University Hospitals Bristol and Weston NHS Foundation Trust

BOARD OF DIRECTORS (IN PUBLIC)

Meeting to be held on Thursday, 15 June 2023 at 13.45 – 17.00 in City Hall, College Green, Bristol

AGENDA

NO	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS
Preliminary Business				
1.	Welcome and Apologies for Absence	Information	Chair	
2.	Declarations of Interest	Information	Chair	
3.	Patient Story	Information	Patient and Public Involvement Lead	13.45
4.	Minutes of the Last Meeting – 18th April 2023	Approval	Chair	14.05
5.	Matters Arising and Action Log	Approval	Chair	
6.	Chief Executive's Report	Information	Chief Executive	14.10
Strategic				
7.	UHBW Strategic Priorities - 2023/24 delivery plan	Approval	Executive Managing Director	14.20
8.	Board Assurance Framework: Strategic Risk Register	Approval	Director of Corporate Governance	14.30
Quality and Performance				
9.	Review of PHSO Complaints	Assurance	Chief Nurse and Midwife	14.45
10.	Quality and Outcomes Chair's Report	Assurance	Chair of the Quality and Outcomes Committee	14.55
11.	Performance Report	Assurance	Chief Operating Officer; Chief Nurse and Midwife; Chief People Officer; Chief Medical Officer	15.00
12.	UHBW Annual Quality Account	Approval	Chief Nurse and Midwife	15.15
13.	Maternity Survey Results	Information	Chief Nurse and Midwife	15.25
14.	Six Monthly Safe Staffing Report	Assurance	Chief Nurse and Midwife	15.30
BREAK 15.30 – 15.40				

Research and Innovation				
15.	Research and Innovation Report	Assurance	Chief Medical Officer	15.40
Financial Performance				
16.	Finance & Digital Committee Chair's Report	Assurance	Chair of the Finance and Digital Committee	15.50
17.	Trust Finance Report	Assurance	Chief Financial Officer	15.55
18.	Digital Update – *verbal update*	Discussion	Joint Chief Digital Information Officer	16.05
People Management				
19.	Freedom to Speak Up Annual Report	Assurance	Director of Corporate Governance	16.15
20.	People Committee Chair's Report	Assurance	Chair of the People Committee	16.25
Governance				
21.	Audit Committee Chair's Report	Assurance	Chair of the Audit Committee	16.30
22.	NHS Self-Certification	Approval	Director of Corporate Governance	16.35
23.	Revised Terms of Reference: • Finance & Digital Committee • Audit Committee	Approval	Director of Corporate Governance	16.45
24.	Register of Seals	Information	Director of Corporate Governance	16.50
25.	Governors' Log of Communications	Information	Director of Corporate Governance	16.55
Concluding Business				
26.	Any Other Urgent Business	Information	Chair	
27.	Date of Next Meeting: **Tuesday, 12 September 2023**	Information	Chair	

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**What Matters to Me – a Patient Story**
Report Author	**Tony Watkin – Experience of Care and Inclusion Team**
Executive Lead	**Deirdre Fowler – Chief Nurse and Midwife**

1. Purpose

Patient stories reveal a great deal about the quality of our services, the opportunities we have for learning, and the effectiveness of systems and processes to manage, improve and assure quality.

The purpose of presenting a patient story to Board members is:

- To set a patient-focussed context for the meeting.
- For Board members to understand the impact of the lived experience for patients and for Board members to reflect on what the experience reveals about our staff, morale and organisational culture, quality of care and the context in which clinicians work.

2. Key points to note *(Including any previous decisions taken)*

A paediatric neuroscience team offers expertise in diagnosing and managing a complex array of neurological disorders affecting children and young people. It provides care to some of the most vulnerable children and their families at a time of distress and anxiety.

This account is both a reflection of the impact of the cancellation of neurosurgery and a celebration of the generous kindness, commitment and expertise of NHS staff at a time of great pressure.

3. Strategic Alignment

This work aligns to the True North Experience of Care strategic priority.

4. Risks and Opportunities

None.

5. Recommendation

This report is for Choose an item.

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

6. History of the paper

Please include details of where paper has <u>previously</u> been received.

N/A	

University Hospitals Bristol and Weston NHS Foundation Trust

BOARD OF DIRECTORS (IN PUBLIC)

Minutes of the Meeting held on Tuesday 18 April 2023 at 13.00–15.30 in Lecture Theatre 2&3, Education and Research Centre, Upper Maudlin Street, Bristol, BS2 8HW

Present

Board Members

Name	Job Title/Position
Jayne Mee	Chair
Eugine Yafele	Chief Executive
Arabel Bailey	Associate Non-Executive Director
Paula Clarke	Executive Managing Director, Weston General Hospital
Jane Farrell	Chief Operating Officer
Marc Griffiths	Non-Executive Director
Neil Kemsley	Chief Finance Officer
Jane Norman	Non-Executive Director
Roy Shubhabrata	Non-Executive Director
Martin Sykes	Non-Executive Director
Stuart Walker	Chief Medical Officer
Julian Dennis	Non-Executive Director
Emma Wood	Chief People Officer
Bernard Galton	Non-Executive Director

In Attendance

Sarah Dodds	Deputy Chief Nurse
Rebecca Dunn	Director of Business Development and Improvement
Emily Judd	Corporate Governance Manager (minutes)
Eric Sanders	Director of Corporate Governance
Tony Watkin	Patient and Public Involvement Lead (for Item 3: Patient Story)
Sarah Windfeld	Director of Midwifery and Nursing (for Item 11: Maternity Items)

Apologies

Deirdre Fowler	Chief Nurse and Midwife

The Chair opened the Meeting at 13.00

Minute Ref.	*Item*	*Actions*
01/04/23	**Item 1 - Welcome and Apologies for Absence**	
	Jayne Mee, Chair, welcomed members of the Board to the meeting. Jayne informed the Board that the meeting would be recorded and published on the Trust's YouTube account for public access following the meeting. Apologies of absence had been received from Deirdre Fowler, Chief Nurse and Midwife. Jayne informed Board members that this would be Julian Dennis', Non-Executive Director, last Board meeting. Jayne thanked Julian on behalf of	

Minute Ref.	*Item*	*Actions*
	the Board for all his work and contribution to the Trust Board over the last nine years.	
02/04/23	**Item 2 - Declarations of Interest**	
	There were no new declarations of interest relevant to the meeting to note.	
03/04/23	**Item 3 - Patient Story**	
	Tony Watkin, Patient and Public Involvement Lead, introduced Alun Davies who had returned to update the Board about being a champion and ambassador to advance health equity for patients. Alun shared the importance of sharing lived experiences to improve services and the value of working consistently with community partners to do so. Alun explained how, by working collaboratively with the Trust, he had played an influential role in advancing the Trust's overall compliance with the Accessible Information Standard. Alun said from experience there were pockets within the hospital that understood his care, and some that didn't and thought leadership from senior management was critical in providing a better experience for lived experience patients. The newly formed trust-wide Accessible Information Standard Delivery Group would co-ordinate the delivery of the Trust's new Health Equity Plan which Alun noted was a great commitment to the Trust and the change was welcome and positive. Jane Norman, Non-Executive Director, asked whether services for visual impairments had improved. Alun said the systems to record patient's records and to organise appointments came with challenges, and suggested the hospital could offer choice to patients about the format of communications and appointments to mitigate against digital exclusion. Alun noted a simple improvement would be to change any fonts to Arial size 14. Stuart Walker, Chief Medical Officer, noted the positive progress that had been made since Alun's last patient story and asked what assistance the hospital and Trust Board could further provide. Alun said having the opportunity to present to the Board provided him with assurance that support was available and he noted the influence that Board members held over improving hospital services for lived experiences. Alun summarised his discussion by emphasising the need for face-to-face hospital appointments, as well as digital, and how clinicians could take time to understand a patient's choice for the format of appointments. Jayne thanked Alun on behalf of the Board for his patient story and assured him that all feedback would be considered by the Board to make further improvements in support of the renewed equality objectives. *Alun Davies and Tony Watkins left the meeting.*	
04/04/23	**Item 4 - Minutes of the Last Meeting**	
	The Board reviewed the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust Board held in public on 22nd February 2023. **Members of the Board approved the above minutes as a true and accurate record.**	

Minute Ref.	*Item*	*Actions*
05/04/23	**Item 5 - 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: **<u>05/02/23 Matters Arising and Action Log - Community Midwives</u>** *Deputy Chief Nurse to update the Quality and Outcomes Committee on the provision of Wi-Fi and digital access for community midwives.* A discussion was held at the Quality and Outcomes Committee in February 2023, and it was agreed for the Committee to monitor the progress. **Action Closed** **<u>07/02/23 Acute Provider Collaborative Board Chair's Report</u>** *Trust Secretariat to organise the sharing of the Digital Convergence Roadmap at the next Finance and Digital Committee.* The Digital Convergence Roadmap presentation was shared with the Finance and Digital Committee meeting on 10th March. **Action Closed** Members of the Board noted the updates against the action log.	
06/04/23	**Item 6 - Chief Executive's Report**	
	Eugine Yafele, Chief Executive, provided a verbal update on the following key issues: • **Industrial Action**: The Trust saw a 96-hour period of industrial action by Junior Doctors in training. Following social media comments by the British Medical Association (BMA) regarding derogations for patient safety at Weston General Hospital, the Board was assured that the Trust had not misled the situation and the Trust had provided accurate staffing levels information to NHS England and the BMA on a rapidly evolving situation. Eugine noted thanks to all staff that had pulled out all the stops to keep a watchful eye over vulnerable staffing groups during a fast-changing situation to ensure patient safety. It was noted that the Royal College of Nursing (RCN) had rejected the pay offer made to the unions representing Agenda for Change colleagues, although Unison had agreed it. The Trust was not clear on a national agreed pay deal and planning was underway for further strike days. Eugine noted the challenges when balancing the need to maintain safe services and respecting colleagues' rights to take part in industrial action. Eugine said the real impact was on patient cancellations and this list was being worked through to see how the position could be recovered. The Board was assured that patient safety and safe staffing remained at the heart of all decision-making by the Trust. • **Healthy Weston 2**: The Healthy Weston 2 Phase 1 Full Business Case (FBC), was agreed by the Integrated Care Board, and was the first part in the operationalisation of Healthy Weston 2, ensuring the people of Weston had access to the urgent and emergency care to meet national standards. The plans would be put into action and Eugine noted his thanks to the teams for reaching this position.	

Minute Ref.	*Item*	*Actions*
	• **Junior Doctors in Training:** NHS England had contacted the Trust to confirm that all Junior Doctors in training that had been pulled from Weston General Hospital could return to the hospital, albeit for a number of specialities that would remain in Bristol due to senior cover. Eugine noted this was a testament to staff at Weston General Hospital who had worked to improve the issues outlined by the Care Quality Commission (CQC) A letter would be sent form the General Medical Council (GMC) to outline the impact of this return on conditions. • **NHSE Single Oversight Framework**: The Trust had been rated as "segment 3" based on its performance in quarter 3 of the 2022-23 financial year. It was hopeful following a review over the last quarter, that the Trust would move into a better segmentation outcome due to the improvements made at Weston General Hospital. • **No Criteria To Reside (NCTR):** The Trust had contributed toward a system visit from the national discharge team visit and a formal report was awaited. The Department of Health was holding a Summit to talk about the ongoing improvements that needed to be made in this area. It was noted that at the time of the meeting, the Trust had 140 NCTR patients, which was an improving picture. In response to a query from Jane Norman, Non-Executive Director, Eugine said the picture had improved due to simple things being done well, such as better patient discharge. A focused piece of work had been undertaken by North Bristol NHS Trust which the Trust would replicate. Jayne Mee requested for the National 3 Year Delivery Plan for Maternity and Neonatal Services to be circulated to the Non-Executive Directors for information. **Action: Trust Secretariat to circulate the National 3 Year Delivery Plan for Maternity and Neonatal Services to Non-Executive Directors.** Jayne Mee informed the Board that she had taken part in her first reciprocal mentoring session as part of the Bridges Talent Management Programme and Jayne encouraged other Board members to be involved with the second cohort that was being rolled out to the Trust. **Members of the Board received the Chief Executive's report for information**.	Trust Secretariat
07/04/23	**Item 7 - Annual Business Plan**	
	Neil Kemsley, Chief Financial Officer introduced the Annual Business Plan and highlighted the following: • The report summarised the outputs of the Trust's annual planning process, and provided an overview of the workforce, finance activity, and performance plans. • The plan was submitted to the regulator, NHS England (NHSE) as part of the system submission on 30th March 2023.	

Minute Ref.	*Item*	*Actions*
	• As part of the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) plan, there was a planned net income and expenditure position of break-even. • The Trust's 2023/24 Financial Plan was a break-even net income and expenditure position which included a savings requirement of £27.1m (approximately 3% of turnover). • The Trust's turnover had increased by 30% over three years. • The key investments within the year ahead had been outlined within the report though included an £18m investment for elective recovery. • The funding for escalation beds into 2023/24 would continue. • There would be £5.5m in 2023/24 for Covid related expenditure including enhanced cleaning, testing and protective equipment. • There would be investment for the Healthy Weston 2 Phase 1 Pre-Consultation Business Case (PCBC) of £1.9m. • The Trust was planning to deliver the Trust-initiated internal savings of £19.2m in year. • The 2023/24 BNSSG system Capital Departmental Expenditure Limit (CDEL) as advised by NHSE would be £75.3m and after the split of the CDEL across the system partner organisations, the Trust would receive £39.2m. • Funded establishment is planned to increase by 1.2% (137 FTE) in 2023/24. • The planned increase in workforce numbers would be 2.5% (291 FTE) by March 2024. • The Trust's target for international recruitment for 2023/24 was around 230 nurses between April and November 2023. • The Trust's activity plan would step up significantly from the previous rolling year and included increased elective inpatient activity levels. The ambition to eliminate patients waiting 65 weeks or longer necessitates the increase and would be supported by the operational division's productivity-driven delivery plans. • Funding from the national programme would support better hospital flow and included discharge to access, virtual wards and same day emergency care initiatives. • Key risks were outlined within the report and future industrial action was noted as a key risk. The Board thanked Neil Kemsley and the team for the Annual Business Plan. Marc Griffiths, Non-Executive Director, queried whether the additional resource outlined within the report to support additional intensive care beds was included within the overall expansion of the establishment. Neil Kemsley explained that it was not included, and the team awaited confirmation of the funding to open these beds. In response to a query from Sue Balcombe, Non-Executive Director, Neil said there was a possibility there could be performance data available for	

Minute Ref.	*Item*	*Actions*
	system schemes, such as virtual wards, and noted the importance of having this data in order to escalate any issues to a system-level. Jane Norman, Non-Executive Director, asked how long Covid enhanced cleaning regimes would be required for, and Neil said it was subject to review. Eric Sanders, Director of Corporate Governance, queried where the organisational quality objectives were covered within the Annual Plan. The Board discussed this gap within the Annual Plan, and it was agreed for the quality objectives to return to the Quality and Outcomes Committee. **Action: Chief Operating Officer, Chief Medical Officer, Chief Nurse and Midwife, to present the quality objectives to a future Quality and Outcomes Committee.** In response to a query from Martin Sykes, Non-Executive Director, relating to the Board's leadership priorities, Paula Clarke said internal strategies and objectives would be linked to Patient First to ensure that improvement could be driven in the right areas. Paula said a plan was in development which would be finalised with the Board. Jayne Mee supported this approach and noted the need for the Board to be better sighted on productivity, theatre utilisation and outpatients. **Members of the Board received the Annual Business Plan for information**.	COO, Chief Medical Officer, Chief Nurse and Midwife
08/04/23	**Item 8 - Quality and Outcomes Chair's Report**	
	Sue Balcombe, Chair of the Quality and Outcomes Committee, provided the following updates from the Committee meeting held in March 2023: • The Committee approved The Health Equity Delivery Plan for 2023/24 to 24/25 noting that a new multidisciplinary Health Equity Delivery Group had been set up to oversee the delivery of the plan. • The Committee received the latest composite CQC Action Plan and supported the recommendation that 19 further actions should be considered closed, leaving 8 actions outstanding. The progress of these actions would be monitored via the Clinical Quality Group. The Board raised no questions. **Members of the Board received the Quality and Outcomes Chair's Report for assurance.**	
09/04/23	**Item 9 - Performance Report**	
	Jane Farrell, Chief Operating Officer, introduced the Performance Report to provide an update on the key performance metrics for 2022/23 and the Trust Leadership priorities. It was noted that the full Integrated Quality and Performance Report (IQPR) had been included within the Document Library for reference. Jane Farrell, Chief Operating Officer highlighted the following timely care key performance points:	

Minute Ref.	Item	Actions
	• At the end of February 2023, there were no patients waiting over 104+ weeks, compared to 349 at the end of April 2022. The Trust would be able to sustain this position going forward. • Patients waiting over 78 weeks would not be eradicated by the end of March 2023 due to the impacts from industrial strike action. The forecast for April was around 190 patients on this list. • The industrial strikes were expected to deteriorate diagnostic performance to be just off trajectory, however significant improvements had been made and sustainable improvements were expected. • Improvements had been seen for patients who had a trolley wait in excess of 12 hours and ambulance handovers. Julian Dennis, Non-Executive Director, asked for the reasons behind the deteriorating performance in diagnostics and Jane Farrell said there had been challenges within the area which was becoming a national picture due to increased numbers of patients since the pandemic. In response to a query from Arabel Bailey, Associate Non-Executive Director, Jane Farrell said there were 140 No Criteria To Reside (NCTR) patients in hospital which was an improving picture. Jane Norman, Non-Executive Director, commended the improvements around performance, however noted the risk registers were off target. The Board heard about contributing factors for not reaching targets and were assured that the report presented a snapshot in time with the detailed risk registers showing the risk profile and aligning with the performance trajectories from an operational perspective. Eugine Yafele suggested the risk targets should be tested to ensure they were realistic. Marc Griffiths, Non-Executive Director, noted the improved performance for patients who had a trolley wait in excess of 12 hours and ambulance handovers, however noted a decline in those waiting in the 30 minutes plus category. Jane Farrell responded that a range of initiatives were being progressed across adult services to reduce overcrowding, ambulance queueing and long waits, including the expansion of the Same Day Emergency Care (SDEC) provision, and working with staff to boost their motivation to reach these targets. Sarah Dodds, Deputy Chief Nurse, highlighted the following quality and safety points: • The metrics for infection control and Clostridioides Difficile (C.Diff) infection had been high. Several actions had been underway to improve this picture which included regular audits and disseminating learning to staff. It was noted that clinical ward engagement had been good, and the system was leading shared learning across provider organisations from the Trust post reviews infection reviews. Stuart Walker, Chief Medical Officer, noted the following updates: • The Summary Hospital Mortality Indicator for the Trust over the last rolling 12 months had fallen below the ‘as expected’ category.	

Minute Ref.	*Item*	*Actions*
	A detailed report would be presented to the Quality and Outcomes Committee. • Concerns relating to staff wellbeing were noted which was expected to worsen with further industrial strike action. Full engagement with the Trust's wellbeing services would be maintained. Jayne Mee asked whether there had been evidence of Junior Doctors leaving the Trust for better employment packages outside of the United Kingdom. Stuart Walker responded that there had been evidence of lower numbers within the training teams but could not break down the data to explore whether this was related. Emma Wood, Chief People Officer, noted the following People key points: • The Trust's overall vacancy position had reduced, meeting the overall target, and the Trust would be welcoming 12 additional consultants. • Good performance overall had been reported for turnover and sickness absence. Industrial action was having an impact on staff and risks would be identified at a later stage. • A new strategy had been launched to drive down agency staff and overall agency staff usage had reduced. • Realistic metrics would be considered, taking into account national, regional and local trends. For example, mandatory training performance was expected to reduce due to industrial action and so a new target in this area would support this picture. • Stuart Walker, Chief Medical Officer, informed the Board that there had been an increase in violence and aggression towards staff. Two new Victim Support Officers had commenced with the Trust in September 2022 and had so far supported 290 colleagues. Emma Wood added the importance of these roles to provide support to staff by increasing the number of prosecutions of offenders who committed acts of violence and aggression. The Board shared their disappointment at the increased incidents of violence and aggression. In response to a query from Roy Shubhabrata, Non-Executive Director, relating to staff wellbeing, Emma Wood said the Trust was still running food banks for staff, and other initiatives around accessing pay earlier, and being paid for extra shifts almost immediately rather than waiting for the usual pay date. Emma said there were cases of staff leaving the Trust for better rates of pay. **Members of the Board received the Performance Report for assurance.**	
10/04/23	**Item 10 - Cleft Review Report**	
	Stuart Walker, Chief Medical Officer introduced the Cleft Review Paper to the Trust and Board. Key Points were as follows:	

Minute Ref.	*Item*	*Actions*
	• This report summarised the review of patients impacted by delays in the Southwest Cleft Service. Assessments were undertaken for 268 individual patients treated between 2020 and 2022 that experienced delay to treatment. • The outcomes of the review had been taken through our governance system and it was flagged that when it was reviewed by the Care Quality Group (CQG), it was recommended that the review process needed to be reviewed due to the risk matrix scores and it needed to be converted to base it around the National Learning and Reporting Service (NLRS) framework. • There were 57 children whose long-term situation had been impacted. The harm that had occurred related to speech and language development, socialisation, schooling, psychological harm, and family dynamic. • The recommendations within the report were underway and would be monitored to provide future assurance via divisional structures and CQG. The Board agreed this was a sobering report. Bernard Galton, Non-executive Director, queried how different care systems would identify the children within this review in terms of their care going forward. Stuart Walker assured the Board that he was comfortable the clinical network in place would be suitable. Leading on from this, Martin Sykes, Non-Executive Director, asked how patient care would be reviewed and monitored going forward. Stuart Walker said a Cleft Review Group had been implemented to track key action points. In response to this, the Board heard that patients from the review were being monitored on the Trust's waiting lists alongside all other areas of recovery, and it was clear this area had been an outlier. The Board were assured that harm on the waiting lists would continue to be monitored and specialty areas would be reviewed to see whether services could be outsourced. In response to a query from Sue Balcombe, Non-executive Director, Stuart Walker confirmed that most speech and language therapy and follow-up appointments for these patients could be held locally, but not the full range. It was noted that a new locum would support the operating procedures in Plymouth. **Members of the Board received the Cleft Review Report for assurance.**	
11/04/23	**Item 11 - Maternity Perinatal Quality Surveillance Matrix (PQSM) Update Report**	
	Sarah Windfeld, Director of Midwifery and Nursing joined the meeting to present the monthly oversight regarding the safety metrics of the maternity and neonatal services for the month of January 2023. The following points were highlighted: • The Trust had been one of the first involved in "PERIPrem", a perinatal care bundle to improve outcomes for premature baby's interventions. Since launching in 2020, the national neonatal	

Minute Ref.	*Item*	*Actions*
	audit programme last two annual reports showed that units across the Southwest had achieved on average the: Highest rate of delayed cord clamping for the last two years in a row, with six units in the Southwest appearing in the national top twenty; Second highest rates of maternal early breast milk; Third lowest rates of mortality to discharge for babies born at less than 28 weeks. • The Trust had declared compliance with Clinical Negligence Scheme for Trusts (CNST) standards and Saving Babies' Lives. • Funding had been secured for additional governance roles within the unit. • Training compliance of medical staff in obstetric emergency training and fetal monitoring had reduced and staff would be encouraged to attend. • The service continued to prepare for a Care Quality Commission (CQC) visit with safety walkarounds and preparing data request information. A date for the visit had not yet been announced. • Capacity issues with the flow of inductions remained a challenge. In response to Arabel Bailey, Associate Non-Executive Director, Sarah said the risk that newly qualified midwifery staff would be more attracted to work at neighbouring Trust due to the neighbouring Trust offering a recruitment incentive was currently low and would be monitored. Emma Wood, Chief People Officer, noted that any competition to such recruitment within the area was not beneficial, but it did happen, and if the situation changed, there would be internal discussions about how to coordinate the issue internally. Jayne Mee thanked Sarah for joining the meeting and noted that it was clear the unit had worked hard to recognise and address the main challenges within the area. **Members of the Board received the Maternity Perinatal Quality Surveillance Matrix (PQSM) Update Report for assurance.**	
12/04/23	**Item 12 - People Committee Chair's Report**	
	Bernard Galton, Non-Executive Director and Chair of the People Committee introduced the Chair's Report from the last meeting held in March 2023 and noted the following updates: The Board raised no questions. **Members of the Board received the People Committee Chair's Report for assurance.**	
13/04/23	**Item 13 – Finance & Digital Committee Chair's Report**	
	Martin Sykes, Non-Executive Director and Chair of the Finance and Digital Committee introduced the Chair's Report from the last meeting held in March 2023 and the following updates were provided:	

Minute Ref.	*Item*	*Actions*
	• The Committee received and discussed a detailed report around the Trust financial plan and budget for 2023/24. The proposed budget was recommended to the Board for approval. • A revised plan for the rollout of digital noting in outpatients was presented with 105 out of 141 subspecialties currently on plan. The Board raised no questions. **Members of the Board received the Finance and Digital Committee Chair's Report for assurance.**	
14/04/23	**Item 14 - Trust Finance Report**	
	Neil Kemsley, Chief Finance Officer, introduced the Trust Finance Report and highlighted the following: • The report informed the Board of the Trust's financial performance for the period 1st April 2022 to 28th February 2023. • Since writing the report, the Trust had ended the year with a small surplus in terms of income and expenditure. There was an overspend on the capital budget by around £40k which was anticipated to be covered within the system. • The Trust delivered CIP savings of £16m which was £1m ahead of target. It was noted only 54% of the Trust's forecast savings were recurrent. The Board raised no questions. **Members of the Board received the Trust Finance Report for assurance.**	
15/04/23	**Item 15 - Governors' Log of Communications**	
	Eric Sanders, Director of Corporate Governance, said there were three questions on the Governors' Log of Communications, which awaited responses from Governors. The Board raised no questions. **Members of the Board received the Governors' Log of Communications for information**.	
16/04/23	**Item 16 - Any Other Urgent Business**	
	Jayne Mee asked the Board for any other urgent business. Arabel Bailey, Non-Executive Director, queried who was acting as the Trust's digital lead for the forthcoming System C visit due to Neil Kemsley's absence during this period. Neil Kemsley confirmed he was the Executive Lead for digital role until the joint Chief Digital Information Officer started with the Trust and confirmed that the concerns around the Careflow Medicines Management (CMM) services delivery programme would be reviewed with System C, who had initially responded to the issues raised positively. *The meeting closed at 15.30.*	
17/04/23	**Item 17 - Date of Next Meeting:** Thursday 15th June 2023, 13:45 – 16:45	

University Hospitals Bristol and Weston NHS Foundation Trust

Public Trust Board of Directors Meeting on Thursday, 15 June 2023
Action Log

Outstanding actions from the meeting held in April 2023					
No.	**Minute reference**	**Detail of action required**	**Executive Lead**	**Due Date**	**Action Update**
1.	**06/04/23**	Trust Secretariat to circulate the National 3 Year Delivery Plan for Maternity and Neonatal Services to Non-Executive Directors.	Trust Secretariat	June 2023	**Suggest Action Closed** <u>June Update:</u> The National 3 Year Delivery Plan for Maternity and Neonatal Services to Non-Executive Directors was circulated.
2.	**07/04/23**	Chief Operating Officer, Chief Medical Officer, Chief Nurse and Midwife, to present the Quality Objectives to a future Quality and Outcomes Committee.	Chief Operating Officer, Chief Medical Officer, Chief Nurse and Midwife,	June 2023	**Suggest Action Closed** <u>June Update:</u> Quality Objectives were presented to the Quality and Outcomes Committee in May 2023.
Closed actions from the meeting held in April 2023					
No.	**Minute reference**	**Detail of action required**	**Action for**	**Due Date**	**Action Update**
1.	**05/02/23**	**<u>Matters Arising and Action Log - Community Midwives</u>** Deputy Chief Nurse to update the Quality and Outcomes Committee on the provision of Wi-Fi and digital access for community midwives.	Chief Nurse	April 2023	**Action Closed** A discussion was held at the Quality and Outcomes Committee in February 2023 and it was agreed for the Committee to monitor the progress.
2.	**07/02/23**	**<u>Acute Provider Collaborative Board Chair's Report</u>** Trust Secretariat to organise the sharing of the Digital Convergence Roadmap at the next Finance and Digital Committee.	Director of Corporate Governance	April 2023	**Action Closed** The Digital Convergence Roadmap presentation was shared with the Finance and Digital Committee meeting on 10th March.

University Hospitals Bristol and Weston NHS Foundation Trust

Addendum to paper:

Harm Review: Cleft service patients who experienced treatment delays

Professor Stuart Walker, Chief Medical Officer

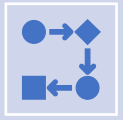
We are supportive respectful innovative collaborative. We are UHBW.

Inspected and rated Good CareQuality Commission

Paper Summary: Harm review: Cleft service patients who experienced treatment delays

University Hospitals Bristol and Weston NHS Foundation Trust

Summary of the South West Cleft Service assessments undertaken for 268 individual patients treated between 2020 and 2022



Process followed, the review findings the improvement recommendations made by the review team.

Process followed in terms of duty of candour and our communication with patients and their families.

We are supportive respectful innovative collaborative. We are UHBW.

Inspected and rated Good CareQuality Commission

Mapping to the National Reporting and Learning System (NRLS)

Original review utilised a bespoke 5-point scale (catastrophic, major, moderate, minor, none) plus a 'greater risk of harm' category to recognise potential future harm. There were no catastrophic outcomes.

Following review by Clinical Quality Group in Feb 23 and feedback from the Patient Safety Lead, the impact was mapped against the definitions of harm used by the National Learning and Reporting Service (NLRS) guidelines in order to inform the Duty of Candour process

This is also a 5-point scale (death, severe, moderate, minor, none). The 'greater risk of harm' category was also retained. There were no deaths.

The sub-specialty groupings of surgery, orthodontic, Speech & Language, Nursing and Psychology were unchanged

Mapping to the National Reporting and Learning System (NRLS)

In the spirit of openness and full disclosure, we are presenting both outcome data sets today.

The principle difference was the interpretation of severe / major categories compared to the moderate category

The overall number of moderate and major/severe harm combined remains the same between both sets.

University Hospitals Bristol and Weston NHS Foundation Trust

Cleft Harm Review Data Comparison

NLRS Data Scores

	overall	By sub-specialty				
		Surgical	Nursing	SLT	Orthodontic	Psychological
Severe	2	0	0	0	2	0
Moderate	91	6	5	65	3	38
Minor	25	1	12	9	1	5
None	93	261	251	137	262	225
Greater risk of harm	57	0	0	57	0	0
Total	268	268	268	268	268	268

Cleft Harm Review data

	overall	By sub-specialty				
		Surgical	Nursing	SLT	Orthodontic	Psychological
Major	49	0	3	33	5	25
Moderate	44	6	2	32	0	13
Minor	25	1	12	9	1	5
None	93	261	250	137	262	225
Greater risk of harm	57	0	0	57	0	0
Total	268	268	268	268	268	268

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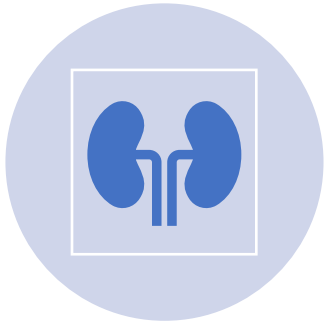
Recovery Actions

University Hospitals Bristol and Weston NHS Foundation Trust



A cleft recovery group was established in January 2022 in response to the pressures on the service and is now progressing the review recommendations.

The group includes senior members of the cleft team, the surgical divisional triumvirate, with the support of colleagues in the Southwest Surgery in Children Operational Delivery Network.

A detailed action plan to monitor the implementation of the recommendations is in place and is reviewed on a fortnightly basis by the recovery group.

The Recovery Actions have not changed considering the presented risk score process and we remain committed to delivering an improved service

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University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**Chief Executive Report**
Report Author	**Executive Directors**
Executive Lead	**Eugine Yafele, Chief Executive**

1. Purpose
To provide an update on key strategic and operational issues affecting the Trust, system and the wider NHS.
2. Key points to note *(Including any previous decisions taken)*
The report seeks to highlight key issues not covered in other reports in the Board pack and which the Board should be aware of. These are structured into four sections: • National Topics of Interest • Integrated Care System Update • Strategy • Operational Delivery
3. Strategic Alignment
This report highlights work that aligns with the Trust's strategic priorities.
4. Risks and Opportunities
The risks associated with this report include: • The potential impact of strikes on the availability of services and quality of care delivery.
5. Recommendation
This report is for Information The Board is asked to note the report.
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**
N/A

Chief Executive's Report

Background

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

National Topics of Interest

Industrial Action and the national Pay Deal

Since the last written report, the Trust has overseen the BMA Junior Dr strike on 11 April – 15 April and the RCN strike on 30 April – 1 May. The RCN action was shortened following the High Court Ruling that the last 12 hours fell outside the 6-month period allowed for strike action.

Following an extraordinary meeting of the NHS Staff Council on 2 May the NHS Staff Council trade unions confirmed the outcome of their individual ballots and recommended that the pay offer made to them by the government should be implemented.

Following endorsement, the Secretary of State Steve Barclay confirmed that the government will now make arrangements to implement all pay elements of the deal from June 2023.

Six of the NHS Staff Council trade unions were in formal dispute with the government regarding pay for 2022/23: UNISON, the Royal College of Nursing (RCN), Unite, GMB, the British Dietetics Association and the Chartered Society of Physiotherapists. These unions now find themselves in different positions.

The position of UNISON, GMB, the British Dietetics Association and Chartered Society of Physiotherapists to accept the non-consolidated payments set out in the offer for 2022/23, signals the end of the industrial relations disputes for these unions. However, RCN and Unite members who did not individually vote to accept the pay offer continue to be in dispute with the government, despite the pay offer now proceeding to be implemented.

The potential risks of further disruptive strike action cannot be ruled out should these trade unions secure a further mandate for any action from their membership. The RCN has already announced its intention to re-ballot its members (23 May – 23 June 2023) to secure another strike action mandate, and it is likely that other unions that voted to reject the offer. The Society of Radiographers is balloting for strike action between 7 – 28 June and the BMA are holding a similar ballot of Consultants from 15 May to 27 June 2023.

In addition to the above, we are planning again for a further round of industrial action by junior doctor members of the BMA – due to take place from 14-17 June inclusive. All Divisions are acting proactively to get ready and we have excellent support from system partners – including over staffing in the system Clinical Advice Service (remote assessment and management of patients seeking urgent care in order to avoid an ED attendance). The strike dates also coincide with part two of the system frailty remote management pilot which sees partners from primary and secondary care, community, social care and SWAST coming together to look after people with acute frailty needs at home, rather than being conveyed and probably admitted to hospital.

Nursing and Midwifery Council (NMC) investigation

The NMC announced last month that it is investigating potentially fraudulent activity at a test centre in Ibadan, Nigeria.

The NMC will write to the 512 current registrants who took their computer-based test (CBT) at this test centre to set out what's happened, and to open cases to determine whether or not they gained fraudulent or incorrect entry to the register.

Individuals in receipt of a letter are being asked to contact the NMC within the next 14 days with information about their employment. Trusts will also be contacted in due course by the NMC should any of their registrants have taken their test at this centre. At this time, no sanctions have been placed on the individuals' registration and there is no action to be taken by employers in relation to their employment. 512 registrants are affected. UHBW have employed 33 Nigerian nurses with 2 in our pipeline. Only 1 nurse has been affected.

The NMC who are responsible for the CBT testing process have assured Trusts that they have reviewed every test site globally and found no evidence of similar fraudulent activity at any other site.

Integrated Care System (ICS) Update

ICS Strategy

A further draft of the ICS Strategy has been produced, this is now with partners for review and UHBW has taken part in an extraordinary session to provide feedback. The ICB team who are leading the development of this document are aiming to have a final version published by the end of June 2023 and the ICP Board will have opportunity to review and feedback at their next meeting. This document will align closely with the Joint Forward Plan, which UHBW has also been involved in developing. The Joint Forward Plan will cover the deliverables that system partners are focused on over the next 2-5 years, in pursuit of the overarching ICS Strategy. The work compliments the System Operating Plan, which was signed off in April 2023, and covers the first 1-2 years of delivery.

Linked to the above, all the UHBW Divisions have now signed off their operating plans. The Divisional Operating Plans will provide the internal delivery plans for each of the Trust's Clinical and Corporate Divisions and align the work of the Trust to the shared requirements of the system.

Joint HR Workstream

The Acute Provider Collaborative (APC) Corporate Services Board oversees the Joint HR workstream, which comprises of two overarching agreed deliverables with North Bristol Trust, these are Recruitment, (in particular international recruitment) and a Collaborative bank. There is a shared draft vision of what can be achieved over the next three years of 'Single or co-delivered models of delivery which improve the quality of our colleagues' experiences and improve efficiencies.'

The teams from both organisations have held scoping workshops within their organisation and have respective transformation programmes underway within these services. The next step is to bring the two teams together in a joint workshop in July to share the outcomes of these programmes and best practice from the scoping workshops, which will inform the key deliverables to achieve the vision. In the meantime, respective leads are already meeting, sharing good practice and working collaboratively.

Strategy and Culture

Transfer of Care Hubs

Establishment of the two UHBW Transfer of Care Hubs is progressing ahead of trajectory due to high levels of interest from candidates in the posts which are currently being advertised. The Hubs will be based onsite at the BRI and Weston with an integrated "Homefirst Team" comprising of UHBW discharge case managers and co-ordinators, social workers and care navigators, Sirona community therapy leads and voluntary sector agencies working together to create discharge options for patients with a bias towards home rather than interim placement options. The Flow and Discharge Co-ordinators are a new role for UHBW, and will be based with ward teams supporting them with discharge processes and building on the success ward teams have started to embed through their Every Minute Matters work – respecting patients' time and ensuring well planned timely discharges.

Perfect Week in Ambulance Handover

We are running a "Perfect Week in Ambulance Handover" in June at the BRI, with Weston to follow shortly after. This is a partnership improvement event planned with colleagues from SWAST, and with the aim of unblocking process issues which may be contributing to lost handover time.

Health and Safety Executive (HSE) inspection update

The HSE inspectors returned to Weston last month to review progress against 2 improvement notices.

One improvement notice relating to how Weston hospital investigates incidents has been closed (Improvement Notice 312992316). The second Improvement Notice (312992321) was not signed off following some concern that theatres were not able to demonstrate a complete awareness of safety procedures. An extension was granted until the 2nd August to concentrate solely on Theatre management. The Weston management team received feedback and are overseeing the action plan.

Gender Development Services

UHBW has entered into a partnership with NHS England as a potential phase 2 provider of gender development services. Gender development services are currently subject to an independent review, commissioned by NHS England and NHS Improvement, to make recommendations on the services provided to children and young people who are exploring their gender identity or experiencing gender incongruence. The independent review is being led by Dr Hilary Cass OBE, a consultant paediatrician and former President of the Royal College of Paediatrics and Child Health. It aims to ensure that children and young people are able to access the best possible support from the NHS, and a high standard of care that meets their individual needs.

As a partner, UHBW will work with NHS England and Phase 1 providers to explore the viability of establishing a service based in the South West.

Operational Delivery

Performance – Planned and Urgent Care

Elective performance recovery was adversely impacted by the RCN and BMA industrial action in the months of March and April. The cumulative impact of industrial action has contributed to an increase in the reported number of RTT long-waiting patients at the end of April, but despite these challenges the Trust continues to incrementally improve, sustaining the zero tolerance for waiting times greater than 104 weeks and making good progress on 78-week wait elimination.

The Trust has set an ambition to meet the national cancer waiting times targets as set out in the Operating Plan. Performance in April was challenged due to industrial action, but the Trust expects to return to trajectory by end of June.

A range of initiatives are being progressed with the aim of reducing overcrowding, ambulance queuing and long waits. During March and April, ED 4-hour waits had improved to levels not achieved since May 2021. Ambulance handover performance has also been improving since December, with April being the best performing month since Q2 2021/22.

Elective Recovery

During May, the Trust received further guidance from NHS England regarding elective care 2023/24 priorities. The publication acknowledges the improvement that has been made at a national level in reducing long RTT and cancer waiting times over the last year or so and recognises the challenges in complexity in delivering elective recovery over the year ahead. The Trust also received specific guidance from NHS England concerning patient choice. This publication set out the roles and responsibilities of primary care, secondary care and ICBs in ensuring that patients are offered choice. The Trust is awaiting further details and will update in due course.

Tiering

On the 23rd May Jim Mackay, National Director of Elective Recovery NHSE, wrote to acknowledge the exceptional progress that has been made in recent months across both elective and cancer waiting times. This has led to the review of the Trusts' position in terms of regulatory oversight, and confirmation that University Hospitals Bristol and Weston NHS Foundation Trust will be de-escalated from the Tiering Programme completely, effective immediately.

2022/23 Financial Position

The Trust ended the 2022/23 financial year with a £22k net income and expenditure surplus. 2022/23 was the Trust's twentieth year of break-even or better. This is a fantastic achievement for the Trust and means we step into the 2023/24 financial challenge on solid foundations. Of course, none of this would be possible without the

fantastic work of all our colleagues and their diligent management and stewardship of our resources.

Agency and bank use

In April we launched a new strategy for significantly reducing Agency use. The first stage of this was to tackle Tier 4 Agency use, through the introduction of a new "Break Glass" bank rate and improve internal controls.

Staff working the new Break Glass rate receive a similar amount to Tier 4 rates, but without the agency mark-up thereby enabling savings to be made. To date this has been very successful with approximately half of all Tier 4 agency shifts being removed during April and May. We have reduced Tier 4 Agency expenditure from £820,000 in April 2022 to £215,000 in April 2023. he Tier 4 reduction initiative has been developed collaboratively with North Bristol Trust who launched the same rate at the same time with similar success.

Recommendation

The Board is asked to note the report.

Eugine Yafele
Chief Executive

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**UHBW Strategic Priorities - 2023/24 delivery plan**
Report Author	**Cathy Caple, Associate Director of Improvement & Innovation**
Executive Lead	**Paula Clarke, Executive Managing Director (Weston General Hospital)**

1. Purpose

This report sets out the Trust's strategic priorities for 2023/24 (formerly known as Annual Corporate Objectives). The strategic priorities are focussed on the key improvement projects that will significantly contribute to and "turn the dial" on achieving our True North strategic goals under our new Patient First approach.

The attached slide deck summarises Patient First and the benefits this brings to provide context for this new way of operating in UHBW.

2. Key points to note *(Including any previous decisions taken)*

The Trust's strategic priorities for 2023/24 have been developed by the Executive Team with engagement from the Senior Leadership Team and Board members. They have been developed using our Patient First approach, which is a new way of working for UHBW where we focus on fewer priorities around which to concentrate the collective efforts of the whole organisation in making improvements. Fundamentally this is about changing the way we do things to ensure we genuinely have the patient at the heart of everything we do and means we have a shared vision and destination for the Trust - our True North.

By avoiding spreading our resources too thinly we will be able to accelerate the time it takes to make service changes for the benefit of our patients and carers and our staff, and we will use our data more effectively to identify the key objectives that will drive genuine improvement and transformation. We will be training and coaching our staff in using the tools, processes and behaviours that are required to make sustained improvements, empowering everyone to resolve problems and issues at a local level and at a more focussed corporate level.

The strategic priorities are summarised as our organisational strategy "plan on a page" (slide 5), with more detail provided around each strategic priority and how they will be delivered by our staff through breakthrough objectives in the next 12 months (slides 6-11). Breakthrough objectives are where we focus improvement energy from our frontline teams to our Board in the year ahead. Corporate projects and strategic year 1 initiatives will have more central, corporate delivery focus, with Divisions assessing where they can contribute greatest impact towards the Trust's overall

target and what the Divisional target will be. This will create Divisional scorecards that concentrate collective efforts and monitoring of improvements on the actions that will make the most difference. We are continuing to hone down the scope of exactly what we will aim to deliver in 2023/24 through project charters and will reflect this into future Board reports.

It is important to note that the individual projects and objectives for 2023/24 are interdependent and contribute across all or some of the True North strategic priorities. This supports our commitment to move from trying to do too many things and not making the impact we want, to working together on fewer goals and doing them well. For this reason, not every strategic priority needs a breakthrough objective.

The strategic priorities and key improvement projects will be communicated widely to our staff through our communications channels, including Chief Executive and Ask an Executive briefings, divisional meetings, and the Patient First intranet hub.

Delivery of the 2023/24 strategic priorities will be monitored by the Executive Directors through the monthly divisional strategy deployment reviews and assurance will be provided to the Board via the Board Committees. The schedule of reporting to the Public Board is proposed as follows:

Quarter 2: October 2023
Quarter 3: January 2024
Quarter 4: April 2024

3. Strategic Alignment

The strategic priorities are aligned to the Trust's True North.

4. Risks and Opportunities

Risk 2992: Risk that benefits of transformation, improvement and innovation are not realised.

The Patient First approach directly addresses this risk. However there remains a risk that staff will not have the capacity to deliver the improvement projects due to ongoing operational pressures and industrial action.

5. Recommendation

This report is for Approval.

The Board is asked to approve the Trust's strategic priorities for 2023/24 and the schedule of reporting.

6. History of the paper

Please include details of where paper has <u>previously</u> been received.

N/A

University Hospitals Bristol and Weston NHS Foundation Trust

Our strategic priorities 2023/24 delivery plan

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University Hospitals Bristol and Weston NHS Foundation Trust

The Patient First approach

Framework for how an organisation **operates**, which **aligns activities** and decisions to **improve performance.**

A long-term data driven approach to **continuous improvement** that is all about giving staff the **freedom and capability** to identify and make positive, **sustainable** change.

Puts the '**customer**' at the centre of improvements by focussing on **what adds value** to them.

Visual management enables greater **communication**, and is supported by a **governance structure.**

Teams are trusted and **empowered to deliver improvements** using a standard methodology, working collaboratively and breaking down silos.

Refers to the system of controls, **communication**, and activity to achieve the **organisational strategic priorities.**

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University Hospitals Bristol and Weston NHS Foundation Trust

Benefits of Patient First

A **credible, sustainable,** continuous improvement approach.

Puts the **patient** at the **heart** of every element of change.

Leadership **commitment** to work differently, **not 'another'** thing to do.

Equal voices for all focusing on removing **barriers** and **empowering** staff.

Reconnects and **aligns** the organisation to the Trust strategy.

Fewer organisational **priorities** from **floor to board.**

We will **stop** doing some things – which requires **bravery.**

Builds on our **strengths** – we're not starting from scratch.

Values and **leadership** behaviours embedded.

Shifts our culture from reactive to **empowered.**

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Our organisational strategy

Our strategic priorities	Our vision	Our strategic goals	Our 3-5 year targets	Our 12 month breakthrough objectives	Our 12-18 month corporate projects	Our strategic initiatives Year 1
Experience of care *Exceptional patient experience*	Together, we will deliver person-centred, compassionate and inclusive care every time, for everyone.	We will be in the top 10% of NHS organisations for providing an outstanding experience for all our patients as reported by them and as recognised by our staff.	98% or more of inpatients will rate their care as good or above. Feedback will be representative of the patients we care for. We will be in the top 10% of non-specialist acute trusts: for staff recommending our organisation for treatment of a friend or relative.	Improve experience of care through better communication.	No corporate project in 2023/24.	• Develop and implement our Experience of Care Strategy.
Patient safety *Excellent care, every time*	Together, we will consistently deliver the highest quality, safe and effective care to all our patients.	Building on the many things we do well to keep our patients safe, we will reduce avoidable patient harm events - aspiring for zero avoidable harm, and further developing a "no blame" and "just culture."	10% reduction in avoidable harm events year on year.	Consistency in the early recognition of sepsis.	**Mission critical corporate projects:** • Implementing Careflow Medicines Management. **Important corporate services projects:** • Delivering the NHS Patient Safety Strategy. • Delivering our Deteriorating Patient Programme.	• Development of a joint clinical strategy with North Bristol NHS Trust. • Delivering Healthy Weston 2. • UHBW clinical strategy developed.
Our people *Proud to be #TeamUHBW*	Together, we will make UHBW the best place to work.	We will improve the employment experience of all our colleagues to retain our valuable people.	We will be in the top 10% of NHS organisations for staff recommending us as a place to work, a 5% improvement year on year.	Staff turnover is no more than 14% in 2023/24 and our Divisions meet the staff group targets set.	**Mission critical corporate projects:** • Funded Retention Strategy developed. **Important corporate services projects:** • Optimising Medical Workforce.	• Eliminate violence & aggression & bullying and harassment. • Embedding Respecting Everyone principles. • Delivering education pathways • Embedding our leadership & management offer.
Timely care *Timely access to care for all*	Together, we will provide timely access to care for all patients, meeting their individual needs.	By streamlining flow & reducing variation, we will eliminate avoidable delays across access pathways.	A 10% year on year improvement in ambulance handover times as a measure of improved patient flow through our hospitals	33% of our patients who are ready for discharge leave by 12 midday.	**Mission critical corporate projects:** • Proactive Hospital (patient flow). **Important corporate services projects:** • Improve Theatres productivity & efficiency. • Improve outpatients productivity & efficiency.	• New Trust website. • New Trust intranet. • Channel review and implementation. • Brand project delivered.
Innovate & improve *Unlocking our potential*	Together, we will drive improvement every day, engaging our staff and patients in research and innovative ways of working to unlock our full potential.	We will be in the top 10% of NHS organisations for our staff stating they can easily make improvements in their area of work.	A 2% improvement year on year in staff reporting they are able to make improvements.	No breakthrough objective in 2023/24.	**Important corporate services projects:** • Scoping and developing our Business Intelligence function.	• Patient First deployment. • Development of a Joint Digital Strategy with North Bristol NHS Trust.
Our resources *Making the most of all our resources*	Together, we will reduce waste and increase productivity to be in a strong financial position to release resources and reinvest in our staff, our services and our environment.	To achieve a 1% income and expenditure surplus from 2025/26 onwards, creating a recurrent source of funding for strategic investment.	Year-on-year improvement to deliver a circa £10 million Income & Expenditure surplus. We will treat more patients with elective care needs, exceeding 2019/20 activity levels.	No breakthrough objective in 2023/24.	**Mission critical corporate projects:** • Reduce premium workforce costs. **Important corporate services projects:** • Space review. • Digital procurement, stores and materials management transformation.	• Develop the Marlborough Hill business cases.

University Hospitals Bristol and Weston NHS Foundation Trust

Experience of care

Exceptional patient experience

Our vision: *What do we aspire to?*	Together, we will deliver person-centred, compassionate and inclusive care every time, for everyone.
Our goal: *What does that look like?*	We will be in the top 10% of NHS organisations for providing an outstanding experience for all our patients as reported by them and as recognised by our staff.
Our 3-5 year target: *How will we know we are getting there?*	98% or more of inpatients will rate their care as good or above. Feedback will be representative of the patients we care for. We will be in the top 10% of non-specialist acute trusts: for staff recommending our organisation for treatment of a friend or relative.
Our 12 month breakthrough objective: *What will move us forward fastest?*	We will improve experience of care through better communication.
Our measure: *How will we monitor progress against our breakthrough objective?*	Monthly inpatient and maternity surveys.

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University Hospitals Bristol and Weston NHS Foundation Trust

Patient safety

Excellent care, every time

Our vision: *What do we aspire to?*	Together, we will consistently deliver the highest quality, safe and effective care to all our patients.
Our goal: *What does that look like?*	Building on the many things we do well to keep our patients safe, we will reduce avoidable patient harm events - aspiring for zero avoidable harm, and further developing a “no blame” and “just culture.”
Our 3-5 year target: *How will we know we are getting there?*	10% reduction in avoidable harm events year on year.
Our 12 month breakthrough objective: *What will move us forward fastest?*	Consistency in the early recognition of sepsis.
Our measure: *How will we monitor progress against our breakthrough objective?*	Quarterly review of harm events.

University Hospitals Bristol and Weston NHS Foundation Trust

Our people *Proud to be #TeamUHBW*	
Our vision: *What do we aspire to?*	Together, we will make UHBW the best place to work.
Our goal: *What does that look like?*	We will improve the employment experience of all our colleagues to retain our valuable people.
Our 3-5 year target: *How will we know we are getting there?*	We will be in the top 10% of NHS organisations for staff recommending us as a place to work, a 5% improvement year on year.
Our 12 month breakthrough objective: *What will move us forward fastest?*	Staff turnover is no more than 14% in 2023/24 and our Divisions meet the staff group targets set.
Our measure: *How will we monitor progress against our breakthrough objective?*	Trust and Divisional staff turnover data. Annual Staff Survey results.

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University Hospitals Bristol and Weston NHS Foundation Trust

Timely care

Timely access to care for all

Our vision: *What do we aspire to?*	Together, we will provide timely access to care for all patients, meeting their individual needs.
Our goal: *What does that look like?*	By streamlining flow & reducing variation we will eliminate avoidable delays across access pathways.
Our 3-5 year target: *How will we know we are getting there?*	A 10% year on year improvement in ambulance handover times as a measure of improved patient flow through our hospitals.
Our 12 month breakthrough objective: *What will move us forward fastest?*	33% of our patients who are ready for discharge leave by 12 midday.
Our measure: *How will we monitor progress against our breakthrough objective?*	Monthly & quarterly review of ambulance handover data.

University Hospitals Bristol and Weston NHS Foundation Trust

Innovate & improve *Unlocking our potential*	
Our vision: *What do we aspire to?*	Together, we will drive improvement every day, engaging our staff and patients in research and innovative ways of working to unlock our full potential.
Our goal: *What does that look like?*	We will be in the top 10% of NHS organisations for our staff stating they can easily make improvements in their area of work.
Our 3-5 year target: *How will we know we are getting there?*	A 2% improvement year-on-year in staff reporting they are able to make improvements.
Our 12 month breakthrough objective: *What will move us forward fastest?*	No breakthrough objective in 2023/24.
Our measure: *How will we monitor progress against our breakthrough objective?*	Not applicable in 2023/24.

University Hospitals Bristol and Weston NHS Foundation Trust

Our resources *Using our resources wisely*	
Our vision: *What do we aspire to?*	Together, we will reduce waste and increase productivity to be in a strong financial position to release resources and reinvest in our staff, our services and our environment.
Our goal: *What does that look like?*	To achieve a 1% income and expenditure surplus from 2025/26 onwards, creating a recurrent source of funding for strategic investment.
Our 3-5 year target: *How will we know we are getting there?*	Year-on-year improvement to deliver a circa £10 million Income & Expenditure surplus. We will treat more patients with elective care needs, exceeding 2019/20 activity levels.
Our 12 month breakthrough objective: *What will move us forward fastest?*	No breakthrough objective in 2023/24.
Our measure: *How will we monitor progress against our breakthrough objective?*	Not applicable in 2023/24.

Meeting of the Board of Directors in Private on Thursday 15 June 2023

Report Title	**Quarter 4 Strategic Risk Paper**
Report Author	**Sarah Wright, Head of Risk Management & Information Governance**
Executive Lead	**Eugine Yafele, Chief Executive**

1. Purpose

The Trust's Board Assurance Framework is formed of two elements:

- Part A - Assurance around the achievement of the Trusts strategic objectives
- Part B - Assurance that any risks to the achievement of the strategic objectives are being adequately mitigated or controlled.

This report forms part B of the Trust's risk Board Assurance Framework and is the mechanism for reporting on the management and treatment of strategic risks (*risks to the achievement of the Trusts strategic objectives)*.

2. Key points to note *(Including any previous decisions taken)*

There are 13 risks on the Strategic Risk Register

- 0 new risks
- 0 risks have increased
- 1 risk has reduced
  - Risk 2741 - Sustaining research activity
- 1 risk recommended for reassessment and de-escalation
  - Risk 5317 – ICS implementation

- The profile section describes how risks are split across the risk domains and by score. The purpose of which is to help the organisation understand where the majority of its key risks are impacting.

- The risk profile has remained fairly static over the quarterly periods this financial year. In Q4 the greatest number of risks has changed from the domain of Business to Workforce reflecting the alignment of strategic risks to the People Strategy. In-year, four corporate risks have escalated from the Corporate Risk Register to the Strategic Risk Register; two under the statutory domain (5032 – PSIRF, 3763 – CQC), one under the quality domain (423 – Demand and Capacity) and a patient safety risk (3115 – digitalising the patient record). There has been no change to the number of risks in the Financial and Environmental domain. Risks assessed against the domains of Patient Safety, Quality and Environmental are fewest, with no risks in the domain of Reputational or Health and Safety at strategic level.

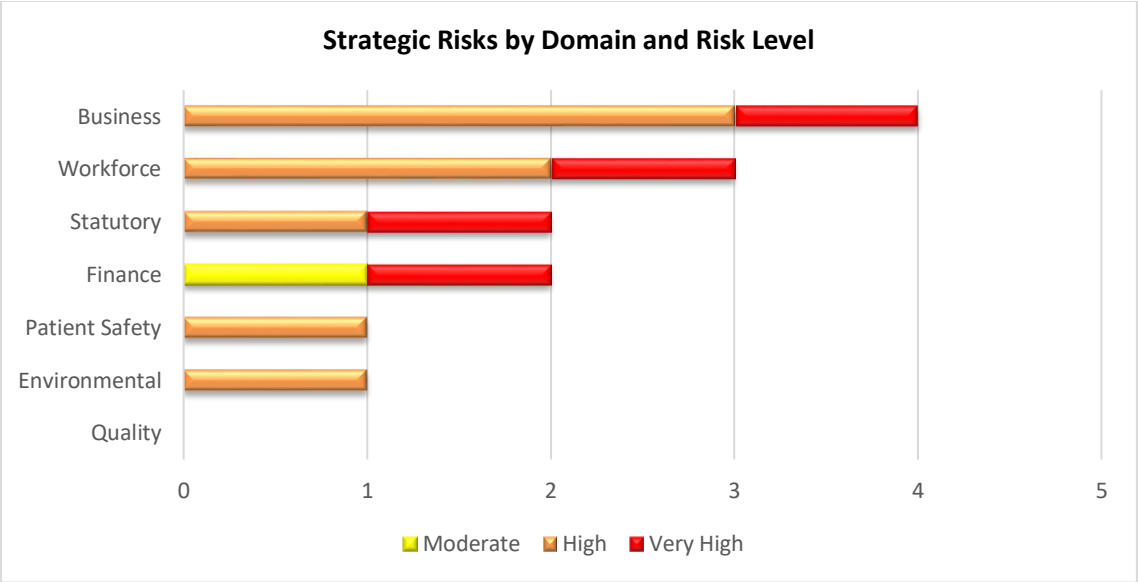
- Conversely, the majority of corporate risks continues to be assessed against the Patient Safety and Quality domains which is commensurate with our divisional-level risk profile, meaning overall our operational risk profile is very much focussed on mitigating risks to patient safety and quality, then workforce. Workforce is in the top three risk domains across both strategic and operational risk profiles.

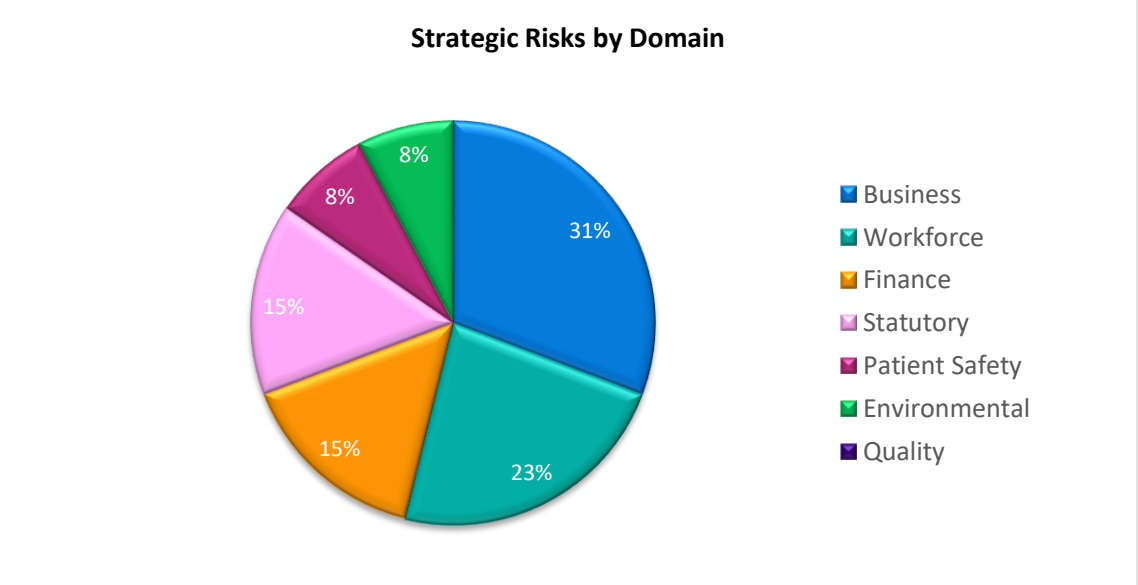
- The risk profile section includes a chart to map the projected achievement of the target risk score over time. This chart will help support review of risk actions and key milestones in mitigating risk and align decision-making on planned mitigations within our risk appetite and tolerance to approach and manage risks to an acceptable level.
- The narrative to describe changes to the risks in the quarter is ordered in line with the domains so that similar risks can be considered together.

3. Strategic Alignment
This report forms part B of the Trust's risk Board Assurance Framework and is the mechanism for reporting on the management and treatment of strategic risks (*risks to the achievement of the Trusts strategic objectives)*.
4. Risks and Opportunities
See attached report.
5. Recommendation
This report is for Approval Board is asked to approve the reported Q4 strategic risk position, specifically the proposed de-escalation of risk 5317, ICS implementation.
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**

Executive Directors (via email)	14/04/2023
People Committee (relevant risks) *Risks presented to sub-group PLDG*	*12/04/2023*
Finance & Digital Committee (relevant risks),	25/04/2023
Quality and Outcome Committee (relevant risks)	25/04/2023
Audit Committee	27/04/2023
Trust Board *Meeting cancelled - risk paper re-scheduled from 09 May 2023*	15/06/2023

Risk Profile: **Strategic Risks**



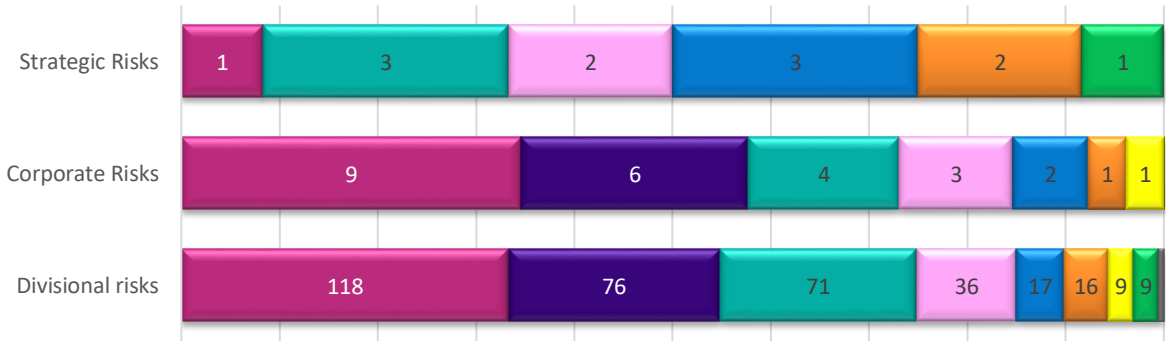


	2022/23			
Domain	**Q1**	**Q2**	**Q3**	**Q4**
Patient Safety	-	1	1	1
Quality	1	-	1	-
Workforce	3	2	2	3
Statutory	-	2	2	2
Business	4	4	4	4
Finance	2	2	2	2
Environmental	1	1	1	1

The risk profile remains fairly static across the periods. Movements in-year relate to

Patient Safety	One patient safety risk was escalated to the Strategic Risk Register from the Corporate Risk Register (3115 - Digitalising the patient record)
Quality	One quality risk moved to Business Domain (423 – Bed Capacity)
Finance	One finance risk has increased in score from 16 to 20 (416 – Funding the Strategic Capital Programme) One finance risk has reduced in score from 9 to 6 (2741 – Research activity)
Business	Two strategic business risks closed this year (5369 – delivery of a suitable service model for WGH and 5317 – ICS Implementation) One business risk was escalated to the Strategic Risk Register from the Corporate Risk Register (423 - Bed Capacity)
Workforce	One new quality strategic risk (285 – Fully diverse workforce) transferred to the workforce domain.
Statutory	Two statutory risks were escalated to the Strategic Risk Register from the Corporate Risk Register (3763 – CQC and 5032 – PSIRF).

Comparison of Risk Domains across Risk Levels



	Divisional risks	Corporate Risks	Strategic Risks
Patient Safety	118	9	1
Quality	76	6	0
Workforce	71	4	3
Statutory	36	3	2
Business	17	2	3
Financial	16	1	2
Health & Safety	9	1	0
Environmental	9	0	1
Reputational	2	0	0

ID	Strategic Risks, Projected Timeline for Mitigation	2022/23			2023/24				2024/25				2025/26			
		Q3		Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
423	Demand for inpatient admission exceeds available bed capacity	20	↔	20	20	20					8					
416	Fail to fund the Strategic Capital Programme	20	↔	20	20	20		8								
737	Unable to recruit sufficient substantive staff	16	↔	16	16	16										?
5032	National patient safety strategy requirements are not delivered	16	↔	16	9	9	6									
3763	May not meet standards to comply with CQC Regulations	12	↔	12	12	12					8					
3115	Clinical decision making based upon incomplete information	12	↔	12	12	12						4				
2694	Unable to retain substantive workforce	12	↔	12	12	8										
5317	ICS Implementation reduces decision making powers	12	↔	12	4											
2642	Unable to develop and modernise the Trust estate	12	↔	12	12	12			8							
3472	Fails to meet sustainable development strategy commitments	10	↔	10	10	10							5			
2992	Transformation, improvement and innovation benefits not realised	9	↔	9	9	9		6								
285	Fail to have a fully diverse workforce	9	↔	9	9	9									4	
2741	Research and Innovation is not adequately supported	9	↓	6*												
	← History →				← Projection →											

KEY *Risk has met the target score ? Date for achievement of target score to be agreed

Changes in date of achievement of projected target score between Q3 and Q4

Achieved target score sooner than predicted:

- Risk 2741 - Research (was Q4 2024/25, now Q4 22/23)

Slippage of one quarter in reaching target score:

- Risk 5032 - Patient Safety Strategy (was Q2 23/24, now Q3 23/24)
- Risk 5317 – ICS Implementation (was Q4 22/23, now Q1 23/24)

Change in projected target score:

- Risk 3763 – CQC Regulations (from 6 in Q3 24/25 to 8 in Q3 24/25

Q4 Update – Strategic Risks		
3115	**Risk that clinical decision making may be based upon incomplete information**	**12 ↔**
CMO Patient Safety	Digital storage of information is the key to enabling clinicians to have access to the complete record. The digital hospital programme is progressively transferring the paper record into a digital format with the aim of giving clinicians fast, simple, and controlled access to patient information for safe clinical care and effective service optimization. Projects underway include the Digital Outpatients programme which is now live in paediatric oncology, haematology, BMT, gastroenterology, hepatobiliary, Dental and lipids. A key enabler for projects that replace paper notes is the ability to dictate directly into digital forms. The Trust has secured a new speech recognition contract. The project is underway and preparing for go-live in pilot areas. Due to some small delays in the project and eLearning not being available to staff until the beginning of May a short BigHand contract extension is being sought to allow enough time for all users to complete the Fluency Training The Careflow Medicines Management Project has been delayed due to outstanding technical issues that need to be fixed before testing can continue. A new go-live date has not been agreed. The Diagnostics convergence programme to consolidate Bristol's and Weston's ICE, PACS and RIS systems is underway. Bristol and Weston ICE's are being upgraded to matching versions of the software in March to ready them for consolidation. A strategy for consolidating the PACS and RIS systems is being developed and Digital Services hopes to commission the work by the end of April. *This risk is linked to strategic 737 (recruitment), strategic 2694 (Retention), corporate 793 (Workplace stress), corporate 4748 (WGH Clinical Staffing), corporate 5477 (Nurse Staffing).*	

3763	**Risk that the Trust may not meet standards to ensure compliance with CQC Regulations**	**12 ↔**
CNM Statutory	The latest CQC action plan update was reported to QOC in March 2023 providing a progress report on outstanding CQC inspection actions. Only 8 actions remain (of the original 158). The target is now to close the remaining actions by the end of June 2023 if possible. The composite action plan is to be extended to include the key actions which pertain to potential matters of regulation even if these have not been identified through formal CQC inspection. CQC core services self-assessments are currently being taken forward for critical care and end of life care. CQC inspections of maternity and SARC have been postponed due to industrial action. Focus remains on inspection readiness. The CQC schedule for completion of all maternity inspections has now been extended into Summer 2023. The CQC relationship with Weston has been reset by the CQC to a 'business as usual' footing, monthly meetings with CQC have been stood down following evidence of significant improvements. A new CQC staffing framework is effective from April 2023 with CQC monitoring visits recommencing in due course.	
5032	**Risk that national patient safety strategy requirements are not delivered in UHBW**	**16 ↔**
CNM Statutory	The Patient Safety Incident Response Plan (PSIRP) was approved by the UHBW Board and ICB. The required supporting resources are under final development. The communications plan, policy and training matrix is behind schedule and posts to support the new learning response model have been recruited to. The first cohort of After-Action Review training has been delivered with more training planned for Q1 of 23/24. Patient Safety Partners have been inducted and are being supported to deliver their role. The Deteriorating Patient workstream has been agreed as a True North patient safety objective for Patient First. A new protocol and NEWS2 training have been developed and Respect Plus system wide work is underway.	

423	**Risk that demand for inpatient admission exceeds available bed capacity**	**20 ↔**
COO Business	Rapid patient reviews are now being run regularly in the bed bases in BRI and Weston with ongoing PDSA cycles to get to the optimum model in terms of numbers of patients reviewed. Front door reviews at Weston are running when staffing allows, with recruitment into staffing to enable daily reviews underway. Further mitigations in progress to manage the risk include expansion of Medical SDEC and the acute medical model, maximising benefits from the roll-out of Every Minute Matters and delivering the BHI extension. The action plan required updating as all actions have exceeded their planned completion date. *This risk is linked to corporate risks 910 (Ambulance queue), 2614 (Extra Capacity), 801 (NHS Oversight Framework), 1035 (Cancelled ops) and 2244 (Outpatient Waits) as well as strategic risk 416 (Finance).*	
2642	**Risk that the Trust is unable to develop and modernise the Trust estate**	**12 ↔**
DOF Business	The review of the capital project team is underway including updating JD's and banding. Capital allocation is to be finalised and it is understood that the Capital team need to deliver to the final budget. The feasibility of the capital projects is at an early stage to improve the scope and deliverables. Access to operational areas still the underlying risk to the non-delivery of a modernised and safe estate. *This risk is linked to strategic 416 (Financial Plan), strategic 5317 (ICS Implementation).*	
2992	**Risk that benefits of transformation, improvement and innovation are not realised**	**9 ↔**
EMD Business	Phase 2 of Patient First has been completed with strategic priorities agreed for 2023/24. Phase 3 is now in progress which comprises developing project charters for each project/programme, including defining scope and stratifying data; developing communication materials for staff across the organisation to understand the priorities and delivering training to senior leaders. As at the end of Q4, 351 (75%) A3 thinking structured problem solving and 285 (61%) Patient First for Leaders training sessions had been delivered. Phase 4 of Patient First is in the planning phase which will focus on developing training materials for Patient First for Teams and developing a readiness assessment template which will inform the roll-out plan for divisions, specialties and teams. Strategic priorities continue to be shared with NBT to identify opportunities for alignment. *This risk is linked to strategic risk 3115 (IM&T).*	
5317	**Risk that the Integrated Care System Implementation reduces the Trusts decision making powers**	**12 ↔**
EMD Business	The ICB decision making framework is now available and this risk can now be re-assessed with a view to de-escalation. Going forward, the Trust remains very engaged in the system planning and system strategy structures. The planned mitigation around the review of 22/23 planning has exceeded its completion date. *This risk is linked to strategic 416 (Financial Plan) and strategic 2642 (Estate Modernisation).*	

285	**Risk that the Trust fails to have a fully diverse workforce**	**9 ↔**
CPO Workforce	The Trust's diversity data and staff survey results show that UHBW does not have a fully representative workforce and that the experience of staff from ethnic monitories or with a disability is less favourable than that of white, non-disabled staff. Divisional Model Employer recruitment targets have been set and added to the controls, along with Bridges Talent Management Programme. February was the launch of the second cohort of the Bridges talent management programme, with 50 successful candidates. The launch of the recruitment campaign for EDI advocates delayed due to a requested pause on developing EDI advocate brand while a Trust wide brand is developed by the Communication Team. In the meantime, Divisions continue to encourage colleagues to become advocates, using the role descriptor to highlight role and the network continues to grow and become more active. 2 of the actions have exceeded their planned completion date. *This risk is linked to strategic 737 (recruitment), strategic 2694 (Retention), corporate 793 (Workplace stress) and corporate 5477 (Nurse Staffing).*	
737	**Risk that the Trust is unable to recruit sufficient numbers of substantive staff**	**16 ↔**
CPO Workforce	There was a small reduction in the Trust vacancy position at the end of Q3 (down from 7.7% to 7.4%), however, this remains over the target of 7%. International recruitment continues for general and paediatric nursing, and this is likely to continue for the next couple of financial years due to the depleted domestic and newly qualified market for nursing. International recruitment is also underway for midwives, radiographers and OTs, however, the international recruitment market is becoming more and more challenging. The domestic recruitment market is also becoming more challenging specifically for entry level admin roles due to the effect of Brexit and post pandemic. To address this an admin and clerical recruitment day was held in January 2023 to build on the success of the event held in May 2022. The HCSW vacancy position continues to grow and to address this a bespoke recruitment plan was developed which included a mass recruitment event in February 2023 and a system wide recruitment event in March. 2 of the actions have exceeded their planned completion date. *This risk is linked to strategic 285 (Diverse Workforce), strategic 2642 (Estate Modernisation), strategic 2694 (Staff Retention) and strategic 2741 (Research).*	
2694	**Risk that Trust is unable to retain members of the substantive workforce**	**12 ↔**
CPO Workforce	A robust communication plan was deployed to distribute the National Staff Survey results 2022 across the organisation. The preliminary Staff Survey 2022 results were reported both to SLT and People Committee in January. The cascade of the Divisional Staff Survey detailed reporting in the form of `heat maps 'and engagement reports was delivered to divisions on 1st February 2023. The early release of this detailed reporting allowed for the development of local and organisational priorities and the objectives of the Divisional Culture and People plans for April 2023. The quarterly People Pulse Survey intention is to track staff engagement throughout the year as well as providing a platform to measure the impact on organisational programmes of work. In Quarter 4, the engagement score remained consistent in line with the annual staff survey at 6.9 (out of 10). The impact of the staff values has been measured during the last three pulse surveys with consistent results; 98% of colleagues who responded to the survey are familiar with the values, with 90% agreeing colleagues role model the values and 77% of managers role model the values. The Recognition nomination campaign for the annual staff awards in preparation for the Annual Recognising Success event in April took place during Q1 with a record number of 1124 nominations received. The planned mitigation relating to a governance review and formation of R&R Group has exceeded its completion date. *This risk is linked to strategic 737 (Recruitment), corporate 2639 (Appraisals), strategic 2741 (Research) and corporate 6145 (HCSW).*	

416	**Risk that the Trust fails to fund the Trust's Strategic Capital Programme**	**20 ↔**
DOF Financial	The Trust has completed its 2023/24 Financial Plan (for revenue and outline capital) and submitted it to the BNSSG ICB and Regulator on 30th March 2023 in accordance with the national timetable. The Finance & Digital Committee has recommended its onward approval by the Trust's Board of Directors on the 18th April 2023. The Trust's 2023/24 revenue plan is break-even. However, The Trust's underlying or recurrent deficit is estimated at £55m and mitigation of this position will require action with an agreed three-year Financial Recovery Plan. The Trust is continuing to work through the detail of its capital plan for 2023/24 and 2024/25 due to the significantly reduced capital envelope. The Trust's capital envelope (or CDEL) as advised by NHSE is £42m and £39m for 2023/24 and 2024/25 respectively compared with capital expenditure of c£65m per year over the last three financial years. The Trust is expecting to complete its strategic and non-strategic capital planning for 2023/24 by the end of April 2023. The completion and publication of the BNSSG ICB Joint Clinical Strategy in the Spring of 2023 will also shape the future direction of strategic capital and potentially the allocation of CDEL. *This risk is linked to strategic risks 2642 (Estate Modernisation), 5317 (ICS Implementation), corporate risks 674 (High-Cost Agency) and 423 (Capacity).*	
2741	**Risk that Research and Innovation is not adequately supported**	**6 ↓**
CMO Financial	There continues to be a strong commitment to research across the trust, maintaining visibility and good engagement with divisions. The Increased capacity in grant development and new joint commercial research function (with NBT) has caused the financial assessment of this risk to reduce. A Joint Commercial Research Manager and a Joint Commercial Research Projects Manager are now in post across UHBW and NBT. A Research Grants Post Award Manager is also in post, increasing the capacity to support and develop staff to develop and submit grants. Grants have been awarded (with further outcomes awaited outcome) at higher level than 2021/22. However, retaining (and replacing) skilled research delivery staff is proving challenging, particularly as we recruit from the same pool as NBT. There has also been a reduction in research capability funding, as expected. Due to the reassessment of this risk it has now achieved its target score, however, further mitigation has been identified to improve controls.	
3472	**Risk that the Trust fails to meet its commitments under the Sustainable Development Strategy**	**10 ↔**
DOF Environmental	The ICS Sustainability lead advised that under the current Bristol City Council tariffs for carbon emissions the Bristol Health system will face an annual £150 million cost pressure if emissions are not reduced. A joint ICS Green Plan has been developed and submitted for board approval. This sets the ambition for sustainability across the ICS and for UHBW replaces the Sustainable Development Strategy 2020 – 2025. The Sustainability Team has been involved in discussions for ICS capital prioritisation and has agreed 10% of funding will be allocated to the net-zero programme from the 2024/25 finance year. Discussions are advancing with contractors that operate a city centre district heating system for possible connection which could eliminate 80% of emissions from direct operations. We're developing a commercial proposal for this which will be coming to execs for review over the next few months. Air quality monitoring systems previously installed around the Bristol estate are showing consistent levels of pollution above world health organisation limits and above the general Bristol background level of pollution. We are installing plug-in points for ambulances so they can connect and turn off their engines when waiting which will hopefully help the issue. Data is currently being gathered for reporting on annual progress towards the sustainable development strategy for the 2022/23 finance year. A NED visit recently took place looking at waste management and energy. The feedback was overall positive with a few recommendations.	

