University Hospitals Bristol and Weston NHS Foundation Trust

Board of Directors (in Public)

Meeting of the Board of Directors to be held in Public on
Tuesday 30 November 2021 at 11.00am – 2.00pm
Engineers House
AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
Preliminary Business				
1.	Welcome and Apologies for Absence *(Verbal update)*	Information	Interim Chair	11:00
2.	Declarations of Interest *(Verbal update)*	Information	Interim Chair	11:02
3.	Patient Story	Information	Chief Nurse and Midwife	11:05
4.	Minutes of the Last Meeting: 30 September 2021	Approval	Interim Chair	11:25
5.	Matters Arising and Action Log	Approval	Interim Chair	11:27
6.	Chief Executive's Report	Information	Chief Executive	11:30
7.	CQC Final Inspection Report	Information	Chief Executive	11:40
Strategic				
8.	Genomics Medicine Service Alliance (*Presentation from Professor Chrissie Thirlwell, Clinical Director SW GMSA*)	Information	Chief Executive	11:50
9.	System Oversight Framework Report	Information	Chief Executive	12:05
10.	Strategic Capital Programme Report	Assurance	Director of Strategy and Transformation	12:10
11.	Integration Report	Assurance	Director of Strategy and Transformation	12:20
12.	Sustainability Annual Report	Assurance	Director of Strategy and Transformation	12:25
13.	H2 – oversight of submission	Information	Director of Strategy and Transformation	12.30
14.	Acute Provider Collaborative Board Chair's Report	Information	Interim Chair	12:35
Break				12:40
Quality and Performance				
15.	Quality and Outcomes Committee Chair's Report 15.1 Integrated Quality & Performance Report 15.2 Quarterly Maternity Perinatal Quality Surveillance Matrix	Information/ Assurance	Committee Chair	12:50

NO.	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
	15.3 Infection Control Annual Report 15.4 Six-Monthly Nurse Staffing Report 15.5 Learning from Deaths Report Quarters1&2			
Research				
16.	Research and Innovation 6-monthly Report	Information	Interim Medical Director	13:15
People Management				
17.	People Committee Chair's Report 17.1 Embedding of the new Trust Values 17.2 Diversity and Inclusion Report/WRES and WDES Action Plan 17.3 Flu Board Assurance Framework 17.4 Freedom to Speak Up Quarter 2 Report	Information/ Assurance	Committee Chair	13:20
Finance				
18.	Finance and Digital Committee Chair's Report 18.1 Trust Finance Performance Report	Assurance	Committee Chair	13:40
Governance and Risk				
19.	Register of Seals Quarter 2	Assurance	Director of Corporate Governance	13:50
20.	Governors Log of Communications	Information	Director of Corporate Governance	13:55
Concluding Business				
21.	Any other urgent business 21.1 Amendment to Standing Financial Instructions	Information Approval	Interim Chair Director of Finance and Information	14:00
22.	Date of next meeting: **28 January 2022 11am**	Information	Interim Chair	

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

Report Title	**What Matters to Me – a Patient Story**
Report Author	**Tony Watkin, Patient and Public Involvement Lead**
Executive Lead	**Deirdre Fowler – Chief Nurse and Midwife**

1. Report Summary

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 this patient 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 decisions taken)

In this patient experience story we will hear from Victoria. Victoria was diagnosed with Crohn's disease at 15 years old and has attended the Bristol Royal Infirmary many times over the past 7 years both as an in-patient and out-patient. Victoria was most recently an in-patient at the BRI in October and took part in a patient experience interview as part of a Bedbase project in the Division of Medicine[1].

In sharing her story Victoria will explain some of the key differences she experienced whilst receiving care as an in-patient both pre and post Covid. Drawing on her most recent stay, Victoria will acknowledge the pressure the hospital and ward staff were under and the concern she felt for nurses who were "too stretched." In particular, Victoria will recount an episode in ambulatory care where her medication was compromised. She will go on to explain that, whilst ordinarily a patient on a gastroenterology ward, as a patient on a busy outlier ward she felt left to her own devices at times taking on an advocacy role both for her own care and that of others. To illustrate this, Victoria will talk about the concerns she held for other patients and how she supported a fellow patient to access suitable meals.

[1] The Bedbase project sits within the Division of Medicine and aims to:

- provide equitable experience, safe, quality and effective care to all our patients
- get patients to the right specialty to provide treatment at the earliest point in their pathway
- attract and retain talented health professionals across all disciplines
- use the medicine division beds in the most effective way to support flow through the hospital

Referencing her experience as an out-patient Victoria will note that the care from both the inflammatory bowel team and the nutrition team has been consistently good, including the introduction of video appointments.

To conclude, Victoria will talk about how at the end of her stay with us her much loved Bear and companion on many an in-patient stay went missing. Happily, after a search, Bear was found amongst the laundry and re-united – much to the delight of Victoria and everyone involved. Victoria will reflect on how this experience holds a mirror up to the complexities and contradictions of caring for people in its widest sense.

3. Risks

The risks associated with this report include:
N/A

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

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

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

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

University Hospitals Bristol and Weston NHS Foundation Trust

Minutes of the Board of Directors Meeting held in Public
Thursday 30 September 2021, 12:00-14:30
Engineers House, The Promenade, Clifton Down, Bristol, BS8 3NB
Broadcast live online for public viewing

Present

Board Members

Name	Job Title/Position
Jayne Mee	Interim Chair
Robert Woolley	Chief Executive
David Armstrong	Non-Executive Director
Sue Balcombe	Non-Executive Director
Julian Dennis	Non-Executive Director
Deirdre Fowler	Chief Nurse and Midwife
Bernard Galton	Non-Executive Director
Neil Kemsley	Director of Finance and Information
Emma Redfern	Interim Medical Director
Mark Smith	Deputy Chief Executive and Chief Operating Officer
Martin Sykes	Non-Executive Director

In Attendance

Name	Job Title/Position
Natashia Judge	Head of Corporate Governance
Sarah Murch	Membership Manager (minutes)
In Attendance via videoconference:	
Matthew Areskog	Patient Experience Manager (Item 03/09/21 only)
Tony Watkin	Patient and Public Involvement Lead (Item 03/09/21 only)
Mark Stevens	General Manager, Bristol Eye Hospital (Item 03/09/21 only)
Gillian Schiller	Associate with PHAST CIC (Public Health Action Support Team Community Interest Company) (Item 03/09/21 only)
Louis	Patient (Item 03/09/21 only)
Alistair Johnstone	Guardian of Safe Working (Item 14/09/21 only)
Anthea Ward	Medical Records and Clinical Coding Manager (shadowing Alex Nestor)

The Chair opened the Meeting at 12:00

01/09/21	**Welcome and Introductions/Apologies for Absence**	
	Jayne Mee, Interim Chair of the Trust, welcomed the Board and members of the public to the meeting. As the meeting was taking place during the Covid-19 pandemic and members of the Board were attending in person, Jayne Mee confirmed that all attendees had conducted a lateral flow test before attending and were symptom free. In order that members of the public did not also need to attend in person, the meeting was being livestreamed on YouTube for public access and the recording would be available online for two weeks. Apologies had been received from Alex Nestor, Interim Director of People, Jane Norman, Non-Executive Director, Eric Sanders, Director of Corporate	

	Governance, Paula Clarke, Director of Strategy and Transformation, and Steve West, Non-Executive Director.	
02/09/21	**Declarations of Interest**	
	There were no new declarations relevant to the meeting to note.	
03/09/21	**Patient Story**	
	Tony Watkin, Patient and Public Involvement Lead, introduced Louis, a patient who had attended the Bristol Eye Hospital for a number of years. Louis explained to the Board that he was blind, though lived fully independently and worked full-time. He could not read printed letters, and so needed communications to be sent to him either in Braille or via e-communications (email or website) so that he could use a screen-reader. Louis had asked medical and reception staff at Bristol Eye Hospital repeatedly for a number of years to send him communications in Braille or by email, but this had not happened. This had meant that he was unaware of clinic appointments earlier in 2021 which had been sent to him by post. No text reminders had been sent to him. He had also been unaware of a letter informing him that he had been referred back to his GP because he had missed two appointments. When he finally found out, he had been mortified at the thought of wasting the NHS's time. Louis made a complaint through the Trust's complaints procedure and spoke of his appreciation of the honesty and openness of the response he received. However, given that he was able to receive information in an accessible format from many other organisations including banks and energy firms, he also expressed surprise that this had not been possible for an eye hospital. He asked the Board to improve its focus on providing inclusive communications to patients and to consider the support beyond medical support that should be offered, including signposting to other organisations, so that people with disabilities could feel independent and not be defined by their disability. Jayne Mee thanked Louis for sharing his story and asked whether any measures had been taken since his complaint to resolve the issue. Louis responded that he now received communications from Bristol Eye Hospital in Braille. He had also been informed that the Trust was putting effort into making staff more aware of the support needs of patients. He asked that the Board continue to raise awareness of accessible information needs across all its hospitals. There was a discussion about the use of digital solutions, and it was noted that as not all patients would be able to access digital communications, a dual approach offering digital solutions alongside Braille and other hard copy communication methods was needed. Deirdre Fowler, Chief Nurse and Midwife, confirmed that the Trust was undertaking a baseline assessment to establish its current performance against accessible information standards and was working on a framework to better address them. In response to a question about working with patient groups, Mark Stevens, General Manager, Bristol Eye Hospital added that the hospital had a good relationship with the Bristol Sight Loss Council and worked with them to ensure a collaborative approach to service developments and staff training.	

	Matthew Areskog, Patient Experience Manager, added that Louis's experience had highlighted how the Trust's compliance with the NHS Accessible Information Standard (AIS) could be improved. The AIS was a piece of legislation introduced six years ago which set the expectation that NHS organisations would ask patients about their communication needs, add an appropriate note to their patient record, flag it, share it with other providers and ensure that the need was met. As part of the Trust's work this year to refresh its approach to the AIS, two successful staff workshops had so far been held to raise awareness. Board members noted that this was a Trust-wide issue and emphasised the need for any learning from Bristol Eye Hospital to be shared across the Trust. They thanked Louis for attending, and he left the meeting. *Matthew Areskog, Tony Watkin, Mark Stevens and Gillian Schiller also left the meeting.*	
04/09/21	**Minutes of the previous meeting**	
	The Board reviewed the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust Board held in public on 29 July 2021. **Members of the Board RESOLVED to approve as a true and accurate record the above minutes.** **[POST-MEETING NOTE]** It was noticed that the July minutes reported the Trust's trajectory for Clostridium difficile infections as 32, rather than the correct figure of 72. The minutes would therefore be amended to reflect this correction.	
05/09/21	**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: 03/07/21 Patient Story *Mark Smith, Deputy Chief Executive and Chief Operating Officer, agreed to take forward the importance of a multi-disciplinary approach to virtual appointments, as well as a suggestion on digital support volunteers, to the Trust's Outpatient Improvement Group.* Mark Smith confirmed that discussions had taken place with regard to implementing a multidisciplinary approach to virtual appointments. This issue was also being discussed with other organisations through the Outpatients workstream of the Integrated Care System. **Action Closed.** 23/07/21 Bi-Annual Equality and Diversity Report *The Board Business Cycle to be updated regarding WRES/WDES and Gender Pay Gap information.* The planner had been updated. **Action Closed.** 19/05/21 Research and Innovation Report *Benchmarking against other Trusts to be included in the Annual Report for Research and Innovation*. Emma Redfern reported that following discussions with the Research and Innovation Team, it had been decided that the best measure to use for benchmarking UHBW's performance against other Trust would be research capability funding. This would be recorded in the Annual R&I Report going forward. **Action Closed.**	

	13/03/21 Patient Complaints Report *The Patient Complaints Report to be updated to show year-on-year trends going forward and to be presented at the Quality and Outcomes Committee.* Deirdre Fowler, Chief Nurse and Midwife, confirmed that work was in progress, and this would be included in future reports. **Action Ongoing.** 14/03/21 Six-monthly Safe Staffing Report *To include the consultant workforce data in the Six-monthly Staffing Report going forward.* The Board noted that it was not currently possible to collate the consultant workforce data as Allocate had not yet been rolled out to the medical workforce. Emma Redfern, Interim Medical Director, added that discussions were ongoing with other teams in the region and there was a possibility of using alternative software. **Action Ongoing.** There were no comments on the closed and completed actions from previous meetings. **Members of the Board resolved to note the updates against the action log.**	
06/09/21	**Chief Executive's Report**	
	Robert Woolley, Chief Executive, provided a verbal update on the following key issues: • The Senior Leadership Team had approved the Trust's draft Estates Strategy. This would be received by the Board for approval in due course, but potentially not until the end of the year because there was further work to do to articulate the strategy around the Weston General Hospital site. • Robert welcomed investment announced by the government through the comprehensive spending review and the creation of the Health and Social Care Levy. An additional £5.4bn had been announced to support the NHS in the second half of the financial year. However, the extent to which the pandemic had changed the calculus for health and social care given the continuing restrictions on capacity and staffing numbers was highlighted. • The Trust was experiencing exceptional levels of emergency demand at the same time as increased demand for planned care. It was therefore facing difficult choices in terms of how to meet demand at the same time as recovering backlogs and there would be a very challenging winter ahead. There were still a significant number of COVID-19 admissions, and this had only slightly declined in recent weeks. The Bristol Royal Hospital for Children was also experiencing significant levels of demand relating to respiratory viruses in children and children with mental health issues. The Trust was therefore working extremely hard to create alternatives to admission to hospital, and the Board would be kept informed of developments in this regard. It was also clear that the wider health and care system needed to be communicating clearly and with urgency with the public as to how to access the most appropriate care for their needs. • The Trust was still experiencing challenges around trainee doctor provision at Weston General Hospital in the Department of Medicine. Trainee doctors had been removed from the department by Health Education England (HEE) earlier in the year because of concerns about supervision. The Trust was continuing to mitigate this and was working with HEE to try to bring them back. • The Trust had organised a successful Weston Arts and Health Week the week before the meeting. This had been a partnership between the Trust's Arts and	

	Culture Programme, and Culture Weston and had included live and online events and activities including a public commemorative art installation (In Memoriam by Luke Jerram) which had received significant media coverage. • Finally, in Newsweek published today, the Bristol Royal Hospital for Children had been ranked 14th out of the world's 250 best specialised hospitals for paediatrics, and 2nd in the UK. Jayne Mee congratulated the children's hospital on behalf of the Board for this incredible achievement. Sue Balcombe, Non-Executive Director, referred to new guidance on COVID-19 restrictions in wards and enquired how long it would take the Trust to implement them and measure their impact. Robert Woolley explained that the new guidance meant that the Trust could relax some but not all restrictions, which would give it benefit in terms of throughput in specialised facilities such as theatres and would mean that the Trust would be able to re-open beds that it had needed to close previously, subject to local risk assessments and the availability of staff. This would be reported back to the Board in due course. **Members of the Board resolved to receive the Chief Executive's Report for information**.	
07/09/21	**Healthier Together Sustainability and Transformation Partnership (Integrated Care System) Update**	
	Robert Woolley, Chief Executive, presented a report which provided an update on ongoing work in relation to the Healthier Together partnership: the Integrated Care System (ICS) for Bristol, North Somerset, and South Gloucestershire (BNSSG). Robert highlighted that the public consultation on the potential reconfiguration of stroke services had concluded. The output from this was now being considered by the BNSSG Clinical Commissioning Group and could change the level of service provision at Bristol and Weston next year. The coming year was also likely to see the disestablishment of the Clinical Commissioning Group and the establishment of the Integrated Care System on a statutory footing, though these were both dependent on the Health and Care Bill going through Parliament later this year. The recruitment processes for the ICS Chair and Chief Executive roles were now in train. Julian Dennis, Non-Executive Director, enquired how the ICS's digital strategy aligned with UHBW's. Robert Woolley confirmed that UHBW was represented in ICS digital strategy discussions, and that there was engagement from all system partners. It was now being decided how the pooled resource across the system could be most effectively used. There was an aspiration to move from a draft strategy to an implementation plan by the end of December 2021. In response to a request from David Armstrong, Non-Executive Director, for more information about the ICS's £650K project to establish a shared standardised approach to continuous improvement, Robert Woolley explained that this had been the result of a joint bid from UHBW and North Bristol NHS Trust. It would initially focus on the two acute providers and would support the creation of a consistent approach to develop joint initiatives. **Members of the Board resolved to receive the Healthier Together Integrated Care System Update for information**.	

08/09/21	**Healthier Together Draft ICS Memorandum of Understanding**	
	Robert Woolley, Chief Executive, presented a report seeking the Board's approval of the Memorandum of Understanding (MOU) that had been developed between partners of the Bristol, North Somerset, and South Gloucestershire (BNSSG) Integrated Care System (ICS). Robert emphasised that it was not a legally binding document and that it was designed to help to guide the way that system partners would work together through the remainder of the 2021-22 financial year and had therefore only six months of applicability. Robert asked the Board to delegate authority to himself and Jayne Mee to agree any minor changes that may be necessary. **Members of the Board resolved to:** • **Approve the Memorandum of Understanding (MOU) and supporting frameworks to govern the Integrated Care System (ICS) ahead of statutory changes anticipated for 2022, an** • **Delegate authority to the Chair and Chief Executive to approve any final minor amendments.**	
09/09/21	**Integration Progress Report**	
	Robert Woolley, Chief Executive, presented the Integration Progress report to the Board, which set out the progress of the post-merger clinical and corporate integration programme for the Trust across its Bristol and its Weston services. Robert highlighted that there had been good progress on corporate services integration, with only the Communications Team still to complete its consultation. Progress had been slower in clinical services due to the pandemic, but work was continuing. An enhanced leadership team was now in place at Weston General Hospital, with a Managing Director, Medical Director and Deputy Chief Nurse to help strengthen operational delivery and to coordinate improvement and staff and stakeholder engagement. Orders totalling £2.3m had been placed to address the backlog of Estates maintenance issues on the site. Work was underway with partner organisations as part of Phase 2 of the Healthy Weston programme to develop proposals to achieve a sustainable clinical service model for the hospital site as part of a wider integrated health and care delivery vision. The outcome of this would be reported to the Board in due course. The end point of the integration programme had been re-evaluated to ensure that the right model was being developed and the Board would receive regular updates on this. The Board discussed the report and welcomed the progress that was now being made. David Armstrong, Non-Executive Director, noted that the Audit Committee had agreed to take forward the discussion on corporate services integration, to ensure that this reached beyond organisational constructs to also encompass the embedding of policies and processes. Discussions had taken place though this had not yet been reflected in the reports and he believed there was still more work to do on this. In response to a request from Sue Balcombe, Non-Executive Director, for an update on the recruitment of overseas nurses and the impact on staffing levels of registered nurses at Weston General, Deirdre Fowler, Chief Nurse and Midwife,	

	reported that this was a positive story, and a detailed breakdown report could be shared with the Board. **Action: Chief Nurse and Midwife to send a report to the Board detailing the progress of the recruitment programme for overseas nurses** **Members of the Board resolved to receive the Integration Progress Report for assurance**.	Chief Nurse and Midwife
10/09/21	**Transforming Care Programme Board Report Quarter 2**	
	Robert Woolley, Chief Executive, introduced the Transforming Care Programme Report, which provided the Board with highlights from the Trust's key transformation and improvement work that had progressed during Quarter 2 (July – September 2021). The Transformation Team Annual Report 2020/21 was also provided for information. Robert commended the positive work that the Transformation Team was doing and the breadth of their priorities in the year, which included supporting vaccinations, infection prevention and control, equipment, information, the proactive hospital project, clinical genetics review, the development of the advanced care practitioner workforce, and a proposed new leadership and management development platform. The Board welcomed the innovative work that the Trust was undertaking. David Armstrong, Non-Executive Director, added that the annual report could improve the articulation of the mechanisms through which the Trust identified opportunities for improvement. Bernard Galton, Non-Executive Director, commented that there had been excellent work on the leadership and management development platform, and thanked Sarah Green, Associate Director of Education, who would soon be leaving the Trust, for driving this forward. In response to a question from Sue Balcombe, Non-Executive Director, about the impact of the newly implemented virtual Covid-19 wards, it was confirmed that this would be monitored and reports would be received by the Quality and Outcomes Committee. **Members of the Board resolved to receive the Transforming Care Programme Board Report for information.**	
11/09/21	**Acute Services Review Programme Board Chair's Report**	
	Martin Sykes, Non-Executive Director and Co-Chair of the Acute Services Review Programme Board, introduced a report of its most recent meeting in September 2021. The ASRPB was a committee-in-common set up by UHBW and North Bristol NHS Trust to oversee closer working and opportunities for collaboration and would henceforth be part of the nationally-directed move towards Provider Collaboratives. There had been a lot of debate at the meeting about how to strike the right balance between developing a collaborative between UHBW and NBT and engaging other local providers including those in community and primary care. The Committee had reviewed the performance of the projects underpinning the programme. Good progress was noted in regard to the stroke consultation, cancer, diagnostics and genomics. There had been some slippage in relation to the NICU project, due to capital funding and staffing issues. They had received a	

	good presentation on the joint business case for enhancing intensive care bed provision. The Committee had also noted a request to submit a joint bid into the NHS New Hospital Programme. A number of aligned bids were being considered following a review of the strategic capital plans of both Trusts at the Joint Clinical Sponsorship Board. **Members of the Board resolved to receive the Acute Services Review Programme Board Chair's Report for assurance.**	
12/09/21	**BHI Ward Beds draft Outline Business Case**	
	Neil Kemsley, Director of Finance and Information, presented a report requesting Board approval to progress the draft Bristol Heart Institute Ward Beds Outline Business Case to Full Business Case (FBC). Approval would be subject to the finalisation of design costs, which were expected to be in the region of £11m. The request was being made ahead of the receipt of final costs to avoid compromising the forecast delivery schedule for 18 additional adult general ward beds by July 2023. The urgency to progress this case was underpinned by the Trust's in-year deficit of up to 100 beds across adult Divisions which would seriously affect the Trust's ability to restore and recover services in line with local and national directives. The Board was asked to note that at this stage it had not been decided which specialty would occupy the additional 18 beds and so the staffing costs had been costed as General Medical Ward beds for the draft OBC submission. The Finance and Digital Committee had considered the paper at this month's meeting and had recommended approval, though Neil Kemsley confirmed that revenue costs would be challenged as requested by the Committee. Updates would be brought back to the Board in due course. **Members of the Board resolved to:** • **Approve the progression from draft OBC to Full Business Case (FBC) noting that:** **- this approval is subject to receipt of the OBC construction costs and subsequent triaging of the scheme within the strategic capital programme funding envelope if the costs materially exceed £11m** **- approval will support commissioning FBC design and associated fees that maintain the delivery timeline of March-July 2023** • **Note the timeline, next steps, and gaps within the OBC that would be completed as part of the FBC.**	
13/09/21	**Quality and Outcomes Committee Chair's Report** **13.1 Integrated Quality & Performance Report** **13.2 Patient Experience Report Quarter 1** **13.3 Patient Complaints Report Quarter 1** **13.4 Annual Complaints Report**	
	Quality and Outcomes Committee Chair's Report Julian Dennis, Non-Executive Director and Chair of the Quality and Outcomes Committee, introduced reports of the Committee's last two meetings which had taken place on 3 September 2021 and 24 September 2021.	

As well as the usual business of the meetings, the Committee had acknowledged the exceptional operational pressures and the incredible amount of work that teams were doing to try to resolve them. They understood that while the Trust was trying to restore services to pre-COVID-19 levels, the loss of beds and other challenges were profound. The Committee had felt that there were relatively few levers that the Trust could pull to try to resolve this: it was a system-wide problem which could only be resolved at system-level. The Committee had noted the staffing challenges including staffing levels and staff morale and had emphasised the need to adequately support staff.

13.1 Integrated Quality & Performance Report
The Board received the Integrated Quality and Performance Report which provided an overview of the Trust's performance on Quality, Workforce, Access, and Finance standards. The report, which had been discussed by all Board Committees, described the performance against NHS constitutional standards which continued to remain extremely challenged.

Mark Smith, Deputy Chief Executive and Chief Operating Officer, updated the Board regarding the following points:

- The Trust was experiencing sustained operational pressure across the whole campus. He described it as a perfect storm, with increased pressures across urgent care and planned care.
- In an effort to provide independent assurance to the Board that the Trust was doing everything that it could, an external consultancy was being engaged to examine the Trust's work and to advise as to any further actions that could be taken. The outcome of this would be shared with the Quality and Outcomes Committee and the Board.
- The Board was aware of the pressure on the workforce and would do what it could to support them while maintaining patient safety. The recruitment of overseas nurses would help. A relaxation of some of the COVID-19 guidance, particularly distancing, and a review of pathways might also deliver back some beds and productivity.
- The Trust had been waiting for the second-half year planning guidance which had just come out. This may include guidance around elective restoration which would need to be reflected in the work going forward.
- Numbers of COVID-19 positive patients in August were still relatively high at 88, similar to February's numbers.

Deirdre Fowler, Chief Nurse and Midwife, clarified that 147 nurses recruited from overseas would have joined the Trust's rosters by December 2021. While this was a positive development, it would be important to achieve a sustainable pipeline of nursing staff going forward.

Deirdre brought to the Board's attention the extraordinary increase in violence and aggression from the public towards staff in the Emergency Departments in the Bristol Royal Infirmary, the Bristol Royal Hospital for Children, and Weston General Hospital. A survey conducted by the Emergency Department team had revealed that more than 50% of their staff had experienced violence and aggression recently, and 1 in 6 members of staff were considering changing roles as a result.

The Board discussed the report. In response to a question from Martin Sykes, Non-Executive Director, as to why 'Green to Go' numbers (patients medically fit for discharge) were at an all-time high, Mark Smith responded that the community and primary care sectors were experiencing similar staffing challenges to UHBW,

making it harder to discharge patients who required ongoing care. The Trust was trying to implement measures to reduce the numbers as best it could.

Robert Woolley, Chief Executive, emphasised that the underlying constraint was that the workforce was not available and that this was affecting not just primary care and community services, but also had caused a crisis in domiciliary care. Robert provided assurance that the leadership of the Trust's partners in the area all understood the situation, but the question remained as to what actions would make a difference given the scale of the problem.

Jayne Mee asked whether the Executive Team could do more to protect staff from violence and aggression. Robert Woolley noted that various measures had been taken and that Emergency Departments were sharing learning with each other as to what worked.

David Armstrong, Non-Executive Director, noted that essential training targets were still not being met, and asked for assurance that the Trust had a robust plan to achieve them. Bernard Galton, Non-Executive Director, added that the People Committee had requested a report explaining exactly what was required and why, and what was planned to improve it. Robert Woolley reminded the Board that national guidance had instructed Trusts to deprioritise the achievement of essential training targets at the start of the pandemic, but as the pandemic became routine business it would be important going forward that the Trust was clear on requirements.

13.2 Patient Experience Report Quarter 1
Deirdre Fowler, Chief Nurse, presented the Quarter 1 Patient Experience Report to the Board, noting that this had been received by the Quality and Outcomes Committee. The report provided a comprehensive review of patient survey data and Patient and Public Involvement activities being carried out at the Trust. At a Trust-wide level, both the inpatient tracker score and outpatient tracker score were above target. However, at divisional level, there was evidence that the impact of sustained pressure on operational services arising from the pandemic, staffing levels, and staff morale were all being reflected in patient feedback. Friends and Family Test (FFT) scores deteriorated during Quarter 1, particularly in the Emergency Department.

The team was developing a Patient Experience Hub: a means of ensuring better local ownership of patient feedback. There was a drive to improve equality, diversity, and inclusivity standards for patients, and to understand the experience of patients who had virtual appointments and patients who were on the Trust's waiting lists. Bernard Galton, Non-Executive Director, asked that the Trust ensure that the forward plans for diversity and inclusion cover all the protected characteristics.

13.3 Patient Complaints Report Quarter 1
13.4 Annual Complaints Report
The Board noted these reports, which had been received and discussed by the Quality and Outcomes Committee. There had been a high volume of enquiries in Q1 which had reflected the pressure on clinical teams.

Members of the Board resolved to receive the Quality and Outcomes Committee Chair's Report, the Integrated Quality & Performance Report, the Patient Experience Report Quarter 1, the Patient Complaints Report Quarter 1, and the Annual Complaints Report for assurance.

14/09/21	**People Committee Chair's report** **- 14.1 Guardian Annual Report**	
	People Committee Chair's Report Bernard Galton, Non-Executive Director and Chair of the People Committee, presented the report from the Committee's meeting on 28 September 2021. The Committee had considered the strategic risks and objectives within their remit. The key areas of focus for the meeting had been recruitment and retention. They had requested greater focus on exit interviews and exit surveys and would be monitoring the implementation of the new exit survey procedure that the Trust had introduced. The Committee had requested a deep dive into the Trust's strategic recruitment requirement and had also requested more information on the timeline for the deployment of the overseas nurses and further assurance that sufficient pastoral support was being provided for them. The Committee had been concerned about the overall HR metrics in the Estates and Facilities department, particularly sickness absence, recruitment, and retention. This would be discussed in more detail at a future meeting. The Committee had received an update on progress against the People Strategy but acknowledged that this had not been reviewed in over a year and required a refresh to ensure that all the experience of the past 18 months was reflected. An update on the Education Strategy was received. The Committee had welcomed the Leadership and Management Development Review, alongside confirmation that while the interim offer of management training was not mandatory, the new offer would be. This was an issue that had been raised repeatedly by the Council of Governors, and Non-Executive Directors would now be able to provide assurance that it was being taken forward. The Committee had also considered the health and wellbeing offer for staff and appraisal rates, which were below target. Robert Woolley explained that, as with essential training compliance, appraisal rates had not been a focus for the Trust during most of the pandemic, under national direction. However, the Senior Leadership Team was now committed to getting back to target by the end of the calendar year. In response to a query from Mark Smith as to whether the Committee received quantitative and qualitative data from exit interviews, Bernard Galton confirmed that they did not receive this at present but agreed that it was needed. *14.1 Guardian Annual Report (Bristol hospitals)* Dr Alistair Johnstone, Guardian of Safe Working for the junior doctors in the Trust's Bristol hospitals, presented his annual report on rota gaps, vacancies and exception reporting for doctors and dentists in training for 2020/21. Alistair reported that while in some area's rota gaps had been made worse during the pandemic due to staff illness and shielding, the Trust's Bristol hospitals were a better position than they had been four or five years ago. There had also been an improvement in the position around exception reporting over recent years as a number of structural issues had been resolved.	

	In terms of forthcoming challenges, he asked the Board to note that there were changes in contractual arrangements on the horizon to enable doctors to work more flexibly, which may impact the amount of clinical time each doctor would be able to provide. This required urgent attention. The pandemic had also given rise to an issue for trainee doctors in that they were not always able to achieve the breadth of experience that they needed to achieve their training. This could affect the Trust during the next couple of years. Recruitment was currently difficult, particularly as the UK's Exit from the European Union and the global pandemic had impacted on the number of international medical graduates the Trust had been able to attract and employ. The recent innovation of developing physician's associates, and other allied health professional advanced practitioner roles, had been extremely successful and was welcomed by junior doctors in the Trust. The Trust was still making slow progress in implementing a truly digital eRostering solution. The pandemic and the required social distancing rules had also highlighted a real need to improve staff facilities and rest areas such as outside spaces and break rooms. Alistair asked that the Board focus on this during any future building developments. Finally, he thanked junior doctors for their hard work and flexibility during a challenging period. These sentiments were echoed by the Board. *Weston General Hospital Guardian of Safe Working Annual Report July 2020 – July 2021* The Board also received a report as to the working patterns and challenges faced by Doctors in Training at Weston General Hospital. They noted that the Weston Guardian of Safe Working had now left and a new one would take up post on 1 October 2021. David Armstrong, Non-Executive Director, suggested that there was a need for greater assurance to be provided to Board on the problems implementing e-rostering, as this had been an issue for years. It was agreed that the Finance and Digital Committee would receive a more detailed report on the implementation plan and the obstacles. **Action: Finance and Digital Committee to receive a detailed report on the status of e-rostering implementation including challenges** The Board discussed improving rest and recuperation areas for staff and it was confirmed that this was one of the Trust's priorities over the next 6 months. A review had taken place to establish current facilities, how they were maintained and what extra facilities were needed. A report would be received by People Committee. **Action: People Committee to receive a report on staff rest facilities.** *Alistair Johnstone left the meeting.* **Members resolved to receive the People Committee Chair's Report and the Guardian Annual Reports for assurance.**	Director of Finance and Information Interim Director of People

15/09/21	**Finance and Digital Committee Chair's report** **15.1 Trust Finance Performance Report**	
	Finance and Digital Committee Chair's report Martin Sykes, Chair of the Finance and Digital Committee, reported back from the Committee's meeting on 28 September 2021. The Committee had noted that limited progress had been made against the Trust's Digital Strategy, with considerable constraints on its achievement including staffing, resourcing, implementation of systems, scheduling and workload volumes. The Committee was to receive an updated version of the strategy in due course. There had been a discussion around strengthening the governance arrangements in place for new systems and product implementation. In terms of the Trust finances, the Committee had been assured that the situation was steady, with a small surplus and an expectation of break-even by year end. There had been a wider discussion around system financial plans and the Trust's part in them. The Committee had also received two business plans for approval. *15.1 Trust Finance Performance Report* Neil Kemsley, Director of Finance and Information, introduced a report informing the Board of the financial position of the Trust for the period of 1 April 2021 to 31 August 2021. The Trust's year to date net income and expenditure performance, excluding technical items, was a net surplus of around £600,000 compared with a plan of break-even. The planning guidance for the next six months had been released, and this would present a challenge to be worked through. The Trust was still taking action in face of the operational challenges that it was facing, for example the considerable investment in the recruitment of overseas nurses. In value terms, the Trust was achieving 90% of the value of activity compared with this time two years ago pre-Covid, which was a significant achievement. Neil warned the Board that there had been an increase in Bank nurse expenditure in August, driven by high levels of staff absence, and that this had a significant financial implication for the month. The Trust had spent around £24m on capital investment in the year to date. The year-end capital programme was £84m, which had gone up marginally and so there remained a challenge to achieve this and avoid the further impact of slippage into next year's limit. The Trust's financial position included around £9m of CIP delivery, but only £4m of this would be achieved on a recurrent basis. The Board was asked to note the impact of this on the underlying financial position of the organisation, and also that it would be difficult to get wider organisational commitment to this given the current challenges. The Board noted that the report had been discussed in depth at the Finance and Digital Committee. **Members of the Board resolved to receive the Finance and Digital Committee Chair's Report and the Trust Finance Performance Report for assurance.**	
16/09/21	**Weston Charity Committee Chair's report**	
	Jayne Mee, Interim Chair, introduced a report of the final meeting of the Weston Charity Committee held on 15 September 2021. The Committee had approved the	

	charity's Annual Report and Accounts for 2020/21; however, the accounts had not been prepared on a Going Concern basis due to the planned merger of the Weston Charity with Above and Beyond on 1 October 2021. The Board was asked to note that the Deed of Transfer and Memorandum of Understanding for the merger had been signed and sealed by Robert Woolley, Chief Executive, and Neil Kemsley, Director of Finance and Information. The date of transfer of 1 October 2021 had now been confirmed. Above and Beyond had requested liquidation of the investment assets into cash and this would incur an estimated charge of £3,940. The new charity would be called Bristol and Weston Hospitals Charity. Bernard Galton, Non-Executive Director, sought assurance that effective communication plans were in place around the change of name, given that Above and Beyond was very well-known in Bristol. Jayne Mee responded that Above and Beyond had launched a social media campaign and that there was a Weston communications cascade as well. The Weston Charity Committee had emphasised the need for a robust plan for communications and engagement. **Members of the Board resolved to receive the Chair's report from the final meeting of the Weston Charity Committee for assurance.**	
17/09/21	**South West and South Wales Congenital Heart Disease Network Annual Report 2020/21**	
	Emma Redfern, Acting Medical Director, presented the South West and South Wales Congenital Heart Disease Network Annual Report 2020/21. This set out the key achievements of the network in the past year and key priorities for future years. Despite the challenges of the past year, including staff redeployment to help with the pandemic, the network had made significant progress against its workplan, particularly in relation to digital platforms and virtual clinics, and had provided expertise to develop a network in Wales. Future priorities included tackling restoration plans, progressing work to improve transition from children's services to adult services, and expanding the adult CHD workforce. The Board expressed their appreciation for a well-presented report. **Members of the Board resolved to receive the South West and South Wales Congenital Heart Disease Network Annual Report 2020/21 for information.**	
18/09/21	**Appointment of a Responsible Officer**	
	Natashia Judge, Head of Corporate Governance, introduced a report seeking Board approval for the appointment of Emma Redfern, Interim Medical Director, to the role of Responsible Officer. Board members noted that the Trust was required to nominate a Responsible Officer who must be a medical practitioner. This position was previously held by Medical Director William Oldfield who had left the Trust this month. They voiced support for the appointment of Emma Redfern, noting that she had already completed the necessary training. **Members of the Board resolved to approve the appointment of Emma Redfern, Interim Medical Director, as the Trust's Responsible Officer.**	
19/09/21	**Governors Log of Communications**	
	Natashia Judge, Head of Corporate Governance, introduced a report which provided the Board of Directors with an update on questions submitted by	

	governors to the Governors' Log of Communications and responses received since the previous meeting. She added that a further two questions had now received responses since the report was submitted and that these would be included in the next Board report. **Members of the Board resolved to receive the Governors Log of Communications for information.**	
20/09/21	**Any Other Urgent Business**	
	There was no other urgent business.	
21/09/21	**Date of next meeting: 30 November 2021.**	

University Hospitals Bristol and Weston NHS Foundation Trust

Public Trust Board of Directors Meeting
30 November 2021
Action Log

Outstanding actions from the meeting held on 30 September 2021					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	09/09/21	**Integration Progress Report** Chief Nurse and Midwife to send a report to the Board detailing the progress of the recruitment programme for overseas nurses.	Chief Nurse and Midwife	November 2021	**Suggest action closed** Action complete after the September Board meeting.
2.	14/09/21	**People Committee Chair's Report** Finance and Digital Committee to receive a detailed report on the status of e-rostering implementation including challenges.	Director of Finance and Information	November 2021	**Suggest action closed** This has been discussed between Committee executive leads and People Committee agreed to be the more appropriate home for this report. This has been added to the People Committee work plan for the next meeting in January.
3.	14/09/21	**People Committee Chair's Report** People Committee to receive a report on staff rest facilities.	Director of Finance and Information	November 2021	**Suggest action closed** This will be covered as part of the strategic update to People Committee in November.
4.	13/03/21	**Patient Complaints Report** The Patient Complaints Report to be updated to show year-on-year trends going forward and to be presented at the Quality and Outcomes Committee.	Chief Nurse and Midwife	July 2021	**Suggest action closed** This is included in the Quarterly Report presented to the Quality and Outcomes Committee.
5.	14/03/21	**Six-monthly Safe Staffing Report** To include the consultant workforce data in the Six-monthly Staffing Report going forward.	Interim Medical Director	September 2021	**Work in progress** Allocate had still not been rolled out, a meeting would take place this week regarding this. It is not currently possible to collate the consultant workforce data as Allocate as not yet been rolled out to the medical workforce. Emma Redfern, Interim

					Medical Director, added that discussions were ongoing with other teams in the region and there was a possibility of using alternative software
Closed actions from the meeting held on 30 September 2021					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1	03/07/21	**Patient Story** Mark Smith, Deputy Chief Executive and Chief Operating Officer, agreed to take forward the importance of a multi-disciplinary approach to virtual appointments, as well as a suggestion on digital support volunteers, to the Trust's Outpatient Improvement Group.	Deputy Chief Executive, Chief Operating Officer	September 2021	**Action closed.** Mark Smith confirmed that discussions had taken place with regard to implementing a multidisciplinary approach to virtual appointments. This issue was also being discussed with other organisations through the Outpatients workstream of the Integrated Care System.
2	23/07/21	**Bi-Annual Equality and Diversity Report** The Board Business Cycle to be updated regarding WRES/WDES and Gender Pay Gap information.	Head of Corporate Governance	September 2021	**Action closed.** The planner had been updated.
3	19/05/21	**Research and Innovation Report** Benchmarking against other Trusts to be included in the Annual Report for Research and Innovation.	Medical Director	September 2021	**Action closed.** Emma Redfern reported that following discussions with the Research and Innovation Team, it had been decided that the best measure to use for benchmarking UHBW's performance against other Trust would be research capability funding. This would be recorded in the Annual R&I Report going forward.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

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

1. Report Summary

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

2. Key points to note
(Including decisions taken)

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

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

The risks associated with this report include:
N/A

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

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

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

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

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – NOVEMBER 2021

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in October and November 2021.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **approved** the set up of a Design Authority with clinical and managerial implementation from Divisions to inform requirements for the delivery of the Performance Management Framework.

3. STRATEGY AND BUSINESS PLANNING

The group **noted** updates on progress around the Campaign Plan.

The group received and **supported** the new Values for recommendation to the Trust Board.

The group **approved** the recommendation to implement the proposed car parking application process in November.

The group **approved** the Outline Business Case for the Patient First Continuous Improvement programme to move towards development and deployment.

The group **approved** the funding for the continuation of posts considered essential to the Integration Programme at Weston.

The group **approved** the proposed changes to the future Weston Management model.

The group **approved** the development of a full business case for the Acute Medical Service.

The group **noted** the system and Trust approach taken to prepare the H2 submissions.

The group **approved** the proposal to make the Testing Hub core staffing model a permanent team.

The group **noted** the update on the University of Bristol proposal for Dental Education.

The group **approved** the preferred location proposed for Maggie's Centre.

The group **approved** the development of a Bristol and Weston Hospital Charity Lottery.

4. RISK, FINANCE AND GOVERNANCE

The group **received** updates on key highlights from the financial position 2020/21.

The group **approved** the proposal to delay the launch of the 2022/2023 Operating Plan process until December 2021 and for a preparation phase in October, November and December.

The group **supported** recommendations to enhance the governance of the management groups that report to the Senior Leadership Team.

The group **received** an update on the themes of concerns raised and progress against the Freedom to Speak Up Strategy.

The group **noted** the update on progress that had been made in respect of the Genetics Development Programme.

The group **noted** a report on the learning and feedback from the South Bristol Community Hospital transfer into Sirona Health and Care.

The group **received** a report on the Testing Hub, Vaccinations Hub and Results Hub.

The group **approved** revised terms of reference for the Division of Surgery Management Board.

The group **approved** the Corporate and Strategic Risk Registers for submission to the Trust Board.

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

The group **received** three Internal Audit Reports for Data Security and Protection Toolkit, Risk Management and Consultant Additional Medical Payment Claims

The group **received** for assurance the Weston composite CQC Inspection Action plan.

Reports from subsidiary management groups were **noted,** including updates from the Senior Leadership Team Delivery Group, Clinical Quality Group, Sustainability Programme Board, Cellular Pathology Performance/Governance Group and Weston Integration Board.

The group **received** Divisional Management Board minutes for information.

The group **received** the Serious Incident Themed Report prior to submission to Trust Board.

The group **received** the 2020 National Adult inpatient survey results prior to submission to Trust Board.

The group **received** the Strategic Capital update prior to submission to Trust Board.

The group **received** the Sustainability Annual Report prior to submission to Trust Board.

5. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
November 2021

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30th November 2021

Report Title	**Final report following CQC core services and well led inspection, June 2021**
Report Author	**Stuart Metcalfe, Clinical Audit & Effectiveness Manager**
Executive Lead	**Deirdre Fowler, Chief Nurse and Midwife**

1. Report Summary

The Trust has received the CQC's final report following its core services and well-led inspection in June 2021. The report was released by the CQC under embargo on 3rd November and published on 4th November. Further accompanying documentation has also been received; a covering letter and a response to the Trust factual accuracy submission.

The final reports includes 35 requirements (Must do) / recommendations (Should do):

Area	Must do	Should do	Grand Total
Trustwide	3	2	5
Bristol Medical	2	9	11
Weston Medical	12	5	17
Weston Outpatients	1	1	2
Grand Total	**18**	**17**	**35**

An action plan is in the process of being developed. The CQC have asked that this is returned to them by 4th January 2022.

2. Key points to note

(Including decisions taken)

In the final report:

- The Trust's overall rating has declined from Outstanding to **Good**.
- The rating for the Bristol site has declined from Outstanding to Good (the rationale for this is detailed in the CQC covering letter).
- The CQC's rating for the Weston site is Inadequate, although the rating for Weston's outpatient service is Good (this is the first occasion since merger when the CQC has assigned ratings for services at Weston General Hospital).
- The CQC have confirmed that Weston General Hospital's ratings have not been aggregated within the Trusts' overall rating.
- The Trust's well-led rating has declined from Outstanding to Good.

Recommendations have been circulated to the relevant Divisional teams. An action plan is in development in response to the CQC's findings and will be brought to QOC in December following scrutiny at Execs.

The plan will initially cover the Bristol site, Weston General Hospital, and corporate well-led actions but will evolve into a wider 'composite' plan as any future recommendations or improvement plans are identified

The Board is reminded that an action plan has previously been agreed in respect of medical

care services at Weston General Hospital, following concerns raised by the CQC at the time of the inspection – this action plan will therefore be updated as part of the Trust's overall response to the inspection report. A communications plan and materials have been prepared. Corporate communication materials have been updated as appropriate to reflect the Trust's new rating. These are being sent to staff.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
Risk 3763 - Risk that the Trust may not meet standards to ensure compliance with CQC Regulations
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
This report is for **information**.
5. History of the paper **Please include details of where paper has previously been received.**
N/A

University Hospitals Bristol and Weston NHS Foundation Trust

Inspection report

Marlborough Street
Bristol
BS1 3NU
Tel: 01179230000
www.uhbw.nhs.uk

Date of inspection visit: 8 to 24 June 2021
Date of publication: 04/11/2021

Ratings

Overall trust quality rating	**Good**
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**
Combined quality and resource rating	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

Overall summary - Trust

The merger of University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust took place on 1st April 2020. This was the coming together of these organisations to form University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). When a trust acquires or merges with another service or trust in order to improve the quality and safety of care, we will not aggregate ratings from the previously separate services or providers at trust level for up to two years. Therefore, we have rated services at Weston General Hospital as this inspection. However, these ratings do not form part of the Trust's overall current rating.

The merger of the two organisations and the plan for integration of the hospitals had been significantly impacted by the COVID-19 pandemic. For the periods, 30 January 2020 to 31 July 2020 and 5 November 2020 to 25 March 2021, the NHS was in a level 4 emergency incident. This meant that the Trust was subject to national command and control directives and procedures. Plans were put on hold to allow efforts to be focused on the response to the pandemic and integration had not happened as quickly as planned.

The previous ratings for the former Weston Area Health NHS Trust no longer apply and a new rating for the Weston General Hospital location, under UHBW has been given following this inspection.

Our findings

On 8 and 9 June 2021, we carried out an unannounced inspection of the trust's medical care service at both the UHBW Bristol main site and Weston General Hospital. We also carried out an unannounced inspection of the trust's outpatients service at Weston General Hospital. We spoke with 238 members of staff including members of the senior leadership team, nurses, doctors, managers, allied healthcare professionals, housekeeping and support staff. We also spoke with 51 patients and two visitors and reviewed 59 sets of patient records.

We also inspected the well-led key question for the trust overall. During the well led assessment we undertook a number of staff focus groups including junior doctors, clinicians, divisional directors, nursing sisters and staff representative groups.

At our last comprehensive inspection of University Hospitals Bristol NHS Foundation trust, undertaken in 2019, the trust was rated overall as outstanding.

In February 2021, we carried out a focused inspection of the Bristol Royal Infirmary (part of UHBW Bristol main site) urgent and emergency care service for adults (also known as accident and emergency or A&E) as part of our winter pressures inspection programme. A number of concerns were identified during this inspection. Notably, the service did not have enough medical staff to meet the recommended guidance for the type and size of the department or to be able to expand the service. The trust senior leadership were perceived by some staff as not having been present enough in the department to provide assurance and support, demonstrate recognition and awareness of the risks. Senior leaders were not sufficiently visible and approachable for some staff. There were serious concerns among the staff about the escalation in violence and aggression on staff working in the emergency department and the lack of action to resolve this over many months.

During that inspection and our current well led assessment of the trust, a number of staff contacted us expressing safety concerns caused by insufficient staffing levels. They described some care and treatment which was not of satisfactory quality or safety due to serious concerns around flow, performance, crowding, and timely access to safe care. Although we recognise demand for A&E services was under intense pressure, concerns remain about the trust leadership, management, and ability to support the department through this difficult time.

We undertook an inspection of medical care at Weston General Hospital in March 2021 focusing on the safe and well led key questions. Our inspection resulted in a number of concerns and led to us requesting immediate (same day) assurance about staffing levels for the following weekend.

A Letter of Intent to potentially undertake further enforcement action was also issued. An action plan was provided by the trust to explain how the risks were to be mitigated and managed. For an initial period of three months, beginning in April 2021, we increased the level of engagement with the trust to discuss the actions taken in the medical care service at Weston General Hospital.

During our core services element of this inspection, undertaken on 8 & 9 June 2021 we were significantly concerned about the safe care and treatment of patients receiving medical care at Weston General Hospital and imposed urgent conditions upon the trust's registration. Within these urgent conditions, the trust was required to take urgent action to protect patients who will or may be exposed to risk of harm. We made this decision for the following reasons:

- The trust had not assured those patients were receiving care and treatment in a ward or department to meet their clinical needs.
- The trust did not have sufficient medical and nursing staff to meet the needs of patients.

Our findings

- There was no effective clinical leadership to ensure the patients not exposed to the risk of harm.
- Leaders in Weston General Hospital did not demonstrate the capacity to run the service. They understood, but did not manage, the priorities and issues the medicine service faced. They were not always visible or felt to be supportive or approachable in the service for staff.
- The trust senior leadership team were perceived not to be present enough on the wards to understand the issues staff faced.

These were issues raised at previous inspections undertaken by us during the past six months.

The provision of training at Weston General Hospital for trainee doctors has been the subject of some 18 triggered visits by Health Education England (HEE) and the General Medical Council (GMC) since 2012. Much of the focus has been on clinical supervision including that of FY1 trainee doctors (although eight years of this time period related to the former provider of this service).

Following a quality intervention visit undertaken by HEE on 21 January 2021, three immediate mandatory requirements were raised to ensure immediate access to senior, patient facing, clinical supervision for foundation year one (FY1) trainee doctors. This was in response to evidence that these trainees were still not being adequately supervised as they managed patients in the department of medicine. In April 2021, due to continuing concern, HEE made the decision, supported by the GMC, to relocate 10 FY1 trainee doctor posts in medicine out of Weston General Hospital to the Bristol hospitals within the trust.

Following this inspection in June 2021, the ratings for both the core service inspections and the well led assessment deteriorated.

For medical care at University Hospital Bristol and Weston, we rated the main Bristol site as requires improvement for safe, this is a deterioration as this was previously rated as good. We rated the key questions of effective, caring and responsive and well led as good and the overall rating was good

For medical care at Weston General Hospital, we rated the key questions of safe and well led as inadequate. We rated effective and responsive as requires improvement. Caring was rated as good. Overall, the medical care service was rated as inadequate.

For outpatients at Weston General Hospital, we rated safe, caring, effective and well led as good. Responsive was requires improvement and overall, the service was rated as good.

We rated well-led for the trust overall as Good.

We did not inspect a number of core services at both the Bristol and Weston locations. We remain monitoring the progress of improvements to services.

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

What we found – Medical Care – UHBW Bristol main site

Our rating of this service stayed the same. We rated it as good because:

Our findings

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and staff were committed to improving services continually.

However:

- The service provided mandatory training in key skills to staff but not all staff had completed it.
- Premises were not always being used for their intended purpose. For example, additional bed spaces added to wards could compromise patient care and privacy.

What we found – Medical Care – Weston General Hospital

We rated it as inadequate because:

- The service did not always have enough nursing and medical staff to care for patients and keep them safe. The service provided mandatory training in key skills but not all staff had completed it. The design, maintenance and use of facilities, premises and equipment did not always keep people safe, the areas used for outlier patients were not suitable for this use. Staff did not always keep people safe by following systems and processes when prescribing, administering, recording and storing medicines. The service did not always learn from incidents and accidents as they did not consistently make changes and improvements when they happened.
- Staff gave patients enough food and drink to meet their needs. This service was not seen to be the same service provision for patients using escalation areas. Access to pharmacy support was not available in all escalation areas. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care but there was not always a clear record of how those capacity decisions had been made.
- The service responded reactively to meet the needs of local people and the communities served, which meant care was sometimes delayed. Forward planning to meet demand was not used. Patients could not always access services when needed and not all received treatment in the right speciality ward or area.

Our findings

- Leaders had not yet managed the priorities and issues the service faced. The trust vision and strategy were not known by staff. Staff all expressed that they loved working at the hospital but did not feel supported and valued and often felt isolated within the trust. Governance processes were not effective in developing the service. Learning from the performance of the service was not always maintained or used to make positive changes. The management of risks were reactive and not planned which sometimes left patients at risk.

However:

- Staff understood how to protect patients from abuse. The infection risk were controlled well and kept equipment and the premises visibly clean. Staff managed clinical waste well. Staff completed and updated risk assessments for each patient and removed or minimised risks when possible. Staff identified and quickly acted upon patients at risk of deterioration. Staff kept good care records. Staff collected safety information on each ward and used it to improve the service.
- Managers monitored the effectiveness of some aspects of the service. Staff worked well together using a multidisciplinary approach for the benefit of patients. Key services were available seven days a week. The patients were complementary about the meals and availability of food and drinks. Staff ensured patients had enough to eat and drink and gave them pain relief when they needed it.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers.
- The service was inclusive and took account of patients' individual needs and preferences. Staff were focused on the needs of patients receiving care. Staff felt pride in their role and work they undertook. The service promoted equality and diversity in daily work. Engagement was being developed by the trust with staff to improve morale

What we found – Outpatients – Weston

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink when remaining in the departments for lengthy periods, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Our findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

People could not access the service when they needed it and had too long waits for treatment.

Outstanding practice

We found the following outstanding practice:

- In outpatients there was development of a phlebotomy hub in the hospital car park to avoid vulnerable patients entering the hospital. Patients made an appointment with a time slot and waited in their car. Staff took a note of their number plate and returned to collect and escort them to the hub. Bloods were taken and patients were able to leave straight away. This was standard practice for the last year and only stopped when patients no longer had to shield. Patient feedback had been very positive. There were future plans to develop community phlebotomy hubs across the local area.
- As a result of limited face-to-face appointments for dermatology outpatient patients, YouTube videos were provided by clinicians to guide patients to check their skin and lymph nodes. This had proved to be popular with over 127,000 views.

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements.

1. **Trust wide**

- The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services and to provide ensure high quality, sustainable care at all locations. To do this, the trust must ensure systems or processes must be established and operated effectively to ensure compliance. (Regulation17 (1), (2), (a), (b), (e), (f).
- The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f).

Our findings

- All premises and equipment used by the service provider must be properly maintained. (Regulations 15 (1) (e).

Location Level

Action the trust MUST take to improve:

Bristol Medical Care

- The trust must ensure patients in interim beds have access to equipment and have privacy in line with the trust standard operating procedure. For example, access to electrical sockets, call bells and privacy screens. The trust must ensure boarding patients and those in the same bay can be safely accessed should urgent treatment be needed. Regulation 12 Safe care and treatment 12 (2) (d).
- The trust must ensure medical staff receive and complete mandatory training in line with trust targets. Regulation 18 Staffing 18 (2) (a).

Weston General Hospital Medical Care

- Ensure that there are enough numbers of nursing staff, with the right skills to meet patients' needs at all times. Regulation 18 (1) Staffing.
- Ensure nursing and medical staff are supported to maintain mandatory training skills including safeguarding training. Regulation 18 (1) Staffing.
- Ensure there is always adequate cover and support for the medical workforce, including out of hours. To develop and implement an audit in order to provide assurance. Regulation 18 (1) Staffing.
- Ensure the management of consultant behaviours is in accordance with professional standards and that patients are seen by the appropriate consultant within 24 hours of admission. Regulation 18: Staffing.
- Ensure that areas used by patients are suitably risk assessed and have the right environment and equipment to meet patient's needs. This includes the escalation areas, discharge lounge and waterside unit. Regulation 15 (1) Premises and equipment.
- Ensure the management of outlier patients are safe and ensure appropriate medical oversight. Regulation 12 – safe care and treatment.
- Ensure that venous thromboembolism (VTE) risk assessments are completed and recorded according to trust policy and appropriate prescribing of medicines or compression is in place. Regulation 12 – safe care and treatment.
- Substances hazardous to health must be stored securely. Regulation 15 (1) Ensure incidents are investigated without delay and appropriate action and learning is shared to mitigate the risk of reoccurrence. Regulation 17 (1) Good governance.
- Ensure that for patients lacking capacity to make their own decisions a capacity assessment has been completed to provide a clear audit trail of decisions made. Regulation 9 (1) Person centred care.
- Ensure governance systems work effectively to support leaders to make sustainable proactive improvements. Regulation 17 (1) Good Governance.
- Ensure that medical staff attend mandatory training to achieve the trust compliance level. Regulation 18 (2): Staffing.

Weston General Hospital Outpatients

Our findings

- The trust must ensure referral to treatment time performance is in line with national standards. Not all referral to treatment times were meeting national standards (Regulation 9 (1) Person-centred care.

Action the trust SHOULD take to improve:

Trust wide

- The trust should continue to ensure staff are involved in the development of the trust's values of the organisation.
- The trust should consider strategies to improve the representation of staff from black and minority ethnic groups on the board and in senior leadership roles. Continue focus on improving career progression for these groups.

Location Level

Action the trust SHOULD take to improve:

UHBW Bristol main site - Medical Care

- Consider how training can be provided to ensure all nursing staff are supported to complete mandatory training to achieve trust targets.
- Review level three safeguarding adult training and ensure all staff who require this training are identified.
- Review the environment on the endoscopy unit to ensure infection and prevention control standards are met and the premises are suitable for their intended use.
- Consider confidentiality in relation to personal information being on display in ward areas.
- Ensure staff receive regular appraisals.
- Review the need to reinstate a dedicated older person assessment unit which was repurposed due to COVID-19.
- Review effectiveness of wellbeing initiatives to support morale of staff at all levels.
- Review effectiveness of the Freedom to Speak up process to ensure staff are confident to raise concerns.
- Consider ways to improve executive team engagement with staff.

Weston General Hospital Medical Care

- Ensure that checks to ensure patients have the correct medicines (medicines reconciliation) follow national best practice.
- Ensure that patients who may lack mental capacity to make decisions about their medicines are supported to receive medicines in their best interest.
- Ensure that medicines storage areas are only accessible to authorised staff and are within an appropriate temperature range.
- Consider how electronic records could be made less visible when not in use.
- Consider the suitability of moving patients late at night.

Weston General Hospital – Outpatients

Our findings

- The trust should consider how data about medical staffing is collated to be able to easily provide information about the number of medical staff working in the service, the vacancy or turnover rates, sickness rates, and the level of bank and locum staff.

Our rating of well led went down. We rated the trust overall as good because:

- During the core service inspection of medical care at the Weston General Hospital in June 2021, we were significantly concerned about the safe care and treatment of patients receiving medical care. Because of our concerns we imposed urgent conditions upon the trust's registration. The trust was required to take urgent action to protect patients who will or may be exposed to or at risk of harm. We made this decision because the trust had not assured those patients were receiving care and treatment in a ward or department which meet their clinical needs. Also, the trust did not have sufficient medical and nursing staff to meet the needs of patients and there was no effective clinical leadership. These are continued and repeated concerns. We found there were gaps in clinical medical leadership and oversight. Whilst the trust has taken immediate steps to address our concerns, we have yet to be fully assured that the actions taken will be sufficient and sustainable to ensure safe service provision.
- Whilst the board and senior leadership team were aware of the importance of the integration of Weston General Hospital and the wider trust, they recognised more work was needed to further develop this work and to engage with staff to ensure there was a collective and agreed set of values which were not yet in place.
- There were some concerns with culture in the trust and staff being confident about speaking up. There were issues for some members of the black, Asian and minority ethnic staff. For example, we heard from a number of staff who had been told by a line manager to use a westernised name as this would be easier for people to pronounce. Another member of staff was not called by their name in a meeting and no effort was made to learn to pronounce it. Some staff told us they did not always raise concerns as they were not always taken seriously or appropriately supported when they did.
- There were ongoing and unresolved concerns with the support and supervision of a group of trainee doctors based at Weston General Hospital. In both February 2021 and April 2021 Health Education England made the decision, supported by the General Medical Council, to relocate 10 foundation year one trainees (FY1) doctor posts in medicine out of Weston General Hospital. They were moved to Bristol hospitals within the trust, due to the continuation of significant concerns regarding supervision and support for FY1 trainee doctors.
- A number of staff reported they felt no effort had been made to foster good working relationships between staff on the Weston General Hospital and the Bristol sites. However, there had been collaboration and good outcomes in respect of COVID-19 vaccinations for patients and staff.
- There were areas of the trust estates which were in a poor state of repair. However, the trust was working with the estates team to ensure that potentially unsafe areas for both patients and staff were given the priority needed.

However:

- The trust had maintained a safe service during the pandemic. Staff had contributed to decision-making and changes to routines to help avoid pressures from the pandemic compromising the quality of care.
- The senior leadership team told us that they saw themselves as leaders and key partners in the integrated care system of Bristol, North Somerset and South Gloucestershire (BNSSG). They collaborated well with partner organisations to help improve services for patients.
- The trust leaders and teams used systems to manage performance effectively. Teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Our findings

- The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure and generally well-integrated. Data or notifications were consistently submitted to external organisations as required.
- The organisational priorities were in a 'pause, reflect and recover and reset mode'. We were told by senior leaders this was to ensure there was time to reflect and consider opportunities, identify risks with associated development plans and give sufficient priority and pace. This initiative, which created an opportunity for staff and the organisation to focus on wellbeing during a week focused campaign, aimed to 'reset' ahead of the values engagement work which would then commence.
- The patient experience team was clear the focus at the present time was giving a quality response. However, with the pandemic adding to workload pressures, this had led to some delays in complaints investigation and response times at Weston General Hospital.
- The diligent work undertaken by the infection prevention control teams (IPC) teams, not just in prioritising the risks associated with the pandemic, but also in ensuring that business as usual areas were not impacted. The commitment from this team, their flexibility and resilience and supporting other teams was found to be exemplar.
- There was a committed approach to engagement with patients and communities and learning from their experience and expectations of care.
- The trust was committed to improving services by learning from when things go well in particularly in research and innovation.

Is this organisation well-led?

Our rating of well-led went down. We rated it as good because:

We recognise the dedication and professionalism of everyone working in health and social care and how COVID-19 has been, and continues to be, the biggest challenge to face the health and care system.

Our comprehensive inspections of NHS trust have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level.

We also look at how well a trust manages the governance of its services, in other words how well leaders continually improve the quality of its services and safeguards high standards of care by creating environment for excellence in clinical care to flourish.

We carried out this inspection as we had concerns about the integration of the Weston General Hospital location into the wider University Hospital of Bristol and Weston NHS trust.

The trust had been subject to significant intervention by Health Education England in the removal earlier this year of F1 junior doctors from the Weston General Hospital location.

This summary is focused on the senior and executive management of the trust as well as our core service level assessments of medical care at both Weston General Hospital and the Bristol main site and outpatients' services at Weston General Hospital.

W1 Leadership

Our findings

The leadership was knowledgeable about issues and priorities for the quality and sustainability of services for its Bristol sites. It understood what some of the challenges for the Weston General Hospital location were and had the intention to address them. However, the organisation had not given these sufficient priority to ensure high quality, sustainable care.

Leaders had the skills, knowledge and experience and integrity they need, when appointed and on an ongoing basis. The senior leadership had recently changed with a number of new executive appointments to a large executive team.

There was a process for induction of non-executive directors (NEDs) which was tailored to their individual background and needs. The trust and the NEDs decided how best to spend that time considering whether this was the first non-executive role, or they were already a non-executive in a similar role. There was a focus on building relationships and tailoring accountability and responsibility particularly around any committees they chaired or attended. The NEDs were given access to all the essential documents and information they needed, and key people and teams.

Most trust board governors were elected from members of staff, the public and representatives of stakeholders. There was an active three-year cycle with elections every two years to keep a fluid mix of existing and new governors. The induction programme made it clear about the role of governors in representing their communities.

In terms of the Fit and Proper Person Regulation, the trust policy described how to ensure it was met. The usual employment checks were carried out as required of all directors. Each director would self-declare their fitness every year and the full checks were rerun every three years.

From this and previous inspections undertaken this year at both Weston General Hospital and the main Bristol site we were told by some staff that not all leaders were visible. We were informed by the CEO that senior leaders, during the pandemic, were prioritising safety and were adhering to government and the trust owns infection control procedures. To address some of the staff perceptions in relation to senior leadership engagement the CEO had commenced a weekly pre-recorded broadcast to staff and had increased leadership communications, which we were told had been well received.

Some staff at the well-led inspection told us there was little collaboration to create or understand the vision, values, and expected behaviours for the new organisation, and they did not all know how they fitted into the structure. There was further evidence from our last inspection at Weston General Hospital in March 2021, when we reported staff did not know or understand what the trust's vision, values and strategy were, and their role in achieving them.

The board and senior leadership team were aware of the importance of the integration of Weston General Hospital and the wider trust. Maternity services had undergone an integration in June 2019, 10 months before the trust's merger had occurred. However, the leaders of that program had not been asked to share the lessons they had learnt during that time. A managing director for medicine (Weston General Hospital location) had been appointed from the Bristol medicine team and started in June 2021. This post was created to provide support to the senior clinical leadership to the department of medicine at the Weston General Hospital location and to address the opportunities, integration, risks and sustainability issues at this location. An interim clinical lead for medical education had also been appointed based full-time at Weston General Hospital. The medical director, as did other members of the senior leadership team, told us they felt well supported under the leadership of the chief executive and other members of the senior leadership team and they were sighted on the priorities for ensuring sustainable, effective leadership, which included leadership development programmes, team building and succession planning.

Our findings

Leaders told us they understood the challenges to quality and sustainability and had identified actions needed to address them. The trust reported the process of integrating the clinical services across the Bristol and Weston site post-merger was being accelerated.

Concerns in relation to performance issues in medical care had been raised by external key stake holders during quality surveillance group meetings. Following requests by the trust for additional support, further senior leadership support had been provided from within the local integrated care system. A deputy medical director for NHS England and NHS Improvement southwest region joined the team to support and tackle some of the performance issues in medical care. They would support service transformation as well as engaging with external stakeholders and initiating a stabilisation plan.

At the request of the trust, the ICS had re-established the Healthy Weston Programme Board in April 2021. This was to review the delivery of clinical service development proposals which had been agreed following public consultation in 2019 and to explore further opportunities for developing sustainable models of clinical care in Weston.

Whilst significant challenges existed within the nursing workforce, nurse leadership was felt to be strong, with good support and leadership development in place. Non-medical leadership was also to be strengthened further by the appointment of a head of allied health professionals who would be reporting to the chief nurse. Divisional directors also described support and development to allow them to deliver their roles. However, medical leaders felt they were facing significant challenge, particularly in addressing the challenges brought about by integration, but that they lacked support and development to deliver their role effectively. Several senior staff spoke of the challenge exposed by COVID-19, with staff needing to shield or recover from sickness, leading to a reduction in workforce and an increase in workload. This had exposed an organisation they felt was too "lean." In other words, the organisation did not have sufficient capacity in bed numbers and staffing levels to perform at the level required and further support was required to particularly support the medical leadership at divisional level to meet those challenges.

The main priorities for the senior leadership team were:

1. Medical recruitment. Applications to work at Weston General Hospital, where there was a high reliance on locum doctors, were low and sometimes zero. This was for all levels of doctors.
2. Capacity. Morale was mostly good, but the challenge was felt to be insufficient bed numbers for general and Intensive care unit (ICU) patients.
3. The blending of the Bristol and Weston location workforces. The process had been delayed by the pandemic and diverse cultures. Actions were being taken to find an equitable solution and senior staff were brought in to support teams at Weston General Hospital.
4. The vacancy rate for the whole organisation was said to be incredibly variable. The biggest concern was the inadequate medical cover for Weston General Hospital which was expected to lead to sickness and stress. With mounting pressures on staff this anxiety was not limited to the Weston General Hospital but also the Bristol sites.

A program of nurse recruitment was underway, including the appointment of a cohort of nurses from overseas. The strategic plan for the medical team included work on recruitment, ongoing work related to capacity, and culture.

In June this year, a new managing director was seconded to work at Weston General Hospital from the Bristol Royal Infirmary. He spoke clearly of the challenges, risks, and opportunities that the Weston General Hospital location had to offer. Although new to this post he was an experienced senior leader and spoke with confidence of the resources, support, and commitment of both the executive team and the organisation. A senior consultant from the Bristol Royal

Our findings

Infirmary was now at Weston General Hospital five-days a week and the clinical director for medicine, also from the Bristol Royal Infirmary, attended one-day a week. The Associate Medical Director for Appraisal and Revalidation was based on site one day per week to assist with any queries and to work on recruitment of medical staff. In addition, the Medical Director was based on site one day per week. A monthly verbal update was provided to the Weston General Hospital senior medical staff by the Medical Director as part of the HMAC Meeting. A clinical chair was in Weston five days per week, a Deputy Medical director five days per week and a Clinical director two days per week. The objective was to further integrate services into the wider trust, and ensure consultants had joint oversight of their service of specialty across the whole trust. All pathways for patients would be unified, in order to provide a consistent approach to processes and standards of work.

As part of the inspection process, we engaged with key stakeholders including Heath Education England (HEE). In January 2021, HEE, through the Southwest Deanery, undertook quality interventions visit. The purpose of the quality interventions visit was to review the education and training environment at Weston General Hospital for foundation year one trainee doctors. The visit sought to follow up on the required actions that were required by HEE from the previous visit in June 2020. Senior leaders at the trust told us they had reviewed the cross-site structure of Post-Graduate Medical Education and agreed a unified, integrated structure across Bristol and Weston, which is now in place. The two legacy structures have been dissolved and there is now an overarching Trust-wide Director of Medical Education (recruited and in post) supported by five Deputy DMEs (recruited and in post) with cross-site educational opportunities in place.

Continued concerns were raised around clinical supervision arrangements for the foundation year one trainee doctors working in the medical division, particularly within the geriatric, medical stroke, and respiratory teams. Whilst HEE found sustained improvements in the supervision and overall experience of GP and foundation trainees in the emergency department, the review team from HEE found significant failures in the provision of educational and clinical supervision in the department of medicine and a lack of patient facing senior supervision, resulting in concerns about both trainee and patient safety. To address feedback from National Health Service England/Improvement (NHSEI) the General Medical Council (GMC) and Health Education England (HEE), the trust added programme management resource to consolidate and coordinate activity into a single detailed workstream action plan. This work continued and the trust was aware this must continue at pace.

A consultation process for pharmacy integration was in progress. However, at the time of inspection pharmacy services in Bristol and Weston locations had different leadership, structures and governance processes.

The lead pharmacist at Weston General Hospital was line managed by the Weston divisional director and did not have a direct route to report Weston specific risks to the trust's medical director. Pharmacy staff at Weston said the trust senior leaders had been open and honest in terms of the executive issues around merging a week into a pandemic. However, the removal of the Weston executive team had led to diminished leadership on site which had been difficult for the staff.

W2 Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action for the Bristol sites, which had been developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy for Bristol and the surrounding areas. Leaders and staff understood and knew how to apply them and monitor progress. However, the vision, strategy and values of the organisation had not been reviewed and updated to reflect the recent merger of the two trusts.

The vision and strategy for Weston General Hospital was not known by staff. The statement of vision and guiding values for Weston General Hospital was incomplete, out of date, and the trust's overarching strategy was not directly linked to

the vision and values of the whole organisation. The trust had involved clinicians, patients, key stakeholders, and groups from the local community in the development of the strategy approved in 2019 for the then University Hospitals Bristol NHS Foundation Trust. This process involved the North Somerset population served by Weston General Hospital and the Weston Area Health NHS Trust patient council and provided a clear plan to provide high quality care with financial stability. The Transaction Business Case and Post Transaction Implementation Plan that supported the merger between the trusts set out the intention to develop the identity of the new trust and engage staff in agreeing the mission, vision and values in year one as part of the organisational development programme. This plan had been disrupted by the pandemic and the associated need to focus clinical and managerial capacity on responding to operational challenges and maintaining safety. The work to develop new shared values had commenced in April 2021, however this was not as progressive for Weston General Hospital. Whilst work was in progress to develop the values for the new organisation, these were not yet confirmed.

The plans to review and update the vision, strategy and values of the merged organisation in the first-year post-merger (2020/21) as set out in the Transaction Business Case, had been delayed as a result of the pandemic response. A review of the 2025 strategy including the vision, priorities and objectives, was undertaken in 2020 against a number of "new world drivers" which included the integration of Weston and Bristol and extensive engagement with staff to develop the UHBW values was in early-stage *process* at the time of the inspection.

During our inspection of medical care at Weston General Hospital in March 2021, we reported that staff told us they did not know or understand what the trust's vision, values and strategy were or their role in achieving them. This view was held by some staff despite the evidence provided by the trust demonstrating extensive engagement with staff at Weston both pre- and post-merger. Staff told us they felt there was little collaboration to create or understand the vision, values, and strategy for the new organisation, and they did not know how they fitted into the structure. In our well led assessment, and during our core service inspections undertaken in June 2021, staff spoke about the current, although differing, trust's values. It was recognised by the senior leadership team that the values for the organisation were still those which existed before the merger, and they had yet to be renewed for the new trust. However, those leaders and staff we talked with could see how important they were. They said they were powerful when staff did not act in accordance with the trust's values to bring things into focus, and to recognise positive behaviour. Staff were also looking forward learning of the new values for the merged organisation.

It was noted in the people committee board papers for May 2021 that the coming year (2021/22) would see a focus from the trust on embedding an improvement culture across the organisation. This would consider feedback from staff through the assessment of the level of awareness of quality improvement across the trust and would also link with the trust's values work currently underway. The trust risk register had recognised and captured the benefits of transformation, improvement and innovation had yet to be realised. The trust risk register recorded the potential risk that benefits of transformation, improvement and innovation are not realised due to insufficient priority given to developing the trust's culture and the capacity and capability of staff. This potential risk was recognised as mitigated through the Transformation Improvement and Innovation strategy and associated action plan with six-monthly assurance reports provided to the people committee on progress of delivery of the action plan. The trust had recognised the delivery of the action plan within this strategy would mitigate this risk, while the senior leadership were aware of the organisation's priorities following the merger.

Many of the senior leadership team and other senior trust staff recognised the work was not as advanced as would have been hoped largely as a result of the impact of the pandemic and prioritising staff capacity to cope with operational

challenges. At the time of inspection, progress had been made against the merger plans to integrate 21 of 23 corporate functions including the estates and facilities teams and 9 of 32 clinical services. While some senior staff expressed disappointment with the progress and the way in which integration had been managed, others were more positive and said the trust had the skills and resources to make the merger a success.

The Healthier Together Sustainability and Transformation Partnership for Bristol, North Somerset, and South Gloucestershire (BNSSG) brings together 13 organisations from Health and Social Care to work towards creating an integrated care system for the local population by 2021. Executives played a key role in the Integrated Care System, working closely with partner organisations to drive change and development for the region. The trust's strategy "Embracing Change, Proud to Care – our 2025 Strategy", set out the trust's strategic priorities for the next five years. The strategy made references to undertaking an audit against checklist for building improvement capability once the merger had taken place was referenced.

Senior leaders and staff told us they were keen to see progress in system working (as an integrated care system (ICS)) and saw this as positive. They told us they had a great working relationship with the universities and other key stakeholders and saw plenty of opportunities as an organisation to learn and develop.

The medicines optimisation strategies had yet to be aligned following the merger in 2020, but there were some examples of shared priorities. For example, revision of the outsourced outpatient pharmacy service in both locations to ensure contracts were coterminous. Some progress had been made on delivery of the medicine's optimisation strategy. An independent prescribing pharmacist had been appointed within the emergency department at the Bristol Royal Infirmary and a 'flow' pharmacist worked within the medical admissions unit. These appointments had improved the rates of medicines reconciliation prior to admission onto wards and medicines safety, at the Bristol site. Additional funding had allowed for recruitment of medicines management technicians and pharmacists at Weston General Hospital. However, due to other workforce pressures within the pharmacy stores and dispensary at Weston General Hospital, staff were often pulled back from the wards to focus on medicines supply. Development of an electronic prescribing and medicines administration system (ePMA) had stalled in some areas due to its complexities and bespoke models of the system were being utilised.

W3 Culture

Most, but not all staff felt respected, supported and valued. All staff we met were focused on the needs of patients receiving high quality and compassionate care.

The trust told us it promoted equality and diversity in daily work, but this had failed to support a number of staff from multicultural backgrounds and not all felt they were provided with opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, not all staff felt safe or secure about speaking up.

The trust recognised further work was needed to engage with staff to ensure there was collective and agreed set of organisational values and expected behaviours for staff to work to. Work was in its infancy to ensure that staff all levels were engaged, involved, and had ownership of these in relation to their daily roles.

Not all staff felt supported, respected and valued, and staff satisfaction was variable. Improving the culture and staff satisfaction was on the trust's list of priorities as an area for attention and further development. During the inspection

we found teams working in 'silos' and we were told management and clinicians do not always work cohesively. Leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, however, some staff told us that to not always raise concerns as they are not always taken seriously or appropriately supported when they do.

Many staff told us that they were proud to work at trust, and during the inspection, whilst finding some silo working, we also found some strong collaboration and interface working across sites/teams.

Staff described the past 18 months as being pressurised and challenging due to the pandemic, but that individuals, teams, and the organisation were cohesive and committed during this time to provide safe care and treatment for patients in an environment where people were safe at work.

Staff were proud of the work of the trust in leading for Bristol, Somerset, North Somerset and South Gloucestershire (BNSSG) in the national COVID-19 vaccination programme. By April 2021, approximately 30,000 vaccines had been administered across Weston and Bristol.

As an NHS foundation trust, the trust had a Council of Governors whose membership included elected public and staff governors, and governors elected by key stakeholders.

In November 2020, the trust had appointed an external organisation commissioned to undertake an engagement exercise with staff and key stakeholders in respect of the values of the organisation.

The divisional managers felt the wellbeing of staff at the trust, particularly during the pandemic, had been supported and a major priority for the organisation. They spoke highly of the psychological services offered to help staff. Staff also told us of the wellbeing benefits of this support. The pandemic had been overwhelming for many staff including the human resources team (HR). The HR team worked closely together and endeavoured to make the guidance for the wider organisation clear and meaningful, but some staff told us it was overwhelming at times with so many changes.

Staff went out of their way to provide help and support to each other and other teams wherever they could. They helped with moving departments and wards when needed and accommodated/supported patients they were not always used to working with. For example, the children's hospital accommodated young adults in a reconfigured ward to help with pressure on adult services. Also, the intensive care staff from the children's hospital went to support the adult unit when they could. The oncology team were enabled to use the dental hospital. The ophthalmology service and one of the children's teams used part of the Bristol NHS Nightingale Hospital. There was a great deal of innovation and collaboration at this time, although some staff were sad to see most of this now stood down as all services returned to normal ways of working.

However, many staff were feeling the pressure from the pandemic and in some teams or with individuals, the mood was described as low. Staff told us this had contributed to some key staff having left or leaving. It was felt by some staff we spoke with that morale was the lowest it had ever been. There were anxieties around recruitment and retention of staff, and the ownership and ability of the executive team to bring support, raise morale and solve the crisis.

However, for the clinical teams we met, the divisional directors were described as providing strong leadership along with the excellent support from the nursing and allied health professional staff. Staff told us the challenge of the pandemic had been met "incredibly well" by "really passionate and committed clinicians" of all different disciplines. Individual directorates and specialties had been well led with clinical leads enabled to make decisions and changes at the height of the pandemic to cope with the new ways of working.

Our findings

There was a disconnect between management and some clinical staff. This had not been helped by a lack of meaningful clinical and general staff engagement. Many staff who had roles with close links to cultural change, including divisional directors and consultants, reflected there was a lack of staff engagement.

The culture did not allow all colleagues to feel they were treated equitably, and equality and diversity was not always protected in the organisation. Some staff from a black, Asian and minority ethnic background felt the mindset of people they worked with and some patients and families they cared for or supported had not changed despite all the policies and efforts around them. Some felt there remained an imbalance in promotion opportunities and had examples of being overlooked for new roles despite being better qualified than successful candidates. Several staff felt non-white staff were disproportionately disciplined, and they felt more vulnerable to criticism. Some said they felt they had to work twice as hard and have a lot more qualifications just to fit in.

As described by some members of the trust's multicultural staff community, there were concerns around equitable treatment for staff from a Black, Asian and Minority Ethnic background. Diversity and inclusion training was provided, however some staff said were not aware of any training available to them or their managers to help deal with racial abuse by patients or others and practice zero tolerance.

Staff told us about experiencing some forms of micro aggression in their day-to-day working life. Some said responding to these can be taken by other staff as being aggressive. It was said micro aggressions were not well understood by colleagues who are not from a minority background. Nevertheless, many teams can be "brilliant" to work with, but some also can be "very nasty."

We were given several examples of poor experiences for staff which we will not report here to avoid identifying them. However, they were disappointing and showed unhelpful attitudes from across the spectrum of white colleagues and some colleagues from a multicultural background to other colleagues.

Some multicultural staff had noted the use of outdated terms and a proliferation of stereotypes in patient care for those from a non-white background. The concern was this could lead to mismanagement of patient safety and care from stereotypes or incorrect assumptions.

Some staff would report incidents of aggression or racism, but most we spoke with felt this was not done enough. Some staff had felt knocked-back when reporting and made to feel they were the problem. Some staff said they were not afraid to complain if they felt racially abused but equally, they just wanted to get on with their job without this being a part of their lives. They also did not want to relive these things repeatedly.

The staff we spoke with were not aware of any member of trust staff being disciplined around discrimination. There was a lack of diversity in some teams which meant to multicultural staff they were not representative either of the patients and families they were looking after. They felt a wider diversity would help with knowledge and experience of patient care as well as give them more moral support together.

A number of people told us about incidences where members of staff had refused to use someone's name in a meeting as they had not taken the time to find out how to pronounce it. We were also told senior colleagues had changed someone's name to a more western-sounding name as they said they preferred it and had asked staff not to refer to them by their given name.

Our findings

The trust had networks for staff with protected characteristics. The recent appointment of a head of equality was a much-anticipated appointment and there was an expectation that this role and the surrounding support will help to improve standards and awareness this area.

From the trust's perspective, the first bi-annual equality, diversity, and integration (EDI) integrated performance report and the Q1 EDI progress update against the action plan 2021/22 were being reviewed and prepared for governance reporting at the time of this inspection. The report was shared with us and was comprehensive and encompassed all areas of the organisation. It stated the challenges and set-out the strategic action plan for the next year. Progress and exceptions on the action plan would be monitored by the six-weekly EDI steering group, with quarterly updates to the trust's people committee.

Data from the *Workforce Race Equality Standard (*WRES) supported the concerns of multicultural staff. Indicators from the 2020 NHS staff survey showed a statistically significant difference in scores between white and Black, Asian and Minority Ethnic (BME) staff. The results showed 27.9% of BME staff experienced harassment, bullying or abuse from staff in the past year which was significantly higher when compared to 21.7% of white staff. The survey also showed 71.4% of BME staff believed the trust provided equal opportunities for career progression and promotion which was significantly lower when compared to 88.6% of white staff. It was also a concern to note 18.3% of BME staff experienced discrimination from a colleague or manager in the past year which was significantly higher when compared to 5.5% of white staff.

During our core service inspections, and prior to the well led assessment of the trust, we invited staff to complete an anonymous online survey. Staff of all levels and across all sites were invited to take part. There were 1,521 responses. Of these responses, 1,298 responses came from the Bristol site and 221 from Weston. Two responses had an unknown site.

The lowest positive responses centred around senior management and the executive team, including confidence in the executive team, communication from senior managers and senior managers involving staff in decisions.

The survey also showed us that 9.1% of staff reported personally experiencing discrimination at work in the past 12 months from a manager, team leader or other colleagues. At Weston, 14% of staff who responded said they had experienced discrimination.

Staff at Weston General Hospital reported fewer positive responses in all statements in the survey compared to Bristol staff. In 12 out of 17 statements, more than 20% fewer staff at Weston reported positive responses compared to Bristol. The largest difference between Bristol and Weston positive responses was for recommending the organisation as a place to work. Our survey found 74.1% of staff reported they agreed (agreed or strongly agreed) they would recommend the organisation as a place to work while 9.5% disagreed (disagreed or strongly disagreed) with this statement. At Weston General Hospital only 45.7% of staff agreed.

Some staff told us they did not feel listened to. It was noted at a private board meeting in 2021, issues around both clinical and non-clinical staff feeling disconnected were "complex and multifactorial". Factors included the practical element of remote working, the changed working relationships, and fragmented teams. The Board had a concern that staff may be feeling disconnected as a result of the pandemic and remote working arrangements – as a result, in April 2021 the Board invited the Head of Psychology Services and Consultant Clinical Psychologist and Lead Psychologist for staff wellbeing (trust-wide), paediatric palliative care and paediatric oncology services to attend the Board to share the key themes from their interactions with staff to help the Board understand how staff were feeling and how best they could support staff.

Our findings

Some staff mentioned not seeing senior managers on the units and this caused them to feel separate from the rest of the organisation.

There were concerns about equitable treatment for staff at all grades, and particularly for staff at a lower grade. Not all staff felt safe and secure about speaking up. The trust's relationship with those representing the unions and elected staff-side members was said to have been less effective in the last year, whereas it worked well prior to that. This may have been linked to the pandemic, but it had been perceived by some teams that senior decision-making staff seemed unwilling or unable to contribute as they had done before. There was now limited representation of trust senior managers outside of the human resources team at the staff partnership forum and staff representatives felt wider issues were now not always heard.

There was a list of issues brought to the trust by those representing the unions and elected staff-side members which were open for resolution, some of which were said to have been discussed and unresolved for several years. This included inaccurate payments to staff on a lower grade having not been resolved for around two years. There were concerns and perceptions from some staff, from their own experiences, that suspensions took a disproportionate amount of time for lower banded staff as opposed to higher banded staff. We heard staff at a lower-grade, often cleaners and maintenance staff, were quick to be suspended if disciplinary action was commenced, while other more senior staff were moved to other roles and not suspended. Staff believed the suspensions also took a long time to be reviewed for lower-grade staff. This gave mixed messages to staff and made staff at a lower grade feel more threatened in their position and fearful to speak up.

Staff members of the unions had reported not wanting to speak out for fear of losing their jobs. There were staff without substantive contracts who did not feel they had the right or courage to speak out. Staff were said to feel less brave now about speaking out than before and it was felt it was safer to be anonymous when reporting anxieties. There was some concern raised about staff being mocked by other more senior staff if they spoke out.

Within union representation, the staff-side team did not feel they were given the opportunity to engage well in the recruitment process, and not heard when there were issues raised around fairness and equity. We were given several examples of concerns that had been raised but were yet to be addressed around equitable short-listing processes and appointment of candidates.

There were mechanisms for providing staff at every level with the development they needed, including appraisal and development conversations. However, compliance with staff appraisal had dropped considerably during the pandemic, although was a priority for the trust to improve.

NHS England and Improvement issued guidance in March 2020 and January 2021. That guidance specifically advised providers to reduce mandatory training for staff (other than that directly relevant to the COVID response) and to suspend staff appraisals, including medical appraisal.

Staff appraisal was measured as a percentage of staff (excluding consultants) who have had their appraisal signed-off by their manager. The target was 85% trust wide. In April 2021, 6,902 members of staff were compliant out of 10,392 (66.4%). Overall appraisal compliance had increased to 66.4% from 64.9% compared to the previous month. All divisions were non-compliant. To support closing the compliance gap, a simplified form had been developed by the trust which was introduced at the end of May. The work programme to review and align appraisals had been on hold due to the pandemic. However, this had now recommenced. Appraisal training had also restarted in addition to the bitesize videos and guidance available through HR resources to support all managers and staff with appraisal completion.

Our findings

Experience of culture in pharmacy teams was variable among staff groups. There were some significant areas in Weston where some staff felt unsupported and not valued. There was a Freedom to Speak Up advocate within pharmacy at Bristol and Weston. They reported that staff have been speaking up more about concerns in the past year. Feedback was also received through the trust's 'Happy App'. The 'Happy App' is a tool that staff can use to quickly capture their mood and provide more information about what is going right or wrong. Weston pharmacy staff said they received a lot of notifications from the trust in the application about wellbeing, but then did not know where to go or who to speak to about their own wellbeing, despite a wide range of well-being resources available and signposted throughout the trust, for example through COVID-19 updates, posters and weekly staff newsletters.

Pharmacy staff based at the main Bristol site felt there was a caring culture in the trust and leaders appreciated people's efforts. However, they felt the value of pharmacy staff specifically, was not recognised, especially non-ward-based services such as technical services. The trust had sent thank you cards to all staff which included 'seeds of hope' for staff to plant at home. The 'seeds of hope' was described by some as not wanted or necessary, others appreciated this gesture. As with other staff, the rate of pharmacy staff annual appraisal had dropped significantly below the 85% target during 2020 (March 2021 was approximately 57% - which was below the average of the trust overall).

At Weston General Hospital not all pharmacy staff had an annual appraisal and newly qualified pharmacists did not have clinical supervision. Morale at Weston General Hospital was low in the team, and staff felt they were not always delivering a safe service. This had not been identified by pharmacy leaders at Weston. Pharmacy staff did not know who their counterparts were in the different locations of the trust. They reported to us that they felt no effort had been made to foster working relationships between staff on the different sites, although there had been some collaboration around the COVID-19 national vaccination programme.

W4 Governance

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

There were clear responsibilities, roles and systems of accountability to support good governance and management.

There was a clear performance management reporting structure with monthly governance meetings looking at operational performance at divisional level. Integrated performance reports from divisions were reviewed and then taken up through the internal governance process to the quality outcomes committee. This included a review of incidents reported, complaints, staffing, audit status, infection control, risks identified on the risk register and risk management, and education and training.

During the pandemic, a programme of trust board work was carried on virtually. We were told this broadly worked, but all executive members were said to be keen to get back to face-to-face meetings recognising the value of these.

The board this year were looking at two broad themes:

- Restoration, including digital changes and learning from the pandemic.
- System working where the trust wants to be an anchor organisation for the ICS (Integrated Care System) and 'influencers'.

Our findings

These two themes would flow through the development programme this year and beyond. Although there was a board plan, this was recognised as needing to be fluid to enable it to adapt to meet demands on the NHS and new membership at the board.

Governance and management functioned effectively and interact with each other appropriately. The senior leadership team (SLT) was the executive arm of the organisation. Within this group, senior corporate and organisational executives and managers oversaw the organisational governance and risk. Members of the executive board and divisional directors attended SLT meetings with a formal agenda and the SLT reviewed all reports around risk which went up to the board.

The board assurance framework (BAF) was described as a two-part framework covering strategic risks and corporate objectives. In addition, the board and committees considered the corporate risks every quarter alongside the BAF. Both strands were looked at against the strategy of the organisation and reviewed quarterly at board meetings. The BAF review process would then determine whether further assurances were needed on a certain risk or whether a deep dive into a specific topic should be requested. The BAF was used to provide assurance of delivery of the strategy and aligned with the priorities of the corporate risk register.

Information presented to the quality and outcomes board committee (QOC) was corroborated by the non-executive directors by attending several other committees alongside those they chaired. This included finance and digital, and the audit committee. Non-executive directors told us they had confidence in the papers presented to the quality and outcomes committee. The minutes of this committee were a good reflection of the challenge presented and we were told these had hugely improved over the years. There were action plans following meetings which would always have a due date alongside. These were well monitored.

Safeguarding remained a key priority for the trust and this year's annual report summarised the key safeguarding activities, developments, and achievements in what had been a challenging reporting period. The report provided assurance that the trust was fulfilling its statutory safeguarding duties and responsibilities.

Board level assurance of safety at Weston General Hospital was determined by tracking safety metrics such as falls, serious incidents, pressure ulcers, and staffing levels, which were all retrospective events. We were not assured the process allowed for the mitigation of immediate safety risks and how to manage future known risks. We were told by the new clinical director that the organisation had recognised it was not fully aware of all the risks associated with the Weston General Hospital location, which included the need for clinical review and integration. It was noted in the quality and outcomes committee (QOC) report for March 2021 that a number of processes in relation to the investigation of serious incidents had been delayed including the completion investigations and ensuring actions were closed promptly; this applied across all the Divisions but in particular to the Weston General Hospital division due to the volume of serious incidents being progressed. There were a small number of pre-merger outstanding actions, and it was hoped these would be completed shortly. A new patient safety lead for Weston General Hospital had been appointed and it is anticipated by the trust that this role and surrounding processes and governance would improve the processes around serious incidents management. From data we reviewed it was too early to tell if these interactions were having an impact.

The governance at divisional level was crucial to the quality of data coming to the QOC and data was considered to be of good quality and all useful. The integrated performance report also came through QOC first for scrutiny before going to the trust board. The chair of the QOC would then present this key performance report to the board alongside a written

summary report of key messages. However, we were concerned that board sub committees were held in the same week as the board, and as such, on occasion verbal sub board meeting updates were delivered rather than written papers. If written reports were submitted, the timing of meetings meant there was limited time for board members to read ahead of the board meeting.

There was a strong view by senior staff that notwithstanding the unplanned cancellation of operations in the pandemic and the growing length of time for referral to treatment, the quality of care for patients had been maintained. This was supported by many of the staff we spoke with throughout the trust and was described as happening due to “a superb effort from the staff.”

Following concerns, the trust had initiated a standard operating procedure (SOP) designed to ensure routine supervision happened through board and ward rounds on medical wards at Weston General Hospital. Compliance was reported at a quality and surveillance group meeting in May 2021, noting an improvement in consultant attendance, however the associated improvement in the quality of supervision had not yet been seen.

There were effective structures, processes and systems of accountability in pharmacy governance, although some recently improved for Weston General Hospital. Weston general Hospital location was represented at divisional level not at a pharmacy level. There were various medicines governance sub-groups that fed up to the medicines governance group (MGG) or medicines advisory group (MAG), both chaired by the director of pharmacy.

The medicines advisory group (MAG) were responsible for protocols requiring clinician support, National Institute for Clinical Excellence (NICE) approvals, and individual funding requests. The medicines governance group (MGG) was a working group with strong nursing representation looking at aspects of medicines safety, controls, and incidents.

Membership of the MGG included representatives from all divisions including the Weston General Hospital divisional lead. The MGG reported to the patient safety and clinical quality group, chaired by the chief nurse or medical director. There was a pause of these meetings during the pandemic and a new process with gold and silver command was introduced. This coincided with the trust merger and ceasing of Weston General Hospital specific governance groups and was described by a member of the team as a “governance void.” Initially there was no pharmacy representation at the Weston General Hospital divisional quality and safety group. However, the lead pharmacist at Weston General Hospital had worked with the lead nurse and medical lead at Weston General Hospital to ensure pharmacy was now represented at a divisional level.

There was a program of internal audits across all divisions which were reported into divisional governance meetings. A safe and secure handling of medicines audit at Weston General Hospital had identified some key themes and an action plan had been drawn up to improve the safety and quality of medicines storage. However, there was limited pharmacy staff to help implement this action plan.

The director of pharmacy for the trust for the Bristol site reported to board on medicines optimisation annually, including key patient safety markers, audit outcomes, progress against strategy. The lead pharmacists for both the Weston General Hospital and Bristol sites reported controlled drug (CD) incidents to the CD local intelligence network and submitted quarterly occurrence reports.

W5 Management of risks, issues, and performance

Our findings

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid operational pressures compromising the quality of care.

There were clear and well embedded arrangements for identifying, recording, and managing risks, issues, performance and mitigating actions in most areas across the trust. From our discussions with senior leaders and staff, a review of the board assurance framework, quality outcomes committee and board meetings, we could see there was an alignment between the recorded risks and what staff told us.

There are arrangements in place for identifying, recording and managing risks, issues and mitigating actions. Staff were able to reports risks within the organisation and anyone could add something to the local risk register. Where this was part of their role, they were involved in monthly meetings looking at risks. Staff said they ensured during governance meetings that divisions were aware of risks within the allied health professional staff group, as these could have potentially detrimental effect on timely patient care and treatment. The patient safety team regularly reviewed the risks and the actions being undertaken to ensure they had been completed. Many staff we spoke with felt the trust had a well embedded and assured risk-management process.

The trust recognised it needed to do more to embed risk management within Weston General Hospital. There were significant risks relating to recruitment, especially at Weston General Hospital. Senior leadership team recognised the issues with the medical workforce at Weston General Hospital did not have an immediate solution, but the team had seen steady, incremental improvement. There were new appointments made and some departments, such as trauma and orthopaedic teams, were a clear success.

There had been a marked deterioration in the performance of the emergency departments. In the year from July 2020 to June 2021, the trust (across all emergency departments) had seen a deterioration in the number of patients seen against the NHS four-hour standard. The standard was to admit, transfer or discharge at least 95% of patients attending the accident and emergency department (A&E).

The average for the year 2020/21 was 80.1% but this had fallen to 73% for the first quarter of 2021/22 and to 70.1% by June 2021. This was reduced to 66.7% when accounting for type 1 emergency patients only. The trust did not report this result against the national average to be able to show a comparison. However, the national average for June 2021 for type 1 emergency patients was 73.2%.

There were also a significant number of patients waiting more than 12 hours on a trolley in the accident and emergency departments. In the emergency department in Bristol this had traditionally not happened in the recent past, but delays caused by a steep rise in demand and a lack of flow of patients (lack of beds) meant this was now a significant factor. At the peak in January 2021, 468 patients waited more than 12 hours on a trolley (12% of 3,825 nationally and the highest in England). By June this had dropped but there were still 146 patients in this category. This was 11% of the number of patients nationally and the second highest in England.

As stated, this performance should be seen among a significant rise in demand for accident and emergency services, as is the national picture. In July 2020, the trust had 12,969 patients attend. In May and June 2021, attendances had risen to 16,523 and 16,871 respectively.

During the medical care inspection undertaken at Weston General Hospital earlier this year, we were concerned that the service did not have enough medical staff at all levels to meet the recommended guidance for the department. There were insufficient numbers of consultants in post and there was also a shortage of junior doctors, with a heavy and

persistent reliance on locum staff. There were only three substantive medical consultants at the Weston General Hospital location when there were posts for 13. The risks to medical and nurse staffing were known and had been included as the highest risk in the merger transaction. Management of the risk and partial mitigation was planned through a recruitment and retention plan at the point of merger alongside on-going operational action to manage rotas. While reports into the organisation and people committee demonstrate continuous actions to seek to recruit medical staffing, we were concerned these actions had not addressed the risks posed to quality and safety also raised by external regulators.

There was also a shortage of registered nurses and heavy reliance on bank and agency staff across many areas of the organisation, but most noticeably at Weston General Hospital. The risks to nurse recruitment have been well recorded nationally, however the trust had been heavily reliant on a workforce in the main from local universities and had only just undertaken an overseas recruitment campaign to address the shortfall. Plans for international recruitment for nurses continued. The trust target date for completion of recruitment of additional staff for the emergency department of the Bristol Royal Infirmary was October 2021.

The trust acknowledged these recruitment challenges put the organisation in a concerning position regarding its ability to provide the required standards of care to patients particularly in the medical care and care of the elderly specialities.

In the organisation, any risk added in the organisation rated through the risk matrix calculation (risk likelihood and severity) as 12 and upwards went to the senior leadership team (SLT) meeting, chaired by the CEO, for review. These risks would have firstly been through the specialty or the division to review before being raised to the SLT. Any risk of 12 or above was allocated a patient safety lead. The senior leadership team would then decide where and by whom in the organisation risks were managed and owned, to ensure appropriate governance, oversight and mitigation were in place.

Operating with limited bed capacity was described as being one of the main risks for the organisation with almost all teams reporting bed shortages. The pandemic had particularly exposed this risk as did the ongoing issues with the timeliness of access to community care packages to facilitate earlier discharges. The increasing number of patients who were fit for discharge but had no onward place to be discharged to was recognised at board level and at system level.

The trust had always had a strong financial position and was felt by members of the finance committee that it remained in a strong position today. Nevertheless, it was recognised plans and budgets were disrupted and skewed by the pandemic for all NHS organisations, and this trust was no different. There was a massive impact on expenditure for items such as medicines, medical devices, and PPE. However, the trust board and finance committee felt in control of the expenditure and that which was centrally funded.

Financial pressures were managed so they did not compromise the quality of care. Service developments and efficiency changes were developed and assessed with input from clinicians so their potential impact on the quality of care was understood. However, we were told by members of the clinical leadership how business cases were slow to process and going through what was described as “layers of bureaucracy.” Important decisions were said to be stuck in endless process and financial governance and there was a recognition that tight finance controls exhibited previously meant areas of the trust estate were in need of considerable investment now.

There were programmes of clinical and internal audit to monitor quality, operational and financial processes and there were systems in place to identify where action should be taken. Board committees had multiple members and there was a clear overlap between committee membership so actions or issues at other meetings could be shared where they had an impact on finance. The finance committee had recently changed in its format to now also incorporate the trust’s digital work. This provided the committee with an even broader range of knowledge and trust insight.

Our findings

The chair of the finance committee felt the work was well balanced, and the level of detail was about right. They were confident about the information provided and its accuracy and integrity. If there were any errors, they were infrequent, but were identified very quickly, were small, and were reported and addressed. This gave reassurance in staff being willing to highlight errors with confidence.

The key role for the non-executive chair of the finance committee was to ensure patient care was safe and finances were available to provide the structure for care to be of a high standard and quality. Assurance of this came also from the other board committee work and the board itself.

The trust was monitoring any safety impact on patients for those receiving treatment They were monitoring the mortality rates at Weston General Hospital which was noted to be within expected parameters and were triangulating this with the Medical Examiner's office. Audits of patients' notes had been undertaken along with a review of significant incidents and review of unexpected escalations of patient to intensive care. All are within anticipated benchmarks and the trust will continue to monitor these.

To work closely with the consultant body at the trust and to also oversee risk, issues and performance, the medical director spent time in wards and departments with clinical teams when on call. He attended board sub-committees and had regular conversations with staff. He described "amazing teamwork" during the pandemic, and this was confirmed by many of the other staff and groups we spoke with. For example, ophthalmology staff retrained to support other specialities and dentists came to support patients and staff. There was support to the emergency department (ED) at the Bristol Royal Infirmary from staff working in multiple specialties.

Executives recognised the response to increased demand was challenging. They were concerned about resilience of the emergency departments (ED) due to the elevated levels of demand currently seen. The reduced and 'too-small' bed-base was limiting and delaying the movement of patients from the ED who needed to be admitted. The intensive care unit (ICU) was also very challenged with patient clinical needs rising due to delays in treatment in the pandemic.

Beds within the Bristol Royal Infirmary were lost as a result of responding to COVID-19 requirements to separate blue and green pathways when the emergency department majors' service was moved into the medical assessment unit, which was relocated elsewhere with less space and therefore less beds. Medical teams were also stretched throughout services.

All aspects of outpatient performance continued to be heavily impacted by COVID-19. Initially capacity was lost at Weston General Hospital due to additional infection prevention and control measures, a shortfall of staff, social distancing and patient choice not to attend. As a result, services did not always meet people's needs. This was recorded on the local service level risk register which clearly identified individual risks and the action taken to mitigate the risks. The position was monitored at monthly meetings within the Weston division.

Outpatient activity had not exceeded pre-COVID-19 levels, except in March 2021. Provisional data for April 2021 showed outpatients at Weston General Hospital were around 90% of April 2019 levels. It was recognised this would not be sufficient activity to manage the follow up backlog demand as well as the ongoing new demand. Capacity was being focused on the delivery of the most clinically urgent cases and was being monitored and recorded on risk registers. There had been significant expansion of telephone or video appointments and 32% of outpatient's appointments were now routinely delivered in this way.

Our findings

From February 2020 to January 2021 the average length of stay for medical elective patients at the trust was 6.4 days, which is lower than the England average of 6.7 days. For medical non-elective patients, the average length of stay was 6.8 days, which is higher than the England average of 5.9 days

From October 2019 to March 2021 the trust's referral to treatment time (RTT) for admitted pathways for showed a deterioration from January 2021 to February 2021, this is in line with most organisations during this time due to the pressures of the pandemic.

From March 2020 to February 2021, the four specialties of rheumatology, thoracic medicine, gastroenterology, and dermatology were above the England average for admitted RTT (percentage within 18 weeks).

Although, the relative risk of re-admission for elective admissions overall were in line with the England average, clinical haematology and gastroenterology had a much higher risk of re-admission compared to the England average

Managers were planning and organising services to meet the needs of the local population and the changing COVID-19 situation. The trust launched an elective restoration programme in April 2021, led by members of the senior leadership team, to coordinate recovery activities based on the core priorities of patient safety, workforce, capacity and capability.

There were arrangements for identifying, recording and managing risks in pharmacy services. The director of pharmacy produced an annual pharmacy performance report that laid out key strategic priorities, key performance indicators and risk. Risks included different pharmacy work practices across the two locations, differing targets and baseline data or unavailability of data for certain metrics from Weston General Hospital.

Both locations had a medicines safety officer (MSO) who investigated and reported on medicines incidents. At Bristol, the MSO had oversight of incident reports from all Bristol locations. The MSO worked with pharmacy and clinical staff at other locations (e.g., St Michael's, the children's hospital, and the eye hospital) to investigate medicines incidents. At Weston, the MSO received all medicines incidents reported solely from Weston General Hospital. They reported to the divisional quality and safety group as needed. Both MSOs were effective at investigating incidents, being involved in root cause analysis and developing learning or process change. They contributed to the independent performance and quality report (IPQR) on medicines incidents causing moderate harm or above.

Not all risks were aligned with what staff said was worrying them. A number of staff told us they were concerned about the estates and the conditions of buildings, along with the reduction in the bed base among rising demand and pressures on the system. Some felt they were required to become even more efficient in getting patients through their care and treatment, when for some specialties they had the lowest length of stay in the country already.

Risks in relation to the estate were recorded on the risk register. There were significant concerns about the condition of the estate. Some areas of the estate were described to us by staff as "embarrassing" with "litter and debris not cleared up effectively." A number of staff at focus groups told us there was inadequate storage in many parts of the premises. Some of the premises had leaks, including raw sewage coming into buildings. Staff raised concerns with us about the safety of some of the estate and sent us photographs showing a corridor with buckets and towels placed to deal with roof leaks in a corridor at St Michael's Hospital. They also said that St Michael's had leaking roofs in gynaecology and staff office areas. Staff also told us of water coming in through the roof in main theatres of the Bristol Royal Infirmary. We were also told the ceiling leaked in the theatre block when it rained.

The risk register showed the trust was aware of its estate backlog maintenance requirements and had targeted its capital investment programme to manage the highest risks within the clinical environment and elsewhere. It had also

looked to invest on additional improvements to the estate targeted on staff wellbeing. The executive team had approved funding for the new Level 9 staff rest areas and support for the temporary extension at Weston General Hospital was confirmed. The Bristol Heart Institute atrium had a temporary staff area that was due to be enhanced. However, it was noted in recent trust board papers that estates had a significant backlog of work which could affect the delivery of the above.

W6 Information management

Leaders and teams collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Appropriate and accurate information was processed, challenged and acted upon. There is an understanding of data by the organisations leaders and teams, and it was used to measure performance. Staff received data which supported them to adjust and improve performance, as necessary, and performance information was used at to hold management and staff to account. The information used in reporting, performance management and delivering quality care was accurate, valid, reliable, timely and relevant, with plans to address any areas of deficit.

Quality and sustainability received sufficient coverage in relevant meetings and staff had access to information to support those conversations. Information technology systems were used to effectively monitor and improve the quality of care. Although work had been done at UHBW (Weston) to improve the quality of discharge medicines and summaries, we were told by medicines management technicians that they do not use their own discharge summaries as a source of medicines reconciliation if people are readmitted, as their accuracy cannot be relied on.

We were informed that the roll-out of an electronic prescribing and medicines administration system (ePMA) had been delayed due to software issues. This had been raised at the trust digital programme board. The intensive care unit, haematology and oncology at Bristol and Weston General Hospital, as well as the Bristol Eye Hospital and outpatients at Bristol Royal Infirmary used electronic prescribing.

There are established arrangements to ensure data and notifications were consistently submitted to external organisations as required. There were arrangements for the availability, integrity and confidentiality of patient identifiable data, records, and data management systems. Information technology systems were used effectively to monitor and improve the quality of care.

The trust was able to provide assurance on information governance breaches reported to the Information Commissioner and through the role of the Caldicott Guardian.

During the pandemic staff recognised the pressures on the information technology (IT) team. Setting up home working for so many staff was said to have caused logistical challenges, however, the IT set-up was said to be run by a strong committed team. The pace of system and process change was said to be “fantastic” and new ways of working had been appreciated. Staff said they got to know so many more people they worked with, and this would remain something which continued in the future.

W7 Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Our findings

People who use services, their views and experiences were gathered and acted on to shape and improve services, this included people in a range of equality groups. The patient experience team were dedicated and well-resourced to provide a patient-focused approach. For example, we were told that caseworkers offered to people the opportunity for people who had cause to complain to speak with them directly, in order to show empathy and an understanding of the concerns and to ensure the voice of the patient was listened to.

The complaints team worked in responding to patients or complainants in a timely manner although this had been impacted by the pandemic and we were aware of a backlog of complaints being dealt with in respect of Weston General Hospital. This was monitored by the board, and recent performance had improved in this area. The priority for the team was the response being fair and what the complainant needed, rather than it being rushed, or not personalised in order to meet key performance indicators in relation to response times. The quality was measured by the very low number of complaints being returned to the trusts complaints team due to them being unsatisfactory to the receiver. The Parliamentary Health Service Ombudsman had also not upheld any complaints in the last year.

Each division of the trust had a complaints coordinator and members of staff from the division were involved in producing the response. Learning from complaints was a key part of the work for the patient experience group. Actions taken for learning were shared with the complainant and they were told they could contact a specific named person at the trust if they wanted assurance the actions had been completed. Actions were shared more widely through the trust in order that learning might help other teams to avoid similar situations. There was a process to ensure any changes made to process or practise had responded to the original complaint and dressed any shortcomings.

People who use services, those close to them and their representatives were actively engaged and involved in decisions to shape services. The patient experienced team were engaging patients in key decisions about the organisation. A focus group had recently been undertaken with sickle cell patients and families in the Afro Caribbean community. This was to address their concerns about healthcare and how it could better support treatment for this illness. There was a growing relationship to the integrated care system and looking at what could be shared to learn from patient experience. This included involving community partners more closely.

In other community work, the patient experience team told us how they had worked with the Sikh community to find out what really mattered to them when coming to hospital. Much was learned from this engagement work. Staff were also being trained to look out for minority groups and check they were given a voice to be heard.

Quality improvement training at the trust had a patient participation angle included. All projects undertaken had to consider patient participation and involvement so patient experience was embedded within the organisation and its change programme. The team was also looking at how to develop the organisational culture around patient participation in areas such as training and development for staff.

Focus groups with patients and communities had been much better attended during the pandemic with the access being through virtual contact. Meetings had continued and flourished with groups such as those speaking for people who were vision impaired or hearing impaired.

There had been a large amount of work looking at virtual visiting for families. Teams in the hospital had tried to be very flexible and address the emerging need to support visitors in a very different way. The patient engagement team had been able to link families together with patients through virtual connections. This had enabled the families to see not just the patient but the staff caring for them and the environment in which they were receiving treatment. Training was still being rolled out to enable staff to manage this system well.

Our findings

The trust was in the initial stages with the patient engagement team of developing 'digital inclusion volunteers' to buddy up with someone to make them feel more confident with technology which had been identified as a need following the greater move to remote consultations brought about by the pandemic.

The volunteers who supported the trust had been a valuable resource for many years. The strategy was now being redeveloped after the pandemic and thinking differently about the future. Some of the actions from a survey of volunteers had included developing a role for mentors for volunteers, and the development of young people as volunteers. The pandemic had hit this group of people hard, with a lot needing to shield and having anxieties about attending hospital sites. However, this gave an opportunity to the trust to develop new roles for volunteers and to restart the programme in a different way. The trust was now offering welcome back sessions, looking at bespoke roles for younger people, and psycho-social roles. There was a plan to look at connecting with isolated patients and to bridge the gap between community and acute services. The trust team told us they felt they has a real opportunity to do something innovative.

There was transparency and openness with stakeholders about performance and there are positive and collaborative relationships with external partners. This is in order to build a shared understanding of the challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The director of pharmacy team for the Bristol sites had developed established links and support networks regionally and nationally. The medicines safety officers (MSO) for both Weston General Hospital and the Bristol sites joined regional and national networks to share and learn from best practice. The medical safety officer for Weston General Hospital had recently presented a poster at the Bristol Patient Safety Conference on the Making Insulin Treatment Safer (MITS) project, which was well received.

UHBW (Bristol) hosts the regional pharmacy procurement specialist post. This provides a vital link and support between NHS contracting/procurement for medicines and providers as part of an NHS England service. This post also supports national and regional medicines shortages with oversight of all secondary care stock holding in the southwest, supporting and coordinating reallocation of medicines if required.

The period of engagement to develop a single cross organisational set of values had recently commenced, though many staff we spoke with were unaware of this piece of work.

W8 Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There were clear systems and processes for learning, continuous improvement and innovation. There was a strong and well-established learning culture embedded within the trust. There were effective governance around serious incidents, mortality, and mental health, as well as an ability to effectively learn from complaints and patient experience.

The trust had a research and innovation strategy and there were long-standing, well-established relationships with Bristol University and the University of the West of England. Its research and innovation team liaised with the clinical team within the specialties to deliver clinical trials. There were various ways in which leads for research and innovation promoted research activity within the trust. These included a number of trials during the pandemic, including a number of studies which will look at the side effects and immune response given when people received their COVID-19 booster and flu vaccine at the same appointment.

Our findings

The Transformation, Improvement and Innovation Strategy, the three action half-yearly plan updates, along with examples of the Transforming Care quarterly update the Board. The Transformation Annual Report 2019/20 were shared with CQC provided a number of examples of the quality improvement and innovation initiatives at the trust; these included a bright Ideas competition. The trust also has a quality improvement (QI) hub to provide support to staff, and a QI Forum to share improvements and learning. There is also a QI Academy in place for 3 1/2 years provides QI, project management and change management training for all staff. The trust also has learning from the wider system through membership of Association of Groups, Beneficial Changes Network and Shelford Transformation Network.

Also, staff had articles published in the British Medical Journal, published Sep 20 about #TakePhonership, an element of the Trust Customer Care transformation programme.

There were standardised improvement tools and methods, and staff had the skills to use them. The new role of the medical examiner was now the primary focus for learning from deaths at the trust. The role was undertaken at an integrated care system level with around 18 or 19 medical examiners working across the Bristol, North Somerset, South Gloucestershire (BNSSG) NHS organisations. Around 95% of all adult deaths were reviewed by the team and discussed at monthly meetings.

There were system to support improvement and innovation, including systems and processes for evaluating and sharing the results of improvement work. The structured judgement review process had now been standardised across the organisation. This process was introduced to try to standardise the way patient deaths were reviewed and provide a consistent approach to learning. As a result of learning from death, ReSPECT forms had been introduced in all relevant patient care and extended to include being made available by colleagues from primary medical services. ReSPECT forms describe patients' preferences and any clinical recommendations in relation to their care and any advance decisions they have made. They are not legally binding, and can be adapted as circumstances change, but can help medical professionals meet the wishes of patients in their care. All patients were required to have a ReSPECT form on admission.

The trust had appointed mortality leads for each of the three directorates. The team produced a mortality report which went through divisional governance boards and up to the trust's quality and outcomes committee. The board received an annual report on learning from death which was correlated against the information from the medical examiner to validate data.

Learning from deaths, which was recognised as needing to be shared with others, would go back through the governance process and to the regular speciality mortality and morbidity (M&M) meetings. It was recognised the M&M meetings were well-developed in the surgery teams, but needed to be more formalised in medical teams, and this was planned for improvement. The trust was supported at board level by a non-executive director who supported the work on learning from deaths.

The deputy medical directors we spoke with described some of the learning which had come from patient deaths and how they had included families and carers in the process. This had led to learning around what would be more important or equally important for patients and their families and friends, which may be less apparent to hospital staff within clinical priorities.

Other involvement with patient's families was being gathered through the role of the medical examiner, but this had been impacted due to the pandemic, particularly with some of the limitations around family visiting.

The endoscopy units at both the Weston General Hospital and the Bristol Royal infirmary locations have Joint Advisory Group (JAG) accreditation. To gain this accreditation, the units were assessed against several national standards and

continued to monitor their own service provision to ensure compliance. A review of this award was due in April 2021". The JAG accreditation is a voluntary process for services to engage in. JAG accreditation work to an accreditation pathway which involves self-assessment and quality improvement against the standards. To gain this accreditation, the unit was assessed against several national standards and continued to monitor its own service provision to ensure compliance. Staff take time out to work together to resolve problems and to review individual and team objectives. The Southwest regional Pharmacy Workforce Development South (PWDS) were based within the Bristol Royal Infirmary. This team were responsible for pharmacy education, training and development and funded predominantly through service level agreements with Health Education England (HEE) South and Southwest acute provider trusts. The PWDS is commissioned by HEE South to deliver the pre-registration pharmacist programme to Southwest trainees. The PWDS also deliver the NVQ Levels 2 and 3 in pharmacy services and provide a range of post-registration pharmacy accreditations to support professional development and to meet the needs of workforce. The trust was involved in clinical trials and prescribing and administering genomic medicines.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Nov 2021	Good →← Nov 2021	Outstanding →← Nov 2021	Good →← Nov 2021	Good ↓ Nov 2021	Good ↓ Nov 2021

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
South Bristol NHS Community Hospital	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
UHBW Bristol Main Site	Requires Improvement →← Nov 2021	Good →← Nov 2021	Outstanding →← Nov 2021	Good →← Nov 2021	Outstanding →← Nov 2021	Good ↓ Nov 2021
Weston General Hospital	Inadequate Nov 2021	Requires Improvement Nov 2021	Good Nov 2021	Requires Improvement Nov 2021	Inadequate Nov 2021	Inadequate Nov 2021
Central Health Clinic	Good Dec 2014	Not rated	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Overall trust	Requires Improvement →← Nov 2021	Good →← Nov 2021	Outstanding →← Nov 2021	Good →← Nov 2021	Good ↓ Nov 2021	Good ↓ Nov 2021

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for South Bristol NHS Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Outpatients and diagnostic imaging	Good Dec 2014	Not rated	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Surgery	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Overall	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014

Rating for UHBW Bristol Main Site

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Nov 2021	Good →← Nov 2021	Good →← Nov 2021	Good →← Nov 2021	Good →← Nov 2021	Good →← Nov 2021
Services for children & young people	Good Aug 2019	Outstanding Aug 2019	Good Aug 2019	Good Aug 2019	Outstanding Aug 2019	Outstanding Aug 2019
Critical care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014
End of life care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Outpatients and diagnostic imaging	Good Mar 2017	Not rated	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Good Aug 2019	Good Aug 2019	Outstanding Aug 2019	Outstanding Aug 2019	Outstanding Aug 2019	Outstanding Aug 2019
Urgent and emergency services	Requires improvement Mar 2021	Good Aug 2019	Outstanding Aug 2019	Requires improvement Mar 2021	Good Mar 2021	Requires improvement Mar 2021
Maternity	Requires improvement Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019
Overall	Requires Improvement →← Nov 2021	Good →← Nov 2021	Outstanding →← Nov 2021	Good →← Nov 2021	Outstanding →← Nov 2021	Good ↓ Nov 2021

Rating for Weston General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Inadequate Nov 2021	Requires Improvement Nov 2021	Good Nov 2021	Requires Improvement Nov 2021	Inadequate Nov 2021	Inadequate Nov 2021
Outpatients	Good Nov 2021	Good Nov 2021	Good Nov 2021	Requires Improvement Nov 2021	Good Nov 2021	Good Nov 2021
Overall	Inadequate Nov 2021	Requires Improvement Nov 2021	Good Nov 2021	Requires Improvement Nov 2021	Inadequate Nov 2021	Inadequate Nov 2021

Rating for Central Health Clinic

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Dec 2014	Not rated	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Overall	Good Dec 2014	Not rated	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014

Weston General Hospital

Grange Road
Uphill
Weston-super-mare
BS23 4TQ
Tel: 01179230000
www.uhbw.nhs.uk

Description of this hospital

Weston General Hospital provides urgent and emergency services, medical care, surgery, critical care, maternity, services for children and young people, end of life care and outpatient core services.

On 1 April 2020, University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust merged to form a new organisation, University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).

Following the merger the previous ratings for Weston General Hospital do not apply.

When a trust acquires or merges with another service or trust in order to improve the quality and safety of care, we will not aggregate ratings from the previously separate services or providers at trust level for up to two years. Therefore, we have rated services at Weston General Hospital as this inspection. However, these ratings do not form part of the Trust's overall current rating.

Our rating of this location is inadequate. This rating is based on the inspection of two core services.

We rated medical care as inadequate overall and outpatient services as good overall:

- The medical care service did not always have enough nursing and medical staff to care for patients and keep them safe. The service provided mandatory training in key skills but not all staff had completed it. The design, maintenance and use of facilities, premises and equipment did not always keep people safe, the areas used for outlier patients were not suitable for this use. Staff did not always keep people safe by following systems and processes when prescribing, administering, recording and storing medicines. The service did not always learn from incidents and accidents as they did not consistently make changes and improvements when they happened.
- Medical care staff gave patients enough food and drink to meet their needs This service was not seen to be the same service provision for patients using escalation areas. Access to pharmacy support was not available in all escalation areas. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care but there was not always a clear record of how those capacity decisions had been made.
- Medical care staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers.

Our findings

- The medical care service responded reactively to meet the needs of local people and the communities served, which meant care was sometimes delayed. Forward planning to meet demand was not used. Patients could not always access services when needed and not all received treatment in the right speciality ward or area.
- Medical care leaders had not yet managed the priorities and issues the service faced. The trust vision and strategy were not known by staff. Staff all expressed that they loved working at the hospital but did not feel supported and valued and often felt isolated within the trust. Governance processes were not effective in developing the service. Learning from the performance of the service was not always maintained or used to make positive changes. The management of risks were reactive and not planned which sometimes left patients at risk.
- People could not access the outpatient service when they needed it and had too long waits for treatment.

However:

- The outpatient service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Outpatient staff provided good care and treatment, gave patients enough to eat and drink when remaining in the departments for lengthy periods, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Outpatient staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The outpatient service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Outpatient leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.
- Medical care staff understood how to protect patients from abuse. The infection risk were controlled well and kept equipment and the premises visibly clean. Staff managed clinical waste well. Staff completed and updated risk assessments for each patient and removed or minimised risks when possible. Staff identified and quickly acted upon patients at risk of deterioration. Staff kept good care records. Staff collected safety information on each ward and used it to improve the service.
- Medical care managers monitored the effectiveness of some aspects of the service. Staff worked well together using a multidisciplinary approach for the benefit of patients. Key services were available seven days a week. The patients were complementary about the meals and availability of food and drinks. Staff ensured patients had enough to eat and drink and gave them pain relief when they needed it.

Our findings

- The medical care service was inclusive and took account of patients' individual needs and preferences. Staff were focused on the needs of patients receiving care. Staff felt pride in their role and work they undertook. The service promoted equality and diversity in daily work. Engagement was being developed by the trust with staff to improve morale.

Medical care (including older people's care)

Inadequate

Is the service safe?

Inadequate

This was the first comprehensive inspection of this service.

We rated it as inadequate.

Mandatory Training

The service provided mandatory training in key skills but not all staff had completed it.

Nursing staff had not received and kept up to date with their mandatory training.

The trust had set a compliance level of 90% for mandatory training, this had not been achieved in all areas of training. Overall mandatory training compliance for Weston Hospital medicine division was 89%. At this inspection we found that training levels for nursing staff varied with shortfalls seen in moving and handling, patient safety, resuscitation and safeguarding to level three. We did not see any impact on patients caused by the reduced training levels.

Training was provided virtually for all mandatory areas except basic life support, which was a practical face-to-face training session. Staff completed training outside of working hours but were paid for their time. Staff told us they received specific training when needed to provide non-invasive ventilation, management of sepsis and how to provide dementia care.

Medical staff had not kept up to date with their mandatory training.

The trust had set a compliance level of 90% for mandatory training, for medical staff this had not been achieved in most areas. Overall mandatory training compliance for Weston Hospital medical staff was 66%. Medical staff told us that time was being made to support their ongoing training. We were told that locum staff do not access the same level of training.

The mandatory training was comprehensive and the content met the needs of patients and staff.

Staff told us the quality and content of the training was appropriate and relevant to their needs. Training compliance was recorded and monitored through an electronic staff record. Staff confirmed that they were alerted by email when training was due. They told us that some delays in training were caused by staff shortage but catch up training was being provided.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. Some staff were not up to date with this training.

Nursing staff we spoke with told us they had completed safeguarding training for adults and children, and the level of training varied with their role.

Medical care (including older people's care)

The trust risk register identified as a high risk that staff were non-compliant with level three safeguarding training. However, there were no actions listed to mitigate the risks posed to patients if staff did not have up to date training. Staff told us that staffing levels sometimes had meant that they could not attend planned training. Nursing staff training records identified that 64% of nursing staff had attended safeguarding adults' level three training.

Medical staff had access to safeguarding training which they confirmed they had attended when able. The trusts training records identified that 67% of staff had completed safeguarding adults' level two training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff demonstrated an understanding of anti-discrimination and provided person-centred care. For patients with mental health problems staff would consider patient support and safety as part of their risk assessments and provide the appropriate care when possible.

Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff understood the different forms of abuse and what action to take to promote patient safety. Staff explained the training enabled them to identify potential safeguarding issues and could get access to further safeguarding support and advice if needed. Staff were confident to report safeguarding concerns to ensure the patient's safety.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff used electronic systems to alert safeguarding risks to the safeguarding team and the local authority.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The safe storage of chemicals was not seen on some wards. Chlorine tablets were accessible in some areas which if ingested would be hazardous to health. We informed staff at inspection who removed them immediately.

Housekeeping staff were allocated to wards we visited, and we saw good levels of cleanliness and hygiene. Housekeeping staff told us they enjoyed their role and felt supported. They were made aware of any risks of cross infection and they had access to personal protective equipment.

The service used monitoring tools to ensure good standards of cleanliness were maintained. We saw cleaning schedules on wards which had been completed, signed and dated. Each ward completed audits and displayed scores at the ward entrance. We saw on wards we visited scored between 97% and 100% for hygiene levels. Hand hygiene audits were displayed on all the wards and departments we visited and results for most areas were good, with most being 100% compliant.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff followed infection control procedures. Staff were arms bare below the elbow, in line with trust policy. Staff used personal protective equipment, such as gloves and aprons, when required, and disposed of these correctly in clinical waste bags. We observed doctors and nursing staff washing their hands and using anti-bacterial gel in line with trust policy. Single rooms were used for patients with potential or confirmed infections, to reduce any risks of cross infection. These rooms were clearly signed with appropriate personal protective equipment available to staff and visitors before entering.

Wards had various prompts to remind everyone to consider infection risks. On Sandford ward patients' visitors were issued with a letter, which informed them of their responsibilities around infection control. On Uphill (the stroke ward) a bell sounded hourly to prompt nursing staff to clean around them.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff cleaned equipment after each patient contact and labelled equipment to show when it was last cleaned. The endoscopy unit used established cleaning protocols on scopes and equipment.

Staff disposed of clinical waste safely.

Single use items of equipment were disposed of appropriately, either in clinical waste bins or sharps instrument containers. We saw that sharps disposal bins were closed when not in use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. However, there was an issue with the emergency call system in the discharge lounge.

A recent incident in the discharge lounge highlighted the need for clear procedures in an emergency. A patient needed urgent medical attention, the emergency bell was used and found that it only sounded in the discharge lounge and immediate surrounding area. The procedures for getting further urgent assistance needed a call to be put out via switchboard. Due to a lack of call bell sound to surrounding areas, the risk would be that nearby services would not be alerted to come and provide immediate assistance

The trusts risk register noted as a moderate risk that patient safety was compromised if the emergency bell was not audible, resulting in a delay to emergency treatment. The risk register item did not refer to the discharge lounge and the mitigating actions noted in the risk register did not reference how this would be managed at this location.

We observed that staff responded promptly to general call bells. We saw that staff were allocated to bays and remained in those bays to support patients as needed.

The design of the environment did not follow all national guidance.

Not all areas were safe for patients suffering from mental health crisis. We saw on the Medical Assessment Unit (MAU) and Kewstoke ward there were ligature risks in toilets, which we were not able to confirm if they had been risk assessed to promote patient safety. Staff told us this risk would need to be assessed for all patients and would require extra monitoring to ensure patients at risk of self-harm were safe.

Medical care (including older people's care)

Staff mostly carried out daily safety checks of specialist equipment.

Emergency equipment was mostly checked daily in accordance with trust policy. Equipment for urgent and emergency situations was kept in tamper-evident trolleys and was mostly checked daily by staff. Records of these checks were signed and dated. We saw two trolleys on the Medical Assessment Unit (MAU) and Sandford ward which had some gaps in checks. This meant there was a potential risk items needed in an emergency may not be available.

The service did not always have suitable equipment to help them to safely care for patients.

Escalation areas used at times of high operational pressure were not always suitable and safe for patients and staff.

The use of escalation spaces on the surgical day case unit, the Waterside unit and the Geriatric Emergency Medicine (GEM) were not always used within the standard operating policy completed by the trust. The environmental risk assessments identified by the trust as being needed for each patient, were not consistently used and so did not always ensure the safety of patients admitted there.

Surgical day case unit

The surgical day case unit was not a suitable or safe place for medical patients. The unit ran as a day case facility opening at 8am and closing at 5pm. The unit had a standard operating procedure (SOP) for patients to remain overnight if necessary. This SOP was for surgical patients and did not include the details needed for medical patients to remain overnight. On 08/06/2021 at midday we visited the surgical day case unit where four medical outlier patients had been admitted overnight and were awaiting medical review. An outlier is a hospital inpatient who is classified as a medical patient but has at least one move to another ward during their hospital stay.

There was an identified risk that the surgical day case unit did not have the appropriate facilities for use by outlying patients. The trust risk register included that using the surgical day case unit as an inpatient area could lead to patient harm. Risks were identified and rated. However, no action plans were provided to ensure that appropriate actions were considered, and no ongoing reviews was used to monitor patient's safety.

The facilities within the unit were not suitable. The unit had one toilet and sink and had no showering facilities. There were enough sinks and handwash facilities for staff. The unit had access to oxygen at two of its five beds and so should a patient deteriorate or require oxygen, bed moves may be needed. there was inadequate lighting available for inpatients overnight and there were no lockers to store personal items.

The unit also did not have pharmacy support or available medicine stocks. This meant that where patients arrived without medicines, there could be delays in accessing medicines. See the medicines section of this report.

Waterside Unit

The Waterside unit was a small unit separate from the main ward areas. It had been used originally as a surgical ward for private patients. All rooms were single rooms off a central corridor. The private unit had been used by the trust during the COVID-19 pandemic and now provided a three bedded "Blue area" for patients admitted with COVID-19 identified symptoms. The remaining beds were being used at an admissions ward, taking patients from the emergency department with a maximum anticipated length of stay of 72 hours. All beds were in single rooms.

Medical care (including older people's care)

The use of the Waterside Unit for medical patients was not safely managed. The Waterside Unit had not been assessed or identified as a suitable place for medical patients, however it was being used for this purpose.

There was no standard operating procedure or guidelines to identify and guide staff regarding the appropriate and safe use of this unit. As a result, patients with varying level of severe illness were admitted. Staff confirmed that patients admitted included those requiring cardiac monitoring and non-invasive ventilation.

The risks to patients of using the Waterside unit were identified in the trust risk register and included a risk that a lack of respiratory staff available to care for patients needing ventilation support (high risk identified 06/11/2020), that anti ligature points were not fitted on the unit (high risk 09/10/2018). The register also noted that patients couldn't be moved safely due to mobile hoist faults (10/12/2019 high risk), that high levels of agency staff were used (10/01/2019 high risk) and that a lack of essential monitoring equipment and skilled staff to care for acutely ill patients may lead to harm (02/11/2020- moderate risk). The register also noted the risk that patients could not be observed due to no viewing window in patient doors (03/10/2020- moderate risk) and no medicines reconciliation was available so risks of incorrect medicines being given and a risk due to inadequate staffing (04/04/2020 – moderate risk).

The doors into each side room needing glass to enable nurses to see the patients had been formally identified as a risk following an incident. The trust risk record noted this as a moderate risk because patients could not be observed due to no viewing window in patient doors. In January 2021, the register noted a request to adapt doors to include a window or remove doors and add clear curtains, however, at the time of our inspection this had not been completed.

The unit was staffed by four nursing staff which meant that because of the lack of visibility, patients went for periods of time unobserved and at risk.

Geriatric Emergency Medicine unit

The geriatric assessment unit was a three bedded unit close to the medical assessment unit. Its original use was a frailty unit to enable frail patients to be reviewed and assessed with a view to potential admission to the hospital. There were no allocated permanent nursing staff with medical and nursing staff being mostly provided from the medical assessment unit. There were no toilets or showers available and therefore these had to be accessed outside the unit when required.

The use of the Geriatric Emergency Medicine (GEM) unit for medical and surgical admissions when the hospital needed more beds for patients, was not safely managed. There were no risk assessments by the trust for the use of this environment as an escalation area and no planning for staffing levels for this unit when in this use.

The SOP for this area stated that patients admitted to the GEM unit ideally should be reviewed by the nurse in charge of the medical assessment unit prior to transfer, to ensure they met the identified criteria. However, three staff described incidents when this assessment had not been completed and admission had not been agreed with the nurse in charge of the MAU. Patients had been admitted to the GEMS unit outside of the criteria specified.

The SOP identified patients should be low risk, ambulant, self-caring, not monitored and medically stable. On both days of our inspection, we found there were patients who did not meet the SOP criteria for admission.

Following our inspection, CQC took enforcement action against the trust and as a result these three areas were closed to use as escalation areas.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration. Risk assessments for outlier patients did not ensure their safety.

At our previous inspection in January 2021, we saw there were sometimes delays in recognising deteriorating patients and that escalation to medical staff was not always timely. Audits of the tools used to recognise deterioration, were not used to improve practice. At this inspection, we saw that the issue had improved, and the charts viewed had been accurately completed and we saw records of prompt and appropriate action taken.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Patients were monitored and assessed using the National Early Warning Score (NEWS) framework. This was a system of monitoring patient's vital signs, such as temperature, respiration rate, blood pressure and pain. A score was calculated, and actions were advised for nursing staff according to the score. Any patient whose condition was deteriorating could be identified and their condition escalated for further medical review. The five patient NEWS charts we reviewed were completed and acted upon as needed.

Staff demonstrated the handheld device used to gather the patient observation information and how this prompted action if the scoring identified a risk.

Staff completed risk assessments for each patient on admission and reviewed this regularly, including after any incident.

Staff completed risk assessments for each patient on admission or arrival onto the ward, using a booklet which contained the risk assessment templates. However, staff told us there were occasions where staffing shortages and operational pressures meant they were not always able to complete the assessments in a timely way. A delay in recognising concerns had the potential to cause harm to patients. We looked at records and saw that there were very few cases when the assessments as part of patient admission had not yet been fully completed in a timely way.

Staff completed audits monthly to ensure the NEWS were being completed correctly and to ensure patient safety.

Staff knew about and dealt with any specific risk issues.

Once patient risks were identified, care plans were developed to inform staff of the individual care and treatment the patient needed. We found that staff reviewed the risk assessments and associated care plans regularly, including after any incident such as a fall or deterioration or change in health needs. However, we also noted that venous thromboembolism assessments had not been consistently completed and reviewed. This created a risk for patients who were then given anticoagulant medicine.

Work was being undertaken by the falls lead nurse, looking at how to reduce the risk of patient falls. Patients at high risk of falls have a member of staff in the bays with them and the trust refer to this system as using tag bays. A tag bay is a specified area where before a member of staff cannot leave without a replacement to take over from them. We saw this in practise during our inspection.

There was a falls lead nurse for Weston Hospital, and they had audited the number of falls at Weston Hospital. The data was for the whole hospital and was not specific to the medicine directorate. They explained that the trust set target for falls per 1000 days was 4.8, the trust achieved below that at 3.10 days and had not seen an increase during the COVID-19 pandemic.

The trust recognised the risks of skin pressure damage and we saw data which may identify a high reporting level of tissue viability incidents. We saw that tissue viability specialist staff supported the wards. We did not see any data which indicated an increased risk of hospital acquired pressure damage and viewed a record of one patient who had a hospital acquired pressure sore and saw that learning and appropriate action had been taken.

Shift changes and handovers included necessary key information to help keep patients safe.

At our previous inspection in January 2021, we saw that the management of laboratory results had the potential to create delays in the right doctor receiving and reviewing the results. At this inspection, we saw that this issue appeared mostly to be resolved. Staff demonstrated using the computer systems to show that laboratory results were now allocated to the patients record and requesting doctor. The trust standard operating procedure for 'interim ward cover on medical base wards and outlier wards' (professional standards) stated that when a patient moved between wards, and therefore to another consultant, the named consultant would also be changed on the computer system to ensure all laboratory test were returned to the correct consultant. An audit was planned to ensure that the system was effective, however at the time of inspection the trust did not have assurance of the systems success.

Staffing

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

At our previous inspection in January 2021, we saw that the service did not have enough nursing or therapy staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Gaps in planned staffing levels could not always be filled by agency or bank staff. At this inspection we saw that while there were still not enough nursing staff numbers, there were sufficient therapy staff.

Managers calculated the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance but did not ensure that staffing met that level.

At our previous inspection we found there was a chronic staffing shortage which resulted in delays for patient care and poor staff morale. At this inspection there remained high vacancy rates on the wards with over 100 nurse vacancies identified and gaps in rotas covered by agency and bank staff. When bank or agency staff were not available, the shifts remained uncovered.

The trust had an action plan to address staff shortages. However, the actions had not progressed enough to ensure staffing levels were safe. The bed occupancy level at the hospital was 100% and that meant that staffing levels should have exceed the existing full staffing requirements, but these levels had not been met.

The trust risk register noted that there was a high risk that nurse staffing would not be at the required numbers. The actions identified to mitigate the risks were not seen to be successful on the wards. A plan to recruit had been developed. However, staff had not felt the benefit of any increase in staffing levels.

The risk trust register noted as a low risk that patients could come to harm due to inadequate staffing. Staff told us that the impact on patients was minimal because they worked hard to ensure patients' needs were met and that they felt cared for. Staff told us that the impact of that extra workload was seen in staff morale. Staff felt that reduction and retention of staff had not been addressed.

Medical care (including older people's care)

The service did not have enough nursing and support staff to keep patients safe.

A safer staffing tool was used to review levels of patient need and associated staffing requirements. The numbers of planned and actual staff on duty was displayed at the entrance to each ward. Most wards we visited during our inspection did not have the right number staff on duty, as planned for. This meant that the nursing levels were not as they needed to be, and staff were spread wider across the wards.

Staff we asked, without exception, told us they were exhausted with working short of the identified staffing levels. We saw on the medical assessment unit, Sandford ward, Kewstoke ward, Harptree ward and Berrow ward that the calculated and planned staffing levels were not covered by staff. Staff confirmed they frequently worked with less numbers of trained staff than agreed.

We saw examples of shifts not covered. On day one of our inspection at 4pm, Kewstoke and Berrow wards had shifts for that night not yet covered and on day two of our inspection, the surgical day case unit (used as an escalation area for medical patients) and three other wards had vacancies for nursing staff not yet covered.

Staff described the management of staffing as reactive, not proactive. We saw staff being asked to move from wards to escalation areas and other areas that were short of staff. The forward planning to staff areas to their planned level and to anticipate increased need to cover escalation areas was not effective to ensure sufficient staffing at all times. At this inspection, we found the hospital at full capacity with delays in discharges. We saw that the predicted admissions of patients through the emergency department would need escalation areas to be opened to meet the demand for admission bed. However, these areas were not staffed in advance, which meant that staff were always being pulled from other areas and this put them under pressure and patients at risk. Senior ward staff explained that when bank and agency staff were not available, they had no other option than to work with less staff.

The trust used a ratio of patient to staff as a guideline for staffing levels. This had been explained to staff as one registered nurse to six patients each day and one registered nurse to eight patients at night. This system did not consider fluctuating levels of patient acuity or surges of demand and so required staff to be sourced at relatively short notice.

We saw when staffing levels had not been met. On Friday 4th June 2021 we observed on Sandford ward that there was a trained nurse in charge and one other agency trained nurse and four health care assistant staff. This meant that the trusts standards of one registered nurse to eight patients overnight would not be met and staff would have more than eight patients each to care for. We saw another example on the same ward on Friday 4th June, when one registered nurse had nine patients to look after and six discharges. This increased workload also did not consider the acuity of the patient's needs.

The Waterside unit was staffed mostly by nurses from other areas or by agency staff. The safer staffing tool was used to identify staffing levels, but staff confirmed this tool did not consider the acuity of patients transferred from the emergency department or the lack of visibility caused by the single room design. There was no visual access to monitors or equipment outside of the rooms. This meant patients with non-invasive ventilation or cardiac monitors would need enhanced nursing supervision, this would need an increase in staffing but was not available.

Staff told us the management of GEMS was usually chaotic with staff diverted from an already short-staffed MAU or another ward. The unit was required to be staffed by a registered nurse who was usually from the medical assessment unit or agency staffed. During our inspection we found on more than one occasion that there were no staff present on the GEM. We raised this with MAU nurse in charge who explained that there were no staff available to cover when staff allocated were on breaks. A health care assistant was to be allocated as an interim measure.

The matron of the day could adjust staffing levels according to the needs of patients.

Staff explained the system for requesting bank and agency staff was not effective. Safer staffing meetings were held at 08:15 each day and then reviewed as part of bed management meetings throughout the day. Matrons, other senior nursing staff and site coordinators attended, to discuss staffing resource and patient acuity. Ward staff requested staff for the next 24 hours at the 08:15 staffing meeting. The matron of the day would then attempt to fill the posts with bank staff in the first instance. If this was not possible, they would make a request to the head of nursing to request agency staff. This may or may not be agreed. Staff were not informed if the shortages of staff were addressed or unable to be filled and would arrive to work to find they were short of the planned staffing number.

We were told of an example on 07/07/2021, when those requests were made to the matron of the day at 08:15 for trained nurse cover for the following day. However, by 4pm no cover had been provided. Therefore, on the day, the ward which had a planned registered nurse staffing number of four, had only two registered nurses. Other staff had to be found from elsewhere to staff the ward.

There was an additional pressure created by staff being counted within the ward complement when they had not yet developed enough skills to work independently. These included staff on induction or newly qualified nurses, so while the numbers of staff appeared almost suitable; the skill mix was not correct and was a further pressure of responsibility for the existing, experienced staff.

Therapy staff were accessible on wards. The stroke unit had its own physiotherapist and occupational therapists and these staff were not shared across the medical division. This enabled a concentration on rehabilitation for stroke patients. Speech and language therapists were available by referral. To mitigate for the times the speech and language therapists were not available, ward staff had completed the training to undertake swallow assessments. This meant patients did not have to wait without liquids and food for a referral to be activated.

Medical staffing

The service did not have enough medical staff to provide the right care and treatment.

The service did not have enough medical staff to keep patients safe. The service had increasing vacancy rates for medical staff. The medical staff available did not match the planned number.

At our previous inspection in January 2021, the service did not have enough medical staff to meet the recommended guidance. There were insufficient numbers of consultants in post. There was also a shortage of middle grade doctors. At this inspection, we saw that this remained the case with three consultants in substantive posts and the remaining consultants being locum doctors. There also remained a shortage of middle grade doctors.

