NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

BOARD OF DIRECTORS (IN PUBLIC)

Meeting to be held on Tuesday 9th August 2022 at 11.00 – 14.30 at Conference Hall, City Hall, College Green, Bristol, BS1 5TR

AGENDA

NO	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
Preliminary Business				
1.	Welcome and Apologies for Absence	Information	Chair	11:00
2.	Declarations of Interest	Information	Chair	
3.	Patient Story	Information	Chief Nurse and Midwife	
4.	Minutes of the Last Meeting – 27 May 2022	Approval	Chair	11:25
5.	Matters Arising and Action Log	Approval	Chair	
6.	Chief Executive's Report	Information	Chief Executive	11:30
Strategic				
7.	Operational Plan 2022/23	Approval	Director of Strategy and Transformation / Deputy Director of Finance	11:45
8.	People Strategy Update	Approval	Director of People	12.00
9.	Board Assurance Framework • Strategic Risk Register	Assurance	Chief Executive	12:15
Quality and Performance				
10.	Quality and Outcomes Committee Chair's Report	Assurance	Committee Chair	12:25
11.	People Committee Chair's Report	Assurance	Committee Chair	12:30
12.	Integrated Quality & Performance Report	Assurance	Deputy Chief Executive and Chief Operating Officer, Chief Nurse and Midwife, Medical Director	12:35
Break				12:45
13.	Learning from Deaths Annual Report	Assurance	Medical Director	13:00
14.	Maternity Perinatal Quality Surveillance Matrix (PQSM) Quarterly Update Report	Assurance	Chief Nurse and Midwife	13:10
Finance and Digital				

We are supportive respectful innovative collaborative. We are UHBW.

NO	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
15.	Finance and Digital Committee Chair's Report	Assurance	Committee Chair	13:15
16.	Trust Finance Performance Report	Assurance	Deputy Director of Finance	13:20
Governance				
17.	Audit Committee Chair's Report	Assurance	Committee Chair	13:30
18.	Annual Report Medical Appraisal and Revalidation	Approval	Medical Director	13.35
19.	NIHR CRN Annual Report (hosted body report)	Approval	Medical Director	13:45
20.	Review of Terms of Reference – • Audit Committee • Quality and Outcomes Committee	Approval	Director of Corporate Governance	13.55
21.	Changes to the Trust Constitution	Approval	Director of Corporate Governance	14.05
22.	Governors' Log of Communications	Information	Director of Corporate Governance	14.15
Concluding Business				
23.	Any other urgent business	Information	Chair	
24.	Date of next meeting: 11 October 2022	Information	Chair	

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th August 2022

Report Title	**What Matters to Me – a Patient Story**
Report Author	**Tony Watkin, Patient and Public Involvement Lead**
Executive Lead	**Deidre Fowler – Chief Nurse & 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 patients and for Board members to reflect on what the experience reveals about our staff, morale and organisational culture, quality of care and the context in which clinicians work.

2. Key points to note

(Including decisions taken)

The Board Seminar in July focussed on the emerging priorities for the Trust in relation to health inequalities and EDI for patients and communities. Continuing this journey, in this story we will hear from Alun Davies of the Bristol Sight Loss Council about why a consistent approach to providing accessible information and communication is central to people receiving effective healthcare. Alun will be joined by Jerry and Anela who will share their own experiences, both positive and negative, of receiving care and why it is essential that our patients receive information about their care and treatment from us in a way they can access and understand.

The story is set in the context of a collaborative and supportive relationship between the Trust and the Bristol Sight Loss Council culminating in the launch today of two new films with the goal of raising awareness about the Accessible Information Standard (AIS) and improving health information for blind and partially sighted people right across the country.

The first film, Make AIS work, shares the experiences and stories of local people who are blind and partially sighted in getting health information in an accessible format. It highlights the work at UHBW, and specifically the Bristol Eye Hospital, in implementing AIS and provides practical examples other NHS Trusts and health organisations can make that will benefit patients.

The second film, A strategic perspective on the Accessible Information Standard, outlines why equality of access is so important to the trust and the efforts being made to fully implement the Standard.

The films note that whilst the AIS implementation at UHBW is under way, there is significantly more to be done to achieve full and consistent compliance with the Standard. A series of multi-disciplinary workshops in 2021 engaged staff and community partners in developing a refreshed AIS implementation plan to move forward and highlighted the resources required to do so.

In closing Alun will note the value of working with community partners in addressing health inequalities.

Board members are invited to view the new films before their official launch using the links below.

By way of further context:

- The Accessible Information Standard (AIS) was introduced by NHS England in 2016 and was designed to ensure people who need healthcare information in an accessible format, for example Braille, audio or large print, receive this.
- More than five years after the AIS was introduced, research by Sight Loss Councils has found that 90% of blind and partially sighted people still do not receive health information they could read. In addition, more than half of local NHS bodies have not developed local policies to deliver on the standard's requirements. This research has led the Government to agree to review the standard.
- Our obligations to patients with a disability, impairment or sensory impairment in this respect are detailed in the Accessible Information Standard and there is an anticipatory duty under the Equality Act (2010) to provide reasonable adjustments.
- Sight Loss Councils are funded by Thomas Pocklington Trust and are led by blind and partially sighted volunteers who advocate the needs of blind and partially sighted people, and influence positive change.
- The films, which premier on 9th August 2022 can be viewed here:
  Make AIS work: https://www.youtube.com/watch?v=JtNLsV-ffRw
  A strategic perspective of the
  AIS: https://www.youtube.com/watch?v=xJXDWgIdk5U

  Note that both films are currently unlisted and can only be accessed using the links provided.

3. Risks
The risks associated with this report include: 1702 - Risk that the Trust is not compliant with the Accessible Information Standard.
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

Minutes of the Board of Directors Meeting held in Public at 11:00-14:00 on Friday 27 May 2022, via videoconference

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

Present

Board Members

Name	Job Title/Position
Jayne Mee	Chair
Eugine Yafele	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
Jane Norman	Non-Executive Director
Mark Smith	Deputy Chief Executive and Chief Operating Officer
Martin Sykes	Non-Executive Director
Stuart Walker	Medical Director
Emma Wood	Director of People

In Attendance

Name	Job Title/Position
Eric Sanders	Director of Corporate Governance
Natashia Judge	Head of Corporate Governance
Tony Watkin	Patient and Public Involvement Lead (for Item 3: Patient Story)
Chris	Family member of a patient (for Item 3: Patient Story)
Ed Roberts	Assistant General Manager, Bristol Royal Hospital for Children (for Item 3: Patient Story)
David Wynick	Consultant Director of Research (for Item 8)
Diana Benton	Head of Research and Innovation (for Item 8)
Andy Jeanes	Director of Estates and Facilities (for Item 11)
Sarah Windfeld	Head of Midwifery/Assistant Director of Nursing (for Item 15)
Sneha Basude	Consultant, Obstetrics and Gynaecology (for Item 15)
Ziju Elanjikal	Consultant, Neonatal Intensive Care Unit (for Item 15)
Emma Treloar	Consultant, Obstetrics and Gynaecology (for Item 15)
Sarah Murch	Membership Manager (minutes)

The Chair opened the Meeting at 11:00

Minute Ref.	*Item*	*Actions*
01/05/22	**Item 1 - Welcome and Introductions/Apologies for Absence**	

	Jayne Mee, Trust Chair, welcomed members of the Board to the meeting. She reminded the Board that the meeting was being live streamed on YouTube for public access. Apologies had been received from Paula Clarke, Director of Strategy and Transformation. The Board welcomed Eugine Yafele to his first Board meeting as UHBW Chief Executive. Eugine Yafele commented positively on the welcome he had received since arriving and on the reports he had received from people using the Trust's hospitals on the care they had been given and the compassion of our services.	
02/05/22	**Item 2 - Declarations of Interest**	
	There were no new declarations relevant to the meeting to note.	
03/05/22	**Item 3 - Patient Story**	
	Deirdre Fowler, Chief Nurse and Midwife, and Tony Watkin, Patient and Public Involvement Lead, introduced Chris who was in attendance to tell the Board his story of using the Trust's services. Chris talked about his 13-year-old son and the care that he had received last year both at the Seashore Centre at Weston General Hospital and at Bristol Royal Hospital for Children. His son had focal epilepsy and last year had been suffering with acute headaches, but following a number of tests, his diagnosis had not been completely clear and they had needed to try a number of medications before getting the right one. With his son in extreme pain, Chris described the difficulty that he had getting in touch with specialists at the hospital, with calls, messages and emails going unanswered. Things had only got moving when in desperation he had sent a letter of complaint to the Chief Executive. He felt that some of the administrative staff that he had encountered were more focussed on keeping the pressure off senior clinical staff than listening to the needs of the patients, and he had noticed 'silo working' and a lack of willingness to take responsibility. He hoped to encourage the Board to think how this culture could be improved and what could be done better. Board members thanked him for his story. Jayne Mee, Trust Chair, apologised on behalf of the Trust for the difficulties that he had when accessing services. She hoped that by working together that changes and improvements could be made. This was echoed by other members of the Board. Deirdre Fowler, Chief Nurse and Midwife, added that the Trust was beginning a continuous improvement programme called Patient First, with the aim of facilitating a more patient-centred and accessible culture, and she invited Chris to get involved as his feedback would be very useful. In response to a question from Sue Balcombe, Non-Executive Director, about whether Chris felt the Trust had learned from his complaint and if things had changed, he explained that while he now knew more about different methods and tactics to contact Trust staff, there was still a longer-term cultural and structural shift needed to ensure that patients were listened to effectively. He agreed to help the Trust with the Patient First initiative from a patient perspective. In response to questions from the Board about how his son was now, he responded that once they had the right medication his situation had improved and he was doing well. The Chair thanked Chris for attending and Chris, Tony Watkin and Ed Roberts left the meeting.	

04/05/22	**Item 4 - 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 30 March 2022. There were no comments. **Members of the Board approved the above minutes as a true and accurate record.**	
05/05/22	**Item 5 – Matters Arising and Action Log**	
	Board Members received and reviewed the action log. Updates on completed actions were noted, and others were discussed as follows: **08/03/22 Quality and Outcome Committee Chair Report** *Metrics and objectives to be linked to enable Board to be more focussed on the Trust's priorities – in conjunction with the Board governance review as part of the Patient First initiative.* This was still a work in progress and would be brought back to a future meeting. **Action Ongoing.** **10/03/22 Ockenden Review of Maternity Services** *Schedule a Board seminar session on maternity in the wake of Ockenden 2* A seminar had been scheduled for 12 July 2022. **Action Closed.** **09/03/22 Learning from Deaths Report** *David Armstrong to assist with embedding lessons learnt in changes to the Learning from Deaths report* An update had been provided. The meeting with David Armstrong and other interested parties had taken place and a template mechanism for embedding lessons from multiple sources discussed would include Learning From Deaths (LFD). The Medical Director had subsequently met with the LFD leads to discuss mechanisms for obtaining information on mortality from multiple sources within the Trust and correlating those in future Board reports to drive thematic learning. The generic learning processes highlighted by David Armstrong would be further considered at a planned away day. **Action Closed.** **12/03/22 Finance and Digital** *Small group to be convened to discuss how to take forward output of the digital workshop at the recent Board seminar* A meeting had taken place and a workshop will be convened in early July. **Action Closed.** **13/01/22 Review of Board Committee Terms of Reference** *Audit Committee Terms of Reference to be amended and circulated to the Board.* A meeting had been held with the Chairs of the Audit and Quality and Outcomes Committees and drafts of the Terms of Reference had been redrafted and shared for their comment. Once agreed these would be shared with the Board prior to seeking approval. **Action Ongoing**. **Members of the Board noted the updates against the action log.**	
06/05/22	**Item 6 – Chief Executive's Report**	
	Eugine Yafele, Chief Executive, provided a verbal update on the following key issues:	

	Performance: He advised the Board that UHBW was still struggling with flow through its hospitals in terms of people accessing services and being discharged in a timely manner. This was particularly evident in the Emergency Department where there were still unacceptable ambulance handover delays. The Trust was supporting staff and working with system partners to look at how to discharge people safely into the community once they no longer needed hospital care. The Trust's focus was to support staff to work creatively to reduce ambulance handovers and on how to enable people to have timely access to care, particularly around cancer and elective procedures. **Annual Financial Planning**: In the last two years the Trust had received funding in a different way due to the pandemic. This was moving to a more localised arrangement and the Trust was adapting to this and finalising the activity that it would be doing in the year. The Trust was working hard in relation to timely access for people waiting for elective procedures, but as there were a number of interdependencies with partner organisations in the community, this work had inherent risks. **Health and Care Act 2022**: The Health and Care Act came into force in April 2022 and brought Integrated Care Systems onto a legal and statutory footing. The Integrated Care Board for Bristol, North Somerset and South Gloucestershire would become a legal entity from 1 July 2022. All partners within the System had been asked to nominate a representative to sit on the Board, and Eugine would be the representative for UHBW and the sector. He would feed back to the Board following the first ICB meeting on 1 July. **Monkeypox outbreak in the UK:** Stuart Walker, Medical Director, explained that there had been 90 cases of monkeypox confirmed in the UK: none in the South West, though there had had been a number of people potentially exposed. There were a number of difficult logistical issues about how to respond to this including suitable places for testing (this was currently taking place in sexual health clinics but it was acknowledged that these were not the most appropriate places), and then also about delivery of vaccination. Bristol Royal Infirmary was one of two smallpox-vaccine holding centres in the South West, so there may be a need to set up an in-house vaccine delivery system. If there were a large number of cases, the Trust may end up with local admissions, but this was not thought to be likely at present. Public health advice was changing on a daily basis and there were difficulties in managing this alongside operational reality, but he assured the Board that the Trust was taking all necessary actions. **Members of the Board received the Chief Executive's report for information**.	
07/05/22	**Item 7 – Acute Provider Collaborative Board Chair's report**	
	Jayne Mee,Chair, reported back from the meeting that she had chaired on 25 April 2022 of the Acute Provider Collaborative Board, which oversaw joint working between UHBW and North Bristol NHS Trust (NBT). Delayed discharge had been a key focus of the meeting. Jon Scott, Chief Operating Officer at the Integrated Care System, had attended to provide an overview of the work currently being undertaken at System level to better understand the bed base and to improve patient flow, specifically the business case around discharge-to-assess. They had also discussed the other key operational priorities of the two acute Trusts, which included Emergency Department delays, insufficient bed capacity and long waits for treatment. Stuart Walker, Medical Director for UHBW, had	

	presented the proposed approach to a Joint Clinical Strategy for NBT and UHBW. They had also looked at corporate priorities and ways of working together and had received an update on the Patient First programme, which both Trusts were undertaking together. In response to a question from Sue Balcombe, Non-Executive Director, about the governance around the Discharge to Assess initiative, Eugine Yafele explained that it was currently led by the Clinical Commissioning Group but would soon be led by the Integrated Care Board, and that it included different components including supporting care out of hospital and the implementation of different pathways. **Members of the Board received the Acute Provider Collaborative Board Chair's report for assurance.**	
08/05/22	**Item 8 – Research and Innovation Strategy Update**	
	David Wynick, Consultant Director of Research, and Diana Benton, Head of Research were in attendance for this item and gave the Board a presentation describing successes and challenges of the last year and current priorities. The Board heard that good progress had been made over the year. Among the highlights was the successful bid for NIHR CRF (National Institute for Health and Care Research Clinical Research Facility) designation and funding, which would enable the Trust to further develop experimental medicine and early phase trial potential. He outlined research funding and grant income received over the year, much of which had focussed on Covid-related research. He highlighted the strength of research capability funding at UHBW, particularly when considered together with North Bristol NHS Trust and the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG), as they were all among the highest in the country. Among key priorities for the coming year was the positioning of the CRF for successful launch in September 2022. He also described the Research Team's support for the NHS Reset programme (restarting and resetting non-Covid research) and the work of Bristol Health Partners in bringing together organisations and translating the outcomes of the research into patient clinical impact. He discussed the cross-system working that this enabled and reminded the Board that BNSSG was the first region in England to formally integrate its Academic Health Science Centre with the work of the ICS. Board members voiced their support for the Trust's research programme and commended its strong position nationally in relation to research capability funding. In response to a question from Julian Dennis about support for non-medics (nurses, AHPs etc) to get involved in research, David Wynick explained that dedicated research time had been a block, so extra funds had been made available to allow people to buy out their time for 6-12 months to start their research. Diana Benton added that a new research facilitator post had been created in order to increase this and to free up grant support. **Members of the Board received the Research and Innovation Strategy update for assurance.**	
09/05/22	**Item 9 – Integration Update report**	

	Neil Kemsley, Director of Finance and Information, introduced a report which set out the progress made on the clinical and corporate integration programme since the merger of the Bristol and Weston Trusts in April 2020. He explained that the programme of clinical services integration had paused at the end of 2021/22, with the number of clinical services formally integrated remaining at 12 out of 32, but this had now been picked up again. A new Weston General Hospital leadership team was being established from 1 October 2022, replacing the current Weston Division, and would be responsible for leading the site. In parallel, the system-led Healthy Weston Programme would be working to deliver the second phase of their work to secure a sustainable future for the hospital. He drew the Board's attention to the successful completion of a major IT project in April, linking the patient administration system (Medway) at Weston to the CareFlow Electronic Patient Record (EPR) system across the rest of UHBW. The report also detailed the recruitment being undertaken to fill vacancies, and the plans for a second post-merger review. The review, which included input from David Armstrong, would consider the progress made against the original March 2020 merger plans and its findings would inform the next phase of work. Mark Smith, Deputy Chief Executive and Chief Operating Officer, explained that the Trust had been struggling to recruit to the Weston site but positioning it as centre of excellence for certain specialties through the Healthy Weston programme should help. In relation to the Patient Record system, he added that through the original convergence to the Weston Medway system, 118,000 orphaned records had been identified of patients who were on treatment pathways but for whom the outcome had not been recorded. The Trust had worked to validate these through a nine-month exercise and he could now confirm that there had been no harm identified and this project could now be closed. Board members welcomed the report but suggested that integration progress looked slower than expected. They asked for assurance that there was sufficient momentum and resource to ensure the timely completion of clinical services integration. It was agreed that the next report to Board would include more detail around which specialties were due to merge on which dates with reference to the new management arrangements and to Healthy Weston 2. **Action: Board members to receive a report at their next meeting specifying merger dates for the remainder of clinical services.** **Members of the Board received the Integration Update for information**.	
10/05/22	**Item 10 - Transforming Care Programme Board Report Q4**	
	The Board noted the Transforming Care Programme Report which provided highlights of the key transformation and improvement work that had progressed during Quarter 4. It was agreed that questions on the report could be sent to the Trust Secretariat to be passed on to the appropriate team. **Members of the Board received the Transforming Care Programme Board report for information**.	
11/05/22	**Item 11 – Estates Strategy**	
	The Estates Strategy was presented to the Board for approval. Mark Smith, Deputy Chief Executive and Chief Operating Officer, introduced the report. He	

	highlighted key challenges which included embedding infection control in Estates planning going forward post-pandemic, backlog maintenance, and effective utilisation of both campuses. Andy Jeanes, Director of Estates and Facilities, was in attendance for this item. He explained that while the Bristol elements of the strategy had been seen by the Board before, it now also included the Weston site development plan. Areas of focus for Weston included rationalising the Weston estate in relation to administration and storage, improvements to teaching facilities and staff wellbeing areas, and exploring the possibilities for future clinical service development. He asked the Board to focus on embedding learning from the pandemic and on the financial perspective: with greater control of finances by the Integrated Care System, the Trust would need a clear focus on priorities, finances, and risks. Emma Wood, Director of People, questioned the Trust's reliance on Targeted Investment Fund and System funding to upgrade clinical infrastructure rather than having its own capital allocation and enquired as to the level of confidence that this would be received. Andy Jeanes acknowledged the uncertainty around this, adding that there was no money allocated to the Weston site apart from funding for the maintenance backlog. The Trust would need to engage with the Integrated Care System and Healthy Weston. Neil Kemsley added that the newly-formed ICB would be required to develop its own Estates Strategy and Digital Strategy for the system as a whole. If UHBW was unsuccessful in securing additional funding, there would be a triage process whereby it would revisit its existing commitments in terms of strategic capital and re-prioritise them. Board members voiced approval for the Strategy but asked for an update to be provided on the plan for translating it into action at a future meeting. **Action: Update on the Estates Strategy to be received at a future Board meeting with more detail on the action plans to implement it.** **Members of the Board approved the Estates Strategy**.	
12/05/22	**Item 12 - Quality and Outcome Committee Chair Report**	
	Quality and Outcomes Committee Chair's Report Julian Dennis, Chair of the Quality and Outcomes Committee briefly introduced the report of the committee's meeting on 24 May 2022. Key issues were as follows: • The Committee had received an operational update and had discussed the pressure nationally and from the System to reduce 104 and 76 week waits to zero. The Committee could see that work was going on to reduce waiting lists but recognised that a change in approach may be needed for this level of reduction. The Committee were concerned that there were still high numbers of patients in the Trust's hospitals with no criteria to reside, which continued to cause problems with flow and access. • They had received an update on the problems that the Trust was experiencing with its supply chain, which was a national issue and had been added to the risk register. • Stuart Walker, Medical Director, had advised the Committee on the current position with arrangements for dealing with any cases of monkeypox. • The Committee had received a report on the closure of 118,000 incomplete referrals and had been assured that this was safe and that no harm would come from the closures. Assurance was also gained from the expert national team who looked at them too.	

	• The Committee had received an update on the Patient Safety Improvement programme and had voiced support for this work. **Members of the Board received the Quality and Outcomes Committee Chair's report for assurance.**	
13/05/22	**Item 13 - Integrated Quality and Performance Report**	
	Mark Smith, Deputy Chief Executive and Chief Operating Officer, introduced the Integrated Quality and Performance Report, which provided an overview of the Trust's performance on Quality, Workforce, Access, and Finance standards. Key points were as follows: • There was a renewed focus on the System plan which included prioritising elective recovery, cancer, and a balanced plan as its core elements. There had been a recently announced national expectation that 104 and 78 week waits would be reduced to zero. The deliverability of these assumptions was currently being tested and the Board would receive a letter detailing how the Trust needed to oversee this. Over the last two years, the Trust's waiting lists had virtually doubled so there would be a real challenge in hitting the zero trajectories and in conjuring up the capacity to do that. • The Trust was still running very hot, utilising 53 extreme escalation areas to manage demand, and also with very high 'no criteria to reside' numbers (patients who no longer meet the criteria to receive care in our hospitals, but who are unable to be safely discharged elsewhere). At the beginning of week there had been 221 of patients who were classified as no criteria to reside. Discharging these patients was therefore a key priority in order to create headroom and space for flow required for elective recovery and decompression. • Performance in the Emergency Department remained suppressed, reflecting congestion and lack of flow through the hospitals, but a reduction in trolley waits and ambulance handovers had stabilised and was starting to show some improvement. Diverts from Weston General Hospital Emergency Department to the BRI had slowed which was helping performance. • Cancer performance for 62 day and 104 day treatment was within trajectory which was good considering the pressures. • The Integrated Quality and Performance Report had been extended to included health inequality data which was illuminating particularly in the light of the Board's new Patient First initiative. Deirdre Fowler, Chief Nurse and Midwife, voiced her concerns around the 'no criteria to reside patients', noting that they were at risk of deconditioning if they stayed in hospital for too long. Emma Wood, Director of People, referred to the Workforce metrics in the report, which had been reset in line with national and local benchmarking. The Trust had started to change some of its practices to improve its use of resources. This included auto-enrolment to the Bank (temporary staffing bureau) when people start at the Trust and work around reducing the use of Tier 4 and off-framework agencies, which was exceptionally high in Bristol. Turnover continued to be highest the Trust had ever experienced, around 15%, particularly in the Division of Medicine, and she intended to look at how the People Strategy could be used to improve retention of nurses. However, staff sickness levels were down, particularly staff sickness related to covid. The Trust was now looking at how it proactively provided psychological services to staff.	

	Board members discussed the report. Jayne Mee enquired whether it was intended to put metrics into the IQPR in the same format as presented to People Committee. Emma Wood added that this would be difficult but that she was working with the Trust Secretariat team to ensure Board oversight of these metrics. Martin Sykes referred to the investment being made by the Integrated Care Board into the Discharge-to-Assess project and asked how the UHBW Board could receive frequent reports on monitoring and tracking its progress and help as an organisation to drive it forward, as it would be a key focus for the Trust over the next year. Mark Smith and Eugine Yafele agreed that it would be useful for the Discharge to Assess project to provide updates to all Boards to include metrics and trajectories to enable measurement of the programme and ensure mutual accountability. Other Board members supported this proposal. **Action: It was agreed to ask the Discharge to Assess Board to provide timely and relevant regular information on the progress of the initiative.** David Armstrong, Non-Executive Director, commented that the Well-Led and Use of Resources metrics in the IQPR did not appear to be the right ones to give assurance in these areas. It was agreed that he would discuss this outside the meeting with Mark Smith. **Action: David Armstrong and Mark Smith to liaise about whether the metrics in the IQPR are the right ones.** **Members of the Board received the Integrated Quality and Performance report for assurance**.	
14/05/22	**Item 14 - CQC Action Plan**	
	Deirdre Fowler, Chief Nurse and Midwife, introduced a composite Care Quality Commission action plan which listed all actions relating to UHBW CQC inspections since January 2021. The plan also included actions from the CQC's inspection of the Emergency Department at Weston General Hospital. It showed the current status of the 141 actions in the plan. Of these, 26 were deemed behind schedule, but there was a high degree of confidence that these would be closed promptly. The composite action plan had been brought to the Quality and Outcomes Committee in March 2022 and QOC had suggested some further work before closing. The main themes of the actions included Omicron, medicines management, Freedom to Speak Up, and Weston actions. She drew the Board's attention to the immediate next steps and advised the Board that the CQC had informed the Trust that a re-inspection at Weston General Hospital was imminent. The Board discussed the report. Jayne Mee suggested that given the discussion at People Committee the previous day, the actions around violence and aggression should not yet be closed, as this was still a significant problem around the Emergency Department site. The Board would need greater assurance as to whether the Trust's action plan around violence and aggression was working. Emma Wood noted that some of the actions from the CQC were very specific so had been delivered but acknowledged that there was work to do in this area. Jayne Mee asked that this be actioned before the CQC actions were closed and reported back to Quality and Outcomes Committee.	

	Action: Quality and Outcomes Committee to receive greater assurance around reducing violence and aggression towards staff before closure of the relevant CQC actions. It was noted that the remit of the group tasked with the management of violence and aggression at the Trust had been extended to encompass tackling bullying and harassment between staff. In response to a question from David Armstrong as to whether staff were exited from the Trust for habitual bullying and harassment, Emma Wood responded that she was not aware but that going forward the group would receive monthly reports on the current state of cases. Board members noted that there was still a surprising number of outstanding actions and requested greater assurance that support and monitoring were in place to progress the actions. It was noted that a more up-to-date report would be received by the Quality and Outcomes Committee in June. **Members of the Board received the CQC Action Plan update for assurance.**	
15/05/22	**Item 15 - Maternity Updates**	
	This item was discussed before the previous item. Sarah Windfeld, Head of Midwifery/Assistant Director of Nursing, Sneha Basude, Consultant, Obstetrics and Gynaecology, Ziju Elanjikal, Consultant, Neonatal Intensive Care Unit and Emma Treloar, Consultant, Obstetrics and Gynaecology were in attendance for this item. a. Ockenden 2 Review of Maternity Services Sarah Windfeld, Head of Midwifery, presented a report explaining how the Trust was performing against the recommendations of the second Ockenden report published at the end of March 2022. Julian Dennis confirmed that the paper had been discussed at the Quality and Outcomes Committee. It was highlighted that the Trust's performance in relation to the implementation of Continuity of Carer was better than it appeared: with implementation currently at 48% this was good compared with other Trusts. b. Maternity Perinatal Quality Surveillance Matrix (PQSM) Quarterly Update Report The Board received the quarterly report providing oversight with regards to the safety matrices of UHBW maternity and neonatal services in the period. They heard that there were challenges in relation to the elective caesarean section list and capacity for induction, but received reassurance that plans were in place. Jane Norman, Non-Executive Director, enquired as to the Trust's response to the findings in the 2021 National Maternity Survey in relation to women being involved in decision-making about their care, where UHBW had performed worse than average. Sarah Windfeld explained that this had been addressed at a recent staff meeting, and the staff themselves had written an action plan to address concerns. The Maternity Voices Partnership was also involved in developing personalised care plans, and the team was increasing the use of media, website and apps to show women the choices they have. **MBRRACE presentation on expected rate of mortality of pre-term babies.** Ziju Elanjikal, Consultant, gave the Board a brief presentation on the Trust's performance in relation to MBRRACE UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), which conducted surveillance and investigated the causes of maternal deaths, stillbirths and infant	

	deaths. He took the Board through a comparison between UHBW and similar neonatal units, which he explained was difficult as there were only three or four other centres in the country that did the same work as UHBW. Emma Treloar, Lead Obstetrician at St Michael's Hospital also explained that the South West as a whole was an outlier in terms of having babies born in the right unit. The region was trying to address capacity issues around this and it would be taken forward with the Bristol neo-natal review. **Members of the Board received the Maternity Updates for assurance**.	
16/05//22	**Item 16 – Six-Monthly Safe Staffing Report**	
	Deirdre Fowler, Chief Nurse and Midwife, introduced a paper providing assurance to the Board on how the Trust had managed nursing, midwifery and AHP safe staffing across all inpatient wards over the last six months. The full assessment of nurse safe staffing including an evidence-based review using the Safer Nursing Care Tool (SNCT) of all inpatient areas, emergency departments, outpatients, theatres, day case and clinical nurse specialists would be included in the next six-monthly report to the Trust Board. She highlighted to the Board that the impact of the pandemic on staff and patient experience could not be underestimated. Over the past six months, the Trust had consistently been unable to meet the planned levels of nurse staffing, due to vacancy rates, high attrition rates and COVID absence. In March 2022, the vacancy rate was 16.3% and the turnover was 15.7% for the Trust's Band 5 nurses (nurses who provide the majority of hands-on care to patients). There were however signs of improvement since March. She noted the link between nurse staffing challenges, and MRSA cases, Cdifficile, falls and pressure ulcers. She highlighted challenges in staffing the additional capacity which had been opened during the past few months to deal with some of the emerging risks e.g. additional queue space for trolleys, the Emergency Department, and additional boarding beds and escalation beds. However, the development of practice educators was reaping benefits and a full benefits assessment was underway to plan for substantive posts. In relation to midwifery, again, staffing had been incredibly challenged, but the Trust had been able to maintain 1-1 midwifery care over the last six months by redeploying staff. Finally, in relation to Allied Health Professionals, the Trust had been running at around 70-75% staffing levels against establishment for some time, and innovative ways of working had been required including skill mixing and working differently to optimise numbers. Julian Dennis, Non-Executive Director, queried the use of the word 'correlation' in the report to describe the link between the reduced registered nurse fill rate and the increase in the number of hospital-acquired MRSA and increases in the number of falls and pressure ulcers. It was agreed that these were likely to be multi-factorial. **Members of the Board received the Six-Month Safe Staffing report for assurance**.	