Q4 - Strategic Risk Register								Inherent				Controls			Assurance			Current Assessment					Target				Review	
ID	Opened	Domain	Origin	Proximity	Strategy	Assurance	Executive	Principal Risk Description	C	L	S	Risk level	Key Controls	Adequacy	Gaps in Controls	Form of Assurance	Level	Gaps in Assurance	C	L	S	Risk level	Action Details	Due date	C	L	S	Risk level	Next Review	Status
285	01/11/2011	Workforce	Internal	Is Currently an Issue	People Strategy	People Committee, Quality and Outcomes Committee	Chief People Officer	**If** our Governance, recruitment and retention processes are not inclusive, accessible and wide-reaching, **Then** the Trust will not have a fully diverse workforce, **Resulting in** a negative impact on patients' clinical outcomes, patient & staff experience, recruitment and retention and reputational damage for the Trust.	Moderate	Likely	12	High Risk	We are mandated to report on the Workforce Race Equality Standards / Workforce Disability Equality Standards & Gender Pay Gap annually. Workforce Diversity & Inclusion strategy for 2020-25 is in place. The strategy supports delivery of Strategic objectives which are monitored by the Equality, Diversity and Inclusion Steering Group that feeds into People Learning and Development Group and People Committee. Bridges Talent Management programme running. Recruitment targets set for all Divisions to meet Model Employer ambitions and reduce Race Disparity Ratio. This is further supported by: -Anonymous recruitment framework -Trust Values -Staff development programmes -Freedom to Speak up framework	Inadequate	Trust focus on Race and Disability; may be detrimental to staff with other protected characteristics. Benefits not yet realised from the Staff Development programmes and targets in the divisions to support closing of the gaps associated with Model Employer and Race Disparity Ratio. Values not yet fully embedded and creating positive cultural change. Evidence suggests recruitment and promotion processes still favour staff from non-diverse backgrounds (less diversity seen in higher pay bands, than the rest of the Trust). Trust estate is not easily accessible for staff with mobility issues.	NHSE/I has oversight of our published data on Workforce Race Equality Standards / Workforce Disability Equality Standards & Gender Pay Gap Equality Act 2010 makes it illegal to discriminate against anyone based on their protected characteristics	Second Line Assurance - Risk and Compliance	None noted.	Moderate	Possible	9	High Risk	Delivering Supporting Positive Behaviours plan. Use knowledge gained from the TCM diagnostics to implement and embed a new approach to resolution. Detail as per EDI BRAG action plan. Launch recruitment campaign for EDI advocates Develop guidelines to include positive actions for recruitment at Band 8a+, designed to support the delivery of the Divisional Model Employer Targets. Develop compassionate leadership programme for colleagues at all levels of leadership. To incorporate talent management programmes and link to the appraisal process	31/03/2023 30/06/2023 30/01/2023 30/06/2023	Minor	Unlikely	4	Moderate Risk	01/07/2023	Action Required Risks
416	01/11/2011	Financial	External	In the next 3-5 Financial Years	Financial Strategy	Finance and Digital Committee	Chief Financial Officer	**If** the Trust's planned income and expenditure position of break-even or better is not delivered, or the cost and number of capital schemes increase beyond that provided for in the Trust's Strategic Capital Programme, or the Trust's share of system CDEL is reduced, **Then** the Trust's Strategic Capital Programme may not be able to affordable within the funding constraints, **Resulting in** the requirement to reduce the cost of the Strategic Capital Programme through scheme deletion, deferral or reduction in scope.	Catastrophic	Likely	20	Very High Risk	Periodic review and update of the Strategic Capital Programme and the underpinning five year revenue Long Term Financial Plan (LTFP). The Trust has completed its Strategic Capital Review in August 2021 with sign off by SLT and Trust Board. Effective reporting, monitoring and review of operational plan to identify issues requiring a financial recovery plan. Established contract monitoring and commissioner dialogue to minimise external factors arising from contracting issues. Established working relationship with Charitable partners to manage donations. Fully worked up schemes in advance with experienced staff input, control of tenders and costs and effective monitoring and reporting of costs. A managed contingency reserve. Engagement at a national level regarding any proposed external regulation. A comprehensive, committed capital programme proceeding at pace. The BNSSG system DoFs have agreed the principles and process to deliver a system prioritised 5 year capital plan that is compliant with NHSEI's Capital Department Expenditure Limit (CDEL).	Adequate	Currently, there is great uncertainty regarding NHS revenue and capital funding. This, and the scale of the Trust's and the systems recurrent financial deficit, means there is potentially a significant impediment to the Trust in making future strategic capital and knock-on recurring revenue investment decisions. Therefore, significant risks to the Trust's strategic capital investment ambitions exist hence the risk score remains unchanged.	Detailed monthly submission of financial performance submitted to the Regulator, NHS Improvement. Strong statement of financial position. Liquidity metric of 1 (highest) and Use of Resources Rating of 1 (highest rating). Monthly reporting to the Finance & Digital Committee and Trust Board. Monthly Pay Controls Group, Non Pay Controls Group and Nursing Controls Group scrutiny of Divisions performance. 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance & Digital Committee and Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Delivery of the capital programme, including the prioritisation and allocation of strategic capital.	Second Line Assurance - Risk and Compliance	None noted.	Major	Very Likely	20	Very High Risk	The BNSSG ICS and its partners are producing their individual five year medium term revenue and capital plans as a first draft. This will inform the revenue and capital funding envelopes and affordability of capital plans. The BNSSG ICS and its partners will need to develop a strategic capital prioritisation and CDEL allocation process to ensure both the financial and workforce constraints are recognised in deciding the priority order of capital investments for providers and the system over the coming five year term. The Trust will be constructing a medium term Financial Improvement Plan (FIP) in order to mitigate the scale of the Trust's projected recurrent deficit. The FIP should ensure the Trust does not significantly deplete its accumulated cash balances for revenue purposes but retains its cash balances for strategic capital investment.	30/09/2023 30/06/2023 30/09/2023	Major	Unlikely	8	High Risk	01/07/2023	Action Required Risks
423	18/09/2012	Business	Internal	Is Currently an Issue		Quality and Outcomes Committee	Chief Operating Officer	**If** demand for inpatient admission exceeds available bed capacity, **Then** increased occupancy will impacts on flow, **Resulting in** poor ED performance, increased staff workload and a negative patient experience. There will also be a knock on impact on the elective programme, including increased likelihood of cancellations.	Major	Very Likely	20	Very High Risk	Established D2A Board, chaired by Sirona COO, to oversee delivery of D2A business case, with Programme Director in place. Internal Integrated Discharge Group set up to work on UHBW actions to support across discharge pathways. Roll out of Every Minute Matters across adult services is progressing according to plan, and covers SAFER bundle, proactive board rounds, use of the discharge lounges and daily criteria to reside reviews.	Inadequate	None noted.	Reporton activity to Board and Subcommittees.	Second Line Assurance - Risk and Compliance	None noted.	Major	Very Likely	20	Very High Risk	Roll out the Every Minute Matters approach (includes SAFER bundle, knowing how we are doing, well organised ward, releasing time to care) to support reducing LOS and improving discharge planning. Report to Proactive Hospital Steering Group . Complete review of space on inpatient wards with a view to converting into additional inpatient bed spaces. To report to Recovery Delivery Board w/c 2 May Working with system partners, deliver the enhanced capacity and process improvements associated with the Discharge to Assess (D2A) business case in order to reduce beddays accumulated by patients with no criteria to reside in hospital. Roll out of Rapid Patient Reviews involves the following: 1) Use of the Top Ten "direct to" pathways referral document to be embedded in both Weston and BRI ED board rounds in order to help facilitate admission avoidance where clinically appropriate. This starts with a pilot in Weston ED on 26 Sept. 2) Rapid reviews will also be implemented across the bedbases (BRI and Weston) during which all inpatients with LOS >7 days will be reviewed, with any blocks to their treatment or care challenged, and use of alternative pathways to facilitate discharge explored.	28/02/2023 30/12/2022 30/12/2022 17/10/2022	Major	Unlikely	8	High Risk	01/07/2023	Action Required Risks

Q4 - Strategic Risk Register									Inherent				Controls			Assurance			Current Assessment					Target				Review	
ID	Opened	Domain	Origin	Proximity	Strategy	Assurance	Executive	Principal Risk Description	C	L	S	Risk level	Key Controls	Adequacy	Gaps in Controls	Form of Assurance	Level	Gaps in Assurance	C	L	S	Risk level	Action Details	Due date	C	L	S	Risk level	Next Review	Status
																							Implement the expanded SDEC and acute medical models, as per the recent demand and capacity bid made to the region, which was funded. Includes 7/7 SDEC and increased AMU bedbase.	30/12/2022						
																							Progression of BHI extension business case through to delivery.	31/03/2023						
737	16/07/2014	Workforce	External	Is Currently an Issue	People Strategy	People Committee	Chief People Officer	**If** the Trust is unable to recruit sufficient numbers of substantive staff and to fill specific staff groups/occupations where there is a limited supply, **Then** continuity, effectiveness and quality of services may suffer, impacting on patient care. **Resulting in** increased reliance on other staff members and likelihood of reliance on expensive agency cover, and increased chance of 'Burnout' and a negative experience of working for UHBW.	Major	Very Likely	20	Very High Risk	A Tactical Recruitment Group is established to drive clinical recruitment across the organisation. A clinical recruitment plan is being developed to target all hard to recruit to posts and areas which will then be managed through the Tactical Recruitment Group. A dedicated D&T recruitment manager is in post to give recruitment input to roles such as Radiographers, Sonographers, Neurophysiology and Audiology, where there is a national and international shortage. International nurse recruitment programme in place.	Inadequate	Turnover in nursing remains high. The nursing vacancy position remains a challenge in areas such as Care of the Elderly, T&O, Oncology & Haematology. Ongoing challenges exist with Radiographers, Sonographers, Neurophysiology and Audiology. The Trust is dependent upon Health Education England to allocate sufficient numbers of doctors in training. The number of doctors the Trust is allocated does not correlate with optimum staffing levels. Ongoing gaps in consultant posts such as Respiratory and Acute Medicine. The Weston Division has significant vacancy rates across all clinical roles especially across the medical staff groups which is creating a significant risk with rota gaps on the junior doctor rota.	Monitoring achievement of Strategic Workforce Plan objectives though People Committee. Divisional performance is monitored monthly at Performance and Operational Reviews.	Second Line Assurance - Risk and Compliance		Major	Likely	16	Very High Risk	TRAC functionality now fully rolled out across medical recruitment and a full suite of medical KPI's introduced. Work ongoing to ensure that consultants more fully use the functionality available through TRAC.	31/12/2023	Major	Unlikely	8	High Risk	01/07/2023	Action Required Risks
																							Strategic Workforce Planning for Junior Doctors. Introduce new roles and innovative T&C's to attract new junior doctors in training.	31/12/2023						
																							Marketing & attraction – ongoing marketing plan for innovative campaigns using recruitment videos, targeted email shots, social media and recruitment microsites, all underpinned with a strong marketing brand.	31/03/2023						
																							European head hunters now being used to target hard to recruit to nursing and medical vacancies. Success being reviewed on a quarterly basis.	31/03/2023						
																							Partnership Working. Develop mutually beneficial relationships across the BNSSG healthcare economy and beyond to increase workforce supply.	31/12/2023						
2642	29/06/2018	Business	Internal	In the next 3-5 Financial Years	Estates Strategy	Audit Committee	Chief Financial Officer	**If** the Trust has restricted access to clinical areas due to operational pressures, **Then** the existing estate may not be modernised and developed in line with the aspirations of the strategic plan, **Resulting in** an environment with facilities that do not support improved efficiencies in patient care, streamlined pathways, improvements in patient experience and a deterioration in staff engagement.	Major	Very Likely	20	Very High Risk	Medium Term Financial Plan. Strategic Capital Plan and Operational Plan. Planned preventative maintenance budget. Trust Capital Group Chaired by Divisional Director, Surgery, receives monthly status reports on Capital Projects from Divisions and Assistant Director of Estates. SED Programme Board to oversee all SEDP schemes, chaired by Director of Strategy and Transformation. Financial Control Procedures, including the scheme of delegation and Standing Financial Instructions in place. Approved Five year Medium Term Capital Programme. Delivery of the capital programme, including the prioritisation and allocation of strategic capital. Delivery of the Operational plan without significant deterioration in the underlying run rate to ensure availability of strategic capital is available for future investment.	Inadequate	Restricted access to clinical areas to deliver project improvements due to operational pressures	Monthly KPI report through Divisional Board on Reactive maintenance. Prioritisation of backlog maintenance through Capital Programme Steering Group Reports from Trust Capital Group to Capital Programme Steering Group. Reports from Phase 5 Programme Board to Capital Programme Steering Group. Chairs reports from Capital Programme Steering Group to Finance Committee. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Regular Reporting to the Finance Committee and Trust Board.	Second Line Assurance - Risk and Compliance	Lack of assurance that capital expenditure controls for delegated Divisional Capital are fully effective.	Major	Possible	12	High Risk	Review of capital project team underway including updating JD's and banding	30/09/2023	Major	Unlikely	8	High Risk	01/07/2023	Action Required Risks

Q4 - Strategic Risk Register									Inherent				Controls			Assurance			Current Assessment					Target				Review	
ID	Opened	Domain	Origin	Proximity	Strategy	Assurance	Executive	Principal Risk Description	C	L	S	Risk level	Key Controls	Adequacy	Gaps in Controls	Form of Assurance	Level	Gaps in Assurance	C	L	S	Risk level	Action Details	Due date	C	L	S	Risk level	Next Review	Status
2694	13/08/2018	Workforce	Internal	In the next Financial Year	People Strategy	People Committee	Chief People Officer	**If** staff are not engaged, motivated, involved and are not positive advocates, **Then** staff turnover will be too high, **Resulting in** a negative impact on organisational turnover retention and absence as well as other workforce KPIs, an increase in Agency costs, instability in the workforce, a negative impact on staff wellbeing.	Major	Very Likely	20	Very High Risk	The People Strategy objectives and measures places staff experience at the heart of people programmes of work delivered via four pillars of: • Growing for the Future • New Ways of working • Inclusion and belonging • Looking after our people The Organisational Development strategic priorities plan and local Divisional Culture and people plan set out to improve staff engagement and workforce KPIs with a focus on: • Staff Engagement: Recognition and Performance • Wellbeing • ED&I • Leadership and Management Development Immersion of new staff values and leadership behaviours throughout 2022/23 supporting engagement and sense of belonging, impact measurement through the annual survey cycle in Quarterly people Pulse Monthly HR/OD partnership meetings in place to review all plans which are then presented to the people management group and the supporting sub groups of wellbeing and Diversity and Inclusion. Each division has a workforce committee to provide assurance on this agenda Divisional Performance reviews monitoring progress against these KPI's	Inadequate	None noted.	The annual engagement score is monitored quarterly with annual targets to improve the annual score by 2025 to 7.5 (out of 10) Quarterly update to the the people committee and the Trust Board	Second Line Assurance - Risk and Compliance	Not achieving a score in the upper quartile nationally among peer Trusts.	Major	Possible	12	High Risk	A governance review is being undertaken which will lead to the formation of a new recruitment and retention group who will provide the assurance of work programmes and support the developing aspiration of the new People Strategy	30/09/2022	Major	Unlikely	8	High Risk	01/07/2023	Action Required Risks
2741	19/09/2018	Financial	Internal	In the next 3-5 Financial Years	Research Strategy	Quality and Outcomes Committee	Chief Medical Officer	**If** financial pressures, service pressures or failure to recognise the value of research cause it to be deprioritised, **Then** the Trust will be unable to sustain research activity, **Resulting in** loss of income, reputation and ability to attract and retain highly skilled and motivated staff, a limitation of patient choice, loss of potential to offer novel and/or cutting edge treatments and inability to contribute to the evidence to improve patient care.	Moderate	Likely	12	High Risk	- Memorandum of agreement with University of Bristol. - Joint Posts and Clinical Networks. - Research Standing Operating Procedures. - Process in place for corrective and preventative actions where breaches of GCP/protocol are identified to support learning by PI/CI and research team. - Regular review of research recruitment on a trust-wide level and focus on delivery of our sponsored research. Key Performance Indicators at divisional level (bed holding only) agreed for regular divisional review. Regular review of appropriateness of KPIs within the current context/environment. - Appropriate study selection to maximise fit with patient pathways and minimise high resource use at times of clinical pressure. - Research grants, Research Capability Funding, commercial and delivery income maintained. - Close oversight and support of research delivery teams by R&I and divisions via Research Matron, with clinical line management of research teams and peer networks across the trust to support this. SPAs recognised in consultant job plans. Experienced and dedicated research teams to support delivery of clinical research. - NIHR award £12m over 5 years for Biomedical Research Centre to Trust and UoB partnership (2022 to 2027). - NIHR CRF award of £1m, commencing Sept 2022, to support early phase and experimental medicine. - Review of impacts of research and engagement with SLT, board and divisional management teams to demonstrate value of research in NHS. - Regular interaction with comms team to maintain visibility of research as part of every day business. - New post to support grant development now filled, and work ongoing to support optimisation of grant setup - Increased engagement with NMAHP staff to support them in grant development, working closely with D&T on this. - Recommendations for allocation of consultant research SPAs, now explicitly funded (wef 1/4/23) in divisions.	Adequate	None noted.	Reporting structures for divisional research committees/groups to Trust Research Group. Regular reports to divisions and the Board on KPI reviews (Trust-wide & divisional). Internal and External Audits and inspections. Process in place to identify and address poor performance within R&I Dept.	Second Line Assurance - Risk and Compliance	No clear mechanism for protecting time for non-medical PIs who do not hold funded research role recruiting to National Institute of Health Research portfolio trials not in place.	Moderate	Unlikely	6	Moderate Risk	Continue to work with our researchers, with the RDS and with trials units to encourage them to submit high quality applications to NIHR funding streams. NIHR project grants draw in Research Capability Funding. Therefore increasing the number and value of NIHR project grants will lead to an increase over time of RCF. Drawing in successful grants also increases the research activity of the trust. Review, update and adjust processes in place for grant support, award, post award and handover to setup to ensure light touch where possible, and reduce chance of single point of failure. Review current content of R&D web pages, edit and remove content as appropriate. Work with comms team to develop appropriate and useful content for new platform	31/03/2024 31/12/2023 31/03/2024	Moderate	Unlikely	6	Moderate Risk	01/07/2023	Action Required Risks

Q4 - Strategic Risk Register								Inherent				Controls		Assurance			Current Assessment					Target				Review	
ID	Opened	Domain	Origin	Proximity	Strategy	Assurance	Executive	Principal Risk Description	C	L	S	Risk level	Key Controls	Adequacy	Gaps in Controls	Form of Assurance	Level	Gaps in Assurance	C	L	S	Risk level	Action Details	Due date	C	L	S	Risk level	Next Review	Status
2992	28/12/2018	Business	Internal	In the next 3-5 Financial Years	Quality Strategy	Quality and Outcomes Committee	Executive Managing Director (Weston)	**If** sufficient priority is not given to developing the Trust's culture and the capacity and capability of staff for delivering transformation, improvement and innovation, **Then** staff in the organisation may not be able to support the scale and pace of change necessary to work in new ways and deliver the organisation's and system's strategies, **Resulting in** a partial or non-realisation of benefits, loss of reputation as an innovative organisation, poor performance, demotivation of staff, associated impact on recruitment and retention, and a reduced influence as a leader in our Local system.	Moderate	Possible	9	High Risk	Transformation, improvement and innovation strategy Transformation and improvement priorities embedded into annual Trust and Divisional operating plans. Comprehensive QI programme – QI gold provides training, coaching and mentoring for divisional teams to deliver larger transformation projects, and the transformation team support these either divisionally or cross-organisationally Regular updates on Transforming Care programme to Strategic SLT and Public Trust Board Staff engagement embedded in planning service improvement and transformation work. Transformation and other service improvement leads networked across the divisions. Working in partnership with the Academic Health Science Network to access latest training materials and external courses for enhanced training. Quality Improvement Academy established 2017 and "dosing plan" for training developed. Digital Hospital programme a priority within the Transformation programme with Digital Hospital Committee aligning actions into clinical safety and operational decisions. Transformation, Improvement and Innovation strategy approved by Trust Board, and delivery of actions reported to People Committee six monthly for assurance Commenced Patient First Programme which will address organisational culture by embedding improvement into the way we work at all levels of the organisation	Inadequate	Staff unable to be released to partake in training and/or deliver their improvements. Patient First programme year 2 (2023/24) may include some budget for backfill for staff to be released.	Reporting to Strategic Senior Leadership Team. Evidence of wide range of innovation and improvement programmes completed/underway including good response to programmes such as Bright Ideas, Trust Recognising Success awards , Quality Improvement Hub, QI annual forum and achievement of local / national awards. Audit and inspections. Quarterly summary of Transformation activity to public Trust Board Benefits realisation plans in place for all Transformation projects. Routine departmental assurance by programme management office for all digital and IM&T projects and activities reported to IM&T Management Group.	First Line Assurance - Operational	None noted.	Moderate	Possible	9	High Risk	Establish the Patient First Continuous Improvement approach. Remaining milestones: . Phase 3 strategy deployment: roll out PF to divisions from January 2023 . Phase 4 strategy deployment: roll out PF to front line staff from May 2023 . Develop roll out plan for the Patient First Improvement System for front line staff and divisional team (PFIS) Mar 2022. . Draft resource plan developed and presented to Executive Committee Dec 2022, to be discussed through 2023/24 annual planning process	31/03/2024	Moderate	Unlikely	6	Moderate Risk	01/07/2023	Action Required Risks
3115	07/03/2019	Patient Safety	Internal	Is Currently an Issue	Digital Strategy	Audit Committee, Finance and Digital Committee, Quality and Outcomes Committee	Chief Financial Officer	**If** Clinical information is held across multiple IT systems and paper record libraries **Then** clinicians may not have access to all necessary information in order to make the best decision regarding a patients care **Resulting in** imperfect treatment, potentially causing harm to a patient or delays in their care.	Major	Possible	12	High Risk	Clinicians can access digital information held in Careflow and Evolve and can request paper notes if needed The Clinical workspace brings together information from multiple systems reducing the burden of multiple logins Connecting care brings together data from primary care, GP Practices and secondary and community care providers. Medical records monitor the performance of the scanning bureau to maintain service levels Training is available on the Trust's corporate clinical IT Systems	Inadequate	The Trust requires a Medicines Management system Digital pathways need to be developed to replace paper records and support the capture and use of patient data on a patient's clinical pathway. A project to rollout a digita l outpatient pathway is underway The Trust holds has many paper records that need to be scanned into Evolve. Projects underway to improve the situation include back scanning at the Eye Hospital and Children's hospital. A project is also underway to start scanning at Weston General Hospital. The scanning process includes an unavoidable period of time when records are not viewable because they are in transit or waiting to be scanned The scanning bureau is experiencing challenges with staff retention and recruitment Clinicians can find accessing information held by other organisations challenging	None noted.	First Line Assurance - Operational	None noted.	Major	Possible	12	High Risk	Achieve national Minimum Digital Foundation target (including HIMSS L5) This requirement includes implementing Caeflow Medicines Management Converging on to single Order Coms, PACS and RIS Systems Transferring Paper Record to Evolve Electronic Document Management	29/03/2024	Major	Rare	4	Moderate Risk	01/07/2023	Action Required Risks
3472	30/10/2019	Environmental	External	In the next 3-5 Financial Years	Sustainability Strategy	Audit Committee	Chief Financial Officer	**If** the Trust fails to educate and drive changes in how we deliver our services, in the behaviour and the ways of working of staff, contractors and in the supply chain, **Then** the Trust may fail to meet its commitments under the Sustainable Development Strategy, **Resulting in** an inability to contribute to making a positive impact on combatting climate change and the associated environmental, health, financial, regulatory and reputational impacts.	Catastrophic	Possible	15	Very High Risk	Sustainability Strategy approved at Trust Board in September 2019. Sustainability Plan in place to support delivery of strategy objectives. A Sustainable Development Board with supporting governance structure and work streams to oversee delivery of the Sustainable Strategy has been approved by SLT and meets quarterly Sustainability team established Sustainability Implementation Group responsible for leading the Trust's work to become more sustainable; socially, environmentally and economically, across all areas.	Inadequate	Until such time as the carbon neutrality target is delivered there will always be a risk that it will not be delivered as no one has control of future events. Therefore it will require an adaptive response to the changing climate emergency and mitigation will change over the period of delivery of the strategy. Carbon neutrality is not currently embedded in Trust decision making. Business cases do not consider net zero carbon target. Every procurement from 1st April 2022 is required to have minimum 10% social value/net zero weighting in scoring this is not currently controlled. Trust is required to have a Green Plan - this is currently achieved through the sustainable development strategy but is required to be updated into the green plan format and aligned with the ICS green plan.	Reports to SLT and Trust Board.	Second Line Assurance - Risk and Compliance	Carbon neutrality is not currently embedded in Trust decision making. Business cases do not consider net zero carbon target. Every procurement from 1st April 2022 is required to have minimum 10% social value/net zero weighting in scoring this is not currently controlled. Trust is required to have a Green Plan - this is currently achieved through the sustainable development strategy but is required to be updated into the green plan format and aligned with the ICS green plan.	Catastrophic	Unlikely	10	High Risk	Identify ways to embed carbon neutrality in Trust decision making Working with purchasing consortium to bring social value 10% weighting requirements into all tenders	31/07/2023 30/06/2023	Catastrophic	Rare	5	Moderate Risk	01/07/2023	Action Required Risks
3763	25/02/2020	Statutory	Internal	Is Currently an Issue		Audit Committee, Quality and Outcomes Committee	Chief Nurse & Midwife	**If** the Trust is unable to meet the quality and safety requirements set out in CQC Regulations **Then** the CQC may determine that the Trust is in breach of regulatory requirements **Resulting in** new regulatory or enforcement action by the CQC.	Major	Very Likely	20	Very High Risk	Robust corporate quality and performance reporting to Board level. Consolidated CQC action plan to address outstanding inspection actions, with accompanying governance framework agreed by SLT/QOC. Clinical accreditation programme. Ongoing monitoring of compliance with CQC Regulations, including through self-assessment. CQC engagement in various forms including direct monitoring visits.	Inadequate	Outstanding actions relate to: - closing actions from previous CQC inspections - seeking lifting of Section 31 Enforcement Notice at Weston - addressing concerns raised by CQC in respect of clinical genetics accommodation at StMH - planning for future inspection readiness, incorporating new CQC regulatory framework The Clinical Accreditation Programme requires resource to effectively deliver its objectives and sustain the increasing volume of assessments. There is insufficient clinical operational resource and administrative resource identified to sustain the programme.	None noted.		None noted.	Major	Possible	12	High Risk	To introduce the principles of the new CQC Inspection Framework, initially through the self-assessment programme.	31/12/2023	Major	Unlikely	8	High Risk	01/07/2023	Action Required Risks

Q4 - Strategic Risk Register								Inherent				Controls		Assurance			Current Assessment					Target				Review	
ID	Opened	Domain	Origin	Proximity	Strategy	Assurance	Executive	Principal Risk Description	C	L	S	Risk level	Key Controls	Adequacy	Gaps in Controls	Form of Assurance	Level	Gaps in Assurance	C	L	S	Risk level	Action Details	Due date	C	L	S	Risk level	Next Review	Status
5032	12/02/2021	Statutory	Internal	Is Currently an Issue	Quality Strategy	Quality and Outcomes Committee	Chief Nurse & Midwife	**If** additional funding or sufficiently skilled and experienced staff are not available to implement key patient safety roles, **Then** the Trust may be unable to support changes in culture, processes and practices associated with the implementation of the national patient safety strategy, **Resulting in** continuation of repeated occurrences of similar incidents, missed opportunities to reduce harm to patients, subsequent clinical negligence claims, potential regulatory action and a lack of a consistent just and restorative culture throughout the Trust negatively impacting on staff engagement and well-being.	Major	Very Likely	20	Very High Risk	There is some existing limited resource for managing patient safety in divisions and in the THQ team but this is insufficient to deliver on the new national requirements which include seniority and new comprehensive training requirements for expert investigators. UHBW model for responding to incidents changed to include a core team of expert investigators with more agile local learning responses in divisions. Investment in staff to support this new model secured and posts recruited to but some new staff yet to start. Patient Safety Partners recruited and inducted and are being supported to deliver their role. LFPSE compliant version of DatixWeb in test system and signed off by the national team, but needs further update before being suitable for deployment.	Inadequate	This is a Trust wide risk. Non-delivery is not an option The background information in this risk outlines the significant changes that need to be put in place across UHBW for which there is no existing resource.	Patient Safety Partners in place and being supported to carry out their role. Central Patient Safety Investigation Team in place, transfer to PSIRF completed, Board approved Patient Safety Incident Response Plan being implemented. UHBW incident management system (Datix) upgraded, reconfigured and integrated with national Learning from Patient Safety Events (LFPSE) system. Patient Safety Culture: NRLS benchmarking 2021/22 shows UHBW in top quartile indicating an open reporting culture. This national reporting will cease after March 2023.	First Line Assurance - Operational	Patient Safety Culture: responses to national Staff Survey questions about treating people fairly following an incident 2022/23 onwards (questions omitted in survey for 2021/22). Future safety culture/climate surveys. No more than a 15% drop in incident reporting numbers for no longer than 3 months on transfer to a LFPSE integrated version of Datix. Future reporting to the Board against PSIRF standards, progress against PSIRP and improvement work arising from insights from incident learning responses.	Major	Likely	16	Very High Risk	Publish UHBW's Patient Safety Incident Response Plan that will deliver the requirements of the national PS strategy. Work with the Datix/Risk team to redesign the incident reporting system to support PSIRF Deliver assigned elements of stakeholder communications plan for project	30/04/2023 30/04/2023 30/04/2023	Moderate	Unlikely	6	Moderate Risk	01/07/2023	Action Required Risks
5317	15/06/2021	Business	External	In the next Financial Year	Trust Strategy	Audit Committee	Executive Managing Director (Weston)	**If** a conflict arises between the objectives and plans of the ICS and those of the Trust, **Then** the Trust may have a limited ability to make some investment and service funding decisions, **Resulting in** non-achievement of the Trust's Strategy in relation to delivery of specialised and tertiary services, the service mix not being optimal and impacting on the quality of care and recruitment and retention of staff and potential non-compliance with regulatory standards such as CQC and JAG accreditation.	Major	Very Likely	20	Very High Risk	Chief Executive is a member of the Healthier Together Chief Execs Group who are directly involved in shaping the ICS for BNSSG. The Trust is a member of a number of System working groups where ICS development is influenced. BNSSG System is developing an ICS development plan. Members of the Trust are involved in these workshops and are SROs for various aspects of the plan. Trust Chair is a member of the shadow ICS partnership Board. As a subset of this plan, UHBW & NBT have formed a 'provider collaborative' as part of the wider ICS. Adopting an approach of pro-active planning and willingness to show flexibility with regard to emerging national picture, based on the assumption that guidance won't change significantly for Acute providers and that there is likely to be a good degree of latitude in terms of how local Systems manage the delivery. Responsive process to ensure appropriate governance arrangements can be put in place to underpin ICS working through the ICB and ICS Partnership Board. The BNSSG system DOFs have delivered a system prioritised 5 year capital plan to NHSEI that is compliant with NHSEI's Capital Department Expenditure Limit (CDEL).	Inadequate	None noted.	Board reporting vis the Healthier Together Update Report and via the CEO Update. Board Seminar on the development of the system MoU - June 2021	Second Line Assurance - Risk and Compliance	Final ICS outcomes and current objectives remain to be finalised in 2022/23. Tertiary services commissioning structures to be defined.	Major	Possible	12	High Risk	As a core planning group we have been reflecting on the 22/23 planning round. There are some issues arising from that that we would wish to put forward to the system to influence future planning rounds, and equally some considerations for us as Trust moving forward on how we conduct business planning in the 'new world'. This is currently a work in progress.	30/11/2022	Major	Rare	4	Moderate Risk	01/07/2023	Action Required Risks

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**Review of PHSO complaints**
Report Author	**Tanya Tofts, Head of Complaints**
Executive Lead	**Deirdre Fowler, Chief Nurse & Midwife**

1. Purpose

The purpose of this report is to provide the Board with a summary of the outcome of UHBW complaints referred to the Parliamentary and Health Service Ombudsman (PHSO) since April 2020 and how the Trust has performed in comparison with national data.

2. Key points to note *(Including any previous decisions taken)*

- The PHSO was set up by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS in England.

- Upon receipt of a complaint from a member of the public, the PHSO will initially decide whether the complaint warrants further investigation. Following an initial review of the complaint file and relevant patient records, they will either decide that no further action is required, or they will commence a detailed investigation, which will result in the complaint being either upheld, partly upheld, or not upheld.

- Since April 2020, the PHSO has carried out either preliminary or detailed investigations of 26 UHBW complaints, of which:

  - None have been upheld
  - Four have been partly upheld
  - 21 have been recorded as not upheld or 'no further action'.

- The PHSO has not upheld or partly upheld a single complaint about UHBW where the trust was first notified of PHSO interest during the past two years. However, four complaints were partly upheld in the year 2020/21 and details of these cases are included in this report.

- The comparative data included in the attached report shows that the percentage of cases upheld or partly upheld is lower for UHBW than for comparable acute trusts nationally.

- Whilst the data reflects that UHBW has good complaints processes, policies and standard operating procedures in place, there is still work to be done in respect of learning and culture.

3. Strategic Alignment

Aligns with the Trust's Patient First strategic priority to eliminate poor experience of care.
4. Risks and Opportunities
Reputational risk relating to upheld cases. Opportunities for learning from independent review.
5. Recommendation
This report is for Assurance.
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**
N/A

The role of the PHSO

The role of the Parliamentary & Health Service Ombudsman (PHSO) is to make final decisions on complaints that have not been resolved by the NHS in England, UK government departments and other public organisations. This is done fairly and independently, without taking sides, and is free of charge.

From May 2023, the PHSO has changed the way they handle complaints about the NHS, having reviewed the approach taken during the Covid-19 pandemic and embedding that into their process. They therefore will now only look further into the more serious complaints, in order to prioritise cases where people have suffered a significant injustice, and to bring them in line with the other Ombudsman services in the UK. Due to a backlog of cases, they have also advised that it is currently taking them around six months to even look at new NHS complaints they receive from members of the public.

In 2020, the PHSO produced a report entitled 'Making Complaints Count', focussing specifically on the NHS complaints process. The findings from this research led the PHSO to introduce a new 'Complaint Standards Framework,' to provide consistency and support to frontline staff, as well as assisting senior leaders to promote a positive culture of learning from complaints. It also provides the basis for a central training platform for staff, to give them the support and development they need, and to recognise that handling and resolving complaints is a professional skill. The four key standards are explained below.

Promoting a learning and improvement culture
An effective complaint system demonstrates its commitment to promoting a just and learning culture that is open and accountable when mistakes occur. It uses learning to improve its services. It makes sure every member of staff knows their role in promoting a 'learning from complaints' culture. It puts in place clear ways to demonstrate how the organisation uses learning to improve

Positively seeking feedback
An effective complaint system goes out of its way to create a positive environment in which complaints are welcomed and resolved at the earliest opportunity. People know how to complain and can do this easily and without fear that it will affect their care. People have confidence that their complaint will be taken seriously, will be looked at with empathy and will be answered as quickly as possible.

Being thorough and fair
An effective complaint system makes sure staff take a thorough, proportionate, and balanced look into the issues raised by a complaint, and makes sure people get a fair and open answer to their questions based on the facts and takes full accountability for mistakes identified.

Giving fair and accountable decisions
An effective complaint system makes sure organisations enable staff to give a fair and balanced account of what happened and what conclusions they reached on every complaint. When appropriate, organisations openly identify times when things have gone wrong, or services have had an unfair impact and take accountability for these. Organisations ensure staff can offer a range of ways to put things right for the individual. Staff also look at what action will be taken to learn from the experience to continuously improve services and help support staff.

UHBW Performance
Whilst University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) largely conforms with the PHSO standards mentioned above, through its written policies, standard operating procedures and processes, there is still work to do to embed this in practice across all divisions and all staff tasked with managing and responding to complaints.

Referral of UHBW complaints to the PHSO – 2020 to 2023
For the purposes of this report, and in order to provide the most up to date information available, a review has been undertaken of all complaints in which the PHSO has notified the Trust of their interest in a complaint from 1 April 2020 to 31 March 2023. All data is based on the date on which the PHSO first notified the trust of its interest in a case.

During this three-year period, UHBW has been notified of PHSO interest in 26 complaints as follows:

- 2020/21 - nine
- 2021/22 - seven
- 2022/23 - 10
- 2023/24 - at the time of this report, no cases

Of the 26 cases where the PHSO notified the trust of its interest over the last three years, none were Upheld, four were Partly Upheld, one was Not Upheld and 16 were closed with the PHSO outcome of No Further Action. This latter outcome is given to cases where the Ombudsman requested further information from the trust, usually in the form of a copies of the complaint file and the patient's medical records, and then decided that a full investigation was not necessary. There is also one where the PHSO's Early Response Team asked the trust to make an ex-gratia payment of £100 to the complainant and a full investigation was avoided. This was agreed by the trust and the complainant.

The remaining four cases are pending an outcome from the PHSO – the Trust was notified of PHSO interest in all four of these cases in 2022/23.

Comparison of UHBW performance with national data 2019 to 2021
It is important for the trust to concentrate not on the number of cases *referred* to the Ombudsman, but on the learning from those which are upheld or partly upheld. As UHBW has low numbers of these (four cases in three years), it does mean that it is difficult to identify trends and themes.

In order to provide some context for UHBW's performance, it is helpful to look at how the trust compares with other acute hospital trusts in England. As this data is only available from the PHSO for 2019/20 and 2020/21, data for these two years is included in Table 1 below, so that a direct comparison can be made. This also clearly shows how the Covid-19 pandemic impacted on the number of complaints investigated in 2020/21 compared with the previous year.

The Trust has not had a single case either upheld or partly upheld by the PHSO in the last two years since this data was published, based on the date on which the trust was first notified of the PHSO's interest in the case..

Table 1: PHSO Investigations

Trust	No. of complaints investigated by PHSO	Upheld	Partly Upheld	Not Upheld / No Further Action	Upheld/Partly Upheld Rate
University Hospitals Bristol & Weston Foundation Trust 2019/20	15	1	0	14	6.7%
All Acute Trusts (England) 2019/20	722	51	340	331	54.2%
University Hospitals Bristol & Weston Foundation Trust 2020/21	9	0	4	5	44.4%
All Acute Trusts (England) 2020/21	308	38	156	114	63%

UHBW cases Upheld/Partly Upheld by the PHSO
A breakdown of the four cases that were partly upheld by the Ombudsman in the last three years (all of which fell within the 2020/21 reporting year) is shown in Table 2 below. The cases were from four different divisions.

Table 2: Upheld/Partly Upheld cases

Failings identified	Recommendations made	Learning
Case 1 - 2020/21 • Failure to plan surgery within the recommended	• Trust to acknowledge its failure to meet NICE guidelines.	Since this patient's admission, UHBW has made improvements to the service to ensure that patients who suffer from cholecystitis (symptomatic gallbladder)

timescale on two occasions. • Failure to carry out a full surgical assessment in line with NICE guidelines. • Failure to follow up patient as an outpatient in line with NICE guidelines.	• Trust to apologise to patient's husband for the missed opportunity for surgery and the distress and uncertainty this caused. • Trust to review why the failings occurred and produce an action plan to prevent a recurrence.	are provided with better opportunities for surgery. This approach includes ring-fencing seven surgical theatres slots per week on day case theatre lists to ensure that patients receive treatment within clinically acceptable timeframes. This capacity will have ongoing review to ensure that it is meeting the demand for acute surgery.
Case 2 - 2020/21 • Failings in advice given to ambulance crew by midwife, stating that patient could make her own way to hospital. • Paperwork relating to the advice given by the midwife was insufficiently completed, lacking clear details of who gave the advice and their role. Sections of the paperwork, including the time of the call, were not completed.	• Trust to acknowledge failings identified in advice given by midwife, take responsibility for these failings, and apologise to the patient. • Trust to consider why the failings occurred in the advice given to the ambulance crew and produce an action plan detailing actions taken/to be taken to avoid a repeat of these failings. • Trust to make financial redress in the sum of £500 in recognition of the distress experienced by the patient.	As a result of this complaint, a new telephone triage system was introduced by the midwives, with a dedicated midwife on each shift to take calls from patients and ambulance crews. The maternity unit also obtained funding to open a new triage area away from the delivery suite, with a dedicated telephone triage area.
Case 3 - 2020/21 • Failings in communication with family during end-of-life care • Whilst the PHSO did not find any failings in respect of the patient's care or treatment, they did find that staff failed to notify the patient's daughter early enough for her to say goodbye and be with her mother when she passed away.	• Trust to write to the complainant to acknowledge that staff should have contacted her sooner when the patient's condition changed. • Trust to produce an action plan confirming what it will do to ensure families are kept informed in a timely manner.	A Safety Brief was produced in respect of timely contact of patients' relatives. In addition, staff were instructed to speak to patients and their families about the patient's wishes, including who should be contacted in an emergency, and for this to be recorded in the patients' notes. A review of the handover process was also carried out by the Ward Sister, to ensure vital information such as patients' and families' wishes are included in all handovers.
Case 4 - 2020/21 • Failings in communication with complainant when responding to complaint. • Whilst the PHSO did not find that anything went wrong with the patient's surgery, they did find that the Trust provided conflicting information in its complaint responses and got some of its facts wrong, which led to a loss of faith in the answers provided and left the complainant feeling that she was not being taken seriously.	• Trust to send a letter of apology to the complainant, acknowledging the failings identified and apologising for the impact this had. • Trust to make financial redress in the sum of £300 in recognition of the loss of faith caused by the inconsistencies and inaccuracies in its complaints responses.	A review was carried out into how the trust shares clinical advice in its complaint responses when there are opinions/advice from more than one clinician. In these cases, a clear explanation is to be included in the response to make this clear and to confirm that the two clinicians have discussed this with each other. In this particular case, the complaint was managed across two divisions, with statements provided by clinicians from both. It later transpired that, although the clinicians from each division did liaise with each other at all stages, this was not adequately explained in the letter of response, which led to confusion for the complainant.

Prior to agreeing to review a case, the PHSO will ask the trust whether all attempts at local resolution have been exhausted, i.e. whether the trust has done everything possible to resolve the complaint directly with the complainant. In the majority of cases, the complainant will therefore have gone through the dissatisfied process, whereby further attempts are made by the trust to resolve any outstanding issues or concerns. Further (dissatisfied) responses were sent in respect of two of the four cases in Table 2 above. One of the cases was received by Weston Area Health Trust prior to the merger with University Hospitals Bristol and no further responses appear to have been offered following an initial meeting with the complainant and, in the remaining case, further investigation was offered by the trust, but the complainant wished to go straight to the PHSO to ask them to review her complaint.

Assurance
As reported to the Quality & Outcomes Committee (QOC) in December last year, the Board is asked to note the following:

- The Trust's complaints processes meet The Parliamentary & Health Service Ombudsman's NHS Complaints Standards and their recently published 'Model Complaints Handling Procedure for NHS Services in England.' However, there is still work to do in terms of learning and culture Trustwide.

- The Trust's complaint processes meet the Patients' Association 'Good Practice Standards for NHS Complaints Handling.'

- The Trust's Complaints Policy and its processes have recently been under the close scrutiny of Niche Health & Social Care Consulting during its review and subsequent report on the 'Baby J' case. Niche approved of and were complimentary about, the complaints processes in place; their recommendations in respect of the Complaints Policy have now been implemented and the policy is progressing through the Trust's approval and sign-off process via the relevant committees/groups.

- The Standard Operating Procedure (SOP) for divisional approval of complaints, states that all formal complaint responses must be approved by one of the divisional triumvirates before being forwarded to PSCT and onwards to the Executive Team.

Looking forward

- The focus for 2023/24 is on upskilling and training relevant divisional personnel on complaints handling and associated learning to avoid repetition of previous mistakes and to ensure staff are working in line with the PHSO's model complaints handling guidelines.

- All complaint response letters returned by Executives with amendments required, to be checked by the Head of Complaints to identify any errors/issues that should have been picked up by PSCT caseworker. Any issues, patterns, gaps in training to be monitored and individual caseworkers held to account in respect of repeated mistakes/failure to improve performance.

- Complaints review panels with divisions will continue, focusing on potential learning from dissatisfied complaints, with the aim of further limiting the number of complainants finding it necessary to take their complaints to the PHSO.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Trust Board of Directors in public – 23 May 2023

Reporting Committee	**Quality and Outcomes Committee**
Chaired By	**Marc Griffiths, Non-Executive Director**
Executive Lead	**Jane Farrell, Interim Chief Operating Officer** **Deirdre Fowler, Chief Nurse and Midwife** **Stuart Walker, Chef Medical Officer**

For Information

Quarterly Infection Control Report – the committee received the quarterly report. It was reported that the Quality and Compliance team had undertaken work with Theatres in readiness for the upcoming CQC monitoring visit of which further details would be confirmed later that today. The concerns regarding the Heygroves Theatre were also discussed and it was confirmed that there was a long term solution in train.

Strategic emerging risks and issues – it was reported that the BMA Junior doctors committee had added new strike dates from 14th to 16th June for 72 hours which would repeat on monthly basis. Mediation attempts had failed to find a solution to date. It was also noted that WHO and NHSE have downgraded the Covid Pandemic and had to start giving evidence to the public Covid enquiry.

Maternity Services – the committee noted that the Trust declared compliance with CNST standards and Saving Babies Lives audits. The ventilation issues on Level E of St. Michael's Hospital, and the impact this had on staff and patients, was discussed. The potential for an upcoming CQC inspection of maternity services was also discussed and it was confirmed that work was already underway in respect of this.

Performance Report – the following operational points were highlighted:

- At the end of April 2023, there were no patients waiting over 104+ weeks. The Trust continues to maintain zero 104-week Referral to Treatment (RTT) breaches.
- During April, industrial action contributed towards a deterioration in the Trust position and at the end of April 2023, there were 182 patients waiting longer than 78 weeks.
- During April, there has been a deterioration in the number of patients waiting over 62 days on a cancer pathway. March had seen an improvement, with the Trust reporting 178 patients waiting 62 days or more, against the Cancer Alliance defined baseline of 180 patients, but by the end of April this had increased to 218 patients due to the impact of industrial action.

Reports for assurance - the following reports were received for assurance:

- Quarterly Thematic Patient Safety Report
- Patient Safety Incident Investigation
- Monthly Nurse Safe Staffing Report
- Medicines and Healthcare products Regulatory Agency (MHRA) Updates in respect of blood transfusions, medical devices and medicine.

University Hospitals Bristol and Weston NHS Foundation Trust

Key Decisions and Actions	
Quality Strategy and Annual Quality Account – The committee received an update on the Quality Strategy 2021-2025 as it reached its midpoint. This was one of the seven enabling strategies underpinning the Trust's current 2020-2025 strategy. It was reported that progress had been made it respect of 77% of the existing priorities, and three new goals have been added to the Quality Strategy as part of the mid-term refresh. Two goals – Implementation of clinical accreditation, and agreement of a new Health Equity Delivery Plan for 2023-2025 – have been added retrospectively in recognition of their significance to the quality agenda, whilst the development of a dedicated Experience of Care Strategy (due 2024) has been added as third new objective. The committee also received the Annual Quality Account and endorsed it prior to its submission to the Trust Board for approval in June.	
Date of next meeting:	**27th June 2023**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15th June 2023

Report Title	**Performance Report**
Report Author	**David Markwick, Director of Performance** **Philip Kiely/Lucy Parsons, Deputy Chief Operating Officers** **James Rabbitts, Head of Performance Reporting** **Anne Reader/Julie Crawford, Head/Deputy Head of Quality (Patient Safety)** **Alex Nestor, Deputy Director of Workforce Development** **Kate Herrick, Head of Finance**
Executive Lead	**Overview and Access – Jane Farrell, Chief Operating Officer** **Quality – Deirdre Fowler, Chief Nurse and Midwife/Stuart Walker, Chief Medical Officer** **Workforce – Emma Wood, Chief People Officer** **Finance – Neil Kemsley, Chief Financial Officer**

1. Purpose	
To provide an overview of the Trust's performance on quality, access and workforce standards.	
2. Key points to note *(Including any previous decisions taken)*	
Please refer to Executive Summary	
3. Strategic Alignment	
This report aligns to the objectives in the domains of "Quality and Safety", "Our People", "Timely Care" and "Financial Performance".	
4. Risks and Opportunities	
Risks are listed in the report against each performance area and in a summary.	
5. Recommendation	
This report is for Assurance	
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**	
Quality and Outcomes Committee	Tuesday 23 May 2023

University Hospitals Bristol and Weston NHS Foundation Trust

Performance Report

May 2023

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

INTRODUCTION

This report provides a monthly update of the key performance metrics within the NHS Oversight Framework for 2023/24 and the Trust Leadership priorities. Further information within the full Integrated Quality and Performance Report (IQPR) is available in the reading room to provide additional background detail if required.

Performance Report

Reporting Month: April 2023

EXECUTIVE SUMMARY

Quality and Safety

The Summary Hospital Mortality Indicator for UHBW for the 12 months January to December 2022 was 100.4 and in NHS Digital's "as expected" category. This is slightly above the overall national SHMI of 100 for our peer group of English NHS trusts.

In Infection Control, there were twelve hospital attributable C.difficile cases in April. The 2023/24 target is to have no more than eight per month. In addition, there was one Trust apportioned MRSA case in April. Contributory factors to C.difficile cases include poor prescribing practice of antibiotics (not within guidelines / protocols), compromised cleaning standards (including commodes and sluices if inadequately cleaned) or linked ribotyping of cases in a single geographical location. Ribotyping is a molecular technique for bacterial identification. All positive samples are sent for specialist ribotyping. Very few of the ribotyping results reveal causation linked to location.

For MRSA (and MSSA) infections, observationally the learning is that practice in cannula care could be improved in terms of skin cleaning and insertion records, use of correct resources, and ongoing care (including robust recording and at least twice cannula checks) with the priority being to remove the cannula if no longer required. Intravenous (IV) line care is not the sole causation for MRSA or MSSA bacteraemia's occurring in hospital, but is a significant risk.

April VTE risk assessment compliance remains relatively static at 82% but remains below expected level of 90-95%. As part of preparation for the implementation of the Careflow Medicines Management (CMM) electronic prescribing system, options for electronic VTE risk assessment are being reviewed.

In April, there were 56 Fracture Neck Of Femur (NOF) patients. Of these 54% of patients had surgery within 36 hours and 43% received an Ortho-geriatrician assessment within 72 hours. This is below the 90% standard for both metrics. There is continued difficulty in time to theatre in Bristol driven by the increase in demand for general trauma. There is difficulty in increasing theatre capacity whilst maintaining cancer theatre capacity.

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

EXECUTIVE SUMMARY

Our People

The vacancy position has reduced again to 4.2%. In addition, there has been a further reduction in the Registered Nursing and Midwifery vacancy rate, given the changes to establishment for various service changes during the year, these figures will be validated in next month's report. However, UHBW continues to have a healthy pipeline of Internationally Educated Nurses (IENs) joining the Trust over the next six months. The significant vacancy at band 2 and over-establishment at band 3 are due to the movement of healthcare support workers from band 2 to band 3. Staff have been moved but the funded establishment has not been transferred in the finance ledger yet. This work has been incorporated into budget setting for 2023/24 but has not yet been actioned for month 1. The combined (band 2 and 3) picture is unaffected.

Turnover for the 12-month period reduced to 14.2% compared to 14.6% (updated figures) for the previous month. Seven divisions saw a reduction whilst one division remained static in turnover in comparison to the previous month. The largest divisional reduction was seen within Weston General Hospital, where turnover reduced by 1.1 percentage points to 12.4% compared with 13.5% the previous month. Work is taking place to reduce turnover is supporting the uptake of Leaver's Feedback Conversations, which has increased following the re-launch of the leavers process. This process is now being adapted to include 'stay' conversations.

Sickness absence has decreased across all staff groups following the seasonal variation of the last couple of months and is now at 4.1%.

Overall appraisal compliance is at 75.7%, compared to 76.8% in the previous month, and there is a programme of work to improve the quality of appraisals conversations and a revised target of 81% for the new financial year for divisions to meet.

Mandatory training levels have remained static but are close to the 90% target at 88.9% compliance.

Agency usage has reduced further to 1.7%. Bank usage at month one is at 6%, a reduction from 6.1% in the previous month.

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

EXECUTIVE SUMMARY

Timely Care

At the end of April 2023, there were no patients waiting over 104+ weeks. The Trust continues to maintain zero 104 week Referral To Treatment (RTT) breaches.

At the end of March 2023, there were 165 patients waiting longer than 78 weeks, against the operating plan trajectory of 497. During April, industrial action contributed towards a deterioration in the Trust position and at the end of April 2023, there were 182 patients waiting longer than 78 weeks.

At the end of April 2023, 1,549 patients were waiting 65+ weeks against the operating plan trajectory of 1,950. As part of the 2023/24 Annual Planning Process (APP), clinical divisions are developing plans to move towards the national ambition of patient waiting longer than 65 weeks by end of March 2024.

During April, there has been a deterioration in the number of patients waiting over 62 days on a cancer pathway. March had seen an improvement, with the Trust reporting 178 patients waiting 62 days or more, against the Cancer Alliance defined baseline of 180 patients, but by the end of April this had increased to 218 patients due to the impact of industrial action. It is anticipated that this will recover by the end of June.

During April, 70.7% of attendances spent less than 4 hours in the Emergency Department (ED), from arrival to discharge or admission. This is the highest reported position since May 2021.

72% of ambulance handovers were in excess of 15 minutes, compared to 78% in March, 80% in February and 83% in January. A range of initiatives are being progressed across adult services to reduce overcrowding, ambulance queueing and long waits including expansion of Same Day Emergency Care (SDEC) provision.

Performance Report

Reporting Month: April 2023

EXECUTIVE SUMMARY

Financial Position

At the end of April there is a net I&E deficit of £3,949k against a deficit plan (excluding technical items) of £2,261k. Total operating income is £740k adverse to plan due to higher than planned income from activities of £305k and lower than planned other operating income of £1,045k. Operating expenses are £1,625k adverse to plan primarily due to higher non-pay expenditure. Pay and depreciation are broadly in line with plan. Technical and financing items are £410k favourable to plan.

The key issues underlying the financial position are recurrent savings delivery below plan – Trust-led CIP delivery is £827k or 55% of plan of which recurrent savings are £198k, 13% of plan. Failure to achieve the annual target of £27m (including transformational savings) in full may result in the Trust failing to meet the financial plan. Delivery of elective activity recovery below plan – elective activity must be delivered in line with plan. Failure to do so will result in a loss of income of up to c£30m which may result in the Trust not achieving its financial plan. Corporate mitigations not delivered in full – non-recurrent mitigations of c£25m must be achieved to support delivery of the plan. Failure to deliver the financial plan – failure to deliver the actions and therefore the financial plan will result in regulatory intervention and the risk of the Trust going into 'special measures'.

Performance Report

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

SUMMARY SCORECARD – FINANCIAL YEAR 2022/23

DOMAINS: "Quality and Safety" and "Our People"

			Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Infection Control: C.Diff Cases (Hospital Attributable)	Risks: 800 and 4651	Actual	6	8	12	13	7	9	6	13	7	5	8	6
		Trajectory	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4
Infection Control: MRSA Cases (Hospital Onset)	Risks: 800 and 4651	Actual	0	0	0	0	0	1	0	1	1	2	1	1
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Fracture NOF: Theatre Within 36 Hours		Actual	38.5%	38.8%	63.6%	60.4%	51.9%	57.1%	55.3%	56.3%	47.9%	58.8%	60.5%	56.0%
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Fracture NOF: Geriatrician Review Within 72 Hours		Actual	98.1%	69.4%	100.0%	96.2%	100.0%	97.6%	100.0%	93.8%	93.8%	66.7%	48.8%	58.0%
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
VTE Risk Assessment	Risk: 720	Actual	81.3%	81.9%	82.4%	82.5%	83.7%	83.5%	84.0%	84.9%	81.3%	85.3%	84.5%	83.5%
		Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Workforce: Agency Usage	Risk: 674	Actual	2.0%	2.1%	2.3%	2.6%	2.3%	2.2%	1.9%	2.0%	1.9%	2.0%	1.9%	1.9%
		Trajectory	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%
Workforce: Turnover	Risk: 2694	Actual	15.3%	15.3%	15.4%	15.7%	15.7%	15.7%	15.7%	15.5%	15.1%	14.9%	14.8%	14.6%
		Trajectory	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%
Workforce: Staff Sickness		Actual	6.3%	5.1%	5.6%	6.5%	5.1%	4.9%	5.4%	5.5%	6.2%	4.7%	4.6%	4.6%
		Trajectory	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%
Workforce: Staff Vacancy	Risk: 737	Actual	5.7%	8.0%	8.3%	8.4%	7.2%	7.3%	7.7%	7.4%	7.2%	6.8%	6.7%	6.4%
		Trajectory	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%

			Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Summary Hospital Level Mortality Indicator (SHMI)		Actual	99.3	100.5	99.3	98.8	100.0	100.5	100.2	99.1	99.3	97.5	98.4	100.7
		Trajectory	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Performance Report

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

SUMMARY SCORECARD – FINANCIAL YEAR 2022/23

DOMAIN: "Timely Care"

			Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Referral To Treatment 78+ Weeks	Risk: 801	Actual	944	975	926	813	756	743	763	755	877	678	471	166
		Trajectory	944	961	1,050	1,002	1,066	1,025	770	717	663	610	557	497
Referral To Treatment 104+ Weeks	Risk: 801	Actual	349	293	236	131	97	58	39	33	26	8	0	1
		Trajectory	336	281	197	182	167	138	109	87	72	50	33	29
Cancer 62+ Days	Risk: 801	Actual	179	232	237	261	416	399	381	337	326	290	201	178
		Trajectory	180	180	180	180	180	180	450	450	400	300	250	180
Cancer Treated Within 62 Days	Risk: 801	Actual	68.1%	71.3%	61.8%	69.4%	52.2%	64.9%	48.2%	46.4%	54.0%	43.1%	45.1%	67.4%
		Trajectory	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Diagnostics: Percentage Waiting Under 6 Weeks	Risk: 801	Actual	57.9%	60.1%	61.2%	63.5%	62.2%	64.5%	65.3%	68.5%	65.8%	65.9%	72.1%	74.3%
		Trajectory	58%	60%	62%	63%	65%	66%	68%	70%	71%	72%	73%	75%
Diagnostics: Number Waiting 26+ Weeks	Risk: 801	Actual	1,633	1,655	1,496	1,359	1,240	1,554	1,345	1,032	973	853	665	606
		Trajectory	1,654	1,676	1,474	1,304	1,174	1,076	901	802	743	676	613	500
Emergency Department: Percentage Spending Under 4 Hours	Risks: 910 and 4700	Actual	61.5%	61.7%	63.0%	60.1%	62.3%	62.0%	59.6%	56.2%	53.4%	63.4%	61.9%	66.9%
		Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Emergency Department: 12 Hour Trolley Waits	Risks: 910 and 4700	Actual	809	579	576	878	758	717	941	862	1,217	1,006	427	545
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Emergency Department: Handovers Over 15 Minutes	Risks: 910 and 4700	Actual	80.5%	76.0%	74.4%	82.3%	80.8%	79.4%	82.3%	81.6%	87.7%	82.7%	79.7%	77.8%
		Trajectory	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Every Minute Matters: Timely Discharges (12 Noon)	Risk: 423	Actual	22.4%	20.0%	20.6%	19.7%	21.6%	20.9%	22.3%	19.6%	21.8%	19.9%	20.7%	20.7%
		Trajectory	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%
Every Minute Matters: Discharge Lounge Use (BRI and Weston)	Risk: 423	Actual	11.2%	14.5%	16.9%	21.8%	24.7%	24.8%	21.6%	22.0%	16.6%	22.6%	22.9%	22.0%
		Trajectory												
Every Minute Matters: No Criteria To Reside Average Beds Occupied	Risk: 423	Actual	147	197	182	196	214	212	228	205	196	175	174	176
		Trajectory												

Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

SUMMARY SCORECARD – FINANCIAL YEAR 2023/24

DOMAINS: "Quality and Safety" and "Our People"

			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Infection Control: C.Diff Cases (Hospital Attributable)	Risks: 800 and 4651	Actual	12											
		Trajectory	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3
Infection Control: MRSA Cases (Hospital Onset)	Risks: 800 and 4651	Actual	1											
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Fracture NOF: Theatre Within 36 Hours		Actual	53.6%											
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Fracture NOF: Geriatrician Review Within 72 Hours		Actual	42.9%											
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
VTE Risk Assessment	Risk: 720	Actual	82.0%											
		Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Workforce: Agency Usage	Risk: 674	Actual	1.7%											
		Trajectory	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
Workforce: Turnover	Risk: 2694	Actual	14.2%											
		Trajectory	14.0%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%
Workforce: Staff Sickness		Actual	4.1%											
		Trajectory	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Workforce: Staff Vacancy	Risk: 737	Actual	4.2%											
		Trajectory	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%

			Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Summary Hospital Level Mortality Indicator (SHMI)		Actual	100.4											
		Trajectory	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Performance Report

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

SUMMARY SCORECARD – FINANCIAL YEAR 2023/24

DOMAIN: "Timely Care"

			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Referral To Treatment 78+ Weeks	Risk: 801	Actual	182											
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Referral To Treatment 65+ Weeks	Risk: 801	Actual	1,549											
		Trajectory	1,950	1,910	1,870	1,670	1,470	1,260	1,050	840	630	420	210	0
Cancer 62+ Days	Risk: 801	Actual	218											
		Trajectory	180	178	176	174	172	170	168	166	166	164	162	160
Cancer Treated Within 62 Days	Risk: 801	Actual												
		Trajectory	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Diagnostics: Percentage Waiting Under 6 Weeks	Risk: 801	Actual	71.8%											
		Trajectory	75%											85%
Diagnostics: Number Waiting 26+ Weeks	Risk: 801	Actual	358											
		Trajectory	500											tbc
Emergency Department: Percentage Spending Under 4 Hours	Risks: 910 and 4700	Actual	70.7%											
		Trajectory	61%	61%	62%	63%	64%	65%	67%	68%	70%	72%	73%	76%
Emergency Department: Percentage Spening Over 12 Hours	Risks: 910 and 4700	Actual	5.4%											
		Trajectory	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Emergency Department: Handovers Over 15 Minutes	Risks: 910 and 4700	Actual	72.0%											
		Trajectory	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Every Minute Matters: Timely Discharges (12 Noon)	Risk: 423	Actual	21.2%											
		Trajectory	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%
Every Minute Matters: Discharge Lounge Use (BRI and Weston)	Risk: 423	Actual	22.3%											
		Trajectory												
Every Minute Matters: No Criteria To Reside Average Beds Occupied	Risk: 423	Actual	159											
		Trajectory												

Performance Report

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Quarter 4 Draft Position

CORPORATE RISKS

ID	Corporate Risks, Projected Mitigation	22/23	2023/24				2024/25				2025/26				26/27
		Q4	May	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
801	NHS System Oversight Framework 2021/22	20	20			8									
2244	Long waits for Outpatient follow-up appointments	20	20	12			4								
6502	Industrial action impact on patient safety	20	20	5											
910	Patients in ED do not receive timely and effective care	16	16					6							
972	Fire Safety Regulations	16	16	16											4
2264	Delays in commencing induction of labour	16	16			4									
1035	Cancelled operations, breached performance targets	16	16		4										
856	Emotional and mental health needs of children and YP	15	15	15	8!										
5477	Nurse staffing levels	15	15	12		6									
588	Patient deterioration is not identified and responded to	15	15	15	12				5						
4700	Patients held in the ambulance bay	15	15												?
1595	Mental health patients in Adult ED for prolonged periods	12	12					8!							
422	Patients and staff experience V&A	12	12			6									
674	Agency use - national pricing caps	12	12		4										
1598	Patients suffer harm or injury from preventable falls	12	12	12			9!								
2614	Patients being cared for in extra capacity locations	10	10	6		4									
793	Staff experience work-related stress	12	9!*												
2639	Staff compliance with appraisal requirements	12	9		6										
921	Staff compliance with their Essential Training	9	9	6											
2695	Robust governance processes	9	9	6											
800	Trust operations impacted by (COVID-19) pandemic	9	9*												
4651	Covid -19 is transmitted within the Trust	9	9!*												
291	Critical IT equipment fails	8	8*												
720	VTE prevention and management	8	8			4									
3369	UoB relationship impact the quality of the teaching	8	8	4											
6145	New national guidance on HCSW duties	6	6*												

* Risk has met the target score

? Date for achievement of target score to be agreed

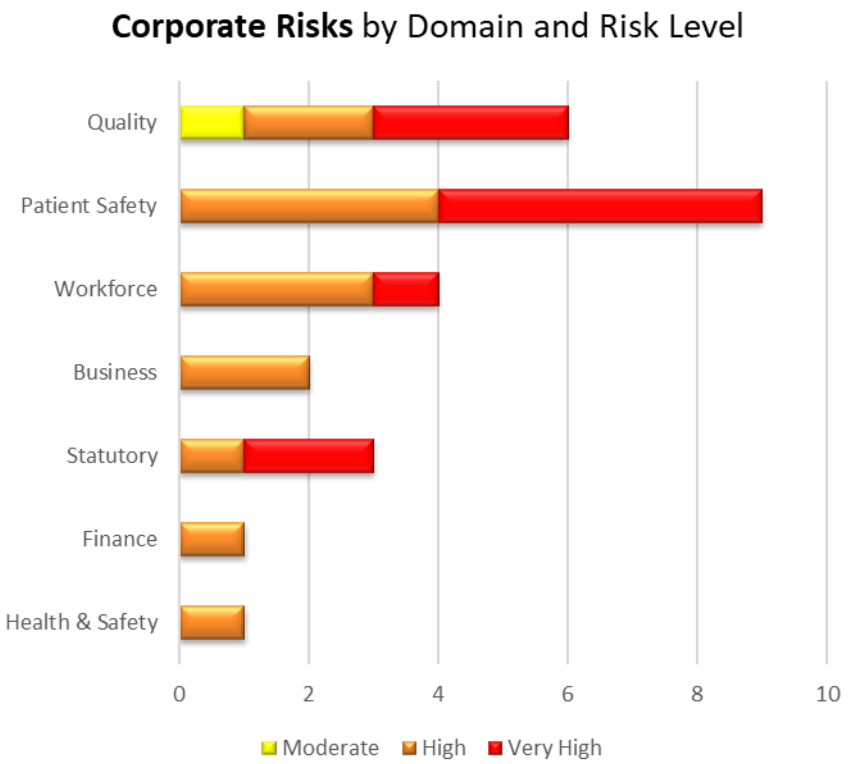
! Target score is above the tolerance level for the risk domain

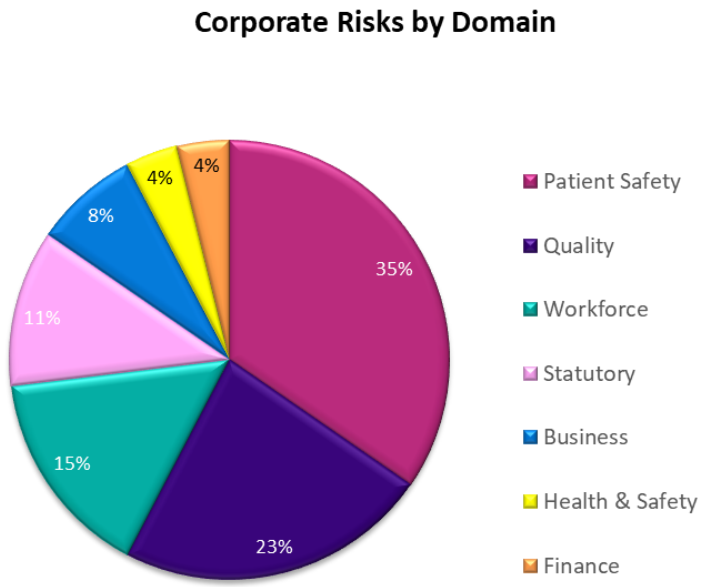
Performance Report

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Quarter 4 Draft Position

CORPORATE RISKS





Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: December 2022

STANDARD	QUALITY AND SAFETY: MORTALITY - SHMI (SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR)
Background:	Mortality indicators are used as alerts to identify something that needs closer investigation. This indicator is published nationally by NHS Digital and is six months in arrears. This data is now provided by NHS Digital as a single figure from UHBW. SHMI is derived from statistical calculations of the number of patients expected to die based on their clinical risk factors compared with the number of patients who actually died. There is no target. A SHMI of 100 indicates these two numbers are equal, but there is a national statistically acceptable range calculated by NHS Digital and a SHMI that falls within this range is "as expected".
Performance:	The Summary Hospital Mortality Indicator for UHBW for the 12 months January 2022 to December 2022 was 100.4 and in NHS Digital's "as expected" category.
National Data:	UHBW's total is slightly above the overall national peer group of English NHS trusts of 100.
Actions:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to diagnosis group level if required and investigating any identified alerts.
Risks:	tbc

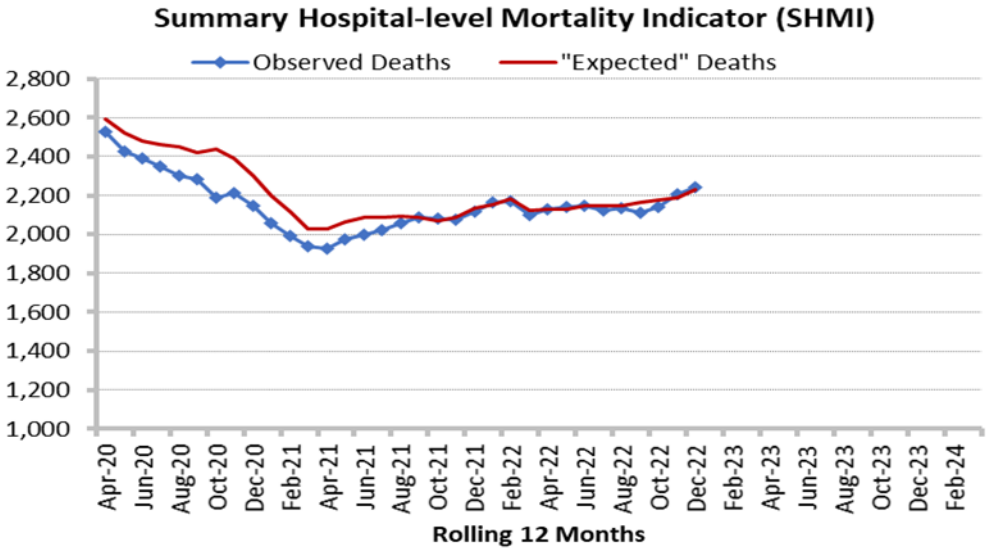
Rolling 12 Months To:	Observed Deaths	"Expected" Deaths	SHMI
Jan-22	2,165	2,155	100.5
Feb-22	2,170	2,185	99.3
Mar-22	2,100	2,125	98.8
Apr-22	2,130	2,130	100.0
May-22	2,140	2,130	100.5
Jun-22	2,150	2,145	100.2
Jul-22	2,125	2,145	99.1
Aug-22	2,135	2,150	99.3
Sep-22	2,110	2,165	97.5
Oct-22	2,140	2,175	98.4
Nov-22	2,205	2,190	100.7
Dec-22	2,240	2,230	100.4

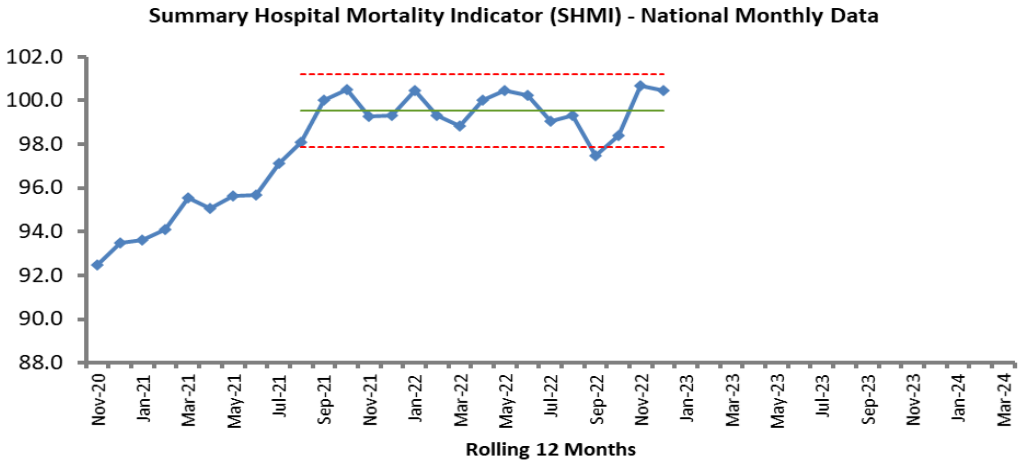
Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: December 2022

STANDARD	QUALITY AND SAFETY: MORTALITY - SHMI (SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR)





Performance Report

Reporting Month: April 2023

STANDARD	QUALITY AND SAFETY: INFECTION CONTROL– C.DIFFICILE AND MRSA
Background:	For this section there are two infections reported: C.difficile and methicillin-resistant Staphylococcus aureus (MRSA). Infections are reported in two different categories for infections associated with hospital care: 1. Hospital Onset – Healthcare Associated (HOHA). Patient is an inpatient in an acute trust and has 3 or more days between admission and a positive specimen. 2. Community Onset – Healthcare Associated (COHA). Patient returns a positive specimen within 28 days of discharge from an elective or emergency hospital admission. For C.difficile, two measures are reported: HOHA and COHA. For MRSA it is the HOHA cases only. The limit of C.difficile cases for 2023/24 as set by NHS England is 88. This limit will give a maximum monthly number of approximately 7.3 cases. For MRSA the expectation is to have zero cases.
Performance:	There have been seven Trust HOHA and five COHA C.Difficile cases reported in April 2023. Contributory factors to C. difficile cases include poor prescribing practice of antibiotics (not within guidelines / protocols), compromised cleaning standards (including commodes and sluices if inadequately cleaned) or linked ribotyping of cases in a single geographical location. All C.difficile positive samples are sent for specialist ribotyping. Very few of the ribotyping results reveal causation linked to location. There was one trust-apportioned MRSA case in April 2023.
National Data:	See next page.
Actions:	**C.Difficile** • The collaboration continues with regional NHS England colleagues focused on quality improvement. Separately the ICS are leading shared learning across provider organisations from the Trust post reviews infection reviews. A gap remains with community onset cases of C/diff to identify if specific learning points can be achieved if a patient has received ongoing care delivered by primary care services. It has been agreed to start with a single patient review, sharing resource from the ICS and providers. • Ongoing Trust sluice auditing of cleanliness standards including commodes continues with recurrent themes being address around cleaning, Actichlor plus use and information as well as the not using of 'I am clean' tape. • An investigation into the learning themes identified for 2022/2023 C.*difficile* cases was undertaken. These include patients' receiving multiple courses of antibiotics, albeit appropriately prescribed, history of gastrointestinal surgery, clinical equipment cleanliness in a few cases, poor compliance to completing the admission risk assessment on admission. There was not a causational link identified resulting in patients acquiring infection. There were five cases identified that if the stool sample had been sent in a timely manner, the cases would had been attributed as COCA. • NB: in seven of HOHA cases 2022/2023 ribotyping results indicated that the patients did not have C.difficile infection. *…continued over page*

Performance Report

Reporting Month: April 2023

STANDARD	QUALITY AND SAFETY: INFECTION CONTROL– C.DIFFICILE AND MRSA
Actions (continued):	**MRSA** • Observationally the learning is that practice in cannula care could be improved in terms of skin cleaning and insertion records, use of correct resources, and ongoing care (including robust recording and at least twice cannula checks) with the priority being to remove the cannula if no longer required. • There is the need to consider if UHBW should use a best practice approach as a Peripheral Vascular Cannula (PVC) management bundle including insertion packs, a different approach to timed skin cleansing, minimal disconnection of lines, etc. • IV line care is not the sole causation for MRSA or MSSA bacteraemia's occurring in hospital, but a significant risk. • The vascular access group continue to focus on cross divisional learning with increasing momentum building with ANTT auditing of clinical practice for line care. • Earlier in the year, an exercise in medical SDEC has seen intensive cannula and ANNT training delivered by a company with a product trial. The effect has seen improved clinical practice in cannula care. The project has now completed, and feedback will be provided summarising any gaps identified in clinical practice. • The MRSA screening guidance for the Trust has been updated and refreshed with Weston Hospital now aligning to the Bristol based sites.
Risks:	800: Risk that Trust operations are negatively impacted by (COVID-19) pandemic 4651: Risk that Covid -19 is transmitted between patients and staff within the Trust

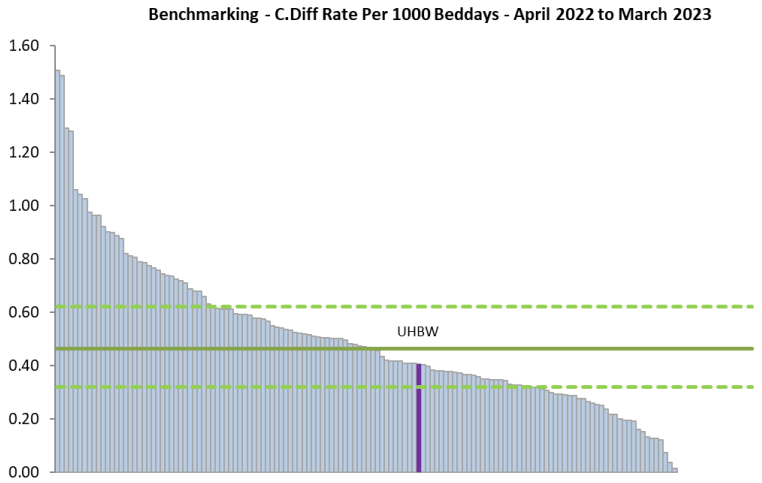
Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

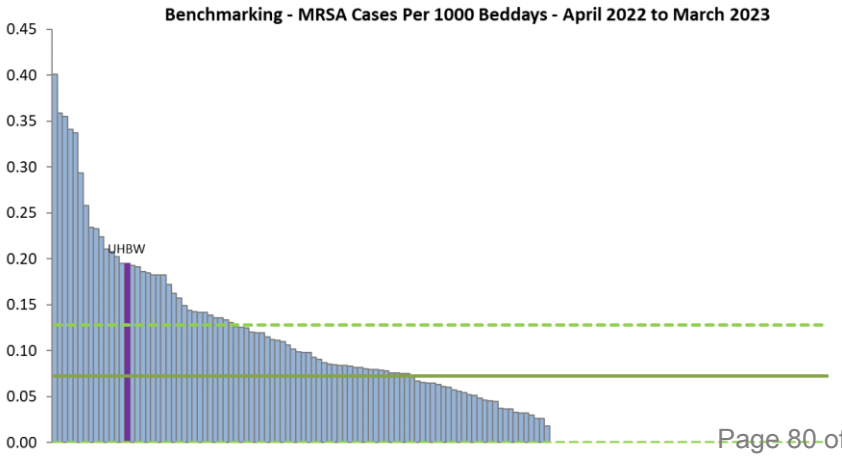
STANDARD **QUALITY AND SAFETY: INFECTION CONTROL– C.DIFFICILE AND MRSA**

	Apr-23		2023/2024		2022/2023	
	HOHA	COHA	HOHA	COHA	HOHA	COHA
Medicine	2	2	2	2	23	4
Specialised Services	1	2	1	2	8	3
Surgery	1	0	1	0	11	1
Weston	3	1	3	1	27	7
Women's and Children's	0	0	0	0	8	3
Other	0	0	0	0	1	4
UHBW TOTAL	**7**	**5**	**7**	**5**	**78**	**22**



MRSA

	Apr-23	2023/2024	2022/2023
Medicine	0	0	1
Specialised Services	0	0	1
Surgery	1	1	2
Weston	0	0	1
Women's and Children's	0	0	2
Other	0	0	0
UHBW TOTAL	**1**	**1**	**7**



Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

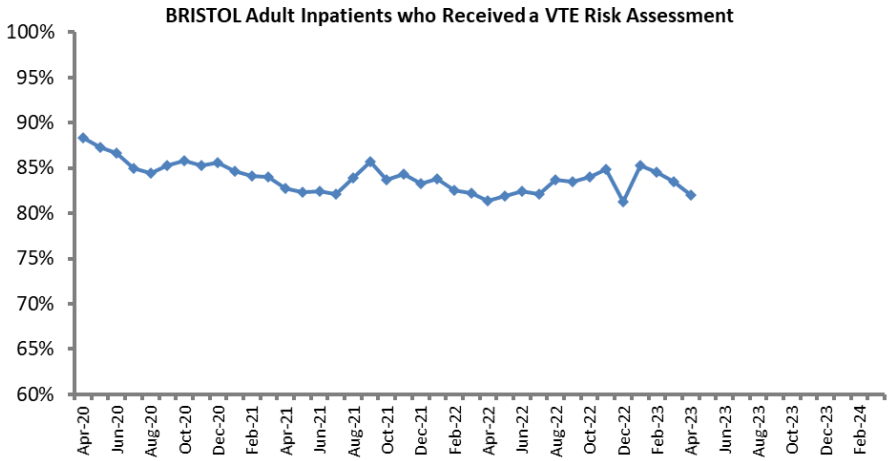
STANDARD	QUALITY AND SAFETY: VENOUS THROMBOEMBOLISM (VTE) RISK ASSESSMENT
Background:	Venous Thromboembolism (VTE) is a significant cause of mortality and disability in England. At least two-thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and the administration of appropriate thromboprophylaxis. The expectation for UHBW was to achieve 95% compliance, with an amber threshold to 90%.
Performance:	Recent VTE risk assessment compliance is 82.0% (excluding Weston due to data feed issues). Diagnostics and Therapies Division continues to be 100% compliant. Medicine, Surgery and Women's and Children's Divisions have seen a further slight reduction in compliance (change of -2.6% to 71.4%, -0.7% to 79.8% and -0.6% to 87.1% respectively). Specialised Services compliance also decreased by 0.7% to 91.9%.
Actions:	Underlying Issues: • VTE risk assessment compliance remains below expected levels. As part of preparation for the implementation of the Careflow Medicines Management (CMM) electronic prescribing system, options for electronic VTE risk assessment are being reviewed. • The VTE lead remains vacant, but creative role development to increase the chance of successful recruitment is being progressed. • The VTE metric data requires review, agreement and sign off by a VTE lead in order to align UHBW VTE risk assessment compliance data. Actions: • Ongoing discussions with digital services regarding CareFlow Medicines Management (CMM) system and the correlation with VTE Risk Assessments to support improved compliance (and safe practice) continues. Options appraisal for VTE processes within CMM will be presented to CMM Board for decision on how to progress. • VTE Lead remains vacant; plans to re-advertise. • Thematic review of historical outstanding Datix cases of HAVTE completed (April 2021-October 2022); reviews of new cases is not currently being undertaken due to VTE Lead role remaining vacant. • There is a requirement for the Trust VTE metric data (logic for the 'not at-risk cohort') to be clinically reviewed and agreed as correct for a merged Trust, prior to sign off by Medical Directors Team. Meeting with previous VTE Lead to determine next steps; action required to set up a working group to look at Day Case exclusions/defining a set of rules (cohort approach) for both sites (merged trust). Identified Clinical Lead in absence of VTE Lead required to progress this work further.
Risks:	720: Risk that VTE risk assessments are not completed

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD **QUALITY AND SAFETY: VENOUS THROMBOEMBOLISM (VTE) RISK ASSESSMENT**



Division	SubDivision	Number Risk Assessed	Total Patients	Percentage Risk Assessed
Diagnostics and Therapies	Radiology	21	21	100.0%
Diagnostics and Therapies Total		**21**	**21**	**100.0%**
Medicine	Medicine	1,972	2,762	71.4%
Medicine Total		**1,972**	**2,762**	**71.4%**
Specialised Services	BHOC	2,121	2,192	96.8%
	Cardiac	315	458	68.8%
Specialised Services Total		**2,436**	**2,650**	**91.9%**
Surgery	Anaesthetics	23	23	100.0%
	Dental Services	91	118	77.1%
	ENT & Thoracics	246	355	69.3%
	GI Surgery	901	1,126	80.0%
	Ophthalmology	274	277	98.9%
	Trauma & Orthopaedics	121	175	69.1%
Surgery Total		**1,656**	**2,074**	**79.8%**
Women's and Children's	Children's Services	23	35	65.7%
	Women's Services	1,190	1,357	87.7%
Women's and Children's Total		**1,213**	**1,392**	**87.1%**
Grand Total		**7,298**	**8,899**	**82.0%**

Performance Report

Reporting Month: April 2023

STANDARD	QUALITY AND SAFETY: FRACTURE NECK OF FEMUR (#NOF)
Background:	Fractured neck of femur best practice comprises eight elements, all of which need to be provided within relevant time scales to demonstrate care provided to individual patients has met best practice standards. Two of the eight individual criteria are monitored in this report: time to theatre within 36 hours and ortho-geriatrician review within 72 hours. Both standards have a target of 90%.
Performance:	In April, there were 56 patients eligible for Best Practice Tariff (BPT) across UHBW (27 in Bristol and 29 in Weston). • For the 36 hour standard, 53.6% achieved the standard (30 out of 56 patients). • For the 72 hour standard, 42.9% achieved the standard (24 out of 56 patients). At Bristol: 18 patients missed the 36 hour target time to surgery because of theatre space, due to other trauma and limited number of trauma theatre available. Twenty four out of 27 patients received an Ortho-geriatrician assessment within 72 hours. Staff availability over the Easter bank holiday contributed to three patients being seen after 72 hours. At Weston: The target time to surgery was missed for five patients because of theatre space, due to other trauma and limited number of trauma theatre available and an additional three patients missed the target due to unavoidable diagnostic and medical issues. None of the patients had an Ortho-geriatrician assessment.
Actions:	Bristol: • There is continued difficulty in time to theatre in Bristol driven by the increase in demand for general trauma. It is difficult to increase trauma theatre capacity whilst maintaining cancer theatre capacity. Staffing issues have resulted in an inability to run extra trauma lists. (Risk 3505) • Bed pressures within the trust have compounded the problem with outlying patients being placed on T&O wards. • Trust-wide theatre staffing recruitment campaign underway which includes internationally educated theatres nurses and operating department practitioners. Weston: • Extra theatre space is available via emergency (CEPOD) lists or occasional short notice cancellation of elective lists. • The ortho-geriatrician post remains vacant and unchanged from previous months following unsuccessful recruitment. The post was re-advertised on 12th May with a refreshed advert designed to be more attractive to potential applicants.
Risks:	924: Risk that there is a delay in hip fracture patients accessing surgery within 36 hours of admission. 1834: Risk of failure to achieve best practice tariff and good quality care for patients with #NOF