The consultant rotas showed that from January 2021 to the date of this inspection, there were 12 consultant posts across the medicine directorate. Of those three were filled with permanent staff, one had not started yet, and one was leaving in July 2021. There were a further two vacant posts not yet filled. The remaining posts had been filled with locum

consultants. The hospital had employed locum doctors (non-substantive doctors who did not have a permanent contract) to fill the staffing gaps. While a significant number of locum doctors had been in post for a long time and therefore the workforce was generally stable, a lack of substantive staff meant that the department could not plan well for the future.

The trusts risk register noted as a very high risk that the numbers of available consultants were insufficient to fill the on-call rota. During out of hours (21:00-08:00) there was a consultant physician on call every night. They were always contactable by phone and could attend site if required. At weekends there was a consultant physician on site between 08:00-21:00. We reviewed the medical staff on call rota for consultants from January to June 2021 and saw that while one consultant on call cover had been found for each day, a second on call consultant post had not been filled on most occasions.

There were not enough registrar level doctors working in the medical division to cover areas of the staff rota. We were told the registrars continued to manage patient outliers and so were not always accessible or available, and there were times when one registrar would be required to cover more than one ward or area. We reviewed the registrar doctor level rota and saw gaps where shifts had not been covered. We saw that there were 11 registrars in total with five vacancies. Of the 11 registrars, eight were included in the on-call rota. That meant a significant on call responsibility for the eight registrars. The registrar rota also showed gaps in cover. For example, from December 2020 to March 2021 shifts not covered were noted each month totalling 27.

The service had high rates of bank and locum staff

We reviewed the core medical training or Senior House Officer doctor level staff duty rota. There were 22 in total, with four being locum staff and one being a bank employee. The rotas showed that as of 16 June 2021, the on-call rota had gaps of 9 days to cover for July 2021 and 18 days to cover for August 2021. There were gaps for core medical training doctors from August 2020 to March 2021, totalling 60 shifts.

The medical staff booking records showed that from April 2020 to March 2021 48% of all shifts were bank staff and 40% were agency staff. The record noted that 720 shifts were presumed unfilled.

The service did not always have a consultant on call during evenings and weekends.

There were also areas of consultant workload and behaviours which required continued management to ensure patient safety. The trust leadership team had previously implemented a system to manage consultant workload and behaviours.

The leaders acknowledged consultants needed to act more flexibly, improve the supervision of trainee doctors, and to improve how they worked on the wards, and ensure their behaviours were in accordance with professional standards. Action taken so far had not been effective. For example, a standard operating procedure (SOP) was introduced to describe the “mechanisms for the allocation and recording of consultant responsibility for wards and patients and the monitoring mechanism for professional standards”. The aim was that a named consultant physician was identified for every medical patient admitted to the hospital, and to ensure each ward had at least two full ward rounds per week where patients were seen by the consultant and board rounds on other days where patients were reviewed was achieved mid-week. However, no consultant attended the wards at the weekend, with on call consultants noted to be available by telephone if needed.

We also saw that behaviours were not in accordance with professional standards. The SOP identified that new patient admissions would be seen by a consultant within 24 hours of arrival to the ward. This was not yet successful. This aspect of the SOP continued to not be consistently managed, as consultants were not available on the wards, including the medical assessment unit at the weekends. The leadership team were planning to audit compliance with the SOP and manage underperformance, but no audit outcomes had yet been available.

A further project had been started by the management team, looking at board rounds and how they were managed and the level of consultant attendance. This included the timing of ward rounds and how this impacted on the service, for example delayed ward rounds impacting on delayed discharges. Staff told us that currently only the stroke ward completed ward rounds early enough to facilitate discharges before lunchtime.

The management of patients in the surgical day case unit was not in line with the trust standard operating procedure. The SOP stated that all patients transferred to this unit must have an identified consultant and contact numbers for the appropriate on call doctor documented in the patients notes. However, we found that staff were not made aware of the patient's consultant or responsible doctor. The staff had not been informed who was medically responsible for each of the outlier patients, they did not know who would be reviewing them or when that would be. They told us they would have to telephone around the medical team to find which doctor had been allocated these patients. They confirmed this frequently happened. If the patients deteriorated, they told us would call the on-call site medical team or the emergency response team. The trust's risk register noted if a patient's responsible consultant could not be easily identified, that was a high risk.

Medical staffing on the Waterside unit was variable and did not have a regular consultant presence. The unit had a consultant led round Monday to Friday with the weekend round being completed by the on-call registrar. The Waterside unit was staffed daily by two senior house officer level doctors and by the out of hours medical on call team overnight. There was no registrar allocated to the area, if support was needed the medical staff could contact the medical registrar on duty. A consultant was allocated to the area but this changed each week so there was no consistency of support or practice.

Records

Staff kept detailed records of patient's care and treatment. Records were clear and most but not all, were completed and updated. Records were mostly stored securely and easily available to staff providing care.

At our previous inspection in January 2021, we saw that while comprehensive risk assessments were mostly being completed for patients that needed them; staffing shortages created a risk that deteriorating patients were not always recognised in a timely way. At this inspection, we saw that most records were well completed but some risk assessments had not been completed.

Patient notes were comprehensive, and staff could access them easily.

Patients' records demonstrated a multidisciplinary approach with assessments and care plans from the medical team, nursing team and allied health care professionals. There were paper observational records stored with the patient by their beds to enable a continuous record to be easily available to nursing and medical staff.

Medical care (including older people's care)

Paper booklets were used for the patient's initial assessments and for their inpatient stay. These included care plans. These documents were generic templates which staff were required to complete. We looked at 13 sets of records and found that most nursing and allied health professional notes were well completed and legible. Staff explained that changes in the paper records used was as a result of the integration with Bristol Royal Infirmary. Staff told us that it had taken some getting used to, as a small proportion of staff had received training on the use of the records.

We found that most medical records were clear, accurate, legible, and almost all were completed. However, we saw that some patients' medical plans lacked detail to inform care and treatment. Some nursing records were not fully completed for patients needing mental capacity assessments and venous thromboembolism (VTE) risk assessments.

An electronic records system had been implemented. This was a telephone sized piece of equipment held by each nurse. Staff confirmed that the connection to the server was rarely a problem, but if this was the case, a paper record would be maintained.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medical staff completed discharge summaries for patients who were discharged from hospital. A copy was provided to the patient and another sent to their GP, to ensure important information about ongoing care was shared effectively.

Records were not all stored securely.

Patient paper records were stored securely but some computer records were visible to the public. Records were in paper format and kept in trolleys with number key code locks, which were secured when not in use. Staff we observed were mostly careful to ensure records were not left accessible and confidentiality was not compromised. However, on Sandford ward we saw that an electronic screen with patients' details was left visible for periods of time while staff left the area to continue working. This meant patients personal details could be accessed by anybody passing.

Medicines

The service used systems and processes to prescribe, administer, record and store medicines.

The service had systems and processes to administer and record medicines use, these processes were not always followed by staff and governance arrangements were not robust to identify and improve systems. Limited pharmacy workforce meant that patients did not always receive their medicines at the right time.

Staff did not always keep people safe by following systems and processes when prescribing, administering, recording and storing medicines.

During the inspection, we looked at seven medicine administration records. Medicines were prescribed on prescription and administration charts, including routine medicines that patients would take at home. However, in four cases there was no record that the patient took routine medicines. Two patients had routine medicines prescribed, but these medicines had not been administered. The reason for non-administration was not recorded for one of these patients. Another patient was not able to take a medicine as it had not been ordered from the pharmacy. One patient did not have a medicine given as the dose had not been recorded on the prescription chart. Where variable doses were prescribed, for example one or two tablets, the dose given was not always recorded.

Medical care (including older people's care)

Medicines advice and supply was available during weekdays and Saturday morning. An on-call pharmacist was available outside of core working hours. However, ward staff told us they could not always contact pharmacy if required for advice or medicines supply. Nurses on surgical day case unit reported that pharmacy did not respond to contact before 11am midweek.

Assessments to determine the risk of patients developing a venous thromboembolism (VTE) were not always completed or recorded. Medicines to prevent a VTE were sometimes prescribed without a recorded assessment. This meant it was not possible to tell if patients were receiving the right treatment according to their risk of developing a VTE.

Staff reviewed patients' medicines regularly but did not always provide specific advice to patients and carers about their medicines.

Prescribers recorded the indication and duration of treatment when prescribing antibiotics. Intravenous antibiotics were regularly reviewed and switched to oral preparations if appropriate.

Patients were not always provided with medicines counselling to explain changes in medicines or when new medicines were started. The healthcare assistant in the discharge lounge told us that no-one checked that patients who received their take home medicines in the discharge lounge understood how to take them at home. This was for patients who have got the take home medicines whilst in discharge lounge. There was some ward counselling from nurses and pharmacy.

The trust did not always store and manage all medicines and prescribing documents in line with the provider's policy.

We checked medicines storage arrangements in MAU, Sandford, surgical day case and the discharge lounge and found medicines were not always stored securely. On the medical admissions unit we saw that medicines waiting for return to the pharmacy, may be accessible to non-authorised staff, visitors and patients. There was no door on the treatment area where these medicines were stored. This had been identified on a safe and secure medicines audit in 2020, however, action had not been taken. We also found, there was no dedicated medicines storage area in the discharge lounge to store medicines, including controlled drugs or medicines needing fridge storage, while patients were waiting for transport.

Medicine trolleys and patient's bedside lockers were also used. Medicines stored in these areas were safe and secure.

Temperatures of medicines storage areas were not monitored to make sure medicines were being stored as recommended by the manufacturers. We found that medicines storage in the medical admissions unit felt hot and was in direct sunlight. Staff had no risk assessments or monitoring to show that medicines were stored at the recommended temperature. We raised this with the deputy lead pharmacist and the ward sister.

Prescription forms (FP10s) were stored securely and there was a robust system to track their use.

Staff did not always follow current national practice to check patients had the correct medicines.

Medicines reconciliation was completed in the medical admissions unit and Sandford ward. Medicines reconciliation is the process of accurately listing a patient's medicines. This could be done when the patient is admitted into the service or when their treatment changes. On Sandford ward, delays in receiving care notes meant that medicines reconciliation was sometimes delayed. Sandford didn't have a ward clerk which meant notes sometimes took a long time to arrive at

the ward when a person was admitted. This meant pharmacy technicians couldn't refer back to medicines prescribed during previous admissions. Queries identified on patients' prescriptions during medicines reconciliation were not followed up to make sure they were actioned and completed. If patients were receiving medical care overnight on the surgical day case unit, they would not receive a clinical pharmacy service.

Pharmacy staff used dashboards to identify patients to prioritise for medicines reconciliation. The percentage of patients having their medicines checked was improving, but there was still work to do to meet national best practice.

Medicines for discharge were dispensed from a transcription of the prescription chart. Staff told us that discharge summaries were not reliable to use as a source of medicines reconciliation.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The medicines safety officer provided medicines communication and education across the trust and ensured that procedures were amended in line with any safety alerts and changes in guidance. Medicines incidents were investigated, and any learning shared.

Incidents

The service did not manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and returned the information, but this was not shared, and lessons were not learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

At our previous inspection in January 2021, we saw that the service had not always managed patient safety incidents well. Staff mostly recognised incidents but did not always report them. Lessons learned were not always shared with staff. At this inspection, we found that staff were reporting incidents, but there was very little feedback or learning evident to staff.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff were encouraged to report incidents and other concerns. The trust policy was that every incident reported was looked at every working day by the divisional and corporate patient safety teams, in addition to the management of any required actions by the ward manager.

We saw examples of when staff reported shortages of staff on the wards. They used the electronic reporting system and submitted their alerts. The staff reported the incident which was then returned to the same staff member for investigation. When a response had been collated for that incident, they were submitted again. However, staff told us that the resubmitted responses did not go to the matron who was managing staffing. No further feedback was provided to the ward staff about these incidents and no learning outcomes or change of practice were evident to staff.

Managers did not share learning with their staff about never events that happened elsewhere.

An action plan was in progress to develop shared learning. There were also local safety messages, screen savers and safety huddles used in Weston Hospital.

Medical care (including older people's care)

Staff confirmed that they sometimes had updates from Weston Hospital areas but did not receive learning and updates regularly from other departments of the hospital and the wider trust.

Staff had not received feedback from investigation of incidents, both internal and external to the service.

Staff at Weston Hospital reported incidents well. From January 2020 to April 2021. The most reported type of incidents from Weston Hospital were pressure ulcer (meeting the serious incident criteria) (40%) and slips/trips/falls (27%).

Weston Hospital medicine directorate reported 15 incidents, and the most reported incidents were pressure damage to skin.

From January 2021 to June 2021, the trust reported zero never events for medicine. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong.

The duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff at all levels were able to describe what the duty of candour involved, the actions required and where to look for guidance on the hospital's intranet if needed.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The safety thermometer data showed the service achieved harm free care within the reporting period. Staff used the safety thermometer data to further improve services.

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The safety thermometer was used to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

All wards and departments displayed monthly safety audits at the ward entrance. This included the latest number of falls and pressure ulcers for the information of patients and their families and carers. The evidence provided showed that audits undertaken each month demonstrated a high level of achievement and success.

Is the service effective?

Requires Improvement

This was the first comprehensive inspection of this service.

Medical care (including older people's care)

We rated effective as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed policies to plan and deliver quality care according to best practice and national guidance.

Policies and guidelines had been developed in line with national policy. These included the National Institute for Health and Care Excellence (NICE) guidelines. We observed staff following NICE guidance CG139 Healthcare- associated infections: prevention and control in primary and community care when hand washing.

The endoscopy unit used the world health organisation (WHO) checklist for invasive procedures. The WHO guidance (2008) underpinned the process of theatre checks for safety with a standard operating procedure to ensure staff were aware of their responsibilities in line with national guidance.

Staff accessed clinical policies and procedures via the staff website for support. The system used allowed the addition of other local guidance and provided a library to link to audit projects.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients' religious, cultural and other needs. This was not seen to be the same service provision for patients using escalation areas.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff gathered patient information that informed them about patient's nutritional care and fluid needs and created a care plan for how they were to be met. We saw clear instructions recorded for patients with identified nutritional needs. The kitchen staff maintained a board that showed patients' diet needs. This was not available on escalation areas such as the surgical day case unit or the Geriatric Emergency Medicine (GEM) unit. There the management of nutrition was more reactive with patient's nutrition being supported without planning. This meant there was a risk that patients may not have what they needed or be delayed in receiving any special diets

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

The trust used a nationally recognised nutrition screening tool to identify patients at risk of being malnourished or with specialist nutritional needs. This screening tool was designed to categorise patients risk as being at low, medium or high risk and an appropriate care plan was completed.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Nursing staff supported patients who needed assistance to eat and drink. Those patients needing assistance had food delivered on a red tray, to discreetly inform staff. The food and fluid charts we saw were kept up to date.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Therapist were available including speech and language therapist and dietitians to support those patients who needed it. These therapists were available by referral and did not work out of hours or at weekends. For patients needing a swallow assessment, for example a patient having suffered a stroke, staff had been trained to enable this to be completed promptly. This meant patients did not have restrictions on eating and drinking over a weekend.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Access to pharmacy support was not available in all escalation areas.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff used a pain assessment tool to identify the severity of patients' pain and we heard staff asking patients about their levels of pain. We saw from records that pain relief was given when needed.

Patients mostly received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

Medicine charts reflected when and what medicine had been administered and the rationale for any omissions or delays. It was evident that escalation areas being used such as the GEMS unit and the surgical day case unit, did not have pharmacy support and so stocks of pain relief medicines were not available. These medicines, if needed, would have to be prescribed and so would create a delay for patients.

Patient outcomes

Staff monitored the effectiveness of care and treatment on the wards. They used the findings to make improvements and achieved good outcomes for patients. The trust submitted data to some national audits.

The service participated in relevant national clinical audits. Outcomes for patients did not all meet national standards.

National benchmarks such as the Myocardial Ischaemia National Audit programme in July 2020, showed that in some areas insufficient data had been submitted and other areas did not meet the standard.

The Heart Failure Audit produced in July 2019 showed that some areas performed better than others. Inpatients admitted with heart failure who received input from the specialist team and those patients who received cardiology follow up was worse than the national average, while those discharged on medicines for their condition was better than the national average.

Stroke services submitted data to the Sentinel Stroke National Audit Programme (SSNAP) 2019 audit and had a score of D, which meant that some aspects of the stroke service had room for improvement. These areas included the time spent on the stroke unit and the access to therapist. The data provided demonstrated good door to needle times. This meant that the time taken from the patient arriving at the hospital with symptoms to the start of treatment. This can be used to evaluate the quality of the stroke care provided.

Audit data for the trust prior to March 2020, for the Bristol Royal Infirmary and the Weston Hospital were published separately. From the March 2020 data set, it was a combined data which meant that each hospital could not directly identify how they were scoring. The Summary Hospital Mortality Indicator for UHBW for the 12 months to October 2020, was 89.8 and in the "as expected" category. This was better than the overall national peer group of English NHS trusts of 100.

Medical care (including older people's care)

During the pandemic, the National Clinical Audit & Patient Outcome Programme (NCAPOP) was effectively suspended. During this time, members of the trusts clinical audit and effectiveness team were re-deployed to support other key services. The trust maintained a small central team to continue to provide support, but much of the work had to be limited. The team were currently working through the national audits to update the latest positions. In August 2020, the trust purchased a new project management system and the implementation was planned to be in several phases. This included plans to streamline processes for assurance against national guidance.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers made sure staff understood information from the audits.

A structured approach was taken to ward based audits and produced daily, monthly and quarterly reports for cleanliness of the environment, hand hygiene, falls and infections. Dashboards were produced which showed audit activity and results.

Audits showed that delays in discharges had an impact on the hospital. The trust risk register identified as a high risk that some discharges of patients with complex needs did not occur in a timely manner. The data for delayed transfers of care showed that from April 2020 to March 2021, as a result of these delays there was a loss of 866 bed days to the trust. These delays meant that beds were not available for new patients to be admitted.

Some audits showed capacity issues at the hospital. Bed occupancy rates overnight showed that during 2019 to 2020 at Weston Hospital, occupancy rates were higher than the England average and higher than occupancy rates at the Bristol Royal Infirmary.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. The levels of appraisal and supervision varied.

At our previous inspection in January 2021, we saw that the service did not always ensure staff were competent for their roles. Not all staff had the training to cover the scope of their work. Patients did not always have their assessed needs, preferences and choices met by staff with the right skills and knowledge. This was because during the COVID-19 pandemic, patients were on non-medical wards. At this inspection we saw that this had improved. Patients had returned to the speciality wards, enabling nursing staff with appropriate medicine speciality skills to care for medically sick patients. This was except for the surgical day case unit, the GEM unit and the Waterside unit, which were not always staffed by nursing staff experienced or specifically skilled in the medical patient group.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave new staff an induction tailored to their role before they started work.

Staff had the right skills and knowledge to provide safe care and treatment for patients. Staff received induction and new staff we spoke said they were well supported by other staff. However, we were told by staff that two days "shadowing" another experienced staff member, was not enough for staff to feel competent. Staff explained that training was not a priority when busy and the training sessions were delayed.

There were varied levels of supervision to support staff.

Medical care (including older people's care)

NHS England had provided guidance to NHS trusts to pause appraisals between January 2020 to July 2020, and between 5 November 2020 to 25 March 2021 in order to respond to the pandemic.

Consultant supervisions were at 61% compliance and appraisal rates for nursing staff varied between wards. The lowest appraisal rates being on care of the elderly wards, the discharge lounge, Kewstoke ward and Sandford ward.

Some wards told us that team meetings did not take place regularly, often due to pressures on the service and staffing levels. They told us updates were provided when time allowed.

Registrars continued to lack access to training opportunities in their own specialty. They were required to cover medical duties and ward rounds during their day and due to their reduced number, they told us there was reduced time to dedicate to training.

In early 2021 junior doctors from the medicine department had mostly been removed This action was taken due to a lack of training and supervision for them which mean their learning needs could not be met. At the time of this inspection there were no confirmed plans for their return.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Specialist nurses provided training and guidance to staff when needed. Some staff had obtained additional qualifications, for example venepuncture and echocardiograph within their speciality.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. The escalation areas did not have the same multidisciplinary structures, due to the lack of medical staff allocated to them.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked collaboratively to ensure continuity of care to patients and ensure the appropriate professionals were involved in care and treatment. Nursing, medical and therapy staff on wards and units worked together to facilitate care and treatment and assist patients to improve enough to go home.

Multidisciplinary team meetings took place on the wards to ensure a full medical overview was maintained and action plans completed. We attended a meeting where multiple agencies worked together to support the patients. Each patient identified for the meeting was discussed and the team looked at arrangements for their future care. Patients were spoken about respectfully and their views and that of their families, who would be providing ongoing support were considered.

Referrals to other agencies were discussed as well as mental capacity and any safeguards needed.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Patients identified on admission as needing frailty support were seen in the emergency department and then transferred to an appropriate ward. There was no specific frailty area so the frailty consultant would visit patients across a range of wards. The frailty team consisted of two physiotherapists and two trained nurses. However, there was a lack

of geriatricians and geriatric frailty unit. Staff told us that a change in records being used meant that the scoring system for identification of frailty was no longer on the front of the admission documentation, so staff felt this had lost the visual prompt for staff to complete it. The inclusion of frailty as a mandatory record on the computer system had been used but had also been removed, this meant an opportunity was lost for a virtual oversight of frailty patients.

Oncology support was provided across the medical wards as there was no specific oncology ward. Chemotherapy could be administered at the day case unit, enabling patients to go home and attend daily for treatment. If a patient's chemotherapy regime lasted over three days, the trust policy was that patients would have to receive treatment at the Bristol Royal Infirmary.

Patients with a life limiting condition and who were at the end of life, were cared for by nursing staff across wards and received the specific support of the specialist palliative care team. The specialist palliative care team worked with the acute oncology team and were part of multidisciplinary team working to ensure patients received the care and treatment they needed. This team provided training and support for staff and for the use of pain-relieving delivery devices called syringe drivers.

Seven-day services

Key services were not all available seven days a week to support timely patient care.

Consultant led daily ward rounds did not take place each day on all wards, including weekends.

The provision of seven-day services is to ensure that patients receive consistent high-quality safe care every day of the week. Patients located on the medical admissions unit should be seen by a consultant each day and each patient should be reviewed within 14 hours of admission by a consultant and then referred to a speciality medicine consultant.

This provision was not maintained as there was no consultant presence on the medical assessment unit at the weekends. This meant decisions regarding patients ongoing care and treatment including transfer, discharge, referrals could be delayed.

The critical care outreach team were available 24 hours a day, and they undertook the assessment and development of treatment plans for patients needing critical care. They also worked with the non-invasive ventilation (NIV) nurse and provided support for staff for the use of NIV and oversaw all patients requiring ventilation support. The lead NIV nurse provided specific training to staff to enable safe management of NIV. They worked alone in this role at Weston Hospital but were integrating with the nurse holding the same position at Bristol Royal Infirmary. Over the period of the COVID-19 pandemic, they had trained 452 staff in the management of NIV. When NIV patients were admitted through the emergency department alerted the NIV nurse to ensure that they could locate them.

The NIV nurse had the support of a band eight physiotherapist. There was no specific NIV consultant available and support from the intensive care consultant was sought when needed. A clear plan was made for patients requiring NIV for the weekend. The nurse had developed a NIV care plan template for nursing and medical staff. This care plan and the subsequent outcomes were being audited and evidence indicated that at the last point of review in December 2020, there was 75% compliance with NIV national guidance. The NIV lead had instigated actions to work towards full compliance.

The medical day case unit provided a day facility Monday to Friday, to deliver infusions and transfusions to patients who could return home that day. This was a nurse led service to patients under care of gastroenterology, rheumatology, haematology and cardiology teams. The department was opened from 9am to 6pm.

Medical care (including older people's care)

Therapy staff provided care and treatment Monday to Friday, with a reduced service at the weekends and out of hours.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The critical care outreach team were available to support patients and staff throughout the hospital seven days a week. The hospital at night team had been developed by the trust. This team included trained nurses and intensive care trained staff. They met each night with the outreach team to assess patients needing additional support and to plan how this would be managed overnight.

Patients had access to x-ray services 24 hours a day seven day a week, including diagnostic scanning services. However, out of hours there was availability for urgent scans only.

Staff had access to mental health liaison services seven days a week. Staff made referrals to the mental health liaison team, who would review and triage referrals each day. Out of hours a referral could be made but there would be a delay in the patients being seen until daytime working hours.

There was access to out of hours pharmacy support and an on-call pharmacist. Pharmacy was on site for clinical service and supply of stock medicines.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff provided health promotion information for patients on wards. The previous access to written information in the form of leaflets had been discontinued during the COVID-19 pandemic as it present an infection control risk.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Staff assessed each patient when admitted and looked at aspects of health that created risks and looked at what support was available. We saw posters and information on wards promoting healthier lifestyles and directing patients to ask for more information. For example, one patient said, "I was on a particular diet before I came in, so I was really happy that I've had food to help me with this during my stay here."

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

We observed staff talking with patients and obtaining consent when providing care. As part of that engagement, staff were heard to ask patients for their understanding of the care to be given and their agreement and consent.

Medical care (including older people's care)

Staff were aware of policies regarding consent, mental capacity act and deprivation of liberty safeguards. We saw that when the safeguards were used, they were well recorded, and staff understood their scope of use.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care but there was not always a clear record of how decisions had been made.

The recording of mental capacity assessments was not well managed. The trust had a mental capacity act policy which stated that if a patient lacks the capacity then an assessment was required. Not all patients identified as lacking capacity to consent had a mental capacity assessment completed. This meant that there was no audit trail of how the decision about lack of capacity had been made and if the involvement of the patient had been considered. Staff told us that this shortfall had been created because the assessment template was now located in a different record.

Not all patients identified as lacking capacity to consent in the document used as a treatment escalation record had a mental capacity assessment completed. For example, we looked at two records on Sandford ward which identified the patient did not have capacity to make decisions about their care and treatment, but there was no assessment to identify how that decision had been made.

The patient's records noted that the patient did not have capacity by the word "No" being circled. There was no assessment document completed which would identify how that decision had been made and if the involvement of the patient had been considered.

Staff told us that this shortfall had been created because the assessment template was now located in a different record. They showed us this assessment in the admission booklet, it was a short series of questions which staff said was used to ascertain capacity. This change in paperwork had been implemented when the trusts had merged in April 2020. Staff explained that some changes in paper records had not been implemented with sufficient training for all staff and so some processes were not correctly followed.

Staff were not assessing patient's mental capacity to make decisions about medicines. For example, we saw that routine medicines for patients living with dementia were not given and the reason recorded as 'patient refused'. There was no assessment to determine if patients had the mental capacity to make that decision, or any recorded best interest decisions. We did not see any medicines specific mental capacity assessments.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

We saw that for one patient Deprivation of Liberty Safeguards had been completed.

On the medical assessment unit some patients came onto the ward with mental health issues. Staff could describe and knew how to access policies and get accurate advice about the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Medical care (including older people's care)

This was the first comprehensive inspection of this service.

We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients.

Patients spoke positively about the care they were receiving. One patient said, “They are quick to come if anything is wrong or if I press the call button. They always come by and check and ask if I am OK.” When one patient called out complaining of pain, staff responded quickly. The staff talked to them and checked the pain medicines that the patient was prescribed and explained that as they had been asleep, they hadn't had their pain medicine earlier on. They immediately went and got the medicine and ensured the patient had something to eat before taking it.

Patients privacy was protected because staff closed curtains around beds when giving personal care, or when having confidential conversations. Staff spoke softly to minimise the risk of other patients or visitors overhearing conversations.

Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients appreciated the time staff spent with them. One patient said, “Staff are very nice when they come along to see you and they do have a chat with us.” Nursing and cleaning staff were seen to take time to talk with patients while carrying out tasks on the wards. Patients responded positively to these conversations.

During our observations and interviews we could see that positive relationships had been built up between staff, patients and relatives. One patient said, “I will miss them when I leave here due to the fantastic care, they have given me. They are busy and short staffed and often get taken to help on other wards, but I've never overheard a miserable conversation from the nursing staff.”

Patients said staff treated them well and with kindness.

We saw staff providing kind and thoughtful care. One patient said, “Staff are busy but always courteous.” Another patient said, “They're all lovely to me and get to know our names and I get to know their names.” During our observations a patient walked slowly with a walking frame. Staff walked by the side of them with a hand gently on their hip for support. They gave constant encouragement to the patient, not rushing them and letting them move in their own time.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff took time to explain to someone why they needed to clean their bed. They made several attempts to explain to them and respected and listened to what the patient said back to them. Patient dignity was protected during these discussions because staff closed the curtains around beds. We heard staff explain to patients what they wanted to do and asking for their permission before doing it, for example before taking someone’s socks off as they were getting into bed. The patient refused and staff did not press the issue when the person wanted to leave them on.

Medical care (including older people's care)

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Patients told us that their needs and preferences had been respected and met by staff. A patient said, “I do things when I want to do them, not when the nurses want me to do things - like washing and showering. I just need to tell the nurse beforehand and they accommodate as much as they can.”

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

During a multidisciplinary team meeting, staff discussed the emotional needs of patients and if there was anything that could be done to support them. A multidisciplinary team meeting is where a group of professionals from one or more clinical disciplines come together make to decisions regarding recommended treatment of individual patients. For example, one patient had worries about going home and a discussion took place into what could be done to help them and increase their confidence.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Nursing staff and representatives of different faiths were available to offer support to patients, relatives and staff in times of need. There was always a Chaplain on call should patients or relatives request their presence. There was a multi faith area available for prayers or quiet reflection and an on-call list for leaders of other faiths should they be needed. The hospital Chaplain described a recent occasion when an Iman had been called and together with the support of the translation services had supported a patient and their relatives. The Chaplain provided pastoral care for staff, as well as patients and would come in when needed out of their normal hours. They explained to us that during COVID-19 a lot of support had been needed.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Staff talked about patients compassionately and with knowledge of their circumstances and those of their families. One patient said, “The staff feel like a family working together and they all give good care.”

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff involved patients in discussions about their care. One patient said, “They keep me informed about what is happening to me and I ask questions if I'm not sure - they've given me a list of what medicines I'm taking and I do feel involved in what is happening to me.” Staff were observed talking with a patient and their relative about the possibility of going home. Staff asked the patient if they felt well enough and could they cope at home. They discussed options with them and checks that they may need to do with the patient such as seeing them walk before they could go home. The person was fully involved in the conversation and their family member was also involved.

Medical care (including older people's care)

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients felt included in the decisions about their care. One patient said, “The doctors are good they make sure I understand what they're saying. I was impressed as they showed me all the charts and explained it all to me.”

Where patients first language may not be English, translators had been arranged to support. The trust had a communication team who staff could contact for help and guidance. One staff member explained, “We arranged a translator for a patient, who came in most days so the patient could understand what we said. The patient’s family came in to support and assist the patient for the days that the translator couldn't be there.” Additionally, communication cards had been put into place so the patient could communicate directly if the translator or family were not around. This enabled staff to ask questions around pain management, and if the patient needed anything such as the toilet, food or a drink.

Staff supported patients to make informed decisions about their care.

Patients felt included in decisions about their care. One patient said, “They tell me the reason why they want to do things, like when taking my blood pressure and I am aware I can say no if I want to.” During our observations staff were heard to give information to patients about care and support, and they listened to and respected the patient’s decision.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients felt able and supported to give feedback. A patient said, “I know how to make a complaint and I would feel comfortable doing that.” Feedback forms could be completed when patients left the hospital, and the results were posted for others to see. Outside ward entrances noticeboard displayed the latest patient feedback using a ‘You said, we did’ format. Additionally, on one of the wards, a display had been arranged to show the many thank you cards had been received, along with excerpts of the feedback given.

The hospital sought views of patients and relatives by use of the Friends and Family Test. The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving NHS care or treatment. From December 2020 to May 2021, 285 responses for medical care had been received, with a 93% positive score achieved.

Patients gave positive feedback about the service.

A relative said, “They have been absolutely brilliant here, every one of them.” Written feedback from patients included, “I witnessed nurses caring and talking to patients like they were their own parents and family” and, “Thank you for the brilliant care you gave and your kindness and support to me - You went out of your way to keep me informed on progress.”

Is the service responsive?

Requires Improvement

Medical care (including older people's care)

This was the first comprehensive inspection of this service.

We rated responsive as requires improvement.

Service planning and delivery to meet the needs of the local people

The service did not always respond in a timely way to meet the needs of local people and the communities it served. It worked with others in the wider system and local organisations to plan care.

There was limited planning to meet the needs of the local population.

There was no visible planning to manage the increased demand for beds in the hospital. The use of predictor tools to identify the level of probable admissions each day, did not prompt action to meet the demand. The bed management team were under considerable pressure to find beds for patient admissions, but the lack of movement in the hospital made this difficult. Bed management staff told us they were supported by clinical commissioners to find safe discharge routes out into the community. However, systems in the hospital did not support weekend discharges or promote early ward rounds to enable discharges on the same day.

Planning for next winters pressures had not been considered. Staff told us that the winter plan was not yet being considered and that last winter's plan document had been delayed in being available.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Patients were cared for in either female or male (single sex) bays wherever possible. Every effort was made to support care to be provided in single sex areas including escalation areas.

Facilities and premises were not all appropriate for the services being delivered.

Some areas of care were seen to not provide an appropriate environment, facilities or service for patients. The facilities used as escalation areas to enable patients to be admitted while they waited for a speciality bed or to be discharged, were not suitable for this purpose.

The trust had a discharge lounge where patients who were clinically stable and ready for discharge, could be transferred to while they waited for ongoing care. The discharge lounge had a standard operating procedure to outline the number of patients and the scope of its use. The lounge was located some distance from other ward areas and was staffed by a healthcare assistant and had no pharmacy provision. This meant that when patients arrived for discharge without their take home medicines, the health care assistant had to leave the area to collect them. This left patients unobserved for periods of time.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had arrangements, known to most staff on duty, to meet patients' urgent mental health care needs, including outside office hours and in an emergency.

The service relieved pressure on other departments when they could treat patients in a day.

Medical care (including older people's care)

The ambulatory care area was used whenever safely possible, to treat patients and return them home. The area was staffed by nursing staff and was planned to lighten the pressure on the emergency department and medical services. Staff confirmed that its level of use was variable.

The medical day case unit was available to support patients who required infusions and transfusions who could return home each evening.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs.

Ward staff considered how to meet the needs of patients living with dementia. Staff had completed some dementia care training and were using this to consider patient's needs. For example, staff described how they supported patients who wanted to walk and used this as an opportunity to interact by looking at paintings on the walls and trying to make the walking purposeful.

Staff understood and applied the trusts guidelines on meeting the information and communication needs of patients with a disability or sensory loss.

Staff were aware of how to support patients with additional communication needs. Staff described how to access interpretation services and the gave examples of when language helplines had been needed to interpret medical and care needs.

Access and flow

People could not always access the service when they needed it and did not all receive the right care promptly.

Patients could not always access and receive treatment in the right speciality ward or area.

We saw the systems used to promote flow through the hospital, were not all effective and the increasing demand outweighed the available capacity. Throughout our inspection, the hospital had 100% bed occupancy with no beds available (with the exception of one designated COVID–19 bed) for any admissions.

Senior leaders at the hospital understood that to continue to provide care for patients, the model needed to change. Prior to the COVID-19 pandemic, the hospital was calculated to have between 30 and 40 beds short of what they needed to meet the needs of the local community. Since that time up to 30 further beds had been lost to achieve social distancing. Extra beds have been used to meet escalating needs by using up to five beds on the surgical day case unit and three beds on the Geriatric Emergency Medicine (GEM) unit. We saw that a private ward of single rooms had created 11 bed spaces. These spaces were not ideally placed, staffed or equipped to meet patient's needs.

The hospital had problems maintaining flow from admission to timely discharge. This was caused in part by the trust not having sufficient beds available to meet demand. There was a further reduction in beds available due to COVID-19 restrictions and the need to create socially distance bed spaces. There were other contributing factors for example, ward

rounds carried out later in the day which impacted on discharge timeliness and there were reduced numbers of medical staff with the authority to discharge patients. Reduced medical and nursing staffing, meant a lack of staff available to implement patient discharge plans. There were also delays in discharges to the community, as there were difficulties accessing resources for continued care.

Managers monitored waiting times but could not ensure patients could access emergency services when needed or receive treatment within agreed timeframes and national targets.

The hospital monitored the demand on its service, and this demonstrated that it was a higher demand than it could meet. The Operational Pressures Escalation Framework (OPEL) detailed how the trust identified and responded to pressures within its system daily, as well as at times of extraordinary pressure. This framework relates to adult beds and includes medical beds. Each day bed meetings took place at 08:30 and 16:00, to review the flow of patients through the hospital. Those meetings were attended by bed managers and department nurses in charge. Some staff attended virtually.

From September 2020 to May 2021 (with a gap in available data for January and February 2021) the OPEL framework had reached level three for 33 days and the highest level, OPEL 4, on eight days. This indicated the high level of pressure the hospital had been under.

Managers and staff worked to make sure patients did not stay longer than they needed to but this was not achieved.

While considerable work was undertaken to reduce length of stay, we saw that some patients stayed longer than needed. This was due in some part to lack of beds in the hospital and as onward care was delayed. For example, in May 2021 there were 213 patients who experienced a delayed discharge. This created many days when beds were not available for patients coming into the hospital.

The service moved patients only when there was a clear medical reason or in their best interest. Staff confirmed that movement of patients was not always suitable or appropriate.

Patients' bed moves were avoided whenever possible but were taking place both during the day and night-time. Staff told us that bed moves at night varied but were minimised when possible. Discharging patients out of hours was undertaken in both day and evening time. The trust policy stated that patients should not be moved after 10pm.

The movement of patients at night was not always suitable or appropriate. Staff told us of occasions when patients were moved very late at night, to enable further admissions to the hospital. For example, a patient who was unsteady and was receiving enhanced supervised care was transferred at 11:45 pm from a medical ward to a surgical ward to free up space for a new medical admission patient. Because of the late hour their family had not been informed until the following day.

There were not always arrangements for doctors to review outlying medical patients.

The trust had a policy for staff to follow for management of outlier patients, but this was not always followed. This policy had specific criteria to define the safety considerations needed but not all areas of the policy were followed. There were not always clear arrangements for medical cover, which put patients at risk of delayed care.

Medical care (including older people's care)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

Patients, relatives and carers knew how to complain or raise concerns.

Patients knew how to make a complaint and felt they could raise concerns with staff. Patients, carers and relatives were able to complain by letter, email, telephone, via the Patient Advice Liaison Service or in person to any member of staff. Leaflets describing how to complain were no longer available on the wards due to infection control measures. Staff described the process they would follow to try and resolve any issues locally and directly and advise patients of how to escalate their concerns if not satisfied.

Staff understood the policy on complaints and knew how to handle them.

The trust risk register identified a high risk that the Weston divisional complaints process was inadequate. From May 2020 to April 2021, across the Weston hospital there had been 250 complaints, of which 133 were formal complaints. It was not possible to identify which of these complaints were related to the medicine division. Of those formal complaints, 39% were responded to within the trust and divisional timescales. It was also noted that 11% of complaints were dissatisfied with the response they had received from the trust about their complaint.

Managers investigated complaints and identified themes. Managers did not always share wider trust feedback from complaints with staff and learning was not always used to improve the service.

Staff told us that they may get learning from their own ward investigations but that they had not received learning from the wider trust. Staff could give examples of how they used patient feedback from their own wards to improve daily practice. For example, staff explained that concerns raised about patients' pressure damage were actioned immediately and learning was used in future practice.

Is the service well-led?

Inadequate

This was the first comprehensive inspection of this service.

We rated well-led as inadequate.

Leadership

At our previous inspection in January 2021, we saw that leaders at Weston Hospital did not demonstrate that they had the capacity to run the service. They understood, but did not manage, the priorities and issues the medicine service faced. They were not always visible or felt to be supportive or approachable for staff. The trust's senior leadership team were perceived not to be present enough on the wards to understand the issues staff faced. At this inspection, staff told us very little had changed, but staff recognised at ward level that integration with Bristol Royal Infirmary was in its infancy and changes were starting to happen.

Medical care (including older people's care)

Leaders had the skills and abilities to run the service but had not managed the priorities and issues the service faced. They were developing a visible approach in the service, which was not yet evident to all staff.

The senior leadership team at Weston Hospital and board members from the trust were not known to staff.

The Weston Hospital division of University Hospitals Bristol and Weston NHS Trust was led by a divisional director, a head of nursing, and a clinical chairperson. This triumvirate approach had been used since the creation of the Weston division in April 2020. This senior leadership team oversaw services running from the Weston Hospital site. All posts in Weston triumvirate had been appointed to, with additional support in place via deployment of the Deputy Chief Nurse and Deputy Medical Director for periods of time.

The senior management team considered that they were working together to look after staff.We spoke with many staff and were told they could not recognise the senior leadership team and did not know their names. They told us they did not attend their departments and were not familiar to them.

We met with the senior management team who described the hospitals difficulties with change as the two hospitals integrated. They recognised that leaders had different managerial capacity to manage change and so some difficulties had been experienced. The senior team recognised that visibility during the COVID-19 pandemic had been an issue and while they were still not a recognised visible presence on the wards, some inroads had been commenced to meet with staff.

At ward level staff felt supported and listened too, but there was a disconnect between the ward level staff and the senior leadership within the trust.

None of the staff we spoke with knew who the trust board were and told us they never saw members of the board on the wards. This was except for the chief nurse. Staff told us their leadership came from matrons and ward managers and not from higher in the trust.

There appeared to be a disconnect between Weston senior management team and ward staff. The senior management team recognised that the issues of staffing at Weston Hospital were a priority. Staff told us they did not know if leaders prioritised or were aware of the pressure the reduced staffing was having on them. The senior management team told us that they understood that without improved staffing, staff and services would continue to be under pressure. They were looking at ways to make Weston Hospital a more attractive place to work. They had recruited from overseas and looked forward to that increased nursing support. However, while these actions were ongoing, the staff remained in the same position and without evident visible senior management team leadership.

The leadership team were developing ways to engage with staff. A staff forum had been set up with meetings every two weeks to try and engage with staff. There had been an attendance of 10 to 15 staff members. We asked staff about this forum however, the staff we spoke with did not know about this. Social media was starting to be used to reach staff and leaders considered the feedback from this forum to be valuable. A record was being maintained to demonstrate actions taken as a result of this feedback.

Vision and Strategy

At our previous inspection in January 2021, we saw that staff did not know or understand what the trust's vision, values or strategy were, or what their role was in achieving them. At this inspection we saw that little had changed. The merger of the two organisations on 1 April 2020 and the plan for integration of the hospitals had been impacted by the COVID-19 pandemic.

Medical care (including older people's care)

The trust had a vision for what it wanted to achieve and a strategy to turn it into action. This vision and strategy was not developed with Weston Hospital staff and was not known by staff there.

Staff did not know or understand what the vision, values and strategy were, or their role in achieving them.

Staff told us there was little collaboration to create or understand the vision, values and strategy for the new organisation, and they did not know how they fitted into the structure. This view was held by some from staff despite the evidence provided by the Trust demonstrating extensive engagement with staff at Weston both pre and post merger. Some staff were aware of the PRIDE vision which had been the vision for the Weston General Hospital prior to the merger and some were able to tell us mostly what it meant; some, however, were unaware of the vision and strategy of University Hospitals Bristol and Weston.

The PRIDE vision is:

People - Showing high care standards or specifically helping a patient, visitor or colleague

Reputation – Actions that have helped to maintain the Trust's good name in the community

Innovation – Showing a fresh approach or finding a new solution to a problem

Dignity – Contributing to the Trust's Dignity in Care priorities

Excellence – Being considered 'excellent'

Senior leaders recognised they needed to create and promote the vision and accelerate the strategy for Weston Hospital. Most of the staff we spoke with did not know the vision for trust or the strategy to achieve it.

The trust had an implementation plan which outlined the requirements and stages for the integration of clinical and corporate services. Staff understood that the integration of the hospitals into one trust would require changes to be made, but some felt that the way changes were made was not supportive of them. They told us that they felt that some practices being changed had not needed changing. For example, they told us that training to use new paperwork was not provided to all staff and this increased pressure on them. They described systems to access equipment had been changed, which created delays they had not previously experienced.

Culture

Staff all expressed that they loved working at the hospital but did not feel respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work.

At our previous inspection in January 2021, we saw that staff did not always feel respected, supported and valued. Staff were focused on the needs of patients receiving care, this was despite feeling isolated and lacking supportive leadership. At this inspection, we saw that although the pressures of the pandemic were receding, staff were tired, and morale was low.

The culture centred on the needs and experiences of people who use services.

Medical care (including older people's care)

All staff spoke positively about patient care and how patients were the centre of their focus. They were proud of the team working and felt reassured by the feedback from patients.

One member of staff summed up a collective response from staff we spoke with when they said, “It’s a lovely hospital, the medical and nursing staff are begging for help”.

The trust risk register noted as a high risk that there was low morale and engagement with staff.

The staff turnover rate was 27.9% and the vacancy rate was 17.8%. Areas with the highest staff turnover were Berrow ward, Draycott ward, Sandford ward and medical staff across the medicine services. These were higher levels compared to Bristol Royal Infirmary, where staff turnover was 18% and the staff vacancy rate was 9%.

There were cooperative, supportive and appreciative relationships among staff.

Staff felt pride in their role and work they undertook; this was despite feeling isolated and lacking supportive leadership. We saw staff look after each other by taking on extra work to support their teams. However, we were told that staff took on extra shifts to support their team but became disgruntled when they were then moved to work on wards they did not know. They considered this detrimental to their team working.

Staff were aware of how to speak out about their concerns but felt it did not prompt change.

Staff appeared to have the systems to enable them to speak up, but they said there was little point as they felt nothing changed. Data provided by the trust showed that when staff at Weston Hospital had raised concerns via the Freedom to Speak Up Guardian, action had been taken. Staff were aware of the trust’s freedom to speak up guardian, who provided independent and impartial support to workers to speak up. Patients and relatives, we spoke with told us they felt confident about speaking up without fear.

Staff received training on, and understood, the duty of candour. We heard of examples of staff having applied the duty of candour in response to incidents.

Governance

At our previous inspection in January 2021, we saw that governance processes were not effective in developing the service. Staff were not clear about their roles and accountabilities. Opportunities to meet were not consistent and learning from the performance of the service was not always maintained. At this inspection, we saw that the governance systems were not seen to have supported changes to the service.

Governance systems were not used to support the development of a quality service. Learning from the performance of the service was not always maintained.

The governance was not used to develop the service and address the issues impacting on the service and staff. Although it was acknowledged by managers that governance systems needed to be improved, there was no evidence that systems were regularly reviewed, or any plans were put to support improvement.

Medical care leaders were not managing identified issues early or promptly enough to prevent them from becoming problems. We also saw that when relevant risks and issues were raised and actions identified to reduce their impact, these were not acted upon to prevent ongoing safety risks.

As examples:

Escalation areas did not always have safe nursing levels and identified and named medical staff available and this placed patients at risk. The divisional risk register identified some patient risks, but these did not include the risk of not being able to staff the escalation areas. The Quality and safety committee meeting records did not reflect the risks associated with using the escalation areas.

Not all ward areas met the planned safe nursing staffing levels identified by the trust. When this was escalated, appropriate action was not taken. The Quality & Safety Committee meeting minutes showed that in February 2021, staff reported 19 incidents of lower than expected staffing levels for nursing. This increased in March 2021 to 34 incidents reported. The systems used to review how staffing was managed, were not effective to create change and improve the quality of service provision.

The management of the Waterside unit had not been reviewed to establish the quality and safety of the service being provided. The Quality & Safety Committee meeting minutes showed that the Waterside unit consistently had some of the highest levels of incident reporting in the Weston medicine division, however, this was not reflected in actions taken to promote safety.

Governance systems did not ensure actions were completed. The risk registers and risk assessments used to monitor the ward and unit environments and the action needed for safety, did not ensure agreed actions were completed. The acknowledged issues including the Waterside unit visibility access windows and the call bell in the discharge lounge had not been actioned.

The systems used to monitor consultant availability and accessibility had not been measured. This meant that the standard operating procedures implemented to ensure consultant behaviours were standardised and quality standards met, had not been overseen. We saw that there remained no consultants available on the medical assessment unit at the weekends and so patients were not seen by a consultant within 24 hours of admission there.

There remained reduced oversight by registrar level doctors of junior doctors' practice due to lack of staff available. As a result, no audits had been completed of junior staff work to ensure that they received appropriate feedback to support improvement. We saw that registrars were very busy and so there was limited capacity to do this and senior management team had not facilitated any action to address this issue.

There were no audits of the changes to documentation to ensure that the changes were effective for patients, especially those lacking mental capacity. This meant that patients may not have been involved in decisions made about them.

Governance processes were not effective in developing the service.

The trust's risk register noted as a high risk that the governance systems and process were not fully established and embedded through the Weston division, from speciality level through to divisional board. There was a disconnect at divisional level, so information did not transfer from ward to board and back again. For example, the divisional leadership team described actions taken to improve recruitment, including safer staffing, but safer staffing was not happening on the wards and staff did not feel involved or updated on developments to improve staffing.

Incident reporting of staffing issues did not create a change in staffing levels. Staff demonstrated that reporting staffing issues did not make any changes to the practices and was not used for learning.

Nursing staff told us that staffing constraints meant that while they audited their own wards for safety and quality; they received little learning and had limited engagement in the monitoring of the quality of the wider hospital services.

Medical staff could not support governance, as well as clinical work due to capacity constraints caused by insufficient staffing and demand on the service.

Performance review meetings did not reflect the service provided.

The division held monthly quality and safety committee meetings. The quality and safety team undertake analysis of key metrics, comprehensive overview of patient outcomes, staff experience and share this information with the internal governance team.

We saw some records for the quality and safety divisional meeting minutes. These records looked at the incidents and safety issues for the division. However, they did not include the safety issues we noted at inspection, for example the use of unsafe areas for outliers or staffing levels. We noted that outlier areas were not included in the incident reporting data. The minutes for these meetings for January to February 2021, noted that feedback from ward teams had highlighted a gap between the investigation of incidents and the wider dissemination of learning. As a result, bimonthly meetings were planned to be held with ward staff in the divisions to share relevant incidents raised / lessons learned and restorative actions being taken. Staff told us this had not yet happened.

The trust planned an internal audit of governance processes. This would include an executive led monthly performance management review of quality governance, performance and finance, corporate patient safety group and quality & safety committee. This had not yet been implemented and so the trust does not yet have that facility to provide itself with assurance.

Management of risk, issues and performance

Although leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact, these were not always revisited in times of crisis.

At our previous inspection in January 2021, we saw that although leaders and teams identified and escalated relevant risks, issues and identified actions to reduce their impact; these were not always revisited in times of crisis. At this inspection, we saw that management of risk continued to be reactive instead of being planned and managed in a safe way.

There was not always a planned management of risk.

The trust recognised further work was required to enhance risk identification, mitigation and reporting throughout the division. The trust told us about a risk management policy used, which described the processes for managing risk. It was proposed to undertake a review of the existing risk reporting to identify any further gaps and actions required.

The management of risk did not ensure that those risks known were acted on in a timely way or that learning was taken to change future practice.

We reviewed the Emergency Clinical Governance and Risk Group minutes for the previous five meetings. None of the issues we found during our inspection such as the flow of patients through the hospital, escalation spaces opened for outlier patients and the need for some areas to have safety work completed were mentioned. This demonstrated the governance processes were not effective at identifying risks.

The trust provided us with the risk register for the Weston division, which noted some risks had not been reviewed by the target date or did not have a target date. This meant the trust could not be assured that risks were treated with the required urgency or acted upon promptly. At this inspection we saw that some risks recorded were not acted upon in a timely and responsive way to ensure patient safety. For example, in January 2021 the lack of windows in doors and lack of patient monitors on the Waterside unit was recorded, but when we visited this area five months later, these issues had not been actioned.

The management of issues and performance continued to present a challenge to the trust.

The stroke service had not completed enough thrombolysis procedures in the last year. The recommended amount was 600 procedures and the location had completed 240. The trust had not raised this on their risk register as a concern.

The endoscopy unit has Joint Advisory Group (JAG) accreditation. To gain this accreditation, the unit was assessed against several national standards and continued to monitor its own service provision to ensure compliance. A review of this award was due in April 2021.

Leaders explained recruitment was a challenge and the service were not meeting this challenge. There was little time for staff involvement in governance and opportunities for discussions to look at management of performance. Staff told us they felt that they were trying to solve problems in isolation. Doctors were struggling with one consultant covering wards and the registrars were busy covering multiple wards. The pressures of working in the reduced staff numbers had impacted on development and shared learning.

Information Management

The service collected data and analysed it. The information systems were secure. Data was consistently submitted to external organisations as required.

At our previous inspection in January 2021, we saw that information was not always handled in line with information governance requirements. At this inspection we mostly saw records were stored securely however, screens with patient information were sometimes left unattended and so accessible.

Data was gathered and used to look at themes and trends across the trust. The medicine division had a dashboard which identified levels of sickness for staff, appraisal compliance, training compliance, turnover rate and vacancy rates for staff.

The Quality and Safety report for the medical division meeting for February 2021, records incidents and those showing increased levels of incidents and includes themes and trends.

A dashboard was used to look at audit outcomes and where action was needed. Notifications were submitted when needed to ensure that recordable information was gathered.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Patient and visitor engagement had prompted some ward changes. We saw that in one instance a patient expressed that they were bored. In response there was free WIFI implemented and access to an electronic tablet for music and movies and further resources of books and magazines were supplied.

Medical care (including older people's care)

In line with guidance from NHS England, the Friends and Family Test was suspended during the COVID-19 pandemic and formal submission restarted for December 2020 data in January 2021. From December 2020 to May 2021, Weston medical care had 285 responses, of which 265 would recommend the service.

The trust board papers for March 2021 stated that integration of the division of Weston into the trust's patient experience programme continued to be a key priority; specifically, extending the current Bristol Royal Infirmary postal survey process for inpatients and outpatients to replace the existing exit survey at Weston, to create comparable data across the hospitals.

Engagement with staff was being developed. The leadership team were seeing developments through a staff forum, however staff we spoke with did not know about the forum and so far, the leadership team confirmed around 15 staff had attended each session.

Staff felt that retention of staff was not considered and that engagement to find out why this was, had not been considered. Staff explained that a high level of staff had left, and they were still leaving. Staff felt that attempts to retain staff at Weston Hospital had not been considered. The staff turnover rate and vacancy rate was seen to be higher at Weston Hospital than the Bristol Royal Infirmary.

The trust had put in some systems to support junior doctor issues. Weekly Wednesday afternoon 'junior doctor clinics' commenced early February 2021; where juniors were encouraged to attend to feedback any issues and concerns and to receive information on current challenges. This clinical discussion group was led by the Deputy Medical Director.

A recruitment video for Weston Hospital had been completed as part of the leadership teams' efforts to make Weston Hospital an attractive for newly qualified nurses to come and work there.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Staff were enthusiastic about developing their own services and were keen to tell us about the ideas they had and how they wanted to drive them forward. For example, a member of staff had developed a sepsis project with an allocated project manager supplied from the Bristol quality improvement team. There were three workstreams – identifying patients, education of staff and educating patients while in hospital. The project team included consultants, doctors, nurses and was ready to go. Unfortunately, the project had been stopped with no reason given and staff were hoping to hear that they could proceed.

Outpatients

Good

Is the service safe?

Good

We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Most staff were up to date with the trust's mandatory training programme or had dates booked to attend training in the near future. This meant that most staff were up-to-date with their skills and knowledge to enable them to care for patients appropriately.

The mandatory training was comprehensive and met the needs of patients and staff. Most staff told us mandatory training updates were delivered to meet their needs and they were able to access training as they needed it.

There were a range of topics including equality, diversity and human rights, health and safety infection prevention and control, information governance, conflict resolution, and adult basic life support. Mandatory training was available using a range of methods to maximise accessibility, including face-to-face sessions and e-learning. Staff also had the option to complete training at home if they preferred.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training performance reports were available to review training attendance and staff could check their compliance with mandatory training. This supported the appraisal discussion and personal development planning. Managers saw which members of their team were in date and were able to plan when team members needed to complete refresher training. Email reminders were sent to all staff reminding them in advance of when the training was due. Compliance was reported monthly to the trust board as part of the governance report.

The trust set a target of 85% for completion of mandatory training for all courses. The compliance rate for the period from May 2020 to April 2021 ranged from 85.7% to 100% with six modules having 100% compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Safeguarding training completion rates showed 100% compliance for safeguarding adults and children, level two.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were knowledgeable about the trust's safeguarding policy and processes and were clear about their responsibilities. They described what actions they would take should they have safeguarding concerns about a patient. All staff were confident to challenge to ensure the safety of patients.

Outpatients

Staff followed safe procedures for children visiting the departments. The trust provided information to staff within safeguarding policies and procedures. This included the action to take when staff had concerns regarding child protection and domestic abuse.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. In all areas we visited, the floors, walls, curtains, trolleys and areas in general were visibly clean.

The service generally performed well for cleanliness. The service used a ward inspection application to capture information about infection control and cleanliness on smartphones or tablets. Data for cleanliness of scopes and wipe systems, hand hygiene and donning of personal protective equipment (PPE) showed 100% compliance.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were dedicated teams of a housekeeper and cleaning staff who ensured the areas were clean and tidy and they were fully integrated with the clinical teams. There were daily schedules and weekly tasks, alongside deep cleaning as and when required. Cleaning staff were able to show us their work schedules. Cleaning equipment was colour coded, clean and well maintained, and stored in a locked area. Workloads were high in all areas as a result of COVID-19 requirements.

Staff followed infection control principles including the use of personal protective equipment (PPE), such as face masks, gloves and aprons. These were readily available to staff. There were PPE stations in each consulting room. There were infection prevention and control champions in the departments who were available to remind all staff, patients and visitors to follow Public Health England COVID-19 advice.

Waiting chairs were cleaned regularly with wipes and a bell would be rung every hour to remind staff to clean the surfaces in the waiting room.

Staff, patients and visitors to the ward had access to antibacterial gel and handwashing facilities. We saw these used regularly throughout our inspection. Nursing and medical staff washed their hands and applied antibacterial hand gel between each patient contact. We also saw non-clinical staff, including reception and administrative staff and cleaning staff using hand gel. The antibacterial hand gel was located at the entrance to the hospital and throughout the outpatient departments.

Patients were asked to complete COVID-19 screening questionnaires on arrival in order to identify and isolate anyone who may have COVID-19 symptoms.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The service was divided into a main outpatient department and the Quantock department.

Outpatients

In response to COVID-19, risk assessments had been completed for all outpatient environments to maintain social distancing. A self-assessment tool had been completed for each outpatient department to consider the adjustments that needed to be made to support social distancing.

Patients and visitors were provided with guidance on attending outpatient appointments through the trust website, appointment leaflets, appointment letters and signage across the trust.

Chairs in the waiting areas were appropriately spaced to observe social distancing requirements. Protective screens had been installed at reception desks and signage on walls and floors had been installed to reflect the current COVID-19 requirements.

The service had enough suitable equipment to help them to safely care for patients. There was access to emergency equipment. The emergency trolleys in both departments were clean, tamper evident and ready to use. Staff carried out daily and weekly checks of the equipment and medicines to ensure they were ready to use and in date. This was evidenced by the signature of the staff member carrying out the check. From the records we reviewed during a three-month period there were no gaps in the log.

We saw a range of equipment was readily available and most staff said they had access to the equipment they needed for the care and treatment of patients in all specialties.

Staff carried out daily safety checks of specialist equipment. There were regular inspections to identify any faulty equipment and this was removed from use and the fault reported. As part of a ward inspection application, there were monthly inspections to assess the condition of the patient chairs or couches. Compliance was at 100%.

Staff disposed of clinical waste safely. Disposable items of equipment were discarded appropriately, either in clinical waste bins or sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments relating to patients needs were completed and evaluated. There were clear processes to deal with patients where their medical condition was deteriorating.

Staff responded promptly to any sudden deterioration in a patient's health. Staff knew about and dealt with any specific risk issues. Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. A flow chart supported staff to follow the process.

Staff shared key information to keep patients safe when handing over their care to others. A number of standard operating processes had been introduced in response to COVID-19 working arrangements. These included a framework for patients in the 'shielded' and 'very high risk' category who needed to attend and another to assess if patients were presenting with symptoms of COVID-19 or had contact with others presenting with symptoms prior to attending their appointment. Others related to patients requiring a bone marrow aspiration and for the protection of vulnerable patients who arrived unwell.

Outpatients

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants

and healthcare assistants needed in accordance with national guidance. There was a process for

monitoring and ensuring safe staffing in line with current national recommendations and this was

reviewed monthly by the head of nursing.

Managers could adjust staffing levels daily according to the needs of patients. Daily nurse staffing was monitored and reviewed to ensure the right staff were in the right place at the right time. This was confirmed through senior oversight by the senior sister and matron against a standard operating procedure for safe staffing.

There was a mix of skilled and experienced nurses and healthcare assistants in both departments. There were senior nursing staff in band eight (matron), band seven (senior sister) band six (sisters) and supporting band five (nurses). The band seven nurse oversaw the day-to-day running of the nursing teams in the departments.

Data from May 2020 to April 2021 showed the service had low turnover rates and most staff had been part of the team for many years. There was a 14% vacancy rate with 3.44 full time equivalent (FTE) vacancies out of a budgeted 24.4 9 FTE, of which 25% vacancy rate 2.03 FTE out of a budgeted 8.11 FTE, was for registered nurses.

The service had a 12.1% sickness rates as a result of long-term sickness absence, which was being managed in line with trust policy.

Managers limited their use of bank staff and requested staff familiar with the service. There was no agency use with shifts being covered by bank staff.

Staff said they had been stretched at times during the last year when capacity and demand had been consistently high as a result of COVID-19.

Medical staffing

We were not able to see any data to show there were enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Despite our requests to see data showing the number of medical staff working in the service, the trust were unable to easily provide this information due to the way information was collated. Information about vacancy or turnover rates, sickness rates, or the level of bank and locum staff was also unavailable.

However, managers were assured there were enough staff to keep patients safe and staff were similarly positive about the staffing numbers.

Staff said there had been use of locums during the last year when additional medical staff were needed. They had received a full induction to the service before they started work.

Outpatients

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. We reviewed ten sets of patient records. They had a standard layout and format which assisted the clinician to locate the information they needed specific to the patient's condition.

All notes were signed and dated. Information was complete and concise and care plans were up to date. The records were well completed and reflected the needs of patients. Each set of records provided detail of the care and treatment plan and included information. Completion of records was regularly audited and actions taken to address any shortfalls.

Consent forms for sharing information and consent for procedures were completed. All patients had a recommended summary plan for emergency care (ReSPECT) form at the front of the notes.

Records were stored securely. Cabinets and trolleys were locked and could only be accessed by appropriate people.

When patients transferred to a new team, there were no delays in staff accessing their records. Patient's records could be tracked and located using a tracer system. On occasions when records had not been correctly tracked for outpatient attendance, staff said it was easily rectified and did not cause any delays in treatment.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely in locked cupboards and trolleys and doors were locked to treatment rooms with access restricted to appropriate staff. There were no controlled drugs. Regular balance checks were performed in line with trust policy. The cupboards were well organised and functional.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Prescriptions were dispensed in the hospital pharmacy. These were signed, dated and logged. Prescription forms (FP10s) were stored securely and there was a robust system to track their use.

Medicines refrigerators and treatment room temperature records showed medicines were stored at the correct temperatures. There were weekly medicine audits where all medicines were checked, discarded if out of date and reordered.

Nursing and medical staff had access to pharmacists who were available between 8.30am and 5pm on Monday to Friday.

Staff followed current national practice to check patients had the correct medicines. Policies and procedures were available and accessible to staff on the trust intranet. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines. Information was also available to all staff.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff knew how to report incidents or near misses on the trust's electronic reporting system. Staff felt confident in raising an incident should they need to. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Outpatients

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff reported serious incidents clearly and in line with trust policy. There were systems to make sure incidents were reported and investigated appropriately. Staff were open, transparent and honest about reporting incidents and said they would have no hesitation in reporting incidents and were clear about how they would report them. All staff received training on incident reporting.

Staff knew what incidents to report and how to report them. All incidents were reported directly onto the incident reporting system. This provided a single record of each incident, subsequent investigation, agreed learning, and evidence of the learning and its effectiveness.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff said they were encouraged to report incidents promptly.

The service had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Although we did not see any examples of where duty of candour had been applied, staff demonstrated an understanding of their responsibilities and could describe the process and what they would do. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Staff received feedback from investigation of incidents in the outpatient service. Learning from incidents started at the point where the event happened, with any necessary local action being taken to minimise a similar event from reoccurring.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The incident reporting policy set out the processes for reporting and managing incidents and described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process.

Managers debriefed and supported staff after any serious incident. Staff confirmed they received feedback after reporting an incident and an action plan was shared. Learning was shared using a variety of methods. Firstly, there was an immediate response and any local action taken to help prevent a reoccurrence and formal feedback methods such as team meetings to help spread any learnings from events.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed in the department for staff and patients to see.

Outpatients

Staff used the safety thermometer data to further improve services. The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

We saw that a safety audit was completed monthly and included; infection, prevention and control, hand hygiene and equipment. During the months of April and May 2021, the department had been 100% in compliance with these audits. The department had introduced the National Safety Standards for Invasive Procedures (NatSSIPs) checks for hysteroscopy (a hysteroscopy is a procedure used to examine the inside of the womb using a hysteroscope) and flexible cystoscopy (flexible cystoscopy is an examination of the interior of the bladder with a fine, soft tube with a telescopic camera called a flexible cystoscope). This was not a national requirement for these particular procedures and we saw that in April, March and May 2021 the department had 100% compliance.

Is the service effective?

Good

This was the first comprehensive inspection of this service.

We rated it as good. There was insufficient information to rate this question previously.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies, care and treatment pathways, and clinical protocols had been developed in line with national best practice recommendations. These included the National Institute for Health and Care Excellence (NICE).

Policies were available to all staff on the trust intranet system and staff demonstrated they knew how to access them.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. Packed lunches and drinks were provided for patients who were attending for lengthy periods. Vending machines were also located in both outpatient departments.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Outpatients

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. There was guidance in care plans about pain management for patients where it was appropriate. Patients had their pain assessed and appropriate methods of reducing pain were offered.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. There was an annual audit plan which enabled the service to benchmark the standard of care provided at the trust against local and national standards. For example, the service participated in the national inflammatory arthritis audit and the fracture liaison audit. Local audits included nurse and nursing assistants competency assessments for; flexible cystoscopy (flexible cystoscopy is an examination of the interior of the bladder with a fine, soft tube with a telescopic camera called a flexible cystoscope), venepuncture (venepuncture is the process of obtaining intravenous access, most commonly for the purpose of blood sampling) and for the administration of topical eye drops.

Managers used information from the audits to improve care and treatment. Audits were monitored and action plans to address areas of improvement were regularly reviewed.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The service participated in national safety standards for invasive procedures (NatSSIPS) with consistently positive outcomes.

Managers shared and made sure staff understood information from the audits. Information was shared at unit meetings and by email. Staff confirmed they were kept up to date with results and any actions required.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Data showed 80% of staff had received an appraisal and others had dates booked in the near future.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Clinical supervision enabled staff and managers to identify training needs, develop competence and enhance clinical practice. Most staff were positive about the frequency of clinical supervision they received.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Minutes of meetings were emailed to all staff and a paper version was available for staff to read.

Managers gave all new staff a full induction tailored to their role before they started work. Staff confirmed they received a comprehensive induction. They felt confident and prepared to work in the departments.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

Outpatients

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and there was good teamwork. Staff were encouraged to keep up to date with their continuing professional development and there were opportunities to attend external training and development in specific areas.

There was a trust-wide electronic staff record where all training attended was documented. Managers were informed of training completed and alerted to those staff requiring updates for mandatory training through regular competency reports.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, a new rolling trainee programme had been introduced for a trainee role in the fracture clinic plaster room. This ensured cover was available during periods of absence.

Managers made sure staff received any specialist training for their role. The service undertook a range of education and practice development activities aimed at enhancing the knowledge, skills and awareness and development of the staff.

Ophthalmologists peer reviewed and audited each other's work monthly. Phlebotomists and plaster room technicians did the same in their peer groups.

There were service specific competency assessments for nurses and nursing assistants, for example in hysteroscopy and flexi-cystoscopy, spirometry, vision field training and orthopaedics.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were multidisciplinary (MDT) integrated clinical pathways to improve the patient outcomes. Staff worked across health care disciplines and with other agencies when required to care for patients.

Patients could see all the health professionals involved in their care at one-stop clinics. For example, diagnostic tests would be scheduled at the same time as other appointments to ensure patients could make one visit to the hospital.

Staff referred patients for mental health assessments when they showed signs of mental ill health.

Seven-day services

Key services were not available seven days. The departments were open on weekdays from 8.30am to 6.30pm.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in patient areas.

Outpatients

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Health promotion was a routine part of all care provided to patients. All staff worked collaboratively to assess aspects of general health and to provide support and advice to promote healthy lifestyles.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff said they were confident in making capacity assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Throughout the inspection we saw staff explaining the assessment and consent process to patients and any need to share information with other professionals such as GPs, before obtaining written consent.

Staff made sure patients consented to treatment based on all the information available. Staff said they obtained consent from patients prior to commencing care or treatment. They said patients were given choices when they accessed their service.

Staff clearly recorded consent in the patients' records. This was clearly recorded in all the records we reviewed.

When patients could not give consent, staff made decisions in their best interests, taking into account patients' wishes, culture and traditions.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were aware there were additional steps to consider if the patient did not consent to treatment. Staff contacted the approved mental health practitioner team at the local mental health trust.

Is the service caring?

Good

This was the first comprehensive inspection of this service.

We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Outpatients

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we observed positive interactions between staff and patients. Staff were open, friendly and approachable and interactions were very caring, respectful and compassionate.

Patients said staff treated them well and with kindness. Care from the nursing, medical staff and support staff was delivered with kindness and patience. The atmosphere was calm and professional, without losing warmth. Staff were focused on the needs of the patients and ensured they felt respected and valued as individuals.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. They were knowledgeable about the trust framework to support communication with families who were non-English speakers, or for whom English was a second language. Support was also available for patients with hearing or visual impairment, or who had learning disabilities.

The comments we received from patients were unanimously positive. They spoke positively about their experience in the hospital from staff at the front door, the reception staff and consultants and nurses. They confirmed the staff were kind and helpful to them. We observed medical and nursing staff interacting and engaging with patients.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff providing emotional support to patients during their visit to the departments. Patients individual concerns were promptly identified and responded to in a positive and reassuring way.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Throughout our inspection, we saw patients being treated with dignity and respect. Voices were lowered to avoid confidential or private information being overheard despite the difficulties of COVID-19 measures i.e. wearing face masks and having perspex screens at reception. All patients said their privacy and dignity was maintained.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Difficult information was discussed in a sensitive manner and a patient told us how supportive the entire team had been when they delivered such information.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients were spoken with in an unhurried manner and staff checked if information was understood. Staff talked about patients compassionately and with knowledge of their circumstances and those of their families.

There was good support from the hospital multi-faith chaplaincy team who were available in the hospital during normal office hours.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Outpatients

Staff made sure patients and those close to them understood their care and treatment. Patients were involved with their care and decisions taken. Patients said all procedures had been explained and they felt included in the treatment plan and were well informed.

Staff talked with patients in a way they could understand, using communication aids where necessary. We observed staff explaining things to patients in a way they could understand to help them become partners in their care and treatment.

Staff supported patients to make informed decisions about their care. Patients were encouraged to be involved in their care as much as they felt able to. Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities or autism.

Patients gave positive feedback about the service. The trust used the NHS friends and family test to find out if patients would recommend their services to friends and family if they needed similar treatment or care. A high proportion of patients gave positive feedback about the service in the test.

The trust used a separate patient experience programme to gather patients' feedback about their experience. There was a separate measure for kindness and understanding. Responses exceeded the trust target score of 90 or over.

Is the service responsive?

Requires Improvement

This was the first comprehensive inspection of this service.

We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that sometimes met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

All aspects of outpatient performance continued to be heavily impacted by COVID-19. Initially capacity was lost due to additional infection prevention and control measures, a shortfall of staff, social distancing and patient choice not to attend. As a result, services did not always meet people's needs.

Managers were planning and organising services to meet the needs of the local population and the changing COVID-19 situation. The trust launched an elective restoration programme in April 2021, led by members of the senior leadership team, to coordinate recovery activities based on the core priorities of patient safety, workforce, capacity and capability.

The plans included extending endoscopy opening times, standardising waiting list initiatives, maximising the utilisation of rooms and adapting the space where possible, increasing advice and guidance and deploying more specialties to patient initiative follow-ups. Face-to-face appointments were also a priority while retaining the option of virtual and telephone appointments.

Outpatients

The team were involved in developing plans for integration of clinical services and were working to re-design the programme to achieve the goal of completing all service integrations by March 2022.

The planned service transfer of the Weston urology service to a neighbouring trust remained a key priority. It had been delayed but was now expected to go ahead in autumn 2021.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. One stop appointments were arranged to avoid multiple attendance for vulnerable patients. For example, diagnostic tests and appointments with a urology consultant were arranged on the same day.

During the last year, a number of processes had been adjusted to ensure patient's safety during the pandemic. For example, shielding patients arriving for blood tests were advised to wait in their car in a disabled bay in the car park. A phlebotomist would call the patient in through fire exit door located next to the treatment room.

Facilities and premises were appropriate for the services being delivered. The trust had been mindful to support vulnerable patients attending outpatient appointments during the pandemic. This included new patient information leaflets to provide reassurance and revised letters and text messages to keep patients informed about accessing services. There was clear signage and staff greeted patients at the front door and guided them to the outpatient departments.

Staff could access emergency mental health support for patients with mental health problems, learning disabilities and dementia. There were arrangements to meet patient's urgent or emergency mental health care needs from the local mental health team.

Managers monitored and took action to minimise missed appointments. Patients were sent text reminders about their appointments. Where patients cancelled an appointment at the last minute, a same day appointment could be offered to other local patients who were available at short notice.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. There were dementia champions to support patients who visited the departments. Two appointment slots would be booked for patients requiring more time and a quiet space would be set aside, where possible. However, referrers in the community did not always alert the team about patient's needs prior to their booking and staff, on occasions, had to be very creative in supporting patients on arrival.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The access to the department and use of equipment met the needs of patients and visitors with a disability.

The service had information leaflets available in languages spoken by the patients and local community. This ensured patients and their families and carers had access to written information about their illness and/or conditions.

Outpatients

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Support was available for communication with patients and carers for whom English was a second language, people with hearing or visual impairment, or who had learning disabilities. There was telephone interpreting, video conferencing and written translation services. Face-to-face interpretation had been suspended as a result of COVID-19 working arrangements. Information could also be provided in large print, in braille, or a British Sign Language interpreter was available.

The hospital's chaplaincy team provided pastoral support and spiritual care to patients and their families. They provided support for all faiths (and none) and maintained close contact with faith leaders in the community. There was a chapel on the hospital site open at all times.

Access and flow

Some people were not able to access the service when they needed it and did not receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Although we found the service largely responded well, not all referral to treatment times were meeting national targets and some elements required improvement. All aspects of outpatient referral to treatment time (RTT) performance continued to be heavily impacted by COVID-19.

Outpatient referrals and outpatient attendances had not returned to the pre-COVID-19 levels of 2019/2020. Data showed there were 96,947 outpatient appointments (including non-attendances and cancellations) from April 2020 to December 2020. Data at the end of March 2021 showed performance was at 57% of previous levels.

Managers monitored waiting times and were taking actions to improve patients' access to services within agreed timeframes and national targets. The key considerations for outpatients were tackling each of the specialty backlogs and reinstating pre-COVID-19 activity.

Patient pathways and flow through the outpatient departments had been reviewed. There were recovery trajectories and although these had started to perform better than at the same point last year, this was not sufficient to recover the backlog of waiting lists.

Managers were concerned if the service was unable to provide sufficient capacity to meet the demand, it would fail to achieve the RTT recovery trajectory, and would continue to be in a position where waiting times lengthened and patients would continue to wait longer for treatment. This had the potential to impact on the clinical outcomes for patients.

The national standard for referral to treatment times (RTT) pathway and the percentage waiting less than 18 weeks was that over 92% of the patients should be waiting under 18 weeks. NHS England / Improvement also issued guidance that trusts should aim to reduce the overall waiting list size, with trusts being expected to reduce volume from the end of January 2020.

From April 2021 targets had been set at 70% of the baseline 2020 position; then each consecutive month the position had to increase by 5% until the end of July; if this figure was achieved the trust would be eligible for the Elective Recovery Fund (ERF); this was an incentive scheme for system providers.

Outpatients

From March 2020 to February 2021, the referral to treatment time (RTT) for non-admitted pathways had been lower than the England overall performance.

The 18-week performance deteriorated in May 2020, with the lowest performance reported in August 2020 (50%). Performance then started to improve again with non-admitted patients treated within 18 weeks in October 2020 at (65.2%). However, performance deteriorated again for the seventh consecutive month to 49.7% in April, with 927 patients waiting over 52 weeks (12 % of the total list size). Around 13% of the longest waiting patients were currently choosing to delay their treatment due to COVID-19 related concerns, being unable to isolate or waiting to receive both doses of the COVID-19 vaccination before commencing treatment.

Endoscopy (including cystoscopy) continued to improve with 42.38% of patients managed within the 6-week standard. Job plans and scheduling for the endoscopy suite was under review and there was work underway with the Bristol site to confirm ongoing access to the independent sector.

In February 2021, 535 patients who were treated in a non-admitted setting had waited over 52 weeks for their treatment, compared to four in February 2020. In February 2021 this represented 6.2% of all patients treated in a non-admitted session. Specialties with the most non-admitted patients treated at 52 weeks or more were ophthalmology, and trauma and orthopaedics.

The average performance for cancer waiting times as a percentage of patients seen within two weeks of an urgent GP referral was below the 93% operational standard. However, in February 2021, 96.2% of patients were seen by a specialist within two weeks of an urgent GP referral. This was higher than both the south west average and the England average.

In the most recent reported quarter, the trust performed above the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis. The operational standard was not met in February 2021 with 92.2% of patients receiving a first definitive treatment within 31 days of a decision to treat. This was below the south west average and the England average.

In the latest reported quarter, the trust performed similar to the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.

Managers explained cancer performance over the summer might be impacted if demand increased above normal variation, due to ‘pent up demand’ as lockdown eased. This was a particular risk for dermatology services, which always saw a large seasonal increase in demand in the same time period. Services were being encouraged to have contingency plans to enable capacity to be flexed up in response to demand surges, although it was recognised that such flexibility was limited whilst COVID-19 precautions were needed.

As a result of the COVID -19 response there had been a loss of capacity in outpatients for follow up appointments. Outpatient activity had not exceeded pre-COVID-19 levels, except in March 2021.

Provisional data for April 2021 showed outpatient attendances were around 90% of April 2019 levels. It was felt this would not provide sufficient capacity to manage the follow up backlog demand as well as the ongoing new demand. Capacity was being focussed on the delivery of the most clinically urgent cases and harm reviews were conducted to minimise risks to patients experiencing long waits.

Outpatients

There had been significant expansion of non face-to-face appointments. 32% of outpatients appointments were now routinely delivered in this way. This had been 3% pre-COVID-19. This was predominantly telephone clinic activity. Video consultation (attend anywhere) had been rolled out trust wide. Patient survey results showed a positive response, with 89% saying they would happily have another video appointment.

Access to an advice and guidance platform had seen a significant increase in requests during the last year. The average response time was 2.5 days. Patient survey results about the effectiveness of the service had been positive.

There was flexibility in most specialties to offer a range of appointments, although this could be difficult for urgent clinics such as diabetes foot clinic. The team did their utmost to accommodate patient's preferences for morning or afternoon appointments. Rheumatology clinics had been scheduled specifically in the afternoon as these patients often had mobility difficulties and found it easier to attend afternoon appointments.

The consultants had been proactive and flexible in working with the team to look at their job plans for their specialty. As a result, extended clinics and flexible lists had been agreed.

The service used an e-referral system. Consultants triaged all patients based on their previous medical history, family and social history. The consultant could either agree with the GP or request a different appointment, such as face-to-face, telephone, delay for three months, change or reject the referral.

There was a centralised appointment centre and patient access team who managed waiting lists. The patient access system had migrated from one system to another to be in line with the system in Bristol. The team would make up to three separate attempts to contact patients at different times of day, by phone and text message.

Following the migration to the new patient system, data quality issues had been uncovered where waiting lists totals were incorrect. An external validation had been undertaken to gain an accurate reflection. As a result, the number of patients experiencing long waits for an appointment had been reduced from 9,000 to 5,500.

Managers worked to minimise the number of cancelled appointments. Cancellation rates were starting to normalise and did not attend (DNA) rates were moving towards the figures seen before COVID-19. The Access Team made every effort to telephone and speak with patients to book appointments to help reduce DNA rates. Improvements had been seen since the return of text reminders. The DNA target at trust level was to be below 6.7%, with an amber tolerance of between 6.7% and 7.2%. In March 2021, the DNA rate was 6.4% across Bristol and Weston sites.

For appointments cancelled by the trust, the target was to be on or below 9.7% with an amber tolerance from 10.7% to 9.7%. The hospital cancellation rate was 10.1% and every effort was made to rebook an appointment within three months.

We spoke with patients who said, given the restrictions as a result of COVID-19, they were satisfied with the speed of appointments and waiting times were kept to a minimum, and they were always informed if the clinics were running late.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Outpatients

Patients, relatives and carers knew how to complain or raise concerns. Patients said they felt they could raise concerns with the clinical staff they met. Most patients told us if any issues arose, they would talk to the senior nurse available.

The service clearly displayed information about how to raise a concern in patient areas. Information about making complaints was available in all the areas we visited. Leaflets were available in all departments and information could be accessed on the trust website with links about how to resolve concerns quickly and how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. There were policies and processes to appropriately investigate, monitor and evaluate patient's complaints.

Managers investigated complaints and identified themes. During complaint investigations staff were required to provide comments, and when indicated, written statements. The complaints and Patient Advice and Liaison Service (PALS) supported the trust in the delivery of the complaints investigation policy.

There had been 52 formal and informal investigations complaints. The categories with the most complaints related to appointments (17), attitude and communication (17), and clinical care (13).

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff were aware of complaints and any learning that had resulted. All staff we spoke with were aware of the complaints system within the trust and the service provided. They were able to explain what they would do when concerns were raised by patients. They said they would always try to resolve any concerns as soon as they were raised, but should the patient remain unhappy, they would be directed to the manager or the trust complaints' process.

Managers shared feedback from complaints with staff and learning was used to improve the service. Every complaint and PALS concern was reviewed to identify the issues raised by the complainant to ensure learning and continuous improvement.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

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

The leadership of outpatients at the Weston site consisted of the divisional director and deputy divisional director of surgery; they were supported by an assistant general manager and three band seven specialty managers. Weston outpatients sat within the surgical division.

Outpatients

Senior managers had the right skills and abilities to run a service providing high quality and sustainable care. The consultants and senior sister were an experienced and strong team with a commitment to the patients who used the service, and to their staff and each other. It was an integrated and strong team with an emphasis on providing consistent and high-quality care.

The members of the senior management team were relatively new in post. They were embedding as a team and making progress with confidence, a clear structure and lines of responsibility. They were proceeding with cautious optimism to restore services. They were keen to listen to the lessons learned during COVID-19 and wanted to harness the enthusiasm and commitment of the new team. However, the specialty managers had fixed term contracts and there was uncertainty about the future of their roles, which posed a risk to their resilience and retention as a team in the future.

The leadership teams of managers, medical and nursing staff clearly understood the challenges in restoring the service and delivering good quality care. They were engaged with the programme to integrate services with the larger Bristol site and could identify the opportunities in sharing knowledge and skills. However, they were frustrated about the pace of change and the dilution of their autonomy to make changes at a local level. They were concerned about decisions being centralised in the larger Bristol site and preferred to retain control and management at a local level.

The team were knowledgeable and passionate about the service and actively worked to improve delivery of care. They were visible and available to staff, and we heard about support for all members of staff in the departments.

Staff said managers were approachable and they felt able to openly discuss issues and concerns with senior staff and their managers. They believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed. The senior management team communicated with staff by email and face-to-face.

The senior sister operated an ‘open door’ policy, which staff were positive about. Staff were supported to develop their skills and competencies within their roles and with a view to internal promotion. We received consistently positive feedback from staff who had a high regard and respect for their managers.

Managers encouraged learning and a culture of openness and transparency. They had an awareness that staff required different leadership styles and were flexible in their approach to the needs of their teams.

All staff we met said they felt valued and part of the team and were proud to work in the team. They felt supported by the senior management team, senior sister and their colleagues.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

At trust level, there was an outpatient steering group with divisional and clinical representation. The team contributed to the healthier together outpatient group at a system level.

An outpatient redesign programme had been developed in collaboration with system partners.

The key priorities for the programme were restoration, delivery of patient initiated follow up and the roll out of community phlebotomy.

Outpatients

Managers had ambitious plans and recovery trajectories for the coming year and expected to be in a more comfortable position next year. These plans relied on the retention and knowledge of the team. Managers acknowledged reserves were limited and the team were working at maximum capacity.

There was a programme of integration of clinical services between the Weston division and the wider trust and another local trust. There was a standardisation of clinical operating processes and patient pathways, for example, ophthalmology, trauma and orthopaedics, gynaecology and ear nose and throat (ENT).

There were plans to merge the electronic referral service with the wider UHBW service, and to integrate the patient access teams. Managers were exploring the use of the independent sector as part of their recovery plans.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Managers encouraged learning and a culture of openness and transparency. Senior staff agreed that staff or teams would speak up to them when they needed to and would be heard. Staff said they were encouraged to speak up and felt comfortable about raising any concerns. Staff were also aware they could raise concerns about patient care and safety, or any other anxieties they had with the Freedom to Speak Up Guardian.

Staff talked with us about how the trust would share learning and take action when a never event, serious incident, or near miss occurred.

The team was positive about their role and felt supported to deliver care to patients**.** All the staff we met said they felt valued, confident and proud of the care they provided. The team told us they were proud of being able to make a difference and felt supported by the leadership team and their colleagues.

Patients and their families were at the centre of the service. There was an emphasis on the importance of education and awareness for patients and their families. During our conversations with staff and observations on the departments it was clear staff had the patients at the centre of their work. They were passionate about services for patients and were dedicated to their roles and approached their work with flexibility.

The team provided support to each other. It was clear their work was important to them and they felt passionate about their contribution to care and were committed to improving the health of local patients.

Managers said they were proud of the staff they supervised. They said there was a high level of commitment to providing quality outpatient services. In addition, managers explained a number of staff had volunteered to move to inpatient areas at the height of COVID-19 and had shown great resilience and commitment to the wider trust during a time of crisis and had made a real difference.

Staff were positive about working for the trust, although there had been times when they felt stretched and under pressure during the last year. Many staff had worked in the departments for some time and were very proud of their length of service.

Staff felt listened to and were encouraged to make suggestions and to develop services. One member of staff explained how she had been supported with an idea to develop a service.

Staff were aware of the whistleblowing policies and procedures and felt able to approach managers to raise any concerns or suggestions and were confident they would be listened to and action taken.

There was an opportunity for staff to access support and debriefing when this was required. The trust also had a staff support/counselling service available to all staff.

Governance

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

Leaders operated effective governance processes. There was a clear governance structure driving change. Staff at all levels were clear about their responsibilities, roles and accountability within the governance framework.

There was a clear performance management reporting structure with monthly governance meetings looking at operational performance. This included a review of incidents reported, complaints, staffing, audit status, infection control, risks identified on the risk register and risk management, and education and training.

An extensive set of policies was readily available on the intranet and was supported by standard operating procedures and processes.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust had systems for identifying risks and plans to eliminate or reduce them. The service maintained a local service level risk register which clearly identified individual risks and the action taken to mitigate the risks. The position was monitored at monthly meetings.

The service monitored the effectiveness of care, treatment and performance. The service took part in national and local audits and evidence of improvements or trends were monitored. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results.

There were local contingency plans for the department if there were significant capacity and staffing issues, and problems with equipment. Actions were described for staff to follow and escalate depending on the status of the situation.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The information systems were integrated and secure. The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Outpatients

Staff had access to information they required to provide good patient care. All staff had access to the trust's intranet, which contained the information and guidance for staff to carry out their duties. Staff we spoke with were familiar with the trust intranet and knew where to find the information they needed.

Staff had access to information about patients to ensure they had sufficient and up-to-date knowledge to provide safe care and treatment. Staff used electronic systems to manage patient information such as referrals to the specialist care teams and to gain access to information about results of investigations such as blood tests.

As some clinics were run by another local trust, there were two patient access systems. This had initially caused problems for staff due to limited access to systems. This had been resolved with the purchase of additional licences to use the system.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

In line with guidance from NHS England / Improvement, the Friends and Family Test was suspended during the COVID-19 pandemic and formal submission restarted in December 2020. Data from December 2020 to May 2021 showed 95.3% of patients would be likely to recommend the service.

A patient experience survey was also implemented to fall in line with systems in Bristol. This included for the first time postal survey data for April 2021 for patients seen in Weston. The five topics included the things patients said mattered most to them. The overall score was 90 out of 100 and exceeded the trust target of 85. There was a separate measure for kindness and understanding, with a target score of 90 or over. Performance for April 2021 showed a score of 92.

A dip in patient experience scores had coincided with the first lockdown and uncertainty concerning COVID-19. Scores had improved in recent months being driven by patient reported waiting times being much reduced and the availability of non face-to-face appointments.

There were concerns about groups of patients being disadvantaged in terms of accessing technology. The trust were looking at the demographics and to hone responses to cater for these groups.

There were effective systems to engage with staff. In the NHS 2020 staff survey, in the question asked of staff whether they would be happy about the standard of care provided to a relative or friend by the organisation, 81% of staff said they would. This was against a sector average of 75%.

There were regular meetings to discuss, share information and provide feedback to staff. Minutes were taken of each meeting and emailed to staff and paper copies were available to ensure those that could not attend had access to the information.

Staff told us they felt engaged, informed and up to date with what was happening within the wider trust. Information was shared through different forums. These included unit meetings, secure social media pages, verbally and through the recently improved staff forum.

Staff said they were encouraged to speak up and voice their suggestions and solutions.

Staff had access to health and wellbeing services. There were informal reflective debrief sessions and counselling services were available through the occupational health service. A quiet room in the Macmillan Centre had been repurposed into a wellbeing hub for staff during the height of the pandemic. Staff rest areas and shower facilities had improved, and an extended covered area in the staff restaurant would be developed in the near future.

Staff told us about random acts of kindness from their managers, for example a cup with coffee / tea with a meaningful individual handwritten note of appreciation for staff efforts during the last year. Other initiatives included a nurse of the week and the outpatient team had been awarded a team spirit award in the pride awards.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was an emphasis for continuous, evidence-based improvement for improved health and better care. Staff told us they were always keen to learn and develop the service.

Innovation and improvement were encouraged with a positive approach to achieving best practice. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care to ensure the delivery of high-quality care for patients. Staff and managers felt there was scope and a willingness amongst the team to develop services through training and research and by learning from when things went well and when they went wrong.

There were a number of examples of innovations. These included:

- The development of a phlebotomy hub in the hospital car park to avoid vulnerable patients entering the hospital. Patients made an appointment with a time slot and waited in their car. Staff took a note of their number plate and returned to collect and escort them to the hub. Bloods were taken and patients were able to leave straight away. This was standard practice for the last year and only stopped when patients no longer had to shield. Patient feedback had been very positive. There were future plans to develop community phlebotomy hubs across the local area.
- As a result of limited face-to-face appointments for dermatology patients, YouTube videos were provided by clinicians to guide patients to check their skin and lymph nodes. This had proved to be popular with over 127,000 views.

UHBW Bristol Main Site

Bristol Royal Infirmary
Upper Maudlin Street
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BS2 8HW
Tel: 01179230000
www.uhbw.nhs.uk

Description of this hospital

On 1 April 2020, University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust merged to form a new organisation, University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).

The University Hospitals Bristol Main Site campus comprises:

- Bristol Royal Infirmary
- Bristol Eye Hospitals
- Bristol Haematology and Oncology Centre
- Bristol Heart Institute
- Bristol Royal Hospital for Children
- St Michaels Hospital
- Central Health Clinic

We rated the medical care core service at UHBW Bristol Main Site as good for the effective, caring, responsive and well led domains and requires improvement for the safe domain.

Therefore, our rating of this location stayed the same.

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

Our findings

- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's values, and how to apply them in their work. Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and staff were committed to improving services continually.

However:

- The service provided mandatory training in key skills to staff but not all staff had completed it.
- Premises were not always being used for their intended purpose. For example, additional bed spaces added to wards could compromise patient care and privacy.
- Medical staff did not always receive appraisals.

Medical care (including older people's care)

Good ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe went down. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to staff but not all staff had completed it.

Most nursing staff kept up to date with mandatory training. The overall trust target for compliance with training in key skills was 90%. Compliance was met within the specialised service division where the overall completion rate was 92%. The trust compliance target had just been missed for nursing staff across the medicine division with an overall 89% completion rate.

Staff were provided with e-learning packages which allowed them to complete training virtually. Some face-to-face training had been cancelled due to the COVID-19 pandemic which had impacted upon completion rates. As a result, there were significant gaps in training within both divisions, particularly around safeguarding adults' level three training, basic and intermediate life support training and fire safety.

Leaders told us extra training sessions were being provided and staff were given time to complete mandatory training in order to 'catch up'. However, staff told us it was difficult to find the time to complete training due to staffing pressures.

Medical staff had not all received and kept up to date with their mandatory training. The overall trust target for compliance with training in key skills was 90%. This had not been achieved for medical staff across both the specialised services and medicine divisions. Within the medicine division there was a 66% overall completion rate and within specialised services there was a 70% overall completion rate. There were significant gaps in training around fire safety, life support and safeguarding training.

Medical staff told us they felt well supported to undertake their training. However, there had been pressure on time during the pandemic and some face-to-face training had been suspended.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us the content of training was appropriate. Nursing staff told us face to face training, such as immediate life support training was well received as it was presented well and informative.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was recorded on an electronic system, which sent out automatic emails to staff to remind them to complete their training. Each division monitored their essential training compliance rates through monthly workforce reports, which were presented to the divisional board.

Staff told us they received emails and their managers were supporting them to complete essential learning that had been missed due to the COVID-19 pandemic and the increased demand on services.

Training compliance was recorded as a risk on the divisional risk register for medicine from August 2020. The current risk level was graded as 'very high' and control measures were highlighted including the fact e-learning could be accessed by staff from home and line managers could view training compliance at any time. Matrons were identifying staff who were not compliant and providing the option for staff to be paid overtime to complete training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse. However, not all staff were up to date with safeguarding training at the required level.

Medical and nursing staff completed training specific for their role but there were low levels of compliance with level three safeguarding adults' training. For nursing staff in specialised services and medicine divisions, 94% had completed level two safeguarding adults' training with completion rates above the trust target of 90%. However, only 56% of nursing staff in the specialised services division and 64% of nursing staff in the medicine division had completed level three safeguarding adults training.

Medical staff had access to some levels of safeguarding training, but training compliance did not meet the trust target of 90%. For medical staff, compliance with safeguarding adults' level two training was 69% in specialised services division and 67% in the medicine division. Data showed no medical staff had received level 3 safeguarding training. We were told by the trust they were in the final stage of implementing the recommendations of the intercollegiate document 'Adult safeguarding: roles and competencies for health care staff'. The numbers of staff identified as requiring level 3 training had been agreed with other local health providers and the local clinical commissioning group. The trust had identified the risk of not achieving targets of mandatory training compliance, which included safeguarding. We also saw a recorded risk specifically around level three safeguarding training compliance for staff working in the emergency department. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were able to describe how they supported patients with protected characteristics to provide person centred care.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us they felt confident in identifying adults and children at risk and gave examples where referrals had been made to other agencies. We saw safeguarding risks were discussed during handover meetings. For example, we observed a handover meeting where a consultant agreed to follow up a safeguarding referral after concerns were identified.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Nurses we spoke with were aware of safeguarding processes and how to get advice from the trust safeguarding team. Staff told us there were link nurses and the safeguarding team were available and approachable. Forms to complete a safeguarding referral and guidance were accessible to staff. Nursing staff also told us information relating to safeguarding risks were discussed in daily safety briefs.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

From April 2020 to April 2021, the trust reported 31 infection control incidents across all sites. Eight of these incidents (44%) were reported within medicine at the UHBW Bristol main site and related to COVID-19.

Ward areas were visibly clean and had suitable furnishings which were well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed all ward areas we visited to be visibly clean and corridors uncluttered. We saw up-to-date cleaning records displayed outside patient rooms and in bays on all wards we visited.

Staff followed infection control principles including the use of personal protective equipment (PPE). All wards we visited had access to hand sanitising gel, and we observed staff regularly washing their hands or using gel. All staff we observed, followed the trust policy of arms being 'bare below the elbow' and wore PPE. We saw clear guidelines on doorways of individual rooms or bays to describe the infection risk within that area and the type of PPE which should be worn. There were good quantities of PPE available, including gloves and aprons. Staff told us there had been shortages of some PPE in March 2020, at the beginning of the COVID-19 pandemic, but these were quickly resolved, and PPE was readily available thereafter.

Staff tested patients for COVID-19 and all patients had a 'COVID-19 passport' at the front of their paper record. This document showed the results of COVID-19 testing on days one, three, seven and 14 in line with trust policy. Staff used a colour-coded system which was used for patient notes, an electronic patient whiteboard system and to label patient isolation rooms. Staff discussed patient's infection status as part of handover meetings.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used green 'I am clean' stickers to label when equipment had been cleaned. We saw this used in all wards we visited.

Environment and equipment

The design, maintenance and use of facilities and equipment mostly kept people safe. However, the use of premises outside of their intended purpose could compromise patient care and privacy. Staff mostly managed clinical waste well.

The design of the environment followed national guidance in most ward areas. However, the endoscopy unit, based in Queens Day Unit, did not meet the requirements of the Joint Advisory Group on GI endoscopy (JAG). For example, while 'clean' and 'dirty' areas (used for decontamination of equipment) were separated, access to 'dirty' areas was not restricted.

Patients could reach call bells and staff responded quickly when called most of the time. We observed staff responded to calls bells within good time on most wards. However, we did note two occasions where call bells were not answered for over five minutes. We also observed where patients were in 'boarding beds' (an additional bed in a bay used in times of demand) patients did not always have access to call bells. We raised safety concerns about this at the time of the inspection and the trust took action to review all 'boarding beds' and ensure patients had access to call bells.

Staff carried out daily safety checks of specialist equipment. Tamper evident resuscitation trolleys were checked on a daily basis to ensure they were stocked, and items were within their use by date in order to respond to emergencies. We found all checks we reviewed were completed daily. Records showed the name of the member of staff who had checked the equipment, the date and signature.

The service had suitable facilities to meet the needs of patients' families. For example, the stroke unit had a room that patients' families could use. Visiting had been restricted during the COVID-19 pandemic. Some wards had reintroduced visiting in line with government guidelines, this was limited to one nominated visitor at any time within a four bedded bay.

The service mostly had enough suitable equipment to help them to safely care for patients. Physiotherapy staff we spoke with confirmed they had good access to equipment, including when the rehabilitation gym was closed during the COVID-19 pandemic. We were told about a lack of cardiac monitors on specialist wards. The issue had been escalated, was recorded as a risk on the divisional risk register and monitors had been ordered.

We saw equipment was clearly labelled as being ready to use and dates of the next service were noted on the equipment. We checked a number of pieces of equipment throughout the hospital and saw they were within service date.

Staff mostly disposed of clinical waste safely. We saw clinical waste was separated and disposed of safely on most wards we visited. However, we saw clinical bins were left open in some areas. On ward A800 we saw two bottles of urine left unsupervised in a human waste disposal machine for several minutes. This could pose an infection risk.

Substances hazardous to health were not always kept securely. We saw examples where sluice doors were closed but not locked, despite having key code systems to be able to secure them. In one unlocked sluice we saw substances hazardous to health were inside. We found 16 tubs of chlorine releasing disinfectant on a shelf, which had the potential to cause harm if ingested. We raised this safety issue with the trust at the time of the inspection.

The use of the premises could compromise patient care and privacy during times of increased demand. The trust was using additional beds put into bays to accommodate increases in demand. This process was known as 'boarding'. We saw this happening on a number of wards. We were told by the divisional leadership team there were 28 'opportunities' for boarding patients within the hospital site. The division had taken the decision to undertake 'boarding' as a safer option than opening escalation wards, which they were not able to safely staff.

There was a standard operating procedure for ensuring the boarding of patients took place when certain criteria were met. We did not see any inappropriately placed individuals that did not meet these criteria. However, we saw patients with no access to calls bells or electricity on wards A800 and C805 during the inspection. In spaces where there was no access to electricity, beds were not able to be used to their full function.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients were monitored and assessed using the National Early Warning Score (NEWS2) framework. This was a system of monitoring patient's vital signs, such as temperature, respiration rate, blood pressure and pain. A score was calculated, and actions were advised for nursing staff according to the score. A patient whose condition was deteriorating could be identified and their condition escalated for further medical review. We reviewed 36 patient notes and saw all NEWS2 scores were calculated correctly and escalated appropriately to act on any risk of deterioration.

We saw evidence of patients whose condition was deteriorating being escalated for medical review in line with guidance. For example, records we reviewed showed that an individual had been monitored and their oxygen levels rechecked after 20 minutes, after they had scored highly on NEWS2 due to low oxygen saturation levels.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 36 patient records during the inspection. We saw risk assessments were completed for each patient on admission and were reviewed regularly.

Staff told us risk assessments were easy to complete and there was a booklet where risk assessments could be completed.

Staff knew about and dealt with any specific risk issues. Staff told us there was a clear process to follow should a patient experience a fall and reporting incidences of falls was easy to do.

We saw records which clearly showed risk assessments for patients at risk of developing pressure ulcers. With each risk assessment there was a clear care plan of what needed to occur to prevent ulcers from occurring.

Risk assessments were completed to establish the risk of a patient developing a venous thromboembolism (VTE) this was a condition in which a blood clot forms in a vein, most commonly in the deep veins of the legs or pelvis. Since August 2019, the trust had completed VTE risk assessments electronically using a computer system. This ensured risk assessments could be completed in full, timed, dated and signed accurately by the person completing them and could be accessed at any time.

Staffing

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff an induction. However, staff felt pressured and impacted by ward changes.

The service had enough nursing and support staff to keep patients safe. NHS England collects data on a monthly basis to show staffing levels in relation to patient numbers on inpatient wards within hospitals. This is known as the Care Hours Per Patient Per Day (CHPPD) figure. In December 2020, the trust average CHPPD was 10.32, which was better than the England average of 9.1. The average number of CHPPD for registered nurses within medicine was 6.97, which was better than the England average of 5.46.

The service provided us with information regarding their staffing levels. Within medicine the extent of rota hours filled by registered nurses was 98.6%. The service ensured gaps in rotas were filled with additional support staff, which was reflected in the overall combined rate of filled hours of 102%.

Staff told us staffing levels were pressured during the COVID-19 pandemic with staff being moved between wards regularly. The wards ensured a band six nurse worked on all shifts to provide additional support.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. There was a process for reviewing the required numbers and skill mix of staff needed to safely provide patient care. A nationally recognised tool was used by ward managers to assess the acuity of patients and the number of staff required to care for them. We observed a site meeting during the inspection where matrons provided a live update on staffing levels to the divisional directors. This ensured all leaders within the division had a complete picture of staffing pressures throughout the hospital.

The service had low sickness rates. From September 2019 to January 2021, nursing staff within medicine had an average sickness rate of 4%. This was below the England average and trust overall rates. The most reported reason within medicine for sickness was anxiety, stress and cold or flu symptoms.

Medical care (including older people's care)

The service had low vacancy rates but there was an increase in April 2021. Vacancies were low with under 5% vacancies within specialised services and the medicine division. However, vacancy rates had increased to 9% in the medicine division in April 2021.

The service had low turnover rates. The turnover rates in the medicine and specialised services division were 18% and 12% respectively in April 2021.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Agency staff were used less often than bank staff. When using agency staff the trust would attempt to use the same staff so they were familiar with the service. Data showed agency staff usage for both medicine and specialised services between April 2020 and March 2021, was low with 1% usage. Bank staff usage ranged between 8-11% for the medicine division and 3-6% within the specialised services division.

Staff told us their biggest concerns remained staffing levels. Staff told us they had the numbers of staff they needed, but this often meant bringing in staff from other wards and relying on bank or agency staff. Numbers of expected and actual staffing arrangements were on display outside each of the wards we visited. During the inspection, we saw wards were not always staffed as planned but action had been taken to ensure staffing was safe. For example, we saw ward A800 had one registered nurse under their expected staffing level. However, an additional nursing assistant was available and the nurse in charge was available to support. Staff told us this happened on a regular basis and impacted upon the nurse in charge having less time in a supervisory role.

Nursing staff told us they felt able and supported to raise incidents where they felt the staffing levels on wards were not safe.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff an induction.

The service had enough medical staff to keep patients safe. Data showed there were enough medical staff to keep patients safe. At the time of the inspection, there were 413 full time equivalent (FTE) medical staff employed by the medicine and specialised services divisions against a budget of 401. The service was therefore over their established needs by 3%. However, budgeted targets were being reconsidered as trainee doctors had recently joined the medical divisions from within the trust and this had not yet been taken into consideration.

We saw vacancies of medical staff within several areas of the divisions including dermatology (2.9%), cardiology (2.5%) and rheumatology (2.5%). The highest vacancies were within the ‘care of the elderly’ specialities (3.9%).

Leaders monitored where there were gaps within medical staffing and identified areas of risk. There were rolling recruitment campaigns and staff were being supported to develop into roles. For example, advanced care practitioners and physician associates were supporting stroke services where recruitment had been difficult, and levels of medical staffing presented a risk to the service.

Medical staffing was recorded as a risk on divisional risk registers. A recruitment and retention group had been introduced into the governance structure and reported to the divisional workforce committee. This provided oversight and dedicated planning for recruitment and retention.

Medical care (including older people's care)

Managers could access locums when they needed additional medical staff. The agency usage of medical staff was for 2.86 full time equivalent in April 2021.

Sickness rates for medical staff were low. Medical staff had an average sickness rate of 1.1% and rates were consistently lower than the England and trust overall rates.

The service had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. Some patient identifiable and confidential information was not always stored securely.

Patient notes were comprehensive, and all staff could access them easily. We reviewed 36 sets of patient records and found them all to be up to date and included risk assessments with care plans for risks including manual handling assessments, bedrails and pressure ulcers. Records were stamped by nursing staff to ensure legibility of their name and registration number and then signed. Medical plans were clear, and we saw evidence of observations being taken in line with plans.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff used a computer application which could be accessed on a mobile phone or tablet device to be able to record observations of patients and to raise tasks with other specialisms such as pharmacy or dietitians.

Some patient identifiable and confidential information was not always stored securely. Paper records on wards were kept in locked trolleys or within locked rooms where only staff had access. Mostly staff were observed to be careful to maintain confidentiality of paper records. However, we saw one occasion on ward A524 where a handover sheet with confidential patient information was left unsupervised.

We observed personal information was visible to other patients on ward A400. For example, a whiteboard in front of a nurse station had details about a patients' plan of care, diagnosis and mental health needs. This was raised at the time of the inspection with the matron and the nurse in charge and changes were made to the whiteboard to ensure confidential information was removed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when prescribing, administering, recording and storing medicines. Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours. Staff were well-informed of this and knew the routes to contact pharmacy at all times of the day. Medicines supply was available out of hours by searching a database to identify stock within the hospital or via the pharmacy robot. Nurses used patient group directions to administer some medicines.

Where patients had specific medicines administration needs, these were clearly documented and staff followed protocols to administer medicines safely, for example via a feeding tube.

Medical care (including older people's care)

Patients on wards were supported to self-administer their medicines if a risk assessment showed it was safe for them to do so. Patients waiting to go home in the discharge lounge were encouraged to self-administer medicines to promote independence. A carer or family member could also assist patients to take medicines while waiting to go home. Any medicines administration in the discharge lounge was recorded on patients' prescription charts.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

All patients records we checked had an assessment for venous thromboembolism (VTE) and were prescribed a prophylactic medicine when appropriate. Records for one person showed that pharmacy had asked for a review of VTE prophylaxis the previous day and this had not been actioned by medical staff. We asked the ward pharmacist and they said the person was not being discharged with this medicine, so review was not urgent.

Staff provided counselling to patients and/or their carers to explain changes in medicines or when new medicines were started. Patients were provided with summaries of their medicines at discharge that showed all changes, new medicines and dates when any current medicines should be stopped.

Staff provided support to patients to inform them about their medicines, allow them to raise concerns and ask questions. Staff took account of patients' personal, cultural and religious needs. People were supported to continue taking over the counter or complementary medicines if they were safe to do so.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. On the wards, medicines were stored in dedicated secure storage areas with access restricted to authorised staff. Medicine trolleys and patient's bedside lockers were also used. We checked storage arrangements on four wards we visited and found medicines, including emergency medicines, were stored safely and securely.

Prescription stationary was stored securely, and its use tracked appropriately.

Antibiotic audits demonstrated that the trust was mainly compliant with prescribing in line with national and local guidance. However, the reason for prescribing an antibiotic was not always recorded on prescription charts.

Staff followed current national practice to check patients had the correct medicines. We looked at electronic medicine records for 14 patients in the hospital. Medicines reconciliation was initiated in the emergency department by a pharmacist prescriber and completed within the medical admissions unit. We identified one prescription for an antibiotic where the clerking proforma said the patient was allergic to this group of antibiotics. We highlighted this to the ward pharmacist who checked previous admission records and spoke with the patient. A recording error had been made on the clerking proforma and the pharmacist amended this record, but this had not been identified prior to prescribing the antibiotic.

Pharmacists in the medical assessment units joined the multi-disciplinary team meetings to ensure they were aware of patients taking high risk medicines.

Medicines issues that might affect discharge were identified early, for example people who would need a medicines compliance aid at discharge. This improved the flow of patients through the hospital, medicines were dispensed at the time of discharge and therefore delays to discharge were proactively minimised.

Medical care (including older people's care)

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The trust acted rapidly to ensure patients were kept safe considering alerts or highlighted risks. The Medicines Safety Officer ensured that procedures were amended in line with any National Patient Safety Agency alerts and changes in guidance.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We did not see any patients being given medicines hidden in food or drink (covert administration), however, staff could explain the requirements of the Mental Capacity Act (2005) and how patients would be assessed, and best interest decisions made. Pharmacy advice was available to make sure if medicines were given covertly, they were safe and would be effective.

When a medicine was administered to manage agitation or aggression (rapid tranquilisation), a policy was in place to enable medicines to be appropriately prescribed and monitored. Staff we spoke with understood the requirements within the policy.

We reviewed the records of some patients living with dementia, or people with a learning disability. No patients were prescribed psychotropic medicines to control their behaviour.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. All staff we spoke with told us there was a strong learning culture and staff were actively encouraged to report incidents in order to support learning and improvement. There was an application on the desktop computers to allow for staff to report incidents quickly and in a timely way.

Staff raised concerns and reported incidents including serious incidents and near misses in line with trust policy. Between 1 January 2020 to 12 May 2021 the most reported incidents for medicine were patient accidents (16%), 7% more than reported trust wide. For the same period implementation of care and ongoing monitoring / review (15%) and medication incidents (12%) were the second and third most reported incidents within medicine. Percentages remained similar to the corresponding period in 2019/20. Most incidents over this period were reported to have caused no harm (76%) or were classified as low harm incidents (21%).

The Serious Incident Framework, 2015 stated that an incident should be considered as a serious incident (SI) if a patient's death was unexpected or avoidable which was contributed to or caused by weakness in care or service delivery. From April 2020 to April 2021, the UHBW Bristol Main Site location reported 18 serious incidents within medicine**.** The most reported incidents at Bristol Royal infirmary were health care associated infections or infection control incidents meeting SI criteria, eight incidents 44% of all incidents reported for this site , pressure ulcer meeting SI criteria, five incidents (28%) and slips/trips/falls meeting SI criteria four incidents (22%).

From January 2021 to June 2021, the trust reported zero never events in specialised services or medicine divisions at UHBW Bristol main site. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Medical care (including older people's care)

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with demonstrated a clear understanding of the duty of candour and discussed how they would be open and honest with patients. The duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.

Staff met to discuss the feedback and look at improvements to patient care. Staff we spoke with told us learning from incidents was discussed at morning 'safety huddle' meetings and details of learning shared across the trust through emails and debriefs. For example, infection prevention and control leads for both the medicine and specialised services divisions told us there had been some lapses in infection control practices that were highlighted through incident reporting. The leads went back to staff to discuss feedback around this and engaged staff with teaching sessions and quick access guidance. Practice was seen to improve as a result.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The trust had an incident reporting policy which outlined the roles and responsibilities of those investigating incidents. We viewed meeting minutes where incidents were discussed, and actions taken to share learning.

Managers debriefed and supported staff after any serious incident. We were told of situations where support was offered for staff to debrief after a patient death with emotional and occupational health support provided. Managers provided emails to members of staff who had raised concerns outlining a response and actions taken.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. The service audited the prevalence of patient harms such as pressure ulcers and falls to analyse and monitor their performance. We saw the service used a healthcare governance application to carry out safety audits on wards in order to monitor their performance. A quick response (QR) code was displayed at the entrance of wards we visited. Patients, staff and visitors could use any smart device such as a tablet or mobile telephone to access the results.

Staff used this information to improve services. We saw the trust held a performance dashboard, which enabled each division to report their audit and quality information on a monthly basis.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Medical care (including older people's care)

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies, care and treatment pathways, and clinical protocols had been developed in line with national best practice recommendations. These included the National Institute for Health and Care Excellence (NICE) guidelines and quality standards.

Policies were available to all staff on the trust intranet system and staff demonstrated they knew how to access them.

The trust conducted audits to ensure NICE guidelines and quality standards were being followed including:

- CG103: Delirium: prevention, diagnosis and management
- CG161: Falls in older people: assessing risk and prevention
- CG184: Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management
- NG89: Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients told us food was of a good quality. One patient told us food choices were available, meals were “well cooked and nicely presented”. Housekeeping staff on one ward told us they had been working with dietitians in the trust who usually work with patients with a cancer diagnosis whose sense of taste had been affected by treatment. They used this information to provide snacks for patients who had lost their taste due to COVID-19. They provided salty crisps, milkshakes and smoothies to support those affected, to eat and drink.

We observed nursing teams supporting housekeeping staff to provide meals and food was served hot. Mealtimes were ‘protected’, so visiting times were at a different time to food being served to encourage people to eat in a calm environment without distraction.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. A malnutrition universal screening tool (MUST) was used by the trust to determine individual hydration and nutritional risks. This was completed on admission and once a week thereafter. We saw clear information on diet types were maintained on patient doorways and whiteboards. Where patients were not eating or drinking well, we saw fluid and food charts were being used.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. We reviewed 36 patient records and saw fluid and nutrition charts completed accurately including where specialist feeding, and hydration techniques were needed. In records we viewed we noted there were times where no running total of fluids was added. While not unsafe, this meant more time was needed for staff to determine input and output.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff told us specialists could be referred to easily through the trust computer systems. We saw documentation completed by dietitians who had prescribed a clear dietary regimen. The name and registration number of the dietitian were clear and legible.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. A nationally recognised tool was used to assess patients' pain. In addition to this, the Abbey Pain score was used for patients who were unable to communicate their experience of pain verbally. The tool was based on using facial expressions and body language to determine pain levels. We saw staff making observations and completing pain assessments regularly on all wards we visited.

Patients received pain relief soon after requesting it. Patients told us and we observed staff on all wards asking about levels of pain and assessing patient comfort levels. Patients told us they received medication promptly and were not left in pain.

Staff prescribed, administered and recorded pain relief accurately. Staff discussed patients pain management needs during handovers to ensure pain was managed appropriately. We reviewed 14 patients' medical records and found pain relief to be appropriately prescribed and recorded accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under some relevant clinical accreditation schemes but had not achieved the standards for endoscopy services to be accredited by the Joint Advisory Committee.

The service participated in relevant national clinical audits. The National Clinical Audit & Patient Outcome Programme (NCAPOP) was mostly suspended during periods of the COVID-19 pandemic. Members of the trust clinical audit and effectiveness team were re-deployed to support other key services. Due to the challenges of the pandemic, audit work had been limited in 2020 and the team were starting to resubmit audits to establish their latest benchmarks at the time of inspection.

The trust had purchased a new project management system to manage and track audits. There were plans to streamline processes for assurance against national guidance. The system commenced in May 2021.

The service was able to benchmark against the following national audits, and performance in most audits was in line or above national averages:

- Myocardial Ischaemia National Audit programme published in July 2020, showed the hospital was meeting the national standard for proportion of patients receiving all appropriate secondary prevention medications and for the rate of referral to a cardiac rehabilitation programme after discharge.
- The Heart Failure Audit published in July 2019, showed the numbers of inpatients admitted with heart failure who received input from the specialist team and those discharged with medicines for their condition was better than the national average. However, the number of patients who received cardiology follow up was worse than the national average.
- The National Prostate Cancer Audit published in March 2021, showed the percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following radiotherapy was within the expected range.

- The National Bowel Cancer Audit, published in December 2020, showed indicators were in line with expected levels. The post-operative length of stay (more than five days) after a major resection was favourably comparable (63%) with the national aggregate (62%). The National Lung Cancer Audit published in September 2019, showed four indicators were within the expected range. However, the proportion of patients seen by a cancer nurse specialist (83%) was below and therefore worse than the national standard of 90%.
- Stroke services submitted data to the Sentinel Stroke National Audit Programme (SSNAP) 2019 audit and had a score of B overall. We spoke with the consultant stroke lead for the service and were told the data showed there was progress to be made with direct admission to stroke services within four hours and seven day working. Improvement work was ongoing.

The Bristol Haematology Centre was accredited by the Joint Accreditation Committee of the International Society for Cellular Therapy and the *European* Group for Blood and Marrow Transplantation. This was Europe's only official accreditation body in the field of stem cell transplantation and cellular therapy. It promoted high quality patient care and medical and laboratory practice through a voluntary accreditation scheme.

The endoscopy service was not accredited by the Joint Advisory Group (JAG) at the last visit in 2019. The main challenges related to the environment. The service needed to continue to work towards JAG accreditation and completed twice yearly submissions to JAG and completed the necessary audits.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Audits were completed which fed into a divisional dashboard to provide assurance to the trust board.

Competent staff

The service mostly made sure staff were competent for their roles. Managers did not always provide an appraisal of their staff's work performance. Staff did feel supported in opportunities to develop.

Managers gave most new staff an induction, but the content and length of induction programmes had been impacted by the COVID-19 pandemic. Medical staff did not always receive an induction, with a 74% completion rate in both medicine and specialised services divisions. We saw this was rated by the division as being below their expected threshold.

Data showed nursing staff in both the specialised services and medical divisions received an induction, with 100% compliance in medicine and 91% compliance in specialised services. This was above the trust expected threshold.

We heard concerns from staff regarding induction for new starters, in particular for health care assistants. We were told during the COVID-19 pandemic the induction process had been reduced with time restraints impacting upon the ability of new staff being able to ask questions. This could impact upon patient safety, as staff may not be fully prepared for their role. However, we spoke with one member of staff who had recently started working for the trust who was positive about the support they had received during their induction period. Managers of the endoscopy service had worked to improve their induction training programme by organising competencies into three stages for staff to work through.

Staff did not always receive regular appraisal by their managers. Appraisal rates for nursing staff in both divisions did not meet the trust target. Appraisals had been impacted by the increased demands of the COVID-19 pandemic. NHS England had provided guidance to NHS trusts to pause appraisals between January 2020 to July 2020, and between 5 November 2020 to 25 March 2021 in order to respond to the pandemic.

Medical care (including older people's care)

During the period May 2020 to April 2021, appraisal rates for non-consultant staff in the specialised services division varied between 72-82%. In the medical division appraisal rates for non-consultant staff varied between 52-57%, which was significantly below the trust target. Nurses we spoke with were positive about the appraisal process and told us they were also able to discuss training needs outside of the formal, annual appraisal.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. We were told about the trainee nursing associate role where band three staff were supported to reach band four, and from there had the option to receive training to become registered nurses. Staff told us this was a good initiative which boosted morale.

The trust employed practice education facilitators to support staff to continue to learn within their own divisions and services. We saw there were practice educators in cardiology, respiratory and endoscopy services. These individuals supported new starters and provided bedside training.

Medical staff were positive about the support they were given to develop and learn. Medical staff told us they felt very well supported in both their training and non-training roles. Consultants were available and gave opportunities for speciality learning and mentoring.

Doctors in training (trainees) told us there was a good mix of registrar and consultant led teaching sessions. All trainees were allocated a named educational and clinical supervisor. Trainees were informed of this allocation at the start of their placement and retained their educational supervisor throughout the placement. A clinical supervisor was assigned each time they moved to a new speciality within the placement.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Nursing, medical and therapy staff worked together well and were all involved in the support and treatment of patients to improve their care. We observed board rounds throughout the service, which included discussions amongst members of the whole multidisciplinary team to support patients. For example, during a meeting we saw discussion around a patient who was awaiting discharge, where an occupational therapist gave updates on equipment needs as well as discussion of another patient where there were safeguarding concerns to be considered.

Staff worked across health care disciplines and with other agencies when required to care for patients. However, there were concerns about access to social work support. We saw evidence of multidisciplinary working throughout the inspection. Care records we reviewed demonstrated clear management plans by medical staff as well as involvement from the wider multidisciplinary team. We observed conversations taking place on wards between diabetes nurse specialists, pharmacists and psychiatric liaison staff.

Staff told us they worked well across disciplines and all staff were “open, helpful, and patient focused”. Staff on the haematology ward told us multidisciplinary working was “exceptional”, communication was good and patient care needs were escalated in good time.

Medical care (including older people's care)

Staff raised concerns about a lack of social work presence on the wards. In response to the COVID-19 pandemic, the local authority had made the decision for social work staff to not attend the wards. This had increased the workload of nursing and therapy staff and impacted upon patient discharge. There was a worry this could impact upon outcomes for older people in particular.

Staff referred patients for mental health assessments when they showed signs of mental ill health. The psychiatric liaison team could be accessed by ward staff. Drug specialist nurses also supported with discharge planning for patients with substance misuse issues. This specialist nurse team of four nurses worked across the hospital, Monday to Friday.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Consultants led daily ward rounds on acute wards. Patients were reviewed by relevant consultants depending on the care pathway. All patients had a clinical assessment once admitted by a consultant or registrar. This was undertaken within 12 hours.

We observed board rounds on a number of wards, which took place at 9am each morning. We saw consultants, doctors, therapists and nursing staff were all in attendance. We saw discharge plans being discussed with clear plans and members of the team were able to communicate freely.

Patients who were not being cared for on the correct speciality ward for their presenting complaint (known as outliers) were seen by a consultant from the outlier team. This team tracked patients using the trust computer system and visited these patients as a matter of priority wherever they were within the hospital. We visited these patients at the time of the inspection and found they were reviewed by the outlier team in a timely manner.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests but these were not always available 24 hours a day, seven days a week. Therapy services on respiratory wards were available on-site Monday to Friday and were on call over the weekends.

Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours.

The endoscopy service provided an out of hours response for patients who may experience a medical emergency overnight or at the weekend.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. Staff provided health promotion information for patients on all wards we visited. For example, on the haematology and oncology wards we saw information about lifestyle changes as well as infection control in light of COVID-19.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff assessed each patient when admitted and reviewed aspects of health that created risks and looked at what support was available. Patients had access to a drug and alcohol specialist team where patients that were reliant on alcohol or other substances were supported to safely withdraw, using a symptom trigger chart. Medicines prescribed to support withdrawal were reviewed by a pharmacist.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limited patients' liberty appropriately.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. The trust had policies regarding consent, assessment of mental capacity and the use of deprivation of liberty safeguards. Staff told us they were aware of these policies, and we saw evidence of completed mental capacity assessments in care records we reviewed.

We saw patients were given the opportunity to ask questions about their care, staff assessed their understanding and supported patients to make informed decisions about their care.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Nursing staff knew their responsibilities in terms of what action should be taken if a person did not have the capacity to make decisions about their care. Staff were aware of the need to make a written record of mental capacity assessments and to make best interest decisions in line with legislation.

There was a frustration that the local authority would only accept mental capacity assessments and applications for the authorisation of deprivation of liberty safeguards from medical staff. This was not in line with the Mental Capacity Act 2005 and nursing staff were often better placed to undertake these assessments. We were told this had potential to delay applications and increased workload for medical staff.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, mostly respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Patients we spoke with told us they felt well looked after and call bells were responded to promptly. One patient told us they could "not fault" the care staff who were all "very helpful" and they were "treated with respect".

Patients said staff treated them well and with kindness. We observed a patient being discharged who was very grateful and clearly had developed a good relationship with those caring for them. A number of nursing staff came to wish the individual well and this appeared to be a genuine and positive interaction.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed a health care assistant ask if they could check an individual's blood pressure and explained to them what they would be doing. They also used this time to speak with the patient about any pain or discomfort they may be experiencing.

Medical care (including older people's care)

Staff followed policy to keep patient care and treatment confidential most of the time. During the inspection we saw staff lowering their voices and using curtains to maintain confidentiality when providing patient care. However, we saw patients using an additional bed added to a bay were not always afforded privacy. We saw a conversation between a patient and a medical staff member, which could be overheard by other patients due to the lack of space. There were also no privacy screens used around the bed at the time of the conversation. We were told by staff temporary privacy screens were usually available.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. During the inspection we observed a patient waiting to have a procedure. We saw staff providing reassurance, talking with them and keeping them updated on what would be happening.

We saw numerous examples of staff providing reassurance to patients who may need additional support. For example, walking with patients who may have mental health needs to ensure their safety and minimise any distress.

All staff we spoke with were aware of Enhanced Care Observations to provide one-to-one support for those people with complex needs. Staff saw the benefit of having this support, in terms of being able to monitor and understand an individual's behaviour to be better able to provide individualised care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed board rounds on a number of different wards and saw staff discussed the entirety of the needs of patients including physical, social and emotional. We heard from staff how the emotional needs of older people in particular were being considered and the impact of bed moves on their recovery was well understood.

The trust had a department of spiritual and pastoral care where people of all faiths, or none, could access spiritual support from members of a team who covered a range of religious faiths and traditions. The team provided a 24-hour service in conjunction with two local NHS trusts. There were a number of multi-faith 'sanctuaries' on the Bristol main site where people could access a quiet space for contemplation or prayer. These were based in the Haematology and Oncology centre and Bristol Royal Infirmary hospital.

Staff were conscious of the impact of visiting restrictions on patient's wellbeing. Staff were aware of the need to make exceptions, for example patients at the end of their life or with additional needs. Staff supported patients to speak with relatives over the telephone and were glad to receive more visitors when restrictions had been lifted.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us they had dealt with very difficult situations during the COVID-19 pandemic and they had developed increased empathy with patients. Several staff had contracted COVID-19 and understood patient's experiences and anxieties.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff talked about patients compassionately and with knowledge of their circumstances and those of their families. A patient told us they felt well looked after and their needs were fully met, with additional support provided for eating and showering.

Medical care (including older people's care)

Staff told us they supported families who were unable to visit during the COVID-19 pandemic. This was especially difficult for those patients reaching the end of their life where families were unable to be with them. Staff were compassionate and provided emotional support and reassurance they would care for patients in the absence of family or friends.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients told us there were clear plans for their care and staff kept them informed about any changes. We saw a nurse explaining to a patient why and how a dressing change to a wound would be provided and gave the patient the opportunity and time to ask questions. We also saw on numerous occasions nursing staff contacting families to give updates on their relative's progress. For example, we saw a health care assistant giving a detailed update on a patient's condition and well-being to a family member over the telephone in a polite and friendly manner.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff were aware of the types of communication aids that could be used to support patients. Staff were clear about how to access interpreting services and where to go for additional support if needed. Patients told us staff were clear when speaking with them and they could understand what care and treatment was being provided.

Staff supported patients to make informed decisions about their care. We saw a patient being supported in their choice of treatment. The individual was provided with information about the types of treatment available and why a certain treatment would be beneficial. On being given this information they made the decision to refuse treatment. They told us they felt supported in their ability to make this decision and their wishes were respected.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust used a national patient survey run by NHS England called the Friends and Family Test, to gather feedback on the service. The national survey was paused in February 2020 due to the COVID-19 pandemic but relaunched on 1 December 2020. From December 2020 to May 2021, the medicine division had received 1862 responses. The results were positive with a high percentage (95.8%) of those asked stating they would recommend the hospital.

The trust also carried out their own patient experience survey. The service asked patients for their feedback on the kindness and understanding showed by staff and scored positively between 92-99%.

Patients gave positive feedback about the service. All patients we spoke with were positive about the service they had received. One patient told us their care had been "excellent" and another that the nurses and doctors had been "very professional" and their experience had been "great".

We saw a number of wards displaying thank you cards on their walls. We saw personal messages of thanks from patients who felt they had received good care. One read "you all do such an incredible job. You are all amazing".

Is the service responsive?

Good ➔➔

Medical care (including older people's care)

Our rating of responsive stayed the same. We rated it as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Managers worked with the wider health care system to plan care and deliver services. The clinical site team held daily meetings with the clinical commissioning group, a local ambulance trust and a local acute hospital trust within the area to understand demand and to request or offer mutual aid.

The stroke service consultant lead was working closely with local commissioners and the wider system. There was a public consultation on the future of hospital-based stroke services at the time of inspection. The stroke service consultant lead was positive about providing timely access to stroke services at the hospital. They felt they had the support from the trust board.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We saw patients were cared for in either female of male bays wherever possible. There were some areas, when used in escalation, that did not allow for this. For example, in times of increased demand the endoscopy unit was used as an escalation area to provide beds for patients. Despite having access to separate toilet facilities at either end of the ward, the ward could not be guaranteed to provide single sex accommodation. The service reported when this area was required and when a mixed sex breach occurred. This was not in use at the time of the inspection.

Facilities and premises were mostly appropriate for the services being delivered. Most ward areas we observed were appropriate for the care being provided. They had adequate space and access to equipment. However, the hospital was challenged in terms of the size of the building, to meet the demand for services. As a result, some services were delivered in areas outside of their intended use. For example, patients who were cared for in an additional bed (boarding), did not always have access to electricity or calls bells. Privacy was impacted and should a patient require urgent treatment some bays were not large enough to accommodate emergency equipment.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health needs, learning disabilities and dementia. There were arrangements for staff to access urgent mental health support. Staff told us they knew how to request services and there was not an issue with accessing these in a timely manner.

The service relieved pressure on other departments when they could treat patients in a day. We saw initiatives within specialities to support patients who could be safely discharged from the service. Cardiology leads told us there were plans for suitable patients to be discharged within 24 hours with remote rehabilitation support. The frailty team included a consultant, nurses and a pharmacist to support older people to prevent admission or support timely discharge wherever possible.

The service had systems to help care for patients in need of additional support or specialist intervention. Specialist nurses were available to ensure additional support or intervention was provided. For example, we saw diabetes and substance misuse specialist nurses being accessed for support and present on wards we visited.

Meeting people's individual needs

Medical care (including older people's care)

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health needs, learning disabilities and dementia, received the necessary care. Staff completed dementia care training during their induction to the service. Staff we spoke with, especially on speciality wards caring for older people, were understanding of the needs of patients living with dementia. We saw boards with resources for staff and patients to support good practice in working with those living with dementia. For example, an emphasis on getting patients dressed and out of their pyjamas to mentally prepare people for discharge.

We saw a gastroenterology ward which was a dedicated 'young person friendly ward'. The adaptations to the ward had come about through a piece of work around transitions with the children's hospital for young people aged 16-17. This ward supported younger adults with eating disorders or mental health needs and recognised the unique support these individuals required.

Wards were designed to meet the needs of patients living with dementia. We observed clear signage throughout patient areas on wards. For example, pictures as well as words being used to show where toilets were located.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us they were able to access translation services easily. Staff were able to give examples of where they had requested clear masks to be able to communicate effectively with people who relied upon lip reading. Staff in the discharge lounge described how they supported patients who may need translation services or other reasonable adjustments to support communication, including providing advice on medicines.

The service had information available in languages spoken by the patients and local community. Patients had access to information in a language they understood. Information was available on the trust website in several languages used by the local community.

Staff supported patients living with a learning disability by using patient passports. We reviewed 36 records and found examples of hospital passports being used for people with a learning disability, to support their care when an inpatient. One record showed a person with a learning disability was referred to the trust's learning disability and autism team within 48 hours of admission. The hospital passport for this patient identified their communication and support needs. It also documented their need to be supported to take their medicines by a close family member whom they trusted. This allowed staff to be aware of individual needs and ensure care was personalised.

Access and flow

People could access the service when they needed it and received the right care promptly. The percentage of people receiving treatment within 18 weeks from the time of referral was mostly above and therefore better than the national average.

Managers and staff worked to make sure patients did not stay longer than they needed to, but delays did occur. From February 2020 to January 2021, the average length of stay for medical elective patients at Bristol Royal Infirmary was 4.5 days, which was lower than the England average of 6.7 days. For medical non-elective patients, the average length of stay was 6.9 days, which was higher than the England average of 5.9 days.

Patients in cardiology stayed on average 1.3 days longer compared to the England average. General medicine had a longer length of stay compared to the England average, by 1.2 days.

Medical care (including older people's care)

Some patients stayed longer than needed despite work being undertaken to reduce lengths of stays. For example, from April 2020 to March 2021, there was a loss of 644 bed days to the trust in medicine and a further 104 bed days lost in the specialised services division where patients had experienced a delayed discharge from hospital. This created days when beds were not available for patients coming into the hospital.

In response to the COVID-19 pandemic, social work staff from the local authority were no longer present on the wards. Staff felt this impacted upon their workload and ability to discharge patients in a timely way to the most suitable care.

We observed discharge planning was discussed during handover meetings and the discharge lounge was well used. Staff from the lounge visited wards to support the discharge of patients every morning.

Staff tried to avoid moving patients between wards at night, but this did occur in times of increased demand. Staff told us they were aware this was against trust policy and reported when this did occur as an incident so it could be monitored. We were told of examples within the last month where patients who were living with dementia had been moved late at night.

Managers worked to keep the number of cancelled treatments to a minimum. Data showed operations cancelled by the hospital at the last minute occurred in less than 1% of cases.

Managers made sure they had arrangements for medical staff to review any medical outlier patients. An ‘outlier’ team made up of medical staff including consultants, were responsible for reviewing medical patients who were being cared for on non-medical wards. Patients were ‘tracked’ on the trust computer system to make it clear where an individual was in an outlying bed. We visited patients who were identified as being cared for on non-medical wards and saw they had all been reviewed promptly by medical staff.

Managers worked to minimise the number of medical patients on non-medical wards. During the inspection we saw there were 16 patients across the trust in an outlying bed and five patients were ‘boarding’ (an additional bed used in a bay).

A clinical site team managed flow throughout the hospital and met regularly during the day to ensure oversight of patient numbers and staffing levels. The clinical site team also liaised with a local trust, ambulance service as well as the local clinical commissioning group on a daily basis, to monitor demand and gain support from the wider healthcare system.

The trust had an escalation policy and a number of standard operating procedures to support safety at times of high demand. We saw standard operating procedures were clear that patients in boarding beds or on escalation wards, should have access to specific equipment and not stay in those beds for longer than 48 hours. However, we saw patients who had been in these beds for up to five days, which was not in line with procedure.

Staff noted they felt escalation and the use of additional beds had become “the norm” and the procedures needed to be reviewed to ensure demand was managed safely.

During the COVID-19 pandemic many wards were repurposed to manage demand on the service. In particular this had led to the loss of a dedicated admission area for the care of older patients. Care of the elderly beds had also been reduced to 58 from 75 beds. Staff were aware this may lead to increased lengths of stay for people due to the likelihood of bed moves and increased delirium impacting upon discharge. Divisional leaders were aware of these risks and were in the process of developing a business case to request the reinstatement of a dedicated area.

Medical care (including older people's care)

The percentage of people receiving treatment within 18 weeks from the time of referral were mostly above and therefore better than the national average. From March 2020 to February 2021, four specialties were above the England average for admitted referral to treatment time (percentage within 18 weeks). These were; general medicine, rheumatology, thoracic medicine, gastroenterology and dermatology. One specialty, cardiology, was below (47.8%) and therefore worse than the England average (68.6%). Waiting times nationally had been affected by the COVID-19 pandemic.

The number of patients waiting longer than 52 weeks for treatment increased from April 2020 to March 2021. Cardiology and gastroenterology had the highest numbers of patients waiting for treatment.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they felt safe and able to raise any issues with staff on wards.

The service clearly displayed information about how to raise a concern in patient areas. Information about making complaints was available in all areas we visited. We saw posters were available in all departments. The trust website had links to information about how to resolve concerns and how to make a complaint. Patients could use an online enquiry form, email, telephone or in writing. However, the face-to-face 'drop in' service was stopped in line with COVID-19 restrictions.

Staff understood the policy on complaints and knew how to handle them. There were policies and processes to appropriately investigate, monitor and evaluate patient's complaints.

Managers investigated complaints and identified themes. The service monitored complaints and identified themes. From May 2020 to April 2021 across the medicine division there had been 385 complaints, of which 120 were formal complaints. Of those formal complaints 58.5% were responded to within the trust timeframe. 4% of patients who had complained were dissatisfied with the response. Within specialised services there was 190 complaints of which 40 were formal complaints. Of those formal complaints 82% were responded to within trust timeframe. 6.38% of patients who had complained were dissatisfied with the response.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff were able to explain the complaints process and told us they would look to support patients to raise a complaint formally if they were unable to resolve the situation in the first instance.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us feedback was given to them regarding any complaints in daily huddles. We saw examples where complaints had been used to inform training and a poster developed to support learning.

Is the service well-led?

Good

Medical care (including older people's care)

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. Not all staff felt the executive team were visible.

The medicine and specialised services divisions were led by a divisional director, a deputy director, a clinical chair, a head of nursing, a lead allied health professional and clinical directors. All posts in each divisional triumvirate (divisional director, clinical chair and head of nursing) were filled and leaders had the skills and abilities to run the service.

Staff told us they received strong leadership from their direct managers, matrons, ward managers and the heads of nursing. Nursing staff told us matrons had based themselves on wards to provide additional support to staff, which was appreciated.

Medical staff felt divisional directors were approachable and supportive. The directors told us they were not as visible across the service during the COVID-19 pandemic as they would have liked, due to competing demands. They had reflected on this and recognised where improvements could be made. Leaders were aware of the challenges facing their services. For example, the loss of beds for older people, in particular the specialist unit being repurposed in response to the pandemic, staffing levels and the challenge to integrate with Weston hospital as part of the recent merger.

Staff told us they received weekly emails from the chief executive but did not feel the executive team were visible. This was particularly felt on wards where there had been changes in response to COVID-19. Staff felt managers “did the best they could” but the situation had been very difficult.

Leaders spoke positively about their staff and told us they recognised the incredible efforts they had made across the trust during the COVID-19 pandemic.

Vision and Strategy

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

Divisional leaders told us the merger with Weston hospital went ahead in April 2020 but the plans to integrate services had been significantly impacted by the COVID-19 pandemic. Plans were put on hold to allow efforts to be focused on the response to the pandemic and integration had not happened as quickly as desired.

Staff told us they had not been impacted by the merger with Weston Hospital. Some staff were not aware a merger had taken place.

All staff were aware of the trust values and told us those values were meaningful for them. We saw the trust values were highlighted on posters and information boards throughout the trust. These were respect everyone, embracing change, success and working together. Staff felt the trust upheld these values.

In May 2021 divisional leads had launched a strategy to improve patient flow and to support staff to become involved through consistent quality improvement methods to support safe and timely patient care.

Medical care (including older people's care)

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. While staff knew how to raise concerns without fear, they were not confident that changes would always be made as a result.

Managers encouraged learning and a culture of openness and transparency. Senior staff agreed that staff or teams would speak up to them when they needed to and would be heard. Staff said they were encouraged to speak up and felt comfortable about raising any concerns. Staff were also aware they could raise concerns about patient care and safety, or any other anxieties they had with the Freedom to Speak Up Guardian. However, not all staff thought that it was worth speaking to the Freedom to Speak Up Guardian as they were not confident this would lead to change.

Staff told us they were well supported by their immediate managers and matrons and were able to raise issues. However, they felt less supported by the executive team and the trust. Staff told us they often experienced low morale as they were not able to provide the level of care they wanted for patients in times of increased pressure. Staff were not convinced the executive team understood the challenges they faced or respected their efforts.

Staff described the months during the COVID-19 pandemic as “horrific”. Staff told us they felt exhausted. Excellent teamworking and support from colleagues were the main reasons they were able to continue. Staff told us they were supported in terms of their wellbeing and debriefs were encouraged by direct managers.

The divisional leadership teams from both divisions recognised the need for staff to be supported to maintain their wellbeing. At the beginning of the pandemic, counselling was available, but the team were aware that wellbeing initiatives needed to be brought to staff on the wards, as there was pressure on time. A wellbeing lead and wellbeing representatives were introduced, and champions were identified on each ward to support staff where it was needed. We saw wellbeing noticeboards were located near staff rooms and posters with quick response barcodes, which staff could scan to access several wellbeing resources.

We heard of positive examples where staff were supported in their own wellbeing. These included debriefs following the death of a patient and staff being supported well if they needed time off or a phased return to work.

We saw staff on ward A400 and A413 were nominated for the “star of the ward” awards. Staff were provided with gifts as a boost to morale.

Staff were passionate about providing the best care to patients. They described how good care could be achieved through care planning and effective risk assessments and were aware of their responsibilities and roles.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and in most areas had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear performance management reporting structure with monthly governance meetings looking at operational performance. This included a review of incidents reported, complaints, staffing, audit status, infection control, risks identified on the risk register and risk management, and education and training.

There was a governance framework and monthly meetings held within each speciality service. These then fed into the divisional quality and patient safety committee, which was held once a month. From this meeting, risks would be escalated to the trust level quality, safety and risk management boards.

We reviewed the divisional level quality and patient safety committee meeting minutes from February to April 2021. Three meetings had been held in that time and the minutes provided a sufficient level of detail to document the conversations that had taken place and the decisions made.

Quality and patient safety committee meetings were well attended by individuals with the appropriate level of seniority for decisions to be made. There was a standard agenda, which ensured discussion of clinical incidents and patient experience, as well as assurance reports from specialities within the divisions.

Not all staff were able to attend team meetings on wards due to time constraints. We were told by a number of staff on different wards there were no formal team meetings held due to time restrictions. Communication folders were used by managers to relay key messages and staff did attend a daily huddle to be able to discuss patient safety issues.

Management of risk, issues and performance

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

The trust had systems for identifying risks and plans to eliminate or reduce them. However, in some circumstance's risks had been identified without sufficient mitigation for long periods of time.

The medicine and specialised services divisions each held a risk register which clearly identified individual risks, control measures and the actions taken to mitigate them. Risks were graded and monitored at monthly meetings.

The service monitored the effectiveness of care, treatment and performance. The service took part in national and local audits and evidence of improvements or trends were monitored. The trust kept a dashboard to monitor performance data. This data was collated to determine the current performance. This information was presented to the trust board to provide assurance.

Since August 2019, the venous thromboembolism (VTE) risk assessment was completed electronically using a computer system. By moving to this format VTE risk assessments were able to be completed in full with the date, time and person completing them recorded, which could be accessed anywhere. Compliance was measured in real time and presented in different formats. Compliance for completion of these electronic documents in March 2021 was 84%, which was below the trust target. We saw evidence this risk was recorded on the risk register, reviewed and actions were being taken to improve compliance.