17/05/22	**Item 17 – People Committee Chair's Report**	
	Bernard Galton, Chair of the People Committee, gave a report of the Committee's most recent meeting, highlighting the following key points • The Committee had welcomed Charlotte Nicol as the new substantive Equality, Diversity and Inclusion Manager and noted that recurrent investment that had been secured for key organisational development roles. • An Exit Interview report had given the People Committee for the first time substantive evidence as to why the Trust was losing staff and therefore why turnover was so high. • The Committee had welcomed the work to develop the metrics and management information in the People Performance Report. • The Committee had discussed the risks relating to Education. • He felt that while there was now clear momentum and enthusiasm across the People and Education agenda, it was important that there was a corporate approach to the People Strategy and consistent application across the organisation to make a difference. **Members of the Board received the People Committee Chair's Report for assurance.**	
18/05/22	**Item 18 – Finance and Digital Committee Chair's Report**	
	Finance and Digital Committee Martin Sykes, Chair of the Finance and Digital Committee, introduced a report of his committee's most recent meeting on 26 May 2022. Key points were as follows: • Prior to the meeting, the Committee had virtually reviewed and approved the Standing Financial Instructions and the Scheme of Delegation. • **Digital Services**: The Committee had received an update on the mobilisation of electronic prescribing within the Trust, the planned launch date for which had been set as September 2022. • The Committee had emphasised that it was now important to embed e-rostering and other digital HR services. • The Committee heard that the upgraded 'Vitals' system enabling digital recording of patient observations had been successfully completed. • The Committee had sought assurance on improvements to logging-on difficulties in the Emergency Department and distance working for Midwives. • They had received an update on cybersecurity and the work going on to close vulnerabilities. • **Finance**: The committee had received a brief update on the Month 1 finances and a detailed update on the 2022/23 financial plan, which remained in draft format, but which showed that the wider System and the Trust were carrying significantly increased financial risk. **Members of the Board received the Finance and Digital Committee Chair's Report for assurance.**	
19/05/22	**Item 19 – Trust Finance Performance Report**	
	Neil Kemsley, Director of Finance and Information, introduced the Finance Report, which informed the Board of the financial position of the Trust for April 2022. The	

	report was abridged for the first month of the new financial year to allow for completion of the 2022/23 budget setting process. He highlighted that the report was based on the provisional System plan and Trust plan for 2022/23 as submitted on the 28 April: with a £38 million deficit for the System plan and a deficit of £13 million for the Trust plan. There had since been a letter offering an additional System allocation of £29m but there were a significant number of criteria to be met to be in receipt of the funding, which needed to be worked through. This would be shared with the Board and discussed at a meeting of the Board on 16 June 2022. **Action: Board to receive the letter about potential additional funding and discuss it at a meeting on 16 June 2022.** He further highlighted challenges in supporting divisions to increase productivity and savings. **Members of the Board received the Trust Finance Performance Report for assurance**.	
20/05/22	**Standing Financial Instructions**	
	Approval was sought from the Board on changes to the Trust's Standing Financial Instructions and Scheme of Delegation. Neil Kemsley, Director of Finance and Information, explained that this was an interim review to reflect the change in the name of the charity from Above and Beyond to Bristol & Weston Hospitals Charity. The Board agreed to approve this change, and also to extend the amendments to the SFIs which they had agreed in November 2021. **Members of the Board approved the Standing Financial Instructions.**	
21/05/22	**Freedom to Speak Up Annual Report**	
	It was agreed that this item needed more discussion than time would allow and it would be postponed to a future meeting. **Action: Freedom to Speak Up Annual Report to be discussed at a future meeting**	
22/05/22	**Item 22 - NHSI Self-Certification (against G6)**	
	Eric Sanders, Director of Corporate Governance, presented the proposed self-certifications against the Provider Licence conditions for approval by the Board. The paper set out the Trust's response to the licence conditions, evidence, risks and mitigations. The Board confirmed that they were content with the confirmation that the Trust was compliant with the provisions and agreed that this could now be signed off by the Chair and Chief Executive. **Members of the Board received the NHSI Self-Certification Report for information.**	
23/05/22	**Item 23 - Register of Seals – Quarter 4**	
	Eric Sanders, Director of Corporate Governance, asked the Board to note an update to the Register of Seals, which confirmed that the Trust Seal had been used on 12 occasions since the previous report in January 2022.	

	Members of the Board received the Register of Seals report for information.	
24/05/22	**Item 24 – Governors' Log of Communications**	
	The Board noted recent questions and responses on the Governors' Log of Communications**.** **Members of the Board received the Governors' Log of Communications report for assurance.**	
25/05/22	**Item 25 – Proposed Changes to the Trust's Constitution**	
	Eric Sanders, Director of Corporate Governance, introduced a report setting out two proposed changes to the Trust's Constitution for approval by the Trust Board and the Council of Governors. One related to the signature of documents (Standing Orders, Annex 6 of the Trust Constitution, Paragraph 9) and one proposed that the Trust revise the composition of the Board of Directors (paragraph 24), to give the Trust the scope to increase Executive Directors by one if it decided that this would help it achieve its strategic aims. Board members supported the two proposed changes. **Members of the Board approved the proposed changes to the Trust's Constitution.**	
26/05/22	**Item 26 – Any Other Urgent Business**	
	There were no further items of urgent business. The Chair thanked everyone for attending and closed the meeting at 13:30.	
27/05/22	**Date of next meeting: 9 August 2022, 11:00-13:30**	

University Hospitals Bristol and Weston NHS Foundation Trust

Public Trust Board of Directors Meeting on Tuesday 9 August 2022
Action Log

Outstanding actions from the meeting held in May 2022					
No.	**Minute reference**	**Detail of action required**	**Executive Lead**	**Due Date**	**Action Update**
1.	**09/05/22**	**Integration Update Report** Board members to receive a report at their next meeting specifying merger dates for the remainder of clinical services.	Director of Strategy and Transformation	July 2022	**Work in Progress** August update: Update provided in CEO report.
2.	**09/05/22**	**Integration Update Report** Update on the Estates Strategy to be received at a future Board meeting with more detail on the action plans to implement it.	Deputy Chief Executive and Chief Operating Officer	July 2022	**Work in Progress** August update: An update on the Estates Strategy would be going to Private Board.
3.	**13/05/22**	**Integrated Quality and Performance Report** It was agreed to ask the Discharge to Assess Board to provide timely and relevant regular information on the progress of the initiative.	Deputy Chief Executive and Chief Operating Officer	July 2022	**Work in Progress** August update:
4.	**13/05/22**	**Integrated Quality and Performance Report** David Armstrong and Mark Smith to liaise about whether the metrics in the IQPR are the right ones.	Deputy Chief Executive and Chief Operating Officer	July 2022	**Suggest action closed** August update: The Board held a discussion at its seminar on 12th July.
5.	**14/05/22**	**CQC Action Plan** Quality and Outcomes Committee to receive greater assurance around reducing violence and aggression towards staff before closure of the relevant CQC actions.	Director of People	July 2022	**Suggest action closed** August update: QoC members have been sent the POC paper for assurance.

6.	**19/05/22**	**Trust Finance Performance Report** Board to receive the letter about potential additional funding and discuss it at a meeting on 16 June 2022.	Director of Finance and Information	July 2022	**Work in Progress** August update: Verbal update to be provided
7.	**21/05/22**	**Freedom to Speak Up Annual Report** Freedom to Speak Up Annual Report to be discussed at a future meeting	Trust Secretariat	July 2022	**Suggest action closed** August update: The Freedom to Speak Up Annual Report was discussed by the Board at its meeting on 12th July.
8.	**08/03/22**	**Quality and Outcome Committee Chair Report** Metrics and objectives to be linked to enable Board to be more focussed on the Trust's priorities – in conjunction with the Board governance review as part of the Patient First initiative.	Trust Chair/ Executive Leads	May 2022	**Work in Progress** May 2022: This was still a work in progress and would be brought back to a future meeting. August update: Verbal update to be provided.
9.	**13/01/22**	**Review of Board Committee Terms of Reference** Audit Committee Terms of Reference to be amended and circulated to the Board.	Director of Corporate Governance	March 2022	**Suggest action closed** August update: The updated Terms of Reference for both Committees had been included with the meeting papers for August's meeting and recommended for Board approval.
Closed actions from the meeting held in May 2022					
No.	**Minute reference**	**Detail of action required**	**Action for**	**Due Date**	**Action Update**
	10/03/22	**Ockenden Review of Maternity Services** Schedule a Board seminar session on maternity in the wake of Ockenden 2	Chief Nurse / Trust Secretariat	May 2022	**Action Closed** May 2022: A seminar had been scheduled for 12 July 2022.
	09/03/22	**Learning from Deaths Report** David Armstrong to assist with embedding lessons learnt in changes to the Learning from Deaths report	Medical Director	May 2022	**Action Closed** May 2022: An update had been provided. The meeting with David Armstrong and other interested parties had taken place and a template mechanism for embedding lessons from multiple sources discussed would include Learning From Deaths (LFD). The Medical Director had subsequently

					met with the LFD leads to discuss mechanisms for obtaining information on mortality from multiple sources within the Trust and correlating those in future Board reports to drive thematic learning. The generic learning processes highlighted by David Armstrong would be further considered at a planned away day.
	12/03/22	**<u>Finance and Digital</u>** Small group to be convened to discuss how to take forward output of the digital workshop at the recent Board seminar	Director of Finance and Information	May 2022	**Action Closed** <u>May 2022:</u> A meeting has taken place and a workshop will be convened in early July.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9 August 2022

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

1. Report Summary
To provide an update on key strategic and operational issues affecting the Trust, system and the wider NHS.
2. Key points to note *(Including decisions taken)*
The report seeks to highlight key issues not covered in other reports in the Board pack and which the Board should be aware of. These are structured into four sections: • National matters of interest • Integrated Care System • Strategy Deployment • Operational Delivery
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
The risks associated with this report include • Non-delivery of Trust objectives
4. Advice and Recommendations *(Support and Board/Committee decisions requested)***:**
• This report is for **Information.** The Board are asked to note the report.
5. History of the paper **Please include details of where paper has previously been received.**

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supportive
respectful
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Chief Executive's Report

Background

This report sets out briefing information for Board members on national matters of interest, an update from our Integrated Care Board, how we are deploying our strategy and operational delivery

NHS Pay Award

The NHS Pay review body, the Doctor and Dentist review body and Senior Service Review Body have made recommendations to the government on the annual pay awards which have been accepted in full.

These awards offer most Agenda for change colleagues a pay award of £1400 or 4%. The basic award will be a more significant pay rise for lower paid staff who will receive c9%. Medics will receive pay rises of 4.5% and Very Senior Managers and Executive up to 3.5%

The pay uplifts amount to an additional circa 5 per cent investment in the overall NHS pay bill. However, NHS England has only been allocated enough money in its budgets to cover a 3 per cent investment in pay increases for staff. Unless the extra investment cost is funded by the Treasury this will have to be drawn from existing budgets

The Trust will await pay advisory notices regarding implementation. The greatest risk relating to the pay awards lie with the likelihood of Trade Unions rejecting the offer and moving to ballot for Industrial Action.

Integrated Care System

National Review of Planning

BNSSG are one of very few systems asked to contribute to a national review of planning processes due to the close working of planning and financial teams. Internally, a review of our operating plan approach is underway to consider where we can improve, adapt and simplify our processes in line with the changing national context and move away from full Payment by Results, as well as to influence externally as systems and processes begin to be developed in the ICS. We will also be considering how business planning will align with the Patient First approach.

Strategy Deployment

Development of a Joint Clinical Strategy

Following the commitment of North Bristol NHS Trust and UHBW to develop a joint clinical strategy within the Acute Provider Collaborative to support improvement and sustainability of services for patients, work is being commissioned by UHBW. The Medical Director and Director of Strategy and Transformation are leading this work which will be delivered in an accelerated way by bringing in additional analytical capacity. This

will support a SWOT analysis of a broad range of our clinical services against the domains of Quality; Critical mass; Model of care; Capacity; Finance followed up with a more targeted analysis of approx. 6-12 priority specialties for increased strategic collaboration. It is planned to complete this work by the end of September.

Transforming Care

Transforming Care is the Trust's current continuous improvement programme. The priorities for 2022/23, both corporate and divisional, were agreed by the senior leadership team in May 2022. The quarter one report is available on the Transforming Care connect pages and reflects the breadth of improvement activity and impact across the whole Trust.

Key achievements for quarter one include:

- Skin analytics pilot commenced to understand if the use of artificial intelligence to identify skin cancer, shortens a patient's pathway, and reduces the need for patients with non-cancerous results to attend the hospital.
- Seven improvement projects from Divisions commenced cohort 3 of our Quality Improvement Gold programme. This are programmes addressing significant opportunities for example, reducing re-admissions through implementation of a Discharge Medicines Service.
- Outpatient Parenteral Antibiotic Therapy (OPAT) is an integrated service across BNSSG, delivered by UHBW, North Bristol Trust and Sirona. The service facilitates early supported discharges or provides alternative pathways to prevent admission. At the end of quarter one 1,458 bed days have been saved since the launch in November 2021.
- Preparation for piloting robotic process automation technology in Trust recruitment processes has been undertaken, plans to go live in quarter two.

Weston Integration and Healthy Weston

The final 14 clinical services are planned to integrate at the same time as the new Weston General Hospital management and leadership arrangements come into operation on 17th October 2022. Divisional Boards are confirming these decisions at their August meetings. Integration of three services will complete in July/August - the Patient Access Team (July), Radiology and Orthotics (August). The total number of integrated clinical services Trust wide is now 16.

The Weston General Hospital (WGH) Team will formally replace the Weston Division from 17th October and provide a strong leadership team, accountable for direct provision of emergency services, acute medicine, care of the elderly services plus all ward staff, Theatres and Day unit, and Outpatients. Final assurance on governance arrangements will be supported through a Gateway meeting at the end of September where transfer

arrangements will be thoroughly tested, before approval to proceed is confirmed or contingency plans enacted.

The future Weston management arrangements require changes to the way in which our staff work, and a staff consultation was launched on 20th June affecting up to 90 staff, predominantly in managerial and leadership positions. This runs for 40 days until early August. Feedback from staff is being used to adjust proposals where sensible to do so, before rolling out the changes with staff over the next two months.

The Healthy Weston Phase 2 proposals are currently undertaking eight-weeks of public engagement, being led by the Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) until 14 August.

Operational Delivery

I would like to thank all colleagues working across the Trust for everything that they have done and will continue to do over the coming months, to address the significant operational challenges in University Hospitals Bristol and Weston NHS Foundation Trust and across the wider Bristol North Somerset and South Gloucestershire system.

Although we are well into summer and would traditionally be experiencing an easing in demand for services and the operational pressures across the organisation, trust services remain remarkably busy with recovering services and delivering care for our population.

The Trust Board has endorsed the priorities for the year which are; Quality and Safety, Our People, Timely Care, Weston Renewal and Financial Performance. In recognition of the challenged performance position of our organisation and indeed the significant operational load across the breadth of our services, it is necessary to provide a deeper dive into timely care in this month's report to the Board.

Our ability to deliver timely care for our patients very much depends on the commitment and compassion of the 13,500 strong UHBW team. The wellbeing of everyone across UHBW remains my priority and focus. I am confident that our wellbeing offers, and indeed the work to embed the People Strategy, will enable us to direct effort and energy to ensure that colleagues feel supported, empowered, and able to look after their wellbeing to help us deliver outstanding care.

The number of patients with COVID-19 across the Bristol and Weston sites has fallen and as of the 1st of August there were 70 Covid positive patients. The evolution of our infection prevention and control procedures has meant that all patients have been cared for in specialist areas, negating the creation of COVID positive and non-COVID wards.

The reduction in COVID-19 numbers allows our clinical teams to focus on recovery of elective caseloads. Over the first quarter of this year, the Trust has delivered performance of 87% against the elective recovery target of 104% of pre-pandemic activity for 2022/2023. Whilst this remains below what we all expect to be delivering, I

would like to assure the Trust Board, that the executive will maintain a relentless focus on performance to deliver better outcomes for our patients.

It is worth highlighting that the specialties where are most challenged are paediatric and general surgery. Mutual aid has to date not improved our position; therefore, a direct arrangement is now being explored between the Bristol North Somerset and South Gloucestershire and Bath Swindon and Wiltshire systems to improve both capacity and performance.

Our cancer performance also remains a concern. Although we continue to forecast achieving the cancer 62-day target by the end of the year, our current performance, whilst not deteriorating, is not improving as quickly or consistently as I would wish for a variety of reasons. A significant contributory factor is the high covid infections, both for staff and patients.

Because of our performance challenges, NHS England has placed UHBW in Tier One for 78 week waits. Our performance will be monitored closely by the national team with support tailored to the specific challenges we face. I will be presenting the UHBW improvement plans to the national / regional teams on a regular basis and as required to the Secretary of State until we are designated as a Tier Two organisation, at which point the regional team will assume oversight.

Across our emergency care pathway, the 4-hour standard has not been met at the Bristol Royal Infirmary, Bristol Children's Hospital or Weston General Hospital. The Bristol Eye Hospital remains the exception where the standard is being met, therefore in aggregate, the Trust's emergency pathways are struggling to meet the 4-hour target.

There is also an increase in the number and frequency of 12-hour trolley waits and ambulance handover delays across the Bristol and Weston sites over the last year, albeit with month-on-month improvement for these measures in the last quarter. The Trust Integrated Quality and Performance report provides more detail on the overall performance for emergency care which also remains challenged and under pressure.

Patients who no longer meet the criteria to reside have remained high and consequently a considerable proportion of our bed base is therefore not available to treat other patients. The NHS Chief Operating Officer wrote to all Provider Chief Executives requesting that we redouble our efforts to improve discharge in the next 100 days to ensure that we have improved bed capacity by the autumn. The Chief Operating Officer at the Integrated Care Board is co-ordinating the system response and we are actively leading and responding as part of the system effort to improve discharge.

It is evident that our organisation is under considerable pressure to respond to the demand for care and to recover services. In addition to the actions and initiatives already outlined in this report, the following actions are highlighted to provide the Board with further assurance;

- The scale of our operational challenges requires that Board to be assured that we have the capacity and capability to improve and maintain performance. Working with the Chief Operating Officer and I will ensure that this is in place.

- In our response to the 100-day challenge, Every Minute Matters, our continuous improvement programme that focusses on the basic and fundamental principles to optimise flow, becomes an important enabler. The Chief Operating Officer will continue to implement this methodology and develop the metrics to track progress over the summer.
- The Medical Director and Chief Nurse will ensure better engagement of our clinical leaders to support them in making the necessary clinical changes and to adopt innovation across our services.
- The Chief People Officer will finalise the arrangements for leadership support and development and continue to deploy and improve wellbeing offers across the Trust.
- Through the ICB Board, I will continue to influence and direct as appropriate, the system focus and resources to improve discharges and flow across our hospitals.
- The entire Executive will maintain a relentless focus on performance and delivery and I will continue to report back to the Board of Directors on progress.

In addition to operational performance improvement, there is also a need to focus on improving our financial performance over the year. We have an ambitious financial plan, which after the last 2 years of the pandemic, and because of the current and considerable operational demands will be more stretching and challenging to deliver.

The Director of Finance is developing proposals which will include recovery actions to support areas of the business that are struggling to deliver the 2022/23 plan.

Although we have a considerable task ahead, I remain determined to improve overall performance through Executive focus and engagement and implementing rigorous improvement actions across the Trust.

Recommendation

The Board is asked to note the report

Eugine Yafele
Chief Executive

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th August 2022

Report Title	2022/23 Operating Plan Summary
Report Author	Evelyn Elliott – Head of Commissioning and Planning Caitlin Moss – Associate Director, Strategy & Business Planning Jeremy Spearing - Director of Operational Finance Dean Bodill – Head of Financial Management Vicky Lyons – Head of Strategic Workforce Planning Rob Presland – Associate Director of Performance
Executive Lead	Paula Clarke, Director of Strategy & Transformation Presented by Jeremy Spearing, Director of Operational Finance

1. Report Summary

The purpose of this paper is to:

- Conclude the operating plan for 2022-23,
- Conclude the capital plan for 2022-23.
- Provide an overview of the Trust workforce, finance, activity and performance plans; and
- Identify the key risks associated with delivery of the plans and ensure we have processes to monitor and mitigate.

2. Key points to note

(Including decisions taken)

In response to the requirements of the Regulator, NHSE, the Trust Board approved the submission of an ambitious plan for 2022/23 on the 20th June 2022, which includes both stretching financial, activity and performance targets. The key risks to the Trust's and Divisions' delivery of these plans include:

- Dependency on system schemes to deliver out of hospital benefits e.g., discharge to access.
- Delivery of the key financial requirements assumptions in the plans e.g., 2% Cost Improvement Plans (CIP), delivering further non-recurrent cost reductions of £21.6m and mitigating the Elective Services Recovery Fund (ESRF) clawback of c£12m.
- Significant workforce challenges, including recruitment and retention of staff, particularly where recruitment is constrained due to non-recurrent funding.
- Future covid waves and the further impact of covid as either lost elective recovery and/or increased staff absence; and
- Bed capacity, flow and the increasing impact of "no criteria to reside patients."

Monitoring
Divisional delivery will be monitored with escalation and support requirements discussed at monthly and quarterly Divisional review meetings with the Executive team.

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

A risk assessment is provided in section 2.2.and section 7

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

The Board is asked to:

- **Note** the 2022/23 Operating Plan summary.

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

Senior Leadership Team	20th July 2022
Finance & Digital Committee	25th July 2022

2022-23 Operating Plan Summary

1. Introduction

The purpose of the paper is to:

- Conclude the operating plan for 2022-23, both internally and externally as a system;
- Provide an overview of the Trust workforce, finance, activity and performance plans;
- Identify the key risks associated with delivery of the plans and ensure we have processes to monitor and mitigate;

2. Approach taken to developing the Operating Plan in 2022-23

2.1 Planning Approach and Principles

Planning for 2022/23 has been very challenging for the Trust. This has been due to the uncertain planning environment including Covid waves, transitioning commissioning structures and changing national planning and financial guidance. National planning guidance has accelerated system working, and the Trust was required to submit plans that were aggregated and agreed at a system level. Whilst working more collaboratively as a system is positive, understanding the workforce, activity, and financial plans of all organisations in the system takes time and increasingly, this does come with a loss of autonomy and speed in decision-making, particularly regarding financial decisions.

The Trust aimed to take a light touch approach to the business planning process, and this included undertaking a stocktake process at the end of 2021 to agree the starting position for divisional plans, simplifying processes as far as possible, and holding monthly divisional OPP reviews with executive directors, to ensure decisions and discussions could support the development of divisional plans.

2.2 Key risks to delivery of the plan

In response to the requirements of the regulator, NHSE, the Trust Board approved the submission of an ambitious plan for 2022/23 on the 20 June 2022, which includes stretching financial, activity and performance targets. The key risks to the Trust's' delivery of these plans include:

- Dependency on system schemes to deliver out of hospital benefits e.g. discharge to assess;
- Delivery of the key financial requirements e.g. 2% Cost Improvement Plans (CIP), delivering further non-recurrent cost reductions of £21.6m and mitigating the Elective Services Recovery Fund (ESRF) clawback of c£12m;
- Significant workforce challenges, including recruitment and retention of staff, particularly where recruitment is constrained due to non-recurrent funding;
- Future covid waves and the further impact of covid as either lost elective recovery

and/or increased staff absence;
- Other cost pressures emerging at divisional level, particularly medical workforce and enhanced rates of pay;
- Bed capacity, flow and the increasing impact of patients with “no right to reside”

Further details on the risks to delivery of the plans are articulated in section 7 below.

3. Financial Plan

3.1 BNSSG Integrated Care System (ICS) plan

The Bristol, North Somerset and South Gloucestershire Integrated Care System (BNSSG ICS)submitted a deficit plan of £38.2m to NHSEI on 28 April 2022. The key drivers of the deficit were:

Inflationary pressures (above planning expectations)	£29.0m
Excess covid costs continuing into Q1	£3.4m
Lost ESRF in Q1 (due to covid)	£5.8m
	£38.2m

As part of a national review the System was subsequently offered an additional allocation of c£29m, with various caveats including the requirement to submit a final, break-even plan, at system level. The BNSSG ICS subsequently agreed and submitted a break-even plan, in aggregate and at organisational level to NHSEI on the 20 June 2022.

3.2 Summary of Trust Position

The Trust’s improvement from the April submission planned 2022/23 net deficit of £13.3m to a final plan of break-even was supported by additional funding of £7.6m and a revised national approach to reporting ESRF risk. The Trust’s break-even position also includes non-recurrent revenue support funding of £16.2m from the BNSSG ICS and the requirement to take further actions to reduce expenditure this year by £21.6m, in addition to the current year Trust savings requirement. The delivery of the Trust’s break-even plan this year will require a huge collective effort on the part of all budget holders and service leaders as we shift the focus from planning to delivery in the remaining nine months of the financial year.

The BNSSG ICS recurrent deficit of c£76m and the Trust’s recurrent deficit of c£40m going into 2023/24 means the financial outlook is very challenging. The BNSSG system and Trust will be developing a long-term three to five year financial plan during the Autumn. The long-term plan will need to include a series of actions including a five-year savings plan to eliminate the Trust’s and system recurrent deficit.

3.3 Trust Savings Plan

The savings targets for divisions and corporate services for 2022/23 has been set based on 2% of 2021/22 recurrent budget excluding pass through costs. The target for each division is summarised in table 1 below. The 2% is broadly in line with the system savings requirement. All divisions and corporate services are expected to deliver this target in year. In addition, the Trust is required to work with and support the delivery of system transformation savings of £7.4m. The savings targets and system transformation savings are summarised below:

Table 1: Summary of Trust saving targets for 2022/23

Division	Savings Targets £k
Diagnostics & Therapies	1,384
Medicine	1,777
Specialised Services	1,788
Surgery	2,514
Women's & Children's	2,900
Weston Division	1,666
Estates & Facilities	907
Finance	156
Trust Headquarters	339
Human Resources	225
Digital Services	342
Subtotal – Trust	**13,998**
Corporate requirement	953
Total – Trust	**14,951**
System Transformation savings requirement	
Discharge to assess	2,100
Frailty / Ageing well	1,379
Mental Health	689
Outpatients Transformation	2,068
One T&O	1,130
Grand Total	**22,317**

It should be noted that the Weston division target above includes £1.2m relating to Weston integration benefits. The residual Weston division target of £0.5m is based on 2% of the division's recurrent budget excluding medical and nursing staff.

The savings target has been set at 2%. However, in the current operating environment, it is recognised that delivery against these targets may to a significant extent be achieved on a non-recurrent basis. All divisions and corporate services are however required to have identified recurrent savings equal to the 2% target by the end of September 2022.

Divisions are also required to make progress towards addressing any shortfall of recurring savings targets carried forward from 2021/22 as part of delivering a balanced financial plan for the year.

The Trust continues to use the existing and well-established system of process and governance. The development of both divisional and corporate plans is an integral element of the Trust's transformation agenda under the Transforming Care programme aiming to ensure that schemes, wherever possible, release recurring savings based on operational efficiency and productivity improvements. Schemes also include opportunities to reduce costs through improved purchasing agreements and improving controls on expenditure. All opportunities and ideas to eliminate waste and improve efficiency are investigated.

The Trust also continues to use all available benchmarking sources in order to identify areas for improvement and develop actions plans to ensure delivery. The Trust is using the "Model

Hospital" as the key tool to identify efficiency opportunities and a more formal process is being rolled out across the Trust to follow up all opportunities from this source.

The Trust has a series of programmes focussing on increased and robust controls including in the areas of non-pay, drugs and pay areas particularly medical staffing and nursing. Further work streams dedicated to delivering transactional savings have also been established.

Savings schemes are assessed for impact on quality and patient safety through the completion of Equality Quality Impact Assessments templates (EQIA) where required based on a clear set of criteria. The EQIA templates are reviewed by the Chief Nurse and Medical Director.

Performance against savings targets is reported monthly and reviewed at regular divisional accountability reviews. Oversight of delivery is through the monthly cost savings delivery group. Progress against plans is also reviewed monthly at divisional finance and operational reviews.

The Trust will be relaunching its approach to productivity with an event planned for September this will involve active participation from divisional management teams and key clinical staff. The event will enable us to refocus on the requirement to deliver productivity improvements and will highlight the renewed approach to measuring and more importantly delivering productivity improvements.

3.4 System financial risk

The most significant financial risk at system level is ESRF. To support improvement in elective performance, the final System submission included a further £6.3m of agreed investments in UHBW, in addition to the £10.3m of spend that had been previously authorised.

Activity plans suggest an aggregate risk of c£18m being clawed back leaving a c£18m over-commitment against ESRF at System level and c£12m for UHBW.

Other System financial risks include:

- Full recurrent delivery of the system savings requirement of £63m;
- Delivery of £53m of non-recurring actions to reduce expenditure;
- Increased share of South Western Ambulance Service cost pressures;
- c£17m further inflationary cost pressures; and
- c£6m due to delays in social care.

3.5 Capital programme for 2022/23

The full prioritised programme stands at £82.8m, this is summarised in table 2 and 3 below by programme area and division. The programme is compliant with the financial plan submitted to NHSE on 20th June 2022.

Table 2: Summary of 2022/23 capital plan by Programme area

Programme area	Budget £'000
Major Strategic Schemes	33,111
Medical Equipment and MEMO	11,506
Operational Capital	17,774
Fire Improvement Programme	510
Information Technology	11,033
Estates Replacement	7,038
Weston	357
Elective Space	1,500
Total	**82,830**

Table 3: Summary of 2022/23 capital plan by Division

Division	Budget £'000
Dental	348
Diagnostics and Therapies	7,892
Digital Services	10,409
Estates and Facilities	9,172
Medicine	598
MEMO	2,945
Specialised Services	2,225
Strategy	36,963
Surgery	**2,460**
Trust Services	4,941
Unallocated	629
Weston	1,737
Women's and Children's Services	2,511
Total	**82,830**

The capital programme includes:

- Assumed donations and other funding of £8.4m
- Overprogramming of £21m (this is assumed to be an impact in the following year arising from managed slippage)
- Unallocated contingency on operational capital and major medical equipment of £2.2m (prior to any allocations at July Capital Programme Steering Group)
- New divisional capital for 2022/23 of £0.6m
- Specific deferrals into future periods amounting to £9.8m.

3.6 Commissioning and contracting

Commissioning has been challenging in the current financial context. However, commissioners have agreed to fund some developments including for example:

- Retrieve – adult critical care retrieval service for the South-West, hosted by UHBW;
- ECMO service, which will be delivered jointly by both UHBW and NBT;
- An extension of the Haemoglobinopathy service until March 2024;
- Cannabidiol - access to the NICE Technology Appraisal for South West patients;
- Neonatal Retrieve for the South West (details have yet to be agreed);

- Delivery of Adult and Paediatric Sapropterin; and
- Delivery of Thrombotic Thrombocytopenic Purpura.

During the 2022/23 planning process there has not been an agreed approach to review and make decisions around Trust service development proposals at system level. Therefore, we have been in discussion with local and regional commissioners to agree an in-year process to review any service developments.

Contracts have been agreed and signed off with the BNSSG CCG (ICB) and associated commissioners, and we are in the process of agreeing contracts with NHSE/I Specialised Commissioning.

4. Workforce plan

4.1 System approach

The BNSSG workforce planners network has provided oversight in the construction of each organisation's workforce plan ensuring that they are developed consistently and in line with NHSE/I guidance. The Trust's plan was submitted alongside a narrative submission in advance of the final NHSE/I deadline to provide a system wide response.

4.2 Summary of Trust plan

Funded establishment (demand) is planned to increase by 2.6% (298 full-time equivalent) in 2022/23. This increase is due to approved Accelerator Programme developments, agreed investments and cost pressures.

The planned increase in workforce numbers (supply) is 1.7% (194 full-time equivalent) by March 2023. This takes account of vacancies that might be filled, as well as temporary staffing requirements and overtime.

Table 4: Summary of 2022/23 Workforce plan

	Funded Establishment		
	Year End (31-Mar-22)	Year End (31-Mar-23)	Change
	FTE	FTE	FTE
Total Workforce (WTE)	11,444	11,742	298

	Staff-in Post		
	Year End (31-Mar-22)	Year End (31-Mar-23)	Change
	FTE	FTE	FTE
Total Workforce (WTE)	11,358	11,552	194
Total Substantive	10,550	10,744	194
Total Bank	614	614	-
Total Agency	194	194	-

4.3 International recruitment

Our target for international recruitment for 2022/23 is 219 nurses. Currently we have offered roles to 150 nurses and 54 nurses have arrived since April. Our cohorts have been slightly smaller up until this point due to issues with visas and the Ukraine situation, however, we are on track for the rest of the year with cohorts of 30 nurses arriving each month until end of December.

Next steps

- Further interrogation of workforce expansion areas undertaken to identify where posts are already filled and where resourcing activities need to be focused
- Link in with resourcing team to align with ongoing recruitment activities and specific campaigns
- Monitoring of the plan to be managed via the monthly Provider Workforce Returns (PWR) returns to NHSE/I and shared with the integrated care board (ICB)

5. Activity Plan

5.1 Summary of system and Trust approach

The Trust has worked collaboratively with system partners to agree consistent planning assumptions for the 2022/23 Operating Plan. This has been coordinated through the ICS System Planning Group and the ICS Analytics Cell.

The Trust approach was initiated with a demand-based modelling exercise to inform activity requirements. This model was based on a three year scenario to achieve 92% of day case / elective inpatients waiting no more than 12 weeks by March 2025, with 95% of new outpatients waiting less than 6 weeks, and the overdue follow up backlog held at no more than 9 months.

Divisions made an assessment of core capacity available to meet these modelled activity levels and in February 2022 the Chief Operating Officers' team led a stress testing exercise with Divisions to test the feasibility of delivering activity alongside capacity for beds, theatres, outpatient clinics, diagnostics and workforce.

In March and April further changes to the activity plan were required following the release of national guidance that changed Infection, Prevention and Control requirements for COVID. This resulted in a significant step up in activity in areas such as outpatients, day case areas and theatre recovery. These adjustments have now been included in the plan.

The final activity plan was submitted to NHSE in June 2022.

The Trust plan also showed key outpatient transformation performance metrics at 5% for patient initiated follow up from July and 23% of activity as non face to face. The Outpatient Programme will continue to push for non face to face activity above the 25% national requirement, although this is balanced with the need for backlog recovery where more face to face appointments are required compared to the baseline period.

5.2 Independent sector utilisation and mutual aid

Sub-contracted independent sector activity plans have been included in the Trust operating plan submission, predominantly on the basis of continuing run rates from the previous financial year.

