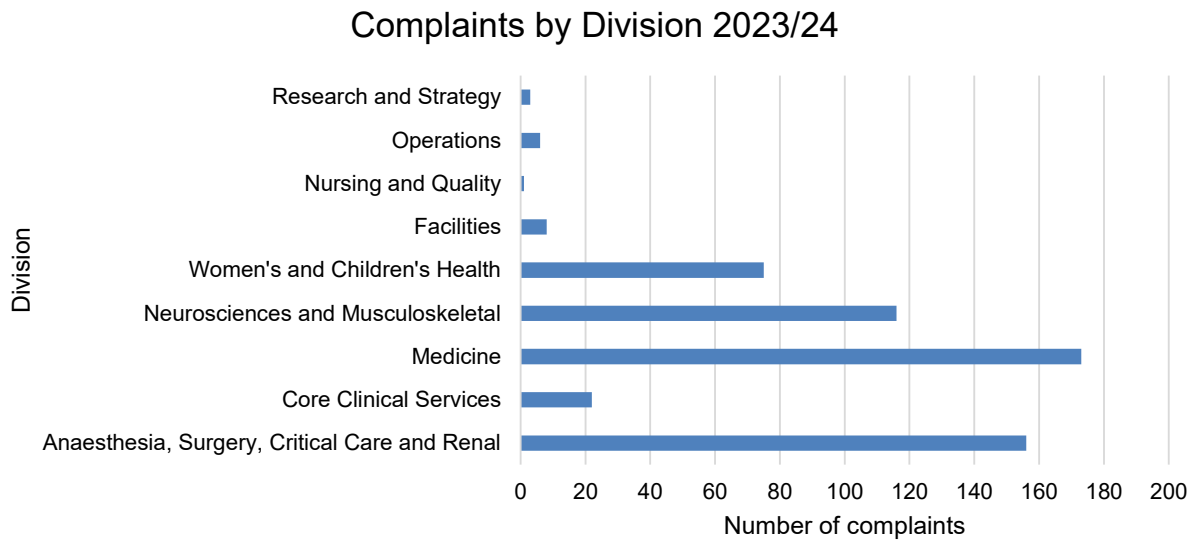
4.1 Complaints

The NHS constitution and NHS Complaints Regulations 2009, clearly set out the rights of patients about raising complaints and expectations on how these should be managed. As a Trust, we take this duty very seriously. We want to know when someone is unhappy with the treatment or service they have received. This means we can put things right and learn from the experience of our service users.

4.1.1 Activity

The overall number of formal complaints received by the organisation fell by 15% in 2023/24 to 560.

The graph below shows the number of complaints received by each of the divisions. The Medicine division received the most complaints followed by Anaesthesia, Surgery, Critical Care and Renal. This is consistent with the previous year where these two divisions received the most complaints.



4.1.2 Performance

Under this commitment, we set ourselves an objective to respond to 90% of complaints within agreed timeframes. This is our Trust's internal target. Unfortunately, we did not meet this target. On average, we responded to 73% of complaints within agreed timeframes. This is 4% lower than the previous year. This is disappointing given that we had significantly fewer complaints this year; however, benchmarking against other organisations has provided helpful comparisons and we are reassured that this is still a good performance (we were 2nd for performance compared to 5 similar-sized organisations).

Despite not reaching our internal targets for complaint response times, our service is responsive at initial contact with 100% of complainants receiving an acknowledgement of their complaint within three working days.

The table below shows our performance against key performance measures.

Measure	2019/20	2020/21	2021/22	2022/23	2023/2024
Complaint Acknowledged within 3 working days	-	100%	100%	100%	100%
Overdue complaints (Average per month)	8	0	5	5	5
Response Time (within timescale)	80%	93%	77%	77%	73%
Returned rate	-	6%	4%	5%	6%

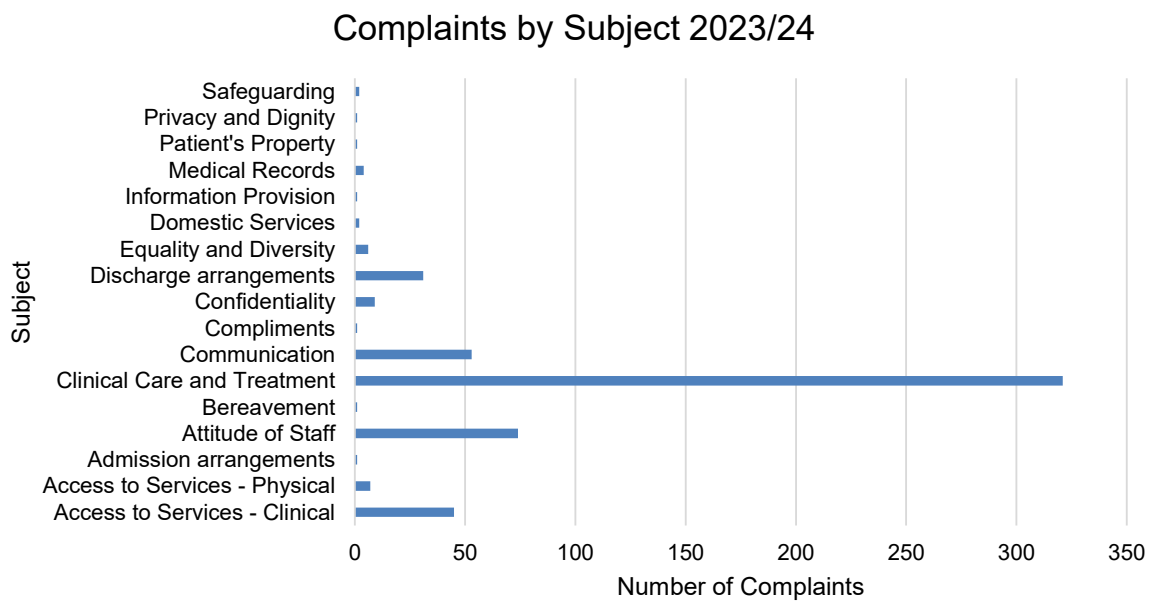
The team have also been working through an action plan to ensure the implementation of the new Parliamentary and Health Service Ombudsman (PHSO) standards for complaints handling. This year we have also updated the Trust's policy for the management of complaints and concerns.

The table below shows the number of complaint cases that were investigated by the PHSO. In 2023/24, 52 cases were received by the PHSO for consideration. This means 9% of complaint cases were escalated by the complainant to the PHSO. This is a slight increase from the previous year where 7% of cases were escalated to the PHSO, however, it is consistent with years before this. Three cases were accepted for investigation by the PHSO and to date we have received 2 outcomes which were both partly upheld.

Year	Number of cases received by the PHSO	Number of cases accepted for investigation by the PHSO	Number of cases upheld or partly upheld
2019/20	61	3	0
2020/21	28	2	1
2021/22	59	1	1
2022/23	47	5	1
2023/24	52	3	2

4.1.3 Themes

The chart below shows a breakdown of complaints received by theme. Like last year the most common theme for complaints in 2023/24 was 'Clinical Care & Treatment'.



In September a report was presented to the Trust Board which provided a deep dive into the complaint theme 'Clinical Care and Treatment'. This deep dive showed that the main specialities receiving complaints about Clinical Care and Treatment were Emergency medicine, Obstetrics, Urology, Maternity, General medicine and Trauma and Orthopaedics

The underlying issues varied between specialities but there were some consistencies including:

• Something happening during the episode of care the patient was not expecting.

• Outcomes, potential complications, and risk of procedures not being fully explained.

• Not being able to manage a patient's expectation of time.

• Patients feeling ignored, not listened to and not part of the decision-making process.

• Perceived delays in treatment and/or interventions.

• Attitudes of staff and expectations of professionalism (kindness and compassion) of doctors.

• Supporting with the activities of daily living i.e., eating, drinking and personal care.

• Perceived confidence in nurses and the differences experienced between day and night, substantive and agency staff.

From this, we noted key actions including accelerating the implementation of shared decision-making, to ensure there is 'no decision about me, without me' and continued focus on recruiting permanent colleagues and reducing turnover. This will reduce the reliance on a temporary workforce.

4.1.3 Accessibility of the Complaints Process

We collect equality monitoring data about those accessing the complaints service through a non-mandatory form. In 2023/24 we received 40 responses. This is a response rate of 7%. The data shows that:

- Most complainants are aged between 31-45 years.
- 38% of complainants disclosed that they had a disability.
- 82% of complainants are White-British.

We know that this is not reflective of our local population and those accessing our services. For the past year, we have welcomed Healthwatch Bristol on-site to run a monthly feedback stall from our hospital atrium. This is an alternative method of giving feedback for people who may feel uncomfortable raising concerns directly to the Trust.

We also continue to seek feedback about the accessibility of the PALS and complaints processes from service users through a questionnaire. Results show that 83% of respondents

found it easy to find out how to raise a concern to PALS and 66% of respondents found it easy to find out how to raise a complaint.

4.1.4 Complaints Lay Review Panel

Our coveted Complaints Lay Review Panel, regarded as a national standard setter, has continued to convene this past year, meeting once a quarter and reviewing three anonymous complaints. They look at how we handled the case, providing a score, noting areas of good practice, opportunities for improvement and whether we have closed off agreed actions. A member of the panel shares the findings with our Divisional Patient Experience Group who can take back learning to their clinical divisions.

Whilst the panel is exceptional with skilled and dedicated members, in 2024/25 we have an objective to bring some new perspectives and grow and diversify the panel further.

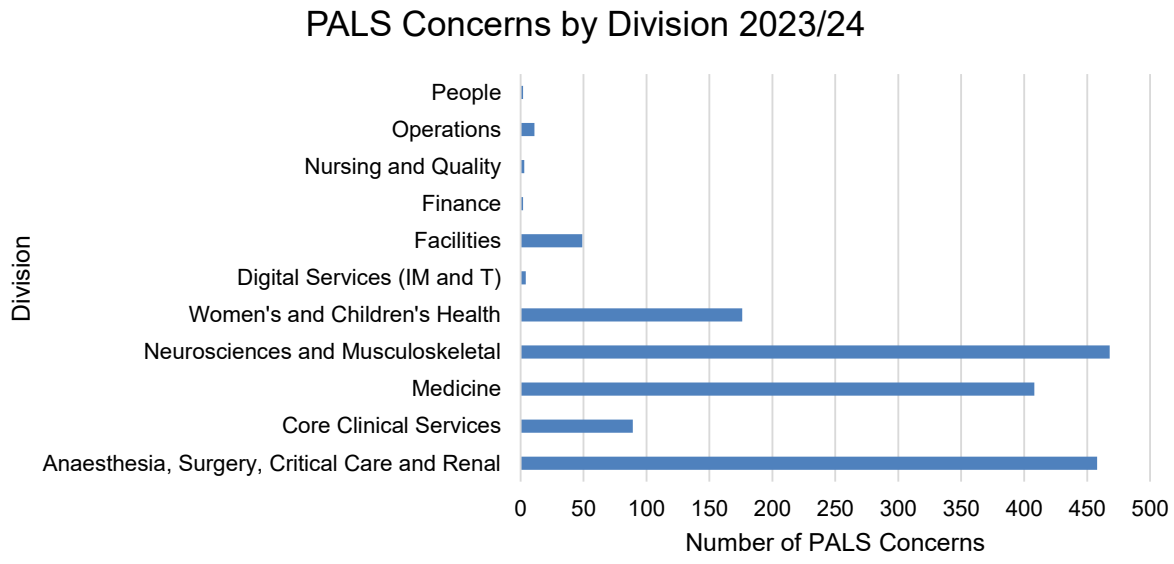
4.2 Patient Advice and Liaison Service

Since its launch in 2019, PALS has continued to grow busier, demonstrating its importance as a support for patients, carers, families, and staff. The service aims to help resolve low-level concerns quickly and provide advice, support and signposting for patients, family, and carers as well as staff.

4.2.1 Activity

In 2023/24 1,670 PALS concerns were received, this is two more than the previous year. The chart below shows the number of PALS concerns received by divisions. NMSK received the most PALS concerns, followed by ASCR and Medicine, this is consistent with previous years.

The specialities that received the most concerns were Urology, Neurology, Trauma and Orthopaedics and Gynaecology.



4.2.2 Performance

We aim to acknowledge all PALS concerns within 1 working day of receipt. This year we acknowledged 100% of PALS concerns in this timeframe.

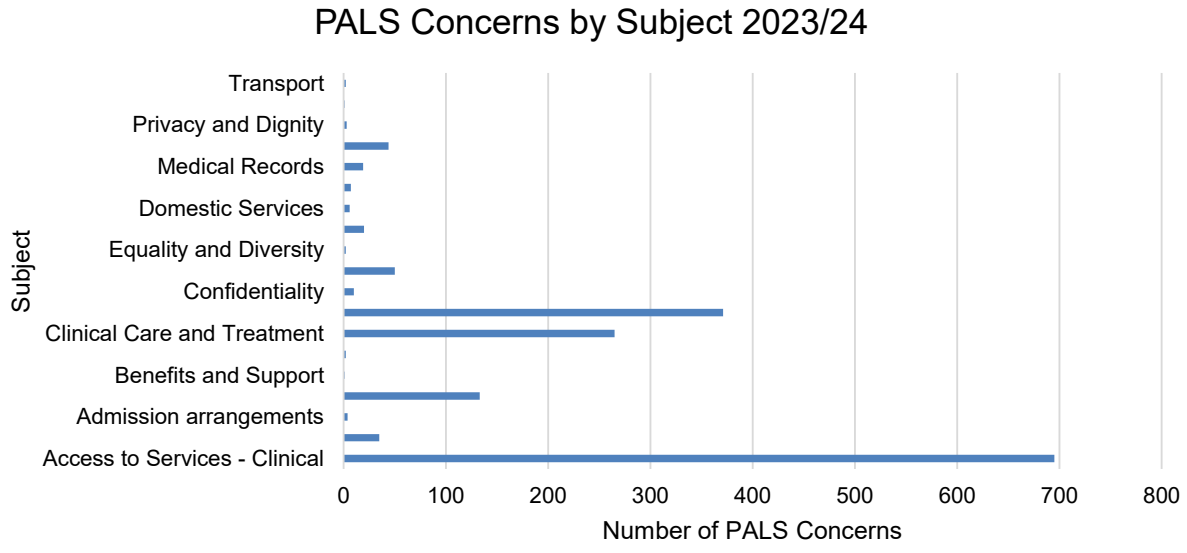
We aim to provide a response or resolution to PALS concerns in five working days; however, we acknowledge that this timeframe is guidance and that some will take less time, or more time to resolve. We, therefore, ask investigators to agree on timeframes with the person raising concerns and to respond within the agreed timeframe. In 2023/24, 75% of PALS concerns were completed within the agreed timescale. This is consistent with the previous year.

Feedback from users of PALS shows that 83% would recommend the service and 83% felt their concerns had been listened to.

4.2.3 Themes

The chart below shows a breakdown of PALS concerns received by theme.
The most common subject was ‘Access to Services- Clinical.’ Followed by ‘Communication’ and ‘Clinical Care and Treatment’.

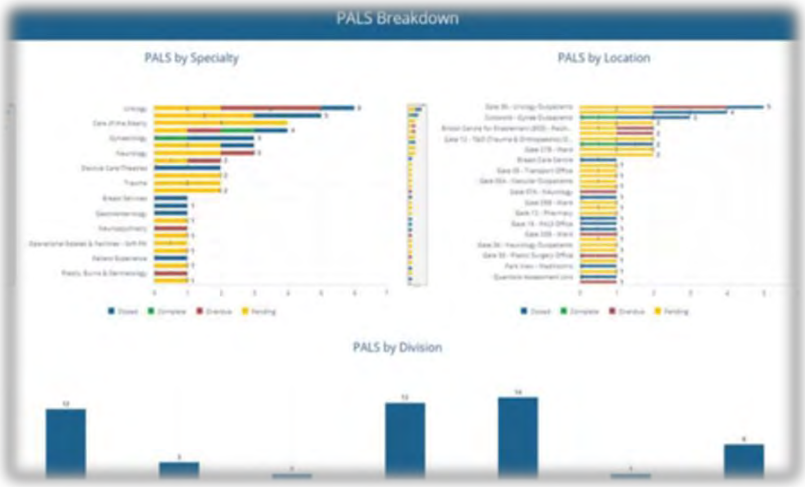
This is consistent with the previous few years with cases relating to length of wait for an outpatient appointment, length of wait for surgery and communication around this.



4.3.3 Radar

One of our stretch objectives under this commitment, 'being responsive and striving for better' was to optimise our reporting and management of PALS and Complaints through our new quality governance system, Radar.

We are pleased that we have successfully transitioned from our previous quality governance system, Datix, to our new system, Radar, for the management of complaints and PALS concerns.



Over the last 18 months, we have worked to design new, streamlined workflows for complaints and PALS concerns making it much faster for our PALS and Complaints Officers to input new cases.

We also took the opportunity to review our themes for complaints and PALS concerns and have refined these to allow for more meaningful understanding of the issues raised. This includes improving the tracking of processes and themes through visualisations and dashboards tailored to user needs.

In rolling out Radar, the central team have provided 4 demo sessions, and 4 training sessions to key divisional staff. User and how-to guides have also been created. Early feedback on the system has been positive and we're excited to continue optimising its use over the next year.

4.3 Compliments

This year we formally logged 5,781 compliments. This is a slight decrease from last year. We know that this is only a small proportion of the total compliments and 'thank yous' received by our staff across the Trust every day.

5. Putting the spotlight on patient and carer experience.

Our fourth commitment in the Patient and Carer Strategy is to put the spotlight on patient and carer experience. We want to ensure that the patient's voice is heard from the ward to the Board and that we have a vibrant Trust-wide vision of what a good patient experience looks like and how we can improve this.

5.1 Patient stories

Patient stories continue to be an effective mechanism by which we can put a spotlight on an individual's experience and hear their voice directly. One of our objectives under this commitment was to ensure that the patient's voice is heard from the ward to the Board through patient stories. We also stated that we will not shy away from hearing stories where things have not gone well.

In June 2023, we approved the Trust's Framework for Patient and Carer Stories. This framework, intended for staff and potential storytellers, sets out our vision for patient and carer stories.

Alongside the framework, a forward plan for 2023/24 was agreed for stories to the Board and the Patient and Carer Experience Committee. It was agreed that stories to the Board would be varied across divisions and show a more balanced view of patient experiences, including stories linked to complaints, risks, or incidents. Stories to the Patient and Carer Experience Committee would be linked to the three Trust objectives: Deliver Great Care, Healthcare for the Future and Anchor in the Community.

Against this plan, 10 stories were successfully delivered to the Board and the Patient and Carer Experience Committee. Other stories were collected during the year and used in forums such as staff training, divisional governance groups or Trust away days.

We have developed a Patient Story Hub on our intranet where stories are held and can be accessed by staff.

Thank you to all the incredible, brave storytellers who took the time to share their experiences with us this year.

5.2 Newsletter

Another of our objectives under this commitment was to increase the visibility of patient experience across the Trust by working with our Communications team and agreeing on a plan for sharing progress and developments within Patient Experience.

We agreed that a Patient Experience Newsletter would be a great way to showcase all our teams' amazing work, in a creative and engaging way, that could be shared across the Trust and externally.

We launched our first newsletter in September 2023 and at the time of writing this report, we have published three editions (one each quarter). The newsletters contain a small update from each of the services within Patient Experience and a guest blog from one of our team (including our Patient and Carer Partners or volunteers).

We are incredibly proud of the newsletter which is distributed in person by our team across the Trust and published electronically on our website (along with an accessible version). Feedback about the newsletter is that it is a fantastic idea and staff have enjoyed reading it.

6. Looking ahead to 2024/25

We have a lot to be proud of and to celebrate from the past 12 months. It has been a year of significant progress, stretching ourselves with new innovative programmes of work whilst sustaining our services to a high standard. We successfully delivered on twelve of our thirteen objectives. We look to further build on this year over the next 12 months.

Each of the individual workstreams within Patient Experience has chosen objectives from their respective strategic plans (Fresh Arts Strategic Plan, Spiritual Pastoral and Religious Care Strategic Plan, Voluntary Service Strategic Plan). For more information on these please contact the relevant service leads.

All these service-level objectives dovetail with the overarching objectives we have set ourselves for year 2 of the Patient and Carer Experience Strategy.

In conjunction with the divisional patient experience teams, central teams, patient and carer partners, the Director for Quality Governance, and the Chief Nursing Officer, we have agreed on the following year 2 objectives. Some of these have been chosen as they align with Quality Priorities, or priorities arising from other Trust Strategies such as the new Mental Health Strategy.

Listening to what patients tell us	Sustain	We will continue to share patient experiences at Board and through other governance committees, to ensure the voice of the patient is heard.
Listening to what patients tell us	Stretch	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).
Listening to what patients tell us	Stretch	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.
Working together to support and value the individual and promote inclusion	Sustain	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.
Working together to support and value the individual and promote inclusion	Sustain	We will meet the needs of patients with lived experience of Mental Health or Learning Disability and neurodivergent people in a person-centred way.
Working together to support and value the individual and promote inclusion	Sustain	The voice and the involvement of carers will be respected and integral in all we do.
Working together to support and value the individual and promote inclusion	Stretch	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"
Working together to support and value the individual and promote inclusion	Stretch	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.
Being responsive and striving for better	Sustain	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
Being responsive and striving for better	Sustain	We will continue to undertake the annual Patient Led Assessments of the Care Environment (PLACE) audits and respond to areas of improvement.
Being responsive and striving for better	Stretch	We will involve the volunteer voice within feedback to shape future volunteer roles and patient engagement opportunities.

Putting the spotlight on patient and carer experience	Sustain	We will refresh the Patient Experience portal on our website and staff intranet
Putting the spotlight on patient and carer experience	Stretch	We will develop a Patient Experience e-learning module to support the ongoing need of staff for easy access to busy frontline staff.

Updates on progress against these objectives will be shared with the Board through the monthly Integrated Performance Report. Detailed updates on specific programmes of work will be provided to the Patient and Carer Experience Group. The Patient and Carer Experience Committee will also continue to monitor progress against these objectives at regular intervals over the next 12 months.

Report To:	Public Trust Board			
Date of Meeting:	25 July 2024			
Report Title:	Mental Health Strategy 2024 – 2028			
Report Author:	Gifty Markey, Associate Chief Nursing Officer for Mental Health, Learning Disability and Neurodiversity			
Report Sponsor:	Prof. Steve Hams, Chief Nursing Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
	X	**X**	**X**	
Recommendations:	The Trust Board is asked to: • Discuss and approve the Mental Health Strategy 2024 – 2028. • Note the four key priorities and associated commitments. • Receive an annual update on progress. • Delegate assurance oversight to the Patient and Carer Experience Committee on behalf of the Board.			
Report History:	The Strategy was developed following extensive consultation with a range of partners and organisations, people with lived experience and colleagues.			
Next Steps:	• The Mental Health Operational Group will continue to review and monitor the delivery of this strategy providing upward reports to the Patient and Carer Experience Committee.			

11

Executive Summary

In June 2023, the Clinical Strategy for North Bristol NHS Trust (NBT) was published with a strong commitment and ambition to meet the needs of patients with mental health challenges. The clinical strategy identified about 14% of our patient interaction at NBT involve a mental health diagnosis, and a wider proportion of patients will experience anxiety, low mood, and other forms of distress relating to the health condition that they are presenting with.

The clinical strategy identified six areas of focus, to achieve parity of esteem it was deemed essential that the Trust had a clear strategic vision for mental health, and as such a mental health strategy was the first step in delivering our ambition for parity of esteem. Following a period of consultation with our patients, staff, voluntary organisations and system partners, the Trust has developed its first Mental Health Strategy identifying four key priority areas to deliver during the next four years (2024-2028).

The four key priorities identified in the strategy are as follows:

- Timely and responsive access to mental health service for all.
- Support our staff to deliver effective care and outstanding experience for mental health patients.
- Support our staff with their mental health needs
- Working in partnership to tackle health inequalities associated with mental health

Each priority has a series of commitments that will help the Trust deliver on the priorities. The Mental Health Operational Group will be responsible for overseeing the delivery plan for this Strategy.

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	x
	Innovate to Improve – *Unlocking a better future*	x
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	x
	Commitment to our Community - *In and for our community*	x
Link to BAF or Trust Level Risks:	N/A	
Financial implications:	N/A	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No. The strategy is a positive example of inclusion, recognition and respect of diversity and there are no barriers to equality.	
Appendices:	Appendix 1 – Mental Health Strategy 2024-2028 Appendix 2 – Mental Health Strategy 2024-2028 (easy read)	

Mental Health Strategy
2024 – 2028

1. Purpose

1.1 The purpose of this report is to provide an update on the development of the First Mental Health Strategy of North Bristol NHS Trust and how this has been developed.

1.2 North Bristol NHS Trust (NBT) published a five-year Clinical Strategy published in June 2023 which identified Mental Health as one of the six specific areas of focus.

1.3 Following the publication of the Clinical Strategy a plan was established to develop our first Mental Health Strategy to ensure the mental health needs of patients who access our services are identified and met.

1.4 The Mental Health Strategy has identified four priorities in which the Trust will commit to meet the parity of esteem and the ensure there is a holistic approach to caring for patients.

2. Background

2.1 The World Health Organisation's 2022 World Mental Health Report: *Transforming mental health for all* sets out a clear vision for all nations, rich or poor, to prioritise mental health for all: It states clearly as set below its vision:

> "Our vision is a world where mental health is valued, promoted, and protected; where mental health conditions are prevented; where anyone can exercise their human rights and access affordable, quality mental health care; and where everyone can participate fully in society free from stigma and discrimination."

2.2 It highlights the important fact that "ultimately, there is no health without mental health."

2.3 The NHS long term plan highlights a national commitment to enhancing mental health services and achieving parity in the delivery of both physical and mental healthcare.

2.4 NBT is dedicated to the parity of esteem and committed to not only addressing our patients' physical health but also supporting their mental well-being.

2.5 This strategy seeks to align with the NBT Clinical Strategy themes of Patients, People, Population, Progress and Partnership, ensuring the Trust works with the BNSSG Integrated Care System's All Age Mental Health and Wellbeing Strategy.

2.6 The Integrated Care System (ICS) all age strategy identifies six Core ambitions which include holistic care, prevention and early help, quality treatment, health equality, sustainable services and a great place to work.

2.7 As a system partner, NBT is committed to working in line with the ICS all age Mental Health and Wellbeing Strategy

2.8 The Mental Health Strategy seeks to deliver the ambitions set out in the mental health focus chapter of our Clinical Strategy.

2.9 The Clinical Strategy Mental Health Ambitions seek to achieve five key aims as follows:

- *To shift culturally from liaising and reacting to providing an embedded and proactive 24/7 mental health service.*
- *To better understand inequalities associated with mental health to best support those under our care.*
- *To ensure all our workforce are capable of recognising and responding appropriately to a patient with mental health needs.*
- *To solidify our relationships with system mental health partners to jointly manage the physical and mental health needs of our communities.*
- *To adopt digital technologies to improve mental health assessments and support patients*.

2.10 The NBT Clinical Strategy identified that 14% of our patients' interactions at NBT involve a mental health diagnosis, and a wider proportion of patients will experience anxiety, low mood, and other forms of distress relating to the health condition that they are presenting with.

3. Key Priorities of the Mental Health Strategy

3.1 Following extensive consultation with staff, patients, carers and our key stakeholders, the Trust has developed a Mental Health Strategy with a commitment to 4 key priorities to work on in the next four years as follows:

- Timely and responsive access to mental health service for all.
- Support our staff to deliver effective care and outstanding experience for mental health patients.
- Support our staff with their mental health needs.
- Working in partnership to tackle health inequalities associated with mental health.

4 Delivery Plan

4.1 The delivery plan will be developed and monitored through the Trust Mental Health Operation Group and report to the Patient and Carer Experience Group/Committee.

4.2 An annual update will be shared at the Trust Board to review progress.

5 Recommendations

5.1 The Trust Board is asked to

- Discuss and approve the Mental Health Strategy 2024 – 2028.
- Note the four key priorities and associated commitments.
- Receive an annual update on progress.
- Delegate assurance oversight to the Patient and Carer Experience Committee on behalf of the Board.

Mental Health Strategy 2024–2028

NHS
North Bristol
NHS Trust

NBTCARES

Mental Healthcare

Vision

Foreword

Mental health challenges pose a significant contemporary health issue, bearing substantial implications for both our lives and society. Individuals with severe mental health conditions face a notable reduction in life expectancy, typically ranging from 15 to 20 years.

This depicts the gravity of the impact of mental ill-health on individuals and the broader societal landscape. The NHS long term plan laid out an ambitious transformation plan to improve mental healthcare provision across England and North Bristol NHS Trust, working with local communities, voluntary sector organisations and local partner organisations seeks to support this agenda through this strategy and its implementation plans.

It is heartening to see that mental health is receiving increased attention and open discussions. Challenging the stigma surrounding mental health is crucial for fostering a supportive and understanding environment. When individuals feel comfortable talking about their mental health, it can lead to better awareness, empathy, and ultimately improved access to support and treatment. Public awareness campaigns, celebrities sharing their own struggles, and policy changes have contributed to the increasing acceptance of mental health discussions. However, it is important to note that there is still work to be done. Many individuals may continue to face challenges in seeking help due to persistent stigma or lack of access to mental health services. Continued efforts to promote mental health education, de-stigmatise seeking help, and ensure accessible and affordable mental health services are essential for creating a society where individuals can openly address their mental health concerns without fear of judgment. The collective acknowledgment and acceptance of mental health challenges contribute significantly to the overall well-being of communities.

Our Clinical Strategy published in 2023 acknowledged the importance of mental health to both out patients and our colleagues, for it is clear there is 'no health without mental health' and as a provider of physical health services we have a responsibility to care for both the physical and mental health of our patients.

This strategy articulates a coherent vision of the Trust which puts mental health at its heart to ensure our patients, communities and our colleagues recognise that we value good mental health, and we are committed to supporting those who need our care and support during periods of mental ill health.

We are truly grateful to the individuals, organisations and communities that have supported the development of our strategy, many of whom have 'lived experience' of mental health, we remain committed to honouring the time you have given to ensure this strategy becomes a living reality for those who use our services.

Wherever you read this and whoever you are, we invite you to join us in making this vision to improve the experience and outcomes of patients with mental health challenges a reality.

Maria Kane
Chief Executive

Professor Steve Hams
Chief Nursing Officer

Contents

1. Introduction

North Bristol NHS Trust (NBT) set out a new 5-year Clinical Strategy in June 2023 which identified Mental Health as one of 6 specific areas of focus:

"It is important to note that 14% of our patients' interactions at NBT involve a mental health diagnosis, and a wider proportion of patients will experience anxiety, low mood, and other forms of distress relating to the health condition that they are presenting with. We want to provide a mental health service that recognises and responds to illnesses presenting in crisis and the needs of inpatients with chronic mental health disorders.

The total number and proportion of admissions for patients with mental health conditions are increasing at NBT, with 80% of our hospital bed days being occupied by people with co-morbid physical and mental health problems. Patients with a mental health condition present specific requirements and challenges."

- NBT Clinical Strategy 2023

This strategy is key in setting the direction of how we plan as a Trust to meet this complex and increasing need of our patient population ensuring experience and outcomes are optimised in line with our Trust Values and Vision.

Although this strategy primarily focuses on patients where the principal reason for their attendance at North Bristol Trust is for a mental health diagnosis. However, it is important to recognise the wider emotional needs of the community of people the Trust supports across our services.

1.

NBT is a large Acute Hospital and major trauma centre with a large Emergency Department (ED) that sees a significant number of patients with mental health needs.

These cases are varied and are increasing in complexity and cover an age range from 16-year-olds and above. The nature of individual's experiences and support needs will vary on a spectrum, from those with emotional distress associated with the biopsychosocial adjustment to physical health conditions, who may be seen across our organisation, to those with clinically significant levels of distress that may include a formal mental health diagnosis that is the primary reason for their attendance at NBT.

The main access point for mental health patients into NBT is via the ED with predominantly walk in cases, but also ambulance transfers and police attendance as a designated 'Place of Safety' (POS). The vast majority of mental health cases are in the department for treatment of an intentional overdose or an act of deliberate self-harm and trauma injuries. Also, most of the cases that present are complex and are at risk of harm to self or others.

Mental health issues touch the lives of most individuals, whether through personal experiences, caring for a family member, or supporting friends and colleagues. Several factors influence mental health, including trauma, stigma, interpersonal difficulties, physical health, social factors, and the environment.

Many mental health conditions are preventable, and almost all are treatable, offering the potential for full recovery. There is a lot we can collectively do to reduce the severity of distress people can face, and a range of interventions that have been shown to be effective in managing this.

The World Health Organisation's 2022 World Mental Health Report:

Transforming mental health for all sets out a clear vision for all nations, rich or poor to prioritise mental health for all. It sets out the vision in the following statement:

> **"Our vision is a world where mental health is valued, promoted, and protected; where mental health conditions are prevented; where anyone can exercise their human rights and access affordable, quality mental health care; and where everyone can participate fully in society free from stigma and discrimination."**

It highlights the important fact that **"ultimately, there is no health without mental health."**

The NHS long term plan highlights a national commitment to enhancing mental health services and achieving parity in the delivery of both physical and mental healthcare.

1.

This goal will be realised by promoting the integration of services, fostering a holistic approach across health and social care systems. Perceptions of the relationship between physical and mental health have changed, it is now widely acknowledged that this relationship is complex, reciprocal and acts through multiple pathways. Untreated mental disorders result in poor outcomes for co-morbid physical illnesses. Individuals with mental disorders have an increased risk of suffering from physical illness because of diminished immune function, poor health behaviour, non-compliance with prescribed medical regiments and barriers to obtaining treatment for physical disorders.

NBT is dedicated to the parity of esteem and committed to not only addressing our patients' physical health but also supporting their mental well-being.

We are passionately committed to challenging the stigma and discrimination surrounding mental health and ensuring that our staff are well-equipped and confident in understanding the mental health needs of both patients and their own mental health.

NBT is also committed to working in a trauma-informed way, in line with the ICB guidance on trauma informed working. This recognises that:

> **"Experiences of trauma and adversity are common and can have a profound, wide-reaching impact on the lives of individuals, families, and communities. These are experiences which can take place across the life course and over generations and can influence how people interact, interpret the world, and engage with services. We commit to developing our knowledge and understanding in this area to improve the design and delivery of our services. We recognise that early intervention and prevention approaches are integral to helping people live fulfilling lives. We will work together with individuals, families, and communities to build on existing strengths and maximise opportunities for recovery."**
>
> **- Trauma-Informed Bristol, North Somerset & South Gloucestershire: A pledge for partners-2024**

1.

The recently published National Suicide Prevention Strategy acknowledges the need for frontline agencies to work together to respond to people in crisis. It highlights the importance of breaking down the shame that can deter people from seeking help *(Suicide prevention in England: 5-year cross-sector strategy, 2023)*.

The strategy highlights the need to support the needs of patients who self-harm, children and young people, autistic people, pregnant and young mothers, people in contact with mental health service, middle aged men and many more. These are people who will use our services in many ways, and it is important to ensure our services have the skilled workforce to support these high-risk groups when they contact us. The need to meet "Core 24" for all general hospitals is highly recommended as an ambition in the strategy and the Trust is committed to working to this standard through this strategy.

This strategy seeks to align with the NBT Clinical Strategy Priorities of Patients, People, Population, Progress and Partnership, ensuring the Trust works with the BNSSG Integrated Care System's All Age Mental Health and Wellbeing Strategy.

The Integrated Care System (ICS) all age strategy identifies 6 Core ambitions which include holistic care, prevention and early help, quality treatment, sustainable services, health equality and a great place to work. Linking these to the needs of out patient population at NBT. As a partner in the system, NBT is committed to work with the core ambitions that relate to our patients and staff to ensure we are collaborating in the delivery of this overarching system strategy.

2. National Context

In England, statistics from MIND in 2021 reveal that one in four adults and one in ten children contend with various forms of mental health challenges each year.

Particularly during pregnancy and postpartum, women face an elevated risk of encountering mental health issues, ranging from low moods to psychosis. Those with a history of mental health conditions may find a recurrence or exacerbation of their challenges during this period.

Optimal mental well-being and resilience play a crucial role not only in our physical health but also in shaping our relationships, education, training, and overall potential, as emphasised in the "*No Health Without Mental Health,*" Report of 2011.

The impact of declining mental health is universal and can affect anyone at any time. It is acknowledged that individuals seeking care in Emergency Departments (ED), Inpatient, and Outpatient settings often require support for their mental health. National initiatives underline a clear association between mental and physical health, citing examples such as the increased likelihood of depression in people living with diabetes.

The Department of Health estimates that half of the patients in general hospitals are older individuals, a demography expected to double over the next 30 years, with 330 out of 500 beds in an average hospital occupied by older individuals. Of these, 220 may be contending with mental disorders like depression, psychotic disorders, dementia etc. Notably, depression in later life is recognised as a significant factor in suicidal tendencies (NHS England 2015). Reports, such as the "*Treat as One,*" document in 2017, emphasises the need to bridge the gap between mental and physical health care in general hospitals. A similar focus is reiterated in "*Mental Healthcare in Young People and Young Adults,*" in 2019, which points out the increased presentation of mental health conditions in Emergency Departments compared to other health issues.

The Kings Fund in 2016 stressed that all health and care professionals should contribute to achieving closer integration to address the needs of both physical and mental health. Physical and mental health are closely linked – people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than the general population – one of the greatest health inequalities in England. People with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care, yet much of the time this goes unaddressed. There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. In line with the NHS long-term plan, this strategy is our organisation's way of describing our improvement strategy and what we want and expect to achieve in the next four years for our mental health patients. This is our contribution in delivering the parity of esteem.

2.

Research evidence suggests the importance of professionals adopting a 'whole person' perspective and possessing the requisite skills to do so. Post the 2020 Coronavirus Pandemic, a noticeable decline in mental health has been observed in communities. NBT is committed to comprehending the needs of its population and endeavours to address mental health simultaneously with physical health.

As a Care Quality Commission (CQC) regulated organisation we have a responsibility under section 140 of the MHA (1983) and a duty for all mental health related patients as well as people with neurodiversity who are prone to experiencing mental health challenges with a high risk of suicide rates.

In 2020, the CQC's review of the assessment of mental health services in an acute trust programme, identified the importance of treating patients with mental health problems with the same importance as their physical health. They highlighted the following key elements in their report.

2.

The following requirements will support shaping the priorities set in this strategy to ensure NBT is working to achieve this when caring for patients who present with mental health issues in our service.

Key elements identified by CQC	Where are we at NBT	When will this be achieved?
All acute trusts need to have a mental health strategy.	• Mental Health Strategy now in place.	July 2024.
Mental health care should be considered frequently by the boards of acute Trusts.	• Not regularly tabled at Trust Board but at sub board committee meetings when requested.	July 2024 with strategy updates twice yearly to the Patient and Carer Experience Committee.
Mental health services in acute Trusts should meet nationally recognised quality standards.	• The NBT Mental Health Liaison Team has (since 2017) achieved accreditation with The RCPsych Psychiatric Liaison Accreditation Network (PLAN) meeting. • Not fully Core24 compliant.	Core24 is partly delivered and will be progressed further during 2024/25.
In ED patients held in safe rooms must be provided with essential food, drink, medicines, and communication with friends and family.	• NBT has one room that is considered a safe space for Mental Health patients to be assessed. This is the only one in the Trust. • There is a process in ED to get patients food when needed, they can also make phone calls to family or friends. • Patient is in ED can have access to food and drinks when needed and all who stay for over 12 hours, have access get a hot meal.	There is opportunity to have one more room dedicated as a safe room. This can be utilised as a safe room but when we have multiple patients, this may be a challenge.

2.

Key elements identified by CQC	Where are we at NBT	When will this be achieved?
Acute Trusts should have clear governance processes for administering and monitoring the Mental Health Act 1983, which may be done in conjunction with a mental health Trust.	• NBT has a Service Level Agreement (SLA) with Avon and Wiltshire Mental Health (AWP) Trust and all the administration goes to their MHA Administrators. • Section papers are monitored by Mental Health Liaison Team (MHLT). • NBT has access to a lead approved Mental Health Professional to consult if needed. • Also, the Trust has access to second opinion doctors. • We also monitor section 132 rights through MHLT.	Operational policy in place for this.
Training provided should give staff the necessary knowledge, skills, and confidence for meeting people's mental health needs.	• Training in place. • More to be designed and fully evaluated to show effectiveness. • Specialist training for complex patients under review with Mental Health Matron and Team. • Mental health module on LEARN. • Simulation training in place.	Training Needs Analysis to be completed by August 2024.
Better mental health care for patients should be provided alongside better support for staff wellbeing.	• This is identified in the MH strategy being developed. • Staff wellbeing offer. • MHLT work closely with the staff Psychology Team to support staff at risk of mental health.	July 2024: MH Strategy will link this with staff wellbeing and collaboration with staff experience team.

3. Organisational Context

Trust Strategy

Our new Trust strategy was launched in February 2023 and Patient First is the approach we are adopting to implement this 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 patient.**

Our reason for existing as an organisation is to put the patient first by delivering outstanding patient experience and that is the focal point of our strategy. The development of the Mental Health Strategy is to support the delivery of this for all patients who encounter our services with a mental health diagnosis or challenge.

Our five Improvement Priorities are:

1. High quality care:

We will make our care better by design.

2. Innovate to improve:

We will unlock a better future.

3. Sustainability:

We'll make best use of limited resources.

4. People:

You will be proud to belong to NBT.

5. Commitment to our community:

We will be in our community, for our community.

In 2022, NBT revised and updated its Values, through an extensive programme of engagement with colleagues, patients, and our communities. The Trust agreed on the four Values of Caring, Ambitious, Respectful and Supportive.

Clinical Strategy

Our Clinical Strategy published in June 2023 places outstanding patient experience at the core of our future approach to service development and outlines our approach to how clinical services will be developed and configured over the coming years.

The Strategy has five strategic themes, patients, people, population, partnership, and progress. The strategy also has six focus chapters and mental health is one of the six. This Mental Health Strategy seeks to deliver on the ambitions and plans identified in our clinical strategy. This will be achieved through our 5 key priorities of this Mental Health Strategy.

3.

Mental Health Liaison Service

The Mental Health Liaison Team (MHLT) is a specialist team within the Medicine Division (cluster 1) but providing a service to the whole of Southmead Hospital.

The team consists of two defined areas of responsibility. "The Emergency Zone" and the "Inpatient Service."

The Emergency Zone Service covers ED and the Acute Medical Unit. This part of the service is operated 7 days per week/ 365 days per year and is operational from 07:00 hrs – 22:00hrs. (Midnight extension with resource). The team covers all mental health concerns and presentations working side by side with all levels of clinicians to deliver high quality assessment and treatment options within timescales outlined nationally. The Emergency Zone Team covers all ages with 16-17yr olds predominantly being assessed by Child and Adolescent Mental Health Services (CAMHS) and by Avon and Wiltshire Mental Health Trust (AWP) colleagues.

The Emergency Zone Team also provide a Planned Assessment Clinic (PAC) which is joining the work of Same Day Emergency Care (SDEC) in providing an alternative to waiting for long periods in ED and providing a face-to-face appointment at a given time within an outpatient environment.

This service has also been awarded a parliamentary regional award.

The emergency zone sees approximately 3000 referrals annually and Integrated Care Board (ICB) state shows a mean of 4% of all ED referrals are mental health coded.

The "Inpatient Liaison Service" is a component of the Mental Health Liaison Team which covers all wards within Brunel and the retained estate, inclusive of Maternity services. This part of the service operates Monday - Friday 9.00am – 17.00pm, weekends will be commencing shortly. The ward-based work consists of wide-ranging psychiatric conditions and and oversees a caseload of patients whilst in Southmead, helping deliver holistic continuous care.

Recently our inpatient service became an active member of the Transfer of Care (ToC) Hub with mental health midday where the Mental Health Liaison Team attend at midday every day to contribute to the Multi-Disciplinary Team (MDT) discussions to ensure early intervention to reduce length of Stay (LoS) within the NBT bed base.

The Inpatient service sees approximately 2000 referrals a year.

3.

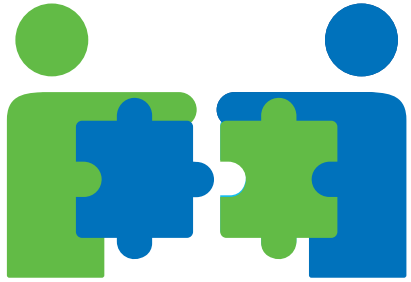
The Mental Health Liaison Team also provides the Engagement Support Workers who are an alternative to Registered Mental Health Nurse (RMN's) for 1:1 observation and will also provide emotional support to any patient that requires this support, they also specialise in areas such as supporting those patients with eating disorders.

The service consists of Mental Health Nurses at a senior level and includes social worker Mental Health Practitioners. The service also has a full grade range of psychiatric medical staff inclusive one of the first appointments of NBT psychiatrists substantively to the team.

The service is PLAN (Psychiatric Liaison Accreditation Network) accredited by the Royal College of Psychiatry. This is the national mark of excellence with over 300 elements the service needs to deliver to the highest standard. The service has been accredited twice in its history, consecutively. The service is currently in discussion with the ICB and system partners to extend our service to Core 24 where psychiatric support will be available 24/7.

The clinical health psychology service

Clinical health psychologists have expertise in the assessment and provision of specialist psychological interventions for individuals adjusting to physical health conditions, including support around decision-making around important decisions (e.g., surgery, other treatment), and engagement in rehabilitation. They provide an outpatient and inpatient service to patient, consultation with teams, as well as a dedicated service for supporting staff wellbeing. Clinical psychologists work closely with mental health liaison and other health professionals as part of multi-disciplinary teams. The service is overseen by our Chief Psychology Professions Officer (CPPO).



4. Consultation

Who we have listened to in developing this strategy

4.

Our patients, staff and partners have responded positively to the development of our first Mental Health Strategy. We have further developed our strategy based upon the feedback that we have received making it more ambitious, responsive, extensive, and collaborative.

In September 2023, we ran a series of consultations with our staff and patients. This involved surveys, virtual workshops and in person interaction on the 10th of October 2023 commemorating World Mental Health Day. The online workshops were attended by diverse staff including psychologist, nurses, consultant psychiatrist, administrative staff, staff from our Wellbeing Team and staff with lived experience of mental health. A total of 40 staff shared their views including the survey and workshops. 600 patients were written to by the Mental Health Liaison Team and 25 responded to the survey with a further 6 committing to being contacted for an interview or focus group.

Further consultations were planned with community groups, our system partners to ensure this strategy remains the voice of our patients, our staff and system partners in a collaborative way.

The strategy priorities were also shared for comments and feedback with the following groups.

- Clinical Strategy Delivery Group
- Dementia Strategy Group
- Senior Professionals Forum
- Patient and Carer Partnership Group
- Patient and Carer Experience Group
- Carers Strategy Group
- Learning Disability and Autism Steering Group
- Divisional Directors and Matrons
- Mental Health Liaison Team
- Bristol Autism Spectrum Service (BASS) Patient Group at the Create Centre
- Ambleside Renal Unit
- Patient and Carer Experience Committee
- BNSSG Mental Health and Learning Disability Health Care Improvement Group
- VCSE Mental Health Alliance
- Quality Governance Team
- NBT Safeguarding Committee
- AIS Steering Group
- Maternal Mental Health Team
- ICS partners
- Black Mothers Matters
- Ticplus- Home - Tic+ (ticplus.org.uk)
- Clinical health psychology Services (supports patients and staff)
- System Partners including AWP senior leaders
- Trust Board

5. Key Priorities

Our Key Priorities

Timely and responsive access to mental health services for all.

Support our staff to deliver effective care and outstanding experience for mental health patients.

Support our staff with their mental health needs.

Working in partnership to tackle health inequalities associated with mental health.

6. How we plan to achieve this

Priority 1: *Timely and responsive mental health service for all.*

Our Commitment

We will:

- Offer a 24/7 Mental health provision to meet the needs of our local population and the core 24 ambition.
- Patients requiring emergency response will be assessed and triaged within four hours of coming into our ED.
- Patient needing urgent response will be assessed and have a plan of care in place within 24hours of visiting our ED- (Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance (england.nhs.uk)
- We will measure patient experience based on patients reported outcome measure base on the National Institute of Health and Care Excellence Standard.
- Work in a trauma informed way, in line with the BNSSG Trauma informed 8-point pledge for partners (and in liaison with the ICB lead for trauma informed care).
- Explore digital solutions to our mental health offer e.g., developing and using apps that will make our offer effective and sustainable.
- Use national data for high-risk patients to ensure our interventions are targeted e.g., Deaf community, Autistic patients, LGBTQ+ groups.
- Work with our services in all Divisions to ensure there is clear parity of esteem between physical health and mental health of our patients.
- We will work with our women and children divisions to improve access to access to perinatal mental healthcare for women and birthing people accessing antenatal and maternity care at NBT. This will include mothers with babies in our Neonatal Intensive Care Unit (NICU).
- Recruit five patient partners with lived experience to join our patient and carer partnership group to help us improve the patient voice.
- Run campaigns to reduce stigma and shame associated with mental health presentation.
- Work with our specialist teams to ensure patients with cognitive impairment or diagnosis of dementia are assessed and supported in a timely and least restrictive way.
- Recruit volunteers with lived experience of mental health to support patients in our hospital.
- Develop links with the BNSSG VCSE Mental Health Alliance to identify service delivery gaps and develop a framework of peer support for mental health patients in ED or our inpatients settings.
- Pilot new mental health focused mortality review approaches to address current gaps in standardised data, while providing a blueprint for the wider system through the Mortality Improvement Programme. This will support more robust surveillance and quality improvement for mental health patient cohorts.
- Offer a mental health service that complies with the Accessible Information Standard. (AIS)

6.

Priority 2: *Support our staff to deliver effective care and outstanding experience for mental health patients.*

Our Commitment

We will

- Offer appropriate training for our staff to enhance effective care of patients with the psychological adjustment to physical health issues (e.g., Level 2 psychological skills training, training in trauma-informed practice), as well as training on mental health issues (including psychological risk).
- Increase the workforce's knowledge into potential risk behaviours associated with a decline in mental health that results in risk to self.
- Develop specialist nurse practitioners and specialist leads in the MHLT and clinical health psychology services to support and case manage patients with complex needs. This includes offering specialist psychology in the emergency zone.
- Train staff on complex risk management and care planning for our high intensity and complex patients.
- Work with staff through training to deliver trauma informed care to improve patient safety and experience.
- Develop Restrictive Intervention Policy and ensure use of force is monitored and training is available to support staff to optimise patient in line with the MHA and the MCA safety.
- Support our staff to recognise situations where there may be a need to ensure safeguarding of adults at risk of abuse or neglect and children at risk as a priority.
- Train staff into specialist roles to link with gaps in the services and provide regular supervision.
- Provide training on the Mental Health Act (MHA), Mental Capacity Act (MCA).
- Provide support and training for our bank Registered Mental Health Nurses (RMNs) to ensure consistency of care.

6.

Priority 2: *Support our staff to deliver effective care and outstanding experience for mental health patients.*

- Provide supervision for all our bank RMNs.
- Provide, in collaboration with our Learning and Development Team suicide prevention training.
- Support each division to have wellbeing champions, who have access to training in mental health, work-based trauma, trauma-informed approaches, and suicide reduction.
- Work to provide regular peer supervision for staff where they have a key role in supporting the effective and compassionate management of patients with emotional and mental health needs.
- Ensure all teams have regular ways to check in together and out together at the beginning / end of their shifts (e.g., through approaches like (Start Well>Endwell) as part of healthy and supportive team cultures.
- Work with our educational institutions to ensure training is optimised when training needs have been identified.
- Collaborate with our lead mental health provider (Avon and Wiltshire Mental Health Partnership) where possible to enhance the training of our staff in areas where gaps are identified.
- Provide opportunities for developing research in mental health, specifically mental healthcare in acute hospitals.
- Work with our Digital Team to fully integrate patient records with CareFlow to support real time patient communication accessible to all staff to enhance patient safety.

6.

Priority 3: *Support our staff with their mental health needs.*

Our Commitment

We will:

- Recognise the impact of work-based incidents and cumulative stressors (including the support of patients with marked distress) on staff wellbeing, and ensure there is support in place (preventative, enhanced, specialist) e.g., through the Staff Trauma Support pathway.
- Collaborate with our staff experience and Psychology Team to ensure the wellbeing of our staff remain a priority linking in with the workforce plans.
- Embark on a campaign to promote staff mental health – "No Shame No Stigma" Campaign.
- Encourage staff to share their stories and experience to break the barriers and stop stigmatisation of mental illness.
- Provide training on suicide reduction.
- Make NBT a proud place to work through effective support for our staff wellbeing, including providing adequate resource to meet our populations needs.
- Work with our staff Psychology Team to raise awareness of the pathway for assessment and support for those with mental health needs, including signposting to services for those needing support:
  - Get Psychological Help Now
  - Flowchart risk to self
  - Flowchart risk to colleague
- To develop a register where there are unmet needs (e.g., in accessing appropriate mental health support within the community) and to work with the ICB to explore ways to better meet the need.
- Work and collaborate with charities, local and community groups to raise awareness of mental health support for our community.
- Work with our staff Psychology Team to design support and assessment pathway for staff who become mentally unwell without stigmatisation.
- Support managers to support their staff informally before they get into crisis or formal processes.
- Support managers and our People's Team to develop reasonable adjustment for staff going through formal proceedings to minimise the risk of mental health illness and suicide.
- Make colleagues aware of the range of resources available through in house and external services (including talking therapies, wellbeing apps).
- Ensure staff mental health wellbeing is prioritised during staff appraisals. (Wellbeing conversations in appraisals and supervision for staff).
- Supporting staff who are carers and the impact of this on their mental health.

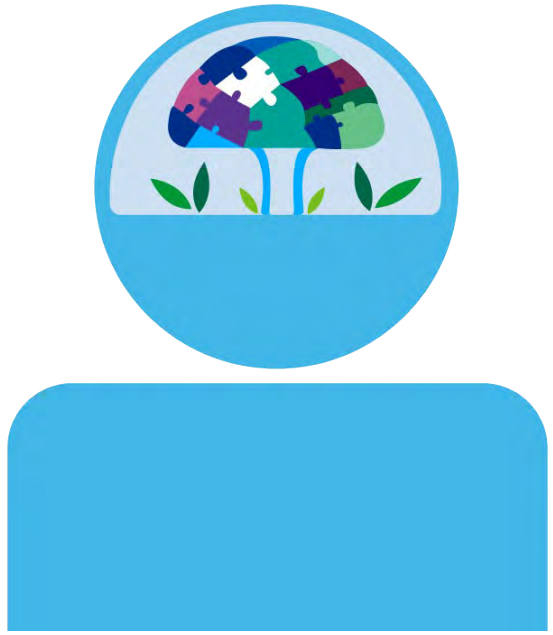
6.

Priority 4: *Working in partnership to reduce health inequalities for patients with mental health.*

Our Commitment

We will:

- We will partner with our communities with high risk to reduce health inequalities and mitigate risk through coproducing improvements.
- We will work with each of our local authority Director's of Public Health to better understand the mental health needs of our communities, supporting the development of the Joint Strategic Needs Assessment for mental health.
- We will work with our voluntary sector partners and local community specialist group to offer and deliver training and offer resources on gaps identified. E.g., Working with HOPE on Suicide prevention, using BNSSG VCSE Mental Health Alliance's expertise on self injury support.
- We will partner with our communities with high risk of deprivation to work to reduce health inequalities and mitigate risk through coproducing improvements.
- Collaborate with our specialist Mental Health Providers (AWP) to optimise specialist training.
- We will work in collaboration with system partners in the ICS to ensure we tackle mental health inequalities.
- Work with our local educational institutions to develop research focus clinical staff to support improve the care of mental health patients using evidence-based approaches.
- We will work with our BNSSG VCSE Mental Health Alliance to develop referral pathways that will enable the Trust to offer innovative delivery options.
- We will work with people with lived experienced of mental health to coproduce improvements.
- We will work in line with our ICS commitment and pledge to Trauma Informed practice through training and collaboration.
- Work closely with the NBT Safeguarding team to ensure practitioners are skilled and knowledgeable to recognise issues that may require a safeguarding intervention.



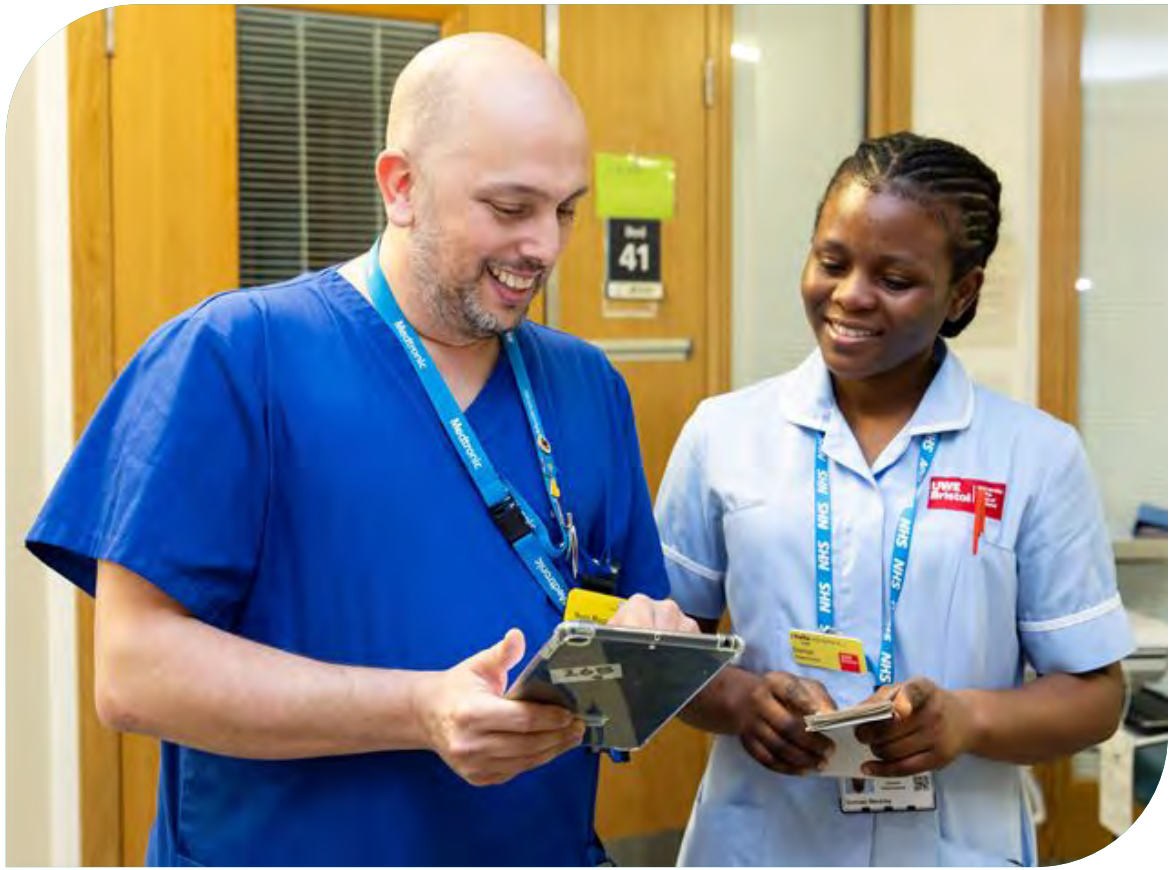
6.