Performance Report

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

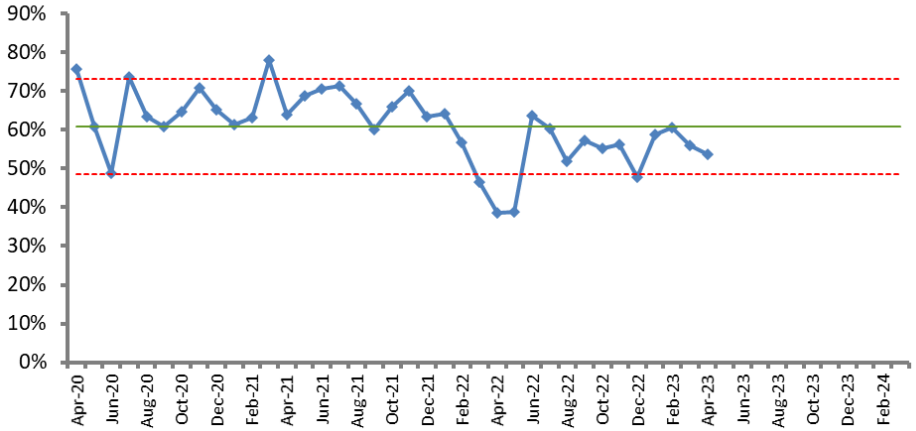
Reporting Month: April 2023

STANDARD **QUALITY AND SAFETY: FRACTURE NECK OF FEMUR (#NOF)**

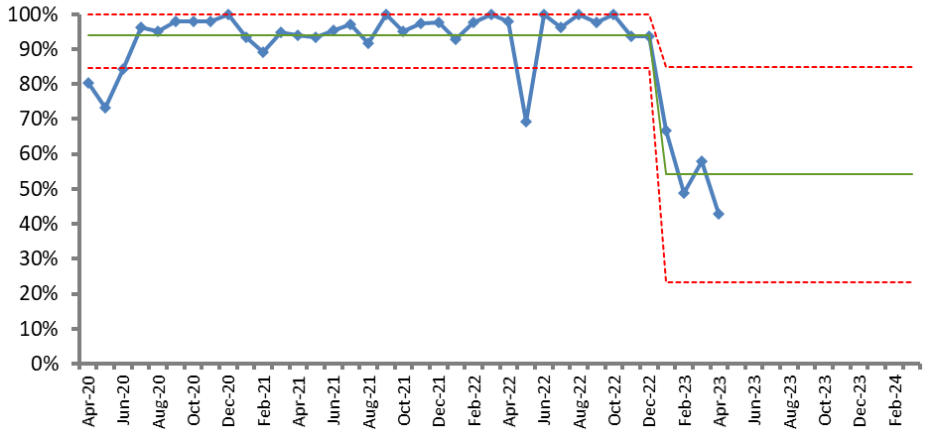
Apr-23

		36 Hours		72 Hours	
	Total Patients	**Seen In Target**	**Percentage**	**Seen In Target**	**Percentage**
Bristol	27	9	33%	24	89%
Weston	29	21	72%	0	0%
TOTAL	**56**	**30**	**53.6%**	**24**	**42.9%**

Fracture Neck of Femur Patients Treated Within 36 Hours



Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours

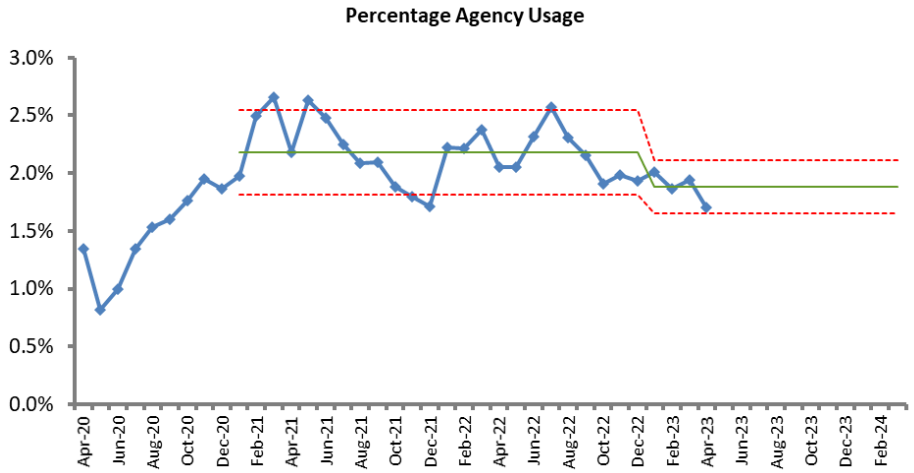


Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD	OUR PEOPLE: WORKFORCE AGENCY USAGE
Performance:	Agency usage reduced by 31.2 FTE to 1.7%. There were no increases within any division. There were reductions within six divisions. The largest divisional reduction was seen within Surgery, where usage reduced to 26.6 FTE from 39.6 FTE in the previous month.
Actions:	• As part of system wide working the Trust continues to work with healthcare partners and the neutral vendor to drive an increase in the supply of lower cost agency nurses and reduce reliance on high cost non framework suppliers through active management of the neutral vendor contract. • Internal work continues within the Trust as part of the Patient First Agency Controls working group to drive down the reliance on agency supply especially the high cost non framework usage. • As part of the Patient First work a new task and finish group has been set up to support the launch of increased bank rates for Band 5 nurses which will go live on 5th June 2023. This work includes direct approaches to agency workers to join the Trust Bank, a significant internal and external promotional campaign and during the summer a relaunch of the Bank. • Active recruitment continues to substantive medical roles in the Weston Division to drive down the demand for high-cost agency usage. • Ongoing trial of a new approach to tackle the reliance on off-framework Tier 4 Agency with a new enhanced "Break Glass" rate which is only accessible 26 hours prior to a shift being worked. The process for booking these Break Glass Bank Shifts will be the same as for the current Tier 4 shifts, and escalation/signoff will be through Directors of Nursing/Deputy Directors of Nursing in hours, and on call manager to Strategic on call out of hours. This will be assessed frequently and other agency improvements are underway.
Risks:	674: Risk that use of agencies who are non-compliant with national pricing caps does not reduce

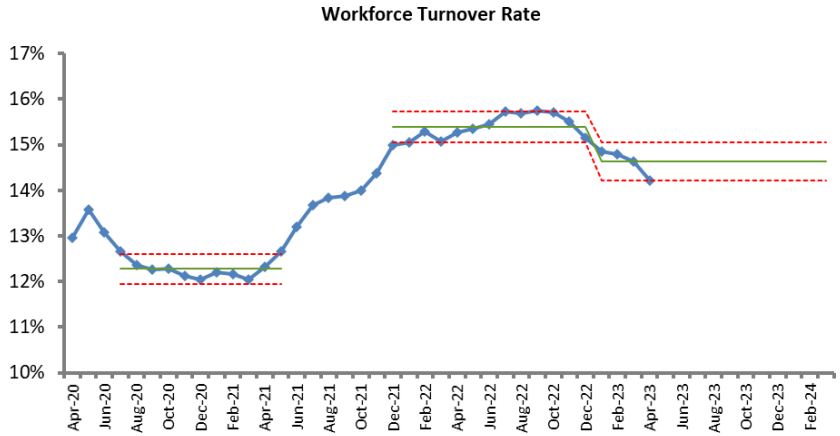


Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

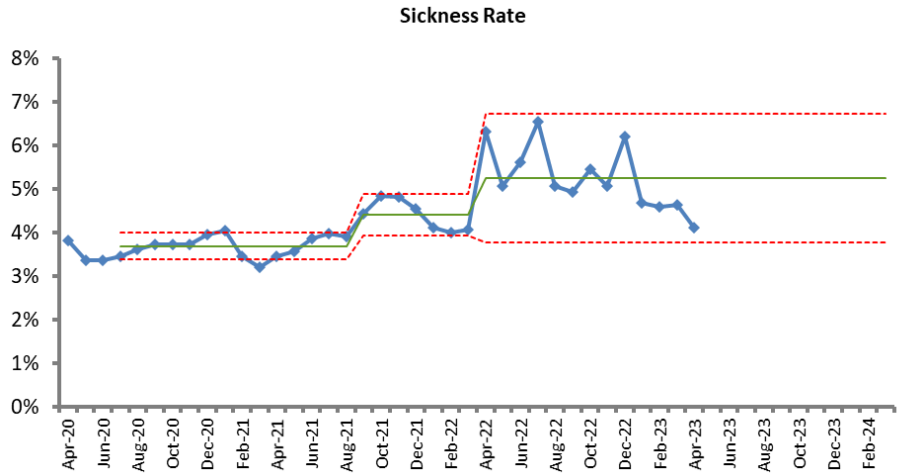
STANDARD	OUR PEOPLE: WORKFORCE STAFF TURNOVER
Performance:	Turnover for the 12-month period reduced to 14.2% compared to 14.6% (updated figures) for the previous month. • Seven divisions saw a reduction whilst one division remained static in turnover in comparison to the previous month. • The largest divisional reduction was seen within Weston General Hospital, where turnover reduced by 1.1 percentage points to 12.4% compared with 13.5% the previous month. • One staff group saw an increase, whilst six staff groups saw a reduction in comparison to the previous month. • The only staff group increase was seen within Additional Clinical Services, where turnover increased by 0.5 percentage points to 19.9% compared with 19.4% the previous month. • The largest staff group reduction was seen within Allied Health Professionals, where turnover reduced by 1.4 percentage points to 16.9% compared with 18.3% the previous month. • Turnover rate for Band 5 nurses April is 16.2%.
Actions:	• The uptake of Leaver's Feedback Conversations has increased following the re-launch of the leavers process. This process is now being adapted to include 'stay' conversations. • The new long service vouchers process is now in place for colleagues celebrating 30/40/50 years continuous NHS Service. Following the introduction of a revised approach to recognising colleagues for their achievements over 1000 nominations were submitted and shortlisted for the annual awards. The annual recognition event was held on April 21st celebrating the shortlisted nominees; continuous NHS service colleagues and those colleagues being celebrated by individuals. All nominees received congratulation cards in recognition of their achievements. • Quarterly Pulse Survey: April 3rd – 30th temperature check of the organisational engagement score with additional questions focusing on the impact of the appraisal 'check in' conversation.
Risk:	Strategic Risk 2694: Risk that Trust is unable to retain members of the substantive workforce



Performance Report

Reporting Month: April 2023

STANDARD	OUR PEOPLE: WORKFORCE STAFF SICKNESS
Performance:	Sickness absence reduced to 4.1% compared with 4.6% in the previous month, based on updated figures for both months. This figure is now combined with Covid Related absence. There were reductions within all eight divisions, the largest divisional reduction was seen within Medicine, reducing by 1.0 percentage points to 3.9%, compared to the previous month. There were reductions within all nine staff groups. The largest staff group reduction was seen within Nursing and Midwifery Unregistered, reducing to 6.2% from 7.3% compared to the previous month.
Actions:	Work taking place to reduce sickness absence is as follows: • Commencement of new Workplace Wellbeing Lead and transfer of Workplace Wellbeing Nurse from Occupational Health Service to the Corporate Workplace Wellbeing team (OD) to ensure a holistic approach and delivery of strategic wellbeing objectives including proactive strategies to promote health and wellbeing and prevention of sickness and absence. • Refresh of 9 bitesize eLearning modules to support personal and whole team wellbeing. • Launch of a dedicated 'wellbeing hub' at Weston to offer rest decompression to colleagues away from the service area and to access confidential wellbeing resources and interventions. • The Supporting Attendance Policy review has commenced and the policy will focus on wellness at work and reduce the amount of monitoring undertaken of colleagues with reasonable adjustments in place. This is a fundamental change and will support the People strategy objective of making UHBW the best place to work and support a reduction in turnover of staff.
Risks:	tbc



Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

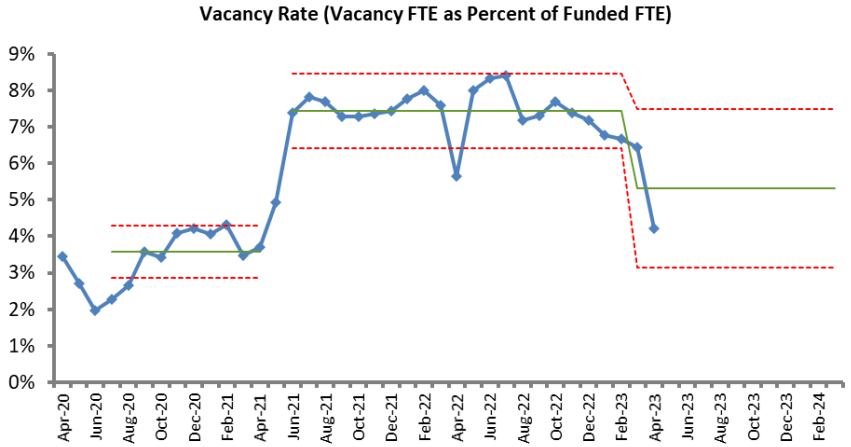
STANDARD	OUR PEOPLE: WORKFORCE STAFF VACANCY
Performance:	Overall vacancies reduced to 4.2% (485.1 FTE) compared to 6.4% (760.2 FTE) in the previous month. • The largest divisional increase was seen in Diagnostics and Therapies where vacancies increased to 74.1 FTE from 27.9 FTE the previous month. • The largest divisional reduction was seen in Surgery, where vacancies reduced to 82.5 FTE from 173.1 FTE the previous month. • The largest staff group reduction was seen in Nursing, where vacancies reduced to 226.3 FTE from 437.5 FTE the previous month. • The largest staff group increase was seen in Allied Health/Scientific Professions, where vacancies increased to 16.1 FTE from -23.9 FTE. • Consultant vacancy has reduced to 28.3 FTE (4.0%) from 35.5 FTE (4.7%) in the previous month. Unregistered nursing vacancies can be broken down as follows: **Band** / **Vacancy** AfC Band 2 / 547.2 FTE AfC Band 3 / -410.7 FTE AfC Band 4 / -164.0 FTE The significant vacancy at band 2 and over-establishment at band 3 are due to the movement of healthcare support workers from band 2 to band 3. Staff have been moved but the funded establishment has not been transferred in the finance ledger yet. The work will be incorporated into budget setting for 2023/24, but has not yet been actioned for month 1. The combined (band 2 and 3) picture is unaffected. The band 4 over establishment is where there is a large number of newly qualified nursing staff awaiting their NMC PINs. Once these staff become fully qualified and have received their PIN, this should reduce the band 4 over establishment, reduce the registered nursing vacancy position, and increase the unregistered nursing vacancy position, which is a much more accurate reflection of the nursing vacancy position. This month is a transitional month with a significant amount of budget amendments for the new financial year, therefore producing swings in vacancy comparison figures to the previous month.
Actions:	Work taking place to reduce the vacancy rate is as follows: • 44 new internationally educated nurses joined the Trust in the month of April. • A second recruitment trip to India is being planned for mid-May to keep the pipeline of international nurses strong for the new financial year. • 27 substantive Healthcare Support Workers (HCSW) started in the Trust during April and another 25 have been offered. 39 Bank Healthcare Support Workers (HCSW) started in the Trust during April and another 16 have been offered. • The third HCSW apprenticeship assessment centre took place in April for adults and children services, seven candidates were offered for adults and eight candidates for children's. • The Registered Nurse Degree Apprenticeship (RNDA) campaign launched at the end of April, adverts have been posted for all areas within our Trust and drop-in sessions will be taking place throughout May. Page 88 of 312 *...continued over page*

Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD	OUR PEOPLE: WORKFORCE STAFF VACANCY
Actions (continued):	• Shortlisting took place for the Trainee Nursing Associate (TNA) programme finished in April and 16 candidates have been invited to attend an assessment centre at the start of May. • The Trust is expecting another international Radiographer appointed to join the Trust at the end of May. • The adverts for the system wide AHP recruitment event alongside NBT and Sirona are due to close at the beginning of May. So far, the Trust has received 156 applications for the Newly Qualified Physiotherapist vacancy and five applications for the Newly Qualified Occupational Therapist vacancy. The interviews are scheduled to be held at UWE on 11th May. • Ten substantive Allied Health Professionals and five substantive Healthcare Scientists joined the Diagnostics and Therapies division in the month of April. • One consultant and two clinical fellows started in Weston in the month of April. A further two non-consultant grade doctors were cleared for start dates in May. • In the month of April, the Trust offered a further three Clinical Fellows and one consultant across the Weston site and 13 non-consultant grade doctors are currently going through pre-employment checks for the Weston site to support Rota gaps.
Risks:	Strategic Risk 737: Risk that the Trust is unable to recruit sufficient numbers of substantive staff



Performance Report

Reporting Month: April 2023

STANDARD	RFERRAL TO TREATMENT (RTT) LONG WAITS
Performance:	At the end of April: • 5,472 patients were waiting 52+ weeks against the Operating Plan trajectory of 5,400. • 1,549 patients were waiting 65+ weeks against the Operating Plan trajectory of 1,950. • 182 patients were waiting 78+ weeks. • 0 patients were waiting 104+ weeks. For 2023/24 the Operating Plan assumes that no patients will be waiting over 78 weeks. The next national ambition is to have no patients waiting 65+ weeks by the end of March 2024.
National Data:	For March 2023, across all of England, 5.0% of the waiting list was waiting over 52 weeks. UHBW's performance was 8.1% (5,383 patients) which places UHBW as the 15th highest Trust out of 170 Trusts that reported RTT wait times.
Actions:	• At the end of April 2023, there were no patients waiting over 104+ weeks. • There is a focus on ensuring that no patients are waiting longer than 78 weeks beyond April 2023. At the end of April there were 182 patients waiting over 78 weeks, of which 41 related to cornea grafts. There is currently a national shortage of cornea graft material which is contributing to delays in treating these patients. There is a nationally led process to allocate graft material to Trusts based on the clinical priority and length of waiting time. • As part of the 2023/24 Annual Planning Process (APP), clinical divisions are developing plans to move towards the national ambition of patient waiting longer than 65 weeks by end of March 2024. • During the Industrial Action in April, 175 admissions and 1834 outpatient appointments were cancelled due to this Industrial Action. This doesn't represent the opportunity loss given that a number of specialties paused booking of outpatients, diagnostics and theatre sessions on these dates. • Dental services have additional Independent Sector capacity under contractual agreements with both Nuffield and St Joseph's to support their recovery in some areas and insourcing using KPI Health for paediatric dental extractions which commenced mid-January, with schedules being provided each month. The contract agreement with KPI Health has been extended into quarter 1 of 2023/24. • Within General Surgical Specialties, locums have been secured and some consultants have provided additional weekend and evening time to help reduce care backlogs. The service has been working with Somerset Surgical Services (SSS) to support provision of additional treatment to be undertaken on the Weston site. Patients who are currently on the Appointment Slot Issue (ASI) are being will be contacted to ask for their consent to transfer them for treatment to SSS who can provide capacity within 4-6 weeks. Of the 269 patients identified, 130 have been contacted of which 52 have consented to being treated by SSS. The Trust continue to make contact with the remaining 139 patients. • The Trust are currently seeking locum support for dental services and have recently appointed a cleft locum due to start in June. In May there will be adverts for both a Restorative Dentistry Consultant and a Paediatric Dentistry Consultant to extend the capacity in the team further. *…continued over page*

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD	RFERRAL TO TREATMENT (RTT) LONG WAITS
Actions (continued):	• The Trust continues to contact patients who are waiting for treatment dates to ask if they would accept treatment at an alternative provider. For Paediatric patients, the department continues to give suitable patients the choice of transferring their care to University Hospitals Plymouth (UHP) for treatment. In the summer of 2023, UHP were planning on opening an additional theatre which UHBW could use to support the transfer of paediatric patients from UHBW who live within the peninsula, however the theatre has been further delayed beyond the summer. UHP have offered some support specifically for Paediatric Urology patients via an insourcing arrangement. There has been little capacity provided nationally to support the paediatric patients who have agreed to be transferred to alternative providers. • The Trust continues to bolster additional capacity through other insourcing providers and waiting list initiatives. • Where patients are too complex for transferring outside of the organisation for treatment under mutual aid arrangements, theatre schedules are being maximised across all sites to ensure that suitable capacity is available for the longest waiting patients. This continues to be a challenge due to the high volumes of cancer cases, inpatient capacity constraints (including High Dependency) and staff shortages.
Risk:	801: Risk that the six oversight themes within the NHS Oversight Framework for 2022/23 are not met

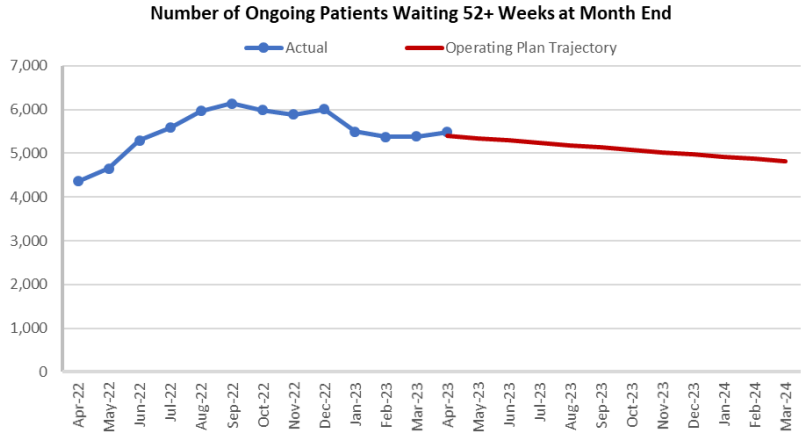
Performance Report

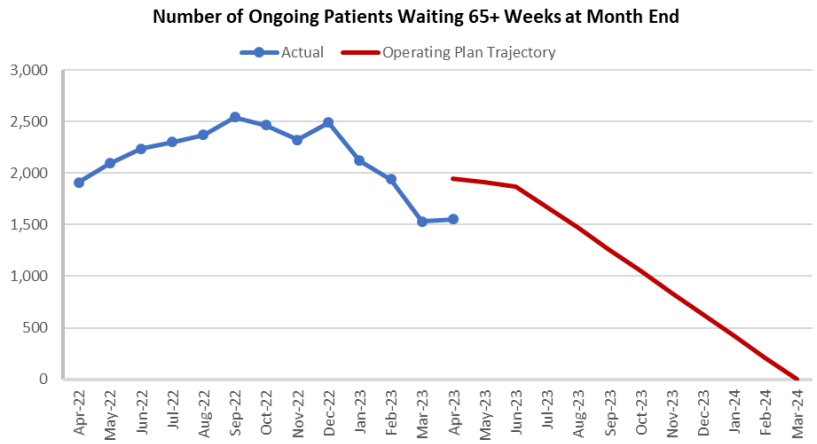
University Hospitals Bristol and Weston NHS Foundation Trust

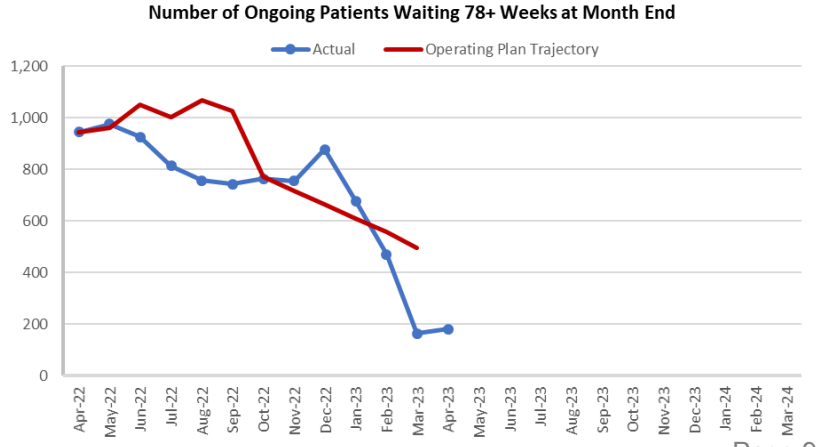
Reporting Month: April 2023

STANDARD **RFERRAL TO TREATMENT (RTT) LONG WAITS**

	Apr-23		
	52+ Weeks	65+ Weeks	78+ Weeks
Diagnostics and Therapies	1	1	0
Medicine	942	147	1
Specialised Services	153	59	7
Surgery	3,559	1,047	123
Women's and Children's	817	295	51
Other	0	0	0
UHBW TOTAL	**5,472**	**1,549**	**182**







Performance Report

Reporting Month: Mar/Apr 2023

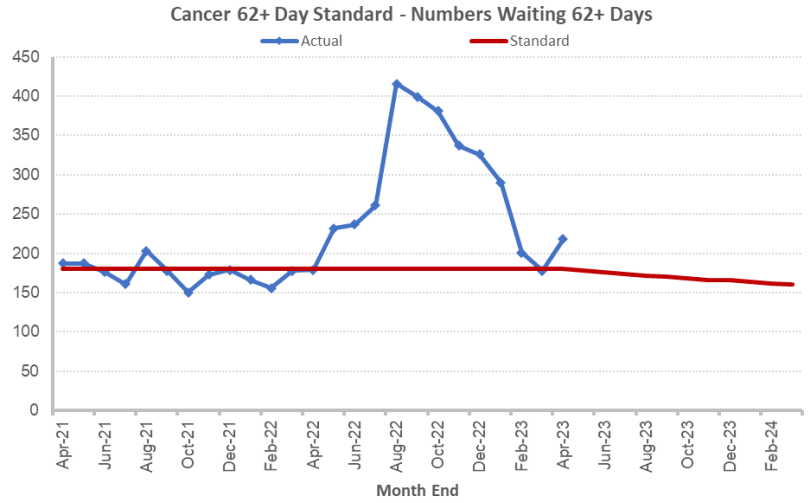
STANDARD	CANCER PATIENTS WAITING 62+ DAYS
Performance:	As at end of April, the Trust had 218 patients waiting 62+ days on a GP suspected cancer pathway. The Trust has a target of not exceeding 180 patients, reducing to 160 by March 2024. The performance for patients treated within 62 days of an urgent GP referral is also reported but is a month in arrears. For March, 67.4% of patients were seen within 62 days. Performance across quarter 1 was 66.9%, quarter 2 was 61.4% and quarter 3 was 49.0% and quarter 4 performance was 52.3%. The "Faster Diagnosis Standard" (FDS) is also reported, and this measures time from receipt of a suspected cancer referral from a GP or screening programme to the date the patient is given a cancer diagnosis, or told cancer is excluded, or has a decision to treat for a possible cancer. This time should not exceed 28 days for a minimum of 75% patients. Performance in March was 65.4% of 1,868 patients achieved this standard.
National Data:	National data for patients treated within 62 days of an urgent GP referral is shown on the next page. Latest national data for quarter 4 2022/23 shows UHBW at 52.3% against an England average of 58.8%. This puts UHBW 110th out of 145 Trusts.
Actions:	The target for the ongoing standard for patients waiting over 62 days on GP referred cancer pathway is currently off track due to the impact of industrial action but is expected to be recovered by the end of June. In March, the Trust achieved the subsequent radiotherapy and subsequent chemotherapy treatment standards. Performance against the other retrospective standards remains non-compliant due to the impact of clearing the backlogs caused by Covid in 2022 but improvement was seen in the 62-day GP constitutional standard, the faster diagnosis standard, and the first appointment standard was stable despite the impact of industrial action. Industrial action and bank holidays pose a short-term threat to all standards, but the Trust is planning to recover promptly. A single action plan is in place for improving all standards, with a national focus on the 62-day GP ongoing standard and the combined faster diagnosis standard. Patient safety is at the heart of all performance management in cancer and is being maintained.
Risk:	801: Risk that the six oversight themes within the NHS Oversight Framework for 2022/23 are not met.

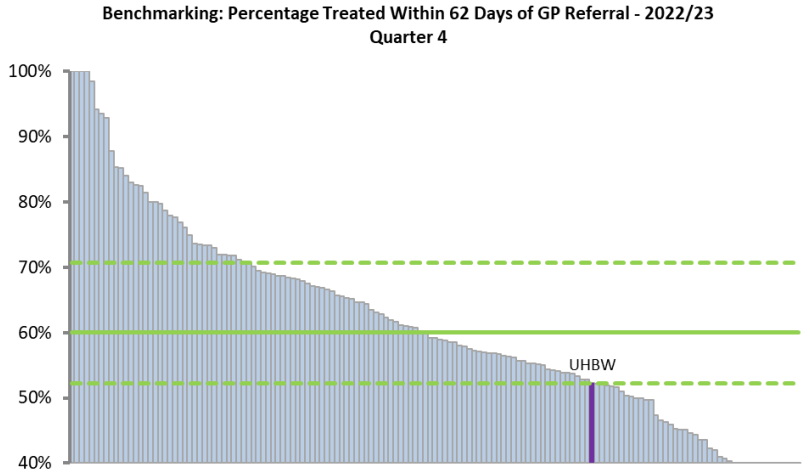
Performance Report

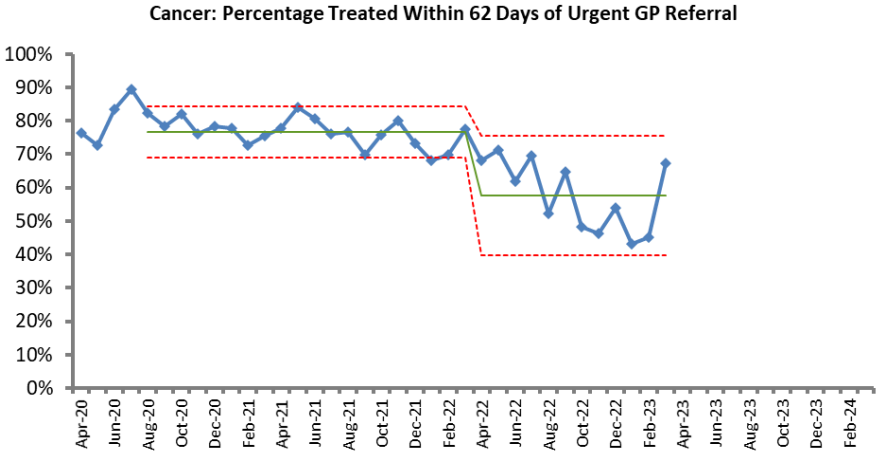
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

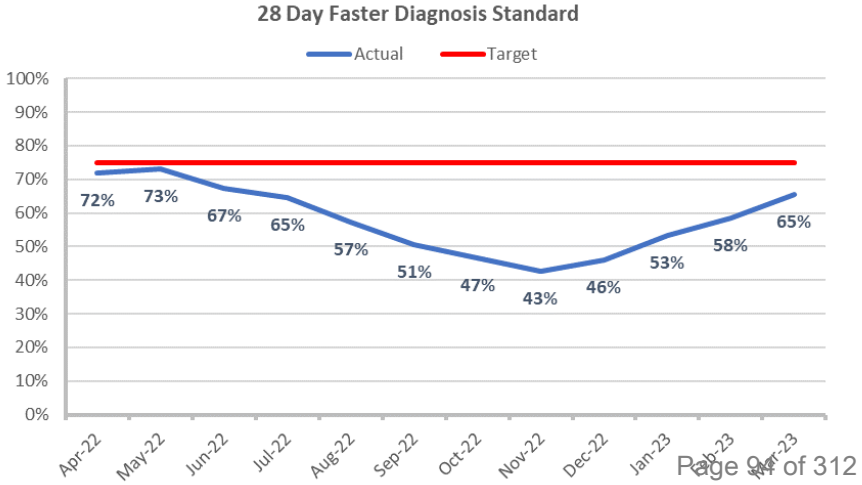
Reporting Month: Mar/Apr 2023

STANDARD CANCER PATIENTS WAITING 62+ DAYS









Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

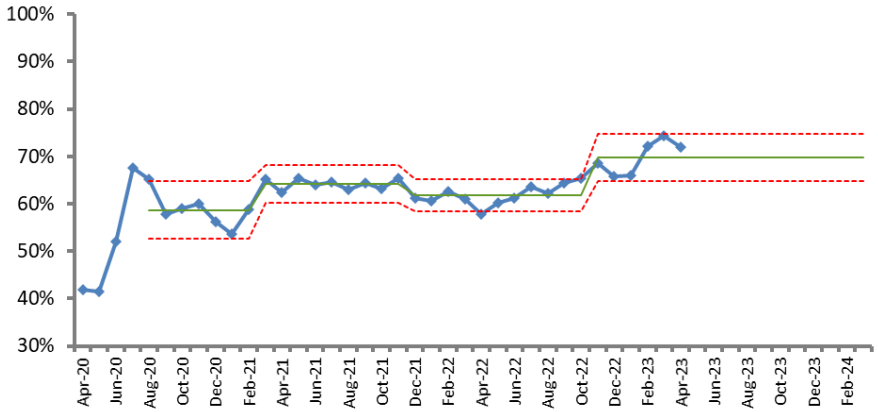
STANDARD	DIAGNOSTIC WAITING TIMES
Performance:	At the end of April, 71.8% of patients were waiting under 6 weeks. The constitutional standard is 99%. The operational planning requirement was for Trusts to return to 75% by March 2023. The UHBW operating plan submission sets an improvement trajectory of 85% by end of March 2024 and the monthly trajectory is currently being prepared. At the end of April, there were a total of 358 patients waiting 26+ weeks which is 2.2% of the waiting list. There is a requirement to clear the 26+ week backlog by March 2024, with the March 2023 operating plan trajectory being no more than 500, which the Trust achieved.
National Data:	For March 2023, the England total was 73.6% of the waiting list was under 6 weeks. UHBW's performance was 72.1% which places UHBW as the 46th lowest Trust out of 146 Trusts that report diagnostic wait times.
Action/Plan:	• Diagnostic performance in April 2023 has deteriorated, with 72% patients waiting under 6 weeks, compared to 74.3% in March. • The Trust achieved the operating plan target to reduce long waiters to less than 500 over 26 weeks by March 2023. Long waiters continued to reduce further in April with 358 currently waiting over 26 weeks. 1,310 patients were waiting more than 13 weeks at the end of April 2023. • Modality level trajectories and plans for 23/24 are currently being agreed across the Trust. • Challenges in the administrative workforce have further impacted performance improvement in MRI and Non-obstetric Ultrasound. Actions are underway to resolve these challenges, with resulting improvement expected to be seen through the year. • Performance in MRI and Non-obstetric Ultrasound modalities continue to become an increasing risk to Trust performance. There are a number of actions being taken to mitigate this risk and regain performance improvement, including the improvement of resilience within certain staffing groups, further rigour for performance monitoring across all imaging modalities in the Diagnostics and Therapies Division and increasing mutual aid transfers wherever possible. • Dexa performance deteriorated during April, primarily attributed to workforce and capacity challenges. Recovery actions are in place and improvement is expected by September 2023/24. • Long waiters in Endoscopy continue to reduce for the sixth consecutive month and 6 week wait performance improved significantly in April 2023. Endoscopy performance remains a challenge, but the recovery actions are starting to yield the results anticipated.
Risk:	801: Risk that the six oversight themes within the NHS Oversight Framework for 2022/23 are not met

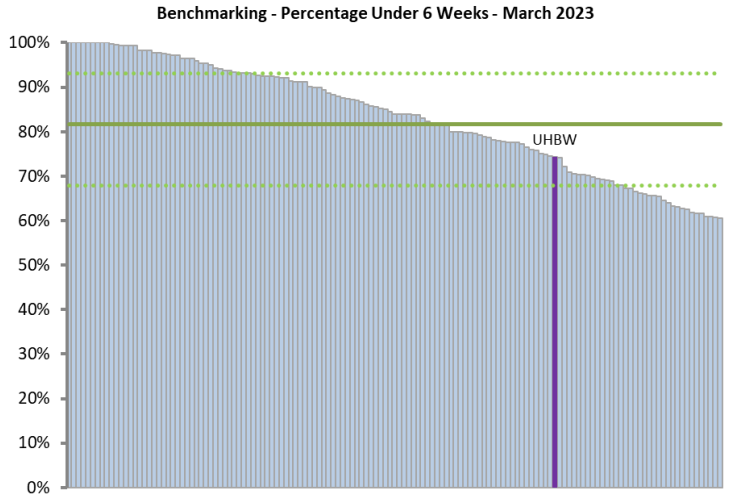
Performance Report

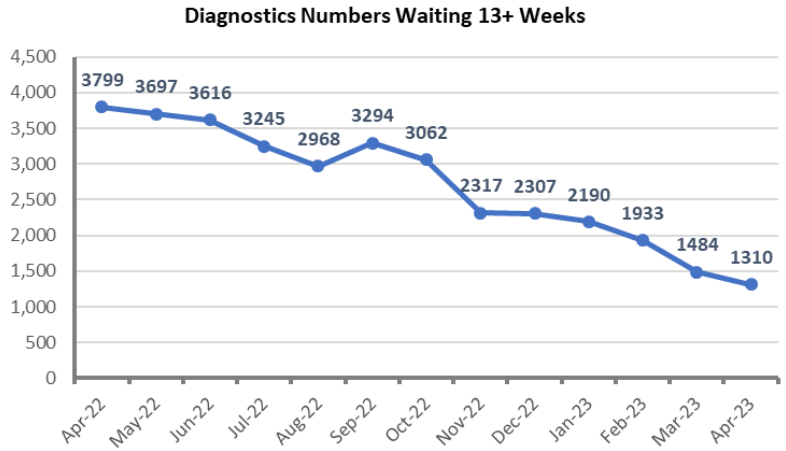
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

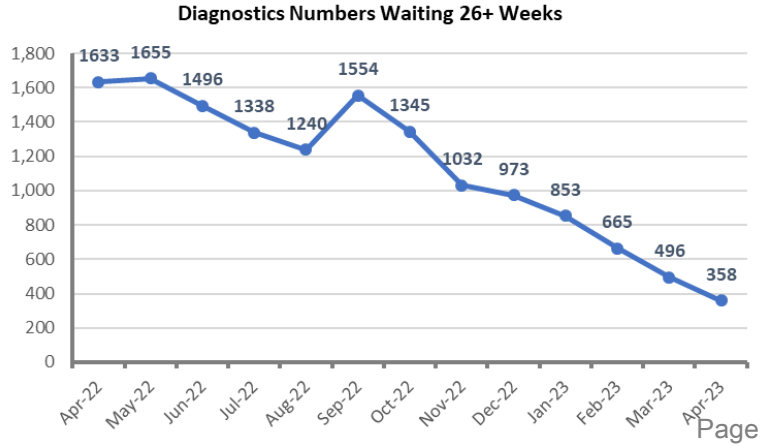
Reporting Month: April 2023

STANDARD **DIAGNOSTIC WAITING TIMES**









Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD **DIAGNOSTIC WAITING TIMES**

End of April 2023

Modality	Total On List	6+ Weeks		13+ Weeks		26+ Weeks	
		Number	Percentage	Number	Percentage	Number	Percentage
Audiology Assessments	727	41	6%	3	0%	1	0%
Colonoscopy	540	282	52%	189	35%	101	19%
Computed Tomography (CT)	3,172	582	18%	70	2%	2	0%
DEXA Scan	958	492	51%	179	19%	1	0%
Echocardiography	1,622	331	20%	54	3%	0	0%
Flexi Sigmoidoscopy	173	99	57%	56	32%	29	17%
Gastroscopy	604	356	59%	244	40%	98	16%
Magnetic Resonance Imaging (MRI)	3,124	544	17%	187	6%	117	4%
Neurophysiology	186	5	3%	0	0%	0	0%
Non-obstetric Ultrasound	5,328	1,917	36%	313	6%	0	0%
Sleep Studies	155	22	14%	15	10%	9	6%
Other	0	0		0		0	
UHBW TOTAL	**16,589**	**4,671**	**28.2%**	**1,310**	**7.9%**	**358**	**2.2%**

Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD	EMERGENCY DEPARTMENT
Performance:	**Time Spent in Department** The total time spent in the Emergency Department (ED) measures from arrival time to discharge/admission time. There are two standards reported: 1. The "4 Hour Standard". This is the standard that has been reported in previous years and had a constitutional standard of 95%. For 2023/24, Trusts are now required to return performance to 76% by March 2024, i.e. 74% of ED attendances should spend less than 4 hours in ED. 2. The "12 Hour Standard". This is a new standard from April 2023. The target is to achieve no more than 2% exceeding 12 hours by March 2024. Note: the "4 Hour Standard" applies to all EDs. The "12 Hour Standard" applies to Type 1 EDs, so will exclude the Eye Hospital ED. Trust level 4 hour performance for April was 70.7% of patients spending less than 4 hours in ED across all four Emergency Departments. The end of April 2024 operating plan trajectory was 61.0%. Trust level 12 hour performance for April was 5.4% of patients spending over 12 hours in ED across all three Type 1 Emergency Departments. The improvement trajectory for this standard is being developed. **12 Hour Trolley Waits** This standard is for patients who are admitted from ED, and measures from the Decision To Admit (DTA) time to the Admission Time. This is a standard that has been reported in previous months and will continue to be reported in 2023/24. There were 324 12 Hour Trolley Waits in April 2023: 74 in Bristol and 250 at Weston. **Ambulance Handovers** Ambulance handover refers to the process of moving a patient from an ambulance to an Emergency Department upon arrival at a hospital. The South Western Ambulance Service NHS Foundation Trust (SWASFT) provide data on all handovers to hospitals in the South West. The two metrics reported here are the number and percentage of handovers that exceed 15 or 30 minutes. The NHS Standard Contract sets the target that "all handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 30 minutes". In April there were 3,773 ambulance handovers. Of these: • 2,716 ambulance handovers were in excess of 15 minutes which was 72.0% of all handovers. • 1,396 ambulance handovers were in excess of 30 minutes which was 37.0% of all handovers.
National Data:	There are 19 Trusts in the South West that the Ambulance Service cover. For April 2023, overall number of handovers over 15 minutes was 65.6% across the South West. The BRI was the 4th highest at 74.5% and Weston was the 2nd highest at 84.2%. In April 2023, 123 Trusts reported 12 hour trolley waits (26,899 in total). UHBW was the 36th highest Trust with 324.

Performance Report

Reporting Month: April 2023

STANDARD	EMERGENCY DEPARTMENT

Actions:	A range of initiatives are being progressed across adult services to reduce overcrowding, ambulance queueing and long waits including:
	• Expansion of Same Day Emergency Care (SDEC) provision, comprising:
	  ○ Expansion of Surgical SDEC capacity: recruitment is in train and funding for substantive posts approved. An Acute Surgical Hub (ASH) /SDEC working group has been set up to oversee all improvements to the SDEC service. A revised business case for ASH staffing is being finalised.
	  ○ Development of the SDEC offer at Weston: pulls from ED have now been increased to three times daily and the team is now fully staffed. Activity has remained stable in April (average of 17.3 patients daily in April and 17.2 patients per day in March. This is a significant increase from 2022. Work is ongoing to increase communications to Primary Care colleagues to increase direct referrals to the unit, avoiding ED. During May new SOPs will go live to support direct SWASFT admissions to SDEC. A new referral pathway for SDEC to refer to Rapid Access Chest Pain Clinic will also launch
	  ○ BRI medical SDEC has successfully reduced late closures over April through the use of AMU and SDEC evening huddles. April saw a decrease in patients seen within SDEC in line with the decreased in ED attendances over the month. SDEC Practitioner Led model is now due to commence mid-May.
	  ○ Cardiology SDEC commenced at the beginning of March and progress continues to be monitored. Four Advanced Clinical Practitioners (ACPs) have been recruited for Cardiology SDEC.
	• A review and update of Internal Professional Standards is now underway. This will be clinically led and will involve engagement with specialties and co-production of a set of standards to support the best possible care for our patients.
	• In BRI majors, the ITA has now been relocated from corridor to the A300 footprint. The High Intensity Users Team will move into the old ITA to provide central office for Operations Hub for clinical oversight and operational flow assessment and the patient flow coordinator will move to the nurse in charge desk for better oversight and CareFlow updates.
	• 4 and 12 hour ED performance improvement plans are in development for 2023/24. This includes a review of expected patient pathways (with speciality specific actions) and demand and capacity reviews.
	• The Weston ED observation and assessment unit is now open and in use. In April 22 patients were transferred to the EOU beds on the 11 days the beds were available for use.
	• In BRI fast flow. MDT board rounds are in place three times daily. A GEMBA review has been undertaken and an action plan is now in place to resolve issues identified. An SDEC pull pilot from Fast flow is due to commence 08/05.
	• Radiographer led discharge project is no longer being progressed due to the number of minor injuries now being redirected to UTCs.
	• A further workstream is focusing on pathology turnaround times for ED. Change to the preanalytical urgent workflow during core hours (9:00-17:30) has resulted in reduction in turnaround time breaches and reduced average turnaround times during this time period.

Risks:	910: Risk that patients in ED do not receive timely and effective care 4700: Risk that a patient may deteriorate whilst being held in the ambulance bay

Performance Report

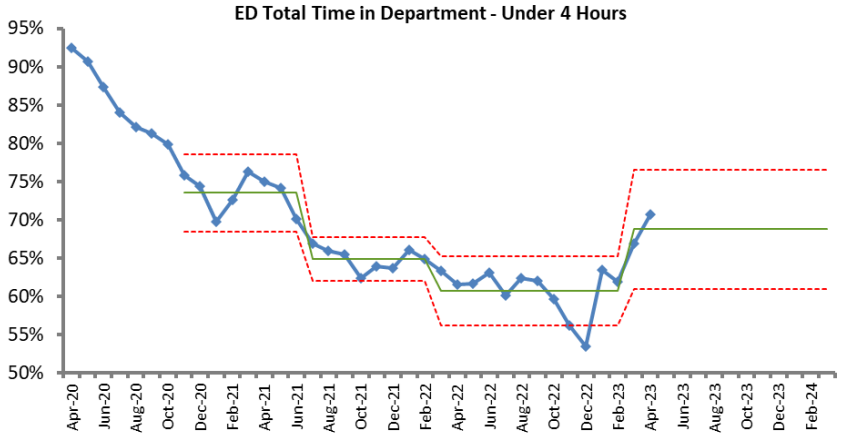
University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD **EMERGENCY DEPARTMENT**

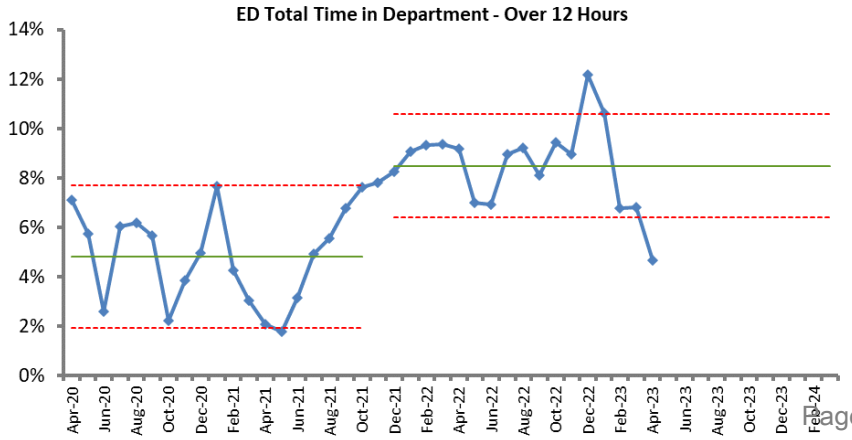
Patients Who Spend Under 4 Hours In ED (Arrival to Discharge/Admission)

4 Hour Performance	Apr-23	2023/24	2022/23
Bristol Royal Infirmary	60.4%	60.4%	46.14%
Bristol Children's Hospital	81.81%	81.81%	71.14%
Bristol Eye Hospital	97.63%	97.63%	95.97%
Weston General Hospital	61.61%	61.61%	55.05%
UHBW TOTAL	**70.67%**	**70.67%**	**60.94%**



Patients Who Spend Over 12 Hours In ED (Arrival to Discharge/Admission)

12 Hour Performance	Apr-23	2023/24	2022/23
Bristol Royal Infirmary	4.4%	4.4%	12%
Bristol Children's Hospital	0.8%	0.8%	2%
Weston General Hospital	11.1%	11.1%	15%
UHBW TOTAL	**5.4%**	**5.4%**	**9.9%**



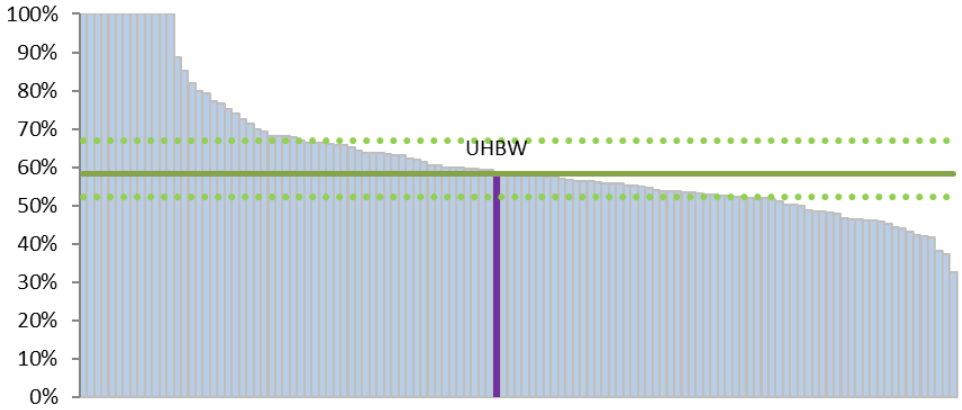
Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

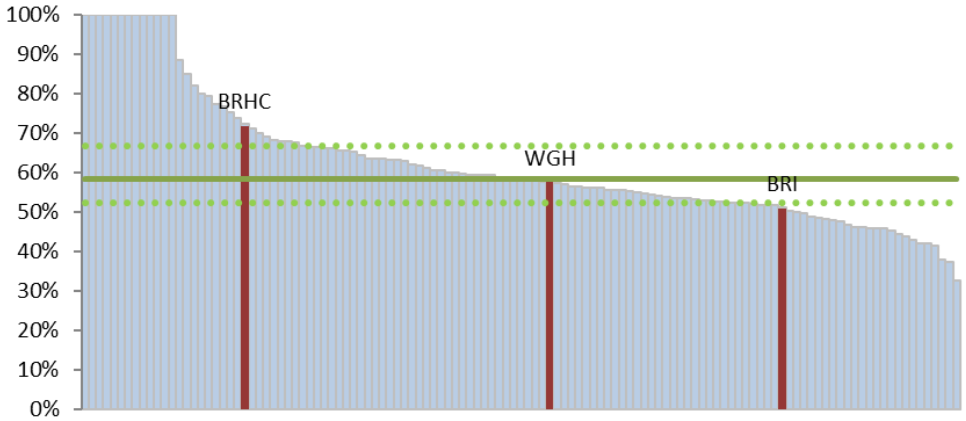
Reporting Month: April 2023

STANDARD **EMERGENCY DEPARTMENT**

Benchmarking - ED 4 Hour Performance 2022/23 Quarter 4



Benchmarking - ED 4 Hour Performance 2022/23 Quarter 4



Performance Report

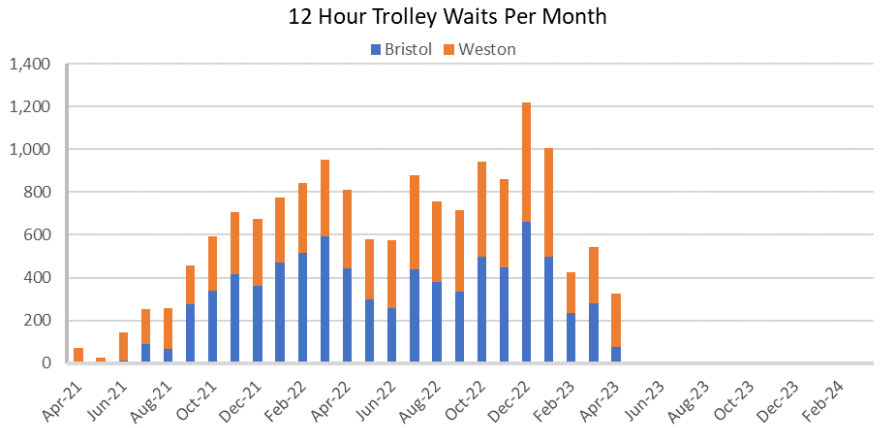
University Hospitals Bristol and Weston NHS Foundation Trust

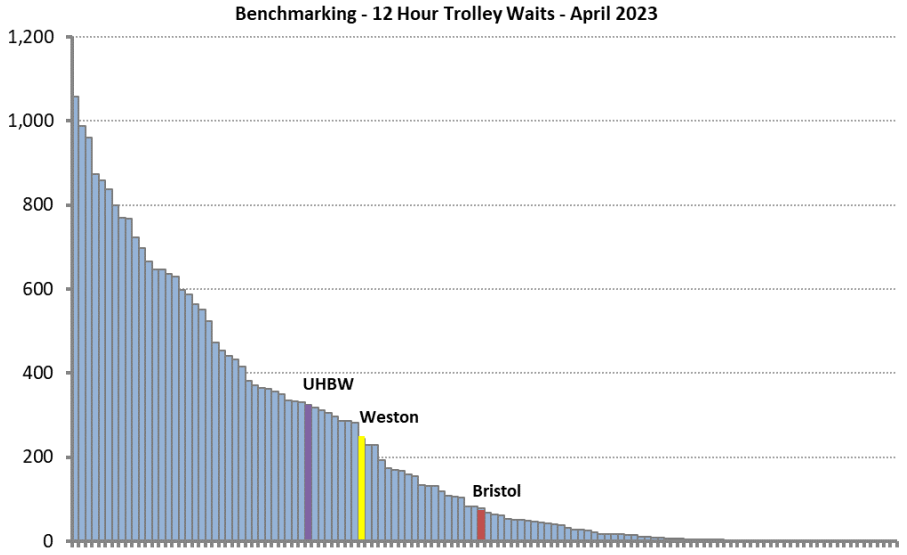
Reporting Month: April 2023

STANDARD **EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND 12 HOUR TROLLEY WAITS**

12 Hour Trolley Waits – Admitted Patients Who Spend 12+ Hours from Decision To Admit (DTA) Time to Admission Time

2022/2023												2023/2024											
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
443	297	257	437	379	334	496	449	659	500	235	278	74											
366	282	319	441	379	383	445	413	558	506	192	267	250											
809	**579**	**576**	**878**	**758**	**717**	**941**	**862**	**1217**	**1006**	**427**	**545**	**324**											





Performance Report

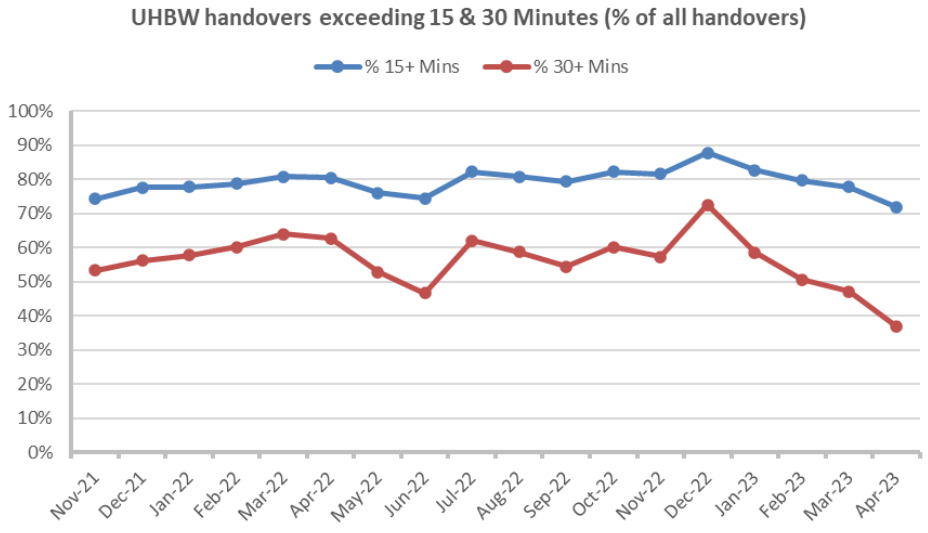
University Hospitals Bristol and Weston NHS Foundation Trust

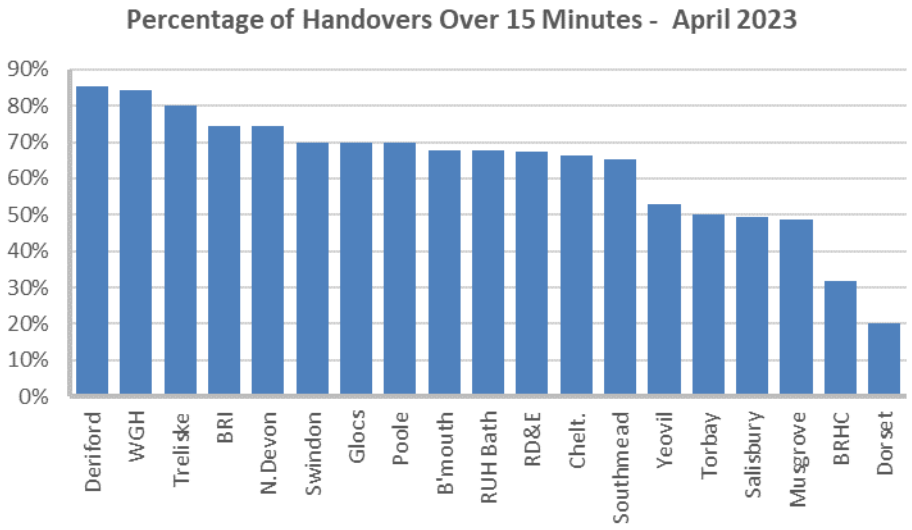
Reporting Month: April 2023

STANDARD **EMERGENCY DEPARTMENT**

Ambulance Handovers

	Apr-23				
	Total Handovers	15+ Mins	% 15+ Mins	30+ Mins	% 30+ Mins
Bristol Royal Infirmary	2259	1703	75.4%	869	38.5%
Bristol Children's Hospital	499	150	30.1%	66	13.2%
Weston General Hospital	1015	863	85.0%	461	45.4%
UHBW Total	**3773**	**2716**	**72.0%**	**1396**	**37.0%**





Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD	EVERY MINUTE MATTERS - TIMELY DISCHARGE AND NO CRITERIA TO RESIDE (NCTR)
Background:	The Every Minute Matters (EMM) programme has four work streams. **1. Implementation of the SAFER bundle – including Estimated Date of Discharge EDD:** A bundle of principles that advocates best practice in optimising flow. It includes early senior review, flow of patients from admission units to downstream wards before 10am, timely discharges and daily review of all patients with a length of stay greater than seven days. **2. Proactive Board Rounds:** Focuses on implementing daily board rounds with a consistent structure that proactively progresses adult patients towards safe, timely discharge through effective multidisciplinary collaboration. **3. Criteria to Reside - Using the MCAP tool:** Comprises 11 nationally defined criteria to ensure patients who require acute care are in the most appropriate bed. The criteria identify where patients no longer require acute care and can be discharged safely to their home or within the community. MCAP is the digital system that determines whether a patient is in the right bed for their care, whether there is a delay in their pathway, and what their next care location should be. **4. Optimising use of the Discharge / Transition Lounge:** Optimising the use of the discharge lounge so that it is embedded as a routine part of the inpatient pathway - freeing acute beds early for new unplanned admissions and elective activity.
Performance:	Three metrics are reported as the high-level priorities: 1. Percentage of patients with a "timely discharge" (before 12 noon). April had 21.2% discharged before 12 noon. The system-level standard is to achieve 33%. 2. Percentage of patients discharged via the BRI or Weston Discharge Lounges. In April 22.3% of eligible discharges went through the Weston or BRI Discharge Lounges. This was 450 patients, averaging 22.5 patients per working day. a. BRI achieved 24.5%, with 339 patients. This averages to 17.0 patients per working day. b. Weston achieved 17.6% with 111 patients. This averages to 5.6 patients per working day. 3. At the end of April there were 160 No Criteria To Reside (NCTR) patients in hospital. 4. There were 4,755 beddays consumed in total in April by NCTR patients (1 bedday = 1 bed occupied at 12 midnight). This means, on average, 159 beds were occupied per day by NCTR patients.

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD	EVERY MINUTE MATTERS - TIMELY DISCHARGE AND NO CRITERIA TO RESIDE (NCTR)

Actions:	• MCAP validations have now moved to quarterly, to reduce workload for matrons and ward managers. This process will be further reviewed when the EMM Clinical Lead is in post.
	• EMM meetings have moved to fortnightly (from weekly) with refreshed membership to reflect ongoing programme of work.
	• Active Hospitals project team set up, with benefits monitoring plan drafted. Next steps will be to review lessons learnt and previous approach from the Proactive Board Rounds, MCAP & SAFER roll out to support in planning and implementation phases.
	• New Proactive Hospital Improvement coach started in post 09th May and EMM Clinical Lead and Improvement Practitioner posts have been banded and job matched in preparation for recruitment.
	• Proactive Board and Ward Rounds e-learning module is now live on the Trust's training system, Kallidus 152 staff members have access the EMM training on Kallidus between Feb-April 2023.
	• Criteria Led Discharge (CLD)
	  ○ A CLD pathway for cardiac surgery went live on 10th May and work is ongoing to monitor the impact of this pathway, and progress next steps for TAVI and Pacemaker.
	  ○ In Weston, a PDSA approach to CLD is proposed for MAU and Sandford to embed the use of a clinical note for CLD for undefined patient pathways, this will allow clinicians to input their own criteria for discharge whilst still enabling automated monitoring.
	  ○ Criteria led discharge pathways are now also being developed in A515 and A900.
	• Next steps will also involve the development of a CLD 'Toolkit' to support the introduction of new CLD pathways ensuring learning from the above pathway projects.
	• Chief Registrars in medicine are working on an A3 project, supported by Proactive Hospital teams, to target weekend discharges. Thorough data review is underway to determine wards where focused intervention may have the biggest impact. Qualitative feedback from weekend discharge shifts have been collated (GEMBA) and process mapping is also in progress – specifically looking at Friday preparations and AMU processes.
	• Weston Hospital is also beginning to use the weekend discharge care flow tags / lists in April 2023.
	• A second weekend discharge event took place on Saturday 22nd April at Weston hospital. learning from both events will be reviewed with divisional representation to plan an approach moving forward.
	• A new model of 'weekend huddles' has launched in BRI, with two weekends of weekend huddles taking place. Feedback will be reviewed at the next EMM programme Group meeting; next steps will include roll out to Weston.

Risks:	423: Risk that demand for inpatient admission exceeds available bed capacity

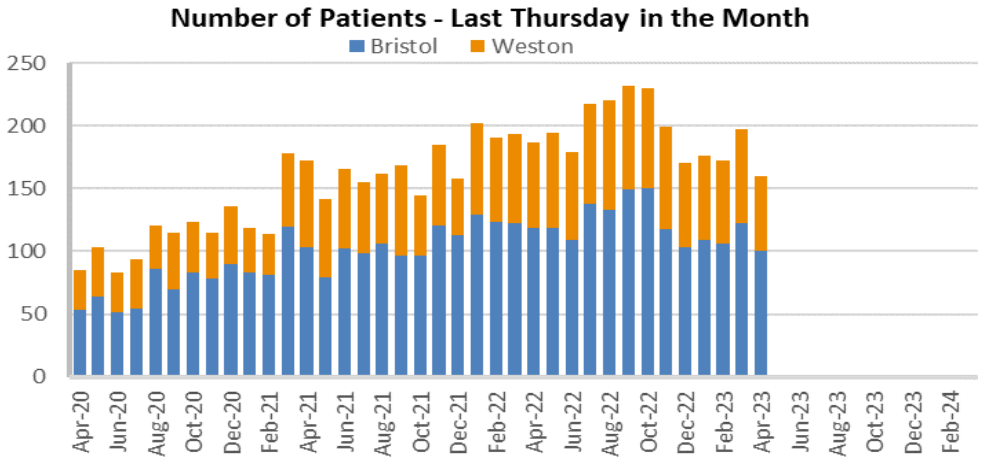
Performance Report

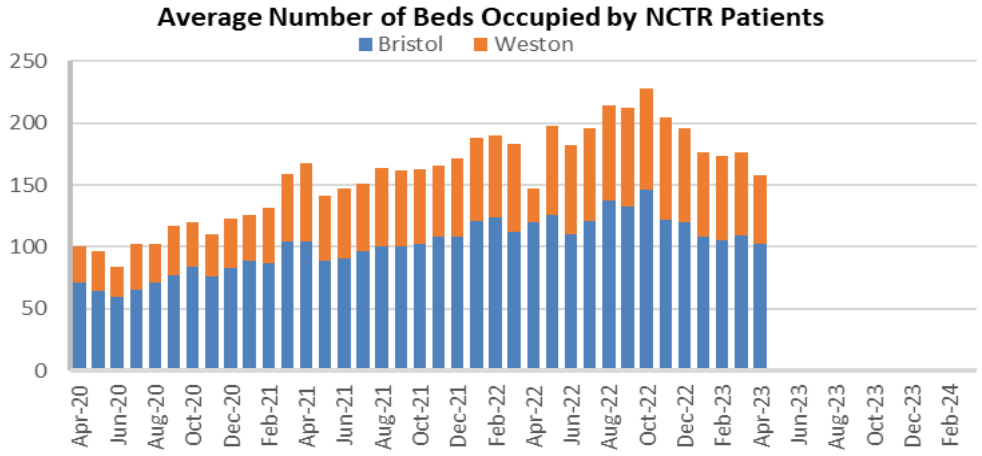
University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD	EVERY MINUTE MATTERS - TIMELY DISCHARGE AND NO CRITERIA TO RESIDE (NCTR)

No Criteria To Reside (NCTR) Summary





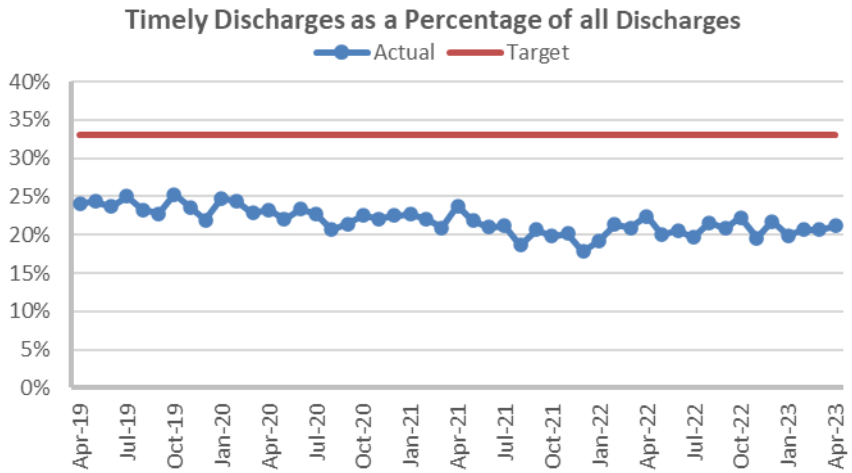
Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD **EVERY MINUTE MATTERS - TIMELY DISCHARGE AND NO CRITERIA TO RESIDE (NCTR)**

Timely Discharge Summary



Summary of High Volume Specialties - April 2023

	Total Discharges	% Before Noon
Cardiac Surgery	90	7.8%
Cardiology	268	19.0%
Clinical Oncology	54	18.5%
Colorectal Surgery	137	14.6%
ENT	104	19.2%
Gastroenterology	118	27.1%
General Medicine	660	17.4%
General Surgery	72	15.3%
Geriatric Medicine	309	33.7%
Gynaecology	124	20.2%
Ophthalmology	54	37.0%
Paediatric Surgery	70	17.1%
Paediatrics	164	15.2%
Thoracic Medicine	170	17.1%
Trauma & Orthopaedics	187	31.0%
Upper GI Surgery	89	25.8%
UHBW TOTAL	**3,481**	**21.2%**

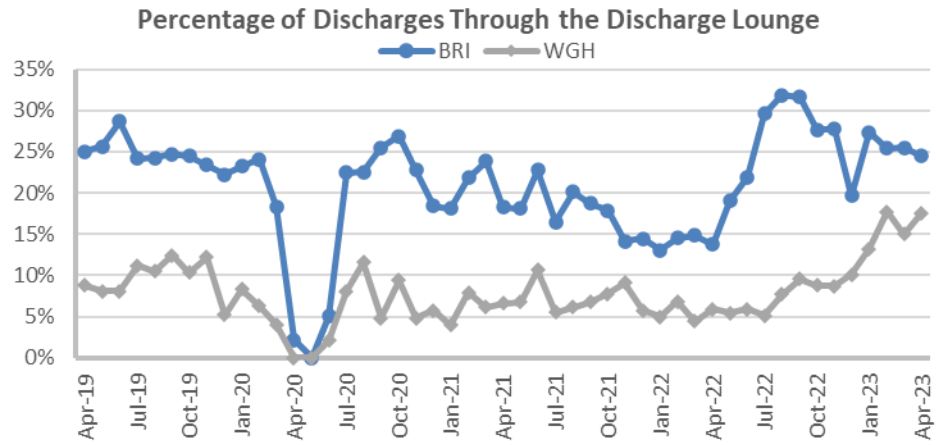
Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

STANDARD **EVERY MINUTE MATTERS - TIMELY DISCHARGE AND NO CRITERIA TO RESIDE (NCTR)**

Discharge Lounge Use Summary



Summary of High Volume Specialties - April 2023

	BRI	WGH	TOTAL
Accident & Emergency	7.0%	0.0%	6.4%
Cardiac Surgery	69.4%	-	69.4%
Cardiology	52.0%	25.0%	50.3%
Colorectal Surgery	14.1%	30.0%	15.8%
ENT	4.7%	-	4.7%
Gastroenterology	11.4%	25.5%	19.8%
General Medicine	23.3%	12.6%	17.2%
General Surgery	0.0%	20.0%	17.3%
Geriatric Medicine	28.6%	19.5%	27.2%
Hepatobiliary and Pancreatic Surgery	8.3%	-	8.3%
Maxillo Facial Surgery	6.7%	-	6.7%
Thoracic Medicine	12.0%	13.7%	12.6%
Thoracic Surgery	2.9%	-	2.9%
Trauma & Orthopaedics	11.5%	29.5%	18.9%
Upper GI Surgery	9.8%	46.7%	19.6%
UHBW TOTAL	**24.5%**	**17.6%**	**22.3%**

Performance Report

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: April 2023

FINANCIAL SUMMARY

YTD Income & Expenditure Position	• Net I&E deficit of £3,949k against a deficit plan of £2,261k (excluding technical items). • Total operating income is £740k adverse to plan due to higher than planned income from activities of £305k and lower than planned other operating income of £1,045k. • Operating expenses are £1,625k adverse to plan primarily due to higher non- pay expenditure. Pay and depreciation are broadly in line with plan. • Technical and financing items are £410k favourable to plan.
Key Financial Issues	• *Recurrent savings delivery below plan* – Trust-led CIP delivery is £827k or 55% of plan, of which recurrent savings are £198k, 13% of plan. Failure to achieve the annual target of £27m (including transformational savings) in full may result in the Trust failing to meet the financial plan. • *Delivery of elective activity recovery below plan* – elective activity must be delivered in line with plan. Failure to do so will result in a loss of income of up to c£30m which may result in the Trust not achieving its financial plan. • *Corporate mitigations not delivered in full* – non-recurrent mitigations of c£25m must be achieved to support delivery of the plan. • *Failure to deliver the financial plan* – failure to deliver the actions and therefore the financial plan will result in regulatory intervention and the risk of the Trust going into 'special measures'.
Strategic Risks	• Assessment and implications of the financial arrangements relating to Healthy Weston 2 Phase 2 – pending completion of the business case in December 2023; • Understanding the risks and mitigations associated with the capital regime; and how the CDEL limit and system prioritisation restricts future strategic capital investment – pending completion of the Trust's capital plan for 2023/24 and 2024/25. • Understanding the implications of the Trust's recurrent deficit of c£60m, the requirement to implement a 3 year Financial Recovery Plan to address the recurrent deficit and the impact this will have on future investment decisions and autonomy.

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

TRUST YEAR TO DATE FINANCIAL POSITION

Trust Year to Date Financial Position

	Month 1		
	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's
Income from Patient Care Activities	79,424	79,729	305
Other Operating Income	9,273	8,228	(1,045)
Total Operating Income	**88,697**	**87,957**	**(740)**
Employee Expenses	(55,550)	(55,465)	85
Other Operating Expenses	(31,707)	(33,413)	(1,706)
Depreciation (owned & leased)	(2,908)	(2,913)	(5)
Total Operating Expenditure	**(90,165)**	**(91,790)**	**(1,625)**
PDC	(1,037)	(1,037)	0
Interest Payable	(221)	(218)	3
Interest Receivable	250	515	265
Other Gains/(Losses)	0	0	0
Net Surplus/(Deficit) inc technicals	**(2,476)**	**(4,574)**	**(2,098)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	215	625	410
Net Surplus/(Deficit) exc technicals	**(2,261)**	**(3,949)**	**(1,688)**

Key Facts:

- The position at the end of April is a net deficit of £3,949k against a deficit plan of £2,261k.
- During April, the Trust spent £542k on costs associated with internationally educated nurses.
- Pay expenditure in April is in line with plan at £55,465k, but c£1,500k higher than the run rate. This is driven by increased enhanced payments due to bank holidays and cover during the periods of industrial action.
- Agency expenditure in month is £2,415k, compared with £2,981k in March. Overall, agency expenditure in month is 4% of total pay costs.
- Other operating expenditure in April is c£4,000k higher than the average for Q4 2022/23 but £1,706k higher than plan. This is mainly due to higher than expected costs on clinical supplies, reflecting an increase in activity during the month.
- Operating income is marginally behind plan in April due to lower than planned 'other operating expenditure'.
- Trust-led CIP achievement for the year is 55% of plan at £827k, excluding system transformation plans.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**Quality Account 2022/23**
Report Author	**Chris Swonnell, Associate Director of Quality & Compliance**
Executive Leads	**Deirdre Fowler, Chief Nurse & Midwife** **Stuart Walker, Chief Medical Officer**

1. Purpose

The draft annual Quality Account for UHBW is presented here for approval.

2. Key points to note *(Including any previous decisions taken)*

The Quality Account is presented here as a final draft for approval. The final draft will be formally proof-read by the Trust's Communication Team following Board approval, ahead of publication which is required by 30th June 2023.

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 services is measured in terms of patient safety, effectiveness of treatments, and experience of care provided.

The Board is reminded that NHS trusts are no longer required to obtain assurance from their external auditor on their Quality Accounts. Similarly, NHS foundation trusts are no longer required to include Quality Accounts in their Annual Reports.

3. Strategic Alignment

The Quality Account is aligned to the Trust's Quality Strategy 2021-2025, which is one of seven enabling strategies underpinning the Trust's current 2020-2025 strategy.

Two of the Trust's quality objectives for 2023/24 relate directly to Patient First strategic priorities.

4. Risks and Opportunities

Risk of non-achievement of corporate quality objectives.

5. Recommendation

This report is for Approval.

6. History of the paper

Please include details of where paper has <u>previously</u> been received.

Clinical Quality Group	3/5/23
Quality & Outcomes Committee	23/5/23

University Hospitals Bristol and Weston NHS Foundation Trust

Quality Account 2022/23

Contents

Part 1

1.1 Introduction from the Chief Executive

This has been my first year as Chief Executive at UHBW and I am very proud of all that has been achieved by our people. Against a backdrop of challenges, so much good work has taken place and the focus, dedication and determination of every single person at the Trust has hugely benefited our patients and their loved ones during their time of need.

Team UHBW has much to feel proud about as we look back on 2022/23. Like many of our colleagues in the NHS, we faced another challenging year. We made significant progress in tackling the ongoing impacts of the pandemic including our elective waiting lists against the backdrop of strike action across the health sector and beyond. We continued to go from strength to strength, building on the solid foundation of our combined hospitals and living our Trust values.

It is three years since University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust came together to form UHBW. The ambitions of the merger and the commitment of our talented, dedicated workforce has brought positive change for communities across the region. This has been evident in Weston General Hospital's improved Care Quality Commission (CQC) rating in October 2022, with three of the five quality domains assessed now rated as Good.

In 2022/23, the impact of the strikes by members of the British Medical Association (BMA), Chartered Society of Physiotherapists (CSP) and Royal College of Nursing (RCN), as well as by colleagues at Southwestern Ambulance Service NHS Foundation Trust (SWAST), was felt across all our hospitals. Balancing colleagues' legal right to strike with patient safety was essential and we witnessed exceptional collaboration between clinical and non-clinical colleagues during every strike event. From administrative support to free up colleagues, to pharmacists doing drug rounds and doctors helping patients at mealtimes, everyone pulled together. We have learned lessons from every strike and whatever the coming months bring, we have the knowledge, skills and experience to keep our patients safe and essential services running.

I strongly believe that our ability to care with compassion and kindness for those who need us most, starts within. The people that make up Team UHBW are our most important asset, and we know the previous 12 months have been tough on many of them. To support and improve the experience for everyone who works for or accesses UHBW services, we must continue to evolve and improve as an organisation. In 2022/23 we took a significant step forward in our ambition to do this by introducing the Patient First approach to continuous improvement. Patient First is a practical framework with tools and methodologies that enable deep analysis of problems or opportunities within the organisation, for which solutions should be developed and successes replicated. We will use the approach to align activities across the organisation and make decisions for the purpose of improving our performance and the advantage of our patients.

I commend this Quality Account to you. I am confident that the information in this report accurately reflects the services we provide to our patients.

Eugine Yafele
Chief Executive

1.2 Statement on quality from the Chief Nurse & Midwife and Chief Medical Officer

We are proud to be leaders in a Trust where staff dedicate themselves to continually improving the quality of care for patients. This Quality Account once again includes a number of great examples of quality improvement.

Amongst the many new developments and initiatives you will read about in this report, there are two which we would like to highlight in particular. Firstly, during 2022/23, we have introduced a new system of clinical accreditation. This is our new way of carrying out comprehensive quality checks on our wards and in other departments. Accreditation creates a sense of healthy competition and pride as we all strive together to provide the best services for patients we possibly can. You can read more about this programme on page 43 of this report.

Secondly, we are also delighted that 2022/23 has been a year when the Trust has for the first time published a Health Equity Delivery Plan. You can find out more about health equity on pages 18 and 61 of our Quality Account. Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. As leaders for healthcare quality in our Trust, we are 100% committed to the objectives of our Health Equity Delivery Plan, which include improving access to, experience of, and outcomes from our services, and building the confidence and skills of our people to meet the needs of our diverse patient population.

In his introduction to this Quality Account, Eugine has talked about Patient First, an approach to quality improvement. As we look ahead to 2023/24 and beyond, we firmly believe Patient First has the potential to transform the way we work and to continuously improve the experience of the people whose care is entrusted into our hands.

Thank you to all our staff who are constantly doing that little bit extra every day to help patients and their families and who contribute to the Trust's reputation for providing high quality care.

Professor Deirdre Fowler
Chief Nurse and Midwife

Professor Stuart Walker
Chief Medical Officer

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 2022/23

Five corporate quality objectives were selected for 2022/23. We agreed to carry forward existing objectives relating to delivering the NHS Patient Safety Strategy and improving patients' experience of discharge.

We also set three new objectives:

- Supporting patients to 'wait well'
- Developing a new Trust strategy for Healthcare Inequalities, with a focus on equality diversity and inclusion for patients and communities
- Developing and delivering a new vision for post-pandemic volunteering

In each case, by the year-end we had completed the work we set out to do in 2022/23.

Objective 1	**Delivering the NHS Patient Safety Strategy (Year 2)**
Rationale and past performance	In July 2019, NHS Improvement published the first ever national patient safety strategy, setting the direction of travel for patient safety in the NHS in England for the foreseeable future. The strategy recognises that: • Patient safety has made great progress since the publication of "To err is human" 20 years ago but there is much more to do. • The NHS does not yet know enough about how the interplay of normal human behaviour and systems determines patient safety. • The mistaken belief persists that patient safety is about individual effort. People too often fear blame and close ranks, losing sight of the need to improve. More can be done to share safety insight and empower people – patients and staff – with the skills, confidence and mechanisms to improve safety. • Getting this right could save almost 1,000 extra lives and £100 million in care costs each year from 2023/24. The potential exists to reduce claims provision by around £750 million per year by 2025. Addressing these challenges will enable the NHS to achieve its safety vision; to continuously improve patient safety. To do this, the NHS will build on two foundations: a patient safety culture and a patient safety system. Three strategic aims will support the development of both: 1. improving understanding of safety by drawing intelligence from multiple sources of patient safety information (Insight)

	2. equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement) 3. designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement).
What we said we would do	We said: In 2022/23, we will deliver Year 2 of UHBW priorities to implement the national strategy. To do this we will: 1. Insight • Be ready to transition to new Patient Safety Incident Response Framework from October 2022 by: o Conducting a thematic situational analysis on which to base a UHBW incident response plan by end Q1 2022/23 o Developing a UHBW patient safety incident response plan by July 2022. o Putting in place a team of expert investigators to lead investigations into our identified highest risk patient safety themes (subject to funding approval) o Transferring to Patient Safety Incident Response Framework (end Q2 2022/23) o Ensuring our local risk management systems is ready to link with the new national "Learning from Patient Safety Events" system from 2023. 2. Involvement • Conduct a "readiness for involvement" assessment and develop our involvement plan. • Recruit Patient Safety Partners into our organisation by March 2023 • Further developing our communications and engagement plan across UHBW and our wider communities to support the changes in implementing year 2 of the Patient Safety Strategy • Refining UHBW patient safety training matrix and content for all staff to incorporate additional national Head Education England training as it becomes available 3. Improvement • Continue our patient safety improvement programme focus on the identified highest risk patient safety themes whilst remaining alive to new emerging themes 4. Culture development • Further develop our patient safety culture which underpins our approach to keeping people safer, including the recruitment of a human factors specialist to inform our insight, education and improvement work (subject to funding approval).
Measurable target/s for 2022/23	• Thematic situational analysis completed by end of Q1 2022/23. • Patient Safety Incident Response Plan developed by July 2022. • Transferring to Patient Safety Incident Response Framework by the end of Q2 2022/23.