Securing mutual aid for areas where the Trust has long waiting lists is also a key priority for 2022/23. A standard operating procedure for accessing mutual aid has been designed with the ICS and regional NHSE/I teams to facilitate patient transfers, where consent is provided, to alternative providers. This will be based on different pathways where there is high clinical risk (life and limb) or routine treatment required that presents a performance issue in regard to long waiting patients.

Additional requirements for Independent Sector capacity will continue to be brokered by the Chief Operating Officer team and Trust / ICS contract managers.

5.3 Summary of Trust plan

The Trust activity plan steps up activity significantly from the previous rolling 12 months, although in elective inpatients and emergency inpatients, is still suppressed from the levels delivered in 19/20. April 2022 changes to infection prevention and control (IPC) guidance have enabled an increase in activity to support recovery but the principal risks to delivery are due to limited beds, high volumes of patients with no criteria to reside (with associated length of stay increases) and a workforce that continues to be affected by Covid and fatigue.

An overview of the Indicative Activity Plan (with Trust adjustments to the 19/20 baseline) is shown below.

Table 5: Summary of Trust 2022/23 indicative activity plan

Row Labels	2019/20 Adjusted Recurring (Val)	2022/23 Plan (Val)	2022/23 Plan - 2019/20 Adjusted Recurring (Val)	2022/23 Plan / 2019/20 Adjusted Recurring (Val)
Accident & Emergency	£36,709,859	£35,114,766	-£1,595,094	-4%
Bone Marrow Transplants	£9,502,286	£8,775,616	-£726,670	-8%
Critical Care Beddays	£63,350,614	£65,378,289	£2,027,674	3%
Day Cases	£53,775,532	£56,043,625	£2,268,093	4%
Elective Inpatients	£61,205,976	£58,694,060	-£2,511,916	-4%
Emergency Inpatients	£159,487,715	£141,953,150	-£17,534,565	-11%
Excess Beddays	£10,216,887	£8,613,863	-£1,603,024	-16%
Non-Elective Inpatients	£37,077,931	£37,238,033	£160,102	0%
Other	£77,603,791	£76,588,616	-£1,015,174	-1%
Outpatients	£102,718,559	£99,068,200	-£3,650,359	-4%
Grand Total	**£611,649,152**	**£587,468,219**	**-£24,180,933**	**-4%**

5.4 Key risks and challenges

The suppressed volume of emergency inpatients remains a risk to the delivery of the operating plan and is dependent upon demand management interventions curtailing additional non elective growth that could restrict the level of planned elective activity under the recovery programme.

Other risks include:

- Insufficient beds for elective care patients
- 104ww patients who are low clinical priority but high complexity
- Inability to send patients to IS where we are the tertiary centre
- Lack of mutual aid support within region
- Increase in referrals beyond 3% assumed growth in plan (including risk of "lost" demand materialising).

6 Performance

6.1 Impact of national guidance and system approach

The Trust is still working towards delivering the NHS constitutional standards, although national guidance for 2022/23 has introduced a number of additional targets to support the pace of recovery during the year (such as eliminating patients waiting longer than 2 years on an incomplete referral to treatment pathway).

6.2 Summary of Performance Targets and Objectives

The table below shows the national constitutional standards and Trust objectives for 2022/23.

Table 5: National constitutional standards and Trust objectives for 2022/23

National standard	Target	2018/19	2019/20	2020/21	2021/22
A&E maximum wait of four hours	95%	86.3%	80.4%	80.1%	67.1%
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	95.6%	97.2%	81.1%	83.9%
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	49.3%	50.2%	68.0%	48.7%
A&E Unplanned re-attendance within seven days	<5%	3.3%	3.6%	4.5%	2.9%
A&E Left without being seen	<5%	1.7%	1.6%	1.0%	2.9%
Cancer – Two-week wait (urgent GP referral)	93%	95.3%	93.4%	81.9%	84.7%
Cancer – 31-day Diagnosis To Treatment (first treatment)	96%	97.2%	95.8%	95.1%	93.8%
Cancer – 31-day Diagnosis To Treatment (subsequent surgery)	94%	96.1%	92.5%	84.1%	85.9%
Cancer – 31-day Diagnosis To Treatment (subsequent drug therapy)	98%	98.4%	98.6%	99.4%	99.3%
Cancer – 62-day Referral To Treatment (urgent GP referral)	85%	85.6%	85.5%	78.7%	76.3%
Cancer – 62-day Referral To Treatment (screenings)	90%	66.7%	71.1%	57.1%	49.4%
Cancer – 62-day Referral To Treatment (upgrades)	85%	83.7%	86.6%	86.8%	87.6%
18-week Referral to Treatment Time (RTT) incomplete pathways	92%	89.0%	83.2%	61.7%	59.5%
Six-week diagnostic wait	99%	96.7%	95.2%	65.2%	62.5%

A key priority for 2022/23 will also be to significantly reduce 12 hour trolley breaches in Emergency Departments and improve ambulance handover times. Part of this plan includes a focus on reducing patients with no criteria to reside by at least 50% from the December 2022 baseline over the course of the year.

6.3 Summary of bed modelling and key mitigations

Bed modelling has been undertaken using the most recent rolling 12 months length of stay, applied to the divisional activity plans and the core bed stock.

The bed modelling has shown:

- In Year 1, we can expect to have periods where there is a deficit of General & Acute (non ITU) beds. This unmitigated position is in the region of 46 in the Adults BRI, or 43 across all of UHBW (all sites, adults and children).
- In Year 2 non elective growth of 3% would, at times, require up to 14 additional beds in the Adults BRI, and 8 in Weston. This would be repeated again in Year 3.
- The model assumes that elective demand (activity +/- change in waiting list size) remains at the baseline level, and non elective activity does not suddenly increase to 19/20 volumes or beyond this.
- Current operating plan is at 85% for emergency and non elective (non emergency) inpatients and 93% for elective inpatients when compared to the adjusted baseline for 19/20 (87% for elective inpatients without these adjustments, due to transfers of Breast and Urology services to North Bristol NHS Trust)
- BRI plan requires c. 100 additional beds at 21/22 length of stay compared to 19/20, representing a significant productivity opportunity.

Planned mitigations and risks include:

- A701 / A801 Phase 2 (additional 10 beds) BRI – May 2022
- Knightstone Ward Short Stay Surgical Unit (12 beds)
- Impact of Stroke transfer to NBT (14 beds from October 2022) and Discharge to Assess business case (25 beds from October 2022 increasing to 56 beds by March 2023) shown as neutral (i.e. no planned closures to core stock). Benefits reflected in activity plan for elective inpatients from October 2022 onwards.

This results in a total mitigated deficit of 45 beds for 2022/23. This analysis does not include Trust escalation capacity as this is not a sustainable approach to capacity/delivery.

6.4 Key risks and challenges

The key risks to delivery of the performance objectives will be underpinned by our capability to maintain core elective capacity to ensure priority surgical patients are treated in a timely way, but to also maintain capacity for routine work that reduces the backlog of long waiting patients. Key to unlocking this will be improvements to urgent care flow and realising the benefits of initiatives such as every minute matters and additional community capacity for discharge to assess pathways that should facilitate productivity improvements for length of stay, reduced medical outliers and provide capacity for higher volumes of elective work.

The key risks are further described in section 7 below.

6.5 Next steps

- Focussing on improvement in hospital flow, including the optimal configuration of inpatient bed capacity, and the work of the Proactive Hospital Programme, and launch of Every Minute Matters.
- Theatre scheduling and patients being booked in order. A new report has been developed to report the clinical prioritisation and waiting time of patients that have been booked for their procedure. This is to ensure that priority is given to clinical urgent and long waiting patients.
- Weekly detailed reviews of waiting lists through PTL meetings and reforecasting 104 weeks wait performance weekly to ensure that there is close management to trajectories.
- The Theatre Improvement Delivery group meets on a weekly basis to focus on improvements to theatre productivity and efficiency. Planning to extend the arrangement we have with a management consultancy called Four Eyes Insight that specialises in supporting trusts to improve theatre performance.
- System working ongoing – admission avoidance, Healthier Together Hospital at Home, Minors redesign project, Healthy Weston etc

7 Summary of key risks and challenges to delivery of the Trust plans

We have summarised some of the key risks and challenges for the Trust in 2022/23 below:

7.1 Financial

The key financial risks and challenges for the Trust in 2022/23 are as follows:

- Achieving the 2% CIP target recurrently we have already applied to budgets, noting that many divisions also have a target brought forward from previous periods
- Covering £21.6m through additional non-recurrent and recurrent expenditure reductions – including reducing the on-going cost of Covid below funded levels
- Planned elective activity recovery and mitigating the risks of ESRF clawback/over-commitment of c£12m, without further unfunded costs impacting at Trust level
- Significant workforce gaps leading to premium costs within an increasingly challenging retention and recruitment environment
- The treatment of unavoidable cost pressures we have already flagged to the System; for International Recruitment (£4.0m) and F1 issue in Weston (£1.5m)
- Other cost pressures emerging at divisional level; particularly around medical workforce; additional bed capacity; agency/bank/overtime and enhanced rates of pay
- Our approach to managing the remaining inflationary and non-inflationary cost pressures, service developments and the strategic revenue investment proposals

7.2 Operational

The key risks to delivery of activity and performance plans include:

Bed capacity

The Adult BRI G&A bed base core stock of 500 is currently reduced due to:

- Variable numbers of Covid patients in the bed base, and therefore reduced availability for general surgery in real terms
- A sustained level of c.120 patients with no criteria to reside
- On average c.25 Weston repats / overnight admissions
- 80 bed length of stay deterioration
- Medical outliers in bed base, escalation capacity already being used in Summer.

Impact of patients with no Criteria to reside
Trust-wide we have almost 200 beds with patients that have no criteria to reside. There is expected benefit realisation from extension of discharge to assess (D2A) and increased capacity due to timely discharge of patients from October, but this is at risk of being consumed by non-elective growth. The Trust must focus on what is within our control to improve flow and reduce length of stay while working with partner providers to seek assurance on and support, successful delivery of out of hospital capacity.

Infection prevention control measures
Risks include the impact on workforce resilience, physical space and the testing requirements.

7.3 Workforce

The key workforce risks for 2022/23 include:

Recruitment and retention
Recruitment and retention of staff remains a key workforce priority and area of challenge and specifically:

- There is an increasing reliance on international recruitment for Nursing and Medical and some specialist roles and the impact of higher associated costs
- The Trust is seeing a rising vacancy factor and staff turnover across all divisions
- Recruitment into specific agreed schemes will be challenging e.g. Knightstone, specialist consultant roles, diagnostics
- Recruitment into administrative and management roles remains challenging

Impact of COVID on workforce
The Trust is still managing the impact of Covid on workforce. For example, as at early July 2022 there are 138 staff absent for COVID related reasons (1.2%) and total sickness 4.4%. The Trust still has shadow rotas in place to mitigate the impact of COVID.

Additional capacity
The willingness of staff to complete waiting list initiatives and the impact of incentive payments balanced against current financial position remains a key challenge.

Risks will be monitored alongside mitigating actions where possible, through Divisional review meetings.

8 Operating plan next steps and recommendations

Divisional delivery will be monitored with escalation and support requirements discussed at monthly Divisional review meetings with the Executive team.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th August 2022

Report Title	**People Strategy Refresh**
Report Author	**Emma Wood, Director of People**
Executive Lead	**Emma Wood, Director of People**

1. Report Summary

To provide the Board with the final draft of the refreshed People Strategy for ratification.

2. Key points to note

(Including decisions taken)

- There were numerous corporate documents which set out the People priorities which created a complex landscape for the People Directorate to operate within.
- The People Committee agreed in January 2022 to rationalise these and refresh the People strategy to improve clarity of ambition and simplify programmes of work.
- The intent was for the revised strategy to provide clarity on the deliverables at an operational level and to improve Board assurance on programmes of work.
- The People SLT commenced design of the refreshed people strategy by engaging with a number of stakeholders including HRBPs, Divisions, Staff Side, Staff Networks and SLT to check and test content. We also considered feedback from a number of internal data sources - staff survey, our 2025 strategy, Blue Goose values programme, Employee Relations cases and Freedom to Speak Up concerns.
- The People SLT considered external data and information from sources such as the NHS People Plan, SW Regional People Board, BNSSG priorities, CQC, Health Education England (HEE), NHSE and model hospital. The intention was to ensure any improvements UHBW had been asked to make (such as through CQC and HEE inspections) were captured, future work was aligned to national and regional priorities and any KPIs set benchmarked against SW and model hospital peers.
- The strategy describes:
  - Where we are now;
  - Where we want to be by 2025;
  - The pillars of delivery which will help us to move to 'where we want to be':
    - These pillars align to the NHS People Plan and our values
    - Under each pillar are the 4-5 key strategic objectives and initiatives which will help the Trust to drive delivery
  - The metrics to measure success:
    - These are aligned to model hospital and national benchmarks which will enable some external comparison of performance;
    - They will flow into the Divisional Executive review processes;
  - The future voice of our staff and patients has been captured to measure progression against the objectives.
- We have an animation/video of c2 minutes in length which describes the strategy and has been segmented into 4 smaller clips introducing each pillar. This will be used to illustrate our commitments to staff as part of the launch plan.

- The People teams have agreed work programmes and plans to deliver the objectives and a recent Away Day sought to emphasise the ambition and roles of each team.
- The patient first programme of work has informed the strategy and vice versa.
- The leadership priorities agreed by the Board for 'Our People' align to the People Strategy Pillars and an accountability and assurance mapping exercise has been carried out to describe to the People committee how they will receive appropriate reports on progress.

Next steps

- To release the animation to describe our promise to staff.
- To refresh the Education Strategy so it aligns to the People Strategy.

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

The risks associated with this report from our strategic and corporate risk register include:
A refreshed People Strategy should seek to mitigate the strategic workforce risks
Risk 737 – risk that the Trust is unable to recruit sufficient numbers of substantive staff,
Risk 2694 – Risk that the Trust is unable to retain members of the substantive workforce
Risk 793 – Risk that staff experience work related stress
Risk 422 – Risk that patients and staff experience violent or aggressive behaviour
Risk 674 – Risk that the use of agencies who are non compliant with national pricing caps does not reduce
921 Risk that staff are not fully compliant with their Essential Training
2693 Risk that staff are not fully complaint with appraisal

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

- This report is for **Approval.**

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

People Committee	25 Jan, 25 March and 26 May 2022
SLT	16 March and 4 May 2022
People Education Group	16 Feb and 27 April 2022
HR SLT	2 March and 13 April 2022

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

People strategy
2022-2025

We are
supportive
respectful
innovative
collaborative

Our **People**

“

Together we will make UHBW the best place to work

Introduction

People are at the heart of the services we provide and are key to delivering our mission to improve the health of the people we serve by delivering exceptional care, teaching and research everyday.

The COVID-19 pandemic has taken a toll on our colleagues. Colleagues have worked incredibly hard in all areas across the Trust to keep patients safe and support one another at a time of unprecedented demand. The operational challenges will remain with us for some time but there are opportunities through the new Integrated Care System to organise our services differently to manage these pressures collectively and give patients and staff an improved experience.

This refreshed People strategy places colleague experience at the heart of our programmes of work to ensure UHBW remains a great place to work. Our colleagues report they are proud to work at UHBW and they believe passionately in providing excellent care. Every person at UHBW whether in a clinical, non clinical or support role is motivated to ensure they play a part in delivering exceptional care, teaching or research.

Our recent staff survey tells us we need to work harder to enable colleagues to be the best they can be. To support their health and wellbeing, their career aspirations, listen to their feedback and lived experience and promote inclusion. We want every person to be able to come to work and be led by compassionate and inclusive leaders and to embed our values so they become part of what we do. Our values collaborative, innovative, respectful and supportive were chosen by colleagues and are at the heart of our People strategy and will drive our programmes of work.

By delivering upon programmes under 4 headings; Growing for the Future, New ways of working, Looking after our People and Belonging and Inclusion we will be able to deliver upon the NHS People promise and create an employment offer which is as exceptional as the people who work at UHBW.

We are collaborative | We are innovative | We are respectful | We are supportive

Where we are **now**

We are collaborative

We are innovative

We are respectful

We are supportive

We still have colleagues who report feeling bullied and harassed and that their personal characteristics prevents them from to being treated fairly. We need to continue to build an inclusive culture and deliver our commitment to 'inclusion in everything we do'.

Our people have a wealth of knowledge and experience but many colleagues tell us there are not enough staff in the organisation to do their job properly.

We have invested to attract talent into the Trust, but we need to expand and develop clear career paths to be a beacon of outstanding education.

We have integrated and merged to create UHBW. However, colleagues feel there is more we can do to collaborate to become one united Trust.

Colleagues tell us they are proud to work at UHBW and feel they offer outstanding care to patients, but there needs to be a stronger focus on helping our people feel valued and supported.

Leadership development has not consistently been at the heart of our people practice. Colleagues tell us there needs to be a continued commitment to develop confident and empowering leaders at all levels.

Our people strongly feel that the organisation takes wellbeing seriously; we need to keep momentum and ensure that our wellbeing programmes are accessible and responsive to the needs of the individual.

We have successfully collaborated across the ICS but still compete for shortage skills

Many of our people systems are manual and paper based. We need to make better use of digital solutions to manage data and information so we can, deliver great people services.

Where we **want to be**

We are collaborative

We are innovative

We are respectful

We are supportive

We will attract and retain new talent into the Trust as an Employer of choice. Through the development of meaningful workforce plans we will be agile, develop and integrate innovative roles and provide opportunities for training, education, research and development.

We will celebrate diversity, providing equal opportunities for all. We will build an inclusive culture, recognising and respecting our differences.

We will have skilled colleagues who have the right expertise to provide excellent care Colleagues will tell us they feel supported, developed and that there are enough people employed to deliver care around the patient.

There will be a strong sense of belonging and our colleagues will tell us they are proud to work for UHBW. We will champion difference where everyone can be their best, fulfilling their potential with education development opportunities.

Colleagues will tell us they feel confident to challenge and speak up.

Colleagues will tell us leaders demonstrate their compassion and authenticity. They will feel listened to and have regular, meaningful conversations.

We will become digitally enabled and skilled to transform services and people practice across all sites.

We will collaborate to place the patient at the centre of our decisions and will reduce unnecessary duplication.

We will take a positive and proactive approach to supporting colleague's health, safety and wellbeing.

Judd,Emily
03/08/2022 15:27:16

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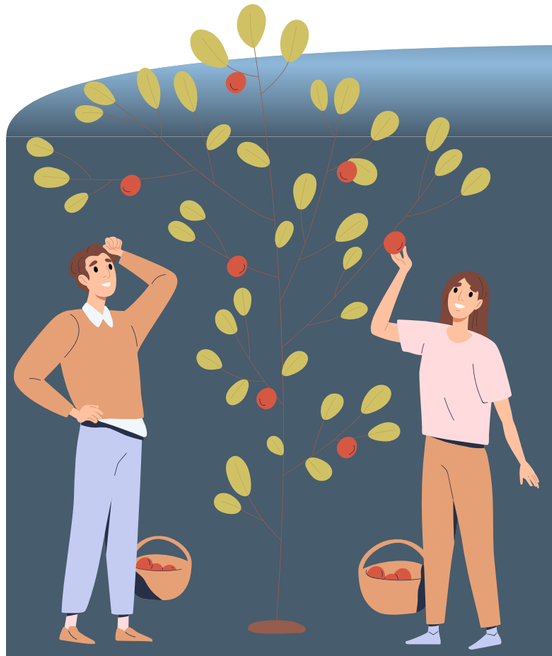
About the **People Strategy**



Growing for the Future

New ways of Working

Inclusion & Belonging

Looking after our People

Objectives

Growing for the Future

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Invest in high quality innovative learning and development opportunities that recognises, develops and retains talent across UHBW for all learners	• Ensure continuous improvement of education content and material to develop an agile and innovative blended learning approach • Develop a comprehensive education offer clearly communicated, accessible and inclusive of all learners • Support and develop programmes which develop skills via non accredited and accredited means • Target the needs of colleagues linked to our operational and workforce plans and Trust training needs analysis • Increase appraisal compliance to meet Trust target to ensure all staff have individual development plan • Increase the range of simulation based activity available to all Trust staff groups • Develop clear career progression pathways for all staff groups • Improve placement feedback within NET's, GMC survey and HEE	• Deliver upon the education requirements of nurse, midwifery, AHP and Healthcare Scientist career pathways • Ensure education and development pathways align to and meet the needs of our True North • Provide programmes which enable colleagues to develop personal skills via either accredited or non–accredited means • Improve the gap in grade attainment between learners in the Trust • Improve curriculum materials to be more representative of all learner groups • Develop an inclusive knowledge management strategy for all staff groups • Develop the Kallidus Learn platform to host education provision • Revamp all eLearning to engage staff groups • Integrate electronic transfer of ESR records into the LMS pass porting • Integrate ICS CPD offer developed working with partners to achieve economies of scale	• Be recognised as a learning organisation • Colleagues will recognise the Trust as investing in careers and report that there are good opportunities for promotion and training • Reduced turnover and improve retention and stability index to be best in class against peers

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Objectives

Growing for the Future

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Embed a strong, unique employer brand to attract the best talent	• Identify opportunities to jointly market shortage roles across system • Understand how UHBW is placed in recruitment market to improve brand awareness • Drive new programmes to engage and develop internal ambassadors and create new platforms of attraction (social media) • Review all materials / marketing of roles in line with new values to reinforce brand • Collaborate with communications team to devise a new employer brand and proposition	• Increase applications from hard to fill roles • Reduce vacancy rate to meet peer benchmarks • Reduce spend on locums, agency and interim staff • Reduce spend and reliance on international markets	• Reduce agency spend to meet NHSEI cap • Vacancy rate and stability index is best in class • International recruitment is limited only to occupational shortage skills

Objectives

Growing for the Future

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
An agile and efficient recruitment and onboarding processes with new approaches to fill hard to recruit roles	• Map end to end recruitment process and identify improvements using digital approaches and innovative assessment methods • Identify and target hard to fill roles and implement talent acquisition approach to all these roles • Review and improve recruitment and on boarding • Improve attraction and pipeline of candidates reducing hard to fill roles • Establish a means to gain feedback on the recruitment process • Improve medical recruitment processes • Scope opportunities to collaborate on recruitment with BNSSG • Reduction in agency and locum spend for hard to fill roles	• Reduced time to hire and time to onboard to meet peers • Positive feedback from applicants and hiring managers on the hiring process	• Be recognised nationally as an agile employer with innovative recruitment practice • Shared people practice in line with national HR and OD review

Objectives

Growing for the Future

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Increase and coordinate our placement capacity and supervision to ensure students have a positive experience	• Maximise student placement capacity and Improve student experience • Improve collaborations with HEI to meet the needs of the Trust • Develop a placement strategy with ICS partners for all learning programmes • Submit bids for further funding to support the placement strategy • Maximise the impact of roles, such as the Collaborative Learning in Practice (CLiP) role upon pre-registration nursing	• Increase nursing placement by 10% • Develop the resource to support the preceptorship programme • Implement a full review of graduate and newly qualified retention rates • Develop the support needed to ensure that all students are effectively supported	• Develop a system wide placement capacity tool which identifies capacity for T-level students, Apprentices, work experience, undergraduate and post-registration placements

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Voices of the future

Growing for the Future

I have lots of opportunities to learn

It feels like there are fewer vacancies

My placement and supervision has been excellent

The application process was really easy and I settled into my new role well

STAFF

It feels like there are more staff around to help me

I have confidence in the skills of the people looking after me

I can see staff care and are confident and proud to work here

PATIENTS

HOW WE'LL MEASURE IT:

- Vacancy factor - Trust and by staff group/division
- Stability index - Trust and by staff group/division
- Turnover
- Inclusive and ethical recruitment
- Established Workforce plans
- Use of temporary resources (Bank, agency, interims)
- Appraisal and essential training

Objectives

New ways of working

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Collaborate with BNSSG to improve system working to deliver new patient pathways and stream lined services	• Design and develop with system partners an inclusive shared education and training offer • Design and develop new career pathways across the system • Develop Pass portable training record across the BNSSG ICS and local HEIs for all new starters • Support staff to work in new system led patient pathways • Review opportunities to reduce variations in roles and banding which creates unnecessary competition • Scope opportunities to share best practice and reduce transactional duplication	• Develop a system based OSCE bootcamp for international registered nurses • Ensure consistency of mandatory essential training across all ICS partner organisations • Ensure effective pass porting of training records across ICS partner organisations and local HEIs for all new starters • Deliver collaborative career pathways and joint delivery of education programmes for all staff • Deliver programmes which reduce duplication of transactional services	• Develop the pass porting of training records with wider HEIs for all new students starting • Collaborate with systems partners to develop and share training needs analysis across the ICS • Learning and training offer developed and available across ICS partners

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Objectives

New ways of working

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Embed our new comprehensive leadership, management and coaching offer to develop compassionate and inclusive leaders who role model our Trust values	• Develop a compassionate leadership, management, coaching and mentoring programme for all staff groups which embeds the Trust values and leadership behaviours • Promote the leadership and coaching development opportunities within Apprenticeship standards • Expand the LAG and OD offer in BNSSG to deliver on leadership offers and a system coaching faculty • Ensure SW Leadership Academy offers are well publicised and linked to our newly formed leadership framework	• Improve the colleagues survey ratings for: immediate manager, quality of appraisals & colleagues engagement; to be the best across our peers • Embed a coaching and mentoring offer for all Trust colleagues • Ensure all managers in post follow a mandated leadership and training framework • Ensure our leadership programme integrates the True North leadership behaviours	• Be recognised as offering people managers professional development and accreditation • Be recognised as having embedded a coaching and continuous improvement culture • Ensure all managers are suitably qualified leaders • Coaching and mentoring culture is fully integrated across the Trust • Embed True North leadership behaviours in frameworks

Objectives

New ways of working

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Ensure digital solutions drive improvements in people practice	• Devise a strategy for the implementation of e job planning and e rostering for medics and A&C staff • Devise a strategy for ESR self service and management modules • Pilot new solutions for temporary resourcing needs • Scope the use of call centre technology for HR services and recruitment teams • Develop digital skills of all staff groups • Pilot new solutions for temporary resourcing needs • Promote agile working	• Deliver upon the strategy for e job planning and e rostering and ESR • Improve the compliance of rota's and rostering • Utilise digital solutions to improve engagement • Develop a training offer which enables staff to develop skills across all digital platforms • Introduce call centre technology for HR services and recruitment teams • Deliver some estates benefits from agile and flexible working to provide increased clinical space	• Trust is recognised as a digital exemplar for people systems

Objectives

New ways of working

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Continue to expand our Apprenticeship portfolio	• Increase the range of apprenticeship programmes available to staff groups • Seek greater synergy between the CPD portfolio and apprenticeship programmes • Maximise the use of the apprenticeship levy • Defining our apprenticeship offer for clinical roles as linked to our training needs analysis and workforce plans • Define the transition pathways for apprentices e.g. HCSW to TNA to RN • Implement a retention and progression strategy for healthcare support workers to reduce turnover to meet peer performance • Implement a comprehensive 16-18 year old apprentice strategy	• Review all apprenticeship provision and training providers with ICS partners to ensure the quality of provision • Expand partnership arrangements to maximise apprenticeship opportunities across BNSSG • Develop T Level pathways across each relevant staff group • Provide clear progression routes for trainee nursing associates to nurse degree programmes • Implement an effective work experience and outreach programme • Implement an ICS careers hub to attract talent	• Improved apprenticeship quality metrics for all staff groups, in terms of retention and completion by 85% • Achieve the national public sector recruitment target for apprenticeships (2.3%) • Ensure effective and complete use of the apprenticeship levy at 100% • Implement the nurse degree apprenticeship • Be an exemplar for the HCSW programme nationally

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Objectives

New ways of working

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Use robust workforce planning to understand supply and demand of skills and roles internally and across BNSSG	• Develop a 5 year internal workforce plan, aligned to system wide priorities and market which establishes gaps, future gaps and provides plans to resolve these within divisions • Develop a BNSSG work force plan to collaborate and improve upon supply and alternative career pathways • Support Healthy Weston 2 implementation and deliver the integration plan • Support staff across service changes and moves as linked to the operating plans and 2025 strategy • Consider opportunities for collaboration to meet workforce plans such as International recruitment • Reduced agency, interim and locum spend • Embed the BNSSG neutral vendor contract • Identify local pipelines for growing talent into identified shortage roles particularly within diverse communities. • Re-energise work experience programmes • Ensure workforce plans consider and identify opportunities to embed new and advanced roles and skill mix reviews are undertaken to support these expansions	• Develop system plans to develop supply and upskill colleagues to meet the needs of patients and patient pathways • Devise an apprenticeship hub across the system • Successfully embed new ways of working in Healthy Weston 2 • Widespread use of new roles and skills mixes in workforce plans across divisions	• Rated as good for 'use of resources' • Recognised as managing workforce demands collaboratively across the system

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Voices of the future

New ways of working

I can complete tasks like booking leave and shifts more easily

There are lots of opportunities for me to advance in the Trust

I can work and study at the same time to develop my career

My manager cares about me

STAFF

I can see care is organised around me and feels joined up

I know who is in charge on my ward

I know I am getting the best care

PATIENTS

HOW WE'LL MEASURE IT:

- E-job planning, e-Rostering, ESR self service
- Enhanced learning offer
- New and advanced role growth
- Apprenticeship growth
- Talent management
- System roles and integration of career paths
- Staff actively engaged in research

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Objectives

Inclusion and Belonging

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Remove the experience gap between colleagues with minority protected characteristics	• Develop a Trust wide approach to capture and present diversity data to ensure improved decision making and help address issues raised through the WRES, WDES, staff survey and Gender pay gap • Ensure each division has a plan for reducing the variation of inequitable treatment across the protected characteristics • Improve our collaboration within BNSSG and Bristol City Council to improve the representation of the staff we employ • Agree the model employer aspirations and our disparity ratios and action plan at divisional level to improve representation of ethnic minority colleagues • Ensure our employment and recruitment practices and policies are fair, transparent and inclusive	• Improve and close reported experience gaps as measured by the WRES, WDES and Gender Pay Gap and staff survey measures • Meet year 2 model employer aspirations • Plan and deliver programmes to reduce the disparity ratio by reducing the gap between ethnic minority colleagues and white counterparts at shortlisting and appointment stage • Develop a BNSSG stepping up programme for our ethnic minority, disabled and LGBTQ+ colleagues • Improve the percentage of staff from minority groups who access learning opportunities	• Close the Gender Pay Gap • Annual reports indicate no experiential differences between minority protected charactristics • Meet year 3 model employer aspirations • Reduce the disparity ratio to match best in class Trusts

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Objectives

Inclusion and Belonging

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Develop a culture where we embed our values in policy and practice	• Embed values in appraisal, recruitment, education and development, staff recognition • Design the Just and Learning Culture principles for managing employee concerns and issues to ensure increased fairness, transparency and inclusivity • Design and launch an approach to Pulse Surveys and tailor this intervention to test our values culture • Develop a listening framework where listening into action is a key component • Integrate our values into our Human factors training	• Improve experience indicators as measured by the staff survey to be in the top quartile of peers • Embed the listening framework and measure the success in people pulse surveys • Embed the Just and Learning culture principles for managing employee concerns and issues to ensure increased fairness, transparency and inclusivity	• Colleagues can describe the organisation as being value led and this is recognised by staff engagement scores which are best in class

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Objectives

Inclusion and Belonging

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Celebrate and value the contributions of all our colleagues by ensuring they have a voice and are listened to	• Embed the staff networks and introduce new networks such as a women's network • Formalise reporting of networks to ensure that staff voice is heard and issues recognised and resolved • Clarify the roles of Divisional EDI Leads and EDI Advocates • Expand the programme of staff stories to demonstrate listening into action • Design a reciprocal mentoring programme • Agree new channels for communication and engagement • Improve mechanisms of communication from ward to board • Embed new ways of working with our Staff side colleagues locally and regionally through the SPF • Embed Freedom to Speak Up Champions • Improve the uptake of listening into action e learning	• Staff networks and groups will become formal partners in decision making • Every Division will be represented by a diverse group of EDI advocates and improvements in local areas will be evidenced in the bi annual reports • embed reciprocal mentoring across the divisions • Improved engagement and feedback loops for colleagues and utilise new digital means of communication • Colleagues feel engaged and consulted upon matters important to them through our partnership forums • Increased numbers of colleagues speaking up and feeling safe to do so	• Colleagues will report they are involved in decisions and influence their role as measured in the staff survey • Variation of colleague experience as measured in the staff survey across the main protected characteristics will be eliminated • Colleagues will report feeling confident and safe to raise a concern as measured in the staff survey

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Voices of the future

Inclusion and Belonging

I feel safe to raise concerns

My differences are embraced

I can see more people who look like me progressing to senior roles

I believe inclusion does matter to my manager

STAFF

I am being cared for by people who understand my individual needs

My differences are respected in the delivery of my care

PATIENTS

HOW WE'LL MEASURE IT:

- Model employer goals
- Disparity ratio
- Board level by protected characteristics
- Staff in post by protected characteristics
- Eliminating the ethnicity gap in formal disciplinary processes
- Improving metrics of colleagues with protected characteristics
- Proportion of staff who agree that the organisation acts fairly with regard to career progression, promotion regardless of protected characteristics
- Improving metrics of colleagues feeling confident and safe to Speak Up

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Objectives
Looking after our People

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Provide a safe working environment	• Reduce colleague absence rates for MSK and mental health illness in line with peers • Design KPI's relating to maintenance and upkeep of staff rest areas • Improve the timeframe for reporting of RIDDOR incidents • Reduce safety incidents in key areas – manual handling, falls, sharps • Deliver top 3 divisional requests for staff rest areas and improve upon catering offerings • Plan a review of working patterns for all staff on rosters/rotas to ensure safety and fairness	• Be recognised as having safe systems of work for colleagues • Develop a rolling programme of improvements for rest areas • Reduce late RIDDOR repots by 50% • Develop principles for balanced working patterns and rosters to meet service demands and staff well-being	• Be best in class for safety and engagement scores in the staff survey • Be recognised nationally for health, safety and wellbeing services • All RIDDOR repots are made within the legislative framework • Recognition by external auditors for delivering excellent health and safety governance and systems • Staff rest areas are recognised as meeting their needs • Champion innovative rosters/rotas that promote both staff welfare

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Objectives
Looking after our People

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Eliminate Violence and Aggression, bullying and harassment from our colleague's working lives	• Design a Just and Learning Culture and practice to reduce formal cases and resolve bullying and harassment more rapidly and informally • Reduce time to resolve employee concerns • Deliver the Violence and Aggression action plan • Improve mechanisms to manage violent and aggressive patients and members of the public • Reduce reported cases of violence and aggression • Increase training capacity and range of training provision to meet local need which raises confidence to manage and respond to incidents of Violence and Aggression	• Improved resolution of bullying and harassment and Violence and Aggression resolution cases • Reduction of cases relating to bullying and harassment • Improved staff survey results for Violence and Aggression and bullying and harassment to be best in class across peers • Improved compliance for conflict resolution to 90% through increased attendance at training sessions • Full implementation of mechanisms for improving controls for dealing with aggressive patients and members of the public	• Colleagues have confidence that the Trust takes a zero tolerance approach to violence, aggression, bullying and harassment • Reduced number of Violence and Aggression serious incidents reported on Datix

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Objectives
Looking after our People

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Develop an outstanding employment experience which meets colleagues aspirations of their work	• Improved retention, reduced vacancy factor and Trust turnover to peers • Design a talent management system to identify and retain talent linked to the appraisal process • Improve and promote the Reward and Benefits offer • Improve access to flexible working • Design career pathways to meet colleagues ambitions • Establish and promote clear learning and education offers for colleagues	• Improve retention, vacancy factor and stability index to above peers • Expand the offers of alternative roles as linked to the annual planning and investment process • Have an established talent management programme • Be recognised as offering outstanding learning and education opportunities (as measured by staff survey)	• Reduced turnover and improved retention and stability index to be best in class against peers • Staff will report in the staff survey that they would recommend UHBW as a place to work and this ranks in the top quartile of all Trusts • Be recognised as an employer of choice (awards, CQC, CIPD, HSJ..)