Priority 4: *Working in partnership to reduce health inequalities for patients with mental health.*

- We will work with families, carers, and system partners to support safeguarding initiatives such as “professional curiosity” and “think family” in assessing risks to patients and their family and to promote the message that we all have the right to live our lives free from neglect and abuse.

- We will work closely with the Mortality Improvement Programme to:

    - Align specialty-level mortality review guidelines for the pilot mental health workstream.
    - Develop minimum mandatory mental health data points to ensure richer case reviews.
    - Leverage analytic capabilities and cross-trust data linkages to strengthen mental health mortality tracking.



7. Conclusion and next steps

This Mental Health Strategy outlines our ambitions and commitments for North Bristol NHS Trust from 2024 - 2028, which aligns with our clinical strategy ambitions, and our Patient First Strategy.

The delivery of this strategy will be guided and monitored through our Mental Health Operational Group, with assurance on behalf of the Board by the Patient and Carers Experience Committee (PCEC). We will formally review our progress annually to ensure our actions remain on track.

We will continue to listen and work with local organisations, those with lived experience of mental health, those who care for them and our colleagues to continually improve the care we provide our patients.

NHS
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NHS Trust

If you would like this document in an alternative format, please contact the Patient Experience Team at **pals@nbt.nhs.uk** or 0117 414 4569

Se desejar este documento em um formato alternativo, entre em contato com a Equipe de Experiência do Paciente em **pals@nbt.nhs.uk** ou 0117 414 4569

Jeśli chcesz otrzymać ten dokument w alternatywnym formacie, skontaktuj się z zespołem obsługi pacjenta pod adresem **pals@nbt.nhs.uk** lub pod numerem 0117 414 4569

ਜੇ ਕਰ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਕਿਸੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਵਿੱਚ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਰਿਪਾ ਕਰਕੇ **pals@nbt.nhs.uk** ਜਾਂ 0117 414 4569 'ਤੇ ਮਰੀਜ਼ ਅਨੁਭਵ ਟੀਮ ਨਾਲ ਸੰਪਰਕ ਕਰੋ।

اگر آپ اس دستاویز کو کسی متبادل شکل میں چاہتے ہیں تو براہ کرم مریض کے تجربہ کی ٹیم سے pals@nbt.nhs.uk پر رابطہ کریں یا 0117 414 4569 پر کال کریں۔

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As jy hierdie dokument in 'n alternatiewe formaat wil hê, kontak asseblief die Pasiëntervaringspan by pals@nbt.nhs.uk of 0117 414 4569

Haddii aad rabto dukumeentigan oo qaab kale ah, fadlan kala xidhiidh Kooxda Khibrada Bukaanka ee pals@nbt.nhs.uk ama 0117 414 4569

Kung gusto mo ang dokumentong ito sa alternatibong format, mangyaring makipag-ugnayan sa Patient Experience Team sa pals@nbt.nhs.uk o 0117 414 4569

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Thanks to all who contributed in shaping this Strategy through the consultation process.

NBTCARES

11.1

NHS
North Bristol
NHS Trust

Mental Health Strategy

2024 – 2028

11.2

1

July 2024

All about us

Southmead hospital is a big hospital in Bristol, with doctors and nurses caring for lots of patients.

The Care Quality Commission check to make sure we are providing good care.

Sometimes patients who come to our hospital need help with their mental health.

Mental health can mean feeling low and feeling worried and anxious.

Being physically and mentally healthy means being able to do the things you enjoy.

Looking after you and your mental health

When you come to hospital, looking after your mental health is one of our top priorities.

If you come to hospital as an emergency, we have a special team of nurses and doctors to look after you.

If you have to stay in hospital the same team will make sure you are getting better.

When you are in hospital, we encourage family and friends to visit.

We work with lots of organisations and people with experience to help us improve.

Our priorities for improving mental health

When you come to hospital and you are worried about your mental health, we will see you quickly.

When you are worried about your mental health, we will make sure you get the best treatment.

We will help our hospital team look after their own mental health.

We will work together to improve the care we provide and help everyone have a good experience.

We have lots of plans to make sure we get even better.

Find out more or get in touch

You can email us.
pals@nbt.nhs.uk

You can go to our website.
www.nbt.nhs.uk

You can find us on X (twitter).
@northbristolnhs

This was written by Gifty and Steve.

We want to thank Photo Symbols for the pictures.

Report To:	Public Trust Board			
Date of Meeting:	25 July 2024			
Report Title:	Equality, Diversity, and Inclusion Plan Progress Update			
Report Author:	Rhona Galt, Associate Director of Culture, Leadership and Development			
Report Sponsor:	Peter Mitchell, Interim Chief People Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			X	
Recommendations:	The Committee is asked to note the update on the Trust's EDI Plan for 2024/25.			
Report History:	• People and EDI Committee update 02.07.24			
Next Steps:	• Actions to progress via EDI Operational Group • Regular updates to return to People & EDI Committee • Full EDI Plan refresh to Board in December 2024			

Executive Summary		
• The Trust's 3-year Equality, Diversity & Inclusion Plan was published in November 2023 and contains an action plan across four themes. • The plan included 12 immediate actions which are now complete or on track for completion. • The Trust Executive have agreed ED&I objectives for 2024/25 to reflect the updated Staff Survey results and WRES data. • A full refresh of the ED&I plan is due in October 2024 alongside WRES, WDES and Gender Pay Gap updates.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	X
	Commitment to our Community - *In and for our community*	X
Link to BAF or Trust Level Risks:	N/A	
Does this paper require an EIA?	*No - paper is an update on existing plan, no change to policy or strategy.*	

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NHS North Bristol NHS Trust

Equality, Diversity, and Inclusion Plan Progress Update

1. Purpose

1.1 This paper provides an update to the Trust Board on the actions within the EDI Plan, alongside details of newly agreed Executive Director EDI objectives for the new financial year 2024/25 to reflect the 2023 Staff Survey results.

1.2 Based on the data from the 2023 Staff Survey Results, the Senior Leadership Group (SLG) has agreed to three ED&I objectives for the 2024/25 financial year:

- Increasing ethnic diversity of staff at senior levels (Band 8a and above)
- Improving the quality of appraisals for staff from ethnic minority backgrounds
- Introducing Trust-wide anti-racism training

1.3 This paper provides details behind each of these objectives and an update on progress.

2. EDI Plan Update

2.1 The Trust's 3-year Equality, Diversity & Inclusion Plan was published in November 2023 and contains an action plan across four themes: ensuring EDI ownership and accountability; eliminating discrimination, harassment, bullying and violence; embedding diverse and fair recruitment; and closing the pay gap. Within the Plan there are 12 immediate actions identified across these themes. Progress against each of these actions is detailed below.

Action	Status	Due Date	Progress/ Outcome
Action 1: Launch new EDI governance structure	Complete	31 December 23	ED&I & People Committee established in December 2023 and the new Operational Equality, Diversity & Inclusion Group had its first meeting in January 2024
Action 2: Agree one smart EDI objective for all Board members and senior leaders	Complete	31 March 24	*Diversity Matters* supported with Board Development sessions and with the development of EDI objectives.
Action 3: Each Division/Service to identify at least one area of improvement in EDI based on their data	Complete	31 March 24	All divisions and HRBPs have been engaged with and have shared their Divisional actions. All Divisions have developed at least one EDI objective. These have been collated and progress will be monitored through new EDI Group.
Action 4: Launch a zero-acceptance campaign and approach to discrimination, harassment, bullying and abuse	Complete	31 January 24	Zero acceptance approach added to updated *Disciplinary Policy* and guidance drafted and launched alongside a 3-month themed *'we do not accept'* campaign, which commenced in February and is running through till the end of May 2024. Programme will be fully evaluated and progress shared.
.**Action 5:** EMT & SLG 'Senior Leader Champions' identified and assigned to tackle each theme identified by the Triangulation Group	In Progress	31 March 24	Regular reporting to occur to EMT from the Triangulation Group. 'Champions' for each EDI theme are still to be agreed.
Action 6: Individual 'Speaking Up' campaigns launched for every Division	Complete	From 31 March 24	Divisions through their HRBPs have confirmed their speaking up campaigns. Most are focused on re-promoting bystander to upstander resources and increasing awareness of Freedom To Speak Up as a key speaking up mechanism. Progress will be monitored through EDI Group.
Action 7: Launch Positive Action campaign	Complete	30 Nov 24	Successfully launched, and we are monitoring progress. New recruitment policy embedding Fairer Recruitment principles has been launched

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NHS North Bristol NHS Trust

Action	Status	Due Date	Progress/ Outcome
Action 8: All posts Band 8a/above starting to be advertised as 'positive action'	Complete	01 Dec 24	Launched and in place. All roles band 8a/above have a positive action statement encouraging under-represented groups to apply. We have used the 'general statement' for **50 roles** and **2 roles** have been advertised as fixed-term 'stretch' development opportunities for under-represented groups. Diverse Recruitment Panels launched for all posts band 8A+ from 1.4.24 and DRP members have already been used in two recruitment processes.
Action 9: Track divisional and service improvement in disparity ratio and hires from deprived communities via new EDI governance structure	Complete	31 January 24	We now have baseline position for all divisions to allow divisions to track progress. KPI being measured through new Operational EDI Group.
Action 10: Review and commence implementing actions from the 'Mend the Gap' review for medical workforce	In progress	From 31st January 24	Actions have been agreed and built into the *Long -Term Retention Plan*. Actions to extend Diverse Recruitment Panels to medical staff have been agreed with plans to commence during June 2024. A review of Flexible Job Planning Policy to be in place by early 2025.
Action 11: Complete NHSE gender pay gap self-assessment by 31st December and publish pay gap action plans for gender and ethnicity by 31st March 24	Complete/on track	31st March 24	Assessment complete. This year's WRES/WDES data due to be uploaded onto the reporting portal by 31 May 2024. As with last year, we will pull gender pay gap 2024 data earlier this year and develop and publish plans to address WRES, WDES and GPG in July 2024.
Action 12: Run divisional campaigns to increase staff network involvement, supporting the release of staff	In progress	By 31st March 24	Promotional material has been produced and has been used by some Divisions to share through their comms channels to grow staff network membership. The EDI Group will monitor progress and success. More collaborative work is required with the staff networks.

2.2 The priorities for the remaining months of the first year of the EDI Plan are detailed below.

Next 6-month's priorities (1 May – 31 October 2024):

Theme	Action	Link to NBT EDI Plan and NHSE EDI High Impact Actions (HIA)
'*We do not accept…*' campaign	Evaluate and review key learning from the campaign; share and reflect this back to the organization and ensure follow-up actions are followed through into 'business as usual'	Eliminating discrimination, harassment, bullying & violence (Action 3) HIA6: Eliminate conditions and environment in which bullying, harassment and physical harassment occurs
WRES, WDES, Gender Pay Gap	Upload data from 2023/24 onto portals (when open), share summary data and publish follow-up actions by 30.9.24 Continue to implement actions from the *'Mend the Gap'* assessment	Closing the Pay Gap (Action 1) HIA3: Eliminate total pay gaps with respect to race, disability and gender
WDES project outcomes	Implement the recommendations from the WDES project around organizational barriers and improved experience for Disabled and Neurodiverse staff. Co-ordinate the work of the MSc student's research project on Reasonable Adjustments at NBT	Disability (Actions 3, 4 and 6) HIA6: Eliminate conditions and environment in which bullying, harassment and physical harassment occurs
Follow up 2023 Staff Survey weakest area: ethnicity-related discrimination	Review and analyse data. Develop a Trust-wide response and actions to the '*Too hot to handle*' paper, seeking wide engagement and input from the B.A.ME staff network and support from SW EDI Leads group. Review 'Red Card to Racism' as part of this work	Eliminating discrimination, harassment, bullying & violence (Action 6) HIA6: Eliminate conditions and environment in which bullying, harassment and physical harassment occurs
Sexual Safety & Domestic Abuse and Sexual Violence (DASV)	Fully implement the Sexual Safety Charter and develop and launch a DASV policy at NBT by 30.9.24	Eliminating discrimination, harassment, bullying & violence (Action 2) HIA6: Eliminate conditions and environment in which bullying, harassment and physical harassment occurs
Delivery of Trust-wide and divisional specific EDI objectives and actions	Continue Diverse Recruitment Panels and Positive Action, evaluating their success and impact from 1.10.24. Oversee delivery of divisional progress via the EDI Operational Group. Support and lead of key elements of NBT's 'Commitment to the Community' plan	Ensuring EDI ownership & accountability (Action 3) HIA2 Overhaul recruitment processes and embed Talent Management processes

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3. EDI Objectives 2024/25

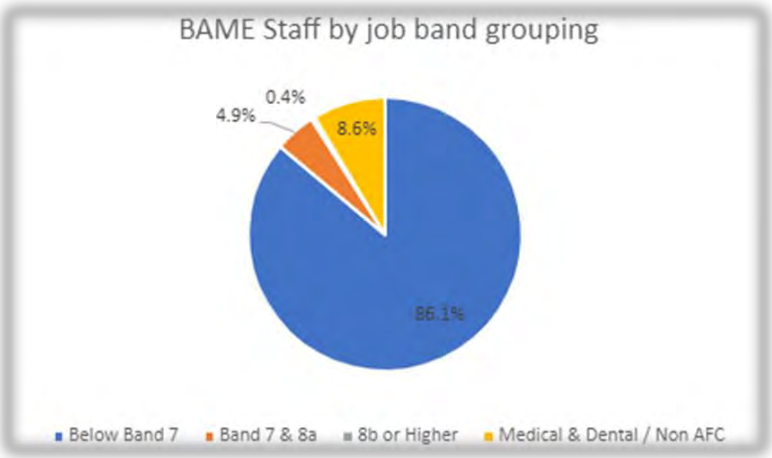
3.1 Improving Senior Representation

3.1.1 The number of staff from an ethnic minority background at NBT is increasing year on year, up 590 people since 2022/23 (see Table 1). However, the largest growth was from 233 internationally recruited staff which is as a recruitment pipeline is due to end in 2024. Despite the growth in headcount, ethnic minority staff are still disproportionately represented at lower banded posts, with only 12 people in senior roles, agenda for change 8b+ (see graph 1 on % BAME staff by job band).

Table 1: NBT workforce composition 2023/24

Financial Year	White Head Count	White %	BAME Head Count	BAME %	NULL/Non-Stated Head Count	NULL/Non-Stated %	NBT Total
2020/21	7597	79.31%	1642	17.14%	340	3.55%	9579
2021/22	7264	76.12%	1872	19.62%	407	4.26%	9543
2022/23	7052	71.84%	2244	22.86%	520	5.30%	9816
2023/24	6958	65.72%	2834	26.77%	796	7.52%	10588
Difference between 22/23 & 23/24	-94.00	-6.13%	590.00	**3.91%**	276.00	2.22%	

Graph 1: BAME staff by job band



3.1.2 The Senior Leadership Group have committed to a SMART (specific, measurable, achievable, realistic, timely) target of achieving at least 12.5% of staff at Band 8a and above to come from an ethnic minority background over the next two years. The target is shown in graph 2 below as a stretch target above the underlying expected growth in staff numbers.

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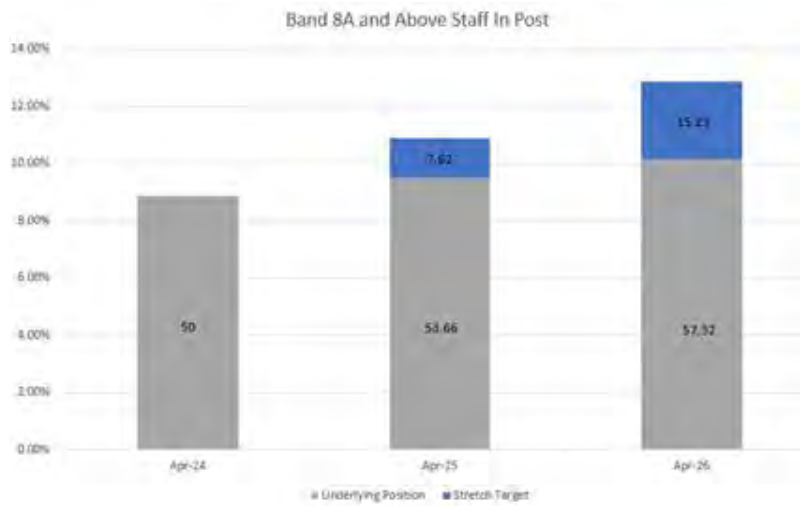
Graph 2: Stretch Target for improve senior representation



3.1.3 Actions within the ED&I Plan to address the under-representation include:

- A Positive Action campaign launched in November 2023
- A new recruitment policy embedding Fairer Recruitment launched in March 2024
- All posts Band 8a and above are advertised as 'positive action' since December 2023
- Diverse interview panels for all Band 8a and above posts launched in March 2024

3.1.4 Further work is planned by the Learning and Development Team to ensure staff from ethnic minority backgrounds are accessing suitable career development opportunities under the Trust's HELM leadership programme. Overall, HELM has a 25% diversity target for participants from under-represented groups. The Accelerate programme is specifically aimed at staff with protected characteristics from Bands 2-5. To date 61 people have participated in the Accelerate programme and follow on work is required to support the participants on an ongoing basis with career progression and development. Additionally, two cohorts of reciprocal mentoring have been run for staff from ethnic minority backgrounds, and a wider evaluation of this work is required before launching further cohorts.

3.2 High Quality Appraisals

3.2.1 Within our staff survey and WRES data sets there continue to be evidence of inequity in career development and promotion opportunities for staff from ethnic minority backgrounds. We have a disparity ratio of 1.53 for BAME staff between shortlisting and appointment, and staff from BAME background are 8% less likely to believe the Trust provides equal opportunities for career progression.

3.2.2 The Trust's senior leadership team has agreed an EDI objective for 2024/25 to focus on improving the quality of appraisals for staff, with a view to supporting greater career progression through meaningful development conversations.

3.2.3 The Trust's appraisal window is April to July 2024, and new appraisal training has been launched alongside this. This year the Trust is using a new online appraisal system 'My Appraisal' which collects feedback from appraisees in real time, which enables us to monitor the feedback on quality of appraisals. This new dataset should enable our People team to identify problem areas and to improve training.

3.2.4 In collaboration with the BAME staff network a series of 'fishbowl' appraisal sessions are planned for October 2024, during Black History Month. These sessions are designed to facilitate open and dynamic group discussion in understanding what makes a good appraisal and will be aimed at nursing staff across Bands 5 – 7. The sessions will explore common barriers to progression such as appraisers having limited understanding of internationally trained staff's prior knowledge and experience; academic barriers to post-registration development; lack of understanding of career ladders and opportunities.

3.3 Becoming an Anti-Racist Organisation

3.3.1 We know that racist discrimination occurs in our Trust. From the staff survey results, BAME staff are more than twice as likely to experience discrimination at work from their manager compared to white staff (13.8% Vs 5.7%) and there has been a 5.62% increase in discrimination based on ethnicity since 2022, 4.5% worse than our comparator Trusts.

3.3.2 The Trust's Executive and Senior Leadership Team has committed to an EDI objective for 2024/25 of becoming an 'anti-racist organisation' with an initial plan to introduce mandatory anti-racism training to all staff.

3.3.3 A supplier analysis of specialist ED&I training companies has been undertaken, including consideration of approaches in development at UHBW and NHS England.

3.3.4 The recommended approach is to join a collaboration with Health Innovation West of England (HIWE), Representation Matters and BCohCo to develop a bespoke training model based on the successful Black Maternity Matters (BMM).

3.3.5 The BMM programme has been evaluated and found to have had significant impact on the anti-racist knowledge and practices of midwives who participated. Importantly the programme was designed by Bristol based ED&I specialists, whose approach has been described as both inspirational and challenging.

3.3.6 The anti-racism training would be aimed at improving the knowledge of staff on the topic of racism, and position the work within NBT's CARES values, that to be anti-racist is also to be caring, respectful and compassionate. The project would take small pilot cohorts across senior leaders, 'champions' from HR, Trade Unions and Staff Networks, and all-staff groups, and using evaluation to refine the approach before seeking agreement on wider rollout.

3.3.7 This new collaboration would enable NBT to co-produce and pilot a programme of anti-racism training for staff using an existing evidence-based framework and using QI principles. The training is proposed to develop programmes for three different staff cohorts.

SLT Training Model: 25 Participants for a 6-month programme, 3 x in-person training sessions, 3 x Virtual 90-minute book clubs, Virtual Quality Improvement sessions & coaching BHM Champion. All learning resources and materials provided and venue, catering and refreshments. Organisation, administration, and project management including communication and engagement and recruitment support. Community of practice and collaborative working through the BMM collaborative.

Staff Champion Training Model: 25 Participants for a 6-month programme 3 x in-person training sessions, 3 x Virtual 90-minute book clubs, Quality improve sessions & coaching All learning resources and materials provided and venue, catering and refreshments. Organisation, administration, and project management including communication and engagement and recruitment support. Community of practice and collaborative working through the BMM collaborative Support and collaborative working through existing BMM Champion Network

Whole staff Anti-Racism Pilot Training (x 2 Cohorts): 25 per cohort for three-hour online workshop sessions. Co Production and development of content with NBT EDI Staff Working Group. Bespoke

content design and development. 1 x three hour online facilitated workshop session per cohort. All learning resources and materials provided. Pre and post course learning tasks. Initial pilot evaluation.

3.3.8 It is recognised by the Senior Leadership Group that the above training proposal will require significant commitment from staff against a backdrop of competing training demands. It is proposed that the whole staff anti-racism pilot will be accessible online, to avoid direct clinical care being affected. As part of the pilot consideration will be given to scalability and rollout, such as tiered rollouts across services. Alongside this current Mandatory and Statutory training requirements will be reviewed for opportunities to release staff time and cost to support this new model.

3.3.9 Work is in progress to develop this programme with a view to launching a pilot in October 2024, during Black History Month celebrations.

4. Additional Activities

4.1 In addition to the three Trust-wide EDI objectives, the following activities are also in progress:

- Reviewing the 'Red Card to Racism and Abuse' campaign based on feedback from our BAME staff network.
- Raising awareness of the trust's Trauma Support Pathway to support staff affected by racial trauma, delivered by our new staff clinical psychologist who leads on BAME staff support.
- Presenting our WRES data to the Operational EDI Group, People Oversight Group and Executive Team Meeting in August, with a presentation to Board in October for assurance and information.

5. Summary and Recommendations

5.1 The Trust Board is asked to note the update on progress against the actions within the ED&I plan in year 1.

5.2 The Trust Board is asked to note the 2024/25 ED&I objectives of:

5.2.1 Increasing ethnic diversity of staff at senior levels (Band 8a and above)

5.2.2 Improving the quality of appraisals for staff

5.2.3 Introducing Trust-wide anti-racism training

5.3 A full refresh of the ED&I Plan is due in late 2024 alongside WRES, WDES and Gender Pay Gap updates.

Report To:	Public Trust Board			
Date of Meeting:	25 July 2024			
Report Title:	Quality Committee Upward Report			
Report Author:	Aimee Jordan-Nash, Senior Corporate Governance Officer & Policy Manager			
Report Sponsor:	Shawn Smith, Non-Executive Director			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	That the Trust Board receive the report for assurance and note the activities Quality Committee has undertaken on behalf of the Board.			
Report History:	The report is a standing item to the Trust Board following each Committee meeting.			
Next Steps:	The next report will be received at Trust Board in September 2024.			

Executive Summary		
The report provides a summary of the assurances received and items discussed and debated at the Quality Committee (QC) meeting held on 4 July 2024.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	✓
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	Link to BAF risks: • Patient Flow and Ambulance Handovers • Long Waits for Treatment	
Financial implications:	No financial implications identified in the report.	
Does this paper require an EIA?	No as this is not a strategy or policy or change proposal	
Appendices:	N/A	

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1. Purpose

1.1 To provide a highlight of the key assurances received, items discussed, and items for the attention of the Trust Board from the Quality Committee (QC) meeting held on 4 July 2024.

2. Background

2.1 The QC is a sub-committee of the Trust Board. It meets monthly with alternating deep-dive meetings and reports to the Board after each meeting. It was established to provide assurance to the Trust Board on the effective management of quality governance.

3. Meeting on 4 July 2024

3.1 Medical Examiner Service - Annual Report 2023/24 and Update

The Committee were joined by the Lead Medical Examiner Officer who presented the Medical Examiner Service Annual Report for 2023/24 which detailed an update of the service activities for 2023-24 and summarised the key 'next steps' during 2024-25. It was noted that the service would become a statutory medical examiner system from 9 September 2024, and so, by law, all non-coronial deaths in England and Wales would require scrutiny by a Medical Examiner service prior to their registration. However, there were no anticipated changes for North Bristol Trust (NBT) as a result of becoming statutory and the Committee received reassurance that the focus would be on quality rather than implementation.

The Committee received assurance that the referral rate to Trust governance for further investigation was 10.9% which was within the national average but noted that University Hospital Bristol and Weston NHS Foundation Trust (UHBW) had a higher percentage. It was suggested that this was due to the difference in processes between the organisations, and the Committee were reassured that work was ongoing to align the processes via the Mortality Improvement Programme.

The Committee received reassurance that the Patient Safety Group (which was an Executive led committee) thoroughly discussed all deaths of patients with learning disabilities and assessed the necessity of any further investigations. In addition, the Summary Hospital-Level Mortality Index (SHMI) data showed that the Trust was in a safe position for mortality.

The Committee welcomed the report and noted all the hard work to support the service and recognised the impact of the service. The Committee noted the positive feedback from patients regarding their experience of the death and bereavement support provided by the service.

3.2 Learning From Deaths/Mortality Annual Report 2023/24

The Committee were joined by the Clinical Audit & Effectiveness Manager who presented the 2023/24 Learning From Deaths/Mortality Annual Report described good learning, the links with the Medical Examiner service and the forward plan. The report also detailed and the ongoing work to develop the mortality improvement programme.

The Committee received assurance that:

- the Trust has a robust system in place to deliver the key requirements and support learning and continuous improvement,

- that NBT remains a safe hospital for patients, with Summary Hospital-Level Mortality Index (SHMI) data confirming that NBT ranks favourable with peer groups for overall low mortality.
- that mortality review outcomes reported that 98% of overall care was rated as Adequate, Good or Excellent.
- that an enhanced review process was in place for Learning Disability and Autism (LDA) deaths and were not a result of the care provided.

The Committee discussed the trajectory of the completion of mortality reviews and received reassurance that the fluctuation was related to the LDA team and that it was anticipated to be corrected as the LDA team expanded. The Committee also noted the ongoing work to encourage consistent engagement with specialities and obtain real-time data that could be tracked for closer oversight.

It was noted that the annual report would be separately presented to the Trust Board in line with guidance from the National Quality Board.

3.3 Deteriorating Patient Group

The Committee were joined by the Deputy Medical Director who presented an update Deteriorating Patient Group and the work being undertaken to ensure a safer hospital for acutely unwell patients. The update set out the progress made across the various workstreams of the Deteriorating Patient Group since the previous report to May's QC meeting and the ongoing work to implement Martha's law.

The report highlighted:

- the key achievements, including the development of training packages, the resurrection of the Deteriorating Patient Group and the progress to develop the rapid response team.
- the key challenges, including the interface/accessibility of policies and guidelines for clinical staff, the agility of System C to adapt to changing guidelines and implementing the third element of Martha's law.
- the next steps such as launching the mandatory training, recruitment for the rapid response team and improving guideline accessibility.

The Committee received assurance that relevant clinical policies had been updated but recognised that the challenge remained with the accessibility of those documents for clinical staff. The Committee noted the LINK replacement project that was underway, which embedded the requirements for clinicians access to policies and consideration of the convergence with UHBW.

The Committee received assurance that the compliance with observations completed on time was on a healthy trajectory and had increased from 45% to 84% with breaches reduced to 11.9%. The Committee was reassured regarding the plan to improve observation performance through targeted deep dives into specific wards.

Discussion focused heavily on the need for a digital solution to deliver the third element of Martha's Law and concerns were raised regarding the agility/responsiveness of System C to adapt to the changing national sepsis guidelines, particularly as they are unable to adapt the Vitals platform to the new guidelines until 2026.

The Committee welcomed the report, noting that it provided a great deal of assurance on the progress made and agreed to receive an update in three months' time.

3.4 Healthcare Legal Update

The Committee received an update on the Trust's healthcare legal activity for Q3 and Q4 2023/24 and included summarised lessons learned from claims and inquests.

The report provided assurance that:

- The organisation benchmarks well, and is not an outlier for healthcare legal action,
- Learning from healthcare legal claims and inquests is identified and shared across the organisation.

The Committee discussed the cost-savings of the inhouse legal team and noted that it was calculated in terms of external cost avoidance.

3.5 Trust-wide Clinical Policies & Guidelines Progress Report

The Committee received an update on the status of the Trust-wide clinical policies and guidelines, particularly those currently overdue for review. It was noted that there were some delays (specifically for Infection prevention Control (IPC) and Venous thromboembolism (VTE) policies) as a result of the complex work to align the policies across the system.

The Committee received assurance that positive progress has been made to reduce the backlog of policies past review date and that there was a strong governance process in place. The Committee received reassurance that risk assessments for policies past review date were a priority and were being actively chased.

3.6 Maternity

Perinatal Quality Surveillance Matrix (PQSM)

The Committee received the PQSM report which detailed the perinatal safety intelligence for June 2024. The Committee received assurance that:

- the Perinatal Mortality Review (PMRT) was fully compliant with the Maternity Incentive Scheme (MIS) year six requirements,
- there were no Perinatal services referrals to Maternity and Newborn Safety Investigations (MNSI) in May 2024,
- the midwifery vacancy rate was at 2.68% - the lowest it has been since January 2022,
- the Avoiding Term Admissions Into Neonatal Units (ATAIN) had overall admission rate of 3.7% against the national target of 5%. This was a 1.3% reduction from last month.

The Committee also received a summary of the themes arising from the community walkaround feedback and received assurance that a community task and finish group was being established to address the issues raised, such as:

- implementing a governance and decision-making processes to ensure the community's voice was heard at divisional level.
- increasing productivity through focusing on effectiveness of appointments.

The Committee also received reassurance that this triangulated with the systematic review of the Women and Children's workforce and estate issues and that a detailed action plan had been developed.

Discussion focused on the obstetric workforce, the implications of the two new obstetric posts and how they would be realised in practice.

Maternity Safety Champion Update
The Committee received a verbal update from the Director of Nursing (Quality and Professional Standards) on the ongoing work from the Maternity Safety Champions and the outcomes from the walkarounds.

It was noted that the last visit to the Community teams showed improvement and there was a plan in place to conduct regular visits. The Committee received assurance that patient partners were part of the process and offered valuable challenges. The Committee welcomed the ongoing work to review how to replicate this type of learning in other patient safety areas.

3.7 **Other items:**
The Committee also received the following items for information:

- The Organ Donation Committee Annual Report which set out NBT's organ donation activities for the 2023/24 financial year and provided assurance on the ongoing effective delivery of these services.
- The quarterly quality report for the BNSSG System Vaccination Programme.
- Sub-committee upward report(s):
    - Control of Infection Committee
    - Drugs & Therapeutics Committee
    - Patient Safety & Clinical Risk Committee
- Quality Committee forward work-plan 2023/24

4. Identification of new risks & items for escalation

4.1 The agility/responsiveness of System C to adapt to the changing national sepsis guidelines, particularly as they are unable to adapt the Vitals platform to the new guidelines until 2026.

5. Summary and Recommendations

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

Report To:	Public Trust Board			
Date of Meeting:	25 July 2024			
Report Title:	Learning from Deaths Annual Report 2023/24			
Report Author:	Sarah Waters, Clinical Audit & Effectiveness Manager Paul Cresswell, Director of Quality Governance Joydeep Grover, Deputy Medical Director			
Report Sponsor:	Tim Whittlestone, Chief Medical Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
	N/A	**N/A**	**N/A**	**N/A**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	The Trust Board is requested to discuss and approve the contents of the report as recommended by Quality Committee			
Report History:	This covering report and the full Annual Report was reviewed and endorsed by the Quality Committee on 4th July 2024.			
Next Steps:	A number of further actions to continuously improve Mortality Governance are set out within the report, including those that support alignment within the hospital group with University Hospitals Bristol & Weston Foundation Trust.			

Executive Summary

Background

The Learning from Deaths national guidance was published in March 2017, by the National Quality Board (NQB). NBT has consistently achieved the key requirements.

Purpose

The purpose of this agenda item is to provide the Quality Committee with the LFD Annual report for 2023-24, to request its review and approval and to provide assurance that a robust system is in place to deliver the key requirements and support learning and continuous improvement as a consequence of these activities.

Links with Medical Examiner Service

This item links with the Lead Medical Examiner's Annual Report for 23-24, which was also reviewed at the July Quality Committee. This service is hosted by NBT and whilst independently established in terms of its line management accountabilities and governance, the service is supported operationally within NBT's corporate functions, and clinically through the joint service board established with UHBW. It is one of the very few Medical Examiner Services established

from the outset across separate NHS acute trusts covering an ICS footprint, which has been beneficial from several perspectives.

Overview

NBT remains a safe hospital trust - with a Standardised Hospital Mortality Index (SHMI) of 95, 5 more patients are expected to survive for every 100 when they are cared for by our excellent clinical teams as compared to equivalent matched hospitals across the UK. While this is a measure of confidence in our clinical care which we continue to monitor, there remain areas for improvement in our reviews – particularly in shortening the times taken to review of deaths, analysing the data in more detail linked to speciality and wards, and in formalising feedback loops to improve shared learning.

Despite the challenges posed by Covid and post-Covid surge in demand, complicated by repeated industrial action, our mortality program improved to consistently review 99.6% of all deaths within NBT. This provides confidence that this stream of work is now established and 'business as usual', which is much to the credit of the sustained work by the NBT's Quality Governance and Patient Safety Teams.

Around 8% of deaths in NBT are marked for further review – roughly half of these are 'mandatory' reviews of special circumstances such as deaths in patients with learning disability, and review of these and the others provide a valuable set of learning which is detailed in the latter half of the Annual Report.

Forward Plan

In 2024, NBT launched the Mortality Improvement Programme in collaboration with University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). The programme brings together various workstreams and projects under a shared vision - to set new standards of excellence for mortality review, and for our approach to become a national and regional model for Learning from Deaths and evidence-based care transformation.

Our ambition is to become a national exemplar of how learning from deaths can progress from being a regulatory requirement to being a source of improved and exceptional patient care, by providing the right tools to our clinical teams, and confidence to the patients we serve.

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	X
	Innovate to Improve – *Unlocking a better future*	X
	Sustainability – *Making best use of limited resources*	X
	People – *Proud to belong*	X
	Commitment to our Community - *In and for our community*	X
Link to BAF or Trust Level Risks:	SIR 14: Sustained demand and increased acuity of patients in hospital will impact on patient safety and outcomes, leading to harm in patients and poorer patient experience.	

Financial implications:	None specifically as a consequence of the activities set out within this report. The completion of mortality reviews is an embedded expectation within clinical specialties.
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	Considered within individual mortality reviews as applicable to individual cases, for example the reviews for patients with Learning Disabilities or Autism are undertaken jointly by a consultant and one of the Learning Disability Liaison team to ensure care is considered holistically.
Appendices:	**Appendix 1 -** Learning from Deaths Annual Report 2023/24

NHS
North Bristol
NHS Trust

Learning from Deaths Annual Report 2023/24

Foreword

2023-24 has continued to establish and improve the mortality review services at NBT. Despite the challenges posed by Covid and post-Covid surge in demand, complicated by repeated industrial action, our mortality program improved to consistently review 99.6% of all deaths within NBT. This provides confidence that this stream of work is now established and 'business as usual,' which is much to the credit of the sustained work by the NBT's Quality Governance and Patient Safety Teams.

Around 8% of deaths in NBT are marked for further review – roughly half of these are 'mandatory' reviews of special circumstances such as deaths in patients with learning disability, and review of these and the others provide a valuable set of learning which is detailed in the latter half of this report. Our processes of monitoring and channelling feedback have continued to improve and some examples of this across all divisions are also highlighted.

We have successfully managed to fund and recruit to the position of Mortality Improvement Lead in December 2023, and this has been reflected in the development of the mortality improvement program spanning NBT, ICB, and UHBW which was launched in January this year. This is an ambitious and exciting program to move our 'learning from death' program to the next level, and I'm sure you will be pleased by the rapid and extensive progress made as detailed in section 5 of the report. Further NBT is now actively participating, and in fact leading, in the National Mortality Leads forum to share best practice and continues to engage with peers regionally.

NBT remains a safe hospital trust - with a SHMI of 95, 5 more patients are expected to survive for every 100 when they are cared for by our excellent clinical teams as compared to equivalent matched hospitals across the UK. While this is a measure of confidence in our clinical care which we continue to monitor, there remain areas for improvement in our reviews – particularly in shortening the times taken to review of deaths, analysing the data in more detail linked to speciality and wards, and in formalising feedback loops to improve shared learning.

With the independent ME service now established and hosted at NBT, our Mortality Improvement Program aims to improve our analysis function and translate it to learning across Bristol – both within the hospital as well as community settings. Our ambition is to become a national exemplar of how learning from deaths can progress from being a regulatory requirement to being a source of improved and exceptional patient care, by providing the right tools to our clinical teams, and confidence to the patients we serve.

Dr Joydeep Grover

Medical Director – Safety and Quality

July 2024

Contents

Section 1: Mortality Indicators

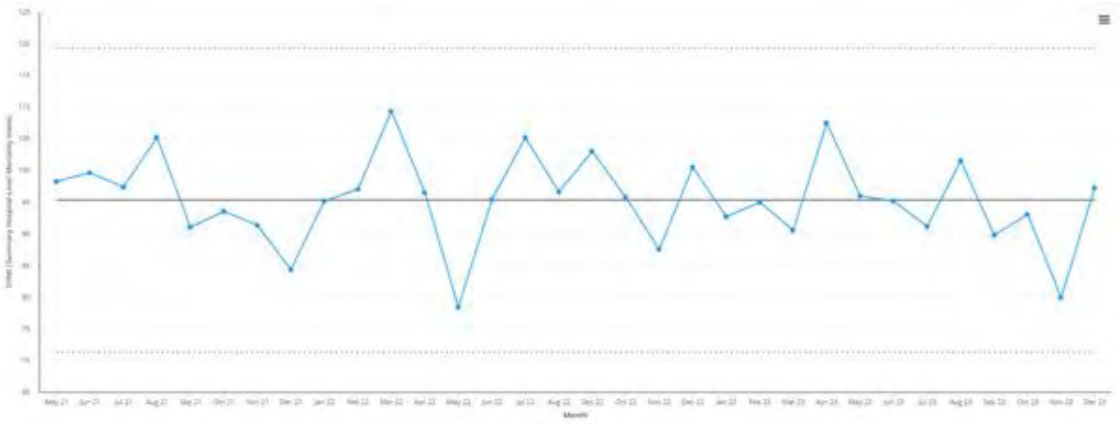
1.1 SHMI

The Standardised Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation (up to 30 days post-discharge) at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated here. SHMI considers more variables than HSMR particularly co-morbidities and the emergency/elective split of admissions. **It is seen nationally as a more reliable mortality indicator than HSMR.**

The most up-to-date available data for SHMI covers the period May 2021 – December 2023. NBT's value for that full period is 95.11 and our peer value is 100.29 indicating that we are performing better than our peer organisations.

We have seen some normal variation in our in-month SHMI values, but this has not been outside the process limits; indicating statistical stability with no individual months outside of the control limits prompting concern.

FIG 1| NBT SHMI SPC CHART MAY 2021 – DECEMBER 2023 (EXTRACTED FROM CHKS)



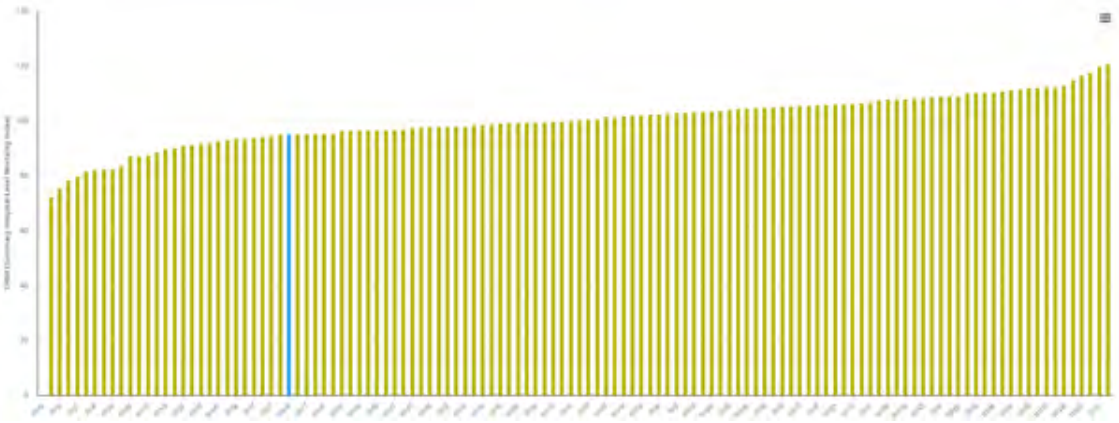
Our trajectory for SHMI follows that of our peer organisations but is lower on all occasions between May-21 and December-23.

FIG 2| NBT SHMI TIME SERIES CHART (NBT IN BLUE) CHART MAY 2021 – DECEMBER 2023 (EXTRACTED FROM CHKS)

Green line – NBT Peer Comparison Group	Blue line – NBT data

Our peer distribution shows that NBT is at the lower end of the scale.

FIG 3| SHMI PEER DISTRIBUTION (MAY-21 – DECEMBER-23) – EXTRACTED FROM CHKS



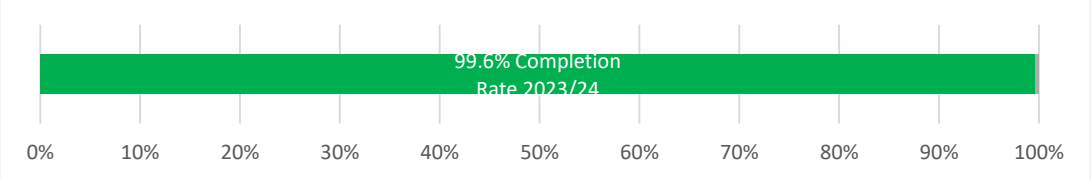
Section2: Mortality Review Activity and Outcomes

Some form of review should be undertaken on all deaths that happen at NBT. These generally are undertaken at two levels – a high level screening of the case undertaken either by the specialty or the Medical Examiner to identify if there are potential issues that might require further investigation, and a more in-depth case note review. Some categories of deaths require a full case note review regardless of whether concerns are indicated, these are cases where the patient was an elective admission, had a serious mental illness, had a learning disability or autism, where a significant care concern has been raised by bereaved families and carers or staff, all deaths in a service specialty where an 'alarm' has been raised, all deaths in areas where people are not expected to die and all deaths where learning will inform the provider's existing or planned improvement work. There have been no new alarms raised during the 2023/24 reporting period.

2.1 Mortality Review Completion Rate

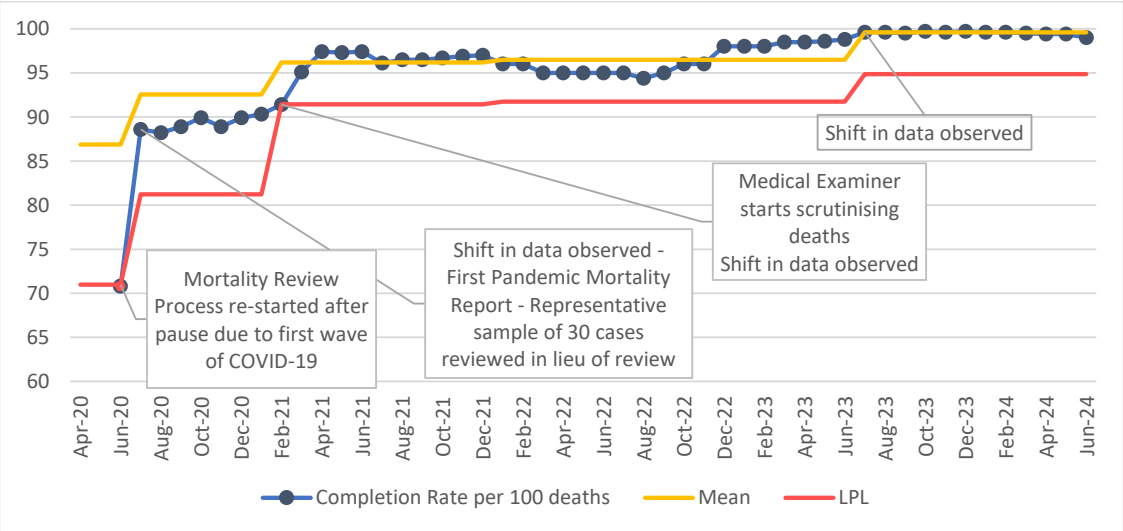
The following charts (Figs 4 & 5) indicate the mortality review completion rate per 100 deaths. A review completion includes a screening review with no concerns flagged, or Medical Examiner scrutiny, or a full mortality case note review (Structured Judgement Review). Monthly data is reported as the summation of the previous 12 months, **2 months in arrears** – this is to allow a completion window for the cases.

FIG 4| MORTALITY REVIEW COMPLETION RATE 2023/24



The data shows that NBT records a consistently high level of completion for mortality reviews.

FIG 5| MORTALITY REVIEW COMPLETION OVER TIME APR-20 – JUN-24 (DATE BY REPORTING MONTH)

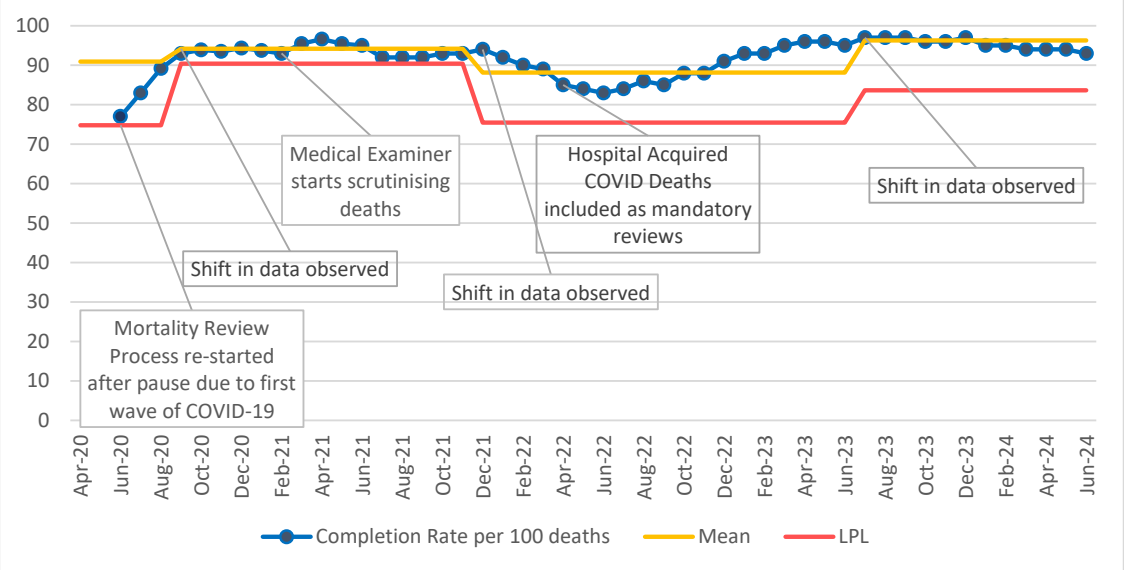


The latest shift in the data from July 2023 onwards is further evidence of continued ongoing improvement in completing a mortality review for inpatient deaths at some level at NBT. This is a highly stable process which has little chance of deviating below the lower control limit, indicating a culture of sustained good practice in this area.

2.2 Mortality Review Completion Rate – High Priority Cases

Mortality reviews labelled as high priority are those that fall into the mandatory review categories of patients with a learning disability or autism, patients with a serious mental illness, elective admissions, cases that have been screened for review either by the Medical Examiner or the Trust due to a care concern. All high priority reviews are usually undertaken using a Structured Judgement Review, however in exceptional cases where there is high-complexity a round table review might be undertaken with outcomes recorded in an SJR format. Inquests or patient safety incident investigations may supersede an SJR but will still count as a high priority review completion.

FIG 6| MORTALITY REVIEW COMPLETION RATE – HIGH PRIORITY CASES APR-20 – JUN-24



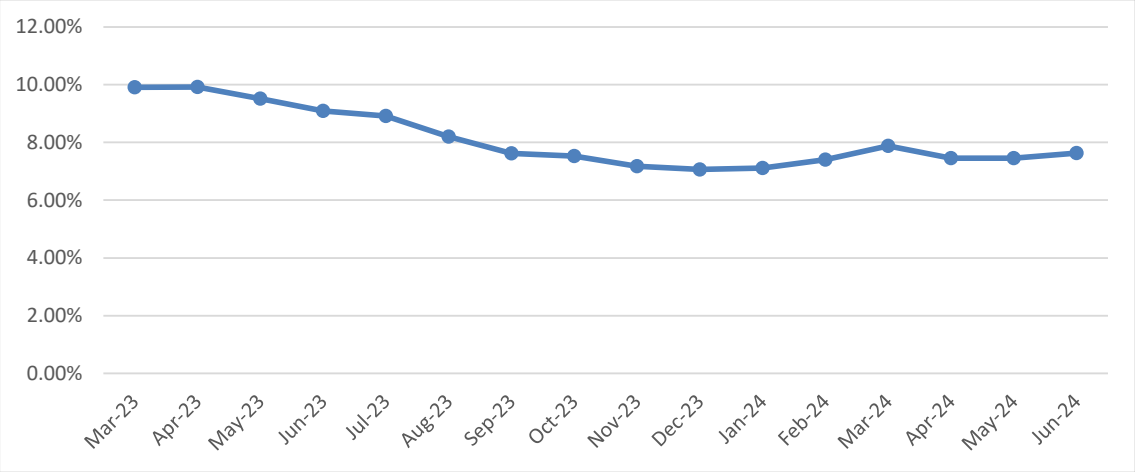
There is normal statistical variation in this process where completion of high priority reviews remains consistently high. There is room for improvement, however it is recognised that clinical pressures across the Trust in the last year, including ongoing doctors' strikes has made completing reviews more difficult for staff. Cases that are currently overdue for completion for patients that died within 2023/24 are as follows:

- Cases where the patient was an elective admission: 2
- Cases where the patient had a serious mental illness: 4
- Cases where the Medical Examiner suggested an SJR was undertaken and this was confirmed by the division: 2
- Cases screened in for learning: 1
    - Patient was on home day visit when they passed away.

2.3 Structured Judgement Review (SJR) Distribution

All cases get looked at by the Medical Examiner Service but NBT only further reviews some of its cases via SJR where there is a concern that care may not have been up to our usual excellent standards raised by either the family or a clinician, or the patient is part of a group that would not be expected to die (e.g. elective admissions), or is from a group that may be more vulnerable to experiencing less than good healthcare (e.g. patients with a learning disability).

FIG 7| STRUCTURED JUDGEMENT REVIEWS AS A PERCENTAGE OF ALL DEATHS (12 MONTH ROLLING DATA, REPORTED 2 MONTHS IN ARREARS)



NBT undertook SJRs on 7.6% of our deaths during the 12 months from April 2023 to March 2024. There is no target for the number of SJRs that should be undertaken but we would want to make sure of the following:

- Reviews are distributed across all areas of the Trust.
- There may be a concentration of reviews in particularly high-risk areas.
- We are reviewing enough deaths to give a representative picture of the Trust/department.

FIG 8| STRUCTURED JUDGEMENT REVIEW DIVISIONAL DISTRIBUTION 2023/24

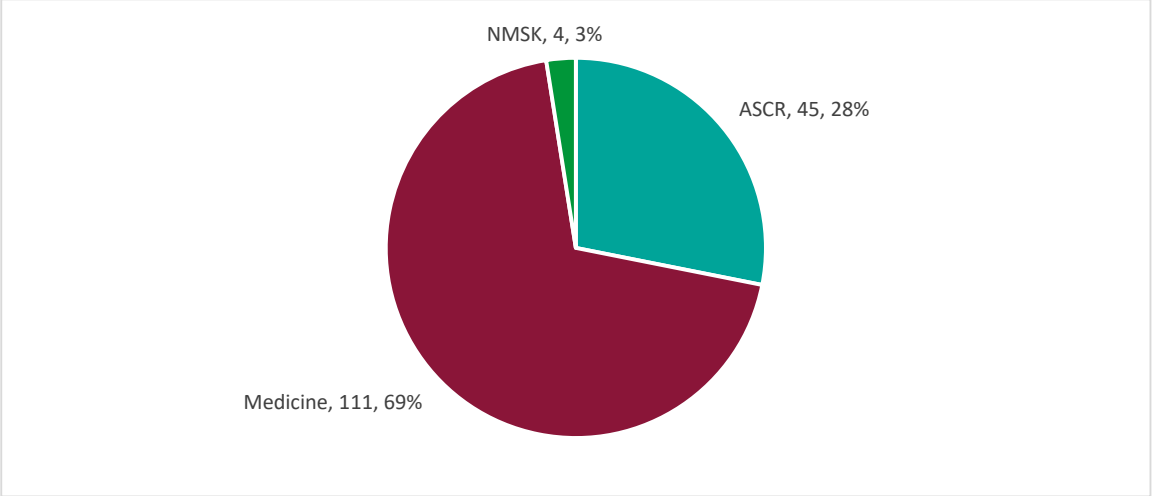
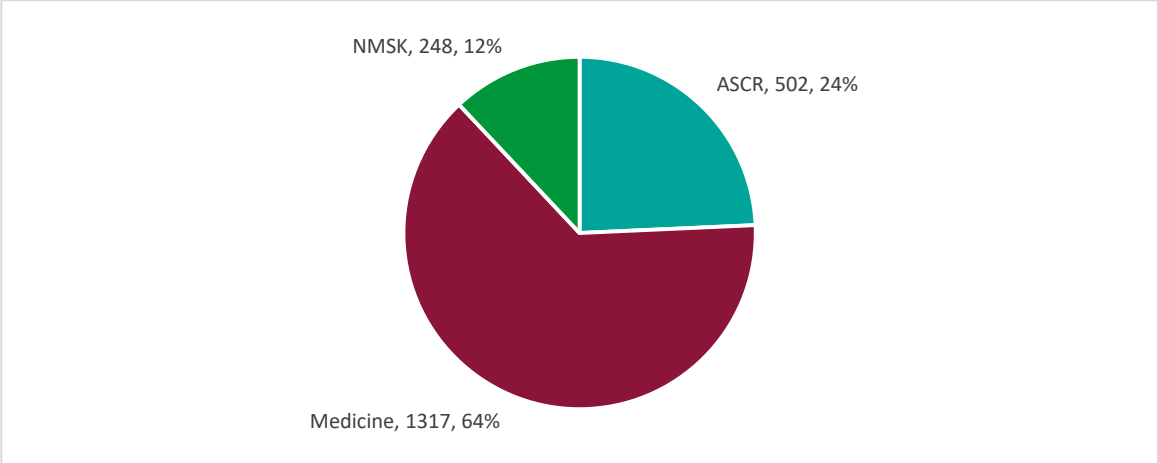


FIG 9| DEATHS ACCORDING TO SJR DIVISION 2023/24



Over the last year our reviews across the Trust have not been evenly distributed. We can see this further as we break the reviews down to specialty level. As we review and re-form our SJR process we aim to create a system in which there is a representative sample of reviews, that forms a representative indicator of care across the whole Trust. Some specialties choose to review all, or most, of their deaths, but we need to ensure that there are not areas in the Trust where no reviews are undertaken.

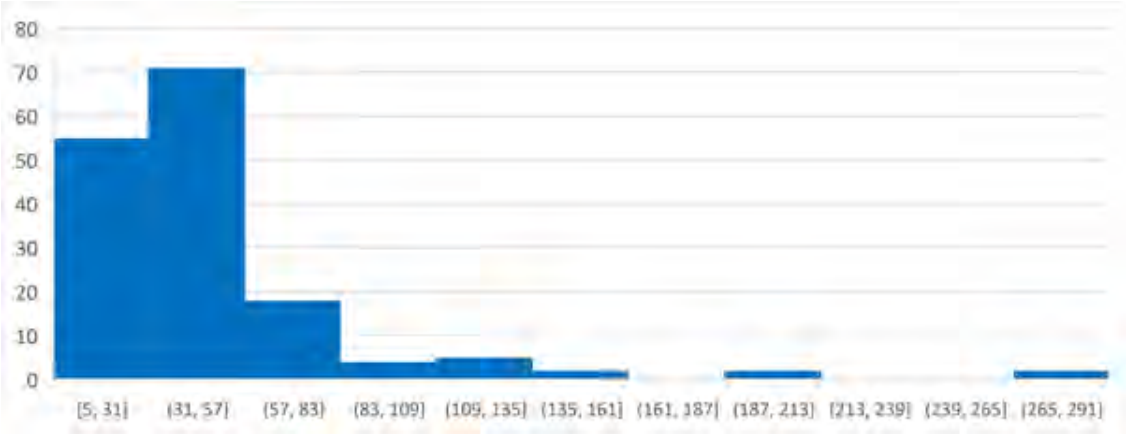
FIG 9| STRUCTURED JUDGEMENT REVIEW SPECIALTY BREAKDOWN 2023/24

	2023/24
ASCR	**45**
Critical Care	36
General Surgery	1
Nephrology	1
Urology	4
Vascular	2
Medicine	**111**
Acute Medicine	12
Care of the Elderly	15
Emergency Medicine	72
Gastroenterology	2
General Medicine	1
Respiratory Medicine	9
NMSK	**4**
Stroke	4

2.4 Structured Judgement Review – Time to Review

Every attempt is made to review cases in a timely manner, but we still require clinician time to complete reviews. The median time to undertake a review is 38 days, with a range of 5-284 days. The majority of our reviews are completed in under 57 days as shown by the chart below, but we recognise the need for improvement in this area. It is important to make sure we are targeting the right cases for review so that the most value can be sought from them.

