University Hospitals Bristol and Weston NHS Foundation Trust

Public Trust Board Meeting Papers

Date: Thursday 28 January 2021

Time: 11.00 – 13.30

Venue: Video Conference

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Conference Room, Trust HQ, Marlborough St, Bristol, BS13NU

University Hospitals Bristol and Weston NHS Foundation Trust

Board of Directors (in Public)

Meeting of the Board of Directors to be held in Public on Thursday 28th January 2021 at 11.00 – 13.30 Video Conference
AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
Preliminary Business				
1.	Apologies for Absence – *Verbal update*	Information	Chair	11.00
2.	Declarations of Interest – *Verbal update*	Information	Chair	
3.	Minutes of the Last Meeting • 27 November 2020	Approval	Chair	
4.	Matters Arising and Action Log	Approval	Chair	11.05
5.	Chief Executive's Report	Information	Chief Executive	11.15
Strategic				
6.	Integration Update	Assurance	Director of Finance and Information	11.25
7.	Strategic Capital 6 monthly Update	Assurance	Director of Finance and Information	11.35
Quality and Performance				
8.	Integrated Performance Report	Assurance	Deputy Chief Executive and Chief Operating Officer, Chief Nurse, Medical Director, Director of People	11.40 To follow
9.	Committee Chair's Reports • ASR Programme Board • Finance & Digital • People • Quality and Outcome • Audit • Charity	Assurance	Chairs of the Committees	11.55 To follow
10.	Quality Strategy	Approval	Medical Director	12.00

NO.	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
11.	Quality Accounts a. University Hospitals Bristol b. Weston General Hospital	Approval	Medical Director	12.10
12.	Maternity Provider Annual Report	Assurance	Chief Nurse	12.20
13.	Ockenden Review of Maternity Services	Assurance	Chief Nurse	12.30
14.	Learning from Deaths Quarter 2 Report	Assurance	Medical Director	12.45 To follow
15.	Patient Experience Report – Q2 Update	Information	Chief Nurse	12.55
16.	Patient Complaints Reports – Q2 Update	Information	Chief Nurse	13.05
17.	Finance Report	Assurance	Director of Finance and Information	13.10
People Management				
18.	Diversity and Inclusion Update	Assurance	Director of People	13.15
Governance				
19.	Role of the UHBW nominated Trustee on the Board of Trustees of Above & Beyond	Assurance	Director of Corporate Governance	13.20
20.	Governors' Log of Communications	Information	Director of Corporate Governance	13.25
21.	Register of Seals	Information	Director of Corporate Governance	13.30
Concluding Business				
22.	Any other urgent business	Information	Chair	
23.	Date of next meeting: **31 March 2021**	Information	Chair	

University Hospitals Bristol and Weston NHS Foundation Trust

Minutes of the Board of Directors Meeting held in Public

Friday 27 November 2020, 11:00-13:30, by videoconference

In line with social distancing guidance at the time of this meeting due to the COVID-19 Coronavirus pandemic, this meeting was held as a videoconference and broadcast live on YouTube for public viewing.

Present

Board Members

Name	Job Title/Position
Jeff Farrar	Chair of the Board
Robert Woolley	Chief Executive
David Armstrong	Non-Executive Director
Sue Balcombe	Non-Executive Director
Julian Dennis	Non-Executive Director
Bernard Galton	Non-Executive Director
Kam Govind	Non-Executive Director (Associate)
Matt Joint	Director of People
Neil Kemsley	Director of Finance and Information
Jayne Mee	Non-Executive Director
Carolyn Mills	Chief Nurse
William Oldfield	Medical Director
Guy Orpen	Non-Executive Director
Martin Sykes	Non-Executive Director
Steve West	Non-Executive Director

In Attendance

Name	Job Title/Position
Eric Sanders	Director of Corporate Governance
Mark Pender	Head of Corporate Governance
Laura	Patient (for Item 3)
Tony Watkin	Patient and Public Involvement Lead (Item 3)
Shazad Sarwar	NHS Aspiring Chair Programme participant
Sarah Murch	Acting Membership Manager (minutes)

The Chair opened the Meeting at 11:00

01/11/20	**Welcome and Introductions/Apologies for Absence**	
	The Chair, Jeff Farrar, welcomed attendees to the meeting, extending a particular welcome to Shazad Sarwar who was observing the Board meeting as a member of the national NHS Aspiring Chair's programme. He also welcomed members of the public who were viewing the meeting	

	live via YouTube. It was also noted that it was the last Board meeting for Carolyn Mills, Chief Nurse who was moving to a new role at another Trust in the new year, and Guy Orpen, Non-Executive Director, who was retiring at the end of December. Jeff Farrar paid tribute to them both and Board members agreed that they would be greatly missed. The Board noted apologies from Paula Clarke, Director of Strategy and Transformation, who this week had moved to a secondment position on the national leadership team for the COVID-19 Coronavirus vaccine roll-out programme for the next four months. The Board also noted apologies from Mark Smith, Deputy Chief Executive and Chief Operating Officer, who had been called away to deal with significant operational pressures that the Trust was currently experiencing due to the Covid pandemic.	
02/11/20	**Declarations of Interest**	
	Members of the Board noted the following interests: • Guy Orpen and Steve West, Non-Executive Directors, held senior positions at the University of Bristol and the University of the West of England respectively. Steve West also noted positions on the Academic Health Science Network and the West of England Local Enterprise Partnership. • Kam Govind, Non-Executive Director (Associate) was an employee of Bristol City Council.	
03/11/20	**What Matters To Me – A Patient Story**	
	The meeting began with a story from a patient, Laura. Laura talked about her experience of giving birth at St Michael's Hospital in April 2020 during the first wave of the Coronavirus pandemic. She had never been a hospital patient before, and she described what it was like to have her first hospital experience during a national pandemic with the extra anxiety and restrictions that this involved. Additionally, the birth had not turned out the way she had planned, with a four-day labour and an eventual need for an emergency caesarean. However, she mainly wanted to highlight how phenomenal the staff had been, and she gave examples of how caring, supportive, patient and friendly they were throughout. Despite the pandemic, and despite how vulnerable she had felt, she had felt she was in safe hands and that it was one of the most positive experiences she could have hoped for. Board members thanked Laura for her story. They asked that the names of the staff members be recorded so that they could be appropriately	

	recognised. **Action: Ensure that staff are appropriately recognised for their contribution to Laura's care.** In response to a question about whether the Trust could have done more to prepare Laura for the possibility that her plans might not work out, Laura noted the importance of high-quality antenatal education in providing women with tools to be flexible in their expectations and suggested that perhaps St Michael's Hospital could provide more education about hypnobirthing. In relation to other improvements, she suggested a video tour to show people where to go and what to do when they came in, and more links on the St Michael's app to resources and information. She also suggested a poster or leaflet explaining the different roles of different staff, so that people were aware who they could ask for what. The Chair asked that her suggestions be taken on board. **Action: Consideration be given as to how to take forward the suggestions for improvements for information to give to patients and their families at St Michael's Hospital.** The Chair thanked Laura for attending and she left the meeting.	Chief Nurse Chief Nurse
04/11/20	**Minutes of the previous meeting**	
	The Board reviewed the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust held in public on 29 September 2020. **Members of the Board resolved to approve as a true and accurate record the above minutes.**	
05/11/20	**Matters arising and action log**	
	Board Members received and reviewed the action log. Updates on completed actions were noted, and others were discussed as follows: **13/09/20: Finance Report** **Agenda item to be changed to reflect additional focus on the digital agenda.** This had been changed accordingly. Action closed. **17/09/20: Safe Working Hours Guardian Report Implementation** **Programme for the roll-out of e-rostering to be provided to the Board including timeframe.** Matt Joint, Director of People, noted that the implementation plan had needed to be significantly revised to take into account the second wave of Covid-19. Action ongoing. **23/09/20: Education Annual Report**	

Appreciation to be communicated to Sarah Green, Director of Education, for Education Annual Report. This had been done. Action closed.

25/09/20: Standing Financial Instructions

Board committee changes to the Standing Financial Instructions to be addressed. This had been completed. Action closed.

28/09/20: Any other urgent business

Update on Board annual business cycle to be provided

The Board noted that Eric Sanders, Director of Corporate Governance, and David Armstrong, Non-Executive Director, had discussed this and it was confirmed that agendas now were being created using the revised annual business cycle. Action closed.

03/07/20: What Matters To Me – A Patient Story

Details of the patient pathway relating to the Patient Story to be obtained for the Chair to write a letter to individual staff members involved with this successful story. This had been done. Action closed.

07b/07/20: Board Assurance Framework – Corporate Risk Register

Director of Corporate Governance to review how the corporate objectives were reviewed at Committee level to minimise duplication. The Board had implemented an alignment of corporate objectives with each Board Committee. Each committee would be asked henceforth to focus on their specific objectives. Action closed.

11/07/20: Strategic Capital Update

Chief Executive to review the strategic capital connection to the wider STP. Action paused pending issue of national guidance about the capital funding regime for 2020/21 and future framework for system capital planning. Action ongoing – to be reviewed in January 2021.

12/07/2020: Integrated Performance Report

The Board requested a future discussion on the increased amount of violence being experienced by staff from patients. The Director of People to bring a report to the Board. Matt Joint, Director of People, reported that the Trust had now established a Managing Violence and Aggression Committee which had representation from all senior divisional leads. A campaign had been launched aimed at patients and visitors asking them to treat staff with respect, there was a bodycam pilot for staff, new training was planned for staff to help them deal with difficult situations, and reassurance was being provided to staff that the Trust's leadership was fully supportive of them on this issue.

Jeff Farrar added that he had also raised this with the Chief Constable asking for police support for staff when they need it in the Emergency

	Department. Action closed. **<u>17/07/20: Emergency Preparedness Annual Report</u>** **Director of Corporate Governance to review the statutory responsibilities of the Non-Executive Directors.** The Board heard that this piece of work was ongoing and that an update would be brought back to Board in January 2021. Action ongoing. **<u>84/09/2019: Chief Executive's Report</u>** **Report to be brought back to the Board on opportunities and risks facing South Bristol Community Hospital. Board oversight of SBCH on an ongoing basis to be considered as part of the Board cycle.** It was agreed that Eric Sanders, Director of Corporate Governance, would liaise with Neil Kemsley to ensure sufficient Board oversight on this issue. Action ongoing. **Members resolved to:** • **Approve** the action log.	
06/11/20	**Chief Executive's Report**	
	Chief Executive Robert Woolley gave a verbal update on the following key issues: • The Chancellor's spending review had revealed an additional £3 billion non-recurrent funding for the NHS next year. However it was not yet known whether this would be sufficient nor how it would relate to the planning guidance and financial framework for 2021/22. Further updates would be brought back to the Board in due course. • The NHS in England remained in Incident Level 4 due to the severity of the current wave of the COVID-19 Coronavirus pandemic. Bristol, North Somerset and South Gloucestershire (BNSSG) was one of the worst affected areas in England. In the regional tier system that would be implemented next week once lockdown was lifted, BNSSG would be therefore placed in Tier 3 which had the greatest restrictions. • With high numbers of Covid patients in its hospitals, the Trust had been experiencing very significant pressure for several weeks. In recent days there had been a welcome reduction in the rate of community infection, but this would take time to have an effect on hospital admissions. There had been local media coverage of the work of the hospitals this week which had been well-balanced and had provided an insight into the pressures faced as well as the phenomenally hard work of staff at this time. • A new adult critical care retrieval service hosted by UHBW had been launched. It was one of the first of its kind in England, working across the South West to manage the transfer of adult patients needing critical care. • Within the Trust, the extreme pressures had meant an urgent implementation of short-term changes to ward staffing ratios. The	

	increase in the numbers of patients needing non-invasive ventilation for Covid meant that the nurse-to-patient ratio for these patients had been increased. However, in order to do this, the Trust had needed to dilute the nurse-to-patient ratio of 1:6 in the day and 1:8 at night on its general wards to 1:10 in the day and 1:12 at night. This had created some concern across the Trust but had been done as a temporary measure in a very considered way, taking account of the balance of safety risks for patients and staff. • The Trust had this week introduced lateral flow antigen testing for staff. This would help the Trust to determine the extent of asymptomatic Covid infection amongst staff and would help staff manage their safety and that of their colleagues. Progress on this would be reported at future Board meetings. • The Trust was also preparing for mass vaccination. Vaccines were still subject to approval, but this was a very fast-moving situation and it now looked as though the Trust would be able to start vaccinating staff from December 2020. The Board would be kept informed. • He provided assurance that the Trust had taken very strong account of the lessons learned from its Covid outbreak at Weston General Hospital in May and was managing all pathways at present to keep segregation of Covid and non-Covid patients as far as possible. • The NHS was standing up its strategic incident programme to ensure operational readiness for both the end of the EU exit transition programme on 31 December 2020 and Covid at the same time. National guidance was being released to all NHS bodies about contingency planning in relation to the flow of medicines, medical equipment and vaccines in and out of the UK. UHBW was also managing the Trust-level response to the UK Exit through its internal response mechanisms, headed by Mark Smith, Deputy Chief Executive and Chief Operating Officer. Members of the Board asked the Chief Executive to note how much they appreciated the efforts and the resilience of staff during such challenging times. They expressed support for the Trust's efforts to publicise the pressure and the challenges through local media. They emphasised the importance of encouraging the population of BNSSG to continue to abide by the guidelines in order to protect the NHS in our region. **Members resolved to:** • **Receive the Chief Executive's Report for information.**	
Strategic Items		
07/11/20	**Covid-19 Update**	
	Robert Woolley, Chief Executive, presented a report providing an update on the Trust's response to the COVID-19 coronavirus pandemic and the impact of the present surge of infections on the recovery actions that had been taken to re-establish normal business. The following points were highlighted to the Board: • Covid cases were without a doubt in excess of the first wave. The Trust was currently treating 127 confirmed Covid-positive patients, of	

	which 15 were in intensive care units. The Trust had needed to open up intensive care surge capacity and reconfigure its hospitals in order to cope with this. This had significantly restricted the Trust's flexibility to deal with other patients, particularly as emergency admissions had not reduced in the way that they had during the first lockdown. • There were significant efforts both inside and outside the Trust to deal with this. Among initiatives in the wider health and care system, 300 community beds had been commissioned to help discharge of patients out of acute hospitals in BNSSG. Members of the Board discussed the report and sought assurance around the measures taken to deal with the current wave of the crisis. They asked for consideration as to how best to ensure that staff were aware of the Board's gratitude for their enormous efforts during this part of the pandemic. **Action: consider ways in which the efforts of staff could be adequately recognised.** Kam Govind, Non-Executive Director (Associate) enquired whether the Trust was charging those people who did not usually have access to NHS treatment for Covid tests and treatment. Neil Kemsley, Director of Finance and Information, responded that the Trust policy matched the national position, which since January 2020 had been that there would be no charges for Covid testing or any associated treatment. Sue Balcombe, Non-Executive Director, enquired about the impact of the pressures of the last few weeks on core services, particularly around cancer waiting times. Robert Woolley responded that there had been a higher proportion of cancellations but that higher priority elective care was being maintained as much as possible. The Trust was using the independent sector for elective services, and also the Bristol Nightingale Hospital was now being used for children's day cases and for adult outpatient procedures and ophthalmology diagnostics. **After further discussion, members resolved to:** • **Receive the Covid-19 Update for assurance.**	Director of People
08/11/20	**UHBW Integration Update**	
	Neil Kemsley, Director of Finance and Information, introduced a report which provided an update on service integration following the Trust's merger on 1 April 2020. There had been positive progress on a number of fronts despite operational pressures. This included: • The Weston divisional leadership team had been strengthened through the appointment of a Deputy Chief Operating Officer, Deputy Chief Nurse and Deputy Clinical Director. • A partner had now been appointed to support the organisation-wide staff development programme. • There had been significant investment in pharmacy services across the merged function. • The patient administration system used at Bristol had gone live for	

	Weston General Hospital in September. Members of the Board suggested that the Trust put more focus into publicising the positive aspects of the merger and engaging stakeholder groups in Weston and the surrounding area. **Members resolved to:** • **Receive the UH Bristol/Weston Integration Update report for assurance.**	
09/11/20	**Healthier Together Sustainability and Transformation Partnership Update**	
	Robert Woolley, Chief Executive, introduced this report, which focussed on six priorities as the Healthier Together partnership entered the winter period. These were Covid escalation, winter planning, staff testing, mass vaccination, the Healthier Together programme, and Integrated Care System designation. He highlighted that some of Healthier Together's other plans had been curtailed in order to do release capacity to manage Covid pressures. The Board noted that the region was working to prepare for potential designation as an Integrated Care System from April 2021. The legislative underpinnings of Integrated Care Systems were expected in 2021 for potential implementation from April 2022. There was therefore no certainty yet as to the form of system governance during the next financial year, and this was the subject of current work to develop a system-wide memorandum of understanding. **After further discussion, Members resolved to:** • **Receive the Healthier Together report for assurance.**	
Quality and Performance		
10/11/20	**Integrated Performance Report**	
	Board members received the report on the Trust's performance on Quality, Workforce and Access standards. In terms of Quality standards, William Oldfield, Medical Director, reported that although it had been an extremely challenging few weeks, the Trust was maintaining good quality of care, with performance against medicines safety and mortality indicators continuing as expected. There had been recruitment into the orthopaedic team, and the integration process of this service between Bristol and Weston was continuing at pace in collaboration with North Bristol NHS Trust. He asked the Board to note one area of concern which related to the way in which the Trust assessed people for their potential risk of Venous Thromboembolism. Work was ongoing to improve this while the Trust awaited the	

implementation of an electronic system to make this easier.

Quality and Outcome Committee Chair's Report: Julian Dennis, Chair of the Quality and Outcomes Committee reported the key issues from the committee's November meeting.

- The Committee had discussed the Covid report and the Integrated Performance Report
- The Committee had heard how exhausted the Trust's staff were and asked that the Board do their best to support them.
- Issues were raised about staff training, in particular resuscitation compliance. Also a lack of investigative capacity was leading to delays in responding to employee relation cases.

Workforce Indicators: Matt Joint, Director of People, reported that workforce indicators were steady: with low turnover and a low vacancy rate. Staff sickness rates were remarkably stable even allowing for Covid-related absences. Essential training and appraisal compliance were both down, though there was some progress in terms of fire safety e-learning, and managers were being asked to use appraisals as an opportunity to have a wellbeing check-in with their staff. The response rate for this year's national staff survey (which had closed today) was around 50%.

Given the current difficulties in recruiting, Matt Joint was pleased to announce to the Board that the Trust was set to receive £100,000 from NHSE/I following a bid for money to help recruit 50 international nurses.

People Committee Chair's Report: Bernard Galton, Chair of the People Committee, reported the key issues from his committee including:

- There was ongoing concern that appraisal rates were below target.
- The Committee had received a presentation from the Head of Resourcing which introduced a new virtual welcome pack for consultant appointments.
- The Committee had received an update on the newly piloted Talent Liberation programme to develop the talents of staff.
- An update on the Working From Home Survey was provided along with an overview of the new HALT (Hungry Angry Late or Tired) Campaign, a new initiative to encourage all staff to take care of themselves.
- The Committee had requested a strategic workforce plan for its next meeting.

Jeff Farrar, Trust Chair added that the Trust had recently held a Diversity and Inclusion seminar at which all Divisions had reported their achievements in this regard. He thanked Sam Chapman, Head of Organisational Development, for co-ordinating this. He also thanked

	Lorna Hayles (Chair of the Black, Asian and Minority Ethnic Staff Forum) for organising a Black History Month webinar for the Trust which had included several inspirational speakers. Guy Orpen, Non-Executive Director, noted that the reported staff turnover for the Weston Division appeared substantially higher than that of the rest of the Trust and asked if this reflected the up-to-date position. Matt Joint confirmed that turnover in Weston was higher than the rest of the Trust but there had been work done in recent months to strengthen the senior team and develop a recruitment brand and this was expected to lead to an improvement by the summer. **Following further discussion Board members resolved to:** • **Receive the Integrated Performance Report and Committee Chairs' reports for assurance.**	
11/11/20	**Finance Report**	
	Neil Kemsley, Director of Finance and Information, presented the monthly Finance Report informing the Board of the current financial position of the Trust. He highlighted the following points: • The NHS financial regime in 2020/21 had been substantially different from previous years in response to the pandemic. After ending the first half of the year in a break-even position, the Trust had a planned deficit of £13.5m in the second half of the year as part of a regional system deficit of £40m. Negotiations were continuing with the regional tier of NHS England/Improvement as to the assumptions leading to this projected deficit. • The Trust's position at month 7 was a deficit of £1m against a planned deficit of £1.1m. The Trust had spent a further £2.2m on additional costs directly attributable to Covid, taking this figure to £21m for the year to date. • There was also a challenge for the year in relation to the Trust's capital programme. £24m had been spent in the year-to-date against an available envelope of £73m, though part of this was due to additional allocation of £20m in the last two months relating to investment in urgent care, critical infrastructure and intensive bed capacity. There was a risk that if the Trust did not spend up to the envelope this year, it could decrease the resources available for the next financial year. **<u>Finance and Digital Committee Chair's Report</u>** Martin Sykes, Chair of the Finance and Digital Committee, reported the key areas of focus from his committee including: • The Committee had discussed risks and mitigations for the rest of the financial year. • At its next meeting, the Committee would be reviewing plans for the next financial year including early review of the savings programme for the coming year. • The Trust was developing a programme to strengthen	

	governance around the digital environment. A Board seminar was planned for next week on digital readiness. David Armstrong, Non-Executive Director, asked that the Finance and Digital Committee review the Trust's risk position in relation to cybersecurity. Neil Kemsley responded that the Trust was about to undertake an internal audit into cybersecurity arrangements and offered to share the terms of reference. Guy Orpen, Non-Executive Director, suggested that the Trust liaise with the university's Chief Information Officer. **Action: Terms of reference for internal audit into Trust cybersecurity arrangements to be shared with the Board** **Members resolved to:** • **Receive the Finance Report and the Finance and Digital Committee Chair's Reports for assurance.**	Director of Finance and Information
12/11/20	**Committee Chair Reports**	
	Note: The Chairs' reports for the People Committee, Quality & Outcomes Committee and Finance & Digital Committee were discussed as part of minute numbers 10/11/20 and 11/11/20 above. **<u>Acute Services Review Board</u>** Jayne Mee, Non-Executive Director, reported back from the second meeting of the Acute Services Review Board held on 16 November 2020. This was a new committee-in-common for UHBW and North Bristol NHS Trust to oversee closer working and opportunities for collaboration between the two organisations. Items discussed had included the following; • The Programme Board had received and approved a proposed memorandum of understanding which had been revised to widen the scope of the programme to encompass consideration of the wider organisational relationship between the two Trusts rather than just acute services. The MOU had now been approved by the UHBW Board. • The Programme Board noted that the initial areas of priority for the programme would be critical care and cancer services as well as continuing support for the ongoing work to align the Trusts' stroke services and neo-natal intensive care units. Update reports on each of these areas had been received, though the impact of immediate operational pressures on progress so far was noted. An initial communications plan was also discussed along with the possibility of changing the name of the Acute Services Review to better reflect its focus. • The Programme Board had noted that Owen Ainsley had been appoint as Programme Director and was expected to formally start in the role in due course.	

	Members resolved to: • **Receive the Acute Services Review Board report for assurance.**	
13/11/20	**Flu Vaccination Programme**	
	Matt Joint, Director of People, introduced a report providing the Board with assurance that progress was being made on the seasonal influenza vaccination programme which commenced on 28 September 2020 and would conclude on 28 February 2021. The target this year was to achieve 90% vaccination uptake among frontline healthcare workers. Last year, the Trust had achieved 84.1%. Progress to date was 73%. Trusts had been asked whether they could hit the vaccination rate by the end of November, and while this was not achievable, UHBW would be making great efforts to get it done as quickly as possible, particularly as it was understood that there needed to be at least two weeks between having the flu vaccination and having the first Covid vaccination. The Chair, Jeff Farrar, expressed surprise that staff take-up so far was not higher, given the genuine importance of the vaccine for NHS staff. **Members resolved to:** • **Receive the Flu Vaccination report for assurance.**	
15/11/20	**Review of Committee Terms of Reference**	
	Eric Sanders, Director of Corporate Governance, introduced this item. He explained that the Audit Committee, Quality and Outcomes Committee and People Committee had recently reviewed their terms of reference, which was done on a regular basis to ensure that they remained fit for purpose. The Terms of Reference were now presented to the Board of Directors for approval. **Members resolved to** • **Approve the Committee Terms of Reference**	
16/11/20	**Register of Seals – Q2 Update**	
	Eric Sanders, Director of Corporate Governance, introduced a report providing a summary of the applications of the Trust Seal made since the previous report in July 2020. There had been two applications in this period: one relating to a deed of surrender for Brislington House Playing Fields, and the second in relation to a transfer of a registered title for the Children's Centre at the Barn, Clevedon, from UHBW to Avon and Wiltshire Mental Health Partnership NHS Trust. **Members resolved to:** • **Receive the Register of Seals Q2 update for assurance.**	

17/11/20	**Governors' Log of Communications**	
	The Board noted the most recent questions and responses raised by governors via the Governors' Log of Communications. It was noted that Item 244 (Learning Disability Nurses) had now received a response. In relation to Item 243 (Weston Hospital Emergency Department), Robert Woolley commented on measures that the Trust was taking to assure appropriate staffing in the Emergency Department at Weston General Hospital. He provided assurance that the Trust had undertaken a significant recruitment drive, had made appointments both at consultant and middle-grade level and were putting the final elements of a plan together to make sure that there was no interruption to services at Weston. It would be kept under review and the Board would be kept updated in future meetings. **Members resolved to:** • **Receive the Governors' Log of Communications for information.**	
Concluding Business		
18/11/20	**Any other urgent business**	
	• Robert Woolley, Chief Executive, informed the Board that the Trust would be issuing communications this afternoon to staff across the Trust about the forthcoming mass vaccination programme. • As it was the last Board meetings for both Guy Orpen, Non-Executive Director, and Carolyn Mills, Chief Nurse, Jeff Farrar publicly thanked them both on behalf of the Board and the Trust for their considerable contribution over the years. Guy Orpen and Carolyn Mills both warmly paid tribute to the outstanding work of the Board and the Trust and the team that they would be leaving, and wished the Trust all the best for the future. The Chair closed the meeting at 12:55.	
19/11/20	**Date of next meeting**: 28 January 2021 by video conference.	

University Hospitals Bristol and Weston NHS Foundation Trust

Public Trust Board of Directors Meeting
28 January 2021
Action Log

Outstanding actions from the meeting held on 27 November 2020					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	03/11/20	**What Matters To Me – A Patient Story** Ensure that staff are appropriately recognised for their contribution to Laura's care.	Chief Nurse	January 2021	**Completed since last meeting**
2.	03/11/20	**What Matters To Me – A Patient Story** Consideration be given as to how to take forward the suggestions for improvements for information to give to patients and their families at St Michael's Hospital.	Chief Nurse	January 2021	**Completed since last meeting** Suggestions/learning for service developments have been discussed at Women's governance meeting
3.	07/11/20	**Covid-19 Update** Consider ways in which the efforts of staff could be adequately recognised.	Director of People	January 2021	**Work in Progress** Verbal update to be given
4.	11/11/20	**Finance Report** Terms of reference for internal audit into Trust cybersecurity arrangements to be shared with the Board	Director of Finance and Information	January 2021	**Work in Progress** Verbal update to be given
5.	17/09/20	**Safe Working Hours Guardian Report** Implementation programme for the roll-out of e-rostering to be provided to the Board including timeframe.	Director of People	November 2020	**Work in Progress** Verbal update to be given
6.	11/07/20	**Strategic Capital Update** Chief Executive to review the strategic capital connection to the wider STP.	Chief Executive	January 2021	**Recommended for closure** Latest advice is that the national planning round will be deferred to Q1 2021/22 in the light of the pandemic. Propose the Board action is closed and responsibility for monitoring future development of the

					capital planning framework is delegated to the Finance and Digital Committee.
7.	17/07/20	**Emergency Preparedness Annual Report** Director of Corporate Governance to review the statutory responsibilities of the Non-Executive Directors.	Director of Corporate Governance	September 2020	**Work in Progress** Verbal update to be given
8.	84/09/2019	**Chief Executive's Report** Report to be brought back to the Board on opportunities and risks facing South Bristol Community Hospital. Report due to come back in 4-6 months on the strategy for SBCH. Board oversight of SBCH on an ongoing basis to be considered as part of the Board cycle.	Director of Strategy and Transformation and Director of Corporate Governance	July 2020	**Work in Progress** An update to Board on the new model of delivery at SBCH would be provided in October or November.
Closed actions from the meeting held on 27 November 2020					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	13/09/20	**Finance Report** Agenda item to be changed to reflect additional focus on the digital agenda.	Director of Corporate Governance	November 2020	**Completed since last meeting** Agenda item updated accordingly.
2.	25/09/20	**Standing Financial Instructions** Board committee changes to the Standing Financial Instructions to be addressed.	Director of Finance and Information	November 2020	**Completed since last meeting** Changes had been made to the document - any outstanding issues to be picked up at the next review in 2021/22.
3.	03/07/20	**What Matters To Me – A Patient Story** Details of the patient pathway relating to the Patient Story to be obtained for the Chair to write a letter to individual staff members involved with this successful story.	Deputy CE/COO	September 2020	**Completed since last meeting** Completed in October.
4.	23/09/20	**Education Annual Report** Appreciation to be communicated to Sarah Green, Director of Education, for Education Annual Report.	Director of People	November 2020	**Work in Progress** Verbal update to be given

5.	07b/07/20	**Board Assurance Framework – Corporate Risk Register** Director of Corporate Governance to review how the corporate objectives were reviewed at Committee level to minimise duplication.	Director of Corporate Governance	September 2020	**Work in Progress** Proposal drafted which will be discussed by the Executive Team this week and then will share with the Committee chairs.
6.	28/09/20	**Any other urgent business** Update on Board annual business cycle to be provided.	Director of Corporate Governance	November 2020	**Work in Progress** Verbal update to be given
7.	12/07/2020	**Integrated Performance Report** The Board requested a future discussion on the increased amount of violence being experienced within the Trust. The Director of People to bring a report to the Board.	Director of People	September 2020	**Work in Progress** The Managing Violence and Aggression Steering Group now established to facilitate collaboration, sharing of best practice and prioritisation of resources. The group includes representation from Divisional Directors, Clinical Chairs and a Heads of Nursing. A programme of activities would follow.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28 January 2021

Report Title	**Chief Executive Report**
Report Author	**Robert Woolley, Chief Executive**
Executive Lead	**Robert Woolley, Chief Executive**

1. Report Summary

To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team.

2. Key points to note
(Including decisions taken)

The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in December 2020 and January 2021.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
N/A

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **Information.**
- The Board is asked to **NOTE** the report

5. History of the paper
Please include details of where paper has previously been received.

[Name of Committee/Group/Board]	**[Insert Date paper was received]**
N/A	

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – JANUARY 2021

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in December 2020 and January 2021.

2. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** the current position in respect of performance against NHS Improvement's Oversight Framework.

The group **received** updates on the Covid-19 pandemic.

3. STRATEGY AND BUSINESS PLANNING

The group received an update on the next steps in relation to Phase 3 planning and **approved** principles for the 2021/2022 operational planning process.

The group **approved** the Quality Strategy for 2021-2025 for onward submission to the Quality and Outcomes Committee and Trust Board.

The group supported proposals and **approved** next steps to progress the development of extra corporeal membrane oxygenation (ECMO) in Bristol.

The group **supported** a three year plan to recruit 300 international nurses to the Trust. **Approval** was given to progress with the 2021/2022 year plan to recruit 100 international nurses at a cost of £598,000 for year 1.

The group **supported** the pre-consultation business case for Bristol North Somerset and South Gloucestershire Stroke Reconfiguration, subject to satisfactory progress being made in reducing the affordability gaps presented.

4. RISK, FINANCE AND GOVERNANCE

The group **received** updates on the financial position 2020/21, budget setting for the remainder of the year and for 2021/2022.

The group **received** an update on the status of completion of actions with 'must do' requirements and 'should do' requirements arising from the Care Quality Commission core services inspection at Weston Area Health Trust in 2019.

The group received an update and **approved** the action plan in respect of the status of completion of actions in response to the Care Quality Commission's focussed inspection at Weston Emergency Department in July 2020, prior to submission to the Quality and Outcomes Committee.

The group **received** an update on the Business Intelligence platform, previously presented to the Quality and Outcomes Committee.

The group **approved** the establishment of a short-life working group to refine the Performance Management Framework principles.

The group **supported** the option to increase the utilisation of referral assessment triage, ensuring robust engagement with the clinical leads and alignment with the System.

The group **received** an update on the data quality assurance programme.

The group **supported** a training proposal for prevention and management of violence and aggression training for staff across the Trust.

The group noted and **supported** proposals for more flexible utilisation of continued professional development funding so that it was not lost.

The group **received** an update on assurance of actions in respect of the hepatobiliary surgical service, noting good progress was being made. .

The group **received** an update on the work of the Freedom to Speak Up Guardian.

The group **received** a quarterly update from the Guardian of Safe Working Hours, for onward submission to the People Committee and Trust Board.

The group received the closure report for UHBW Hospital Acquired Covid Co-ordinating Group and **supported** the recommendation to stand the group down with ongoing monitoring of the remaining recommendations to sit with appropriate business as usual groups.

The group **received** an update on the Trust's preparedness actions and an assurance position to mitigate against the potential disruption of the UK leaving the EU.

The group **received** the Corporate and Strategic Risk Registers prior to submission to Trust Board.

The group **received** an update on progress against the Corporate Quality Objectives.

The group **received** an update on progress against the Corporate Objectives.

The group **received** an update on progress of the Strategic Estates Development Programme.

The group **received** an update on progress of the Transforming Care Programme.

The group **received** the risk exception reports from Divisions.

Reports from subsidiary management groups were **noted,** including updates from the Cancer Steering Group, Clinical Quality Group, Trust Research Group, Digital Hospital Programme Board, Weston Integration Programme Board and the Cellular Pathology Performance Group.

The group **received** Divisional Management Board minutes from the Divisions of Weston, and Estates and Facilities for information.

5. RECOMMENDATIONS

The Board is recommended to note the content of this report and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda.

Robert Woolley
Chief Executive
January 2021

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28th January 2021

Report Title	**Integration Progress Report**
Report Author	**Robert Gittins, Programme Director**
Executive Lead	**Neil Kemsley, Director of Finance and Information**

1. Report Summary
This report provides an update to the Board on the progress of the Trust's Integration Programme.
2. Key points to note *(Including decisions taken)*
Board members should note: • The progress being made with the programme and the steps being taken to adjust the schedule in light of the Covid19 impact.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
Corporate risk, 4539 states that 'Trust core activities and performance are adversely affected by the allocation of resources required to manage service level integration'
4. Advice and Recommendations *(Support and Board/Committee decisions requested)***:**
• This report is for **Assurance**
5. History of the paper **Please include details of where paper has previously been received.**

Recommendation Definitions:

- **Information** - report produced to inform/update the Board e.g. STP Update. No discussion required.
- **Assurance** - report produced in response to a request from the Board or which directly links to the delivery (including risk) of one of the Trust's strategic or operational priorities e.g. Quality and Performance Report. Requires discussion.
- **Approval** - report which requires a decision by the Board e.g. business case. Discussion required.

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

DRAFT
Meeting of Board of Directors in Public
January 2021

Report Title	**Integration Progress Report**
Report Author	**Rob Gittins, Programme Director**
Executive Lead	**Neil Kemsley, Executive Director of Finance and Information**

1. Introduction

Progress with the schedule of work on clinical services integration has slowed in the last two months, reflecting the operational impact of Covid. Where it has been sensible to do so, we have continued to work with individual services on their integration plans, particularly corporate services, and those clinical services less affected by Covid. Fostering closer working together across sites continues to help us to build up service resilience, and create opportunities for joint working and improvements to patient care.

As part of the Trust's response to the impact of Covid, the integration team has also released several staff to support clinical teams at Weston as well as to the mass vaccination programme.

2. Clinical services update

The programme to bring together clinical services across Bristol and Weston continues, although the pace of work has understandably been affected as a result of resources being prioritised to meet the Covid response. We are currently working closely with eleven of our clinical services to develop their plans for integration, with the plan to take proposals through Divisional Boards in February and March providing that they are ready to do so and do not detract from current operational priorities.

The planned service transfer of the Weston Urology service to NBT management is now expected to take place on 1st July 21, provided that the necessary internal business case sign offs are satisfactory completed by end March 21.

3. Corporate Trust Services integration

During the next three months, and as part of the post-merger plan, it is expected that the process to bring together over 90% of our corporate services into single teams across the Trust will be completed. The remaining teams expect to start their staff consultations in the next period and to integrate their respective teams by 1st July 2021.

4. Staff welfare

Our staff continue to go to great lengths to care for our patients and each other during these challenging times.

There are a number of wellbeing services available to staff across the Trust, including access to 24/7 counselling, drop-in support clinics at Weston and workplace wellbeing packs. Staff forums are being held to give staff the opportunity to ask questions and raise

concerns, as well as staff having the opportunity to raise concerns confidentiality or through their line manager.

To ensure that UHBW continues to be a diverse and inclusive place to work that attracts, develops and retains exceptional people, we continue to build and develop a shared vision and values across our Bristol and Weston sites. This crucial programme of work has now commenced, supported by an external specialist partner.

5. Digital Convergence

The Medway patient administration system deployment in September is working well. It now forms the basis for enabling the roll out of additional functionality for clinical teams to further support safe patient care, starting with single therapies forms across the Trust.

In addition, to support service integration, the patient IT system used by the Intensive Care Unit at the Bristol Royal Infirmary (from technology provider Philips) is also being rolled out at Weston General from March 21 to enable the joint monitoring and management of critical care patients across the sites.

6. Monitoring the impact of the merger

A nine-month post-merger review has been undertaken to take stock of how our plans for integration have been implemented. This shows that whilst we have put in place robust implementation arrangements and that the Trust is now operating as a single entity, with corporate services integration broadly on track, further assurance is required in a number of areas, on our plans that are behind where we expected them to be.

Meeting of the Board in Public on Thursday 28 January 2021

Report Title	**Strategic Capital Update**
Report Author	**Carly Palmer, Assistant Director of Estates**
Executive Lead	**Neil Kemsley, Director of Finance and IT**

1. Report Summary

This paper provides Trust Board with an update on the overall progress of the Strategic Estates Development Programme, setting out the status of live schemes and, where applicable, significant dates for construction or design completion.

The report also provides an update for the ongoing Rapid Review process, explaining in detail the aims of the review, the planned outputs and key milestones.

2. Key points to note
(Including decisions taken)

- Range of strategic schemes continuing to be actively progressed either in design or on-site construction
- First Procure22 scheme, Cardiology & GICU Stage 1, to complete on site in April 2020. Handover of additional beds in advance, due first week in February

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:

- 2642 strategic risk register - Risk that the Trust is unable to invest in maintaining and modernising the Trust estate.

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **Information.**
- The Board is asked to **NOTE** the report.

5. History of the paper
Please include details of where paper has previously been received.

Business SLT	**20/01/21**

Recommendation Definitions:

- **Information** - report produced to inform/update the Board e.g. STP Update. No discussion required.
- **Assurance** - report produced in response to a request from the Board or which directly links to the delivery (including risk) of one of the Trust's strategic or operational priorities e.g. Quality and Performance Report. Requires discussion.
- **Approval** - report which requires a decision by the Board e.g. business case. Discussion required.

STRATEGIC CAPITAL PROGRAMME UPDATE
Quarter 3 2020/21

1. Background

This paper provides Trust Board with a summary update on progress against the Strategic Estates Development Programme (formerly Strategic Capital Clinical Services programme) and the ongoing process to re-assess and review the programme for assurance that the Trust is providing the right environment to be able to deliver our strategic objectives.

2. Update on review process

As discussed with Trust Board Seminar in September 2020, a review of our strategic capital programme has been initiated and is due to complete at the end of March 2021.

The overall aim of the review is to confirm the content of the strategic capital programme into 2021/22 and beyond. The objectives are;

- To understand the factors driving the changes in costs within the programme.
- To take stock of the current strategic capital programme in the changed context in which we are operating and to test the scope of the schemes currently within the programme.
- To take account of the changes in the national financial regime as well as the financial position and financial outlook for the Trust, in order to further test the affordability of our plans.
- To ensure there is clear strategic alignment with the outline plans in the programme and ensure our investment decisions are being driven by our Trust and System strategic priorities and our known risks as an organisation.
- To ensure there is a clear and objective basis upon which the scale of developments are planned and that this is underpinned by consistent capacity planning.
- To have a clear and risk stratified understanding of the infrastructure requirements of the estate.
- To establish a set of options which outline a clear way forward for the programme as a whole and agree a basis for re-prioritisation as required.
- To assess the affordability of the potential options for the content of the strategic development programme and develop options to address any outstanding affordability gap.
- To ensure divisions are key in driving the process and outcomes of the review.
- To make recommendations on the appropriate governance structures and arrangements which need to be in place to drive the further development and implementation of the programme.

The planned outputs of the review are as follows;

- A clear statement of capital availability with a recommendation of how the available funds could be allocated.
- To provide a recommendation on how the scope of existing schemes may need to be amended based on our new operating environment, a reassessment of the revenue affordability of schemes based on the new financial regime and the capacity planning exercise.
- To provide a clear and costed view of the infrastructure requirements of the estate.
- To provide a set of options for how the estate could be developed to deliver our agreed priorities, for consideration and identification of preferred option. This will focus on the combined options for the major strategic schemes, rather than the consideration of these as totally separate schemes.
- To develop and communicate a shared understanding of the outstanding affordability gap associated with the options above with a set of options for how this could be addressed.
- To establish the basis for re-prioritisation of schemes as may be required to ensure the affordability of the programme.

The key milestones to be delivered in Quarter 4 to complete the review are as follows;

- The delivery of these actions is being coordinated via a detailed action plan and the oversight of delivery is managed by the Strategic Estates Development Programme Board (SEDPB), as a subgroup of Strategic SLT.

No.	Action	Owner
1.	Complete **stocktake of all projects** within programme and share with Divisional Directors	End Nov-20
2.	Complete building level surveys to inform clarification of **infrastructure risks** and requirements	Jan-21
	Produce **standard communications** regarding status of programme and next steps for use within Divisions	Jan-21
4.	**Review scope of existing schemes** within the programme in changed context and identify key areas to be addressed	End Jan-21
5.	**Review MTCP and indicate available capital in line with updated LTFP**	Jan-21
6.	**Completion of master schedule for financial status of the programme**, reconciling current position with agreed Board position	Jan-21
7.	**Review financial position of current cases** assess and assess revenue affordability	Feb-21
8.	**Complete refreshed capacity planning exercise** with external support	Mar-21
9.	External support to develop scenario planning **and revised estate master-planning options for linked solution to strategic schemes**	Mar-21
10.	**Confirm affordability gap and options to resolve**, including basis of re-prioritisation	Mar-21
11.	**Review and make recommendation on revised** governance for next steps of design and delivery of programme	Mar-21
13.	**Produce package of information for SLT consideration. To include clear set of strategic choices with recommendations**	Apr-21

The aim is draw the output of each of these actions into a review of the options for progressing the content of the programme at Senior Leadership Team in April, with further recommendations to be made to the Board as required.

3. Update on live / approved schemes

In recognition of the requirement to maintain momentum around the strategic capital programme a number of schemes are continuing to progress through existing governance routes. The status of those schemes is summarised below:

- Cardiovascular Research Unit – FBC drafted however scheme now cancelled due to the scheme no longer being affordable, with forecast costs exceeding £10.8m against an original budget of £8m. The material nature of the project costs meant there was very limited scope for further value engineering, without significant compromise to the footprint and functionality of the building.

  The financial impact of the pandemic has limited the ability of both UHBW and UoB to commit further capital beyond the original budget. The Trust has also received confirmation that the bid for charitable support via a British Heart Foundation grant was not successful.

  The combination of these factors has led the Trust to regrettably conclude that the development is unable to proceed. Discussions will continue in terms of options for the future of the CRU and the space associated with the original scheme.

- Cardiac & General Intensive Care Unit (GICU) Stage 1 - Construction commenced on site in April 2020 with handover of levels 7 & 8 beds expected early February, representing a 1 week delay to approved programme. The delay has been as a direct result of not being able to access existing ward areas to make electrical connections due to Covid-19. The remaining Cath lab works on level 6 are planned for completion by April 2021.

- GICU Stage 2 – an initial feasibility study was completed in October 2020, following which Trust Board approved the OBC. The Construction OBC design is now currently underway and due to complete in March 2021.

- Cardiac Stage 2 - planned later in strategic programme.

- Level 7 Ward – This was planned to commence following the construction of the Cardiovascular Research Unit in approx. August 2021. However, as CRU scheme now cancelled, bed capacity to be determined through Capacity & Demand assessment (part of Rapid Review) with alternative options to be identified to create required capacity.

- BHOC Stage 1 – Work on site is currently underway with x-ray and supporting office areas on level 5 handed back to operational use before Christmas. The remaining works are due to complete in March 21.

- BHOC Stage 2 – Feasibility design currently underway, due to complete by end Feb / early March 21.

- D603 (100% charitably funded) – currently on hold pending review of wider issues within BHOC (see above).

- Neonatal Intensive Care Unit (NICU) expansion (system approved OBC) – Feasibility study completed. OBC stage design expected to commence in early 2021.

- Medical education facilities improvements (ring-fencing already approved) – Initial improvement works underway within Dolphin House. Additional investment into wider education facilities to be undertaken although scope not yet defined.

- Holistic Centre (100% charitably funded) – SOC approved by Trust and Charity boards. Scheme to be managed and delivered by Maggie's.

4. Update on remaining schemes

All other schemes within the current Strategic Programme are subject to the wider Rapid Review due to complete in March 2021.

Individual scheme requests for feasibility study, OBC or FBC design funding will be taken to CSPG for approval.

A brief summary of the schemes contained in the programme, those originally outlined in 2018 as well those that have emerged through more recent Strategy updates in 2019, is included in Appendix 1.

5. Recommendations to Trust Board

- **Note the overall content of this report**

Appendix 1: Strategic Capital Clinical Services Programme Summary (Initial Priority List September 2018)

Scheme	Brief summary of schemes
Myrtle Road Acquisition and refurbishment	Purchase of the Myrtle Road property at top of St Michael's Hill to provide additional non-clinical space to enable the transfer of non-clinical functions out of core clinical areas to support the other schemes in the programme. Strategically, this will also support an improved and modern environment for non-clinical staff.
Cardiology Expansion Stages 1 and 2	Cardiology services are part of our core specialist and regional provision and the service has demonstrated year on year growth. Increased contracts for additional activity have been agreed with local and specialised commissioners and additional physical space for catheter laboratories and in-patient beds is required to ensure we can continue to realise our strategic priority to develop our specialist offer.
Cardiovascular Research Unit	Cardiac research is central to our research and innovation agenda and to ensure patients can continue to access leading edge interventions. This scheme proposes to co-locate the Cardiac Research Unit currently provided on Queen's building L7 with the BHI and also vacates core clinical space on L7 of the Queens Building to enable re-provision of medical ward capacity in support of the expansion of cardiac and cardiac inpatient facilities.
D603 (BHOC inpatient ward refurbishment)	Refurbishment of Bristol Haematology and Oncology Centre (BHOC) inpatient wards, providing an improved and modernised environment for staff and patients.
GICU stage 1 and 2	The provision of critical care facilities is core to the development of our specialist surgical cancer and cardiac work, which are central to the strategic development of our specialist and regional services portfolio. The proposed scheme will assess the opportunities to integrate general and cardiac ICU provision, along with expansion in the bed base on a phased basis to address the current constraints in capacity and account for future growth.
BHOC expansion stage 1 and 2	Cancer services are core to providing high quality services to the local population and to continue to develop and innovate in our specialist and regional services. Sustained growth has been experienced in haematology and oncology services over the last 5 years, supported by increased contracts with our commissioners and income growth in these areas. Additional physical capacity and modernisation of the environment is required in BHOC to respond to this growth and maintain an appropriate environment for staff and patients alongside expanding oncology service access in more local units.
Holistic Well-being Centre/Maggie's Centre	Patient feedback has continued to reflect the need for an appropriate environment aligned to, but separate from, the hospital environment for patients with cancer or other long term conditions. Work is underway to progress a Maggie's Centre for our patients including a collaboration between the Trust, Maggie's and Penny Brohn charities. This programme is strategically aligned to our quality objectives, as well as our development of general and specialist cancer services.

St Michaels Hospital level E (maternity) refurbishment	Upgrade of outdated environment at St Michael's Hospital (STMH) for maternity services. Strategically aligned to providing a modern and up to date environment for our staff and patients and to achieving high quality care in our general services for the local population we serve.
Bristol Eye Hospital ground floor design	This scheme proposes to change the layout of areas of the BEH identified as suboptimal to enable new ways of working and models of care to improve the productivity of outpatient services, expand capacity to match increased demand and provide a modern environment for staff and patients. There is clear alignment of this programme to our current and future strategic objectives, both in relation to environment and driving productivity and efficiency and to the development of our local and specialist service offer.
Bristol Royal Hospital for Children Expansion	The delivery of local, regional and supra-regional services for children is a core strand of our clinical, teaching and research agenda, both currently and for the future. Since the centralisation of specialist paediatric services, we have continued to experience growth across a number of our paediatric services. This has led to the requirement for additional space in the children's hospital and this proposal is to expand facilities in the Emergency Department, outpatients, inpatient beds and paediatric intensive care services. This will result in high quality modern environment for staff and patients, as well as enabling the future strategic development of our paediatric services.
Expansion of the Neonatal Intensive Care Unit	The provision of high quality neonatal intensive care facilities is central to the strategic development of our maternity and paediatric services portfolio. Work is currently underway with North Bristol NHS Trust (NBT) and commissioners to progress plans to collaborate to deliver safe, sustainable services for the local and regional population into the future.
Dermatology upgrade and expansion	The environment within the current dermatology department requires significant refurbishment in order to provide an adequate clinical and non-clinical environment for staff and patients. Its current location is also suboptimal, with patients experiencing difficulty in accessing the department. In addition, dermatology activity has grown significantly over the last 5 years, supported by increased commissioner contracts. This has included the transfer of activity from Weston and more recently, from Taunton. Dermatology services are core to our clinical services strategy, both in relation to general services we provide to our local population and the development of specialist work for the wider region. The proposal is to build a new and modern unit to provide the required space for the expanding service, as well as a modern environment for staff and patients.
Queen's Level 7 Ward	An additional medical ward is required on the Bristol Royal Infirmary (BRI) site to support the development of cardiology services as part of the scheme outlined (i.e. provide space within the Bristol Heart Institute (BHI) to increase cardiology ward capacity) and

	support resilience of patient flow in the context of increasing medical admissions. The development of medical and cardiology inpatient services is core to our provision of urgent and planned care services for our local and regional populations.
BEH 5thTheatre	Surgicube theatre development to facilitate the essential maintenance of existing theatres, also providing potential future capacity expansion.
Urgent & Emergency Assessment Centre & Theatres / Endoscopy scheme	Proposed review and potential redesign of the current theatre and endoscopy facilities, with a focus on Queen's Day Unit (Level 4 BRI) to support the development of endoscopy and theatre facilities. The development of additional theatres will facilitate the essential refurbishment of existing theatres to maintain resilience and provide potential future expansion capacity.
	Expansion of ED facilities to meet increasing levels of demand. Combined business case with Radiology in order to create a single integrated department to deliver significant improvements in Emergency Department (ED) reporting turnaround times would be the redevelopment of the main Radiology department. Options being explored to either expand services within current location (Level 3 Queens) or a new build development elsewhere in the main hospital site.
Pharmacy – aseptic services	Appointment of external specialist approved to review aseptic services and provide a recommendation for future service provision. Review to include potential relocation of services into a single development and will also explore commercial opportunities.
Medical Education Facilities	Capital investment into education facilities to modernise and improve both environment and increase teaching and training capacity.
Transport Hub	*Scheme not supported – planning refused*

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors on 28 January 2021

Reporting Committee	**Acute Services Review Programme Board**
Chaired By	**Jayne Mee, Non-Executive Director (University Hospitals Bristol and Weston NHS Foundation Trust UHBW) and John Iredale, Non-Executive Director (North Bristol NHS Trust - NBT)**
Executive Lead	**Neil Kemsley, Director of Finance and Information (UHBW), Chris Burton, Medical Director (NBT)**

For Information

This report provides a summary of the third meeting of Acute Services Review Programme Board (ASRPB) held on 11th January 2021. The ASRPB is a meeting in common of the North Bristol NHS Trust Acute Services Review Committee and the University Hospitals Bristol and Weston NHS Foundation Trust Acute Services Review Committee, which are both formal sub-committees of the respective Trust Boards. It meets bi-monthly and reports to the Board after each meeting.

1.1 NICU update

Ian Barrington, Women & Children Divisional Director (UHWB) and NICU Project Lead, presented a NICU update, including the reasoning behind the proposal to set-up a joint NICU Board.

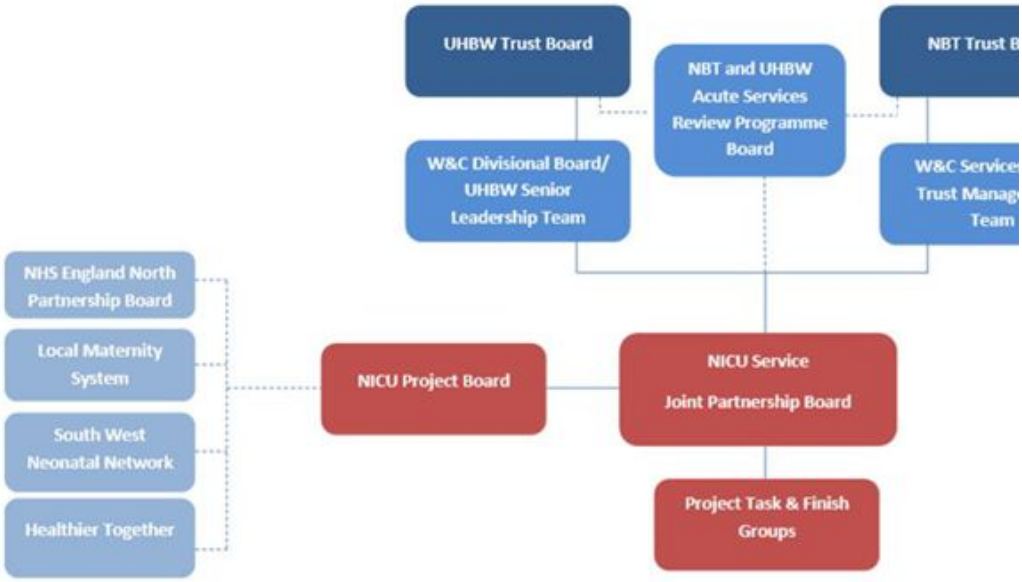
The Committee was advised that work was in progress to create a full business case, following approval in 2019 of the NICU outline business case regarding reconfiguration of neonatal intensive care services in Bristol and proposed centralisation at UHBW's St. Michael's site. A number of items still require confirmation and agreement, including the financial (particularly capital) costs associated with the reconfiguration.

The ASRPB was assured that the proposed changes sought to deliver service enhancements and improved patient outcomes and that the changes mirrored work happening in other regions. The changes were also endorsed by the South West Neonatal Operational Delivery Network as part of their Neonatal Critical Care Review implementation plan, and addressed the request by NHS England in 2017 that UHBW and NBT work jointly to review the Bristol NICU services to bring them in line with national guidance.

The ASPB supported the immediate establishment of a Joint NICU Service Partnership Board between UHBW and NBT and approved the Terms of Reference and proposed governance route. It was agreed that the Partnership Board would allow progress on service improvements, pending the completion of the full business case.

This was also scheduled for presentation to TMT (NBT) and SLT (UHBW) in February 2021 for approval on behalf of both organisations. The Terms of Reference are attached for Trust Board's information (Appendix 1) and governance structure for the NICU Service Joint Partnership Board are detailed

in the below image.



1.2 Stroke Update

The ASRPB received an update via a presentation from Chris Burton, Medical Director (NBT), regarding the BNSSG Stroke Reconfiguration Programme. The update detailed current stroke services and financial position, collaboratively developed options for future service provision (including associated costs, long term care benefits and risks of not proceeding) and the governance required to meet the programme timetable.

The Committee was enthusiastic in its support for the reconfiguration programme, and the respective Executive leads were encouraged to be bold in reconfiguration of services. It was noted that sensitivity would be needed regarding anxiety of clinicians at both NBT and UHBW. It was further noted that Stroke Reconfiguration work could be used as a template for future cross-organisation working.

The Pre-Consultation Business Case (PCBC) for Stroke Reconfiguration detailing the reconfiguration options was approved at TMT following the ASRPB, and is due to be received at UHBW's and NBT's January Trust Boards for approval, as the system required assurance that all partners formally supported the reconfiguration of the stroke service. Once approved by partners, it will progress to the CCG for formal decision regarding public consultation.

1.3 Cancer

The ASRPB received an update via a presentation from Owen Ainsley, ASR Programme Manager, regarding the cancer work-stream. The update described the Cancer Services Scoping Event which took place on 7 December 2020 as

having good engagement. It was noted that at the event there was agreement on the high level aims of the cancer work stream such as improving communication between organisations, increasing patient engagement with treatment, and enhancing diagnostics. However, it was identified that the scheduled February 2021 event required diagnostics representatives to benefit discussion.

It was agreed that a Project Initiation Document (PID) and resulting action plan for the Cancer ASR work-stream be brought to March's ASRPB, dependent on the availability of clinicians during the current wave of the pandemic.

1.4 Adult Intensive Care Update

ASRPB acknowledged that it was a busy time for ICU clinicians but that UHBW and NBT staff were working well together within the Severn Network and that the pandemic had assisted the development of collaborative working and set-up of the Regional Retrieval Service. Cross-organisational relationships would continue to be developed through joint decision-making regarding difficult ventures such as implementation of extracorporeal membrane oxygenation (ECMO).

It was reported that the key areas of focus was expansion of both Trust's critical care units; and scoping of a city-wide solution for delivery of ECMO services as part of a wider plan. ASRPB was highly supportive of having a united Bristol voice regarding these and encouraged continued partnership working within the Severn Network.

1.5 Resourcing

Owen Ainsley, ASR Programme Manager, presented a paper as requested at the previous ASRPB that summarised initial priorities for the programme moving into 2021 and additional resources required to enact the programme.

In addition to the current agreed resource (Programme Manager and ad hoc clinical leads and lead executives), ASRPB supported the proposed resource plan that requested the following additional roles:

- Programme coordinator (B5), 1 FTW
- Programme Manager (8B), 1 FTW
- HR Lead (8B/C), 0.4
- Finance Lead (8B/C), 0.2
- Informatics Lead (TBC), 0.2
- Communications Lead (TBC), 0.4 (for 6 months)

It was noted that the HR, Finance and Informatics roles would be sought from secondments and the two organisations were requested to consider whether these could be met from within existing resources, or whether backfill was required. It was agreed that secondments would allow careful skills matching to identify the best person to fill the complex roles.

The Executive Team will consider and confirm the route of approval for recruitment and funding to the above additional roles in line with the SFIs.

1.6 ICS Next steps Consultation Document

Professor John Iredale, NED and ASRPB Co-Chair, noted positively that both Trusts were already carrying out Integrated Care System (ICS) work and that both Boards had submitted feedback regarding NHSE consultation on ICS's. It was agreed that a further discussion at ASRPB be scheduled for March 2021 when ICS timetables would be known.

For Board Awareness, Action or Response

The Trust Board is asked to:

- Note the activity undertaken by the ASRPB, including development of BNSSG Stroke Reconfiguration, approval for establishing a Joint NICU Service Partnership Board, and development of a 2021 ASR Programme resourcing and prioritisation plan;
- Note the proposed additional resources for the ASR Programme.

Date of next meeting:	**16 March 2021**

Terms of Reference – NICU Service Joint Partnership Board

Document Data	
Corporate Entity	NICU Service Joint Partnership Board
Document Type	Terms of Reference
Document Status	DRAFT
Executive Leads	North Bristol NHS Trust Medical Director University Hospitals Bristol and Weston NHS Foundation Trust Director of Finance/ Director of Strategy and Transformation
Director Leads	University Hospitals Bristol and Weston NHS Foundation Women's & Children's Divisional Director North Bristol NHS Trust Clinical Director for Women's & Children's Services
Document Owners	University Hospitals Bristol and Weston NHS Foundation Women's & Children's Divisional Director and North Bristol NHS Trust Clinical Director for Women's & Children's Services
Approval Authority	Acute Services Review Programme Board on behalf of UHBW and NBT Trust Boards
Review Cycle	6 months
Next Review Date	*June 2021*

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision (Major/ Minor)**	**Description of Revisions**
03/06/2020	v0.1	Amanda Saunders	Major	1st Draft
12/08/2020	v0.2	Amanda Saunders	Minor	Amends following review at NICU Project Board
25/11/2020	v0.3	Amanda Saunders	Minor	Amends to reflect ASR Programme Board
11/12/2020	v0.4	Amanda Saunders	Minor	Amends to reflect guidance re membership
16/12/2020	v0.5	Amanda Saunders	Minor	Amends to reflect Joint Project Meeting
05/01/2021	v0.6	Amanda Saunders	Minor	Amends to reflect Trust Secretary guidance

Contents

1. Constitution of the NICU Service Joint Partnership Board

The NICU Service Joint Partnership Board is a non-statutory entity that has been established by North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation (UHBW) to support the delivery of the 'Achieving Centralisation of Neonatal Intensive Care services in Bristol' proposal. The NICU Service Joint Partnership Board will provide a new forum in under which two key objectives would be realised; integration of services where there is an agreed benefit ahead of a proposed transfer of activity, and delivery of a Full Business Case.

It follows the work undertaken by the NICU Project Board which had oversight and responsibility for the development of the Outline Business Case.

2. Purpose and function

The purpose of the NICU Service Joint Partnership Board is to oversee joint working between the NBT and UHBW to ensure delivery of the centralisation of Neonatal Intensive Care services for the population of Bristol, North Somerset and South Gloucestershire and the wider South West Neonatal Operation Delivery Network region.

The Partnership Board will:

a. Support the integration of the NBT and UHBW neonatal services, ahead of a transfer of activity or formal change in the service model, where there is an identified and agreed benefit. Areas expected to include;
    - Research and education
    - Staff training and development
    - Procurement - clinical systems, medical equipment, service consumables
    - Responding to and implementing work that addresses national guidance

b. Have oversight and responsibility for the development of a Full Business Case for the proposal to centralise Neonatal Intensive Care services in Bristol to include;
    - A recommended new management model that must deliver a 'single service' whereby the LNU at Southmead is formally designated as part of the NICU at St Michael's mitigating any risk to the sustainability of the service
    - The development of the final stage designs for the capital scheme for the expansion of the Unit at St Michael's including a process of staff and parent stakeholder engagement.
    - A final affordability assessment for the proposed service change that is in line with the recommended management model

c. Lead strategic planning for Acute Neonatal Services at NBT and UHBW and ensure both Trusts are sighted on developments which may impact on the integration of services, for example the procurement of medical equipment and clinical digital systems.

d. Facilitate a shared understanding of strategic and operational risks that may impact on implementation of the Achieving centralisation of Neonatal Intensive Care services in Bristol Full Business Case, and shared responsibility for agreed mitigating actions.

e. Liaise where necessary with other boards or committees on issues relevant to the purpose of NICU Service Joint Partnership Board.

The NICU Service Joint Partnership shall have the power to commission reports on any topics or issues which are relevant to its remit, as set out in these terms of reference.

3. Membership and attendance

The NICU Service Joint Partnership Board shall be comprised of membership that reflects both partner organisations and shared leadership for delivering the agreed purpose and function.

Where indicated UHBW and NBT will nominate leads who will liaise with their respective counterpart, thereby sharing responsibility of the role whilst maintaining an effective use of staff time.

- Chair - UHBW Director of Finance/ Director of Strategy & Transformation or NBT Medical Director (shared attendance)
- UHBW Women's and Children's Divisional Director
- NBT Women and Children's Health Clinical Director
- UHBW Neonatal Service Clinical Director
- NBT Women's and Children's Health Divisional Operational Director
- UHBW St Michael's Hospital General Manager
- NBT NICU Matron
- UHBW NICU Matron
- NBT Women and Children's Health Head of Nursing/ UHBW Head of Midwifery (shared attendance)
- NBT Deputy Director of People and Transformation/ UHBW Deputy Director of People (shared attendance)
- NBT Deputy Director or Finance/ UHBW Deputy Director of Finance (shared attendance)
- NBT Director of Estates, Facilities and Capital Planning/ UHBW Director of Estates
- UHBW/ NBT Neonatal Services Project Manager

Duly nominated deputies should attend in the event the named lead is unable to join the meeting, notifying in advance the Chair of the Board and Project Manager.

In accordance with the agenda other delegates will be invited to join the meeting as needed.

4. Quorum

The quorum necessary for the transaction of business shall be a minimum of 4 representatives from each Trust and the Chair.

A duly convened meeting of the Partnership Board at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable as set out in these Terms of Reference.

5. Roles and Responsibilities

The NICU Service Joint Partnership Board shall discharge the following duties to establish and effectively implement systems and/or processes to:

(a) Develop a programme of strategic and operational actions that support the integration of the NICU services in Bristol.

(b) Agree its programme of work in line with the requirements to develop a Full Business Case for the proposal to centralise Neonatal Intensive Care services.

(c) Develop a recommended new management model that must deliver a 'single service' whereby the LNU at Southmead is formally designated as part of the NICU at St Michael's mitigating any risk to the sustainability of the service

(d) Facilitate a shared understanding of strategic and operational risks that may impact on implementation of the Achieving centralisation of Neonatal Intensive Care services in Bristol proposal, and shared responsibility for agreed mitigating actions.

(e) Liaise where necessary with other boards or committees on issues relevant to the purpose of NICU Service Joint Partnership Board.

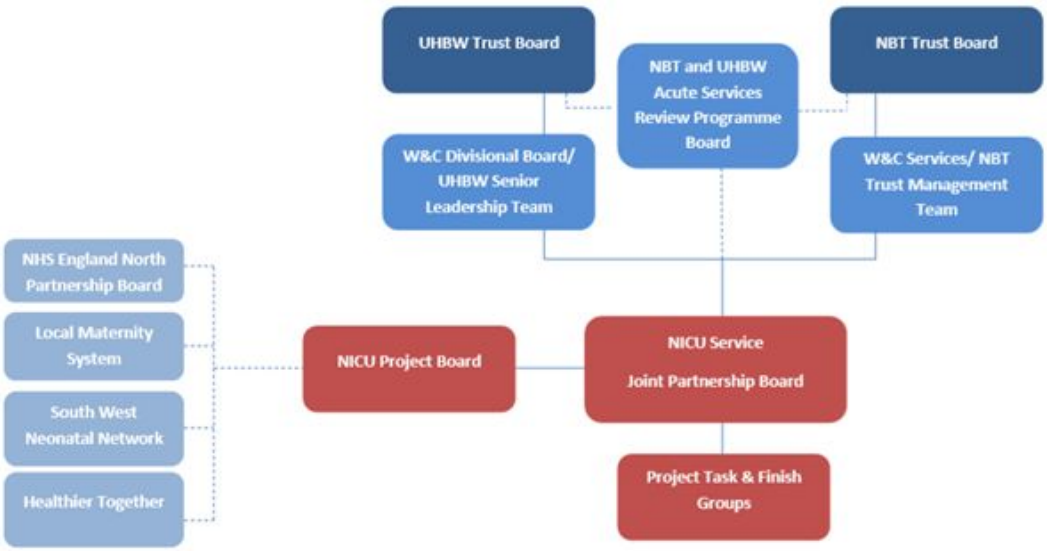
6. Reporting

The NICU Service Joint Partnership Board and will report formerly to Trust Boards via the Trust Management Team/ Women's & Children's Services Management Board at NBT and Senior Leadership Team/ Women's & Children's Divisional Board at UHBW.

The NICU Project Board shall be retained to ensure effective stakeholder engagement with key partner organisations and their associated governance structures and via the NICU Service Joint Partnership Board will continue to report to the Trust Management Team at NBT and Senior Leadership Team at UHBW.

The Acute Services Review Programme Board would also provide oversight and links to Trust Boards. The Partnership Board will report back to the NICU Project Board, and when needed the UHBW and NBT Trust Board's.

The overview of the structure below sets out the proposal for relationships and channels of communications between the connected groups:



There will be ongoing monthly reporting to the Healthier Together Acute Care Collaboration Steering Group via the Verto reporting system.

The Joint Chairs of the Partnership Board shall liaise with the Chairs of other Committees / Boards where necessary to ensure that cross-committee issues receive adequate oversight.

7. Administration

Administration of the NICU Service Joint Partnership Board will be facilitated by the Neonatal Services Project Manager.

Meetings of the Partnership Board shall be called by Chair, and the schedule of meeting dates and times will be issued for the year in advance of the first meeting,

Unless otherwise agreed an agenda of items to be discussed and supporting papers shall be made available to each member of the Partnership Board and any other person required to attend no later than five working days before the date of the meeting.

The Neonatal Services Project Manager will minute the proceedings and resolutions of all Partnership Board meetings, including the names of those present/ in attendance and agreed actions from the meeting with details of responsible owners.

Draft minutes of meetings shall be made available no later than five working days after the meeting and be made available to all members of the Partnership Board.

8. Frequency of Meetings

The NICU Service Joint Partnership Board shall meet on a monthly basis unless otherwise advised by the Chair and/or the NICU Project Board.

9. Review of Terms of Reference

The NICU Service Joint Partnership Board will schedule to review its own performance and Terms of Reference at 6 months from commencement to ensure it is operating at maximum effectiveness.

University Hospitals Bristol and Weston NHS Foundation Trust

Paper to follow:

Agenda item 9(b)

Finance & Digital Committee Chair's Report

University Hospitals Bristol and Weston NHS Foundation Trust

Paper to follow:

Agenda item 9(a)

People Committee Chair's Report

University Hospitals Bristol and Weston NHS Foundation Trust

Paper to follow:

Agenda item 9(d)

Quality & Outcomes Committee Chair's Report

University Hospitals Bristol and Weston NHS Foundation Trust

Paper to follow:

Agenda item 9(e)

Audit Committee Chair's Report

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors on 28 January 2021

Reporting Committee	**Charity Committee - meeting held on 17th December 2020**
Chaired By	**Jeff Farrar, Trust Chair**
Executive Lead	**Neil Kemsley, Director of Finance & Information**

For Information

- The Committee considered a summary of fund balances as at 31 November 20202, which stood at £647k. There had been an increase in the fund balances of £261k over the first eight months of the year. The Charity had also received a further £50k from NHS Charities Together from their second wave of Covid funding in November. T was confirmed that there was a clear divisional process in place to ensure this funding was used in the best way possible.

- The Committee received a presentation from J.M. Finn which provided an overview of the Charity's investment portfolio over the past year.

- The Committee received and noted an update on the project to take the Charity to independent status and potential merger with Above & Beyond. The project was progressing well and in line with the plan, with due diligence being undertaken by both parties. The next step was to draft a deed of understanding which was expected to be done by the end of January.

Key Decisions and Actions

The Committee considered a number of applications for charitable funding and made the following decisions in respect of these:

Mobile Digital Radiography X-ray (£75,000): Declined as it was felt this equipment formed part of the hospital's core business which should not be funded by charitable funds.

- Christmas presents for patients on Christmas Day (£1,248): Approved.
- Staff Physio Clinic for 2020-21 (£7,464): Approved
- 2 Sofas for Berrow Ward staff room (£1,100): Approved
- Tilt in space specialist wheelchair (£1,635): Declined as it was felt this equipment formed part of the hospital's core business which should not be funded by charitable funds.
- Tilt in space specialist wheelchair (Tall) (£1,693): Declined as it was felt this equipment formed part of the hospital's core business which should not be funded by charitable funds.
- Christmas tokens to staff £3,500: Approved.

Date of next meeting:	**18 February 2021**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28 January 2021

Report Title	**Quality Strategy**
Authors	**Chris Swonnell, Head of Quality & Patient Experience** **Anne Reader, Head of Quality & Patient Safety**
Executive Leads	**Deidre Fowler, Interim Chief Nurse** **William Oldfield, Medical Director**

1. Report Summary

UHBW's proposed Quality Strategy for 2021-2025 is presented here for approval following scrutiny by the Quality & Outcomes Committee in December 2020.

2. Key points to note

(Including decisions taken)

The new strategy, delayed significantly due to the pandemic (and therefore now presented as a four year strategy commencing in 2021), is the result of extensive consultation with Trust leaders and stakeholders, as described in the document.

The Quality Strategy seeks to build on the quality foundations established by UH Bristol's previous Quality Strategy for 2016-2020 (WAHT did not have an equivalent strategy document) and the quality ambitions described in the Trust's overarching five year strategy, 'Embracing Change, Proud to Care' (2020-2025).

The Quality Strategy sets out four strategic priorities for quality at UHBW for the next four years:

- to make quality the first priority for every member of staff, the "why" behind everything we do;
- to reduce unwanted variation in the quality and safety of services through an unswerving focus on continuous evidence-informed improvement;
- to work closely with patients, families and other healthcare partners to improve healthcare experience and co-design better joined up care; and
- to be recognised by our patients, staff and regulators for delivering consistently outstanding patient care.

These strategic priorities are supported by quality goals which when joined up describe a culture of continuous and consistent improvement across our whole organisation.

This strategy describes the organisation that we are seeking to be, in line with the NHS Patient Safety Strategy, and aligned to other key UHBW strategies. The Quality Strategy describes our continuing organisation-wide commitment to delivering the safest treatment and care, with the best possible patient experience and world-class clinical outcomes built on the latest research evidence. Each year, we will use our Quality Accounts to publish specific annual objectives linked to realising the quality

goals described in this strategy; the process of planning for 2021/22 will begin once the strategy has been approved.

Whilst the assumption is that the Quality Strategy will be delivered broadly within existing resources, there are notable exceptions to this. Additional funding will need to be identified to support two specific elements of implementing the NHS Patient Safety Strategy: harm panel reviews, and the creation of a centralised team for conducting Root Cause Analysis investigations.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **Approval.**

5. History of the paper
Please include details of where paper has previously been received.

Senior Leadership Team	17/12/20
Quality & Outcomes Committee	18/12/20

University Hospitals Bristol and Weston NHS Foundation Trust

EMBRACING CHANGE, PROUD TO CARE – OUR 2025 STRATEGY

UHBW QUALITY STRATEGY 2021-2025

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

INTRODUCTION

Foreword From Medical Director & Chief Nurse

Our Trust strategy 'Embracing Change, Proud to Care' aims to deliver exceptional care, teaching and research every day; it expresses the Trust's long-term commitment to delivering outstanding care, placing patient and public engagement at the heart of everthing we do, making access to services as simple as possible and making better use of digital technology to improve quality. These are core commitments which we have carried through to, and embedded in, our Quality Strategy for 2021-25.

This Quality Strategy is a central component of the Trust's overall five year strategy. It represents a key step on our ongoing journey to becoming one of the outstanding centres for care delivery, healthcare teaching, research and innovation. Our ambition is to deliver the safest care with the best patient experience in the NHS.

The strategy sets out four strategic priorites for quality: to make quality the first priority for every member of staff, the "why" behind everything we do; to reduce unwanted variation in the quality and safety of services through an unswerving focus on continuous evidence-informed improvement; to be recognised by our patients, staff and regulators for delivering consistently outstanding patient care; and to work closely with patients, families and other healthcare partners to improve healthcare experience and co-design better joined up care. The strategic priorities are supported by quality goals which when joined up describe a culture of continuous and consistent improvement across our whole organisation. This strategy shows our commitment to a continued focus on quality.

We want our patients to be confident that the Trust is always safe, effective, caring, well led, and responsive to their needs. We want people working within and alongside the Trust to know that they are providing the best service they can, and that what they do is important and valued. The challenge we put to every team, and every member of staff, is to hear that message and to commit to consistently delivering these goals. We have an exceptional workforce, and every single one of us has a role to play: firstly, by understanding how our job contributes to quality; secondly, by identifying and highlighting opportunities to improve services and work smarter; thirdly, by participating in quality improvement activities; and fourthly, by 'calling out' any concerns about quality so that we keep patients and staff safe.

This strategy builds on robust foundations of quality laid over the past decade, but there is so much more for us to do together.

Carolyn Mills, Chief Nurse
William Oldfield, Medical Director

1. TRUST MISSION AND VISION

Our Mission and Vision

Trust Mission
Our mission as a Trust is to improve the health of the people we serve by delivering exceptional care, teaching and research, every day

Trust Vision for 2025
• **Anchor our future as a major specialist service centre and a beacon of excellence for education** • **Work in partnership within an integrated care system locally, regionally and beyond** • **Excel in world-class clinical research and our culture of innovation**

The Quality Strategy is one of seven enabling strategies underpinning the Trust's 2020-2025 strategy:

The Quality Strategy defines what we mean by 'exceptional care' in the Trust's mission statement and outlines our strategic approach to delivering it. Our five year vision for quality is: **To deliver the safest care with the best patient experience in the NHS.**

The Quality Strategy necessarily has strong links with other Trust strategies in the model above. The following inter-dependencies are particularly significant:

- Clinical Services Strategy – which describes the Trust's clinical service priorities for the period covered by the Quality Strategy, including developing integrated clinical pathways across BNSSG and South West England, focusing in particular on the Trust's portfolio of specialist services including cancer treatment and surgery, cardiac services, children's services, and dermatology
- Improvement and Innovation (Transformation) Strategy – which will develop and embed clinically led care pathway re-design and processes that are efficient and deliver improved patient outcomes.
- Research Strategy – which delivers an expanding, active research programme in collaboration with academic and commercial partners and supporting the contribution of research to delivering new approaches to medicine and the delivery of new treatments to our patients.
- Digital Strategy – which provides the technological platform to support the delivery of consistently excellent care, which is data driven, efficient and reduces unwarranted variation.
- People Strategy – which focuses on investing in our staff; securing and retaining outstanding staff, supporting their education, development and wellbeing and improving diversity at all levels in the organisation.
- Estates Strategy – which sets out our plans for the ongoing renewal of our hospital estates and facilities, reflecting a key element of how patients experience the treatment and care we provide.

Trust strategic priorities relating to quality (as expressed in the Trust's 2025 strategy 'Embracing Change, Proud to Care')
1. Deliver outstanding care evidenced through our CQC rating
2. Place patient and public engagement at the heart of everything we do / co-design more joined up care
3. Make access to services as simple as possible
4. Keep an unswerving focus on quality of communications
5. Make better use of digital technology to improve quality

Givens
• **Retaining CQC Outstanding rating as UHBW**
• **Achieving and sustaining upper quartile performance across a range of key quality metrics, including national patient surveys**
• **Improving the experience of the "2%", with a specific focus on inclusion and diversity**
• **Delivering quality-related commitments made in Trust 2025 strategy (e.g. commitment to service co-design)**
• **Delivering the new NHS Patient Safety Strategy locally**

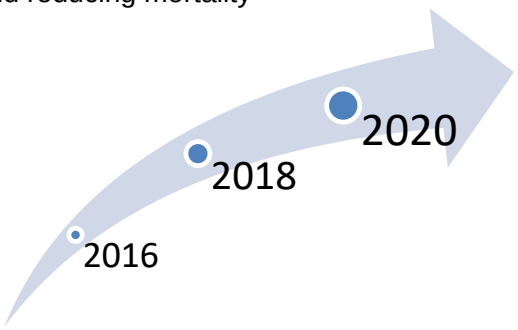
2. BACKGROUND and CHANGING ENVIRONMENT

Background and what we have already achieved: our journey of quality

Previous achievements

University Hospitals Bristol NHS Foundation Trust (UH Bristol) and Weston Area Health NHS Trust (WAHT) merged on 1st April 2020 to become University Hospitals Bristol & Weston NHS Foundation Trust (UHBW). WAHT did not have a written strategy for quality, so this is the first such document covering services at Weston General Hospital. UH Bristol's previous Quality Strategy covered the period 2016-2020; that strategy had four overarching themes, which together expressed the Trust's view of quality at the time:

- Ensuring timely access to services
- Delivering safe and reliable care
- Improving patient and staff experience, and
- Improving outcomes and reducing mortality



Amongst our achievements during this period, the UH Bristol first achieved and then retained an Outstanding rating from the Care Quality Commission (CQC); prior to this, UH Bristol had been rated as Requires Improvement (which was also WAHT's CQC rating at the point when UH Bristol and WAHT merged). For each year covered by the 2016-2020 Strategy, UH Bristol also achieved a Top 10 rating for acute non-specialist NHS acute trusts in the CQC's national survey of inpatient experience (UH Bristol was the top-rated Trust in 2016 and 2018).

The strategy set out a total of 39 separate improvement goals, ranging from learning from deaths, to developing the maturity of our patient safety culture, to creating a customer service mind set amongst our staff (including in how we respond to complaints). The vast majority of these goals were achieved, and the progress made at UH Bristol since 2016 has created a strong platform for UHBW to build on for the benefit of the people of Bristol and Weston-super-Mare.

Drivers and motivators for continuous improvement

Nationally:

- The requirements of the CQC's regulatory framework mean that we must be able to demonstrate that our services are safe, effective, caring, responsive and well-led.
- The NHS Patient Safety Strategy, published in 2019, which describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems.

- The NHS Outcomes Framework, which sets out national outcomes that all providers of NHS-funded care should be contributing towards:
    - Preventing people from dying prematurely
    - Enhancing quality of life for people with long-term conditions
    - Helping people to recover from episodes of ill-health or following injury
    - Ensuring people have a positive experience of care
    - Treating and caring for people is a safe environment and protecting them from avoidable harm
- Commitments and priorities outlined in previous significant national guidance, including the NHS Five Year Forward View, placing an emphasis on improving cancer and mental health care.
- The ongoing need to improve the access, experiences and health outcomes for all patients and communities, set out in Section 149 of the Equality Act 2010 Equalities Act.