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Objectives
Looking after our People

OBJECTIVE	MILESTONE YEAR 1	MILESTONE YEAR 2	MILESTONE YEAR 3
Promote a culture of health and wellbeing	• Create new support pathways for staff to promote health and wellbeing • Embed and improve ICS offers and their integration with Trust initiatives • Establish a means to proactively identify colleagues who need additional support • Promote healthy lifestyles and programmes • Establish an effective reasonable adjustments process for colleagues with disabilities • Increased use and access of holistic well being offer • Health and wellbeing hubs open • Reduced absence in musculoskeletal & stress to match peers • Improve uptake of Flu/Covid 19 vaccinations to be best in class	• Be recognised as best in class for Health and well being offers • Improve the staff survey outcomes relating to health and wellbeing to be best in class • Improve the experience of disabled colleagues and be in top quartile of Trusts • Access to well being offer increased across all divisions and staff groups • Absence rates reduced to best in class	• Be recognised as a disability confident employer and best in class for WDES results • Ensure that disabled staff report the same experiences as non disabled staff • Be recognised nationally for health, safety and wellbeing services • Be a beacon of best practice for vaccination programmes

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Voices of the future
Looking after our People

I feel safe at work

Health and wellbeing services meet my needs

Bullying and harassment and Violence and Aggression is treated seriously by my manager

I can work flexibly and in a way which suits my needs

I can resolve issues and problems quickly

STAFF

I can see staff enjoy their work and are happy

I can see staff respect each other

I feel safe when I visit for my care

PATIENTS

HOW WE'LL MEASURE IT:

- Absence rate by Musculoskeletal
- Absence rate by anxiety, stress and depression
- Health and wellbeing access
- Percentage of staff who have experienced harassment or bullying or abuse
- Vaccination uptake (flu and covid)
- Percentage of staff satisfied by flexible working offers
- Proportion of staff considering leaving within the next 12 months or will leave as soon as they have another role
- Reduced safety incidents/RIDDOR
- Zero tolerance to proven bullying and harassment and Violence and Aggression
- Improve mechanisms for managing employee concerns - reducing case management time and formal mechanisms

Trust Board of Directors in Public on Tuesday 9th August 2022

Report Title	**Q1 Strategic Risk Register**
Report Author	**Sarah Wright, Head of Risk Management & Information Governance**
Executive Lead	**Chief Executive**

1. Report Summary

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

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

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

2. Key points to note

- The report has been amended to include information on the risk profile of the Trust from a strategic risk perspective.
- The risk profile seeks to show the strategic risks, their change over time and, the report will in future iterations show the forecast position in 6 months' time.
- The profile section also describes how the risks are split across the risk domains and by score in the domains. The purpose of which is to help the organisation understand where the majority of its key risks are originating.
- The narrative to describe changes to the risks in the quarter is now ordered in line with the domains so that similar risks can be considered together.
- There are 11 risks on the Strategic Risk Register. One risk has been closed off the Strategic Risk Register.
- The full risk register is available in the resources section of AdminControl for information.
- The November Board seminar will include a review of the Trust's risk appetite statements and a refresh of the risks to the delivery of the Trusts strategic objectives.

3. Risks

See attached appendix.

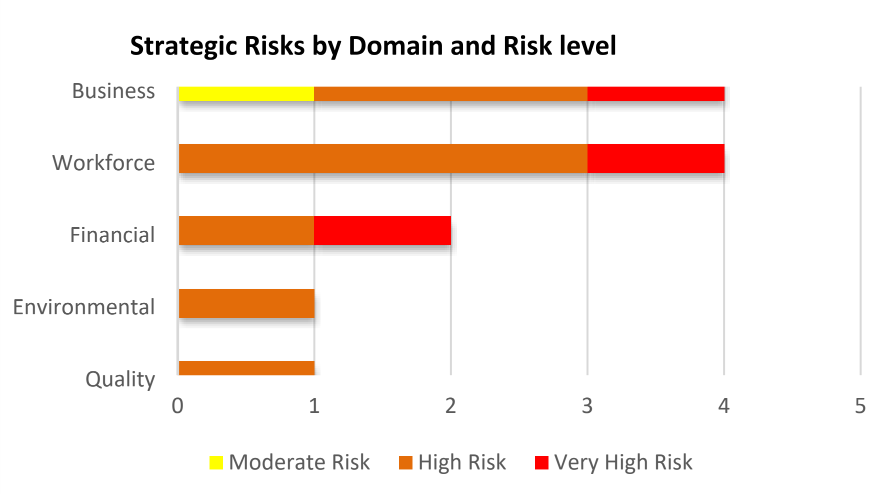
4. Advice and Recommendations:

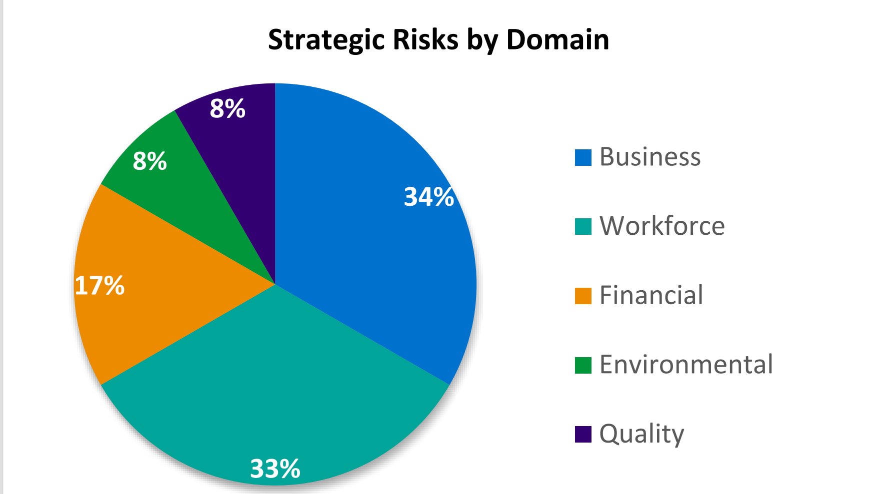
This report is for **Assurance.**

5. History of the paper

Risk Management Group	06/07/2022
Senior Leadership Team (for Information)	20/07/2022
Finance & Digital Committee (relevant risks) and People Committee (relevant risks)	25/07/2022
Audit Committee and Quality and Outcomes Committee (relevant risks)	26/07/2022
Trust Board of Directors	09/08/2022

Strategic Risk Register Profile





To Note: *Business Risks* are assessed against project budget or slippage, and loss or interruption of service

Risk ID	Strategic Risks Timeline	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23		6 month Forecast	Target
5369	Risk that the Trust is unable to deliver a suitable service model for WGH	16	16	16	16	16		TBC	8
737	Risk that the Trust is unable to recruit sufficient numbers of substantive staff	16	16	16	16	16		TBC	6
416	Risk that the Trust fails to fund the Trust's Strategic Capital Programme	15	15	15	15	15		TBC	10
2694	Risk that Trust is unable to retain members of the substantive workforce	12	12	12	12	12		TBC	4
5317	Risk that the Integrated Care System Implementation reduces the Trusts decision making	12	12	12	12	12		TBC	4
3472	Risk that the Trust fails to make a positive impact on combatting climate change	10	10	10	10	10		TBC	5
2992	Risk that benefits of transformation, improvement and innovation are not realised	6	9	9	9	9		TBC	6
2741	Risk that Research and Innovation is not adequately supported	9	9	9	9	9		TBC	6
5277	Risk that the objectives of the Trust wide education strategy are not delivered	12	12	12	9	9		TBC	4
2633	Risk that Trusts IM&T Systems fail to deliver the required levels of efficiencies	8	8	8	8	8		TBC	4
2642	Risk that the Trust is unable to invest in modernising the Trust estate	6	6	6	6	6		TBC	3

Q1 Update - Strategic Risks		
2642	Risk that the Trust is unable to invest in modernising the Trust estate	6
Business	External consultancy support has been secured to ensure effective project delivery. Enhanced governance, resourcing and reporting processes are currently being rolled out across the Strategic programme. *This risk is linked to strategic 416 (Financial Plan), strategic 5317 (ICS Implementation).*	
2992	Risk that benefits of transformation, improvement and innovation are not realised	9
Business	Patient First Phase 1 (readiness assessment) is complete and SLT approval was gained in March 2022 for the interim full business case. Phase 2 is now in progress (Strategy Development). The Executive Team has been leading development of the True North and it's strategic themes. Q2 and Q3 will focus on Breakthrough Objectives and preparations to commence, in the new year, Phase 3: Strategy Deployment of Patient First into Divisions and front-line staff. The Communications and Engagement Plan intends to deliver, by the end of December 2022, a basic understanding of Patient First to more than 60% of our staff. Presentations are being delivered to senior teams and online resources introducing Patient First have been shared. *This risk is linked to strategic 2633 (IM&T).*	
5317	Risk that the Integrated Care System Implementation reduces the Trusts decision making powers	12
Business	We continue to work in partnership to support the development of the ICS and influence from a Trust perspective. The annual planning round for 22/23 has highlighted that the transitioning commissioning structures are complex and that decision-making pathways are not clear in all areas of planning, however we do know that investment decisions greater than £250k will require system approval. We are working on reflections on the current planning round and will seek to create key areas where we wish to influence system planning and decision-making for the future. A gap has been identified around a forum for strategy development at system level and we are also seeking to create influence in this area. *This risk is linked to strategic 416 (Financial Plan) and strategic 2642 (Estate Modernisation).*	
5369	Risk that the Trust is unable to deliver a suitable service model for Weston General Hospital	16
Business	The business case for a Business Unit was approved by SLT in March 2022. Leadership resource is still required in order to progress with the integration and therefore the impact of a possible reduction in leadership resource for delivery of BAU Trust corporate objectives is still a risk. Extension of the Weston Division Management and Integration timeline to March 2023 has been approved. Permanent Hospital Director role appointment commencing July 2022. Clinical Chair appointed to June 2022. *This risk is linked to strategic 737 (recruitment), strategic 2694 (Retention), corporate 4748 (WGH Clinical Staffing), corporate 5477 (Nurse Staffing), strategic 4539 (Delivery of Corporate Objectives), corporate 920 (Drs in Training).*	

737	**Risk that the Trust is unable to recruit sufficient numbers of substantive staff**	16

Workforce

Due to increased turnover across all staff groups closing the vacancy gap remains a significant challenge. In addition, the effect of Brexit and the post Covid economy recovery has significantly reduced the candidate pool. The Trust has invested in the recruitment of a further 219 international nurses by the end of 2022. The Trust's talent team is investing significant effort to develop innovative recruitment campaigns to try and attract candidates from a dwindling talent pool including international recruitment for shortage AHP areas such as radiology. The Trust has also invested in increased pastoral care to set us out as an employer of choice. A key focus at present is the recruitment of a robust medical workforce for the Weston Division. Head hunters are being actively engaged and the Trust has invested in a 6 month pilot to evaluate the need for increased pastoral care for our international medical graduates to improve onboarding experience and reputation / employer brand.

This risk is linked to strategic 2642 (Estate Modernisation), strategic 2741 (Research), strategic 5277 (Education Strategy), strategic 5369 (Weston), corporate 920 (Drs in training).

2694	**Risk that Trust is unable to retain members of the substantive workforce**	12

Workforce

Following the publication of the National Staff Survey 2021 results in March 2022 a programme of work to set out the governance and delivery of organisational and local priorities has been mobilised across the Trust, in order to strategically address the focus on the delivery of improved measures and actions that will have the greatest impact on staff experience.

The feedback from the survey identified two main areas of the people promise as a priority:

- We are always learning: a focus on appraisal
- We work Flexibly: work life balance and opportunities for flexible working patterns

The corporate response to the staff survey is based on the reported bottom and most declined question level scores therefore priority programmes of work are:

- Appraisal- developed into an OD priority with a detailed plan that sits in risk 2639
- The opportunities for flexible working patterns to be developed as a key workstream within the new recruitment and retention group which has its inaugural meeting in July, and progress against this group will be reported into People and Education Group and People Committee as part of the newly developed business cycle.
- Not enough staff in the organisation to enable colleagues to do their job properly - several workstreams are enabling this to be improved as part of the People Strategy and progress against this work will be reported into PEG and People Committee as part of the newly developed business cycle.

In support of mitigating this risk the newly developed People Strategy serves as the guiding document for the delivery of objectives and measures for the organisation, people team, and local divisional action plans. The People Strategy has been developed alongside the emerging patient first programme to ensure alignment and a shared vision is created in support of both programmes being as successful as possible and all aligned to the above governance.

Organisational Development (OD) has worked with each divisional HRBP/Deputy HRBP to support the development of the plans and provide expert advice, aligning organisational priorities and determining any local intervention OD support required. The action plans set out the divisional priorities and actions from feedback in from staff survey data, and includes aligning to organisational and Divisional plans, utilising KPI measures of success.

This risk is linked to corporate 737 (Recruitment), corporate 2639 (Appraisals), corporate 2741 (Research), strategic 5277 (Education), corporate 920 (Drs in training).

5277	**Risk that the objectives of the Trust wide multi-disciplinary education strategy are not delivered**	9
⇔	The Education Strategy is under review. Risks to achieving the revised strategy will be re-assessed once ratified.	
416	**Risk that the Trust fails to fund the Trust's Strategic Capital Programme**	15
⇔ Financial	A revised break-even 2022/23 financial plan was submitted to NHSEI on 20 June 2022 compared with the deficit 2022/23 financial plan of £13.3m submitted on 28 April 2022. The three-year system revenue funding envelopes have been delayed meaning further work to refresh the Trust's five-year revenue long term financial strategy has been postponed to November as agreed by the Finance & Digital Committee in May 2022. *This risk is linked to strategic 2642 (Estate Modernisation), strategic 5317 (ICS Implementation), corporate 674 (High-Cost Agency), corporate 423 (Capacity).*	
2741	**Risk that Research and Innovation is not adequately supported**	9
⇔ Financial	Clinical vacancies in some services that support research are impacting on the setup of new studies and the ability to deliver some active studies. This means that new study setup may be delayed or stalled, and we may need to suspend some active trials if there is not capacity to support. The Portfolio is under regular review and there is no immediate change to the risk score.	
2633	**Risk that Trusts IM&T Systems fail to deliver the required levels of efficiencies**	8
⇔ Quality	A revised Digital Hospital Programme Plan has been presented to Digital Hospital Programme Board. The Board agreed to significant points regarding the way forward for Speech Recognition to support the capture of better information as well as dictation for clinical communications, and for the acquisition of Medicines Management (formerly EPMA) through the adoption of Careflow Medicines Management. Digital Services are confident they have capacity to deliver the programme within existing resources. But there is concern that the clinical areas will not have capacity to support the rollout of new clinical software, which will impact the Trust's ability to release the potential efficiencies from the new IT Software. The programme is awaiting the outcome of the OPP process to see if additional investment is available to support clinical engagement with the programme. Projects are underway to back scan the Children's Hospital and Eye Hospital medical records and resource day forward scanning in these areas. This will increase the overall percentage of medical records available electronically. But a substantial amount of the Trust is still relying on paper. Any further long-term investment in increasing scanning capacity is dependent on the OPP process. Digital Services has been asked to provide an update on the situation across the Trust's medical record libraries, including the Dental Hospital Library, which is full. Ultimately, efficient interaction with the medical record will be achieved through the transition from paper records and scanning to direct entry of patient information into CareFlow. To that end a project to rollout Outpatient digital communications is currently in initiation. *This risk is linked to corporate 793 (Work Related Stress), strategic 2992 (Transformation), corporate 3115 (Clinical Information).*	

3472	Risk that the Trust fails to make a positive impact on combatting climate change	10
Environmental	ICS Green Plan consultations with Primary Care, Transport, Procurement have started. The Greener Together staff sustainability engagement programme launched in April with a webinar. The funding bid for an air quality monitoring project with University of Bristol was successful. The SW Greener NHS funded Warpit software for reuse of furniture has already paid for itself. A successful supplier engagement day with Ecoquip+ sustainable waste management was jointly held with NBT and NHSE&I. The Bristol precinct has been de-steamed, saving 1700 tonnes of CO2 and £400k of gas. An Energy & Sustainability apprentice has started. WECA funding has been awarded for 3 cargo bikes tested with Digital Services and CSSD staff and news coverage. The Trust's energy broker consultancy has been extended for a further 3 years. A Sustainability Impact Assessment was completed for Healthy Weston II. A Travel website has been launched with public and staff information covering travel and the clean air zone.	

Closed Strategic Risks	
2646	**Risk that the Trust has insufficient leadership capacity**
Workforce	People Committee supported the closure of this risk as part of re-setting the People risks in light of the new People Strategy.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Trust Board of Directors in Public on Tuesday 9th August 2022

Reporting Committee	**Quality and Outcomes Committee – Meeting held 26 July 2022**
Chaired By	**Julian Dennis, Non-Executive Director**
Executive Lead	**Mark Smith, Deputy Chief Executive and Chief Operating Officer** **Deirdre Fowler, Chief Nurse and Midwife** **Stuart Walker, Medical Director**

For Information

Clinical and Service Quality Compliance and Performance.

Mark Smith, Deputy Chief Executive and Chief Operating Officer, told the committee that because the Integrated Quality and Performance Report (IQPR) had grown so much, further revision and rationalisation of the report was now underway. This revision was also timely and necessary because of the new NHS Single Oversight Framework recently published.

It was noted that there has been an increase in Clostridium difficile infections, 3 of which at Weston General Hospital appeared to be linked. An increase in hand hygiene audits had been implemented and a review of these infections was underway.

The CQC had to postpone their visit to Weston General Hospital because of illness, however, Health Education England did visit and it was very positive with sanctions being lifted and the likelihood of junior doctors being reinstated into training posts later in the year.

Philip Kiely, Deputy Chief Operating Officer, presented an excellent paper, updating the Trust's position on the restoration of outpatient services and also answering a number of queries concerning patient appointment letters, particularly associated with the eye hospital. Good progress had been made in restoring outpatient services. However, there remained problems with the estate (poor accommodation, small outpatient areas) and a distributed model of outpatient appointment management, which was now being reviewed. Concern with multiple patient letters had been an issue for some time and was a consequence of how Careflow (Medway), the patient administration system, was configured. Because it was normal for patients attending appointments at the eye hospital to require a number of diagnostic tests before their consultation, it was usual for them to receive an appointment letter for each test. This was clearly not satisfactory or efficient and work was underway to try and amalgamate all the appointments into one letter.

The successful role out of the clinical accreditation process was reported with two wards receiving gold awards. This process was linked with Patient First and would support the improvement in patient experience and care. The NEDs would be joining the accreditation visits and it had already engendered a sense of internal competition and pride.

The progress and success of the discharge lounge was also commented on with a large increase in the timely discharge of patients, safely and successfully, from the hospital.

Benchmarking, Learning and Quality Improvement.

Sarah Dodds, Deputy Chief Nurse, presented the Monthly Nurse Safe Staffing report. Pressure remained on staffing wards to their full complement, but focus remained on ensuring that wards were safe, and recruitment and retention remained a high priority.

A paper was also presented on the implementation of NICE guidance which showed a robust and effective process. However, it was recognised that there may be a weakness in ensuring proper baseline assessments. This was being addressed.

Transfer of patients between sites was also discussed. South West Ambulance Service NHS Foundation Trust (SWAST) being under pressure and, as a result, patients having to wait extended periods before transfer, the use of other transport providers was explored. The committee was reminded of the need for a doctor to travel with severely ill patients so, in these circumstances, the choice of transport provider is limited, but other providers are being used.

Key Decisions and Actions
The Committee supported the revision and updating of the IQPR. An update on the investigation into the increase into the number of Clostridium difficile infections will be reported to the next meeting. The Committee will be kept informed of the progress with the restoration of outpatient services and the progress with improving patient clinic appointment letters.

Date of next meeting:	**26 August 2022**

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Meeting of the Trust Board of Directors in Public on Tuesday 9th August 2022

Reporting Committee	**People Committee - Meeting held 25 July 2022**
Chaired By	**Bernard Galton, Non-Executive Director**
Executive Lead	**Emma Wood, Director of People**

For Information

The meeting welcomed new NED colleagues, Roy Shubhabrata, Marc Griffiths with apologies from Gill Vickers. The Executive Team was well represented, and I was delighted that the Chief Executive was able to join for most of the meeting. It was also great to have some of the HR Business partners present.

The new style Agenda was in line with the agreed People Strategy and it's four main pillars. This meeting focussed on the Inclusion and Belonging pillar although other urgent items such as Violence and Aggression report and Patient First discussion were also Agenda items.

The 2021/2022 Health and Safety report was signed off by the Committee, having been discussed at the May meeting, but included an amendment Committee members asked to be included.

Inclusion and belonging items included a comprehensive paper on Staff Survey Action plans, Freedom to speak up report midyear report on Equality and Inclusion covering the status on WRES, WDES and Gender Pay Gap.

A Staff Survey report was discussed at length. Committee members sought assurance about the communication to staff and how well the progress is understood throughout the Trust.

Freedom To Speak Up shows a slight reduction in issues raised, but concerns were expressed about outstanding actions that have still to be completed and it was asked for a further update at the next meeting.

Committee members congratulated Charlotte on an excellent Diversity and Inclusion report. The content provided considerable food for thought and discussion. This is a mid-year report but provided an excellent stock take on where we are in terms of the key indicators highlighted in the report. Clearly more work to be done and further discussion to be held at forthcoming meetings.

The Performance Report provided an excellent snapshot on key People metrics. I complemented Emma and her team for the work undertaken to create a common set of indicators throughout the organisation. Those in red including the old favourites of appraisal compliance and mandatory training were raised again as concerns. A new approach to appraisals was outlined and the committee asked for a progress report later this year. It was noted that a review of mandatory training requirements will be undertaken this year and the committee were in agreement that the Trust needs to be very focussed on what constitutes essential mandatory training across clinical and non-clinical training as there is a risk that if too many items are included compliance may actually reduce. Two further ongoing reviews were also discussed around Flexible Working and Recruitment processes. The former is being informed by the lessons learned during the pandemic with the aim to emphasise the benefits flexible working has to the organisation

not just individuals. Recruitment processes are seen as lengthy and an impediment to securing timely appointments and the Director of People stated that improvements had already been identified.

An excellent and enlightening report on performance in the medical department was outlined by Emma Harley. It is always fascinating and levelling to hear directly from divisions on the performance within their area and the constraints and issues they face. The excellent work on reviewing Strategic and Corporate People risks was commended by the Committee and a further update was asked for.

For Board Awareness, Action or Response

There was an engaging conversation about the funding of key new roles including the commitment to recruit Trinee Nurse Associates. We are currently non-compliant with NHSE and System requirements CEO and Finance Director commented in detail on the current position and on going Executive discussions. CEO and Executive Team members were supported in their aspiration to find solutions to these vexed issue which strikes at the heart of the urgent need for future investment in our workforce.

The Equality and Diversity report gave a mid-year update and further focus on this by Board and Executive colleagues is needed to ensure a more positive outcome by year end.

Key Decisions and Actions

All the items discussed represent key people issues concerned with engaging our staff and improving wellbeing and belonging. All are essentially work in progress and updates will take place during the year and reviewed at future meetings.
Specific actions highlighted during discussions will be highlighted in the minutes of the meeting

Additional Chair Comments

I felt this was a very positive meeting and excellent papers helped to focus discussions.

Date of next meeting:	**27th September 2022**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Quality and Outcomes Committee on Tuesday 26th July 2022

Report Title	**Integrated Quality & Performance Report (IQPR)**
Report Author	**Rob Presland, Associate Director of Performance** **James Rabbitts, Head of Performance Reporting** **Anne Reader/Julie Crawford, Head/Deputy Head of Quality (Patient Safety)** **Laura Brown, Head of HR Information Services**
Executive Lead	**Overview and Access – Mark Smith, Deputy Chief Executive and Chief Operating Officer** **Quality – Deirdre Fowler, Chief Nurse/Stuart Walker, Medical Director** **Workforce – Emma Wood, Director of People** **Finance – Neil Kemsley, Director of Finance**

1. Report Summary
To provide an overview of the Trust's performance on quality and access standards
2. Key points to note *(Including decisions taken)*
Please refer to Executive Summary for an overview. This month the IQPR Appendices (CQC Rating, Explanation of Charts, COVID and Vaccination Summaries and Trust Scorecards) have been presented in a separate document.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **Assurance.**
5. History of the paper **Please include details of where paper has previously been received.**

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

We are
supportive
respectful
innovative
collaborative.
We are UHBW.

University Hospitals Bristol and Weston NHS Foundation Trust

Integrated Quality & Performance Report

July 2022

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University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: June 2022

The daily average for A&E attendances continues to exceed last financial year's volumes by 2.5% in the year date, but conversion to admission remains low in comparison, with emergency inpatients 4% below plan and 15% below the same point in June 2019 (pre-pandemic). This month the Trust has continued to experience some bounce back in elective activity following the easing of social distancing measures and the implementation of recovery plan actions, but elective inpatient activity is still suppressed compared to pre-pandemic. The main contributing factor is the impact of patients in the bed base with no criteria to reside, where in June there were an average of 182 beds lost. Improvements to flow and associated benefits anticipated from the extension of discharge to assess community capacity in the local health care system remain a critical enabler to supporting all aspects of performance recovery in 2022/23, where currently several NHS constitutional standards are not being met (*Datix Risk ID 801 - Risk that one or more standards of the NHS Oversight Framework are not met*).

In urgent and emergency care, 4 hour response times in the Emergency department was at 63.04%. Ambulance handover delays remain above the South West average and the volume of 12 hour trolley waits remains at 576 breaches, which was a small improvement of 3 fewer breaches than reported during May. The Trust Every Minute Matters Programme has launched to improve length of stay and plans are in place to improve weekend discharge and focus on quality of discharge reviews before 12pm on weekdays. Community capacity is also being ramped up by October to support improvement in flow as part of system wide recovery plans.

In planned care, the Trust remains focused on interventions to reduce the volume of patients waiting over two years for treatment. At the end of June the Trust was 39 patients worse than the operating plan trajectory of 197, although the list size continues to reduce with almost a 40% reduction since February 2022. Weekly forecasting is in place as part of recovery plans to eliminate 104 week waits by the end of July 2022 (with the exception of those patients choosing to wait, or where patients require highly complex procedures). Referral to treatment time performance was 58.8% against the national 92% standard in June. Diagnostic performance remained steady in June but is still well below constitutional standard at 61.2% within 6 weeks, with endoscopy capacity being a key constraint to recover backlogs. The Trust recovery plan is targeting an improvement to 75% for combined diagnostic performance by March 2023, with an elimination of any patient waiting longer than 26 weeks.

Staffing shortages in several high volume specialities have contributed towards a deterioration in cancer performance this month, with attempts to recruit replacement permanent or locum staff unsuccessful due to national shortages. Patients waiting over 104 days for cancer treatment following GP referral for suspected cancer are within threshold, but there is increasing pressure on the waiting list over 62 days. Two week wait performance improved to 68% but there are ongoing risks to future performance due to skin and colorectal pathway capacity constraints, with options for pathway and access improvements due to be reviewed with local health care partners during July.

SPORT

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: June 2022

Safe | **Caring**

Successes	Priorities
• The Audiology department have recently been successful in gaining the Improving Quality in Physiological Services Accreditation. UKAS accredited inspections and certified activity provides reassurance that good practices are being consistently observed with quality patient outcomes at its core. • Bristol Eye Hospital Diagnostic Assessment Hub Project team have won The Future NHS Award, in the South West regional section, and were finalist in the NHS Parliamentary Awards 2022. • Thoracic Clinical Nurse Specialist team who have won the Society of Cardiothoracic Surgery Nursing and AHP Team of the year award. • A community naso-gastric feeding service for children with eating disorders has been established to enable children to be cared for in the community rather than requiring admission. • 118 new nurses are expected to join Bristol Children's Hospital in the Autumn and an increase in the nurse staffing establishment Children's ED in response to operational pressures has been agreed. • UHBW maternity services have the lowest stillbirth rate in England (HSIB quarterly review report April 2022). • Falls prevention: National Falls Audit Jan-Dec 2020-UHBW was better (81%) than the national average (76%) for completion of the multifactorial falls risk assessment.	• A Trust wide Staff Survey has been launched asking staff to tell us about their key patient safety concerns to inform the Trust's new Patient Safety Incident Response Plan to be published later on 2022/23. The survey was developed following an initial situational analysis of current key patient safety risks using a range of data sources including patient and public feedback. • The Vascular Access Group is focusing the care of invasive devices with a cross Divisional work plan, beginning with an audit of device use linked to strategies such as ANTT - aseptic non-touch technique.

SPORT

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: June 2022

Safe | **Caring**

Opportunities

- A catheter use / prevalence survey across the Trust and an audit of compliance with best practice started in June. The learning will then enable an approach to catheter management and assurance of compliance with standards of care.
- To respond to the latest report of the National Neonatal Audit Programme which shows that UHBW is a significant outlier for having a documented parental consultation within 24 hours of their baby being admitted to the Neonatal ICU.
- To implement improvements identified in the National Falls Audit Jan-Dec 2020 particularly relating to vision assessment and lying and standing BP.