Staff felt able to raise issues around risk to their managers. Ward staff told us they were aware of specific risks that had been escalated including cardiac monitors that needed to be replaced. Staff told us they had raised the issue; they knew the issue had been acted upon and identified as a risk on the divisional risk register and had been told monitors had been ordered.

The environment on the endoscopy ward had been recorded as a risk since 2016. The poor environment had led to the loss of the Joint Advisory Accreditation. The plans to upgrade this service were part of a long-term strategic capital programme.

Medical care (including older people's care)

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

During the inspection we saw records were kept securely. Paper records were stored in lockable trolleys or in rooms with restricted access. However, we did see some whiteboards which held patient identifiable information with too much detail about individual health needs in ward areas.

Staff could easily access the trust intranet, which provided all policies and guidelines. Staff were able to tell us how they would make referrals to the safeguarding team or other specialists through the intranet.

Information held in the trust electronic system was used by specialist teams. For example, frailty and therapy teams were able to 'track' patients within the hospital and use this to determine who would benefit from their support rather than have to wait for a referral.

Staff told us patient information was clear and records were easy to use. Electronic systems were used to monitor observations, and this provided 'real time' information. This was visible on electronic whiteboards and triggered a need for escalation for any patients whose medical condition was deteriorating.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

In line with guidance from NHS England, the Friends and Family Test was suspended during the COVID-19 pandemic and formal submission restarted in December 2020. 1862 patients had responded to the survey for medical care services in Bristol. Data from December 2020 to May 2021 showed 95.8% of medical care patients would be likely to recommend the service.

There was an awareness of the need for improved well-being and support for staff. A workplace well-being lead had been appointed and the trust were advertising for a well-being screening nurse to provide additional support to staff.

The clinical site team liaised daily with other local hospitals, ambulance services and clinical commissioning groups, to understand demand in the local area in order to support or request support as needed.

A daily briefing was held on all wards we visited however; some wards did not hold formal team meetings in addition to this. They instead held adhoc, informal meetings and used a communication book kept in staff areas to keep members of the team up to date.

Email updates were sent from the chief executive, but staff did not always have the time to read these and staff felt engagement from the executive team could be improved.

The trust took part in the 2020 NHS staff survey. Results showed the trust scored lower than the England average in relation to themes of "quality of care" and "team working".

Medical care (including older people's care)

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff and leaders told us there was a strong commitment to learning and improving services. Staff informed us the pandemic had allowed some positive changes to occur, with new ways of working being developed in a shorter time. There was participation in research trials.

We were told of the following examples of learning and innovation:

- Leaders were introducing a quality improvement approach to improve flow throughout the hospital.
- Practice education facilitators were used within the hospital. The facilitators supported training at the bedside for nursing staff, which included simulation and induction training. The aim of this role was to improve safety and patient care.
- Within cardiology a recovery programme had been developed to allow suitable patients to be discharged from the coronary care unit with 24hours. Patients could be supported to complete rehabilitation programmes in their own home and benchmark their journey with remote support.
- A consultant had set up a cardiac liaison service to enhance the care of older patients in the Bristol Heart Institute. The service was in a six-month pilot at the time of the inspection and a business case was waiting for approval.
- The frailty team were undertaking quality improvement work to determine the impact of frailty assessments on length of stay and outcomes for individuals. The team provided training to medical, nursing and therapy staff to promote an understanding of the needs of older people accessing hospital services.

NHS
South West
Genomic Medicine Service Alliance

South West Genomic Medicine Service Alliance

Prof. Chrissie Thirlwell Clinical Director SW GMSA

University Hospitals Bristol and Weston NHS Trust Board
30th November 21

@SWGenomics

Genomic sequencing linked to NHS long term plan priorities

NHS South West Genomic Medicine Service Alliance

Inherited and rare disease

- Focus on areas of unmet needs and NHS long term plan priority areas
- Rare Mendelian and non-Mendelian disorders

Cancer & clinical trials

- Provide detailed molecular stratification and drive clinical trials in the UK
- New cancer biomarkers

Newborn genomics

- Prospective cohort to assess benefits of WGS for newborn screening
- Expand coverage of under-represented ethnic groups

Pharmacogenomics

- Expand knowledge of gene-drug interactions to improve safety, efficiency and effectiveness of prescribing

New technologies and analytics

- Advanced analytics, artificial intelligence, multi-omics and therapeutic innovation

Towards 5M

700,000 – 1,000,000 whole genomes

NHS Genomic Medicine Service

- Support the transformation of UK healthcare and enable the move to a prevention focussed model
- Provide evidence base and support to expand the use of genomics within the health service e.g. through the annual genomic test directory reviews

The National Genomic Test Directory

NHS South West Genomic Medicine Service Alliance

- The 2020/2021 National Genomic Test Directory specifies which genomic tests commissioned
- For rare & inherited disorders and cancer
- Explains which patients will be eligible to access to a test
- https://www.england.nhs.uk/publication/national-genomic-test-directories/
- Updated in October 2021 with more indications for whole genome sequences

Genomic Medicine Service Alliances

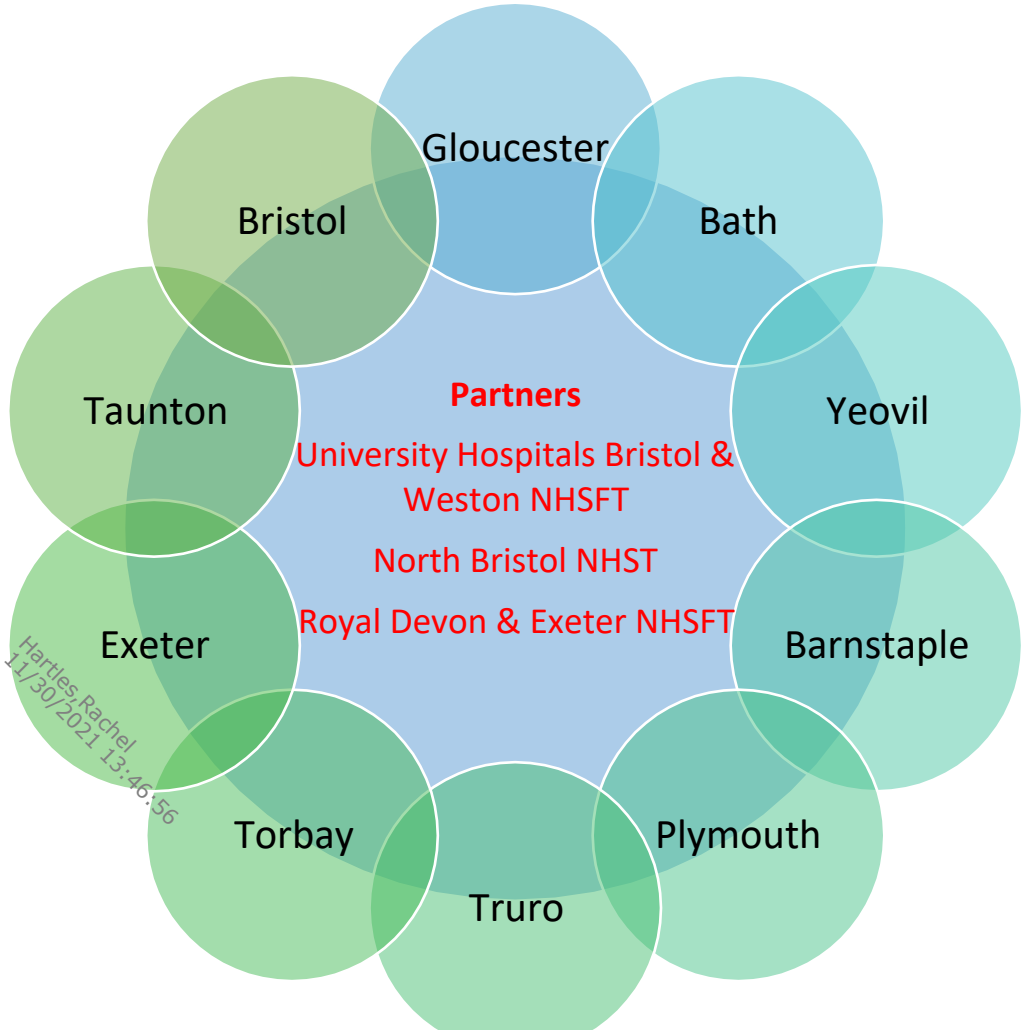
NHS South West Genomic Medicine Service Alliance

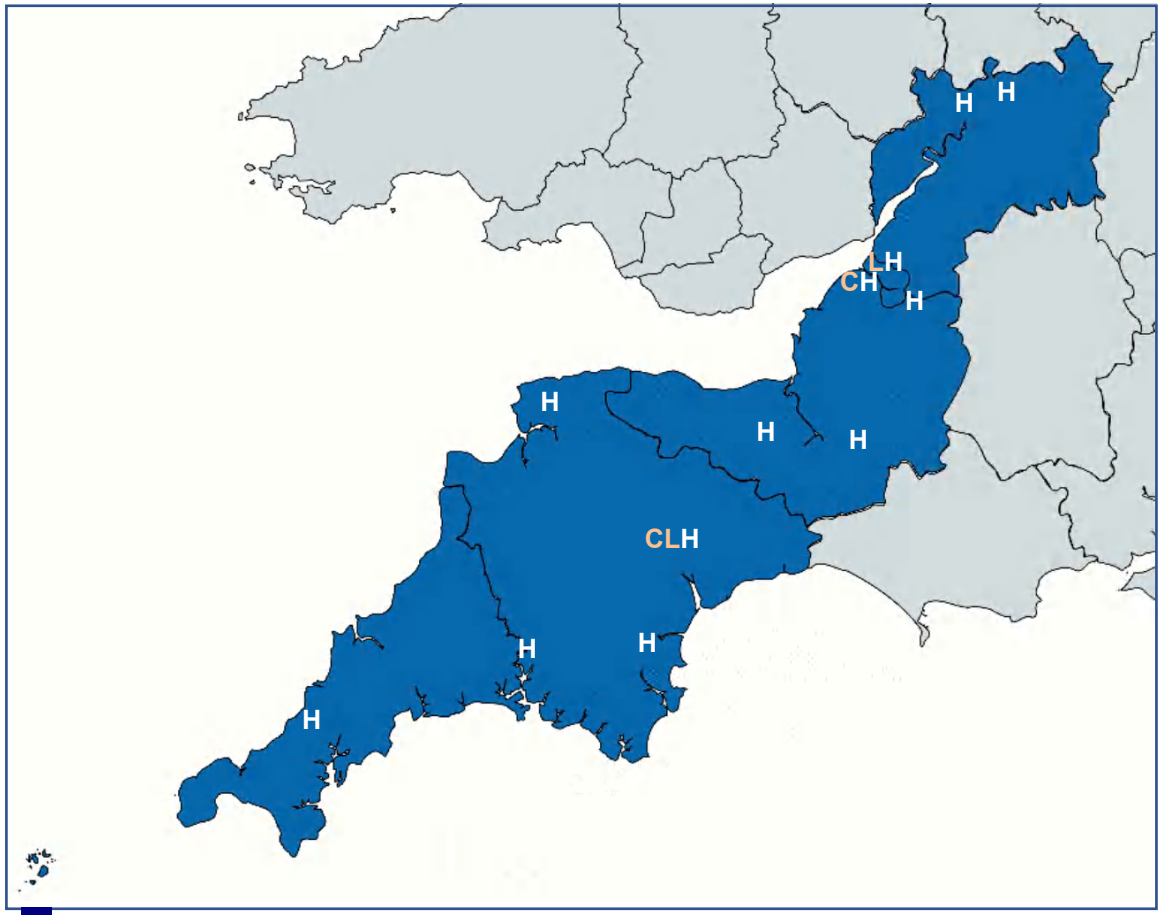
- Seven GMSAs established from February
- Aligned with 7 Genomic Laboratory Hubs
- Bring together providers to work in partnership support the systematic implementation of genomic medicine into the NHS by creating a learning environment to support the rapid adoption and spread of scientific advances.
- Accountable for:
  - i) equitable access to standardised genomic testing and clinical genetics and genomic counselling services;
  - ii) access to treatments and medicine optimisation driven by comprehensive genomic and diagnostic characterisation;
  - iii) increasing access to clinical trials
  - iv) active participation in genomic research across England

South West Genomic Service Alliance

NHS South West Genomic Medicine Service Alliance

- 6 ICS - Gloucestershire, BNSSG, BSW, Somerset, Devon, Cornwall





H=Acute Hospital Trust
L =Genomic Laboratory Hub
C =Clinical Genomic Service

SW GMSA in numbers

NHS
South West
Genomic Medicine Service Alliance

Geography

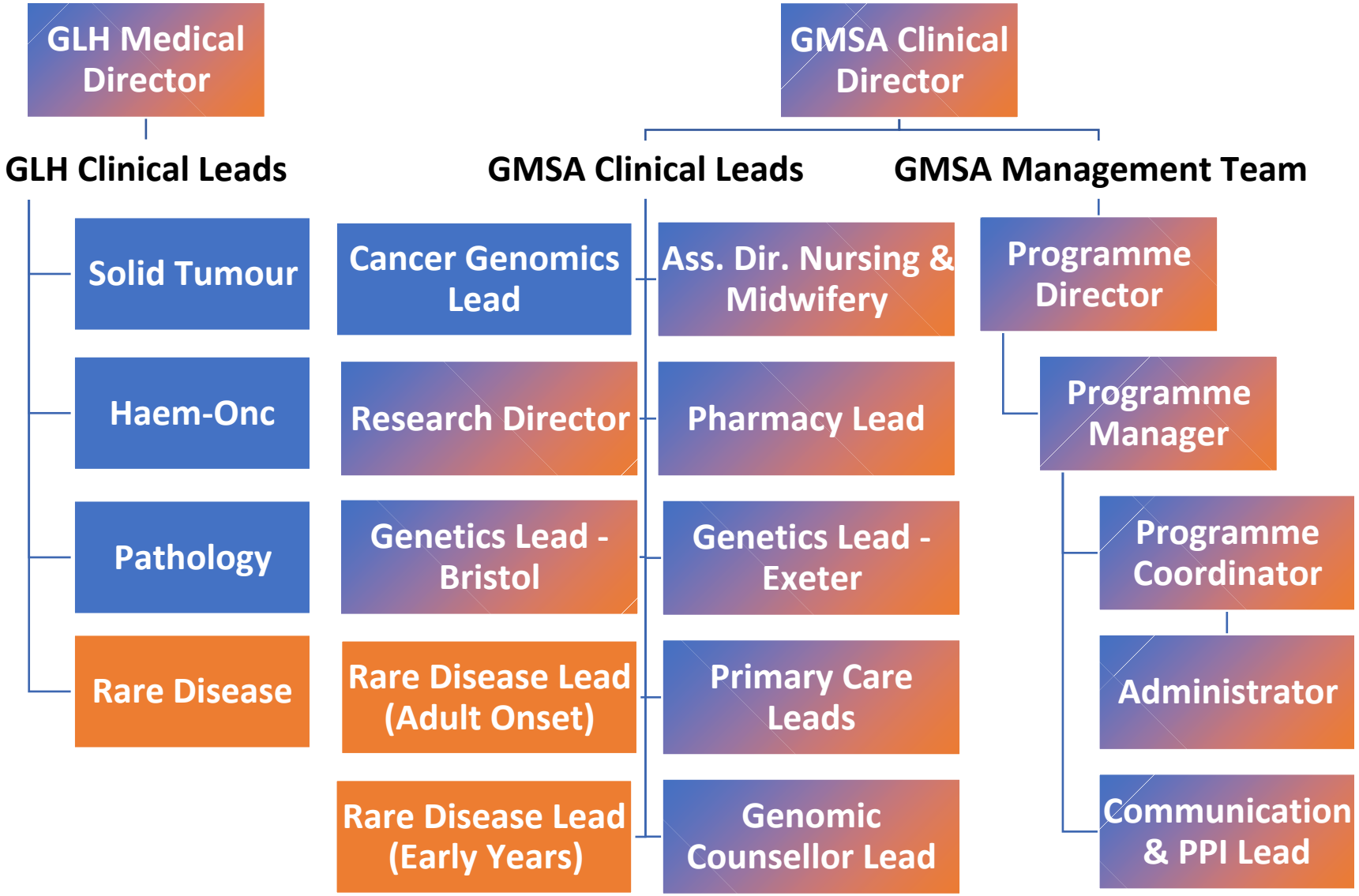
- 4.7 million people
- 6 STPs (inc. part of BSW)
- 11 Acute providers

Funding

- £958k for Infrastructure (core team)
- £133k for 100,000 Genomes Additional Findings
- £538k for Transformation Projects

SW GMS Core Team

NHS South West Genomic Medicine Service Alliance



All Genomics

Cancer

Rare & Inherited Disease

Hartles Rachel
11/30/2021 13:46:56

SW GMSA Governance

NHS South West Genomic Medicine Service Alliance

SW GMSA Board

- Chair, Robert Wooley, CEO UHBW
- Medical Directors of 3 Partners
  to represent the GLH and both Clinical Genetic Services
- NHS E&I SW Medical Director
- Nurse Director, Chief Pharmacist, Chief Midwife, Chief Operating Office, Finance Director drawn from partners and members

GMSA and its Partners

NHS South West Genomic Medicine Service Alliance

- SW GMSA is a partnership of the 3 providers of genomic services and the wider NHS.
- Although the GMSA has dedicated staff, it should not be seen as a separate entity, but a collaboration of the partners and the wider NHS
- NHS England has asked for an “integrated governance” between GMSAs and GLHs. We believe the current Board delivers this.
- A number of requirements of the GLH arose in the absence of the GMSA, whose establishment was delayed by Covid. We are committed to a coordinated approach to delivering the collective objectives.
- Important relationships exist between
  - NBT and the RD&E in running the GLH
  - NBT and UHBW – as the provider of not only Bristol Clinical Genetics but a number of specialist services that are heavy users now of genomics

SW GMSA Approach

NHS
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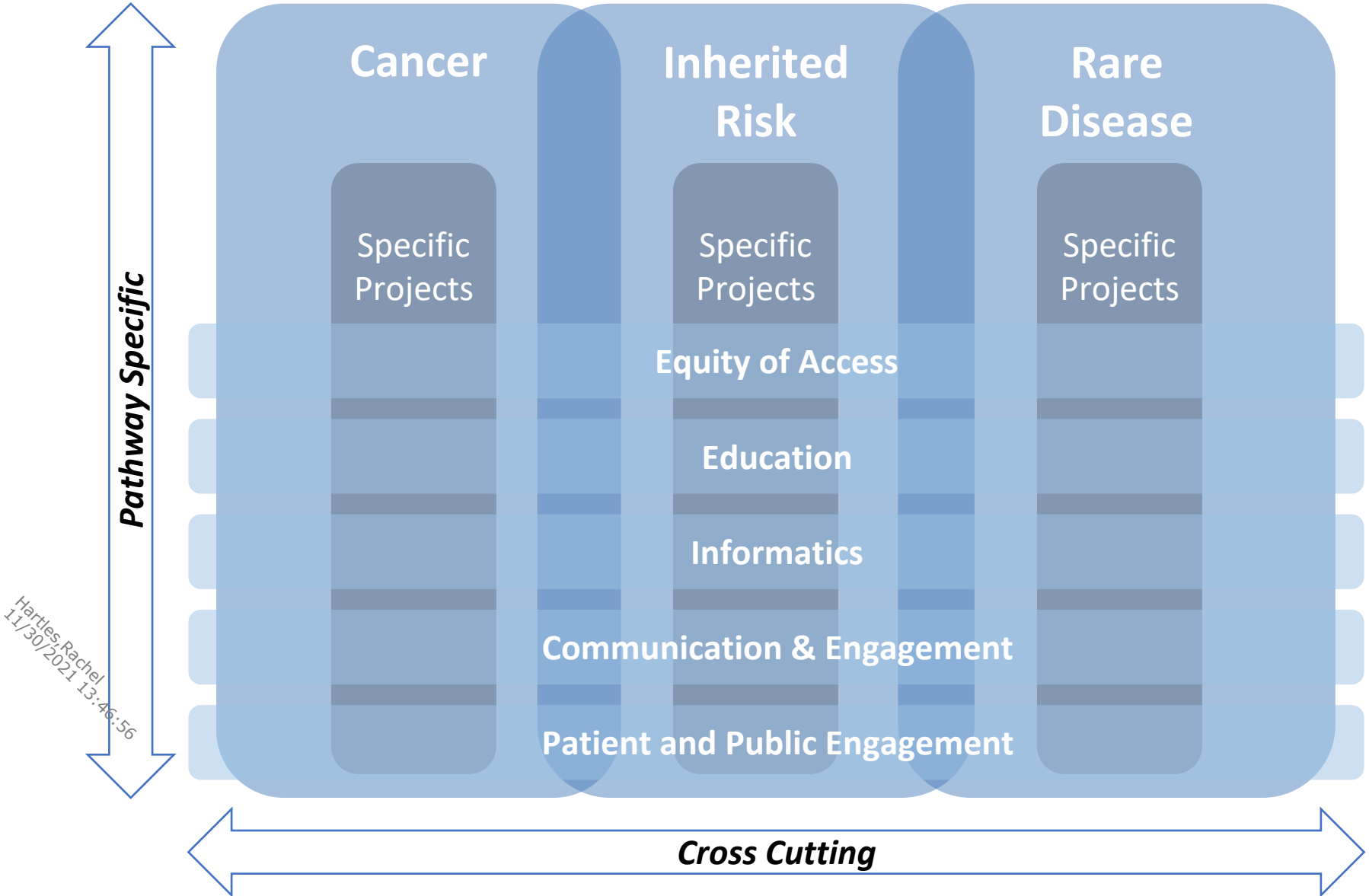
Genomic Medicine Service Alliance



Mainstreaming

NHS South West Genomic Medicine Service Alliance

For Patients
Consent, Research, Co-design

For Clinicians
Education, advice as needed

Knowledge

Information

Support

Simple

Data
Finding innovators, targeting support, improving equity of access

Technology
Digital ordering & reporting, embedding results in patient records

Risk Register – SW GMSA Board

NHS South West Genomic Medicine Service Alliance

- Pathology – Cancer pathways
- Clinical Genetics – Increased workload
- Whole Genome Sequencing – increasing clinical indications

Any questions?

christina.thirlwell@nhs.net

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

Report Title	**Single Oversight Framework – Segmentation**
Report Author	**Eric Sanders, Director of Corporate Governance**
Executive Lead	**Robert Woolley, Chief Executive**

1. Report Summary

To update the Board on the latest position of the Trust in relation to the Single Oversight Framework segmentation decision.

2. Key points to note

(Including decisions taken)

The purpose of the NHS System Oversight Framework is to:

a) align the priorities of ICSs and the NHS organisations within them

b) identify where ICSs and NHS organisations may benefit from or require support to meet the standards required of them in a sustainable way, and deliver the overall objectives for the sector in line with the priorities set out in the 2021/2 Operational Planning Guidance, the NHS Long Term Plan and the NHS People Plan

c) provide an objective basis for decisions about when and how NHS England and NHS Improvement will intervene in cases where there are serious problems or risks to the quality of care.

The oversight framework is built around five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts, commissioners, and ICSs: quality of care, access, and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability. It is further built around a single set of metrics across ICSs, trusts, clinical commissioning groups (CCGs) and primary care, aligned to the five national themes, and a sixth theme, local strategic priorities.

NHS England and Improvement monitor and gather insights about performance across each of the themes of the framework to support the early identification of emerging issues and concerns.

Regional teams allocate ICSs, trusts and CCGs to one of four 'segments'. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

The Regional team have confirmed that the Trust has been moved into Segment 3, which is described as "Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)". The letter confirming this segmentation decision is attached in Appendix 1.

3. Risks

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

The risks associated with this report include:

The allocation of the Trust into segment 3 indicates concerns from the regional team about the Trust's performance in one or more areas of the Single Oversight Framework. Specifically highlighted were concerns about Quality at the Weston General Hospital site as identified by the CQC and concerns regarding training of junior doctors by Health Education England. These concerns are known to the Board and are therefore not new risks to

highlight. The risk of moving into Segment 3 is the enhance regulatory scrutiny that this change will bring.
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **Information.** The Board is asked to note the change in segmentation and that work will continue with system and regional colleagues to address the concerns raised in relation to the Single Oversight Framework.
5. History of the paper **Please include details of where paper has <u>previously</u> been received.**

Sent via email to:
Robert Woolley, Chief Executive
University Hospitals Bristol and Weston NHS Foundation Trust

cc Jayne Mee, Chair, UHBW
Julia Ross, Chief Executive, BNSSG

Elizabeth O'Mahony
Regional Director South West
South West House
Blackbrook Park Avenue
Taunton
TA1 2PX
Email: e.omahony@nhs.net

3 November 2021

Dear Robert

University Hospitals Bristol and Weston NHS Foundation Trust: NHS system oversight framework segmentation review

Thank you for your email of 20 October regarding University Hospitals Bristol and Weston NHS Foundation Trust being placed into SOF segment 3 and mandated support, as per my letter dated 15 October.

I can confirm that this has been discussed with our senior team and the documentation leading up to the SOF segmentation letters has been fully reviewed. This has confirmed that, unfortunately, there was a wording error within the letter.

To confirm, the SOF segment 3 decision was based on concerns relating to elective performance and waiting times and staff engagement. In addition, the decision was informed by concerns around quality and the wording error in the letter was relating to "the findings of the recent CQC Inspection, which saw the Trust rating change from Outstanding to Requires Improvement". This was incorrect.

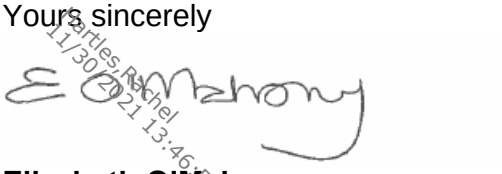
However, having reviewed with our Quality team, it is still considered that the assessment of SOF segment 3 for Quality was based on the published (but not rated under CQC methodology) Weston General site CQC report, which raised concerns at the site and resulted in three requirement notices being issued to the Trust. At a similar time, Health Education England also took the decision to remove a group of trainee doctors from working at the site.

With this clarification, and the views of our Performance and Workforce teams that the Trust triggered for SOF segment 3, it remains our decision that University Hospitals Bristol and Weston NHS Foundation Trust is placed in SOF segment 3.

The process of drafting exit criteria for segment 3 organisation has commenced and our Regional Oversight & Assurance team will be in contact with the Trust in due course to seek your views on this and on what improvement support might be most helpful.

Please accept my apologies for any frustrations or concern caused by the error in the SOF letter, which I am grateful to you for bringing to my attention.

Yours sincerely



Elizabeth O'Mahony
Regional Director South West

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

Report Title	**Strategic Capital Programme bi-annual update**
Report Author	**Kirstie Corns, Associate Director of Strategy & Business Planning**
Executive Lead	**Paula Clarke, Executive Director of Strategy & Transformation**

1. Report Summary

The purpose of this paper is to provide Trust Board with a bi-annual update of the Trust's Strategic Capital Programme. Trust Board is asked to note the content of the report.

2. Key points to note

(Including decisions taken)

The following areas are included within the report:

- Reminder of the scheme categories
- Confirmation that the programme has moved out of the review phase and into delivery
- Output of the Archus Report
- Update on the draft estates strategy
- Outcome of the category 2 and 3 moderation and order of priority
- Update on the programme delivery schedule and monitoring arrangements
- Update on the Financial plan
- Update on the communications plan

3. Risks

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

The risks associated with this report include:

Funding decisions relating to category 2 and category 3 schemes are dependent upon production of a Trust 5 Year Capital Plan which details the financial envelope available for the programme. Development of the 5 Year Capital Plan is dependent upon;

- Clarity from NHSEI regarding the National financial regime for CCGs and provider Trusts.
- The BNSSG system capital envelope (CDEL) which cannot be breached.

Sourcing of funding from alternative external sources will continue to be explored as part of the business case development if the Trust is to achieve its ambitions for all schemes within the programme (e.g. charitable donations, nationally funded capital/new hospital programme).

4. Advice and Recommendations

*(Support and Board/Committee decisions requested)***:**

- This report is for **Information.**

5. History of the paper

Please include details of where paper has previously been received.

Business Senior Leadership Team (BSLT)	**Wednesday 17th November 2021**

Recommendation Definitions:

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

Title: Strategic Capital Programme bi-annual update

Audience: Trust Board (Public)

Date: Tuesday 30th November 2021

1. Objective

The purpose of this paper is to provide Trust Board with a summary update on progress of the mobilisation of the Strategic Capital Programme.

2. Background

In September 2018, the Trust Board approved investment of c.£120m into major clinical services strategic schemes as part of the overall Medium-Term Capital Plan to 2022/23. In 2020/21 the Trust paused and reviewed the strategic capital investment programme to ensure the impact of the pandemic and other operating contextual factors for the Trust were appropriately reflected. In June 2021 the Trust's Senior Leadership Team (SLT) approved the formal close down of the Strategic Capital Review and approved a new action plan for progression to the mobilisation stage of the strategic capital programme.

SLT also supported the approach to categorising schemes into Category 1, 2 and 3 dependent upon their time criticality and scale / complexity.

1. Category 1 - Infrastructure and Restoration (1-2 years)
2. Category 2 - Medium scale strategic developments (2-4years)
3. Category 3 - Major strategic developments (3 -5+ years)

This approach enables quick decisions to be taken to support our urgent restoration and infrastructure agenda, whilst allowing the time to develop our complex strategic plans to the level of detail required and secure the requisite approvals. Category 1 schemes have received a mandate to either commence or continue design for expected delivery across 2021/22 and 2022/23. A reminder of the schemes within each category is included within Appendix A.

The programme is now rapidly moving into implementation stage with an action plan developed for each of the three categories. Final governance arrangements have been approved with a project structure and resources being established around the development and delivery of each scheme supported by an overarching programme plan.

During the delivery phase of the programme, the following influencing factors will continue to be managed, with business cases and prioritisation adapted accordingly when required:

- Our commissioning environment and associated income arrangements will become less uncertain over the next 6-12 months and scope for external funding sources will be pursued.
- The future strategic direction for Weston will be further developed through the Healthy Weston programme identifying opportunities for capital development at the Weston campus.
- Our provider collaboration and strategic partnership with NBT will continue to develop supporting identification of opportunities for joint clinical service and estates planning.
- Opportunities and impact from innovation and new models of care, including enhanced community based care options delivered at place level by ICPs, will emerge.

- Workforce plans to support major service change will be developed and secured.

3. Archus Report & draft Estates Strategy

3.1 Archus report

Archus were commissioned to undertake analysis on behalf of the Trust to help support the Rapid Review process, which concluded in June 2021. The key findings of their investigations demonstrated that in majority of cases the independent Archus modelling broadly aligned with the business case projections for increased capacity across the relevant modalities.
The report also put forward suggestions for performance improvements in some areas (e.g. Theatres, Endoscopy) to potentially reduce level of physical expansion.

The report also sets out a number of recommendations to strategically develop the Trust estate which align and substantiate the internal work previously undertaken, notably the development of Marlborough Hill site.

3.2 Draft Estates Strategy

The draft Estates Strategy was shared with Trust Board in September where the quality of the document was well received. It was agreed that the Trust would continue to develop the strategy while progressing category 1 and 2 schemes and undertake further work to incorporate a site development plan for Weston General Hospital. The strategy will come to Trust Board in March 2022 for final approval.

4. Moderation of schemes

To assess how Category 2 and Category 3 schemes could be scheduled within an overall delivery programme, Divisional Directors completed a moderation exercise in July 2021. In an independently chaired session, supported by members of the Strategic Capital Programme Team, Divisional Directors reviewed all Category 2 and 3 schemes. Their recommendation was shared with SSLT on 4th August where further discussion around sequencing took place. SSLT approved the recommendation subject to Divisional Triumvirates confirming that they supported the sequencing which they subsequently did. The output of this work has been incorporated into the final programme schedule for Category 2 and Category 3 schemes and can be found in Appendix B.

5. Programme delivery schedule

A detailed programme exists for Category 1, 2 & 3 schemes and shows key dates for approvals and construction over the financial years 2021/22 and 2022/23. In addition to this, a high level master programme has been developed for Category 2 and 3 schemes which aligns with the sequencing priorities agreed as part of the moderation exercise. This outline programme includes a high level assessment of timings for essential activities such as business case developments and approvals, design stages, planning submissions (where relevant) and construction periods.

The overall sequencing within the programme will be influenced by any construction complexities and decant dependencies which will become evident as designs and discussions progress. Both programmes are live documents and will be regularly updated and reviewed by Strategic Estates Development Programme Board.

6. Financial plan

Funding decisions relating to category 2 and category 3 schemes are dependent upon production of a Trust 5 Year Capital Plan which details the financial envelope available for the programme. Development of the 5 Year Capital Plan is dependent upon;

- Clarity from NHSEI regarding the National financial regime for CCGs and provider Trusts.

- The BNSSG system capital envelope (CDEL) which cannot be breached. A final system five year capital plan was submitted mid-October 2021.

The Trust will plan for the fact that the cost of the schemes exceeds the funding available within the 5 Year Capital Plan and will therefore consider a longer planning timeframe of up to 10 years.

Sourcing of funding from alternative external sources will continue to be explored as part of the business case development if the Trust is to achieve its ambitions for all schemes within the programme (e.g. charitable donations, nationally funded capital/new hospital programme). This process has commenced with a joint Expression of Interest submission made with NBT for two schemes into the New Hospitals programme potential additional opportunities, and a submission for the NICU development into the national process for implementing the recommendations of the National Neonatal Critical Care Review, supported by the SW Operational Delivery Network. The outcome of both processes is awaited.

7. Communications

A communications plan and a range of communication and briefing materials for internal and external stakeholders are in development that reflects our ambitious and exciting strategic estates capital programme which aims to:

- Improve our buildings and infrastructure to benefit patients and staff.
- Increase our capacity for delivering care and restoring services impacted by COVID-19, alongside supporting more care outside of our hospitals.
- Drive forward our strategy to be a lead provider of outstanding clinical services, teaching and research over the next 10 years.

During August- October, Executives and Divisional leaders engaged with Divisional Boards to support understanding of the review process and the way forward for individual schemes and the whole programme alongside wider corporate communication activities. The final communication plan and communications materials will be published this month.

8. Recommendation

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

Authors: Kirstie Corns, Associate Director Strategy & Business Planning

Presented by: Paula Clarke, Executive Director of Strategy & Transformation

Appendix 1: Categories

Category 1 schemes: Infrastructure and restoration delivered over 1-2 years
Category 2 schemes: Medium scale strategic developments delivered over 2-4 years
Category 3 schemes: Large scale strategic developments delivered over 3-5+ years

Ref	Division	Scheme name	Summary description
	Category 1		
SC09	Surgery	**GICU Stage 2**	Creation of 11 additional general intensive care beds at the BRI
SC14	Medicine / Surgery / Sps	**BHI Ward Beds**	An extension of the BHI building to create 18 additional adult general ward beds to support capacity gaps for the Trust.
SC19	Trust Services	**Medical Education**	**Phase 1:** Redesign and refurbish South Bristol Academy Medical Education facilities in Dolphin House for postgraduates **Phase 2:** Maximise use of flexible teaching space at the Education & Research Centre for medical postgraduates and staff training
SC24	Estates & Facilities	**Infrastructure**	Very high and high risk infrastructure improvements (e.g. upgrading ventilation, heating, cooling and drainage).
SC25	Trust Services	**Staff Well-being (including Well-Being Hub)**	£1m investment to support staff well-being facilities including staff rest areas and the potential development of a wellbeing 'legacy' hub
TBC	Trust Services	**Urgent Adult Ward Beds**	Identification of schemes to increase the number of adult ward beds for the Trust and improve flow
	Category 2		
SC01	Women's & Children	**STMH Level E Maternity redevelopment**	Refurbishment of Level E in St Michael's Hospital to provide an improved and modernised environment for patients and staff. To include: improved ventilation, heating and cooling; enhancing mother/baby and family rooms on the maternity wards; the antenatal unit and fetal medicine unit.
SC02	Surgery	**BEH Ground Floor Redesign**	Reconfiguration of the Bristol Eye Hospital ground floor to support delivery of new and improved patient pathways and an additional 20 outpatient rooms / clinic spaces.

Ref	Division	Scheme name	Summary description
SC03	Surgery	**Endoscopy / QDU**	Redevelopment of endoscopy facilities in Bristol to achieve JAG accreditation for Bristol and ensure that the facilities are fit for purpose for the recovery of endoscopy services and that JAG accreditation continues to be maintained across other UHBW sites.
SC05	Specialised Services	**D603 refurbishment**	Complete refurbishment of ward D603 in the Bristol Haematology and Oncology Centre to modernise the ward and provide improved facilities for our patients and staff, supported through charitable funds.
SC06	Corporate	**Holistic Centre**	Creation of a new Holistic Centre to provide information and support for patients cared for at our Bristol sites. This will be fully charitably funded by Maggie's and initially focus on cancer patients and extend support thereafter. The project paused through the pandemic, but has recently been re-established, with an architect and a landscape designer appointed.
SC17	Women's & Children	**Bristol cross-city NICU reconfiguration**	Joining together the running of Bristol's two neonatal intensive care units at St Michael's and Southmead hospitals. STMH would continue to provide all levels of care including intensive care. Southmead would provide high dependency and special care services.
SC22	Surgery	**BEH 5th Theatre**	Creation of a 5th operating theatre in the Bristol Eye Hospital.
SC23	Medicine	**Dermatology redevelopment**	Redevelopment of dermatology facilities in Bristol to include creation of additional outpatient rooms, new theatres and supporting office and research accommodation to support current levels of provision and anticipated growth.
	Category 3		
SC20	Medicine / Surgery / D&T	**UEAC (Marlborough Hill)** *An alternative name for this scheme will be considered and agreed by the UEAC Programme Board.*	Development of a new purpose built Integrated Urgent and Emergency Assessment Centre on the Marlborough Hill site. The UEAC will co-locate adult ED, ambulatory units and assessment beds alongside diagnostics, radiology, endoscopy and new theatres. This scheme is an enabler for the BRHC expansion and redevelopment scheme.
SC12	Specialised Services	**BHOC Expansion (Stage 2)**	Phase 2 of the Bristol Haematology and Oncology Centre redevelopment to modernise facilities and to expand the building to further increase inpatient, outpatient and diagnostic capacity.
SC18	Women's & Children	**BRHC expansion and redevelopment**	Expansion of the Children's Hospital to include: an increased emergency department with additional assessment cubicles, additional observation beds and additional resus spaces; additional PICU beds; additional outpatient rooms and associated space to support flow; additional inpatient beds and additional

Ref	Division	Scheme name	Summary description
			rehabilitation beds (dependent upon the UEAC Marlborough Hill scheme).

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

Report Title	**Integration Progress Report**
Report Author	**Robert Gittins, Programme Director**
Executive Lead	**Paula Clarke, Director of Strategy and Transformation**

1. Report Summary

This report sets out the progress being made with the integration programme. Clinical and corporate teams across the Trust continue to work together to realise the benefits of integrated services for patients, staff and local people, driving improvement across a range of services, systems and clinical specialities.

The Integration Programme Report (IPR) is a monthly report used within the organisation to enable the senior leadership team and Board committees to scrutinise the performance of the programme.

2. Key points to note

Clinical services

Palliative care, Gynaecology and Pharmacy services transferred in October and are now Trustwide services, bringing the total number of clinical services integrated to date to 13. 27 services have now commenced the integration process, with Critical care services planned to transfer accountability next month.

Corporate services

We have successfully consolidated 20 out of 21 corporate services into Trustwide teams; with the Communications team having now completed a staff consultation and ready for integration in February 2022. A recent review of the benefits of corporate integration reported that about 50% of the benefits that we expected at this point have been realised, with plans in place for those remaining.

Staffing, training and education

We have been making progress in recruitment and this continues to be a priority. By the end of December an additional 248 registered nurses will have joined UHBW this year, with a further 72 nurses due to join us by the end of March 2022. We have also recruited to a full complement of both junior and middle grade doctors in medicine in Weston, and we have bolstered the education and training environment to support medical trainees. This is overseen by our Director of Medical Education and we have recently appointed an Associate Dean to further enhance educational support.

The Weston apprenticeship programme is now integrated Trustwide, with increased numbers of apprenticeships coming online, as well as a first cohort of trainee nursing associate's with Weston college commencing in September 2021.

Volunteer restart also continues to gather momentum with 'Meet and Greet' volunteers in place at Weston.

Urology services

From 1 December 2021, urology services at Weston General Hospital will become part of the Bristol Urological Institute (BUI) run by North Bristol NHS Trust (NBT). There will be no change to the way in which care is delivered, with patients continuing to have tests, appointments and surgery at Weston General Hospital, delivered by the same staff, including their consultant clinical team. However, the transfer ensures the service is part of an organisation which has the right expertise to continue to develop the service and enables the staff working within it to become part of a more resilient specialist team.

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

Corporate risk, 4539 states that 'Trust core activities and performance are adversely affected by the allocation of resources required to manage service level integration'

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

- This report is for **Assurance**

The Board is asked to note the Integration Report and the progress being made on integration against the reset schedule.

5. History of the paper

Integration Programme Board (IPB)	**November 21**
Senior Leadership Team (SLT)	**November 21**

University Hospitals Bristol and Weston NHS Foundation Trust

Integration Programme Report

October 2021

Contents

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

Highlights

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

Progress in month

Clinical

- Palliative care, Gynaecology and Pharmacy transferred 04/10/21 and are now Trustwide services. This brings the total of clinical services integrated to 13 out of 27, and we are supporting a further 8.
- In month, 6 services have changed status to "off track".

Corporate

- Communications staff consultation has completed, with implementation of full team integration scheduled for 1st February 22. This concludes all of the corporate service integrations.
- At the end of October, expenditure on transitional posts is c£870k, c£320k less than plan of c£1,190k.

Benefits realisation

- At the end of September £125k was identified against the financial mitigations in relation to nurse agency savings. Medical savings continue not to be realised, largely due to continued additional investment in staffing on the Weston site.
- Medical and nursing agency savings are forecast to achieve £875k or 32% of the £2,700k annual target.

Workforce and Organisational development

- Registered Nursing (Whole Time Equivalent-WTE- in post) is above the expected trajectory position at Quarter 2.
- Consultant (WTE in post) remains below the expected trajectory position at the end of Quarter 2 (Q2).
- A Weston Medical recruitment film was launched on social media and has resulted in an increase in applications.
- A number of Non-Consultant grade doctors under offer; with 7 planned start dates for November 2021.
- 3 consultants have agreed start dates with the Weston Division on 1st November 2021.
- 7 Clinical Fellow (ST1/2) joined the Weston Division in October 2021.
- Recruitment for registered nurses ongoing.

Key Actions over the next 4 weeks

- Financial review of Transaction Business case assumptions
- Complete the Communications team consultation
- Conclude transfer of accountabilities for Critical care & Anaesthesia and Pre-op in November
- Confirm remaining benefit owners
- Work with Internal Audit to scope and agree the 18 months post merger review parameters and work on a maturity index.

Issues being escalated

- Delay to the full transfer of accountability for critical care and anaesthesia, pre-op and ophthalmology.
- Capacity of the Division of Weston over the next 3/6 months to engage with the integration change process with competing priorities to deliver the business as usual, restoration and Healthy Weston programme agendas.

Successes, Priorities, Opportunities, Risks & Threats (SPORT)

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: October 2021

Successes

- Palliative care, Gynaecology and Pharmacy transferred 04/10/21, bringing the total number of clinical services to 13 successfully transferred.
- Urology transfer transition – revised transfer date with NBT agreed as 1st December 21, with full completion by 1st Feb 2022.
- Communications team consultation closed 1st October and are now undergoing a review period.
- The Corporate services 6 month benefits realisation review has been completed, with 50% of benefits realised. This includes :
  - Weston apprenticeship programme now integrated Trustwide, with Increased numbers of apprenticeships coming on line and 1st cohort of trainee nursing associate's with Weston college commencing in Sep 2021.
  - Voluntary Services team across hospital sites using a new database 'Assemble' to support consistency in recruitment, training and management. Volunteer restart continues to gather momentum with 'Meet and Greet' volunteers in place at Weston and ward-based roles (meal-time support / befrienders) in development

Priorities

- Agree the site management model post integration to enable transfer of accountabilities.
- Complete the transfer of Critical Care and Anaesthesia to the Division of Surgery.
- Review and reset benefits tracker work completed. Ensure traction with benefit owners.
- Continued progress with the Weston Terms and Conditions and pay control group.

Opportunities

- Opportunity to deploy the Clinical Practice Group (CPG) tool kit with some services which have already integrated.
- Feedback from services and Human Resources Business Partners (HRBPs) that have already integrated and analysing lessons learnt.

Risks & Threats

- Continuing operational pressures and workforce availability is adversely affecting ability to move the integration plan forward in some specialities.
- Surgical & medical service transfers of accountability relies on ongoing triumvirate discussions.
- Loss of momentum to integration is a risk
- Risk that the expected financial mitigations in the Transaction Business Case are under delivering, with the plan currently under review.

Dashboard

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

Critical Success Factor	Objective	Status	Movement since last report
Business Function	Corporate Services Integration completed	A	—
Delivery Streams	Clinical Services Y2 Integration schedule completed	A	—
	WGH management arrangements post October 22 agreed	A	—
	Healthy Weston programme (phase 1) delivered against revised schedule	A	—
Workforce & OD	Clinical admin job matching exercise completed	A	—
	Job planning policy and Premium Payment controls harmonised and applied to Clinical Services	R	—
	Recruitment and Retention plan delivered for Medical and Nursing	A	—
	HR Systems Integration completed	A	—

Critical Success Factor	Objective	Status	Movement since last report
Cultural Integration	Cultural Integration Programme Completed	A	—
Policies & Processes	Key clinical, HR, finance and corporate policies are aligned across the combined UHBW Trust	A	—
Estates & Facilities	Backlog maintenance programme (Y2) delivered	G	—
IT & Technologies	Year 2 clinical digital systems convergence programme complete	A	—
Risk Management	Mitigate and manage the risks of integration	G	—
Benefits realisation & Strategic Intent	Business Case financial synergies achieved (Y2)	R	—
	Monitoring of Y2 Programme Benefits realisation in place	A	—
	Integration delivery programme (year 3) approved	G	↑

↑	Upwards movement	R	Not Achieved
—	No movement	A	Delayed/partially achieved
↓	Downwards movement	G	Achieved/On Track

Business Functions

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

A *Delayed/Partially Achieved*

Progress Against Corporate Services Integration Plan

Service Integration Status	% of Services	Number of Services
Completed	95%	20
In progress - off track	0%	0
In progress - on track	5%	1
Staff Consultation Not started	0%	0
Total	**100%**	**21**

Key Points:

- All Corporate services have now integrated except for Communications. For a full list of services and their status see Appendix 1.
- Communications launched their consultation 2nd September and closed 1st October 2021. They are currently undergoing a review period, and planning to transfer 1st Feb 22.
- Recruitment to transitional funded posts remains behind plan in October. Two transitional posts have not been recruited to, with both posts under review for extended transitional funding past March 22 before recruiting to.
- At the end of October, there are 2 core posts that have not been recruited - no change from previous month.
- At the end of October, expenditure on transitional and core posts is c£870k, c£320k less than the plan of c£1,190k.

Recruitment Update

Corporate Recruitment Plan - Posts	Planned Recruitment	Recruited		In Post	
		No. Posts	% of Plan	No. Posts	% of Plan
Transitional Posts	13	11	85%	7	54%
Core (Recurrent) Post	43	39	91%	31	72%
Total	**56**	**50**	**89%**	**38**	**68%**

Corporate Recruitment Plan - £000's	Year to Date			Full Year		
	Plan	Actual	Variance	Plan	Forecast	Variance
Transitional Posts	302	140	162	518	182	336
Core (Recurrent) Post	884	729	154	1,589	1,362	227
Total	1,186	869	317	2,107	1,544	563

Reasons for Non-Recruitment

	Transitional Posts	Recurrent Posts
Reason Description	Number of Posts	Number of Posts
Awaiting Consultation Outcome	0	0
Awaiting Job Banding	0	0
In Recruitment Phase	0	1
Other	2	1
Total Posts Not Recuited	**2**	**2**

Recovery Actions:

- Project Management Office (PMO) to prioritise the completion of Communications integration.
- Work with Internal Audit to scope and agree the 18 months post merger review parameters and work on a maturity index
- PMO to confirm approved transitional posts beyond March 22 to heads of service.

Delivery Streams – Clinical Services

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

A *Delayed/Partially Achieved*

Progress Against Clinical Services Integration Plan

Service Integration Status	% of Services	No. of Services
Completed	36%	12
In progress - off track	30%	10
In progress - on track	15%	5
Not started	18%	6
Total	**100%**	**33**

Key Points:

- Palliative care, Gynaecology and Pharmacy transferred 04/10/21 and are now Trustwide services. This brings the total of clinical services integrated to 13 out of 27, and we are supporting a further 8.
- In month, 6 services have changed status to "off track".

Recovery Actions:

- Continue to work closely with the Weston Managing Director to support the Clinical Services Integration through tri to tri meetings with all clinical divisions.
- Ensure key clinical input into the Healthy Weston programme Clinical Design and Delivery Subgroups

Phase	Service	Receiving Division	Status	Original Divisional Board Decision Date	Revised Divisional Board Decision Date	Notes
Phase 1	Sexual Health	Medicine	[illegible]	08 October 2020		[illegible]
	Laboratory Services	DS&T	[illegible]	30 September 2020		[illegible]
	Therapies	DS&T	[illegible]	30 September 2020		[illegible]
	Gynaecology	W&C	[illegible]	06 November 2020	Approved 07/05/21	Transferred 04/10/21
	Pharmacy	DS&T	[illegible]	28 October 2020	Approved 25/11/20	Transferred 04/10/21
Phase 2	Paediatrics	W&C	[illegible]	05 February 2021	[illegible]	[illegible]
	Resus	DS&T	[illegible]	27 January 2021	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	27 January 2021	[illegible]	[illegible]
	Palliative Care	[illegible]	[illegible]	27 January 2021	[illegible]	Transferred 04/10/21
	Integrated Discharge Service (IDS)	[illegible]	[illegible]	[illegible]	Approved 06/05/21	[illegible]
	Patient Flow	[illegible]	[illegible]	[illegible]	Approved 06/05/21	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Critical Care and Anaesthesia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Gastroenterology & Hep	Medicine	[illegible]	[illegible]	[illegible]	
	Care of the Elderly	Medicine	[illegible]	[illegible]	[illegible]	[illegible]
	Stroke	Medicine	Not started	TBC	TBC	[illegible]
	Emergency Department (inc. EEMS)	Medicine	[illegible]	[illegible]	[illegible]	[illegible]
Phase 3	Outpatient [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Phase 4	[illegible]	[illegible]	[illegible]	23 September 2021	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	23 September 2021	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	23 September 2021	[illegible]	
	[illegible]	[illegible]	[illegible]	23 September 2021	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	23 September 2021	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	5 October 2021	[illegible]	
	[illegible]	[illegible]	[illegible]	5 October 2021	[illegible]	
	[illegible]	[illegible]	[illegible]	5 October 2021	[illegible]	
	[illegible]	[illegible]	[illegible]	29 September 2021	[illegible]	
	[illegible]	[illegible]	[illegible]	22 September 2021	[illegible]	

Figure 1: A table to show the progress of clinical integrations against revised schedule

Workforce

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

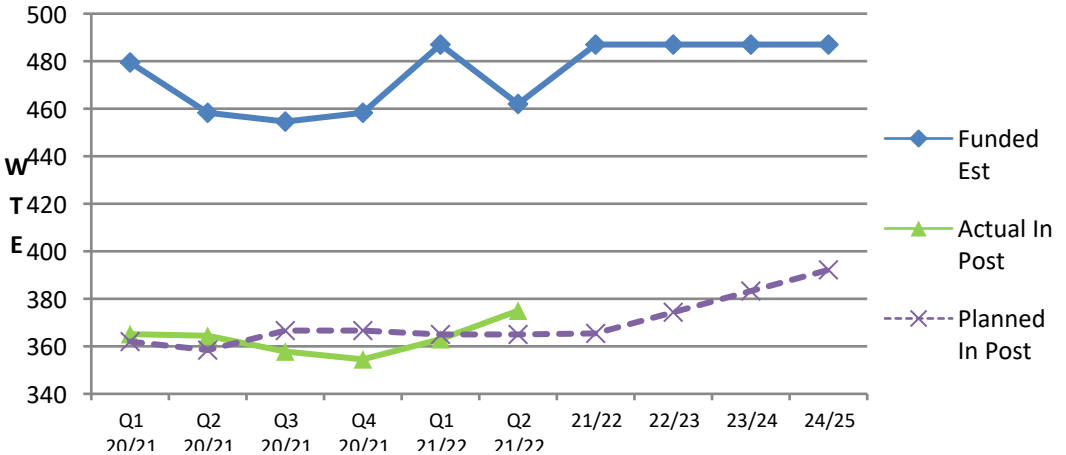
R *Not Achieved*

A *Delayed/Partially Complete*

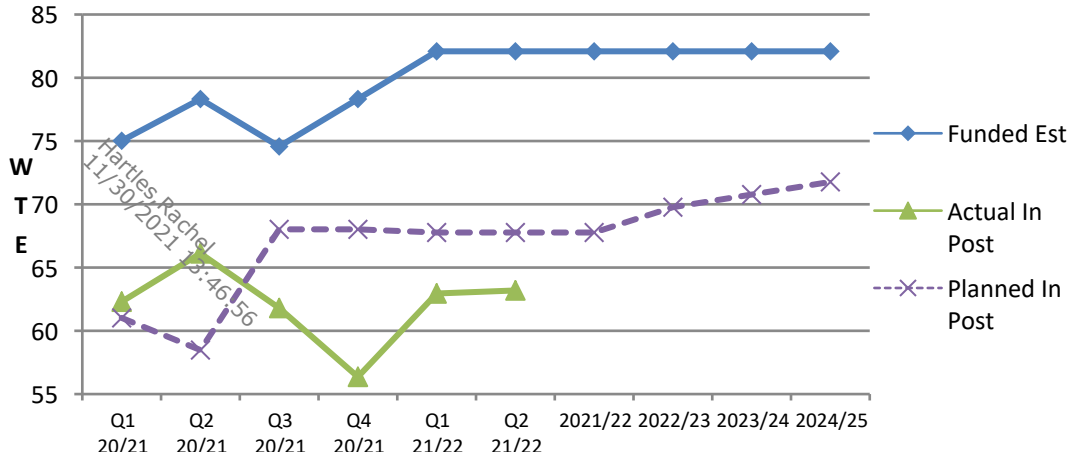
A *Delayed/Partially Complete*

A *Delayed/Partially Complete*

Weston Division RN Vacancy Trajectory



Weston Division Consultant Vacancy Trajectory



Key Points:

- The Q2 figures have been updated and reflect the effect of new arrivals and turnover.
- Registered Nursing (Whole Time Equivalent-WTE- in post) is above the expected trajectory position at Quarter 2.
- Consultant (WTE in post) remains below the expected trajectory position at the end of Quarter 2 (Q2).
- A Weston Medical recruitment film was launched on social media and has resulted in an increase in applications.
- A number of Non-Consultant grade doctors under offer; with 7 planned start dates for November 2021.
- 3 consultants have agreed start dates with the Weston Division on 1st November 2021.
- 7 Clinical Fellow (ST1/2) joined the Weston Division in October 2021.
- Recruitment for registered nurses ongoing.
- The Trust is advertising for Trainee Nurse Associates with drop-in recruitment sessions for Bristol and Weston throughout November.
- A Bank campaign has been developed with a focus on earning extra money in the lead up to the festive period.

Recovery Actions:

- A further recruitment manager coaching session has been delivered in Weston.
- A replacement international recruitment pastoral care manager will start in November, to pick up Allied Health Professional's and medical staff joining the Weston Division.
- A replacement Senior Recruitment Manager has been recruited with a key focus on the Weston Division has started 2 days per week.

Cultural Integration Programme

October 2021

A *Delayed/Partially Complete*

Theme	Action	Update	RAG
Appraisal	Close the compliance gap for appraisal	Appraisal trajectories have not been realised due to exceptional operational pressures. A revised plan went to SLT in August and a revised trajectory of end of December was agreed. All divisions are currently conducting a deep dive analysis to target low compliance areas in order to realise an improvement in appraisal in line with the revised deadline.	
	Launch 'one model' for Appraisal	A governance group has been established to ensure there is a roadmap to enable one model as of April 2022. A detailed plan was produced in August 2021 in conjunction with HR systems, with weekly scrum meetings in place.	
Diversity and Inclusion	Delivery against the D&I plan.	Delivery against Diversity and Inclusion plan is on target.	
Recognition	Conduct a full review of recognising success and its	Review completed. A paper was due to go to SLT in October, however this is behind plan so will now got to SLT in December 21.	
Values and Leadership Behaviours	Commence stakeholder work with Blue Goose	Values to be ratified at Board on 29th October 21. A robust communications and engagement plan is in place to launch and immerse our teams from the middle of November 21, in a plan that will last 6 months.	
	Leadership Development	A full review of leadership and management development across the Trust has commenced, quarterly progress against this will go to the people committee in September.	
		Wider leadership development programme work to be done in conjunction with Education Team – specific Weston SMT plans have been developed in division. Plan on target, approved at people committee in September.	

Key Points:

- **Appraisal-** A new revised date for appraisal completion was agreed for end of December 2021. All divisions are currently conducting a deep dive analysis to target low compliance areas in order to realise an improvement in appraisal in line with the revised deadline.
- **Diversity and Inclusion-** Strategy plan on target. Each division has its own local plan which is reported into People Committee on a 6 monthly basis.
- **Recognition-** Review has been completed; options appraisal to be presented to Senior Leadership Team (SLT) December 21.
- **Values & Leadership Behaviours-** The new values and leadership behaviours will be ratified at Board on 29th October 21. A robust communications and engagement plan is in place to launch and immerse our teams from the middle of November 21, in a plan that will last 6 months.

Recovery Actions:

- Deep dive analysis into appraisal.

Policies and Processes

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

A *Delayed/Partially Achieved*

Policies and Procedures – Trustwide, Financial, Human Resources (HR) and Clinical

Policy Type	Metric	Update
Trustwide	The total number of Weston polices at 1st April	282
Trustwide	The number that have been either deleted, incorporated into a common UHBW policy or have been converted into a Divisional guideline	168
Trustwide	**Number remaining for review**	**114**

Policy Type	Metric	Update
Finance	Capital Investment Policy review complete	Completed- June 2021
Finance	Standing Financial Instructions review complete	Completed - Sept 2020
Finance	Scheme of Delegation review complete (Appendix 2 of SFI)	Completed - Sept 2020

Policy Type	Metric	Update
HR	Total number of policies that can be aligned	11
HR	Total number of policies that have been aligned	11
HR	Total Number of new policies introduced	20

Policy Type	Metric	Update
Clinical	Clinical procedures and guidelines, documents relating to ED emergency admissions	Completed - pre-merger
Clinical	Total number of services integrated since April 2020 in a position to review clinical procedures and guidelines commenced	9
Clinical	Total number of services integrated since April 2020 policies review completed	0

Key Points:

- Position updated quarterly (last updated July 21 report). A review of how this data is collected is currently under review, therefore no update has been given Oct 21.
- Review of financial policies has been completed including the Capital Investment Policy which was completed following the refresh of the Trust Strategy.
- HR Policy review process in employee services now in place.
- The Corporate Team with Trust Secretariat are taking the following steps to address known risks and issues with the management of policies and guidelines in the Trust:
  - A report on Clinical guidelines will be presented on a bimonthly basis to the Clinical Quality Group, and a monthly report will be presented to the Senior Leadership Team.
  - The Trust Procedural Document Management Policy will be updated
  - The Document Management Service (DMS) settings for Weston and Bristol will be aligned so that obsolete documents are not visible to staff.
  - All document owners will be contacted.
  - Enhanced support will be given to the Weston division to ensure they understand the process to follow and to review the escalation route within the division.
  - The Trust Secretariat will work with the Integration Team to ensure that guidelines are a key consideration of the clinical integration work.
  - Electronic Document Management – proposal approved by Digital Convergence Programme Board and Finance – starting 2022 post merger.

October 2021

G *Achieved*

Weston Estates Backlog Tracker

Cost Centre Name	Comments	RAG Rating (please select)
Weston Backlog Fire Compartmen	**First Phase of works completed.**	Green
Weston Backlog Roof/Gutter Rep	Front of hospital rainwater system and soffitt materials on plan to complete march 22	Green
Weston Backlog Pathology Roof	**Project Completed September 21 overspend of 30K due to unforseen works on roof slab.**	Green
Weston Backlog Switches	**Project Completed.**	Green
Weston Toilet refurbishment	**Project Completed August 21.**	Green
Weston Backlog Roof Repair & Drain s	Work progressing on rear of Estates and on plan to complete March 22.	Green
Weston Backlog Fire Alarm upgrade ar	Order placed and materials received and invoiced on site at Weston 170K , install start November.	Green
Histo Conversion	**Project Completed.**	Green
Ambleside Boiler Replacement	**Project Completed.**	
Reconfig Ed At Wgh	**Project Completed . Cancelled by Weston Division.**	Green
Estates Backlog Pdc (Holding)		
Weston Estates Backlog Staffin		Select

Orders value YTD	**£2,051,882.00**
Pending Future Orders:	**£685,904.00**
Capital spend taken 20/21 UHBW not PDC	**£237,786.00**
Capital Balance Remaining 21/22	**£0.00**
Total capitalApplications To date:	**£2,362,000.00**
Full Year Allocation 21/22	**£2,500,000.00**

Clinical and Corporate Information Management &Technology (IM&T) Systems Integration Plan

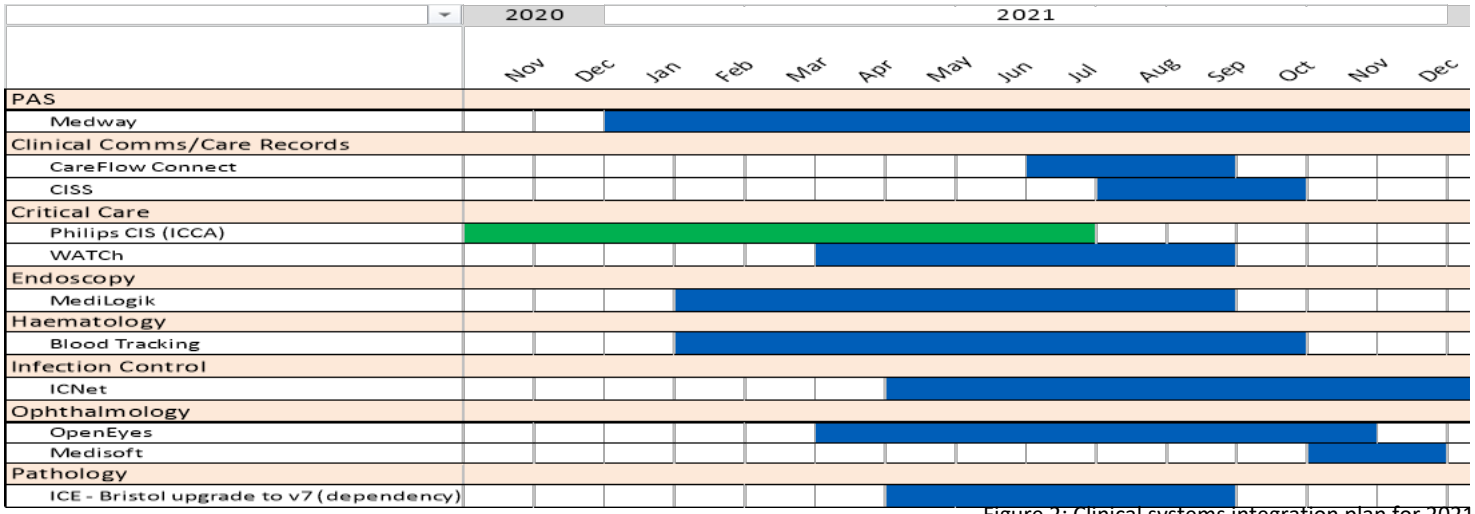


Figure 2: Clinical systems integration plan for 2021

Key Points: Medway

Phase 2 –In Design and Build stage. Updates to note;

- Second test cycle commenced. Workshop being organised with Weston division management on impacts.
- CareFlow Connect second phase planning commenced – rollout from November.
- CareFlow Workspace – planning has commenced – target delivery November 15th for Go Live coupled with CTE risk assessment and new drug chart rollout at Weston General Hospital.
- Pen test for Weston network commissioned – test and report due in November.

Key Points: Other

- Electronic Document Management – proposal approved by Digital Convergence Programme Board and Finance – starting 2022 post merger.
- Therapies – plan to implement Bristol forms into Weston – delivery from November 2021.
- Systemic Anti-Cancer Treatment (SACT) group formed for UHBW oncology solution – programme team part of this group – focus on requirement and contractual matters and way forward
- PACS/RIS plans – initial request to Diagnostics & Therapies Director to meet to plan out this requirement, commercials and then project. Link to Integration Programme Board and Integration programme alignment timescales

See Figure 2 for clinical systems integration plans for 2021. See Appendix 4 for draft whole clinical services integration schedule.

Risk Management

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

G *Achieved*

Integration Programme Significant Risks – (scores of 15 or above)

3430	16/10/2019	Business	Sanders, Eric	Risk that governance processes in the Division of Weston are unable to provide assurance	Training has been provided to Divisional Management. Risk Management Workshops held with risk owners. Ongoing support from Corporate Risk Management Team.	16	Provision of ongoing support to Divisional Management to identify improvements and to embed Trust processes and implement divisional action plan to address gaps in controls such as: - Compliance with Duty of Candour Policy - Compliance with incident Management Policy - Compliance with Risk Management Policy - Compliance with Safety Alert Policy Review recommendations in relation to risk management from ASW Governance Review and support division with their implementation.
4806	10/11/2020	Financial	Kemsley, Neil	Risk that the financial benefits identified in the Transaction Business Case (TBC) will not be achieved.	Financial mitigations are reported on a monthly basis to IPB via the integration Programme Report. Weston Division has established a nursing controls group. A Benefits realisation workstream reviews progress and takes corrective action on a monthly basis.	15	Financial review of the Transaction Business case once the 22/23 NHS financial regime is published, to take stock of the financial mitigation framework (Kate Herrick).

Key Points:

- The table above shows that 2 risks have a current rating that is 15 or over ('very high'). This is the one less than the number of 'very high' risks as the end of last month.
- 1 new risk was added in October as follows:
  - Risk that integration progress may stall as a result of reconsidering the management model at Weston- rated 'high risk'
- Risk no. 3324 regarding UHBW being responsible for a marooned Urology service if it does not transfer to North Bristol has gone from being rated 'very high risk' (score 15) to 'high risk' (score 9) in month. This is due to a new transfer date being agreed.
- There are 22 live risks at the end of October 21. With the exception of the 2 'very high' rated risks above:
  - 18 have a risk rating considered 'high' (a risk score of between 8 and 12)
  - 2 have a risk rating considered 'moderate' (a risk score of between 4 and 6)

Strategic Intent

October 2021

R *Not Achieved*

A *Delayed/Partially Complete*

A *Delayed/Partially Complete*

Year 2 Benefits – Progress Against Financial Mitigations

Financial Mitigations £000's	Plan 2021/22	FY Forecast	FY Variance	YTD Plan	YTD Actual	YTD Variance
Medical Agency Savings	1,000	475	(525)	583	0	(583)
Nursing Agency Savings	1,000	500	(500)	583	292	(291)
Medical Workforce Productivity	500	0	(500)	292	0	(292)
Total	2,700	975	(1,725)	1,458	292	(1,166)

Benefits Progress Summary

Provisional	6
Not Started	7
Behind Plan	9
On Track	10
Realised	0
Total	32

Figure 3: A summary of performance measure status

Recovery Actions:

- Benefits have been reassigned designated benefit owners who will agree appropriate performance measures and confirmed definitive ownership. Priority in month is to confirm the 6 provisional performance measures.
- Work is in progress to re-confirm the timescale for each benefit, including its start date and it's delivered by date, as part of the programme reset process.

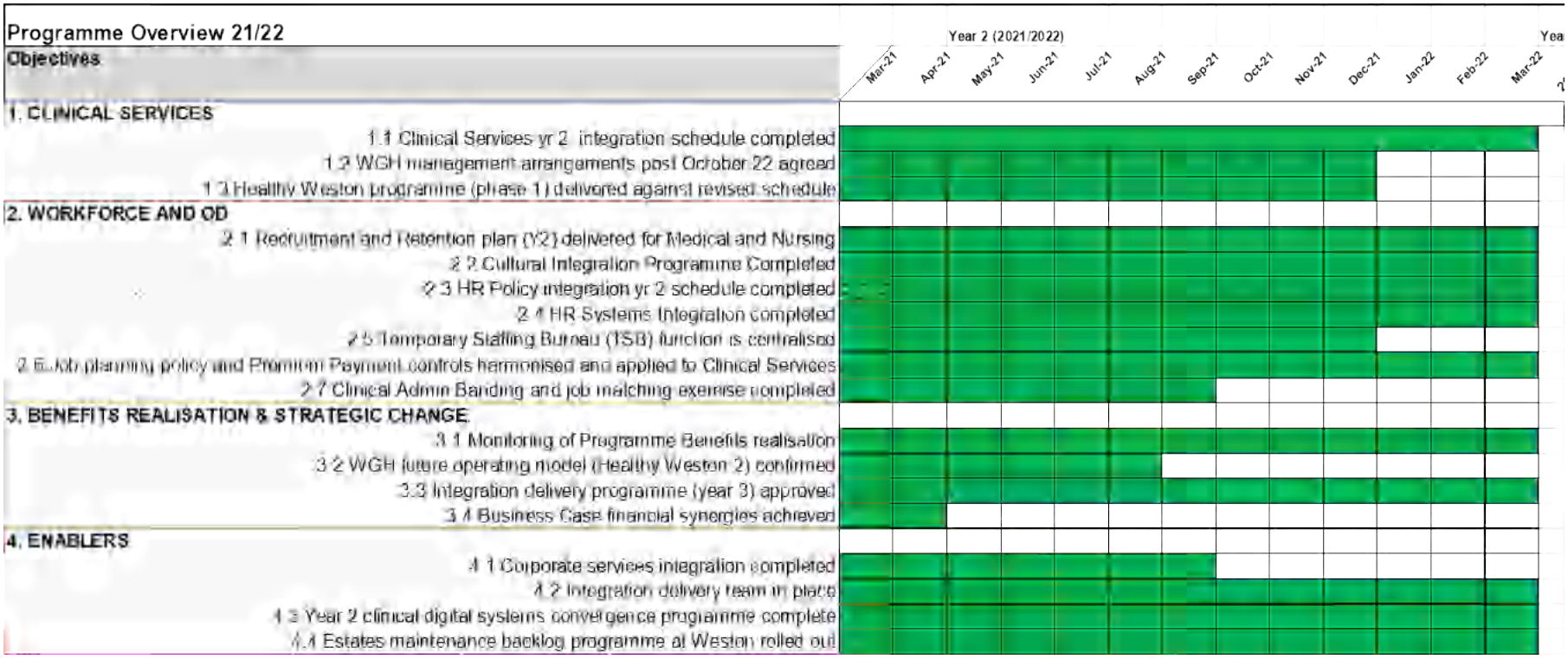
Key Points:

- At the end of October £292k was identified against the financial mitigations in relation to nurse agency savings. Medical savings continue not to be realised, largely due to continued additional investment in staffing on the Weston site.
- Medical and nursing agency savings are forecast to achieve £875k or 32% of the £2,700k annual target.
- There are 17 benefits associated with integration, along side 32 individual performance measures that have been specifically selected to provide more detailed measurement of the benefit.
- The status of performance measures will be reported quarterly (benefits progress summary shown in Figure 3).
- In month, provisional patient experience and staff resilience focused benefit associated with integration has been drafted and are in the process of being agreed with benefit owners.
- See Appendix 6-7 for further details.

Current Forward View

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021



Key Points: 21/22 Programme objectives were agreed by the Integration Board in February and an updated forward view has been produced above.

Appendix 1 – Corporate Services Integration Plan

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

Corporate Services Function - Integration Status

Phase	Corporate Service	Status
Phase 0	Risk management	Completed
	Information Governance	Completed
	HR E rostering AFC	Completed
	HR OD	Completed
Phase 1	Legal Services	Completed
	Payroll	Completed
	Training and Education	Completed
Phase 2	Employee services	Completed
	Medical e-Rostering - No consultation required	
	Medical HR	Completed
	Resourcing	Completed
Phase 3	Clinical Audit and Effectiveness	Completed
	Financial Services	Completed
	Patient Experience and Involvement	Completed
	Patient Safety and Clinical Governance	Completed
	Patient Support and Complaints - not required	
	Safeguarding Adults and LD	Completed
	Transformation	Completed
	Voluntary Services	Completed
	Facilities	Completed
Phase 4	Communications and Engagement	In progress - on track
	Digital Services	Completed
	Research	Completed
	Estates	Completed

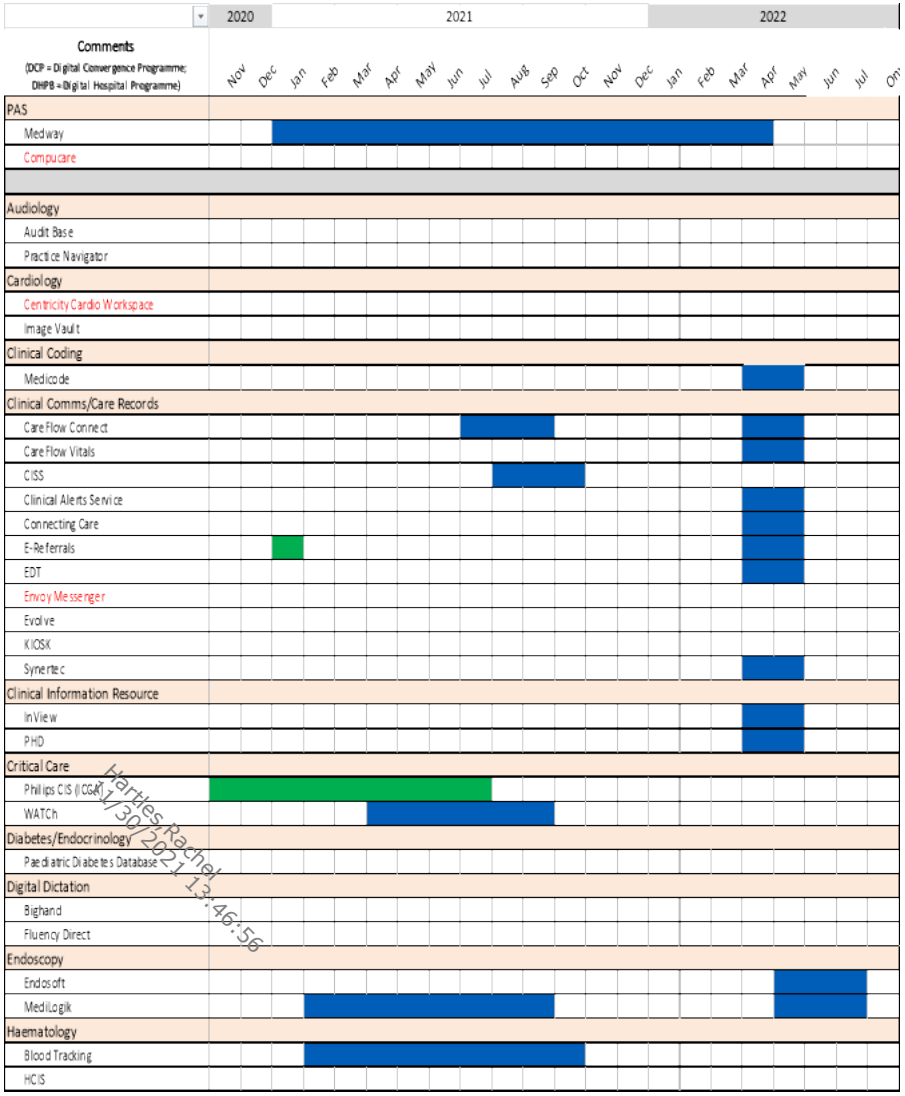
Notes:

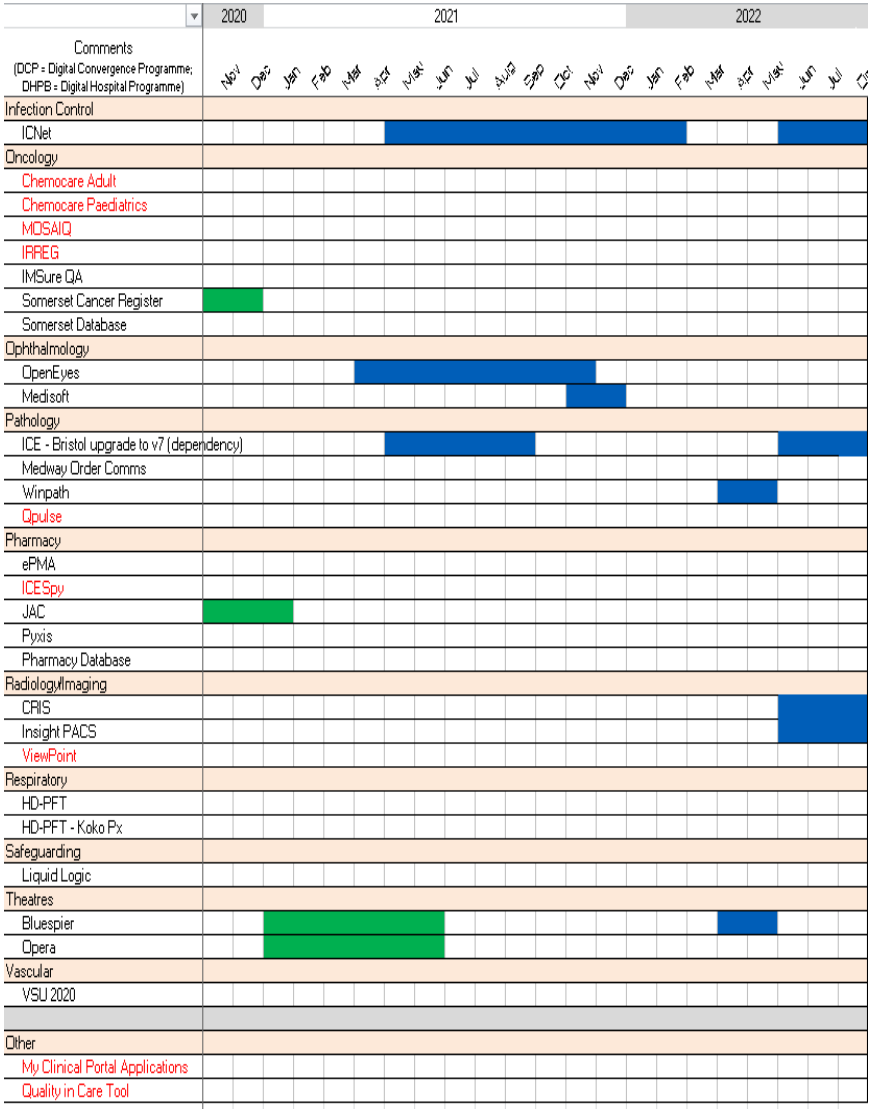
- All corporate services, with the exception of Communications, have integrated.
- The launch date for Communications took place 2nd September, and consultation closed 1st October 21. The service are now undergoing a review period, and are currently due to integrated 1st Feb 2022.

Appendix 2 – Clinical Systems Integration Schedule

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: October 2021





Appendix 3 - Benefits Realisation Schematic

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

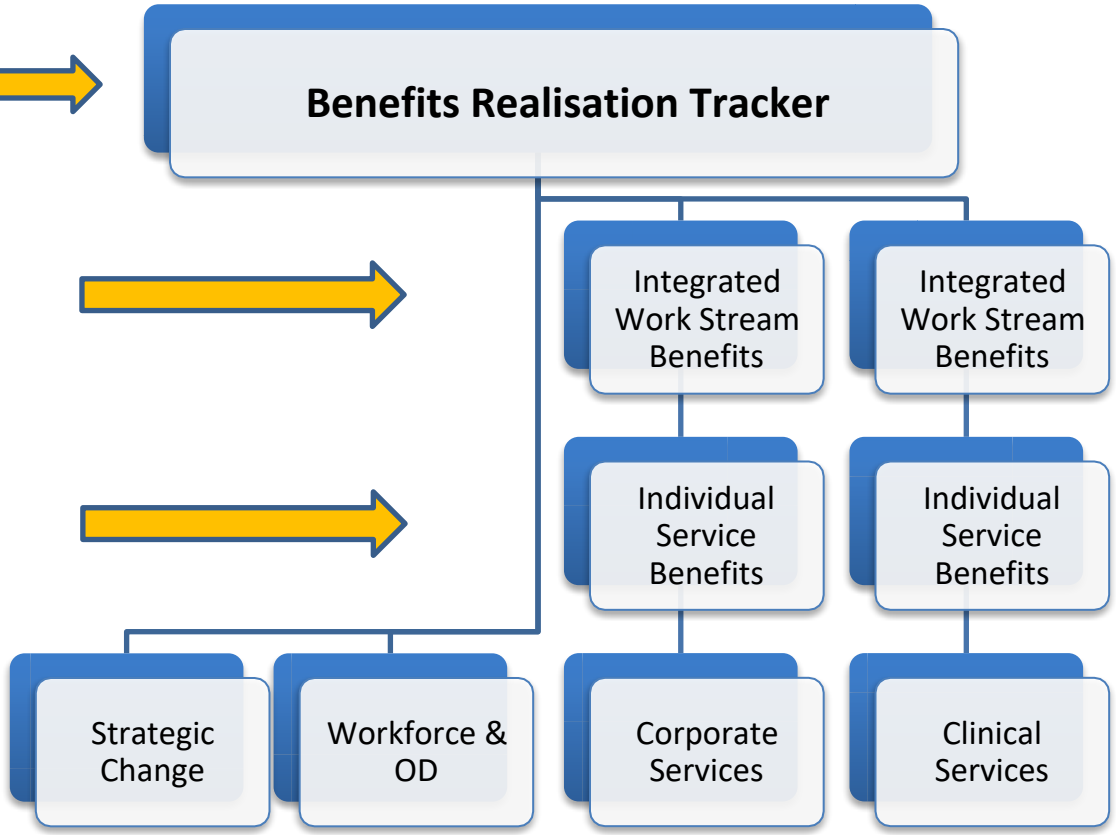
Report Month: October 2021

Reviewed and monitored by Benefits Realisation & Strategic Change work Stream

Monitored through Benefits Realisation Tracker, Managed by Work Stream

Monitored by Work Stream, Managed by Service Leads

Integration Programme Work Streams



- The Integration Programme now has 3 work streams. A function of the Strategic Change work stream is to monitor benefits associated with the merger (Strategic Change & Benefits Realisation Work Stream).
- In April 21, the Clinical Services, Corporate Services, Strategic Change and Workforce & OD workstreams produced their top 5 benefits which are monitored through the Benefits Realisation Tracker.
- Due to the reset of the Integration Programme on June 21, these benefits have been redefined in August 21, and are to be confirmed with benefit owners in subsequent months.
- The benefits included consist of those stated in the Transaction Business Case and those subsequently identified.

Appendix 4.1- Benefits Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Report Month: October 2021

Workstream	Key type of benefit	Strategic intent statements (Transaction Business Case)	Description of benefit	Performance Measure	Status
Workforce & OD		Providing a strengthened workforce with improved flexibility, recruitment and retention through maximising the opportunity of UHB's reputation and brand	Improved recruitment and retention of medical staff (Medical agency expenditure savings) - Reduction in medical staff vacancies, improved rostering and financial controls	Reduction in medical agency expenditure	Behind Plan
				Reduction in medical vacancies – Consultants, Career Grades & Clinical Fellows in Weston	Behind Plan
				Reduction in medical turnover rates at Weston	On Track
Workforce & OD		Providing a strengthened workforce with improved flexibility, recruitment and retention through maximising the opportunity of UHB's reputation and brand	Improved recruitment and retention of nursing staff (Nursing agency expenditure savings) - Reduction in vacancies, improved rostering, lost time management and financial controls	Reduction in RN agency expenditure	Behind Plan
				Reduction in RN vacancies in Weston	Behind Plan
				Reduction in RN turnover rates in Weston	On Track
Workforce & OD		Realising benefits of alignment of clinical services and opportunities to reduce variation, improve productivity and to reduce operational and quality risks currently associated with some services	Improved Medical Workforce Productivity – Improved job planning and reduction in premium payments	Reduction in premium payments to consultants	Behind Plan
				% Weston consultants with an up to date job plan	Not Started
Workforce & OD		To develop a new set of leadership behaviours and values across the new organisation, shaping a new culture	Establish shared vision and values for the single UHBW organisation	New UHBW Values embedded	On Track
Workforce & OD		TBC	Stabilised staff engagement in Weston as a result of improved advocacy, motivation and involvement	Engagement score calculated as a result of responses given to the Staff Survey	Provisional

Appendix 4.2- Benefits Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Report Month: October 2021

Workstream	Key type of benefit	Strategic intent statements (Transaction Business Case)	Description of benefit	Performance Measure	Status
Corporate Integration	 Quality - Patient Experience	TBC	Improvement in Patient Experience at Weston	TBC	Provisional
Corporate Integration	 Recruitment and Retention	Providing a strengthened workforce with improved flexibility, recruitment and retention through maximising the opportunity of UHB's reputation and brand	Reduction in vacancies and sickness rate across Corporate functions	% of vacancies across corporate functions	Behind Plan
				% sickness rates within Corporate functions	On Track
Corporate Integration	 Corporate synergies	Realising efficiencies in shared corporate services	Improved value for money on Estates and Facilities contracts through rationalisation across the Trust	Reduction in no. standalone Weston Estates and Facilities contracts Reduction in overall Estates and Facilities contracts spend	Not Started
Clinical Integration	 Clinical Alignment and Reduction in Variation	Realising benefits of alignment of clinical services and opportunities to reduce variation, improve productivity and to reduce operational and quality risks currently associated with some services	Reduction in overall wait times for clinical services	Reduction in elective wait times	Provisional
Clinical Integration	 Flow and Impact	The merger allows alignment of ways of working and benefit to changes to clinical models at pace, as part of a single organisation	Increased care closer to home for non specialist care and increased specialist care undertaken at a specialist centre	Increase in % of patients with NS postcodes treated at Weston General Hospital for non-specialist care across all services	Not Started
				Increased in % of patients with NS postcodes treated on Bristol Royal Infirmary campus for specialist care across all services	Not Started

Appendix 4.3- Benefits Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Report Month: October 2021

Workstream	Key type of benefit	Strategic intent statements (Transaction Business Case)	Description of benefit	Performance Measure	Status
Clinical Integration	 Pace and Impact	The merger allows alignment of ways of working and benefit to changes to clinical models at pace, as part of a single organisation	Increased care closer to home for non specialist care, and increased specialist care undertaken at a specialist centre	Increased in % of patients with NS postcodes treated on Bristol Royal Infirmary campus for specialist care across all services	Not Started
Clinical Integration	 Resilience of acute Services	Addressing in a controlled manner the current known risks to the resilience of acute clinical services across Bristol and North Somerset	Enhanced work with system partners - identify sustainable solutions to ensure high quality outcomes for patients - e.g. Urology transfer to NBT	Completion of Urology transfer to NBT	On Track
Clinical Integration	 Clinical Alignment and Reduction in variation	Realising benefits of alignment of clinical services and opportunities to reduce variation, improve productivity and to reduce operational and quality risks currently associated with some services	Create standardised clinical pathways - ensure that patients receive consistent and high quality care across all sites reducing unwarranted variation, improving delivery and outcomes	Total Number of clinical pathways reviewed and single pathway agreed	Not Started
Strategic Change	 Improved Utilisation of the Estate	Greater scope to make best use of the combined available capacity and buildings in order to deliver our service goals	Improved Utilisation of the combined UHBW Estate	Reduction in 'very high' infrastructure risks at WGH	Behind Plan
				ERIC Metrics - Total Running Cost per Sqm	Not Started
				Engage in and contribute to estate optimisation plans for BNSSG	Not Started

Appendix 4.4- Benefits Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Report Month: October 2021

Workstream	Key type of benefit	Strategic Intent/alignment (Transaction Business Case)	Description of benefit	Performance Measure	Status
Strategic Change	 Resilience of Acute Services	Addressing in a controlled manner the current known risks to the resilience of acute clinical services across Bristol and North Somerset	Increase in resilience of acute clinical services and a reduction in risk at Weston	Reduction in number of 'must do' and 'should do' CQC actions	Provisional
				Reduction in 'very high' risks on the Weston Division Risk Register	On Track
Strategic Change	 Improve Digital Capabilities	Improve digital capabilities – provision of services across remote sites will provide a positive stimulus for the development of digital solutions to enhance and improve the quality of service delivery	Enhance delivery of corporate and clinical services due to integration of multiple IT systems across UHBW sites	Introduction of single Medway PAS system	On Track
				% of planned clinical systems integrated	On Track
Strategic Change	 Staff Training & Development	Supporting staff to access a greater range of training and development, education, training and research opportunities across a wider organisation. Establishing the WGH as an 'anchor institution' in North Somerset with a reputation for providing high quality training and education	Increased recruitment in clinical trials at Weston due to an integrated R&I team	Number of participants completing trails in Weston	On Track
Strategic Change	 Staff Training & Development	Supporting staff to access a greater range of training and development, education, training and research opportunities across a wider organisation. Establishing the WGH as an 'anchor institution' in North Somerset with a reputation for providing high quality training and education	Increased range of staff development opportunities and increased access to training	Apprenticeship new starts as % of workforce	Behind Plan
				Essential Training compliance	Behind Plan
				Library- number of evidence searches	On Track

Meeting of the Public Board of Directors on 30th November 2021

Report Title	**Sustainability Annual Report**
Report Author	**Sam Willitts, Head of Sustainability**
Executive Lead	**Paula Clarke, Director of Strategy & Transformation**

1. Report Summary

This report is to provide the Trust Board with assurance that we are making progress in achieving the commitments in our Sustainable Development Strategy.

2. Key points to note
(Including decisions taken)

The report highlights where successes have been made with the Trust's Sustainable Development Strategy, and shows continued progress towards sustainability targets and objectives for each of the workstreams: Carbon Neutral, Sustainable Models of care, Clean air, Sustainable Procurement and Sustainable Waste. Key successes: Awarded £17million of decarbonisation funding. Installed over 5500 LED light fittings. New Combined Heat & Power operational - 80% reduction in grid electricity imported. Introduced recycling coffee cups, bread bags, crisp packets, metals and pallets. Reduced single use plastic: Straws 96% Cups 91% Lids 75% Plates 82%. Increased cycle capacity to over 200 bike spaces. Increased fleet to 7 electric vans, 8 new electric bikes. Switched from disposable surgical hats to washable saving 25,000 hats per year. Biodiversity surveys completed for Bristol and Weston sites.

Whilst progress has been made in reducing our carbon footprint in areas under our direct control our supply chain carbon footprint has increased, so this will be a key focus for achieving our **net zero carbon target by 2030**. Other areas of sustainability focus will be on:

- Improving health and patient care and reducing health inequalities
- Building a more climate resilient healthcare system
- Becoming a clean air hospital
- Achieving zero waste to landfill by 2025 and minimise all waste by 2030

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

The risks associated with this report include:
Risk that the Trust fails to make a positive impact on combatting climate change. ID: 3472

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

- This report is for **Assurance.** The Board is requested to recognise the successes, and to support the step change required for delivery of the strategy going forwards.

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

[Name of Committee/Group/Board]	**[Insert Date paper was received]**
Sustainability Implementation Group	**5th October 2021**
Sustainable Development Board	**6th October 2021**

Recommendation Definitions:

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

University Hospitals Bristol and Weston NHS Foundation Trust

Annual Sustainability Report 2020-21

Pictures all submitted by staff to monthly nature and wellbeing calendar competition

LOVE LIFE, LOVE BRISTOL & WESTON

INTRODUCTION

Robert Woolley, Chief Executive

The past year has been unlike any other. The continuing impacts and pressures of COVID-19 have remained, whilst major strides have been made nationally to develop the sustainability ambition for the NHS.

As we've reconfigured healthcare services to meet the needs of our communities over the course of the pandemic, we've experienced both sustainability opportunities and challenges, some of which are reflected within this year's Annual Sustainability report.

The COVID-19 pandemic has exposed and exacerbated health inequalities, with disproportionate effects on disadvantaged communities. The effects of climate change will similarly affect and disrupt our communities, if action is not taken to reduce our carbon emissions and adapt to an already changing climate.

Demands on both frontline and support services staff have been extraordinary. We have worked flexibly, collaboratively and at pace, all of which will be needed for a modern, sustainable healthcare service; however, the ability of staff to consider and reduce the environmental impact of the services they deliver has been affected. Due to the ongoing pressures on staff, Employee Health and Wellbeing has been a major focus for the Trust and this has been reflected within our sustainability programme.

We aim to be one of the most sustainable healthcare providers in the world. Since declaring a climate emergency we have made progress, but there are many opportunities to do things in better, smarter and more effectively – for the good of patients, staff and our communities in Bristol and Weston.

2020-21 Highlights

Awarded decarbonisation funding £17million

Increased cycle capacity to over 200 bike spaces

Introduced recycling coffee cups, bread bags, crisp packets, metals and pallets

Biodiversity surveys completed for Bristol and Weston sites

Installed over 5500 LED light fittings

Reduced greenhouse gas emissions from anaesthetics equivalent to 50 cars off the road

New Combined Heat & Power operational 80% reduction in grid electricity imported

Recruited 32 Healthcare advocates

8 new electric bikes

Procurement reviewed against sustainability standard ISO20400

Reduced single use plastic:
Straws 96%
Cups 91%
Lids 75%
Plates 82%

Improved 4 outdoor spaces for wellbeing and nature

Set up 5 sustainability workstreams

Solar panels generated 46,260 KWh of electricity

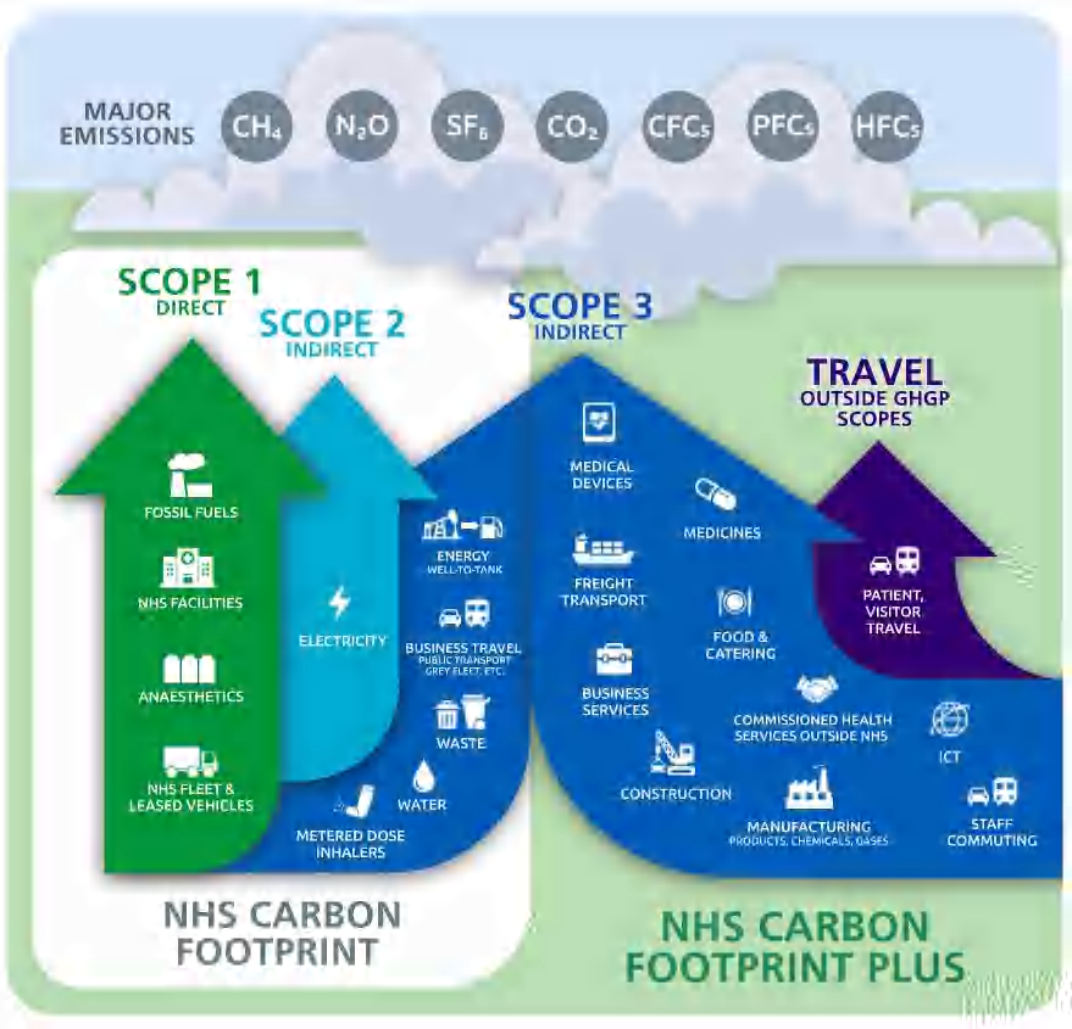
Sustainability Team increased to 12 staff, plus Transport Team of 22

Increased fleet to 7 electric vans

Switch from disposable surgical hats to washable. saved 25,000 hats per year

Goals

In October 2020 NHS England and NHS Improvement released the Delivering a 'Net Zero' National Health Service report outlining headline targets to reduce system wide carbon emissions within our direct control (NHS Carbon Footprint) to net zero by 2040, and wider indirect carbon emissions including the supply chain (NHS Carbon Footprint Plus) by 2045, with interim 80% reduction targets by 2028-2032 and 2036-39 respectively. These are the most ambitious targets of any healthcare system in the world and we have a collective responsibility to address the impact of the sector, and address the climate and health emergency.



The Delivering a Net Zero NHS report provides us with a stronger mandate to accelerate the required changes to Trust culture and infrastructure and to deliver against our ambitious commitments under the Bristol One City plan and contribute to the UN Sustainable Development Goals

A regional Greener NHS programme has now been established, and we are encompassing the aims of this programme within our wider sustainability strategy.

Whilst we must focus on our core delivery of health services (across 10 sites, with over 13,000 staff serving a core population of 500,000 people with an annual turnover nearing £1bn) we must also consider our wider influence on supply chains and society including the influence that can be achieved in supporting individuals, patients and community to support their health through healthy lifestyles and choices

- The Trust is an Anchor organisation in Bristol - what we do makes an impact. How we manage our buildings, activities and supply chains matters.
- We are building sustainability into all our business and operating planning.
- We are committed to and actively contributing to delivering Bristol's One City Plan including achieving carbon neutrality by 2030.
- We are committed to contributing to all 17 of the UN Sustainable Development Goals by 2025.

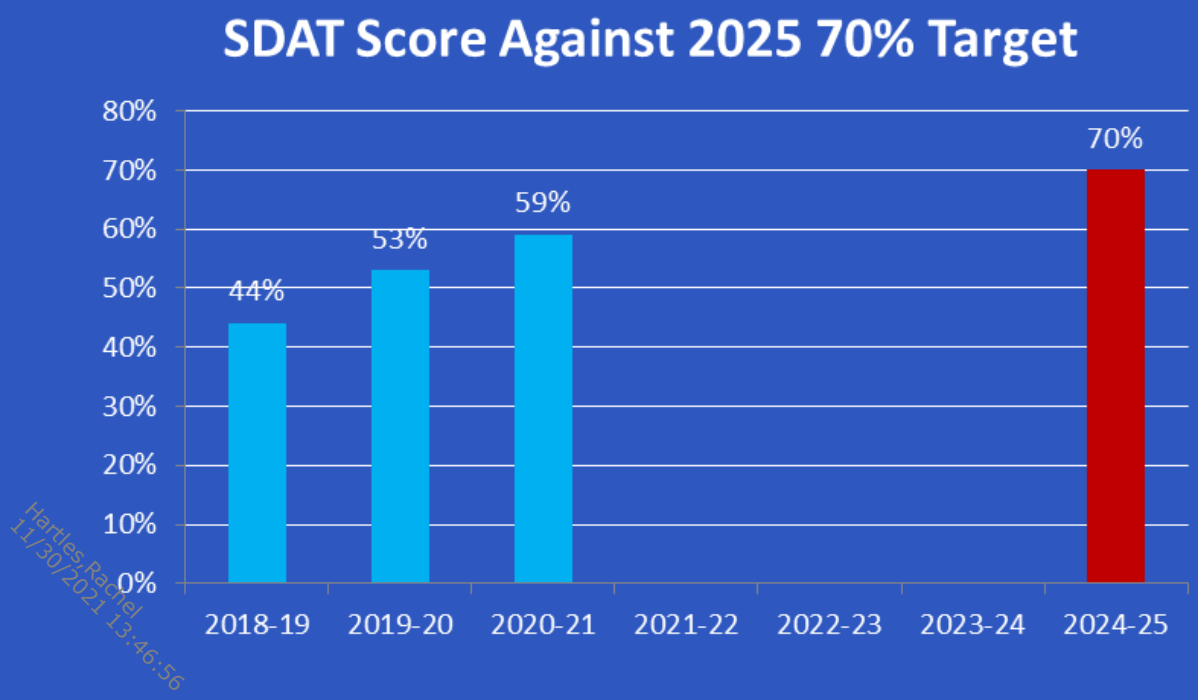
PROGRESS IN 2020-21

Assessing Performance

Our Sustainable Development Strategy covers a comprehensive set of targets developed from the NHS's own exemplar sustainability mapping tool known as the Sustainable Development Assessment Tool (SDAT). This report uses the SDAT to measure our performance over time across a broad range of sustainable areas, as well as providing an update from the members of the sustainability team.

Sustainable Development Assessment Tool (SDAT)

Area	2018-19	2019-20	2020-21
Asset Management and Utilities	70%	80%	86%
Travel and Logistics	49%	58%	71%
Adaption	27%	40%	53%
Capital Projects	44%	52%	63%
Green Space & Biodiversity	33%	41%	46%
Sustainable Care Models	41%	41%	44%
Our People	66%	69%	69%
Sustainable use of Resources	32%	38%	38%
Corporate Approach	40%	55%	60%
Carbon/GHGs	41%	51%	59%
Overall Score	**44%**	**53%**	**59%**

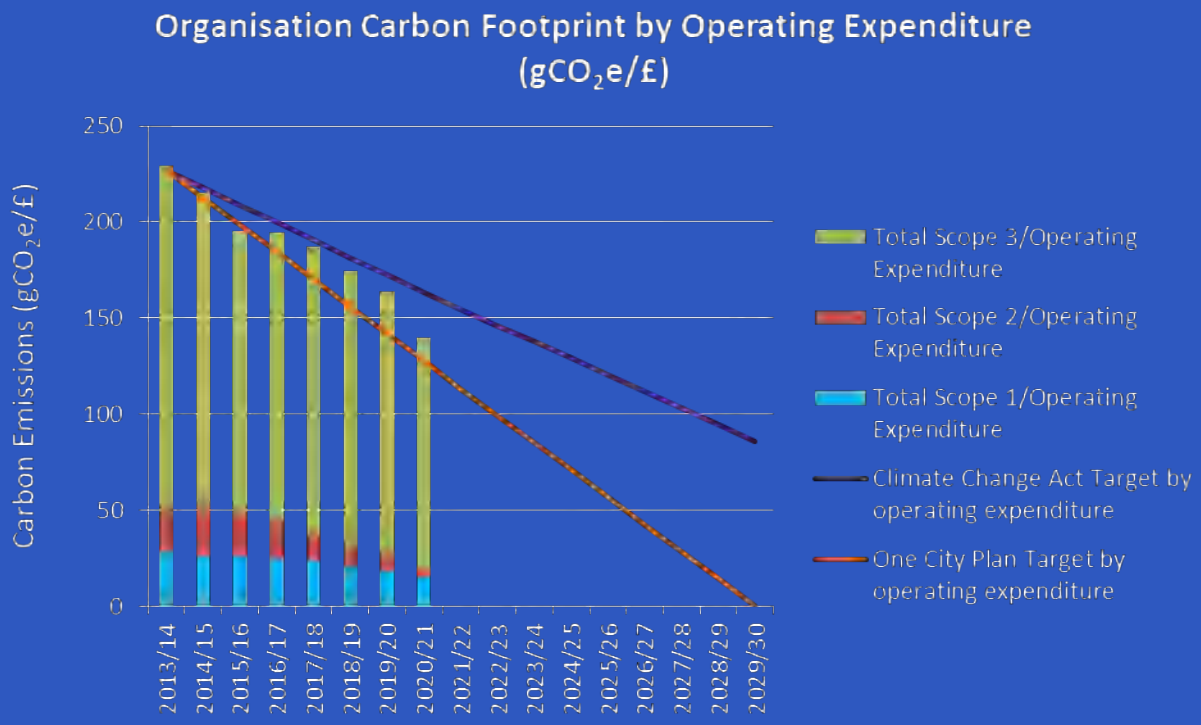


Carbon Neutral Work Stream
Target – We aim to be carbon neutral in all our activities by 2030.

Ned Maynard, Senior Energy and Sustainability Manager

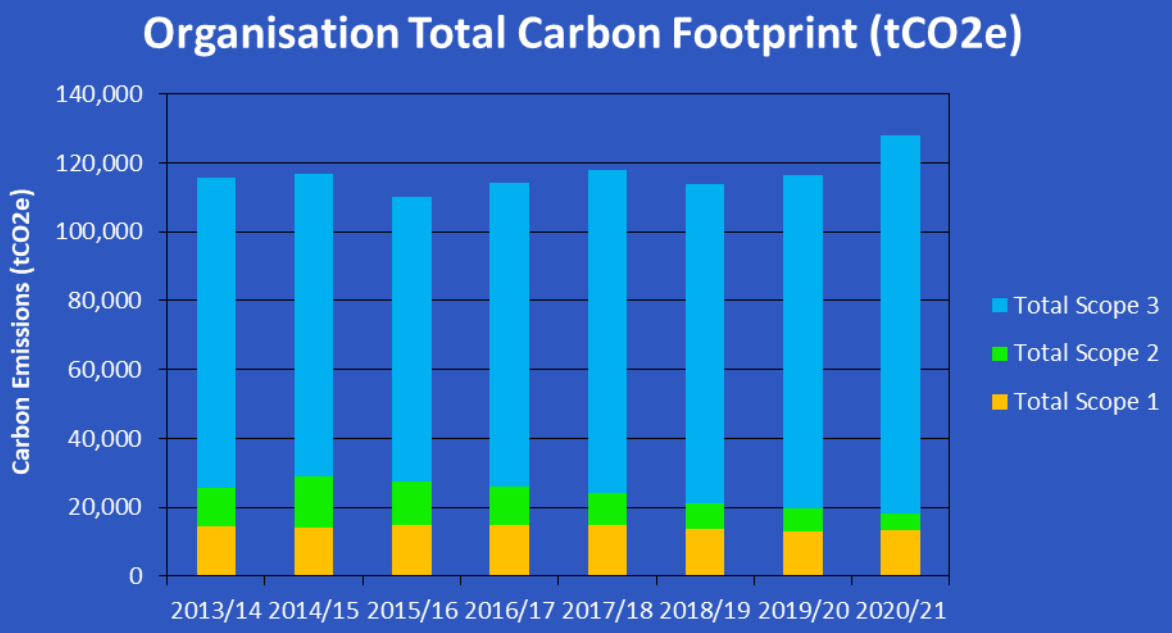
The last year has seen work towards our 2030 carbon neutral objective really kick off in a big way. Most notably the Trust applied for and was awarded £17m for a range of decarbonisation projects across Bristol and Weston via Salix Finance. At Bristol we are currently half way through the upgrade of our district heating system which will lower emissions in the short term and serve as a prerequisite for further emissions reductions as we move through the 2020s.

We've also seen progress separately to the Salix works, particularly on Anaesthetic Gases, some of which have a significant greenhouse gas impact. We have shut down the BRI Nitrous Oxide manifold system. We are still supplying Nitrous to the theatres, but have removed the leaking and wasteful piped network system which should result in emission reductions equivalent to taking 50 cars off the road.



The above graph shows that the intensity of our emissions has reduced, as total emissions have stayed the same, yet we've spent more capital delivering services. By this measure, we're on track to decarbonise in line with the Climate Change Act and Bristol One City Plan.

Unfortunately when considering total emissions data, we've not seen a reduction. The below graph shows total Scope 2 (electricity) is slowly decarbonising, driven by wider changes from National Grid. However, total Scope 1 (emissions from direct operations) and total Scope 3 (emissions from our supply chain) are not reducing over time. 2020/21 should hopefully be the peak year for Trust emissions, as we begin to see the benefits of increased investment over the past 12 months.



Our plans for next year are to finish off the Salix schemes and move ahead with the next phase of the journey – lowering distribution temperatures. We're also looking to expand the success of the BRI manifold project by removing all anaesthetics manifold systems from the Trust, and we'll be improving the efficiency of our building control strategies with our upgraded building management systems.

Joel Kirby, Energy and Sustainability Manager

Of the £17m Salix funding, £2.1m has been allocated to Weston General Hospital to cover a range of schemes including;

- Heating system optimisation works
- Building Management System (BMS) upgrade
- LED lighting rollout
- 140KW PV installation across 2 of the hospitals buildings
- Installation of the Trust's first air-source heat pump
- Metering throughout
- De-gassing of the hospitals cooking equipment

Initial testing of the BMS upgrade suggests huge potential savings of up to 25% of our heat load in summer. Overall the schemes are estimated to reduce the carbon footprint of the hospital over 350 tCO_2e per year and align Weston General to the Trust's overall heat decarbonisation road map.

In addition to these projects, we've been continuing to work across the hospital to reduce our consumption of water, gas and electricity. We're currently working closely with Camfil to trial energy efficient filters on our air handling units, with initial trials achieving between 5-20% saving in energy usage from reduced resistance across the units. We're also actively working to reduce our water usage with Elite-Mech who are installing new Airgap valves on all of our toilet cisterns. These work to reduce wastage by delaying the refill following a flush. The project is projected to save in the region of 3.5 million litres of water each year.

Sustainable Procurement Work Stream (Supply Chain)
Target – We aim to help our supply chain achieve carbon neutrality by 2030.

Rachael Pemberton, Bristol and Weston Purchasing Consortium

Our Sustainable Procurement work stream will be pushing for the sustainability of our supply chain going forward. Given the level of expenditure and buying power of the Trust, we have a huge opportunity to influence our supply chain. We want to work with all our suppliers engaging them in how they can support us in reducing our carbon emissions.

Before 2020, sustainability did not play a formal role in our procurement of goods and services. From 2020, all schemes over £1m in value will now be subject to a Sustainable Impact Assessment (SIA), with targets for 100% of business cases to include an SIA by 2025.

Bristol and Weston Purchasing Consortium are working with UHBW and North Bristol Trust to develop a sustainable procurement strategy to embed sustainability into our procurement processes and leverage the very significant influenceable spend as a force for good to bring our supply chains into delivering net zero carbon targets.

Amelia Pickard, Consultant Paediatric Anaesthetist

Emissions from our supply chain contribute the majority of our total carbon footprint, around 85%. Every piece of equipment (clinical and non-clinical) and medicine that we purchase and use increases our carbon emissions. The Covid-19 pandemic has also shown clearly the fragility of the supply chain, and future procurement strategies must take this into account.

Given this huge impact we have to look in detail at the products that we are bringing into our hospitals and find ways to reduce their impact. We are doing this in a couple of ways:

EcoQuip Plus – Zero-waste theatres is a collaborative innovation project which involves undertaking the procurement process in a way that stimulates the supply chain to invest in developing better goods and services to meet our needs. Operating theatres use high volumes of 'kit' and were therefore chosen as our target area.

Progress has been a little slower than anticipated due to the pandemic but is now moving forward well and a new project board has been set up to ensure that we have all the relevant stakeholders involved.

We have developed a Statement of Demand which demonstrates our requirement for solutions and alternative products that will support our transition to zero-waste theatres.

This statement has received overwhelming support from NHS Trusts and healthcare networks across the country who have put their names to the document demonstrating their agreement with this need. An event hosted in collaboration with Healthcare without Harm demonstrated that there is a significant level of interest within the supply chain.

The project is now in the market engagement phase and we are receiving feedback from our suppliers prior to the formal pro-innovation tendering process.

Individual products - We are also looking at individual single-use products that we buy, identifying re-usable alternatives and writing business cases to support their introduction into the Trust.

Of course unless we really understand our carbon footprint in this area we can't measure our improvements. Carbon foot-printing of products is incredibly complex and only one or two of our suppliers are currently doing this for their own products. We are therefore working in partnership with Eunomia Consultancy who will be performing a carbon footprint assessment of our supply chain. This will allow us to identify further areas of focus and demonstrate improvement over time.

Currently we focus almost exclusively on cost when purchasing products. Switching to incorporate wider value criteria requires our staff to understand the aims of sustainable procurement, so we are collaborating with the Institute of Environmental Management and Assessment (IEMA) to set-up and deliver certified training on the principles of sustainability to our procurement staff.

The challenges in this area are significant but given the level of national support for our objectives we are confident that the supply chain will move with us. Sustainable procurement must become business as usual for the Trust and to that end we will continue to engage with staff moving forward to disseminate knowledge but also to use staff expertise to identify areas of opportunity.

Morad Toussaad, Quality & Regulatory Affairs Manager for Clinical Engineering (MEMO)

As scientists and engineers in healthcare managing medical devices, we all have a responsibility to tackle the reduction of our carbon footprint to support our NHS Long term goals for the environment.

With 6 years consecutive involvement in the Trust engagement programme, Green Impact, Clinical Engineering (MEMO) has contributed to the Trust environmental targets via the sustainable procurement, maintenance and end-of-life management of medical devices.

We are currently reviewing our Trust medical devices management policy to streamline our processes, and so we have an opportunity to embed sustainable principles into this. One of the key aspects we are considering is sustainability impact assessments on all major medical device procurement activities, along with staff training and engagement.

With an average of 4,500 assets procured yearly, dealing with over 250 suppliers, our challenge remains a stronger engagement with our supply chain and manufacturers of medical devices to bring innovative solutions in reducing our carbon emissions by 2030.

Clean Air Work Stream (Transportation)

Target - We aim to becoming an excellent rated Clean Air Hospital by 2025.

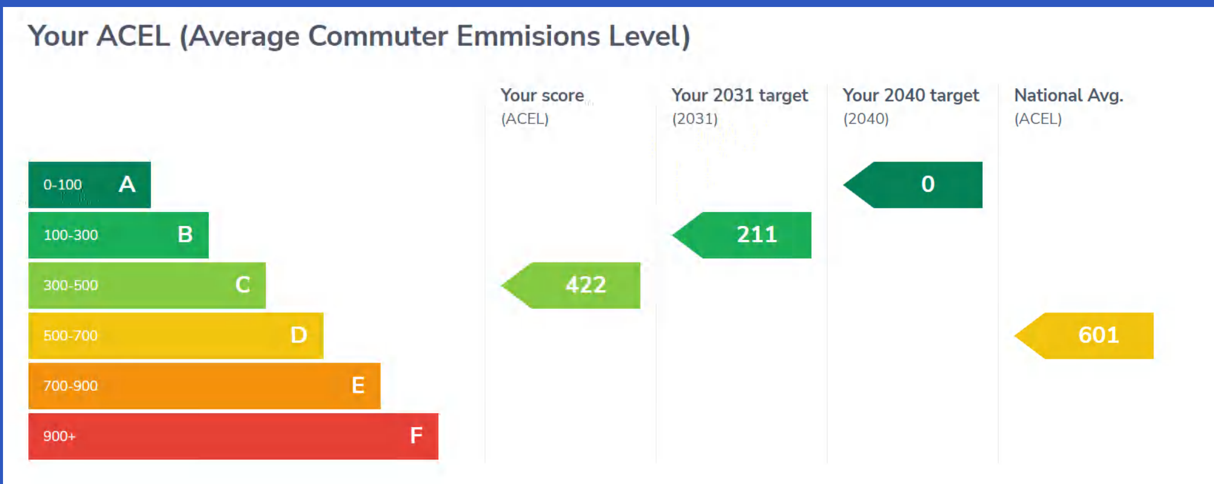
Stewart Cundy, Senior Sustainable Transport and Travel Manager

28th September 2020 was an exciting date for me. It was the date that after 22 years working for the Facilities department I transferred to Estates and the Sustainability Team. This allowed me to have more influence over implementing sustainable travel alternatives for Bristol and Weston hospitals.

Since my appointment we've invested a significant amount of funding to improve the cycle facilities for staff . Trust HQ has new two tier cycle stands with an increased the capacity for over 200 bikes. A new dedicated cycle centre was installed at Bristol Haematology & Oncology Centre. Weston has a new cycle shelter with showers and security CCTV has been rolled out across the Trust. There is also a new cycle lane on Marlborough Street that supports safe movement of bikes around our Bristol city centre hospitals.

We have consulted with staff car parking arrangements, and how we can reduce our traffic into the city centre. The hospital bus shuttle service has been enhanced to operate more frequently and later into the evening .We've also electrified our Trust vehicle fleet with 7 new electric vehicles purchased over in the last year.

The Trust has also entered into a partnership with Mobilityways which will enable the trust to capture data from how the staff travel to work and will give the trust an benchmark ACEL (average commuter emissions level) score.



The continuation of free car parking for NHS staff due to Covid-19 continues to be a challenge for sustainable travel. It is estimated this has put levels of staff that drive to work in a single occupancy vehicle back to 2002 levels. The next year will be challenging as Summer 2022 will see the introduction of the Clean Air Zone in Bristol and new car parking arrangements will be

introduced so that more staff that need to are able to park on site. The Trust will seek to support and encourage all the staff that have been driving to work to switch to more sustainable alternatives.

Dave Wilson, Green Travel & Car Parking Coordinator

Within the Clean Air Work Stream we have the sustainable travel and car parking team which I love being part of. We work with industry partners like Bristol City Council, Cabot Circus, The Galleries, First & Metro Bus and Great Western Rail to get our staff the best possible deals on safe and sustainable travel options. By the end of the year we will have 4 additional members to support staff with personal travel to work plans and administer the cycle to work and plans for an electric car salary sacrifice scheme.

The last cycle to work scheme we ran from April to June had 104 successful applicants who requested to use £123,385 for their purchases. To promote the scheme and greater adoption of cycling we ran 'Cycle Days' for all UHBW staff at the Bristol Trust HQ where staff could get their cycles security marked by the police and get a free service from 'Dr Bike'.

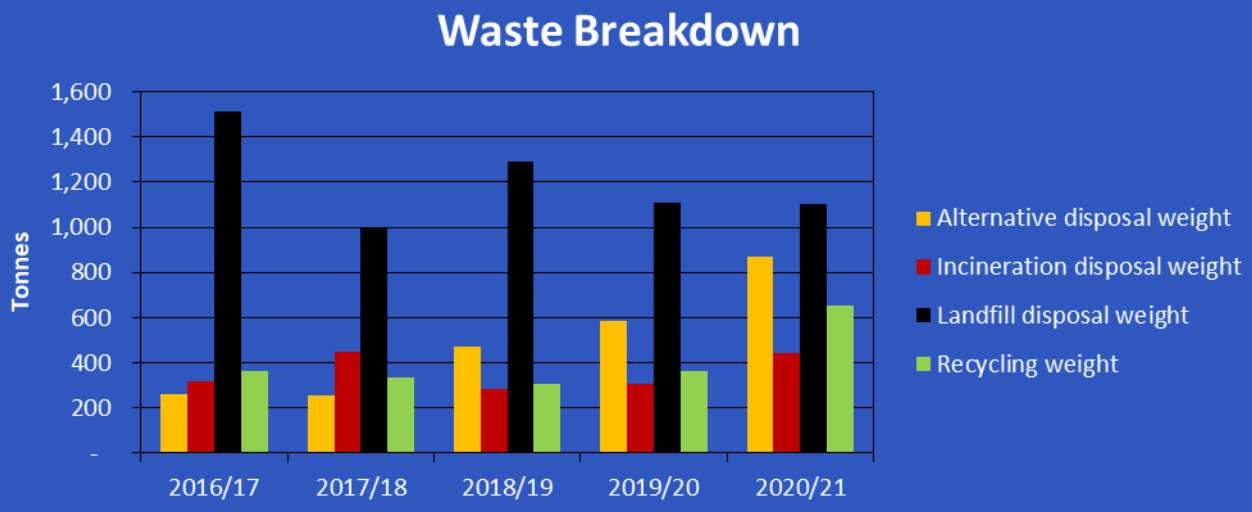
I really enjoyed seeing the ongoing success of the cycle to work scheme over the last year as it continues to grow in popularity with staff who wish to commute to work in a sustainable way. Looking ahead we plan to make people even more aware of what we can all do to help the local environment as well as promote health & fitness on their daily commute!

Waste Management Work Stream
Target - We aim to send zero waste to landfill by 2025.

Joaquim Duarte, Senior Sustainable Waste Manager

As well managing extraordinary levels of waste due to COVID-19 We've been busy developing new approaches to waste, such as the launch of coffee cup recycling stations in cafes across Bristol and Weston. We can also now recycle bread bags and crisp packets from our catering teams, and re-useable metal sharps from our clinical teams in theatres, day care, Endoscopy and Podiatry.

To reduce waste we have set up a collaboration initiative with the University of the West of England to supply out of date clinical items for use in their training facilities that would otherwise have gone to landfill.



Looking at the data for the last year we can see that recycling has increased, but landfill still remains our biggest waste stream.

The biggest development in waste management at the Trust has been through our Ecoqiuip+ project in collaboration with North Bristol NHS Trust. The project is supporting us in developing the innovative sustainable solutions and innovative procurement needed across the waste management sector in our hospitals and beyond.

Our focus going forward is to award waste management contracts to suppliers who will support our sustainable waste vision. We are exploring the possibilities for sustainable methods of disposal for food waste and face masks, as well as implementing an electronic system for furniture re-use alongside e-learning waste training packages.

Sustainable Care Models Work Stream

Sam Willitts, Head of Sustainability

Reducing the carbon impact of our care pathways is essential in achieving our 2030 carbon reduction target. Prevention of illness and avoiding the need for treatment gives us the best prospect of reducing environmental impacts.

Working across the health system – the Healthier Together Health and Sustainability Group, Digital work stream and Trust projects working on telemedicine, outpatients and smarter working are improving services, delivering care closer to home and reducing our environmental impact.

We are introducing sustainability impact assessments into decision making so business cases and operating plans to ensure they consider the environmental, social and financial impacts.

Joint working with our Transformation Team has enabled us to integrate sustainability into our quality improvement programme. The Transformation Team are capturing the sustainability improvements being delivered through their work.

Our experience with managing the COVID-19 crisis has shown how we can effectively provide remote consultations. Our capabilities for flexible and remote working have been developed considerably with staff wellbeing benefits. This has also opened up the possibilities of repurposing spaces in our hospitals.

Communications & Engagement Work Stream
Target – We aim to engage as many people as possible on sustainability.

Alexandra Heelis, Sustainability Officer

Unfortunately due to Covid-19 our normally annual Green Impact programme has been placed on hold. That hasn't however stopped our works on communications and engagement!

Since April 2020 43 members of staff have signed up to the Sustainability@UHBW newsletter. The monthly edition includes updates on sustainable healthcare as well as local, national and even global sustainability initiatives. The mailing list currently stands at 430.

The Sustainability Team launched a new Sustainable Healthcare Advocate role in 2021. This voluntary role is open to all staff members to help raise awareness, increase action and spread key messages regarding sustainable healthcare throughout the Trust. The role encourages and enables cross-departmental staff networking and collaboration as well as the opportunity to become directly involved with the work of the Sustainability Team. We have so far recruited 32 Sustainable Healthcare Advocates across all 8 Divisions within the Trust, and hope to recruit many more in the future. You can read the role description on the Sustainability@UHBW Connect pages.

In partnership with Bristol based charity, City To Sea, we have worked to raise awareness of the plastic content and correct disposal of menstrual products; the 5th most common item found on European beaches, ahead of single-use cups, cutlery and straws! A workshop was held for staff within our Women's and Children's Division about plastic-free and reusable menstrual products to raise awareness amongst colleagues and to pass on this knowledge to patients. We hope to be able to offer similar workshops in the future to staff across the Trust.

Following on from this work, we have collaborated with colleagues in Estates and in Facilities to tackle the issue of blocked drains at the Trust. In the 2020-2021 financial year the Trust spent over £160,000 unblocking drains. The main culprits were hand towels, sanitary items and rubbish. We have started a communication campaign, which will fully launch in Unblocktober (a national campaign to improve the health of our drains, sewers, watercourses and seas) raising awareness that the only items that should be disposed of down our toilets are toilet paper, poo and pee! Our work so far has already seen a saving of £12,361 in the first quarter of 2021-2022.

Arts and Sustainability

Anna Farthing, Arts Programme Director

The Arts + Culture team have supported the development and delivery of the Trust's sustainability objectives in a number of ways. Having come from the arts sector with fixed budgets and immovable deadlines, I am accustomed to working efficiently, and making the very best use of existing resources, including reciprocal relationships with civic, cultural and academic organisations. Other team members have previously worked with organisations with sustainable objectives such as Scrapstore and Bristol Green Capital.

Creative approaches and design thinking: reviewing design proposals and questioning where value can be added to best serve existing and future needs. Examples include addition of bespoke artwork during a refurbishment (BHOC) suggestion of replacement windows to incorporate energy efficiency into a scheme (Dermatology) improving the aesthetic impact of spaces that have no windows with the addition of landscape photographs taken by staff (numerous Trust wide). Also suggesting cost free design interventions to make working areas more efficient, moving existing furniture and making small changes to create more effective work spaces.

Boredom Buster: patient activity resource printed on paper. Thematic content includes biophilia, NHS Forests, landscape design, holistic use of green space, upcycling and recycling. Resource produced by UHBW and shared with 42 other NHS Trusts. Giving patients meaningful ways of staying occupied aids recovery, improves discharge rates and saves staff time.

Outdoor realm: making better use of outdoor realm to maximise useable space on the hospital estate, for people, for planet, for pollinators, for the circular economy. Encouraging staff to take breaks outside relieves pressure on staff rooms and benefits health and wellbeing.

- Creation of BHOC Roof Garden for staff wellbeing, transformation of a redundant space, contributing to recruitment and retention.
- Installation of Wellbeing Garden in BHI Courtyard. All materials re-used from London Nightingale disposal (wall planting, pots, furniture) and leftover building materials from our own sites (slabs, soil, hardcore). The project was delivered by professional contractors who volunteered their time.
- Installation of benches at Weston General Hospital, all commissioned from the Somerset Wood Recycling project and installed by Wilmott Dixon, who donated leftover and remnant building materials to the project.
- Improvement to soft landscape planting at front of BRI to increase biodiversity and reduce maintenance

Circular economy. Refurbishment of offices in Dolphin House using all recycled materials: desks, chairs and cabinets from CollectEco, IT equipment and telephones recycled from internal sources.

Community engagement: working with local craft groups to supply laundry bags for staff made from pillowcases and tea towels, and gift cards for patients unable to receive visitors. Builds reciprocal communities of care.

Weston Arts + Health Week has attracted funding from BNSSG Green Social Prescribing to investigate and report on barriers to engagement with outdoor physical activity among people who attend festival events in the parks and public spaces neighbouring the hospital. The report will inform future partnership working with Alliance Homes, Weston College, the Healthy Living Centre, and North Somerset Council.

Internally, we have partnered on projects to encourage active travel, including initial design planning for a combined walking, cycling, bus and pollinator stop. Look out for the Buzz Stop coming soon.

Collaboration

We are already working hand-in-hand with our North Bristol NHS Trust counterparts to harness the more than 20,000 people in our combined staff. We are active in the development of our Healthier Together Health and Sustainability Group working across the system. This collaboration will be extended as we move to an Integrated Care System (ICS) that will help the NHS operate more joined up and collaboratively rather than as individual Trusts.

Forming an ICS will allow for more efficient allocation of resources to take action on future areas including:

- single use plastics;
- recycling and disposal of waste;
- greenhouse gas emissions of anaesthetics;
- energy use for heating and lighting;
- energy from sustainable sources;
- water use;
- vehicle emissions;
- Digital innovation;
- sustainable food sourcing

Climate Change Adaption

The climate is changing. The UK is already seeing the impacts of climate change which affect the health of our population, from higher peak temperatures to more extreme weather events. How we cool our buildings, manage rain water and provide secure roofing and cladding in higher than average winds must be considered. Water scarcity will also become a more drastic issue as we move through the 21st century. Our approach will be informed by national guidance and partners across our region.

Beyond our estate, we need to support our communities in becoming resilient and ensuring our supply chains are able to cope with impacts of climate change.

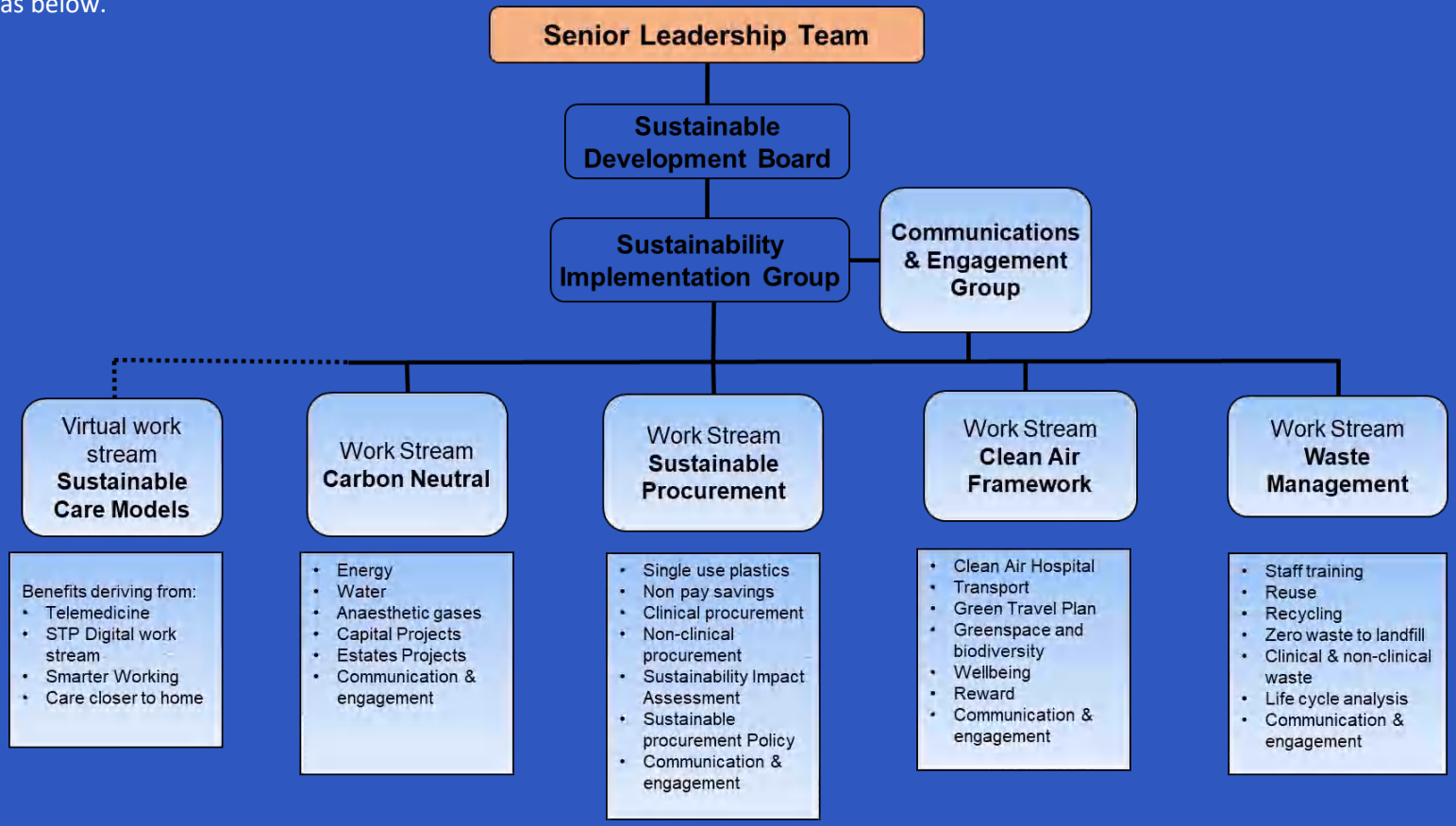
To plan for the future in this regard, we have adopted the Healthier Together Climate Change Adaption Plan 2018-23 that we played an active role in creating. We will be undertaking climate risk assessments to ensure all our services are resilient and prepared for the future.

Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Keeping Us On Track

Sustainability Governance Structure - We have a number of work streams, each of these reports into a governance structure overseen by the senior leadership team as below.



We have developed Key Performance Indicators (KPIs) across all our workstreams based on our Sustainable Development Strategy objectives. These are managed by our sustainability team to inform quarterly Board updates and monthly sustainability management updates. Further detail can be found in Appendix 2 Performance Tracker.

SUMMARY

The Greener NHS campaign was launched to tackle the climate 'health emergency' in January 2020. In its Net Zero Strategy, published in October 2020, the NHS set out a vision to become the world's first net zero carbon health service and respond to climate change, improving health now and for future generations. The plan commits the NHS to ambitious targets for carbon emission reduction

Whilst this report reflects on the great work undertaken by the Trust and our people to improve our impact on the environment and to also encourage sensible uses of natural resources, the challenge ahead remains considerable. The NHS is responsible for 4-5% of the UK's total carbon footprint, whilst the UK Government has now committed to net-zero by 2050. The NHS has responded to this challenge in England by committing to a 2045 target. We as a Trust have committed to our own target of 2030, aligning with our partners in Bristol's One City Plan.

As well as reducing our emissions under our direct control, we will build on the national commitment that before the end of the decade, the NHS will no longer purchase from suppliers that do not meet or exceed the NHS commitment to net zero.

Whilst carbon is a major consideration for sustainability, as this update shows, it is only one part of sustainable development. so in addition to the net zero target and in line with the greener NHS programme we will also focus on:

- Improving health and patient care and reducing health inequalities
- Building a more climate resilient healthcare system
- Becoming a clean air hospital
- Achieving zero waste to landfill by 2025 and minimise all waste by 2030

Since the last update, the Trust has continued to work towards being the most sustainable healthcare provider in England. We have also invested in our infrastructure, from our new CHP to improved cycling facilities. We have strengthened our sustainability team, established a Sustainable Development Board to oversee delivery of the many stringent targets we have set for ourselves within the wider NHS SDAT framework and ensure we are embedding sustainability in our decision making.

In this COP26 year of crucial decision making for our environment we recognise the challenges ahead and that there will be difficult decisions for the Trust. We will continue to work with our staff and other organisations to develop the innovative solutions required to overcome the challenges and move us towards a more sustainable healthcare system.

Your Trust needs you!

How you can get involved with theTrust

Becoming a member of University Hospitals Bristol and Weston NHS Foundation Trust is a great way to support, find out more, or get involved in the work of our hospitals.