Our definition of Quality

A single definition of quality in the NHS was first set out in "High Quality Care for All" (2008), following the NHS Next Stage Review led by Lord Darzi. This definition has since been embraced by staff throughout the NHS. This definition sets out three dimensions to quality, all three of which must be present in order to provide a high quality service:

- **Patient safety** – quality care is care which is delivered so as to reduce the risk of avoidable harm to patients and a culture of support, openness and honesty when something has gone wrong.
- **Patient experience** – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect. The patient experience domain of quality also embraces accessibility, understood in the sense that we must provide services in an inclusive way that recognises the diversity of our population.
- **Clinical effectiveness** – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;

At UHBW, we believe that this continues to be the most intuitive and easily-understood way to explain quality to staff and patients alike. UH Bristol's previous Quality Strategy 2016-2020 recognised that positive staff and patient experience are inseparable and set goals relating to staff experience; research repeatedly shows us that happy, engaged and motivated staff deliver better services. Since 2016, the Trust has developed a new People Strategy as the vehicle through which its commitment to staff engagement is now expressed, so our Quality Strategy no longer includes specific goals relating to staff experience.

Staff and teams affected by this strategy

Clinical Divisions:
Each year, our divisional triumvirates (Clinical Chair, Divisional Director and Head of Nursing) identify and agree specific areas of service quality they want to improve. These ambitions, expressed through annual operating plans (OPPs), need to be anchored in a shared understanding of the Trust's quality journey as set out in this strategy.

Corporate teams:
This strategy will inform and direct the work of a number of corporate teams who support our Divisions in achieving their annual quality ambitions and contributing to the achievement of Trust-wide annual quality objectives. This includes, but is not limited to, the following teams:

- Patient Safety Team
- Patient Experience Team
- Clinical Audit and Effectiveness Team
- Patient Support and Complaints Team
- Transformation Team

All our staff:
All our staff are fundamental to the delivery of a quality service to our patients; it is important that they understand their unique contribution to providing a high quality service and the personal impact/difference that they can make to patients.

Where are we now? (SWOT analysis)

Strengths	**Weaknesses**
• Strong organisational platform of quality performance and improvement to build from • An established system-wide collaborative approach for patient safety innovation and improvement within the West of England Patient Safety Collaborative • Capable and committed clinical and non-clinical teams with effective links into national/peer groups and networks • Organisational commitment to quality improvement opportunities, with a growing spread of QI skills amongst staff • Strong Governor commitment and engagement around quality themes • Availability of high quality data • Cultural focus on, and moral commitment to quality and safety • Patient Inclusion and Diversity Group provides an effective engagement forum to develop our thinking around equality related to patient service delivery	• Lack of designated expert resource to deliver objective systems-based patient safety incident investigations and support patients and families to become involved in reducing patient safety risks • Overly bureaucratic approach can lessen organisational agility to progress quality projects quickly • Initiatives frequently rely on individuals and are not sustained when they leave • Lack of a mechanism to address challenges assigned to the “too difficult” box • Limited capacity to drive significant new projects whilst doing the ‘day job’ • Divisional quality assurance groups may focus on patient safety to exclusion of other dimensions of quality
Opportunities	**Threats**
• NHS Improvement’s Patient Safety Strategy 2019 provides a step change of national commitment and drive requiring NHS trusts to deliver differently and at pace on patient safety insights, involvement and improvement • Greater use of Transformation Team expertise to support delivery of Quality Strategy goals	• Organisational tendency to risk aversion • Ability of clinical staff to release time to engage and participate in quality improvement activities • Potential for further waves of COVID-19 pandemic to impact upon our plans • Risk of reversion to insularity and

	• Learning from the best of both UHBW predecessor organisations, including strength of links with local community at Weston General Hospital • Learning from UH Bristol's previous response to national cancer survey findings, i.e. longer term investment in wider change, instead of incremental yearly adjustments to services in response to feedback • Potential for further integration of corporate approach to co-ordination, governance and support of QI activities – develop a QI Board? • Expand partnership working with peers and networks • Continue to develop intelligent use of data to direct/underpin decision-making	protection of what's 'ours' as a Trust • Impact of cost savings targets on corporate and divisional resources to deliver quality ambitions	

3. Process for the development of the strategy

Outline of process to develop strategy and engagement undertaken

How we consulted	What we heard and how this has influenced our strategy
We asked our patients, Trust members, governors, staff and members of the public, and the groups and individual who together make up our Involvement Network two questions via an on-line survey: "Thinking about healthcare services, what does 'quality' mean to you?" And "If you need hospital care, what matters most to you?" More than 300 people replied.	Feedback from the survey (summarised in the next section below) affirmed the core tenets of our understanding of quality: keeping people safe, delivering world-class clinical outcomes, making the experience of being in hospitals as good as it can possibly be. In response to the survey, we have committed to making "What matters to you?" a core strand of our plans for improving patient experience.
We held a membership engagement event in January 2020 to hear in person about "what matters to me". Quality Counts was attended by approximately 40 people.	Patients rightly assume that we will keep them safe and that we have the expertise to deliver effective treatments; feedback tends to focus instead on experience of care. Attendees at the event told us that their experiences were increasingly influenced by four things:

		- Our ability to embrace the digital age - The quality of the hospital environment - The quality of face-to-face communication – empathy, honesty active listening skills, personalisation. In short, staff need to "Ask, Listen and Act" - Identifying and acting upon 'friction points' in care pathways, working in partnership at system-level if solutions lie at that level. Our strategy commits to embedding our previously-developed customer service principles across the organisation, and to further developing our early exploration of measuring patient experience across a range of customer touch-points in the same healthcare journey.
	We reviewed feedback received by the Trust when it consulted on its organisational strategy in 2019, and also the key quality-related commitments subsequently made by the Trust	The feedback the Trust received from the public and its governors in 2019 highlighted very similar themes to our 'Quality Counts' event, namely: - Keep modernising buildings and facilities - Understand that communication is the key determinant of overall patient experience – and make more use of digital technology to improve how we communicate - Work in partnership with other NHS partners and other agencies, keeping the focus on the patient - Provide *consistent* high quality care Our Quality Strategy recognises: the centrality of communication not just to patient experience but also to patient safety; the importance of partnership working; and focuses on reducing unwanted variation in quality. The key quality-related commitments made by the Trust in its 2025 organisational strategy are reflected in our Quality Strategy.
	We met with the senior leadership teams at UH Bristol and WAHT to understand their priorities for quality.	WAHT's senior management committee highlighted three priorities for quality: - We need to keep patients at the heart of our plans, setting targets that reflect what matters to patients (otherwise we risk "hitting the target whilst missing the point") - We need the fundamentals of quality – i.e. keeping people safe, delivering world-class clinical outcomes, and providing the best possible patient experience – to be the most important thing for all our staff, i.e. quality is everyone's business. - We need to empower all our staff to act on quality challenges.

		UH Bristol's senior leadership team agreed, adding that: - Our goal must be to retain our CQC Outstanding rating, but also to ensure that all domains or all core services at all locations are rated as at least Good. - We want staff to feel proud of the care they deliver. - We need to ensure that care is delivered in the safest and most clinically appropriate settings. - There needs to be a mechanism to enable Divisions to come together to address quality challenges are otherwise in the "too difficult" box. - Quality improvement must become part of our cultural 'DNA'. - Lastly, SLT agreed with feedback from the Quality Counts event about the need to effective communication and personalisatioon of care – specifically, "Ask, Listen and Act". These priorities are reflected in our strategy.	
	We reviewed best practice nationally across the NHS, including NHS peer trusts. We also reviewed our own existing quality strategy.	We gained insights and ideas from reading other trusts' quality strategies and by reflecting on UH Bristol and WAHT's respective quality journey's thus far.	
	We gathered together leaders within the Trust who are responsible for different aspects of patient and carer experience to talk about their ambitions for quality.	Feedback from this group has informed our choice of patient experience ambitions expressed in this strategy.	
	We shared an early draft of this strategy with our Governors, and with stakeholders including our local CCG, local Healthwatch and the Trust's Involvement Network.	Feedback from this group was that Governors supported the identified quality improvement priorities	
	We completed an Equality Impact Assessment as part of the process of developing this strategy.	The EIA confirmed that this strategy will support the Trust's ambitions to deliver the highest quality care to everyone, whatever their protected characteristics.	
	We reviewed our draft Quality Strategy in the autumn of 2020, specifically to consider our emerging understanding of 'new normal' in light of the COVID-19 pandemic.	Our review affirmed the continuing relevance and appropriateness of the ambitions for quality set out in this strategy.	
	We formally reviewed our draft strategy at the following Trust groups and committees prior to approval by the Board: Clinical Quality Group,	The draft strategy was agreed without amendment.	

Senior Leadership Team and Quality & Outcomes Committee.	

What people told us in our on-line survey

Although quality means different things to different people, our survey revealed a consistent shared understanding of the core elements of quality which are reflected in the definition of quality we have chosen for this strategy. The wordcloud below contains some of the key words that people associate with high quality patient care:

The following quotes perhaps best summarise the key messages we heard in the survey:

“It means providing the best care possible. That is when the patient needs it, in the right place, with the right person. It is safe and effective, it involves the patient in the decision-making process and engages them to take an interest in self-care.”

“Safe environment, cutting-edge treatments, being seen on time, patient choice, low mortality rates, good communication…”

“Professionalism combined with humanity and kindness”

“Knowing that you are being cared for by staff who are at the top of their profession and who have access to the most appropriate investigations and treatments in the country, if not the world.”

“Well trained and informed staff, patient-focused with patient engagement embedded into service development, sufficient staff, resources and equipment to deliver safe care, good leadership, fair treatment of staff…”

“When I trained, I was taught to ask myself the question, “if the next patient through the door is your mother, your sister, your child – will you still be happy with the job you’re done?”

4. Strategic priorities

Our key strategic priorities for Quality

Taking account of our quality journey to this point, national and local drivers, and the feedback we have received during the consultation phase of the development of this strategy, we have identified four key strategic priorities for quality which have been tested with our Senior Leadership Team:

Strategic priorities for Quality
1. To make quality the first priority for every member of staff – the 'why' that's behind everything we do
2. To reduce unwanted variation in the quality and safety of services through an unswerving focus on continuous evidence-informed improvement
3. To work closely with patients, families and other healthcare partners to improve healthcare experience and co-design better joined up care
4. To be recognised by our patients, staff and regulators for delivering consistently outstanding patient care

This section of our Quality Strategy explains what each of our four strategic priorities means in practice. It also describes the outcomes we want to achieve.

The use of quality goals will help us do a number of things:

- Work towards existing objectives in a more systematic and productive way
- Spread aspects of quality improvement over more realistic time periods, rather than just one year
- Inform the most appropriate allocation of resources and avoid wasteful duplication
- Support the Trust's strategic objectives
- Support better co-ordination of aims and objectives across many different portfolios (e.g. patient safety, patient experience, clinical audit, workforce and finance) allowing these aims to be aggregated towards a common quality goal
- Support each division to include the quality goals most relevant to their service in their annual business plans.

	Strategic priority	What this means	Quality goals (what Quality at UHBW will look like by 2025)
1.	To make quality the first priority for every member of staff – the 'why' that's behind everything we do	Making quality the number one priority involves: - Embedding clear and consistent messages about quality at key touch points for staff throughout their UHBW employment. - Creating a culture that empowers people to identify and act upon opportunities to innovate and improve the ways in which care is delivered.	- All UHBW staff and managers will be required to reflect on quality as part of annual appraisals, identifying and recognising their personal contribution to quality - All staff will have easy access to information about quality of care to know how they are doing - Our Trust's quality improvement training capacity will have been significantly expanded (delivered via the Transformation, Improvement and Innovation Strategy, which is a key enabler to the Quality Strategy) - There will be a more streamlined, co-ordinated and collaborative approach to quality improvement in place throughout our hospitals, creating better support, governance and learning around QI - There will be widespread evidence that staff are comfortable with the concept of 'speaking up for quality', i.e. highlighting quality concerns
2.	To reduce unwanted variation in the quality and safety of services through an unswerving focus on continuous evidence-informed improvement	This strategic priority involves: - Developing a consistently open and just culture across UHBW where people feel able to raise concerns without fear of reprisals and feel psychologically safe to fully share information to maximise learning and appropriately targeted action in response to incidents. - Striving to make UHBW the safest place to receive treatment in the NHS - Promoting and enabling evidence-based treatment and care - Continuing to develop intelligent use of quality data (including clinical audit) throughout the organisation to	By implementing the 2019 NHS Patient Safety Strategy, we will: - Have improved systems for insight and learning from incidents through implemenation of the new national patient safety incident response framework and patient safety incident management system and the medical examiner system. - Have developed role of patient safety specialists within the Trust who are active in leading safety improvements across the system - Have reconfigured our patient safety training plans to ensure our staff have access to, and are supported to, undertake patient safety training and education in line with the national patient safety syllabus commensurate with their role - Have ensured systems are in place to equip staff to learn from what goes well, as well as to respond appropriately to things going wrong - Have embedded a just culture and a restorative culture of learning and support, where staff feel able to speak up and report incidents without fear of reprisals and patients, families and staff are supported to overcome the impact of incidents - Be working closer with patients and their families when things have gone wrong and impacted them specifically and in improving patient safety more generally (see below). - Be delivering locally on the national patient safety improvement priorities working with partners in the West of England Patient Safety Collaborative. - Be delivering our refreshed patient safety improvement programme across UHBW in line with priorities identified from further thematic analysis post-COVID

		measure what matters and to better understand what data is really telling us.	We will also: - Have implemented a new central registration, monitoring and reporting system for clinical audit and wider governance/quality projects; improving the visibility and connectivity of quality activity and results to help drive quality improvement - Through continued systematic assessment against clinical recommendations from national/professional bodies (not just NICE), improve our understanding of the quality of services we provide, and reduce variation - Work with colleagues at the Bristol Biomedical Research Centre to enable our staff to safely introduce new and innovative interventional procedures into clinical practice
3.	To work closely with patients, families and other healthcare partners to improve healthcare experience and co-design better joined up care	This kind of relationship with service users involves: - Making UHBW a provider of choice for all people. - Placing patients at the heart of our plans for service improvement – "nothing about me without me". - Fundamentally, focusing on getting our communications with patients and their carers right (this is what feedback from service users consistently tells us). - Designing services in partnership with the people who use them. - A willingness to work in partnership with other local NHS and social care providers, for the good of the people we serve.	- The question "What matters to you?" will be part of our organisational 'DNA' and in widespread use across our clinical services - Our "Here to help" customer service brand will be visible throughout the Trust, and our customer service principles will be widely understood; we will also be using patient feedback data intelligently to identify and act upon key customer 'touch points' in their experience of care (one of the attendees at our Quality Counts event also used the term 'friction points') - We will experience increasingly positive and transformed relationships with groups in Bristol and Weston who represent the views and needs of our diverse communities - We will have developed the role of 'patient safety partner' and put in place a system to provide training, support , reimbursement and opportunities to enable patients, carers, families and lay people to play an active role in patient safety as equal partners e.g. safety governance, service and pathway design, strategy and policy - Patients' experience of care will be consistently positive, regardless of disability or any protected characteristics under the Equality Act; every patient will rate their overall experience of care at UHBW as at least Good (currently, in 2020, 1-2% do not – hence the reference to "the 2%" earlier in this strategy document) - Our approach to patient and public involvement and service co-design will have evolved, adapting where necessary to embrace new technologies in a post-COVID world - Co-design skills and practices will have become a routine part of how the Trust's Transformation Team operates, ensuring a strong patient voice in any major service redesign activity; every clinical Division will also be able to demonstrate evidence of co-design in their annual Operating Plans - We will be able to point to a small number of key areas where we are working with NHS partners to improve patient experience, providing system leadership where appropriate

			- Always Events® will be in evidence in our organisation (deliberately named in contrast to patient safety Never Events, Always Events are aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time) - Volunteering activities at both Bristol and Weston will be consistently focussed on enhancing patient experience (delivered through the Trust's Volunteering Strategy)
4.	To be recognised by our patients, staff and regulators for delivering consistently outstanding patient care	This recognition includes: - Care Quality Commission ratings - Performance in national and local patient (and parent) surveys over a number of years. - Scores achieved in the staff Friends and Family Test (the staff FFT asks staff whether they would recommend the Trust). - Benchmarking a range of standardised quality and safety measures with peers and other NHS trusts.	- The Trust will have retained its overall CQC rating of Outstanding, and will be rated as at least Good for every dimension of every core service at every registered location - We will have demonstrated to NHSE/I, commissioners and other stakeholders how the National Patient Safety Strategy is being delivered locally. - We will also have retained our status as a Top 10 non-specialist acute hospital in the CQC annual national inpatient survey - We will have achieved year-on-year improvements in staff FFT scores - We will be consistently achieving and sustaining upper quartile performance across a broad range of standardised quality performance measures monitored by the Board

5. Delivery Model

How will the strategy be delivered?

How we will achieve and deliver against our strategic priorities and initiatives

Each year we are asked by our commissioners to identify key quality priorities for the Trust's Annual Plan. In future, these priorities will align with quality goals set out in this strategy. Each year, we will select a number of annual corporate quality objectives which support our four strategic priorities for quality, relate to our quality goals, and contribute to achieving the vision for quality we have described in our strategy. These annual quality objectives will be agreed in consultation with our Senior Leadership Team and our Governors, and will be published in our annual Quality Report/Account.

We will expect our Divisions to do similar, selecting locally-appropriate quality goals which contribute to our strategy and/or directly support the achievement of annual corporate quality objectives.

To make this work, we will need to change the way currently plan for quality, bringing our corporate planning cycle forward from the spring to autumn/winter*.

In recent years, UH Bristol has held an annual January membership engagement event called 'Quality Counts' which has informed our thinking about quality priorities (as indeed it has informed our thinking in this strategy). We are absolutely committed to retaining the voice of our members in our annual quality planning cycle, but we will need to re-think the means by which we do this (from 2021 onwards) in light of the COVID-19 pandemic.

The five key tests we will apply to our annual plans for quality, both at divisional and organisational level, are:

- Are they patient-centred?
- Are they inclusive?
- Are they evidence-based?
- Are they ambitious?
- Are they affordable?

It is also vital that resources follow the annual corporate quality objectives that we agree. This means:

- Creating capacity in the corporate Quality Team to oversee and steer our journey
- Allocating Transformation Team support to provide some of the project management and QI 'rocket fuel' we may need to help reach our destination
- Where necessary, prioritisation of quality objectives in annual financial planning rounds

*****we propose to commence quality planning for 2021/22 when this strategy receives Board approval at the end of 2020.

6. Governance, Assurance and Accountability

How we will assure ourselves of the effectiveness and success of the enabling strategy

The governance process to monitor delivery and provide assurance and oversight including management of any risks to the delivery of the new strategic priorities

The Quality Strategy will be monitored against a range of improvement measures outlined in this document and assured through our organisational governance structures:

Divisonal level - Divisions will have a clear set of quality objectives and metrics that will be agreed and introduced through the annual planning cycle prior to the start of every financial year. These objectives will be aligned with the Quality Strategy and delivery monitored through quarterly divisional reviews.

Corporate committee level – Our Executive-led committees will review implementation of the Quality Strategy in the areas of patient safety, patient experience and clinical effectiveness. Every year, a summary of progress will be presented to the Trust's Clinical Quality Group and Quality and Outcomes Committee. Ultimately, the Quality Strategy will be sponsored, and overseen, by the Trust Board. The Board will need to be assured that the improvement objectives described in the strategy are being consistently achieved.

7. Communications plan

How we will raise awareness of this strategy

Our Quality Strategy will be promoted both internally and externally using a variety of channels which will include:

Our staff	- Dissemination through Divisional Management Boards - Newsbeat - Dedicated page on our intranet site - Core induction for new staff
Our members	- Article in Voices magazine
Our Governors	- Presentations to Governors' Quality Focus Group and Council of Governors
Our patients and the public	- Dedicated page on our public website - Annual updates through our Quality Report/Account
Our stakeholders	- Strategy issued formally to our stakeholders - Annual updates through our Quality Report/Account on delivery

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28 January 2021

Report Title	**Quality Account 2019/20 for UH Bristol**
Authors	**Chris Swonnell, Head of Quality & Patient Experience**
Executive Leads	**Deidre Fowler, Interim Chief Nurse** **William Oldfield, Medical Director**

1. Report Summary

The annual Quality Account for UH Bristol for 2019/20 is presented for approval following scrutiny by the Quality & Outcomes Committee in December 2020.

2. Key points to note
(Including decisions taken)

A Quality Account is a report about the quality of services offered by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

The Department of Health and Social Care requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS website – usually by June 30 each year. While primary legislation continues to require providers of NHS services to prepare a Quality Account for each financial year, the amended regulations mean that, in light of pressures caused by COVID-19, there is no fixed deadline by which providers must publish their 2019/20 Quality Account (the recommended deadline for NHS providers was 15 December 2020).

For 2019/20, NHS providers have not been required to obtain assurance from their external auditor on their Quality Account / Quality Report. Similarly, NHS foundation trusts were not required to include a Quality Report in their Annual Report for 2019/20 – hence the document presented this year for UH Bristol is technically a Quality Account, not a Quality Report.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **Approval.**

5. History of the paper
Please include details of where paper has previously been received.

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Senior Leadership Team	17/12/20
Quality & Outcomes Committee	18/12/20

.

University Hospitals Bristol
NHS Foundation Trust

Quality Account 2019/20

Contents

Part 1

1.1 Statement on quality from the Chief Executive

The coronavirus pandemic was declared as the year 2019/20 was drawing to a close, since which time the NHS has faced the greatest challenge in its history. I am humbled every day by what I see from teams across our hospitals and the lengths they go to, to provide compassionate high-quality care. My wholehearted thanks and admiration go out to our staff for their commitment, bravery and professionalism in these most challenging of times.

Whilst the impact of the pandemic has overshadowed much of what went before, it is important to register some significant achievements in the course of 2019/20 through the pages of this report, where you will once again read about what we have been doing to keep patients safe, to provide world-class clinical treatments and to give patients the best possible experience when they need hospital care.

Our mission as a Trust continues – to deliver exceptional care, teaching and research every day. Our five year strategy *Embracing Change, Proud to care – our 2025 vision* sets out our ambition: to grow our specialist hospital services and our position as a leading provider in south west England and beyond, work more closely with our health and care partners to provide more joined up local healthcare services and support improvement in the health of our communities, and become a beacon for outstanding education and research and our culture of innovation.

I am hugely proud to be part of this organisation and I was delighted that the Trust was rated Outstanding by the CQC in August 2019 for the second time in a row. Our staff are very special people, and I was thrilled that their hard work was recognised in this way.

Our plans in 2019/20 encompassed our growing partnership with Weston Area Health NHS Trust, which involved me taking a dual Chief Executive role across Bristol and Weston from 1 September 2019 and culminated in a successful merger on 1 April 2020. The merger has helped to bring stability to Weston General Hospital and created a new organisation with a greater shared purpose. When we merged we became University Hospitals Bristol and Weston NHS Foundation Trust – a sign of our determination to ensure that Weston General Hospital has a bright and certain future at the heart of its local community. Together we now have more than 13,000 staff, working together to deliver exceptional healthcare services.

The benefits of our merger and the extent to which our services have been affected by the pandemic will both feature in next year's report. In the meantime, I commend our Quality Account for 2019/20 to you. As ever, my thanks go to those who have prepared and contributed to this report, including Healthwatch, our commissioners and our governors. I am pleased to confirm that the Board of Directors has reviewed this 2019/20 Quality Account and I confirm that it is an accurate and fair reflection of our performance.

Robert Woolley
Chief Executive

Part 2

Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

2.1.1 Update on quality objectives for 2019/20

In early 2019, the Trust identified eight specific areas of practice where we committed to improve quality in 2019/20. A progress report is set out below, including a reminder of why we selected each theme, our improvement objective/s and an overall 'RAG' (Red/Amber/Green) rating of the extent to which we achieved each ambition. Overall, we achieved our stated quality improvement objectives in four areas and made significant progress in the others.

Objective 1	**Enabling improvements in patient safety through the use of digital technology**
Rationale and past performance	In 2016, UH Bristol was selected as a 'digital exemplar' site, trialling pioneering digital technology to drive radical improvements in the care of patients. For 2019/20, we identified three specific patient safety themes where we believe digital technology can play a vital role in improving patient safety. These themes are: **Improving the management of intravenous cannulas** Until now, intravenous cannulas have been documented on drug charts, with inspections carried out once per shift. In reality, practice has been inconsistent, with no reporting mechanism to enable visibility of those cannulas that need a check and those that are due for removal. Documenting all intravenous cannulas in our Vitals e-observation system enables this visibility. **Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores)** Performance used to be sampled as a monthly audit via the patient safety thermometer, however, implementation of the Vitals system supports a full sample of all patients in real time, highlighting patients who do not get their observations taken on time as recommended by the NEWS2 escalation plan and ensuring that there is the correct oversight of observations by registered nurses. **Improving compliance with VTE (Venous thromboembolism) assessment** Previously, VTE assessment compliance has been measured from paper records when patients are discharged; we recognise that this has not provided a true measure of VTE assessment compliance rates. Use of an electronic VTE risk assessment in Medway on admission will support a full sample survey of all patients in real time.
What did we say we would do?	**Improving the management of intravenous cannulas** In 2019/20, we said that we would implement the use of the electronic system Vitals to document all peripheral intravenous cannulas. By using real time data, we would improve compliance with IV line monitoring, line related infection surveillance and reduce the number of line infections.

	Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores) In 2019/20, we said that we would work to embed the routine use of the e-observation system including improving ward managers' understanding of the ability to monitor patients' NEWS in real time and to identify any overdue observations. We would also work at divisional level and Trust level to ensure that prompt action is taken in response to any overdue observations. **Improving compliance with VTE (Venous thromboembolism) assessment** In 2019/20, we will implement and embed the use of the proposed digital tool to improve performance. We will also embed the use of dashboards and ward-view screens to highlight any patients who need a VTE assessment.
Measurable target/s for 2019/20	**Improving the management of intravenous cannulas** We said that we would measure the number of cannulas/lines that are left in beyond the date for removal and will reduce the number of infections related to cannulas left in beyond the time they should have been. **Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores)** We said we would reduce the number of incidents where adverse variations in observations have not been acted on as per Trust policy. **Improving compliance with VTE (Venous thromboembolism) assessment** We said that we would meet the national standard, which requires at least 95 per cent of appropriate inpatients to have a VTE risk assessment.
How did we get on?	<u>Intravenous cannulas:</u> Electronic monitoring has been implemented in all adult areas apart from ED, theatres and the Queen's Day Unit. Real-time monitoring of IV line compliance is in place. However, issues have been identified with inconsistent recording of IV line insertion which, in turn, leads to inconsistent clinical practice (if you don't record the insertion on Vitals, you won't receive electronic prompts to check the patient). Historical baseline data is not available and there are currently some challenges relating to extracting data from the system which shows the patient's most recent IV line check, but not the full history of compliance. We are actively working to resolve. A standard operating procedure has been devised to support a consistent approach to IV line insertion documentation; this has been trialled in ward areas across each division to ensure that the SOP meets the needs of all areas. Theatres are awaiting training to enable them to use E-Obs however cannula insertion is currently captured on Blue Spier. Further scoping is ongoing with ED. Progress will continue to be monitored via the Digital Clinical Operational Group. <u>Timely observations:</u> Baseline data gathered in Q4 2018/19 showed that full observations were taken on time on 140,085 occasions, and were late on 79,333 occasions (breached and overdue combined), i.e. 63.8 per cent taking place on time. This measure was across all sites (BRI, BHOC, SBCH, STMH, BEH) and excluded patients under 18. In 2019/20, timeliness of observations improved by only 3 per cent compared to baseline. This poor compliance with NEWS2 protocols suggests a continuing gap in implementation of NEWS2 guidelines at ward level. A new digital implementation group chaired, by the

	Chief Nurse, has been established and is working on methods to improve understanding and monitoring of the timeliness of observations. We are now able to share real time reports at ward, specialty and divisional level and the plan is to incorporate review of performance at divisional executive reviews. <u>VTE assessment:</u> Electronic VTE risk assessment in Medway (the Trust's patient administration system) was implemented in August 2019, enabling the collection of accurate, real-time data. This also means that VTE risk assessments are completed in full with digitally recorded date, time and the name of the person completing them. Following an intensive work programme, monthly performance in the second half of 2019/20 was consistently around 80 per cent (against the national target of 95 per cent). Significant barriers to compliance included the fact that VTE risk assessment is a "stand alone" task in Medway and not currently integrated into another routine process (such as admission or prescribing). We had anticipated that a fully integrated system with a 'force' function (enabling full compliance with the national standard) would become available during the year, however this was delayed due to issues with our external system supplier. Extreme pressures on capacity in the Trust have also been an issue, particularly in the emergency and assessment units. Compliance on wards responsible for acute admissions has been disappointing. These areas present a particular challenge due to the high turnover of patients, multiple members of staff being involved and the volume of tasks which need to be completed on admission. By streamlining workload, we are optimistic of achieving improvements going forward. Towards the end of the year, consultant and junior doctor-led Quality Improvement projects have been initiated in acute medicine and surgery. We also plan to incorporate digital VTE risk assessment into routine pre-op assessment to improve compliance for elective surgical patients. The roll out of digital risk assessment to children 16 years and over at Bristol Royal Hospital for Children and the Bristol Eye Hospital commenced as planned in February 2020, but was subsequently paused due to the Covid-19 pandemic.
RAG rating	Amber – we made important progress towards achieving this objective in 2019/20, but further work is needed, particularly in respect of meeting the national VTE standard during 2020/2021

Objective 2	**Reducing the risk of Never Events**
Rationale and past performance	Never Events are defined as "serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers" (NHS Improvement January 2018). Recent serious incident investigations, including those conducted by the independent Healthcare Safety Investigation Branch (HSIB), had concluded that the implementation of guidance and safety recommendations does not, on its own, prevent certain Never Events because of the human elements and human interactions within the system designed to prevent them

	happening. In 2018/19, 496 never events were reported nationally across the NHS. There were five Never Events which were reported by UH Bristol during 2018/19: • Retained broken off tip of a central venous line guidewire (child) (August 2018) • Alleged retained vaginal swab -occurring during care by a sub-contracted third party provider (November 2018) • Wrong side nerve block for a hip procedure (December 2018) • Wrong side laparoscopic testicular surgery (child) (December 2018) • Left ovary removed during laparoscopic hysterectomy when the plan was to conserve both ovaries (March 2019)
What did we say we would do?	We said that we would: • Work with surgical teams / Local Safety Standards for Invasive Procedures work stream leads to identify guidance for when additional "stop checks" time outs should be called. "Stop checks" are where the team pauses and refocuses, for example reconfirming the patient, procedure and laterality if a team member changes or an unexpected event happens during a procedure. • Incorporate into patient safety training awareness of the impact of hierarchical behaviours on calling time outs. By hierarchical behaviours we mean behaviours that belittle or embarrass team members and juniors, leading to, for example, them not feeling able to speak up if they see something that might be about to go wrong. • Provide training in high risk specialties about high risk Never Events, e.g. laparoscopic procedures where laterality is relevant, to include foresight and simulation training. • Test physical barriers to proceeding with nerve blocks until 'Stop before you Block' has been completed, and implement if effective barrier identified. • Commence three year work stream to understand and reduce the frequency and impact of interruptions and distractions on human error. • Conduct a "review and check" exercise to proactively revisit and recheck implementation of patient safety alerts designed to reduce the risk of Never Events. • Conduct a "review and check" exercise to ensure Local Safety Standards for Invasive Procedures incorporate the latest local learning and HSIB investigations. • Participate in system-wide collaborative work on reducing Never Events.
Measurable target/s for 2019/20	We said that we would judge success by the completion of the above actions.
How did we get on?	There were four surgical procedure never events in 2019/20 as reported in the patient safety section of this report. In 2019/20 we have: • Completed work with surgical teams to identify guidance for when additional "stop checks" time outs should be called. This work has determined that it is not possible to develop specific guidance due to the multiplicity and complexity of situations when an additional time out would be appropriate. • Incorporated into patient safety training awareness of the impact of

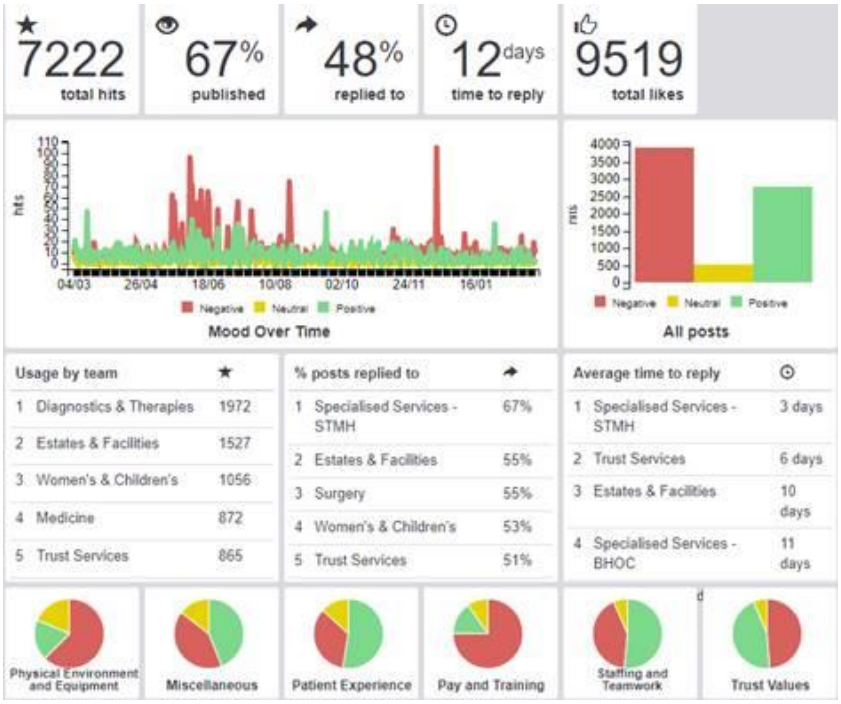
	hierarchical behaviours on calling time outs. By hierarchical behaviours we mean behaviours that belittle or embarrass team members and juniors, leading to, for example, them not feeling able to speak up if they see something that might be about to go wrong. • Provided on-going simulation training in high risk specialties about high risk never events and were planning work with system partners to develop system-wide foresight training, but the funding bid for this was unsuccessful. • Tested and implemented physical barriers to proceeding with nerve blocks until 'Stop before you Block' has been completed. • Started a three year work stream to understand and reduce the frequency and impact of interruptions and distractions on human error, but this work remains paused due to the Covid pandemic. • Conducted a "review and check" exercise to proactively revisit and recheck implementation of patient safety alerts designed to reduce the risk of never events. An action plan has been developed in response to this review and is being taken forward. • Conducted a "review and check" exercise to ensure Local Safety Standards for Invasive Procedures incorporate the latest local learning and HSIB investigations. An action plan has been developed in response to this review and is being taken forward. • Participated in system-wide collaborative work on reducing never events.
RAG rating	Amber – we completed the majority of our planned improvement actions, however we still reported four Never Events in 2019/20

Objective 3	**Improving the provision of information and support to meet the needs of young carers across the Trust**
Rationale and past performance	Following the re-launch of UH Bristol's carers strategy in 2018, this objective set out to re-focus and improve support provided to young carers at UH Bristol. The objective also supported a pledge made in the NHS Long Term Plan (2019) to maintain the focus on identifying and supporting carers.
What did we say we would do?	In 2019/20, we said we would: • Work to identify young carers as early as possible when they are in contact with our services. • Review the information and signposting available for young carers across the Trust. • Review the information available to young carers on the Trust's website and through social media. • Re-launch carers awareness training across the organisations. • Continue to work with Bristol Young Carers' Voice support group. • Work in partnership with young carers to improve our understanding of their experiences of our services • Deliver a UH Bristol site tour for young carers from Young Carer Voice to attend. • Plan and deliver a Health Matters event on the topic of supporting carers including young carers in secondary care.
Measurable target/s for 2019/20	We said we would measure success by delivery of the actions listed above.
How did we get on?	Following a successful visit to the Adult Emergency Department, by members of the Bristol Young Carers support Group – to consider the young carers experience in the department a number of improvement priorities were

	identified by the Young Carers, and actions agreed with department staff, including: • Develop posters to inform and raise awareness to Young Carers - How to Identify/recognise a Young Carer and what to do for them - completed • Plan training and resources to be delivered to Pharmacists and other health care teams – in progress • Raise carer awareness through the Trust Youth Involvement Group The online information available to young carers on the Trust website has been reviewed and updates identified. Carer awareness training for staff has been updated and delivered virtually by the Carers Liaison Team. This includes contributions to the preceptorship programme pre-social distancing requirements. The Health Matters event was postponed but eventually took place in October 2020 due to the impact of Covid-19. This was a well-attended event supported by Trust Governors with many carers in attendance who shared their perspectives on what matters most to carers attending hospital. Looking ahead, this work has helped define a closer working relationship with the Carers Support Centre enabling us to understand and respond to the needs of people with caring responsibilities more effectively. Both UHBW and North Bristol NHS Trust intend to re-launch the joint Carers Charter in early 2021 to reflect our joint commitment to carers as partners in care.
RAG rating	Green – we made good progress in 2019/20 and although our Health Matters event was delayed by the pandemic , this has now also taken place

Objective 4	**Driving positive staff engagement through expanded use of the Happy App**
Rationale and past performance	One of the specific improvement goals of our Quality Strategy 2016-2020 has been to roll out the 'Happy App' to measure real-time staff experience. Launched in the autumn of 2016, Happy App serves as an anonymous, self-reporting communication tool to collect and measure mood and morale, and to capture inter-team experience via anecdotal comments. This online platform allows colleagues to voice opinions without fear of retribution and enables managers to gain insight and understanding on colleagues' behaviour, values, motives, intent, actions, frustrations, goals and desires.
What did we say we would do?	We wanted to extend and improve the organisational reach, functionality and reporting capability of the Happy App. Our plan for 2019/20 included: • Implementation of a stakeholder communications and engagement plan to achieve high level awareness and usage with the Happy App across all staff groups, including targeted promotion within hard-to-reach teams. • Consultation with colleagues Trust wide to identify and exploit opportunities to further promote usage of the Happy App and to resolve staff engagement issues raised. • Exploring additional report functionality with the system provider to include supplementing the current dashboard reports used by Divisions to help to identify and deliver engagement and improvement activities to meet requirement.

	• Introduction of a text analysis tool to search for keywords contained within the comments posted by colleagues, within any data period required. This has enabled managers to generate word clouds based on any of five reporting categories: *Emotion Lens; Employers Branding; System Themes; Benchmarking; and Improvement.* This helps Divisional or team leaders to know where to focus efforts in terms of staff experience and engagement. • Evaluation of the effectiveness of internal marketing efforts and internal advertising channels used to promote the Happy App.
Measurable target/s for 2019/20	In 2019/20, our target was to increase the number of clinical and non-clinical teams registered for Happy App by 10 per cent against a baseline which we measured on 1st June 2019, i.e. three months on from our refresh of the system. We also said that we would more closely monitor moderator responses against the comments posted by their as a measure of the effectiveness of the feedback process.
How did we get on?	Key achievements in 2019/20: • The Trust exceeded its target to increase the number of teams registered for the Happy App by 10 per cent. We the end of 2019/20, we had 215 teams and 340 moderators* registered onto the system with a commitment to continue to increase engagement throughout next year. • Communication and engagement activities outlined in the annual stakeholder communications and engagement plan continue to sustain awareness and widespread usage within clinical and non-clinical environments. • The number of comments (hits) posted by colleagues saw a significant increase from 3,668 in 2018/19 to 7,222 in 2019/20, as can be seen from the dashboard report below. **Happy App Dashboard Report: 4th March 2018 – 3rd March 2019** 

	Happy App Dashboard Report: 4th March 2019 – 3rd March 2020  • Each Division has introduced a mechanism for reviewing Happy App use at local level, to include review by senior leads. This feedback is used to inform the direction of staff engagement provision required by the respective workforce. • The Trust staff engagement score, as measured by the 2019 NHS staff survey is higher than the national average. The Happy App is considered to be a positive contributor to this success. • Service leads have begun to use the Happy App to meet the needs of their users for example, the Trust Library promote the Happy App as a means to gain feedback and suggestions for improvement. During national 'Values' week, colleagues across the organisation were invited to pledge their personal values via the Happy App whereby they can select 'values' as one of the theme options. * Moderators are team leads e.g. line managers who are responsible for regular responses to posts for an individual team.
RAG rating	Green – we implemented our stakeholder communications and engagement plan for 2019/20; overall usage of the Happy App has continued to improve and we will continue efforts to maintain high level engagement across each Division

Objective 5	**Improving the availability of information about physical access to our hospitals to ensure patients and visitors know how to get to services in the easiest possible way, particularly patients with disabilities.**
Rationale and past performance	The hospitals which make up UH Bristol's main site are built on a hill and have grown and developed over the past hundred years. We receive consistent feedback that our estate can be challenging to navigate,

	particularly for patients and visitors with a physical disability. In January 2019, we held a 'Quality Counts' engagement event which had an equality theme and the issue of difficult physical access for some patients/visitors was highlighted as an area that had a negative impact on patients' experience and should be improved.
What did we say we would do?	We said we would improve the information that we provide to patients and visitors on how to get to the various hospital sites on the main campus and within the sites. As part of this work we wanted to identify where we should be prioritising our resources to improve physical access to our hospitals in the future.
Measurable target/s for 2019/20	We said that our measures of success would be the creation of: • a detailed web-based access guide for patients and the public, providing visual and descriptive information about our estate. • a 'recommendations matrix' to guide decisions about how and where we could improve access, as and when funds permit this.
How did we get on?	The year began with a series of exploratory conversations with stakeholders, including the director of AccessAble, a nationally recognised provider of web and app-based access guides, and exploration of potential funding sources. By the end of the year, we had secured funding thanks to the generosity of our charitable trustees, Above & Beyond, and agreed to enter into partnership with AccessAble. Since the end of 2019/20, we have also secured additional funding from the League of Friends of Weston General Hospital to enable our access guides to be extended into the new Weston Division. Comprehensive site surveys in Bristol and Weston will be required to gather the information required to produce the access guides – this work remains scheduled for 2020/21 but has been impacted by the coronavirus pandemic.
RAG rating	Amber – in 2019/20 we successfully secured charitable funding to enable the Trust to partner with AccessAble to develop access guides

Objective 6	**Improving patient experience through roll out of the real time outpatients initiative**
Rationale and past performance	We recognise the inconvenience and stress caused to patients when there are delays to communication and booking of next steps following an outpatient clinic attendance. From a Trust operational perspective, delays in sending out the clinic letter also result in failure to meet the national seven-day clinic letter turnaround target. Missing or incorrect outcomes and delays in booking next steps increase the risk of breaching referral and treatment targets and the possibility of the patient coming to harm. The real time outpatients (RTOP) initiative is designed to allow all of the administrative tasks relating to a patient's clinic appointment to take place on the day of the visit. This means that patients will leave the clinic knowing what the next step in their treatment is, and when that will take place. It will significantly reduce waste within the system by shortening the turnaround time for clinic letter production, enabling diagnostics, follow- up and 'to come in' (TCI) dates to be booked in a more timely manner. Finally, RTOP enables the appointment outcome, next steps on the patient pathway, and discharge (if applicable) to be confirmed as correct, known as validation in real time. Real time outpatients was agreed as a corporate objective for the Trust and the aim is to roll out to all specialities and Divisions by 2021.

	This would: • Ensure the clinic letter turnaround time meets the national seven-day target; performance in January 2019 was only 70 per cent across the Trust; where possible letters are dictated, checked and approved within 24 hours of the appointment. • Allow patients to have plain film X-Ray and blood tests on the same day as their appointment and book a date for complex imaging before they leave the hospital. • Ensure all outcomes are accurately recorded on the day of clinic and updated following approval of the letter, ensuring patients' next steps are booked in a timely manner; this reduces time spent validating missing or inaccurate outcomes, and hopefully reduces the 'Did not attend' rate in participating specialities by improving patients' understanding of the importance of their appointment.
What did we say we would do?	In 2019/20, we said we would roll out real time outpatients to a number of specialities within each division. Cardiology went 'live' in November 2018, as did Rheumatology in April 2019, whilst discussions are ongoing with Women's and Children's services, Surgery, and Diagnostics and Therapies to identify early adopters. All Divisions had signed up to the initiative and included real time outpatients in their operating plans for 2019/20. Each Division had identified a real time outpatients champion within the management team to support the central outpatients team. Each speciality would have an implementation plan. The plan was that real time outpatients would also support further digitalisation of outpatient clinics and administrative processes. Roll out in each Division was planned to include the following: • Ensuring that clinic letters are dictated on the same day as clinic, either after each patient or at the end of the clinic. • Ensuring there is secretarial support linked to the clinic so that the letter can be checked and ready for approval on the same day. • Approving letters between patient appointments, or soon after clinic. • Direct booking at reception of all follow-ups within six weeks. • Discharging the patient from Medway (the Trust's patient administration system) by the secretary if a discharge letter is proof-read. • Checking that any complex scans are booked on ICE (our radiology booking system) by the secretary when proof-reading the letter. • Accurately recording the outcome when the patient leaves clinic; checked by the secretary. We also wanted to work with radiology to pilot and then formally introduce booking of radiological scans immediately following an outpatient appointment; the plan was to begin by trialling this with adult CT scans.
Measurable target/s for 2019/20	Our targets were: • Achieve seven day turnaround for all appropriate letters in specialities where real-time outpatients is implemented. • Improve the number of letters that are dictated checked and approved within 24 hours of the clinic appointment. • Reduce the number of letters sent out 14 days after clinic. • Reduce the number of missing outcomes (at the end of each appointment, an outcome must be recorded on the Trust patient administration system Medway; this is how the next step for the patient

	is booked) and the time spent by staff validating outcomes each month. • Reduce the 'Did not attend' rate for outpatient clinics.
How did we get on?	2019/20 was a busy year for the real-time outpatients project, with more than its fair share of successes and challenges. For example: At Bristol Royal Hospital for Children, there were some examples of excellence – in November and December 2019, Spinal surgery turned 100% of letters around in 7 days. The Paediatric Trauma and Orthopaedic service joined the project in January 2020. However, turnaround times in Paediatric Rheumatology returned to previous baseline performance. IT challenges delayed roll-out in Adult Respiratory and Sleep services, however pilot schemes ran in a number of areas including Thoracics, Dermatology and Gynaecology. Elsewhere, Radiology built a module within CRIS (the Radiology booking system) to enable CT and MRI scan appointments to be booked before they have been vetted by a radiologist. Heading into winter 2019/20, the rate of expansion of real-time outpatients inevitably slowed as teams faced winter pressures. A roll out options appraisal was presented to the Trust's Transformation Board in February 2020, however events were subsequently overtaken by the Covid-19 pandemic.
RAG rating	Amber – in 2019/20 we took important steps towards implementing real-time outpatients into a number of clinical specialties, however progress was impacted by staff vacancies and sickness, IT systems, winter pressures, and ultimately the Covid-19 pandemic

Objective 7	**Planning and overseeing implementation of the Medical Examiner System**
Rationale and past performance	From April 2019, a national system of Medical Examiners (MEs) was being introduced to provide support for bereaved families and to improve patient safety. Overseen by a National Medical Examiner, MEs are specifically trained independent senior doctors from any speciality. They scrutinise all deaths that do not fall under the coroner's jurisdiction. The introduction of MEs supported our aims for transparency and improving the experience of patients and their families at the end of life. Implementation would provide opportunity to consider further ways of improving our services. At the same time, we recognised that support for families in adult care is not of the same level as the wrap-around support offered in, for example, children's services.
What did we say we would do?	In 2019/20, we said we would: • Work closely with local Trusts within the Academic Health Service Network to agree a standardised implementation strategy for the ME system; this would include provisions for outside office hours to take account of religious requirements for burial within a set timeframe. • Meet with interested medical staff initially as an engagement and information sharing event, but then to help shape the business plan and understand how to provide the required ME service by job planning. • Visit and learn from early implementation sites. • Ensure that the current bereavement office is suitably prepared and equipped for the introduction of MEs and Medical Examiners Officers (MEOs) to work alongside existing systems, staff and roles. • Train and prepare our existing bereavement officers in the role of MEOs via the completion of online training modules.

	• Consider the introduction of a bereavement survey to compliment ME conversations with families to ensure we are obtaining feedback and providing an excellent service. As part of this objective, we will wanted to use the year to develop our understanding of what outstanding bereavement care and support looks like in the adult service setting, learning from trusts who are rated by the CQC as outstanding in this area of practice; we will also consider how learning might be applied from our own children's services.
Measurable target/s for 2019/20	Our target was that, by the end of 2019/20, we would have successfully implemented the new Medical Examiners system, in partnership with local acute Trusts. We will wanted to complete our scoping exercise for adult bereavement care as a platform for future service improvement.
How did we get on?	<u>Medic al Examiners:</u> 2019/20 was a year of collaborative working with North Bristol NHS Trust and Weston Area Health NHS Trust (as-was), to successfully implement Medical Examiners across the three organisations. The project, which was overseen by a small team of staff based at Southmead Hospital (part of NBT), was also supported by the Avon Coroner and the Academic Health Service Network. Medical staff engagement was vital: initially sharing information, then receiving expressions of interest in the Medical Examiner role and helping to shape the business plan. A Lead Medical Examiner and Lead Medical Examiners Officer have been appointed and their respective teams of MEs and MEOs have also been recruited to. A significant amount of time has also been invested in establishing key working relationships with the Trust's existing Patient Affairs Team (bereavement office), which is complementary to the new ME service. <u>Bereavement support in adult services:</u> Alongside the implementation of Medical Examiners, our additional local scoping exercise identified a number of 'best practice' ideas and opportunities from other NHS trusts, which UHBW could explore in the future: 1. Creating an on-site death registration service, e.g. as per Southmead Hospital. 2. Introducing 'Bereavement Cafés', where people can meet others who may have been through a similar bereavement. 3. Creating a dedicated single point of contact for each family following death, e.g. if a family had questions – likely role for Medical Examiner. 4. Creating a new bereavement policy to sets out the parameters of bereavement care for the Trust; the Trust currently has various SOPs but no overall policy document. 5. Reviewing and expanding the Trust's Bereavement Books given to families following a death, e.g. to include information about Medical Examiners and learning from deaths; also improving signposting to bereavement care provided by other agencies and support groups. 6. Sending personalised bereavement letters to every family, e.g. from a consultant or ward; current practice varies throughout the Trust. 7. Systematically offering support to staff affected by a patient death as part of health and well-being. We will begin to explore some of these ideas with ME colleagues once the ME service is fully established.
RAG rating	Green – the Medical Examiner service was successfully implemented and the additional scoping exercise relating to adult bereavement support was

	completed

Objective 8	**Developing and implementing a training programme for Trust lay representatives to support and develop their participation in Trust groups and committees**
Rationale and past performance	This objective set out to influence and develop the practice of lay partner involvement (also known as lay representation) in UH Bristol as part of a growing move in the NHS to develop the concept and practice of patient leadership. This represents a continuation of a journey which commenced in 2016 with the patient and community leadership programme, "Healthcare Change Makers", which was a collaboration between UH Bristol, North Bristol NHS Trust and Bristol Community Health, with additional input from the local Clinical Commissioning Group and Healthier Together, with facilitation provided by the Centre for Patient Leadership and The King's Fund.
What did we say we would do?	To realise our ambition to improve how we work with and support lay representatives we undertook work across three themes: • Lay representation recruitment process • Lay representation training and development • Working with others **Lay representation recruitment process** Our aim for this work stream was to improve the way in which we attract and recruit lay representatives to join the Trust to include a review of the application and recruitment process for lay representatives. **Lay representation training and development** We recognised the need to invest in our lay representatives so that they are supported and able to develop their own skills to function well in their roles. We made a commitment to scope out the core features and learning objectives for a training package, drawing from the Healthcare Change Makers patient and community leadership model and other models of good practice including The King's Fund. **Working with others** As part of a wider network of health care providers in the area we recognised the need to explore how we could work with other local providers so that the training and approach to lay representation was shared across organisations.
How did we get on?	Following a mapping exercise to understand the full extent of lay representation in steering groups, committees and networks across the Trust we were able to work with existing lay representatives to learn from their experiences of working in the Trust. This helped us understand more about what mattered most to them in terms of their recruitment, support and development. This process included a lay representative survey, survey of managers working with lay representatives and an event at which lay representatives were able to discuss their roles in greater depth. This insight was matched with learning from other patient leadership work the Trust had undertaken namely the Healthcare Change Maker Programme, and best practice from NHS England. This information has been used to further improve the application and recruitment processes to ensure greater clarity and expectations about the

	roles. To support this we have aligned our recruitment process to that used by the Trusts Volunteer Services so that newly recruited lay representatives benefit from the support offered by that service. We have also used this insight to plan how an on-going support and development programme for lay representatives will look. The programme will balance personal support with skills development such as, how to work together effectively and dealing with difficult or sensitive situations. This programme will be formally launched in 2020/21 as part of an on-going focus on this work. In addition, there will be further work done to explore how these developments can support lay representatives in other local providers and in doing so offer a greater degree of consistency in the health community.
RAG rating	Green – we delivered the majority of our lay representative project milestones for the year and have established a significant improvement in the application and recruitment process for lay representatives

2.1.2 Quality objectives for 2020/21

In view of the merger of University Hospitals Bristol NHS Foundation Trust (UH Bristol) with Weston Area Health NHS Trust (WAHT) on 1st April 2020 to form University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), it was agreed that the Trust's quality objectives for 2020/21 would focus on four areas where UH Bristol did not fully achieve its goals in 2019/20, and that these quality objectives would apply across the merged organisation. It was further agreed that any outstanding annual quality objectives for WAHT would be taken forward via the annual operating plan for the newly created Weston Division. It should be noted that these objectives were agree prior to the Covid-19 pandemic.

Objective 1	**Improving compliance with VTE (Venous thromboembolism) assessment**
Rationale and past performance	Previously, VTE assessment compliance has been measured from paper records when patients are discharged; we recognise that this has not provided a true measure of VTE assessment compliance rates. Use of an electronic VTE risk assessment in Medway was implemented in August 2019 to support a full sample survey of all patients in real time. Compliance initially improved markedly to 79%, then fell away, before returning to a similar level by the end of 2019/20. Compliance needs to be optimised by support from divisions / specialities / consultants. Current significant barriers include that Medway is not used for other functions yet in some specialities and ward rounds are not done using mobile computer devices, although these are available. The extreme pressures on capacity in the Trust are also an issue, as is a culture that VTE risk assessment is a low priority and there are no consequences for staff if it has not been done. Phase 2 (to include 16-18 year olds and Bristol Eye Hospital) is due to be rolled out later in 2020.
What will we do?	To improve compliance, the Medical Director has established a performance management process to encourage individual teams to be responsible for their own compliance and development of solutions for improvement. This has already had a positive impact on completion of risk assessments, and the potential to appoint a dedicated VTE prevention nurse is being explored. Compliance has been particularly poor in the wards responsible for acute admissions. These areas are a challenge due to the high turnover of patients, multiple members of staff involved and other tasks to be completed on admission. A number of new initiatives led by key clinicians have now commenced and we expect performance, through streamlining workload, to

	improve the efficiency and completion of VTE risk assessments going forward. We now have designated consultants and junior doctors doing quality improvement projects in acute medicine and surgery. We also plan to incorporate digital VTE risk assessment into routine pre-operative assessment which will improve compliance for elective surgical patients. Lastly, planned VTE work streams at Bristol Eye Hospital and for 16-18 year old patients at the Bristol Royal Hospital for Children will be delayed due to the COVID-19 pandemic.
Measurable target/s for 2020/21	Although our target continues to be to meet the national standard, which requires at least 95 per cent of appropriate inpatients to have a VTE risk assessment, we do not anticipate this will be happen until such time as there is a digital fully integrated system with a force function (a force function means that staff cannot complete a subsequent step of a process without completing a preceding step), but unfortunately, the introduction of this facility has been delayed. We also expect the COVID-19 pandemic to negatively influence compliance due to staff working in unfamiliar settings.
How progress will be monitored	Progress will be monitored by the Trust's Infection Prevention and Control Committee, and through the Divisional Review processes, led by the Medical Director.
Board sponsor	Medical director
Implementation lead	Consultant haematologist lead for VTE, and chief clinical information officer

Objective 2	**Improving the availability of information about physical access to our hospitals to ensure patients and visitors know how to get to services in the easiest possible way, particularly patients with disabilities.**
Rationale and past performance	The hospitals which make up the Trust's Bristol site have grown and developed over the past hundred years. We receive consistent feedback that our estate can be challenging to navigate, particularly for patients and visitors with a physical disability. In 2019/20 we successfully secured charitable funding to enable the Trust to partner with an organisation called AccessAble.
What will we do?	In 2020/21, working with AccessAble, we will create a detailed web-based access guide for patients and the public, providing visual and descriptive information about our Trust estate, including Weston General Hospital (WGH). Note: at the start of 2020/21, however, the project is temporarily on hold until COVID-19 restrictions enabling surveyors to come on site. In the meantime, a quotation is being sought to extend the project roll-out to WGH.
Measurable target/s for 2020/21	Success will be measured by implementation of the project, including production of a 'recommendations matrix' to guide future decisions about how and where we could improve access, subject to future funding.
How progress will be monitored	Via Patient Inclusion and Diversity Group, reporting to Patient Experience Group
Board sponsor	Chief nurse
Implementation lead	Patient experience and involvement team manager

Objective 3	**Improving patient experience through roll out of the Trust's outpatients strategy and guiding principles**
Rationale and past performance	We continue to recognise the inconvenience and stress caused to patients when there are delays to communication and booking of next steps following an outpatient clinic attendance. From a Trust operational perspective, delays in sending out the clinic letter also result in failure to meet the national seven-day clinic letter turnaround target. Missing or incorrect outcomes and delays in booking next steps increase the risk of breaching referral and treatment targets and the possibility of the patient coming to harm. The real time outpatients (RTOP) initiative is designed to allow all of the administrative tasks relating to a patient's clinic appointment to take place on the day of the visit. This means that patients will leave the clinic knowing what the next step in their treatment is, and when that will take place. It will significantly reduce waste within the system by shortening the turnaround time for clinic letter production, enabling diagnostics, follow- up and 'to come in' (TCI) dates to be booked in a more timely manner. Finally, it will enable the appointment outcome, next steps on the patient pathway, and discharge (if applicable) to be confirmed as correct, known as validation in real time. In 2019/20, we took important steps towards implementing RTOP into a number of specialties, however various factors limited progress, e.g. staff vacancies and sickness, IT systems, winter pressures, etc. As part of the Trust's response to COVID-19, we have taken the opportunity to redesign elements of outpatient pathways, deploying e-RS (electronic referral service) advice and guidance. This service allows GPs and consultants to discuss and plan referrals making the most out of outpatient referrals. We have also deployed non-face-to-face video conferencing services, enabling attendance anywhere. This deployment has been Trust-wide and at scale. These changes represent significant improvements in the digitisation of the outpatient pathway and improved communication with patients and primary care.
What will we do?	During 2020/21, we will take a new approach to RTOP, incorporating it into our broader strategic approach to the outpatients programme. These changes will be reflective of the overall national strategy and guiding principles of BNSSG CCG for the delivery of outpatients. This strategy will include further digitisation of outpatient pathways, which will include improvements in the production of letters, clinical triage, outcomes, patient communications and appointment bookings. This will include a review of outpatient service delivery in Weston General Hospital and alignment of service access where possible.
Measurable target/s for 2020/21	Our targets are to: • Achieve seven day turnaround for all appropriate letters in specialities where real-time outpatients is implemented. • Improve the number of letters that are dictated checked and approved within 24 hours of the clinic appointment. • Reduce the number of letters sent out 14 days after clinic. • Reduce the number of missing outcomes (at the end of each appointment, an outcome must be recorded on the Trust patient administration system Medway; this is how the next step for the patient is booked) and the time spent by staff validating outcomes each month. • Reduce the 'Did not attend' rate for outpatient clinics. • Achieve seven day turn around for advice and guidance requests.
How progress will be	Via Outpatient Steering Group

monitored	
Board sponsor	Deputy chief executive / chief operating officer
Implementation lead	Outpatient services manager (Trust-wide)

Objective 4	**Supporting and developing the participation of lay representatives in Trust groups and committees**
Rationale and past performance	This objective sets out to influence and develop the practice of lay partner involvement in UH Bristol as part of a growing move in the NHS to develop the concept and practice of patient leadership. This represents a continuation of a journey which commenced in 2016 with the patient and community leadership programme, "Healthcare Change Makers", which was a collaboration between UH Bristol, North Bristol NHS Trust and Bristol Community Health, with additional input from the local Clinical Commissioning Group and Healthier Together, with facilitation provided by the Centre for Patient Leadership and The King's Fund. In 2019/20, we completed a mapping exercise to identify which UH Bristol groups, formal networks, and committees have "lay representatives" on them and, in doing so, identified new opportunities for lay representation, including maternity services and the Learning Disabilities Steering Group. We also successfully piloted our new lay representative training programme; the aim of the training is to develop and support lay representatives as patient leaders in the thinking and planning processes of Trust groups and in doing so enable better dialogue and joint working.
What will we do?	During 2020/21 we will: • Ensure that all of our lay representatives have attended our new training session • Develop and run a six-monthly update training and support programme • Develop an internal communications plan to more effectively publicise and promote the value of working with lay representatives and the processes for recruitment/training • Update our internal guidance for staff who are considering recruiting lay representatives • Undertake a mapping exercise of lay representation and networks at Weston General Hospital, including the existing Patient Council, with a view to implementing our new training there • Explore opportunities to partner with local health and social care providers so that UHBW training can be shared across organisations. Note: at the start of 2020/21, however, patient and public involvement activity at the Trust has temporarily been suspended due to COVID-19.
Measurable target/s for 2020/21	Our targets for 2020/21 are: • For all Trust lay representatives to attend introductory training • To develop and deliver an internal communications plan, to be launched in Quarter 3 2020/21 • To design and launch a half-yearly training update programme by the end of 2020/21
How progress will be monitored	Via quarterly reports to Patient Experience Group
Board sponsor	Chief nurse
Implementation lead	Patient and public involvement lead

2.2 Statements of assurance from the Board

2.2.1 Review of services

During 2019/20, UH Bristol provided relevant health services in approximately 70 specialties via five clinical divisions (Medicine; Surgery; Women's and Children's Services; Diagnostics and Therapies; and Specialised Services).

During 2019/20, the Trust Board has reviewed and selected high-level quality indicators covering the domains of patient safety, patient experience and clinical effectiveness as part of monthly performance reporting. Sufficient data was available to provide assurance over the services provided by the Trust. The Trust also receives information relating to the review of quality of services in all specialties via, for example, the Clinical Audit Annual Report. The income generated by UH Bristol services reviewed in 2019/20 therefore, in these terms, represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2019/20.

2.2.2 Participation in clinical audits and national confidential enquiries

For the purpose of the Quality Report/Account, the Department of Health published an annual list of national audits and confidential enquiries, participation in which is seen as a measure of quality of any trust's clinical audit programme. This list is not exhaustive, but rather aims to provide a baseline for trusts in terms of percentage participation and case ascertainment. The detail which follows relates to this list.

During 2019/20, 52 national clinical audits and four national confidential enquiries covered NHS services that University Hospitals Bristol NHS Foundation Trust provides. During that period, University Hospitals Bristol NHS Foundation Trust participated in 96 per cent (50/52) of national clinical audits and 100 per cent (4/4) of the national confidential enquiries of which it was eligible to participate in.

Table 1 lists the national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2019/20 and whether it did participate:

Table 1

Name of audit / programme	Participated
Acute, urgent and critical care	
Assessing Cognitive Impairment in Older People (Care in Emergency Departments)	Yes
Care of Children in Emergency Departments	Yes
Case Mix Programme (CMP) – Intensive Care	Yes
Mental Health (Care in Emergency Departments)	Yes
Major Trauma Audit (TARN)	Yes
National Audit of Seizure Management in Hospitals (NASH3)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Emergency Laparotomy Audit (NELA)	Yes
Perioperative Quality Improvement Programme (PQIP)	Yes
Sentinel Stroke National Audit programme (SSNAP)	Yes

Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes
Blood and infection	
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes
Surgical Site Infection Surveillance Service	Yes
Cancer	
Endocrine and Thyroid National Audit	No
National Audit of Breast Cancer in Older People (NABCOP)	Yes
National Bowel Cancer Audit (NBOCA) – part of NGICP[1]	Yes
National Lung Cancer Audit (NLCA)	Yes
National Oesophago-Gastric Cancer (NAOGC) – part of NGICP[1]	Yes
National Prostate Cancer Audit (NPCA)	Yes
Elderly care	
Fracture Liaison Service Database (FLS) – part of FFFAP[2]	Yes
National Audit of Inpatient Falls (NAIF) – part of FFFAP[2]	Yes
National Hip Fracture Database (NHFD) – part of FFFAP[2]	Yes
National Audit of Dementia (NAD)	Yes
National Joint Registry (NJR)	Yes
End of life care	
National Audit of Care at the End of Life (NACEL)	Yes
Heart	
Adult Cardiac Surgery (ACS) – part of NCAP[3]	Yes
Cardiac Rhythm Management (CRM) – part of NCAP[3]	Yes
Myocardial Ischaemia National Audit Project (MINAP) – part of NCAP[3]	Yes
National Audit of Cardiac Rehabilitation (NACR)	Yes
National Audit of Percutaneous Coronary Interventions (PCI) – part of NCAP[3]	Yes
National Congenital Heart Disease Audit (NCHDA) – part of NCAP[3]	Yes
National Heart Failure Audit (NHF) – part of NCAP[3]	Yes
Long term conditions	
National Asthma Audit – part of NACAP[4]	Yes
National COPD Audit – part of NACAP[4]	Yes
National Early Inflammatory Arthritis Audit (NEIAA, formerly NCAREIA)	Yes
National Diabetes Core Audit (NDA)	Yes
National Diabetes Foot Care Audit (NDFA) – part of NDA	Yes
National Diabetes Inpatient Audit (NaDIA) – part of NDA	Yes
National Pregnancy in Diabetes Audit (NPID) – part of NDA	Yes
National Ophthalmology Audit (NOD)	Yes
National Smoking Cessation Audit	Yes
UK Cystic Fibrosis Registry	Yes
UK Parkinson's Audit	Yes
Inflammatory Bowel Disease programme / IBD Registry	No
Women's & Children's Health	

National Audit of Seizures and Epilepsies in Children and Young People	Yes
National Maternity and Perinatal Audit (NMPA)	Yes
National Neonatal Audit Programme (NNAP)	Yes
National Paediatric Diabetes Audit (NPDA)	Yes
Neurosurgical National Audit Programme	Yes
Paediatric Intensive Care Audit Network (PICANet)	Yes
Confidential enquiries/outcome review programmes	
Child Health Clinical Outcome Review Programme	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes
Medical and Surgical Clinical Outcome Review Programme	Yes
Mental Health Clinical Outcome Review Programme	Yes

[1] NGCIP: National Gastro-Intestinal Cancer Programme
[2] FFFAP: Falls and Fragility Fractures Audit Programme
[3] NCAP: National Cardiac Audit Programme
[4] NACAP: National Asthma and COPD Audit Programme

Of the above national clinical audits and national confidential enquiries, those which published reports during 2019/20 are listed in Table 2 alongside the number of cases submitted to each, where known. Where relevant, this is presented as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 2

Name of audit / programme	
Acute, urgent and critical care	
Assessing Cognitive Impairment in Older People (Care in Emergency Departments)	120*
Care of Children in Emergency Departments	158*
Case Mix Programme (CMP)	100% (2750)
Major Trauma Audit (TARN)	91-100%
Mental Health (Care in Emergency Departments)	130*
National Emergency Laparotomy Audit (NELA)	84% (132)
National Audit of Seizure Management in Hospitals (NASH3)	32*
Sentinel Stroke National Audit programme (SSNAP)	≥90% (470)
Blood and infection	
Surgical Site Infection Surveillance Service	148*
Cancer	
National Audit of Breast Cancer in Older People (NABCOP)	39*
National Bowel Cancer Audit (NBOCA)	108% (193)**
National Lung Cancer Audit (NLCA)	235*
National Oesophago-Gastric Cancer (NOGCA)	75-84% (133)
Elderly care	
Fracture Liaison Service Database (FLS)	111% (1549)**
National Hip Fracture Database (NHFD)	89% (278)
National Audit of Dementia (NAD)	102% (51)**
National Joint Registry (NJR)	68% (>16)

End of life care	
National Audit of Care at the End of Life (NACEL)	41*
Heart	
Cardiac Rhythm Management (CRM)	1110*
Myocardial Ischaemia National Audit Project (MINAP)	138% (1574)**
National Audit of Percutaneous Coronary Interventions (PCI)	1857*
National Congenital Heart Disease Audit (NCHDA)	1192*
National Heart Failure Audit (NHF)	60% (262)
Long term conditions	
National Asthma Audit	90*
National COPD Audit	515*
National Early Inflammatory Arthritis Audit (NEIAA, formerly NCAREIA)	166*
National Diabetes Core Audit (NDA)	80*
National Diabetes Foot Care Audit (NDFA)	60*
National Diabetes Inpatient Audit (NaDIA)	74*
National Pregnancy in Diabetes Audit (NPID)	105*
National Ophthalmology Audit (NOD)	99% (3958)
Women's & Children's Health	
National Maternal and Perinatal Audit (NMPA)	5657*
National Neonatal Audit Programme (NNAP)	100% (1022)
National Paediatric Diabetes Audit (NPDA)	464*
Paediatric Intensive Care Audit Network (PICANet)	99.9% (2159)
Confidential enquiries/outcome review programmes	
Medical and Surgical Clinical Outcome Review Programme	14*
Child Health Clinical Outcome Review Programme	2*
Maternal, Newborn and Infant Clinical Outcome Review Programme	100% (45)

*No case requirement outlined by national audit provider/unable to establish baseline
** Case submission greater than expected (e.g. estimated from Hospital Episode Statistics (HES) data)

The reports of 10 national clinical audits were reviewed by the provider in 2019/20. University Hospital Bristol NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

National Neonatal Audit Programme
A local project was conducted to gather further data on thermoregulation of neonates on admission to the Neonatal Intensive Care Unit, following performance in the previous audit report that, while better than the national average, left room for improvement. A bundle of measures has been identified to improve the numbers of neonates with a normal temperature on admission.

Fracture Liaison Service Database
A Fracture Clinic Quality Improvement Project was established to improve patient engagement in the FLS service and osteoporosis treatment. Internal IT processes have been reviewed to improve efficiency.

National Maternal and Perinatal Audit
A working group has been set up to look at how to manage the increase in the rate of induction of labour.

National Audit of Dementia
Training on delirium and its relationship to dementia has been included in the existing dementia training at induction and delirium e-learning has been produced.

National Pregnancy in Diabetes
The Trust is one of 20 teams across the UK participating in the national Quality Improvement Collaborative focusing on improving pre-conception care of women with diabetes.

RCEM Venous Thromboembolism (VTE) Risk in Lower Limb Immobilisation
Changes were made to the Virtual Fracture Clinic referral forms on the Medway system to ensure that clinicians complete a VTE risk assessment when referring.

National Clinical Audit Benchmarking (NCAB)
The Healthcare Improvement Partnership (HQIP) produce benchmarking information based on the data that trusts submit to national audits. Along with the national reports produced, this allows trusts to see how they compare to national results and those of other organisations. In 2019/20, the Trust reviewed the following benchmarking summaries:

- Intensive Care – Case Mix Programme (CMP)
- Trauma Audit (TARN)
- National Lung Cancer Audit (NLCA)
- National Oesophago-Gastric Cancer Audit (NAOGC)
- Adult Cardiac Surgery (ACS)
- Myocardial Ischaemia National Audit Project (MINAP)
- National Heart Failure Audit (NH)
- National Chronic Obstructive Pulmonary Disease Audit
- National Ophthalmology Database Audit (NOD)
- National Joint Registry (NJR)
- National Audit of Inpatient Falls (NAIF)

2.2.3 Participation in clinical research

The number of patients receiving relevant health services provided or subcontracted by UH Bristol in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 7,011. This compares with 10,236 in 2018/19.

2.2.4 CQUIN framework (Commissioning for Quality and Innovation)

A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between University Hospitals Bristol NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

A radically different approach to CQUINs was introduced in 2019/20. The value of the national CQUIN scheme for both CCG and PSS schemes was reduced by half to 1.25 per cent with a corresponding increase in core prices. As lead provider of Hepatitis C virus (HCV) Operational Delivery Networks, a top up of 0.3 per cent was included within the PSS CQUIN scheme, making

a total value of 1.55 per cent. The amount of potential income in 2019/20 for quality improvement and innovation goals was approximately £6.92 million based on the sums agreed in the contracts (this compares to £11.85 million in 2018/19). The following 11 CQUIN targets were agreed, with the Trust estimating to achieve 82.5 per cent of the £6.92m total potential income:

- Antimicrobial Resistance – Lower Urinary Tract Infections in Older People, Antibiotic Prophylaxis in colorectal surgery
- Staff Flu Vaccinations
- Alcohol and Tobacco – Screening, Tobacco and Alcohol Brief advice
- Three high impact actions to prevent hospital falls
- Same Day Emergency Care – Pulmonary Embolus, Tachycardia with Atrial Fibrillation, Community Acquired Pneumonia
- Medicines Optimisation
- Towards Hepatitis C Virus (HCV) Elimination
- Cystic Fibrosis Self-Care
- Clinical Utilisation Review
- Dental Managed clinical networks
- Bowel Screening Workforce Development Plan – Public health screening programmes

2.2.5 Care Quality Commission registration and reviews

University Hospitals Bristol NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without compliance conditions'. The CQC did not take enforcement action against the Trust in 2019/20.

A planned CQC core services inspection took place at UH Bristol between March and May 2019. The Trust retained its previous 'Outstanding' rating. Detailed ratings are presented below:

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Care	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Requires improvement →← May 2019	Good ↓ May 2019	Requires improvement ↓ May 2019
Medical Care (including older people's care)	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Good →← May 2019	Good →← May 2019	Outstanding →← May 2019	Outstanding ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019
Critical care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014
Services for children and young people	Good →← May 2019	Outstanding →← May 2019	Good →← May 2019	Good →← May 2017	Outstanding ↑ May 2019	Outstanding ↑ May 2019
End of life care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Maternity	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Outpatients and diagnostics	Good Mar 2017	Not rated	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Overall trust	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Good ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019

2.2.6 Data quality

UH Bristol submitted records during 2019/20 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES), which are included in the latest published data.

The percentage of records:

- which included the patient's valid NHS number was: 99.5 per cent for admitted patient care; 99.8 per cent for outpatient care; and 97.5 per cent for accident and emergency care.
- which included the patient's valid general practice code was: 99.5 per cent for admitted patient care; 99.9 per cent for outpatient care and 98.9 per cent for accident and emergency care.

(Data source: NHS number, Trust statistics. GP Practice: NHS Information Centre, SUS Data Quality Dashboard, April 2019 – March 2020 extracted 21/04/2020)

UH Bristol completed 106 of 116 mandatory requirements in the 2019/20 Data Security and Protection Toolkit and submitted an Improvement Plan to NHS Digital to achieve the remaining requirements. NHS Digital approved this Improvement Plan and UH Bristol's Data Security and Protection Toolkit Assessment is "Standards Not Fully Met – Plan Agreed".

National Payment by Results audits have ceased in England and it has been delegated to each Trust to organise its own clinical coding audit programme.

In March 2020, the Trust commissioned an External Clinical Coding Audit to fulfil the DS&P Toolkit requirement. The Audit reviewed a total of 200 episodes from the Specialities of Ophthalmology, Respiratory Medicine and General Medicine. The episodes audited were randomly selected from September – December 2019 data. The audit focussed on primary diagnoses and procedures as well as completeness of codes including comorbidities. These percentages achieved meet the mandatory level of attainment for an Acute Trust in line with HSCIC's Data Quality Standard 1 and exceed that for Standard 3 Training.

The following levels of accuracy were achieved:

- Primary diagnosis accuracy: 96.0 per cent
- Primary procedure accuracy: 94.6 per cent

(Due to the sample size and limited nature of the audit, these results should not be extrapolated)

The Trust has taken the following actions to improve data quality:

- The data quality programme involves a regular data quality checking and correction process. This involves the central information system team creating and running daily reports to identify errors and working with the Medway support team and users across the Trust in the correction of those errors (this includes checking with the patient for their most up to date demographic information).
- The clinical coding team have a plan in place to follow through on the recommendations from the External Audit to improve the quality of coding.

2.3 Mandated quality indicators

In February 2012, the Department of Health and NHS Improvement announced a new set of mandatory quality indicators for all Quality Accounts and Quality Reports. The Trust's performance in 2019/20 (or, in some cases, latest available information which predates this) is summarised in the table below. The Trust is confident that this data is accurately described in this Quality Report.

Table 3

Mandatory indicator	UH Bristol Most Recent	National average	National best	National worst	UH Bristol Previous
Venous thromboembolism risk assessment	77.9% 2019/20 Q3	95.3%	100%	71.6%	85.3% 2019/20 Q2
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over). Total Cases	29.2 2018/19	34.9	0.0	168	32.7 2017/18
Rate of patient safety incidents * reported per 1,000 bed days	76.3 Oct19-Mar20	50.66**	110.2**	27.5**	60.1 Oct17-Mar18
Percentage of patient safety incidents* resulting in severe harm or death	0.39% Oct19-Mar20	0.33**	0.0%**	0.86%**	0.35% Oct17-Mar18
Responsiveness to inpatients' personal needs	71.3 2018/19	67.2	85.0	58.9	71.2 2017/18
Percentage of staff who would recommend the provider	85.4% 2019 survey	70.5%	87.4%	39.7%	84.9% 2018 survey
Summary Hospital-level Mortality Indicator (SHMI) value and banding	96.4 (Band 2 "As Expected") Jul19-Jun20	100.0	67.6	120.7	104.6 (Band 2 "As Expected") Jul18-Jun19
Percentage of patient deaths with specialty code of 'palliative medicine' or diagnosis code of 'palliative care'	34% Jul19-Jun20	37%	60%	9%	34% Jul18-Jun19
Emergency readmissions within 30 days of discharge: age 0-15	10.2% 2018/19	13.1%	1.8%	69.2%	10.0% 2017/18
Emergency readmissions within 30 days of discharge: age 16 or over	13.3% 2018/19	12.3%	2.1%	57.5%	13.3% 2017/18

* Incidents meeting criteria for reporting to the National Reporting and Learning System include some incidents categorised locally as health and safety incidents

**National Reporting and Learning System acute non-specialist trust peer group

Part 3

Review of services in 2019/20

3.1 Patient Safety

The safety of our patients is central to everything we want to achieve as a provider of healthcare. We are committed to continuously improving the safety of our services and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will achieve this by successfully implementing proactive patient safety improvement programmes and by working to better understand and improve our safety culture. We will continue to conduct thorough investigations and analyse when things go wrong, identifying and sharing learning, and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident and will strive to eliminate avoidable harm as a consequence of the care we have provided.

3.1.1 Our Patient Safety Improvement Programme 2019-2021

#DeliveringSaferCare

Our new Patient Safety Improvement Programme commenced in 2019. The purpose of the Trust's Patient Safety Improvement Programme is to provide a framework and structure to take forward quality and safety improvements across the trust, focus on internal and external improvement opportunities identified from systematic learning and new developments. The programme underpins the Trust's commitment to continuous improvement and stated aims of the Quality Strategy 2016-2020: to deliver safe and reliable care, improve outcomes and decrease mortality.

The aims of the Patient Safety Improvement Programme 2019-2021 are:

- To systematically improve safety and quality across the trust to reduce risks to patients and drive harm reduction.
- To align with the priorities of NHS Improvement's emerging patient safety strategy and national and regional programmes, such as the National Maternity and Neonatal Health Improvement programme and the West of England Patient Safety Collaborative programme.

We set our patient safety priorities for 2019-2021 by gathering information from several sources to identify what our priorities should be for the next three years.

A thematic analysis of the information gathered identified the following key themes on which to focus our improvement work for 2019 to 2021. These workstreams are as follows:

a) Deteriorating Patients and Sepsis
b) Medication Safety
c) Peri-operative Never Events
d) Leadership and Culture
e) Paediatrics
f) Maternity and Neonatal care
g) ReSPECT
h) Interruptions and Distractions

A summary of the key safety and quality achievements of our 2019/2020 Patient Safety Improvement Programme follows.

3.1.1.1 Improving the management of the deteriorating patient:

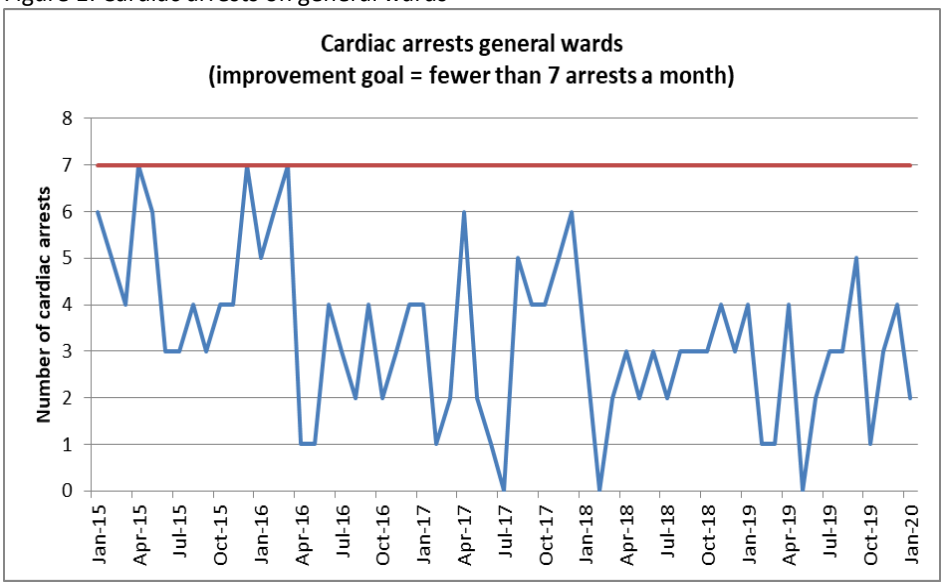
Assessment of a patient's physiological status, recognition of deterioration and obtaining a prompt response from a more senior healthcare professional continues to be one of the foundations of healthcare provision. Use of early warning scores calculated from measurement of physiological parameters is one of the tools used to help detect underlying deterioration, even if a patient may appear relatively well.