	• Team of expert investigators in place by end Q3 2022/23 (subject to funding approval). • Readiness for involvement assessment conducted by end Q2 2022/23. • Patient Safety Partners in place by end Q4 2022/23.
How progress will be monitored	Through quarterly reporting to: Patient Safety Group, Clinical Quality Group and Senior Leadership Team.
Board sponsors	Chief Nurse & Midwife, and Medical Director
Implementation lead	Head of Quality and Patient Safety
Designated Head of Nursing	Head of Nursing, Division of Surgery
How did we get on?	Dates for achieving the specific elements have been later than planned at the start of the financial year but are largely achieved by year end. **Insight** • The updated Patient Safety Incident Response Framework was published by NHS England on 16th August 2022. The framework is supported with additional guidance and templates and recommends a staged approach over a 12-month period, with an expectation the NHS providers will transfer by June 2023. The UHBW PSIRF project plan was reviewed in response to these publications. A transfer date is set for the end of April 2023. • The thematic situational analysis is complete and our first Patient Safety Incident Response Plan has been produced. This was approved by our Board and the ICB in March 2023 ready for transfer to PSIRF in April. • Recruitment to a new centralised patient safety incident investigation team to facilitate the transfer to the Patient Safety Incident Response Framework is complete. • The national timeline for migration to "Learning from Patient Safety Events (LFPSE)" has been extended to 30th September 2023. We have a LFPSE-compliant incident reporting form in our local risk management test system by 31st March 2023 which has been signed off by the national Patient Safety Team. We aim to go live with the new system in Quarter 2 2023/24. **Involvement** • UHBW has successfully recruited two Patient Safety Partners (PSPs) who are now participating in our Trust Patient Safety Group. • National Patient Safety Syllabus training is now available for staff and Level 1 is mandated for all new UHBW staff. A revised patient safety training matrix is being finalised in April 2023. **Improvement** • Our patient safety improvement programme continues with a key focus improving the recognition and response to patient deterioration in line with national improvement priorities. A maternity

	improvement programme is also in place working in collaboration with our local maternity system. **Culture development** • New resources to support a Just and Restorative learning response to incidents were launched in November 2022, including a podcast. • The Associate Director or Quality and Patient Safety is an integral part of the working party to produce a new Resolution Framework for the Trust as part of the Supporting Positive Behaviours work. The Resolution Framework will align with, and is based on, a Just and Restorative learning response and will cover a broader range of processes that are triggered in response to events, such a disciplinary process or a bully and harassment incident. • A Head of Human Factors post has been recruited to inform our insight, education and improvement work, starting in May 2023.
RAG rating	Objective for 2022/23 completed, with more work planned for 2023/24

Objective 2	**Improving patient experience of discharge from hospital (Year 2)**
Rationale and past performance	Last year (2021/22) we set ourselves an objective to improve patients' experience of discharge from hospital. We know from patient feedback that receiving a safe, coordinated, and planned discharge helps patients and their families to leave hospital feeling as if they have been well looked after, and well prepared to adapt back to their home environment. The ongoing impact of the pandemic meant that our focus in 2021/22 was largely on diagnostic activity, to gain a better understanding of a complex topic, with improvement work being assigned to 2022/23.
What we said we would do	We said: We will use the diagnostic exercises completed in 2021/22 to inform a number of workstreams to deliver improvements in 2022/23. This includes patient and staff survey data gathered by local Healthwatch. A new workstream called "Every Minute Matters" has been initiated by the Trust and will be central to our plans for the year. One outcome of this programme of work is to improve patient experience of their discharge, reduce delays and identify a process of who to contact after discharge for further information. The aim of the programme will initially be to relaunch the SAFER Patient Flow Bundle, which will include implementation of the Clinical Utilisation Review programme (CUR), criteria led discharge (CLD), enhancing the robustness of board rounds, and effective use of estimated date of discharge (EDD). The SAFER Patient Flow Bundle is a practical tool to reduce delays for patients in adult inpatient wards (excluding maternity); evidence shows that when the tool is followed consistently, length of stay reduces and patient flow, experience and safety improves. CUR is a clinical decision support software tool that enables clinicians to make objective, evidence-based assessments of whether patients are receiving the right level of care in

	the right setting, at the right time based on their individual physical and mental health needs. CLD is a process where the clinical parameters for patient discharge are clearly defined using individualised criteria; once patients meet the criteria, a trained member of staff can manage their discharge rather than waiting for the medical team to facilitate the discharge. A dedicated task and finish group and associated governance framework has been established to deliver this. We will plan clear communication to manage discharge effectively including monitoring with a performance dashboard and utilising an education plan for developing staff awareness and education.

Measurable target/s for 2022/23	• Increased number of patients discharged by midday.
	• Increased usage of discharge lounge
	• Decreased average length of stay for medically fit for discharge patients.
	• Improved patient feedback to the following questions via our monthly post-discharge survey:
	  ○ "Do you feel you were kept well informed about your expected date of discharge from hospital?"
	  ○ "On the day you left hospital, was your discharge delayed for any reason?"

How progress will be monitored	Every Minute Matters Steering Group Flow and Discharge Steering Group reporting to Recovery Delivery Programme Board
Board sponsors	Chief Nurse and Chief Operating Officer / Deputy Chief Executive
Implementation leads	Deputy Chief Operating officer Deputy Chief Nurse Assistant Director of Operations Assistant Chief Nurse
Designated Director of Nursing	Directors of Nursing, Division of Medicine, and Weston Division
How did we get on?	**Every Minute Matters** In 2022/23, the UHBW Every Minute Matters (EMM) programme was initiated, focussing on releasing time, both in term of how long patients spend in hospital, and also how we enable the best use of staff time. After focused planning and preparation in Quarter 2 the EMM workstream went live across the Trust. Initial results are positive and the workstream is being recognised nationally and across the Integrated Care Bureau (ICB) as a well-planned and structured delivery programme. Our focus going forward is ensuring sustainability of the initiatives that were identified when commencing the programme. 40 inpatient wards have now completed their 12-week EMM programme. The biggest improvements have been the recognition of the need to have a multidisciplinary team (MDT) touchpoint as early in the day as possible whereby concise updates can be provided about patient progress with a focus on time limited tasks including the discharge of a patient. The MDT is a clinical team which includes nursing, medical, allied health professionals, and staff from the hospital discharge bureau. The inclusion of the Criteria to Reside data input in the morning board round is progressing well; having this data allows us

to understand the numbers of patients in the hospital that have criteria to reside against NHS England (NHSE) criteria and of those with no criteria to reside, we can now see reasons why those patients remain in our hospital beds. Such visibility of data enables the hospital to focus attention on those delays to discharge and allow work to take place to resolve the delays and enable the patient to be discharged from hospital.

The roll out phase of the Proactive Board Round and Criteria to Reside workstreams of Every Minute Matters was completed in January 2023. Support remains in place to ensure the work is embedded and sustained. Following the completion of the rollout, the EMM task and finish group has focused on the following priorities:

- Initiation of divisionally led 'EMM oversight' groups. Leads for these groups are now provided with summary data packs for their relevant wards which highlight performance against the key EMM metrics. Links to existing dashboards are provided to allow the oversight groups to review data in detail where required and is accessible to all ward staff.
- Ongoing coaching support for wards relating to proactive board rounds, validations, and Criteria to Reside submissions.
- Development of scorecards which present data such as a patient's length of stay, the use of the discharge lounge or the timeliness of the patients discharge which are reviewed at the Flow and Discharge Steering Group.

Data

To enable teams to see the results of the Criteria to Reside data, we have a number of resources in place including:

- The 'Flow and Discharge Dashboard'
- The Audit Management and Tracking system (AMAT) dashboard shows Proactive Board Round validation checklist outcomes.
- An EMM benefits monitoring report which has now been converted to a dashboard form, enabling comparison of key metrics year on year. This also enables an 'at-a glance' view of top performing wards.

Improving weekend discharges

The first of a series of weekend discharge events was undertaken in February 2023 at the Bristol Royal Infirmary (BRI). The next event is scheduled at the Weston General Hospital in April 2023. The first BRI event was supported by:

- An additional discharge focussed medical registrar.
- Additional discharge team members
- NHS@Home attend the hospital to see if they could support any patients in their own home.
- Regular weekend huddles including clinical site team, therapy, pharmacy,
- Use of a Care flow team and patient list for focussed review of patients identified using selected MCAP delay codes and EDDs within 3 days.

Learning from this event has been collated into an action plan which is being overseen by the EMM Task and finish group. Some key areas of focus include:

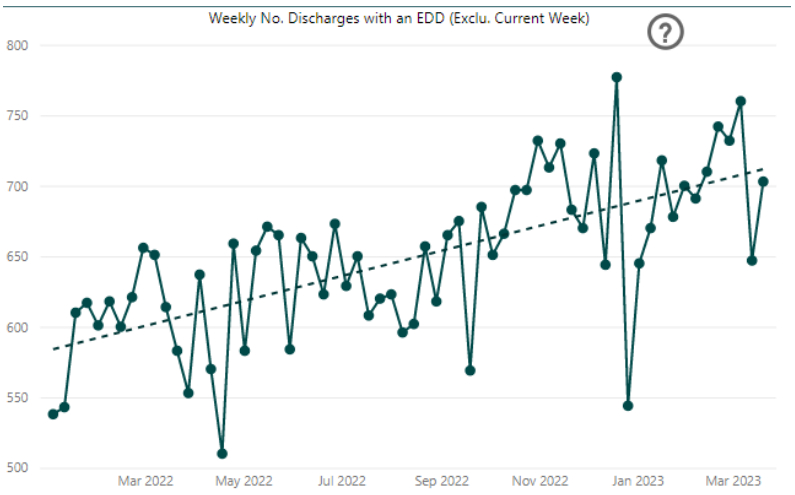
- Supporting completion of medication prescriptions and discharge summaries prior to the weekend
- Digitalising a 'blank' criterion led discharge clinical note.
- Use of care flow tags and patient lists to identify patients for weekend review.
- Refining use and understanding of community discharge pathways, including palliative care / end of life.

EDD (Estimated Date of Discharge)

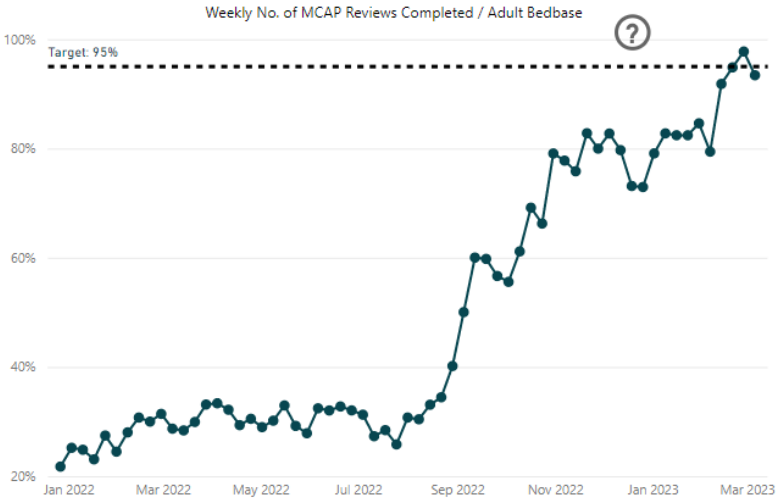
During our first weekend discharge event in Quarter 4, we tested the ability to use EDDs to focus reviews of patients who were anticipated to be ready for discharge within the next three days to see if their discharges could be brought forward. Findings from the weekend indicated that whilst the EDDs highlighted a reasonable number of patients fitting this criterion, there were limited opportunities to reduce lengths of stay. We have revisited the use of EDDs with a focus on ensuring that the data is adding value to patients and supporting inpatient hospital flow. A series of focus groups have been undertaken to collect feedback from a range of hospital teams including nursing, medical, pharmacy and therapy colleagues regarding the EDD process.

The EDD is available to see on digital whiteboards in each clinical area and a change has been developed whereby if the patient has an EDD of today, this will turn red on the board, and if the EDD is set for the following day the EDD will be orange. This helps teams see at a glance who is expecting to be discharged on that day / the next day to also help prioritise any actions. We see the value in using EDD so will be continuing to focus on using this during 2023/2024 with a focus on the patients' involvement and awareness of when their discharge is planned so they can prepare for that discharge date.

We are starting to see improvement in the use of EDD:



Across UHBW, we have seen a significant increase in the daily number of Criteria to Reside reviews completed as a result of the MDT discussion and the proactive board rounds.



Criteria Led Discharge (CLD)
Data from proactive board rounds is highlighting that Criteria Led Discharge is not used as much as it could be. As a result, the EMM team is currently working with two cardiology wards, and a cardiac surgery ward to develop and trial the use of a clinical note (within Careflow) to support CLD for patients who have undergone Cardiac Surgery, and Pacemaker procedures.

In addition, a 'blank' Criteria led Discharge clinical note is also in development, with the aim of supporting discharges for patients where medical teams can define the specific criteria at the point of assessment. This would replicate areas across the trust where paper notes are used to support CLD. The benefits of digitalising this process would be the ability for the teams whom mange patient admissions and discharges to identify patients on a CLD pathway, and support ward teams to progress discharges. The data captured by the digital forms will enable identification of barriers to the CLD being completed and create meaningful objectives to ongoing improvement of the process.

Use of the reformed Transfer of Care Document (Toc Doc)
In July 2022, the digital Transfer of Care Document (ToC Doc) was implemented within UHBW, replacing the Single Referral Form (SRF), encouraging effective integrated working across health and social care. The ToC Doc is important for identifying the ongoing care for the patient after discharge from hospital, providing a communication tool between acute and community care. This has meant a reduction in time spent completing and sending forms and means that amendments are possible without needed to complete a whole new form if there queries.

This document is now embedded in practice and is being monitored within our Flow and Discharge dashboard. We are seeing very positive

results in the reduced time from submission of the ToC Doc to discharge.

We have seen a steady decrease in the number of days between a patient's admission and their Toc Doc being submitted.

Bristol Royal Infirmary:

Average LOS Admission to First TOC Doc			
	Apr-22	Feb-23	Diff from
P1	10.4	10.4	0.0
P2	12.1	14.2	2.1
P3	16.3	13.4	-2.9

Average LOS First TOC Doc to Discharge			
	Apr-22	Feb-23	Diff from
P1	13.3	8.0	-5.3
P2	15.2	15.4	0.2
P3	36.1	31.0	-5.1

Weston General Hospital:

Average LOS Admission to First TOC Doc			
	Apr-22	Feb-23	Diff from
P1	14.8	11.1	-3.6
P2	12.8	12.2	-0.6
P3	30.0	19.3	-10.7

Average LOS First TOC Doc to Discharge			
	Apr-22	Feb-23	Diff from
P1	6.4	5.8	-0.7
P2	16.9	10.9	-6.0
P3	21.8	18.8	-3.0

Use of the Discharge Lounge

In the year 2022/23, the use of the discharge lounge on the BRI site has increased by 6.7% compared to 2021/22. Quarter 4 of 2022/23 also saw a similar increase in use of the discharge lounge in Weston.

Healthwatch Patient Experience P3 Pathway Report
During 2021/22 Healthwatch conducted their own project, focusing on the experience of patients within the P3 discharge pathway (for those who are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs). The aim of this project was to gain staff and user feedback via face to face and questionnaires to develop a qualitative report. In Quarter 2 of 2022/23 staff from UHBW met with the Healthwatch team to discuss the feedback, focusing on the recommendation to facilitate patients with

	clear information about their discharge pathway (P0, P1, P2, P3) and development of a discharge passport/diary aiding communication between care provider and patient and family. Content will include description of pathways and space for documentation of discussions and next steps for any healthcare professional who visits the patient. The passport, which will held by the patient/relative for them to use when they continue their pathway on discharge from the hospital, will now be developed through the new hospital programme called Active Hospitals.
RAG rating	Objective for 2022/23 completed, with more work planned for 2023/24

Objective 3	**Waiting Well**
Rationale and past performance	As a result of the COVID-19 pandemic, there has been an increase in the size of the planned care backlog, also known as the 'waiting list'. This is in the context of a growing waiting list pre-pandemic. The recovery of care backlogs will be, by necessity, multi-year. Therefore, in the short term, care backlogs are likely to continue to grow, and in the medium term, long waiting times for care and treatment are likely to subsist. This presents a risk to patient safety, experience and equitable access. In this context, UHBW has recognised a need to ensure that patients within the care backlog are Safe to Wait, that they have the support and information that they need to be Waiting Well, that we address any issues relating to Health Inequality that serve to disadvantage certain groups, and that, in the event that harm is caused to patients, that we learn from these events through a Harm Review, and make improvements to our processes and prevent future harms. This quality priority focuses on 'Waiting Well'. For context, in 2019/20, National Voices was asked by NHS England and Improvement to explore the experience of waiting for care in the context of the pandemic. The aim was to understand how waits, delays and cancellations impact on people and their families, particularly those living with long-term and multiple conditions. It is clear from the evidence that patients and carers understand that waiting will be a necessary part of their experience, but it is also clear that poorly managed waits have a detrimental impact on their physical health, mental health, employment, housing, and relationships. The report offers three key recommendations for providers: 1) Understand the importance of improving the experience of waiting; 2) Invest in development patient-centred information and communication; 3) Support people while they wait through: - self-management support and shared decision making, - signposting and partnerships with voluntary and community services,

	- monitor / check-in routinely and provide clear pathways to specialist advice when required and - developing a virtual healthcare offer. Crucially, the report also offers a set of good practice principles for designing a more positive experience of waiting. We will adopt these principles at UHBW.
What we said we would do	Three waiting well priorities have been agreed, taking account of patient experience feedback: - Acknowledgment - Communication - Signposting The aim is to put in a place a range of accessible measures that provide person-centred information and support for patients whilst they wait: • Send people and acknowledgement of receipt of referral; • Help people understand by publishing information about how we make decisions about waiting, what the wait for service is like and what might change (including the My Planned Care App); • Tell people how to contact the Trust and when (for example if their condition deteriorates); • Check in with some groups of patients during the wait and use Shared Decision Making to enhance good conversations; • Provide/signpost to support and self-management; • Provide/signpost to support for carers and family; • Offer and signpost to peer support, social prescribing and other Voluntary and Community sector based-support; • Provide on-line and printed information about the appointment /procedure and what to expect/how to prepare (for example through the prehabilitation programme. • Under the patient experience of waiting (for those patients waiting over 6 months) to understand what is working well and what we need to improve
Measurable target/s for 2022/23	1) A 'waiting well' page on the UHBW website for patient and the public to access up-to-date and helpful resources to support them (measured by link clicks / downloads or resources; 2) Published links to the My Planned Care website across a range of digital and printed materials; 3) Increase in referrals to VCSE support from baseline 4) Percentage of eligible patients who had at least one 'check-in' conversation provided during their wait (increase from baseline) 5) Evidence of updated and consistent patient information (online and published) with what to expect / how to prepare for procedure
How progress will be monitored	Through quarterly reporting to: Planned Care Steering Group, Patient Experience Group, Clinical Quality Group and Senior Leadership Team.
Board sponsor	Chief Operating Officer / Deputy Chief Executive
Implementation lead	Deputy Chief Operating Officer – Planned Care

Designated Director of Nursing	Director of Nursing, Division of Specialised Services
How did we get on?	• In October 2022, a Waiting Well group was established as a sub-group of the Planned Care Steering Group. This group meets monthly. The group is chaired by the Deputy Chief Operating Officer. • A Health Matters event on 'Waiting Well' took place on 2 November 2022 inviting patients, staff, public to talk about concerns and ways of managing expectations. Between 20-25 members of the public (including UHBW Governors) attended this event. Feedback from the event and the breakout groups was captured and has been used to inform of future plans. Key themes that emerged from the Health Matters event included: frustration, worry and feeling abandoned, with communication described as inadequate and confusing. Following the Health Matters event, we successfully appointed two lay representatives to join the Waiting Well group. • We also looked for themes in our 'patient feedback via Friends and Family Test and monthly surveys. General reflections included some very positive experiences about the care received on the day. However, there were concerns expressed about administrative processes being difficult to navigate. Key themes included: patients having to chase the hospital for updates about their care, difficulties being able to communicate with the hospital. There was also failure to manage expectations about likely waiting times, and when delays did happen, a lack of acknowledgement or apology. • In November 2022, the group received a presentation from VitaHealth so that we can consider how best to signpost patients to the mental health / talking therapies support that is on offer. For patients that come from outside of our immediate system, there may be a different provider of these services which we would need to consider. • In March 2023, with the support of the Trust's Communications Team we launched a Waiting Well webpage on the Trust's internet site. This webpage provides information for patients about waiting for their hospital appointment, how to keep well while they wait, and preparing for surgery. It also signposts patients to other sources of information including the national My Planned Care website, our pre-procedure optimisation (prehabilitation) services, and our recently published AccessAble guides to our hospitals. • The Waiting Well group has been considering how and when we should be communicating with patients from the point of referral, to booking an appointment, to the point of discharge from hospital services. As part of this process the group has reviewed the use of the electronic Referral System (eRS), and the implications for being able to communicate with patients that have been referred, but not yet booked into an outpatient appointment; the use of 'dummy' clinic booking and how this is potentially problematic; the opportunities associated with the use of the DrDoctor platform which is being rolled out Trust-wide. This tool provides functionality such as the ability, for patients that choose to, for viewing clinic letters through a web portal, the ability to rebook outpatient appointments through

	this portal, and the facility to send patients text messages and assessment forms to help prioritise and better manage their care. • The group is in the process of developing an ideal model for communication with patients including acknowledgment of receipt of referral and management of expectations in terms of likely waiting times, signposting to sources of information including the Trust's Waiting Well webpage and services for patients experiencing low mood, depression, or anxiety. A prototype communication model was presented at the Waiting Well group in April 2023. • Two working groups have been established at system level with representation from both UHBW and NBT. One is considering perioperative practice and prehabilitation. The focus of this group is on the use of the DrDoctor Assessments tool to help to gather information to support the optimisation of patients before their surgery. The second working group is focussing on health inequality and data sharing. The specific focus is on patients that have a higher rate of not attending their clinic appointments, and how we can address any issues related to equity of access to our services. • An initial pilot of the C2Ai tool was completed in October 2022 including an assessment of how the tool could be used to prioritise patients and aid the pre-operative optimisation of patients awaiting surgery. A Power BI dashboard has been developed including a feature that is being tested tracking patient level scores for risk of deterioration or complications on a week-to-week basis. The Trust is now focussing on engaging with clinical teams in the roll out of the use of this tool. The Trust is also considering the C2Ai Observatory tool, which provides retrospective trend analysis against a range of quality metrics.
RAG rating	Objective for 2022/23 completed, with more work planned for 2023/24

Objective 4	**Developing a new Trust strategy for Healthcare Inequalities, with a focus on Equality Diversity & Inclusion for patients and communities**
Rationale and past performance	Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. Health inequalities are ultimately about differences in the status of people's health. The term is also commonly used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives, both of which can contribute to their health status. Health inequalities can therefore involve differences in: • health status, for example, life expectancy and prevalence of health conditions; • access to care, for example, availability of treatments; • quality and safety of care; • behavioural risks to health, for example, smoking rates; • wider determinants of health, for example, quality of housing. The COVID-19 pandemic has exposed longstanding inequities in society and without focused positive action, this will have long-term implications

	for health and health inequalities. The impact of health inequalities include: • Significant differences in life expectancy • Avoidable variation in mortality • Avoidable variation in health outcomes • Avoidable variation in harm and safety • Increased risk of long-term health conditions • Increased risk of mental ill health • Poor access to and experience of health services The Trust has direct control over some aspects of the health inequalities landscape, in particular access to care and treatment, the quality of care the Trust providers and how services are designed and delivered so they are equitable for the diverse patient population we service. We also have influence as part of the wider Integrated Care Partnership over other drivers of health inequality. The Trust has an established workforce Equality, Diversity and Inclusion (EDI) strategy and plans in place to achieve this strategy, however, there is no strategy that articulates and coordinates action on EDI for patients and communities. This quality priority will address this. Nationally, NHS England & Improvement have published the Core20Plus5 framework which is an approach designed to support ICPs to drive targeted action in health inequalities improvement. There is also a new contractual requirement in 2022/23 for the Trust to develop a health inequalities action plan, aligned to the local ICP priorities.
What we said we would do	In 2021/22, we commissioned an independent baseline review of our approach to EDI for patients and communities from a national social enterprise, PHAST CIC. The focus of the review was to understand how well our people, processes, systems, structures and organisational culture support us in: - advancing equality for patients and communities and - providing accessible and inclusive services for our patients - tackling health inequalities. The baseline review report will be available by the end of Quarter 1 2022/23. A Board Seminar is planned in July 2022 to review the key findings from the review and to consider the recommendations in detail and to begin to prioritise a set of equality objectives for the next 2-3 years. Following the Board Seminar, we will develop a concise set of priorities for our programme of EDI work for patients and communities. These priorities will bring together existing workstreams, for example, our work to become fully compliant with the NHS Accessible Information Standard, our work to provide comprehensive access information to patients about our locations, as well as emerging areas of focus as a result of the baseline review.

	We will test out the potential areas of focus with our workforce, patients and community partners to ensure we prioritise those areas that will make the most difference to our diverse patient population. We will publish the EDI strategy and the accompanying health inequalities action plan by Quarter 3 2022/23 with clear equality objectives visible on the Trust's website and promoted internally to our workforce.
Measurable target/s for 2022/23	a) EDI baseline report received by 31 May 2022 from PHAST CIC b) Board Seminar session (to receive recommendations from baseline review) takes place on 12 July 2022 c) Strategy is developed with staff, patients and community partners d) Strategy objectives deliverable (i.e. they are carefully prioritised and resourced across the Trust) e) A health inequalities action plan is developed (part of schedule 2N of the Trust's contract with the CCG) f) There is a health inequalities / EDI governance structure in place that guides the work with a clear accountability and Board leadership g) The Trust is fully aligned to ICP (system) work on health inequalities and proactively participating in relevant fora and workstreams
Board sponsor	Chief Nurse & Midwife
Implementation leads	Associate Director of Quality & Compliance and Head of Experience of Care & Inclusion
Designated Director of Nursing	Director of Midwifery
How did we get on?	In Quarter 1 2022/23 we received the final report from the independent baseline review by Public Health Action Support Team (PHAST Community Interest Company) that was commissioned during 2021/22. The independent EDI baseline review for patients was reviewed at a Board Seminar in July 2022. Trust Board endorsed the three overarching recommendations within the report. A full list of the recommendations in the PHAST report was reviewed and compiled to inform the plan. The work to develop the Health Equity Delivery Plan commenced in Quarter 3. The development of the plan included a review of best-practice from other NHS trusts, a synthesis of priorities from a national, system and internal perspective and feedback from patients, staff and community partners. The draft Health Equity Delivery Plan was considered by Clinical Quality Group in February 2023 and was then approved by Quality and Outcomes Committee in March 2023. Our vision for UHBW's approach in tackling health inequalities is 'exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes'. We have agreed five objectives we will deliver over the next two years: 1. Improve access to, experience of and outcomes from our services;

	2. Collaborate with the Integrated Care Partnership to tackle health inequalities; 3. Foster organisational capability, creating the foundation to drive forwards our health equity programme; 4. Build the confidence and skills of our people to meet the needs of our diverse patient population; 5. Develop patient EDI data and intelligence to inform planning and priority setting. Alongside the development of the plan a multi-disciplinary group came together in Quarter 3 to consider the broad range of EDI work planned or underway at the Trust and to reflect on whether we have the right governance structure in place to support us to deliver on our aims to be an inclusive employer and a provider of accessible and equitable healthcare services. A roadmap has been agreed to reach integration of the Patient and People EDI agendas at UHBW by April 2025, culminating in an integrated EDI strategy. In March 2023, a new multi-disciplinary 'Health Equity Delivery Group' met for the first time which reports to Clinical Quality Group and to Trust Board (via Quality and Outcomes Committee). The remit of the group is to oversee the successful delivery of the Health Equity Delivery Plan. This structure provides a mechanism to ensure that the quality, operational and performance aspects of the Health Equity agenda is covered in reporting and assurance structures. The group is co-chaired by the Trust Deputy Medical Director and Deputy Chief Nurse.
RAG rating	Objective for 2022/23 completed and the new Health Equity Delivery Plan is being implemented

Objective 5	**Developing and delivering a new vision for post-pandemic volunteering**
Rationale and past performance	Pre-pandemic, UHBW had a thriving volunteer programme with hundreds of volunteers giving their time to support patient and staff alike every week. Like many Trusts in the country, the volunteer programme at our hospitals was 'paused' at the start of the COVID-19 pandemic to ensure the safety of volunteers, staff and patients. Since Summer 2021, we have been growing the number of volunteers on site in key roles, doing so carefully with a tireless focus on keeping volunteers safe. It has become clear in restarting the volunteer programme that we need to refresh our thinking to ensure that we maximise the incredible value the volunteers offer our hospitals. Whilst there was a surge of support by local people and communities to volunteer and 'give back' to the NHS, for example at COVID-19 Vaccination Hubs, evidence nationally suggests that the number of people volunteering their time to organisations across the country has in fact shrunk for the first time in many years. This means we need to be increasingly creative to attract volunteers to our Trust.

	The Trust's previous volunteering strategy expired in 2020 and the planned refresh was paused last year due to pandemic pressures. However, we were able to undertake engagement with staff so they could tell us what they would like to see from a future volunteer programme. These are some of the many reasons that the Trust needs to review its volunteer programme and set out a new vision for volunteering over the next few years.
What we said we would do	The Voluntary Services team will develop a new Volunteer Strategy for 2022-2025, with an ambitious vision and a core set of strategic objectives for volunteering at UHBW. The new strategy will be informed by a review of what worked well in the previous strategy and any lessons learned from the delivery of the former strategy. We will develop the strategy by reviewing best-practice nationally and locally and we will ensure the priority areas for delivery are co-designed with volunteers and staff alike. We will develop the strategy to firmly place our hospitals at the heart of the community and in doing so, recognise the unique and special value that volunteers bring to patients and staff at our hospitals. We now have a unique and exciting moment to set out an ambitious vision for volunteering at the Trust, anchoring the Trust as a 'go-to place' for exciting volunteering opportunities in Bristol and Weston, rewarding volunteers for their contribution and dedication and aligning the volunteer programme to ensure that all roles support an outstanding patient experience.
Measurable target/s for 2022/23	1) A review of feedback collated as part of the Voluntary Services staff survey in Summer 2021 to inform the strategy by 31 May 2022; 2) Engagement with key internal and external stakeholders to inform the strategy, including current volunteers by 30 June 2022; 3) A desktop review of volunteering best-practice in NHS and VCSE organisations by 31 May 2022 4) Volunteer Strategy 2022-2025 drafted by 30 September 2022 5) A collaborative Board Seminar in July 2022 to review draft and agree priority areas of focus; 6) Published strategy by 31 December 2022
How progress will be monitored	Through quarterly reporting to the Patient Experience Group, Clinical Quality Group and Senior Leadership Team.
Board sponsors	Chief Nurse & Midwife
Implementation lead	Head of Experience of Care & Inclusion and Voluntary Services Coordinator
Designated Director of Nursing	Director of Nursing, Children's Services
How did we get on?	Following a period of extensive engagement with volunteers and colleagues during 2021/22 and 2022/23, as well as a desktop review of best practice in NHS and VCSE organisations, a draft vision and set of

	strategic goals was developed for the Volunteer Strategy 2022-2025. A presentation on the emerging goals was received by People Committee in September 2022 who were supportive of the direction of travel. Following feedback from People Committee, the full draft strategy was developed with each of the key goals aligning to the ambitions set out in the UHBW People Strategy. Input from an external designer has a resulted in a clear, coherent and visual strategy document. The strategy was approved by People Committee in January 2023. Our vision is 'to offer a thriving volunteer programme for our diverse communities and our hospitals, providing meaningful, rewarding and creative opportunities for volunteers, to enrich the experience of our patients and our people". We have agreed four goals we will deliver over the next three years: 1. Create a vibrant and varied volunteering programme that mirrors the rich diversity of our communities 2. Develop innovative roles that put the patient and staff experience at the forefront of what we do 3. Embed our volunteering programme as a visible and valued part of #TeamUHBW 4. Unlock the potential of volunteers, with opportunities that reward and recognise their value In October 2022, Voluntary Services Steering Group re-started and is overseeing the delivery of the new strategy. 
RAG rating	Objective for 2022/23 completed and the new Volunteering Strategy is being implemented

2.1.2 Quality objectives for 2023/24

This year, we have again identified five quality objectives. These include three objectives we are carrying forward: Year 3 of our objectives to deliver the NHS Patient Safety Strategy and to improve patients' experience of discharge, and an ongoing focus on supporting patients to 'wait well'.

We have also identified two new objectives associated with Patient First. Patient First is a long-term, visual, data-driven approach to continuous improvement, placing the patient at the heart of everything we do; in effect, a new management operating system for UHBW, aligning our divisions and teams with Trust strategy. Patient First means that in future we will focus energy on fewer priorities, creating more time to solve problems. The Trust's six Patient First strategic priorities are: experience of care; patient safety; timely care of our patients; our people; innovating and improving together; and making the most of all our resources. For 2023/24, we have set two quality objectives based on the experience of care and patient safety priorities. These objectives are:

- Eliminating poor experience of care
- Achieving a significant reduction in patient harm events

The continuation of our existing objective to improve patients' experience of discharge also supports the Patient First priority of timely care.

Objective 1	**Delivering the NHS Patient Safety Strategy**
Rationale and past performance	In July 2019, NHS Improvement published the first ever national patient safety strategy, setting the direction of travel for patient safety in the NHS in England for the foreseeable future. The strategy recognises that: • Patient safety has made great progress since the publication of "To err is human" 20 years ago but there is much more to do. • The NHS does not yet know enough about how the interplay of normal human behaviour and systems determines patient safety. • The mistaken belief persists that patient safety is about individual effort. People too often fear blame and close ranks, losing sight of the need to improve. More can be done to share safety insight and empower people – patients and staff – with the skills, confidence and mechanisms to improve safety. • Getting this right could save almost 1,000 extra lives and £100 million in care costs each year from 2023/24. The potential exists to reduce claims provision by around £750 million per year by 2025. Addressing these challenges will enable the NHS to achieve its safety vision; to continuously improve patient safety. To do this, the NHS will build on two foundations: a patient safety culture and a patient safety system. Three strategic aims will support the development of both, by: • improving understanding of safety by drawing intelligence from multiple sources of patient safety information (Insight)

	• equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement) • designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement). This quality priority is a continuation of an objective we set ourselves in 2022/23.
What will we do?	In 2023/24, we will deliver Year 3 of UHBW priorities to implement the national strategy. To do this we will: Insight • Implement and embed new Patient Safety Incident Response Framework (PSIRF) throughout UHBW in 2023/24 • Ensure our local risk management system is ready to link with the new national "Learning from Patient Safety Events" system in line with the revised NHSE timescales. • Develop a revised patient safety learning framework Involvement • Embed the role of Patient Safety Partners within UHBW • Develop a new patient safety Engagement and Involvement Framework enhancing opportunities for patients, families and staff to contribute to learning responses with a focus on inclusivity • Refine the UHBW patient safety training matrix and content for all staff to incorporate additional national Health Education England training as it becomes available. Improvement • Align our patient safety improvement programme with Patient First objectives and ensures systems-focused improvement work arising from PSIRF learning responses feed into the Patient First management operating system • Ensure reduction of health inequalities is taken into account when developing improvement work arising from learning responses Culture development • Develop a Human Factors Faculty across UHBW • Develop new feedback mechanisms for monitoring the experience and impact of PSIRF on patients, families and staff
Measurable target/s for 2023/24	• Achieve compliance with the new Patient Safety Incident Response Framework (PSIRF) standards following transfer to PSIRF in Q1 2023/24. • Meet the NHSE milestone for progress against transferring to the national Learning From Patient Safety Events system by the end of September 2023. • Meet the revised NHSE deadline for transferring to the national Learning from Patient Safety Events System once published.

	• Develop an Engagement and Involvement Framework for patient safety in conjunction with our Patient Safety Partners by the end of Q2 2023/24 • Develop a Human Factors Faculty across UHBW by end 2023/24
How progress will be monitored	Through quarterly reporting to: Patient Safety Group, Clinical Quality Group and Quality & Outcomes Committee
Board sponsors	Chief Medical Officer / Chief Nurse and Midwife
Implementation lead	Associate Director of Quality and Patient Safety

Objective 2	**Improving patient experience of discharge from hospital (Year 3)**
Rationale and past performance	Over the previous two years we have set ourselves an objective to improve patients' experience of discharge from hospital. We know from patient feedback that receiving a safe, coordinated, and planned discharge helps patients and their families to leave hospital feeling as if they have been well looked after, and well prepared to adapt back to their home environment. Throughout 2021/22 we largely focused on diagnostic activity, to gain a better understanding of this complex topic. During 2022/23 we progressed into developing a workstream entitled "Every Minute Matters" (EMM) using the diagnostic activity and information obtained the previous year. For 2023/24 we aim to progress and sustain the EMM programme and continue our focus on new initiatives to continue to enhance patients' and families' experience of their discharge.
What will we do?	During 2022/23 we developed a new workstream called "Every Minute Matters" across the Trust. The programme focused on releasing time, both in term of how long patients spend in hospital, and how we enable the best use of staff time. Initial results from this work have been encouraging and the workstream is gaining recognition both locally and nationally. Our focus going forward in 2023/24 is ensuring sustainability of the initiatives under the EMM programme so that Divisional teams take ownership of the initiatives and manage the activity as part of their everyday working, and to direct our focus onto some specific activities within the EMM programme which are: • achieving 33% of all patients discharged before noon • promoting the use of criteria-led discharge • promoting weekend discharges • maximising the use of the Hospital@home pathways. Our focus will be on promoting the early discharge of patents by ensuring everything patients needs for their discharge is prepared and ready for the day of discharge. This includes the process of providing Tablets to Take Away (TTAs) and information about the patient's medication. In 2022/23 we started using the "Mapps" App to provide

printed medication-specific information for patients and we will develop this further through a roll out across all our hospital clinical areas, undertaking a comprehensive review of the process of providing TTAs at the same time. This also aligns with an action from the National Inpatient Survey 2022.

Criteria Led Discharge
We know from our data from proactive board rounds that Criteria Led Discharge is not used as much as it perhaps could be. The EMM team have commenced working with two cardiology wards, and a cardiac surgery ward to develop and trial the use of a clinical note (within the Careflow system) to support CLD for patients who have undergone Cardiac Surgery, and Pacemaker procedures. Our aim for 2023/24 is to take the learning from the initial CLD pathways and to expand this further and develop additional pathways across all Divisions in the Trust.

Weekend Discharges
There is already a project of work in place to increase the number of patient discharges at the weekend, with a target for there to be 80% of weekday discharges at weekends. In 2022/23 we achieved 65%. A suite of activities is being used to improve this performance which includes a multi-professional weekend discharge staff event with a focus on making improvements to the discharge process, including detailed mapping of Friday activity which patients are identified for discharge over the weekend. A new model of 'weekend huddles' will be implemented, proposed to begin in April 2023, supported by Ops Matron teams and our Proactive Hospital Improvement Coach.

Hospital at Home (H@H)
H@H provides clinical care for people who are acutely unwell in their own homes across Bristol, North Somerset, and South Gloucestershire. The service enables people to get the care they need at home safely and conveniently, rather than being in hospital. The following pathways are currently available for patients to be referred to: heart failure, frailty, respiratory and provision of antimicrobial medication at home. Existing and new pathways are being developed and our focus will be on ensuring we are taking full advantage of this service and ensuring we have the right internal process for patients to access this service.

Active Hospital
We have committed to implementing the Active Hospital - Enabling Home First programme across UHBW during 2023/24. We have the benefit of an Active Hospital's coordinator funded by Ageing Well, via Age UK Bristol to support implementation of the programme.

The Active Hospitals programme aims to:

- Change the physical activity culture in hospitals
- Encourage patients to stay active during their stay
- Create an enablement ethos amongst all staff
- Improve patient experience and flow through the hospital

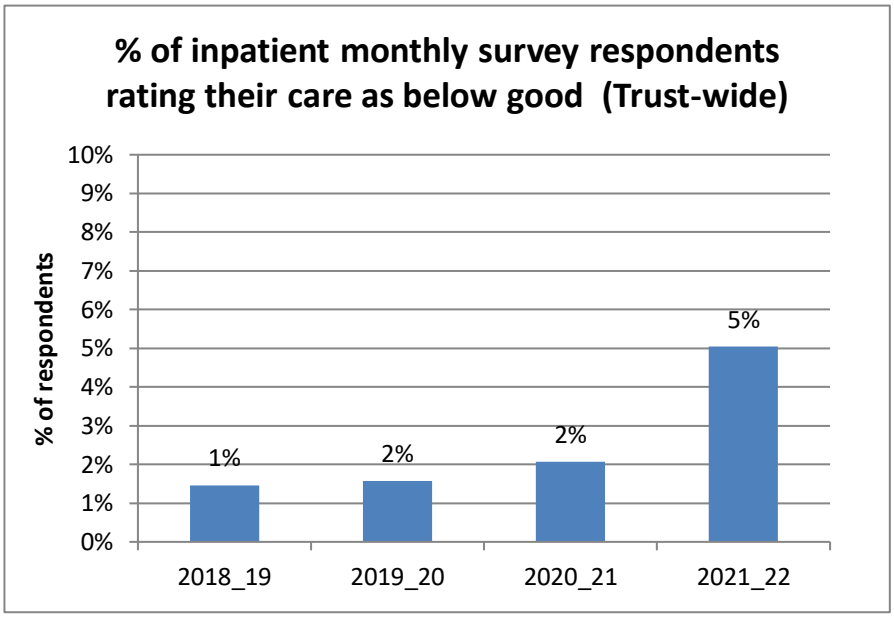
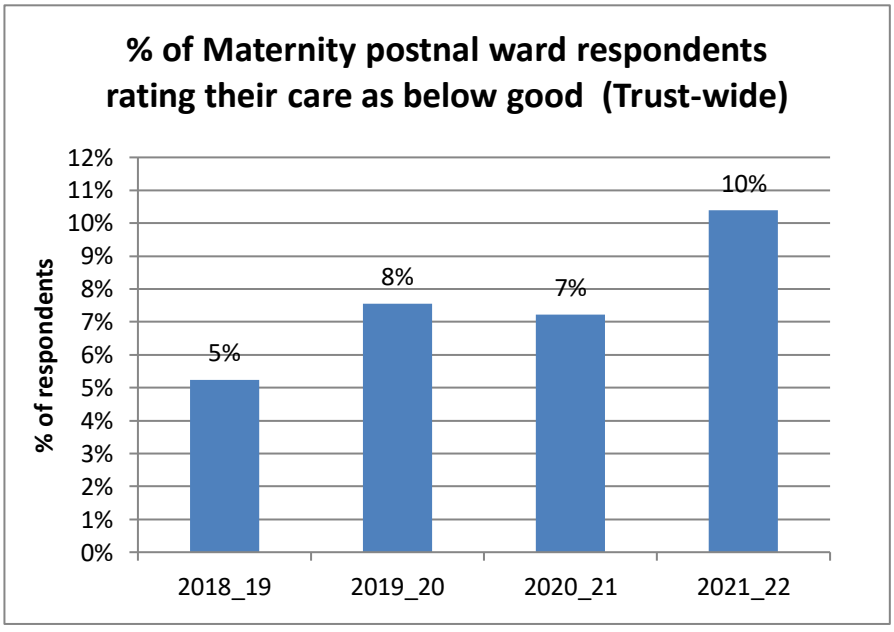
	• Enable earlier discharge and decreased care needs The programme will be delivered through: • Trust commitment for long term planning and sustainable cultural change • Enthusiasm and commitment at all levels from the Board down to the ward staff • Support in the community • Working in collaboration with internal and external stakeholders and networks • Data collection and analysis to demonstrate the benefits of embedding physical activity into hospitals • Considering patient outcomes and staff wellbeing. We are currently scoping the delivery of the Active Hospitals programme which will be reporting through the EMM steering group.
Measurable target/s for 2023/24	• Increased number of patients discharged by midday • Increased number of weekend discharges (target = 80% of weekday discharges) • Increased usage of discharge lounge • Decreased average length of stay for medically fit for discharge patients. • Improved patient feedback to the following questions via our monthly post-discharge survey: o "Do you feel you were kept well informed about your expected date of discharge from hospital?" o "On the day you left hospital, was your discharge delayed for any reason?"
How progress will be monitored	Every Minute Matters Steering Group Patient Flow & Discharge Group reporting to Recovery Delivery Programme Board
Board sponsors	Chief Nurse & Midwife / Chief Operating Officer
Implementation leads	Deputy Chief Operating officer Deputy Chief Nurse Assistant Director of Operations Assistant Chief Nurse
Designated Heads of Nursing	Directors of Nursing, Division of Medicine, and Weston Division

Objective 3	**Waiting well**
Rationale and past performance	As a result of the COVID-19 pandemic, there has been an increase in the size of the planned care backlog, also known as the 'waiting list'. This is in the context of a growing waiting list pre-pandemic. The recovery of care backlogs will be, by necessity, multi-year. Therefore, in the short term, care backlogs are likely to continue to

	grow, and in the medium term, long waiting times for care and treatment are likely to subsist. This presents a risk to patient safety, experience and equitable access. In this context, UHBW has recognised a need to ensure that patients within the care backlog are Safe to Wait, that they have the support and information that they need to be Waiting Well, that we address any issues relating to Health Inequality that serve to disadvantage certain groups, and that, in the event that harm is caused to patients, that we learn from these events through a Harm Review, and make improvements to our processes and prevent future harms. This quality priority focuses on 'Waiting Well' and is a continuation of an objective we set ourselves in 2022/23.
What will we do?	Three waiting well priorities have been agreed, taking account of patient experience feedback: - Acknowledgment - Communication - Signposting Our goals for 2023/24 are: • To further develop the information presented on the Trust's Waiting Well web pages including the creation of content designed to meet the need of children and young people, their parents, guardians, or carers. • To improve how we communicate with our patients from the point of referral to discharge. This will include how we acknowledge receipt of referral, signpost patients to sources of information and support, and confirm patients' wishes about remaining on a waiting list. We will reflect the diverse needs of our population including Accessible Information Standards. • To undertake a further Health Matters to share the progress we are making to support patients waiting and gather feedback to inform next steps. • To work with system partners to develop a health screening questionnaire for patients waiting for surgery, across both hospital trusts, completed as early as possible in their pathway, to increase opportunities to improve their health prior to their procedure. • To use the C2Ai clinical risk stratification tool to identify patients who would benefit the most from targeted health preparation prior to surgery, and to prioritise the treatment of patients at higher risk of deterioration or complications. • To capitalise on the opportunities offered by the DrDoctor platform roll out to improve patients' experience of engaging with our hospital services including the Quick Book, Quick Question, Digital Letters, Assessments and Patient Led Booking modules.
Measurable target/s for 2023/24	We will seek improvements in the following metrics:

	• The number of unique visitors to the Trust's Waiting Well web pages • The number of patients re-prioritised for surgery. • The number of services using the C2Ai tool. • The number of services utilising the DrDoctor modules following the pilot phase. It is anticipated that this platform will deliver improvements across a range of metrics including DNA rates, reduction in the number of patients reported as overdue their follow-up appointment, and response times to telephone calls to our Appointment Centre and Patient Access teams. • The percentage of services using the questionnaire, and percentage of completed questionnaires • Patient feedback about feeling prepared.
How progress will be monitored	Waiting Well Group, reporting to Planned Care Steering Group
Board sponsor	Chief Operating Officer
Implementation leads	Deputy Chief Operating Officer – Planned Care
Designated Heads of Nursing	Director of Nursing, Division of Specialised Services

Objective 4	**Eliminating poor experience of care**
Rationale and past performance	Patient First is our new approach to continuous improvement at UHBW. Experience of Care has been chosen as one of six strategic priorities to focus our improvement efforts to ensure we deliver on our True North (our shared vision and purpose at UHBW) – 'patients at the heart of all that we do'. Background: Whilst most patients give us very positive feedback, a significant number tell us that their overall experience of care provided is less than 'good'. By this, we mean they have rated their care as fair, poor or very poor in monthly patient surveys. Our position has deteriorated in some areas relative to other comparable non-specialist acute NHS providers since 2019/20, and this is particularly apparent in inpatient care and maternity care. Problem: Data from patient feedback and complaints indicates that in maternity and inpatient care we are inconsistent in the way we provide person-centred, compassionate inclusive care and that some patients from diverse groups have poorer experience and outcomes. In addition, our feedback is not always representative of the communities that we serve. Impact: Too many patients have a poor experience of our services and staff are not satisfied with the standard of care they provide. Scope: Our data analysis as part of Patient First has revealed that we need to focus on inpatient care on wards in Division of Medicine and

	wards at Weston General Hospital as well as our Maternity wards to make the most significant improvements in experience of care. This quality priority excludes all other areas, for example Outpatients and Emergency Department care.  
What will we do?	Our vision is to provide person-centred, compassionate, inclusive care for patients with a particular focus on our diverse communities every time. As part of this quality priority, we will co-design an Experience of Care Strategy with our people and our communities which will guide our work

in this area over the next 3-5 years. The strategy will be approved and published by March 2024.

During 2023/24, we will:

Quarters 1 and 2 (April to September 2023)

1. Work with relevant Divisions* to agree an approach for this improvement work
2. Establish/adapt a governance structure to ensure that progress can be monitored (from ward to Board) and issues and risks to delivery escalated appropriately and in a timely way
3. Refresh and provide detailed baseline data (based on patient feedback) by ward for Division of Medicine, Maternity wards and Weston General Hospital wards.

Quarter 3 (October to December 2023)

4. Undertake in-depth data analysis of the patient journey for specialties in scope, combined with Division-led A3 thinking (a model used as part of Patient First)
5. Develop and approve detailed improvement plans for the top contributing areas (as highlighted by baseline data)

Quarter 4 (January to March 2023)

6. Implement improvement plans and monitor performance via the Patient Experience Hub (our real-time patient feedback system)
7. Start to evaluate success, assess sustainability of improvements made and embed in standard work and practice within wards

As part of our Health Equity Delivery Plan 2023/24, we have committed to improve access to, experience of, and outcomes from our services for our diverse communities. As part of this, we will develop a community outreach programme in collaboration with partners in the Voluntary and Community sector to better understand and improve the experience of marginalised communities. We will ensure the community outreach programme is informed by the priorities emerging in Medicine, Weston and Maternity services as part of the delivery of this quality priority (i.e. which communities do not provide us with feedback in these services via our standard survey routes and how will we address this).

Measurable target/s for 2023/24

1) Greater or equal to 98% of patients* will rate their care as good or above in our local patient surveys by 2027/28

Area	Baseline (Oct 21 – Sep 22)	End 2023/2024	Target 2027/28
Medicine inpatient wards	90.5%	92.0%	98.0%
Weston inpatient wards	87.6%	89.7%	98.0%
Maternity wards	91.9%	93.1%	98.0%

2) Ensure feedback is representative of the communities we service via a range of community engagement and survey approaches

	3) Achieve a top 10% score for the NHS staff survey question: "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" by 2027/28 Baseline 2022 survey: 71.1 Target 2023/24: 72.6 Target 2027/28: 78.7
How progress will be monitored	Divisional Experience of Care Groups, Trust-wide Experience of Care Group, Clinical Quality Group, Quality and Outcomes Committee, Board
Board sponsors	Chief Nurse and Midwife
Implementation lead	Associate Director of Quality and Compliance Head of Experience of Care & Inclusion

Objective 5	**Achieving a significant reduction in patient harm events through focus on sepsis recognition**
Rationale and past performance	Patient First is our new approach to continuous improvement at UHBW. Patient Safety has been chosen as one of six strategic priorities to focus our improvement efforts to ensure we deliver on our True North (our shared vision and purpose at UHBW) – 'patients at the heart of all that we do'. Background: We are continuously improving our systems for keeping people safer in our hospitals, but there are a number of key components of a well-functioning safety system where we know we have scope to improve further. These include our reflective learning processes, our implementation of human factors principles, our recording and use of contemporary safety data, and our staff engagement in a safety culture. Problem: A minority of patients come to avoidable harm under our care resulting in poorer clinical outcomes and higher patient mortality. This also risks poor patient, carer and family experience, and moral injury for our staff. Scope: The deteriorating patient and sepsis-related risks • Recognised internationally as likely commonest cause of inadvertent patient harm in hospitals • Our SHMI (Summary Hospital-level Mortality Indicator) data shows that sepsis-related deaths (sepsis is the body's extreme response to an infection; a life-threatening medical emergency) are increasing and although they are still within expected levels for our peer group and we have not received a formal outlier alert, we are undertaking a data 'deep dive' to investigate this further to fully inform our decision making. • Failure to recognise/escalate deteriorating patients has been one of our six most frequently reported incidents over the last two years and is a common theme in patient safety incidents and medical examiner referrals.

	• Often deterioration is infection/sepsis based, but even when it isn't, many of the required actions remain clinically pertinent. Our year 1 'breakthrough objective' for this Patient First strategic priority is to focus on sepsis recognition. There are challenges to this, for example, significant changes to national sepsis guidelines from NICE (National Institute for Health Care and Excellence) are imminent, and compliance with sepsis assessment and pathway care can only be monitored manually, e.g. by reviewing notes and the outcome measures are often "proxy" rather than actual.
What will we do?	Our vision is to consistently deliver the highest quality safe and effective care, aspiring for eliminate avoidable harm caused to patients under our care. Central to what we do will be the desire to create a "just culture" where patient safety is paramount. Current and planned work for our Deteriorating Patient Programme includes: • Launching and ongoing monitoring and support of the Critical Care Outreach team across all adult sites • Deteriorating Patient Education – completing a full review and update of e-learning for recognition and management of adult patients; also developing a UHBW e-learning module on NEWS (National Early Warning Scores) to replace the Royal College of Physicians' guidance so we have a locally-provided and therefore more relevant and flexible set of modules that can be adapted and updated to reflect changes to guidance, and in line with our Vitals upgrades and project progress • Pregnant patient in non-maternity areas – at present we have significant challenges getting accurate data regarding numbers of pregnant patients treated in non-maternity areas. Our aim is to implement MEOWS (Modified Early Obstetric Warning Scores) across the organisation for pregnant patients outside maternity areas with in-reach provided from maternity services in St Michael's Hospital which will improve recognition and escalation of deteriorating pregnant patients and give non-maternity staff expert support which is easily accessible. • ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) / ReSPECT Plus review and implementation, and monitoring of quality of end-of-life planning including a thematic analysis/harm panel of safety incidents, complaints, claims and medical examiner referrals where end of life planning was a contributory factor, which will generate actions and recommendations.
Measurable target/s for 2023/24	• To develop a Deteriorating Patient Data Dashboard for monitoring and reporting. • To undertake a 'deep dive' of our sepsis-related mortality data to identify action to improve the accuracy of reporting into HSMR (Hospital Standardised Mortality Ratio) and SHMI datasets. • To develop outcomes measures for monitoring reduction in harm from unrecognised clinical deterioration which will be included in the dashboard. This aims to include delayed recognition of deterioration; delayed escalation; and delayed response to escalation which are

	difficult to measure directly. Proxy measures of this will include a combination of factors such as: o rates of unplanned ICU (Intensive Care Unit) admissions o critical care outreach team referral and trigger activity and outcomes o e-vitals activity o RESPECT form and RESPECT-plus completion and quality data o themes from medical examiner referrals around quality and frequency of deaths related to unrecognised deteriorating patients o identifying pregnant patient being cared for in non-maternity areas and ensuring they are monitored using MEOWS with in-reach support from maternity services
How progress will be monitored	Deteriorating Patient Group, Trust-wide Patient Safety Group, Clinical Quality Group, Quality and Outcomes Committee, Board
Board sponsor	Chief Medical Officer
Implementation lead	Associate Medical Director for Patient Safety, and Director of Nursing for Surgical Division

2.2 Statements of assurance from the Board

2.2.1 Participation in clinical audits and national confidential enquiries

For the purpose of the Quality Account, the Department of Health and Social Care published an annual list of national audits and confidential enquiries/outcome reviews, 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 2022/23, 50 national clinical audits and seven national confidential enquiries covered NHS services that University Hospitals Bristol and Weston NHS Foundation Trust provides. During that period, the Trust participated in 81% (42/52) of national clinical audits and 100% (7/7) of the national confidential enquiries in which it was eligible to participate. The majority of national audits were back to normal data collection schedules, after some having suspended mandatory data submissions during the first year of the COVID-19 pandemic.

Table 1 lists the national clinical audits and national confidential enquiries that University Hospitals Bristol and Weston NHS Foundation Trust was eligible to participate in during 2022/23 and whether it did participate:

Table 1

Name of audit / programme	Participated
Acute, urgent and critical care	
ICNARC Case Mix Programme (CMP)	Yes
Pain in children – part of RCEMQIP[1]	No[†]
Assessing for cognitive impairment in older people – part of RCEMQIP[1]	No[†]
Mental health self-harm – part of RCEMQIP[1]	No[†]
Major Trauma Audit (TARN)	Yes
ICNARC 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
Cancer	
National Bowel Cancer Audit (NBoCA) – part of NGICP[2]	Yes
National Lung Cancer Audit (NLCA)	Yes
National Oesophago-Gastric Cancer (NOGCA) – part of NGICP[2]	Yes
Elderly care	
Fracture Liaison Service Database (FLS) – part of FFFAP[3]	Yes
National Audit of Inpatient Falls (NAIF) – part of FFFAP[3]	Yes
National Hip Fracture Database (NHFD) – part of FFFAP[3]	Yes
National Audit of Dementia (NAD)	No[R]

Name of audit / programme	Participated
UK Parkinson's Audit	Yes
National Joint Registry (NJR)	Yes
Respiratory	
Adult Asthma Secondary Care – part of NACAP[4]	Yes[B]
COPD Secondary Care – part of NACAP[4]	Yes[B]
BTS Adult Respiratory Support Audit	No
UK Cystic Fibrosis Registry	Yes
Heart	
Adult Cardiac Surgery (ACS) – part of NCAP[5]	Yes
National Audit of Percutaneous Coronary Interventions (PCI) – part of NCAP[5]	Yes
Myocardial Ischaemia National Audit Project (MINAP) – part of NCAP[5]	Yes
Cardiac Rhythm Management (CRM) – part of NCAP[5]	Yes
National Heart Failure Audit (NHF) – part of NCAP[5]	Yes
National Audit of Cardiac Rehabilitation (NACR)	Yes
National Congenital Heart Disease (CHD) – part of NCAP[5]	Yes
Long term conditions	
Cleft Registry and Audit Network (CRANE)	Yes
National Early Inflammatory Arthritis Audit (NEIAA)	Yes
National Diabetes Core Audit – part of NDA[5]	Yes[O]
National Diabetes Inpatient Safety Audit – part of NDA[5]	No[R]
National Pregnancy in Diabetes Audit (NPID) – part of NDA[5]	Yes
National Ophthalmology Database Audit	Yes
Inflammatory Bowel Disease programme / IBD Registry	Yes
UK Renal Registry Chronic Kidney Disease Audit	Yes
Women's and Children's Health	
Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes
BTS National Smoking Cessation Audit (Maternity)	No
National Maternity and Perinatal Audit (NMPA)	Yes
National Neonatal Audit Programme (NNAP)	Yes
National Paediatric Diabetes Audit (NPDA)	Yes
Neurosurgical National Audit Programme	No
National Acute Kidney Injury Audit	No
Paediatric Asthma Secondary Care – part of NACAP[3]	Yes
Paediatric Intensive Care Audit Network (PICANet)	Yes
Other	
Elective Surgery: National PROMs Programme	Yes
National Audit of Care at the End of Life (NACEL)	No[R]
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes
Confidential enquiries/outcome review programmes	
Child Health Clinical Outcome Review Programme	Yes
Learning Disabilities Mortality Review Programme (LeDeR)	Yes[O]

Name of audit / programme	Participated
National Perinatal Mortality Review Tool	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes
Medical and Surgical Clinical Outcome Review Programme	Yes[O]
National Child Mortality Database	Yes
National Perinatal Mortality Review Tool	Yes

[1] RCEMQIP: Royal College of Emergency Medicine Quality Improvement Programme
[2] NGCIP: National Gastro-Intestinal Cancer Programme
[3] FFFAP: Falls and Fragility Fractures Audit Programme
[4] NACAP: National Asthma and COPD Audit Programme
[5] NCAP: National Cardiac Audit Programme
[6] National Diabetes Audit programme

[†] Difficulty registering Bristol and Weston sites as one trust and agreeing funding. Issues resolved and registered/entering data for the 2023/24 programme.
[R] Resources/staffing issues. Agreed to participate in 2023/24.
[B] Bristol site only
[O] Organisational/service level data submitted only.

Of the above national clinical audits and national confidential enquiries, those which published reports during 2023/23 and where the Trust submitted data, are listed in Table 2 alongside the number of cases submitted to each audit. Case ascertainment is shown in brackets where known.

Table 2

Name of audit / programme	Participated
Acute, urgent and critical care	
ICNARC National Cardiac Arrest Audit (NCAA)	26
National Emergency Laparotomy Audit (NELA)	115 (82%)
Sentinel Stroke National Audit programme (SSNAP)	656
Society for Acute Medicine Benchmarking Audit (SAMBA)	~50
Cancer	
National Bowel Cancer Audit (NBoCA) – part of NGICP[1]	240 (>80%)
National Lung Cancer Audit (NLCA)	337
National Oesophago-Gastric Cancer (NOGCA) – part of NGICP[1]	165
Elderly care	
Fracture Liaison Service Database (FLS) – part of FFFAP[2]	1682 (100%)
National Audit of Inpatient Falls (NAIF) – part of FFFAP[2]	12
National Hip Fracture Database (NHFD) – part of FFFAP[2]	591(100%)
UK Parkinson's Audit	50
National Joint Registry (NJR)	82 (100%)
Respiratory	
Adult Asthma Secondary Care – part of NACAP[4]	62
COPD Secondary Care – part of NACAP[4]	272
UK Cystic Fibrosis Registry	293

Name of audit / programme	Participated
Heart	
Adult Cardiac Surgery (ACS) – part of NCAP[3]	3179 (100%)
National Audit of Percutaneous Coronary Interventions (PCI) – part of NCAP[3]	4825 (100%)
Myocardial Ischaemia National Audit Project (MINAP) – part of NCAP[3]	698 (66%)
Cardiac Rhythm Management (CRM) – part of NCAP[3]	658
National Heart Failure Audit (NHF) – part of NCAP[3]	400 (65%)
National Congenital Heart Disease (CHD) – part of NCAP[3]	2591(100%)
Long term conditions	
National Early Inflammatory Arthritis Audit (NEIAA)	96 (100%)
National Ophthalmology Database Audit	526 (100%)
UK Renal Registry Chronic Kidney Disease Audit	47 (100%)
Women's and Children's Health	
Seizures and Epilepsies in Children and Young People (Epilepsy 12)	277
National Maternity and Perinatal Audit (NMPA)	4111 (100%)
National Neonatal Audit Programme (NNAP)	586 (100%)
National Paediatric Diabetes Audit (NPDA)	521
Paediatric Asthma Secondary Care – part of NACAP[4]	71
Paediatric Intensive Care Audit Network (PICANet)	711 (100%)
Other	
Elective Surgery: National PROMs Programme	74

The outcomes and proposed actions from completed projects are reviewed by the Trust Clinical Audit Group. Details of the changes and benefits of audit projects completed during 2022/23 will be published in the Trust's Clinical Audit Annual Report, available in July 2023.

2.2.2 Participation in clinical research

Our role as a specialist research active teaching trust positioned us well for the award of a National Institute for Health and Care Research Clinical Research Facility (NIHR CRF), and a second NIHR Biomedical Research Centre (BRC), both of which started in 2022/23.

The NIHR Bristol CRF launched in September 2022 and provides dedicated clinic space and expertise to deliver experimental medicine and early translational research in our core therapeutic areas of Vaccine development and Oncology & Immunotherapy. The NIHR Bristol BRC commenced in December 2022 and leads experimental research with our university and NHS partners in mental health, respiratory and orthopaedic disorders, diet and physical activity and new surgical procedures. It has a special focus on population health and use of large data sets for research.

UHBW holds a position as a key partner in and host of Bristol Health Partners Academic Health Science Centre (BHP AHSC), which brings together university, NHS and city council partners to improve health and service delivery across Bristol, North Somerset

and South Gloucestershire (BNSSG). BHP AHSC now acts as the research delivery strategy and oversight committee for the regional Integrated Care System (BNSSG ICS).

Our NIHR-funded portfolio includes the Applied Research Collaborative (ARC West), the Biomedical Research Centre (Bristol BRC), and NIHR Bristol Clinical Research Facility, as well as a substantial number of NIHR career development awards and project and programme grants. Alongside these awards, we are host for the NIHR Clinical Research Network West of England, whose responsibility is delivery of NIHR research in the region.

Work with researchers to increase the number of NIHR project and programme grants we are awarded has started to bear fruit, underpinned by the small grants scheme which Bristol and Weston Hospitals Charity supports. We continue to monitor our performance, focusing efforts on delivering our open grants according to plan, and recruiting participants to our hosted studies to time and target.

The COVID vaccine research we were part of during the pandemic has acted as a launchpad for further adult and paediatric vaccine research, working with industry and academic funders and sponsors to address areas of need in public health, and we continue to prioritise that work.

Across all our specialties, the number of patients receiving relevant health services provided or subcontracted by UHBW in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 9,582. This compares with 10,840 in 2021/22.

2.2.3 CQUIN framework (Commissioning for Quality and Innovation)

Following a national two-year suspension of CQUINs during 2020/21 and 2021/22, to support recovery of services, throughout 2022/23 a smaller number of directed short term CQUINs across core clinical priority areas were proposed by NHS England and NHS Improvement. There has been a national requirement to report performance data on all schemes throughout the year, albeit there are several schemes where existing data flows exist nationally for collection of data.

The following CQUINs were agreed for delivery across UHBW in 2022/23 with commissioners:

BNSSG ICB CQUINs

- Staff flu vaccinations
- Appropriate antibiotic prescribing for UTI in adults aged 16+
- Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
- Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
- Cirrhosis and fibrosis tests for alcohol dependent patients

Specialised Commissioning CQUINs

- Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery

- Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres
- Delivery of Cerebral Palsy Integrated Pathway assessments for cerebral palsy patients in specialised children's services
- Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines

2.2.4 Data quality

UHBW submitted records during 2022/23 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 for UHBW:

- which included the patient's valid NHS number was: 99.7% for admitted patient care; 99.9% for outpatient care; and 99.0% for accident and emergency care.
- which included the patient's valid general practice code was: 99.7% for admitted patient care; 99.9% for outpatient care and 99.6% for accident and emergency care.

(Data source: NHS number, Trust statistics. GP Practice: NHS Information Centre, SUS Data Quality Dashboard, April 2022 – January 2023 extracted 17/03/2023.

UHBW completed 107 of 109 mandatory requirements in the 2021/22 Data Security and Protection (DSP) Toolkit and submitted an improvement plan to NHS Digital to achieve the remaining requirements. NHS Digital approved this improvement plan and UHBW's Data Security and Protection Toolkit Assessment is "21/22 Approaching Standards".

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 2023, the Trust commissioned an External Clinical Coding Audit in Bristol and one in Weston (January 2023) to fulfil the DSP Toolkit requirement. The Bristol audit reviewed a total of 200 episodes from the Specialities of General Medicine/Stroke and General Medicine, Endoscopy, Trauma and Orthopaedics, Medical Oncology, Clinical Oncology and Clinical Haematology. The episodes audited were randomly selected from April-October 2022 data.

The preliminary results for Bristol are that the DSP Toolkit level is 'Met'. The attainment level for 'Met' is primary >90% and secondary > 80%.

The following levels of accuracy were achieved:
- Primary diagnosis accuracy: 91.5% (-5% from 2021)
- Primary procedure accuracy: 90.8% (-8% from 2021)

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

The external Audit in Weston in January 2023 reviewed a total of 200 episodes from the Specialties of General Medicine, Paediatric Medicine, Respiratory Medicine, Trauma and

Orthopaedics and Upper GI. The episodes audited were randomly selected from April-October 2022 data.

The preliminary results for Weston are that the DSPT level is 'Met'. The attainment level for 'Met' is primary >90% and secondary > 80%

The following levels of accuracy were achieved:

- Primary diagnosis accuracy: 93.0% (-2.5% from 2021)
- Primary procedure accuracy: 97.5% (-0.9 % from 2021)

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 use of daily reports by the Medway support team that have identified errors and queries in Medway. Some errors are corrected centrally but may involve users across the Trust in the correction (this includes staff in clinical divisions checking with the patient for their most up to date demographic information).
- The Trust is awaiting the final Audit Reports for both Bristol and Weston and once received, an Action plan will be put in place to work on the Audit Recommendations with the aim of improving percentages over the following 12 months. The reports will also be shared with the Data Quality Improvement Group.

2.2.5 Care Quality Commission registration and reviews

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) is required to register with the Care Quality Commission (CQC).

UHBW currently has an overall CQC rating of ‘Good’.

In last year’s Quality Account we reported that the Trust had been issued with a formal notice from the CQC in respect of concerns about safe staffing, use of escalation areas, and clinical leadership at Weston General Hospital. In August 2022 the CQC re-inspected Weston General. In response to the improvements demonstrated during the inspection, the CQC formally lifted the previous notice. The CQC also highlighted a number of requirements and recommendations to further improve quality care, in response to which the Trust has developed a comprehensive action plan, the progress of which is monitored by our Trust Board. The full report from this inspection, and all previous inspections, can be read at https://www.cqc.org.uk/provider/RA7.

The Trust did not receive a CQC core services inspection at its Bristol site during 2022/23. However, the CQC did carry out specialist IR(ME)R (Ionising Radiation Medical Exposure) inspections at the Trust’s radiology and radiotherapy facilities in Bristol, plus informal monitoring visits at the Bristol Royal Hospital for Children and to the Trust’s critical care facilities in both Bristol and Weston.

2.2.6 Clinical accreditation

During 2022/23 UHBW embarked on implementing a ward and department accreditation programme across all clinical areas of the Trust, entitled Accreditation of Quality Care (ArQC).

The programme ensures the constant monitoring, assessing and improvement of the quality of care that is being given at ward or department level and gives regular feedback to clinical staff. Clinical Accreditation brings together key measures of nursing and multi-professional clinical care into one overarching framework to enable a comprehensive assessment of the quality of care at ward, department, and unit at team level. Clinical areas are objectively scored against agreed standards for a range of nurse/ multi-professional sensitive quality indicators or metrics.

The wards and departments at UHBW are assessed against multiple standards grouped under the following four ambitions:

- High Quality Compassionate Care
- Leadership (Well led)
- Avoidable Harm
- Effective Patient Care

A total of 143 standards sit beneath these ambitions.

Preparation for an accreditation visit involves a comprehensive review of quality data, enabling the identification of any themes that the team wish to explore further. The next step involves an assessment team reviewing the clinical area. The assessment team comprises an overall lead, a senior nurse or Allied Health Professional (AHP) and an independent clinical or non-clinical lead who will complete a 15-step assessment, talk to staff, patients and relatives. A patient record review is also undertaken. High-level feedback is given on the day of the visit, and a follow up report is provided detailing recommendations the ward or department should implement or consider implementation to enhance quality standards.

A clinical area that achieves compliance with 75%-89% of the standards achieves a silver accreditation and above 90% achieves a gold accreditation. Silver accredited areas will be assessed again after six months and for a gold area, this would be one year. If a gold area sustains gold again after one year, they are awarded a diamond accreditation.

UBHW has fifty-five inpatient areas across the Bristol and Weston sites, both adults and children. Since ArQC was commenced in March 2022, 40 clinical areas have had a first assessment completed and nineteen of these areas have been reassessed for a second time. Three out of the seven Trust emergency departments have been assessed for the first time and four day-case areas have been assessed for the first time. In total 66 clinical area have been assessed across the Trust. Gold accreditation has been achieved in seven clinical areas; all other areas have achieved silver accreditation.

As well as providing an internal assessment of quality assurance / improvement and patient safety delivered within each clinical area, implementing the programme within UHBW has delivered the following additional benefits:

- Frontline staff have welcomed the opportunity to speak to senior nursing staff and meet staff from other Divisions, providing an opportunity to share practice and support developing a culture of team working.
- Staff have been encouraged to be able to describe examples of learning from complaints and serious incidents, demonstrating a learning and improvement environment across the Trust.
- Variation in clinical practice has been identified and reduced, releasing more time for staff to focus on direct patient care.
- The assessment teams have felt involved and had a reason to visit the clinical areas, providing an increased feeling of job satisfaction.

Overall, there has been a sense of pride within clinical teams and a celebration of what they have achieved, and for our patients and relatives an assurance that they will receive a high standard of care during their stay in our hospitals.

2.3 Mandated quality indicators

In February 2012, the Department of Health and Social Care and NHS Improvement announced a new set of mandatory quality indicators for all Quality Accounts and Quality Reports. The Trust's performance in 2021/22 (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**
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over). Total Cases	49.2 2021/22	43.7	0.0	138.4	48.6 2020/21
Rate of patient safety incidents reported per 1,000 bed days	104.7 Apr21-Mar22	NA	NA	NA	82.5 Apr20-Mar21
Percentage of patient safety incidents resulting in severe harm or death	0.27% Apr21-Mar22	NA	NA	NA	0.34% Apr20-Mar21
Responsiveness to inpatients' personal needs	*Data not published*				77.6 2020/21
Summary Hospital-level Mortality Indicator (SHMI) value and banding	100.8 "As Expected" Dec21-Nov22	100.0	71.7	122.2	99.3 "As Expected" Dec20-Nov21
Percentage of deaths with specialty code of 'palliative medicine' or diagnosis code of 'palliative care'	39.2% Dec21-Nov22	40.8%	66.0%	12.6%	39.0% Dec20-Nov21
Emergency readmissions within 30 days of discharge: age 0-15	10.5% 2021/22	3.3%	12.5%	46.9%	9.3% 2020/21
Emergency readmissions within 30 days of discharge: age 16 or over	12.8% 2021/22	2.1%	12.0%	142.0%	14.6% 2020/21

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

Part 3

Review of services in 2022/23

3.1 Patient safety

The safety of our patients is central to everything we want to achieve as a provider of healthcare. 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.

During 2022/23 we have continued work to implement the NHS Patient Safety Strategy and adopting the new national Patient Safety Incident Response Framework (PSIRF).

This new framework sets out the NHS approach to developing and maintaining systems and process for responding to patient safety incidents for the purpose of learning and improving patient safety. This builds on previous work and provides a fundamental change to the way we think about patient safety, how we review and learn from events and how we engage with patients, families and our staff and the wider healthcare system to improve safety. It is underpinned by a culture of continuous improvement where people feel safe and supported to speak up and where the focus is on learning and improvement. The changes we make in practice, especially about how we respond to patient safety incidents will help support and develop our safety culture.

An update of our quality objective for 2022/23 for implementing the patient safety strategy is provided in section 2.1.1.

Our Patient Safety Incident Response Plan outlines how we will respond to patient safety incidents for the next 18-24 months and can be found on our Trust website.

3.1.1 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 improve safety systems and 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 following a Rapid Incident Review meeting, informing the decision to investigate and the terms of reference of any further learning response. Throughout 2022/23, 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 2022/23 was 109 for UHBW, compared to 84 in 2021/22. Two serious incidents were downgraded following investigation. A breakdown of the categories of the 109 serious incidents is provided in Figure 1.

Themes from serious incidents reported in 2022/23 continue to reflect the legacy effects of the COVID-19 pandemic in terms of harm identified relating to delays in providing diagnostics and treatment as we restore elective services; and the significant operational pressures experienced in urgent and emergency care across the system, and the staffing impact related to continued COVID-19 infection sickness related absences, staffing vacancies and high staff turnover.

All patient safety incident investigations aim to make recommendations to address identified system issues to produce robust actions plans 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).

3.1.2 Never events

There were three never events reported in our Trust in 2022/23:

- Insertion of the wrong dioptre lenes during ophthalmology surgery at the Bristol Eye Hospital (July 2022)
- Wrong site nerve block in orthopaedic surgery at the Bristol Royal Infirmary, (September 2022)
- Implantation of the wrong burr hole shunt is Paediatric Neurosurgery at the Bristol Royal Hospital for Children (December 2022).

One investigation has concluded and two are currently developing action plans in response to the investigation recommendations. Examples of improvement recommendations we have made as a result of our investigations include:

- Introduction of the adoption of the new “Prep stop block” standardised checking process in theatre. The introduction of the additional “Prep” stage introduces an increased focus on handover of care and the preparation of equipment prior to the procedure.
- A programme of work to aim to reduce unnecessary interruptions in theatre.
- Simulation training to understand the potential patient safety risks in checking processes and reducing the risk of confirmation bias.
- Regular auditing of check processes in theatre to provide assurance.
- Development of an intraocular lens standard operating procedure that integrates the new national safety standard for invasive procedures (NatSSIPs2 guidance).

3.1.3 Learning from Patient Safety Incident investigations and never events

The main learning themes identified from our serious incident investigations in 2022/23 relates to:

- Systems for ensuring continuity of care and safe handover of care, both internal and external to the organisation
- Follow-up of incidental diagnostic findings
- Systems in place for undertaking inter-hospital transfers between Trust sites.

Thematic reviews of incidents in these cases have produced system-wide recommendations which we are taking forward in collaboration with system partners to implement system-wide solutions.

Falls improvement work has continued in 2022/23 both at Bristol and Weston sites including targeted falls prevention training in areas with higher numbers of falls and in areas that are identifying new falls risks as a result of operational pressures and delays, such as Emergency Departments and extra capacity areas. The Enhanced Care

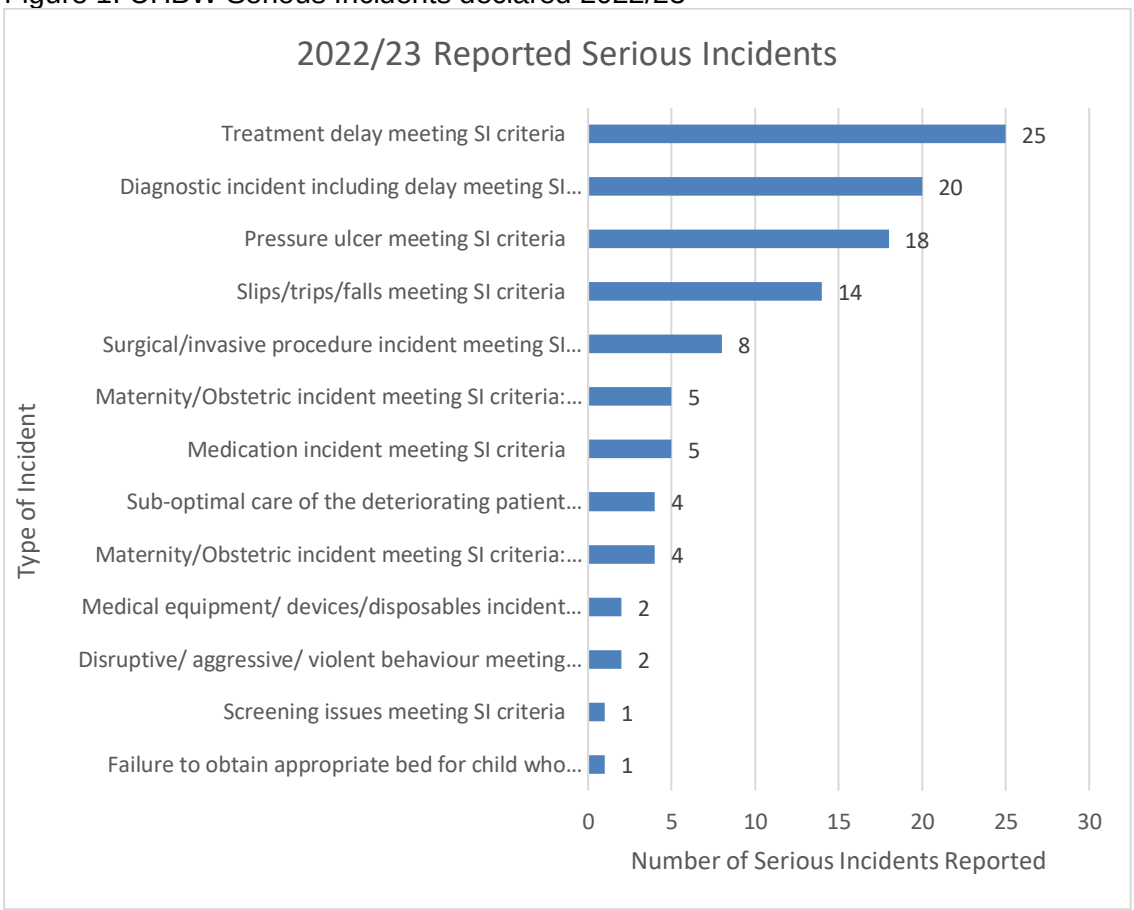
Observation Policy has been significantly updated to make it clearer as to what the requirements are to help prevent falls in our most vulnerable patients.

Tissue viability improvement work has been refocussed in 2022/23 undertaking the delivery ward-based training and audit. Revitalising the Tissue viability link nurses in clinical areas and providing new innovative approaches to disseminate learning such as the use of a monthly tissue viability newsletter, competitions and UHBW twitter account. We continue to focus on improvement work for the early recognition and response to deterioration in patients' condition in 2022/23 as part of our deteriorating patient workstream aligned with national priorities as described in section 3.1.1.

Internally, there are local and Trust-wide systems to learn from patient safety incident investigations and never events, including safety briefs, Learning After Significant Event Recommendations (LASER) posters, governance and specialty meetings, clinical audit days, newsletters, and safety bulletins.

Outcomes from reviewing and learning from incidents are fed into improvement plans that set out actions and initiatives to reduce risk to be taken forward within each year.

Figure 1. UHBW Serious Incidents declared 2022/23



Source: StEIS and UHBW serious incident log

3.1.4 Duty of Candour

We continue to comply with the statutory and regulatory requirements for Duty of Candour. Audits using a Trust standardised duty of candour audit tool has demonstrated 100% compliance with duty of candour for all completed serious incidents in 2023/23.

3.1.5 Our Patient Safety Improvement Programme 2021-2023

The aim of the Patient Safety Improvement Programme is to systematically improve safety and quality across the Trust to reduce risks to patients and drive harm reduction. The programme underpins the Trust's commitment to continuous improvement and aims to embed processes and systems that are efficient and deliver improved patient outcomes.

It provides a framework and structure to take forward safety and quality improvements across the Trust, with focus on internal and external improvement opportunities identified from systematic learning and new developments. The following information outlines the workstreams that are the agreed priorities for the programme and highlight some of the key work that has been progressed.

Deteriorating Patient (Adults):

Following detailed diagnostic work in Summer 2022 a refreshed programme was developed. The aim of the programme is to have effective and timely recognition, escalation, and response to improve the care, outcomes, and experience of patients whose condition is deteriorating; optimising the use of digital systems to enable patient care. There are four key workstreams:

- Designing and implementing a 24/7 Critical Care Outreach service for adult patients on the main Bristol site in order to ensure equitable and quality care for all acutely unwell, critically ill adult patients irrespective of location. The new service was launched in October 2022. Since implementation, direct ward referrals to the adult intensive care unit in Bristol are occurring at an earlier stage in a patient's deterioration, and the transfer time for patients requiring intensive care admission has been reduced by 50%, with 70% completed in less than three hours.
- Vitals[1] re-fresh in-patient wards. This workstream aims to improve timely recognition of patient deterioration by ensuring staff understand the full system functionality and it's use as an enabler to care and to support recognition, escalation, and the response to the deteriorating patient. This work has continued throughout 2022/23 and will continue to do so in 2023/24.
- Implementation of Vitals in our adult emergency departments has been achieved in 2022/23 on Bristol and Weston sites. This provides improved visibility of deteriorating patients within the Emergency Department, accurate and automated NEWS2 calculations to reduce human error, assists in bed management decisions and enables ward nurses already using Vitals to see patient physiological observations prior to them arriving on the ward so they can prepare accordingly.

[1] Vitals is electronic software deployed for use at the bedside to record patient observations, calculate an early warning score and prompt escalation of deteriorating patients.

- Recommended Summary Plan for Emergency Care and Treatment (ReSPECT[2]). The focus for 2022/23 has been ensuring use of a single ReSPECT form to standardise processes across UHBW adult services and to prepare for the introduction of ReSPECT Plus across the Integrated Care System. ReSPECT Plus is an electronic form to record discussions and decisions made with individual patients and supports the sharing of valid information between clinicians in acute and community settings. In relation to the ReSPECT project, we are in a scoping, gathering data, and understanding our current situation phase at the moment; so, it's too early to demonstrate the impact of the project.

Deteriorating Patient (Paediatrics):

The acuity of children being admitted to BRHC over the last several years has increased. Following admission to a ward, some of these children may deteriorate requiring unplanned admission to the Paediatric Intensive Care Unit (PICU) or High Dependency Unit (HDU). It is essential to understand whether these children received timely escalation and appropriate management which is key to us providing optimal care and safe management.