It's free to join and how much you choose to get involved is up to you. You can:

- Have a say in how we develop our services
- Come along to our health matters events
- Receive regular e-news updates
- Stand as a governor
- Receive discounts from many brands

You can join online at:
www.uhbw.nhs.uk/p/working-with-us/become-a-member-of-our-trust

For more information please contact the membership office:

Telephone: (0117) 342 3764

Email: foundationtrust@uhbw.nhs.uk

Contact the Sustainability Team

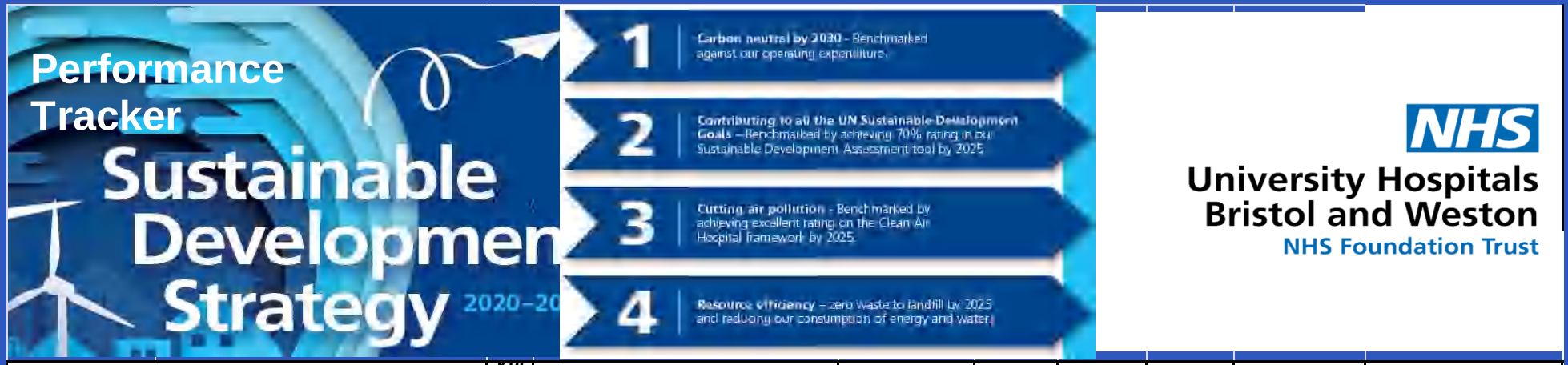
Email: sustainability@uhbw.nhs.uk

Appendix 1

Carbon footprint (tCO2e)

Area	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Grand Total (All Scopes)	**116,847**	**110,250**	**114,321**	**118,083**	**113,973**	**116,612**	**127,799**
Total Scope 1	**13,922**	**15,011**	**14,675**	**14,786**	**13,743**	**13,107**	**13,366**
Gas	10,126	11,159	11,169	11,520	10,438	10,411	11,721
Oil	304	322	233	195	198	306	181
LPG							2
Diesel	0	0	0	40	42	41	10
Anaesthetic Gases	3,493	3,531	3,274	3,031	3,065	2,350	1,452
Total Scope 2	**15,133**	**12,587**	**11,400**	**9,333**	**7,413**	**6,684**	**4,748**
Grid Electricity	15,133	12,587	11,400	9,333	0	0	0
REGO Electricity	0	0	0	0	7,413	6,684	4,748
Total Scope 3	**87,792**	**82,652**	**88,246**	**93,965**	**92,817**	**96,821**	**109,685**
Gas (WTT)	1,359	1,502	1,517	1,742	1,611	1,354	1,524
Oil (WTT)	57	61	43	43	37	58	34
LPG (WTT)							0.3
Electricity (Transmission & WTT)	3,829	3,070	2,898	2,500	1,825	1,579	1,064
Diesel (WTT)							2
Travel (Patient and Visitor)	10,294	10,485	10,844	11,377	11,808	11,823	8,876
Travel (Staff Commute)	1,999	2,186	2,252	2,299	2,367	2,471	2,926
Water (Use)	80	81	86	80	77	78	94
Water (Waste Treatment)	149	150	160	147	141	143	174
Waste (Recycling)	7	5	8	7	7	8	14
Waste (Other Recovery)	0	7	6	5	10	13	19
Waste (Incineration)	24	6	7	10	6	7	9
Waste (Landfill)	386	464	693	457	592	509	505
Business services	8,206	8,430	8,897	9,928	9,922	10,461	12,773
Construction	14,013	7,526	9,458	8,037	7,119	7,910	7,910
Food and catering	5,975	6,138	6,478	7,229	7,224	7,617	9,300
Freight transport	3,158	3,244	3,424	3,820	3,818	4,025	4,915
Information and communication technologies	1,243	1,277	1,348	1,504	1,503	1,585	1,935
Manufactured fuels chemicals and gases	3,410	3,503	3,697	4,126	4,123	4,347	5,308
Medical Instruments /equipment	17,532	18,010	19,008	21,211	21,197	22,350	27,290
Other manufactured products	2,918	2,998	3,164	3,530	3,528	3,720	4,542
Other procurement	0	0	0	0	0	0	0
Paper products	2,387	2,452	2,588	2,888	2,886	3,043	3,715
Pharmaceuticals	6,921	7,110	7,504	8,374	8,368	8,823	10,773
Business Travel and fleet	1,968	2,021	2,133	2,380	2,379	2,508	3,063
Commissioned health and social care services	1,876	1,927	2,034	2,269	2,268	2,391	2,920

Appendix 2 Performance Tracker



SDS Objectives		KPI Identifier	Performance Standard Description	Target Performance	Reporting cycle	2020 Septemb	2021 August	Responsibility	Comments
Corporate Approach									
Ensure sustainability is embedded within organisational decision making:	Deliver, monitor and report on sustainability progress, Senior staff, stakeholders and governors are engaged in, and accountable for, delivering our SDS, and policies, procedures, business cases and processes reflect this.	CO1	Sustainable Development Assessment Tool (SDAT) Score	70% by 2025	Annual	53%	59%	Sustainability Implementation Group	Tool due to be replaced
		CO2	Number of Departments with completed SDAT reviews	1 per month	Monthly	Not currently reported	1	Sustainability Implementation Group	W&C SDAT review planned for July
		CO3	Percentage of business cases over £1million with SIA	100%	Monthly	0	2	Deputy Head of Commissioning and Planning	
		CO4	Divisional Operating plans with SIA review and measurable targets	100%	Annual	0	1	Associate Director Strategy and Business Planning	To include in business planning later 2021
		CO5	Annual staff sustainable development awareness survey score	Annual improvement	Annual	Not Currently reported	Not Currently reported	Sustainability Implementation Group	

Capital Projects									
Reduce the environmental impact of building works during design, refurbishment, construction, operation and decommissioning stages:	Embed sustainability and efficiency using smart design and emerging technologies across our improvement works, including refurbishment and new build. Take a whole life cycle approach to projects by scrutinising sustainability in design, construction, commissioning, operation and decommissioning, helping to future-proof our organisation.	CA1	Percentage of capital projects with SIA completed	100%	Monthly	0	2	Associate Director, Capital	
		CA2	Percentage of Estates projects with SIA completed	100%	Monthly	Not currently reported	Not currently reported	Associate Director, Estates	
		CA3	Percentage of new build capital projects achieving BREEAM Excellent	100%	Monthly	Not currently reported	Not currently reported	Associate Director, Capital	To be replaced with NZC standard
		CA4	Percentage of refurbishment capital projects achieving BREEAM Very Good or mitigation actions implemented where BREEAM not applicable	100%	Monthly	Not currently reported	Not currently reported	Associate Director, Capital	To be replaced with NZC standard
Asset Management & Utilities									
Derive 100% of our energy from renewable sources, embed energy and water efficient technologies and practices throughout our Estate and services, and deliver year-on-year reductions in consumption:	Accurately measure utilities and reduce consumption to make sure we're getting the best value for money and minimising environmental impact. Embed more efficient practices, new technologies and improve staff awareness to improve utility efficiency across everyday activities and as part of longer-term plans.	AS1	Percentage of electricity from imported renewable sources.	100%	Annual	100%	100%	Energy and Sustainability Manager	
		AS2	Percentage of heat from renewable sources.	100% by 2030	Annual	0	0	Energy and Sustainability Manager	CHP generated is heat is less carbon intensive so an imrovement but not renewable
		AS3	Reduction of Electricity Consumption	Reduction on month of previous year	Monthly	-8%	-10%	Energy and Sustainability Manager	
		AS4	Reduction in Non - CHP (HDD adjusted) gas use	Reduction on month of three year rolling average	Monthly	0%	No data	Energy and Sustainability Manager	Boilers compensating for no CHP generated heat
		AS5	Combined Heat and Power Availability	90% running days per month	Monthly	N/A	**90%**	Energy and Sustainability Manager	Engine removed replacement expected September
		AS6	Reduction of Water Consumption	Reduction on month of previous year	Monthly	-15%	**13.70%**	Energy and Sustainability Manager	

Sustainable Use of Resources

Work to minimise our use of resources, improve our waste management, and reduce waste production year-on-year:

	RE1	Procurement supply chain intensity - carbon footprint/operating expenditure	carbon neutral by 2030	Annual	-3%	-7%	Chair of sustainable procurement workstream	currently annual report only
Meet legal responsibilities to make sure that waste is properly segregated, handled and disposed of.	RE2	Percentage of suppliers engaged with making sustainability improvements	100% by 2025	Annual	Not currently reported	Not currently reported	Chair of sustainable procurement workstream	survey to out
Reduce unnecessary use of resources across all of our organisational activities. Procurement constitutes the largest proportion of our carbon footprint	RE3	Percentage of procurement exercises that have an SIA	100% above £X value	Monthly	Not currently reported	Not currently reported	Chair of sustainable procurement workstream	
Apply the waste hierarchy, rethinking traditional waste models and working closely with our staff and supply chain, we can move towards a circular economy approach and away from a throwaway culture.	RE4	Number of single use products replaced with reusable alternatives	1 per month	Annual	0	0	Chair of sustainable procurement workstream	
Zero waste to landfill	RE5	Amount assessed of the 15 plastic product groups responsible for 69% estimated overall plastic content goods	1 per month	Monthly	Not currently reported	Not currently reported	sustainable procurement workstream	
	RE6	Incineration - high temp disposal	Reduction on previous month	Monthly	15%	18%	Sustainable Waste Manager	
	RE7	Other recovery Alternative Treatment EFW	Reduction on previous month	Monthly	41%	19%	Sustainable Waste Manager	
	RE8	Offensive Waste	Reduction on previous month	Monthly		14%	Sustainable Waste Manager	
	RE9	Recycling	Increase on previous month	Monthly	62%	24%	Sustainable Waste Manager	
		Landfill	Reduction on previous month zero by 2025	Monthly	30%	33%	Sustainable Waste Manager	
	RE10	Internal reuse of durable goods	value of goods reused £	Monthly		£3,250.00	Sustainable Waste Manager	
	RE11	External reuse of durable goods	value of goods reused £	Monthly	Not currently reported	Not currently reported	Sustainable Waste Manager	

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Carbon/GHGs									
Carbon neutral by 2030	Engage staff, suppliers and contractors with our SDS to reduce our carbon footprint. Measure our carbon emissions, identify hotspots and take targeted action to reduce this year-on-year in line with our 2030 carbon neutrality target.	GH1	reduction in carbon footprint from Energy, water, Anaesthetic Gases	carbon neutral by 2030	Annual	-8%	-8%	Head of Sustainability	Currenlty only annual report
		GH2	reduction in carbon footprint from Waste	carbon neutral by 2030	Annual	-13%	2%	Sustainable Waste Manager	Currenlty only annual report
		GH3	reduction in carbon footprint from Travel and Transport	carbon neutral by 2030	Annual	1%	-18%	Chair of Trust Clean Air Workstream	Currenlty only annual report
		GH4	reduction in carbon footprint from procurement broken down by key areas	carbon neutral by 2030	Annual	Not currently reported	Not currently reported	Chair of sustainable procurement workstream	
		GH5	Number of suppliers engaged in reduction in carbon footprint	100% by 2025	Annual	Not currently reported	Not currently reported	BWPC sustainability lead	survey response
Climate Change Adaptation									
Ensure our whole organisation is prepared to deal with the effects of climate change, particularly extreme weather events, and continues to invest in adaptation and mitigation	Assess the impacts of climate change and adapt to mitigate the negative effects of past and future climate-altering actions.	AD1	Reduced risk rating in our climate change risk assessment	Reduction on previous year	Annual	0	0	Head of Sustainability	
	Ensure our infrastructure, services, procurement, lo	AD2	Capital and Estates projects incorporating future climate predictions in design	100%	Monthly	Not currently reported	Not currently reported	Director of Estates and Facilities	included in standard specification

Greenspace and Biodiversity									
Maximise the quality and benefits from our green spaces and reduce biodiversity loss by protecting and enhancing natural assets:	Improve green spaces to maximise benefits for mental and physical wellbeing. Improved air quality, noise reduction, support biodiversity and help combat climate change.	BI1	Value of natural capital	Increase	Annual	Not currently reported	Not currently reported	Chair of Trust Clean Air Workstream	
	By collaborating with partners and local communities we will implement a clear strategy that helps us contribute to local biodiversity and make the best use of available green space	BI2	Increase in area (m2) of our sites improved/managed for biodiversity and staff wellbeing	increase	Annual	Not currently reported	Bio Diversity survey carried out in Bristol and Weston	Chair of Trust Clean Air Workstream	Bio Diversity survey carried out in Bristol and Weston
Sustainable Care Models									
Deliver the best quality of care while being mindful of its social, environmental and financial impact and take a whole systems approach to the way it is delivered:		MO1	Carbon hotspots identified and environmental impact mitigation plan produced for areas such as medical equipment and pharmaceuticals	1 per month	Annual	0	0	Head of Sustainability and BWPC sustainability lead	
	Improve the environmental sustainability of care pathways, and better integrate healthcare services to improve efficiency.	MO2	improved Patient feedback and scores (e.g. PLACE).	improved Feedback relating to the care environment (e.g. temperature, light).	Annual	Not currently reported	Not currently reported	Patient Environment Operational Group - Facilities Performance and Projects Manager	
	Embrace new and existing digital technologies to reduce the environmental impact of care, prevent ill health and manage long-term health conditions.	MO3	Number of sustainable models of care initiatives showing Financial, environmental and social benefits being delivered		Monthly	Not currently reported	Not currently reported	Transformation Programme Director	
	Work with partners and stakeholders to identify and deliver solutions that reduce the number of hospital visits, such as the provision of treatment closer to home	MO4	Reduction in hospital admissions due to sustainable models of care		Monthly	Not currently reported	Not currently reported	Transformation Programme Director	
		MO5	Increase in non-face to face outpatient contacts.	Jan - March 2020: 8% of appointment non face to face (Bristol only)	Monthly	8%	43%	Transformation Programme Director	

Travel and Logistics

Minimise the environmental and health impacts associated with the movement of goods and people on Trust business:

	TR1	Number of service change proposals with SIA - assessing travel options and impacts when planning changes to our services (using Health Outcomes of Travel Tool)	100%	Monthly	Not currently reported	Not currently reported	Chair of Trust Clean Air Workstream	travel options were assesed as part of relocating clinics for Covid response
increase in staff that respond to the Travelwest travel to work survey	STR1	City Council supported travel to work survey. This provides the Trust with data about staff habits when travelling to work	25% of staff to take part by 2025	Annual	8%	11%	Chair of Trust Clean Air Workstream	communication is key to deliver this
reduction in % of staff travel to work by Single Occupancy vehicle (SOV)	STR2	Staff to be supported to not rely on the car when travelling to work. Covid 19 and free car parking for NHS staff has meant that more staff intend to drive to work	year on year % decrease in staff that use SOV for travel to work 10% by 2025	Annual	46%	47%	Chair of Trust Clean Air Workstream	the continued free car parking for NHS staff has meant that staff that used alternative means previously are now driving to work
increase in % staff that car share to travel to work	STR3	staff that car share to travel to work need to be supported by being provided with adequate facilities for this eg: dedicated parking spaces	year on year %increase of staff that car share 10% by 2025	Annual	5%	7%	Chair of Trust Clean Air Workstream	this is a good result considering for most of 2020 and into 2021 people are encouraged not to car share
increase in % staff that walk to work	STR4	walking to work has many benefits. It is better for the environment as well physical and mental health wellbeing benefits.Staff should be supported to walk to work with adequate facilities provided for them in the workplace	year on year % increase of staff that walk to work 20% by 2025	Annual	14%	13%	Chair of Trust Clean Air Workstream	
increase in % staff that cycle to work	STR5	cycling to work has many benefits. It is better for the environment as well physical and mental health wellbeing benefits.Staff should be supported to cycle to work with adequate facilities provided for them in the workplace	year on year % increase of staff that cycle to work 17% by 2025	Annual	12%	12%	Chair of Trust Clean Air Workstream	
increase in staff that use the bus or other forms of public transport to travel to work	STR6	Covid 19 restrictions has lead to a lack of confidence in using public transport for travel to work. Reduced capacity on the buses has also meant that the Bus currently cannot be relied upon as a means of travel to work	year on year % increase of staff that use the bus for work 30% by 2025	Annual	13%	17%	Chair of Trust Clean Air Workstream	
maintain % of staff that work from home	STR7	Covid 19 restrictions has meant that more staff have started to work from home. This needs to be encouraged and supported where possible.	maintain the % of staff that work from home with a target of 13% of staff working from home for at least 50% of the time	Annual	10%	14%	Chair of Trust Clean Air Workstream	staff continue to work from home with 14% of staff working from home entirely.20% of staff alternate working from home with working on site

Minimise the environmental and health impacts associated with the movement of goods and people on Trust business:

Reduction in mileage of fleet vehicles using fossil fuels	BTR1	baseline set November 2020		Annual		Not currently reported	Chair of Trust Clean Air Workstream	the telematics can record this and a base line will be set in November 2021
increase in mileage of fleet vehicles that are EV	BTR2	baseline set November 2020		Annual		Not currently reported	Chair of Trust Clean Air Workstream	the telematics can record this and a base line will be set in November 2021 the Trust now has 7 Electric vehicles
Reduction in mileage claimed by staff for Grey Fleet use	BTR3	baseline set November 2020		Annual		Not currently reported	Chair of Trust Clean Air Workstream	still unable to obtain this data from Payroll
increase in staff use of Trust EV pool cars or E Bikes for business use	BTR4	Owned Electric and PHEV mileage		Annual		Not currently reported	Chair of Trust Clean Air Workstream	bookings through Transport team
Patient and visitor Travel surveys	PTR1	Patient and visitor travel question to be included on Kiosk/Car park activity report	surveys to be carried out	Annual	Not currently reported	Not currently reported	Chair of Trust Clean Air Workstream	
reduction in % of patients and visitors travelling to hospital by car	PTR2	Patient and visitor travel question to be included on Kiosk/Car park activity report		Annual	59%	Not currently reported	Chair of Trust Clean Air Workstream	info taken from 2020 survey for baseline
increase in % of patients that travel to hospital by sustainable methods	PTR3	Patient and visitor travel question to be included on Kiosk/Car park activity report		Annual	41%	Not currently reported	Chair of Trust Clean Air Workstream	info taken from 2020 survey for baseline
monitor the air quality within and external to our buildings	PTR4	Air quality within and external to our buildings.		Annual		Not currently reported	Chair of Trust Clean Air Workstream	air quality monitors were installed September 2021 the information from them is that recommended levels of PM10 and PM 2.5 are being exceeded regularly
	TR9	Clean air hospital framework score.	Excellent by 2025	Annual	Not currently reported	Not currently reported	Chair of Trust Clean Air Workstream	

Our People									
Support staff to improve sustainability at work and home and empower them to make sustainable choices and improve their health and wellbeing:		PE1	Number of environmentally-focused staff benefits.	increase annually	Annual	Not currently reported	Not currently reported	Workplace Wellbeing Team	
	Staff engaged and enabled to adopt sustainable practices and to take ownership within their own areas of influence.	PE2	Staff participation in sustainability programmes.	incease % of staff	Annual	Not currently reported	Not currently reported	Sustainability Officer	
	All staff clear in their roles in delivering this strategy.	PE3	Social Value Calculator. CQUIN performance.		Annual	Not currently reported	Not currently reported	Sustainability Manager, Senior Commissioning and Planning Manager	
	Sustainability leadership in our communities; staff empowered to make sustainable choices at work, home, across our supply chain and beyond.	PE4	Staff sickness	reduction attributable to Sustainability initiatives	Annual	Not currently reported	Not currently reported	Workplace Wellbeing team, Green travel team, Line Managers	

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

Report Title	Operational Planning Process 2021/22: H2 Planning Oversight of Submission
Report Author	Evelyn Elliott, Head of Commissioning and Planning
Executive Lead	Paula Clarke, Executive Director Strategy & Transformation and Mark Smith, Deputy Chief Executive and Chief Operating Officer

1. Report Summary

This paper provides an update to the 2021-22 Operating Plan paper submitted to the board in July 2021 and includes:

- National planning guidance update
- Updates to the Trust performance
- Targeted Investment Fund (TIF) approach and summary of proposals
- Timelines and next steps

2. Key points to note

(Including decisions taken)

The Trust has worked collaboratively with system partners to submit Activity, Finance and Workforce plans. In addition work has been undertaken to respond to the national request to submit bids against the Targeted Investment Fund (TIF). The Trust is still awaiting the outcome of the submitted bids imminently.

The Trust has updated the activity and performance from those submitted in H1.

The System plan was submitted on 16 November 2021 and included; Activity and performance plans, Workforce plans, Supporting narrative, and a System finance plan. A Trust Finance submission is due for submission on 25 November 2021

The next steps for H2 plans and TIFs include:

1. Developing detailed implementation plans for approved TIF bids, commence mobilisation and agree the delivery and governance mechanisms for these schemes both within the Trust and the system.
2. Embed H2 Elective recovery plan in the Trust processes and Campaign Plan priorities
3. Use H2 Elective recovery forecasts to inform 22/23 Operating Plan and development of the multi-year recovery plan

3. Risks

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

The risks associated with this report include:

The key risks associated with the delivery of the TIF bids are:

- Workforce and recruitment
- Capacity to deliver the schemes, particularly if there is a capital element

- Impact of non-recurrent funding

The most significant risks to overall delivery of activity and performance plans are as follows:

- The number of patients who are Medically Fit For Discharge (MFFD) in acute beds due to insufficient community pathway capacity
- Insufficient protected green bedded capacity to support planned care delivery
- Clinical prioritisation of patients on the elective wait list means that often the longest waiting patients wait longer when it is not clinically indicated for them to be seen ahead of shorter waiting, more clinically urgent patients. Patients are presenting later and therefore likely to be more complex and higher priority.
- Access to inpatient beds and ICU beds
- Unknown impact of winter non elective demand
- Unknown impact of further COVID-19 surges and/or Influenza/RSV.
- Access to Independent Sector capacity – Independent Sector will have a limited role in recovery due to their capacity/desire to accept patients, case mix and their own lengthening wait times.
- Workforce shortages, particularly in Theatres, ICU and in the wards.
- Deteriorating patients as a result of extended waits – treatment sub-optimal – poor patient experience/outcomes and potential for extended length of stay.

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

- This report is for **Information.**

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

Business Senior Leadership Team	**17 November 2021**

Recommendation Definitions:

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

University Hospitals Bristol and Weston NHS Foundation Trust

Operational Planning Process 2021/22: H2 Planning Guidance and Next Steps

1. Introduction

This paper provides an overview of the approach to H2 planning, completion of submissions and next steps.

2. National Planning Guidance Update

NHS England published the following operational planning documents on the 30 September 2021:

- 2021/22 priorities and operational planning guidance: October 2021-March 2022
- Guidance on finance and contracting arrangements for H2 2021/22
- Submission guidance
- Activity, performance and workforce technical definitions

These documents are available to read in full at https://www.england.nhs.uk/operational-planning-and-contracting/.

The key points for the Trust to consider from the H2 planning are highlighted below:

- The Trust is required to develop triangulated plans across activity, workforce and finance for the second half of the year (known as H2). The Trust is expected to work with partners in the BNSSG Integrated Care System (ICS) to produce these plans.
- Two funds will be made available to support elective recovery during H2: a Targeted Investment Fund (TIF) which will aim to target investment at systems in return for specific delivery commitments; and an Elective Recovery Fund (ERF) to support activity.
- The South West regional allocation of the TIF is approximately £70m. Systems and providers were asked to submit by 14 October:
  a. Initial elective recovery and capacity plans
  b. Bids against Targeted Investment Fund (TIF) of £70m (£25m digital capital, £25m other capital and £20m flexible capital/revenue) to support elective recovery
- In H2 the Elective Recovery Fund will be focussed on completed referral to treatment (RTT) pathway activity rather than total cost weighted activity which was used in H1.
- Systems are required to refresh their people plans to show greater progress on equality, diversity and inclusion; progress on compassionate and inclusive cultures; and increasing workforce supply.
- There is an ambition for systems to:
  - Eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer ('P5' and 'P6' patients)

- Hold or where possible reduce the number of patients waiting over 52 weeks
- Stabilise waiting lists around the level seen at the end of September 2021

- The current block contract payments approach will continue in H2 2021/22 for NHS providers. System funding envelopes are based on H1 2020/21, adjusted for known pressures. H2 funding also includes an increased efficiency requirement from H1. Signed contracts between NHS commissioners and NHS providers are not required for the 2021/22 financial year.
- To ensure consistency in submissions, systems and providers have been asked to assume that:
  - Overall non-elective demand (from COVID and non-COVID) is at pre-pandemic (2019/20) levels, subject to the impact of any planned service developments.
  - COVID general and acute bed occupancy remains at the current level across the second half of the year.

3. Approach to Targeted Investment Fund (TIF) Bids

The system has worked collaboratively to submit TIF bids to the region within a short timescale. Bids were encouraged that demonstrated system working and/or joint bids with system partners. Prioritisation was on the basis of overall impact in H2 or 2022/23.

The process for review and approval of TIF bids:

1. Approval by system Chief Executives to submit bids for regional approval
2. Review and sign off by the regional team
3. Submission to the national team for approval

Initial bids submitted by the system were expected to deliver, and have an impact on elective recovery in H2 or 2022/23.

Following the comprehensive spending review an additional £1.5bn of funding was announced nationally to support elective services recover for the three year period 2022/23 to 2024/25. As a result the system was asked to review the initial TIF bids submitted and a further opportunity was provided to submit more strategic bids that would deliver in 2022-2025. The system prioritised bids that already had initial worked up plans.

The Trust submitted the following two strategic bids:

1. GICU Stage 2 additional adult intensive care beds
2. BHI Ward Beds - additional adult general ward beds as a more strategic bid.

National approval for TIF bids has not yet been received; however the system has agreed to go at risk with the revenue element and activity impact of the following schemes:

- Community Heart Failure (UHBW, NBT, Sirona) to support admissions avoidance
- Waiting List validation and clinical prioritisation
- NBT Diagnostics
- Robotic Process Automation
- Expansion of Remote Monitoring capability
- General Practice Employee Staff Record
- Integrated Care Bureau Collaborative Work Lists
- Digital First - integrated respiratory care
- Digital Advice & Guidance
- Cystic Fibrosis Health Hub
- MSK Digital Enablers for waiting list recovery

The key risks associated with the delivery of the TIF bids are:

- Workforce and recruitment
- Capacity to deliver the schemes, particularly if there is a capital element
- Impact of non-recurrent funding
- Inability to guarantee that schemes will stop the waiting time clock, especially for long waiting patients.

4. Trust H2 performance plan

The Trust has taken a top down approach to the H2 plan, with some specialty level adjustments based on accelerator impact and targeted clock stop plan. The Trust H2 plan has used the H1 run rate as a starting point and included adjustments from the elective accelerator programme.

As a system it was agreed to include the impact of TIF bids and clock stop impact in the provider activity plans. At the time of writing several TIF schemes are yet to be confirmed and planning assumptions especially around elective inpatient activity are considered to be high risk for delivery over the Winter.

Summary of the H2 plan

- Outpatients - The H2 plan increases activity to 84% of the same period in 2019/20.[1] The plan also assumes Non Face to Face activity is increased from 25% of outpatient activity to 27% by March 2022. In addition, the H2 plan also assumes that Patient initiated Follow up will increase to 4% of overall activity by March 2022.

- Day Cases – The H2 plan assumes that the Trust delivers 96.7% of 19/20 actual[2], this is an additional 341 day cases in H2 compared to H1 (an additional 2.7 patients per working day). The Cardiology Day Case Expansion will give a net benefit of 11 patients per week from March 2022. The additional Day Case activity includes an additional 90 cases from TIF schemes which are high risk due to delay in regional approval.

[1] All references to comparisons in 2019/20 are based on SUS data and include a counterfactual volume for March 2020 to adjust for the impact of COVID. This in all cases will overstate the activity actually carried out in the baseline year. It is therefore used for indicative purposes only.
[2] Ibid

- Elective Inpatients – The H2 plan assumes that the Trust will deliver 91.2% of 2019/20 actual[3]. This will be an additional 221 inpatients in H2 compared to H1 (an additional 1.7 patients per working day and 221 spells equivalent to 5 additional beds over H2 period). The additional activity includes an additional 183 elective inpatients from TIF schemes which are high risk due to delay in regional approval. Key projects enabling this are increased staffing of the BRHC Admissions Lounge to improve throughput and utilisation of theatres, improved productivity in Paediatric Surgery through Accelerator Programme funded capital improvements and the impact of Targeted Investment Fund (TIF) schemes for H2 21/22, which are not yet approved, but include the impact of investment in Critical Care, Urgent and Emergency Care and orthopaedic pathway improvements to increase activity).

- Diagnostics
  - MRI - 4% reduction in H2 compared to H1 due to reduced Biobank capacity. 86% of H2 19/20.
  - CT - 3% increase in H2 compared to H1 due to mobilisation of SBCH scanner from end of January. 110% of H2 19/20
  - NOUS - no change from H1 run rate. 98% of H2 19/20
  - Endoscopy – Overall a 6% increase in H2 compared to H1 due to Nuffield additional weekly list, outsourcing / insourcing and impact of TIF on theatre productivity. Gains offset by Weston washer replacement (10% drop in Weston activity Nov / Dec) and loss of QDU capacity over Winter. 109.5% of H2 19/20
  - Echo – baseline adjustment and echo recovery plan in Weston. 7% increase in H2 compared to H1. 98.5% of H2 19/20
- RTT - Admitted clock stops at 76% of 19/20, and Non admitted clock stops at 102% of 19/20.
- Waiting lists - 52 week waits at 3,991 by March (3,110 end of September 2021) and 104 week waits at 188 by March (173 end of September 2021). Overall wait list 56,788 by March (53,697 end of September 2021)
- Cancer - 62 day trajectory recovered below February baseline (180 through H2), and 31 day treatment set at 19/20 baseline adjusted for working days.

Impact on performance ambitions:

- **Eliminate waits of over 104 weeks by March 2022 (except where patients P5 and P6 choose to wait longer)** – The Trust is reporting 144 incomplete RTT pathways above 104 weeks (as at 15 October 2021). The impact of elective recovery interventions including TIF support brings the forecast position to 188 breaches by the end of March 2022, which is inclusive of patients that have chosen to delay their care (P5 and P6 patients). This is estimated at 61 based on those currently in the 78 week + cohort (i.e. assuming their preference does not change).

- **Hold or where possible reduce the number of patients waiting over 52 weeks (Based on levels seen at the end of September 2021) –** The Trust was reporting 3,288 incomplete RTT pathways above 52 weeks (15 October 2021). The Trust is planning for for

[3] Ibid

a revised end of March position of 3,991 incomplete RTT pathways at 52 weeks and above (this assumes the impact of TIF bids if they are supported).

- **Stabilise waiting lists around the level seen at the end of September 2021** – The Trust is forecasting an end of year RTT waiting list of 56,788 (compared to 54,177 in October 2021). current assumptions includes the addition of monthly appointment slot issues at the rate of 1,400 per month, in addition to the inclusion of a 3% ROTT rate (removal other than treatment). The Trust is also including the impact of TIF support and additional day case activity and elective inpatient activity from the Trust Elective Accelerator Programme, which have delayed benefits expected to commence in H2. A key risk to achieving this is due to the uncertainty around latent demand.

Key risks to delivery of activity plan and performance trajectories

The most significant risks to overall delivery of plans are as follows:

- The number of patients who are Medically Fit For Discharge (MFFD) in acute beds due to insufficient community pathway capacity
- Insufficient protected green bedded capacity to support planned care delivery
- Clinical prioritisation of patients on the elective wait list means that often the longest waiting patients wait longer when it is not clinically indicated for them to be seen ahead of shorter waiting, more clinically urgent patients. Patients are presenting later and therefore likely to be more complex and higher priority.
- Access to inpatient beds and ICU beds
- Unknown impact of winter non elective demand;
- Unknown impact of further COVID-19 surges and/or Influenza.
- Access to Independent Sector capacity – Independent Sector will have a limited role in recovery due to their capacity/desire to accept patients, case mix and their own lengthening wait times.
- Workforce shortages, particularly in Theatres, ICU and in the wards.
- Deteriorating patients as a result of extended waits – treatment sub-optimal – poor patient experience/outcomes and potential for extended length of stay.
- Delay in regional approval of TIF business cases and mobilisation of associated delivery plans.

5. Workforce Impact Assessment

An assessment of the resulting workforce implications arising due to a number of additional schemes of work which are now being delivered by UHBW will be undertaken by the end of November 2021. This will examine workforce expansion as a result of scheme (TIFs, Accelerator programme, winter plan etc.) and will identify risks to delivery as a result of any workforce shortfall/difficulty to recruit to or resource. Consideration of deploying staff to the highest impact activities will be required.

This information will be fed back into the Core Planning Group for monitoring and action.

6. Next steps

The system submission of H2 plans was submitted on the 18 November 2021, with a further provider finance submission due on 25 November 2021.

Next steps for H2 plans and TIFs:

- Develop detailed implementation plans for approved TIF bids, start mobilisation and agree the delivery and governance mechanisms for these schemes both within the Trust and the system.
- Embed Trust H2 Elective recovery plan in trust processes including as a priority in the Campaign plan
- Complete the composite assessment of workforce requirements and risks/deployment
- Use H2 Elective recovery forecasts to inform 22/23 Operating Plan and development of the multi-year recovery plan

Report To:	Trust Board		
Date of Meeting:	UHBW: 30 November 2021 NBT: 25 November 2021		
Report Title:	Acute Provider Collaborative Board Upward Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary, NBT		
Executive/Non-executive Sponsor (presenting)	UHBW: Jayne Mee, UHBW Interim Chair and APCB co-chair NBT: Michele Romaine, NBT Chair and APCB co-chair		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	None	**None**	**None**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is asked to note the activity undertaken by the APCB, including: • the endorsement of an outline communications plan • discussion of the Patient First programme, and • delegation to Chief Finance Officers to agree the extension of ongoing programme resource for the APC.		
Report History:	This is a standing agenda item at Trust Board, following meetings of the APCB.		
Next Steps:	The next meeting of the APCB will take place in January 2022, hosted by NBT.		

Executive Summary
The report provides a summary of the business undertaken by the APCB at its meeting held on 4 November 2021, hosted and administrated by UHBW colleagues.
Strategic Theme/Corporate Objective Links (NBT) 1. **Provider of high quality patient care** 2. **Developing Healthcare for the future** 3. **Employer of choice** 4. **An anchor in our community**

Board Assurance Framework/Trust Risk Register Links	N/A
Other Standards Reference	N/A
Financial implications	The resource implications for the support of the ASR are still under discussion.
Other Resource Implications	N/A
Legal Implications	The governance of the Programme Board has been arranged so as to comply with the statutory and regulatory frameworks applying to NHS and NHS Foundation Trusts.
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices:	

1. Purpose

2.1 To provide a highlight report setting out the business undertaken at the inaugural meeting of the APCB on 4 November 2021.

2. Background

2.2 The APCB is a meeting in common of NBT and UHBW and is a formal sub-committee of the respective Trust Boards. It meets bi-monthly and reports to the Board following meetings.

3. Key business for the attention of Trust Board – from 4 November 2021 APCB, hosted by UHBW

3.1 Communications Update

The APCB received a report from Communications Directors of both Trusts, setting out an outline communications plan for the Acute Provider Collaborative (APC).

The plan outlined a number of key communications principles:

- Proactive approach to communications, regularly updating on progress
- Acute Trusts to usually speak with a united voice and occasionally speak with one voice
- Where positions aren't aligned, communications implications and approach to be agreed in advance
- Content is the focal point with the collaborative being the strategic context
- No surprises for either Trust
- Staff communications is the number one priority – staff shouldn't hear anything significant from an external source before being told via official NBT / UHBW channels and staff in each organisation should receive information at the same time.
- Key messages to be regularly validated and reviewed
- Wherever possible, a one voice approach to be adopted in response to media enquiries relating to the Programme

The following key messages were identified for staff and trade unions:

- We're working together in this new way to improve outcomes for patients and reduce health inequalities
- But we also think that this new approach will have a big positive impact on staff
- It will open up greater career development opportunities, enabling staff to move seamlessly between the two Trusts without having to contend with different systems and incentives as well as unfamiliar equipment and working practices
- It will also make us more resilient; mutual aid will be more effective and responsive, reducing the pressure on patient facing staff in those most difficult of moments
- It will aid recruitment into the health and care sector, enabling a more joined-up and place-based approach to recruitment, maximising the benefits of Bristol as a destination and the scale of the APC as a 30,000-employee partnership

- But it will also involve change – in some corporate areas we will be combining our teams, seeking standard ways of approaching tasks and delivering efficiencies for reinvestment in the front-line
- It will also require patient facing staff to be open to changing approaches; standardisation will require movement from one or both Trusts

Comments from the APCB included a request to be clear with stakeholders that the APC is not a merger and ensuring no inconsistencies with the wider ICS messaging. It was also noted that the messaging for staff may need to become more nuanced, as different parts of the organisations may need slightly different messaging. This was acknowledged by the Communications leads and will remain under review as the programme progresses.

3.2 Patient First and Next Steps

The ACPB received a paper providing an update on the discussions at the October Board-to-Board meeting where it was agreed that the organisations would seek to align their adoption of the Patient First improvement programme.

The ACPB discussed whether the approach would be two organisations undertaking the programme separately but in an aligned manner, or whether it should be considered one programme across both organisations.

The ACPB members concluded that a single programme approach was preferred, including alignment to a joint timetable and a clear preference for a joint programme resource.

An updated programme proposal from UH Sussex is expected imminently and will be progressed via organisational Trust Boards as appropriate.

3.3 Next Steps on the Provider Collaborative

The Committee received an update on the proposed next steps on the ACP, which had already received both Board's endorsement at the October Board-to-Board meeting. This included:

Clinical priorities:	Corporate priorities:
Elective recovery through intermediate care	Exploration of a combined payroll
Winter contingency planning & Urgent/Emergency Care (joint planning & workforce)	Transaction HR (including international nursing, consistent pay and conditions)
Heart failure admissions avoidance	Aligned PMO & transformation (Patient First)

In addition to the ongoing workstreams from the Acute Services Review.

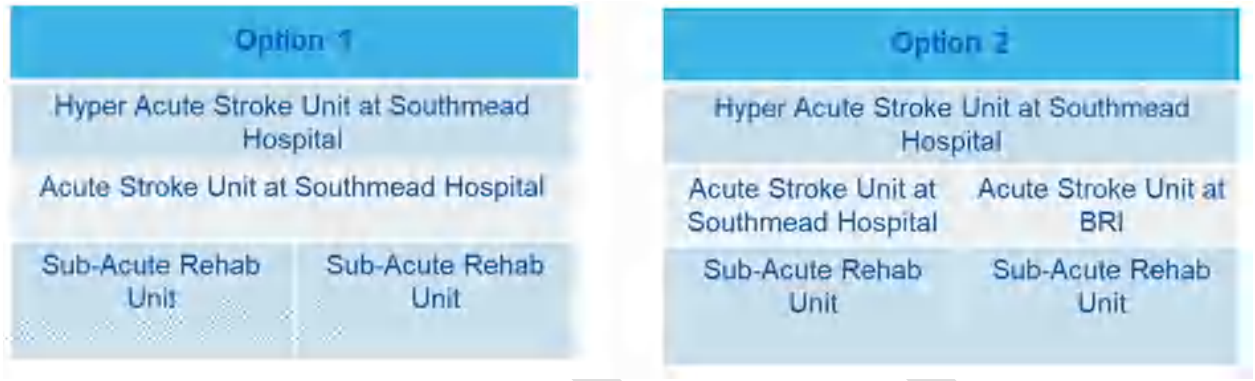
It was agreed that the clinical workstream needed to be updated to include nurse leadership representation.

The Committee noted the need to consider the acute providers' contribution to funding Healthier Together programme costs given that they are now also funding resource within the Acute Provider Collaborative.

The ACPB expressed in principle support to extend the existing programme resource for the Provider Collaborative, and delegated to the two organisations' Chief Finance Officers, together with the NBT Chief Operating Officer and the UHBW Director of Strategy & Transformation, to approve the final programme resourcing for the 2022/23 financial year.

3.4 Stroke Consultation Feedback

The Committee received feedback on the stroke consultation. Two options were presented to the public over the Summer:



Public feedback was:

- 65% of respondents fully or partially supported having a single centre of excellence Hyper-Acute Stroke Unit (HASU) at Southmead
- Respondents were split (50:50) on the question of having one or two ASUs
- 45% of respondents supported having two Stroke Sub-Acute Rehab Units (SSARU) in the community in response to the direct question; but 76% of respondents stated a preference for more than two Sub-acute Rehab Units (SSARU – inpatient community rehab)
- 85% of respondents fully or partly understood the reasons for having a SSARU at the Weston General Hospital site
- 48% of respondents stated a preference for Elgar Ward at Southmead for the second SSARU site; reasons given included: equitable distribution of sites across BNSSG, ease of access, transport links; 25% stated a preference for South Bristol Community Hospital and 18% the retained site at Frenchay.

The key themes that emerged from the consultation are:

- Positive regarding the vision (94% understood need for change, most specialist)
- Wanted more of each unit
- Organisational responses supportive
- Capacity: not enough for area size/population
- Travel time; transport issues
- Demographics: age & size of population, rurality, tourists and growth

Following clinical evaluation, the following consensus recommendations were received from clinicians:

- centralisation of immediate stroke care at a Hyper-Acute Stroke Unit (HASU) at Southmead;

- the proposal to have two inpatient rehabilitation units (Sub Acute Stroke Units (SSARUs) and not three as supported by public response to the consultation; one site to be at the Weston General Hospital site; and
- South Bristol Community Hospital (SBCH) as the proposed site for the second Sub-Acute Stroke Unit.

Further work is required to review and consider the proposal for one or two Acute Stroke Units (ASU).

A decision-making business case will be taken to Healthier Together Executive Team for consideration in early December, and flow through to provider governance in January 2022.

3.5 APCB Programme dashboard

The committee reviewed the dashboard which provided an overview of all project workstreams, overarching aims of the programme, the workstreams programme summary and status, and key risks or issues.

3.6 Joint Clinical Sponsorship Board Upward Report

The Committee received a verbal update on the planned Joint Clinical Strategy and Clinical Sponsorship Board taking place on 5 November 2021. This will explore a roadmap for a joint clinical strategy.

4. Summary and Recommendations

The Trust Board is asked to note the activity undertaken by the APCB, including:

- the endorsement of an outline communications plan
- discussion of the Patient First programme, and
- delegation to Chief Finance Officers to agree the extension of ongoing programme resource for the APC.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public – 30 September 2021

Reporting Committee	**Quality & Outcomes Committee – meeting held on 25 November 2021**
Chaired By	**Sue Balcombe, Non-Executive Director**
Executive Lead	**Mark Smith, Deputy Chief Executive and Chief Operating Officer** **Deirdre Fowler, Chief Nurse and Midwife** **Emma Redfern, Interim Medical Director**

For Information

The meeting considered a range of quality, safety and access information and the following was highlighted and discussed:

The Committee reviewed the Integrated Quality and Performance Report, with the following noted:

- It was noted that the Trust had remained in internal critical incident throughout October and November, with the pressures escalated to Opel 4 at system level requiring sign-off by the South West Regional Director of NHS England.
- The bed base continued to be impacted by COVID IPC restrictions and a high number of patients who are medically fit for discharge.
- The Emergency Department issues continued, with 12-hour trolley waits being noted. The committee was assured that redirection to other services was being implemented as well as a review of new direct admission pathways to further relieve the pressure on ED.
- The Committee was informed that the Division of Medicine Business Case for 10 acute physicians had been approved at the SLT to support providing safe care at the front door.
- The readmission rate for the Trust was 3.5%, a reassuring figure that underlined that patients were being cared for appropriately and not discharged too soon.
- A clinical summit had been held recently, attended by 83 senior clinicians along with the Chief Executive and Executive Directors. Breakout sessions considered how to manage and balance risk across urgent and elective care, with colleagues asked what were the top three things they could deliver to improve the Trust's position. The summit had been well received. A paper on this would be taken to the Senior Leadership Team, with an update at the Quality and Outcomes Committee in December.
- There had been 13 mixed sex breaches, but these had been considered justified.
- The fill rate for safe staffing continues to be very low; there had been a grade 4 pressure ulcer in the Division of Medicine.

- The number of complaints had increased significantly, and the Committee was assured that an advert had been placed to recruit further staff in the complaints team to manage this going forward.

The Deputy Chief Executive and Chief Operating Officer provided an update on the Accelerator programme as below:

- It was noted that the Eye Diagnostic Hub was now up and running in what had previously been the lecture theatre in the Education Centre, and greater activity was being achieved.
- The independent sector expansion was highlighted, and Philip Kiely was thanked for his work on this, in particular the transfer of some Trauma and Orthopaedic patients to Bath. The independent sector would continue to be used to help to mitigate issues in the elective recovery programme.

The Head of Nursing for Midwifery provided an update on the CQC Maternity Monitoring visit and the Maternity Perinatal Quality Surveillance Matrix Monthly Update as follows:

- An informal CQC visit had taken place, and two focus groups had been held with staff and then a meeting with the leadership team. The feedback was that this had demonstrated that the leadership team were aware of the issues in the service and concerns raised by staff. It was noted that safety was paramount for all staff that the CQC had spoken with.
- The maternity perinatal surveillance paper was highlighted, and this showed that the rates for Caesarean sections in the hospital were higher than ever before. The details of a serious incident was shared with the Committee.
- The work that had been undertaken 10 years ago with the Somali population was mentioned; this was related to the Somali community feeling that they were being treated differently to other patients and this issue had been raised again recently. Sarah Windfeld had met with Somali representatives from the community and work was underway to rectify this issue and build bridges. Tony Watkin, Patient Involvement Lead for the Trust, was working with the team on this.

The Committee considered the Serious Incident Report Quarter 2 report and noted that the format of the report was under development to ensure this was more concise, and noted the backlog of historic incidents in Weston and that there were several overdue investigations for incidents pending a decision around serious incident status.

The Committee considered the Monthly Nurse Safe Staffing Report, and it was reported that there were significant staffing pressures in all adult services and also paediatric services with the availability of agency staff becoming more challenging. The committee noted that the positive impact of international nursing recruits on the wards was starting to be felt.

The Infection and Prevention Control Report Quarter 2 was presented to the Committee, and it was noted that mandatory training compliance had reduced and had been added as a risk. It was noted that compliance with Day 3 and 7 COVID swabbing was now under review

The Infection and Prevention Control Annual Report was highlighted to the Committee. The excellent work of the IPC team during the pandemic was highlighted and the

committee noted the continued high levels of assurance against the 10 criteria of the Health and Social Care Act.

The Quarterly Impact Assessment Report Quarter 2 was highlighted, and the external development service proposals were mentioned. This would go through the Trust approvals process in Quarter 4.

The National Inpatient Survey Results 2020 was highlighted. The Trust was in the top 20 of trusts in the region in these results. The breakdown of the patient feedback was summarised, in particular regarding hospital food. It was suggested that patients, carers and families should be more involved in the feedback around this going forward.

For Board Awareness, Action or Response

An update on the recent Clinical Summit would be provided at the Quality and Outcomes Committee in December.

The Committee Work Plan was considered and it was emphasised that the timing of reports needed to be aligned with the meeting dates and this would be further reviewed.

The COVID vaccination uptake and the potential risk to staffing, and impact on service delivery, was discussed. It was agreed that performance should be added to the Integrated Quality and Performance report and that this should be monitored by the People Committee.

Key Decisions and Actions

N/A

Date of next meeting:	**17 December 2021**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on 30th November 2021

Report Title	**Integrated Quality & Performance Report**
Report Author	**James Rabbitts, Head of Performance Reporting** **Rob Presland, Associate Director of Performance** **Anne Reader/Julie Crawford, Head/Deputy Head of Quality (Patient Safety)** **Deborah Tunnell, Associate Director of HR Operations**
Executive Lead	**Overview and Access – Mark Smith, Deputy Chief Executive and Chief Operating Officer** **Quality – Deirdre Fowler, Chief Nurse and Midwife/Emma Redfern, Interim Medical Director** **Workforce – Alex Nestor, Interim Director of People** **Finance – Neil Kemsley, Director of Finance and Information**

1. Report Summary

To provide an overview of the Trust's performance on Quality, Workforce, Access and Finance standards.

2. Key points to note
(Including decisions taken)

Please refer to Executive Summary for an overview.

Two new sections on Mixed Sex Accommodation and Maternity Services have been added to the Effectiveness section.

Referral to Treatment (RTT) 104 Week Recovery Trajectory and additional Medically Fit For Discharge (MFFD) totals have been included in the Responsive section.

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

Not applicable as this report is for information and assurance only, although risks referenced within the main body of the report.

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

- This report is for **Assurance.**

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

Quality and Outcomes Committee	**25 November 2021**
People Committee	**26 November 2021**

Recommendation Definitions:

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

- **Approval** - report which requires a decision by the Board e.g. business case. Discussion required.

University Hospitals Bristol and Weston NHS Foundation Trust

Integrated Quality & Performance Report

November 2021

Contents – Headline Indicators

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: October 2021

Executive Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

The Trust declared an internal critical incident throughout October and unprecedented urgent care demand and poor flow out of hospital have continued to affect performance against NHS constitutional standards (*Datix Risk ID 801 - Risk that one or more standards of the NHS Oversight Framework are not met*). 101 COVID patients were diagnosed following admission to hospital this period, which means that whilst the increase experienced in September has levelled off, monthly COVID admissions are still running at the same level as February 2021. There were 55 beds occupied with COVID patients at the end of October, which was 5.5% of the total occupied beds. This remains in line with Trust modelling. Trust wide performance against the Emergency Department 4 hour target deteriorated to 62.4% this month. Unfortunately, there were 594 trolley waits in excess of 12 hours across UHBW sites and more than half of ambulance handovers were delayed greater than 30 minutes. UHBW 12 hour trolley wait performance is currently the most challenged nationally and worse than at any time during the pandemic. The onset of the Winter period represents a significant risk to delivery (*Datix Risk ID 423 - Risk that demand for inpatient admission exceeds available bed capacity*). Recruitment is underway to stabilise Same Day Emergency Care as a 7 day service in the BRI and Standard Operating Procedures are being followed to safely open escalation capacity. Redirection of minor injury / illnesses to alternative services is in place, and system wide initiatives are in place for the front door (including development of a virtual clinical assessment service) and the back door (including a business case to extend discharge to assess capacity across providers).

The elective care programme and associated performance continues to struggle as a consequence of urgent care pressures. Outpatient capacity has increased this month with the opening of the Eye Diagnostic Hub in a repurposed Lecture Theatre, but elective inpatient activity dropping to 68% of the monthly plan in October. Waiting list recovery is a national priority and the Trust is working towards an ambition of zero patients waiting longer than 2 years on a referral to treatment time pathway by March 2022, whilst holding overall waiting lists at the current position. There were 187 patients waiting over 104 weeks at the end of October, who are mostly lower clinical priority patients on an admitted pathway and safer to wait longer. The pressure on beds and existing cancellations of higher priority (seen in less than 1 month) patients in areas such as Cardiac and Cardiology gives an indication of the scale of the challenge to clear lower clinical priority long waiting patients. The Trust has a targeted strategy to support recovery in each specialty area, including capitalising on Independent Sector capacity and mutual aid opportunities.

Executive Summary

Reporting Month: October 2021

The status of waiting lists is as follows:

- Referral to Treatment patients waiting 104+ weeks. At the end of October there were 187 patients waiting over two years for the start of treatment (below trajectory of 211). The overall incomplete RTT wait list size showed a marginal month on month increase, although 52 week wait breaches increased by 138 patients (4.4% compared to September).
- Diagnostic waiting lists, where 63.3% were waiting within the 6 week standard. Performance remains particularly challenged in CT Cardiac, MRI Cardiac, MRI Paediatrics, echocardiography and Dexa scans.
- Outpatients, where 89,324 patients currently have a partial booking follow up status showing as overdue, 29% of which are greater than 9 months. The Trust is reviewing waiting list validation capacity and targeting clinically higher risk areas to reduce delays and look for alternative methods of follow up under the Personalised Follow Up programme, including Patient Initiated follow up; and
- Patients on a cancer pathway, where the number of patients waiting >62 and >104 days on a 62 day GP referred suspected cancer pathway are at pre pandemic levels. 2 week wait performance for urgent GP suspected cancer referrals did not deliver the national standard this month, and actions are underway to evaluate the colorectal pathway to improve accessibility to straight to test pathways before March 2022.

The Trust remains focused on delivering recovery priorities between now and March 2022 and it remains imperative to uphold patient safety and staff wellbeing as we approach what is expected to be a very difficult Winter period.

SPORT

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: October 2021

Safe | **Caring**

Successes	Priorities

• Patient Safety Strategy engagement workshops commenced in October in preparation for implementation of the new national Patient Safety Investigation Framework within the Trust.
• A new Rapid Incident Review (RIR) meeting has being successfully tested in Weston. The enables more agile decision making regarding identification of serious incidents with greater divisional involvement. This is now to be implemented in other divisions.
• The ward clinical accreditation pilot has commenced and has received significant clinical engagement in the pilot sites. The accreditation involves wards and departments being assessed against multiple standards grouped under the following four ambitions:
  ○ High Quality Compassionate Care
  ○ Leadership (Well led)
  ○ Avoidable Harm
  ○ Effective Patient Care
	• The Dementia, Delirium and Falls Lead has arranged some focussed falls prevention training in the Division of Weston.
	• Pressure injury prevention: An Extension of the "Why Wait?" campaign named "Pillow Talk". This provides information about immediate interventions to prevent pressure injury using illustrated posters explaining the simplicity of using pillows to effectively off-load pressure on the sacral / spinal region.
	• Alignment of low molecular weight heparin (LMWH) VTE prescribing guidance across Weston and Bristol sites is being undertaken in November 2021 across all sites introducing a standardised approach and making efficiency savings.
	• Monthly, national reporting of Mixed Sex Accommodation (MSA) breaches has been reinstated in October 2021 and will be reported in the monthly IQPR. The revised standard operating procedure for managing same sex accommodation has been widely disseminated to ensure that all staff are fully aware of its requirements.

SPORT

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

Safe | **Caring**

Opportunities	Risks & Threats
• A perinatal quality matrix is included in this report alongside the scorecards for quality to provide additional visibility for Board members. • A joint Dementia, Delirium and Falls study day is planned for December 2021; this will be an opportunity to refresh the focus on falls with clinical staff, but with an emphasis on supporting patients with a cognitive impairment. • The Falls Lead is working with the Patient Safety Team to implement a hot debrief approach following a fall for rapid learning and improvement actions.	• Risk Ongoing pressure on staff is evident in increased reporting of 'lower than expected staffing incidents'. Most wards have consistently worked at staffing levels below their agreed establishment throughout October and the impact on staff cannot be underestimated. The positive impact of international recruitment and newly qualified nurses starting on wards will be felt further next month. • Updates are provided regarding two existing risks below relating to two patient safety alerts that have breached or are forecast to breach the required implementation date. ○ Risk 5349: Risk that patients may come to harm from using their Philips ventilation device. This is linked to a national patient safety alert (NatPSA/2021/005/MHRA). The risk to patient safety is low and mitigation has been put in place by clinical teams. However, it is forecast that we will be unable to complete one action by the deadline 17/12/2021 to provide replacement devices and training for patients in their use. As a regional sleep service we have over 10,000 patients who require training on the replacement devices issued by the manufacturer. Patients have been prioritised by clinical risk for replacement devices. Replacement devices are being allocated centrally and are anticipated to be made available by the end of November 2021; therefore it is highly unlikely that it will be possible to train all patients by 17/12/2021. ○ Risk 3052/3014/2974/2979: The risk of administration of piped medical air to patients rather than oxygen. This risk is linked to the NPSA/2021/003/NHSPS alert. All actions have been completed for adult services, but it is not possible to comply with the requirements of one action of the alert for niche areas in UHBW where critically ill babies and children are cared for. To implement the alert actions would risk introducing unintended patient safety consequences for these patients. There has been ongoing dialogue with the national patient safety team who are considering whether alternative actions can be taken. This alert has breached its implementation date of 16/11/2021.

SPORT

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

Responsive | **Effective**

Successes

- The Accelerator programme project to repurpose Lecture Theatre 2 as an Eye Diagnostic Hub was completed this month, which will result in additional 450 outpatient procedures per week for patients overdue glaucoma and medical retina follow up.
- Cancer standards: the first definitive treatment, subsequent oncology treatment, and both 28 day faster diagnosis standards were achieved in September 2021. The Trust also remains below its given maximum number of 'long waiting' (<62 day) patients on a GP suspected cancer pathway.
- A request to our PAS supplier, system C has been made for c. 60,000 legacy records on the Weston PAS to be block discharged. This is following these records passing the NHSE Intensive support team's cohort methodology for waiting list validation. This work continues and will be completed prior to the integration of PAS in April 2022.
- The Community Phlebotomy was deployed on the 31st of October. Since July, over 4,000, delegated requests have been sent to primary care following the new process.
- A suitable pathway for long waiting orthopaedic patients has been identified in October, with a number of patients safely transferring to the Independent Sector to receive treatment.
- Mutual aid has been agreed within the South West region for the treatment of paediatric patients requiring cleft lip and palate treatment.
- Urgent care mitigations to protect elective care include extension of the Same Day Emergency Care service at the Bristol Royal Infirmary to 7 days, with an ambition for unified management of medical and surgical takes across BNSSG, including direct access by paramedics.

Priorities

- Operational delivery for October 2021 to March 2022 requires elimination of 104 week breaches, the stabilisation of 52 week waits and the overall incomplete RTT waiting list. The end of October 104 week breaches were confirmed as 187 and the mitigated forecast is 188 breaches by end of March 2022. A specialty level targeted improvement plan has been coordinated by the COO team and Divisions to improve this trajectory towards the nationally mandated zero breaches ambition. This will be used for the Divisional tactical meetings on a weekly/fortnightly basis to discuss progress.
- Ensuring all cancer patients are treated in a clinically safe timescale during the ongoing emergency pressures and over winter, and secondly to maintain performance against the 'ongoing' cancer standards for numbers waiting (once clinical priority has been taken into account).
- Overdue follow ups continue to grow as a result of outpatient clinics being cancelled to support patient flow through our acute hospital sites. National funding has been requested to support waiting list validation and divisions have been asked to create plans to support the process (Datix Risk ID:2244).
- Infection Prevention and Control (IPC) guidance circulated to divisions to support a risk assessed approach to the reduction of social distancing in outpatient spaces where IPC controls can be adequately controlled.
- Delivery of projects within the Elective Accelerator Programme which were reviewed in October and illustrate the potential for an additional 17,500 outpatients, c. 950 day cases and c. 200 additional elective inpatients in the second half of the financial year.
- Mobilisation of the campaign plan priorities for urgent and planned care, which includes the delivery of several Targeted Investment Fund (TIF) schemes to enable the delivery of elective care recovery whilst supporting improvement in hospital flow.

SPORT

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: October 2021

Responsive | **Effective**

Opportunities	Risks & Threats
• Staffing solutions are being reviewed for the Short Stay Surgical Assessment Unit in Weston which currently remains closed. We have not yet been able to staff the ward as this is set in the context of a pre-existing Band 5 nursing vacancy rates of 27% at Weston and limited availability of Tier 3 / 4 agency staff to backfill other Ward staff. This would open up elective activity opportunities for long waiting specialties such as Orthopaedics and Urology. • Improving the run rate on Ophthalmology waiting time clock stops by transferring suitable patients to the Independent Sector, with SpaMedica offering additional capacity for cataracts in the BNSSG system as a new provider on the market. We will also be looking at new waiting list initiative incentive arrangements for the Bristol Eye Hospital, including the consideration of time limited insourcing arrangements to increase theatre capacity on site for non IS suitable patients. We will also be working with the CCG to consider time limited partial limitations on new referrals where there are Independent Sector suitable patients that could be triaged and referred to Any Qualified Provider, rather than be added to the Bristol Eye Hospital waiting list where arrangements for Inter provider transfer might be delayed. • Extension of the hospital discharge service including the addition of discharge tracker roles with a view to mobilising a longer term significant investment in discharge to assess capacity across the system.	• Should recent levels of emergency pressures and staff absences due to Covid isolation requirements persist or increase, there will be a detrimental effect on cancer waiting time standard compliance. These issues particularly affect cancer pathway patients at low clinical risk from delay. (Datix Risk ID 42). • Continued pressure on Advice and Guidance services raised with BNSSG CCG. Decline in 7 day response times of 80% in July to 60% in Oct (Datix Risk ID: 5347 Departmental). Further requests for service closures and restrictions expected. • Failure to recruit to additional posts, fill roles for additional sessions and protect capacity from urgent care pressures remains a threat to elective recovery over the Winter period. • Operational and clinical capacity to deliver the projects over the next 6 months remain stretched, and the BNSSG system is working on a business case to provide additional support for recovery. • Fully saturated Independent Sector market could impact on Trust capability to transfer long waiting patients who are lower clinical priority.

Reporting Month: October 2021

Well-Led

Successes	Priorities
• 129 of the 258 overseas registered nurses have now arrived at the Trust. 68 of whom have their NMC Pin. First time OSCE pass rates are high. • A Pastoral Support and Relocation Manager has been appointed to support overseas medical and AHP recruits joining the Weston Division. • The first Medical Support Workers funded by NHSE/I, are being deployed in November/December to the Division of Medicine. • During October, training records for 36 new starters were "passported" to UHBW, saving the equivalent of 191 training hours. • Over a 160 people attended the UHBW 'Managing Menopause at Work' conference in October which received widespread positive feedback on content, opportunity to share experiences, tools and resources. • The Black History Month online event in October saw nearly 100 attendees. The programme had wide ranging speakers bringing to life stories and experiences, inspiring a lively and informative event. It was supported by the `proud to be black ` photo art exhibition in both Bristol and Weston.	• Disseminating communications regarding the launch of NHSJobs3 in early December. • Undertaking workforce impact assessments to understand the workforce expansion challenge as a result of the recovery programmes, winter pressure requirements and the Campaign Plan. • Mitigating the increasing issue of delays with roster sign-off as a result of the significant operational pressures, impacting on the validation of sickness reporting and potentially staff pay. • Implementing plans for 'doubled capacity' inductions for Nursing Assistants, to increase training capacities up to 36 NAs per corporate induction from November and into 2022. • Delivery of the 'winter wellbeing at UHBW' plan of events, support, resources, wellbeing activities and staff treats from November 2021 to April 2022 as part of the Staff First campaign. • Launching the new staff values and leadership behaviours.

SPORT

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

Well-Led

Opportunities	Risks & Threats
• Additional financial support is being offered by NHSE/I for overseas nurse recruitment activity, supporting arrivals between January and December 2022. A bid is being prepared in time for the deadline, with senior Executive support. • Planning and engagement has commenced with Women's and Children's for an accelerated roll out of medical e-Rostering with Allocate's support. • Establishing the programmes of work agreed as the five high impact strategic priorities at the Senior Leadership Team Workforce Summit in November. • Extending the newly launched 'health check' provision funded by the Bristol and Weston Charity to provide a workplace smoking cessation advisory service in Q3. • Celebrating Disability History Month with a virtual event will be held in December 2021. • Scoping of the use of Datix as the case management system has been completed. HR Services has the relevant access with focus now on team training and the uploading of cases on to the system.	• Ongoing increased use of high cost, non-framework nurse agency supply. • The NMC's SLA of 10 days to return a PIN for overseas nurses is currently not being met, with waits of over 30 days following successful completion of their OSCE examination. • Microsoft's support for IE11 will end in June 22 which will impact on several systems including the Employee Staff Record (ESR). Discussions are taking place with UHBW's Digital Services and IBM (the supplier of ESR) and an emerging risk will be raised. • Due to the continuing operational pressures there remains a risk in relation to appraisal compliance meeting target across all Divisions. • The annual Staff Survey 2021 response rates may be negatively affected due to the internal operational pressures. • The Agenda for Change job banding process is being delayed due to staff absence and lack of Staff Side capacity.

Dashboard

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

CQC Domain	Metric	Standard Achieved?
Safe	Infection Control (C. diff)	N
	Infection Control (MRSA)	Y
	Infection Control (E.Coli)	Y
	Serious Incidents	N/A
	Patient Falls	Y
	Pressure Injuries	P
	Medicines Management	Y
	Essential Training	N
	Nurse Staffing Levels	N/A
	VTE Risk Assessment	N
Caring	Patient Surveys (Bristol)	Y
	Patient Surveys (Weston)	P
	Friends & Family Test	N/A
	Patient Complaints	N

CQC Domain	Metric	Standard Achieved?
Responsive	Emergency Care - 4 Hour Standard	N
	Delayed Transfers of Care	N/A
	Referral To Treatment	N
	Referral to Treatment – Long Waits	P
	Cancelled Operations	N
	Cancer Two Week Wait	N
	Cancer 62 Days	N
	Cancer 104 Days	N/A
	Diagnostic Waits	N
	Outpatient Measures	N
	Outpatient Overdue Follow-Ups	N
Effective	Mortality (SHMI)	Y
	Mortality (HSMR)	Y
	Fracture Neck of Femur	P
	Mixed Sex Accommodation	Y
	Maternity Services	N/A
	30 Day Emergency Readmissions	Y

CQC Domain	Metric	Standard Achieved?
Well-Led	Bank & Agency Usage	P
	Staffing Levels – Turnover	N
	Staffing Levels – Vacancies	N
	Staff Sickness	N
	Staff Appraisal	N
Use of Resources	Average Length of Stay	N/A
	Performance to Plan	N/A
	Divisional Variance	N/A
	Savings	N/A

N	Not Achieved
P	Partially Achieved
Y	Achieved
N/A	Standard Not Defined

Infection Control – C.Difficile

October 2021

N *Not Achieved*

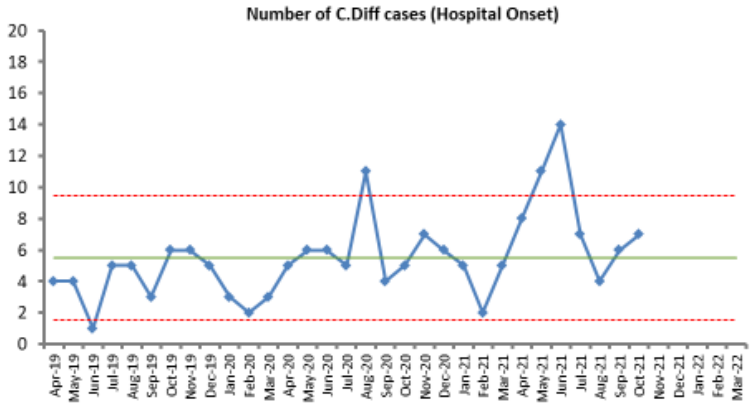
Standards:	For this section, two measures are reported: Healthcare Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA). HOHA cases include patients where C.Difficile is detected from Day 3 after admission. COHA cases include patients where C.Difficile is detected within 4 weeks of discharge from hospital. The NHS standard contract for 2021/22 includes a threshold for the maximum number of cases for the year. For this Trust, the C.Difficile threshold is 57 cases for the year, which equates to 4.75 per month.
Performance:	There were eight cases of C-Difficile of which seven HOHA have been identified in UHBW in October 2021, with one COHA case reported. Each case requires a review by our commissioners before determining whether it will be Trust apportioned if a lapse in care is identified. Hospital Onset Healthcare Associated (HOHA) C-Difficile cases are attributed to the Trust after patients have been admitted for two days (day 3 of admission).
Commentary:	Further post-infection reviews are scheduled to deal with each of the remaining outstanding quarters in 20/21. Increased cases have been identified across both Bristol and Weston sites. Actions taken: • A structured collaboration commenced in September 2021 across the BNSSG provider organisations, facilitated by the CCG and a regional NHSE/I quality improvement collaborative is being established. • Increased environmental auditing within areas of increased rates is taking place. • Anti- microbial stewardship reviews led by Pharmacy/ Microbiology have now restarted which is focusing on areas where C-Difficile infection has been identified to ensure compliance with guidance. • Microbiology weekly clinical reviews are focussing on C-Difficile patients in each division.
Ownership:	Chief Nurse

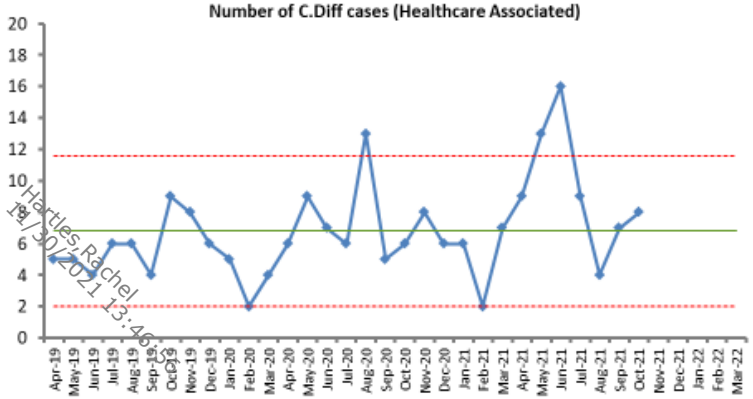
	Oct-21		2021/2022		2020/2021	
	HA	HO	HA	HO	HA	HO
Medicine	2	2	19	19	25	24
Specialised Services	2	2	16	14	23	18
Surgery	2	2	8	8	11	11
Weston	1	1	15	11	12	8
Women's and Children's	0	0	5	5	7	6
Other (Bristol)	1	0	3	0	3	0
TOTAL	**8**	**7**	**66**	**57**	**81**	**67**

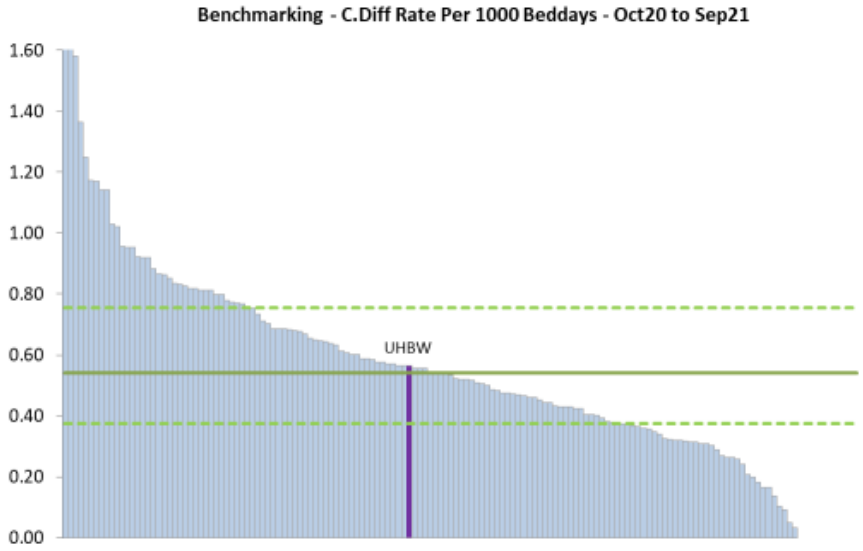
HA = Healthcare Associated, HO = Hospital Onset

Infection Control – C.Difficile

October 2021







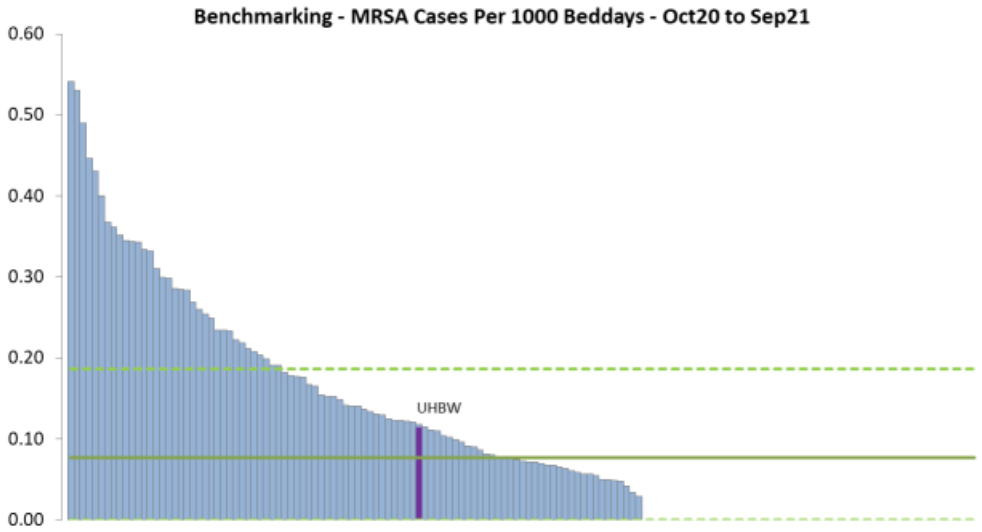
Infection Control - MRSA

October 2021

Y *Achieved*

Standards:	No Trust Apportioned MRSA cases. This is Hospital Onset cases only.
Performance:	There were no new cases of MRSA bacteraemia in UBHW in October 2021. There has been one case reported this financial year
Commentary:	The source of the one bacteraemia is thought to be attributed to an intravenous line infection; the formal post infection review outcome is awaited.
Ownership:	Chief Nurse

	Oct-21	2021/2022	2020/2021
Medicine	0	1	0
Specialised Services	0	0	1
Surgery	0	0	0
Weston	0	0	1
Women's and Children's	0	0	2
TOTAL	**0**	**1**	**4**



Infection Control – E. Coli

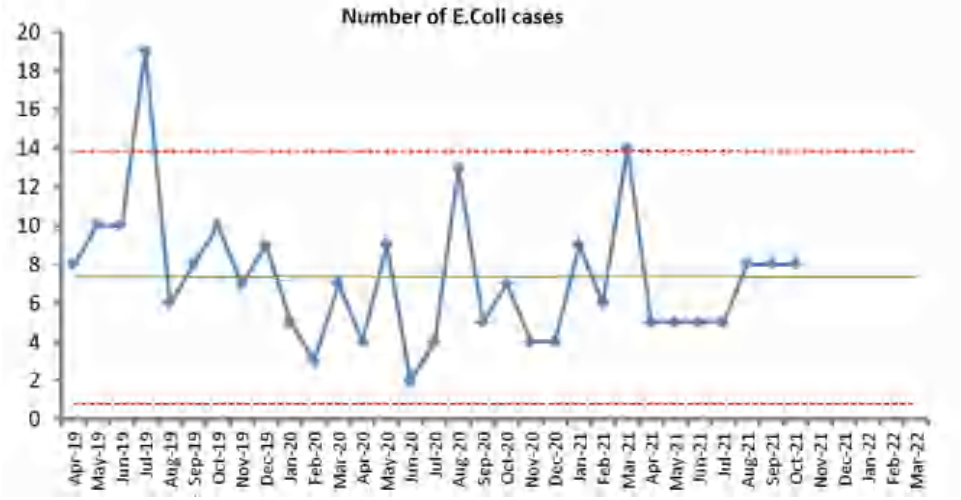
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

Y *Achieved*

Standards:	Enhanced surveillance of *Escherichia* coli *(E.coli)* bacteraemia is mandatory for NHS acute trusts. Patient data of any bacteraemias are reported monthly to Public Health England (PHE). As a result in the national rise in *E.coli* bacteraemia rates, a more in-depth investigation into the source of the *E.coli* bacteraemias is initially undertaken by a member of the Infection Prevention and Control team. Reviews include identifying whether the patient has a urinary catheter and whether this could be a possible source of infection. If any lapses in care are identified at the initial review of each case, a more complete analysis of the patient's care is carried out by the ward manager through the incident reporting mechanism. There is a time lag between reported cases and completed reviews. The NHS standard contract for 2021/22 includes a threshold for the maximum number of cases for the year. For this Trust, the E.Coli threshold is 190 cases for the year, which equates to 15.8 per month.
Performance:	There were eight Hospital Onset cases in October, giving 44 cases year-to-date. This is below the new trajectory of 15 per month.
Commentary:	The community prevalence of E.coli cases has been noted to be increasing throughout this year. A Urinary Tract Infection (UTI) was identified as the potential source of E.coli bacteraemia in one of the five identified cases. The remaining cases the source of infection were not established. None of the cases were identified as urinary catheter related. A catheter use / prevalence survey across the Trust and an audit of compliance with best practice is planned.
Ownership:	Chief Nurse

	Oct-21	2021/2022	2020/2021
Medicine	1	8	27
Specialised Services	2	11	17
Surgery	2	12	21
Weston	2	10	9
Women's and Children's	1	3	7
TOTAL	**8**	**44**	**81**



Serious Incidents (SI)

October 2021

N/A *No Standard Defined*

Standards:	UHBW is committed to identifying, reporting and investigating serious incidents and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence. Serious Incidents (SIs) are identified and reported in accordance with NHS Improvement's Serious Incident Framework 2015. In 2021/22, the new Patient Safety Incident Response Framework is to be implemented and an initial scoping exercise including stakeholder workshops have commenced.
Latest Data:	Six serious incidents were reported in October 2021, two in the Division of Medicine, three in the Division of Weston and one in Women's & Children's. These serious incidents comprise: one pressure injury, one medication incident, one unexpected death, one maternity/obstetric incident, one diagnostic incident including delay and one sub-optimal care of the deteriorating patient. There were no never events reported in the month.
Commentary:	The outcomes and improvement actions of all serious incident investigations will be reported to the Quality and Outcomes Committee (a sub-committee of the Board) in due course.
Ownership:	Chief Nurse

	Oct-21	2021/2022	2020/2021
Medicine	2	21	31
Specialised Services	0	6	6
Surgery	0	6	13
Trust Services	0	0	1
Weston	3	11	50
Women's and Children's	1	11	8
Other/Multiple Divisions	0	1	0
TOTAL	**6**	**56**	**109**

Harm Free Care – Inpatient Falls

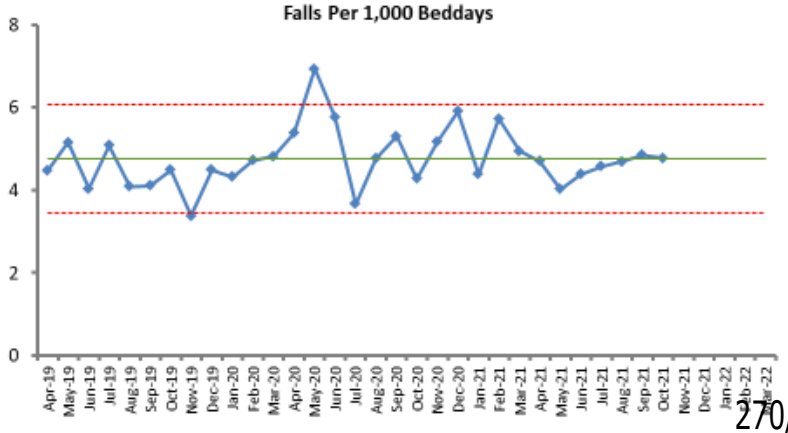
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

Y *Achieved*

Standards:	To reduce and sustain the number of falls per 1,000 bed days below the UHBW threshold of 4.8 and to reduce and sustain the number of falls resulting in moderate or higher level of harm to two or fewer per month.
Performance:	During October, the rate of falls per 1,000 bed days was 4.78 across UHBW and remains within the statistical process control limits. Bristol rate was 4.67 and Weston rate was 5.13. There were 154 falls in total (116 in our Bristol Hospitals and 38 in the Division of Weston) . There was one fall with moderate harm, within Weston division. There were no falls with major harm this month.
Commentary:	The number of falls has risen slightly this month. There has been continued operational pressures and staff shortages across the Trust which has proved challenging with an increase in the numbers of patients requiring enhanced care observation. The Divisions continue to manage those patients at risk of falls and review and investigate these falls as timely as possible to ensure learning is obtained and shared. Cognitive impairment continues to be a factor, around 30% which is in keeping with the patient caseload. Actions: • The Dementia, Delirium and Falls team continue to work with the Divisions with the falls management and action plans. • A joint Dementia, Delirium and Falls study day is planned for December 2021; this will be an opportunity to refresh the focus on falls with clinical staff, but with an emphasis on supporting patients with a cognitive impairment. • The format and agenda of the Falls Steering Group has been reviewed following approval at the October meeting with a plan to move towards learning and action based meeting, based on the North Bristol Trust model and this will commence in January. • The Dementia, Delirium and Falls Lead is arranging a series of falls training with Weston staff and will be spending two sessions a month on site at Weston to provide support, ad hoc training and help embed good practice. • The Falls Lead is jointly working with the Patient Safety team to implement a hot debrief approach, post fall to help roll out learning in a more timely manner. It is hoped to pilot this in November.
Ownership:	Chief Nurse

	Oct-21	
	Falls	**Per 1,000 Beddays**
Diagnostics and Therapies	1	-
Medicine	65	7.59
Specialised Services	25	5.19
Surgery	20	5.46
Weston	38	5.13
Women's and Children's	5	0.64
Other/Not Known	0	-
TRUST TOTAL	154	4.78
Bristol Subtotal	*116*	*4.67*



Harm Free Care – Pressure Injuries

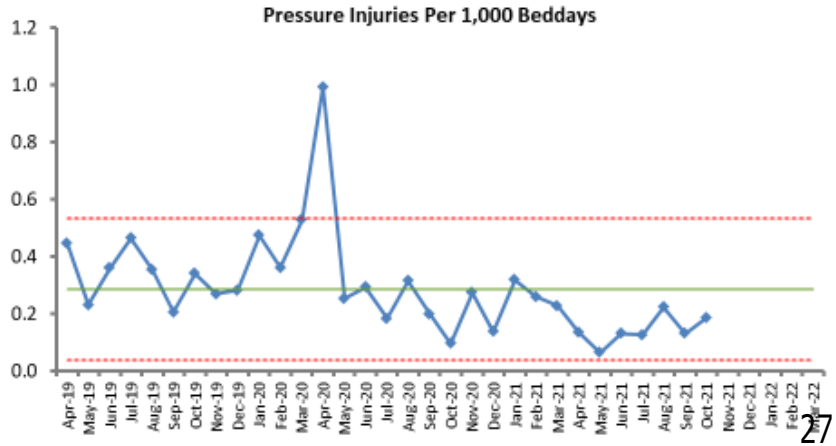
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

P *Partially Achieved*

Standards:	To reduce and sustain the number of hospital acquired pressure injuries per 1,000 beddays below an improvement goal of 0.4. Pressure Injures are classified as Category 1,2,3 or 4 depending on depth and skin/tissue loss, with category 4 the most severe. For this measure category 2,3 and 4 are counted. There is an additional category referred to as "Unstageable", where the final categorisation cannot be determined when the incident is reported. However the Tissue Viability Team has agreed that these will be reported as Category 3 pressure injuries within this measure.
Performance:	During October, the rate of pressure injuries per 1,000 beddays was 0.19 across UHBW. Across UHBW there were a total of five category 2 pressure injuries, one in Surgery Division (sacrum), two in Medicine Division (Sacrum and heel) and two medical device related injuries in Weston Division (both ears secondary to oxygen tubing).There were no category 3 pressure injuries reported in the month. There was one Category 4 pressure injury (sacrum) in Medicine Division. An investigation is underway for this incident.
Commentary:	Actions, all sites: • New 1:1 15 minute Micro teaching sessions offered to staff – posters disseminated to encourage individual staff to contact the team to arrange at their convenience. • Extension of the Why Wait Campaign named "Pillow Talk" – illustrated posters explaining the simplicity of using pillows to effectively off-load the sacral / spinal region. • Key messages communicated to staff via the monthly training sessions and tissue viability newsletter including importance of dynamic mattress provision based on patient pressure ulcer risk assessment and the importance of regular re-positioning to manage pressure prevention care. • Tailored micro-teaching sessions around prevention of medical device related pressure injuries in Weston Division. • Re-introduction of face to face study days in Bristol and Weston from November 2021. • Pressure Ulcer and Wound Care training sessions planned from November as part of "Ward Survival Study Days" for newly recruited International Nurses.
Ownership:	Chief Nurse

	Oct-21	
	Injuries	**Per 1,000 Beddays**
Diagnostics and Therapies	0	-
Medicine	3	0.35
Specialised Services	0	0.00
Surgery	1	0.27
Weston	2	0.27
Women's and Children's	0	0.00
Other/Not Known	0	-
TRUST TOTAL	6	0.186
Bristol Subtotal	*4*	*0.16*



Medicines Management

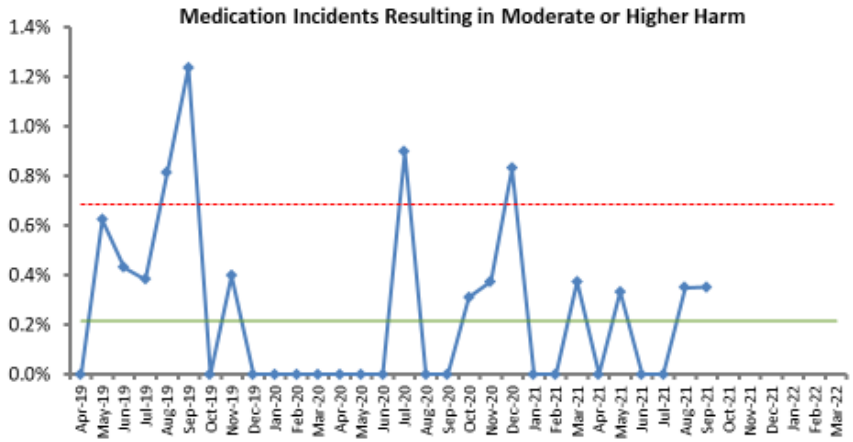
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Sep/Oct 2021

Y *Achieved*

Standards:	Number of medication errors resulting in moderate or greater harm to be below 0.5%, with an amber tolerance to 1%. Please note this indicator is a month in arrears. Percentage of non-purposeful omitted doses of critical medicines to be below 0.75% of patients reviewed in the month.
Performance:	Bristol: • There was one moderate harm incident (0.37%) out of 267 reported medication incidents in September. • There was one omitted dose of critical medicine (0.44%) of 225 patients audited in September. Weston: • There were no moderate harm incidents out of 18 (0.0%) reported medication incidents in August.
Commentary:	The moderate harm incident involved an oral anticancer agent which was prescribed at too high a dose for the patient's weight. This was not identified during the screening process and the patient experienced thrombocytopenia requiring admission and a platelet transfusion. The investigation has resulted in an audit of patients receiving this particular medicine and a proposal to reduce the dose prescribed on initiation of treatment to prevent further patients experiencing severe adverse effects with this medicine. The omitted dose was an anticoagulant that was not stocked on the ward. It was ordered urgently and administered to the patient two hours later. Weston is to agree an action plan following the omitted doses of critical medicines audit that was completed in Weston over the August bank holiday weekend.
Ownership:	Medical Director

	Sep-21		
	Moderate or Higher harm	Total Audited	Percentage
Diagnostics and Therapies	0	0	-
Medicine	0	52	0.00%
Specialised Services	0	62	0.00%
Surgery	1	55	1.82%
Weston	0	18	0.00%
Women's and Children's	0	47	0.00%
Other/Not Known	0	51	-
TRUST TOTAL	1	285	0.35%



Essential Training

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

N *Not Achieved*

Standards:	Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%, which was set by Bristol and has been adopted by Weston.
Performance:	In October 2021, Essential Training overall compliance reduced to 83%, compared with 84% in the previous month (excluding Child Protection Level 3).
Commentary:	October 2021 overall compliance for Core Skills (mandatory/statutory) training reduced to 83% compared with 84% the previous month across the eleven programmes. There were reductions in all eleven programmes, with Infection Prevention and Control and Information Governance both reducing by 2% whilst the remaining nine programmes fell by 1%. Overall compliance for the 'Remaining Essential Training' for Bristol and Weston remained static at 85%. • Corporate Education's 'Managers' Forums' continue to run with an increased focus upon the Trust's upgrade to the 'Kallidus Learn' learning management system in early 2022. • In October, 50 clinicians, 29 Nursing Assistants and 36 Overseas Registered Nurses attended corporate inductions
Ownership:	Director of People

Essential Training	Oct-21	KPI
Equality, Diversity and Human Rights	90%	90%
Fire Safety	78%	90%
Health, Safety and Welfare (formerly Health & Safety)	90%	90%
Infection Prevention and Control	82%	90%
Information Governance	76%	95%
Moving and Handling (formerly Manual Handling)	79%	90%
NHS Conflict Resolution Training	88%	90%
Preventing Radicalisation	89%	90%
Resuscitation	64%	90%
Safeguarding Adults	86%	90%
Safeguarding Children	86%	90%

Essential Training	Oct-21	KPI
UHBW NHS Foundation Trust	83%	90%
Diagnostics & Therapies	87%	90%
Medicine	80%	90%
Specialised Services	83%	90%
Surgery	81%	90%
Women's & Children's	79%	90%
Trust Services	87%	90%
Facilities & Estates	89%	90%
Weston	84%	90%

Nurse Staffing Levels

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

N/A *No Standard Defined*

Standards:	It is an NHS England requirement to publish and report monthly safer staffing levels to the Trust Board. High level figures are provided here and further information and analysis is provided in a separate more detailed report to the Board. The data is reported against Registered Nurse (RN) and Unregistered Nursing Assistant (NA) shifts.
Performance:	The report shows that in October 2021 (for the combined inpatient wards) the Trust had rostered 307,464 expected nursing hours, against the number of actual hours worked of 276,499 giving an overall fill rate of 89.9%.
Commentary:	Most wards have continued to work at staffing levels below their agreed establishment throughout October and the impact on staff cannot be underestimated; however the effect of the International Recruits in now expected to help improve the staffing levels. Due to the increased number of registered nurse vacancies in order to maintain safe staffing; the use of temporary agency staff has increased, the Trust has been working closely with the neutral vendor to support an increase in fill rate; however with the current available supply the use of non-framework agencies has been required though these have not always been filled either. Actions: • The Band 5 Registered Nurse vacancy position for October improved from 16.7 % to 13.6% reflective of both the International nurse recruitment in place and the newly qualified students who have started over the past month. • The Trust continues to look at incentives for both substantive and temporary staff to encourage additional working and with having recently introduced some in key areas within the Trust, the impact of these are being closely monitored and assessed. • The Trust has just commenced a project to review all nursing establishments in line with the NHSEI framework. The outputs from this will then be incorporated into both the monthly and six monthly staffing reports and provide the evidence base for the annual staffing reviews.
Ownership:	Chief Nurse

Staffing Fill Rates	Oct-21		
	Total	RN	NA
Medicine	90.1%	88.3%	92.4%
Specialised Services	93.9%	86.4%	116.4%
Surgery	90.4%	84.9%	104.4%
Weston	91.8%	81.7%	103.7%
Women's and Children's	86.6%	89.2%	72.6%
TRUST TOTAL	**89.9%**	**86.7%**	**97.2%**

Venous Thromboembolism (VTE) Risk Assessment

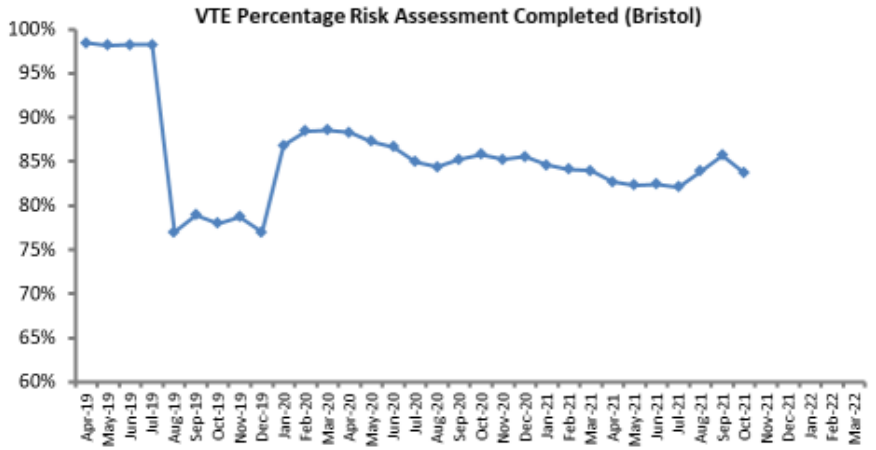
October 2021

N *Not Achieved*

Standards:	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 thrombo-prophylaxis. From 2010, Trusts have been required to report quarterly on the number of adults admitted as inpatients in the month who have been risk assessed for VTE on admission to hospital using the criteria in the National VTE Risk Assessment Tool. The expectation was to achieve 95% compliance, with an amber threshold to 90%.
Performance:	In our Bristol hospitals, since August 2019, the VTE risk assessment is completed electronically using the Medway system; the most recent figure for October 2021 is 83.7%..
Commentary:	In our Bristol hospitals, since August 2019, the VTE risk assessment is completed electronically using the Careflow system (formerly known as Medway). When this was initially launched, EPMA (digital prescribing) was being used in BHOC and BHI and was planned for roll out elsewhere in the trust. There was an expectation that a fully integrated digital system was imminent, whereby VTE risk assessments would be integrated within either digital prescribing or admission. Digital risk assessment has several advantages including: • VTE risk assessments completed in full including name and date of person completing • VTE risk assessment can be completed and accessed anywhere, even when the drug chart cannot be located • Compliance data available in real time, with performance reports according to ward or speciality at the click of the button. However, further digital roll out has been delayed and this has resulted in digital VTE risk assessment standing alone within Careflow, which has generated a significant barrier to compliance. Until recently, Weston has used a different drug chart and a different LMWH type (tinzaparin) for thromboprophylaxis. In Weston General Hospital, VTE risk assessments were still completed on the paper drug chart and monitoring compliance has been a challenge as it requires manual collection and review of charts. There have been 2 spot checks performed by the patient safety improvement nurses, the most recent of which was in July 2021 demonstrated a 67% compliance with VTE risk assessment completion. The results highlight the ongoing need for improvement in VTE risk assessment completion which is significantly below the national target. Recent measures to improve compliance and harmonise processes in Bristol and Weston include: 1. Access to VTE risk assessment through Careflow electronic patient record (EPR), this will complete implementation in Weston in November. 2. VTE QI projects underway in Trauma & Orthopaedics, Medicine and Surgery led by speciality consultants. 3. A project involving the Pharmacy, Digital services, VTE clinical leads and the Patient safety Improvement Nurses has successfully launched a new drug chart at the Bristol sites and this will be completed trust wide by a launch in Weston in November. A prompt on this new drug chart points to the completion of the Careflow risk assessment prior to prescribing. 4. An alignment of low molecular weight heparin (LMWH) VTE prescribing guidance across Weston and Bristol is in progress undertaken in November 2021 across all sites. Tinzaparin will no longer be used in Weston and Inhixa will be used in both sites (generic version of enoxaparin) 5. Weston and Bristol VTE leads are delivering focused training to the junior doctors as part of the new trust wide roll out of the new drug chart/ electronic VTE assessment launch in Weston.
Ownership:	Medical Director

Venous Thromboembolism Risk Assessment

October 2021



The table to the right shows October's Bristol data based on the admitting specialty.

Division	SubDivision	Number Risk Assessed	Total Patients	Percentage Risk Assessed
Diagnostics and Therapies	Chemical Pathology	2	2	100.0%
	Radiology	25	25	100.0%
Diagnostics and Therapies Total		**27**	**27**	**100.0%**
Medicine	Medicine	1,761	2,348	75.0%
Medicine Total		**1,761**	**2,348**	**75.0%**
Specialised Services	BHOC	1,875	1,971	95.1%
	Cardiac	353	506	69.8%
Specialised Services Total		**2,228**	**2,477**	**89.9%**
Surgery	Adult ITU	4	4	100.0%
	Anaesthetics	9	9	100.0%
	Dental Services	107	130	82.3%
	ENT & Thoracics	181	316	57.3%
	GI Surgery	901	1,070	84.2%
	Ophthalmology	155	156	99.4%
	Trauma & Orthopaedics	109	127	85.8%
Surgery Total		**1,466**	**1,812**	**80.9%**
Women's and Children's	Children's Services	32	41	78.0%
	Women's Services	1,502	1,675	89.7%
Women's and Children's Total		**1,534**	**1,716**	**89.4%**
Grand Total		**7,016**	**8,380**	**83.7%**

Friends and Family Test (FFT)

October 2021

N/A ***No Standard Defined***

Standards:	The FFT question asks "Overall, how was your experience of our service?". The proportion who reply "Good" or "Very Good" are classed as Positive Responses, and this is expressed as a percentage of total responses where a response was given. The Trust fully integrated the FFT approach across Bristol and Weston hospitals as of April 2021. FFT data are collected through a combination of online, SMS (for Emergency Departments and Outpatient Services), postal survey responses and FFT cards. There are no targets set.
Performance:	We received 5,963 FFT responses in October 2021, which represents a 26% increase in the number of responses received in September (4,728). Please refer to the summary table on the next page for a breakdown of the FFT scores. Headlines: • Bristol Royal Infirmary Emergency Department score has remained low at 72% (by historical standards) but stable; • The Children's Hospital ED score deteriorated for the second consecutive month to 76% (September was 85%); • Weston ED score has dipped for the second consecutive month to 81% (September was 83%).
Commentary:	The latest available benchmarking data from NHS England shows the average ED FFT score was 75% (from September 2021) which suggests that the profile locally at our EDs reflects trends seen nationally; Maternity responses were not received in time for processing by our external patient survey data contractor for October 2021 data which has led to an extremely low response rate across this service area. FFT scores for inpatients, day cases, and outpatients are extremely positive and broadly consistent with September figures. Actions: • The Patient Experience Team continue to share FFT Emergency Department trend data via the Heads of Nursing to ensure there is operational oversight on patient experience in the Trust's EDs and to offer support in reviewing key themes. • Maternity services have been reminded of the need to send FFT cards for processing on a fortnightly basis and have been added to reminder emails.
Ownership:	Chief Nurse

Friends and Family Test (FFT)

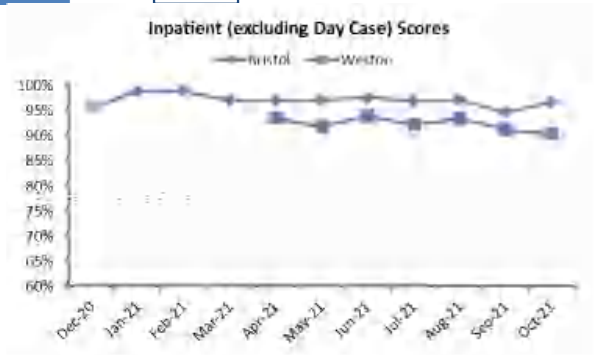
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

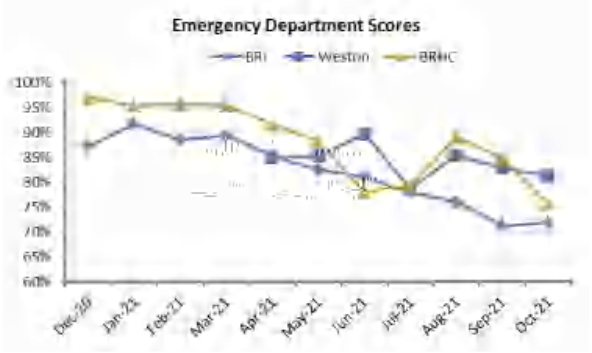
October 2021

		Positive Response	Total Response	Total Eligible	%Positive	Response Rate
Inpatients	Bristol	671	698	2,519	96.7%	27.7%
	Weston	122	141	673	90.4%	21.0%
	UHBW	793	839	3,192	95.7%	26.3%
Day Cases	Bristol	302	303	2,005	100.0%	15.1%
	Weston	230	231	504	99.6%	45.8%
	UHBW	532	534	2,509	99.8%	21.3%
Outpatients	Bristol	2,806	3,015		93.9%	
	Weston	216	235		93.1%	
	UHBW	3,022	3,250		93.9%	

		Positive Response	Total Response	Total Eligible	%Positive	Response Rate
A&E	BRI	202	282	4,549	71.9%	6.2%
	BRHC	306	407	3,721	75.6%	10.9%
	BEH	275	292	1,910	94.5%	15.3%
	Weston	288	354	2,619	81.4%	13.5%
	UHBW	1,071	1,335	12,799	80.5%	10.4%
Maternity	Antenatal	2	2	251	100.0%	0.8%
	Birth	0	0	432	#DIV/0!	0.0%
	Postnatal (ward)	0	0	410	#DIV/0!	0.0%
	Postnatal (community)	2	3	308	66.7%	1.0%
	UHBW	4	5	1,401	80.0%	0.4%

TOTAL RESPONSES	5,963





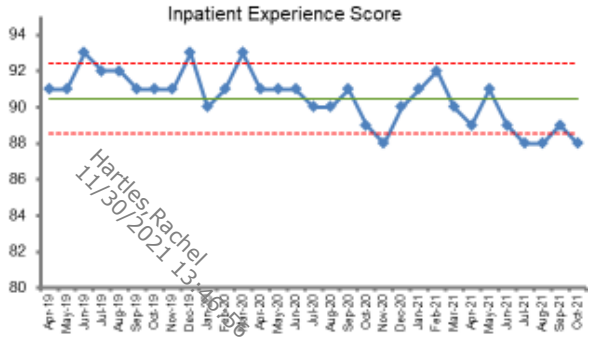
Patient Surveys (Bristol)

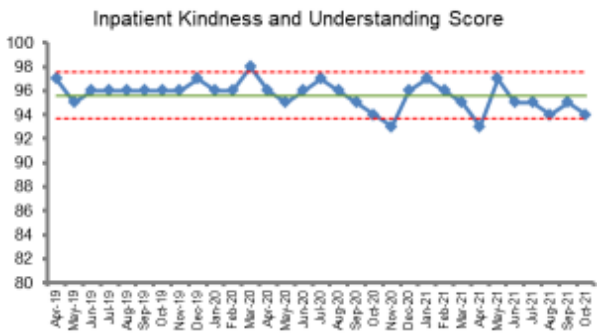
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

Y *Achieved*

Standards:	Please note this data relates to Bristol hospitals only. Data for Division of Weston is reported on the following page. For the inpatient and outpatient postal survey, five questions relating to topics our patients have told us are most important to them are combined to give a score out of 100. For inpatients, the target is to achieve a score of 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target score of 90 or over.
Performance:	For October 2021: • Inpatient score was 88 (September was 89) • Outpatient score was 93 (September was 94) • Kindness and understanding score was 94 (September was 95)
Commentary:	The latest (October) data exceeded the target thresholds. The inpatient experience tracker score for Division of Medicine has been below target since the start of 2021/22 but has recovered for the second consecutive month in October to reach 86 (from 82 in August and 85 in September).
Ownership:	Chief Nurse



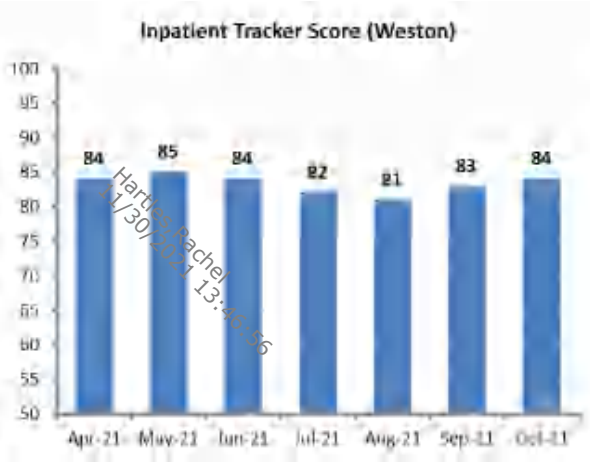


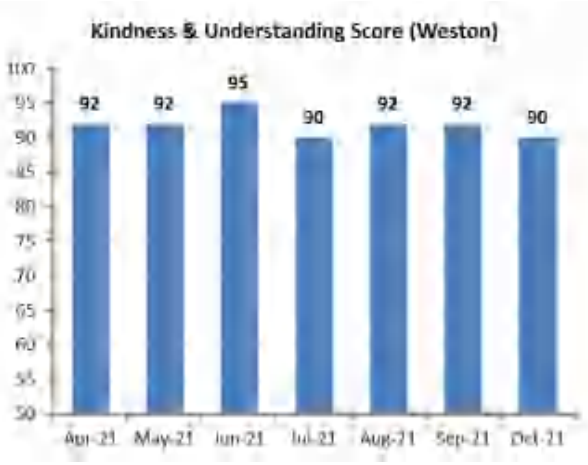
Patient Surveys (Weston)

October 2021

P *Partially Achieved*

Standards:	Please note this data relates to Division of Weston only. For the inpatient and outpatient postal survey, five questions about topics our patients have told us are most important to them are combined to give a score out of 100. For inpatients, the Trust target is to achieve a score of 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target score of 90 or over.
Performance:	For October 2021: • Inpatient score was 84, which is below target (September was 83). • Outpatient score was 95, above target (September was 88). • Kindness and understanding score was 90, which is on target (September was 92).
Commentary:	Note that the inpatient experience tracker score has improved for the second consecutive month in Division of Weston (from 81 in August). Actions: • Ward-level analysis of patient feedback will be prepared by the Patient Experience Manager and provided to the Head of Nursing to better understand what areas of experience of care are most affected and where, and to identify what can be done to improve the position.
Ownership:	Chief Nurse





Patient Complaints

University Hospitals Bristol and Weston NHS Foundation Trust

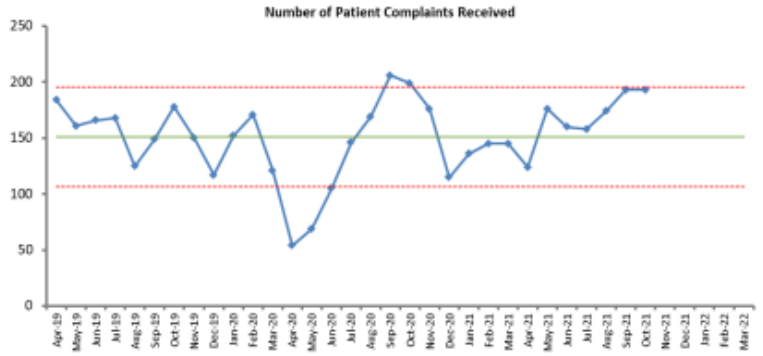
October 2021

N ***Not Achieved***

Standards:	For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe, with a lower tolerance (Red) of 85%. In addition the requirement is for divisions to return their responses to the Patient Support & Complaints Team (PSCT) seven working days prior to the deadline agreed with the complainant. Of all formal complaints responded to, less than 8% should be re-opened because complainant is dissatisfied, with an upper tolerance of 12%.
Performance:	In October 2021: • 193 Complaints were received (27 Formal and 166 Informal). • Responses for 54 Formal and 58 Informal complaints were sent out to the complainants in October. • 63% of formal complaints (34 out of 54) were responded to within the agreed timeframe. • Divisions returned 72% (39 out of 54) of formal responses to the PSCT by the agreed deadline, which is consistent with 72.5% reported in September and 71% in August 2021. This is the deadline for responses to be returned to PSCT; seven working days prior to the deadline agreed with the complainant. • 88% of informal complaints (51 of 58) were responded to within the agreed timeframe, compared with 86% in September and 87% in August 2021. Over half of these breaches of the informal deadline (four) were for the Division of Medicine, with one each for Specialised Services, Surgery and Weston. • There were nine complaints reported where the complainant was dissatisfied with our response, which represents 10.6% of the 85 first responses sent out in August 2021 (this measure is reported two months in arrears).
Commentary:	The 63% formal complaint response performance is a slight improvement on the 57.5% reported in September 2021; although still significantly below the 95% target. 15 of the 20 breaches were attributable to delays within the divisions, with three due to a delay during the checking process by the Patient Support & Complaints Team (PSCT) and two due to a delay during the Executive signing process. More than half of the breaches (11) were for the Division of Weston, with three for Medicine, two each for Specialised Services and Women & Children and one each for Trust Services and Surgery. However, it should be noted that none of the breaches for the Divisions of Medicine or Surgery were attributable to delays within the Division.
Ownership:	Chief Nurse

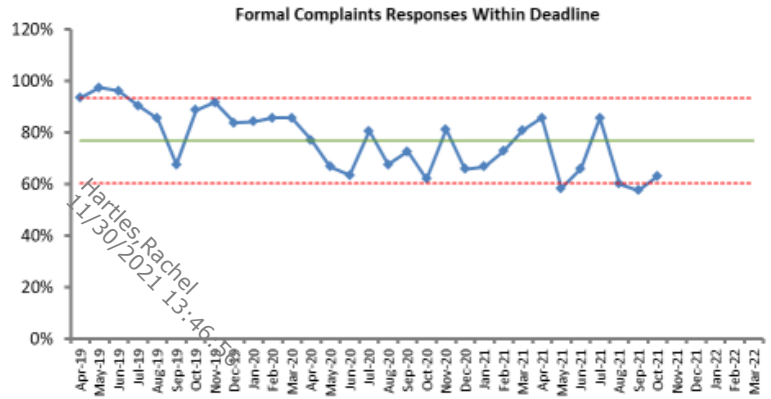
Patient Complaints

October 2021



Complaints Received

	Oct-21	2021/2022	2020/2021
Diagnostics and Therapies	9	42	56
Medicine	36	238	385
Specialised Services	28	162	190
Surgery	51	293	406
Trust Services	3	18	56
Weston	18	150	250
Women's and Children's	43	245	273
Estates and Facilities	5	30	49
TOTAL	**193**	**1178**	**1665**



Responses Within Deadline	Oct-21	
	% Within Deadline	Total Responses
Diagnostics and Therapies	100.0%	1
Medicine	70.0%	10
Specialised Services	50.0%	4
Surgery	85.7%	7
Trust Services	0.0%	1
Weston	47.6%	21
Women's and Children's	80.0%	10
Estates and Facilities	0.0%	0
TOTAL	**63.0%**	**54**

Emergency Care – 4 Hour Standard

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

N *Not Achieved*

Standards:	Measured as length of time spent in the Emergency Department from arrival to departure/admission. The national standard is that at least 95% of patients should wait under 4 hours. Due to the Covid pandemic, trajectories for 2021/22 have not been agreed with NHS Improvement. There is also an expectation that no patient will wait more than 12 hours in ED after a decision to admit has been made, called "Trolley Waits". There is also an expectation that no Ambulance Handover will exceed 30 minutes.
Performance:	Trust level 4 hour performance for October was 62.4% across all four Emergency Departments (17,041 attendances and 6,411 patients waiting over 4 hours). There were 594 patients who had a Trolley wait in excess of 12 hours (337 in Bristol and 257 at Weston). Between 1st October and 11th November 2021 there were 2,834 Ambulance Handovers that exceeded 30 minutes across all departments. This represents 55% of all Handovers.
Commentary:	**Bristol Royal Infirmary:** Performance against the 4 hour standard deteriorated in October to 45.9% (from 46.6% in September) with average daily attendances remaining high at around 214 per day which is unprecedented for this time of year (compare with 180 per day in October2020 and 179 in March 2021). 12 hour trolley waits have spiked further still to 311 breaches reflecting the highly challenging picture in urgent care across the local health and care system. This is driven by high demand, workforce shortages and availability of supporting services in the community (e.g. social care beds and packages of care to support discharge and primary care alternatives to hospital for minor illness and injury). The Trust has been in "internal critical incident" status for the duration of October (2nd September to 11th November). Achieving flow remains a key enabler to minimising overcrowding, ambulance queueing and long waits. Medical SDEC (Same Day Emergency Care)was established on 11th October expanding the range of patients that can bypass or be streamed out of ED without the admission to a ward bed. The service currently operates Monday to Friday, but recruitment is underway to stabilise the service and expand to a 7 day service. Internal measures already in place to manage overcrowding include escalation capacity (ward boarding, Queens Day Unit, Cardiac Catheter Labs) and ambulance cohorting (8 patients). An internal decompression checklist and strict redirection of minor illness/injury to appropriate alternative services (Urgent Treatment Centres/Minor Injury Units, GPs and pharmacy) is embedded as business as usual. The Trust is also exploring increasing boarding capacity and redesigning pathways for patients with chest pain and surgically expected patients. Further work is being done by System partners to reduce avoidable attendances to the ED through improving capacity, access and signposting to alternatives to ED. This includes development of a virtual system CAS (clinical assessment service), city centre face to face minors service, expansion of pharmacy appointments and student health.

Emergency Care – 4 Hour Standard

October 2021

Commentary:	**Bristol Eye Hospital:** Performance was improved in October to 97.5 % compared to 95.9 % in September. Attendances were slightly less this month, with 1,915 attendances compared with 1,959 in September. In October, there were 47 four hour breaches, 25 for diagnostics, 1 of which needed to be admitted, 12 Doctor delays, 1 speciality reviews and 9 needing BEH treatment which took longer than 4 hours but were not admitted. Emergency Department staffing for nurses is the same as the previous month, Band 5/6 job is out to advert. Still awaiting confirmation of permanent technicians. **Bristol Royal Hospital for Children:** 4 hour performance was 69.8% in October 2021 with 4,599 attendances. Attendances continue to rise. In addition, within an increase in 12 hour breaches. The department has seen an increase in 4 hour breaches due to availability of beds. During busy times, with the high volumes of attendances, social distancing within the waiting area is a significant problem. The department continues to use outpatient areas where possible, but more patients are presenting with respiratory symptoms and are requiring cubicles. Patients requiring High Dependency beds has been impacting on flow in getting patients out of the emergency department. Nursing and Medical staffing throughout the hospital have experienced high levels of absences due to sickness and isolating. Within ED there are vacancies (including 10 WTE NA). Aggression against staff has increased due to long waits and enforcing mask wearing. The department currently has an Interim Care Ward that should improve flow.

Emergency Care – 4 Hour Standard

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

Commentary:	**Weston General Hospital:** Weston's performance against the 4 hour standard in October has decreased at 64.4% (from 68.1% in September). The Emergency Department remained busy with high demand which is mirrored against urgent care and health care across the system. There was a decrease in overall attendances and an increase in breaches which reflects the current pressures. Flow throughout the department continues to be one of the main challenges which has resulting in 257 x 12 hour breaches. Around 80% of discharges happen after 12:30 meaning patients are remaining in the ED waiting for a speciality bed for prolonged periods of time after being bedded overnight in the ED. Occupancy for Medically Fit for Discharge patients remains at 26% of Weston's bed base which equals to more than 1 in every 4 patients which has significant impact on flow. The department had streaming and redirection work continues within the Emergency Department to Clevedon Minor Injuries Unit (MIU), however on occasion this hasn't always been a streaming option that was available. The Division is working closely within UHBW and other system partners on projects to improve patient flow and to further improve redirection work ensuring patients go to the right healthcare service.

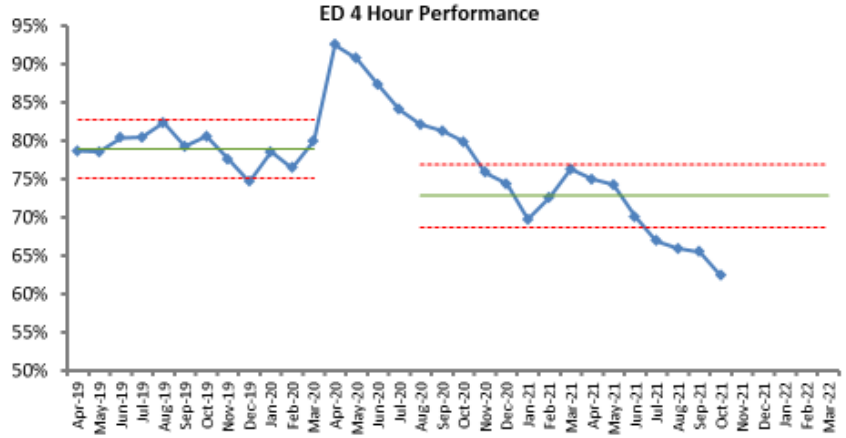
4 Hour Performance	Oct-21	2021/2022
Bristol Royal Infirmary	45.9%	52.2%
Bristol Children's Hospital	69.8%	79.5%
Bristol Eye Hospital	97.5%	97.4%
Weston General Hospital	64.4%	70.0%

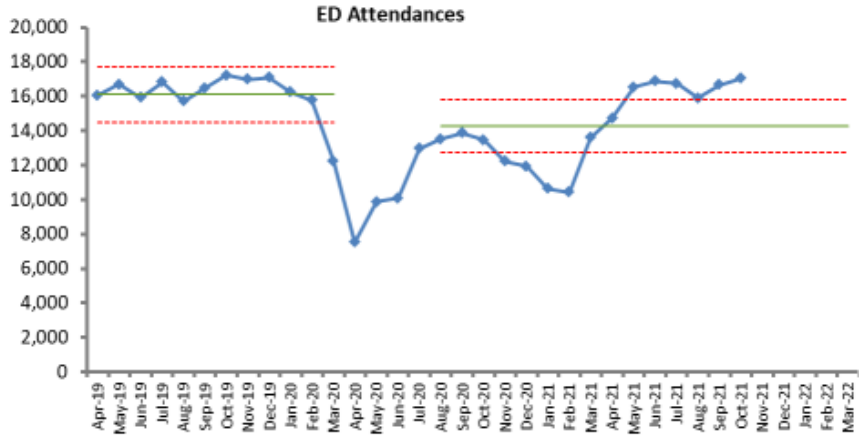
Total Attendances	Oct-21	2021/2022
Bristol Royal Infirmary	6,618	45,170
Bristol Children's Hospital	4,599	28,180
Bristol Eye Hospital	1,915	13,138
Weston General Hospital	3,909	27,963

Emergency Care – 4 Hour Standard

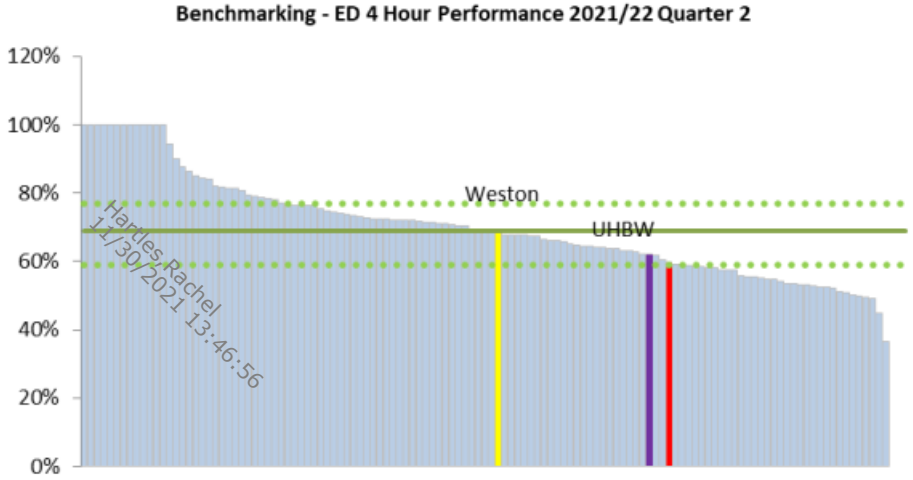
University Hospitals Bristol and Weston NHS Foundation Trust

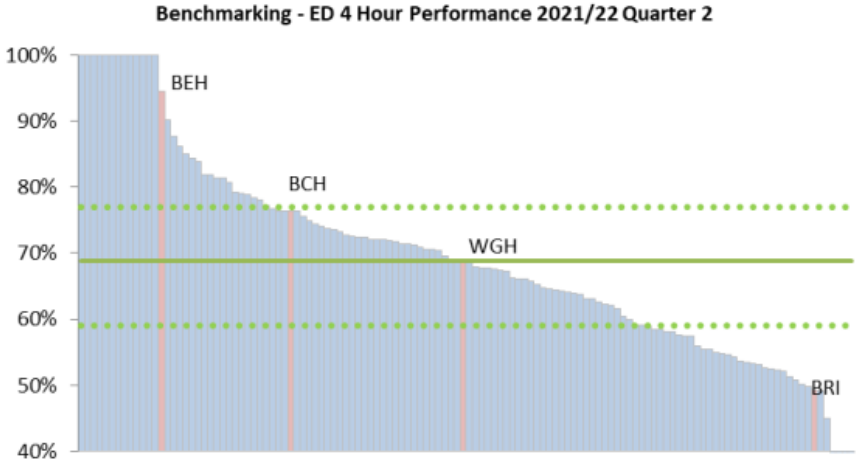
October 2021





Note:
The above charts are now Bristol and Weston data for all months. The Benchmarking chart below is for Type 1 EDs, so for UHBW it excludes the Eye Hospital.





Emergency Care – 12 Hour Trolley Waits

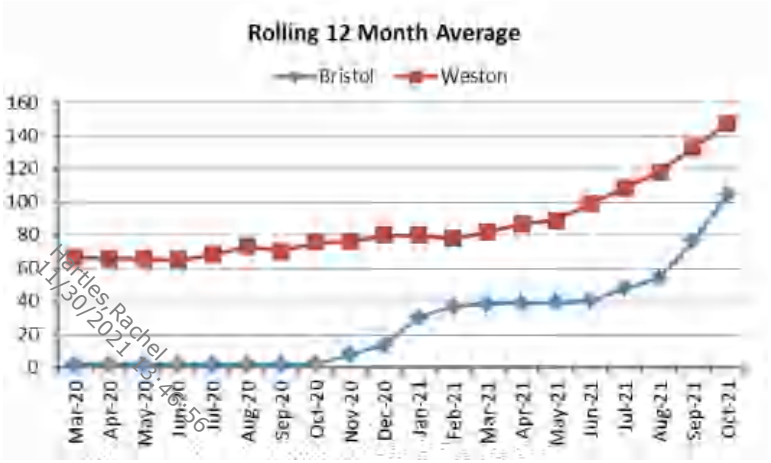
University Hospitals Bristol and Weston NHS Foundation Trust

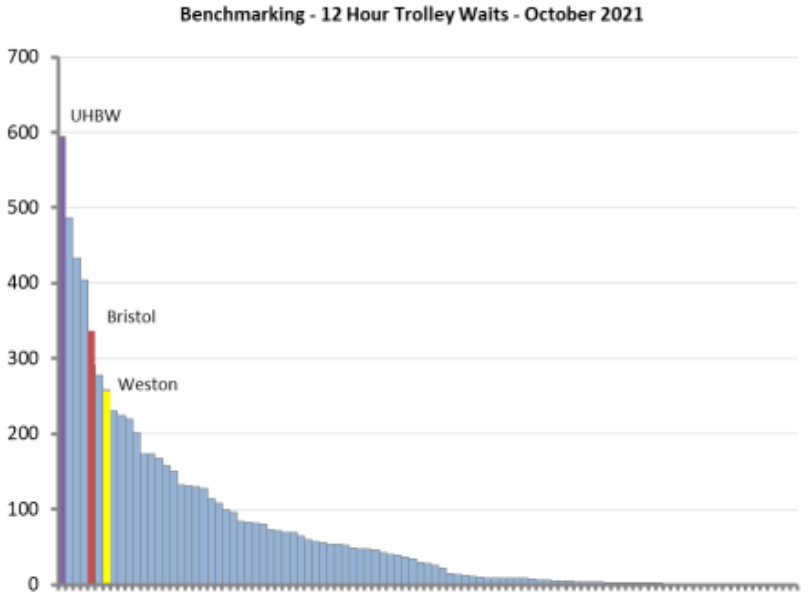
October 2021

12 Hour Trolley Waits

A supporting measure for Emergency Care is the "12 Hour Trolley Wait" standard. For all patients admitted from ED, this measures the time from the Decision To Admit (within ED) and the eventual transfer from ED to a hospital ward. The national quality standard is for zero breaches. Datix ID 5067 Risk that patients will come to harm when they wait over 12 hours to be admitted to an inpatient bed

	2020/2021												2021/2022											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Bristol	0	0	0	0	0	0	3	66	79	211	82	18	9	4	12	91	69	276	337					
Weston	0	1	7	58	68	6	84	135	168	257	113	84	62	24	134	164	188	180	257					
UHBW	0	1	7	58	68	6	87	201	247	468	195	102	71	28	146	255	257	456	594					



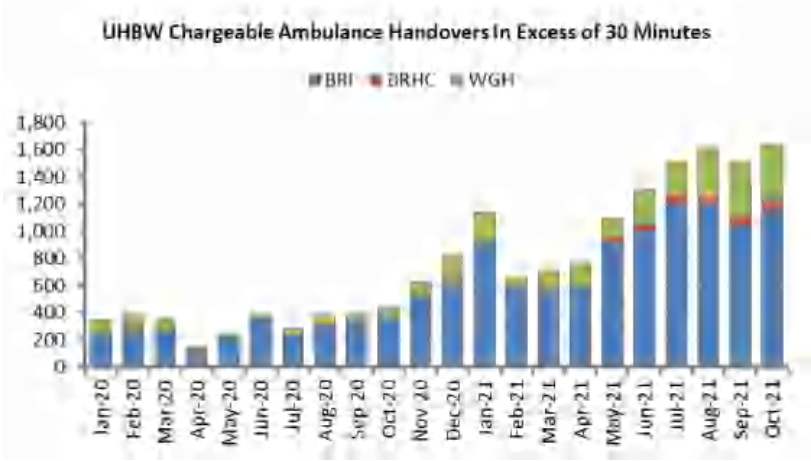


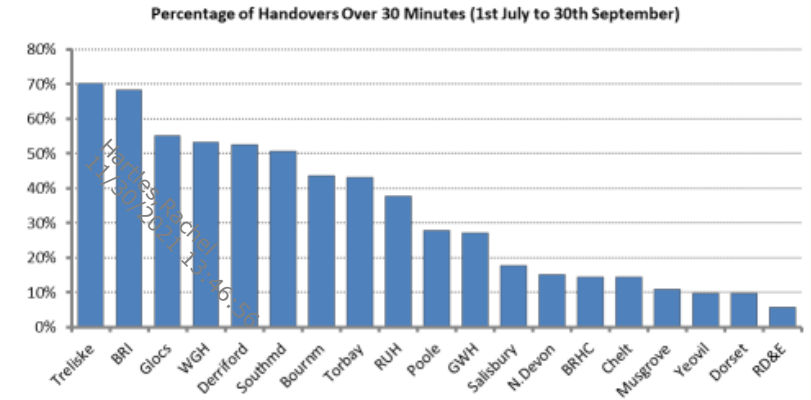
Emergency Care – Ambulance Handovers

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

This data is supplied by the South Western Ambulance Service NHS Foundation Trust (SWASFT).
The Handover Time is measured from 5 minutes after the ambulance arrives at the hospital and ends at the time that both clinical and physical care of a patient is handed over from SWASFT staff to hospital staff. This time is not just the time that a verbal handover is conducted; it also includes the time taken to transfer the patient to a hospital chair, bed or trolley.





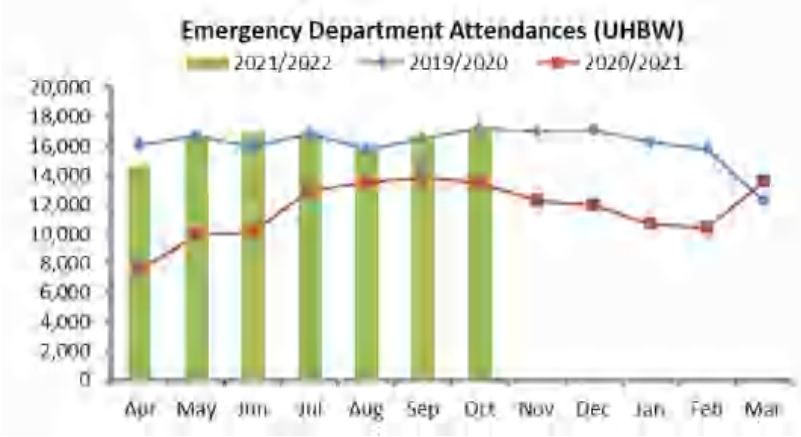
Total Ambulance Service Handovers - South West Region - 1st October to 14th November 2021

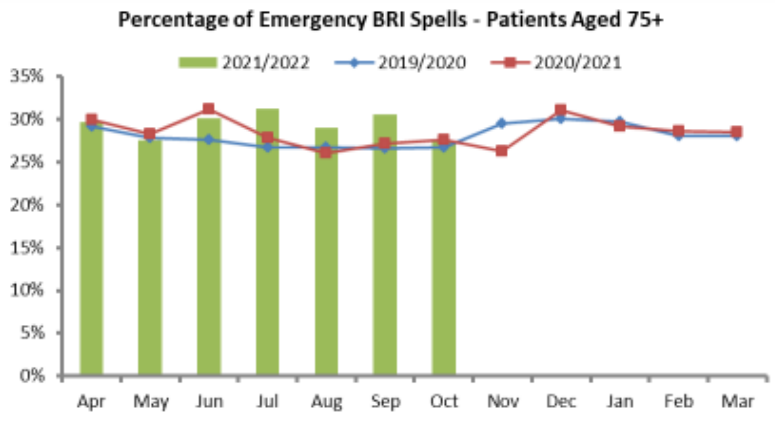
Hospital	Total Handovers	Number Over 30 Minutes	% Over 30 Minutes	Number Over 1 Hour	Number Over 2 Hours
BRISTOL ROYAL HOSP FOR CHILDREN	949	138	15%	20	5
BRISTOL ROYAL INFIRMARY	2,955	2,020	68%	1,361	806
CHELTENHAM GENERAL HOSPITAL	786	113	14%	26	9
DERRIFORD HOSPITAL	4,341	2,282	53%	1,519	919
DORSET COUNTY HOSPITAL	2,185	214	10%	65	6
GLOUCESTER ROYAL HOSPITAL	4,682	2,581	55%	1,475	604
GREAT WESTERN HOSPITAL	3,416	928	27%	387	116
MUSGROVE PARK HOSPITAL	3,521	383	11%	77	5
NORTH DEVON DISTRICT HOSPITAL	2,044	308	15%	72	4
POOLE HOSPITAL	2,887	805	28%	297	79
ROYAL BOURNEMOUTH HOSPITAL	2,868	1,254	44%	662	260
ROYAL DEVON AND EXETER WONFORD	4,492	253	6%	14	1
ROYAL UNITED HOSPITAL - BATH	3,725	1,404	38%	757	231
SALISBURY DISTRICT HOSPITAL	1,794	317	18%	122	34
SOUTHMEAD HOSPITAL	4,114	2,083	51%	1,187	566
TORBAY HOSPITAL	3,226	1,389	43%	804	378
TRELISKE HOSPITAL	4,010	2,819	70%	2,191	1,509
WESTON GENERAL HOSPITAL	1,271	676	53%	473	278
YEOVIL DISTRICT HOSPITAL	2,011	198	10%	30	0
All Hospitals Attended	**55,277**	**20,165**	**36%**	**11,539**	**5,810**

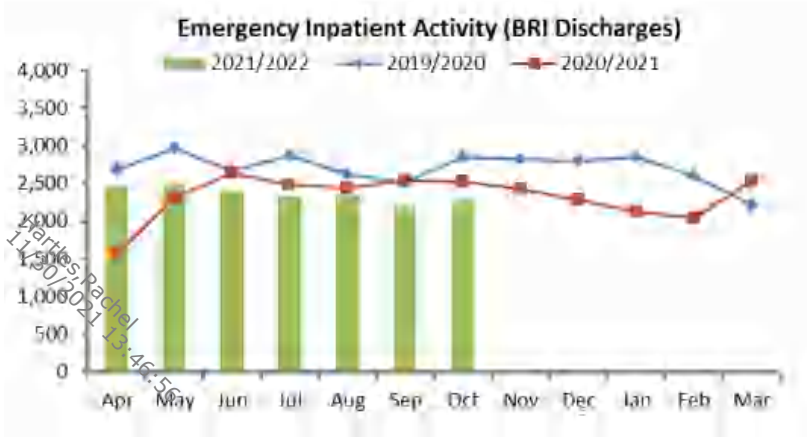
Emergency Care – Supporting Information

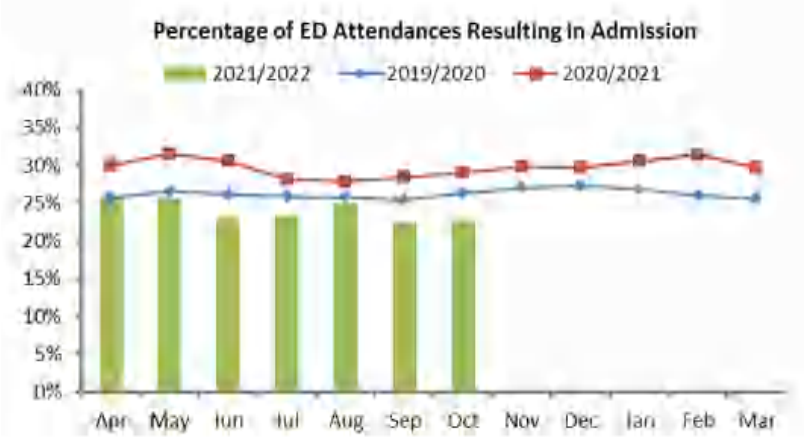
University Hospitals Bristol and Weston NHS Foundation Trust

October 2021









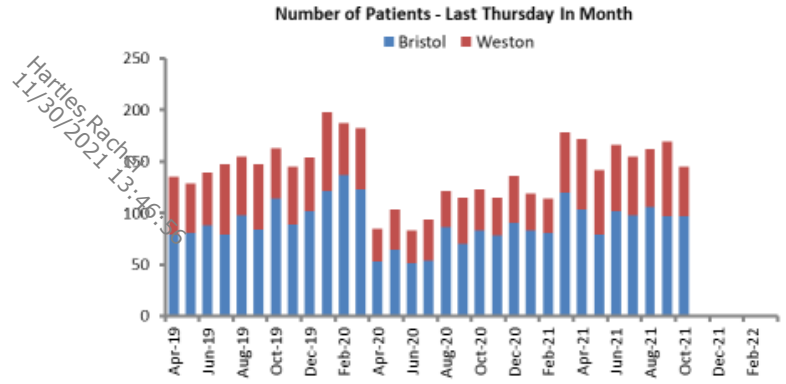
Delayed Discharges

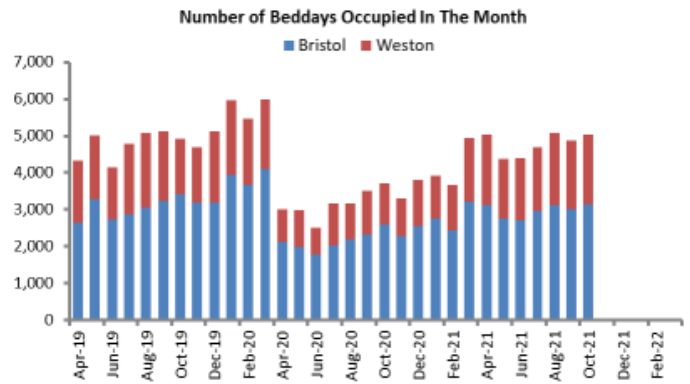
University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

N/A *No Standard Defined*

Standards:	Patients who are medically fit for discharge should wait a minimal amount of time in an acute bed. Pre-Covid, this was captured through Delayed Transfers of Care (DToC) data submitted to NHS England. This return has been discontinued but the Trust continues to capture delayed discharges through its Medically Fit For Discharge (MFFD) lists. These are patients whose ongoing care and assessment can safely be delivered in a non-acute hospital setting, but the patient is still in an acute bed whilst the support is being arranged to enable the discharge. Patients are transferred through one of three pathways; at home with support (Pathway 1), in community based sub-acute bed with rehab and reablement (Pathway 2) or in a care home sub-acute bed with recovery and complex assessment (pathway 3).
Performance:	At the end of October there were 145 MFFD patients in hospital: 97 in Bristol hospitals and 48 at Weston. There were 5,043 beddays consumed in total in the month (1 bedday = 1 bed occupied at 12 midnight). This means, on average, 163 beds were occupied per day by MFFD patients.
Commentary:	In October 2021, the demand across all the pathways in Bristol and Weston continued to exceed capacity: • Pathway 1: Demand for slots in the community continued to exceed capacity. BRI: there were 35 patients who did not meet the criteria to reside waiting for a P1 slot (12 more than at the end of September). WGH: Pathway 1 turnover is consistent with 7 on the list. Discharge dates are given early, allowing for patients to go home with family support to await the care, saving significantly on hospital LOS. • Pathway 2: BRI: there were 13 patients waiting at the end of October at the BRI. It is unclear when the remaining 15 beds at SBCH will re-open but Sirona's extensive recruitment programme is underway. WGH: Significantly improved situation compared to previous months with a drop from over 20, to 8 patients awaiting this pathway. Work ongoing internally around reassessing regularly for pathway 1 where appropriate, as well as greater movement around Community P2 beds. • Pathway 3: BRI: there were 30 patients waiting for a P3 Bed at the BRI (7 more than at the end of September). New P3 contracts have been issued to care homes in Bristol (with particular focus on patients requiring complex dementia care) in an effort to meet demand. WGH: 10 awaiting P3 with work ongoing around transitional beds to further reduce this number.
Ownership:	Chief Operating Officer





Delayed Discharges

19th November 2021

Bristol: Current Breakdown of Medically Fit For Discharge (MFFD) Patients, 19th November 2021

Pathway	Number of Patients	Percentage	7+ Days on Latest Pathway	14+ Days on Latest Pathway	21+ Days on Latest Pathway
P1	25	23.1%	4	1	0
P2	22	20.4%	5	1	1
P3	34	31.5%	19	12	7
Awaiting Decision	12	11.1%	2	0	0
Awaiting Referral	12	11.1%	3	1	0
Other	3	2.8%	1	0	0
Total	108	100%	34	15	8

P1 – patients awaiting package of care
P2 – requiring rehabilitation or reablement
P3 – Nursing or Residential home required

Similar summary for Weston is in development

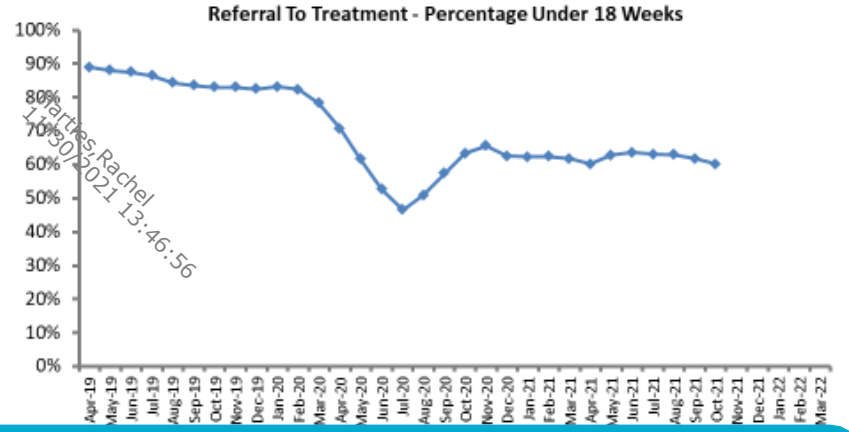
Referral To Treatment

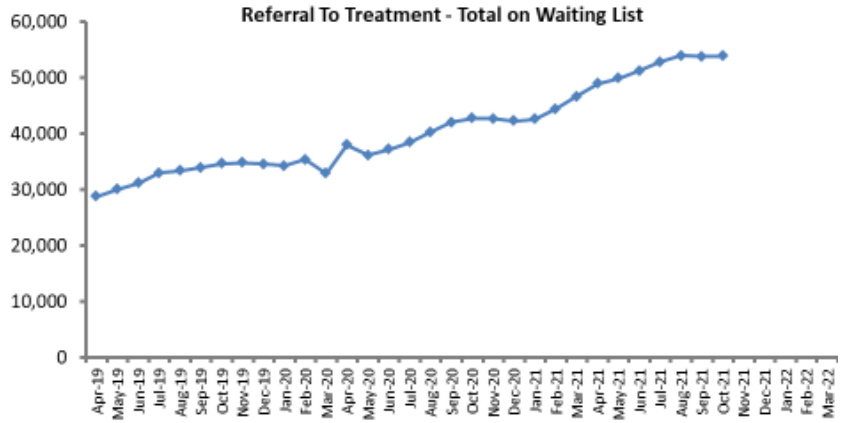
University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

N *Not Achieved*

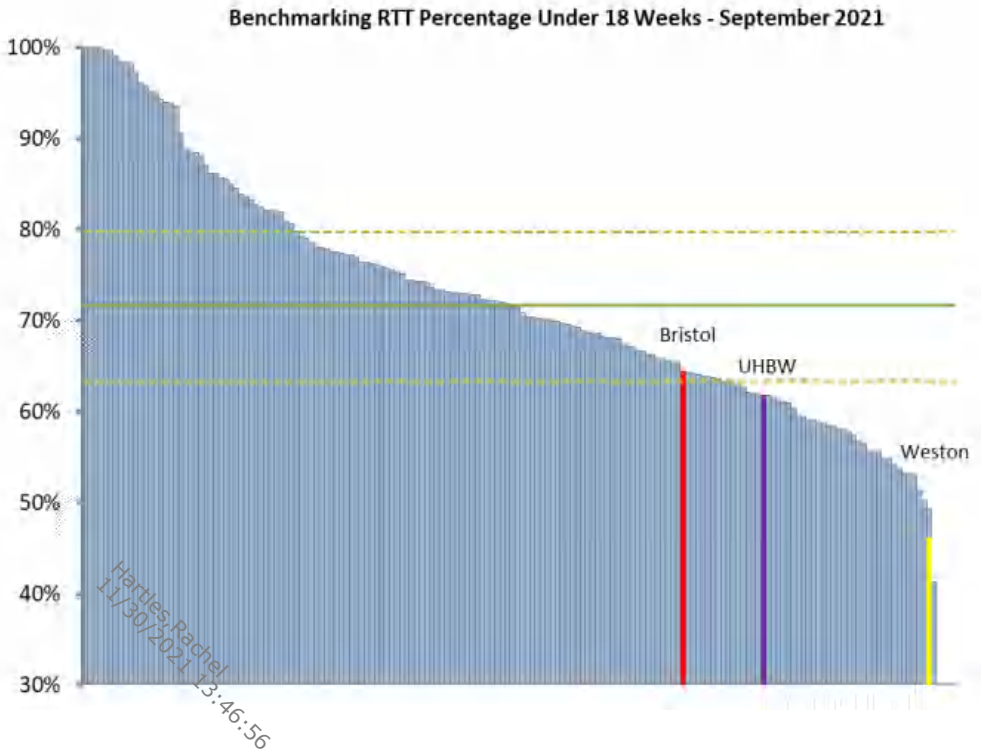
Standards:	The number of patients on an ongoing Referral to Treatment (RTT) pathway and the percentage that have been waiting less than 18 weeks. The national standard is that over 92% of the patients should be waiting under 18 weeks.
Performance:	At end of October, 60.2% of patients were waiting under 18 weeks. The total waiting list was 53,743 and the 18+ week backlog was 21,390. Comparing the end of April 2020 with the end of October 2021: • the overall wait list has increased by 15,849 patients . This is an increase of 42%. • the number of patients waiting 18+ weeks increased by 10,287 patients. This is an increase of 93%.
Commentary:	The focus of discussions with divisions and wider system partners is eradication of patients who are currently 104 weeks wait by the end of March 2022. This will involve transfer of patients who are suitable to the independent sector and ensuring full utilisation of the available capacity internally is maximised with the use of extra lists that have been arranged through waiting list initiatives. In addition we are seeking mutual aid with the support of the CCG where current long waiting patients (i.e. Thoracic) may require transfer to another specialist centre for treatment due to the lack of bed/HDU capacity to bring these patients in for treatment. The requirement from NHSE and the local CCG is to demonstrate that we have explored all options for our long waiting patients to be treated before end of March 2022. The largest Bristol increases in waiting list size , when compared with April 2020, are In Ophthalmology (5,166 increase, 131%), Adult ENT & Thoracics (2,930, 179%) and Dental Services (2,515increase, 30% increase). The Weston list has increased by 335 over the same time period, a 5% increase. The largest Bristol volumes of 18 +week backlog patients at the end of October are in Dental (5,323 patients), Ophthalmology (2,978), ENT & Thoracics (2,326) and Paediatrics (2,243). Weston has 3,853 patients waiting 18+ weeks at the of September.
Ownership:	Chief Operating Officer





Referral To Treatment

September/October 2021



	Oct-21		
	Under 18 Weeks	Total Pathways	Performance
Diagnostics and Therapies	333	333	100.0%
Medicine	3,672	4,675	78.5%
Specialised Services	3,369	4,927	68.4%
Surgery	16,071	28,409	56.6%
Weston	3,642	7,495	48.6%
Women's and Children's	5,266	7,904	66.6%
Other/Not Known	0	0	-
TRUST TOTAL	32,353	53,743	60.2%
Bristol Subtotal	*28,711*	*46,248*	62.1%

Referral To Treatment – Long Waits

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

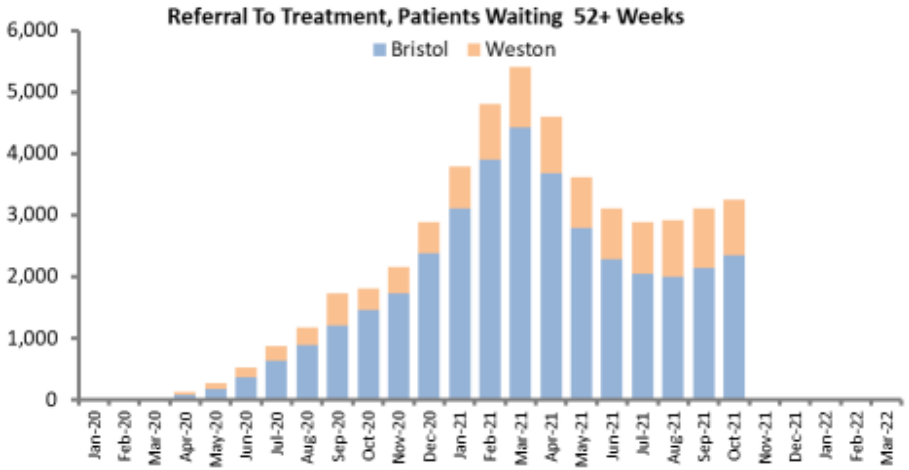
P *Partially Achieved*

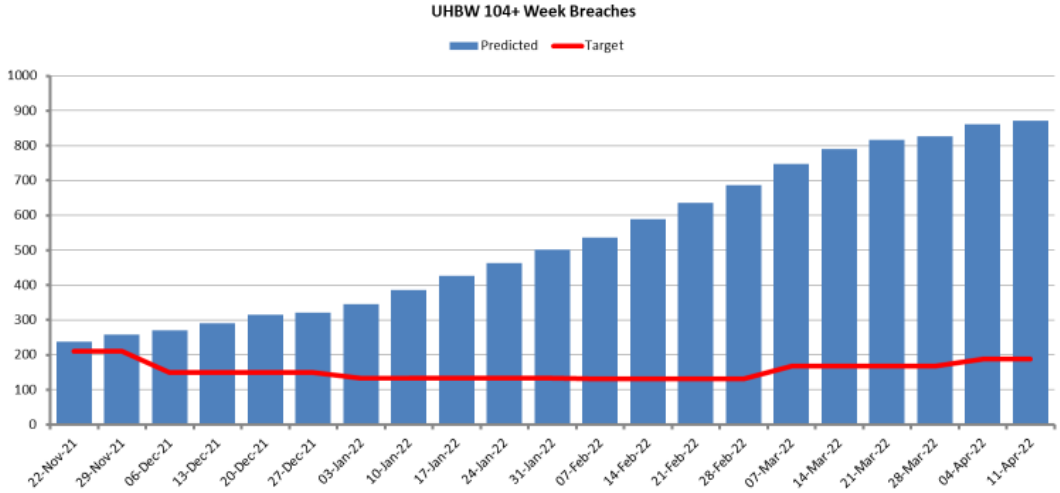
Standards:	Pre-Covid, the expectation was that no patient should wait longer than 52 weeks for treatment. As part of the Elective Recovery Programme Trusts were required to submit plan that eliminated patients waiting 104+ weeks (2+ years) for treatment by the end of March 2022. UHBW's submitted trajectory has 188 patients waiting 104+ weeks by end of March 2022 with an October 2021 trajectory of 211.
Performance:	At end of October 3,248 patients were waiting 52+ weeks; 2,355 across Bristol sites and 893 at Weston. At the end of October, 187 patients were waiting 104+ days, which was below the recovery trajectory target of 211.
Commentary:	The trend has been downwards for 52 week waiters over the past few months but in October this increased by 138 compared to the previous month. This is due to the volume of long waiters in the lower weeks wait cohort tipping into the 52+ week cohort whilst divisions try to date the longer waiting patients. It is still extremely difficult to date the longer waiting patients who are waiting for routine operations when there is a lack of capacity due to the continual high demand of emergency and cancer admissions. This has been further exacerbated by the critical incident position across the Trust. The demand and capacity modelling and trajectory setting for the next 6 months, which are being finalised, will demonstrate the short falls in our capacity to recover against the demand. Clinical prioritisation of patients who are on the waiting list without a "to come in" date continues with processes in place to ensure this is now business as usual. 93% of the patients who are on the RTT admitted waiting list have now been clinically prioritised with 0.6% of those being assigned a P2 status. There is an offer of increased capacity within the independent sector and work is underway to review our long waiting patients who meet the criteria to have a transfer of care to the IS. Previous challenges of theatre closures is becoming less of an issue as theatres are almost back to full capacity, however the challenge of anaesthetic cover, gaps in nursing and therapies staff, social distancing restrictions, the increases in Covid cases and lack of ward beds continues to be an issue for routine patients. NHS England, and local commissioners, continue to request weekly reporting of patients waiting 78+ and 104+ week, as part of the drive to eradicate 104-week breaches at the end of March 2022. Weekly analysis and exception reporting is underway, alongside clinical validation of the waiting list however the volumes of patients who have been clinically prioritised as requiring treatment within a month against the Royal College of Surgeons guidelines, still outweigh the capacity we have available to be able to offer this cohort a TCI date which currently doesn't give assurance that we will be able eradicate the 104-week breaches within this timescale. All data sets are shared on a weekly basis with NHSE via a waiting list minimum data set (WLMDS) and weekly meetings are now set up with the CCG and NHSE where the requirement is to provide assurance on a patient level basis what the next steps are with each of our long waiting patients.
Ownership:	Chief Operating Officer

Referral To Treatment – Long Waits

October 2021

	Oct-21		
	52+ Weeks	78+ Weeks	104+ Weeks
Diagnostics and Therapies	0	0	0
Medicine	38	5	0
Specialised Services	190	53	15
Surgery	1,626	559	87
Weston	893	334	70
Women's and Children's	501	154	15
TOTAL	**3,248**	**1,105**	**187**
Bristol	*2,355*	*771*	*117*





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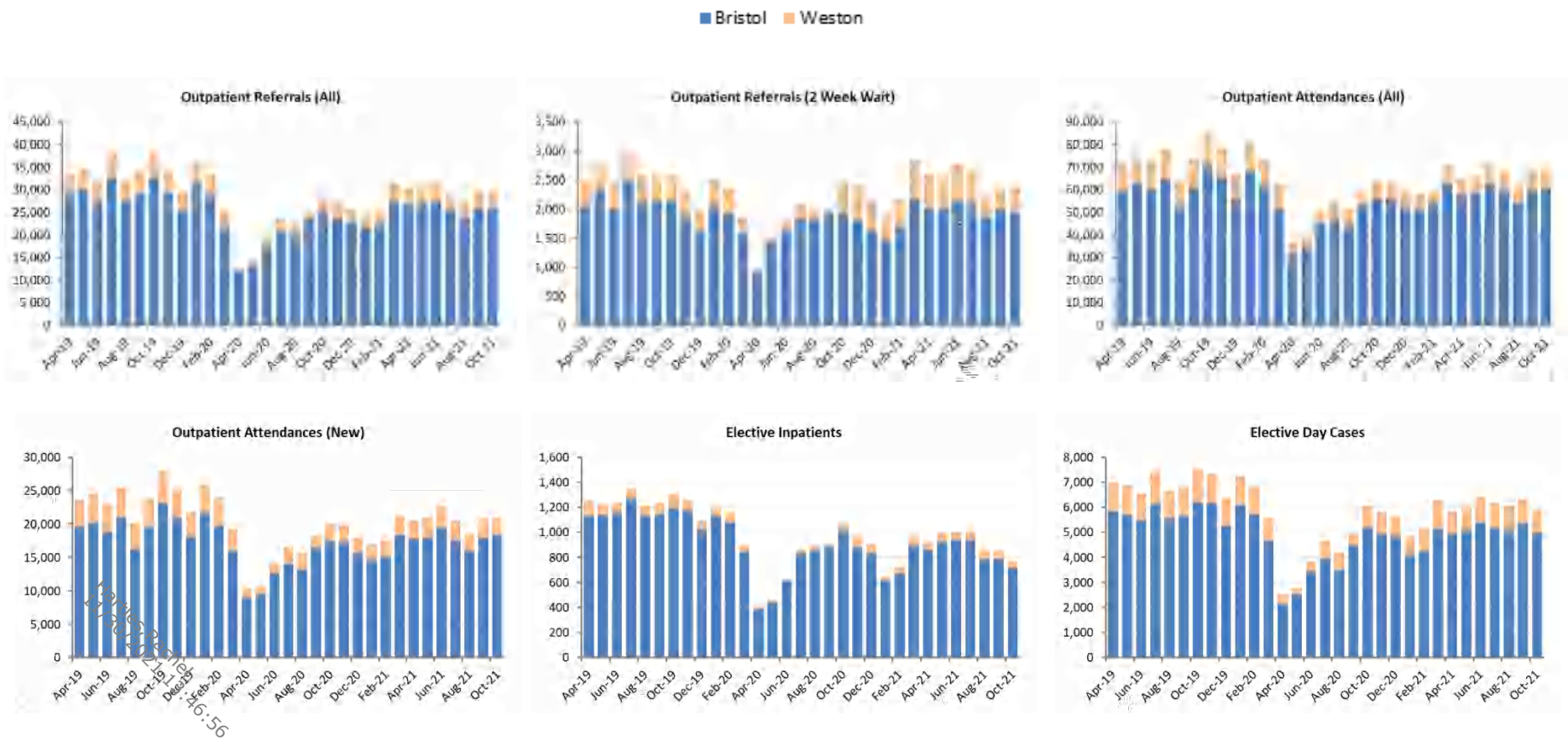
"Predicted" – Number of currently Undated RTT patients who will exceed 104 weeks wait

Elective Activity and Referral Volumes

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

BRISTOL AND WESTON PLANNED ACTIVITY AND REFERRALS APRIL 2019 TO OCTOBER 2021



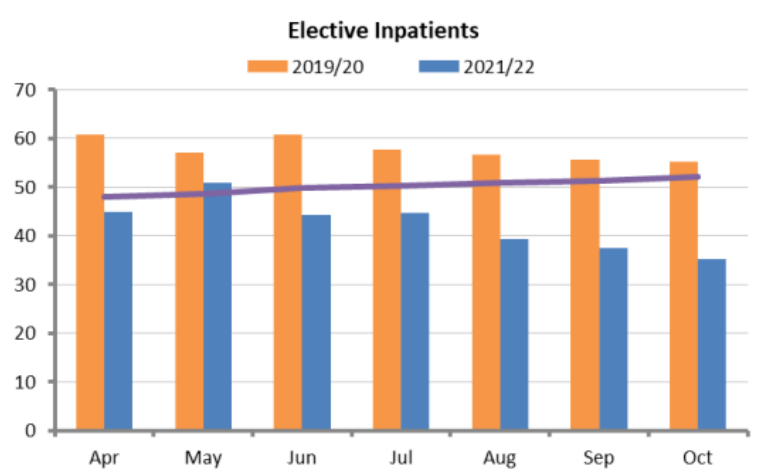
The above data is sourced from the Patient Administration Systems (PAS) and is not the final contracted activity that is used to assess restoration or Business As Usual (BAU) levels.