Judd Emily
03/08/2022 15:27:16

Risks & Threats

- This financial year to date we have had twenty six clostridium difficile HOHA and COHA cases for 2022/23, we are currently above our trajectory for this year. It is of note that the numbers in June have seen a 50% increase, with a specific issue identified in Weston. At Weston a cohort ward has been enacted as a containment approach, with additional scrutiny.
- The numbers of COVID positive patients in our hospitals has started to rise again in June. The level of Covid in our community has also impacted staffing numbers. Additional oversight and support for nurse staffing has been required by Heads of Nursing and Deputy Chief Nurses to ensure the balance of safe staffing is achieved across the Trust.
- Maternity and neonatal staffing: Central Delivery Suite is not currently compliant with holding an evening/night consultant ward round and Neonatal ICU is an outlier from a GIRFT review for not achieving BAPM (British Association of Perinatal Medicine) staffing standards for medical and neonatal staff.
- There is an existing risk in (Risk 288) Risk that Out of Hours CAHMS service may not follow the correct pathway for children and young people current score = 12 . Medicine Division have raised this as an increasing risk due to the volume of young people being seen in UHBW adult services awaiting specialist beds due to lack of available capacity in the service.
- We are seeing an increase in Risk 3332: Risk that BEH paediatric patients assessments will be delayed due to staff shortage and recruitment delays, current score = 16.
- Continuing risk of patient harm associated with delays in patient flow and staffing in the Children's ED reflected in:
    - Risk 4638 - Risk that a seriously ill child will have a significant delay in treatment, current score =12.
    - Risk 573-risk that potential delays in the recognition of a deteriorating child in the CED waiting room will result in a poor outcome, current score =16.
    - Risk 2297 Risk that the CED nursing establishment is insufficient current score =16.
    - An increase in the nurse staffing establishment Children's ED in response to operational pressures has been agreed.

SPORT

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: June 2022

Responsive | **Effective**

Successes

- Cancer standards: the subsequent radiotherapy and chemotherapy standards were compliant in May.
- Outpatient activity levels were above 19/20 levels in June suggesting normalisation post COVID, whilst elective inpatients were also above plan in June (albeit still suppressed from volumes seen during the same month in 19/20).
- The number of patients waiting over 104 weeks has reduced by 38.9% since the peak of February 2022. There were only 17 patients remaining on the list due to capacity reasons as at 21st July 2022, with the remaining 105 patients consisting of complex cases or patients choosing to wait longer.

Judd Emily
03/08/2022 15:27:16

Priorities

- Ensuring all cancer patients are treated in a clinically safe timescale during the continued pressure on the Trust from the pandemic and its longer term impact, and to recover the 'ongoing' position of patients waiting <62 days on a GP suspected cancer pathway to pre-pandemic levels.
- Following NHSE's Intensive support team review the following actions are in progress:
  - Validation of 2,803 e-RS 180 day drop off back log. Divisions to book all 3,174 ASI and RAS list patients at 3 month+. All 1,337 RAS pre-triage patients to be triaged within 7 days and escalated for action within 1 month.
  - Option appraisal and business case for the validation of 15,012 patients waiting +12 months on the trust On Hold and 36,661 patients on Inactive lists.
  - Work has begun with the BI team to develop a trust non-RTT PTL.
  - Option appraisal and business case development for the validation resources to support the management of Non-RTT RTL.
- Following a recent NHSE Intensive support team visit, the patient access policy has been highlighting as requiring review. The review has commenced between UHBW, NBT and the ICB. Once finalised the UHBW internal SOP will require re-write and re-issue.

SPORT

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: June 2022

Responsive | **Effective**

Opportunities

- The Trust continues to pursue mutual aid opportunities for patients who are waiting over 104 weeks, deemed clinically appropriate and have consented for treatment elsewhere. This includes the support from the national team from NHS Improvement and NHS England. Currently the regional and national teams have been identified Gloucester NHS FT (GHFT) as suitable, five patients have been deemed suitable for transfer and we await confirmation of TCI dates.
- UHBW has identified capacity externally through their own conversations for 17 patients to be treated at other providers (Plymouth (Paediatrics) and Nuffield (dental) and will use capacity at Weston for five Colorectal patients.
- Launch of the Every Minute Matters programme to reduce inpatient length of stay.
- ED Streaming Tool in Bristol Royal Infirmary to be launched late July to support redirection of minor illness/injury redirection to GPs, Urgent Treatment Centres and community pharmacy

Risks & Threats

- A challenge to flow is the high numbers (over 100 per day) of patients who are medically fit for discharge (MFFD) but whose discharge is delayed due to the lack of system capacity to support their social care needs out of hospital.
- Continued risk that community phlebotomy non-recurrent posts will not be funded through system funding or planning rounds. This has the potential to add further operational pressure to specialities.
- There is an ongoing impact on cancer waiting time standard compliance due to the pandemic, system emergency pressures, rising demand, and staffing shortages in areas where it is also difficult to recruit. Very high Covid sickness in multiple teams in June and July has also impacted. These issues particularly affect cancer pathway patients at low clinical risk from delay. (Datix Risk ID 42).
- There is a risk that the trust will not achieve the 104ww breach position of 105x patients waiting for treatment at the end of July due to the increase in Covid positive cases. This is affecting both staffing levels and the volume of patients who are testing positive, both of which result in “to come in” (TCI) dates to be cancelled
- There is a risk of increasing appointment slot issues (ASIs) where patients are unable to find a bookable appointment in outpatients due to capacity constraints. Options for improvement including demand management alternatives are being considered in areas such as ENT and Dermatology. The Trust has also implemented an action plan following the recommendations received to support recovery from the NHS Elective Care Intensive Support Team.

Dashboard

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: June 2022

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	P
	Pressure Injuries	Y
	Medicines Management	Y
	Essential Training	N
	Nurse Staffing Levels	N/A
	VTE Risk Assessment	N
Caring	Patient Surveys	Y
	Friends & Family Test	N/A
	Patient Complaints	N

CQC Domain	Metric	Standard Achieved?
Responsive	Emergency Care - 4 Hour Standard	N
	Delayed Discharges	N/A
	Referral To Treatment	N
	Referral to Treatment – Long Waits	N
	Cancelled Operations	N
	Cancer Two Week Wait	N
	Cancer 62 Days	N
	Cancer 28 Day Faster Diagnosis	N
	Diagnostic Waits	N
	Outpatient Measures	N
	Outpatient Overdue Follow-Ups	N
Effective	Mortality (SHMI)	Y
	Mortality (HSMR)	N
	Fracture Neck of Femur	N
	Mixed Sex Accommodation	Y
	Maternity Services	N/A

CQC Domain	Metric	Standard Achieved?
Well-Led	Staffing Levels – Agency Usage	N
	Staffing Levels – Turnover	P
	Staffing Levels – Vacancies	N
	Staff Sickness	Y
	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

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

N *Not Achieved*

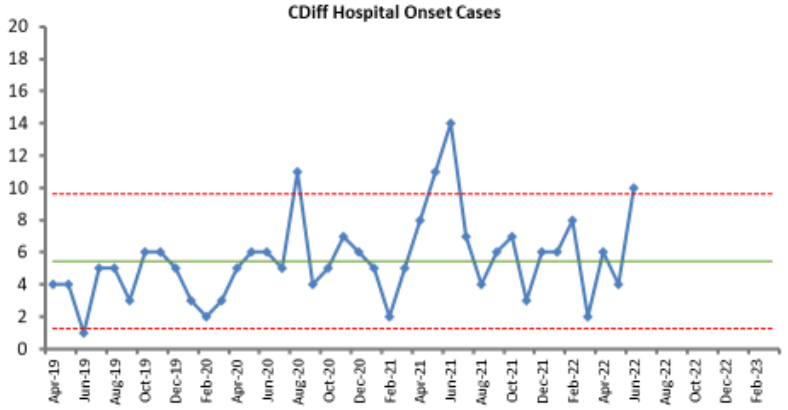
Standards:	For this section, two measures are reported: Healthcare Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA). HOHA cases include patients where C.Difficile is detected from Day 3 after admission. COHA cases include patients where C.Difficile is detected within 4 weeks of discharge from hospital. Healthcare Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA) CDifficile cases are attributed to the Trust. The limit of Clostridium Difficile cases for 2022/2023 as set by NHS England is 89. This limit will give a trajectory of approximately 7.4 cases a month.
Performance:	There were twelve cases of C-Difficile, of which ten were identified as HOHA in UHBW in June 2022, with two COHA cases reported. Each case requires a review by our commissioners before determining whether it will be Trust apportioned if a lapse in care is identified.
Commentary:	Underlying issues • Post infection reviews for C-Difficile cases continue, noting the increased incidence. • The C-difficile review process with the Integrated Care System (ICS) has begun. The learning approach is evolving for C-difficile case management. • Sluice and commode auditing has been re-established and formal environmental auditing has been scheduled across the clinical areas within the Trust, led by Infection Prevention and Control (IPC) Team. Actions taken: • Ongoing collaboration with the ICS as an improvement collaborative. Information sharing about learning across organisations within this Integrated Care System (ICS) has begun with summary data and key learning involving North Bristol Trust, Sirona and Avon & Wiltshire Mental Health Partnership (AWP). The first meeting has now taken placed as a shared learning forum chaired by the ICS. • The regional collaborative with NHSE/I support equally continues which underpins directly the work with the CCG. • At Weston a C-difficile cohort ward has been enacted as a containment approach, with additional scrutiny. • A trust wide IPC link practitioners learning event is planned in July focusing on C-difficile, first session already delivered.
Ownership:	Chief Nurse

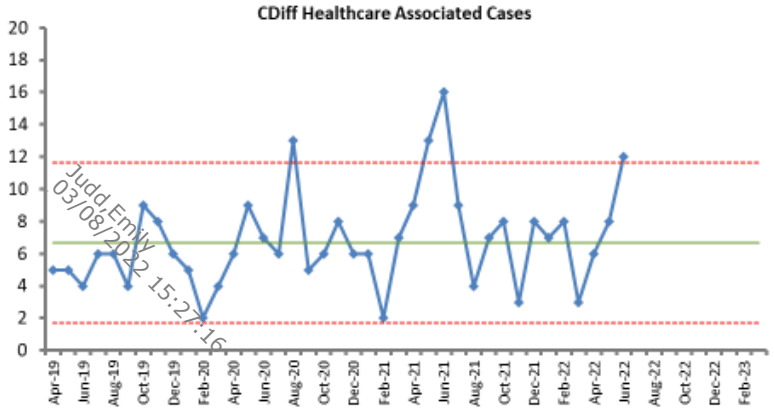
	Jun-22		2022/2023		2021/2022	
	HA	HO	HA	HO	HA	HO
Medicine	3	3	7	6	32	31
Specialised Services	0	0	1	1	16	12
Surgery	1	1	4	3	13	13
Weston	6	6	8	8	19	14
Women's and Children's	1	0	4	2	12	12
Other	1	0	2	0	3	0
UHBW TOTAL	**12**	**10**	**26**	**20**	**95**	**82**

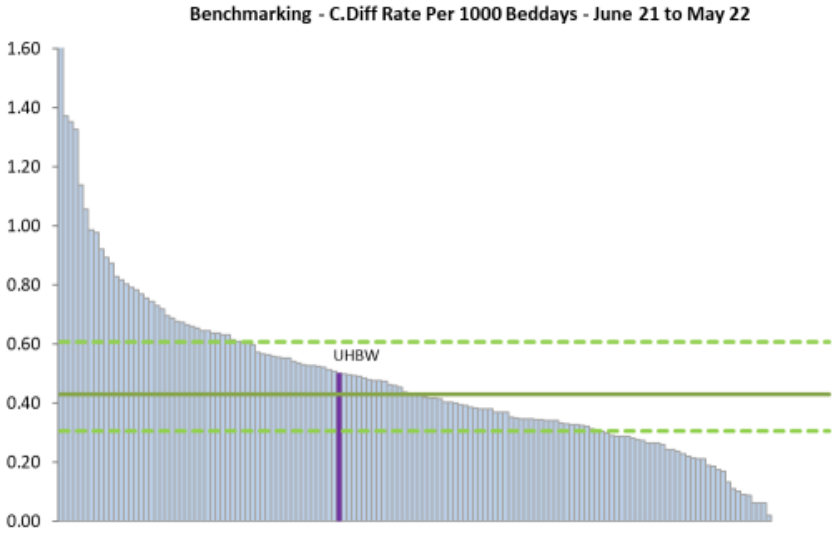
HA = Healthcare Associated, HO = Hospital Onset

Infection Control – C.Difficile

June 2022







Infection Control - MRSA

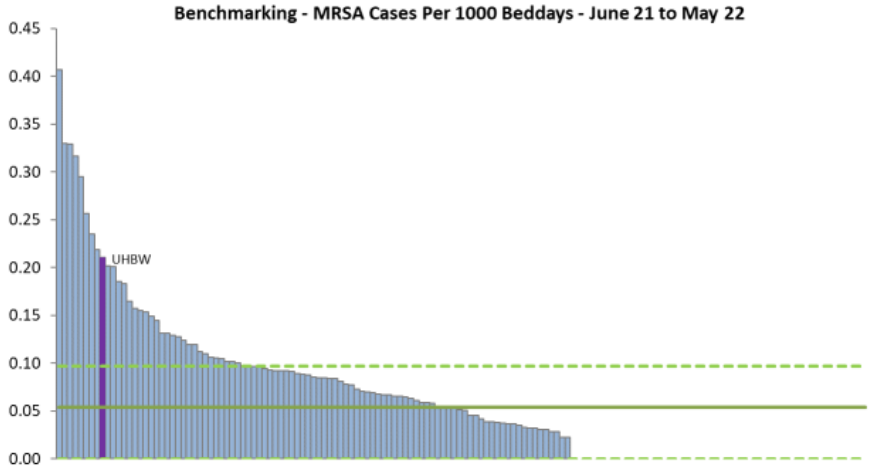
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

Y *Achieved*

Standards:	The standard is to have zero Trust Apportioned MRSA cases. This is Hospital Onset cases only.
Performance:	There have been no trust-apportioned MRSA cases in June 2022. As such there have been no cases of MRSA bacteraemia in UBHW reported in the year to date 2022/23.
Commentary:	Policies and guidelines need to be refreshed to be aligned across the organisation including screening requirements. There is an ongoing focus on indwelling vascular device management and a focus on improvements in care. Actions taken: • The Vascular Access Group is evolving and refocusing attention and the care of invasive devices with a cross Divisional work plan, beginning with an audit of device use linked to strategies such as ANTT - aseptic non-touch technique. • Collaboration with the monitoring of vascular devices in situ has progressed.
Ownership:	Chief Nurse

	Jun-22	2022/2023	2021/2022
Medicine	0	0	6
Specialised Services	0	0	0
Surgery	0	0	0
Weston	0	0	0
Women's and Children's	0	0	1
Other	0	0	0
UHBW TOTAL	**0**	**0**	**7**



Infection Control – E. Coli

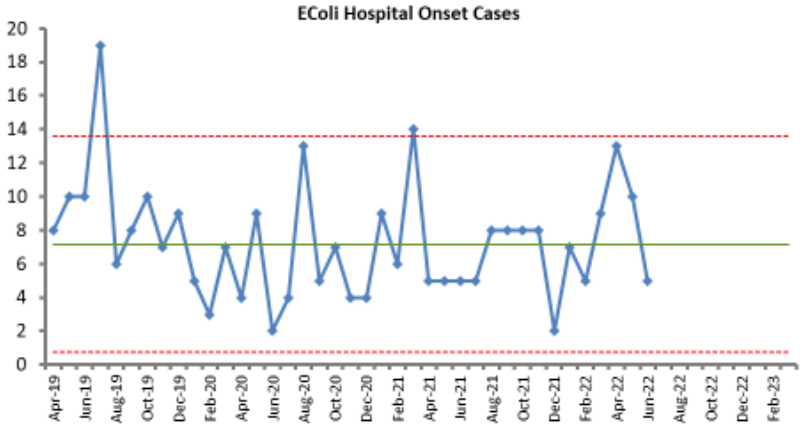
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

Y *Achieved*

Standards:	Enhanced surveillance of Escherichia coli (E.coli) bacteraemia is mandatory for NHS acute trusts. Patient data of any bacteraemia 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 bacteraemia are 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. An annual limit of E.coli cases has now been confirmed with NHS England as 119 for 2022/23. This would give a trajectory of approximately 9.9 cases per month.
Performance:	There were five Hospital Onset cases in June 2022. This gives 28 cases year to date.
Commentary:	The community prevalence of E.coli cases has been noted to be increasing throughout this year. Of the five cases in June: • Intravascular device was identified as the potential source of E. coli bacteraemia in one of the cases. • The potential source of infection for one of the cases was lower urinary tract. • The potential source of infection for one of the cases was gastrointestinal or intraabdominal collection. • The potential source of infection for one of the cases was lower respiratory tract. • The source of infection for the other case has not been identified. 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 started in June. The learning will then enable an approach to catheter management and assurance of compliance with standards of care.
Ownership:	Chief Nurse

	Jun-22	2022/2023	2021/2022
Medicine	3	10	19
Specialised Services	0	5	16
Surgery	1	8	15
Weston	1	2	18
Women's and Children's	0	3	7
Other	0	0	0
UHBW TOTAL	**5**	**28**	**75**



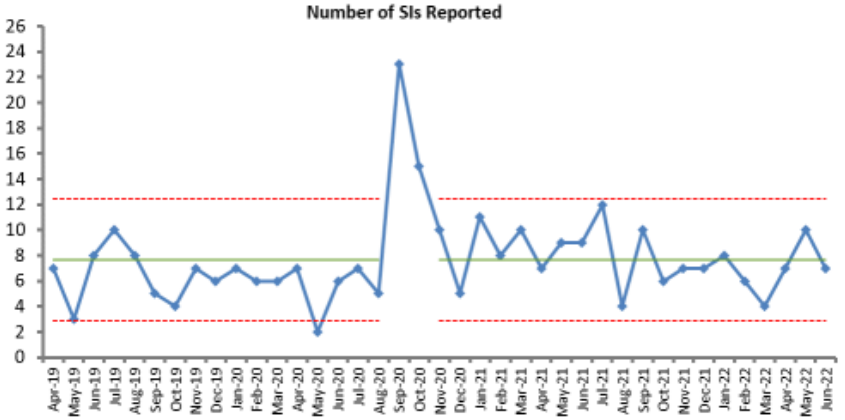
Serious Incidents (SIs)

June 2022

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.
Latest Data:	Seven serious incidents (SI's) were reported in June 2022: Three SI's declared were in the Women's & Children's Division, two in Specialised Services Division, one in Weston Division and one as a combined investigation for Surgery and Medicine. These serious incidents comprised: Three maternity obstetric incidents, two treatment delay and two slip trip and falls. There were no new Healthcare Safety Investigation Branch (HSIB) maternity investigations or Never Events declared in June 2022.
Commentary:	In 2022/23, the new Patient Safety Incident Response Framework is to be implemented and an initial scoping exercise including stakeholder workshops and a situational analysis to identify Patient Safety priorities in the organisation are underway. A PSIRF project manager has commenced in post in June 2022. 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

	Jun-22	2022/2023	2021/2022
Medicine	0	2	29
Specialised Services	2	2	8
Surgery	0	4	9
Trust Services	0	0	0
Weston	1	9	22
Women's and Children's	3	6	19
Other/Multiple Divisions	1	1	1
TOTAL	**7**	**24**	**88**



Harm Free Care – Inpatient Falls

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

P *Partially Achieved*

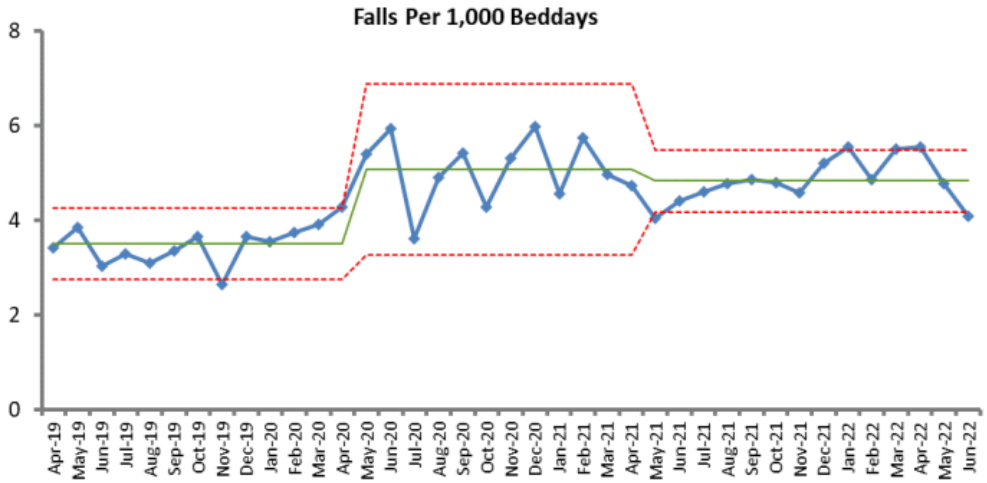
Standards:	To reduce and sustain the number of falls per 1,000 bed days below the UHBW threshold of 4.8 and to reduce and sustain the number of falls resulting in moderate or higher level of harm to two or fewer per month.
Performance:	During June 2022, there were 132 falls across the Trust, which per 1000 beddays equates to 4.09. There were 87 on the Bristol sites and 45 at Weston site. There were four falls with harm, one at Weston and three at the Bristol site - all were major harm.
Commentary:	The number of falls across the Trust reduced in June to below the threshold of 4.8 per 1000 beddays. However, the numbers of falls with harm remains consistent. The ongoing operational pressures, staffing levels and increased dependency of patients, all contribute to the ongoing falls risk. There are continued requirements for patients to have enhanced care, particularly levels 3 & 4. Current staffing challenges have impacted on these shifts being filled; with wards managing these complex patients within their existing numbers. Actions taken: • Wards and Divisions have falls on the respective risk register. It also remains on the Trust risk register. • The Dementia, Delirium & Falls team will be operating under reduced capacity for the next 3-4 months. The Band 7 nurse retired at the beginning of July and the Band 8a / Lead is moving to a new post at the end of July. Recruitment to the two posts is underway, with the posts expecting to be filled in the Autumn. Work is underway also to develop a Band 7 post at the Weston site, which will sit under the team. • There was a Trust wide Dementia Action week at the beginning of July. Activities took place on numerous wards, including musicians, craft activities. This was well received by both patients and staff. There were opportunities to link falls prevention with dementia / delirium care. Several wards introduced new information boards to reflect the principles of #endpjparalysis and the importance of own footwear. Discussions about longer term projects to engage patients in activity are underway, including use of volunteers and the Arts team. • The Bed Rails Standard Operating Procedure and Risk Assessment has been updated; to include trollies. It has been agreed, with minor changes, by the Falls & Dementia Steering group and will go to the next group imminently. It is anticipated that it will be able to be rolled out in September.
Ownership:	Chief Nurse

Harm Free Care – Inpatient Falls

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

	Jun-22	
	Falls	Per 1,000 Beddays
Diagnostics and Therapies	3	-
Medicine	51	6.80
Specialised Services	15	2.88
Surgery	14	3.08
Weston	45	5.50
Women's and Children's	3	0.45
Other/Not Known	1	-
TRUST TOTAL	**132**	**4.09**
Bristol Subtotal	*87*	*3.61*



Harm Free Care – Pressure Injuries

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

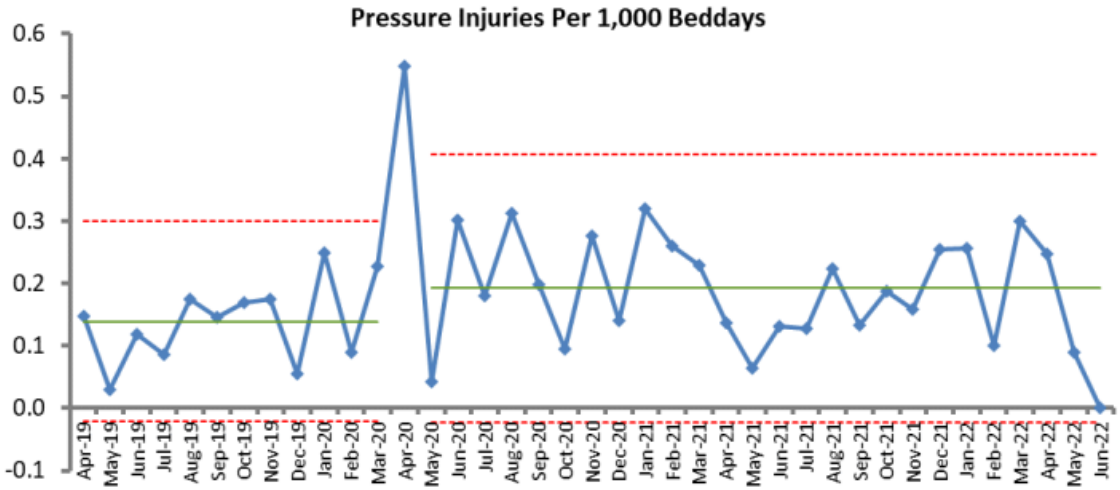
Y *Achieved*

Standards:	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. The Tissue Viability Team has agreed that these will be reported as Category 3 pressure injuries within this measure. The aim is to reduce and sustain the number of hospital acquired pressure injuries per 1,000 beddays below an improvement goal of 0.4. In addition there should be no Category 3 or 4 injuries.
Performance:	During June 2022, the rate of pressure injuries per 1,000 bed-days was 0.093 across UHBW. Across UHBW there were a total of two Category 2 pressure injuries. Both injuries occurred in Weston Division (sacrum and heel). Lack of documented skin checks and delay in commencing Pressure Ulcer Care Plan were themes identified with these injuries. There was one unstageable pressure injury in Surgery Division which was reported via SIRONA. This injury had been validated as a hospital acquired suspected deep tissue injury (Natal cleft) which evolved into an unstageable injury post discharge. An RIR investigation is underway within the Division.
Commentary:	The number of category 2 injuries in June, as with May remained significantly lower than previous months. Areas of success have been noted over the last month. ED have successfully rolled out inflatable trolley toppers which aid pressure relief and will be used for patients undergoing long ambulance waits who are at high risk of developing pressure injury. In Weston Division the monthly pressure ulcer refresher sessions continue to be well attended by ward staff from across the division. Actions (all sites): • Continued 15-minute micro teaching sessions offered to staff: tailored 1:1 sessions on the ward for individual staff members or small groups. • Implementation of Repose Trolley-toppers in Bristol and Weston ED's to reduce risk of pressure damage in high-risk patients undergoing long ambulance waits. • Key themes disseminated via monthly TV Newsletter and UHBW Twitter account. Weston Specific Actions: • Tailored tissue viability training sessions booked with Weston ED to support them with first line dressing choices and to re-emphasise the importance of timely skin checks and documentation of skin damage on admission to ED. • Face to face monthly one hour pressure ulcer training sessions for staff across all wards. • Ongoing Division wide ward based Linet pressure relieving mattress education and training delivered by Linet Clinical Advisor.
Ownership:	Chief Nurse

Harm Free Care – Pressure Injuries

June 2022

	Jun-22	
	Injuries	Per 1,000 Beddays
Diagnostics and Therapies	0	-
Medicine	0	0.00
Specialised Services	0	0.00
Surgery	1	0.22
Weston	2	0.24
Women's and Children's	0	0.00
Other/Not Known	0	-
TRUST TOTAL	**3**	**0.093**
Bristol Subtotal	*1*	*0.04*



Medicines Management

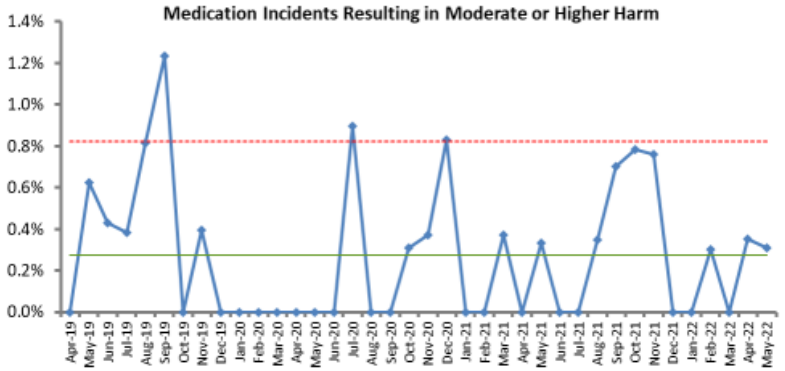
University Hospitals Bristol and Weston NHS Foundation Trust

May/June 2022

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:	There was 1 (0.31%) moderate harm incident out of 324 reported medication incidents in May. There were 2 (0.65%) omitted doses of critical medicines out of 310 patients audited in June.
Commentary:	The moderate harm incident related to an infusion injury in a neonate. The infusion was immediately interrupted and medical review occurred. Photographs of the infusion injury were taken. Of the reported omitted doses of critical medicines, one was an unintentional omission of an anticoagulant. It was identified prior to the next dose that the dose had not been given, but the dose was held in order that the next due dose which was due imminently could be given on time. The second omitted dose related to an antiepileptic which was not available on the ward. The medicine was ordered urgently and administered later in the day. Actions taken: • Advice given regarding scheduling of omitted dose of anticoagulant. • Medicine ordered urgently and dose administered later in the day.
Ownership:	Medical Director

	May-22		
	Moderate or Higher harm	Total Audited	Percentage
Diagnostics and Therapies	0	21	0.0%
Medicine	0	59	0.00%
Specialised Services	0	72	0.00%
Surgery	0	44	0.00%
Weston	0	30	0.00%
Women's and Children's	1	98	1.02%
Other/Not Known	0	0	-
TRUST TOTAL	**1**	**324**	**0.31%**



Essential Training

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

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 Q4 21/22 (March data), overall compliance for Core Skills training (mandatory/statutory) was 80% across all eleven programmes. Overall compliance for the remaining essential training (ET) topics was 81%. April saw the first increase in Core Skills compliance since August 2021, increasing to 81%. Remaining ET also increased to 82%.
Commentary:	Now, at end of Q1 22/23 (June data), overall compliance for Core Skills has improved to 83%, having risen each consecutive month since March, with improvement in each of the core skills (see below). Similarly, the remaining ET topics are also at 83%. Improved access to training through the Kallidus Learn portal and release of staff have positively impacted compliance. Two core skills remain under 80% compliance - Moving and Handling (65%), and Resuscitation (64%), although both have improved since March (see comparative table below). M&H is in focus at present, looking at all aspects of provision and possible further improvement.
Ownership:	Director of People

	March 2022 compliance	June 2022 compliance	Improvement
1. Equality, Diversity and Human Rights	90	92	+2
2. Fire Safety	79	85	+6
3. Health, Safety and Welfare	89	91	+2
4. Infection Prevention and Control	79	84	+5
5. Information Governance	75	80	+5
6. Moving and Handling	64	65	+1
7. NHS Conflict Resolution Training	85	88	+3
8. Preventing Radicalisation	88	90	+2
9. Resuscitation	62	64	+2
10. Safeguarding Adults	84	87	+3
11. Safeguarding Children	83	88	+5

Nurse Staffing Levels

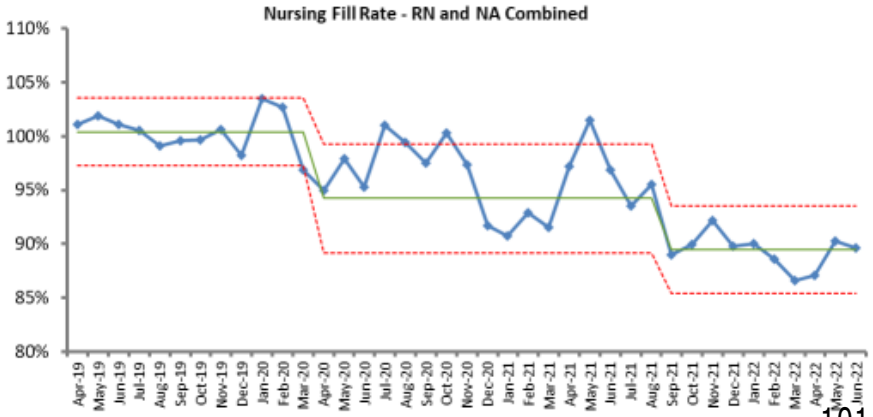
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

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 June 2022 (for the combined inpatient wards) the Trust had rostered 305,839 expected nursing hours, against the number of actual hours worked of 274,066 giving an overall fill rate of 90%
Commentary:	Underlying issues: • Wards continue to work at staffing levels below their agreed establishment throughout June with fill rates across all shifts slightly down on May. • The international recruitment programme continues to bring in new recruits each month at pace, with a high number currently in the non-registered workforce numbers awaiting completion of their induction programmes. • The impact on staff well-being is evident, the numbers of COVID patients has started to rise again in June. The level of community Covid has also impacted on staffing numbers. To balance the risk, staff continue to be moved from their base wards at very short notice and are moved to cover other wards and support the ED queue when necessary. • There was a marginal increase in Band 5 RN vacancy levels from 15.4% to 15.7% with turnover increasing slightly to 18.0% across the Trust. • In June there was an increase in staff sickness due to COVID- 19 transmission, this follows a similar pattern seen last year. Actions taken: • Additional oversight and support for nurse staffing has been required by Heads of Nursing and Deputy Chief Nurses to ensure the balance of safe staffing is achieved across the Trust. • The agreed incentive for some specialist areas have now ceased at the end of June. The impact of this is being closely monitored by Divisions. • Updated the staffing tools to provide a clearer oversight of staffing pressures on both the Weston and Bristol sites.
Ownership:	Chief Nurse