Bristol Royal Hospital for Children (BRHC) successfully implemented 'Phase 1' of Vitals across wards, high dependency units and the Children's Emergency Department in July 2022. The new system which includes the recording of physiological and neurological observations for infants and children, documentation of respiratory distress and respiratory devices, sepsis screening and urinalysis, has been embraced by the multi-disciplinary team. The implementation provides electronic calculation of the Paediatric Early Warning Score (PEWS) with the resulting 'Action / Response / Escalation' process to any high PEWS currently remaining a person centric escalation, rather than automated. This long-awaited multi-professional, digital approach to caring for infants and children admitted to BRHC helps our teams assess and recognise any patient deterioration more effectively and efficiently. In 2023/24 we plan to adopt a national PEWS when finalised and use automated alerts to inform the Paediatric Outreach Service when a patient has a high PEWS.

Venous Thromboembolism (VTE) prevention:

The Trust reports on the number of adults admitted to hospital as inpatients in the month, who have been risk assessed (against the criteria in the National VTE Risk Assessment Tool); the expectation is to achieve 95% compliance. Compliance through our 2022/23 has remained around 83%. The aim of this workstream is to improve compliance with risk assessments and reduce hospital associated VTE. The Patient Safety Improvement Team continue to undertake diagnostic work to identify emerging and existing issues relating to VTE prevention to inform improvement priorities. Work has also been progressed to improve the process for learning from hospital acquired VTE (HAVTE), and a recent thematic analysis of possible HAVTE incidents (April 2021-October 2022) was completed. This identified key learning themes around the lack of consistent recording of the VTE risk assessment and adherence to best practice National Institute for Clinical Excellence (NICE) guidelines to inform the VTE prescribing process. The main focus of improvement work for VTE is implementing an electronic

[2] ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides healthcare professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment.

prescribing system (Careflow Medicines Management) which will continue during 2023/24. This system provides options for integrating VTE risk assessments alongside thrombo-prophylaxis prescribing to make it easier for staff to complete both in the same system (rather than two separate systems) and support reduction of hospital associated VTE.

Invasive Procedure Safety:

The aim of this workstream is to support the reduction of risks associated with invasive procedures and to standardise invasive procedure safety Trust-wide. Work is being progressed by the clinical teams for early adoption of recently published revised National Safety Standards for Invasive Procedures (NatSSIPs2) standards. This implementation includes a focus on cultural development (including clinical staff attitude surveys) and testing a "Prep, Stop, Block" process to reduce risk of wrong side nerve blocks.

Maternity and Neonatal Work Stream

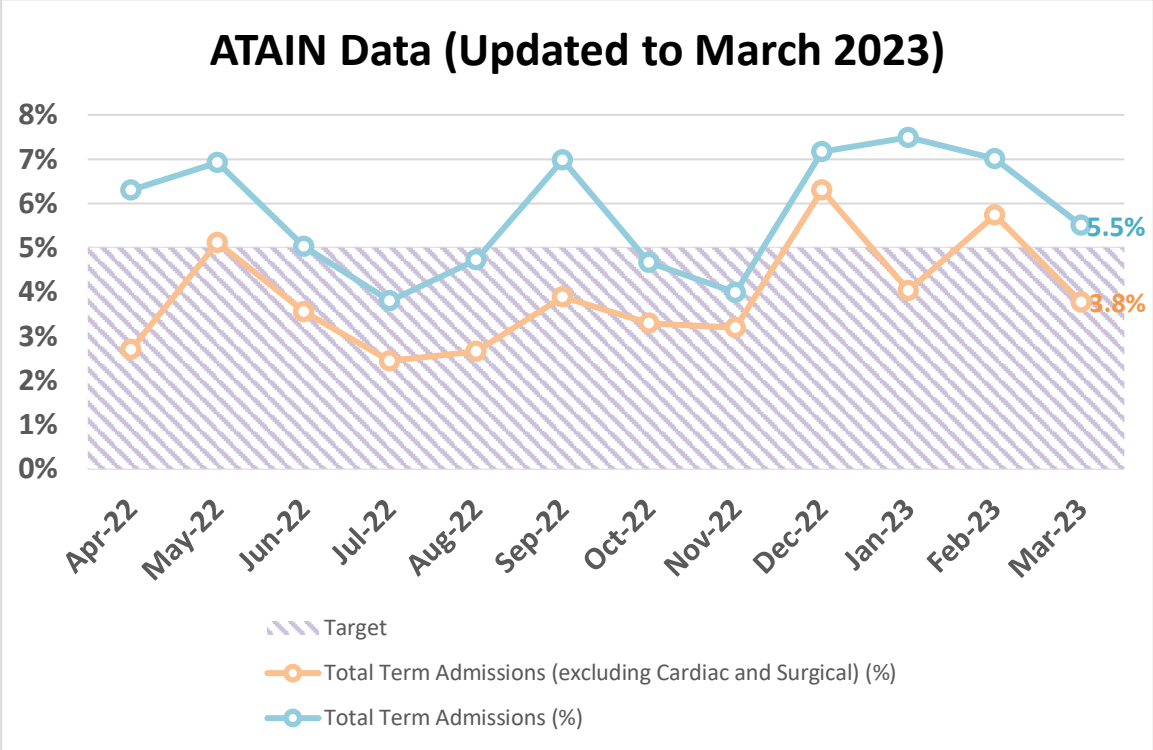
The main aim of the improvement workstream for maternity and neonatal care is to improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide high quality healthcare experience for all women, babies, and families within our care.

NHS England's national target for all women, babies and families across all maternity care settings in England are to reduce the rate of stillbirths, neonatal death and brain injuries occurring during or soon after birth by 20% by 2020 and by 50% by 2025. Maternity and neonatal services at UHBW are actively engaged across the local maternity and neonatal system (LMNS), the Southwest Academic Health Science Network and the maternity and neonatal safety improvement programme network (MatNeoSIP).

The key quality improvement priorities that were identified in 2022/23 are:

- An improvement to meet the target of a minimum of 80% compliance with for four consecutive months of carbon monoxide recording at antenatal booking and at 36 weeks of pregnancy and the increased promotion of smoking cessation to tackle health inequalities caused by smoking during pregnancy. UHBW has become an early implementer for enhanced smoking cessation support with funding from NHSE and a full-time smoking cessation advisor commenced in post in March 2023. The impact of this will be monitored during 23/24.
- Avoiding term admissions into the Neonatal Intensive Care Unit (ATAIN). The objective of this workstream is to ensure that term babies are born in good condition reducing the requirement for admission to Neonatal Intensive Care Unit (NICU) at birth. The aim of the workstream is to reduce term admissions to NICU to 5% or below (excluding cardiac and surgical cases). Figure 2 below demonstrates variable achievement throughout 2022/23, however we met the improvement goal in December 2022 and February 2023 will now aim to consistently sustain improvement in 2023/24.

Figure 2



Other improvement workstreams in the maternity programme underway include:

- Improving the detection and management of diabetes in pregnancy
- Improving the early recognition and management of deterioration during labour & early post-partum period**.** This is an identified priority in our Trust Patient Safety Incident Response Plan (see section 3.1)
- Utilisation of the PERIPREM (Perinatal Excellence to Reduce Injury in Premature birth) care bundle.
- Improving the optimisation and stabilisation of the very preterm infants.

The Patient Safety Improvement Programme is continuously reviewed, ensuring that the workstreams are aligned with the identification of any new Trust-wide strategic and safety priorities.

3.1.6 Freedom to Speak Up

The Trust has a Freedom to Speak Up Guardian (FTSUG) and a deputy guardian with whom all staff can raise concerns, either directly or via a dedicated confidential raising concerns email or telephone line.

The role of the FTSUGs is to raise awareness and build confidence in speaking up and ensure our leadership and management training, which became mandatory for all managers at the end of 2022, is informed by the feedback and learning from staff raising concerns.

Individuals who speak up are supported by the FTSUGs and receive feedback following investigations into their issues or concerns. Their work is supported by a network of 80 volunteer staff speaking up champions, representative of various staff groups and backgrounds. Champions receive training by the FTSUG to provide support for staff to talk through issues or concerns in confidence, and can signpost to further support, but do not handle cases.

Posters, cards and leaflets on display and distributed around the Trust describe what speaking up is and how to contact the FTSUG. Regular communications about speaking up are included in the weekly all-staff newsletter, alongside FTSUG updates to different teams and departments and fortnightly walkrounds to meet staff.

Mandatory essential speak up training for all staff was introduced in February 2021 and compliance in March 2023 was 78% across the Trust.

In the past year, 109 concerns from all staff groups were raised via the FTSUG (compared to 102 concerns the previous year). Most concerns are raised by admin/clerical staff (30%) and nursing staff (25%).

In terms of themes of concerns, the majority (36%) relate to policies and processes, followed by 34% relating to inappropriate attitudes and behaviours, including bullying and harassment. Concerns within these categories include those related to pay and reward; working culture, and opportunities for development and progression.

There were six quality and safety concerns raised in the year. Where there are concerns relating to quality or safety, these are escalated to the chief nurse/medical director or their deputies to investigate and take appropriate action.

The FTSUG is not the only mechanism through which staff can get their voice heard. The Trust also has the following groups which support staff, alongside an external employee assistance programme. The FTSUG works with staff in these groups and others in triangulating themes of concerns:

- HR services
- Staff Side
- Occupational health
- Patient Safety team
- Safeguarding team
- Victim Support Officers
- Staff networks

The Board and its People Committee receive a quarterly update on the FTSU programme, including numbers and themes of concern and learning. The FTSU annual report is published on the Trust website: www.uhbw.nhs.uk

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

The Trust has two Guardians of Safe Working for Junior Doctors – Dr James McDonald for the Bristol hospitals and Dr William Hicks for the Weston site. Guardian of Safe Working for Junior Doctors reports are published by the Trust at https://www.uhbw.nhs.uk/p/about-us/reports-and-publications

3.1.8 Overview of monthly Board assurance regarding the safety of patients 2021/22

Table 4 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 and challenging yet achievable.

Table 4

Quality measure	Data source	21/22 Actual	Target 2022/23	Quarter 1	Quarter 2	Quarter 3	Quarter 4	22/23 Actual
Infection control and cleanliness monitoring								
MRSA Hospital Onset Cases	National Infection Control data (PHE)	7	0	0	1	2	4	7
MSSA Hospital Onset Cases	National Infection Control data (PHE)	41	No set target	8	9	11	12	40
CDiff Hospital Onset Cases	Infection Control system (MESS)	82	< 89	20	25	21	12	78
CDiff Healthcare Associated Cases	Infection Control system (MESS)	95	No set target	26	29	26	19	100
EColi Hospital Onset Cases	Infection Control system (MESS)	75	< 119	28	17	18	12	75
Serious incidents and never events								
Number of Serious Incidents Reported***	Datix/local data	89	No set target	24	30	23	33	110
Total Never Events	Datix/local data	3	0	0	2	1	0	3
Patient falls								
Falls per 1,000 bed days	Datix/Medway	4.83	< 4.8	4.82	4.8	5.31	5.16	5.02
Total number of patient falls resulting in harm	Datix	35	< 24	8	9	4	10	31
Pressure ulcers developed in the Trust								
Pressure Injuries Per 1,000 Beddays	Datix/Careflow	0.174	< 0.4	0.143	0.09	0.166	0.111	0.128
Pressure Injuries - Grade 2	Datix	53	No set target	13	5	12	5	35
Pressure Injuries - Grade 3	Datix	11	No set target	1	4	4	6	15
Pressure Injuries - Grade 4	Datix	1	No set target	0	0	1	0	1
Venous Thromboembolism (VTE)								
Adult inpatients who received a VTE Risk Assessment*	Careflow	83.3%	≥95%	81.9%	83.1%	83.5%	84.4%	83.3%
Medicines								
Medication incidents resulting in harm	Datix	0.29%	< 0.5	0.34%	0.22%	0.18%	1.01%	0.37%
Non-purposeful omitted doses of the listed critical medication**	Local audit	0.36%	< 0.75	1.14%	0.87%	1.65%	1.45%	1.28%
Staffing levels								
Staffing Fill Rate - Combined	National Unity return	92.5%	No set target	89.0%	89.2%	89.1%	90.5%	89.4%
Staffing Fill Rate - RN Shifts	National Unity return	88.3%	No set target	86.6%	86.4%	87.9%	90.7%	87.9%
Staffing Fill Rate - NA Shifts	National Unity return	101.9%	No set target	94.2%	95.1%	91.8%	90.0%	92.7%

*excludes Weston General Hospital where electronic VTE risk assessment recording is not yet in place
**excludes Weston General Hospital as a programme of systematic monitoring audits is not yet in place

3.2 Experience of Care

The experience that patients have as part of the healthcare we provide is a core component of quality. At UHBW, we believe that experience is more than simply satisfaction with a service we provide. We want all patients and carers to be treated with dignity and respect, to be fully involved in decisions affecting their care and to receive accessible, inclusive and equitable services. Our goal is to continually improve by engaging with and listening to patients, carers and the public when we plan and develop services, by asking patients about their experience of care and how we can make it better by taking positive action in response to that learning.

3.2.1 National patient surveys

Each year, the Trust participates in the national patient survey programme which is coordinated by the Care Quality Commission and Picker Institute. The results from the national patient survey programme tell us how the experience of patients at UHBW compares with other NHS acute trusts in England. The results of each national survey, along with improvement actions/learning, are reviewed by the Trust's Experience of Care Group and the Trust Board.

National patient survey results published during 2022/23[3] demonstrate that:

In the **National Adult Inpatient Survey** (sampled November 2021), the overall experience of care rating for UHBW was 8.2/10, a fall from 8.6/10 from our 2020 results. Our score was in line with the national average. At national level the percentage of patients who scored Trusts '9' or '10' out of 10 for this question has reduced since 2020, suggesting an overall decline in inpatient experience across the country. In terms of the overall hospital experience rating question in the survey, UHBW ranked 56th out of 134 participating Trusts, a fall from 26th place in the 2020 results.

The main areas for improvement identified, which formed into an action plan, were:

- Re-think the support available in the lead up to discharge by involving patients in discharge planning (including around their medication needs), keeping patients informed of what will happen next and working with community partners to ensure patients right support in place at home (i.e. equipment);
- Reflect on how patients' views on low staffing levels impact on both relational and personal aspects of care and in doing so, take action to increase patients' confidence that they will be able to talk to a member of staff when they need to, and ensure they get the right support to wash;
- Reduce noise at night from staff to support patients to rest well in our hospitals;
- Improve the quality and choice of food to better support meeting the nutritional needs of patients;

In the **National Cancer Patient Experience Survey** (sampled April to June 2021); patients scored the Trust 9 out of 10 for the 'overall experience of care' question. This result, higher than the national average rating, places UHBW in the top 30% of Trust's nationally. Given the context, that this feedback was collected in 2021 from patients who

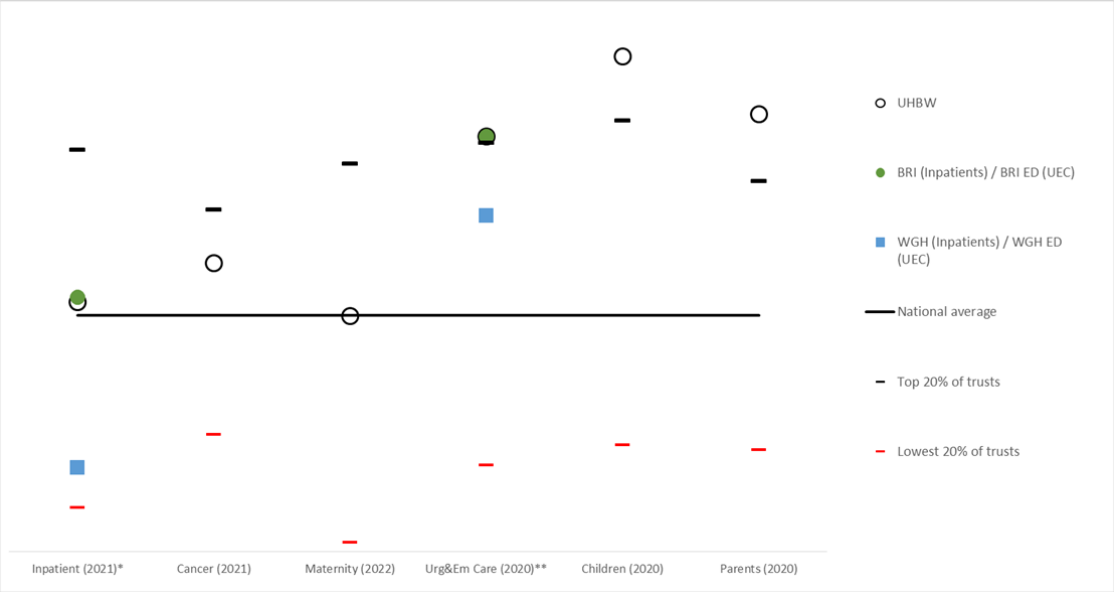
[3] National surveys results are published around ten months after the participating patients attended hospital.

were experiencing their cancer diagnosis and care during the height of the COVID 19 pandemic, there are a lot of positive reflections and evidence that many services have been sustained despite these challenges. There are consistent themes of good practice across UHBW, including information giving and the quality of care and positive attributes of staff.

In the **National Maternity Survey** (sampled February 2022), UHBW broadly performed in line with the national average with a score of 7.8 out of 10.0. Using this metric, UHBW ranked 51st out of 121 Trusts in the 2022 survey which is a significant improvement from the rank of 101st place in the 2021 results. UHBW's 2022 national maternity survey results saw an improvement in many areas when compared to the results from 2021. On the back of the 2021 results, a multi-disciplinary 'Women's Experience Group' was formed to oversee the successful delivery of the maternity experience improvement plan. There is evidence from the 2022 results that the improvement efforts are translating into a more positive experience for women and their partners. There is more work to do to ensure that experience is positive across all aspects of the maternity pathway, particularly in relation to care in hospital after birth. The improvement plan is being reviewed, updated, overseen and monitored by the Women's Experience Group following the publication of the 2022 results.

A visual summary of how UHBW performed in the most recent national patient survey publications can be found in Figure 3 below.

Figure 3: Overall experience of patients at UHBW relative to national benchmarks[4]



Source: UHBW analysis of Care Quality Commission data.

[4] 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.

3.2.2 Feedback from our monthly survey programme

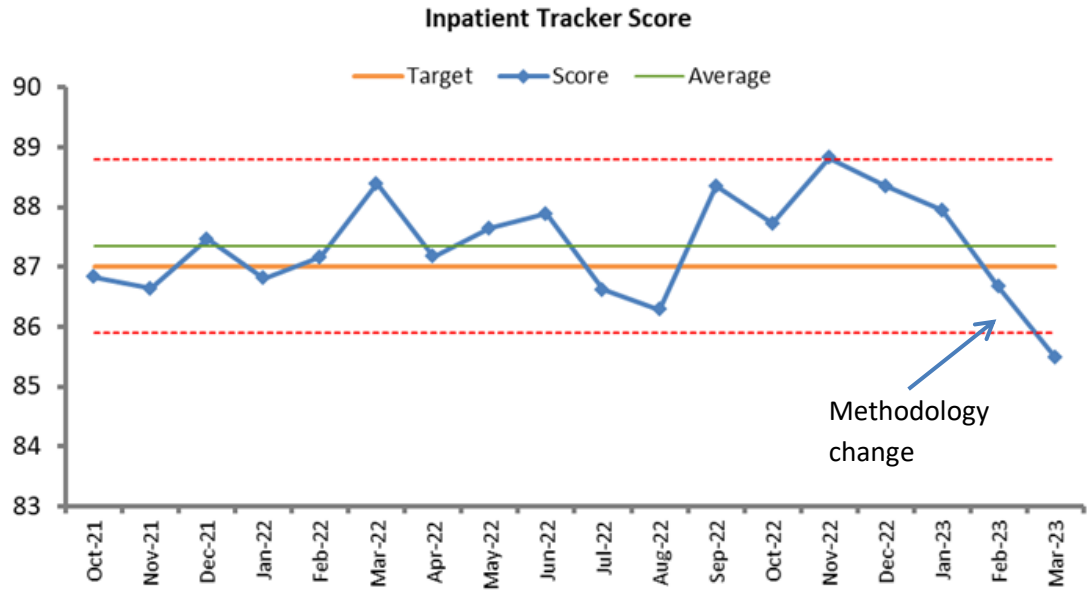
UHBW has a comprehensive local survey programme which ensures that ongoing and timely feedback from patients forms a key part of our quality monitoring and improvement approach**.** Our extensive patient feedback processes provide us with important insights from patients and people who visit our hospitals about what we are doing well and what we need to change to offer an outstanding experience of care.

A suite of key patient experience measures is routinely to Experience of Care group, Clinical Quality Group and Quality and Outcomes Committee. These measures are taken from a monthly survey which is sent to a sample of inpatients, outpatients and women seen in maternity services. Two of these measures are the inpatient and outpatient experience tracker scores. These 'composite' scores are made up of key questions from each monthly survey that patients told us are important to them. They include questions on communication with nurses and doctors, whether respondents felt they are treated with dignity and respect, and whether respondents felt involved in decisions about their care and treatment.

The charts below show the inpatient and outpatient experience tracker scores as well as a third chart which displays whether patients reported they were treated with kindness and understanding during their stay in hospital.

The inpatient experience tracker score for 2022/23 (as a whole) was above the minimum target (87). There were four occasions during 2022/23 where the score dipped just below target, however the decline seen in February and March 2023 is largely driven by a change in methodology for the monthly survey which is now available to patients digitally (via text message) with a paper copy automatically sent to those over 80 and for patients who request a paper copy. This change aligns to the CQC National Patient Survey methodology. Age group has an impact of how patients rate their experience of care, for example Q4 2022/23 data shows patients ages 18-59 are three times more likely to rate their care as poor or very poor compared to those aged 60+.

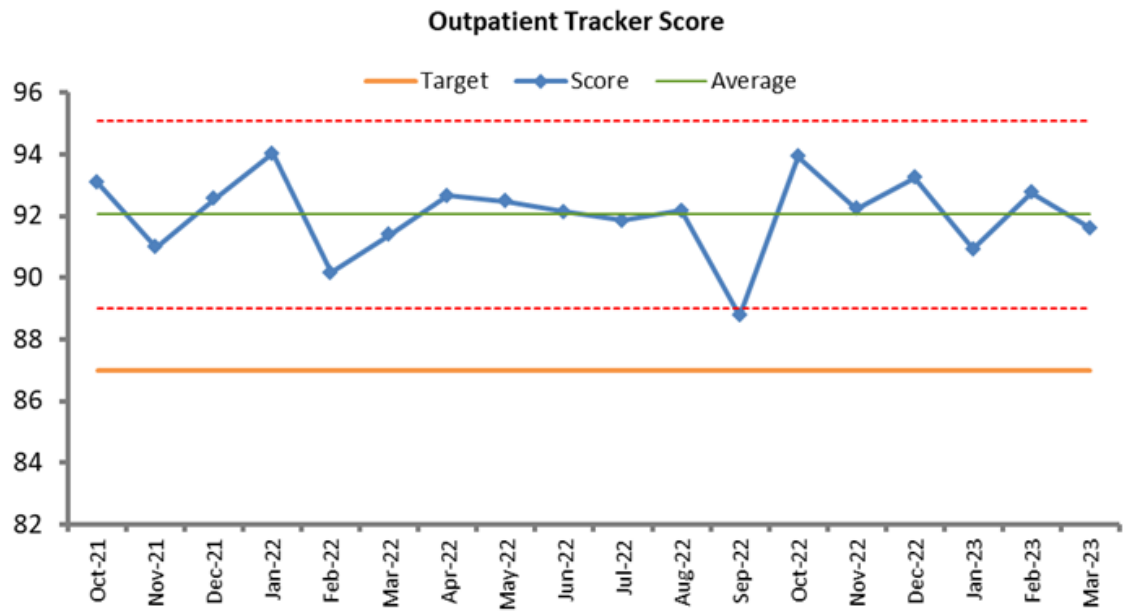
Figure 4: Inpatient Experience Tracker Score



Source: UHBW monthly survey

The outpatient experience tracker score has remained above target throughout 2022/23. The score continues to track above the pre-pandemic average. This has been the case since the introduction of video clinics at the start of the COVID-19 pandemic

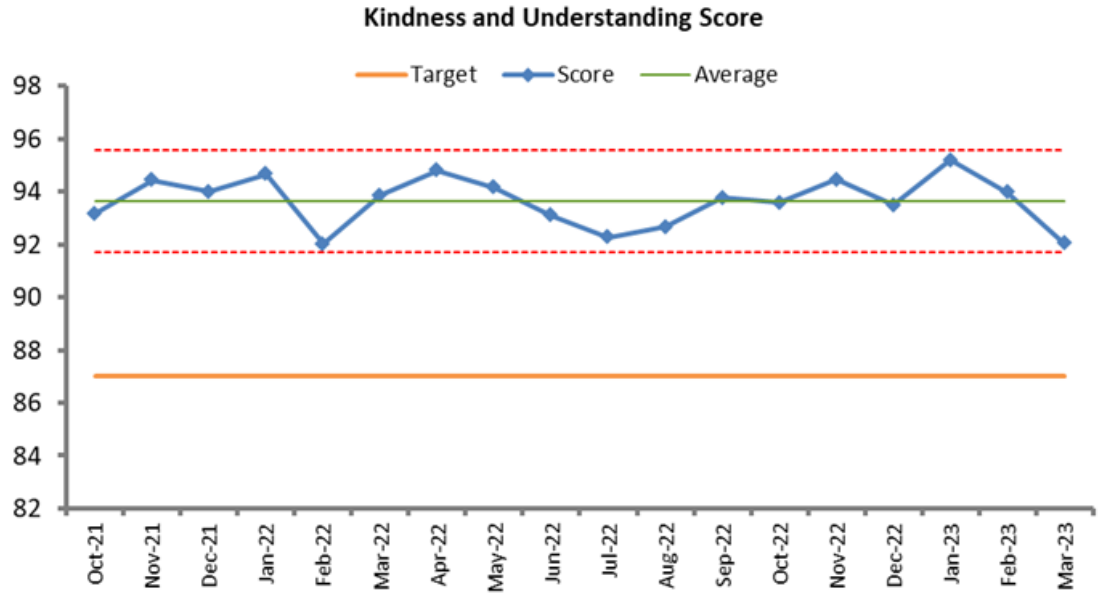
Figure 5: Outpatient Experience Tracker Score (Trust-level)



Source: UHBW monthly survey

The kindness and understanding score has remained above target throughout 2022/23.

Figure 6: Kindness and understanding score (Trust-level)



Source: UHBW monthly survey

3.2.3 Patient Experience Hub

During 2022/23, we launched the 'Patient Experience Hub' at UHBW and have so far trained over 250 staff to use this innovative system. The Hub brings most of our patient feedback into one place using a system called IQVIA (represented in the image below). It provides instant access for staff across the Trust to patient feedback right down to ward and department level. It provides staff with set of analysis reports (benchmarking, filtering, heat maps, thematic analysis) for quality improvement activity and enables staff to share positive and negative feedback easily with their teams. The Hub also ensures patients can feedback in a variety of ways, maximising digital routes where possible, with some feedback collected directly in to IQVIA and then available in real-time.

Real-time access by Divisions:

- Women's and Children's
- Surgery
- Medicine
- Diagnostics and Therapies
- Specialised Services
- Weston (Management team)
- Trust Services

3.2.4 Patient and Public Involvement

Public and Patient Involvement (PPI) encompasses working with people (patients, carers, visitors, the public) and communities who use our services or care for patients. By working with people in this way it helps us understand and respond to the needs of our diverse community and bring an influential user insight into our quality improvement work. In understanding what matters to people and communities we can plan and deliver better care and we do this by using a range of involvement activities to help evaluate and inform the planning and delivery of our services.

Some key highlights of our PPI activity during the year included:

- The completion of a review of our emergency departments in partnership with Bristol Autism Support Services to understand how these services can better support Autistic people. The BRI ED now benefits from a Sensory Suite, a quieter area to sit, apart from the traditional waiting area. Resources kept in the Suite include a communication guide, ear defenders, eye masks, ear plugs, memory cards and fidget toys. These can be used to help communicate with patients and assist with supporting anxious patients.
- The recruitment of two Lay Patient Safety Partners to bring an external assurance and patient/carer perspective to this work.
- The recruitment of six Lay partners to steering groups starting in 2023/24 that will focus on improving aspects of Dermatology care including Inflammatory Skin Disease.
- Continued work with the Bristol Deaf Health Partnership to ensure our services are responsive to the needs of the D/deaf and hard of hearing community.
- Working with the Bristol Sight Loss Council to review the access arrangements for visually impaired people attending the BRI Emergency Department. This includes an audio description of how to navigate to the BRI ED from the Welcome Centre.
- Working with the Bristol Sight Loss Council and Bristol Eye Hospital to deliver a new video exploring the importance of the Accessible Information Standard.
- Launching the UHBW on-line Access Guides offering comprehensive information to the public about the Trust's locations and access arrangements. In 2022/23 there were 16,000 users of the service and 45,000 page views.
- Sharing in-person patient stories at Public Trust Board enabling Board members to reflect on the experiences of people attending our hospitals.
- Working with patients and their families to design a new ECMO service (extra-corporeal membrane oxygenation), a form of life-support that we offer to patients with the most severe forms of heart and lung failure. As a result of this work a model of peer-support for patients and families is being developed as part of a wider wellbeing initiative that includes the introduction of a patient diary which enables patients and families to reflect on and understand their experience of care.
- Working with marginalised people who are referred to our High Impact User Team because of their repeat attendance at the BRI Emergency Department to better understand and respond to their needs. The priorities for improvement will be to change the name of the service so it better reflects how it supports people and to improve the content of personal care plans so that they are more reflective of the individual.
- Re-launching the My Journey volunteer programme that enables patients and community partners to undertake service evaluation work including bringing a non-clinical perspective to the Clinical Accreditation process. 12 Volunteers have been recruited to this programme.
- Re-launching the Trust Carers Steering Group and enhancing the opportunities for an influential Carers voice in that group in collaboration with the Carers Support Centre.

During the coming year we will further develop our online support for colleagues so they are better able to work with patients and communities as part of their evaluation and improvement work, further develop the support we offer our lay representatives/patient partners, establish a community outreach programme to better understand and respond to the needs of our diverse communities including a collaboration with Bristol Black Carers, and lead the development of a new Experience and Care Strategy with community partners.

3.2.5 Health Equity

2022/23 was a pivotal year in the UHBW's ambition to play a proactive and leading role in the local healthcare system on tackling health inequalities and making our services more accessible and inclusive for our diverse communities.

During 2022/23:

- UHBW has worked with external partner, AccessAble, to create detailed access guides' to facilities, wards, and departments all of our hospital sites across Bristol and Weston General Hospital. The guides, funded by Bristol & Weston Hospitals Charity, contain facts, figures and photographs to help patients, visitors and staff plan their journeys to and around hospital sites, including information on parking facilities, hearing loops (audio induction loops) for people with hearing aids, walking distances and accessible toilets.
- The independent equality, diversity and inclusion (EDI) baseline review report was received in May 2022 from Public Health Action Support Team (PHAST), the national social enterprise who were commissioned to undertake the review. The report was discussed at a Board seminar in July 2022 and the three overarching recommendations from the baseline review were approved.
- UHBW funded a new substantive Patient EDI manager post as part of the Experience of Care and Inclusion Team to bring dedicated strategic resource to coordinate the efforts of UHBW, as part of the ICS, to advance health equity for our patients and communities.
- As part of a 2022/23 Quality Priory, a Health Equity Delivery Plan was developed, drawing on the recommendations of the EDI baseline review, and approved by Quality and Outcomes Committee in March 2023. The plan is being shared widely internally and with external stakeholders via the Integrated Care System (ICS) and community partners. The plan:
    - Sets out an ambitious programme of equality objectives, such as reaching compliance with the NHS Accessible Information Standard (AIS), improved learning and training opportunities for colleagues on different aspects of equality and diversity knowledge and practice, as well as improved data collection and use of EDI intelligence to improve planning and priority setting
    - Sets out a phased approach towards greater cohesion and integration of workforce and patient/community EDI activity. In practical terms, there will be more opportunities for the sharing of knowledge and experiences across our organisation through the lens of EDI. Organisational Development EDI colleagues are working closely with the new Patient EDI resource towards a more collaborative approach.
- Deirdre Fowler, Chief Nurse and Midwife was established as the Executive Lead for Health Equity at UHBW
- A new multi-disciplinary 'Health Equity Delivery Group' has been established, chaired by the Trust' Deputy Medical Director which reports to Clinical Quality Group and to Board via QOC.

3.2.6 Complaints received in 2022/23

In 2022/23, 1,898 complaints were reported to the Trust Board, compared with 1,873 in 2021/22. The majority of the complaints (1,219 of 1,898 or 64.2%) were investigated via

informal resolution, with the remaining 679 addressed through the formal complaints process.

In addition, the Patient Support and Complaints team dealt with 1,493 other enquiries, including compliments, requests for support and requests for information and advice; a similar number to the 1,489 enquiries dealt with in 2021/22. The team also received and recorded an additional 765 enquiries which did not proceed after being recorded (an increase on the 721 reported in 2021/22). In total, the team received 4,156 separate new enquiries into the service in 2022/23; a small increase of 1.8% on the 4,083 reported the previous year.

In 2022/23, the Trust had 10 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO), representing a 66.7% increase on the six cases referred the previous year, although still a very low total overall. During the same period, 12 cases were closed by the PHSO. Of these 12 cases, none were 'upheld'; three were 'partly upheld'; one was 'not upheld' and the remaining eight cases were closed without a full investigation and recorded as 'no further action'. At the end of the year 2022/23, four cases were still under investigation by the PHSO.

615 complaints were responded to via the formal complaints process in 2022/23 and 71.1% of these (437) were responded to within the agreed timescale, which is an improvement on the 62.8% achieved in 2021/22, but below the Trust's target of 95%. A total of 872 complaints were responded to in 2022/23 via the informal complaints process and 86.4% of these (753) were responded to within the agreed timescale, a deterioration on the 92.7% achieved the previous year. The informal process encourages rapid resolution by the specialty manager responsible for the service involved.

At the end of the reporting year, 10.9% of complainants had expressed dissatisfaction with the formal response they had received. This represents a total of 73 of the 667 first formal responses sent during the reporting period, which is a small increase on 2021/22 (9%).

3.2.7 Learning and improving

Our approach to listening to experience of patients is grounded in the Trust's belief that we must learn from what people tell us in order to make improvements to the way services are designed and delivered. Over the past year, there have been many examples across our hospitals where this has happened. The examples below are improvements to experience of care that have been introduced following feedback from our patients, carers, parents and communities from surveys, complaints and other sources:

- In the Bristol Heart Institute (BHI), a new idea launched called the 'Golden Sunshine Patient'. The idea is to support patients who are identified on the board round each day to leave the ward with a member of staff to go to the hospital garden on level 5 in the BHI garden to have some fresh air during their stay in hospital. Feedback from patients that have been given this opportunity has been positive and also the staff that have had the opportunity to leave the ward area for 15 minutes to support a patient to do this.
- In Caterpillar Ward at Bristol Royal Hospital for Children, projectors have been installed into the cubicles as entertainment for patients and families.

- Positive feedback has been received on patient experience relating to 'Dancing on Draycott' which takes place every Wednesday afternoon at Weston General Hospital, this supports movement and engages patients in activity. There is also an Age UK activities coordinator on Kewstoke Ward who engages the patients in games and activities which supports their recovery and rehabilitation. The project is in the process of being evaluated.
- As part of the Black Maternity Matters project, the Practice Education Facilitator undertook community outreach with Somali Women in East Bristol to better understand their experience of Maternity services provided by UHBW and identify how to improve communication and information sharing with this community.
- Within the BRI Emergency Department, the Patient Experience Hub is accessed weekly and themes identified each month for action. Information is cross referenced with identified complaint actions. Examples of improvements made during 2022/23 include:
    - More healthy options in vending machines
    - Fixing some accessibility issues with disabled toilets (toilet riser and grab rails fitted
    - Temperature issues have been resolved in the waiting room during the winter months
    - Improved signage to facilities
    - Ambulance queue information leaflets for those waiting with South West Ambulance NHS Trust
    - Facilities and décor in the relatives room has been improved (painted, coffee making facilities, signage)
    - Phone charging points have been installed in the waiting room

3.2.8 Overview of monthly Board assurance regarding patient experience

Table 5 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.

Table 5

Quality measure	Data source	Actual 2021/22	Target 2022/23	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2022/23
Monthly patient surveys								
Inpatient experience tracker Score	Monthly monthly survey	91	≥ 87	88	87	88	87	87
Kindness and Understanding	Monthly monthly survey	96	≥ 90	94	93	94	94	94
Outpatient experience tracker Score	Monthly monthly survey	93	≥ 85	92	91	93	92	92
Inpatient Score	Friends and Family Test	97.6%	≥ 90%	94.2%	94.2%	95.9%	96%	95.1%
ED Score	Friends and Family Test	84.2%	≥70%	83.3%	84.8%	81.1%	87.6%	84.2%
Maternity Score	Friends and Family Test	96.7%	≥92%	98.9%	97.7%	99.1%	98.3%	98.5%
Patient complaints								
Number of Patient Complaints	Patient Support and Complaints Team	1,873	No set target	417	441	567	473	1,898
Formal Complaints Responded To Within Trust Timeframe	Patient Support and Complaints Team	62.8%	≥ 95%	75.2%	71%	72.1%	66.7%	71.1%
Informal Complaints Responded To Within Trust Timeframe	Patient Support and Complaints Team	92.7%	≥ 95%	88.8%	86.7%	86.7%	83.2%	86.4%
Percentage of Responses where Complainant is Dissatisfied	Patient Support and Complaints Team	9%	< 8%	9.7%	9.9%	11.4%	12.9%	10.9%

3.3 Clinical effectiveness

We will ensure that 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 NHSX (formally NHS Digital) 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% 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 7, the blue vertical bars represent UHBW 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%). Latest comparative data available is from December 2021 to December 2022 shows that the Trust remains in the 'as expected' category. In this period the Trust had 2,240 deaths compared to 2,230 expected deaths; a SHMI score of 100.4.

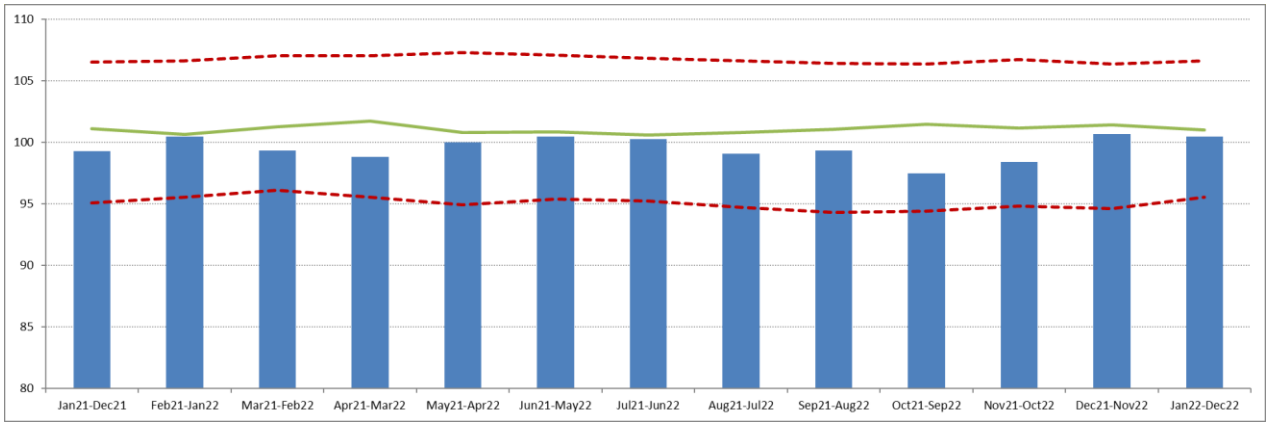
Understanding the impact of our care and treatment by monitoring mortality and outcomes for patients is a vital element of improving the quality of our services. To help facilitate this, the Trust has a Quality Intelligence Group (QIG) whose purpose is both to identify and be informed of any potential 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 Trusts' Associate Director of Quality and Patient Safety

In January 2023, the Trust undertook a deep dive looking into mortality figures after observing a reported increase in HSMR over a time period where SHMI remained

unchanged. This work included a comparison of the differences in methodology between the two measures to define any areas for concern specific to UHBW. Other areas of scrutiny in addition to the usual alerts that are managed through QIG, included spell versus superspell coding, length of stay data and its relation to mortality reporting, changes to mortality risks during the timeframe in question and palliative care data.

No areas of concern have been identified through these reviews; the palliative care data review is ongoing at the time of writing and HSMR has now normalised.

Figure 7



Source: CHKS benchmarking

3.3.2 Learning from deaths (local mortality review)

During the period of April 2022 to March 2023, 2,064 of University Hospitals Bristol and Weston NHS Foundation Trust patients died. This comprised the following number of deaths that occurred in each quarter of that reporting period:

- 487 in the first quarter
- 479 in the second quarter
- 570 in the third quarter
- 528 in the fourth quarter

By 31 March 2023, 80 case record reviews have been carried out in relation to 2,064 deaths. The number of deaths in each quarter for which a case record review was carried out was:

- 30 in the first quarter
- 14 in the second quarter
- 28 in the third quarter
- 8 in the fourth quarter

These numbers have been calculated from the Trust's Mortality Review Database, integrated into Careflow PAS (patient administration system).

Internal processes

The Mortality Surveillance Group continues to work closely with the Medical Examiner's Office (MEO); the MEO reviews 100% of adult deaths where the person has died in hospital and is now expanding its work into the community. Acute cases that raise concerns are shared with the medical director's office who triage each case so that it follows the most appropriate process (structured judgement review, patient safety review, complaints process or informal feedback to the clinical area).

Dr Rebecca Thorpe continues in the post of Associate Medical Director with a portfolio covering patient Safety and mortality. She has strengthened the mechanisms for informal concerns and feedback to be passed to clinical areas for reflection in circumstances that do not trigger structured judgement reviews so feedback goes to the End of Life Steering Group as well as to individual clinical areas. Furthermore, the Mortality Steering Group has initiated a rolling thematic system of shared learning to ensure that areas of good practice and learning can be shared more widely across the Trust. The Trust's Learning from Deaths Policy has also been updated this year. The Trust had led on setting up ICB-wide multidisciplinary Learning from Deaths education events, the first of which was hosted by UHBW and well attended by colleagues from other providers, community colleagues, medical examiners and mortality teams.

Learning themes arising from mortality reviews and directed into appropriate improvement programmes have included:

- Access to palliative care teams, especially at weekends
- Ward communication with families
- Delayed transfers between hospitals and hospitals sites
- Care of medical 'outlier' patients (patients who, due to pressures on hospital admissions, are accommodated in beds which are not in their medical specialty)
- Delayed administration of antibiotics
- Anastamotic leaks after bowel surgery at Weston site
- Delays in chest drain insertion in specific areas

The Trust had led on setting up ICB-wide multidisciplinary Learning from Deaths education events, the first of which was hosted by UHBW and well attended by colleagues from other providers, community colleagues, medical examiners and mortality teams. Regionally, work has been undertaken to align the processes and share learning between UHBW and North Bristol NHS Trust. A group has been established and an agreement reached that both trusts will work together to engage with the national "Better Tomorrow" programme.

3.3.3 Overview of monthly board assurance regarding clinical effectiveness

Table 6 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.

Table 6

Quality measure	Data source	21/22 Actual	Target 2022/23	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2022/23
Mortality								
Summary Hospital Mortality Indicator (SHMI)	NHSX	98.3	<100	100.2	98.6	98.4	-	
Hospital Standardised Mortality Ratio (HSMR)	CHKS	103.7	No target	112.8	114.5	106.4	-	
Fracture neck of femur								
Patients treated within 36 Hours	National Hip Fracture Database	63.4%	≥ 90%	46.2%	56.5%	53.1%	56.9%	52.7%
Patients seeing orthogeriatrician > 72 Hours	National Hip Fracture Database	96.1%	≥ 90%	89%	98%	95.8%	76.4%	91.7%
Patients achieving best practice tariff	National Hip Fracture Database	58.7%	≥ 90%	36.6%	51.7%	39.2%	48%	43.8%
Readmissions								
Emergency readmissions percentage	Careflow	2.4%	< 3.62	3.5%	4.03%	4.29%	5.49%	4.12%
Stroke Care								
Stroke Care: Percentage Receiving Brain Imaging within 1 Hour	SSNAP	56.7%	≥ 80%	48.8%	60.4%	57.8%	73.7%	57%
Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	SSNAP	63.7%	≥ 80%	60.3%	52.7%	53.1%	68.4%	57%

3.4 Performance against national priorities and access standards

3.4.1 2022/23 Priorities and Operational Planning Guidance

On 24 December 2021, NHS England and NHS Improvement (NHSEI) released the 2022/23 priorities and operational planning guidance.

The guidance outlined the priorities for the NHS in 2022/23 including improvements in elective and urgent and emergency care (UEC) performance.

A range of performance standards were defined in the document, which are summarised in table 7 below.

Table 7

Priority areas	Performance standards
Maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services.	- Eliminate waits of over 104 weeks as a priority by July 2022 and maintain this position through 2022/23 (except where patients choose to wait longer). - Eliminate waits of over 78 weeks by April 2023, except where patients choose to wait longer or in specific specialties. - Develop plans that support an overall reduction in 52-week waits where possible, in line with an ambition to eliminate them by March 2025, except where patients choose to wait longer or in specific specialties. - Accelerate the progress made towards a more personalised approach to follow-up care in hospitals or clinics, reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 and going further where possible. - Patient initiated follow-up (PIFU) to be expanded to all major specialties, moving, or discharging 5% of outpatient attendances to PIFU pathways by March 2023. - Referral optimisation, including through use of specialist advice services to enhance patient pathways – delivering 16 specialist advice requests, including advice and guidance (A&G), per 100 outpatient first attendances by March 2023.
Complete recovery and improve performance against	- Return the number of people waiting for longer than 62 days to the level in February 2020.

cancer waiting times standards.	- Improve performance against cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31-day decision-to-treat to first treatment standard.
Diagnostics.	- Increase diagnostic activity to a minimum of 120% of pre-pandemic levels across 2022/23.
Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity – keeping patients safe and offering the right care, at the right time, in the right setting.	- Reduce 12-hour trolley waits in EDs towards zero and no more than 2%. - Minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards, including: o Eliminating handover delays of over 60 minutes, o Ensuring 95% of handovers take place within 30 minutes. o Ensuring 65% of handovers take place within 15 minutes.

3.4.1.1 Development of BNSSG Operating Plan for 2022/23

Following the publication of the 2022/23 Priorities and Operational Planning Guidance, the Trust, with other partner organisations, contributed to the development of the 2022/23 BNSSG Integrated Care System (ICS) operating plan.

The Trust used demand and capacity modelling to determine the requirements to deliver the performance standards. There was also an assessment of bed, theatre, outpatient capacity and workforce to deliver these improvements.

In support the achievement of these ambitions, the ICS agreed additional investment of £6.35m with the following objectives:

Objective 1: Increase elective inpatient activity towards 2019/20 activity levels.

- The Trust established its Proactive Hospital Programme, and launch an initiative called Every Minute Matters, which focussed on improving length of stay and ensuring timely discharge of patients from hospital.

- Funding was also agreed to expand our Same Day Emergency Care (SDEC) services to reduce hospital admissions.

- £1.3m funding was agreed for the Weston General Hospital Surgical Short Stay Unit (Knightstone Ward) to extend its use from August 2022 to March 2023.

Objective 2 – Reduction in follow up backlogs with a specific focus on reducing delays to avoid preventable sight loss in Ophthalmology.

- The COVID-19 pandemic had resulted in the Trust reporting a significant increase in overdue follow ups. In this context, the Trust and BNSSG Integrated Care System's plan did not reflect the ambition outlined in the operational planning guidance to reduce follow-up volumes by 25%. Our plan was based on a modest reduction in long waiting overdue follow-ups.

- There was a particular increase in overdue follow-ups in Ophthalmology. The Trust's plans were based on the eye diagnostic hub being moved to a new, larger location within the Broadmead Galleries shopping centre and was expected to generate more than 28,000 additional outpatients follow up procedures.

Objective 3 – Reduction in the number of long waiting patients, and improvements in diagnostic and cancer performance.

- £2m of funding was agreed to improve waiting times in endoscopy, paediatrics, dental specialties, oncology, gynaecology, and cardiac echo.

- Diagnostic plans included at least a 10% reduction on the May 2022 diagnostic waiting list size, elimination of patients waiting over 26 weeks and delivery of a Trust wide standard of 75% waiting under 6 weeks.

These investments contributed to a recovery of care backlogs, including an improvement in the number of patients anticipated to wait over 78 weeks and 104 weeks at the end of March 2023.

The Trust's performance trajectories in our operating plan submission are summarised in the following table.

3.4.1.2 Performance trajectories in the Trust's operating plan submission

Table 8

	Waiting time standard	Operational Planning Requirement	UHBW Plan Submission (by March 2023)
Referral to Treatment (RTT) Long Waits	104 Weeks	0 (Excluding patient choice)	197 by July 2022 29 by March 2023
	78 Weeks	0 (Excluding patient choice)	675
	52 Weeks	Reduce where possible	4,472
Outpatients	Outpatient Follow-up Activity	25% lower than 2019/20	-
	Patient Initiated Follow-up (PIFU) rate	5%	5%

	Advice & Guidance (ratio of requests to outpatient first attendances)	16:100	16:100
Cancer	62+ Day waits	180	180
	62-day urgent referral to first treatment	85%	85%
	28-day faster diagnosis standard	75%	75%
	31-day decision-to-treat to first treatment standard	96%	96%
Diagnostics	Diagnostic activity	Increase to 120% pre-pandemic levels.	UHBW targets for high volume modalities: Echo 105% Colonoscopy 243% CT 112% Flexi Sigmoidoscopy 82% Gastroscopy 100% MRI 100% Non-Obstetric Ultrasound 99%
Urgent & Emergency Care (UEC)	12-hour trolley waits	no more than 2%	0
	Ambulance handover delays greater than 60 minutes	0	0
	Ambulance handovers within 30 minutes	95%	-
	Ambulance handovers within 15 minutes	65%	-

3.4.2 NHS Oversight Framework 2022/23

The NHS Oversight Framework 2022/23 outlined the approach taken by NHS England and NHS Improvement (NHSEI) to oversee Integrated Care System (ICS) and NHS provider performance and identify where organisations may need support.

The framework is built around five national themes:

- Quality of care, access, and outcomes
- Preventing ill-health and reducing inequalities
- Finance and use of resources
- Leadership and capability
- People

The delivery of performance standards as described in the 2022/23 Priorities and Operational Planning Guidance are associated with the quality of care, access and

outcomes theme. The framework describes the measures that are used to assess performance.

Based on these themes, ICBs and NHS trusts are segmented into categories from 1 to 4. Segmentation indicates the scale and nature of support needs: segment 1 indicates no specific needs, whereas segment 4 indicates a requirement for mandated intensive support.

The default segment for all ICBs and NHS trusts is segment 2 unless the criteria for moving into another segment are met.

An NHS trust will be moved into segment 3 if they have significant support needs against one or more of the five national themes and in actual or suspected breach of the NHS provider licence. They will be moved into segment 4 if they are in actual or suspected breach of the NHS provider licence with very serious, complex issues manifesting as critical quality and/or finance concerns.

The Trust and BNSSG ICS plan for 2022/23 did not meet the requirements outlined in the 2022/23 Priorities and Operational Planning Guidance related to the elimination of waiting times greater than 104 and 78 weeks.

Therefore, the Trust and BNSSG ICS has been subject to performance management by NHSEI throughout 2022/23.

The current segmentation for the Trust is segment 3 on 15 February 2023. The segmentation for the Trust and partner organisations is summarised in Table 9.

Table 9

Type	Organisation	Segment
Provider segmentation	University Hospitals Bristol and Weston NHS Foundation Trust	3
	North Bristol NHS Trust	3
Integrated care system segmentation	Bristol, North Somerset & South Gloucestershire (BNSSG) ICS	3

At present, 7% of NHS trusts are in segment 1, 38% in segment 2, 40% in segment 3, and 15% in segment 4. The current segmentation of the BNSSG ICS is segment 3. Information related to the segmentation of ICSs and NHS trusts is published on the NHS England website.

The following sections summarise performance against performance standards in 2022/23.

3.4.3 Referral to Treatment (RTT) Long Waits

The operational planning guidance required Trusts to eliminate referral to treatment waiting times over 104 weeks by July 2022 (excluding patient choice).

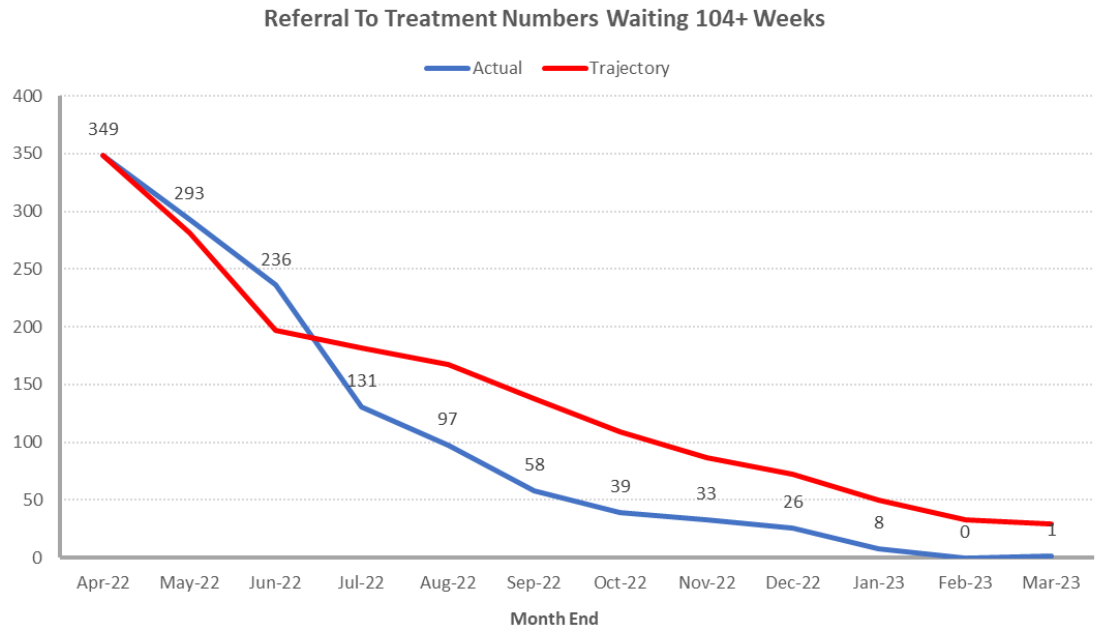
The Trust submitted a plan of 197 patients waiting over 104 weeks by July 2022, and 29 patients waiting over 104 weeks by March 2023. It was assumed that the 29 patients would be waiting over 104 weeks because of patient choice.

At the end of June 2022, the Trust reported 236 patients waiting over 104 weeks. This exceeded the operational planning requirements and the Trust's own trajectory for improvement.

However, the Trust demonstrated sustained improvement in reducing long waits throughout the remainder of 2022. In February 2023, the Trust reported that it has eliminated all patients waiting over 104 weeks.

At the end of March 2023, there was one patient waiting over 104 weeks. Therefore, the end of the year performance exceeded the planning requirements and the Trust's trajectory for improvement.

Figure 8

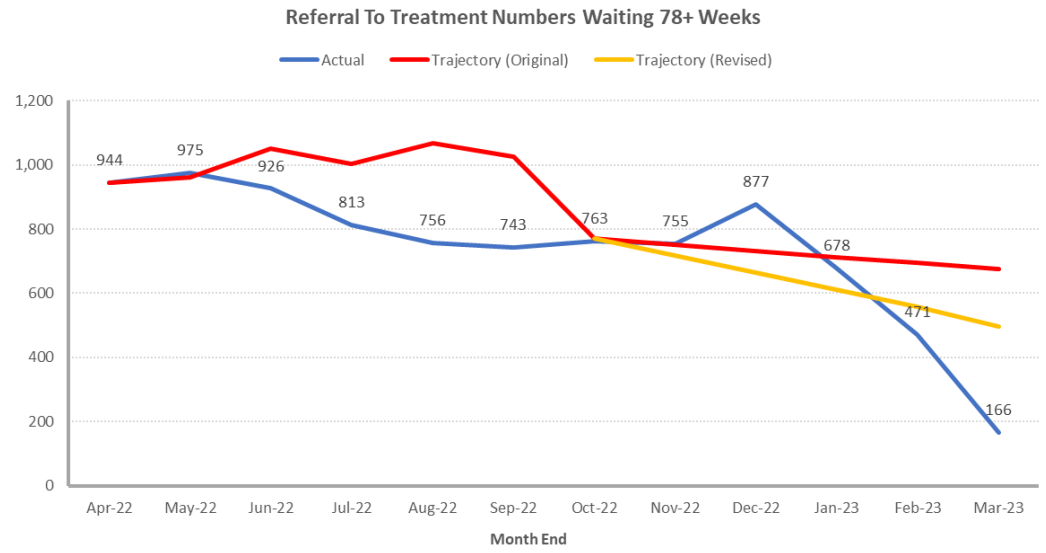


The operational planning guidance also stipulated that waiting times over 78 weeks should be eliminated by the end of March 2023. The Trust's plan was to reduce the care backlog to 675 patients waiting over 78 weeks by the end of March 2023.

The Trust continued to focus on reducing the patients waiting over 78 weeks. In October 2022, the Trust improved its plan from 675 to 497 patients waiting over 78 weeks at the end of March 2023.

At the end of March 2023, the Trust reported 166 patients waiting over 78 weeks. Although this number exceeds the requirements set out in the operational planning guidance, it does represent a significant improvement against the revised plan of 497 patients waiting over 78 weeks at the end of March 2023.

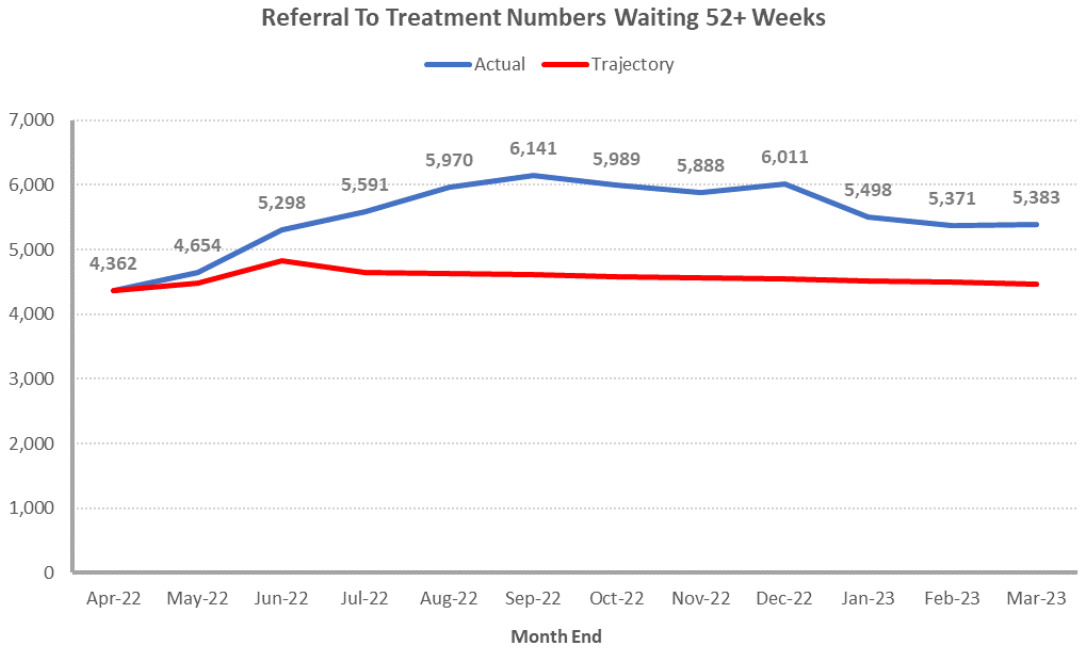
Figure 9



The operational planning guidance asked providers to reduce waiting times over 52 weeks where possible. In April 2022, the Trust reported 4,362 patients waiting over 52 weeks. Based on demand and capacity modelling, the Trust's plan anticipated that there would be 4,472 patients waiting over 52 weeks at the end of March 2023.

At the end of March 2023, the Trust reported 5,383 patients waiting over 52 weeks. This represents an increase in the total size of our 52-week backlog and reflects growth in the overall size of the referral to treatment waiting list over the same period.

Figure 10



The Trust will continue to focus in 2023/24 on reducing long waiting times towards an elimination of waiting times over 78 weeks in a sustainable manner.

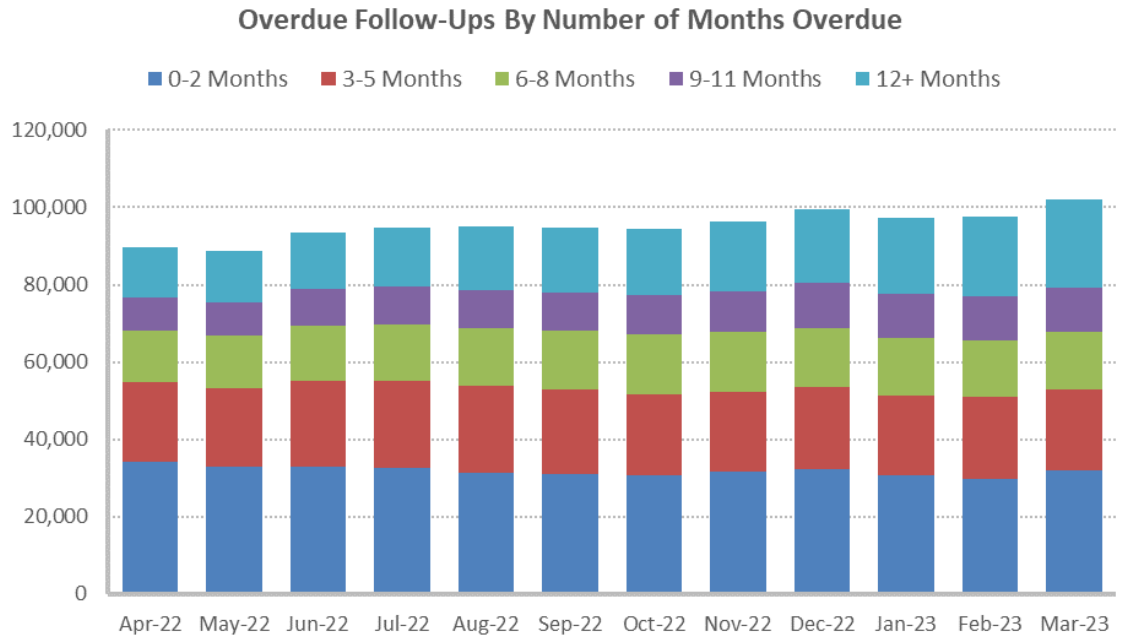
3.4.4 Outpatients

The operational planning requirement was to reduce the volume of follow-up activity delivered in 2022/23 by 25% compared to 2019/20.

In the context of the COVID-19 pandemic, the Trust's outpatient care backlogs have increased. Therefore, the Trust did not plan to reduce outpatient follow-up volumes and modelled the activity required to reduce the longest waiting follow-up care backlogs.

In 2022/23, the number of patients overdue their follow-up has increased from 89,591 in April 2022 to 101,950 at the end of March 2023. There has been a particular increase in the longest waiting cohorts of patients either 9-11 months or 12+ months overdue.

Figure 11



An important strategy to reduce the number of lower clinical priority routine follow-up attendances is the use of patient-initiated follow-up (PIFU). This means that patients can decide if and when they need to access a follow-up appointment. The operational planning guidance required PIFU levels to be at 5% of attendances.

The Trust has two PIFU pathways – one for patients that are discharged, with the ability for patients to initiate a follow-up if required, and the other for patients will long term condition which means that there are longer intervals between follow-up appointments, with the ability for the patient to initiate a follow-up if required.

In March 2023, 3,762 patients were discharged to a PIFU pathway and an additional 1,244 were moved to PIFU on a Long Term Condition pathway. This is approximately 6.8% of all outpatient attendances in March 2023.

Advice and guidance is used to support the reduction of new referrals into hospital services. This means that general practitioners can seek advice and guidance from hospital specialists and continue to manage their ongoing care in the community.

The operational planning guidance required Trusts to deliver 16 advice and guidance requests for every 100 outpatient first attendances (i.e. 16% of first attendances). The advice and guidance metric includes pre-referral activity (advice and guidance) and post-referral activity (pre-triage, referral and advice services).

For the month of March 2023, the Trust advice and guidance performance included 1,756 advice and guidance responses. Data available for February confirms the Trust performance of 13% against the 16% target.

3.4.5 Cancer

One of the metrics being used by NHSEI to monitor recovery of cancer care backlogs related to the COVID-19 pandemic is the number of patients on a cancer pathway waiting more than 62 days.

NHSEI asked that all Trusts return to, or below, the number of patients waiting over 62 days pre-pandemic. This number is different for each organisation and the Cancer Alliances have a role to play in determining the appropriate target for each Trust and integrated care system.

In 2022/23, the target for the Trust was to have no greater than 180 patients waiting over 62 days.

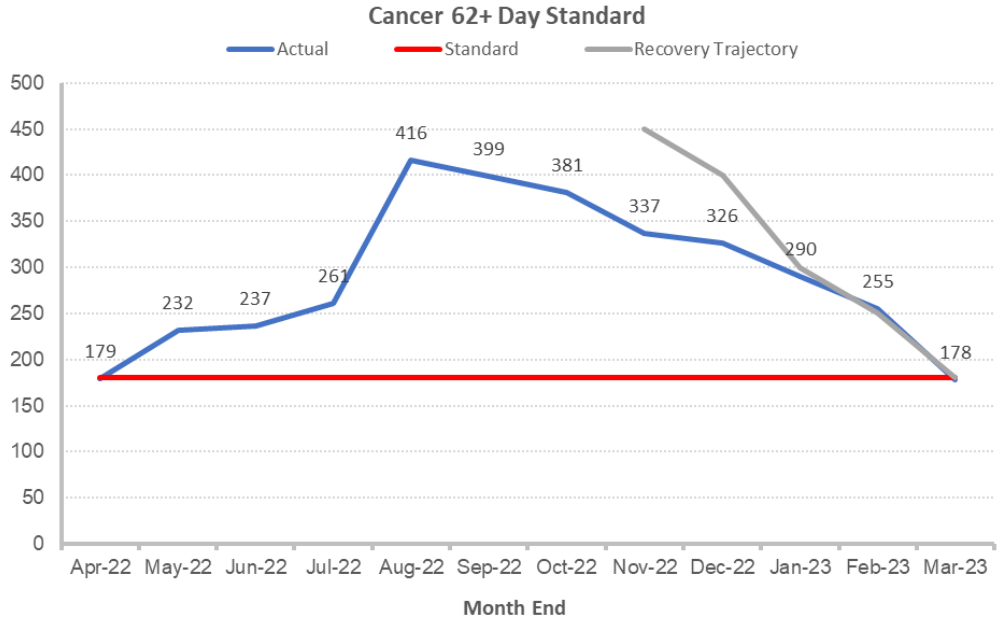
Note that the 62-day NHS constitutional standard is different from this metric as it is based on patients who start treatment. The measure of patients waiting over 62 days considers the number of patients waiting on a 62-day pathway prior to treatment or confirmation of cancer diagnosis.

In the late Summer / early Autumn of 2022, several of our clinical teams were impacted by the COVID-19 wave that resulted in high levels of sickness absence in some of our high-volume cancer specialties. The Trust also experienced an increase in referrals during this period that resulted in a significant increase in the number of patients waiting over 62 days.

In October 2022, the Trust developed a recovery plan to reduce the number of long waiting patients back to the pre-COVID target of 180 patients.

The Trust has successfully delivered this recovery plan and reported 178 patients waiting over 62 days at the end of March 2023.

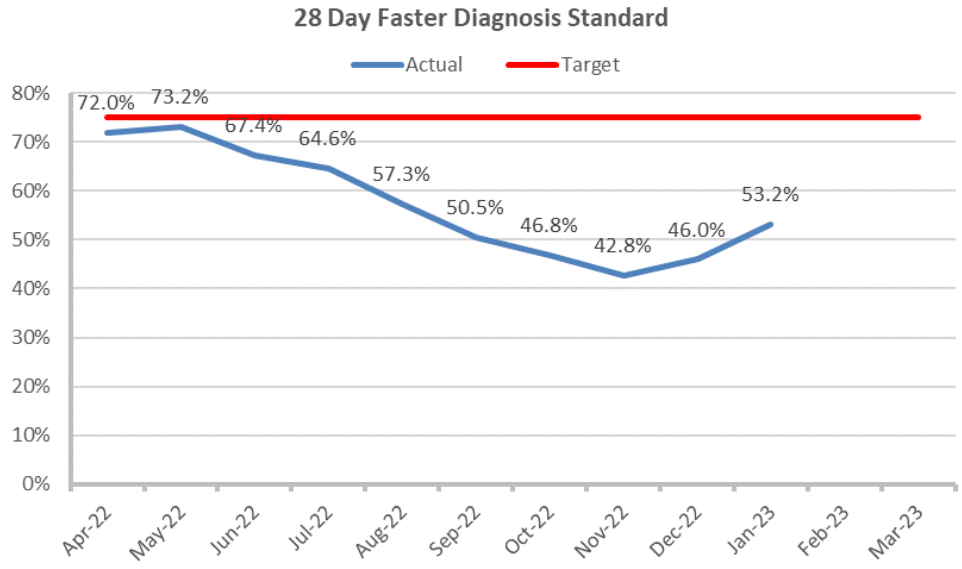
Figure 12



The increase in demand and shortfall in capacity during the late Summer / early Autumn period also impact the Trust's performance against the Faster Diagnosis Standard. The Faster Diagnosis Standard (FDS) is designed to measure the time from referral to a patient receiving a diagnosis, or having cancer ruled out, within 28 days. This standard is likely to replace the 2 Week Wait standard which measures the time from a patient being referred with a suspected cancer to see a specialist within 14 days of being referred by their GP or cancer screening programme.

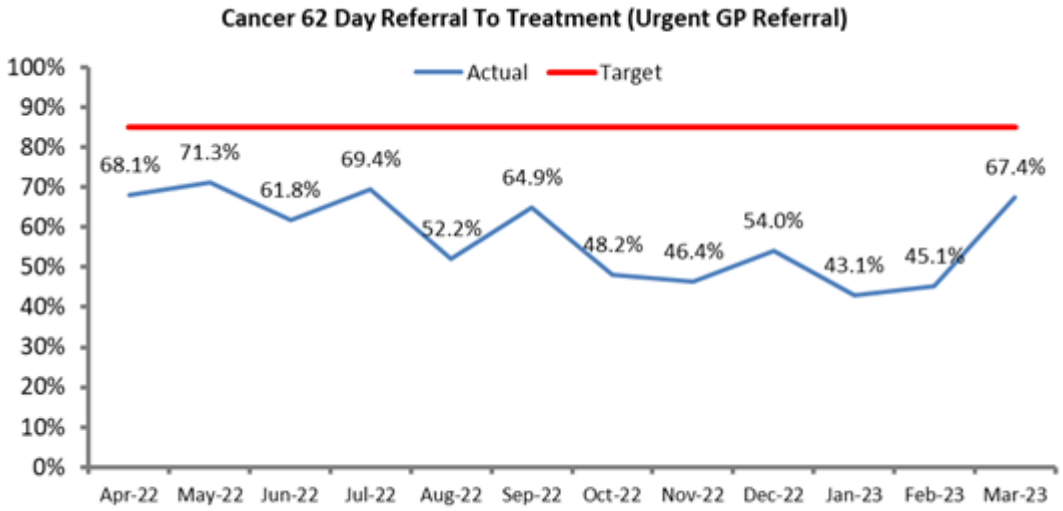
In March 2023, the Trust reported that 65.4% of patients received a diagnosis, or had cancer ruled out within 28 days. Although this is some way below the FDS standard of 75% it does demonstrate a month-on-month improvement since November 2022.

Figure 13



The impact of delays in the early stages of the cancer pathway has also impacted on the Trust's performance against the NHS constitutional standards. Performance has deteriorated against the 62-day urgent GP referral to treatment standard.

Figure 14



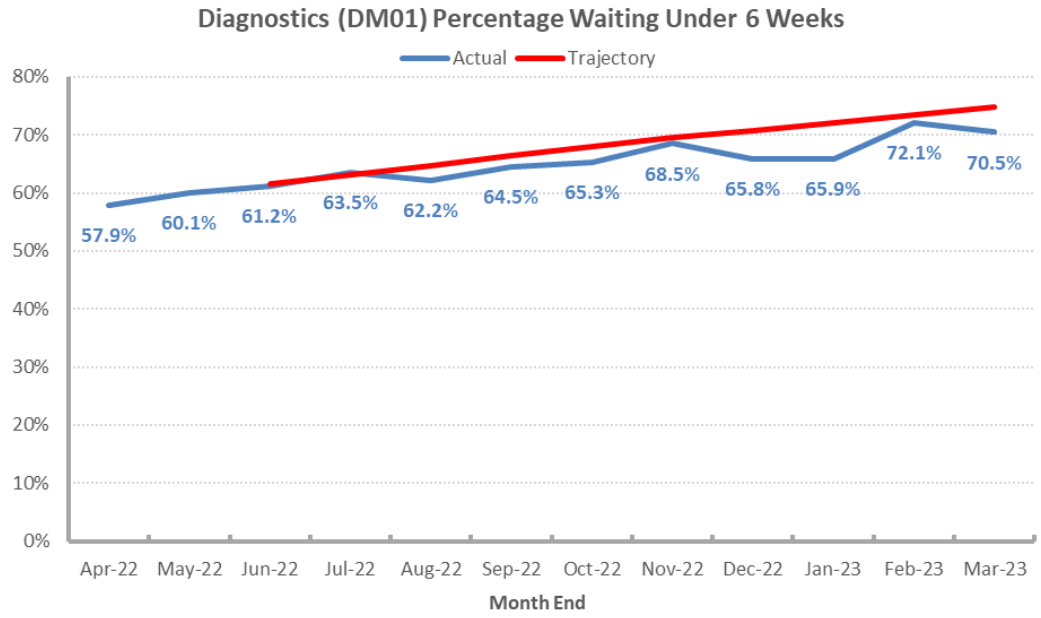
In April 2022, the Trust's performance against this standard was 68%. At the end of March 2023, performance had recovered to 67.4%. It is anticipated that as waiting times in the early part of the cancer pathway, performance against this retrospective standard will improve.

3.4.6 Diagnostic waiting times

The Trust planned to reduce diagnostic waiting times by increasing activity levels for high volume modalities. The plan was intended to increase the percentage of patients waiting under six weeks towards 75% at the end of March 2023.

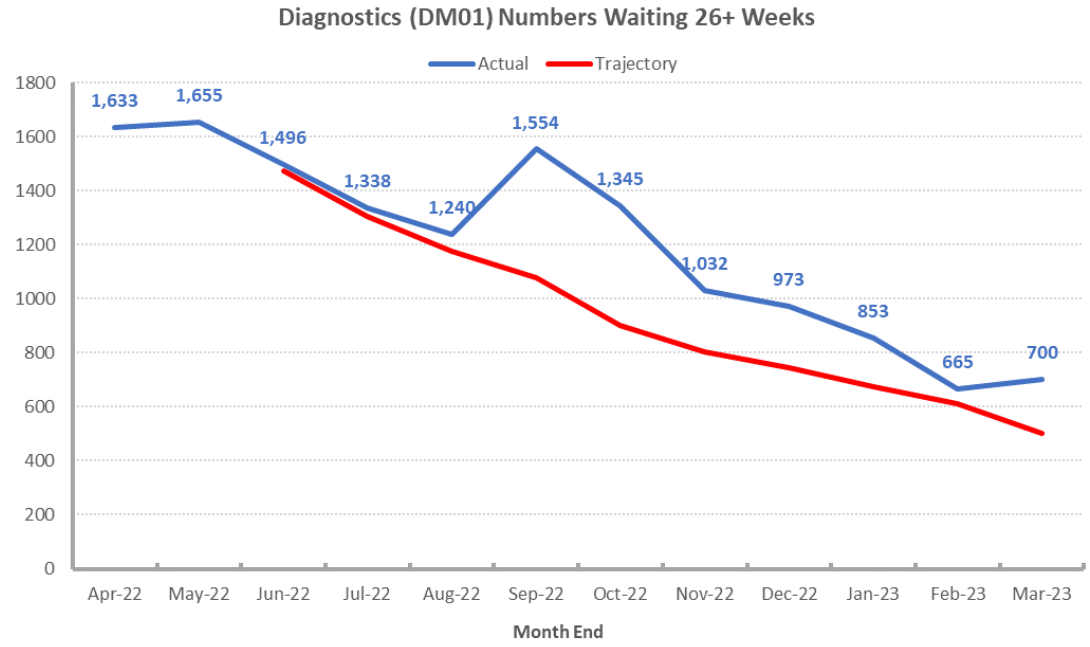
Throughout the year, there has been sustained improvement. At the end of March 2023, the Trust reported 74.3% of patients as waiting under six weeks.

Figure 15



The Trust's plan also focussed on reducing long waits for diagnostic investigation. The Trust's plan was based on a reduction to no more than 500 patients waiting greater than 26 weeks for a diagnostic investigation (418 endoscopy and 82 MRI only).

Figure 16



In April 2022, the Trust reported 1,633 patients waiting over 26 weeks for a diagnostic investigation. The Trust has demonstrated sustained improvement throughout the year. At the end of March 2023, the Trust reported 496 patients waiting over 26 weeks.

3.4.7 Urgent & Emergency Care (UEC)

Overall, ED attendances normalised to 2019/20 levels outturn experienced in 2021/22. Overall Activity Volumes are shown below.

Table 10: Total attendances at Emergency Departments

	Total Attendances			
Hospital	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**
Bristol Royal Hospital For Children	44,499	28,417	47,205	48,795
Bristol Eye Hospital	24,941	18,110	22,325	24,661
Bristol Royal Infirmary	73,499	59,952	74,852	73,444
Weston General Hospital	50,228	33,582	45,841	46,571
Grand Total	**193,167**	**140,061**	**190,223**	**193,471**

Table 11: Average daily number of attendances at Emergency Departments

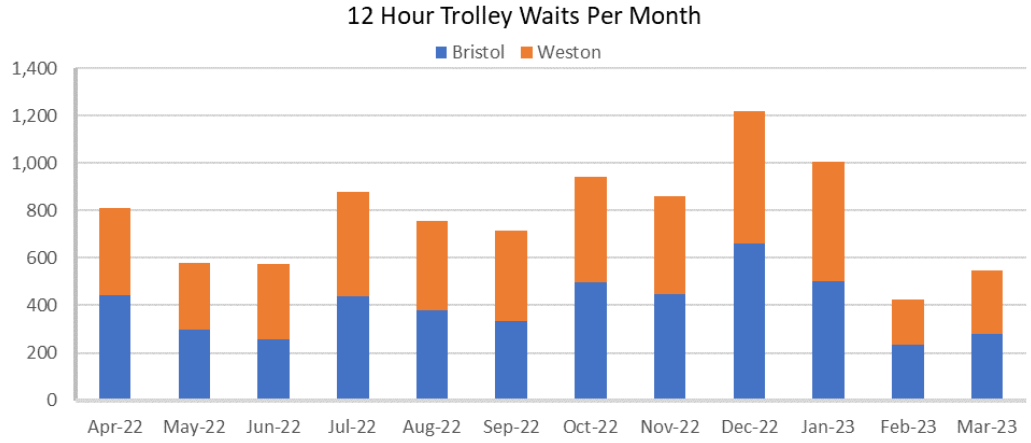
	Average Attendances Per Day			
Hospital	**2019/2020**	**2020/2021**	**2021/2022**	**2022/2023**
Bristol Royal Hospital For Children	122	78	129	134
Bristol Eye Hospital	68	50	61	68
Bristol Royal Infirmary	201	164	205	201
Weston General Hospital	138	92	126	128
Grand Total	**529**	**384**	**521**	**531**

The operational planning guidance set out requirements to eliminate 12-hour trolley waits and ambulance handover delays greater than 60 minutes.

In 2022/23, there have been 9,315 12-hour trolley waits. This is the time from a decision to admit to the eventual admission to a ward.

There continue to be challenges in flow out of the emergency departments following the COVID-19 pandemic, including management of infections requiring cubicles. This is challenging due to the proportionately low ratio of cubicles to bay beds, particularly on the Weston site.

Figure 17



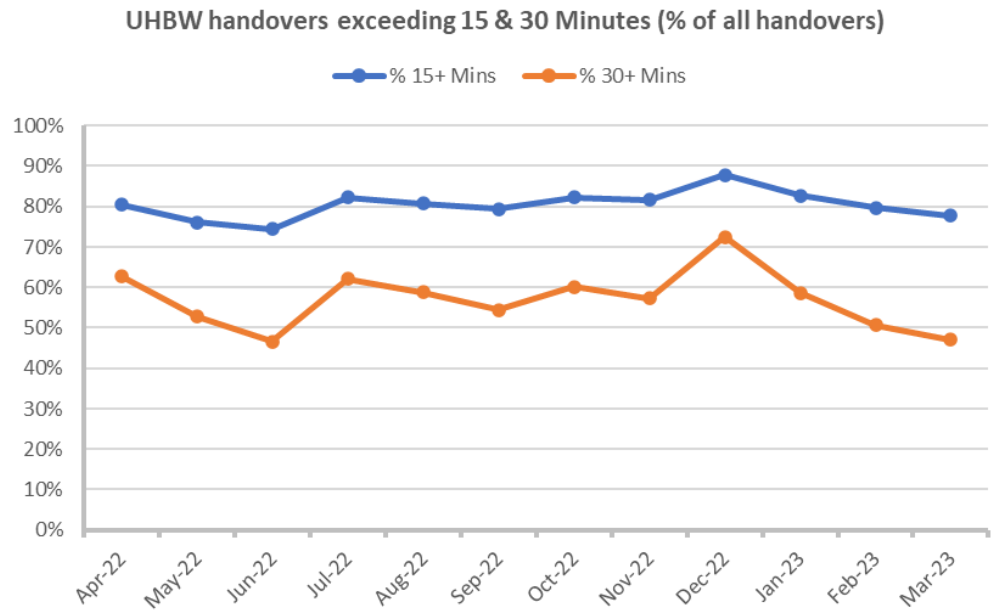
Table

Table 12: Total number of 12-hour trolley waits.

Hospital	2019/2020	2020/2021	2021/2022	2022/2023
Bristol Royal Hospital For Children	2	0	154	372
Bristol Eye Hospital	0	0	0	0
Bristol Royal Infirmary	23	459	2,999	4,392
Weston General Hospital	796	981	2,608	4,551
Grand Total	**821**	**1,440**	**5,761**	**9,315**

Ambulance handover performance has also remained challenging across the Trust, with some improvement towards the end of the year.

Figure 18



As part of the refreshed workplans across urgent care in UHBW, there is a refocus on the 15 minute standard, including improvement work on the process of handover and escalation to prevent delays. We are also working with the ambulance service on real time data reporting to drive improvement.