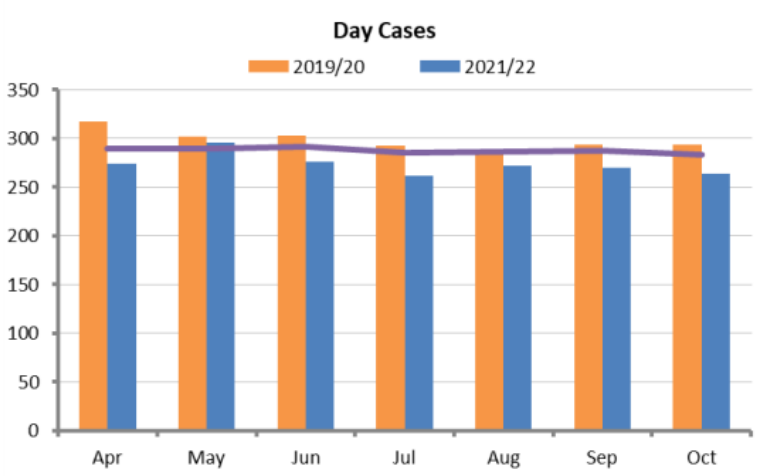
Elective Activity – Restoration

University Hospitals Bristol and Weston NHS Foundation Trust

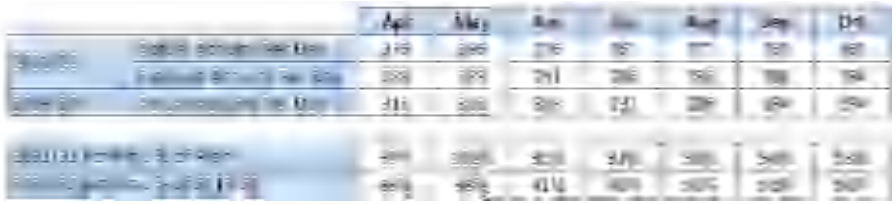
October 2021

Activity Per Day, By Month and Year





		Apr	May	Jun	Jul	Aug	Sep	Oct
2021/22	Actual Activity Per Day	45	51	44	45	39	38	35
	Planned Activity Per Day	48	49	50	50	51	51	52
2019/20	Actual Activity Per Day	61	57	61	58	57	56	55
2021/22 Activity % of Plan		93%	105%	89%	89%	77%	73%	68%
2021/22 Activity % of 2019/20		74%	89%	73%	78%	70%	67%	64%

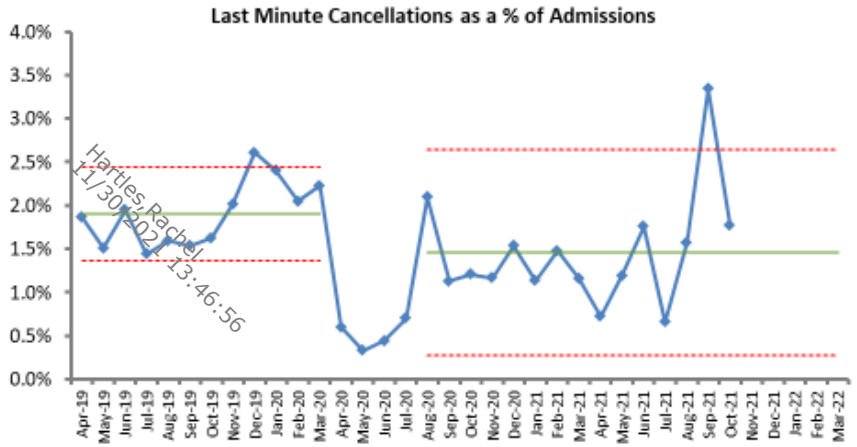


Cancelled Operations

October 2021

N *Not Achieved*

Standards:	For elective admissions that are cancelled on the day of admission, by the hospital, for non-clinical reasons: (a) the total number for the month should be less than 0.8% of all elective admissions (b) 95% of these cancelled patients should be re-admitted within 28 days
Performance:	In October , there were 99last minute cancellations, which was 1.8% of elective admissions. There were 178 cancellations at Bristol and 31 at Weston. Of the 178 cancelled in September, 155 (87%) had been re-admitted within 28 days.
Commentary:	September saw a significant increase in cancellation volumes. This is due to uncertainty of elective capacity that will be available each day due to emergency pressures on the same capacity (beds). This has improved in October, with 99 last minute cancellations. The largest volumes in Bristol were in Cardiac/Cardiology (22), Ophthalmology (20 and Paediatrics (17), General Surgery (22). The most common cancellation reasons in Bristol were: Ran Out Of Operating Time (17),No Critical Care Bed (12) and No Surgeon (12). National reporting of Cancelled Operations was suspended from Quarter 4, so there is no current benchmarking data.
Ownership:	Chief Operating Officer



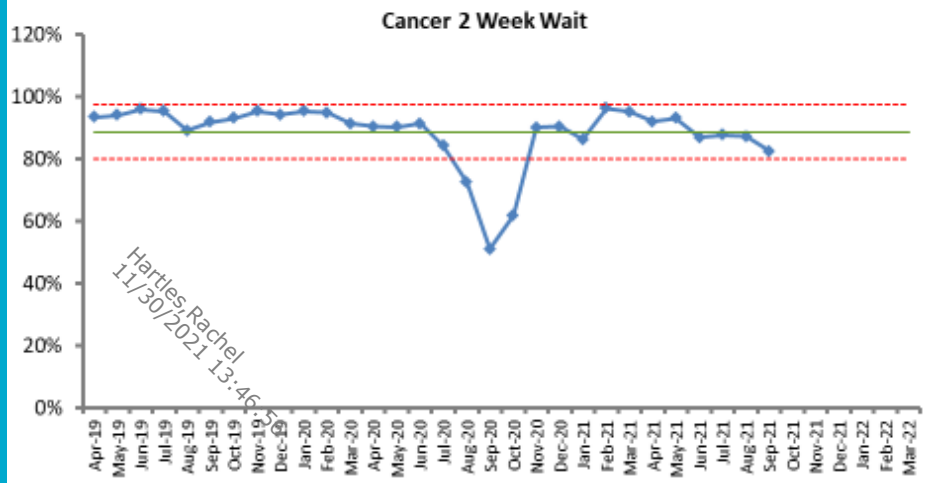
	Oct-21		2021/2022	
	LMCs	% of Admissions	LMCs	% of Admissions
Medicine	0	0.00%	8	0.16%
Specialised Services	22	1.02%	138	0.88%
Surgery	50	2.84%	328	2.59%
Weston	2	1.18%	63	2.77%
Women's and Children's	25	3.28%	130	2.05%
Other/Not Known	0	-	0	-
TRUST TOTAL	**99**	**1.77%**	**667**	**1.59%**

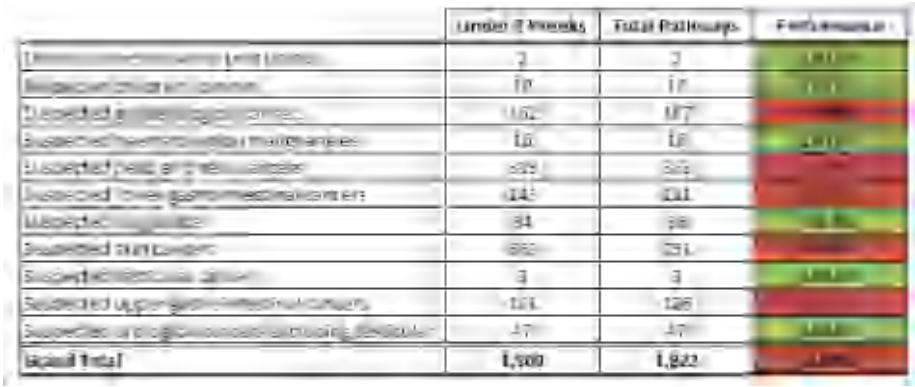
Cancer Two Week Wait

September 2021

N *Not Achieved*

Standards:	Urgent GP-referred suspected cancer patients should be seen within 2 weeks of referral. The national standard is that 93% of patients should be seen within this standard
Performance:	For September, 82.3% of patients were seen within 2 weeks. This is combined Bristol and Weston performance. Overall performance for Quarter 1 was 90.4%. Overall performance for Quarter 2 was 85.7%.
Commentary:	The standard was non-compliant in September (82.3% against a 93% standard). It is expected that compliance will continue to be challenging until all precautions and restrictions related to Covid are lifted. Capacity challenges have occurred in specific areas as a result of surges in demand, likely due to 'pent up' demand built during the lockdowns earlier in the year, and also due to the regional change to the colorectal pathway and the impact of Covid on primary care practice which has decreased the proportion of patients eligible for straight-to-test investigations. The Trust is contributing to the regional evaluation of this pathway however that will not be complete until May 2022.
Ownership:	Chief Operating Officer





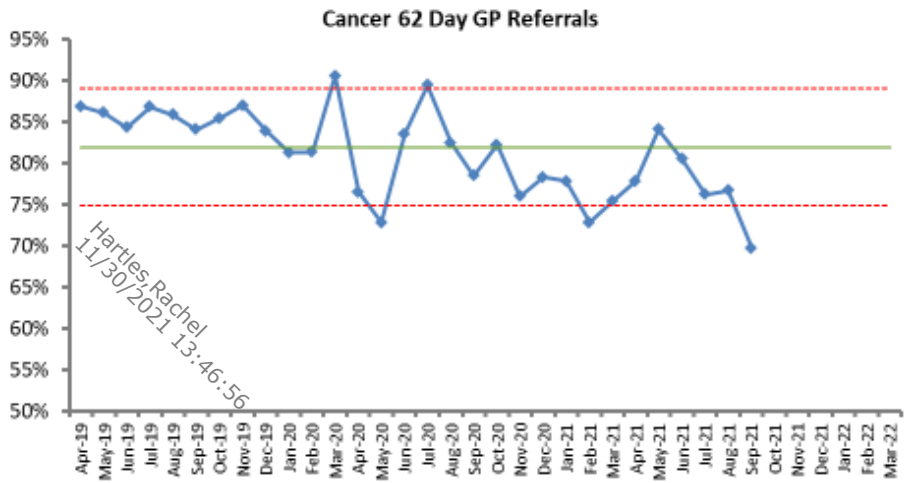
Cancer 62 Days

University Hospitals Bristol and Weston NHS Foundation Trust

September 2021

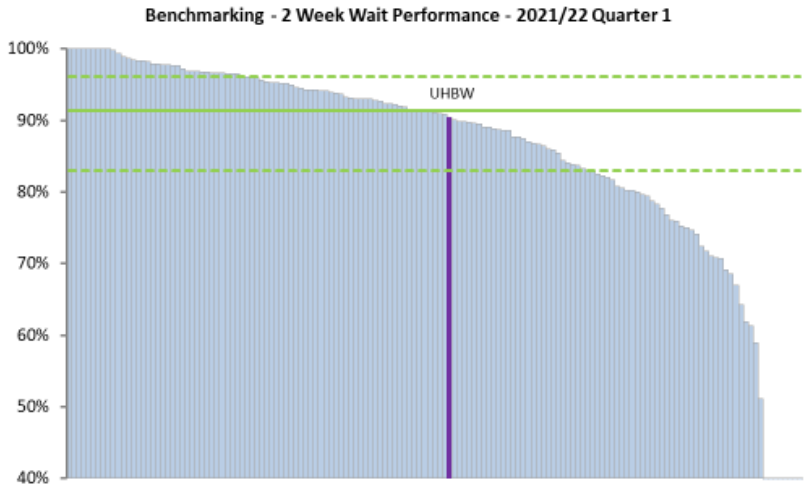
N *Not Achieved*

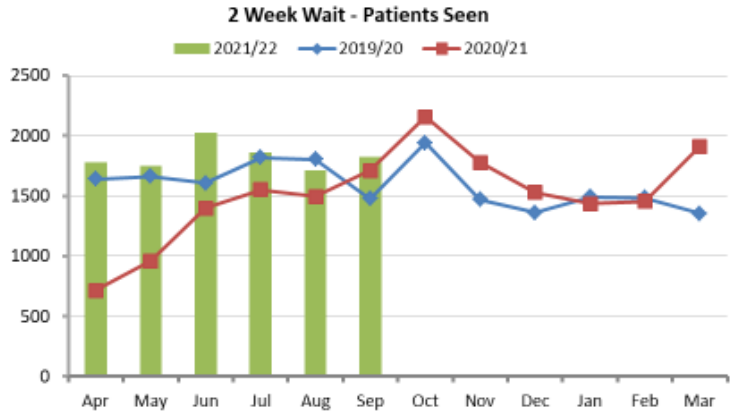
Standards:	Urgent GP-referred suspected cancer patients should start first definitive treatment within 62 days of referral. The national standard is that 85% of patients should start their definitive treatment within this standard. Datix ID 4060 Risk that delayed cancer outpatients and diagnostics during the Covid 19 Pandemic will affect cancer performance and outcomes
Performance:	For September, 69.7% of patients were seen within 62 days. This is combined Bristol and Weston performance. The overall Quarter 1 performance was 80.9%. The overall Quarter 2performance was 74.1%.
Commentary:	The standard was non-compliant in September (69.7% against an 85% standard). The impact of the Covid pandemic on all areas of capacity continues to be at the root of the majority of potentially avoidable target breaches. Achieving compliance with the 85% standard remains unlikely in the short term, particularly in light of ongoing emergency pressures and staff being obliged to isolate. The majority of patients continue to be treated within clinically safe timescales with clinical safety review embedded into waiting list management practice. Additional measures have been taken in colorectal to minimise risk of harm after a small number of cases of potential harm, due to the increased numbers of high risk patients presenting to the Trust. These appear to have been effective.
Ownership:	Chief Operating Officer

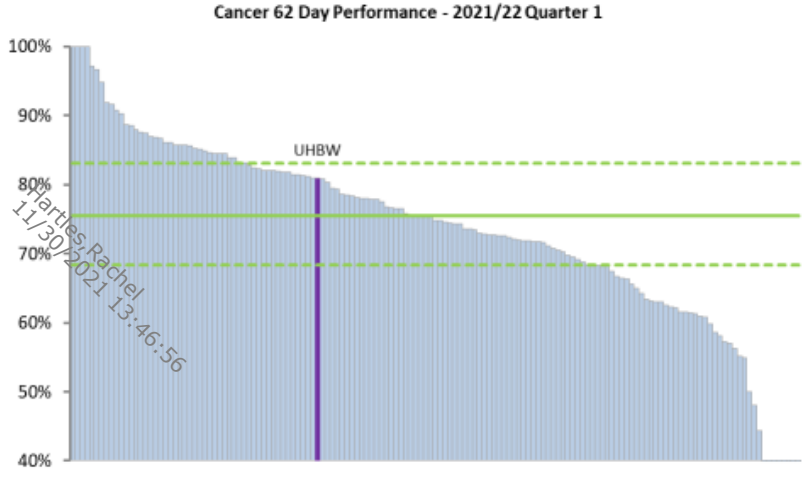


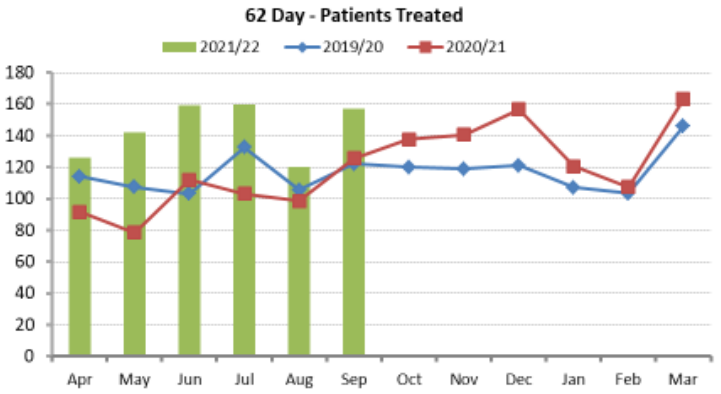
	Within Target	Total Pathways	Performance
Breast	2.5	2.5	100.0%
Gynaecological	5.0	12.0	41.7%
Haematological	5.0	8.0	62.5%
Head and Neck	7.0	11.0	63.6%
Lower Gastrointestinal	6.5	18.0	36.1%
Lung	16.5	20.0	82.5%
Other	0.0	1.5	0.0%
Sarcoma	0.5	1.5	33.3%
Skin	52.0	56.5	92.0%
Upper Gastrointestinal	8.5	13.0	65.4%
Urological	6.0	13.0	46.2%
Grand Total	**109.5**	**157.0**	**69.7%**

Cancer – Additional Information









Cancer 104 Days

University Hospitals Bristol and Weston NHS Foundation Trust

Snapshot taken: 7th November 2021

Standards:	This is not a constitutional standard but monitored by regulators in conjunction with the 62 day standard for cancer treatment after a GP referral for suspected cancer. Trusts are expected to have no patients waiting past day 104 on this pathway for inappropriate reasons (i.e. those other than patient choice or clinical reasons). The Trust has committed to sustaining <10 waiters for 'inappropriate' reasons.
Performance:	Prior to the Covid-19 outbreak the Trust consistently had 0 patients waiting over 104 days for inappropriate reasons (i.e. those other than patient choice, clinical reasons, or recently received late referrals into the organisation). As at 7th November 2021 there were 2 such waiters. This compares to a peak of 53 such waiters in early July 2020.
Commentary:	The Trust is aiming to sustain minimal (<10) waiters over 104 days on a GP referred cancer pathway for 'inappropriate' reasons. The number of such waiters remains below this threshold.. Avoiding harm from any long waits remains a top priority and is closely monitored. During this period of limited capacity due to the Covid outbreak, appropriate clinical prioritisation will adversely affect this standard as patients of lower clinical priority may wait for a longer period, to ensure those with high clinical priority are treated quickly. This is because cancer is a very wide range of illnesses with differing degrees of severity and risk and waiting time alone is not a good indicator of clinical urgency across cancer as a whole. An example of this is patients with potential thyroid cancers awaiting thyroidectomy, who have been clinically assessed as safe to wait for several more months (and most of whom will not ultimately have a cancer diagnosis), but who have exceeded the 104 day waiting time.
Ownership:	Chief Operating Officer

Cancer – Patients Waiting 62+ Days

University Hospitals Bristol and Weston NHS Foundation Trust

Snapshot taken: 7th November 2021

Standards:	This is one of the metrics being used by NHS England (NHSE) to monitor recovery from the impact of the Covid epidemic peak . NHSE has asked Trusts to return to/remain below 'pre-pandemic levels'. NHSE defines this as 180 patients for UHBW. Note that the 62 day constitutional standard is based on patients who start treatment. This additional measure reviews the patients waiting on a 62 day pathway prior to treatment or confirmation of cancer diagnosis.
Performance:	As at 7th November the Trust had 150 patients waiting >62 days on a GP suspected cancer pathway, against a baseline of 180.
Commentary:	The Trust remains below the 'pre-Covid' baseline, currently by a comfortable margin. This position is difficult to maintain due to the emergency pressures on the hospital and ongoing impact of Covid on services, however every effort is being made to minimise long waiting patients and, of those who do wait longer, ensure there is a low risk of harm from the delay.
Ownership:	Chief Operating Officer

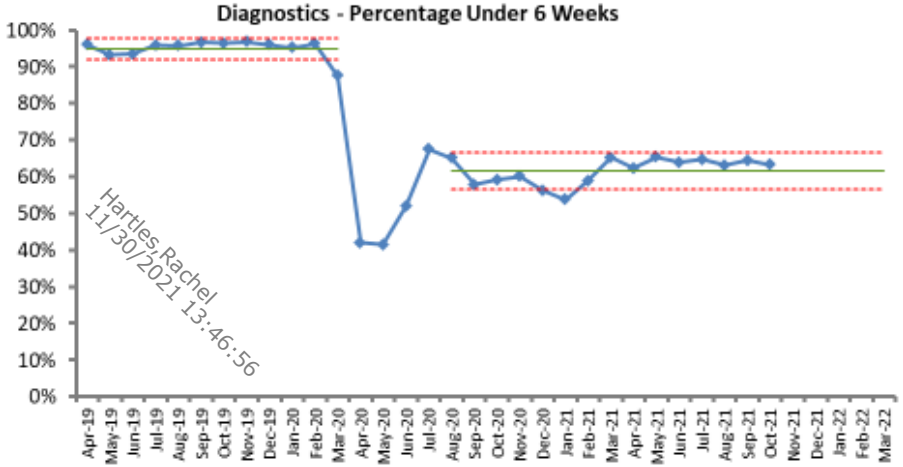
Diagnostic Waits

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

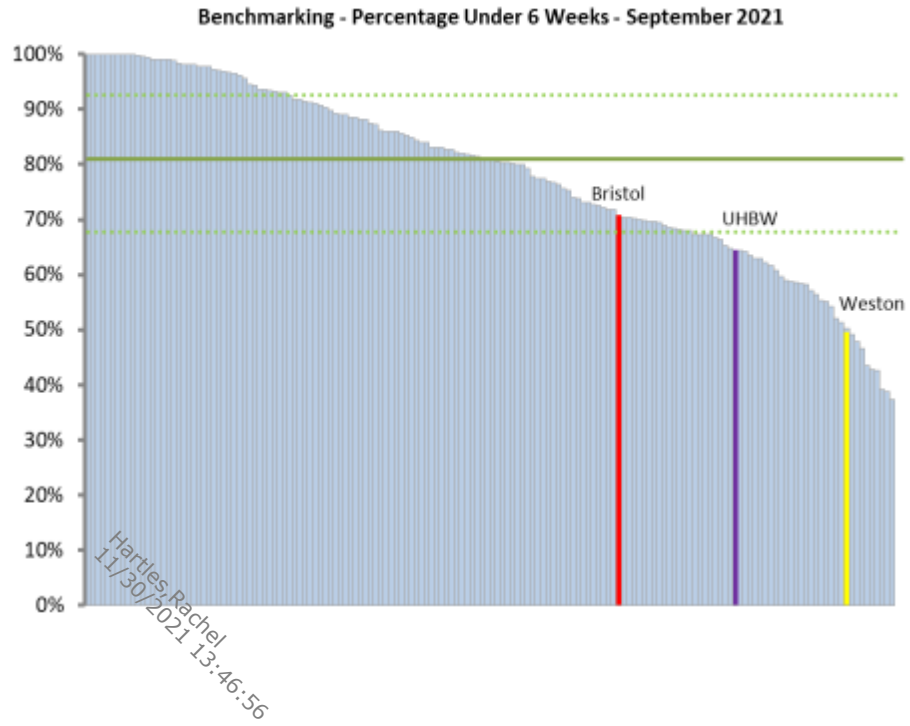
N *Not Achieved*

Standards:	Diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is that 99% of patients referred for one of the 15 high volume tests should have their test carried-out within 6 weeks, as measured by waiting times at month-end.
Performance:	At end of October, 63.3% of patients were waiting under 6 week, with 14,125 patients in total on the list. This is Bristol and Weston combined.
Commentary:	• Diagnostic clinical prioritisation programme is progressing with diagnostic imaging modalities being reported according to the nationally defined categories. Further work required for some modalities, in particular, endoscopy. • Non obstetric ultrasound outsourced capacity procurement completed but new risk relating to capacity of provider to deliver. Impact being quantified but may restrict access to a zero hours contract (one list per week) • CT scanner "early adopter" operating at 1/3rd of plan in Weston due to radiographer staffing issues and lack of agency staffing. South Bristol Hospital CT scanner delayed until January 2022 due to delay in installation works. • Business case to extend Biobank imaging capacity to end of March 2021 completed. • Dexa scan performance in UHBW is poor and cross site collaboration is under review between divisions to improve the long wait position. • Radiology reporting outsourcing agreed to speed up results for patients in diagnostic modalities where capacity is tight. • Echo cardiography outsourcing proposal being developed in Weston.
Ownership:	Chief Operating Officer



	Oct-21		
	Under 6 Weeks	Total Pathways	Performance
Diagnostics and Therapies	4,873	5,972	81.6%
Medicine	126	221	57.0%
Specialised Services	1,127	2,167	52.0%
Surgery	469	1,223	38.3%
Weston	2,129	4,285	49.7%
Women's and Children's	213	257	82.9%
Other/Not Known	0	0	-
TRUST TOTAL	**8,937**	**14,125**	**63.3%**
Bristol Subtotal	*6,808*	*9,840*	69.2%

Diagnostic Waits



WESTON - October 2021	6+ Weeks	13+ Weeks	Total On List	% Under 6 Weeks
Audiology - Audiology Assessments	0	0	0	
Cardiology - echocardiography	1,129	894	1,387	18.6%
Colonoscopy	10	4	68	85.3%
Computed Tomography	3	2	302	99.0%
Cystoscopy	302	218	421	28.3%
DEXA Scan	372	241	506	26.5%
Flexi sigmoidoscopy	4	2	39	89.7%
Gastroscopy	10	3	88	88.6%
Magnetic Resonance Imaging	1	0	372	99.7%
Non-obstetric ultrasound	325	116	1,102	70.5%
Grand Total	**2,156**	**1,480**	**4,285**	**49.7%**

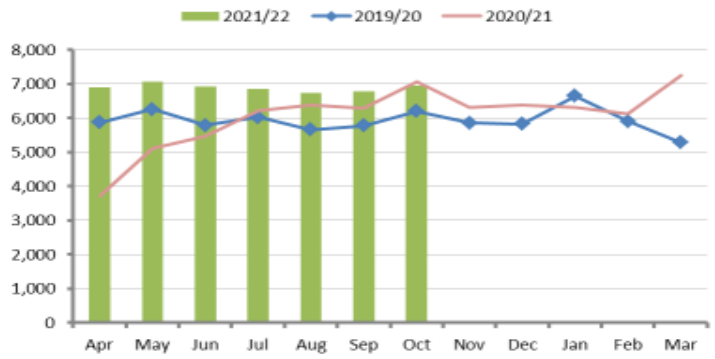
BRISTOL - October 2021	6+ Weeks	13+ Weeks	Total On List	% Under 6 Weeks
Audiology - Audiology Assessments	2	0	452	99.6%
Cardiology - echocardiography	342	6	1,260	72.9%
Colonoscopy	342	245	597	42.7%
Computed Tomography	301	199	1,331	77.4%
Cystoscopy	7	7	11	36.4%
DEXA Scan	8	0	379	97.9%
Flexi sigmoidoscopy	175	140	215	18.6%
Gastroscopy	274	210	469	41.6%
Magnetic Resonance Imaging	952	660	2,217	57.1%
Neurophysiology - peripheral neurophysi	0	0	99	100.0%
Non-obstetric ultrasound	542	140	2,687	79.8%
Respiratory physiology - sleep studies	87	82	123	29.3%
Grand Total	**3,032**	**1,689**	**9,840**	**69.2%**

Diagnostic Activity – Restoration

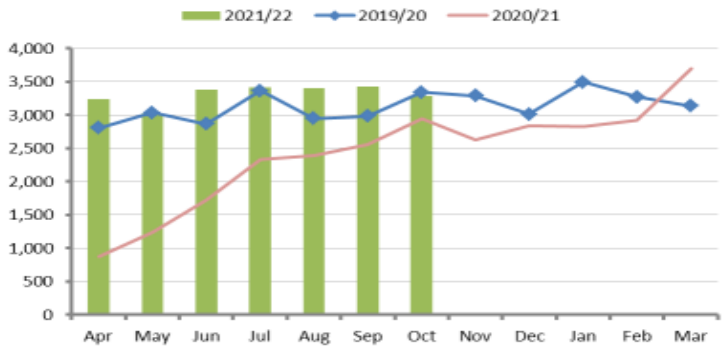
University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

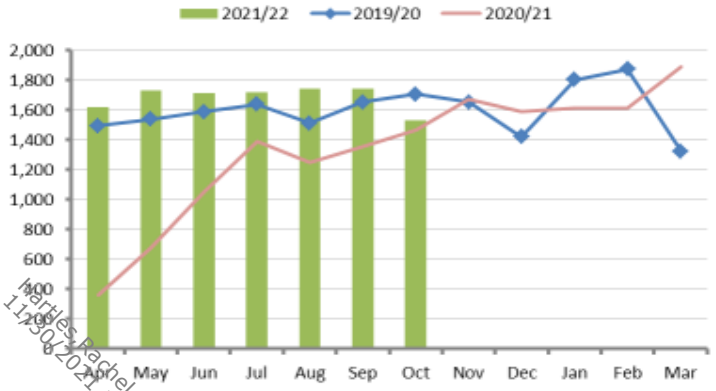
Computed Tomography (CT)



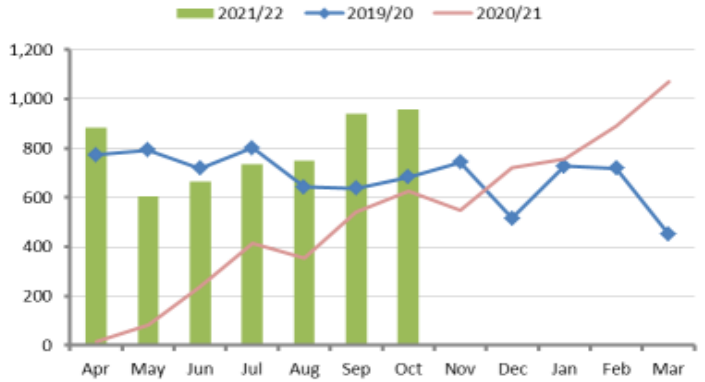
Magnetic Resonance Imaging (MRI)



Echocardiography



Endoscopy *(Gastroscopy, Colonoscopy, Flexi Sig)*



2021/22 as a Percentage of 2019/20

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Computed Tomography	118%	113%	120%	114%	119%	118%	112%					
Magnetic Resonance Imaging	115%	99%	118%	101%	116%	115%	98%					
Echocardiography	108%	113%	108%	105%	115%	105%	90%					
Endoscopy	114%	76%	92%	92%	116%	147%	140%					

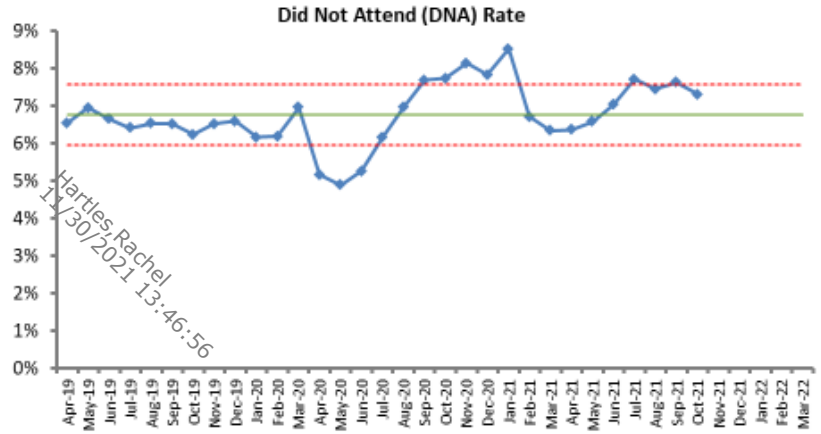
Outpatient Measures

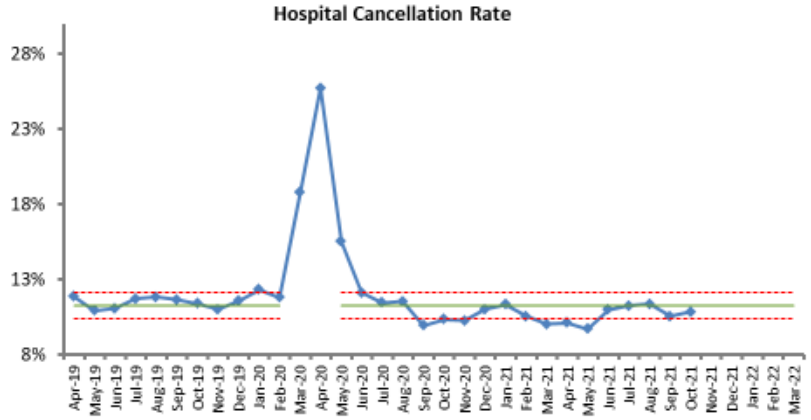
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

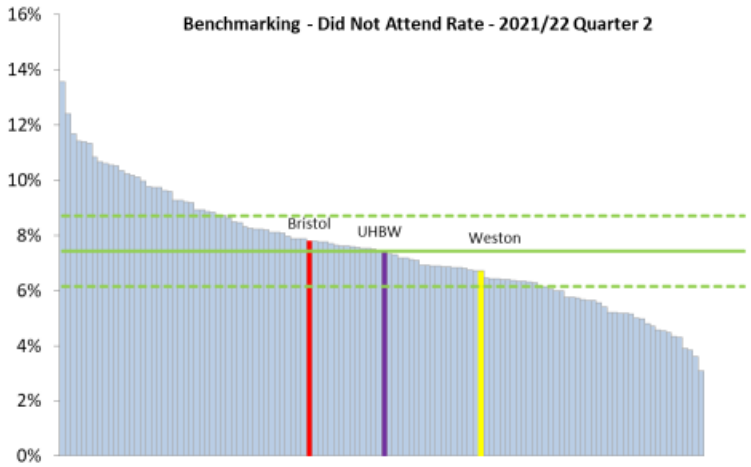
N *Not Achieved*

Standards:	The number of outpatient appointments where the patient Did Not Attend (DNA), as a percentage of all attendances and DNAs The Hospital Cancellation Rate is the number of outpatient appointments cancelled by the hospital, as a percentage of all outpatient appointments made. The DNA Target at Trust level is to be below 6.7%, with an amber tolerance of between 6.7% and 7.2%. For Hospital Cancellations, the target is to be on or below 9.7% with an amber tolerance from 10.7% to 9.7%.
Performance:	In October, the DNA Rate was 7.3% across Bristol and Weston, with 5,349 DNA'ed appointments. The hospital cancellation rate was 10.8% with 10,755 cancelled appointments
Commentary:	• Cancellation rates are outside of tolerance targets in October 10.8% • DNA rates rose in June to 7.0%, this rose in July to 7.7% and has been sustained during August and September at 7.6%. In October this has fallen to 7.3%. This mirrors the urgent care response and the decline in non-face to face activity. • Plans in place increase resources to promote attendance and reduce last minute patient cancellations.
Ownership:	Chief Operating Officer

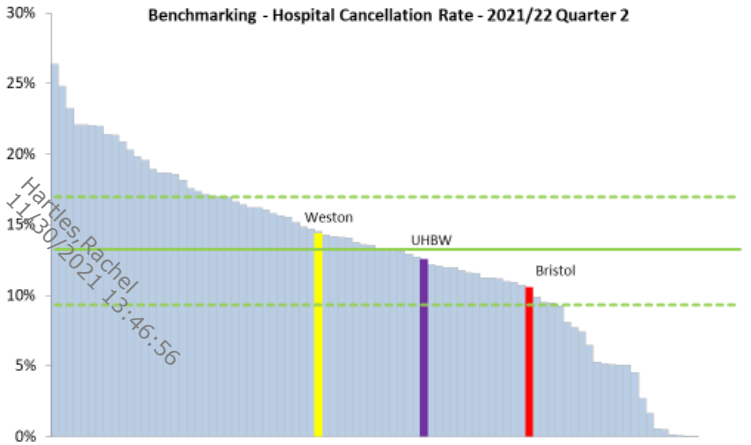




Outpatient Measures



	Oct-21	
	DNAs	DNA Rate
Diagnostics and Therapies	481	6.0%
Medicine	852	9.9%
Specialised Services	612	5.4%
Surgery	1,535	7.3%
Weston	600	6.9%
Women's and Children's	1,269	8.2%
Other/Not Known	0	-
TRUST TOTAL	**5,349**	**7.3%**
Bristol Subtotal	*4,749*	7.4%



	Oct-21	
	Cancellations	Rate
Diagnostics and Therapies	716	7.2%
Medicine	1,426	12.3%
Specialised Services	2,331	15.0%
Surgery	2,494	8.5%
Weston	1,824	15.4%
Women's and Children's	1,964	9.4%
Other/Not Known	0	-
TRUST TOTAL	**10,755**	**10.8%**
Bristol Subtotal	*8,931*	10.2%

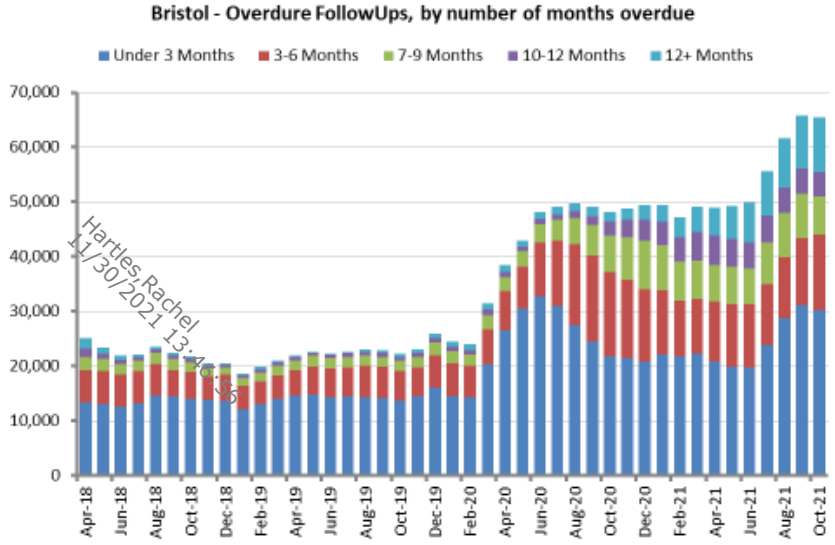
Outpatient Overdue Follow-Ups

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

N *Not Achieved*

Standards:	This measure looks at referrals where the patient is on a "Partial Booking List" at Bristol, which indicates the patient is to be seen again in outpatients but an appointment date has not yet been booked. Each patient has a "Date To Be Seen By", from which the proportion that are overdue can be reported. Datix 2244 Risk that long waits for Outpatient follow-up appointments results in harm to patients.
Performance:	Total overdue at end of October was 89,324 of which 25,837 (29%) were overdue by 9+ months.
Commentary:	• Overdue follow up backlogs have continued to grow during August as a result of outpatient cancellations to support the urgent care response June/July/August /Sept (Datix ID 2244) this stabilised during October. • Outpatient restoration activity October with 91% of activity delivered against the 2021/22 plan which is 82% of 2019/20 activity. Clinical capacity is not sufficient to manage follow up backlog demand as well as the ongoing new demand. Capacity is being focussed on the delivery of the most clinically urgent cases. • National validation programme is expected in late February 2022. H2 bid submitted to support development of UHBW waiting list validation. Divisional engagement is being sought to progress programme ahead of national mandate. • Areas of largest areas of backlog seen in Sleep, Ophthalmology, T&O and Respiratory. Discussions in progress with specialities to review the use of PIFU. Sleep recovery may be affected by risk relating to CPAP/BIPAP machine supply issues and recall (Datix ID 5422)
Ownership:	Chief Operating Officer



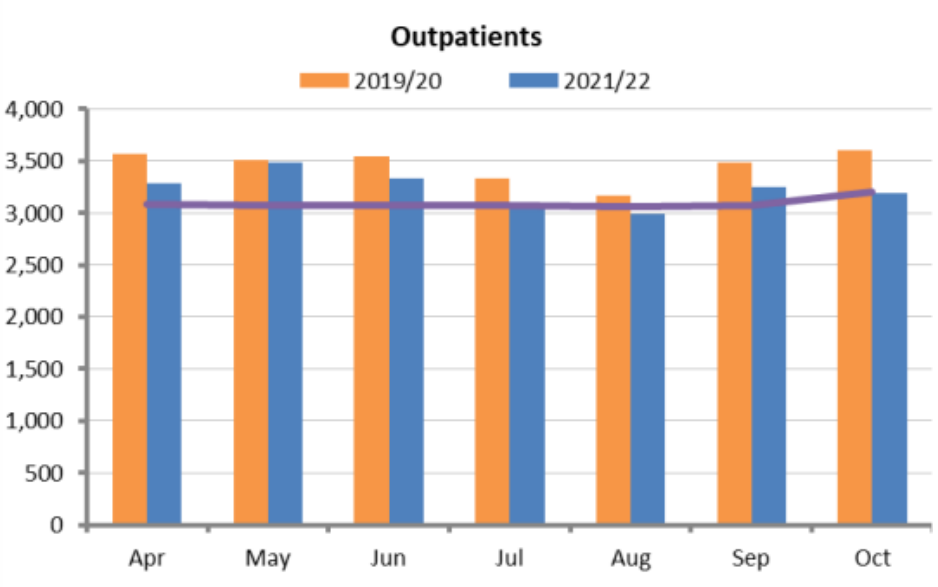
	Under 9 Months	9-11 Months	12+ Months	Total
Diagnostics & Therapies	4,590	29	35	4,654
Medicine	10,987	1,484	4,483	16,954
Specialised Services	6,850	434	553	7,837
Surgery	23,408	2,219	4,553	30,180
Weston	12,442	2,781	8,637	23,860
Women's and Children's	5,210	307	322	5,839
UHBW TOTAL	**63,487**	**7,254**	**18,583**	**89,324**
Bristol Subtotal	*51,045*	*4,473*	*9,946*	*65,464*

Outpatient Activity – Restoration

University Hospitals Bristol and Weston NHS Foundation Trust

September 2021

Activity Per Day, By Month and Year – Outpatient Attendances



		Apr	May	Jun	Jul	Aug	Sep	Oct
2021/22	Actual Activity Per Day	3,289	3,484	3,326	3,099	2,984	3,249	3,189
	Planned Activity Per Day	3,085	3,068	3,078	3,068	3,057	3,068	3,198
2019/20	Actual Activity Per Day	3,568	3,507	3,544	3,327	3,162	3,487	3,604

2021/22 Activity: % of Plan	107%	114%	108%	101%	98%	106%	100%
2021/22 Activity: % of 2019/20	92%	99%	94%	93%	94%	93%	88%

Mortality – SHMI (Summary Hospital-level Mortality Indicator)

University Hospitals Bristol and Weston NHS Foundation Trust

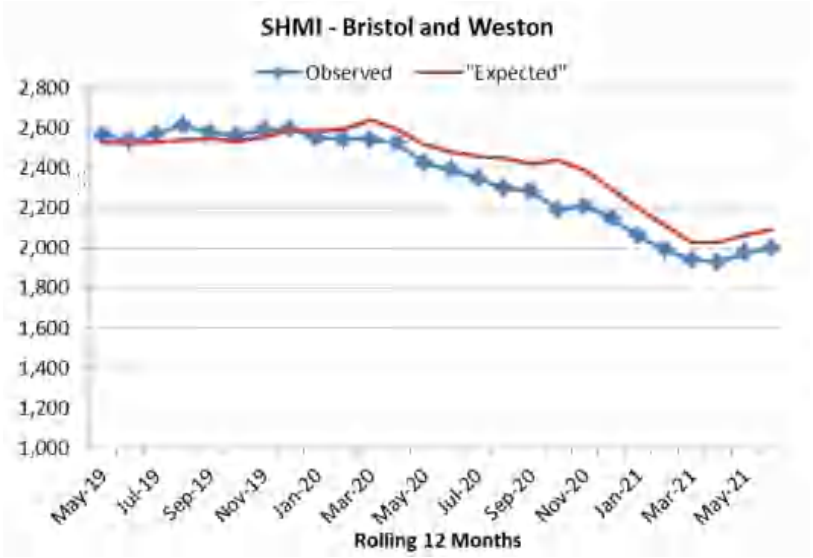
June 2021

A *Achieved*

Standards:	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. The most recent data is for the 12 months to June 2021 and 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 to June 2021 and was 95.67and in NHS Digital's "as expected" category. This is lower than the overall national peer group of English NHS trusts of 100.
Commentary:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to speciality level if required and investigating any identified alerts.
Ownership:	Medical Director

	UHBW		
Rolling 12	Observed	"Expected"	SHMI
Sep-20	2,285	2,420	94.4
Oct-20	2,190	2,440	89.8
Nov-20	2,210	2,390	92.5
Dec-20	2,150	2,300	93.5
Jan-21	2,060	2,200	93.6
Feb-21	1,990	2,115	94.1
Mar-21	1,940	2,030	95.6
Apr-21	1,930	2,030	95.1
May-21	1,975	2,065	95.6
Jun-21	2,000	2,090	95.7

Note: Jan-21 represents 12 month period Feb-20 to Jan-21



Mortality – HSMR (Hospital Standardised Mortality Ratio)

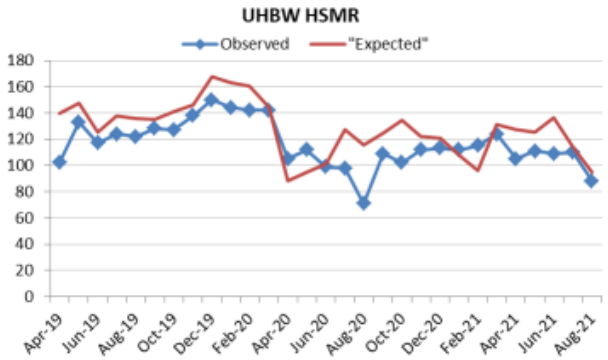
University Hospitals Bristol and Weston NHS Foundation Trust

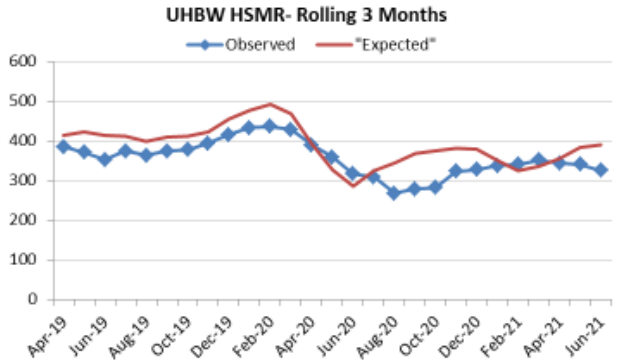
August 2021

A *Achieved*

Standards:	Reported HSMR is from CHKS (Capita Health Knowledge System) and is subject to annual rebasing. HSMR data published by the Dr Foster unit is rebased more frequently so figures will be different, although our position relative to other Trusts will be the same.
Performance:	HSMR within CHKS for UHBW solely for the month of August 2021 is 92.7, meaning there were fewer observed deaths (88) than the statistically calculated expected number of deaths (94.9). Single monthly figures for HSMR are monitored in UHBW as an "early warning system" and are not valid for wider interpretation in isolation. The HSMR for the 12 months to August 2021 for UHBW was 91.0 (National Peer: 90.0).
Commentary:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to speciality level if required and investigating any identified alerts.
Ownership:	Medical Director

	UHBW		
	Observed	"Expected"	HSMR
Sep-20	109	124	87.6
Oct-20	102	135	75.7
Nov-20	112	122	91.5
Dec-20	113	121	93.5
Jan-21	112	108	103.9
Feb-21	115	96	119.4
Mar-21	124	131	94.6
Apr-21	105	128	82.4
May-21	111	125	88.5
Jun-21	109	136	79.9
Jul-21	110	114	96.7
Aug-21	88	95	92.7





Fractured Neck of Femur (NOF)

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

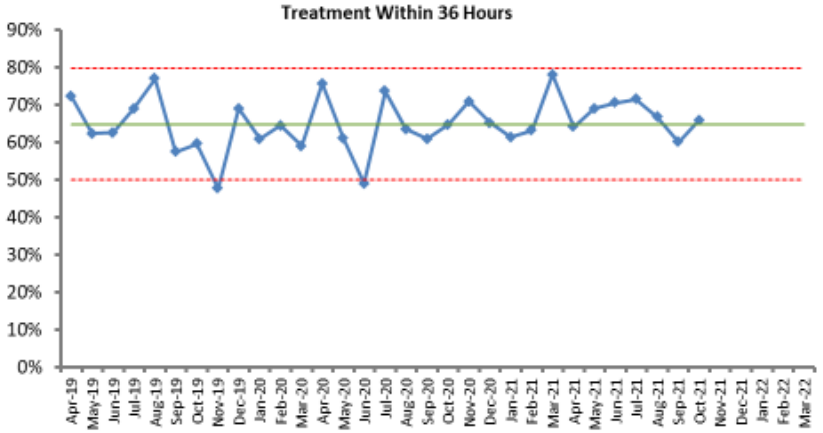
P *Partially Achieved*

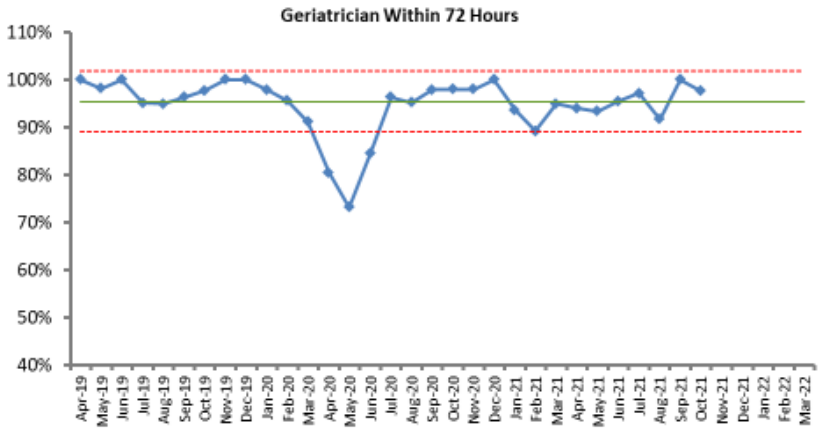
Standards:	Fractured neck of femur best practice comprises eight elements, all of which need to be provided within relevant time scales to demonstrate care provided to individual patients has met best practice standards. Two of the eight individual criteria are monitored in this report: time to theatre within 36 hours and ortho-geriatrician review within 72 hours. Both standards have a target of 90%.
Performance:	In October 2021, there were 41 patients eligible for Best Practice Tariff (BPT) across UHBW (18in Bristol and 23 in Weston). • For the 36 hour standard, 66% achieved the standard (27 out of 41 patients) • For the 72 hour standard, 98% achieved the standard (40 out of 41 patients)
Commentary:	There is continued difficulty in time to theatre in Bristol, mostly driven by the increase in general trauma demand to theatres for #NOF patients and an inability to stand up more trauma theatres due to the necessity to maintain cancer theatre capacity and also a lack of available inpatient beds. Challenges to be addressed in Bristol: • Difficulty accessing theatres to ensure consistent Fracture NOF theatre • The BRI is witnessing a sustained increase of demand on the trauma service as a result of national lockdowns being eased. This has worsened through November and the T&O service is having to stand up extra trauma theatres to address demand. • Inability to address peaks in #NOF demand. • Lack of beds in the right area to have patients seen quickly. This is exacerbated by outliers in the T&O wards. Actions being taken in Bristol: • Reinvigoration of the Silver Trauma meetings to address the ongoing issues with access to theatre as well as developing a complete staffing picture for the service to ensure we have staff to meet demand. • Theatre capacity being actively monitored and prioritised on a weekly basis across all specialties. • Any last minute cancellation from another specialty is usually then backfilled by trauma surgeons. • Formal job planning completed and actioned to provide multi-specialist trauma cover each day. Challenges to be addressed in Weston (October issues): • Limited theatre space due to half day lists on Tuesdays and Thursdays Actions being taken in Weston: • Use Emergency lists where possible for extra capacity when trauma lists are full or limited
Ownership:	Medical Director

Fractured Neck of Femur (NOF)

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021





		36 Hours		72 Hours	
	Total Patients	Seen In Target	Percentage	Seen In Target	Percentage
Bristol	18	9	50%	17	94%
Weston	23	18	78%	23	100%
TOTAL	**41**	**27**	**65.9%**	**40**	**97.6%**

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Mixed Sex Accommodation Breaches

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

A *Achieved*

Standards:	There should be no clinically unjustified Mixed Sex Accommodation (MSA) breaches. There are some clinical circumstances where mixed sex accommodation can be justified. These are mainly confined to patients who need highly specialised care. Therefore, the description of an MSA breach refers to all patients in sleeping accommodation who have been admitted to hospital: A breach occurs at the point a patient is admitted to mixed-sex accommodation outside the guidance.
Performance:	Monthly, national reporting of Mixed Sex Accommodation (MSA) breaches has been reinstated in October 2021. There were 13 justified Mixed Sex Accommodation breaches reported in October 2021. These were short transient breaches (permitted in our policy) caused by significant pressure and overcrowding in the emergency department requiring a patient to be transferred to provide a resuscitation bed and an immediate in-patient stroke bed was required.
Commentary:	The revised standard operating procedure for managing same sex accommodation has been widely disseminated to ensure that all staff are fully aware its requirements. Significant quality improvement programme in place to support and improve patient flow within the Trust, which should assist with reducing the length of time that patients need to wait for a suitable bed.
Ownership:	Chief Nurse

Maternity Services

October 2021

N/A ***No Standard Defined***

Standards:	A Maternity Quality Perinatal Matrix provides additional quality surveillance of the maternity services at UHBW and has been developed following the recommendations made by the Ockenden report (2020) into maternity care at Shrewsbury and Telford Hospital Trust.
Performance:	Please refer to the Perinatal Quality Surveillance Matrix on the next page. • In UHBW, a continued increase in induction of labour (IOL) waiting times remains a concern and has led to complaints. This is attributed to lack of capacity on the central delivery suite (CDS) with mitigation described in risk 2264, delayed induction of labour. • There were 19 reported incidents related to workforce (service provision/staffing) in October 2021, including six related to multiple delayed inductions of labour and nine related to non-compliance with British Association of Perinatal Medicine (BAPM) standards • There was one reported incident of an attempt to divert an ambulance to Southmead Hospital due to lack of capacity in St Michael's Hospital, but this was unsuccessful. • The total LSCS rate increased in October 2021 to 38.7% compared to 35.8% in September and 32.3% in August. This is the highest monthly rate in the year to date.

Commentary:	Actions:
	• Funding been agreed for a separate triage area. It is expected this will support patient flow as often women due for induction are waiting to be transferred to the Central Delivery Suite.
	• Outpatient inductions where clinically appropriate have started from the 1st November which will support women as they can start the process at home.
	• It is part of day to day operational management to address capacity issues to achieve 1:1 care of women in labour 100% of the time, such as:
	  ○ moving staff from hospital antenatal/postnatal and community areas
	  ○ senior doctors acting down to fill junior gaps in the rota, bank or agency staff employed
	  ○ on call staff brought in to cover busy periods where there are staff shortages
	  ○ flexing the bed base
	• There is a monthly forum to share staff concerns with the Maternity and Neonatal Safety Champions and actions are fed back to staff. The current themes align with the data and include: staffing, capacity and delayed IOL
	• Following feedback, the Head of Maternity held a focus group with our Somali representatives to ensure we continue to receive their feedback and learn how we can improve our offer of care to this population group. Feedback is being circulated within clinical teams and further focus groups and actions to address concerns are planned.
	• Focus groups with our "midwifery hubs" service users continue. The feedback about the continuity of carer pathway of care was universally positive from the women, Somali women were also represented in this most recent focus group..

Ownership:	Chief Nurse

UHBW Perinatal Quality Surveillance Matrix

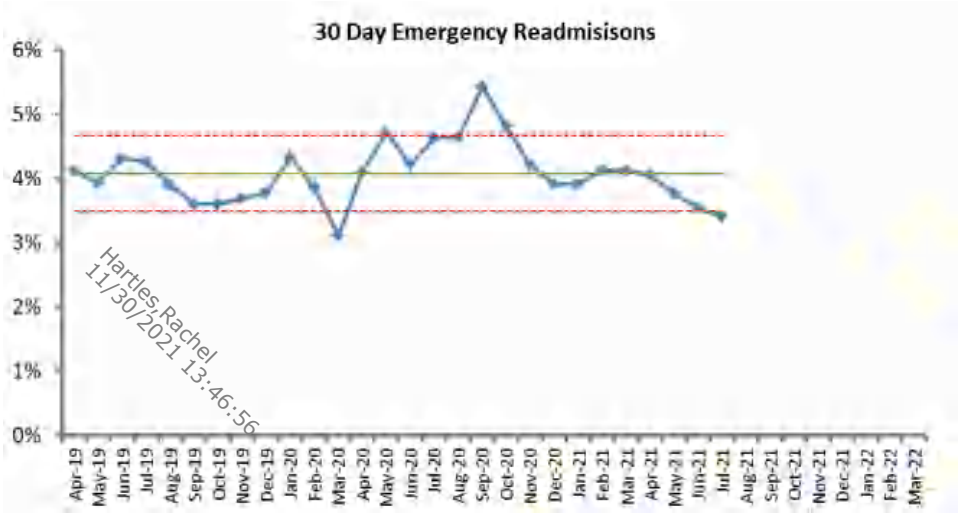
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Number of babies born alive at >=22 to 36+6 weeks gestation	29	27	24	28	38	28	39	24	44	30		
Number of women who gave birth is all gestations from 22+0 weeks	380	384	395	391	415	401	455	421	419	449		
Induction of Labour				151	131	125	119					
Induction of labour rate %	33.7%	29.0%	30%	34.9%	31.3%	31.2%	26.2%	28.4%	27.8%	26.8%		
Unassisted Birth				220	209	214	219					
Unassisted Birth rate %	47.3%	46.6%	52.1%	52.2%	48.5%	50.9%	46.1%	47.0%	45.2%	44.80%		
Assisted Birth				46	68	59	70					
Assisted Birth rate %	18.2%	18.8%	16%	16.6%	16.3%	14.7%	15.4%	20.7%	15.0%	17.50%		
Caesarean Section				125	155	140	178					
Caesarean Section rate (overall) %	34.5%	34.5%	31.9%	31.2%	35.3%	34.4%	38.5%	32.3%	35.8%	38.70%		
Elective Caesarean Section				71	85	82	84					
Elective Caesarean Section rate %	19.7%	21.1%	18.7%	17.6%	18.7%	20.0%	18.3%	18.3%	17.7%	16.40%		
Emergency Caesarean Section				54	70	58	94					
Emergency Caesarean Section rate %	14.7%	13.5%	13.2%	13.6%	16.5%	14.5%	20.7%	14.0%	18.1%	22.30%		

Readmissions

September2021

A *Achieved*

Standards:	This reports on patients who are re-admitted as an emergency to the Trust within 30 days of being discharged. This can be in an unrelated specialty; it purely looks to see if there was a readmission. The target for the Trust is to remain below 2017/18 total of 3.62%, with a 10% amber tolerance down to 3.26%.
Performance:	In September, there were 13,642 discharges, of which 426 (3.1%) had an emergency re-admission within 30 days.
Commentary:	The review of Readmission methodologies and future targets/trajectories across the two Trusts is to be established.
Ownership:	Chief Operating Officer



	Sep-21		
	Readmissions	**Total Discharges**	**% Readmitted**
Diagnostics and Therapies	1	20	5.0%
Medicine	172	2,252	7.6%
Specialised Services	26	2,818	0.9%
Surgery	71	2,439	2.9%
Weston	108	1,971	5.5%
Women's and Children's	48	4,142	1.2%
Other/Not Known	0	0	-
TRUST TOTAL	**426**	**13,642**	**3.1%**
Bristol Subtotal	*318*	*11,671*	*2.7%*

Workforce – Bank and Agency Usage

NHS University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

P *Partially Achieved*

Standards:	Usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2018/19. The red threshold is 10% over the monthly target.
Performance:	In October 2021, total staffing was at 11,292 FTE. Of this, 5.2% was Bank (591 FTE) and 1.9% was Agency (213 FTE).
Commentary:	**Bank usage** increased by 3.7 FTE. There were increases in four divisions, with the largest increase seen in Trust Services, increasing to 33.6 FTE from 28.3 FTE in the previous month. There were reductions in four divisions, with the largest reduction seen in Facilities and Estates, reducing to 92.3 FTE from 95.1 FTE in the previous month. **Agency usage** reduced by 23.1 FTE. There were reductions in five divisions, with the largest reduction seen in Weston, reducing to 40.8 FTE from 62.8 FTE in the previous month. There were increases in three divisions, with the largest increase seen in Specialised Services, increasing to 22.9 FTE from 19.4 FTE in the previous month. • There have been 58 new starters register on the Trust Bank during October across both clinical and non-clinical roles. • Work continues to bring the Weston Medical Bank in-house from an external provider as part of the wider Weston integration work-stream, with go-live scheduled for January 2022. • In light of ongoing operational pressures across the Trust's Intensive Care Units, a short term measure to assist in increasing bank fill rates saw the introduction of a 30% enhancement to the basic bank pay rates for Nursing & Therapies staff, from 2nd to 30th November 2022. • The demand for temporary staffing across nursing has increased by 52% between April and October 2022 as shown below, which reflects the significant pressures.
Ownership:	Director of People

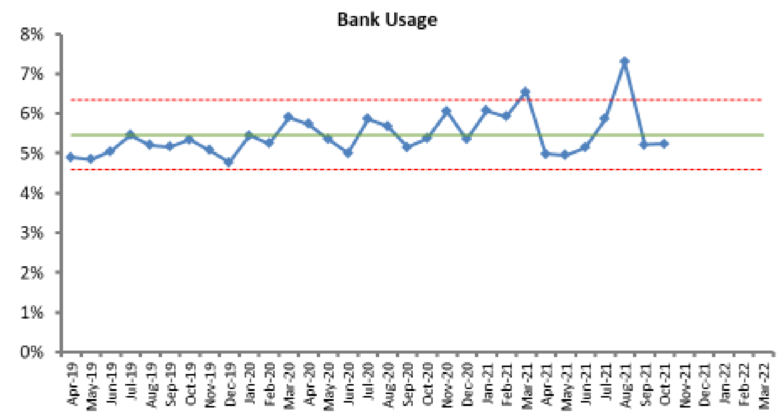
	April 2021	October 2021
Bank Registered nurses	2245 Shifts	2363 Shifts
Bank Nursing Assistants	3137 Shifts	3357 Shifts
Agency Registered nurses	2553 Shifts	2653 Shifts
Agency Nursing Assistants	8 Shifts	10 Shifts
Unfilled	2686 Shifts	7865 Shifts
Total demand	**10,629 Shifts**	**16,248 Shifts**

Workforce – Bank and Agency Usage

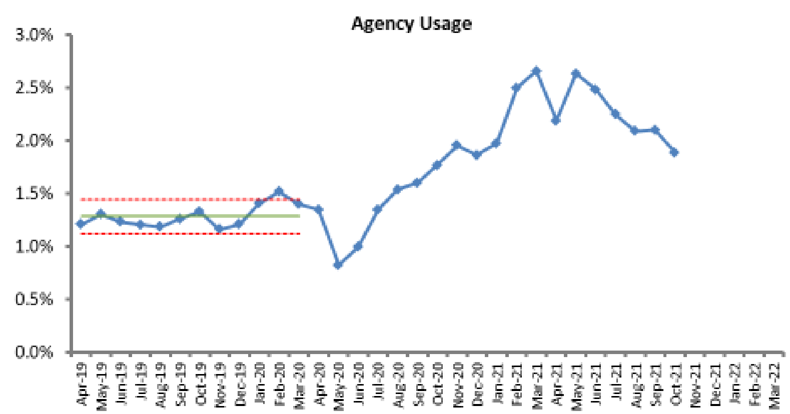
University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

Bank	October FTE	October Actual %	KPI
UHBW NHS Foundation Trust	**587.4**	**5.2%**	**5.5%**
Diagnostics & Therapies	16.1	1.2%	2.0%
Medicine	108.8	7.4%	10.0%
Specialised Services	64.9	5.8%	6.0%
Surgery	92.4	4.8%	5.1%
Women's & Children's	57.9	2.6%	1.2%
Trust Services	28.3	2.9%	4.5%
Facilities & Estates	95.1	10.4%	8.0%
Weston	123.8	10.3%	10.00%



Agency	October FTE	October Actual %	KPI
UHBW NHS Foundation Trust	**236.0**	**1.9%**	**1.8%**
Diagnostics & Therapies	2.1	0.1%	0.9%
Medicine	72.9	4.7%	2.2%
Specialised Services	19.4	2.0%	1.0%
Surgery	35.9	2.0%	1.1%
Women's & Children's	22.4	0.94%	0.86%
Trust Services	15.3	1.6%	0.0%
Facilities & Estates	5.2	0.0%	3.9%
Weston	62.8	3.4%	5.2%



Workforce – Turnover

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

N *Not Achieved*

Standards:	Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.3% by the end of 2018/19. The red threshold is 10% above monthly trajectory.
Performance:	In October 2021, there had been 1221 leavers over the previous 12 months, with 8778 FTE staff in post on average over that period; giving a turnover of 1221 / 8778 = 13.9%.
Commentary:	Turnover for the 12 month period remained static at 13.9% in October 2021 compared with the previous month. Three divisions saw a reduction whilst five divisions saw increases in turnover in comparison to the previous month. The largest divisional reduction was seen within Specialised Services, where turnover reduced by 1.0 percentage points to 13.6% compared with 14.6% the previous month. Diagnostic and Therapies saw the largest divisional increase, rising from 14.7% to 15.6%. • The opportunity for staff to share their experiences at work continues until 26th November 2021 through the annual staff survey. • A Retention Taskforce Group has been established in order to bring together all work-streams supporting retention. Additionally, the Agile Working Policy has now been launched in order to create a culture of flexibility. • There is a potential risk that turnover will increase with some staff not wishing to have the covid-19 vaccination following the Government announcement. Work to align principles for managing the rollout of this requirement is underway and is being undertaken in partnership with other ICS partners and Staff Side. • The exit process is not capturing leavers early enough resulting in missed opportunities to collect data. The priority is to engage operational colleagues in supporting the collation of exit data either before an employee leaves through a stay conversation or immediately upon resignation. The Exit Process Review Group will now report into the Trust's Retention Taskforce Group.
Ownership:	Director of People

Turnover	Oct-21	KPI
UHBW NHS Foundation Trust	13.9%	**12.6%**
Diagnostics & Therapies	15.6%	11.4%
Medicine	19.0%	17.1%
Specialised Services	13.55%	13.52%
Surgery	13.4%	12.7%
Women's & Children's	11.1%	9.8%
Trust Services	11.23%	11.20%
Facilities & Estates	15.0%	13.2%
Weston	14.9%	14.8%

Workforce – Vacancies

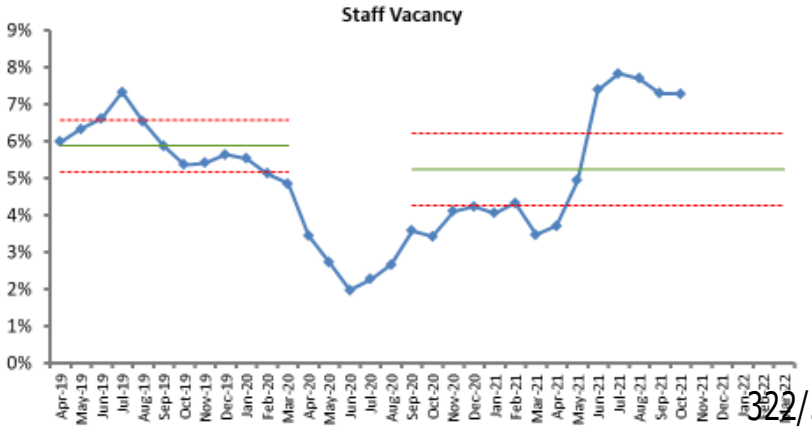
NHS University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

N *Not Achieved*

Standards:	Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.
Performance:	In October 2021, funded establishment was 11,431 FTE, with 823 FTE as vacancies (7.3%).
Commentary:	Overall vacancies remained static at 7.3% compared to the previous month. The largest divisional increase was seen in Facilities and Estates, where vacancies increased to 141.5 FTE from 131.9 FTE in the previous month. The largest divisional reduction was seen in Specialised Services, where vacancies reduced to 104.0 FTE from 114.0 FTE the previous month. • The Trust held its first face-to-face Adult Nurse open days in Bristol and Weston since the beginning of the pandemic. 10 offers in Bristol and 4 offers in Weston were made for newly qualified nurses. An internal recruitment campaign targeting student nurses is scheduled for November to encourage them to join UHBW when they receive their PIN in 2022. • The International Nurse Recruitment team have now made 95% of the 258 offers for the programme, with final interviews happening throughout November. • Work is now underway to establish the Trust's requirement for international nurse recruitment in 2022 aligned with a bid for financial support from NHSEI. • Health Care Support Worker recruitment has resulted in 3 offered Apprentice Nursing Assistants, 34 Bank Nursing Assistants and 27 Experienced Nursing Assistants during the month of October. • A programme of work is underway to address significant workforce shortages in Estates and Facilities. • The Trust will be presenting at a virtual stand at the UK Stroke Forum at the end of November using a variety of information to attract interest. This is a coordinated effort through the Talent Acquisition teams at NBT and UHBW and will include Sirona's requirements as part of the integrated approach to the One Stroke service across the BNSSG System.
Ownership:	Director of People

Vacancy	Oct-21	KPI
UHBW NHS Foundation Trust	7.3%	6.2%
Diagnostics & Therapies	1.9%	5.5%
Medicine	10.2%	6.5%
Specialised Services	8.8%	5.5%
Surgery	8.9%	4.5%
Women's & Children's	0.0%	5.0%
Trust Services	5.3%	4.9%
Facilities & Estates	15.1%	9.1%
Weston	14.3%	11.0%



Workforce – Staff Sickness

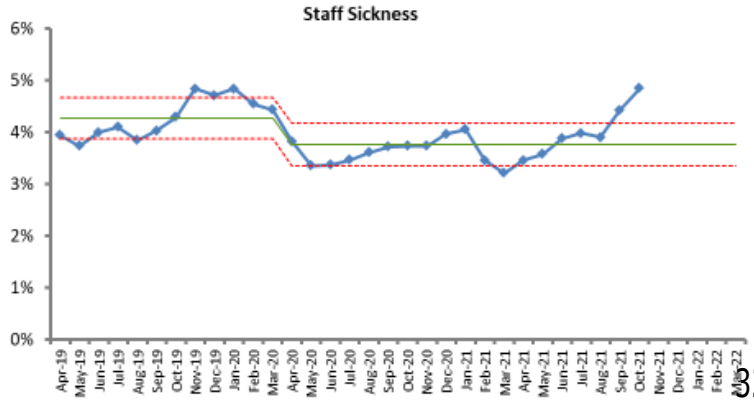
University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

N *Not Achieved*

Standards:	Staff sickness is measured as a percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2018/19. The red threshold is 0.5% over the monthly target.
Performance:	In October 2021, total available FTE days were 324,019 of which 15,663 (4.8%) were lost to staff sickness.
Commentary:	Sickness absence increased to 4.8% compared with 4.4% in the previous month, based on updated figures for both months. This figure now contains Long Covid sickness. It does NOT include Medical Suspension reporting. There were increases within six divisions. The largest divisional increase was seen in Women's and Children's, increasing by 0.9 percentage points to 5.1% from 4.2% the previous month. There was a reduction within the division of Surgery, reducing to 4.7% from 4.8% the previous month. Specialised Services remained static at 4.3% Medical Suspension continues to be the method used to record short-term Covid absences. During October, 1.6% of available FTE was lost to Medical Suspension compared to 1.6% the previous month: 0.6% Covid Sickness, 1.0% Covid Isolation/Shielding. Long Covid accounts for 0.2% of the sickness absence. • The workplace health checks launched in October promote self-care strategies through assessment of behavioural risk factors such as obesity, physical inactivity, smoking, alcohol and physiological risks such as high blood pressure and raised Body Mass Index. • The 12-week weight management programme in train is enabling 25 colleagues to work towards achievement of personal wellbeing goals for better health. • Following the funding agreement by the Senior Leadership Team, the Wellbeing Booster Plan will be launched in November as part of the Trust's Winter Wellbeing Campaign priority 'Staff First'. • A sickness and annual leave reporting programme has been launched which aims to enable more robust absence reporting, allowing bespoke interventions at Divisional level. Additionally, work has commenced across the ICS to establish aligned principles with regards to managing staff who are suffering with long covid.
Ownership:	Director of People

Sickness	Oct-21	KPI
UHBW NHS Foundation Trust	**4.8%**	**4.1%**
Diagnostics & Therapies	3.3%	3.1%
Medicine	6.0%	4.5%
Specialised Services	4.3%	3.3%
Surgery	4.7%	4.0%
Women's & Children's	5.1%	3.9%
Trust Services	4.1%	4.0%
Facilities & Estates	5.8%	6.6%
Weston	5.5%	4.1%



Workforce – Appraisal Compliance

NHS University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

N *Not Achieved*

Standards:	Staff Appraisal in measured as a percentage of staff excluding consultants who have had their appraisal signed-off. The target is 85% Trust-wide.
Performance:	In October 2021, 6,965 members of staff were compliant out of 10,423 (66.8%).
Commentary:	Overall appraisal compliance reduced to 66.8% from 69.2% compared to the previous month. All divisions are non-compliant. There were increases in one division, and reductions in the remaining seven divisions. The largest divisional increase was within Trust Services, increasing to 71.5% from 71.4% in the previous month; The largest divisional reduction was seen within Facilities and Estates where compliance reduced to 63.5% compared with 68.6% in the previous month. • Following the extension of the appraisal compliance rate targets until December 2021, a revised set of divisional target data has been put in place to be addressed at divisional reviews. • In October a deep dive review of non-compliant online appraisals with only one sign-off was completed to ascertain the effect on overall compliance. The result of the exercise demonstrated there could be a potential increase in appraisal compliance by up to 6.5%. Divisions are considering whether to adopt this figure to supplement appraisal compliance, however the process will need governance and Union approval. Confirmation of next steps will be announced at the Culture and People Group in November 2021. • The interim appraisal option remains in place with conversation forms available across the Trust. These interim arrangements will pilot a 'conversation' approach to performance and support future appraisal management. • Online and face to face appraisal training is the focus of the interim internal management development offer.
Ownership:	Director of People

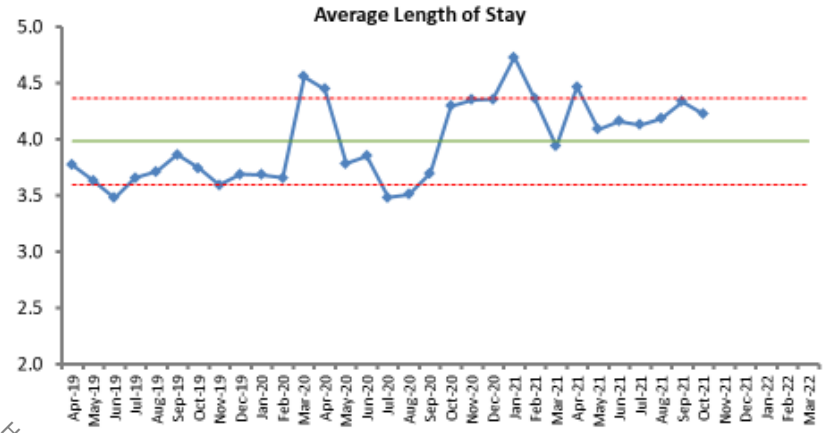
Appraisal (Non-Consultant)	Oct-21	Sep-21	KPI
UHBW NHS Foundation Trust	66.8%	69.2%	**85.0%**
Diagnostics & Therapies	70.5%	74.1%	85.0%
Medicine	59.4%	62.0%	85.0%
Specialised Services	75.0%	79.1%	85.0%
Surgery	54.7%	56.6%	85.0%
Women's & Children's	72.0%	74.0%	85.0%
Trust Services	71.5%	71.4%	85.0%
Facilities & Estates	63.5%	68.6%	85.0%
Weston	69.8%	70.3%	85.0%

Average Length of Stay

October 2021

N/A *No Standard*

Standards:	Average Length of Stay is the number of beddays (1 beddays = 1 bed occupied at 12 midnight) for all inpatients discharged in the month, divided by number of discharges.
Performance:	In October there were 7,070 discharges at UHBW with an average length of stay of 4.22 days.
Commentary:	Current assumptions around length of stay are being reviewed as part of the pathway reconfigurations resulting from the Covid pandemic.
Ownership:	Chief Operating Officer



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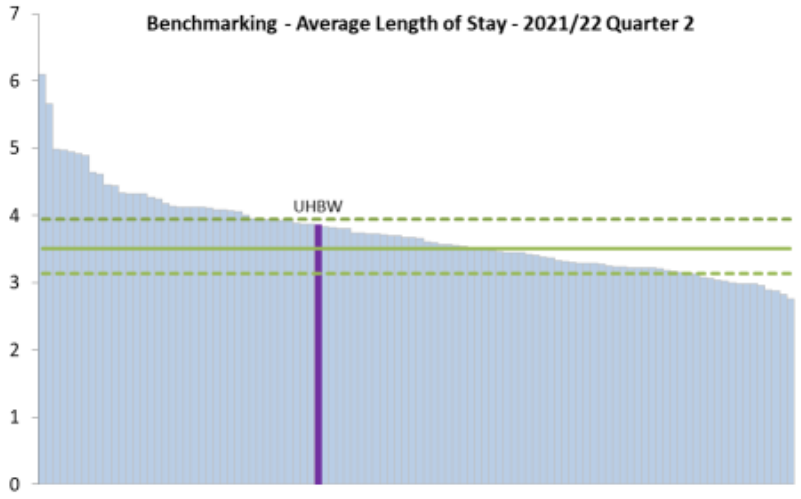
	Oct-21
Medicine	5.1
Specialised Services	7.0
Surgery	4.2
Weston	7.0
Women's and Children's	2.2



Finance – Executive Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

YTD Income & Expenditure Position	• Net I&E surplus of £1,033k against a plan of break-even (excluding technical items). • Total operating income is £10,775k favourable to plan due to higher than planned income from patient care activities of £16,729k (pay award, ERF and high cost drug spend), offset by lower than planned other operating income of £5,947k (relating to grant income). • Operating expenses are £18,353k adverse to plan, primarily due to the impact of the pay award of £6,725k, high-cost drug expenditure of £9,666k and the shortfall in CIP delivery of £2,329k. • Technical and financing items are £6,611k favourable to plan mainly due to the profiling of grant income relating to the Salix decarbonisation scheme.
Key Financial Issues	• The Trust's financial position includes ERF income and matching costs of £9,220k pending a system decision regarding the allocation of ERF within the system. The Trust did not earn ERF in October due to ongoing challenges with bed availability. • Savings delivery of £6,240k or 73% of the plan to date. The savings forecast outturn indicates a shortfall in delivery of £4,507k but it is not expected to lead to non-delivery of the break-even financial plan overall. • With capital expenditure to date of £34,062k, delivery of the CDEL of £84,563k in the second half of the financial year remains very challenging.
Strategic Risks	Although the following items are not expected to have a material impact in this financial year, work has either been completed, or is in hand, or pending to understand and mitigate: • The Trust and BNSSG system underlying financial deficit going into 2022/23 - completed • The Trust and BNSSG system 2021/22 forecast outturn following receipt of the 2021/22 H2 funding envelopes – due for completion in December; • Agreeing a system approach to future financial targets given UHBW's need to service past borrowing – pending – awaiting details regarding the 2022/23 financial regime; • Re-assessing the implications of the financial arrangements relating to the merger and how that may have altered by changes in the national financial regime – pending as above; • Understanding the risks and mitigations associated with the new capital regime, and how the CDEL limit and system prioritisation could restrict future strategic capital investment – in-hand – subject to a system approach and CDEL brokerage discussions with NHSE.

Finance – Financial Performance

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

October 2021

Trust Year to Date Financial Position

	Month 7			YTD		
	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's
Income from Patient Care Activities	73,685	77,589	3,905	529,792	546,525	16,733
Other Operating Income	11,488	12,137	649	80,414	74,466	(5,948)
Total Operating Income	**87,172**	**89,726**	**2,554**	**610,206**	**620,981**	**10,775**
Employee Expenses	(47,832)	(45,420)	2,412	(334,821)	(343,175)	(8,354)
Other Operating Expenses	(33,247)	(37,331)	(4,084)	(232,727)	(243,562)	(10,835)
Depreciation (owned & leased)	(2,306)	(1,024)	1,282	(15,443)	(14,607)	836
Total Operating Expenditure	**(83,384)**	**(83,774)**	**(390)**	**(582,991)**	**(601,344)**	**(18,354)**
PDC	(1,072)	(620)	452	(7,501)	(7,165)	337
Interest Payable	(50)	(76)	(26)	(350)	(257)	93
Interest Receivable	0	0	0		0	0
Other Gains/(Losses)	0	13	13		1	1
Net Surplus/(Deficit) inc technicals	**2,626**	**1,169**	**(1,457)**	**18,382**	**11,353**	**(7,029)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	(1,880)	(1,167)	713	(13,151)	(5,089)	8,062
Net surplus/(deficit) ex technicals	**746**	**72**	**(674)**	**5,231**	**6,264**	**1,033**

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See the Trust Finance Performance Report for full details on the Trust's financial performance.

Key Facts:

- The YTD net surplus is £1,033k (£961k last month) compared with the planned breakeven position.
- Pay expenditure is £4,353k lower in October than September due to the impact of the back-dated pay award in September. YTD expenditure is adverse to plan at £8,354k, mainly due to the pay award.
- Agency spend decreased by £182k in month with bank costs consistent with September. Both remain in line with the pre-August run rate.
- YTD agency expenditure is £17,089k, 5% of total pay costs.
- Operating income is favourable to plan by £10,775k. An over-performance on income from patient care activities (pay award, ERF and high cost drugs) offset by other operating income, primarily due to lower than planned grant income (£6,020k).
- CIP achievement is 73%. £6,240k has been achieved against a target of £8,569k.
- Additional costs of Covid-19 are £6,540k YTD at the end of October, with a marginal reduction in month to £890k from £939k in September.

Care Quality Commission Rating - Bristol

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

The Care Quality Commission (CQC) published their latest inspection report on 4th November 2021. Full details can be found here: **https://www.cqc.org.uk/provider/RA7**

The overall rating was GOOD, and the breakdown by site is shown below:

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
South Bristol NHS Community Hospital	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
UHBW Bristol Main Site	Requires Improvement Oct 2021	Good Oct 2021	Outstanding Oct 2021	Good Oct 2021	Outstanding Oct 2021	Good Oct 2021
Weston General Hospital	Inadequate Oct 2021	Requires Improvement Oct 2021	Good Oct 2021	Requires Improvement Oct 2021	Inadequate Oct 2021	Inadequate Oct 2021
Central Health Clinic	Good Dec 2014	Not rated	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Overall trust	Requires Improvement Oct 2021	Good Oct 2021	Outstanding Oct 2021	Good Oct 2021	Good Oct 2021	Good Oct 2021

Explanation of SPC Charts

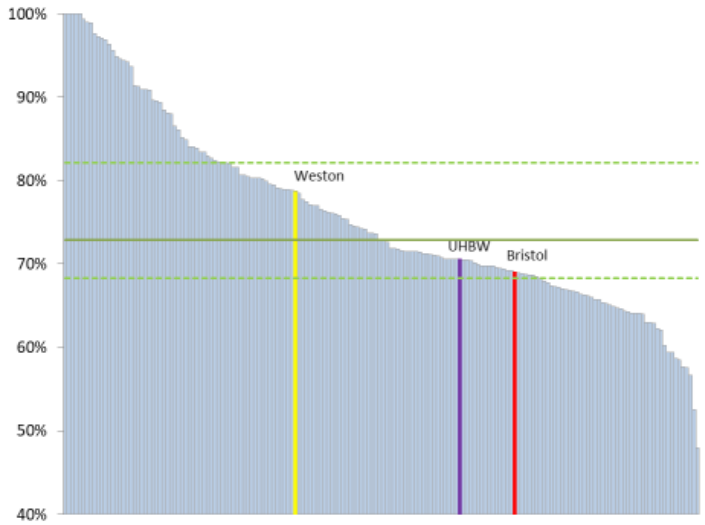
In the previous sections, some of the metrics are being presented using Statistical Process Control (SPC) charts. An example chart is shown below

The blue line is the Trust's monthly data and the green solid line is the monthly average for that data. The red dashed lines are called "control limits" and are derived from the Trust's monthly data and is a measure of the variation present in the data. If the process does not change, then 95% of all future data points will lie between these two limits.

If a process changes, then the limits can be re-calculated and a "step change" will be observed. There are different signals to look for, to identify if a process has changed. Examples would be a run of 7 data points going up/down or 7 data points one side of the average. These step changes should be traceable back to a change in operational practice, changes to flow, patient choice or demand changes; they do not occur by chance.

Explanation of Benchmarking Charts

In the previous sections, some of the metrics have national benchmarking reports included. An example is shown below:



Each vertical, light-blue bar represents one of the (approx.) 140 acute Trusts in England.

The horizontal solid green line is the median Trust performance, i.e. 50% of the Trusts are above this line and 50% are below.

The horizontal dotted green lines are the upper and lower quartile Trust performance, i.e.

- 25% of Trusts are above the Upper Quartile line and 75% are below.
- 25% of Trusts are below the Lower Quartile line and 75% are above.

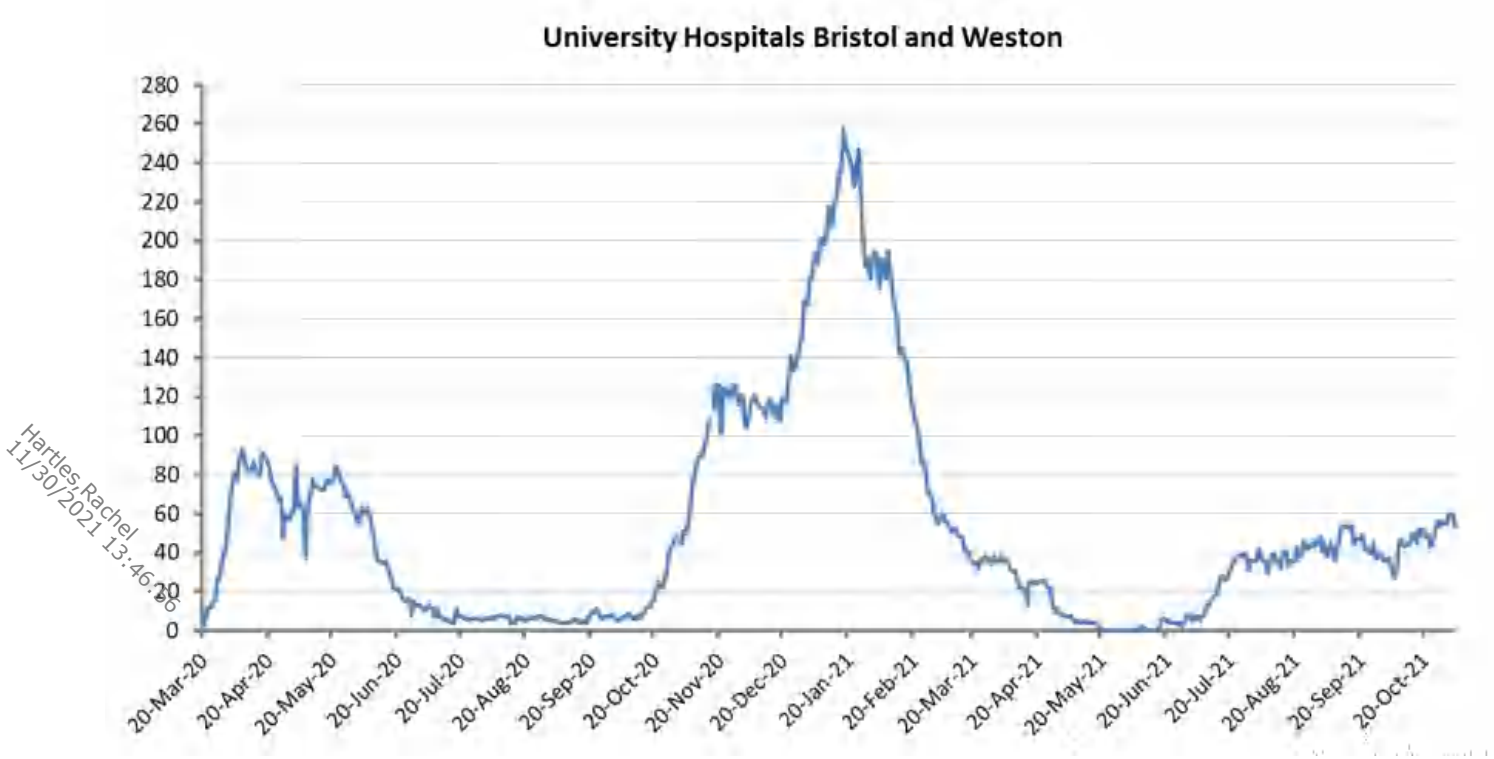
The separate performance for Bristol and Weston Trusts is shown as the vertical red and yellow bars respectively. The combined performance (UHBW) is the vertical purple bar.

Appendix – Covid19 Summary

Source:	COVID-19 NHS Situation Report
Publication Date:	Published data, 11th November 2021, from https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/
Ownership:	Chief Operating Officer

Bed Occupancy

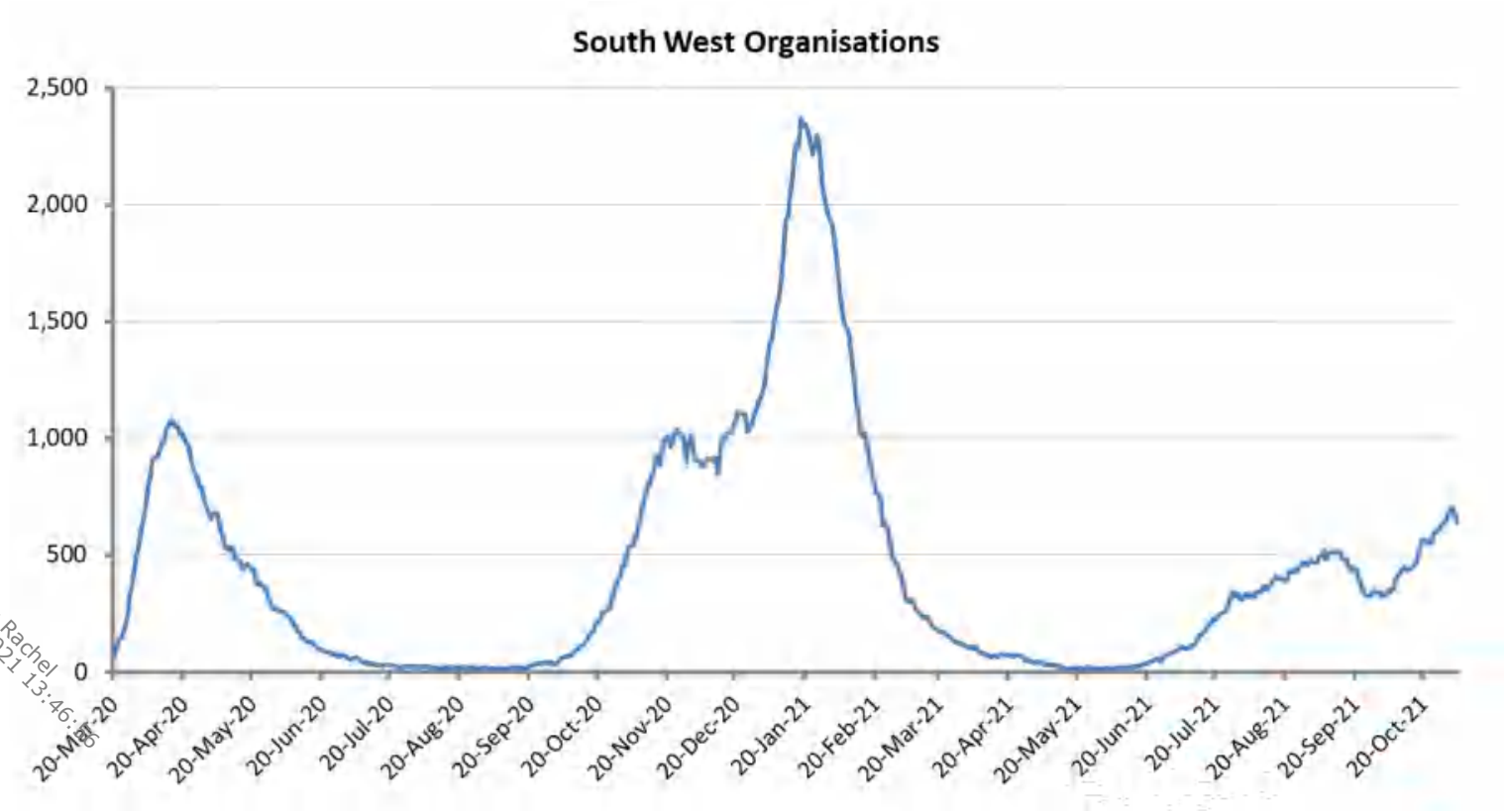
Total beds occupied by confirmed Covid-19 patients as at 8am each day. Data from the "COVID-19 NHS Situation Report". Data up to 4th November 2021.



Appendix – Covid19 Summary

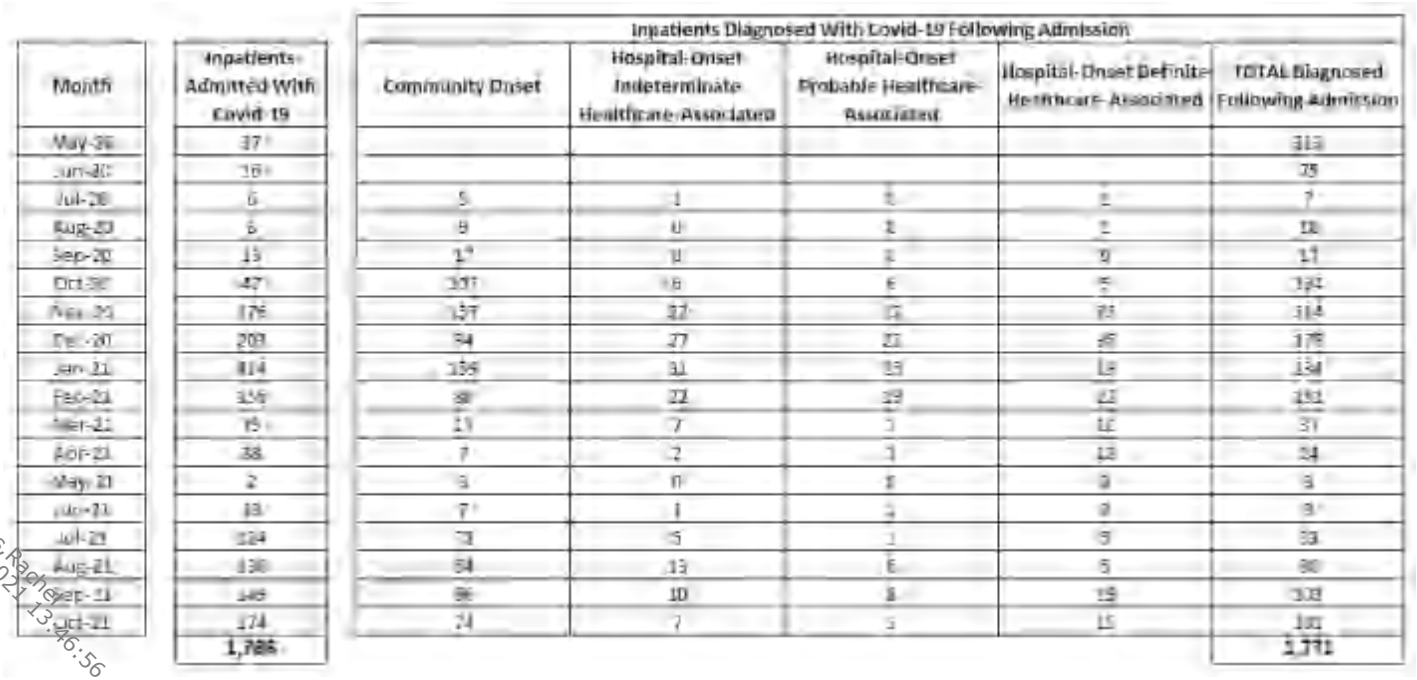
University Hospitals Bristol and Weston NHS Foundation Trust

Source:	COVID-19 NHS Situation Report
Publication Date:	Published data, 11th November 2021, from https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/
Ownership:	Chief Operating Officer



Appendix – Covid19 Summary

Source:	COVID-19 NHS Situation Report
Publication Date:	Retrieved on 16th November 2021 from https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/
Commentary:	Daily monitoring and reporting of all Covid -19 results is reviewed and approved by an Executive Director. The Trust undertakes rapid action when any cases are identified to prevent further spread with the dissemination of the Infection Prevention and Control Covid outbreak pack to ensure all cases are managed consistently with outbreak meetings set up and conducted in line with the Hospital Outbreak of infection policy.
Ownership:	Chief Nurse



Month	Inpatients Admitted With Covid-19	Inpatients Diagnosed With Covid-19 Following Admission				
		Community Onset	Hospital-Onset Indeterminate Healthcare-Associated	Hospital-Onset Probable Healthcare-Associated	Hospital-Onset Definite Healthcare-Associated	TOTAL Diagnosed Following Admission
May-20	37					313
Jun-20	16					78
Jul-20	6	5	1	1	1	7
Aug-20	6	8	0	1	1	10
Sep-20	13	1	0	1	0	11
Oct-20	47	107	16	6	5	134
Nov-20	176	137	32	15	21	204
Dec-20	203	94	27	21	40	179
Jan-21	814	159	31	15	19	184
Feb-21	356	98	22	19	12	151
Mar-21	95	19	7	3	12	31
Apr-21	38	7	2	3	12	24
May-21	2	3	0	1	0	3
Jun-21	13	7	1	1	0	9
Jul-21	124	73	5	1	0	33
Aug-21	130	64	13	6	5	88
Sep-21	149	86	10	8	19	123
Oct-21	174	74	7	5	15	101
	1,786					1,771

- Community-Onset: a positive specimen date less than or equal to 2 days after hospital admission or hospital attendance;
- Hospital-Onset Indeterminate Healthcare-Associated: a positive specimen date 3-7 days after hospital admission;
- Hospital-Onset Probable Healthcare-Associated: a positive specimen date 8-14 days after hospital admission;
- Hospital-Onset Definite Healthcare-Associated: a positive specimen date 15 or more days after hospital admission

Appendix – Trust Scorecards

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT – TRUST TOTAL
SAFE DOMAIN

	Measure	20/21	21/22 YTD	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	20/21 Qtr 3	20/21 Qtr 4	21/22 Qtr 1	21/22 Qtr 2
Infection Control																			
DA01	MRSA Hospital Onset Cases	4	1	0	0	1	0	0	0	0	0	1	0	0	0	1	0	1	0
DA02	MSSA Hospital Onset Cases	45	24	3	6	5	9	2	4	5	4	0	4	3	4	16	13	7	4
DA03	CDiff Hospital Onset Cases	67	57	7	6	5	2	5	8	11	14	7	4	6	7	12	33	17	7
DA03A	CDiff Healthcare Associated Cases	81	66	8	6	6	2	7	9	13	16	9	4	7	8	15	38	20	8
DA06	EColi Hospital Onset Cases	81	44	4	4	9	6	14	5	5	5	5	8	8	8	29	15	21	8
Patient Falls																			
AB01	Falls Per 1,000 Beddays	5.13	4.57	5.18	5.9	4.38	5.72	4.94	4.7	4.02	4.05	4.56	4.88	4.84	4.78	5	4.80	4.7	4.78
	Numerator (Falls)	*1698*	*991*	*151*	*171*	*124*	*154*	*152*	*139*	*126*	*134*	*144*	*147*	*147*	*154*	*430*	*399*	*438*	*154*
	Denominator (Beddays)	*330286*	*216987*	*29161*	*28979*	*28301*	*26905*	*30746*	*29584*	*31351*	*30587*	*31475*	*31380*	*30364*	*32246*	*85952*	*91522*	*93219*	*32246*
AB06A	Total Number of Patient Falls Resulting in Harm	21	19	3	1	0	1	2	5	1	2	1	4	2	1	8	8	10	1
Pressure Injuries																			
DE01	Pressure Injuries Per 1,000 Beddays	0.279	0.145	0.274	0.138	0.318	0.26	0.228	0.135	0.064	0.131	0.127	0.223	0.132	0.186	0.268	0.109	0.161	0.186
	Numerator (Pressure Injuries)	92	31	8	4	9	7	7	4	2	4	4	7	4	6	25	10	15	6
	Denominator (Beddays)	330286	216987	29161	28979	28301	26905	30746	29584	31351	30587	31475	31380	30364	32246	85952	91522	93219	32246
DE02	Pressure Injuries - Grade 2	87	25	8	4	8	7	7	4	1	3	4	5	3	5	22	8	12	5
DE03	Pressure Injuries - Grade 3	5	5	0	0	1	0	0	0	1	1	0	1	1	0	1	2	3	0
DE04	Pressure Injuries - Grade 4	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Serious Incidents																			
S02	Number of Serious Incidents Reported	109	56	10	5	11	8	10	7	9	9	12	4	9	6	29	25	25	6
S01	Total Never Events	0	1	2	0	0	0	0	1	0	0	1	0	1	0	0	1	2	0
Medication Errors																			
WA01	Medication Incidents Resulting in Harm	0.25%	0.22%	0.27%	0.83%	0%	0%	0.37%	0%	0.38%	0%	0%	0.25%	0.7%	-	0.15%	0.11%	0.33%	-
	Numerator (Incidents Resulting In Harm)	8	4	1	2	0	0	1	0	1	0	0	1	2	0	1	1	3	0
	Denominator (Total Incidents)	3213	1781	269	241	257	229	268	293	301	286	329	287	285	0	754	880	901	0
WA03	Non-Purposeful Omitted Doses of the Listed Critical Med	0.48%	0.23%	0.65%	0.38%	1.43%	0.19%	0.28%	0%	0%	0.6%	0%	0.38%	1.1%	0.44%	0.46%	0.22%	0.41%	0.44%
	Numerator (Number of Incidents)	26	8	3	1	3	1	2	0	0	3	0	1	3	1	6	3	4	1
	Denominator (Total Audited)	5638	2590	442	281	210	521	576	439	447	501	440	265	273	225	1307	1387	978	225
	Omitted Doses is Bristol only																		

Appendix – Trust Scorecards

University Hospitals Bristol and Weston NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
SAFE DOMAIN

ID	Measure	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
VTE Risk Assessment													
N01	Adult Inpatients who Received a VTE Risk Assessment	85.2%	85.5%	84.6%	84.1%	84%	82.7%	82.3%	82.5%	82.1%	83.9%	85.7%	83.7%
	Numerator (Number Risk Assessed)	7089	6925	6250	6207	7332	7012	7137	7251	7201	7091	7417	7016
	Denominator (Total Patients)	8317	8095	7386	7377	8732	8477	8671	8794	8769	8449	8654	8380
	VTE Data is Bristol only												
Nurse Staffing Levels ("Fill Rate")													
RP01	Staffing Fill Rate - Combined	97.4%	91.7%	90.7%	92.9%	91.5%	97.2%	101.5%	96.9%	93.6%	95.6%	89%	89.9%
	Numerator (Hours Worked)	295331	294407	288541	266423	292106	283241	300816	284844	285636	288962	263605	276499
	Denominator (Hours Planned)	303349	321059	318057	286794	319187	291290	296455	294105	305258	302404	296280	307464
RP02	Staffing Fill Rate - RN Shifts	96.7%	89.4%	88.6%	89.9%	87.5%	92.4%	97.7%	92.7%	87.9%	88.7%	84.4%	86.7%
	Numerator (Hours Worked)	200175	199025	194810	176959	192919	186768	199598	187080	184059	184918	174331	185524
	Denominator (Hours Planned)	207114	222595	219755	196821	220486	202050	204360	201866	209391	208549	206611	213872
RP03	Staffing Fill Rate - NA Shifts	98.9%	96.9%	95.3%	99.4%	100.5%	108.1%	109.9%	106%	106%	110.9%	99.6%	97.2%
	Numerator (Hours Worked)	95156.2	95381.5	93731.3	89463.7	99187.8	96472.6	101218	97763.7	101576	104044	89274.3	90974.6
	Denominator (Hours Planned)	96235.3	98464.4	98302.4	89972.7	98700.3	89240.1	92095	92238.5	95866.7	93855.2	89669	93591.6

ID	Measure	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22
VTE Risk Assessment						
N01	Adult Inpatients who Received a VTE Risk Assessment	84.2%	82.5%	83.4%	83.7%	
	Numerator (Number Risk Assessed)	19789	21400	21709	7016	
	Denominator (Total Patients)	23495	25942	25872	8380	
	VTE Data is Bristol only					
Nurse Staffing Levels ("Fill Rate")						
RP01	Staffing Fill Rate - Combined	91.7%	98.5%	92.7%	89.9%	
	Numerator (Hours Worked)	847070	868901	838203	276499	
	Denominator (Hours Planned)	924037	881850	903942	307464	
RP02	Staffing Fill Rate - RN Shifts	88.6%	94.3%	87%	86.7%	
	Numerator (Hours Worked)	564687	573446	543308	185524	
	Denominator (Hours Planned)	637062	608276	624552	213872	
RP03	Staffing Fill Rate - NA Shifts	98.4%	108%	105.5%	97.2%	
	Numerator (Hours Worked)	282383	295454	294895	90974.6	
	Denominator (Hours Planned)	286975	273574	279391	93591.6	

Appendix – Trust Scorecards

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
CARING DOMAIN

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

ID	Measure	20/21	21/22 YTD	Nov-21	Dec-21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3
Patient Surveys (Bristol)																			
P01D	Patient Survey (Bristol) - Patient Experience Tracker Score			[illegible]	90	91	91	90	[illegible]	[illegible]	89	89	[illegible]	93	89	91	90	88	88
P01G	Patient Survey (Bristol) - Kindness and Understanding			[illegible]	98	97	98	96	[illegible]	91	95	95	94	95	96	96	95	94	94
P01H	Patient Survey (Bristol) - Outpatient Tracker Score			[illegible]	93	94	94	95	[illegible]	[illegible]	96	95	91	94	93	94	95	92	93
Patient Surveys (Weston)																			
P02D	Patient Survey (Weston) - Patient Experience Tracker Score								84	85	84	82	81	83	84		84	82	84
P02G	Patient Survey (Weston) - Kindness and Understanding								92	92	95	90	92	92	90		93	91	90
P02H	Patient Survey (Weston) - Outpatient Tracker Score								90	94	85	90	92	88	95		89	90	95
Patient Complaints (Number Received)																			
T01	Number of Patient Complaints	1665	1178	176	115	136	145	145	124	176	160	158	174	193	193	426	460	525	193
T01C	Patient Complaints - Formal	546	292	65	24	49	32	43	49	46	51	50	45	24	27	124	146	119	27
T01D	Patient Complaints - Informal	1119	886	111	91	87	113	102	75	130	109	108	129	169	166	302	314	406	166
Patient Complaints (Response Time)																			
T03A	Formal Complaints Responded To Within Trust Timeframe	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	72.5%	68.4%	68.2%	63%
	Numerator (Responses Within Timeframe)	442	355	47	48	46	32	38	47	42	58	77	51	46	34	116	147	174	34
	Denominator (Total Responses)	518	524	58	73	69	44	47	55	72	88	90	85	80	54	160	215	255	54
T03B	Formal Complaints Responded To Within Divisional Timeframe	76.7%	73.7%	84.5%	67.1%	63.8%	77.3%	87.2%	92.7%	62.5%	72.7%	76.7%	70.6%	72.5%	72.2%	74.4%	74.4%	73.3%	72.2%
	Numerator (Responses Within Timeframe)	474	386	49	49	44	34	41	51	45	64	69	60	58	39	119	160	187	39
	Denominator (Total Responses)	518	524	58	73	69	44	47	55	72	88	90	85	80	54	160	215	255	54
T05A	Informal Complaints Responded To Within Trust Timeframe	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	92.9%	91.5%	88.4%	87.9%
	Numerator (Responses Within Timeframe)	686	366	92	55	40	35	55	52	67	43	52	52	49	51	130	162	153	51
	Denominator (Total Responses)	738	408	98	59	41	37	62	57	71	49	56	60	57	58	140	177	173	58
Patient Complaints (Dissatisfied)																			
T04C	Percentage of Responses where Complainant is Dissatisfied	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	5.63%	9.77%	9.14%	-
	Numerator (Number Dissatisifed)	44	37	1	4	2	6	1	5	7	9	7	9	0	0	9	21	16	0
	Denominator (Total Responses)	618	390	58	73	69	44	47	55	72	88	90	85	0	0	160	215	175	0

Appendix – Trust Scorecards

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT – TRUST TOTAL
CARING DOMAIN

NHS University Hospitals Bristol and Weston NHS Foundation Trust

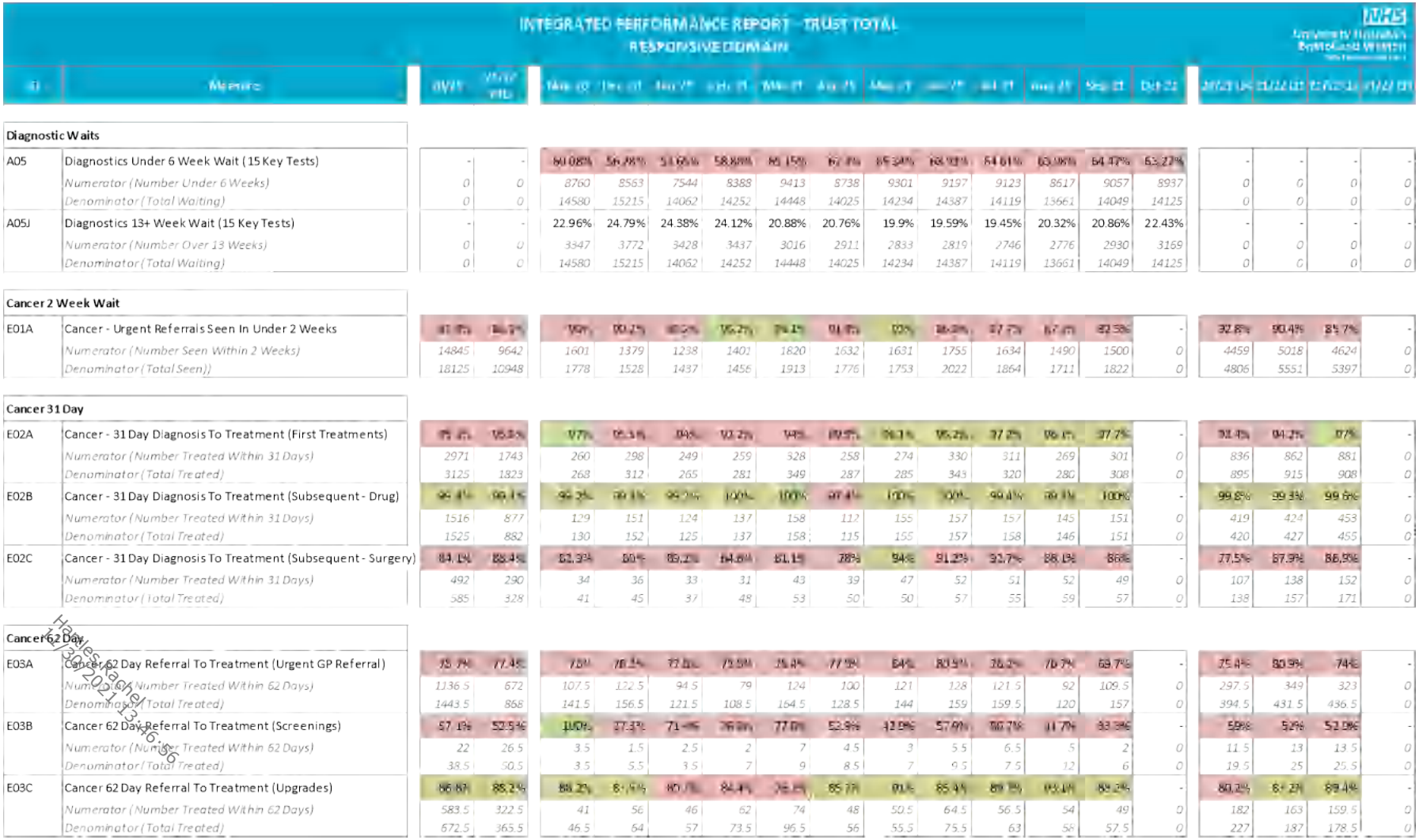
ID	Measure	20/21	21/22 YTD	Mar-21	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3
Friends and Family Test (Inpatients and Day Cases)																			
P03A	Friends and Family Test Admitted Patient Coverage	17%	18.4%	-	21.8%	15.4%	15.2%	21.3%	20.9%	22.5%	3.0%	31.2%	28.3%	25.9%	24.3%	19%	28.1%	30.1%	24.1%
	Numerator (Total FFT Responses)	*3442*	*11777*	*0*	*620*	*662*	*913*	*1247*	*1222*	*1930*	*1960*	*1870*	*1635*	*1787*	*1373*	*2822*	*5112*	*5292*	*1373*
	Denominator (Total Eligible to Respond)	*20211*	*41442*	*0*	*5330*	*4295*	*4790*	*5796*	*5863*	*5994*	*6332*	*5989*	*5782*	*5781*	*5701*	*14881*	*18189*	*17552*	*5701*
P04A	Friends and Family Test Score - Inpatients/Day Cases	96.4%	97.3%	-	97.4%	99.1%	98.0%	98.1%	97.7%	97.7%	97.9%	97.2%	97.8%	96%	97.3%	98.6%	97.8%	96.9%	97.3%
	Numerator (Total "Positive" Responses)	*3346*	*11390*	*0*	*592*	*648*	*895*	*1211*	*1182*	*1882*	*1917*	*1801*	*1592*	*1691*	*1325*	*2754*	*4981*	*5084*	*1325*
	Denominator (Total Responses)	*3400*	*11705*	*0*	*608*	*654*	*903*	*1235*	*1210*	*1926*	*1953*	*1852*	*1634*	*1762*	*1362*	*2732*	*5095*	*5248*	*1362*
Friends and Family Test (Emergency Department)																			
P03B	Friends and Family Test ED Coverage	7.4%	7.5%	-	8.5%	6.4%	5.0%	7.8%	6.2%	8.5%	8.7%	6.3%	9.5%	8.8%	10.4%	7.1%	7.3%	7.6%	10.4%
	Numerator (Total FFT Responses)	*1371*	*6501*	*0*	*572*	*407*	*401*	*591*	*537*	*774*	*1086*	*782*	*1139*	*848*	*1335*	*1399*	*2397*	*2769*	*1335*
	Denominator (Total Eligible to Respond)	*26539*	*82281*	*0*	*6760*	*6126*	*6034*	*7619*	*8598*	*11898*	*12542*	*12385*	*11557*	*12502*	*12799*	*19779*	*33038*	*36444*	*12799*
P04B	Friends and Family Test Score - ED	93.4%	85.0%	-	91.8%	93.0%	89%	90.7%	88%	85.0%	83.2%	78.7%	83.0%	84.3%	80.5%	92.7%	85.3%	83.3%	80.5%
	Numerator (Total "Positive" Responses)	*1811*	*5404*	*0*	*524*	*375*	*367*	*545*	*471*	*660*	*904*	*613*	*971*	*714*	*1071*	*1287*	*2035*	*2298*	*1071*
	Denominator (Total Responses)	*1959*	*6475*	*0*	*570*	*401*	*399*	*589*	*535*	*771*	*1080*	*779*	*1134*	*845*	*1331*	*1389*	*2386*	*2758*	*1331*
Friends and Family Test (Maternity)																			
P03C	Friends and Family Test MAT Coverage	15.8%	9%	-	2%	10.3%	3.5%	10.4%	7.4%	13.7%	21.8%	5%	12.8%	7.3%	0%	19.1%	15%	6.5%	0%
	Numerator (Total FFT Responses)	*240*	*265*	*0*	*18*	*62*	*119*	*41*	*29*	*69*	*83*	*0*	*54*	*30*	*0*	*222*	*181*	*84*	*0*
	Denominator (Total Eligible to Respond)	*1523*	*2931*	*0*	*362*	*381*	*384*	*396*	*392*	*413*	*400*	*454*	*421*	*419*	*432*	*1161*	*1205*	*1294*	*432*
P04C	Friends and Family Test Score - Maternity	99%	88%	-	94.4%	97.4%	99.1%	100%	93.7%	96.4%	98.1%	95%	98.3%	95.2%	80%	99.2%	97.8%	98.6%	80%
	Numerator (Total "Positive" Responses)	*381*	*701*	*0*	*17*	*74*	*205*	*85*	*59*	*133*	*215*	*38*	*145*	*107*	*4*	*364*	*407*	*290*	*4*
	Denominator (Total Responses)	*385*	*715*	*0*	*18*	*76*	*206*	*85*	*61*	*138*	*217*	*40*	*146*	*108*	*5*	*367*	*416*	*294*	*5*
Friends and Family Test (Outpatients)																			
P04D	Friends and Family Test Score - Outpatients	95.7%	94.6%	-	95.1%	96.4%	96%	95.6%	94.8%	95%	94.7%	95.2%	94.8%	94.4%	93.9%	96%	94.8%	94.7%	93.9%
	Numerator (Total FFT Responses)	*8482*	*18022*	*0*	*2233*	*1701*	*2151*	*2397*	*2330*	*2549*	*2310*	*1958*	*2523*	*3330*	*3022*	*6249*	*7189*	*7811*	*3022*
	Denominator (Total Eligible to Respond)	*8861*	*19046*	*0*	*2349*	*1765*	*2240*	*2507*	*2458*	*2682*	*2440*	*2057*	*2660*	*3529*	*3220*	*6512*	*7580*	*8246*	*3220*

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
RESPONSIVE DOMAIN

ID	Measure	20/21	YTD	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	[illegible]	[illegible]	[illegible]	[illegible]
Emergency Department Performance																			
B01	ED Total Time in Department - Under 4 Hours	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	65.47%	[illegible]	73.14%	72.98%	66.11%	62.38%
	Numerator (Number Seen in Under 4 Hours)	112177	78333	9263	8865	7413	7570	10364	11032	12260	11825	11202	10481	10903	10630	25347	35117	32586	10630
	Denominator (Total Attendances)	140061	114451	12213	11924	10633	10433	13588	14723	16523	16871	16738	15901	16654	17041	34654	48117	49293	17041
B06	ED 12 Hour Trolley Waits	1440	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	456	584	765	245	368	584
Emergency Department Clinical Indicators																			
B02	ED Time to Initial Assessment - Under 15 Minutes	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	81.2%
	Numerator (Number Assessed Within 15 Minutes)	46663	22930	3349	3360	3256	3005	3471	3476	3920	3599	3407	3164	2718	2646	9732	10995	9289	2646
	Denominator (Total Attendances Needing Assessment)	54582	26611	3838	3757	3732	3373	3884	3908	4427	4082	3808	3768	3358	3260	10989	12417	10934	3260
B03	ED Time to Start of Treatment - Under 60 Minutes	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Numerator (Number Treated Within 60 Minutes)	90834	51940	8023	7731	7158	6813	8507	8289	8389	7474	6928	7029	7135	6696	22478	24152	21092	6696
	Denominator (Total Attendances)	133798	107823	11974	11713	10368	10088	13117	14208	15824	15936	15599	15005	15518	15733	33573	45968	46122	15733
B04	ED Unplanned Re-attendance Rate	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	3.1%
	Numerator (Number Re-attending)	5113	3343	453	377	342	292	399	398	527	520	494	435	441	528	1033	1445	1370	528
	Denominator (Total Attendances)	139952	114451	12213	11924	10633	10433	13588	14723	16523	16871	16738	15901	16654	17041	34654	48117	49293	17041
B05	ED Left Without Being Seen Rate	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	3.6%	4.3%	[illegible]	[illegible]	[illegible]	4.3%
	Numerator (Number Left Without Being Seen)	1692	3349	181	169	143	126	194	240	295	480	526	484	597	727	463	1015	1607	727
	Denominator (Total Attendances)	140061	114451	12213	11924	10633	10433	13588	14723	16523	16871	16738	15901	16654	17041	34654	48117	49293	17041
Referral To Treatment Ongoing																			
A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	-	-	[illegible]	[illegible]	[illegible]	62.5%	[illegible]	60.1%	62.8%	[illegible]	[illegible]	[illegible]	61.8%	60.2%	-	-	-	-
	Numerator (Number Under 18 Weeks)	0	0	27942	26416	26493	27685	28719	29402	31263	32579	33280	33914	33165	32353	0	0	0	0
	Denominator (Total Pathways)	0	0	42624	42222	42523	44314	46532	48902	49791	51198	52718	53855	53697	53743	0	0	0	0
A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	-	-	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-
A06A	Referral To Treatment Ongoing Pathways Over 78 Weeks	-	-	74	179	240	316	515	687	802	802	960	1217	1272	1105	-	-	-	-
A06B	Referral To Treatment Ongoing Pathways Over 104 Weeks	-	-	4	8	11	19	27	36	48	73	90	120	173	187	-	-	-	-
Referral To Treatment Activity																			
A01A	Referral To Treatment Number of Admitted Clock Stops	27415	18354	3658	2817	2022	1966	2478	2526	2671	2930	2746	2504	2583	2394	6466	8127	7833	2394
A02A	Referral To Treatment Number of Non Admitted Clock Stops	87999	67957	9178	9730	8935	8583	10237	9802	10149	11045	9996	8069	9331	9565	27755	30996	27396	9565
A09	Referral To Treatment Number of Clock Starts	116601	86196	11862	10996	10307	11039	12979	12308	12419	13667	12501	11535	11737	12029	34325	38394	35773	12029

Appendix – Trust Scorecards

University Hospitals Bristol and Weston NHS Foundation Trust



INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
RESPONSIVE DOMAIN

ID	Measure																
Diagnostic Waits																	
A05	Diagnostics Under 6 Week Wait (15 Key Tests)	-	-	60.08%	56.98%	51.65%	58.88%	65.15%	67.3%	65.34%	68.93%	64.61%	63.96%	64.47%	63.27%	-	-	-	-
	Numerator (Number Under 6 Weeks)	*0*	*0*	*8760*	*8563*	*7544*	*8388*	*9413*	*8738*	*9301*	*9197*	*9123*	*8617*	*9057*	*8937*	*0*	*0*	*0*	*0*
	Denominator (Total Waiting)	*0*	*0*	*14580*	*15215*	*14062*	*14252*	*14448*	*14025*	*14234*	*14387*	*14119*	*13661*	*14049*	*14125*	*0*	*0*	*0*	*0*
A05J	Diagnostics 13+ Week Wait (15 Key Tests)	-	-	22.96%	24.79%	24.38%	24.12%	20.88%	20.76%	19.9%	19.59%	19.45%	20.32%	20.86%	22.43%	-	-	-	-
	Numerator (Number Over 13 Weeks)	*0*	*0*	*3347*	*3772*	*3428*	*3437*	*3016*	*2911*	*2833*	*2819*	*2746*	*2776*	*2930*	*3169*	*0*	*0*	*0*	*0*
	Denominator (Total Waiting)	*0*	*0*	*14580*	*15215*	*14062*	*14252*	*14448*	*14025*	*14234*	*14387*	*14119*	*13661*	*14049*	*14125*	*0*	*0*	*0*	*0*
Cancer 2 Week Wait																	
E01A	Cancer - Urgent Referrals Seen In Under 2 Weeks	87.8%	84.2%	75%	80.2%	80.2%	95.2%	84.2%	91.8%	93%	86.2%	87.2%	87.4%	82.5%	-	82.8%	90.4%	84.7%	-
	Numerator (Number Seen Within 2 Weeks)	*14845*	*9642*	*1601*	*1379*	*1238*	*1401*	*1820*	*1632*	*1631*	*1755*	*1634*	*1490*	*1500*	*0*	*4459*	*5018*	*4624*	*0*
	Denominator (Total Seen))	*18125*	*10948*	*1778*	*1528*	*1437*	*1456*	*1913*	*1776*	*1753*	*2022*	*1864*	*1711*	*1822*	*0*	*4806*	*5551*	*5397*	*0*
Cancer 31 Day																	
E02A	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	95.2%	95.8%	97%	95.3%	94%	92.2%	94%	89.5%	96.1%	95.2%	97.2%	96.4%	97.7%	-	93.4%	94.2%	97%	-
	Numerator (Number Treated Within 31 Days)	*2971*	*1743*	*260*	*298*	*249*	*259*	*328*	*258*	*274*	*330*	*311*	*269*	*301*	*0*	*836*	*862*	*881*	*0*
	Denominator (Total Treated)	*3125*	*1823*	*268*	*312*	*265*	*281*	*349*	*287*	*285*	*343*	*320*	*280*	*308*	*0*	*895*	*915*	*908*	*0*
E02B	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	99.4%	99.1%	99.2%	99.1%	99.2%	100%	100%	97.4%	100%	100%	99.4%	99.1%	100%	-	99.8%	99.3%	99.6%	-
	Numerator (Number Treated Within 31 Days)	*1516*	*877*	*129*	*151*	*124*	*137*	*158*	*112*	*155*	*157*	*157*	*145*	*151*	*0*	*419*	*424*	*453*	*0*
	Denominator (Total Treated)	*1525*	*882*	*130*	*152*	*125*	*137*	*158*	*115*	*155*	*157*	*158*	*146*	*151*	*0*	*420*	*427*	*455*	*0*
E02C	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	84.1%	88.4%	82.3%	80%	89.2%	84.8%	81.1%	78%	94%	91.2%	92.7%	88.1%	86%	-	77.5%	87.9%	86.9%	-
	Numerator (Number Treated Within 31 Days)	*492*	*290*	*34*	*36*	*33*	*31*	*43*	*39*	*47*	*52*	*51*	*52*	*49*	*0*	*107*	*138*	*152*	*0*
	Denominator (Total Treated)	*585*	*328*	*41*	*45*	*37*	*48*	*53*	*50*	*50*	*57*	*55*	*59*	*57*	*0*	*138*	*157*	*171*	*0*
Cancer 62 Day																	
E03A	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	75.7%	77.4%	75%	78.3%	77.8%	72.5%	75.8%	77.9%	84%	80.9%	78.2%	76.7%	69.7%	-	75.4%	80.9%	74%	-
	Numerator (Number Treated Within 62 Days)	*1136.5*	*672*	*107.5*	*122.5*	*94.5*	*79*	*124*	*100*	*121*	*128*	*121.5*	*92*	*109.5*	*0*	*297.5*	*349*	*323*	*0*
	Denominator (Total Treated)	*1443.5*	*868*	*141.5*	*156.5*	*121.5*	*108.5*	*164.5*	*128.5*	*144*	*159*	*159.5*	*120*	*157*	*0*	*394.5*	*431.5*	*436.5*	*0*
E03B	Cancer 62 Day Referral To Treatment (Screenings)	57.1%	52.5%	100%	77.3%	71.4%	28.6%	77.8%	52.9%	42.9%	57.9%	80.7%	11.7%	33.3%	-	59%	52%	52.9%	-
	Numerator (Number Treated Within 62 Days)	*22*	*26.5*	*3.5*	*1.5*	*2.5*	*2*	*7*	*4.5*	*3*	*5.5*	*6.5*	*5*	*2*	*0*	*11.5*	*13*	*13.5*	*0*
	Denominator (Total Treated)	*38.5*	*50.5*	*3.5*	*5.5*	*3.5*	*7*	*9*	*8.5*	*7*	*9.5*	*7.5*	*12*	*6*	*0*	*19.5*	*25*	*25.5*	*0*
E03C	Cancer 62 Day Referral To Treatment (Upgrades)	86.8%	88.2%	88.2%	84.4%	80.7%	84.4%	76.8%	85.7%	91%	85.4%	89.8%	93.4%	89.2%	-	80.2%	84.2%	89.4%	-
	Numerator (Number Treated Within 62 Days)	*583.5*	*322.5*	*41*	*56*	*46*	*62*	*74*	*48*	*50.5*	*64.5*	*56.5*	*54*	*49*	*0*	*182*	*163*	*159.5*	*0*
	Denominator (Total Treated)	*672.5*	*365.5*	*46.5*	*64*	*57*	*73.5*	*96.5*	*56*	*55.5*	*75.5*	*63*	*58*	*57.5*	*0*	*227*	*187*	*178.5*	*0*

Appendix – Trust Scorecards

University Hospitals Bristol and Weston NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST LEVEL
RESPONSIVE DOMAIN

ID	Measure																		
Last Minute Cancelled Operations																			
F01	Last Minute Cancelled Operations - Percentage of Admissions	1.15%	[illegible]	1.17%	1.54%	1.13%	1.48%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.25%	1.24%	[illegible]	[illegible]
	Numerator (Number of LMCs)	637	667	66	84	53	74	70	42	72	112	40	93	209	99	197	226	342	99
	Denominator (Total Elective Admissions)	55572	42063	5656	5463	4672	5000	6039	5803	6034	6376	6071	5921	6253	5605	15711	18213	18245	5605
F02	Cancelled Operations Re-admitted Within 28 Days	[illegible]	[illegible]	93%	88.5%	[illegible]	[illegible]	81.5%	100%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	87.1%	78.4%	92.3%	[illegible]	87.1%
	Numerator (Number Readmitted Within 28 Days)	542	415	66	54	64	35	53	60	39	57	21	22	61	155	152	156	104	155
	Denominator (Total LMCs)	650	567	71	61	77	52	65	60	40	69	108	31	81	178	194	169	220	178
Green To Go/Fit For Discharge (BRISTOL Only)																			
AQ06A	Medically Fit For Discharge - Number of Patients (Acute)	-	-	97	125	[illegible]	[illegible]	[illegible]	172	142	[illegible]	155	[illegible]	[illegible]	[illegible]	-	-	-	-
AQ06B	Medically Fit For Discharge - Number of Patients (Non Acute)	-	-	18	11	12	11	10	0	0	0	0	0	0	0	-	-	-	-
AQ07A	Medically Fit For Discharge - Beddays (Acute)	-	-	2745	3356	3572	3218	4540	5088	4384	4398	4687	5093	4886	5043	-	-	-	-
AQ07B	Medically Fit For Discharge - Beddays (Non-Acute)	-	-	564	458	340	445	398	0	0	0	0	0	0	0	-	-	-	-
Outpatient Measures																			
R03	Outpatient Hospital Cancellation Rate	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Numerator (Number of Hospital Cancellations)	121392	72972	9606	9508	9862	9037	10096	9153	8877	11411	11339	10683	10754	10755	28995	29441	32776	10755
	Denominator (Total Appointments)	991263	681611	93597	86421	87100	85656	100725	90420	91369	104003	100720	93959	101961	99179	273481	285792	296640	99179
R05	Outpatient DNA Rate	6.9%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	7%	[illegible]	[illegible]	[illegible]	7.3%	7.1%	[illegible]	[illegible]	[illegible]
	Numerator (Number of DNAs)	49634	36298	5608	5026	5382	4365	4807	4441	4623	5429	5914	4912	5630	5349	14554	14493	16456	5349
	Denominator (Total Attendances+DNAs)	717514	507643	69087	64275	63278	65157	75876	69929	70359	77348	75769	66019	73911	73308	204311	217636	216699	73308
Overdue Partial Booking (Bristol)																			
R22N	Overdue Partial Booking Referrals	37%	49.4%	40.1%	41.8%	42.7%	42.2%	43.2%	43.6%	43.8%	44.6%	47.7%	52.7%	55.6%	56.9%	42.7%	44%	52%	56.9%
	Numerator (Number Overdue)	628959	518835	57315	58965	59977	58540	61487	62485	63868	65641	72765	80288	86014	87770	180004	191994	239071	87770
	Denominator (Total Partial Booking)	1698619	1050166	142817	141025	140442	138821	142381	143376	145793	147031	152402	152396	154813	154355	421644	436200	459611	154355
R22R	Overdue Partial Bookings (9+ Months)	4.4%	14.1%	5%	6.5%	8%	9%	10.3%	11%	11.8%	12.9%	14.2%	15.4%	16.1%	16.8%	9.1%	11.9%	15.2%	16.8%
	Numerator (Number Overdue 9+ Months)	75085	147870	7127	9129	11166	12434	14671	15804	17162	19004	21678	23434	24850	25938	38271	51970	69962	25938
	Denominator (Total Partial Booking)	1698619	1050166	142817	141025	140442	138821	142381	143376	145793	147031	152402	152396	154813	154355	421644	436200	459611	154355
R22H	Overdue Partial Bookings (12+ Months)	2.2%	9.1%	2.5%	2.9%	3.4%	3.9%	5.1%	6.3%	7.2%	8.3%	8.9%	9.9%	10.8%	12.1%	4.1%	7.3%	9.9%	12.1%
	Numerator (Number Overdue 12+ Months)	36638	95683	3521	4068	4747	5482	7243	9028	10508	12134	13571	15043	16755	18644	17472	31670	45369	18644
	Denominator (Total Partial Booking)	1698619	1050166	142817	141025	140442	138821	142381	143376	145793	147031	152402	152396	154813	154355	421644	436200	459611	154355

Appendix – Trust Scorecards

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
EFFECTIVE DOMAIN

ID	Measure	20/21	21/22 YTD	May-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3
Mortality																			
X04	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	94.4	95.5	92.5	98.5	93.6	94.1	95.6	95.1	95.6	95.7	-	-	-	-	94.4	95.5	-	-
	Numerator (Observed Deaths)	*26815*	*5905*	*2210*	*2150*	*2060*	*1990*	*1940*	*1930*	*1975*	*2000*	*0*	*0*	*0*	*0*	*5990*	*5905*	*0*	*0*
	Denominator ("Expected" Deaths)	*28400*	*6185*	*2390*	*2300*	*2200*	*2115*	*2030*	*2030*	*2065*	*2090*	*0*	*0*	*0*	*0*	*6345*	*6185*	*0*	*0*
X02	Hospital Standardised Mortality Ratio (HSMR)	93.2	87.5	91.5	93.5	103.9	119.4	94.6	82.4	88.5	79.9	96.7	92.7	-	-	104.7	83.5	94.9	-
	Numerator (Observed Deaths)	*1272*	*523*	*112*	*113*	*112*	*115*	*124*	*105*	*111*	*109*	*110*	*88*	*0*	*0*	*351*	*325*	*198*	*0*
	Denominator ("Expected" Deaths)	*1365.5*	*598*	*122.4*	*120.9*	*107.8*	*96.3*	*131.1*	*127.5*	*125.4*	*136.4*	*113.8*	*94.9*	*0*	*0*	*335.2*	*389.3*	*208.7*	*0*
Fracture Neck of Femur (NOF)																			
U02	Fracture Neck of Femur Patients Treated Within 36 Hours	66.1%	66.7%	70.8%	65.1%	61.3%	65%	78%	64%	68.8%	71.9%	71.4%	86.7%	80%	65.9%	69.1%	67.6%	65.8%	65.9%
	Numerator (Treated Within 36 Hrs)	*358*	*194*	*34*	*28*	*19*	*29*	*46*	*32*	*31*	*31*	*25*	*24*	*24*	*27*	*94*	*94*	*73*	*27*
	Denominator (Total Patients)	*542*	*291*	*48*	*43*	*31*	*46*	*59*	*50*	*45*	*44*	*35*	*36*	*40*	*41*	*136*	*139*	*111*	*41*
U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Ho	92.1%	95.5%	97.9%	100%	93.5%	89.1%	91.5%	94%	93.3%	95.5%	97.1%	91.7%	100%	97.6%	92.6%	94.2%	96.4%	97.6%
	Numerator (Seen Within 72 Hrs)	*499*	*278*	*47*	*43*	*29*	*41*	*56*	*47*	*42*	*42*	*34*	*33*	*40*	*40*	*126*	*131*	*107*	*40*
	Denominator (Total Patients)	*542*	*291*	*48*	*43*	*31*	*46*	*59*	*50*	*45*	*44*	*35*	*36*	*40*	*41*	*136*	*139*	*111*	*41*
U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	59%	61.9%	64.6%	58.1%	51.6%	58.7%	69.5%	58%	68.7%	52.3%	71.4%	53%	90%	68.3%	64%	61.9%	60.4%	65.9%
	Numerator (Number achieved BPT)	*320*	*180*	*31*	*25*	*19*	*27*	*41*	*29*	*30*	*23*	*25*	*19*	*24*	*27*	*87*	*86*	*67*	*27*
	Denominator (Total Patients)	*542*	*291*	*48*	*43*	*31*	*46*	*59*	*50*	*45*	*44*	*35*	*36*	*40*	*41*	*136*	*139*	*111*	*41*
Emergency Readmissions																			
C01	Emergency Readmissions Percentage	4.41%	3.5%	4.1%	3.9%	3.9%	4.13%	4.17%	4.05%	3.78%	3.54%	3.4%	3.15%	3.12%	-	4.06%	3.78%	3.22%	-
	Numerator (Re-admitted in 30 Days)	*6039*	*2855*	*540*	*481*	*427*	*473*	*565*	*532*	*514*	*491*	*472*	*420*	*426*	*0*	*1465*	*1537*	*1318*	*0*
	Denominator (Total Discharges)	*136884*	*81583*	*12830*	*12328*	*10912*	*11457*	*13729*	*13138*	*13669*	*13887*	*13893*	*13354*	*13642*	*0*	*36098*	*40694*	*40889*	*0*
Stroke Care																			
O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	61%	59.6%	71.7%	74.2%	66.7%	56.5%	58.5%	58.1%	48.7%	64.3%	59.4%	55.6%	56.3%	-	60.6%	55.6%	-	-
	Numerator (Achieved Target)	*250*	*124*	*33*	*23*	*20*	*13*	*24*	*32*	*19*	*18*	*19*	*15*	*21*	*0*	*57*	*69*	*0*	*0*
	Denominator (Total Patients)	*410*	*219*	*46*	*31*	*30*	*23*	*41*	*57*	*39*	*28*	*32*	*27*	*36*	*0*	*94*	*124*	*0*	*0*
O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	71.8%	64.4%	68.3%	64.6%	46.7%	54.5%	62.7%	58.9%	64%	68.8%	61.6%	66.7%	60.4%	-	56.8%	63.2%	66.1%	-
	Numerator (Achieved Target)	*393*	*186*	*41*	*31*	*20*	*18*	*29*	*43*	*32*	*33*	*35*	*18*	*25*	*0*	*57*	*108*	*78*	*0*
	Denominator (Total Patients)	*541*	*289*	*60*	*48*	*30*	*33*	*55*	*73*	*50*	*48*	*55*	*27*	*36*	*0*	*118*	*171*	*118*	*0*

Appendix – Trust Scorecards

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
WELL-LED DOMAIN

ID	Measure	20/21	21/22 YTD	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3
Bank and Agency Usage																			
AF11A	Percentage Bank Usage	-	-	[illegible]	[illegible]	[illegible]	5.93%	6.55%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-
	Numerator (Bank wte)	*0*	*0*	*675.77*	*595.4*	*683.53*	*671.71*	*758.25*	*560*	*552.21*	*574.41*	*655.6*	*833.54*	*587.41*	*591.17*	*0*	*0*	*0*	*0*
	Denominator (Total wte)	*0*	*0*	*11165.2*	*11126.2*	*11253.9*	*11335.3*	*11582.2*	*11232*	*11160.6*	*11163.1*	*11189.7*	*11429.3*	*11252.4*	*11292.1*	*0*	*0*	*0*	*0*
AF11B	Percentage Agency Usage	-	-	[illegible]	[illegible]	[illegible]	2.49%	2.66%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-
	Numerator (Agency wte)	*0*	*0*	*218.18*	*207.2*	*221.92*	*282.54*	*307.47*	*245.28*	*293.62*	*276.8*	*251.31*	*238.53*	*236.02*	*212.91*	*0*	*0*	*0*	*0*
	Denominator (Total wte)	*0*	*0*	*11165.2*	*11126.2*	*11253.9*	*11335.3*	*11582.2*	*11232*	*11160.6*	*11163.1*	*11189.7*	*11429.3*	*11252.4*	*11292.1*	*0*	*0*	*0*	*0*
Turnover																			
AF10	Workforce Turnover Rate	-	-	[illegible]	[illegible]	[illegible]	12.2%	12%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-
	Numerator (Leavers in last 12 months)	*0*	*0*	*1050.79*	*1043.85*	*1061.5*	*1061.77*	*1049.15*	*1071.79*	*1099.6*	*1145.43*	*1188.94*	*1204.66*	*1213.97*	*1221.16*	*0*	*0*	*0*	*0*
	Denominator (Average Staff in Post)	*0*	*0*	*8671.86*	*8670.64*	*8693.68*	*8731.51*	*8714.32*	*8692.17*	*8689.73*	*8678.28*	*8691.24*	*8700.47*	*8751.06*	*8778.05*	*0*	*0*	*0*	*0*
Vacancy																			
AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	-	-	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-
	Numerator (Vacancy wte, Funded minus actual)	*0*	*0*	*438.49*	*455.28*	*437.35*	*468.72*	*378.03*	*401.23*	*534.8*	*521.88*	*871.8*	*861.83*	*818.56*	*822.74*	*0*	*0*	*0*	*0*
	Denominator (Actual WTE)	*0*	*0*	*10709.8*	*10778.9*	*10785.8*	*10849.8*	*10894.5*	*10828*	*10849.6*	*11155.8*	*11154.6*	*11219.1*	*11247.5*	*11310.7*	*0*	*0*	*0*	*0*
Staff Sickness																			
AF02	Sickness Rate	3.6%	4%	[illegible]	[illegible]	[illegible]	3.4%	3.2%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	3.6%	3.6%	4.1%	4.8%
	Numerator (Total WTE Days Lost)	*135412*	*88626.6*	*11466.5*	*12633.9*	*12941.5*	*10047.9*	*10396.8*	*10750.9*	*11403*	*11947.8*	*12669*	*12440.4*	*13743.5*	*15672.1*	*33386.2*	*34101.6*	*38852.9*	*15672.1*
	Denominator (Total WTE Days)	*3740392*	*2212093*	*307597*	*318980*	*319702*	*291312*	*324625*	*311261*	*319464*	*308612*	*318912*	*319164*	*310729*	*323952*	*935639*	*933337*	*943805*	*323952*
Staff Appraisal																			
AF03	Workforce Appraisal Compliance (Non-Consultant)	-	-	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-	-	-	-
	Numerator (In-Date Appraisals)	*0*	*0*	*6891*	*7005*	*6859*	*6728*	*6823*	*6905*	*7106*	*7159*	*7091*	*6994*	*7151*	*6965*	*0*	*0*	*0*	*0*
	Denominator (Total Staff)	*0*	*0*	*10247*	*10277*	*10337*	*10477*	*10510*	*10392*	*10286*	*10248*	*10228*	*10233*	*10339*	*10423*	*0*	*0*	*0*	*0*

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
USE OF RESOURCES DOMAIN

ID	Measure	20/21	21/22 YTD	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3
Average Length of Stay																			
J03	Average Length of Stay (Spell)	4.03	4.22	4.35	4.35	4.72	4.36	3.93	4.46	4.09	4.16	4.13	4.18	4.33	4.22	4.31	4.23	4.21	4.22
	Numerator (Total Beddays)	*317703*	*209620*	*29087*	*28343*	*27360*	*26002*	*28069*	*31095*	*29921*	*29837*	*30376*	*28956*	*30189*	*29246*	*81431*	*90853*	*89521*	*29246*
	Denominator (Total Discharges)	*78740*	*49638*	*6690*	*6512*	*5793*	*5968*	*7134*	*6969*	*7324*	*7173*	*7358*	*6922*	*6966*	*6926*	*18895*	*21466*	*21246*	*6926*

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of Meeting of the Board of Directors in Public on 30 November 2021

Report Title	**Maternity Perinatal Quality/ Surveillance Matrix Monthly Update**
Report Author	**Ingrid Henderson, Quality Patient Safety Manager/Sarah Windfeld, Head of Midwifery**
Executive Lead	**Deirdre Fowler, Chief Nurse/Midwife**

1. Report Summary

This report provides the board monthly oversight with regards to the safety matrixes of our maternity and neonatal services.