Staffing Fill Rates	Jun-22		
	Total	RN	NA
Medicine	100.8%	99.7%	102.2%
Specialised Services	94.1%	88.8%	109.8%
Surgery	90.0%	84.8%	102.9%
Weston	93.2%	87.3%	100.0%
Women's and Children's	77.5%	79.5%	68.2%
TRUST TOTAL	**89.6%**	**86.4%**	**96.7%**



Venous Thromboembolism (VTE) Risk Assessment

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

N *Not Achieved*

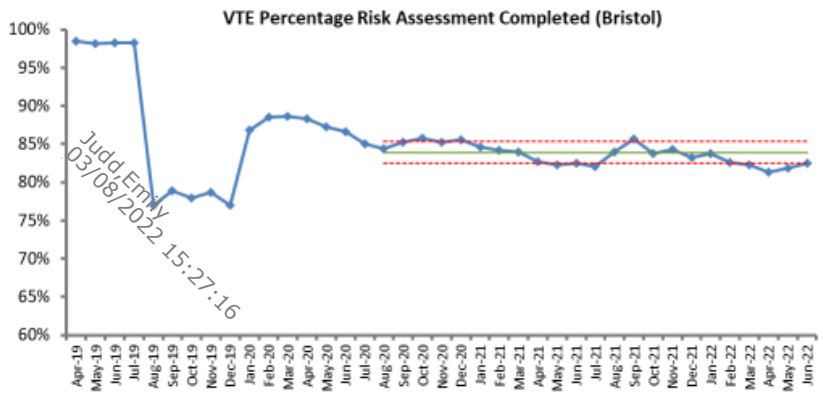
Standards:	Venous Thromboembolism (VTE) is a significant cause of mortality and disability in England. At least two-thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and the administration of appropriate thromboprophylaxis. The expectation for UHBW was to achieve 95% compliance, with an amber threshold to 90%.
Performance:	Recent performance is relatively unchanged 82.4% (excluding Weston). Of note, BHOC compliance is >95%, Medicine 70%, Surgery 80.4% and Cardiac 70.9%.
Commentary:	Prior to August 2019, VTE risk assessments were performed on the paper drug chart in Bristol. Compliance with VTE risk assessment was monitored by a tick box that was checked by ward clerks at the point of patient discharge. Compliance appeared to be excellent with this data (consistently>95%), but when a spot paper audit was performed on adult inpatients, it was clear the data was inaccurate as only 13% of patients met the audit requirements for VTE risk assessment. Of note, this audit took 3 pharmacists 2 full days to perform and therefore, would not be a sustainable way to accurately assess compliance of paper VTE risk assessments. In addition to this audit, Electronic Prescribing and Medicines Administration (EPMA) was launched in the Heart Institute and Oncology Centre, removing the option for paper based VTE risk assessments in these areas. In discussion with digital and clinical teams, in August 2019, digital VTE risk assessment were launched and completed electronically using the Careflow Electronic Patient Record (EPR) system, formerly known as Medway. Digital risk assessment has several advantages including: 1. VTE risk assessments completed in full including name and date of person completing, 2. VTE risk assessment can be completed and accessed anywhere, even when the drug chart cannot be located, 3. VTE reassessment can easily be done without hand-written amendments, 4. Compliance data available in real time, with performance reports according to ward or speciality at the click of the button, 5. Algorithms calculate the optimal VTE prevention based on information uploaded. At the point of digital roll out, there was an expectation at the time that a fully integrated digital system was imminent, whereby VTE risk assessments would be integrated within either digital prescribing or admission, ideally with a force function to make it impossible to avoid completing. National data supports this strategy to be the most effective way to achieve consistent excellent compliance. Unfortunately, EPMA was retracted and further digital roll out plans delayed which has led to the unintended consequence of VTE risk assessment being a stand-alone process. Compliance can be improved by education, speciality specific clinician led QI projects and digital strategies to improve work flow. However, these are considered mitigation strategies rather than solutions and realistically, It is extremely unlikely that VTE risk assessment compliance will be consistently above 95% in the absence of an integrated digital system. Actions taken: • Division/Speciality/Consultant led strategies are needed to improve compliance as well as ownership of poor compliance. There is evidence within specific areas that Quality Improvement (QI) projects can improve compliance. However, sustained effort is essential to avoid standards slipping when motivated individuals move on *…continued over page*

Venous Thromboembolism (VTE) Risk Assessment

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

Commentary (continued):	• Digital Aspects of VTE compliance. Currently, electronic risk assessment sits outside of clinical workflows. This disconnect means that compliance has been challenging. The current UHBW Digital Hospital Strategy has in place plans to procure and deploy an Electronic Prescribing and Medicines Administration (EPMA) solution in the future. In addition, it has plans to roll out software which will start to link and/or mandate linking of tasks to actions. Data from multiple trusts and multiple international organisations shows that it is this mandatory completion of risk assessment before one can then proceed to other tasks (such as prescribing) which will be crucial in driving up compliance. However, whilst there are relatively firm timescales from the supplier for individual elements of the workflow, the timescales for full integration to produce the seamless workflow described above are only currently being finalised by the supplier and may well not be deployed until 2024 at the earliest. In the meantime, a piece of work will continue to refine the current electronic solution to ease of completion but a clinically led workstream will be needed to continue to emphasise the importance of this assessment • Particularly challenging areas of compliance are those with a high patient turnover, relatively short stay, sub-optimal continuity, and wards where patients belong to multiple clinical teams. Acute admissions (particularly medicine) is an area that needs particular focus • Other recent measures to raise the profile include an email from the medical director, VTE lead and patient safety lead to all medical staff as well as a patient safety bulletin release. • The Patient Safety Improvement Team are putting together a slide deck to determine the priorities for VTE improvements moving forward.
Ownership:	Medical Director



Division	SubDivision	Number Risk Assessed	Total Patients	Percentage Risk Assessed
Diagnostics and Therapie	Chemical Pathology	2	2	100.0%
	Radiology	26	26	100.0%
Diagnostics and Therapies Total		**28**	**28**	**100.0%**
Medicine	Medicine	1,577	2,253	70.0%
Medicine Total		**1,577**	**2,253**	**70.0%**
Other Division	Other Directorate	1	2	50.0%
Other Division Total		**1**	**2**	**50.0%**
Specialised Services	BHOC	2,165	2,250	96.2%
	Cardiac	336	474	70.9%
Specialised Services Total		**2,501**	**2,724**	**91.8%**
Surgery	Anaesthetics	11	11	100.0%
	Dental Services	80	117	68.4%
	ENT & Thoracics	251	346	72.5%
	GI Surgery	924	1,147	80.6%
	Ophthalmology	149	151	98.7%
	Trauma & Orthopaedics	130	149	87.2%
Surgery Total		**1,545**	**1,921**	**80.4%**
Women's and Children's	Children's Services	24	33	72.7%
	Women's Services	1,285	1,482	86.7%
Women's and Children's Total		**1,309**	**1,515**	**86.4%**
Grand Total		**6,961**	**8,443**	**82.4%**

Friends and Family Test (FFT)

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

N/A ***No Standard Defined***

Standards:	The FFT question asks "Overall, how was your experience of our service?". The Trust collects FFT data through a combination of online, postal survey responses, FFT cards and SMS (for Emergency Departments and Outpatient Services). There are no targets set.
Performance:	The Trust received 4,540 FFT responses from patients in June 2022, which represents a similar number of responses received in May (4,675). FFT scores for inpatients, day cases, maternity and outpatients are extremely positive (all 90% and above) and broadly consistent with May figures; In terms of ED FFT performance in June 2022: • Bristol Royal Infirmary score has increased to 79% (from 71% in May); • Weston ED reports a score of 81%, a decrease from the score of 86% in May; • Children's Hospital ED score has seen an increase to 87% (from 82% in May); • Eye Hospital ED score remains high at 96% (from 94% in May).
Commentary:	In response to the lower than (long-term) average FFT scores for the BRI ED and Weston ED, weekly reports are sent from the Patient Experience Team to ED divisional leads with their FFT data for the previous week. This results in the data being reviewed in a timelier manner which supports with identifying opportunities for improvements.
Ownership:	Chief Nurse

		Positive Response	Total Response	Don't Know	Total Eligible	% Positive	Response Rate
Inpatients	UHBW	730	791	23	2,965	95.1%	26.7%
Day Cases	UHBW	364	370	1	2,330	98.6%	15.9%
Outpatients	UHBW	2,236	2,381	36		95.4%	
A&E	BRI	212	270	1	4,317	78.8%	6.3%
	BRHC	229	262	0	3,468	87.4%	7.6%
	BEH	136	143	1	2,077	95.8%	6.9%
	Weston	201	247	0	3,126	81.4%	7.9%
	UHBW	778	922	2	12,988	84.6%	7.1%

		Positive Response	Total Response	Don't Know	Total Eligible	% Positive	Response Rate
Maternity	Antenatal	30	30	0	193	100.0%	15.5%
	Birth	17	18	0	357	94.4%	5.0%
	Postnatal (ward)	15	16	0	357	93.8%	4.5%
	Postnatal (community)	12	12	0	231	100.0%	5.2%
	UHBW	74	76	0	1,138	97.4%	6.7%

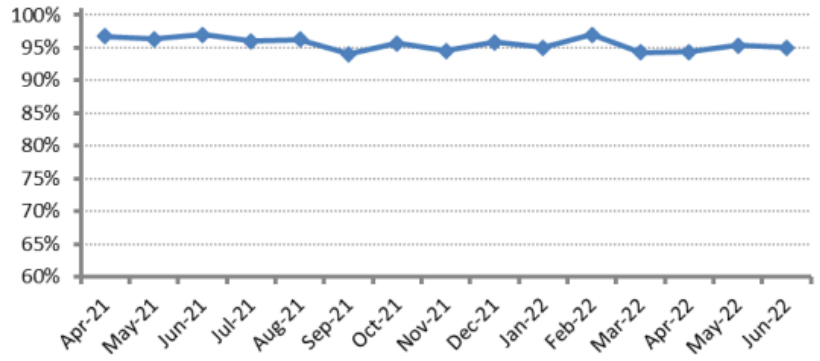
TOTAL RESPONSES	4,540

Friends and Family Test (FFT)

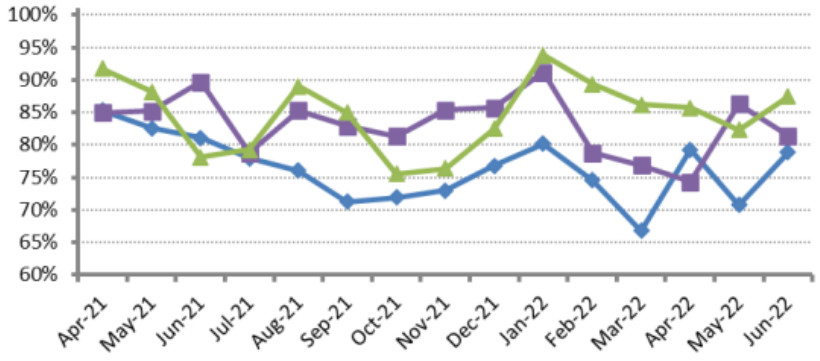
University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

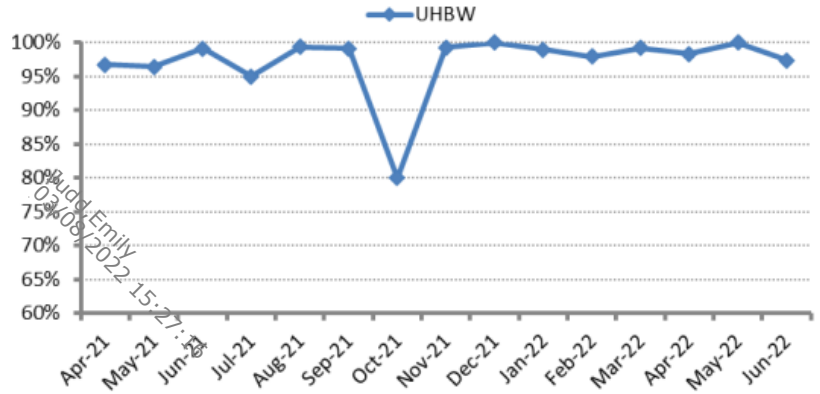
Inpatient (excluding Day Case) Scores



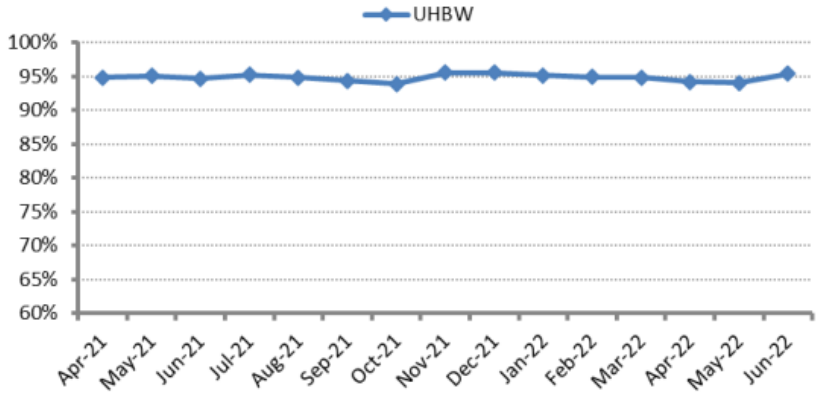
Emergency Department Scores



Maternity Services Scores



Outpatient Scores



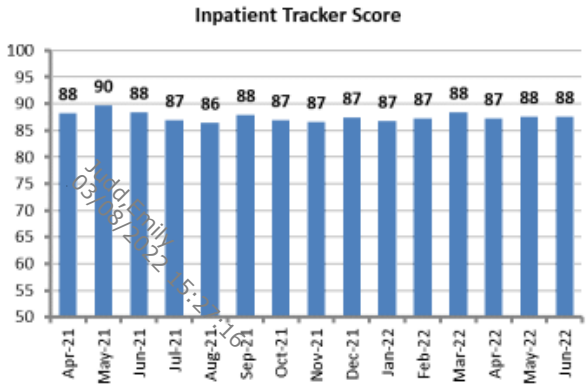
Patient Surveys

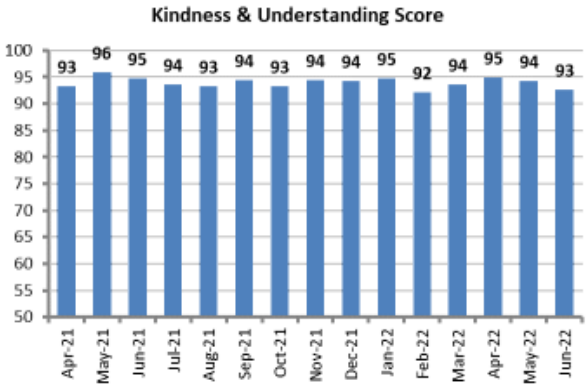
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

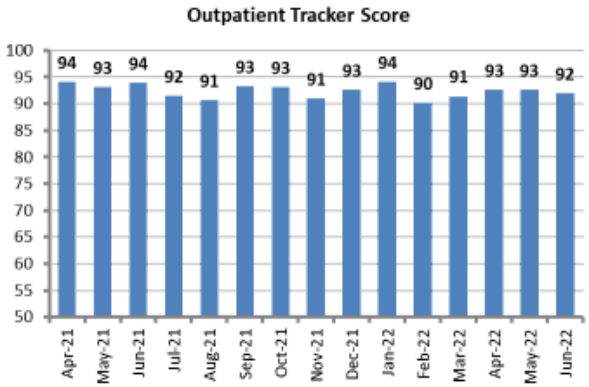
June 2022

Y *Achieved*

Standards:	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. Please note that reporting for monthly patient survey data for Bristol hospital sites and Division of Weston has been integrated from April 2022. Therefore, there is a single set of metrics for the Trust. Divisional level metrics are reported quarterly through the Patient Experience Group (PEG) and Quality Outcomes Committee (QOC).
Performance:	For June 2022: • Inpatient score was 88 (May was 88) • Outpatient score was 92 (May was 93) • Kindness and understanding score was 93 (May was 94)
Commentary:	June 2022 scores exceeded the minimum targets.
Ownership:	Chief Nurse







Patient Complaints

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

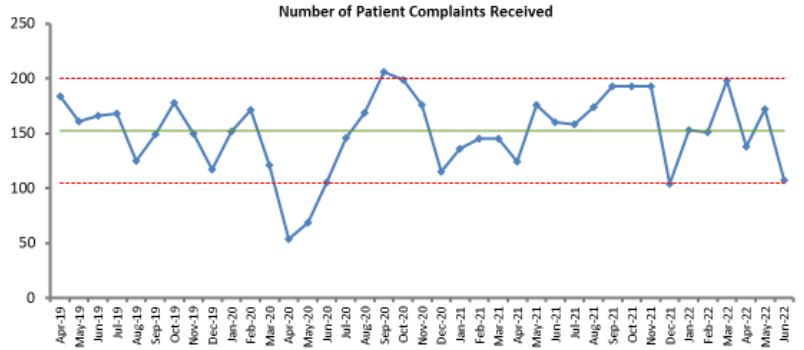
June 2022

N ***Not Achieved***

Standards:	For all complaints (formal and informal), the Trust target is for 95% of responses to be 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 June 2022: • 107 Complaints were received (10 Formal and 97 Informal). • Responses for 37 Formal and 69 Informal complaints were sent out to complainants. • 84% of formal complaints (31 out of 37) were responded to within the agreed timeframe (83.7% in May 2022). • Divisions returned 86% (32 out of 37) of formal responses to the PSCT by the agreed deadline. • 87% of informal complaints (60 out of 69) were responded to within the agreed timeframe (84.6% in May 2022). • There were six complaints where the complainant was dissatisfied with our response, which represents 10.5% of the 57 first responses sent out in April 2022 (this measure is reported two months in arrears).
Commentary:	In June 2022, the Trust sent 31 of 37 formal responses within the agreed timeframe; of the six breaches of deadline, five were attributable to the divisions and one was due to a delay during the Executive signing process. Divisions returned 86% (32 of 37) of formal responses to PSCT by the agreed deadline, which is a deterioration on the 88.4% reported in May (this is the deadline for responses to be returned to PSCT seven working days prior to the deadline agreed with the complainant). 87% of informal complaints (60 of 69) were responded to within the agreed timeframe, a slight reduction on the 87.7% reported in May. There were six complaints reported in June 2022 where the complainant was dissatisfied with the Trust's formal response, which represents 10.5% of the 57 responses sent out in April (this measure is reported two months in arrears). This is a similar percentage to the 10.7% reported in May and above the Trust's target of no more than 8% of complainants advising us that they were unhappy with our response to their complaint. NB. At the time of submitting this report, the data had not yest been validated by divisions.
Ownership:	Chief Nurse

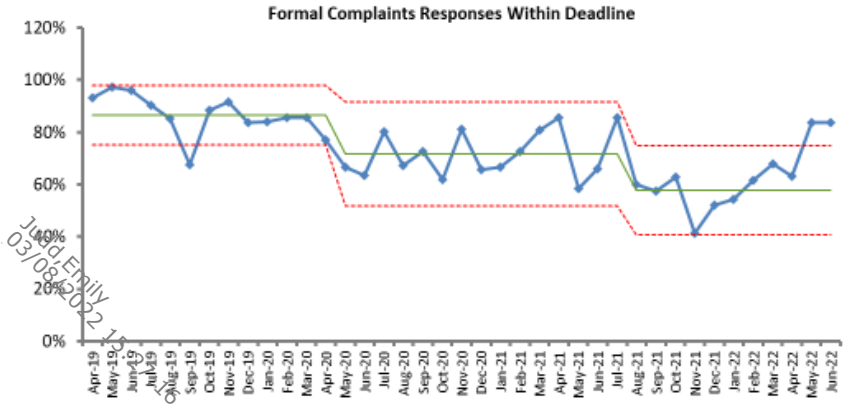
Patient Complaints

June 2022



Complaints Received

	Jun-22	2022/2023	2021/2022
Diagnostics and Therapies	8	33	103
Medicine	26	110	414
Specialised Services	15	49	260
Surgery	24	97	504
Trust Services	5	8	30
Weston	10	45	227
Women's and Children's	18	69	389
Estates and Facilities	1	6	50
TOTAL	**107**	**417**	**1977**



Responses Within Deadline	Jun-22	
	% Within Deadline	Total Responses
Diagnostics and Therapies	100.0%	1
Medicine	85.7%	7
Specialised Services	75.0%	4
Surgery	77.8%	9
Trust Services	100.0%	2
Weston	75.0%	8
Women's and Children's	100.0%	6
Estates and Facilities	0.0%	0
TOTAL	**83.8%**	**37**

Emergency Care – 4 Hour Standard

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

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. 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 June was 63.0% across all four Emergency Departments (16,528 attendances and 6,108 patients waiting over 4 hours). There were 576 patients who had a Trolley wait in excess of 12 hours in June. In June there were 2,495 ambulance handovers in excess of 15 minutes which was 75% of all handovers. In May there were 1,553 ambulance handovers in excess of 30 minutes which was 46% of all handovers.
Commentary:	**Bristol Royal Infirmary:** Performance against the 4-hour standard in June has remained at 45% with average daily attendances at 209 (vs 206 in May). There were 238 12-hour trolley wait breaches (vs 289 in May) and Ambulance handover delays were at 79:18 hours lost per day. However, there is still a challenging picture across the local health and care system. The primary drivers of breaches is a lack of inpatient flow which is constrained by the availability of supporting services in the wider health and care system as well as workforce shortages. A particular challenge is the high numbers (>100 per day) of patients who are medically fit for discharge (MFFD) but whose discharge is delayed due to the lack of system capacity to support their social care needs out of hospital. The Trust is progressing a range of initiatives to reduce overcrowding, ambulance queueing and long waits including: • Launch of the Every Minute Matters programme to reduce inpatient length of stay. • ED Streaming Tool to be launched late July to support redirection of minor illness/injury redirection to GPs, Urgent Treatment Centres and community pharmacy is fully embedded in our practice. • The Trust is also progressing redesign of clinical pathways (chest pain, surgical patients, early pregnancy) to reduce ED attendances. • Working closely with Surgery Head & Neck to embed A312 Fracture clinic, increase streaming of Maxillo Facial, ENT & T&O surgical expected patients away from ED. • Medical Same Day Emergency Care: SDEC helps avoids overnight admissions. Recruitment is ongoing to expand from 5 to 7 day service. • Escalation capacity and reverse queuing is routinely used to support the additional bed demand. *…continued over page*

Emergency Care – 4 Hour Standard

June 2022

Commentary (continued):

Bristol Royal Hospital for Children:
Performance against the 4 hour standard has slight increased to 78%. With an increase in 12 hour breaches from 8 to 19. Acuity and mental health patients remains high.

The challenges faced as a department, impacting performance are:
- Workforce shortage of nursing staff,
- Physical space in the department to see / assess patients,
- Inability to move patients out of the department due to bed flow,
- Evening surge with a high volume of patients in a short period of time, resulting in over-crowding,
- Inability to utilise The Observatory ward to maximum capacity due to nursing staff numbers,
- A recent increase of staff absence with COVID

The initiatives / programmes of work we are running to support our performance is:
- 30% uplift for Bank shifts,
- Surging to outpatients in the evening wherever possible.

There was a recent workshop with the wider system to discuss a paediatric Same Day Emergency Care (SDEC) and what this might look like. More upcoming meetings have been booked. The department are also working on our winter planning proposals.

Weston General Hospital:
Weston's performance against the 4 hour standard for June remained challenged at 57.70% (vs 56.5% in April) with a slight decrease in Emergency Department attendances. The division however seen an increase in patients requiring admission and a rise of 12 hour trolley waits at 282 in month vs 319 in May.

Key challenges:
Staffing in both medical and nursing, particularly escalation and corridor areas.
No right to reside total peaked in June to 82 patients, 30% of the Divisions bed base.
Capacity in the Emergency Department due to high volumes of patients being bedded overnight awaiting an inpatient bed.
Flow throughout the site, whilst managed IPC issues

The Division is currently working on a number of projects at the front door to further support de-escalation and redirection work ensuring patients are seen in the right healthcare setting. Redirection work is embedded and part of the normal day to day running of the department with further developments planned to take place in July where the impact will be monitored an reported.

…continued over page

Emergency Care – 4 Hour Standard

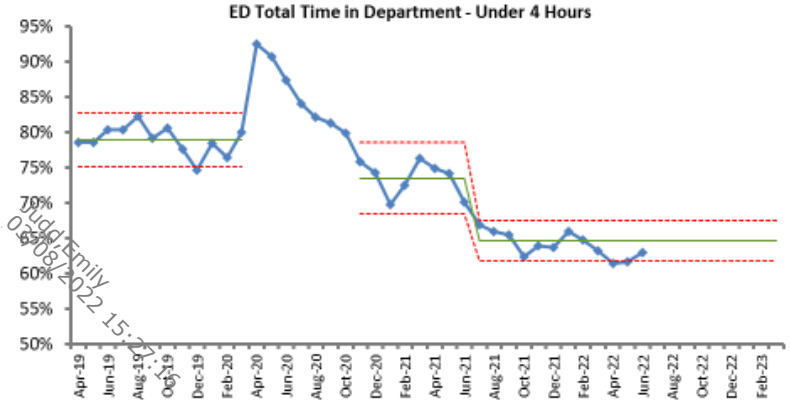
University Hospitals Bristol and Weston NHS Foundation Trust

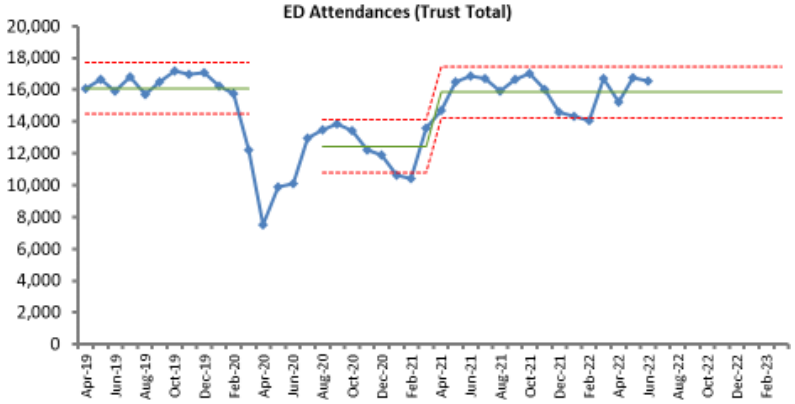
June 2022

Commentary (continued):	**Bristol Eye Hospital:** Performance in June was 96.3% with 2084 attendances. There were 77 four-hour breaches: 27 doctor delay, 31 were diagnostic delay, 18 clinical having treatment to avoid admission and 1 had transport issues for transfer. 23 of four-hour breaches were over 30 minutes to nurse triage. The department have full complement of nursing staff however the majority are very junior and need support. There are six Band 5 nurses who are training to become Ophthalmic Nurse Practitioners, this can be quite challenging at times as enough Band 6/7 nurses are needed on shift to check their work. Awaiting funding decision for permanent band 3 technicians.
Ownership:	Chief Operating Officer

4 Hour Performance	Jun-22	2022/23	2021/22
Bristol Royal Infirmary	45.26%	44.23%	50.41%
Bristol Children's Hospital	78.18%	77.88%	78.01%
Bristol Eye Hospital	96.3%	96.64%	96.96%
Weston General Hospital	57.7%	56.22%	67.28%
UHBW TOTAL	**63.04%**	**62.09%**	**66.79%**

Average Daily Attendances	Jun-22	2022/23	2021/22
Bristol Royal Infirmary	209	204	205
Bristol Children's Hospital	139	133	129
Bristol Eye Hospital	69	67	61
Weston General Hospital	134	130	126
UHBW TOTAL	**551**	**534**	**521**

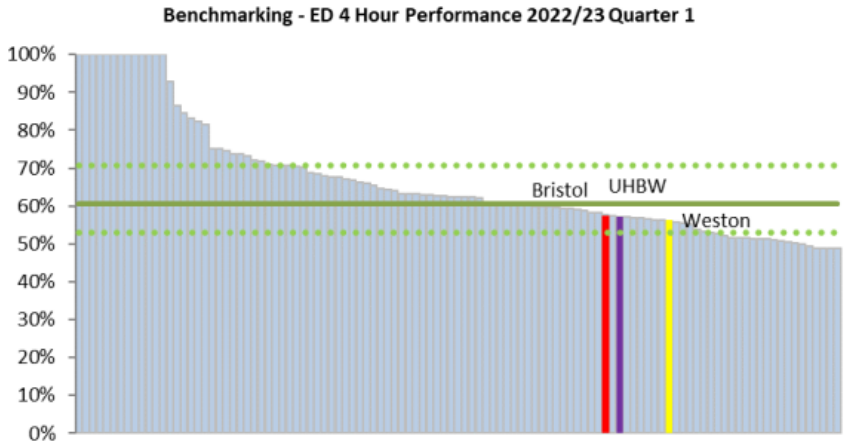


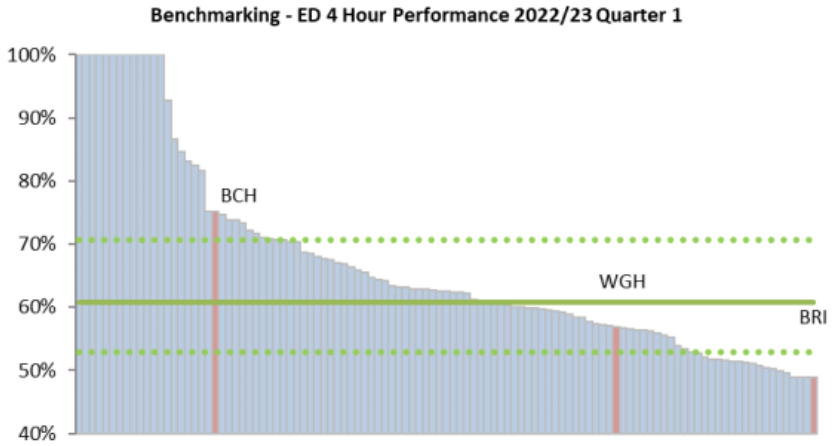


Note:
The above charts cover all four Emergency Departments. The Benchmarking charts on the next page is national performance data for Type 1 Emergency Departments only. For UHBW this excludes the Eye Hospital.

Emergency Care – 4 Hour Standard

University Hospitals Bristol and Weston NHS Foundation Trust





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Emergency Care – 12 Hour Trolley Waits

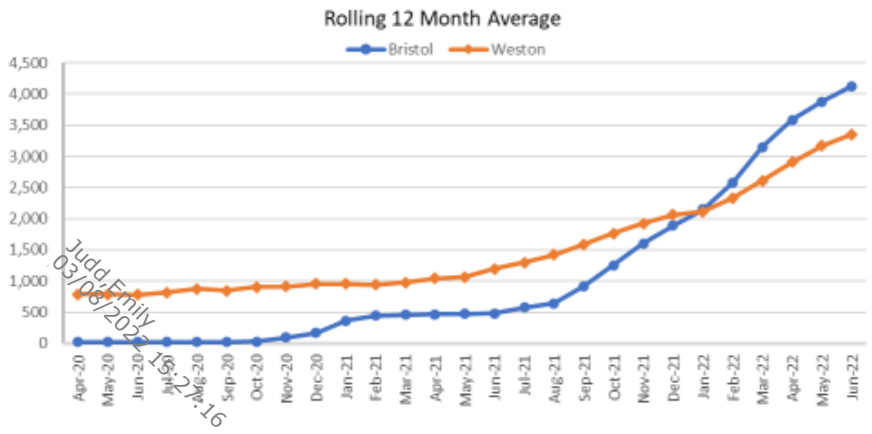
University Hospitals Bristol and Weston NHS Foundation Trust

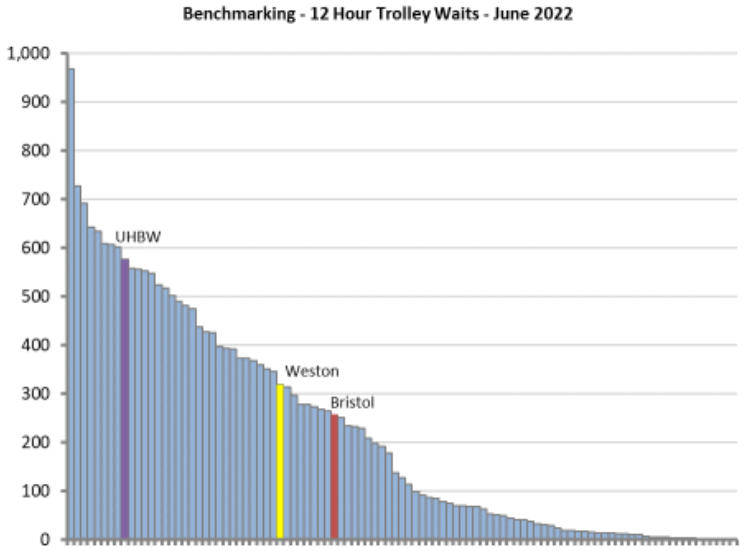
June 2022

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

	2021/2022												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	9	4	12	91	69	276	337	415	363	472	514	591	443	297	257									
Weston	62	24	134	164	188	180	257	291	313	304	330	361	366	282	319									
UHBW	**71**	**28**	**146**	**255**	**257**	**456**	**594**	**706**	**676**	**776**	**844**	**952**	**809**	**579**	**576**									





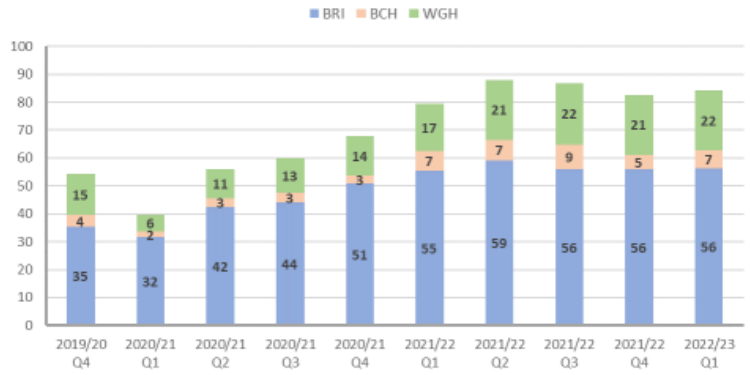
Emergency Care – Ambulance Handovers

University Hospitals Bristol and Weston NHS Foundation Trust

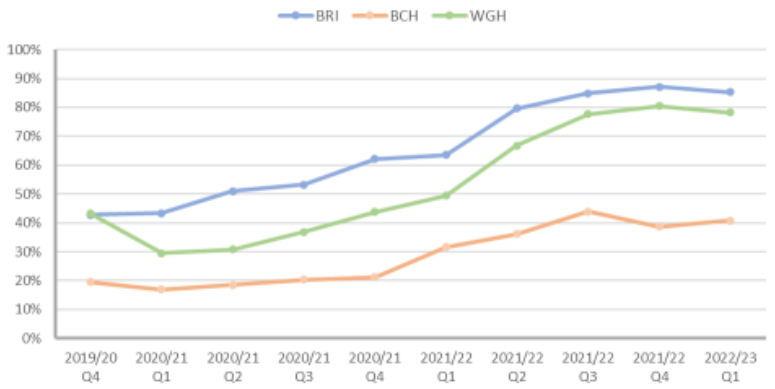
June 2022

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.