APPENDIX A – Feedback about our Quality Account

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

The activity referred to in this Quality Account has taken place during a time of considerable change and challenge. Emergence from the worst effects of the COVID-19 pandemic was a relief: but further surges in infection continued to impact on patients and staff during this year and the backlog caused by the pandemic is considerable. Meanwhile, day-to-day demands have continued to rise for many Trust services and recent industrial action has affected performance at the end of the year.

Flow through the Trust's hospitals continues to be adversely affected by high levels of demand for adults' and children's Emergency Services alongside a lack of capacity in the community care services required to support patients on discharge.

The many challenges faced by the Trust during this time, the impact they have had on performance and the measures pursued to tackle them are clearly acknowledged and reported in this Quality Account.

Accordingly, the governors consider that it offers a clear and fair representation of the Trust's performance and demonstrates a strong commitment to learning from, and acting in response to, feedback and investigations.

Governor involvement with Quality and Performance at UHBW in 2022/23

The governors have a duty to continuously monitor the Trust's performance and hold the Non-Executive Directors (NEDs) on the Board of the Trust to account for it. During this year we have held a full programme of meetings and discussions, continuing with an online format initially but returning to the option of face-to-face meetings as well over the second half of the year.

We have reviewed full agendas of Quality and Performance issues every two months in our Quality Focus Group and then discussed specific topics of concern in more depth with all the NEDs at our regular engagement sessions with them. The Chair and NEDs continue to be open to all our comments and challenges and have fully engaged in answering our questions.

Public Board Meetings at the Trust have continued to be streamed via You Tube during this time enabling the public and governors to witness the Board in action; while a return to face-to-face meetings in recent months has also allowed governors to attend in person.

Questions raised on our publicly available Governors' Log (where they are answered by Trust executives and senior managers) have covered a wide range of topics including outpatient pharmacy services, cancer service targets, safe staffing levels, tackling surgical backlogs, out-of-hours patient discharge and quality of electronic data.

Quality Improvement Activity

UHBW set five quality objectives for 2022/23 and this account contains a full update on the progress made on all of these, followed by a description of the objectives set for the coming year.

Work on implementing the NHS Patient Safety Strategy (published in July 2019) has continued for a second year of very full activity to prepare the Trust for using the new Patient Safety Incident Response Framework (PSIRF) from May 2023 to be followed by reporting into the new national system of Learning from Patient Safety Events (LFPSE) in the second quarter of 2023/24. It is reassuring to know that the necessary staff training syllabus and investigation team to support this are now in place and that two Patient Safety Partners have been recruited, allowing the Trust to keep pace with the national transformation underway in Patient Safety across the NHS. Governors had the opportunity to learn more about this at a recent development seminar and recognise that continuing this work into a third year over 2023/24 has to be a key objective.

A second year of work on improving patient experience of discharge is also reported here with an emphasis on initiation of the Every Minute Matters (EMM) programme which is to be progressed further in the coming year. Discharge remains a key topic of concern for the governors and we welcome priority being given to it both by the Trust and the wider community of our Integrated Care System (ICS).

'Waiting Well' was a new objective for the Trust in 2022/23 aimed at improving the experience of waiting for care in the context of growing waiting lists post-pandemic and the need to continue this into a second year is clear. Use of feedback from the Health Matters event on this topic in November 2022 and the appointment of two lay representatives to join the Waiting Well group at the Trust have been welcome components of this work.

Following the development of a new Trust strategy for Healthcare Inequalities and a new vision for post- pandemic volunteering at the Trust governors will now monitor the delivery of identified goals related to these key strategies with keen interest. The need for progress in Equality, Diversity and Inclusion at the Trust has been championed by the governors for several years now.

The two new quality objectives set for the coming year are both associated with Patient First, the Trust's new approach to Continuous Improvement and the programme that will probably define future quality priorities. The coming year will give us the opportunity to learn more about this programme and identify if it can truly begin to deliver its patient-centred priorities.

Review of Services

This section of the account clearly reflects the on-going impact of the COVID-19 pandemic in delays to diagnostics, treatment and surgery alongside staffing challenges related to Covid-related sickness, vacancies and high turnover. The variable levels of progress with digital transformation at the trust are also clearly demonstrated with 'Vitals' supporting great progress in identifying deteriorating patients in both adult and children's services while the long-awaited electronic prescribing system has yet to be implemented, hindering progress with Venous Thromboembolism (VTE) prevention.

Further work on raising awareness of 'speaking up' and associated training for all staff should offer greater encouragement for staff to report concerns; and efforts to triangulate the key themes from all staff and patient comments received will be welcomed by the governors. The Patient Experience Hub, launched in 2022/23, should make a major contribution towards this.

The wide-ranging work undertaken under the heading of Patient and Public Involvement has been impressive and supported active involvement with the Trust by a number of groups representing people with specific needs. Hopefully, the relaunch of the Trust Carers Steering Group will support similar involvement for carers.

A Trust commitment to learning from all surveys, significant incidents, informal and formal concerns and case reviews following death is clearly described and the contribution the Trust has made to wider, shared learning with North Bristol NHS Trust and colleagues across the ICS is to be commended. Action plans developed from such learning are also described here - including responses to the National Adult Inpatient Survey, the National Maternity Survey and internal mortality reviews as well as local ward-based projects such as 'Dancing on Draycott' at Weston General Hospital.

<u>Other quality-related topics of special interest to the Council of Governors during 2022/23</u>

- Increasing governors' understanding of the monthly Trust Integrated Quality and Performance reports
- Completion of the integration programme for Weston and Bristol hospitals and the introduction of the new management team structure for Weston General Hospital
- The development of the Board and Committee structure within the ICS, initial work on a strategy for the ICS and involvement of Trust Board members within this.
- Introduction of a new Trust People Strategy and Education Strategy to support staff recruitment, retention and development

These topics will remain priorities for us in the coming year as we welcome new colleagues to the Council of Governors after this year's elections and continue to monitor progress with all aspects of patient care at the Trust.

b) Statement from Healthwatch Bristol, North Somerset and South Gloucestershire (BNSSG)

Healthwatch Bristol North Somerset and South Gloucestershire endorses the UBHW quality objectives which are ongoing for 2023/24. In particular we appreciate the complex work that aims to better meet the needs of patients and families in relation to hospital discharge. We especially commend the creation of the discharge passport and the process for managing information in relation to medications. The new model of 'weekend huddles' to process weekend discharge more effectively is an excellent development.

The 2023/24 new objective in relation to eliminating poor experience of care is welcomed. This aim, to improve inpatient care in Hospitals in Bristol and Weston-super-

Mare, and maternity wards, will make a significant difference to the experience of care. Healthwatch and the Maternity and Neonatal Voices Partnership jointly support this work and will provide insight to help measure progress using our Local Voices reports and others.

Finally, Healthwatch welcomes the aim of improving access, experience and outcome with a particular focus on our diverse communities. The Health Equity Delivery Group will be a central plank of this work, and we will aim to support its work however we can over the next few years.

c) Statement from Bristol, North Somerset and South Gloucestershire Integrated Care Board

This statement for University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) Quality Account 2022/23 is provided by the Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB).

UHBW annual Quality Account provides an opportunity to celebrate the Trust's quality and performance during 2022/23. The data provided reflects information shared by the Trust with BNSSG ICB throughout the year. The ICB welcomes the opportunity to review and reflect on the Quality Accounts and fully supports the collaborative working between the Trust and the ICB, with a clear focus on quality improvement. BNSSG ICB acknowledges the continued challenges faced by UHBW in post pandemic restoration including the impact of health professional industrial action. This has inevitably impacted on the achievement levels for a range of quality indicators.

Five quality objectives were selected for 2022/23. The first two were existing objectives related to delivering:

- NHS Patient Safety Strategy
- Improving patients' experience of discharge

UHBW also set three new objectives:

- Supporting patients to 'wait well'
- Developing a new Trust strategy for healthcare inequalities, with a focus on equality, diversity and inclusion for patients and communities
- Developing and delivering a new vision for post-pandemic volunteering.

Objective 1: Delivering the NHS Patient Safety Strategy

UHBW continue on their journey to implementing the NHS Patient Safety Strategy. It is commendable what has been achieved over the last twelve months. Notably ensuring the Patient Safety Incident Response Plan has been produced and approved by April 2023. The ICB acknowledges the continued focus on patient safety, this has been demonstrated by recruiting into key roles:

1. Expert patient safety investigation specialists.
2. Patient Safety Partners
3. Head of Human Factors.

There is no doubt these professionals will support UHBW's Patient Safety Incident Response Framework and will be key in successfully delivering safe quality care to service users as well as driving quality improvement.

Objective 2: Improving patient experience of discharge from hospital

BNSSG ICB commends UHBW on their Every Minute Matters (EMM) programme. The EMM programme has already improved time efficiency in discharging patients since EMM has been implemented. The number of quality improvement processes that have been developed under the umbrella EMM programme is to be commended. This includes but is not exhaustive:

- Improvements made to weekend discharges,
- Utilising a multidisciplinary touchpoint to enable concise updates regarding patients
- Use of the Transfer of Care Document

Objective 3: Waiting well

UHBW's efforts of ensuring patients are 'Safe to Wait' whilst the Trust is recovering from the increased planned care backlog as a result of the COVID-19 pandemic is commendable and appropriate. BNSSG ICB acknowledges the collaborative working with patients and service users to understand the presenting concerns felt as a result of being on a long waiting list. As a consequence of the collaborative 'Health Matters' event, UHBW launched a 'Waiting Well' webpage providing information on what current expectations are, whilst providing signposting material. The innovation associated with using the DrDoctor platform, supporting patients to view clinic letters and rebook outpatient appointments is an excellent development. BNSSG ICB is excited to see the development of the DrDoctor assessment tool to gather information to support optimisation of patients' prior to surgery.

Objective 4: Developing a new Trust strategy for healthcare inequalities, with a focus on equality, diversity and inclusion (EDI) for patients and communities

BNSSG ICB acknowledges the progress made in achieving this objective and the work completed to support the EDI baseline review report. Following this report UHBW have developed the Health Equity Delivery Plan which includes five objectives to be delivered over the next two years. The ICB is looking forward to supporting and collaborating with the Trust in delivering these five objectives.

Objective 5: Developing and delivering a new vision for post-pandemic volunteering.

BNSSG ICB commends UHBW's engagement with volunteers and colleagues to develop the Volunteer Strategy 2023-2026. UHBW's four goals to be delivered over the next three years are an ambitious yet achievable vision. There is clear recognition by UHBW of the value of volunteers and BNSSG ICB commends UHBW's commitment in ensuring that volunteers are embedded colleagues and a valued part of #TeamUHBW. Future Planning.

BNSSG ICB recognises UHBW's five priorities for the coming year; this includes further development of three existing objectives. The ICB would like to thank UHBW for their collaboration and continued focus on patient quality and looks forward to supporting UHBW in achieving a shared vision and purpose – 'patients are at the heart of all we do.'

Michael Richardson
Deputy Chief Nursing Officer, Bristol North Somerset & South Gloucester

d) Statement from Bristol Health Scrutiny Committee

Bristol Health Scrutiny Committee members attended a helpful presentation / question and answer session in relation to the UHBW 2022/23 Quality Account attended by the UHBW Chief Medical Officer and Deputy Chief Executive, Chief Nurse and Midwife, and Head of Quality (Patient Experience and Clinical Effectiveness).

Members' comments are summarised below:

1. The general progress in delivering objectives and key targets/goals, and in improving patient experiences as documented in the Quality Account is welcomed. We understand that in terms of the data relating to patient experiences/perceptions about the quality of care they receive in the Trust's hospitals, this can be broken down by ethnicity and it would be useful to see this data.

2. In relation to cancer diagnosis, we noted that in February 2023, the Trust reported that 57% of patients received a diagnosis, or had cancer ruled out within 28 days. Although this is below the Faster Diagnosis Standard of 75%, we note and welcome the month-on-month improvement since November 2022.

3. We welcome the fact that a new vision is being developed for post-pandemic volunteering and that four specific goals have been set to be delivered over the next three years including:
   - Creating a vibrant and varied volunteering programme that mirrors the rich diversity of communities.
   - Developing innovative roles that put the patient and staff experience at the forefront of the Trust's work.

   We note and welcome an assurance that there is no intention within the Trust to place reliance for services on volunteers; and that volunteering presents an opportunity for added value/benefits, for example in relation to patient experiences. We also welcome the Trust's willingness to promote volunteering from young people and that the Trust's volunteer strategy recognises the importance of celebrating and recognising successful volunteering.

4. We welcome the work taking place to develop a new Trust strategy for healthcare inequalities, with a focus on equality, diversity and inclusion for patients and communities.

5. We suggest that the Trust should look to develop its liaison with schools in terms of work experience opportunities and sharing information on career opportunities for young people. We note and welcome the Trust's commitment to open up opportunities for employment with the aim of reflecting the area's diverse communities within the workforce.

6. Although not falling within the Bristol City Council geographical area, the findings from the latest Care Quality Commission inspection of medical care at Weston General Hospital (August 2022) are welcomed, noting also that the Enforcement Notice (from 2021) has been formally lifted.

e) Statement from North Somerset Health Overview and Scrutiny Panel

No statement provided this year due to purdah.

f) Statement from South Gloucestershire Overview and Scrutiny Panel

No statement provided this year due to purdah.

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 Account, directors are required to take steps to satisfy themselves that:

- the content of the Quality Account is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to March 2023
    - papers relating to Quality reported to the board over the period April 2022 to March 2023
    - 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 inpatient survey
- the Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Account has been prepared in accordance with the 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 Account.

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

Eugine Yafele	Jayne Mee
Chief Executive	Chair

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**National Maternity Survey Report**
Report Authors	**Matthew Areskog, Head of Experience of Care & Inclusion** **Sarah Windfeld, Director of Midwifery**
Executive Lead	**Deirdre Fowler, Chief Nurse & Midwife**

1. Purpose

The purpose of this report is to advise the Board of the findings of the 2022 National Maternity Survey and actions being taken by Maternity Services in response.

In a recent change of reporting, to ensure full transparency, all national patient survey reports are now being reported at Public Board rather than the Quality & Outcomes Committee (QOC). The 2022 Maternity Survey results were originally reported to QOC in February 2023, however the report is now being brought to the Board in line with the aforementioned transition. The accompanying action plan has been reviewed and updated.

2. Key points to note *(Including any previous decisions taken)*

This report contains an analysis of the UHBW results from the Care Quality Commission's (CQC) 2022 National Maternity Survey. The National Maternity Survey is part of the CQC's national patient survey programme. In total, 121 NHS trusts in England participated in this survey in 2022. Women were sent a questionnaire by post if they were aged 16 or over, had a live birth during February 2022, and gave birth in a hospital, maternity unit or at home.

347 women were invited to take part in survey who were under the care of UHBW; of those, 133 responded to the survey, giving a response rate of 39%.

The National Maternity Survey does not ask respondents to give a single overall service experience rating. However, the mean score across all the survey questions can be viewed as a proxy 'overall' measure. This suggests that UHBW performed in line with the national average score. Using this metric, UHBW ranked 51st out of 121 Trusts in the 2022 survey which is a significant improvement from the rank of 101st place in the 2021 results.

In the 2022 National Maternity Survey:

- Our Trust's results were **about the same** as other Trusts for the majority of questions (43 out of 50).
- Our Trust's results were **better** than most trusts for **five** questions, all of which relate to the theme of 'staff caring for you'.

- Our Trust's results were **somewhat better** than most trusts for **one** question.
- Our Trust's results were **worse** than most trusts for **one** question.

UHBW's 2022 national maternity survey results saw an improvement in many areas when compared to the results from 2021. On the back of the 2021 results, a multi-disciplinary 'Women's Experience Group' was formed to oversee the successful delivery of the maternity experience improvement plan.

There is evidence from the 2022 results that the improvement efforts are translating into a more positive experience for women and their partners. The maternity services improvement plan is regularly updated and monitored via the monthly Women's Experience Group. There is more work to do to ensure that experience is positive across all aspects of the maternity pathway, particularly in relation to care in hospital after birth.

The maternity services improvement plan has been reviewed and updated following the publication of the 2022 results. Progress is overseen and monitored by the Women's Experience Group. Since the report was discussed at QOC in February, a number of actions have been completed including:

- Re-introducing partners staying
- Induction workshops for mothers due to be induced (held weekly)
- Increased hours in the mental health team

3. Strategic Alignment

National patient surveys offer a helpful periodic comparison of experience of care in UHBW relative to other NHS Trusts. At the same time, these surveys are limited to a snapshot in time, and data is received many months after the hospital care in question has taken place; national patient surveys therefore represent one piece of our 'jigsaw' of feedback about quality of care.

4. Risks and Opportunities

Opportunity to focus brings additional focus on experience of care in maternity services through Patient First.

5. Recommendation

This report is for Assurance.

6. History of the paper

Please include details of where paper has <u>previously</u> been received.

Quality & Outcomes Committee	23/2/23

Briefing Note: 2022 National Maternity Survey

1. Purpose of this report

This report contains an analysis of the UHBW results from the Care Quality Commission's (CQC) 2022 National Maternity Survey. For context, a summary of the key headlines from the survey at a national level are included as ***Appendix A***.

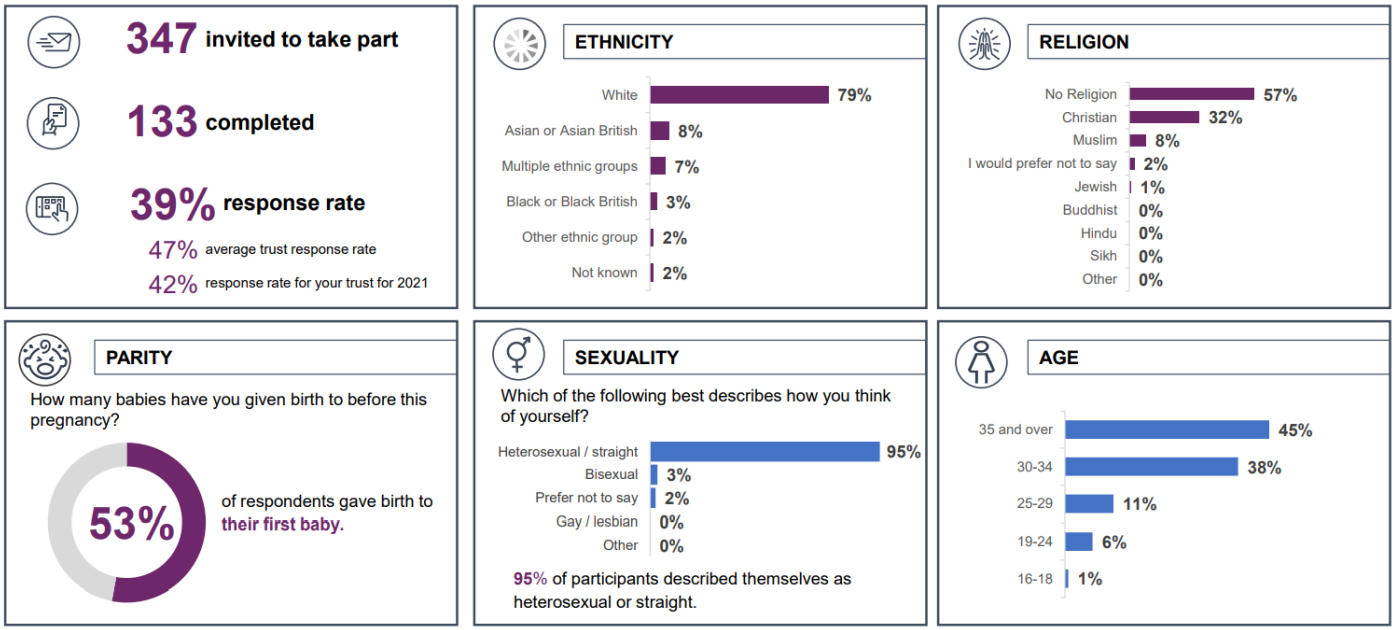
2. Background

The National Maternity Survey is part of the CQC's national patient survey programme. In total, 121 NHS trusts in England participated in this survey in 2022. Women were sent a questionnaire by post if they were aged 16 or over, had a live birth during February 2022, and gave birth in a hospital, maternity unit or at home.

UHBW provides community midwifery services from 11 bases located across south and central Bristol, and three bases in Weston-Super-Mare. All women are under the care of a community midwife during pregnancy and in the first few weeks following the birth of their baby. Women who have more complex needs will have care by a consultant obstetrician as well as a community midwife. UHBW also has a central delivery suite, alongside a midwifery-led unit, antenatal and postnatal wards located at St Michael's Hospital in Bristol, where around 400 babies per month are born. In Weston, there is a standalone birth centre, as well as outpatient antenatal services. A home birth service is also provided by the Trust.

The results of the survey are published up to ten months after the respondents gave birth. UHBW has a monthly maternity survey that allows us to track experience of care on an ongoing basis. Headline results[1] of our local survey are reviewed in-depth by the Women's Experience group on a monthly basis and by Experience of Care Group on a quarterly basis.

Who took part in the survey?



[1] The experience tracker scores for maternity inpatients and kindness and understanding are reported via Experience of Care Group.

3 Summary of results

The National Maternity Survey does not ask respondents to give a single overall service experience rating. However, we can look at the mean score across all of the survey questions as a proxy 'overall' measure. Doing so suggests that UHBW broadly performed in line with the national average with a score of 7.8 out of 10.0. Using this metric, UHBW ranked 51st out of 121 Trusts in the 2022 survey which is a significant improvement from the rank of 101st place in the 2021 results.

In the 2022 National Maternity Survey:

- Our Trust's results were **about the same** as other Trusts the majority of questions (43 out of 50);

- Our Trust's results were **better than most** trusts for five questions, all of which relate to the survey section theme of 'staff caring for you':
    - 'Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you?'
    - 'During labour and birth, were you able to get a member of staff to help you when you needed it?'
    - 'Thinking about your care and birth, were you involved in decisions about your care?'
    - 'Did you have confidence and trust in the staff caring for you during your labour and birth?'
    - 'During your labour and birth, did your midwives or doctor appear to be aware of your medical history?'

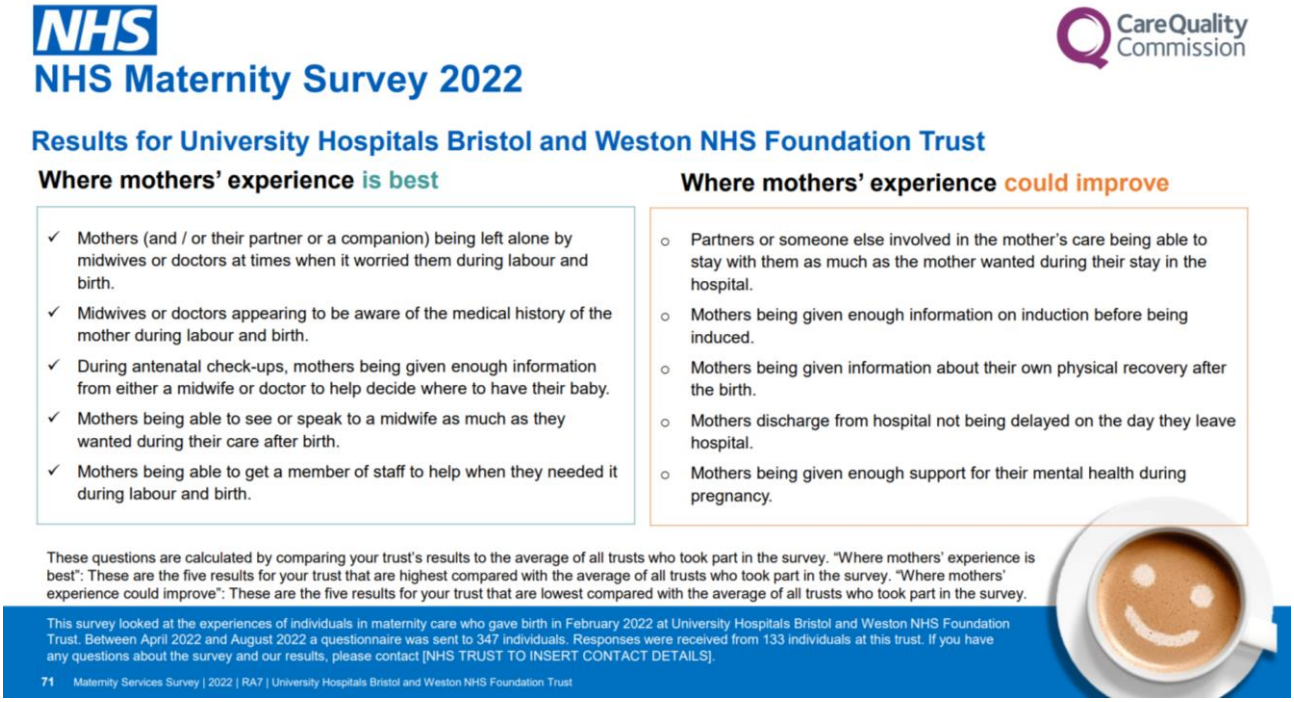
- Our Trust's results were **somewhat better** than most trusts for one question:
    - 'Did you get enough information from either a midwife or doctor to help you decide where to have your baby?'

- Our Trust's results **were worse** than most trusts for one question:
    - 'Were you given information about your own physical recovery after the birth?'

There were three question scores for UHBW from the 2022 survey where a statistically increase is evident when compared to the results from the 2021 survey.

Section / question	2021	2022	Variation
Labour and birth			
C18. During labour and birth, were you able to get a member of staff to help you when you needed it?	8.7	9.4	+0.7
C20. Thinking about your care during labour and birth, were you involved in decisions about your care?	7.9	9.1	+1.2
Postnatal care			
F12. Were you given information about any changes you might experience to your mental health after having your baby?	6.1	7.3	+1.2

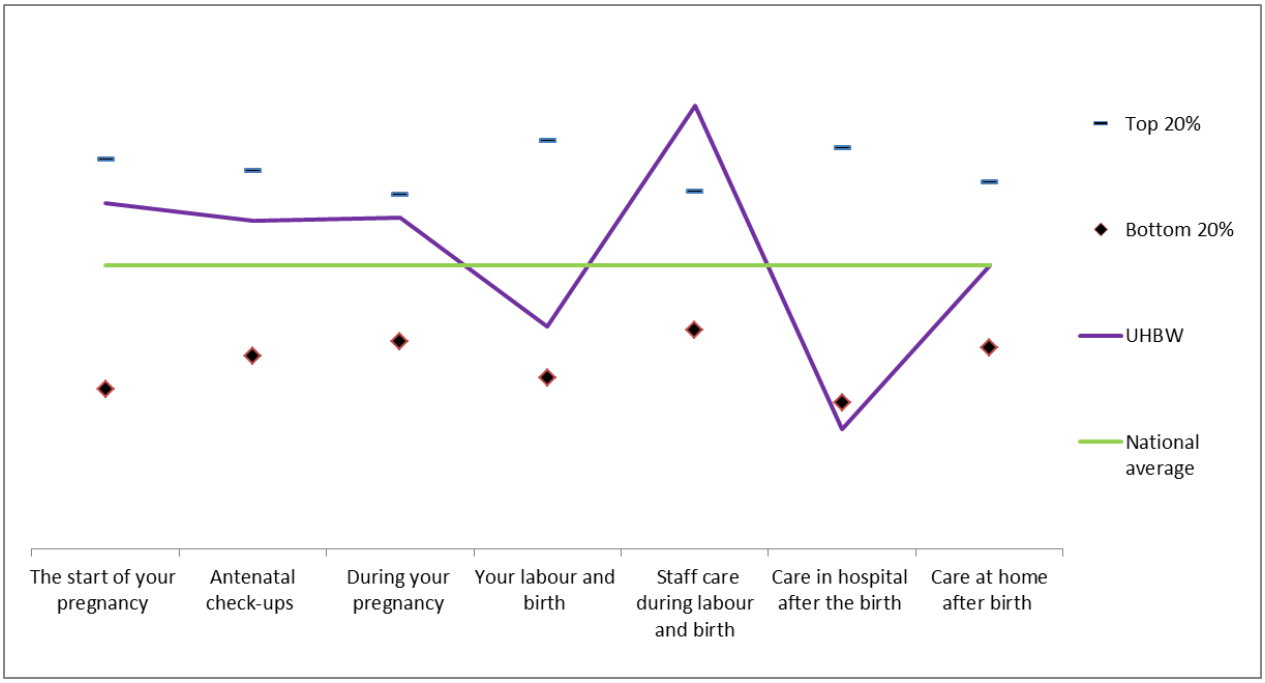
The graphic below provides a simple summary of the highest and lowest scoring questions on the survey when compared to the national profile.



4. National comparisons

Chart 1 (below) provides an overview of how UHBW performed in each section of the 2022 National Maternity Survey, compared to key national benchmarks. Survey scores indicate that UHBW performed above the national average in relation to antenatal care and staff care during labour and birth. This is a notable improvement on the 2021 results where these elements of the maternity pathway scored below the national average. However, there is a clear contrast between experience of staff care during labour and birth (in the top 20% of Trusts) and care in hospital after birth, the latter scored in the bottom 20% of Trusts nationally, which consistent with 2021 results. Please refer to section 6 which details the improvement work planned and underway in relation to this.

Chart 1: UHBW section scores compared to national benchmarks *(note: in this chart the national average is set to 100 and all scores are indexed against this for comparison purposes).*



We can also use the section scores from the survey to compare women's experience of the maternity pathway at key touchpoints. This is shown in Chart 2 below. The chart reinforces the findings that experience of maternity care drops (relative to the UHBW average) for care in hospital after birth.

Chart 2: Touchpoint map of UHBW maternity services *(note: to compare different aspects of our service, the "average" shown in this chart is UHBW's own mean score, not the national average)*

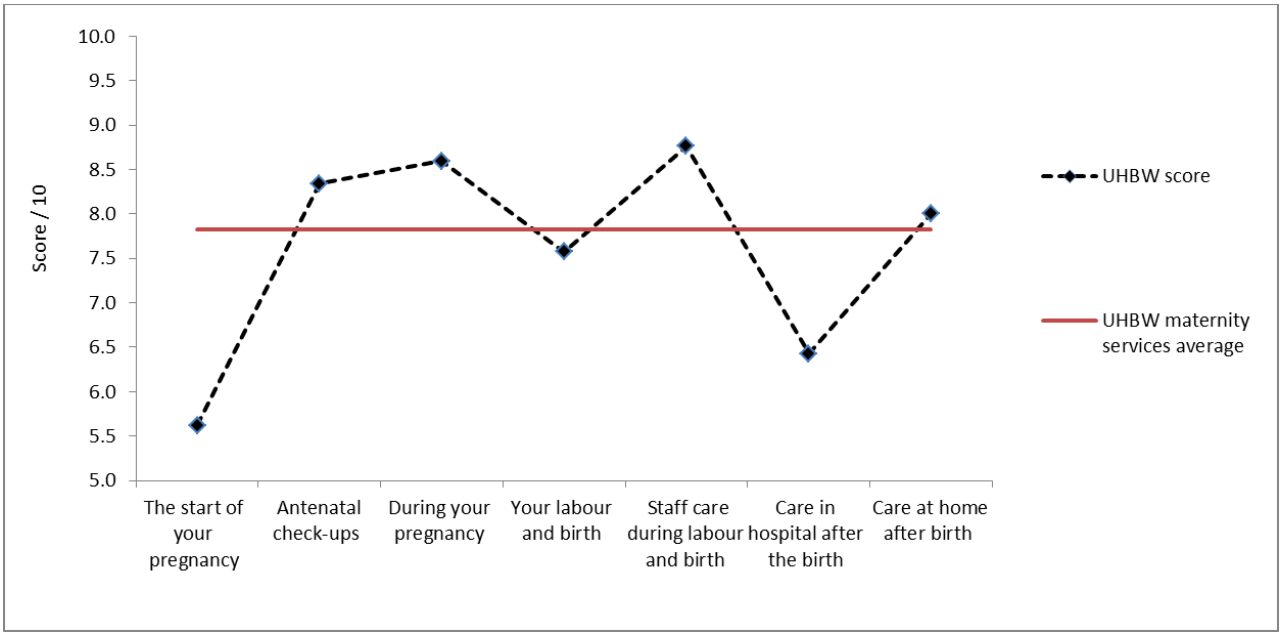


Chart 3 (below) and Chart 4 (overleaf) compare the overall score between geographically neighbouring trusts and large city centre acute Trusts. The overall experience score is calculated as the mean score across all questions in the survey. UHBW was the second lowest scoring Trust in the region for overall maternity experience; however UHBW's improvement of 0.4 points is the largest improvement from 2021 results seen in the region. When comparing to large city acute Trusts, UHBW's overall score was broadly in line with other Trusts.

Chart 3: Overall experience rating amongst geographical neighbouring trusts from 2021 and 2022 National Maternity Survey

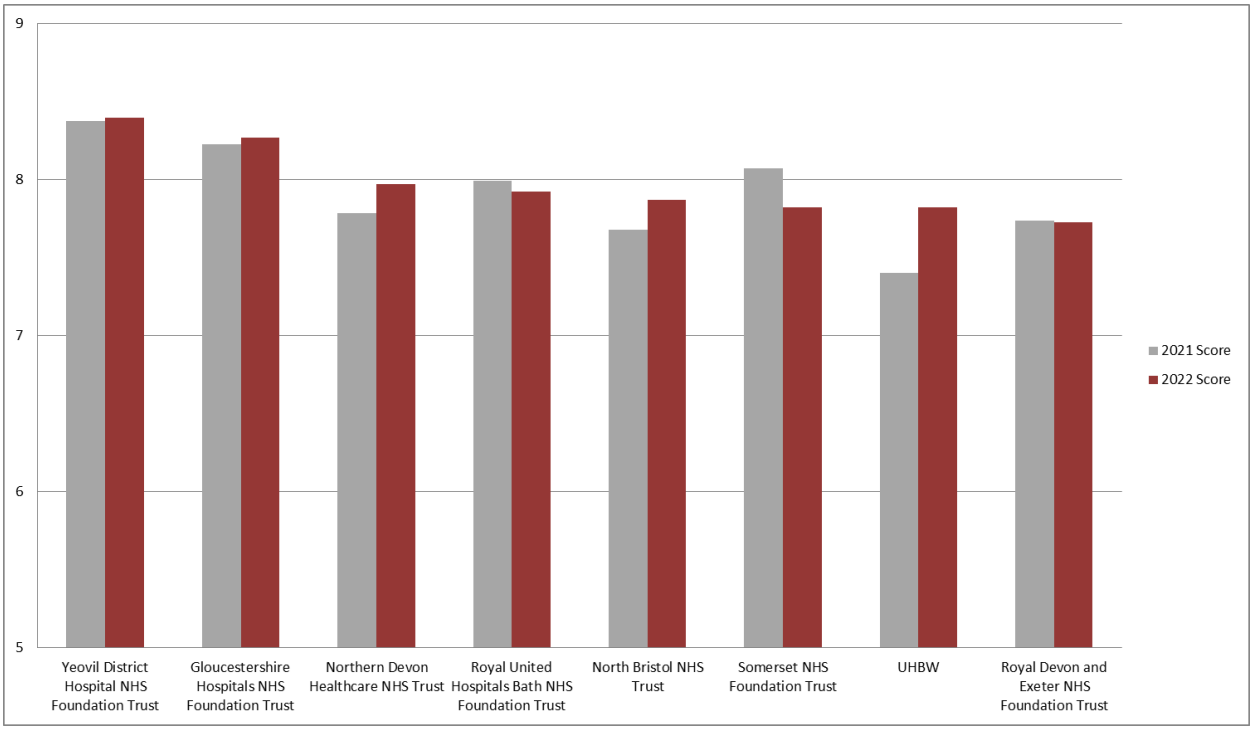
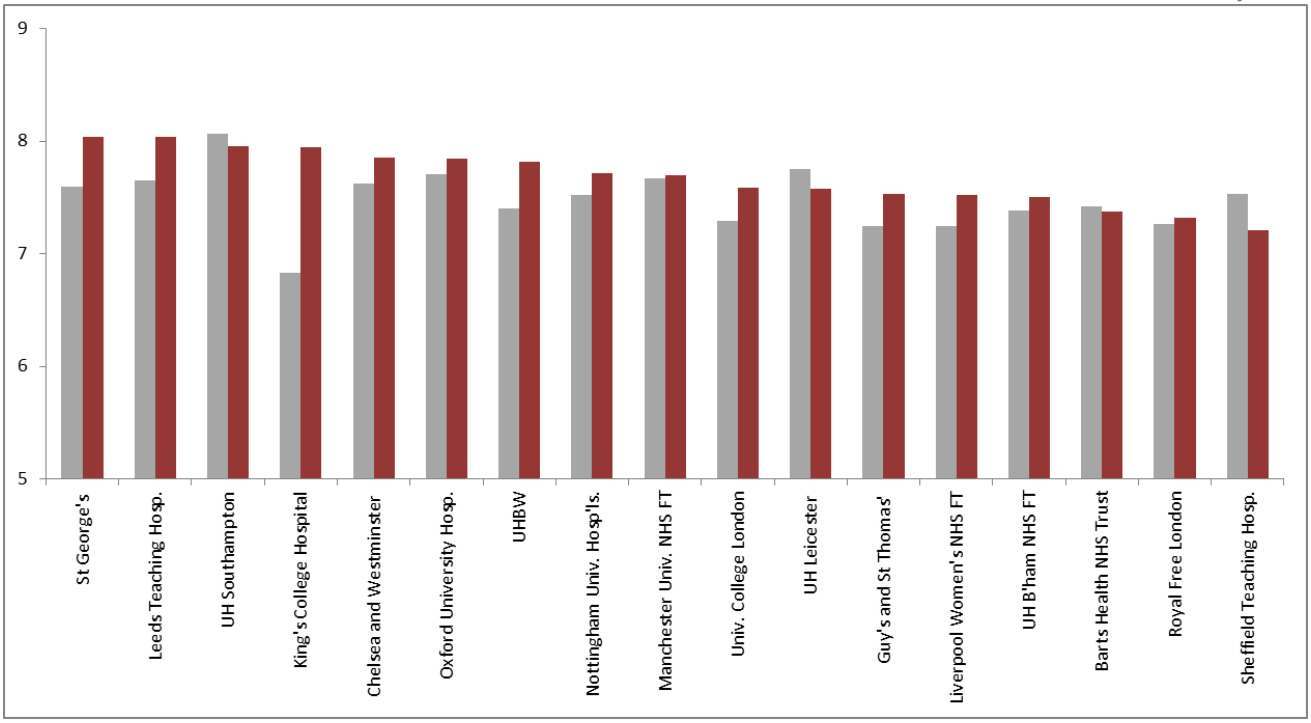


Chart 4: Overall experience rating amongst large city acute trusts from 2021 and 2022 National Maternity Survey



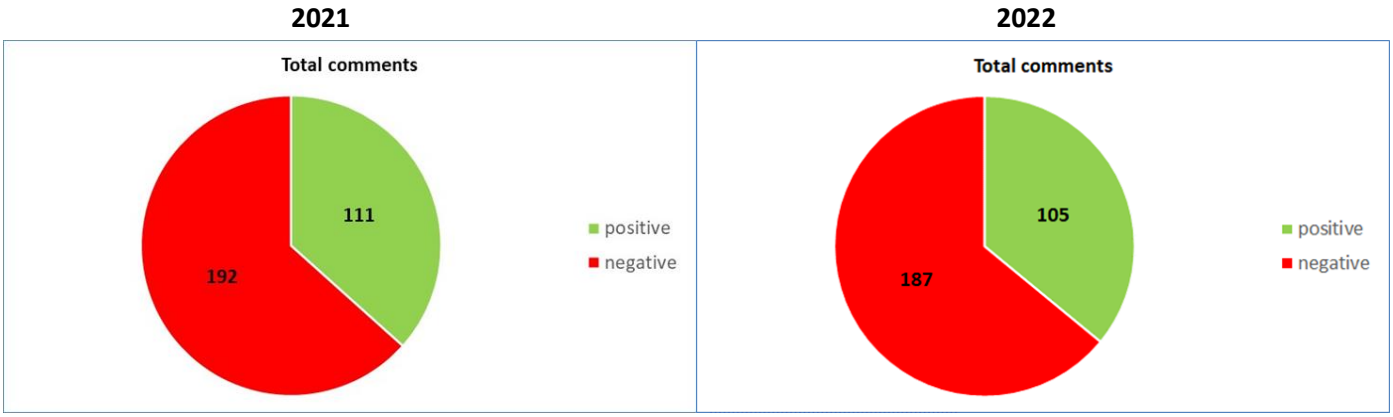
5. Sentiment analysis of patient comments

An analysis of the 292 free-text comments received as part of the survey undertaken. Overall, 105 comments were positive (36%) and 187 negative (64%). This is very similar to the sentiment of comments shared in the 2021 survey as indicated in Chart 5 below.

There were 78 comments about the pathway of care, 75 general comments about staff, 28 about staff communication, and 30 about other staff issues such as training and staff shortages. There were 71 comments about care and treatment and 10 about the hospital environment.

The majority of comments about staff were positive. However, the majority of comments regarding communication by staff were negative.

Chart 5: Total comments by sentiment



6 Improvement opportunities

UHBW's 2022 national maternity survey results saw an improvement in many areas when compared to the results from 2021. The following statement from Divisional Director of Nursing and Midwifery summarises the areas of focus for improvement activity over the past 12 months.

"There is a very active 'Women's experience' group now in place which was relaunched after the last disappointing national survey results from 2021. Membership of the group includes representatives from the local Maternity Voices Partnership, a lay representative, North Bristol Trust midwifery services (who provide part of the pathway for UHBW patients), medical staff, nursing and midwifery staff and radiology staff. The main areas of improvement work, overseen by the group, that have been completed to date are:

1. Improved communication by engaging with existing women's groups in the Voluntary and Community sector. In order to do this, the Trust appointed a Practice Education Facilitator (PEF) to focus on equality, diversity and inclusion (EDI). The PEF engaged with Black, Asian and Minority Ethnic (BAME) women in community spaces and gathered feedback from BAME women on their experience of maternity services. This feedback has been shared with staff to raise awareness about the importance of culturally appropriate language being used in maternity care settings.

2. Increased provision of face-to-face antenatal classes compared to the previous year. All community bases are now holding face-to-face classes for women and partners.

3. Focused on staff wellbeing and support so that patient care can be delivered to a high standard.
    a. Professional Midwifery advocate hours have been increased for 15 hours to 3 months to provide more reflective support for midwives.
    b. Rolling out wellbeing initiatives which are funded by NHS England for Midwifery services. Funding has been allocated to a employing a Retention midwife, an EDI Practice Education Facilitator (PEF) and establishment funding for PEF to support staff in practice.
    c. Maternity services have held a wellbeing away day and rolled out psychological safety and saves lives training package.
    d. Rolled out 'Nip it in the bud' training tool as part of the Trust's approach to tackling bullying in the workplace
    e. After midwife's specific study day ensuring all midwives receive a restorative supervision session run by the Professional Midwifery Advocate.

Specifically in relation to improving experience of women in hospital after birth where UHBW scores are comparatively low:

- Practice Education Facilitators are rolling out kindness and understanding training and initiatives to improve relational aspects of care;
- Maternity Services are employing further Maternity Assistants for the ward to help with care delivery."

A full copy of the Maternity Experience Action Plan can be found as an accompanying document to this report.

The five areas that scored lowest for UHBW compared to the national average in the 2022 survey results were:

- Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in hospital;
- Mothers being given enough information on induction being before induced;
- Mothers being given information about their own physical recovery after the birth;

- Mothers discharge from hospital not being delayed on the day they leave hospital;
- Mothers being given enough support for their mental health during pregnancy.

The five areas above and the wider National Maternity Survey 2022 results are under review by the Women's Experience Group. The Maternity Experience Action Plan will be updated following this to ensure improvement actions are targeted at the areas that will make the most significant difference to the experience of women under the care of UHBW maternity services.

Matthew Areskog, Head of Experience of Care & Inclusion.
Sarah Windfeld, Director of Nursing and Midwifery, Women's and Children's Division.

1st February 2023

Appendix A - CQC Summary at a National Level

National summary - What CQC found[2]

At a national level the 2022 maternity survey shows that people's experiences of care have deteriorated in the last 5 years. Trend analysis was carried out on 26 evaluative questions on data from between 2017 and 2022. Of these questions, 1 showed a statistically significant upward trend, 4 showed no change and 21 showed a statistically significant downward trend. Furthermore, of the 21 questions with downwards trends, results for 2022 were at the lowest point for the 5-year period in 10 cases.

Results for 18 of these questions declined during the height of the pandemic (2021). Out of the 18 questions that saw a large decline in experience in 2021, 5 have seen a further decline in 2022 and 6 have stayed level with 2021 results. This indicates that some experiences of maternity services haven't yet recovered to pre-pandemic levels including care during labour and birth and postnatal care at home and in hospital.

Positive results (at a national level)

Hospital Discharge
Since 2017, there has been a positive upward trend for women and other people who had recently given birth reporting that there was no delay with their discharge from hospital, from 55% to 62% in 2022

Mental health support
Support for mental health during pregnancy is improving, although there remains room for further improvement. Nearly three-quarters of women and other pregnant people (71%) said their midwife definitely asked about their mental health during antenatal check-ups; an improvement compared with 69% in 2021 and 67% in 2019. Furthermore, 85% said they were given enough support for their mental health during their pregnancy; an improvement compared with 83% in 2021. In terms of postnatal care, the vast majority said a midwife or health visitor asked them about their mental health (96% compared with 95% in 2021 and 2019).

Key areas for improvement (at a national level)

Availability of staff
The proportion of women and other pregnant people being given the help they needed when they contacted midwifery team during antenatal care, dropped from 74% in 2017 to 69% in 2022. Women and other pregnant people were less likely to say they were 'always' able to get a member of staff to help them when they needed attention during labour and birth; 63% compared with 65% in 2021 and 72% in 2019. Results are lower still for care in hospital after the birth; 57% said they were 'always' able to get help, a decrease compared with 59% in 2021 and 62% in 2019. In terms of postnatal care, 70% were 'always' given the help they needed when contacting a midwifery or health visiting team, down from 73% in 2021 and 79% in 2019. Less than half (45%) said they could 'always' get support or advice about feeding their baby during evenings, nights or weekends, a downward trend since 2017 (56%)

Confidence and trust
Just over two-thirds (69%) of women and other pregnant people reported 'definitely' having confidence and trust in the staff delivering their antenatal care. Results were higher for staff involved in labour and birth (78%) but there has been a downward trend since 2017 (82%). In terms of postnatal care, while most said they 'definitely' had confidence and trust in the midwifery team (71%); the trend is again a downward one, from 73% in 2017. There has also been a downward trend for 'always' being treated with kindness and understanding whilst in hospital after the birth, from 74% to 71%.

Communication and interactions with staff
The proportion of women and other pregnant people saying they were given appropriate advice and support when they contacted a midwife or hospital at the start of their labour, decreased from 87% in 2017 to 82% in 2022. There has also been a downward trend since 2017 for women and other pregnant people saying that if they raised a

[2] Source: https://www.cqc.org.uk/publications/surveys/maternity-survey-2022

concern during labour and birth, they felt it was taken seriously, from 81% to 77% in 2022. 59% of women and other pregnant people were always given the information and explanations they needed during their care in hospital, down from 66% in 2017.

How experience varies for different groups of people

Women and other pregnant people report some differences in their experiences of maternity care according to certain demographic characteristics. Some of the more consistent differences include women are more likely to report positive experiences of maternity care if they have continuity of carer or have an unassisted vaginal delivery. Women are more likely to report poorer experiences across the maternity care pathway if they have had an emergency caesarean birth do not have continuity of carer (no named midwife) or have not had a previous pregnancy.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Public Trust Board on Thursday 15th June 2023

Report Title	**6 Monthly Safe Staffing report for Nursing, Midwifery and Allied Health Professionals – October 2022 to March 2023**
Report Author	**Sarah Dodds Deputy Chief Nurse, Andy Landon Senior Nurse - Clinical Informatics Sarah Windfeld – Head of Midwifery Vimal Sriram – Director of Allied Health Professionals. Deirdre Fowler – Chief Nurse and Midwife**
Executive Lead	**Professor Deirdre Fowler – Chief Nurse and Midwife**

1. Purpose

The purpose of the paper is to provide assurance to the Trust Board that wards and departments have been safely staffed in line with the National Quality Board guidance and Developing Workforce standards, make recommendations for maintaining a sustainable nursing, midwifery, and allied health professional workforce.

2. Key points to note *(Including any previous decisions taken)*

The key points to note from the report: -

- The fill rate has been consistently in the mid to high 80's for registered nurses and is starting to return to the pre-covid levels above 90%. The night HCSW fill rate remains above 100%, this is to ensure vulnerable patients are kept safe with enhanced care observation.

- All in-patient area fill rates are based on the funded beds however over the winter months all areas have been required to support several unfunded escalation beds. This has added additional pressure on all clinical areas as they continue to care for more patients with the same staffing numbers.

- Fill rates for both RN and HCSW in Childrens remain lower than the Trust average due to the increased vacancy levels across both RN's and HCSWs. Support for wards has been provided by Supervisory Ward Sisters joining the numbers and Clinical Nurse Specialist teams working on their specialist ward.

- Care hours per patient day (CHPPD) is a measure of actual nursing resource deployment and the registered nurse (RN) CHPPD and total CHPPD are included in the metric tables. Trust wide RN CHPPD has remained within the range 5.8 – 6.3. UHBW benchmarks well against peers in the model hospital dashboard and is in the highest national quartile for CHPPD.

- The RN Turnover rate is now on a downward trend from 18.2% to 16.6%, due to the continued recruitment of Internationally Educated Nurses (IEN's) and Newly Qualified

Nurses (NQN's) over the past 6 months.

- The level of red flag reports over the past 6 months has seen a definite reduction in the number reported across all divisions.

- During this 6 Month period the Trust completed a full review and re-band of all eligible band 2 staff to band 3. This was a significant piece for work for the nursing workforce and has required some staffing changes. The associated budgetary changes required will be updated from April 2023. The vacancy levels for band 2/3 are in transition, to provide a clearer picture both have been combined to give an overall HSCW vacancy level.

- The Trust supported three periods of Industrial Action undertaken by the Royal College of Nursing over the past 6 months. The actual number of staff exercising their right to strike has decreased after each session, but this has impacted on fill rate.

From the Trust 6 Monthly Safe Staffing Reviews

- The Trust has now completed 3 cycles of the Safer Nursing Care Tool (SNCT) assessments with increasingly reliable results. The compliance levels for all areas has significantly increased from an average of 85% to 95% as wards became more familiar with the tool.

- Nursing Establishment 6 Monthly reviews were undertaken in April 2023, these used the SNCT results as the basis for the reviews and each Division is working through the outcomes to ensure that all areas have balanced their rosters and establishments to reflect their staffing requirements.

- The reviews evaluated the nurse and midwifery staffing in each Division including In-Patient Ward, ED's, Theatres, Clinical Nurse Specialists. Outpatients Services, Day Case Wards, Research Nurses.

- In line with expected practice the professional judgment component of the SNCT is now being applied to the combined results to complete the evaluation process. This reviews elements not accounted for by the tool. Although no establishments have been fundamentally changed as yet work continues to review the service delivery and the opportunities available using the SNCT tool as a basis for change.

- The reviews highlighted the increased level of training beyond the budgeted allowance required to ensure staff have the correct skills to safely care for patients. This has been steadily increasing over previous years. A detailed piece of work will now be undertaken over the next 6-month period to evaluate these requirements in ward areas. This is more notable in specialised areas where new treatments and clinical guidance requires additional training.

- Key areas that indicate an uplift of nursing establishment initially highlighted in the first SNCT review and backed up in subsequent reviews are: -
    - The Weston Emergency Department
    - The Childrens Emergency Department.

- The Childrens Intensive Care Department (PICU) requires an uplift to the establishment based on acuity and dependency, ability to ensure full staffing of 18 beds to align with the Paediatric Critical Care Society (PCCS benchmark) and with other similar units nationally.

3. Strategic Alignment

Patient Safety

Experience of Care

Our People

Making the Most of all Resources

4. Risks and Opportunities

For all staff groups

Risk Number	Details	Risk Level	Score
737	Risk that the Trust is unable to recruit sufficient numbers of substantive staff – all staff groups	Strategic Risk Register	16
2664	Risk that the Trust is unable to retain staff	Strategic Risk Register	12
5477	Risk that nurse staffing levels will not be met.	Strategic Risk Register	15

For Midwives

Risk Number	Details	Risk Level	Score
33	Risk that inadequate nursing levels in line with BAPM standards 2011 will affect neonatal outcomes	Departmental	12
998	Risk that neonates are transferred out to alternative NICU units due to lack of cot capacity	Departmental	12
3623	Risk that extreme pre-term babies will have a sub-optimal outcome due to inability to deliver in a tertiary centre	Departmental	12
4810	Risk that if the trust does not achieve continuity of carer we will not achieve CNST safety standards	Departmental	12

For AHPs

Risk Number	Details	Risk Level	Score
737	Risk that the Trust is unable to recruit sufficient numbers of substantive staff	Strategic Risk Register	16
2694	Risk that Trust is unable to retain members of the substantive workforce	Strategic Risk Register	12

5. Recommendation

This report is for Assurance

The Trust Board is assured that there is detailed monthly reporting to the Quality and Outcomes committee which provides fill rates by wards, red flag reporting and detailed analysis and review of all the safe staffing incidents reported, along with triangulation of impact on patient quality outcomes and staff experience.

The Trust Board is recommended to review the six-monthly safe staffing report and support the following:

- Continue the approach outlined using the Safer Nursing Care Tool (SNCT) assessments to underpin nursing establishment on all in-patient wards, both adults and children and ED's acknowledging this is a process that will evolve over time after each assessment.
- Support the process of review, enabling uplift of both Weston ED and Children's ED nursing establishment to align with recommended SNCT levels.
- Support the process of review, enabling uplift of the Paediatric Intensive Care Unit nurse staffing establishment for 18 beds as identified.
- Acknowledge the bespoke funded nursing recruitment and retention plan approved in April 2023, which includes further international recruitment, a fully funded pathway including Trainee Nurse Associate and Registered Nurse Degree apprenticeships, funding for CPD, additional Trust wide practice educator roles, Training support staff and funding for victim support officers.

6. History of the paper

Please include details of where paper has <u>previously</u> been received.

Trust Executive Meeting	Wednesday 24th May 2023

University Hospitals Bristol and Weston NHS Foundation Trust

Report on Nurse (RN's), Midwifery (RM's) and Allied Health Professionals (AHP's) Staffing Levels UHBW (October 2022 – March 2023).

Context

Following publication of the Francis Report 2013[1] and the subsequent "Hard Truths" (2014)[2] document, NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery and care staff levels. These include:

- Report and publish a monthly return to NHS England indicating planned and actual nurse staffing by ward. This is published on the NHS Choices website.
- Publish information with the planned and actual registered and unregistered nurse staffing for each shift.
- Provide a 6-month report on nurse staffing to the Board of Directors.

The RCN workforce Standards (2021)[3] report have been fully reviewed and compliance continues to improve with actions in place to support best practice.

Contents

The report aims to provide the Trust Board with assurance that staffing has been managed over the past 6 months in line with the National recommendations[4], with close oversight by the Chief Nurse and Midwife and will make recommendations to the Board regarding actions required to achieve a sustainable and effective nursing workforce.

By using the NQB three expectations approach of right staff, right skills, right place and time to safe staffing levels that can be determined based on patients' needs, acuity and risks, monitored from 'ward to board'. This triangulated approach to staffing decisions, rather than making judgments based solely on numbers or ratios of staff to patients, is also supported by the CQC.

1. Methodology

[1] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK (www.gov.uk)
[2] NHS England » Guidance issued on Hard Truths commitments regarding the publishing of staffing data
[3] Nursing Workforce Standards | Professional Development | Royal College of Nursing (rcn.org.uk)
[4] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/12/C0833_advice-on-acute-sector-workforce-models-during-COVID_with-apps_10dec.pdf

The Trust has utilised the NHS Improvement "Developing Workforce Safeguards" (October 2018)[5] recommendations as a framework for this report: -

- The Trust continues to use the evidence-based acuity and dependency tools to underpin the establishment setting process. A full Safer Nursing Care Tool (SNCT) assessment on all in-patient wards for both adults and children were undertaken in July 2022, November 2022 and February 2023, all of which the recommendations in this report are based. The review also encompassed the three main Emergency Departments (ED's) in Children's, Bristol Royal Infirmary and Weston General hospital.

- The midwifery teams used the Birthrate Plus (BR+) acuity tool to provide a systematic evidence-based calculation for midwifery staffing in June 2022. The report detailed the assessment of the required workforce for the case mix of women and numbers of births at University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). Building on this the midwifery teams now also use the daily Birthrate plus tool to track acuity and dependency in real time for all pregnant women in the hospital.

- There is no current credible acuity tool for use to assess AHP staffing.

- The SNCT and BR + results formed the basis for the discussions during the 6 monthly Safe Staffing Review process supporting the evidence-based assessment of the nursing establishments. The tool will continue to be used biannually to support future reviews and are scheduled in for July and February each year. This will build a comprehensive profile to substantiate the required workforce.

- It is recognised that acuity tool data cannot solely be used to recommend staffing establishments, the role of professional judgement and local intelligence (triangulation) must first be completed before any premature conclusions can be drawn. This mandated part of the exercise is being completed following the 6 monthly reviews to provide the required assurance in the recommended staffing levels.

- In addition, the following areas were also reviewed against existing best practice guidelines to ensure safe staffing levels were being maintained across all services.
    - Theatre Suites,
    - Outpatient Departments,
    - Day Case Wards/ Units,
    - Research Nurses
    - Clinical Nurse Specialists.

- The Deputy Chief Nurse led this 'ward to board' process in collaboration with the Directors of Nursing, Deputies and Matrons and finance colleagues and presented the outcome to the Chief Nurse and Midwife.

- The reviews highlighted the increased level of training beyond the budgeted allowance required to ensure staff have the correct skills to safely care for patients. This has been steadily increasing over previous years. A detailed piece of work will now be undertaken over the next 6-month period to evaluate these requirements in ward areas. This is more notable in specialised areas where new treatments and clinical guidance requires additional training.

- There are 3 specific strategic nurse, midwifery and AHP staffing risks held on the corporate risk register as below. Risk 2664 has been reduced from 16 down to 12 due to the reduction in the Trust's turnover and Risk 5477 has been reduced from 20 down

[5] Developing_workforce_safeguards.pdf (improvement.nhs.uk)

to 15 as the impact of the pandemic decreases.

For all staff groups

Risk Number	Details	Risk Level	Score
737	Risk that the Trust is unable to recruit sufficient numbers of substantive staff – all staff groups	Strategic Risk Register	16
2664	Risk that the Trust is unable to retain staff	Strategic Risk Register	12
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4810	Risk that if the trust does not achieve continuity of carer we will not achieve CNST safety standards	Departmental	12

For AHPs

Two risks (2633 and 2646) were closed over the previous 6 months and Risk 737 and 2741 were both reduced in severity.

Risk Number	Details	Risk Level	Score
737	Risk that the Trust is unable to recruit sufficient numbers of substantive staff	Strategic Risk Register	16
2664	Risk that Trust is unable to retain members of the substantive workforce	Strategic Risk Register	12

- The report highlights the work being undertaken to mitigate the above risks.

2. Nursing Report

NQB Expectation One: Right Staff

Trust Metrics overview

The previous 6 months staffing metrics are now tabled over the next pages commencing with the Trust view followed by the Divisional summary tables. Key points to note: -

- The fill rate has been consistently in the mid to high 80's for registered nurses and is starting to return to the pre covid levels above 90%. The night HCSW fill rate remains above 100%, this is to ensure vulnerable patients are kept safe with enhanced care

observation.

- All in-patient areas fill rates are based on the funded beds however over the winter months all areas have been required to support several unfunded escalation and boarding beds. This has added additional pressure on all clinical areas as they continue to care for more patients with the same staffing numbers.

- Care hours per patient day (CHPPD) is a crude measure of HCSW and registered nurses combined divided by number of patients at 12 midnight. Trust wide RN CHPPD has remained within the range 5.8 – 6.3. UHBW benchmarks well against peer Trusts in the model hospital dashboard and is in the highest national quartile for CHPPD.

- The RN Turnover rate is now on a downward trend from 18.2% to 16.6% due to the continued recruitment of Internationally Educated Nurses (IEN's) and Newly Qualified Nurses (NQN's) over the past 6 months.

- The level of red flag reports over the past 6 months has seen a definite reduction in the number reported across all divisions.

- During this 6 Month period the Trust completed a full review and re-band of all eligible band 2 staff to band 3. This was a significant piece for work for the nursing workforce and has required some re alignment on rosters. The associated budgetary changes required will be updated from April 2023. The vacancy levels for band 2/3 are in transition, to provide a clearer picture both have been combined to give an overall HSCW vacancy level.

- The Trust supported three periods of Industrial Action undertaken by the Royal College of Nursing over the past 6 months. The actual number of staff exercising their right to strike has decreased after each session, but this has impacted on fill rate.

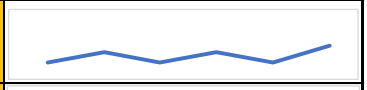
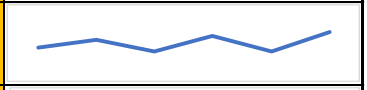
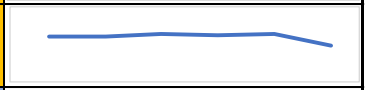
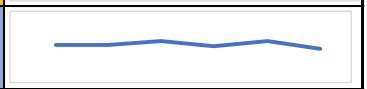
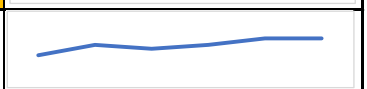
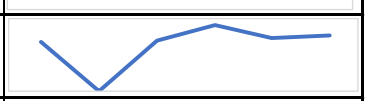
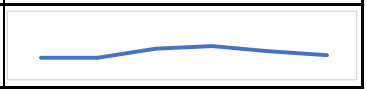
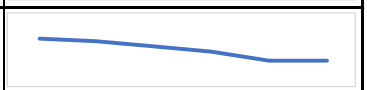
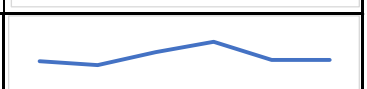
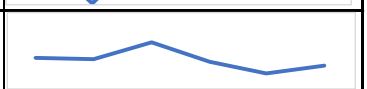
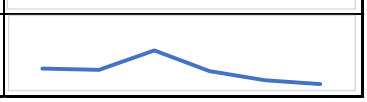
Trust 6 Monthly Safe Staffing Reviews

- The Trust has now completed 3 cycles of the Safer Nursing Care Tool (SNCT) assessments with increasingly reliable results. The compliance levels for all areas significantly increased from an average of 85% to 95% as wards became more familiar with the tool.

- In line with expected practice the professional judgment component of the SNCT is now being applied to the combined results to complete the evaluation process, this element is not accounted for by the tool. Although no establishments in inpatient wards have been fundamentally changed yet work continues to review the service delivery and the opportunities available using the SNCT tool as a basis for change.

- Key areas that have indicated a change to the establishments initially highlighted in the first SNCT review and backed up in subsequent reviews are: -
    - The Weston Emergency Department
    - The Childrens Emergency Department.

- The Childrens Intensive Care Department (PICU) requires an uplift to the establishment based on acuity and dependency, ability to ensure full staffing of 18 beds to align with the Paediatric Critical Care Society (PCCS benchmark) and with other similar units nationally.

Trust Overview Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Registered Nurse Fill Rate - Day	85%	88%	85%	88%	85%	90%	
Registered Nurse Fill Rate - Night	89%	91%	88%	92%	88%	93%	
Unregistered Nurse Fill Rate - Day	85%	85%	87%	86%	87%	80%	
Unregistered Nurse Fill Rate - Night	103%	103%	109%	101%	109%	96%	
All Staff Fill Rate - Overall	89%	91%	90%	91%	90%	90%	
Registered Nurse Care Hours per Patient Day	5.8	6.1	6.0	6.1	6.3	6.3	
Total Care Hours per Patient Day	8.7	9.1	8.9	9.1	9.3	9.3	
Supervisory Ward Sister %	68%	-	70%	91%	74%	77%	
Sickness (Rostering KPI)	7.5%	7.9%	9.5%	6.9%	6.7%	6.7%	
Registered Nurse Band 5 Turnover Rate	18.2	18.0	17.6	17.3	16.6	16.6	
Unregistered Nurse Band 3 % Turnover Rate *	17.8	18.4	18.1	9.4	10.7	11.7	
Unregistered Nurse Band 2 Turnover Rate	21.6	21.5	20.5	31.3	31.6	28.5	
Registered Nurse Band 5 Vacancy WTE	269.6	266.8	275.1	282.7	269.9	269.8	
Healthcare Support Worker Band 2/3 Vacancy WTE	190	188.21	196.86	176.7	185.12	170.34	
% Agency staff used to support substantive staff	9%	-	8%	8%	8%	8%	
% Bank staff used to support substantive staff	15%	-	16%	16%	16%	17%	
Lower than expected Staffing Incidents	89	87	134	80	45	67	
Red Flag Reported incidents	30	27	55	26	12	8	

The Divisional breakdowns are in Appendix 1

Supervisory Ward Sister Role.

- The Trust recognises the essential role of the ward sister in leading the ward team, setting the level of expected care, professional leadership and overall ward and staff management. This position was made supervisory in line with national guidance to

allow Ward sisters ringfenced time to achieve this. All ward establishments were also set up to ensure that the role could continue throughout the year.

- Over the past 12 months the Trust has been reporting the level of supervisory ward sister time due to the number of occasions the Ward Sister has been required to be part of the ward numbers to ensure patient safety. The past 6 months have shown an upward trend to providing this essential role to support both patient safety and staff retention.

*November Report not completed due to Industrial action planning.

6 Monthly Review Summary.

- The SNCT results have been reviewed and are now being fully triangulated in the Divisions. This will inform where potential changes might be able to be made to support new service demands particularly in the revised medical model and front door services for Medicine and Weston.

- All rosters in the divisions have been reviewed to ensure they align with the new budgets and staffing establishments.

- Divisions are reviewing their offerings to band 5 RNs in line with the Trust's retention initiative. This includes new shift patterns, experiential learning programmes and rotations between divisions and sites. Non 24/7 departments e.g. Outpatient departments have raised concerns around future recruitment and retention due to loss of additional payments compared to ward work. This risk will be added to the nursing recruitment and retention plan group to review.

- Medicine division is undertaking some targeted development work with the supervisory ward sister's role to maximize the benefit of the role and enhance recruitment and retention.

- Trust wide Palliative care services hosted by Specialised Services division remain under significant workload pressures and whilst the short-term funding for additional staff provided by the Division will enhance the 5 day per week service, the 7 day per week Palliative care provision remains a risk. In addition, A solution to permanently fund a team of end-of-life practice education facilitators continues to be explored across all divisions.

- The division of Surgery has highlighted difficulties recruiting to anaesthetic roles and is exploring the use of in-house training supervised by a local Higher Education provider.

- Childrens division have identified the requirement to increase the W.T.E per bed to manage the acuity / dependency and demand on the PICU, a detailed plan has been worked up by the division which requires an additional 7.74WTE RN's and 4 WTE Practice Education Facilitators. This suggests bringing the WTE per Bed up to 6.64 in line with Paediatric Critical Care Society (PCCS) standards.

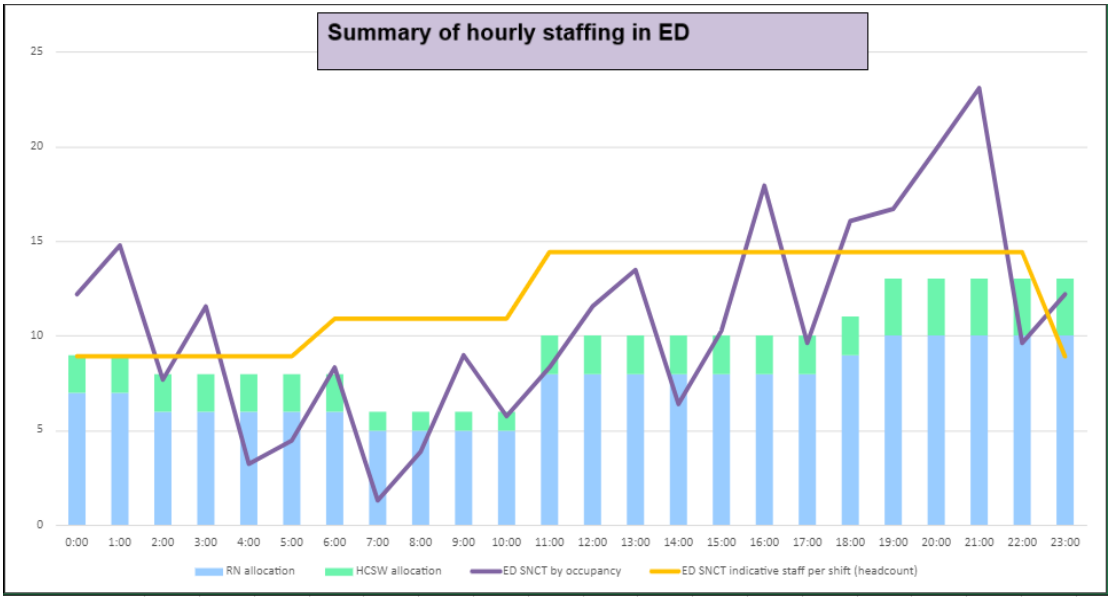
- In Weston, during the review cycles the operating model of Sandford Ward and the Medical Assessment Unit changed, the staffing requirements for this change is in the process of being full evaluated and is expected to be completed ready for the July assessment cycle. This is part of a wider review of the front door provision in part to support Healthy Weston and to provide a more efficient service.

The Emergency Department Safer Nursing Care Tool (SNCT)

- The Safer Nursing Care Tool was introduced into the Trust's ED's in July 2022 and subsequently undertaken again in November 2022 and February – March 2023. The results were consistent for Weston and Childrens ED's showing a staffing shortfall.

- The ED SNCT results for Childrens ED demonstrated significant staffing gaps across the department, this was supported by the consistent level of low staffing incidents reported for this area. November and December were exceptionally challenging for the ED, with record numbers of children attending. There was a requirement to increase the physical environment at this time including overnight which required several additional staff to be moved to support the ED. A full staffing review has been undertaken based on the SNCT, professional judgement and a planned increase in the physical environment, the uplift indicated is 18 RN's, 11 RNA's and 11 HCSW phased over 3 years.
  This is being reviewed by the Trust and the proposal is now moving through the required governance process prior to being fully signed off.

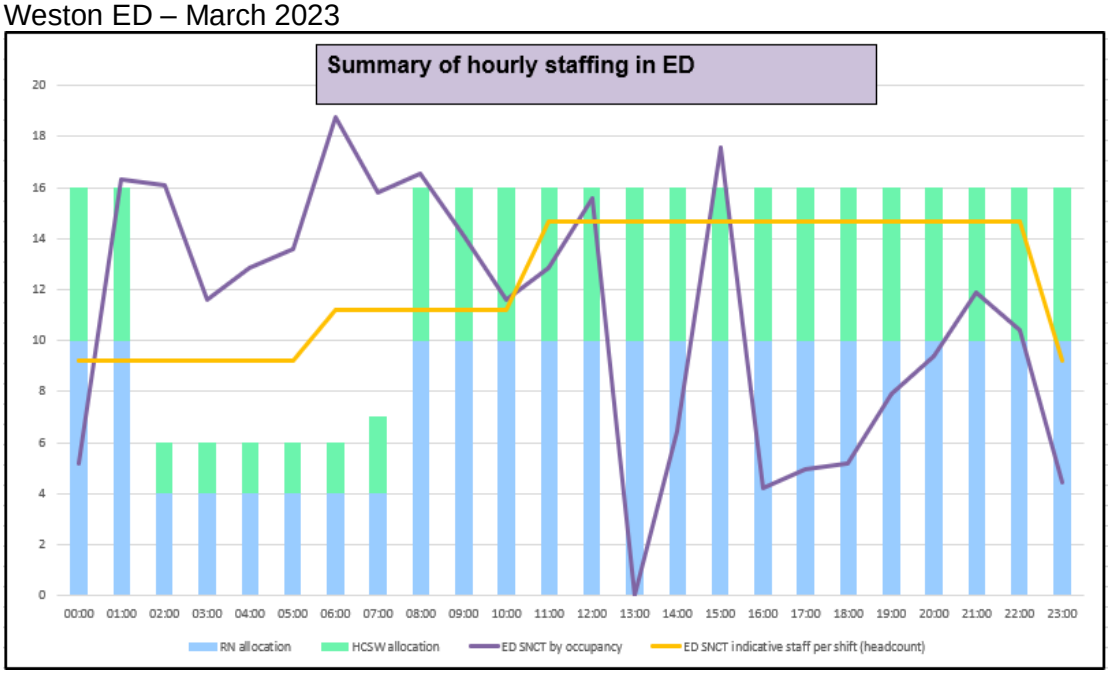
Childrens ED – March 2023



- The Weston ED SNCT reviews showed the ED does require a staffing uplift; this is reflected in the staff experiences in the department. The uplift indicated is 10.15 WTE RN and 10.24 HCSW to provide safe cover across the whole 24-hour period as patients are cared for in ED overnight. The funding for this has been achieved through the Healthy Weston funding.

- In addition, the review highlighted a Band 7 High Impact User nurse post (this would ensure parity of esteem for patients in Weston), and for a rapid assessment and triage service within ED for patients arriving by ambulance. The uplift for this service would be 2.6 W.T.E band 5's and 5.20 W.T.E Band 3's. These posts will require additional funding and are contained within the Annual plan for the division.

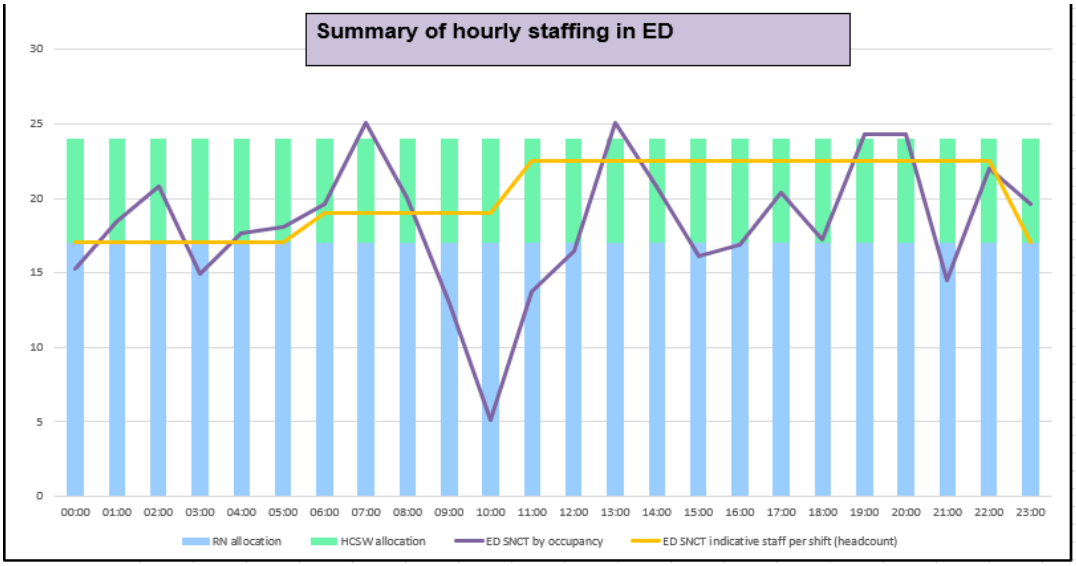
Weston ED – March 2023



- The results for the adult BRI ED have now been reviewed along with the application of professional judgement considering the footprint of the ED department, additional roles,

deployment requirements and short-term flexing of staffing to accommodate timing of attendances and exceptional events. This has highlighted the opportunity to review shifts duration and patterns in the department to provide a more flexible service which is well underway.

Bristol ED – March 2023



NQB Expectation Two: right skills

Workforce planning for the future

The Trust recognises and is committed to ensuring that staff have the appropriate training and competencies to support patient care. This is supported by a plan to invest in new roles to enhance the current workforce model. The Non-medical workforce planning group meets monthly to maintain close oversight of the workforce metrics and workforce planning for the future, roles include: -.

- Nursing Associates
- Advanced Clinical Practitioners
- Nursing Degree Apprenticeships
- International Recruitment
- Newly Qualified Nurses (NQN)
- Practice Education Facilitators
- Professional Nurse Advocates (PNA)
- Health Care Support Workers

Retention Plan

- Each Division continues to focus on supporting the health and wellbeing of staff which has been extremely challenged due to the staffing pressures seen across all services.

- A one-year bespoke funded nursing recruitment and retention plan was approved in April 2023, this includes further international recruitment, a fully funded pathway including Trainee Nurse Associate and Registered Nurse Degree apprenticeships, Funding for CPD, additional Trust wide practice educator roles, Training support staff and funding for victim support officers.

- The Trust retention plan has been published and the 'staff retention' has been identified as a key priority for the Trust as part of the Patient First initiative.

NQB Expectation Three – Right Place and Time

The past 6 months has continued to bring many challenges for ensuring that staff are in place to cover wards, theatres and departments.

- There continues demand to manage the increased pressures both within the ED and with an increased number of ambulances queuing. This has been supported by use of temporary staff and additional incentives to encourage the Trusts staff to cover these shifts.

- Quality Impact assessments have been completed and are regularly reviewed to support the decisions to increase the number of 'Boarding Patients' that can be safely cared for on the wards, an increase in escalation beds and the staffing of areas for queuing of patients waiting for beds in the Emergency departments across both Bristol and Weston.

- The Trust undertook detailed planning to support the Industrial action by staff groups during this period. This has added significant pressure on all nursing areas both due to changes in staffing levels but also individuals' decision to undertake industrial action or come on shift. A Quality Impact assessment was undertaken to support the decisions for safe staffing during Industrial action.

Use of Temporary staff

- The Trust is committed to reducing the overall reliance on agency staff by investing in substantive staff where possible. However due to the nature of healthcare additional support or natural gaps in staffing there will aways be a requirement to use some agency. To maximise the offering to our staff there have been a number of incentives to encourage our substantive and bank staff to work via bank assignments.

- These are managed and overseen by the agency task group using the Patient First approach. This group provide targeted actions in reducing agency spend and work across the Integrated Care system with partners to continue to reduce high-cost agency use. Further work is underway to maximise the offering to bank staff including the ability to pay staff quickly for shifts worked.

Nursing and Midwifery Staff Experience and Satisfaction

Staff are encouraged to feedback on staffing through a variety of means, these include -

- alerting and discussing with their line manager,
- freedom to speak up ambassadors,
- staff side representatives,
- reporting through the Datix incident reporting system,
- well-being survey,
- executive and senior nurse and midwifery staff walkabouts
- bespoke listening events
- the clinical quality accreditation visits to wards and departments.

- the national staff survey.

Triangulation measuring and improving - Performance against key quality metrics. Patient outcomes

A variety of patient surveys and metrics are reported both internally and externally, these are reviewed for learning opportunities when published.

The Trust regularly reports quality indicators on the following to the Trust board each month on the monthly safe staffing paper: -

- Complaints
- Infection control metrics
- Falls
- Pressure ulcers

3. Midwifery report

Introduction

This section of the report details the specific requirements and actions taken by Midwifery Services to ensure that all mothers and babies are given quality care in a safe and secure environment.

The Trust continues to review its services against the landmark publication of the Ockendon Reports in December 2020 and March 2022 to assure the Trust that the Midwifery services are responding appropriately to the recommendations outlined in these two reports.

The Midwifery In-Patient Staffing Metrics are shown below, these are in line with the other divisions.

- The turnover and vacancy figures used here are the band 6 Women's and Childrens figures. Most midwives are band 6 staff.

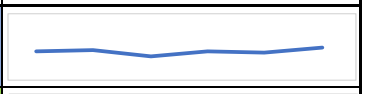
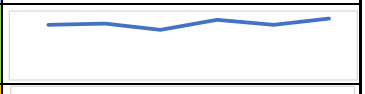
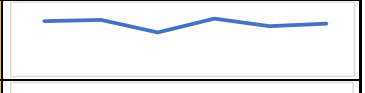
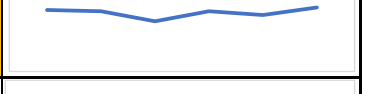
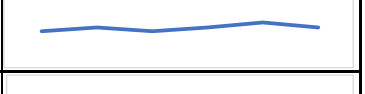
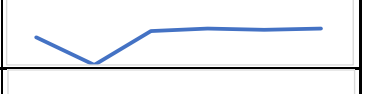
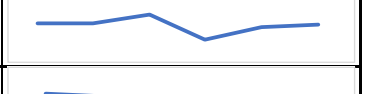
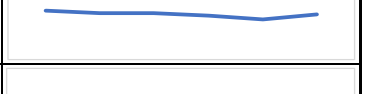
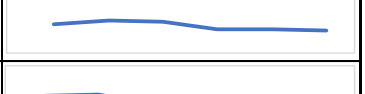
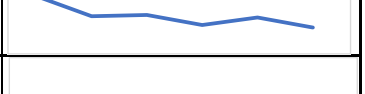
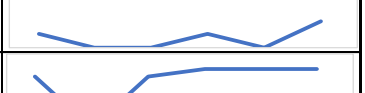
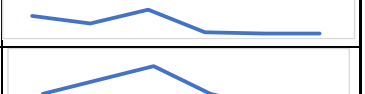
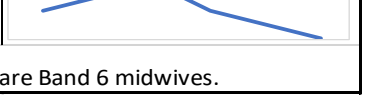
- The level of lower-than-expected safe staffing figures have gradually decreased, these were mostly for NICU rather than midwifery areas due to the requirement to close cots when there are insufficient staff to care for the numbers on the unit. The increased staffing as a result of the IEN programme has reduced the need to close cots.

The Midwifery, NICU and Women's services 6 Monthly safe staffing review was undertaken in April 2023 with the Deputy Chief Nurse, Director of Midwifery and the Matrons.

- The introduction of the emergency Gynae referral service directly to Ward 78 has been a success and reduces pressure on the ED department. The SNCT results for ward 78 are being reviewed to consider the new developments above.

- Birthrate plus has been expanded into all areas of midwifery to provide a real time understanding of midwifery workload. It is gradually being utilised to support daily staffing decisions within the maternity services.

- The supervisory Midwifery ward sister role is being aligned with the rest of the Trust and is working well, the results of achieving this at present is the highest in the Trust.