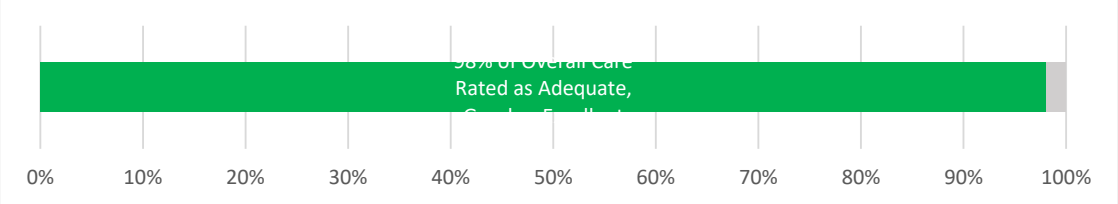
FIG 10| DISTRIBUTION OF TIME TO REVIEW (DAYS) 2023/24



2.5 Structured Judgement Review Care Scores

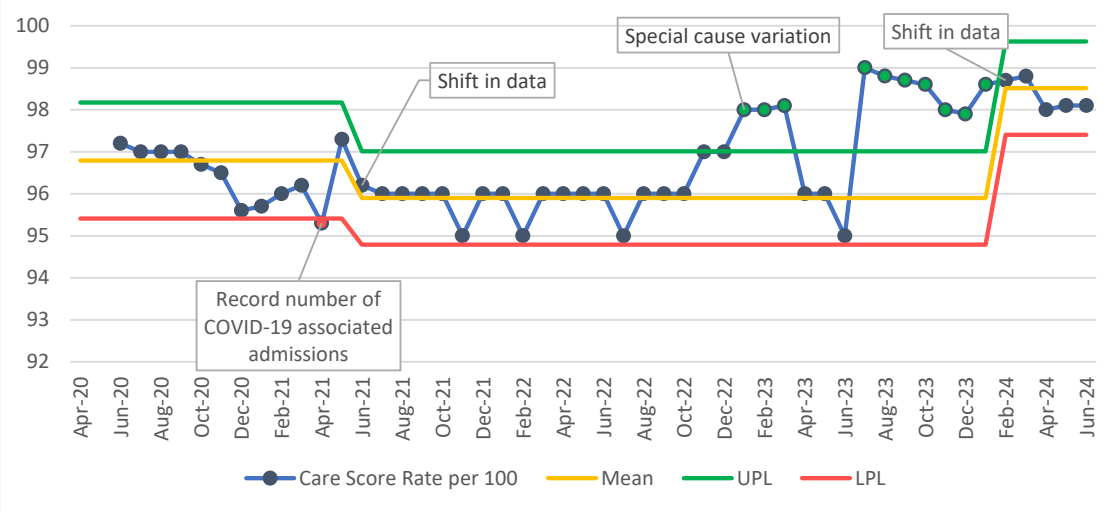
Overall care scores are included as part of Structured Judgement Reviews (SJRs). These are from 1 – Very poor care to 5 – Excellent care. The percentage of cases reviewed with an overall care score of adequate, good, or excellent for 2023/24 was 98.1%.

FIG 11| STRUCTURED JUDGEMENT REVIEW OVERALL CARE SCORES RATED ADEQUATE, GOOD OR EXCELLENT 2023/24



The following chart shows the cases where the care was overall rated as 3 (adequate), 4 (good) and 5 (excellent) as a rate per 100.

FIG 12| STRUCTURED JUDGEMENT REVIEW CARE SCORES OVER TIME APR-20 – JUN-24 (12 MONTH ROLLING - DATE BY REPORTING MONTH)

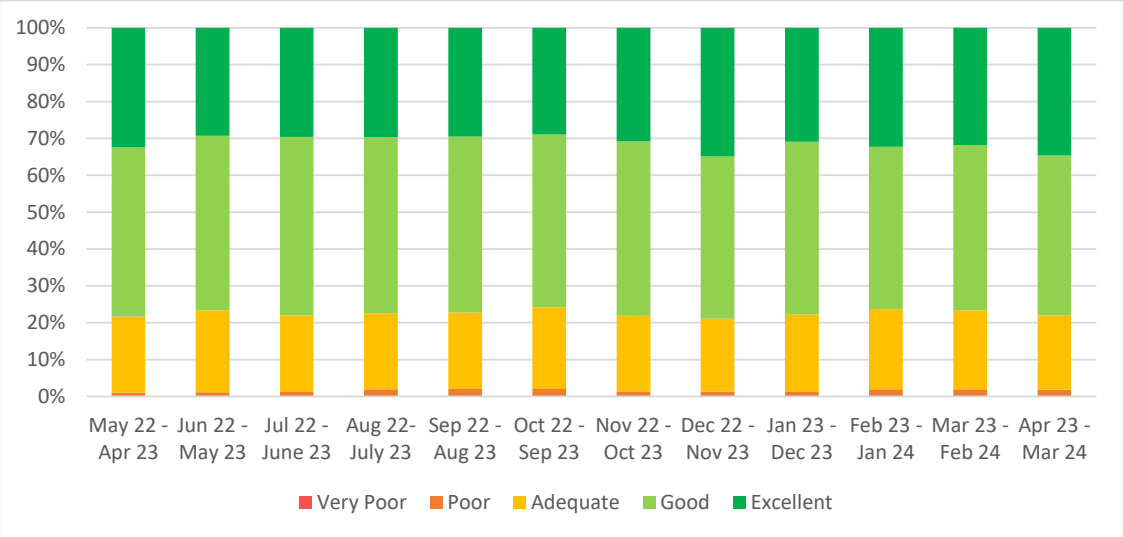


There were seven instances of special cause variation above the upper control limit during the months of Jul-23 – Jan-24. For the January 2024 quarterly report (covering quarters 2 and 3 of 2023/2024) we triangulated the data with various[1] trust operations metrics reported in the Integrated Performance Report (IPR) and found no strong correlation.

There are several challenges when attempting to triangulate this data; primarily the significant difference in case numbers included in the metrics. The special cause variation caused a shift in the data. With such small numbers of poor and very poor care scores it has been identified that there is likely to be a significant amount of positive learning from cases where care is rated between adequate and excellent.

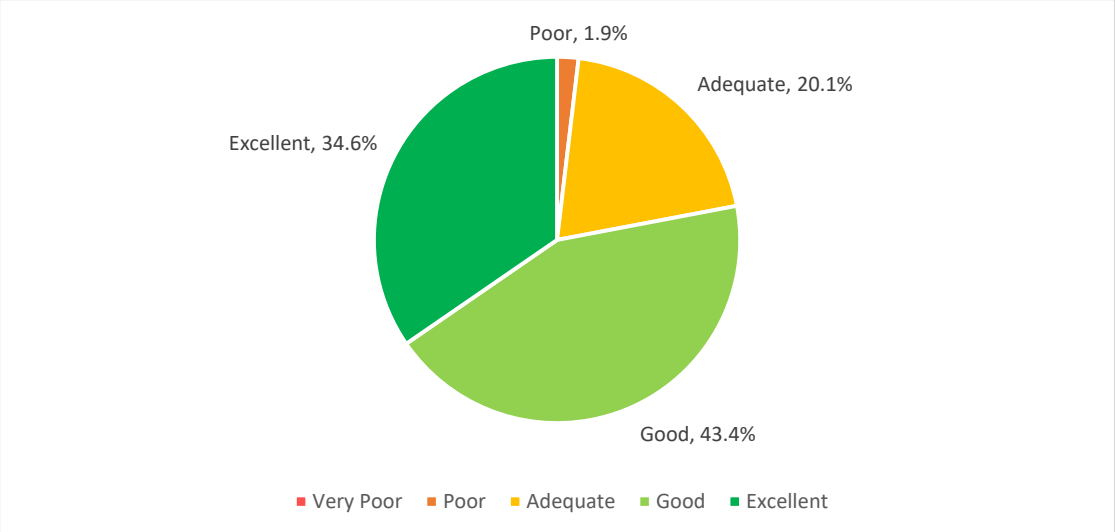
FIG 13| CARE SCORE DISTRIBUTION OVER TIME MAY-22 – MAR-24 (12 MONTH ROLLING)

[1] ED Attendances, Emergency Admissions, ED Performance, Ambulance Handover Delay, Ambulance Handover <15 Mins, Bed Occupancy, Staff Attendance, Filled Roles, Agency Spend, No Criteria to Reside



A look over the last year of 12 month rolling data shows that we are consistent in our care ratings with minimal fluctuation and no reviews rated as 'very poor'. A breakdown of the 2023/24 care scores show that very few cases were rated 'poor' but 20.1% were only given an adequate rating. We need to be more vigilant of the learning derived from reviews where care is rated adequate to improve care.

FIG 14| CARE SCORE DISTRIBUTION 2023/24



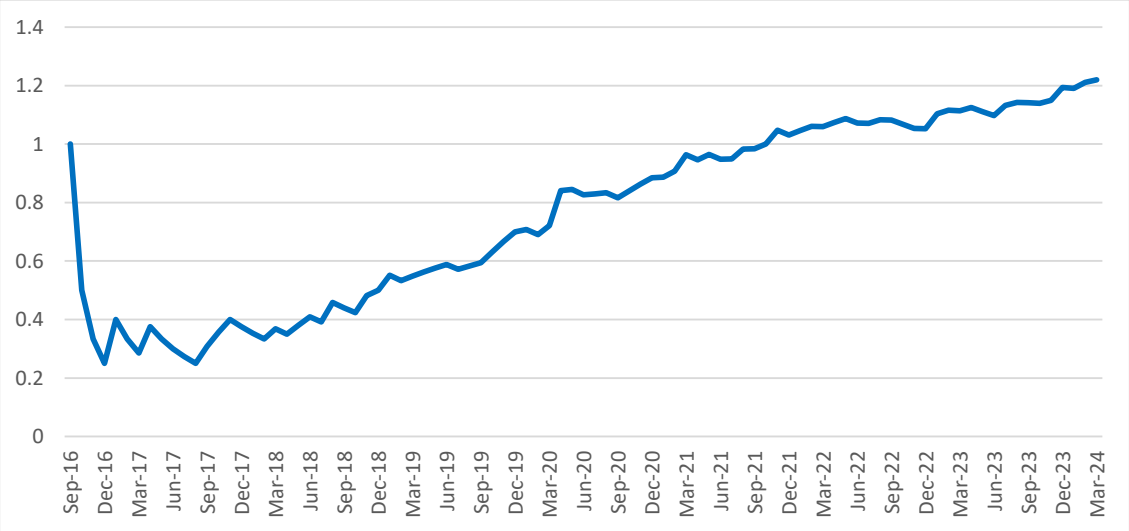
Section 3: Learning Disability and Autism (LD&A) Reviews

A full case note review is required for patients that have died at NBT with a learning disability or diagnosis of autism. During 2023/24 there were 26 deaths within NBT. National research has shown that on average, people with a learning disability and autistic people die earlier than the general public, and do not receive the same quality of care as people without a learning disability or who are not autistic. All deaths of people with a learning disability or who are autistic are required to be reported to the externally completed Learning from Lives and Deaths – People with a Learning Disability and autistic people (LeDeR) review programme where some are selected for case note review at a national level. Because these patients are vulnerable to receiving poor care, NBT ensures that all Learning Disability and Autism deaths are subject to an enhanced review process which involves input from the Learning Disability Liaison Team as well as the reviewing consultant. These reviews are then looked at in the Patient Safety Executive Meeting and learning and actions are scrutinised. All outputs from reviews are fed through the Learning Disability and Autism Steering Group and are used to support improvement initiatives at a Trust-wide level.

3.1 Learning Disability & Autism Mortality and Admission Rates

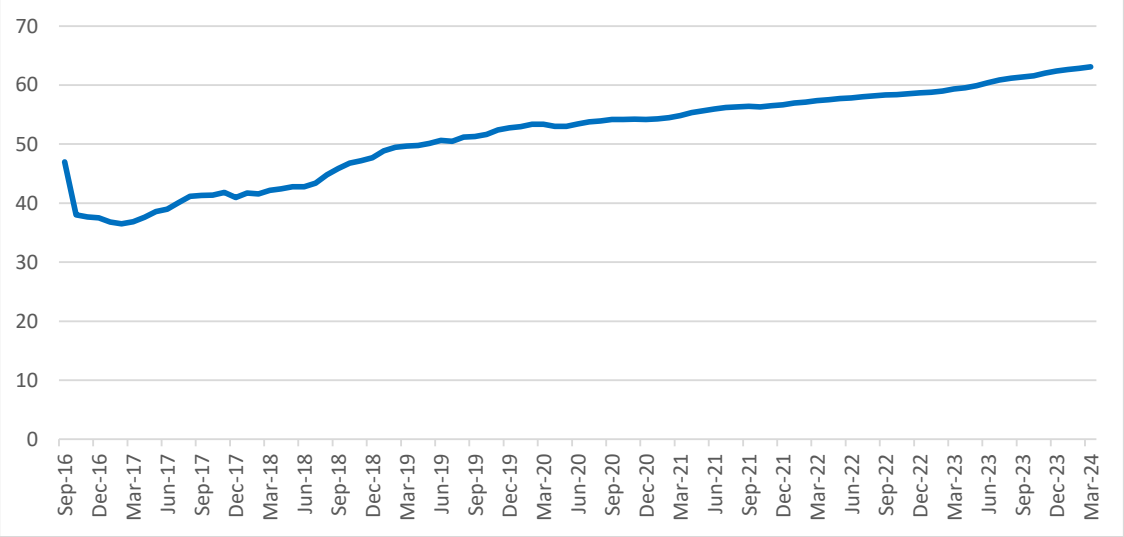
Mortality and admission rates for patients with a learning disability or autism have been tracked over the course of 2023/24. There have been no instances during this period of higher-than-expected deaths.

FIG 15| LEARNING DISABILITY DEATHS (CUMULATIVE AVERAGE) SEPTEMBER 2016 – MARCH 2024 (BASED ON ADMISSION DATE)



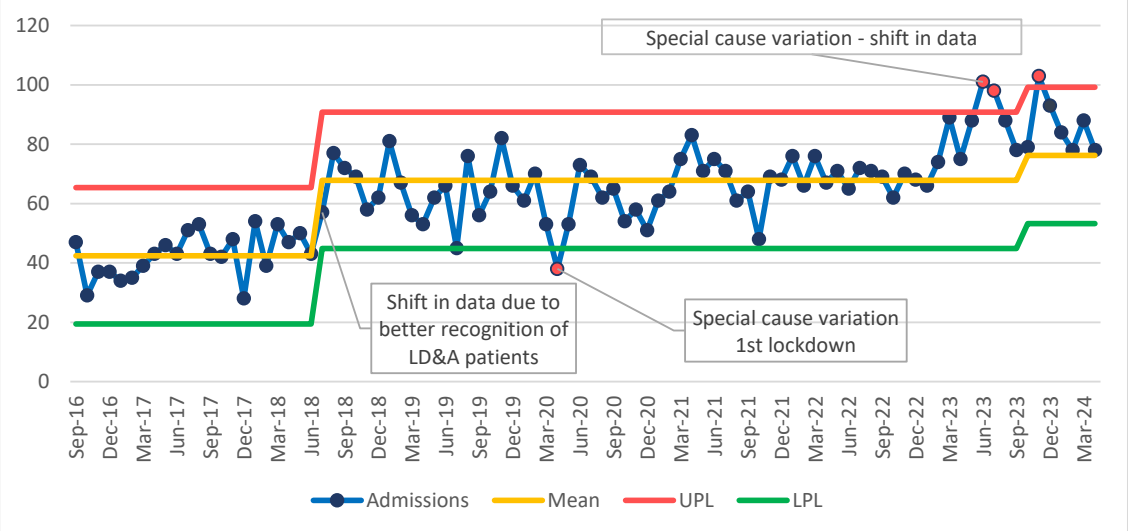
Learning Disability deaths are rising in the Trust, this is mirrored by the rise in admissions seen below (Fig 16). We can be confident that the rise in deaths is not due to any concerns regarding clinical care, since all Learning Disability and Autism deaths are subject to an enhanced review process, with approval via the weekly Patient Safety Executive Meeting, which has not revealed any systemic issues that would lead to additional deaths.

FIG 16| LEARNING DISABILITY ADMISSIONS (CUMULATIVE AVERAGE) SEPTEMBER 2016 – MARCH 2024 (BASED ON ADMISSION DATE)



Looking at the SPC chart for admissions we can see that there have been several instances of special cause variation due to higher admissions over the last year (June 23, July 23, and November 23). This is most likely due to better recognition of these conditions both at NBT and within the community. We will be aiming to collaborate more closely with our community partners over the coming years to strengthen our insights and target learning and improvement into the most impactful areas.

FIG 17| LEARNING DISABILITY ADMISSIONS SEPTEMBER 2016 – MARCH 2024 (BASED ON ADMISSION DATE)



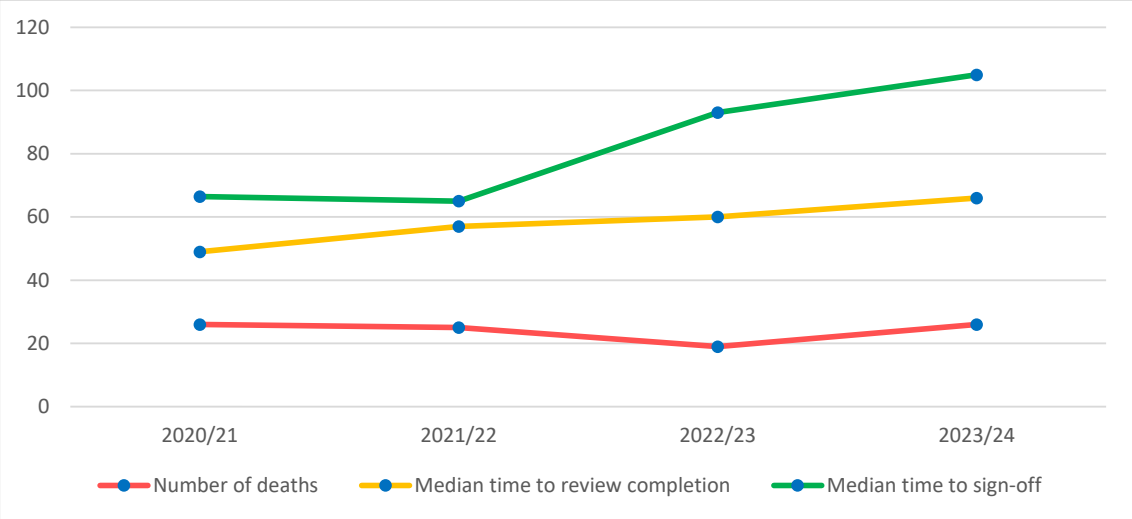
14.1

3.2 Learning Disability & Autism Mortality Review Completion Times

Due to the enhanced review process, completion of mortality reviews for patients with a learning disability or autism can take more time than other high priority review categories. It is our view that the added benefit of a more thorough review outweighs the lengthening of the review process. There are other governance processes in place, such as incident reporting and investigation, complaints and Patient Advice and Liaison Service (PALS) that should support the flagging of immediate concerns that can be responded to in suitable time.

Delays in the process can occur between patient death and SJR completion, and SJR completion and sign-off by the Patient Safety Executive Meeting (PSEM). The median time to SJR completion sits at 66 days from patient deaths that occurred during 2023/24. The median time from death to sign-off for deaths of patients with a learning disability or autism that occurred during 2023/24 is 105 days.

FIG 18| LEARNING DISABILITY AND AUTISM ACTIVITY ANNUAL DATA (DEATHS BETWEEN APRIL 2020 – MARCH 2024)



Median time from death to review completion and median time from death to review sign-off has increased over recent years, whereas our deaths have remained reasonably stable. The increase in review times could be due to the general increase in activity for the Learning Disability and Autism Liaison Team whose capacity is crucial to undertaking reviews. Over the last year there have been issues with long-term sickness and understaffing in the team which has now been rectified due to the hiring of new members which have since been trained on undertaking reviews. It is hoped that this will directly impact our review completion times and we are expecting a drop, or at least a levelling-off of these rates. The below table (Fig 19) gives a full breakdown of figures from 2020/21 – 2023/24.

The gap between the time from review completion and the time to sign-off can be explained in part by the reactive and dynamic nature of the Patient Safety Executive Meeting (PSEM) meaning there is a fluctuating agenda that is governed by how critical the items are and the need to prioritise. More prevalent is the need for reviews to be clarified or further questions answered and then brought back to a subsequent meeting. This shows the value of reviewing SJRs at PSEM, it also shows that there is

work to be done on improving the quality of our SJRs. This work is a part of the Mortality Improvement Programme (see section 5.3.1) that will be running through the course of 2024/25 and onwards.

FIG 19| LEARNING DISABILITY & AUTISM ACTIVITY ANNUAL DATA FIGURES (DEATHS BETWEEN APR 20 – MAR 24)

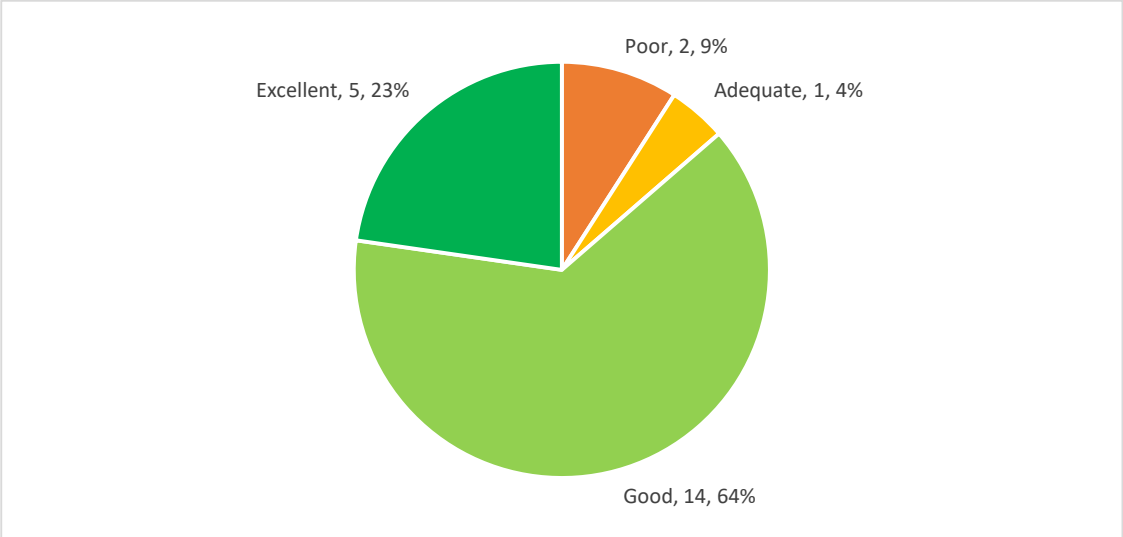
	2020/21	2021/22	2022/23	2023/24
Number of deaths	26	25	19	26
Number of reviews completed	26	25	19	26
Number of reviews signed-off	26	25	19	22
Median time to review completion	49	57	60	66
Median time to review sign-off	66.5	65	93	105

26 reviews have been completed and 22 reviews signed-off for the 26 patients that died during 2023/24. As of 17/06/2024 three of the completed SJRs yet to be signed-off are due to minor changes being needed to the reviews prior to submission to LeDeR and it is anticipated that these will be completed within the next few weeks. The other outstanding SJR will be submitted to the Patient Safety Executive Meeting for review as soon as possible.

3.3 Learning Disability & Autism Structured Judgement Review Care Scores

There were 22 reviews completed and signed-off of patients who died in 2023/24 with a learning disability or autism. Care scores for these cases were judged poor, adequate, good, or excellent. No cases were awarded a very poor care score. The two poor care scores were subject to further review by the Deputy Medical Director and learning and actions were identified.

FIG 20| STRUCTURED JUDGEMENT REVIEW CARE SCORES FOR PATIENTS WITH A LEARNING DISABILITY OR AUTISM (2023/24)



Section 4: Medical Examiner Referrals and Actions

The Medical Examiner is an independent service that scrutinises all inpatient deaths in England. NBT and UHBW host a joint ME service for BNSSG. In November 2020, a process was developed to allow for the signposting of potential concerns referred by the Medical Examiner to NBT out to the relevant governance teams to identify learning, undertake further review and support families.

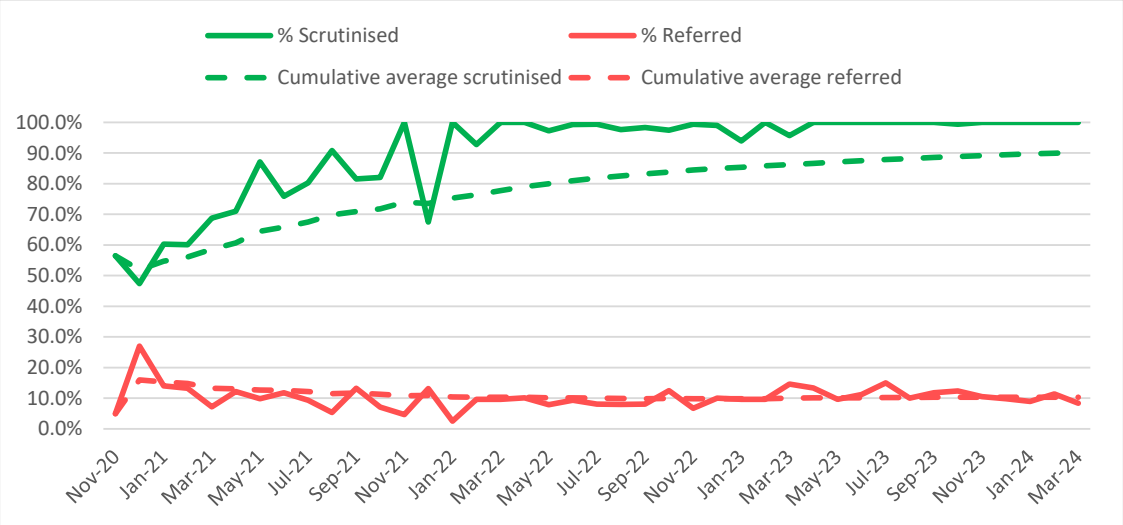
The Medical Examiner's office submits data to NHSE/I on a quarterly basis outlining the nature of referrals.

4.1 ME Referral Rates

The Medical Examiner service has been gradually increasing its scrutiny rate since November 2020. In March 2024 100% of deaths within the Trust were scrutinised by the Medical Examiner, with a referral rate for potential concerns of 8%.

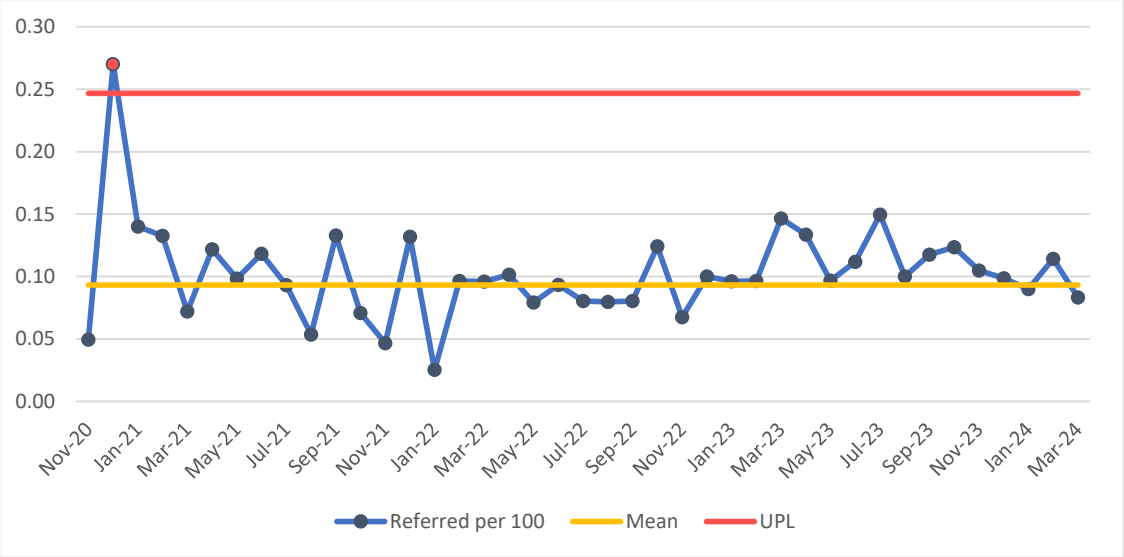
During 2023/24 there were 228 referrals of a potential concern made to NBT. Referral rates from the Medical Examiner into the Trust have remained stable with a referral rate of 10.9% for the entire year. All of these concerns (100%) were signposted to a governance team within the Trust. Not all of these referrals constitute a serious concern raised by the Medical Examiner, and many of these concerns at the point of referral are already known to the Trust and being addressed appropriately.

FIG 21 | ME REFERRALS TO NBT SCRUTINY AND REFERRAL RATES (NOV-20 – MAR-24)



14.1

FIG 22 | ME REFERRAL RATE PER 100 CASES (POTENTIAL CONCERNS) (NOV-20 – MAR-24)

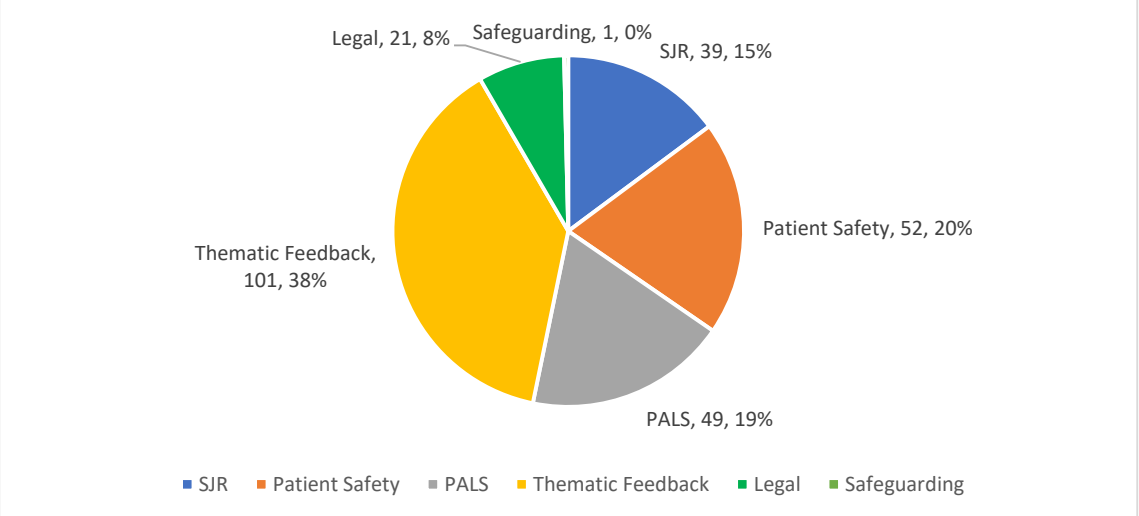


4.2 ME Referrals by Category and Theme

The Medical Examiner refers cases to the Trust that present a clinical concern as well as those where the next of kin feeds back experiential concerns. Concerns can cover both the well-being of the patient and the family and therefore, encompass an extensive range of feedback. It is important to understand and categorise the types of feedback to better understand where improvements may be needed.

There has been a relatively even distribution of referrals of concerns from the Medical Examiner during 2023/24 across patient safety, PALS and SJRs. 38% of the referrals were fed-back to clinical teams to be themed for improvement activity. 21 cases were notified to legal as they were coroner referrals, and 1 case was sent to safeguarding.

FIG 23 | DISTRIBUTION OF ME REFERRALS BY GOVERNANCE TYPE (APR-23 – MAR-24)

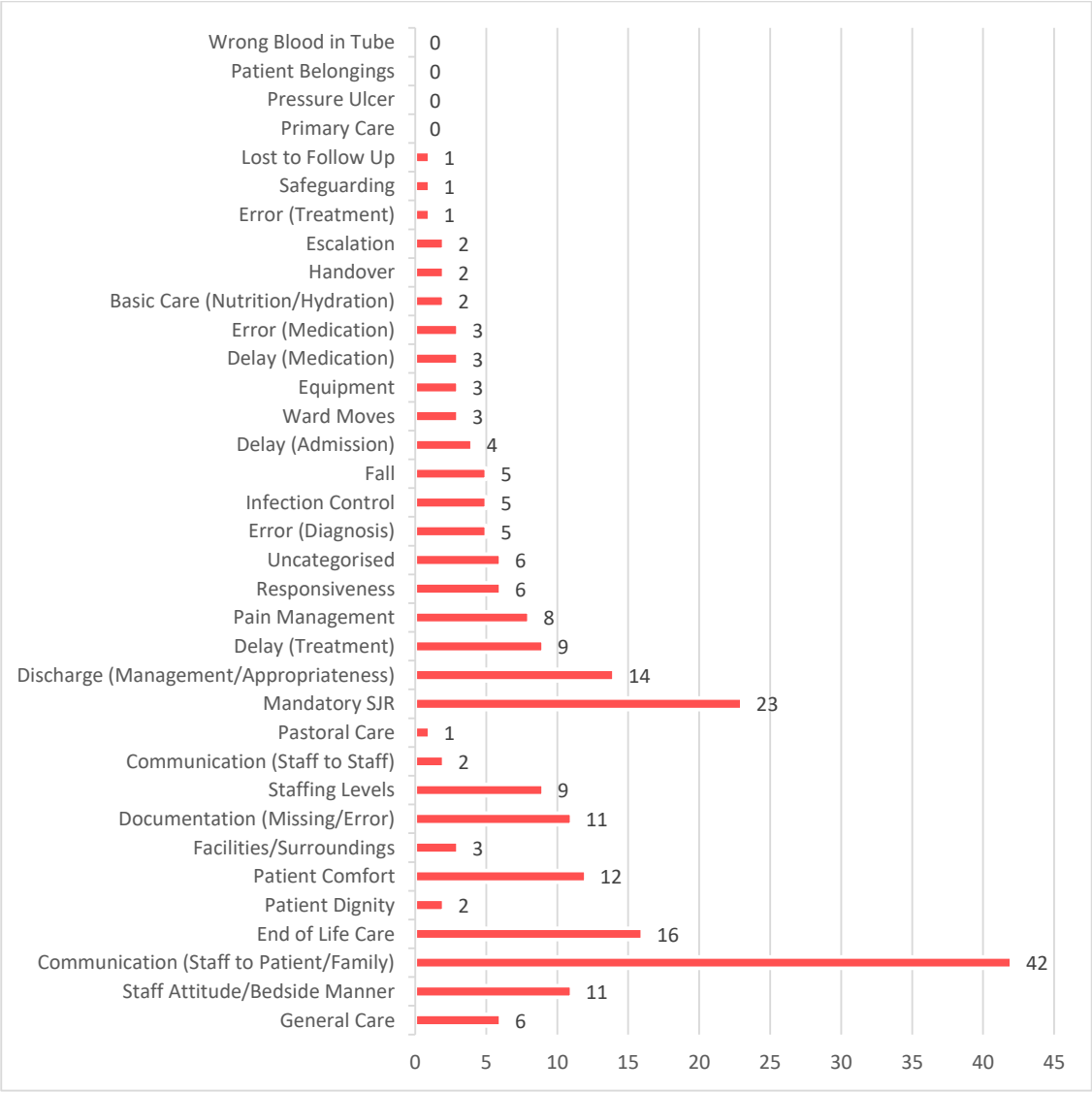


As expected, most concerns raised as a patient safety concern are to do with the quality of clinical care provided to the patient, and most concerns raised where the next of kin has indicated that they would like to contact PALS pertain to patient or family experiential concerns. Of the 39 concerns where an SJR was undertaken 31 (79.5%) were due to the patient falling into a pre-requisite SJR category (Learning Disability or Autism, Serious Mental Illness, Elective Admission) and weren't necessarily reflective of any concerns raised.

Of the 52 concerns that were referred as patient safety 14 (26.9%) were already known to the Trust and confirmed as a patient safety incident on Datix, which suggests some improvements could be made to our safety reporting culture.

A new set of mortality reporting themes was developed on introduction of Radar in June 2023. The below charts show the feedback recorded in the new system during 2023/24.

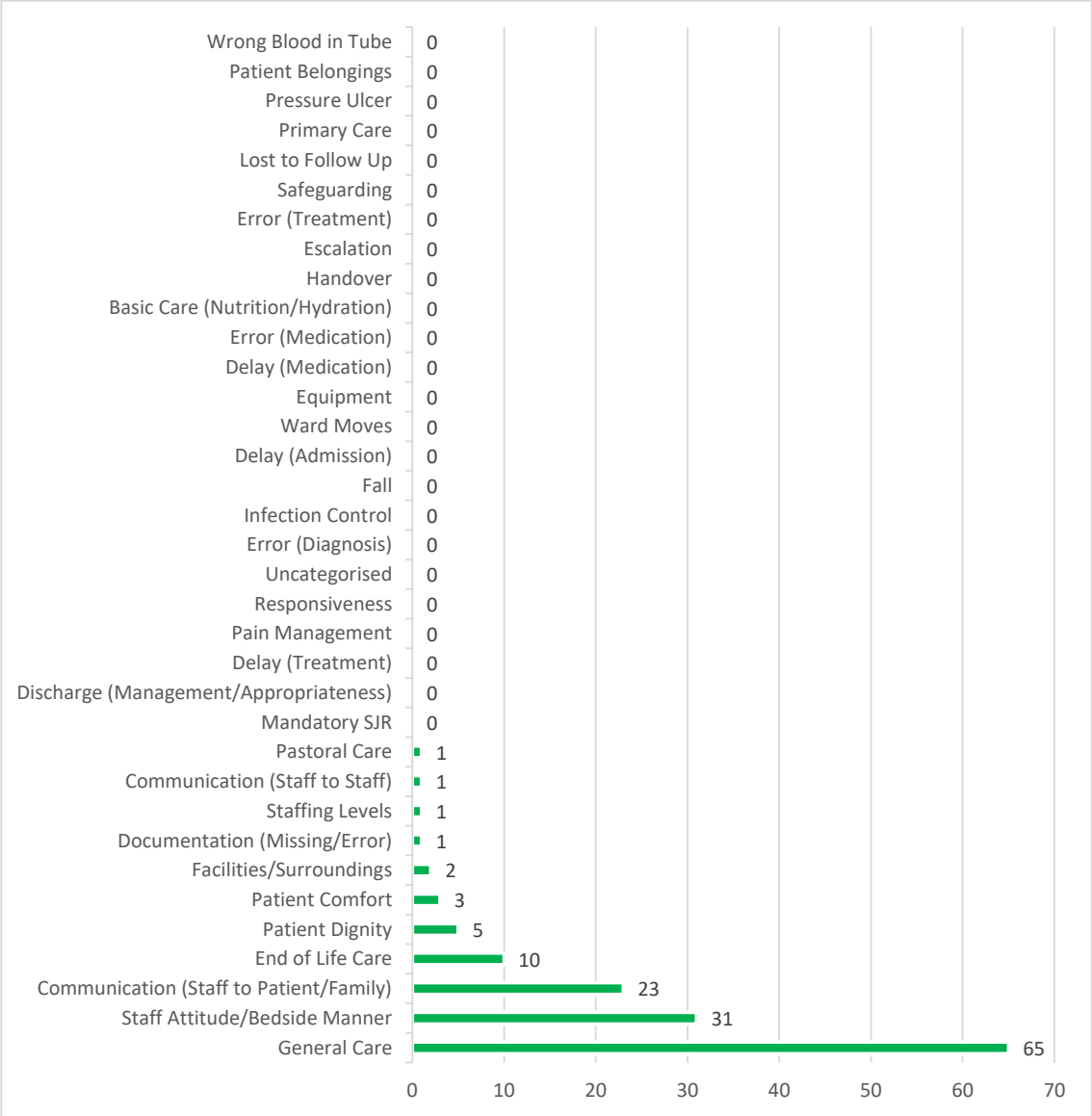
FIG 24 | POTENTIAL CONCERN THEMES (JUN-23 – MAR-24)



14.1

18.8% of the concerns raised were themed as communication (staff to patient/family), sub-themes were added to these categories at the end of 2023/24 to try and understand further where improvements need to be made.

FIG 25 | POSITIVE FEEDBACK THEMES (JUN-23 – MAR-24)



Positive feedback themes from ME referrals were much more restricted than those for potential concerns. Positive feedback is mainly received from families and carers of the deceased and they tend to focus on generalities of good care, the staff's behaviour, communication and the wellbeing of the patient.

Section 5: Learning and Continuous Improvement

5.1 System/Process Learning

System and process learning is about identifying how we can improve our approach to learning from deaths to ensure that the time taken to complete these reviews is valuable. It is important that we can extract learning and tangible actions from these reviews for us to improve our practices. Furthermore, the inputs to the process need to be of sufficient quality to ensure that learning can be identified. We have undertaken the following work during 2023/24 to understand and improve our learning from deaths processes.

5.1.1 Medical Examiner Referrals in Radar

The new Quality Governance System *Radar* is being adopted by NBT as a digital platform to monitor, manage and engage with Clinical Governance processes across the Trust. During June 2023, the Medical Examiner Referral System went live in Radar. This allows the Medical Examiner to refer potential concerns and positive feedback to the Trust, allows the divisions to have easy access to their referrals and signpost the information effectively.

FIG 26 | MEDICAL EXAMINER REFERRAL PROCESS IN RADAR

Radar Step	Details
0 Medical Examiner Referral	Medical Examiner can make a referral for a potential concern or positive feedback
Link Related Event	Radar automatically suggests registered events for the same NHS number. The ME Referral Administrator can review the events and link to the referral if they are relevant
1.1 MER - Medical Examiner Referral Notification	The ME Referral Administrator can assign a division and specialty to the referral
1.2 MER - Medical Examiner Referral Governance	The ME Referral Administrator can categorise for NHSE reporting, and assign themes
2 MER - Divisional Triage	The Divisional Governance Lead can confirm the division's response to the referral
'Add Task' function	Divisional Governance can notify the relevant parties (e.g. matron, ward staff etc.) of the referral and request they action, or simply review for information
'Create/Link Action Plan' function	Divisional Governance can log specific improvement actions needed as result of the referral

The process has been received positively by both the Medical Examiner's service and the divisional governance teams. We are constantly collaborating with both parties to improve and adapt the process to ensure the best possible use of the system, which includes developing dashboards for use by the Trust across multiple workstreams within the system. We are also working with our NBT Radar System Support team, in conjunction with Business Intelligence, to develop Power BI dashboards to

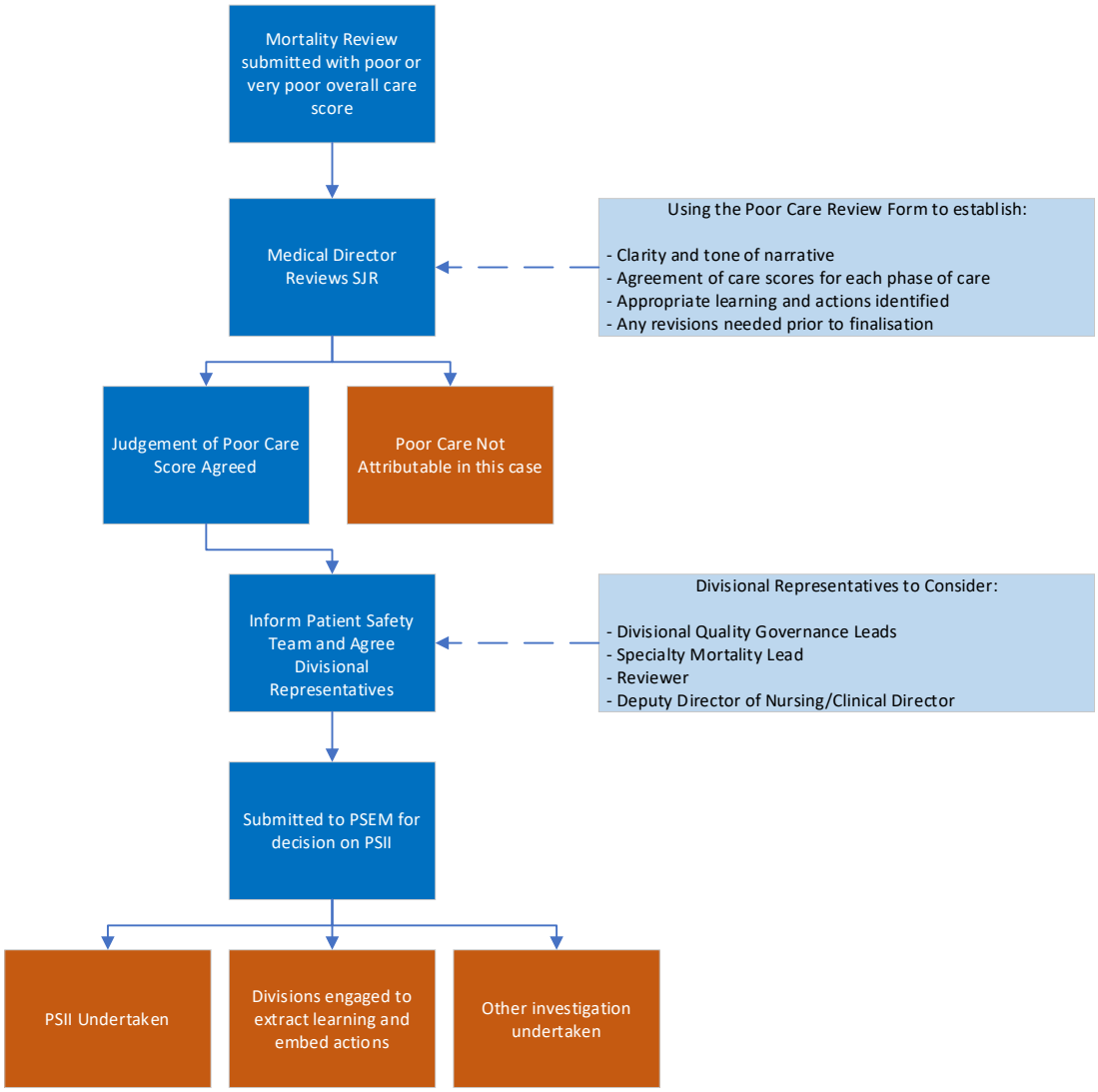
ensure that all relevant areas of NBT have access to the information provided by the Medical Examiner and can thereby effectively enact learning and respond to requirements for improvement.

5.1.2 Poor Care Score Reviews and Targeted Learning

Due to the scarcity of these events, the review, identification, and embedding of learning from poor care scores historically has not been formalised at NBT. During 2023/24 we embedded a new process to ensure that:

- Care scores attributed to a case are justified.
- SMART learning objectives are identified because of the case review.
- Learning can be embedded into team working.
- Outcomes and learning are circulated between teams and areas where the information is relevant.

FIG 27 | POOR CARE SCORE PROCESS



5.1.3 Mortality Surveillance – Who are our peers?

One of our goals over the next few years will be to expand our mortality monitoring to a system level. The Trust has access to CHKS, but mortality surveillance is typically only done within specialties at a case level through mortality reviews, SJRs and M&M meetings. To achieve a holistic view of mortality within NBT we need to start looking at mortality trends within our services and contextually within the whole NHS. One of the barriers to this is understanding how to use the system effectively to obtain a valid and meaningful view of mortality. If we can do this, we will be able to better target limited review resources to ensure we are extracting the most learning and are able to appropriately focus improvements. During the last year Mr Adam Williams, lead for Neurosurgery, has been looking at peer groups within the CHKS system and has demonstrated that using the wrong peer group parameters could give a false alarm that there is an issue. We know as a Trust we need to have a better grasp of our mortality alerts, but it is important to understand that mortality alerts are signals that require investigation which could reveal issues with peer groups or coding, not necessarily the care that we provide. The work undertaken in Neurosurgery has set us in good stead to start to look at alerts and alarms more intelligently and should form the basis of our future developments.

5.2 Clinical/Case Level Learning

Although we understand that the outputs from mortality reviews need to be much more visible and accessible at every level, we have been able to pinpoint some of the learning and actions for improvement that have resulted from specific case reviews. Much of this improvement work is down to individuals recognising when a case presents an opportunity for learning. We aim to make this much less of an individual responsibility with greater accessibility of outputs from mortality review over the coming year.

5.2.1 Learning within Specialties

Specialty Mortality Leads have access to the outputs of all reviews undertaken in their area and as such are in a unique position to be able to identify where actions need to be taken. Cases where learning is identified are often appropriate for further discussion as part of the specialty's Mortality and Morbidity Meeting (M&M) where specific actions can be identified and improvement work undertaken.

Below are examples of learning from Divisions within the Trust where certain specialties have enacted changes because of mortality review.

Clinical Division: Anaesthetics, Surgery, Critical Care and Renal

Burns and Plastic Surgery

We have learnt that the following themes are a priority for improving quality of care for our patients:

- Maintaining close working with specialty teams and ICU when planning ongoing care
- Ensuring patient and family voices are heard to improve the final days and hours.
- Holistic and patient focused care to the end

The specialty is undertaking specific work because of the following cases:

- Cardiac arrest patient undergoing ECT to chest wall – a protocol has been implemented for ECT that involves a different equipment and monitor and synchronises the release of electricity with the heartbeat. This has become standard practice.
- Following a never event related to wrong lesion excision, mandatory photography of all skin lesions booked for excision has been implemented. This has been audited showing good adherence.

ICU

ICU has:

- Reviewed emergency intubation protocols and redesigned the emergency intubation checklist for implementation Trust-wide.
- Implemented the tracheostomy care bundle which includes a guideline, emergency management plan, and a rescue box on ICU. The team is actively reviewing and developing the bundle as it is implemented to ensure its effectiveness.
- Reviewed the referral pathway for acute pancreatitis.

Renal

Renal screens in all patients with CKD5 requiring kidney replacement therapy to be discussed at M&M meetings. This includes all patients with a kidney transplant, haemodialysis patients, peritoneal dialysis and those receiving conservative kidney management.

The specialty then reviews any cases with concerns, as well as those identified by the Medical Examiner. The biggest challenge is the poor quality of historical notes on EDMS to provide meaningful review of often extremely complex cases.

The following themes have been identified:

- Historically the most common concern theme was safe transfer of patients from other regional hospitals (both patients with AKI and dialysis patients who require dialysis +/- another treatment. The frequency of these issues has decreased due to liaison and support from ICU colleagues in the region. Renal has also worked to develop safe transfer guidance to support this process.
- Cases identified by the Medical Examiner for review have demonstrated the increasing complexity of the medicine we are practicing; often involving decisions around dialysis and the complexities of care needed to enable safe dialysis. These cases have required significant input from multiple agencies including the ward teams, therapists, supportive care nurses, palliative care teams, trust legal support, and court protection. Review of these cases is helpful however as there is always learning from these complex cases.
- The specialty's screening process also looks at patients who are on the supportive care register and where these patients die. This includes all patients receiving conservative management of their kidney disease and significant numbers of the dialysis population. It is noted that a considerable proportion of the deaths observed in this population are in patients already identified as having supportive care needs – this is often a tool to flag patients who the specialty thinks may be in their last year of life. There is ongoing work within the renal

supportive care team and the wider renal team to identify patients whose health is deteriorating to help promote advanced care planning, better symptom management, to avoid hospital admission and to support these patients and their families around the end of their lives.

Clinical Division: Medicine

Acute Medicine

The key things from the last M&M meetings have been a consistent theme of early ICU involvement when appropriate and early palliative care on the unit as well which has been great to see. Acute Medicine has picked up a couple of issues in the past 12 months including process errors such as radiology reporting for patients and the addendums to reports being added retrospectively. The specialty mortality lead is progressing this by pursuing the specialty's own radiology meetings in AMU and this is now in the discussion stages to see if a regular x-ray meeting in AMU with a consultant radiologist will improve care.

As a result of a couple of cases of sickle cell crises on the unit in the past 12 months, Acute Medicine are also looking at developing a SOP with the specialty's governance lead and haematology for the management of these patients as their care pathway is changing at the BRI and we are likely to see more of them.

The specialty has reviewed a couple of cases of acute asthma recently also. Once case was investigated as an incident with the governance lead after the patient had been admitted to NBT but was not put on adequate preventer inhaler therapy requiring a further admission to ICU. The asthma bundle is currently in the process of being updated with the respiratory team, and the specialty is involved with this, including undertaking a current audit of our asthma processes to see what improvements can be made.

Particular cases that have instigated change include:

- Patient with a bilateral PE who passed away after mobilising – the unit has now instituted a policy of strict bedrest for those patients with PE and right sided heart strain for 48 hours. We are also exploring a 'PE Box' for urgent thrombolysis required on the unit and this is being explored with pharmacy.
- Patient with an upper GI bleed – Conversations are being had with gastroenterology. Communication difficulties meant the patient had a delayed endoscopy and the specialty is looking at the GI bleed pathway to see how it can be improved.
- An overdose on paracetamol has prompted us to review our guidelines and how we can re-work them to ensure the severe criteria for referral to Kings is clearer.

Care of the Elderly

Most of the reviews that we have undertaken over the last 12 months have been due to the patient falling into a mandatory review category, and the care has been concluded to be very good.

Improvements we have instigated where things could have been done better are as follows:

- As a result of a concern raised by the next of kin when phoned by the Medical Examiner team, it has been agreed that the consultant clinician most involved in the patient's care should be contacted to manage the referral at the point that it is identified to members of the division/specialty.
- As a result of one high-profile care within Trauma and Orthopaedics, and a case within complex care where a patient's high EWS score was not promptly escalated, the specialty has introduced the following:
    - A system where ward coordinators can review all observations on vitals to ensure there is senior nursing oversight of high and overdue observations on the unit.
    - All staff have been prompted to complete EWS training.
    - Staff have been reminded to contact x6999 to report high EWS scores even if there is a doctor on the ward.
    - The specialty's clinical lead has reviewed the consultant roster to ensure more consistent cover, with some cover for ED especially going into winter so that senior support is available more routinely during the day to make plans for these unwell patients.
    - A plan has been agreed that every Care of the Elderly ward should have a named consultant available every day for urgent questions and severely unwell patients, so that the junior medical team have a clear method of escalating.

Emergency Department

The M&M meeting in October 2023 included two cases of pneumothorax and the discussion highlighted some uncertainty around how to set up the new chest drain bottles used in ED. While this did not contribute to the patients' deaths, it brought to our attention a knowledge gap and we have set up a QR code in the handover area for staff to watch a video on how to set up the bottles.

A case that was discussed earlier this year as part of a mortality review had a cardiac tamponade and pericardial aspiration was done by cardiology in ED. This was discussed and recognised as a High Acuity Low Occurrence (HALO) procedure and that there would be benefit in producing some written resources on this and similar procedures so that staff can refer to them in the appropriate circumstances. A folder has now been created by one of the departments registrars and includes detailed information about several procedures which are very important, but uncommonly occur in the ED, including detailed maps of where to find the necessary equipment.

A recent mortality review on a patient with a Learning Disability found that the ED staff were excellent at making reasonable adjustments for the patient and involving the Learning Disability Liaison Team. The same case highlighted that once some of our ED patients are referred to an inpatient team they spend a long time in ED before the inpatient team review them; we are working on implementing safety rounds to ensure that critical medications are prescribed and ongoing acute management is planned for, including second doses of antibiotics for example.

Haematology

Through M&M meetings this year Haematology has recognised the following system changes:

- Improved liaison with GPs about the timing of serum free light chain monitoring in patients being monitored in the community.
- Identification of the need to formalise a pathway for whole node excision in the extent of indeterminant biopsy results from minimally invasive procedures.
- The need to revisit a patient's suitability for high dose autologous transplant approach in myeloma care between the first MDT outcome and treatment initiation, particularly if the clinical situation changes radically.
- Ensure patients on the winter months IVIG replacement programme are reviewed in October prior to initiation of the programme in the month of November. Formal documentation of their ongoing need for IVIG to be made in October and an active list to be updated on a regular basis.
- Highlighted areas of improvement in re-designing the pathway for obtaining Interventional Radiology guided biopsies
- Due to delays in reporting of biopsies a new process has been agreed to limit the use of outsourcing in urgent cases.

Infectious Diseases

Infectious Diseases M&Ms take place monthly. Most of the deaths were expected with no significant concerns raised. The main theme where improvement could be made is communication with families (in particular when patients are confused and cannot communicated clearly with their families or friends. Consultants need to document clearly when they have spoken to relatives and what was said. This helps relatives ask questions too and gives more focussed time with the families.

Respiratory

The following areas of learning have been identified:

- Family feedback about the challenges of communicating with Deaf patients:
    - A member of the respiratory ward is going to attend Deaf awareness training.
    - Disseminate resources for interpreter services.
    - Feedback to patient experience team in medicine to consider whether wider education/awareness programme is warranted.
- Also recognised that family members have been used as translators in the past and education is needed around access to translation services.
- Information has been shared with the respiratory team about how to access IMCAs.
- Learning has been identified and recommendations are being developed around electronic patient transfer in vitals when patients are moved from one location in the hospital to another.

Clinical Division: Neurological and Musculoskeletal Sciences

Stroke

Stroke has made a number of changes as result of case discussions in M&Ms:

- Audit and QI work over decompressive hemicraniectomy (proforma driven pathway)
- Communicating expectations of clinical management with consultant body (e.g. consultant review at least every 48 hours for purple butterfly patients, documentation of suspected stroke aetiology on stroke proforma, direct stroke admission for patients with high clinical suspicion of stroke pending MRI scan)
- Circulation of up-to-date guidelines regarding arrhythmia detection
- Appropriate signage on ward (in response to miscommunication about procedure room)

There are a number of steps being undertaken towards improvement including:

- Exploring how results within stroke and neurology are followed up with the potential to launch a more robust system.
- Exploring with radiology the addition of clinically significant addendums to imaging reports

Neurosurgery

As a result of thematic analysis of emergency referrals, one of which resulted in a death within a year of the referral, and one case of treatment that resulted in survival but with a poor outcome, the specialty in working on a large project around early decision making in frail patients being better guide by a deeper understanding of their outcomes. The specialty hopes to be able to offer more information on the implementation and outcome of this project work in the next year or so.