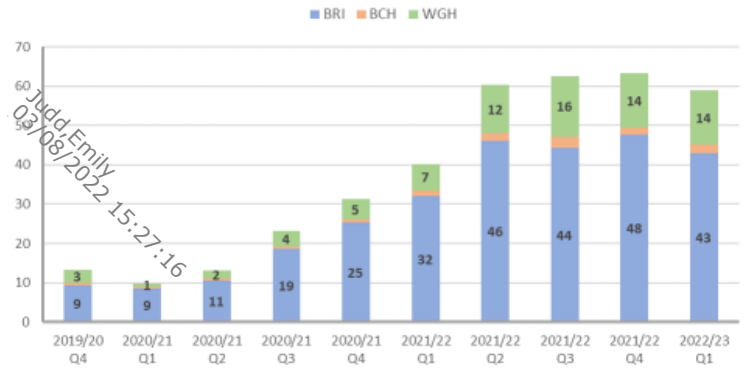
Handovers In Excess of 15 Minutes (Average Per Day)



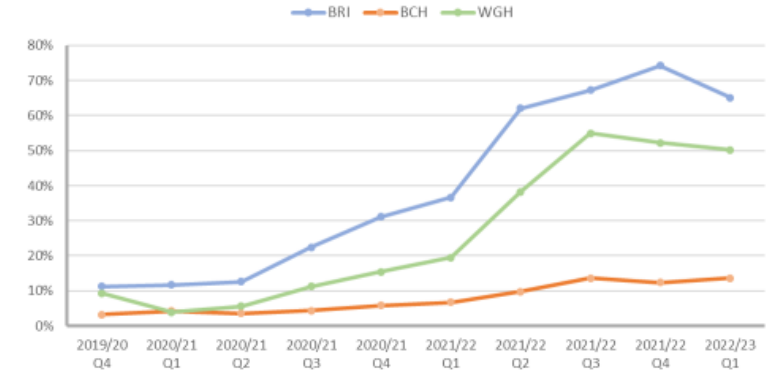
Handovers In Excess of 15 Minutes (As Percentge of All Handovers)



Handovers In Excess of 30 Minutes (Average Per Day)



Handovers In Excess of 30 Minutes (As Percentge of All Handovers)

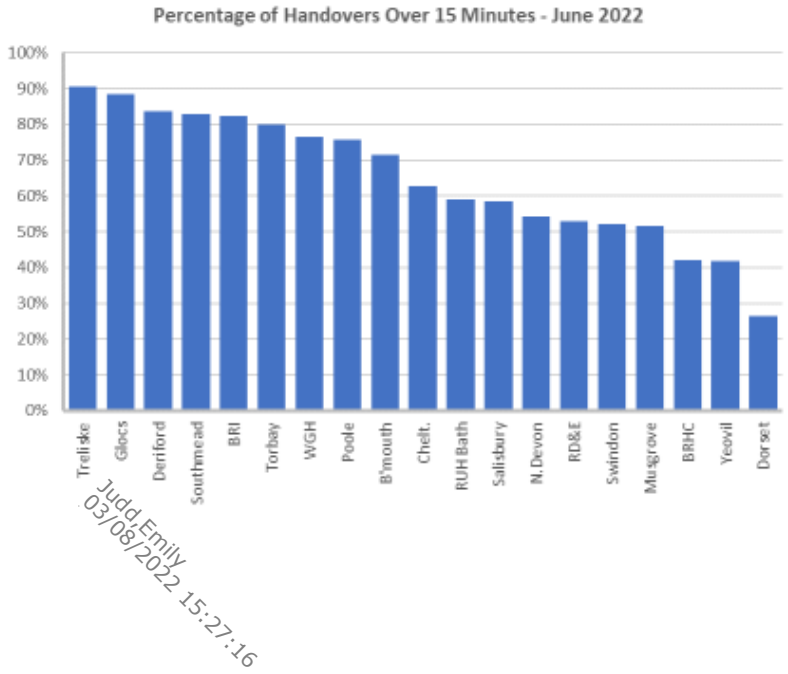


Emergency Care – Ambulance Handovers

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

This data is supplied by the South Western Ambulance Service NHS Foundation Trust (SWASFT).
The data for all Trusts is a daily update and so totals will be slightly lower than the data in the previous slide which is a rolling 5 week update.



	Total Handovers - South West - June 2022						
	Total Handovers	Over 15 Mins	% Over 15 Mins	Over 30 Mins	% Over 30 Mins	Over 1 Hour	Over 2 Hours
BRISTOL ROYAL HOSP FOR CHILDREN	534	225	42.1%	70	13.1%	12	3
BRISTOL ROYAL INFIRMARY	1,963	1,618	82.4%	1,110	56.5%	669	323
CHELTENHAM GENERAL HOSPITAL	553	347	62.7%	201	36.3%	80	19
DERRIFORD HOSPITAL	1,867	1,562	83.7%	1,352	72.4%	1,058	810
DORSET COUNTY HOSPITAL	1,424	378	26.5%	143	10.0%	46	12
GLOUCESTER ROYAL HOSPITAL	2,313	2,043	88.3%	1,727	74.7%	1,239	746
GREAT WESTERN HOSPITAL	1,908	995	52.1%	501	26.3%	270	154
MUSGROVE PARK HOSPITAL	2,276	1,176	51.7%	528	23.2%	224	71
NORTH DEVON DISTRICT HOSPITAL	1,250	680	54.4%	328	26.2%	114	22
POOLE HOSPITAL	1,844	1,395	75.7%	982	53.3%	632	341
ROYAL BOURNEMOUTH HOSPITAL	1,852	1,322	71.4%	922	49.8%	526	240
ROYAL DEVON AND EXETER WONFORD	2,687	1,426	53.1%	635	23.6%	159	15
ROYAL UNITED HOSPITAL - BATH	2,306	1,364	59.2%	785	34.0%	453	225
SALISBURY DISTRICT HOSPITAL	1,073	627	58.4%	345	32.2%	206	95
SOUTHMEAD HOSPITAL	2,551	2,115	82.9%	1,367	53.6%	781	452
TORBAY HOSPITAL	1,768	1,414	80.0%	1,081	61.1%	832	534
TRELISKE HOSPITAL	2,016	1,826	90.6%	1,665	82.6%	1,398	1,067
WESTON GENERAL HOSPITAL	851	652	76.6%	373	43.8%	229	149
YEOVIL DISTRICT HOSPITAL	1,225	513	41.9%	146	11.9%	31	1
SOUTH WEST TOTAL	**32,261**	**21,678**	**67.2%**	**14,261**	**44.2%**	**8,959**	**5,279**

Delayed Discharges (No Criteria to Reside)

June 2022

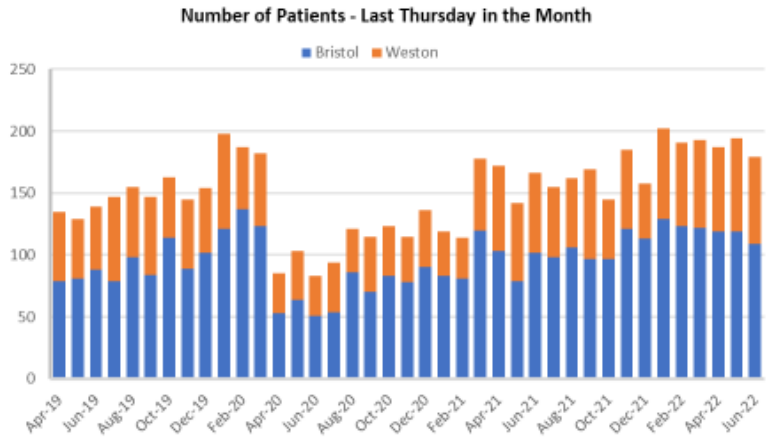
N/A *No Standard Defined*

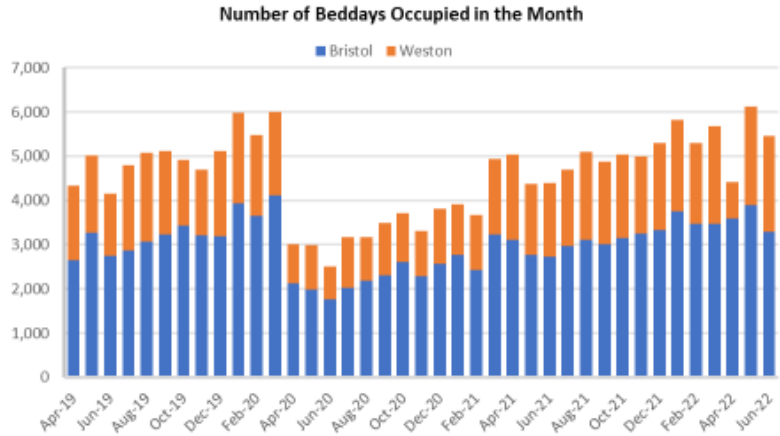
Standards:	Patients who are medically fit for discharge should wait a minimal amount of time in an acute bed. Pre-Covid, this was captured through Delayed Transfers of Care (DToC) data submitted to NHS England. This return has been discontinued but the Trust continues to capture delayed discharges through its No Criteria to Reside (NCR) 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 June there were 179 NCR patients in hospital. There were 5,457 beddays consumed in total in the month (1 bedday = 1 bed occupied at 12 midnight). This means, on average, 182 beds were occupied per day by NCR patients.
Commentary:	The demand across all the pathways in Bristol and Weston continued to exceed capacity in the community. A breakdown of June's performance is provided below: • Pathway 1: In the BRI there were 18 patients who did not meet the criteria to reside waiting for a P1. Short notice discharge dates continue to limit opportunities for earlier discharges with family support for Bristol patients in particular. Work ongoing with Sirona to provide discharge slots in advance. In Weston, there were 8 patients (13 less then in April) in hospital waiting for a P1 slot. Work ongoing around opportunities with the discharge support grant and increased engagement with the discharge MDT meetings. • Pathway 2: At the BRI there were 21 patients waiting at the end of June. Capacity continues to not be able to keep up with demand. SBRU is open to 50 beds (reduction of 10) due to staffing shortages. Work continues with therapies to review patient needs to ensure that they are discharged on the most appropriate pathway. In Weston there were 18 P2's waiting due to continued P2 capacity challenges in North Somerset. Work ongoing with discharge Multi Disciplinary Teams (MDT's) to seek to return home where safe. • Pathway 3: The P3 waiting list consisted of 33 patients in the BRI and 20 patients at Weston. Community capacity constraints remain, ongoing bed and home closures limiting discharges. Work is ongoing around transitional beds to further reduce P3 waits for both sites. 47% of the P3 waiters at the UHBW have a diagnosis of dementia.
Ownership:	Chief Operating Officer

Delayed Discharges (No Criteria to Reside)

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022





Bristol: Current Breakdown of Medically Fit For Discharge (MFFD) Patients, 20th July 2022

Pathway	Number of Patients	Percentage	7+ Days on Latest Pathway	14+ Days on Latest Pathway	21+ Days on Latest Pathway
Pathway 1	25	12.7%	5	2	2
Pathway 2	44	22.3%	14	6	1
Pathway 3	65	33.0%	36	20	13
Awaiting Decision	51	25.9%	16	9	2
Awaiting Referral	6	3.0%	0	0	0
Other	6	3.0%	2	2	2
Total	**197**		**73**	**39**	**20**

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Pathway 1 – patients awaiting package of care
Pathway 2 – requiring rehabilitation or reablement
Pathway 3 – Nursing or Residential home required

Referral To Treatment

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

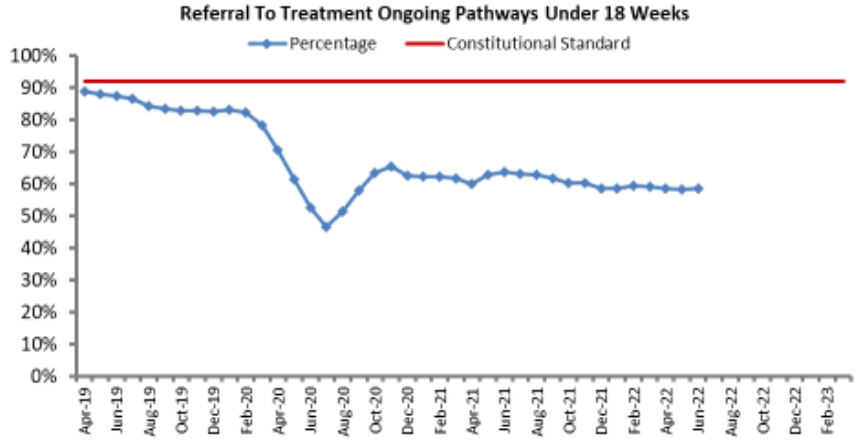
June 2022

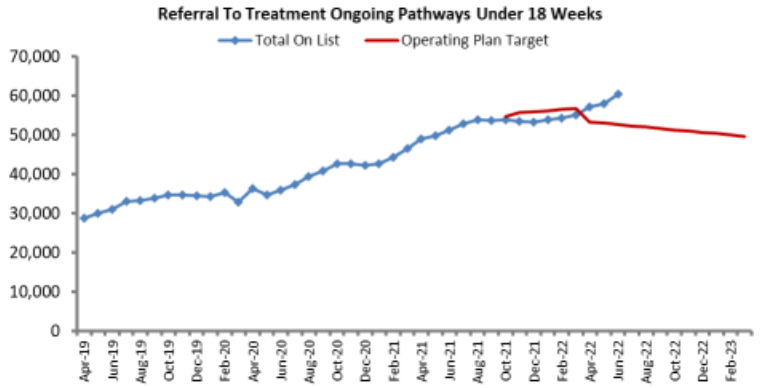
N *Not Achieved*

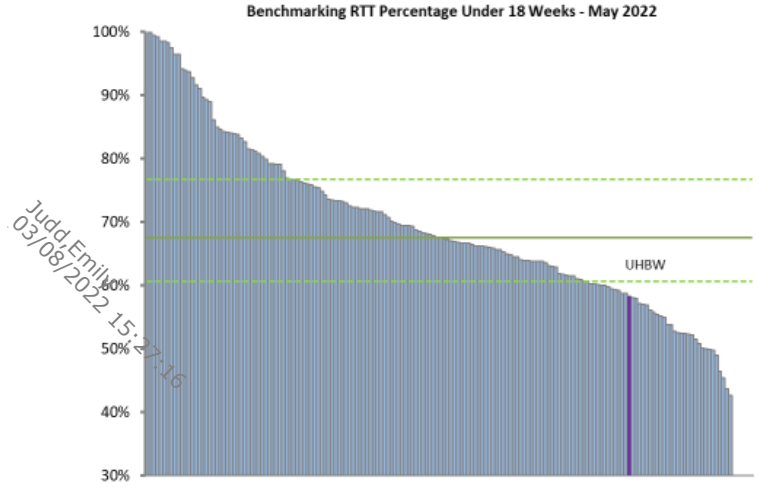
Standards:	The number of patients on an ongoing Referral to Treatment (RTT) pathway and the percentage that have been waiting less than 18 weeks. The national standard is that over 92% of the patients should be waiting under 18 weeks. A recovery trajectory was submitted to NHS England for 2022/23.The end of June target list size was 52,560.
Performance:	At end of June, 58.8% of patients were waiting under 18 weeks. The total waiting list was 60,404 and the 18+ week backlog was 24,910. So the end of June position for total list size exceeded the recovery trajectory. Comparing the end of April 2020 with the end of June 2022: • the overall wait list has increased by 24,192 patients . This is an increase of 67%. • the number of patients waiting 18+ weeks increased by 14,256 patients. This is an increase of 134%.
Commentary:	The focus of discussions with divisions and wider system partners is to clear patients who are currently 104 weeks by end of July 2022. This will require focus on transferring suitable patients to the independent sector, making the best use of internal capacity by ensuring full utilisation is maximised and to bolster additional capacity through Glanso and waiting list initiatives. Where patients are too complex for transferring outside the organisation under mutual aid arrangements for treatment at another specialist centre for treatment, focus should be on maximising our theatre scheduling across all sites and ensure that suitable capacity is available for our longest waiting breaches. This continues to be a challenge due to the lack of bed/HDU capacity and staff shortages due to an increase in Covid positive cases 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 by the end of July. Revised booking in order guidance has been issued to operational teams to ensure patients at risk of waiting 104ww or who have already breached 104ww are prioritised for booking once the P1, P2 cohort have been dated. Some additional elective inpatient capacity has been created internally with the lifting of the P2 cap and patients are now being booked into available theatre slots in July, reducing the overall number of long waiting patients without a plan.
Ownership:	Chief Operating Officer

Referral To Treatment

June 2022







	Jun-22		
	Under 18 Weeks	Total Pathways	Performance
Diagnostics and Therapies	528	584	90.4%
Medicine	5,812	8,648	67.2%
Specialised Services	4,106	5,745	71.5%
Surgery	18,395	34,226	53.7%
Women's and Children's	6,653	11,201	59.4%
Other	0	0	
UHBW TOTAL	**35,494**	**60,404**	**58.8%**

Referral To Treatment – Long Waits

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

N *Not Achieved*

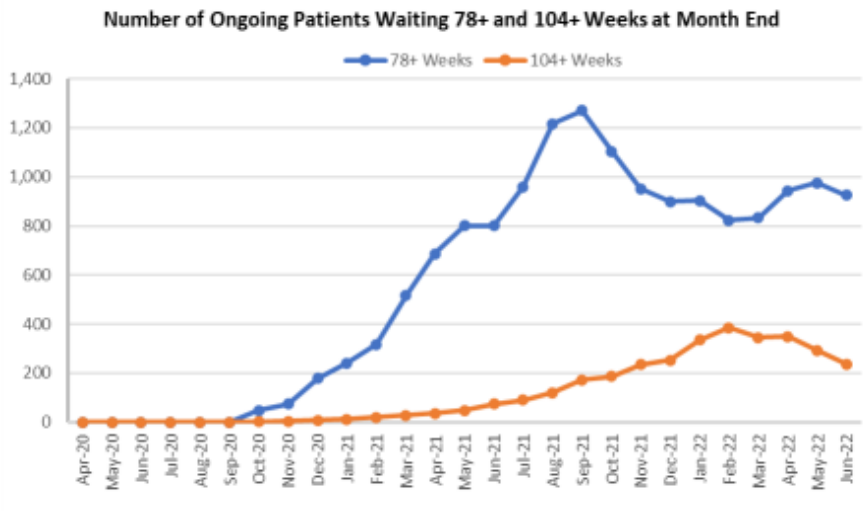
Standards:	Pre-Covid, the expectation was that no patient should wait longer than 52 weeks for treatment. As part of the Elective Recovery Programme Trusts were required to submit plan that eliminated patients waiting 104+ weeks (2+ years) for treatment by the end of June 2022. UHBW's submitted trajectory has 197 by end of June 2022.
Performance:	At the end of June 5,298 patients were waiting 52+ weeks. At the end of June, 236 patients were waiting 104+ weeks, which is 39 patients above the recovery trajectory of 197.
Commentary:	The trend has been upwards for 52-week waiters over the past few months. 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. 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. NHS England, and local commissioners, continue to request weekly reporting of patients waiting 104+ week, as part of the drive to reduce the 104-week breaches and eradicate them by end of July 22. Weekly analysis and exception reporting is underway, alongside clinical validation of the waiting list however in some services (colorectal) 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 there are now daily check in calls with the national team to provide updates on treatment dates for all patients waiting on top of the weekly regional and national meetings twice weekly with the Deputy Chief Operating Officer and the Executive teams.
Ownership:	Chief Operating Officer

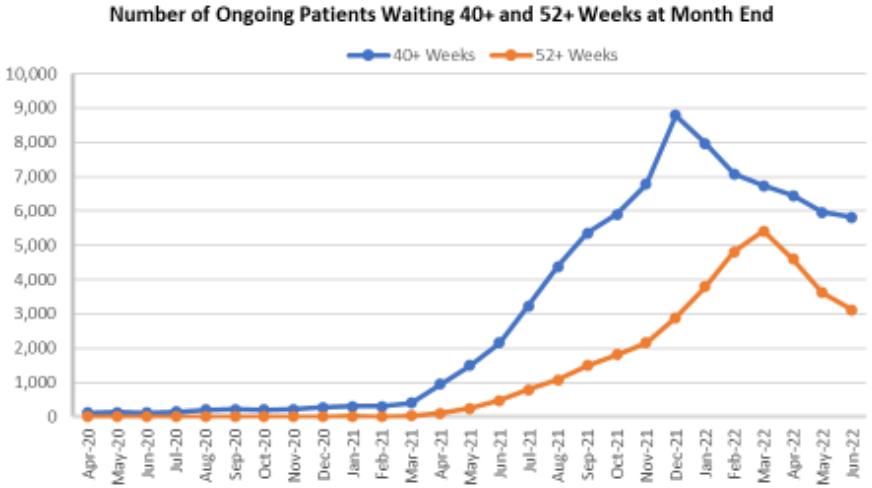
	Jun-22		
	52+ Weeks	78+ Weeks	104+ Weeks
Diagnostics and Therapies	0	0	0
Medicine	524	60	0
Specialised Services	132	8	0
Surgery	3,694	639	206
Women's and Children's	948	219	30
Other	0	0	0
UHBW TOTAL	**5,298**	**926**	**236**

Referral To Treatment – Long Waits

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022





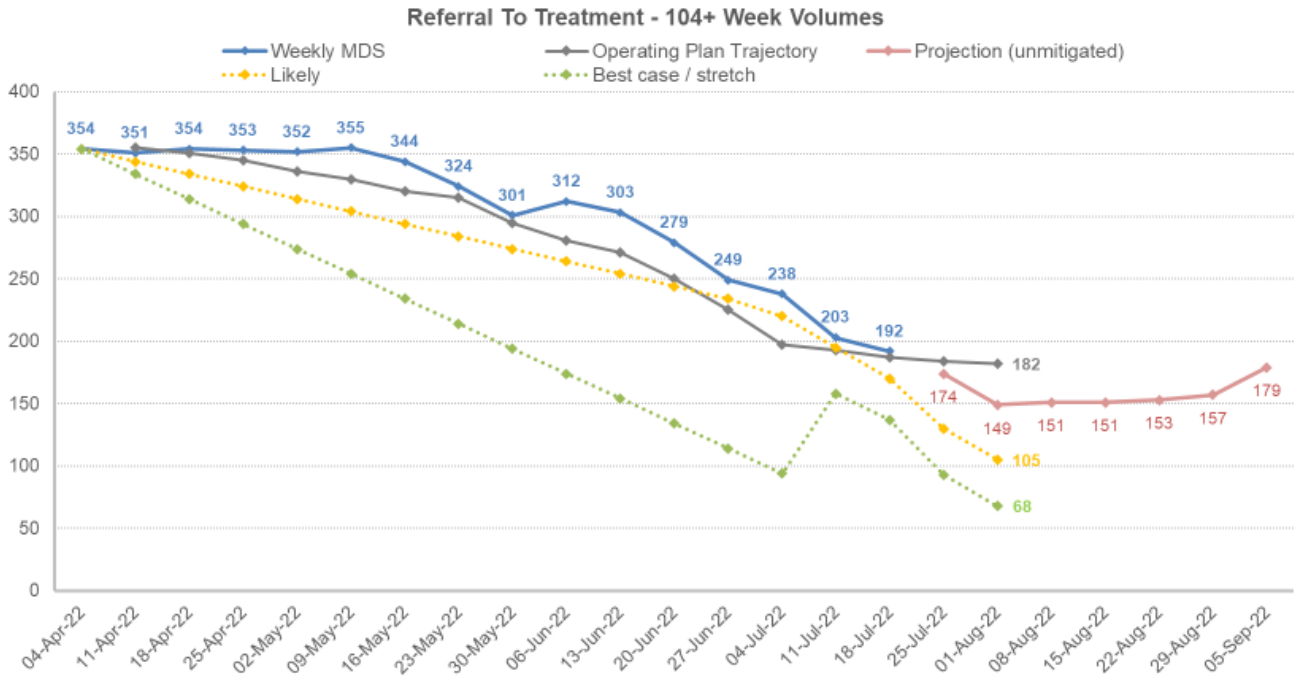
Referral To Treatment – Long Waits

University Hospitals Bristol and Weston NHS Foundation Trust

As At: 17th July 2022

104 Week Trends

Latest Data: Based on position as at end of Sunday 17th July2022



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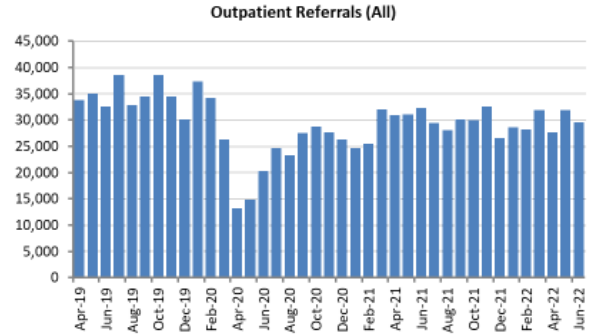
"Projection (Unmitigated)" – Number of currently Undated RTT patients who will exceed 104 weeks wait.
"Likely" – divisional and corporate assessment of position following mitigations, e.g. future capacity still to be booked.
"Best case/stretch" – divisional and corporate assessment of position if all mitigations were implemented
"Operating Plan Trajectory" – nationally submitted trajectory

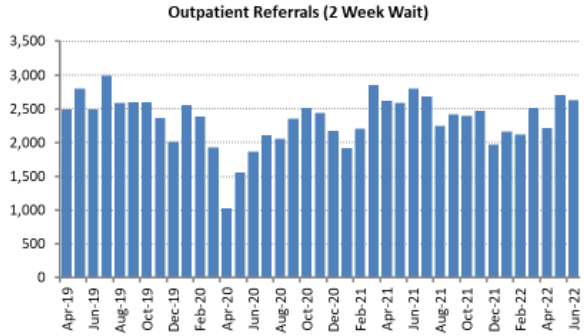
Elective Activity and Referral Volumes

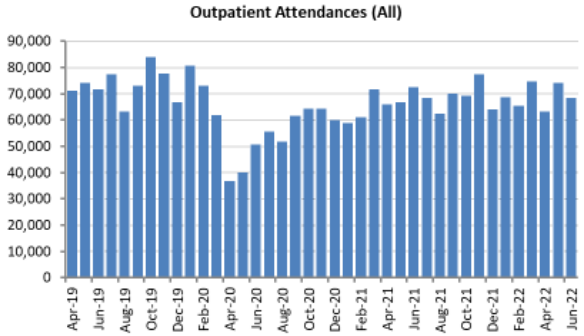
University Hospitals Bristol and Weston NHS Foundation Trust

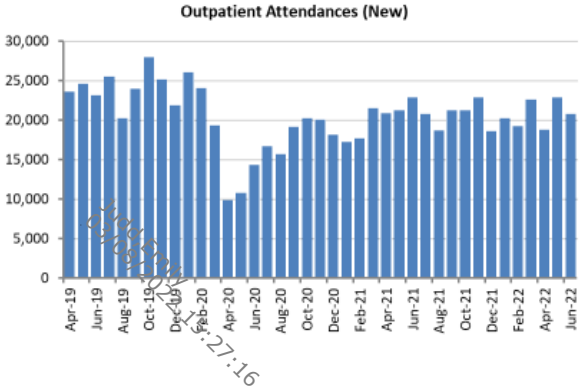
June 2022

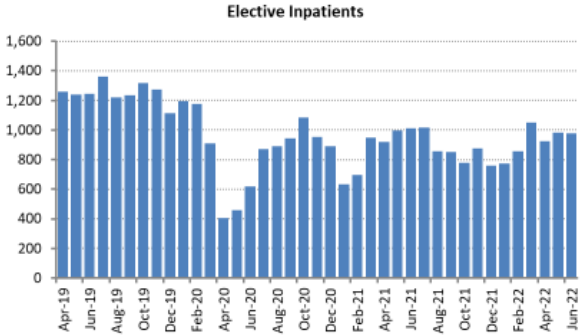
BRISTOL AND WESTON PLANNED ACTIVITY AND REFERRALS APRIL 2019 TO JUNE 2022

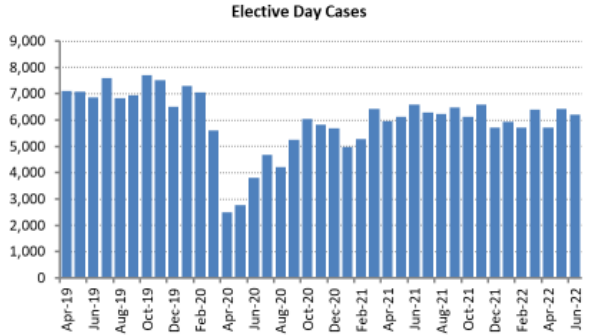












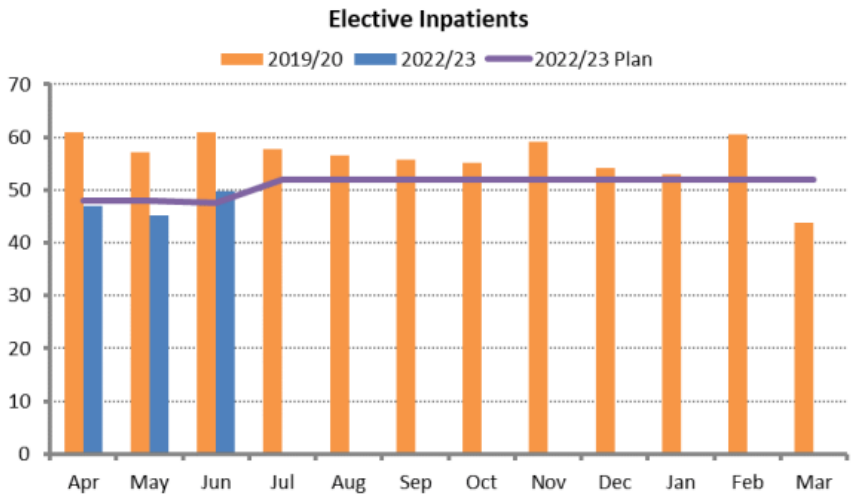
The above data is sourced from the Patient Administration Systems (PAS) and is not the final contracted activity that is used to assess restoration or Business As Usual (BAU) levels.