Our aim by end of 2021, to achieve 365 "days between" an adult patient coming to moderate or above harm as a result of failure to recognise and respond to deterioration or to enact ceiling of care/ end of life decision. To sustain fewer than seven adult cardiac arrests per month on general wards.

Key achievements in 2019/2020:

- We continually meet our improvement goal to sustain fewer than seven adult cardiac arrests on general wards, see Figure 2 for the data. This is due to the early recognition of deterioration of our patients.

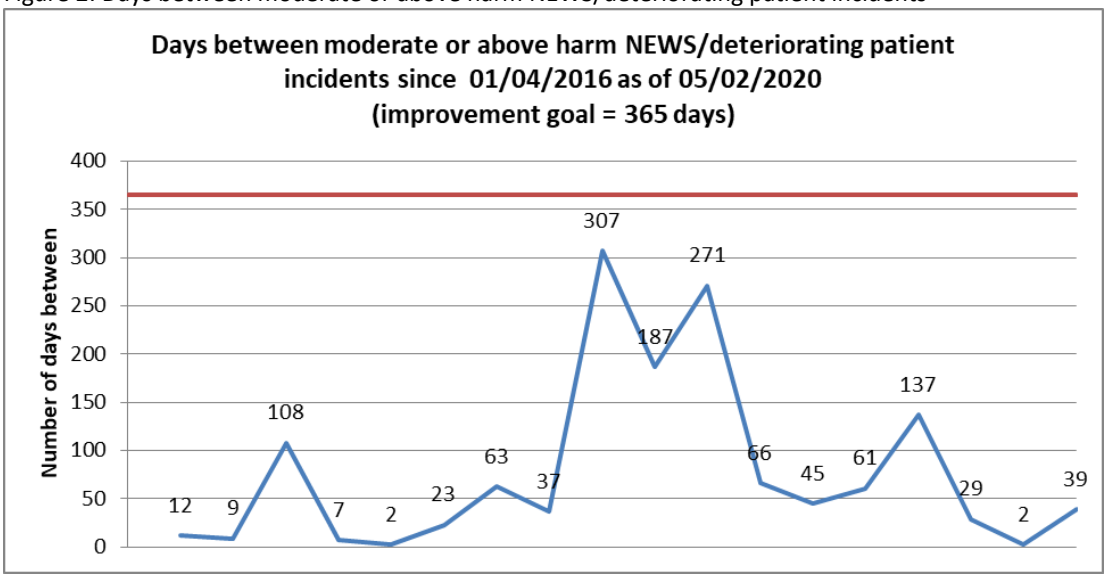
Figure 1: Cardiac arrests on general wards



Source: Monthly UH Bristol Resusication team

- We have not achieved our 'Days between' moderate or above harm incidents related to failure to recognise deterioration improvement goal. Our 2019-2021 programme plans is to implement a system for automatic electronic escalation of deteriorating patients.

Figure 2: Days between moderate or above harm NEWS/deteriorating patient incidents



Source: UH Bristol Datix Risk Management System

- Data is showing we have not achieved our improvement goal of 365 days between NEWS/deteriorating patient incidents resulting in moderate or above harm. Deteriorating patient incidents were particularly notable around December 2019 /January 2020 with many resulting in no harm due to the preventative actions of staff.

3.1.1.2 Improving the early recognition and treatment of patients with sepsis:

"Sepsis (also known as blood poisoning) is the immune system's overreaction to an infection or injury. Normally, our immune system fights infection – but sometimes, for reasons we don't yet understand it attacks our body's organs and tissues. If not treated immediately, sepsis can result in organ failure and death. Yet with early diagnosis, it can be treated with antibiotics."

UK Sepsis Trust

It is important to note that some patients with sepsis will die from organ failure despite early recognition and prompt, appropriate treatment. There is a close link between early recognition and general deterioration of patients and the early recognition and treatment of sepsis; indeed the latest evidence-based trigger for sepsis screening in adults is a raised NEWS score.

We aim to increase survival rates for emergency suspicion of sepsis (SOS) admissions to 94 per cent and Summary Hospital-level Mortality rate (SHMI)[1] less than 90 by December 2021.

[1] The SHMI data is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Key achievements in 2019/2020:

- By the end of 2019, we achieved our 90 per cent improvement goals for sepsis screening, delivering antibiotics within an hour and 72-hour review of antibiotics. Screening in patients with raised NEWS scores for sepsis has been improved by prompts from our e-observations system.
- We implemented sepsis screening and a sepsis pathway in our children's emergency department and maternity services, and are developing inpatient sepsis pathways for children.

3.1.1.3 Improving medicines safety:

There are an estimated 66 million potentially significant medication errors per year in the UK, 29 per cent of these in secondary care. There are currently around 350 reported medication incidents per month in the Trust.

We have drawn from local and national strategies (NHS Patient safety Strategy [Medicines Safety Improvement Programme], Academic Health Science Networks (AHSN) Medication safety project & Patient Safety Collaborative, Bristol, North Somerset and South Gloucestershire (BNSSG) Healthier Together work programme and the World Health Organisation (WHO) Medication Without Harm campaign) to build on previous improvement work and put in place measure to improve medication safety.

Key achievements in 2019/2020:

- We implemented a team-based approach to ward clinical pharmacy services and the development of an electronic dashboard to facilitate patient prioritisation. This has enabled us to target patients more effectively and increase the number of patients for whom we can reconcile their medication within 24 hours of admission.
- We introduced a Pharmacy dashboard revised to show thromboprophylaxis recommendations from the Medway risk assessment.
- Unfortunately, Medway electronic prescribing and medicines administration (EPMA) has been ceased on all adult wards unlikely to be implemented until autumn 2020 – spring 2021. Due to an essential upgrade of the IT systems needed before we can go live for all adult services.

3.1.1.4 Reducing Peri-procedure Never Events:

Our longstanding aim of this workstream is to reduce the incidence of peri-procedure never events: wrong-site surgery, retained foreign object and wrong implant/prosthesis.

We have continued to achieve this by the implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) and focusing on improving engagement of clinical teams in use of the WHO surgical safety checklist. To reduce the risks inherent in providing invasive procedures in ward, ITU and Theatre environments, the use of WHO and LocSSIP checklists are advised although the effectiveness and consistency of their use is not clearly identified in all associated departments across the Trust.

Key achievements in 2019/2020:

- We are further working on ensuring the World Health Organisation (WHO) and Local Safety Standards for Invasive Procedures (LocSSIP) checklists fit for purpose and their use to be universal in all departments carrying out invasive procedures.

- We successfully implemented LocSSIP for Abdominal Paracentesis and Lumbar Puncture procedures carried out on the wards. LocSSIP use is embedded within the Trust. Our improvement goal aim is 80 per cent we have sustained average completion across the Trust.
- We, unfortunately, have not sustained our improvement goal of 80 per cent compliance for LocSSIP chest drain completion; this remains a focus of the workstream with attendance through the QI silver[2] academy programme, working with the ward areas to review their systems and processes.
- Unfortunately, we have not achieved our improvement goal of number of days between peri-procedure never events our improvement goal of 365 days. Further details of never events which occurred in 2019/2020 are provided in section 3.1.3.

3.1.1.5 Improving Leadership and culture:

- We took part in the first-ever World Patient Safety Day on the 17th September 2019; the World Health Organisations (WHO) global campaign to create awareness of Patient Safety. Our Patient Safety Teams held a week-long programme to promote patient safety within the Trust.
- We have made the decision to refresh executive director walk rounds into 2020/21 as leadership walk rounds in conjunction with the Wellbeing Team and Weston Area Health Trust as part of the merger between our two organisations.
- We successfully audited the quality of ward safety briefings and shared with divisions. The key findings were overall safety briefings were standardised across the trust, well attended and embedded in daily practices and compliance of the safety brief were good.

3.1.1.6 Paediatric workstreams:

Since our new Improvement Programme commenced in 2019 Paediatric services have continued to engage and build on their workstream with achievements throughout the programme. The paediatric workstreams echoes the Patient Safety Improvement Programme and Patient Safety Priorities in following the adult workstreams:

- Deteriorating patient and Sepsis
- Medication safety
- leadership and culture
- Peri-operative never events workstream

Key achievements in 2019/2020:

- The deteriorating patient workstream has implemented Mobile Resuscitation Carts (see picture below) which have been fully implemented throughout the hospital to improve compliance and competence with key resuscitation skills. The carts offer training on four

[2] The QI silver programme is part of the QI Academy which focuses on teaching people how to implement improvement ideas through practical workshops, an innovation and improvement toolkit, mentorship from 'improvement coaches', skills training in audits and R&D, and certification upon completion of the academy silver and bronze programmes.

key skills: teenage and infant chest compressions and ventilation. Each skill takes three to five minutes to complete and will reduce the need for face-face training.

- The deteriorating patient workstream showed that the unplanned admissions to PICU have significantly decreased (93 unplanned admissions in 2018 verses 58 unplanned admissions in 2019).
- The leadership and culture workstream have successfully launched Greatix 'learning from excellence tool"[3] across the BRHC. The number of teams using the Greatix tool continues to increase.

3.1.1.7 Maternity and Neonatal Health Safety Collaborative Programmes:

We are working with the Maternal and Neonatal Health Safety Collaborative (MNHSC) a National three-year Quality Improvement Programme that was launched in February 2017 and is led by NHS Improvements Patient Safety team. We are focusing on smoking cessation, venous thromboembolism (VTE) compliance and pain reassessment according to Trust standards as improvement goals.

Key achievements in 2019/2020:

- We are working on reducing the percentage of mothers smoking at time of delivery; this remains a key focus of our workstream.
- We have sustained our improvement goal of the percentage of patients that had had their moderate or severe pain reassessed within an hour post analgesic administration. January 2020 data showed 100 per cent compliance.
- We have not yet achieved our improvement goal of 95 per cent however the QI team at STMH, maternity wards and gynaecology team have focused on this improvement. See Figure 3 below.

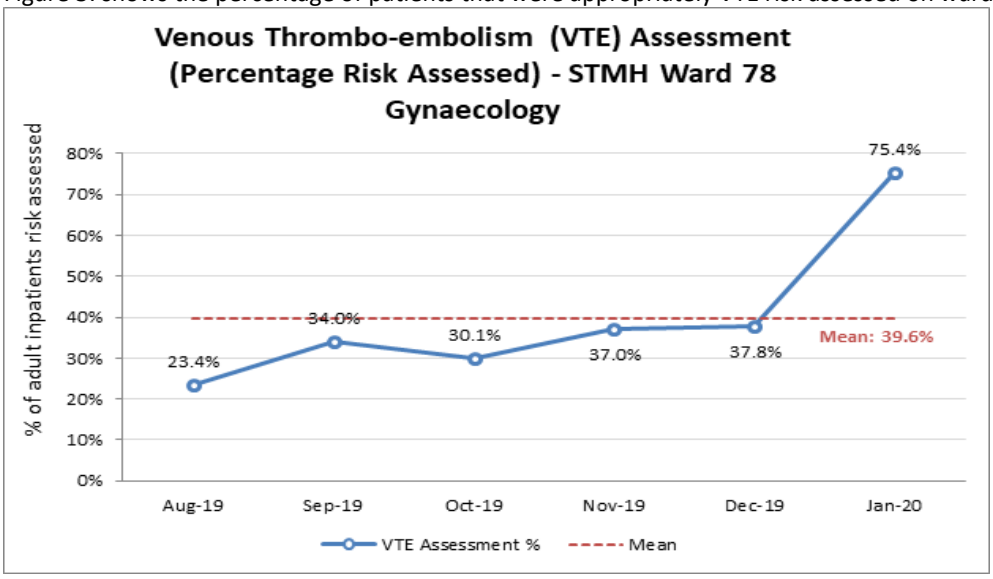
3.1.1.8 ReSPECT (Recommended Summary Plan for Emergency Care and Treatment):

ReSPECT was implemented in The West of England Academic Health Science Network (AHSN) in spring 2019 for documentation of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions but also advanced care planning decisions. The ReSPECT is a process to plan a person's clinical care in the event of a future emergency when they might be unable to make or express choices.

In October 2019, the ReSPECT process was successfully implemented across the WEAHSN for documentation of DNACPR decisions but also for advanced care planning decisions.

[3] 'Learning from Excellence' is an innovation that focuses on capturing and learning from episodes of excellence in healthcare in an attempt to further improve the quality and safety of care that we provide.

Figure 3: shows the percentage of patients that were appropriately VTE risk assessed on ward 78



Source: UH Bristol InfoWeb system

3.1.1.9 Interruptions and Distractions:

The delivery of healthcare occurs within an increasingly complex and pressured system, meaning staff more frequently find themselves in situations which increase the chance of human error occurring. The aim for this workstream is to reduce and/or mitigate the impact of interruptions and distractions on staff, thereby reducing the risk of human error leading to an incident.

This workstream remains in the scoping phase we are working with clinical teams to understand and assess frequency and types of interruptions and distractions via focus groups, reporting of medication errors and the 'clicker challenge'[4].

3.1.2 Freedom to Speak Up

The Trust has a Freedom to Speak Up Guardian (FTSUG) to whom all staff can raise concerns. To support the work of the Guardian, more than 50 staff advocates have been recruited to help raise awareness of speaking up and to provide more local support for concerns. To date, all individuals who have raised concerns have been supported personally by the Guardian and have received feedback following the investigations into their concerns. Overall feedback has been positive in relation to whether individuals would speak up again.

The FTSUG also works to ensure that individuals who raise concerns do not suffer detriment as a result of speaking up and, to date, no-one has identified that they have suffered detriment. In recognising that detriment may not occur immediately after speaking up or an investigation being completed, the FTSUG has committed to following up with individuals approximately three months after providing feedback in cases where there is a risk of detriment, to check that nothing has arisen.

[4] Clicker challenge is a workplace analysis of the frequency interruption and distractions that take place on a normal clinical working day.

Where there are concerns relating to patient safety, these are immediately escalated to the Medical Director and Chief Nurse to investigate and take appropriate action.

However, the FTSUG is only one mechanism through which staff can raise concerns. The Trust also has the following groups or processes which can assist staff:

- Bullying and harassment advisors
- Joint Union offices
- Occupational health
- Employee services
- Safeguarding team
- Patient Safety team

The key challenge is to ensure that staff are aware of the FTSU programme and the role of the Guardian. To support this:

- The Trust has used a FTSU message as a desktop background for all PCs;
- There are regular communications about Speaking Up in the weekly newsletter to all staff (Newsbeat), with case studies on each of the Advocates;
- A video explaining Speaking Up is included in Trust induction for all new starters;
- There are posters and other materials around the Trust which describe what Speaking Up is and how to contact the FTSUG; and
- The FTSUG and Advocates attend meetings with staff groups to personal relay messages and answer questions about Speaking Up.

The Board and its People Committee receive a quarterly update on the FTSU programme which is delivered by the FTSUG. Included in the updates are learnings from the National Guardian Office's case reviews of other Trusts, which could be applied to UH Bristol where appropriate.

3.1.3 Never Events

Despite the work we continue to do on preventing peri-procedure never events, there were four such Never Events reported in our Trust in 2019/20:

- Wrong type of intrauterine device fitted (June 2019)
- Laser eye surgery performed in outpatients on the wrong patient (July 2019)
- An additional tooth extracted ten teeth in total instead of nine (August 2019)
- A historic incident from 2014 where it appears that a fallopian tube was removed in addition to a planned ovarian cyst removal (December 2019)

Investigations from all four never events have been completed. Examples of improvements we have made as a result of our investigations include:

- Changes to the checking process for intrauterine device insertions to clarify whether the device being fitted contains copper or a hormone
- Changes to the GP referral form to make it clear which type of intrauterine device the patient is being referred for
- Development of a bespoke WHO checklist for laser eye surgery to include a 'time out' to check again the patient's identity, consent, procedure, laterality and patient's record
- Change in practice for the operator to vocalise each tooth to be extracted at the point of placing the instrument and for the assistant to confirm the tooth is to be extracted
- Changes to sedation monitoring during dental extractions

3.1.4 Serious incidents

The purpose of identifying and investigating serious incidents, as with all incidents, is to understand what happened, learn and share lessons, and take action to reduce the risk of a recurrence. The decision that an event should be categorised as a serious incident is usually made by an executive director. Throughout 2019/20, the Trust Board was informed of serious incidents via its monthly quality and performance report. The total number of serious incidents reported for the year was 73, compared to 70 in 2018/19. Two serious incidents were downgraded and one serious incident was requested to be downgraded. A breakdown of the categories of the 71 serious incidents is provided in Figure 6 below.

Hospital acquired grade 3 pressure ulcers, patient falls resulting in major harm and diagnostic incidents remain the most frequently reported serious incidents, despite implementing actions to reduce their number. We continue to focus on reducing pressure ulcers, some those reported in 2019/20 have developed underneath plaster casts and splints and some more recent incidents have been associated with delays in obtaining pressure relieving equipment. Actions to reduce risk of patients developing pressure ulcers in hospital and sustaining falls are contained with annual work plans and we are also introducing digital clinical risk assessments for patients to improve visibility and prompt timely updates.

All serious incident investigations have robust action plans, which are implemented to reduce the risk of recurrence. The investigations for serious incidents and resulting action plans are reviewed in full by the Trust Quality and Outcomes Committee (a sub-committee of the Trust Board of Directors).

3.1.5 Learning from serious incidents and Never Events

Internally, we have local and Trust-wide systems to learn from serious incidents and Never Events, including safety briefs, Learning After Significant Event Recommendations (LASER) posters, governance and specialty meetings, clinical audit days, newsletters, and safety bulletins. We also share learning from incidents within patient safety update sessions for staff.

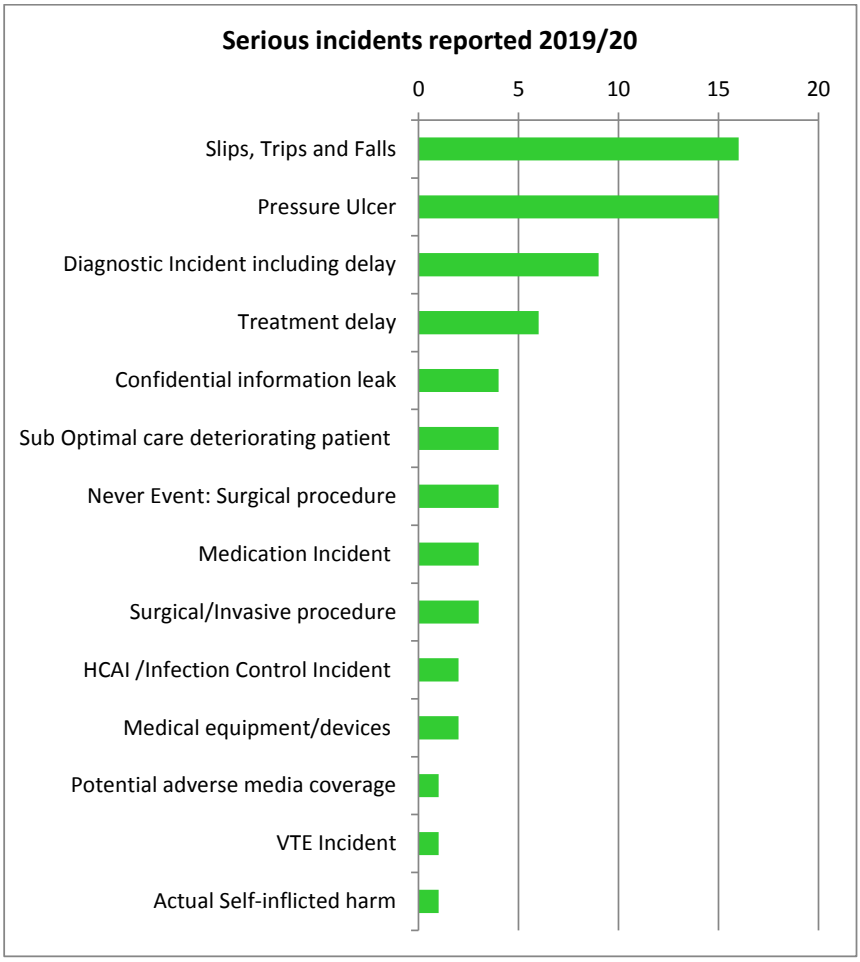
3.1.6 Duty of Candour

We continue to comply with the statutory and regulatory requirements for Duty of Candour as evidenced in each of our serious incident investigation reports and local audits.

3.1.7 Guardian of safe working hours: annual report on rota gaps and vacancies for doctors and dentists in training

Dr Alistair Johnstone is the Trust's Guardian of Safe Working for Junior Doctors. Our Trust Board receives quarterly reports and an aggregated annual report, all of which are available to read at: http://www.uhbristol.nhs.uk/about-us/key-publications/.

Figure 4



Source: UH Bristol Serious Incident Log

3.1.8 Overview of monthly board assurance regarding the safety of patients 2018/19

The table below contains key quality metrics providing assurance to the Trust Board each month regarding the safety of the patients in our care. Where there are no nationally defined targets for safety of patients or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement or sustain already highly benchmarked performance. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable.

Table 4

Quality measure	Data source	Actual 2018/19	Target 2019/20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2019/20
Infection control and cleanliness monitoring								
Number of MRSA Bloodstream Cases	National Infection Control data (PHE)	6	0	0	1	0	3	4
Number of *Clostridium difficile* Cases	National Infection Control data (PHE)	31	< 57	8	14	13	6	41
Number of MSSA Cases	Infection Control system (MESS)	34	< 25	15	15	10	8	48
Hand Hygiene Audit Compliance	Monthly audit	97.1%	≥ 95%	95.9%	97.6%	97.7%	97.6%	97.2%
Antibiotic prescribing Compliance	Monthly audit	78.9%	≥ 90%	79.1%	84.5%	73.5%	79.1%	77.9%
Cleanliness Monitoring - Overall Score	Monthly audit	95.0%	≥ 87%	95.7%	96.0%	96.3%	94.5%*	95.7%*
Cleanliness Monitoring - Very High Risk Areas	Monthly audit	97.0%	≥ 98%	98.0%	97.7%	98.0%	98.5%*	98.0%*
Cleanliness Monitoring - High Risk Areas	Monthly audit	96.0%	≥ 95%	96.3%	96.0%	96.7%	97.5%*	96.5%*
Serious incidents and Never Events								
Number of Serious Incidents Reported	Local SI Log	70	No set target	18	23	17	15	73
Serious Incidents Reported Within 48 Hours	Local SI Log	98.6%	100%	100%	100%	100%	100%	100%
72 Hour Report Completed Within Timescale	Local SI Log	94.3%	100%	94.4%	91.3%	100%	100%	95.9%
Serious Incident Investigations Completed Within Timescale	Local SI Log	96.8%	100%	100%	100%	100%	92.3%	98.5%
Total Never Events	Local SI Log	5	0	1	2	1	0	4
Patient safety incidents								
Number of Patient Safety Incidents Reported	Datix	16,269	No set target	5,069	5,215	5,385	5,091	20,760
Patient Safety Incidents Per 1000 Bed days	Datix/Medway	58.52	No set target	64.84	66.99	66.78	67.17	66.44
Number of Patient Safety Incidents - Severe Harm**	Datix	78	No set target	26	47	43	34	150
Patient falls								
Falls Per 1,000 Bed days	Datix/Medway	4.55	< 4.80	4.48	4.30	4.35	4.95	4.52
Total Number of Patient Falls Resulting in Harm	Datix	24	< 24	3	4	7	12	26
Pressure ulcers developed in the Trust								
Pressure Ulcers Per 1,000 Bed days	Datix/Medway	0.295	< 0.40	0.128	0.180	0.174	0.251	0.182
Pressure Ulcers - Grade 2	Datix	80	No set target	9	9	13	18	49
Pressure Ulcers - Grade 3 or 4	Datix	10	0	1	5	1	1	8
Venous Thromboembolism (VTE)								
Adult Inpatients who Received a VTE Risk Assessment	Medway	98.3%	≥ 95%	98.3%	85.3%	77.9%	87.9%	87.4%
Number of Hospital Associated VTEs	Monthly local pharmacy audit	47	No set target	9	16	5	8*	38*
Number of Potentially	Monthly local	5	0	1	2	0	0*	3*

Avoidable Hospital Associated VTEs	pharmacy audit							
Nutrition								
Fully and Accurately Completed Nutritional Screening within 24 Hours	Quarterly local dietetics audit	91.1%	≥ 90%	84.4%	86.9%	87.9%	88.2%	86.9%
WHO checklist								
WHO Surgical Checklist Compliance	Medway/Bluespier	99.8%	100%	99.8%	100%	99.9%	99.9%	99.9%
Medicines								
Medication Incidents Resulting in Harm	Datix	0.29%	< 0.5%	0.37%	0.80%	0.14%	0%	0.33%
Non-Purposeful Omitted Doses of the Listed Critical Medication	Monthly local pharmacy audit	0.37%	< 0.75%	0.37%	0.14%	0.30%	0.92%	0.41%
Timely discharges								
Out of Hours Departures (20:00 to 07:00)	Medway PAS	8.7%	No set target	8.3%	7.3%	7.4%	8.2%	7.8%
Percentage of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	23.9%	≥ 25%	22.7%	22.2%	23.2%	22.9%	22.8%
Number of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	9815	No set target	2,259	2,236	2,524	2,192	9,211
Staffing levels								
Nurse staffing fill rate combined	National Unify return	99.3%	No set target	100.9%	99.2%	100.0%	101.2%	100.3%

*excludes data for March 2020 as manual audits paused during the first wave of the Covid pandemic
** data subject to manager's harm validation after each month end or following an investigation.

3.2 Patient experience

We want all of our patients to have a positive experience of healthcare, to be treated with dignity and respect and to be fully involved in decisions affecting their treatment, care and support. Our commitment to 'respecting everyone' and 'working together' is enshrined in the Trust's Values. Our goal is to continually improve by engaging with and listening to patients and the public when we plan and develop services, by asking patients what their experience of care has been and how we could make it better, and taking positive action in response to that learning.

3.2.1 National patient surveys

Each year, the Trust participates in the Care Quality Commission's national patient experience survey programme. These national surveys reveal how the experience of patients at UH Bristol compares with other NHS acute trusts in England. UH Bristol achieved the following successes in the national survey results published during 2019/20[5]:

- In the 2018 National Inpatient Survey, fourteen of UH Bristol's scores were better than the national average to a statistically significant degree; with the overall experience rating from patients being the best of any acute non-specialist trust nationally
- Our 2018 National Cancer Patient Experience Survey results showed an improvement for the fourth consecutive year – reflecting the positive effects of the comprehensive improvement plan that we have in place after disappointing results in the survey up to 2014.
- In the 2019 National Maternity Survey, we achieved a "better than national average" rating for the experience that women have at our St Michael's Hospital during their labour and birth - including the best score nationally on women being treated with respect and dignity during this time.
- In the 2018 national children's survey, the Bristol Royal Hospital for Children received an overall hospital experience rating from both children and parents that was amongst the best 20 per cent of trust scores nationally.

Table 5 summarises the number of scores that UH Bristol had above, below, or in line with the national average in each set of national survey results that were released during 2019/20. Figure 5 provides an indication of UH Bristol's performance relative to the national average.

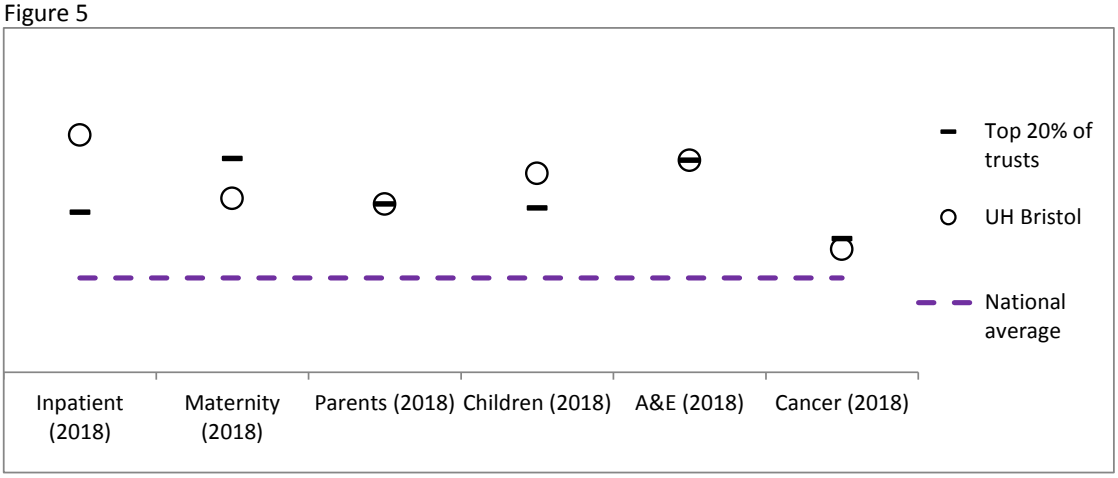
Table 5: Results of national patient surveys received by the Trust during 2018/19 (number of scores above, in line with, or below the national average)

		Comparison to national average		
	Date patients attended	Above (better)	Same	Below
2018 National Cancer Survey	April-June 2018	5	44	0
2018 National Children's Survey	November to December 2016	6	58	1
2019 National Maternity Survey	February 2019	6	46	0
2018 National Inpatient Survey	July 2018	14	49	0

Source: Care Quality Commission Benchmark Report (www.nhssurveys.org)

[5] The national surveys tend to be published around ten months after the participating patients attended hospital.

Figure 5



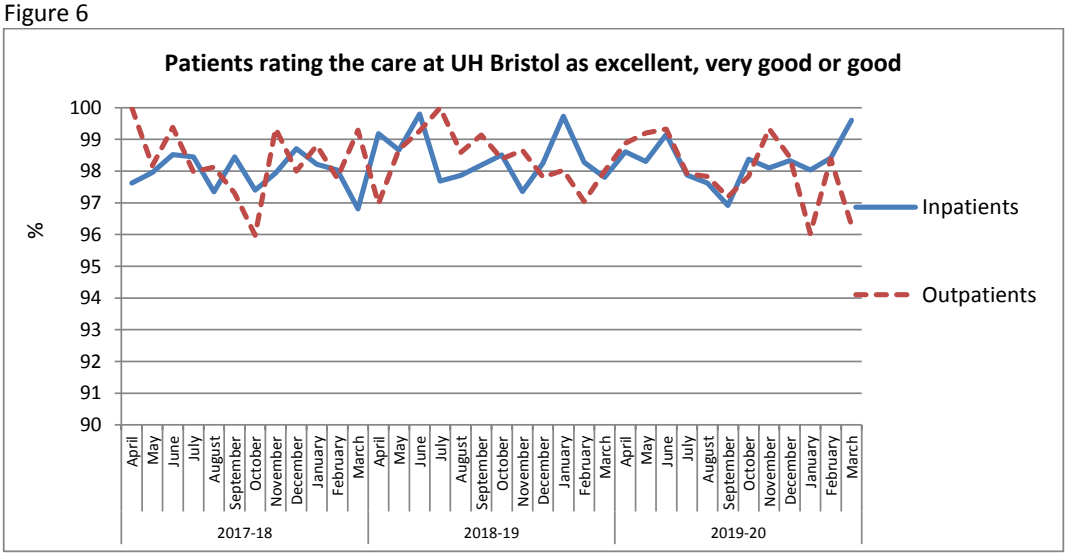
Source: UH Bristol Patient Experience and Involvement Team analysis of Care Quality Commission data

3.2.2 UH Bristol patient survey programme

UH Bristol has a comprehensive local survey programme to ensure that ongoing and timely feedback from patients forms a key part of our quality monitoring and improvement processes.

The Trust continues to receive very positive feedback from service-users in our monthly postal surveys (Figure 8). Over the 2019/20 financial year, 98 per cent of inpatient and outpatient survey respondents rated the care they received at UH Bristol as excellent, very good, or good. Praise for our staff remains by far the most frequent form of feedback that we receive.

Figure 6



Source: UH Bristol postal survey

Our extensive patient feedback processes provide us with important insights from patients and people who visit our hospitals about how we can continually improve our services. During 2019/20 we extended our programme further, with the roll-out of our new electronic feedback and reporting system. This allows patients, visitors and carers to provide feedback in real-time and raise any issues or concerns with us.

We have also carried out a range of improvement activities with the aim of providing a consistently excellent "customer service" across our hospitals. This included securing funding for an advanced customer service training course that will be implemented in 2020/21. This course will target all administrative staff in "front of house roles" (e.g. ward clerks, receptionists, telephone operatives).

As part of a corporate quality objective (see section 2.1.1), we have also strengthened the training and support that we provide for lay representatives on UH Bristol's groups and committees. This will help to ensure that the people who contribute to the development of our services are fully supported to do so and that the benefits of their involvement are maximised.

3.2.3 Patient and Public Involvement

In addition to our surveys, we also carry out a range of engagement activities with our patients, visitors and the public. We do this in a number of ways, for example via focus groups, interviews carried out by our volunteer *Face2Face* Team, and our Involvement Network which reaches out to a wide range of community groups across Bristol and the surrounding areas.

The following are some highlights from this activity in 2019/20:

- The Cardiology and Cardiac Surgery teams carried out patient focus groups to hear about the social and psychological impact of invasive and non-invasive heart procedures. Attendees also contributed to a review of the cardiac surgery pathway being carried out by the management team.
- Patients attending the Bristol Haematology and Oncology Hospital participated in a partnership project with the South West Cancer Alliance to discuss their experiences of social and emotional support as part of their care package.
- The Bristol Eye Hospital management team worked with the Bristol Sight Loss Council on refurbishment plans for the hospital.
- Representatives of the Bristol Physical Access Chain met with the Trust's Operations Transport and Green Travel Manager to influence proposals to improve the arrangements for disabled parking, drop off points, bus and taxi services to the entrance of the Bristol Royal Infirmary.
- Members of the UH Bristol Involvement Network Group joined Trust Members and representatives of the Trusts Young Person's Involvement Group in our annual Quality Counts event.
- A young people's involvement event was held at the Trust's Simulation Centre as part of the Trust's approach to promoting career opportunities in the health service and consisted of hands on simulation activities, workshops and a careers marketplace.
- Members of the Trust's Involvement Network contributed to the revised Trust Complaints Policy as part of the Equality Impact Assessment linked to the policy.
- The Trust's "Face-to-face" volunteer team were actively engaged in a range of patient experience projects again this year, including mystery shopping in our Chemotherapy, Opthalmology and Rheumatology services, and carrying out an interview-based travel survey.

3.2.4 Equality and diversity

The Trust carried a range of activities with the aim of ensuring that we deliver equitable care and services to all sections of the community that we serve. Some of the activities in this respect included:

- Continuing to develop and embed the work of our Patient Inclusion and Diversity Group (PIDG - established in 2018) and its Divisional working sub-group. These groups are the Trust's main vehicle for equality and diversity issues affecting patients and service users.
- Working with representatives from the Transgender community to design and deliver Transgender awareness training sessions for doctors and nurses
- Implementing a process by which appointment letters produced by our external printing provider can be produced in accessible formats
- Procuring a new provider of our external spoken language interpreting services in collaboration with Weston Area Health NHS Trust and North Bristol NHS Trust – to help ensure a degree of consistency for patients across key acute hospital providers
- Extending our remote British Sign Language video interpreting service to more locations around our Trust
- Carrying out a tender for our external translating and interpreting services. This was in collaboration with other local NHS trusts to help develop more seamless support for patients as they move between organisations. Our work on this tender has been used as a national best practice case study by Crown Commercial Services.
- Taking a lead role in the establishment of the Bristol Deaf Health Partnership and the Bristol Visual Impairment Partnership, both of which act as a single forum for sharing information and improving the quality of care for patients and their carers.
- Commissioning an external access audit of the Trust's hospital sites which will provide patients and carers with detailed information about physical access to our hospitals - enabling them to plan their journeys better.
- The Bristol Eye Hospital working in collaboration with the Bristol Sight Loss council on development plans for hospital estate

3.2.5 Complaints received in 2019/20

In 2019/20, 1,785 complaints were reported to the Trust Board, compared with 1,879 in 2018/19[6]. 552 (30.9 per cent) of these complaints were investigated via the formal complaints process, with the remainder addressed through informal resolution.

In addition, the Patient Support and Complaints Team dealt with 903 other enquiries, including compliments, requests for support and requests for information and advice; this represents a 6.4 per cent decrease on the 965 enquiries dealt with in 2018/19. The team also received and recorded an additional 618 enquiries which did not proceed after being recorded (the same amount as in 2018/19). In total, the team received 3,306 separate enquiries into the service in 2019/20; a slight decrease on the 3,428 reported the previous year.

In 2019/20, the Trust had 14 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO), representing a significant 54.8 per cent decrease on the 31 cases referred the previous year. During the same period, coincidentally, 14 cases were closed by the PHSO. Of these 14 cases, none were upheld, one was partly upheld, and the remaining 13 fell into the category designated by the PHSO whereby they carried out an initial review but then decided

[6] Previously 1,874 in 2016/17, 1,941 in 2015/16 and 1,883 in 2014/15

not to investigate and closed their file, citing 'no further action'. At the end of the year 2019/20, 13 cases were still under investigation by the PHSO.

758 complaints were responded to via the formal complaints process in 2019/20 and 88 per cent of these (667) were responded to within the agreed timescale. This is similar to the 87 per cent achieved in 2018/19, which does not meet the Trust target of 95 per cent. A total of 1,004 complaints were responded to in 2019/20 via the informal complaints process and 89.3 per cent of these (897) were responded to within the agreed timescale, an improvement on the 83.5 per cent achieved the previous year.

At the end of the reporting year, 9.1 per cent of complainants had expressed dissatisfaction with the formal response they had received. This represents a total of 62 of the 680 first formal responses sent out during the reporting period and compares with 9.5 per cent in 2018/19 and 9.7 per cent in 2017/18.

3.2.6 Overview of monthly board assurance regarding patient experience

The table below contains key quality metrics providing assurance to the Trust Board each month regarding patient experience. Where there are no nationally defined targets or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable. Some patient experience metrics and targets in Table 7 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2017/18" may vary slightly from the equivalent data in our 2017/18 Quality Report due to finalisation of provisional data.

Table 6

Quality measure	Data source	Actual 2018/19	Target 2019/20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2019/20
Monthly patient surveys								
Patient Experience Tracker Score	Monthly postal survey	91	≥ 87	91	92	92	91	91
Kindness and Understanding	Monthly postal survey	96	≥ 90	96	96	95	96	96
Outpatient Tracker Score	Monthly postal survey	90	≥ 85	90	90	90	90	90
Friends and Family Test (coverage)								
Inpatient Coverage	Friends and Family Test	35.1%	≥ 30%	37.7%	36.7%	34.1%	32.7%	35.5%
ED Coverage	Friends and Family Test	16.4%	≥ 15%	16.8%	16.9%	16.4%	16.0%	16.6%
Maternity Coverage	Friends and Family Test	18.3%	≥ 15%	27.7%	25.9%	26.6%	25.3%	26.5%
Friends and Family Test (score)								
Inpatient Score	Friends and Family Test	98.2%	≥ 90%	98.4%	98.9%	98.5%	98.9%	98.7%
ED Score	Friends and Family Test	82.1%	≥70%	82.0%	83.3%	84.6%	87.5%	84%
Maternity Score	Friends and Family Test	97.3%	≥92%	97.4%	97.4%	98.0%	97.9%	97.6%
Patient complaints								
Number of Patient Complaints	Patient Support and Complaints Team	1,845	No set target	511	442	445	444	1,842
Complaints Responded To Within Trust Timeframe	Patient Support and Complaints Team	86.1%	≥ 95%	95.5%	83.6%	88.3%	85.0%	88.0%
Complaints Responded To Within Divisional Timeframe	Patient Support and Complaints Team	85.5%	No set target	96.6%	88.3%	90.3%	89.2%	91.0%
Percentage of Responses where Complainant is Dissatisfied	Patient Support and Complaints Team	9.1%	< 8%	9.5%	8.8%	6.6%	6.9%	8.0%

3.3 Clinical effectiveness

We will ensure that the each patient receives the right care, according to scientific knowledge and evidence-based assessment, at the right time in the right place, with the best outcome.

3.3.1 Understanding, measuring and reducing patient mortality

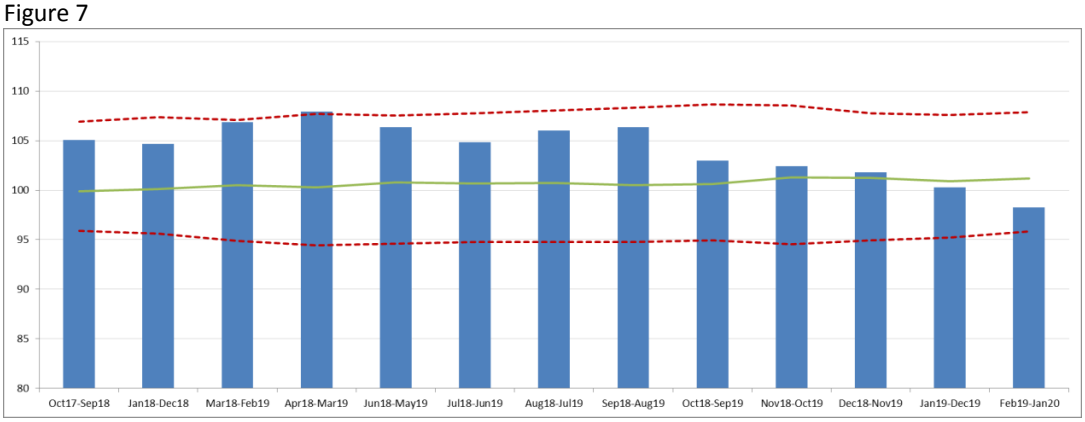
The Trust continues to monitor the number of patients who die in hospital and those who die within 30 days of discharge. This is done using the two main tools available to the NHS to compare mortality rates between different hospitals and trusts: Summary Hospital Mortality Indicator (SHMI) produced by NHS Digital (formally the Health and Social Care Information Centre) and the Hospital Standardised Mortality Ratio (HSMR) produced by CHKS Limited replicating the Dr Foster/Imperial College methodology.

The HSMR includes only the 56 diagnosis groups (medical conditions) which account for approximately 80 per cent of in-hospital deaths. The SHMI is sometimes considered a more useful index as it includes all diagnosis groups as well as deaths occurring in the 30 days following hospital discharge.

In simple terms, the SHMI 'norm' is a score of 100 – so scores of less than 100 are indicative of trusts with lower than average mortality. The score needs to be read in conjunction with confidence intervals to determine if the Trust is statistically significantly better or worse than average. NHS Digital categorises each Trust into one of three SHMI categories: "worse than expected", "as expected" or "better than expected", based on these confidence intervals. A score over 100 does not automatically mean "worse than expected". Likewise, a score below 100 does not automatically mean "better than expected".

In Figure 8, the blue vertical bars represent UH Bristol SHMI data, the green solid line is the median for all trusts, and the dashed red lines are the upper and lower quartiles (top and bottom 25 per cent). Comparative data from February 2019 to January 2020 shows that the Trust remains in the 'as expected' category. In this period the Trust had 1,685 deaths compared to 1,715 expected deaths; a SHMI score of 98.25.

Figure 7



Source: CHKS benchmarking

The latest HSMR data available (published January 2020) shows 93 patient deaths at UH Bristol, compared to 98 expected deaths: an HSMR of 94.5

Understanding the impact of our care and treatment by monitoring mortality and outcomes for patients is a vital element of improving the quality of our services. To help facilitate this, the Trust has a Quality Intelligence Group (QIG) whose purpose is both to identify and be informed of any potential areas of concern regarding mortality or outcome alerts. Where increased numbers of deaths are identified in a specific specialty or service, QIG ensures that these are fully investigated by the clinical team. These investigations comprise an initial data quality review followed by a further clinical examination of the cases involved if required. QIG will either receive assurance regarding the particular service or specialty with an explanation of why a potential concern has been triggered, or will require the service or specialty to develop and implement an action plan to address any learning. The impact of any action is monitored through routine quality surveillance. QIG is chaired by the Medical Director.

Understanding the impact of our care and treatment by monitoring mortality and outcomes for patients is a vital element of improving the quality of our services. To help facilitate this, the Trust has a Quality Intelligence Group (QIG) whose purpose is both to identify and be informed of any potential areas of concern regarding mortality or outcome alerts. Where increased numbers of deaths are identified in a specific specialty or service, QIG ensures that these are fully investigated by the clinical team. These investigations comprise an initial data quality review followed by a further clinical examination of the cases involved if required. QIG will either receive assurance regarding the particular service or specialty with an explanation of why a potential concern has been triggered, or will require the service or specialty to develop and implement an action plan to address any learning. The impact of any action is monitored through routine quality surveillance.

3.3.2 Learning from deaths (local mortality review)

During the period of April 2019 to March 2020, 1,352 of University Hospitals Bristol NHS Foundation Trust patients died. This comprised the following number of deaths that occurred in each quarter of that reporting period:

- 325 in the first quarter
- 294 in the second quarter
- 336 in the third quarter
- 357 in the fourth quarter.

By 31 March 2020, 366 case record reviews and nine investigations have been carried out in relation to 1,325 deaths. In nine cases, a death was subjected to both a case record review and a formal investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 33 in the first quarter
- 46 in the second quarter
- 17 in the third quarter
- 25 in the fourth quarter

Any deaths identified as potentially avoidable are referred for a second review by the medical director team; there was one such case during 2019/20. No patient's deaths during 2019/20 were judged as more likely than not to have been due to problems in the care provided to the patient.

These numbers have been calculated from the Trust's Mortality Review Database, integrated into Medway PAS.

Internal processes

The Learning from Deaths process has been established within the organisation; all adult deaths, excluding out of hospital cardiac arrests, continue to be screened. This process allows the quality of patient care to be assessed and where the patient notes trigger the need for a Structured Case Note Review (SCNR), these are then are distributed to the relevant Division for further assessment and in- depth reviews.

The Trust is now only reviewing the deaths within mandatory categories and this has led to a reduction in the number of notes requiring a full SCNR. This follows on from our extensive previous audit which demonstrated that although screening additional categories produced a large quantity of data, it did not identify any further potentially avoidable deaths. This system is more in line with neighboring Trusts and means there is consistency within the system as we move to developing the cross-Bristol Medical Examiner system which will provide an initial screen of all notes and replace the work of the lead mortality nurse.

A new system overseeing the method of certification of death is being rolled out in England. This system is dependent on the appointment of Medical Examiners (ME) who will review all adult deaths within acute providers and discuss each case with both the clinical team and next of kin prior to the issuing of a death certificate. Both Trusts, UHBW and NBT, approved the business plan for the appointment of a Lead Medical Examiner (LME) for Bristol and Weston and a Lead Medical Examiner Officer. This work is ongoing and has developed over the year (see section 2.1.1 of this report).

During 2019/20, the Learning Disabilities Mortality Review (LeDeR) process for coordinating, reviewing and assessing deaths in patients with learning Difficulties has been refined and embedded into the learning from deaths process. The number of deaths in patients with learning difficulties is being cross reference with the LeDeR team and the reviews of patients with learning difficulties who have died is now being coordinated by a single team with active participation in the Mortality Surveillance group.

During 2019/20, the Senior Leadership team supported the proposal to include a structured Case Note review into the Supporting Professional Activity of all consultants caring for Adults. The philosophy supporting this decision was that it allowed all doctors to review the care being provided within the organisation. There are several outstanding reviews that have spent a long time allocated to reviewers; we are currently working with all the Clinical Divisions to ensure all consultants deliver on their professional responsibilities with regard to the Learning from Deaths process. This work is being coordinated via the MD office and remains ongoing.

With the introduction of the Medical Examiners, there have been or are several changes in personnel in the Learning from Deaths team, and as such, a piece of work is being conducted this autumn, in collaboration with both the lead Medical Examiner and the Divisions to refresh the process of SCNR and learning from deaths as the new system is introduced.

3.3.3 Clinical standards for seven day hospital services

The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

During 2019/20, a board assurance model replaced the bi-annual self-assessment survey previously used to measure progress against the four priority standard. As required by NHS England and NHS Improvement, case note review and assessment were reported to the Board in June and November 2019.

In November 2019, the Trust declared and accepted non-compliance (standard met in <90% of cases) with two of the four standards;

- Clinical Standard 2 – First consultant review within 14 hours
- Clinical Standard 8 – Ongoing consultant directed review

Clinical standard 2 was met in 76% of cases and Clinical Standard 8 was met in 52% of cases for those patient requiring a daily review and 100% of cases where the patient required twice daily review.

Both non-compliance issues relate to consultant provision and job planning. Funding has been identified to increase the number of consultants in Acute Medicine to support compliance but, to date, recruitment has been unsuccessful in spite of multiple attempts.

Service development proposals to address the gaps in seven day coverage in other areas have been discussed with commissioners through contract negotiations in 2017/18, 2018/19, and 2019/20. Commissioners indicated that the proposed investments were not affordable and accepted that the Trust may not be able to meet all the standards until opportunities to improve compliance through service reconfiguration / commissioners re-prioritisation are assessed. We have therefore agreed derogation of the standards in our contract with our commissioners.

Since the last submission to NHS England and NHS Improvement in November, the Trust has had no further contact from the national Seven Day Service Team in relation to this work.

3.3.4 Overview of monthly board assurance regarding clinical effectiveness

The table below contains key quality metrics providing assurance to the Trust Board each month regarding the clinical effectiveness of the treatment we provide. Where there are no nationally defined targets, or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable. Some clinical effectiveness metrics and targets in Table 8 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2017/18" may vary slightly from the equivalent data in our 2017/18 Quality Report due to finalisation of provisional data.

Table 7

Quality measure	Data source	Actual 2018/19	Target 2019/20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2019/20
Mortality								
Summary Hospital Mortality Indicator (SHMI)	NHS Digital	107.2	< 100	105.9	105.1	102.1		
Hospital Standardised Mortality Ratio (HSMR)	CHKS	105.0	No set target	91.0	90.6	92.3		
Re-admissions								
Emergency Readmissions Percentage		3.30%	< 3.26%	3.67%	3.54%	3.36%		
Fracture Neck of Femur								
Patients Treated Within 36 Hours	National Hip Fracture Database	56.3%	≥ 90%	49.2%	52.1%	36.7%	45.9%	45.6%
Patients Seeing Orthogeriatrician > 72 Hours	National Hip Fracture Database	97.5%	≥ 90%	98.3%	97.2%	100%	90.6%	96.3%
Patients Achieving Best Practice Tariff	National Hip Fracture Database	51.3%	≥ 90%	49.2%	52.1%	36.7%	38.8%	43.5%
Stroke Care								
Percentage Receiving Brain Imaging Within 1 Hour	Medway PAS & Radiology Information System	51.1%	≥ 80%	46.1%	50.8%	54.8%		
Percentage Spending >90% Time On Stroke Unit	Medway PAS & Radiology Information System	84.2%	≥ 90%	76.5%	75.4%	69.4%		
High Risk TIA Patients Starting Treatment Within 24 Hours	Medway PAS & Radiology Information System	58.6%	≥ 60%	50.0%	77.1%	72.0%		
Dementia Care								
FAIR Question 1 - Case Finding Applied	Local data collection	83.0%	≥ 90%	85.8%	88.5%	83.3%	76.3%	83.2%
FAIR Question 2 - Appropriately Assessed	Local data collection	94.3%	≥ 90%	92.9%	86.0%	88.1%	90.7%	89.6%
FAIR Question 3 - Referred for Follow Up	Local data collection	85.7%	≥ 90%	81.8%	100%	71.4%	100%	85.2%
Ward outliers								
Bed Days Spent Outlying.	Medway PAS	7,708	< 9,029	1,989	2,079	2,591	3,033	9,692

3.4 Performance against national priorities and access standards

3.4.1 Overview

NHS Improvement's Single Oversight Framework (SOF) has four patient access metrics:

- Accident and Emergency (A&E) four hour waiting standard
- 62 day GP cancer standard
- Referral to Treatment (RTT) incomplete pathways standard
- Six week diagnostic waiting times standard.

The national standards are:

- 95 per cent for A&E four hour waits
- 85 per cent for 62 day GP cancer
- 92 per cent for RTT incomplete pathways
- 99 per cent for six week diagnostic waiting times.

Performance against the 62 day cancer standard was achieved for seven of the twelve months and was achieved for each of the four quarters overall.

Referral to Treatment performance achieved the NHSI recovery trajectory at end of April and May 2019 but not since. The 92 per cent standard has not been achieved at any month-end in 2019/20. The total list size started the year below the March 2018 level of 29,207 (total list size was 28,763 as at end of Apr 2019) but was above that level for the remainder of 2019/20, peaking at 34,739 at the end of November 2019. The waiting list size finished at 32,832 at end of March 2020.

A&E performance did not achieve the NHSI improvement Trajectory, which was 0.5 per cent above the 2018/19 performance level for the corresponding month.

The six week wait for diagnostics has remained below the national standard of 99 per cent and plans to recover by end of Quarter 4 were submitted, but are was not achieved following a loss of Endoscopy capacity.

Table 8: Performance against the agreed trajectories for the four key access standards in 2019/20 during each quarter

Access Key Performance Indicator		Quarter 1 2019/20			Quarter 2 2019/20			Quarter 3 2019/20			Quarter 4 2019/20		
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
A&E 4-hours Standard: 95%	Actual	78.3%	78.0%	81.5%	81.9%	84.8%	81.4%	82.4%	80.3%	76.1%	81.8%	78.4%	81.0%
	Trajectory	84.5%	90.5%	90.5%	90.5%	90.5%	85.5%	89.7%	84.7%	83.5%	85.0%	81.6%	81.7%
Cancer 62-day GP Standard: 85%	Actual (Monthly)	86.8%	86.0%	84.0%	86.8%	85.8%	83.6%	85.4%	87.0%	83.9%	80.8%	82.0%	91.0%
	Actual (Quarterly)	85.7%			85.4%			85.4%			85.5%		
	Trajectory (Monthly)	85%	85%	85%	83%	85%	85%	85%	85%	85%	85%	85%	85%
	Trajectory(Quarterly)	85%			85%			85%			85%		
Referral to Treatment Standard: 92%	Actual	89.0%	88.1%	87.5%	86.5%	84.3%	83.6%	83.0%	83.0%	82.5%	83.2%	82.4%	78.3%
	Trajectory	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	86.9%	86.9%	86.9%	87.9%
6-week wait diagnostic Standard: 99%	Actual	95.3%	93.4%	93.5%	96.2%	95.1%	96.2%	95.9%	96.7%	96.1%	95.2%	95.4%	85.7%
	Trajectory							96.0%	96.5%	96.5%	97.0%	98.0%	98.0%

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved
RED rating = national standard not achieved, the STF trajectory not achieved

Performance against these four SOF standards is covered in detail in the performance report. A summary of the Trust's performance in 2019/20 against the wider range of national access and other Key Performance Indicators is also included in the performance report.

3.4.2 Referral to Treatment (RTT)

The national standard for Referral to Treatment (RTT) is 92 per cent. This has not been achieved for the whole of 2019/20. During April and May 2019 the improvement Trajectory of 88 per cent was achieved.

At the start of 2019/20, the total list size was 28,481 with 89 per cent waiting under 18 weeks. At the end of the year (31st March 2020) the total list size was 32,832 with 78 per cent waiting under 18 weeks

The backlog growth in the main related to Dental, Ophthalmology and Paediatric Trauma and Orthopaedic (T&O). The Dental and Ophthalmology growth was a result of a number of staff vacancies and long term sickness. The Paediatric T&O growth occurred from patients referred into the Referral Assessment Service (RAS) and the lack of clinic capacity to book these patients in.

Significant national developments that impeded recovery of the backlog during the year were the changes to the pension tax and the rates paid for waiting list initiatives, both of which resulted in very poor uptake from staff to do extra sessions to support recovery of the backlog positions.

The Trust's commitment to achieve zero 52-week breaches by September 2019 was not achieved and the Trust reported five 52-week breaches. The 52-week wait position continues to deteriorate due to the impact of cancellations of routine patients during the winter pressures and the lack of HDU/ITU and ward beds. At end of March 2020, the Trust reported thirty 52-week waiters.

In August 2019, the Trust became one of the twelve hospitals who are taking part in the national pilot for Referral to Treatment average weeks waiting. During this period, it was agreed with NHS Improvement that the Trust would focus on achieving an average wait of 10.1 weeks, with

a stretch target of 9.1 weeks. UH Bristol is currently achieving 10.4 average weeks wait. The Trust has been invited to continue this pilot during 2020/21.

3.4.3 Cancer

The Trust achieved the 62 day GP referral to treatment standard in seven months in the financial year and was achieved for each quarter overall. This was in the context of continued national non-compliance with the standard. The main cause of non-compliance was the impact of cancellations and capacity restrictions due to emergency pressure within the Trust, especially over the winter months. The Trust has robust diagnostic pathways and is in a good position to achieve the initial 70 per cent threshold for the faster diagnosis standard being introduced in April 2020.

The Trust met the first appointment standard for cancer in the majority of months but saw a short period of non-compliance in August and September following an unprecedented surge in dermatology demand (33 per cent up on demand in the same period 2018/19). Even with additional capacity it was not possible to meet the standard for all patients, however delays were small and recovery rapid with compliance regained in October and sustained thereafter.

Compliance with the 31 day decision-to-treat to treatment standards was affected by two factors. In the first part of the year, specialised cleaning of the linear accelerators following a major fire caused delays to radiotherapy treatments. This cleaning was concluded and compliance with the subsequent radiotherapy standard regained in July and sustained thereafter.

3.4.4 Diagnostic waiting times

The month end performance for diagnostic waiting times varied between 85.7 per cent and 96.7 per cent, averaging 94.6 per cent at each month end.

As at end of March 2020:

- CT was at 97.0 per cent with challenges in CT Cardiac. These examinations are complex and require the following resource to be available: Radiologist, Registrar, 2 x CT radiographers, Nurse, Radiographic Assistant. Outsourcing options were in place during Quarter 4.
- MRI was at 85 per cent with the main risk being in Paediatric MRI services where the backlog is with children requiring General Anaesthetic. Insourcing through GLANSO is being trialled in Quarter 4 to clear the backlog.
- Adult Endoscopy which is at 52 per cent due to endoscopy capacity being used to provide emergency escalation capacity. The service also lost one of its two new Clinical Fellows to at the end of Quarter 3, who took up a consultant post elsewhere, meaning 10 sessions (40-50) patients per month were lost from the capacity. In/outsourcing options were put in place in Quarter 4, but this did not deliver a recovered position.

3.4.5 Outpatients

In response to the Long Term Plan, pathway redesign work has commenced to reduce the number of follow up appointments and increase the number of follow up appointments delivered non-face to face.

Non-face to face telephone clinics have been piloted in lung nodules and dental biopsy. Progress has been made with video conferencing services with a number of specialties expressing interest in developing attend anywhere pilots. Advice and guidance continues to be progressed in the Trust with nine specialties using the service to triage referrals received from primary care. Plans are in progress to review the outpatient blended Tariff with the CCG and Healthier Together for 2020/21.

The outpatient services DNA rate has reduced further to 6.2 per cent following the continued roll out of the text messaging reminder service to additional clinics. At the end of 2019/20, the service was live in around 70 per cent of clinics. Work has also been progressed on the information provided in the text messages providing patients with more information of the clinic location they are booked to attend and the financial impacts of non-attendance. In support of cost effectiveness and allowing patients to receive information about their appointments in a method that they prefer, email appointment letters was launched in 2019/20. 1,000 letters a month are now sent to patients through email.

The Trust's CQC inspection in March 2019 identified the use of Outpatient reception staff uniforms as an improvement to make staff more easily identifiable for patients. All patient-facing administration staff now wear a standard uniform. In addition, outpatient administration teams have been engaged in delivery of standards of conduct and service delivery standards. This has contributed to a reduction in complaints relating to telephones of 32 per cent trust wide and 53 per cent in the poorest performing departments.

Real Time Outpatients continues to make progress within the Trust (also see sections 2.1.1 and 2.1.2 of this report). Valuable learning has been acquired through this project and it has become apparent that there is a broad requirement for standardisation of service delivery across outpatients and further digitisation of information pathways. Plans are in progress to review and reprioritise the delivery of outpatient service projects linking a number of improvements to the Medway system and dictation software.

Table 9: Performance against national standards

National standard	Target	2017/18	2018/19	2019/20
A&E maximum wait of four hours	95%	86.5%	86.3%	80.4%
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	97.7%	95.6%	97.2%
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	52.2%	49.3%	50.2%
A&E Unplanned re-attendance within seven days	<5%	2.8%	3.3%	3.6%
A&E Left without being seen	<5%	1.9%	1.7%	1.6%
Cancer - Two week wait (urgent GP referral)	93%	94.3%	95.3%	93.4%
Cancer - 31 Day Diagnosis To Treatment (First treatment)	96%	95.8%	97.2%	95.8%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94%	92.0%	96.1%	92.5%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	98%	98.6%	98.4%	98.6%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	94%	96.3%	95.8%	94.6%
Cancer - 62 Day Referral To Treatment (Urgent GP Referral)	85%	81.7%	85.6%	85.5%
Cancer - 62 Day Referral To Treatment (Screenings)	90%	74.8%	66.7%	71.1%
Cancer - 62 Day Referral To Treatment (Upgrades)	85%	85.4%	83.7%	86.6%
18-week Referral to Treatment Time (RTT) incomplete pathways	92%	89.6%	89.0%	83.2%
Number of Last Minute Cancelled Operations	<0.8%	1.19%	1.31%	1.73%
Last Minute Cancelled Operations Re-admitted within 28 days	95%	94.2%	93.4%	92.9%
Six week diagnostic wait	99%	98.3%	96.7%	95.2%
Primary PCI - 90 Minutes Door To Balloon Time	90%	93.2%	92.5%	87.0%

APPENDIX A – Feedback about our Quality Account

a) Statement from the Council of Governors of the University Hospitals Bristol NHS Foundation Trust

The publication of a Quality Account is an annual requirement for all NHS Trusts, providing an opportunity for them to present the public with a review of their performance in key areas of Quality and Performance over the past year. Within this feedback section the governors of Foundation Trusts are then asked to provide comment on whether the account offers a fair representation of the trust's achievements during that time.

The Council of Governors here at UHB FT are happy to comply with this request as we feel both well supported and well informed within our roles at the trust; and have the opportunity to explore Quality and Performance issues at regular intervals and in some depth.

This Quality Account covers the financial year 2019/20 which precedes the merger with Weston Area Health NHS Trust; and as the Covid-19 pandemic only began in the later stages of the final quarter of 2019/20 its impact on the University Hospitals Bristol NHS Foundation Trust (UHBW) is not included.

The report clearly identifies both the trust's significant achievements and areas where performance could be improved, along with recognition of the challenges they faced in pursuing some of their key objectives. Importantly, as we commented last year, the trust has continued to demonstrate evidence of learning from experience, listening to public and patient concerns and taking action in response to all serious incident investigations.

Governor involvement with Quality and Performance at UHBW

As elected Governors of the trust it is our duty to continuously monitor the trust's performance and hold the Non-Executive Directors (NEDs) to account for it. We review Quality and Performance at the trust every two months at our Quality Focus Group (QFG) meetings, attended by the NED Chair of the Quality and Outcomes Committee, the NED Chair of the People Committee, the Medical Director and the Chief Nurse. The QFG is chaired by a governor and the agenda includes presentations on quality issues by senior staff, a review of the questions placed on our Governors' Log and discussion about all the regular trust reports on quality topics. The Focus Group then reports back to the full Council of Governors.

The Governors' Log provides an opportunity for any governor to raise formal questions (often at the behest of members of the public) with the trust at any time. These are allocated to appropriate Executive Directors within the trust and both questions and answers are then available to the public within the papers for the Public Board Meetings

At the two-monthly Public Board Meetings, governors have the opportunity to witness the full board discussions that take place on all their regular agenda topics, including quality and performance, and can raise questions at the end of these discussions. The Governors also meet informally as a group every two months, followed by a joint meeting with the NEDs at which we can raise specific topics or concerns that we want to pursue in greater depth. The Chair and all NEDs at the trust are fully supportive of the governors offering both comment and challenge in this way, and our questions are always handled in an open, engaged atmosphere.

The combination of these activities, quarterly governor development seminars and nationally organised governor training sessions has offered governors the knowledge, tools and

opportunity to raise questions and offer challenges on many of the topics included in this Quality Account.

It should also be noted that during this particular year, the trust underwent a Care Quality Commission (CQC) inspection (in May 2019) following which it retained its previous "Outstanding" rating. The Council of Governors was invited to participate in this inspection and several governors met with the inspection team to talk about their involvement with the trust. Following the publication of the full CQC report in August 2019, this was reviewed in our Quality Focus Group.

Priorities for Quality Improvement

An extensive and wide-ranging number of quality improvement activities take place within the trust, supported in recent years by the development of the Quality Improvement Academy and celebrated in the annual presentation of projects at the trust's Quality Forum.

This Quality Account reports on the eight specific, priority quality objectives set by the trust for 2019/20 and then describes the four objectives set for 2020/21. Of the four objectives set for this year the trust has successfully achieved four of them and been partially successful with the other four. A huge amount of effort has gone into this work and the reasons for limited or delayed achievement of the four objectives rated amber have been identified and acknowledged, allowing for further progress over the coming year. Thus, in setting the four specific objectives for our newly merged trust (University Hospitals Bristol and Weston NHS Foundation Trust) in 2020/21, the need for continued improvement in these areas is recognised.

The governors are aware of the considerable effort and enthusiasm that trust staff put into pursuit of these objectives and we celebrate both the completed work and the commitment to pursue the partially completed objectives across the entire merged organisation during 2020/21.

Review of services

Part 3 of the Quality Account covers a review of trust services under three key headings (Patient Safety, Patient Experience and Clinical Effectiveness) and then describes the trust's performance against national priorities and access standards.

There is clear evidence of the trust's commitment to maintaining, and continuously striving to improve, high standards of patient safety and clinical effectiveness alongside a readiness to acknowledge and learn from all adverse events and comments. The inclusion of structured case note reviews within the Supporting Professional Activity of all consultants caring for adults, as a part of the Learning from Deaths process, is an excellent example of this. The governors can confirm the priority given to these topics at the trust and have been reassured that the latest "Outstanding" rating from the CQC has not resulted in any sense of complacency. Similarly, a generally 'better than average' scoring for the trust in a range of local and national patient surveys is to be commended: but it remains important for the trust to note, and respond to, the specific areas in which it has not scored so well. Further improvement is clearly possible and the trust is committed to continue to review performance in these areas in order to achieve it.

Performance against the national priorities and access standards has been variable over this year and is clearly described, along with the factors that have impacted adversely on this performance. The specific recovery and improvement plans that have been identified are also outlined in this Quality Account, particularly in relation to outpatient services. The governors welcome all the commitments described, while recognising the ever increasing pressures on all these services.

Issues of special interest to the Council of Governors during 2019/20.

Recruitment and retention of staff continues to be a huge challenge throughout the NHS and must be a top priority for any trust. The People Committee at UHBW has become firmly established and the governors welcome the work it is doing in identifying the areas of greatest need and initiating strategies for tackling these. The shortage of junior doctors within many areas of the trust's hospitals, challenges in achieving the expected levels of attendance at staff training, the need to improve staff appraisal rates, and efforts to ensure that the annual staff survey is truly accessible for all staff within the trust, have all been highlighted in our discussions. At the governors' request, we have receivede presentations at our Quality Focus Group on progress to date with the Diversity and Inclusion Strategy and on Tackling Bullying and Harassment at the trust – topics that are hugely important and have been identified as priorities throughout the NHS. The governors have also taken a keen interest in progress with the Freedom to Speak Up initiative at the trust and welcome the recruitment of more than 50 staff advocates to help raise awareness of this and support staff more locally with their concerns.

Discharge
The discharge process is a key part of any patient's journey and can vary greatly in complexity depending on people's individual needs and circumstances. The governors at UHBW have a long-established interest in this and welcomed the development of the Integrated Care Bureau back in October 2018 as a route to centralising resources and integrating planning across all hospital and community services to support the discharge of patients. Full recruitment to this service at UHBW was achieved during 2019/20 and governors were updated on the work of the bureau in May 2019, when we welcomed the evidence of improved joint working across organisations but noted the on-going challenges involved in accessing community care assessments and services. Governors also continued to monitor discharge timing and the factors that impact on this, particularly transport provision.

Wider integration and transformation of healthcare services across our area
The trust has continued to play a full and leading role in the Bristol, North Somerset and South Gloucestershire (BNSSG) Healthier Together programme over the course of this year – aiming to achieve greater integration and transformation within all our care services across this area. Governors have been regularly updated on this work and are fully supportive of the programme and the work of our trust Chief Executive, Robert Woolley, as a Joint Lead Executive for the BNSSG programme.

Merger with Weston Area Health NHS Trust
Work on the proposal for UHBW to merge with Weston was a major priority for the trust and the Council of Governors over the course of 2019/20. An enormous amount of trust time, effort and commitment went into the preparation of the detailed proposal and the governors have been given regular and thorough updates on this, along with every opportunity to raise queries or seek further information.

The level and detail of the due diligence pursued over many months clearly impressed the trust's NEDs and allowed all Board members and the Council of Governors to vote for the merger to go ahead.

Trust staff and board members have continued to prioritise Quality and Performance at UHBW throughout this process and we look forward to a continued emphasis on these areas across the merged trust.

Council of Governors November 2020

b) Joint statement from Healthwatch Bristol, South Gloucestershire and North Somerset

Thank you for the opportunity for respond to your draft Quality Account.

Healthwatch Bristol, North Somerset and South Gloucestershire welcome the Quality Account as an opportunity to see evidence of a learning culture, that UBHW priorities reflect real people's experiences, gain assurance that priorities for improvement are sufficiently challenging and are clear how they will be measured and finally we hope to see triangulation between your evidence and ours about areas that need improvement.

This Quality Account looks back at the performance of the Trust for the year 2019/20. The start of the Covid-19 pandemic, and the formal merger of UHBW with Weston Area Health NHS Trust took place at the end of the final quarter of this period. Therefore, the substantial influence of these two events, not discussed in this account will no doubt will be addressed in next year's Quality Account when we look forward to hearing measures that have been considered from learning during the pandemic.

We are pleased to see that the use of the Happy App to drive staff engagement (objective 4) has had good uptake by the workforce. We would like to know more about the interventions implemented based on the outcomes of learning from this feedback as notably it is indicated that it has informed the "Values" theme.

We note the performance data against each objective, and suggest that this evidence would be even more beneficial if it were provided against the different protected characteristics to ensure that the needs of each demographic is being met. We would like to see measures being taken to achieve this in future Quality Accounts. This would be a suitable response to local and national reports on inequalities. Added quality objectives to address the issues raised in reports that detail health inequalities found in Bristol would also be welcomed.

Developing and implementing a training programme for Trust lay representatives to support and develop their participation in Trust groups and committees is to be commended. How have you been able to ensure that these are representative of the City's demographic relating to Age, Gender, Ethnicity, Religion, Disability, Sexual Orientation and Gender reassignment? Equally, your patient related groups involved in UHBW are of great interest to us, and we would like to hear ways in which you use 'Expert Patients' in your processes.

Freedom to Speak Up is one mechanism through which staff can raise concerns and others in place offer support such as bullying and harassment advisors, Joint Union officers, Occupational Health, Employee services, Safeguarding team and the Patient Safety team. It would be helpful to know how many people use these services and how you measure the success of their support?

You have made efforts to improve the availability of information about physical access to your hospitals to ensure patients and visitors know how to get to services in the easiest possible way, particularly patients with disabilities. The account would benefit from a measure of your performance currently for access for people with disabilities.

We appreciate the efforts to which the Trust has gone to provide this account in trying times. We wish to pass on our sincere thanks to all staff for their continued commitment to patients and quality across the Trust.

c) Statement from Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Account 2019/20 is made by Bristol, North Somerset & South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG).

BNSSG CCG welcomes UH Bristol's quality account, which provides an overall reflection on the quality performance during 2019/20. The data presented has been reviewed and is in line with data provided throughout year, predominantly via the monthly Integrated Performance Report (IPR) and reviewed through the monthly quality contract performance meetings.

BNSSG CCG notes the achievements against the eight quality objectives identified for 2019/20. Four were rated as green, achieved and four were rated as amber, partially achieved. The CCG acknowledges that the final quarter of 2019/20 was a particular challenging period for UH Bristol, with the pending merger of the trust with Weston Area Health NHS Trust (WAHT) and the onset and response to the COVID-19 pandemic.

With regards to Objective 2, enabling improvements in intravenous cannulas, NEWS 2 and VTE through the use of digital technology provided a timely focus on some core areas of patient safety (rated as amber), the CCG notes that VTE risk assessment remains below the expected standard and welcomes the further focus to improve performance in 2020/21. The CCG acknowledges the continuing work planned in 2020/21 on deteriorating patients which will incorporate NEWS2, but would welcome a further narrative on intravenous cannula, noting the current version of the quality account is a draft version.

In respect of Objective 2, reducing the risk of Never Events (also rated as amber), the number of Never Events has reduced in recent years from nine in 2017/18, to five in 2018/19 and four for 2019/20, and will remain a focus for further improvement work, which the CCG supports. The CCG will work to support system learning amongst all providers with regard to Never Events.

The CCG notes the chosen four quality objectives for 2020/21, which are continuing objectives from 2019/20, whilst acknowledging that University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) is continuing with a number of improvement work streams and continues to align functions with Weston General Hospital, also referred to as the Weston Division.

We welcome and thank the trust for its continuing engagement in national audits and national enquiries, contributing to national datasets and associated guidance.

The CCG welcomes the reporting of metrics that demonstrate the continuing improvement in patient experience ratings across a range of national surveys. The CCG notes that the delayed publication of the Quality Account for 2019/20 means that 2019 national inpatient survey data is now available. The Friends and Family Test scores for inpatient areas consistently exceeded 98% (Table 6); this is a familiar rating tool for our population, but not referenced in the narrative.

Falls and pressure injuries are the two highest themed serious incidents for the both the system and UH Bristol (as-was). A reduction in the number of grade 2 pressure injuries is welcomed from 80 to 49, with an associated reduction in the rate per 1000 bed days. A reduction in grade 3 and 4 injuries is also noted, with one case in each of the last two quarters of 2019/20.

The total number of patient falls resulting in harm increased and quarter 4 of 2019/20 appears as a particularly challenging period. We are pleased to acknowledge that you have maintained

the previous improvements in patients receiving an ortho-geriatrician review within 72 hours following a Neck of Femur fracture, but the percentage of patients treated within 36 hrs has deteriorated, as has the achievement of the best practice tariff. A further narrative and fuller reference to an improvement plan is encouraged. The CCG recognises that this may require a system approach.

The Trust achieved compliance with the C. difficile target. The total number of cases exceeded the 2018/19 position, which may be due to multiple factors including changes to national assignment definitions. A reduction in MRSA bacteraemia cases from six to four is noted and welcomed, however, a significant increase in MSSA cases is highlighted in your reporting, and we would have welcomed a metric around E.coli bacteraemia given the national reduction plan. More detail on the management of healthcare associated infections in next year's report would be very helpful.

On a final note we welcome and commend your work around staff engagement and the use of the Happy App, and your engagement and partnership working with regard to the Medical Examiners project, further promoting patient safety.

BNSSG CCG acknowledges the good work within the Trust. We note the areas that have been identified by the Trust for further improvement and we look forward to working with the Trust in 2020/21 to deliver those improvements. Significant challenges most certainly lie ahead but we are confident that by working together on these priorities you will continue to deliver safe, effective, compassionate and patient focused care for the people of Bristol, North Somerset and South Gloucestershire.

Our review is based on the draft report shared with the CCG, noting that the final version will go to UHBW's Board in January 2021.

d) Please note that the following will receive this year's Quality Account, but are not formally commenting:

- Bristol City Council People Scrutiny Commission
- South Gloucestershire Health Scrutiny Committee
- North Somerset Health Overview and Scrutiny Panel (QA Sub Committee)

APPENDIX B – Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2019 to March 2020
    - papers relating to Quality reported to the board over the period April 2019 to March 2020
    - feedback from commissioners
    - feedback from governors
    - feedback from local Healthwatch organisations
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the national patient survey
    - the national staff survey
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with Monitor's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Jeff Farrar, Chairman
28th January 2021

Robert Woolley, Chief Executive
28th January 2021

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28 January 2021

Report Title	**Quality Account 2019/20 for Weston Area Health NHS Trust**
Authors	**Juliet Neilson, Head of Nursing, Weston Division** **Rebecca Watkins, Senior Nurse for Quality and Development, Weston Division**
Executive Leads	**Deidre Fowler, Interim Chief Nurse** **William Oldfield, Medical Director**

1. Report Summary

The annual Quality Account for WAHT is presented here for approval following scrutiny by the Quality & Outcomes Committee in December 2020.

2. Key points to note

(Including decisions taken)

This is the final Quality Account for Weston Area Health NHS Trust (WAHT)

The WAHT Quality Account was originally drafted in the spring of 2020. An earlier version of the report was reviewed and agreed by the Quality and Safety Committee of WAHT in March 2020, prior to merger, subject to confirmation of full-year data.

A Quality Account is a report about the quality of services offered by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

The Department of Health and Social Care requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS website – usually by June 30 each year. While primary legislation continues to require providers of NHS services to prepare a Quality Account for each financial year, the amended regulations mean that, in light of pressures caused by COVID-19, there is no fixed deadline by which providers must publish their 2019/20 Quality Account (the recommended deadline for NHS providers was 15 December 2020).

For 2019/20, NHS providers have not been required to obtain assurance from their external auditor on their Quality Account.

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **Approval.**	
5. History of the paper **Please include details of where paper has previously been received.**	
Senior Leadership Team	17/12/20
Quality and Outcomes Committee	18/12/20

Weston Area Health NHS Trust

Weston Area Health NHS Trust Quality Account 2019/2020

Contents

Patient Experience

Clinical Effectiveness

Performance against national priorities and access standards

Appendices

Part 1 Introduction

Statement on Quality from the Chief Executive

Welcome to our Quality Account for 2019/20.

Our merger with University Hospitals Bristol on 1 April 2020 means this will be the final annual quality account for Weston Area Health NHS Trust.

The merger brings an exciting opportunity to create a new organisation with a greater shared purpose, which is seen as a beacon for outstanding education, research and innovation alongside the highest standards of patient care. In preparation for merger, from 1 September 2019, I took up a dual role as Chief Executive across both Weston and University Hospitals Bristol. Following regulatory approval, our two organisations merged to become University Hospitals Bristol and Weston NHS Foundation Trust on 1 April 2020.

I have been hugely impressed with the energy, enthusiasm and mutual support of staff in both trusts as they have embraced the changes the merger has to offer, notwithstanding the disruption inevitably caused by the coronavirus pandemic.

The pandemic was declared as the year 2019/20 was drawing to a close, heralding the greatest challenge faced by the NHS in its history. I am humbled every day by what I see from teams across our hospitals – both in Weston and Bristol – and the lengths they go to, to provide compassionate high-quality care. My wholehearted thanks and admiration go out to all our staff for their commitment, bravery and professionalism in these most challenging of times.

Whilst the impact of the pandemic has overshadowed much of what went before, it is important to register Weston's achievements in the course of 2019/20 in the pages of this Quality Account. I should note as well that, prior to merger, our aim at Weston was to support staff to deliver high quality, safe services specifically for the people of North Somerset. That aim remains in place but now forms part of the wider goals of the merged Trust.

A chapter has now closed on the history of Weston Area Health NHS Trust but Weston General Hospital lives on inside the bigger Trust, with a bright and certain future as a dynamic hospital at the heart of the local community. I commend WAHT's final Quality Account to you. As ever, my thanks go to those who have prepared and contributed to this report. I am pleased to confirm that the Board of Directors of University Hospitals Bristol and Weston NHS Foundation Trust has reviewed this 2019/20 Quality Account and I confirm that it is an accurate and fair reflection of WAHT's performance in that year.

Robert Woolley
Chief Executive

Weston Area Health NHS Trust Profile

Until 31st March 2020, Weston Area Health NHS Trust provided:

- Acute hospital services for adults with acute health problems, including emergency care, critical care, medicine and surgery together with supporting diagnostic services.
- A range of planned services including general surgery, urology, orthopaedics, endoscopy, haematology and some cancer care.
- Children's and Young Peoples Community Health Services.
- Child and Adolescent Mental Health Services from two children's centres located in Weston-Super-Mare and Clevedon.

Activity

The Trust had an annual activity for 2019/20 of 50198 Emergency Department attendances, 16686 planned day case and elective admissions, 14450 emergency admissions and 124250 outpatient attendances.

Resident population

The population using WAHT services in 2019/20 is estimated to be circa 200,000, In addition to the local population, Weston super Mare attracts 3 million day trippers and circa 500,000 staying visitors each year and in peak season; up to 10% of Emergency Department attendances are by out-of-area tourists. Included in the population figures above is the population of North Sedgemoor which has an estimated population of 152,000 (GP registered population).

Services provided within Weston Area Health NHS Trust

During 2019/20 the Weston Area Health NHS Trust (WAHT) provided 40 relevant health services with 3 relevant health services subcontracted.
The Weston Area Health Trust has reviewed all the data available to them on the quality of care in 42 of these relevant health services.
The total BNSSG contract equates to 74.3 million.

Services provided within Weston Area Health NHS Trust

Medicine	Cardiology	Critical Care	High Dependency Unit/ Intensive Care Unit
	General Medicine	Women	Midwife Led Births provided by UHBristol
	Diabetic and Endocrinology Medicine	Paediatrics	Day Case
	Rheumatology		Outpatients
	Gastroenterology		Community Paediatrics
	Geriatric Medicine	Cancer	Acute Oncology
	Stroke Medicine		Outpatient Oncology
	Respiratory		Haematology
	Frailty		Chemotherapy
Surgery	Urology		
	General Surgery	Specialist	
	Gynaecology		Stroke; Acute Stroke Unit
	Trauma and Orthopaedics		Sexual Health
	Upper Gastrointestinal Surgery		Dermatology (by UH Bristol)
	Colorectal Surgery		Palliative Care
	Breast		Child and Adolescent Mental Health
	Ophthalmology (provided by UH Bristol)	Other	Private Patients Unit
	ENT (Out Patients Only)		Radiology
	Anaesthetics		Pharmacy
A&E	Major		Pathology (microbiology and blood sciences. Pathology (cellular pathology provided by North Bristol NHS trust)
	Minor		Therapies Audiology
	Primary Care		

Partnership Working

The Trust has continued to progress the development of formal partnership arrangements with University Hospitals Bristol NHS Foundation Trust (UH Bristol) to ensure that clinical pathways for both general and specialist services are in place and to maintain peer management support for WAHT, and the two organisations have progressed plans to merge.