2. Key points to note

(Including decisions taken)

- Induction of labour (IOL) waiting times remains a concern leading to complaints. This is usually because of capacity on CDS. Has been escalated to trust, is on risk register.
- Non-compliance in night-time consultant ward rounds noted. No change
- There were 19 Datix related to workforce (service provision/staffing) including 6 related to multiple delayed IOL /9 related to non-compliance with BAPM standards
- UHBW Maternity attempted to divert / are on divert ***once*** during the reported period.
- Total LSCS rate up at 38.7% from 35.8 in September and 32.3% in August. Highest monthly rate this year.
- Two serious incidents reported in October. A controlled drug error resulting in an overdose and need for an emergency caesarean section and a baby reported to HSIB but it did not meet their criteria. The MRI confirming HIE* was diagnosed after twelve days of life (*HIE hypoxic ischaemic encephalopathy, a diagnosis of a severe brain injury)
- No HSIB cases
- One postnatal women admitted to ITU following deterioration on the postnatal ward
- Staff concerns shared monthly with the Maternity and Neonatal Safety Champions and actions fed back to staff, current themes include:
- Staffing
- Capacity- delayed IOL
- Estates on level E
- Following feedback the HoM held a focus group with our Somali representatives to ensure we continue to receive their feedback and learn how we can improve our offer of care to this population group. Feedback is being circulated with clinical teams and further focus groups and actions to address concerns are planned.
- Focus groups with our midwifery hubs service users continues. The feedback about the continuity of carer pathway of care was universally positive from the women, Somali women were also represented in this last focus group.

3. Risks

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

The risks associated with this report include:

3343 delayed elective LSCS **2264 delayed induction of labour** **33/3623/988 NICU staffing/BAPM**
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **Assurance.**
5. History of the paper **Please include details of where paper has previously been received.**

Quality Assurance Committee	**19/11/2021**
Quality and Outcomes Committee	**25/11/2021**

Recommendation Definitions:

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

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UHBW perinatal quality surveillance matrix

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Year to date	Trend
Activity														
Number of babies born alive at >=22 to 36+6 weeks gestation	29	27	24	28	38	28	39	24	44	30				↘
Number of women who gave births all gestations from 22+0 weeks	380	384	395	392	419	401	455	421	419	449				↗
Induction of Labour rate %	33.7%	29.0%	30%	34.9%	31.3%	31.2%	26.2%	28.4%	27.8%	26.8				↘
Unassisted Birth rate %	47.3%	46.6%	52.1%	52.2%	48.5%	50.9%	46.1%	47.0%	49.2%	44.8				↘
Assisted Birth rate %	18.2%	18.8%	16%	16.6%	16.3%	14.7%	15.4%	20.7%	15.0%	17.5				↗
Caesarean Section rate (overall) %	34.5%	34.6%	31.9%	31.2%	35.2%	34.4%	38.5%	32.3%	35.8%	38.7				↗
Elective Caesarean Section rate %	19.7%	21.1%	18.7%	17.6%	18.7%	20.0%	18.3%	18.3%	17.7%	16.4				↘
Emergency Caesarean Section rate %	14.7%	13.5%	13.2%	13.6%	16.5%	14.5%	20.7%	14.0%	18.1%	22.3				↗
Perinatal Morbidity and Mortality inborn														
Total number of perinatal deaths	2	4	1	1	6	0	2	1	1	4				↗
Number of late fetal losses 22+0 to 23+6 weeks excl TOP	0	0	0	0	0	0	0	0	0	1				↗
Number of stillbirths (>=24 weeks excl TOP)	0	3	0	0	2	2	1	0	1	2				↗
Number of neonatal deaths : 0-6 Days	0	1	0	0	1	0	1	1	0	0				→
Number of neonatal deaths : 7-28 Days	2	0	1	1	3	0	0	0	0	1				↗
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (HSIB)	1	0	0	0	2	0	0	0	0	1				↗
Maternal Morbidity and Mortality														
Number of maternal deaths (MBRRACE)	1	0	0	1	0	0	0	0	0	0				
Number of women who recieved level 3 care	0	0	1	2	1	0	1	1	1	1				
Insight														
Number of datix incidents graded as moderate or above (total)	1	1	2	1	4	1	3	0	2	2				
Datix incident moderate harm (not SI)	0	0	1	0	0	0	0	0	1	1				
Datix incident SI (excl HSIB)	1	1	1	1	1	1	0	0	1	1				
New HSIB SI referrals accepted	1	0	0	1	2	0	1	0	0	0				
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0	0	0	0	0				
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0				
Workforce														
Datix related to workforce (service provision/staffing)	4	2	10	6	7	14	28	15	26	19				
MDT ward rounds on CDS (minimum 2 per 24 hours)	100%	100%	100%	100	100	100	100	100%	100%	100%				
One to one care in labour (as a percentage)	100	100%	100%	100	100	100	100	100%	100%	100%				
Number of times maternity unit attempted to divert or on divert	0	3	1	1	2	0	2	2	1	1				
attempted baby abduction	0	0	0	0	0	0	0	0	0	0				
Involvement														
Service User feedback: Number of Compliments (formal)	10	20	12	30	40	36	36	31	5	23				
Service User feedback: Number of Complaints (formal)	3	4	3	5	0	6	6	7	7	4				
Staff feedback from frontline champions and walk-abouts (number of themes)	5	7	5	1	4	4	7	4	4	4				
Improvement														
Progress in achievement of CNST /10	6	6	7	10	10	9	9	8	8	7				
Training compliance in maternity emergencies and multi-professional training (PROMPT)	94%	94%	92%	92%	97%	94%	94%	90%	80%	80%				
training compliance core competency 4. personalised care	n/a	n/a	n/a	61%		54%	56%	63.8%	64%	64.7%				
Continuity of Carer (overall percentage)	36%	36%	36%	38%	45.9%	46%	44.4%	48.3%	47%	40%				

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Public Board of Directors 30th November 2021

Report Title	**Infection Prevention and Control Annual report**
Report Author	**Martin Williams, Director of Infection Prevention and Control. Trevor Brooks, Deputy Director of Infection Prevention and Control,**
Executive Lead	**Deirdre Fowler, Chief Nurse and Midwife**

1. Report Summary

This Annual report is to provide the overarching summary of UHBW's performance in 2020 / 21 linked directly to the Health and Social Care act (2008) and the Infection Prevention and Control Code of Practice. This report will be accessible on the Trust external website.

2. Key points to note

(Including decisions taken)

It has been an unprecedented year for IPC associated with the SARS-CoV-2 (COVID-19) pandemic.

Issues of note:

1. The Trust did not meet its *Clostridioides* (*Clostridium) difficile* (CDI) objective of no more than 71 Trust apportioned cases in 2020/2021, finishing the year with 81 cases.
2. There were 3 Trust apportioned Meticillin-resistant S*taphylococcus aureus* (MRSA) bloodstream infections in 2020/21 against a zero trajectory.
3. Influenza immunisation of front line staff was reported as 86.2% in 2020/21. Equally the organisation was responsive to the demand to vaccinate staff against COVID-19 and vaccination centres were set up rapidly on both the Bristol and Weston sites.
4. Antimicrobial Stewardship auditing has reduced as an impact of the pandemic.
5. The monthly cleanliness audits were re-introduced Trust wide in all clinical areas from January 2021.
6. The Patient Led Assessment of the Care Environment (PLACE) did not occur in 2020/21 due to the pandemic.
7. Plans and ambitions for 2021/22 have been linked to the constantly changing demands on the IPC team from the pandemic.

The Infection Prevention and Control Board assurance framework has been reviewed and updated throughout the year in line with National updates.

3. Risks

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

The risks associated with this report include:

The organisational risks are included in the report and have been reviewed.

- Risks 3687- replacement for ICNET
- Risk 968 – organisational IPC risk associated with norovirus
- Risk 4462 – The impact of COVID-19 on Trust activity
- Risk 3216 – The likelihood of exceeding the Trust C/diff limit.
- Risk 4651- Nosocomial transmission of COVID-19 in Trust hospitals.

4. Advice and Recommendations

(Support and Board/Committee decisions requested):	
• This report is for **Assurance.**	
5. History of the paper **Please include details of where paper has previously been received.**	
Quality and Outcomes Committee	25 November 2021
Clinical Quality Group	3rd June 2021
Infection Control Group	22nd July 2021

Recommendation Definitions:

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

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Infection Prevention and Control Annual Report 2020/2021



University Hospitals Bristol and Weston NHS Foundation Trust

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)

Infection Prevention and Control (IPC) annual report 2020/2021

1. Executive summary

The Annual Report for 2020/2021 informs patients, public, staff, Trust Board members and the Clinical Commissioning Group (CCG) of the Infection Prevention and Control (IPC) activities undertaken within the Trust and demonstrates progress against the required performance targets.

The merger of Weston Area Health NHS Trust with University Hospitals Bristol NHS Foundation Trust to become University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) was completed in April 2020.

It has been an unprecedented year for IPC associated with the SARS-CoV-2 (COVID-19) pandemic.

- The Trust has not meet its *Clostridioides* (*Clostridium) difficile* (CDI) objective of no more than 71 Trust apportioned cases in 2020/2021, finishing the year with 81 cases. Each case has been fully reviewed to determine whether there have been any lapses in care and hence whether the case could have been avoided. In total, 67 Hospital Onset-Healthcare Associated (HOHA) and 14 Community Onset-Healthcare Associated (COHA) were identified.
- There were 3 Trust apportioned Meticillin-resistant S*taphylococcus* a*ureus* (MRSA) bloodstream infections in 2020/21 against a zero trajectory.
- Sixty five Trust apportioned *E. coli* bloodstream infections were reported during 2020/21. Each case has been reviewed and learning shared. In total, 24 of the cases related to urinary sepsis; 12 of these patients had a urinary catheter.
- Influenza immunisation of front line staff was reported as 86.2% in 2020/21. Equally the organisation was responsive to the demand to vaccinate staff against COVID-19 and vaccination centres were set up rapidly on both the Bristol and Weston sites.
- Hand hygiene compliance remained good during 2020/21, with an average compliance rate of 97%.
- The Infection Prevention and Control Team completed a moderated annual programme of work in 2020/21; prioritising a programme of healthcare associated infection (HCAI) surveillance, policy review, audit, education and training. Post infection reviews continue for all hospital acquired infections including surgical site infections.
- Antimicrobial Stewardship auditing has reduced as an impact of the pandemic.
- The monthly cleanliness audits had not been possible in COVID-19 restricted wards but had continued in non-COVID-19 areas. However, cleanliness auditing was re-introduced Trust wide in all clinical areas from January 2021.
- The Patient Led Assessment of the Care Environment (PLACE) did not occur in 2020/21 due to the pandemic.
- Plans and ambitions for 2021/22 have been linked to the constantly changing demands on the IPC team from the pandemic.

The Trust Board wishes to formally acknowledge and thank the Director of Infection Prevention and Control and the IPC team for their leadership, guidance and commitment to ensuring high quality patient care during the pandemic. The multi professional teams across the Trust are to be commended for their rapid understanding, and implementation of guidance issued over the past year during such a challenging time.

2. Introduction

The purpose of the report is to inform patients, public, staff, Trust board members and the Clinical Commissioning Group of the Infection Prevention and Control activities undertaken in 2020/21 within University Hospitals Bristol and Weston NHS Foundation Trust, and to demonstrate delivery against performance targets. All NHS organisations must have effective systems in place to control healthcare associated infections as set out in the Health and Social Care Act (2008). Infection Prevention and Control is part of University Hospitals Bristol and Weston NHS Foundation Trust's overall risk management strategy. This report provides assurance to the Board that the Trust has discharged its responsibilities as per the Health and Social Care Act.

The authors would like to acknowledge the contribution of other colleagues to this report, in particular, the sections on decontamination, Facilities and Estates, and Pharmacy.

3. Director Infection Prevention & Control (DIPC) Report to the Board

Corporate Responsibility

The Chief Nurse is the responsible Executive Director within the Trust for Infection Prevention and Control and reports to the Chief Executive and the Board of Directors. The Director for Infection Prevention and Control (DIPC) is a consultant microbiologist in the Trust.

Infection Prevention and Control Governance

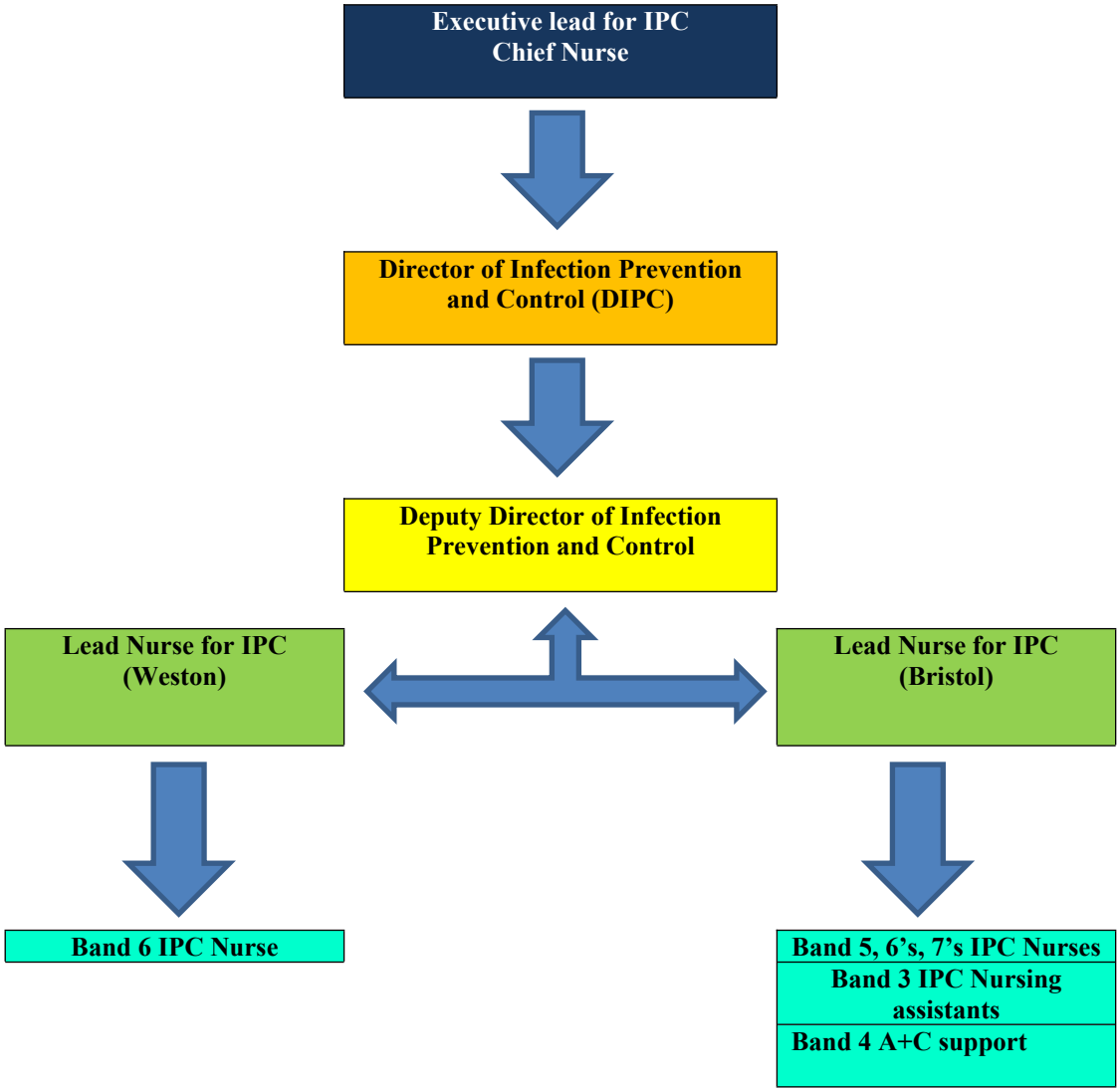
The Infection Control Group (ICG) is responsible for ensuring that there is internal oversight and assurance of compliance with national IPC standards, local policies, guidelines and external assessments e.g. decontamination standards, Care Quality Commission standards and the Patient Led Assessments of the Care Environment (PLACE). The ICG is chaired by the Chief Nurse who is the executive lead for Infection Prevention and Control or the DIPC. The group meet bi-monthly. Reports are received at each meeting from the subgroups which are; Decontamination Board, Antimicrobial Stewardship Group, Facilities and Estates, Occupational Health and each clinical Division. ICG reports to the Clinical Quality Group, and Quality and Outcomes Committee (Board subcommittee).

DIPC Reports to Board of Directors

The DIPC reports quarterly to the Quality and Outcomes Committee. Key Infection Prevention and Control performance metrics are reported monthly as part of the Board quality and performance report. The IPC annual report is submitted to the Board of Directors.

4. Infection Prevention & Control Structure

Infection Prevention and Control (IPC) Structure (2020)



5. **Compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance**

Compliance Criterion 1.
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

- The Infection Prevention and Control Team (IPCT) have Infection Prevention and Control Nurses (IPCNs) and includes the deputy Director of Infection Prevention and Control, antimicrobial pharmacists and administrative support.
- The Director of Infection Prevention and Control (DIPC) who is also a consultant microbiologist and Infection Control Doctor leads the team and reports directly to the Chief Nurse.
- The Chief Nurse chairs the Infection Control Group (ICG) which meets bi-monthly.
- The Trust Board receives monthly infection control exception reports within the quality report for key performance indicators related to infection.
- The Quality and Outcomes Committee (Board sub-committee) receives quarterly infection control reports.
- The IPCT has an annual work plan which is monitored by the ICG.
  All IPC incidents are managed through the Trust's incident reporting process and any risks that relate to IPC are managed via the Trust's risk management process. The ICG reviews and monitors all IPC corporate and divisional risks. Divisional reports to the group include updates on risks and their management.
- There is a programme of cleanliness audits with monthly audits conducted in high and very high-risk areas. The reports from these audits are presented through ICG and disseminated across the Divisions for local action and re-audit accordingly.
- Reportable healthcare associated infections are reported via the Datix incident management system and are also reported externally via the Public Health England data capture system.
- All IPC training is mapped against the UK Core Skills Training Framework Statutory/Mandatory Subject Guide, Version 1.4 (2017). This includes measures to prevent risks of infection.
- The IPCT are responsible for the development and updating of Trust wide infection control policies which are ratified through the ICG.
- Audits to monitor compliance against key policies are undertaken as per the annual audit plan this includes monthly hand hygiene audits and audits relating to Aseptic Non-Touch Technique (ANTT) practice.
- The Trust water safety group oversees the work to deliver the requirements set out in the HTM 04 revision. This multi-disciplinary group ensures that there are systems and processes in place to manage the complex water systems and a water safety plan is in place. Estates currently share information/ assurance around maintenance activities undertaken, share sample results and identify where risks might be in line with guidance documentation. The group shares knowledge, learning from past experiences and ensures that the governance structures are in place. Background levels of *Pseudomonas aeruginosa* in augmented care areas are monitored and microbiology flag areas of concern. Investigations take place as required and exception reports are reviewed at the ICG.
- The Trust Ventilation Group provides a means for the joint review of issues relating to the effective management and review and co-ordination of aspects of the performance of the site's ventilation

systems. This includes the development of strategies and approaches to manage risks associated with those ventilation systems and accepts ownership of, and to be accountable for Ventilation Risk Management in accordance with all current legislation and guidance documentation. The group develops a Ventilation Action Plan (VAP) which provides a risk-management approach to the safe operation of ventilation systems. The group monitors and advises on ventilation across the sites in line with the VAP and assists with understanding and mitigating risks associated with ventilation systems. The group provides a forum for joint strategic discussion, considering actual and anticipated changes to the service provision.

Compliance Criterion 2.

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

- The Trust has designated leads for environmental cleaning and decontamination of equipment.
- Annual audits relating to decontamination are conducted by external auditors to monitor compliance.
- An external auditing body conducts annual audits CSSD against the ISO 13485:2016 standard.
- There is a system in place to ensure decontamination before equipment is maintained/serviced/repaired whether within the area or transferred from the area via a DC1 form. Staff members complete this form when returning items to MEMO for repair.
- MEMO is audited by the British Standard Institute twice a year as part of the ISO 13485:2016 quality management standard.
- Monthly cleanliness audits are carried out within all clinical areas. Areas for improvement are identified and follow up audits are undertaken to ensure improvements in standards have been made.
- Cleaning schedules are available for public view within each clinical area.
- There are suitable handwashing facilities in all appropriate areas and alcohol hand gels with signage on entry to each ward area.
- The Trust has policies in place to manage the clinical environment and ensure appropriate cleaning mechanisms are used at all times. This includes cleaning an environment after a patient with an infection is discharged.
- When an enhanced deep clean is undertaken due to an infection, the standards of cleaning are signed off by a senior person within the clinical area to confirm they meet the requirements.
- All clinical staff receives training on IPC which includes decontamination and cleaning of equipment. Compliance with infection control training at the end of 2020/21 was above 80%. The reduction in training compliance was due to the training requirement changing from three yearly to annually, in line with national guidance and also the inability to provide face-to-face training due to the pandemic restrictions.
- Within the current linen policy, it states the Trust will ensure that throughout the collection and distribution functions that used linen is segregated from clean linen. Monthly service user meetings are held with the clinical teams, where the laundry quality and satisfaction are discussed and documented. Quarterly contract performance review meetings are held with the supplier, where it is evidenced the compliance with the agreed Key Performance Indicators (KPIs).

- Within the current linen policy, it clearly states the colour coding of bags to be used for used and infected linen.
- The overriding regulatory documentation for the provision of linen is the Health Technical Memorandum HTM 01-04 – Decontamination of Linen for Health and Social Care. HTM 01-04 supersedes earlier versions of laundry guidance including HSG (95)18.

Compliance Criterion 3.

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

- Joint specialist pharmacist/microbiologist ward rounds were suspended during the COVID-19 pandemic. When reinstated these include auditing antimicrobial prescriptions for compliance with the anti-infective guidelines, providing advice on the management of all infections where appropriate and applying the Start Smart Then Focus (SSTF) principle to all prescriptions. Application of the Sepsis Six toolkit ensures patients with sepsis are treated promptly and the review team follow them up to ensure therapy is narrowed where possible.
- Antimicrobial Steering (AS) Group meet quarterly, and discuss, compliance with guidelines, expenditure, anti-infective incidents, guidelines, Anti-Microbial Resistance (AMR) CQUIN targets and other items relating to antimicrobial use. Membership includes the medical director, DIPC, consultant microbiologists, paediatric ID, senior clinicians representing the divisions, representation from the NMPs, representation from Infection Control, director of pharmacy and the anti-infective specialist pharmacists. AS prescribing compliance is reported monthly to the trust board, divisional leads and consultants throughout the Trust.
- The Trust has an Anti-Infective Prescribing Policy and guidelines covering all the points below. These are available on the Trust's intranet (dedicated anti-infective pages) and the Microguide app (Horizon Strategic Partners Ltd) which is freely available for all users. Compliance is monitored weekly as detailed above. Regional and national benchmarking is undertaken; the Trust has participated in an annual Point Prevalence Audit within the South West Region, and the South West Regional Antimicrobial Group that meet quarterly. National benchmarking is available on the NHSE Fingertips website, UHBW submit data for inclusion.
- Microbiology systems provide readily accessible computer data and telephone advice both in and out-of-hours on microbiological data and susceptibility results.
- Trust induction covers expectations and signposting to guidelines etc. for those prescribing antimicrobials. Foundation Year 1s (FY1s) are provided with a teaching session that covers antimicrobial resistance, common infections and the rationale for stewardship practices. Anti-infective pharmacists provide ad-hoc teaching to FY1s on any other related topics as required.

Compliance Criterion 4.

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
• National information is utilised for patient and public information on IPC where appropriate. • Where local information is produced this is submitted to the patient experience lead and the Trust communications team for appropriate approvals. • Posters, leaflets and signage is used to promote good hand hygiene practices, inform patients and visitors if there are particular requirements for IPC and also to provide public health information and advice. • Information is also available on the Trust website and relevant information is sent out using social media. • Patient confidentiality is maintained at all times and information is only shared with other organisations in accordance with Data Protection principles.

Compliance Criterion 5.
Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
• The Trust IPCT work closely with partnering organisations including Public Health England, the CCG and other healthcare providers to ensure any information regarding infections within the local area is known and action is taken accordingly. • Public Health England is informed of any notifiable infection and any outbreaks or serious incidents are notified to Public Health England and the CCG. • The responsibility for IPC is devolved to all groups in the organisation and Trust wide representation at the alternate monthly infection control group ensure timely and effective cascading of information to all areas.

Compliance Criterion 6.
Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
• All staff receives infection prevention and control training on induction to the Trust, which also includes volunteers. • In addition, the Trust adheres to the UK Core Skills Training Framework on all training including updates. • IPC is core within all job descriptions for staff employed within the Trust. • Additional training and competencies are in place for skills such as Aseptic Non-Touch Technique and urinary catheterisation. • Leaflets are available for all contractors.

Compliance Criterion 7.

Provide or secure adequate isolation facilities.

- The Trust has policies in place for the appropriate isolation of patients as required.
- There is a ward on the Bristol site (ward A900) that can be converted into a 6 bedded cohort ward should this be required in the situation of an outbreak. Weston site outbreaks are managed according to guidelines within individual wards in the first instance.
- The Trust's estates strategy has seen an investment in facilities for isolating patients on the Bristol site. The Trust has a number of standard side rooms plus specialist ventilation rooms. Specialist ventilation rooms are required for patients with certain infections such as those that are airborne, diseases of high consequence or for patients who are highly immunocompromised (Department of Health, 2013).

The table below shows the breakdown of the isolation/ side room facilities across the Trust by Division/location:

Division/location	Specialist ventilation	En-suite side room	Room only (no en-suite)
Weston	1	29	18
Medicine (Bristol)	2	63	3
Surgery (Bristol)	5	43	6
Women's (Bristol)	0	6	17
Specialised Services (Bristol)	9	48	3
Children's (Bristol)	4	42	25
Total	21	231	72

Compliance Criterion 8.

Secure adequate access to laboratory support as appropriate.

- Microbiology is accredited to UKAS ISO: 15189 standards.
- Appropriate policies and procedures are in place.

As a consequence of the pandemic additional SARS-CoV-2 / COVID-19 near patient testing was introduced in key locations in the Trust. This was to allow for timely near patient screening in the Emergency Departments.

The governance route for Trust approval and rapid implementation was followed and formal accreditation against ISO: 15189 standards will follow with the revalidation of the laboratories in the year ahead.

Compliance Criterion 9.

Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
• The Trust has policies within each of the areas specified within this criterion and audits are undertaken where appropriate to identify compliance. • All policies are available to staff on the internal website and are updated in accordance with their requirements. • All new or amended Trust wide IPC policies are approved through ICG and the Clinical Quality Group prior to being disseminated.

Compliance Criterion 10.
Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
• All staff can access occupational health services or access appropriate occupational health advice between 08:00–17:00 with advice line being open 08:30–15:30, 5-days-a-week. • There is a website that includes guidance on general matters and in the HR Web guidance on referrals etc. • Occupational Health policies on the prevention and management of communicable infections in care workers are in place • Occupational Health have risk assessment categories according to post that are applied at the time of commencing work, instigated by the recruitment process • In keeping with Occupational Health recommendations, an independent confidential recording system is in place. • All health risks are assessed pre-employment and clearance is based on the Department of Health Guidance. Vaccination compliance is also addressed at the time of screening with managers being informed of the applicant's current status. • Those staff at constant risk due to non-conversion (protection against Hepatitis B) and who involved in exposure prone procedures (EPP) are recalled annually to prove they are infection free. • Occupational Health liaises with the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses (BBV) when advice is needed on procedures that may be carried out by BBV-infected care workers, or when advice on patient tracing, notification and offer of BBV testing may be needed; clinicians see each affected staff member and monitor as needed • A risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids is undertaken. • Out-of-hours contamination injuries initially go via the site manager following the SOP. If deemed high risk the staff member should attend ED where an out-of-hours post-exposure prophylaxis (PEP) treatment may be commenced following risk assessment. • Arrangements are in place for the provision of influenza, and now COVID-19 vaccination for healthcare workers (as summarised below):

2020/ 2021 (Overall Trust figures for seasonal influenza vaccination – front line workers)

Occupational Group	Total Frontline Healthcare Workers	Frontline Healthcare Workers Vaccinated	Uptake
Doctors	1,575	1,543	98.0%
Qualified Nurses, midwives and health visitors	3,286	3,018	91.8%
All other professionally qualified clinical staff	1,133	1,132	99.9%
Support to Clinical Staff	2,898	1,987	68.6%
Total	8,892	7,680	**86.4%**

By Division 2020/21

Division	Total Staff	Total Vaccines	% Staff Vaccinated
Women's and Children's	2,493	2,119	*85%*
Diagnostics and Therapies	1,324	984	*74%*
Medicine	1,694	1,238	*73%*
Weston	1,280	1,233	*96%*
Specialised Services	1,371	1,069	*78%*
Surgery	2,187	1,531	*70%*
Trust Services	1,196	809	*68%*
Estates and Facilities	1,133	451	*40%*
Total	**12,678**	**9,434**	***74.4%***

SARS-CoV-2 (COVID-19) vaccinations

In December 2020 the Trust rapidly set up a vaccination hub on both Weston and Bristol sites to deliver the Covid-19 vaccination to health and social care staff across BNSSG. These hubs provided first and second doses vaccines and were open up to seven days per week. With administering a total of 30,675 doses across UHBW by the time of decommissioning the hubs in April 2021.

Occupational Health

Avon Occupational Health Partnership (AOHPS) provides services across UHBW for our employees. The data reported for inoculation incidents for Jan 2020 – March 2021:

Numbers of contamination incidents		
Month	**2020**	**2021**
January	27	17
February	19	22
March	13	19
April	17	
May	11	
June	13	
July	24	
August	15	
September	29	
October	31	
November	36	
December	32	
Grand Total	**267**	**58**

The Blood Borne Virus (BBV) contamination injury numbers for March to August 2020 are in the lower region but then the Trust saw an increase from September to December 2020, likely linked to increased activity.

Contact tracing

This service has been maintained throughout the pandemic assisting in the management and follow up of staff exposed to tuberculosis (TB) and other infectious diseases.

Immunisations and vaccinations

APOHS has provided face-to-face services for vaccinations in line with the Faculty of Medicine Guidance. There has been a reduced provision of vaccines, such as Hepatitis B or MMR, to provide protection for staff whilst minimising the risk of COVID-19.
Blood testing to ensure patient safety for staff fitness to carry out exposure prone procedures has continued and IGRA blood tests for possible latent TB in staff joining the Trust from countries of high incidence of the disease has also continued.

SARS-CoV-2 Pandemic

The Occupational health advice line has been very busy with an increasing workload over the year providing information and advice to staff and managers in relation to COVID-19. This included shielding, risk assessments, fitness for work, skin and mask issues.

Management referrals

This service has continued using telephone consultations rather than face-to-face for all appointments. This has worked well in the majority of cases, however, there were some issues e.g. mask or skin problems, where face-to-face appointments would have been better.

6. SARS-CoV-2 (COVID-19) Pandemic

The impact of the pandemic across the entire Trust has been momentous. The response to it has been equally as impressive, with staff maintaining their focus in the interests of patient safety and maintaining safe, high quality services throughout adversity and the challenges of the all the changes which have come with the management of the pandemic.

On the 11th March 2020, the World Health Organisation declared the pandemic of SARS-CoV-2 (COVID-19). The impact on the Organisation, its patients and staff cannot be underestimated and required a level of resilience and determination to maintain patient and staff safety throughout the most challenging of years. The IPC team have been at the heart of the response. The first wave was demanding and the second wave created an unprecedented surge in activity across the organisation. The organisation and the IPC team continue to prepare for further demands of the pandemic, and the predicted 3rd wave.

Since the declaration of the pandemic, the strategic IPC issues for the organisation have been coordinated through the daily Trust 'Silver' meetings, with IPC involvement. Clinical IPC guidance within the Trust has primarily been based on guidance received from Public Health England, and NHS England/Improvement which has evolved and changed throughout this last year often requiring an immediate response to change in practice. In addition, a 'bronze' IPC meeting was established to rapidly identify and escalate issues through to 'Silver'. This group met fortnightly but had the ability and did stand up exceptional meetings when required. A number of guidelines have been developed and the IPC team have worked with all divisions to ensure that proposed plans to deliver patient care is COVID-19 safe and secure, whilst maintaining staff safety and wellbeing.

Personal Protective Equipment (PPE) was managed centrally through the Sterile Service Team to control and manage the available PPE which was challenging in the early stages of the pandemic. Since that time all PPE supplies, with appropriate updated advice have been available when required for all clinical teams.
Responsive communications have been established to ensure that all clinical staff receives timely messages of IPC guidance and changes which has required a level of agility in how messages are shared through the organisation. At the height of the pandemic this was as a daily COVID-19 staff briefing. This is now a weekly briefing in addition to all other staff communication strategies.

The impact of the pandemic has required all Divisions in collaboration with IPC to work through appropriate segregated pathways for all patients entering the Trust , to reduce nosocomial risk, whether an outpatient, emergency or elective admission. Wards and departments have changed locations, including the Emergency Department at the BRI as a direct response.
Inpatients are now screened tested for SARS-CoV-2 on day 1, 3 and 7, then every 7 days thereafter using a variety of 'near patient' testing approaches and central laboratory facilities.

Numerous COVID-19 outbreak scenarios which are summarised later in this report, as consequence of the pandemic, have required increased SARS-CoV-2 testing regimes testing for staff, as a containment measure. The Trust Staff testing hub was set up at the start of the pandemic and has responded to the operational requests immediately when additional staff testing has been required.
All members of staff have been provided with the facility to undertake lateral flow and have been encouraged to participate in lateral flow SARS-CoV-2 testing.

The Trust Board review the Corporate Risk Register quarterly. There are five risks on the corporate risk register related to Infection Prevention and Control. These are reviewed bi-monthly at the Infection Control Group which are summarised later in the report.

7. HCAI Statistics and Surveillance against National Limits

Overview

University Hospitals Bristol and Weston NHS Foundation Trust continues to take part in mandatory surveillance of meticillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections, meticillin-sensitive *Staphylococcus aureus* (MSSA) bloodstream infections, *Escherichia coli* (*E.coli*) bloodstream infections and *Clostridioides* (*Clostridium) difficile* infections.

To support the ambition to reduce the number of healthcare-associated Gram-negative bloodstream infections (GNBSI) by March 2021, NHS England /Improvement extended mandatory reporting to include *Klebsiella* species and *Pseudomonas aeruginosa*. Together with *E. coli* these organisms account for more than 70% of all healthcare associated GNBSI. GNBSI continue to increase in England and cause significant morbidity and mortality in our patients.

Public Health England definitions of Healthcare associated infection.

Public Health England

Trust Exposure Definitions

Hospital Onset – Healthcare Associated:
- Patient is an inpatient in an acute trust and has 3 or more days between admission and positive specimen

Community Onset – Healthcare Associated:
- Patient returns a positive specimen within 28 days of discharge from an elective or emergency hospital admission within the reporting trust

Community Onset – Indeterminate Association (*C.Diff* only):
- Patient returns a positive specimen between 28 and 84 days of discharge from an elective or emergency hospital admission within the reporting trust

Community Onset – Community Associated:
- Patient has not been discharged from an elective or emergency hospital admission in the reporting trust in the last 84 days for *C.Diff* and 28 days for all other organisms

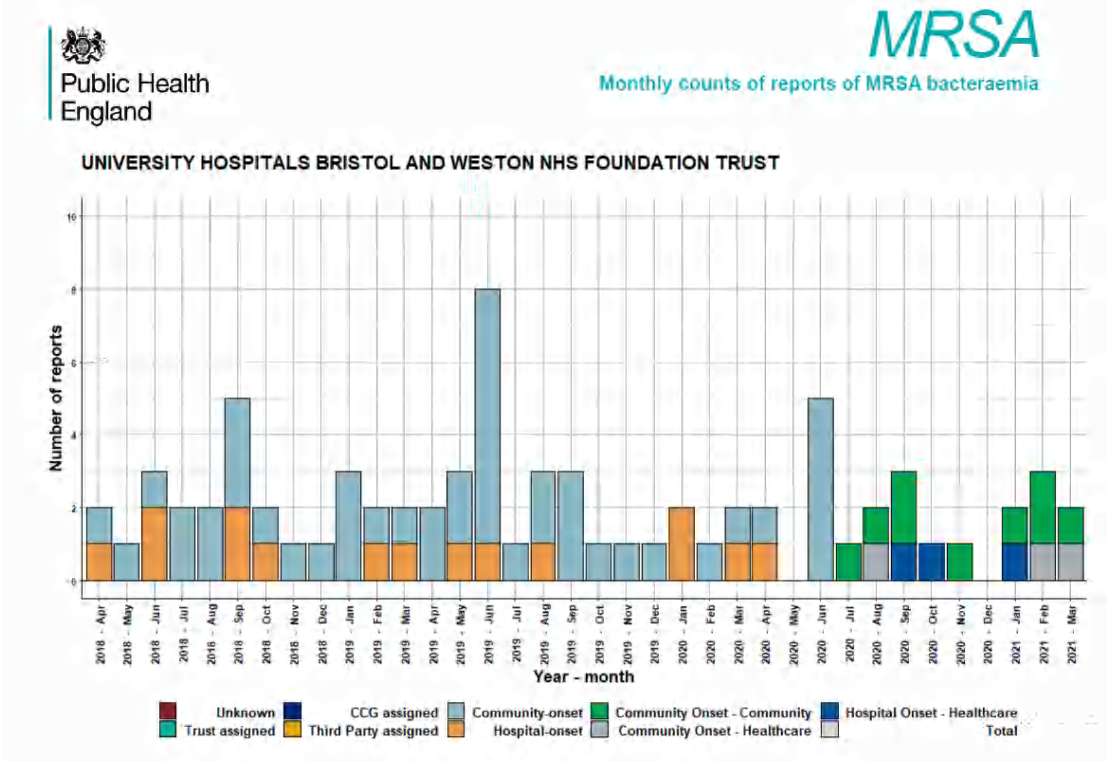
Please refer to HCAIDCS User guide for more information on trust exposure definitions:
https://hcaidcs.phe.org.uk/ContentManagement/LinksAndAnnouncements/HCAIDCS_Supporting_Documents_PHE_Prior_Trust_Exposure_User_Guide.pdf

National Limits

Meticillin-resistant *Staphylococcus aureus (MRSA)* bacteraemias

Staphylococcus aureus is a gram-positive bacterium carried harmlessly in the nose of approximately a third of the population. In healthcare settings, where patients are often undergoing invasive procedures it can cause serious illness including wound, respiratory and bloodstream infections. Meticillin-resistant *Staphylococcus aureus* (MRSA) is a strain of *Staphylococcus aureus* that has acquired resistance to flucloxacillin and may be resistant to other classes of antibiotics.

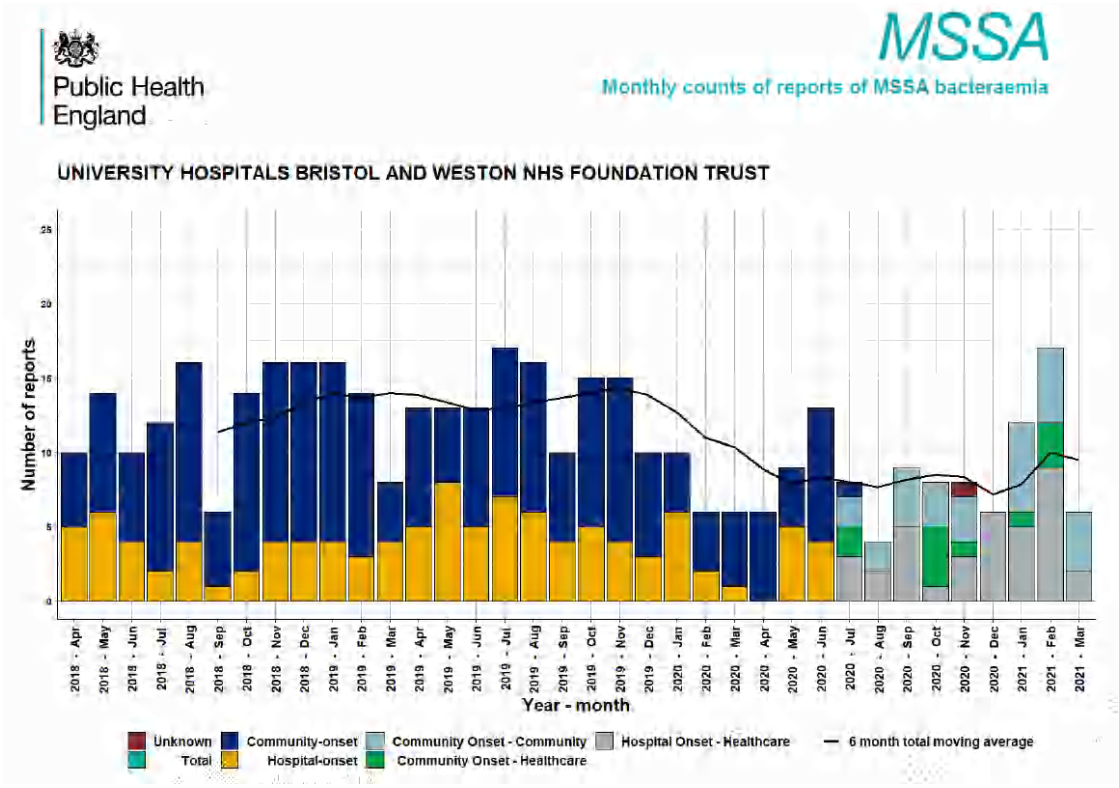
Public Health England (PHE) has carried out mandatory enhanced surveillance of MRSA bloodstream infections since October 2005 for NHS acute Trusts. Patient-level data of any MRSA bloodstream infections are reported monthly to PHE. Independent Sector (IS) Healthcare Organisations providing regulated activities also undertake surveillance of MRSA bloodstream infections.



Although, under the present national guidance, a full post-infection review is not required, the Trust re-introduced this to ensure that any lapses in care would be highlighted and actions taken to address them.

MRSA screening has continued for specific groups of patients on the Bristol sites and with all patients admitted to the Weston division, due to challenges with the estate and the inability to isolate patients.

Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias

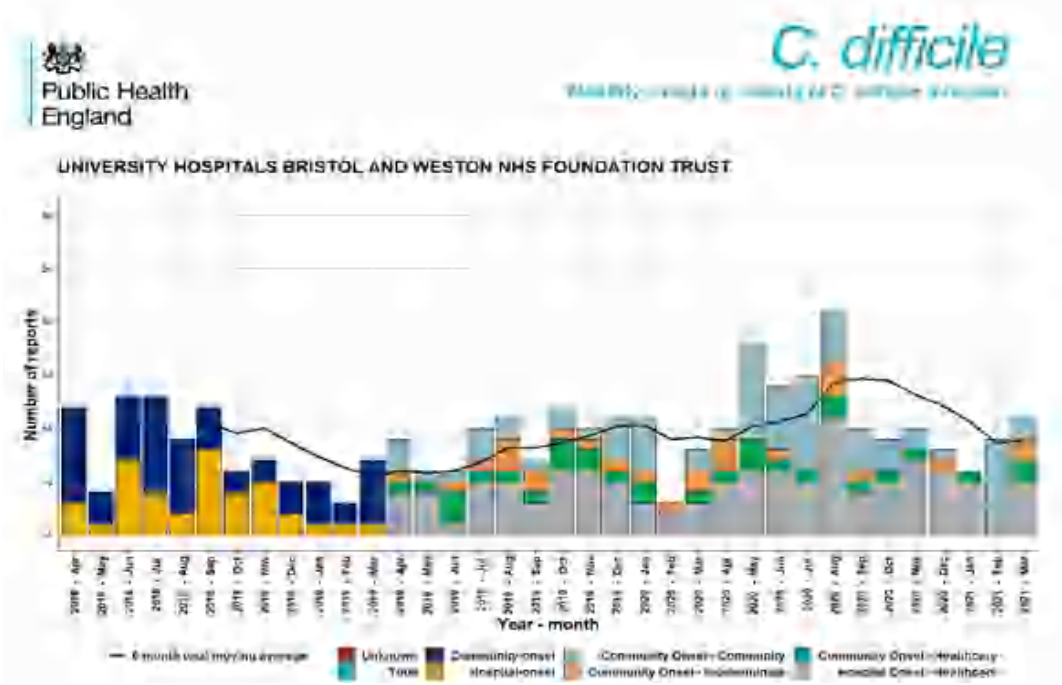


The standard for cases that could be Trust attributed is measured by patients in hospital for more than 2 days. The Trust limit was no more than 30 cases in the year. The Trust reported 35 cases, which is a higher number of cases than expected. A review of all the cases was undertaken to identify any improvement themes such as cannula care.

All Trust attributed MSSA bloodstream infections are investigated and reviewed by the Clinical Commissioning Group (CCG). A post infection review is completed, an action plan generated and recorded in the Datix system for each infection.

***Clostridioides (Clostridium) difficile* infections (CDI)**

The limit set for CDI for 2020/21 was 71. The Trust had 81 Trust apportioned *C. difficile* infections. 67 of the cases were Hospital Onset-Healthcare Associated and 14 Community Onset-Healthcare Associated. The two combined categories are attributed to the Trust. All cases are investigated and validated by our commissioners to identify which cases are found to be avoidable. Due to the SARS-CoV-2 pandemic, *C.difficile* cases attributed to the Trust found to be avoidable, have yet to be validated by the commissioners.



Guidance by Public Health England, outlining the assessment criteria and which cases will fall under the Trust acquired status.

- Hospital onset healthcare associated cases (HOHA): detected in the hospital, two or more days after admission.
- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case within the previous four weeks (COHA).

There were clear themes for improvement where “lapses in care” were identified. These were as follows:

- Incomplete documentation
- Delays in sending stool samples
- Inappropriate antibiotics prescribed

Action taken:

- Documentation reviewed and updated

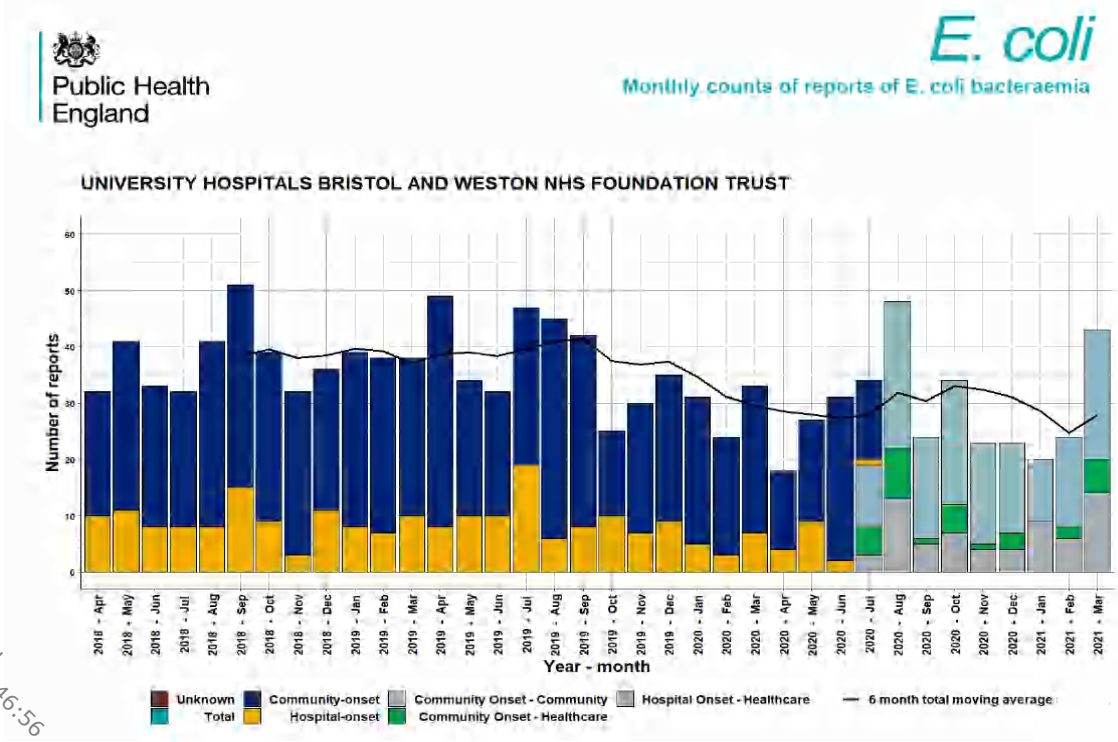
- Bespoke ward-based training on infection prevention and control delivered to incorporate learning
- Updated Trust wide training programmes
- Amended review of paperwork to improve investigating and reporting
- Hand hygiene audit tool reviewed with improved reporting mechanisms
- Joint specialist pharmacist/microbiologist ward rounds to most wards at least weekly, auditing antimicrobial prescriptions for compliance with the Anti-infective Guidelines

E.coli

The UK has seen a steady increase in the number of E.coli blood stream infections (BSI) in the past few years. This is despite the reduction in the number *of Methicillin Resistant Staphylococcus Aureus* Blood Stream Infections and *Clostridium difficile* cases.

In 2017 the Secretary of State for Health launched an ambition to reduce the Healthcare-associated Gram-negative BSI by 50 % by 2021. Gram-negative BSI is thought to have contributed to approximately 5,500 deaths in the UK NHS in 2015. The most common source of infection is the urogenital tract at 51.2% of all E.coli BSI infections. Urinary catheter passports are used across BNSSG CCG to standardise clinical practice this is led by the urology teams at North Bristol Trust. Compliance with the use of the Urinary Catheter passports has been in abeyance as a result of the pandemic and will be restarted in the coming 12 months.

***E.coli* bacteraemias**



8. Surgical Site Infection Surveillance

The Surgical Site Infection Surveillance (SSIS) team collect data and carry out surveillance on PHE categories: large bowel surgery, small bowel surgery, gastric surgery, cholecystectomy (non-laparoscopic), and adult and paediatric cardiac surgery and coronary artery bypass grafts. Data is entered onto PHE website with reports generated after six months; these provide benchmarked trends across all participating hospitals in England.

The role of the Surgical Site Infection Surveillance nurse is to enhance the quality of patient care and assist in reducing the rate of surgical site infection. This is done by ongoing surveillance and review of infection trends over a period of time, working collaboratively with the surgical teams and providing consistent, accurate reporting and feedback to the surgeons. The team follow patients throughout their inpatient stay, carrying out surveillance and reporting any potential SSIs to the DIPC for validation. The patients are followed up at 30 days with a post discharge phone call and questions are asked using the PHE Post Discharge Questionnaire to ensure an infection has not occurred.

A Surgical Site Infection Review (SSIR) tool has been developed by the SSIS Team, with surgical team input, to critically analyse each deep incisional and organ space infection. The investigation tool will review the patient journey from pre-op assessment through to discharge, identifying any potential areas of learning or improvement. Through work with the patient safety team, the tool has been embedded within Datix thus following the format of established Healthcare Associated Infection investigations.

SSIS has not been carried out in the Weston Division during 2020/21 noting the exceptionally low number of surgical procedures due to COVID-19. SSIS will be re-introduced in Weston in 2021/22.

9. Untoward Incidents including Outbreaks

Overview

All outbreaks are reported via the Datix incident management system. Notifiable diseases and outbreaks (2 or more linked cases of infection) are also formally reported via the NHSE/I electronic portal.

The Trust Board review the corporate risk register quarterly. There are five risks on the corporate risk register related to Infection Prevention and Control. These are reviewed at the Infection Control group bi-monthly.

Deaths related to COVID-19 which could be considered to be hospital-acquired are formally reviewed by the Trust Harm Review Panel, chaired by the Medical Director.

SARS-CoV-2 (COVID-19) Pandemic

As a consequence of the pandemic, there have been a number of COVID-19 outbreaks in UHBW with a significant impact on operational service delivery models mainly in the Bristol Royal infirmary, South Bristol Community and Weston Hospitals. The PHE recommendations for streaming all patients, regardless if they are in an elective or non-elective pathway, has been challenging to deliver. Routine screening is undertaken

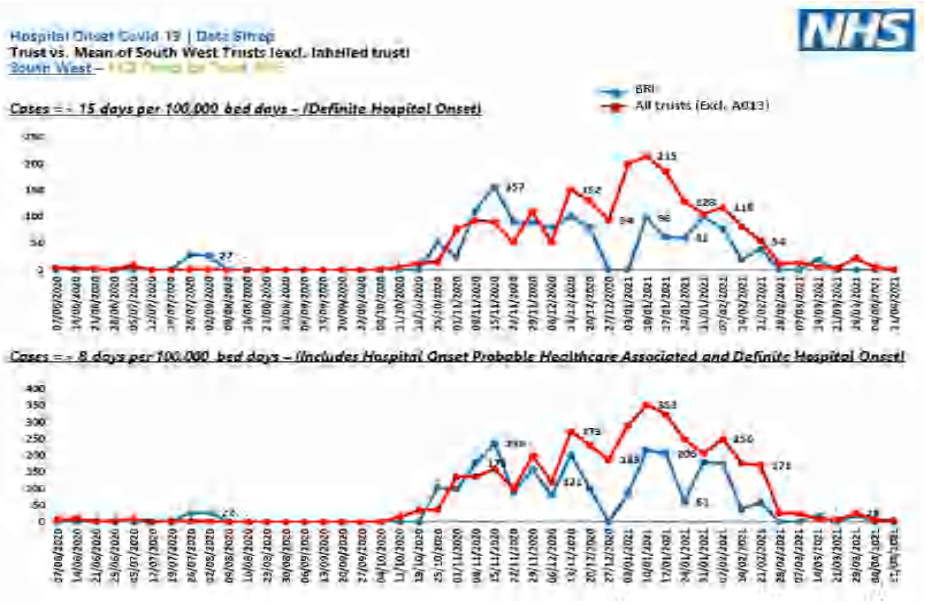
at day 1 of admission, day 3 and day 7, and every 7 days thereafter unless the patient should become symptomatic. All patients are streamed for their risk of having COVID-19 on admission. Patients with suspected or confirmed COVID-19 have a clearly segregated pathway in each Division. Arrangements are in place to de-escalate patients at 14 days from their positive diagnosis when appropriate.
Nosocomial (healthcare-related transmission) PHE definitions for COVID-19 were established in June 2020, and are highlighted below:

Duration from admission	Acquisition
2 days or less	Community
3-7 days	Indeterminate
8-14 days	Probable hospital-acquired
15+ days	Definite hospital-acquired

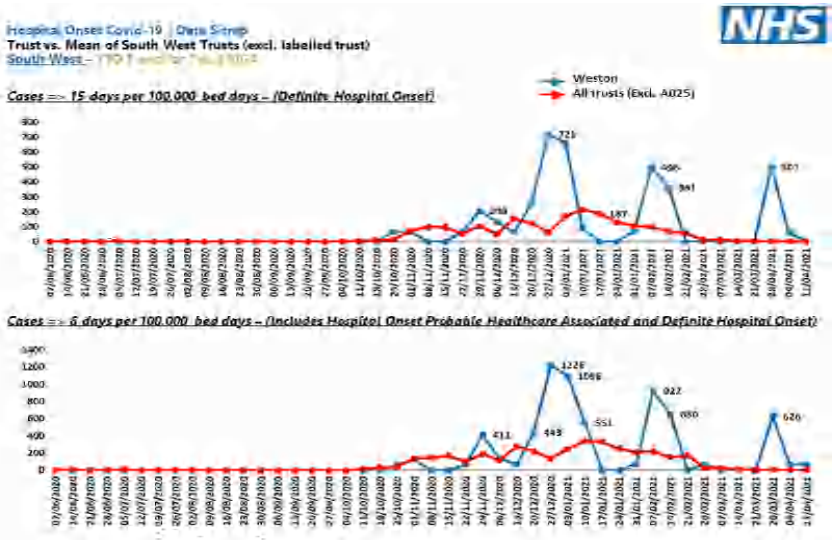
Patients who have died with COVID-19 are reviewed by the Trust Harm Panel and cases investigated formally by the Trust Patient Safety Team.

The graphs below demonstrate surges in activity related to cases of hospital acquired transmission, but does not include the cases that occurred before June 2020.

Bristol Data for COVID-19



Weston Data for COVID-19



Month	Inpatients Admitted With Covid-19	Inpatients Diagnosed With Covid-19 Following Admission				
		Community-Onset	Hospital-Onset Indeterminate Healthcare-Associated	Hospital-Onset Probable Healthcare Healthcare-Associated	Hospital-Onset Definite Healthcare-Associated	TOTAL Diagnosed Following Admission
May-20	37					313
Jun-20	16					75
Jul-20	6	5	1	0	1	7
Aug-20	8	9	0	0	1	10
Sep-20	13	17	0	0	0	17
Oct-20	47	107	6	6	5	124
Nov-20	176	157	22	12	23	214
Dec-20	203	94	27	22	35	178
Jan-21	414	159	31	25	19	234
Feb-21	156	88	22	19	22	151
Mar-21	75	17	7	3	10	37
	1151					**1360**

The operational impact of the pandemic has been significant with ward, department and hospital closures. Weston as a site has experienced a more significant impact of outbreaks and required a full hospital closure and divert in May 2020 and then a partial divert in early 2021. These were managed within the parameters of the Outbreak Policy and with the system support, which should be commended, as the particular response to the full closure of Weston in May 2020.

There were a number of ward closures linked to outbreaks in Q1/ Q2 – 2020/21 for both Bristol and Weston in wave 1 of the pandemic. This has been the subject of a Root Cause Analysis (RCA).

The reported COVID-19 outbreaks in wave 2 (through Q3/ Q4 – 2020/21) of the pandemic in different locations are summarized below:

Ward closures linked to COVID-19 for UHBW (Q3 / Q4) from October 2020 – March 2021:

Month	Ward	Total number of patients tested positive SARS-CoV-2	Total number of staff tested positive SARS-CoV-2	Ward	Total number of patients tested positive SARS-CoV-2	Total number of staff tested positive SARS-CoV-2
	Bristol sites (BRI / SBCH)			Weston		
October 2020	A605	7	2	Cheddar	5	3
November 2020	C805	8	7	Draycott	9	4
	A515	2	1	Steepholm	10	3
	C705	2	8			
	A522	7	0			
	Ward 100	7	0			
December 2020	A515	5	5	Harptree	13	12
	A602	6	8	Uphill	21	12
	Ward 200	4	1	Kewstoke	21	19
	A605	8	2	Steepholm	4	2
				Berrow	14	3
January 2021	A522	15	4	Sandford	4	1
	A525	7	9	Harptree	8	0
	C705	6	0			
	Ward 200	3	3			
February 2021	A605	8	2	Steepholm	9	0
				Cheddar (bay)	3	0
March 2021				Hutton	15	3

All outbreaks are managed by the IPC team, and any lessons learned are shared.

On identifying a probable/ definite healthcare acquired SARS-CoV-2 case the affected individual is moved into the appropriate pathway, and the remainder of the ward is re-screened. If additional cases are identified then the ward is closed to new admissions, and staff testing is instigated at weekly intervals, for a period of 3 weeks. In order for the ward to be re-opened there must be no additional cases on the ward for 14 days. The ward is observed for a further 14 days (two incubations) before the outbreak is closed. If the number of exposed patients is sufficiently small, and there is capacity to isolate them in side rooms or a cohort area, for

the remainder of their isolation period (14 days), then these patients are re-located, the ward deep cleaned, and then re-opened.

All patients are now screened for COVID-19 with a PCR test as per PHE guidelines. For elective care this occurs 72 hours prior to admission. These guidelines have been implemented in a timely way based on PHE recommendations. All patients, once admitted either in an elective or emergency pathway, are screened on admission then at day 3, day 7 and every 7 days thereafter. At Weston in addition, because of the limited numbers of isolation rooms, all inpatients (COVID-19 negative) are screened twice a week.

There are segregated pathways within each speciality/ Division on different sites across the Trust for COVID-19 negative patients, and those who are COVID-19 positive from the emergency department into all wards.

A number of issues remain which increase the risk of further ward based transmissions, especially if a third wave occurs. This includes the poor ventilation in certain parts of the organisation, especially in the Queen's building, BRI and at Weston.

In addition it has been recognised that in certain areas there is an inability to maintain a 2 metre social distancing around the bed spaces due to the ward configurations. In May 2020 all inpatient beds were assessed for compliance. The measurement methodology was mid bed to mid bed with considerations of chair positioning also taken into account. The net result of this work was as follows:

- Division of Surgery – 0 bed removals
- Division of Medicine – 1 bed removed on A515
- Division of Specialised Services – 1 bed removed on D603
- Division of Weston – 13 beds removed (re-reviewed and confirmed in August 2020 following the whole hospital covid-19 outbreak)

A further review of bed-spacing was undertaken in February 2021, using a more stringent approach of measuring from bedframe to bedframe. The change in approach to bedframe to bedframe measurements was intended to reflect a more realistic picture of how patients use bay facilities. A 10% tolerance was considered as acceptable during times of low community activity. The impact on bed numbers at 2m and 1.8m is highlighted in the box below:

	Non-Boarding bed spaces		Boarding spaces
	Number of bed losses if >2m compliance required	Number of bed losses if >1.8m compliance required	Non-compliance
Medicine	20	17	12
Surgery	7	2	5
Specialised services	0	0	12
Weston	33	25	0
Grand Total	63	46	27

A robust multi-professional Quality Impact Assessment (QIA) has been undertaken in association with the work and aligns to the decision making process.

Norovirus Activity

Norovirus cases are proactively managed with involvement from the IPCT. Patients are managed and tested in accordance with local and national policy, reporting cases through the Public Health England voluntary norovirus reporting system. The IPCT support the reopening of areas as appropriate. Levels of norovirus activity in the community for 2020-21 have been low, and there have been no ward-based outbreaks detected.

Influenza

The Trust introduced rapid influenza testing in blood sciences at the BRI site in 2019, for critical care areas and the emergency departments during the winter period. This service is not available at Weston. The results were reported back to the clinical areas within two hours. The incidents of influenza identified in the Trust have been very low in 2020/21.

***Staphylococcus warneri* in cardiac surgery**

Three patients who had undergone cardiac surgery under one surgical team in June/July 2020 have been identified as having infection with an indistinguishable strain of *Staphylococcus warneri* (two with prosthetic valve endocarditis, and one bloodstream infection). A review of all *Staphylococcus warneri* bloodstream infections in the Trust has not identified additional cases. The clinical team are undertaking a Route Cause Analysis' of the care received by these patients which is yet to conclude.

Vancomycin resistant *enterococcus faecium* (VRE) outbreak on A600

Nineteen patients have been identified mainly on general ITU and CICU who have become colonised/ infected with a clone of VRE (ST80 which is part of CC17) during their admission. To date, five are designated BRIS14-EC19, and two are BRIS14-EC-18 (so two different clusters). Two are unique and there are ten where typing is currently not available.

All clinical isolates (i.e. not screening samples) have been referred to the reference laboratory for confirmation of relatedness. Outbreak meetings have been convened and an action plan has been established. In addition to admission and weekly VRE screens, this now includes active review by the clinical team, review of IPC practice and cleaning standards.

New Dehli metallo-beta lactamase-1 (NDM-1) producing *Klebsiella pneumoniae* outbreak on Starlight ward.

NDM-1 is a metallo-beta-lactamase with activity against carbapenems. These Carbapenemase producing enterobacterales (CPE) have limited therapeutic / treatments options, but are an increasing issue, both across the UK and internationally. Infections with CPE are now considered a notifiable infection, and new national guidance has been developed.

The IPCT have identified an outbreak of NDM-1 producing *K.pneumoniae* in seven children on Starlight ward that are indistinguishable by VNTR typing (33301141527). Outbreak meetings were convened and an action plan produced. This included environmental sampling, review and update of practice with the clinical team and review of operational challenges of the environment.

Some CPE colonisation was identified in the environment within the unit. Remediation work is being undertaken to address any issues.

The unit has subsequently been reopened to new admissions. An additional case has been identified linked to the ward, but there was variance in the antibiogram suggesting they were unlinked. This has subsequently been confirmed by VNTR typing undertaken at the reference laboratory.

Naso-endoscope Decontamination Failure Incident, ENT Outpatients – St Michael's Hospital

In December 2020 it was identified that the Automated Endoscopic Washer (one of three), located in ENT outpatients department in St Michaels Hospital, had its chemicals inserted in an incorrect sequence resulting in a failure of the decontamination process. The unit is used to decontaminate flexible naso-endoscopes that have no internal channel and C-mac laryngoscope blades from theatres.

Following an incident meeting Public Health England were contacted for advice regarding the clinical risk to patients (although considered very low) estimated to be approximately 100 individuals. PHE's response was "*Our joint public health risk assessment based on the information available is that while this this is a poorly evidenced area, we see the risks to patients as very low and do not see the need for patient notification in respect of transmissible infections as being justified. (This does not include the Trust's duty of candour). It follows that post exposure hepB vaccination is also not indicated*".

Following this the incidence was graded as minor and therefore did not meet the threshold for formal Duty of Candour disclosure. Remedial actions have been put in place and the incident closed.

Paediatric Renal Dialysis Unit Incident

In February 2021 the IPC team were alerted to concerns from the renal dialysis unit that children were developing systemic symptoms soon after commencing dialysis. A number of remedial actions were undertaken, but no specific pathogen was identified. The unit has now re-opened and an RCA is being produced.

UHBW Corporate IPC Risk summary (2020/21)

There are five IPC risks on the corporate risk register as summarised below.

Title	Description	Controls in place	Risk level (current)
3687 Risk of ICNet system malfunction due to the current IT version being made obsolete	The current version of the ICNet system used by the IPCT to obtain information is no longer supported. The project to replace the system is a collaborative with NBT led by the Trusts IM&T department.	Pending delivery in 2021/22. There are no mitigations in place.	Risk rating 9 (High Risk)
968 Risk of decreased patient flow due to impact of norovirus outbreaks	Risk of decreased patient flow due to impact of norovirus outbreaks and subsequent bed closures. Norovirus outbreaks affecting inpatients and leading to ward closures will also introduce significant risk to the ability to achieve right patient right bed and 4 hour target 4hour target and elective targets.	Outbreak Policy and plans amended following review of adequacy of controls. -All patients are formally assessed for risk of norovirus on admission	Low Risk (Risk Rating 2)
4462 Risk that UHBW will have reduced bed capacity and subsequent strain on services due to third wave of COVID-19	With the planned increase in activity in the Trust, there may be an increase in patients being admitted or developing COVID-19.There may also be an increase in staff with the infection. This may affect patient flow and bed capacity due to closures of ward areas. PPE availability	Screening of patients on admission, Implementation of day 1,3,7 and weekly screening instigated across the trust in accordance with National guidance All policies/SOPS on Trust intranet for staff. Divisional plans frequently reviewed in line with government guidance for management of patients	Moderate risk (Risk rating 8)
3216 Risk that new national *C.diff* criteria will increase the number of Trust apportioned cases	Risk that new national *C.diff* criteria will increase the number of Trust apportioned cases. This may result in financial implications for the Trust and a higher proportion of patients being identified. National requirement. Numbers increase. Financial penalties.	Policies in place and compliance high. Training in staff induction and update. Post-infection reviews undertaken for each case and action plans developed if required. Learning shared with staff.	Moderate risk (Risk rating 6)
4651 Risk that COVID-19 is transmitted between patients and staff in areas within the Trust	If the Trust's COVID-19 related infection prevention and control policies and PPE guidelines are not adhered to, then the virus may be transmitted between staff and patients within the Trust, resulting in an increase in infection rates and a potential outbreak which would have a significant adverse effect on patient outcomes/patient flow, staff health and availability to provide a service.	Assurance is against the PHE guidance / assurance framework. There are segregated pathways for all patient groups – green, amber and blue as well as those who are COVID-19 recovered. 1, 3 and 7 day testing is in pace. Outbreak Control Policies used as required. The community prevalence has reduced but the risk score remains current for the organisation	High Risk (Risk rating 10)

10. Audit and Quality improvement (including Hand Hygiene and IPC audit with Perfect Ward)

Hand hygiene auditing has continued throughout 2020/21, however there have been some challenges with data uploading and system changes e.g. the upgrade of the Perfect Ward application for Weston and its introduction in Bristol. A Trust wide unified hand hygiene auditing approach across Bristol and Weston will be Perfect Ward which will incorporate hand hygiene compliance and a ward IPC COVID-19 checklist. There is the potential for Perfect Ward to include peripheral venous cannula (PVC) and urinary catheter assurance audits and this is currently being reviewed.

There are a number of collaborative quality improvements supported by the Trust Transformation team which are ongoing, specifically linked to COVID-19 that have been initiated by IPC:

- COVID-19 patient pathways and information pack with Operations and Divisions.
- 2 metre bed spacing review for PHE compliance with Operations and Divisions.
- IPC guardian for non-clinical teams with Occupational Health, Education, Health and Safety, Human Resources.
- Front entrance messaging and PPE for non-staff attendees to all hospital sites with the Facilities and Estates team, Health and Safety and Divisions.
- Perfect Ward IPC audits delivered Trust wide.

11. Board Assurance Framework (Version1.6 – February 2021)

The Board Assurance Framework is a comprehensive record of the areas of IPC compliance across the Trust. The document covers a wide range of IPC related domains and compliance is formally reported into the Trust Quality and Outcomes Committee with the evidence of compliance held centrally. The content is reviewed quarterly as a multidisciplinary panel review process which includes Divisional representation, Facilities and Estates, Health and Safety and is led by the Chief Nurse team.

12. Antimicrobial Stewardship

The term 'antimicrobial stewardship' is defined as 'an organisational or healthcare system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness' (NICE, NG15, August 2015). Antimicrobial Stewardship operates across all clinical areas of UHBW as part of the Trust's antimicrobial stewardship programme. The activity of the antimicrobial stewardship team is monitored through the Bristol Royal Infirmary (BRI) Anti-infective Steering Group (ASG), chaired by the medical director.

Both the ASG and the ASC regularly review compliance, expenditure, antimicrobial CQUIN delivery, incident trends, update and produce new guidelines, feedback audits and deliver education and training, in line with the recommendations from the Department of Health (DoH) on the delivery of a robust antimicrobial stewardship programme.

Both groups usually meet quarterly but due to the COVID pandemic and staff availability, meetings only occurred twice in the Bristol Royal Infirmary (BRI) during 2020, in March and September. During this time, any urgent business was conducted via email and quarterly meetings resumed in January 2021.
Weston ASC meetings were also hampered by the pandemic and key staff absences; these meetings will be re-instated for 2021/22 and both sites will continue with regular meetings, attended by both Weston and Bristol.

Prescribing Compliance

Bristol: The COVID pandemic brought about a number of changes to the way the antimicrobial pharmacy team in Bristol worked; during the first wave, all team members were transferred into the 7-day ward pharmacy working pattern and to limit non-essential footfall on the wards, antimicrobial stewardship ward rounds were cancelled. Antimicrobial consumption, in terms of total use plotted against admission data continued to be monitored by the team but contemporaneous prescribing compliance data could only be compiled by drug chart reviews; thus no meaningful compliance data was collected for Adult patients in Bristol between April 2020 and February 2021. The Paediatric team continued Antimicrobial ward rounds and data collection across the Bristol Children's Hospital (BCH) throughout 2020. The anti-infective pharmacists have re-started rounds for some wards in Bristol and the microbiologists continue to provide advice to the Intensive Care Units, virtual ward rounds for some of the specialities (including Bristol Haematology and Oncology Centre and the Bristol Heart Institute) and via telephone enquiries.

Weston: In the Weston Division, the pandemic also brought antimicrobial ward rounds and data collection to a halt. Weston has been particularly stretched without a consultant microbiologist on-site for much of the time.

Point prevalence anti-infective prescribing compliance audit is being undertaken at the time of writing in both Weston and Bristol and the plan is to replicate this quarterly until such time as electronic prescribing is introduced across the Trust.

When stewardship review data is collected in Bristol, the reviews continue to be entered on to Medway; the details are visible as a clinical note attached to each patient. This allows clinicians to see the results of prescription reviews, any recommendations made, and which member of the team carried out the review. As systems merge (April 2022), the team will endeavour to adopt the same process in the Weston Division. As we move toward electronic prescribing, we are reviewing data collection and thus the stewardship rounds will inevitably change although the team aim to maintain a presence on wards.

Antimicrobial CQUIN 2020/2021

Antimicrobial CQUINs planned for 2020/21 were cancelled due to the pandemic; discussion is underway at a national level to determine whether they will be re-instated for the 3rd and 4th quarters of 2021/22.

Antifungal stewardship: A dedicated antifungal stewardship team continue to meet virtually; complex patients are reviewed with mycology and microbiology and prescribing practice is monitored.

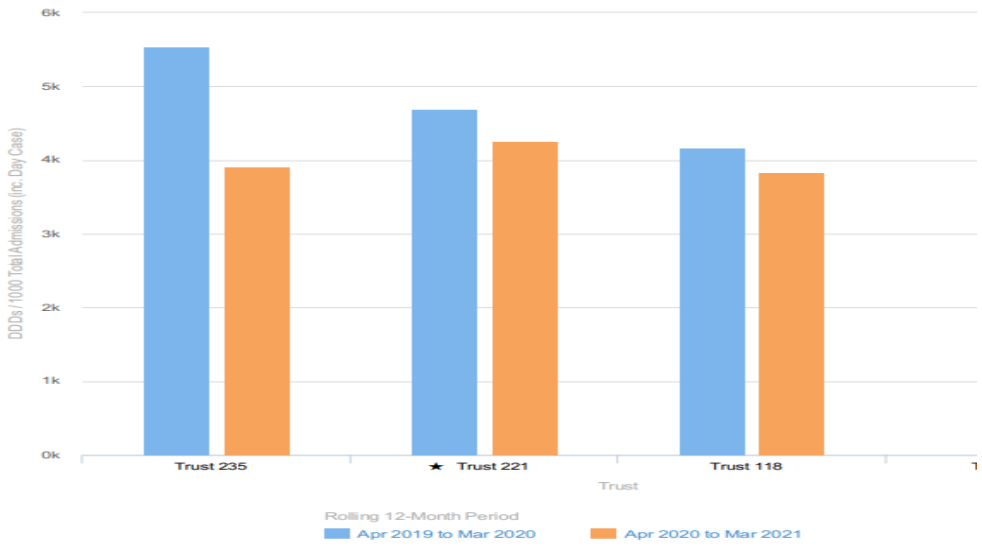
Total Antibiotic Consumption 2020/2021

A reduction in total antibiotic consumption (1% reduction on previous year) is part of the NHS standard contract.

Bristol: From April 2020–March 2021 there was a 9.4% reduction in total antibiotic consumption in comparison to the previous financial year. Consumption in the BRI increased immediately before the first wave of the pandemic as clinicians provided at risk patients with prophylactic antibiotics to prevent admissions into the acute care setting; overall consumption increased by 25% compared to March 2019.

Weston: From April 2020 –March 2021 there was a 29.5% reduction in total antibiotic consumption in comparison to the previous financial year. (Data extracted from Define continues to be reported separately for Bristol and Weston).

Figure 1: Total systemic antibiotic use, defined daily doses/1,000admissions: Weston (Trust 235) and Bristol (Trust 221)



(Trust 118 – within BNSSG STP)

The NHS standard contract also had a target to increase the use of narrow spectrum antibiotic agents as a proportion of total consumption. There has been no change for either Bristol or Weston; in Bristol, the 2020/21 percentage remains the same as 2019/20 consumption (45% narrow-spectrum agents) and for Weston the figure remains at 50% .The original target was to have a proportional use of ≥55% of narrow-spectrum antibiotics (the Access group) or to increase from the 2016 baseline by 3%. Neither Bristol nor Weston has been able to achieve this target. The NHS Standard Contract target for 2021/2022 has yet to be set although trusts are encouraged to continue to limit the inappropriate use of broad-spectrum agents.

Guidelines

Bristol: There are 79 antimicrobial guidelines in use in the BRI. Guidelines are reviewed on a 2-yearly basis (or sooner if new evidence or national guidance is available).

Weston: There are 61 treatment guidelines in use at the Weston Division of UHBW which are reviewed in the same format as the Bristol site. At present the guidelines are available via a variety of routes – the Weston intranet, 'Rx Guideline' (app based guideline system), and the DMS. This poses the risk that individuals may use the incorrect version of a document. This risk will be mitigated as Weston and Bristol sites begin to align antimicrobial guidelines (where possible), removing old versions as this happens. 'Rx Guideline' has recently been acquired by 'Microguide'. As policies align, Weston will move across to using 'Microguide'. This will need to have occurred by end of calendar year 2021, as Rx Guideline will cease to exist.

Work has started on aligning antimicrobial guidelines across both Weston and Bristol hospitals.

Audit and Quality Improvement

Completed in 2020/21:

- BCH Paediatric ED antimicrobial prescribing audit – compliance with guidelines good
- All Antimicrobial Guidelines hosted on Microguide app & desktop alone (removed from DMS)
- Penicillin-allergy de-labelling project in the pre-op assessment clinic (POAC) (BRI); stage 1 completed, some data analysis undertaken, feedback to POAC completed, to be discussed further with anaesthetists and microbiology, aim to plan BNSSG-wide project following discussions

Expenditure

Anti-infective expenditure continued on a downward trajectory throughout 2020/2021 financial year for both Bristol and Weston sites; the reduction in total consumption due to the pandemic was a contributory factor, but even accounting for activity, antimicrobial drug costs continued on a downward trend.

13. Infection Prevention and Control Guidelines and Policies

It should be noted the significant policy change has occurred as a direct result of the pandemic. Often the guidance changed from PHE at very short notice requiring an agile response from the IPC team. A number of IPC related policies have been informally reviewed and extended and will be reviewed in 2021/2022 to try and simplify the approach that satisfies mandatory IPC requirements and offers clinical teams accessible advice when they need it.

14. Education and Training

IPC remains a mandatory part of staff induction and update training across the Trust. All induction and annual updates are now provided via e-learning using the national infection prevention and control modules. Additional training to support the pandemic has been delivered including 'FIT' testing to ensure the safe use of different makes of FFP3 masks and compliance with donning and doffing of personal protective equipment (PPE). Training compliance is reported at the bi monthly at ICG.

15. Decontamination: (Annette Giles, Trust Decontamination Manager)

The Trust Decontamination Board fornmally report into the Trust Infection Control Group.

Decontamination service developments for year 2020-2021

- CSSD Kingsdown retained accreditation to ISO 13485:2016. Continued improvements in departments that undertake local decontamination during the annual audit undertaken by the AED
- Drawing up and implementation of action plan following AED annual trust-wide decontamination audit.
- Purchase and installation of 1 additional AER for BCH theatres
- Commencement of Process Control Device testing of washer disinfectors in CSSD

As a consequence of the pandemic the decontamination team had taken a lead role in the organisation and management of PPE in the Trust.

PPE at Bristol

- Overnight setting up of a dedicated PPE hub, team and ordering process for all Bristol sites in response to COVID-19 pandemic
- Continuous PPE stock management and issuing of over 15 different PPE items to all Bristol sites from April onwards
- Close working with procurement to source PPE items not available from government stocks
- Close working with neighbouring healthcare organisations to support with PPE mutual aid when necessary
- Daily reporting to regional and national teams of PPE stocks so Trust could be approbatively replenished on a daily basis

PPE in Weston

- The site stores team picked up the PPE response in addition to their routine non-pay stock tasks.

16. Facilities and Estates

Facilities (Dena Ponsford, Assistant Director, Facilities)

Facilities and Estates strive for the best patient environment experience through continual improvements to performance and working strategy. A key challenge at the end of the financial year was the COVID-19 pandemic.

Facilities Cleaning/Linen

Auditing

During the first wave of the COVID-19 pandemic from March 2020 to May 2020, cleanliness auditing was suspended. From June 2020 auditing re-commenced on a gradual basis which included visual auditing, using full PPE and social distancing. Auditing of COVID-19 wards was introduced with communal areas and was fully audited from January 2021.
University Hospitals Bristol NHS Foundation Trust and Weston Area health NHS Trust merged in April 2020. Weston General Hospital was mapped for auditing in June 2020 and auditing fully commenced from July 2020. Auditing covered the whole Trust with over 200 areas audited and covered very high risk, high risk and significant risk areas.

Cleaning
During the COVID-19 pandemic we have increased our cleaning workforce to accommodate the 'touch point cleaning' in low risk pathways as set out in the NHSE/II COVID- 9 pandemic guidance for the remobilisation of services within health and care settings. This guidance remains in place until further guidance is issued.
Additional cleaning resources were implemented to support increased frequency cleaning in high risk areas such as Emergency Departments, Intensive Care Units, A900 and A800.
The frequency of deep cleans requested by the clinical teams increased during the pandemic and additional staffing levels were deployed to support the additional requests. Cleaning schedules Trust wide were adapted to reflect the national guidelines for being in contact with a positive patient.
Throughout the pandemic different working practices across Facilities were implemented to cover operations effectively including Personal Protective Equipment, cleaning regimes, auditing and staff training.

Linen
Large quantities of scrubs were purchased during the COVID-19 pandemic to support continuous supply in high risk areas for all staff members.
During the last 12 months our current linen supplier Royal Devon & Exeter NHS Foundation Trust and Elise who supply the Weston site, have been able to provide the required levels of laundered linen to meet service need appropriately in all areas at all sites.

Waste management
During the COVID-19 pandemic all waste material collections were increased across all wards and departments.

Catering
For a temporary period during the pandemic a one week menu cycle was introduced across the Trust; this ensured adequate supply of all menu items at all times.

PLACE (Patient Led Assessment of the Care Environment) 2020/21 has not been completed in 2020/21 due to pandemic restrictions

Estates - Water Safety and Ventilation (Matt James, Assistant Director of Estates)
Water Safety

The Trust Water Safety Group meets quarterly and oversees the work to deliver the requirements set out in the HTM 04-01. This multi-disciplinary group ensures that there are systems and processes in place to manage the complex water systems and a water safety plan is in place. The estates currently share information / assurance around maintenance activities undertaken, share sample results taken and identify where risks might be in line with guidance documentation. The group shares knowledge, learning from past experiences and ensures that the governance structures are in place. Background levels of *pseudomonas* in the augmented care areas are monitored and microbiology flag areas of concern. Investigations take place as required and exception reports go through ICG.

Risks and incidents are managed through the Trust risk management system, Datix, and monitored at the Water Safety Group.

The COVID-19 pandemic has impacted on the water safety controls over the past year. Firstly, access for planned maintenance activities has on occasion been restricted to minimise the risk of hospital transmission and the risks to the Estates maintenance staff. Secondly, some areas of the Trust have had reduced activity or reduced number of staff on-site. This has led to more areas being little used and flushing regimes have been difficult to maintain and monitor.

The Trust has an appointed Authorising Engineer as recommended in HTM 04-01 and they have undertaken an annual audit. The findings of the annual report have been shared with the Water Safety Group and actions are being monitored through that group.

The Weston Estate has been integrated into the current Trust governance process and management systems. A contractor has been appointed to undertake water maintenance statutory obligations and monitoring of this going forward will sit within the Estates existing management structures.

Ventilation Safety

The Trust Ventilation Safety Group (VSG) provides a means for the joint review of issues relating to the effective management and review / co-ordination of aspects of the performance of the sites' ventilation systems including the development of strategies and approaches to manage risks associated with those ventilation systems and accepts ownership of, and to be accountable for Ventilation Risk Management in accordance with all current legislation and guidance documentation.

The group has developed and approved a Trust ventilation safety policy and provides a risk-management approach to the safe operation of ventilation systems.

The Trust has an appointed Authorising Engineer as recommended in HTM 03-01 and they have undertaken an annual audit. The findings of the annual report have been shared with the Ventilation Safety Group and actions are being monitored through that group.

Specialised ventilation (as defined in HTM 03-01) is checked and verified annually by a specialist sub-contractor and actions arising from these verifications are recorded and monitored through the VSG.

The impact of the COVID-19 pandemic on ventilation safety has been significant. The VSG work over the past years has been focused to specialised ventilation systems only. As a result of COVID-19 there has been added oversight and requirement to understand the non-specialised ventilation system that the Trust has and the

detail of individual room ventilation rates on a specific ward. The Trust has undertaken air flow measurement where requested and findings have been shared with clinical colleagues. This has enabled clinical teams to assess the use of rooms that may have aerosol generating procedures undertaken and the potential fallow times between patients. This exercise has also identified that in a number of areas, especially within the older Estate that falls short of where the Trust would want it to be in relation to staff safety and management of COVID-19 positive patients.

There have been a number of capital projects included within the strategic capital programme and the improvement of the ventilation systems to meet current standards are being included with the scope of these projects.

17. Infection Prevention and Control Plans and Ambitions 2021/2022

Recovery from the IPC activity following the second wave of the COVID-19 pandemic to further reduce incidence of healthcare associated infections will remain a priority objective for the Trust in 2021/2022. Associated with this is to be responsive as an IPC team to the ongoing demands of the pandemic and therefore to build a resilient workforce. IPC is an effective quality marker to underpin the strength of the organisation.

The merger between Weston Area Health NHS Trust and University Hospitals Bristol NHS Foundation Trust into a single integrated Trust is an ongoing process for the IPC team who have actively engaged in team development to focus with the ongoing challenges that the current situation demands of us.

18. References

Department of Health (2013) Health Building Note 00-09: Infection control in the built environment.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/170705/HBN_00-09_infection_control.pdf

Health and Social Care Act (2008) – Code of Practice on the prevention and control of infections.
https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

National Institute for Health and Care Excellence (NICE) Quality Standard 113 (2016) Healthcare-associated infections, NICE
https://www.nice.org.uk/guidance/qs113

National Institute for Health and Care Excellence (NICE) Guidance NG15 (2015) Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use, NICE
https://www.nice.org.uk/guidance/ng15

NHSE - Board Assurance Framework (version1.5 February 2021)

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/ipc-board-assurance-framework-v1.5-feb-2021.pdf

NHSE - Every action Counts
https://www.england.nhs.uk/coronavirus/publication/every-action-counts/
NHSE – COVID-19 guidelines for secondary care
https://www.england.nhs.uk/coronavirus/secondary-care/

COVID-19 Guidance for Maintaining Services within Health and Care settings. IPC recommendations
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/954690/Infection_Prevention_and_Control_Guidance_January_2021.pdf

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on 30th November 2021

Report Title	**Six-Monthly Safe Staffing report for Nursing , Midwifery and Allied Health Professionals February 2021 to September 2021**
Report Author	**Sarah Dodds, Deputy Chief Nurse** **Andy Landon, Clinical Informatics**
Executive Lead	**Deirdre Fowler, Chief Nurse and Midwife**

1. Report Summary

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[1] and Developing Workforce standards[2] .

This report details:

Nursing and Midwifery

- Any significant changes that have occurred in nursing and midwifery staffing establishments and skill mix in the last eight months and any risks on the corporate risk register related to nursing and midwifery staffing.
- Assurance regarding safe staffing of wards over the last eight months, including Care Hours Per Patient Per Day and Weighted Activity Unit data
- The impact on staffing due to the pandemic and workforce planning for the future

Allied Healthcare Professionals (AHPs)

- Any significant changes that have occurred in Allied Healthcare Professionals staffing establishments and skill mix in the last eight months and any risks on the corporate risk register related to Allied Healthcare staffing.
- Assurance regarding safe staffing over the last eight months, including Weighted Activity Unit information

The past 8 months have been extremely challenging to ensure safe staffing across the Trust, a revised model for managing staffing during COVID -19 was in place until May 2021 when all the wards reverted to their planned staffing model. However, due to a high number of vacancies, reduced availability of temporary staff, the requirement for staff isolation and increased demand for elective recovery and use of escalation beds, the wards have frequently worked with less staff than planned as evidenced and outlined in monthly reports to the Quality and Outcomes Committee. There is a surge staffing plan in place with a clear escalation process from ward to board, this enables a flexible response whilst maintaining safety which includes review by the Head of Nursing of the day responsible for safe staffing and onwards escalation when further mitigation is required to the Chief Nurse/ Deputies.

- The number of registered nurse vacancies peaked in August at 17% and in recognition of this a further business case was approved in August 2021 for 108 International Nurses and 50 Trainee Nursing associates.
- The registered nurse turnover rate increased to a peak in July 2021 of 14%.
- The AHP vacancy rate remains relatively stable at 3.2%
- The Divisional staffing reviews have all taken place, however further work using the

[1] 2904770 NQB Guidance v1_2_with links A (england.nhs.uk)

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

evidenced based Safer Nursing Care tool[3] is required in order to ensure that all the nursing establishments reflect the patient acuity and dependency needs. Training in the use of this tool is underway.

- Due to increased acuity a review of Midwifery staffing is planned using the Birthrate plus tool.
- With the reduced staffing levels experienced there has been an increasing number of both safe staffing and red flag incident reporting over the past 5 months.
- The CHPPD is above the national mean and that of the model hospital peer group giving assurance that the Trust has maintained safe levels of staffing. This figure also needs to be considered alongside the WAU productivity measure and the Trust's performance against quality and workforce metrics.
- Workforce planning is progressing with roles for the future including Nursing Associates and Advanced Clinical Practitioners with oversight by the Non-medical Workforce planning group.
- The AHP teams monitored staffing in line with service requirements and as with other professions were significantly depleted due to Covid related absence, staff also upskilled and worked alongside nursing staff.
- The Trust recognises and supports staff well-being and has invested in employment of additional well-being staff, Practice Education Facilitator roles and Professional Nurse and Midwifery advocates.

2. Key points to note

(Including decisions taken)

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 quality.

The Trust Board is recommended to review the safe staffing report and note the following:

- Across the Trust over the past 8 months the Trust has not been able to meet the planned levels of Nursing and midwifery staff on the wards, this has undoubtedly affected staff resilience and staff morale.
- The impact of staffing on patient quality outcomes at ward level will continue to be monitored through the monthly reporting to the Quality and Outcomes Committee.
- The opening of any additional capacity within the Trust will always be balanced against whether it is safe to open these areas based on the availability of safe staffing.
- In order to enable skills development, recruitment and retention of the existing workforce, the Trust should support substantive recruitment of the Practice Education Facilitators posts.
- There will be a continued requirement for Trainee Nursing Associates to augment the Registered Nurse shortfall which continues to occur and it will be necessary to review the numbers of registered nurses in areas in order to facilitate this.
- Subject to business planning there will be on going investment required to support the continuation of the International Nurse recruitment programme and HR infrastructure in place for the recruitment and retention of this group of staff.

[3] shelford_group_safety_care_nursing_tool.pdf (ulh.nhs.uk)

• There is an ambition to support the development of the Registered Nurse Degree apprenticeships which will support training and retention for some of our staff, with identification of funding being progressed. • Future workforce plans include commitment to and progression of the training of Advanced Clinical Practitioners and the use of Non-Medical Consultants as key roles to ensure that UHBW is prepared for the future NHS workforce plans.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
The risks associated with this report include: Risk 5477 'Risk that nurse staffing levels will not be met'
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **Assurance.**
5. History of the paper **Please include details of where paper has previously been received.**

Recommendation Definitions:

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

University Hospitals Bristol and Weston NHS Foundation Trust

Report on Nurse, Midwifery and Allied Health Professionals (AHP's) Staffing Levels UHBW (February 2021- September 2021).

November 2021 Trust Board

1.0 Introduction

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 monthly report on nurse staffing to the Board of Directors.

The NHS Improvement "Developing Workforce Safeguards" (October 2018)[3] has several recommendations that Trusts should include and report on, the Trust has utilised these recommendations to produce this report, it is recognised that there are some outstanding elements which the Trust needs to progress and therefore there is currently a gap analysis underway to assess against the Developing Workforce Safeguards requirements in order to prioritise ready for the next reporting period. The usual 6 monthly safe staffing reviews have been delayed due to the COVID- 19 pandemic which has led to several ward re-location and specialty changes. In view of this the report has covered an 8-month period and it is acknowledged that there will likely be on-going changes to future ward specialities and configurations.

This report includes the significant challenges to the professions safe staffing which have occurred during the past 8 months where there has been sustained pressure and impact from the pandemic, an early surge in Children's Respiratory Syncytial Virus(RSV), increased Adult and Children's Mental Health attendances and the impact of the Elective 'Accelerator' restoration work.

The report aims to provide the Trust Board with assurance that staffing has been managed during this time in line with the National COVID recommendations[4], with close oversight by the Chief Nurse and the Incident Management structure which was in place.

[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] Developing_workforce_safeguards.pdf (improvement.nhs.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

An outcome of this review which has taken place is that detailed work using the Safer Nursing Care tool (SNCT) (Shelford 2015) [5]is needed. This is an evidenced based tool which allows nurses to assess patient acuity and dependency, the data collected is matched with preset staffing multipliers to ensure that nursing establishments reflect patient needs in evidence based acuity and dependency. It is recognised that the SNCT data cannot solely be the tool used to recommend staffing establishments, the role of professional judgement and local intelligence cannot be underestimated and should be applied to increase confidence in recommended staffing levels and provide assurance.
Ward sisters and Matrons have recently had training in the use of the tool and over the next 6 months, a plan is in place to collate two data collection periods which will enable a more accurate picture for reviewing establishments via our Safe Care software, which will be revised and rolled out via a refreshed programme of work.

This report details:

1.1 **Nursing and Midwifery**

- Any significant changes that have occurred in nursing and midwifery staffing establishments and skill mix in the last eight months and any risks on the corporate risk register related to nursing and midwifery staffing.
- Assurance regarding safe staffing of wards over the last eight months, including Care Hours Per Patient Per Day and Weighted Activity Unit data
- The impact on staffing due to the pandemic and Workforce planning for the future

1.2 **Allied Healthcare Professionals (AHPs)**

- Any significant changes that have occurred in Allied Healthcare Professionals staffing establishments and skill mix in the last eight months and any risks on the corporate risk register related to Allied Healthcare staffing.
- Assurance regarding safe staffing over the last eight months, including Weighted Activity Unit information

2.0 Significant changes to staffing levels in the last eight months

2.1 Nursing and Midwifery

Staffing required during Covid surge

The past 8 months have been extremely challenging to ensure safe staffing across the Trust; a revised model for managing staffing during COVID-19 was in place until May 2021 when all the wards reverted to their planned staffing model. However, due to a high number of vacancies, reduced availability of temporary staff, the requirement for staff isolation and increased demand for use of escalation beds, the wards have frequently worked with less staff than planned as outlined in monthly reports to the Quality and Outcomes Committee. There is now a surge staffing plan in place with a clear escalation process from ward to board, this enables a flexible response whilst maintaining safety which includes review by the Head of Nursing of the day

[5] shelford_group_safety_care_nursing_tool.pdf (ulh.nhs.uk)

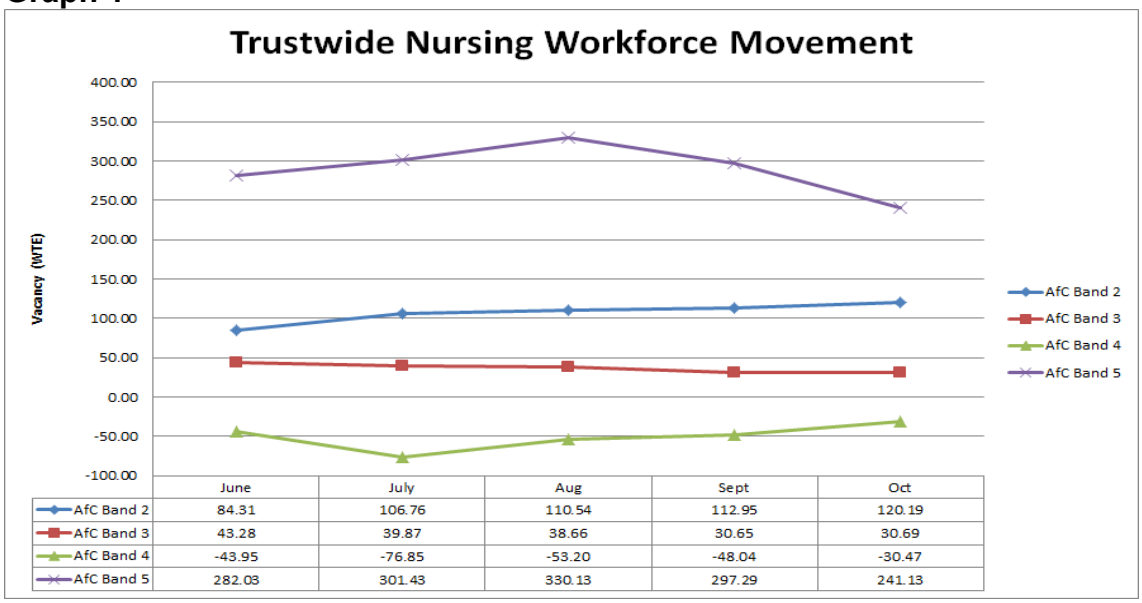
responsible for safe staffing and onwards escalation when further mitigation is required to the Chief Nurse and Deputies.

The hospitals have been reconfigured on more than one occasion to enable the safe zoning of patients into blue, amber, or green areas, depending on their COVID status which has led to a change in the ward reconfiguration across both Bristol and Weston sites impacting on nursing staff, many of whom have moved specialty or ward to accommodate these changes. To support staff with these changes, there has been a Trust wide focus on well-being support, with the appointment of more wellbeing staff, consultations with staff in order that they can choose the specialty that they would prefer to work in and investment in nurse and midwifery education, the introduction of Professional Nurse advocates and further Practice Education Facilitator roles which are in place throughout the Trust.
It is hoped that all of this additional investment will start to enhance the retention of staff.

Vacancies:

The current vacancy level of Registered Nurses continues to be a risk in ensuring that all areas are safely staffed and is a factor considered carefully when opening additional bed capacity.
In August 2021, the percentage of Band 5 Registered Nurses vacancies across the Trust peaked at 330 wte (17%), however as predicted in September the impact of the international nurses obtaining their registrations and moving from band 4 to band 5 posts along with the annual newly qualified nurses commencing has started to take effect. The number of vacancies by Division over the past 5 months has seen the highest numbers in both the divisions of Medicine and Weston.

Graph 1

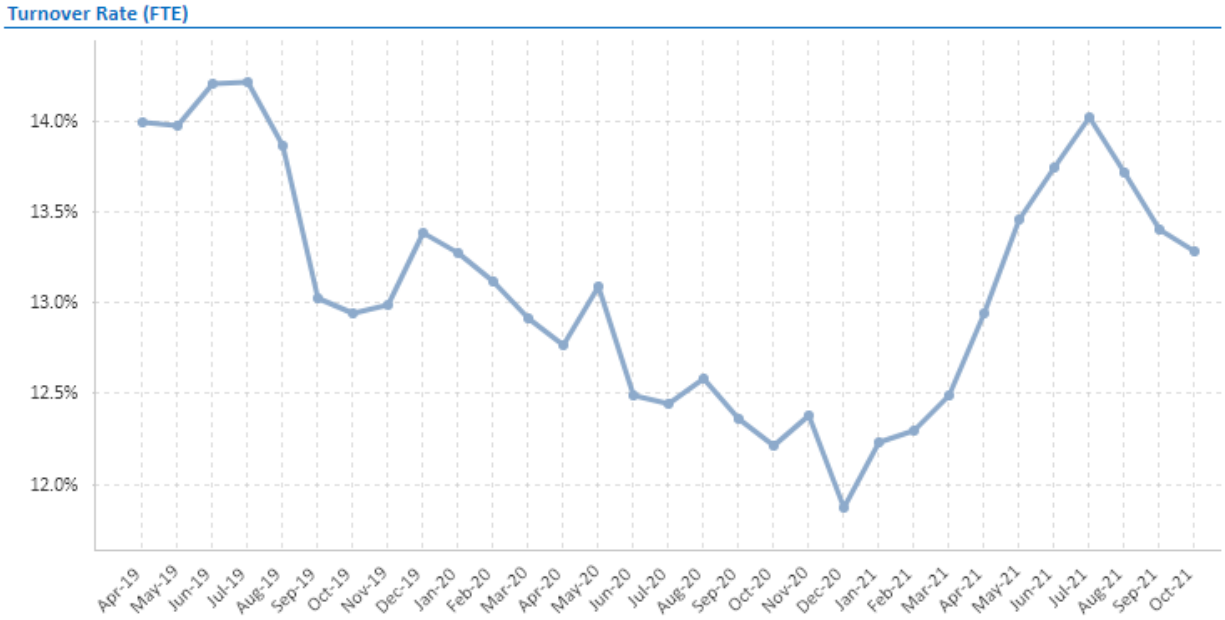


	June	July	Aug	Sept	Oct
AfC Band 2	84.31	106.76	110.54	112.95	120.19
AfC Band 3	43.28	39.87	38.66	30.65	30.69
AfC Band 4	-43.95	-76.85	-53.20	-48.04	-30.47
AfC Band 5	282.03	301.43	330.13	297.29	241.13

The Trust has continued to prioritise at pace improving the vacancy position using a variety of advertising strategies, along with the planned international recruitment. It was evident in July 2021 that the numbers of new starters were going to be insufficient to cover the projected vacancies over the next 8 months; therefore, a further business

case was prepared and approved for an additional 108 International nurses to be recruited along with a plan to recruit 50 Nursing associates who will supplement the future Nursing workforce and enable a more sustainable nursing workforce pipeline. The registered nurse turnover rate also increased and peaked in July at 14% which meant that the reduction in vacancies was challenging to achieve.

Graph 2 Registered nurse turnover



Divisional Staffing reviews

Led by the Deputy Chief Nurse, all the divisional reviews of nursing and midwifery establishments and skill mix took place from July to October. This involved assessment of the workforce against national guidance, review of the risks to safe staffing, understanding and sharing of the Divisional challenges and successes, skill mix assessments and recruitment plans within each of the Divisions to provide assurance for ongoing safe staffing.

All divisions reported on the challenges and toll of ensuring that staff well-being was supported throughout the past year with the fact that most areas were consistently working understaffed on every shift. To mitigate the shortages, the Ward sisters have been working within the staffing numbers on the wards on a regular basis with more support from Clinical nurse specialists and other non-ward-based staff required to ensure safety. The strength of leadership by the ward sisters and matrons was consistently celebrated by the Heads of Nursing along with the role of the Practice Education Facilitators which were introduced across the Trust; these have been instrumental in supporting the new ward staff, international nurses and providing stability to the substantive ward staff.

Wards

Specific challenges remain in the wards where the ratios of Registered nurse to patient have needed to be stretched at times, particularly within the Divisions of Medicine and Weston, when due to sickness, vacancies, and the inability to fill shifts with temporary staff several wards are functioning as ‘red risk’ rated. When this occurs an

assessment by the Head of Nursing takes place and is escalated through to the Chief Nurse and deputies if mitigation and safe staffing cannot be achieved. Staff are encouraged to also complete safe staffing incident reports.
The balance of ensuring safe staffing across all areas including the requirement at times to open escalation capacity is closely watched and is not opened unless the staffing position enables this to happen.

Emergency Departments

The adult emergency departments on both Bristol and Weston sites have seen increased numbers of patients attending the departments, with patients having to remain in ambulances and queuing within the departments, this has required additional staffing to ensure safety is maintained for these patients.
The Children's Hospital emergency department has seen unprecedented numbers of attendances over the past few months and an early surge of RSV coupled with increasing numbers of children suffering from Mental Health conditions and cases of COVID which has led to a pressurised department, requiring a review of the current environment and staffing numbers needed.
The staffing within all these areas will continue to be managed closely by the heads of nursing flexing as required dependent on the numbers of patients within the departments, there has been some temporary changes in staffing made which will be kept under review.

Intensive Care units

All the adult Intensive Care Units (ICU's) have been working closely together to manage the COVID surges and the requirements to maintain elective recovery activity as much as possible. All units are funded in line with the Guidelines for the Provision of Intensive Care services (GPICS) however experienced nationally there has been a requirement to work to a surge model of staffing at times when one to one Nursing care is not able to be provided with the current nursing workload supply. The surge staffing Standard Operating Procedure has been co created with the nurse leaders of the units. During the earlier waves of the pandemic the Paediatric Intensive Care unit was able to provide additional staff to the adult ICU's , however they have now also witnessed an early surge in RSV as predicted nationally and the winter staffing plan which is always pre planned had to be enacted over the summer months. This has been challenging whilst waiting for the newly registered staff to start, and with the current level of vacancy within the Children's Hospital.

The following changes have taken place as part of the divisional reviews:

Division	Service	WTE
Women's	**Maternity:** no further increases in the past 6 months, however in view of increases in acuity, the impact of the continuity of care model and the complexity of mothers being cared for; a Birth rate plus review is underway and the outcome of this is awaited. **Women's**: Gynaecology practice education facilitator post	Band 6 0.6 wte
Specialised Services	Review of all areas took place during staffing review, no further changes required in the past 8 months	

Surgery	Review of all areas took place during staffing review, there are some wards in different locations with different bed bases which are being managed in line with overarching Trust principles for safe staffing. In line with the operating plan there was an increase in bed base on Surgical Assessment Unit where additional staffing has been approved.	Band 2 – 5.2wte Band 5 – 5.2wte Band 7 – 0.6wte
Medicine	Review of all areas took place during staffing review with no changes to establishments required in the past 8 months. Further changes in specialty wards have very recently changed and staffing will continue to be monitored closely should any changes be required. Temporary changes within the Emergency Department have been required: • 1 additional RN has been increased across both day and night shifts to provide additional cover and maintain safety in managing and supporting the ambulance queue	Band 5- 5.2 wte
Weston	Temporary changes in the nurse staffing with the Emergency Department establishment have been approved to include the following: • Nursing Assistants (NA's) have been increased from 3 to 5 NA's per long day shift, and from 1 to 2 NA's on the Twilight shift. • 1 additional RN has been increased for the late shift and twilight shift to oversee patients in the queue / ambulance bay. As patients are remaining in these areas for a lengthy period, they need an RN to administer medications, and professional overview. Kewstoke ward use has recently changed its specialty and a new workforce model has been drafted for review, this will be formally approved when full and final implementation is planned.	Band 2-7.91 wte Band 5–3.84 wte
Children's	Review of all areas took place during the staffing review , some temporary changes in support roles for the wards (e.g increase in outreach nurses , emergency department mental health practitioners and paediatric vascular access roles have been approved and the benefits and impact of these will be evaluated at the next staffing review .	

2.2 **Allied Healthcare Professionals (AHPs)**

In line with service changes and to support some Covid recovery work there have been some changes to establishments agreed. The current vacancy rate for AHP's trust wide for September 2021 is 3.2%.

The changes are seen overleaf:

Division	Service	WTE
Women and Children	**Paediatric Dietetics** Band 7 neurosciences Band 7 community (temporary 1 year-Sept 2021-2022) **Speech and Language Therapist** Band 6 neurosciences	 Band 7 - 0.7 wte Band 7 –1.0 wte Band 6 –0.5 wte

3.0 Principles of Safe Staffing for General Inpatient Wards

The principle for the ratio of registered to unregistered nurses across UHBW adult inpatient areas has been set based on a 60:40 ratio, registered nurse to nursing assistant in general inpatient areas. This will be higher in some specialist ward areas due to the increasing complexity of care, for example medication regimes and the number of intravenous drugs given and increased dependency and complexity of elderly patients being admitted.

For the ratio of number of patients per nurse when setting wards establishment and skill mix, UHBW uses the principles of one registered nurse to 6 patients on a day shift and one registered nurse to 8 patients on a night shift.

The ratio of registered to unregistered staff for UHBW for adult inpatient areas continues to range between 50:50 on some care of the elderly wards and 90:10 for some critical care areas. Where the ratio of registered nurses is less than 60% this is based on the professional judgment of the senior nurses and supported by patient acuity and dependency scoring.

For wards and departments that have specialty specific safe staffing guidance the divisional staffing reviews have confirmed that the Trust is compliant with the relevant guidance/ recommendations.

The Trust uses the Allocate SafeCare module to capture live acuity and dependency however the use of this also requires a refocus now that some of the ward numbers and changes have stablised. The e-rostering team is in the process of rebasing the wards and the clinical teams are engaged as part of the planned Trust wide refocus.

4.0 Regulatory requests for staffing information

There was a Trust Care Quality Commission (CQC) inspection in June 2021 covering the Medical Division on the Bristol Site, and both Medical services and Outpatients services on the Weston Site.
One of the regulatory requirements identified specifically relating to nurse staffing was:

CQC inspection (June 2021)	Weston Medical	(Must do)	Ensure that there are enough nursing staff, with the right skills to meet patients' needs at all times. Regulation 18 (1) Staffing.

The Trust has been providing weekly assurance to the CQC and meeting as part of the regular engagement meetings to update on the recruitment, retention and staffing plans for the nursing staff at Weston.

The Trust has undertaken an assessment against the Royal College of Nursing (RCN) workforce standards (2021)[6], these standards set out the detailed expectations of employers, regulators and organisations to support nurses' work and patient safety. The standards do not define specific models or tools of nursing workforce planning and the standards should be used alongside established practice or setting specific guidance.

Initial completion of the assessment identified compliance with 36 of the 42 standards. The remaining 6 were identified as being partially met with further actions required over the next 6 months. These will continue to be monitored through the Non-medical workforce planning group.

5.0 How do we get our assurance of safe staffing over the last six months?

National Quality Board (NQB) Expectations: A triangulated approach to Staffing decisions

The NQB three expectations (right staff, right skills, right place, and time) support an approach to determining safe staffing levels based on patients' needs, acuity and risks, monitored from 'ward to board'. This triangulated approach to staffing decisions, rather than making judgements based solely on numbers or ratios and staff to patients, is supported by the CQC.

5.1 **Nursing and Midwifery**

The Trust continues to submit monthly returns to the Department of Health via the NHS national staffing return. This return details the overall Trust position on actual hours worked versus expected hours worked for all inpatient areas, the percentage fill rate for Registered Nurses (RN) and Nursing Assistants (NA) for day and night shifts, together with the overall Trust percentage fill rate. This includes care hours per patient per day (CHPPD).

A detailed report on nurse staffing is received and reviewed monthly at the Quality and Outcomes Committee, a Non-Executive sub-committee of the Board. This report gives a detailed breakdown of any staffing variances by ward/department and Division. It includes detailed information regarding any NICE (2014)[7] staffing red flags that have been reported, the reasons and any actions that have been taken.
The graph and table below (Fig 1) show 6 monthly staffing fill rates for inpatient ward areas.

Key issues to note:

- The total average fill rate for RN and NA staffing has remained within the green threshold over 95% for only 4 months in this period (April, May, June and August). The likely reason for the August level was due to the accelerator pay enhancement rate being in place all month.

[6] RCN Workforce Standards | Publications | Royal College of Nursing
[7] Overview | Safe staffing for nursing in adult inpatient wards in acute hospitals | Guidance | NICE

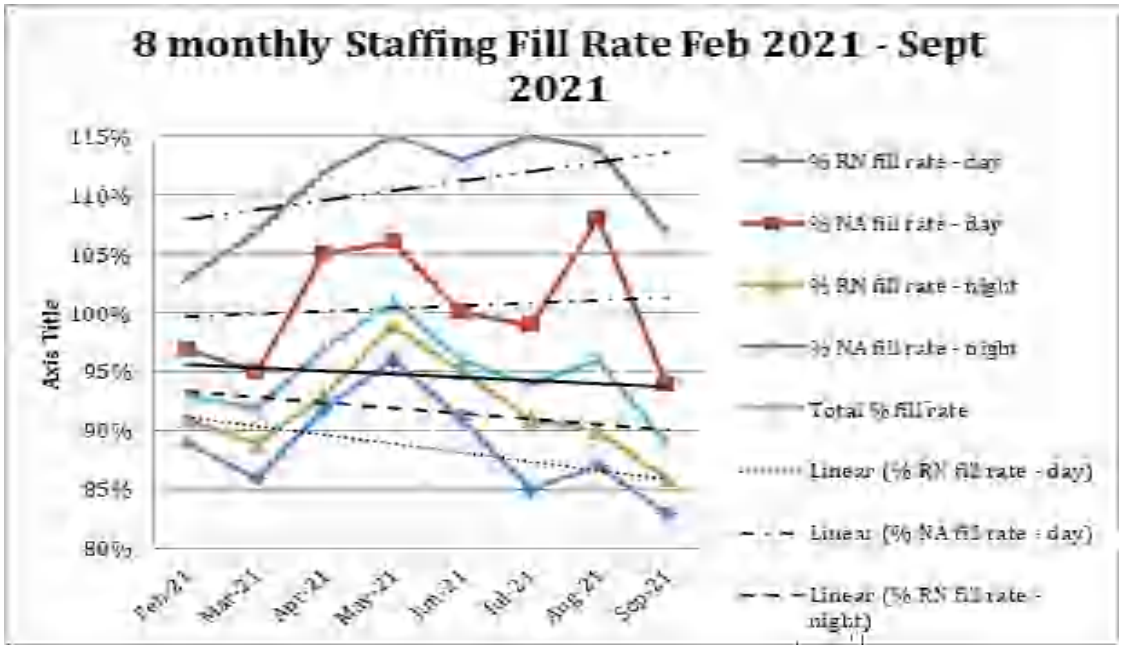
- The average RN Day fill rate for the Trust has remained just below 90% for the period. In April May and June as the COVID rate fell within the Community and the Trust the % fill rate increased. Since July it has been challenging maintaining consistent staff levels above 85% due to vacancies, sickness and Covid absence and planned staff leave.

- The average RN night fill rate follows a similar pattern as the day fill rate; however, it has been maintained above 90% for the majority of months. There has been the occasional dip below (February and September) The overall fill rate for RNs at night has not exceeded 100% in any month.

- The average NA Day fill rate has also increased to just above 100% in most months. These shifts have been easier to fill than RN shifts. September was a challenging month for NA staffing due to staff absence, leave and Covid absence. This has previously trended above 100% in all months.

- The NA night fill rate continues to be consistently above the planned staffing levels for nights. This is driven by the requirement to cover most of the Enhanced Care Observation assignments due to having less staff on duty at night. The fill rate above 100% has been maintained through this 8-month period.

Fig.1



RAG rating for Fill Rate	Red	Amber	Green	Blue
Thresholds **(75% is the national red flag level)**	< 75%	76%- 89%	90%-100%	101%>

UHBW Trust Position	% RN fill rate - day	% NA fill rate - day	% RN fill rate - night	% NA fill rate - night	Total % fill rate
Feb-21	89%	97%	91%	103%	93%
Mar-21	86%	95%	89%	107%	92%
Apr-21	92%	105%	93%	112%	97%
May-21	96%	106%	99%	115%	101%
Jun-21	91%	100%	95%	113%	96%
Jul-21	85%	99%	91%	115%	94%
Aug-21	87%	108%	90%	114%	96%
Sep-21	83%	94%	86%	107%	89%
Trust 8 month Average	89%	101%	92%	111%	95%

Note: the red rating has been set at 75% to be in line with the national guidance that states that:

- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 33 hours of registered nurse time, a red flag event would occur if 5:45 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).

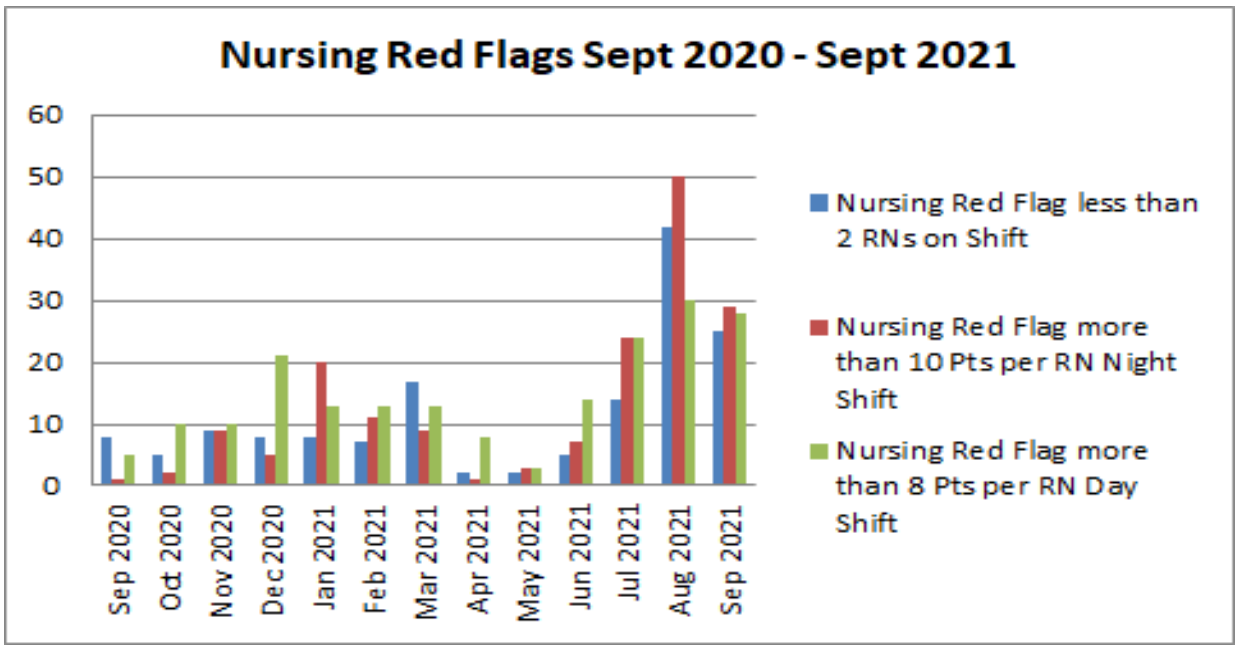
5.2 **Red Flags**

The combined UHBW red flag incident (fig 2) reporting commenced from April 2020.

- The number of reported red flag incidents across all in patient wards for this period (8 months) was 381, compared to 156 in the previous 8 months (see Fig 2). This shows a 244% increase in reporting. Many of these red flags incidents (more than 10 patients per RN night shift / more than 8 patients per RN day) were reported in the last 3 months. There is a red flag reporting facility for staff when they have concerns that there will be less than 2 RN's per shift. Those reported have all been reviewed and mitigated in real time by the matron to ensure that no ward is then left with less than 2 RN's on shift.

- It should be noted that there has been an increase in the number of reported Red flag incidents as the nurse staffing numbers were reduced during the waves of the pandemic.

Fig. 2



The two most common themes identified through a review of the reported red flags in the last eight months were:

- Unfilled staffing gaps where the Trust was unable to secure a temporary staff member to cover at short notice due to Covid related absence. This included shifts escalated to Tier 4 agencies. In this situation the Trust Standard Operating Procedure for ensuring safe staffing was followed.

- Staff have been very flexible by moving from ward areas to care for patients in other areas of the Trust. The requirement to continue this with the increased levels of vacancy and sickness/Covid absence has made managing safe staffing exceedingly difficult. This movement of staff is always risk assessed by the Heads of Nursing/on call/site management teams and staff are moved to minimize, as much as possible, risks balanced in staffing levels in other areas.

Staff Experience and Feedback

Staff are encouraged to feedback on staffing through a variety of means, these include alerting and discussing these with their line manager, vis freedom to speak up ambassadors, reporting via the Datix incident reporting system, opportunities for feedback through increased visibility of senior nursing and midwifery staff and Executives and the Chief Nurse engagement session with staff at Weston. Updates to staff on the number of newly registered nurses and the international nurses starting were well received and hearing a commitment that staffing to the planned numbers remains a priority for the Trust.

5.3 **Weighted Activity Unit (WAU) and Care Hours per Patient Day (CHPPD) (see appendix two for definitions)**

5.3.1 Weighted Activity Unit (WAU)

Nursing and Midwifery

The graphs below (fig 3) show the total staff cost for UHBW nursing and midwifery staff per Weighted Activity Unit. It should be noted however, that this remains the latest information available on the Model Hospital dashboard. This metric includes both substantive and temporary staff.

For the financial year 2019 – 2020 Bristol and Weston are now combined (fig 3) and UHBW sits in quartile 1 (best) for cost per WAU. For Bristol this shows a slight increase £819 up from £812 from the previous report and Weston a decrease for £1127. This means that the UHBW spends less on staff per unit of activity than a number of Trusts both nationally and within our peer group (Trust Size -Clinical Output).

Fig. 3 **April 19- Mar 20 Weighted Activity Unit Data – UHBW**

Allied Healthcare Professionals (AHPs)

For the financial year 2019 – 2020 Bristol (fig 4) sits in quartile 2 (This is the latest data set available).

E-Rostering is in place for a number of AHP teams, this will now be extended to all AHP and HealthCare Scientists as part of the main AHP e-Rostering rollout

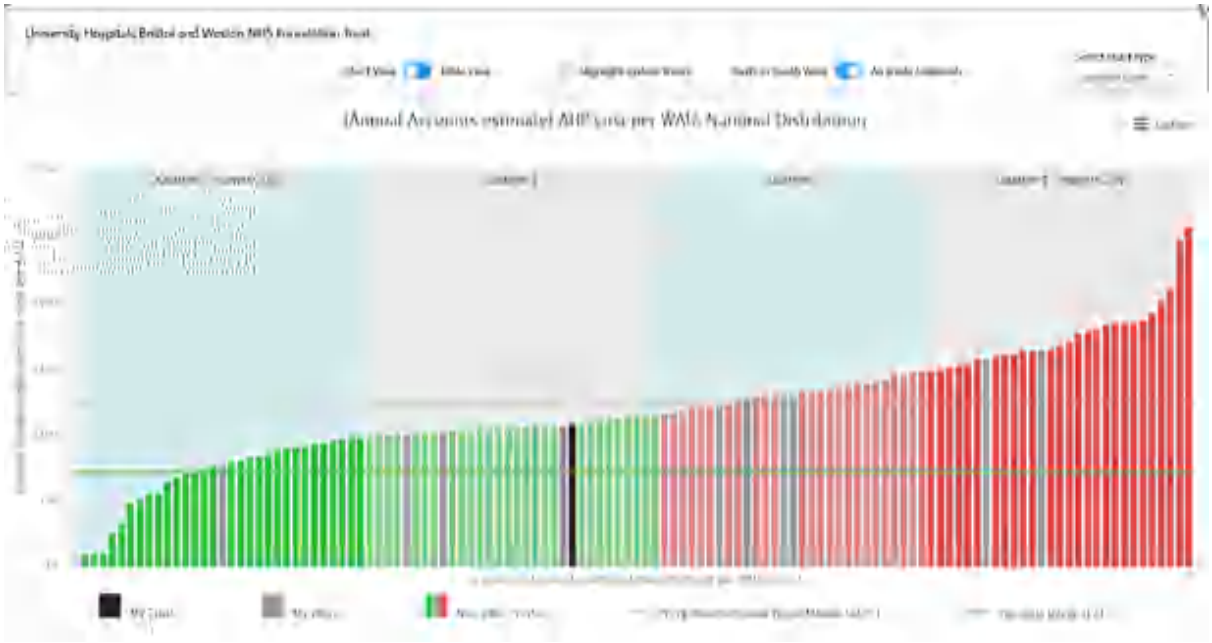
Those that are now on the system now include:

- All Adult Physiotherapists, Occupational Therapists, Dieticians and Speech and Language Therapists within the Diagnostics and Therapies Division.
- Adult Radiology including MRI and Radiotherapy – Bristol site

In line with NHS Improvement levels of attainment work mandating all clinical teams are on e-Rostering by 2021, a capital bid has been successful to extend e-Rostering to all the other AHP groups and the revenue costs will now be included in the divisional operating plans for 2022/23.

This will provide improved reporting on AHP activity and resource management and will be included in the next 6 monthly staffing report.

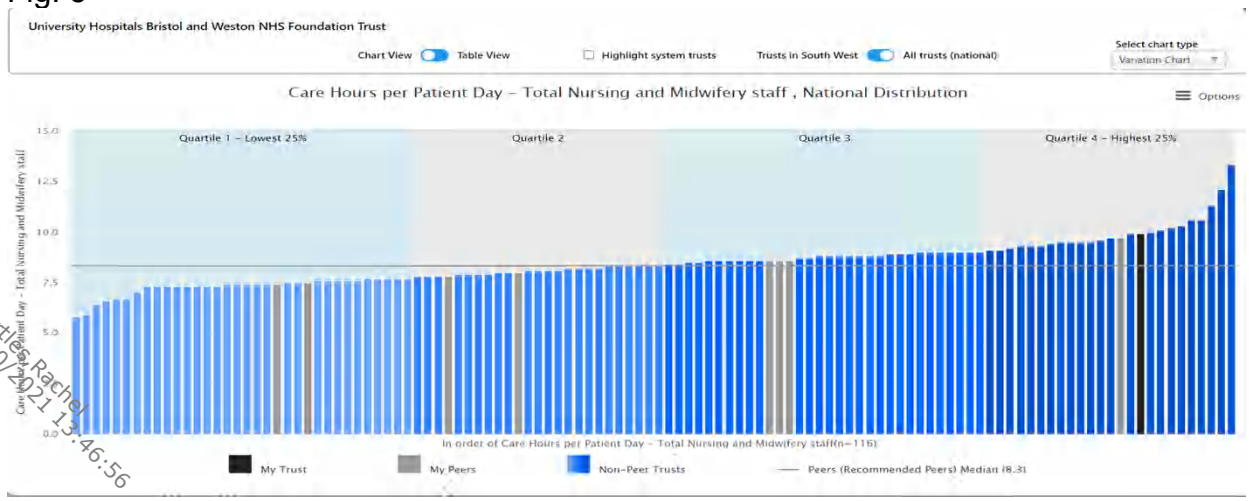
Fig. 4 - **April 19- Mar 20 Weighted Activity Unit Data – UHBW**



5.3.2 <u>Nursing Care Hours per Patient per Day (CHPPD)</u>

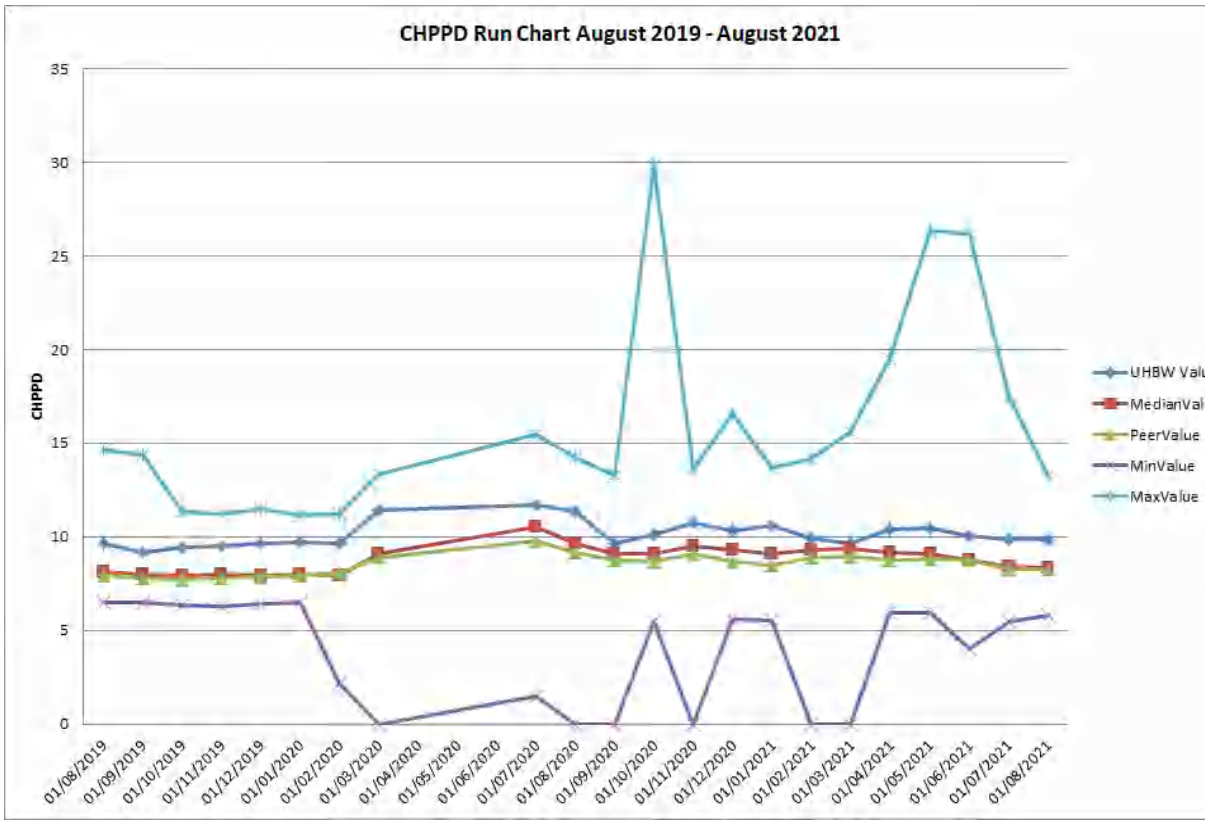
The graph below (fig 5) for August 2021 shows that UHBW CHPPD, sits above the national mean and that of the model hospital peer group giving assurance that the Trust has maintained safe levels of staffing. This figure also needs to be considered alongside the WAU productivity measure and the Trust's performance against quality and workforce metrics to give a clear picture of impact.

Fig. 5



The Model Hospital updates were halted during the initial COVID-19 lockdown and restarted in August 2020.The run chart (Fig 6) illustrates the impact of Covid across the Trust, peer group and National median, all showing changes in the last 8 months as they have had to adapt to significant changes in working practices and staffing levels. Although the Trust CHPPD sits above the Peer and National Median level it compares favorably and it tracks a similar picture.

Fig. 6 - **CHPPD August 2019 – August 2021 – Bristol, (Weston is included from 1st April 2020)**



6.0 Staffing Risks held on the corporate risk registers

6.1 **Nursing and Midwifery**

There is one nursing workforce related risk on the corporate risk register relating to nurse staffing.

This is the 'Risk that nurse staffing levels will not be met' and with the mitigations currently in place it continues to be rated at 12. This risk will continue to be reviewed through the Non-Medical workforce planning group.

Several nurse staffing risks are held by the divisions which are reviewed regularly at Divisional Board meetings, on a rotational basis at the Trust Risk Management Group and were reviewed at the recent Divisional staffing reviews.

6.2 **Allied Healthcare Professionals (AHPs)**

There are no AHP staffing risks on the corporate risk register. A number of AHP staffing risks are held by divisions which are reviewed regularly at Divisional Board meetings and on a rotational basis at the Trust Risk Management Group.

7.0 Performance against key quality metrics.

The Trust level quality performance dashboard for Safety and Caring domains over the last eight months are reported below in Fig 7, with more detailed review monthly within each Division, through to the clinical quality group and triangulated through the monthly detailed safe staffing report to the Quality and Outcomes committee.

Fig.7 - **Integrated Performance report for Safe and Caring domains**

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
SAFE DOMAIN

NHS University Hospitals Bristol and Weston NHS Foundation Trust

ID	Measure	20/21	21/22 YTD	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3
Infection Control																			
DA01	MRSA Hospital Onset Cases	4	1	0	0	1	0	0	0	0	0	1	0	0	0	1	0	1	0
DA02	MSSA Hospital Onset Cases	45	24	3	6	5	9	2	4	5	4	0	4	3	4	16	13	7	4
DA03	CDiff Hospital Onset Cases	67	57	7	6	5	2	5	8	11	14	7	4	6	7	12	33	17	7
DA03A	CDiff Healthcare Associated Cases	81	66	8	6	6	2	7	9	13	16	9	4	7	8	15	38	20	8
DA06	EColi Hospital Onset Cases	81	44	4	4	9	6	14	5	5	5	5	8	8	8	29	15	21	8
Patient Falls																			
AB01	Falls Per 1,000 Beddays	5.14	4.57	5.18	5.9	4.88	5.72	4.94	4.7	4.02	4.38	4.58	4.68	4.84	4.78	5	4.36	4.7	4.78
	Numerator (Falls)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Denominator (Beddays)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
AB06A	Total Number of Patient Falls Resulting in Harm	22	15	3	1	3	3	2	5	1	2	4	4	2	1	8	8	10	1
Pressure Injuries																			
DE01	Pressure Injuries Per 1,000 Beddays	0.279	0.143	0.274	0.138	0.318	0.26	0.228	0.135	0.064	0.121	0.127	0.225	0.132	0.186	0.268	0.109	0.161	0.186
	Numerator (Pressure Injuries)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Denominator (Beddays)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
DE02	Pressure Injuries - Grade 2	87	25	8	4	8	7	7	4	1	3	4	5	3	5	22	8	12	5
DE03	Pressure Injuries - Grade 3	5	5	0	0	1	0	0	0	1	1	0	2	1	0	1	2	3	0
DE04	Pressure Injuries - Grade 4	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Serious Incidents																			
S02	Number of Serious Incidents Reported	109	56	10	5	11	8	10	7	9	5	12	4	9	6	29	25	25	6
S01	Total Never Events	6	3	2	0	0	0	0	1	0	0	1	0	1	0	0	1	2	0
Medication Errors																			
WA01	Medication Incidents Resulting in Harm	0.25%	0.17%	0.37%	0.83%	0%	0%	0.37%	0%	0.33%	0%	0%	0.35%	0.35%	-	0.13%	0.11%	0.22%	-
	Numerator (Incidents Resulting in Harm)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Denominator (Total Incidents)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
WA03	Non-Purposeful Omitted Doses of the Listed Critical Medicati	0.46%	0.31%	0.68%	0.36%	1.43%	0.13%	0.35%	0%	0%	0.6%	0%	0.33%	1.1%	0.44%	0.48%	0.22%	0.41%	0.44%
	Numerator (Number of Incidents)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Denominator (Total Number)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
CARING DOMAIN

NHS University Hospitals Bristol and Weston

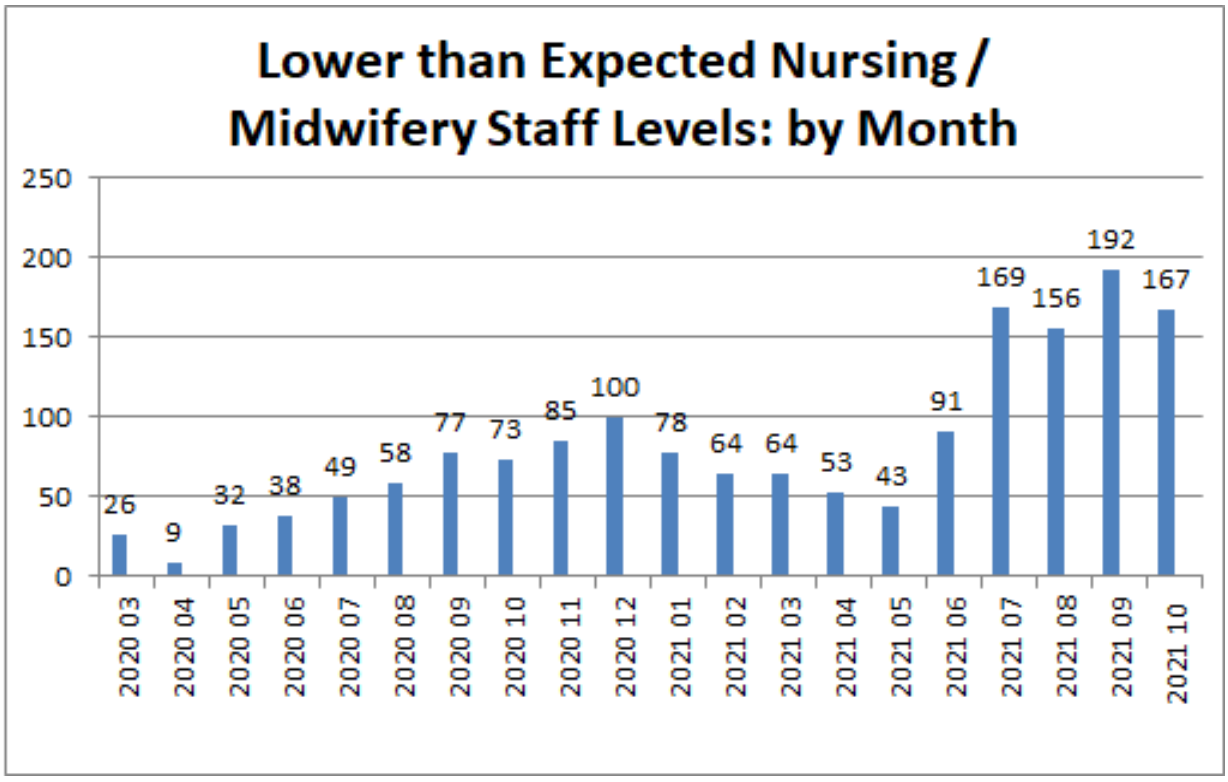
ID	Measure	20/21	21/22 YTD	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3
Patient Surveys (Bristol)																			
P01D	Patient Survey (Bristol) - Patient Experience Tracker Score	#N/A	#N/A	88	92	91	92	90	89	93	89	88	88	89	88	91	90	89	88
P01G	Patient Survey (Bristol) - Kindness and Understanding	#N/A	#N/A	93	95	97	96	95	93	97	95	95	94	95	94	96	95	94	94
P01H	Patient Survey (Bristol) - Outpatient Tracker Score	#N/A	#N/A	94	93	94	94	95	89	93	94	92	90	94	93	94	95	92	93
Patient Surveys (Weston)																			
P02D	Patient Survey (Weston) - Patient Experience Tracker Score	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	84	89	94	92	91	93	94	#N/A	84	92	94
P02G	Patient Survey (Weston) - Kindness and Understanding	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	92	92	95	90	91	92	90	#N/A	91	91	90
P02H	Patient Survey (Weston) - Outpatient Tracker Score	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	90	94	85	90	92	88	93	#N/A	89	90	95
Patient Complaints (Number Received)																			
T01	Number of Patient Complaints	1665	1178	176	115	186	149	145	124	176	160	158	174	198	193	426	466	505	193
T01C	Patient Complaints - Formal	546	292	65	28	49	32	43	49	46	51	50	85	24	27	124	146	119	27
T01D	Patient Complaints - Informal	1119	886	111	91	87	113	101	75	130	109	108	129	169	166	302	314	404	166

7.1 **Staffing Incidents**

Nursing and Midwifery

The number, content and any themes arising from incidents related to staffing, are reviewed and discussed monthly at the non-medical workforce planning group and via the Divisional Performance and Operational Reviews

Fig. 8



There was a significant increase in reported incidents during June to Sept 2021 due to the impact of vacancies, staff sickness and the continuation of the COVID 19 pandemic on all areas and functions in the Trust.

There has been a significant increase in 'lower than expected staffing incidents' reported since June, with the actual level of harm generally been assessed as near miss to minor actual harm impact, however there were four lower than expected staffing incidents reported that had a moderate level of harm and one major harm. The four moderate harm incidents required re-prioritising of care across the shift to maintain safety. The major harm incident resulted from care being delayed due to the reduced staffing levels. All these incidents were followed up as per the expected governance arrangements in each division.

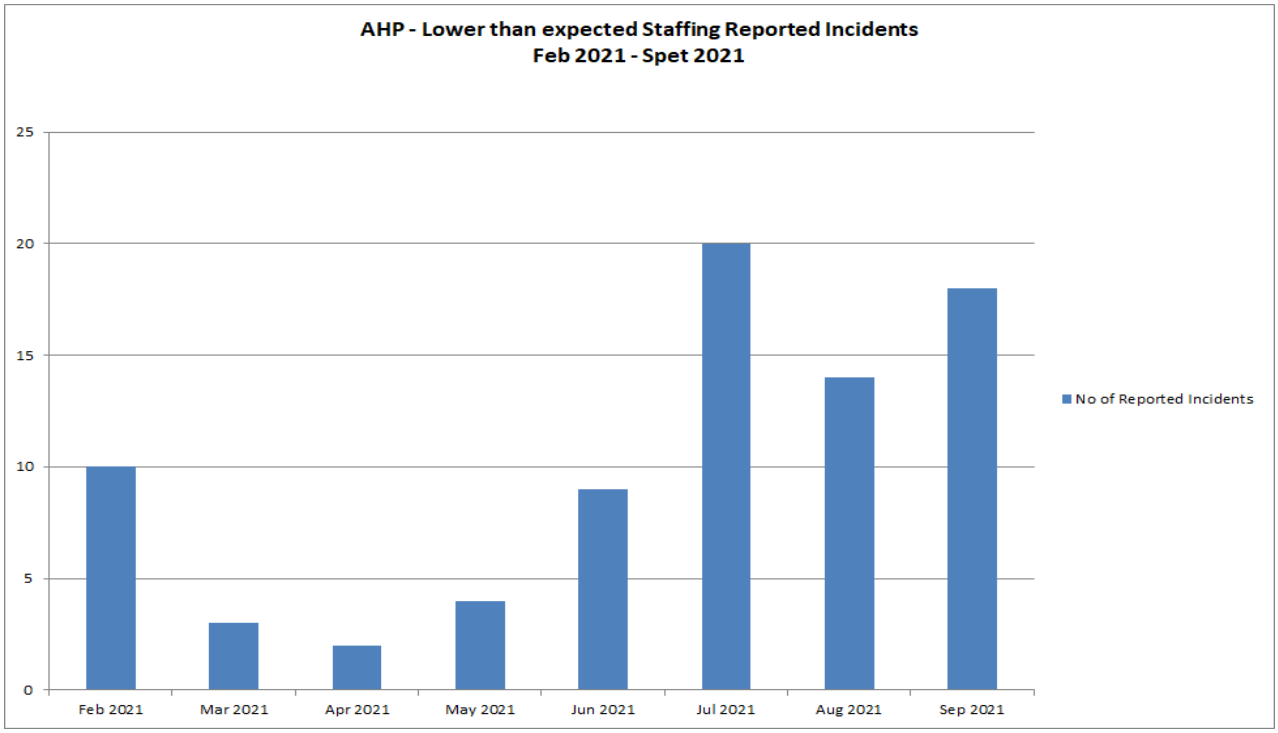
Allied Healthcare Professionals (AHPs)

The number of lower than expected staffing level incidents for AHP's for February 2021 – Sept 2021 was 80, compared to 42 reported between August 2020 to January 2021 is shown in Fig 11.