Division - Womens in Patient Wards Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Registered Nurse Fill Rate - Day	88%	92%	73%	90%	84%	101%	
Registered Nurse Fill Rate - Night	85%	87%	76%	92%	84%	95%	
Unregistered Nurse Fill Rate - Day	80%	81%	64%	83%	73%	75%	
Unregistered Nurse Fill Rate - Night	94%	82%	84%	81%	86%	84%	
All Staff Fill Rate - Overall	90%	88%	74%	89%	83%	94%	
Registered Midwife/ Nurse Care Hours per Patient Day	8.1	8.6	8.2	8.6	9.3	8.6	
Total Care Hours per Patient Day	9.9	10.5	10	10.5	11.3	10.4	
Supervisory Ward Sister %	77%	-	94%	100%	98%	100%	
Sickness	5.2%	5.2%	6.3%	3.0%	4.6%	4.9%	
Registered Nurse Band 6 Turnover Rate *	11.7	11.3	11.3	10.9	10.4	11.0	
Unregistered Nurse Band 3 % Turnover Rate *	25.8	29.1	28.1	20.9	20.6	19.9	
Unregistered Nurse Band 2 Turnover Rate *	31.8	32.2	28.7	30.0	28.4	27.4	
Registered Nurse Band 5 Vacancy WTE	28.4	35.3	34.7	39.2	43.6	45.5	
Healthcare Support Worker Band 2/3 Vacancy WTE	35.26	21.73	22.22	15.67	20.3	13.28	
% Agency staff used to support substantive staff	1%	-	0%	1%	0%	2%	
% Bank staff used to support substantive staff	7%	-	7%	8%	8%	8%	
Lower than expected Staffing Incidents	15	10	20	3	2	2	
Red Flag Reported incidents	2	3	4	2	1	0	

* figures shown are Womens and Childrens. Band 6 used as most staff in Womens are Band 6 midwives.

Midwifery vacancies

There are currently 2.68 WTE vacancies in March 23. The maternity service has employed 3 international midwives (IEM) with a further 2 in the pipeline, with 10 WTE Newly Qualified Midwives planning to start in October 23. With the turnover rate and the expected dropout rate from Band 5 Registered Midwives, the midwifery vacancy rate is expected to remain stable.

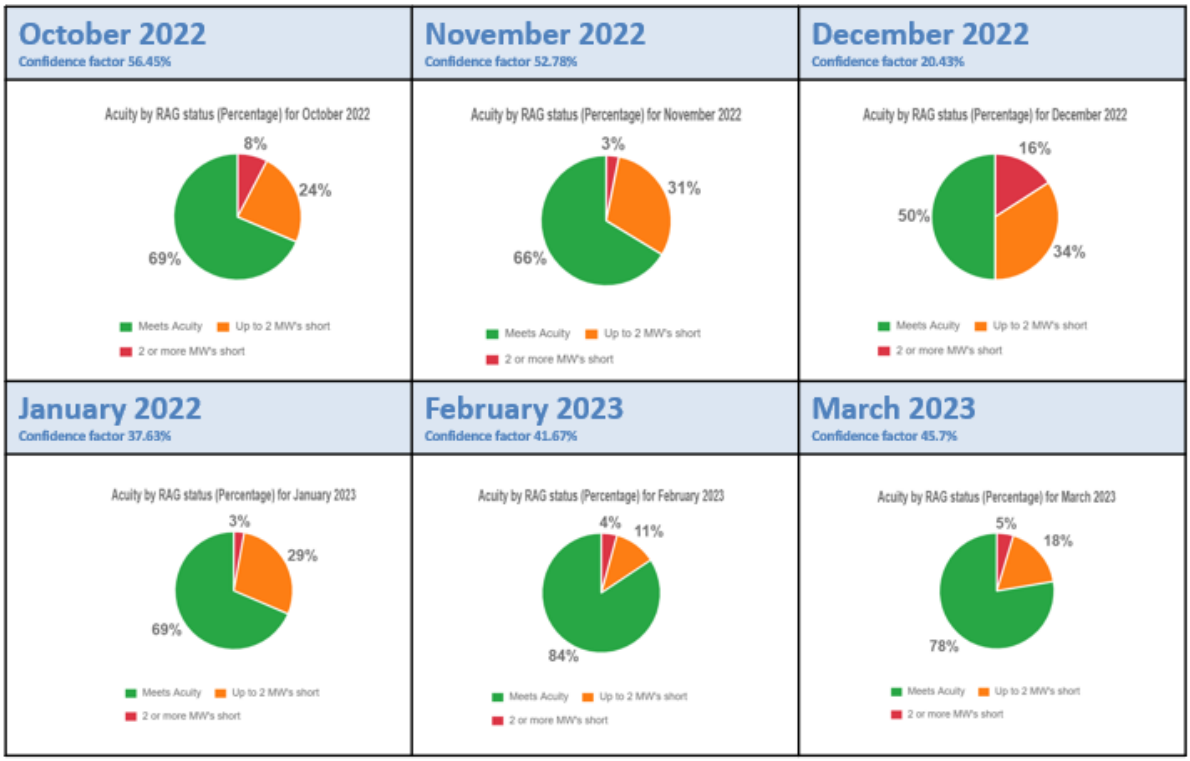
2 Nurses have commenced the Health Education England (HEE) funded 20 month shortened midwifery training programme with funding secured for a further 2 posts.

Birthrate plus Acuity Tool

Birthrate plus acuity tool has been used on delivery suite since the 01/05/2022, to assess staffing requirements against the needs of the patient. The Birthrate score system is based upon indicators of normality in the progress and outcome of labour and the health of the baby at birth, together with other indicators which identify changes from normality. The score sheet provides a research-based method to enable the midwife to assess the midwifery workload required to care for a woman at any time in the intrapartum and immediate post-delivery period.

The score sheet will also underpin the Birthrate acuity tool on the Maternity ward which covers Antenatal/Postnatal and Induction of labour.

An assessment of the patients is performed four times a day by the band 7 in charge of the unit and is recorded electronically.



Comparison of factors

- In this period, we have seen a 20% reduction in staffing factors e. g. unable to fill vacant shifts.

- Management actions have stayed static at 15%, with a small increase of 6% in redeployment of staff to maintain 1:1 care. The most significant change is the unit diverted 4 times over this period instead of 9.

The tool is embedding into everyday practice and compliance continues to be variable mainly due to the increased acuity seen over the winter. This tool can then provide greater decision support for staffing deployment in maternity services.

NICU nurse staffing

Nurse staffing has been a challenge and is the key issue driving the current restriction on cot numbers, however NICU will be at full establishment by the end of June with twenty new international nurses having commenced along with twelve newly qualified nurses. This will bring the establishment up to the level expected by the BAPM standards to staff the commissioned 22 cots. In addition to this there are plans to recruit a further Band 6 educational role to support the volume of new starters.

Patient Feedback

Women's services have a very active Patient Experience group with lay representation and have an action plan which is a result of Trust survey feedback, feedback from Maternity voices partnership and issues raised in the National maternity survey. The most recent improvement made due to feedback is to allow partners to stay on the post-natal wards to support new mothers.

Summary and Recommendations

There are challenges at times with staffing but with the flexibility of the workforce and joint working between midwifery and neonatal staffing ensures patient safety. The post-natal/ ante natal ward now has a supervisory sister and there are two supervisory Band 7's in the community teams with a plan for a further one to support the continuity teams. This continues the work to bring midwifery in line with the Trust for all clinical areas to have supervisory ward sister cover.

4. Allied Health Professionals (AHP's) report

AHPs are an integral part of the multi-disciplinary team and work across all divisions within the Trust. AHP's provide clinical care within outpatient, inpatient and community settings for local and regional patient cohorts.

The Trust provides a prosthetics and orthotics service which is outsourced in adult and children's services. The Trust also employs psychologists, platy therapists, pharmacists, healthcare scientists and bioengineers who are not included in this report.

Data Metrics

The Trust currently (April 2023) employs 9 professional groups under AHPs:

- 829 (695.84) registered Allied Health Professionals (Bands 5-8D)

- 118 (92.13 WTE) support workers and assistants (Bands 2-4) across all divisions in the Trust.

- The current AHP staffing turnover has increased and is at 18.3%, vacancies within the specialties and professional groups vary.

There is no acuity tool for AHP's at present or standard approach to inform staffing levels required in services provided by AHP's. Levels are generally determined via a range of methods, which include:

- the use of demand and capacity data,

- data collected on patient and non-patient related activity,

- patient complexity and acuity.

In addition, guidance that is nationally available for specific clinical services and/or conditions is also used e.g. stroke services, critical care and cancer services.

The current vacancy rate amongst AHP's reflects the current national trends and some groups are over recruiting i.e. Diagnostic radiographers to compensate for any leavers during the year which helps mitigate some vacancies. This has now also been implemented in Adult Therapies.

Different methods for recruitment are also being explored including open days, international recruitment and joint recruitment activity with NBT and Sirona for Occupational therapists and Physiotherapists to increase potential recruitment.

Progress on additional services such as weekend and twilight services in adult therapies have been slow due to a combination of funding and recruitment issues.

In line with national guidance the adult therapies are planning to review their job planning and productivity measures to ensure that the appropriate skill-mix is set and achieved.

Recruitment and Retention:

- The 3 key risk areas for recruitment and retention for AHP's are in the occupational therapy, radiography and sonography workforce, these areas also continue to be on the national shortage list.

- There are several retention initiatives aimed at AHP's:

    - Site integration to allow greater flexibility for cross site working.
    - Use of academic posts in higher education to support evidence-based practice and research.
    - Continued exploration of advanced and enhanced practice roles in each specialty
    - Extending work of the BNSSG AHP faculty focusing on several areas including preceptorship, apprenticeships, leadership development and student placement expansion.

Workforce Planning for the Future

- There has been an increased number of students placed within the Trust as one part of the overall strategy for recruitment.

This includes student placement on research placements as well as exploring leadership placement opportunities.

- Rolling out apprenticeships in Dietetics in Childrens' services in partnership with Sirona and progressing physiotherapy and occupational therapy apprenticeships in adult therapies.

5. Assurance statement and summary.

The Trust continues to closely monitor staffing levels and comply with the recommendations outlined in the Developing Workforce Safeguards guidance. The SNCT cycles completed over the past 12 months support the nursing establishment setting process using a recognised evidence-based approach. Noting the staffing information detailed in this report, alongside the robust escalation and mitigation of short- and long-term staffing shortfalls. In summary, the Trust has in place sufficient processes and oversight of its staffing arrangements to ensure safe staffing is prioritised as part of its routine activities, whilst also supporting development for both the registered and non-registered Nursing and Midwifery workforce and the AHP staff.

The last 6 months have continued to be an extraordinarily challenging time due to the residual effects of the pandemic with areas reconfiguring to maximise resources and the requirement to open additional escalation areas to reduce ambulance queuing and overcrowding within the ED's. The level of absence, though reduced, continues to impact staffing levels across the Trust. The Trust has, though, been successful in gradually reducing the overall level of staffing vacancies through both International Recruitment and continuing to maximize the number of newly qualified nurses recruited.

6. Recommendations for Trust Board

The Trust Board is assured that there is detailed monthly reporting to the Quality and Outcomes committee which provides fill rates by wards, red flag reporting and detailed analysis and review of all the safe staffing incidents reported, along with triangulation of impact on patient quality outcomes and staff experience.

The Trust Board is recommended to review the six-monthly safe staffing report and support the following:

- Continue the approach outlined using the Safer Nursing Care Tool (SNCT) assessments to underpin nursing establishment on all in-patient wards, both adults and children and ED's acknowledging this is a process that will evolve over time after each assessment.

- Support the process of review, enabling uplift of both Weston ED and Children's ED nursing establishment to align with recommended SNCT levels.

- Support the process of review, enabling uplift of the Paediatric Intensive Care Unit nurse staffing establishment for 18 beds as identified.

- Acknowledge the bespoke funded nursing recruitment and retention plan approved in April 2023, which includes further international recruitment, a fully funded pathway including Trainee Nurse Associate and Registered Nurse Degree apprenticeships, Funding for CPD, additional Trust wide practice educator roles, Training support staff and funding for victim support officers.

Appendix 1 Overview Grids
Division of Medicine.

- Day fill rates have been consistently lower than the night fill rates. Support and mitigation during the day was by ad hoc cover for short periods of time e.g specialist nurses, practice education team.
- Care hours per patient day CHPPD has remained consistent over the winter.
- Sickness levels remain elevated above the Trust average for the whole of the 6-month period.
- Medicine continues to have the highest level of temporary staffing use for both bank and agency as often required for short term unfunded escalation capacity in the ED and assessment areas particularly.

Division - Medicine Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Registered Nurse Fill Rate - Day	87%	91%	91%	93%	87%	88%	
Registered Nurse Fill Rate - Night	97%	100%	99%	105%	91%	101%	
Unregistered Nurse Fill Rate - Day	85%	87%	81%	86%	87%	80%	
Unregistered Nurse Fill Rate - Night	98%	102%	99%	101%	108%	96%	
All Staff Fill Rate - Overall	92%	95%	92%	96%	93%	91%	
Registered Nurse Care Hours per Patient Day	4.7	4.9	5.1	5.2	5.5	5	
Total Care Hours per Patient Day	8.4	8.9	9.0	9.4	9.8	9	
Supervisory Ward Sister %	82%	-	77%	92%	76%	80%	
Sickness	9.0%	8.6%	12.5%	9.7%	7.8%	8.1%	
Registered Nurse Band 5 % Turnover Rate	17.1	16.4	17.0	18.0	17.2	16.1	
Unregistered Nurse Band 3 % Turnover Rate	15.3	15.9	18.2	7.9	8.5	7.4	
Unregistered Nurse Band 2 % Turnover Rate	27.6	25.4	25.1	38.1	38.1	32.6	
Registered Nurse Band 5 Vacancy WTE	78.2	86.1	83.6	83.4	85.2	85.5	
Healthcare Support Worker Band 2/3 Vacancy WTE	75.1	81.8	84.8	76.8	77.0	76.2	
% Agency staff used to support substantive staff	15%	14%	15%	17%	17%	14%	
% Bank staff used to support substantive staff	21%	22%	22%	22%	24%	25%	
Lower than expected Staffing Incidents	54	29	34	24	19	10	
Red Flag Reported incidents	23	6	14	11	5	1	

Specialised Services

- The high requirement for HCSW overnight continues to support the care of vulnerable patients at night requiring enhanced care observation.
- The RN CHPPD is higher reflecting the increased requirement for specialist nursing e.g., oncology, haematology and specialist cardiac care.
- The turnover rate for Band 5 RNs has steadily decreased over the last 6 months.
- There has been an improvement in the Supervisory Ward Sister fill from the previous 6-month period.
- The number of red flag incidents has decreased back down to pre-Covid numbers now that the level of vacancies in the Division has reduced.

Division - Specialised Services Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Registered Nurse Fill Rate - Day	88%	89%	87%	88%	87%	89%	
Registered Nurse Fill Rate - Night	91%	91%	92%	90%	91%	92%	
Unregistered Nurse Fill Rate - Day	88%	89%	94%	89%	99%	80%	
Unregistered Nurse Fill Rate - Night	137%	130%	127%	124%	159%	116%	
All Staff Fill Rate - Overall	93%	93%	93%	92%	96%	91%	
Registered Nurse Care Hours per Patient Day	6	6.3	6.3	6.3	6.2	6.6	
Total Care Hours per Patient Day	8.1	8.7	8.5	8.7	8.7	8.9	
Supervisory Ward Sister %	77%	-	61%	90%	73%	80%	
Sickness	7.7%	7.7%	10.0%	9.7%	7.2%	5.5%	
Registered Nurse Band 5 Turnover Rate	17.6	16.4	16.4	15.4	13.7	14.4	
Unregistered Nurse Band 3 % Turnover Rate	23.5	21.7	19.1	14.2	14.1	13.7	
Unregistered Nurse Band 2 % Turnover Rate	19.1	22.2	24.3	37.4	39.4	35.5	
Registered Nurse Band 5 Vacancy WTE	58.8	34.3	45.4	48.4	46.5	54.6	
Healthcare Support Worker Band 2/3 Vacancy WTE	28.18	26.78	28.73	29.29	30.62	28.53	
% Agency staff used to support substantive staff	6%	-	8%	6%	5%	5%	
% Bank staff used to support substantive staff	14%	-	16%	14%	15%	15%	
Lower than expected Staffing Incidents	11	4	6	7	0	9	
Red Flag Reported incidents	4	3	5	2	0	1	

Division of Surgery

- The RN CHPPD level is higher reflecting the increased requirement for specialist nursing e.g. Critical care beds.

- The day HCSW fill rate has decreased over the 6-month period, this is reflected in the increased vacancy level for band 2 but also because of the 2/3 band reviews that have impacted on HCSW numbers.

- The Supervisory Ward Sister % fill rate has increased over the 6-month period and is now consistently above 70%.

- Red flag reports for low staffing events have reduced, this is in part due to the decreased vacancy level experienced.

Division - Surgery Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Registered Nurse Fill Rate - Day	84%	83%	81%	85%	82%	88%	
Registered Nurse Fill Rate - Night	87%	88%	87%	90%	88%	94%	
Unregistered Nurse Fill Rate - Day	81%	80%	87%	81%	79%	73%	
Unregistered Nurse Fill Rate - Night	130%	113%	130%	113%	124%	104%	
All Staff Fill Rate - Overall	90%	88%	90%	89%	89%	89%	
Registered Nurse Care Hours per Patient Day	6.6	7.2	6.9	7.0	7.2	7.7	
Total Care Hours per Patient Day	9.9	10.6	10.2	10.2	10.4	10.8	
Supervisory Ward Sister %	39%	-	67%	92%	74%	79%	
Sickness	9.9%	6.9%	8.5%	6.6%	7.5%	6.9%	
Registered Nurse Band 5 Turnover Rate %	17.1	17.9	16.7	17.2	17.3	17.3	
Unregistered Nurse Band 3 % Turnover Rate	10.1	10.2	9.4	4.4	7.5	9.7	
Unregistered Nurse Band 2 % Turnover Rate	11.2	13.1	13.4	18.1	16.1	12.6	
Registered Nurse Band 5 Vacancy WTE	58.0	51.9	57.1	54.4	46.1	34.0	
Healthcare Support Worker Band 2/3 Vacancy WTE	33.27	30.15	31.43	34.48	33.79	31	
% Agency staff used to support substantive staff	12%	-	10%	8%	7%	8%	
% Bank staff used to support substantive staff	18%	-	17%	17%	16%	17%	
Lower than expected Staffing Incidents	25	10	24	18	8	22	
Red Flag Reported incidents	9	3	8	2	0	2	

Division of Childrens' Services

- Fill rates in both RN and HCSW remain lower than the Trust average due to the increased vacancy levels across both RN's and HCSWs. Support for wards has been provided by Supervisory Ward Sisters joining the numbers and Clinical Nurse Specialist teams working on their specialist ward.

- The CHPPD is greater than the Trust average due to the specialist nature and higher ratios required to care for children.

- The RN and HSCW turnover rates remain elevated above the Trust level. The pipeline is strong with newly qualified and international nurses commencing Autumn 2023. To mitigate the vacancies there are some bank incentives in place, an increased use of agency staff and where necessary the closure of beds to ensure safety is maintained.

Division - Childrens Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Registered Nurse Fill Rate - Day	82%	89%	84%	87%	84%	87%	
Registered Nurse Fill Rate - Night	82%	87%	82%	85%	85%	86%	
Unregistered Nurse Fill Rate - Day	67%	69%	71%	70%	85%	71%	
Unregistered Nurse Fill Rate - Night	52%	62%	60%	60%	69%	63%	
All Staff Fill Rate - Overall	78%	84%	80%	82%	83%	80%	
Registered Nurse Care Hours per Patient Day	11.0	10.5	10.2	10.5	10.0	10.3	
Total Care Hours per Patient Day	12.7	12.2	12.2	12.5	11.8	12.1	
Supervisory Ward Sister Time	64%	-	60%	88%	62%	66%	
Sickness	6.9%	6.0%	9.1%	6.6%	6.4%	6.8%	
Registered Nurse Band 5 Turnover Rate % *	20.8	21	20.6	20.1	18.6	19.7	
Unregistered Nurse Band 3 % Turnover Rate *	25.8	29.1	28.1	20.9	20.6	19.9	
Unregistered Nurse Band 2 %Turnover Rate *	27	24.1	21.3	31.7	28.6	29.1	
Registered Nurse Band 5 Vacancy WTE*	63.4	67.7	70.3	78.1	82.8	79.4	
Healthcare Support Worker Band 2/3 Vacancy WTE*	21.01	21.73	22.22	15.67	20.3	13.28	
% Agency staff used to support substantive staff	7%	-	5%	8%	9%	12%	
% Bank staff used to support substantive staff	6%	-	7%	7%	7%	7%	
Lower than expected Staffing Incidents	18	17	21	15	9	19	
Red Flag Reported incidents	1	1	6	0	5	2	

*Figures shown are for the Women's and Childrens Division. Band 5 vacancy figures are used in Childrens as Midwives are predominantly band 6. The HCSW figures are at Women's and Childrens level not just Childrens.

Weston Division (Weston General Hospital)

- The overall fill rate has remained above 90% for the whole of the period. The HCSW fill rate at night has been above 100% for nights to support the confused and vulnerable patients overnight.

- The RN CHPPD for Weston continues to be lower than in all areas in the BRI but closer to Medicine in comparison. This is likely reflected in the variable case mix seen by Weston Hospital.

- Supervisory Ward sister % fill is improving as the vacancy levels decrease.

- The vacancy level and turnover for RN's is on a downward trend with a strong pipeline identified for the future.

- Red flag submissions have reduced over this period as the RN vacancy level decreased.

Division - Weston Measure	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Registered Nurse Fill Rate - Day	84%	88%	85%	87%	87%	89%	
Registered Nurse Fill Rate - Night	89%	94%	88%	95%	84%	97%	
Unregistered Nurse Fill Rate - Day	92%	91%	87%	96%	87%	92%	
Unregistered Nurse Fill Rate - Night	109%	112%	103%	113%	105%	110%	
All Staff Fill Rate - Overall	93%	95%	90%	96%	90%	96%	
Registered Nurse Care Hours per Patient Day	3.3	3.4	3.2	3.2	3.6	3.6	
Total Care Hours per Patient Day	6.5	6.7	6.4	6.4	7.1	7.0	
Supervisory Ward Sister %	66%	-	69%	91%	72%	70%	
Sickness	7.5%	8.4%	9.6%	7.2%	6.7%	6.8%	
Registered Nurse Band 5 Turnover Rate	16.3	15.0	15.2	13.4	13.9	12.1	
Unregistered Nurse Band 3 % Turnover Rate *	6.0	6.0	6.0	0.8	3.5	7.3	
Unregistered Nurse Band 2 Turnover Rate	22.8	23	20.7	33.4	36.5	34.5	
Registered Nurse Band 5 Vacancy WTE	31.3	28.4	21.7	17.8	13.3	18.9	
Healthcare Support Worker Band 2/3 Vacancy WTE	35.26	29.58	30.56	22.28	24.41	22.35	
% Agency staff used to support substantive staff	6%	-	7%	5%	7%	5%	
% Bank staff used to support substantive staff	19%	-	19%	18%	19%	20%	
Lower than expected Staffing Incidents	11	17	29	17	5	5	
Red Flag Reported incidents	8	11	18	11	1	2	

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**Research and Innovation Report**
Report Author	**David Wynick, Joint Director of Research**
Executive Lead	**Stuart Walker, Chief Medical Officer**

1. Purpose	
The purpose of this report is to provide an update on performance and governance for the Board.	
2. Key points to note *(Including any previous decisions taken)*	
See executive summary in written report.	
3. Strategic Alignment	
Aligns with strategic priority “Innovate and Improve together”	
4. Risks and Opportunities	
Two draft risks are linked to bullet points two and three within ‘Risks and Threats’ under section 4. These are risks 6772 and 6773.	
5. Recommendation	
This report is for Information	
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**	
N/A	**N/A**

Research & Development Board Report: June 2023

1. Executive Summary

Post pandemic, Research Recovery and Reset is still a high priority for the DHSC and NIHR, in the context of continued pressure on NHS capacity which also impacts on clinical research. Nationally, the Reset programme is having a positive impact; locally we are engaging with funders and research teams for our NIHR UHBW-sponsored studies, focusing on recruiting participants to time and target.

Across the UK, commercial contract studies are recovering less quickly than non-commercial. To help address this, and to maintain the UK as a desirable location for industry-sponsored clinical research, DHSC and NHSE have written to NHS sites asking them to expedite the set up and delivery of commercial contract studies. We are working closely with teams to support rapid setup, and ensure we focus on keeping studies in the pipeline that are viable (i.e., it will be possible to recruit to time and target) and for which setup is best use of limited resources, whilst maintaining a portfolio that remains relevant to our patient population. This activity is being supported by our commercial research manager, whose role now extends to working jointly across both UHBW and North Bristol Trust.

We are working closely with the CRN to prepare for a range of commercial trials which are in development by a range of sponsors for novel mRNA cancer and non-cancer vaccines.

The core team and department supporting research across UHBW has been renamed as R&D (Research and Development) rather than R&I. This change was implemented across both UHBW and NBT to provide clarity for our service users, against the backdrop of the implementation of the Patient First Programme, which has a clear focus on “innovate to improve” our services.

2. *Performance*

The Clinical Research Network High Level Objectives now prioritise two areas: recruitment of the target number of participants within the agreed time period (as above) and feedback from patients about their experience in clinical research. As noted above, we are focussing on ensuring our portfolio of research is deliverable, with particular emphasis on our sponsored studies. We work closely with the CRN in this and are well supported. Our performance in the Participant in Research Experience Survey (PRES) remains good and is supported by PRES champions across UHBW.

3. *Infrastructure Funding/ hosting*

The outcome of bids for the new NIHR Research Support Service has been notified to contract holders. This is the replacement for the NIHR Research Design Service, which provides signposting, methodological and statistical support to NIHR grant applicants. The Southwest bid, with the main contract holder in Exeter, was not successful, and we are working through the complex implications for the region beyond the end of the contract in October 2023.

The contracts with host organisations for the NIHR Clinical Research Networks have been extended by 6 months, pending formal public announcements about hosting arrangements for the new NIHR Regional Research Delivery Networks and the co-ordinating centre. Staff have been appointed to support the smooth transition from CRN to RRDN.

4. Overview

Successes	Priorities
• Successful launch of the new NIHR Bristol Biomedical Research Centre • Development and central delivery of a suite of training to support new and existing research delivery staff in place • Successful delivery of Clinical Research Start up Seminars with very positive feedback • 1st UK patients recruited in 4 commercial studies in W&C, Weston (Dermatology) and Specialised Services (one in Cardiology, one in Haematology)	• Position the Bristol NIHR CRF as a specialist centre of early phase research within the South West, engage with industry partners, and maximise the research the CRF can support • Review baseline data collected from staff and patients on their research awareness and develop appropriate communication strategies and improve engagement. • Continue to work with the NIHR to expedite set up of commercial contract research. • Optimise our research portfolio for continued deliverability and relevance to our patient population across Bristol and Weston.
Opportunities	**Risks and Threats**
• Introduce research link staff to raise the profile of research and awareness about the value of research to the NHS. • Collect protected characteristics data for research participants as a pilot in the CRF with the aim of identifying ways to include a wider and more diverse group of patients and the public in clinical research. • Use learning gained from our new joint working arrangements to benefit our commercial research portfolio. • Work with our BHOC team to improve setup times and deliverability of our adult cancer portfolio using patient first and other mechanisms.	• Risk that industry sponsors may place commercial trials in other centres due to the backlog of studies and slow set up times in some areas, alongside potential loss of reputation and income. • Workforce issues are being felt across research teams, resulting in high numbers of vacancies and consequent reduction in capacity to deliver research, both in clinical and support services. This has been compounded by industrial action. • After the Research Design Service contract ends in October 2023, there is lack of clarity about how we will support researchers and transition to the new Research Support Service which will be operated on a virtual basis outside our region. • Longer term there is uncertainty around what measures the new NIHR Regional Research Delivery Network will implement to measure performance when they commence in autumn 2024.

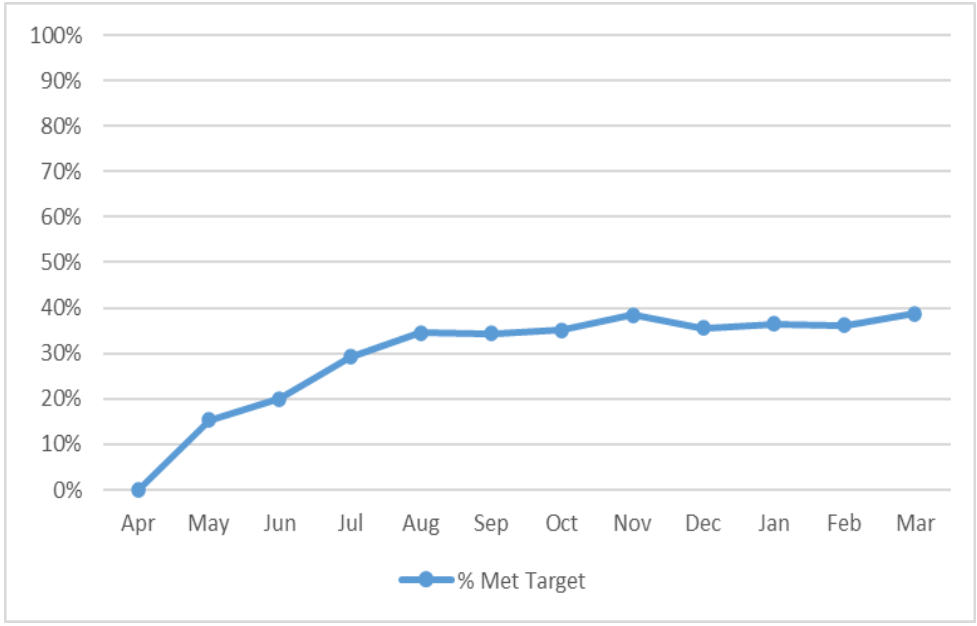
Research & Development Board Report: June 2023

5. Performance Overview

This section provides information about performance against key performance indicators. All KPIs are financial or drive the income we receive.

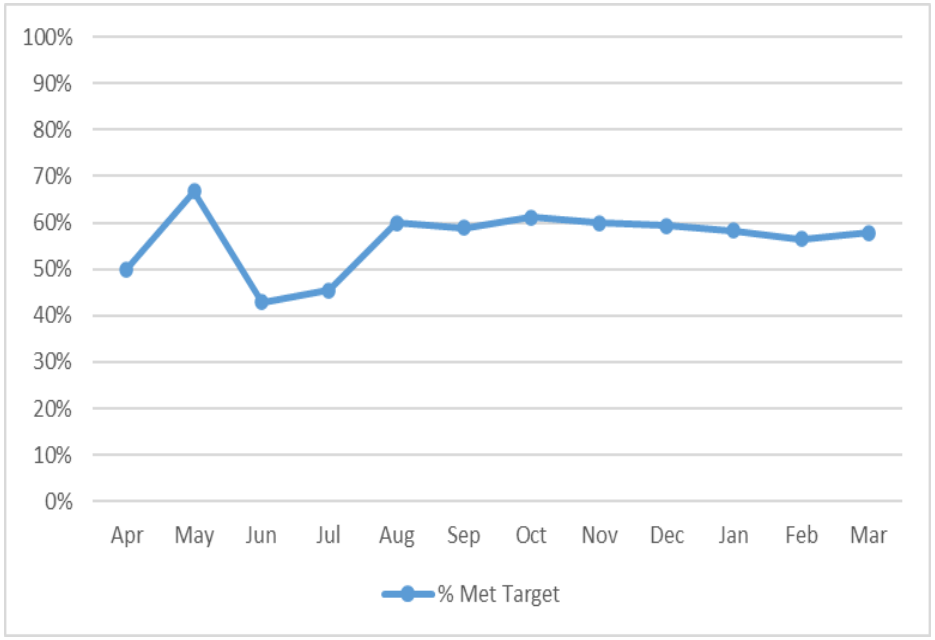
a) Cumulative Recruitment to Commercial and Non-Commercial NIHR Studies

b) Proportion of closed non-commercial NIHR studies achieving or surpassing their recruitment target

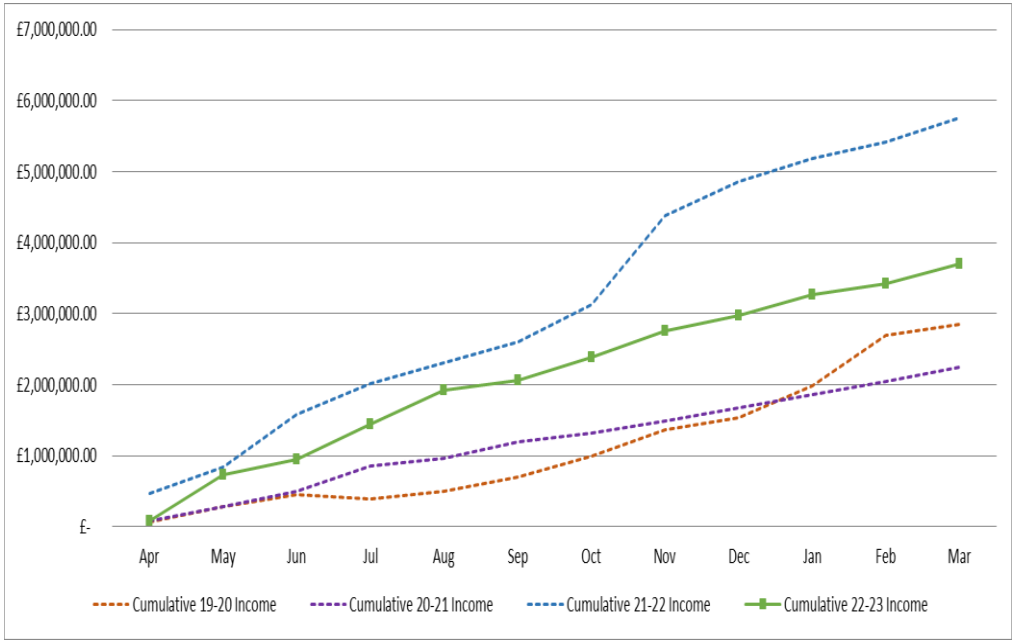


Research & Development Board Report: June 2023

c) Proportion of closed commercial NIHR studies achieving or surpassing their recruitment target

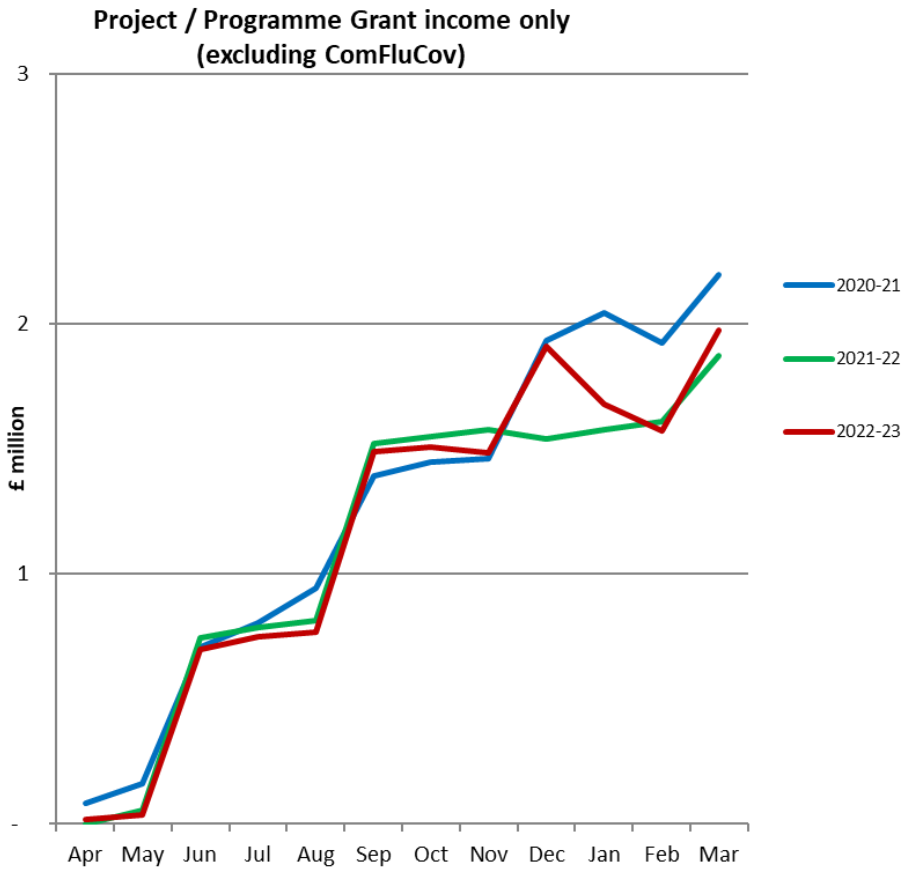


d) Monthly commercial income

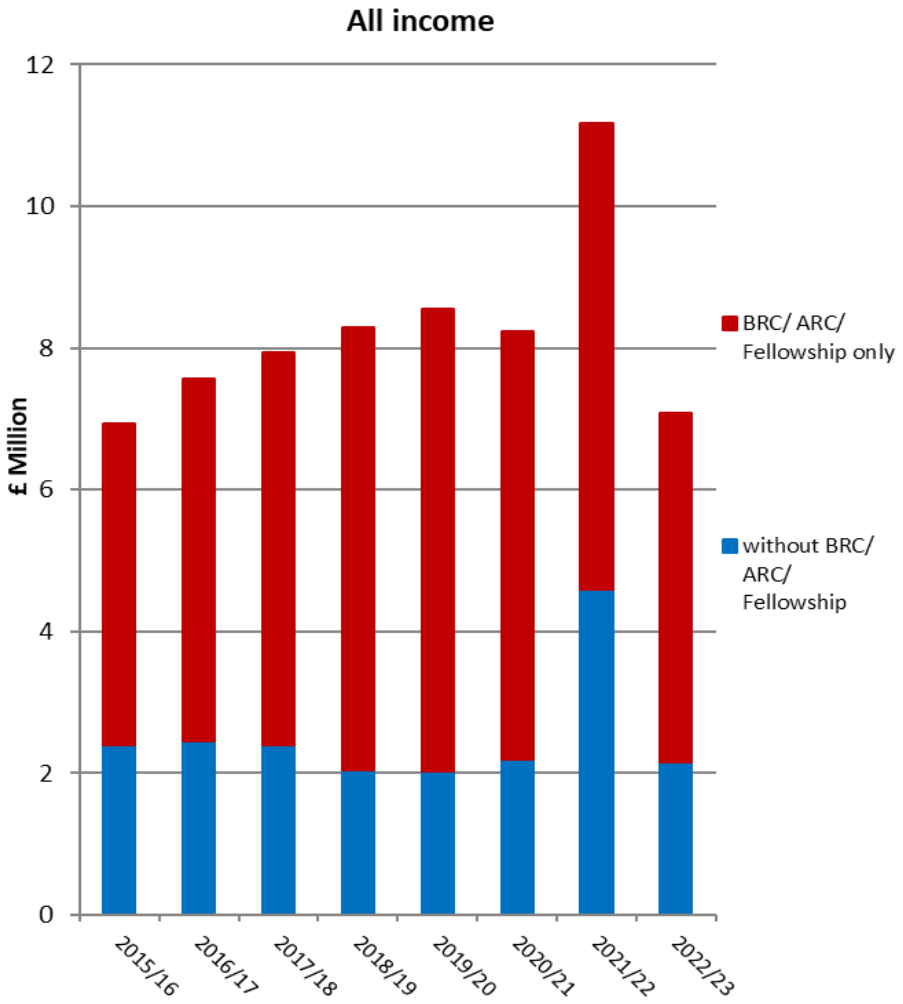


Research & Development Board Report: June 2023

e) NIHR monthly grant income – year on year comparison



f) NIHR grant income – drives research capability funding



University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Trust Board of Directors in Public on Thursday 15 June 2023

Reporting Committee	**Finance & Digital Committee – meeting held on 25th April 2023**
Chaired By	**Martin Sykes, Non-Executive Director**
Executive Lead	**Neil Kemsley, Chief Financial Officer**

For Information

Digital Services Report

The Committee received an update on the ongoing digital projects, of note being the start of back scanning eye hospital clinical notes (160,000 notes to be digitised) and the ongoing progress with the implementation of digital noting in outpatients.

Progress on Electronic Prescribing (Careflow Medicines Management) was presented in the form of a 'deep dive'. The Committee noted the risks and benefits of the rollout with the first go-live planned for June 2023.

Finance Report

The Committee received the 2022/23 year-end financial report and were pleased to note the small surplus achieved against the planned break even.

The Committee noted the delivery of the 2022/23 savings plans and that a proportion of these were non-recurrent.

Financial and Digital risks were reviewed. The Committee discussed how financial and performance delivery might be best monitored in 2023/24 and in particular how operational efficiency might be measured and benchmarked. This and other Board Committees would need to monitor and drive efficiency in their domains.

The Committee terms of reference were reviewed with the main change being the addition of Estates to the Finance and Digital Committee. This change was supported and the revised ToR recommended to the Board.

For Board Awareness, Action or Response

Revised Committee Terms of Reference to be approved.

Note the requirement for a greater focus on operational efficiency to support the delivery of the financial and operational plans for 2023/24

Key Decisions and Actions

None

University Hospitals Bristol and Weston NHS Foundation Trust

Additional Chair Comments
None

Date of next meeting:	**25th May 2023**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**M1 Trust Finance Performance Report**
Report Author	**Jeremy Spearing, Acting Chief Financial Officer**
Executive Lead	**Jeremy Spearing, Acting Chief Financial Officer**

1. Purpose

To inform the Trust Board of the Trust's financial performance for April 2023.

2. Key points to note *(Including any previous decisions taken)*

The Trust's month 1 net income and expenditure position is a net deficit of £3.9m against a planned deficit of £2.3m. The adverse position against plan is due to higher than planned operating expenditure driven by additional activity related non pay costs and a shortfall in savings delivery.

Elective activity delivery was ahead of plan in April at 105% of plan for day cases and 104% of plan for inpatients.

The Trust's cash position increased to £136.5m in April.

2023/24 savings - The Trust delivered savings of £0.8m in April, £0.7m behind plan. The forecast for recurrent savings delivery is £4.4m, a shortfall of £7.2m excluding system transformation savings. All services will be supported to identify 75% of their recurrent savings target by the end of June.

The Trust delivered capital investment of £3.2m in April, broadly in line with plan.

3. Strategic Alignment

This report is directly linked to the Patient First objective of 'Making the most of our resources'. Achieving break-even ensures our cash balances are maintained and therefore we can continue to support the Trust's strategic ambitions subject to securing CDEL cover.

4. Risks and Opportunities

416 – Risk that the Trust fails to fund the strategic capital programme. Unchanged risk score of 20 (very high).

5. Recommendation

This report is for Assurance

The Board is asked to note the Trust's financial performance in April.

6. History of the paper

Please include details of where paper has <u>previously</u> been received.

Finance and Digital Committee	Thursday 25th May 2023

University Hospitals Bristol and Weston NHS Foundation Trust

Trust Finance Performance Report

Reporting Month: April 2023

Executive Summary

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2023

YTD Income & Expenditure Position	• Net I&E deficit of £3,949k against a deficit plan of £2,261k (excluding technical items). • Total operating income is £740k adverse to plan due to higher than planned income from activities of £305k and lower than planned other operating income of £1,045k. • Operating expenses are £1,625k adverse to plan primarily due to higher non- pay expenditure. Pay and depreciation are broadly in line with plan. • Technical and financing items are £410k favourable to plan.
Key Financial Issues	• *Recurrent savings delivery below plan* – Trust-led CIP delivery is £827k or 55% of plan, of which recurrent savings are £198k, 13% of plan. Failure to achieve the annual target of £27m (including transformational savings) in full may result in the Trust failing to meet the financial plan. • *Delivery of elective activity recovery below plan* – elective activity must be delivered in line with plan. Failure to do so will result in a loss of income of up to c£30m which may result in the Trust not achieving its financial plan. • *Corporate mitigations not delivered in full* – non-recurrent mitigations of c£25m must be achieved to support delivery of the plan. • *Failure to deliver the financial plan* – failure to deliver the actions and therefore the financial plan will result in regulatory intervention and the risk of the Trust going into 'special measures'.
Strategic Risks	• Assessment and implications of the financial arrangements relating to Healthy Weston 2 Phase 2 – pending completion of the business case in December 2023; • Understanding the risks and mitigations associated with the capital regime; and how the CDEL limit and system prioritisation restricts future strategic capital investment – pending completion of the Trust's capital plan for 2023/24 and 2024/25. • Understanding the implications of the Trust's recurrent deficit of c£60m, the requirement to implement a 3 year Financial Recovery Plan to address the recurrent deficit and the impact this will have on future investment decisions and autonomy.

Reporting Month: April 2023

Successes	Priorities
• Delivery of capital investment of £3.2m in April, broadly in line with plan. • The Trust's cash position remains strong at £136.5m. • BPPC continues to be maintained with 89% of invoices by value and 90% by volume paid within 30 days. • Elective activity delivery in April is higher than plan at c105% for inpatients and day cases.	• Divisions to prioritise the delivery of their 2023/24 operating plans, including recovery of elective activity to planned levels to enable the Trust to retain ERF. • Divisions and Corporate Services to ensure recurrent CIP schemes are fully identified in Q1 to meet 2022/23 recurrent CIP shortfall and 2023/24 target. • Delivery of the Trust's non-recurrent corporate mitigations. • Re-assessment of the Trust's underlying financial position from 2022/23 actual outturn as a starting point for its financial recovery plan. • Finalisation of the 2023/24 capital programme. • EROS requisitioners and budget managers must receipt orders and code invoices promptly to ensure payment within 30 days.
Opportunities	**Risks & Threats**
• Dialogue with regional and national Specialised Commissioning colleagues in relation to CDEL uplifts to accommodate the hosting of regional specialist tertiary services. • Progress continues on Community Diagnostics Centre Business Case to NHSE to support elective recovery.	• Workforce supply challenges to fill vacant posts and staff absences continues to impact on the Trust's ability to meet emergency and elective demand. • System challenges with patient flow continues to undermine elective activity recovery plans, especially tertiary activity. • Under-delivery on the Trust's recurrent savings programme will contribute to a deterioration in the Trust's underlying deficit. • CDEL and the underlying revenue financial position of the Trust and the system is likely to constrain the Trust's strategic capital plans over the next three financial years.

Financial Performance – Income & Expenditure

April 2023

Trust Year to Date Financial Position

	Month 1		
	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's
Income from Patient Care Activities	79,424	79,729	305
Other Operating Income	9,273	8,228	(1,045)
Total Operating Income	**88,697**	**87,957**	**(740)**
Employee Expenses	(55,550)	(55,465)	85
Other Operating Expenses	(31,707)	(33,413)	(1,706)
Depreciation (owned & leased)	(2,908)	(2,913)	(5)
Total Operating Expenditure	**(90,165)**	**(91,790)**	**(1,625)**
PDC	(1,037)	(1,037)	0
Interest Payable	(221)	(218)	3
Interest Receivable	250	515	265
Other Gains/(Losses)	0	0	0
Net Surplus/(Deficit) inc technicals	**(2,476)**	**(4,574)**	**(2,098)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	215	625	410
Net Surplus/(Deficit) exc technicals	**(2,261)**	**(3,949)**	**(1,688)**

Key Facts:

- The position at the end of April is a net deficit of £3,949k against a deficit plan of £2,261k.
- During April, the Trust spent £542k on costs associated with internationally educated nurses.
- Pay expenditure in April is in line with plan at £55,465k, but c£1,500k higher than the run rate. This is driven by increased enhanced payments due to bank holidays and cover during the periods of industrial action.
- Agency expenditure in month is £2,415k, compared with £2,981k in March. Overall, agency expenditure in month is 4% of total pay costs.
- Other operating expenditure in April is c£4,000k higher than the average for Q4 2022/23 but £1,706k higher than plan. This is mainly due to higher than expected costs on clinical supplies, reflecting an increase in activity during the month.
- Operating income is marginally behind plan in April due to lower than planned 'other operating expenditure'.
- Trust-led CIP achievement for the year is 55% of plan at £827k, excluding system transformation plans.

Savings – Cost Improvement Programme

NHS University Hospitals Bristol and Weston NHS Foundation Trust

April 2023

Divisional Finance Report Apr – 2023/24 Savings Programme Summary including 2022/23 recurring shortfall carry forward

Division	2023/24 Programme			Progress to Date					Forecast Outturn					Full Year Forecast Outturn	Full Year Forecast Outturn Variance
				2023/24 Programme					2023/24 Programme						
									Current Year						
	2022/23 Recurrent shortfall	2023/24 Target (1.1%)	2023/24 Total Plan	Plan	<-------- Actual -------->			Variance	Plan	Recurring	Non-Recurring	Total	Variance		
					Recurring	Non-Recurring	Total	Fav / (Adv)					Fav / (Adv)		Fav / (Adv)
Financial Performance	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Diagnostics & Therapies	1,496	887	2,383	182	20	174	194	12	2,383	322	2,223	2,544	161	354	(2,029)
Medicine	1,065	1,047	2,112	134	44	107	151	17	2,112	1,282	1,310	2,592	480	1,320	(793)
Specialised Services	596	1,062	1,658	108	39	73	111	3	1,658	764	1,187	1,951	294	929	(728)
Surgery	1,307	1,625	2,932	240	3	34	37	(202)	2,932	301	410	712	(2,221)	390	(2,542)
Weston	5	505	510	41	18	13	30	(11)	510	232	150	383	(127)	241	(269)
Women's & Children's	2,124	1,663	3,787	308	11	176	187	(121)	3,787	268	2,170	2,439	(1,348)	273	(3,514)
Estates & Facilities	484	544	1,028	74	26	34	59	(15)	1,028	439	359	798	(230)	487	(542)
Finance	125	120	245	20	20	–	20	0	245	245	–	245	0	245	0
HR	–	135	135	11	8	6	14	3	135	100	67	167	32	100	(35)
Digital Services	366	208	574	58	1	14	14	(44)	574	8	41	49	(525)	8	(566)
Trust HQ	348	221	569	47	8	–	8	(40)	569	94	0	94	(475)	94	(476)
Corporate	231	(40)	191	16	–	–	–	(16)	191	–	–	–	(191)	–	(191)
UHBW merger benefits	–	1,200	1,200	100	–	–	–	(100)	1,200	–	–	–	(1,200)	–	(1,200)
OP Transformation & Demand Management	–	1,875	1,875	156	–	–	–	(156)	1,875	–	–	–	(1,875)	–	(1,875)
			–												
Divisional Sub Totals	8,147	11,053	19,200	1,496	198	629	827	(669)	19,200	4,056	7,918	11,974	(7,226)	4,441	(14,759)
System Transformational Plans	–	7,850	7,850	–	–	–	–	–	7,850	–	–	–	(7,850)	–	(7,850)
Grand Totals	8,147	18,903	27,050	1,496	198	629	827	(669)	27,050	4,056	7,918	11,974	(15,076)	4,441	(22,609)

Key Points:

- The Trust's 2023/24 savings target is £27,050k. This includes £7,850k attributable to planned system transformation savings.
- At the end of April, the Trust had achieved savings of £827k, or 55% against a plan of £1,496k, resulting in a shortfall of £669k.
- System savings are not planned to deliver until July 2023.
- The current year forecast outturn for 2023/24 is £11,974k against a plan of £27,050. £7,850k of the shortfall currently assumes under delivery of system savings, pending assessment.
- The recurring forecast outturn for the 2023/24 is £4,441k resulting in a shortfall of £22,609k, £7,850 is attributable to system saving plans.
- At the end of April, all divisions apart from Finance, had a shortfall against their recurring plans and six of the divisions had a shortfall against their non-recurring plans.
- Currently 66% of forecast savings are non-recurrent, which is a major cause for concern. A step change in identification and delivery is paramount to securing the full delivery of CIP on a recurring basis.

Appendix 1 – Action Log & Developments

Summary of Recovery Actions

Ref	Date	Description of Action	Action Owner	Date Due	Committee Month	Status	Revised date	Update
014	Jun-21	Present the Trust Five Year Financial Strategy	OpDoF	Oct-21	November	Open	Q2 2023/24	Pending the release of the BNSSG ICB Joint Clinical Strategy – expected June 2023
030	May-22	Include a summary of the ICS financial position	HoFFP	TBC		Open		Reporting of the ICS financial position currently under discussion
036	Jun-22	Development of a financial recovery plan	CFO	Nov-22	December	Open	Q2 2023/24	BNSSG ICB will require a three year financial recovery plan by the end of Q2 2023 that addresses the Trust's recurrent deficit.
044	Jul-22	Review and address increased costs for patient transport services. (Trust Services)	HoFMI	Aug-22	September	Open	TBC	Subject to system wide procurement of non-emergency patient transport during Q4 - system process not yet concluded (March 2023)
047	Nov-22	Focus on increasing Somerset Surgical Services activity through theatres.	HoFMI	Mar-23	April	Open	Q1 2023/24	
050	Dec-22	HFMA A9/E - Review existing process for identification of CIP to ensure robustness, increasing clinical and operational collaboration and the system.	HoFMI	Q4	April	Open	Q1 2023/24	Action from HFMA Checklist Self-Assessment
051	Dec-22	HFMA A11 - Establish a programme of work to support the productivity agenda	HoFMI	Q4	April	Open	Q1 2023/24	Programme to be established during Q1 2023/24
052	Dec-22	HFMA C2 - Review where run-rate reporting is being used routinely and identify where additional reporting may be beneficial.	HoFFP	Apr-23	May	Open		Action from HFMA Checklist Self-Assessment
054	Dec-22	HFMA G5 - Review policies to identify gaps	HoFFP	Jan-23	February	Open	Q1 2023/24	Review has been re-prioritised due to operational planning commitments. However, the department is represented in the membership of the Trust's Policy Group. Current finance policies remain in date.
055	Dec-22	HFMA H - Rollout revised financial training programme	HoFFP	Apr-23	May	Open	Q2 2023/24	Planning for the financial training programme will commence Q2 2023/24.

Key:

Role	Description	Name
CFO	Chief Financial Officer	Neil Kemsley
OpDoF	Operational Director of Finance	Jeremy Spearing
HoFMI	Head of Financial Management & Improvement	Dean Bodill
HoFFP	Head of Finance - Financial Performance	Kate Herrick

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**Freedom to Speak Up Annual Report 2022/23**
Report Author	**Eric Sanders, Freedom to Speak Up Guardian** **Kate Hanlon, Deputy Freedom to Speak Up Guardian**
Executive Lead	**Emma Wood, Chief People Officer**

1. Purpose

To present the annual Freedom to Speak Up Report to the Board for information and discussion to support cultural change in the Trust.

2. Key points to note *(Including any previous decisions taken)*

- There is an increasing level of threat to staff from internal (e.g. operational pressures, environment) and external sources (cost-of-living crisis, pay, industrial action) which are impacting on the culture within the Trust.
- The latest NHS Staff Survey results shows a further decline in the percentage of respondents who felt safe to speak up and had confidence in the Trust's response if they did speak up. Only two thirds of the staff who responded said they felt safe to speak up and just over half felt confident in the Trust's response.
- There have been many encouraging achievements in the year, including positive responses from managers to concerns raised, improved awareness of speaking up through increased training compliance, greater visibility of the Freedom to Speak Up Guardians and Champions, cross system working and influencing to change processes to address concerns particularly around perceived unfairness at times with recruitment.
- Areas which require further improvement though relate to how managers, in some areas, respond to concerns and the individuals who are raising the concerns. In some rare instances, individuals are seen as troublemakers or agitators, and their concerns can be dismissed/not taken seriously. There are concerns which have not been resolved even though they were raised some years ago via the Freedom to Speak Up (FTSU) process and subsequently closed. This lack of perceived response has a detrimental impact on the culture and the effectiveness of the FTSU process.
- Further work is underway, aligned with Patient First, and supported by the Director of Performance, to understand and triangulate data which will help to pinpoint whether further targeted support might be required for services to support cultural change.
- The FTSU Guardian and Champions are supporting the launch of the Respecting Everyone framework later in the year to help support different conversations at an early stage and a positive change to organisational culture.

3. Strategic Alignment
This report seeks to flag key issues for the Board in relation to the development of the culture of UHBW, which will support the achievement of the Trust's strategy.
4. Risks and Opportunities
The main risks and opportunities associated with this report include: • The increasing level of internal and external threats to staff are impacting on engagement and confidence in the Trust to act on concerns. • By not addressing longstanding concerns, the Trust is not taking the opportunity to give confidence that concerns will be addressed and support further speaking up. • There remain some areas in the Trust where managers and leaders do not respond positively to staff raising concerns, which is having an impact on worker experience and workplace culture.
5. Recommendation
This report is for Assurance The Board is asked to note the contents of the Annual Report for 2022/23 and discuss the actions it should now take in response.
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**
N/A

Freedom to Speak Up Annual Report 2022/23

1. Purpose

1.1. To present the annual Freedom to Speak Up Report to the Board for information and discussion to support cultural change in the Trust.

2. Introduction

2.1. Everyone who speaks up at UHBW is asked for their feedback on the process and their experience. This quote is shared with the permission of the individual. It is a helpful reminder to the Board of the way that staff sometimes feel and sets the context for the challenge the organisation faces in implementing cultural change:

*"In terms of how the Trust treats its employees in the future to ensure nobody else has to go through what I've been through – openness, honesty and transparency. The ability to recognise failures and apologise for them would be hugely beneficial for both the Trust and its employees. It's not rocket science, it's basic humanity. Stop the 'corporate cr*p' and think about the individual."*

3. Context/Background

3.1. The report by Sir Robert Francis, *Freedom to Speak Up: An Independent review into creating an open and honest reporting culture in the NHS (2015)* highlighted 20 Key Principles for NHS organisations to implement, which included an emphasis on creating a culture of safety, raising concerns, culture free from bullying; visible leadership, and valuing staff.

3.2. In addition, the review introduced the role of the Freedom to Speak Guardian to act as an:

> *"…independent and impartial source of advice to staff, with access to anyone in the organisation including the CEO, or if necessary outside the organisation. They can ensure that the primary focus is on the safety issue; that the case is handled appropriately, investigated promptly and case addressed; and that there are no repercussions for the person who raised it."*

4. National and local context

4.1. This report is written at a time when the NHS, wider society and colleagues across the Trust are under a wide range of threats. These threats include the cost-of-living crisis, large numbers of vacancies, pressure to address operational performance and specifically to address the backlog in waiting lists, and an increase in reporting of moral injury.

4.2. Post the worst of the Covid-19 pandemic, staff have been under increasing pressures, not just in UHBW, but across the NHS. This has culminated in industrial action, mainly relating to pay, by most staff groups. Whilst a pay deal has been agreed for Agenda for Change staff, colleagues in medical professions and the Royal College of Nursing are either planning further strike action or balloting on the prospect of further strike action.

4.3. Coupled with these threats, staff are also reporting the challenges they face in relation to factors, such as the condition of the estate and the areas they work in.

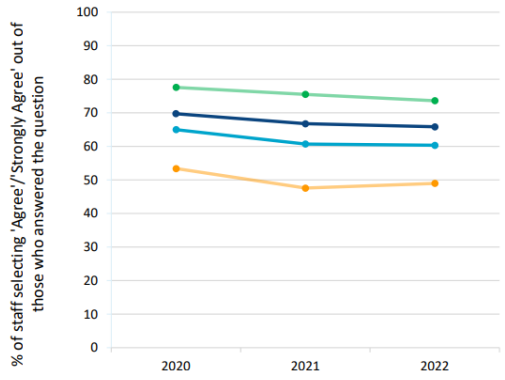
4.4. Working under threat can impact on behaviours – including stifling creativity, narrowing focus, increasing governance, and decreasing appetite for risk.

4.5. All these threats have an impact on staff wellbeing and engagement. There are proven links between the level of threat that staff feel under and their level of engagement with an organisation and specifically with change.

4.6. The National Guardian's Office reported a decline against all measures relating to raising concerns in the NHS Staff Survey, both relating to raising concerns about clinical safety and speaking up more generally.

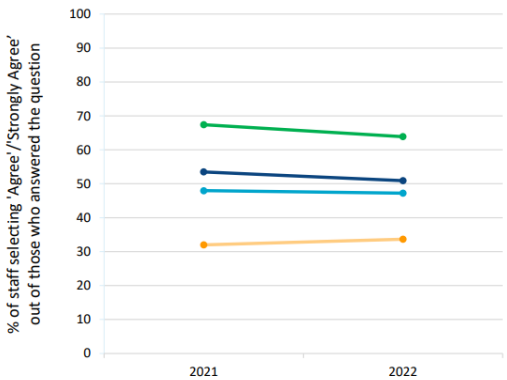
4.7. At UHBW, we reported a reduced response rate to the survey, a static staff engagement score, and a reduction in key metrics relating to speaking up, specifically:

Q23e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022
Your org	69.7%	66.8%	65.9%
Best	77.6%	75.5%	73.6%
Average	65.0%	60.7%	60.3%
Worst	53.4%	47.6%	49.0%
Responses	5844	5068	5194

Q23f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022
Your org	53.5%	50.9%
Best	67.4%	63.9%
Average	48.0%	47.2%
Worst	32.0%	33.7%
Responses	5067	5190

University Hospitals Bristol and Weston NHS Foundation Trust Benchmark report

4.8. Furthermore, recent CQC reports into organisations across the country, have identified issues relating to fears of speaking up, the quality and timeliness of speaking up responses and the visibility and accessibility of managers.

4.9. In an update to the NHS England Board on 18 May 2023, the National Guardian Jayne Chidgey-Clark highlighted:

> *"High-profile reports and incidents have also been published (e.g. the Kirkup report 'Reading the Signals: maternity and neonatal services in East Kent'; BBC Panorama investigation into mental health services at the Edenfield Centre, Manchester; The Berwick Report, University Hospitals Birmingham). These underlined what Freedom to Speak Up guardians and the NHS Staff Survey are telling us: that not all workers feel safe enough to raise matters of concern or get a consistent high-quality response to the matters they raise, sometimes with serious consequences."*

5. Summary of highlights

5.1. There have been several positive changes and impacts from a Freedom to Speak Up perspective during the year (appendix 1 includes further details alongside the key data for 2022/23):

- Most concerns that came through the FTSU route (109 in 2022/23) were responded to positively by managers and leaders, who listened to staff and took appropriate action.
- The Trust has committed to Speak Up training being a mandatory requirement for all staff and current compliance is 78% (91% in Estates and Facilities).
- The number of concerns from staff working in the division of Weston has started to stabilise and the division is no longer such an outlier. While the figure for concerns raised per FTE remains higher than other divisions, it has fallen year on year.
- The FTSU Guardians and Champions are more visible and accessible to staff. The Guardians are regularly attending inductions and department meetings.
- The diversity of the champion network has been maintained in year (job roles, age, gender, ethnicity is largely reflective of the UHBW workforce).
- There are quarterly champion network meetings and monthly informal champion support sessions where themes of issues and concerns are shared. Most of the champions are now trained, with the training aligned with the national guardian training.
- Alongside the South West FTSU Guardian network meetings, a sub-regional network of Guardians has been set up to share best practice across Bristol, North Somerset and South Gloucestershire (including UHBW, North Bristol NHS Trust, Avon and Wiltshire Mental Health Partnership NHS Trust; Sirona; Spire). A key success was the development of a joint letter to agencies (October 2022) to share the arrangements for speaking up, should any of their staff wish to raise concerns whilst working in one of the partner organisations.
- FTSU has influenced the Trust's recruitment process to help reduce the prevalence of unfair recruitment practices and perceived nepotism. This has resulted in a sharp decline in the number of concerns being raised about recruitment.
- Concerns about how bank workers are treated and how concerns they raise are dealt with have been highlighted and are helping to change the perception about the value of this key part of the workforce.
- Mandatory training for managers introduced at the end of 2022 as part of a wider programme of Leadership and Management Development should also start to make a difference, as there is a clear and consistent understanding of how to listen to staff when they need to raise concerns and to support the development of the psychologically safe culture for staff to raise concerns.

6. Further areas for improvement

6.1. There remain several areas where further work is required to support the creation of a culture where staff feel safe to speak up. As described in the context section, the NHS Staff Survey indicates that a decreasing proportion of staff feel safe to speak up. At UHBW only 65 per cent of staff state that they feel safe to speak up, and only 51 per cent of respondents stated that they had confidence that the organisation would address their concerns if they spoke up. Whilst the percentages place the Trust above the national average it is not good enough.

6.2. Aligned to the NHS Staff Survey are the results of a survey undertaken by Internal Audit to support their audit of the Trust's FTSU process in 2022. The survey (352 responses) asked what would make staff feel safer and more confident in raising concerns. 149 respondents opted to provide a comment in this area. Staff were concerned about confidentiality, confrontation and challenging difficult personalities. Some comments indicated that there was a fear of retaliation from speaking up. There was also some frustration expressed in relation to concerns/issues not getting resolved in a way that staff members consider satisfactory, as well as frustration around actions taking a long time to implement or actions/change not actually materialising.

6.3. This is supported by the fact that there are several concerns that have yet to be fully resolved which were raised and closed via the FTSU process some time ago. There are three specific concerns affecting different clinical and corporate services which remain unresolved after several years. The lack of perceived action by managers in the divisions to act on the concerns has a detrimental impact on the organisational culture and the perception of speaking up in the Trust.

6.4. A further example relates to the issues of racism, discrimination and microaggressions experienced and raised by staff in August 2022 and identified by the CQC in their inspection of Weston General Hospital. A listening action group started in January and meets monthly and listening events have taken place regularly in Weston. A video from the Weston leadership team was produced in October 2022 to remind staff about the Trust values and expected behaviours. However, the feeling from some staff is that more work needs to be done around communicating and engaging with staff to demonstrate that the Trust is taking the issues seriously and to share the actions it is taking.

6.5. A common theme among the concerns which remain the most challenging to fully address is a lack of ownership of the issue to drive change and improve the experience for staff (whether because of complexity; a fear of getting it wrong; busyness).

6.6. A final point to highlight is that, on occasion, staff who have raised concerns and have not seen demonstrable action, are labelled as troublemakers or agitators. While these are rare occurrences, no one should be labelled in this way. We are missing the opportunity to fully understand the concerns being raised and the context. This is also a barrier for some staff in raising concerns.

6.7. Two initiatives that the Trust is implementing that will support addressing these areas for improvement are the new Leadership and Management Development Programme, and the Respecting Everyone framework which will be launched in November 2023. These approaches will support managers with the right skills to

recognise the need to listen to staff and have different conversations. In addition, the Respecting Everyone Framework should empower individuals to have the confidence to raise issues and concerns directly.

7. Forward look 2023/24

7.1. The FTSU strategy is due for review and this process will start in the summer and aim complete in the autumn. Initial engagement will be undertaken with the FTSU Champions, then staff side, staff networks, and colleagues in corporate services including patient safety and HR. A draft will be shared and discussed with the People Committee before being presented to the Board.

7.2. A revised Standard Operating Procedure is under consultation to seek to ensure the appropriate escalation and resolution of concerns. This will be launched in the summer.

7.3. The Guardians will continue to grow, develop, and support the champion network to ensure visibility and access to support for all staff, in all locations and all staff groups.

7.4. The FTSU Guardian and Champions are supporting the launch of the Respecting Everyone framework later in the year to help support different conversations at an early stage and a positive change to organisational culture.

7.5. Further work is underway, aligned with Patient First, and supported by the Director of Performance, to understand and triangulate data which will help to pinpoint whether further targeted support might be required for services to support cultural change.

8. Recommendations

8.1. The Board is asked to note the contents of the Annual Report for 2022/23 and discuss the actions it should now take in response.

Appendix 1: Key data for Freedom to Speak Up set against the three objectives of the Freedom to Speak Up Strategy

<table>
<tr><th></th><th>Data 2022/23</th><th>Description of changes in year and proposed areas of focus</th></tr>
<tr><td colspan="3">Awareness of Freedom to Speak Up</td></tr>
<tr><td>Compliance with mandatory Speak Up training (e-learning)</td><td>
<table>
<tr><th></th><th>Diagnostics & Therapies</th><th>Medicine</th><th>Specialised Services</th><th>Surgery</th><th>Trust Services</th><th>Estates & Facilities</th><th>Weston</th><th>Women’s & Children’s</th></tr>
<tr><td>March 23</td><td>77% (+26%)</td><td>76% (+29%)</td><td>77% (+17%)</td><td>72% (+26%)</td><td>86% (+24%)</td><td>91% (+18%)</td><td>86% (+23%)</td><td>72% (+22%)</td></tr>
</table>
</td><td>A 23% increase (average) in compliance against one-off mandatory Speak Up training since March 2022.</td></tr>
<tr><td>Number of updates to staff and other workers in the Trust about speaking up</td><td>
<table>
<tr><td>St Michael’s Theatres team</td><td>12/08/2022</td></tr>
<tr><td>BRI - A528 - ED, A300 with wellbeing nurse lead for the division</td><td>04/10/2022</td></tr>
<tr><td>BRHC - level 5 wards and PICU</td><td>18/10/2022</td></tr>
<tr><td>Patient safety/FTSU walk round - BEH (pharmacy, outpatients, theatres, Gloucester ward)</td><td>03/11/2022</td></tr>
<tr><td>Therapies team</td><td>09/11/2022</td></tr>
<tr><td>NICU – department visit with National Guardian</td><td>30/11/2022</td></tr>
<tr><td>SDEC ward meeting on A307</td><td>06/12/2022</td></tr>
<tr><td>Education and research team</td><td>06/12/2022</td></tr>
<tr><td>Weston (ground floor departments and external offices)</td><td>14/12/2022</td></tr>
<tr><td>Porter meeting (at BRI and BEH)</td><td>16/01/2023</td></tr>
<tr><td>Gynae outpatients audit meeting</td><td>17/01/2023</td></tr>
<tr><td>AMU</td><td>20/02/2023</td></tr>
<tr><td>Weston – all wards and depts level 1</td><td>07/03/2023</td></tr>
<tr><td>BHI – all levels – with wellbeing nurse lead for the division</td><td>13/03/2023</td></tr>
<tr><td>International nurse induction (ongoing since Sept 2021)</td><td>Monthly</td></tr>
</table>
</td><td>Programme of presentations and walk round by FTSU Guardians to continue in 2023/24 – linking with wellbeing and patient safety leads</td></tr>
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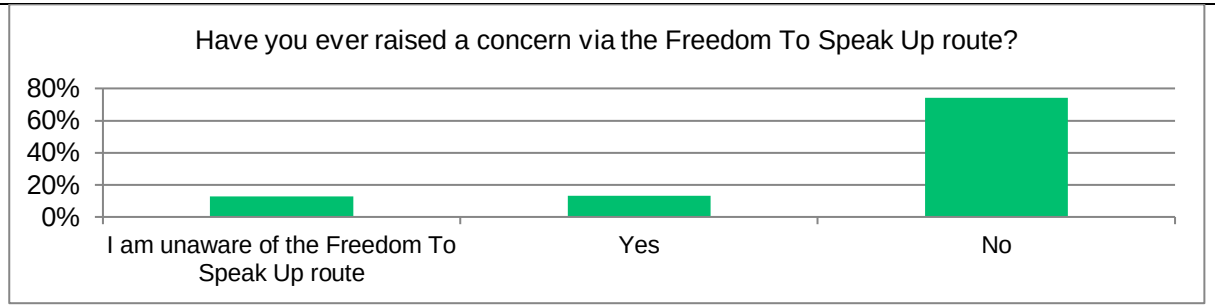
Response to internal audit survey (2022) relating to awareness of Speaking Up		Survey completed as part of internal audit into Freedom to Speak Up process. 352 responses in total – 331 staff declared their division: Weston 13% Women's and Children's 35% Medicine 4.5% Surgery 4.5% Diagnostics and Therapies 13% Specialised Services 7% Trust Services 23%
Number and location of Freedom to Speak Up staff champions across the Trust	Diagnostics & Therapies 5 Medicine 9 Specialised Services 6 Surgery 13 Trust Services 24 Estates and Facilities 3 Weston 8 Women's & Children's 13	Number of staff advocates decreased slightly in year from 99 to 81. However, champions remain on all sites across the Trust. Champion training is held regularly and is delivered in house, supported by the psychological services team.

Confidence in the Freedom to Speak Up process

Number of cases raised through the Raising Concerns phone, email or directly with the FTSU Guardians		**Q1**	**Q2**	**Q3**	**Q4**	**Total**	Similar number of concerns raised compared to 2021/22 (102 in the last financial year). In terms of themes of concerns, the majority (36%) relate to policies and processes, followed by 34% relating to inappropriate attitudes and behaviours, including bullying and harassment.
	Number of cases raised with the FTSU Guardian	**28**	**23**	**35**	**23**	**109**	
	Cases relating to quality / patient safety	1	2	2	1	6	
	Cases relating to bullying or harassment	2	2	3	3	10	
	Cases relating to worker safety or wellbeing	8	5	4	3	20	
	Cases relating to inappropriate attitudes or behaviours	5	4	13	5	27	

Numbers of concerns raised by division

Division	Diagnostics & Therapies	Medicine	Specialised Services	Surgery	Trust Services	Estates & Facilities	Weston	Women's & Children's
Concerns	5	14	8	12	21	13	21	15
Full-time equivalent April 23	1,349	879	1,330	1,188	2,116	1,222	786	2,164
Concerns per FTE	3.7	10.6	15.9	6.0	10.1	9.9	26.7	6.9

Concerns were raised in all divisions – as per the previous financial year. The number of concerns raised by staff in the division of Weston has continued to fall.

Numbers of concerns raised by staff group

Allied Health Professionals	Medical and Dental	Registered Nurses and Midwives	Admin/ clerical	Additional professional scientific and technical	Additional clinical services	Estates and ancillary	Not known	Other
3	5	27	33	4	21	12	1	3

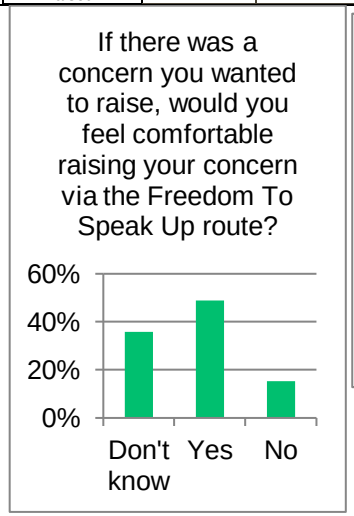
Concerns were raised across all staff groups, though predominantly from admin/clerical staff and registered nurses and midwives, in line with the national picture.

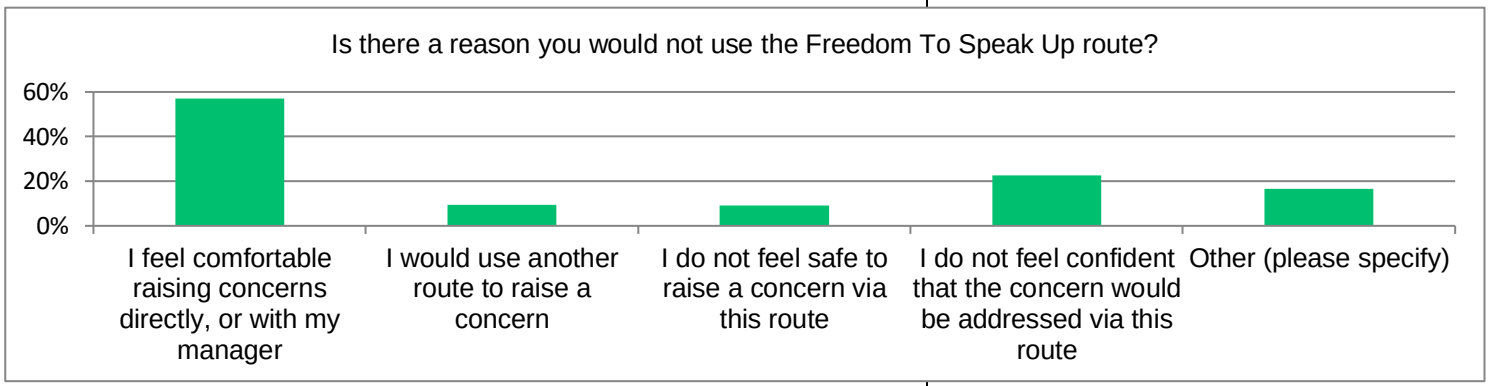
Response to 'speaking up indicators' in the NHS Staff Survey by division (figures in brackets are 2021 results for comparison)

		Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery	Trust Services	Weston	Women's & Children's
Description	n = 5222	n = 717	n = 567	n = 564	n = 600	n = 648	n = 759	n = 375	n = 992
Would feel secure raising concerns about unsafe clinical practice	72.2% (74.8%)	77.8% (76.5%)	58.5% (61%)	76.9% (77.8%)	78.0% (79.0%)	69.7% (74.3%)	64.5% (71.1%)	73.5% (69.0%)	78.5% (80.6%)
Would feel confident that organisation would address concerns about unsafe clinical practice	57.6% (59.9%)	53.6% (59.2%)	57.1% (52.5%)	60.3% (61.4%)	61.6% (62.6%)	54.9% (59.6%)	56.4% (63%)	56.3% (41.9%)	60.0% (66.1%)
Feel safe to speak up about anything that concerns me in this organisation	65.4% (66.4%)	66.6% (66.7%)	62.0% (61.3%)	65.5% (66.7%)	71.4% (70.0%)	59.8% (64.4%)	65.4% (70.3%)	64.2% (52.2%)	67.0% (70.2%)
Feel organisation would address any concerns I raised	50.7% (53.1%)	48.9% (53%)	51.7% (48.7%)	47.2% (52.2%)	56.7% (55.5%)	46.8% (52.5%)	51.4% (57.9%)	45.6% (34.3%)	53.8% (58.5%)

The NHS Staff Survey results show an overall decline in the scores for the key metrics relating to speaking up across divisions, except for Weston and Facilities and Estates, which showed improvements.

Key responses to internal audit survey of staff (2022) – 352 responses



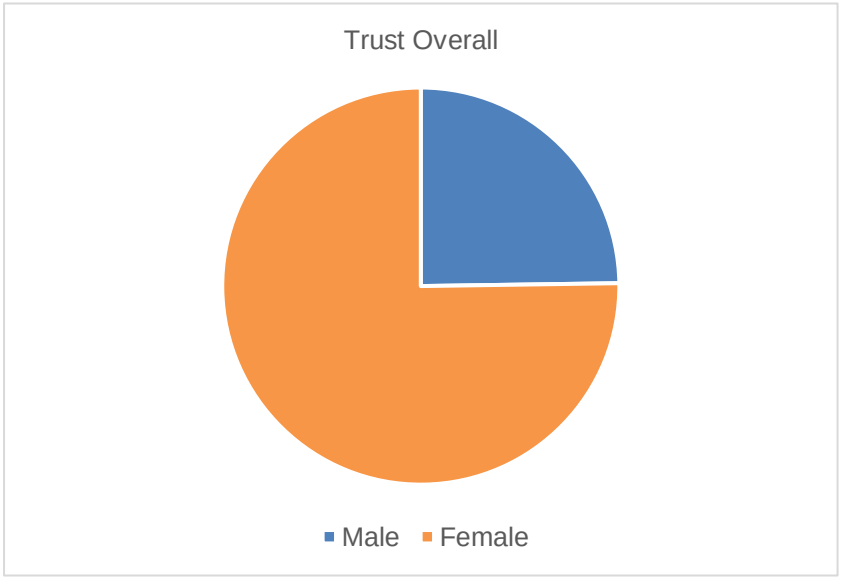


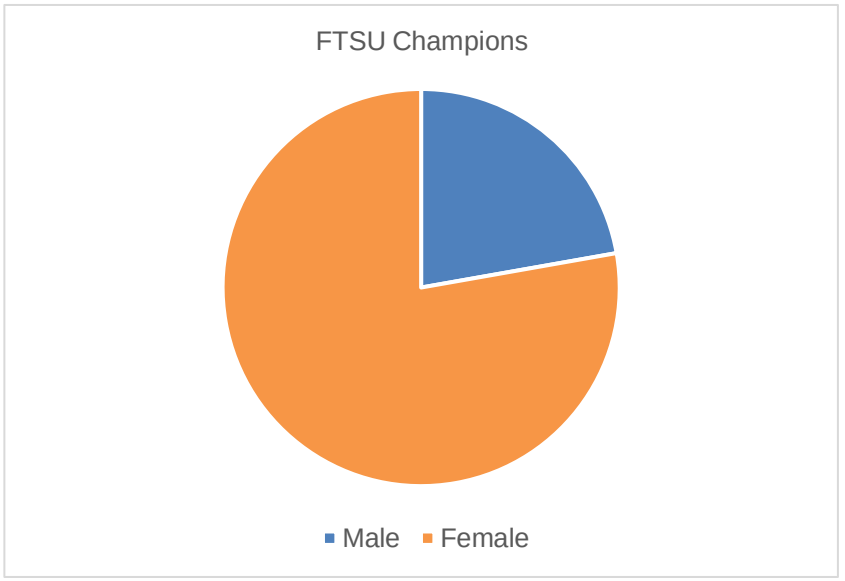
Internal audit identified from staff comments in the survey that the main barriers to speaking up are: • A general lack of awareness around the FTSU process, including how to raise a concern in the first place • Concerns about anonymity when raising a concern • A lack of confidence about whether raising a concern will result in their desired outcome.