In November 2019, UH Bristol formally approved the Full Business Case (FBC) for the merger by acquisition of WAHT, and the FBC was supported by the WAHT Trust Board on the same day. Formal consultation with staff to TUPE transfer to UH Bristol commenced at the beginning of December 2019, and closed at the end of January 2020. It has been agreed that the newly merged organisation will be called University Hospitals Bristol and Weston NHS Foundation Trust

UHBW. In April we became a merged organisation and are now a division of UHBW.

Staff from three services will transfer to alternate specialist providers on 1 April 2020, with services continuing to be provided from the same premises. These services are Specialist Community Children's Services (child and adolescent mental health services (CAMHS) and community paediatrics).

During 2019/20, two services were transferred to other providers. Maternity services were transferred to UH Bristol, with the maintaining of a midwife led birthing unit on the Weston General Hospital site, and strengthened community midwifery service provision. Cellular pathology services transferred to NBT, which included the move of the service to the purpose built Pathology Services Building on the Southmead site, a move in line with the Carter Review and the West of England Pathology Network vision.

Community services (excluding community-based Children's services and paediatrics provided by Weston Area Health NHS Trust, and community-based maternity services provided by UH Bristol) are provided by North Somerset Community Partnership, and Mental Health services for adults are provided by Avon and Wiltshire Mental Health Partnership NHS Trust.

Local NHS bodies and other providers

The Trust's largest commissioner during 2019/20 was Bristol, North Somerset & South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) with the WAHT contract being circa £74.3m In addition, the Trust receives other non-patient related income including education and training monies.

We recognise that we work in collaboration with our other providers which includes the local health and social care economy including two Local Authorities, namely North Somerset Council, responsible for North Somerset and Somerset County Council, responsible for the Sedgemoor area of Somerset.

During 2019/20, the BNSSG CCG undertook the extensive 'Healthy Weston' consultation, culminating in the approval of the Decision Making Business Case (DMBC) in October 2019, which set out a number of commissioning changes for WAHT and improvements in services within the community. Senior doctors and clinicians from WAHT and across the system were involved in the design and evaluation of the proposals, and the Trust is in the process of implementing the changes in line with the timeframes as set out in the DMBC.

Planning for service delivery is increasingly being undertaken on a BNSSG-wide basis as part of the Sustainability and Transformation Plan (STP), "Healthier Together". This approach is intended to overcome inefficiencies, duplication, variation and unnecessary boundaries and interfaces for patients and staff to navigate and ensure that care is provided in appropriate care settings for all patients. During 2019/20, planning assumptions from the Trust formed part of the system Long Term Plan.

This five year plan has a clear ambition: to build one health and care system, so that community becomes the preferred place for care, high quality hospital services are used only when needed and people can maximise their health, independence and be active in their own well-being.

There are eight steering groups within the STP, and the Trust has been actively engaged in the relevant areas: children and families; integrated care; acute care collaboration; urgent care; mental health; workforce; digital; and estates.

Our vision and values

The vision of Weston Area Health NHS Trust is to:

"Work in partnership to provide outstanding healthcare for every patient"

By achieving this vision we will:

- Deliver your local NHS with Pride.
- Deliver joined up care which feels integrated for patients and their families.
- Enable patients from Weston-super-Mare, North Somerset and North Sedgemoor to access a full range of services.
- Deliver services which are valued and respected by patients, carers, commissioning CCGs and referring GPs.

Our key strategic aim is to:

Deliver safe, caring and responsive services

This vision and strategic aims are supported by a series of local values which guide actions, behaviors and decision making within the organisation and which are consistent with the NHS Constitution.

These values are:

People and Partnership – working together with colleagues, other organisations and agencies to achieve high care standards or specifically helping a service user, visitor or colleague.

Reputation – actions which help to build and maintain the Trust's good name in the community.

Innovation – demonstrating a fresh approach or finding a new solution to a problem.

Dignity – contributing to the Trust's Dignity in Care priorities (Care and Commitment, Communication, Compassion, Competence).

Excellence and equality – demonstrating excellence in and equality of service provision.

We will adopt the vision and values of University Hospitals Bristol NHS Foundation Trust when we become one organisation.

Our staff

We are proud of the awards and achievements that our staff have achieved throughout 2019/20 with the following awards and achievements.

Awards and Achievements

- At the Comparative Health Knowledge System (CHKS) hospital awards – WAHT was again awarded one of the CHKS Top Hospitals for 2019, a prestigious award made on the basis of an analysis of data from all hospital trusts in England, Wales and Northern Ireland. Over 20 indicators of performance were analysed by healthcare improvement specialists CHKS.
- The Director of Nursing annual awards were presented for six categories on International Nurses Day 2019, celebrating the contribution of our nurses and midwives.
- We held the annual Celebration of Success awards evening which recognised staff that go above and beyond the call of duty to care for our patients.
- 11 members of our staff took part in the South West Military Challenge in September 2019 and came 10th out of 20 trusts.
- Our Geriatric Emergency Medicine Service (GEMS) in A&E (Accident and Emergency) became the south west regional winners for Urgent and Emergency Care in the NHS Parliamentary Awards – beating A&Es to win the accolade in larger hospitals from Bristol and Taunton down to Cornwall.
- More than 84% of staff were vaccinated against influenza in 2019. This was an improvement from last year by nearly 4%.
- The Trust signed up to the Dying to Work Charter, a charter aimed at helping employees who become terminally ill at work.
- We successfully achieved a bid for investment from the national NHS winter funds to refurbish our medical day case unit and discharge lounge.
- We completed a successful TUPE of maternity staff to University Hospital Bristol NHS Foundation Trust to ensure the best possible care for all patients and ongoing support and development for staff.

Support for staff raising concerns

In his review of care concerns at Mid Staffordshire Foundation Trust, Robert Frances QC found that staff can be reluctant to raise concerns and introduced the concept of a freedom to speak out guardian.

A Freedom to Speak Up (F2SU) Guardian is a senior member of staff based in NHS trusts. Their role is to work with trust leaders to create effective local processes to enable staff to raise concerns about patient safety and advice and support staff who seek to do so.

More recently, in its response to the Gosport Independent Panel Report (2018), the Government committed to legislation requiring all NHS trusts in England to report on staff who raise concerns (including whistleblowers). Ahead of such legislation, NHS trusts and NHS foundation trusts have been asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment.

The Trust Board Secretary at WAHT was appointed as the Freedom to Speak Up Guardian (FTSU) in September 2016 and has met monthly with the Chief Executive Officer and regularly with the Non-Executive Lead for the role – as well as regularly reporting to the Trust Board. In 2018 the Trust also trained three Freedom to Speak Up Ambassadors who support the Freedom To Speak Up Guardian and sign post staff who have concerns to the right person(s). To date, all individuals who have raised concerns have been supported personally by the Guardian and have received feedback following the investigations into their concerns. Overall feedback has been positive in relation to whether individuals would speak up again. The Guardian also works to ensure that individuals who raise concerns do not suffer detriment as a result of speaking up, and, to date, no-one has identified that they have suffered detriment.

Where there are concerns relating to patient safety, these are immediately escalated to the Medical Director and Director of nursing to investigate and take appropriate action.

The Guardian is only one mechanism through which staff can raise concerns. The Trust also has the following groups or processes which can assist staff:

- Bullying and Harassment Advisors
- Union Officers
- Occupational Health
- Employee Services
- Safeguarding Team
- Governance Team

A key challenge is to ensure that staff are aware of the FTSU programme and the role of the Guardian. To support this:

- Speaking Up is included in Trust induction for all new starters
- Speaking Up is included in mandatory training updates for all staff
- There are posters around the Trust which describe what Speaking Up is
- The Guardian attends meetings with staff groups to personally relay messages and ask questions about Speaking Up

The Trust Board and its Senior Management Committee receives a quarterly update on the FTSU activity. Included in the updates are reviews to consider the learning from the National Guardian Office's case reviews of other Trusts, with learning identified where appropriate. In November 2018 the Board reviewed its performance in support of the programme using the self-review tool provided by the Office of the National Guardian – and agreed actions for improvement.

2 Priorities for improvement and statements of assurance from the Board

Priorities for Improvement

We identified five quality priorities to be our focus for improvement during 2019/20. These were a combination of quality priorities that we had not fully achieved in 2018/19 and new objectives which included improvements to patient and staff experience and improving our governance processes. We engaged with and obtained views from patients, staff and the wider public. Progress on achievement is detailed below, including why we selected each priority and each priority has been categorized by 'RAG' rating with; Red - not achieved, Amber – not fully met but improvement evident, and Green - achieved. We have partially achieved all of the identified priorities and made significant progress on each of them however as they have not been fully achieved they will be continued as Quality Priorities during 2020/21 as Quality objectives for the Division of Weston.

Priority One:

Improving our governance processes and response to and learning from concerns raised.

Why we chose this priority

Ensuring that a robust governance process is established within the Trust supports the organisation to run efficiently and effectively and ensures that we are open and honest to our staff, patients and governing bodies that we are accountable too. We continued to review and strengthen our governance processes to ensure we have the correct processes and structures in place, risks are identified and managed and we continually learn and improve on the way we work.

What did we say we would do?

- We wished to ensure that complaints are responded to in a timely manner and responses are tailored to the needs of patients and their carers. We have not achieved the 35 day response target for responding to patient complaints. The focus has been on ensuring a high quality response to all the complainants concerns. Teaching & education has been provided. Within the directorates the Associate directors of nursing have been tasked to ensure there is a clear sign off process and that the responses are completed on time for each stage of the sign off process. In addition the process of who writes the complaint has changed to enable less clinical staff to write them and the speciality managers to provide the responses where appropriate. SOPs in place for escalation, extensions and processes

- Staff will have a better understanding of the process of investigating concerns and developing meaningful action plans to drive improvement. Staff have been invited to the executive panel meetings to ensure that there is a greater knowledge and understanding of the investigation process with shared learning across the trust. Training is provided to all staff groups to develop their understanding of governance.

- We will ensure that governance processes are well embedded and managed with a clear reporting process and that we are able to support learning from incidents at specialty directorate and trust wide levels. We have undertaken patient safety trolley dashes around the organisation to ensure that learning gets out to the staff on the wards and departments, also a number of patient safety posters have been developed.

What difference did it make?

We now hold an Executive weekly review panel, this is an open forum with attendance from the Medical Director and Director of Nursing which reviews incidents and complaints across the Trust and decisions are made as to whether an incident requires further investigation and recommendations for learning are made. This was evidenced by an observational visit by NHS England and Improvement.

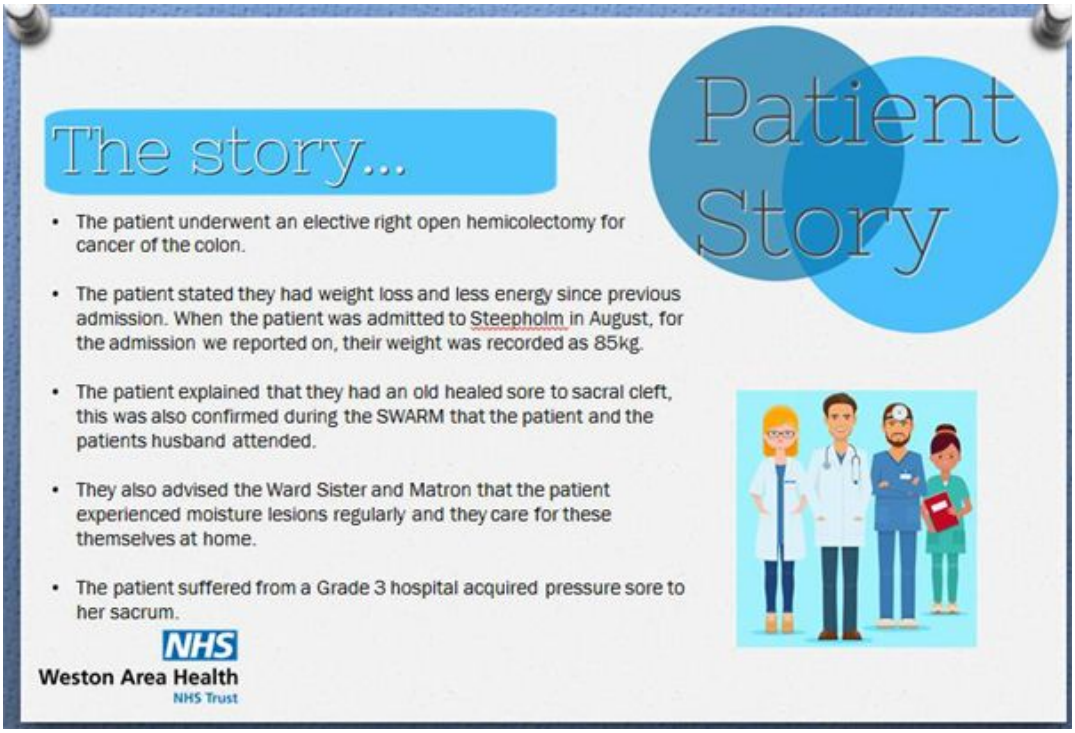
''At the Executive Panel weekly meeting, the team witnessed a tight grip by the clinical executives on the operational issues..... The Executive Panel felt at ease with each other and members were not afraid to challenge''(*NHS England and NHS Improvement February 2020)*

We have started to embed the new governance processes over the past year with a noted reduction in the number of outstanding investigations but we recognise that there is still more work to be done across all the wards and departments to ensure that these new processes are fully understood, robustly and consistently managed and that learning is obtained, shared widely and tested in practice**.**

In August the Trust held a patient safety week to launch the CQC improvement plan for the Trust. With significant engagement from the clinical teams within the hospital at the launch event.

The WAHT Governance team facilitated in the learning and education of a number of patient safety areas across the Trust. This included reduction of high harm patient falls, promoting staff wellbeing, increasing use of the discharge checklist, improving documentation and increasing awareness of the importance of completing patient ID bands.

Patient stories have been developed to provide learning across the trust from serious incidents. There is a statutory duty to provide a report to the Clinical Commissioning group (CCG) when a serious incident has occurred. This report is very clinical so the governance team have taken the report and made it more tangible to a multi-disciplinary audience.



A Governance intranet page has been developed to provide staff with advice and toolkits for learning relating to Governance.

What will we do next?

We would now like to focus our efforts in the timely completion of our responses now that the quality has improved. We are developing a 72 hour workshop to look at the quality, timeliness and ensuring that understanding of the process is embedded, working from ward to board level, enabling staff to create their own projects with the data that is available to them. We endeavour to ensure that governance is truly embedded at the local level.

RAG rating	Amber: Whilst we have made significant improvements in the governance processes and the learning from incidents, we needed to embed the learning trust wide to fully achieve this priority.

Priority Two:

Promoting inclusion, involvement and engagement for patients and carers

Why we chose this priority

Our Staff/patient/user group quality conversations asked us to do more on addressing diversity, co-designing services and engagement with patients who have specific needs and requirements to support them with accessing hospital care.

We recognised that in 2018/19 we achieved our priority with improving care for frail patients with dementia but felt that we needed to do more for certain other patient groups who were in danger of being over looked or their voices not being heard.

What did we say we would do?

We will continue our education plan for staff to recognising dementia and delirium to ensure timely and effective treatment, support and education.

We will continue our work, that was commenced last year through the “GEMS” team and the Admiral Dementia Nurse Specialist supporting the frail and elderly patients and also those with a dementia, drawing on the benefits the roles bring to patients and their carers.

We will work to increase the involvement of the Patient Council in undertaking surveys to capture patient experience and feedback.

We will listen to the patient and carer voice in a variety of forums in order to ensure that we communicate with some of the 'harder to reach' groups of patients. We have done this by using patient stories and complaints to ensure that we are learning.

We will hold an Autism Awareness Event.

As part of the NHSI Improvement Standards, service users with a Learning Disability who have used our organisation over the last 12 months have been encouraged to feedback on their patient experience.

We will work closely with our Mental Health Liaison Team and CAMHS to explore how we can involve our patients in ensuring that the services we offer are accessible and in line with what the patient needs.

We will ensure that service users are signposted to help whilst waiting for their CAMHS assessment, ensuring that the patients are being monitored and risk assessments are completed for each patient.

We will reinvigorate the 'Hello my name is Campaign' to improve our communication with patients and carers.

What difference did it make?

We have continued to work alongside Dementia UK to develop the Admiral Nursing service, as one of less than twenty Trusts in the UK who have this designated specialist role.

We have continued our commitment to providing a Dementia friendly hospital for our patients.

- This year we started work on a 'quiet bay' in ED, where patients can be supported in a calmer environment which we hope will help reduce the understandable anxiety and stress that can be part of being in a busy hospital environment. We worked to ensure that this not only met recognised guidelines for best practice but we consulted people living with dementia and acted on their suggestions.
- Following on from this we now have representation from a person who lives with dementia and a carer on our dementia steering group.
- Building on our refurbishment work last year with our care of the elderly ward, we have started a 'Bus Stop' project. Secured a bus stop and personalised timetable from 'First' and the support of a local graphic designer who is creating a decal to mirror Weston Seafront. This has also demonstrates our strong partnership working with our mental health colleagues, as this is a joint initiative with Avon and Wiltshire Mental Health Partnership.

In 2019 our Admiral Nurse accepted a total of 142 referrals for families who have a loved one living with a dementia. Undertaking a total of 1805 contacts with families, patients and colleagues, working in a 'triangle of care' to ensure better outcomes. For example a reduction in repeated admissions to hospital for some of our patients

Providing a calm and supportive environment for people who live with a dementia has shown to have a positive impact on their wellbeing and reduce some of the negative effects of the condition, such as misinterpreting shapes and colours. Ensuring that the voices of people who experience the condition are heard helps us know that we are moving in the right direction with our decisions. It also demonstrates that having a dementia diagnosis does not mean that your opinions and contribution are diminished.

Other areas in the country that have trialled a 'Bus Stop' project have found it has reduced agitation in patients living with dementia as it helps them focus on something familiar when they

become anxious or worried.

We have built on our commitment to people living with dementia and their families by launching 'Lillian's Memory Café', a monthly space for people living with dementia, their carers and anyone who is worried about their memory to come and meet people, have a cup of tea and get some advice and support.

We have expanded our collaborative working with North Somerset Hospital Carers Support Scheme, NSHCSS, working with the team to share our knowledge and experience of carers needs.

In collaboration with NSHCSS we have been completing 'Dementia carers feedback' forms to gain an understanding of what really matters to the carers of people living with dementia within our trust.

The patient's council have undertaken a number of surveys that capture patient experience and feedback these included a survey regarding the overnight closure of the Emergency Department (ED) and the type of presentations that patients come to ED with and their views on the closure of ED overnight. They have also undertaken a survey regarding noise at night and what measures can be put in place to minimise the noise that patient's experience this was as a result of numerous complaints.

Our CAMHS service acknowledge referrals and then provide families with a letter which signposts them to websites and services that are available to them whist on the waiting list to be seen by a specialist this has resulted in a reduction in complaints which was the primary reason for most complaints.

What will we do next?

We will be involving the patient's council in a number of patient experience projects one of which is how patients felt their discharge from hospital went? This will be important in seeing the areas that we need to focus on to ensure that patients are getting the best care and advice on discharge from hospital.

We will complete our 'Bus Stop' project and then take steps to evaluate what impact it may have on our patient's wellbeing.

Work on recommendations from our last Royal College of Psychiatry Dementia Audit, looking at areas such as patient moves and discharge discussions. Complete the next round of Dementia Audit.

We will review the new national guidelines for adult carers, (NICE). To ensure that we are supporting carers in line with their recommendations.

We will review the first round of dementia carers questionnaires to in order to look at the best ways to improve on the support we currently give.

Moving into 2020 we have an Autism awareness day planned in May with external speakers; raising the awareness Autism following the LeDeR review of Oliver McGowan, at this point we will be launching our new reasonable adjustments cards for patients and carers to use, along with a revised Hospital passport developed with North Somerset People First. The Learning Disability team are aiming to make a short film 'The Pledge' raising the awareness of communication/Makaton with non-verbal patients. NHS Futures shared a Condolence Card for

Learning Disability, which our local service user group and Learning Disability team at Weston General Hospital will be taking forward as a new initiative. Collaborative working will continue with North Somerset Community Team in identifying our top 3 reasons for hospital admission and potential admission avoidance. We will be working with University hospitals Bristol as of April 2020 and will align services and national objectives, however our focus will remain on our local service users.

RAG rating	Amber: We made significant improvements but there is still work to be done.

Priority Three:

Reducing harm from medicines.

Why we chose this priority;

Medicines safety is ensuring that wherever possible patients do not suffer avoidable harm from medicines.

In 2018 the World Health Organisation launched an initiative to decrease avoidable harm from medicines by 50% across the globe by 2023. In response to this initiative BNSSG CCG launched in 2019 a medicines optimisation quality and safety group with the aim of improving medicines safety in all areas of healthcare in the local area. Two working groups have been set up focusing on using high risk drugs such as insulin and anti-coagulants (blood thinning drugs) safely.

What did we say we would do?

We identified four specific areas to target to reduce avoidable harm to patients from medicines:-

- Insulin – we have reinstated a programme of regular training by the diabetes specialist nurses of ward staff on the safe use and administration of insulin. As well we ran a week long campaign for all staff on how to recognise and act on the signs that a patient has low blood sugars which can indicate the patient has had too much insulin. We have arranged in March 2020 for Queens University Belfast to train our doctors in a programme to make insulin treatment safe.

- Anticoagulants – we have reviewed the drug charts used to prescribe heparin infusions to make sure it is clear and to avoid any confusion on the amount given to patients and the speed at which it is given. We said that we would implement a single use Heparin chart this hasn't happened due to capacity of staff however will be focus moving forward.

- Medicines reconciliation – we agreed extra investment into the pharmacy team to allow them to make sure that, for 80% or more patients, the medicines they have been prescribed on admission to hospital are the same as those they were taking beforehand.

- Missed doses – we have implemented the learning from the Parkinson's QI project on Kewstoke across the Trust to make sure that patients receive these critical medicines at the right time and they are not missed or delayed. All Parkinson's patients are highlighted by a yellow sticker on the front of their drug charts alerting nursing staff for the need to administer medicines on time all the time to prevent patients symptoms worsening. Wards are also highlighting other time critical medicines for other conditions such as epilepsy on their drug charts.

What difference did it make?

Overall the proportion of medicines related incidents this year that have been reported as causing harm was 21% which has exceeded the target we set of 14%. However there were only 3 incidents rated as causing moderate harm (compared with 13 the previous year) and none as causing severe harm or death.

During the year we noticed an increasing number of patients suffering from adverse effects following administration of a contrast media in our radiology department. As we monitor the incidents reported in the Trust to cause harm we were one of the first Trusts in the country to notice these incidents, to report them nationally and to switch to an alternative product.

1. Insulin – we will continue with our programme of training for staff on the safe use of insulin and keep monitoring the incidents that cause harm to see how many are due to treatment with insulin. In 19/20 there were 7 incidents involving insulin which were reported as causing harm. This accounted for 7% of all incidents reported as causing harm compared with 9.3% in the previous year.
2. I.V Anticoagulants – following the update of our drug chart we will continue to monitor the incidents that cause harm to our patients to see how many are due to treatment with IV anticoagulants. There have been no incidents for 19/20.
3. Medicines reconciliation – although the extra staffing was agreed for pharmacy earlier in the year we struggled to recruit people into these posts and had to wait until January 2020 before we have been fully established with all the staff in place.

Once the new staff have completed their training we would expect the number of patients to have

their medicines checked and confirmed on admission to rise from 75% in January to over 80% by the end of the year. All staff have been recruited into post and are awaiting start dates. Rates fell in March to 62% due to the effect of Covid on the department. They have risen in April and May to 90%.

Although it has been slow progress it is pleasing that we expect our target number of patients to have the medicines they are prescribed on admission to hospital confirmed as correct to be reached by the end of the year? Whether it's been achieved at the beginning of 20/21.

4. Missed doses –The proportion of medication incidents reported involving patients missing a dose of their medication or there being a delay in the administration of their medicines remains high at 26% however it is below the target set of 30% of all incidents.

The proportion of patients who miss being given their medicine is 9.69% which is below our local target and the national average of 10%. The proportion of patients who miss a dose of a critical medicine that may lead to harm is 3.88% which is well below our target and the national average of 6.34%.

This shows that the work that we have been doing over a number of years has led to a reduction in the number of patients missing doses of a critical medicine with the possibility of this leading to harm.

What will we do next?

- Insulin, anticoagulants and other high risk drugs- we will continue to work with partners from all healthcare sectors in the local area to help reduce avoidable harm to patients from these drugs. Next year the group is looking at ways to avoid problems with high risk drugs when patients move from one area of healthcare to another.

- Medicines reconciliation – we will continue to work over the next year to increase the number of patients who have their medicines confirmed on admission and as our service expands to cover weekends to increase the speed at which that occurs so that for the majority of patients this happens within the first 24 hours of their admission.

- Missed doses – we will continue our work with wards to make them more accountable for the doses that are missed and delayed on their ward and for developing local quality improvement plans to address their particular issues. Missed doses will also be reported from the medication safety thermometer on the ward to board dashboard.

RAG rating	Amber: Whilst we have reduced the number of medication incidents causing harm to patients and undertaken a series of medication quality improvement programs we have not achieved the targets we set.

Priority Four:

Developing and making the most of our workforce

Why we chose this priority

Workforce challenges remain one of the highest threats to quality for the whole health service. We recognise the need to ensure that we support our staff to be the best that they can be and that we invest in training and development, providing new opportunities for existing staff and those who wish to join our organisation.

Our staff continue to tell us that we need to do more to raise morale and make them feel listened to and this is part of our vision for the future.

What did we say we would do?

We will further develop our workforce plan to enable staff to professionally develop into new roles such as trainee advanced care practitioners.

We will listen to our staff to hear “what is important” to them through the “happy app”, staff briefings and staff discussions/ listening events.

We will invest in and develop our clinical and managerial leaders to help them shape and deliver our clinical services.

We will improve the quality of our staff appraisals through further training in the use of the new

achievement review document.

We will build on the improvements in our staff survey, namely their health and wellbeing, leadership development and communicating with all staff.

We will increase the numbers and range of Apprenticeships offered.

What difference did it make?

The development of the trainee Advanced Care practitioner program has not taken place based on the availability of staff and capacity to facilitate this change. However, the merger of Weston Area Health Trust and UH Bristol will see significant work taking place to adopt processes and pathways from the centralised training and education function within the merged Trust, and the new facilitation roles will be implemented to support staff development. Please see ' what we will do next' for more information.

The Happy App has been rolled out Trust wide and is successfully utilized in a number of departments which has improved localized communication. Monthly briefings held by the Executive Team have given staff continual opportunities to hear about what is happening in the Trust and how we are performing, which has been well received. A number of listening events called ' Hopes & Fears' have been held with an external facilitator prior to the merger between WHAT and UHB, which has given staff the opportunity to have their voice heard and raise concerns, suggestions and feedback specifically relating to the merger.

We have invested in our clinical and managerial leaders by implementing a specific two-date development program for band 6s and 7s ('Leadership for Managers') to help develop best practice managerial skills. Sixty Three managers have attended to date and the feedback has been positive.

We have continued to offer regular training sessions for managers in how to conduct effective Achievement Reviews as well as effectively complete the review process. This has been beneficial for managers to have targeted development in supporting their teams in this way, and they are able to attend regularly to refresh their skills if they would like to.

In addition to the leadership development and communication improvements outlined above, significant work has been done to build on the improvements reported from our Staff Survey; in terms of health & wellbeing, we have implemented a new Employee Assistance Programme (EAP), trained a number of Mental Health First Aiders to support staff, and held events to promote positive behaviours as well as continually evolving the health & wellbeing resources our staff can access via the intranet and signposting them to external sources of support. We hope to see a further improvement in the responses to the questions around health & wellbeing in the next staff survey.

The Trust recognises the important contribution that apprentices can make to the workforce and also the importance of ensuring that our valued staff have a platform that supports their professional and personal development.

Working with our procured educational providers, and the regional Sustainability and Transformation Partnership (STP), we have continued to procure a wider range of apprenticeships to meet the various demands of the workforce. We have continued to recruit a number of apprentices into both administrative roles and nursing roles.

With the proposed merger with UH Bristol, as a trust we look forward to the joint relationships we can build on to develop a sustainable workforce which will focus on the apprentice, this will include

nursing apprenticeships.

What will we do next?

- **Professional development of staff;** the Advanced Care Practitioner qualification is now available as an apprenticeship for staff to apply for. Via a number of dedicated facilitation roles that will be recruited into the Trust post-merger between WAHT and UHB, we will be able to develop multiple new professional development pathways for staff.
- **Listening to our staff;** a new Staff Forum, 'The Voice', will be launched to understand what is most important to staff. The main focuses of the forum will be hearing ideas and suggestions, as well as 'myth busting' and asking for their views on potential site improvements, such as increasing rest area capacity. We will ask for advocates from each department to bring forward the views, ideas, suggestions and concerns from their teams for direct discussion with the Senior Management Team. Feedback from the forum will then be relayed back to staff.
- **Investing in our managers;** A number of clinical and managerial leads have been nominated to be part of the Peloton development programme to support them in developing their skills, relationships, networks, and facilitating change across the BNSSG region. Managers will continue to be nominated in ongoing waves of the programme. We will also share details of other potential external development opportunities with managers, such as those available via the South West Leadership Academy, as well as developing our internal offering on developing capability around HR policies and staff development.
- **Improving the quality of appraisals;** the format we use for appraisals will change following the merger between WAHT and UH Bristol, so that it is aligned across both sites and all conversations around development are structured in a similar way; this format will eventually be moved online for accessibility. Line managers will be developed in how to use the new system and continue to have effective conversations with staff.
- **Building on improvements in the staff survey;** to further improve the flow of communication to all staff, a weekly Manager Bulletin will be developed to share key workforce messages with managers, for them to share with their team. The results of the next Staff Survey will be reviewed and a priority plan put together to determine our next areas of focus based on staff feedback.
- **Apprenticeships;** through the introduction of x 2 dedicated Apprenticeship facilitation roles at Weston, we will continue to expand our apprenticeship offering to both support development of existing staff and also expand our ability to recruit & retain new staff for example by offering Healthcare Assistant/Nursing Assistant apprenticeships.
- **Cultural and People development;** In order to make the most of our workforce, staff need to feel safe, valued, recognised, developed and work in a respectful environment free from harassment or bullying. To incorporate and build on our workforce priorities outlined above, a Culture & People plan will be developed on the basis of the following priority areas, with dedicated initiatives linked to each priority to improve the working lives of our staff.

RAG rating	Amber: A number of elements of the plan have been achieved and further achievements will be enabled by the organisational merger between WAHT and UH Bristol.

Priority Five:

Optimising safe discharges.

Why we chose this priority

The optimising of safe discharges as a quality priority matters to us as ultimately the safe discharge of a patient improves the patient experience, anxiety and improvement in the overall health of the patient.

Reputation of the Trust is reliant on the safe flow of a patient's journey through the hospital and seamless transition into the community. This also allows for the patients, families and carers to have confidence that the aspect of discharge has equal bearing and importance in the whole patient journey.

Reducing the length of stay of patients and readmissions will affect the ability to effectively use the resources at Weston and limit the increasing financial burden of delays in hospital.

What did we say we would do?

The trust has re- invigorated the 'safer bundle' and 'model ward rounding tool' , engaging all of the clinical teams to ensure discharge is a focus from admission, with an emphasis on reducing delays whilst in hospital and providing timely responses to required actions to deliver care

effectively.

The use of the e- flow electronic boards has been reviewed, with an idea to improve the multi-disciplinary communication, and the social plan from the Integrated Discharge Team has been designed to link information from the Green to Go database directly to the e-flow electronic boards.

As part of the wider BNSSG collaborative work to improve the discharges at weekends, an initiative to use the discharge checklist designed as an individual envelope, a safety process pre discharge, has been introduced. The checklist allows for a final check to be carried out ensuring that all relevant documentation and referrals including contacting the patient's next of kin has been undertaken to ensure the patients safe discharge.

The collaborative BNSSG out of hospital delivery group have produced a 'managing expectations policy', this ensures patients understand the process of timely discharges and how this will be achieved.

Current work with the medical teams is underway to improve the information, timeliness and quality of the discharge summaries produced, with specific emphasis on those patients with Chronic Obstructive Pulmonary Disease (COPD). This will include the COPD discharge bundle; if successful the aim will be to increase the number of conditions, allowing for an improved communication to the patient and community. This will optimise self-care of the patient's specific conditions.

What difference did it make?

The current initiatives will continue to be monitored and improvements identified, by the reduction of incidents, complaints and a reduction in the patients length of stay. The hope being that the numbers of medically fit patients awaiting social input will be reduced. This will also be monitored by the effective use of community services. The improved communication will assist patients with identifying community services that could be used prior to a hospital admission. There has also been a community discharge event which looked at the main route causes of incidents reported into Weston. The outcome of the meeting was improved communication and better understanding of pathways, between Weston and partners.

What will we do next?

The focus on discharge as a quality priority will be a constant focus for the Division of Weston as part of the merged organisation with UHBristol. There are many supporting actions that need to be fulfilled to address the challenge of discharging a community of patients with varying and complex needs. We will be undertaking an audit of discharge in collaboration with the patients council to look at areas of improvement. We will have a newly refurbished discharge lounge for staff to be able to relax in prior to discharge which will support discharges from the ward environment.

RAG rating	Amber We have made a number of discharge improvements however we feel that there is still a considerable amount of work to be done.

Quality Priorities for 2020/2021

From April 2020 WAHT will become a new merged organisation with University Hospitals Bristol

NHS Foundation Trust and we will adopt the quality priorities identified in the Quality Account of the new organisation of University Hospitals Bristol and Weston NHS Foundation Trust. The newly established Division of Weston will continue with the quality priorities identified within the WAHT 2019/20 Quality Account to sustain and embed the learning that we have achieved against these quality priorities.

How will we measure progress of these priorities?

The Quality priorities that were identified in 2019-20 will roll into 2020/21. A number of the actions have been achieved and identified actions will become the division of Weston's focus in the merged organisation, patient and staff will report into the Division of Weston's lead governance group and divisional board.

Participation in Clinical Audits

During 2019/20, there were 42 national clinical audits and two confidential enquiries covered relevant health services that Weston Area Health Trust provides.

During that period Weston Area Health Trust participated in 88% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. There were a small number of national audits that we chose not to take part in. This was, for example, because our patient case mix did not meet the necessary criteria – or because of a shortage of clinical staff to dedicate the time required..

The national clinical audits and national confidential enquiries that Weston Area Health NHS Trust was eligible to participate in during 2019/20 were as follows:

Eligible National Clinical Audits 2019/20

National Clinical Audit Title	% Participation Rate if data completed In 2019/20
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Continuous data collection
Diabetes (Paediatric) (NPDA)	Continuous data collection (Data submitted via Bristol)
National Chronic Obstructive Pulmonary Disease Audit	Continuous data collection
National Asthma Audit	Started data collection in July 2019
National Heart Failure Audit	Continuous data collection
Mental Health (self-harm)	100%
Assessing for cognitive impairment in older people	100%
Care of children in ED	100%
National Audit of Seizures in Hospital (NASH3)	0%
National Diabetes Audit – National Diabetes Inpatient Care	0%
National Diabetes Audit – continuous harm database	Continuous data collection
National Diabetes Audit – Type 1 diabetes	Continuous data collection
Sentinel Stroke National Audit Programme (SSNAP)	Continuous data collection
Bowel Cancer (NOCAP)	Continuous data collection
Maternal, newborn and infant clinical outcome review programme	Continuous data collection
National Hip Fracture Database	Continuous data collection
Case Mix Programme (CMP)	Continuous data collection

National Joint Registry (NJR)	Continuous data collection
National clinical audit rheumatoid and early inflammatory arthritis	Continuous data collection
Elective Surgery (National PROMS programme)	Continuous data collection
Inflammatory Bowel Disease (IBD) programme	0%
National Audit of Breast Cancer in Older Patients	Continuous data collection
National Emergency Laparotomy Audit (NELA)	Continuous data collection
National Lung Cancer Audit (NLCA)	Continuous data collection
National gastro-intestinal cancer programme	Continuous data collection
Perioperative quality improvement programme (PQIP)	0%
Prostate Cancer	Continuous data collection
National Comparative Audit of Blood Transfusion programme – Re-audit of the medical use of blood	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	0%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance	Continuous data collection
National Audit of Care at the End of Life (NACEL)	100%
Mandatory surveillance of blood stream infections and clostridium difficile infection	Continuous data collection
Surgical site infection surveillance	Continuous data collection
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Continuous data collection
National Maternity and Perinatal Audit	Continuous data collection
National Cardiac Arrest Audit	Continuous data collection
National Smoking Cessation Audit	0%
Falls and fragility fractures audit programme: fracture liaison service database	Continuous data collection
National Vascular Registry	Continuous data collection (Data submitted via Bristol)
UK Parkinson's Audit	100%
Seven Day Hospital Services	100%
National Audit of Inpatient Falls (NAIF)	Continuous data collection
National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	**Did WAHT participate?**

Number of Audits participated in during 2019/20

National Clinical Audit Title	**% Participation Rate if data completed In 2019/20**
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Continuous data collection
Diabetes (Paediatric) (NPDA)	Continuous data collection (Data submitted via Bristol)
National Chronic Obstructive Pulmonary Disease Audit	Continuous data collection
National Asthma Audit	Started data collection in July 2019
National Heart Failure Audit	Continuous data

	collection
Mental Health (self harm)	100%
Assessing for cognitive impairment in older people	100%
Care of children in ED	100%
National Diabetes Audit – continuous harm database	Continuous data collection
National Diabetes Audit – Type 1 diabetes	Continuous data collection
Sentinel Stroke National Audit Programme (SSNAP)	Continuous data collection
Bowel Cancer (NOCAP)	Continuous data collection
Maternal, newborn and infant clinical outcome review programme	Continuous data collection
National Hip Fracture Database	Continuous data collection
Case Mix Programme (CMP)	Continuous data collection
National Joint Registry (NJR)	Continuous data collection
National clinical audit rheumatoid and early inflammatory arthritis	Continuous data collection
Elective Surgery (National PROMS programme)	Continuous data collection
National Audit of Breast Cancer in Older Patients	Continuous data collection
National Emergency Laparotomy Audit (NELA)	Continuous data collection
National Lung Cancer Audit (NLCA)	Continuous data collection
National gastro-intestinal cancer programme	Continuous data collection
Prostate Cancer	Continuous data collection
National Comparative Audit of Blood Transfusion programme – Re-audit of the medical use of blood	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance	Continuous data collection
National Audit of Care at the End of Life (NACEL)	100%
Mandatory surveillance of blood stream infections and clostridium difficile infection	Continuous data collection
Surgical site infection surveillance	Continuous data collection
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Continuous data collection
National Maternity and Perinatal Audit	Continuous data collection
National Cardiac Arrest Audit	Continuous data collection

Falls and fragility fractures audit programme: fracture liaison service database	Continuous data collection
National Vascular Registry	Continuous data collection (Data submitted via Bristol)
UK Parkinson's Audit	100%
Seven Day Hospital Services	100%
National Audit of Inpatient Falls (NAIF)	Continuous data collection
National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	**Did WAHT participate?**

Weston Area Health NHS Trust completed 33 local clinical audits and quality improvement projects during 2019/20. The outcomes of the audits are shared with relevant staff at specialty meetings and directorate governance meetings. The Clinical Audit Team maintains a register of all local (and national) audits, their results, and the subsequent actions by the Trust.

Examples of actions arising from these audits that the Trust has implemented or intends to implement to further improve the quality of care are provided:

Clinical Audits completed and outcomes identified

Clinical audit title	Outcomes
Holistic Needs Assessment (HNA) Patient Questionnaire	Patients strongly agreed to being able to raise concerns, felt listened to, had the opportunity to ask questions, talk about fears/worries. 78% of patients questioned would recommend a HNA. The HNA documentation has been changed following the questionnaire to be more explicit as to what the patient is having.
Coeliac disease audit to ensure we are meeting NICE guidance	The results reflect good practice in compliance with NICE guidance for the management of coeliac disease. No improvements were suggested to the team as this audit showed that they were complying with current NICE guidance.
Appropriateness of CT head requests re-audit	All the head injury scans are as per in hospital/trust protocols and NICE guidelines. Continued adherence to current ongoing strategy of creating awareness amongst all hospital doctors about the importance of NICE guidelines and to follow them
Assessing the impact of changing lung biopsy technique on patient safety and diagnostic accuracy	We are meeting the British Thoracic Society guidelines on complication rates and diagnostic accuracy following CT guided lung biopsy.
Oncology and Haematology Day Unit Patient Satisfaction Survey	There were an exceptional number of excellent and positive comments detailed in the report that reflect the continued high standards of patient centred care delivered by the Oncology and Haematology Day Unit team. The nurses, doctors, reception staff and volunteers are dedicated to delivering care and treatment while supporting patients through a very

	difficult time. The team are all continually committed to learning, developing skills and adapting to change of work processes in this diverse and complex speciality and should feel very proud of their achievements.
Pabrinex Dose for prevention of Wernicke's Encephalopathy in patients with history of excessive alcohol intake	All patients were managed according to trust guideline. However, the trust guideline does need to be updated in view of updated data and national guidelines. A re-audit is planned in 2020 to ensure patients are being managed according to updated guidelines.

NICE Quality Standards

NICE Quality Standards are concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of healthcare. They are derived from the best available evidence such as NICE guidance and other sources accredited by NICE. Quality standards consider all areas of care, from public health to healthcare and social care.

A revised process for the implementation of all NICE guidance, including NICE Quality Standards, has been put in place during 2019/20. All newly released NICE guidance (including NICE Quality Standards) are identified and collated by the Clinical Audit Manager. The list is then sent to a consultant Microbiologist and the Lead Pharmacist to identify the appropriate member of staff to review the guidance. This is supported by the Consultant Rheumatologist and Associate Medical Director for Surgery and Emergency as required.

The guidance is then sent to that member of staff, asking them to review and complete the assessment form, which is then collated by the Clinical Audit Manager. If no responses are received, reminders are sent and the responses are tracked and reviewed by the Clinical Effectiveness Committee.

Overview of NICE implementation in 2019/20

Type of Guidance	Total published April 19 to December 19	Reviewed and NOT relevant to Weston	Gap analysis undertaken and current practice consistent with guidance	Gap analysis undertaken and current practice NOT consistent with guidance	Awaiting response
Quality Standards (QS)	7	0	5	0	2
Diagnostics Guidance (DG)	4	4	0	0	0
NICE Guidelines (NG)	26	7	4	4	11
Interventional Procedures Guidance (IPG)	20	18	0	0	2
Medical Technology Guidance (MTG)	4	3	0	0	1
Total	**61**	**32**	**9**	**4**	**16**

Overview of technology appraisals in table below:

Total number of TAs published April 19 to December 19	Not relevant to Weston	Technology appraisal terminated	Reviewed and no further action required	Awaiting response
44	17	8	16	**3**

The overall report has been reviewed at the Development Clinical Effectiveness meeting, to review risks around non-compliance and highlight lack of responses, with onward assurance through to the Quality and Safety Committee.

Research

We undertake many different types of research in Weston. This ranges from simple studies using questionnaires or sample collection right up to complex studies offering different therapies or new treatments.

Access to high quality research studies gives patients the opportunities to have therapies and treatments that may not be available yet. Participation in research enables our staff to remain up to date with the latest treatments and contributes to achieving the best outcomes for our patients.

The number of patients receiving health services provided or sub contracted by Weston Area Health NHS Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee were 281 patients and staff.

This year Weston participated in 16 recruiting studies with approximately 300 patients being followed up from previous years to see how they are progressing following treatment.

We have recruited people into the following studies:

Project	Speciality	Recruited
Add-Aspirin Trial - Investigating whether aspirin can reduce the risk of their cancer coming back.	Cancer	5
ADDRESS 2 - Incident and high risk type 1 diabetes cohort.	Diabetes	1
ELAN: Early versus late initiation of direct oral anticoagulants in post-ischaemic stroke patients with atrial fibrillation. For people who have had a stroke.	Stroke	1
FLO-ELA: Fluid optimisation in emergency laparotomy. For people undergoing emergency abdominal surgery.	Anaesthetics	1
Fatigue - Reducing its Effects through individualised support Episodes in Inflammatory Arthritis (FREE IA). For people with certain types of arthritis who are experiencing fatigue.	Rheumatology	6
Healthcare professional's perspectives on the dietary advice they provide to people with an ileostomy.	Staff	3
IBD Bioresource – a registry for people with inflammatory bowel disease.	Gastroenterology	41
OPTIMA – Personalised treatment for breast cancer.	Cancer	3
PREDICT: Prostate Patient Study – a tool to predict risk for men with prostate cancer.	Cancer	6
PrEP Impact Trial – for people at risk of HIV.	Sexual Health	35
SATiRe: Staff attitudes towards clinical research in the NHS	Staff	134
STAMPEDE – comparing different treatments for men with prostate cancer	Cancer	2
STAMINA: supported exercise training for men on ADT – for men with prostate cancer receiving hormone treatment.	Cancer	24
Sunflower Study – for people who have their gallbladder removed.	Surgery	11
TrialNet – for people with type 1 diabetes.	Diabetes	5
Vedolizumab long term safety study – for people with ulcerative colitis or Crohn's disease.	Gastroenterology	3
Total		**281**

What difference did it make?

Offering studies to patients locally increases access for our patients. Otherwise either they would miss out on the opportunity or they would have to travel to a larger hospital.

For example the STAMINA study provides a personal trainer and access to a network of gyms to men with prostate cancer who are receiving hormone treatment. NICE guidelines recommend resistance and other exercises for these men however in practice this is something that is often not available to them.

The FREE IA study follows on from a previous study for people with inflammatory arthritis. This study evaluates the effectiveness of a programme, which aims to reduce the effects of fatigue, delivered during routine clinic visits.

What will we do next?

We have a number of new studies that will open to recruitment in the next year. We will continue to seek high quality research studies that are of relevance to our patients and fits with the *Healthy Weston* initiative.

Merging with University Hospitals Bristol NHS Foundation Trust will increase the number and

types of research opportunities we can offer to our patients at their local hospital.

National and Local Quality improvement and innovation goals (CQUIN)

CQUIN stands for Commissioning for Quality and Innovation. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care**.**

A proportion of Weston Area Health trusts income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between WAHT and any persons or bodies they entered into a contract, agreement or arrangement with for the provision of relevant health services through the commissioning for Quality and Innovation payment framework.

CQUIN Targets 2019/20

CQUIN Indictors	Aim
Antimicrobial Resistance – Lower Urinary Tract Infections in Older People	To achieve 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.
Antimicrobial Resistance – Antibiotic Prophylaxis in colorectal surgery	To achieve 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.
Improving the uptake of flu vaccinations for frontline clinical staff	To achieve an 80% uptake of flu vaccinations by frontline clinical staff.
Alcohol and Tobacco - Screening	To achieve 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use.
Alcohol and Tobacco – Tobacco Brief Advice	To achieve 90% of identified smokers given brief advice.
Alcohol and Tobacco – Alcohol Brief Advice	To achieve 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.
Three high impact actions to prevent Hospital falls	To achieve 80% of older inpatients receiving key falls prevention actions
Same Day Emergency Care – Pulmonary Embolus	To achieve 75% of patients with confirmed pulmonary embolus (PE) being managed in a same day setting where clinically appropriate.

Same Day Emergency Care – Tachycardia with Atrial Fibrillation	To achieve 75% of patients with confirmed atrial fibrillation (AF) being managed in a same day setting where clinically appropriate.	
Same Day Emergency Care – Community Acquired Pneumonia	To encourage patients with confirmed Community Acquired Pneumonia (CAP) to be managed in a same day setting where clinically appropriate.	

Due to the pandemic a majority of the indicators were not able to be audited due to staff being reassigned to clinical duties.

CQUIN Targets 2019/20

CQUIN Indictors	Aim	Achieved
Antimicrobial Resistance – Lower Urinary Tract Infections in Older People	To achieve 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.	42.8%
Antimicrobial Resistance – Antibiotic Prophylaxis in colorectal surgery	To achieve 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.	80.4%
Improving the uptake of flu vaccinations for frontline clinical staff	To achieve an 80% uptake of flu vaccinations by frontline clinical staff.	84%
Alcohol and Tobacco - Screening	To achieve 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use.	95.9%
Alcohol and Tobacco – Tobacco Brief Advice	To achieve 90% of identified smokers given brief advice.	46.2%
Alcohol and Tobacco – Alcohol Brief Advice	To achieve 90% of patients identified as drinking above low	53.4%

	risk levels, given brief advice or offered a specialist referral.	
Three high impact actions to prevent Hospital falls	To achieve 80% of older inpatients receiving key falls prevention actions	51.6%
Same Day Emergency Care – Pulmonary Embolus	To achieve 75% of patients with confirmed pulmonary embolus (PE) being managed in a same day setting where clinically appropriate.	56.3%
Same Day Emergency Care – Tachycardia with Atrial Fibrillation	To achieve 75% of patients with confirmed atrial fibrillation (AF) being managed in a same day setting where clinically appropriate.	67.6%
Same Day Emergency Care – Community Acquired Pneumonia	To encourage patients with confirmed Community Acquired Pneumonia (CAP) to be managed in a same day setting where clinically appropriate.	78%

Care Quality Commission Inspection

Weston Area Health NHS Trust (WAHT) is required to register with the Care Quality Commission (CQC). As of 31st March 2020, WAHT had the following condition on its registration: CQC issued a warning notice for the Emergency Department on 7th October 2019.

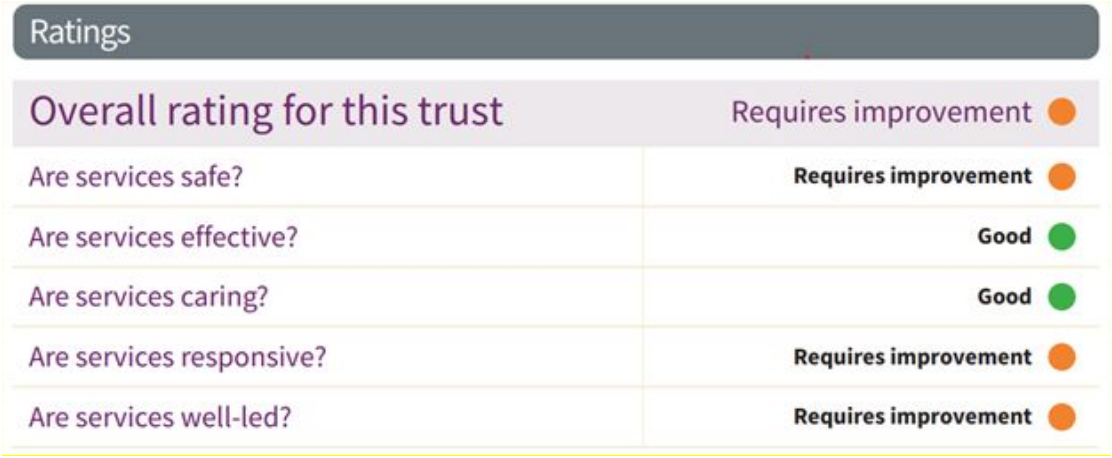
In February and March 2019 the CQC undertook a full inspection of four core services of the Trust; Urgent and Emergency Care, Medicine, Surgery and Child and Adolescent Mental Health Services (CAMHS) along with a Well Led review and a review of Use of Resources. A Section 29a warning notice was received in April 2019 for both CAMHS and the Emergency Department where it was identified that the quality of health care provided in these areas required significant improvement.

The Trust received a further unannounced visit by the CQC on 17 September 2019 in order to assess improvements in line with the warning notice. The initial feedback at this time noted improvements and meeting of the warning notice requirements within the CAMHS service with some work still to be embedded, and whilst some changes had been seen within the Emergency Department there remained concerns with regards to governance processes, risk and adequate training, and supervision and support for staff to carry out their roles and responsibilities safely. A further warning notice was issued for the Emergency Department on 7 October 2019 and the CQC improvement plan was enhanced to include the additional requirements.

Following the core services inspection in March 2019 the CQC inspection report was published on the 26 June 2019 which rated the Trust as overall 'Requires Improvement', with some areas showing improvement since the previous March 2017 inspection. The 2019 report identified 27

'Must do' requirements for action and 48 'Should do' recommendations.

2019 Inspection



Ratings	
Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Jun 2019	Good ↑ Jun 2019	Good →← Jun 2019	Requires improvement ↑ Jun 2019	Requires improvement →← Jun 2019	Requires improvement →← Jun 2019

Ratings for Weston General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ➔➔ Jun 2019	Requires improvement ➔➔ Jun 2019	Good ➔➔ Jun 2019	Requires improvement ↑ Jun 2019	Inadequate ➔➔ Jun 2019	Inadequate ➔➔ Jun 2019
Medical care (including older people's care)	Requires improvement ➔➔ Jun 2019	Good ↑ Jun 2019	Good ➔➔ Jun 2019	Requires improvement ↑ Jun 2019	Requires improvement ➔➔ Jun 2019	Requires improvement ➔➔ Jun 2019
Surgery	Good ➔➔ Jun 2019	Good ➔➔ Jun 2019	Good ➔➔ Jun 2019	Requires improvement ➔➔ Jun 2019	Good ➔➔ Jun 2019	Good ➔➔ Jun 2019
Critical care	Good Jun 2017	Good Jun 2017	Good Jun 2017	Requires improvement Jun 2017	Good Jun 2017	Good Jun 2017
Services for children and young people	Good Aug 2015	Good Aug 2015	Good Aug 2015	Requires improvement Aug 2015	Good Aug 2015	Good Aug 2015
End of life care	Good Aug 2015	Good Aug 2015	Outstanding Aug 2015	Requires improvement Aug 2015	Good Aug 2015	Good Aug 2015
Maternity and gynaecology	Good Aug 2015	Good Aug 2015	Good Aug 2015	Good Aug 2015	Good Aug 2015	Good Aug 2015
Outpatients and diagnostics	Good Aug 2015	N/A	Good Aug 2015	Requires improvement Aug 2015	Good Aug 2015	Good Aug 2015
Overall*	Requires improvement ➔➔ Jun 2019	Good ↑ Jun 2019	Good ➔➔ Jun 2019	Requires improvement ↑ Jun 2019	Requires improvement ➔➔ Jun 2019	Requires improvement ➔➔ Jun 2019

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Inadequate ↓↓ Jun 2019	Requires improvement ↓↓ Jun 2019	Good ↓ Jun 2019	Inadequate ↓↓ Jun 2019	Inadequate ↓↓ Jun 2019	Inadequate Jun 2019

By 31st March 2020, Weston Area Health NHS Trust had completed actins arising from the two warning notices.Throughout the year there has been continuous monitoring and robust management of the improvement plan, via monthly senior management team meetings, monthly directorate governance meetings and the trust's quality and safety committee, with assurance against actions assessed and validated by the lead executive for each recommendation.

Engagement between the Care Quality commission and Provider

As part of a new engagement process between the provider and the CQC, quarterly review meetings have focussed on the core services of medicine, outpatients and end of life care.

Hospital Episode Statistics and Secondary Users service

Weston Area Health NHS Trust submitted records during 2019/20 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Data Quality of Secondary User Services Data

Weston Area Health NHS Trust	Weston 2018/19	2019/20 (Apr – Dec) * latest data available	
		Weston	National average
% of records including the patient's valid NHS number:			
Admitted patient care	99.9%	99.8%	99.4%
Outpatient care	100%	99.9%	99.7%
Accident and emergency care	99.8%	99.3%	97.7%
% of records including the patient's valid General Medical Practice Code:			
Admitted patient care	100%	100%	99.7%
Outpatient care	100%	100%	99.6%
Accident and emergency care	100%	100%	99.7%

Clinical Coding Audit

In line with the Data Security and Protection Toolkit standards (former information Governance Toolkit Requirements 505 and 514), 200 episodes have been reviewed by external auditors D&A Clinical coding consultancy LTD in December 2019 to ensure the coded information continues to be accurate and adequate. The following results have been achieved:

Data Security Standard 1 Data Quality

The Trust has achieved the following attainment level – **Standards Met**

Data Security Standard 3 Training

The Trust has achieved the following attainment level – **Standards Met**

Conclusions

Weston Area Health NHS Trust has satisfied the requirements for Data Security Standards 1 and 3, this is to be commended.

An outstanding high level of commitment is demonstrated from all the clinical coding staff in striving to enhance the clinical coding function for the Trust.

A robust clinical validation programme with regular peer coder discussions are in place and this is proving successful in increasing the quality of data.

HRG changes have been greatly reduced from 16.5 %(2019) to 7%: and this financial deficit reported should potentially be recouped by the trust during the data reconciliation process

Coding accuracy

% Diagnoses Coded Correctly		% Procedures Coded Correctly	
Primary	**Secondary**	**Primary**	**Secondary**
91.50	**94.31**	**94.17**	**89.14**

Data Quality

Action we have taken to improve data quality

Weston Area Health NHS Trust has taken the following actions to improve data quality:

- The Trust has a Data Quality Policy and an Information Improvement Team. This policy, along with a wide range of others relevant to data quality, is regularly reviewed by the Trust's Health Informatics Committee which also monitors the work of the Information Improvement Team and Health Informatics in general.
- We have set up new initiatives, including the establishment of a Data Quality Group with our commissioners which will steer the data quality improvement plan.
- The Board regularly discusses a very wide range of data regarding quality and patient safety, operational performance, human resources and finance. This helps to improve data quality and presentation through robust discussion, questioning and analysis by Executive Directors, non-executive directors, patients' representatives and members of the general public.

In order to achieve further transparency the Trust continues to benchmark its date against HES via CHKS statistics (an independent provider of healthcare intelligence and quality improvement services.).

Learning from patient deaths

All NHS Trusts are required to have in place a process to look at the care of patients who die in hospital. Many patients choose to die in hospital and a standardised review of these expected deaths is designed to find examples of both excellent care and areas where care could be improved.

The Trust committed to performing a standardised review of care for >50% of deaths occurring in hospital and ensuring that learning from these reviews was shared widely within the organisation.

The Trust's chief registrar has continued to lead the learning from deaths process. In the first 9 months of the 2019/20 financial year there were 440 deaths in the Trust. The trust achieved its target of 50% of deaths receiving a structured review. Three reviews were judged to demonstrate possible avoidable harm and these cases were subject to more detailed investigation.

Examples how lessons learned from reviews have been shared this year include:

- Junior doctor teaching session on specific cases using patient story approach.
- Quality improvement project started by Respiratory Specialist Nurse team on the correct use of non-invasive ventilation in patients following issues identified during learning from deaths review.

- WESMILE patient safety magazine; updated with mortality data and learning.
- Learning from deaths focus of medical grand round to all medical staff.
- Peer to peer learning from deaths reviews set up between pairs of medical wards.
- Learning from Deaths Workshop attended in Exeter in November by Chief Registrar; Weston Area Health Trust on track currently. Medical Examiner Officer recruitment is beginning and Weston services are being mapped into the Regional plan for the South West.

Learning from deaths reviews have improved the care given to patients that die in hospital especially those whose deaths are expected. Sharing good practice and focusing on specific areas of improvement has contributed to the recognition of our excellent end of life care by the Care Quality Commission and the National Audit of Care at the End of Life

The Trust will continue to focus on learning lessons from reviewing the care given to patients that die in hospital and look to widen our learning with our primary care and community partners to those patients who die soon after leaving hospital.

In 2020/21 the new University Hospitals Bristol and Weston NHS Foundation trust will work with partners in BNSSG to implement the new national Medical Examiners process. This process looks to standardise the process of completing death certificates and will ensure that all patients that die in hospital will receive a consistent review of care by a senior doctor. Pilot schemes of this process have demonstrated that medical examiners are able to provide information and explanation about care to the families of patients who have died which in turn leads to reduced levels of distress and worry at what can be a very difficult time.

Patient Reported Outcome Measures (PROMs)

The Trust has participated in the Patient Reported Outcome Measures (PROMs) programme since April 2009 for hernias, knee and hip replacements. The programme involves patients completing a pre-operative questionnaire and then a questionnaire either 3 or 6 months after the operation (dependent on type of operation).

The Trust is responsible for identifying relevant patients, offering them a pre-operative questionnaire and returning completed questionnaires to the national coordinating centre. The Trust posts the initial questionnaire to patients before they attend pre-operative assessment, this enables any queries to be discussed in person at that appointment. The questions asked are based on quality of life measures.

The national coordinating center data return includes all surveys returned to it, even when patients turn out to not be eligible; hence the percentage participation rate sometimes exceeds 100%. Also the center takes a long time to process the results, which therefore means that the data is only available a year in arrears.

PROMS Participation Rate: (*cannot update these as NHS digital haven't published yet)*

	WAHT Participation Rate April 16 to March 17	NHS Participation Rate April 16 to March 17	WAHT Participation Rate April 17 to March 18	NHS Participation Rate April 17 to March 18
Hernia	29%	80.9%		
Hip	75%	85.9%	115%	86.1%
Knee	106%	94.6%	123%	87.3%

PROMS Performance:

	WAHT Health Gain Average April 16 to March 17	NHS Health Gain Average April 16 to March 17	WAHT Health Gain Average April 17 to March 18	NHS Health Gain Average April 17 to March 18
Hernia	Not measurable**	0.086		
Hip	0.395	0.437	0.475	0.468
Knee	0.334	0.324	0.368	0.337

**"Not measurable" means numbers of patients who responded were so low that the analysis was withheld by NHS Digital for confidentiality reasons.
Questionnaires for hernia activity are no longer collated

The performance data shows that the trust performance is similar to the national average for hip and knee. The hernia performance is suppressed by the national database on the grounds of patient confidentiality i.e. the number of patients participating is so small that the results may enable individual patients to be identified.

Hospital readmission

The data made available to the trust by NHS Digital with regard to the percentage of patients aged

(i) 0 to 15; and

(ii) 16 or over

Re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period. The readmissions rates within 28 days for 19/20 are:

Hospital Readmissions

Age Range	Site Numerator	Site Denominator	Apr 19 – Jan 20
16+ years	1995	24530	8.13%
0-15 years	21	803	2.62%

Data taken from CHKS 02/03/2020

Reducing harm from infection

Clostridium difficile infections

The table shows the rate of hospital acquired *Clostridium difficile* (*C. difficile*) infections there have been within the Trust per 100,000 bed days. (Children under 2 are not included)

Clostridium difficile (*C. difficile*) infections

	2019/20		2018/19
	Weston	National average	Weston
Rate per 100,000 bed days of cases of *C. difficile* infection	8.39	15.42	8.13
Data source: Public Health England			

In 2018/19 the Trust maintained its low rates of *Clostridium difficile* infections, reporting seven cases. In 2019/20 the criteria for reporting of *Clostridium difficile* infections changed. Cases are split between hospital onset, healthcare associated (HOHA) and community onset, healthcare associated (COHA). COHA cases occur in the community or within two days of admission when the patient has been an inpatient in our care in the previous four weeks. The Trust has reported eight cases of HOHA and seven cases of COHA against a threshold of 14 cases; our rate remains well below the national average. Each case has undergone a comprehensive post infection review which has been assessed against national guidance criteria.

In all but two cases, we have been able to demonstrate that there have been no cases of cross transmission of *Clostridium difficile* between patients on our wards. The reason we could not categorically exclude cross-transmission was due to not being able to sub-type the *Clostridium difficile* to prove this. Learning has been identified in areas such as prompt isolation, sampling and review of antibiotic prescriptions. Every case is presented to the Infection Prevention and Control Committee where action plans are either signed off or it is agreed that further work is required.

At Weston, a high proportion of patients admitted to this hospital are over 65 years in age and up to a third of these patients are receiving antibiotic treatment at any one time. These are significant risk factors for *Clostridium difficile* acquisition.

The strategies introduced over the last 5 years are now embedded and our continuing success in reporting low numbers of *Clostridium difficile* infections is testament to their success.

The strategies that have contributed to this include:

- Continued updating of our antibiotic guidance and the use of mobile technology in the form of a Smart phone App to enable our Doctors to access these guidelines at the point of care.
- Recruitment of antimicrobial pharmacist in June 2019.
- Daily auditing of antibiotic prescribing by a designated pharmacist and the Consultant Microbiologist with prompt feedback to prescribers and their teams from July 2019.
- Use of the Diarrhoea Assessment Tool to assist clinical staff with the prompt isolation of symptomatic patients and in determining when specimens should be sent.

The gap in the antimicrobial pharmacist post from July 2018 until June 2019 impacted on the ability to undertake daily auditing during this period.

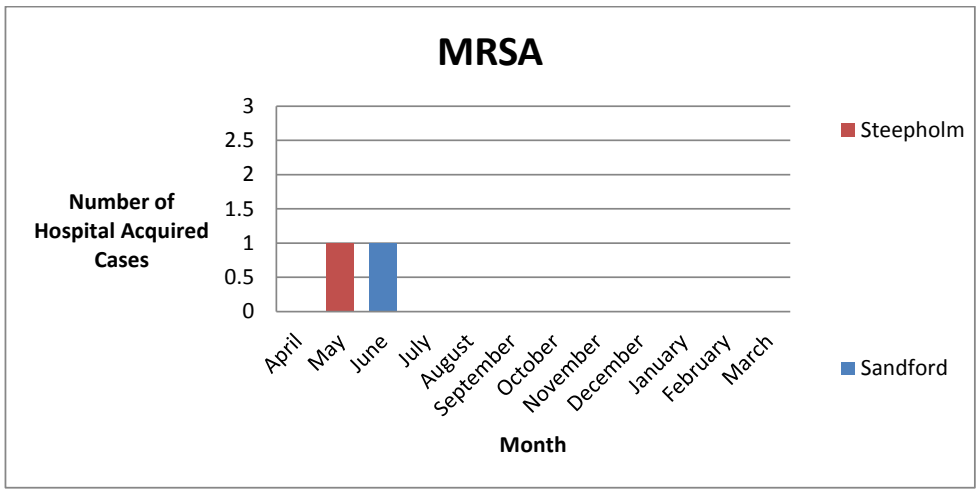
The Trust will continue to support the work across the local health community and meets quarterly with the Commissioners to discuss and improve antimicrobial prescribing and to review learning from incidents across the health care economy.

MRSA (Methicillin Resistant *Staphylococcus Aureus*) bloodstream infections

All MRSA bloodstream infections are reported nationally and are assigned as being related to the Trust, or not related to the Trust (acquired in the community or other settings) following a post infection review.

Two cases were reported during 2019/20 against the Trust's zero threshold. The cases were both fully investigated and involved patients that had previously been colonised with MRSA. No lapses in care were able to be identified that directly contributed to these cases. Learning was identified, however, in relation to peripheral vascular cannula documentation in one of the cases. Work is ongoing to improve compliance with this.

Total MRSA cases 2019/20



MSSA (Methicillin Sensitive *Staphylococcus Aureus*) bloodstream infections

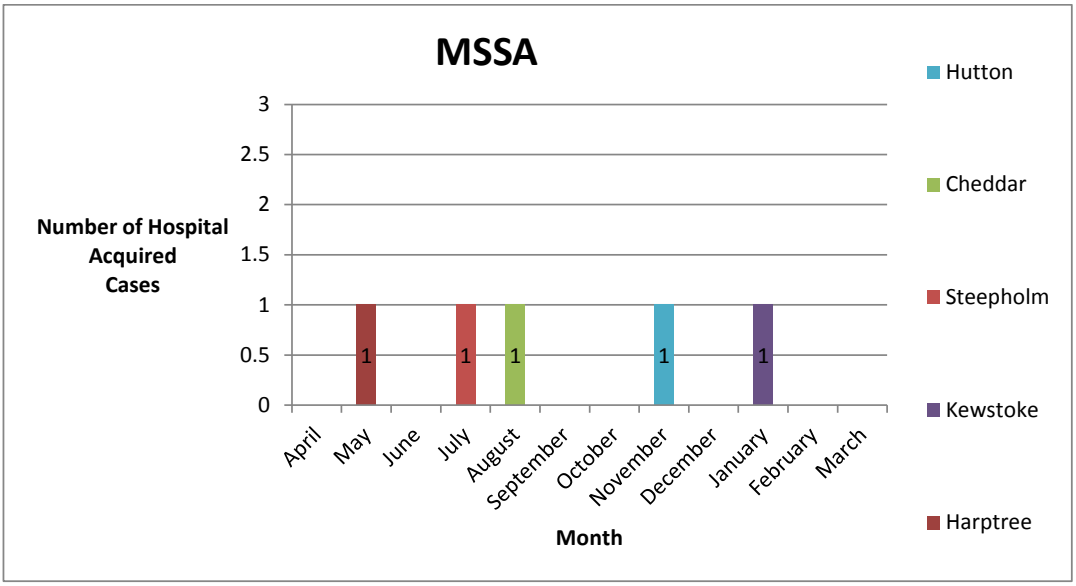
The same reporting and investigation for MSSA bloodstream infections is carried out as for MRSA infections.

The Trust has seen a 45% decrease in the number of cases of MSSA reported this year, reporting five cases compared to nine in 2018/19.

Post infection reviews for each case were completed. One of the cases was related to the care of invasive devices, particularly a peripheral vascular cannula (PVC). A piece of work to improve compliance with invasive device care is ongoing and is being led by our practice development nurses.

Other sources of MSSA infection were the urinary tract and soft tissue.

Total MSSA cases 2019/20

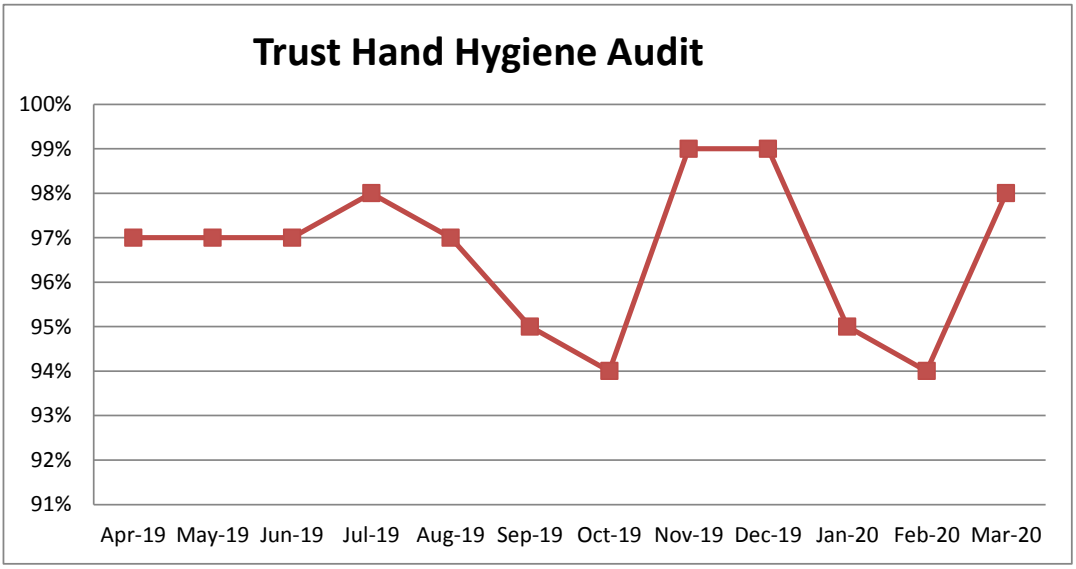


Hand Hygiene Audit

Monthly internal audits continue to be undertaken by the Ward Sisters. Peer audits have also been undertaken by Ward Sisters from different wards. Hand hygiene is audited in all clinical areas and departments using the Infection Prevention Society's Quality Improvement Tools. This encompasses the World Health Organisation's '5 moments of hand hygiene' to determine compliance and identify specific areas for improvement. 'Bare below the Elbow' compliance is continually monitored in the clinical areas and any concerns addressed at the time of the audit.

External validation hand hygiene audits are completed quarterly in four different clinical areas. The areas chosen for these audits are not just those with a low compliance percentage but those areas that consistently report 100%. Results from these audits are often lower than the ward reported audits and areas for improvement are always fed back to the respective teams.

Hand Hygiene Audits 2019/20



Escherichia coli bloodstream infections

There has been a continued focus this year on the reduction of *Escherichia coli (E. coli)* bloodstream infections. *E. coli* infections represent 65% of Gram-negative infections and there is a UK government ambition to significantly reduce them. The Clinical Commissioning Group set the Trust a 10% reduction ambition of healthcare associated cases against our 2018/19 data.

Over 85% of *E. coli* bloodstream infections are present when the patient is admitted to hospital. The cases that develop in hospital (healthcare associated) are fully investigated and any learning identified is shared with both the medical and nursing teams.

The Trust reported 129 cases of *E. coli* bloodstream infection in 2019/20, of which 19 were deemed healthcare associated. This compares to the Trust reporting 127 cases in 2018/19 with 22 assessed as healthcare associated. The further 10% reduction ambition set by the Clinical Commissioning Group has therefore been met.

Mortality Outcomes – SHMI Data

The Trust reviews a large number of indicators on a regular basis to ensure that patients receive safe and effective care when receiving treatment in the hospital.

A key indicator is the Summary Hospital-level Mortality Indicator (SHMI) which is published on a quarterly basis from NHS Digital. SHMI compares the actual number of deaths following time in hospital with the expected number of deaths. The expected number of deaths is estimated using the characteristics of the patients treated; age, sex, method of admission, current and underlying medical condition(s). It covers patients admitted to hospitals in England who died either while is hospital or within 30 days of being discharged. A higher number of deaths than predicted can be an early indication of unrecognised problems with aspects of patient care.

The trust's Clinical Effectiveness Group monitors several different mortality measures on a monthly basis and has looked at specific patient groups or disease types to ensure that there are no patterns of care that might have contributed to a higher than predicted number of deaths. The group also ensures that learning from reported incidents of harm or poor care are shared widely within clinical teams and (where appropriate) lead to focused quality improvement.

The Trust's SHMI has remained within the expected range since December 2017 and has been consistently below the average for all acute Trusts in England since March 2018

Weston Area Health NHS Trust	April 18 to March 19	July 18 to June 19	Oct 18 to Sept 19
SHMI value	0.88	0.92	0.98
National Upper Limit	1.18	1.14	1.14
National Lower Limit	0.88	0.88	0.87
Banding	As expected	As expected	As expected

From 1st April 2020 the newly merged University Hospitals Bristol and Weston NHS Foundation Trust will continue to publish its SHMI and monitor the quality and effectiveness of its care.

Venous Thromboembolism (VTE)

Venous thromboembolism (a blood clot in the veins) is considered one of the commonest causes of serious avoidable harm for patients in hospital. Ensuring that all patients admitted for care are assessed for their risk of blood clots and given appropriate treatment to prevent them is a vital part of keeping our patients safe.

We have continued to educate all clinical staff about the importance of risk assessment in the prevention of harm from venous thromboembolism. The topic is covered at junior doctor induction and has been the subject of a safety poster campaign.

The trust has achieved the national standard of greater than 95% of eligible inpatients for each quarter of the 2019/20 financial year. Each case of hospital acquired thrombosis (where a patient has developed a blood clot in hospital or soon after discharge is subject to an independent review from a senior clinician to look for any failures in our assessment or treatment processes and lessons learned are reported through the trusts harm free care group to the Quality and Safety Board sub-committee.

We will continue to ensure we exceed the national requirement to risk assess patients for VTE. Following the merger with University Hospitals Bristol, and implementation of the Trusts digital transformation programme, the audit of VTE risk assessment will be automated, increasing the capacity of the quality improvement team. The oversight of the prevention and treatment of VTE will pass to a Venous thromboembolism group within the corporate governance structure of the new organisation.

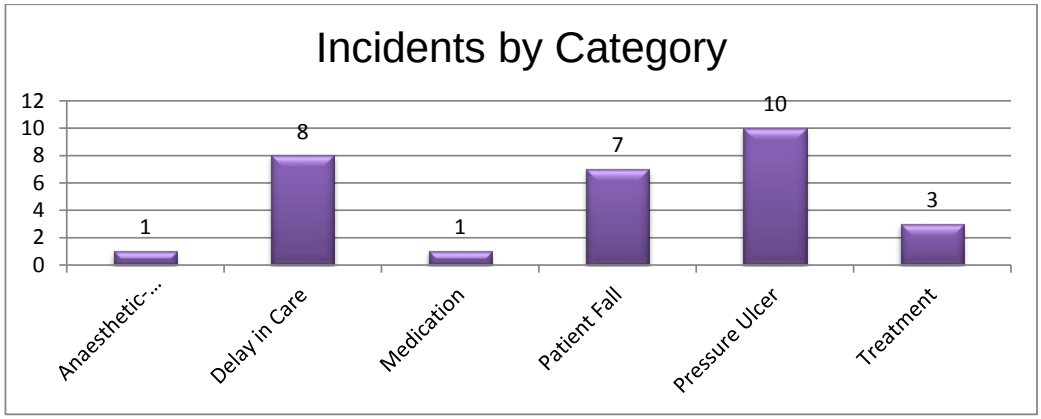
Patient Safety Incidents 2019/20

Serious incidents identified and reported within in an organisation help to understand what is happening, promotes learning, sharing of lessons learnt and identifies actions being taken to reduce any further incidents occurring.

The total number of serious incidents reported within WAHT for 2019/20 was 30 compared to 42 in 2018/19 and 53 in 2017/18 This shows a 57% decrease in serious incidents over the last 2 years. The organisation has a robust process whereby incidents are reviewed by the Executive Review panel, before being identified as a serious incident, which then requires a full investigation through a root cause analysis methodology and reporting to the national Safety database (STEIS).

There has been a Trust wide focus and training on improving the reporting of incidents and the closure of them to ensure that learning is extracted and shared.

Serious incidents by category



All serious Incidents have robust action plans developed, which are implemented to reduce the risk of an incident recurring.

The number of patient safety incidents reported within WAHT during 2019/20 and the number and percentages of such patient safety incidents that resulted in severe harm or death are presented in the table below.

Reported safety incidents and serious Incidents

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Number of Patient Safety Incidents	1587	1752	1635	884	5858
Incidents of Severe Harm	13	18	11	9	22
Percentage of Incidents with Severe Harm	0.8%	1 %	0.3%	0.6%	0.4%
Number Serious Incidents	9	12	6	3	30
Percentage of Serious Incidents	0.6%	0.7%	0.4%	1 %	0.5%
Total Number of Never Events	0	0	1	0	1
Data Source: NRLS and Internal Datix					

Never Events

Never events are a medical error that should never happen within a hospital. Never events can be defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers.

There has been one Never Event within WAHT which was reported in December 2019, this was reviewed by the Executive panel and declared a Never Event and has been identified as wrong site surgery and reported externally.

Friends and Family Test – Patients

The Friends and Family Test is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. As well as the standard six-point response for wards we have included additional questions to generate a richer data base to inform learning and change. The Trust introduced this survey tool in January 2013 for all acute wards and the Accident and Emergency (A&E) Department. In October 2013 the survey was extended to include Maternity services. Each Directorate and ward receives a breakdown of the outcome of their survey results to allow them to take relevant action. In October 2014 the survey was extended to outpatients.

The Trust Friends and Family response rate and recommendation score is compared with the average scores for NHS acute services across England.

The results for 'Would Recommend' have been calculated using the formula:

$$\text{Recommend (\%)} = \frac{\text{(Extremely Likely + Likely)}}{\text{All responses}} \times 100$$

The responses are divided into four categories; inpatients outpatients, maternity and A&E attendees. Our maternity, outpatients and results and A&E recommendation score has compared favourably with the national average. It should be noted that the Trust does not provide a service for Postnatal Care in hospital (Trust 3).
The tables below give further detail.

			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Would Recommend	In-Patient	Trust	98%	96%	96%	97%	97%	98%	96%	97.%	98%	98%	98%	NR
		England	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	NR
	A&E	Trust	93%	93%	98%	95%	92%	92%	95%	94%	92%	93%	92%	NR
		England	85%	86%	85%	85%	86%	85%	85%	84%	84%	85%	85%	NR
	Out patient	Trust	93%	97%	96%	97%	95%	98%	98%	97%	99%	97%	99%	NR
		England	94%	94%	94%	94%	98%	98%	94%	94%	94%	94%	94%	NR
	Maternity	Trust 1	100%	100 %	100 %	NR	NR	100 %	NR	NR	NR	NR	NR	NR
		England	95%	95%	95%	95%	94%	95%	95%	95%	95%	95%	95%	NR
		Trust 2	100%	100 %	100 %	100 %	100 %	100 %	NR	NR	NR	NR	NR	NR
		England	96%	97%	95%	95%	96%	97%	97%	96%	97%	97%	97%	NR
		Trust 3	NR	NR	NR	NR	NR	NR	100 %	NR	NR	NR	NR	NR

		England	95%	95%	97%	97%	96%	95%	96%	94%	95%	95%	95%	NR
		Trust 4	100%	94%	100 %	NR	100 %	100 %	100 %	100 %	NR	NR	NR	NR
		England	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	NR
Response Rate	In-Patient	Trust	44.89 %	46.3 1%	46%	44.2 6%	42.9 2%	37.8 5%	42.7 3%	40.1 8%	39%	39%	39%	NR
		England	24.8%	24%	25.1 %	26.1 %	25.6 %	25%	25%	24.8 %	22.6 %	24.4 %	24%	NR
	A&E	Trust	5.53%	3.56 %	3.68 %	5.24 %	4.68 %	2.93 %	11.2 9%	10.8 5%	9.04 %	10%	9%	NR
		England	11.5%	12.1 %	12.1 %	12.4 %	13.3 %	12.2 %	12.6 %	12%	11.6 %	12.1 %	11.7 %	NR
	Maternity (Births)	Trust	18%	11%	9%	3%	9%	8%	NR	NR	NR	NR	NR	NR
		England	20.5%	19.7 %	20.5 %	21.3 %	21.1 %	20%	19.8 %	20.9 %	18.2 %	19.9 %	18.6 %	NR

Friends and Family Test –Staff

The staff friends and family test (SFFT) is an organisational temperature check to see how staff are feeling. It takes place every quarter except for quarter 3 when the National staff survey is undertaken.