Where lower than expected staffing forms were submitted, they were assessed as near miss to minor actual harm impact only.

Most reported incidents were due to unforeseen service provision reduction due to the pandemic; this was across the entire AHP workforce.

Fig. 9



8.0 Workforce Planning for the Future

Nursing and Midwifery

The Trust is committed to ensuring that clinical staff have the appropriate training and the right competencies to support the patient care within services. This is supported by a desire to invest in new roles to enhance the current workforce model and in turn ensure that there is a strong workforce plan in place for the future. A newly refocused Non-medical workforce planning group now meets monthly to review the workforce metrics and equally ensure that workforce planning for the future is maintained.

8.1 **Nursing Associates**

The introduction of Nursing Associates aims to bridge the gap between healthcare support workers and registered nurses providing a clear career pathway into the latter role, the role is a registered role with the Nursing and Midwifery Council focussed on supporting Registered Nurses to spend more time using their skills and knowledge to focus on complex clinical duties and leading decisions in the management of patient care.

A business case for 20 Trainee Nursing Associates per year, over 3 years was approved by the Trust Senior Leadership Team in June 2019.

The first cohort commenced their training in October 2019 of which 14 remain on the programme.

The programme was paused across the Bristol, North Somerset and South Gloucestershire (BNSSG) system during the start of the pandemic but has subsequently recommenced. A cohort of 16 started in March 2021 and an active marketing and recruitment campaign was developed ready for the next cohort including some work to support the upskilling of current health care support workers so that they are able to fulfil the excepted entry criteria of the programme for October 2021.

The first cohort of registered Nursing associates will graduate in March 2022, and the scope of practice has now been developed to support their role. In view of the decreasing numbers of available registered nurses and in recognition of the opportunities this role will bring, a further 50 Trainee Nursing Associate places were approved in August 2021. Future funding for these roles will require further review of the staffing skill mix.

8.2 **Nursing Degree Apprenticeships**

Health Education England announced additional national funds for organisations able to support a nursing degree apprenticeship. The funding may go some way toward backfill however, the scale of supernumerary demands of the programme still results in significant affordability questions, the Trust is currently exploring a solution to how this might be progressed to provide an opportunity for suitable applicants currently working within UHBW.

8.3 **Advanced Clinical Practitioners (ACP)**

Over the past 6 months the Trust has set up a steering group to review the current position and progress the implementation of the ACP workforce across the Trust.

Considerable progress has been made through working with Health Education England to ensure that a Trust Readiness document is in place and agreement to go ahead with development of the Trust ACP strategy was presented to the Senior Leadership Meeting in August where it was agreed to progress with a Trust Wide implementation plan, this was further endorsed at the Senior Leadership Team Workforce summit as a key priority and the planning and education for these roles is progressing.

The Trust is also considering other roles within advanced practice including Non-medical Consultant roles in certain specialties which will augment the current workforce model and ensure robust plans for the future.

8.4 **Health Care Support Worker (Nursing Assistants)**

In November 2020, NHS England funding was received to accelerate Healthcare Support Worker (HCSW) recruitment, and to address the ongoing challenges of Covid-19 and winter pressures. The funding aimed to achieve a position of zero vacancies by

end of March 2021 and to support induction, on-boarding of new staff, pastoral support, mentorship and retention.

A significant reduction in vacancies was achieved, the additional funding enabled a team for a fixed term period to be appointed; they are now in place and are starting to make a difference to the previous high turnover rates experienced in this staff group.

There is recognition that more work is needed however to ensure that a clear pathway of progression for staff is in place, the trust has recently reviewed the competencies for Band 3 HCSW who now will be developing skills ensuring role enrichment.
A review of education delivered to the Health Care Support workers has recently taken place to ensure that they are well trained and prepared for the wards and departments that they join.

8.5 **International Recruitment**

The first business case for international nursing across the Trust supported in December 2020 was achieving 100 nurses to arrive in the first year, following a review of the vacancy and recruitment and retention situation the Trust further approved another 108 international nurses to be recruited in August 2021, this has been supported with NHS England funding and these nurses have been recruited and are now planned to arrive by May 2022.

The team of Nursing and Human Resource leads manage the international nursing process, providing pastoral support, ensuring education and preparation for the Objective Structured Clinical examination and a bespoke ‘ward ready’ programme prepares them for joining the wards with more support provided by the clinical digital specialists and the practice education facilitators on the wards and departments.

8.6 **Use of temporary staff**

The Trust has continued to recruit to the staff bank in order to supplement the staffing across all wards and departments. There has been a bank incentive in place since April 2021 for all bank shifts for registered and unregistered nursing staff who undertake an ‘Allocate on Arrival’ shift and a system wide incentive for all staff was in place for a 6-week period when the entire BNSSG system was experiencing extreme staffing shortages with the requirement to isolate due to the Pandemic. The benefits of these incentive schemes are currently under review and evaluation.

The Trust has worked hard to reduce the use of temporary agency staff, however with the volume of vacancies, and increase in demand for temporary staffing there remains increased use, in order to ensure consistency of staff, blocking booking is in place whenever possible until vacancies can be filled. There is still the requirement to use Tier 4 non framework agencies to cover critical shifts.

9.0 Conclusion

Nursing and Midwifery

Reviewing and aligning nursing and midwifery staffing against the care needs of our patients remains a high priority across the Trust.

The last 8 months have been an extraordinarily challenging time due to the pandemic with the Trust reconfiguration of beds and staff adjusting to new environments and teams. There has been an increase in absence due to sickness for both non Covid and Covid related reasons coupled with an increase in turnover and demand for the use of temporary staff.

The Chief Nurse and Divisional Teams have continued to review and monitor both short and long term staffing, skill mix and establishments, in line with UHBW principles for initiating a staffing review and the principles of safe staffing in line with speciality specific guidance/recommendations the 'Developing Workforce Safeguards guidance' and the National COVID staffing recommendations.

The Trust has recognised the importance of staff wellbeing and support throughout the pandemic and has invested using Health Education England money to employ several Practice educator facilitators to work within each Division.

This paper can assure the Board of Directors that UHBW has had sufficient processes and oversight of its staffing arrangements in place to manage safe nursing and midwifery staffing levels. However, the impact of the pandemic on ensuring safe staffing over the past 12 months has presented significant challenge across all staff groups. It is anticipated that the next 6 months will continue with this level of demand on safe staffing along with the requirement to open extra capacity to manage the number of emergency patients and to increase the elective recovery programme.

The next 6 monthly report will also include detailed staffing reports for theatres, outpatients and day case staffing.

Allied Healthcare Professionals

With the information available, this paper can assure the Board of Directors that UHBW has had sufficient oversight of its staffing arrangements to ensure safe AHP staffing levels over the last eight months.

During the pandemic the AHP teams monitored staffing in line with service requirements and as with other professions it was significantly depleted due to Covid related absence. Staff however adapted rapidly and upskilled to support their inpatient and community therapy colleagues and worked alongside nursing staff at the bedside and within the critical care areas.

The level of detail and evidence to assure the Trust of safe staffing for AHP's will significantly increase when e-Rostering is fully rolled out to all AHP staff groups.

10. Recommendations

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 quality.

The Trust Board is recommended to review the safe staffing report and note the following:

- Across the Trust over the past 8 months the Trust has not been able to meet the planned levels of Nursing and midwifery staff on the wards, this has undoubtedly affected staff resilience and staff morale.

- The impact of staffing on patient quality outcomes at ward level will continue to be monitored through the monthly reporting to the Quality and Outcomes Committee.

- The opening of any additional capacity within the Trust will always be balanced against whether it is safe to open these areas based on the availability of safe staffing.

- In order to enable skills development, recruitment and retention of the existing workforce, the Trust should support substantive recruitment of the Practice Education Facilitators posts.

- There will be a continued requirement for Trainee Nursing Associates to augment the Registered Nurse shortfall which continues to occur and it will be necessary to review the numbers of registered nurses in areas in order to facilitate this.

- Subject to business planning there will be on going investment required to support the continuation of the International Nurse recruitment and HR infrastructure in place for the recruitment and retention of this group of staff.

- There is an ambition to support the development of the Registered Nurse Degree apprenticeships which will support training and retention for some of our staff, with identification of funding being progressed.

- Future workforce plans include commitment to and progression of the training of Advanced Clinical Practitioners and the use of Non-Medical Consultants as key roles to ensure that UHBW is prepared for the future NHS workforce plans.

Appendix 1:

University Bristol and Weston NHS Foundation Trust principles for initiating a nurse staffing review (2014)

As a minimum a staffing and skill mix ratio review will be undertaken annually for each clinical area.

OR when there is:

- A significant change in the service e.g. changes of specialty, ward reconfiguration, service transfer.
- A planned significant change in the dependency profile or acuity of patients within a defined clinical area e.g. demonstrated by sustained high acuity/dependency scores or an increased enhanced care requirement.
- A change in profile and number of beds within defined clinical area.
- A change in staffing profile due to long term sickness, maternity leave, other leave or high staff turnover.
- If quality indicators in the key performance indicators a failure to safeguard quality and/or patient safety.
- A Serious Incident (SI) where staffing levels was identified as a significant contributing factor.
- If concerns are raised about staffing levels by patients or staff.
- Evidence from benchmark group that UHBW is an outlier in staffing levels for specific services.

Appendix 2:

Care Hours per Patient Per Day and How it's calculated

CHPPD was developed, tested and adopted by the NHS to provide a single consistent way of recording and reporting deployment of staff on inpatient wards/units. The metric produces a single figure that represents both staffing levels and patient requirements, unlike actual hours alone. The data gives a picture of how staff are deployed and how productively they are used. It is possible to compare a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals. If a wide variation between similar wards is found it is possible to drill down and explore this in more detail.

Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day. This figure is reported monthly to NHSI.

The care hours per patient day required to deliver safer care can vary in response to local conditions, for example the layout of wards or the dependency and care needs of the patient group it serves. Therefore, higher levels of CHPPD may be completely justifiable and reflect the assessed level of acuity and dependency. Lower levels of CHPPD may also reflect organisational efficiencies or innovative staffing deployment models or patient pathways.

Weighted Activity Unit

Weighted Activity Unit (WAU) is defined as a 'common currency' to describe an amount of clinical activity, with a weighting applied that takes account of case mix and complexity. It is used in the Model hospital, following the work under taken by Lord Carter, as a method of viewing NHS operational productivity and comparing this between Trusts.

A WAU is quantity of any types of clinical activity including inpatients, outpatients, diagnostic testing and others. The national average cost is taken of each clinical activity, and divided by 3,500 to say how many WAUs that clinical activity is 'worth'. The national average cost of a procedure comes from reference costs. One WAU equates to £3,500 'worth' of healthcare services.

Slightly different methodologies are used to calculate all staff cost per WAU (weighted activity unit) metrics at trust level and for individual clinical service lines

A simple calculation is used for staff cost per WAU metrics at clinical service line level, using data from ESR (the Electronic Staff Record) for costs:

$$\text{Clinical service line pay cost per WAU} = \frac{\text{Pay cost from ESR}}{\text{Number of WAUs for clinical service line}}$$

Meeting of the Public Board of Directors 30th November 2021

Report Title	**Learning from Deaths**
Report Author	**Mark Callaway Deputy Medical Director, Alice Hillyard Business Manager MD team**
Executive Lead	**Emma Redfern, Interim Medical Director**

1. Report Summary

This report summarises the learning from deaths process for quarters one and two 2021/22

2. Key points to note
(Including decisions taken)

The report describes the structures of the learning from deaths programme across the Trust and introduces the newly embedded Medical Examiner's office.

In addition the number of ME referrals and SRJs requested are included in section 4.0

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

The risks associated with this report include:
See section 7.0:

- No Weston mortality lead in post
- Risk around smooth interface between Medical Examiner and Trust teams

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

- This report is for **APPROVAL**
- The Board is asked to **APPROVE** the report

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

Quality and Outcomes Committee October 2021

1.0 Introduction

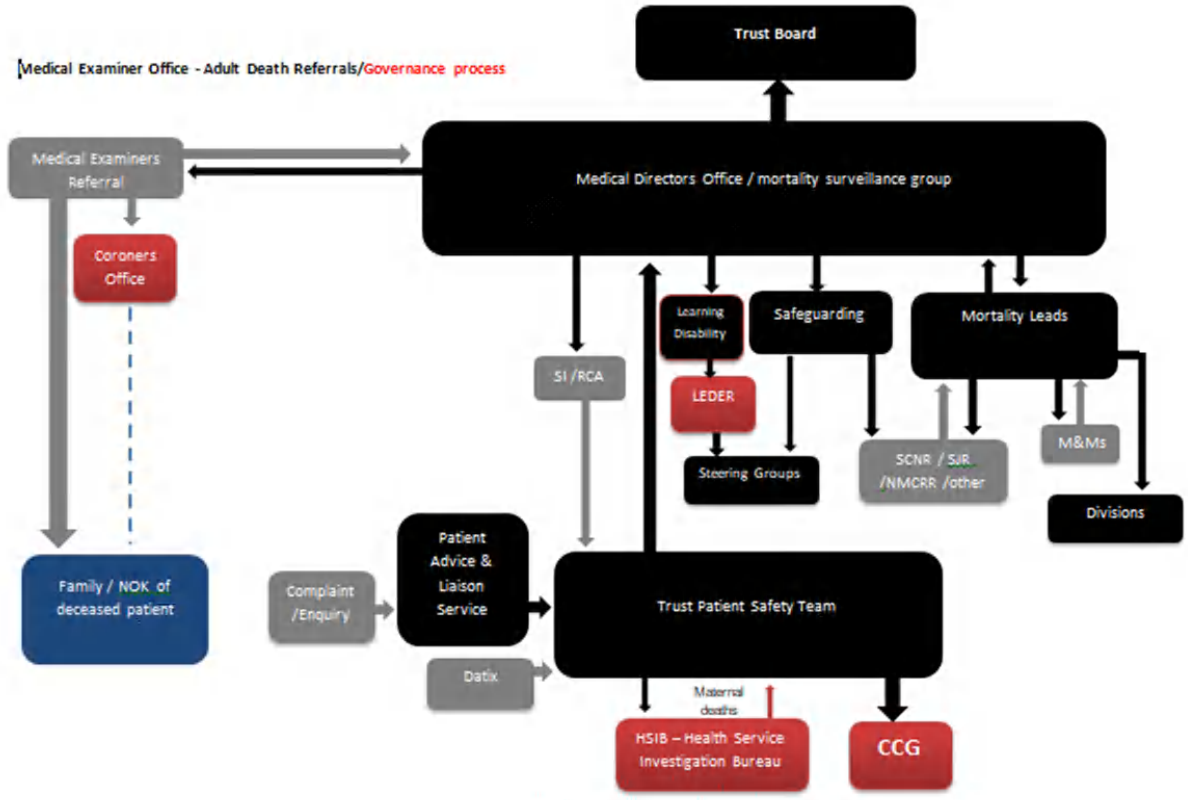
This paper will set out the progress and report on the results of the Trust's "learning from deaths" programme in the first two quarters of 2021/22. This will cover the embedding of the Medical Examiner team within the Trusts processes and the referrals and structured judgement reviews (SJRs) undertaken by the Trust in this period.

This report has been prepared for information.

2.0 Programme Structure

For the first half of the year the programme has continued to be led by Dr Mark Callaway, Deputy Medical Director via the Mortality Surveillance Group which meets monthly. This group is comprised of divisional mortality leads; mental health lead; learning disabilities lead; the Lead Medical Examiner, the Lead Medical Examiner's Officer and the Programme Support Officer.

Fig 1: Learning from deaths process map



3.0 Role of the Medical Examiner

The Medical examiner's office was introduced in the Bristol area in 2020 as part of a national network established as recommended by the Shipman, Mid-Staffordshire and Morecambe Bay public inquiries. The Medical examiners service functions independently of the Trust and has its own governance and reporting to NHS England/ Improvement. This is a newly established service and is not expected to become statutory until April 2022 at the earliest.

The Medical examiners and officers are responsible for:

- Review all adult deaths that occur in hospitals. It is anticipated that the ME team will review paediatric deaths in due course.
- Liaise with stakeholders of the patients who have died including the bereaved families, clinical teams and where necessary the coroner to issue a cause of death certificate if appropriate. If not appropriate then the ME office will refer the death to the coroner.
- Where issues or problems are identified the medical examiner's office should further progress the case as required, by signposting families to the Trust's Patient Support and Complaints Team, the Trusts governance structures or similar.
- It has been locally agreed that the ME Office will contribute to the LFD programme so that learning can be shared and themes identified. As such the lead Medical Examiner and Lead Medical Examiner Officer are invited to attend the Mortality Surveillance Group.

The Medical examiner's office "went live" during 2020/2021 but due to COVID and delays in appointments was up to full capacity by February 2021.

Furthermore the Learning from Deaths policy has been updated to reflect the role of the Medical Examiner and is in the process of being ratified.

4.0 Referrals to Mortality Group

Quarter 1 2021/22	
Referrals from ME Office	**44**
Referrals meeting SJR criteria	**23**
Referrals for SJR by division Medicine Surgery Specialised Services Women and Children Weston	 **6** **2** **2** **1** **12**
Total number of deaths Bristol Medicine Surgery Specialised Services Women and Children Weston	**260** 138 31 72 19 123

Quarter 2 2021/22	
Referrals from ME Office	**57**
Referrals meeting SJR criteria	**25**
Referrals for SJR by division Medicine Surgery Specialised Services Weston Learning disabilities / Mental health	 **3** **2** **2** **17** **6**
Total number of deaths Medicine Surgery	**337** 220 38

Specialised Services Women and Children Weston	64 16 130

5.0 Harm Panels and other COVID work

COVID-19 death harm panels were held in May and August and the conclusions of these meetings have been reported to previous QOCs.

Two cases have been escalated to the coroner by Dr Callaway of patients who died in the spring of 2020 (wave one Weston COVID deaths) where the Trust has been unable to identify a lead clinician for each patient. The Trust are awaiting a decision as to whether the coroner will wish to pursue any further actions in relation to these.

Further to a formal internal investigation the Trust is also exploring whether to refer two further cases to the coroner from the same outbreak for the same reasons.

6.0 Analysis:

The number of SJRs identified is lower than in previous quarters, although the numbers of deaths was also lower than in the corresponding quarters of 2020/21 which is surprising considering that the Trust was undertaking less elective activity at that time.

Percentage of deaths referred for SJRs in quarter one:
BRI 11/260 = **4.2%**
Weston 12/123 = **9.8%**

BRI 13/337 = **3.6%**
Weston 17/130 = **13.1%**

The lower volume of cases where concerns have been raised will be likely caused by the implementation of the new screening system led by the medical examiner's office.

As identified above the proportion of deaths that required an SJR was significantly higher in the division of Weston than in the other divisions.

No deaths were reported as avoidable in quarter one following an SJR, quarter two SJRs and still being undertaken.

7.0 Risks

There is currently no mortality lead identified for Weston division. This is of particular concern, as Weston is responsible for a disproportionately high percentage of the SJRs that should be carried out. The completion of these reviews is a statutory requirement. This post has been discussed with Alison Edwards, Clinical Chair but is one of several governance roles that the division have been unable to fill.

There are further risks associated with the integration of the Medical Examiners processes whilst maintaining the two teams' independence from each other. As the structures have different governance processes and reporting there is a risk that patients will be missed or teams will not communicate with each other effectively. A recent example of this is on the

Weston site where there was a coinciding period where there was no bereavement or ME presence onsite. This caused huge challenges for the mortuary team. A meeting has been established to resolve this.

8.0 Conclusions and Future work

As of 1st October 2021 Dr Mark Callaway has stepped down from his role as Deputy Medical Director at the Trust and relinquished his role as Trust mortality lead. A new Associate Medical Director for Patient Safety has been appointed and it has been agreed that morality and learning from deaths will form part of her portfolio. Dr Rebecca Thorpe will commence in post on 1st November and lead the programme from this point.

The Committee is requested to note the above report and its contents.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public 30th November 2021

Report Title	**Research & Innovation summary report**
Report Author	**David Wynick**
Executive Lead	**Emma Redfern, Interim Medical Director**

1. Report Summary	
The purpose of this report is to provide an update on performance and governance for the Board	
2. Key points to note *(Including decisions taken)*	
See executive summary in report.	
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**	
The risks associated with this report include: N/A	
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **Information.**	
5. History of the paper **Please include details of where paper has previously been received.**	
[Name of Committee/Group/Board]	**[Insert Date paper was received]**
N/A	**N/A**

Recommendation Definitions:

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

Executive Summary

During the reporting period we have focused efforts on reopening previously suspended research (or closing them where no longer feasible to continue) and currently only 10% of the previously suspended 449 research studies remain suspended. This is a fantastic achievement and testament to the hard work and commitment of our research staff. Our current priorities are to continue to support the vitally important COVID-19 research whilst also increasing our recruitment into non-COVID trials to approaching pre-pandemic levels. Supporting our research workforce and keeping them well and in work is critical at this point, particularly in the light of the clinical pressures which are impacting on our ability to set up and deliver our research commitments.

COVID-19 Research Update:

Participation in a range of important COVID-19 trials has had tangible impacts on the way COVID is managed in the UK and worldwide.

Results from our sponsored trial, ComFluCov have shown that Influenza and COVID vaccines can be given safely at the same time and with no drop in efficacy, and this has guided national policy on vaccinations as we approach winter. Successful delivery of this multicentre trial is a testament to our medical research leadership and close collaborative working with the University of Bristol (Bristol Trials Centre) and colleagues across multiple departments within the Trust.

The RECOVERY trial has continued recruiting at both Bristol and Weston, and there has been a range of arms introduced to test potential treatments for COVID. Going into the winter, patients with influenza will also now be recruited alongside COVID patients, who might be admitted with either or both viruses.

HEAL-COVID is a trial looking at treatments to help alleviate the longer term consequences of COVID. Bristol and Weston combined recruitment to HEAL-COVID is highest in the country, and we have recruited 8% of all patients nationally.

REMAP-CAP is a trial for any patient critically ill with COVID-19 on the wards or in ITU. We have recruited 125 patients out of a total 5149 from the UK, and are 6th highest UK recruiter overall, and the highest recruiter for ward patients. The ward domain was initiated in the first wave, a tremendous achievement.

For these treatment trials there is embedded medical leadership of this research in the divisions, and we have introduced associate principal investigators (PI), which underpins training of new PIs and increased recruitment.

Performance: Current total recruitment into trials is exceeding previous years due to a single trial (AVONCAP) which is recruiting patients with Community Acquired Pneumonia, including COVID-19 patients. Recruitment excluding this trial is at lower levels than in previous years. Commercial income is noticeably high due to the number of vaccine trials delivered at UHBW.

Funding: Bids for NIHR Bristol Clinical Research Facility and Bristol Biomedical Research Centre have been submitted with outcomes expected at end of January and May 2022, respectively.

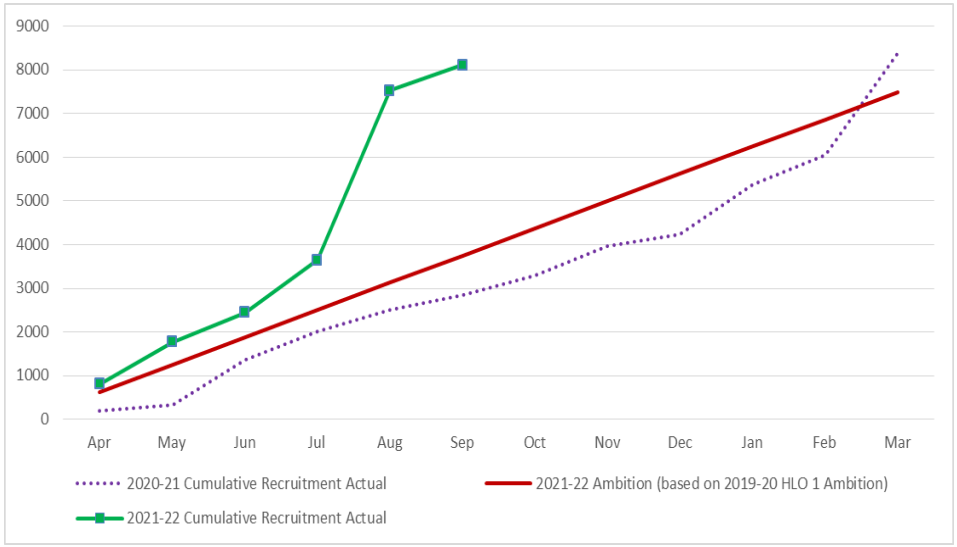
Overview

Successes	Priorities
• UHBW currently has 27 Associate PIs under the scheme run by the NIHR. Feedback has been really positive with APIs being key in increasing recruitment. • UHBW sponsored trial ComFluCov paper has been published in the Lancet: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02329-1/fulltext and has influenced policy makers decision on administering COVID boosters simultaneously with flu vaccine.	• Continue to deliver Urgent Public Health trials to support further vaccine development and treatment against COVID-19 • Work with the NIHR to reopen all previously suspended non COVID research in a managed way under the national Recovery, Resilience and Growth programme • Capture our baseline performance in recruiting participants with wide ranging backgrounds as part of our equality, diversity and inclusion work stream, and work with our partners to increase the proportion of participants from minority social and ethnic groups.
Opportunities	**Risks and Threats**
• Support the research team at Weston to increase research activity and align ways of working. Line management of the Weston team, who can support research in any adult specialty, has moved to corporate R&I under the Research Matron. • Strengthening links with Digital Services will allow us to explore more efficient ways of using data to support research	• Further COVID -19 surge would put at risk our ability to successfully reopen non-COVID research • Clinical services stretched due to backlog and accommodating social distancing measures, reducing the opportunity to deliver research. • Fatigued research workforce who have worked tirelessly through the pandemic and have had no time for recovery.

Performance Overview

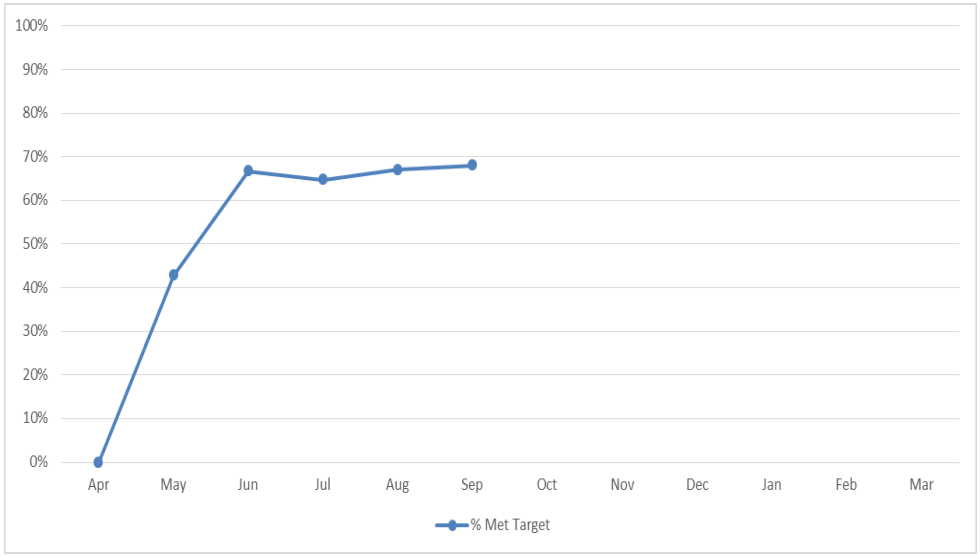
This section provides information about performance against key performance indicators. All KPIs are financial or drive the income we receive.

a) Cumulative Recruitment to Commercial and Non-Commercial NIHR Studies

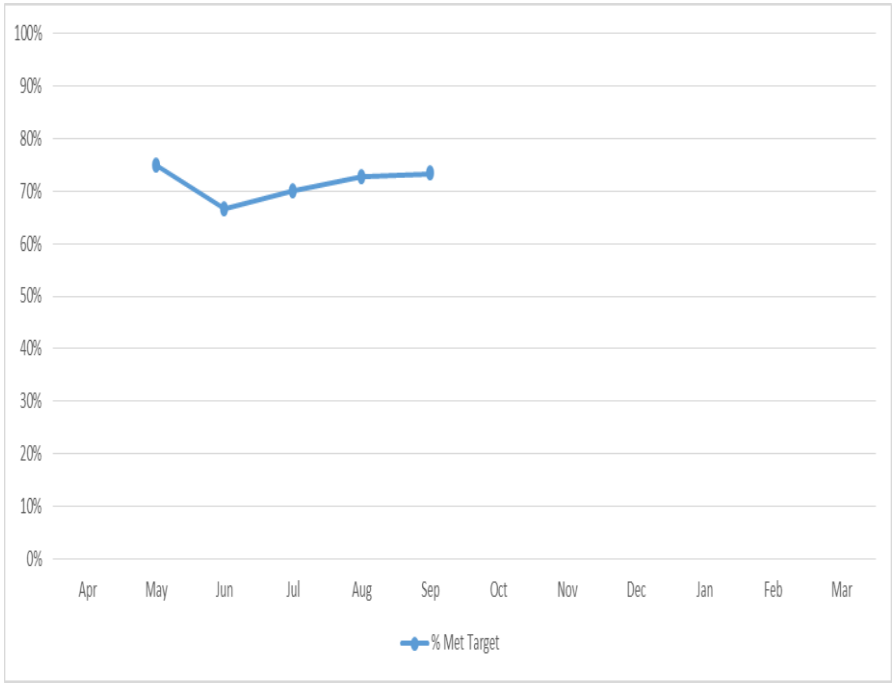


High recruiting study called AVONCAP accounts for 71% recruitment activity.

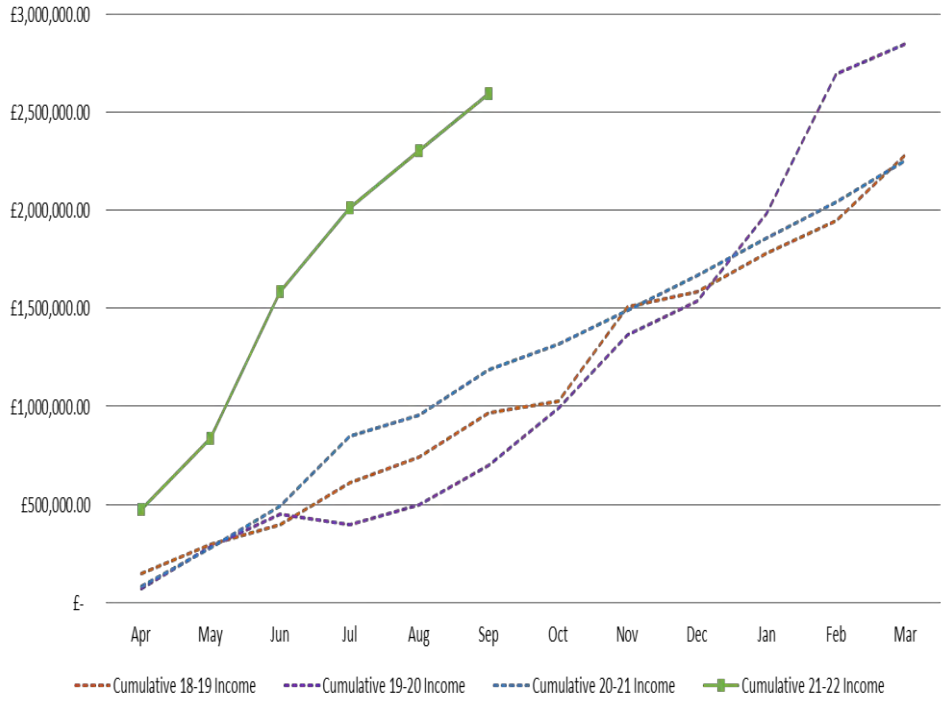
b) Proportion of closed non-commercial NIHR studies achieving or surpassing their recruitment target



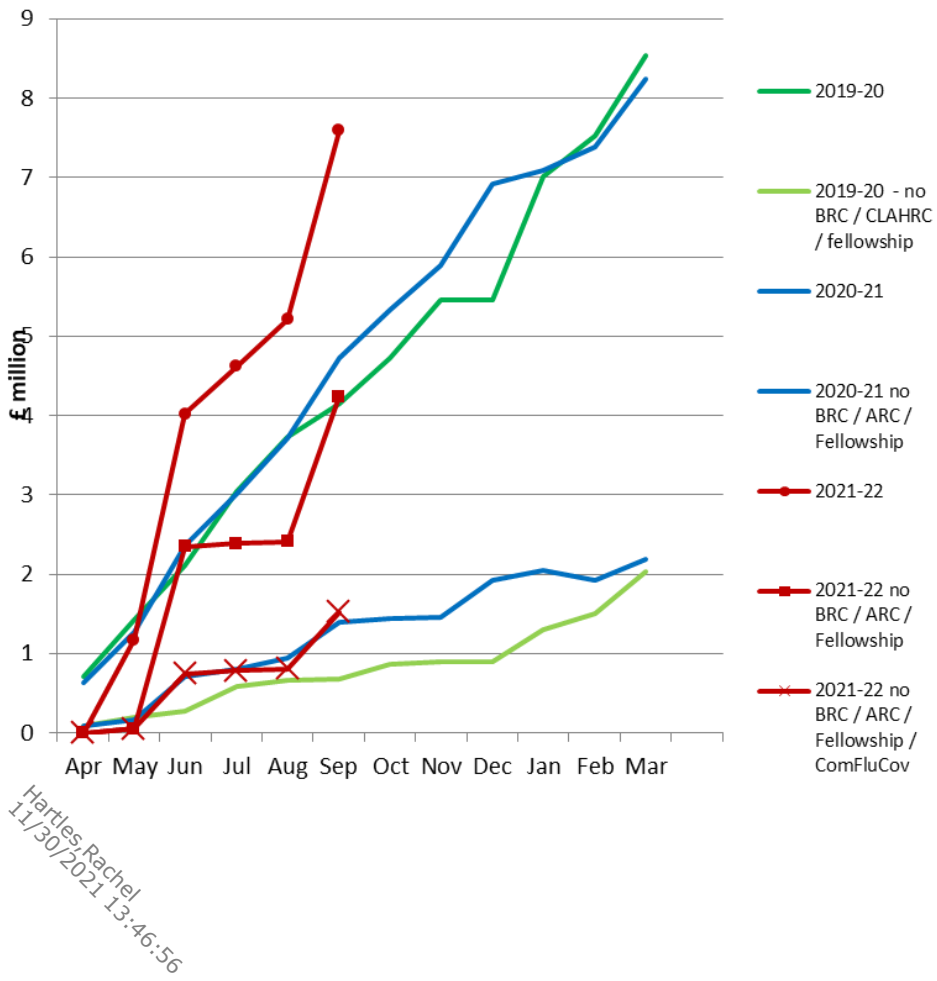
c) Proportion of closed commercial NIHR studies achieving or surpassing their recruitment target



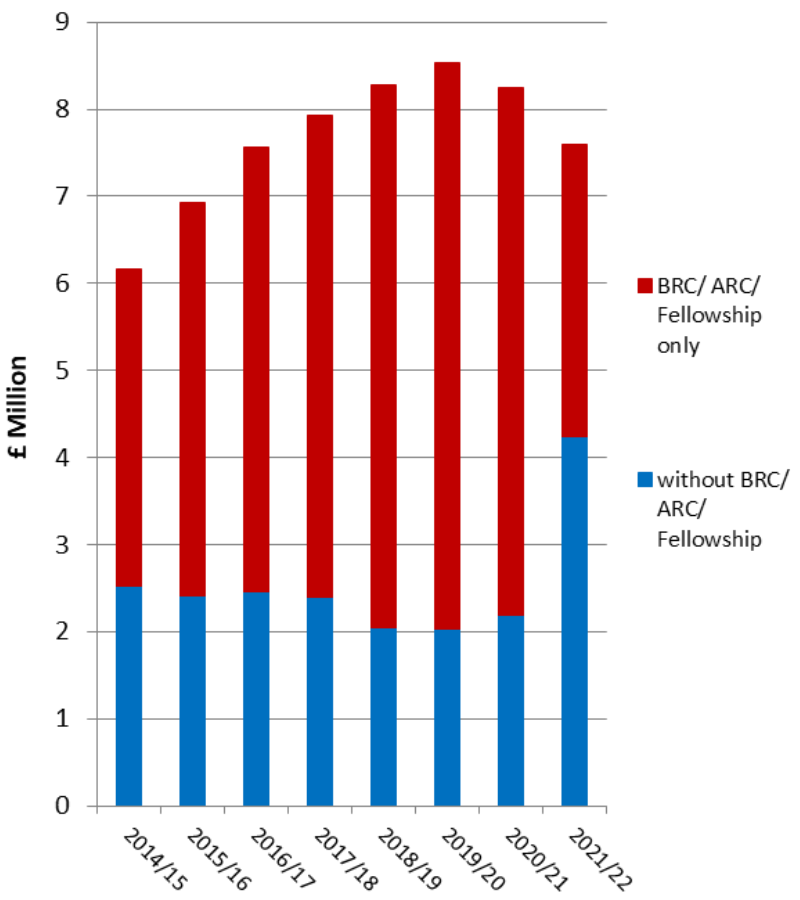
d) Monthly commercial income



e) NIHR monthly grant income – year on year comparison



f) NIHR grant income – drives research capability funding



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Meeting of the Board of Directors on 30 November 2021

Reporting Committee	**People Committee**
Chaired By	**Bernard Galton, Non-Executive Director**
Executive Lead	**Alex Nestor, Interim Director of People**

For Information

The Committee considered the key people performance metrics focusing on recruitment and retention. The successful overseas recruitment programme was acknowledged and the pipeline of further staff joining the Trust was noted. There were delays noted for some overseas staff to receive either PIN, which was then delaying their ability to start in post.

The successful menopause conference was noted which had received very positive feedback from the 160 people who had attended.

The Black History Month online event in October also saw nearly 100 people attend to share stories and information, and aligned with the “proud to be black” photo art exhibition in both Bristol and Weston.

The work to improve compliance with mandatory training was discussed and actions to address were noted.

Progress to deliver the Trust’s Transformation, Improvement & Innovation Strategy was received for the first two quarters of the year. Although good progress had been made, the expansion of the Quality Improvement (QI) Bronze and Silver courses was behind plan due to operational pressures affecting staff availability. However proposed work to implement a new continuous improvement programme would help create a culture of ‘everyday’ improvement across all our staff groups.

For Board Awareness, Action or Response

Following the launch of the new Trust values on Monday 17 November, the Committee received a presentation describing the approach to embedding the new values. This included the executive video launch, welcomes briefing for all divisions, a comprehensive communications plan including leaflets and guides to support understanding of the values and associated behaviours. Values training was to be rolled out to all staff, and a realignment of the leadership and management development offer to align with the new values.

Following discussions at the Quality and Outcomes Committee, the People Committee have agreed to lead on the oversight of staff vaccination performance and assurance around the proposed changes to mandatory vaccinations. Metrics would be included in the Integrated Quality and Performance Report related to both flu and Covid vaccination performance.

Key Decisions and Actions

The Committee agreed to monitor staff vaccination rates, focusing on flu and covid vaccinations.

Additional Chair Comments	
Date of next meeting:	**25 January 2022**

University Hospitals Bristol and Weston NHS Foundation Trust

Staff Values and Leadership Behaviours Immersion briefing

Aims

University Hospitals Bristol and Weston NHS Foundation Trust

- Introduce the new Staff Values and Leadership Behaviours
- Present the roll-out plan and clarify your leadership role in making this successful
- Introduce the resources for Values and Leadership Behaviours

How we got here...

University Hospitals Bristol and Weston NHS Foundation Trust

OUR RESEARCH

ALL STAFF FOCUS GROUPS

19 SESSIONS TO LISTEN AND TEST

117 ATTENDEES INCLUDING WESTON, CLINICAL AND NON-CLINICAL

FIVE SENIOR WORKSHOPS

- GOVERNORS
- CLINICAL CHAIRS
- DIVISIONAL DIRECTORS
- HEADS OF NURSING
- SET-UP WORKSHOP

NINE SENIOR LEADER 1:1 INTERVIEWS

- JEFF FARRAR
- ROBERT WOOLLEY
- BILL OLDFIELD
- RHONA THOMAS
- JAYNE MEE
- ERIC SANDERS
- DEIDRE FOWLER
- MARK SMITH
- PAULA CLARKE

TWO SURVEYS

3,230 COMPLETIONS

22 QUESTIONS

- WHAT 'IT'S LIKE' TODAY, WHAT'S WANTED IN FUTURE?
- WHICH VALUES AND LEADERSHIP BEHAVIOURS WOULD YOU CHOOSE?

VALUES VOTING

2,096 VOTED

53% CLINICAL

47% NON-CLINICAL

DESKTOP RESEARCH

INSIDE

- 2025 STRATEGY
- CURRENT VALUES
- UHB LEADER BEHAVIOURS
- COMMS STRATEGIES
- 2020 STAFF SURVEY
- CO-CREATE RECO'S

OUTSIDE

- KINGS TRUST – IMPROVING NHS CULTURE AND CASE STUDIES
- PRESS REPORTS

5,396

staff across clinical and non clinical roles and all divisions.

A reliable representation of the full workforce.

We are

supportive

We're always there for each other.
We try and do the right thing for patients and colleagues everyday.

We are

respectful

We always look for the best in people.
We are inclusive, welcoming and treat everybody fairly.

We are

innovative

We're full of bright ideas.
We're open to using research, learning and finding new ways of working.

We are

collaborative

We do things together. We share our experience and expertise for the benefit of the Trust and our communities.

Leadership Behaviours

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	our values – It's who we are	We are supportive	We are respectful	We are innovative	We are collaborative
LEADERSHIP BEHAVIOUR THEMES	Lead by example	Put staff first	Enable openness and accountability	Show strategic and agile leadership	Harness difference and togetherness
STRATEGIC IMPACT	• Sets the standard for a strong, open and trusting community within all leadership groups	• Promotes a culture that puts staff first, and enables everyone to contribute to it	• Builds the Trust's ability to listen, be inclusive and welcome challenge	• Continuously improves processes in response to changing demands on the Trust	• Highlights local contributions as a source of Trust-wide pride and recognition
IMPACT ON OTHERS	• Promotes an environment of belonging, where all staff feel welcome and valued • Demonstrates best-practice care, where all decisions are based on evidence and strive for better outcomes for staff and patients	• Puts the staff experience and their development at the heart of everything we do, because quality care depends on staff wellbeing • Shows care and curiosity in all interactions with staff (especially in times of change and adversity) and is visible and approachable • Supports everyone in contributing to the success of the Trust as a whole, not just their own jobs	• Creates safe space to discuss and evaluate how work has gone, what can be learned and improved on • Sets clear goals and gives feedback to support continuous improvement • Sees the team as individuals, and values the skills and knowledge they offer	• Encourages all staff to use evidence and try new ways of working to learn and grow and deliver better patient experiences and care • Inspires others - guided by the Trust's vision and purpose - and in doing so presents change as necessary and positive • Promotes organisational learning for the benefit of all staff	• Encourages others to work together and treat each other fairly across all divisions and teams • Seeks different views when making decisions, especially from people who might be affected by potential outcomes • Encourages staff with different roles, skills, and experiences to work together, promoting diversity of thought, learning and innovation • Recognises and celebrates the contributions different divisions and teams make to the Trust-wide vision
PERSONAL IMPACT	• Gathers regular feedback from different people / teams to ensure standards are being met • Models the Trust's values • Stays calm under pressure and keeps focus on shared goals	• Considers the direct and indirect impact that decisions and behaviours have on others • Shows empathy and respect for everyone – in words and actions • Puts outcomes for all staff and patients before self-interest	• Demonstrates open, honest and respectful conversations • Leads the way in speaking up if something is wrong • Makes personal commitments to improve the Trust, and keeps everyone informed of your progress	• Thinks strategically, anticipating and adapting to future trends and changing patient needs • Explores new ways of meeting changing demands placed on the Trust • Open to trying new ideas and approaches, believing that even those that do not work still help us to learn and improve	• Actively seeks out and listens to opinions from everyone • Creates opportunities to collaborate so that different perspectives inform decision-making

University Hospitals Bristol and Weston NHS Foundation Trust

Roll-out Plan

Twelve Month Immersion Plan

University Hospitals Bristol and Weston NHS Foundation Trust

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Inform and Energise

'I get this and I am excited about the future'

University Hospitals Bristol and Weston NHS Foundation Trust

Immersion plan commences with the 'tease' campaign November 15th for one week.

Full launch of the Staff Values and Leadership Behaviours commences 22nd November and includes:

- Executive launch video
- Welcome briefing pack containing all resources delivered to divisions
- Communications across all networks to be utilised

Key dates for leadership immersion:

- Chief Executive Leadership Briefing either 8th/9th December (awaiting confirmation)
- 10th November 2021: Trust Governors
- 24th November 2021: Executive Team
- 26th November 2021: People Committee
- 1st December 2021: Senior Leadership Team
- 9th December 2021: Staff-side briefing

Inform and Energise

'I get this and I am excited about the future'

University Hospitals Bristol and Weston NHS Foundation Trust

Leaders immersion

As well as resources provided in the Welcome pack leaders will have available:

- **Leadership Behaviours leaflet:** for quick reference to use daily
- **Leadership Behaviours Guide**: an introduction to UHBW's leadership behaviours to help you explore and understand your impact on each behaviour and how they link to our values
- **Leadership Behaviours: your toolkit for leading the way** - to help explore the values and leadership behaviours through self-directed learning
- **Leaders Connected**: an interactive leadership development portal will also be launched on 25th November and will support the 'inform' and 'convince' stage of the roll-out plan

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Inform and Energise

‘I get this and I am excited about the future’

University Hospitals Bristol and Weston NHS Foundation Trust

Divisional Immersion

Divisional Directors, Clinical Chairs and HR Business Partners are developing local plans to ensure the immersion of the Staff Values and Leadership Behaviours locally, this will include:

- Briefing at Divisional Boards
- Divisional Workforce and OD committees
- Staff Networks
- Team Meetings
- Values training sessions

Divisional updates will be provided monthly and communicated out to the organisation as part of the ‘inform and energise’ phase.

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Inform and Energise

'I get this and I am excited about the future'

University Hospitals Bristol and Weston NHS Foundation Trust

Staff Immersion

Immersion resources provided for staff will be:

- **Values Training:** available both virtually and face to face, please book using Kallidus- we have two 30 minute sessions running each week until the end of March

- **Values and Behaviour resources available on HR Web and Connect :** these are designed for supporting the embedding of our Values and include, values appreciation cards, posters and bite-size videos.

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Resources

Leadership Behaviours Resources

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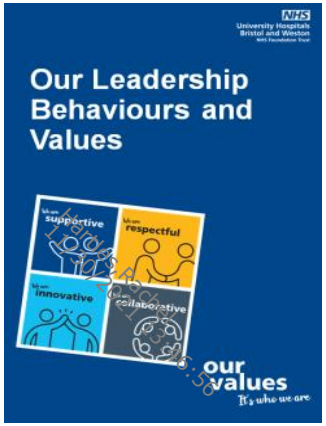
- **Leadership Behaviours leaflet:** quick reference guide
- **Leadership Behaviours Guide:** your introduction to UHBW's leadership behaviours to help you explore and understand your impact on each behaviour and how they link to our values
- **Leadership Behaviours: your toolkit for leading the way** - to help you explore the values and leadership behaviours through self-directed learning



Cascade Resources

University Hospitals Bristol and Weston NHS Foundation Trust

- Presentation for Divisional and local cascade
- Bite-size videos for Values and Leadership Behaviours
- All staff training – 50 x 30 minute sessions bookable via Kallidus
- HRWeb Values page update to contain all resources
- Poster pack delivered to divisions includes:
  - Posters
  - Leadership behaviours leaflets
  - Stickers
  - Values appreciation card

Convince- The plan for 2022

'I see the link between the Values and my role'

University Hospitals Bristol and Weston NHS Foundation Trust

The plan for 2022 will include:

- Continuation of Values training
- Alignment and revision of our leadership and management development offer
- Utilising the Leaders Connected platform to promote the Values and Leadership Behaviours
- Building links to Values by sharing stories and Values appreciation examples across our communication channels
- Design and develop our appraisal conversation framework linking Values and Leadership Behaviours
- Integrating our recognition offer bringing the Values to life

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our values

It's who we are

We are supportive

We are respectful

We are innovative

We are collaborative

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Meeting of the Public Board of Directors on 30th November 2021

Report Title	**Diversity and Inclusion Report/WRES and WDES Action Plan Bi-annual Equality, Diversity & Inclusion Integrated Performance Report (April 2021 to Sept 2021)**
Report Author	**Harjinder Bahra Workforce Equality, Diversity and Inclusion Manager**
Executive Lead	**Alex Nestor – Interim Director of People**

1. Report Summary

The Trust has produced its second bi-annual equality, diversity and inclusion integrated performance report covering the period from April 2021 to Sept 2021. The purpose of the bi-annual report is to ensure that the Trust has developed a robust assurance and delivery plan that mitigates risk on compliance with our public sector equally duty across all protected characteristics and responding to findings from staff surveys, Equality Delivery System (EDS2), Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap.

The second bi-annual report sets-out Q1 & Q2 corporate and divisional progress against the Trust's 2021/2022 EDI strategic action plan.

The report also integrates the WRES & WDES 2021 report and action plan.

2. Key points to note
(Including decisions taken)

The Trust Board is asked to receive the report for assurance and ratification.

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

The risks associated with this report include:
Risk 285: (Risk of non-compliance with the Public Sector Equality Duties and equalities legislation resulting in reputational damage.)

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

- This report is for **ASSURANCE and RATIFICATION**

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

EDI Steering Group	**30 Sept 2021**
People Committee	**26 Nov 2021**

"The publication of the second bi-annual EDI integrated performance report, continues to show that we are making good progress on the Trust five-year diversity and inclusion strategy.

In September 2021, the whole Trust Board engaged in an equality, diversity and inclusion workshop with reinforced leadership and commitment to deliver on our ambitious mission and vision to be an exemplar Trust in equality, diversity and inclusion.

I am also particularly proud to see the launch of our EDI Advocates Programme, which we hope will encourage a new and meaningful way of engaging with colleagues from across all protected characteristics."

Alex Nestor, Interim Director of People

University Hospitals Bristol and Weston NHS Foundation Trust

Workforce Equality, Diversity and Inclusion (EDI)

Bi-annual Integrated Equality, Diversity and Inclusion Performance Report (April 2021 – September 2021)

DRAFT (30/09/2021)

Report sign-off pathway and glossary

Report author - Harjinder Bahra, Trust Equality, Diversity and Inclusion Manager			
Sign-off pathway for the bi-annual EDI integrated performance report			
1	Feedback	EDI Steering Group	30 Sept 2021
2	Assurance	People Committee	26 Nov 2021
3	Ratification	Trust Board	30 Nov 2021

Glossary	
EDI	Equality, Diversity and Inclusion
BAME	Black, Asian and Minority Ethnic
D&I	Diversity and Inclusion
WRES	Workforce Race Equality Standard
EDS2	Equality Delivery System (version 2)
WDES	Workforce Disability Equality Standard
GPG	Gender Pay Gap
BNSSG	Bristol, North Somerset And South Gloucestershire (Systems approach to Healthier Together)

Executive Summary

Our Vision

Our vision is to be '**inclusive in everything we do**'. We aim to do that through a programme of change initiatives that realises the following benefits:

- A culture of inclusion and engagement at University Hospitals Bristol and Weston for all staff
- Valuing and empowering staff to ensure better outcomes for individuals, the organisation and patients
- Ensuring talent is maximised in the organisation
- Our Leadership teams represent the community we serve
- An inclusive approach to development, education and promotion
- Greater innovation; as research shows that diverse teams are more likely to increase organisational effectiveness

Our Ambition

Our ambition is to become an inclusive employer of choice. We aim to achieve this through:

- Leadership and cultural transformation
- Accountability and assurance
- Positive action and practical support
- Monitoring progress and benchmarking

About this report

This is the Trust's second bi-annual equality, diversity and inclusion integrated performance report covering the period April 2021 to September 2021. The report sets out Q1 & Q2 corporate and divisional progress against the Trust's EDI strategic action plan 2021/22.

The purpose of the bi-annual EDI report is to ensure that the Trust has developed a robust assurance and delivery plan that realises our vision and ambition and mitigates risk by:

- Compliance with the public sector equally duty for all protected characteristics
- Responding to findings from staff surveys
- Responding to the Workforce Race Equality Standard (WRES) and adopting the Model Employer Framework and Goals
- Responding to the Workforce Disability Equality Standard (WDES)
- Responding to the People Plan and the people Promise
- Developing and supporting
- Using the Equality Delivery System (EDS2) goals three and four as an organisational cultural of care barometer
- Addressing Gender Pay Gap (GPG)

"Success is the sum of small efforts, repeated day in and day out"

Robert Collier

"Coming together is a beginning; keeping together is progress; working together is success"

Edward Everett Hale

"Success is not measured by what you accomplish, but by the opposition you have encountered, and the courage with which you have maintained the struggle against overwhelming odds."

Orison Swett Marden

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Key successes on Trust EDI action plan

The following slides set-out some of the key successes the Trust has made in the last six months on its five-year EDI strategy.

Committed to inclusion in everything we do

Key Successes

Trust Board EDI Workshop on 17 September 2021

The whole Trust Board engaged in an equality, diversity and inclusion workshop with reinforced leadership and commitment to deliver on our ambitious mission and vision to be an exemplar Trust in equality, diversity and inclusion.

Launch of the EDI Advocates Programme

The Trust EDI Advocates Programme was launched on 13 September 2021. Our aim is to recruit 200 staff over the next 12 months who will be trained and skilled-up to be the cultural change agents at a team, service and divisional level on implementing EDI policy and behaviours.

Microaggressions awareness video

The Trust launched a short awareness video, 'call me by my name' to address microaggressions in the workplace, which has been well received.

Development support for staff networks

Funding has been identified to support the development of staff networks including half-day a week protected time where possible for staff network chairs/co-chairs for six months including the launch of the Trust Women's StaffNetwork.

Inclusive Recruitment Forward Plan

Inclusive Recruitment Forward Plan 2021/22 approved by Senior Leadership Team in July 2021 that incorporates six key actions on inclusive recruitment and promotion identified in the People Plan, Race Disparity Ratio Goals, Dataset Task & Finish Working Group and systems BAME Talent Management Programme and also a proposal to setup a Trust Inclusive Recruitment Task & Finish Working Group.

Representative BAME workforce in resource media

Great response from Trust BAME staff to come forward and be photographed to represent the diversity in our workforce in all Trust resource materials and media platforms.

"When we listen and celebrate what is both common and different, we become wiser, more inclusive, and better as an organisation."

Pat Wadors

"Diversity is being invited to the party. Inclusion is being asked to dance."

Verna Myers

"The NHS needs people to think of themselves as leaders, not because they are personally exceptional, senior or inspirational to others, but because they can see what needs doing and can work with others to do it"

Kings Fund

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Trust EDI Action Plan

The following slides sets out:

- The Trust 5-year Diversity & Inclusion strategic objectives
- The EDI Advocates Programme
- Development of Staff Networks
- Progress on the EDI Action Plan 2021/22

Committed to inclusion in everything we do

The Trust is committed to inclusion in everything we do. This is guided by our Workforce Diversity and Inclusion (D&I) Strategy 2020/25. We are currently in year two of the D&I strategy.

The Trust has a public website which sets out our plans, reports, progress and intentions on EDI which can be viewed at the link below:

https://www.uhbw.nhs.uk/p/about-us/equality-diversity-and-inclusion-edi

Ten Objectives – Diversity & Inclusion Strategy 2020/25

As leaders we role model the Values and Leadership behaviours creating an environment that encourages feedback and where staff feel safe to challenge

Our Education Strategy focuses on inclusion and is a key enabler to delivering the vision supported by our Trust values

We are committed to inclusion in everything we do and this is evident in all our people policies and practices

Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible

We celebrate and value the contribution all of our staff make at all levels of the organisation

Staff forums grow to become an increased staff voice who represent our workforce and the community we serve

We will encourage shared learning by openly sharing our diversity data in a meaningful way

We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves

Hartles Rachel
11/30/2021 13:46:56

Our strategy is communicated at all levels reflecting our commitment to change.

We will seek opportunities to learn from others, developing our partnerships at a regional and national level.

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"When the world is silent, even one voice becomes powerful"

Malala Yousafzai

"I learned a long time ago the wisest thing I can do is be on my own side, be an advocate for myself and others like me"

Maya Angelou

"No voice is too soft when that voice speaks for others"

Janna Cachola

EDI Advocates Programme

The following slides sets out information about the Trust EDI Advocates Programme. This is our most ambitious EDI programme. Our aim is to recruit 200 staff over the next 12 months who will be trained and skilled-up to be the cultural change agents at a team, service and divisional level on implementing EDI policy and behaviours.

Committed to inclusion in everything we do


Video-Advertising-the-role-of-EDI-Advocates
Introducing the role of the
Equality, Diversity and
Inclusion Advocate
Hartles Rachel
11/30/2021 13:46:56
00:03

Why do we need EDI Actions?

Everyone has the right to come to work as a unique person without exception

This means being treated with dignity and respect at work regardless of your age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race or ethnicity or nationality, religion or belief or no belief, sex and sexual orientation – these are the nine human characteristics protected by law from unlawful discrimination

If we do not take action individually, and as a Trust on inclusion, biases can easily lead to a culture of bullying and harassment, victimisation and unlawful discrimination in teams, divisions and services

What the role involves

staff understand what EDI is and the importance it holds for an inclusive workplace.

gaps in EDI training, education, practices and areas for improvement.

of EDI through conversations, story telling, lived experience, team meetings, posters, leaflets and signposting.

staff to areas of support such as unions, staff networks, bullying and harassment advisors, Workplace Wellbeing Advocates and Freedom to Speak Up Champions.

EDI Advocate Network meetings when possible.

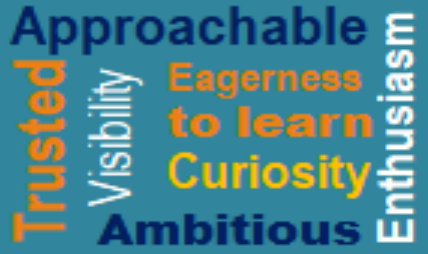
and Awareness of EDI through commemorating historical events, social movements, awareness events, celebrating religious and other festivals and all protected characteristics.

for involvement, including self-education on current and emerging EDI issues.

at the annual/quarterly staff survey within your division/team.

EDI Advocate expected personal qualities

Personal Qualities



Ambitious: Solutions-oriented approach and ready to be the culture change agent for your team and division

Approachable: Having empathy and giving colleagues and patients a safe space to have open conversations about EDI

Curiosity: Having an open mind to venture outside of your own comfort zone on EDI

Eagerness to learn: Giving yourself permission to listen and appreciate the complex and challenging EDI journeys of our colleagues and patients

Enthusiasm: Eager to improve patients, colleagues and your own experience of EDI

Trusted: Remaining professional with integrity, taking appropriate action when necessary and maintaining confidentiality

Visibility: Being an ally to both staff and patients from all protected characteristics

Building EDI knowledge and skills

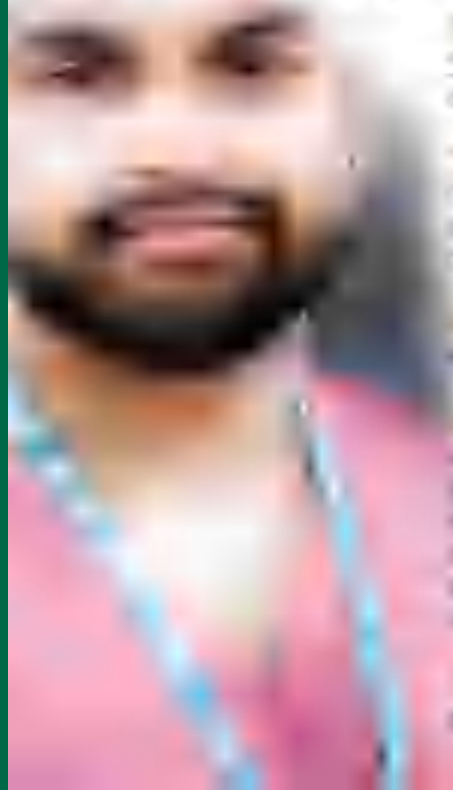
Building knowledge

Once you have committed to becoming an EDI Advocate for your division/team, we would not expect you to be an expert on EDI.

We will work with you to communicate, build your knowledge, skills and confidence to a level that you should be able to:

- Demonstrate an understanding of EDI and how it applies in the workplace
- Maintain objectivity in supporting and sign-posting staff, students and volunteers on EDI
- Ability to engage and collaborate in a meaningful way with others across the divisions and Trust to spread best practice and opportunities to advance EDI wider across systems
- Ability and confidence to lead on challenging EDI issues within your team or division to successful outcomes.
- Ability and confidence to work with EDI support partners to deliver on local and Trust-wide EDI action plans.

Tips for maintaining boundaries



How will you be supported in your role?

EDI is a complex area, but extremely rewarding when we get it right.

As an EDI Advocate you will not be left to your own devices.

There is a huge network of partners to support you on this rewarding and meaningful journey.

EDI Advocate capacity-building workshops (subject to staff feedback)

1. Demystifying microaggressions in the workplace
2. Demystifying race equality
3. Resolving conscious and unconscious biases
4. Sex vs. Gender – what is the difference?
5. Demystifying Human Rights
6. Destigmatising disability in the workplace
7. Creating and managing personal/professional boundaries in the workplace

"Without deviation from the norm, progress is not possible"

Frank Zappa

"Never confuse movement with action"

Ernest Hemingway

"Those who do not move, do not notice their chains"

Rosa Luxemburg

"You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete"

Buckminster Fuller

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Progress update on Trust EDI action plan 2021/22 (April 2021 to September 2021)

The following slides set-out progress the Trust has made in the last six months on the EDI action plan 2021/22.

Committed to inclusion in everything we do

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update (April 2021 to September 2021)

KPIs	No	Objective	Who	Progress	RAG
PSED EDS4.1 DPP6	1	In partnership with the national team launch the national reciprocal mentoring (RM) programme across divisions with recruitment of 20 mentor pairs across the Trust.	EDI Manager Barnard Galton Sam Chapman	• In Q2 the national reciprocal mentoring team confirmed the national programme rollout has been put on hold until additional resources can be allocated to support Trusts Q3 will focus on: • A systems approach to developing a RM programme with support from the South West regional leadership academy	
EA2010 PSED BSS1 BSS2&3	2	Develop leadership tools and support the development of the EDI advocates and divisional leads to have the knowledge, skills and abilities to embed EDI in everything we do.	EDI Manager Divisional EDI leads	• EDI induction training for newly recruited overseas nurses is now on Cohort 7 • Trust launched a short awareness video, 'call me by my name' to address microaggressions in the workplace. • The EDI Advocates Programme was launched on 13 Sept that included a short video describing the role of an EDI Advocate Q3 will focus on: • Recruitment and induction workshops for EDI Advocates • Development and delivery of EDI capacity-building training workshops/eLearning for EDI Advocates	

RAG Key:

On Plan	Blue
Complete	Green
Risks slippage	Amber
Barriers: not achieved	Red

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update (April 2021 to September 2021)

KPIs	No	Objective	Who	Progress	RAG
EDS3.1 DPP1	3	Ensure EDI is further embedded into our recruitment processes ensuring the diversity of our workforce increases year on year.	EDI Manager Peter Russell	• A regional action plan on overhauling Trust recruitment and promotion processes has been developed and submitted to NHS England/Improvement (NHSE/I) 30/8/21 • Ongoing monthly systems EDI Leads' meeting on progress against recruitment & promotion processes action plan • Inclusive Recruitment Forward Plan 2021/22 approved by Senior Leadership Team in July 2021 that incorporates six key actions on inclusive recruitment and promotion identified in the People Plan, Race Disparity Ratio Goals, Dataset Task & Finish Working Group and systems BAME Talent Management Programme and also a proposal to setup a Trust Inclusive Recruitment Task & Finish Group Q3 will focus on: • Establishing and supporting the work of the Inclusive Recruitment Task & Finish Working Group focusing on Trust recruitment and promotion processes with the aim of having a meaningful plan in place by March 2022	
EDS3.6 PSED	4	Develop an effective communication plan for sharing and promoting use of EDI resources and initiatives across the Trust that is embedded in to the UHBW cultural programme.	EDI manager Comms team Staff networks EDI leads	• 80 staff from BAME background have volunteered to be photographed to reflect the 15.2 % of BAME workforce across all resource media platforms • Trust is holding a virtual mini-conference on Thursday 21 Oct to mark Black History Month • In Oct 21 a portrait exhibition begins in Bristol and Weston to celebrate and appreciate our staff from Black communities. Q3 will focus on: • Marking and celebrating Black History Month (Oct) and Disability History Month (Nov-Dec)	

RAG Key:	
On Plan	Blue
Complete	Green
Risks slippage	Amber
Barriers: not achieved	Red

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update (April 2021 to September 2021)

KPIs	No	Objective	Who	Progress	RAG
WRES WDES GPG DPP3 DPP4 DPP5 PSED EDS3.6	5	Develop a robust assurance and delivery plan to respond to our Public Sector Equalities Duties (PSED) across all protected characteristics.	EDI Manager HRIS team Workforce D&I Group	• A Task & Finish dataset working group has been proposed to undertake a detailed analysis of current data held by the Trust across a range of activities and functions with a view of developing a robust framework of current future data requirements to deliver EDI action plan. • Due to operational challenges the Task & Finish group could not be set-up in Q2 Q3 will focus on: • The augural meeting of the Task & Finish group for end of Nov 2021 with the group feeding into EDI steering group with regular updates • Final report and recommendations from the Task & Finish group will be agreed by end of Q4	
EA2010 PSED WRES WDES GPG	6	Ensure there is a robust reporting framework to communicate progress against the Trust's 5-year D&I strategy.	EDI Manager Workforce D&I Group	• The Trust Board ratified the first bi-annual EDI integrated performance report (Oct 2020 to Mar 2021) and it has been published on the Trust public website: https://www.uhbw.nhs.uk/p/about-us/equality-diversity-and-inclusion-edi	

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update (April 2021 to September 2021)

KPIs	No	Objective	Who	Progress	RAG
EA2010 PSED WRES WDES EDS2	7	Provide inclusive education that nurtures staff motivation and aspirational career development and values the individual and the teams that work together.	EDI Manager Senior Education Quality Manager Divisional EDI leads	• Education EDI representative at all levels of EDI trust-wide working groups • EDI now forms a standing agenda point on the Education Managers meeting • Quality metric reporting established on the breakdown of EDI data across our funded training programmes • Nip it in the Bud Training embedded into local induction across all education • EDI objectives included in appraisals • Supported widening participation and EDI through apprenticeship routes such as Training Needs Analysis, especially supporting first cohort as part of Weston division Q3 will focus on: • building on the above and also rollout of EDI Advocates within each team of the education department. • Embedding unconscious bias training as a theme across all new training modules produced. • Developing extensive library reading lists aligned with the EDI i.e – Pride and Black History month • Continued representative on University of West England (UWE) Bristol BAME student placement project	

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RAG Key:	
On Plan	Blue
Complete	Green
Risks slippage	Amber
Barriers: not achieved	Red

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update (April 2021 to September 2021)

KPIs	No	Objective	Who	Progress	RAG
EA2010 PSED WRES WDES EDS2	8	Ensure there are robust divisional plans in place to enable the effective delivery of the strategy at a local level and to ensure local solutions are embedded in response to the staff survey.	EDI manager Divisional EDI leads Operational EDI leads Staff Network chairs HRBPs	• All divisions have published EDI action plans that acknowledge successes in the previous two quarters, current EDI priorities areas and also embedding EDI as a leadership team. Q3 will focus on: Developing cultural change interventions particularly when the EDI Advocates Programme embeds within divisions and teams.	
EA2010 PSED WRES WDES EDS2	9	Develop staff networks to have increased membership, greater reach and impact to support under-represented or disadvantaged staff across all protected characteristics.	EDI Manager Staff network chairs	• The interim Trust chair identified funds to support the development of staff networks plus the launch and support of the Trust Women's Staff Network (WSN) Q3 will focus on: • Supporting the four staff networks to become sustainable with greater reach and positive impact for the workforce. • Black History Month mini-conference and portrait exhibition in Bristol and Weston • 6 month work plans for each staff network • Disability History Month (mid-Nov to mid-Dec)	

RAG Key:

On Plan	Blue
Complete	Green
Risks slippage	Amber
Barriers: not achieved	Red

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update (April 2021 to September 2021)

KPIs	No	Objective	Who	Progress	RAG
PSED EA2010 EDS2 WRES WDES	10	Ensure there is robust governance pathway across all divisions that reports into the corporate infrastructure and allows for a two way dialogue to monitor progress and share best practice.	EDI Manager Divisional EDI leads Operational EDI leads	• A robust framework of governance and assurance pathways are in place Q3 will focus on: • Overhauling recruitment processes and developing interventions that encourage job applicants from local people across all protected characteristics. • EDI Advocates as culture change agents	
WRES WDES PSED EA2010 EDS2	11	The Trust to actively play a leading role in contributing and learning from EDI strategies, activities and policies in partnership locally, regionally and nationally for the benefit of our staff and patients.	EDI Manager	• Ongoing co-production of a systems approach to overhauling recruitment and promotion processes (BNSSG) • Ongoing support for the UWE BAME student placement project • Ongoing support for Bristol Race Equality Strategic Leaders' Group Q3 will focus on: • Developing systems action plan on overhauling recruitment and promotion processes with spotlight on BAME staff plus closing the race disparity gap between White and BAME in career development opportunities • Developing a University of West England (UWE) pilot on BAME student placement and EDI pathways	

RAG Key:	
On Plan	Blue
Complete	Green
Risks slippage	Amber
Barriers: not achieved	Red

"A diverse mix of voices leads to better discussions, decisions, and outcomes for everyone"

Sundar Pichai

"Staff networks are not just here to celebrate diversity and the communities they make up. They are fundamental to the running of the organisation"

Jo Portlock

"The single greatest people skill is a highly developed and authentic interest in the other person"

Bob Burg

"Instead of better glasses, your network gives you better eyes"

Robert Burt

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Trust Staff Networks

Staff networks play a key role in meeting the objectives set in the Trust's five-year EDI strategy. Currently the Trust has three staff networks.

The following slides set-out the development action being taken to make staff networks sustainable with greater reach and impact for the workforce and across the Trust.

Committed to inclusion in everything we do

Trust Staff Networks

Developing Staff Networks

- In Q3 the Trust is refocusing on developing all three existing staff networks plus launching the Women's Staff Network
- Limited funding has been identified to support the development of staff networks including half-day a week protected time where possible for staff network chairs/co-chairs for six months
- The learning from the limited funded support for staff networks will inform the business case for ongoing financial commitment in the 2022/23 Trust budget to ensure sustainability for staff networks

ABLE+ (supporting staff with physical, sensory or mental impairments)

LGBTQIA+ (supporting Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex and Asexual + staff)

BAME (supporting staff from the Black, Asian and ethnic minority communities)

LGBTQIA+ Staff Network update

Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex and Asexual + staff

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. Personal Pronouns video and working with departments to spread the knowledge of Personal Pronouns
2. Promoting Rainbow badge campaign at Weston with over 150 staff signing pledges at Weston during Pride Month
3. Building connections for future work with the CCG Proud Network & Sirona LGBT+ Network

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Current EDI priorities

Three EDI priority areas we are currently working on for the next six month

1. Improving support for staff who are gender non-binary around uniforms/dress code
2. Network visibility at both Weston General & Bristol sites working with our fellow staff network chairs and members
3. Marking World Aids Day on 1 December 2021

Our EDI action plan going forward

Three ways we will embed EDI into everything we do as a staff network

1. Improve intersectionality by working closely with our other staff networks
2. Spreading the word that we welcome Allies to our network
3. Reviewing and developing an LGBTQIA+ workforce equality standard framework similar to WRES and WDES

ABLE Plus Staff Network update

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. We have progressed the Campaign around Disabled Staff Parking/ Trust accessibility By holding the Wheelchair Challenge (Pictures)

2. We have reached and have provided support for 100 staff with Dyslexia/Dyspraxia and Dyscalculia

3. We with support from Information Management & Technology (IM&T) now have a named support to aid in IT configuration of software needs

Current EDI priorities

Three EDI priority areas we are currently working on for the next six month

1. Continue our Campaign to highlight accessibility Issues within the Trust

1. Improve Network visibility at both Bristol and Weston sites working with our staff network chairs and members

2. Marking Disability Week in December with a workshop (unseen disabilities - how do we recognise and support these)

Our EDI action plan going forward

Three ways we will embed EDI into everything we do as a staff network

1. Improve the understanding of support for staff with unseen disabilities

2. Ensuring that everyone knows that Allies are always welcome at our meetings

3. Reviewing the reasonable adjustments programme and educate our new EDI Advocates how to sign post staff to this service

BAME Staff Network update

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. Contributed to a systems approach to developing and supporting BAME staff networks (BNSSG and South West England Regional EDI leads)

2. Co-produced the systems response to the six priority areas in the People Plan to support BAME staff in the NHS in relation to inclusive recruitment, promotion and talent development

3. Great response from BAME staff network members to come forward and be photographed to represent the diversity of our workforce in Trust resource materials and media platforms

Current EDI priorities

Three EDI priority areas we are currently working on for the next six month

1. Black History Month mini-conference on 21 October 2021

2. Portrait exhibition in Bristol and Weston celebrating and acknowledging the contribution of our staff from Black background

3. Set-up a Task & Finish group to re-launch of the BAME Staff Network . The aim is to make it more inclusive with greater reach and focused on delivering race equality for our BAME workforce.

Our EDI action plan going forward

Three ways we will embed EDI into everything we do as a staff network

1. Actively involve members to participate in the development and delivery of the Workforce Race Equality Standard (WRES) Action Plan 2021/22

2. Actively involve members in the overhaul of the Trust recruitment and promotion processes to create space for BAME staff to thrive by eliminating race discrimination

3. Work with divisional EDI Advocates to raise awareness of racism and other factors that disenfranchise some staff from BAME backgrounds, particularly in relation to career progression

"In diversity there is beauty and there is strength"

Maya Angelou

"We need to give each other the space to grow, to be ourselves, to exercise our diversity. We need to give each other space so that we may both give and receive such beautiful things as ideas, openness, dignity, joy, healing, and inclusion"

Max De Pree

"Diversity: the art of thinking independently together"

Malcolm Forbes

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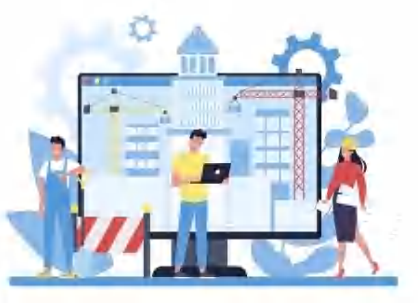
Divisional EDI action plan update

The Trust comprises of eight divisions. Each division has developed an EDI action plan with support from divisional EDI leads, operational EDI leads and HR Business Partners.

The following slides set-out the progress and forward planning the eight divisions have made on the Trust diversity and inclusion strategy 2020/22.

Committed to inclusion in everything we do

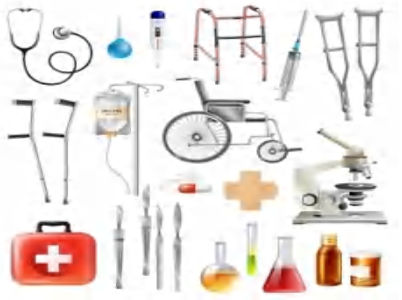
Divisional equality, diversity and inclusion action plan update



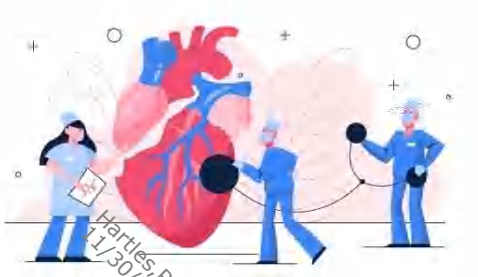
Estates and Facilities

Women's & Children's Services

Surgery



Diagnostics and Therapies



Specialised Services

Trust Services

Weston

Medicine

Estates and Facilities Division

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. Increased awareness and participation of all managers/leaders/supervisors to complete Cultural Awareness for an Inclusive Workplace.

2. Promotion of Diversity and Inclusion at internal meetings, team meetings and through departmental newsletters such as 'Nuts and Bolts' and 'HR Bites'.

3. In partnership with HR Services, produced and rolled out a fact finding template to ensure that appropriate decisions are made when incidents or concerns are raised to ensure any actions are in line with Just Culture'.

Current EDI priorities

Three EDI priority areas we are currently working on for the next six month

1. Recruit more EDI representatives from each hospital site through our Staff Forums.

2. Utilise EDI reps to increase awareness and understanding of D&I within the division and encourage staff to share their experiences.

3. Talent Liberation project in progress to increase Diversity and Inclusion in recruitment and access to opportunities are easily accessible for all staff.

Our EDI action plan going forward

Three ways we will embed EDI into everything we do as a leadership team

1. Continuous improvement around EDI based upon feedback provided by staff at Staff Forums and other listening events.

2. Reach out to traditionally underrepresented employee groups – invite staff stories regularly at Divisional Board.

3. Champion the EDI Advocates and the role they play in improving equality, diversity and inclusion.

Women's and Children's Division

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. Launched Diversity and Inclusion Advocate programme to promote awareness, education and to provide support.
2. Midwifery: Established Continuity of Carer Team in an area with a high BAME population to improve outcomes.
3. Gynaecology: Improved physical access to outpatients clinic.
4. Established specialist asthma clinics in areas with high asthma rates. The service targets those children with severe asthma to improve health outcomes.
5. Introduced young people onto our Divisional Board and other divisional activities [e.g. staff awards]; enabling them to shape decisions about our services.

Current EDI priorities

Three EDI priority areas we are currently working on for the next six month

1. Provide maternity care to Afghan refugees based in Bristol.
2. Continue to implement Diversity and Inclusion action plan including actions to raise awareness through our Divisional patient and staff engagement events.
3. Midwifery: Further engagement with Somali population / patients to improve understanding of maternity services.
4. Review and secure ongoing funding for our Somali Outreach worker – currently embedded within the diabetes service improving access, outcomes and patient/family experience.
5. Develop and support the Care of Childhood Obesity (CoCo) service improving outcomes of children with severe obesity. Work with partners to secure funding for a 'tier 2' obesity service.

Our EDI action plan going forward

Three ways we will embed EDI into everything we do as a leadership team

1. Champion Diversity and Inclusion Advocates and support the delivery of the action plan
2. Continue to support our young people on our Divisional Board supporting them to shape the decisions that we make.
3. Actively address health inequality by working with the Children's Alliance to develop a Artificial Intelligence (AI) DNA predictor tool. This tool will use criteria such as 'no access to transport' or 'previous non-attendance' to identify those children least likely to attend appointments and treatment.
4. Support the implementation of Trust flexible working scheme.

Division of Surgery

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. Our Divisional EDI score in the 2020 National Staff Survey increased again, from 8.9 to 9.0. Our Safe Environment score (bullying & harassment) also increased, by 0.4 to a score of 7.9

2. Secured funding from Above & Beyond to purchase and deliver Active Bystander training to c.30 staff in management and clinical leadership roles to support the Division goal of ensuring a safe and supportive working environment for colleagues through raising confidence to challenge poor behaviours, to prevent these becoming normalised.

3. A Psychological Trauma Masterclass was delivered to Division Leadership, enhancing skills and confidence to support teams and colleagues in this sensitive aspect of their wellbeing, thereby promoting a more inclusive culture

Current EDI priorities

Three EDI priority areas we are currently working on for the next six months

1. Recruiting a Divisional EDI Steering Group lead, together with EDI advocates across the Division of Surgery

2. Establishing a Divisional Workforce Development Steering Group, whose remit will include equality of access for staff to undertake further study and development, as well as promoting staff from under-represented groups to apply for development that may not have been considered had there been no 'nudge'

3. Promote diversity of thought and recognition of difference across the Division with the introduction of new roles of Physician Associate, Nursing Associates and Medical Support Workers

Our EDI action plan going forward

Three ways we will embed EDI into everything we do as a leadership team

1. Monthly review of the Division People plan, into which EDI improvements are embedded, by the Workforce Committee (a sub-committee of the Divisional Board)

2. Maintain the visibility and importance of EDI through the standing agenda item on the monthly Divisional Workforce Committee, and strengthen this with a monthly update from the new Divisional EDI Steering Group Lead

3. Continue to strive for a working environment where fairness and consistency underpin management practices, and where Colleagues are treated with dignity and respect.

Diagnostics and Therapies Division

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. The Divisional score for EDI in the 2020 staff survey results which were released in April 2021 was 9.5 . The highest score for the Trust

2. We have formed a Divisional Education Group. One of the central aims is to ensure equity in access to education across the Division

3. One of our Heads of Service attended a workshop on 'Storytelling: How the story serves the leader' as a foundation for reciprocal mentoring

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Current EDI priorities

Three EDI priority areas we are currently working on for the next six month

1. To hold a session with our Staff Forum on EDI within Diagnostics and Therapies Services, with presentations from our EDI Leads and Trust EDI Manager and service level feedback from the Staff Forum Representatives

2. To recruit an EDI Advocate in each service and form our Divisional EDI Group to address issues and develop ideas specific to our Division and Services

3. To work with our resourcing team to explore ways to promote our Diagnostics and Therapies services and career paths to increase awareness of opportunities across a more diverse demographic

Our EDI action plan going forward

Three ways we will embed EDI into everything we do as a leadership team

1. Divisional EDI group to be developed, including a member of the Leadership team, with actions captured in the Divisional EDI action plan which will be monitored and reviewed regularly by the Workforce Committee (a sub-committee of the Divisional Board)

2. Introduction of 360° feedback for the Divisional Leadership team which will include an EDI Dimension

3. A session on "leading a culture of EDI "to be held with our Divisional Board members facilitated by our Trust EDI Manager

Specialised Services Division

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. Held two phases of EDI Sharing Lived Experience events, facilitated by senior managers and attended by staff within the division.

2. Developed our EDI Divisional Staff Forum (to commence October 2021); the purpose of which is to plan and implement activities aimed at supporting staff from the nine protected characteristics, in order to improve their experience of working in the division.

3. Raised the EDI profile with Workforce Committee by presenting demographic data for debate and encouraging two members of staff to present their stories at Divisional Schwartz Round.

Current EDI priorities

Three EDI priority areas we are currently working on for the next six month

1. Continue to promote our EDI Divisional Staff Forum and increase participation so that we have representation across all staff groups, bands and protected characteristics.

2. Continue to raise the EDI profile and strongly encourage all staff to complete Cultural Awareness eLearning, highlighting unconscious bias and self awareness.

3. Continue to develop and review divisional priorities based upon feedback provided from EDI Staff Forum and EDI Advocates.

Our EDI action plan going forward

Three ways we will embed EDI into everything we do as a leadership team

1. EDI Leads to support Divisional Board members to develop and include EDI objectives within their personal appraisals.

2. Develop EDI Leads and Advocates knowledge by providing appropriate Education opportunities.

3. Continuous improvement around EDI based upon feedback provided by staff at Staff Forums and EDI Advocates, e.g. consider BAME observers at all interviews (following Medical model).

Trust Services Division

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. Increased representation on our Divisional EDI group, which now meets regularly. Some departmental EDI groups have also been established, which is increasing the level of conversation and engagement
2. Several members of Trust Services have been selected for the Stepping Up course
3. Increased appraisal and mandatory training compliance
4. We have piloted balanced shortlisting, and are investigating how to overcome some of the barriers identified in the pilot
5. Considerable progress in the Education team, including quality metric reporting established for funded training programmes, supporting widening participation through apprenticeship routes and launch of a BNSSG initiative to support people into work with Language, Literacy, Numeracy and Digital skills.

Current EDI priorities

Three EDI priority areas we are currently working on for the next six month

1. Identifying and recruiting more EDI advocates
2. Work on providing guidance and best practice on how language acts as a barrier to good communication, recruitment and progression
3. Analysis of Trust Services employment data to understand more about the landscape and identify tailored actions.

Our EDI action plan going forward

Three ways we will embed EDI into everything we do as a leadership team

1. Further unconscious bias training
2. Investigate reciprocal mentoring within the division
3. Share EDI-related objectives and outcomes to develop a bank of information and inspire others
4. Monthly reporting to be introduced into how each Education Department feeds into the Trust-wide EDI strategy and action plan
5. Ensure greater EDI focus in recruitment to include an EDI question at all interviews and representation in the recruitment process of senior posts.

Trust Services Division - Education

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. Education EDI representative at all levels of EDI trust-wide working groups
2. Quality metric reporting established on the breakdown of EDI data across our funded training programmes
3. Diversity and Inclusion objectives included in appraisals
4. Roll our of EDI Advocates across education
5. Launch of a pilot BNSSG initiative Project Search - supporting people into work with Language, Literacy, Numeracy and Digital literacy
6. Identification of training modules created to support staff with skills gap and upskilling through Life Skills package
7. Nip it in the Bud Training embedded into local induction across all education
8. Supported widening participation and EDI through apprenticeship routes such as training needs analysis, especially supporting first cohort as part of Weston division

Current EDI priorities

Three EDI priority areas we are currently working on for the next six month

1. Ensure an EDI Advocate within each team of the education department.
2. Reporting metrics against staff undertaking Nip it in the Bud Training across education.
3. Active promotion of inclusion and access to funded training programmes.
4. Unconscious bias training embedded as a theme across all new training modules produced.
5. EDI now forms a standing agenda point on the Education Managers meeting
6. BNSSG outreach virtual work experience being undertaken
7. Dedicated role based at Weston Division to support apprenticeship and widening engagement activity
8. BNSSG continue to have a high EDI representation across many platforms
9. Developing extensive library reading lists aligned with the EDI i.e – Pride and Black History Month

Our EDI action plan going forward

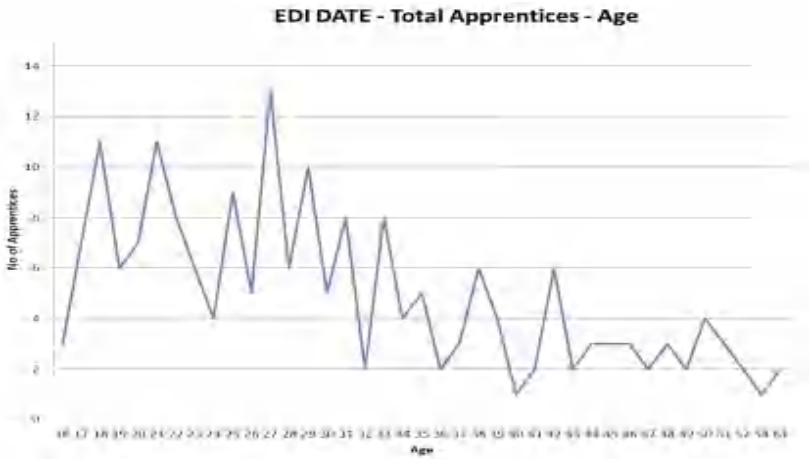
Three ways we will embed EDI into everything we do as a leadership team

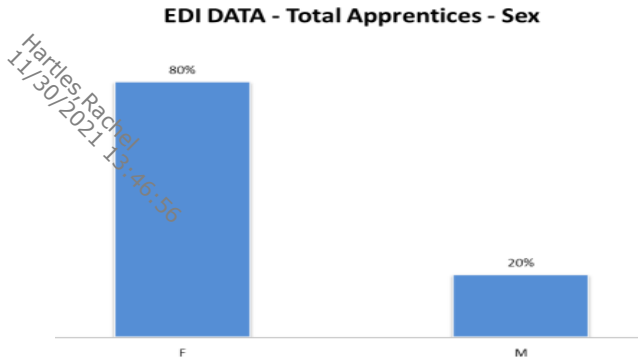
1. Continual identification on how language acts as a barrier to good communication, recruitment and progression and further training modules created to support our staff through Life Skills
2. Monthly reporting to be introduced into how each education departments feeds into the Trust-wide EDI strategy and action plan
3. Champion the EDI Advocates and the role they play in improving equality, diversity and inclusion
4. Continued representative on University of West of England Bristol (UWE) BAME student placement project

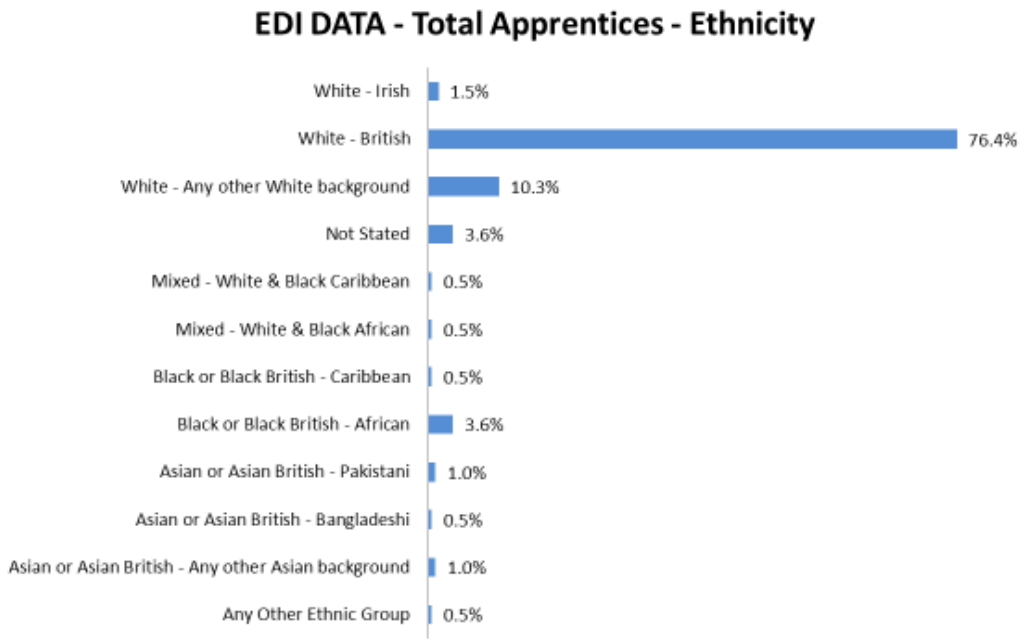
Trust Services Division – Education – EDI Data

Equality, Diversity and Inclusion data across our apprenticeship routes:

As part of our commitment to being an inclusive and diverse employer, we have launched the monthly dashboard report which includes the diversity data of our learners to gain a better understanding of equality, diversity and inclusion (EDI) across our apprenticeship cohort. This is vital information that we will use to create and develop policies, regulatory processes and strategies across education that will accurately reflect the diversity of our registrants. Equality within education should play a central role in improving the practices, access to learning, processes and policies that guide the delivery and quality of outcomes and services by health and care professionals. This should form a central part of the quality assurance processes. In order to co-create holistic learning opportunities that are representative of staff and service users, the perspectives, knowledge and lived experiences of people from a diverse range of professional, demographic and social backgrounds should be considered when developing curriculums.







Weston Division

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. The construction and launch of a Weston staff forum (The Voice)
2. Completion of Cultural awareness training by Senior Management Team
3. Development of both a Culture and People plan and a People Committee for Weston.

Current EDI priorities

Three EDI priority areas we are currently working on for the next six month

1. Recruiting EDI advocates for the division of Weston as well as a divisional EDI operational lead.
2. Staff stories –for both Trust board and divisional board. A framework for inviting Staff Stories is being written up and is expected to be launched by the end of 2021.
3. Establishing a divisional Education committee to ensure equality to anyone wishing to undertake studies as well as encouraging under represented groups to look into the courses the Trust provides/have procured in order to support their own development and progression.

Our EDI action plan going forward

Three ways we will embed EDI into everything we do as a leadership team

1. A process is being developed to implement 'Request to Hire' meetings following all Pay Control Panel approvals for vacancies to be filled. The aim of these meetings will be to make sure recruiting managers have all the information and tools available to recruit the right person, into the right role, at the right time, in a fair and inclusive way.
2. Hold EDI listening events once advocates are in place.
3. Launch reciprocal mentoring programme in line with Trust launch.

Medicine Division

Progress in the last six months

Three things we feel proud to have done or made progress on EDI since April 2021

1. EDI has now been embedded as a standing agenda item within our divisional Staff Wellbeing & Experience Group, raising it's profile in the division.

2. Division has finalised it's Culture & People plan for 2021/22; with EDI objectives set for next 12 months.

3. Divisional education funding review process successfully completed for 2021/22 financial year. This process ensures fair and equitable funding allocation across the division.

Current EDI priorities

Three EDI priority areas we are currently working on for the next six month

1. Actively signpost divisional colleagues to the Trust EDI Advocate recruitment campaign; grow internal network of expertise/support.

2. Increase uptake of Cultural Awareness E-learning across the division.

3. Contribute to Trust Overseas Nursing Recruitment group, including the cultural framework being developed to support new nurses joining from overseas.

Our EDI action plan going forward

Three ways we will embed EDI into everything we do as a leadership team

1. Review and scrutinise divisional EDI data, including that of casework representation, within divisional board on regular basis, to ensure EDI is considered at all times in divisional decision-making and appropriate action are developed.

2. Identify a new EDI divisional operational lead to lead local advocate network and attend Staff Wellbeing & Experience Group as EDI champion.

3. Support the Trust reverse mentoring scheme, putting senior leaders forward as reverse mentees.

"The very serious function of racism is distraction. It keeps you from doing your work. It keeps you explaining, over and over again, your reason for being"

Toni Morrison

"If you are neutral in situations of injustice, you have chosen the side of the oppressor"

Desmond Tutu

"I wish they would only take me as I am"

Vincent Van Gogh

There is no such thing as race. None. There is just a human race – scientifically, anthropologically"

Toni Morrison

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Workforce Race Equality Standard (WRES)

The WRES programme requires organisations employing the 1.3 million-strong NHS workforce to report against nine indicators of race equality; and supports continuous improvement through robust action planning to tackle the root causes of discrimination particularly in relation to Black, Asian and Minority Ethnic (BAME) staff.

The following slides set-out the first full UHBW WRES data across all nine indicators of race equality as at 31 March 2021. The slides also set-out the Trust's WRES strategic action plan for 2021/22.

Committed to inclusion in everything we do

2021 WRES spotlight on Trust Black, Asian & Minority Ethnic (BAME) staff

15.2% of UHBW staff are from a BAME background

White applicants are **1.64 times** more likely to be appointed from shortlisting than BAME applicants

BAME staff are **2.48 times** more likely to enter a formal disciplinary process than white staff

71.4% of BAME staff believing the organisation provides equal opportunity for career progression/promotion compared to white staff **88.6%**

18.3% of BAME staff experienced discrimination from **manager/team leader** compared to white staff **5.5%**

27.9% of BAME staff reported experiencing harassment, bullying or abuse from **staff** compared to white staff **21.7%**

Key findings from the WRES 2021 data

UHBW 2021

WRES indicator 1

% of staff in each of the Agenda for Change (AfC) Bands 1–9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce

Non-Clinical Staff

	White	BME	Unknown
Band 1	75	86	3
Band 2	629	126	33
Band 3	592	57	18
Band 4	469	32	15
Band 5	271	22	4
Band 6	171	17	4
Band 7	154	8	4
Band 8A	92	4	2
Band 8B	58	1	0
Band 8C	36	2	0
Band 8D	13	0	0
Band 9	15	2	1
VSM	6	0	0

Clinical Staff - Non-Medical

	White	BME	Unknown
Band 1	81	36	2
Band 2	1093	281	39
Band 3	401	56	10
Band 4	323	38	19
Band 5	1587	433	74
Band 6	1303	181	35
Band 7	941	62	12
Band 8A	266	17	1
Band 8B	65	6	0
Band 8C	38	0	0
Band 8D	9	1	1
Band 9	4	0	0
VSM	2	0	0

Clinical Staff – Medical & Dental

	White	BME	Unknown
Consultants (including Senior Medical Staff)	486	108	48
Non-consultant career grades	206	141	31
Trainee grades	489	108	57
Other	25	3	17

Key findings from the WRES 2021 data

WRES indicator 2 **Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants**	**White staff are 1.64 times more likely to be appointed from shortlisting than BME staff.**

WRES indicator 3 **Relative likelihood of BME staff entering the formal disciplinary process compared to white staff**	**Relative likelihood of BME staff entering the formal disciplinary process is 2.48 times greater than white staff.**

WRES indicator 4 **Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff**	**Relative likelihood of white staff accessing non-mandatory training is 0.95 times greater**

WRES indicator 5 (Staff Survey) **% Staff experiencing harassment bullying or abuse from patients relatives or members of the public in last 12 months**	**UHB** **2019 %**	**UHBW** **2020 %**	**+/-**
BME: Trust	26.7	24.8	1.9
BME: Acute average	29.9	28.0	1.9
White: Trust	24.5	22.9	1.6
White: Average	28.2	25.4	1.2

Key findings from the WRES 2021 data

WRES indicator 6 (Staff Survey 2020) % Staff experiencing harassment bullying or abuse from staff in the last 12 months	UHB 2019 %	UHBW 2020 %	+/-
BME: Trust	25.2	27.9	2.7
BME: Acute average	28.8	29.1	0.3
White: Trust	22.7	21.7	1.0
White: Average	25.8	24.4	1.4

WRES indicator 7 (Staff Survey 2020) % Staff believing the organisation provides equal opportunity for career progression/promotion	UHB 2019 %	UHBW 2020 %	+/-
BME: Trust	68.9	71.4	2.5
BME: Acute average	74.4	72.5	1.9
White: Trust	89.7	88.6	1.1
White: Average	86.7	87.7	1.0

Key findings from the WRES 2021 data

WRES indicator 8 (Staff Survey 2020) % Staff experienced discrimination from manager/team leader or other colleagues in last 12 months	UHB 2019 %	UHBW 2020 %	+/-
BME: Trust	14.9	18.3	3.4
BME: Acute average	13.8	16.8	3.0
White: Trust	5.2	5.5	0.3
White: Average	6.0	6.1	0.1

WRES indicator 9 (UHBW 2021) % difference between the organisation's board voting membership and its overall workforce	• 100 % of Voting Board Members are White • 0% of Voting Board Members are BME • 0% of Voting Board Members are of unknown/not stated ethnicity • 15.00% of the overall workforce are BME • Percentage difference between Voting Board Membership & overall workforce is –15.00% • Exec Board membership = 100% White

WRES Strategic Action Plan 2021/22

Overhauling our recruitment and promotion processes (1)

At a Trust and system level, we are currently developing our response to the **six high impact actions** identified by the national EDI team as set out in the People Plan. These include:

1. Ensuring Executive and Very Senior Managers own the agenda:

- As part of culture changes in organisations, with improvements in BAME representation (and other under-represented groups) as part of objectives and appraisal

2. Constructive Interviews:

- Introduce a system of constructive and critical challenge to ensure fairness during interviews.

3. Talent management panels:

- Create a 'database' of individuals by system who are eligible for promotion and development opportunities such as Stretch and Acting Up assignments
- Agree positive action approaches to filling roles for under-represented groups
- Set transparent minimum criteria for candidate selection into talent pools

WRES Strategic Action Plan 2021/22

Overhauling our recruitment and promotion processes (2)

4. Enhance EDI support:

Train organisations and HR policy to complete robust / effective Equality Impact Assessments in recruitment and promotion policies

- Ensure that for Bands 8a roles and above, hiring managers include requirement for candidates to demonstrate EDI work / legacy during interviews.

5. Overhaul interview practise:

- Training resources on EDI good practice to ensure fair and inclusive practices are used.
- Adoption of values based shortlisting and interview approach
- Consider skills-based assessment such as using scenarios

6. Adopt resources, guides and tools to ensure productive conversations about race

Progress to date:

- A regional action plan has a been developed and submitted to NHSE/I (30 Aug 2021)
- Ongoing monthly systems EDI Leads meetings on progress against the action plan
- Inclusive Recruitment Forward Plan 2021/22 approved by Trust Senior Leadership Team in July 2021 that incorporates the six key actions on inclusive recruitment and promotion as identified in the People Plan and WRES Race Disparity Ratio Goals
- Trust Inclusive Recruitment and Promotion Task & Finish Working Group to be set-up in Oct 2021 to ensure a meaningful action plan is in place by March 2022

WRES Strategic Action Plan 2021/22

Trust Dataset Task & Finish Working Group

- Without a full and meaningful dataset about our HR processes, recruitment and a host of EDI data across all nine protected characteristics, we will not meet our objective to become an inclusive employer of choice

- A Task & Finish dataset working group is being set-up with membership comprising divisional EDI leads, HR business partners, HR information services, employment services and the Trust EDI lead

- The group will undertake detailed analysis of current data held by the Trust across a range of activities and functions and develop a robust framework of current available data and future data requirements to progress Trust D&I strategy and EDI action plan

Progress to date:

- Draft Terms of Reference completed

- Inaugural meeting will take place by end of Nov 2021

- Working group interim progress updates will feed into D&I group

- Final report and recommendations will be agreed by end of March 2022

WRES Strategic Action Plan 2021/22

Retaining and developing our People – Systems Race Equality Talent Development Programme

A BAME talent development programme is in the process of going live that will support both the 6 key actions and help reduce the race disparity gap ratios. Through partnership working across our system and with regional and national teams, the goal of the programme is to:

- Increase engagement and retention of BAME colleagues across the BNSSG system, both clinical and non-clinical
- Increase the opportunity for BAME colleagues to achieve their potential within our organisations and wider system
- Build links with mainstream talent management colleagues and programmes to embed the race equality programme and equality, diversity and inclusion perspectives
- Increase the diversity of our Talent pipelines health & care professions; increasing leadership and management capability, representation and innovation

Progress to date:

- Funding identified and Project Initiation Document developed with project managed by NBT (Q1 2021)
- Project manager appointed and engaged (August 2021)
- Scoping and needs analysis for each organisation begun by project manager with input from EDI & Resourcing Leads (Sept 21 onwards)

WRES Strategic Action Plan 2021/22

WRES Model Employer Goals and Race Disparity Ratio Goals

The BAME staff comprise 15.2% of the total Trust workforce in substantive posts. However, as can be seen below that at bands 6 and above (2020 UHBW data) there is a significant fall in BAME representation

Non-Clinical Staff

	White	BAME	Unknown
Band 1	48.2%	45.9%	5.9%
Band 2	83.1%	11.1%	5.7%
Band 3	87.0%	9.9%	3.1%
Band 4	92.8%	5.6%	1.6%
Band 5	91.6%	7.2%	1.2%
Band 6	91.9%	6.8%	1.4%
Band 7	93.1%	4.6%	2.3%
Band 8A	96.0%	4.0%	0.0%
Band 8B	94.0%	4.0%	2.0%
Band 8C	95.7%	4.3%	0.0%
Band 8D	100.0%	0.0%	0.0%
Band 9	100.0%	0.0%	0.0%
VSM	100.0%	0.0%	0.0%

Clinical Staff - Non-Medical

	White	BAME	Unknown
Band 1	65.0%	32.4%	2.6%
Band 2	80.1%	18.5%	1.4%
Band 3	85.8%	12.9%	1.3%
Band 4	92.9%	6.7%	0.4%
Band 5	79.6%	18.8%	1.6%
Band 6	89.1%	10.1%	0.8%
Band 7	94.5%	5.0%	0.5%
Band 8A	92.6%	6.5%	0.9%
Band 8B	96.6%	3.4%	0.0%
Band 8C	95.2%	2.4%	2.4%
Band 8D	85.7%	0.0%	14.3%
Band 9	100.0%	0.0%	0.0%
VSM	100.0%	0.0%	0.0%

Clinical Staff – Medical & Dental

	White	BAME	Unknown
Consultants (including Senior Medical Staff)	80.0%	14.9%	5.0%
Non-consultant career grades	66.4%	26.7%	6.9%
Trainee grades	75.1%	16.1%	8.8%
Other	56.5%	8.7%	34.8%

The Trust has adopted the WRES Model Employer Goals on Race Disparity Ratio and developing its 5-year action plan to ensure that at band 6 and above, BAME staff comprise at least 15.2% of the workforce.

Progress to date:

- Baseline 2021 racial disparity ratio data sent to the national WRES team (30 June 2021)
- The Trust 5-year action plan on addressing the racial disparity gap is being developing as part of the Dataset Task & Finish Working Group, BNSSG Race Equality Talent Development Programme and overhaul of the Trust recruitment and promotion processes as previously described

"The worst thing about a disability is that people see it before they see you"

Easter Seals

"It's not our disabilities, it's our abilities that count"

Chris Burke

"I have a Disability yes that's true, but all that really means is I may have to take a slightly different path than you"

Robert M. Hensel

"Because I'm able to bring my all to work, I'm able to give my all at work"

Kathy Martinez - Assistant Secretary for Disability Employment Policy

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) programme requires organisations employing the 1.3 million-strong NHS workforce to report against ten matrix indicators of disability equality; and supports continuous improvement through robust action planning to tackle the root causes of discrimination in relation to disabled staff.

The following slides set-out the first full UHBW WDES data across all ten indicators of disability equality as at 31 March 2021. The slides also set-out the Trust's WDES strategic action plan 2021/22.

Committed to inclusion in everything we do

2021 WDES spotlight on disabled staff

2.75% of UHBW staff have described themselves as disabled with another **8.96%** of staff with an unknown status

Non-disabled staff were **0.98** times more likely to be appointed from shortlisting compared to disabled staff

Disabled staff are **4.46** times more likely than non-disabled staff to enter the formal capability process.

80.7% of staff with long term conditions believing the organisation provides equal opportunity for career progression/promotion compared to staff with no long term conditions **87.8%**

17.4% of staff with long term conditions experienced discrimination from **manager/team leader** compared to staff with no long term conditions **9.1%**

24.4% of staff with long term conditions reported experiencing harassment, bullying or abuse from **staff** with no long term conditions **16%**

KEY FINDINGS from the WDES data 2021

WRES indicator 1 - UHB (excluding Weston)

% of staff in each of the Agenda for Change (AfC) Bands 1–9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce

Hartles Rachel 11/30/2021 13:46:56

Matrix 1a - Non-Clinical Staff						
	Disability		No Disability		Not Stated	
	No	%	No	%	No	%
Band 1	5	3.0%	153	93.3%	6	3.7%
Band 2	32	4.1%	622	78.9%	134	17.0%
Band 3	33	4.9%	571	85.6%	63	9.4%
Band 4	22	4.3%	460	89.1%	34	6.6%
Band 5	14	4.7%	259	87.2%	24	8.1%
Band 6	12	6.3%	166	86.5%	14	7.3%
Band 7	6	3.6%	151	91.0%	9	5.4%
Band 8a	2	2.0%	89	90.8%	7	7.1%
Band 8b	1	1.7%	52	88.1%	6	10.2%
Band 8c	1	2.6%	34	89.5%	3	7.9%
Band 8d	0	0.0%	11	84.6%	2	15.4%
Band 9	0	0.0%	16	88.9%	2	11.1%
VSM	0	0.0%	6	100.0%	0	0.0%
Other	0		0		0	

KEY FINDINGS from the WDES data 2021

Matrix 1b - Clinical Staff						
	Disability		No Disability		Not Stated	
	No	%	No	%	No	%
Band 1	2	1.68%	108	90.76%	9	7.56%
Band 2	37	2.62%	1245	88.11%	131	9.27%
Band 3	9	1.93%	415	88.87%	43	9.21%
Band 4	9	2.37%	312	82.11%	59	15.53%
Band 5	39	1.86%	1916	91.50%	139	6.64%
Band 6	42	2.76%	1378	90.72%	99	6.52%
Band 7	27	2.66%	925	91.13%	63	6.21%
Band 8a	5	1.76%	265	93.31%	14	4.93%
Band 8b	0	0.00%	68	95.77%	3	4.23%
Band 8c	1	2.63%	36	94.74%	1	2.63%
Band 8d	0	0.00%	8	72.73%	3	27.27%
Band 9	0	0.00%	4	100.00%	0	0.00%
VSM	0	0.00%	2	100.00%	0	0.00%
Medical & Dental Staff, Consultants	6	0.93%	548	85.36%	88	13.71%
Medical & Dental Staff, Non-Consultants career grade	5	1.32%	332	87.83%	41	10.85%
Medical & Dental Staff, Medical and dental trainee grades	23	3.52%	551	84.25%	80	12.23%
Other	1	4.0%	13	52.0%	11	44.0%

KEY FINDINGS from the WDES data 2021

Metric 2

Metric 2 reports the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

The 2021 data shows that non-disabled staff were 0.98 times more likely to be appointed from shortlisting compared to disabled staff.

Metric 3

Metric 3 reports the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. This is based on a two-year rolling average from this year and the previous year.

Disabled staff are 4.46 times more likely than non-disabled staff to enter the formal capability process.

Metrics 4, 5, 6, 7, 8 and 9a - These metrics are part of the NHS Staff Survey UHBW 2020.

There are six questions in the Staff Survey that measure the Workforce Disability Equality Standard (WDES); out of the six questions there are two positive responses compared to last year. We compare more favourably to the average of Acute Trusts in 5 out of 6 questions.

LTC = Long Term Condition

KEY FINDINGS from the WDES data 2021

Metric 4 (Staff Survey 2020) % Staff experiencing harassment bullying or abuse from patients relatives or members of the public in last 12 months	UHB 2019 %	UHBW 2020 %	+/-
LTC: Trust	27.7	28.0	0.3
LTC: Acute average	33.9	30.9	3.0
Without LTC: Trust	24.1	22.0	2.1
Without LTC: Average	27.3	24.5	2.8

Metric 5 (Staff Survey 2020) % Staff experiencing harassment bullying or abuse from manager in the last 12 months	UHB 2019 %	UHBW 2020 %	+/-
LTC: Trust	17.4	17.4	
LTC: Acute average	19.7	19.3	0.4
Without LTC: Trust	9.0	9.1	0.1
Without LTC: Average	11.0	10.8	0.2

KEY FINDINGS from the WDES data 2021

Metric 6 (Staff Survey) % Staff experiencing harassment bullying or abuse from other colleagues in the last 12 months	UHB 2019 %	UHBW 2020 %	+/-
LTC : Trust	24.5	25.4	0.9
LTC: Acute average	28.1	26.9	1.2
Without LTC : Trust	16.7	16.0	0.7
Without LTC : Average	18.4	17.8	0.6

Metric 7 (Staff Survey 2020) % Staff Experiencing Harassment bullying or abuse at work they or a colleague reported it	UHB 2019 %	UHBW 2020 %	+/-
LTC: Trust	51.0	50.4	0.4
LTC: Acute average	46.7	47.0	0.7
Without LTC: Trust	45.4	48.0	2.6
Without LTC: Average	45.6	45.8	0.2

KEY FINDINGS from the WDES data 2021

Metric 8 (Staff Survey) % Staff believe organisation provides equal opportunity for career progression or promotion	UHB 2019 %	UHBW 2020 %	+/-
LTC: Trust	84.1	80.7	3.4
LTC: Acute average	79.1	79.6	0.5
Without LTC: Trust	88.0	87.8	0.2
Without LTC: Average	85.6	86.3	0.7

Metric 9a (Staff Survey 2020) % Staff felt pressure from manager to come to work despite not feeling well enough	UHB 2019 %	UHBW 2020 %	+/-
LTC: Trust	25.4	26.7	1.3
LTC: Acute average	32.7	33.0	0.3
Without LTC: Trust	17.5	20.5	3.0
Without LTC: Average	24.4	23.4	1.0

KEY FINDINGS from the WDES data 2021

Metric 9b

Metric 9b reports action taken to facilitate the voices of disabled staff at the Trust to be heard. The Trust has an active and well supported disabled staff network (ABLE Plus Staff Network) which meets every six weeks to voice the concerns of disabled staff feeding into the Equality, Diversity & Inclusion Steering Group and also directly to the Trust Chair and the Director of People at their monthly meetings with all staff network chairs. ABLE Plus Staff Network recently conducted a 'wheelchair challenge' exercise with executive members of the Trust to highlight the daily obstacles that wheelchair users have to navigate to het to work or for patient appointments.

Metric 10 reports the percentage difference between the Trust Board's voting membership and the Trust's overall workforce, disaggregated.

	Disabled	Non-disabled	Unknown
Number of staff in overall workforce	334	10716	1088
Total Board members - % by Disability	6.25%	87.50%	6.25%
Voting Board Member - % by Disability	6.25%	87.50%	6.25%
Non Voting Board Member - % by Disability	0%	0%	0%
Executive Board Member - % by Disability	0%	100%	0%
Non Executive Board Member - % by Disability	12.50%	75%	12.50%
Overall workforce - % by Disability	2.75%	88.28%	8.96%
Difference (Total Board - Overall workforce)	3%	-1%	-3%
Difference (Voting membership - Overall Workforce)	3%	-1%	-3%
Difference (Executive membership - Overall Workforce)	-3%	12%	-9%

Trust WDES Strategic Action Plan 2021/22

At a Trust and system level, we are developing our action plan to address some of the key WDES findings locally, regionally and nationally. This includes:

Supporting the ABLE Plus Staff Network

The Trust is currently scoping and reviewing how best to support staff networks to become sustainable with greater reach and impact for all disabled staff and other staff across all protected characteristics .

Wheelchair challenge

Following the Wheelchair Challenge in May 2021, the ABLE Plus staff network will be working with Estates and Facilities and the communications team to raise awareness of the physical obstacles that wheelchair staff and patients have to navigate within the hospital/work environment.

Reasonable adjustments resource room

A resource room is being identified in the Trust library where staff and managers can view accessibility aids and IT software solutions that can be purchased to make reasonable adjustments for disabled to remain in employment.

Training for EDI Advocates on disability

EDI Advocates play a crucial role in helping change the culture of the Trust. To facilitate culture change, EDI Advocates will be trained on all aspects of physical and sensory disability so that they can be voice and allies of disabled staff.

Overhaul of recruitment and talent development

At a Trust and system level, we are currently developing our response to WDES on recruitment of local disabled people and talent management programme for disabled staff.

Equality monitoring data on Electronic Staff Record (ESR)

The Trust working with the ABLE Plus staff network will be running an internal campaign to raise awareness of what a disability is and encouraging staff to record their disability on ESR.

Policies and practice

The Trust will review policies such as absence management and reasonable adjustments to identify any gaps and make improvements.

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Equality Delivery System (EDS2)

EDS2 provides a compressive evidence-based approach to equality, diversity and inclusion for staff and patients.

The following slides set-out the Trust's EDS2 self-assessment (RAG grades to be agreed) on workforce goals three and four. The evidence drawn upon for the rating should be read in conjunction with the whole Trust EDI reporting and governance pathways including staff surveys.

Equality Delivery System (EDS2)

EDS2 – a framework for NHS organisations.

EDS2 is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.EDS2 is an equality, human rights and health inequalities reporting framework for the NHS containing four goals and 18 related outcomes.

The four goals are:

1. Better health outcomes.
2. Improved patient access and experience.
3. A representative and supported workforce.
4. Inclusive leadership.

EDS2 – an integrated approach to equality, diversity and inclusion

The Trust has developed a robust 5-year diversity and inclusion strategy that integrates EDS2 reporting framework and other key performance indicators

Determining the RAG rating:

RAG rating is determined by evidence showing how the Trust is meeting the health needs of **'none, some, most or all'** of the protected groups, so that:

- Red – Underdeveloped (people from all protected groups fare poorly compared with people overall or evidence is not available)
- Amber – Developing (people from only some protected groups fare as well as people overall)
- Green – Achieving (people from most protected groups fare as well as people overall)
- Purple – Excelling (people from all protected groups fare as well as people overall)

Goal 3: A representative and supported workforce

3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• The Trust's Recruitment Policy follows the NHS Employment Standards. Advertised posts are recruited to through the NHS Jobs website or the TRAC online recruitment system. • The systems do not allow shortlisting managers to have access to an applicant's personal details, although applicants may request a guaranteed interview those with a disability who are seeking employment. • The Trust has been accredited to use the Disability Confident Symbol (which has replaced the Double Tick disability symbol accreditation) in its recruitment literature, and has signed up to the Mindful Employer charter. • As of 31 March 2021, Trust workforce with substantive employment contract comprised of 12,054 (77.1% Female; 22.9 % Male; 71.9% White British; 24.7% BAME and Other White; 3.4% Not stated) • The recruitment and selection processes are currently subject to a comprehensive corporate and divisional review • The Trust is developing an action plan on the NHSE/I recruitment and promotion six priority areas • The Trust has acknowledged through its reporting against the relevant WRES that there is under-representation of BAME staff at senior levels, as well as a greater likelihood of white staff staff being appointed from shortlisting than BME staff, and is developing more detailed actions to address these issues. • The Trust is developing a WRES action plan including the five year Race Disparity Ratio action plan. • The Trust is setting up an EDI dataset Task & Finish working group to develop a comprehensive staff dataset for all protected characteristics particularly to address disability and sexual orientation data gaps • Currently, there is no staff data available on gender reassignment, marriage and civil partnership

Goal 3: A representative and supported workforce

3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• Equal pay has been set nationally as part of 'Agenda for Change' • The Trust allocates posts to pay bands – staff are placed in one of nine pay bands on the basis of their knowledge, responsibility, skills and effort needed for the job • The Trust has published its annual Gender Pay Gap report and action plan for the past four years • The Gender Pay Gap report 2020 will be published by 5 October 2021 • The first full UHBW NHS FT Gender Pay Gap report 2021 will be published by 31 March 2022.

Goal 3: A representative and supported workforce

3.3 Training and development opportunities are taken up and positively evaluated by all staff

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• The Trust is diligent in ensuring that all staff are provided with training, learning and development opportunities • Further evidence can be found in the staff survey 2021 and divisional heat maps

Goal 3: A representative and supported workforce

3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• The Trust is diligent in ensuring that when at work, staff are free from abuse, harassment, bullying and violence from any source • The Trust has a bullying and harassment policy in place • The trust has a dedicated bullying and harassment lead that sits in OD • Further evidence can be found in the staff survey 2020 and divisional heat maps

Goal 3: A representative and supported workforce

3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• The Trust is diligent in ensuring that flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives: • There is a flexible working policy in place with a number of different flexible working options. • Further evidence can be found in the staff survey 2020 and divisional heat maps

Goal 3: A representative and supported workforce

3.6 Staff report positive experiences of their membership of the workforce

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• The Trust is diligent in ensuring that staff report positive experiences of their membership of the workforce along with a good working environment • Further evidence can be found in the staff survey 2020 and divisional heat maps

Goal 4: Inclusive leadership

4.1 Governing body members and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• Trust board members, divisional board members and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations • The whole Trust Board engaged in an equality, diversity and inclusion workshop on 17 Sept 2021 with reinforced leadership and commitment to deliver on our ambitious mission and vision to be an exemplar Trust in equality, diversity and inclusion. • Regular reports to the people committee and board on EDI progress and assurance • Trust chair and interim chair regular attendees and contributors at the Bristol Race Equality Strategic Leaders' Group meetings • Interim Trust chair is sponsoring the launch and support of the new Trust Women's Staff Network • Interim Trust chair identified funds to support the development of staff networks through protected time

Goal 4: Inclusive leadership

4.2 Papers that come before the governing body and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• Trust execs monitor EDI risks on a quarterly basis as part of the Risk Management Group • EDI risk registered on Datix (285) as: (1) Risk of non-compliance with the public sector equality duty and equalities legislation resulting in reputational damage, inequity of experience for all staff and potential legal action (2) Risk that the Trust fails to ensure equity of experience for all staff • Regular reports to the people committee and board on EDI risk, compliance and assurance • Review of risk is a standing item at the 6-wekly EDI steering group meeting • Trust has a robust EDI risk governance and reporting pathways that feed directly to the board via the people committee that is chaired by a board non executive director (NED) • SW regional standardised single equality impact assessment template and guidance being developed • At this point in time, however, the Trust cannot fully assure itself because we do not have full staff dataset across all protected groups

Goal 4: Inclusive leadership

4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• There is reasonable evidence to suggest that Trust middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination • Trust has developed a cultural awareness training that has been well received with xxx having completed the training so far • Further evidence can be found in the staff survey 2020 and divisional heat maps

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Gender Pay Gap 2021

The GPG 2021 report and action plan is pending subject to GPG 2021 data analysis and verification

"Accountability is the glue that bonds commitment to results"

Will Craig

"Responsibility, equals accountability, equals ownership. And a sense of ownership is the most powerful weapon a team or organisation can have"

Pat Summit

"The biggest risk a person can take is to do nothing"

Robert T Kiyosaki

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Risk, Compliance and Assurance

The following slides set-out a robust assurance and delivery plan that mitigates risk by:

- Compliance with the public sector equally duty for all protected characteristics
- Responding to findings from staff surveys
- Responding to the Workforce Race Equality Standard (WRES) and adopting the Model Employer Framework and Goals
- Responding to the Workforce Disability Equality Standard (WDES)
- Responding to the People Plan and the People Promise
- Using the Equality Delivery System (EDS2) goals three and four as an organisational cultural of care barometer
- Addressing Gender Pay Gap (GPG)

Committed to inclusion in everything we do

Risk, Compliance and Assurance

- When we come to work as a whole self, **we also bring our biases and prejudices** into the professional office/environment
- It is essential that we have clear **personal/professional boundaries** at work
- The Equality Act 2010 was created to protect people at work (and outside of work) who have one or more of these **nine human characteristics** from prejudices, stereotypes and unlawful discrimination
- It's important to remember that **each one of us has at least five** of these nine protected characteristics and we acquire more in life depending on the choices we make and our health

Risk, Compliance and Assurance

The Equality Act 2010 makes it unlawful to discriminate against someone at work or wider society on the grounds of any of these nine characteristics: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion/belief, sex (gender) and sexual orientation. Other grounds include bullying and harassment or victimisation. In addition, public sector bodies, like NHS Trusts, also have a separate 'equality duty'.

Public Sector Equality Duty

The Trust, like all other public bodies, has a public sector equality duty which has three crucial aims to embed EDI in everything we do:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010

2. Advance equality of opportunity between people who share a protected characteristic and those who do not

3. Foster good relations between people who share a protected characteristic and those who do not

Risk, Compliance and Assurance

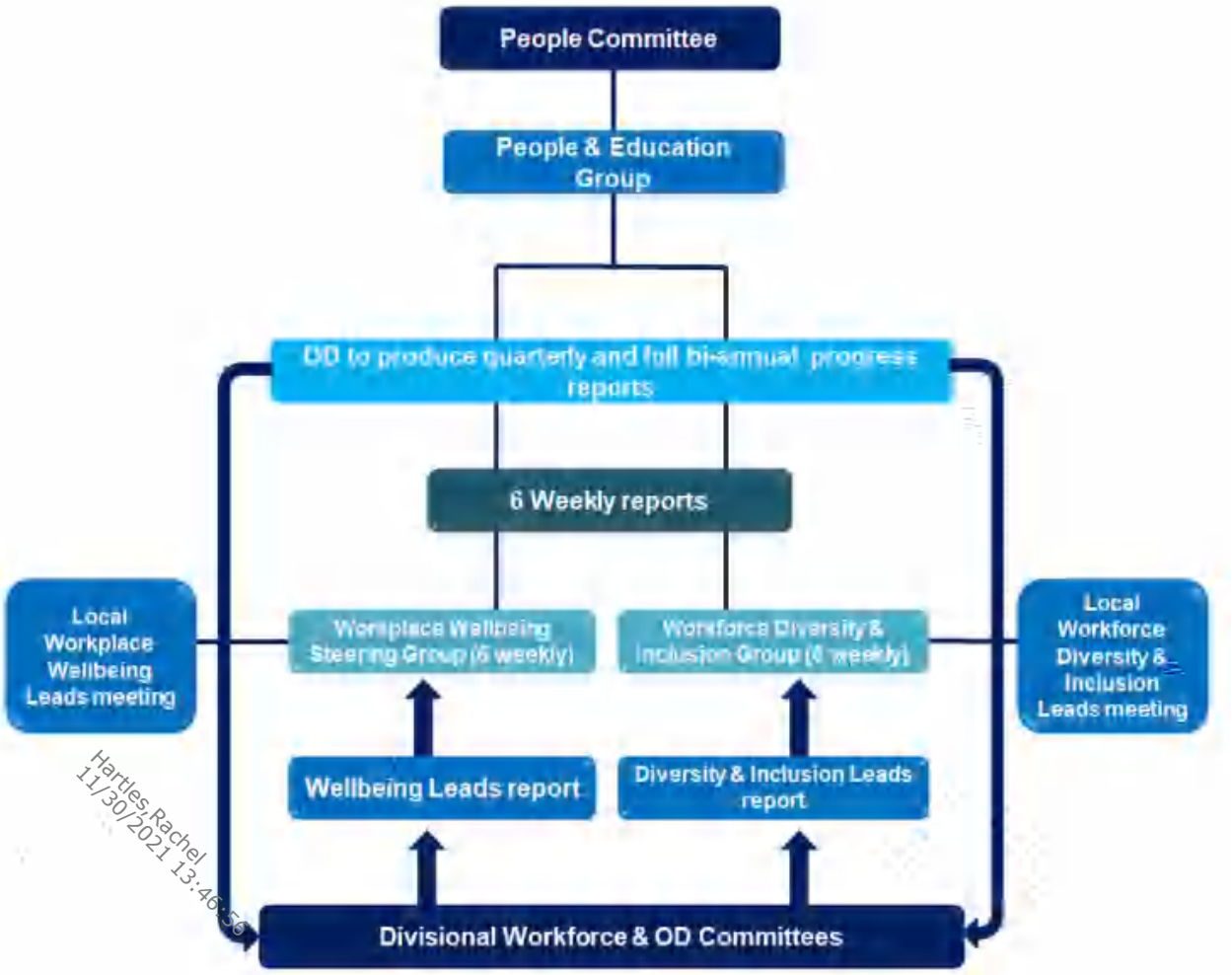
If our HR governance and recruitment processes are not more inclusive, accessible and wide-reaching, the Trust may fail to realise the benefits of the equality, diversity and inclusion strategy resulting in a negative impact on staff recruitment, poor staff retention and reputational damage for the Trust.

To mitigate risk on compliance, the Trust has developed a robust assurance and delivery plan to respond to our public sector equally duty across all protected characteristics including the findings from staff surveys, Equality Delivery System (EDS2), WRES, WDES and Gender Pay Gap. EDI risk is also registered on Datix as 285.

On Datix, Risk 285 is defined as:

'Risk that the Trust fails to ensure equity of experience for all staff'

Workforce Equality, Diversity and Inclusion Governance Pathway



- Organisational Development has established a robust governance pathway for workforce EDI and wellbeing
- Divisional and corporate EDI leads provide 6-weekly strategic updates on progress against the Trust 5-year D&I strategy to the EDI steering group
- In addition, operational EDI leads provide 6-weekly updates on local EDI activities and share best practice at the operation EDI group
- The People and Education Group provides challenge and support for the plan and associated programmes of work
- People Committee are the assurance group for EDI feeding directly into the Board

Mitigating compliance, inclusion and reputational risk

- Bullying and harassment
- Discrimination and victimisation
- Fair recruitment process at all levels
- Talent management
- Inclusive leadership at all levels
- Career development opportunities
- Valuing and celebrating staff diversity across all protected groups
- People policies and practices
- Health and wellbeing of all our staff

- Supported and representative workforce
- Developing partnerships at local, regional and national level
- Dignity and respect
- Being allowed to come to work as a whole person
- Career/personal development opportunities
- Values and leadership behaviours
- Embedding inclusion in everything we do
- UHBW – inclusive employer of choice

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Equality, Diversity and Inclusion Action Plan April 2021 to March 2022

The following slides set-out the strategic action plan for the remainder of 2021/22. Progress and exceptions on the action plan will be monitored by the six-weekly EDI steering group with quarterly updates to the People Committee.

Equality, diversity and inclusion strategic objectives action plan 2021/22

Strategic Priorities: Leadership and Cultural Transformation.

KPIs	No	Objective	Who	When and How
Objective 1: As leaders we role model the Values and Leadership behaviours creating an environment that encourages feedback and where staff feel safe to challenge				
PSED EDS4.1 DPP6	1	In partnership with the national team launch the national reciprocal mentoring programme across divisions with recruitment of 20 mentor pairs across the Trust	EDI Manager Barnard Galton Sam Chapman	This is currently on hold due to the national pause
Objective 2: We are committed to inclusion in everything we do and this is evident in all our people policies and practices				
EA2010 PSED BSS1 BSS2&3	2	Develop leadership tools and support the development of the EDI advocates and divisional leads to have the knowledge, skills and abilities to embed EDI in everything we do.	EDI Manager Divisional EDI leads	EDI advocates in place by September 2021 with bitesize training videos and capacity-building EDI training for the remainder of 2021/22
EDS3.1 DPP1	3	Ensure EDI is further embedded into our recruitment processes ensuring the diversity of our workforce increases year on year	EDI Manager Peter Russell	Year plan being developed to further improve recruitment practices which will include the creation of a EDI working group within Resourcing to take forward this agenda. Q1 focus on recruitment of overseas nurses and divisional recruitment processes.
Objective 3: We celebrate and value the contribution all of our staff make at all levels of the organisation				
EDS3.6 PSED	4	Develop an effective communication plan for sharing and promoting use of wellbeing resources and initiatives across the Trust that is embedded in to the UHBW cultural programme.	EDI manager Communications team Staff networks EDI leads	This has commenced with LGBT history month and will be ongoing throughout 2021/22.

Equality, diversity and inclusion strategic objectives action plan 2021/22

Strategic Priorities: Accountability and Assurance.

KPIs	No	Objective	Who	When and How
Objective 4: We will encourage shared learning by openly sharing our diversity data in a meaningful way.				
WRES WDES GPG DPP3 DPP4 DPP5 PSED EDS3.6	5	Develop a robust assurance and delivery plan to respond to our Public Sector Equalities Duties (PSED) across all protected characteristics.	EDI Manager HRIS team Workforce D&I Group	With effect from June, a business cycle will be in place to ensure effective reporting and alignment of all findings to inform integrated solutions. This will include but not be limited to; staff survey results, WRES, WDES, gender pay gap and staff network action plans
Objective 5: Our strategy is communicated at all levels reflecting our commitment to change.				
EA2010 PSED WRES WDES GPG	6	Ensure there is a robust reporting framework to communicate progress against the Trust's 5-year D&I strategy	EDI Manager Workforce D&I Group	This has been completed and is part of the aforementioned business cycle

Equality, diversity and inclusion strategic objectives action plan 2021/22

Strategic Priorities: Positive Action and Practical Support.

KPIs	No	Objective	Who	When and How
Objective 6: Our Education Strategy focuses on inclusion and is a key enabler to delivering the vision supported by our Trust values.				
EA2010 PSED WRES WDES EDS2	7	Provide inclusive education that nurtures staff motivation and aspirational career development and values the individual and the teams that work together.	EDI Manager Senior Education Quality Manager Divisional EDI leads	Build on existing EDI dataset across all educational programmes for impact analysis and action including developing and supporting under-graduate medical students' EDI pathways at the Academy Continue to build on external partnerships including participate in the UWE-led project supporting students' EDI pathways in clinical practice placement.
Objective 7: Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible.				
EA2010 PSED WRES WDES EDS2	8	Ensure there are robust divisional plans in place to enable the effective delivery of the strategy at a local level and to ensure local solutions are embedded in response to the staff survey	EDI manager Divisional EDI leads Operational EDI leads Staff Network chairs HRBPs	With effect from June divisional EDI action plans in place EDI advocates support pack to launch in September 2021
Objective 8: Staff forums grow to become an increased staff voice who represent our workforce and the community we serve				
EA2010 PSED WRES WDES EDS2	9	Develop staff networks to have increased membership, greater reach and impact to support under-represented or disadvantaged staff across all protected characteristics.	EDI Manager Staff network chairs Jeff Farrar Matt Joint	Refreshed governance arrangements for staff networks and 12-month work plan to be in place by May 2021. This programme of work will be for the duration of 2021/22

Equality, diversity and inclusion strategic objectives action plan 2021/22

Strategic Priorities: Monitoring Progress and Benchmarking.

KPIs	No	Objective	Who	When and How
Objective 9: We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves.				
PSED EA2010 EDS2 WRES WDES	10	Ensure there is robust governance pathway across all divisions that reports into the corporate infrastructure and allows for a two way dialogue to monitor progress and share best practice	EDI Manager Divisional EDI leads Operational EDI leads	April onwards Relaunched EDI steering group with new terms of reference and six weekly reporting which will report into corporate governance for assurance Refreshed divisional EDI leads and operational leads reporting pathways which will report into corporate governance for assurance
Objective 10: We will seek opportunities to learn from others, developing our partnerships at a regional and national level.				
WRES WDES PSED EA2010 EDS2	11	The Trust to actively play a leading role in contributing and learning from EDI strategies, activities and policies in partnership locally, regionally and nationally for the benefit of our staff and patients.	EDI Manager	Membership at all regional and national forums ensuring best practice is adopted and shared. Learnings will be incorporated into the strategy plan as appropriate Partnership working has progressed with the development of a system wide EIA process commencing in July 2021

Equality, Diversity and Inclusion Key Performance Indicators (KPIs) Glossary

KPI	EQUALITY ACT 2010
EA2010	Protection against unlawful discrimination for the nine protected characteristics in the workplace
PSED	Public sector equality duty (the equality duty): • Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act. • Advance equality of opportunity between people who share a protected characteristic and those who do not • Foster good relations between people who share a protected characteristic and those who do not
KPI	**STAFF SURVEY**
BSS1	Not experience harassment, bullying, or abuse from patients/service users, their relatives or members of the public.
BSS2	Not experience harassment, bullying or abuse from mangers.
BSS3	Not experience harassment, bullying or abuse from other colleagues.
BSS4	Last experience of harassment/bullying/abuse reported
DSS1	Organisation acts fairly: career progression.
DSS2	Not experiences discrimination from patients/service users, their relatives or other members of the public.
DSS3	Not experiences discrimination from manger/team leader or other colleagues.
DSS4	Disability: organisation made adequate adjustment(s) to enable me to carry out work.
KPI	**GENDER PAY GAP**
GPG	Publish annual report with specific figures about gender pay gap, narrative and actions (if applicable)

Equality, Diversity and Inclusion Key Performance Indicators (KPIs) Glossary

KPI	PEOPLE PLAN
APP2	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.
DPP1	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.
DPP2	Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.
DPP3	Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce.
DPP4	51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes
DPP5	Support organisations to achieve the above goal, including establishing robust decision- tree checklists for managers, post-action audits on disciplinary decisions, and pre-formal action checks.
DPP6	Refresh the evidence base for action, to ensure senior leadership represents the diversity of the NHS, spanning all protected characteristics.
DPP7	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.
DPP8	Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.
DPP9	Prevent and tackle bullying, harassment and abuse against staff, and create a culture of civility and respect.
KPI	**WORKFORCE RACE EQUALITY STANDARD (WRES) INDICATORS**
WRES1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.
WRES2	Relative likelihood of staff being appointed from shortlisting across all posts.
WRES3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
WRES4	Relative likelihood of staff accessing non-mandatory training and CPD.
WRES5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

Equality, Diversity and Inclusion Key Performance Indicators (KPIs) Glossary

KPI	WORKFORCE RACE EQUALITY STANDARD (WRES) INDICATORS
WRES6	Percentage of staff saying they have experienced harassment, bullying or abuse from staff in the last 12 months
WRES7	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.
WRES8	Percentage of staff personally experiencing discrimination at work from their manager/team leader or another colleague in the last 12 months
WRES9	Percentage of difference between the organisations' Board voting membership and its overall workforce. (Note: Only voting members of the board should be included with considering this indicator.)
KPI	**WORKFORCE DISABILITY EQUALITY STANDARD (WDES) INDICATORS**
WDES1	Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.
WDES2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.
WDES3	Relative likelihood of Disabled staff compared to non-disables staff as entering the formal capability process, as measured by entry into the formal capability procedure.
WDES4	a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public; managers; other colleagues b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
WDES5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion
WDES6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
WDES7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

Equality, Diversity and Inclusion Key Performance Indicators (KPIs) Glossary

KPI	WORKFORCE DISABILITY EQUALITY STANDARD (WDES) INDICATORS
WDES8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
WDES9a	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation
WDES9b	Has your trust taken action to facilitate the voices of Disables staff in your organisation to be heard?
WDES10	Percentage difference between the organisations Board voting membership and its organisations overall workforce, disaggregated: • By voting membership of the board • By executive membership of the board
KPI	**EQUALITY DELIVERY SYSTEM 2 (EDS2)**
EDS2G3	**Goal 3: A representative and supported workforce**
EDS3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
EDS3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
EDS3.3	Training and development opportunities are taken up and positively evaluated by all staff
EDS3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source
EDS3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
EDS3.8	Staff report positive experiences of their membership of the workforce
EDS2G4	**Goal 4: Inclusive leadership**
EDS4.1	Governing body members and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
EDS4.2	Papers that come before the governing body and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
EDS4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

Report Title	**Flu Board Assurance Framework** **Seasonal Influenza Vaccination Programme: Progress Update**
Report Author	**Ginny Nash, Vaccination Programme Lead**
Executive Lead	**Alex Nestor, Interim Director of People** **Deirdre Fowler, Chief Nurse and Midwife**

1. Report Summary	
This paper outlines the current Influenza and COVID-19 vaccination activity taking place across University Hospitals Bristol and Weston NHS FT and includes the Trust's self-assessment against the National healthcare worker flu vaccination best practice checklist for assurance, in line with National and Local requirements.	
2. Key points to note *(Including decisions taken)*	
This paper demonstrates that the Trust has undertaken a self-assessment and associated action plan (See Appendix) against the National healthcare worker flu vaccination best practice management checklist, required for public assurance by December 2020.	
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**	
The risks associated with this report include: N/A	
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **Assurance.** The Board of Directors are asked to: • Note current compliance against the self-assessment tool by: o Receiving actions to achieve full compliance o Receiving an evaluation of the flu vaccination programme 2021/22 at its March meeting	
5. History of the paper **Please include details of where paper has previously been received.**	
People Committee	**26 November 2021**

Seasonal Influenza Vaccination Programme: Progress Update

1.0 Introduction

The National Flu Immunisation Programme 21/22 letter (July 2021) requests NHS providers to complete a self-assessment against the National healthcare worker flu vaccination best practice checklist to be published in public board papers by December 2020.

This report provides the Board with the outcomes of this self-assessment and provides assurance that the Trust meets the requirements as set out by The Department of Health and Social Care, NHS England and Public Health England.

Since September the Trust's Vaccination Programme Team have stood up an Influenza and COVID-19 vaccination service for both eligible staff and patients, in line with National and Local requirements.

The first influenza vaccination was administered on the 2nd October and the Trust will continue administering influenza vaccinations until the 28th February 2022. This is supported by ~250 Influenza-trained vaccinators across the Trust.

The first Phase 3 (Phase 3 stood up from 20th September) COVID-19 vaccination was administered on the 20th September and the Trust will retain an on-site offer of COVID-19 vaccinations to meet the mandate deadline for all healthcare workers to have had their 1st and 2nd COVID-19 vaccination by the 1st April 2022. This is supported by ~150 COVID-19-trained vaccinators across the Trust.

With every COVID-19 vaccination appointment we are offering the co-administration of an influenza vaccination at the same time.

The Vaccination Programme is co-ordinated by the Vaccination Programme Team with leadership from the Vaccination Programme Lead. The Programme's Governance comprises:

- The Trust Senior Leadership Team Delivery Group
- BNSSG Vaccination Programme
- Public Health England
- Clinical Commissioning Group
- NHS England/NHS Improvement
- National Immunisation and Management System

2.0 Current position

Last year the Trust achieved a frontline healthcare worker influenza vaccination uptake rate of 88%. This year's national target is to achieve a 100% offer with an 85% ambition. At this point in time, the Trust has achieved 52% uptake of frontline healthcare workers* and 53% overall – frontline and non-frontline workers.

With uptake data now coming out of the first couple months of this year's campaign we now flexing our delivery model and promotional activity to improve vaccination uptake within identified staff groups (including by ethnicity, job role and Division) to meet the 85% target by the end of February.

**please note, in line with National Operational Guidance (C1008, 26 January 2021) the definition and therefore denominator for frontline healthcare workers has changed for this year (with the count up by 2,876 staff). It is important to note this when comparing this year's Frontline uptake % to last year. These percentages do also not account for all those who will have had their vaccination outside the Trust – we are encouraging staff to let us know and will feed these numbers into our figures.*

3.0 Next Steps

The Board of Directors are asked to:

- Note current compliance against the self-assessment tool by:
  - Receiving actions to achieve full compliance
  - Receiving an evaluation of the flu programme 2021/22 at its March meeting.

The Trust Board is requested to note the contents of this report, and to seek additional assurance or information as required.

University Hospitals Bristol and Weston NHS Foundation Trust

Appendix: Seasonal Influenza Programme: Implementation Plan 2021-2022

The Trust takes a multicomponent approach to increasing uptake of flu vaccination among front-line and non-patient facing colleagues. The series of objectives (A to D) and self-assessment reflects a best practice checklist based on 5 key components of developing an effective flu vaccination programme. It is reviewed throughout the project lifecycle by the UHBW Vaccination Programme Lead and Implementation Group.
NB This plan should be read in conjunction with the pending phase 3 Covid booster vaccination delivery plan 2021/22.