5.2.2 Learning from Learning Disability Case Reviews

Cases where it has been identified that the patient has a Learning Disability or Autism undergo an enhanced review process whereby input is taken not only from the specialty consultant but also the learning disability liaison team. The outputs are scrutinised by the Patient Safety Executive Meeting before being fed into the national review team and locally to the Trust Learning Disability Steering Group. Because of this, these reviews can provide much more insightful learning that feeds into tangible actions. Outputs from these reviews can also be used to support and highlight agreed improvement work for the steering group as part of their quality focus for the year.

The 2022 BNSSG LeDeR Annual Report was received in June 2023 and has been shared across different forums in the Trust to showcase areas of good practice and areas for improvement. The report highlights 65 deaths reported in the 2022 financial year, two of these reported deaths were for autistic patients and both had had died by suicide. The report also highlighted the main recurrent themes as follows:

- Constipation
- Obesity
- Aspiration pneumonia
- Catheter care
- Reasonable adjustment

- Mental capacity assessment and best interest decision meetings
- Cancer-late diagnosis leading to poorer outcomes.

The ICB has worked across local organisations with peer specialist to address some of these recurrent themes with some positive results this includes the following:

- Annual Health Checks- work was undertaken with peer specialist from Brandon Trust and this has seen an increase in Health Action plan to 98%
- Constipation – there is ongoing work with North Somerset People First on Poo Matters
- Obesity- "Healthy Me Cookery school" launched in partnership with Square Food have supported the work on this.
- Aspiration Pneumonia- Awareness creation. Choking flyer, Swallowing Awareness in residential settings
- Cancer Screening and treatment access – The system has now funded a permanent band 7 practitioner to support cancer screening in the system.
- Relationship and sexual Health – work commissioned with the Hive to coproduce with people with lived experience.
- Independent living skills- Work commissioned through Hives.

5.2.3 Learning from Medical Examiner Referrals

39 concerns were referred from the Medical Examiner which suggested a Structured Judgement Review during 2023/24. Of these 39, 8 (20.5%) were because of concerns being raised by the family or the Medical Examiner. The others were because of the patient being diagnosed with a learning disability, autism, or a serious mental illness. Of these 8, the division agreed to undertake an SJR in 4 instances. The other four cases were addressed as part of the complaint process (1) and as a local review (3).

Medical Examiner referrals provide an opportunity for the Trust to address care concerns either from the Medical Examiner team or from patients' family and carers. These are particularly significant as it allows for an independent service to raise care concerns with the Trust and allows the patient's family or carers to have concerns addressed.

Communication to patients and families is a key learning theme outlined in these case studies. We are aware that embedding learning from mortality review is one of the key issues we need to tackle over the coming years, and as we are now moving towards being able to draw out this learning, we will look at how best to align these themes to existing improvement work being undertaken within the Trust. Outlined below are the case studies:

Case Study 1

Medical Examiner Concern

The family raised a concern that there was 6 hours following the admission of their relative in which nothing happened, nor did the family receive any information once things started to happen. They

ended up having to reach out to someone they knew higher up in the Trust to try and figure out what was going on.

Structured Judgement Review

The reviewer recognised that there was a delay in giving fluids to the patient and that there was no documentation of conversations with the family.

Learning

There would not have been a change in the patient's outcome had care been provided differently, but there is a need to have better conversations with families at the earliest opportunity.

Case Study 2

Medical Examiner Concern

The next of kin raised concerns about delay in ambulance transfer times. They also had questions as to why the AAA was not repaired on first diagnosis a few months prior to the patient's death.

Structured Judgement Review

Although there was a delay in ambulance transfer, the patient was pre-alerted and met on arrival by an ED registrar. Care thereafter was prompt including a CT within 30 minutes of arrival and both ICU and vascular were informed.

Learning

Ambulance delays are a well-known systemic issue in the NHS. NBT has actively been trying to improve flow through the hospital to ensure patients can be seen earlier. Better communication needs to be had with patients and families to ensure they participate in, and aware of, treatment decisions. This feedback from the next of kin was also shared with the patient's GP.

Case Study 3

Medical Examiner Concern

This referral was made by the Medical Examiner detailing multiple missed opportunities in the patient's care particularly regarding a possible AKI.

Structured Judgement Review

The patient developed an AKI because of their acute illness, and whilst that did not result in hyperkalaemia, this was never severe or life-threatening. After a delay it was treated successfully and was noted as normal the day before the patient's death. As the patient had a paced cardiac rhythm no ECG changes of hyperkalaemia would have been reliably visible. The reviewer notes that K was never >6.0 and therefore might not always mandate treatment.

Learning

There were places of good practice with cohesion of nursing team, upper GI surgical doctors and geriatrics. There is a need for more cover during weekend ward rounds with a targeted patient approach considering there is a considerable number of patients to cover.

Case Study 4

Medical Examiner Concern

Family was distressed that the hospital did not believe that there was something stuck in the patient's throat, when this was addressed, and the patient taken for a CT scan the family was worried as the patient had stated before that he does not like undergoing a CT. The patient died on return from CT.

Structured Judgement Review

The reviewer noted that aspiration pneumonia is the leading cause of death in people with Parkinson's disease. Transfer to CT is lower risk than is used to be due to the location and speed of scans but is still a period of risk.

Learning

Scanning in a lateral position with explicit documentation of the rationale for avoiding an NG tube, and discussion with neurology pre-scan may have been helpful in this case. The complaint from the family was handed to the Patient Experience team and is in the process of being answered with a more in-depth review into this aspect of the patient's care.

5.2.4 Learning from Poor Care Scores

Of the deaths that occurred during 2023/24 that were reviewed using the SJR tool, 5 were rated as poor care. During this period we formalised our process around the review and monitoring of poor care scores, so they are now all reviewed by the Patient Safety Executive Meeting. As a result of this one case was declared as a Patient Safety Incident Investigation (PSII). Examples of learning from these cases are outlined below:

- Improved clarity around the acute cardiogenic shock pathway
- Early decision-making leads to better pathways for care and potentially less invasive procedures
- Improved clarification around symptoms chart recording
- Hospital Traffic Light needs to be kept up-to-date.
- Identification of the deteriorating patient and escalation in treatment is key.
- It is important to practice good documentation of discussions had with next of kin and to ensure they are kept informed.
- Ongoing improvement programme to improve the timeliness of the monitoring of physiological observations and the identification and management of the deteriorating patient.

- Embed the use of the established Malignant MCA Syndrome and Decompressive Hemicraniectomy Proforma for patients who are identified as being at risk of requiring surgery.
- Education for the Hyper Acute Stroke Unit (HASU) medical and nursing staff on the management of alcohol withdrawal for stroke patients using the recently published Assessment of Alcohol Use and Detoxification Guidelines.

5.3 Continuous Improvement

It is important that learning outcomes from mortality review are considered and acted upon throughout the year – not only regarding the clinical care but also about how we can improve our processes to ensure that we identify useful learning.

5.3.1 Mortality Improvement Programme

In 2024, NBT launched the Mortality Improvement Programme in collaboration with University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). The programme brings together various workstreams and projects under a shared vision - to set new standards of excellence for mortality review, and for our approach to become a national and regional model for Learning from Deaths and evidence-based care transformation.

To achieve this, we will:

- Establish an NBT and system-wide programme – to uphold and build on our excellent standards of equitable, compassionate care through collaborative learning and data optimisation.
- Pioneer best practices for standardised qualitative and quantitative data capture at scale - to contextualise mortality metrics related to quality of care and patient and family experiences.
- Promote transparency, accountability, and a learning culture through collaboration on mortality data review and embedded shared learning forums – to enable translation of insights into assurance around existing performance as well as focused improvement initiatives across care settings.
- The programme is closely aligned with our Joint Clinical Strategy, our Patient First approach, the NHS Patient Safety Strategy, and the National Learning from Deaths framework. It also supports the delivery of key priorities and objectives outlined in the NHS England 2024/25 operational planning guidance, including:
- Quality and Patient Safety - Building on our established culture of learning and improvement, in line with the Patient Safety Incident Response Framework (PSIRF).
- Maternity and Neonatal Services - Supporting teams to progress towards national safety ambitions.
- Mental Health - Developing targeted mental health mortality reviews to identify and reduce physical health inequalities.
- Digital and Data - Enhancing digital and data maturity through integrated mortality review solutions and optimised data surveillance.

- Prevention of Ill-health and Tackling Health Inequalities - Monitoring mortality trends in the CORE20+5 populations, collaborating with our public health colleagues, and informing targeted interventions.

Key progress to date includes:

- Appointment of a lead for the mortality improvement programme in December 2023 and official launch of the programme in January 2024.
- Completion of a programme Equality Impact Assessment (EIA), which indicates positive impacts across all areas, aligning with our Trust objectives and the National CORE20+5 approach to reduce healthcare inequalities.
- Initiating projects across all workstreams, with clinical and non-clinical leads and key stakeholders across the Bristol, North Somerset, and South Gloucestershire (BNSSG) healthcare system, including close collaboration with the Medical Examiner's Office.
- Transitioning mortality review processes into the new Quality Governance digital system, Radar, and developing a standardised approach for multidisciplinary team (MDT) input.
- Taking a leading role in the National Mortality Leads and Learning from Deaths Community of Practice Group, to drive collaboration and enhance the quality of Learning from Deaths processes across NHS organisations in England.

Over the coming year, the programme will focus on:

- Establishing two key governance groups, the Mortality Group to set the direction and ensure delivery, and the Collaboration Forum to engage stakeholders and explore future partnerships.
- Developing detailed project plans for enhancing Structured Judgement Review (SJR) training, implementing effective mortality data dashboards, and strengthening learning processes.
- Delivering key improvement projects to expand mortality surveillance capabilities and introduce joint analyses and shared learning forums with UHBW and our BNSSG Heathcare partners.
- Exploring opportunities to expand to broader specialty-level indicators for assurance and mortality review, while maintaining a strong foundation of trust-wide mortality data governance.
- Progressing further enhancements and expansion of targeted reviews and analyses for key populations, including mental health, learning disability and autism, in alignment with national priorities.

Report To:	Public Trust Board			
Date of Meeting:	25 July 2024			
Report Title:	Patient and Carer Experience Committee Upward Report			
Report Author:	Richard Gwinnell, Deputy Trust Secretary			
Report Sponsor:	Kelvin Blake, Non-Executive Director and Committee Chair			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	The Trust Board is recommended to: (1) receive the report for assurance and note the business undertaken by the Committee on behalf of the Board and (2) approve the Committee's amended terms of reference.			
Report History:	The report is a standing item to each Public Trust Board meeting following a Patient and Carer Experience Committee meeting.			
Next Steps:	The next Patient and Carer Experience Committee will be held in September 2024. The subsequent upward report from the Committee will be submitted to the Trust Board's next available public meeting.			

Executive Summary		
The report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the Patient and Carer Experience Committee meeting held on 10 June 2024.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	**X**
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	None arise directly from this report.	

Financial implications:	None arise directly from this report.
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No
Appendices:	Appendix 1 – Patient and Carer Experience Committee Terms of Reference (with tracked changes for approval)

1. Purpose

1.1 To provide a highlight of the key assurances, any escalations to the Board and identification of any new risks from the Patient and Carer Experience Committee meeting held on 10 June 2024.

2. Background

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

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

3. Key Assurances and items discussed

3.1 Patient Story

The Committee heard (via a face-to-face interview recorded and shown via YouTube) from Msiskia, a patient who had developed multiple sclerosis, about her positive experience of the Neuro Early Supported Discharge (ESD) service. Msiskia described the service she had received from ESD staff as "amazing". The staff had been incredibly supportive and provided physical rehabilitation and mental health support to her at home, after she left hospital, visiting her two or three times a week for several weeks. The service provided was personalised to her individual needs, which she said had enabled her to get back to walking her dog and going back to work much earlier than would otherwise have been the case, which were very important to her. She said: "without the team, I just don't know how I would have coped" and "I can't thank you enough".

The Committee also heard from Sarah Wingent, who supported Msiskia at home. Sarah explained how the ESD service enabled patients to go home from hospital earlier than would otherwise be the case, helped their physical and mental rehabilitation, helped them

regain their independence, and resulted in reduced readmissions to hospital and reduced complications during their recovery.

The Committee was comprehensively assured by the story, describing the service as "leading the way", providing an "extraordinary patient experience" and "an amazing example of patient centred, life changing care". They discussed the huge value of the service and the massive opportunity cost of not providing it, as Msiskia would have needed to go back to her GP, go back to hospital and other healthcare services potentially and spend a lot more time off work (in the social care sector), meaning her clients and workplace would also have suffered from her extended absence (and someone else may have had to take time off work to care for Msiskia). The Committee noted that the service was funded temporarily and if productivity alone was the deciding factor for funding, it may not be possible to provide the service at all. They were keen to ensure a business case was progressed, so that the service could be sustained beyond its current two years, and thanked Sarah and the team for all their "amazing" work.

3.2 Patient Story Framework: end of year one report

The Committee received an update from the Head of Patient Experience on the Patient Story Framework, providing an overview of year one of operation of the framework, an outline of the various patient stories received by the Committee and the Board, how these stories provided insight into the Trust's objectives and priorities, and key learning and themes drawn from the stories and how they had been told.

The Committee noted that the new Care Quality Commission (CQC) framework would require patient feedback to be gathered for each of the Trust's 34 quality statements and that patient stories were needed in the context of the Clinical Strategy moving forward (e.g. the move to single managed services for cardiology, stroke and perinatal services).

The Committee welcomed and was assured by the range, quality and depth of patient stories received, how they were received and how they showed how open NBT was about sharing patient stories and putting things right when they occasionally went wrong. The importance of enabling patients to tell their story in a variety of ways (of their choosing) and tackling health inequalities through patient stories (e.g. ensuring people whose voices were seldom heard had the opportunity to tell their story) were emphasised and the team's work in this regard was welcomed. The Committee discussed the importance of continuing the search for patient stories (including from autistic people and people with learning disabilities) and using patient stories, triangulated with other patient feedback, to continuously improve. A request was also made for more patient stories, where multiple services were involved in a patient's treatment or care, and patient transition was a factor (such as the Transfer of Care Hub). The importance of continuing patient and carer events was also emphasised, and the team was thanked for all their good work.

3.3 Patient and Carer Experience Strategy delivery: annual report 2023/24 and plan for the year ahead

The Head of Patient Experience presented an update on progress with the delivery of the Patient and Carer Experience Strategy over the last year, along with "sustain and stretch" plans and targets for the year ahead. The Committee heard that twelve of the original thirteen objectives were met in the last year (the target missed was around the time taken

to respond to complaints, but NBT still compared well against other trusts' performance) and were provided with details of particular highlights and achievements over the last year including:

- the introduction of real-time feedback from patients and carers
- the inclusion of Fresh Arts in the Patient Experience team
- a new quality governance system for managing complaints and PALS
- work to understand the experience of people with seldom-heard voices
- the hosting of the first Faith Leaders Event
- two new volunteering roles introduced and recruited to ("appointment buddies")
- six new patient and carer partners recruited
- better partnership working (e.g. with Healthwatch and the Sight Loss Council, young carers, the gypsy and traveller community and homeless people) and
- a patient experience newsletter and more use of social media.

The Committee welcomed and was assured by the "incredible" work of the Patient Experience team and congratulated them. They discussed and welcomed the improved patient engagement and patient conversations, surveys and communications generally and asked what plans were in place to improve further, hold more e-surveys, improve complaints response times and work more closely with UHBW. The need for greater ownership of complaints responses by divisions was emphasised, as was the ongoing effort to continuously improve ways of gathering patient feedback, and the positive working relationships with UHBW. The Director of Quality Governance referred to historical staffing shortages and the team's confidence that they could build on the successes to date.

The Committee acknowledged that delivery of the strategy was already very good and hoped even more could be achieved in future. They welcomed the plans for the year ahead.

3.4 Patient Experience Risk Report

The Head of Patient Experience and the Chief Nursing Officer provided an update on two Trust level patient experience risks and their current mitigating actions:

- Risk 1701, ASCR; the risk to patient experience due to the significant demand and capacity gap and three-year wait for a first appointment in the tier 3 weight management service and
- Risk 1697, Medicine; the risk of delayed transfers of care for patients requiring a mental health bed/placement when medically fit, which could extend periods in an inappropriate environment.

The Chief Nursing Officer (CNO) explained that work was continuing across the BNSSG system around the mental health risk and that Southmead Hospital received a disproportionate (and vastly increasing) number of people sectioned under the Mental Health Act, as Southmead was deemed a "place of safety" and patients came to Southmead (sometimes in a Police car) rather than other hospitals and stay longer than needed, as there was a lack of other suitable places to go.

The Committee discussed this and the increasing tendency for four-bed bays to be occupied by five patients, due to the increasing number of patients needing treatment, sometimes in a hospital, when they should be in a social care setting. The CNO reminded the Committee that NBT had 25% of patients with no criteria to reside and that work was ongoing across the System to reduce this. The Committee also discussed the experience of patients who had to wait in corridors and the importance of ensuring dignity. The Chair asked for a further report on "corridor care" in due course.

The Committee noted the challenges and the mitigating actions being taken.

3.5 Mental Health Strategy

The Committee received a report from the Associate Chief Nursing Officer (Mental Health, Learning Disabilities and Neurodiversity) (ACNO, MHLD&N), advising them of NBT's first Mental Health Strategy, the priorities of the strategy and the plans to achieve those priorities. The ACNO, MHLD&N explained:

- the commitment and ambition set out in the Clinical Strategy (and by the World Health Organisation) to meet the needs of patients with mental health challenges
- that 14% of patient interaction at NBT involved a mental health diagnosis (with more patients experiencing anxiety and other forms of distress which were not diagnosed as a mental health issue)
- that the NBT Strategy aligned closely with the BNSSG Integrated Care System's All Age Mental Health and Well-being Strategy
- that the NBT Strategy had been the subject of extensive engagement with staff, patients, carers and other key stakeholders including partner organisations
- that the NBT Strategy would be submitted to the Board for approval in July and
- the commitments and key aims and priorities of the Strategy, including providing a proactive 24/7 mental health service.

The Committee welcomed the Strategy, emphasised the importance of responding effectively to patients with mental health challenges and welcomed the commitment to work as an acute hospital to support people's mental health, as well as their physical health. They welcomed the links between this strategy and others, such as the Clinical Strategy, and the patient feedback, albeit asking whether the ambitious targets could be achieved, given the available resources, and whether more patient feedback could be gathered, from a more diverse range of patients.

The Committee was assured that extensive engagement had taken place with many partner organisations, who represented patients, even if the number of patients feeding back individually was low. The lack of resources was a challenge and the Strategy would help focus on what was required and present data to make the case for more resources.

Jane Khawaja (Non-Executive Director) undertook to provide feedback separately to the ACNO, MHKD&N on the accessibility of the Strategy's vision.

3.6 Cancer Improvement Collaborative

The Committee received a report and presentation from Shamim Kholwadia, Senior Project Manager, on this project, to improve access to reasonable adjustments for people

with cancer. Shamim explained the engagement underway and planned, the good work taking place already in some areas and the structure and components of the project. Completion of focus groups, analysis of relevant data and liaison with clinical teams was planned, with a view to co-designing and co-producing resources and recommendations to enable improvement of BNSSG cancer pathways. She gave an example of one patient (not at NBT) who could not deal with the anxiety of going to hospital for her operation and whose operation had to be cancelled twice as a result. All the patient needed was loud music playing during the procedure, which, when provided, meant the operation could go ahead. This demonstrated that reasonable adjustments could be very simple, but very effective.

The Committee welcomed the project and looked forward to receiving further news on its outcomes and findings, emphasising that it showed the vital importance of listening to patients, finding out what they wanted and being flexible with solutions.

3.7 Additional updates were received on:

- Patient and Carer Experience Group Highlight Report:
  The Committee received updates and was assured on the work of the Patient and Carer Experience Group, noting that all identified key workstreams were rated green (meaning: “positive assurance exists that the Trust is primarily meeting its objectives in this area”).
- Learning Disability and Autism Steering Group Highlight Report:
  The Committee received updates and was assured on the work of the Learning Disability and Autism Steering Group, noting that all identified key workstreams were rated green (meaning: “positive assurance exists that the Trust is primarily meeting its objectives in this area”). The Committee particularly welcomed progress with the rollout of Level 1 of the Oliver McGowan training, with 77% of all staff having received the training to date. They also noted an increase in the mortality rate of patients with learning disabilities or Autism and that further details would be provided in future.
- End of Life Steering Group Highlight Report:
  The Committee received updates and was assured on the work of the End of Life Steering Group, noting that all identified key workstreams were rated green (meaning: “positive assurance exists that the Trust is primarily meeting its objectives in this area”) except one (care after death) which was rated amber (meaning: “some objectives are being achieved, but risks exist that may breach others”). Committee members referred to the “fantastic” work taking place and noted the huge difference this work made to people’s lives.
- Committee self-evaluation results and Committee terms of reference:
  The Committee noted the results of the self-evaluation survey undertaken earlier in the year, noted that they had a great deal of business to discuss in the short time available in quarterly meetings and agreed the proposed changes to the Committee’s terms of reference (subject to the approval of the Trust Board).
- The Committee’s work programme: which the Committee noted.

4. Escalations to the Board

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

5. Summary and Recommendations

The Trust Board is recommended to:

(1) receive the report for assurance and note the business undertaken by the Committee on behalf of the Board and
(2) approve the Committee's amended terms of reference.

Terms of Reference of the Patient and Carer Experience Committee (P&CE Ctte)

Chair:	Kelvin Blake, Non-Executive Director. In the absence of the appointed Committee Chair, another Non-Executive Director will chair the meeting.
~~Other~~ **Members:**	Membership of the Patient and Carer Experience Committee shall include: • Three Non-Executive Directors, one of whom shall Chair the Committee • The Chief Nursing Officer • The Chief Medical Officer • Two Patient and Carer Partners. ~~Lay Members~~. The officers set out above may appoint a named deputy to attend a particular meeting in their place, subject to the Chair's pre-approval. A deputy should be nominated only in exceptional circumstances, for a particular meeting.
Other Attendance:	The Patient and Carer Experience 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 Patient and Carer Experience Committee, the following officers (or their nominated substitutes where appropriate) shall normally attend all meetings and may contribute to discussions, but have no voting rights nor contribute to the quorum: • Director of Corporate Governance/Trust Secretary • Director of Quality Governance • Head of Patient Experience • Chief Allied Health Professional • Divisional Director of Midwifery and Nursing • ~~Head of Equality, Diversity and Inclusion~~. The Committee can request the attendance of any other director or senior manager if an agenda item requires it. Attendance at meetings is essential. In exceptional circumstances when an Executive Director member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf.
Quorum:	The quorum necessary for the transaction of business for the Patient and Carer Experience Committee is at least two members, of whom one must be a Non-Executive Director and one an Executive Director (or nominated deputy).

Declaration of Interests	All members must declare any actual or potential conflicts of interest relevant to the work of the Patient and Carer Experience 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, with advice from the Secretary and reference to the Standing Orders, will decide whether a declared interest represents a material conflict.
Frequency of Meetings:	The Committee will meet quarterly. The dates will be set in advance as part of the Trust Board and Committees annual calendar of business. Further meetings may be called at the request of the Chair.
Notice of Meetings:	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.
Inputs:	The Patient and Carer Experience Committee will receive reports on issues within the remit of the Committee, so as to ensure timely discussion and decision-making. This will include: • Patient and Carer Stories • Progress in meeting the commitments in the Patient and Carer Experience Strategy • ~~Patient Involvement Action Plan~~ • Complaints and Patient Advice and Liaison Service (PALS) Annual Report • Quality Strategy: Patient Experience Priorities • Health Inequalities • Accessible Information Standards • National Patient Experience Surveys led by the Care Quality Commission (CQC) or Local Patient Surveys as relevant and timely • Annual Patient-led Assessments of the Care Environment (PLACE) audits and associated improvement plans • Patient Experience Risks • Patient Experience Group and other Steering Group Highlight or feedback reports. Individual members may also raise concerns/risks/issues relevant to the Committee's remit on an ad hoc basis but will do so with sufficient notice to ensure that agendas can be set and managed effectively. The Patient and Carer Experience Committee can request a report on any subject or issue relevant to its terms of reference.

Outputs:	The Committee shall produce a set of minutes and a log of actions arising. Minutes will be sent in confidence to all members of the Committee and shall be made available on request to NHS England / NHS Improvement and the Trust's internal and external auditors. The Committee shall report to the Trust Board on its proceedings (with an "upward report") after each meeting to provide assurance and to escalate any issues to the Board as appropriate. ~~The Committee will provide an annual report to the Board, setting out how it has discharged its responsibilities as set out in these terms of reference.~~
Responsible for the following Strategies and Policies:	The Committee will ensure that an effective patient experience strategy is developed, delivered and embedded across the Trust.
Sub-Committees:	None
Committee Secretary:	The Trust Secretary or his nominee is responsible for: • Agreement of agenda and collation and distribution of papers. • Taking the minutes and keeping a record of actions arising and issues to be carried forward. • Preparing upward reports to the Board after each meeting.

Formatted: Justified

1. Purpose

1.1 The Patient and Carer Experience Committee is established to:

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

2. Authority

2.1 The Patient and Carer Experience Committee is constituted as a Standing Committee of the Trust Board, from which it receives its authority. Its constitution and terms of reference are set out in this document, subject to amendment by the Trust Board.

2.2 The Committee is authorised to seek information it requires from any employee of the Trust. All members of staff are directed to co-operate with any request made by the Committee.

2.3 The Committee is authorised to obtain legal or other independent professional advice and to secure the attendance of advisors with such expertise that it considers necessary.

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

3. Duties

Implementation:

3.1 The Committee will:

- Ensure a trust-wide approach to patient experience is maintained which continually reviews intelligence and drives outcome-based improvements.
- Work with the Patient Experience Group to identify areas of concerns and celebrate best practice.
- Ensure the Trust is sourcing inclusive feedback from all groups which are representative of the local population.
- Ensure the Trust has a patient engagement programme which also includes interaction with patient support groups and encourages involvement in the redesign of services.

Performance Monitoring

3.2 The Committee will:

- Review performance and associated outcomes against patient experience metrics and targets and ensure that action is taken to address issues arising.
- Identify good patient experience and ensure that this is shared throughout the Trust.
- Review examples of learning which have resulted from patient feedback
- Ensure that poor patient experience is understood and challenged effectively, resulting in plans to address it.

Review and Compliance

3.3 The Committee will:

- Have overview of the work of the Patient Experience Group and its sub-groups and will receive regular reports from that group setting out the business it has undertaken, decisions made and performance against that group's objectives.
- Receive and analyse patient, relative and carer feedback on services provided by the Trust.
- Review and identify issues/themes resulting from PALS, complaints, social media and all forms of patient feedback and associated improvement actions.
- Review results of all national patient surveys and ensure that appropriate action plans are developed and implemented to deliver effective outcomes. Compare and correlate with local surveys.
- Review and compare results of staff surveys to patient survey and adverse event data; support the process for joint improvements.

- Review information received from external sources such as Patient Opinion/NHS Choices, Healthwatch and ensure it is considered alongside other ~~date~~ data to contribute to patient experience improvement activity.
- Review national guidance, initiatives and reports relating to patient experience; propose action in response.
- Review and monitor CQC Compliance Assessments relating to areas of patient experience.

Risk Management

3.4 The Committee will: review risks to providing a high standard of patient experience and seek assurance that appropriate action is being taken to mitigate.

Version:	2.3~~2~~
Ratified by / responsible committee:	Ratified by P&CE Ctte on: TBC ~~19 December 2022 (old format)~~. To be ratified by Trust Board on: TBC ~~26 January 2023~~.
Date ratified:	~~26 January 2023~~ TBC
Name of originator / author:	Trust Secretary
Lead for Executive Team Meeting:	Trust Secretary
Date issued:	TBC ~~January 2023 (in new terms of reference format)~~
Review date:	TBC ~~December 2023 (P&CE Ctte)~~

Report To:	Public Trust Board			
Date of Meeting:	25 July 2024			
Report Title:	People & Equality, Diversity and Inclusion (EDI) Committee Upward Report			
Report Author:	Tomasz Pawlicki, Corporate Governance Officer			
Report Sponsor:	Kelvin Blake, Non-Executive Director, and Chair of People Committee			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	That the Trust Board receive the report for assurance and note the activities the People & EDI Committee has undertaken on behalf of the Board.			
Report History:	The report is a standing item to the Trust Board following each Committee meeting.			
Next Steps:	The next report will be received at the Trust Board in September 2024.			

Executive Summary		
The report provides a summary of the assurances received and items discussed and debated at the People, Equality, Diversity and Inclusion (EDI) Committee meeting held on 9 July 2024.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	✓
	Commitment to our Community - *In and for our community*	✓
Link to BAF or Trust Level Risks:	Reports received support the mitigation of various BAF risks.	
Financial implications:	No financial implications as a consequence of this report.	
Does this paper require an EIA?	No, as this is not a strategy or policy or change proposal	
Appendices:	Appendix 1 – Health & Safety Annual Report Appendix 2 - Appraisal rates	

1. Purpose

1.1 To provide a highlight of the key assurances received, items discussed, and items for the attention of the Trust Board from the People & EDI Committee meeting held on 9 July 2024.

2. Background

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

3. Meeting on 9 July 2024

Chief People Officer Update

3.1 The Committee received the Chief People Officer update which focused on the following key areas:

- The significant improvements in staff turnover within the organisation with an overall reduction since November 2022.
- The significant improvement in turnover of Healthcare Support Workers from 25.1% in November 2022 to 13.9% in May 2024.
- The ongoing Commitment to our Community work with the focus to employ staff from 30 of the most challenged communities.
- The ongoing work and improvements to reduce the temporary staff and agency workforce within the Trust.
- The reduction in reported numbers of sickness and absence within the Trust in the last 12 months.
- The overall vacancy rate has decreased by 1.56% in May 2024. This is a significant decrease as new funding for the financial year is normally added into figures in April and it takes a couple of months for the information from the financial ledger to reconcile with the workforce data.
- The ongoing work and planning for the 2024 Staff Attitude Survey.

The Committee welcomed the update, particularly the Commitment to our Community work. Discussion focused on apprenticeships and the ongoing divisional engagement for work experience and T-level students on the wards.

3.2 Operational Workforce Update

The Deputy Chief People Officer presented the Operational Workforce Update and highlighted:

- The staff turnover and retention improvements (aligned to the one-year retention plan), particularly regarding Healthcare Support Workers.
- Time to hire which remains at 18 days.
- The planned improvements in the Disparity Ratio and employing staff from 30 most socio-economically challenged communities with metrics and actions outlined in the Commitment to our Community Plan.
- The data on recruitment and temporary staffing performance, as well as data on eRostering, eJob planning, people policy compliance and mandatory training compliance

- The data relating to sickness absence, which continues to improve.
- The ongoing work to improve appraisal compliance. It was noted that there are some changes to the way medical appraisals should be reported and this will be updated in the next report.
- The Committee welcomed the updates particularly improvements with Commitment to our Community Plan and discussed ongoing work on engagement with divisions to provide more work opportunities.

3.3 Workforce Plan Forecasting Data

The Committee received an update from the Head of Strategic Workforce Planning on the Workforce Plan Forecasting Data which accompanies the Long-Term Workforce Plan update taken to the Trust Board in May 2024 and acknowledged the next steps associated with further developing the use of the tool and underpinning assumptions.

The Committee was updated on three areas of the plan:

The Base Case which involves changes to the raw data inputs for both supply and demand in the plan. The key updates from version one to version two include a new starting point for the plan, which now reflects the impact of 2024/25 operational planning, and an extension of the plan's timeline to 2029/30, previously set to end in 2028/29.

Intervention Themes have also been updated, with changes to the themes and their associated modelling. These updates include a quantified impact of the intervention themes as improvement work progresses, targets change, and the overall gap reduces.

The Next Steps, that focus on developing the use of the tool considering internal and external factors, the impact of other workforce forecasting tools, and align with system partners.

The Committee welcomed the changes and informative report. The Committee discussed the positive work that has led the Trust to the current workforce situation and ongoing work to align the Workforce Plan with University Hospitals Bristol & Weston NHS Foundation Trust (UHBW). The Committee agreed that a detailed update would be presented at a future meeting and, after endorsement from the People & EDI Committee, will be presented to the Trust Board.

3.4 Bank Staff Survey Results and Actions

The Committee received a positive update on Bank Staff Survey Results and Actions which showed improvement in both the response rates and scores and that all the People Promise scores have improved from 2022. The Committee received assurance on the ongoing efforts relatingto the Bank Optimisation Programme, which aims to further engage and develop our Bank workers across the Trust, so that they feel valued, supported and part of a team.

The Committee discussed historical challenges in reducing the agency workforce to and converting agency to bank. Additionally, the Committee were informed of the current changes within the North Bristol Trust (NBT) Extra team leading the work on

the Bank Optimisation Programme, and the exciting work underway with UHBW to develop a collaborative bank between the two Trusts.

3.5 Appraisal rates

The Committee were joined by the Head of Learning & Development who presented the Appraisal rates update. The update highlighted the launch of the new electronic appraisal system and the positive engagement from the staff with over 47.3% completed appraisals and over 3500 reviews in progress.

The Committee received reassurance that the Trust would achieve the target of 80% appraisals complete by the end of July 2024. The Committee discussed the accessibility of the new appraisal system and surveys in place to collect feedback from staff who have completed their appraisals.

The Committee welcomed the feedback and congratulated the Appraisal Team for their achievements so far and positive work towards achieving the target.

3.6 Levels of Attainment and Rostering Audits

The Committee received an update on the Levels of Attainment and Rostering Audits. It was noted that e-Rostering and eJob Planning Levels of Attainment and Meaningful Standards are criteria published by NHS England (NHSE) that support providers to meet the commitments in the NHS Long-Term Plan to deploy and optimally use electronic rostering and job planning solutions. The report set out what the Levels of Attainment and Meaningful Use Standards are, the current position in the Trust at profession level, future plans, and the governance arrangements proposed to monitor the delivery of improvement plans.

Discussion focused on staff engagement regarding e-Rostering and Radar systems, particularly medical staff, and the ongoing collaboration work with UHBW to align systems.

3.7 EDI Plan Update

The Committee were joined by the Associate Director of Culture, Leadership & Development who provided an update on the EDI plan and highlighted the following key activities:

- Reviewing the ‘Red Card to Racism and Abuse’ campaign based on feedback from the Black, Asian and Minority Ethnic (BAME) staff network.
- Raising awareness of the Trust’s Trauma Support Pathway to support staff affected by racial trauma, delivered by the new staff clinical psychologist who is the lead for BAME staff support.
- Presenting the Workforce Race Equality Standard (WRES) data to the Operational EDI Group, People Oversight Group and Executive Team Meeting in August 2024, with a presentation to the Board in October 2024 for assurance and information.

The Committee noted that the staff survey and WRES data reported the ongoing inequity in career development and promotion opportunities for ethnic minority staff. The Senior Leadership Group (SLG) set an EDI objective for 2024/25 to enhance the quality of appraisals, aiming to support career advancement through meaningful development conversations. The appraisal window is open from April to July 2024, with training and the introduction of the online system 'My Appraisal' which collects

real-time feedback. This will help the People Team identify and address problem areas to improve training.

The Committee discussed the long-term work on appraisals, which involved positive feedback and ongoing efforts from the divisions regarding the opportunities and support provided for the staff to help in their development. The Committee were also updated on the work to develop and pilot anti-racism training and were pleased with the progress of this.

3.8 Trust-Level Risks (TLR) and Board Assurance Framework (BAF)

The Committee were joined by the Director of Corporate Governance and Trust Secretary who updated the Committee on risk ID Harm to pedestrians, damage to vehicles or damage to a pressurised gas pipeline due to concrete ducting within the road near Pathology 2 (Southmead) being in very poor condition.

The Director of Operational Estates and Facilities provided reassurance that the mitigations for the risk are in place and repairs are in place.

3.9 Health & Safety Annual Report

The Committee received the Health & Safety Annual Report which outlined that divisions and professions have improved compliance with training, quality of risk assessment, understanding of health and safety fundamentals, and provided assurance that risks are better understood, communicated, and managed. It was noted that plans for 2024-2025 aimed to further embed good practices, develop training and reference resources throughout the Trust.
Furthermore, the Committee was informed of the effective escalation of the “Abuse of staff” from divisions to the Trust Health and Safety Committee and the People & EDI Committee resulting in the formation of the Violence and Aggression Reduction Group.

The Committee discussed the fact that an internal audit has been commissioned regarding violence, aggression and abuse in the Trust and agreed that the report would come to a future People & EDI Committee meeting after it was presented at the Audit & Risk Committee.

3.10 Joint Consultative and Negotiating Committee for Non-Medical Staff Unions + Joint Local Negotiating Committee for Medical Staff Unions (JCNC) +(JLNC) Annual Update

The Committee received the annual JCNC + JLNC update which outlined that the Unions and the Trust have worked closely together to address several issues of importance to the Trust’s staff.
The below key JCNC + JLNC focuses were noted:

- Staff wellbeing
- Growing cost of living
- Bank staff optimisation and agency reduction
- Enhanced rates to support workforce challenges
- Agile working, restorative just culture
- Policy development, job evaluation
- The impact of changes to Band 2/3 roles
- Staff experience and retention.

The Committee noted that industrial action for Postgraduate Doctors continued through 2023 into 2024. The Trust recognises the unions' position on industrial action and has worked closely with the JLNC to provide staff and managers with the necessary information and support during these periods.

The Committee received assurance on the positive engagement with Trade Unions and that established positive relationships have been maintained.

4. Other items:

The Committee also received the following items for information:

- Health & Safety Committee Upward Report – The Committee received an update on the Breach of Security within the Mortuary that occurred in February 2024, several actions, inspections, and reports have been completed and presented.
- Sub-Committee Upward Reports: People Oversight Group

5. Identification of new risks & items for escalation

5.1 No specific new risks were identified.

6. Summary and Recommendations

6.1 The Trust Board is asked to receive the report for assurance and note the activities the People & EDI Committee has undertaken on behalf of the Board.

North Bristol NHS Trust

Report To:	People Committee			
Date of Meeting:	09 July 2024			
Report Title:	Health and Safety Annual Report April 2023 – March 2024			
Report Author:	Timothy Johnston, Operational Health and Safety Manager			
Report Sponsor:	Glyn Howells, Chief Finance Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
			✓	
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				✓
Recommendations:	Maintain current arrangements and resourcing.			

Executive Summary

Health and Safety Services is a small team which collaborates with clinical divisions and core services throughout NBT and the wider health community of BNSSG. These coalitions with other teams, divisions and professions has improved compliance with training, quality of risk assessment, understanding of health and safety fundamentals and assurance that risk is understood, communicated and managed better. Plans for 2024-2025 see further embedding of good practice and developing training and reference resources throughout the trust as key aims.

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	✓
	Sustainability – *Making best use of limited resources*	✓
	People – *Proud to belong*	✓
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:		
Financial implications:	No change	
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No	

North Bristol NHS Trust

Annual Report
Health and Safety: 2023-2024

Executive Summary
Health and Safety Services is a small team which collaborates with clinical divisions and core services throughout NBT and the wider health community of BNSSG. These coalitions with other teams, divisions and professions has improved compliance with training, quality of risk assessment, understanding of health and safety fundamentals and assurance that risk is understood, communicated and managed better. Plans for 2024-2025 see further embedding of good practice and developing training and reference resources throughout the trust as key aims.

Health and Safety Services Team

Based in Beaufort House at the heart of the Southmead campus, Health and Safety Services operates in partnership with teams, divisions and functions throughout NBT.

Regular reviews of the Health and Safety resource allocation are required to ensure the Trust remains compliant with The Management of Health and Safety at Work Regulations 1999 5(1).

Team organisational chart is located as figure 1 at the end of this document.

Health and Safety Governance
The Trust Health and Safety Committee and it's subgroups have developed and refined membership, structure and record keeping to ensure effective communication at all levels and across all areas of the Trust.

A tabular overview of subgroups is located as figure 2 at the end of this document.

Health and Safety Risk Management
Almost all risk register entries assigned to Facilities division are now managed by a chair of a relevant subgroup for the Trust Health and Safety Committee (financial risks are managed by division director). All risks are reviewed in accordance with the trust recommended review intervals, with action progress scrutinised by subgroups. High scoring risks are included within upward reports to Trust Health and Safety Committee and those meeting Trust Level Risk thresholds, which are reviewed monthly, are also monitored by the Risk Management Group.

Following KPMG internal audit actions, risk register entries have been reviewed and updated to:
- Clearly identify the risk
- Specify risk owner and handler
- Identify executive risk sponsor if trust level
- Detail 'SMART' actions including date and action owner

North Bristol NHS Trust

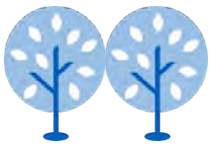
Health and Safety Incident Response

Health and Safety Services have reviewed 3073 incidents during the period 1 April 2023 – 31 March 2024, an increase of 42% from the previous year's total 2159. These are predominantly incidents where the reporting member of staff has selected an incident type which is 'health and safety', but includes 246 (8%) where incident managers have flagged to Health and Safety for support during their investigation and 937 (30%) which have been 'screened out', predominantly where incorrect categories have been selected by the reporter.

NBT reported 68 incidents under RIDDOR, returning to pre-COVID typical level. 20 of these reports were beyond the notification window, which is subject to analysis with intention to introduce further action to improve.

Figure 5 at the end of this document shows the overall number of incidents seen by Health and Safety Services. Figure 6 at the end of this document shows the health and safety specific incidents with a risk value which includes both number and harm score factors. This offers a more considered comparison of risk profile.

Themes and trends from incidents inform conversations at subgroups, with divisions and at Trust Health and Safety Committee. Growing concern about violence and aggression towards staff (the 'Abuse of Staff' category on the charts) has been effectively escalated from division to Trust Health and Safety Committee and to People Committee resulting in the formation of the Violence and Aggression Reduction Group.



Engagement with Organisational Divisions and Functions

For a team as small as Health and Safety Services to achieve significant impact across the organisation, it is crucial to build coalitions with the organisational divisions. Each of the three Health and Safety Advisors works closely with two divisions, building relationships, attending monthly meetings with divisional governance teams, and providing proactive and reactive support.

Risk Register

- 81 Health and Safety risks closed
- 22 Health and Safety risks added

Improvement Plan

Internal Audit by KPMG in July 2023 provided assurance that the changed team structure over the preceding year or so has greatly improved management of Health and Safety at NBT. Just two moderate impact recommendations and three minor impact recommendations were made:

1	Moderate impact	Develop replacement training for all managers and designate as 'statutory'. *In progress, due Summer 2024*
2	Moderate impact	Initiate programme of spot checks and feedback to managers regarding quality and timeliness of information entered on Datix about incidents. *Completed Feb 2024*
3	Low impact	Review local procedure for incident monitoring within Health and Safety services. Request divisional governance structures systematically review 'near miss' incidents. *Local procedure completed Aug 2024* *Divisional governance near-miss systematic review pending QG team capacity*
4	Low impact	Incident investigation timescales are not specified. *Procedure completed Jan 2024*
5	Low impact	The Control of Contractors policy is overdue review. *Policy completed Sep 2023*

Mandatory and Statutory Training

Subject	Compliance	Trend
Health and Safety	93%	↑
Manual Handling	90%	↑
Fire	91%	↑

North Bristol NHS Trust

Training Delivery

Classroom Training Delivery

Subject	No. Sessions	No. Trained
H&S Induction	26	1843
Manual Handling	144	1342
COSHH	14	79
Risk Assessment	12	82

Throughout 2023-2024, Health and Safety Services has continued to refresh and reintroduce classroom based training.
By the end of 2023-2024, Health and Safety Services provides:

- Health and Safety Induction Workshop
- Patient Handling Induction for Support Workers
- Patient Handling Induction for Clinically Registered Staff
- Health and Safety including Manual Handling updates for Consultants
- Control of Substances Hazardous to Health Risk Assessment
- General Risk Assessment and Manual Handling Risk Assessment

Operational Plan for 2024-2025

The plan for 2024-2025 sets out the work streams and engagement for Health and Safety Services with key areas being advice, training, compliance and governance.

Aside from the 'business as usual' aspects of the plan, which include, daily incident reviews, RIDDOR reporting and investigation, advice requests, staff and DSE assessments, complex patient advice, there is a substantial requirement of the team's resource to ensure implementation of RADAR Healthcare's incident management module and discontinuation of the incumbent Datix platform achieves the requirements of Health and Safety Management legislation and governance good practice.

Project highlights include:

- Team development and competency assurance programme
- Supporting RADAR system development and implementation
- Development of new training workshops for: managers, health and safety link role
- Development of audit plan
- Re-start of practical manual handling update training

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Figure 1: Health and Safety Services organisational chart

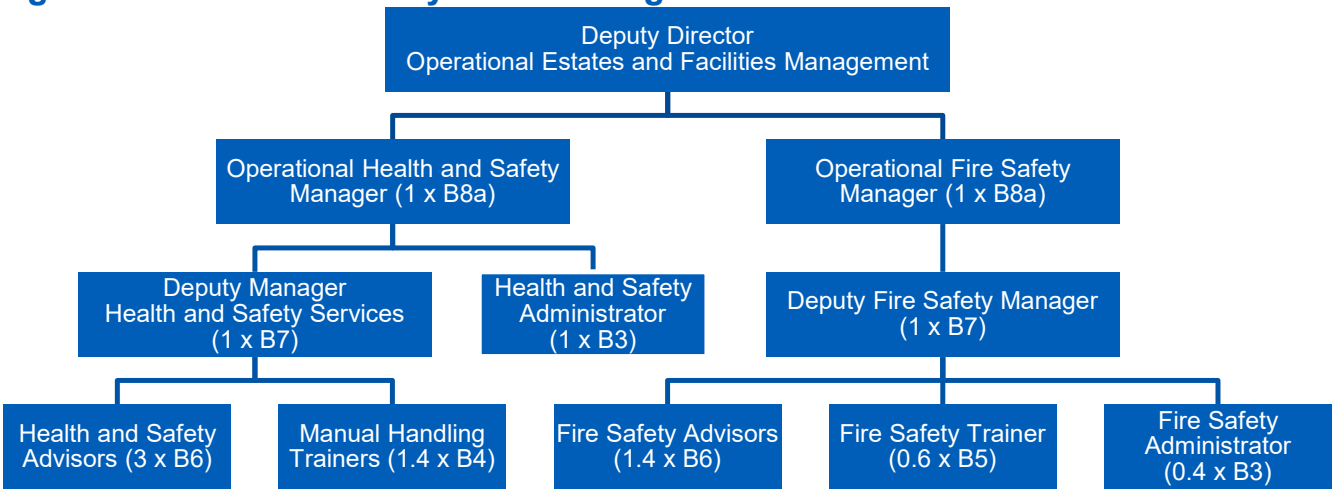


Figure 2: Trust Health and Safety Committee subgroup overview

Subgroup	Nominal Contacts		Risk Register Entries	
	Responsible	Chair / SME	No. TLRs	No. Total
Health and Safety Steering Group	**Matt Chick**	Tim Johnston		4
Feeders include: • Medical Gas • Wellbeing • Radiation Protection • Divisional H&S Forumns				
Fire Safety Group	**Matt Chick**	Nicky Ricketts		18
Feeders include: • Fire Technical Working Group • Fire Integrity Project Group				
Hard FM Compliance Group	**Paul Jenkins**	Andy Webb	**5**	17
Feeders include: • Ventilation Safety • Water Safety • Electrical Safety • PUWER and LOLER • Pressure Systems • Asbestos Management • Working at Height • Confined Spaces • Control of Contractors				
Soft FM Compliance Group	**Paul Jenkins**	Andy Kettle		14
Feeders include: • Decontamination • Transport • Waste Management • Catering inc Food Safety • Security inc Parking				
Violence and Aggression Reduction Group	**Dominique Duma**	Tony Hudgell	**1**	1
Feeders include: • National Violence Reduction Standards working group • MAYBO training				

North Bristol NHS Trust

Figure 3: Risk Register – Trust Health and Safety Committee oversight

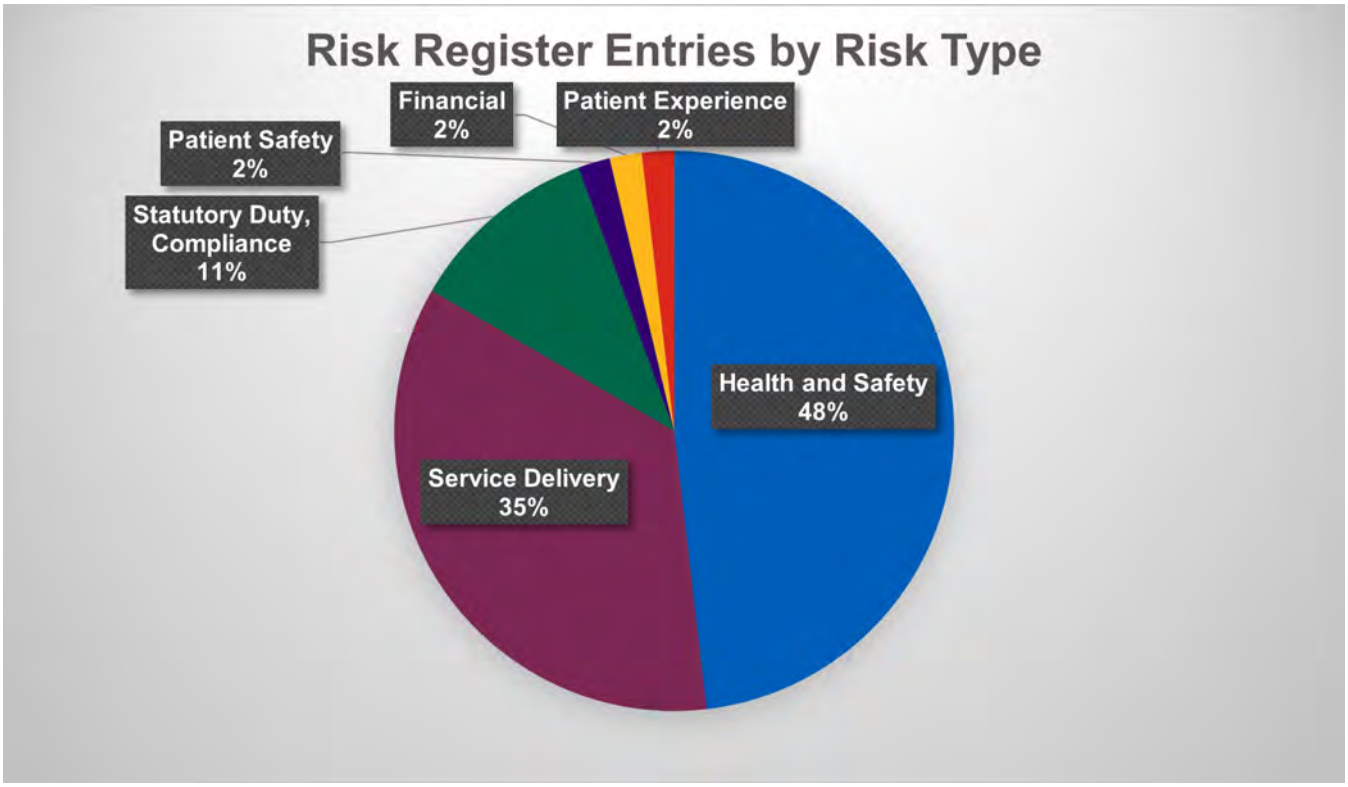
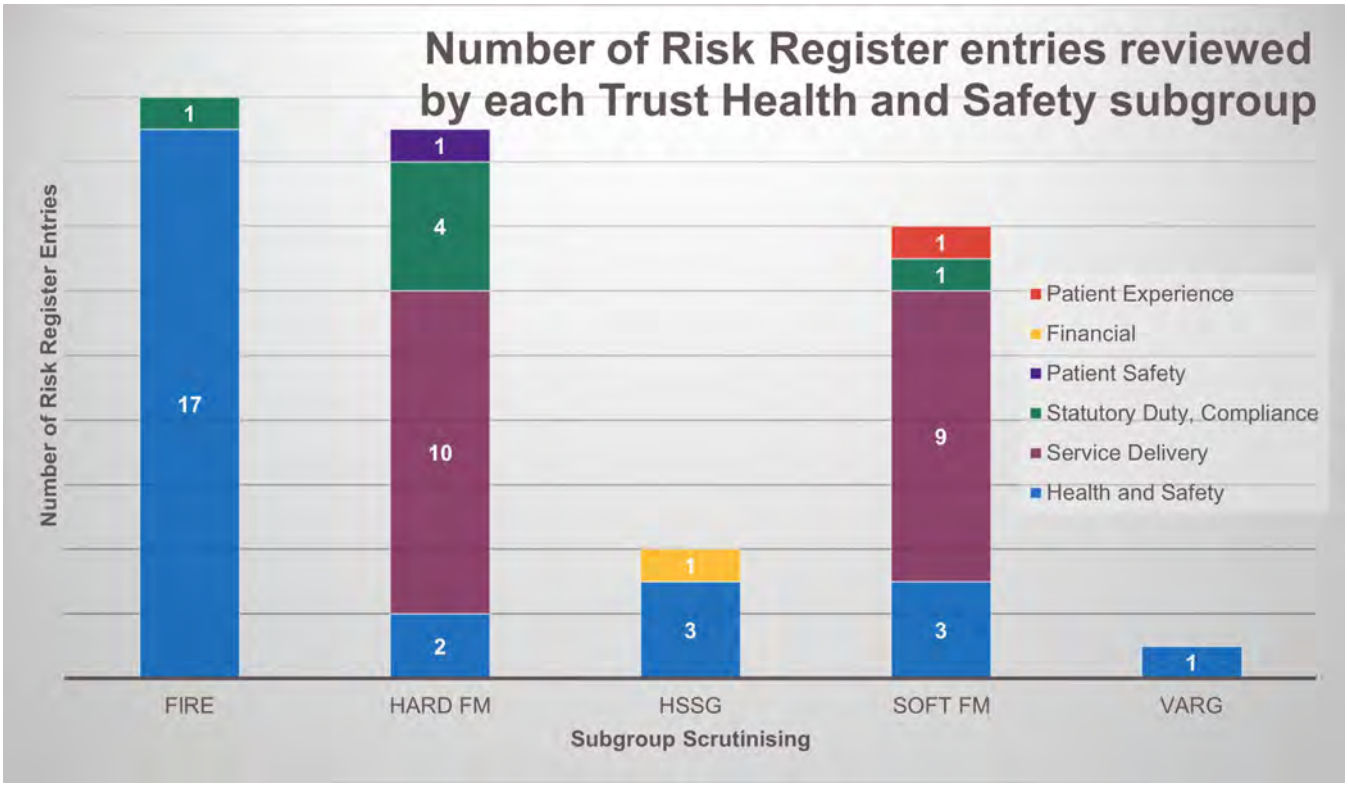


Figure 4: Risk Register – subgroup scrutiny



North Bristol NHS Trust

Figure 5: Incidents – number of Datix reported incidents

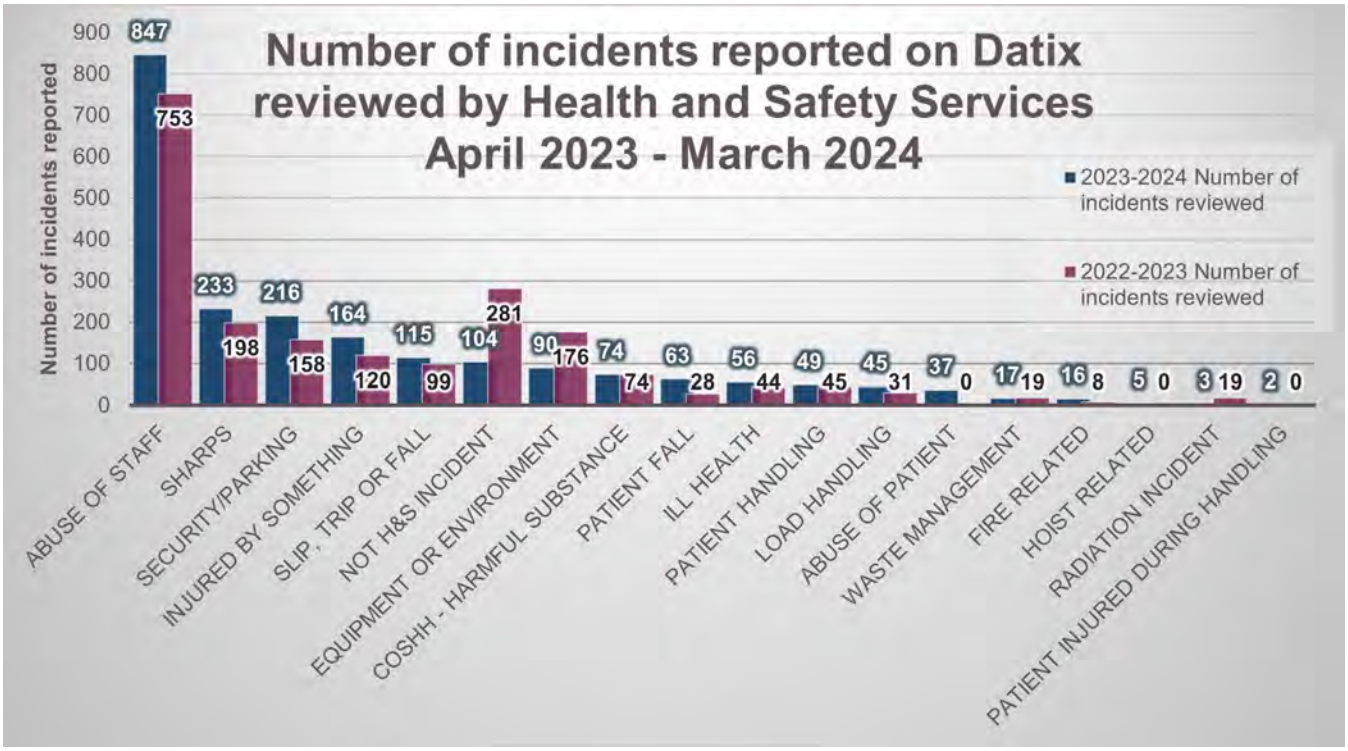
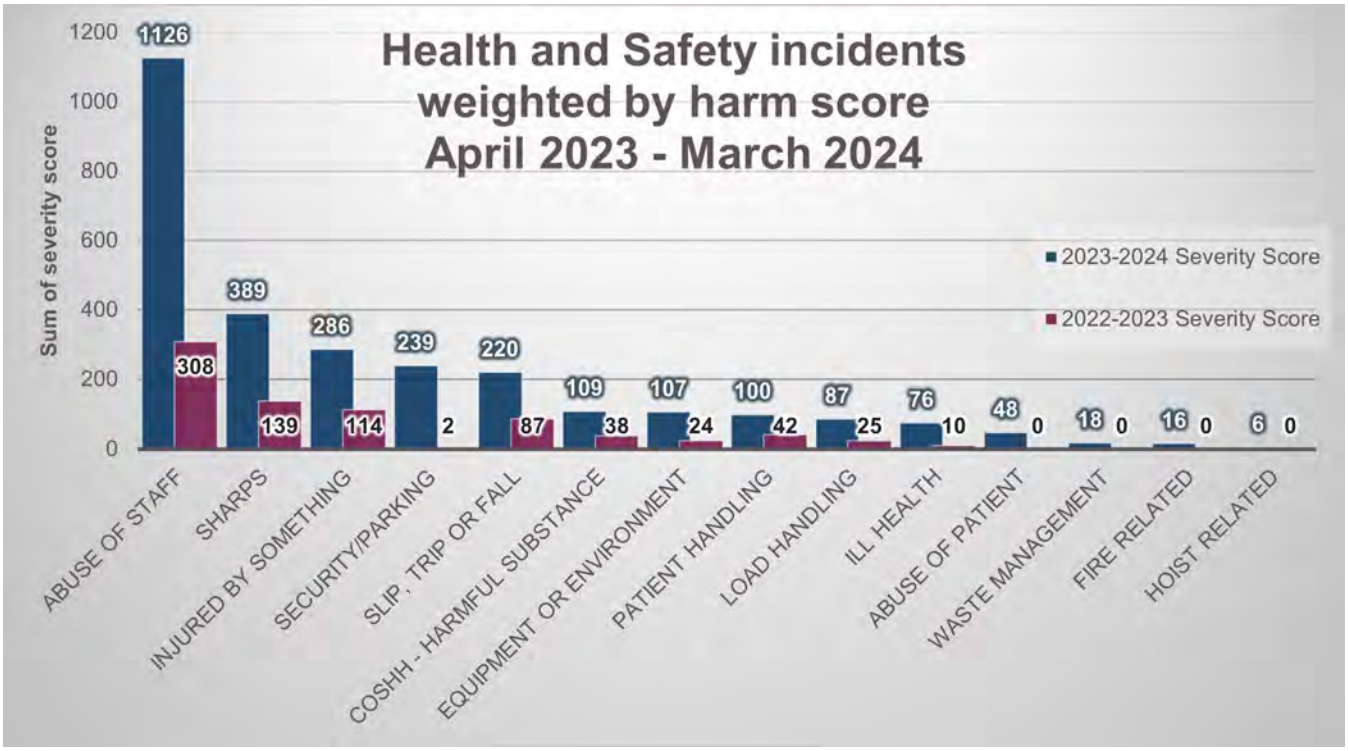


Figure 6: Incidents – weighted risk from Datix reported incidents



Report To:	People & EDI Committee			
Date of Meeting:	9 July 24			
Report Title:	My Appraisal Update			
Report Author:	Jonathan Cresswell, Head of Learning & Development			
Report Sponsor:	Sarah Margetts, Deputy Chief People Officer Peter Mitchell, Interim Chief People Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			X	
Recommendations:	The Committee is asked to note the progress against appraisals at end June 2024.			
Report History:	N/A			
Next Steps:	A final update will be provided once the appraisal window closes on 31 July 2024.			