Staff are asked to answer two questions and have the opportunity to provide more detailed comments.

The two questions we ask are:

"How likely are you to recommend this organisation to friends and family if they needed care or treatment?"

"How likely are you to recommend this organisation to friends and family as a place to work?"

Staff friends & family results 2019/20

Staff Friends and Family Test Results 2019/20						
	Quarter 1		Quarter 2		Quarter 4	
	Question 1	Question 2	Question 1	Question 2	Question 1	Question 2
Recommended	69%	56%	63%	49%	61%	50%
Not Recommended	13%	23%	12%	29%	14%	25%

Part 3: Other Information

This section provides an overview of the quality of care offered by Weston Area Health NHS Trust based on performance in 2019/20 against indicators selected by the board in consultation with stakeholders. These indicators have been chosen as they detail the activity undertaken within the Trust to promote the safety and experience of our patients.

Unless otherwise indicated within the text the data provided all comes from internal sources within the organisation.

Patient Safety

The safety of our patients is central to everything that we want to achieve as a provider of healthcare. We are committed to continuously improve the safety of our services, and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by successfully implementing proactive patient safety improvement programmes and by working to better understand and improve our safety culture. We will also continue to conduct thorough investigations and analyse when things go wrong, identifying and sharing learning, and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident, and will strive to eliminate avoidable harm as a consequence of care we have provided.

Sign up to Safety

We remain committed to the Sign up to Safety Campaign and the five key pledges; these are evident throughout our quality priorities for 2019/20.

The five key pledges are:

1. Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.
2. Make organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring the safety of services.
3. Be transparent with people about progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
4. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
5. Help people to understand why things go wrong and how to put them right, including giving staff the time and support to improve and celebrate the progress.

Falls

Every year patients in Weston Area Health NHS Trust fall and injure themselves.

Sometimes severely and often the fall results in the person needing to stay in hospital and can permanently reduce their physical and mental health and wellbeing. Sometimes these falls could have been prevented, or the repercussions of the fall reduced.

The overarching falls reduction programme has been to focus on timely interventions to prevent falls by identifying those;

1. Likely to have a fall, through risk assessment.
2. Helping those likely to fall, through care planning.
3. Working effectively with patients who have fallen to help reduce the likelihood that they will fall again, through physiotherapy assessment and with enhanced nurse supervision to maintain safety and build confidence.

The key elements that the teams have focused on in 2019 – 2020 were;

1. To have a clutter free ward that assesses hazards that can cause trips or falls → twice a year environmental audits were introduced which have been used to effect improvements in the clinical areas.
2. Effective risk assessment and care planning → continued to imbed the multidisciplinary risk assessment for falls prevention.
3. Patients undergoing enhanced supervision → ABC observations
   - **Activity** prior to behaviour – Did anything provoke behaviour?
   - **Behaviour** – What is the patient actually doing?
   - **Consequence** – What was your reaction?
   - How did the patient respond?

This has helped us to understand patients who are experiencing delirium and how they respond to stimuli. This has allowed for meaningful interaction and care planning along with inclusive decision making for both the patient and the carer.

4. Bay "tagging" → a concept in workforce planning for the shift to ensure that a nurse is present in a bay at all times. This has been helped with the introduction of Allocate an electronic on duty rota for nurses which allows for three times a day assessment of acuity and dependency on the wards.
5. Ward to board reporting aided by a detailed falls dashboard → this allowed teams to assess areas of risk during high activity on their wards which allows staff to be deployed effectively.

Together this has resulted in a 15% reduction in falls when compared to same time period in 2018 – 2019

What did we do?

The team has continued to build on the work of 2018 – 2019 as mentioned and during 2019-2020 focused on the following key actions that also have direct links to the CQUIN CCG7: Three high impact actions to prevent hospital falls in practice:

1. Delirium pathway – This has been led by the frailty team. A new pathway has been tested and supported by the medical team which has resulted in staff being now aware of the signs of delirium and together with the ABC observations have helped to identify triggers and risky behaviour that may lead to a fall especially in the care of the elderly and orthopaedic and trauma wards. When the pathway is applied the use of hypnotics or antipsychotics or anxiolytics is now clearly documented with rationale.
2. Get up, keep moving – Prevent muscle wasting and therefore preventing falls from fatigue. The concept of walk with me, not sit with me has been encouraged with the aid of the physiotherapy team and encourages patients to mobilise and walk with staff. When the falls risk assessment and mobility risk assessment are managed appropriately it allows for the correct use of mobility aids to be made available and build individual confidence to maintain a level of independence
3. Trust-wide Safety Week – The practice development nurses spent time with teams asking

"Why do we undertake a falls Risk assessment?" and "What is the importance of a lying and standing blood pressure?" - Simple conversations and active learning at the bedside was received well in the clinical areas from staff, patients and families. This was extended to the Emergency Department who now actively participate in the falls reduction programme especially for patients who are admitted following a fall as if appropriate they will assess lying and standing blood pressure on admission.

What difference did it make?

Data from April 2019 to January 2020 demonstrated:

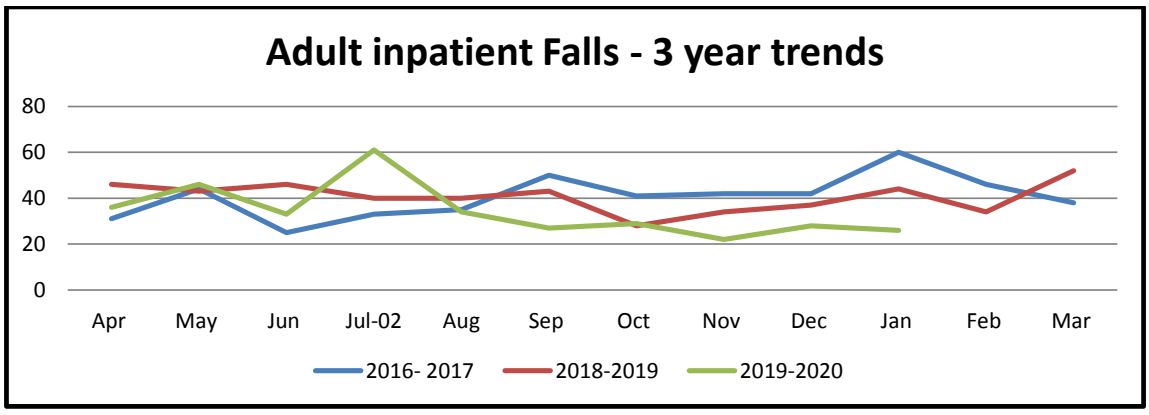
1. Reduction in total falls by 59 (15%) in year.
2. No reduction in falls with harm with 7 incidents that required further investigation and went on to become Serious Incidents for further investigation.

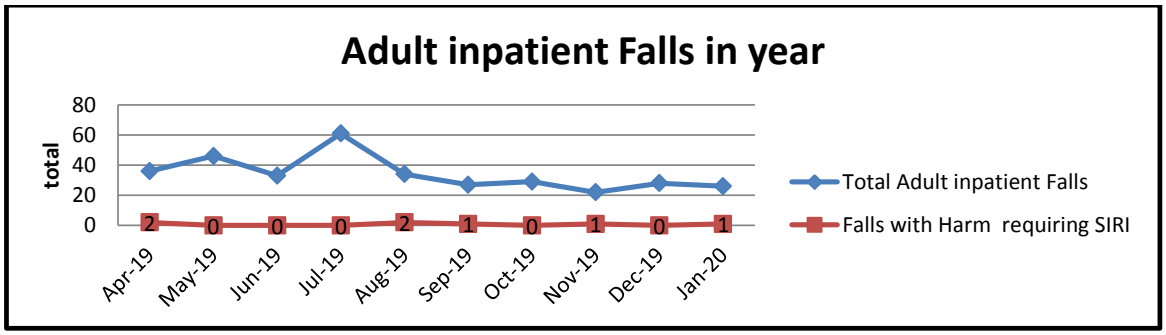
Safe levels of care are maintained. Following the introduction of a new electronic nurse staffing system (Allocate) Matrons have been able to monitor acuity and dependency levels on the wards in real time. This has demonstrated that safe levels of care were maintained and those patients at risk have been supervised.

CQUIN data and improvements in care have been met.

On average (for the 10 months) this means that there has been.

1. 1.1 falls per day = reduction of 0.21
2. 34.2 falls per month = reduction of 5.9





What will we do next?

A Thematic review of the 7 falls with harm requiring a serious incident review has shown that learning and improvement needs to be focused in the following areas

1. Risk assessment in regards to bed rails – when to use, and when it is best to leave down.
2. Strengthening the mobility programme- Continue to work with the physiotherapy team.
3. Education and training leading to improve care planning and management of those patients who are suffering with delirium especially it they are experiencing terror, resulting in aggressive behaviour.
4. Care planning with families for those patients who have been admitted following falls. This needs to include realistic care planning and future care needs.

Pressure Injuries

We continue our attempts to reduce avoidable pressure injuries for our patients, particularly the deeper injuries which are serious incidents because of the harm they cause to our patients.
In 2018/19 we had 8 grade 3 pressure injuries and 1 grade 4. In 2019/20 we have reported the same number of deep pressure injuries; therefore we did not achieve our target of 50% reduction grade 3's and 100% reduction of grade 4's. However the number of Grade 2 pressure injuries have reduced by 18%. Grades 2's have a Directorate Level SWARM completed and for every Grade 3 or 4 there is an Executive Level SWARM. This enables any immediate learning to be shared across the Trust and will be discussed at the Pressure Ulcer Steering group. A SWARM is where a rapid response to a patient incident occurs, staff come together to discuss the incident, allowing a quick investigation and prompt action to be taken if required.

We focused on developing our leadership and developing staff knowledge of promoting tissue viability through implementing education at Thursday teaching sessions.

A decrease in resource for the team this year has reduced the education and learning opportunities. Wound care representatives have been utilised as a teaching resource to assist the tissue viability nurse.

We are working collaboratively with our North Somerset Community Partnership now Sirona, for national initiatives and with the BNSSG CCG for example working together, and will continue to improve patient care and enhance patient safety and satisfaction.

With the merger with University Hospitals Bristol NHS Foundation Trust there will be changes within the tissue viability team which will support the workload capacity of the tissue viability nurse.

Preventing clinical deterioration of the patient and Sepsis

During 2019/20 we continued to work on improving the recognition, escalation and management of deteriorating patients. The most common cause of patient deterioration includes sepsis, blood clots developing within the lungs, sudden onset of confusion, and acute kidney injury (AKI). All conditions were included within the wider deteriorating patient programme. In line with the neighboring Trusts in BNSSG to monitor a patient's risk of deterioration we changed from the first National Early warning score (NEWS) to NEWS2. This means that all inpatients within the hospital have their physiological observations (respiratory rate, levels of oxygen, pulse, blood pressure, level of consciousness and temperature) measured and recorded in accordance with the Hospital Deteriorating Patient and Escalation Policy.

Cardiac arrests in hospital are rarely a sudden event, so we have tried to reduce our number of cardiac arrests by focusing on implementing the NEWS2 scoring and escalation of unwell patients to prevent further patient deterioration and cardiac arrest occurring.

What did we do?

We continued to develop the two Quality Improvement (QI) projects for the deteriorating patient and one for escalation of the deteriorating patient. The aim is to improve the number and quality of the Safety Huddles, and ensure an accurate National Early Warning Score (NEWS2) monitoring through the following interventions:

- Escalation and use of Situation, Background, Assessment, and Recommendation (SBAR).
- Increasing the education around deteriorating patient, monitoring of patients deteriorating and escalation to the appropriate medical teams.
- A quality improvement week titled 'Good NEWS2 week' took place in January 2020, where all inpatient NEWS2 charts were reviewed and audited against the Trust policy.
- The 'Deteriorating Patients' audit questions on Perfect Ward were reviewed and improved, to ensure the monitoring of NEWS2 and fluid balance charts were sufficient.
- Continued to improve NEWS2 scoring and vital signs recording, as we recognise this is the most effective tool for identifying at-risk and deteriorating patients.
- All clinical and non-clinical staff joining the Trust are trained in Sepsis awareness and promotion at Trust induction.
- There is a strong emphasis on sepsis care throughout the organisation where we have created a learning culture and sharing of safety lessons to learn from past harms and we look at what we can do to improve care using quality improvement methodology.
- A sepsis champion role has been maintained, where Registered Nurses and Nursing Assistants deliver further sepsis training to their teams and discuss good practice.
- The Sepsis screening tool derived from the National Institute of Clinical Excellence (NICE) guidelines has continued to be proactively used in the Emergency Department. This helps us to ensure patients are being screened for sepsis and treated quickly.

What difference did it make?

- 'Good NEWS2 Week' highlighted areas of potential improvement needed to see an improvement in the accurate recording of NEWS2 scores.
- We have seen an increase in the percentage of observations being recorded in the Emergency Department when a patient is admitted.
- We have increased our staff confidence in caring for a deteriorating patient by using simulation scenarios and holding deteriorating patient study days provided by the Trust Resuscitation officer.
- We have seen an increase in appropriate medical plans being put in place for patients who have become unwell, thus helping us keep those patients safe.

- There has been continued improvement in the reduction of true cardiac arrests within the hospital.
- We have increased the training of staff of the deteriorating patient through practical assessment, simulation and focused debriefing for all foundation doctors and nursing staff.

What we plan to achieve for 2020/21

We will be implementing electronic observations which are proven to assist with recognising early signs of deteriorating patients and cardiac arrests. This project is to be implemented across the Trust with an electronic vital signs capture and messaging system called Careflow Vitals.

This will allow staff on the wards and across the Trust to have greater visibility of their most critically unwell patients. The system also supports staff at the time of taking observations with early actions required if observations are abnormal.

Careflow Connect will also be rolled out Trust-wide to link to Careflow Vitals. “CareFlow Connect” is a secure and mobile clinical communications and collaboration solution designed to facilitate faster and safer care co-ordination for teams within Weston Area Health NHS Trust. Initially it is hoped this system will be used to inform the Critical Care Outreach Team of patients requiring urgent assessment at the immediate time of their electronic observations being completed on Careflow Vitals.

Managing patient safety incidents and duty of candour

Duty of Candour was introduced for HealthCare providers after the publication of the Francis Inquiry in 2013 this looked into the failings of the Mid Staffordshire NHS Foundation Trust. There is a contractual requirement to undertake duty of candour for NHS bodies in the standard contract, and professional requirements for candour in the practice of a regulated activity. In interpreting the regulation on the duty of candour we use the definitions of openness, transparency and candour.

- Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question is asked about.

Weston Area Health NHS Trust is committed to minimising the risk of harm to patients in the course of their treatment and care. However incidents do occur and we aim to adopt a proactive approach to prevent incidents and learn lessons to improve patient safety. Occasionally people in our care are involved in a safety incident. A small number of these incidents cause harm.

When things go wrong, we have a duty to inform our patients and their families what has happened. This is very much part of our culture. Last year we produced patient and staff leaflets about the duty of candour to help our staff follow the correct process and this helps our patients and their loved ones understand what will happen.

We are committed to talking to patients and their carers at a very early stage to explain our investigation process, understand what happened and, where necessary, learn the lessons that will prevent it happening again to improve the safety of our future patients.

If something happens, we investigate the incident or complaint and:

- Ask how much the patient and their relatives or carers wish to be involved in the investigation process.
- Review the patient's medical and nursing notes.
- Talk to the staff involved in the patient's care.
- Identify the cause(s) of the incident.
- Share our findings with the patient, their family or carers.
- Share learning and improvements across the Trust.
- Let the patient and their family or carers ask any questions.

A member of the investigation team will sometimes meet with the patient and / or their loved ones to talk to them about what went wrong. This will usually be the consultant or nurse looking after them. The patient's family or a friend can attend this meeting and be part of these conversations.

We have also introduced an audit of compliance for completion of the Duty of Candour process.

Seven Day Service

10 clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

Standard 2 – Time to first consultant review

Standard 5 – Access to diagnostic tests

Standard 6 – Access to consultant-directed interventions

Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others.

We recognise that as a small Trust we have significant challenges in meeting all of the requirements of the 7 Day Standards. Our workforce challenges mean that increasing staff cover to ensure clinical services are identical across 7 days is not practical.

We have focused on key areas of improvement, including ensuring accurate documentation of the timeliness of consultant review, and working with other hospitals in the area to ensure formalised pathways to allow patients to access diagnostic tests at weekends.

The results of the Trust's Seven Day Service Audit in November 2019 demonstrated a significant improvement in response to concerted quality improvement work around documentation The proportion of patients reviewed by a consultant within 14 hours of admission at hospital - weekday = 83%; weekend = 77%; total 81%. Whilst this does not achieve the 90% standard it represents a 65% improvement on the 2018 data.

The Trust reported achieving standard 5 and 6 and partial achievement of standard 8 (100% of patients requiring twice daily senior review received this although the daily review of all stable

patients remains challenging at weekends when numbers of senior staff are reduced.

Further analysis of the weekday data suggests that the trust is able to achieve 100% on some weekdays but performance dips during time of operational pressure. This is likely to be due to a backlog of patients waiting for assessment by the medical team in the afternoon and evening that therefore miss an opportunity for evening review by the medical consultant in the evening. The trust has expanded the established numbers of medical registrars to allow an extra medical registrar to assess patients in the evening when we recognise admissions increase, however slow recruitment means that this is likely to come into effect in 2020. Weekend reviews have also improved and it is recognised that the current operating model for surgical review at weekends does not support compliance. From April 2020 the trust will seek to implement new surgical care models following the Healthy Weston service review and consultation. A move to focus on an ambulatory surgical model provided 7days per week across 12 hours will mean that a reduced number of patients will be admitted and there will be an increase opportunity for consultant review at the weekends.

It is anticipated that the forthcoming merger with University Hospitals Bristol NHS FT will allow further scope for improvement in all of the 7 day service standards as new models of care are implemented and clinical integration further improves weekend staff cover.

Patient Experience

Improving Patient Experience

We aim to provide exceptional quality services for our patients ensuring the patient experience is to a high standard and fulfils their needs and expectations. From reviewing the annual National patient survey results with staff, patient representatives and members of Healthwatch we are focusing on aspects that are important to patients and those that have higher problem scores. The agreed areas for improvement are developed with staff and patients.

The annual adult inpatient survey is carried out in all Trusts (www.cqc.org.uk) by a company called the Picker Institute. The findings from the survey are received in January each year and public report is received in February from the CQC which includes benchmarks against other NHS Trusts.

The survey asks the views of people that have stayed in hospital at least one night as an inpatient. Patients are asked what they thought about different aspects of the treatment and care they received. The purpose of the survey is to understand what patient's think of the services provided by the Trust; from the patients perspective what are their priorities and concerns.

The survey was sent to discharged inpatients who attended Weston in the summer of 2018. 1179 questionnaires were sent to patients who were eligible to complete the survey. The Trust received 604 completed responses giving a response rate of 51%. This was an improvement from 2017 which was 45%.

The survey highlighted many positive aspects of the patient experience.

- Discharge: delayed by no longer than 1 hour 22%.
- Hospital: food was very good or good 65%.
- Hospital: did not share sleeping area with opposite sex 96%.
- Admission: did not have to wait long time to get to bed on a ward 69%.
- Discharge: was not delayed 63%.

Pleasingly the report indicates improved responses regarding;

- Hospital: not bothered by noise at night from other patients 60%.
- Nurses: always or nearly always enough on duty 59%.
- Discharge: told of danger signals to look for 60%.
- Procedure: told how to expect to feel after operation or procedure 90%.

Involvement of Patients and the Public and Involving our Board in staff and patient experience

The voice of the patient and our staff is highly valued at Weston Area Health NHS Trust. Every second month patients/carers and staff share a story at the Public Trust Board meeting, this is also shared with staff through various forums.

These have included patients attending the Board to tell their story and some telling the story to our Patient experience team who convert this into a presentation format. Some examples are positive and excellent experiences of care and others where the Trust recognises that we have not got it right and need to make a change. One such example which has led to a change was the cancellation of surgery procedure and ensuring that patients are not kept nil by mouth for an extended period of time when this occurs.

A patient council representative also attends the Trust Board in order to share the patient experience agenda and they are also active within different committees such as Quality and Safety, Nursing and Midwifery, Patient Experience Review Group, Infection Control committee and Clinical Effectiveness Group. They are also active in a number of audit projects. Ongoing recruitment to the Patient Council is essential to continue to maintain the value of their contribution.

Supporting our Workforce - Staff Survey Questions

Improvement in Staff Attitude Survey scores for:

Health and wellbeing

There has been an increase in staff reporting that the trust takes positive action on health and wellbeing, improving from 20.6% in 2018 to 22.1% in 2019.

There has also been a slight decline in staff felling unwell as a result of work related stress, from 40.8% in 2018 to 40.5% in 2019.

Managers and colleagues

The encouragement staff get from their managers has stayed relatively static (64.8% in 2018 to 64.5% in 2019).

Staff report being increasingly involved in choices about how they do their jobs (54.4% in 2018 to 54.4% in 2019).

Respect between colleagues has increased, with 71.5% of staff reporting in 2019 that they receive the respect they deserve at work, compared with 67.2% in 2018. This is mirrored in a reported improvement in relationships between colleagues, with a reduction in people reporting that

working relationships are strained from 42.7% in 2018 to 40.8% in 2019.

Staff engagement

There has been a slight increase in staff looking forward to coming to work (up to 54.8% in 2019 from 54.4% in 2018) and feeling enthusiastic about their job (up to 75.1% in 2019 from 72.3% in 2018.

Supporting Apprenticeships

The Trust recognises the important contribution that apprentices can make to the workforce and also the importance of ensuring that our valued staff have a platform that supports their professional and personal development.

Working with our procured educational providers, and the regional Sustainability and Transformation Partnership (STP), we have continued to procure a wider range of apprenticeships to meet the various demands of the workforce. We have continued to recruit a number of apprentices into both administrative roles and nursing roles.

With the proposed merger with UHBristol, as a trust we look forward to the joint relationships we can build on to develop a sustainable workforce which will focus on the apprentice, this will include nursing apprenticeships.

Continuing Professional Development

Competent staff with regular access to training, who work well in teams, and are supported by effective leaders deliver safer, more effective care. Developing the skills of our workforce is vital in ensuring that our staff remain up-to-date with best practice. The organisation offers various Continuing Professional Development (CPD) opportunities from academic courses, apprenticeships, to one-off training events and attendance at regional and national conferences. During 2019/20 we were successful in securing funded places at University of the West of England (UWE), these courses ranged from enhancing specific clinical knowledge to developing leadership and innovation.

Course	Number of Staff Attended
Post Registration Academic Courses undertaken	49
Clinical Skills Days	433
Conferences and Workshops	24
HR Courses	166
Management & Leadership Courses	74
E-Learning courses for CPD	231
Teaching Thursdays	788
Total	1,765

During 2019/20 we have employed a dedicated Practice Development Nurse (PDN) in the Emergency Department who works alongside the other PDNs to support our staff development. These staff join the practice development staff employed in the Theatre Unit to provide face to face support for all staff as required. The Practice Development Team also work closely with the Trust Specialist Nurses to provide weekly bespoke training for all staff on 'Teaching Thursday'. These sessions have been well attended and received by staff at all levels and will continue throughout the coming year.

During 2019/20 we have collaborated with the Management Trainer at University Hospitals Bristol NHS Foundation Trust, to deliver a 2 day Leadership for Managers course specifically aimed at Band 6 and 7 managers.

Learning from PALS and complaints

The Trust has a well-established Patient Advice and Liaison Service (PALS) and a complaints-management system, supported and facilitated by a Senior Manager. Both services are used to ensure that patients and people using Trust services are supported in navigating the system and finding resolution to questions, concerns and complaints. The information from these questions, concerns and complaints is routinely analysed and used to inform service development and reported to the Trust Board through formal monthly reports.

The Senior Manager for complaints and PALS actively engages in supporting the development of staff to ensure they are able to respond appropriately and sensitively to complaints, whilst handling sensitive situations and data. Staff training in complaints resolution is available a part of the Trusts annual corporate training programme and remains high on the training agenda for the Trust.

The Trust received a total of 213 formal complaints during 2019/20 which represents an increase from the 2018/19 total of 181.

The Trust looks for trends in complaints to see if there are any recurring or growing issues that may need special attention. The main subjects of complaint are around communication and medical treatment: with communication the most significant theme. Discharge is one of the top three of the complaint themes.

To improve the standards of care the Trust has delivered a number of initiatives related to main themes:

Communication

- Care Rounds have been introduced on the medical wards to improve communication with patients and relatives by both clinical and nursing staff.
- To ensure the patient is fully aware of where they are on their care pathway and know when all their appointments are the pathways specific in relation to communication have been strengthened between the administration staff and the patient.

- The Nurse in charge of the shift wears a red badge so that they are clearly identifiable to patients and visitors.
- To refocus staff on dignity and respect in care the Trust has reintroduced “my name is”; running focused training sessions for staff and promoting through trust wide communication.
- Visiting hours were extended to allow family to communicate with doctors for effectively and in a timelier manner.
- Training on effective communication skills for all clinical staff in the Emergency Department was delivered in August and November by the Emergency Medicine Consultants and Senior Nursing Team which has resulted in an improvement in the feedback from patients related to communication.

Medical treatment from doctors

The Emergency Department have developed a specific pathway on managing and investigating falls, hip fractures and ongoing limb pain, to be followed for patients with or without a history of a fall to improve patient safety through effective risk assessment.

Throughout the year the themes of all complaints are reviewed. Directorates report on the learning that has been identified from the complaints resolved during the month. The Matrons and Departmental Managers ensure that any learning identified through complaints is shared across teams within the Directorates and that all improvements identified are fully implemented.

Complainants are always invited to come into the Hospital and discuss their concerns with the relevant staff, and this helps staff to get a better understanding of how things are from a patient’s or family’s perspective as well as helping patients and families to hear the staff view.

The table below shows the main types of complaints received during 2019/20 and the changes from last year.

Main types of complaints received during 2019/20:

	2017/18	**2018/19**	**2019/20**
Complaints about staff attitude - %	12% (50)	10% (33)	9% (19)
Complaints about discharge arrangements -%	8%(35)	10% (34)	13% (27)
Complaints about medical treatment - %	29% (118)	22%(75)	37% (78)
Complaints about nursing care - %	9% (38)	11% (38)	12% (25)
Complaints about communication - %	25% (104)	30% (103)	22% (47)

Parliamentary and Health Service Ombudsman

The Parliamentary Ombudsman can investigate complaints when individuals feel they have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England. The Ombudsman can decide not to investigate, to agree with how the original complaint was dealt with, or to uphold a complaint and insist that the public organisation puts things right.

During 2019/20 there was one complaint referred and accepted for investigation by the Ombudsman. This case was not upheld by the Ombudsman.

Perfect Ward

Perfect Ward is the smartphone application (app) used for healthcare inspections, led by ward sisters and matrons. The app releases time for senior clinical staff to provide direct patient care, it also enables access to real time information. Perfect Ward reporting provides assurance for leaders that the quality of care that is being delivered, is at a consistent high standard.

What did we do?

The Perfect Ward app was implemented in 2016 at Weston Area Health NHS Trust. Throughout this time it has been refined and adapted to the required need, there are selected questions relating to the standards of care, defined by the Care Quality Commission (CQC) which helps our staff and patients ensure that their areas are meeting the CQC five domains which are:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are services well led?

In 2019, all questions were reviewed and significant improvements were made to the inspection questions. The vast majority of questions originated from recurrent themes highlighted in patient safety incidents, many were also improved to reflect updated current practice.

Patient experience and staff wellbeing questions were added to capture how our staff and patients feel and what we could be doing better. This helps teams and services provide sufficient assurance to demonstrate we are doing all we can to improve and share learning and safety lessons.

What difference did it make?

- With all inspection questions being service specific, there has been an uptake in clinical inspections being completed on time and in more areas, such as Oncology and Haematology Day Unit and the Intensive Care Unit.
- It has enabled us to receive real time results and feedback on the quality of care being delivered.
- It has enhanced the quality of the inspection audits, working and collaborating with teams, senior nurses and the patient experience manager.
- Many areas have been able to utilise their audit results ensuring their effectiveness and efficiency is shared amongst the teams so that improvements can be made.
- We have developed a network for ongoing learning and development.
- It has allowed us to better understand exactly what the patients feel we need to improve through talking to them and recording their comments.
- It also enables us to take immediate action to address things (where possible) when patients tell us what is important to them.

What will we do next?

- We aim to improve monthly completion compliance to 100% by August 2020, across all inpatient wards, Oncology and Haematology, Endoscopy, Outpatients, Ambulatory Care Unit, Medical Day Case Unit and the Emergency Department.
- We will produce high level reports to be presented to monthly Directorate Governance meetings, Ward Wednesday and Harm Free Care. This will ensure that results from audits are reviewed.
- We will develop new approaches to embed the feedback from the audits to demonstrate continuous improvements in the quality of care provided.

Improve Cancer Patient Experience (access and working with patients/carers)

We are committed to developing and promoting cancer services within Weston Area Health Trust, ensuring that the services provided are suitable to meet the needs of the Somerset and North Somerset population, now and for the foreseeable future.

Cancer services within Weston Area Health NHS Trust are made up of many different areas and require the input of a range of teams and services to support day to day delivery.

During the past year the Macmillan support centre has become well established as the central point of contact for all cancer patients. It continues to serve a diverse but mainly elderly population.

The number of people being diagnosed with cancer in North Somerset is similar to the England average, as is the one-year survival rate which is sometimes used as a proxy measure of diagnosis of cancer at a later stage.

As well as providing support for Weston Super Mare and the surrounding area in 2019 we have supported people from Gloucestershire, Bristol, Taunton, Cornwall, France and Australia.

The Trust, along with neighbouring Acute Trusts (University Hospitals Bristol NHS Foundation Trust and North Bristol Trust) aspires to provide the best possible service to the patients that are referred into the service, aiming to provide a comprehensive holistic service meeting the physical, psychological and spiritual needs of all cancer patients and their loved ones. Some of the new improvements include online information library for all cancer services enables accurate and up to date information for our patients and families. A smaller version of this document is also available for patients on the Trusts website.

Activity analysis of the Macmillan Centre 2019/20

Centre Attendances - 1330
Female - 903
Male - 426

44% of visitors have a cancer diagnosis
76% of all contacts are carried out in the centre.

Personalised care and support in cancer

Personalised care and support in cancer has aligned cancer support workers to all specialties

supporting patients practical, emotional and spiritual needs through a Holistic Needs Assessment (HNA) and has enabled Weston hospital to deliver health and wellbeing events specifically focusing on what help and support is available, life style, managing symptoms and empowering patients to be more involved in their access to services as required. The first Clinical Psychological Service at Weston, funded by Macmillan is embedded and being well received by our patients.

Following the award of transformation funding in Somerset, Wiltshire, Avon and Gloucestershire (SWAG) West Cancer Alliances, Weston General Hospital received monies for 2 years to increase the roll out of the recovery package, the focus being on 3 metric sites, colorectal, breast and urology-prostate.

End of Life Care

The hospital palliative care team provides holistic support for patients and those close to them who have a life limiting illness.

During the last year we have contributed to the National Audit for Care at the End of Life (NACEL). This was the second year of a three year data collection cycle.

Results from the 2018/19 audit have been analysed, The key findings are:

It appears we are good at recognising patients who are likely to die within the next few days. However 46.2% died soon after it had been recognised that they were dying. We ideally need to be identifying dying patients as early as possible and continue with ongoing education to try to improve this.

We are doing well at devising and documenting an individualised plan of care for the last days of life. This was completed in 77.4% of patients compared to 61.5% nationally. This is probably partly due to the work which was undertaken to develop the Individualised Care for the Last Days of Life booklet. It is encouraging to see that this education initiative has improved practice.

The audit also showed that the plan for end of life is generally discussed with the nominated person. We are very aware that we don't have designated quiet spaces for relatives and carers on all the wards. This needs to be considered on a ward by ward basis.

Holistic assessments are being undertaken for the majority of patients. The evidence shows that our assessments and documentation is generally good, however

In 22.6% there was no documentation regarding who was present at the time of death. This might be something which we could consider how to improve e.g. through different prompts on the care after death.

Overall, carers reported that the care provided to the patient in the last few days of life in Weston General hospital was outstanding or excellent in 90% (NACEL- 60%).

These global assessments of the care provided to our dying patients and their family/carers is extremely encouraging.

We have continued to work to promote appropriate use of the Hospital treatment Escalation Plans (TEP) these have also been key to the introduction of the respect community Treatment Escalation plan which are used for patients who are discharged with a TEP. Audit has shown that the number of TEP forms being completed is increasing and the number of patients who have

complex medical problems and no TEP in place is decreasing. The emphasis is not on withholding any treatments, but having a discussion about what would be appropriate and likely to be of benefit as well as acceptable to the patient.

The number of patients being referred for non-cancer diagnosis continues to appropriately increase. Figures were over 40% for last year.
We have developed a policy for Moving Patients at the end of life to try to ensure that patients are not moved around the hospital in their last hours to day of life, unless on balance this is in their best interest.

We have shown appropriate use of the hospital TEP forms, both for clarifying treatments that would not be appropriate as well as documenting what treatments would be suitable.
The documentation for individualised care at the end of Life is being well used.

Ongoing education for all staff groups to ensure that dying patients are recognised as early as possible, is a high priority for us.

We are looking at working with medical teams regarding the use of High Flow oxygen in the Trust.

Dementia Care

There are over 850,000 people living with dementia in the UK and in North Somerset alone the number of people in the over 65 age group is estimated to be **3,354.** People who are living with a dementia and are admitted to hospital end up staying longer, they are also more likely to be readmitted once they have left and are less likely to return to their own homes than someone who does not have a dementia.

As a Trust we are committed to supporting people with dementia to have the best possible outcomes and we support this by continually looking at ways to make our hospital more dementia friendly and listening to and acting on the feedback we receive from both our patients and carers.

- We have continued to work alongside Dementia UK to develop the Admiral Nursing service, as one of less than twenty Trusts in the UK who have this designated specialist role.
- We have continued our commitment to providing a Dementia friendly hospital for our patients.
- This year we started work on a ‘quiet bay’ in ED, where patients can be supported in a calmer environment which we hope will help reduce the understandable anxiety and stress that can be part of being in a busy hospital environment. We worked to ensure that this not only met recognised guidelines for best practice but we consulted people living with dementia and acted on their suggestions.
- Following on from this we now have representation from a person who lives with dementia and a carer on our dementia steering group.
- Building on our refurbishment work last year with our care of the elderly ward, we have started a ‘Bus Stop’ project. Secured a bus stop and personalised timetable from ‘First’ and the support of a local graphic designer who is creating a picture on special paper which is then transferred to glass or porcelain to mirror Weston Seafront. This has also demonstrates our strong partnership working with our mental health colleagues, as this is a joint initiative with Avon and Wiltshire Mental Health Partnership.
- In 2019 our Admiral Nurse accepted a total of 142 referrals for families who have a loved one living with a dementia. Undertaking a total of 1805 contacts with families, patients and colleagues, working in a ‘triangle of care’ to ensure better outcomes. For example a reduction in repeated admissions to hospital for some of our patients
- Providing a calm and supportive environment for people who live with a dementia has shown to have a positive impact on their wellbeing and reduce some of the negative effects of the

condition, such as misinterpreting shapes and colours. Ensuring that the voices of people who experience the condition are heard helps us know that we are moving in the right direction with our decisions. It also demonstrates that having a dementia diagnosis does not mean that your opinions and contribution are diminished.

- Other areas in the country that have trialed a 'Bus Stop' project have found it has reduced agitation in patients living with dementia as it helps them focus on something familiar when they become anxious or worried.

Supporting and listening to Carers

There are 7 million people in the UK who provide care for disabled, seriously ill or older loved ones, that's 1 in 10. Their commitment and support saves the UK economy £132 billion pounds a year.

Weston Area Health NHS Trust recognises and values the vital role of carers in the health and well-being of the people that they care for.

Therefore, we have a commitment to actively encourage the involvement and opinions of carers and an assurance that carers are supported throughout their involvement with our trust.
We recognise that carers are uniquely placed to offer us invaluable knowledge about the health, needs and wishes of those patients within our care.

- We have built on our commitment to people living with dementia and their families by launching 'Lillian's Memory Café', a monthly space for people living with dementia, their carer's and anyone who is worried about their memory to come and meet people, have a cup of tea and get some advice and support.
- We have expanded our collaborative working with North Somerset Hospital Carers Support Scheme, NSHCSS, working with the team to share our knowledge and experience of carers needs.
- In collaboration with NSHCSS we have been completing 'Dementia carers feedback' forms to gain an understanding of what really matters to the carers of people living with dementia within our trust.
- Loneliness and isolation are particular problems if you live with dementia or care for someone that does, (Alzheimer's society 2018). Having a designated space where you can meet people in similar situations and gain advice and support from local services can go a little way to alleviate that.
- North Somerset Hospital Carers Support Scheme has supported a total of 546 carers last year. Alongside the 146 families that the Admiral Nurse has also supported we have started to gain some valuable feedback which will allow us to prioritise areas that we need to develop further as a trust.
- One such area is around carer involvement in the decisions we make about the care we deliver. We are honoured to now have the family carer of former patient who lives with dementia as an active member of our steering group.

Safeguarding Children

Safeguarding Children is concerned with ensuring that children are kept safe from harm. Where risks to children are identified, we have a statutory duty to take the necessary actions to minimise the risk. This involves working closely with families and other departments and agencies, sharing information appropriately and in a timely manner, to enable the correct support to be implemented.

At a strategic level it is about monitoring safeguarding practices in the Trust, promoting good

practice, providing staff with training, advice and support to carry out their roles effectively, engaging in multi-agency work, and implementing best practices that are identified locally and nationally.

Over the past year we have introduced the National Child Protection-Information Sharing system (CP-IS) into all relevant areas, allowing us to check Child Protection involvement with children from across the country at the point of registration, informing our care plans and allowing us to improve, multi-agency working, information sharing and outcomes for children.

We have developed and appointed to a Children Safeguarding Practitioner role, expanding the teams skills and resources, allowing us to improve our ad-hoc and scheduled Safeguarding Supervision across all paediatric services, make progress on our audit programme for the first time in 2 years, and focus some much needed resources on the promotion of valuable (but poorly utilised) safeguarding resources such as Early Help, Social Care Referral Threshold Document, and Escalation Policy.

We have completed 2 Serious Case Reviews – both of which involved our CAMHS's and paediatric services. This required a lot of dedicated time for the purpose of investigation, reflection, supporting staff, identifying learning, acting of findings, and multi-agency working.

The CP-IS audits to date have been reassuring, demonstrating good uptake of the new process and an increase of children we can now identify as already being recognised as 'at risk'. Through this we have been able to share information with primary care and social care across the country for those children at high risk, where as previously this was predominantly limited to children from North Somerset.

Through the introduction of the additional role of Children Safeguarding Practitioner and the developments outlined above we are slowly but surely improving staff knowledge and skills and improving practice and therefore outcomes for children. This role was introduced permanently in June 2019 and therefore data is still being collected to evidence any resulting improvements, as changes in cultures and practices develop over time, but anecdotally staff awareness seems to be improving, and practice appears to be uplifted.

Current identified work streams include:

- Level 3 Children's Safeguarding training – efforts to improve attendance and notify relevant managers of future dates to aid compliance.
- Continue to progress the supervision provisions in the Trust – Supervision Policy, improved compliance, audit quality and actioned.
- Continue to progress the audit programme which was reinstated in November 2019, in which a few key areas are being audited. But on a wider scale we collect a lot of data and have a fairly good overview of how things generally stand but we need to conduct the analyses to provide evidence and inform action plans
- With the upcoming merger with UH Bristol there has been a lot of work to align the 2 services and regular monthly meetings held to assist the merger and work alongside the UH Bristol safeguarding Team.

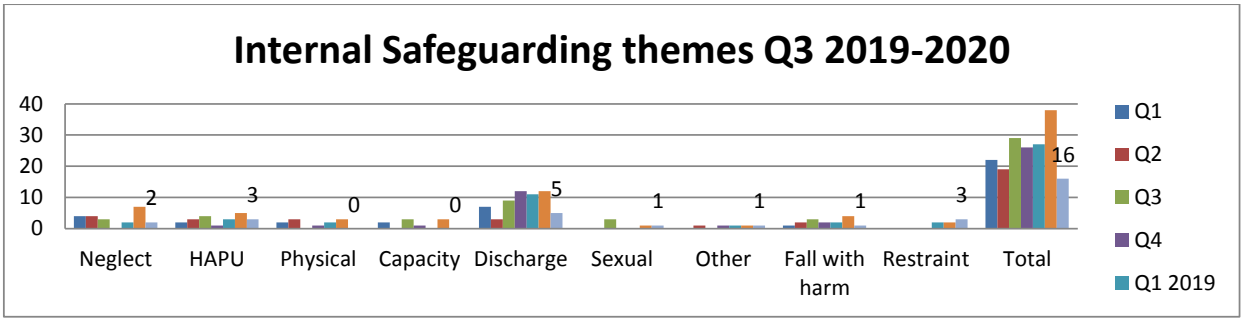
Safeguarding Vulnerable Adults

All Trust staff are encouraged to raise concerns for any element of suspected abuse (as detailed in the Care Act 2014). This clear message is promoted throughout statutory mandatory safeguarding training. Safeguarding awareness training for all staff at Weston General Hospital is currently 90%. Great value has been placed upon safeguarding training and a whole day approach has

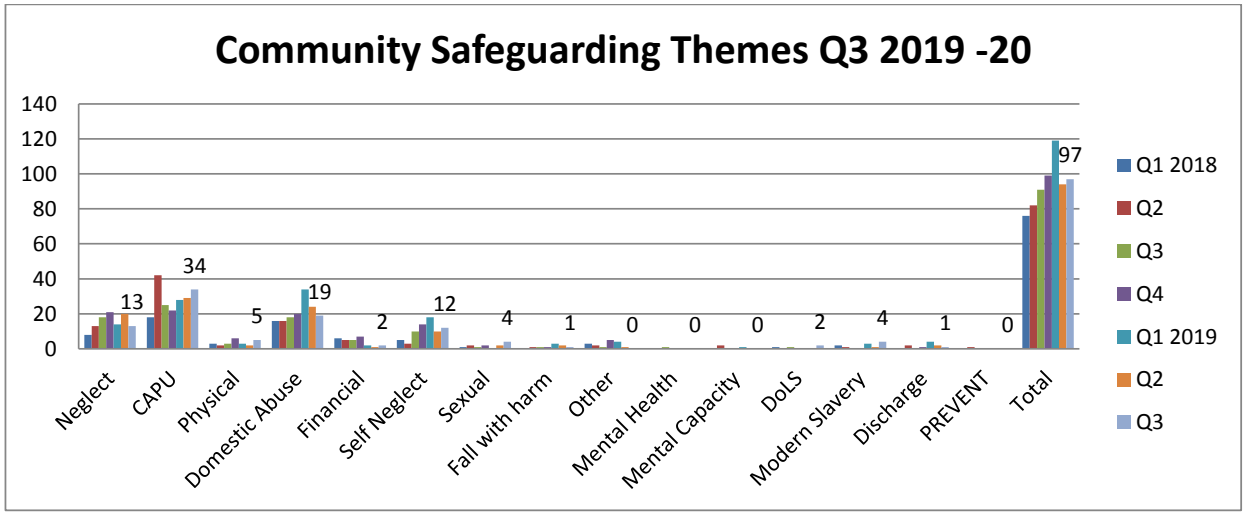
been incorporated within the training matrix for staff. The day enables staff to deliver safe care to various groups of vulnerable adults and children and includes the Mental Capacity Act and Deprivation of liberty Safeguards, Safeguarding Adults and Children , Learning Disability, Autism, Dementia and Prevent (Governments de-radicalisation programme).

The Trust saw an increase in safeguarding activity within 2019/2020 raising 388 community related concerns and 97 internal concerns.

The number of Internal Safeguarding Concerns raised 2019/2020



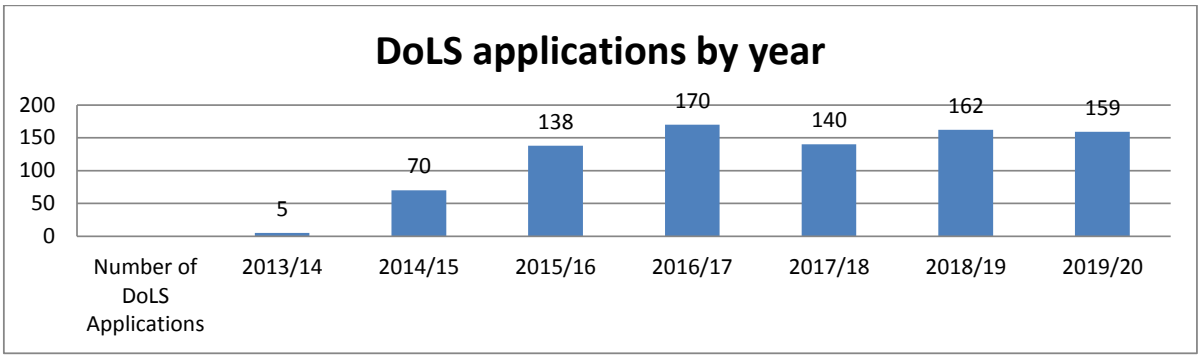
The number of community safeguarding incidents raised 2019/20



Deprivation of Liberty Safeguards

The Supreme Court ruling on Deprivation of Liberty Safeguards (DoLS) came into force in March 2014. The Trusts position for identification of eligible inpatients and consequent submission of applications has improved. The data in the following graph reflects the improvement within this area of Safeguarding for 2019/20. Our staff assess those patients who may require an application submission and where required are supported by the Trust Safeguarding Adults team. The ward based DoLS process is monitored closely by the Safeguarding Adults team via spot audits.

The number of DOLS applications made 2019/20



Learning Disability

The Trust provides a robust Learning Disability service for both inpatients and outpatients. The service is overseen by the Named Nurse for safeguarding adults at risk with clinical support from the Complex Needs Sister. The service accepts referrals for people with a Learning Disability that require reasonable adjustments or pre admission best interest planning.

The Learning Disability team recorded 105 contacts for people with a Learning Disability, 14 patients within the Emergency Department, 18 as an outpatient and 73 as an inpatient.

The Trust Learning Disability steering group has had an exciting year, with key professionals attending sharing expert knowledge on a range of topics including health and nutrition, sleep deprivation and medicine management.

The Trust has engaged with the NHSI improvement standards and supporting LeDeR with structured judgment reviews on all patients deceased in Weston General Hospital with a learning Disability. Autism has been introduced into statutory mandatory training, reflecting learning from the death of Oliver McGowan.

The Trust submits quarterly commissioned standards data to the commissioners for acute learning disability care. The data is favourable and reflects the Trust delivering a safe and inclusive service.

The Complex needs sister who is a Registered Learning Disability Nurse also supports inpatient and outpatient areas with complex patients; advising on Mental Capacity decisions.

Specialist Community Paediatrics

The Community Paediatric Team works with Children and Young People aged 0-18 years.
We offer assessment and treatment for neurodevelopmental conditions such as Attention Deficit Hyperactivity Disorder and Autism Spectrum Condition. We also provide ongoing care for children and young people with neurodisabilities.

We are a team of Paediatricians and Nurses, who are committed and passionate about providing the best possible care to our patient group. Additionally, we work in partnership with our colleagues in the community; for example, school nurses, health visitors, social workers and education to ensure care we deliver is integrated, holistic and collaborative.

This year has seen a period of stability for the Community Paediatric Team, enabling the team to galvanise the quality improvements highlighted in the 2018/19 Quality Account.

Over the last financial year, we have:

- Funded training to allow a nursing team member to undertake the Non-Medical Prescribing course enabling a more responsive service for patients. A second member of the team is now completing the course.

Community Paediatric and Community Paediatric Therapies teams have utilised CCG non-recurrent funding to address Autistic Spectrum Disorder diagnosis long waits in South Gloucestershire and North Somerset, to appoint a Locum Psychologist to further improve patient flow on Social Communication Autism Multi-Professional Pathway (SCAMP)

- Nurse Led clinics are fully embedded into the service delivery model.
- Utilised clinic space at Quantock Outpatients to provide more clinics which in turn improves Referral to Treatment Time (RTT) facilitating access to the service in a more timely way.
- Continuation of jointly held clinics in Specialist Education Provisions and with Community Paediatric Therapies Colleagues ensures the delivery of joined up bespoke care.

We have continued to represent WAHT Specialist Community Children's Services at external meetings and events (e.g SEND Board, Social Communication Fayre, Transitions Steering Group, Transitions Fayre, North Somerset SEND Patient Participation Engagement Group.

- The number of formal and informal complaints continues to decline.
- Patient experience data remains positive.
- Locally collected data from Nurse Led clinics indicates that 89.8% of families felt listened to.
- RTT time reduced from Red to Amber in the first month of delivering clinics at Quantock.
- Positively representing the organisation at external meetings has improved organisational reputation and has supported the development of a positive narrative.

As a service, we are looking forward to the opportunities that joining with Sirona Health and Care will bring as we merger as a service from 1st April 2020.

As the direction of travel around pathways across Sirona Community Children's Services becomes clearer, we will welcome the opportunity to work collaboratively and align with existing pathways across the geographical location.

It is our aim to have substantive clinicians in post and not to be reliant on locum cover.
Business cases (Qb, Neurodisability Nurse, SCAMP Clinical Psychology Lead) will be taken forward.

We will continue to deliver business as usual to the same high standard, during this period of organisational change and development.

Child and Adolescent Mental Health Services

Weston Area Health NHS Trust provides child and adolescent mental health and learning disability services (CAMHS) from two sites: Drove House in Weston-Super-Mare and the Barn in Clevedon; services are delivered by one multidisciplinary team across the two sites. Community paediatric services were also based at these sites and delivered services from these locations.

The CAMHS teams provide services for children and adolescents with severe and complex mental health issues. The multidisciplinary team provided services from the two main bases but also from clinics, schools, early years settings and in families' homes. The team offered the

following therapies/services:

- Generic and specialist mental health assessments.
- Individual interventions including counselling, cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT), eye movement desensitisation reprocessing (EMDR), art psychotherapy and art protocol for trauma.
- Systemic psychotherapy, family work and a solution focused therapy.
- Medication.
- Groups for parents and young people.
- The CAMHS team used set referral criteria to ensure access to assessment and treatment for children and young people who need it most.

Clinical Effectiveness

Cancelled operations

The Trust recognises that having to cancel operations is distressing for patients and their families at a time that is already worrying. The national target is to cancel no more than 0.8% of operations for the year. Unfortunately, due to the significant pressures experienced nationally during the winter months there was a need to cancel elective operations during this period.

Cancelled operations

Stroke

All Trusts have been set a target to ensure 80% of stroke patients spend 90% or more of their stay in a specialised stroke unit. As at the end of January 2020 the Trust have achieved 76.60% during 2019/20, which has decreased from 84.47% during 2018/19. We have a specialist Stroke team and we thrombolyse patients with a confirmed stroke Monday to Friday 9-5 and outside of these hours patients attend North Bristol for treatment.

Work is being done within the Trust to ensure that wherever possible we keep a “hot” bed available on the stroke ward to ensure that when a patient requires admission to a Stroke Ward, there is a bed available and the patient does not have to start their admission on a different ward.

MRSA (Methicillin Resistant *Staphylococcus Aureus*) bloodstream infections

All MRSA bloodstream infections are reported nationally and are assigned as being related to the Trust, or not related to the Trust (acquired in the community or other settings) following a post infection review.
Two cases were reported during 2019/20 against the Trust’s zero threshold. The cases were both fully investigated and involved patients that had previously been colonised with MRSA. No lapses in care were able to be identified that directly contributed to these cases. Learning was identified, however, in relation to peripheral vascular cannula documentation in one of the cases. Work is ongoing to improve compliance with this.

Escherichia coli bloodstream infections

There has been a continued focus this year on the reduction of *Escherichia coli (E. coli)* bloodstream infections. *E. coli* infections represent 65% of Gram-negative infections and there is a UK government ambition to significantly reduce them. The Clinical Commissioning Group set the Trust a 10% reduction ambition of healthcare associated cases against our 2018/19 data.

Over 85% of *E. coli* bloodstream infections are present when the patient is admitted to hospital. The cases that develop in hospital (healthcare associated) are fully investigated and any learning identified is shared with both the medical and nursing teams.

The Trust reported 110 cases of *E. coli* bloodstream infection in 2019/20, of which 16 were deemed healthcare associated. This compares to the Trust reporting 127 cases in 2018/19 with 22 assessed as healthcare associated. The further 10% reduction ambition set by the Clinical Commissioning Group has therefore been met.

Performance against national priorities and access standards

Access to Clinical services

Overview

NHS improvement's Single Oversight Framework (SOF) has four performance metrics

The national standards are:

- 95 per cent for A&E 4 hour waits
- 85 per cent for 62 day GP Cancer
- 92 per cent RTT incomplete pathways
- 99 per cent for 6 week diagnostic waiting times
- Accident and Emergency (A&E) 4 –hour waiting standard

The Trust is required to meet the standard of 95% of patients spending four hours or less from arrival to ED to admission to a ward, transfer to another hospital or discharged home.

The 4 hour standard is a key quality indicator for hospitals and patients to ensure that patients are seen, treated and then admitted or discharged from the Emergency Department within 4 hours.

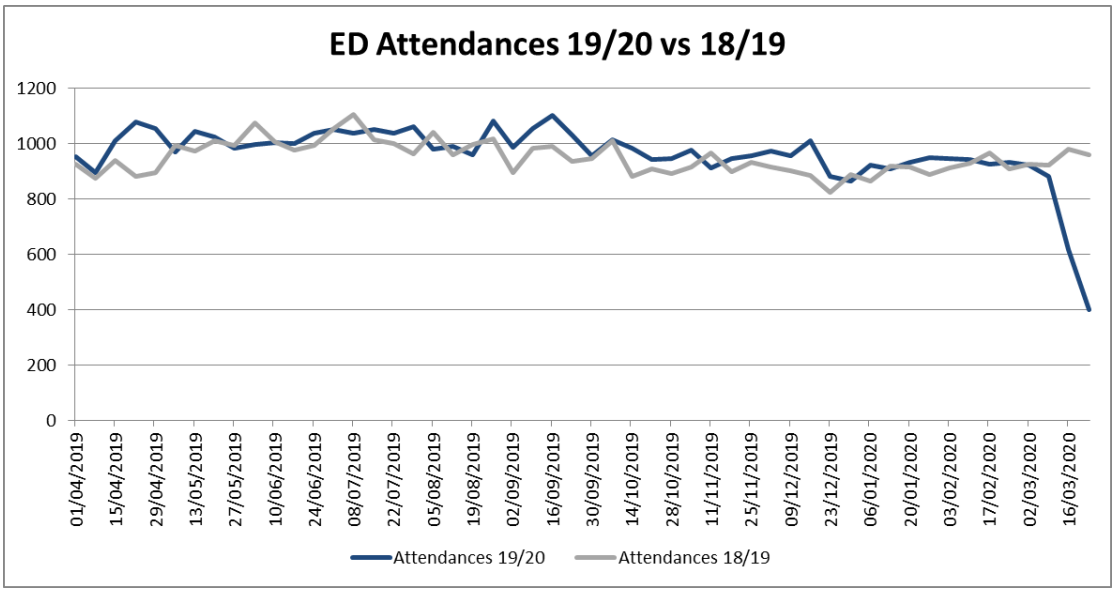
Within the standard there are a number of timings that support how we treat patients, these are:

- Transferring patients in the emergency department from an ambulance within 15 minutes.
- Having an initial assessment by a qualified clinician within 15 minutes of arrival.
- Having a review a by a decision making clinician within 60 minutes.

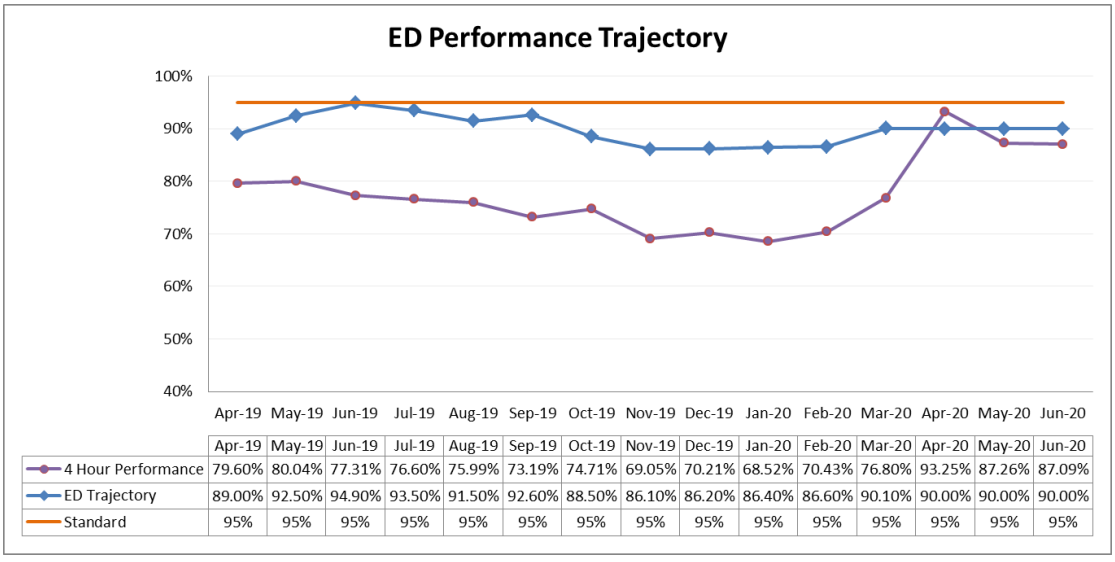
The indicator is calculated as the % of patients who have a total time in ED of four hours or less from arrival to admission, transfer or discharge, compared with the total unplanned ED attendances.

The trust did not meet the national 95 percent standard for the number of patients discharged, admitted or transferred within four hours of arrival in our Emergency Department.

Total number of ED Attendances



Four Hour Emergency Access performance 2019/20



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
4 Hour Performance	79.60%	80.04%	77.31%	76.60%	75.99%	73.19%	74.71%	69.05%	70.21%	68.52%	70.43%	76.80%	93.25%	87.26%	87.09%
ED Trajectory	89.00%	92.50%	94.90%	93.50%	91.50%	92.60%	88.50%	86.10%	86.20%	86.40%	86.60%	90.10%	90.00%	90.00%	90.00%
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Four Hour Emergency access

The 4 hour standard is a key quality indicator for hospitals and patients to ensure that patients are seen, treated and then admitted or discharged from the Emergency Department (ED) within 4 hours.

Within the standard there are a number of timings that support how we treat patients, these are:

- Transferring patients in the emergency department from an ambulance within 15 minutes.
- Having an initial assessment by a qualified clinician within 15 minutes of arrival.
- Having a review a by a decision making clinician within 60 minutes.

We also strive to ensure that all patients have a clear treatment plan within 2.5 hours from arrival into the department.

- There is an Emergency Department Recovery Plan in place to improve the performance against the four-hour key performance indicators. Actions we have undertaken to date include:

    - We have made change to our Consultant Rota to ensure safety and support for junior staff.
    - Capacity and Demand work has been undertaken to help us understand how we need to staff our rotas and what future developments we need to consider.
    - We are now informing patients on arrival what the waiting time should be after triage.
    - We have developed an Induction pack for locum staff.
    - When staffing allows, we undertake a rapid assessment to determine what investigations and immediate treatment is needed, this is known as RAT (Rapid Assessment and Treatment).
    - We have created a new Fit-to-Sit area for minors patients.
    - Following a staffing review we have implemented a Minors Area Nurse Co-ordinator
    - The Safety Sister role is now embedded within the department
    - We have relocated the Patient Flow office to be alongside the ED department for ease of communication
    - ED Patient Tracker role has been developed further and is in place in majors and minors areas of the Department.
    - We have introduced an Information Board at the front door for navigation for patients to alternative services, with their waiting times which is updated hourly.

The Trust is required to meet the standard of 95% of patients spending four hours or less from arrival to admission, transfer or discharge. The Trust will not achieve the target by 31st March 2020, with the current position being 74.41%, as shown in the table below. There is an Emergency Department Recovery Plan in place to improve the performance against the four-hour key performance indicators.

The 4 hour standard is a key quality indicator for hospitals and patients to ensure that patients are seen, treated and then admitted or discharged from the Emergency Department (ED) within 4 hours.

Whilst our four-hour access target is not currently being achieved, this is not an accurate reflection of how well patients are treated in our Emergency Department. What the current position is showing us is that we have an issue with flow across the hospital, rather than suboptimal care within the Emergency Department:

During 2019/20 our average time to an initial assessment by a qualified clinician has been 17 minutes (slightly over the target of 15 minutes)

During 2019/20 our average time to a review a by a decision-making clinician has been 71 minutes (slightly above the target of 60 minutes)

We also strive to ensure that all patients have a clear treatment plan within 2.5 hours from arrival into the department.

We are aware that there is much work to be done to bring us back in line with our recovery plan. The following work is either underway or due to start within the next 6 weeks.

- Implement recruitment and retention strategy, to support safer staffing for both nursing and medical staff.
- We are introducing a service called 'Push Doctor', where patients who would be better placed seeing a GP, can have a virtual consultation instead of being seen in the Emergency Department
- Plans to increase the footprint, medical model and pathways of Ambulatory Emergency Care and Same Day Emergency Care.
- We are working with Alamac to refresh the SAFER flow bundle across the Trust.
- We are in the process of refurbishing and relaunching the Discharge Lounge to increase early flow from the wards.

In addition to the above, a small working group has been established to identify the key issues that are preventing us from achieving our four-hour target. Once the issues have been identified, a series of actions will be agreed, along with time frames for achievement and expected outcome in terms of effect on the four-hour target. From this work we will be able to develop a trajectory for improvement and a plan for how we will move towards achieving 95%.

- **62 day GP Cancer standard**

  This indicator is calculated as Patients should receive their first definitive treatment for suspected cancer within 62 days following urgent GP referral. The national standard is 85%. Weston NHS Trust achieved 60.85% at the 31st March 2019.

- **Referral to treatment (RTT) Incomplete pathways standard**

  The Percentage of incomplete pathways within 18 weeks for patients with incomplete pathways at the end of the reporting period 2018/2019 is a key quality indicator for hospitals.

  The Trust performed well against this national target which sets a maximum of 18 weeks from initial point of referral to the start of any treatment necessary for planned care. This demonstrates that the Trust continues to deliver efficient and effective pathways of care to our patients. The national target is 92%.

  The indicator is calculated as the percentage of patients on an incomplete pathway at the end of the reporting period that have been waiting no more than 18 weeks, compared with the total number of patients on an incomplete pathway at the end of the reporting period.

  In accordance with the national Referral to Treatment (RTT) target, we try to ensure that at least 92% of our patients have their required treatment within 18 weeks of referral by their GP. A challenging area for meeting the RTT target is Child and Adolescent Mental Health Services – there are difficulties nationally in meeting this particular target.

  Whilst the Trust are taking action to reduce the waiting list, there remains a risk to children and young people who are waiting to be seen, and as such it is essential that risks of these children and young people waiting to be seen are clearly and accurately documented and actively monitored.

  The current process was reviewed by a senior team of managers and clinicians to identify how children and young people waiting for treatment could be reviewed to ensure they did not

decline or require more urgent treatment whilst on the waiting list.

A process of risk assessment of every child and young person on the waiting list was put in place. This involved contacting every person (or their parent/carer as appropriate) to undertake a risk screen to assess whether their risk had increased, decreased or stayed the same and whether any urgent action was required, or indeed whether the symptoms had resolved and the person no longer required to be on the waiting list.

These risk screens are undertaken by trained CAMHS practitioners to ensure that patient safety was paramount at all times.

By following the Standard Operating Procedure (SOP) and developing a risk screen for all patients who have been referred into CAMHS, to ensure that they are monitored whilst waiting for treatment, we can be assured that they are safe whilst waiting for treatment.

In addition, we have also developed a SOP to ensure that every child or young person on the case load has a comprehensive risk assessment and that this is kept in the front of their case notes to ensure it can be reviewed and updated at each appointment.

We also put in place a monthly case note audit, which is undertaken by clinical staff on a random sample of ten sets of note each month, to ensure that the risk screen and risk assessments are accurate and documented.

All of the above actions ensure that children and young people are safe whilst awaiting treatment.

The initial risk assessment of the complete waiting list was complete.

If there is any evidence of a change in risk (increased or decreased) during the risk screen, the risk screen will be updated and will be undertaken every 12 weeks for low risk, every 4 weeks for medium risk and where an urgent assessment is deemed necessary, the child or young person will be expedited into an urgent assessment.

- **6 week diagnostic waiting times standard**

This covers the top 15 high volume diagnostic tests. The standard is that at each month-end 99 percent of patients waiting for one of those tests should have been waiting under six weeks.

The monthly diagnostics collection collects data on waiting times and activity for 15 key diagnostic tests and procedures, the below demonstrates where we have performed against national data, during the reporting period 2019/2020 a refurbishment of our endoscopy unit had an impact on our capacity and alternative arrangements were put in place at the time.

Performance Metric

Key Performance Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
A&E 4 Hours	Actual	79.60%	80.04%	77.31%	76.60%	75.99%	73.19%	74.71%	69.05%	70.21%	68.52%	70.43%	76.80%
	Trajectory	89.05%	92.51%	94.90%	93.50%	91.50%	92.62%	88.52%	86.24%	86.24%	86.41%	86.60%	90.10%
Cancer (62 Days)	Actual	85.11% *	53.33%	61.43%	73.17%	50.00%	57.38%	53.62%	78.57%	60.00%	45.28%	58.82%	64.52%
	Actual Quarter	65.00%			58.75%			62.00%			57.87%		
	Trajectory	73.10%	75.00%	75.80%	77.30%	81.80%	83.30%	81.50%	78.30%	82.60%	85.70%	80.00%	80.00%
RTT	Actual	91.02%	89.23%	87.14%	86.61%	84.69%	85.63%	83.43%	83.63%	84.07%	84.72%	84.60%	83.19%
	Trajectory	93.12%	93.12%	93.12%	92.65%	93.55%	93.55%	93.12%	92.32%	92.58%	92.57%	92.60%	92.00%
6 Week Diagnostic	Actual	97.99%	92.37%	93.37%	94.51%	97.88%	98.67%	98.91%	97.51%	95.57%	94.75%	98.83%	97.62%
	Trajectory	99.04%	99.04%	99.04%	99.04%	99.04%	99.04%	99.04%	99.04%	99.04%	99.04%	99.04%	99.04%

*Nationall

National Standards

National Standard	Target	2016/17	2017/18	2018/19	2019/20
A&E Maximum wait of 4 hours	95%	76.10%	84.86%	86.87%	74.63%
A&E Median Time to Initial Assessment	00:15	00:12	00:13	00:12	00:17
A&E Median Time to Treatment	01:00	00:41	00:39	00:44	01:12
A&E Unplanned re-attendance within 7 days	1-5%	6.48%	6.43%	6.28%	6.25%
A&E Left Without being seen	<5%	2.08%	1.55%	1.45%	2.29%
Breast Symptoms referred to a specialist who are seen within 2 weeks of referral	≥93%	89.10%	94.56%	90.47%	96.39%
31 days for second or subsequent cancer treatment- surgery	≥94%	99.46%	94.66%	88.37%	83.72%
31 days for second or subsequent cancer treatment- drug treatment	≥98%	96.36%	97.82%	98.89%	96.77%
National screening programme who wait less than 62 days from referral to treatment	≥90%	100%	76.92%	87.03%	***
Cancer reform strategy 62 upgrade standard	≥90%	93.20%	80.95%	86.71%	77.83%
2 week wait (urgent GP appointment to 1st outpatient appointment)	≥93%	91.55%	94.14%	91.78%	90.30%
NHS cancer plan 31 day standard	≥96%	100%	98.40%	96.48%	98.31%
NHS cancer plan 62 day standard	≥85%	77.00%	70.73%	65.75%	62.01%
Referral to Treatment within 18 weeks incomplete pathways	≥92%	93.71%	92.94%	92.04%	84.72%
Cancelled Operations on the day for non-clinical	≤ 0.8%	6.95%	2.77%	2.28%	3.60%

reasons					
Cancelled Operations rescheduled within 28 days	95%	95.45%	94.44%	94.44%	93.33%
6 Week Diagnostic Wait	99%	99.50%	98.29%	99.28%	95.84%

62 Day Cancer Performance

The 2009 Cancer Reform Strategy sets out eight national cancer performance objectives for Trusts to deliver against. During 2019/20 the Trust met one of the national targets.
The following table sets out the eight key targets and the Trust performance against each.

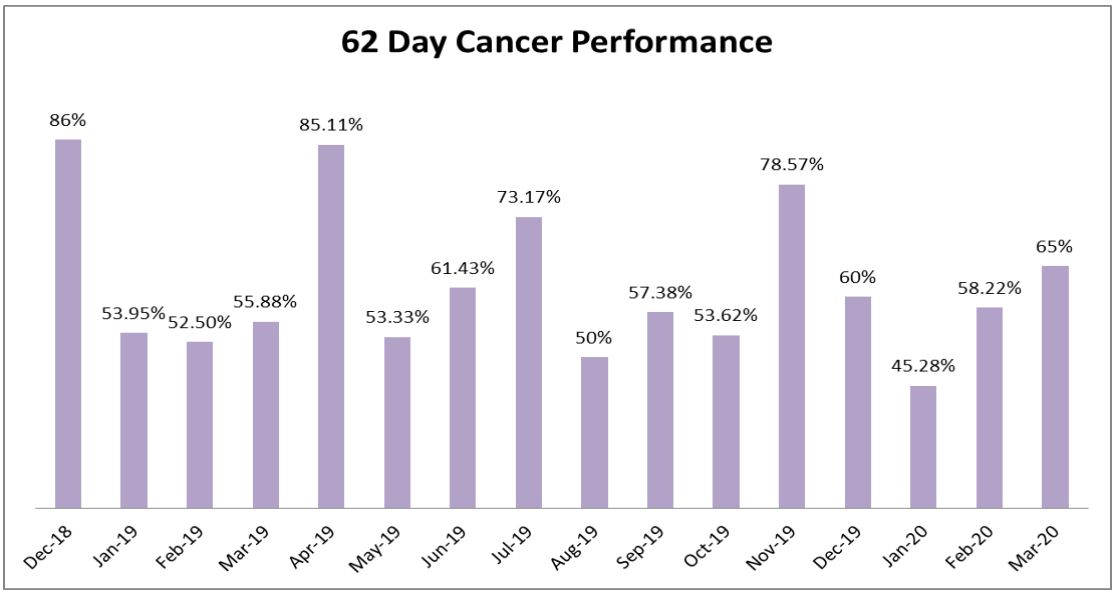
Cancer Targets

	National Target	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Breast Symptoms referred to a specialist who are seen within 2 weeks of referral	≥93%	97.20%	96.60%	93.50%	90.90%	88.68%	89.10%	94.56%	90.47%	94.17%
31 days for second or subsequent cancer treatment-surgery	≥94%	100%	98.60%	95.30%	99.30%	98.81%	99.46%	94.66%	88.37%	88.52%
31 days for second or subsequent cancer treatment-drug treatment	≥98%	100%	100%	99.10%	99.97%	99.08%	96.36%	97.82%	98.89%	97.87%
National screening programme who wait less than 62 days from referral to treatment	≥90%	95.80%	98.10%	86.40%	100%	92.05%	100%	76.92%	87.03%	n/a
Cancer reform strategy 62 upgrade standard	≥90%	94.20%	93.40%	86.10%	77.96%	94.73%	93.20%	80.95%	86.71%	78.47%
2 week wait (urgent GP appointment to 1st outpatient appointment)	≥93%	96.50%	96.00%	95.30%	97.26%	96.30%	91.55%	94.14%	91.78%	91.72%
NHS cancer plan 31 day standard	≥96%	99.80%	100%	99.20%	99.65%	98.84%	100%	98.40%	96.48%	98.23%
NHS cancer plan 62 day standard	≥85%	92.30%	88.30%	81.40%	89.08%	77.50%	77.00%	70.73%	65.75%	60.85%

Long waiting specialties

The information pertained within the graph below is representative of information collected and demonstrated within our Somerset Cancer Registry and this may vary slightly from that published nationally due to the nature of data and historic data quality issues.

Long wait specialities – compliance against 62 days performance

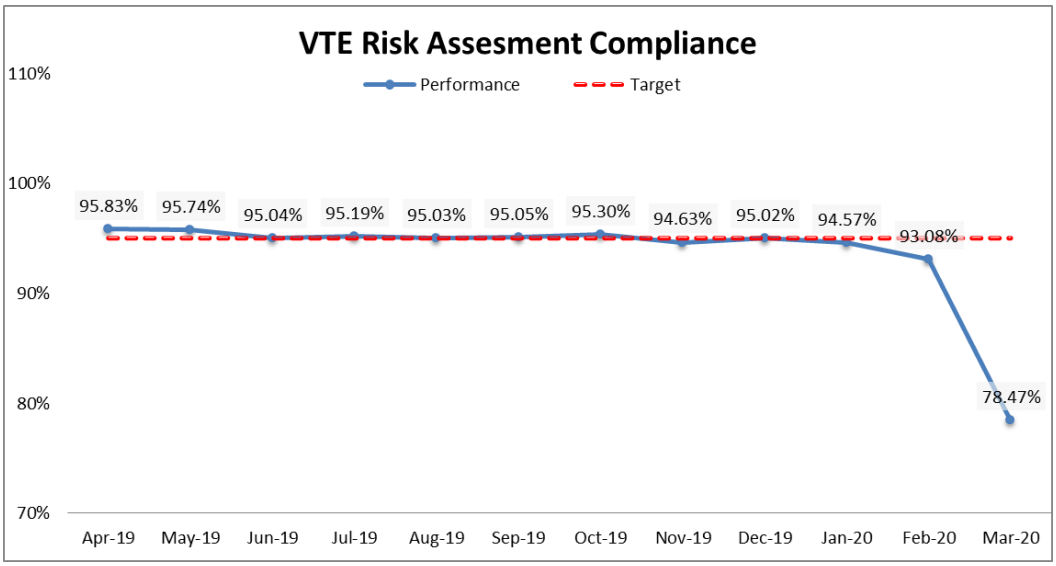


Venous Thromboembolism (VTE)

It is a national requirement that 95% of patients admitted to hospital should be assessed on their risk of developing a venous thromboembolism (blood clot) within 24 hours of admission.

The trust has achieved the national standard of greater than 95% of eligible inpatients for each quarter of the 2019/20 of the financial year.

VTE Risk Assessment Compliance 2019/20



	National Target	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
% Patients VTE Assessed	≥90%	95.00%	96.10%	78.95%	97.16%	95.34%	63.02%	82.02%	94.52%	93.84%

VTE assessment for Q4 has not been validated due to returns being suspended due to Covid-19

The data collection process has been reviewed, ensuring robustness of the data collection, efforts are being concentrated on understanding the common themes in patient records where we are unable to demonstrate completion of a risk assessment and also looking at those ward areas where completion figures is low. The Trust continues to see sustained improvement in the assessment of in patients at risk of venue thromboembolism. Currently performance is audited manually which can delay full validation of results. The trust plans to move to an electronic audit tool in 2019/20 which should ensure timelier reporting

Clostridium Difficile infections

The table shows the rate of *Clostridium difficile* (*C. difficile*) infections there have been within the Trust per 100,000 bed days. (Children under 2 are not included).

Clostridium difficile (*C. difficile*) infections

	2019/20		2018/19
	Weston	National average	Weston
Rate per 100,000 bed days of cases of *C. difficile* infection	8.18	15.6	8.13
Data source: Public Health England			

In 2018/19 the Trust maintained its low rates of *Clostridium difficile* infections, reporting seven cases. In 2019/20 the criteria for reporting of *Clostridium difficile* infections changed. Cases are split between hospital onset, healthcare associated (HOHA) and community onset, healthcare associated (COHA). COHA cases occur in the community or within two days of admission when the patient has been an inpatient in our care in the previous four weeks. The Trust has reported seven cases of HOHA and seven cases of COHA against a threshold of 14 cases; our rate remains well below the national average. Each case has undergone a comprehensive post infection review which has been assessed against national guidance criteria.

In all but two cases, we have been able to demonstrate that there have been no cases of cross transmission of *Clostridium difficile* between patients on our wards. The reason we could not categorically exclude cross-transmission was due to not being able to sub-type the *Clostridium difficile* to prove this. Learning has been identified in areas such as prompt isolation, sampling and review of antibiotic prescriptions. Every case is presented to the Infection Prevention and Control Committee where action plans are either signed off or it is agreed that further work is required.

At Weston, a high proportion of patients admitted to this hospital are over 65 years in age and up to a third of these patients are receiving antibiotic treatment at any one time. These are significant risk factors for *Clostridium difficile* acquisition.

The strategies introduced over the last 5 years are now embedded and our continuing success in reporting low numbers of *Clostridium difficile* infections is testament to their success.

The strategies that have contributed to this include:

- Continued updating of our antibiotic guidance and the use of mobile technology in the form of a Smart phone App to enable our Doctors to access these guidelines at the point of care.
- Recruitment of antimicrobial pharmacist in June 2019.
- Daily auditing of antibiotic prescribing by a designated pharmacist and the Consultant Microbiologist with prompt feedback to prescribers and their teams from July 2019.
- Use of the Diarrhoea Assessment Tool to assist clinical staff with the prompt isolation of symptomatic patients and in determining when specimens should be sent.

The gap in the antimicrobial pharmacist post from July 2018 until June 2019 impacted on the ability to undertake daily auditing during this period.

The Trust will continue to support the work across the local health community and meets quarterly with the Commissioners to discuss and improve antimicrobial prescribing and to review learning from incidents across the health care economy.

Improving the discharge of patients from hospital

We discharge many patients each day from our Trust to a variety of care settings, and for the majority of patients this is a positive experience. However, we continue to strive to improve the process of discharge, working closely with patients and partners to reduce the length of time patients stay in hospital when they no longer need acute care services.

Part of our work around “Improving Discharge from Hospital” is to ensure patients and their relatives or carers are involved in the discussions around their discharge. We are also working towards improving the provision of the right support so that people are able to return to their living accommodation, rather than a care home placement or community hospital.

During 2019/20 we built upon the work already undertaken with the implementation of the Integrated Discharge Service. Training sessions continued with the wards to ensure that they are aware of the discharge pathways available and how to access them. And also the continued development of the integrated care bureau, this is in conjunction with Bristol, North Somerset and South Gloucester community partners.

The Integrated Care Bureau provides a single referral process to access community and social services develop the correct support for patients at discharge, the main focus to ensure that patients were being referred onto the right pathway for their needs.

In order to achieve this a new “Single Referral Form” was developed and implemented across the Trust. This form changed the way referrals were made as, rather than prescribing a pathway for the patient, the form would describe what the patient’s needs were (such as assistance with washing and dressing, mobility issues, help with feeding).

All single referral forms are reviewed by a team of experts (an acute hospital therapist, a social worker and a nurse or therapist from the community provider) within the Integrated Care Bureau, to ensure that the patient is referred to the most appropriate organisation to support their needs.

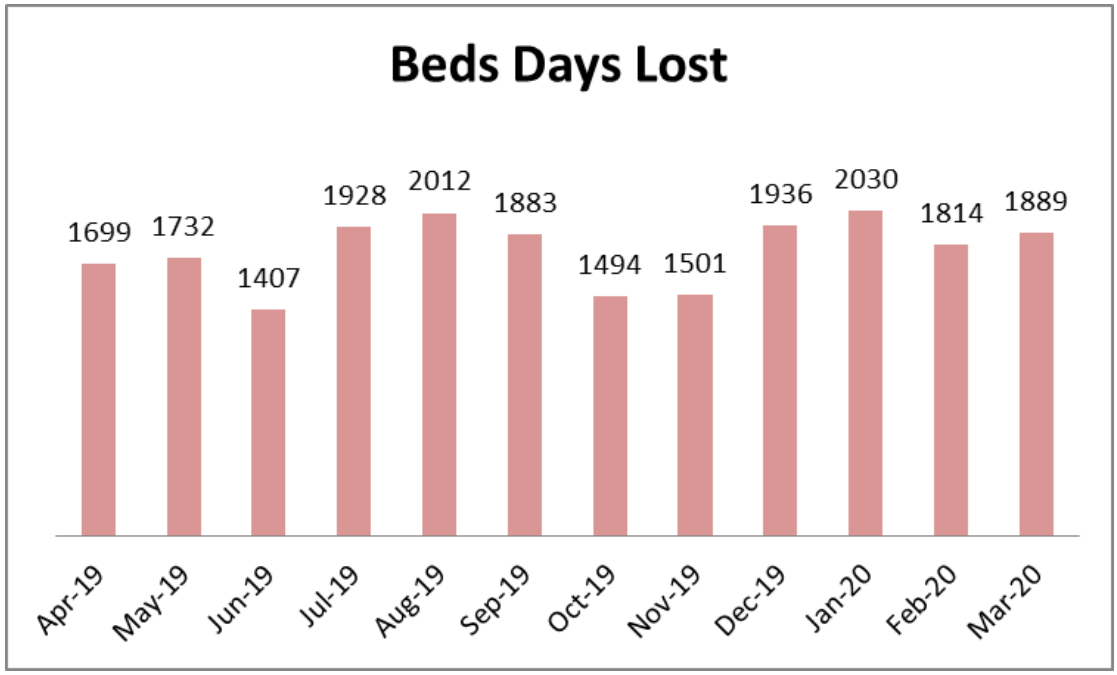
The Case Managers within the Integrated Discharge Service have continued to support and educate the wards around discharge processes and pathways, ensuring that wards are

completing Single Referral Forms at the optimal time, with the necessary information for the Integrated Care Bureau to make their decision; this process is embedded well within the ward areas.