A	Committed leadership	Trust Self-Assessment		Actions	Lead	Timeline	RAG
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers.	UHBW will deliver a 100% offer with an **85%** uptake ambition of Frontline Healthcare Workers (FHCW). Ambition to be recorded at Trust Board in November 2021.	1	Identify 'higher risk environments' with Chief Nurse/HoN colleagues to prioritise early vaccinations.	Chief Nurse	Aug 21	
			2	Monitor uptake within staff groups (including by ethnicity, job role and Division) against Trust % ambition and adapt vaccination delivery model accordingly.	Vaccination Programme Lead	Aug 21-Feb 22	(ongoing)
			3	Submit Board assurance paper at 30th November 2021 public board meeting.	Vaccination Programme Lead	Nov 21	
			4	Create and adopt electronic systems to replace paper consent and pre-screening forms and roll-out as part of eLearning or SOP.	Vaccination Programme Lead Digital Services	Aug 21-Feb 22	

			5	Declination process to be created (e.g. captured within team/survey/ email to flu inbox, etc.) and supported by Divisional Flu Leads.	Vaccination Programme Lead Divisional Flu Leads	Jan – Feb 22	
			6	Uptake data to be submitted to internal/external stakeholders as required e.g. PHE (ImmForm), CCG and NIMS.	Vaccination Programme Lead	Season	(ongoing)
			7	Attend fortnightly CCG System Flu Group.	Vaccination Programme Lead	Season	
			8	Report Vaccination Programme progress to Senior Leadership Team Delivery Group	Vaccination Programme Lead	Monthly	(ongoing)
			9	Partake in SW PHE telecoms (and visit campaign resource centre for national updates).	Comms Lead	Monthly	(ongoing)
			10	Submit Board evaluation for assurance at 30th March 2022 public board meeting.	Vaccination Programme Lead	Mar 22	
A2	Trust has ordered and provided the quadrivalent (QIV) flu	Order of 10,000 doses of Seqirus: Flucelvax® Tetra (Bristol) & 2,150 (Weston Inc. maternity	11	Liaise with vaccine supplier to confirm delivery date/s and any additional stock requirements during the season.	Pharmacy	Season	(ongoing)
			12	Create online vaccine order form and maintain inventory.	Pharmacy	Sept 21	(ongoing)

	vaccine for healthcare workers.	patients). Additional 1,000 Bristol patient stock ordered. Single drop: 27/09/21.	13	Dispatch vaccines and any accompanying paper packs to fridge.	Pharmacy	Season	(ongoing)
A3	Board receive an evaluation of the flu programme 2021 to 2022, including data, success, challenges and lessons learnt.	Report submitted following most successful flu programme to date: 86.4%.	14	Evaluation for the 2021-22 season to be provided to the Board as stated in A1.	Vaccination Programme Lead	Mar 22	
A4	Agree on a board champion for flu campaign.	Alex Nestor Interim Director of People. From 04/01/22 Emma Wood, Director of People	15	Line manager to Vaccination Programme Lead.	Interim Director of People	Season	
A5	All board members receive flu vaccination and publicise this.	Comm's to publicise images of Board vaccinations in internal and external media.	16	Dedicated flu communications plan 2021-22 to be approved to reflect an inclusive mix of board and non-board level engagement and promotional activity.	Comm's Lead	Sept 21	
A6	Flu team formed with representatives from all directorates, staff	Flu Implementation team in place to comprise core	17	Flu Implementation Group with representatives from across the Trust oversee the implementation of this	Flu Implementation Group	July 21-Mar 22	

	groups and trade union representative.	stakeholders from multi-disciplinary backgrounds.		action plan and meet regularly to review progress and agree next steps.			
			18	Access to dedicated workspace available to Flu Implementation Group, flu vaccinators and other internal stakeholders.	Vaccination Programme Lead	Season	
A7	Flu team to meet regularly from Sept. 2021.	See A6 – formed July 2021.	19	Fortnightly meetings planned from August 2021.	Vaccination Programme Lead	Season	
			20	Acquire absence data for S13 cold, cough, flu from HRIS to inform potential impact of vaccination on sickness.	HRIS Lead	Season	(ongoing)

B	Communication Plan	Trust Self-Assessment		Actions	Lead	Timeline	RAG
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions.	Dedicated UHBW Flu comm's plan linked to 'BNSSG Flu Communications and Engagement Plan' and PHE 'Shield' assets with specific focus on BAME colleagues.	1	Explore use of flu wallpaper (both sites).	Comm's Lead	Season	(ongoing)
			2	Utilise BNSSG/PHE resources from flu campaign centre.	Comm's Lead	Season	(ongoing)
			3	Agree design and distribution of promotional materials.	Comm's Lead	Season	(ongoing)

			4	Produce videos of colleagues promoting flu vaccine; (regional videos produced by BNSSSG system flu group)	Comm's Lead	Season	(ongoing)
			5	Attach message to paper and e-Payslip 'message from employer' section.	Comm's Lead	Oct 21 Jan 22	(ongoing)
B2	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper.	Vaccination clinic calendar published on intranet.	6	Liaise with Divisional leads and vaccinators to agree drop-in clinics across estate to advertise to non-clinical colleagues.	Vaccination Programme Lead Comm's Lead	Sept 21	(ongoing)
			7	Explore options for distribution of hard copy clinic calendar.	Vaccination Programme Lead Comm's Lead	Sept 21	(ongoing)
			8	Add QR to view online calendar on any internet device.	Vaccination Programme Lead Comm's Lead	Season	(ongoing)

B3	Board and senior managers having their vaccinations to be publicised.	See A6. Photo of board member having flu vaccination shared.	9	Selfie frame to be commissioned in BNSSG / PHE campaign format to support staff engagement and promotional activity – subject to current PPHE and social distancing rules.	Comm's Lead	Oct 21	
B4	Flu vaccination programme and access to vaccination on induction programmes.	Vaccinations to be available onsite following induction (subject to format & vaccinator availability).	10	Flu Vaccination walk in appointments now available x3/week in the drop-in Vaccination Clinics in The Academy, Weston and BHI Atrium, Bristol	Vaccination Programme Lead	Sept 21	
B5	Programme to be publicised on screensavers posters and social media.	See B1.	11	To be included in dedicated flu communications plan 2021-22.	Vaccination Programme Lead Comm's Lead	Aug 21	(ongoing)
B6	Weekly feedback on percentage uptake for directorates, teams and prof' groups.	See A5.	12	Provide uptake and declination figures to board champion and weekly to Comm's team to include via 'jab-o-metre' illustration/infographic on intranet and dedicated flu pages (Bristol and Weston).	Vaccination Programme Lead Comm's Lead	Season	(ongoing)

C	Flexible Accessibility	Trust Self-Assessment	Actions	Lead	Timeline	RAG

C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered.	477 peer vaccinators in place in 2002-21 – to be encouraged to refresh training to deliver planned and impromptu vaccines as required on shop floor. Div' leads to drive vaccine uptake in their areas/Division.	1	Create a PGD and update UHBW eLearning in line with Flu immunisation training recommendations 2021/22 and eLearning for Healthcare – Flu Immunisation (HEE) to house on Kallidus & ESR training platforms.	Pharmacy Chief Nurse OcH Nurse Vaccination Programme Lead Ed' team	Aug 21	
			2	Undertake recruitment exercise to increase vaccinator network.	Chief Nurse Comm's Lead Vaccination Programme Lead Div' Flu Leads	Season	
			3	Seek support of wellbeing advocates to promote vaccinator role and awareness of clinic offer.	Vaccination Programme Lead Wellbeing Lead	Season	(ongoing)

			4	Maintain engagement with vaccinators to provide feedback, successes and to drive motivation to achieve targets. Flusbeat email template to be considered as in previous campaigns.	Vaccination Programme Lead	Season	(ongoing)
			5	Acknowledge vaccinator contributions and manger support in Newsbeat and via individual thank you messages	Comm's Lead Vaccination Programme Lead	Season	(ongoing)
C2	Schedule for easy access drop in clinics agreed.	See B2.	6	Develop and publicise support available to colleagues with needle phobia within Occupational Health as per comm's plan.	Vaccination Programme Lead Comm's Lead OcH Lead	Season	
C3	Schedule for 24 hour mobile vaccinations to be agreed.	See B2.	7	Availability and register of "roaming" vaccinators to be formed – to visit clinical areas as required/opportunistically.	Vaccination Programme Lead	Season	(ongoing)

D	Incentives	Trust Self-Assessment	Actions	Lead	Timeline	RAG

D1	Board to agree on incentives and how to publicise this.	COSTA sponsorship provides free hot drink via voucher to Bristol based colleagues. Rafters/COSTA to supply drinks to Weston based colleagues – at cost.	1	Liaise with Medirest (via Facilities General manager) re quantity, design and redemption of Bristol COSTA and Weston COSTA/Rafters voucher.	Vaccination Programme Lead	July 21	
			2	Flu Implementation Group to consider incentives/thank you's to vaccinators and teams/Divisions with high % compliance.	Implementation Group	Sept 2020	
D2	Success to be celebrated weekly.	Compliance data publicised per Division, Trust-wide in week 2 and weekly thereafter via Jab-o-Metre on intranet.	3	Create jab-o-metre template and secure position on intranet home page.	Comm's Lead		(ongoing)

RAG Key:

On Plan	Blue
Complete	Green
Risks slippage	Amber
Barriers: not achieved	Red

Updated by Ginny Nash following discussion at Flu Implementation Group: 11/11/2021

References

- JCVI advice on influenza vaccines for 2021/22 (NHSI letter: 01/07/21)
- National flu immunisation programme 2021/22 letter: 17/07/21
- PHE Vaccine uptake guidance and the latest coverage data (ImmForm)
- NICE guidelines on increasing influenza vaccine uptake [NG103]
- Flu vaccination: increasing uptake: Quality standard [QS190]
- Immunisation against infectious disease (The Green Book)
- Flu immunisation training recommendations 2021/22
- eLearning for Healthcare – Flu Immunisation (HEE)

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

Report Title	**Freedom to Speak Up Quarter 2 Report**
Report Author	**Eric Sanders, Freedom to Speak Up Guardian**
Executive Lead	**Alex Nestor, Interim Director of People**

1. Report Summary

To update the Board on the work of the Freedom to Speak Up Guardian in Q2 2021

2. Key points to note
(Including decisions taken)

- In the second quarter the number of concerns raised via the Freedom to Speak Up Guardian remain high (24) but down on the last quarter (30)
- Half of the concerns relate to attitude and behaviours
- Concerns have come from all areas of the Trust however the majority are from the division of Weston as per previous quarters
- Concerns are more complex and taking longer to resolve. Escalation to help resolve concerns at executive level is now in place
- Challenges remain with regard to how the organisation supports managers to respond to concerns, and we learn and make change from concerns raised.

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

The risks associated with this report include:

There is a risk that learnings from concerns are not shared across the organisation and similar concerns continue to be raised, or that concerns take too long to reach a resolution – which may impact on the confidence of staff in the speaking up arrangements in the Trust.

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

- This report is for **Assurance.**

The Board is asked to:

- Note the themes, trends and issues arising from this report
- Continue to seek assurance that plans around leadership and management development, people management and culture change are progressing.

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

Senior Leadership Team	**20 October 2021**

Q2 Freedom to Speak Up Report

1. Introduction

1.1. This report, presented during Speak Up month, reflects back on the second quarter of the year, the themes of concerns raised and progress against the Freedom to Speak Up strategy.

1.2. It is clear that, given the high proportion of concerns related to 'attitudes and behaviours', more focus is required to support managers to hear and manage these concerns, particularly thinking about the impact on staff wellbeing. This triangulates with feedback from the Clinical Psychologist team about what would make the biggest impact on staff wellbeing.

1.3. A number of concerns remain unresolved over a long period, which is likely to erode confidence in speaking up as an effective process. More needs to be done by managers and leaders at all levels to provide a positive and timely response when concerns are raised. This aligns with the organisational priority of 'staff first'.

1.4. The prevalence of similar themes being raised by staff from different areas of the organisation, highlighted in previous reports, suggests that learning from concerns is not happening as it should.

1.5. The Freedom to Speak Up strategy is in the process of being revised, looking at the learning from the last five years in which Freedom to Speak Up has been part of the NHS, and to reflect the themes of concerns the Guardian has heard from staff across the organisation over this time, specifically since the merger of UH Bristol and Weston Area Health NHS Trust in April 2020.

2. Numbers and themes of concerns

2.1. The number of concerns raised in Q2 remained relatively high (24), though has fallen compared to Q1 (30).

2.2. As in Q1, the main theme of half of the concerns raised related to attitude and behaviours (12), followed by policies and processes (6), and quality and safety (3).

2.3. Within the attitudes and behaviours theme are recurring concerns around the language used by staff about other staff; staff personal information not being kept confidential; bullying behaviours not being dealt with; and the ongoing impact of the merger.

2.4. Within the theme of policies and processes, there are concerns around a lack of transparency around recruitment practices, including how roles are advertised and filled; a lack of fairness around development opportunities; bank staff not being recognised and rewarded in line with substantive staff.

2.5. Below is the breakdown of concerns measured against FTE numbers of staff (permanent and fixed term temporary staff) and by number of champions to allow for a more accurate comparison across the divisions. Concerns were raised from all divisions, though the majority continue to be reported from the division of Weston. Staff champions in Weston continue to meet with the Guardian or Deputy Guardian on a monthly basis for support and to discuss the challenges of hearing concerns from staff and appropriate escalation.

Division	Number of concerns	Numbers of full time equivalent staff (at April 2021)	Concerns per 1,000 FTE	Number of FTSU staff champions
Diagnostics & Therapies	2	1,201.25	1.7	7

Medicine	3	1,217.81	2.4	10
Specialised Services	1	1,081.54	2.5	11
Surgery	1	1,810.11	0.9	9
Trust Services	2	1,076.56	1.9	26
Estates and Facilities	2	838.87	0.9	3
Weston	11	1,029.85	10.7	12
Women's & Children's	2	2,170.73	0.9	17

2.6. The breakdown by staff group shows a more diverse mix of staff groups reporting concerns in Q2 than in Q1, with no concerns reported anonymously. All concerns logged are reported either directly to the Guardian or Deputy Guardian or via a Freedom to Speak Up staff champion.

Profession	Q1	Q2
Administrative/clerical staff	12	8
Nurses	9	10
Cleaning/Catering/Maintenance/Ancillary staff	4	2
Healthcare Assistants	4	2
Unknown (anonymous)	1	0
Allied Health Professionals	0	1
Other	0	1

2.7. Of the 24 cases raised in Q2, 12 had been closed at the time of reporting. Four concerns remain open from Q1 and a further four cases remain open from the last financial year. As noted in the Q1 update report, concerns are increasingly complex and are taking longer to reach the point at which the individual who raised the concern is satisfied it can be closed.

2.8. The themes of concerns which take longer to resolve are:

- Behaviours – poor working cultures including, but not limited to, allegations of bullying; and disputes between senior staff (consultants)
- Service delivery – stretched services impacting on the patient and staff experience
- Poor estate/working conditions
- Lack of transparency in recruitment processes
- Ongoing impact on staff of the merger between Bristol and Weston hospitals, including pay disparities.

2.9. Starting in October, more detail relating to the concerns which remain unresolved will be shared with the executive team on a monthly basis – without revealing the identity of those staff who raised the concern and wish to remain confidential. The aim will be

to move Freedom to Speak Up concerns more quickly towards resolution or to keep concerns in focus, and better communicate progress with concerns raised. This aligns with the organisational priority of 'staff first' (improving both the staff experience and their wellbeing). The standard operating procedure for escalating Freedom to Speak Up concerns will be revised to reflect this and other changes since it was published in April 2020.

2.10. Reflecting on the key findings of the recent Wellbeing Survey, staff said they wanted to 'feel more valued and listened to'. Within the top three negative contributors to workplace wellbeing were: 'dealing with the demands on you', 'not having sufficient rest areas in which to take breaks', and 'negative behaviour of colleagues'. From this, it can be inferred that staff concerns being heard and addressed, particularly those around attitudes and behaviours, can have a huge impact on wellbeing.

3. Progress against the Freedom to Speak Up Strategy

Work continues to deliver the three objectives of the strategy, which is due for review this year to reflect the learning since it was developed in 2019. Progress against the current three core objectives (raising awareness, building confidence, and training and support) is as follows:

Raising awareness

3.1. For the first time this quarterly report includes compliance figures against mandatory Speak Up core training for all workers, which was introduced in February 2021. Compliance is currently very low in most of the divisions, with the exception of Weston and Facilities and Estates. It is interesting to note that the division with the highest rate of compliance, Weston, is the division from which the most concerns are raised via Freedom to Speak Up. Low compliance is expected as new training is embedded in the organisation, particularly in a period of high operational pressure. Further reminders about the training will be circulated over the coming weeks to help drive up the figures.

Speak Up core training for all workers – compliance report by division (October data)							
Diagnostics and Therapies	Facilities and Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's and Children's	Weston
36%	62%	32%	48%	34%	48%	37%	64%

3.2. Since July, the Freedom to Speak Up champion network has grown to 95 staff members.

3.3. In September the Deputy FTSU Guardian was invited to speak on the induction for the new cohort of international nurses, which will be an ongoing arrangement.

Building confidence

3.4. The FTSU Guardian/Deputy Guardian held training sessions, in partnership with the psychological health services team, with the FTSU staff champions in July and September with the aim to help champions better understand the context of speaking up and support their colleagues in raising concerns.

3.5. Stories from champions about their own efforts to improve their workplace culture continue to be shared across the organisation via Newsbeat and the wellbeing advocate newsletter. There is evidence that these initiatives are having a positive impact in the departments where they are in place and inspiring other teams to follow suit.

3.6. Feedback from individuals who have been involved in the Freedom to Speak Up process can now be captured anonymously online via IQVIA, replacing the previous format of a Word document circulated via email. This should provide a safer and more effective channel for capturing feedback from staff who have raised concerns, to understand if the process is working and if staff would feel confident to raise concerns again in the future. Feedback from the new online form will be reported in Q3.

3.7. A further 'speaking up summit' was held in September bringing together leads from Patient Safety, Staff Side, Employee Services, Wellbeing, Organisational Development and Education. The group reflected on their purpose in working together to triangulate themes of concerns raised by staff from across the organisation, to better understand how to support staff to resolve concerns informally. The group agreed that the new external resolution framework, which is being procured by the Trust, will be beneficial in providing more support at an early stage to help staff resolve concerns, particularly concerns on the theme of attitudes and behaviours. The external resolution framework will link with the development of the Trust's new values and leadership behaviours, alongside education and training, and the new patient safety programme.

Training and support for managers and leaders

3.8. With the proportion of concerns around attitudes and behaviours remaining high every quarter, it cannot be ignored that managers at all levels need to have the appropriate level of training and support to effectively manage and lead their staff – particularly in relation to listening and following up on issues raised with them – alongside a better mechanism for sharing learning from concerns across the organisation. This remains work in progress.

3.9. Until the time at which the new management and leadership training is launched, the National Guardian's Office and Health Education England have provided a 'Listen Up' training module, which focuses on listening to concerns and understanding the barriers to speaking up. Managers should complete both the 'Speak Up' and 'Listen Up' modules to ensure they understand what speaking up is and how to respond when someone speaks up to them. The training module is available via Kallidus or ESR.

4. Forward look

4.1. As part of the refresh of the Freedom to Speak Up strategy, the FTSU Guardians will meet with their counterparts in similar sized Trusts to understand what good practice looks like elsewhere. The standard operating procedure for the escalation of Freedom to Speak Up concerns, first published in April 2020, will be revised to show clear routes for escalation and timeframes for response with the aim to eliminate any potential delays or other barriers to resolving concerns. The strategy will also revisit the champion network and the role the staff champions play not only in raising awareness of speaking up but also in cultural change.

4.2. Alongside the refresh of the strategy, in 2022 the Board will revisit the NHS Improvement and the National Guardian's Office 'Freedom to Speak Up self-review' last completed in June 2018.

4.3. Speak Up month took place in October, which provided an opportunity for the Guardians and champions to talk to staff about speaking up, collect Speak Up pledges, and share stories of how staff are creating positive 'speak up, listen up, follow up' workplaces. The outcomes and next steps will be shared in the Q3 report.

4.4. The Guardians are working with colleagues in HR and Education to share learning from recruitment concerns – looking at both the recruitment process and training for managers – with the aim to reduce the number of recruitment-related concerns being raised via Freedom to Speak Up.

5. Recommendations

5.1. The Trust's approach to leadership and management development, people management and culture change are all crucial in moving towards making speaking up 'business as usual' at UHBW. And by this we mean speaking up in all its forms – rather than just via Freedom to Speak Up.

5.2. Given that poor behaviours are the driver behind the majority of concerns raised, it is essential that managers:

- find space to listen well and actively engage staff to better understand the challenges they face
- role model good leadership behaviours
- resolve concerns raised with them in a timely way and clearly communicate to staff any actions taken or not taken as appropriate.

The Board is asked to:

- Note the themes, trends and issues arising from this report
- Continue to seek assurance that plans around leadership and management development, people management and culture change are progressing.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors on 30 November 2021

Reporting Committee	**Finance and Digital Committee**
Chaired By	**Martin Sykes, Non-Executive Director**
Executive Lead	**Neil Kemsley, Director of Finance and Information**

For Information

Digital

The Committee received an updated digital report to the meeting which highlighted the current challenges to service delivery and progress to ensure the resilience of the unpinning infrastructure. The Committee were made aware of the timing of the merger of the two Patient Administration Systems in 2022 and the impact this would have on further developments to the system.

The new patient entertain system was congratulated which would improve the experience for patients.

An update on the Digital Strategy was also considered and good progress was noted since the Board seminar. The move was towards staff driving digital transformation, as opposed to being pushed by Digital Services, and this was being to be seen across the Trust. The investment required to deliver the programme was highlighted and it was noted that further work was required to understand all of the competing priorities for funding in the medium term financial plan before committing the requested resources.

Finance

The Committee received the finance report in a revised format which was welcomed by the Committee. The key points to note included:

- A net surplus of £1.033m was being reported against a plan of break-even at the end of month 7.
- The year-end forecast outturn was under consideration now that there was greater clarity on the financial settlement for H2 (the second half of 2021/22). Negotiations with system partners continued to ensure alignment of financial reporting and delivery against the system financial priorities.
- The capital plan was noted and risks to the delivery of the plan and CDEL limit were discussed. A number of mitigations were in place to support achievement of the plan, and further discussions were continuing with system and regional colleagues about the management of the capital plans in line with the capital expenditure limits.

For Board Awareness, Action or Response

The Committee considered the strategic and operational risks from a finance perspective and noted the mitigations in place.

Although the planning guidance for 2022/23 had not yet been published, it was understood to include a gradual step down of Covid support through the year, as opposed to a total cessation on 1 April. This would support continued management of the risks related to responding to the pandemic.

Key Decisions and Actions

The Committee considered changes to the Standing Financial Instructions to support activity recovery and the delivery of the capital programme. The Committee agreed the changes and recommended their approval by the Board.
Additional Chair Comments

Date of next meeting:	**25 January 2022**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

Report Title	**Trust Finance Performance Report**
Report Author	**Jeremy Spearing, Director of Operational Finance**
Executive Lead	**Neil Kemsley, Director of Finance and Information**

1. Report Summary

The purpose of this report is to inform the Finance & Digital Committee of the financial position of the Trust for the period 1st April 2021 to 31st October 2021.

2. Key points to note
(Including decisions taken)

The Trust's year to date net income and expenditure performance, excluding technical items, is a net surplus of £1,033k compared with a plan of break-even. The overall position continues to be driven by slower than planned pick up in costs linked to the Trust's approved 2021/22 investments and elective recovery offset by the shortfall in savings delivery to date.

The Trust has delivered savings of £6,240k to date or 73% the plan to date.

The Trust has invested capital of £34,062k to date.

The Trust's cash balance was £168,776k as at 31st October 2021.

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

A strategic risk assessment is provided in the Executive Summary.

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

- This report is for **Assurance.**

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

[Name of Committee/Group/Board]	[Insert Date paper was received]
Finance & Digital Committee	**26th November 2021**

Recommendation Definitions:

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

University Hospitals Bristol and Weston NHS Foundation Trust

Trust Finance Performance Report

Reporting Month: October 2021

Contents

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

The Finance Performance Report replaces the Finance Director's Report. It considers best practice in presenting a transparent account of the Trust's current financial position and will shift the emphasis into future performance over the coming months as we develop the report. To ensure the report contains all of the relevant information necessary for the Finance & Digital Committee to understand the Trust's financial performance, the report will undergo periodic review at each quarter end. Actions to drive improved performance are detailed in Appendix 1.

Executive Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

YTD Income & Expenditure Position

- Net I&E surplus of £1,033k against a plan of break-even (excluding technical items).
- Total operating income is £10,775k favourable to plan due to higher than planned income from patient care activities of £16,723k (pay award, ERF and high cost drug spend), offset by lower than planned other operating income of £5,947k (relating to grant income).
- Operating expenses are £18,353k adverse to plan, primarily due to the impact of the pay award of £6,725k, high-cost drug expenditure of £9,666k and the shortfall in CIP delivery of £2,329k.
- Technical and financing items are £8,611k favourable to plan mainly due to the profiling of grant income relating to the Salix decarbonisation scheme.

Key Financial Issues

- The Trust's financial position includes ERF income and matching costs of £9,220k pending a system decision regarding the allocation of ERF within the system. The Trust did not earn ERF in October due to ongoing challenges with bed availability.
- Savings delivery of £6,240k or 73% of the plan to date. The savings forecast outturn indicates a shortfall in delivery of £4,507k but it is not expected to lead to non-delivery of the break-even financial plan overall.
- With capital expenditure to date of £34,062k, delivery of the CDEL of £84,563k in the second half of the financial year remains very challenging.

Strategic Risks

Although the following items are not expected to have a material impact in this financial year, work has either been completed, or is in hand, or pending to understand and mitigate:

- The Trust and BNSSG system underlying financial deficit going into 2022/23 - completed
- The Trust and BNSSG system 2021/22 forecast outturn following receipt of the 2021/22 H2 funding envelopes – due for completion in December;
- Agreeing a system approach to future financial targets given UHBW's need to service past borrowing – pending – awaiting details regarding the 2022/23 financial regime;
- Re-assessing the implications of the financial arrangements relating to the merger and how that may have altered by changes in the national financial regime– pending as above;
- Understanding the risks and mitigations associated with the new capital regime; and how the CDEL limit and system prioritisation could restrict future strategic capital investment – in-hand – subject to a system approach and CDEL brokerage discussions with NHSEI.

SPORT

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: October 2021

Successes	Priorities
• The majority of Divisions continue to operate with immaterial variances to budget at less than 2%. • Delivery of capital investment of £34,062k in the period 1st April 2021 to 31st October 2021. • Successfully negotiated arrangements with NHS England to review cost of delivering Zolgensma in future years to reflect changing demands and service delivery costs. • The Trust's flexibility and cash position remains strong at £168,776k after capital investment of £34,062k.	• Following the Trust's recent Workforce Summit and working with system partners, the Trust is developing a short and medium term workforce strategy with a focus on retention and recruitment. • Seek confirmation from NHSEI that CDEL brokerage will be available in 2022/23, following the submission of the 5 year Capital plan in October. • The system has submitted the 2021/22 H2 system financial plan of breakeven. The Trust and system partners will be undertaking a formal forecast outturn for submission in mid December, and this will be provided in the November report. • Delivery of the Trust's 2021/22 CDEL. The Trust has assessed the forecast outturn pre-mitigations and the Trust is now working to formulate further actions to meet the CDEL. • Completion of a review of cost pressures and investments. • Review of all recurrent CIP schemes heading into 2022/23.
Opportunities	**Risks & Threats**
• The Trust/system position in 2021/22 may allow for some non-recurrent flexibility that could help set stronger operational and financial foundations for the coming winter and 2022/23. • Significant opportunity to align the productivity improvements being driven by the Accelerator Programme and the Restoration Oversight Group. • The system has recently submitted Targeted Investment Fund (TIF) capital bids into NHSEI SW in relation to the adult ITU phase 2 expansion OBC and the BHI ward beds expansion OBC.	• Workforce supply challenges to fill existing and new vacant posts continues to impact on the Trust's ability to meet emergency and elective demand. • Workforce availability and system challenges with patient flow continue to undermine elective activity recovery plans. • The potential for enhanced/premium pay rates in Q4 may have a material adverse impact on the achievement of Trust's forecast outturn assessment. • CDEL, the Trust's recurrent shortfall on CIP, the underlying revenue financial position of the Trust and the system may constrain the Trust's strategic capital plans over the next five years.

Financial Performance – Income & Expenditure

NHS University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

Trust Year to Date Financial Position

	Month 7			YTD		
	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's
Income from Patient Care Activities	75,685	77,589	1,905	529,792	546,535	16,743
Other Operating Income	11,488	12,137	649	80,424	74,466	(5,958)
Total Operating Income	**87,172**	**89,726**	**2,554**	**610,206**	**620,981**	**10,775**
Employee Expenses	(47,832)	(45,420)	2,412	(334,821)	(343,175)	(8,354)
Other Operating Expenses	(33,247)	(37,931)	(4,684)	(232,727)	(243,562)	(10,835)
Depreciation (owned & leased)	(2,366)	(2,024)	1,182	(15,443)	(14,607)	836
Total Operating Expenditure	**(83,445)**	**(85,375)**	**(1,930)**	**(582,991)**	**(601,344)**	**(18,353)**
PDC	(1,072)	(620)	452	(7,501)	(7,069)	432
Interest Payable	(50)	(76)	(26)	(350)	(357)	(7)
Interest Receivable	0	0	0	0	0	0
Other Gains/(Losses)	0	13	13			1
Net Surplus/(Deficit) inc technicals	**2,626**	**3,169**	**543**	**18,382**	**11,353**	**(7,029)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	(2,554)	(3,097)	(543)	(18,382)	(10,320)	8,062
Net surplus/(deficit) ex technicals	**0**	**72**	**72**	**0**	**1,033**	**1,033**

Hartles Rachel
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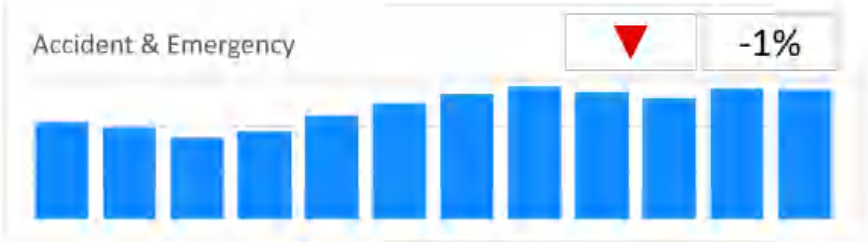
Key Facts:

- The YTD net surplus is £1,033k (£961k last month) compared with the planned breakeven position.
- Pay expenditure is £4,353k lower in October than September due to the impact of the back-dated pay award in September. YTD expenditure is adverse to plan at £8,354k, mainly due to the pay award.
- Agency spend decreased by £182k in month with bank costs consistent with September. Both remain in line with the pre-August run rate.
- YTD agency expenditure is £17,089k, 5% of total pay costs.
- Operating income is favourable to plan by £10,775k. An over-performance on income from patient care activities (pay award, ERF and high cost drugs) offset by other operating income, primarily due to lower than planned grant income (£6,020k).
- CIP achievement is 73%. £6,240k has been achieved against a target of £8,569k.
- Additional costs of Covid-19 are £6,540k YTD at the end of October, with a marginal reduction in month to £890k from £939k in September.

Actual Financial Position – Clinical Activity Volumes

October 2021



Key Points:

- We use calendar days to calculate the volume per day for non-elective points of delivery.
- Accident and emergency attendances per day were 1% lower in October compared with September. For the Trust overall, attendances are at 99% of pre-pandemic levels. However, the position by hospital site is very different with the Bristol Children's Hospital seeing 12% growth and the Eye Hospital being 16% lower This is shown in Appendix 2.
- Emergency inpatient spells have remained fairly static over recent months but are 13% lower YTD than pre-pandemic volumes.
- Non-elective inpatient spells per day were 5% lower in October compared with September.

Year To Date Volume

Board POD	2021/22 Actual Volume Per Day	2019/20 Actual Volume Per Day	2021/22 Planned Volume Per Day	2021/22 Actual / 2019/20 Actual	2021/22 Actual / 2021/22 Plan
Accident & Emergency	3,780	3,813	3,715	99%	102%
Emergency Inpatients	1,041	1,195	1,140	87%	91%
Non-Elective Inpatients	443	400	408	111%	109%

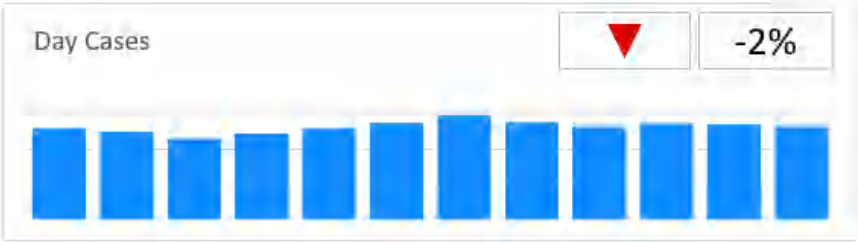
Current Month Volume

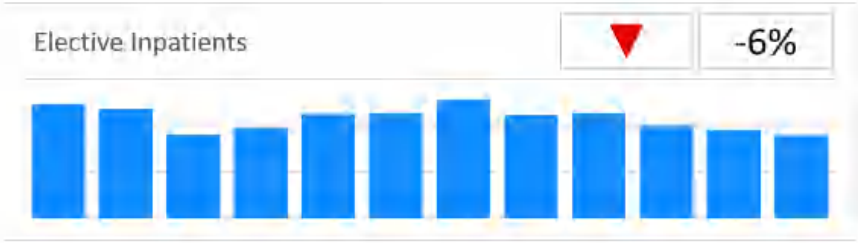
Board POD	2021/22 Actual Volume Per Day	2019/20 Actual Volume Per Day	2021/22 Planned Volume Per Day	2021/22 Actual / 2019/20 Actual	2021/22 Actual / 2021/22 Plan
Accident & Emergency	555	562	545	99%	102%
Emergency Inpatients	146	183	165	79%	88%
Non-Elective Inpatients	63	56	58	114%	109%

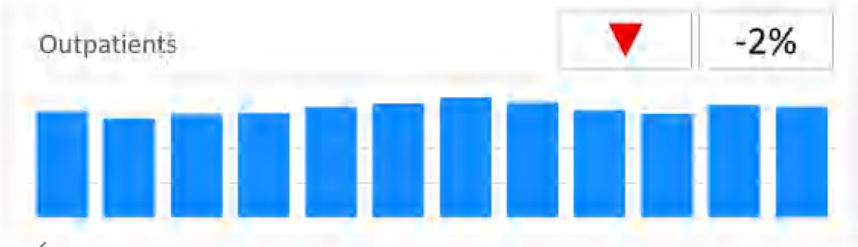
Actual Financial Position – Clinical Activity Volumes

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021







Key Points:

- We use working days to calculate the volume per day for elective points of delivery.
- Day cases per day were 2% lower in October compared with September. To date, day cases are at 92% of pre-pandemic levels. Elective inpatients per day continued the recent downward trend at 6% lower.
- Outpatient attendances per day were 2% lower in October compared with September.
- In general, elective volumes have fallen in recent months, particularly elective inpatients, with volumes per day in October dropping to 64% of pre-pandemic volumes and a YTD position of 73%. This comes at a time when we had planned to increase our elective activity with the accelerator programme.

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Year To Date Volume

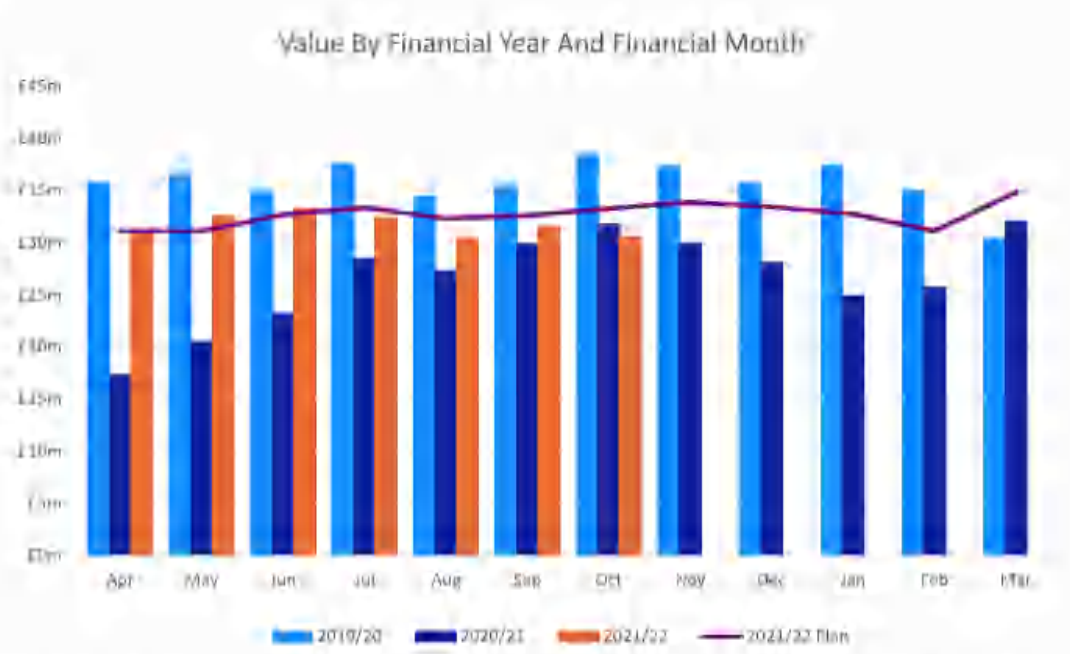
Board POD	2021/22 Actual Volume Per Day	2019/20 Actual Volume Per Day	2021/22 Planned Volume Per Day	2021/22 Actual / 2019/20 Actual	2021/22 Actual / 2021/22 Plan
Day Cases	1,913	2,089	2,013	92%	95%
Elective Inpatients	297	404	351	73%	85%
Outpatients	22,619	24,198	21,621	93%	105%

Current Month Volume

Board POD	2021/22 Actual Volume Per Day	2019/20 Actual Volume Per Day	2021/22 Planned Volume Per Day	2021/22 Actual / 2019/20 Actual	2021/22 Actual / 2021/22 Plan
Day Cases	263	294	284	90%	93%
Elective Inpatients	35	55	52	64%	68%
Outpatients	3,189	3,604	3,198	88%	100%

Actual Financial Position – Clinical Income

October 2021



Key Points:

- Payment by results has been suspended during the pandemic. To give a sense of casemix we have valued the activity we have delivered using the national tariffs.
- The value of activity for the main points of delivery in October was £30.6m compared with £31.6m in September.
- The value of elective activity (including inpatients spells, day cases and outpatients) in October was £13.4m compared with £14.1m in September. The value of non-elective activity (including emergency inpatients and accident and emergency attendances) in October was £17.2m compared with £17.5m in September.
- There were 21 working days in October compared to 22 in September.

Year To Date Value

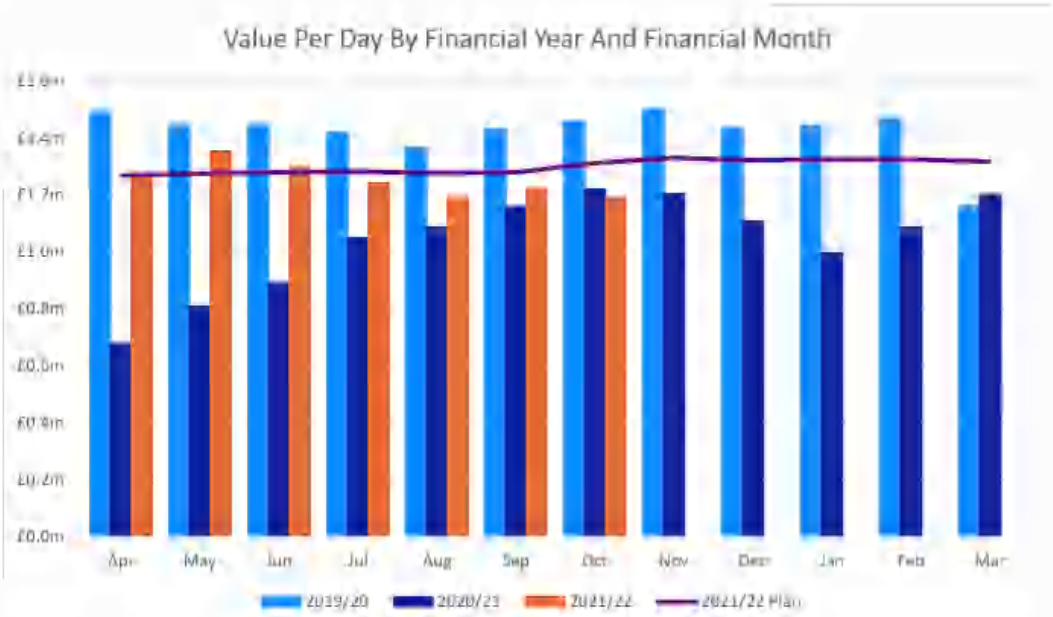
Board POD	2021/22 Actual £000	2019/20 Actual £000	2021/22 Plan £000	2021/22 Actual / 2019/20 Actual	2021/22 Actual / 2021/22 Plan
Accident & Emergency	18,893	19,311	18,757	98%	101%
Day Cases	26,036	30,087	26,789	87%	97%
Elective Inpatients	27,663	36,924	30,979	75%	89%
Emergency Inpatients	81,341	86,865	81,451	94%	100%
Non-Elective Inpatients	21,703	22,199	21,044	98%	103%
Outpatients	46,439	57,633	47,374	81%	98%
Total	**222,074**	**253,018**	**226,394**	**88%**	**98%**

Current Month Value

Board POD	2021/22 Actual £000	2019/20 Actual £000	2021/22 Plan £000	2021/22 Actual / 2019/20 Actual	2021/22 Actual / 2021/22 Plan
Accident & Emergency	2,727	2,873	2,798	95%	97%
Day Cases	3,735	4,597	3,794	81%	98%
Elective Inpatients	3,092	5,630	4,682	55%	66%
Emergency Inpatients	11,398	13,105	11,930	87%	96%
Non-Elective Inpatients	3,088	2,934	3,050	105%	101%
Outpatients	6,534	9,302	7,032	70%	93%
Total	**30,574**	**38,440**	**33,287**	**80%**	**92%**

Actual Financial Position – Clinical Income

October 2021



Key Points:

- The value of emergency activity per working day in October was 5% higher than September.
- Elective activity continues to be low due to capacity and flow constraints. Significant delays in hospital discharges are resulting in high levels of medically fit for discharge patients due to a lack of capacity in the community.
- These factors will continue into the Winter period and further supress elective delivery.

Year To Date Value Per Day

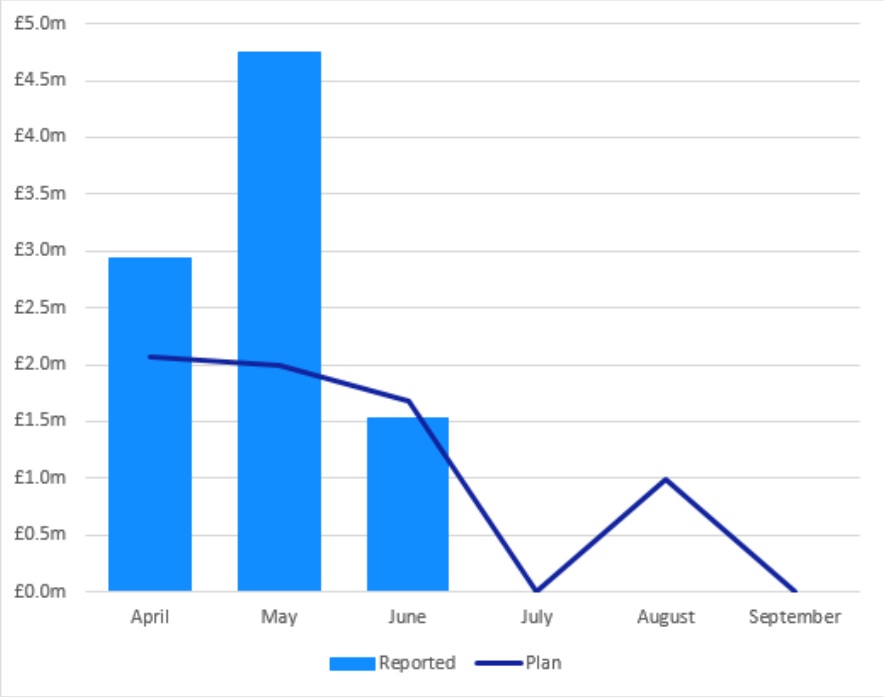
Board POD	2021/22 Actual £000	2019/20 Actual £000	2021/22 Plan £000	2021/22 Actual / 2019/20 Actual	2021/22 Actual / 2021/22 Plan
Accident & Emergency	618	632	614	98%	101%
Day Cases	1,243	1,415	1,276	88%	97%
Elective Inpatients	1,325	1,738	1,473	76%	90%
Emergency Inpatients	2,662	2,841	2,664	94%	100%
Non-Elective Inpatients	710	726	688	98%	103%
Outpatients	2,214	2,708	2,256	82%	98%
Total	**8,772**	**10,059**	**8,970**	**87%**	**98%**

Current Month Value Per Day

Board POD	2021/22 Actual £000	2019/20 Actual £000	2021/22 Plan £000	2021/22 Actual / 2019/20 Actual	2021/22 Actual / 2021/22 Plan
Accident & Emergency	88	93	90	95%	97%
Day Cases	178	200	181	89%	98%
Elective Inpatients	147	245	223	60%	66%
Emergency Inpatients	368	423	385	87%	96%
Non-Elective Inpatients	100	95	98	105%	101%
Outpatients	311	404	335	77%	93%
Total	**1,191**	**1,459**	**1,312**	**82%**	**91%**

Actual Financial Position – Clinical Income

October 2021



Month	Lower Threshold	Upper Threshold	Plan £000	Estimate, Based on SLAM £000	Actual, Based on SUS £000	Reported, Based on SUS/SLAM £000
April	70%	85%	2,071	2,798	2,937	2,937
May	75%	85%	1,995	4,266	4,755	4,755
June	80%	85%	1,679	1,377	1,529	1,529
July	95%	100%	0	0		0
August	95%	100%	987	0		0
September	95%	100%	0	0		0
Total			**6,731**	**8,441**	**9,220**	**9,220**

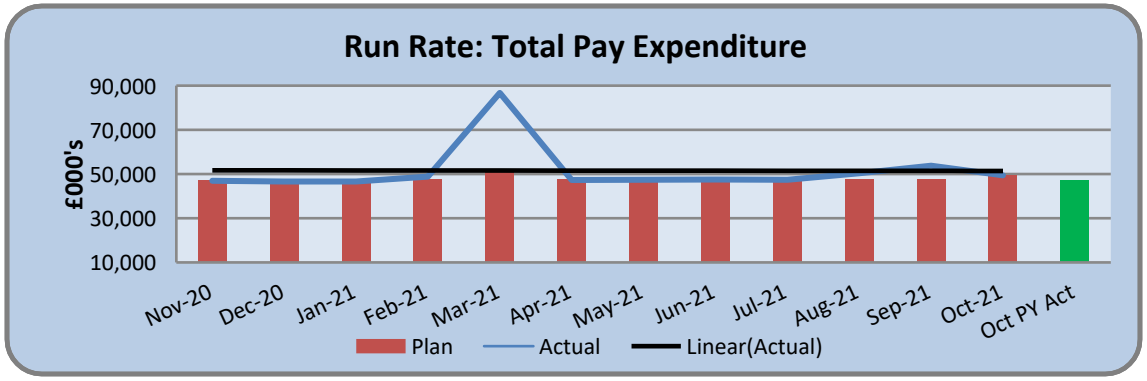
Key Points:

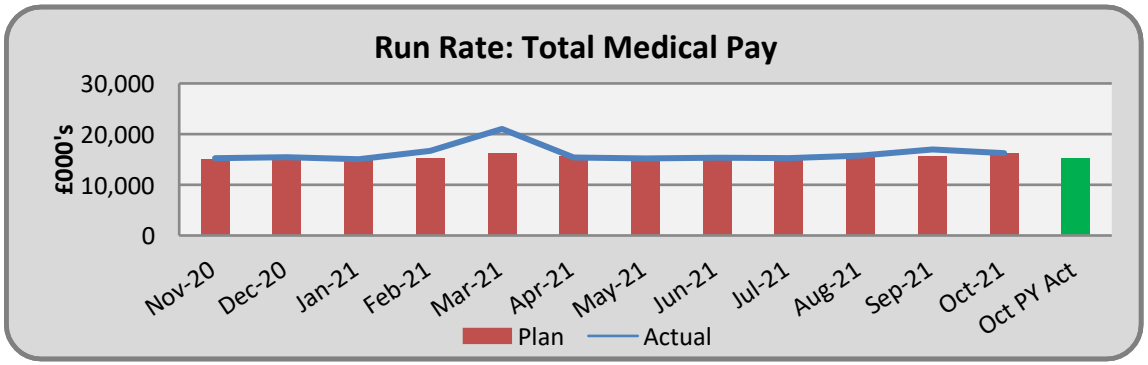
- The Trust's earnings in H1 were £9,220k, £2,489k ahead of plan.
- NHSEI have fundamentally changed the calculation for ERF in H2. Therefore ERF for H2 is still under review. However, the operating conditions are such that the Trust believes ERF earnings will be nil in H2. October has not been assessed at this point but is unlikely to be earned during H2.
- Targeted Investment Funding (TIF) will be available as a source of funds in H2 to support recovery of elective activity.

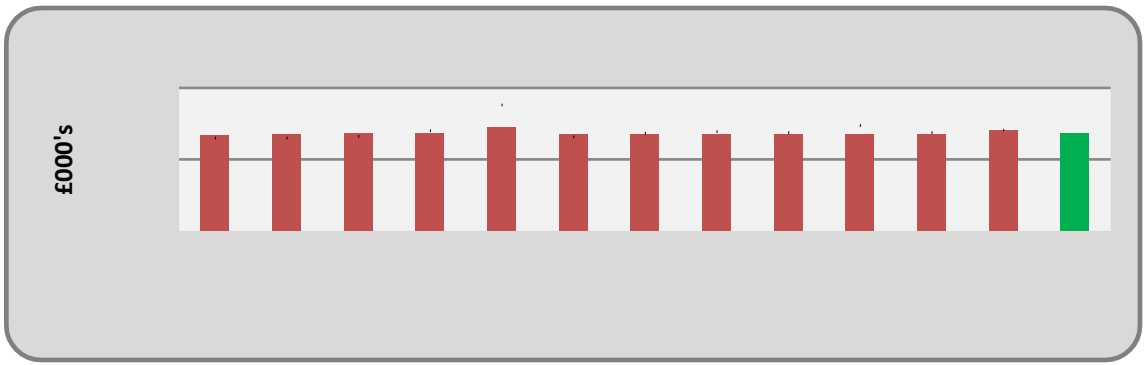
Financial Performance – Workforce Expenditure

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021







Key Points:

- Total pay expenditure in October is £49,420k, £4,353k lower than September but remains in line with previous month after adjusting for the pay award.
- YTD pay expenditure is £8,354k adverse to plan.
- Agency expenditure in October was £2,411k compared with £2,593k in September and £2,084k in August.
- Nursing and Medical agency spend decreased in the month. Nurse agency is in line with the YTD average with Medical dipping marginally in month.
- Bank expenditure was £1,955k in October in line with September and the pre-August run rate.

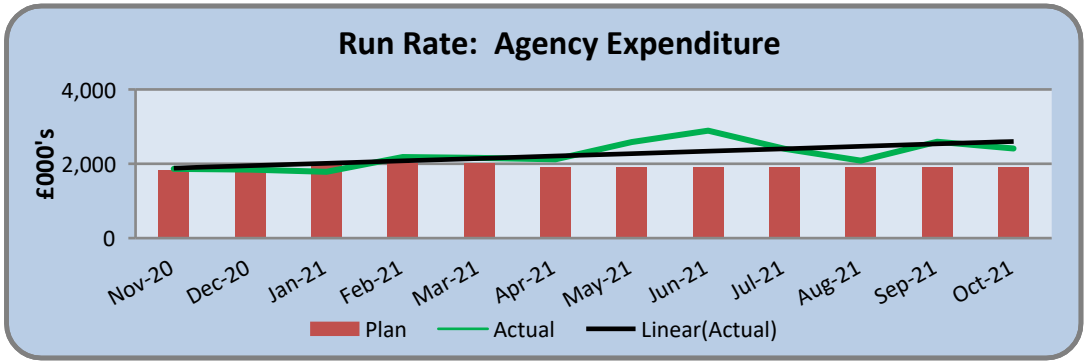
Recovery Actions:

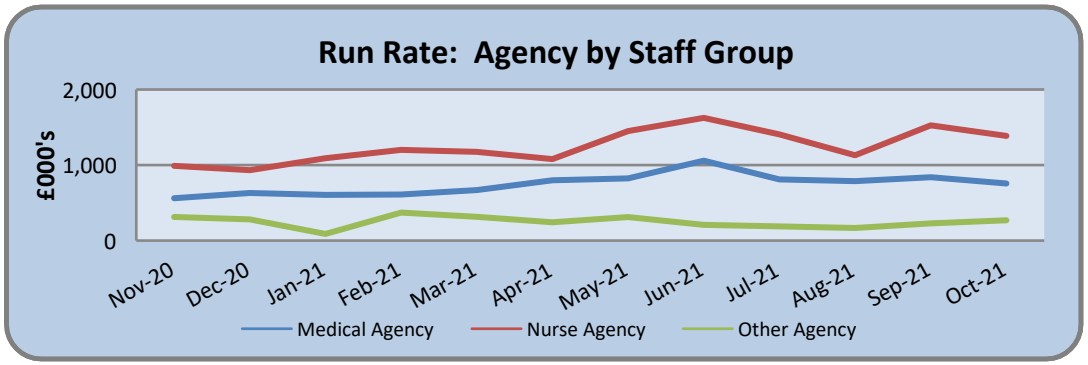
- The Trust's recent Workforce Summit is developing a short and medium term workforce strategy, one of the outcomes of which is to improve recruitment and retention.

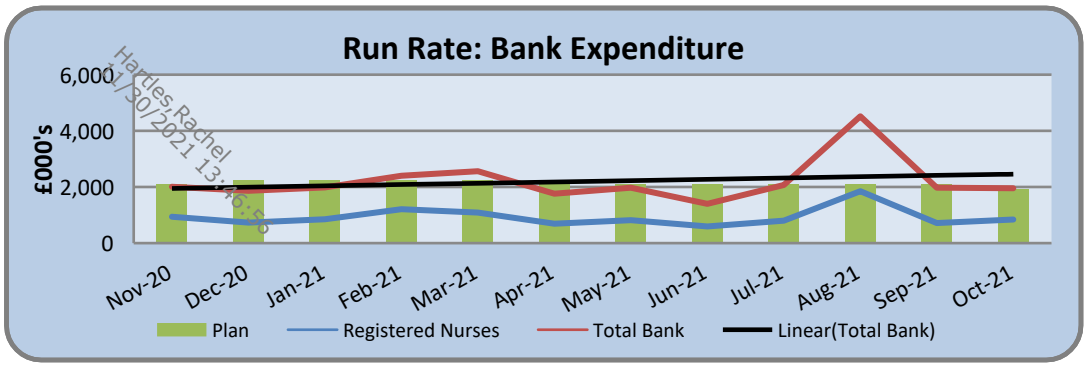
Financial Performance – Bank & Agency

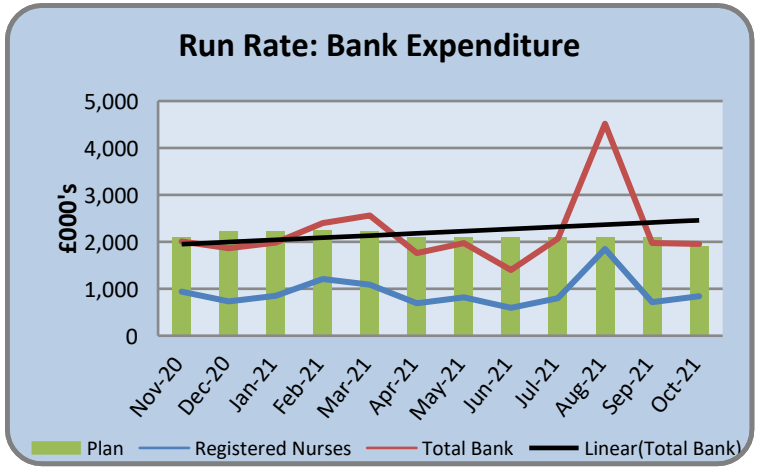
University Hospitals Bristol and Weston NHS Foundation Trust

October 2021







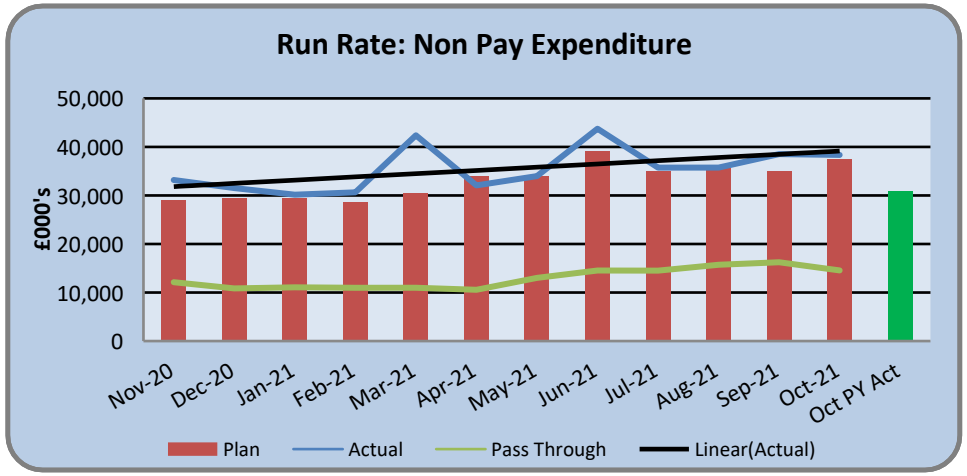


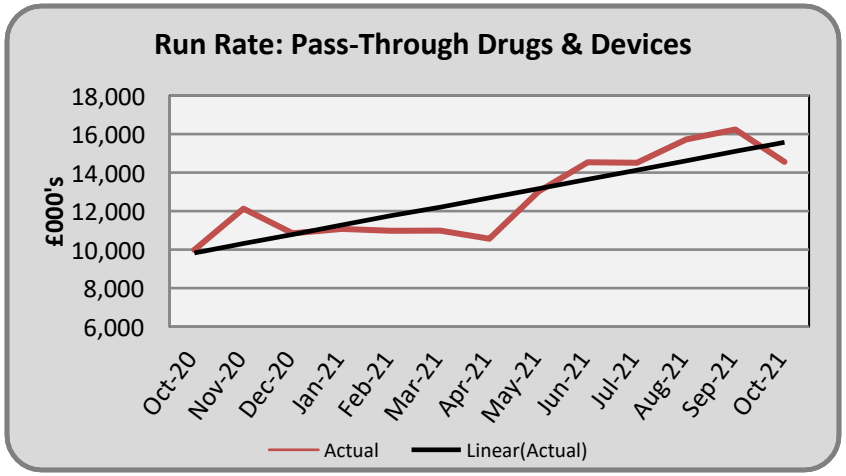
Key Points:

- Agency expenditure in October is £2,411k, £497k higher than plan and £182k lower than September.
- YTD agency expenditure exceeds plan by £3,692k.
- Agency usage continues to be driven by vacancies across nursing and medical staffing. Sickness and the use of mental health nurses are also key drivers.
- Nurse agency shifts increased by 265 or 10% compared with September. Average cost per shift reduced by 18%.
- Medical agency spend decreased by £83k to £756k from £839k in September.
- Bank costs in October are £1,955k, similar to September costs of £1,975k.
- See Appendix 3 and 4 for further details on agency usage.

Financial Performance – Non Pay Expenditure

October 2021





Top 5 Favourable Variances	CURRENT YEAR YTD Plan (£000's)	CURRENT YEAR YTD Expenditure (£000's)	CURRENT YEAR Variance (£000's)	PRIOR YEAR YTD Plan (£000's)	PRIOR YEAR YTD Expenditure (£000's)	PRIOR YEAR Variance (£000's)
Clinical Supplies and services	50,484	46,020	4,464	38,398	39,092	(694)
Transport	2,689	1,803	886	1,657	1,893	(236)
Purchase of healthcare from non-NHS bodies	5,992	5,458	533	3,589	3,698	(109)
Establishment	9,952	9,453	498	8,287	8,828	(541)
Education and training - non-staff	2,091	1,707	385	1,003	1,033	(30)
Total	**71,208**	**64,441**	**6,766**	**52,934**	**54,544**	**(1,610)**

Top 5 Adverse Variances	CURRENT YEAR YTD Plan (£000's)	CURRENT YEAR YTD Expenditure (£000's)	CURRENT YEAR Variance (£000's)	PRIOR YEAR YTD Plan (£000's)	PRIOR YEAR YTD Expenditure (£000's)	PRIOR YEAR Variance (£000's)
Drugs	88,954	98,620	(9,666)	64,983	65,494	(511)
Operating lease expenditure	4,154	4,558	(404)	4,110	4,095	15
Purchase of healthcare from NHS bodies	5,790	5,973	(183)	4,330	4,336	(6)
Consultancy	115	196	(80)	356	356	0
Premises - other	2,314	2,330	(17)	2,246	2,248	(2)
Total	**101,327**	**111,677**	**(10,350)**	**76,025**	**76,529**	**(504)**

Key Points:

- YTD non-pay expenditure of £243,562k is £4,956k or c2% higher than plan. This is primarily due to the shortfall in savings delivery and expected costs associated with ERF.
- The run rate of pass-through drugs and devices reduced in October due to lower levels of oncology drugs.
- Clinical supplies and services is £4,464k favourable to plan and reflects lower than planned elective activity levels.

Recovery Actions:

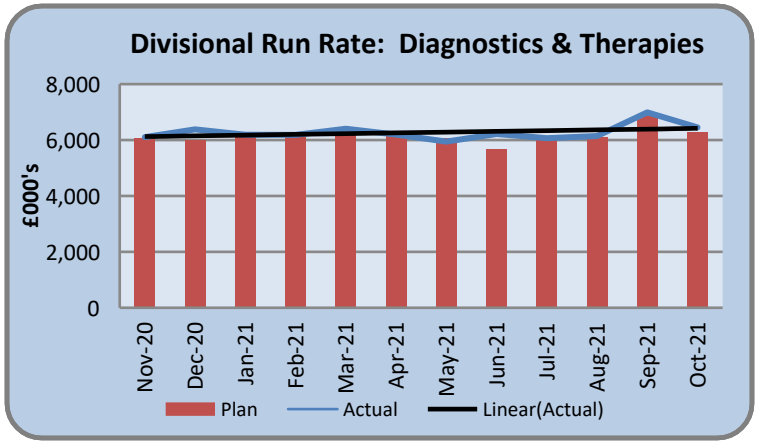
- Assessment of costs associated with the delivery of ERF income will be completed in line with system timescales and incorporated in the formal forecast outturn submission in mid-December.

Financial Performance – Divisional Position

NHS University Hospitals Bristol and Weston NHS Foundation Trust

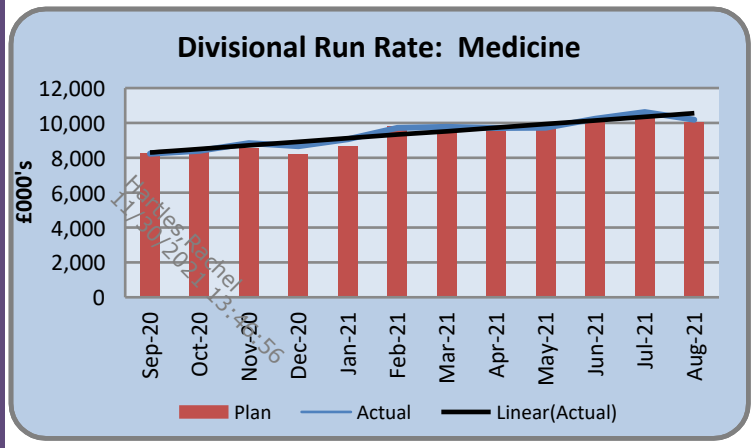
October 2021

	Diagnostics & Therapies		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	94	92	(2)
Other Activity Based Income	45	41	(4)
Other Operating Income	2,705	2,919	214
Total Operating Income	**2,844**	**3,052**	**208**
Nursing and Midwifery	(821)	(800)	21
Medical Staff - Consultants	(3,371)	(3,325)	46
Medical Staff - Others	(611)	(757)	(146)
Other Clinical Staff	(26,206)	(26,210)	(4)
Non Clinical Staff	(2,705)	(2,666)	39
Other Pay	(81)	0	81
Total Employee Expenses	**(33,795)**	**(33,758)**	**37**
Drugs	(3,598)	(4,298)	(700)
Clinical Supplies	(5,533)	(5,712)	(179)
Support Funding	0	0	0
Other Non Pay	(3,178)	(3,291)	(113)
Total Other Operating Expenses	**(12,309)**	**(13,301)**	**(992)**
Net Surplus/(Deficit)	**(43,260)**	**(44,007)**	**(747)**



Diagnostics & Therapies:

- Adverse variance of £747k YTD, an in month deterioration of £148k.
- Favourable variance on income from operations due to increased commercial trial income, clinical engineering income and additional income in radio pharmacy supporting other trusts.
- Adverse variance on drugs due mainly to high tech homecare £453k previously pass through plus other smaller adverse variances.
- Adverse variance on PHE recharges due to higher than planned activity also higher than planned cellular pathology costs
- Currently exceeding year to date savings target by £122k and forecast to deliver target by year end.



Medicine:

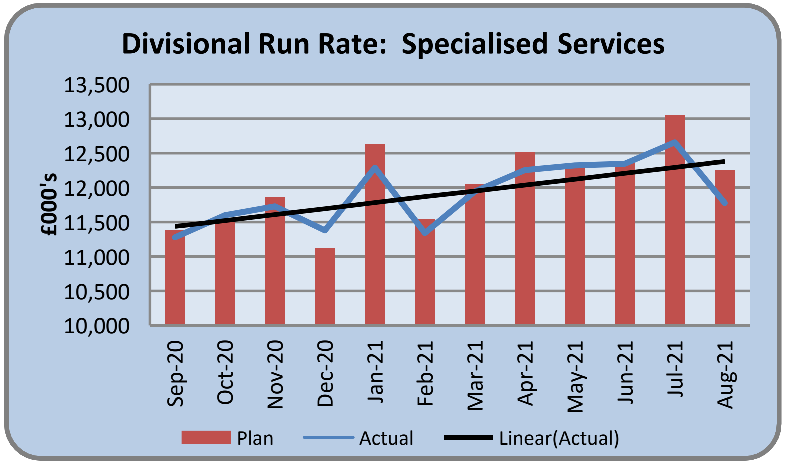
- Adverse variance of £478k YTD and in month deterioration of £170k.
- Savings programme favourable year to date by £44k after inclusion of reduced sleep studies devices costs.
- Adverse variance on medical staff of £1,322k mainly due to Weston F1 pressures and premium payments for medical Consultants including support for outlier patients.
- Favourable variance on other clinical staff due to vacancies, particularly Physicians associates.
- Favourable variance on non-pay due to lower than planned spend on sleep devices and drugs.
- Increasing run rate trend on nursing as Covid costs are now charged to the division as well as impact of the pay award.

	Medicine		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	1,302	1,222	(80)
Other Activity Based Income	12	11	(1)
Other Operating Income	1,179	1,151	(28)
Total Operating Income	**2,493**	**2,384**	**(109)**
Nursing and Midwifery	(23,017)	(22,902)	115
Medical Staff - Consultants	(8,126)	(8,773)	(647)
Medical Staff - Others	(6,722)	(7,397)	(675)
Other Clinical Staff	(1,344)	(1,168)	176
Non Clinical Staff	(4,108)	(4,291)	(183)
Other Pay	0	0	0
Total Employee Expenses	**(43,317)**	**(44,531)**	**(1,214)**
Drugs	(20,478)	(20,343)	135
Clinical Supplies	(3,588)	(2,637)	951
Support Funding	0	0	0
Other Non Pay	(4,602)	(4,843)	(241)
Total Other Operating Expenses	**(28,668)**	**(27,823)**	**845**
Net Surplus/(Deficit)	**(69,492)**	**(69,970)**	**(478)**

Financial Performance – Divisional Position

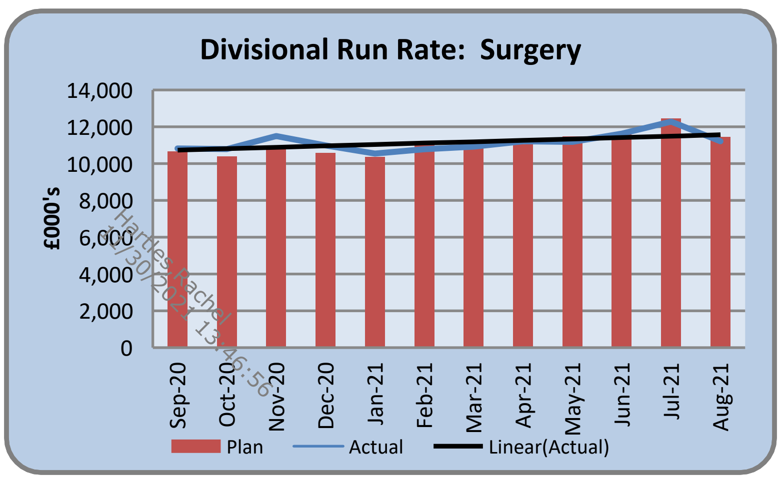
October 2021

	Specialised Services		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	[illegible]	[illegible]	[illegible]
Other Activity Based Income	[illegible]	[illegible]	[illegible]
Other Operating Income	[illegible]	1,916	[illegible]
Total Operating Income	[illegible]	[illegible]	[illegible]
Nursing and Midwifery	[illegible]	[illegible]	[illegible]
Medical Staff - Consultants	[illegible]	[illegible]	[illegible]
Medical Staff - Others	[illegible]	[illegible]	[illegible]
Other Clinical Staff	[illegible]	[illegible]	[illegible]
Non Clinical Staff	[illegible]	[illegible]	[illegible]
Other Pay			0
Total Employee Expenses	[illegible]	[illegible]	[illegible]
Drugs	[illegible]	[illegible]	[illegible]
Clinical Supplies	[illegible]	[illegible]	[illegible]
Support Funding			[illegible]
Other Non Pay	[illegible]	[illegible]	[illegible]
Total Other Operating Expenses	[illegible]	[illegible]	[illegible]
Net Surplus/(Deficit)	[illegible]	[illegible]	[illegible]



Specialised Services:

- Favourable variance YTD of £1,699k, and in month favourable variance of £738k.
- Significant favourable variance on clinical supplies, partly due to lower levels of elective activity this year compared with 2019/20 which continued in October.
- Adverse variance on other activity related income due to lower than planned private and overseas income.
- Pay run rate trend increasing due to new ward beds. Plus impact of the pay award.
- Non pay run rate variable due to variability of pass through blood, drug and devices expenditure. The recent trend has been seen significantly reduced spend due to reduced activity levels.
- Savings on target YTD and FOT.



Surgery:

- Favourable variance to date of £839k.
- Shortfall on savings programme YTD of £838k. Forecast adverse at £1,652k.
- Pay favourable due to vacancies and delays in recruitment of agreed service developments.
- Pay run rate increasing over 2020/21 as ITU expansion now charged to the Division. High levels of vacancies being filled by agency staff and high levels of 1-1 care plus impact of pay award.
- The recent Non pay run rate has shown a reduction in spend reflecting lower levels of elective activity.

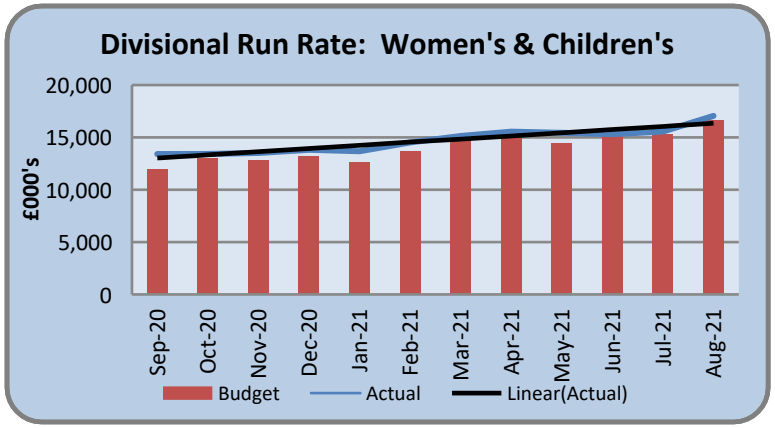
	Surgery		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	(80)	(76)	4
Other Activity Based Income	35	42	7
Other Operating Income	1,674	1,667	(7)
Total Operating Income	1,629	1,634	5
Nursing and Midwifery	(20,398)	(20,768)	(370)
Medical Staff - Consultants	(14,291)	(14,278)	13
Medical Staff - Others	(11,374)	(11,500)	(126)
Other Clinical Staff	(6,578)	(6,216)	362
Non Clinical Staff	(7,473)	(7,142)	331
Other Pay	(55)	0	55
Total Employee Expenses	(60,169)	(59,904)	265
Drugs	(8,283)	(7,855)	428
Clinical Supplies	(9,358)	(8,754)	604
Support Funding			0
Other Non Pay	(3,868)	(4,331)	(463)
Total Other Operating Expenses	(21,509)	(20,940)	569
Net Surplus/(Deficit)	(80,049)	(79,210)	839

Financial Performance – Divisional Position

NHS University Hospitals Bristol and Weston NHS Foundation Trust

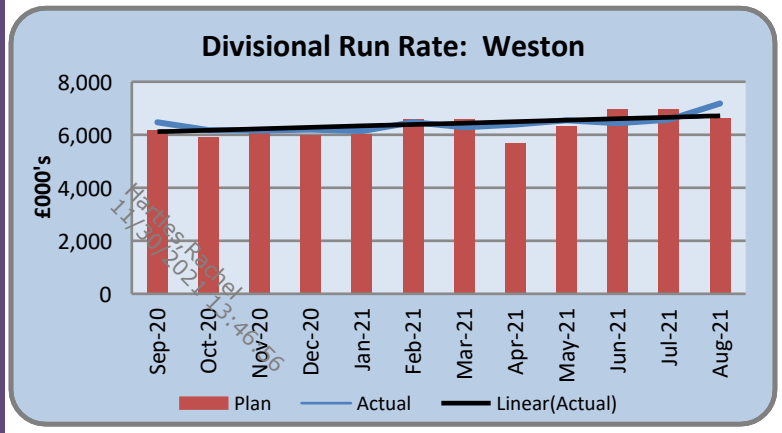
October 2021

	Women's & Children's		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	6,871	7,030	159
Other Activity Based Income			0
Other Operating Income	3,350	2,724	(626)
Total Operating Income	**10,221**	**9,754**	**(467)**
Nursing and Midwifery	(35,083)	(35,494)	(411)
Medical Staff - Consultants	(19,330)	(18,483)	847
Medical Staff - Others	(10,737)	(11,763)	(1,026)
Other Clinical Staff	(5,512)	(5,559)	(47)
Non Clinical Staff	(5,345)	(5,249)	96
Other Pay	513		(513)
Total Employee Expenses	**(75,494)**	**(76,548)**	**(1,054)**
Drugs	(29,719)	(30,087)	(368)
Clinical Supplies	(7,409)	(6,994)	415
Support Funding			0
Other Non Pay	(5,832)	(5,787)	45
Total Other Operating Expenses	**(42,960)**	**(42,868)**	**92**
Net Surplus/(Deficit)	**(108,233)**	**(109,662)**	**(1,429)**



Women's & Children's:

- Adverse variance of £1,429k, an in month favourable variance of £455k.
- Income adverse by £467k including reduced research income.
- Savings programme shortfall of £118k YTD, FOT £601k adverse.
- Significant pay overspend for nursing including PICU and ED with high levels of RMN to support mental health patients.
- Pay run rate consistently increasing over past few months and significantly higher than 2019/20. Driven by continuation of winter staffing levels and pay award.
- Non pay run rate is variable and affected by number of Zolgensma patients. Clinical supplies favourable variance driven by lower than planned activity.



Weston:

- Adverse variance to date of £409k, a deterioration of £170k in month.
- Shortfall on savings programme to date of £495k including shortfall against the residual merger mitigations target.
- Significant pressure on other medical staff budgets due to the on-going staffing issues resulting in agency usage.
- Adverse variance on consultants due to premium payments and shortfall on merger savings plans.
- Pay run rate increasing partly due to medical staff pressures highlighted above plus impact of the pay award.
- Favourable variance on non pay partly due to lower than planned levels of activity and lower than planned spend on establishment, general supplies and services.

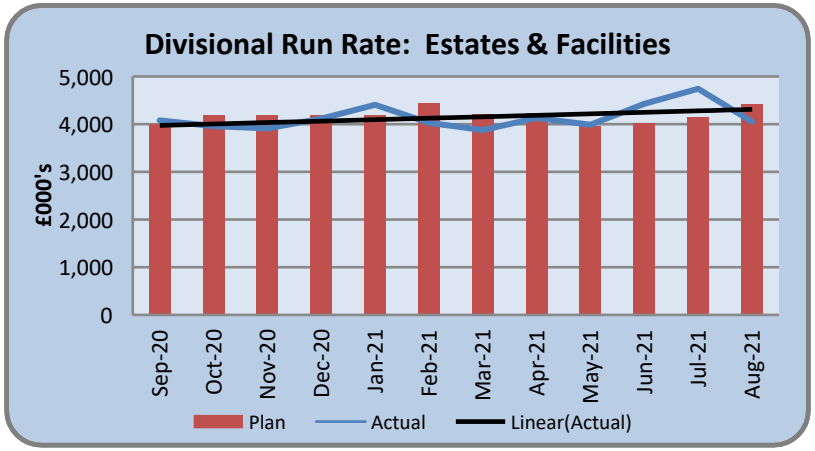
	Weston		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	(21)	494	515
Other Activity Based Income	92	(4)	(96)
Other Operating Income	1,301	1,070	(231)
Total Operating Income	**1,372**	**1,559**	**187**
Nursing and Midwifery	(18,634)	(18,008)	626
Medical Staff - Consultants	(7,094)	(7,957)	(863)
Medical Staff - Others	(6,668)	(7,511)	(843)
Other Clinical Staff	(1,819)	(1,960)	(141)
Non Clinical Staff	(3,455)	(2,973)	482
Other Pay	157	0	(157)
Total Employee Expenses	**(37,514)**	**(38,410)**	**(896)**
Drugs	(5,192)	(5,288)	(96)
Clinical Supplies	(2,566)	(2,732)	(166)
Support Funding			0
Other Non Pay	(1,807)	(1,244)	563
Total Other Operating Expenses	**(9,564)**	**(9,264)**	**300**
Net Surplus/(Deficit)	**(45,706)**	**(46,115)**	**409**

Financial Performance – Divisional Position

University Hospitals Bristol and Weston NHS Foundation Trust

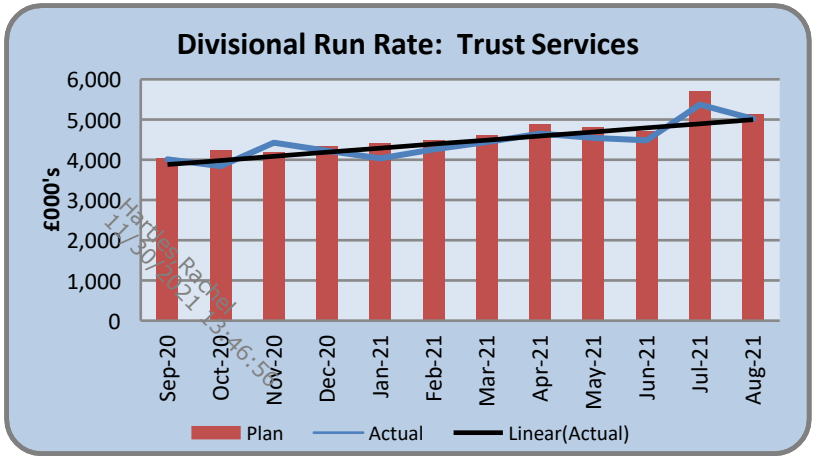
October 2021

	Estates & Facilities		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	0	0	0
Other Activity Based Income	0	0	0
Other Operating Income	2,540	2,538	(2)
Total Operating Income	**2,540**	**2,538**	**(2)**
Nursing and Midwifery	(1)	(7)	(6)
Medical Staff - Consultants	0	0	0
Medical Staff - Others	0	0	0
Other Clinical Staff	(2)	0	2
Non Clinical Staff	(17,127)	(17,539)	(412)
Other Pay	(2)	0	2
Total Employee Expenses	**(17,132)**	**(17,546)**	**(414)**
Drugs	(1)	(6)	(5)
Clinical Supplies	(204)	(201)	3
Support Funding	0	0	0
Other Non Pay	(14,322)	(14,032)	290
Total Other Operating Expenses	**(14,527)**	**(14,239)**	**288**
Net Surplus/(Deficit)	**(29,119)**	**(29,247)**	**(128)**



Estates & Facilities:

- Adverse variance to date of £128k, an in month favourable variance of £100k.
- Significant favourable variance on energy costs due to the impact of the CHP programme.
- Significant adverse vacancies on non clinical staff due to the impact of critical incident pay rates in August and September.
- Favourable variance on savings programme of £111k YTD, FOT £114K favourable.
- Increase in the pay run rate in month 5 and 6 due to the effect of temporary enhanced pay rates and the pay award. Month 7 shows a reduction due to ending of critical incident rates.



Trust Services:

- Favourable variance to date of £397k, a deterioration of £53k.
- Main driver of favourable variance is the number of vacancies in Finance and Digital services.
- Shortfall on savings programme of £282k.
- Increase in non pay run rate due to immigration surcharges and continuing education costs.
- Pay run rate trend has been increasing due to additional cost of management support for the Weston Division and also impact of pay award.

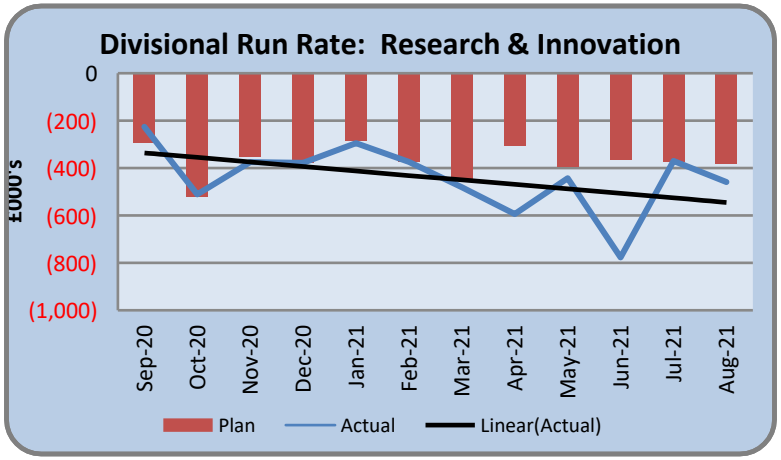
	Trust Services		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	0	0	0
Other Activity Based Income	0	0	0
Other Operating Income	2,809	2,695	(114)
Total Operating Income	**2,809**	**2,695**	**(114)**
Nursing and Midwifery	(4,077)	(3,984)	93
Medical Staff - Consultants	(1,005)	(1,021)	(16)
Medical Staff - Others	(645)	(636)	9
Other Clinical Staff	(525)	(524)	1
Non Clinical Staff	(20,615)	(19,933)	682
Other Pay	(70)	(15)	55
Total Employee Expenses	**(26,937)**	**(26,113)**	**824**
Drugs	(62)	(121)	(59)
Clinical Supplies	(324)	(82)	242
Support Funding	0	0	0
Other Non Pay	(8,645)	(9,141)	(496)
Total Other Operating Expenses	**(9,031)**	**(9,344)**	**(313)**
Net Surplus/(Deficit)	**(33,159)**	**(32,762)**	**397**

Financial Performance – Divisional Position

University Hospitals Bristol and Weston NHS Foundation Trust

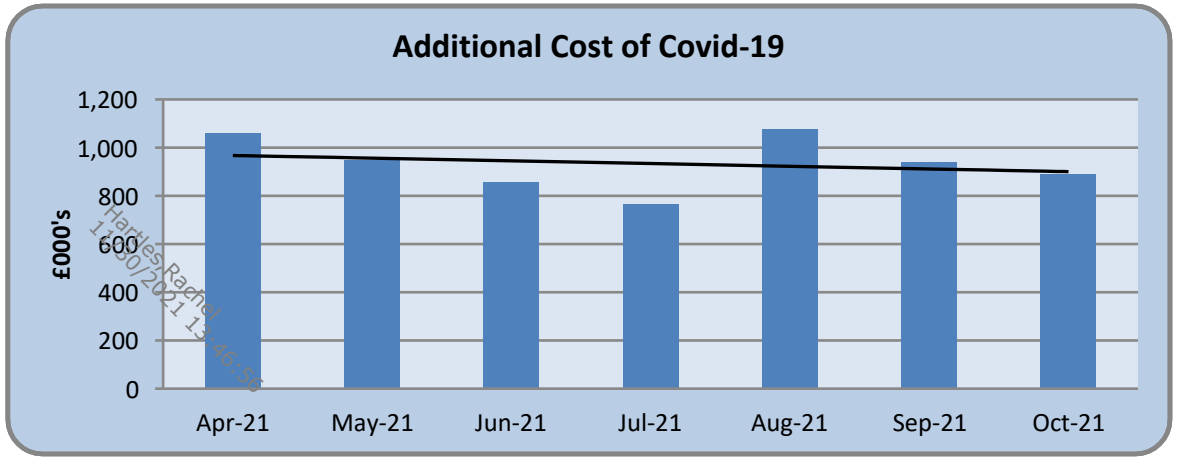
October 2021

	Research & Innovation		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	0	0	0
Other Activity Based Income	0	0	0
Other Operating Income	18,157	18,848	691
Total Operating Income	**18,157**	**18,848**	**691**
Nursing and Midwifery	(793)	(666)	127
Medical Staff - Consultants	(398)	(267)	131
Medical Staff - Others	(69)	(48)	21
Other Clinical Staff	(73)	(40)	33
Non Clinical Staff	(1,960)	(2,044)	(84)
Other Pay	2	0	(2)
Total Employee Expenses	**(3,292)**	**(3,066)**	**226**
Drugs	0	(0)	(0)
Clinical Supplies	(254)	(108)	146
Support Funding			0
Other Non Pay	(11,964)	(12,175)	(211)
Total Other Operating Expenses	**(12,218)**	**(12,283)**	**(65)**
Net Surplus/(Deficit)	**2,647**	**3,499**	**852**



Research & Innovation:

- Favourable variance to date £852k.
- YTD favourable income position driven by commercial research into Covid-19 at c£1,000k.
- Improvement in run rate in October due to reduction in expenditure following one-off expenditure in September relating to the ComFluCov trial.



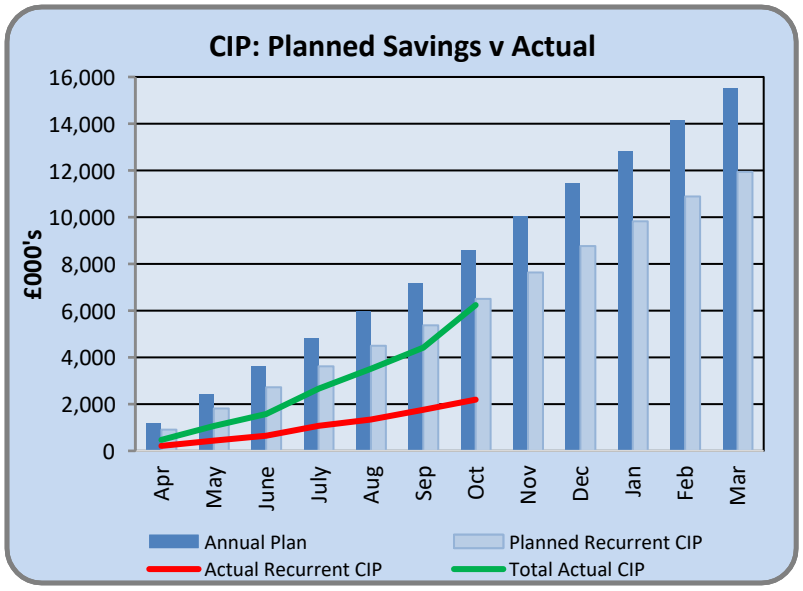
Covid-19 Expenditure:

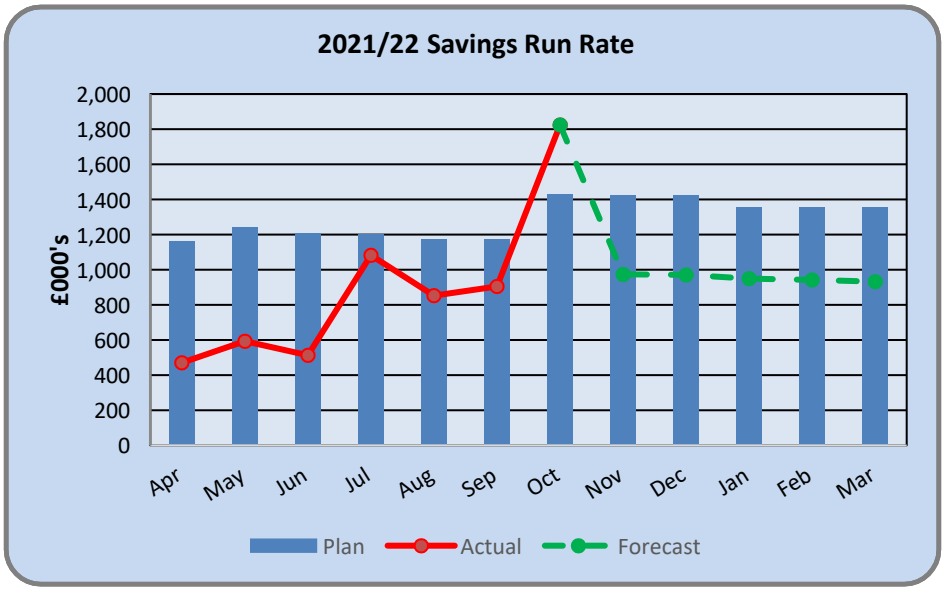
- Expenditure related to Covid-19 is marginally lower at £890k in October compared to £939k in September, against a forecast of c£1,000k.
- Average monthly costs have reduced to c£900k.
- Expenditure is largely driven by non-pay costs including the provision of the vaccination hub.

Savings – Cost Improvement Programme

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021





Workstream	2021/22 Annual Target £000's	M7 Year to Date Plan £000's	M7 Year to Date Actual £000's	M7 Year to Date Variance Fav/ (Adv) £000's	Forecast Outturn £000's
Nursing Pay & Productivity	200	117	138	18	212
Medical Pay & Productivity	65	45	33	(11)	45
Non Pay	3,890	2,277	3,147	1,870	7,324
Productivity	50	22	169	147	580
HR Pay Non Productivity	18	10	--	(10)	11
Income - Non NHS External	85	70	58	58	100
Medicines	499	364	346	62	582
Allied Healthcare Professionals Productivity	24	14	15	1	25
Estates & Facilities	805	386	486		805
Trust Services	364	216	284	68	481
Weston Merger	1,500	875		(875)	
Weston Merger - Medical	500	292	-	(292)	313
Weston Merger - Nursing	500	292	167	(125)	500
Plans to be developed from Pipeline	2,065	518	-	(518)	
Total	15,515	8,569	6,240	(2329)	11,008

Key Points:

- The Trust's 2021/22 savings target is £15,515k.
- At the end of October, the Trust had achieved savings of £6,240k against a plan of £8,569k, a shortfall of £2,329k.
- Divisions behind plan include Surgery (£838k), Weston (£495k), Women's and Children's (£118k) and Trust Services (£281k). Diagnostics & Therapies, Estates & Facilities and Medicine have favourable variances of £122k, £111k and £44k respectively; Specialised Services is on plan.
- The full year forecast is £11,008k or 71%, of plan, a shortfall of £4,507k against the plan of £15,515k. Only £4,276k of the full year forecast is recurrent.
- The increase in the savings run rate has mainly resulted from non recurrent slippage on service developments. Work is ongoing to identify additional projects which will deliver the required level of savings on a recurrent basis.

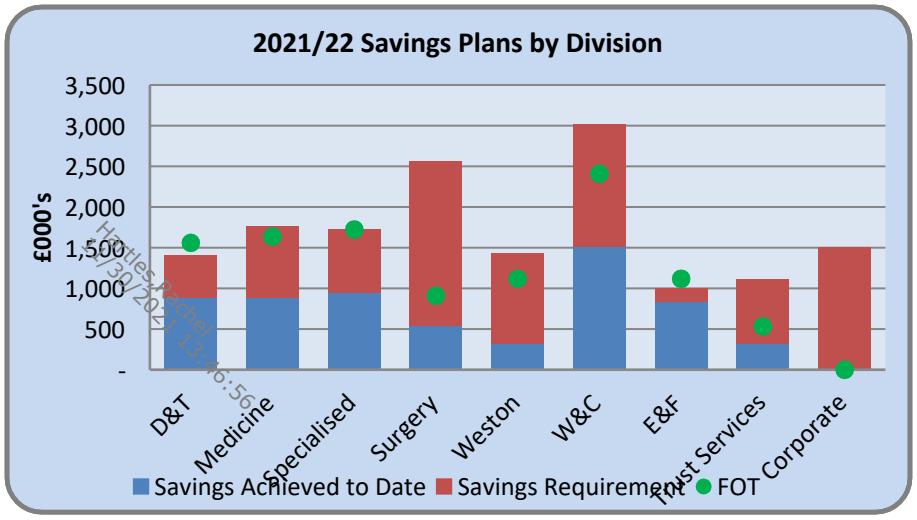
Savings – Divisional Position

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

Division	2021/22 Annual Target £000's	M7 Year to Date Plan £000's	Actual £000's	Variance Fav/ (Adv) £000's	Forecast Outturn £000's
Diagnostics & Therapies	1,408	759	882	122	1,560
Medicine	1,765	847	892	44	1,637
Specialised Services	1,724	943	943	(0)	1,725
Surgery	3,561	1,376	538	(838)	909
Weston	1,430	818	323	(495)	1,118
Women's & Children's	3,009	1,627	1,509	(118)	2,409
Estates & Facilities	1,004	724	835	111	1,118
Finance	202	112	121	9	201
Human Resources	232	105	34	(71)	92
Trust Headquarters	387	209	70	(138)	123
Digital Services	292	153	71	(82)	109
Misc Support Services	-	-	1	1	8
Corporate	1,500	875	-	(875)	-
Total	15,515	8,569	6,240	(2,329)	11,008

Division	2021/22 Annual Target £000's	Forecast Outturn Recurring £000's	Non Recurring £000's	Total £000's
Diagnostics & Therapies	1,408	80	1,480	1,560
Medicine	1,765	570	1,067	1,637
Specialised Services	1,724	201	1,524	1,725
Surgery	2,561	495	414	909
Weston	1,430	973	145	1,118
Women's & Children's	3,009	815	1,594	2,409
Estates & Facilities	1,004	1,031	87	1,118
Finance	202	31	170	201
Human Resources	232	20	72	92
Trust Headquarters	387	21	102	123
Digital Services	292	32	77	109
Misc Support Services	-	8	-	8
Corporate	1,500	-	-	0
Total	15,515	4,276	6,732	11,008



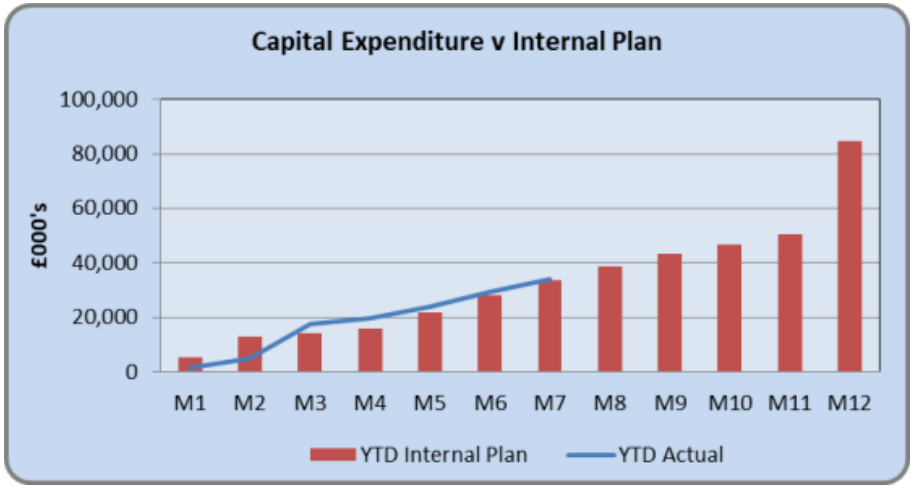
Recovery Actions:

- The current financial regime has meant the focus has shifted to cost reduction and removal of unwarranted variation.
- Terms of reference for the reconstituted Trust Wide Non Pay Steering Group have been drafted with a view to meeting in December 2021.
- Greater accountability for the delivery of savings is required through the following groups: Cost Savings Delivery Board; regular Divisional Savings Reviews; Working Smarter Forums; Drugs and Pharmacy Group; Medical Staffing and GIRFT.
- Developing transformation projects which will deliver recurrent savings, possibly using capital investment to pump-prime.
- Development of 2022/23 savings plans at corporate and divisional level have now started. A first cut of these plans is scheduled for the end of November 2021.

Capital – Capital Programme Summary

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021



Capital Plan 2021/22	2021/22 FOT £000's	2021/22 YTD Internal Plan £000's	2021/22 YTD Actuals £000's	2021/22 YTD Variance £000
Strategic Schemes	10,756	3,135	3,422	287
Medical Equipment	15,465	6,078	6,030	(48)
Operational Capital	41,635	17,420	17,408	(12)
Fire Improvement	4,626	1,318	903	(415)
Digital Services	8,389	3,135	1,925	(1,210)
Estates Replacement	10,018	2,351	3,738	1,387
Weston	2,126	-	636	636
Over-programming	(8,438)	-	-	-
Total Capital Applications	**84,577**	**33,437**	**34,062**	**625**
Analysed as:				
Inside Envelope	**57,064**	**20,352**	**21,077**	**725**
Outside Envelope	**27,513**	**13,085**	**12,985**	**(100)**
Total Capital Applications	**84,577**	**33,437**	**34,062**	**625**

Key Points:

- The Trust continues to report a plan of £84,577km to NHSEI, which is compliant with the Trust's CDEL envelope.
- The divisional capital leads and delivery partners have reforecast the monthly profile and outturn position to establish an updated internal plan.
- There are currently two scenarios for the forecast outturn;
  - delivery partner assessment, which is £5m below CDEL and,
  - risk adjusted assessment, which increases to £14m below CDEL.
- The Capital Programme Steering Group (CPSG) agreed a schedule of mitigations which should increase the forecast outturn.
- The mitigations will be quantified during November and reported back to CPSG in December to prioritise and approve the actions required.
- The Director of Finance continues to explore brokerage opportunities with the NHSEI South West Regional office and the deputy chief finance officer of NHSEI England.
- The year to date expenditure at the end of October is £34,062k, £625k ahead of the updated internal plan. The variance primarily relates to timing differences on Digital Services, Estates Replacement and Weston.
- As part of the Targeted Investment Fund (TIF) the Trust submitted £27,666k of capital bids across three financial years;
  - 2021/22 - £6,007k
  - 2022/23 - £19,772k
  - 2023/24 - £1,887k

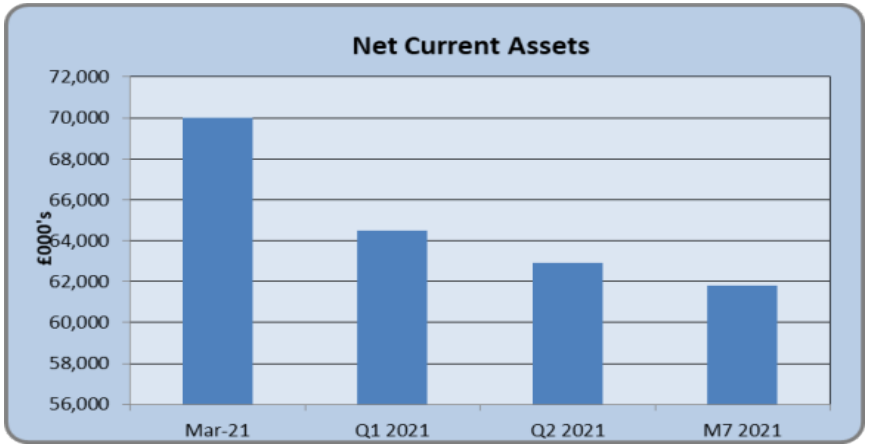
  Confirmation of NHSEI approval is expected in November and is expected to be funded by Public Dividend Capital and therefore sit outside of CDEL.

Financial Position – Statement of Financial Position

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

As at 31 March 2021 £000's		Actual Q1 2021 £000's	Actual Q2 2021 £000's	Actual Month 7 £000's	YTD Movement £000's
	Non-Current Assets				
516,070	Property, Plant and Equipment	525,102	520,487	537,949	17,879
11,617	Intangible Assets	11,715	11,313	11,085	(532)
1,802	Receivables	1,802	1,802	1,802	-
526,489	**Total Non-Current Assets**	**538,619**	**542,602**	**544,836**	**16,347**
	Current Assets				
12,638	Inventories	13,138	12,696	12,518	(120)
32,845	Trade and Other Receivables	56,698	50,707	55,617	22,766
2,074	PDC Dividend Receivable	2,074	-	-	(2,074)
169,644	Cash	160,856	159,888	168,776	(868)
217,201	**Total Current Assets**	**231,741**	**225,381**	**236,905**	**19,704**
	Current Liabilities				
(146,840)	Trade and Other Payables	(166,214)	(163,901)	(161,760)	(15,089)
(6,816)	Borrowings	(6,883)	(6,735)	(6,895)	(78)
(653)	Provisions	(641)	(648)	(638)	15
(12,654)	Other Liabilities	(11,997)	(12,681)	(12,580)	(9,726)
(167,205)	**Total Current Liabilities**	**(167,253)**	**(166,948)**	**(173,083)**	**(27,878)**
69,996	**NET CURRENT ASSETS (LIABILITIES)**	**64,490**	**62,933**	**61,822**	**(8,174)**
598,485	**TOTAL ASSETS LESS CURRENT LIABILITIES**	**603,110**	**605,535**	**606,658**	**8,173**
	Non-Current Liabilities				
(3,097)	Borrowings	(3,168)	(3,017)	(6,191)	3,094
(14,324)	Provisions	(14,389)	(14,251)	(14,239)	85
(60,421)	**Total Non-Current Liabilities**	**(57,557)**	**(57,268)**	**(57,242)**	**3,180**
538,063	**TOTAL ASSETS EMPLOYED**	**545,553**	**548,247**	**549,416**	**11,353**
312,135	Public Dividend Capital	312,135	312,135	312,135	-
150,139	Retained Earnings	156,188	161,432	162,786	12,647
75,704	Revaluation reserve	75,145	74,595	74,410	(1,294)
85	Other Reserves	85	85	85	-
538,063	**Total Taxpayers' Equity**	**545,553**	**548,247**	**549,416**	**11,353**



Key Points:

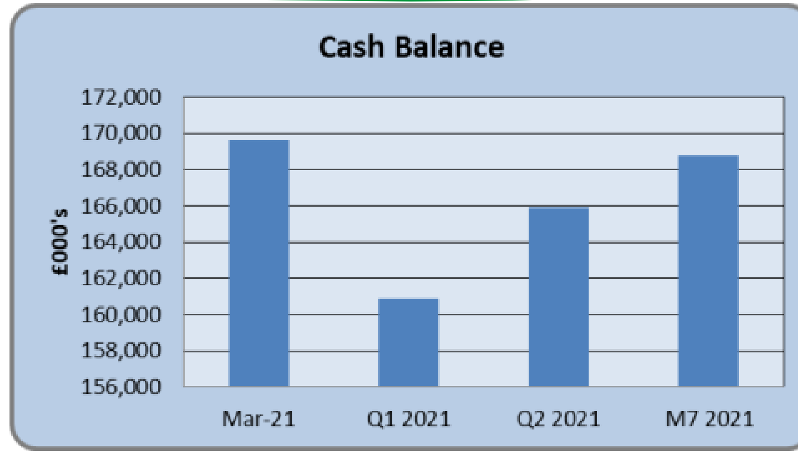
- Net current assets as at 31 October 2021 were £61,822k, £1,111k lower than month 6 and £8,174k lower than the closing year end position.
- The year to date net current asset decrease is primarily driven by the net increase in receivables of £20,692k, offset by increase in payables and other liabilities of £18,089k and £9,726k respectively.
- The receivables balance at month end included a HEE quarterly invoice of £13,623k, which has been paid in month 8. A significant debtor relates to the annual leave accrual funded by NHSEI at c£11m.
- Total Taxpayer's Equity has increased by £11,353k, in line with the year to date net income and expenditure surplus (including technical items).

Financial Position – Cash Flow

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021

Statement of Cash Flows	2020/21 £000's	Q1 2021/22 £000's	Q2 2021/22 £000's	M7 2021/22 £000's
Cashflows from Operating Activities				
Operating Surplus/(Deficit)	13,229	11,257	17,574	19,838
Depreciation and Amortisation	30,988	7,338	15,172	17,898
Impairments and Reversals	2,265	-	-	-
Losses on Disposals	-	12	12	-
Income from Donations	[illegible]	[illegible]	[illegible]	[illegible]
(Increase)/Decrease in Assets	27,926	[illegible]	[illegible]	[illegible]
Increase/(Decrease) in Liabilities	28,779	17,622	23,698	32,225
Net Cash Generated from/(used in) Operations	99,098	5,448	30,980	17,166
Cash Flows from Investing Activities				
Purchase of Assets	(67,047)	(18,002)	[illegible]	[illegible]
Receipt of Cash to Purchase Donated Assets	1,582	7,670	10,236	11,630
Net Cash Generated from / (used in) Investing Activities	(65,465)	(10,332)	[illegible]	[illegible]
Cash Flows from Financing Activities				
Public Dividend Capital - Received	79,506	-	-	-
Loans	[illegible]	[illegible]	[illegible]	[illegible]
Interest Paid	[illegible]	[illegible]	[illegible]	[illegible]
Finance Lease	(563)	[illegible]	[illegible]	[illegible]
Public Dividend Capital - Paid	(11,426)	-	[illegible]	[illegible]
Net Cash Generated from/(used in) Financing Activities	1,778	[illegible]	[illegible]	[illegible]
INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	35,411	[illegible]	[illegible]	[illegible]
Cash at the Start of the Year	134,233	169,644	169,644	169,644
CASH & CASH EQUIVALENTS AT THE END OF THE PERIOD	169,644	160,856	165,888	168,776



Liquidity ratios	Acid test	Liquidity days
Draft target	2:1	30
Mar-21	1.4:1	23
Q1	1.3:1	19
Q2	1.3:1	18
M7	1.3:1	18

Acid test - ability to meet short term debt
Liquidity days - no. days operating costs covered by cash reserves

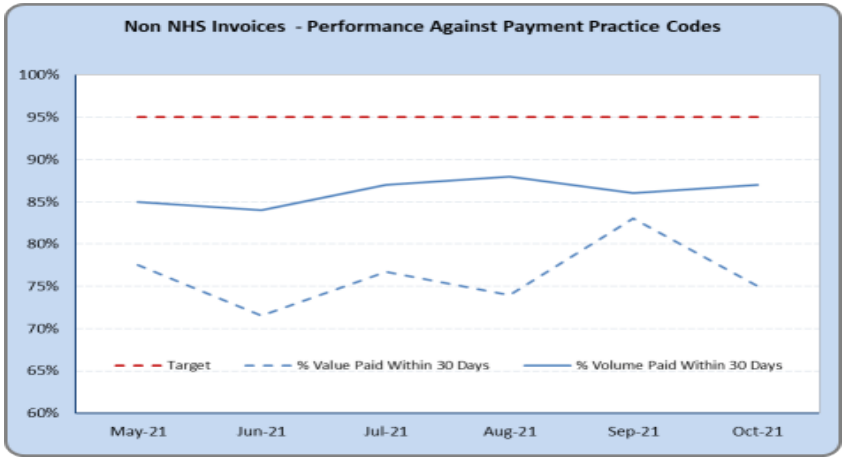
Key Points:

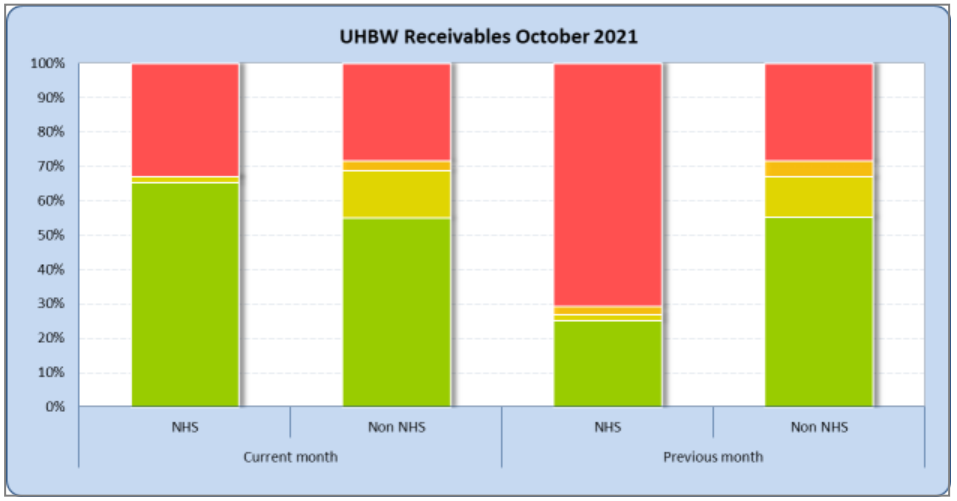
- The cash balance at the end of month 7 is £168,776k, £2,888k higher than the previous month and £868k lower than the opening balance.
- The month on month movement is primarily attributable to an increase in net cash from operations of £7,289k, offset by net capital cash outflow of £4,354k.
- The liquidity ratios show that although the Trust has a high cash balance, the Trust's ability to meet short term debt and the number of liquidity days are below the draft target. The draft target for liquidity days and the acid test will need further consideration in due course against the NHSEI liquidity metrics.

Financial Position - Payment Performance

University Hospitals Bristol and Weston NHS Foundation Trust

October 2021





Key Points:

- In October, 87% of invoices by volume and 77% by value were paid within the 30 day target of the Better Payment Practice Code (BPPC). As noted last month the increase in the September value performance was exceptional, due to the number of payment of high cost drugs, and the current month performance is in line with the average monthly performance.
- The Trust continues to pay all invoices upon authorisation, regardless of payment terms.
- The overall receivables position has increased by £14,404k in month and is primarily due to the HEE income reported in the Statement of Financial Position section.
- The 90+ day aged category continues to be high at £10,348k and is primarily due to an outstanding invoice of £6,146k relating to the 2020/21 year end annual leave accrual. NHS England continue to review the national cash position and will provide an update.

Days	Current Month (£000's)			Previous Month (£000's)			Movement (£000's)		
	NHS	Non NHS	Total	NHS	Non NHS	Total	NHS	Non NHS	Total
90+	8,676	1,672	10,348	8,651	1,581	10,232	0,025	0,091	0,116
60-90	0,004	0,168	0,172	0,281	0,259	0,540	(0,277)	(0,091)	(0,368)
30-60	0,463	0,818	1,281	0,213	0,646	0,859	0,250	0,172	0,422
0-30	17,139	3,246	20,385	3,069	3,082	6,150	14,070	0,164	14,235
Total	**26,281**	**5,904**	**32,185**	**12,213**	**5,569**	**17,781**	**14,069**	**0,335**	**14,404**

Recovery Actions:

- Delivery of the BPPC recovery plan for improving payment performance.
- The Trust has met with North Bristol Trust and will meet with University Hospitals Plymouth NHS Trust in November to understand further potential actions to improve payment performance.

Appendix 1 – Action Log & Developments

University Hospitals Bristol and Weston NHS Foundation Trust

Summary of Recovery Actions

Ref	Date	Description of Action	Action Owner	Date Due	Committee Month	Date Closed	Status	Revised Date	Update
[illegible]	Jun-21	Assessment of costs associated with the delivery of ERF income will be undertaken in month 4.	OpDoF	Jul-21	October		Open	Dec-21	Revised system timescales. Required for FOT assessment in M8
006	Jun-21	Urgent requirement to re-engage operational and clinical staff in delivering the Trust's required efficiency target of £15,515k.	HoFMI	Aug-21	November		Open	Dec-21	Divisional savings pipelines reviewed as part of monthly savings meetings. Paper to SLT w/c 18/10 prioritises the development of 2022/23 savings programme as one of three priorities. Divisions will be required to submit draft 22/23 plans and pipelines by end of November to be reviewed at December divisional exec reviews. Trust will need to align with the system's £108m savings plan.
008	Jun-21	Develop transformation projects which will deliver recurrent savings.	HoFMI	Jan-22	February		Open		PMO to be established linked with COO team to address elective restoration and linked productivity efficiency in clinical areas. This is still work in progress. In addition the Trust is embarking on a programme of Continuous improvement , the first meeting of a working group to take this forward is scheduled for the week beginning 18/10. This will be a long terms project across the system..
013	Jun-21	Reassess the financial implications of the financial arrangements relating to the merger.	OpDoF	Oct-21	November		Open	Feb-22	Awaiting national guidance to inform the 2022/23 financial regime.
014	Jun-21	Present the Trust Five Year Financial Strategy	OpDoF	Oct-21	November		Open	Feb-22	Timescales revised due to delayed national guidance.
015	Jul-21	Assessment of productivity by specialty	OpDoF	Oct-21	November		Open	Feb-22	National approach to assessing productivity now received which the Trust is looking to model through at specialty level.
016	Jun-21	Review of the cost/benefit of the enhanced rates.	HoFPG	Sep-21	October		Open	Dec-21	Review completed. Trust must agree and implement actions following the review.
017	Jun-21	Revision of the 5 Year Capital Plan to ensure compliance with the system CDEL	OpDoF	Oct-21	November		Open	Dec-21	Non-compliant plan submitted on 16th October. Awaiting feedback from NHSEI.
018	Oct-21	Delivery of the BPPC recovery plan	HoFS	Mar-22	April		Open		
019	Oct-21	Meet with University Hospitals Plymouth to discuss BPPC performance and further potential for recovery actions.	HoFS	Nov-21	December		Open		
020	Jul-21	First cut of 2022/23 savings plans at corporate and divisional level.	HoFMI	Nov-21	December		Open		

Summary of Future Developments/Amendments to the Report

Ref	Date	Description of Development	Action Owner	Committee Month
~~1~~	~~Jun-21~~	~~Inclusion of cashflow statement~~	~~HoFS~~	~~Aug-21~~
~~2~~	~~Jun-21~~	~~Further data on reason for agency cover and Tier 4 agency usage~~	~~ADFSC&I~~	~~Aug-21~~
3	Jun-21	Inclusion of a summary of the STP financial position	ADFSC&I	Apr-22

Key:

Role	Description	Name
DoFI	Director of Finance & Information	Neil Kemsley
OpDoF	Operational Director of Finance	Jeremy Spearing
HoFPG	Head of Finance - People & Governance	Kate Parraman
HoFMI	Head of Financial Management & Improvement	Dean Bodill
HoFFP	Head of Finance - Financial Performance	Kate Herrick
HoFS	Head of Financial Services	Catherine Cookson

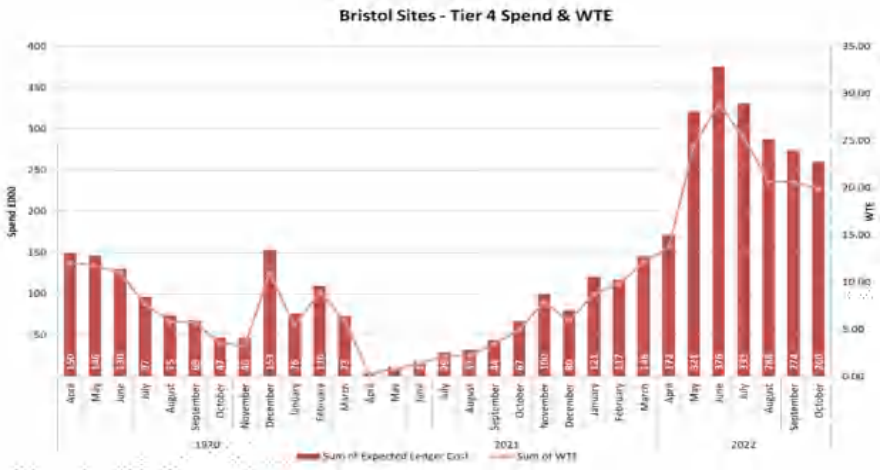
Appendix 2 – ED Activity by Site

Accident & Emergency Attendances, Volume Per Day

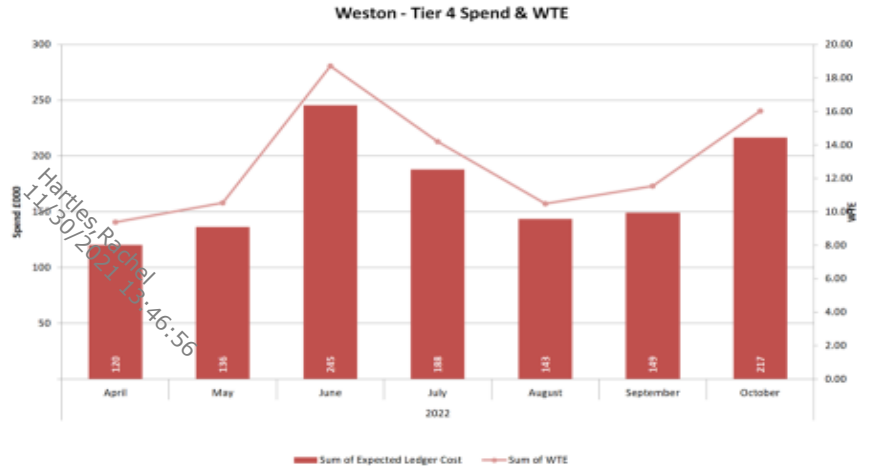
Key Points

- The charts above indicate that the % of Accident and Emergency Attendances in 2021/22, compared to 2019/20, varies between hospitals. In both the Bristol Royal Infirmary and the Bristol Royal Hospital for Children, the number of attendances per day in 2021/22 is higher than 2019/20 at +4% and +12% respectively.

Appendix 3 – Nurse Agency - Tier 4



The graph shows the use of Tier 4 staff at the Bristol sites since the start of 19/20. Across the Trust, the cost of Tier 4 staff increased significantly in M2 and M3 from £172k (13.71wte) in Apr-21 to £321k (24.51wte) in May-21, and further increase in Jun-21 to £376k (29.08wte). There was a slight decrease in July-21 down to £331k (25.37wte) with further decreases each month; Aug-21 £288k (20.63wte), Sep-21 £274k (20.65wte) and Oct-21 £260k (19.95wte).



The graph shows the use of Tier 4 staff at the Weston site since the start of this financial year. The use of Tier 4 staff in April was £123k (9.63wte), with an increase in May to £140k (10.80wte). In June Tier 4 usage almost doubled from April up to £244k (18.93wte). There was a reduction in July down to £186k (14.56wte) with a further reduction in Aug-21 to £143k (10.48wte). September had a slight increase to £149k (11.53wte) followed by a significant increase of £68k to £217k (16.03wte) in October.

Appendix 4 – Reasons for Agency Usage

Top 10 Reasons for Agency Requests - Number of Shifts

Staff Group	Request Reason	May	June	July	August	September	October	Grand Total
Admin & Clerical	A&C Workload Need			5	23	22	17	67
	Additional Cover			1	13	13	8	35
	Staff Vacancy		6	12			32	50
Admin & Clerical Total			6	18	36	35	57	152
AHP	Additional Cover		4	37	27	25	30	123
	AHP/HCST/Med Staff Out of Hours	65	7	74	91	70		307
	Increased Acuity/Dependancy					7	14	21
	Sickness Long Term Planned		7	14	11	9		40
	Staff Vacancy	7	204	91	122	119	88	752
AHP Total		182	222	216	261	228	132	1,243
Facilities	Additional Cover	204		115	246	215	173	953
	Staff Vacancy						118	118
Facilities Total		204		115	246	215	291	1,071
Medic	Additional Cover		14	44	87	25	38	208
	AHP/HCST/Med Staff Out of Hours		5					5
	Compassionate Leave		7					7
	Extra Clinics	1	5					6
	Increased Acuity/Dependancy					304	377	681
	Parental Leave	15	4					19
	Sickness Long Term Planned	14		3		22	21	60
	Sickness Short Term Unplanned	11	9	5	2			27
	Staff Vacancy	90	113	112	119	326	411	1,171
Medic Total		131	155	164	208	677	847	2,182
Nursing	ECO3 NA	42	43	69	9	32	85	280
	ECO4 Psych NA	104	78	43	26	9	5	265
	ECO4 RMN	348	345	142	144	112	199	1,280
	Extra Capacity Beds	160	40	96	52	80	26	424
	Increased Acuity/Dependancy	81	111	72	98	97	144	603
	RMN Required	174	264	147	130	113	110	938
	Sickness Long Term Planned	24	63	82	41	40	41	291
	Sickness Short Term Unplanned	432	505	289	269	234	298	2,027
	Staff Vacancy	1,427	1,435	1,641	1,436	1,498	1,623	9,080
	Supernumerary to Cover New Starters	135	134	103	41	126	12	555
Nursing Total		3,110	3,228	2,966	2,446	2,516	2,770	17,036
Grand Total		3,627	3,811	3,479	3,193	3,671	4,097	22,684

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

Report Title	**Register of Seals Report**
Report Author	**Natashia Judge, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary
This report provides a summary of the applications of the Trust Seal made since the previous report in July 2021.
2. Key points to note *(Including decisions taken)*
Standing Orders for the Trust Board of Directors stipulate that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the person who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust Seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
The risks associated with this report include: *N/A*
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **Information**.
5. History of the paper **Please include details of where paper has previously been received.**
N/A

University Hospitals Bristol and Weston NHS Foundation Trust

Register of Seals

July to November 2021

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
857	04/08/21	Roche Pathology Managed Equipment Service	Robert Woolley, Chief Executive	Mark Smith, Deputy Chief Executive and Chief Operating Officer	Natashia Judge, Head of Corporate Governance
858	13/09/21	Transfer of the Weston Health General Charitable Fund to Above and Beyond	Robert Woolley, Chief Executive	Neil Kemsley, Director of Finance & Information	Natashia Judge, Head of Corporate Governance

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

Report Title	**Governors' Log of Communications Report**
Report Author	**Sarah Murch, Membership Manager**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary

The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust. 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.

2. Key points to note

(Including decisions taken)

Since the last public Board of Directors meeting in September, three new questions have been added to the Governors' Log by governors, and four responses received. The new questions relate to staff consultations (no. 260), the Trust's zero landfill target (no. 259) and dietetics provision (no. 258).

In addition, a question has been re-opened from November 2020 with a follow-up question (no. 244 – relating to the Trust's provision of support for patients with learning disabilities).

3. Risks

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

n/a

4. Advice and Recommendations

(Support and Board/Committee decisions requested):

- This report is for **Information.**

5. History of the paper

Please include details of where paper has previously been received.

n/a	

Governors' Log of Communications

23 November 2021

ID	Governor Name		
260	Paul Hopkins	***Theme:*** Staff Retention following Consultation	***Source:*** Governor Direct

Query **10/11/2021**

What strategy or plan does UHBW have in place to evaluate and review the impact upon staff wellbeing and staff retention following a consultation process? And how is this information captured?

Division: Trust-wide ***Executive Lead:*** *Director of People* ***Response requested:*** 19/11/2021

Response Response Pending

Status: *Assigned to Executive Lead*

ID	Governor Name		
259	**Paul Hopkins**	***Theme:*** Zero landfill target	***Source:*** Governor Direct

Query **01/11/2021**

Follow-up to Log Question 255 (Recycling):

How does UHBW aim to achieve its target of zero landfill in the next 4 years? And, if this is not achievable, what steps will the trust propose to attempt to reach this target in a realistic time frame? And what time frame will that be?

Division: Trust-wide ***Executive Lead:*** *Director of Strategy and Transformation* ***Response requested:*** 02/11/2021

Response **15/11/2021**

Thank you for your very valid question,

Since declaring a climate emergency back in 2019 and the launch of the Sustainability Development Strategy across the organisation, the Trust has invested in the creation of a sustainability team. One of the workstreams the team has been focused on is delivering the Trust sustainable waste management targets. The Trust intends to achieve the target of zero waste to landfill by 2025, by following a clear set of strategic and operational objectives.

This objectives include the review of all current waste management contracts. All of the Trust current waste management contracts will cease in 2022. This gives us the opportunity to ensure our sustainability targets are built into the new contracts by clearly specifying and tendering the Trust requirements.

This approach, supported by the Ecoquip+ innovation procurement project, includes analysing the current and future waste market place, and evaluating innovative sustainable waste management treatment and reduction solutions. We are also building sustainability into our procurement processes to minimise the amount of waste generated in the first place; for instance by changing from single use to reusable items. By working with partners across the region and beyond, we are committed to develop a circular economy across the organisation and beyond. We are working to ensure all of our future contracts, contractors and working partners are aligned to the Trust's sustainability targets.

To further support achieving our sustainable waste management objectives, the Trust is developing a staff sustainable waste management engagement strategy and to deliver training across the organisation.

We are confident that, by following the steps above we will achieve or zero waste to landfill objective by the targeted date. We are now looking at how we can get to zero waste to contribute to our 2030 carbon target.

Status: *Re-opened*

ID	Governor Name		
258	Sofia Cuevas-Asturias	***Theme:*** National standard for full-time dieticians	***Source:*** Governor Direct

Query **01/11/2021**

How far does the Trust meet the national standard for employment of full-time dieticians? Is there a plan to address any shortcomings in this regard, and if so, what is it?

Division: Diagnostics & Therapies ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 02/11/2021

Response

Response pending.

Status: *Assigned to Executive Lead*

ID	Governor Name		
257	Charles Bolton	***Theme:*** Flooding	***Source:*** Governor Direct

Query **14/09/2021**

Noting the steep slope the hospitals are on (or at least some of them), and noting the fact that other hospitals flooded, is the trust confident that of its measures to prevent flooding?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **28/09/2021**

The location of the BRI Precinct on a hill does have some challenges with run-off water during extreme weather conditions and flooding incidents in the past have been localised. We have not experienced significant flooding damage to my knowledge for quite some time.
We do recognise that climate change is causing extreme weather event to become more regular – this includes very heavy downpours over a shorter duration of time. We have referenced this fact in the Trusts Sustainability Development Strategy (2020-2025) in the climate change adaptation section and we continue to work to deliver this strategy through the sustainability agenda.
We have seen a few incidents recently where by our roofs and gutters have struggled to take away the volume of water during heavy rain. We are undertaking a review of our Planned Preventative Maintenance programme on these assets and will look to implement the correct regime and frequencies to adapt to the changes in environmental conditions.

Status: *Awaiting Governor Response*

ID	Governor Name		
256	Charles Bolton	***Theme:*** Climate Change	***Source:*** Governor Direct

Query **14/09/2021**

'Where is the trust at as regards to Climate Change adaptation?'

Is there a strategy? If so, what status does it has and how is it being progressed? Are there any blocks to its progress?

The classic example of climate change is the year (2003 I think) where a heatwave killed thousands of people in France. The point being that come 2050, this will be an average summer. If you think back to the summer here, there was a week or so when it was so hot that people struggled to sleep. In that week, some of the clinic rooms where I work were unpleasantly hot.

I believe the response in France was to increase the tree cover (which has a cooling effect). Is the trust contributing to a city –wide strategy ?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **28/09/2021**

The Trust doesn't have its own climate change adaptation strategy. But, as part of the Healthier Together BNSSG Sustainability and Health Group we have prepared an STP-wide Adaptation Plan. A risk assessment process has been developed for organisations to undertake a site specific review of their climate change resilience.

The next step for the Trust is to ensure the completion of this risk assessment and to get the assessments agreed with the departments impacted. Once we and others have done this we will identify the key shared risks and opportunities to tackle together.

We are providing input to projects to ensure climate change adaptation is integrated into the design of capital projects to ensure our buildings are prepared for the future.

We are also contributing to a city wide heat resilience project that is mapping the areas where people are most vulnerable to heat risk. This will lead to developing ways of increasing resilience.

Status: *Awaiting Governor Response*

ID	Governor Name		
255	Sofia Cuevas-Asturias	***Theme:*** Recycling	***Source:*** Governor Direct

Query **08/09/2021**

1. What are we doing as a trust to increase our recycling of goods?
2. Will we have any initiatives for inhalers to be recycled as per new guidance (https://psnc.org.uk/our-news/pqs-quality-criterion-starting-from-1st-september-2021/?fbclid=IwAR1j5nBHlr6KmlyK9-M8mePPH9UI0AJ1_lCwrrriXuwA-mtzas74kFQVECE)

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **19/10/2021**

What are we doing as a trust to increase our recycling of goods?
As one of the largest organisations in Bristol, we have a significant environmental impact. As a healthcare setting the Trust generates substantial amounts of clinical and non-clinical waste. The Trust have in 2019 launched the Sustainable Development Strategy, where we have commented to ambitious sustainable targets including, achieving carbon neutrality by 2030 and zero waste to landfill by 2025.

To support achieving those sustainable targets and maximizing recyclability across the organisation and beyond, we have implemented various recycling schemes and currently patients, staff and visitors are able to recycle via:
Dry Mix Recycling (DMR) schemes, this recycling stream support the recycling of:

a. Paper including- newspapers, non- confidential papers and magazines
b. Metal Cans- Empty drinks tin cans, tin cans from catering settings
c. Cardboard- Corrugated cardboard, cereal boxes and card
d. Plastic- Plastic bottles, plastic films, empty bottles of milk, empty drink bottles, plastic salad trays, margarine tubs, and microwavable meal trays
e. While not DMR, all of the Trust confidential paper is also recycled, this accounts to a very large proportion of our recycling.

We run Waste Electric Electronic Equipment (WEEE) recycling schemes, where we all staff is able to recycle batteries, IT equipment and heavier equipment including fridges and TV's.

Prior the pandemic we have successfully rolled out the recycling of patients PVC masks and we have managed deviate plastic from being incinerated. Unfortunately due to covid-19 and the transmission risks this scheme was stopped and we are currently working on reinstating the scheme.

Working with a Bristol waste management partners, we have recently launched the coffee cup recycling scheme which have been received with great enthusiasm by our staff. We have rolled out the recycling of crisp packets and plastic bread bags in Weston and we are currently rolling the scheme out within our Bristol hospitals. We are also working on a reusable scheme within the organisation where, staff will be able to utilise furniture items otherwise disposed of previously

ID **Governor Name**

avoiding purchase wherever possible.

We have successfully introduced with the support of clinical staff in Weston the recycling of clinical metal instruments. In Weston we have also introduced within clinical settings reusable sharps bins, this enabled us to remove the need for incinerating single use plastic sharps bins, it is our ambition is to roll the scheme out across the Trust.

We are currently working on a project to identify further recycling options and environmentally friendly innovations to treat non recycling waste. This including the recycling of masks which become a problem globally.

While we control our stocks, at times we have out of date items that otherwise would be disposed of via the waste streams, to combat this problem we have join forces with the University West of England and working in partnership currently there is avoidance of disposing out of date items which can be utilised by medical students in the learning environment.

Will we have any initiatives for inhalers to be recycled as per new guidance
The Trust has attempted to introduce inhaler recycling schemes in the past, but have met a number of barriers. The wider system, however, has looked at the recycling available for inhalers and has a number of plans:

1. BNSSG ICS Pharmacy Strategic plans will engage with environmental impact issues.
2. The Medicine's Optimisation Strategy is being launched across the system and will discuss recognising environmental challenges relating to medicines and minimise impact where possible with all teams.
3. As part of formulary applications and guideline updates (where applicable) the carbon footprint of inhalers is considered and included as part of the decision making process.
4. Primary Care Networks are reviewing environmental sustainability in inhaler prescribing..
5. The BNSSG CCG has published guidance on Reducing Environmental Impact of Inhalers final-environmental-impact-of-inhalers-oct-20.pdf (bnssgccg.nhs.uk) This is broader than recycling but has several suggestions how carbon footprint could be reduced while benefiting patient care.
6. There has also been changes to the NHS community pharmacy contract in 2021/22 which includes return of unwanted and unused inhalers. Pharmacy teams will be speaking to patients, their carers or representatives, for whom they have dispensed an inhaler about the environmental benefits of them returning all unwanted and used inhaler devices for safe and environmentally friendly disposal.

Status: *Closed*

Hartles,Rachel
11/30/2021 13:46:56

ID	Governor Name		
244	Sue Milestone	***Theme:*** Learning Disability Nurses	***Source:*** Governor Direct

Query **02/11/2020**

I understand that other Trusts employ Learning Disability Nurses to ensure adults with learning disabilities have equal access to health care, and to help them feel safe and supported with inpatient and emergency admissions, day surgery, outpatient appointments and planned admissions.

They assess the patient’s needs to make them feel safe, make reasonable adjustments where needed, help with interpreting situations and make sure patients are listened to.

They also communicate with family/carers, care providers, community teams and health/social care professionals. Patients have hospital passports to facilitate staff understanding of their needs. They provide tours of the building pre-admission and address fears around hospital/treatment.

Does UHBW offer this kind of service, and if not, would the Trust consider setting up a similar service for learning disabled patients, while looking at the feasibility of extending it to cover all patients with multiple, complex needs including those with physical disabilities and temporary delirium?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 02/11/2020

Response **24/11/2020**

The Trust has employed Specialist Learning Disability nurses within adult services for a number of years. The LD nursing team have a broad remit, which includes providing specialist advice and support to staff caring for adults with a Learning Disability across the Trust.

The LD nurses provide training and support to clinical staff to enable them to assess and implement a range of Reasonable Adjustment assessments, communicating with patients, families/carers and partner agencies. The use of hospital passports is integral to this and is promoted through training and widely used across the Trust.

A range of other specialist support is also available to patients with other or additional complex needs, including physical disabilities or temporary delirium, and packages of care will be tailored to each patient's individual needs. The Trusts prioritises promoting equal access to all patients, including those with a Learning Disability - work which is monitored closely through the Trust Learning Disability Steering Group.

The Trust is committed to continuing to develop and improve the Learning Disability service and works closely with both partner agencies and local health providers. The Trust has participated in the NHSI LD national service benchmarking exercise since its inception and feedback from this is used to develop the service. Most recently partner collaboration has led to a Community Learning Disability Nurse being based with the hospital team, a model of working which is

ID **Governor Name**

proving to be effective in supporting the continuity of care for patients and their families. Suggestions and feedback from LD patients and their families are invaluable in continuing to develop the LD service within the Trust and the LD nurses are very happy to be contacted with any feedback re the services provided.

Status: *Re-opened*

Follow-up question submitted 10/11/2021: Thank you for this response. I have a further question arising from the following statement: ‘A range of other specialist support is also available to patients with other or additional complex needs, including physical disabilities or temporary delirium, and packages of care will be tailored to each patient's individual needs.’ I would be interested to learn more about how this support is implemented in cases of patients who do not identify as having Learning Disabilities but whose condition - for example delirium - brings on transitory aphasia so they are unable to communicate lucidly. Could you explain how such patients would be identified as being in need of this support?

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 30 November 2021

Report Title	Amendment to Standing Financial Instructions
Report Author	Kate Parraman, Head of Finance (Governance and People)
Executive Lead	Neil Kemsley, Director of Finance and IT

1. Report Summary

The Trust's Standing Financial Instructions (SFIs) are regularly reviewed. The current review is delayed to allow for further work to be completed within several key areas:

- Sections nine and ten which refer to procurement and tendering. Significant work is in progress, in partnership with BWPC and NBT, to review and align these sections to better support the needs of the organisation whilst ensuring sound financial governance and compliance with changing legislation.

- Sections two, three, five and eighteen which refer to budgeting, planning, reporting, contracting and capital investment. Updates are required to reflect the recent national changes to the financial regime and Regulator requirements.

- Sections fifteen and sixteen which refer to patient property and losses and special payments. Updates will follow the work to improve the processes to better support patients and staff.

Therefore, the updated SFIs are expected to be presented early in 2022.

In advance of this full review, an amendment to the SFIs is required to support the Trust to deliver the 2021/22 capital programme and activity recovery programme. The context of this required change is described in the attached SBAR. The Committee is asked to consider the SBAR which recommends that the Trust can waive the need to tender for goods or services when the Trust has recently been through a robust evaluation and selection process and to waive the need to tender for goods or services which BWPC considers could be procured using a compliant framework.

In addition it is proposed to increase the threshold to obtain three written quotations to £10,000. The £5,000 threshold has been in place for over 15 years and does not reflect changes in prices or complexity of the activities of the organisation over this time. The thresholds exist to ensure the Trust demonstrates value for money but this needs to be balanced with the resource required to obtain quotes and document to support the procurement decision.

The proposed amendments have been discussed with, and are supported by, the Director of Finance and the Director of Procurement. They are considered to balance good governance, risk management and effective use of resources.

The proposed amendments will remain in place for a maximum of six months. During this time they will be evaluated and permanent amendments will be proposed as part of the full scale review due in early 2022. As part of this review the Directors of Finance and Procurement will provide their professional assessment of the impact of these changes when presenting any permanent change.

2. Key points to note
(Including decisions taken)

Approval of the proposed amendments require a change to the Trust's SFIs as follows:

Section 9 of the SFIs includes:

> *A minimum of three competitive tenders is required in accordance with the requirements of Section 10 for any purchase of goods or services over £25,000 (excluding VAT) including:*
>
> *a) a specification for equipment, goods, service contract, construction contract or other project*
> *b) a period standing order, call-off contract, framework agreement or other purchase of goods or services where the aggregate value exceeds £25,000 in any year.*
>
> *Where such purchases exceed £5,000 but are less than £25,000 a minimum of three competitive quotations in writing shall be obtained.*
>
> *Where such purchases do not exceed £5,000, non-competitive quotations in writing may be obtained with value for money being demonstrated on all occasions. Best practice should be a minimum of three such quotations.*
>
> *The ordering of goods or services above £5,000 without three or more competitive quotes or £25,000 without three or more competitively priced tenders require approval as a Single Tender Action (STA) via the Trust's Single Tender Action procedure before placing the order.*

The changed SFIs would read:

> *A minimum of three competitive tenders is required in accordance with the requirements of Section 10 for any purchase of goods or services over £25,000 (excluding VAT).*
>
> *The only exception to this is where the tender is for goods or services that the Trust has recently been through a robust evaluation and selection process for or is for goods or services which could be procured using a compliant (already tendered for) framework. BWPC, as independent professionals, will ensure these definitions are properly applied.*
>
> *Where purchases exceed £10,000 but are less than £25,000 a minimum of three competitive quotations in writing shall be obtained.*
>
> *Where such purchases do not exceed £10,000, non-competitive quotations in writing may be obtained with value for money being demonstrated on all occasions.*
>
> *The ordering of goods or services above £10,000 without three or more competitive quotes or £25,000 without three or more competitively priced tenders require approval as a Single Tender Action (STA) via the Trust's Single Tender Action procedure before placing the order.*

These amendments have been revired and approved by the Finance Committee at the meeting on 26th November 2021.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
Following approval at the Finance Committee, the Trust Board is asked to **approve** that: 1. the Trust can waive the need to tender for goods or services that the Trust has recently been through a robust evaluation and selection process for 2. the Trust can waive the need to tender for goods or services which could be procured using a compliant framework 3. the threshold for which three written quotations are required should be raised from £5,000 to £10,000 *(BWPC, as independent professionals, will ensure these definitions are properly applied)*
5. History of the paper **Please include details of where paper has previously been received.**

[Name of Committee/Group/Board]	**[Insert Date paper was received]**
Finance & Digital Committee	**26th November 2021**

Recommendation Definitions:

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

Speeding up our Route to Market

S	**Situation:** There is an increased volume of procurement workload arising from the Trust's activity recovery programme and need to deliver the capital programme in the context of CDEL. Funding continues to be allocated in year by NHSEI for schemes with the expectation that they are delivered at pace. This includes additional capital funding for which there was already a challenge to deliver capital schemes by 31st March to meet the CDEL funding target. There is a need to ensure an efficient and effective procurement process to support the Trust. The current procurement governance structure places an emphasis on spot buying over the use of more efficient purchasing models. Contracts are tendered and let on a scheme by scheme basis. As a result, Trust delivery teams and BWPC are struggling to support the increased procurement requirements, with a risk to delivery of current and future projects. The current approach is also less responsive to operational requirements to meet funding opportunities. Currently the SFI's require all commitments / spend over a value of £5k whether in a single order or aggregation of a number of orders to be subject to a form of competition (*SFI 9.4.2*) unless a waiver (normally in the form of an STA) is granted to permit direct award. During 2020/21 497 STAs were raised exempting spend from the procurement process. All STAs are reported through to the Audit Committee and it should be noted that STAs are used for a number of reasons including where there is only one supplier. Best practice in this area is establish a suite of framework agreements/ call off contracts to manage repeat demands. However, currently the SFI's restrict the use of frameworks above an aggregate value of spend of £25k without using competition to demonstrate best value (SFI 9.4.1). This paper requests that the Trust changes it approach to the use of Frameworks / call off orders and proposes an approach to roll out the use of Frameworks across the Trust.
B	**Background:** UHBW's procurement policy has been established to promote delivery of best value for money and avoid corruption and waste. This is formalised within the SFI's which promote frequent market testing and use market forces to drive down the price of products, ensuring best value for money for the Trust. Whilst this policy has served the trust well for a number of years, it has resulted in a relatively inefficient procurement model that requires high levels of intervention and support without necessarily delivering value across the board. It is recognised that a different approach is required, however the immediate need is to create capacity within procurement to deliver the 2021/22 revenue and capital programmes and make wider scale changes. A further need to change the Trust's approach to procurement arises from the change in Government approach to Public Procurement post EU Exit. The Government has clearly

	set out its objectives (PPN 05/21, Outsourcing Playbook, and green paper transforming public procurement) for increasing management of contracts and of using public money to deliver Social Value outcomes. The implication of these changes is that they are unlikely to be deliverable within our current structure.
A	**Assessment:** We need to create capacity within the procurement process in a controlled way. **1 Follow a risk assessed approach to waiving tendering requirements** We can segment our current spend into 3 groups: 1. Historic spend that has recently been through a robust evaluation and selection process (it is worth noting that most of our spend sits in this area) 2. Historic spend that has not been subject to reasonable evaluation and selection process 3. Spend which is new to the Trust. In order to deliver the level of procurement over the next six months there is a requirement to change our governance model. Historically this has been done reactively by increasing the number of orders being processed via the STA route. An alternative to this would be to take a more risk based approach by classing all group 1 spend as low risk and thereby waiver the requirement to tender. This would free up capacity to focus more time on groups 2 and 3. **2 Allow higher value frameworks into our commercial mix** There are 3 ways that we can quickly increase our stock of frameworks / call offs to simplify our procurement process and free up capacity. 1. Authorise the use of NHS SC or other Government Frameworks as compliant procurement removing the need for using competition **2.** When relevant to an approved commercial strategy, tender for longer term frameworks / call off contracts to reduce the need to frequently return to market **3.** Seek opportunities to utilise other Trust's frameworks/ contracts where it is compliant to do so and they bring commercial advantage This would require a change to the Trust's SFIs **3 Carry out regular benchmarking and market testing to retain value** Require that the BWPC category leads benchmark and/ or market test [10%] by value of all orders placed under frameworks or call offs to validate that the framework is still delivering value to the trust.
R	**Recommendations:** Recognising the need for a wider review of the Trust's SFIs and the procurement practice mandated within them, it is recommended that to be able to deliver the Trust's procurement needs in the next 6 months the Trust should:

	1. Waive the need to tender for goods or services that the Trust has recently been through a robust evaluation and selection process for. It should be left to BWPC to use their professional judgement to define 'recent'. 2. Waive the need for to tender for goods or services which BWPC considers could be procured using a compliant framework By adopting this approach, BWPC resource can be better utilised and less resource will be used on following an STA process. The Committee is asked to: **Note:** The current challenges being faced by the Trust and BWPC in delivery of current and future procurement and commercial activity. **Support:** The proposal to adopt a risk assessed approach to waivering tender requirements. **Agree:** Agree the two recommendations above to simplify routes to market, supported by increased levels of monitoring by BWPC to test value. **Recognise:** That this needs to be part of a longer term plan to optimise our supply chains/ contract structures which will be reflected in further changes to the SFIs.