Feedback from those who have raised concerns	18 feedback forms returned from individuals who raised concerns and whose concerns were closed in the year. Of the 18 individuals who responded all answered 'no' to the question 'do you feel you've suffered in any way as a result of speaking up?' 16 answered 'yes' the question 'would you speak up again?'. 1 answered maybe and 1 answered 'don't know'.	The return on the number of anonymous feedback forms sent out remains low, though in line with last year (17 received).
Training and support for leaders and managers to understand their behaviours and deal positively with concerns		
Take up of management (behaviours) training by division	Mandatory management training introduced in November 2022. Learning from FTSU fed into training. Roll out of Respecting Everyone training to support managers in early resolution of issues and concerns started in spring 2023.	Compliance against mandatory training for managers is monitored by the Education team.
Compliance with listen up training	Compliance against non-essential Listen Up training for managers was 22% in June 2023 (based on 2,385 staff listed as line managers on ESR/Kallidus)	Static since July 2022. Continued promotion of Listen Up training by FTSU Guardians to managers

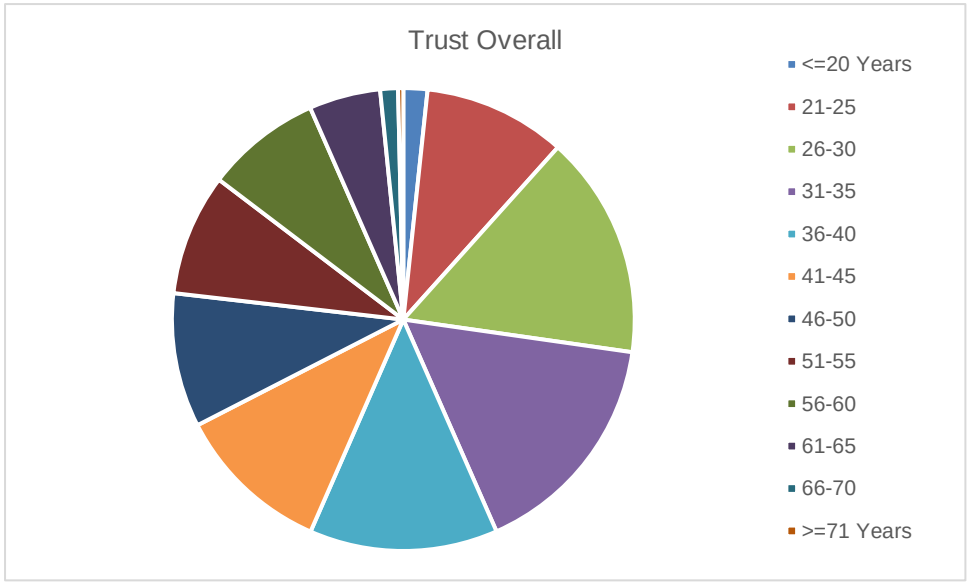
Breakdown of diversity of FTSU staff champions compared to UHBW staff overall

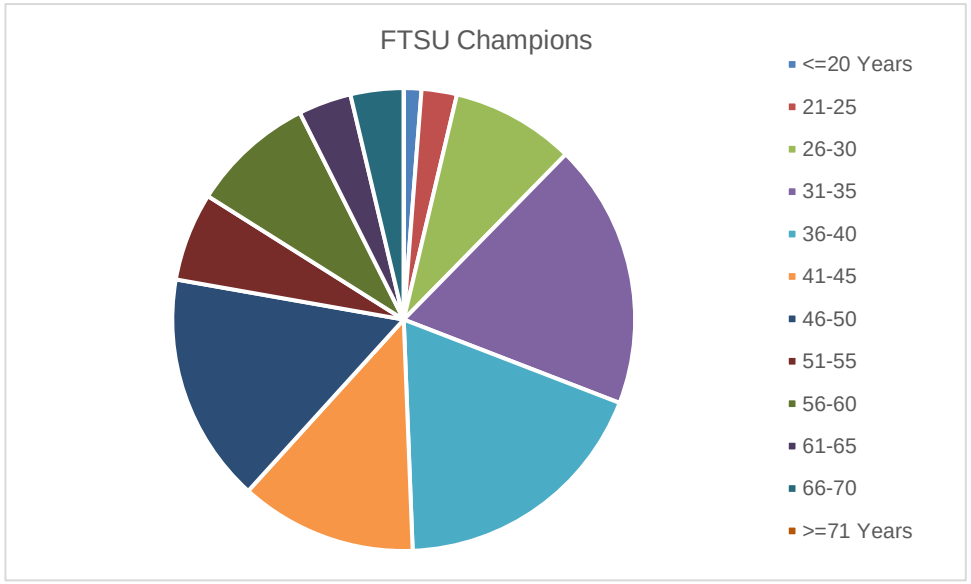
Gender



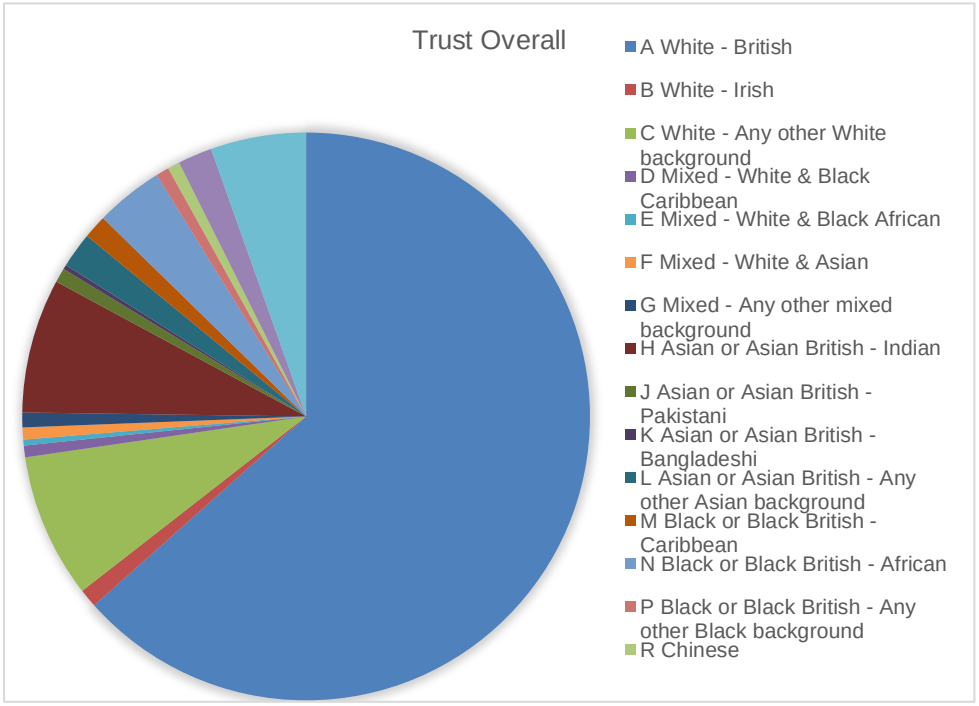


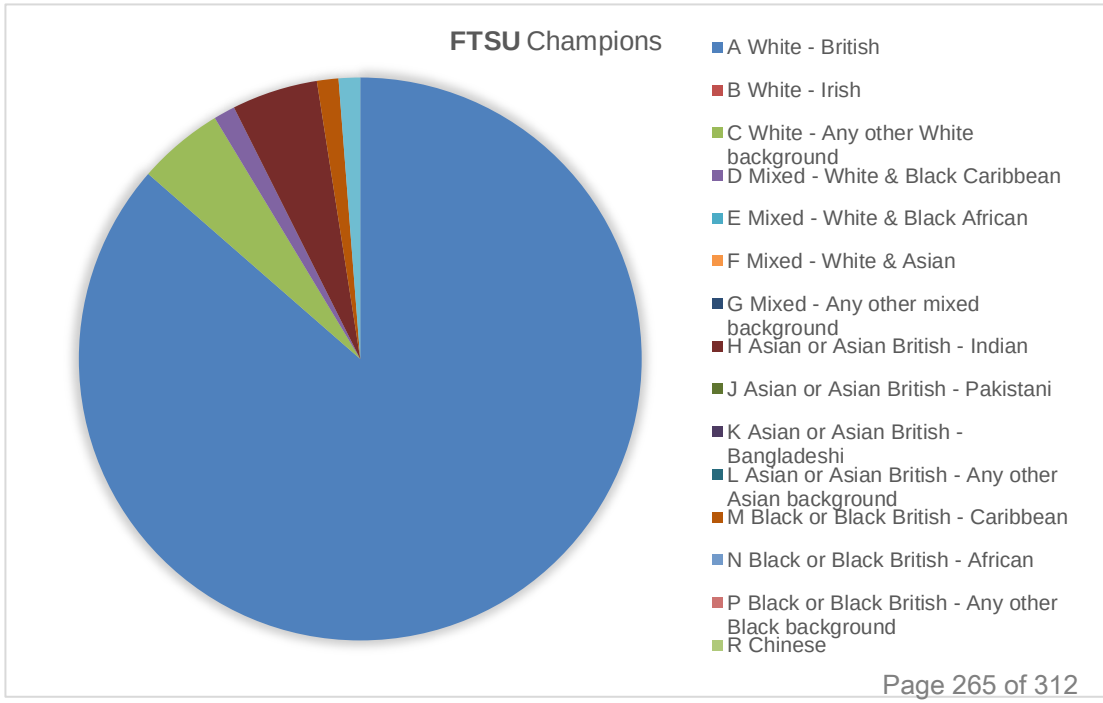
Age



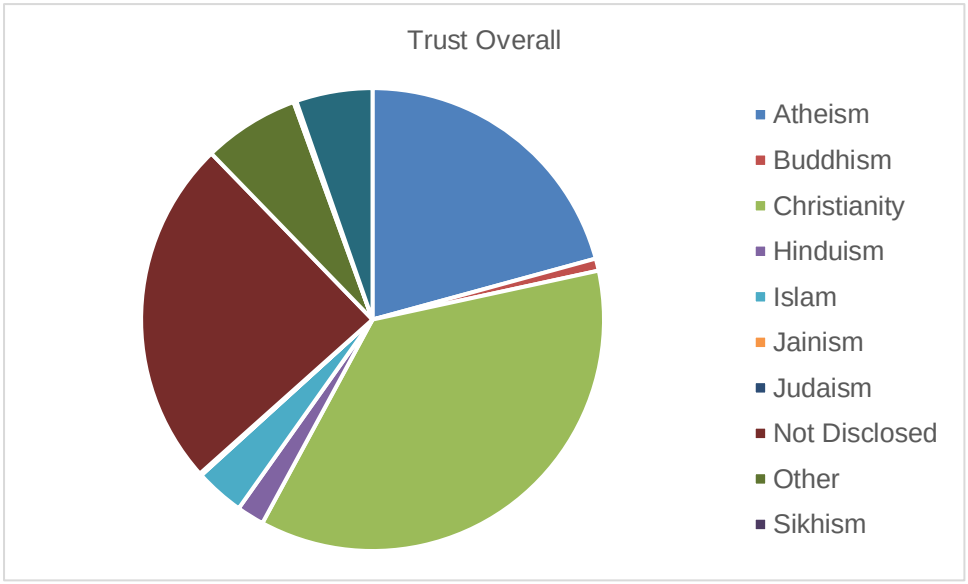


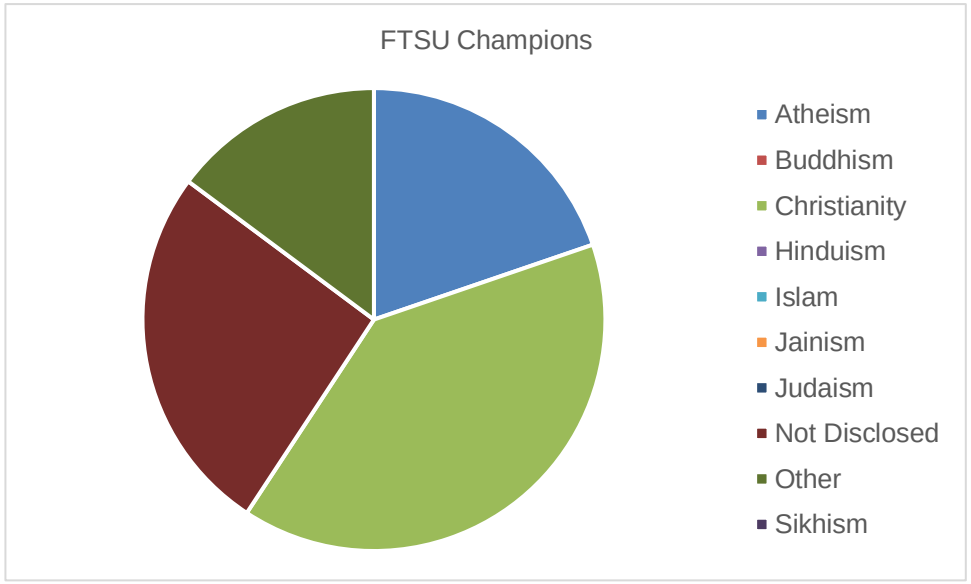
Ethnicity



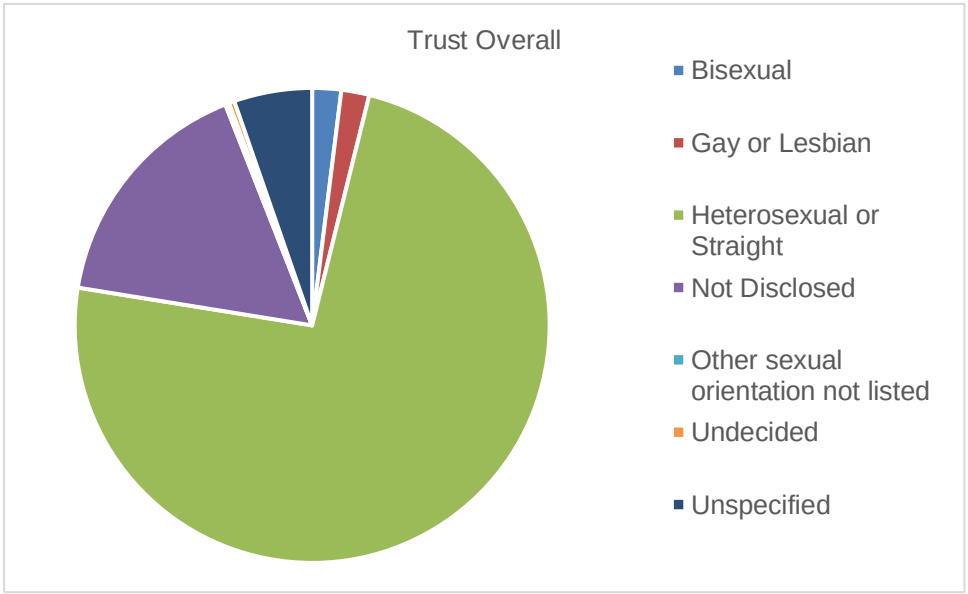


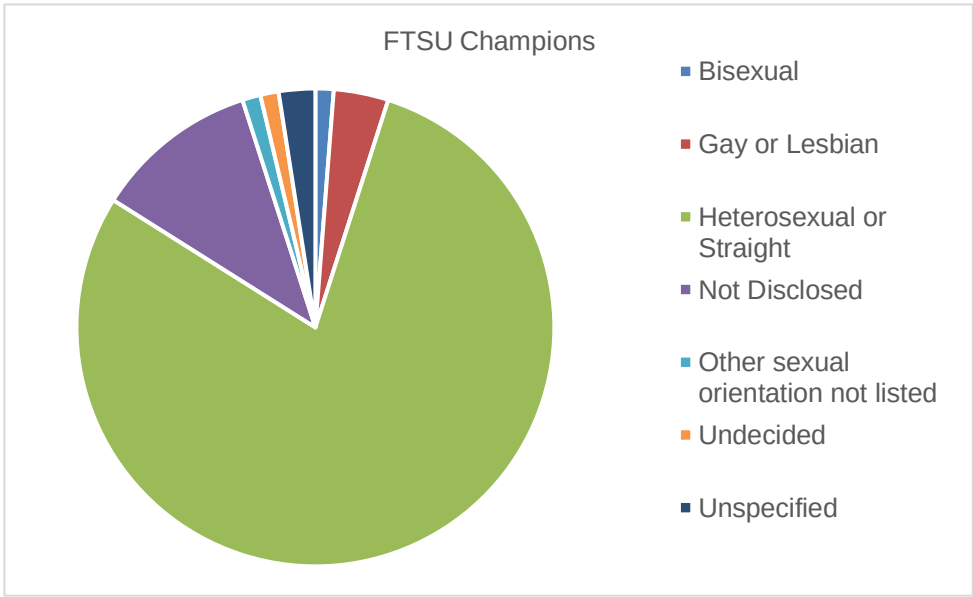
Religion





Sexual orientation





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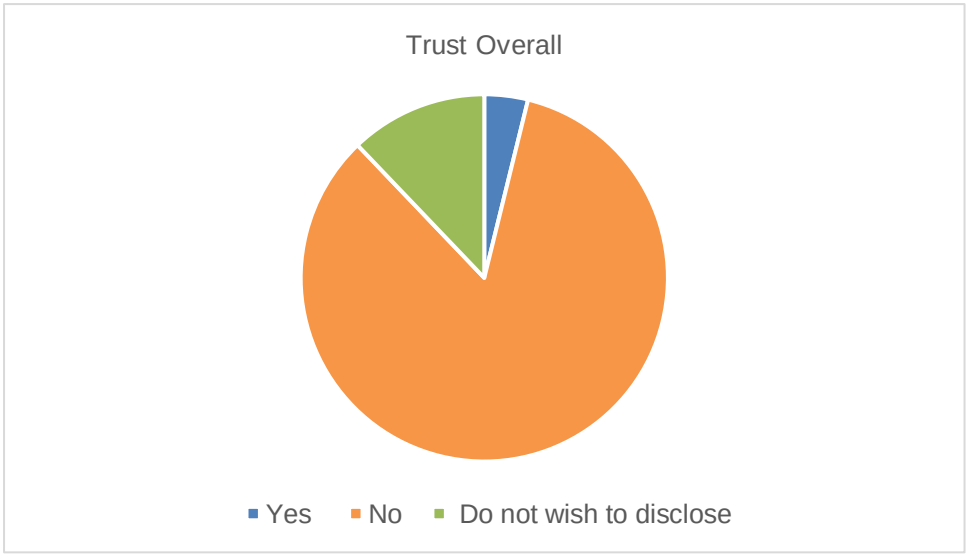

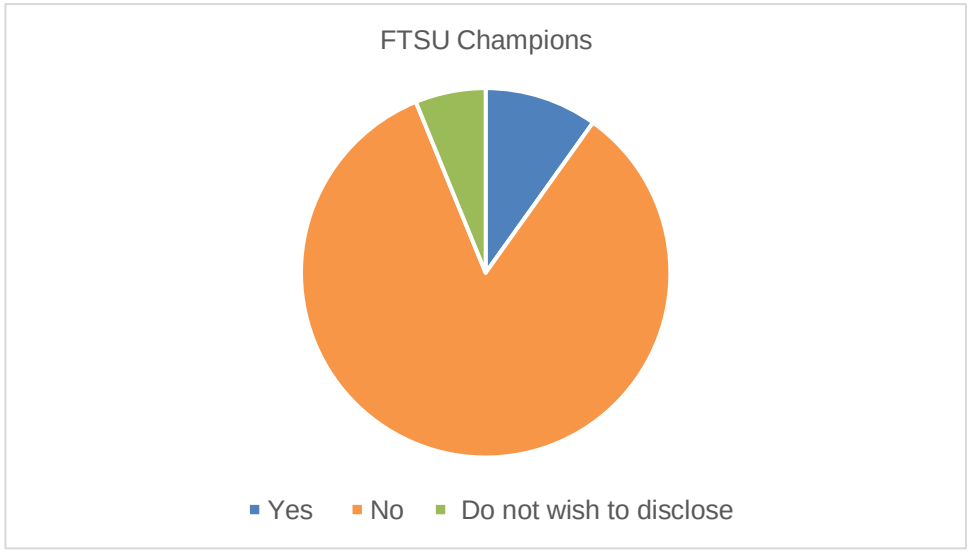

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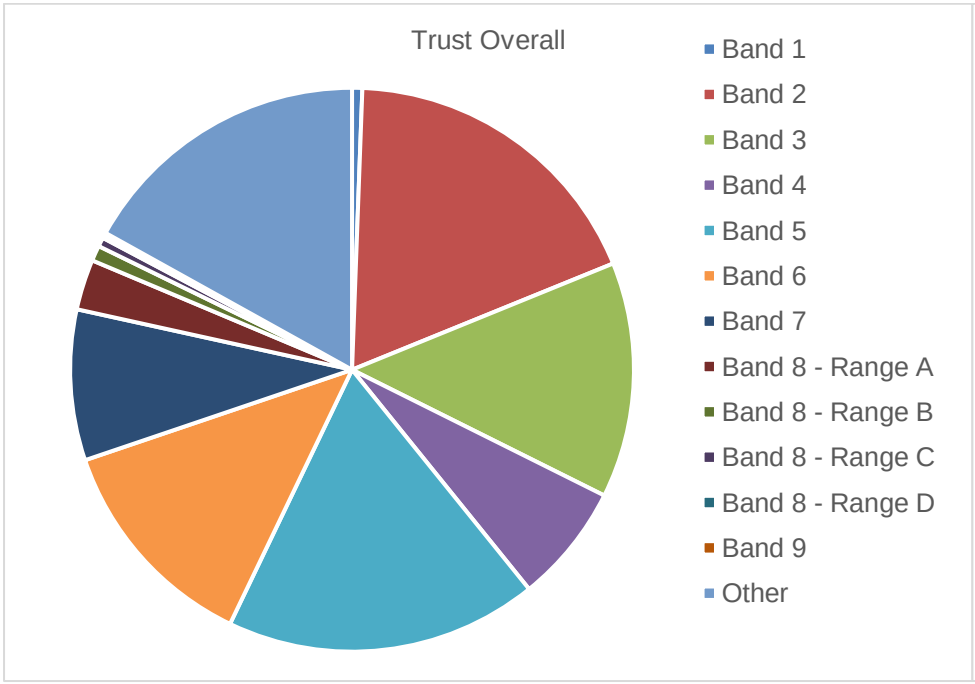

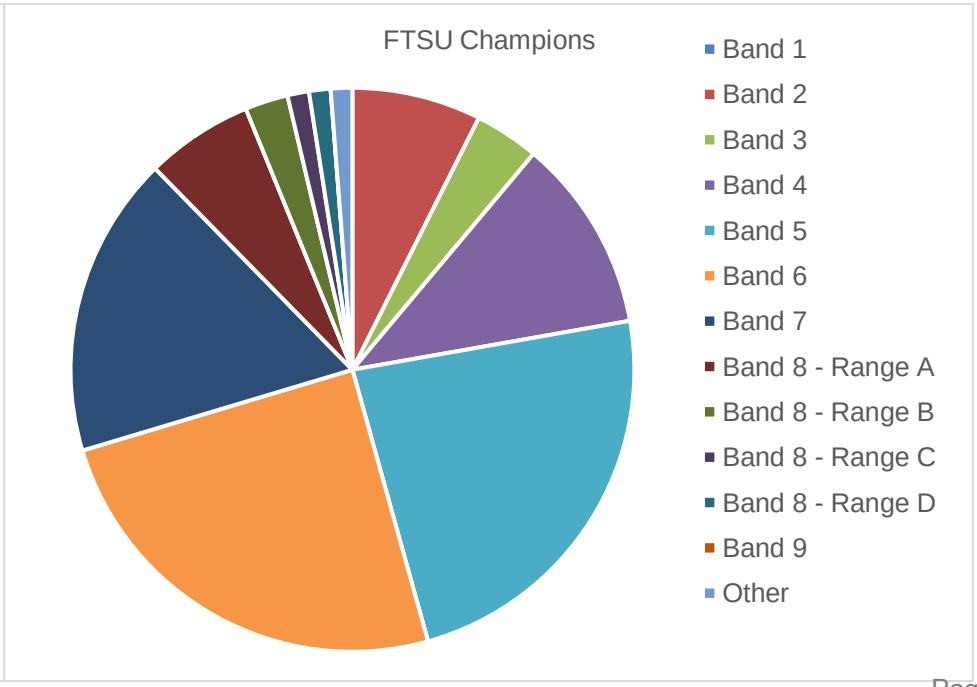

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Committee	**People Committee – 25 May 2023**
Chaired By	**Bernard Galton**
Executive Lead	**Emma Wood**

For Information

The meeting focussed on items relating to the People Strategy pillars: Looking After our People and Inclusion and Belonging, together with emerging strategic items.
Agenda items included:

- Risk Report covering strategic and workforce corporate risks.
- Wellbeing Bi-annual report
- EDI Bi-annual report
- Guardian of safe working hours reports
- Workforce KPIs and performance report and deep dive into workforce performance in Trust Services Division.

For Board Awareness, Action or Response

The Committee expressed nervousness about some of the proposed revisions to the Workforce Risk register, particularly around Freedom to Speak out and the Completion of Appraisals. It was agreed that the CPO would revisit the risk matrix and related policies and report back to the Committee. The Board will need to be aware that many of the risks owned by CPO require specific actions from Executive leaders in terms of mitigating risks. One example is the completion of appraisals where Trust Services are currently below target. The Committee asked the CPO to write to Executive colleagues to remind them to complete appraisals in a timely manner.
The Committee recognised the excellent progress made against 2022/2023 Workforce KPIs and noted the new draft stretched targets for the forthcoming year. These targets are ambitious and will require collaborative support from Board colleagues and wider leadership in the Trust.
The Guardian for Safe Working Hours in Bristol thanked CPO staff for the excellent support in resolving workforce data capture and was able to confirm that safe working patterns are in place. However, workforce data still fails to identify all specialities and further work is needed to provide this additional level of detail.
No significant issues were highlighted by the Weston Guardian for Safe working Hours.

Key Decisions and Actions

There was a very useful discussion about the Wellbeing report and how we communicate with staff and receive meaningful feedback and comments. Surveys are a very blunt tool and rarely achieve high response rates It was agreed to invite Emma Mooney to the next meeting to discuss whether we are taking full advantage of the different and more targeted ways to communicate with staff.

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On the KPI report it was agreed that it would be helpful to gain a greater understanding of workforce plans relating to Allied Health professionals and the Chief Nurse agreed to bring this to the September meeting of the committee.
Additional Chair Comments
I explained that the Agenda for this meeting was designed to provide greater time for discussion and I felt it worked well and would aim to repeat this at future meetings.
Update from ICB Committee
I was not able to attend the last meeting and have not yet received the Minutes. The next meeting is in July.

Date of next meeting:	**27 July 2023**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in public – 15 June 2023

Reporting Committee	**Audit Committee – April and June 2023 Meetings**
Chaired By	**Jane Norman, Non-Executive Director**
Executive Lead	**Neil Kemsley, Chief Financial Officer**

April 2023 Meeting

The Strategic Risk Register was reviewed. there was a total of 13 risks, 3 of which had been highlighted for the attention of the Audit Committee. Sarah further advised that the Estate risks would move across to the Finance and Digital Committee once the revised terms of reference had been approved. The Strategic Risk Register was also reviewed and it was noted that there was a total of 26 risks, to which 5 risks had been highlighted for oversight by the Audit Committee. It was noted that one risk around industrial action and the impact on patient care had increased, as well as the reduction of 3 risks and 5 recommended for de-escalation from the corporate risk register.

The Committee received the internal audit interim report and a discussion took place on whether more could be done to ensure that high risk and overdue actions were being addressed. It was suggested that all those with a higher risk and marked as overdue would be presented to the Executive Committee to clearly reinforce the need for action to be undertaken and closed. The following 3 internal audit reports:

- Report 1 - Conflict of Interests
- Report 2 – Data Quality Framework
- Report 3 – EPRR Follow Up
-

In respect of data quality, the Committee asked to receive assurance regarding the robustness of clinical quality data.

The Committee reviewed the draft Annual Governance Statement for inclusion in the Trust's Annual Report. It was noted that the ongoing impact of the pandemic and the recent industrial action would be highlighted as significant control issues during 2022/23.

The Committee noted the review of losses and special payments and the review of single tender actions.

Key decisions taken at the meeting were as follows:

- The 2023/2024 Annual Counter Fraud Plan and the Annual Review of Accounting Policies were approved by the Committee.

- The Board Register of Interest was received and noted by the Committee.

June 2023 meeting

The Committee received the Trust's draft annual accounts and annual report for 2022/23 for review prior to their submission to the Trust Board for approval. The Head of Internal Audit Opinion for 2022/2023 was also received, which provided significant assurance on the assurance on the work undertaken during 2022/2023.

University Hospitals Bristol and Weston NHS Foundation Trust

The Audit Committee recommended the annual accounts and annual report for 2022/23 to the Trust Board for approval.	
Date of next meeting:	**18 July 2023**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**Provider Licence Self-Certifications**
Report Author	**Mark Pender, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Purpose

To present the proposed self-certifications against the Provider Licence conditions for approval by the Board.

2. Key points to note *(Including any previous decisions taken)*

The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future. All NHS foundation trusts and NHS trusts are required to hold a licence.

The licence has recently been modified The licence has recently been modified following a statutory consultation to bring it up to date to reflect current statutory and policy requirements. These modifications also merge the NHS provider licence and the NHS controlled provider licence. The revised license sets clear expectations of collaboration by NHS trusts and foundation trusts and the following new conditions have been added to the licence:

WS1 - Cooperation: Licensees shall consistently co-operate with other providers of NHS services, including the Integrated Care Board of which they are a partner, in order to develop and deliver system plans and contribute to the delivery of agreed system financial and workforce plans.

WS2 – The Triple Aim: Licensees shall comply with their duty relating to the triple aim, which is the aim of achieving:

- better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing)
- better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)
- more sustainable and efficient use of resources by NHS bodies.

WS3 - Digital Transformation: Licensees shall comply with the information standards published under section 250 of the 2012 Act, and with the required levels of digital maturity where they pertain to the requirements set out in the cooperation condition and the Triple Aim condition.

NHS foundation trusts are required to self-certify, on an annual basis, whether or not they have:

(1) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution);

(2) the required resources available if providing commissioner requested services (CRS);

(3) complied with governance requirements; and

(4) have provided Governors with the necessary training

This paper has been written to provide the Board with assurance that the Trust fully meets the NHS provider licence conditions.

3. Strategic Alignment

N/A

4. Risks and Opportunities

The appendix identifies potential risks to compliance with the governance statement conditions and describes the identified mitigating actions.

5. Recommendation

This report is for Approval

The Board is asked to approve the Trust's provider licence self certifications.

6. History of the paper
Please include details of where paper has <u>previously</u> been received.

N/A

Provider Licence - Self-Certifications

1. Purpose

1.1. To provide evidence of compliance against the Provider Licence to support a decision by the Board.

2. Context/Background

2.1. The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future. All NHS foundation trusts and NHS trusts are required to hold a licence.

2.2. The licence has recently been modified following a statutory consultation to bring it up to date to reflect current statutory and policy requirements. These modifications also merge the NHS provider licence and the NHS controlled provider licence. The Trust received its revised licence under the new conditions on 31st March 2023. Full details can be found at https://www.england.nhs.uk/wp-content/uploads/2023/03/PRN00191-nhs-provider-licence-v4.pdf

2.3 The revised license sets clear expectations of collaboration by NHS trusts and foundation trusts and the following new conditions have been added to the licence:

WS1 - Cooperation: Licensees shall consistently co-operate with other providers of NHS services, including the Integrated Care Board of which they are a partner, in order to develop and deliver system plans and contribute to the delivery of agreed system financial and workforce plans.

WS2 – The Triple Aim: Licensees shall comply with their duty relating to the triple aim, which is the aim of achieving:

- better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing)
- better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)
- more sustainable and efficient use of resources by NHS bodies.

WS3 - Digital Transformation: Licensees shall comply with the information standards published under section 250 of the 2012 Act, and with the required levels of digital maturity where they pertain to the requirements set out in the cooperation condition and the Triple Aim condition.

2.4 NHS foundation trusts are required to self-certify to confirm that they have complied with he conditions of the licence. However the self-certification process has not yet been updated to reflect to the new conditions, and the Trust will therefore continue to the use the self-certification process currently in place. This requires foundation trusts to confirm that they have:

(1) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution);

(2) the required resources available if providing commissioner requested services (CRS); and

(3) complied with governance requirements.

2.5 NHS England issued guidance in 2018 which has been used to inform this paper and the appendices. The guidance can be access at the link below:

https://www.england.nhs.uk/wp-content/uploads/2020/08/Self-certification_2018_-_Consolidated_Guidance.pdf

3 Self-Certification Requirements

3.1 Providers need to self-certify the following after the financial year-end:

NHS provider licence conditions
The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
Publication of condition G6(3) self-certification Condition G6(4)
The provider has complied with required governance arrangements (Condition FT4(8))
The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. This only applies to foundation trusts that are providers of CRS. (Condition CoS7(3))
Governors have received the necessary training to ensure they are equipped with the skills and knowledge they need to undertake their role.

3.2 It is up to providers how they undertake the self- certification; however a number of templates have been provided which the Trust has used as the basis of the document in Appendix 1.

3.3 Trusts are required to state either “confirmed” or “not-confirmed” against each element of the licence condition, and if the Trust chooses “not-confirmed” must provide an explanation why.

3.4 To fulfil the requirement to publish the self-certification, the templates, proposed by NHS England, will be completed and will be signed by the Chair and Chief Executive. These documents will then be added to the Key Publications section of the Trust’s website.

4 Proposed Outcome

4.1 The Director of Corporate Governance has reviewed the statements and evidence sets and is proposing that the Board of Directors responds with

"confirmed" for all elements. The evidence to support the response is outlined in Appendix 1.

4.2 For FT4, the Board is also required to consider any risks and mitigating actions for each element of the provider licence condition. These are described in Appendix 1.

4.3 The responses will be translated into the NHS England template once agreed.

5 Recommendations

The Board of Directors is asked to consider the evidence aligned to each element of the provider licence conditions, which the Board is required to self-certify against, and approve its response, noting the risks and mitigations.

Appendix 1 – Provider Licence Self-Certification

		Proposed Response	Evidence	Risks	Mitigating Actions
FT4 - Corporate Governance Statement					
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Confirmed**	• Annual Governance Statement • Well-led Framework - External Review • Head of Internal Audit Opinion • Board Assurance Framework • Board annual effectiveness evaluation • Compliance with the Code of Governance • External audit of the annual report and accounts • Internal Audits including review of divisional governance and internal control systems e.g. risk management	• The size and complexity of the organisation means there is a risk that good governance is not fully embedded in all divisions	• The Trust utilises its management and committee structures to ensure that good governance is embedded. This is complemented by the risk, performance and planning frameworks, which are overseen by the Executive Committee • Guidance and advice is provided by the Director of Corporate Governance.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time	**Confirmed**	• As above plus: • Alignment of performance reports to the Single Oversight Framework in the Quality and Performance Report	• Guidance is not identified or implemented in a timely manner	• The Trust ensures that regular communications from NHSE, CQC and other key bodies are reviewed and acted upon. • Internal and external audit consider application of good governance during their audit programmes.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	**Confirmed**	• Governance structure • Board and Committee annual effectiveness reviews • Scheme of Reservation and Delegation and Standing Financial Instructions • Committee Terms of Reference • Reports from the Chairs of the Committees to the Board and Council of Governors, and its focus groups	• Committee Terms of Reference are not fit for purpose/aligned with up to dates guidance on effective governance.	• Annual reviews of Committee Terms of Reference, with reference to relevant up to date guidance. • Stakeholder analysis included as part of the review process to ensure all internal and externa requirements are identified and included in the Terms of Reference.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards	**Confirmed**	• Quality and Performance Report and Finance Report to Board each month • Annual Operating Plan and Budget (Trust and Divisional) • Standing Financial Instructions • Head of Internal Audit Opinion • Annual Governance	• The Trust's internal control systems are not sufficiently robust to ensure compliance	• The systems and processes are regularly tested through the internal and external audit programmes, and the robust approach to risk management

		Proposed Response	Evidence	Risks	Mitigating Actions
	binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		Statement • Clinical Audit Programme and Reports • Financial Strategy • Committee Structure and Terms of Reference • External Audit of the Trust Annual Report and Accounts • Risk Management Strategy • Corporate and Divisional Risk Registers • Board Assurance Framework		
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	• Well-led Framework – External Review • Board Skills and Knowledge Review • Board Development Programme • Board member annual appraisals • Non-Executive Director and Executive challenge of proposals • Monthly Quality and Performance Report and finance report • Active engagement with Commissioners, local Health Scrutiny, Health & Well-being Boards and Healthwatch • Quality Governance Framework (safety, experience, outcomes and access)	• As above	• As above
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure	**Confirmed**	• Board Skills and Knowledge Review • Remuneration, Nominations and Appointments Committee Terms	• There is a risk of unforeseen changes at Board level which may impact on the requirements	• There are deputies in post and succession plans for all Executive Directors • The Board has appointed to all Non-Executive Directors roles

		Proposed Response	Evidence	Risks	Mitigating Actions
	compliance with the conditions of its NHS provider licence.		of Reference and work programme • Management and Organisational Development Programmes • Divisional Performance Reviews • Senior Leadership Team oversight • Monthly and Six Monthly Nurse Staffing Reviews • Revalidation and appraisal processes (Medical and non-Medical) • Other workforce metrics included in the Quality and Performance Report		
General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)					
1	Following a review for the purpose of paragraph 2(b) of licence condition G6[1], the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**	• Internal Audit and clinical audit work programmes • Annual Operating Plan reviews • Governance structure • Risk Management Strategy • Corporate Risk Register • Board Assurance Framework • Monthly Quality and Performance Report and Finance Report	N/A	N/A
Continuity of services condition 7 – Availability of Resources					
1	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**	• Annual Operating Plan and Budget • Financial Strategy • Annual accounts and going concern statement	N/A	N/A
Training of Governors					
	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed**	• Seminar Programme • Induction programme • Access to external training via NHS Providers • Specific and targeted training and updates – quality, strategy, auditor appointment	N/A	N/A

[1] "2. (b) regular review of whether those processes and systems have been implemented and of their effectiveness."

		Proposed Response	Evidence	Risks	Mitigating Actions
			• Governor skills audit • Internal Audit of the support to Governors.		

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**Review of Board Committees Terms of Reference**
Report Author	**Mark Pender, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Purpose

As part of its own self review, the Board Committees consider their own terms of reference on a regular basis to ensure they remain fit for purpose and cover the correct remit for the Committee.

The Finance & Digital Committee and the Audit Committee have recently reviewed their term of reference and these are now presented to the Board of Directors for approval (appendices 1 and 2).

2. Key points to note *(Including any previous decisions taken)*

Following a review of the responsibilities of the Board committees, it has been agreed to move responsibility for estates and facilities from the Audit Committee to the Finance and Digital Committee. This reflects the realignment of Executive Director responsibilities, with estates and facilities now being the responsibility of the Chief Financial Officer. The Terms of the reference of the Finance & Digital Committee and the Audit Committee have been reviewed with this in mind. The proposed changes are as follows:

Finance & Digital Committee (Appendix 1)

a) The committee to be renamed the Finance, Digital and Estates Committee.

b) The terms of reference have been amended to incorporate the required changes to allow it to have effective oversight of estates and facilities. Job titles have also been updated where appropriate.

c) The membership of the committee has been updated as follows:

- Addition of the newly appointed Chief Digital and Information Officer as a member of the committee;
- Removal of the Chief Executive as a member of the committee.

d) The list of officers who may be required to attend meetings of the Committee at the invitation of the Chair has also been updated.

The governance of the Digital domain will be reviewed once the new Chief Digital and information Officer has taken up his post, and so the terms of reference will be reviewed again once this has been undertaken.

Audit Committee (Appendix 2)

a) removal of paragraph 7.3.8 relating to the review of the work of the Estates Leadership Team with respect to ensuring Regulatory and Legal Compliance, especially with respect to Emergency preparedness, Business Continuity and Safety.

b) The opportunity has also been taken to update any titles that have changed since the terms of reference were last reviewed.

3. Strategic Alignment

N/A

4. Risks and Opportunities

Risks to the robust governance of the Trust and the Committee's capacity to effectively support the Board in its governance function.

5. Recommendation

This report is for Approval

Board is asked to approve the revised terms of reference.

6. History of the paper

Please include details of where paper has <u>previously</u> been received.

Finance & Digital Committee	25 April 2023
Audit Committee	8 June 2023

University Hospitals Bristol and Weston NHS Foundation Trust

Terms of Reference – Finance, Digital and Estates ~~Digital~~ Committee

Document Data	
Corporate Entity	Finance, Digital ~~-~~and Estates ~~Digital~~ Committee
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Chief Financial Officer~~Director of Finance and Information~~
Document Owner	Director of Corporate Governance
Approval Authority	Board of Directors
Review Cycle	12 months
Next Review Date	~~January 2023~~April 2024

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revisions**
November 2007	N/a	Not recorded	Pre-FT	Not recorded
March 2008	N/a	Not recorded	Pre-FT	Not recorded
07 October 2008	N/a	Not recorded	FT	First Foundation Trust version
March 2009	N/a	Not recorded	Not recorded	Not recorded
22 June 2012	1.1	Trust Secretary	Redraft	To ensure congruence with the Terms of Reference of other committees of the Trust Board of Directors as revised at the beginning of 2011-2012. Endorsed by Finance Committee for approval by Trust Board of Directors with addition of footnote 4.
28 June 2012	2.0	Trust Secretary	Major Version	Approved by Trust Board of Directors.
26 September 2014	3.0	Joint Interim Head of Membership & Governance	Redraft	To ensure congruence with the Terms of Reference of other committees of the Trust Board of Directors ahead of the well led Governance Review to be undertaken in late 2014.
28 July 2016	4.0	Trust Secretary	Minor	Changes to job titles and quorum for the committee. Change from Monitor to NHS Improvement. Additional section 7.2 in relation to the quorum. Change from the Trust Secretary attending from time to time, to each meeting. (6.6 (b)
13/10/2017	5.0	Trust Secretary	Minor	Minor typographical amendments Inclusion of the reporting requirement to the Audit Committee (section 5.2) 4.2 (e) updated to reflect the Capital Investment Policy 8.1 a (x) updated to reflect the Use of Resources Rating 4.3 (e) updated to clarify wording
23/10/18	6.0	Deputy Trust Secretary	Minor	Revisions to make sure Tor align with best practice. Revisions to clarify the risk function (as part of a review of all Board ToR in relation to risk) and to ensure assurance mapping is correct across Committees. Clarity of wording.
02/07/20	7.0	Director of Corporate Governance	Major	Inclusion of Information Technology within the remit of the Committee and a new Stakeholder Analysis section
28/01/2022	8.0	Head of Corporate Governance	Moderate	Minor change to wording of membership and quorum Addition of NED champion responsibilities

17/02/2023	9.0	Head of Corporate Governance	Major	Inclusion of Estates within the remit of the Committee

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1. Constitution of the Committee

1.1. The Finance, ~~and~~ Digital and Estates Committee (the Committee) is a non-statutory committee established by the Board of Directors to discharge the duties set out in these Terms of Reference.

2. Purpose and role

2.1. The purpose of the Committee is to support the implementation of the Board's Strategy by seeking assurance about the Trust's financial, ~~and~~ digital and e~~& E~~state strategies.

2.2. Additionally, the Committee shall carry out the role of 'investment committee' for the purposes of the Trust's Capital Investment Policy.

3. Stakeholder Community

3.1. The Committee's ~~(FDC)~~ primary responsibility is to the Board of Directors, as detailed above. However, in order to discharge these responsibilities appropriately the FDC must work in close partnership with a number of internal and external Stakeholders. These Stakeholders influence the work of the Committee ~~FDC~~ by:

- establishing external benchmark standards and requirements
- providing insights on current and emerging risks
- providing / receiving assurance on the suitability and efficacy of the Trust's approach.

3.2. The Stakeholders of the Committee are identified below:

Internal (accountable to)

- Board of Directors
- Council of Governors
- Accounting Officer (CEO of the Trust)

Internal (peer)

- Audit Committee

Internal (reporting to FDC)

- Internal Audit (sub-contracted)

External

- NHS England ~~and Improvement~~
- NHS X
- NHS Digital
- Health & Safety Executive
- ICS/ICB

Stakeholder Analysis

3.3. The Terms of Reference and the responsibilities of the Committee~~FDC~~ are critically dependent on an accurate understanding of the Stakeholder community and their associated requirements, especially any deliverables that are required, either from or by the FITC.

3.4. The following table provides an analysis of the requirements and dependencies associated with the Committee's ~~FDC's~~ Stakeholder Community.

3.5. **Requirements for the Committee~~FDC~~** - Explains what the Committee is required to do based on the requirements of the stakeholder.

3.6. **Inputs into the Committee ~~FDC~~** - Explains what needs to be provided into the Committee to allow it to fulfil the requirements of the stakeholder.

Internal Stakeholder Community					
Stakeholder	Requirements ~~for FDC~~		Inputs ~~into FDC~~		Section Reference
	General	Formal Deliverables	General	Formal Deliverables	
Board of Directors	To advise on status, risks, opportunities associated with the key parameters listed in 2.1	Chair Report (after each meeting) FITC Annual Report and annual review of the Terms of Reference Feedback on the risks held within the BAF and Trust Risk registers	SRR and CRR Recommendations from high risk Internal Audit Approve Terms of Reference	None	7.1, 10.1, 10.3, 10.4 15.1
Council of Governors	Updates at Governors Focus Group Input into the annual operational plans and budget	None	None	None	10.1
Accounting Officer	Finance reports shared with the Senior Leadership Team	None	None	None	10.1
Audit Committee	None	Chair's Report (each mtg)		None	7.2
Internal Audit (sub-contracted)	None	None	None	Relevant high risk Internal Audit Reports (each mtg)	10.4

External Stakeholder Community					
Stakeholder	Requirements ~~for FDC~~		Inputs ~~into FDC~~		Section Reference
	General	Formal Deliverables	General	Formal Deliverables	

External Stakeholder Community					
NHS England and Improvement	None Ambassador for Procurement Target Operating Model	Report the Trust's financial position	None	Finance reports	10.1 10.5.2
NHS X	None	Global Digital Exemplar requirements	None	Update on compliance with GDE	10.3
NHS Digital		Compliance with National standards for management and use of Information Technology, incl. cyber-sec, DSP, information standards		Update on compliance	10.3 10.5.1
Health and Safety Executive	None	Compliance with relevant health and safety regulations, particularly in respect of fire safety.	None		
BNSSG Integrated Care Board	Ensure alignment with ICB's aspirations in respect of finance, digital and estates.	None		None	

4. Function

4.1. The function of the Committee is to seek assurance, on behalf of the Board of Directors in relation to the Trust's financial, ~~and~~ digital and estates strategies, and specifically:

Financial Strategy

- Progress on the delivery of the Financial Strategy
- Delivery of the financial aspects of the Operational Plan
- The annual financial plans: revenue, budgets, capital, working and associated targets for savings to ensure sustainability going forward
- The Trust's financial plans over the short, medium and long term.
- The availability of financial management information (to ensure a consistent approach to financial management);
- Sustainable service commissioning;

- Review and maintain an overview of financial and service delivery agreements and key contractual arrangements
- Oversee the development, management and delivery of the Trust's annual capital programme [1]
- Consider the effectiveness and alignment of key financial policies e.g. investment policy with the Trust's Strategy
- To consider and recommend for approval by the Trust Board of Directors any proposed changes to Trust Standing Financial Instructions.

Digital Strategy

- Progress on the delivery of the Trust's Digital Strategy and aligned programmes
- The changes being brought about by the use of data, information, knowledge and technology within the Trust
- The opportunities and risks of the changes brought about by the Digital Strategy and the changing expectations of staff, stakeholders, patients, service users and the public
- That the risks associated with the adoption of use of digital technologies are understood, weighted against the benefits and mitigated as far as is possible
- That the Trust is supported by technology that is scalable, interoperable, flexible, fixable, resilient and fit for purpose
- That digital implementation and support structures are properly resourced, are embedded throughout the organisation and appropriately involve users and other stakeholders.

Estates & Facilities

- Progress on the delivery of the Trust's Estates Strategy and aligned programmes
- That the arrangements for compliance with the Trust's statutory, regulatory and legal responsibilities for its estate are robust.
- Monitor the performance of Estates and Facilities and associated programmes.
- Progress on the delivery of the development and upkeep of the estate's infrastructure to support the operational plan.
- Progress on improvements to the estate's compliance in respect of fire integrity.
- Ensure that space utilisation is optimised within the Trust.

5. Authority

5.1. The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. The Committee is authorised by the Board to:

- Review, monitor, and where appropriate, investigate any matter within its terms of reference, and seek such information as it requires to facilitate this activity;
- Obtain whatever advice it requires, including external professional or legal advice if deemed necessary (as advised by the Director of Corporate Governance). In so doing, it may require directors and other officers, or independent specialists to attend meetings to provide such advice.
- The Committee discharges the authority delegated to the members of the Committee (when present) both in the Scheme of Delegation, and from time to time by the Chief Executive as recorded in the minutes of meetings.

5.2. Additionally, the Committee has delegated authority to:

- Approve the investment and borrowing strategy and associated policies;

[1] The Finance Committee shall carry out the role of "investment committee" for the purposes of the Trust's Capital Investment Policy.

- Set financial performance benchmarks;
- Approve Project Initiation Documents (as recommended by the Trust Senior Leadership Team) for capital schemes above the de minimis amount[2];
- Approve capital investments and divestments above the de minimis amount[2];
- Approve Business Cases with a capital cost greater than 0.5% and up to and including 1% of the Trust's turnover as per the Capital Investment Policy.

6. Limitations

6.1. Unless expressly provided for in Trust Standing Orders or Standing Financial Instructions the Committee shall have no further powers or authority to exercise on behalf of the Board of Directors.

7. Reporting

7.1. The Chair of the Committee shall report to the Board of Directors on the activities of the Committee and shall make whatever recommendations the Committee deems appropriate (on any area within the Committee's remit where disclosure, action or improvement is considered necessary).

7.2. The Chair shall provide a report on the activities of the Committee at each Audit Committee.

7.3. The Committee shall prepare a statement for inclusion in the Annual Report about its activities.

8. Membership and attendance

8.1. The Finance, ~~and~~ Digital and Estates Committee is appointed by the Trust Board of Directors and includes:

- One Non-Executive Director (who shall be the Committee Chair)
- Two further Non-Executive Directors
- ~~The Chief Executive;~~
- The Chief Financial Officer~~Director of Finance and Information~~;
- The Chief Operating Officer[3].
- The Chief Digital and Information Officer.

8.2. The Chair of the Trust may be a member of the Committee.

8.3. One of the Non-Executive members will be appointed Chair of the Committee by the Board and will not Chair any other standing Committee of the Board.

8.4. It is expected that members or a nominated appropriate representative will attend a minimum of 75% of committee meetings a year.

8.5. The following officers may be required to attend meetings of the Committee at the invitation of the Chair:

- Chief Information Officer

[2] As set out in the Trust's Standing Financial Instructions.

[3] In circumstances where the Chief Operating Officer is unable to attend a meeting, a suitable deputy shall be designated to attend. Attendance by the designated deputy shall be subject to approval by the Chair of the Finance Committee and the Chief Executive jointly. Their presence shall not contribute to the quorum.

- Chief Clinical Information Officer
- ~~Deputy~~ Director of Operational Finance ~~(Planning)~~[4]
- Deputy Director of Finance (Governance)
- Associate Director of Finance
- Director of Estates & Facilities
- Strategic Capital Programme Director
- Head of Financial Management and Service Improvement;
- Chief Clinical Information Officer
- Chief Nursing Information officer
- Clinical Chairs~~;~~
- Divisional Directors~~;~~
- Divisional Finance Managers.~~,~~

8.6. Only members of the Committee, and other Board members, have the right to attend Committee meetings. However, other individuals, including external advisors, may be invited to attend for all or part of any meeting, as and when appropriate.

8.7. The Director of Corporate Governance shall attend each meeting to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance.

9. Quorum

9.1. The quorum necessary for the transaction of business shall be two Non-Executive members, the Chief Financial Officer ~~Director of Finance~~ or nominated deputy, and one other Executive Director, or nominated deputy).

9.2. In the event the Chief Executive is unable to attend a duly convened meeting, then another Executive Director (other than the Chief Financial Officer~~Director of Finance~~) will be nominated to attend on behalf of the Chief Executive.

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

10. Duties

10.1. The duties of the Committee in relation to Finance are to consider and examine on behalf of the Board of Directors:

- The annual budget
- Key Trust and Divisional financial performance indicators;
- Progress to deliver the capital investment programme, in line with recommendations from the Capital Programme Steering Group
- Risks associated with financial plans (finance risk);
- Financial relationships with the Trust's Commissioners;
- Use of Resources Ratings applied by NHS Improvement
- Financial performance forecasts;
- Financial aspects of the Board Assurance Framework document; and, Business cases classed as 'major' or 'high' risk; making recommendations for approval or rejection to

[4] In the event that the ~~Director of Finance~~ Chief Financial Officer is unable to attend, the ~~Deputy~~ Director of Operational Finance ~~(Planning)~~ is a required attendee. In those circumstances the presence of the Deputy Director of Finance (Planning) does contribute to the quorum.

the Board, and,

10.2. The duties of the Committee in relation to Investments are:

- Approve the investment and borrowing strategy and associated policies;
- Set financial performance benchmarks and monitor the performance of investments;
- Review proposed revisions to the Capital Investment Policy for approval by the Trust Board of Directors each year;
- Seek and consider evidence of organisational compliance with the Capital Investment Policy;
- Approve Project Initiation Documents for all capital schemes above the de minimis amount;
- Approve capital investments and divestments above the de minimis amount, ensuring in each case that the Trust has the legal power to enter into the investment;
- Approve business cases within its delegated authority.

10.3. The duties of the Committee in relation to Information Technology are:

- Review the Digital Strategy to ensure that it aligns with the Trust Strategy and operational objectives, including patient care delivery
- Review and recommendation of the annual Digital plan to the Board
- Update on compliance with the Global Digital Exemplar programme
- Seek assurance about the delivery of IT programmes, including benefits realisation, value for money and approaches to the prioritisation of resources
- Consider the risks to the delivery of the IT programmes and Digital Services, in line with the review of the Strategic Risk Registers and Corporate Risk Registers
- Seek assurance about the resilience of Digital services specifically in relation to the digital infrastructure, defending against, and recovery from, external threats, and review the annual Cyber Security Health Check / assessments for assurance.
-
- Ensuring the linkages between the Trust's transformation programme and the Digital Strategy and programmes.

10.4. The duties of the Committee in relation to Estates are:

- To support the development and implementation of an Estates Strategy, and be assured about its delivery.
- To be assured that the Trust is aware of and acting on estates risks, in particular those relating to fire safety.
- To receive assurances in relation to regulatory compliance.

~~10.4.~~10.5. The Committee will also consider relevant high risk internal audit reports and seek updates on progress to close recommendations.

Non-Executive Director Champion Roles

~~10.5.~~10.6. Following the release of NHS England's ~~/Improvement's~~ publication entitled "Enhancing Board Oversight: A New Approach to Non-Executive Director Champion Roles" in December 2021 the following Non-Executive Director Champion Roles have been aligned with Committee:

10.5.1 Cybersecurity NED Champion
10.5.2 Procurement NED Champion

The Committee shall collectively undertake the statutory duties of these former roles.

11. Secretariat Services

11.1. The Finance Department Secretariat shall co-ordinate secretariat services to the Committee.

12. Notice and Conduct of Meetings

12.1. Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.

12.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, any other person required to attend and all other non-executive directors, no later than seven working days before the date of the meeting.

12.3. Supporting papers shall be made available to Committee members and to other attendees as appropriate, no later than three working days before the date of the meeting.

13. Minutes of Meetings

13.1. The secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and those in attendance.

13.2. Draft Minutes of Committee meetings shall be made available promptly to all members of the Committee and, once agreed, to all other members of the Board, unless a conflict of interest exists.

14. Frequency of Meetings

14.1. The Committee shall meet eight times per year, and at such other times as the chair of the Committee shall require.

14.2. The Committee may convene additional meetings should the Chair of the Committee and the Chief Financial Officer ~~Director of Finance and Information~~ agree, or at the request of the Board of Directors.

15. Review of Terms of Reference

15.1. The Committee shall, at least once a year, review its own performance, constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

University Hospitals Bristol and Weston NHS Foundation Trust

Terms of Reference – Audit Committee

Document Data	
Corporate Entity	Audit Committee
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Director of Corporate Governance
Document Owner	Director of Corporate Governance
Approval Authority	Board of Directors
Review Cycle	12 months
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Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision (Major/Minor)**	**Description of Revisions**
16/02/2011	1	Trust Secretary	Draft	Draft for consideration by the members of the Audit and Assurance Committee
08/03/2011	2	Trust Secretary	Draft	Draft for consideration by the Audit and Assurance Committee
04/05/2011	3	Trust Secretary	Draft	Draft for consideration by the Audit Committee on 09 May 2011
09/05/2011	4	Trust Secretary	Draft	Revisions by Audit Committee
26/05/2011	5	Trust Secretary	Draft	For Approval by Trust Board of Directors
26/05/2011	6	Trust Secretary	Approved version	Approved by the Trust Board of Directors
01/09/2015	7	Trust Secretary	Major	Revised terms of reference for consideration by the Audit Committee 9th September 2015
05/10/2016	8	Trust Secretary	Minor	Revised terms of reference for consideration by the Audit Committee 18 October 2016.
10/10/2017	9	Deputy Trust Secretary	Moderate	Revisions to a) Clarify existing practice, b) Ensure terms of reference reflect ICSA guidance/best practice. c) Reflect input from the Internal and External Auditors, d) Reflect input from the Chair [and the members] of the Committee e) Include minor grammatical corrections.
28/11/2018	10	Trust Secretary and AC Chair	Moderate	Inclusion of Context Section & Stakeholder Analysis. Re-organisation of Section on Duties Clarification re key deliverables
27/10/2021	11	Head of Corporate governance	Minor	Reviewed post-merger and titles updated.
23/05/2022	12	Director of Corporate Governance	Minor	Clarify the role of the committee in relation to Clinical Audit and Emergency, Planning, Resilience and Response. Changes aligned with those made to the Quality and Outcomes Committee ToR.
30/05/2023	13	Head of Corporate Governance	Minor	Remove responsibility for Estates to align with changes to the Finance, Digital and Estates Committee. Director titles updated.

Contents

1. Constitution of the Committee

1.1. The Audit Committee (AC) is a statutory Committee established by the Board of Directors to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for Governance, Assurance and Risk Management.

2. Context

Stakeholder Community

2.1 The Audit Committee's primary responsibility is to the Board of Directors, as detailed above. However, in order to discharge these responsibilities appropriately the AC must work in close partnership with a number of internal and external Stakeholders. These Stakeholders influence the work of the AC by:

- establishing external benchmark standards and requirements
- providing insights on current and emerging risks
- providing / receiving assurance on the suitability and efficacy of the Trust's approach.

2.2 The Stakeholders of the Audit Committee are identified below:

Internal (accountable to)

- Board of Directors
- Council of Governors
- Accounting Officer (CEO of the Trust)
- ~~Director of Finance and Information~~ Chief Financial Officer

Internal (peer)

- People Committee
- Quality and Outcomes Committee
- Finance~~, &~~ Digital & Estates Committee

Internal (reporting to AC)

- Internal Audit (sub-contracted)
- Local Counter Fraud Specialist (sub-contracted)
- Local Security Management Specialist
- Clinical Audit
- Freedom to Speak Up Guardian

External

- External Audit
- National Audit Office
- HM Treasury
- Freedom to Speak Up National Guardian
- NHS Counter Fraud Authority
- Cabinet Office

Stakeholder Analysis

2.3 The Terms of Reference and the responsibilities of the AC are critically dependent on an accurate understanding of the Stakeholder community and their associated requirements, especially any deliverables that are required, either from or by the AC.

2.4 The following table provides an analysis of the requirements and dependencies associated with the AC's Stakeholder Community.

2.5 **Requirements from AC** - Explains what the Audit Committee is required to do based

on the requirements of the stakeholder.

2.6 **Inputs into AC** - Explains what needs to be provided into the Audit Committee to allow it to fulfil the requirements of the stakeholder.

Internal Stakeholder Community					
Stakeholder	**Requirements from AC**		**Inputs to AC**		**Section Reference**
	General	Formal Deliverables	General	Formal Deliverables	
Board of Directors	Feedback on emerging risks	AC Chair Report (after each meeting) AC Annual Report Feedback on the risk management process and specifically the risks held within the BAF and Trust Risk registers Feedback on the overall Annual Report, including the Quality Report	Identification of emerging risks Recommendations for Internal Audit Approve Terms of Reference	Quality Report	7.3 7.10 7.11 8.8 8.11
Council of Governors	Updates at Governors Constitution Focus Group	Recommendation to appoint, re-appoint or remove the external auditor Performance evaluation of the External Auditors Audit Committee draft Terms of Reference for consultation	None	Authorisation to appoint agreed external auditor	7.5 7.12
Accounting Officer	None	Submission for Annual Governance Statement	None	Draft Annual Report (for AC review)	7.3
Chief Financial Officer~~Director of Finance and Information~~	None	None	Identification of emerging risks (Finance, IT) Recommendations for Internal Audit	Accounting Policies Draft Annual Accounts Inputs to Annual Report including FD Report, Accounting Policies, TACs Summarisation Schedules, Single Estimates) Losses and Special payments report (each mtg) Single Tender Report (each mtg)	7.7

Internal Stakeholder Community					
People Committee	None	Results of relevant Internal Audits	Chair's Report (each mtg)	None	7.3.7
Quality and Outcomes Committee	None	Results of relevant Internal Audits	Chair's Report (each mtg)	None	7.3.7
Finance, Estates & Digital Committee	None	Results of relevant Internal Audits	Chair's Report (each mtg)	None	7.3.7
Internal Audit (sub-contracted)	Requirements for Internal Audit (including Freedom to Speak Up issues) Feedback on Reporting	None	None	Internal Audit Plan (annual) Internal Audit Reports (each mtg) Progress Report (each mtg) Head of Internal Audit Opinion (for reference in the Annual Governance Statement – part of the Annual Report)	7.4
Local Counter Fraud Specialist (sub-contracted)	None	None	None	Annual Plan Annual Report Progress report (each mtg)	7.8
Local Security Management Specialist	None	None	None	Progress report (each mtg)	7.8
Clinical Audit (more regular reports via QOC)	None	None	None	Internal audit report	7.6
Freedom to Speak Up Guardian	None	None	None	Annual Report	7.9

External Stakeholder Community					
Stakeholder	**Requirements from AC**		**Inputs to AC**		**Section Reference**
	General	Deliverables	General	Deliverables	
External Audit	Guidance on possible scope of annual audit Informal communication on external audit activities (Without Executives present)			Audit Report (ISA 260 Report) Trust Accounts Consolidation Schedules Management Letter of Representation, Quality Report Management representation letter Assurance Report on the Trusts Quality Report Report to the Council of	7.5

External Stakeholder Community					
				Governors on Trusts Quality Report (annually)	
NHSI	None	Escalation in those instances where the services of the External Auditor are terminated in disputed circumstances. Escalation where exceptional, serious and improper activities have been revealed by the Committee, if insufficient action has been taken by the Board of Directors after being informed of the situation.	None	NHS Code of Governance	7.13 7.14
National Audit Office	None	None	None	Code of Audit Practice	7.1
HM Treasury	None	None	None	Audit and risk assurance committee handbook	7.1
Freedom to Speak Up National Guardian	None	None	None	Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts	7.9
NHS Counter Fraud Authority	None	None	None	Counter Fraud Standards for NHS Providers	7.8
Cabinet Office	Compliance with Civil Contingencies Act (2004)	None	None	Report on legislative and regulatory compliance ~~Annual EPRR Report~~	7.3.10

3. Responsibilities

3.1 As stated above, the purpose of the Audit Committee is to ensure the suitability and efficacy of the Trust's provisions for Governance, Assurance and Risk Management. The activities of the AC are therefore focused on the Policies and Processes of the Trust:

- Definition
- Implementation
- Outcomes

and especially on the approach to Enterprise Risk Management, that is the identification and management of Operational and Strategic Risks which might impact on the Trust's principle objectives.

3.2 The **primary responsibilities** of the Audit Committee are therefore to:

1. Review and seek assurance of the Trust's approach to Risk Management and

internal control

2. Monitor and review the effectiveness of the internal audit function,
3. Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process
4. Seek assurance about Clinical Audit activity

3.3 In addition, the AC has specific responsibilities which it undertakes on behalf of the Board with respect to:

5. Integrity of Financial Reporting
6. Activities to Identify and Counteract Fraud
7. Ensuring the effectiveness of the Freedom to Speak Up Policy

3.4 Finally, the AC must:

8. Communicate and report effectively to all its Stakeholders

3.5 Each of these responsibilities is covered in more detail in section 7. The performance of the Audit Committee is most clearly evidenced by the degree of Stakeholder Satisfaction.

4. Authority

4.1 The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any officer of the Trust and to call any employee to be questioned at a meeting of the Committee as and when required.

4.2 This will include, but is not limited to:

- Evaluating the integrity of the financial statements of the Trust, any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them
- Independently and objectively monitor, review and report to the Board on the adequacy of the policies and processes for governance, assurance, and risk management
- Facilitate the effective implementation of an internal and external audit plan, and so the development, maintenance and implementation of Trust Policies and Processes
- Obtain whatever professional advice it requires (as advised by the Trust Secretary);

4.3 Since the Audit Committee is a Non-executive Committee of the Board of Directors it has no executive powers, other than those specifically delegated in these Terms of Reference.

5. Membership and attendance

5.1 Members of the Committee shall be appointed by the Board of Directors and shall number at least three.

5.2 All members of the Committee shall be independent Non-executive Directors.

5.3 The Committee should identify and agree with the Board of Directors the skills required for Committee effectiveness. These skills will include governance, assurance and risk.

5.4 At least one member of the Committee should have recent and relevant financial

experience sufficient to allow them to competently analyse the financial statements and understand good financial management disciplines.

5.5 The Chairs of the People, Finance, ~~&~~ Digital & Estates and the Quality and Outcomes Committees will usually be members unless this does not meet the skills and experience requirements of the Committee.

5.6 Where the Chairs of the other Board Committees are not members (see above), then they will be invited to attend the meetings.

5.7 The Chair of the Board of Directors shall not be a member of the Committee and should limit his/her attendance to one meeting per annum to support the evaluation of the effectiveness of the Committee.

5.8 Only members of the Committee have the right to attend Committee meetings. However non-committee members may be invited to attend and assist the committee from time to time.

5.9 Members may nominate a deputy to attend where they are unavailable. The deputy must be agreed with the Chair of the Committee and must be an Independent Non-Executive Director of the Trust.

5.10 In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5.11 External Audit and Internal Audit representatives shall be invited to attend all meetings of the AC. At least once a year the Committee should meet privately with the External and Internal Auditors.

5.12 The Chief Financial Officer ~~Director of Finance & Information~~ shall normally attend meetings.

5.13 The Chief Executive and other Executive Directors should be invited to attend as appropriate. The Chief Executive (or his/her nominated deputy) shall be required to attend the review of the Annual Governance Statement.

5.14 The Committee Secretary shall be the Director of Corporate Governance or his/her nominated deputy. The Director of Corporate Governance or his/her nominated deputy shall attend all meetings of the Committee.

6. Quorum

6.1 The quorum necessary for the transaction of business shall be three members, all of whom must be independent Non-Executive Directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7. Duties

7.1 The Committee shall undertake the duties detailed in the HM Treasury's Audit and Risk Assurance Committee Handbook, with reference to the NHSI Code of Governance and with regard to the National Audit Office Code of Audit Practice, see references in section 9. In addition the HFMA's NHS Audit Committee Handbook maybe taken into consideration to determine the governance of the Committee.

7.2 The following sections provide more detail of the specific duties, associated with the responsibilities of the Committee as outlined in section 3.

Review and seek assurance of the Trust's approach to Risk Management and

internal control

7.3 The Committee shall

7.3.1 Review the establishment and maintenance of an effective system of integrated governance, assurance and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of both the organisation's Strategic and Operational Objectives; this includes a review of the Board Assurance Framework, Strategic and Operating Plans and the associated Trust Risk Registers.

7.3.2 Review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

7.3.3 Work with Internal and External Audit leadership teams to establish the level of compliance with External Legal and Regulatory Requirements and Trust Policies and Processes and to identify any associated risks.

7.3.4 Review any Governance, Assurance and Risk related disclosure statements, in particular the Annual Report~~, including the Quality Report~~ and annual statements made by the Internal and External Auditors to ensure that any risks or gaps in controls are identified and appropriate actions are taken;

7.3.5 Review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications to the governance of the Trust. These will include, but not be limited to, any reviews undertaken by the Department of Health Arms-Length Bodies, Regulators, other Trust Committees as well as professional bodies with responsibility for the performance of staff or functions.

7.3.6 Review the scope and status of services hosted by our Trust on an annual basis to identify whether there are any emerging risks which might impact on the Trust's reputation

7.3.7 Review the work of other Committees within the organisation, whose work can help identify current and emerging risks and provide relevant assurance to the Audit Committee's own scope of work

~~7.3.8 Review the work of the Estates Leadership Team with respect to ensuring Regulatory and Legal Compliance, especially with respect to Emergency preparedness, Business Continuity and Safety (called up in ABC)~~

7.3.~~9~~8 Receive regular reports from the Chair of the Risk Management Group (included in ABC).

7.3.~~10~~9 Receive a report on legislative and regulatory compliance in relation to Emergency Planning, Resilience and Response, and the effectiveness of the governance framework which supports delivery in the Trust.

Monitor and review the effectiveness of the internal audit function

7.4 The Committee shall:

7.4.1 Ensure that there is an effective Internal Audit function that provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors;

7.4.2 Consider and approve the Internal Audit strategy and annual plan and ensure it has adequate resources and access to information, including the Board Assurance Framework, and ensure coordination between Auditors to optimise use of audit resource;

7.4.3 Ensure the function has adequate standing and is free from management or other

restrictions;

7.4.4 Review promptly all reports on the Trust from the Internal Auditors including the Executive Management's responsiveness to the findings and recommendations of reports

7.4.5 Ensure the People, Quality and Outcomes and Finance, ~~&~~ Digital & Estates Committees have full visibility of Audit reports that might impact on their work

7.4.6 Meet the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out. The Head of Internal Audit shall be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors and to the Committee;

7.4.7 Conduct a review of the effectiveness of Internal Audit services once every year

Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process

7.5 The Committee shall:

7.5.1 Consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor;

7.5.2 Work with the Council of Governors to manage the selection process for new auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this, and make any associated recommendations to the Council of Governors;

7.5.3 Receive assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts;

7.5.4 Approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted;

7.5.5 Agree and review the policy regarding the supply of non-audit services by the External Auditor and monitor that service, taking into account relevant ethical guidance;

7.5.6 Review and monitor the External Auditors' independence and objectivity and the effectiveness of the audit process annually. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work;

7.5.7 Meet the external auditor at least once a year, without management being present; to discuss their remit and any issues arising from the audit;

7.5.8 Discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, as set out in the annual plan;

7.5.9 Discuss with the External Auditors their evaluation of audit risks and assessment of the Trust, and

7.5.10 Review all External Audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses;

Seek assurance about Clinical Audit activity

7.6 The Committee shall:

7.6.1 The Committee shall work with the Chair of the Quality and Outcomes Committee

to review issues around clinical risk management and ensure that the Clinical Audit function is positioned to effectively identify and facilitate the mitigation of clinical risks.

7.6.2 The Committee will receive the assurance via a periodic internal audit report on the effectiveness of the clinical audit function and compliance with legislation, regulation and other national requirements.

Integrity of Financial Reporting

7.7 The Committee shall:

7.7.1 Ensure the integrity of the annual report, summary financial statements, and all other significant financial statements submitted by the Trust to external stakeholders. In reaching a view on the accounts, the Committee should consider:

- key accounting policies and disclosures
- assurances about the financial systems which provide the figures for the accounts
- the quality of the control arrangements over the preparation of the accounts
- key judgements made in preparing the accounts
- any disputes arising between those preparing the accounts and the auditors

7.7.2 Review these Financial Statements to identify significant issues and judgements and ensure actions are implemented as appropriate

7.7.3 Review the consistency of, and changes to, accounting policies both on a year on year basis and across the Trust and its subsidiary undertakings;

7.7.4 Review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the External Auditor; and

7.7.5 Review at each meeting, reports detailing:

- Losses and special payments
- Single Tender Actions (i.e. procurement without competition)

Activities to Identify and Counteract Fraud

7.8 The Committee shall:

7.8.1 Ensure that there is an effective Counter Fraud function that that meet the required NHS Counter Fraud Authority standards

7.8.2 Consider and approve the Counter Fraud strategy and annual plan and ensure it has adequate resources and access to information to undertake its activities

7.8.3 Undertake regular reviews of the work undertaken to counter fraud and to establish effective security arrangements of the Trust’s assets

7.8.3 Undertake an Annual Review of the Board’s Register of Interests (called up in ABC)

7.8.4 Undertake an Annual Review of the Trust Wide Register of Interests, Gifts and Hospitality

7.8.5 Conduct a review of the effectiveness of Counter Fraud services every year

Ensuring the effectiveness of the Freedom to Speak Up Policy

7.9.1 The Committee shall monitor and receive assurance on compliance with the Trust's Freedom to Speak Up Policy and ensure that the policy allows for proportionate and independent investigation of such matters and appropriate follow-up action. This will be achieved by the Committee receiving an Internal Audit review of the Trust's arrangement for staff to raise issues on an annual basis.

Reporting to Board and other Stakeholders

7.10 The Committee Chair shall prepare and submit a written report after each Audit Committee for review and discussion at the proceeding Board of Directors meeting to:

- Provide assurance that an appropriate system of governance is in place
- Identify any emerging Risks associated with the Trust's System of Governance and its approach to Assurance and Enterprise Risk Management
- Inform the Board of any key decisions that have been taken or actions that have been placed

7.11 In addition, the Committee, having considered its effectiveness, will produce an Annual Report which will be developed in accordance with the Trust's requirements and will include:

- Details of how the committee is discharging its responsibilities.
- Reference to any non-audit services provided by the external auditors, and if so, how auditor objectivity and independence is safeguarded;
- Details of the full auditor appointment / contract termination processes (including the position of the Council of Governors with regard to the decisions taken) and the Committee's reasons for any decisions taken
- The signature of the Chair of the Audit Committee.

Reporting to Other Stakeholders

7.12 The Committee shall make necessary recommendations to the Council of Governors on areas relating to the appointment, re-appointment and removal of External Auditors, the level of remuneration and terms of engagement

The Chair of the Committee shall write to the Independent Regulator of NHS Foundation Trusts (NHS Improvement) in those instances where the services of the External Auditor are terminated in disputed circumstances.

Where exceptional, serious and improper activities have been revealed by the Committee, the Chair of the Committee shall write to NHS Improvement, if insufficient action has been taken by the Board of Directors after being informed of the situation.

8. Administration

8.1 The Committee shall meet a minimum of four times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require allowing the Committee to discharge all its responsibilities.

8.2 Meetings of the Committee shall be called by the Secretary of the Committee at the request of the Committee Chair. The Board of Directors, Chief Executive, External Auditors or Head of Internal Audit may request an additional meeting if they consider it necessary.

8.3 Trust Secretariat shall provide secretariat services to the Committee and shall provide appropriate support to the Chair and Committee members as required.

8.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting.

8.5 Supporting papers, detailing their purpose for inclusion and the actions / decisions that are expected of the Committee shall be made available no later than three working days before the date of the meeting.

8.6 The secretary shall minute the proceedings of all Committee meetings and maintain an "actions arising log". Draft minutes and the actions arising shall be issued promptly to the Chair of the Committee, for review, before formal issue

8.7 The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.

8.8 The Committee shall, at least once a year, review its own performance to ensure it is operating at maximum effectiveness. The Committee shall consider the use of the HFMA's Audit Committee Self-Assessment Checklist for this purpose.

8.9 All papers (notices, agendas, supporting papers and minutes) will be sent in electronic form, except where the recipient has specifically requested to receive documents in paper format.

8.10 The Director of Corporate Governance and Committee Chair shall develop and maintain an Annual Business Cycle detailing the standing agenda items required at each meeting throughout the year in order to discharge the duties detailed herein.

8.11 The Committee shall review its own terms of reference annually.

9. External References

HM Treasury - Audit and risk assurance committee handbook
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/512760/PU1934_Audit_committee_handbook.pdf

NHS Code of Governance
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/327068/CodeofGovernanceJuly2014.pdf

National Audit Office - Code of Audit Practice

https://www.nao.org.uk/code-audit-practice/

NHS Counter Fraud Authority – Standards for NHS Providers

https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Providers_2018.pdf?v=1.0

HFMA – NHS Audit Committee Handbook (available on request from the Trust Secretary)

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**Register of Seals Report**
Report Author	**Mark Pender, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Purpose
This report provides a summary of the applications of the Trust Seal made since the previous report in February 2023**.**
2. Key points to note *(Including any previous 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. 7 sealings have taken place since the last report, as per the attached list.
3. Strategic Alignment
N/A
4. Risks and Opportunities
N/A
5. Recommendation
This report is for Information The Board is asked to note the Register of Seals report.
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**

N/A	

University Hospitals Bristol and Weston NHS Foundation Trust

Register of Seals

March 2023 – May 2023

Reference Number	Document	Date Signed	Authorised Signatory 1	Authorised Signatory 2	Witness
887	Lease of 1st floor kitchen and storeroom, Chapter House, Lower Maudlin Street, Bristol	02/05/2023	Eugine Yafele	Emma Wood	Mark Pender
886	Lease for Heat Substation accommodation at Central Health Clinic, Tower Hill, Bristol between UHBW and Bristol Heat Networks Ltd.	05/04/2023	Neil Kemsley	Emma Wood	Mark Pender
885	Contract for sale of Dental Hospital and Wellcome Building, Lower Maudlin Street, Bristol	28/03/2023	Neil Kemsley	Stuart Walker	Eric Sanders
884	Lease of part of the 1st and 3rd floor of the Bristol Dental Hospital; 3rd Floor of the Wellcome Building; and 3rd floor of Chapter House at Lower Maudlin Street Bristol between UHBW and University of Bristol.	28/03/2023	Neil Kemsley	Stuart Walker	Eric Sanders
883	Lease of 1st, 2nd and 3rd floors of the Dental Hospital; Ground, 1st, 2nd and 3rd Floors of the Bristol Dental Hospital Extension; 3rd Floor of the Wellcome Building; and Ground, 2nd and 3rd floors of Chapter House at Lower Maudlin Street, Bristol between UHBW and the University of Bristol.	28/03/2023	Neil Kemsley	Stuart Walker	Eric Sanders
882	Dental Hospital – transfer of Registered Title (TR1)	28/03/2023	Neil Kemsley	Stuart Walker	Eric Sanders

881	Scheme Agreement – P23 Framework Agreement Lot 3 between UHBW and Laing O'Rourke Delivery Ltd	23/03/2023	Jane Farrell	Emma Wood	Mark Pender

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 15 June 2023

Report Title	**Governors' Log of Communications**
Report Author	**Mark Pender, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Purpose
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 is a means of channelling communications between the governors and the officers of the Trust.
2. Key points to note *(Including any previous decisions taken)*
Since the previous Board of Directors meeting held in public on 18th April: • Five questions have been added to the Governors' Log which relate to Cancer Support Services, apprenticeships, patients fit for discharge, ED services in Weston and Minor Injury Units in North Somerset. • Three questions have been closed. • No questions are overdue.
3. Strategic Alignment
N/A
4. Risks and Opportunities
None
5. Recommendation
This report is for Information
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**
N/A

Governors Log May 2023

Ref	Coverage start date	Governor Name	Description	Executive Lead	Response	Status
278	28/04/2023	Ben Argo, John Sibley	Please can you advise of the present situation regarding bringing a cancer support centre to Bristol? Please can you also confirm that Non-execs have been updated on this project?	Chief Operating Officer	A 'Maggie's Centre' (Maggie's Bristol) is going to be built on the Bristol site at UHBW. The whole process for this project was paused throughout the pandemic, but is back on track again now. Approval for the preferred Bristol site was supported through the Strategic Estates Development Programme Board (SEDPB) and Senior Leadership Team in 2022 and Head of Terms have been finalised (between Maggie's and UHBW) and approved through SEDPB (10/3/22). Maggie's have commenced initial searches / surveys of the site and the architects are developing initial designs, which will then be submitted to UHBW for review. The formal Comms around location and progress is being managed by UHBW and Maggie's Comms teams and will be coordinated with all stakeholders. Wider Comms will be launched when agreed provisional designs of 'Maggie's Bristol' are available. Updates are regularly provided through Cancer Steering Group. An update was also provided at the Quality Focus Group in September 2022, when presenting the latest National Cancer Patient Experience Survey results and action plan. A site visit was held in January 2023 by Maggie's Chief Executive, Design team along with UHBW Chair and Chief Executive.	Closed
279	10/05/2023	Ben Argo, Sarah George	1. What plans does the Trust have to implement, train and supervise new apprenticeships? 2. What impact is this expected to have on day-to-day operations and on medical student placements if senior clinicians need to spend time training and supervising new apprentices? 3. How is the apprenticeships programme going to be monitored and scrutinised by the NEDs? 4. What plans are there to engage with the Universities in planning discussions around this topic?	Chief People Officer	A robust application process is in place to ensure checks have taken place with the appropriate people ensuring there is ample capacity for the apprentice to learn and be supported in their role by a mentor/buddy/learning coach before we allow an application to proceed and engage in the HEI. Assigning a workplace mentor/buddy/learning coach is a powerful tool, ensuring our apprentice settle into their role quickly and thrive in the workplace. A mentor/buddy/learning coach is separate to a line manager and is someone who provides a support system for the apprentice. They can help apprentice resolve issues quickly. A workplace mentor/buddy/learning coach may: •Share their knowledge and experiences. •Provide advice, guidance, and feedback. •Act as a sounding board for ideas and action plans •Offer encouragement and support. •Celebrate the apprentice's success. •Identify development opportunities. •Build an apprentice's confidence, independence, and self-belief. •Set goals. •Support personal development and wellbeing. An apprenticeship report forms part of the Education updates which go to People Committee and provide assurances on progress with apprentices . In addition a paper which describes progress against our workforce plans which includes our apprenticeship offer also goes to the People committee twice a year. NEDs take assurance against the milestones set in the people strategy which relate to apprentices. The Trust runs partnership meetings with all educational providers from the initial planning stage of a new apprenticeship to the on-going monitoring of individual apprentice progress. The department has already actively engaged with Plymouth University concerning the medical degree apprenticeship. Plymouth University are finalising the medical degree apprenticeship offer which will support us to gauge interest in our approach. Plymouth are looking for Trusts that are working as part of a cluster with other healthcare providers, such as primary care, community-based hospitals, hospices. Plymouth envisage that each cluster will provide 4-6 apprentices that will remain in the cluster, but the cluster will work together to provide placement opportunities in different health care environments. This is aligned to all apprenticeship route (nursing and non-clinical) with engagement of their appropriate HEI.	Closed
280	15/05/2023	John Sibley	Please could you tell me how many patients are fit for discharge, but still occupy a hospital bed? Secondly, can you inform me how many of those patients have been waiting longer than 4 weeks for either an assessment by social services or are waiting for a care placement or package?	Chief Operating Officer	Today (25 May 2023) we have 151 patients who are fit for discharge but still residing in hospital – 88 people in the BRI and 63 at Weston. Whilst, on the whole, people no longer wait in hospital for permanent onward care arrangements to be made (eg care packages or care home placements), there are some people who have been fit for discharge for longer than four weeks awaiting discharge plans to become available. The breakdown is as follows: •1 person in the BRI has been waiting longer than 4 weeks for care arrangements at home to be put in place. There are some complicating factors which are being worked through by the system MDT, including training for the person's family on managing their new PEG feeding and medications. •8 people have been waiting longer than four weeks for assessment beds in nursing homes to become available. •5 people have been waiting longer than 4 weeks whilst complex discharge plans are formulated, including a requirement for social care in-reach assessments.	Closed
281	25/05/2023	John Rose	What guidance is there for staff in the A&E department at Weston Hospital regarding how to help people who have been waiting in A&E for an hour or more and are still there at 2200hrs? The background is that an elderly person involved in a serious car accident had presented themselves at Clevedon MIU with serious back pain and needed radiological investigation, but after a long wait was told to go to Weston. After another long wait at Weston they were told that they might get a bed overnight at Weston or they could go home and present themselves at NBT the following day. Being elderly, they chose to go home and eventually were scanned the next day and found to have 3 fractured bones in their spine.	Executive Managing Director (Weston)		Assigned to Executive Lead
282	26/05/2023	Annabel Plaister	I saw a good and long-standing friend who is an ANP in ED in Weston and proudly told me how well they are doing – one of the top performers in UK – it was so lovely to see, for several years it's been more doom and gloom from the Weston staff when I bump into them. She told me they have rooms off the reception now and easy cases are seen by her and other ANP quickly and in and out within 40 minutes, Healthy Weston changes including the SDEC have really helped, staff are settled, less vacancies and they are excited to be getting the junior Dr's back in a few months. Her only frustration is that technically minor injuries should be re-directed to Clevedon and Clevedon have had a lump of money to facilitate this, in reality they find it hard to send their typical type patients up to Clevedon so deal with them and it seems unfair that Weston hasn't had a financial injection. Clevedon is amazing and perfect for patients in Clevedon, Nailsea and Portishead etc. Is the Board aware of this issue and what can be done to either ensure more people are attending minor injuries for minor injuries, or to facilitate this kind of unit closer to Weston?	Executive Managing Director (Weston)		Assigned to Executive Lead