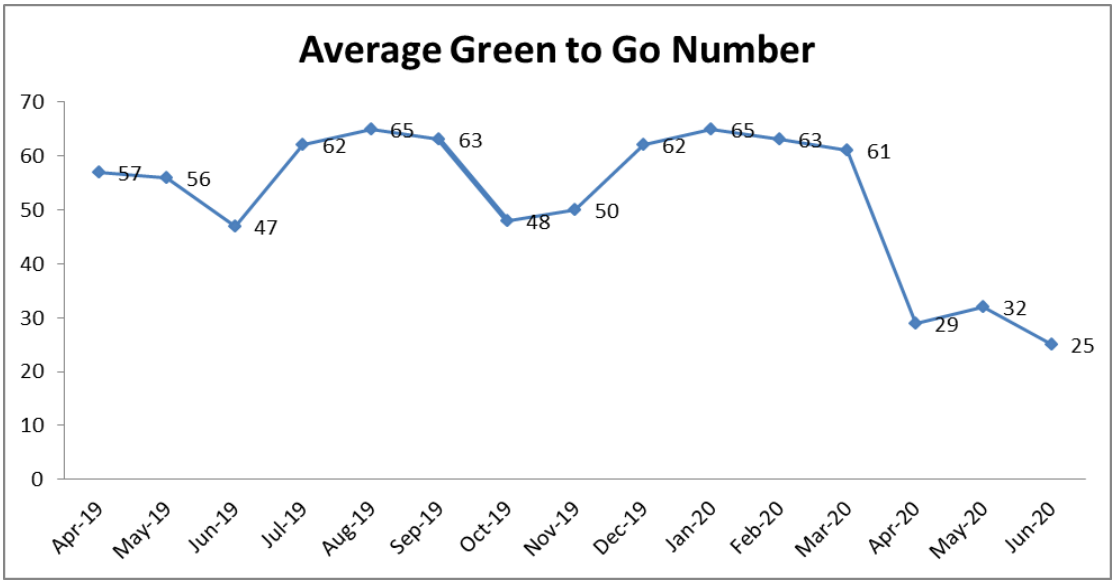
Due to the processes being established, a number of our patients are now being discharged on the day they are ready to be discharged, which means they are not added to the “Green to Go” list – this is a database of those patients for whom we are developing discharge plans (as some planning takes longer than others). The charts below give a picture of how we performed over the last 12 months:

Bed Days Lost to MFFD Patients

The chart below presents the average numbers of bed days lost (this is the number of days a patient spends in hospital after the team have agreed the patient is fit to be discharged). It must be noted that this does not refer to Delayed Transfers of Care Bed Days Lost – these are reported monthly via NHS England.



Average number on the "Green to Go" Database



As demonstrated within the bed days lost table we have seen a steady improvement since October 2019 in the average number of patients who were medically fit for discharge, awaiting ongoing support.

What we will do next

We will continue to work with the wards to improve the way we use the Management of Expectations Policy to ensure that interim measures for discharge that are being offered to patients are accepted and patients do not remain in hospital longer than is necessary, being at risk of infection and deconditioning.

We are working with partners in Somerset to replicate the Home First (Discharge to Assess) pathway that is currently available to other hospitals who have patients living in Somerset. This pathway will allow patients who require a short period of rehabilitation, to have this at their own home.

Appendix A
Feedback about our Quality Report
Statements of assurance

a) Joint statement from Healthwatch Bristol, South Gloucestershire and North Somerset

Thank you for the opportunity for respond to your draft Quality Account.

Weston Area Hospital Trust's final Quality Account shows the wide range of services Weston General Hospital provides for North Somerset residents and the efforts they take to supply a safe, effective, and caring service. Efforts to address the CQC concerns and priorities in 2019/20 are clearly described but are hamstrung by unclear criteria for measuring success and this may have led to their 'not achieved' award they scored themselves on.

WAHT had been closely watched by the Care Quality Commission and others, due to serious shortcomings in A&E services in the year before the merger with University Hospitals Bristol NHS Foundation Trust (UHBW). However, it should be noted that WAHT was rated well for its caring and effective staff.

There are many improvements that the Weston leadership list for the 2020/21 year in this Quality Account, although these may change as a result of merger. Healthwatch will be monitoring the progress Weston General Hospital makes and we look forward to the benefits that will come to Weston patients from the merger.

b) Please note that the following will receive this year's Quality Account, but are not formally commenting:

- Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
- North Somerset Health Overview and Scrutiny Panel (QA Sub Committee)

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28 January 2021

Report Title	**Maternity provider annual report. Ante natal and New born Screening**
Report Author	**Sam Haines. Antenatal and New born screening co coordinating Midwife**
Executive Lead	**Interim Chief Nurse. Deirdre Fowler**

1. Report Summary	
[The Ante natal Screening and new born screening has key performance indicators which need to be achieved to ensure each Trust is providing safe , quality screening programmes for women and babies within the Maternity setting. This report demonstrates the UHBW performance , the successes of the programme and where the Trust needs to make improvements	
2. Key points to note *(Including decisions taken)*	
The report demonstrates that overall UHBW ante natal and new born screening has good performance against the KPI's. There are ongoing concerns regarding the avoidable repeat rate for the new born blood spot test but there is an action plan in progress to address this issue	
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**	
The risks associated with this report include: **3391,4546, 3232.**	
4. Advice and Recommendations *(Support and Board/Committee decisions requested)***:**	
• This report is for **Assurance.**	
5. History of the paper **Please include details of where paper has previously been received.**	
Women's Governance	**16th November 2020**
Women and Children's Quality Assurance Committee	**20th November 2020**
Quality and Outcomes Committee	**24th November 2020**

Recommendation Definitions:

- **Information** - report produced to inform/update the Board e.g. STP Update. No discussion required.
- **Assurance** - report produced in response to a request from the Board or which directly links to the delivery (including risk) of one of the Trust's strategic or operational priorities e.g. Quality and Performance Report. Requires discussion.

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

- **Approval** - report which requires a decision by the Board e.g. business case. Discussion required.

Maternity provider annual report

Introduction

- This document provides an update on the 'trust annual report template' by outlining the rationale for the changes and specifying the core content of the revised report

Background and guidance

- Public Health England regional quality assurance teams developed and used an annual report template for a number of years that was used to inform quality assurance (QA) activities. This proved to be informative in the absence of quantitative data and other information sources

- The report is now less informative for external QA purposes as there are regular quality assurance activities like attendance at programme boards, visits and regular reporting of data on standards and key performance indicators.

- Using the annual report in the above context now creates duplication of effort

- The QA teams and Screening and Immunisations leads (SILs) reviewed the annual report template in 2018 and agreed that the purpose of the annual reports should change in the following ways:

    - The aims of the report should be to highlight areas of shared learning and achievements in the last year, raise the profile of antenatal and newborn screening, highlight ongoing and potential risks and serve as a lever for continuous quality improvement within the provider organisation

    - PHE regional QA teams will **not** ask for a routine yearly submission of the reports but will expect the report to be discussed at a programme board as above. PHE screening quality assurance service will request for planned QA visits the last 2 reports as evidence

    We recommend:

    - A report is produced each year using the template below which has a minimum core content

- The report has appropriate sign off (minimum level by head of midwifery) by the provider organisation

- It should be written for the internal governance board of the provider organisation

- The report is presented and discussed at a screening programme board at the appropriate time of year. We suggest this is sometime between September and December to enable action planning for the following year

Nadia Permalloo
Head of quality assurance development (clinical)
PHE screening- screening quality assurance service

18 June 2018

Core content of maternity provider's annual report

Programme updates

Sickle Cell and Thalassaemia

Key Performance Indicators (KPI)
Q1 1st April – 30th June
Q2 1st July – 30th September
Q3 1st October – 31st December
Q4 1st January – 31st March

Standard ST2 timeliness of test 2019 - 2020
(Acceptable ≤50%, achievable ≤75%)
STMH

Q1 59.5	Q2 53.6	Q3 52.1	Q4 54.8

Weston

Q1 67.1	Q2 54.3	Q3 58.7	Q4 59.6

- Community Midwives/ Antenatal Clinic midwives continue to document that they have seen evidence of results in maternity notes from other units. In, addition they continue to send 'Movers in' forms to ANSC to inform them of evidence of screening from other units.
- We have added a question about Sickle Cell and Thalassaemia screening to the Fetal Medicine Unit referral form – this should ensure a more efficient way of tracking screening results for out of area patients.
- Proposed changes to genetic counselling referral pathway - This issue remains ongoing – several staff had been highlighted to attend study days. This will enable them to counsel low risk couples. Due to the Covid 19 crisis these study days were cancelled. We are awaiting further training dates to be released once current crisis has settled. At the moment the process for giving positive screening results remains the same. The current process for St Michael's Hospital is screening coordinators support midwives in information giving to women/couples. Whereas screening coordinators at Weston contact women/couples, directly providing information. All women are offered referral for clinical genetics counselling.

.

Infectious Diseases of Pregnancy

- Screen positive women - Occasional problems with booking appointments for obstetric antenatal clinic within 10 working days at St. Michael's Hospital. Screen positive women are contacted by a screening coordinator before obstetric consultant antenatal clinic if an appointment is not available within 10 working days in clinic. Reporting of a new screen

positive result and appropriate follow up is arranged once consent gained from patient.

- The community midwives inform the screening coordinator of all women who decline IDPS at the booking appointment. The coordinators will see the patient at the 1st scan appointment if possible, if not then at the time of the anomaly scan. Formal reoffer and counselling of the benefits takes place at this face to face meeting. Community midwives booking to deliver women at UHBW are asked to inform the patient that she will be met by the screening midwife to discuss further the benefits of screening.

Fetal Anomaly Screening Programme

- Standard FA2 data – Submitted by Lead Sonographer. (St. Michael's Hospital).
- Fetal Anomaly Screening. The proportion of pregnant women eligible for fetal anomaly screening who are tested leading to a conclusive result within the defined timescale.

(Acceptable >90% Achievable>95%)

STMH

Q1 99.3	Q2 99.9	Q3 99.6	Q4

Weston

Q1 100	Q2 100	Q3 100	Q4 100

- Screening for Down's syndrome by Quadruple test. Midwives are now asked that if a woman is thought to be greater than18/40 take blood for Quad test and then book for urgent USS. If the woman is thought to be less than18/40 to arrange for urgent USS. Bloods for Quad test will be taken in the department following the scan. This process has changed following feedback from the lab. Samples were being sent and waiting in the lab until scan details were available. There have been occasions when blood samples have been sent too early and were not appropriate for QUAD testing.

Newborn and Infant Physical Examination (NIPE)

- All data for KPI is now extracted from SMART4NIPE. The screening team ensures outcomes for all required standards (eyes/hips /testes) are added to system. There were initial concerns about who would follow up babies that require further input following abnormal hip scan. It has been decided that each baby would have a named consultant on the referral – they would be responsible for ensuring any follows up are arranged.

Standard NP1 – Newborn coverage (NIPE completed within 72 hours).
Acceptable > 95% Achievable >99.5%
STMH

Q1	Q2	Q3	Q4
97.1	97	97.7	97.8

Weston

Q1	Q2	Q3	Q4
96.7	100	100	100

- Midwife run NIPE Clinics have been implemented. They run on a Saturday and Sunday - with one midwife and on maternity assistant to support the process. These midwives run the NIPE failsafe as per QA recommendations.
  To date a big improvement on NIPEs being competed over the weekend and not breaching the 72 hour time frame to due to the workload of neonatologists.
  Midwives do not yet have access to requesting Hip ultrasounds on ICE. The work to move this forward has been delayed due to Covid 19. We hope to move this project forward in the near future.

Standard NP2 – Timeliness of intervention for Developmental Dysplasia of Hips. (DDH).

Acceptable >95% Achievable =100%
STMH

Q1	Q2	Q3	Q4
83.3	100	100	72.7

Weston

Q1	Q2	Q3	Q4
100	100	100	100

New-born Blood Spot

- Ongoing concerns continue re: avoidable repeat rate continues.

KPI data for 2019 -2020

Q1	Q2	Q3	Q4
5.8%	9.5%	10.3%	10.0 %

Acceptable <2% Achievable < 1%

Weston

Q1	Q2	Q3	Q4
3.3	4.1	4.9	3.3

	An action plan has been agreed by ANSC and hospital matrons. It includes • Those that have a rejected NBS are contacted by the screening team and asked to complete and provide evidence of online training. • Visit the NBBS Lab at Southmead • To write a short reflective piece on how your practice aligns with the current NMC Code and how you can improve this skill. • 3 or more avoidable repeats within a month they will be asked to work alongside an identified NBBS expert. For all new starters we are adding a visit to the NBS lab as part of their induction programme. There are discussions around having a NBS Clinic within UHBW. A team of dedicated staff who complete NBS on Day 5. There are concerns that this may lead to the 'deskilling 'of other members of the maternity team. **<u>Newborn Hearing Screening Programme</u>** • KPI 1 (percentage of screens completed within 4 weeks of eligibility for screen) and KPI2 (percentage of babies who have received audiology appointments within 4 weeks of screen completion) met for Q1 to Q3 19/20 (≥ 98 and ≥ 90% respectively). Q4 has been impacted by Covid-19 pandemic and have not been met (93.2 and 67.1% respectively) • Screening during the Covid restrictions was challenging but the screening team and audiology adapted well. The screening team continued to screen all babies in the hospital setting. All audiology referrals are being offered appointments in the time frame and there are no babies outstanding. • Referral rates from screen to audiology had successfully been reduced. Screening as close to discharge as possible, if baby over 18 hours protocol now suggests babies have aABR (automated auditory brainstem response). This has once again increased due to Covid 19 as there has been an increased pressure to screen prior to discharge due to limited community clinics /parents not wanting to attend community clinics. • Parent satisfactions survey was completed in July 2019.

Overall the results of the survey were very positive. In particular 94.3% of parents felt the screener explained the test well, and all parents felt the screener's knowledge of the hearing screening process was excellent (89.4%) or good (10.6 %). Almost all parents felt the screener answered their questions in an understandable way.

- The recent QA visit, November 2019 (NBT) commended us on our presentations given to members of the multidisciplinary team to raise awareness of the newborn hearing screening programme and the roles they play. Recommendations from QA visit : An audit and SOP schedule should be formalised and documented and should include a clear process for sharing findings.

Key Performance Indicators (KPI) Newborn Hearing. These numbers include babies from Bristol and Weston.

ST1 - % screening completed within 4 weeks of birth.
Acceptable >98% Achievable >99.5%

Q1	Q2	Q3	Q4
98.9	98.3	98.2	93.2

ST2 – Well babies referred from OAE1
Acceptable <27% Achievable <22%

Q1	Q2	Q3	Q4
22.4	24.1	23.1	20.7

ST3 – Total referrals to audiology
Acceptable <3% Achievable <2%

Q1	Q2	Q3	Q4
2.7	2.6	3.3	3.0

ST4 % Audiology appointments offered within 4 weeks of screen.
Acceptable >97% Achievable > 99%

Q1	Q2	Q3	Q4
98.6	100	94.1	88.6

<table>
<tr><td></td><td>ST5 % Audiology appointments completed within 4 weeks of screen.
Acceptable >90% Achievable >95%
<table><tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr><tr><td>95.7</td><td>95.7</td><td>90.6</td><td>67.1</td></tr></table></td></tr>
<tr><td>ANNB screening local operational group</td><td>• Antenatal Screening Governance meetings every 3-4 months, consultant obstetrician chair. Good attendance.

• Newborn Screening Governance meetings - group meeting quarterly. Neonatal Consultant chair. Good attendance.

The frequency of these meetings has been disrupted due to Covid 19. Plans to reinstate form September 2020

• Screening information taken to antenatal working party / postnatal working party (monthly). Relevant screening issues are also discussed at the monthly Ward Sister’s meetings, IT meeting (monthly) and Women & Children’s Clinical Governance (twice a year).</td></tr>
<tr><td>Achievements in last 12 months</td><td>• Purchase and installation of 3 new GE E ultrasound machines. Initially problems were recognised regarding accuracy of NT measurements (under-measurements), this was addressed immediately with Application Specialists working with the Sonographers to optimise image quality.
• The ultrasound department now performs all FTCS for the Trust (previously FMU Consultants scanned IVF and twin pregnancies). With additional training and support from FMU, the Sonographers have now been trained to perform IVF and twin pregnancy FTCS and provide this service. This is of benefit to FMU Consultants as they have increased time for more specialised cases and the QA of the FTCS is more standardised (ie. using same machine pre-sets, same team of operators who perform FTCS more frequently)</td></tr>
</table>

	• The FTCS and Anomaly screening programmes have continued successfully through the Covid-19 pandemic. With altered procedures eg. Cleaning, PPE, and some restrictions on accompanying partners, the Ultrasound department has maintaining a high level of service whilst protecting staff and patients. • Temporary closure of Weston Hospital – the ultrasound department at St Michaels covered the screening programmes through the temporary closure of Weston Hospitals due to Covid-19. This was supported by rotation of staff between sited (BRI and SBCH) and additional bank duties. There was no disruption to the screening programmes during this challenging time • Weston Hospital now offers universal testing for Sickle Cell and Thalassaemia to all women. Prior to this Weston was considered a low prevalence area and therefore provided selective screening identifying those women deemed to be high risk following completion of the Family Origin Questionnaire were tested. • NCARDRS report for fetal cardiology – UHB one of the best performing trusts in the country for cardiac screening
Surveys Checks/Failsafe's Audits	There is a SOP and audit schedule for antenatal & newborn. Not all the audits completed regularly are listed here. **Summary of 20 week anomaly scan audit April 2019 – March 2020 – St Michaels Hospital, Bristol** An audit of 24 Sonographers working at St Michaels Hospital was performed between April 2019 and March 2020. Sonographers 4 agency staff 2 temporary bank staff 1 newly qualified 3 sonographers (maternity leave during this period) 2 members of staff have taken long term sick leave. An audit was performed randomly selecting one 20 week anomaly scan for each Sonographer for each quarter. The ultrasound report and stored images were reviewed by the Screening Support Sonographer. A template was used to score the images and report to ensure compliance with FASP and departmental guidelines.

Total number of scans audited = 75

Colour code	Total number	Percentage
Green – fully compliant	64	85.3%
Amber- mostly compliant	10	13.3%
Red – non compliant	1	1.3%

If an amber or red code was given then further images were reviewed to determine whether it was due to patient or equipment factors, human error or whether further training or support was required.
Amber code was given for the following:

- Not commenting on maternal pelvic pathology on report; however in some cases images were stored.
- Not storing image of LS cervix demonstrating placenta site.
- Sub-optimal views due to patient factors
- Head anatomy measured but not reported

Red code was issued for the following:

- A combination of the above

All Sonographers have been emailed their results and any amber or red codes have been directly addressed to the Sonographer at the time of audit.

It is noted that the one red code was given to a sonographer who worked across different sites, undertaking new areas of work and therefore had a period not working in obstetrics. Once this was identified additional support was offered and in the following quarter reported no problems were identified.

There has been an overall improvement compared with the audit results of 18-19 with 85.3% of Sonographers fully compliant in 19-20 (79.1% in 18-19) and 1.3% non-compliant in 19-20 (5.9% in 18-19).

Management of positive syphilis serology in pregnancy
Report July 2019

All antenatal positive syphilis screening results. Because Unity Sexual Health receives referrals from both UHBristol and NBT booked women, the audit took place across both trusts. Information was obtained from the Antenatal Screening Midwife database, Evolve notes, and MillCare (Unity's electronic notes).

Time period for analysis – 2 years (2017 and 2018) – 9 women at

	UHBristol, 11 women at NBT. Criteria – Results reported for UHB only. 1. Antenatal Screening Coordinator to refer all women with a positive Syphilis result to Unity Sexual Health. Target 100% 100% (9/9) (UHB) 2. All women with a Positive Syphilis result to be contacted by a Sexual Health advisor within 5 working days of referral. Target 100% 78% (7/9) (UHB) 3. Face to Face consultation between patient and sexual health specialist within 10 working days of positive syphilis result being reported. Target 100% 78% (7/9) (UHB) 4. Face to Face consultation between patient and sexual health specialist within 10 working days of positive syphilis result being reported Target 100% N/A 5. Referral of any woman requiring treatment for syphilis in their current pregnancy for Fetal Medicine review – ANSW to coordinate Target 100% N/A 6. If treatment required during pregnancy, birth plan documenting neonatal assessment and treatment will be provided by Unity Sexual Health Target 100% 100% (9/9) (UHB) 7. Birth Plan copied to ANSC, Obstetrician, FMU Cons, Neonatologist, Community M/W and GP (all if applicable) Target 100% 100% (9/9) (UHB) 8. Completion of recommended neonatal follow up when required. Target 100% 89% (8/9) (UHB) Women who had previously been treated correctly for past syphilis declined a face-to-face meeting with Unity or their appointment was not felt necessary by the sexual health team. There was good documentation of telephone conversations with the patient. One baby did not have complete follow-up. 2019-2020 Weston had zero screen positive syphilis results.

<table>
<tr><td></td><td>
On-going audit – Completion of QUAD Forms
<table>
<tr><td></td><td colspan="2">CORRECT</td><td colspan="2">INCORRECT</td></tr>
<tr><td></td><td>STMH</td><td>WGH</td><td>STMH</td><td>WGH</td></tr>
<tr><td>Q1</td><td>98.4</td><td>100</td><td>1.6</td><td>0</td></tr>
<tr><td>Q2</td><td>81.25</td><td>100</td><td>18.75</td><td>0</td></tr>
<tr><td>Q3</td><td>89.47</td><td>100</td><td>10.53</td><td>0</td></tr>
<tr><td>Q4</td><td>95.24</td><td>100</td><td>4.76</td><td>0</td></tr>
</table>
Acceptable standard 97%.
Incorrect forms – due to missing information. This includes hospital code, address, IVF, previous trisomy, IDDM and scan date.

To be undertaken:

Audit of tracking register – new tracker form is being designed for use at all bases across Bristol and Weston. The audit will be completed when this tracker form is in use.
Audit of completion and return of Sickle Cell and Thalassaemia alert forms.

</td></tr>
<tr><td>Inequalities</td><td>
Describe how inequalities are identified and addressed. Is there an inequalities analysis and action plan?

Use of NHS screening programme resources – easy read guides and “Screening test for you and Your Baby” translations. Both leaflet and on ‘Your Pregnancy at St Michael’s’ app.
Use of face to face interpreter or telephone interpreting service. This process continued during Covid 19 as thought to be essential in providing important information.
Deprivation of Liberty Safeguards (DoLS)
All Trust policies have Equality Impact Assessments

</td></tr>
<tr><td>Education and training</td><td>

Maternity services training needs analysis includes antenatal & new-born screening services. Has been updated to include new-born hearing session delivered by hearing screeners.
Face to face updates for NIPE Midwife practitioners. Dates set for every 6 months. Midwives to attend at least every 2 years. These sessions have been delayed due to Covid 19.

</td></tr>
</table>

	• Mandatory training for midwives / maternity assistants every 2 years.1 3/4 hours antenatal & new-born screening update. New-born hearing screening now deliver session as part of screening update. These sessions are led by a screening coordinator from Bristol and Weston. All power points have been updated to include information about both areas • As part of their induction, all obstetric doctors have face to face induction with a screening coordinator. • Training /updates of neonatologists led by consultant neonatologists.
Learning from incidents over last 12 months	• 3 incidents of delay in FTCS blood samples not reaching the lab in a timely manner. Samples were located and were able to be processed. There is an issue with the transport from St Michael's Hospital to Southmead. Datix were completed. Along with the FTCS samples there are often samples for FMU. The impact on these sensitive samples getting lost / arriving too late to be processed is huge. Therefore, we have added the issue to the risk register. • Tracking of screening test results. Screening test results not being followed up at 16/40 appointment. Resulting in delay of testing and possibility that screening tests of choice not being able to be performed. A new generic tracker form is in the process of being designed. It will be used across all bases in both Bristol and Weston. We will then complete an audit of the use of these forms. SIAFs • 3 missed QUADs – no root cause found for the incidents. Each incident occurred at a different base and involved a different midwife. Missed QUADs due to human error. • 2 FTCS samples sent on Friday PM sample did not arrive in the lab until Monday AM. As it was not known where these samples had been stored they were not able to be processed. One patient recalled and QUAD repeated. The other patient was in Poland. As it was not possible to repeat the QUAD in the specified timeframe she was offered a NIPT – the trust paid for the cost of the private test. **Weston** • 2 incidents of inaccurate identification of ethnicity on the FOQ. Both were identified by the laboratory which delayed

	screening slightly until clarification was confirmed. Datix were completed. Universal screening has since been implemented in Weston. SIAF Baby was not identified on S4N . Investigation identified; • Weston has two sites on S4N and only one member of staff had access to both sites. • Baby discharged from St.Michaels NIPE status not recorded. • Community midwives failed to identify until day of discharge. All administration staff now has access to both sites on S4N. S4N was checked and confirmed that there were no other babies with an outstanding NIPE. Baby's NIPE did not detect any abnormalities. SIAF Patient consented for haemoglobinopathy (Hbo) screening but had been missed. Investigation identified 2 errors; • Lab processed sample without completing Hbo result. Concluded no instructions in the associated SOP on amending vetting comments once saved. • Hbo result incorrectly recorded on Midwives tracker record as NAD. Patient reoffered screening but declined as had a miscarriage.
User feedback	• Antenatal client satisfaction user survey – questions agreed, needs to be finalised and performed. • Newborn client satisfaction user survey – to be completed Aim is to complete both of these as soon as possible and within the next 12 months
QA action plan	Last screening QA visit was 17/01/2017. All QA actions for antenatal & newborn screening from the visit complete. Visit planned for September 2020 delayed due to Covid 19. .
Issues for escalation/ risks	• Risk 3391 - Risk that without specialist Pegasus Counselling training for Community Midwives new PHE AN screening standard will not be met. It has been decided that Community midwives will not have the capacity to counsel low risk couples and arrange father of baby (FOB) testing. The screening team have been given additional hours to enable them to coordinate/counsel low risk couples and take FOB bloods. The screening

	midwives were booked to attend appropriate study days but these have been delayed – no new training dates have been released. • Risk 4546 - Risk that samples from First Trimester Screening Clinic and Fetal Medicine Unit will arrive late in labs at Southmead Hospital. First trimester combined screening blood tests and any fetal medicine samples are taken to the Porter's Lodge at St Michael's Hospital to be collected by hospital transport at 9AM and 2PM. These samples are taken to the lab at Southmead Hospital for processing. It has been reported by the lab that some samples have not arrived within the usual time frame. The samples were either delivered late or located in areas other than the correct lab area. These tests need to be completed within a strict time frame. If it is not possible to retest this cohort of women the trust might need to offer Non Invasive Prenatal Testing (NIPT) with a private provider at a substantial cost to the trust. The FMU samples will include chorionic villus (CVS) samples and amniocentesis (amniocentesis) samples. The process of obtaining these samples carries a known risk to the pregnancy. To recall these women for retesting could result in adding a further risk of miscarrying the pregnancy or causing infection. • Risk 3232 - Risk that newborn babies will not receive their hearing screen in a timely manner. Madsen Accuscreen used in Newborn Hearing screening, equipment now over 7 years old, showing more frequent errors during screening and daily QA testing. If faults are found the machine need to be repaired resulting in extra cost. New equipment is required to maintain quality and cost effectiveness in the screening programme. If machine gives inconsistent /inaccurate results, then babies may be missed who have a hearing loss and also referrals may increase unnecessarily into Paediatric Audiology. Resulting in decreased capacity in audiology. late referral to audiology, increased risk in speech and social development • Action plan for avoidable repeat NBS – ongoing. We have resourced new Minevette non heparinised blood collecting pipettes – we hope the use of these will improve our unsuitable blood application repeat request.

Planned reconfiguration/re-procurement of services	• From April 2021 – plan for submission of KPI data for Weston and Bristol to be combined. Work to support this currently delayed due to Covid 19. • Weston Area Health Trust has merged with UHB – guidelines/pathways continue to be to be merged. • Processes for giving sickle cell & thalassaemia results to women/couples. New guideline / pathways being developed to support the changes in this process. Awaiting staff to complete appropriate training. • Midwives do not yet have access to request Hip ultrasounds on ICE. The work to push this forward was delayed due to Covid 19. • Weston midwives are not able to electronically request any USS scans via ICE .This has been escalated.
Priorities for next 12 months	• To continue to try to reduce the avoidable NBS repeat rate to below 2% • Training for screening coordinators to enable them to deliver proposed changes for Haemoglobinopathy screening. • To ensure NIPE trained midwives are able to request Hip ultrasounds on ICE. • Implementation of the enhanced Hepatitis B pathway has been postponed until April 2021. • To discuss need for newborn screening links in BRHC needed – need lead contact for NIPE & NBS. We have lead NBS nurses in NICU here and need the same in BRHC for NBS and NIPE.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28 January 2021

Report Title	**Maternity services assessment and assurance tool in response to Ockenden Review**
Report Author	**Ingrid Henderson Quality Patient Safety Manager Women's**
Executive Lead	**Carolyn Mills Chief Nurse**

1. Report Summary

Following the publication on the 11th December 2020 of the initial emerging findings and recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, NHS England and NHS Improvement set out the immediate response required of all Trusts providing maternity services and next steps to be taken nationally.
Consequently the Trust is required to self-assess the Maternity service and provide evidence that the Maternity Service has implemented the full set of the immediate and essential actions (IEAs) identified by Ockenden , and that this process is shared with the Trust Board and the LMS (local maternity system). The attached reports fulfil this requirement.

2. Key points to note

(Including decisions taken)

A self-assessment benchmarking report was shared with the UHBW Chief Executive and the Regional Chief Midwife to confirm the Trust had implemented the 12 urgent clinical priorities from the IEAs by 5pm on 21st December 2020.

Key area where the Trust need to take additional action or provide further evidence to meet the requirements are:

Area 1 - Enhanced safety

- Point (a) - a plan to implement the Perinatal Clinical Quality Surveillance Model. **Action:** a new transforming perinatal safety sub-group to be established to ensure all safety intelligence is triangulated and reviewed by a multidisciplinary team. The report from this group will be shared with women's governance groups, the Trust Board and the LMS at least quarterly.
- Point (b) - all maternity serious incidents (SI) are shared with Trust Boards and the LMS at least quarterly, in addition to reporting as required to HSIB. NHS England requires that all maternity SI are shared directly with the Board. At present they are shared with PSG and signed off by QOC. **Action:** all Maternity SI to be shared directly with the Trust Board at least quarterly. The LMS will add quarterly safety reporting and all maternity SI including HSIB reports as a standing agenda item.
- Action 2. The Trust is at the moment failing to submit accurately to the National Maternity Dataset MSDS2 which is an issue with system C.

Area 3 - Staff training and working together • Point (c) - confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety. **Action:** Trust Board to confirm that this is the case.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
The risks associated with this report include: **Risk 3343/ 2264/ 3688/ 33/ 988**
4. Advice and Recommendations *(Support and Board/Committee decisions requested)***:**
• This report is for **Assurance.**
5. History of the paper **Please include details of where paper has previously been received.**

[Name of Committee/Group/Board]	**[Insert Date paper was received]**
Women's Clinical Governance Group	**18/01/2021**
Quality Assurance Committee	**22/01/2021**

Recommendation Definitions:

- **Information** - report produced to inform/update the Board e.g. STP Update. No discussion required.
- **Assurance** - report produced in response to a request from the Board or which directly links to the delivery (including risk) of one of the Trust's strategic or operational priorities e.g. Quality and Performance Report. Requires discussion.
- **Approval** - report which requires a decision by the Board e.g. business case. Discussion required.

Maternity services assessment and assurance tool

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

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

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

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

Section 1

Immediate and Essential Action 1: Enhanced Safety

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

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
1. Regional clinical oversight	Quarterly safety report to be shared with Trust board and with LMS for external scrutiny. Suggestions for improvement to be incorporated into QI programme.	Feedback from service users and staff. Results of audits shared with governance groups, front line staff and included in safety reports to LMS and Trust Board.	The quarterly safety report requirement will be added to the LMS agenda from Jan 2021 Quarterly reporting to the Trust board to be included on the board meeting agenda.	QPS team to produce reports LMS leads, Tim Overton and Emma Grzyb-Yung Trust secretary under direction of Chief nurse/Medical Director	Admin support Alex Layard Senior project officer Trust secretary	Not a risk

Action 1. Leads in maternity and NICU review cases using PMRT. Multi-disciplinary meetings monthly. **1. External clinical specialist opinion**	UHBW already had a well-established multi-disciplinary team who meet monthly to review all Still Births and Neonatal Deaths. Other trusts are invited to present and be involved with cases that were also looked after by alternative providers. North Bristol Trust regularly attends the meeting and UHBW attend NBT meetings. Since use of the PMRT we have been tightening our timeliness and ensuring parents are involved. Parents are sent a letter which details the review process and asks if they have any questions they wish to be raised. They are then offered a consultant follow-up where the review can be discussed as part of debrief.	Reports shared with clinical teams and Multidisciplinary PMRT meetings across trusts within the southwest region. Evidence Safety Briefing Patent Safety newsletters. Parent PMRT Follow up letter SIs shared with patient safety group, Representative from each Division within the trust sits on this board to disseminate learning across the whole trust. Evidence Minutes from Patient Safety Group. TOR of Patient Safety group. Action plans shared and agreed with working parties. Completion of actions monitored through DATIX and working parties. Evidence DATIX – dated actions and attached evidence. Minutes from Governance groups for Antenatal and CDS working party, Postnatal working Party and NICU governance. Completion of outcome from actions audited on a monthly basis to ensure they have achieved the planned result. Evidence Monthly Audit of Action logs via minutes of governance groups. The Trust uses the Perinatal Mortality Review Tool and has a multi-disciplinary meeting with external representation when appropriate. Evidence PMRT presentations and Action logs. The trust participates in the CNST maternity incentive scheme. Evidence The trust has achieved all standards since implementation.	A plan to implement the Perinatal Clinical Quality Surveillance Model has been agreed. We are awaiting further guidance on the Perinatal Clinical Quality Surveillance Model.	QPS team and consultant governance leads in Maternity and NICU for perinatal mortality and morbidity have allocated time to complete PMRT and present at monthly M&M	Access to the tool and time to complete it Additional support for reviews with babies that have died in PICU who meet the criteria for PMRT. This is being agreed at present to meet CNST standards.	Back fill for long term sick in the QPS team

Action 2. MSDS awaiting system C upgrade which is preventing data submission to required standard. Some data submitted. When upgrade successful will be compliant.	Data analysis allows us locally and nationally to review themes and target areas for improvement. Some data enabled to be submitted MSDS	Medway system allows us to pull some data from the system enabling the trust to review areas of improvement Materityl data set.	Need to work towards paper light system by 2024 Need to improve IT access including connectivity and hardware in all community bases, mobile and in the unit for all patient contacts	IM&T as soon as equipment has been sourced and connectivity issues resolved within community Deadline ? Spring 2024 (NHSX has not issued a date just 2024)	IM&T to secure connectivity and hard wear Business case to finance cost of purchasing new IT equipment Community and inpatient matrons and lead obstetrician to support change in practice	We are waiting for the system C upgrade to be compliant which is not within our gift to sort out. MDS aware as this affects multiple providers using same system. Issue is on the risk register.
Action 10. Yes we have reported 100% of qualifying cases to HSIB and previously to NHS resolution	Respond proactively to all HSIB safety recommendations and feedback through NHS resolution All maternity SIs are shared with Trust boards at least monthly Trust board, via patient safety group, receives a monthly report of our present HSIB referrals. Action plans are overseen by patient safety group monthly	Audit of new standards implemented as a result of recommendations. Feedback from patients and their families. Continue to monitor compliance with new standards and implement further changes if non-compliant. If further errors are noted, action reviewed to consider alternatives to strengthen action. Consider 5 whys for non- compliance. Evidence Reporting to HSIB 100% compliance. Quality intelligence manger audits all admissions to NICU and DATIX and produces a report monthly. HSIB reports directly to NHS resolutions since COVID 19.	All maternity SIs are shared with the LMS at least every 3 months	QPS team and LMS lead obstetrician and lead midwife To start by end of Jan 2021	The Clinical Lead for the LMS needs to ensure that SIs are a standard agenda item on the LMS Delivery Board. The LMS chair needs to sit on CCG Board.	Review of IEA for StMH undertaken and shared with safety champions, LMS and HoN/HoM at NBT and UHBW

Immediate and essential action 2: Listening to Women and Families

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

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

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

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

Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.

(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Action 1: All babies that fit the PMRT criteria are reviewed within a multidisciplinary meeting. Action 7: The LMS has appointed a new chair for the MVP, the post having been vacant for a number of years. Maternity services within UHBW conduct a monthly survey with women who have had involvement with the maternity services. We use the information gathered to improve services. UHBW uses the Patient and Public Involvement Manager to co-produce plans to develop services. Currently, they are looking at the induction of labour process with women, delayed due to Covid-19. Friends and Family Test is used on a rolling basis. Action 9: Identification of an Executive Director with specific responsibility for maternity services agreed Patients can use PALS or the advocacy service for an independent senior advocate	Evidence CNST standard 50% reviewed within 4 months. Trust is compliant MBRRACE report 2020 completed Dec 2020 Parents are sent a follow up letter advising of the PMRT review process and offering an opportunity to feed back to the trust and ask any specific questions they would like answering as part of the review process. Parent letter New Chair in post Patient Survey Evidence from engagement events A patient story from maternity services has recently been to Trust Board and related to maternity patient experience of giving birth during the pandemic. Evidence Minutes from meeting Evidence Monthly survey of patients	Feedback from meetings, engagement with MVP and other service users. To respond to feedback and initiate user suggestions for improvements The Chief nurse is the executive Director for Maternity Services Sue Balcombe is the non-executive Director	Set up monthly meetings between divisional safety champions and exec and non-exec to review safety and challenge compliance evidence	PAs to exec and non-exec to liaise with Sarah Windfeld/Pam Cairns and Sneha Basude in Jan 2021 to arrange monthly meetings with new chief nurse and Sue Balcombe	PA support	QPS manager oversees meetings as requires evidence of meetings for CNST

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

The HOM has reviewed and updated the Morecambe Bay Action plan in relationship to the Ockenden report Action 4: Staff training and working together Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week Action 8: Assurance that a MDT training schedule is in place. Funding allocated for maternity staff training is ring-fenced Any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	Evidence Updated action plan An obstetric consultant-led labour ward round is performed twice daily with the multi-disciplinary team, including the anaesthetic team. During the working week day, a Consultant Obstetric Anaesthetist is present on labour ward. The Trust has a consultant anaesthetist on call 24/7. Evidence A multidisciplinary team CDS handover is also carried out at the start and end of each shift, which is twice daily. Labour ward staffing guidelines Ward round spot audit The Trust has face-to-face MDT training in place which includes live drills. We also have cross-city MDT fetal surveillance days, which are delivered monthly. Evidence Obstetric Emergency Programme/training package Compliance Report All staff training funding is ring-fenced. We have three new Practice Education Facilitator midwife roles which are funded by HEE and the LMS, which are ringed-fenced for education purposes. We have a fetal monitoring midwife and a dedicated Practice Development Midwife. CNST funding is used to improve the maternity pathway each year. This included an additional quality patient safety midwife advisor, and funding of additional sessions to support a separate consultant-led elective c-section list every day, in 2020/21. The obstetric labour ward lead and the neonatal lead have allocated time to co-ordinate the return for the Perinatal Mortality Review Tool and to facilitate the multidisciplinary review. Obstetric labour lead/Neonatal lead/Patient Safety midwife : Evidence Job plans and allocated time	Divisional and trust board and LMS	**Multidisciplinary training and working** This evidence must be externally validated through the LMS, 3 times a year. This will be included within the LMS terms of reference.	LMS lead by end of Jan 2021	Admin support	This is not a risk

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

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

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
a)Managing complex pregnancy Every woman with a complex pregnancy has a named consultant; this is documented in the woman's hand held maternity notes and also recorded on the maternity PAS system. Every woman with additional needs also has a care plan which is kept both electronically and in paper format on CDS; these plans are updated after each visit. **b) maternal medicine specialist** The Trust hosts the maternal medicine team which offers specialist tertiary multidisciplinary care for women with complex medical conditions throughout the South West of England in addition to the local Bristol area. In Bristol there are currently 2 specialist Maternal Medicine services, specialising in different aspects. The Maternity and Neonatal Safety Improvement Programme (MATNEO SIP) will be appointing a Clinical Lead for the South West to lead on further development as a priority.	At present, we do not audit to provide assurance that all the women with a complex pregnancy have a named consultant lead. Evidence Audit of 100 notes to be carried out Women under the care of the maternal medicine team and the fetal medicine team do have an allocated named lead consultant. Evidence Audit of a 100 notes to be carried out	The audits will be reported through women governance groups and highlighted on the new board report to be shared with the maternity safety champions.	A report has been requested from BIU to audit named consultants over the last year. In addition a snap shot audit of handheld notes will be provided. Depending on the results of this audit further audits at intervals to be agreed will be scheduled.	BIU and leads for AN/CDS working party	BIU IT midwives	We are aware there is an issue with patients not having the correct named consultant which is on the risk register and there is a need to improve our processes in this area.

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Risk assessment throughout pregnancy Each woman has a formal assessment at booking and at 36 weeks, as per NICE guidelines. A risk assessment is performed at each antenatal review and when each woman is assessed in labour. This formal assessment is on the front page of the hand held maternity notes and on the partogram. In the midwife-led setting, the service has created a virtual buddy system to be used hourly for risk assessment, which will be launching in January 2021. Regular audits are completed to ensure that maternity guidelines are being followed appropriately. This includes audit of questions women are asked during pregnancy (in line with national guidance) - e.g. domestic abuse and mental health wellbeing.	At present, we do not audit to provide assurance that all pregnancies have a risk assessment documented at both booking and at 36/40. Evidence A notes audit of 100 sets of notes as part of a documentation audit which is undertaken annually will now include this risk assessment confirmation. A snap shot audit of 20 sets of notes will be completed to support this first board report. Antenatal and CDS working party Governance group minutes.	The audits will be reported through women governance groups and highlighted on the new board report to be shared with the maternity safety champions.	Implement virtual buddy system as planned. We will roll out training to midwives to assist the use of the personalised care plans and audit their use.	Community Matron by the end of Jan 2021	Auditors	not a risk

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.
The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term? Risk on risk register 3688 Training needs have been escalated to SLT monthly through CNST updates
Monitoring fetal wellbeing The Trust has a lead midwife and lead obstetrician in place to lead best practice, learning and support, and an obstetric lead for CTG training. Maternity staff participates in yearly fetal monitoring training and the Trust is compliant with the national guidance. We have a three year online fetal monitoring training programme which is MDT-based, and the practice development team monitor compliance with attendance annually. There is a weekly MDT CTG and M&M meeting which is run by a consultant obstetrician. A fetal monitoring multidisciplinary training day commences in January 2021 and is complaint with SBLCSv2. This training is led by the fetal monitoring lead obstetrician and the CTG lead midwife. The CDS Midwifery Lead and Obstetric Labour Ward Lead review all ATTAIN cases and learning is shared through the daily safety briefing. Evidence-based learning is disseminated through a monthly newsletter. The Patient Safety Lead midwife and Head of Midwifery undertake a monthly quality and safety walk around, to engage with frontline staff.	Attendance at training and reviews. Evidence Mandatory training compliance report Feedback from M&M and CTG meetings, Evidence Presentations and Newsletters Minutes form Patient safety walk around. .	Feedback from staff attending training days to improve training where gaps are highlighted 90% or above multidisciplinary training all staff groups involved in birth as per CNST standard 8 achieved by CNST reporting deadline July 15th 2021 Successful completion of on-line/ in class CTG training Improving audits, symphysis fundal height audits Fetal monitoring audits Babies under 3rd centile unexpectedly fetal growth restriction found at birth, cases to be investigated for learning.	Ensure learning is shared floor to board and with LMS	Monthly in board report/dashboard Michelle Hirst to set up sub group to review intelligence reporting for board report initial meeting aim Jan 2021	QPS team to update board report and share with women's governance groups/board /LMS	Sub group to meet to ensure intelligence reporting is being used effectively to highlight issues and ensure learning is actioned.

Immediate and essential action 7: Informed Consent

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

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

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

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Informed consent Information on pathways of care can be accessed via the 'My Pregnancy' App. A link to this and patient information on maternity services can be found on the Trust website, and all women are advised to access this information via the App at booking.	There is an established governance reporting pathway for both complaints and patient experience within the Trust. Evidence -A monthly complaints report is shared at women's governance group/ Quality Assurance Group/Divisional Board and then Trust Board. This report includes all the informal and formal complaints and the learning from them. Evidence A monthly Patient Experience report is shared monthly at Patient Experience Group and Women's Governance/ Quality Assurance Group/Divisional Board and then Trust Board. This report includes feedback from FFT (friends and family survey) We also receive ad hock feedback from local MPs, our Facebook page from the Trust via the communications team. Health Watch also offer ad hock feedback when they have received any from the public. We also receive feedback from patients involved in investigations and those offered debriefs after an episode of care.	The Trust is able to circulate feedback surveys for patient's and receive regular feedback which reassures the Trust that we are able to involve are service users. The maternity service has a MVP who seeks to gain service user feedback and shares this through the LMS. We invite service users to be involved in co-production of service improvements.	Ensure link has been added to trust website, request made. Seek more service user representation for our working parties, especially from BAME and vulnerable groups of women and their families.	MVP chair and transformation team	MVP chair and transformation team	Maternity staff feedback to improvement leads any issues/ideas they receive from their patients. Highlight this to staff though newsletter and team meetings

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

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

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

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Clinical workforce planning gaps in rota reviews, paper escalated through divisional board to executive for oversight Business plans made to improve job planning and cover to minimize gaps in rotas, senior roles acting down when needed to cover junior gaps in rotas.	Medical cover, gaps in rota Evidence report shared with divisional board and reviewed by exec. Actions agreed. Senior staff act down when required.	Staffing levels Datix as red flag and monitored through Datix system.	Temporary staff employed to ensure safe staffing levels.	The trust undertakes an annual staffing review with the Chief nurse	Already in post	Risk 33 and 988 on risk register re BAMP standards for NICU and capacity issues with risk that babies are transferred out to make room for admissions or declined admission due to lack of cot, or staff to open cots. More staff have been employed
Midwifery workforce planning Annual Birth rate plus review and results acted upon	Monthly staffing reports to board. Daily Flow meeting Birth rate plus review in 2020 results shared with board and actions agreed to increase staffing. Evidence- Birthrate Plus report. Minutes of Women's Executive meeting		A bid was submitted on the OPP for additional requirements for staff following BR+ New staffs have been recruited. Evidence – Operating plan , Midwifery Establishment	Birth-rate plus is undertaken every 3 years. Activity and bookings are monitored monthly		

MIDWIFERY LEADERSHIP

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

The Head of Midwifery has direct professional line management by the Chief Nurse and meets with her monthly on a one to one basis and then also meets with her in her role as Maternity Safety Champion along with the other Maternity Safety Champions. The Head of Midwifery also sits on the LMS board and Divisional Board. The Trust does not have a Consultant midwife but has a specialist midwives. These include a practice development midwife who leads a team of Practice Education Facilitators and a CTG lead midwife. The specialist midwives are drugs, mental health, diabetes, infant feeding, Ante natal screening and safeguarding.
The Trust has a team of Research midwives and works closely with the University of West of England to provide continuous practice development courses for midwives.
The Trust has a leadership programme for all staff that midwives can access. The Head of Midwifery has participated in the RCM leadership programme for HOM's and most recently the Trust leadership development programme.
The Head of Midwifery has regular one-to-one contact with the Regional Chief Midwifery Officer.

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Review and update of guidelines/SOP/policies is a standing agenda item on working parties agendas. Corporate team circulates monthly report to highlight guidelines etc. needing to be reviewed. Obsolete guidelines etc. are removed from data management system (DMS). Authors have to request extensions if still working in updating them. NICE/RCOG/Green top are included in reference to ensure review has included any new standards from national guidelines	Evidence Monthly report from corporate team Monthly standing agenda item on working parties Audit action plan maintained by audit facilitator, all mat neo audits are logged with Jon Penny. Evidence Results of audit shared through governance meetings and separate audit meetings for O&G	Reviewed by relevant working parties Oversight by named consultant or midwife	Ensure all guidelines/policies/SOPs have auditable standards	Anne Tomlinson Practice Development Midwife	Admin support from Karen Artus/Jon Penny	Not a risk, process in place

University Hospitals Bristol and Weston NHS Foundation Trust

Paper to follow:

Agenda item 14

Learning from Deaths Quarter 2 Report

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28 January 2021

Report Title	**Quarter 2 Patient Experience & Involvement Report**
Author	**Paul Lewis, Patient Experience and Involvement Team**
Executive Lead	**Deidre Fowler, Interim Chief Nurse**

1. Report Summary

The Quarterly Patient Experience Report provides a comprehensive review of patient survey data and Patient and Public Involvement activities being carried out at the Trust.

2. Key points to note

(Including decisions taken)

The Trust's postal survey data (which currently covers the Bristol hospitals) shows that patients continued to report a positive experience of inpatient services during Quarters 1 and 2 (April-September 2020), despite the challenges presented by the COVID-19 pandemic.

During the pandemic, an increasing number of outpatient appointments have been carried out "remotely" by telephone and online. Our postal survey data suggests that these changes have been received positively by many patients. This also coincides with a decrease in reported wait times in hospital-based clinics. As a result, patient-reported experience of outpatient services, as measured by our postal survey, has been particularly positive in recent months.

Whilst patient-reported experience has remained positive overall, there appears to have been a slight dip in the inpatient survey scores for the Division of Medicine and postnatal maternity wards. The South Bristol Community Hospital inpatient scores are also negative outliers, but seem to have been particularly affected by small sample sizes (over and above the longer-term trend of below-average survey scores for this hospital).

We continue to see some disruption to the Trust's survey programme. In particular, reduced response rates and service reconfigurations hamper our ability to carry out in-depth analysis of our postal survey data below Divisional-level.

The pandemic continues to affect the Trust's ability to undertake Patient and Public Involvement (PPI) activities, which tend to be carried out most effectively in face-to-face settings / groups.

The Friends and Family Test (FFT) will re-start nationally, including at UHBW, during December 2020. This survey has been paused by NHS England since February 2020 in response to the pandemic. Ahead of this national re-launch, the FFT was reinstated locally by the Division of Weston in September 2020 in order to ensure a form of regular, hospital-wide patient experience data for the Division. For the first time, this

quarterly report therefore includes Weston data (FFT only).
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
4. Advice and Recommendations *(Support and Board/Committee decisions requested)***:**
• This report is for **Assurance.**
5. History of the paper **Please include details of where paper has previously been received.**

Senior Leadership Team	17/12/20
Quality and Outcomes Committee	18/12/20

.

University Hospitals Bristol and Weston NHS Foundation Trust

Quarterly Patient Experience and Involvement Report

Incorporating patient survey data up to and including Quarter 2 2020/21

1. Overview of patient-reported experience

Successes	Priorities
The Trust's postal survey data (which currently covers the Bristol hospitals) shows that patients continued to report a positive experience of inpatient services during Quarters 1 and 2 (April-September 2020), despite the challenges presented by the COVID-19 pandemic. During the pandemic, an increasing number of outpatient appointments have been carried out "remotely" by telephone and online. Our postal survey data suggests that these changes have been received positively by many patients. This also coincides with a decrease in reported wait times in hospital-based clinics. As a result, patient-reported experience of outpatient services, as measured by our postal survey, has been particularly positive in recent months.	The Friends and Family Test (FFT) will re-start nationally, including at UHBW, during December 2020. This survey has been paused by NHS England since February 2020 in response to the pandemic. Ahead of this national re-launch, the FFT was reinstated locally by the Division of Weston in September 2020. This was in response to the need for regular, hospital-wide patient experience data for the Division.
Risks & Threats	**Opportunities**
Whilst patient-reported experience has remained positive overall, there appears to have been a slight dip in the inpatient survey scores for the Division of Medicine and postnatal maternity wards. The South Bristol Community Hospital inpatient scores are also negative outliers, but seem to have been particularly affected by small sample sizes (over and above the longer-term trend of below-average survey scores for this hospital). We continue to see some disruption to the Trust's survey programme. In particular, reduced response rates and service reconfigurations hamper our ability to carry out in-depth analysis of our postal survey data below Divisional-level. The pandemic continues to affect the Trust's ability to undertake Patient and Public Involvement (PPI) activities, which tend to be carried out most effectively in face-to-face settings / groups.	The Trust's main postal survey programme currently only covers the Trust's Bristol hospitals. Extending this programme to the Division of Weston is part of the Trust's merger plan. Whilst social distancing measures are in place, the most significant medium-term impact of the pandemic on the Trust's corporate patient experience programme is likely to be on Patient and Public Involvement (PPI) activity. However, this does create an opportunity to re-define our "PPI offer" - in particular through the greater use of online methodologies.

2. About this report

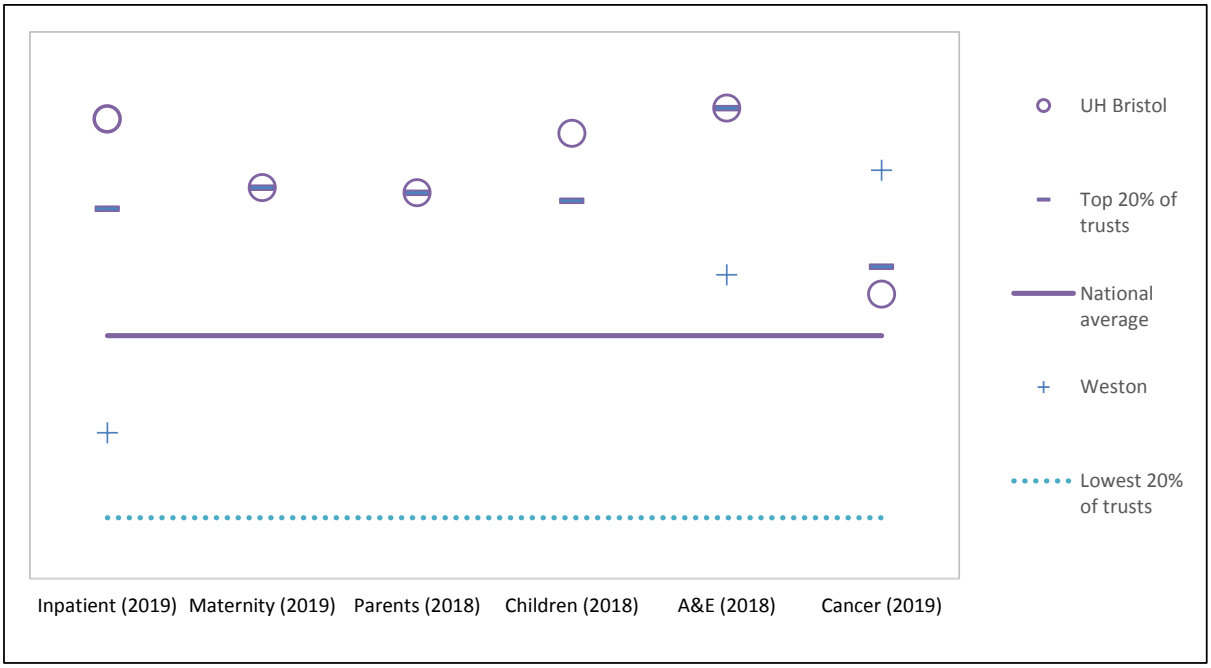
This report provides an analysis of patient-reported experience and summarises Patient and Public Involvement activities being carried out at the Trust. This activity has been disrupted by the COVID-19 pandemic, but we are still able to provide a headline view of patient-reported experience through the Trust's various postal survey programmes.

3. Data review: national benchmarks

The Care Quality Commission's national patient survey programme provides a comparison of patient-reported experience across NHS trusts in England. The data currently available pre-dates the UH Bristol / Weston Area Health Trust merger. Chart 1 shows that UH Bristol (as-was) tended to perform around or above the top 20% of trusts nationally in these surveys; whilst Weston Area Health Trust performed broadly in line with the national average. There were particularly strong performances for UH Bristol in the national inpatient and Children's surveys, and for Weston Area Health in the 2019 National Cancer Survey.

The results of each national survey, along with improvement actions / learning, are reviewed by the Trust's Patient Experience Group and the Quality and Outcomes Committee of the Trust Board. (Please note that no national survey results were due / published in Quarter 2).

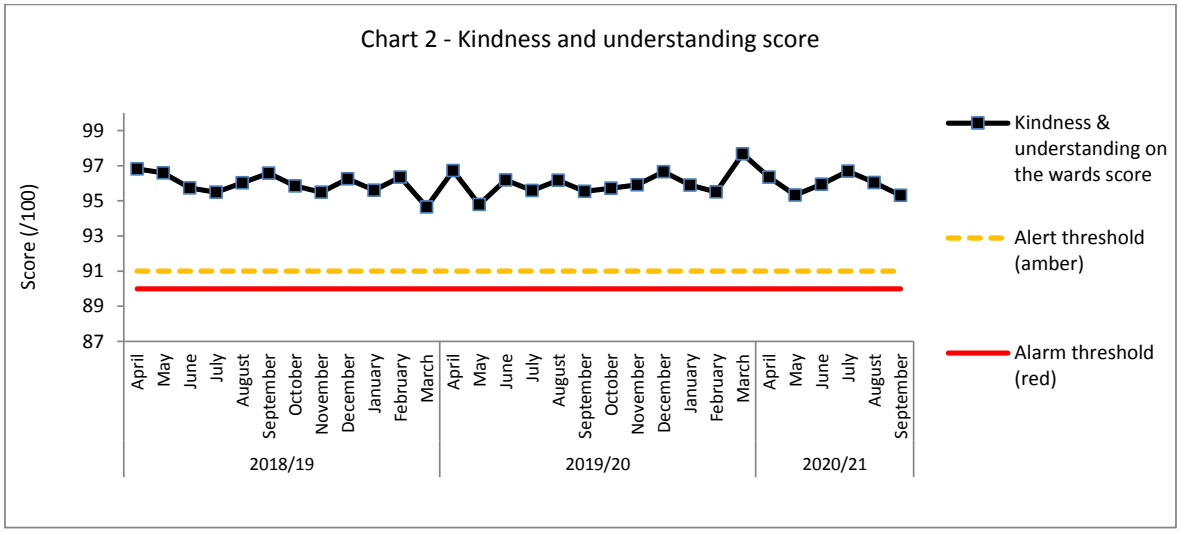
Chart 1: overall experience relative to national benchmarks[1]

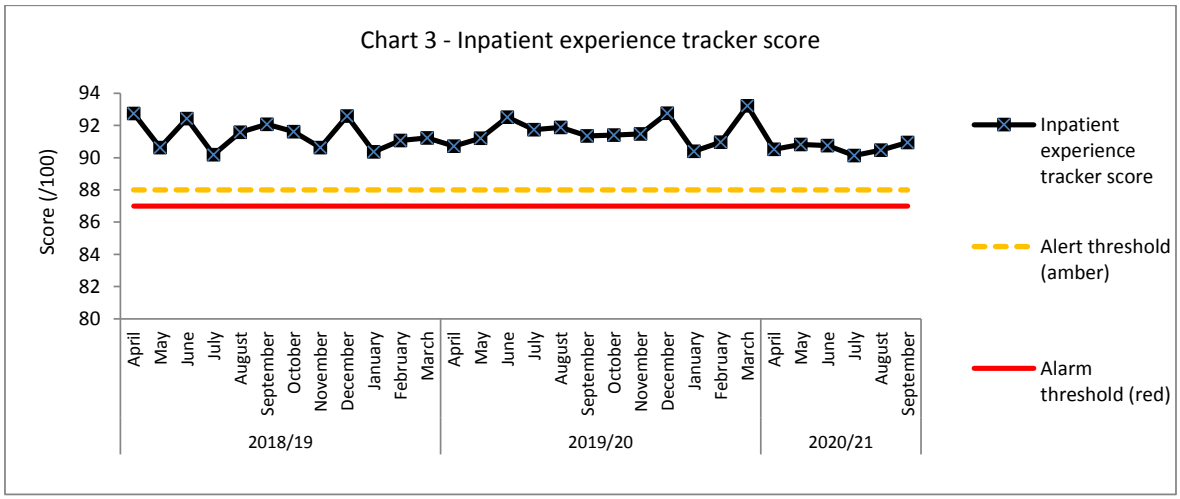


[1] This is based on the national survey question that asks patients to rate their overall experience. We have indexed (=100) each score to the national average to ease comparability. This overall question is not included in the national maternity survey and so we have constructed this score based on a mean score across all of the survey questions. Weston Area Health Trust does not participate in the national children's survey, national A&E survey, or the national maternity survey. Please note that the 2020 National Maternity Survey was cancelled for all Trusts by the CQC in response to the COVID-19 pandemic.

4. Data review: Quarter 2 postal survey scores

The following charts are taken from the Trust's postal survey programme. These surveys are currently sent to patients who attend the Trust's Bristol hospitals (the extension of these surveys to Weston General Hospital is part of the Trust's merger plan). Charts 2 and 3 show that inpatient-reported experience has remained consistently positive during the Covid-19 pandemic. Initially, in March 2020, there was a positive spike in these scores - which possibly may have reflected patients' appreciation of how staff responded effectively and rapidly to the demands of the outbreak. Since then the scores have returned to their normal, very positive levels.





The outpatient survey data in Chart 4 (over) shows an interesting trend. The scores initially dipped in our March 2020 survey, which was completed by patients attending clinics the day before the Government's announced the first COVID-19 "lockdown". This was a time of rapid service reconfiguration and much uncertainty. The scores improved over subsequent months, presumably as staff and services adjusted to the pandemic, and more recently they have been trending above their long-term average. This improvement is being driven by two factors in our data:

- Patient-reported waiting times in hospital outpatient clinics are much reduced
- In response to the pandemic, a number of appointments are now carried out by telephone or online. Chart 5 shows that patients appear to be at least as satisfied with these services as they are with hospital-based appointments - with initial indications being that people might slightly prefer telephone-based appointments.

Caution is needed when interpreting the outpatient data due to the relatively small sample sizes for this survey. Furthermore, we have only been collecting data on appointment type (Chart 5) since August 2020. However, the positive increase in the scores in Chart 4 continued in to October 2020 (not shown) and, as we build up our data, we will be able to gain further insights in to patient experiences of "remote" outpatient services. There is also a growing body of local survey work happening across the Trust's Divisions to understand the quality of remote outpatient services in more depth, including patient-reported experience elements. In short: there are tentative indications that patients generally welcome the changes that the Trust has made to the delivery outpatient services - although, of course, a preference for a remote or hospital-based appointment will vary between individuals and situations.

Chart 4 - Outpatient experience tracker score

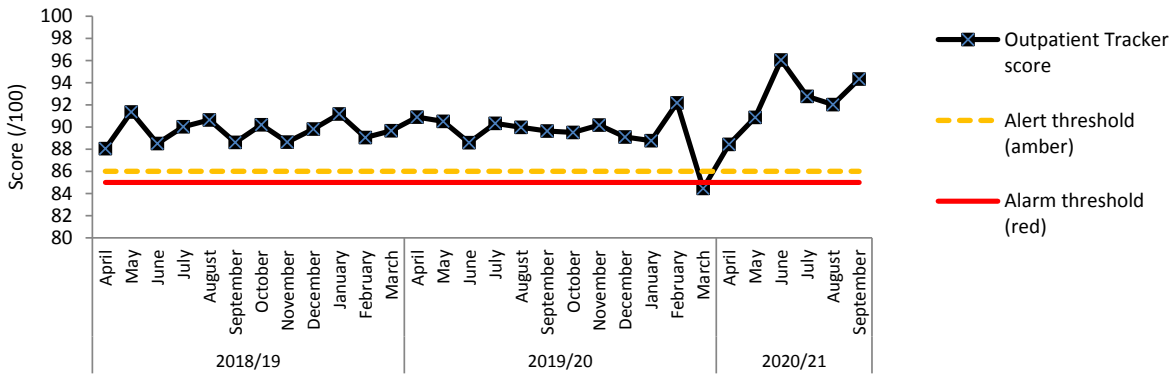
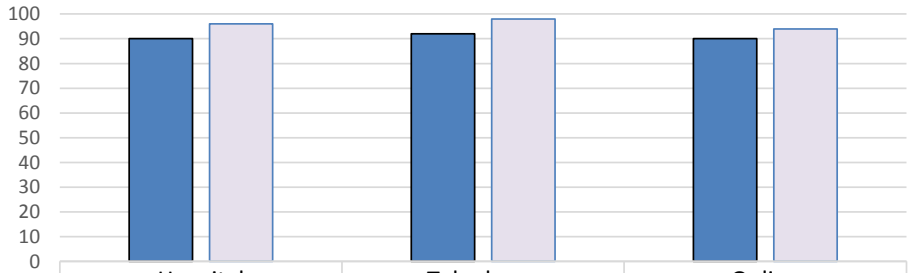


Chart 5: patient experience in outpatient clinics



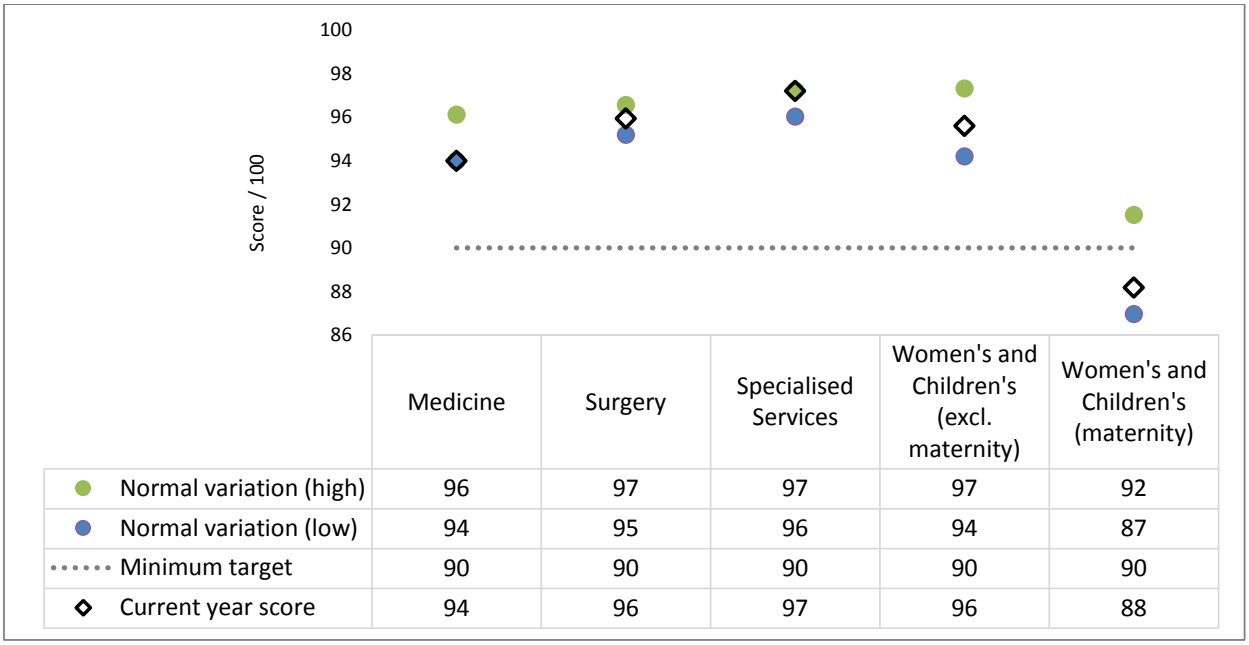
	Hospital	Telephone	Online
Experience rating (/100)	90	92	90
% rating care as "excellent"	96	98	94

It is difficult at present to establish a reliable picture of patient-reported experience below a Trust-level due to the impact of Covid-19 on our surveys[2]. However, with caution, we have been able to examine inpatient-reported experience at a Divisional-level - by aggregating the data for Quarters 1 and 2 (i.e. April to September 2020) and seeing how this compares to the long-term trend score for each Division (Charts 4 and 5).

These Charts suggest that inpatient-reported experience has remained very positive, with most Divisions broadly in line with their long-term average score once normal fluctuation in the data is taken in to account. An exception here is that the scores for the Division of Medicine were at the bottom end of their expected range and, in the case of the tracker score (Chart 5 - over), sat just on our minimum target. The Division of Medicine does tend to achieve slightly lower scores in our inpatient survey, which appears to reflect the presence of a number of "care of elderly" wards in the Division[3]. Whilst the year-to-date fall in the scores for the Division of Medicine is marginal (87/100 compared to the longer-term average of 88/100), and does not reach what is commonly defined as "statistical significance", this dip has been a fairly consistent trend since April 2020 and we can be reasonably confident that it is a real effect.

The maternity "kindness and understanding" score (Chart 4) was below the minimum target. The score (which is in line with national norms for postnatal wards) does tend to fluctuate around this level and is typically lower than for inpatient wards. However, like the Division of Medicine score, it does appear that the score has dipped slightly during the pandemic - from a long term average of 89 /100 down to 88/100 since April 2020.

Chart 4: Divisional kindness and understanding scores April-September 2020. *The two dots in the chart show the usual variation in each score over time (the "standard deviation"); so you would expect the current score, represented by the diamond, to sit somewhere between these two dots.*

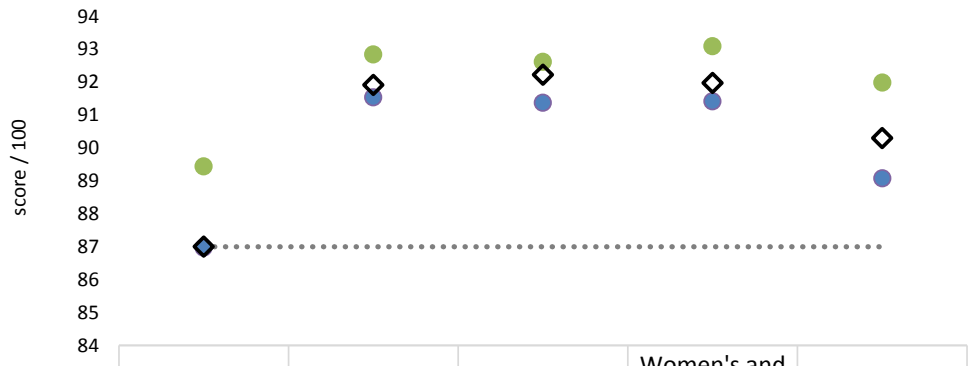


	Medicine	Surgery	Specialised Services	Women's and Children's (excl. maternity)	Women's and Children's (maternity)
Normal variation (high)	96	97	97	97	92
Normal variation (low)	94	95	96	94	87
Minimum target	90	90	90	90	90
Current year score	94	96	97	96	88

[2] The response rates have been lower, leading to smaller sample sizes. A number of hospital services have also been reconfigured, disrupting our ability to aggregate data over several months (which we have to do to get a reliable result at ward level).

[3] Research at a national-level suggests that hospital satisfaction decreases with age. Our own analysis of UH Bristol (as-was) national survey data showed that our "care of the elderly" services were rated positively by patients compared to the national average for these services.

Chart 5: Divisional inpatient experience tracker scores April-September 2020.



	Medicine	Surgery	Specialised Services	Women's and Children's (excl. maternity)	Women's and Children's (maternity)
Normal variation (high)	89	93	93	93	92
Normal variation (low)	87	92	91	91	89
Minimum target	87	87	87	87	87
Current year score	87	92	92	92	90

By aggregating the survey data between April and September 2020, the sample sizes are now large enough to build a picture of inpatient hospital experience during the pandemic (Charts 6 and 7 - over).

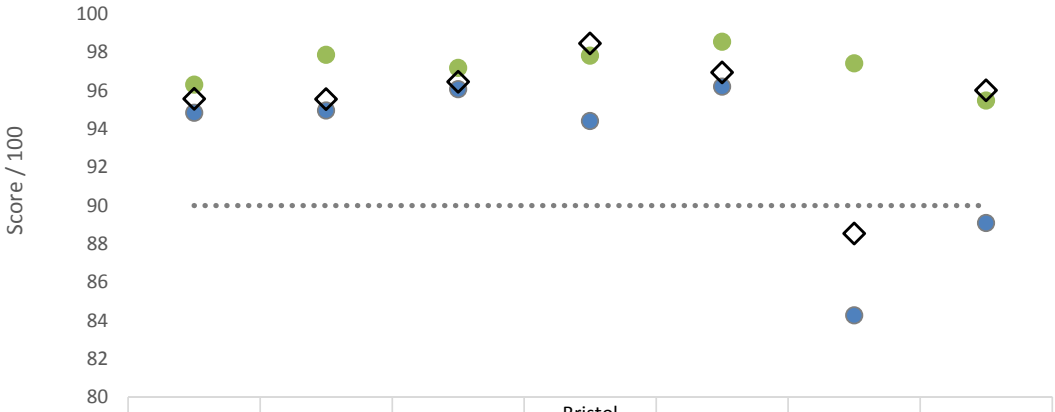
The most notable aspect of this data is that South Bristol Community Hospital (SBCH) is a negative outlier, particularly in respect of the inpatient experience tracker score (Chart 7). Caution is needed here because the sample size for the hospital over this period is very small - around 40 patients - making the margin of error very large[4]. This could easily account for the slightly below-target "kindness and understanding" score (Chart 6), and could also exaggerate the "tracker score" (an aggregate of five key survey scores, primarily relating to the theme of "communication").

Nevertheless, the results for SBCH broadly correlate with a longer-term trend of lower survey scores for the hospital. Patient experience scores do vary between different types of specialty and treatment. SBCH specialises in rehabilitation services - for example for patients following a stroke - which presents unique challenges for both staff and patients. It is not hard to imagine that patients at the hospital, who are often already facing long-term medical support and uncertain clinical outcomes, should have their experience made even more difficult by the current challenges and restrictions of the pandemic.

The Patient Experience and Involvement Team has carried out a number of projects with SBCH hospital staff and also external organisations, such as Healthwatch Bristol, which has shown that patients at the hospital are very positive about the care that they receive. In this respect the surveys scores don't seem to reflect the experience of patients at the hospital when they give face-to-face feedback. However, whatever the nuances of surveys versus qualitative methods, there are clearly opportunities to improve the experience of patients at SBCH at the present time.

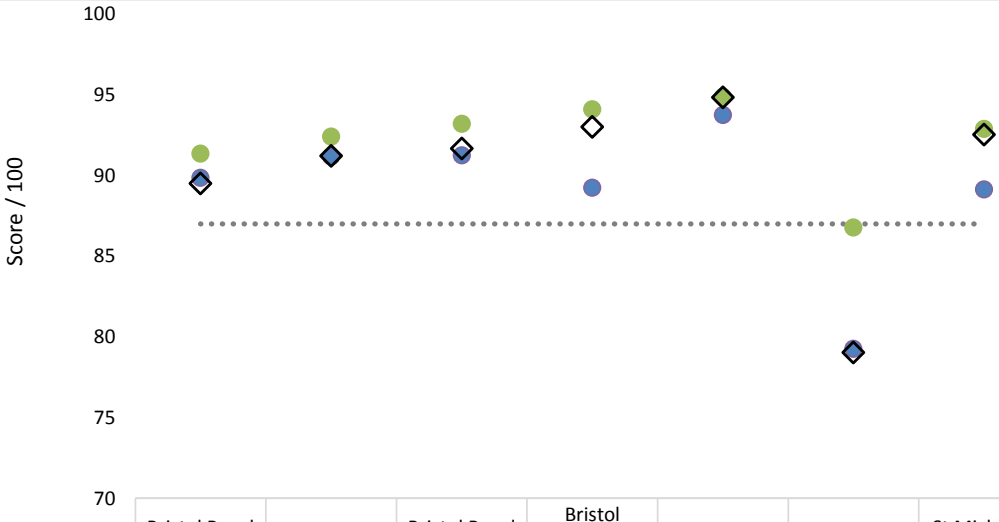
[4] Indeed, since April 2020 the monthly score for the hospital on this measure has fluctuated from a low of 63 to a high of 98, primarily because even one negative response can skew the whole the result.

Chart 6: Hospital-level kindness and understanding scores April-September 2020. *The two dots in the chart show the usual variation in each score over time (the "standard deviation"); so you would expect the current score, represented by the diamond, to sit somewhere between these two dots.*



	Bristol Royal Infirmary (BRI)	Bristol Heart Institute (BHI)	Bristol Royal Hospital for Children	Bristol Haematology and Oncology Centre	Bristol Eye Hospital	South Bristol Hospital	St Michael's Hospital (excl. Maternity)
Normal variation (high)	96	98	97	98	99	97	95
Normal variation (low)	95	95	96	94	96	84	89
Minimum target	90	90	90	90	90	90	90
Current year score	96	96	96	98	97	89	96

Chart 7: Hospital-level inpatient experience tracker scores April-September 2020.



	Bristol Royal Infirmary (BRI)	Bristol Heart Institute (BHI)	Bristol Royal Hospital for Children	Bristol Haematology and Oncology Centre	Bristol Eye Hospital	South Bristol Hospital	St Michael's Hospital (excl. Maternity)
Normal variation (high)	91	92	93	94	95	87	93
Normal variation (low)	90	91	91	89	94	79	89
Minimum target	87	87	87	87	87	87	87
Current year score	90	91	92	93	95	79	93

5. Friends and Family Test – Weston General Hospital

The Friends and Family Test (FFT) is a one-question national patient survey mandated by NHS England. It was paused in February 2020 in response to the pandemic and is due to re-launch in December 2020. At re-launch, the core FFT question will change from asking whether the patient would recommend their hospital care to their friends and family, to a question asking patients to rate their overall experience (see Table 1 – over).

At Weston General Hospital ("Division of Weston"), the FFT was relaunched in September 2020 - ahead of the national go-live - because this was the main hospital-wide satisfaction survey in place there (the Trust's postal surveys will be extended to the Division of Weston as part of the merger plan). Charts 8 and 9 present a view of the previous and September 2020 data for Weston against national benchmarks from 2019/20[5]. This provides assurance that the current scores are broadly in line with their positive pre-COVID-19 levels. There has been a slight dip in the scores since September 2020, but this is marginal and could easily be accounted for by the question change and / or lower response numbers as the survey builds up momentum again[6]. Nationally, trusts will start to report their FFT data to NHS England from January 2020. We will then slowly build up a more reliable picture of how the changes to the survey have affected scores and trends.

Chart 8: Emergency Department FFT scores at Weston General Hospital, against national benchmarks

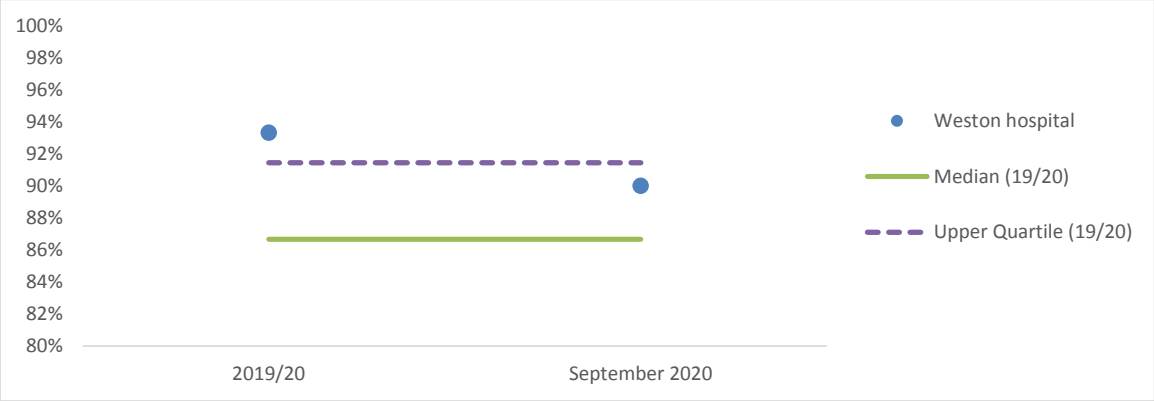
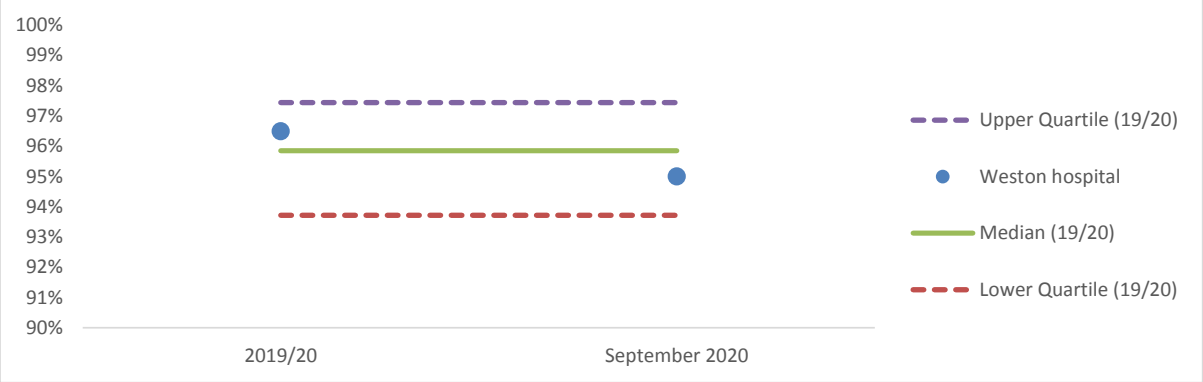


Chart 9: Inpatient Ward FFT scores at Weston General Hospital, against national benchmarks



[5] Specifically, April 2019 to February 2020, at which point the FFT was paused nationally.
[6] Ward / ED staff are involved in administering the survey and so it takes time to re-establish these processes. There were 74 ED responses and 424 for inpatient wards at Weston between September- November 2020. On average, during 2019/20 there were 594 and 1690 responses respectively per quarter. A smaller number of responses make it easier for a negative response to influence the overall results.