Executive Summary		
• The annual appraisal window for staff at NBT is 1 April – 31 July 2024. • Last year the Trust achieved 79.04% appraisal completion within the window. • This year the Trust has launched a new electronic platform 'My Appraisal' to support staff to record appraisals and to enable better monitoring and reporting. • At 30 June 2024 the appraisal completion rate is 38.02%, with 37.8% in progress. • Continued reminders and support from senior leaders are required to ensure the appraisal completion rate achieves the Trust target of 80% by the end of July.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	**X**
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	**X**
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	N/A	
Does this paper require an EIA?	*No* - The paper is an update.	

North Bristol NHS Trust

Appraisal Rates Update

1. Purpose

1.1. To update the People & EDI Committee on Appraisal completion rates and quality of appraisals at 30 June 2024.

2. Background

2.1. The Trust has launched "My Appraisal," an online system to improve our annual appraisal processes. This change from paper-based to digital addresses delays and limited visibility in the old system. "My Appraisal" offers a user-friendly platform accessible from any device, enabling continuous feedback and real-time goal tracking.

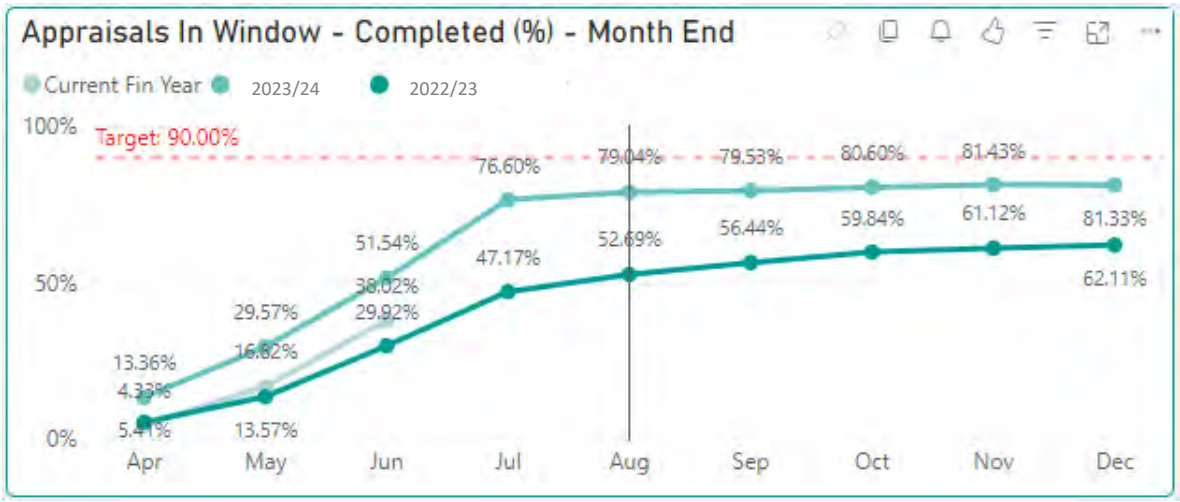
2.2. The system went live on 1 April with the appraisal window open until 31 July 24. This change supports our staff in achieving their goals and shows our commitment to modernising performance management.

2.3. An advantage of the new system is that appraisers are asked to rate the quality of their appraisal conversation. This will provide data to triangulate with other workforce information such as turnover and sickness absence rates to identify departments for focused HR support.

3. Position at 30 June 2024

3.1. Last year, the completion rate was measured based on the appraisal meeting date. This year, an appraisal is considered “complete” when it is signed off by the person being reviewed and the reviewer.

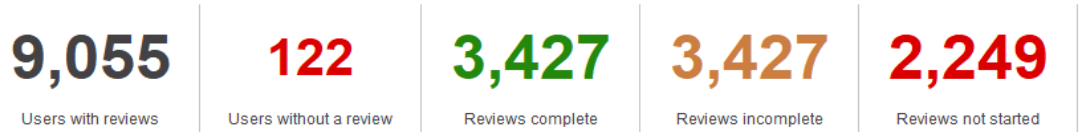
3.2. In the graph below the current completed rate is shown as 38.02% at month end, 30 June 2024, compared to 51.54% at the same stage in 2023/24 and 29.92% in 2022/23.



3.3. Although our completed rate of 38.02% is significantly behind that of the 2023/24 position at end of June, when you combine the completed appraisals and in those in progress, the

total percentage of staff having an appraisal is 78.82%. This suggests there is potential for us to meet if not exceed the 2023/24 final position of 79.04%. However, caution must be applied to combining the completed and in progress numbers, as we do not yet understand the conversion rate of in progress appraisals.

3.4. Statistics – the following statistics are generated in real-time by the Kallidus Perform platform:



(Data correct on 01 July 24)

3.5. The data above shows that 6,854 out of 9,055 employees have engaged with and, in some cases, completed their appraisal.

3.6. Key to the terminology in the picture above.

- Users with reviews – number of staff assigned an appraisal review.
- Users without a review – This may be staff who joined after 1 Apr 24, staff whose manager is out of scope (NBT eXtra, External staff, managers in Medical/Dental roles), or staff with no supervisor assigned in ESR. The system only permits us to assign reviews to staff with a supervisor, as no one would conduct the review.
- Reviews Complete - Both the reviewee and reviewer have signed off the appraisal. Please encourage your divisions to complete their appraisals.
- Reviews incomplete (In Progress) - The reviewee/reviewer has started the review and may or may not have had their appraisal conversation.
- Reviews not started - An appraisal has been assigned to the individual, but the reviewee/reviewer has not yet clicked “Start appraisal” in their My Reviews section.

3.7. Progress by Division / Directorate can be seen in the chart below:

(Data correct on 01 July 24)

4. Actions taken to increase engagement.

4.1. The following actions have been taken to help drive engagement with the new appraisal system.

A new My Appraisal website on Link that has training, FAQs, resources, and links.

Appraisal completion added to QLIK reporting (soon to be Power BI).

Appraisals promoted through HRBPs/People Partners.

Face-to-face sessions with divisions, wards, and teams are held across the trust.

E-learning for reviewees and reviewers is available on Learn.

Weekly update reports to divisional directors and their deputies, operations directors, and People Partners.

Targeted emails to individual staff depending on their review status.

Comms plan throughout implementation and post-implementation.

5. Quality of Appraisals

5.1. After an appraisal conversation has taken place, staff are able to review the quality of their appraisal (question in bold in table below). This information is not visible to the appraiser but enables us to understand the quality of appraisal conversations and inform our approach to training within Learning and Development.

5.2. The table below also shows the responses to the check-in section of the appraisal to demonstrate the kind of analysis the new system will enable. The snapshot below at 30 June 2024 shows an overwhelmingly positive experience of appraisals, which we can then compare to the linked questions in the annual NHS staff survey (as included in table 5.1).

Questions with a Scale answer	Very Happy/Happy
After your appraisal conversation, and before you sign off, please rate the quality of your appraisal conversation.	**98%**
How fulfilled, am I within my current role?	86%
How is my relationship with my colleagues?	95%
How is my relationship with my manager?	96%
How is my work/life Balance?	80%
How manageable is my workload?	78%

6. Measuring Success

6.1. The following Key Performance Indicators will help to measure the benefits of the Kallidus Perform appraisal system:

Key Performance Indicator	2023 Figures %	Best %	Target (+5%) %	Stretch Target (+10%) %	Deadline
Appraisal Completion Rate	75.9 (31 Jul 2023)	N/A	**79.7**	83.5	31 Jul 24
Appraisal Engagement (Completed + in progress status)	N/A	N/A	**83**	87	31 Jul 24
Appraisal Conversation Quality Rating	N/A	N/A	**80**	90	31 Jul 24
(Q23a) in the last 12 months, I have had a review	87.4	94.3	**91.7**	96	Jan 25
(Q23b) It helped me to improve how I do my job.	24.3	39.8	**25.6**	26.7	Jan 25
(Q23c) It helped me agree on clear objectives for my work.	34.8	46.3	**36.5**	38.3	Jan 25
(Q23d) It left me feeling that my work is valued by my organisation	32.8	40.7	**34.4**	36	Jan 25

7. Summary and Recommendations

7.1. The People & EDI Committee is asked to **note** the appraisal completion rate is 38.02%, with 37.8% appraisals in progress at the end of June 2024.

7.2. Continued reminders and support from senior leaders will be required to ensure the Trust achieves its appraisal completion target of 80% by the end of July.

NHS North Bristol NHS Trust

Report To:	Public Trust Board			
Date of Meeting:	25 July 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			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			x	
Recommendations:	The Board of Directors will discuss current Junior Doctor contract issues and as a public authority must, in the exercise of its functions, have due regard to the need to: • All contractual obligations in place • Be satisfied that the role of Trust Guardian is being fulfilled. • Exception Reports being acted upon • Gaps on Junior Rotas being filled as a priority. • Risks to Trust considered – Guardian fines; accountability; staffing			
Report History:	This paper sets outs the background and context around the introduction of the Guardian of 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			
Next Steps:	• Promote and support exception reporting system to consultants and trainees. • Continue to look at creative workforce and IT solutions to minimise gaps			

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

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

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

The NBT Trust Guardian for Safe Junior Doctor Working will:

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

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

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

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

Penalties 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 PGDF will retain the remainder of the penalty amount.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	X
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	• eRostering to alert contract breaches and enable leave booking for trainees. • Exception's alert ISCs	
Financial implications:	NA	
Does this paper require an EIA?	NA	
Appendices:	NA	

HIGH-LEVEL DATA: NBT rota designs have continued to meet the 2016 junior doctor contract requirements.

1. ROTA GAPS
2. GAP MANAGEMENT
3. LOCUM USAGE
4. EXCEPTION REPORTING & PDF

1. ROTA GAPS

Vacancy is currently calculated by looking at funded establishment WTE and staff 'presumed' in post calculated via WTE we are paying.
Posts paid for by other Trusts should be factored in by a 'recharge' calculation.
There is potential inaccuracy if 'recharging' is not factored in – this in fact led to inaccuracy in the last GOSW report where the DiT vacancy was reported as 30WTE in Core Clinical based on the data BI supplied.
Ben Pope 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' over 3 months and potentially move to calculating vacancy via this method.

NHS North Bristol NHS Trust

1a – Vacancy – excluding sickness, maternity and posts paid for by other Trusts.

	Clinical Fellow		Trainee			
	Clinical Fellow WTE		Doctors in Training WTE		PGD WTE	
DIVISIONS	Staff in post	Vacancy	Staff in post	Vacancy	Total staff in post	TOTAL VACANCY
ASCR						
Feb	69.53	-5.48	157.71	8.09	227	Unverified
March	68.53	-4.48	160.72	4.87	229	Unverified
April	71.43	-7.38	160.15	2.44	231	Unverified
May	74.43	-10.38	161.34	1.35	232	Unverified
Core Clinical Services						
Feb	3.44	-0.44	28.67	33.05	32	Unverified
March	5.44	-2.44	27.31	45.59	32	Unverified
April	5.44	0.96	25.51	25.79	31	Unverified
May	6.44	5.19	23.95	24.48	30	Unverified
Medicine						
Feb	54.89	-6.51	113.74	10.59	169	Unverified
March	56.89	-8.51	112.72	11.61	170	Unverified
April	54.89	-5.11	113.22	7.41	168	Unverified
May	55.89	-7.11	113.70	9.93	170	Unverified
NMSK						
Feb	41.67	-24.37	71.89	31.06	114	Unverified
March	42.67	-25.37	70.71	31.61	114	Unverified
April	46.80	-29.50	71.78	30.54	118	Unverified
May	44.80	-27.50	71.78	30.54	117	Unverified
Women and Childrens						
Feb	13.42	-12.27	36.67	1.67	50	Unverified
March	15.33	-14.18	36.63	1.50	52	Unverified
April	15.33	-14.33	36.84	1.29	52	Unverified
May	14.37	-13.37	35.84	2.29	50	Unverified

Table 1. Shows PGD 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.

Vacancy data unverified by BI and implausible – likely error due to recharge calculation

1b – PGD Sickness Absence

'NHS Digital' sickness data for PGDs for same period 2022-2023 (lag in publication) in last column for benchmarking.

Months	ASCR	Core Clinical	Medicine	NMSK	W&C	NBT Average	NHS Digital 2022-2023
Feb	0.6%	2.1%	1.6%	0.5%	0.2%	**1%**	**2.1%**
March	0.5%	2.5%	1.7%	1.0%	0.2%	**1.1%**	**2.0%**
April	0.4%	2.4%	1.4%	0.5%	0.1%	**1.0%**	**1.6%**
May	0.5%	1.6%	1.2%	0.3%	0.1%	**0.8%**	**1.8%**
Average	**0.5%**	**2.1%**	**1.5%**	**0.6%**	**0.2%**		

Table 2. Absence rate – Broken down by Division.

Sickness at NBT is well below the NHS Digital figures for the same time last year.

Absence Reason	Feb	March	April	May
Anxiety/stress/depression/psych illnesses	12%	14%	15%	14%
Other musculoskeletal problems	10%	9%	8%	7%
Cold, Cough, Flu - Influenza	8%	8%	8%	9%
Infectious diseases	8%	6%	5%	5%
Other known causes - not elsewhere classified	40%	41%	43%	44%

Table 3. % Days lost by reason in **all Divisions**: Top 5 reasons (>25% highlighted in red)

Large data hole as >1/3 of all sickness days lost are not classified/unknown.
Meeting held re data gap with People and Transformation – no further update on data hole

2. GAP MANAGEMENT

There will always be gaps from short term sickness.
HR 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 CF need.

A. CF Adverts

- Recruitment into CF gaps is continuous and on-going.

B. Medical Support Workers – have been helpful on bolstering staffing.
40 Clinical Fellow posts appointed within Medicine for August 2023; 12 individuals were MSWs either from cohort 1,2 or from another Trust.

There is unfortunately no further National funding planned to continue with this scheme.

C. Optimising NBT locum reach

- Postgrad Doctors 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
- PGD end user anecdotal feedback on the app usability is good as is feedback from those posting 'last minute' sickness locums.
- Work to feed data from Locums Nest into the QLIK now BI data warehouse needed

D. NBT is in a good position in the future (2024-2025) to potentially diversify and stabilise some parts of the PGD 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 – Emma Page
- Roles to be rotational – help with role development and retention.

E. Medical Workforce Resilience projects

- Ben Pope is leading on a large piece of work looking at the MDT with increased use of PAs, AAs and other allied health professionals.
- Accepting the increase in demand for LTFT positions a working group has been formed with LTFT PGDs, HR and the PGME department. The aims of the group are:
    - Improve schedule and rota accuracy and timely dissemination.
    - Ensure all stake holders are aware of the implications of the 2020 contract refresh:
        - LTFT PGDs cannot be rotaed to work a night on a non-working day without their agreement.
        - Rotas still need to be safely staffed.
        - This new understanding may lead to less of the popular non-working days e.g., Mon and Fri being able to be authorised as non-working days if no LTFT doctors are able to work one night going into or coming out of non-working days.

3. LOCUM USAGE

Locums Nest (LN) roll out for PGD 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.

A shift booked on LN does not pay for breaks – 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.

Retrospective NBT Extra time sheets do pay for breaks – 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.

Division	Feb	Mar	Apr	May
ASCR locum shifts	186	167	120	137
Filled	147	132	92	123
Unfilled	39	35	28	14
Core Clinical locum shifts	2	5		
Filled	2	4		
Unfilled		1		
Medicine locum shifts	628	757	719	774
Filled	563	581	563	621
Unfilled	65	176	156	153
Medics locum shifts	38	51	18	19
Filled	37	45	11	18
Unfilled	1	6	7	1
NMSK locum shifts	96	98	95	135
Filled	81	92	85	120
Unfilled	15	6	10	15
W&C locum shifts	47	28	36	28
Filled	38	19	28	20
Unfilled	9	9	8	8
Grand Total Shifts requested	**997**	**1106**	**988**	**1093**
Grand total requested in WTEs	54	57	49	54
Fill rate %	**87%**	79%	79%	83%

Fill rate is mostly below the Trust target of 85%.

Previous months fil rates were (Data from Locums Nest and NBT Extra):

July 73%, Aug 76%, Sept 84%, Oct 84%, Nov 85%, Dec, 84%, Jan 78%

Medicine cluster 1: ED, Acute Medicine - ED biggest user of locums

	Feb	Mar	Apr	May
Total Shifts requested	385	505	422	458
WTEs	20	25	20	22
Fill Rate %	88%	75%	80%	79%

Payment for locum breaks is not mandated in the contract.

At the time of writing this report NBT LNC was due to discuss the financial implications of considering paying NBT locums for breaks.

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.

4. EXCEPTION REPORTS

Exception Reports (ER) over 4 months Feb-May		Number flagged as immediate safety concern (ISC)
Number relating to hours of working	151	
Number relating to pattern of work	2	
Number relating to educational opportunities	7	
Number relating to service support available to the doctor	0	
TOTAL NUMBER OF EXCEPTION REPORTS	**160**	**0**

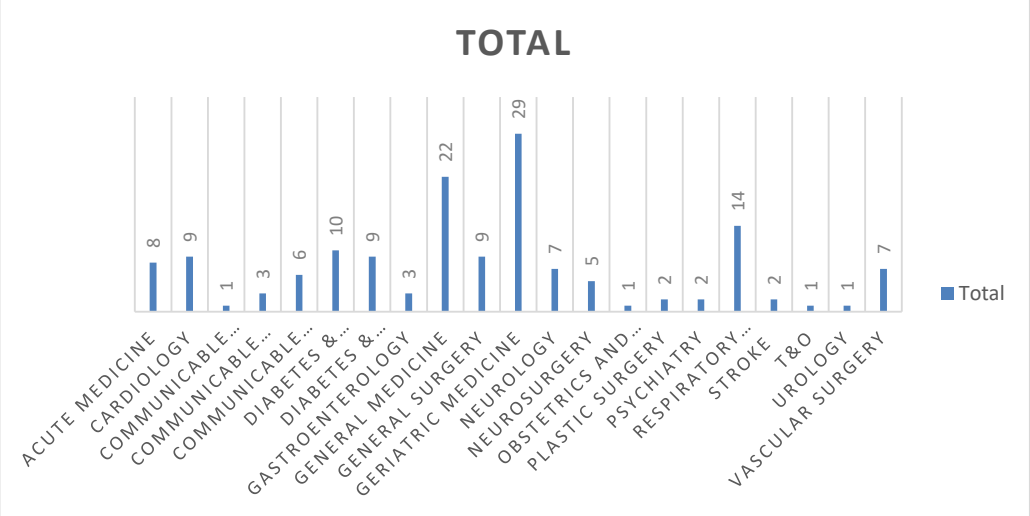
	EXCEPTIONS BY YEAR			
	2021	2022	2023	2024
JAN	37	29	56	28
FEB	33	28	64	45
MAR	16	27	28	42
APRIL	52	31	31	43
MAY	46	28	37	30
JUNE	61	24	40	
JULY	51	44	48	
AUG	27	89	54	
SEPT	44	79	73	
OCT	47	74	67	
NOV	29	40	53	
DEC	21	52	30	

BREAKDOWN EDUCATIONAL REPORTS:

Number of exceptions	Rota	Issues
2	F1/F2 Gen surgery	Core teaching missed
3	ST2 Communicable diseases	Not able to attend clinics this week
1	Neurology F1	Could not take 2/4 self- SDT days due to staffing
1	F1 Urology	Unable to take SDT

- F1/F2 core teaching is mandatory and recorded so available is missed.
- SDT time should be in the work schedules – 1 day every 4 weeks for F1/F2s. Urology management were operating under the belief it was ad hoc. This has been corrected. PGDs in this one instance were paid for the additional service provision they provided as it affected 4 PGDs in urology not getting SDT
- Neurology SDT taken as TOIL. Work schedule review carried out of future F1s

'HOURS' EXCEPTION REPORTS BY SPECIALTY (Feb - May) –



Geriatric have one of the largest bed base – 230 beds – so will be over represented
The Clinical lead has discussed exception reporting with the PGDs.
They feel comfortable exception reporting – a good thing!

POSTGRADUATE DOCTOR FORUM – Held in person and Teams every 2 months

- Improved engagement asked for by Trust Board:
    - **Large increase in Rep numbers and engagement – now 35 Reps across most specialties**
    - 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

- PGDF useful outcomes:
    - **LTFT working group – very positively received by HR.**
    - **Useful feedback generated on strike day communication on minimum staffing.**
    - **Survey recently carried out by a PGD Rep to PGDs and Consultants on views on and barriers to exception reporting – leading to amended videos with greater instructional element and plan to try and remove non-essential data fields ** appendix 1**
    - App for locum contacts – Locums Nest
    - Re-think of Acute block 6-week structure - - due to for re-survey

Other issues arising:

1. **Allocate functionality.**
    - All other Trusts in the Deanery use Allocate for exception reporting. It is therefore beneficial to PGDs rotating through the region to stick with one system i.e., Allocate.
    - NBT has renewed the Allocate contract for a further 2 years.
    - I have met with Guardians OSW for UHBW – Improved understanding of Allocate adaptability possible
    - Worked with HR to set up automatic reminders from Allocate and record all overtime to enable calculations of whether average hours are breached for a PGD over the term of their placement – this would then trigger a fine
    - This brings us in line with UHBW processes.
    - Plan to add location lists into Allocate to better identify hot spots of exception reporting.
    - No app available
    - Added instructions to the induction video and intranet on setting Allocate up on phone ‘desk top’ to allow quick east reporting
    - Investigating removing non-essential data entry fields to encourage reporting

2. **LTFT schedules were late across the Trust this August.**
    - 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 them at 6 weeks prior to commencing duties.
    - The LTFT working group had put in place an SOP to ensure timely and accurate LTFT work schedules and rotas via improved communication and templates within Allocate (as a number of schedules and rotas were inaccurate and late in Aug 2023)
    - A last minute, national requirement, that work schedules and salaries be accurately calculated based on individual's rotas meant that there were delays in issuing the work schedules to ensure accuracy in salary calculations. This particularly affected LTFT doctors
    - This introduces an additional step in an already tight timeline of 4 weeks from getting DiT names at 12 weeks out to issuing schedules at 8 weeks out.
    - **It may be necessary for HR to appoint admin staff with rota writing capabilities prior to Feb to ensure timely work schedule release. Relying on rotating PGDs to write bespoke complex rotas for a mix of full and LTFT doctors in an even tighter time frame is likely to lead to work schedules being delayed again.**

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.
- Webinar BMA GOSW conference was delayed due to consultant strike days – await reschedule.

SUMMARY

NBT is compliant with:

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

Concerns:

- Unfilled gaps in rotas; impact of increasing number of DiT going LTFT
- Trust target of 85% fill rate for locum shifts is not being reached.
- Lack of data on cause of 1/3 of all recorded sickness
- Continued large locum use. Particularly ED.
- Timely issuing of schedules to LTFT PGDs now needs bespoke individual rotas prior to release – time pressure – may need more expert admin staff to facilitate.
- Disparity on payment for locum breaks across the Trust.
- Inaccurate vacancy data due to recharge process

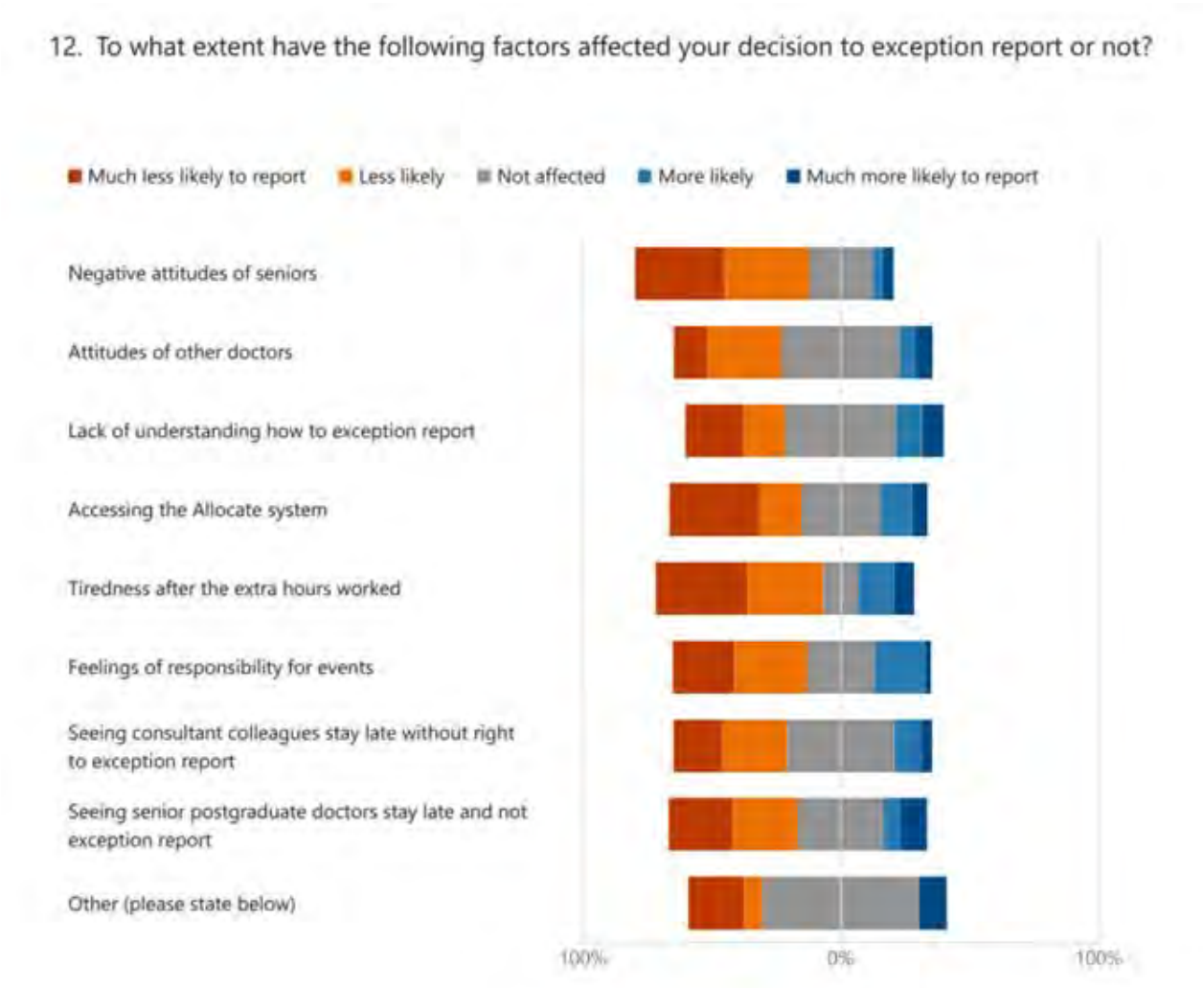
Recommendations:

1. The Board are asked to read and note this report from the Guardian of Safe Working

Dr Lucy Kirkham, Trust Guardian for Safe Junior Doctor Working

Appendix 1

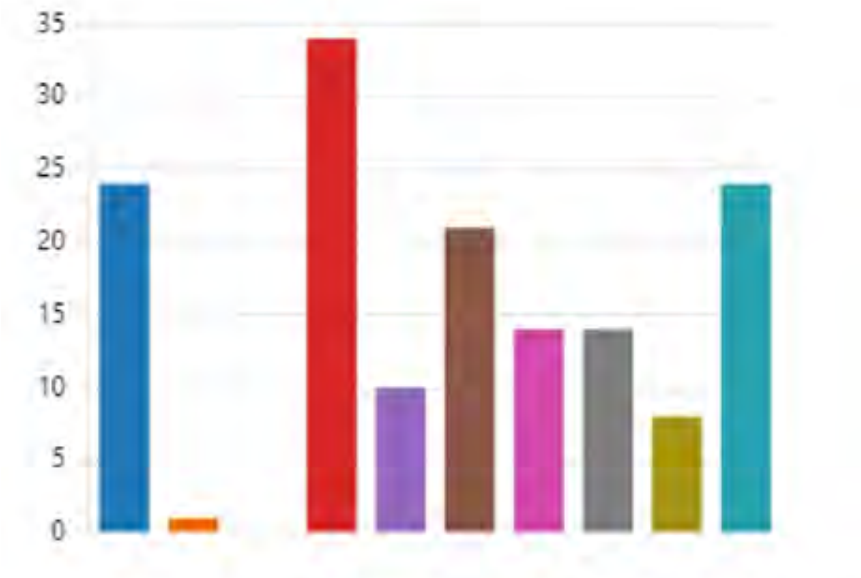
PGD survey result – 51 responses



NHS North Bristol NHS Trust

Consultant survey – 95 responses

Lack of certainty around what constitutes a reason to report	24
Financial burden on the department (directly from paying the doctor)	1
Reprecussions from the GOSW	0
Concern that the exception report is not accurate or justified	34
Lack of space in the rota to award time off in lieu	10
Yourself or other consultant doctors working late without the right to exception report	21
Seeing senior postgraduate doctors stay late and not exception report	14
Unsure how a doctor would access Allocate to exception report (not feeling you can help them with this)	14
Unable to access Allocate yourself in order to accept/decline the report	8
Other	24



Report To:	Public Trust Board			
Date of Meeting:	25 July 2024			
Report Title:	Integrated Performance Report			
Report Author:	Lisa Whitlow, Associate Director of Performance			
Report Sponsor:	Executive Team			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
	N/A	**N/A**	**N/A**	**N/A**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			✓	
Recommendations:	The Trust Board is asked to note the contents of the Integrated Performance Report.			
Report History:	The report is a standing item to the Trust Board Meeting.			
Next Steps:	This report is received at the Joint Consultancy and Negotiation Committee, Operational Management Board, Trust Management Team meeting, shared with Commissioners and the Quality section will be shared with the Quality and Risk Management Committee.			

Executive Summary		
Details of the Trust's performance against the domains of Urgent Care, Elective Care and Diagnostics, Cancer Wait Time Standards, Quality, Workforce and Finance are provided in the Integrated Performance Report.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	✓
	High Quality Care – *Better by design*	✓
	Innovate to Improve – *Unlocking a better future*	✓
	Sustainability – *Making best use of limited resources*	
	People – *Proud to belong*	✓
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	This report links to the following BAF risks: • BAF Significant Internal Risk (SIR) 1 "Patient Flow & Ambulance Handovers" • BAF Significant Internal Risk (SIR) 1.1 "Long Waits for Treatment" • BAF Significant Internal Risk (SIR) 2 " Workforce" • BAF Significant Internal Risk (SIR) 17 "Underlying Financial Position"	

Financial implications:	Whilst there is a section referring to the Trust's financial position, there are no financial implications within this paper.
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	N/A
Appendices:	

North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

July 2024

(presenting June 2024 data)

NBTCARES

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)	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-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%	71.42%	75.15%	71.49%	71.94%	64.33%	60.56%	63.37%	67.17%	63.30%	64.87%	63.77%	63.56%	61.83%	63.21%		55.18%	2/11
	A&E 12 Hour Trolley Breaches	R		0	-	10	12	17	23	223	213	269	318	168	260	324	217	252		7-1775	4/11
	Ambulance Handover < 15 mins (%)		PF	65.00%	-	29.20%	29.55%	27.69%	26.37%	25.78%	30.70%	28.97%	35.05%	39.35%	37.24%	39.99%	40.72%	42.19%			
	Ambulance Handover < 30 mins (%)	R	PF	95.00%	-	76.60%	73.53%	71.35%	65.25%	57.72%	66.27%	61.66%	64.52%	71.47%	68.13%	72.27%	75.47%	74.15%			
	Ambulance Handover > 60 mins		PF	0	-	183	171	183	321	627	455	554	534	329	366	274	210	240			
	Average No. patients not meeting Criteria to Reside				134	198	200	198	195	218	228	243	245	233	211	233	216	218			
	Bed Occupancy Rate			93.00%	-	96.99%	95.81%	93.63%	95.59%	97.12%	96.84%	96.28%	97.81%	97.40%	97.48%	97.86%	97.53%	97.37%			
	Diagnostic 6 Week Wait Performance			5.00%	2.12%	18.64%	15.10%	14.18%	12.50%	11.40%	9.81%	10.11%	12.28%	5.19%	4.22%	3.10%	2.47%	1.38%		23.81%	1/10
	Diagnostic 13+ Week Breaches			0	0	595	300	124	59	17	14	7	4	5	0	0	0	0		0-2654	1/10
	RTT Incomplete 18 Week Performance			92.00%	-	61.02%	60.97%	60.50%	60.53%	61.52%	61.94%	60.14%	61.11%	61.58%	59.75%	60.36%	60.96%	61.97%		55.83%	8/10
	RTT 52+ Week Breaches	R		0	1285	2831	2689	2599	2306	2124	1858	1685	1393	1383	1498	1609	1632	1649		43-16939	4/10
	RTT 65+ Week Breaches				81	619	624	606	582	545	420	388	249	193	146	192	228	218		0-5245	3/10
	RTT 78+ Week Breaches	R			30	59	44	48	48	55	49	50	45	39	27	18	14	6		0-553	3/8
	Total Waiting List	R			47985	49899	50119	50168	48969	48595	47698	47245	46710	46394	46278	46441	46740	46252			
	Cancer 31 Day First Treatment			96.00%	82.28%	81.59%	91.20%	87.36%	87.76%	85.61%	88.14%	86.30%	77.12%	86.18%	83.07%	87.77%	84.83%	-		90.89%	10/10
	Cancer 62 Day Combined	R	PF	85.00%	58.51%	61.31%	61.54%	60.61%	57.96%	60.07%	61.59%	61.20%	53.33%	58.15%	59.14%	60.62%	59.32%	-		62.19%	9/10
	Cancer 28 Day Faster Diagnosis	R		75.00%	72.97%	66.43%	65.14%	57.36%	54.96%	59.46%	71.42%	74.89%	70.88%	74.80%	73.79%	57.28%	67.47%	-		72.83%	8/10
	Urgent operations cancelled ≥2 times			0	-	0	0	0	0	0	1	1	0	0	0	0	0	-			

RAG ratings (Red/Green) are against Current Month Trajectory. For metrics with no trajectory, RAG rating is according to comparison with previous month, except for Bed Occupancy, Diagnostic 6 Week Wait Performance and Urgent Operations Cancelled ≥ 2 times which are RAG rated against National Standard.

NBTCARES

North Bristol Integrated Performance Report

NHS North Bristol NHS Trust

Domain		Description	Regulatory	Trust Patient First Improvement Priority	National Standard	Current Month Trajectory (RAG)	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Quality, Safety and Effectiveness	Trust Quality Metrics	Summary Hospital-Level Mortality Indicator (SHMI)					0.97	0.96	0.96	0.95	0.95	0.94	0.94	0.94	-	-	-	-	-	
		Never Event Occurrence by month			0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	
		Commissioned Patient Safety Incident Investigations					0	0	2	2	2	1	1	2	0	1	1	1	1	
		Healthcare Safety Investigation Branch Investigations					0	0	0	0	0	1	1	2	0	0	0	0	0	
		Total Incidents					1115	1040	1128	1190	1466	1549	1205	1198	1327	1283	1111	1156	1034	
		Total Incidents (Rate per 1000 Bed Days)					39	35	40	42	48	52	39	38	45	40	36	37	34	
		WHO checklist completion				95.00%	97.77%	99.01%	98.58%	97.68%	99.08%	99.36%	99.43%	99.52%	99.82%	99.71%	99.89%	99.96%	99.66%	
		VTE Risk Assessment completion	R			95.00%	94.98%	94.72%	94.33%	93.86%	92.96%	92.83%	91.63%	86.25%	85.22%	84.99%	85.00%	87.34%	86.05%	
		Pressure Injuries Grade 2					18	17	12	14	11	10	12	11	18	10	14	11	4	
		Pressure Injuries Grade 3				0	0	0	2	1	0	0	1	1	0	0	0	0	0	
		Pressure Injuries Grade 4				0	0	0	1	0	0	1	0	0	1	0	0	0	0	
		Pressure Injuries rate per 1,000 bed days					0.55	0.47	0.46	0.46	0.26	0.34	0.33	0.35	0.47	0.28	0.36	0.35	0.10	
		Falls per 1,000 bed days					5.66	4.91	5.73	4.96	6.45	6.56	6.38	5.58	5.72	5.66	5.18	5.20	5.56	
		MRSA	R		0	0	1	1	0	0	1	1	0	0	0	0	1	0	0	
		E. Coli	R			4	7	4	2	7	5	11	5	6	5	2	6	10	4	
		C. Difficile	R			5	11	6	2	5	4	3	2	2	9	8	6	2	4	
		MSSA				2	6	9	5	2	4	3	6	3	3	2	2	2	3	
		Observations Complete					98.89%	99.22%	97.56%	96.48%	99.02%	98.83%	98.66%	98.73%	98.50%	98.60%	98.90%	98.93%	98.96%	
		Observations On Time					45.38%	48.37%	61.62%	69.58%	73.33%	75.00%	72.04%	72.85%	71.82%	72.94%	70.70%	71.10%	71.91%	
		Observations Not Breached					57.47%	58.21%	73.78%	80.83%	85.17%	88.39%	85.54%	85.57%	84.80%	84.52%	83.10%	83.96%	83.81%	
	Maternity	5 minute Apgar 7 rate at term				0.90%	0.72%	0.93%	0.45%	0.64%	0.68%	1.82%	0.78%	0.23%	1.22%	1.90%	1.00%	0.93%	0.93%	
		Caesarean Section Rate					44.37%	40.65%	46.33%	47.02%	42.89%	43.19%	41.26%	44.90%	47.50%	44.74%	45.88%	46.09%	46.07%	
		Still Birth rate				0.40%	0.44%	0.43%	0.21%	0.29%	0.21%	0.21%	0.72%	0.43%	0.00%	0.22%	0.00%	0.22%	0.22%	
		Induction of Labour Rate				32.10%	33.55%	38.04%	32.08%	30.65%	34.31%	30.21%	36.65%	31.67%	31.36%	34.45%	32.71%	29.78%	29.91%	
		PPH 1500 ml rate				8.60%	2.87%	4.13%	2.31%	2.68%	3.97%	2.96%	2.42%	2.38%	4.04%	2.68%	3.52%	4.98%	4.78%	
	Fragile Hip	Fragile Hip Best Practice Pass Rate					43.10%	62.00%	58.00%	55.77%	79.17%	70.59%	61.40%	60.00%	67.92%	71.43%	68.57%	41.18%	-	
		Admitted to Orthopaedic Ward within 4 Hours					27.59%	40.00%	48.00%	36.54%	33.33%	25.49%	21.05%	28.57%	9.43%	14.29%	20.00%	19.61%	-	
		Medically Fit to Have Surgery within 36 Hours					44.83%	62.00%	58.00%	55.77%	81.25%	72.55%	68.42%	64.29%	71.70%	73.47%	68.57%	47.06%	-	
		Assessed by Orthogeriatrician within 72 Hours					93.10%	96.00%	98.00%	96.15%	97.92%	96.08%	91.23%	88.57%	90.57%	95.92%	91.43%	86.27%	-	
	Stroke	Stroke - Patients Admitted					181	133	191	156	155	164	157	184	163	152	174	135	-	
		Stroke - 90% Stay on Stroke Ward				90.00%	85.71%	89.02%	80.91%	84.62%	82.22%	71.95%	77.42%	75.22%	76.47%	78.13%	60.00%	70.73%	-	
		Stroke - Thrombolysed <1 Hour				60.00%	73.33%	44.44%	68.18%	52.38%	75.00%	56.25%	37.50%	85.71%	60.00%	78.13%	72.73%	60.00%	-	
		Stroke - Directly Admitted to Stroke Unit <4 Hours				60.00%	61.86%	66.67%	58.93%	56.19%	59.78%	61.45%	70.97%	58.62%	63.92%	61.54%	40.00%	60.61%	-	
		Stroke - Seen by Stroke Consultant within 14 Hours				90.00%	84.11%	80.00%	86.89%	87.93%	89.80%	85.71%	92.23%	86.47%	95.50%	84.21%	74.55%	81.37%	-	

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.

North Bristol Integrated Performance Report

NHS North Bristol NHS Trust

Domain	Description	Regulatory	Trust Patient First Improvement Priority	National Standard	Current Month Trajectory (RAG)	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Trend
Quality & Caring Patient Experience	Friends & Family Positive Responses - Maternity		PF			91.79%	88.81%	91.00%	89.49%	89.49%	89.29%	91.73%	92.73%	91.16%	93.93%	90.05%	93.37%	93.17%	
	Friends & Family Positive Responses - Emergency Department		PF			81.95%	81.75%	83.58%	74.74%	72.80%	79.33%	80.94%	81.44%	81.12%	73.99%	77.89%	74.65%	78.64%	
	Friends & Family Positive Responses - Inpatients		PF			91.62%	93.65%	93.70%	93.37%	91.96%	92.53%	91.30%	92.71%	91.98%	91.55%	92.73%	91.81%	93.80%	
	Friends & Family Positive Responses - Outpatients		PF			94.67%	95.46%	95.13%	94.04%	94.65%	95.45%	96.01%	95.31%	94.58%	95.12%	95.33%	95.06%	94.90%	
	PALS - Count of concerns					141	145	123	135	139	152	103	191	133	157	137	155	174	
	Complaints - % Overall Response Compliance				90.00%	80.00%	79.63%	64.10%	71.11%	65.00%	60.00%	73.00%	79.00%	71.00%	84.62%	86.11%	72.22%	84.09%	
	Complaints - Overdue					6	5	4	5	9	10	3	5	6	4	2	2	4	
	Complaints - Written complaints					44	42	48	49	60	49	36	44	40	39	36	47	45	
Workforce	Agency Expenditure ('000s)					2342	2402	2242	2182	2093	2184	1610	1507	1592	1368	891	1037	765	
	Month End Vacancy Factor					8.03%	8.25%	7.69%	7.16%	6.62%	6.42%	5.87%	4.87%	4.82%	5.02%	2.55%	3.46%	4.04%	
	Turnover (Rolling 12 Months)	R	PF		-	15.90%	15.19%	15.03%	14.59%	14.13%	13.74%	13.30%	13.09%	12.91%	12.32%	12.01%	11.88%	11.88%	
	Sickness Absence (Rolling 12 month)	R			-	5.07%	4.94%	4.92%	4.91%	4.89%	4.81%	4.70%	4.66%	4.67%	4.65%	4.62%	4.60%	4.61%	
	Trust Mandatory Training Compliance					84.23%	84.73%	86.69%	87.04%	89.39%	90.69%	91.06%	90.14%	89.44%	91.16%	91.50%	91.47%	92.02%	

18.1

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.

NBTCARES

Executive Summary – June 2024

Urgent Care

Four-hour performance reported at 63.21% in June. NBT ranked second out of 11 AMTC providers. There was an increase in 12-hour trolley breaches on the previous month (252 from 217), and an increase in ambulance handover delays over one-hour (240 from 210). The primary drivers continue to be a 3.23% increase in ED presentations compared to June 2023, and a continued high NC2R position leading to high bed occupancy. Discussions amongst System COOs have reached a position where a new NC2R level ambition is being set; to reduce the NC2R percentage within NBT to 15%. This is now a key contingent in the Trust committing to the 78% ED 4-hour performance requirement for March 2025. As yet, there is no evidence of a sustained improvement in line with this ambition. 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

Having delivered the clearance of capacity related 65-week wait breaches at the end of 2023/24, the Trust has submitted a plan which aims to clear all non-capacity related breaches by September 2024. While plans are in place for most specialties, there is an outstanding challenge (related to complex procedures and limited clinical capacity) in clearing the remaining backlog of some specialist breast reconstruction surgery. The position is constantly changing with new options being considered and implemented. There was further industrial action in July, which had a limited impact on elective activity. At this point, there remains reasonable assurance the Trust will meet its RTT obligations for this year.

Diagnostics

Performance in June continued to meet the requirements for 2024/25, reporting at 1.38% (against target of 5%). No patient is waiting longer than 13 weeks for diagnostic and greater than 95% are now receiving their diagnostic test within 6-weeks. The Trust is setting an ambition to go beyond national requirements and return to national constitutional standards of no more than 1% breaching 6-weeks in the coming year.

Cancer Wait Time Standards

As previously reported, overall cancer performance has been impacted by an unplanned loss of capacity in one of our high-volume tumour site specialties i.e. Skin cancer. This interrupted the Trust’s recovery plans following a loss of activity due to previous industrial action. Remedial plans have been enacted, however, given reported cancer breaches occur at the point of treatment, there is a characteristic reduction in performance directly before recovery. Therefore, the April reported FDS position dropped to 57.28%, as expected and as the backlog of treatments have been delivered. The position for May 2024 was in line with plan and the Trust submitted at 67.47% for the combined standard. Early indication is that further improvements will be seen in June and the Trust will be compliant.

Executive Summary – June 2024

Quality

Maternity indicators moved positively in May, reflecting the trend over recent months. The term admission rate to NICU was 3.7% against a national target of 5% and there were no cases referred to MNSI. The midwifery vacancy rate is the lowest it has been since January 2022 at 2.68%. However, there was an indirect maternal death, which occurred within the NICU apartments – the postmortem results are yet to be shared and therefore cause of death not confirmed. During Jun-24 NBT had a rate of 6.3 medication incidents per 1000 bed days, slightly below the 6-month average of 6.6 for this measure. Infection control data for C. difficile reflects a slight breach of annual trajectory, which is similar for E. coli cases. There were no new MRSA cases. The sustained increase in MSSA rates continues, which reflects regional/national trends. Several improvement projects continue across all infection workstreams. The reducing trend in falls rates continued, reflecting the ongoing improvement actions as outlined in the report. In June there were 4 x grade 2 pressure ulcers, which is continues the decreasing trend since April. Delivery of the Year 2 workplan for Patient & Carer Experience is positive across most commitments, reflecting the Trust's approved Quality priorities for Outstanding Patient Experience. Recruitment into vacancies within the Trust's Volunteer Services team is progressing to enable delivery of the amber commitments in coming months. 92.93% of patients gave the Trust a FFT positive rating, an increase on previous month, remaining within the overall expected range of performance. The response rate compliance for complaints improved to 84%. All complaints & PALS concerns are acknowledged within the agreed timeframes.

Workforce

Turnover is stayed stable at 11.88% June, 0.02% below the target set for 2024/25. Work is in progress to identify opportunities for further improvement. 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 68.77% in May to 71.58% in June.
The % of employed staff from our 30 most challenged communities shows statistically significant deterioration, however, the deterioration is driven not by a reduction in employed staff from those communities but by other factors, primarily an increases in the proportion of staff employed residing outside BNSSG. Month on month since April 2023 the actual number of staff employed from our most challenged communities has increased from 3202 to 4008 in June 2024. Our disparity ratio has followed a deteriorating trend since the low point of 1.31 in December 2023 to 1.54 in June 2024, analysis is in progress to better understand the areas driving this position.
Trust-wide agency spend decreased between May and June from 2.2% to 1.60%, which is below the Trust the 2024/25 target of 3.2%. Our watch metrics show statistically significant improvement..

Finance

The financial plan for 2024/25 in Month 3 (June) was a deficit of £1.8m. In month the Trust has delivered a £3.3m deficit, which is £1.5m worse than plan. Year to date the position is a £4.5m adverse variance against a planned £5.8m deficit. This is driven by the impact of unidentified CIP across pay and non-pay creating a £3.9m adverse variance. The Trust cash position at Month 1 is £39.9m, a reduction of £22.8m from Month 12. This is driven by the underlying deficit and capital spend. The Trust has delivered £4.0m of completed cost improvement programme (CIP) schemes at month 3. There are a further £5.9m of schemes in implementation and planning that need to be developed, and £18.9m in the pipeline.

High Quality Care

NHS North Bristol NHS Trust

Responsiveness

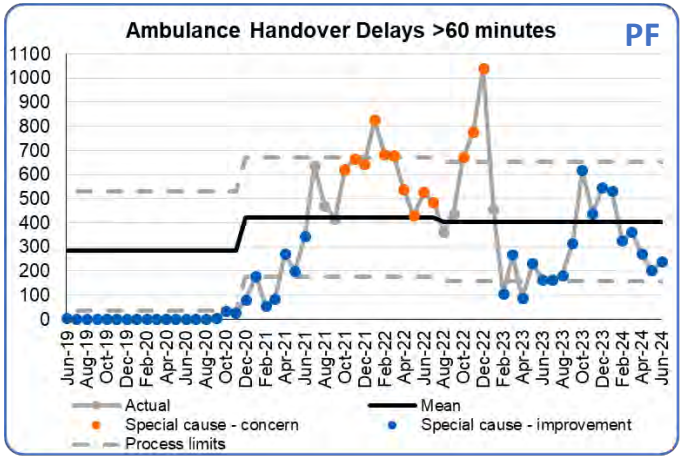
Board Sponsor: Chief Operating Officer
Steve Curry

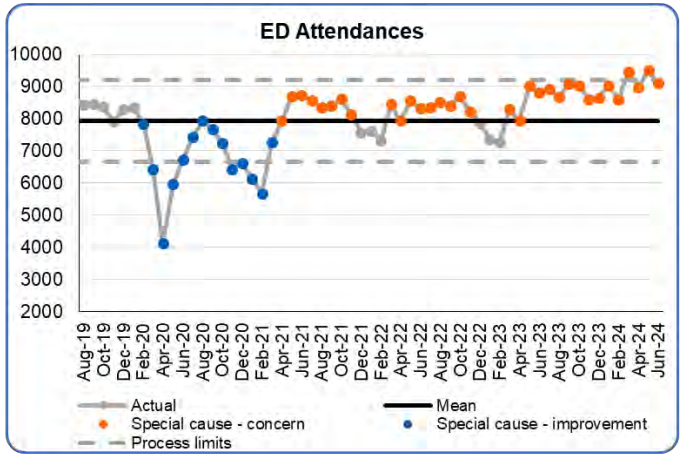
18.1

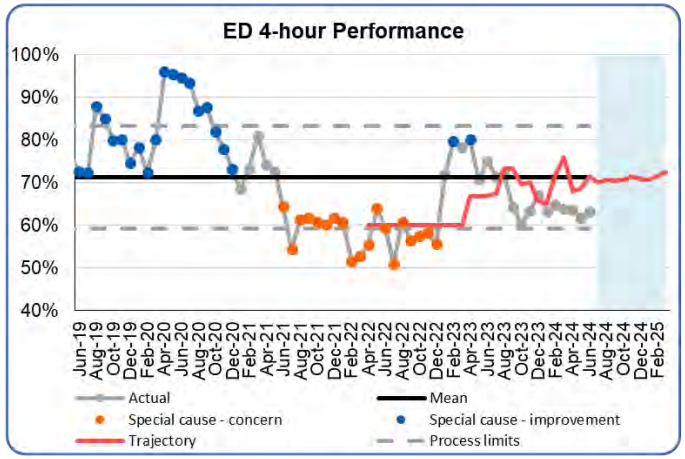
Responsiveness – Indicative Overview at April-2024

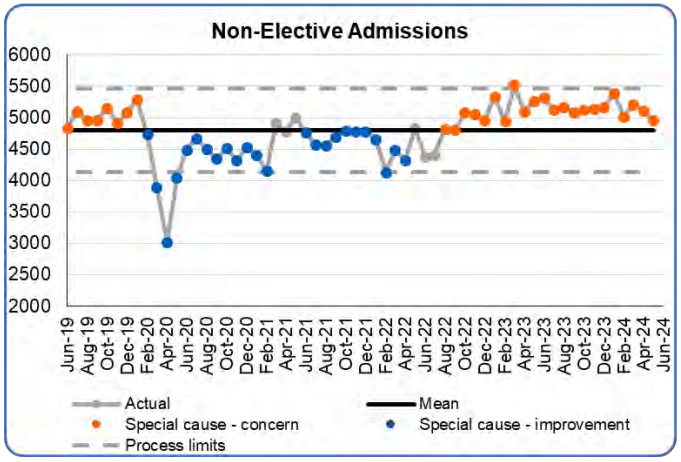
Delivery Theme	Delivery Indicator	Key Improvement /Delivery Action
Urgent & Emergency Care	UEC plan	Internal and partnership actions continue.
	NC2R/D2A	As yet, no evidence of progress to reduced NC2R percentage ambition
RTT	65-week wait	Some progress on specialist area challenges. Limited impact from industrial action.
Diagnostics	5% 6-week target	Achieved and exceeded.
	CDC	Phase 1 (mobiles in place) Phase 2 (fixed build) by the 30/08/2024
Cancer	28-day FDS Standard	Dermatology activity loss recovery actions have taken effect. Significant improvement in May which will be sustained and/or improved further in June. Sustainability remains an issue.
	62-Day Combined Standard	Removed from National tiering. Marginally below in-year trajectory, sustainability issues and wider system/pathway support needed.

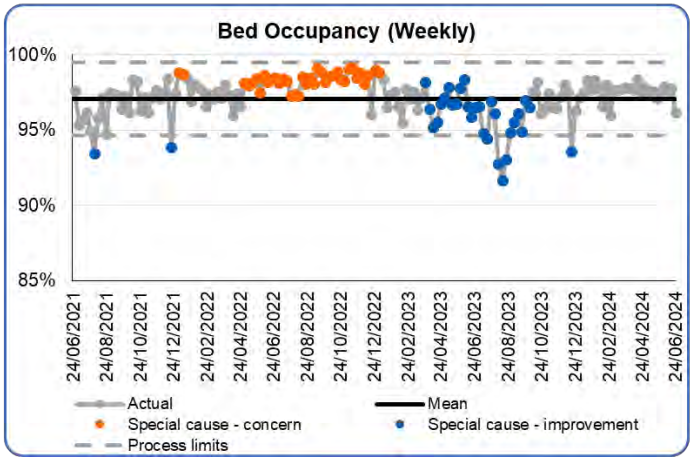
Urgent and Emergency Care

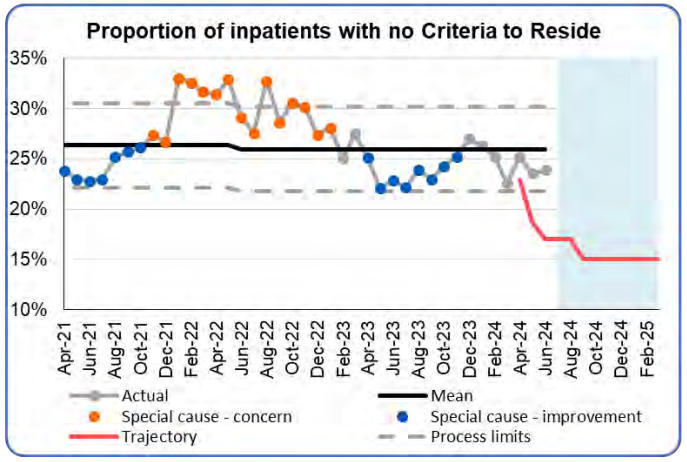












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Urgent and Emergency Care

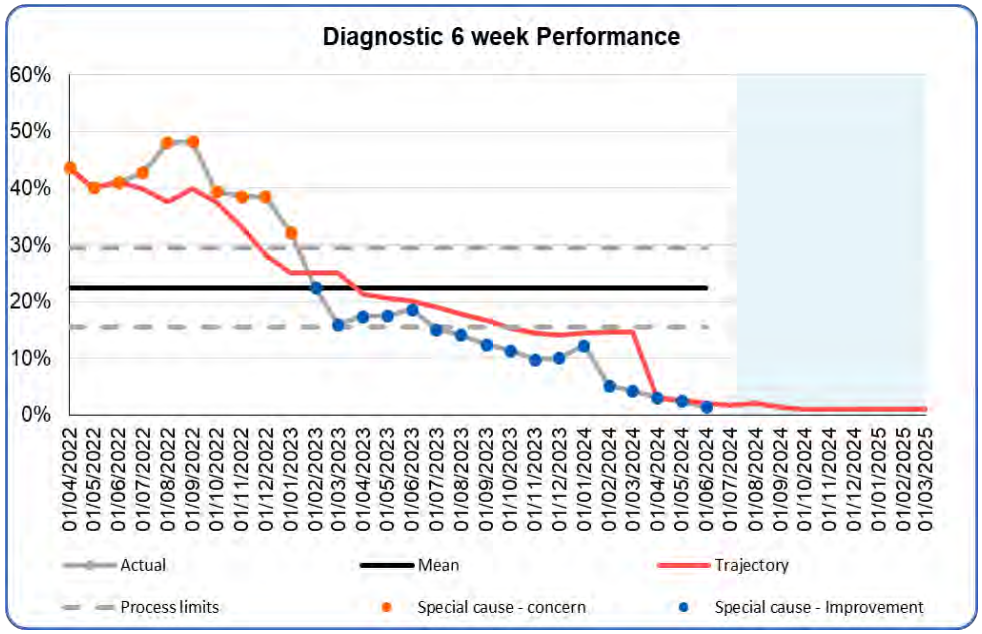
What are the main risks impacting performance?

- Year-on-year ED attendances have been increasing in previous months, but there was a marked increase yet again in June, showing attendances at 3.23% higher than June 2023.
- As yet, insignificant progress in reducing NC2R problems.
- Ongoing industrial action by Junior Doctors.

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.
- Ambulance handovers – the Chief Nursing Officer led a 'refresh' of the continuous flow model in response to December ambulance delays. Although the approach had continued over the summer, its scale of deployment was commensurate with a lower level of patient flow pressure. The approach has been reintroduced more rigorously with two-hourly monitoring in place. The normal risk mitigations which have been previously used continue to apply in using this 'balance of overall risk' approach.
- 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.
- Internal adjustments to the Same-Day Emergency Care (SDEC) pathway being implemented to stream patients away from ED to the appropriate service.

Diagnostic Wait Times



What are the main risks impacting performance?

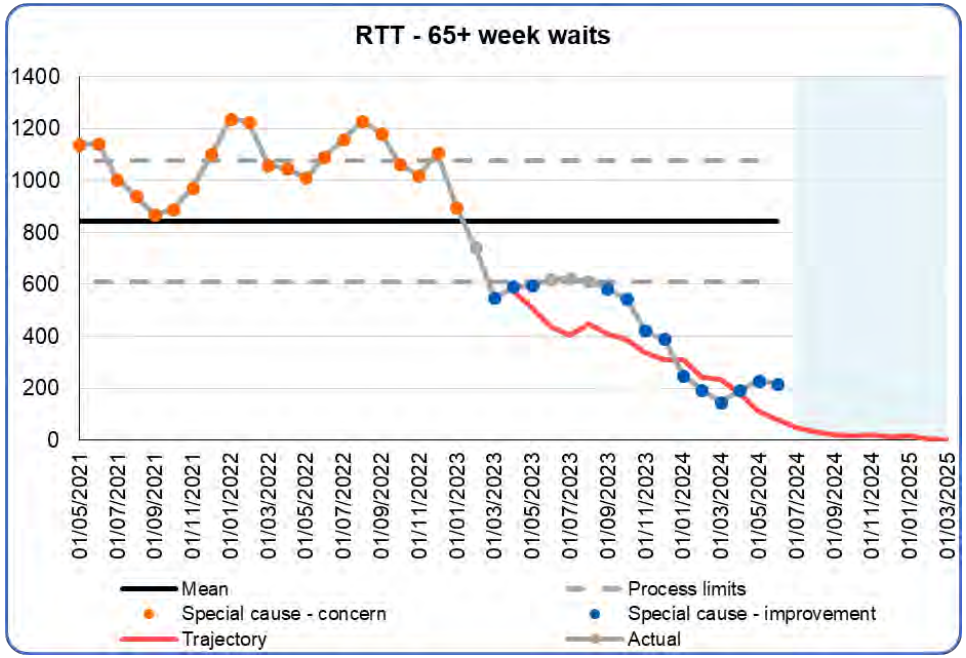
- The Trust continues to achieve target of no more than 5% patients waiting over 6-weeks, with performance reporting at 1.38% for June 2024.
- The Trust is maintaining clearance of all >13-week breaches.
- Staffing gaps within the Sonography service and a surge in urgent demand means that the NOUS position 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.
- CDC commenced 01/04/2024 in temporary accommodation with phase 2 (fixed build) commencing from 30/08/2024.

18.1

Referral To Treatment (RTT)



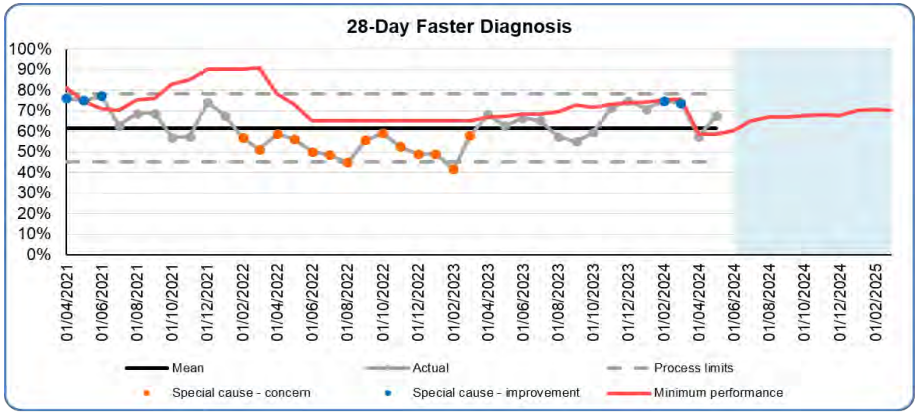
What are the main risks impacting performance?

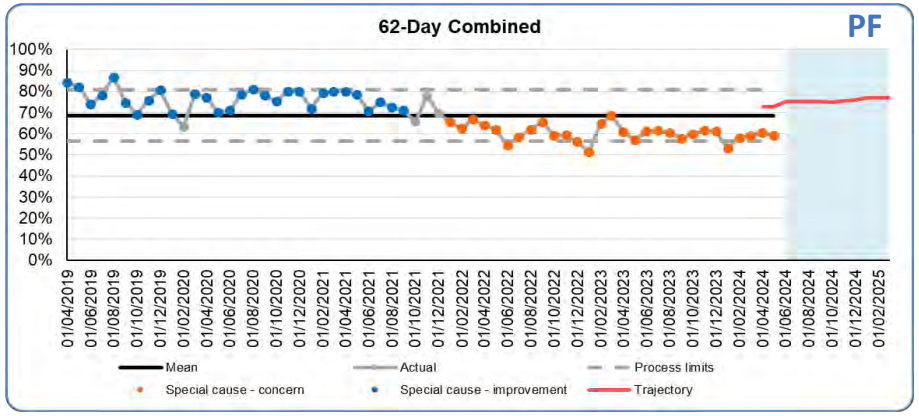
- Impact of July 2024 industrial action – although limited in July IA.
- Rebooking of cancelled cancer and urgent patients is displacing the opportunity to book long-waiting patients.
- Continued reliance on third party activity in a number of areas.
- The potential impact of UEC activity on elective care.
- Challenges remain in a small number of specialist procedures.

What actions are being taken to improve?

- Trust has committed to zero 104-week breaches from the end of June 2024.
- Plans to eliminate 65-week and 78-week wait breaches for all specialties, with the exception of DIEPs, by September 2024.
- 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?

- Last minute year-end capacity loss in Skin clinics impacting the end of year performance.
- 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.
- April reported an increase in 28-day breaches due to backlog clearance plans in Skin and Breast which has had an impact on the Trusts position. Recovery was seen in May.

What further actions are being taken to improve?

- Significant additional activity has been delivered to recover industrial action related deteriorations in Skin and Gynaecology.
- 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.
- High volume Skin ‘poly-clinics’ enacted to recover cancer position. Having achieved the improved >62-Day cancer PTL target, the next phase will be to ensure the revised actions and processes are embedded to sustain this improvement. At the same time, design work has commenced to fundamentally improve patient pathways, which will improve overall Cancer wait time standards compliance.
- 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

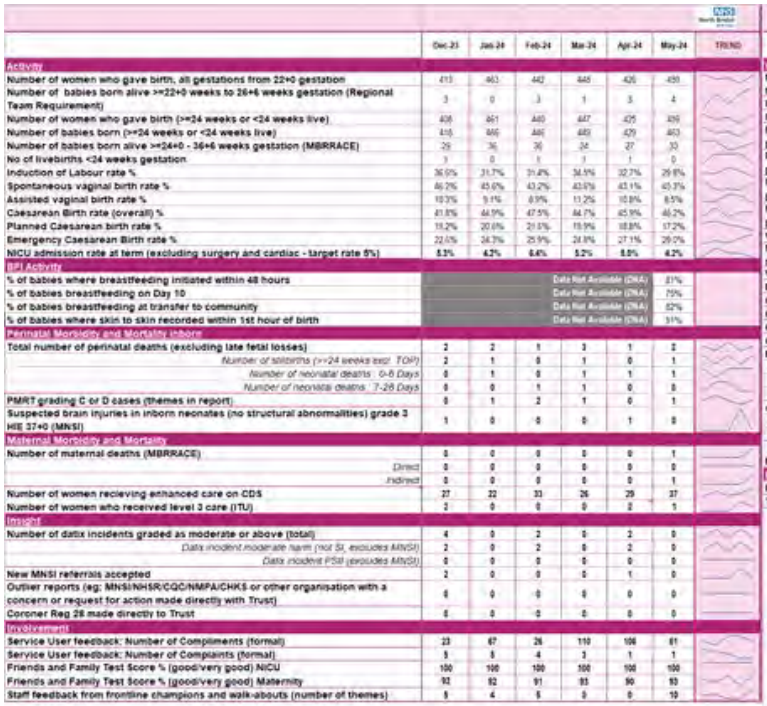
Quality, Safety and Effectiveness

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

18.1

Maternity

Perinatal Quality Surveillance Monitoring (PQSM) Tool – May 24 data



	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	TREND
Activity							
Number of women who gave birth, all gestations from 22+0 gestation	413	463	442	446	426	456	
Number of babies born alive >=22+0 weeks to 26+6 weeks gestation (Regional Team Requirement)	3	0	3	1	3	4	
Number of women who gave birth (>=24 weeks or <24 weeks live)	408	461	440	447	425	456	
Number of babies born (>=24 weeks or <24 weeks live)	416	466	446	449	429	463	
Number of babies born alive >=24+0 - 36+6 weeks gestation (MBRRACE)	29	36	36	24	27	33	
No of livebirths <24 weeks gestation	3	0	1	1	1	0	
Induction of Labour rate %	36.9%	31.7%	31.4%	34.5%	32.7%	29.8%	
Spontaneous vaginal birth rate %	46.2%	45.6%	43.2%	43.6%	43.1%	45.3%	
Assisted vaginal birth rate %	10.3%	9.1%	8.9%	11.2%	10.8%	8.5%	
Caesarean Birth rate (overall) %	41.8%	44.9%	47.5%	44.7%	45.9%	46.2%	
Planned Caesarean birth rate %	19.2%	20.6%	21.5%	19.9%	18.8%	17.2%	
Emergency Caesarean Birth rate %	22.6%	24.3%	25.9%	24.8%	27.1%	29.0%	
NICU admission rate at term (excluding surgery and cardiac - target rate 5%)	5.3%	4.2%	6.4%	5.2%	5.8%	4.2%	
BFI Activity							
% of babies where breastfeeding initiated within 48 hours				Data Not Available (DNA)		81%	
% of babies breastfeeding on Day 10				Data Not Available (DNA)		75%	
% of babies breastfeeding at transfer to community				Data Not Available (DNA)		52%	
% of babies where skin to skin recorded within 1st hour of birth				Data Not Available (DNA)		31%	
Perinatal Morbidity and Mortality (Hours)							
Total number of perinatal deaths (excluding late fetal losses)	2	2	1	3	1	2	
Number of stillbirths (>=24 weeks excl. TOP)	2	1	0	1	0	1	
Number of neonatal deaths - 0-6 Days	0	1	0	1	1	1	
Number of neonatal deaths - 7-28 Days	0	0	1	1	0	0	
PMRT grading C or D cases (themes in report)	0	1	2	1	0	1	
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (MNSI)	1	0	0	0	1	0	
Maternal Morbidity and Mortality							
Number of maternal deaths (MBRRACE)	0	0	0	0	0	1	
Direct	0	0	0	0	0	0	
Indirect	0	0	0	0	0	1	
Number of women recieving enhanced care on CDS	27	22	33	26	29	37	
Number of women who received level 3 care (ITU)	2	0	0	0	2	1	
Insight							
Number of datix incidents graded as moderate or above (total)	4	0	2	0	2	0	
Datix incident moderate harm (not SI, excludes MNSI)	2	0	2	0	2	0	
Datix incident PSII (excludes MNSI)	0	0	0	0	0	0	
New MNSI referrals accepted	2	0	0	0	1	0	
Outlier reports (eg: MNSI/NHSR/CQC/NMPA/CHKS or other organisation with a concern or request for action made directly with Trust)	0	0	0	0	0	0	
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	
Involvement							
Service User feedback: Number of Compliments (formal)	23	67	26	110	100	61	
Service User feedback: Number of Complaints (formal)	5	5	4	3	1	1	
Friends and Family Test Score % (good/very good) NICU	100	100	100	100	100	100	
Friends and Family Test Score % (good/very good) Maternity	92	92	91	93	90	93	
Staff feedback from frontline champions and walk-abouts (number of themes)	5	4	5	0	0	10	

		Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	TREND
Workforce								
Minimum safe staffing in maternity services: Obstetric cover (Resident Hours) on the delivery suite		83	83	83	83	83	83	
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps		2	2	0	0	0	0	
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps		2	2	2	2	2	2	
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)		0	0	0	0	0	0	
Minimum safe staffing in maternity services: Neonatal Consultants workforce (rota gaps)		1	1	1	1	1	1	
Minimum safe staffing in maternity services: Neonatal Middle grade workforce (rota gaps)		0	1	1	1	1	1	
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled bank shifts)		7.0%	23.4%	28.6%	27.8%	37.6%	38.9%	
Vacancy rate for midwives		5.84%	5.59%	8.04%	8.17%	3.06%	2.68%	
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained)		59%	35%	52%	54%	59%	59%	
Vacancy rate for NICU nurses		19	26	11	10	18%	11%	
Datix related to workforce (service provision/staffing)		4	13	9	13	1	2	
Consultant led MDT ward rounds on CDS (Day to Night)		91%	93%	96%	91%	90%	100%	
Consultant led MDT ward rounds on CDS (Day)		100%	100%	100%	97%	100%	100%	
One to one care in labour (as a percentage)		97%	99%	100%	97%	99%	99%	
Compliance with supernumerary status for the labour ward coordinator		100%	100%	99%	100%	100%	100%	
Number of times maternity unit attempted to divert or on divert		1	0	1	0	0	0	
in-utero transfers								
in-utero transfers accepted		7	1	1	5	Data Not Available (DNA)		
in-utero transfers declined		7	Data (DNA)	0	0	Data (DNA)	4	
ex-utero transfers to NICU							4	
ex-utero transfers accepted		1	0	0	11	4	3	
ex-utero transfers declined		1	0	0	2	Data (DNA)	0	
NICU babies transferred to another unit due to capacity/staffing		2	0	0	0	Data (DNA)	1	
Number of consultant non-attendance to 'must attend' clinical situations		0	0	0	0	0	0	
Improvement								
Progress in achievement of MIS /10		10	10	10	10	10	10	
Training compliance in annual local BNLS (NICU)		100%	100%	100%	99%	90%	99%	
Training compliance in maternity emergencies and multi-professional training (PROMPT) * note: includes BNLS	Overall	97%	91%	84%	79%	79%	73%	
	Obstetric Consultants	99%	95%	95%	89%	94%	89%	
	Other Obstetric Doctors	97%	87%	89%	73%	79%	63%	
	Anaesthetic Consultants	100%	79%	72%	62%	69%	68%	
	Other Anaesthetic Doctors	96%	100%	74%	73%	60%	64%	
	Midwives	96%	80%	89%	73%	79%	62%	
	Maternity Support Workers	96%	71%	96%	90%	80%	78%	
	Theatre staff	Data Not Available (DNA)						
	Neonatologist s	Data Not Available (DNA)						
	NICU Nurses	Data Not Available (DNA)						
Fetal Wellbeing and Surveillance	Overall	90%	86%	88%	86%	87%	72%	
	Obstetric Consultants	94%	89%	88%	89%	94%	72%	
	Other Obstetric Doctors	88%	79%	71%	72%	72%	69%	
	Midwives	97%	86%	91%	82%	87%	77%	
Trust Level Risks		7	7	4	3	4	3	

This report is a summary of the data held within the Perinatal Quality Surveillance Matrix for the period of May 2024.

The term admission rate to NICU was 3.7% against a national target of 5%. This a 1.3% reduction from last month.

Perinatal services referred 0 new cases to MNSI in May 2024.

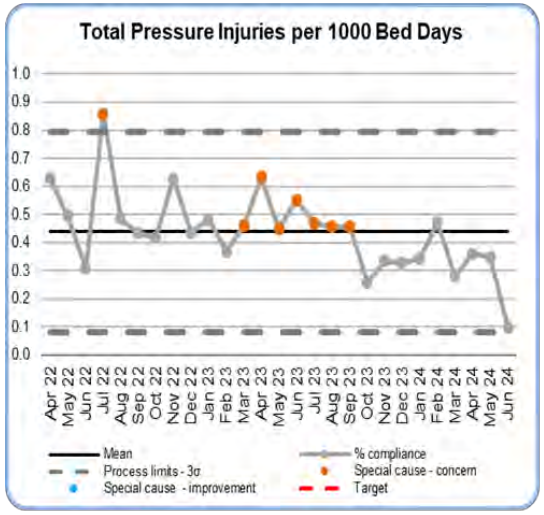
There was 1 indirect maternal death in May 2024 which occurred within the NICU apartments – the postmortem results are yet to be shared and therefore cause of death not confirmed.

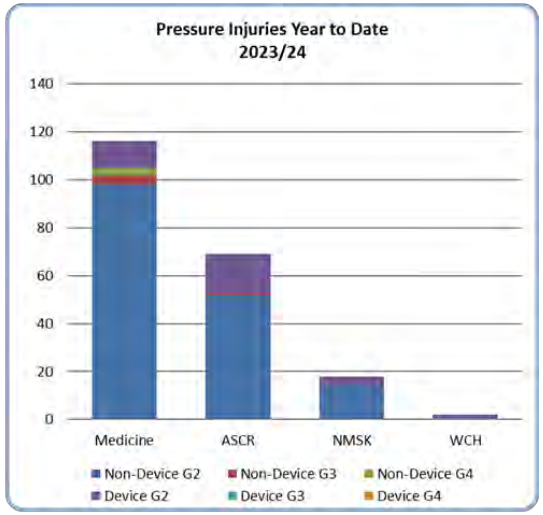
The midwifery vacancy rate is the lowest it has been since January 2022 at 2.68%.

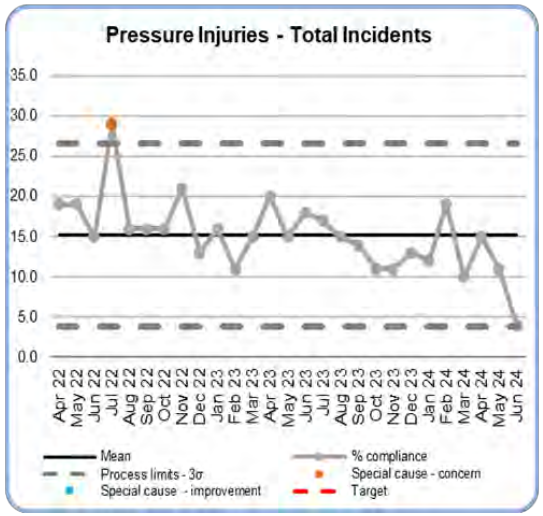
It is acknowledged that the data is reported a month in arrears however any immediate safety concerns would be presented to Divisional Quality Governance, Trust Board and the LMNS as appropriate. See section 3 for emerging issues of note.

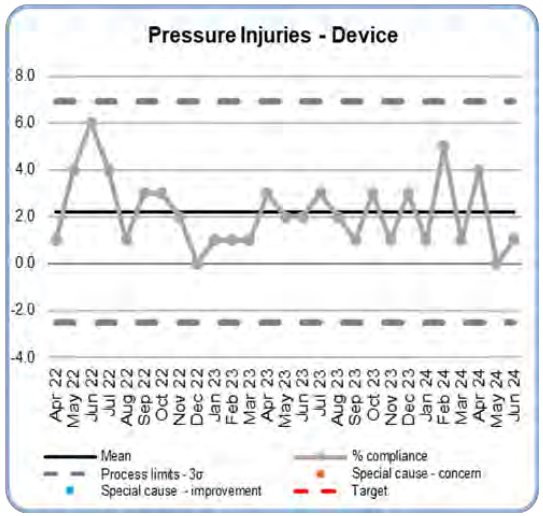
The Perinatal Quality Surveillance Model will be shared with Quality Committee and with Perinatal Safety Champions to ensure there is a monthly review of maternity and neonatal quality undertaken by the Trust Board.

The Perinatal Quality Surveillance Model will be shared with the Local Maternity and Neonatal System to ensure Trust level intelligence is shared to ensure early action and support for areas of concern.









Pressure Injuries

What does the data tell us?

In June there were 4 x grade 2 pressure ulcers, which is continues the decreasing trend since April. Of which 1 x grade 2 was attributed to a medical device.

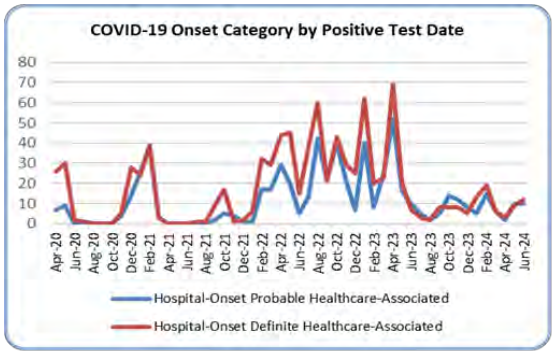
There were no unstageable, grade 3 or 4 reported pressure ulcers reported in June.

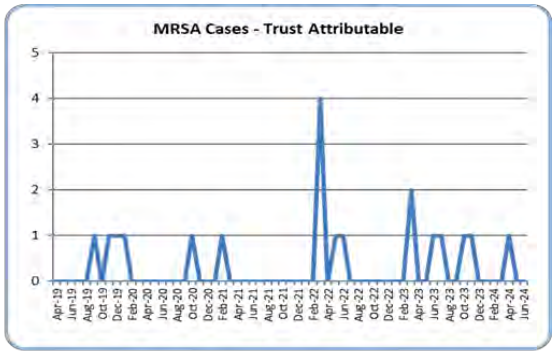
There was also a decrease in DTI prevalence, with 4 reported DTI's .

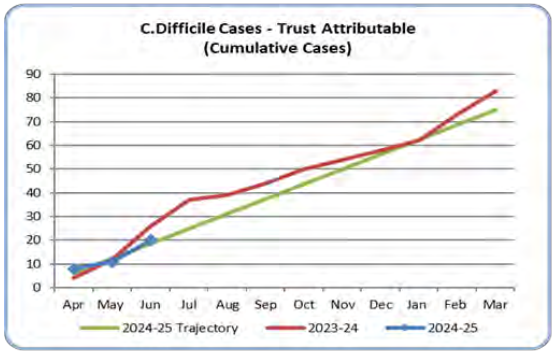
The proposed figures for the PU reduction target are under review given the significant reduction in PU incidents in quarter 1 of 2024-2025. The vision is that there will be a trajectory for the year based on the first-quarter figures. There will be zero tolerance for Grade 3 or 4 PUs, with a 50% reduction on last year's incidents.

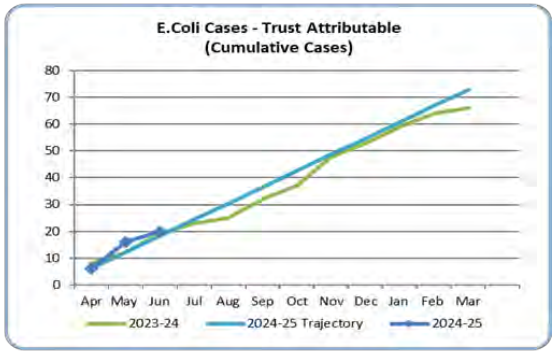
What actions are being taken to improve?

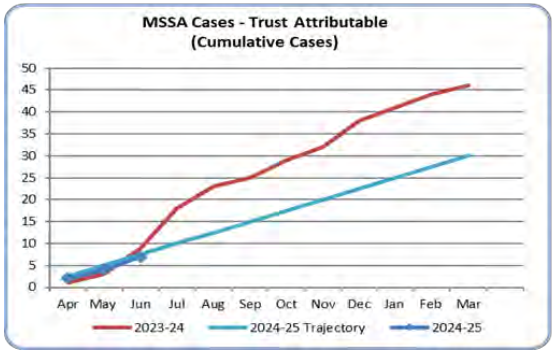
- The TVN team provide a responsive, supportive and educational wound care service across NBT and work collaboratively and strategically within the ICB across the BNSSG system. The team actively seek to work in collaboration with patients, clinical teams and other stakeholders to reduce patient harm and improve clinical outcomes.
- NICU launched their SSKIN bundle pilot in June and there have been positive feedback. This is a collaborative with the NICU sister, who has driven this project. The NICU SSKIN bundle is likely to be adopted outside of the NBT, as this has been presented regionally and there is currently not a recommended NICU SSKIN bundle
- The study on prophylactic dressings in collaboration with Mölnlycke has been moved to August to allow for staff training and ensure that robust outcomes are obtained. This project offers an opportunity to add an adjunct to existing pressure ulcer reduction strategies to the highest risk patients.
- The TVN team have audited the availability and display of the Pressure Ulcer boarding card in the patient bed spaces. The data will be shared at the Pressure Ulcer Steering group and to the divisional quality meetings.

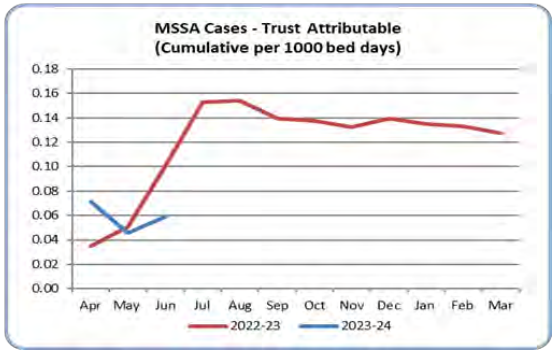












Infection Prevention and Control

What does the data tell us?

COVID-19 (Coronavirus) / Influenza - numbers remain low not causing concern

MSSA – Education / targeted link ambassador session continues to assist with reduction plan with promising results total of 7 cases to date.

C. difficile – Cleaning issues continue to addressed. Monitoring national cleanliness standards and audit scores. A slight decrease from last month noted, notable focus given to wards effected with relevant support and plan to monitor progress.

Gram negative – Work ongoing with hydration and regional/national programmes and initiatives within the continence group.

What actions are being taken to improve?.

- Bacteriemia reduction plans are trust wide with work being undertaken with Medical, Nursing and AHP staff. Prehospital cannula audit completed, showing insertion based on need, re-audit planned due to outcome, work with SWAST to reduce insertion of " Just in Case lines " ongoing.
- Data for MSSA cases in NBT remain consistent with those locally, IPC teams continue collaboration within regional to drive reduction, focusses on looking at the main points of entry being IV devises or chronic wound linked with tissue viability.
- Recognising the rise of *C. difficile* over Q4 and in Q1 ongoing education and planned link ambassadors training is targeting clinical areas with cases focusing on sampling and documentation.
- Continence group has been working with the nutrition assistance to deliver hydration projects and we have increased education related to catheter management. Contributing to the ICB catheter passport

Other infections

Measles – NBT have no current actions or active cases being managed alongside UKHSA

TB – Contact tracing and co-ordination of case management complete

Whooping cough (Pertussis) - New July case is being managed with UKHSA to contact trace.

Other projects

NEW Soap / emollient trust wide roll out in place with education / hand health programme planned with Occupational health.

HCAI trajectories remain not set nationally, awaiting released following the general election.

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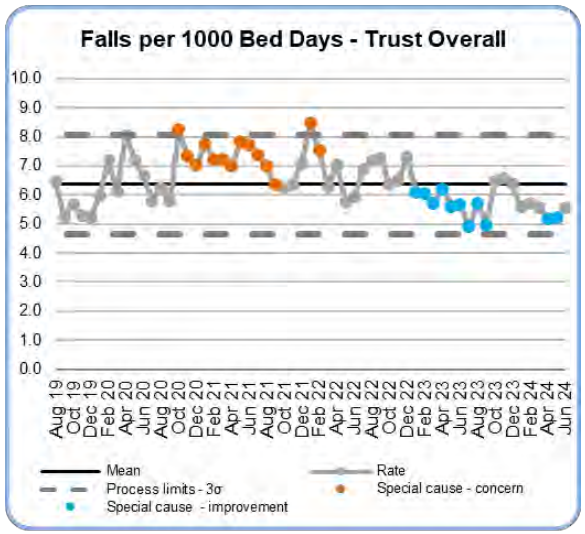
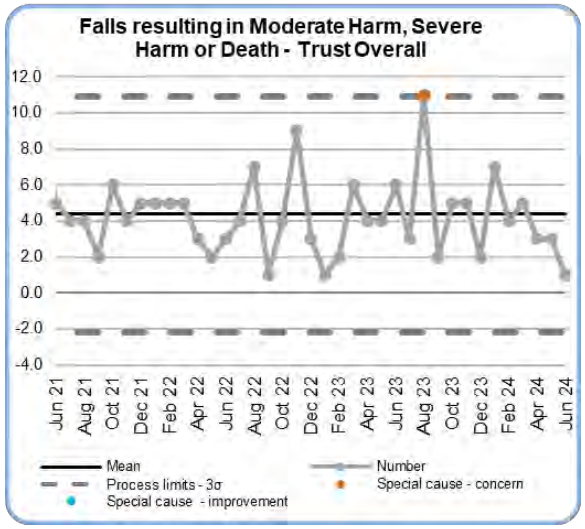




Falls

Falls incidents per 1000 bed days

NBT reported a rate of 5.56 falls incidents per 1000 bed days in June which is below the average of 6.36.
There were 169 falls reported in June. 1 moderate level physical harm and no severe. The moderate harm incident also sustained moderate psychological harm. This patient was since passed away but not because of the fall. There was an additional incident of moderate psychological harm which sustained low physical harm (This is being reviewed).

Medicine division: 114 falls reported. 6th month below their average.
NMSK division: 35 falls reported. Below their average for the second month.
ASCR: 15 falls reported. Below their average for the second month.

Multiple falls accounted for 33% of falls this month which is higher than the average of around 25%. With 6 patients having 3 or more falls.

Older patients continue to be the highest proportion of patients who fall, with 74% of reports in the over 65's.

What actions are being taken to improve?

Funding for the Falls prevention and management team has not been secured beyond July at this point.

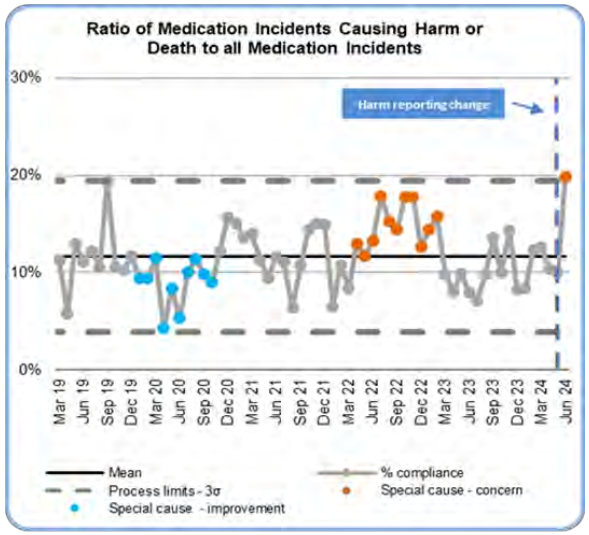
There are 3 focused quality improvement pieces of work underway using the patient first approach. Safe lifting following a fall, good quality multi-factorial risk assessments and improved communication/engagement with patients and carers. Actions required have been identified. Further work is needed to establish how these programs of work will be taken forward beyond July.

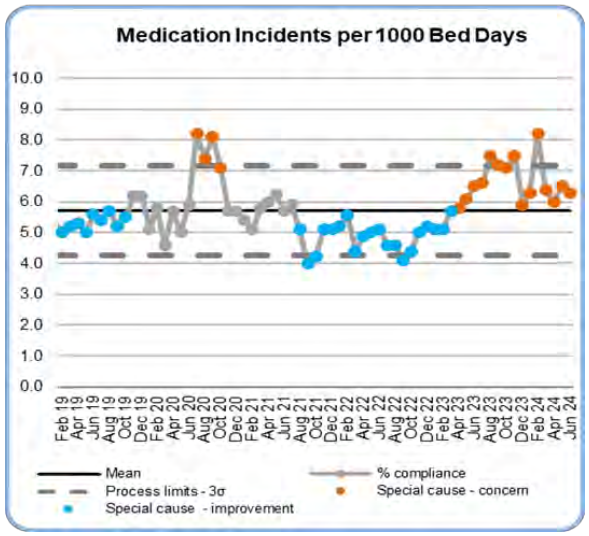
Following the bathroom activity analysis, the falls team have reached out to infection control and estates/facilities to discuss possible adjustments to the bathroom environments. We are awaiting responses and discussions to formulate next steps.

The patient information leaflet is ready for final approval and the eLearning package is expected to be 'live' by mid-July.

There is a plan in place to deliver training to junior doctors around their responsibilities relating to falls care in hospital. This will commence with the program of teaching in September.

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 June 24 NBT had a rate of 6.3 medication incidents per 1000 bed days. This is slightly below the 6-month average of 6.6 for this measure.

Ratio of Medication Incidents Reported as Causing Harm or Death to all Medication incidents
Due to the implementation of the NHS England mandated Learning From Patient Safety Events (LfPSE) system, the way the trust captures harm affecting patients within incident reporting has changed. Options to reflect this appropriately within the IPR are being explored for next month.

Overall comment
In June, the overall number of reported incidents is similar to previous months - the harm data is difficult to interpret due to the changes in process. We are working with the Patient Safety Team and other colleagues who use 'harm' data in their metrics (such as the Falls Lead) to ascertain the best way to present this updated data.

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 is to meet monthly going forward. 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
- Engaging clinical staff to share any thoughts they have about how to achieve conditions in clinical areas which support them to manage medicines safely.
- 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.

Patient

NHS North Bristol NHS Trust

Patient Experience

Board Sponsor: Chief Nursing Officer
Steven Hams

18.1

Patient & Carer Experience – Strategy Delivery Overview June 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.	Patient Stories to Board and other groups/committees being taken forwards as per plan. PE Annual Report being shared with Board in July 2024.
	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.** We are in the process of exploring new technologies, including social listening and digital techniques for theming large narrative datasets. We have also recruited a further 2 new Patient Experience Feedback volunteers to undertake FFT, local surveys and patient conversations across the hospital, improving accessibility for all patients.
	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.	IPR reporting has been refined to include an overview of progress against the Patient & Carer Experience Strategy.
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.	Aligns to KPMG internal audit action plan and VS Strategic Plan which both reference this objective. Work for this is scheduled for quarter 2 due to current vacancies in the team.
	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.** MH Strategy nearing finalisation, with significant system wide engagement in its development and supporting workstreams. We have a patient partner with LD who is actively involved in sharing her lived experience to improve services.
	The voice and the involvement of carers will be respected and integral in all we do.	We celebrated Carers Week in June and attended an event hosted by the Carers Support Centre. We hosted a session on ReSPECT and a stall with information about carers support at NBT.
	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**. Exploring use of 'Ask 3 Questions' as part of shared decision making. Feedback gathered from PCPG (Patient Partners)
	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.	Visit to Gypsy Romany Traveller community completed in June and two visits to sight loss support hubs as part of an accessibility audit we are undertaking with the West of England Sight Loss Council.
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	A prospective new panel member is beginning onboarding processes
	We will continue to undertake the annual Patient Led Assessments of the Care Environment (PLACE) audits and respond to areas of improvement.	Development of physical access working group of patients who will participate in this year's PLACE assessments in November. Presentation on last year's PLACE results scheduled for sharing at PCEG in August.
	We will involve the volunteer voice within feedback to shape future volunteer roles and patient engagement opportunities.	We have recently developed a new volunteer role based on a complaint. Further work for this is scheduled for quarter 2 due to imminent team vacancies (leavers) and need to replace.
Putting the spotlight on patient and carer experience	We will refresh the patient experience portal on our website and staff intranet	Intranet pages recently updated for all PE teams.
	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. This is currently being tested with a small working group before roll out.

Patient & Carer Experience - Overview June 2024

NHS North Bristol NHS Trust

Carers Week

On the13th June we attended the Caring Matters Event at BAWA, hosted by the Carers Support Centre.

We held a stall with our Carers Liaison Worker, Sam and Krys and Troy from the Patient Experience Team. We chatted with carers, gave them information about the work we're doing to support carers at NBT and how we can help.

Dr Rob Grange, End of Life Lead also attended with us to host a session on the ReSPECT process and forms. This was a popular session which was requested by local carers following last year's event.

We have a motivated group of passionate staff and carer representatives helping us take forward our ambitious agenda at NBT to raise awareness about carers and improve the support we can offer as a Trust.

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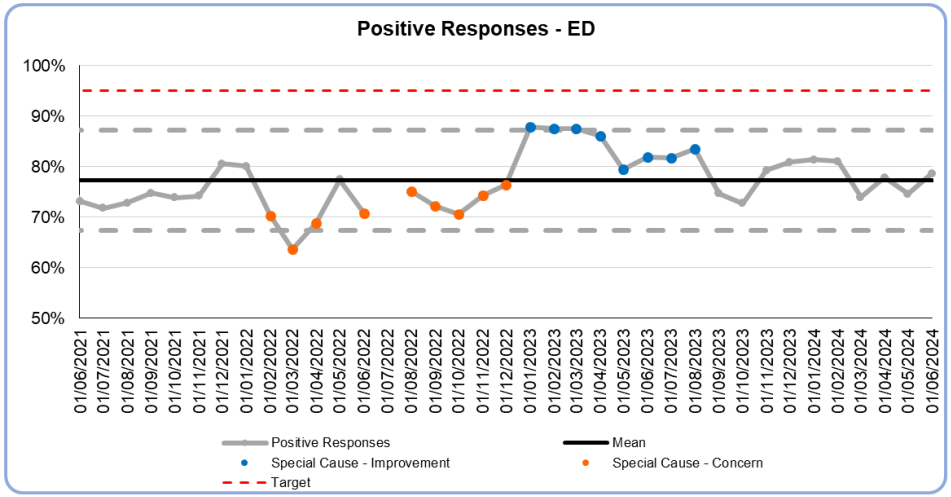
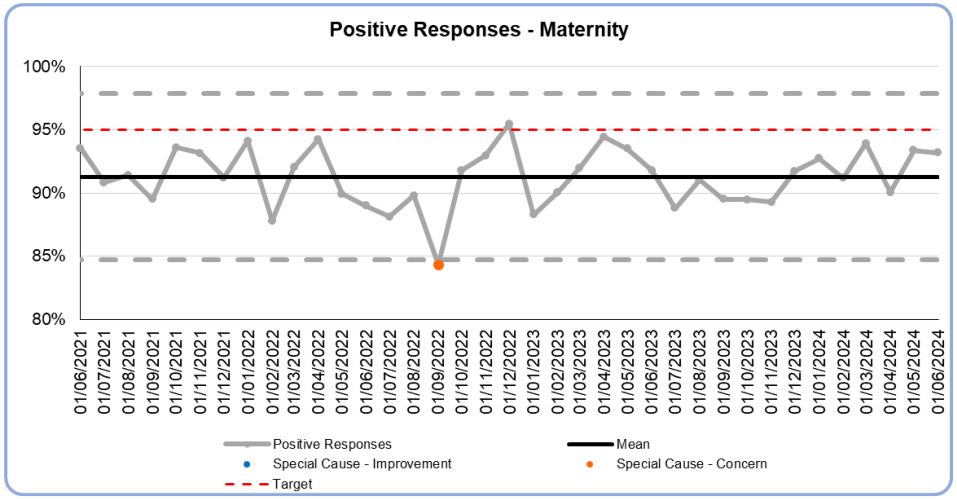
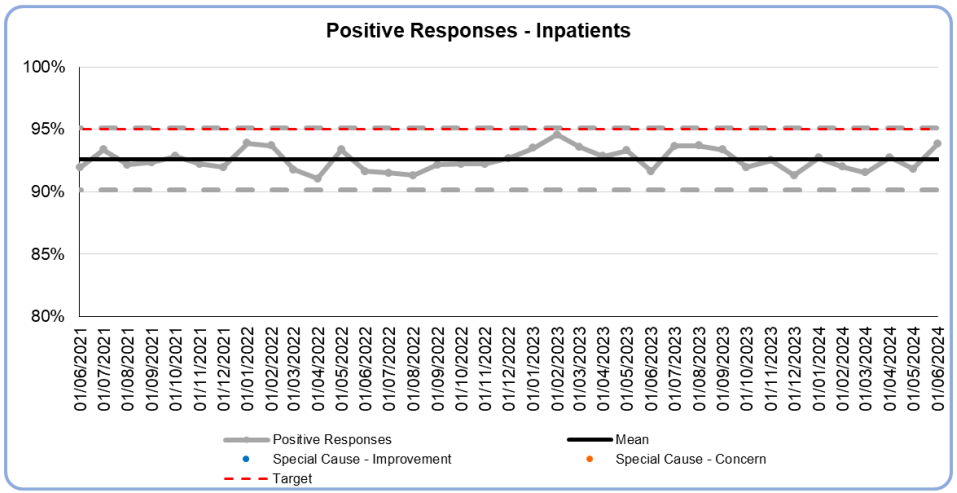
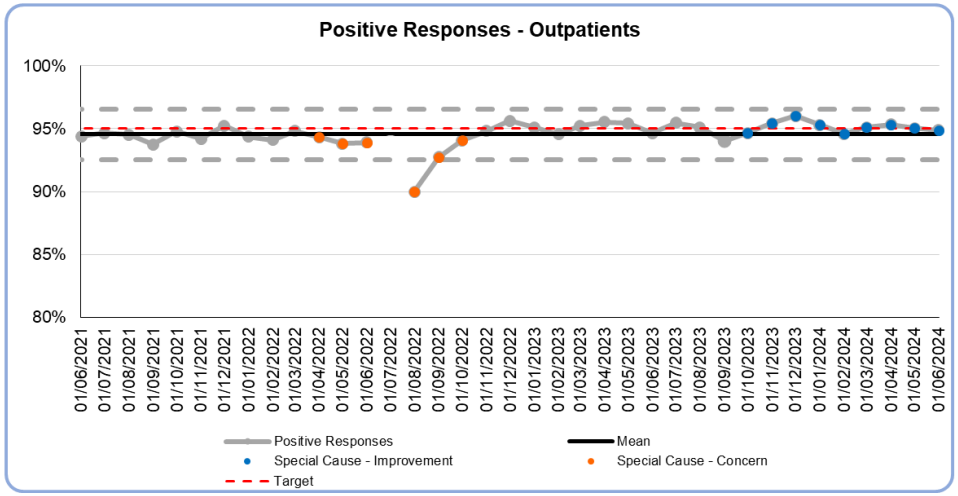
Patient Experience









N.B. no data available for the month of July for ED and Outpatients due to an issue with CareFlow implementation

Patient Experience

NHS North Bristol NHS Trust

What does the data tell us – Trust wide?

- In June, 9490 patients responded to the Friends and Family Test question. 6848 patients chose to leave a comment with their rating.
- We had a Trust-wide response rate of 14%, which is the same as the previous month.
- 92.93% of patients gave the Trust a positive rating. This was in keeping with the previous month (92.20%).
- 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 from 92.7% in May to 93.2% in June. Negative responses have increased from 4.7% in May to 6.2% in June .
- The response rate across Maternity increased slightly from 18% in May to 18.4% in June.
- Top positive theme from comments remains staff.

I was really happy with how I was treated and the way that the birth centre was run. As with the last time I gave birth in 2022, the experience was beautiful and streamlined. The staff were wonderful as well.

What does the data tell us - Emergency Department?

- Positive responses have increased from 74.6% in May to 78.6% in June. Negative responses have decreased from 17.7% in May to 14.5% in June.
- The response rate for ED has decreased slightly from 19% in May to 18.8% in June.
- The top positive theme remains staff.
- The top negative theme remains waiting time.

Waiting for 11 hours, I do however sympathise with you I don't want to criticise the care I received because the staff were fantastic, just the time you have to wait needs to be looked at.

What does the data tell us - Inpatients?

- Positive responses have increased from 89.6% in May to 92.1% in June. Negative responses have decreased from 5.11% in May to 3.5% in June .
- The response rate for inpatients has increased from 23% in May to 24.7% in June.
- Top positive themes from comments are staff, clinical treatment and communication.
- Negative themes from comments are, communication, environment and waiting time.

Well maintained modern hospital. Consultant, doctors and nurses really kind and attentive and so happy and friendly despite being so busy. Food was better than I have previously had in other hospitals. Thanks to everyone for their care and compassion.

What does the data tell us – Outpatients?

- Positive responses slightly decreased from 95% in May to 94.8% in June. Negative responses remain the same as the previous month, 2%.
- The response rate for outpatients increased slightly from 12% in May to 12.1% in June.
- Top positive themes from comments are staff, waiting time and clinical treatment.
- Negative themes from comments are waiting time, communication and staff.

Brilliant staff, super friendly and supportive during an uncomfortable procedure. Slightly longer than expected wait.

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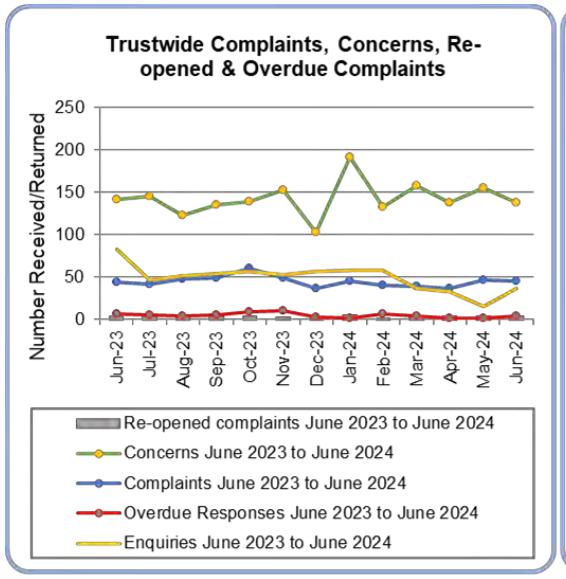

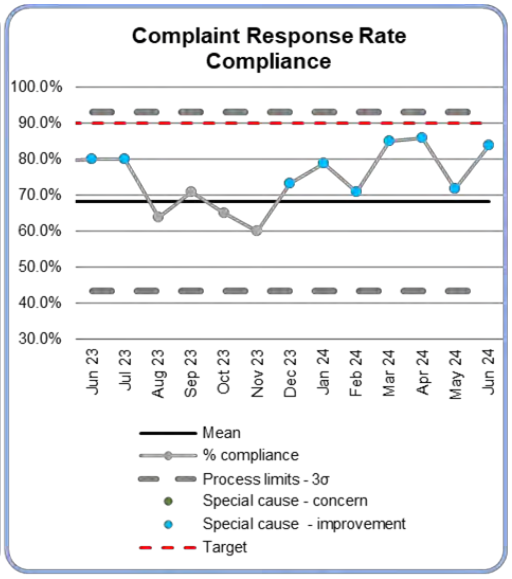

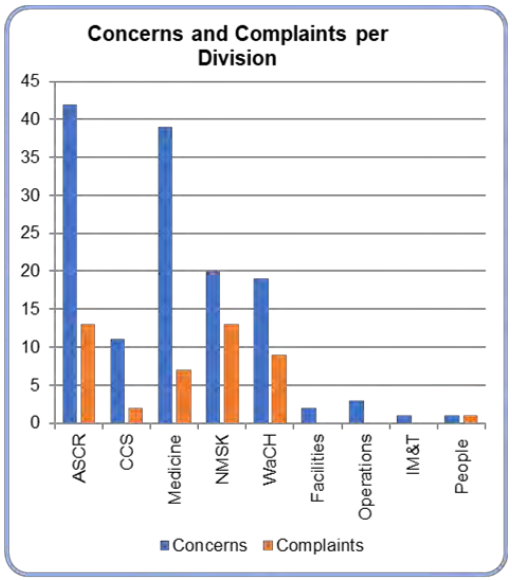

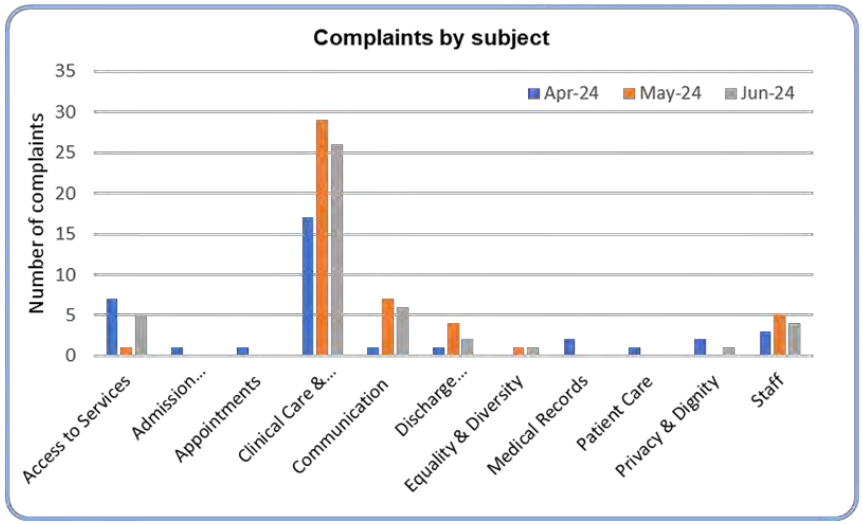

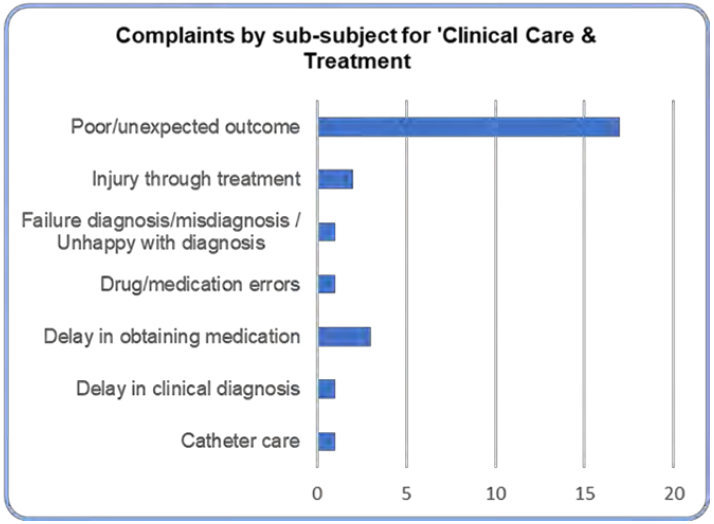

Complaints and Concerns

What does the data tell us?

In June 2024, the Trust received 45 formal complaints. This is 2 less than in May and 1 fewer than the same period last year.

The most common subject for complaints is 'Clinical Care and Treatment' (26). A chart to break down the sub-subjects for 'Clinical Care and Treatment' is included.

Of the 45 complaints, the largest proportion was received by ASCR and NMSK (13 each).

There were 4 re-opened complaints in May (2 NMSK, 1 ASCR, 1 People), the same number as previous month.

The number of overdue complaints at the time of reporting has increased from 2 in May to 4 in June and are with ASCR (2) , NMSK and the People Team.

The response rate compliance for complaints has increased from 72% in May to 84% in June. A breakdown of compliance by clinical division is below:

ASCR – 73% NMSK- 100% Medicine – 93%

WaCH – 75% CCS – 100%

The overall number of PALS concerns received has decreased from 155 in May to 138 in June, which is the same number for this period last year.

In May 100% of complaints were acknowledged within 3 working days and 100% of PALS concerns were acknowledged within 1 working day.

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Research and Innovation

Board Sponsor: Chief Medical Officer
Tim Whittlestone

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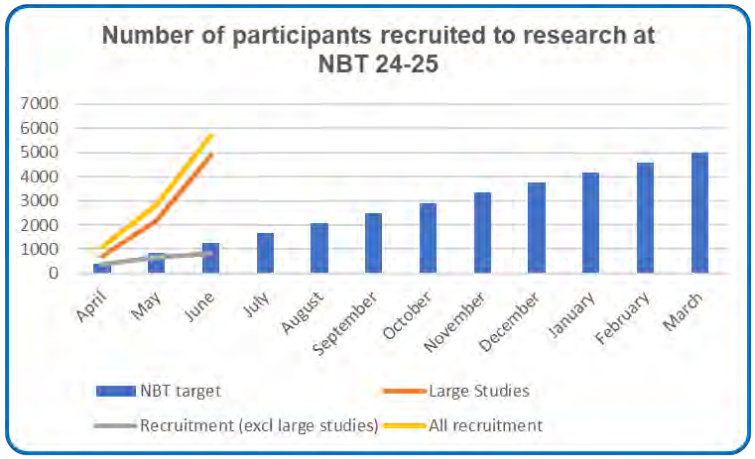
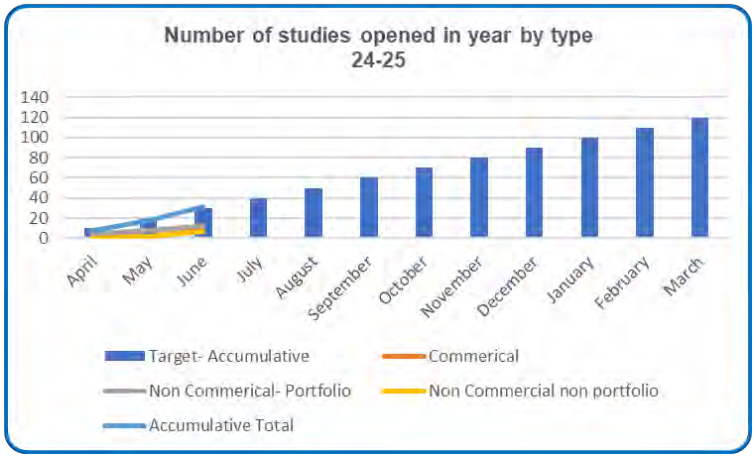




Research and Development

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 826 participants have enrolled in research @NBT with an annual target of 5000 (excluding our 2 large studies). The NBT research portfolio remains strong, we have 219 NIHR Portfolio studies open to recruitment . We have opened 31 new studies year to date, as shown in graph 2 against a target of 30 We are pleased to see steady growth in the number of studies collaborating 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.

Our renal research team have recently been recognised as the UK top recruiter and joint global site to the FINE 1 renal study, this is because of the team's innovative and collaborative approach to delivering studies efficiently and effectively.

Our grants

The level of grant development activity across NBT remains consistently healthy, with 75 research grant submissions supported by R&D, in 2023. Congratulations to Claire Lanfear (staff nurse in cancer services), who was recently awarded NIHR Pre-Application funding to support their clinical academic career development. Also, congratulations to Dr Pippa Bailey on her recent intent to fund for an NIHR HSDR grant, £1.8m, to undertake hybrid-effectiveness-implementation trial of outreach service to improve access to living donor kidney transplantation and Miss Shelley Potter for her recent NIHR HTA intent to fund, £2.6m, to lead a phase III randomized controlled trial comparing Targeted Axillary Dissection vs axillary node clearance. Finally, congratulations to Ronelle Mouton on her recently awarded, prestigious, NIHR Senior Clinical Research Practitioner award, which will provide protected time to further Ronelle's development as an academic leader

The active research grant portfolio at NBT has increased by £5m from this point last year, to a total of £50m, due to both a high level of NIHR grant success 2021-2023 as well as some older grants being extended due to Covid disruption. NBT has been was awarded £1.1m Research Capability Funding for 2023/34, a 53% increase on the previous year's allocation. This allocation put NBT in 9th position, out of 248 NHS Trusts in England, our first time in the top 10. RCF is allocated in direct proportion to the level of NIHR grant income received by an NHS Trust in the previous calendar year. The level of NIHR grant income received by NBT in 2023 was higher than the previous years and the 2024 forecast NIHR grant income is looking to be higher still. 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 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. In addition, with thanks to the Southmead Hospital Charity, R&D has launched a call for applications to our SHC Springboard scheme, seeking applications from NBT staff to undertake small research projects up to £25k, deadline 3rd July. Anyone who is interested in applying to either of these schemes will receive full support from our research development team to prepare an application, previous research experience is not required, early engagement with R&D is encouraged ResearchGrants@nbt.nhs.uk .