Table 1: comparison of previous and new Friends and Family Test (FFT) survey question

	Old FFT question	**New FFT question (from December 2020)**
Question	How likely are you to recommend our service to friends and family if they needed similar care or treatment?	Overall, how was your experience of our service?
Response options	Extremely likely Likely Neither likely nor unlikely Unlikely Extremely unlikely Don't know	Very good Good Neither good nor poor Poor Very poor Don't know

6. Patient and Public Involvement

The most significant medium-term impact of the COVID-19 pandemic on the Trust's corporate patient experience programme continues to be on Patient and Public Involvement, much of which was carried out face-to-face and in groups. These activities remain limited whilst social distancing measures are in place. Nevertheless, the Trust's Patient and Public Involvement Lead continues to support both corporate and divisional initiatives, including:

- Web-based Haemoglobinopathy patient focus groups
- The development of sight loss training for the Bristol Eye Hospital
- The development of a fatigue self-care workbook
- Web-based paediatric audiology translation service developments
- Providing advice on accessing the views of community groups as part of an HIV research grant
- Supporting and facilitating a "Carers Health Matters" event
- Supporting and developing the Trust's new "Message to my loved one" process, which allows friends, relatives and carers of a patient in our care, to send in messages via email or a dedicated phone line, which will then be printed and delivered to the patient.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28 January 2021

Report Title	**Quarter 2 Complaints Report**
Report Author	**Tanya Tofts, Patient Support and Complaints Manager**
Executive Lead	**Deidre Fowler, Interim Chief Nurse**

1. Report Summary

Summary of performance in Quarter 2

	Q2	
Total complaints received	521	↑
Complaints acknowledged within set timescale	84.5%	↓
Complaints responded to within agreed timescale – formal investigation	73.4%	↑
Complaints responded to within agreed timescale – informal investigation	90%	↓
Proportion of complainants dissatisfied with our response (formal investigation)	7.7%	↑

2. Key points to note

(Including decisions taken)

Improvements:

- Following a delay in recruitment to vacancies in the Patient Support & Complaints Team due to ongoing corporate service consultations, the Trust has successfully recruited a new complaints officer to create necessary additional capacity to support the influx of complaints from Weston Division as a result of Trust merger (however, also see risks and threats).
- Despite a significant increase in complaints being handled by the PSCT as a result of becoming a merged organisation, the Trust has continued to respond to the majority of cases received in a timely manner.

However:

- Only 73.4% of formal complaints were responded to within the timescale agreed with the complainant
- Complaints about staff attitude and communication increased in Q2.
- More than half of all complaints responses sent out by Weston Division in Q2 breached the agreed deadline.
- At the time of writing (December 2020), complainants are experiencing a delay of up two weeks in receiving a follow-up call from a complaints officer to discuss their concerns in detail. This operational backlog has resulted from posts held vacant and the influx of complaints from Weston Division. However, vacant posts have now been released for recruitment following conclusion of corporate services

integration, and agency staff are providing temporary additional support in the meantime.	
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**	
4. Advice and Recommendations *(Support and Board/Committee decisions requested)***:**	
• This report is for **ASSURANCE**	
5. History of the paper **Please include details of where paper has previously been received.**	
Senior Leadership Team	17/12/20
Quality & Outcomes Committee	18/12/20

University Hospitals Bristol and Weston NHS Foundation Trust

Complaints Report

Quarter 2, 2020/2021

(1 July 2020 to 30 September 2020)

Author: Tanya Tofts, Patient Support and Complaints Manager

Quarter 2 Executive summary and overview

	Q2	
Total complaints received	521	↑
Complaints acknowledged within set timescale	84.5%	↓
Complaints responded to within agreed timescale – formal investigation	73.4%	↑
Complaints responded to within agreed timescale – informal investigation	90%	↓
Proportion of complainants dissatisfied with our response (formal investigation)	7.7%	↑

Successes	Priorities
• Following a delay in recruitment to vacancies in the Patient Support & Complaints Team due to ongoing corporate service consultations, the Trust has successfully recruited a new complaints officer to create necessary additional capacity to support the influx of complaints from Weston Division as a result of Trust merger (however, also see risks and threats). • Despite a significant increase in complaints being handled by the PSCT as a result of becoming a merged organisation, the Trust has continued to respond to the majority of cases received in a timely manner. • Since 1st July, Weston and Bristol sites have been using the same complainant feedback survey.	• To closely monitor divisional compliance with targets for responding to complaints by the deadline agreed with the complainant and support the divisions with this during a period of high operational pressures. • To re-open the Patient Support & Complaints Team 'drop in' service as soon as this can be done in 2021 whilst maintaining the safety of patients and staff. • To implement a new staff e-leaning package 'handling complaints with confidence' – due to go live in December 2020. • To conclude post-merger staff consultations in Weston Division in order to confirm structure and personnel in the Weston-based complaints team.
Opportunities	**Risks & Threats**
• Opportunity to review the format of this report in 2021 as part of the ongoing integration of the complaints service with the Division of Weston. • At the time of writing this report (December 2020), it is anticipated that the post of Deputy PSCT Manager will be released for recruitment imminently – this will create the operational headroom to enable the PSCT to move beyond 'fire-fighting' and focus once again on service improvement and development.	• The position of Deputy PSCT Manager has been held vacant throughout 2020 due to merger. In the interim, agency staff are being employed to create necessary additional capacity. • Significant work remains to ensure that the divisional complaints team in Weston is appropriately staffed and that Trust systems and processes are fully adopted. • At the time of writing (December 2020), complainants are experiencing a delay of up two weeks in receiving a follow-up call from a complaints officer to discuss their concerns in detail. This operational backlog has resulted from staff vacancies and the influx of complaints from Weston Division. • The Trust's ability to conduct timely complaints investigations continues to be significantly impacted by wider divisional operational capacity in the face of the ongoing pandemic. • Complaints about staff attitude and communication increased in Q2. • 56% of complaints responses sent out by Weston Division in Q2 breached the agreed deadline.

1. Complaints performance – Trust overview

The Trust is committed to supporting patients, relatives and carers in resolving their concerns. Our service is visible, accessible and impartial, with every issue taken seriously. Our aim is to provide honest and open responses in a way that can be easily understood by the recipient.

During Quarter 2 (Q2) of 2020/21, the complaints service received a higher than average number of complaints and enquiries, following a very quiet Q1 (at the height of the Covid-19 pandemic). The number of complaints received in Q2 was 128% higher than in Q1. Q1 is, however, a potentially misleading reference point as this covered a period of national 'lockdown' due to the Covid-19 pandemic; more significantly, the number of complaints received in Q2 as a merged Trust was 38.2% higher than in the same period a year ago. At the time of writing (December 2020), this increase in complaints has been sustained throughout Q3.

1.1 Total complaints received

The Trust received 521 complaints in Q2. This total includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1] but does not include concerns which may have been raised by patients and dealt with immediately by front line staff. Figure 1 provides a long-term view of complaints received per month. The impact of the Coronavirus pandemic was apparent in the reduction in the number of complaints received in Q1, compared with a significant increase during Q2.

Figure 1: Number of complaints received

[1] Informal complaints are dealt with quickly via direct contact with the appropriate department, whereas formal complaints are dealt with by way of a formal investigation via the Division.

Figure 2: Numbers of formal v informal complaints

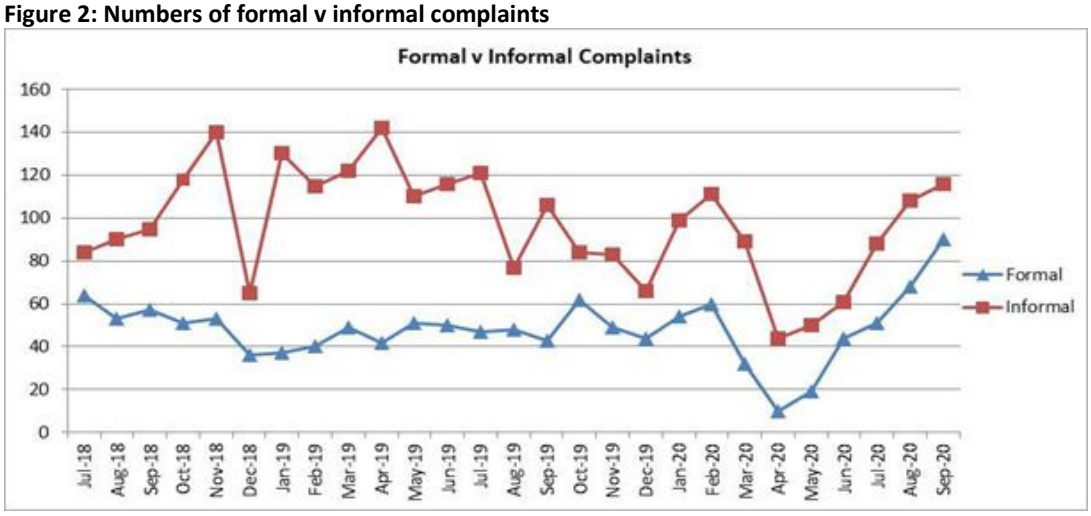


Figure 2 (above) shows complaints dealt with via the formal investigation process (209) compared with those dealt with via the informal investigation process (312), over the same period. We continue to deal with a higher proportion of complaints via the informal process, which means that these issues are being dealt with as quickly as possible and by the specialty managers responsible for the service involved.

1.2 Complaints responses within agreed timescale

Whenever a complaint is managed through the formal resolution process, the Trust and the complainant agree a timescale within which we will investigate the complaint and write to the complainant with our findings, or arrange a meeting to discuss them. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days.

When a complaint is managed through the informal resolution process, the Trust and complainant also agree a timescale and this is usually 10 working days.

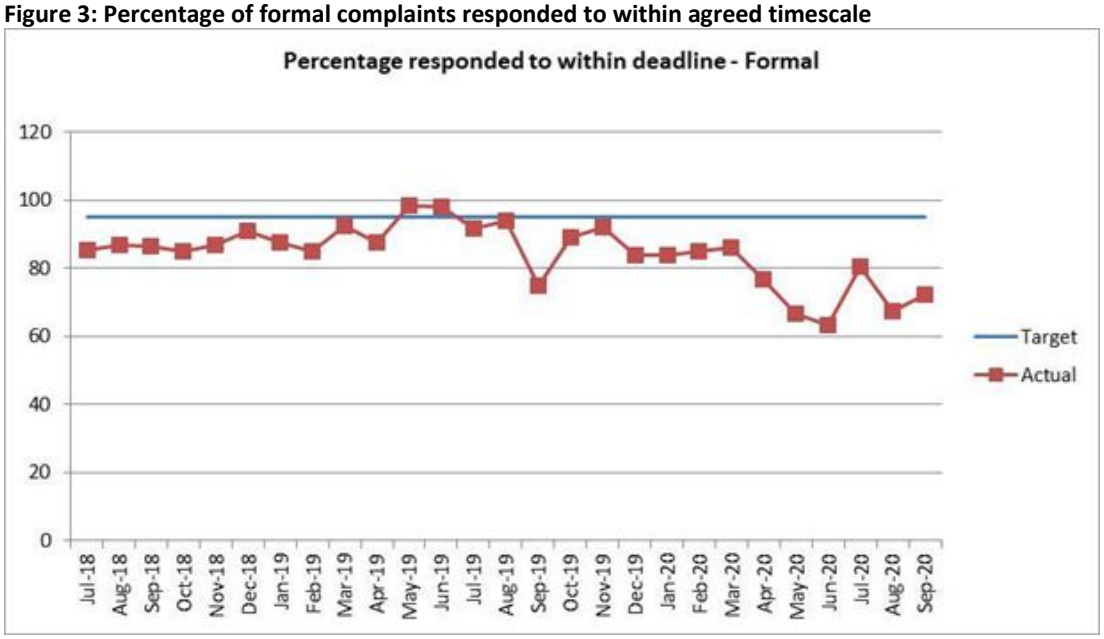
1.2.1 Formal Investigations

The Trust's target is to respond to at least 95% of complaints within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant.

In Q2 2020/21, 73.4% of responses were posted within the agreed timescale. This represents 45 breaches out of the 169 formal complaint responses which were sent out during the quarter[2]. This is a slight improvement on the 71.3% reported in Q1. Figure 3 shows the Trust's performance in responding to complaints since July 2018. Please see section 3.3 of this report for details of where these breaches occurred and at which part of the process they were delayed.

[2] Note that this will be a different figure to the number of complainants who *made* a complaint in that quarter.

Figure 3: Percentage of formal complaints responded to within agreed timescale

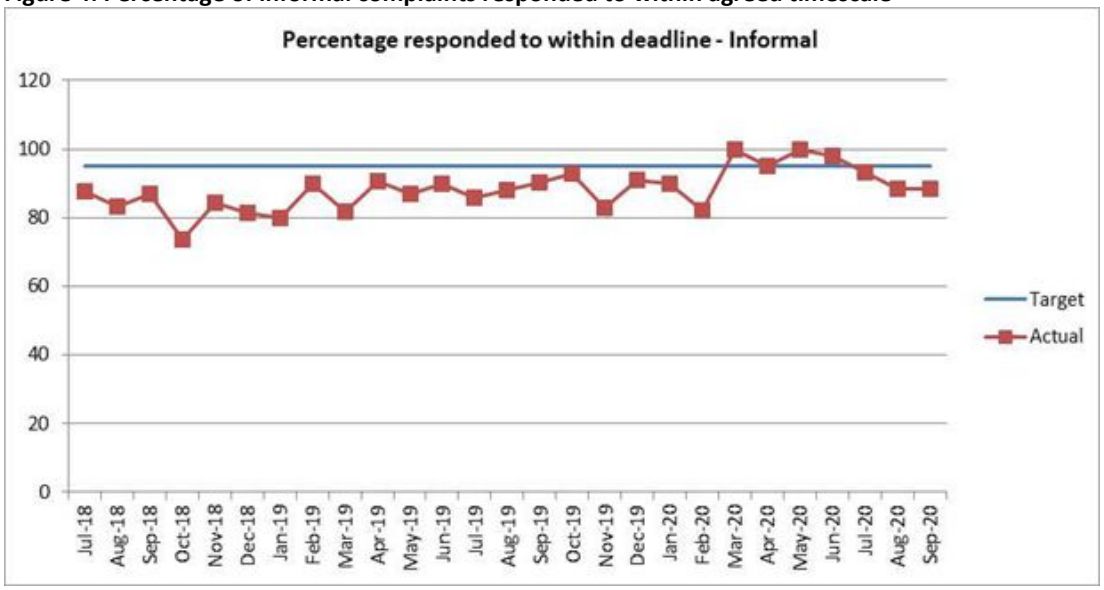


1.2.2 Informal Investigations

In Q2 2020/21, the Trust received 312 complaints that were investigated via the informal process. During this period, the Trust responded to 219 complaints via the informal complaints route and 90% (197) of these were responded to by the agreed deadline, a deterioration on the 97.9% reported in Q1.

Figure 4 (below) shows performance since July 2018, for comparison with formal complaints.

Figure 4: Percentage of informal complaints responded to within agreed timescale



1.3 Dissatisfied complainants

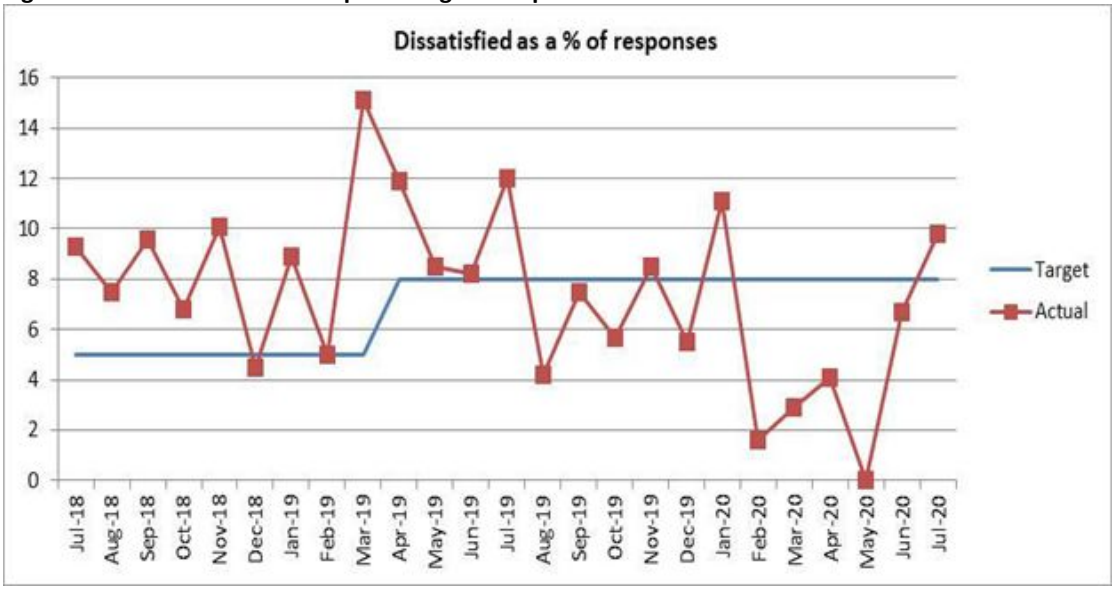
The Trust's target is that no more than 8% of complaints responses should lead to a dissatisfied response.

This data is reported **two months in arrears** in order to capture the majority of cases where, having considered the findings of our investigations, complainants tell us they are not happy with our response.

In Q2 2020/21, we are able to report dissatisfied data for May, June and July 2020. Seven complainants who received a first response from the Trust during those months have since contacted us to say they were dissatisfied. This represents 7.7% of the 91 first responses sent out during that period. This compares with 2.8% reported in Q1, which was unusually low, possibly due to fewer complainants contacting us to say they were unhappy with their responses during the height of the pandemic.

Figure 5 shows the monthly percentage of complainants who were dissatisfied with aspects of our complaints responses since July 2018.

Figure 5: Dissatisfied cases as a percentage of responses



2. Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of eight major categories, or themes. Table 1 provides a breakdown of complaints received in Q2 2020/21 compared with Q1.

Complaints increased in all categories in Q2, which was anticipated given that the Covid-19 pandemic and subsequent lockdown was at its peak during Q1, which was reflected in the number of complaints received during that period.

The top three categories of 'clinical care', 'appointments and admissions' and 'attitude and communication' accounted for 78.3% (408 of 521) of all complaints received, as detailed in Table 1 below.

Table 1: Complaints by category/theme

Category/Theme	Number of complaints received in Q2 (2020/21)	Number of complaints received in Q1 (2020/21)
Clinical Care	178 (34.2% of all complaints) ↑	57 (25% of all complaints) ↓
Appointments & Admissions	126 (24.2%) ↑	39 (17.1%) ↓
Attitude & Communication	104 (19.9%) ↑	66 (28.9% of all complaints) ↓
Facilities & Environment	37 (7.1%) ↑	19 (8.3%) ↓
Information & Support	35 (6.7%) ↑	25 (11%) ↓
Discharge/Transfer/Transport	23 (4.4%) ↑	10 (4.4%) ↑
Documentation	10 (2%) ↑	8 (3.5%) ↓
Access	8 (1.5%) ↑	4 (1.8%) ↑
Total	**521**	**228**

Each complaint is also assigned to a more specific sub-category, of which there are over 100. Table 2 lists the most commonly reported sub-categories, which together accounted for 75.2% of the complaints received in Q2 (392/521).

There are large increases in all sub-categories for the same reason as given above for categories.

Table 2: Complaints by sub-category

Sub-category	Number of complaints received in Q2 (2020/21)	Q1 (2020/21)	Q4 (2019/20)	Q3 (2019/20)
Clinical care (Medical/Surgical)	115 (248.5% increase compared to Q1) ↑	33	85	73
Cancelled/delayed appointments and operations	93 (200% increase) ↑	31	101	95
Communication with patient/relative	34 (88.9% increase) ↑	18	17	20
Clinical care (Nursing/Midwifery)	29 (141.7% increase) ↑	12	10	11
Appointment administration issues	19 (280% increase) ↑	5	30	21
Discharge arrangements	19 (90% increase) ↑	10	6	9
Attitude of Nursing/Midwifery	17 (41.7% increase) ↑	12	9	11
Attitude of medical staff	17 (142.9% increase) ↑	7	12	17
Failure to answer phones / failure to respond	14 (133.3% increase) ↑	6	17	21
Infection Control / Infectious disease enquiry	13 (85.7% increase) ↑	7	2	2
Attitude of A&C staff	11 (83.3% increase) ↑	6	5	10
Referral errors	11 (1000% increase) ↑	1	11	7

The percentage changes listed in this table are potentially misleading because Q1 covered the height of the pandemic when numbers of complaints were significantly suppressed. However, the largest increases in percentages of complaints received were in the sub-categories of 'referral errors', 'appointment administration issues' and 'clinical care (medical/surgical)'.

Of particular note, are the number of complaints recorded under the sub-category of 'infection control/infectious disease enquiry', which were complaints related to Covid-19.

It is also noteworthy that the smallest increase was in respect of 'attitude of nursing/midwifery'.

Figures 6-9 (below) show the longer term pattern of complaints received since July 2018 for a number of the complaints categories and sub-categories reported in Tables 1 and 2. Figure 6 shows that, following a sharp increase at the beginning of 2020, complaints about 'clinical care (medical/surgical)' continued to reduce during Q1 but then rose steeply again in Q2. Figure 7 shows that complaints about 'cancelled/delayed appointments and operations' which reduced significantly during April and May, began to climb again towards the end of Q1 and continued on this trajectory throughout Q2. Figures 8 and 9 show notable increases in complaints about 'attitude and communication' during Q2.

Trends in categories and sub-categories of complaints are explored in more detail in the individual divisional details from section 3.1.1 onwards.

Figure 6: Clinical care – Medical/Surgical

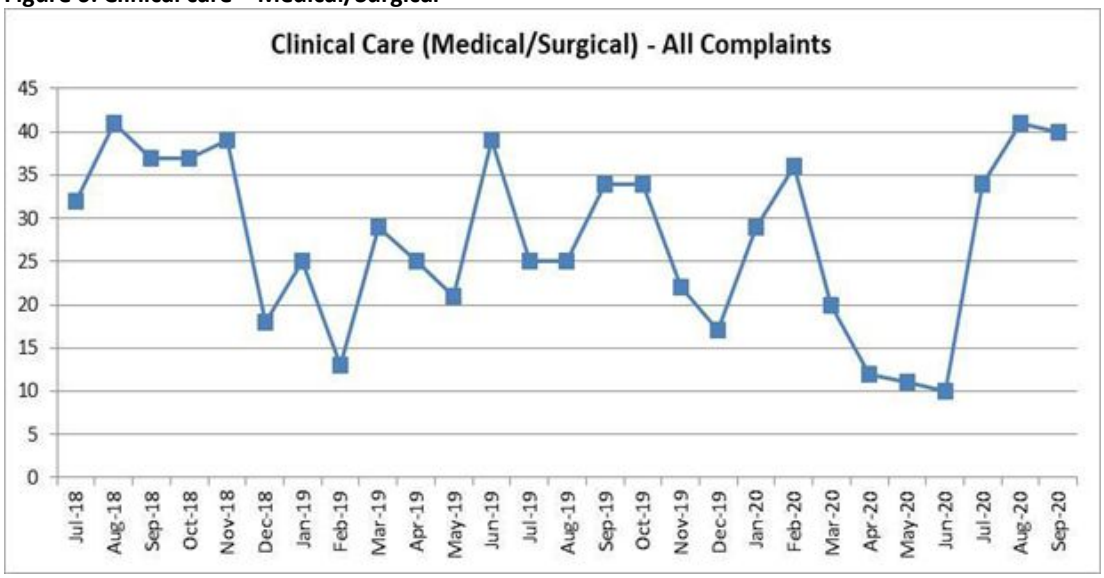


Figure 7: Cancelled or delayed appointments and operations

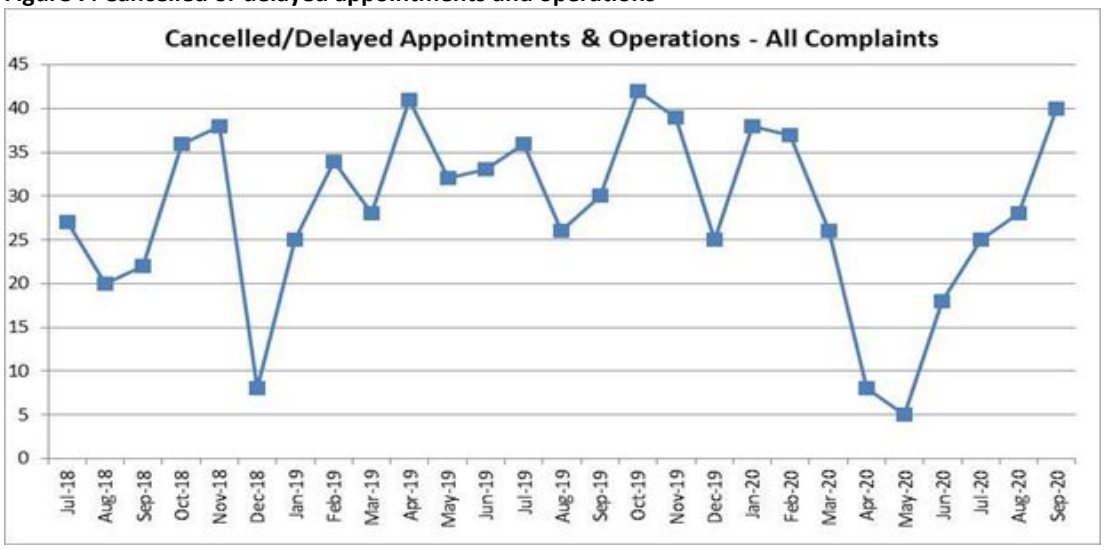


Figure 8: Communication with patient/relative

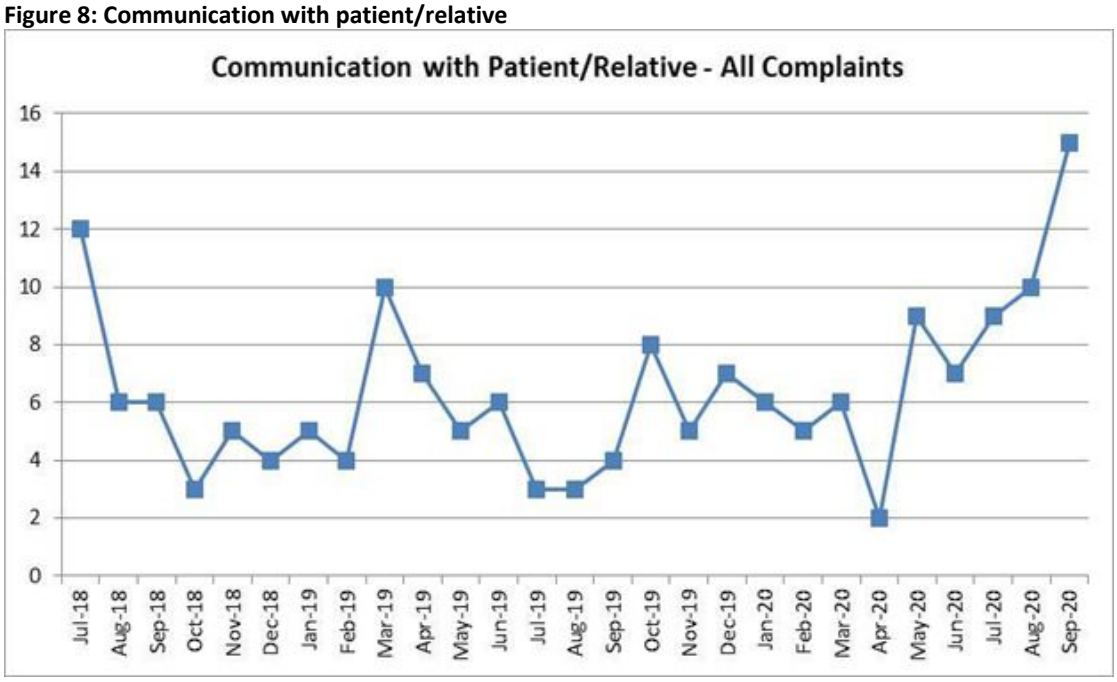
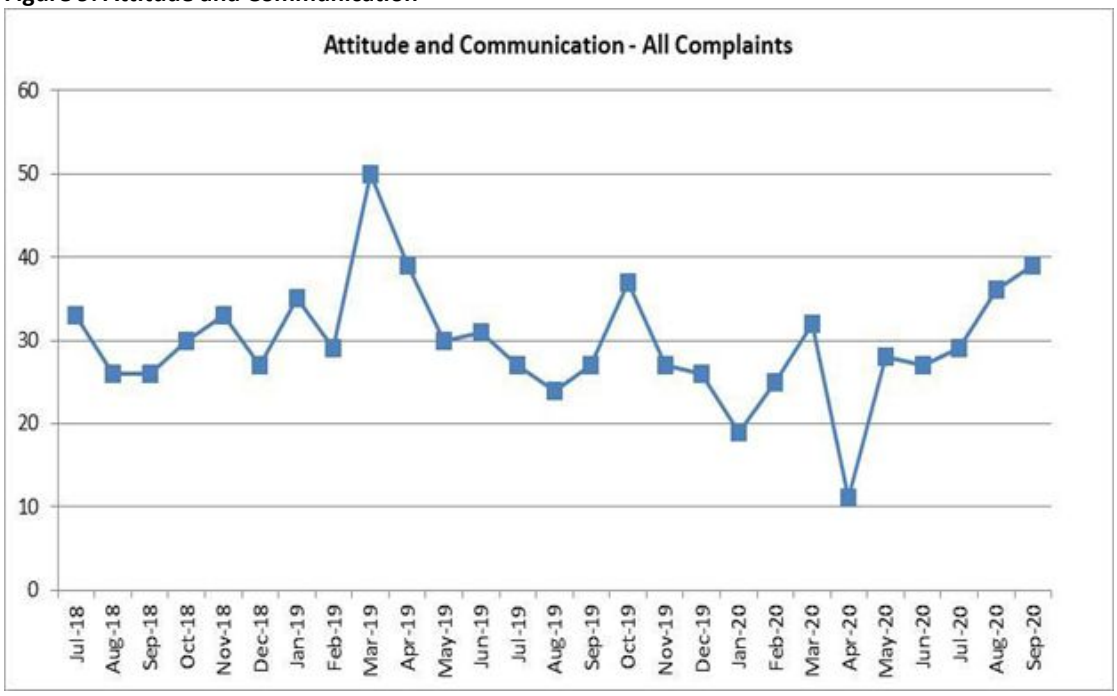


Figure 9: Attitude and Communication



3. Divisional Performance

3.1 Divisional analysis of complaints received

Table 3 provides an analysis of Q2 complaints performance by Division. In addition to providing an overall view, the table includes data for the three most common reasons why people complain: concerns about appointments and admissions; and concerns about staff attitude and communication. Data for the Division of Trust Services is not included in this table but is summarised in section 3.1.7 of the report.

Table 3	**Surgery**	**Medicine**	**Specialised Services**	**Women & Children**	**Diagnostics & Therapies**	**Weston**
Total number of complaints received	120 (57) ↑	107 (59) ↑	51 (28) ↑	91 (33) ↑	19 (7) ↑	103 (18) ↑
Number of complaints about appointments and admissions	57 (21) ↑	15 (4) ↑	14 (10) ↑	19 (4) ↑	6 (0) ↑	15 (0) ↑
Number of complaints about staff attitude and communication	20 (12) ↑	21 (20) ↑	15 (3) ↑	18 (9) ↑	6 (2) ↑	18 (5) ↑
Number of complaints about clinical care	32 (9) ↑	44 (18) ↑	11 (7) ↑	43 (12) ↑	2 (2) =	48 (9) ↑
Area where the most complaints have been received in Q2	Bristol Eye Hospital (BEH) – 23 (18) Bristol Dental Hospital (BDH) – 21 (5) ENT –21 (5) Oral & MaxFax Surgery – 12 (3) Trauma & Orthopaedics – 10 (5) Lower GI – 7 (4)	Emergency Department (BRI) (inc. A413 EMU) – 35 (11) Dermatology – 24 (7) Ward A400 – 8 (4) Unity Sexual Health – 6 (1) Clinic A410 – 5 (3)	**BHI (all) – 39 (18)** **BHOC (all) – 12 (10)** BHI Outpatients – 21 (7) BHOC Outpatients – 4 (5) Ward C705 – 4 (3) Ward D603 – 4 (1)	**BRHC (all) – 46 (18)** (plus 1 paediatric outpatients at Southmead) Carousel Outpatients – 7 (1) Caterpillar Ward – 7 (1) Apollo Ward – 5 (0) **StMH (all) – 41 (14)** (plus 3 community midwifery) Gynae Outpatients – 11 (0) Central Delivery Suite – 8 (3) Ward 73 (Maternity) – 6 (3)	Radiology – 13 (6)	Accident & Emergency – 21 (4) Berrow Ward – 7 (1) Outpatients (Main) – 7 (0) Waterside Ward – 7 (0) Sandford Ward – 6 (1) Outpatients (Orthopaedics) – 5 (0) Outpatients (Quantock) – 9 (2)
Notable deteriorations compared with Q1	Bristol Dental Hospital (BDH) – 21 (5) Oral & MaxFax Surgery – 12 (3) Trauma & Orthopaedics – 10 (5)	Emergency Department (BRI) (inc. A413 EMU) – 34 (11) Dermatology – 24 (7) Ward A400 – 8 (4) Unity Sexual Health – 6 (1)	BHI Outpatients – 21 (7)	Carousel Outpatients – 7 (1) Caterpillar Ward – 7 (1) Gynae Outpatients – 11 (0) Central Delivery Suite – 8 (3)	Radiology – 13 (6)	Accident & Emergency – 21 (4)
Notable improvements compared with Q1	No notable improvements	No notable improvements	No notable improvements	No notable improvements	No notable improvements	No notable improvements

3.1.1 Division of Surgery

As with all Divisions across the Trust, there was a significant increase in the number of complaints received by the Division of Surgery in Q2; 120 complaints, compared with 57 in Q1, 147 in Q4 and 127 in Q3. The majority of these complaints were investigated via the informal complaints process (84) compared with 36 which were investigated through the formal process.

The largest increase was seen in complaints received with a primary category of 'appointments and admissions', with a 47.5% increase compared with Q1. This category includes complaints about cancelled and delayed appointments and operations. There were also significant increases in complaints recorded under 'clinical care' and 'attitude and communication'.

The Division achieved 76.9% (30/39) against its target for responding to formal complaints within the agreed timescale in Q2 and 95.8% (68/71) for informal complaints. Please see section 3.3 Table 16 for details of where in the process any delays occurred – it should be noted that none of the reported breaches were due to delays in the Division.

Table 4: Complaints by category type

Category Type	Number and % of complaints received – Q2 2020/21	Number and % of complaints received – Q1 2020/21
Appointments & Admissions	57 (47.5% of total complaints) ↑	21 (36.8% of total complaints) ↓
Clinical Care	31 (25.7%) ↑	9 (15.8%) ↓
Attitude & Communication	20 (16.7%) ↑	12 (21.1%) ↓
Facilities & Environment	5 (4.2%) =	5 (8.8%) ↑
Discharge/Transfer/ Transport	3 (2.5%) ↑	0 (0%) ↓
Documentation	2 (1.7%) =	2 (3.5%) ↓
Information & Support	2 (1.7%) ↓	7 (12.3%) ↑
Access	0 (0%) ↓	1 (1.7%) ↑
Total	**120**	**57**

Table 5: Top sub-categories

Category	Number of complaints received – Q2 2020/21	Number of complaints received – Q1 2020/21
Cancelled or delayed appointments and operations	40 ↑	15 ↓
Clinical care (medical/surgical)	20 ↑	8 ↓
Appointment administration issues	11 ↑	3 ↓
Referral errors	8 ↑	1 ↓
Clinical Care (Dental)	5 ↑	1 ↓
Attitude of Nursing/Midwifery	4 ↑	2 =
Communication with patient/relative	4 ↑	3 ↓
Attitude of A&C staff	4 ↑	1 ↓

Figure 10: Surgery – formal and informal complaints received

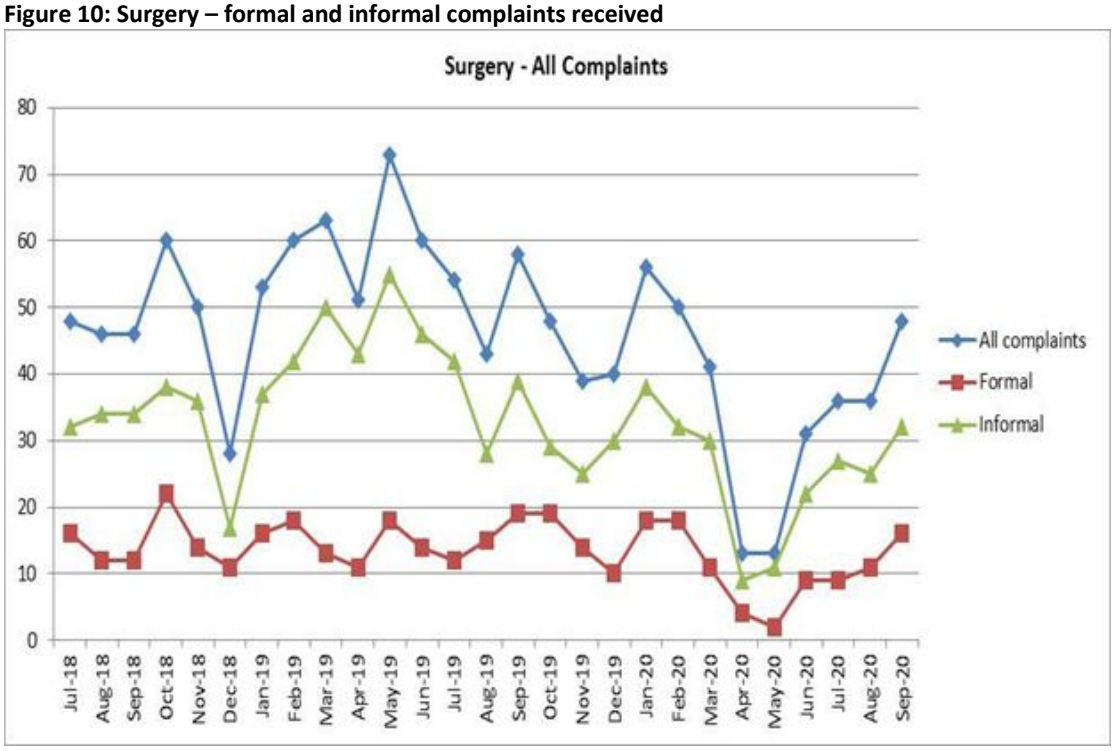
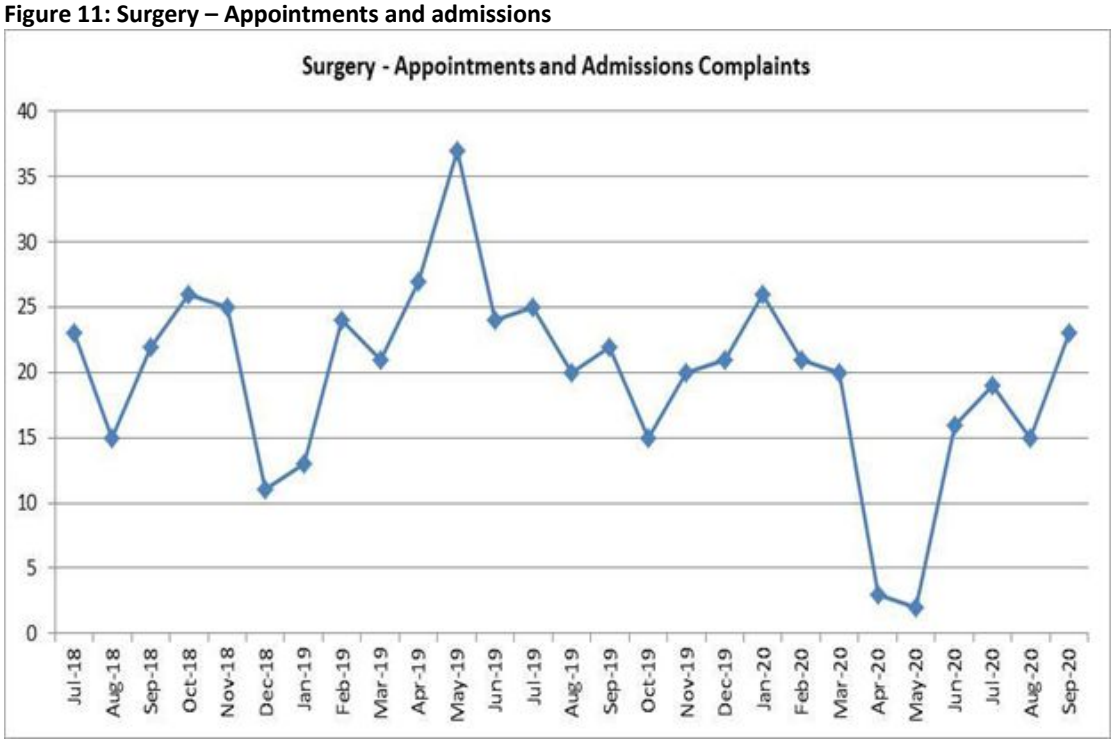


Figure 11: Surgery – Appointments and admissions



3.1.2 Division of Medicine

In line with all other Divisions, Medicine saw a sharp rise in the total number of complaints received in Q2 (107), compared with Q1 (59).

Of the 107 complaints received by the Division in Q2, 34 were investigated via the formal complaints process and 73 the informal route.

The Division achieved 63.2% 73.7% (24/38) against its target for responding to formal complaints within the agreed timescale in Q2, a deterioration on the 73.7% reported in Q1. There was also a reduction in the number of informal complaints being responded to within the agreed deadline in Q2, with 72.9% (35/48) compared with 100% in Q1. Please see section 3.3 Table 16 for details of where in the process any delays occurred.

The largest increase in in complaints was in those recorded in the category of 'clinical care' with a 138.9% increase compared with Q1. There was however only a very small increase in complaints about 'attitude and communication', with reductions in some of the sub-categories in this category.

Table 6: Complaints by category type

Category Type	Number and % of complaints received – Q2 2020/21	Number and % of complaints received – Q1 2020/21
Clinical Care	43 (40.2% of total complaints) ↑	18 (30.5% of total complaints) ↓
Attitude & Communication	21 (19.6%) ↑	20 (33.9%) ↓
Appointments & Admissions	15 (14%) ↑	4 (6.7%) ↓
Discharge/Transfer/ Transport	9 (8.4%) ↑	6 (10.2%) ↑
Information & Support	8 (7.5%) ↑	3 (5.1%) ↓
Facilities & Environment	7 (6.5%) ↑	5 (8.5%) ↓
Documentation	2 (1.9%) =	2 (3.4%) ↓
Access	2 (1.9%) ↑	1 (1.7%) ↑
Total	**107**	**59**

Table 7: Top sub-categories

Category	Number of complaints received – Q2 2020/21	Number of complaints received – Q1 2020/21
Clinical care (medical/surgical)	32 ↑	10 ↓
Cancelled or delayed appointments and operations	10 ↑	5 ↓
Discharge arrangements	7 ↑	6 ↑
Communication with patient/ relative	6 ↓	8 ↑
Attitude of nursing/midwifery	5 ↓	8 ↑
Appointment administration issues	5 ↑	4 ↓
Attitude of medical staff	4 =	4 =
Failure to answer phone / respond	4 ↑	0 ↓

Figure 12: Medicine – formal and informal complaints received

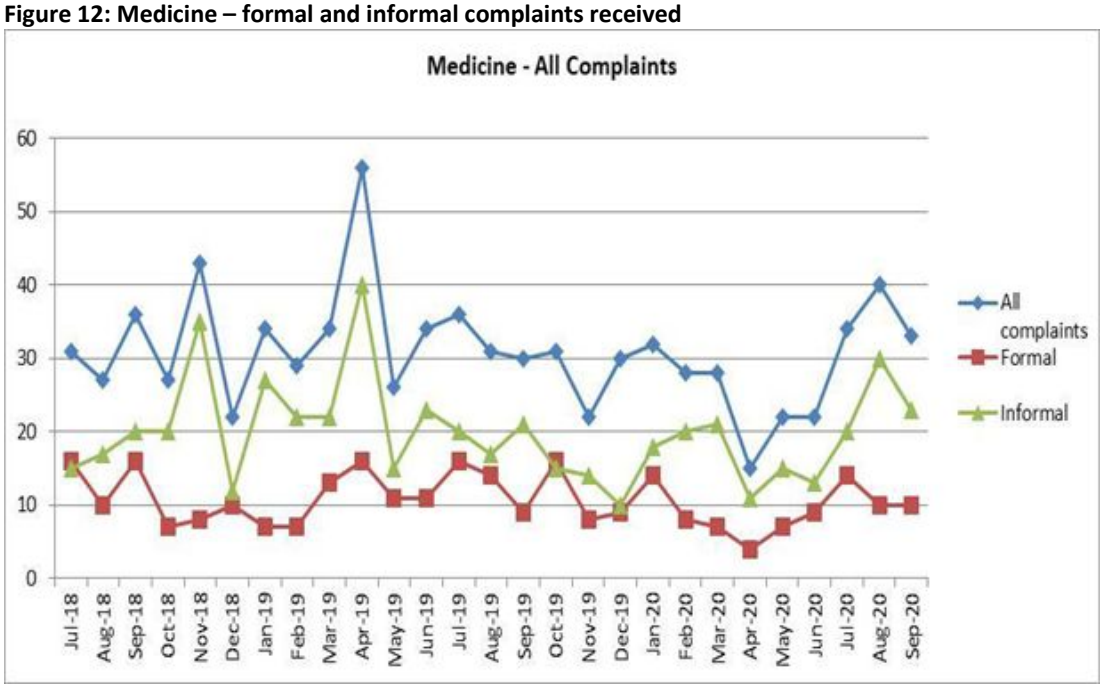
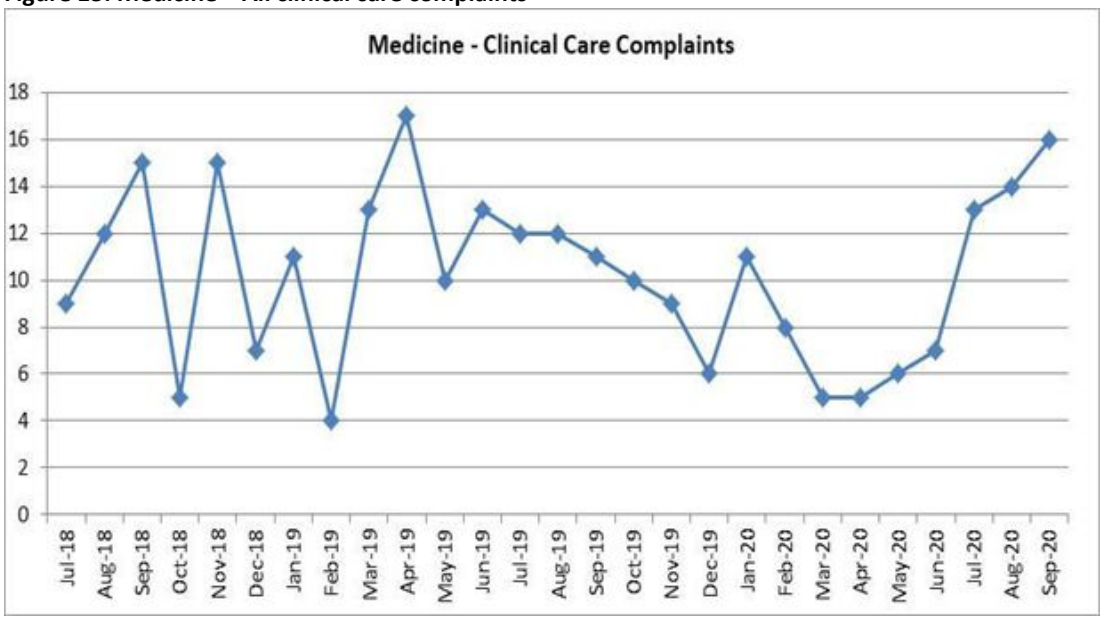


Figure 13: Medicine – All clinical care complaints



3.1.3 Division of Specialised Services

The Division of Specialised Services received 51 new complaints in Q2, compared with 28 in Q1. In line with the other Divisions, this was a significant increase with the previous quarter. In Q2, complaints about 'attitude and communication' took the top spot in the number of complaints by category for the division.

Of the 51 complaints received, 14 were investigated via the formal complaints process, whilst the majority (37) were dealt with informally.

Specialised Services was one of only two divisions in Q2 to achieve 100% of its target for responding to formal (16/16/) and informal (24/24) complaints within the agreed timescale, compared with 66.7% in Q1 for formal complaint responses. The Division achieved 100% performance for informal complaints for the third quarter in succession.

Table 8: Complaints by category type

Category Type	Number and % of complaints received – Q2 2020/21	Number and % of complaints received – Q1 2020/21
Attitude & Communication	15 (29.4% of total complaints) ↑	3 (10.7% of total complaints) ↓
Appointments & Admissions	14 (27.5%) ↑	10 (35.7%) ↓
Clinical Care	11 (21.7%) ↑	7 (25%) ↓
Information & Support	4 (7.8%) ↑	0 (0%) ↓
Facilities & Environment	3 (5.9%) ↓	4 (14.3%) ↑
Discharge/Transfer/ Transport	2 (3.9%) ↑	1 (3.6%) ↑
Documentation	1 (1.9%) ↓	3 (10.7%) ↑
Access	1 (1.9%) ↑	0 (0%) =
Total	**51**	**28**

Table 9: Top sub-categories

Category	Number of complaints received – Q2 2020/21	Number of complaints received – Q1 2020/21
Clinical care (medical / surgical)	10 ↑	7 ↓
Cancelled or delayed appointments and operations	9 ↑	8 ↓
Failure to answer phone / failure to respond	6 ↑	2 ↓
Appointment administration issues	4 =	4 ↓
Communication with patient / relative	4 ↑	0 ↓

Figure 14: Specialised Services – formal and informal complaints received

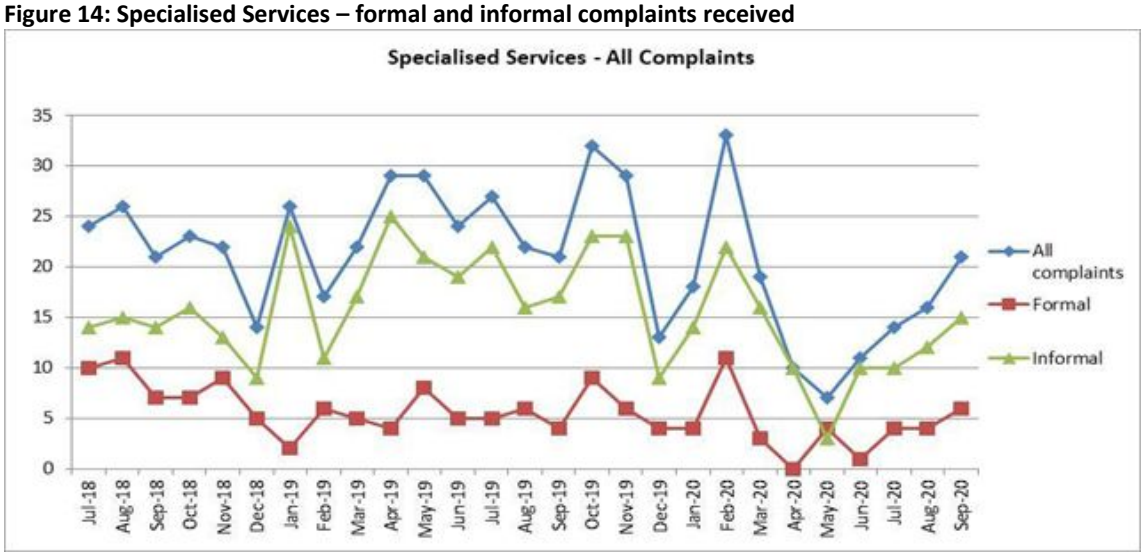


Figure 15: Complaints received by Bristol Heart Institute

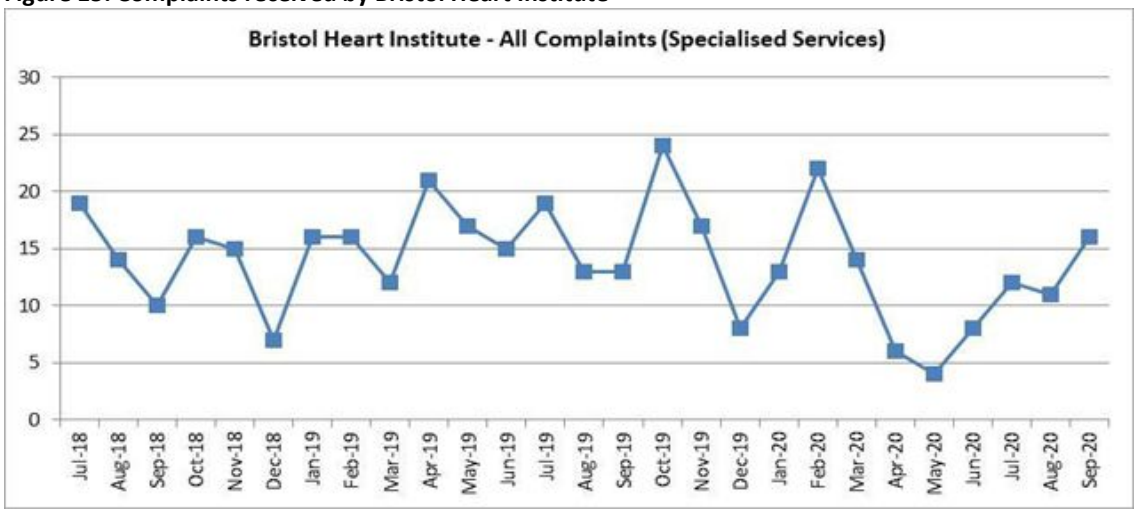
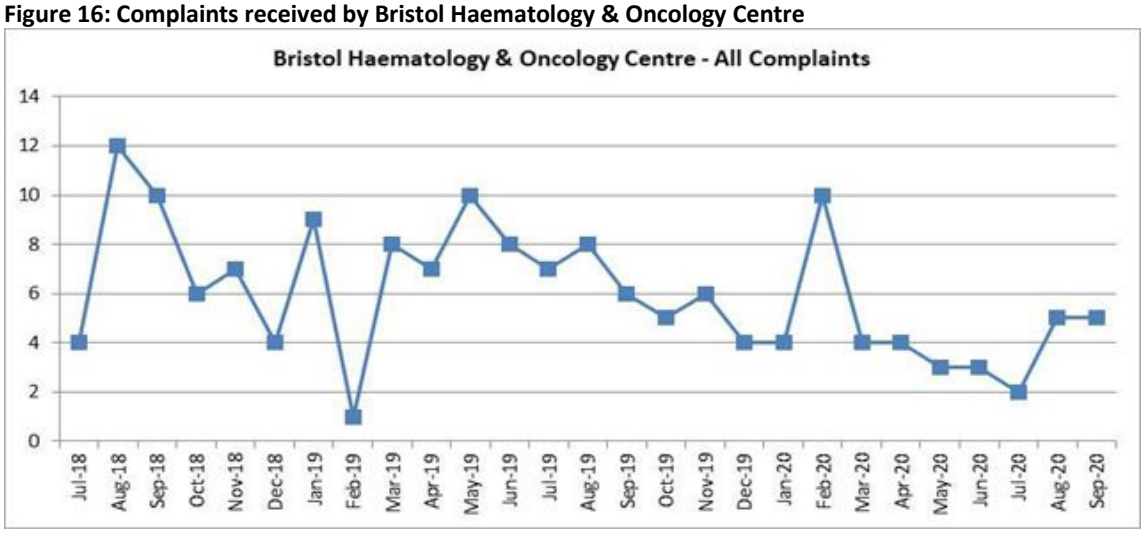


Figure 16: Complaints received by Bristol Haematology & Oncology Centre



3.1.4 Division of Women's and Children's Services

The total number of complaints received by the Division in Q2 1 was 91, a significant increase on the previous quarter (33), in common with all other Divisions. Complaints for Bristol Royal Hospital for Children (BRHC) accounted for 46 of the 91 complaints and 41 were received by St Michael's Hospital (StMH). In addition, there were three complaints for community midwifery services and one for the paediatric outpatients clinic at Southmead.

Of the 91 new complaints received in Q2, the Division managed 47 through the formal complaints process and 44 were investigated via the informal complaints process.

The Division achieved 93.3 % (28/30) against its target for responding to formal complaints within the agreed timescale in Q2, a significant improvement on the 79.2% (19/24) recorded in Q1. They achieved 97.1% (33/34) of target for informal responses within the agreed timescale, compared with 100% (16/16) in Q1. Please see section 3.3 Table 16 for details of where in the process any delays occurred - it should be noted that neither of the reported breaches were attributable to the Division.

Table 10: Complaints by category type

Category Type	Number and % of complaints received – Q2 2020/21	Number and % of complaints received – Q1 2020/21
Clinical Care	43 (47.3% of total complaints) ↑	12 (36.4% of total complaints) ↓
Appointments & Admissions	19 (20.8%) ↑	4 (12.1%) ↓
Attitude & Communication	18 (19.8%) ↑	9 (27.3%) ↓
Information & Support	7 (7.7%) ↑	5 (15.2%) ↓
Access	3 (3.3%) ↑	1 (3%) ↑
Documentation	1 (1.1%) =	1 (3%) ↓
Discharge/Transfer/ Transport	0 ↓	1 (3%) =
Facilities & Environment	0 (0%) =	0 (0%) ↓
Total	**91**	**33**

Table 11: Top sub-categories

Category	Number of complaints received – Q2 2020/21	Number of complaints received – Q1 2020/21
Clinical Care (medical/surgical)	21 ↑	4 ↓
Cancelled or delayed appointment or operation	18 ↑	3 ↓
Clinical Care (nursing/midwifery)	17 ↑	6 ↓
Visiting	9 ↑	0 =
Communication with patient/ relative	7 ↑	3 ↑

Figure 17: Women & Children – formal and informal complaints received

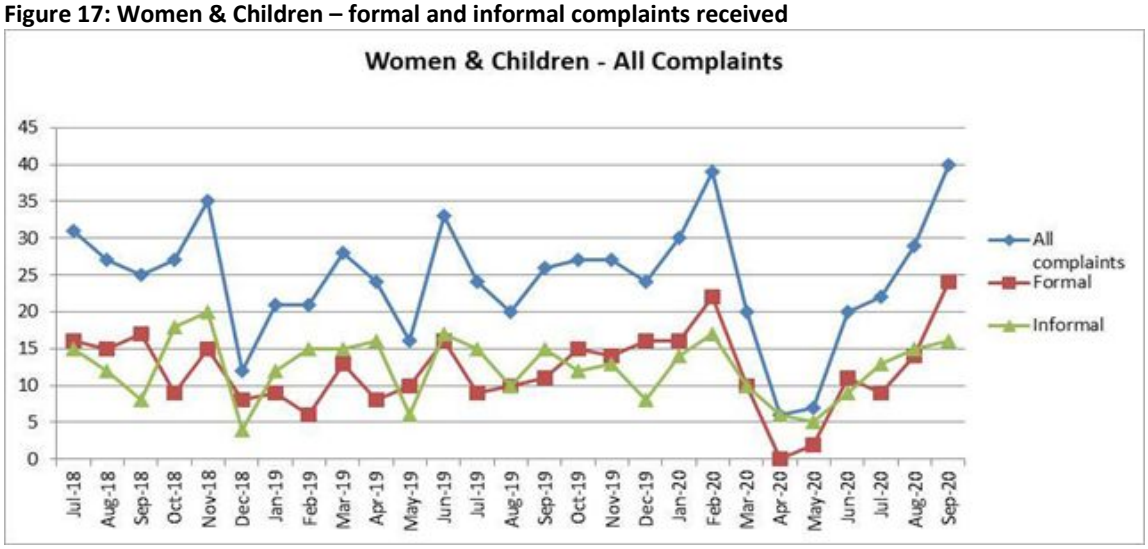


Figure 18: Complaints received by Bristol Royal Hospital for Children

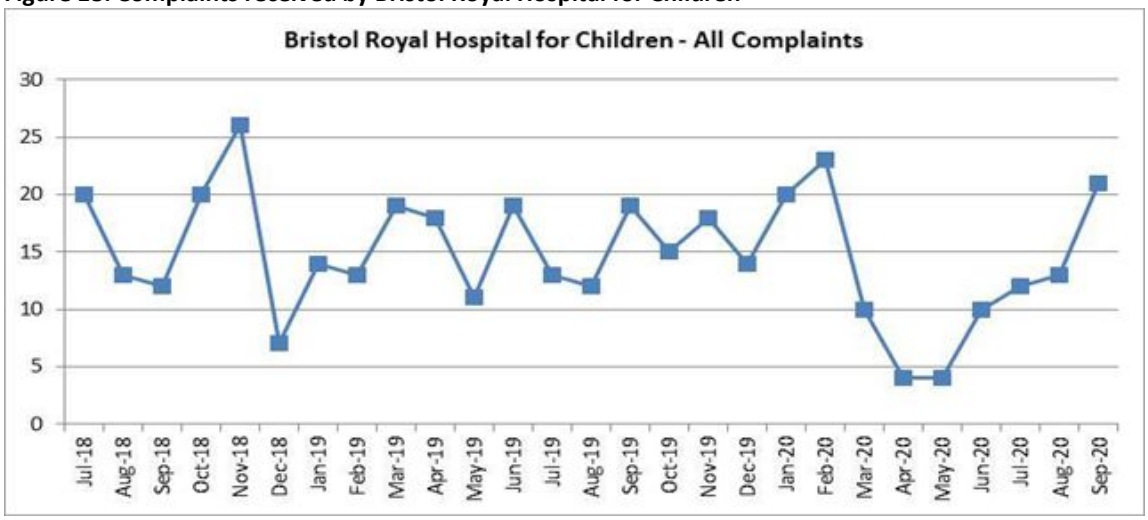
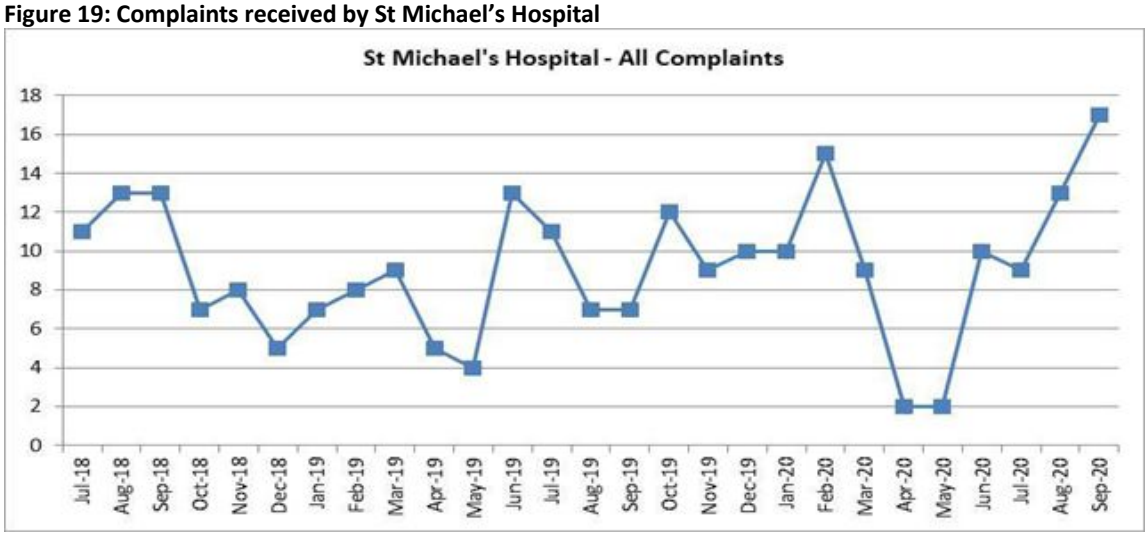


Figure 19: Complaints received by St Michael's Hospital



3.1.5 Division of Diagnostics & Therapies

Complaints received by the Division of Diagnostics and Therapies decreased significantly in Q2, along with all other Divisions – they received 19 complaints , compared with seven in Q1.

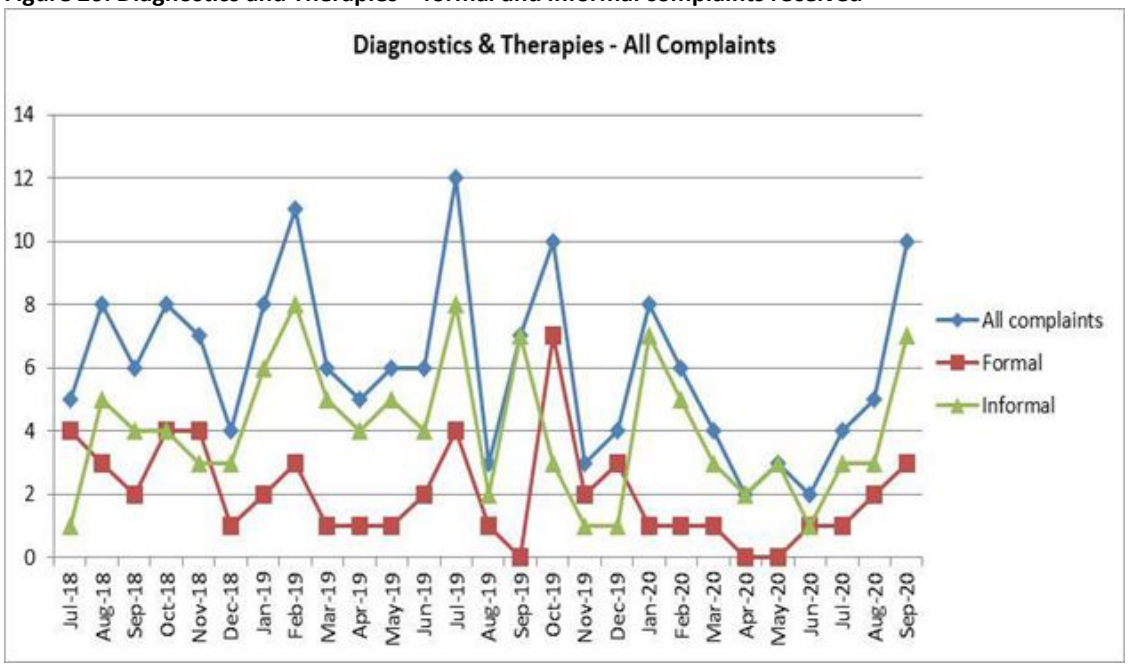
Number of complaints across all categories and sub-categories are very low, although 13 of the 19 complaints received were for Radiology. Six complaints were investigated via the formal complaints process, with the remaining 13 investigated through the informal process.

During Q2, the Division responded to three formal complaints, which were all sent to the complainant within the agreed timescale, meaning that the Division achieved 100% against its target. They also responded to 100% (6/6) of informal complaints within the agreed timescale. Diagnostics & Therapies was one of only two Divisions that achieved 100% in both formal and informal complaint responses in Q2.

Table 12: Complaints by category type

Category Type	Number and % of complaints received – Q2 2020/21	Number and % of complaints received – Q1 2020/21
Attitude & Communication	6 ↑	2 ↓
Appointments & Admissions	6 ↑	0 ↓
Information & Support	3 =	3 ↓
Clinical Care	2 =	2 ↓
Access	1 ↑	0 =
Discharge/Transfer/Transport	1 ↑	0 =
Facilities & Environment	0 =	0 ↓
Documentation	0 =	0 ↓
Total	**19**	**7**

Figure 20: Diagnostics and Therapies – formal and informal complaints received



3.1.6 Division of Weston

Following the merger of University Hospitals Bristol with Weston Area Health Trust, to form University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) on 1 April 2020, this report now includes data for the Division of Weston.

The Division received 103 new complaints in Q2 of 2020/21, compared with 18 reported in Q1. 65 of these new complaints were managed through the formal complaints process and the remaining 38 via the informal process.

During the same period, the Division responded to 34 formal complaints, achieving 44.1% (15/34) 66.7% (4/6) of responses being sent to complainants within the agreed timescale, compare with 66.7% (4/6) in Q1. The Division achieved 90.5% in respect of informal responses being responded to on time 19/21), compared with 80% (4/5) in Q1. See section 3.3 Table 16 for details of where delays occurred.

More information about complaints for the Division of Weston will be included in future Quarterly Complaints Reports, as data is gathered, including identification of themes and trends.

Figure 21: Division of Weston - formal and informal complaints received

Table 13: Complaints by category type

Category Type	Number and % of complaints received – Q2 2020/21	Number and % of complaints received – Q1 2020/21
Clinical Care	48 (46.6% of total complaints) ↑	9 (50% of total complaints)
Attitude & Communication	18 (17.5%) ↑	5 (27.8%)
Appointments & Admissions	15 (14.6%) ↑	0 (0%)
Facilities & Environment	8 (7.8%) ↑	1 (5.6%)
Information & Support	6 (5.8%) ↑	1 (5.6%)
Discharge / Transfer / Transport	6 (5.8%) ↑	2 (11.1%)
Documentation	2 (1.9%) ↑	0 (0%)
Access	0 =	0 (0%)
Total	**103**	**18**

Table 14: Top sub-categories

Category	Number of complaints received – Q2 2020/21	Number of complaints received – Q1 2020/21
Clinical care (medical/surgical)	32 ↑	4
Cancelled or delayed appointment or operation	10 ↑	0
Communication with patient /relative	8 ↑	4
Infection control	7 ↑	0
Discharge arrangements	6 ↑	2
Clinical care (nursing/midwifery)	6 ↑	2
Lost personal property	5 ↑	1
Attitude of medical staff	4 ↑	0
Total	**78**	

3.1.7 Division of Trust Services

The Division of Trust Services, which includes Facilities & Estates, received 30 complaints in Q2 of 2020/21, compared with 26 in Q1. Of the 30 complaints received in Q2, nine were in respect of car parking; four were for the Private & Overseas Patients Team; and four related to patient transport.

Of the 30 new complaints received, seven were investigated via the formal complaints process, with the remaining 23 being managed informally.

The Division achieved 75% (3/4) against its target for responding to formal complaints within the agreed timescale in Q2 and 62.5% (5/8) for informal complaints. Please see section 3.3 Table 16 for details of where in the process any delays occurred.

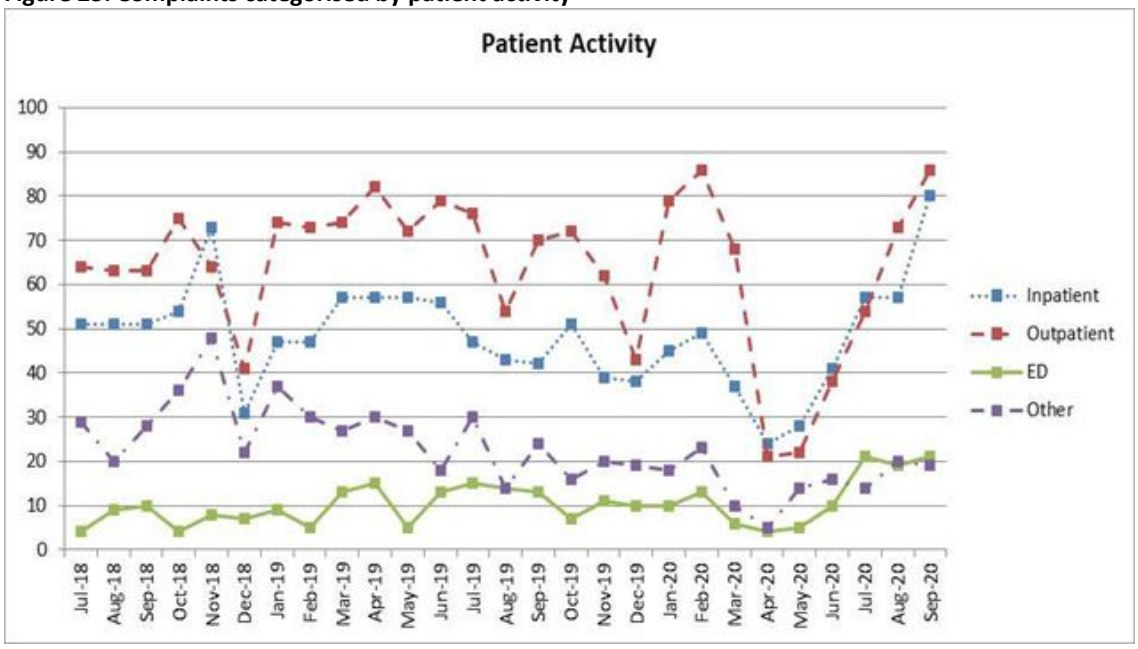
Figure 22: Trust Services – all complaints received

3.2 Breakdown of complaints by inpatient/outpatient/ED status

In order to more clearly identify the number of complaints received by the type of service, Figure 23 below shows data differentiating between inpatient, outpatient, Emergency Department and other complaints. The category of 'other' includes complaints about non-clinical areas, such as car parking, cashiers, administration departments, etc.

In Q2, 41% (*35.5%) of complaints received were about outpatient services, 37.2% (40.8%) related to inpatient care, 11.6% (8.3%) were about emergency patients; and 10.2% (15.4%) were in the category of 'other' (as explained above). ** Q1 percentages are shown in brackets for comparison.*

Figure 23: Complaints categorised by patient activity



3.3 Complaints responded to within agreed timescale for formal resolution process

Specialised Services and Diagnostics & Therapies achieved 100% against target for formal responses sent out by the agreed deadline in Q2. The other divisions all reported breaches of formal complaint deadlines, with a total of 45 breaches reported Trustwide. This is the highest number of breaches since this report commenced and is a significant deterioration on the 27 breaches reported in Q1.

The Division of Weston reported 19 breaches of deadline, Medicine reported 14, Surgery had nine, Women & Children reported two and Trust Services (Estates & Facilities) had one breach. Please see Table 14 below for details of where in the process the delays occurred/who the breaches were attributable to.

In Q2, the Trust responded to 169 complaints via the formal complaints route and 73.4% of these were responded to by the agreed deadline, against a target of 95%, compared with 71.3% in Q1 and 85% in Q4.

Table 15: Breakdown of breached deadlines – Formal

Division	Q2 2020/21	Q1 2020/21	Q4 2019/20	Q3 2019/20
Weston	19 (55.9%)	2 (33.3%)		
Medicine	14 (36.8%)	5 (26.3%)	14 (28%)	12 (29.3%)
Surgery	9 (23.1%)	11 (33.3%)	4 (6.7%)	2 (2.6%)
Women & Children	2 (6.5%)	5 (20.8%)	3 (5.4%)	1 (2.6%)
Trust Services	1 (14.3%)	1 (50%)	4 (26.7%)	2 (40%)
Specialised Services	0 (0%)	3 (33.3%)	6 (22.2%)	5 (19.2%)
Diagnostics & Therapies	0 (0%)	0 (0%)	1 (20%)	1 (11.1%)
All	**45 breaches**	**27 breaches**	**32 breaches**	**23 breaches**

(So, as an example, there were 14 breaches of timescale in the Division of Medicine in Q2, which constituted 36.8% of the 38 complaint responses which were sent out by that division in Q2).

Breaches of timescale in respect of formal complaints were caused either by late receipt of draft responses from Divisions which did not allow adequate time for Executive review and sign-off; delays in processing by the Patient Support and Complaints Team (PSCT); delays during the sign-off process itself; and/or responses being returned for amendment following Executive review.

Table 14 shows a breakdown of where the delays occurred in Q2. During this period, 26 breaches were attributable to the Divisions, 11 to the Executives and eight were caused by delays in the Patient Support & Complaints Team.

Table 16: Source of delay

Breach attributable to	Surgery	Medicine	Specialised Services	Women & Children	Diagnostics & Therapies	Trust Services	Weston	All
Division	0	9	0	0	0	0	17	**26**
PSCT	3	2	0	2	0	0	1	**8**
Execs/sign-off	6	3	0	0	0	1	1	**11**
All	**9**	**14**	**0**	**2**	**0**	**1**	**19**	**45**

3.3.1 Complaints responded to within agreed timescale for informal resolution process

All breaches of informal complaint timescales are attributable to the Divisions, as the Patient Support & Complaints Team and Executives do not contribute to the time taken to resolve these complaints. In Q2, the Trust responded to 219 complaints via the informal complaints route (compared with 137 in Q1) and 90% of these were responded to by the agreed deadline; a deterioration on the 97.9% reported in Q1.

Table 17: Breakdown of breached deadlines - Informal

Division	Q2 2020/21	Q1 2020/21	Q4 2019/20	Q3 2019/20
Medicine	11 (22.9%)	0 (0%)	0 (0%)	7 (17.5%)
Surgery	3 (4.2%)	0 (0%)	7 (8.9%)	8 (11.4%)
Trust Services	3 (20%)	2 (9.5%)	1 (4.2%)	2 (9.5%)
Weston	2 (6.1%)	1 (20%)		
Women & Children	0 (0%)	0 (0%)	2 (6.3%)	1 (3.6%)
Diagnostics & Therapies	0 (0%)	0 (0%)	1 (6.7%	1 (16.7%)
Specialised Services	0 (0%)	0 (0%)	0 (0%)	2 (4.2%)
All	**19**	**3**	**11**	**21**

4. Covid-19 – the impact of the pandemic on the complaints service

From the beginning of April until the end of September 2020, the Trust had received a total of 69 complaints related to Covid-19 and the Coronavirus pandemic, with 30 of these being investigated via the Trust's formal complaints process and the remaining 39 being investigated informally.

The majority of complaints received were for the Division of Weston with 18 complaints, closely followed by Medicine and Surgery with 14 each, Women & Children and Trust Services with eight each, four for Diagnostics & Therapies and two for Specialised Services.

Most complaints were recorded under the primary category of Clinical Care, which accounted for 29.5% (20/69) of all complaints received, closely followed by Information & Support (17), Attitude & Communication (13) and Appointments & Admissions (10).

The main issues that arose from the 69 complaints recorded were concerns over staff wearing the correct Personal Protective Equipment (PPE) and poor communication with families of inpatients. There were also complaints relating to members of staff adding posts to social media that led to allegations of them not adhering to Covid-19 guidelines; appointments being cancelled due to the pandemic; and patients being discharged to care homes without a negative Covid-19 test.

With effect from July 2020, the Patient Support & Complaints Manager commenced weekly complaints reporting to the Covid Outbreak Group, chaired by the Chief Nurse and Medical Director.

5. Learning from complaints

All feedback is welcome, as it creates an opportunity to better understand, and to improve the care and treatment we provide to our service users. All complaints are investigated, learning is identified and any necessary changes to practice are made. Actions resulting from complaints are monitored and reviewed by our Divisions; the Patient Support and Complaints Team also monitor progress.

Below are some examples of actions taken by the Trust in response to complaints during Q2 2020/21.

- A complaint was received from the family of a patient at Weston General Hospital (WGH) who were upset about communication and visiting restrictions in place to see the patient. Concerns were also raised by the patient's wife about a surgical stocking and name band on her husband's ankle that were too tight, causing swelling, and about there not seeming to be a common message relating to PPE requirements at WGH. As a direct result of this complaint, a standard procedure for implementing observations of care was written and this Observations of Care programme was disseminated to all Matrons and Ward Sisters at WGH.

- As a result of a complaint regarding a midwife contacting a patient, not knowing that she had experienced a miscarriage, a daily transfer of information to the Community Midwifery team was implemented regarding confirmed or possible miscarriages. This simple and prompt action will prevent additional upset and anxiety for future patients at such a difficult time (Women & Children).

- As part of a complaint received about the care of a patient who sadly passed away, his wife mentioned that the food her husband had in hospital looked disgusting and probably tasted that way. In response to this complaint, all catering supervisors are now conducting spot checks on wards to inspect the quality of the meals provided and ensure actions are taken to remedy any areas of deficiency (Estates & Facilities).

6. Information, advice and support

In addition to dealing with complaints, the Patient Support and Complaints Team is also responsible for providing patients, relatives and carers with help and support. A total of 269 enquiries were received in Q2, an increase of 14% on the 236 received in Q1. This figure includes 37 concerns recorded by the Patient Advice & Liaison Service (PALS) in Weston, compared with 84 recorded in Q1. The number of concerns recorded decreased significantly due to cases that had previously been recorded as 'concerns' now being recorded by the corporate complaints team as informal (or occasionally formal) complaints.

The Patient Support and Complaints Team also recorded and acknowledged 50 compliments received during Q1 and shared these with the staff involved and their Divisional teams. This is compared with 31 compliments reported in Q1.

In addition to the enquiries detailed above, in Q2 the Patient Support and Complaints Team recorded 172 enquiries that did not proceed, compared with 67 in Q1. This is where someone contacts the department to make a complaint or enquiry but does not leave enough information to enable the team to carry out an investigation (and the team is subsequently unable to obtain this information), or they subsequently decide that they no longer wish to proceed with the complaint.

Including complaints, requests for information or advice, requests for support, compliments and cases that did not proceed, the Patient Support and Complaints Team continues to deal with an increasingly high volume of activity, with a total of 962 separate enquiries in Q2.

7. Acknowledgement of complaints by the Patient Support and Complaints Team

The NHS Complaints Procedure (2009) states that complaints must be acknowledged within three working days. This is also a requirement of the NHS Constitution. The Trust's own policy states that complaints made in writing (including emails) will be acknowledged within three working days and that complaints made orally (via the telephone or in person) will be acknowledged within two working days.

In Q2, 299 complaints were received in writing (277 by email and 22 letters) and 214 were received verbally (6 in person via drop-in service and 208 by telephone). Eight complaints were also received in Q2 via the Trust's 'real-time feedback' service. Of the 228 complaints received in Q2, 84.5% (440 of 521) met the Trust's standard of being acknowledged within two working days (verbal) and three working days (written). This was the first time that this measure fell below 95% and was due to the unusually high volume of complaints and other enquiries received by the team.

8. PHSO (Ombudsman) cases

During Q2, the PHSO notified the Trust of its interest in one new complaint, for which copies of the complaint file and medical records have been sent to them.

Two cases were closed by the PHSO during Q2, both of which were recorded with an outcome of 'No Further Action' (this means that, based on their review of the Trust's complaint file and the patient's medical records, the Ombudsman decided not to carry out a full investigation).

There are currently 12 cases that are open with the PHSO whilst they decide whether or not to carry out a full investigation or for which a decision is awaited following their investigation.

9. Complaint Survey

The Patient Support & Complaints team sends a complaint survey to all complainants six weeks after their complaint is resolved and closed.

Data/feedback has not been included in the report again for this quarter, due to the negligible number of completed surveys being returned, which would render the results inconclusive. The survey has however been extended into Weston Division with effect from 1st July 2020.