18.1

Innovate to Improve | People | Commitment to our Community

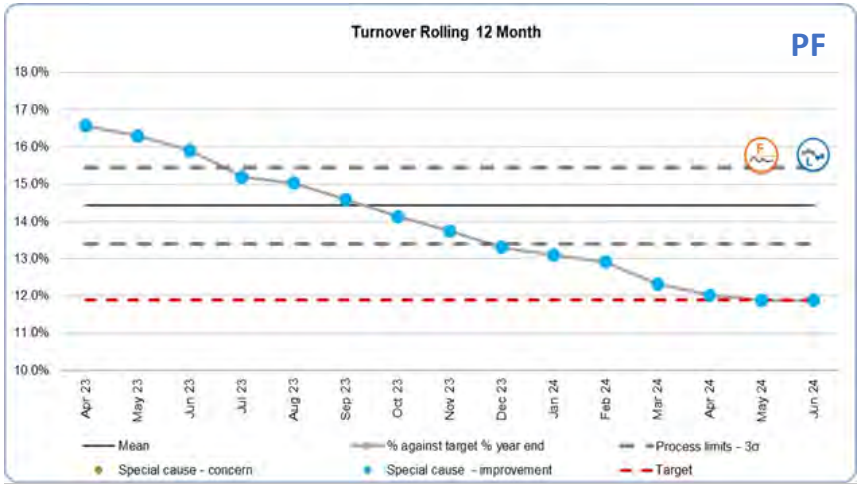
NHS North Bristol NHS Trust

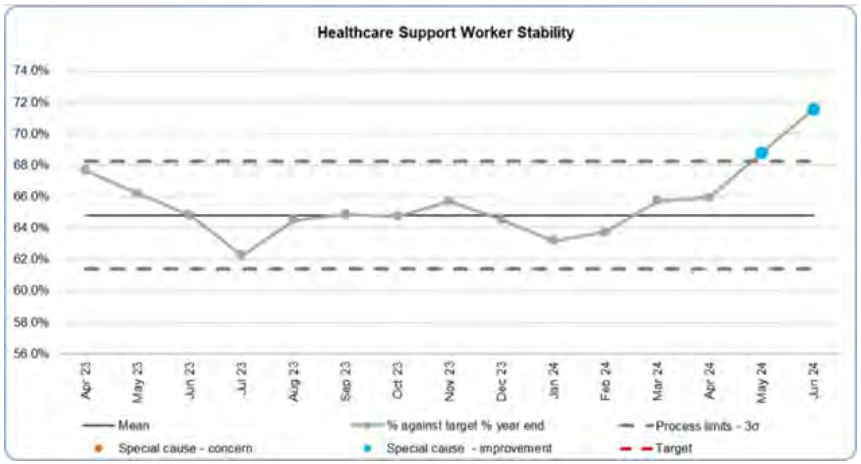
Workforce

Board Sponsors: Chief Medical Officer, Chief People Officer
Tim Whittlestone and Peter Mitchell

18.1

Retention Patient First Priority People





Turnover is stayed stable at 11.88% in June, 0.02% below the target set for 2024/25.
Work continues with divisions to build more stretching targets given current improvement.

Healthcare Support Worker (HCSW) stability (% of staff in post with >12 months service) has improved from 68.77% in May to 71.58% in June. A Retention plan priority is 'Supporting New Starters' - specifically HCSWs where turnover in the first 12 months has been historically high. The Impact of actions to support them in their 1st year will continue to be monitored in 2024/25. Successful engagement sessions with these staff have occurred followed by '*You said, we listened*' comms campaign.

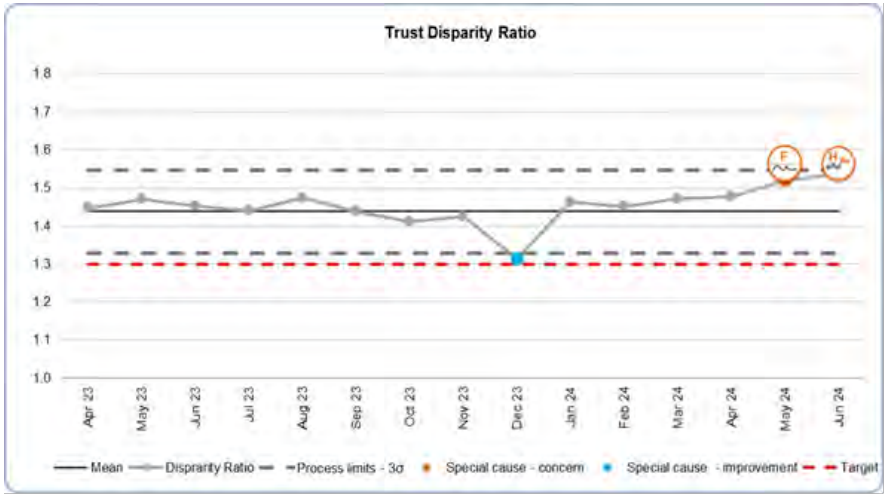
Celebration events for staff within their first year of employment have begun.
9 out 13 actions in our one-year plan are complete with 4 in progress and are continuing to being monitored through delivery of our five-year retention plan. The table below shows our immediate priority actions in the next 3 months:

Driver	Action and Impact	Owner	Due
Induction	New tools are being developed to enhance new starter experience and reduce attrition	Staff Induction Team	Jul-24
Work Life Balance	Working with HR BPs to launch new tools for teams to work flexibly to increase flexible working applications and reduce number of staff leaving due to 'work life balance'	People Promise Manager	Jul-24
Culture	Launch a Civility and Respect framework teams can use to improve their culture and reduce occasions of incivility.	Associate Director of Culture	Aug 24

18.1

Commitment to our Community

Patient First Priority – Commitment to our Community



Disparity Ratio (likelihood of applicants from ethnic minority backgrounds being appointed over white applicants from shortlisting – Workforce Race Equality Standard metric), while it has stayed within statistical process limits it has followed a deteriorating trend since the low point of 1.31 in December'23 to 1.54 in June'24.

Diverse Recruitment Panels (DRP) – work to address unconscious bias in interview selection process with current focus on senior roles initiated on 1st April 2024. New Board level objective agreed to increase minority ethnic staff at band 8A and above to 12.5% by 2025/26. 6-month review of DRP outcomes/success due end September.

Positive Action Programme – all vacancies now include a statement particularly encouraging applications from underrepresented groups and more targeted approach being used as required

% of Employed Staff from 30 Most Challenged Communities – The % of employed staff from our 30 most challenged communities shows statistically significant deterioration, however, the deterioration is driven not by a reduction in employed staff from those communities but by other factors, primarily an increases in the proportion of staff employed residing outside BNSSG. Month on month since April 2023 the actual number of staff employed from our most challenged communities has increased from 3202 to 4008 in June 2024. Our aim is to recruit proportionally more staff into targeted professions and bands from our 30 most challenged communities and our method of tracking delivery of this is under review to ensure we appropriately measure the impact of what our plans are aimed at achieving.

Community Outreach – Commitment to Our Community plan launched 16th July. Launch event 18th July in Careers Hub.

Mentoring Programme – Mentoring and support is being provided to around 60 people from our local area. Some are now seeing employment outcomes.

Work Experience - Review of local Schools / colleges in targeted locations to begin at end of academic year. Career ambassadors launched to support next year's activity. Career roadmaps in development.

Driver	Action and Impact	Owner	Due
Community Outreach	2 week supported work experience scheme is took place in first 2 weeks of July. 3 candidates completed work experience and training.	Community Project Manager	Aug24
Community Outreach	Community drop ins continue with Newsletter scheduled to Launch in August	Community Outreach officer	Aug 24

18.1

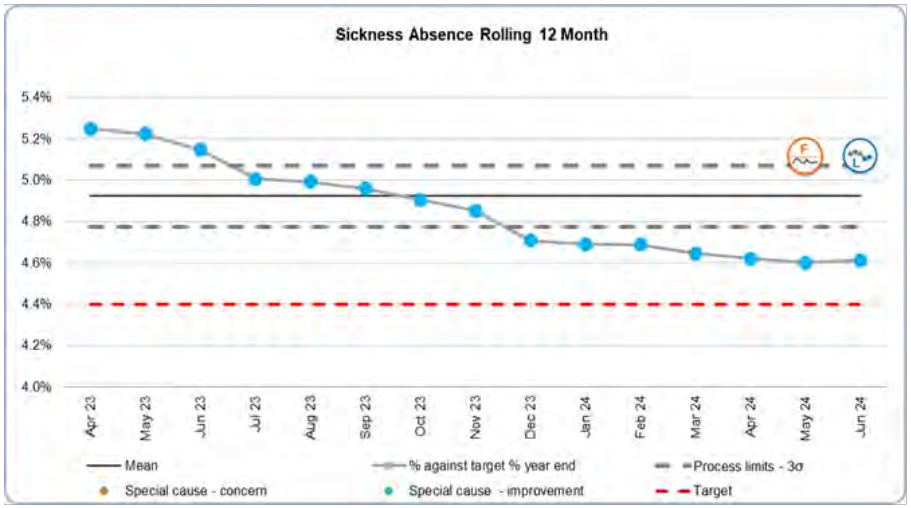
Temporary Staffing

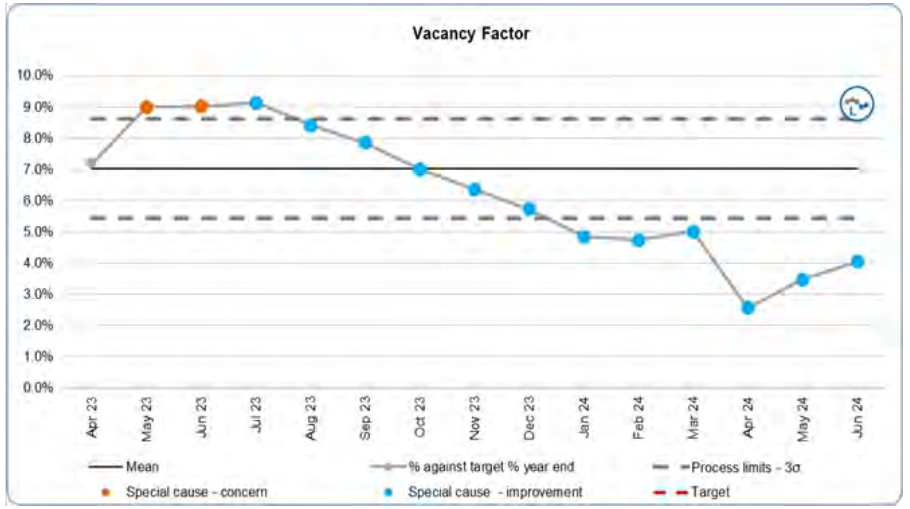
Trust-wide agency spend decreased between May and June and it has stayed below the Trust the 2024/25 target for agency spend – Agency spend must be 3.2% (or less) of the overall pay spend in the Trust. Divisional agency expenditure targets have been set which will deliver the overall Trust target for the year.

Work continues with Divisions to address long term Consultant gaps to further reduce reliance on agency workers, with support from Talent Acquisition with recruitment strategies.
New governance process agreed for new medical agency requests, and new process for non-medical also under review.

Driver	Action and Impact	Owner	Due
Medical Staffing	Medical agency temp staffing reduction group continuation – development of plans to convert long term agency workers to substantive contracts, provide targeted support to Divisions on alternative approaches to filling long term gaps.	Associate Director Medical Workforce	Ongoing
Medical Staffing	Pan-regional South-West Medical Agency rate card implementation to begin on the 1st September for new and ad-hoc agency use with a flight path to Aug 2025 for existing long term agency use.	Associate Director Medical Workforce	Sep-2024
Nursing & Midwifery	South-West Regional agency rate reduction programme continues trajectory for reaching cap compliance (General by July achieved) and Specialist by October 24	Associate Director Nursing Workforce Recovery	Oct-24
Nursing & Midwifery	Focus on Bank usage. Triangulation of key usage data, finance data, and workforce metrics to develop and implement additional controls where identified and required	Associate Director Nursing Workforce Recovery & Deputy Chief Nurse	Sep- 24
Nursing & Midwifery	Collaborative Bank Launch – 5th August for B5 registered Nurses. 3 – 6 month pilot, with discussions commencing around potential next roles/groups to onboard	Resourcing Manager	Aug-24
Non-Clinical Agenda For Change	New governance process to be produced and circulated to ensure all agency usage is requested via NBT eXtra, There is a current gap for Non-Clinical staffing groups..	Resourcing Manager	Aug-24

Watch Measures (CPO)

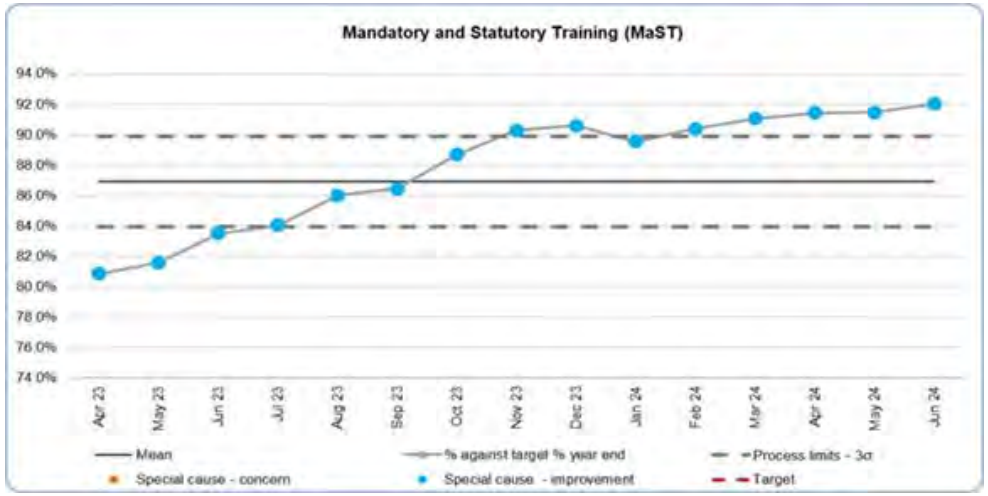




18.1

- The Trust rolling 12-month sickness absence rate continues to show statistically significant improvement over the last six months.
- Vacancy Factor for increased to 4.04% in June from 3.46% in May 2024, however the figures for May were artificially low as some non-recurrent funding for roles had not yet been reflected in the financial ledger.
- Staff Health and Well-being Strategy Group has met and reviewed current data on sickness absence, and current health and wellbeing provision to progress delivery of a strategy and plan with key commitments.
- NHSE Health and Wellbeing diagnostic tool internal evaluation process reviewing the trusts overall health and wellbeing offering in progress to be completed by end of July 2024.

Watch Measures (CPO)



Metric shows statistically significant improvement, having passed the target for the last 6 data points.

Deterioration – hotspots and mitigating actions
Direct communications are sent to individual staff to encourage compliance.

Improvement – celebrate success and any learning
All staff 90.94% (↓ from 91.7%).
Permanent Staff 93.8% (↓ from 94.5 %).
Fixed Term Temp 84.45% (↓ from 87.3%).
Other (NBT eXtra, Honorary) 80.67%.

Last year, the completion rate was measured based on the date of the appraisal meeting. This year, an appraisal is considered "complete" when it is signed off by both the person being reviewed and the reviewer.

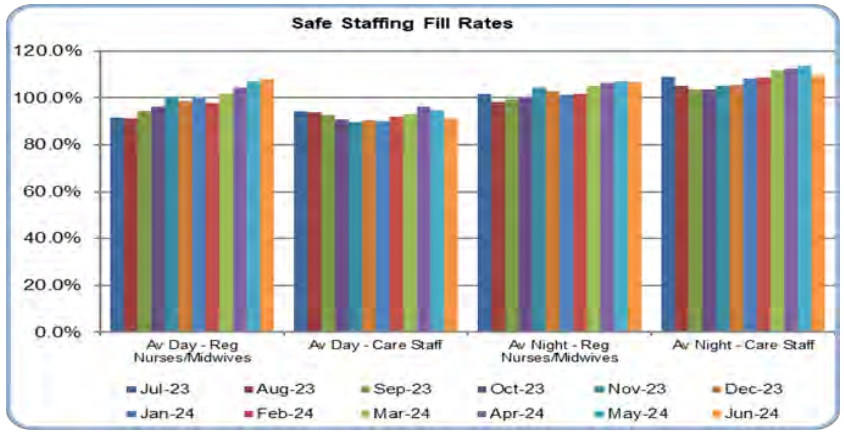
The trust is **49.8% complete** (as at 11 July 24).

There are approximately **3,500 reviews in progress.** If these convert by the end of the window, we will be over 80% complete. Approximately 1400 reviews have yet to start. Working with HRBPs and staff directly to encourage completion.

Approx. **9000 users have set objectives**.

98% of staff rate that they are happy/very happy with the quality of their conversation.

Safe Staffing



Jun-24	Day shift		Night Shift	
	RN/RM Fill rate	CA Fill rate	RN/RM Fill rate	CA Fill rate
Southmead	107.82%	91.13%	106.56%	109.58%

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				
Neuropsychiatry (Non Medical) 25000				
Theatre Medi-Rooms (Pre/Post Op Care) 14966				
Ward 25B 14242				
Ward 26B 14312				
Ward 27A 14402				
Ward 32A CAU 14103				
Ward 32B SAU 14104				
Ward 33A 14221				
Ward 33B 14222				
Ward 34A 14325				
Ward 34B 14324				
Ward 6B (mainly Neuro) 14211				
Ward 7A 14302				
Ward 8A 14410				
Ward 9B Flex Capacity 14501				
		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 June 2024, the combined shift fill rates for days for Registered Nurses (RN)s across the 28 wards was 107.82% and 106.56% respectively for days and nights for RNs. This is reflected through a higher acuity and number of escalation patients in month. The combined shift fill for HCSWs was 91.13% for the day and 109.58% for the night. Therefore, the Trust as a collective set of wards is within the safe limits for June.

June *care staff* fill rates:
- 21.43% of wards had daytime fill rates of less than 80%
- 3.57% of wards had night-time fill rates of less than 80%
- 14.29% of wards had daytime fill rates of greater than 120%
- 35.71% of wards had night-time fill rates of greater than 120%

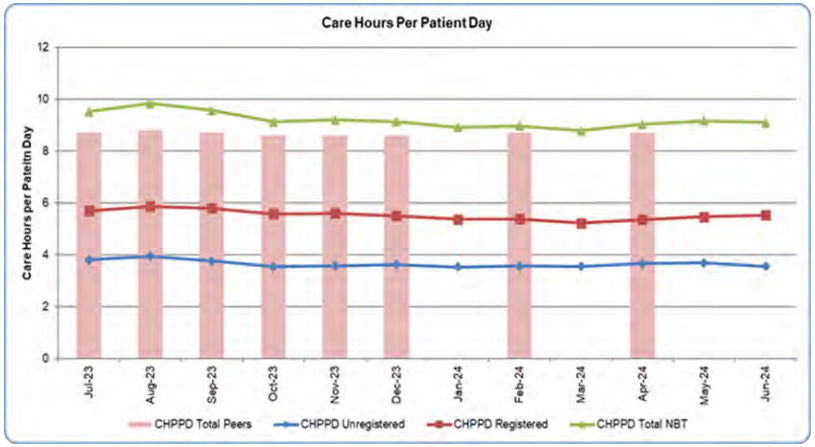
June *registered nursing* fill rates:
- 0.00% of wards had daytime fill rates of less than 80%
- 0.00% of wards had night-time fill rates of less than 80%
- 10.71% of wards had daytime fill rates of greater than 120%
- 14.29% of wards had night-time fill rates of greater than 120%

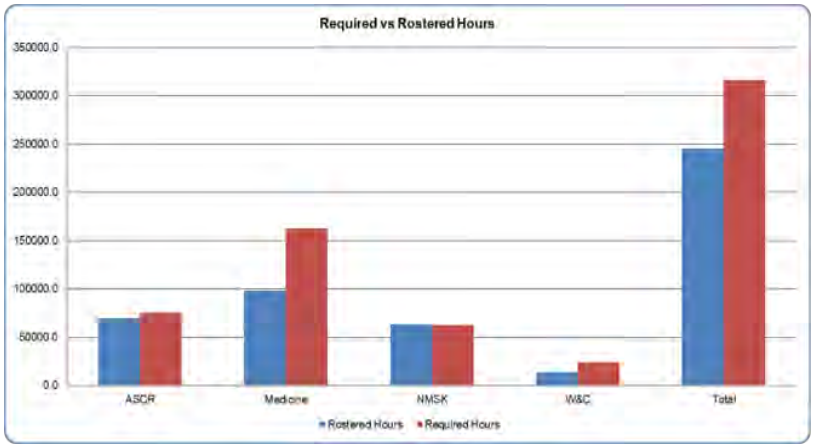
The “hot spots” as detailed on the heatmap which did not achieve the fill rate of 80% or >120% fill rate for both RNs and HCSWs have been reviewed. The fill rate <80% for care staff on the medical wards is due to shortage of HCSWs due to higher number of patients requiring enhanced care and driven by headroom.

For the medical wards, the red-hot spots for HCSWs are off-set by the establishment of RNs. For NMSK, the stroke ward (34b) enhanced care requirements were almost 3 times the usual levels; and high enhanced care requirements for neuro-psychiatry which is a staffed by 1 HCSW so will impact on fill rate levels. For ASCR, 33a and 33b had high requirements for RMNs with each ward requiring 1:1 care and treatment.

Compliance:
The Safe Care Census regularity has been reduced to twice daily to more closely align with shift patterns. The average compliance for June was improved (63% compared to 59.14% in May).

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.

Sustainability

NHS North Bristol NHS Trust

Finance

Board Sponsor: Chief Financial Officer
Glyn Howells

18.1

Statement of Comprehensive Income at 30 June 2024

	Month 3			Year to date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Contract Income	69.5	71.0	1.4	203.6	206.7	3.1
Income	4.9	8.4	3.6	19.2	25.1	5.9
Pay	(46.4)	(48.0)	(1.5)	(139.6)	(144.7)	(5.1)
Non-pay	(29.7)	(34.7)	(5.0)	(89.0)	(97.3)	(8.3)
Surplus/(Deficit)	**(1.8)**	**(3.3)**	**(1.5)**	**(5.8)**	**(10.2)**	**(4.5)**

Assurances

The financial position for June 2024 shows the Trust has delivered a £10.2m deficit against a £5.8m planned deficit which results in a £4.5m adverse variance year to date.

Contract income is £3.1m better than plan. This is driven by additional pass-through income of £1.4m, along with Welsh income of £0.8m, and funding for the consultant pay award of £0.5m

Other income is £5.9m better than plan. The is due to new funding adjustments and pass through items (£4.6m fav). The remaining £1.3m favourable variance is driven by unspent reserves and increased clinical income.

Pay expenditure is £5.1m adverse to plan. New funding adjustments, offset in income, have caused a £2.6m adverse variance, undelivered CIP is £2.5m adverse with overspends on medical and nursing pay £3.1m adverse. This is offset by delayed investments and service developments of £3.2m.

Non-pay expenditure is £8.3m adverse to plan. Of which £2.1m relates to pass through items. This adverse position is driven primarily by increased medical and surgical consumable spend to deliver activity, and multiple smaller non-pay variances. In year delivery CIP is £1.3m adverse to plan.

Statement of Financial Position at 30 June 2024

	23/24 Month 12 £m	24/25 Month 02 £m	24/25 Month 03 £m	In-Month Change £m	YTD Change £m
Non-Current Assets	**538.4**	**536.9**	**536.0**	**(0.9)**	**(2.4)**
Current Assets					
Inventories	11.7	11.8	11.8	(0.1)	0.1
Receivables	49.4	52.6	58.5	6.0	9.1
Cash and Cash Equivalents	62.7	46.2	39.9	(6.3)	(22.8)
Total Current Assets	**123.8**	**110.6**	**110.2**	**(0.4)**	**(13.6)**
Current Liabilities (< 1 Year)					
Trade and Other Payables	(99.9)	(91.4)	(93.0)	(1.6)	(6.9)
Deferred Income	(14.4)	(16.7)	(15.5)	1.2	1.1
Financial Current Liabilities	(23.6)	(23.6)	(23.6)	0.0	(0.0)
Total Current Liabilities	**(138.0)**	**(131.8)**	**(132.2)**	**(0.4)**	**(5.8)**
Non-Current Liabilities (> 1 Year)					
Trade Payables and Deferred Income	(6.2)	(6.7)	(6.7)	0.0	0.5
Financial Non-Current Liabilties	(571.8)	(594.9)	(593.1)	1.8	21.3
total Non-Current Liabilities	**(578.0)**	**(601.6)**	**(599.8)**	**1.8**	**21.9**
Total Net Assets	**(53.7)**	**(85.9)**	**(85.8)**	**0.1**	**(32.1)**
Capital and Reserves					
Public Dividend Capital	485.2	485.2	488.2	3.0	3.0
Income and Expenditure Reserve	(541.8)	(610.8)	(610.8)	0.0	(69.0)
Income and Expenditure Account - Current Year	(69.0)	(32.2)	(35.1)	(2.9)	33.9
Revaluation Reserve	71.9	71.9	71.9	0.0	0.0
Total Capital and Reserves	**(53.7)**	**(85.9)**	**(85.8)**	**0.1**	**(32.1)**

Capital spend is £4.1m year-to-date (excluding leases). This is driven by spend on the Elective Centre and is in line with the forecasted spend for Month 3.

Cash is £39.9m at 30 June 2024, a £22.8m decrease compared with M12. The decrease is driven by I&E deficit and capital spend. It is expected the trend will continue, resulting in the overall reduction of cash position to approximately £17m by Month 12.

Non-Current Liabilities have decreased by £1.8m in Month 3 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

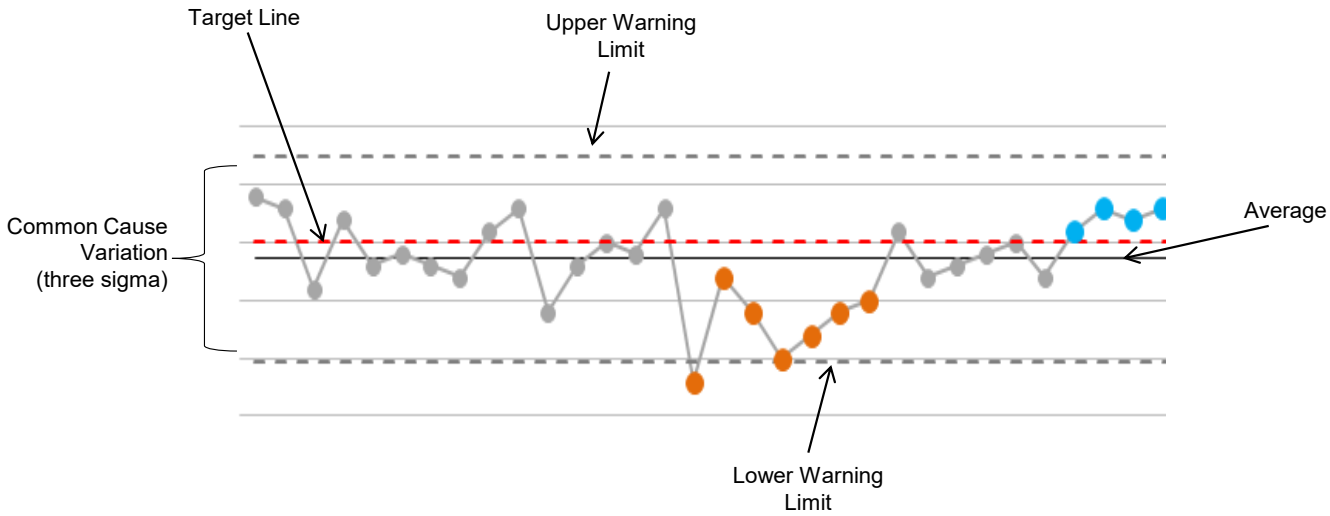
18.1

NHS Provider Licence Compliance Statements at July 2024 - Self-assessed, for submission to NHS

NHS North Bristol NHS Trust

Ref	Criteria	Comp (Y/N)	Comments where non-compliant or at risk of non-compliance
G3	Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)	Yes	A Fit and Proper Person Policy is in place. All Executive and Non-Executive Directors have completed a self-assessment and no issues have been identified. Further external assurance checks have been completed as appropriate and no issues have been identified.
G4	Having regard to NHS England Guidance	Yes	The Trust Board has regard to NHS England guidance where this is applicable. The Organisation has been placed in segment 3 of the System Oversight Framework, receiving mandated support from NHS England & Improvement. This is largely driven be recognised issues relating to cancer wait time performance and reporting.
G6	Registration with the Care Quality Commission	Yes	CQC registration in place. The Trust received a rating of Good from its inspection reported in September 2019. A number of mandatory actions were identified which are being addressed through an action plan. The Trust Board receives updates on these actions via its Quality Committee.
G7	Patient eligibility and selection criteria	Yes	Trust Board has considered the assurances in place and considers them sufficient.
C1	Submission of Costing Information	Yes	A range of measures and controls are in place to provide internal assurance on data quality, including an annual Internal Audit assessment.
C2	Provision of costing and costing related information	Yes	The trust submits information to NHS Improvement as required.
C3	Assuring the accuracy of pricing and costing information	Yes	Scrutiny and oversight of assurance reports to regulators is provided by Trust's Audit and Risk Committee and other Committee structures as required.
P1	Compliance with the NHS Payment Scheme	Yes	NBT complies with national tariff prices. Scrutiny by local commissioners, NHS England and NHS Improvement provides external assurance that tariff is being applied correctly. It should be noted that NBT is currently receiving income via a block arrangement in line with national financial arrangements.
P5	Constructive engagement concerning local tariff modifications	Yes	Trust Board has considered the assurances in place and considers them sufficient. It should be noted that NBT is currently receiving income via a block arrangement in line with national financial arrangements.
IC1	Provision of Integrated Care	Yes	The Trust is actively engaged in the ICS, and leaders participate in a range of forums and workstreams. The Trust is a partner in the Acute Provider Collaborative.
IC2	Personalised Care and Patient Choice	Yes	Trust Board has considered the assurances in place and considers them sufficient.
WS1	Cooperation	Yes	The Trust is actively engaged in the ICS and cooperates with system partners in the development and delivery of system financial, people, and workforce plans.
NHS2	Governance Arrangements	Yes	The Trust has robust governance frameworks in place, which have been reviewed annually as part of the Licence self-certification process, and tested via the annual reporting and auditing processes

Appendix 1: General guidance and 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

NHS North Bristol NHS Trust

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.

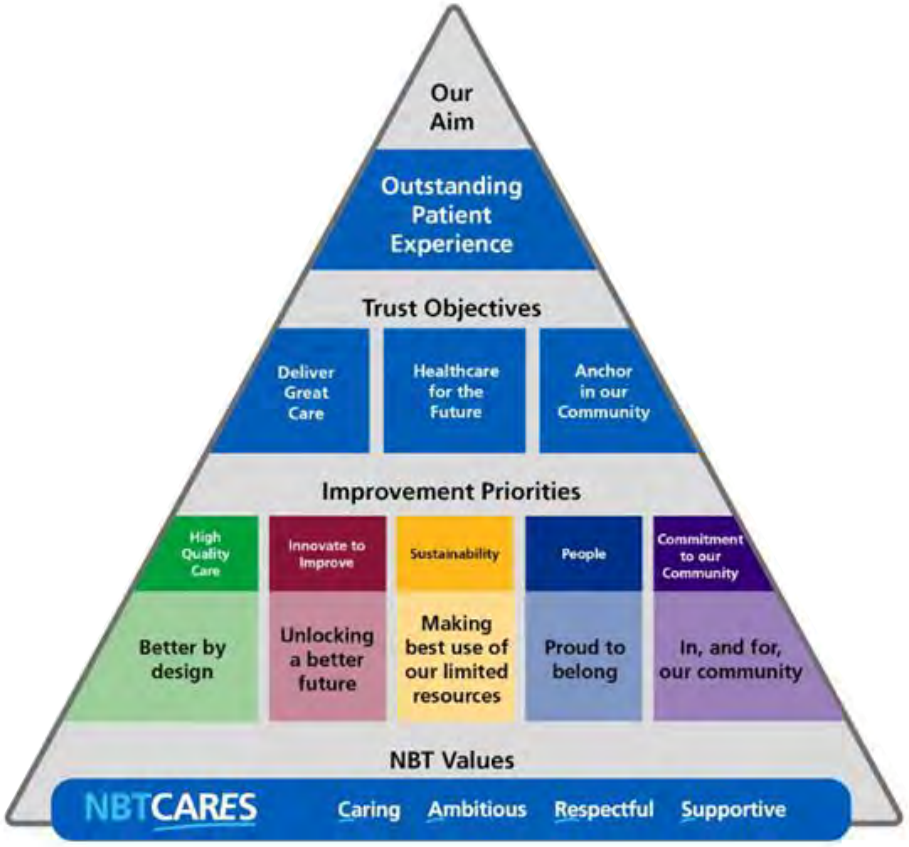
The Patient First approach is about what we do and how we do it and for it to be a success, we need you to join us on the journey.

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.



Patient	Innovate to Improve	Sustainability	People	High Quality Care	Commitment to our Community

18.1

Appendix 2: NBT Strategy – Patient First Improvement Priorities

NHS North Bristol NHS Trust

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

18.1

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

Abbreviation	Definition
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

Abbreviation	Definition
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

Report To:	Public Trust Board			
Date of Meeting:	25 July 2024			
Report Title:	Finance, Digital & Performance Committee (FD&PC) Upward Report			
Report Author:	Aimee Jordan-Nash, Senior Corporate Governance Officer and Policy Manager			
Report Sponsor:	Richard Gaunt, Non-Executive Director & Committee Chair			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
				X
Recommendations:	The Trust Board is asked to: • Receive the report for assurance and note the activities Finance & Performance Committee has undertaken on behalf of the Board. • Note the approved 2024/25 Capital Plan.			
Report History:	The report is a standing item to the Trust Board following each Committee meeting.			
Next Steps:	The next report will be received at Trust Board in September 2024.			

Executive Summary		
The following report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the 18 July 2024 FD&PC.		
Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	✓
	Innovate to Improve – *Unlocking a better future*	✓
	Sustainability – *Making best use of limited resources*	✓
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	
Link to BAF or Trust Level Risks:	Reports received at the meeting support the mitigation of various BAF and Trust Level risks, particularly those relating to patient flow, access to elective care, finance and IMT/Cyber security risks.	
Financial implications:	Business cases approved by the Committee are within the delegated limits as set out in the Trust's Standing Financial Instructions and Scheme of Delegation.	
Does this paper require an EIA?	No as this is not a strategy or policy or change proposal	
Appendices:	Appendix 1: Finance Report	

1. Purpose

1.1 To provide a highlight of the key assurances, escalations to the Board and identification of any new risks from the Finance and Performance Committee meeting held on 18 July 2024.

2. Background

2.1 The Finance and Performance Committee is a sub-committee of the Trust Board. It meets bi-monthly and reports to the Board after each meeting. The Committee was established to provide assurance to the Trust Board that there are robust and integrated systems in place overseeing the Trust's finance, IM&T, transformation, and performance and that they are in line with the organisation's objectives.

3. Key Assurances & matters for the attention of Trust Board

3.1 Operational performance summary

The Committee discussed the most recent performance data across unscheduled care and planned care, including diagnostics, referral to treatment (RTT), and cancer treatment:

- With regards to Unscheduled Care (UEC), achieving the year-end target of 76% remained challenged.
- With regards to Planned Care, the Trust was on track to achieve the national target for zero capacity breaches for patients waiting over 65-weeks for treatment, despite the impact of the recent junior doctor industrial action.
- With regards to Diagnostics, the Trust continued to achieve the internal target to clear >13-week breaches and was on track to deliver the national constitutional standard for diagnostic access. It was recognised that the improvement was across all specialities.
- 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), particularly in Breast, Skin and Urology.

The Committee thoroughly reviewed operational performance, commending the achievements in performance metrics while also recognising the necessity for continuous efforts to tackle challenges and enhance service delivery.

Discussion focused on the cancer performance, and it was acknowledged that the challenges related to capacity, demand and complex pathways. The Committee requested that additional information on the risks and mitigations within Breast, Skin and Urology be included in the next report to provide further understanding of the complexities and to ensure that challenging areas were not masked by the statistics.

The Committee received reassurance that the Trust was on track to achieve the performance targets in all areas except UEC, but recognised that it was not without risk.

3.2 No Criteria To Reside (NC2R) Deep Dive

The Committee received a No Criteria To Reside (NC2R) Deep Dive presentation from the Director of Performance. A series of slides were presented which set out:

- Understanding and agreeing demand
- Re-focusing through the 'harm lens':
    - Reframing the approach through quality and performance metrics.

    - Recognising the relationship between hospital stays, falls, and hospital-acquired infections. Discharging patients promptly is often the best course of action to prevent deconditioning and other complications.
- Addressing the existing backlog of patients.
- How NBT case-mix features:
    - The backlog and case mix at NBT exceed the current capacity, leading to discharge rates not keeping pace with new admissions.
    - There is need to align current capacity with the required capacity to clear the backlog and meet ongoing demand. The difference highlights the need for a faster pace of change.
    - NBT is a significant outlier in the region regarding capacity and demand management.
- The impact on 4-hour Emergency Department (ED) performance: There is an interdependent relationship between 4-hour ED performance, the percentage of NC2R patients, and bed occupancy. These factors form a dependency circle.
- 'Fixing a process Vs Fixing the problem':
    - The key interdependencies across three key areas include: acute referrals, assessment process, pathway waits.
    - The conversation needs to shift towards agreeing on true demand, right-sizing capacity, and measuring the impact on actual demand.
    - The need for recurrent capacity to address issues sustainably.

The Committee discussed the impact of NBT's patient case mix, which was made unique by the hospital's role as a major trauma centre and noted that NBT was an outlier for NC2R patients in comparison to the national average. The importance of mapping community service provisions relative to other institutions to better understand demand and capacity issues was noted. The Committee also discussed the need to design targeted interventions based on a clear understanding of the demand profile.

The Committee recognised the importance of framing the NC2R problem accurately to drive systemic solutions and collaboration at the local authority level to address capacity issues effectively.

The Committee also discussed reviewing internal measures to improve the NC2R position and to expedite patient discharge and alleviate pressure.

The Committee noted that the target to achieve 15% for NC2R patients remained challenging and required a strategic approach to resource allocation to better align with demand and capacity requirements in order to drive long-term improvements.

3.3 Winter Preparedness and Resilience Plan for 2024-25

The Committee were joined by Director of Urgent and Emergency Care who presented the Winter Preparedness and Resilience Plan for 2024-25 which had been developed in conjunction with cross divisional stakeholders and would form part of the wider system plan for Bristol North Somerset and South Gloucestershire (BNSSG). The key components to the plan were outlined and it was noted that the schemes were designed to increase capacity and improve operational resilience in order to mitigate risk and minimise the impact across the Trust.

It was noted that the plan had been developed as early as possible in the operational planning cycle to ensure time for implementation before winter, particularly where recruitment into winter roles is required.

Discussion focused on the development of a digital operations command centre and the benefits and opportunities it would provide and how it could be implemented given the significant capital and estate constraints.

The Committee also discussed the improvement work to expand the usage of Same Day Emergency Care (SDEC) through growing patient suitability rather than increasing operating hours. The importance of ensuring the maintenance of good services, such as the use of converted bathrooms, was also acknowledged.

The Committee endorsed the Winter Preparedness and Resilience Plan for 2024-25.

3.4 2024/25 Capital Plan

The Committee received the report which detailed the capital plan for 2024/25, including the £1.2million over-programming, and set out the prioritisation process and the highest risk items that have not been funded.

The Committee received assurance on the robust prioritisation process in place and approved the capital plan for the year 2024/25. It was acknowledged that the process focused on the deliverability of projects and included evaluating high-risk items and determining the feasibility of actions within the existing operational footprint.

The Committee noted the high-risk items that had not been funded as part of the planning process and requested that an update be provided at a future meeting on the items that remained unfunded.

3.5 Finance Report (Month 3)

The Committee received the Month 3 finance report which outlined:

- The Trust has delivered a £3.3m deficit, which is £1.5m worse than plan. The drivers of this were due to the industrial action, the under-delivery of savings and the variable pay pressures, including bank costs.
- Year to date the Trust has seen the impact of undelivered savings driving £3.9m of the adverse variance across both pay and non-pay. Overall, there is a £4.5m adverse. This also includes the impact of Junior Doctor industrial action in June of £0.4m.
- The Cost Improvement Plan (CIP) position showed £4.0m schemes fully completed, with a further £5.9m in implementation and planning, and a further £18.9m of schemes identified in the pipeline.
- Cash amounted to £39.9m, a reduction of £22.8m from Month 12, which was driven by the Trust underlying deficit and capital spend.

The Committee received reassurance that there was still confidence in achieving breakeven, however further mitigating action was required by divisions to bring pay back to plan. Discussion focused heavily on the mitigating actions and it was noted that the focus would be in three areas: recovering activity within divisions, realising savings and reviewing and reducing variable pay costs.

The full report is appended (see Appendix 1).

3.6 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 an update on the digital procurement project and received reassurance on the mitigations in place and that the project was on track despite the time constraints. The Committee welcomed the positive progress to overcome the technical challenges for the Careflow projects.

The Committee discussed the ongoing work with divisions to identify financial savings and demonstrate cost avoidance benefits. The Committee received reassurance that work was still progressing, and business cases were being developed so that they could progress quickly should further funding become available.

The Committee discussed the recent Synovis attack in London and received assurance on the internal cyber security measures in place and noted the plan to implement yearly training for board members and for those responsible for data risks. The Committee also received reassurance on the plan in place to ensure that all future contracts with suppliers included cyber protection.

3.7 Risk Report

The Committee received and discussed the relevant Trust Level Risks (TLR) across Finance, Performance, Service Delivery and IM&T and Board Assurance Framework (BAF) risks within its purview.

The Committee discussed the risks, acknowledging the increasing risk threshold and the requirement to capture the risks differently as a result. It was agreed that the report to the next meeting would identify additional detail on the resolution, mitigation or contingency for risks related to capital. This will then provide additional context and assurance on how the risks are being balanced.

3.8 **Other items:**

The Committee also received the following items for information:

- An update from the Business Case Review Group
- Noted the Quarterly Theatre Productivity Report KIP report.
- Noted a BWPC Contract Recommendation: Replacement CT Scanner and recommended it to Trust Board for approval.
- Noted the Key Worker Accommodation Project.
- Finance and Performance Committee forward work-plan 2024/25 and agreed to consider the inclusion of divisional KPI reporting.

4. Identification of new risks & items for escalation

4.1 None

5. Summary and Recommendations

5.1 The Trust Board is asked to:

- Receive the report for assurance and note the activities Finance & Performance Committee has undertaken on behalf of the Board.
- Note the approved 2024/25 Capital Plan

NHS North Bristol NHS Trust

19.1

Report To:	Finance, Digital & Performance Committee (FDPC)			
Date of Meeting:	25 July 2024			
Report Title:	Finance Report for June 2024 (Month 3)			
Report Author:	Simon Jones, Assistant Director of Finance – Financial Management			
Report Sponsor:	Glyn Howells, Chief Financial Officer			
Confidentiality (tick where relevant) *:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**	**Other exceptional circumstances**
*If any boxes above are ticked, paper may need to be received in *private.*				
Purpose of the report:	**Approval**	**Discussion**	**Information**	**Assurance**
			X	
Recommendations:	FDPC are asked to note the report for information.			
Report History:	Regular report to FPDC and Trust Board			
Next Steps:	Trust Board- July 2024			

Executive Summary

The financial plan for 2024/25 in Month 3 (June) was a deficit of £1.8m. The Trust has delivered a £3.3m deficit, which is £1.5m worse than plan. Year to date the Trust has delivered a £10.2m deficit, which is £4.5m adverse to the £5.8m deficit plan.

The Month 3 CIP position shows £4.0m schemes fully completed. The Trust has a further £5.9m in implementation and planning, and a further £18.9m of schemes identified in the pipeline.

Cash at Month 3 amounts to £39.9m, a reduction of £22.8m from Month 12. This is driven by the Trust underlying deficit and capital spend.

Key risks:

- At month 3 the cash balance is £11.6m below planned levels. Assuming a breakeven position at year end, the Trust expects to end the year with a cash balance of £17m
- Pay costs continue to exceed plan across the Trust. Currently the impact of this is mitigated by delayed investments but further mitigating action will be required by divisions to bring pay back to plan to ensure the Trust can break even.
- Continued under-delivery of CIP will put a break-even outturn for the year at risk.

Implications for Trust Improvement Priorities: *(tick those that apply and elaborate in the report)*	**Our Aim: Outstanding Patient Experience**	
	High Quality Care – *Better by design*	
	Innovate to Improve – *Unlocking a better future*	
	Sustainability – *Making best use of limited resources*	X
	People – *Proud to belong*	
	Commitment to our Community - *In and for our community*	

Link to BAF or Trust Level Risks:	N/A
Financial implications:	The financial implications are set out in the paper.
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No
Appendices:	Appendix 1: Finance Month 3 Slides

Finance Performance Report

Finance, Digital & Performance Committee: Month 3 2024/25

Author: Simon Jones (Assistant Director of Finance)

Sponsor: Glyn Howells (Chief Finance Officer)

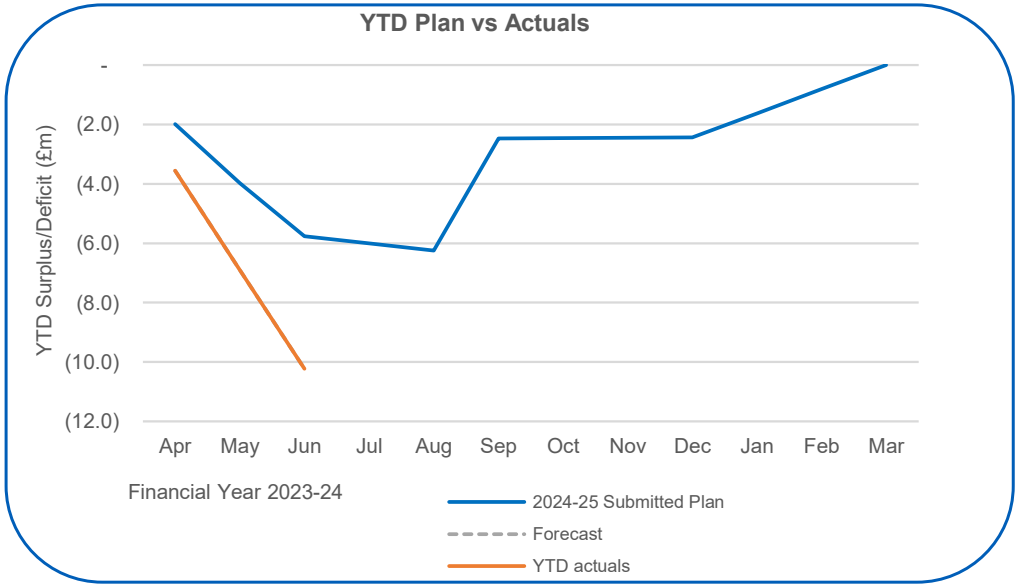
19.1

Finance Performance Report

Month 3 (May 2024)

Finance Summary

	Month 3			Year to date		
	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	69.5	71.0	1.4	203.6	206.7	3.1
Income	4.9	8.4	3.6	19.2	25.1	5.9
Pay	(46.4)	(48.0)	(1.5)	(139.6)	(144.7)	(5.1)
Non-pay	(29.7)	(34.7)	(5.0)	(89.0)	(97.3)	(8.3)
Surplus/(Deficit)	**(1.8)**	**(3.3)**	**(1.5)**	**(5.8)**	**(10.2)**	**(4.5)**



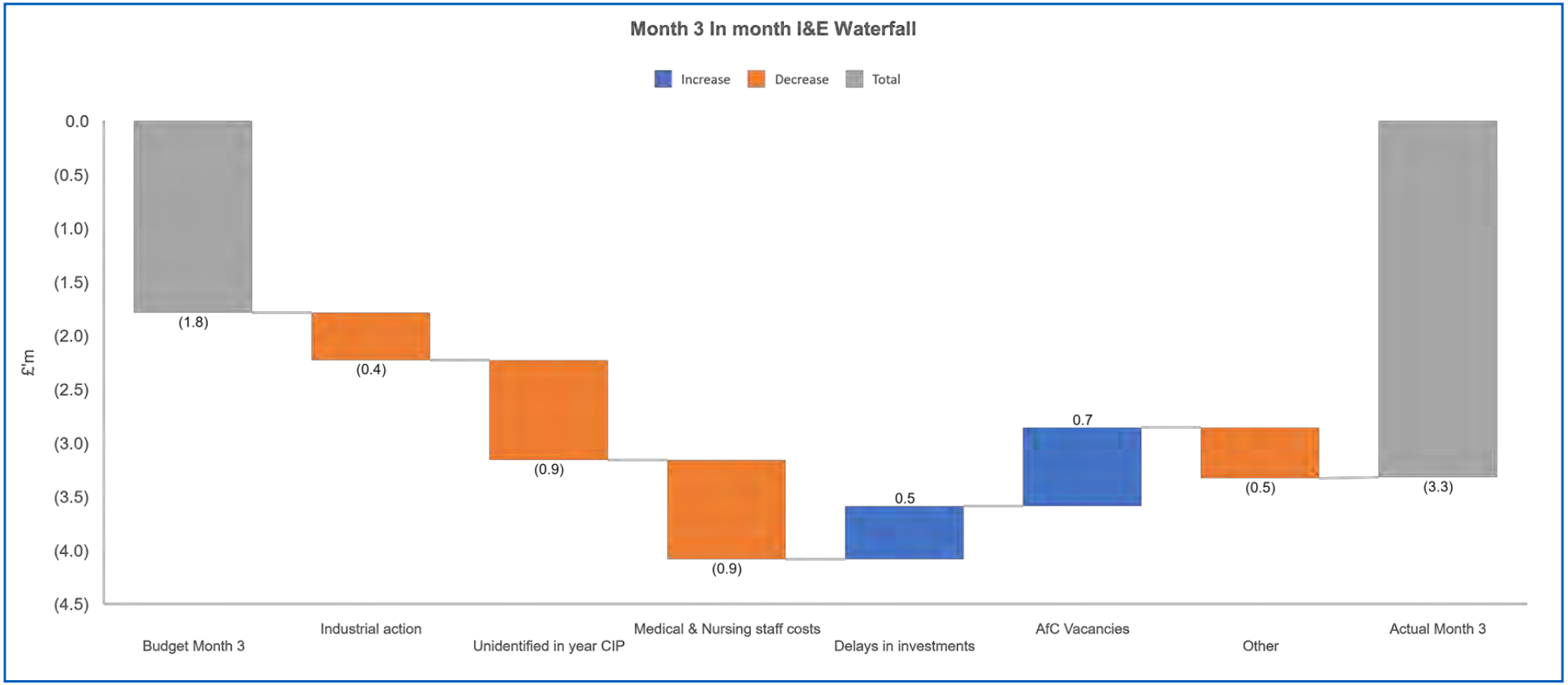
Key messages:

- The financial plan for 2024/25 in Month 3 (June) was a deficit of £1.8m. The Trust has delivered a £3.3m deficit, which is £1.5m worse than plan.
- Year to date the Trust has seen the impact of undelivered CIP (£3.9m adverse) across both pay and non-pay, creating a £4.5m adverse overall variance. This also includes the impact of Junior Doctor industrial action in June (£0.4m), which we expect to be funded but there have been no confirmation as yet from NHS England.
- Whilst the Trust awaits the formal publication of 2024-25 ERF performance from the National team (SUS), based on the ERF activity delivered to date the Trust expects to be in line with the published baselines and therefore has aligned the Trust wide ERF with plan year to date.
- The Trust cash position at Month 3 is £39.9m, a reduction of £22.8m from Month 12. This is driven by the Trust underlying deficit and capital spend.
- The Trust has delivered £4.0m of completed Cost Improvement Programme (CIP) schemes at month 3. There are a further £5.9m of schemes in implementation and planning that need to be developed, and £18.9m 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 3 the cash balance is £11.6m below planned levels. Assuming a breakeven position at year end, the Trust expects to end the year with a cash balance of £17m
- Pay costs continue to exceed plan across the Trust. Currently the impact of this is mitigated by delayed investments but further mitigating action will be required by divisions to bring pay back to plan to ensure the Trust can break even.
- Continued under-delivery of CIP will put a break-even outturn for the year at risk.

Income and Expenditure: In month I&E waterfall



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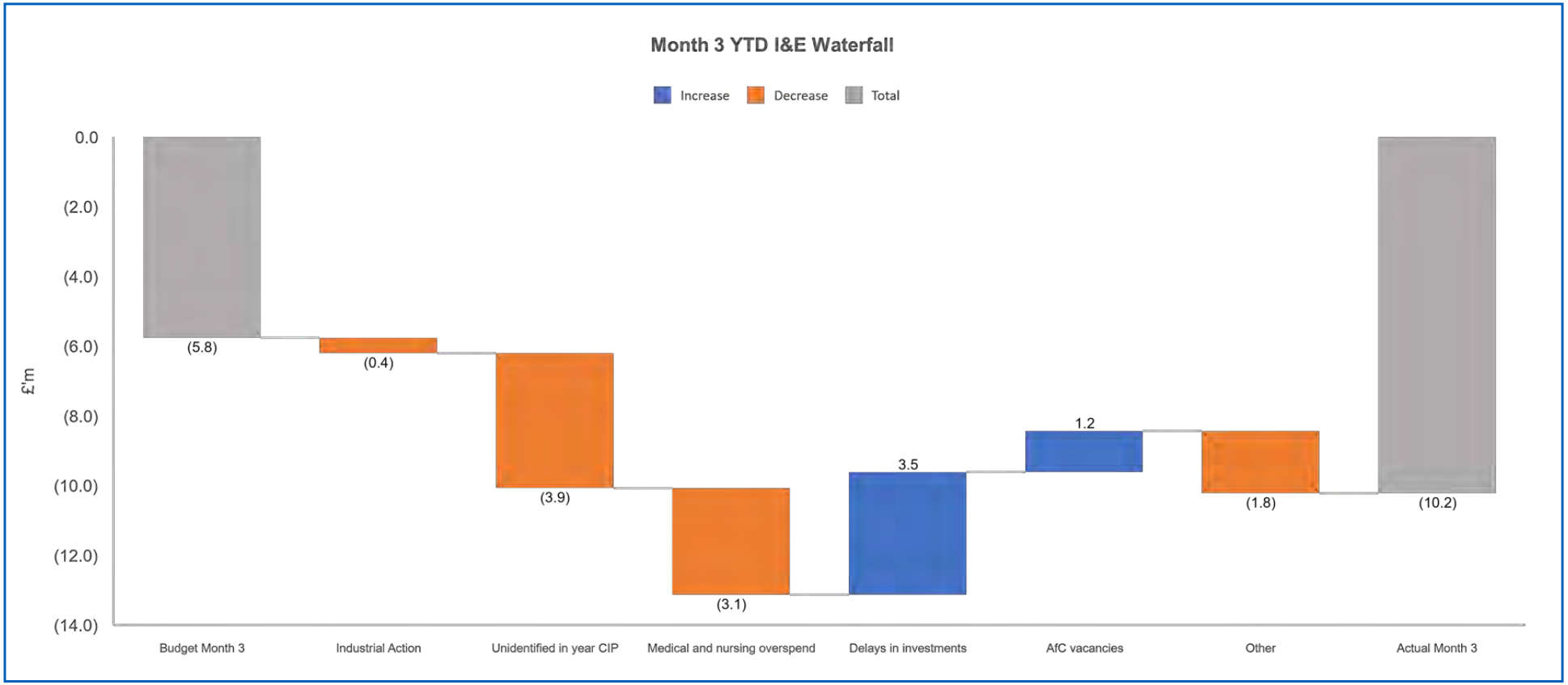
Income and Expenditure: Year to date I&E waterfall



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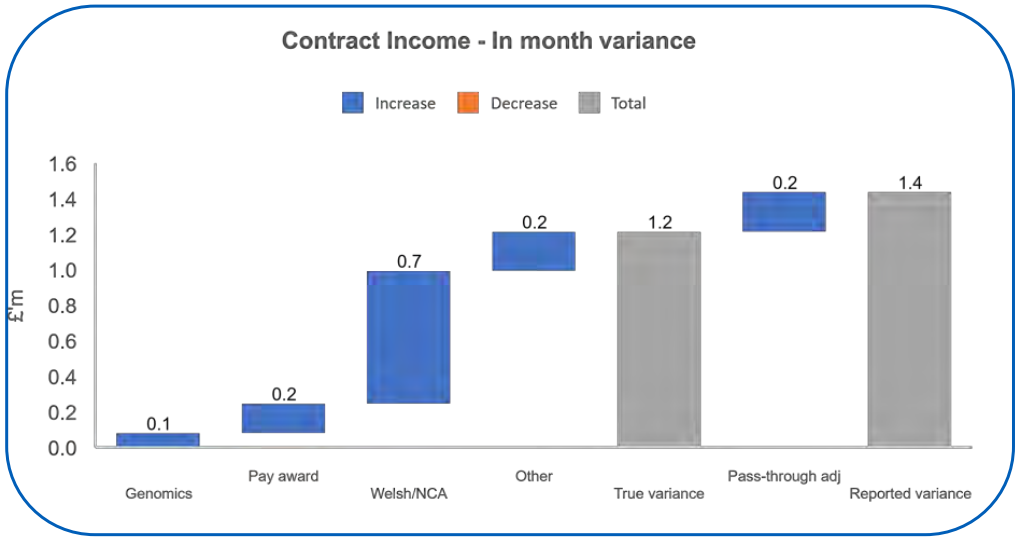
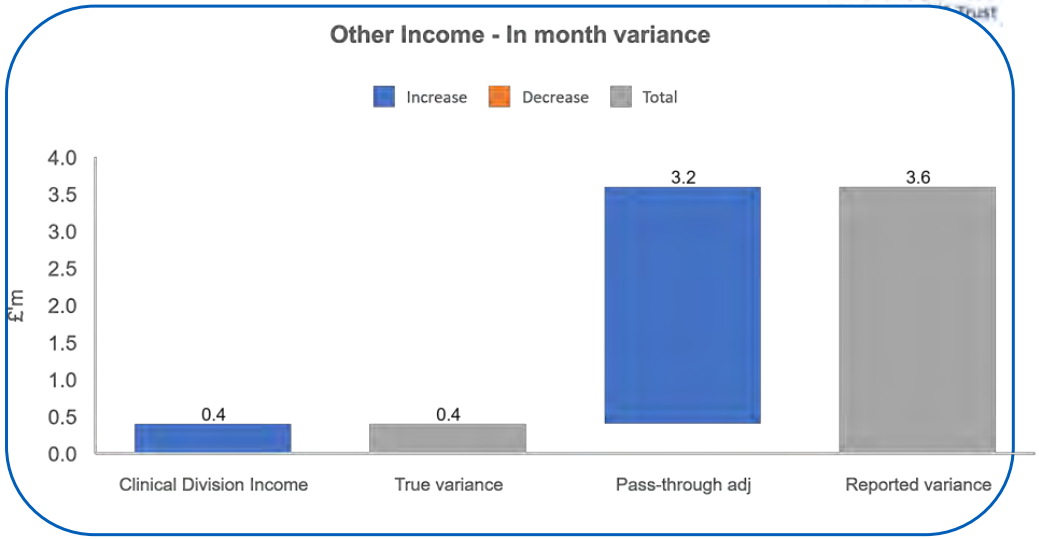
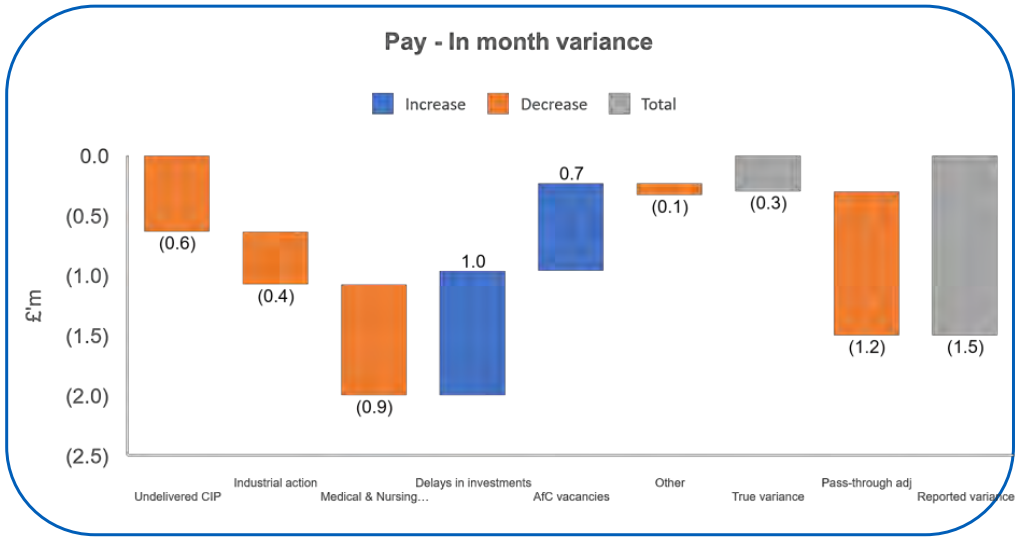
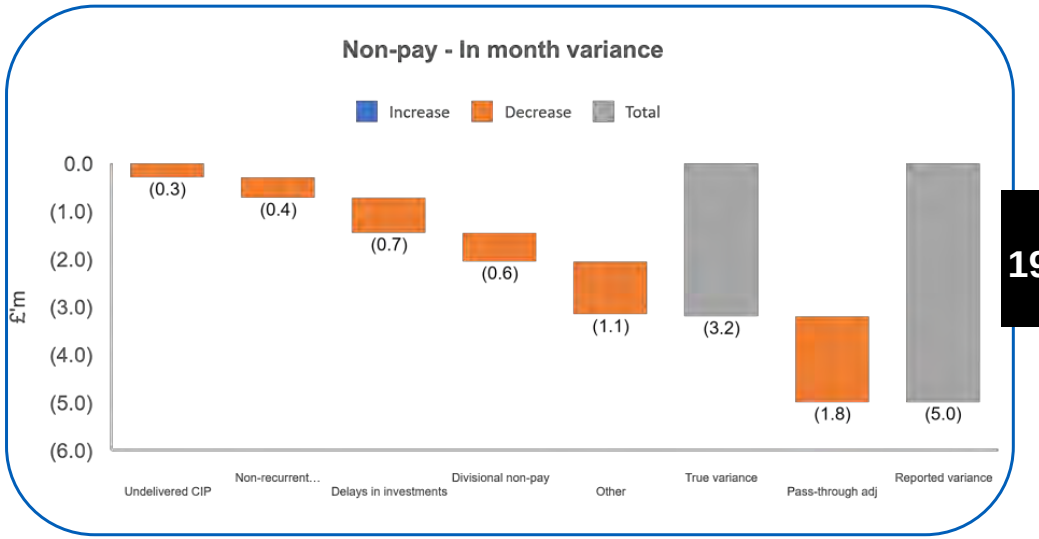
Finance Summary – In Month





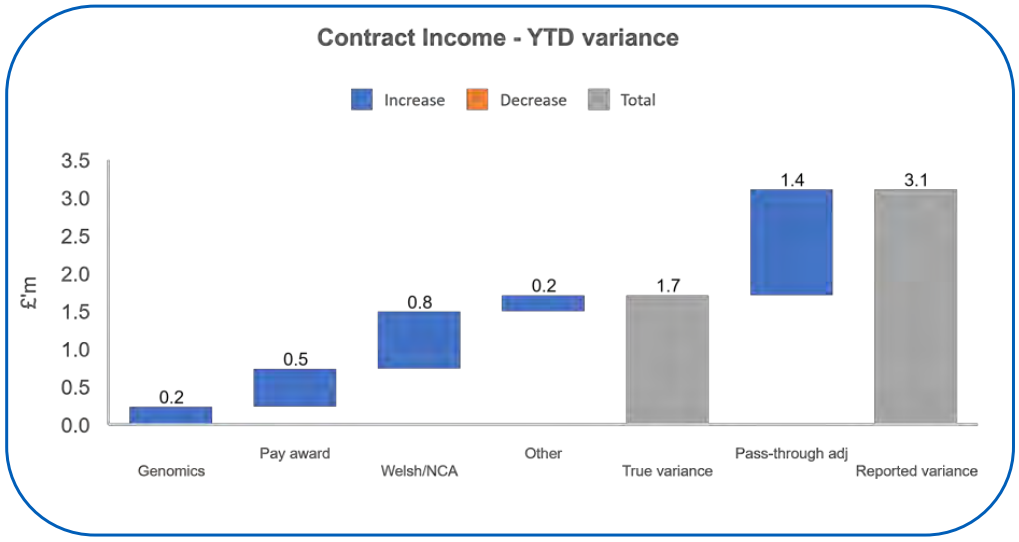


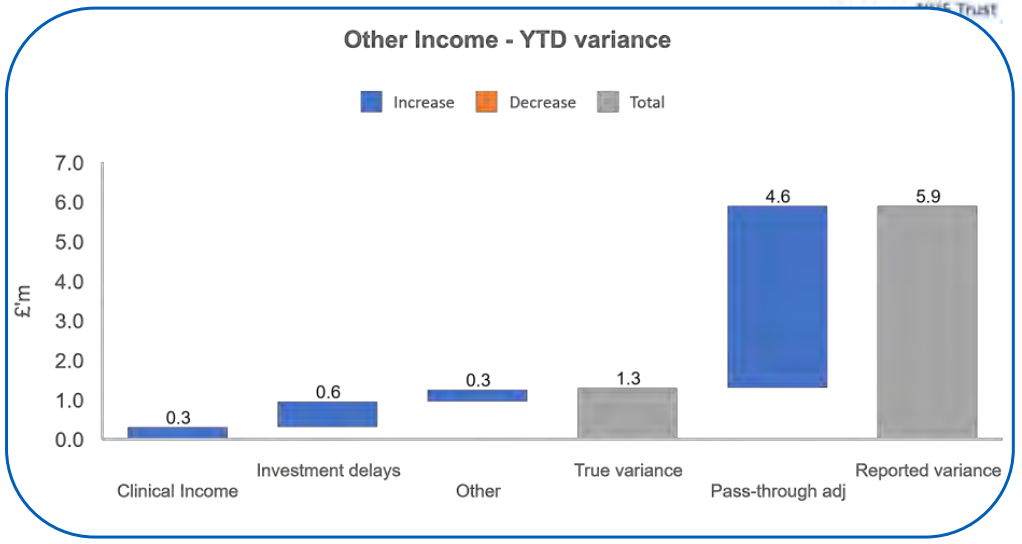


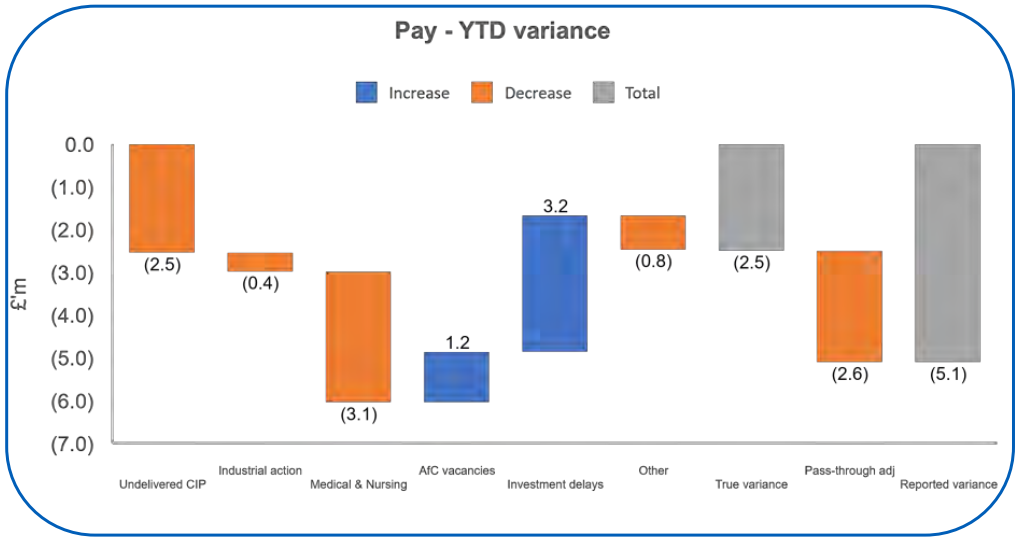
*Note: Further explanation of variances are provided on slides 8-11

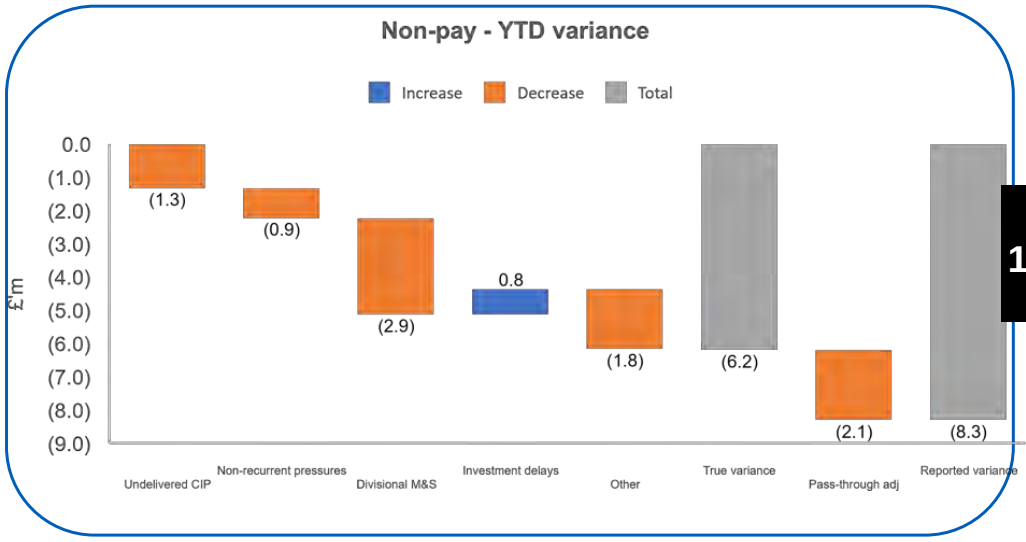
19.1

Finance Summary – Year to date









*Note: Further explanation of variances are provided on slides 8-11

19.1

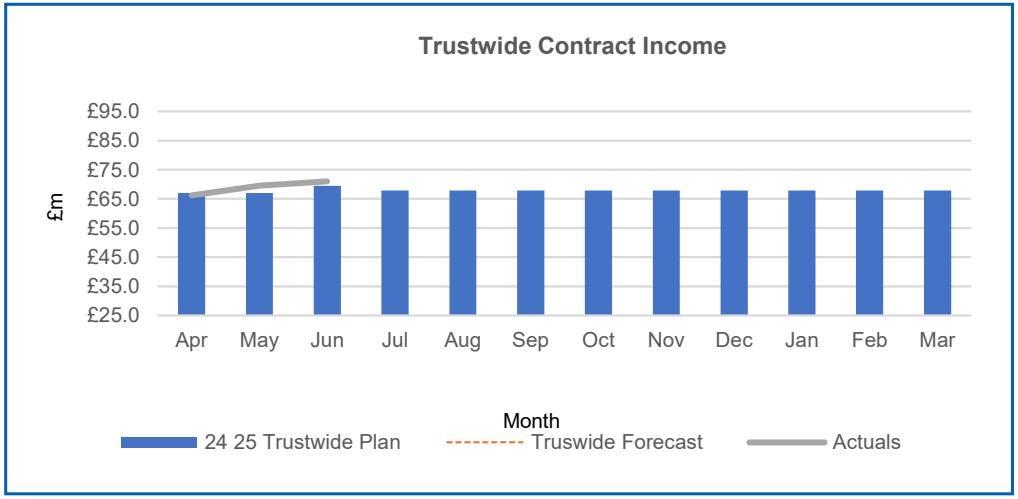
Finance Summary – Pass-through adjustments to reported variance

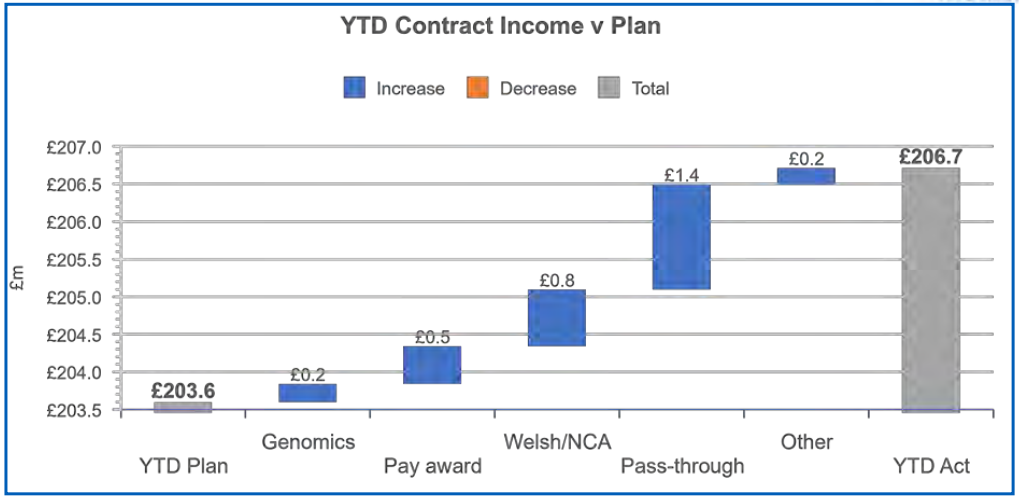
	In month					Year to date				
	Contract Income	Income	Pay	Non-pay	Total	Contract Income	Income	Pay	Non-pay	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Reported variance	**1.4**	**3.6**	**(1.5)**	**(5.0)**	**(1.5)**	**3.1**	**5.9**	**(5.1)**	**(8.3)**	**(4.5)**
Adjustments to remove:										
NHS Plan adjustments	0.0	4.0	(1.3)	(2.4)	0.3	0.0	7.0	(2.7)	(3.8)	0.5
Research & Education funding	0.0	(0.7)	0.0	0.8	0.1	0.0	(2.4)	0.0	2.4	0.1
High cost drugs	0.7	0.0	0.0	(0.7)	0.0	(0.2)	0.0	0.0	0.2	0.0
HCTED	0.5	0.0	0.0	(0.5)	0.0	0.8	0.0	0.0	(0.8)	0.0
Other (<£0.5m)	(1.0)	(0.2)	0.0	1.1	0.0	0.3	(0.0)	(0.0)	(0.2)	(0.0)
True variance	**1.2**	**0.4**	**(0.3)**	**(3.2)**	**(1.9)**	**2.3**	**1.3**	**(2.5)**	**(6.2)**	**(5.0)**

19.1

- The tables above highlight items within the position that have an equal and offsetting impact within income and expenditure.
- As these have a net nil 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: £1.44m fav

YTD: £3.11m fav

In month

- In month Trustwide Contract Income is £1.4m favourable to plan.
- This is driven by additional income of £0.7m with respect to Welsh activity (predominantly thrombectomy) following the Quarter 4 true up. Other upsides include the consultants pay award £0.2m and Genomics £0.1m.

Year to date

- Year to date the Trustwide Contract Income position is £3.1m favourable to plan.
- This is driven by additional pass-through income of £1.4m (mainly high cost drugs and devices), along with Welsh income of £0.8m, the consultants pay award £0.5m (backdated to April) and Genomics income of £0.2m not in plan.

19.1

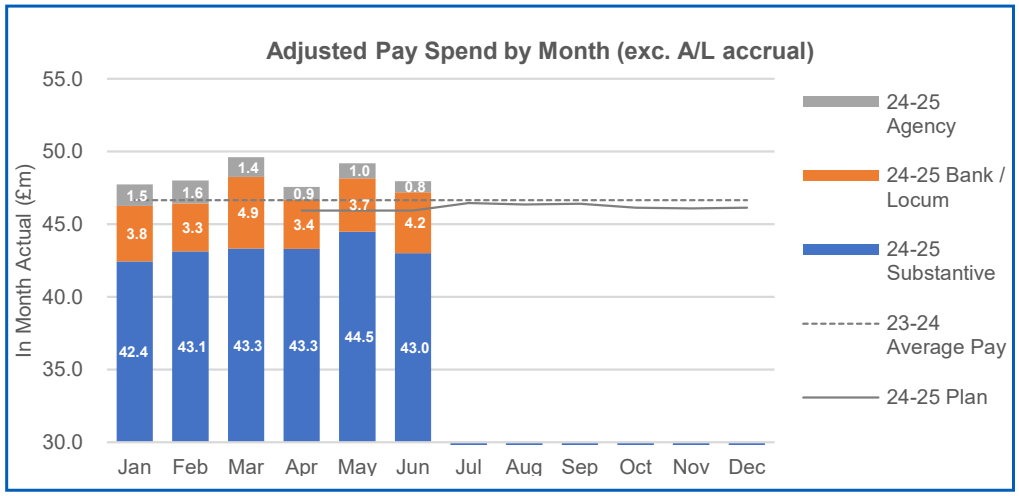
Trend Analysis

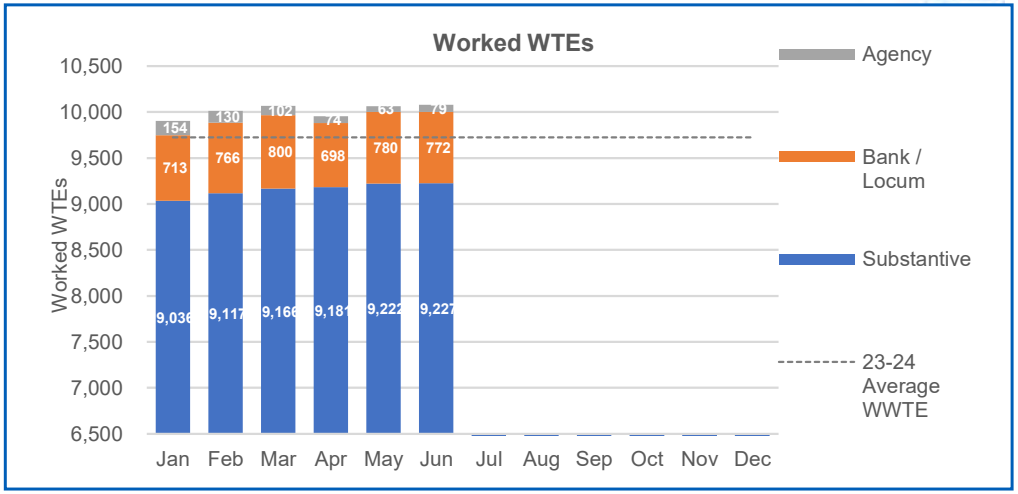
Contract Income trend shows a £1.4m increase on Month 2 and a £3.1m increase on the YTD average.
The favourable variance is driven by additional Genomics income which is mainly pass through, additional Welsh activity following a Quarter 4 true-up, upside for High Cost Drugs and Devices, consultants pay award and several additional SDF allocations including SWAG and Core 24 (Psych Liaison out of hours).

ERF Analysis

Whilst we await the publication of 2024-25 ERF performance from the National team (SUS), based on the ERF activity delivered to date we expect to be in line with the published baselines and therefore we have aligned the Trust wide ERF with plan year to date.

Pay Overview





*Note: Average 23-24 pay has been inflated by 5.5% for Consultant staff and adjusted for one-offs throughout the year (pensions, non-consolidated pay award, annual leave accrual)

Pay

In month spend: £48.0m

In month: £1.5m adv

YTD: £5.1m adv

In month

- Trust wide pay spend is £48.0m driving a £1.5m adverse variance to plan. New funding adjustments offset in Non-NHS income was £1.2m adverse therefore revised pay variance is £0.3m adverse to plan. The Trust has seen the impact of increased nursing and medical spend above budget (£0.9m adverse) due to increased staffing to cover enhanced care, escalation and safer staffing. The in month delivery of pay CIP is £0.6m adverse. Industrial action took place in June which has caused an adverse variance of £0.4m on pay. This is offset by delays in investments (£1.6m favourable) and agenda for change vacancies (£0.7m favourable).
- In month agency spend is £0.7m and bank/locum £4.2m. Slides 22 and 23 in the appendix have a more detailed breakdown.

Year to date

- Year to date Trust wide pay is £144.7m which is £5.1m adverse to plan. Excluding the adjustment for pass-through items, the revised position is £2.5m adverse to plan. Undelivered CIP is £2.5m adverse with overspends on medical and nursing pay £3.1m adverse. In month, the Trust saw industrial action which has caused a £0.4m adverse variance to the pay position. This is offset by delayed investments (£3.2m favourable) and vacancies (£1.2m favourable).

Trend Analysis

(further analysis shown in the Appendix)

- In June, the pay spend was £48.0m compared to the pay in May of £49.2m, a £1.2m decrease. The decrease was in substantive medical driven by the payment of the 24/25 element (backdated) in Month 2. WTE's in June were 10,078 compared to 10,064 in May (agency increased by 16, bank/locum decreased by 8 and substantive increased by 5).
- There has been a £1.4m increase on the 2023/24 year to date average (mean) which is predominantly driven by substantive in ASCR, Medicine and NMSK. WTEs have increased by 352 on the prior year average which is predominantly driven by substantive recruitment (ASCR, Medicine & CCS) and offset partly in reduction in agency use.

19.1

Industrial Action Overview

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
AFC Costs			0.0									
Consultants Costs			0.5									
Pay reduction			(0.1)									
Total cost			0.4									

Industrial action dates 2024/25

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Consultant													
Junior Doctor			4	1									**5**
Nursing													
Total			**4**	**1**									**5**

Industrial action

In month spend: £0.5m

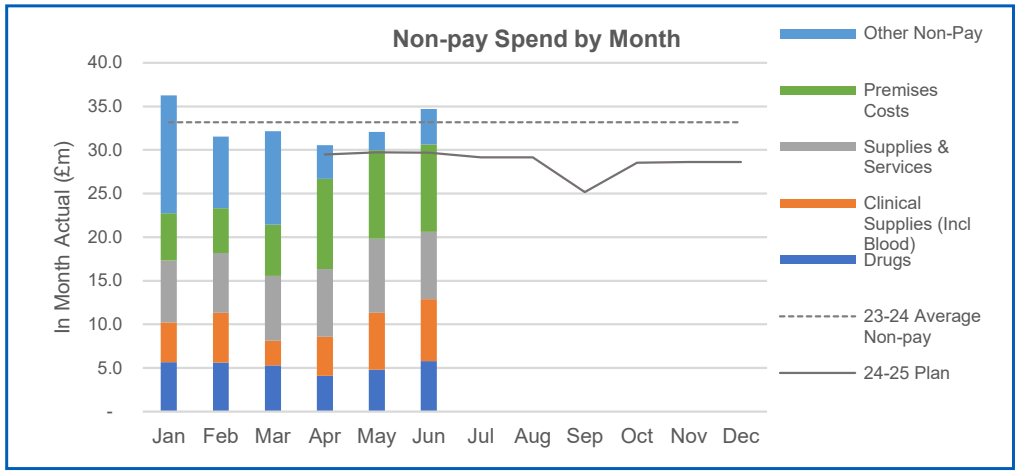
In month deductions: £0.1m

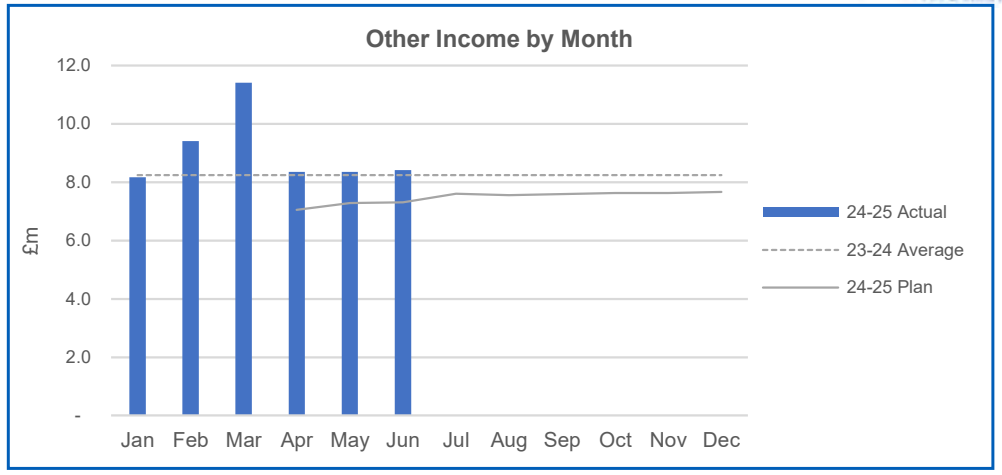
YTD spend: £0.4m

- The Trust has seen industrial action from junior doctors in June
- The graph shows that the Trust has seen salary reductions of £0.1m for all industrial action in 2024/25 so far.
- The additional cost of covering industrial action has been £0.5m with this largely being for medical staff, mainly consultants, covering junior doctor shifts.
- The Trust has agreed a range of enhanced rates during industrial action periods to ensure the hospital is safe for patients.
- The Trust saw industrial action from 27th June to 1st July.
- No further dates for industrial action have currently been agreed post July.

19.1

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: £29.7m

In month: £5.0m adv

YTD: £8.3m adv

In month

- Trustwide non-pay spend was £5.0m adverse offset by pass-through items of £1.8m. The revised variance is therefore £3.2m adverse. This is driven by unidentified CIP (£0.3m), delays in investments due to the non-pay/pay split of funding claimed (£0.7m), non-recurrent mitigations (£0.4m) and divisional non-pay overspends (£0.6m). The remaining £1.1m is made up of smaller overspends in non-pay.

Year to date

- Year to date Trustwide non-pay is £97.3m and £8.3m adverse to plan. Excluding pass-through items the revised position is £6.2m adverse. This adverse position is driven primarily by the in month position which is mentioned above as well as increased medical and surgical consumable spend to deliver activity, and multiple smaller non-pay variances. Divisions are currently reviewing the detail behind the drivers for this overspend on non-pay. In year delivery CIP is £1.3m adverse to plan year to date.

Non-NHS Income

In month income: £8.4m

In month: £3.6m fav

YTD: £5.9m fav

In month

- In month Non-commissioned income was £8.4m creating a £3.6m favourable variance. The favourable position was driven primarily by £3.2m new funding adjustments. The remaining £0.4m favourable variance is driven by increased clinical division income within CCS, Medicine and NMSK.

Year to date

- Year to date Non-commissioned income is £25.1m creating a £5.9m favourable variance. The is due to new funding in the year-to-date position since the final plan was signed off in May and pass through items (£4.6m). The remaining £1.3m favourable variance is driven by investment delays and increased clinical income.

19.1

Savings

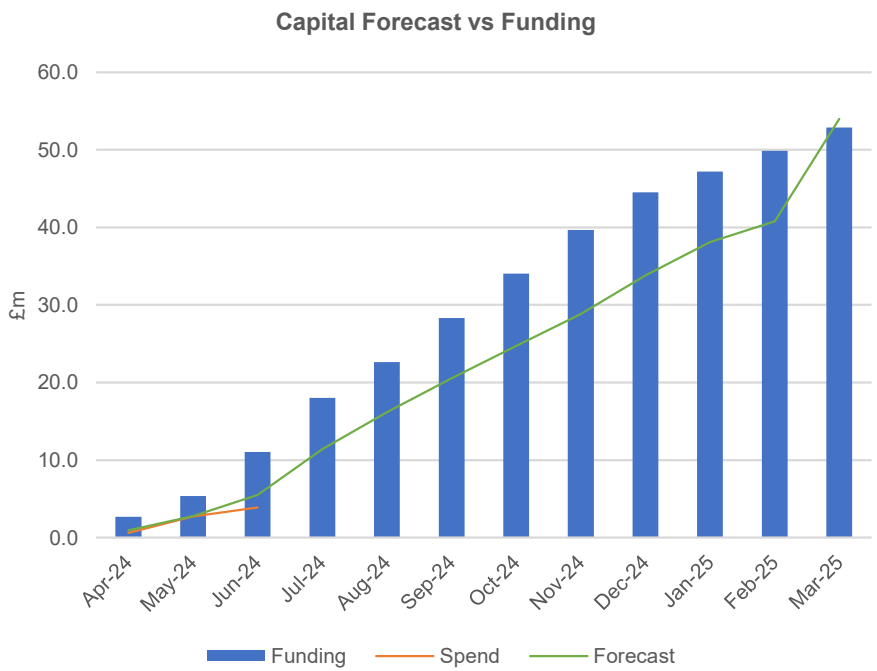
Division (£'m)	FYE Target	Completed Schemes	Schemes in Implementation	Schemes in Planning	Total FYE	Variance FYE	Schemes in Pipeline	Total FYE inc Pipeline
ASCR	5.8	0.9	0.0	2.9	3.9	(1.9)	1.5	5.3
CCS	4.8	1.2	0.0	0.4	1.6	(3.3)	1.7	3.2
MED	4.1	0.2	0.0	0.5	0.7	(3.4)	1.9	2.6
NMSK	3.7	0.5	0.9	0.7	2.0	(1.7)	1.2	3.2
WCH	1.6	0.7	0.0	0.2	0.9	(0.8)	0.4	1.2
FAC	2.5	0.1	0.0	0.1	0.2	(2.3)	1.2	1.4
Corp	1.9	0.5	0.0	0.2	0.7	(1.1)	1.1	1.8
Central	4.3	0.0	0.1	0.0	0.1	(4.2)	10.1	10.1
Total	**28.7**	**4.0**	**0.9**	**5.0**	**10.0**	**(18.7)**	**18.9**	**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 FYE	0.6	0.7	2.7										**4.0**

- The CIP plan for 2024/25 is for savings of £28.7m with £4.7m planned to be delivered by Month 3.
- At Month 3 the Trust has £4.0m of completed schemes on the tracker. There are a further £5.9m of schemes in implementation and planning leaving a remaining £18.7m of schemes to be developed, against this we have £18.9m 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 £4.0m 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 3 the Trust is showing a £3.9m adverse variance for delays due to in year delivery of CIP, which reflects the fact that most schemes delivered in month 3 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.

Capital

Expenditure	FY Funding (£m)	FY Forecast (£m)	FY Forecast Variance (£m)	YTD Spend (£m)
Divisional Schemes	3.8	3.8	0.0	0.1
CRISP Schemes	3.7	4.6	0.9	0.4
IM&T Schemes	2.7	2.6	(0.1)	0.1
Medical Equipment	3.2	3.6	0.4	(0.3)
Sustainability Schemes	1.9	1.9	0.0	0.0
Core Spend	**15.3**	**16.4**	**1.1**	**0.3**
Imaging Network PDC	0.2	0.2	0.0	0.0
Digital Pathology PDC	0.1	0.1	0.0	0.0
Subtotal	**15.6**	**16.7**	**1.1**	**0.3**
Elective Centre	37.3	37.3	0.0	3.6
Total	**52.9**	**54.0**	**1.1**	**3.9**
Charity & Grant Funded	0.5	0.5	0.0	0.1
Leases	10.9	10.9	0.0	0.0
PFI Lifecycle	1.5	1.5	0.0	0.1
Grand Total	**65.7**	**66.9**	**1.1**	**4.1**



19.1

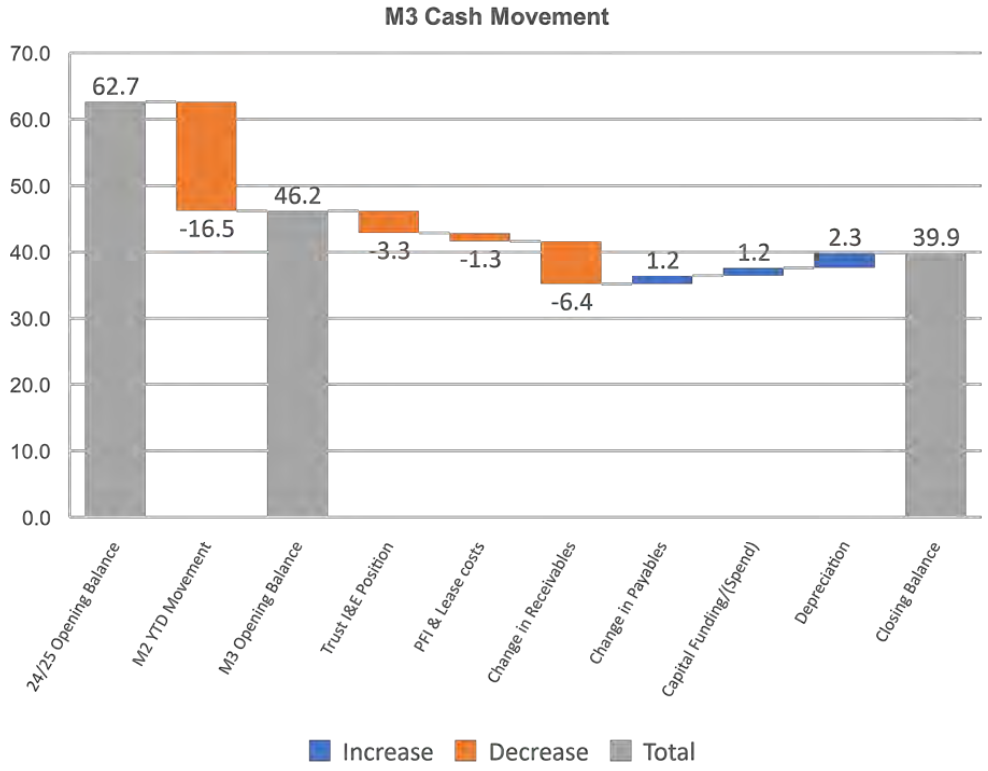
- The capital plan is currently over-programmed by £1.1m against projects funded within the Trust's core capital envelope and by national funding. The current funding position includes an additional £7m of capital funding compared to last month, £5m of system funding and £2m of brokered funding agreed with AWP, which are both to be approved at the July ICB Board meeting. This additional capital has funded previously identified £5m of overprogramming, and allowed further schemes, predominantly Medical Equipment to be brought into the capital plan.
- While the capital plan is currently over-programmed, the CPG is confident that it can be mitigated back to funding envelope by the end of financial year.
- The spend year to date is driven by the Elective Centre project, £3.6m, with spend on Fire Integrity, £0.3m, and EPMA, £0.2m, the other projects of note. The negative position against Medical Equipment is due to a credit note received.
- Overall spend on the Elective Centre project is currently £14.1m, of which £10.1 relates to the main construction contract. Year to date spend is £3.6m, of which £3.2m is on the main construction contract. The remaining project contingency is £1.9m.

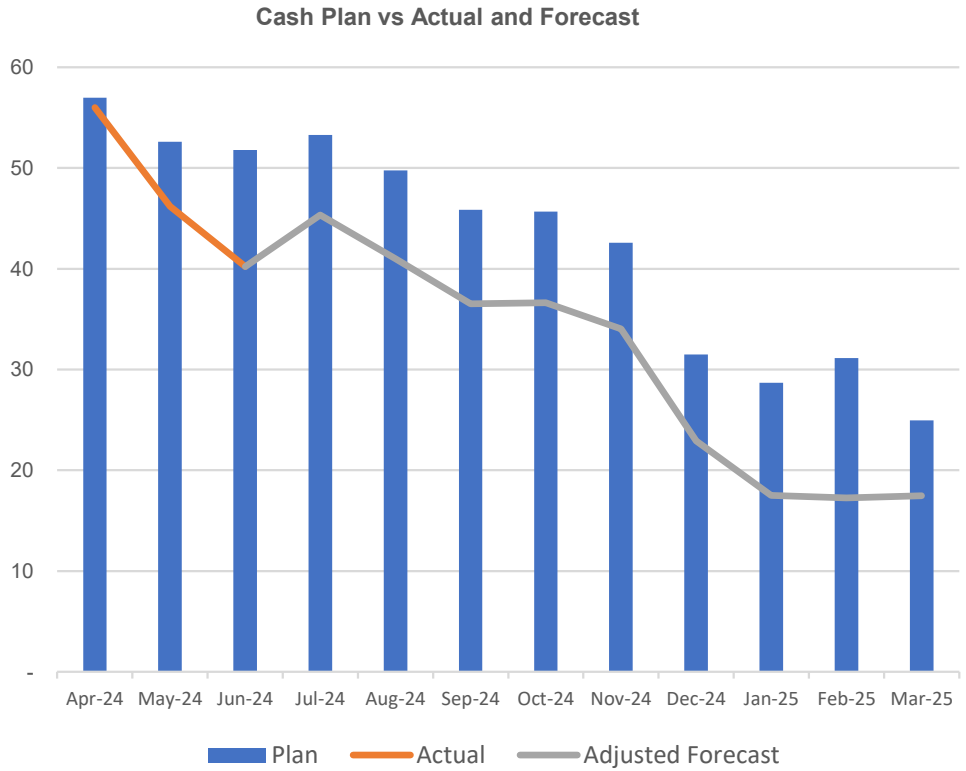
Capital – Large Project Update

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	0.8	0.0	3.7	(0.5)
Mortuary Extension	2.3	0.2	2.1	0.0	2.3	0.0
EPMA	2.6	0.4	1.7	0.3	2.4	0.2

- The above table presents the current capital projects with the budget of over £1.0m.
- Revised Business Cases to recognise the expected spend on the CT Scanner, IR3 Biplane and Fire Integrity are expected to be brought through Business Case Review Group.
- The budget figure for the MRI Scanner reflects the value on the case recommended for approval by Business Case Review Group at the beginning of July, which is currently with the CEO and CFO for final sign off.

Cash Position



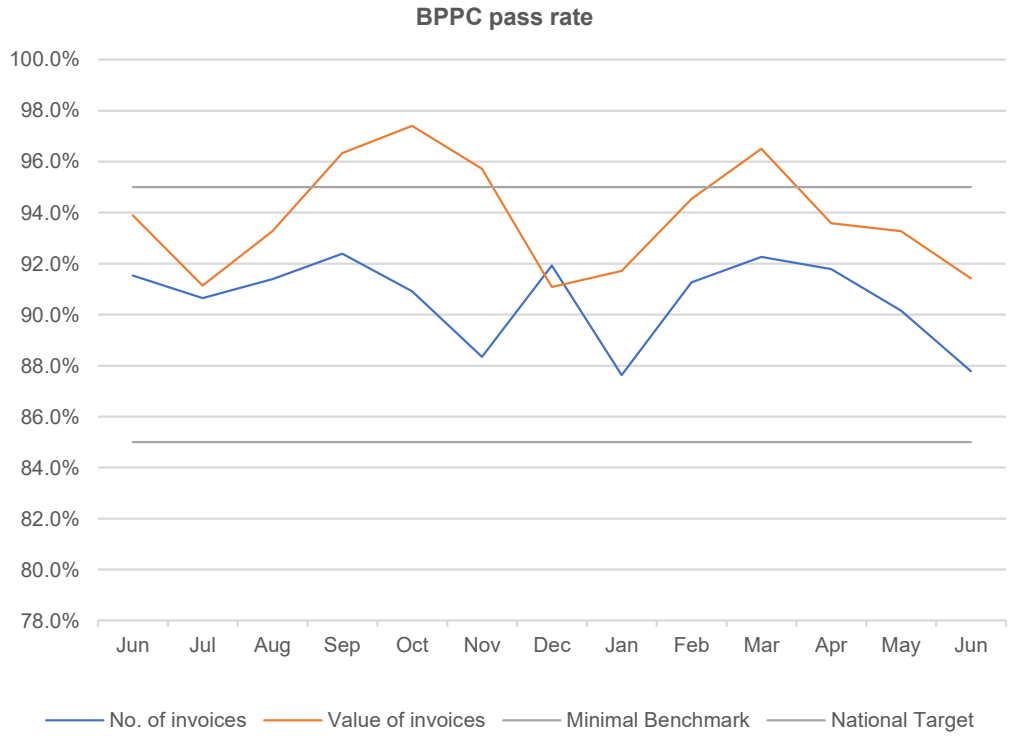


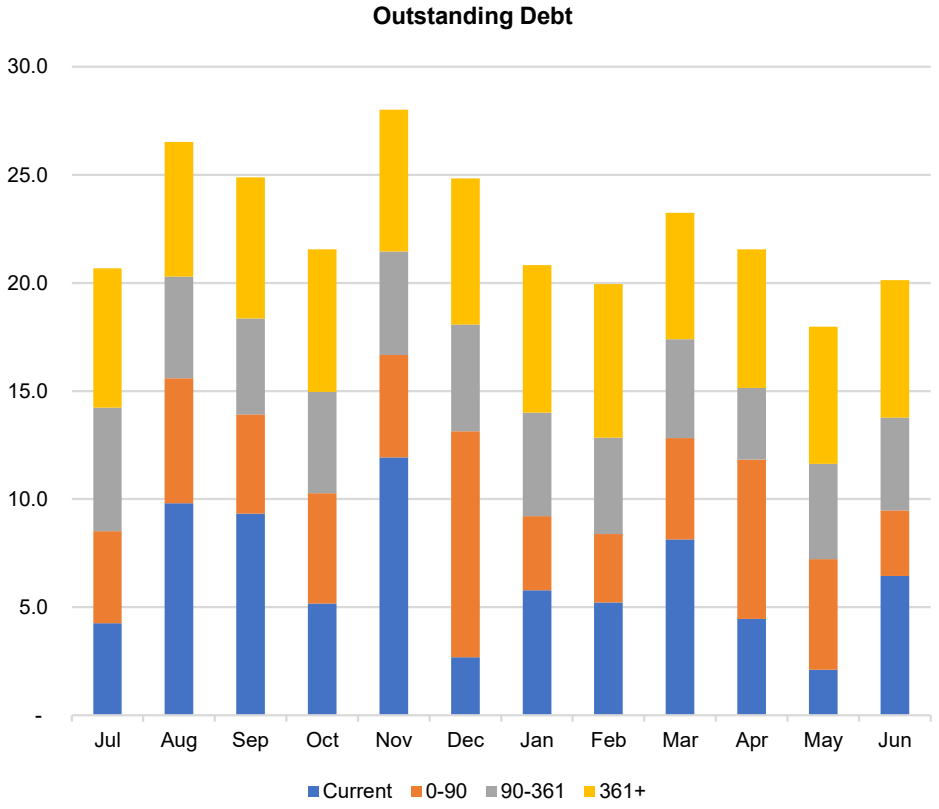
19.1

- In month cash is held at £39.9m, which is a £6.3m decrease from Month 2 driven by I&E deficit as well as increase in receivables, which is a timing issue expected to resolved by end of calendar year.
- The in-month capital spend has a positive impact on the cash position due to receipting of PDC funding to cover expenditure on Elective Centre in the first quarter of the year.
- The cash balance has decreased by £22.8m year to date which is driven by the I&E deficit, capital expenditure and delays in payment of invoices relating to 23/24.
- It is expected the Trust will break even, resulting in the overall reduction of cash position to approximately £17m. This is a reduction of £7m from plan due to 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





19.1

- BPPC pass rates continues to outperform minimum benchmark of 85%. In June, the value performance has decreased due to delays in invoice approval for large value invoices, which is being addressed by AP Team in July.
- The overall downward movement in debt is a result of reduced debts with UHBW & NHSE.
- 57% of the debt over 361 days (£3.6m) relates to Overseas patients.

Risks & Mitigations

Issue	YTD Position £m	Risk	FOT £m	Mitigations	FOT £m	Actions
Under delivery of in year savings	(3.9)	Continued under delivery of CIP	(18.0)	Further development and delivery of pipeline items, with CIP Board holding divisions and directorates to account.	18.0	Continued organisational focus on CIP identification and delivery
Actions to close the gap (planning assumption)	0.0	Trust unable to recurrently reduce cost pressures	(5.0)	Non-recurrent underspends	5.0	
Non-recurrent Income (planning assumption	0.0	Trust unable to identify source of income	(5.0)	Continued engagement with commissioners	5.0	Continued engagement with commissioners to identify additional income opportunities
Industrial action	(0.4)	Junior Doctor industrial action	(1.0)	Industrial action funding	1.0	NHSE to provide funding for additional costs of industrial action
		DIEP activity	(0.8)	Balance sheet mitigations	0.8	Regional funding
Other	(0.1)					
Total	**(4.5)**		**(29.8)**		**29.8**	

- 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 are currently 7.7m of CIP schemes either planned, in implementation or completed leaving a £21m risk remaining.
- 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.
- It is currently still expected that all risks will be fully mitigated to deliver a breakeven outturn at year end.

19.1

Appendix – Financial Statements

Income and Expenditure: Main Heading

	Month 3			Year to Date		
	Budget	Actual	Variance	Budget	Actuals	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	69.5	71.0	1.4	203.6	206.7	3.1
Other Income	4.9	8.4	3.6	19.2	25.1	5.9
Total Income	**74.4**	**79.4**	**5.0**	**222.8**	**231.8**	**9.0**
AHP's and STT's	(7.2)	(6.8)	0.3	(21.2)	(20.5)	0.7
Medical	(13.9)	(15.1)	(1.1)	(41.3)	(42.7)	(1.4)
Nursing	(17.7)	(17.6)	0.1	(52.7)	(52.7)	0.1
Other Non Clinical Pay	(7.7)	(8.5)	(0.8)	(24.3)	(28.8)	(4.5)
Total Pay	**(46.4)**	**(48.0)**	**(1.5)**	**(139.6)**	**(144.7)**	**(5.1)**
Drugs	(5.2)	(5.8)	(0.6)	(15.5)	(14.7)	0.9
Clinical Supplies (Incl Blood)	(6.8)	(7.1)	(0.2)	(17.0)	(18.1)	(1.1)
Supplies & Services	(6.5)	(7.7)	(1.2)	(19.0)	(24.0)	(5.0)
Premises Costs	(9.8)	(10.0)	(0.3)	(28.7)	(30.5)	(1.8)
Other Non-Pay	(1.4)	(4.1)	(2.7)	(8.8)	(10.0)	(1.2)
Total Non-Pay Costs	**(29.7)**	**(34.7)**	**(5.0)**	**(89.0)**	**(97.3)**	**(8.3)**
Surplus/(Deficit)	**(1.8)**	**(3.3)**	**(1.5)**	**(5.8)**	**(10.2)**	**(4.5)**

19.1

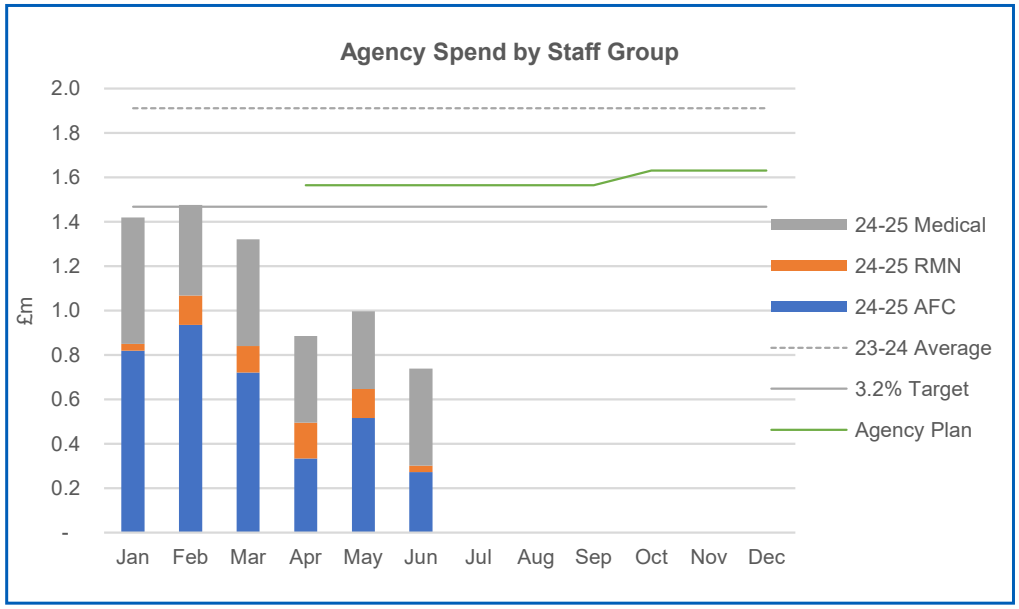
- Detailed Trustwide month 3 and year to date position shown by key headings. This shows further detail from the table shown on slide 2.

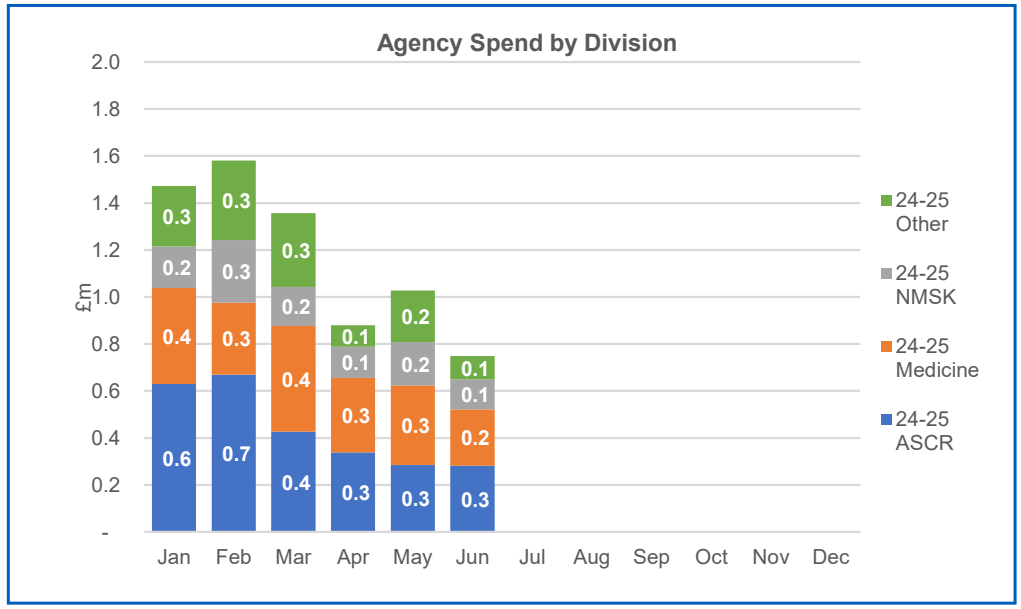
Statement of Financial Position

	23/24 Month 12 £m	24/25 Month 02 £m	24/25 Month 03 £m	In-Month Change £m	YTD Change £m
Non-Current Assets	**538.4**	**536.9**	**536.0**	**(0.9)**	**(2.4)**
Current Assets					
Inventories	11.7	11.8	11.8	(0.1)	0.1
Receivables	49.4	52.6	58.5	6.0	9.1
Cash and Cash Equivalents	62.7	46.2	39.9	(6.3)	(22.8)
Total Current Assets	**123.8**	**110.6**	**110.2**	**(0.4)**	**(13.6)**
Current Liabilities (< 1 Year)					
Trade and Other Payables	(99.9)	(91.4)	(93.0)	(1.6)	(6.9)
Deferred Income	(14.4)	(16.7)	(15.5)	1.2	1.1
Financial Current Liabilities	(23.6)	(23.6)	(23.6)	0.0	(0.0)
Total Current Liabilities	**(138.0)**	**(131.8)**	**(132.2)**	**(0.4)**	**(5.8)**
Non-Current Liabilities (> 1 Year)					
Trade Payables and Deferred Income	(6.2)	(6.7)	(6.7)	0.0	0.5
Financial Non-Current Liabilties	(571.8)	(594.9)	(593.1)	1.8	21.3
total Non-Current Liabilities	**(578.0)**	**(601.6)**	**(599.8)**	**1.8**	**21.9**
Total Net Assets	**(53.7)**	**(85.9)**	**(85.8)**	**0.1**	**(32.1)**
Capital and Reserves					
Public Dividend Capital	485.2	485.2	488.2	3.0	3.0
Income and Expenditure Reserve	(541.8)	(610.8)	(610.8)	0.0	(69.0)
Income and Expenditure Account - Current Year	(69.0)	(32.2)	(35.1)	(2.9)	33.9
Revaluation Reserve	71.9	71.9	71.9	0.0	0.0
Total Capital and Reserves	**(53.7)**	**(85.9)**	**(85.8)**	**0.1**	**(32.1)**

Items to note:
Non Current Assets: Movements driven by capital expenditure are offset by in-year depreciation and amortisation.
Inventories: Only Pharmacy inventory is counted on a monthly basis, therefore, the year-to-date movement is minimal.
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

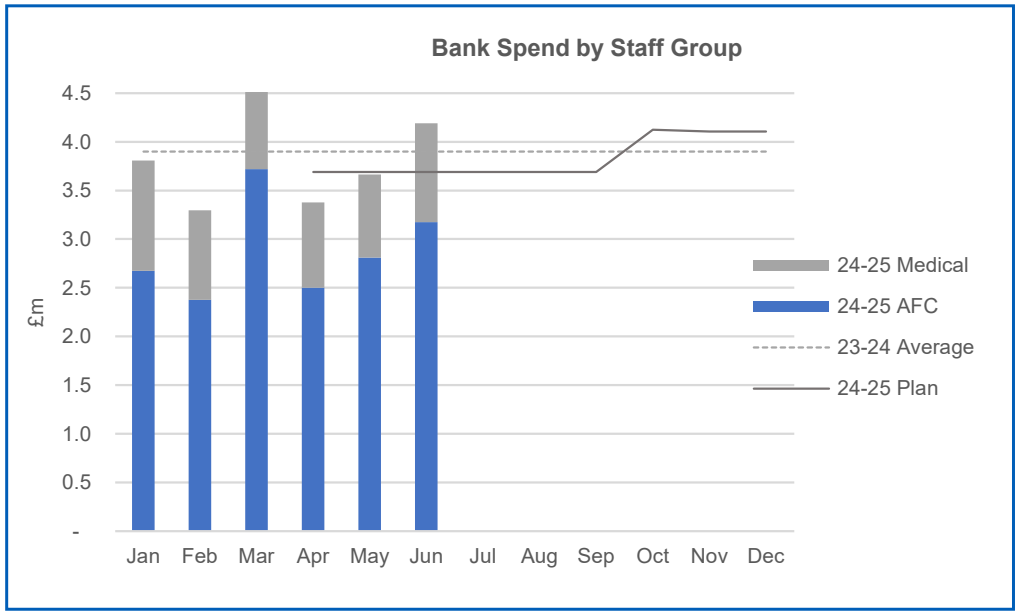
- Agency spend in June has reduced in comparison to Q4 last year, with a month on month decrease in agenda for change staffing.
- Overall spend in month is driven by consultant agency usage in ASCR, NMSK and Medicine covering vacancies as well as nursing agency usage in theatres due to ODP incentives. (ASCR)

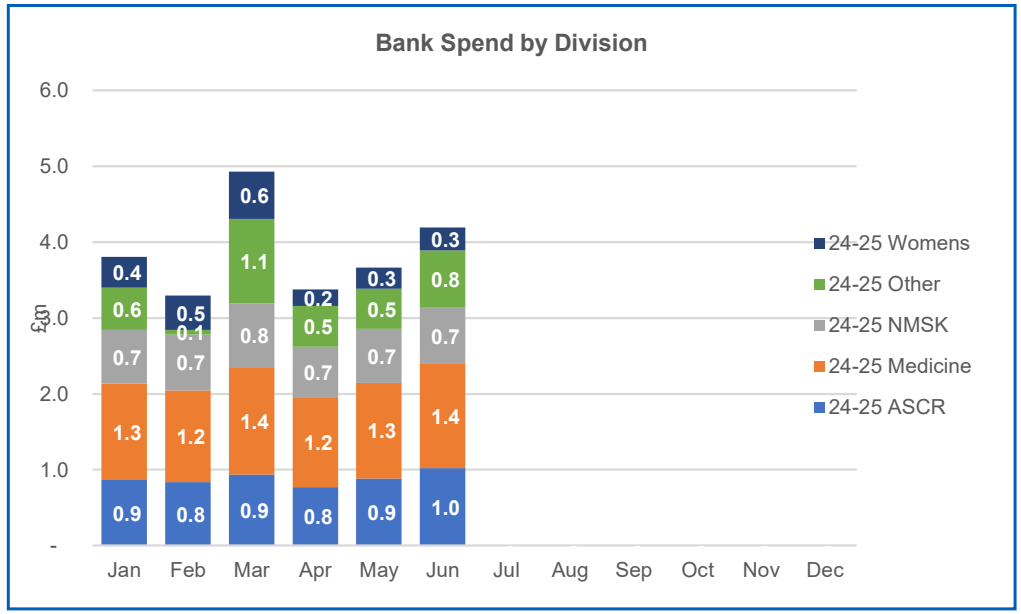
In Month vs Prior Year

- Trustwide agency spend in June is 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.

19.1

Pay: Temporary Staffing - Bank





Bank analysis

Monthly Trend

- In June, bank spend has increased due to high dependence in critical care in ASCR and increases in Medicine for escalation areas.
- Locum spend also remains high within Medicine covering vacancies.
- 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 don't represent additional cost to the trust.
- Within other there were also increases related to Pathology in CCS (£0.1m) and Operational Services in Facilities (£0.1m)

In Month vs Prior Year

- Bank spend in month is higher than 2023/24 average spend. This is driven by increases in escalation in Medicine, and high dependency in Critical Care in ASCR

19.1