10. Severity of Complaints

Since April 2019, the Patient Support & Complaints Team has been recording the severity of complaints received by the Trust using a system of categorisation proposed by researchers at the London School of Economics. This severity rating is based on the nature of the complaint as first described to the Trust by or on behalf of the patient; not after the issues have been investigated. This ensures that the rating is reliable and independent of the outcome of the investigation.

We know from NHS data that Trusts with high levels of incident reporting have fewer instances of severe harm to patients, i.e. organisations with cultures that encourage reporting when things go wrong, learn and provide safer care. The LSE research suggests a similar pattern of data associated with patient complaints, i.e. Trusts who receive high levels of low level severity complaints receive lower levels of high severity complaints, again indicating that a culture of openness to receiving and learning from complaints is associated with safer and higher quality care. Put another way, receiving complaints should not be viewed as a bad thing *per se*; it depends what the complaint is about. A practical example of each of these categories is shown in Table 16 below.

During the next year, as we build our dataset, we hope that this will enable us to begin to differentiate between higher and lower performing areas within the Trust (in terms of the severity of complaints reported) and to use the information to explore opportunities for quality improvement.

Table 18: Examples of severity rating of complaints

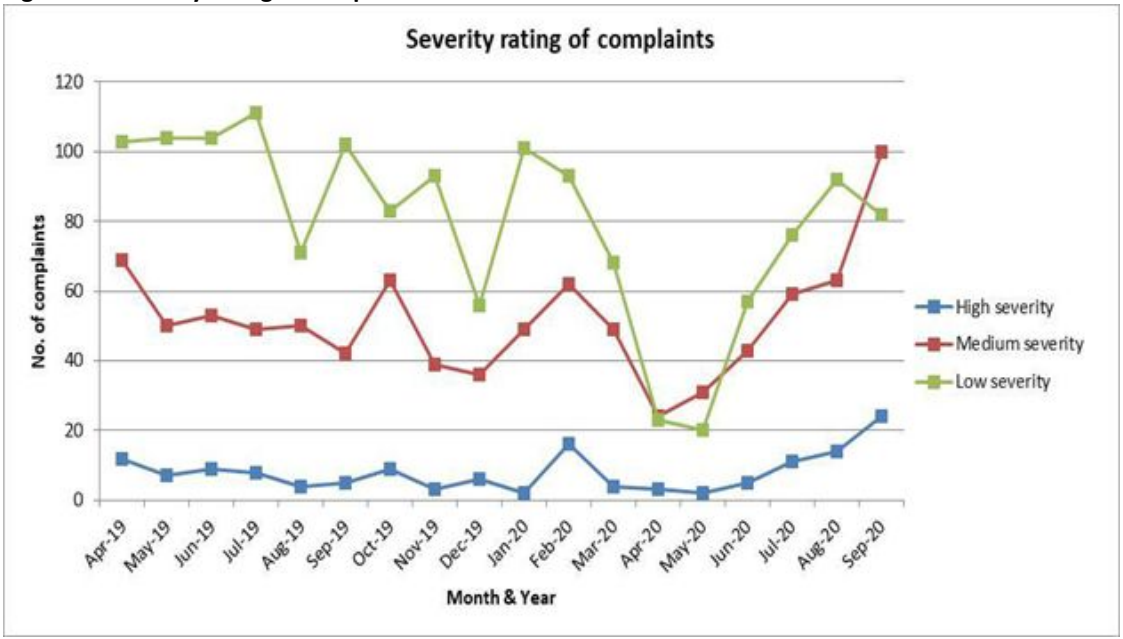
	Low severity	Medium severity	High severity
Clinical problem	Isolated lack of food or water	Patient dressed in dirty clothes	Patient left in own waste in bed
Clinical problem	Slight delay administering medication	Staff forgot to administer medication	Incorrect medication administered
Management problems	Patient bed not ready on arrival	Patient was cold and uncomfortable	Patient relocated due to bed shortage
Management problems	Appointment cancelled and rescheduled	Chasing departments for an appointment	Refusal to give appointment
Relationship problems	Staff ignored question from patient	Staff ignored mild patient pain	Staff ignored severe distress
Relationship problems	Staff spoke in condescending manner	Rude behaviour	Humiliation in relation to incontinence

In Q2, the Trust received 521 complaints, all of which have been severity rated by the Patient Support & Complaints Team. Of these 521 complaints, 249 were rated as being low severity, 223 as medium and 49 as high.

The increase in the number of complaints rated as 'high severity' was due to the number of high risk covid-related complaints received during the quarter.

Figure 24 below shows a breakdown of these severity ratings by month since April 2019.

Figure 24: Severity rating of complaints



University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28 January 2021

Report Title	***Finance Directors Report***
Report Author	***Neil Kemsley / Jeremy Spearing***
Executive Lead	***Neil Kemsley, Director of Finance & IT***

1. Report Summary

The purpose of this report is to inform the Finance & Digital Committee of the financial position of the Trust for the period 1st April 2020 to 31st December 2020.

2. Key points to note
(Including decisions taken)

The system financial plan for months 7-12 is subject to discussions with the Regulator, NHSEI SW, in particular, the resolution of the factors that are driving the system's planned net deficit and the subsequent presentation of the net deficit in the providers financial plans. The conclusion of this issue will be informed by formal feedback from the regulator, NHSEI.

The Trust's year to date net income and expenditure performance, excluding technical items, is a favourable position against plan of £1.436m (£0.445m favourable last month). The further improvement in the position against plan is primarily driven by lower than planned expenditure on elective activity recovery that has been impacted by the second wave of the Pandemic.

The Trust will be formally assessing its year-end forecast outturn using January or M10 actuals due to the increased uncertainty caused by the current wave of Covid-19 admissions seen in UHBW. This timing is consistent across all system partners within the BNSSG STP and has been notified to NHSEI SW.

The agreed STP capital funding envelope for the Trust is £53.161m, which when added to the approved PDC, totals a target spend of £76.300m for 2020/21. Capital expenditure to date is £33.803m leaving a further £42.497m to be delivered in the last quarter. This delivery is also being impacted by the second wave of the Pandemic, in terms of the limited scope for operational and clinical staff to engage in the Programme as well as construction team access to parts of the Estate.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

As reported in November.

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

This report is for **INFORMATION**.

5. History of the paper
Please include details of where paper has previously been received.

Finance & Digital Committee	26 January 2021

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Report of the Finance Director

Section 1 – Executive Summary

Performance against NHSEI Plan	Plan to date Month 9 £m	Actual to date Month 9 £m	Variance to date favourable (adverse) £m
Income from patient care activities	577.744	583.265	5.521
Other operating income	94.432	96.711	2.279
Employee expenses	(414.391)	(413.598)	0.793
Other operating expenses	(229.401)	(236.561)	(7.160)
Depreciation (owned & leased)	(22.775)	(22.722)	0.053
PDC	(8.818)	(8.817)	0.001
Interest Payable	(1.772)	(1.748)	0.024
Interest Receivable	0.001	0.001	0.000
Net surplus/(deficit) inc technicals	**(4.980)**	**(3.469)**	**1.511**
Remove depreciation (donated)	1.415	1.416	0.001
Remove donated income	(0.249)	(0.325)	(0.076)
Net surplus/(deficit) exc technicals	**(3.814)**	**(2.378)**	**1.436**

The performance summary reflects the Provider Finance Return (PFR) submitted to NHSEI by the Trust for month 9. The plan to date in the PFR consists of actual performance for quarter 1 and 2 plus quarter 3 of the Trust's 2020/21 month 7-12 financial plan as submitted to NHSEI on 22nd October 2020.

The system financial plan for months 7-12 is subject to on-going discussions with NHSEI South West, in particular, the resolution of the presumption that NHS providers can restore other operating income to pre-Covid-19 pandemic levels. Representation has been made to NHSEI South West on the issue and we are aware that there are on-going discussions at a national level. The outcome should then conclude the issue of the system net deficit that is currently presented in the provider's financial positions. The Trust's current financial plan is a year-end net deficit of £13.5m.

The Trust's year to date net income and expenditure position including technical items is a net deficit of £3.469m compared with a planned net deficit of £4.980m, a favourable position against plan of £1.511m.

The Trust's year to date net income and expenditure position excluding technical items i.e. the NHSEI reported financial performance position, is a favourable position against plan of £1.436m (£0.445m favourable last month). The further improvement in the position against plan is primarily driven by lower than planned expenditure on elective activity recovery.

Income from patient care activities is £5.521m favourable to plan. This is primarily due to additional variable income from NHS England Specialised Commissioning for variable high cost and low volume pass-through drugs and devices. This additional income, from outside of the BNSSG STP system financial envelope, totals £11.611m compared with £7.529m last month.

Other operating income is £2.279m favourable to plan. This primarily relates to additional education and training income of £1.396m received in November and December. Other operating income for services provided to other NHS bodies such as staff recharges are £0.671m ahead of plan.

Employee expenses are in marginally below plan.

Other operating expenditure is £7.160m adverse to plan primarily due to higher than planned activity related non-pay costs such a clinical supplies £2.703m and drugs £3.160m. The position is mainly due to pass-through drugs and devices and is offset by the additional income due from NHS England Specialised Commissioning.

To date the Trust has incurred £24.884m of additional costs and lost income relating to the Covid-19 pandemic. £1.8m was incurred in December compared with £2.1m in November.

The Trust will be formally assessing its year-end forecast outturn using January or M10 actuals due to the increased uncertainty caused by the current wave of Covid-19 admissions seen in UHBW. This timing is consistent across all system partners within the BNSSG STP and has been notified to NHSEI South West.

Section 1 – Executive Summary continued

The additional revenue costs and income losses associated with Covid-19 are provided by Division in the table below. These costs are held centrally and are therefore excluded from the run rate reports in section 2.

Year to Date COVID Spend/ Income Loss £'000										
Category	**Diagnostics & Therapies**	**Medicine**	**Specialised Services**	**Surgery**	**Weston**	**Women's & Children's**	**Facilities & Estates**	**Trust Services**	**Other**	**Total**
Nursing & Midwifery	(6)	(2,655)	(583)	(726)	(894)	(1,354)	0	(123)	(176)	**(6,517)**
Medical & Dental Pay	(21)	(854)	(265)	(1,156)	(466)	(755)	0	(114)	(24)	**(3,655)**
Other Pay	(469)	(96)	(107)	(95)	(245)	(57)	(350)	(241)	(10)	**(1,670)**
Non Pay	(461)	(2,610)	(314)	(1,321)	(1,102)	(154)	(1,070)	(3,598)	(6)	**(10,636)**
Income from Activities	0	0	0	0	0	(233)	0	0	(13)	**(246)**
Income from Operations	(39)	0	(161)	0	(686)	0	(1,131)	(143)	0	**(2,160)**
Total	**(996)**	**(6,215)**	**(1,430)**	**(3,298)**	**(3,393)**	**(2,553)**	**(2,551)**	**(4,219)**	**(229)**	**(24,884)**

*Note COVID Costs for Weston Site (including Corporate and Facilities and Estates) Month 1-3 are all in Weston Clinical Division, split from Month 4 onwards.

The NHSEI PFR reports additional expenditure of £23.044m. This is higher than the expenditure in the table above as it requires the Nightingale costs to be reported in full rather than the marginal actual cost. The PFR excludes lost income due to Covid-19. The analysis of this expenditure is as follows:

	Q1 £m	**Q2 £m**	**M7 £m**	**M8 £m**	**M9 £m**	**Total £m**
Staff related costs*	4.396	3.485	1.149	0.915	0.592	10.537
National procurement	1.191	0.149	-0.08	0.035	0.059	1.354
Increased ITU capacity (inc staff)	1.057	0.625	0.192	0.336	0.101	2.311
Testing	0.657	0.864	0.366	0.344	0.462	2.693
Release of bed capacity	0.436	0.592	0.206	0.178	0.199	1.611
Nightingale costs (inc staff)	0.53	0.119	0.016	-0.016	0.002	0.651
Other	1.328	1.513	0.325	0.295	0.426	3.887
Total	**9.595**	**7.347**	**2.174**	**2.087**	**1.841**	**23.044**

*Excludes ITU or Nightingale Staff

The expenditure to date on staff includes £5.8m for additional shifts worked by existing staff, £2.4m for workforce expansion and £2.3m for sickness backfill.

The reduction in run rate for Nightingale expenditure is the result of Nightingale Hospital Bristol largely remaining on standby as a critical care facility since the end of quarter 1.

Testing costs have increased in recent months compared with quarter 1 and quarter 2 as additional testing is now being undertaken in response to changes in national policy and increased testing capacity.

Other significant costs include: decontamination (£0.444m); isolation pods (£0.171m); remote working support (£1.021m); enhanced patient travel services (£0.641m); pathway segregation (£0.587m) and other PPE (£0.238m).

Section 2 – Division and Corporate Services Performance

The focus of financial performance is on income and expenditure run rate. Divisional budgets for the second half of the financial year have been reset in line with the Trust's month 7-12 financial plan. Divisional financial performance is summarised in the tables and commentary below. The costs associated with Covid-19 have been removed from both the current and previous months report.

Diagnostics & Therapies	19/20 Actual Monthly Average £'000	19/20 Actual Q4 Average £'000	20/21 Actual Q1 (Excl. Covid) £'000	20/21 Actual Q2 (Excl. Covid) £'000	20/21 Actual M7 (Excl. Covid) £'000	20/21 Actual M8 (Excl. Covid) £'000	20/21 Actual M9 (Excl. Covid) £'000	20/21 Actual YTD (Excl. Covid) £'000
Pay - Nursing & Midwifery	(95)	(89)	(288)	(294)	(100)	(100)	(106)	(889)
Pay - Medical & Dental	(680)	(674)	(2,065)	(2,155)	(720)	(736)	(758)	(6,434)
Pay - Other	(3,119)	(3,146)	(10,839)	(10,868)	(3,663)	(3,749)	(3,753)	(32,872)
Pay Subtotal	**(3,894)**	**(3,909)**	**(13,193)**	**(13,318)**	**(4,483)**	**(4,585)**	**(4,617)**	**(40,195)**
Non Pay - Blood	29	33	39	72	41	29	(1)	180
Non Pay - Drugs	(543)	(627)	(1,685)	(1,779)	(538)	(413)	(586)	(5,003)
Non Pay - Clinical Supplies	(685)	(731)	(1,816)	(2,149)	(866)	(885)	(904)	(6,621)
Non Pay - Other	(520)	(539)	(1,522)	(1,512)	(449)	(522)	(477)	(4,482)
Non Pay Subtotal	**(1,719)**	**(1,864)**	**(4,986)**	**(5,368)**	**(1,813)**	**(1,792)**	**(1,968)**	**(15,927)**
Income from Activities	44	157	6	8	(12)	6	(14)	(6)
Income from Operations	497	541	1,050	1,186	368	394	349	3,347
Total	**(5,072)**	**(5,075)**	**(17,122)**	**(17,490)**	**(5,942)**	**(5,977)**	**(6,249)**	**(52,781)**

Medicine	19/20 Actual Monthly Average £'000	19/20 Actual Q4 Average £'000	20/21 Actual Q1 (Excl. Covid) £'000	20/21 Actual Q2 (Excl. Covid) £'000	20/21 Actual M7 (Excl. Covid) £'000	20/21 Actual M8 (Excl. Covid) £'000	20/21 Actual M9 (Excl. Covid) £'000	20/21 Actual YTD (Excl. Covid) £'000
Pay - Nursing & Midwifery	(2,910)	(3,122)	(8,866)	(8,845)	(2,878)	(2,874)	(2,866)	(26,330)
Pay - Medical & Dental	(1,843)	(1,964)	(5,801)	(6,046)	(2,032)	(2,110)	(2,145)	(18,135)
Pay - Other	(648)	(672)	(2,030)	(2,106)	(711)	(716)	(716)	(6,280)
Pay Subtotal	**(5,401)**	**(5,758)**	**(16,697)**	**(16,998)**	**(5,621)**	**(5,700)**	**(5,727)**	**(50,744)**
Non Pay - Blood	(36)	(41)	(118)	(114)	(36)	(31)	(35)	(333)
Non Pay - Drugs	(1,526)	(2,005)	(5,790)	(5,241)	(2,383)	(2,974)	(2,648)	(19,035)
Non Pay - Clinical Supplies	(463)	(601)	(776)	(923)	(342)	(325)	(334)	(2,700)
Non Pay - Other	(645)	(723)	(1,672)	(1,902)	(668)	(584)	(569)	(5,394)
Non Pay Subtotal	**(2,670)**	**(3,370)**	**(8,354)**	**(8,180)**	**(3,428)**	**(3,914)**	**(3,586)**	**(27,462)**
Income from Activities	213	710	11	2	573	1,401	932	2,919
Income from Operations	209	302	656	537	64	144	172	1,573
Total	**(7,649)**	**(8,116)**	**(24,383)**	**(24,639)**	**(8,413)**	**(8,069)**	**(8,209)**	**(73,714)**

Specialised Services	19/20 Actual Monthly Average £'000	19/20 Actual Q4 Average £'000	20/21 Actual Q1 (Excl. Covid) £'000	20/21 Actual Q2 (Excl. Covid) £'000	20/21 Actual M7 (Excl. Covid) £'000	20/21 Actual M8 (Excl. Covid) £'000	20/21 Actual M9 (Excl. Covid) £'000	20/21 Actual YTD (Excl. Covid) £'000
Pay - Nursing & Midwifery	(1,906)	(1,968)	(5,558)	(5,944)	(2,028)	(1,965)	(1,984)	(17,480)
Pay - Medical & Dental	(1,763)	(1,863)	(5,073)	(5,468)	(1,798)	(1,705)	(1,880)	(15,924)
Pay - Other	(1,043)	(1,068)	(3,175)	(3,247)	(1,122)	(1,077)	(1,083)	(9,705)
Pay Subtotal	**(4,712)**	**(4,899)**	**(13,806)**	**(14,660)**	**(4,948)**	**(4,747)**	**(4,947)**	**(43,109)**
Non Pay - Blood	(650)	(587)	(1,629)	(1,817)	(520)	(679)	(610)	(5,254)
Non Pay - Drugs	(3,221)	(3,617)	(9,813)	(10,936)	(3,668)	(3,476)	(3,639)	(31,532)
Non Pay - Clinical Supplies	(1,523)	(1,802)	(2,824)	(5,358)	(2,186)	(2,186)	(2,253)	(14,806)
Non Pay - Other	(698)	(683)	(1,596)	(1,588)	(706)	(832)	(683)	(5,404)
Non Pay Subtotal	**(6,092)**	**(6,689)**	**(15,861)**	**(19,699)**	**(7,080)**	**(7,172)**	**(7,184)**	**(56,996)**
Income from Activities	433	1,095	303	(56)	580	294	353	1,475
Income from Operations	387	391	569	844	215	357	197	2,181
Total	**(9,984)**	**(10,102)**	**(28,795)**	**(33,572)**	**(11,233)**	**(11,268)**	**(11,581)**	**(96,448)**

Surgery	19/20 Actual Monthly Average £'000	19/20 Actual Q4 Average £'000	20/21 Actual Q1 (Excl. Covid) £'000	20/21 Actual Q2 (Excl. Covid) £'000	20/21 Actual M7 (Excl. Covid) £'000	20/21 Actual M8 (Excl. Covid) £'000	20/21 Actual M9 (Excl. Covid) £'000	20/21 Actual YTD (Excl. Covid) £'000
Pay - Nursing & Midwifery	(2,546)	(2,671)	(7,241)	(7,677)	(2,613)	(2,624)	(2,649)	(22,803)
Pay - Medical & Dental	(3,437)	(3,598)	(10,282)	(10,750)	(3,532)	(3,662)	(3,778)	(32,003)
Pay - Other	(1,697)	(1,691)	(5,157)	(5,185)	(1,720)	(1,720)	(1,773)	(15,556)
Pay Subtotal	**(7,679)**	**(7,961)**	**(22,680)**	**(23,612)**	**(7,864)**	**(8,006)**	**(8,200)**	**(70,362)**
Non Pay - Blood	(93)	(98)	(267)	(286)	(94)	(94)	(102)	(844)
Non Pay - Drugs	(1,295)	(1,238)	(2,437)	(3,005)	(1,054)	(1,110)	(995)	(8,601)
Non Pay - Clinical Supplies	(1,178)	(1,363)	(2,331)	(2,916)	(1,197)	(1,158)	(1,081)	(8,683)
Non Pay - Other	(544)	(615)	(1,398)	(1,380)	(446)	(538)	(552)	(4,315)
Non Pay Subtotal	**(3,110)**	**(3,314)**	**(6,434)**	**(7,587)**	**(2,791)**	**(2,901)**	**(2,730)**	**(22,443)**
Income from Activities	(174)	(44)	33	12	3	21	6	75
Income from Operations	311	296	631	697	232	186	252	1,999
Total	**(10,652)**	**(11,023)**	**(28,450)**	**(30,490)**	**(10,420)**	**(10,699)**	**(10,671)**	**(90,731)**

Weston	19/20 Actual Monthly Average £'000	19/20 Actual Q4 Average £'000	20/21 Actual Q1 (Excl. Covid) £'000	20/21 Actual Q2 (Excl. Covid) £'000	20/21 Actual M7 (Excl. Covid) £'000	20/21 Actual M8 (Excl. Covid) £'000	20/21 Actual M9 (Excl. Covid) £'000	20/21 Actual YTD (Excl. Covid) £'000
Pay - Nursing & Midwifery	(2,807)	(2,849)	(6,808)	(7,343)	(2,496)	(2,531)	(2,381)	(21,558)
Pay - Medical & Dental	(2,278)	(2,384)	(5,816)	(5,956)	(2,166)	(2,144)	(2,172)	(18,255)
Pay - Other	(1,285)	(1,303)	(2,599)	(2,326)	(813)	(724)	(759)	(7,221)
Pay Subtotal	**(6,370)**	**(6,536)**	**(15,223)**	**(15,624)**	**(5,475)**	**(5,399)**	**(5,312)**	**(47,033)**
Non Pay - Blood	(51)	(51)	(136)	(119)	(58)	(45)	(34)	(392)
Non Pay - Drugs	(743)	(721)	(1,774)	(1,822)	(756)	(716)	(710)	(5,778)
Non Pay - Clinical Supplies	(575)	(554)	(702)	(889)	(412)	(313)	(419)	(2,735)
Non Pay - Other	(528)	(607)	(793)	(182)	(226)	(153)	71	(1,283)
Non Pay Subtotal	**(1,897)**	**(1,933)**	**(3,406)**	**(3,011)**	**(1,452)**	**(1,227)**	**(1,091)**	**(10,187)**
Income from Activities	30	25	0	1	0	0	(208)	(207)
Income from Operations	280	300	220	640	214	151	164	1,389
Total	**(7,957)**	**(8,144)**	**(18,409)**	**(17,994)**	**(6,713)**	**(6,475)**	**(6,447)**	**(56,039)**

Women's and Children's	19/20 Actual Monthly Average £'000	19/20 Actual Q4 Average £'000	20/21 Actual Q1 (Excl. Covid) £'000	20/21 Actual Q2 (Excl. Covid) £'000	20/21 Actual M7 (Excl. Covid) £'000	20/21 Actual M8 (Excl. Covid) £'000	20/21 Actual M9 (Excl. Covid) £'000	20/21 Actual YTD (Excl. Covid) £'000
Pay - Nursing & Midwifery	(4,554)	(4,660)	(13,668)	(13,722)	(4,725)	(4,786)	(4,788)	(41,688)
Pay - Medical & Dental	(3,729)	(3,966)	(11,277)	(11,505)	(3,976)	(3,926)	(4,059)	(34,743)
Pay - Other	(1,329)	(1,364)	(4,255)	(4,236)	(1,420)	(1,428)	(1,430)	(12,769)
Pay Subtotal	**(9,612)**	**(9,990)**	**(29,199)**	**(29,463)**	**(10,121)**	**(10,140)**	**(10,276)**	**(89,199)**
Non Pay - Blood	(179)	(198)	(553)	(563)	(189)	(184)	(200)	(1,689)
Non Pay - Drugs	(1,169)	(1,545)	(4,590)	(4,312)	(1,526)	(1,833)	(1,894)	(14,156)
Non Pay - Clinical Supplies	(1,063)	(1,139)	(1,880)	(2,573)	(1,044)	(1,317)	(1,012)	(7,826)
Non Pay - Other	(723)	(814)	(1,970)	(2,014)	(809)	(671)	(775)	(6,239)
Non Pay Subtotal	**(3,134)**	**(3,696)**	**(8,994)**	**(9,462)**	**(3,567)**	**(4,005)**	**(3,882)**	**(29,910)**
Income from Activities	180	400	30	221	54	477	417	1,199
Income from Operations	573	626	1,317	1,091	363	384	364	3,519
Total	**(11,993)**	**(12,660)**	**(36,846)**	**(37,613)**	**(13,271)**	**(13,284)**	**(13,377)**	**(114,391)**

Estates and Facilities	19/20 Actual Monthly Average £'000	19/20 Actual Q4 Average £'000	20/21 Actual Q1 (Excl. Covid) £'000	20/21 Actual Q2 (Excl. Covid) £'000	20/21 Actuals M7 (Excl. Covid) £'000	20/21 Actuals M8 (Excl. Covid) £'000	20/21 Actuals M9 (Excl. Covid) £'000	20/21 Actual YTD (Excl. Covid) £'000
Pay - Nursing & Midwifery	0	0	0	0	(2)	0	(1)	(4)
Pay - Medical & Dental	0	0	0	0	0	0	0	0
Pay - Other	(2,249)	(2,226)	(6,945)	(6,969)	(2,308)	(2,378)	(2,378)	(20,978)
Pay Subtotal	**(2,249)**	**(2,226)**	**(6,945)**	**(6,969)**	**(2,310)**	**(2,377)**	**(2,379)**	**(20,981)**
Non Pay - Blood	0	0	0	(2)	0	0	0	(2)
Non Pay - Drugs	0	0	(1)	(2)	(0)	0	(1)	(3)
Non Pay - Clinical Supplies	(32)	(41)	(126)	(64)	(16)	(16)	(17)	(239)
Non Pay - Other	(2,276)	(2,569)	(6,243)	(6,526)	(2,032)	(2,168)	(2,002)	(18,971)
Non Pay Subtotal	**(2,308)**	**(2,609)**	**(6,369)**	**(6,594)**	**(2,049)**	**(2,184)**	**(2,020)**	**(19,215)**
Income from Activities	7	4	0	0	0	0	0	0
Income from Operations	443	423	639	1,756	399	402	363	3,559
Total	**(4,107)**	**(4,409)**	**(12,675)**	**(11,807)**	**(3,960)**	**(4,159)**	**(4,036)**	**(36,637)**

Trust Services	19/20 Actual Monthly Average £'000	19/20 Actual Q4 Average £'000	20/21 Actual Q1 (Excl. Covid) £'000	20/21 Actual Q2 (Excl. Covid) £'000	20/21 Actuals M7 (Excl. Covid) £'000	20/21 Actuals M8 (Excl. Covid) £'000	20/21 Actuals M9 (Excl. Covid) £'000	20/21 Actual YTD (Excl. Covid) £'000
Pay - Nursing & Midwifery	(368)	(360)	(1,118)	(1,092)	(369)	(357)	(338)	(3,273)
Pay - Medical & Dental	(175)	(205)	(641)	(523)	(218)	(213)	(196)	(1,789)
Pay - Other	(2,776)	(2,896)	(8,414)	(8,445)	(2,814)	(2,893)	(2,910)	(25,476)
Pay Subtotal	**(3,319)**	**(3,460)**	**(10,172)**	**(10,058)**	**(3,401)**	**(3,463)**	**(3,444)**	**(30,539)**
Non Pay - Blood	(2)	0	0	0	0	0	0	0
Non Pay - Drugs	(15)	(15)	(21)	(67)	(17)	(13)	(17)	(135)
Non Pay - Clinical Supplies	(15)	(20)	(37)	(56)	9	66	(6)	(25)
Non Pay - Other	(1,174)	(1,337)	(3,029)	(1,955)	(1,022)	(1,009)	(882)	(7,897)
Non Pay Subtotal	**(1,205)**	**(1,372)**	**(3,087)**	**(2,078)**	**(1,031)**	**(957)**	**(905)**	**(8,057)**
Income from Activities	0	0	0	0	0	0	0	0
Income from Operations	757	1,073	1,373	1,150	399	468	648	4,038
Total	**(3,768)**	**(3,760)**	**(11,886)**	**(10,987)**	**(4,032)**	**(3,952)**	**(3,701)**	**(34,558)**

Section 2 – Division and Corporate Services Performance continued

The narrative below excludes any impact relating to Covid-19.

Diagnostic and Therapies

Run rate

The overall run rate for month 09 is £0.272m higher than month 08 and remains higher than the average for 2019/20 and quarter 04 2019/20.

The pay run rate increased this month by £0.032m, the run rate has been gradually increasing over the year particularly in quarter 03 with quarter three being on average £0.160m higher than quarter 01.The run rate for other clinical staff has remained consistent all year and is higher than for 2019/20 due to vacant posts being filled.

The non–pay run rate increased this month by £0.176m with the increase being across drugs and clinical supplies with variability being caused by pass through costs. Overall the quarter 03 run rate is £0.160m higher than quarter 01. Overall, the non–pay run rate is now higher than the run rate for quarter 04 2019/20.

Income remains in line with the previous months and remains lower than the run rate in 2019/20 partly due to lower than expected research income and the loss of recharge income to Weston.

Variance to budget

The division reports an adverse variance to budget of £0.460m.

Non - pay reports an adverse variance of £0.124m with adverse variances on drugs £0.199m (predominately high tech home care) and clinical supplies £0.453m (includes £0.125m relating to the pathology MES contract) being offset by a favourable variance on other non - pay of £0.528m. A significant element of the clinical supplies adverse variance relates to Memo recharges which is offset within the favourable variance on other expenditure.

Pay reports an adverse variance of £0.188m this being caused by seasonal recruitment to vacancies.

Income reports an adverse variance of £0.148m due to lower than planned private patient income lower than planned research income and lower than planned pathology referrals.

Medicine

Run rate

The overall run rate in month 09 is £0.140m higher than month 08 and is consistent with the average the run rate for quarter 04 2019/20.

The pay expenditure run rate showed an increase this month of £0.027m, the nursing run rate has remained broadly the same as for month 08 and is still higher than the average run rate for 2019/20 though consistent with quarter 04 2019/20. The medical staff run rate increased this month by £0.035m and remains higher than 2019/20 mainly due to the medical staff pay award and more extensive rotas being used as a result of Covid.

The non-pay expenditure run rate decreased this month by £0.328m. The main driver for this being a decrease in the rate of drug expenditure of £0.326m, however, this relates to pass through costs which can fluctuate significant between months. The drug expenditure run rate is now considerably higher than experienced in 2019/20 due to higher expenditure on pass through drugs particularly cystic fibrosis drugs.

The run rate on income though lower than month 08 remains higher than in 2019/20 month this but a significant element of this is the income offset against the increase in variable at cost pass through drugs.

Variance to budget

The division reports a favourable variance of £0.284m this month with a favourable variance of £0.528m on pay, mainly nursing £0.519m offset by an adverse variance on non-pay of £0.102m including a favourable variance on

drugs of £0.206 (lower levels of pass through costs this month) and an adverse variance on income of £0.142m.

Section 2 – Division and Corporate Services Performance continued

Specialised Services

Run rate

Overall run rate increased by £0.313m in month 09 and is now £1.597m higher than the average for 2019/20 and £1.479m higher than quarter 04 2019/20.

The pay run rate at month 09 is £0.200m higher than month 08. However despite relatively minor fluctuations between months the run rate is broadly consistent with the average run rate for quarter 04 last year.

The non-pay run rate increased by just £0.012m this month. The run rate is usually subject to more variability due to changes in pass through costs. The cost of clinical supplies was marginally higher than month 08. The drug expenditure run rate increased by £0.163m this month and this can be variable due to changes in pass through activity.

Variance to budget

The division reports a favourable variance to month 09 of £0.057m. However there is much variability between subjective headings.

Income reports a favourable variance of £0.717m mainly due to higher than planned research and training income and an over performance on private patient activity.

Pay reports a favourable variance of £0.345m, nursing being favourable by £0.195m due to vacancies. Medical staff report a favourable variance of £0.147m.

Non-pay reports an adverse variance of £1.005m. Other non - pay reports an adverse variance of £0.604m due to increased stem cell donor charges for BMT and CART C (donor charges are no longer being reimbursed variably). There has also been charges incurred of £0.075m year to date regarding linacc repairs. Drugs are reporting an adverse variance of £0.114m due to increased pass through costs. Clinical supplies are reporting an adverse variance of £0.287m mainly due to increased pass through costs.

Surgery

Run rate

The month 09 run rate decreased by £0.028m from month 08, however the average run rate for quarter 03 is now £1.113m higher than quarter 01. The overall run rate remains is broadly consistent with that experienced in the final quarter of 2019/20.

The pay run rate in month 09 is £0.194m higher than month 08 and is now £0.239m higher than the run rate for quarter 04 2019/20. The most noticeable increase being in respect of medical staff.

The non-pay run rate in month 09 decreased by £0.171m, the run rate across drugs and clinical supplies has seen a gradual increase over the past few months as activity increases and elective mitigation plans are implemented. The overall non-pay run rate remains below levels experienced in 2019/20 due to lower levels of activity.

Variance to budget

The division reports an adverse variance to budget of £0.630m with an adverse variance on non-pay of £0.846m (mainly on clinical supplies £0.666m) being offset by favourable variances on pay £0.053m due to lower than planned premium rate payments to other medical staff and income from operations £0.166m due to research income recovering from the month 05 position.

Section 2 – Division and Corporate Services Performance continued

Women's and Children's

Run rate

The run rate at month 09 showed an increase over month 08 of £0.093m resulting in the current run rate being higher than the average run rate for quarter 04 2019/20 by £0.717m. It should be noted however that the winter months usually show higher levels of spend than on average.

The run rate decreased on non–pay by £0.123m. However, the non-pay run rate has been increasing through the year with significant increases recently being related to drugs with the month 09 run rate being £0.364m higher than the average for quarter 01. There have been increases in run rate for both pass through and non-pass through drugs. Overall the non–pay run rate is now consistent with quarter 04 2019/20.

The clinical supplies run rate reduced this month by £0.305m although the run rate for clinical supplies is on an upward trend driven by increased spend on cardiology devices, cochlear replacement processors and ventilators this has been a consequence of increased activity.

The pay run rate for month 09 increased by £0.136m over month 08 and is now £0.286m higher than the average for 2019/20. This is primarily due to a seasonal increase in staffing in preparation for winter, which is usual for this time of year. There has also been an increased level of expenditure on junior doctors relating to the introduction of new rotas in PICU, ED and paediatrics.

Variance to budget

The division reports an adverse variance to budget of £2.103m.

Pay reports an adverse variance of £0.556m with this being spread across most pay headings; this is mainly driven by seasonal increases in staffing which is normal for this time of year. Nursing reports and adverse variance of £0.230m and medical staff reports and adverse variance of £0.337m.

Non-pay reports a significant adverse variance of £1.386m. This is driven by increases in costs relating to cochlear implants and repairs as well as increased activity over and above the month 05 run rate.

Income reports and adverse variance of £0.161m this being driven by lower private patient income compared with the revised plan.

Weston

Run rate

The overall run rate is £0.028m lower than for month 08 but remains significantly lower than that experienced in quarter 04 2019/20 and the average for last year. The pay run rate reduced by £0.087m this month following a gradual increase in the previous four months but remains well below the previous financial year particularly for nursing.

The run rate for non-pay showed a decrease in month 09 of £0.136m, the non–pay run rate remains significantly lower than for the previous financial year reflecting lower levels of activity year on year.

Variance to budget

The division reports an adverse variance to budget of £1.081m.

Pay is adverse to budget by £0.441m with adverse variances for nursing £0.064m due to increased use of bank staff and an increased acuity of patients, and medical staff £0.260m mainly due to additional costs of covering sickness and other absence.

Non pay is adverse to budget by £0.554m mainly on clinical supplies £0.399m due to increased activity.

Income reports an adverse variance of £0.086m driven by increased R&D income offset by an adverse variance relating to an backdated adjustment related to an underperformance on the variable element of pass through activity £0.207m.

Section 2 – Division and Corporate Services Performance continued

Estates and Facilities

Run rate

The overall run rate has been consistent all year, and is broadly consistent with 2019/20, this is to be expected as most categories are not impacted by variations in clinical activity.

The pay run rate has remained consistent all year and is only slightly higher than 2019/20. The small increase this year can be attributed to pay awards and an increase in cleaning costs particularly this month which is linked to the increase in activity due to restoring activity.

There has been a reduction in the non-pay run rate in recent months this being due to the impact of the new combined heat and power unit coming on line and delivering the expected savings.

Variance to budget

The division reports a favourable variance to budget at month 09 of £0.625m due to higher than planned car parking income, a number of vacancies and lower than planned expenditure on energy due to the impact of the combined heat and power unit coming on line.

Trust Services

Run rate

The run rate in month 09 is £0.251m lower than month 08 and is broadly consistent with the monthly average for 2019/20 across all headings. This is not surprising as costs in this division vary little with changes in clinical activity.

Variance to budget

Trust services reports a favourable variance to budget of £0.082m with an adverse variance on non-pay of £0.202m and an adverse variance of £0.388m on pay being offset by favourable variances on income from operations of £0.672m. The favourable variance on income is due to increased recharging of staff on secondment and increased income from hosted services.

Section 3 – Clinical and Contract Income

Volumes by Point of Delivery (Bristol Sites)

	2019/20 M1-12 Average	2020/21 Q1 Average	2020/21 Q2 Average	2020/21 M7	2020/21 M8	2020/21 M9
Activity Based						
Accident & Emergency	11,715	7,407	9,882	10,092	9,252	9,075
Emergency Inpatients	4,007	2,872	3,454	3,507	3,366	3,233
Day Cases	5,043	2,390	3,609	4,755	4,497	4,402
Elective Inpatients	1,044	497	886	1,012	903	860
Non-Elective Inpatients	1,241	1,067	1,168	41	1,005	1,019
Excess Beddays	1,508	1,243	901	849	1,640	716
Outpatients	54,090	32,017	41,834	46,596	48,199	45,479
Bone Marrow Transplants	13	9	11	15	14	13
Critical Care Beddays	4,349	3,086	3,568	4,656	3,892	3,890

Volumes by Point of Delivery (Weston Site)

	2019/20 M1-12 Average	2020/21 Q1 Average	2020/21 Q2 Average	2020/21 M7	2020/21 M8	2020/21 M9
Activity Based						
Accident & Emergency	4,184	1,771	3,579	3,363	3,011	2,910
Emergency Inpatients	1,197	638	1,056	1,063	967	890
Day Cases	1,107	337	744	844	842	793
Elective Inpatients	86	12	40	69	86	80
Non-Elective Inpatients	9	9	11	7	1	1
Excess Beddays	388	186	215	254	184	205
Outpatients	10,804	5,387	7,924	7,386	7,501	6,860
Critical Care Beddays	144	106	128	139	146	130

The tables opposite show the changes in activity volumes we have seen this year since April. In general, activity volumes are slightly lower in December compared with November.

NHSE&I have introduced the Elective Incentive Scheme (EIS) with the goal of accelerating the return to near-normal levels of non-Covid-19 health services. Systems will be rewarded or penalised based on the financial value of the activity they perform. The scheme will run between September 2020 and March 2021.

There has been an increase in both the community prevalence of Covid-19 and Covid-19 related admissions since the EIS arrangements were set out. In response, NHSE&I have amended the scheme. In addition, where systems and/or organisations saw more than 15% of their beds occupied with COVID patients and materially higher staff absence in the relevant period, NHSE&I will suspend the scheme.

NHSE&I calculate the EIS retrospectively. There was no financial adjustment for the STP in September 2020. However, NHSE&I analysis suggests that UHBW and independent sector providers were below target by £0.459m and £0.127m, respectively, while NBT was £0.622m above Target. The EIS assessment is excluded from the Trust's financial position.

Under the revised financial arrangements from 1 October 2020, reimbursement for high cost drugs under the Cancer Drugs Fund (CDF) and relating to treatments under the Hepatitis C programme will revert to a pass-through cost and volume basis, with adjustments made to NHS provider block contract values to reflect this. For the majority of other high cost drugs and devices, in-year provider spend will be tracked against a notional level of spend included in the block funding arrangements with adjustments made in-year to ensure that providers are reimbursed for actual expenditure on high cost drugs and devices. This leaves a smaller list of high cost drugs and devices which will continue to be funded as part of the block arrangements.

The nature of these arrangements is such that, for high cost drugs and devices we need to estimate the value of the additional income due to the Trust in the reported position. The estimate of the additional income due in quarter 3 is £11.611m.

Section 4 – Savings Programme

Due to the Covid-19 pandemic and the uncertainty that this has introduced, it is considered unreasonable to set divisions savings targets based on the pre Covid-19 financial plan. Therefore, until the revised level of savings required this year is established and in order that divisions have a reasonable target to work towards, divisions have been advised that they should aim to deliver savings at least equal to the underlying deficit brought forward from 2019/20. The following summary shows progress to date against the phased revised target.

Analysis by work streams:

	2020/21 Annual Target £m	Year to date (Month 09) Plan £m	Actual £m	Variance fav/(adv) £m
Allied Healthcare Professionals	0.062	0.046	0.034	(0.012)
Diagnostic Testing	0.207	0.155	0.052	(0.104)
Estates & Facilities	0.619	0.386	0.310	(0.076)
Healthcare Scientists Productivity	0.198	0.148	0.100	(0.048)
HR Pay and Productivity	0.028	0.028	0.028	-
Income, Fines and External	0.615	0.430	0.147	(0.283)
Medical Pay & Productivity	0.348	0.255	0.202	(0.053)
Medicines	0.535	0.425	0.413	(0.011)
Non Pay	4.063	2.932	2.422	(0.510)
Nursing Pay & Productivity	0.364	0.266	0.266	-
Productivity	2.252	1.751	0.473	(1.277)
Trust Services	0.447	0.335	0.376	0.042
Weston Merger	2.700	2.025	1.336	(0.689)
Plans to be developed from Pipeline	6.138	4.635	-	(4.635)
Total	**18.575**	**13.817**	**6.160**	**(7.658)**

Analysis by Division:

	2020/21 Annual Target £m	Year to date (Month 09) Plan £m	Actual £m	Variance fav/(adv) £m	Forecast Outturn £m
Diagnostics & Therapies	0.868	0.669	0.753	0.084	0.985
Medicine	2.303	1.735	0.731	(1.004)	0.997
Specialised Services	1.407	1.030	0.696	(0.334)	0.859
Surgery	6.019	4.551	0.416	(4.135)	0.533
Weston	3.930	2.889	1.522	(1.367)	2.004
Women's & Children's	3.054	2.223	1.011	(1.212)	1.327
Estates & Facilities	0.505	0.350	0.630	0.280	1.076
Finance	0.000	0.000	0.147	0.147	0.198
Human Resources	0.135	0.103	0.042	(0.061)	0.051
Trust Headquarters	0.090	0.068	0.115	0.046	0.141
Digital Services	0.264	0.198	0.097	(0.101)	0.131
Total	**18.575**	**13.817**	**6.160**	**(7.658)**	**8.301**

The Trust has delivered savings of £6.160m for the year to date, 45% against its target. Forecast savings total £8.301m (45% achievement).

The savings target for 2020/21 is £18.575m. The Trust has achieved savings of £6.160m to date, a shortfall of £7.658m.

Divisions behind plan include Surgery £4.135m; Weston £1.367m; Women's & Children's £1.212m; Medicine £1.004m and Specialised Services £0.334m. Diagnostics & Therapies, Estates & Facilities, Finance and Trust HQ are slightly ahead of the target, while Human Resources and Digital Services are slightly behind target.

Section 5 – Capital Programme

Updated Programme and Forecast Outturn

The Trust's original 2020/21 capital programme was £128.724m before planned slippage.

The agreed STP funding envelope for the Trust is £53.161m, which when added to the approved PDC, totals a target spend of £76.300m for 2020/21.

Further challenge at the Trust's Capital Programme Steering Group (CPSG) produced a revised forecast outturn in December of £76.528m.

Category	Target Spend £m	Revised Forecast Outturn £m	Forecast Outturn Variance £m
STP Envelope - PDC	5.000	5.000	-
STP Envelope - Core	48.161	48.389	0.228
STP Envelope	**53.161**	**53.389**	**0.228**
Outside Envelope - PDC	22.526	22.526	-
Outside Envelope - Donations	0.613	0.613	-
Outside Envelope	**23.139**	**23.139**	**-**
Total Gross Expenditure	**76.300**	**76.528**	**0.228**

The revised forecast outturn was largely in line with the target expenditure and accounts for mitigations agreed at CPSG.

CPSG reviewed the forecast outturn noting it would be a significant challenge to achieve the required level of expenditure in the final quarter. More recently a further deterioration in the Covid situation has increased the risk of additional slippage on both STP and PDC funded projects. CPSG is continuing to scrutinise the forecast outturn figures to identify slippage which may result in a forecast outturn which is below the target expenditure. A number of mitigations have been identified and the Trust will continue to liaise with the STP and Region on the slippage impact and potential next steps.

Year to date expenditure – 31st December 2020

Capital expenditure to 31st December 2020 totals £33.803m, £2.309m behind the internal plan, and is detailed in the table below.

Applications to Month 9	Profile Spend	Actual Spend	YTD Variance
	£m	£m	£m
Strategic Schemes	15.758	14.926	(0.832)
Medical Equipment	6.712	6.973	0.261
Operational Capital	5.546	4.674	(0.872)
Fire Improvement	-	0.384	0.384
Digital Services	4.288	3.383	(0.905)
Estates Replacement	2.465	2.034	(0.431)
Weston	1.343	1.429	0.086
Gross Expenditure	36.112	33.803	(2.309)

The variance is primarily driven by the strategic schemes, operational capital and digital services. There are a number of strategic schemes on hold whilst a review and update of all the business cases is undertaken, and the operational capital and digital services schemes variance are due to scheme delays driven by the Covid-19 pressures.

In order to achieve the target spend of £76.300m, a further £42.497m of capital expenditure has to be delivered in the final three months of the year, a challenging and unprecedented value of capital expenditure for the Trust in a three-month period. This is particularly challenging given the risks to project delivery due to access limitations and potential workforce constraints due to the current Covid situation.

Challenges

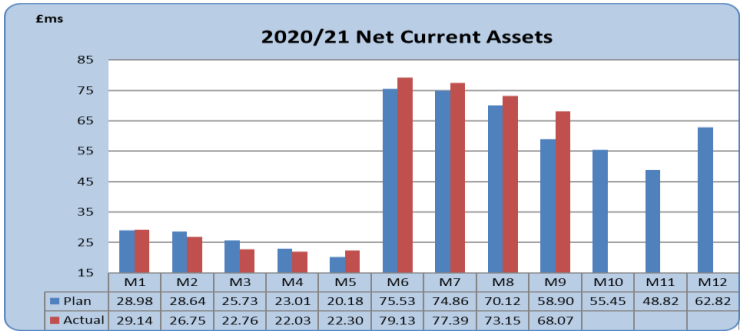
Delivery of £42.497m of capital projects in the remaining three months.

Risks

The potential impact on the Trust of an underspend against the STP CDEL envelope and the PDC national allocations; delivering a capital programme below the STP envelope could potentially reduce the 2021/22 envelope and an underspend on PDC schemes could lead to a loss of cash funding.

Section 6 – Statement of Financial Position and Cashflow

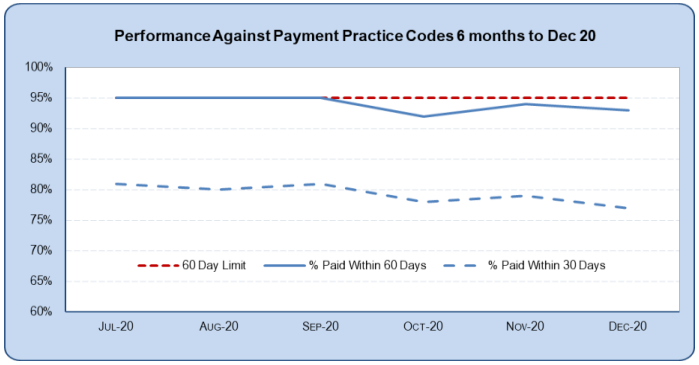
Net Current Assets



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Plan	28.98	28.64	25.73	23.01	20.18	75.53	74.86	70.12	58.90	55.45	48.82	62.82
Actual	29.14	26.75	22.76	22.03	22.30	79.13	77.39	73.15	68.07			

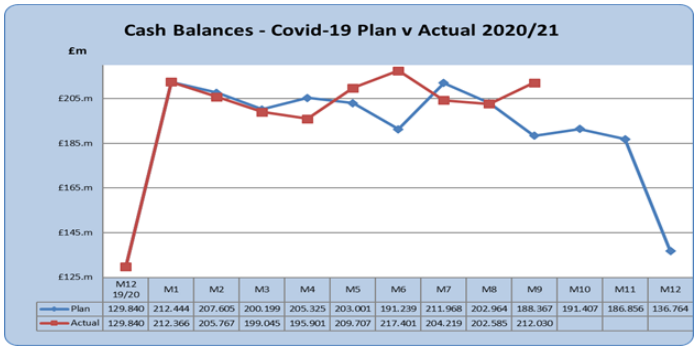
Net current assets as at 31st December 2020 were £68.078m, £9.909m above the plan. The variance primarily relates to the favourable cash balance variance of £23.464m offset by adverse variances on deferred income and trade receivables and payables of £8.703m, £3.533m and £1.647m respectively. The deferred income variance relates to timing differences on Health Education England quarterly income.

Payment Performance



In December, 93% of invoices were paid within the 60 day target set by the Prompt Payments Code and 77% within the 30 day target set by the Better Payment Practice Code (BPPC). The percentages reflect operational pressures and priorities and the Head of Transaction Services is looking at contingency options for divisional approvals.

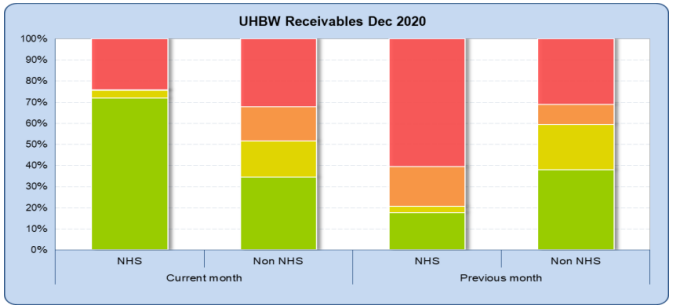
Cash Balance



	M12 19/20	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Plan	129.840	212.444	207.605	200.199	205.325	203.001	191.239	211.968	202.964	188.367	191.407	186.856	136.764
Actual	129.840	212.366	205.767	199.045	195.901	209.707	217.401	204.219	202.585	212.030			

The Trust's cash and cash equivalents balance was £212.030m, £23.464m above plan, and is primarily due to £12.532m cash slippage on the original NHSEI capital investment plan, £9.496m of working capital movements and £1.436m variance on the planned deficit.

Receivables position



Days	Current Month (£M)			Previous Month (£M)			Movement (£M)		
	NHS	Non NHS	Total	NHS	Non NHS	Total	NHS	Non NHS	Total
90+	3.063	2.229	5.292	5.972	1.949	7.921	(2.909)	0.280	(2.629)
60-90	0.037	1.109	1.146	1.842	0.598	2.440	(1.805)	0.512	(1.293)
30-60	0.475	1.184	1.658	0.298	1.342	1.639	0.177	(0.158)	0.019
0-30	9.095	2.373	11.469	1.735	2.377	4.112	7.360	(0.004)	7.357
Total	12.670	6.895	19.565	9.847	6.266	16.112	2.823	0.630	3.453

The receivables position at 31st December 2020 was £19.565m, a £3.453m increase on last month. The year to date balance is split NHS of £12.670m, with £3.1m or 24% over 60 days and Non NHS of £6.895m, with £3.338m or 48% over 60 days.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public Thursday 28 January 2021

Report Title	**Equality, Diversity & Inclusion Update**
Report Author	**Sam Chapman: Head of Organisational Development**
Executive Lead	**Matt Joint: Director of People**

1. Report Summary

This report provides a progress update on the Trust D&I strategy for the reminder of quarter 4 and sets-out the action plan for 2021/22. The key deliverables for quarter 4 are:

- Co-ordinate and implement an EDI performance framework
- Capacity-building Inclusive Leadership Programme for divisional EDI Leads & Advocates
- Supporting and developing Staff Networks
- WRES Cultural Change and Reciprocal Mentoring Programme pilot

2. Key points to note
(Including decisions taken)

The Board is asked to receive the report for assurance and note the progress update.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

Risk 285: Risk that the Trust fails to ensure equity of experience for all staff.

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for Assurance

5. History of the paper
Please include details of where paper has previously been received.

[Name of Committee/Group/Board]	[Insert Date paper was received]
People Committee	25.1.2021

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Strategic Priorities: Leadership and Cultural Transformation.

Objective 2: We are committed to inclusion in everything we do including Recruitment, Induction, Training, Appraisal and Talent Management.

University Hospitals Bristol and Weston NHS Foundation Trust

KPIs	No	Action	Who	When	Progress	RAG
EA2010 PSED BSS1 BSS2 BSS3 BSS4	5	Develop an EDI Inclusive Leadership Programme for Divisional EDI Leads & Advocates. This programme will provide robust baseline capacity-building on legal compliance, equality analysis and practical application of embedding EDI in all Trust activities and functions including equality of opportunity in career progression and development across all protected groups.	EDI Manager Head of Education Head of L&D Staff Networks Divisional EDI leads Divisional EDI Advocates	April 21 onwards	Ongoing support for Divisional EDI Leads & Advocates is already in place. In parallel, a wider scoping and feasibility study is underway to determine EDI capacity-building needs, programme content and delivery mechanisms.	
APP2	6	Support for line-managers to have 'meaningful' EDI conversations in Appraisals. There is a clear juxtaposition between, 'what have you done to improve EDI in the Trust?' and 'how can I support your pathway to EDI in the Trust'.	EDI Manager Oonagh McNeil	Feb 21	Draft guidance currently being developed.	
EDS4.3	7	Cultural Awareness Training.	EDI Manager Mike Sheppard	Ongoing	Training has been well received with 567 having completed it - ongoing promotion	
EDS3.1 DPP1	8	Building EDI into our Recruitment processes.	EDI Manager Peter Russell	April 21	Scoping and feasibility study underway to develop focused interventions.	
EDS3.3 APP2 DSS1	9	Building EDI into Talent Management as part of the Talent Management pilot in Estates to harnesses the talent that is lying dormant in our staff across all protected groups.	EDI Manager Faye Beddow	April 21	Scoping and feasibility study underway to develop focused interventions.	

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Inspected and rated Outstanding ☆ CareQuality Commission

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Strategic Priorities: Leadership and Cultural Transformation.

Objective 3: We celebrate and value the contribution all of our staff make at all levels of the organisation.

University Hospitals Bristol and Weston NHS Foundation Trust

KPIs	No	Action	Who	When	Progress	RAG
EDS4.1 DSS1	10	Review Lift As You Climb pilot and develop an up scaled programme with self-sufficient management system allowing the mentor and mentee to contact directly.	EDI Manager Alex Millar	Feb 21	Review of the Lift As You Climb pilot has been completed and the self-service management system is currently being tested for functionality and integrity. The pilot has been well received and a number of inspirational staff have registered as mentors. The full programme should go live in Feb 21.	
EDS3.6 PSED	11	Celebrating and Valuing the Contribution of all our staff. OD has developed a comprehensive EDI communications plan for 2021 that is in the process of being implemented that showcases the diversity and richness of contribution by Trust staff. There will be particular focus on national and international events e.g. LGBT Month (Feb), Black History Month (Oct) and Disability Month (Dec) and also on festivals (e.g. Diwali) as well as celebration and awareness days/weeks e.g. men's health week.	EDI Manager OD team Staff Networks Divisional EDI Leads Divisional EDI Advocates Comms team	Ongoing 2021	Activities around LGBT Month are at the planning stage with a half-day LGBT conference taking place on 24 Feb (virtual conference).Planning around other events is also in progress.	

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Inspected and rated Outstanding
CareQuality Commission

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Strategic Priorities: Accountability and Assurances.

Objective 4: We will encourage shared learning by openly sharing our diversity data in a meaningful way.

University Hospitals Bristol and Weston NHS Foundation Trust

KPIs	No	Action	Who	When	Progress	RAG
PSED DSS1 APP2	12	Equality of opportunity. The Trust is committed to understanding the barriers to equality of opportunity for career progression and development for all staff across all protected characteristics.	EDI Manager Staff Networks Divisional EDI leads Divisional EDI Advocates	2021-22	Scoping and feasibility study underway to develop focused interventions by understanding key barriers, hot spots and pressure points to EDI in the Trust.	
WRES DPP3 DPP4 DPP5 PSED	13	WRES Cultural Change Programme. The pilot involves deep-dive diagnostics on the WRES data, focus group facilitation and reviewing access to leadership development among other interventions. The learning from this programme will be applied across all protected characteristics to help the Trust build a more representative workforce.	EDI Manager Lorna Hayles Sam Chapman National WRES Team	Feb – Jun 21	The programme initiation meeting is set for Feb 21.	
WDES PSED EDS3.6	14	Improving our WDES & LGBT staff data collection on ESR. The Trust recognises that there are genuine EDI barriers that prevent some staff from registering their disability and/or sexual orientation on ESR. This is a complex area with issues of trust, safety, confidentiality and inclusion needing to be addressed at an individual, team and organisational level. The Trust is committed to cultural change where staff from all protected groups feel safe, supported, valued and respected.	EDI Manager Lorna Hayles LGBT+ Staff Network Chair ABLE+ Staff Network Chair	2021-22	The learning from the WRES Cultural Change pilot, particularly, the diagnostics, gathering of quantitative and qualitative data, will be directly applicable to addressing some of the EDI barriers faced by our LGBT and disabled staff.	

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Outstanding ☆
CareQuality Commission

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Strategic Priorities: Accountability and Assurances.

Objective 5: Our Strategy is communicated at all levels reflecting our commitment to change.

University Hospitals Bristol and Weston NHS Foundation Trust

KPIs	No	Action	Who	When	Progress	RAG
EA2010 PSED	15	EDI visibility on HRWeb. EDI Landing Page to be reviewed and refreshed.	EDI Manager Alex Millar	Jan 21	The EDI landing page on HRWeb has been refreshed with continued development throughout 2021 so it becomes a robust resource for all staff on Equality, Diversity and Inclusion.	
EA2010 PSED	16	EDI visibility on Public Website (external). EDI publications to be migrated from UHB to UHBW new website.	EDI Manager Tasmeen Warr John Kirk	Jan-Feb 21	Discussions are taking place on the timeframe when this can be achieved.	
EDS4.2 EA2010 PSED WRES WDES	17	Bi-annual EDI performance framework report. Develop a bi-annual EDI performance framework report to enable robust local reporting and targeted interventions that goes to People Committee and all governance routes within the Trust.	EDI Manager Sam Chapman	May 21	Draft outline of the framework report is in progress. The final report to be presented to the People Committee on 25 May 2021.	

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Inspected and rated Outstanding ☆ Care Quality Commission

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Strategic Priorities: Positive Action and Practical Support.

Objective 6: Our Education Strategy focuses on inclusion and is a key enabler to delivering the vision supported by our Trust values.

University Hospitals Bristol and Weston NHS Foundation Trust

KPIs	No	Action	Who	When	Progress	RAG
EA2010 PSED WRES WDES EDS2	18	Mystery Shopper - testing the assumptions. The Trust is committed to EDI for staff, students, volunteers and patients. However, we need to test how this works in practice. Therefore, in parallel with the BAME Student Placement Pilot (see action point 27), the Trust is developing a programme that will journal the EDI experience of placement students from other protected characteristics (e.g. LGBT, disability, religion or belief, pregnancy and age) in clinical and educational settings.	EDI Manager Head of Education Head of L&D Head of Medicine Edu. Divisional EDI leads	April 21 onwards	Scoping and feasibility study is underway in advance of the design stage which will include 'safe and confidential space' for honest dialogue for students and supervisors to share about their respective experience of EDI in these settings/relationships.	

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Strategic Priorities: Positive Action and Practical Support.

Objective 7: Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible.

University Hospitals Bristol and Weston NHS Foundation Trust

KPIs	No	Action	Who	When	Progress	RAG
EA2010 PSED WRES WDES EDS2	19	Positive Action and Practical Support on EDI Over the next 12 months, the Trust's focus will be to achieve high visibility on EDI internally (intranet) and externally (public website), with increased focus through our communication channels including Voices, Newsbeat, leaflets, webinars, focused EDI masterclasses and capacity building workshops.	EDI manager Tasmeen Warr John Kirk Staff Network chairs Divisional EDI Leads/Advocates Head of L&D Head of Education	2020-21	EDI landing page on HRWeb refreshed. Focused interventions and messages are being developed as part of the Trust New EDI Offer to all staff, Divisional EDI Leads/Advocates as detailed throughout this report.	

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Inspected and rated Outstanding ☆ Care Quality Commission

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Strategic Priorities: Positive Action and Practical Support.

Objective 8: Staff forums grow to become an increased staff voice who represent our workforce and the community we serve

University Hospitals Bristol and Weston NHS Foundation Trust

KPIs	No	Action	Who	When	Progress	RAG
EA2010 PSED WRES WDES EDS2	20	The Trust is committed to supporting Staff Networks to become sustainable with increased visibility, membership, wider reach and impact across all protected characteristics.	EDI Manager Staff Network Chairs Jeff Farrar Matt Joint	Feb 21	A draft scoping and feasibility study for making Staff Networks sustainable is near completion for wider circulation and engagement.	
WRES WDES PSED EA2010	21	Access to facilities and room at Weston to enable staff based at Weston to attend Staff Network meetings virtually.	EDI Manager Staff Network Chairs Julian Newberry Mark Kellinger	Jan 21	An agreement is in place to provide a IT/Webcam equipped room to ensure that staff based at Weston can participate in all Staff Network meetings.	
WRES WDES PSED EA2010 EDS2	22	Increased visibility of Staff Networks on HRWeb.	EDI Manager Staff Network Chairs Alex Millar	Jan 21	Access to Staff Networks' landing page has been moved to HRWeb top menu below 'Staff Services'. Staff Network pages on HRWeb have also been refreshed with continued development throughout 2021 to become a robust resource for staff.	
WRES WDES PSED EA2010	23	Library facilities and support for Staff Networks to develop areas of expertise and resource.	EDI Manager Thomas Osborne Staff Network Chairs	Mar 21	Further dialogue on hold due to covid vaccine being rolled out from the academy building.	

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Inspected and rated Outstanding ☆ Care Quality Commission

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Strategic Priorities: Monitoring Progress and Benchmarking.

Objective 9: We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves.

University Hospitals Bristol and Weston NHS Foundation Trust

KPIs	No	Action	Who	When	Progress	RAG
PSED EA2010 EDS2 WRES WDES	24	Scoping study that pulls together EDI activities across of all divisions and departments that include good practice, initiatives, innovation and gaps to enable a new EDI offer on support and capacity-building across the Trust.	EDI Manager Divisional EDI leads Divisional EDI Advocates	Feb 21	Draft scoping study in progress.	
WRES WDES PSED EA2010 EDS2	25	Develop a new EDI offer to support divisional EDI Leads and Advocates	EDI Manager Divisional EDI leads Divisional EDI Advocates	Mar 21	Outline of the New EDI Offer is progress with the aim of developing and delivering short, medium and long term interventions with clear reporting mechanism and governance pathways.	

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Inspected and rated Outstanding ☆ Care Quality Commission

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Strategic Priorities: Monitoring Progress and Benchmarking.

Objective 10: We will seek opportunities to learn from others, developing our partnerships at a regional and national level.

University Hospitals Bristol and Weston NHS Foundation Trust

KPIs	No	Action	Who	When	Progress	RAG
WRES WDES PSED EA2010 EDS2	26	The Trust has committed itself to a number of local, regional and national partnership working for 2020/22 these include attending, contributing and co-producing EDI interventions that benefit local people, staff and patients.	EDI Manager	2021/22	Attending and contributing to: • Bristol Race Equality Strategic Leaders Group • Bristol, North Somerset And South Gloucestershire CCG EDI Leads Network • North Bristol City Council stakeholder EDI Leads Network • SWE Leadership Academy • NHSI EDI Programmes	
WRES PSED EDS2	27	BAME Student Support in Practice | A Collaborative Approach Pilot - led by UWE. This is a 18-month pilot that will focus on the EDI experience of BAME students when on formal work experience placement.	EDI Manager Head of Education Head of L&D	Phase 1 10 Feb 21	The Project Initiation Document (PID) published. BAME Student Support in Practice | A Collaborative Approach workshop taking place on 10 Feb	
WRES PSED EDS2	28	BAME Medical Students Pilot This project is led by University of Bristol with a focus on addressing racial harassment and bias in medical teaching.	EDI Manager Education Learning & Development	Phase 1 Feb 21	On-boarding and induction meeting have had to be cancelled due to Covid pressures. They are being rescheduled.	

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Inspected and rated Outstanding ☆ Care Quality Commission

Concluding Comments & Next Steps

University Hospitals Bristol and Weston NHS Foundation Trust

- RAG update to be provided at each people committee
- Bi-annual report to be developed for reporting period October - end of March and presented to people committee in May
- Development of year 3 strategy plan (2021/22) to be worked up alongside the WRES pilot, ED&I divisional plans and ready for April
- Senior team conference in May/June to communicate findings of WRES pilot and impact on strategy plan going forward
- Attached is the OD equality, diversity and inclusion KPI glossary explaining the codes used within the action slides of this report

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

Inspected and rated Outstanding ☆ CareQuality Commission

OD Equality, Diversity & Inclusion KPI Glossary

University Hospitals Bristol and Weston NHS Foundation Trust

KPI	EQUALITY ACT 2010
EA2010	Protection against unlawful discrimination for the nine protected characteristics in the workplace
PSED	Public sector equality duty (the equality duty): • Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act. • Advance equality of opportunity between people who share a protected characteristic and those who do not. Foster good relations between people who share a protected characteristic and those who do not
KPI	**STAFF SURVEY**
BSS1	Not experience harassment, bullying, or abuse from patients/service users, their relatives or members of the public.
BSS2	Not experience harassment, bullying or abuse from mangers.
BSS3	Not experience harassment, bullying or abuse from other colleagues.
BSS4	Last experience of harassment/bullying/abuse reported
DSS1	Organisation acts fairly: career progression.
DSS2	Not experiences discrimination from patients/service users, their relatives or other members of the public.
DSS3	Not experiences discrimination from manger/team leader or other colleagues.
DSS4	Disability: organisation made adequate adjustment(s) to enable me to carry out work.

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

Inspected and rated Outstanding ☆ Care Quality Commission

OD Equality, Diversity & Inclusion KPI Glossary

University Hospitals Bristol and Weston NHS Foundation Trust

KPI	PEOPLE PLAN
APP2	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.
DPP1	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.
DPP2	Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.
DPP3	Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce.
DPP4	51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes
DPP5	Support organisations to achieve the above goal, including establishing robust decision- tree checklists for managers, post-action audits on disciplinary decisions, and pre-formal action checks.
DPP6	Refresh the evidence base for action, to ensure senior leadership represents the diversity of the NHS, spanning all protected characteristics.
DPP7	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.
DPP8	Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.
DPP9	Prevent and tackle bullying, harassment and abuse against staff, and create a culture of civility and respect.
KPI	WORKFORCE RACE EQUALITY STANDARD (WRES) INDICATORS
WRES1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.
WRES2	Relative likelihood of staff being appointed from shortlisting across all posts.
WRES3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
WRES4	Relative likelihood of staff accessing non-mandatory training and CPD.
WRES5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

Inspected and rated Outstanding ☆ Care Quality Commission

OD Equality, Diversity & Inclusion KPI Glossary

University Hospitals Bristol and Weston NHS Foundation Trust

KPI	WORKFORCE RACE EQUALITY STANDARD (WRES) INDICATORS
WRES6	Percentage of staff saying they have experienced harassment, bullying or abuse from staff in the last 12 months
WRES7	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.
WRES8	Percentage of staff personally experiencing discrimination at work from their manager/team leader or another colleague in the last 12 months
WRES9	Percentage of difference between the organisations' Board voting membership and its overall workforce. (Note: Only voting members of the board should be included with considering this indicator.)
KPI	WORKFORCE DISABILITY EQUALITY STANDARD (WDES) INDICATORS
WDES1	Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.
WDES2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.
WDES3	Relative likelihood of Disabled staff compared to non-disables staff as entering the formal capability process, as measured by entry into the formal capability procedure.
WDES4	a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public; managers; other colleagues b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
WDES5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion
WDES6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
WDES7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

Inspected and rated Outstanding
Care Quality Commission

OD Equality, Diversity & Inclusion KPI Glossary

University Hospitals Bristol and Weston NHS Foundation Trust

KPI	WORKFORCE DISABILITY EQUALITY STANDARD (WDES) INDICATORS
WDES8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
WDES9a	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation
WDES9b	Has your trust taken action to facilitate the voices of Disables staff in your organisation to be heard?
WDES10	Percentage difference between the organisations Board voting membership and its organisations overall workforce, disaggregated: • By voting membership of the board • By executive membership of the board
KPI	**EQUALITY DELIVERY SYSTEM 2 (EDS2)**
EDS2G3	**Goal 3: A representative and supported workforce**
EDS3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
EDS3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
EDS3.3	Training and development opportunities are taken up and positively evaluated by all staff
EDS3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source
EDS3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
EDS3.8	Staff report positive experiences of their membership of the workforce
EDS2G4	**Goal 4: Inclusive leadership**
EDS4.1	Governing body members and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
EDS4.2	Papers that come before the governing body and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
EDS4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

PRIDE

Inspected and rated Outstanding
Care Quality Commission

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on 28 January 2021

Report Title	**Role of the UHBW nominated Trustee on the Board of Trustees of Above & Beyond**
Report Author	**Eric Sanders, Director of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary

To present a proposal to clarify the role of the Trust nominated Trustee on the governing body of Above & Beyond.

2. Key points to note

(Including decisions taken)

- The Trust is entitled to nominate a Trustee to the Board of Above & Beyond.
- To date there has not been clarity about the role of the nominated Trustee and this document seeks to describe this.
- The contents of the document have been broadly agreed with the Chair and Chief Executive of Above & beyond, and have been discussed with Executives including the Medical Director who currently undertakes this role.

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:

A lack of clarity on the role of the nominated Trustee may impact on the relationships with Above & Beyond and a lack of clarity on the Trust's strategy and relationship with Above & Beyond.

4. Advice and Recommendations

*(Support and Board/Committee decisions requested)***:**

- This report is for **Approval.**

The Board is asked to discuss the contents of the document and agree the role of the person nominated to be a Trustee on the governing body of Above & Beyond.

5. History of the paper

Please include details of where paper has previously been received.

Role of the UHBW nominated Trustee on the Board of Trustees of Above & Beyond

Purpose

To present a proposal to clarify the role of the Trust nominated Trustee on the Board of Above & Beyond.

Context

At the point of moving Above & Beyond to independent status, the Board of Directors agreed a Deed of Understanding, which provided the Trust the opportunity to nominate a Trustee to the Board of Above & Beyond. This is in section 2.1.4:

> 2.1.4 (…the Receiving Charity shall): confer on the NHS Foundation Trust the power to nominate a trustee to the board of the Receiving Charity; and

The document does not describe the role of the Trustee or how the role connects back into the Trust.

The Trust has nominated the William Oldfield, Medical Director, to be a Trustee on the Board of Above & Beyond and the Trustees approved Bill's appointment.

General Role of the Trustee

Trustees of charities have specific legal duties which they must meet. These are described in the document entitled "The essential trustee: what you need to know, what you need to do"[1]. The specific legal duties are:

Your legal duty	It's vital that you
Act in your charity's best interests	Deal with conflicts of interest
Manage your charity's resources responsibly	Implement appropriate financial controls Manage risks
Act with reasonable care and skill	Take appropriate advice when you need to, for example when buying or selling land, or investing (in some cases this is a legal requirement)

Interpretation of the Deed of Understanding

In noting that the Trust can nominate a Trustee to the Board of Above & Beyond, it does not describe further the expected relationship. In considering what the role of the nominated Trustee should be, the Trust should be cognisant that whoever undertakes the role must meet the legal duties of a charity trustee and the Trust should not require anything that would put the Trustee in a position which conflicts with this requirement.

It should be noted that the Trust has an Executive lead for our charity relationships, the Director of Strategy and Transformation. That role is to coordinate strategic and operational discussions between the Trust and our charity partners, including ensuring alignment between fundraising and strategic projects.

It is proposed that the role of the nominated Trustee is therefore to:

- Act as an individual in line with the statutory duty of a trustee, including to act in the best interests of the charity

[1] https://www.gov.uk/government/publications/the-essential-trustee-what-you-need-to-know-cc3/the-essential-trustee-what-you-need-to-know-what-you-need-to-do#trustees-duties-at-a-glance

- To provide advice and guidance to the Board of Trustees as an individual – in the case of the Medical Director this may include using his expertise as a clinician and academic
- To utilise their specific knowledge of the Trust's overall strategy, delivery of clinical divisional plans and particular projects, to support the strategy and direction of Above & Beyond.

Both the Trust and Above & Beyond will need to be mindful of the potential conflicts of interest which arise from the appointment, where the Board nominates one of its members to undertake this role.

The role is not to:

- Act as a conduit for information between the Trust and Above & Beyond
- Seek to performance manage the charity on behalf of the Trust
- Conflate the role of Trust employee (e.g. Medical Director) with that of Trustee

A role description from Above & Beyond is attached in Appendix 1.

Recommendation

The Board is asked to discuss the contents of the document and agree the role of the person nominated to be a Trustee on the Board of Above & Beyond.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28 January 2021

Report Title	**Governors' Log of Communications**
Report Author	**Sarah Murch, Membership Manager**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary

The purpose of this report is to provide the Board of Directors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous meeting. The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust.

2. Key points to note
(Including decisions taken)

Since the last public Board of Directors meeting there have been two questions added to the Governors' Log of Communications. Two responses have been received, and one question is awaiting response.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

N/A

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **Information.**

5. History of the paper
Please include details of where paper has previously been received.

N/A	

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Governors' Log of Communications

21 January 2021

ID	Governor Name		
246	Sophie Jenkins	***Theme:*** Staff rest rooms	***Source:*** From Constituency/ Members

Query **07/01/2021**

I would like assurance that there are adequate, accessible rest areas across the Trust to provide respite for all our staff at a time when many staff may be experiencing the undue pressure of this pandemic across our sites. Do we know where all our rest rooms are to give us a full picture of what we provide for staff in their breaks or when they need some downtime - this includes such items as a kettle or microwave/adequate seating/ access to water etc?

Division: Trust-wide ***Executive Lead:*** *Director of People* ***Response requested:*** 07/01/2021

Response

Response Pending.

Status: *Assigned to Executive Lead*

ID	Governor Name		
245	Ray Phipps	***Theme:*** Cardiac rehabilitation services	***Source:*** Governor Direct

Query **05/11/2020**

In UHBW we have a brilliant and dedicated organisation doing its utmost to deliver care in these challenging times. Could you provide some information as to how the pandemic is affecting cardiac rehabilitation services?

The Trust must need to work closely with primary care, community providers and others to provide these services. Is the Trust able to comment on how well-integrated and effective this joint working is, particularly given the difficulties in holding group meetings at this time?

Division: Specialised Services ***Executive Lead:*** *Medical Director* ***Response requested:*** 25/11/2020

Response **30/11/2020**

Thank you for the opportunity to discuss the management of our cardiac rehabilitation service and the changes made to support patients during the pandemic. We have recently conducted a review of the service to evaluate the impact of the changes.

Pre-Covid programme: Pre-Covid the cardiac rehabilitation program was split into 4 phases;
- Phase I – Patients who have suffered a heart attack are seen on the ward, shown a British Heart Foundation (BHF) health education DVD and brief group discussion held regarding management of risk factors. Patients outside of BRI catchment were, at this stage, referred on to their local providers.
- Phase II – patients were brought into clinic for review and assessment and offered enrolment onto the rehabilitation programme.
- Phase III – core programme – 8 week course of exercise and education. Patients attended once a week to exercise and to be given an educational presentation on a variety of subjects (risk factors, medication, basic life support, active lifestyle, diet etc). Sessions were run at the BRI gym (2 per week) and Hengrove Leisure Centre (2 per week). Each class could accommodate a maximum of 15 patients per session with all sessions averaging an attendance of 8-9 patients per week. Sessions were run by 2 Cardiac Nurse Specialists and one specialist physiotherapist.
- Phase IV – patients referred onto local phase IV providers (exercises sessions run by private providers around Bristol).

Post initial lockdown restrictions: the team commenced remote working utilising the Heart Manual combined with telephone support and home exercise programmes.

The Heart Manual (HM) service was launched on 25th June 2020. Currently 7 members of the team (inc 2 physios) are now trained to deliver the Heart Manual with Weston also having received training and now delivering the Heart Manual. The Heart Manual is an innovative home based supported self-management programme for individuals recovering from acute Myocardial Infarction and/or Revascularisation. The programme is focused on an evidence based approach to cardiac rehabilitation that can be supported by the cardiac rehabilitation team but under taken at home.

Since commencing the Heart Manual at the BRI 76 patients have completed the HM programme and 81 patients are currently enrolled on HM programme. Overall 172 patients have been supported with 157 on the Heart Manual program.

ID **Governor Name**

Post cardiac intervention patients are still seen on the ward for early rehab (previously “Phase I”) though are now seen on a one to one basis rather than as a group; in part in response to Covid safety measures but also to improve the bespoke nature of the service. Patients living outside of the catchment are referred on to the relevant service; those inside our catchment being commenced on the Heart Manual.

Patients receive a minimum of 3 telephone calls post discharge, timelines and numbers of calls are tailored to individual patient requirements. More calls can be scheduled if requested or required. Patients are initially commenced on a walking programme to aid recovery with an exercise programme being offered if safe at an appropriate stage.

Patients are asked to complete National Association of Cardiac Rehabilitation (NACR) Assessments at the beginning and end of the programme to chart their progress and gather information that allows the team to highlight issues and areas for focus. The Duke Activity Status Index is used to provide a functional capacity assessment.

Heart Failure Patients: The REACH Heart Manual is currently being piloted as a method to support heart failure patients in their rehabilitation. The number of patients on this pilot is limited to 2 due to restrictions in the number of trained staff available (physio cover is reduced during the winter periods due to the specialist physio being pulled back to work on ICU).

Feedback: Patients are sent feedback cards at point of discharge. We received constructive feedback which has helped to shape the future of service. Particularly positive were comments regarding access to the team and communication.

In summary, we have maintained support to our cardiac patients by rapid introduction of the Heart Manual system and received positive feedback from patients regarding this. Non face to face support has been instituted and maintained throughout the pandemic. Links with primary care and community have not been disrupted and referral pathways unchanged. Reviewing the innovation we have introduced has created new goals that will embed these pathways into our cardiac rehabilitation program.

Status: *Closed*

ID	Governor Name		
244	Sue Milestone	***Theme:*** Learning Disability Nurses	***Source:*** Governor Direct

Query **02/11/2020**

I understand that other Trusts employ Learning Disability Nurses to ensure adults with learning disabilities have equal access to health care, and to help them feel safe and supported with inpatient and emergency admissions, day surgery, outpatient appointments and planned admissions.

They assess the patient's needs to make them feel safe, make reasonable adjustments where needed, help with interpreting situations and make sure patients are listened to.

They also communicate with family/carers, care providers, community teams and health/social care professionals. Patients have hospital passports to facilitate staff understanding of their needs. They provide tours of the building pre-admission and address fears around hospital/treatment.

Does UHBW offer this kind of service, and if not, would the Trust consider setting up a similar service for learning disabled patients, while looking at the feasibility of extending it to cover all patients with multiple, complex needs including those with physical disabilities and temporary delirium?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 02/11/2020

Response **24/11/2020**

The Trust has employed Specialist Learning Disability nurses within adult services for a number of years. The LD nursing team have a broad remit, which includes providing specialist advice and support to staff caring for adults with a Learning Disability across the Trust.

The LD nurses provide training and support to clinical staff to enable them to assess and implement a range of Reasonable Adjustment assessments, communicating with patients, families/carers and partner agencies. The use of hospital passports is integral to this and is promoted through training and widely used across the Trust.

A range of other specialist support is also available to patients with other or additional complex needs, including physical disabilities or temporary delirium, and packages of care will be tailored to each patient's individual needs. The Trusts prioritises promoting equal access to all patients, including those with a Learning Disability - work which is monitored closely through the Trust Learning Disability Steering Group.

The Trust is committed to continuing to develop and improve the Learning Disability service and works closely with both partner agencies and local health providers. The Trust has participated in the NHSI LD national service benchmarking exercise since its inception and feedback from this is used to develop the service. Most recently partner collaboration has led to a Community Learning Disability Nurse being based with the hospital team, a model of working which is proving to be effective in supporting the continuity of care for patients and their families. Suggestions and feedback from LD patients and their families are invaluable in continuing to develop the LD service within the Trust and the LD nurses are very happy to be contacted with any feedback re the services provided.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 28 January 2021

Report Title	**Register of Seals Report – Q3 Update**
Report Author	**Mark Pender, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary
This report provides a summary of the applications of the Trust Seal made since the previous report in **November 2020.**
2. Key points to note *(Including decisions taken)*
Standing Orders for the Trust Board of Directors stipulate that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the person who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust Seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
The risks associated with this report include: *N/A*
4. Advice and Recommendations *(Support and Board/Committee decisions requested)***:**
• This report is for **Information**.
5. History of the paper **Please include details of where paper has previously been received.**
N/A

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

University Hospitals Bristol and Weston NHS Foundation Trust

Register of Seals

November 2020 – January 2020

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
839	23/12/20	Deed of Termination and Deed of Surrender between the University of Bristol and UHBW in respect of the Clinical Research Imaging Centre, St Michael's Hospital, Bristol.	Robert Woolley, Chief Executive	Neil Kemsley, Director of Finance & Information	Mark Pender, Head of Corporate Services