Elective Activity – Restoration

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

Activity Per Day, By Month and Year



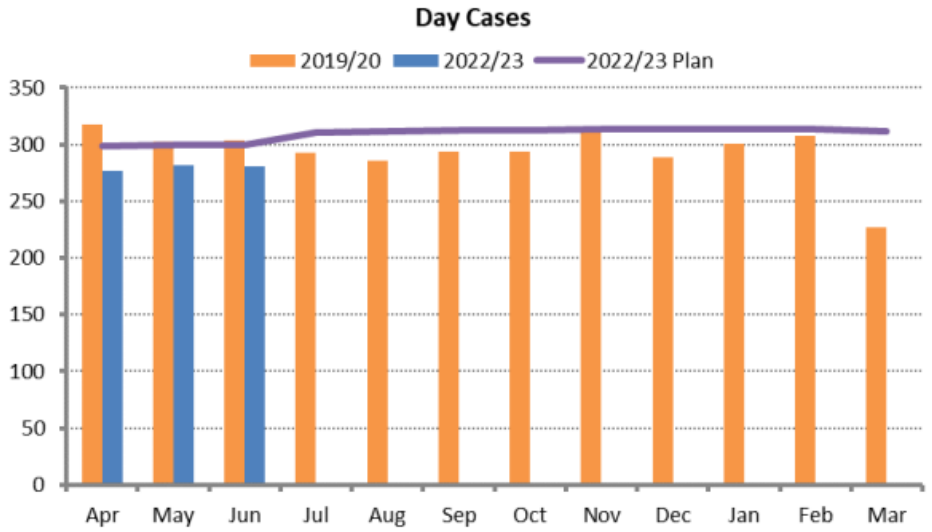
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	Actual Activity Per Day	61	57	61	58	57	56	55	59	54	53	60	44
2021/22	Actual Activity Per Day	45	51	44	45	39	38	36	39	35	38	41	44
2022/23	Actual Activity Per Day	47	45	50									
	Planned Activity Per Day	48	48	48	52	52	52	52	52	52	52	52	52
2022/23 Activity: % of Plan		98%	94%	105%									
2022/23 Activity: % of 2019/20		77%	79%	82%									

Elective Activity – Restoration

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

Activity Per Day, By Month and Year



		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	Actual Activity Per Day	318	302	303	292	286	294	294	313	288	301	307	226
2021/22	Actual Activity Per Day	279	300	280	265	275	272	268	276	253	280	266	259
2022/23	Actual Activity Per Day	276	282	281									
	Planned Activity Per Day	299	300	300	311	312	313	313	314	314	314	314	312
2022/23 Activity: % of Plan		92%	94%	94%									
2022/23 Activity: % of 2019/20		87%	93%	93%									

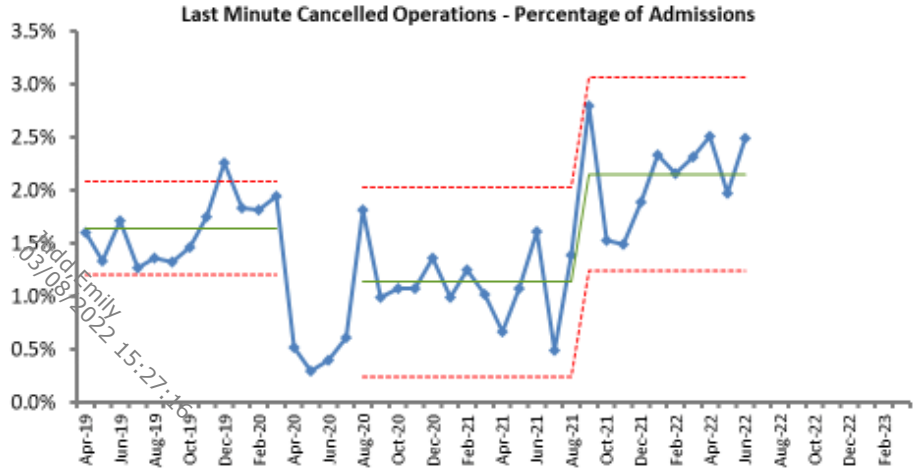
Cancelled Operations

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

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 June, there were 171 last minute cancellations, which was 2.5% of elective admissions. Of the 134 cancelled in May, 119 (89%) had been re-admitted within 28 days.
Commentary:	The largest volumes were in Ophthalmology (37), Cardiac/Cardiology (29), General Surgery (27), Paediatrics (25) and Dental Services (20). The most common cancellation reasons were: Rescheduled/ Postponed (34), No Theatre Staff (34), Ran out of Operating Time (28), Other Emergency Patient Prioritised (23) and No Surgeon (18).
Ownership:	Chief Operating Officer



	Jun-22		
	LMCs	% of Admissions	Performance
Diagnostics and Therapies	0	28	0.0%
Medicine	12	878	1.4%
Specialised Services	36	2,657	1.4%
Surgery	94	2,271	4.1%
Women's and Children's	29	910	3.2%
Other	0	116	
UHBW TOTAL	**171**	**6,860**	**2.5%**

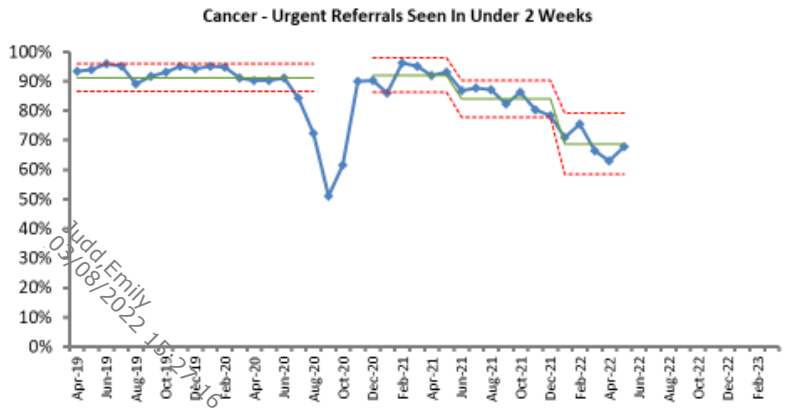
Cancer Two Week Wait

University Hospitals Bristol and Weston NHS Foundation Trust

May 2022

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 May, 68.0% of patients were seen within 2 weeks. Overall performance for Quarter 1 was 90.4%. Overall performance for Quarter 2 was 85.7%. Overall performance for Quarter 3 was 81.8%. Overall performance for Quarter 4 was 70.6%.
Commentary:	The standard was non-compliant in May (68.0% against a 93% standard). It is expected that compliance will deteriorate again due to very high Covid sickness in multiple teams in June and July. Staffing shortages in several high volume specialities are also a problem, with attempts to recruit replacement permanent or locum staff unsuccessful due to national shortages.
Ownership:	Chief Operating Officer



	Under 2 Weeks	Total Pathways	Performance
Other suspected cancer (not listed)	2	2	100.0%
Suspected children's cancer	17	18	94.4%
Suspected gynaecological cancers	177	217	81.6%
Suspected haematological malignancies	14	18	77.8%
Suspected head and neck cancers	452	518	87.3%
Suspected lower gastrointestinal cancers	156	238	65.5%
Suspected lung cancer	32	46	69.6%
Suspected skin cancers	390	780	50.0%
Suspected upper gastrointestinal cancers	111	150	74.0%
Grand Total	**1,351**	**1,987**	**68.0%**

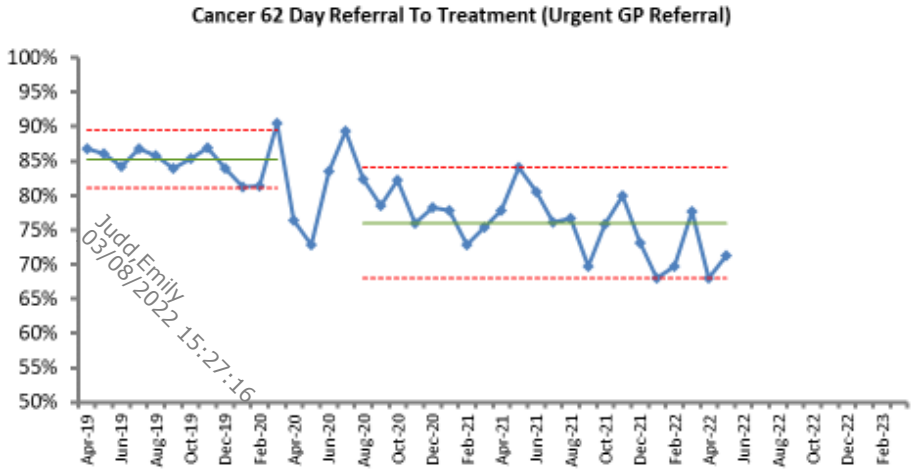
Cancer 62 Days

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

May 2022

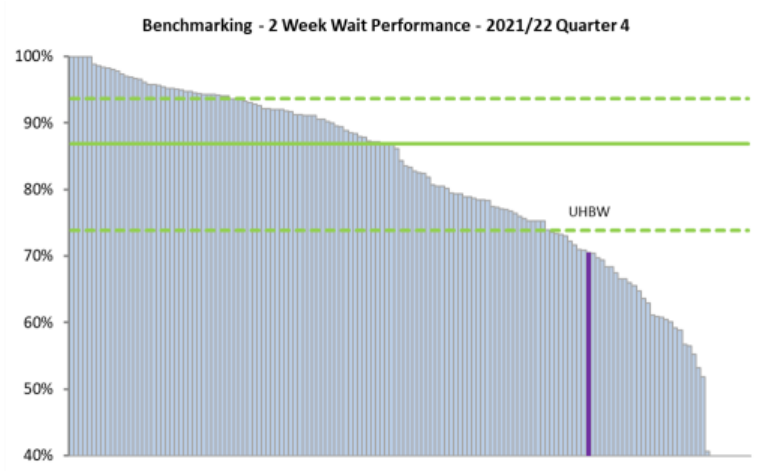
N *Not Achieved*

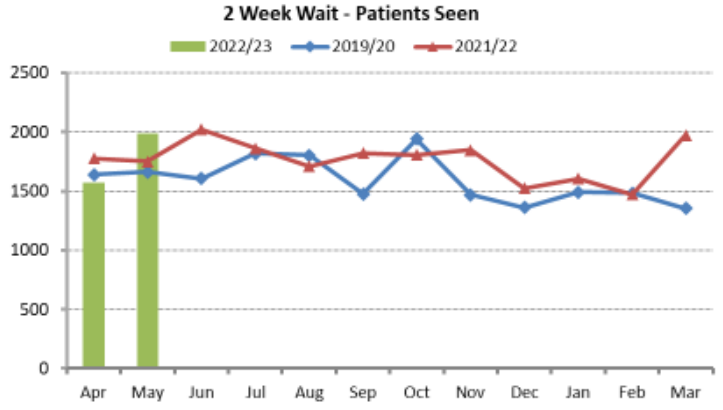
Standards:	Urgent GP-referred suspected cancer patients should start first definitive treatment within 62 days of referral. The national standard is that 85% of patients should start their definitive treatment within this standard.
Performance:	For May, 71.3% of patients were seen within 62 days. The overall Quarter 1 performance was 80.9%. The overall Quarter 2performance was 74.1%. The overall Quarter 3 performance was 76.5%. The overall Quarter 4 performance was 72.2%.
Commentary:	The standard was non-compliant in May (71.3% 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, as Covid continues to impact the health service, with very high staff sickness in June and July. The majority of patients continue to be treated within clinically safe timescales with clinical safety review embedded into waiting list management practice.
Ownership:	Chief Operating Officer

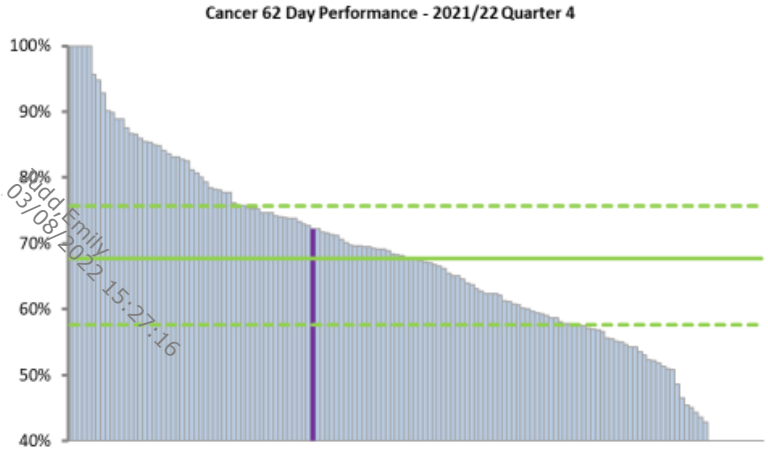


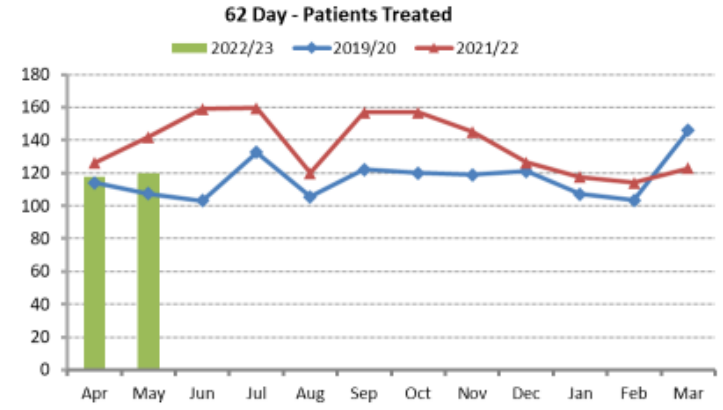
	Within Target	Total Pathways	Performance
Breast	1.5	1.5	100.0%
Gynaecological	2.5	6.5	38.5%
Haematological	5.0	7.0	71.4%
Head and Neck	7.0	12.0	58.3%
Lower Gastrointestinal	6.5	9.5	68.4%
Lung	7.5	13.5	55.6%
Other	3.0	4.0	75.0%
Sarcoma	1.0	2.0	50.0%
Skin	47.5	53.0	89.6%
Upper Gastrointestinal	4.0	9.0	44.4%
Urological	0.0	2.0	0.0%
Grand Total	**85.5**	**120.0**	**71.3%**

Cancer – Additional Information









Cancer – 28 Day Faster Diagnosis

NHS University Hospitals Bristol and Weston NHS Foundation Trust

May 2022

N *Not Achieved*

Standards:	The standard measures time from receipt of a suspected cancer referral from a GP or screening programme to the date the patient is given a cancer diagnosis, or told cancer is excluded, or has a decision to treat for a possible cancer. This time should not exceed 28 days for a minimum of 75% patients. The standard is reported separately for GP referred and screening referred patients.
Performance:	In May the Trust delivered 74.2% against the GP referred standard and 49.4% against the screening standard.
Commentary:	The GP referred standard was just below the compliance threshold this month. The screening standard, which has a low denominator and is mostly composed of colorectal patients, continues to be non-compliant. The standards are being impacted by capacity issues in several high volume specialities due to staff shortages. The screening standard is also affected by extremely high patient choice in the small patient cohort measured by the standard. Delays for endoscopy due to staffing shortages and physical capacity, and delays for hysteroscopy due to a demand surge, are a significant factor in the deterioration. Delays for first appointments and biopsies in dermatology due to staff shortages are the other significant driver of underperformance. Recruitment in all of these areas is challenging due to national shortages of qualified staff. High Covid sickness in multiple teams from June means the position is likely to deteriorate.
Ownership:	Chief Operating Officer

Month	Measure	Number Within 28 Days	Total Patients	Percentage Compliance
Feb-22	GP Referred	975	1,240	78.6%
	Screening	27	47	57.4%
	Combined	**1,002**	**1,287**	**77.9%**
Mar-22	GP Referred	1,282	1,687	76.0%
	Screening	38	101	37.6%
	Combined	**1,320**	**1,788**	**73.8%**
Apr-22	GP Referred	1,120	1,522	73.6%
	Screening	20	61	32.8%
	Combined	**1,140**	**1,583**	**72.0%**
May-22	GP Referred	1,358	1,829	74.2%
	Screening	40	81	49.4%
	Combined	**1,398**	**1,910**	**73.2%**

Cancer 104 Days

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Snapshot taken: 10th July 2022

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 10th July 2022 there were 8 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: 10th July 2022

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 10th July the Trust had 237 patients waiting >62 days on a GP suspected cancer pathway, against a baseline of 180.
Commentary:	The Trust is exceeding the 'pre-Covid baseline' for the second month, although the figure is currently stable and not deteriorating. This is due to demand having returned to (and in some areas, exceeded) pre-pandemic levels, whilst capacity remains restricted by the pandemic's impact. Very high staff sickness due to Covid in June and July means the position is likely to deteriorate in coming weeks due to delays in multiple services as a result of staff absence. Patients being unwell with Covid is also a factor, as patients cannot be admitted for tests and treatments until recovered from the illness. It is therefore very unlikely that the Trust will regain compliance with the baseline until late autumn at the earliest (exact timings dependent on the Covid prevalence levels).
Ownership:	Chief Operating Officer

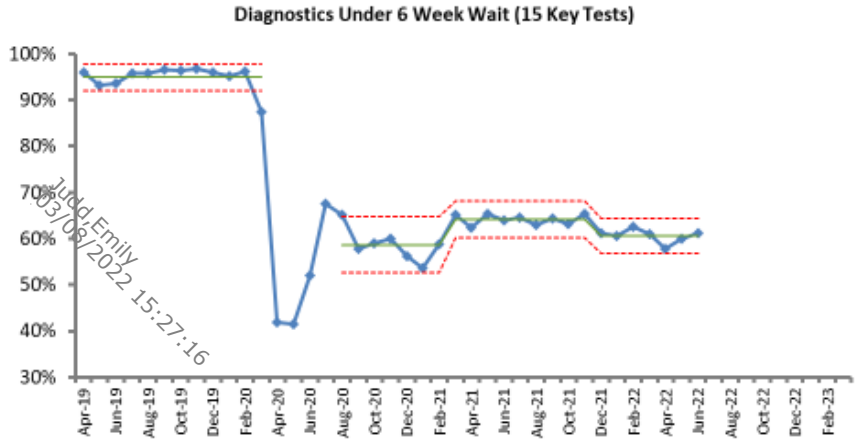
Diagnostic Waits

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

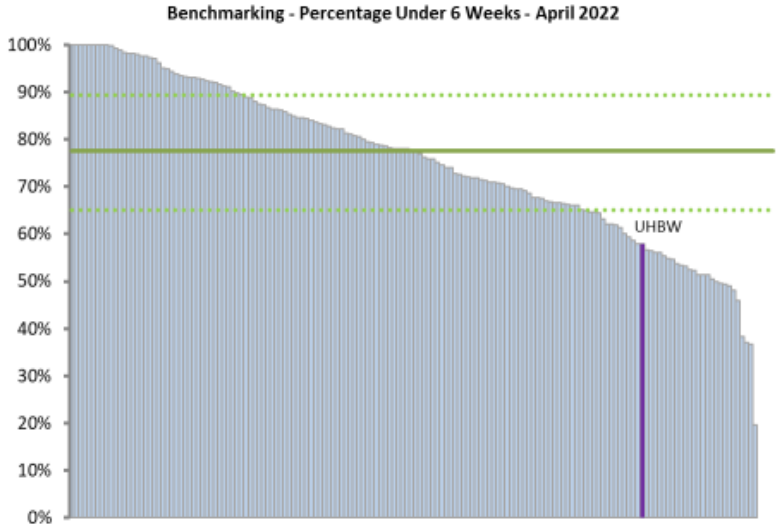
N *Not Achieved*

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 June, 61.2% of patients were waiting under 6 week, with 16,042 patients in total on the list
Commentary:	Diagnostic activity levels are being held overall, but pressure points are Endoscopy (where additional insourcing and use of independent sector lists is offset by loss of QDU capacity due to escalation), Adult MRI (Cardiology) and Cardiac MRI (where additional reporting capacity is being investigated to recover backlogs) and echo (predominantly at Weston, where long wait reviews are in place with Bristol and additional capacity is being investigated within the Independent Sector). There are also some niche constraints in MRI Paediatric GA pathway where mutual aid opportunities are being looked into within the SW region and Wales, but which rely on the provision of anaesthetists. Recovery plans for long waiting patients over 26 weeks have also been completed this period and are currently being reviewed by NHS England and NHS Improvement. The Trust is also aiming to ensure all patients are waiting less than 26 weeks for a diagnostic test by March 2023 (i.e. to eliminate long waiters) and aiming to achieve 75% compliance with the 6 week wait standard.
Ownership:	Chief Operating Officer



	Jun-22				
	Under 6 Weeks	Total On List	% Under 6 Weeks	13+ Weeks	26+ Weeks
Diagnostics and Therapies	7,512	9,511	79.0%	786	237
Medicine	81	129	62.8%	19	11
Specialised Services	1,334	3,832	34.8%	1,468	475
Surgery	578	2,086	27.7%	1,232	705
Women's and Children's	316	484	65.3%	111	68
Other	0	0		0	0
UHBW TOTAL	**9,821**	**16,042**	**61.2%**	**3,616**	**1,496**

Diagnostic Waits



End of June 2022

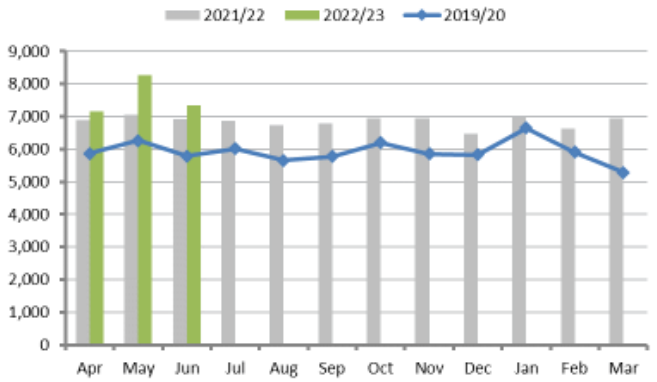
Modality	Total On List	6+ Weeks		13+ Weeks		26+ Weeks	
		Number	Percentage	Number	Percentage	Number	Percentage
Audiology Assessments	567	55	10%	1	0%	0	0%
Colonoscopy	963	689	72%	568	59%	324	34%
Computed Tomography (CT)	1,936	300	15%	111	6%	3	0%
Cystoscopy	29	21	72%	15	52%	10	34%
DEXA Scan	669	190	28%	10	1%	2	0%
Echocardiography	3,014	1,902	63%	1,071	36%	385	13%
Flexi Sigmoidoscopy	290	222	77%	185	64%	143	49%
Gastroscopy	981	720	73%	575	59%	296	30%
Magnetic Resonance Imaging (MRI)	3,058	905	30%	613	20%	175	6%
Neurophysiology	147	4	3%	0	0%	0	0%
Non-obstetric Ultrasound	4,314	1,189	28%	450	10%	149	3%
Sleep Studies	74	24	32%	17	23%	9	12%
Other	0	0		0		0	
UHBW TOTAL	**16,042**	**6,221**	**38.8%**	**3,616**	**22.5%**	**1,496**	**9.3%**

Diagnostic Activity – Restoration

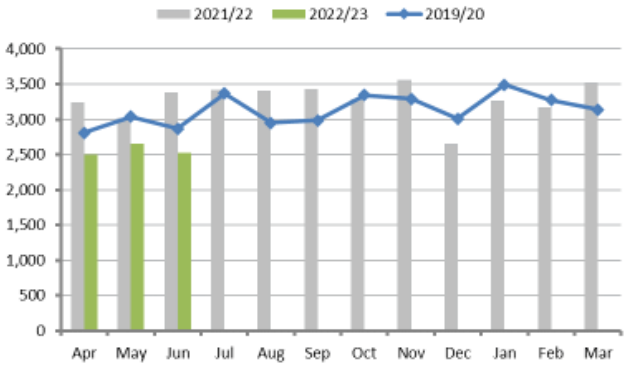
University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

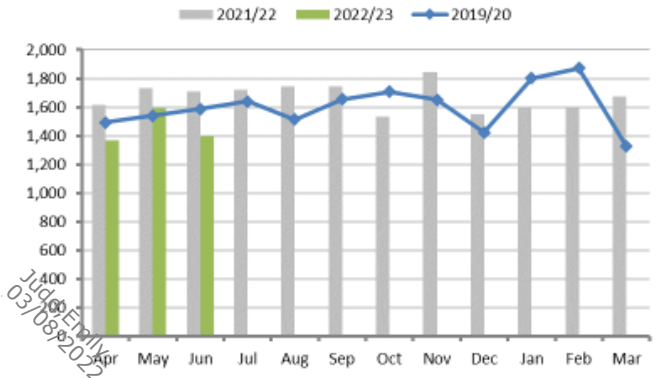
Computed Tomography (CT)



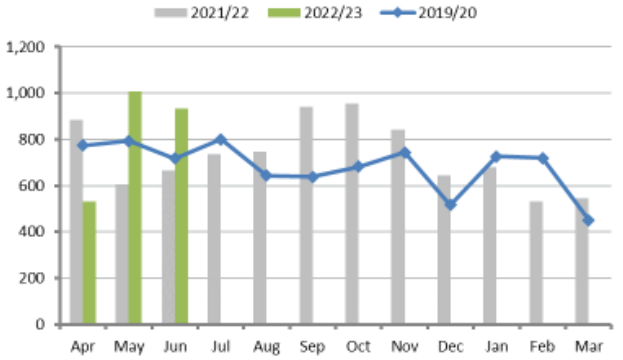
Magnetic Resonance Imaging (MRI)



Echocardiography



Endoscopy *(Gastroscopy, Colonoscopy, Flexi Sig)*



2022/23 as a Percentage of 2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Computed Tomography	122%	132%	127%									
Magnetic Resonance Imaging	89%	87%	88%									
Echocardiography	91%	103%	88%									
Endoscopy	69%	127%	130%									

Outpatient Measures

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

N *Not Achieved*

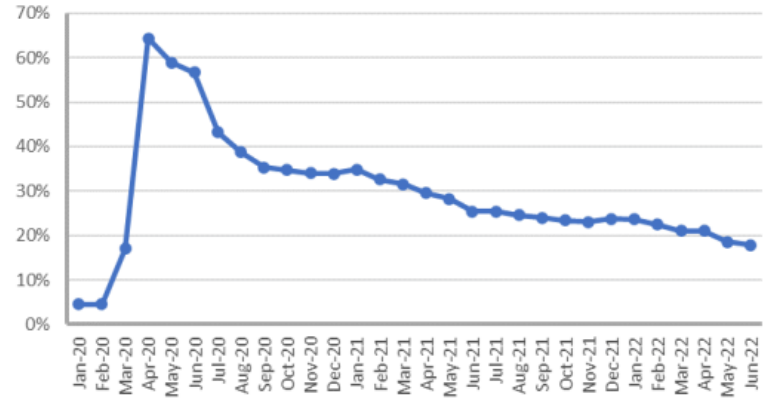
Standards:	There are three outpatient measures covered in this section. • Proportion of outpatient consultations that are non face-to-face (including ones that are delivered by video, as opposed to telephone). The target is to have at least 25% delivered as non face-to-face. • Advice and Guidance (A&G) is a service within the electronic Referral Service (eRS) which allows a clinician to seek advice from another, providing digital communication between two clinicians: the "requesting" clinician and the provider of a service, the "responding" clinician. The aim is for a minimum of 12 advice and guidance requests to be delivered per 100 outpatient new attendances (i.e. 12%) • Patient Initiated Follow-Up (PIFU) is one possible outcome following an outpatient attendance. This gives patients and their carers the flexibility to arrange their follow-up appointments as and when they need them rather than the service booking a follow-up. The target is to have 5% of all outpatient attendances moved or discharged to a PIFU pathway.
Performance:	In June: • 17.8% of outpatient attendances were delivered non face-to-face. Of these, 9.3% were delivered as a video consultation. • There were 1,427 Advice & Guidance Responses sent out, which was 7.0% of all New outpatient attendances. • There were 2,648 outpatient attendances that were outcome as PIFU, which was 3.9% of all outpatient attendances.
Commentary:	• June PIFU activity has risen to 3.9% of outpatient attendances. Engagement continues with specialities to develop PIFU further in the trust. • Non face-to-face activity has reduced to 17.8% this is reflective of divisions increasing face to face activity to tackle backlogs. The deployment of DrDoctor has seen an improvement in non face-to-face as video data recording and activity, performance has plateaued at 9.3%. • Advice and Guidance request activity has reduced November to June and this is reflective of extending waiting times for responses and increasing backlogs of requests. There are a number of resourcing challenges faced across the trust impacting on delivery. The system's Healthier Together programme has identified the priority specialities for A&G service development for 2022/23. NHSE now includes RAS as A&G activity this report will be changed to include this activity.
Ownership:	Chief Operating Officer

	Non Face To Face		Non Face To Face (Video)		Advice & Guidance		Advice & Guidance Responses		Patient Initiated Follow-Up	
	Total	% of All Attendances	Total	% of All Non Face To Face	Total Responses	% of New Attendances	Responses Within 7 Days	% Responses Within 7 Days	Total PIFU'ed Outcomes	% of All Attendances
Diagnostic & Therapy	1,292	15.8%	228	17.6%	55	1.4%	54	98.2%	542	6.6%
Medicine	2,641	35.7%	319	12.1%	474	19.1%	165	34.8%	293	4.0%
Specialised Services	4,697	38.1%	237	5.0%	297	11.8%	265	89.2%	262	2.2%
Surgery	1,511	6.3%	52	3.4%	181	2.9%	148	81.8%	615	2.6%
Women's & Children's	1,861	12.3%	285	15.3%	420	8.2%	320	76.2%	936	6.2%
TOTAL	**12,005**	**17.8%**	**1,121**	**9.3%**	**1,427**	**7.0%**	**952**	**66.7%**	**2,648**	**3.9%**

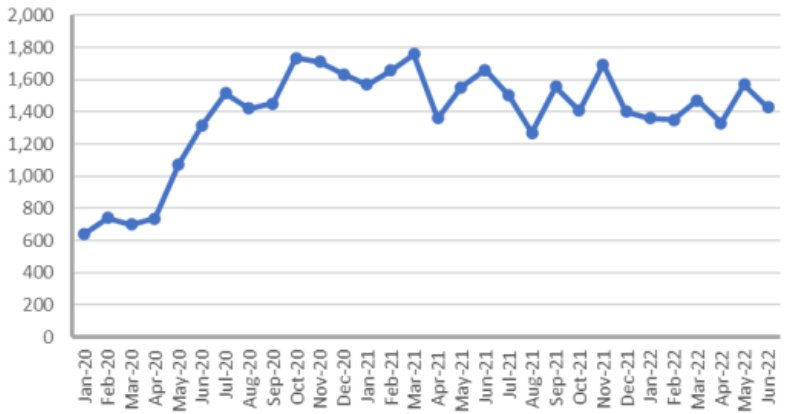
Outpatient Measures

June 2022

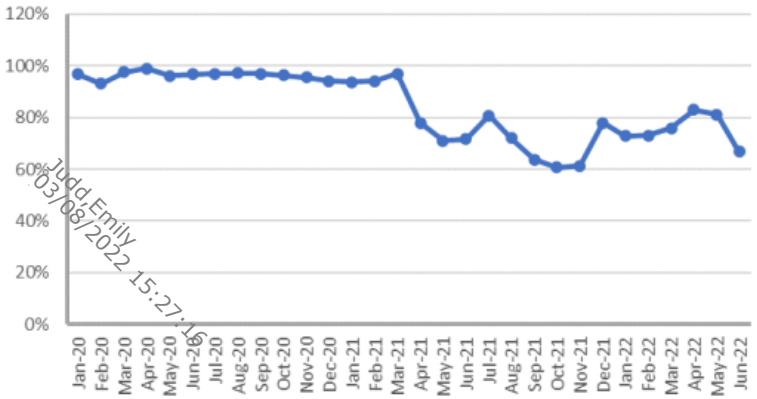
Outpatient Attendances - % Non Face To Face



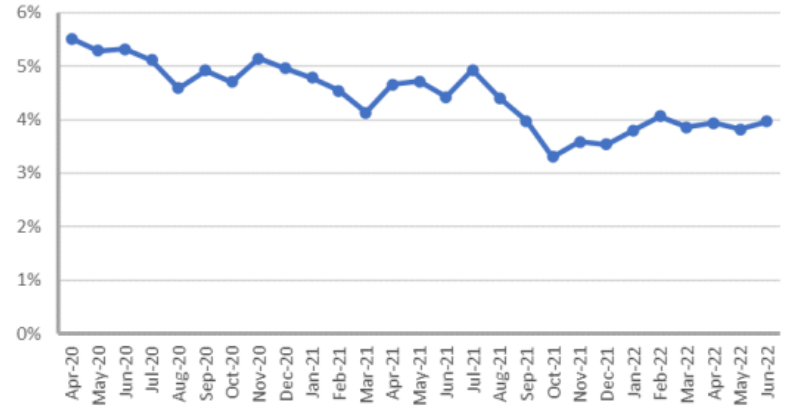
Number of Advice and Guidance Responses



Percentage of A&G Responses in 7 Days



Percentage of Attendances with PIFU Outcome

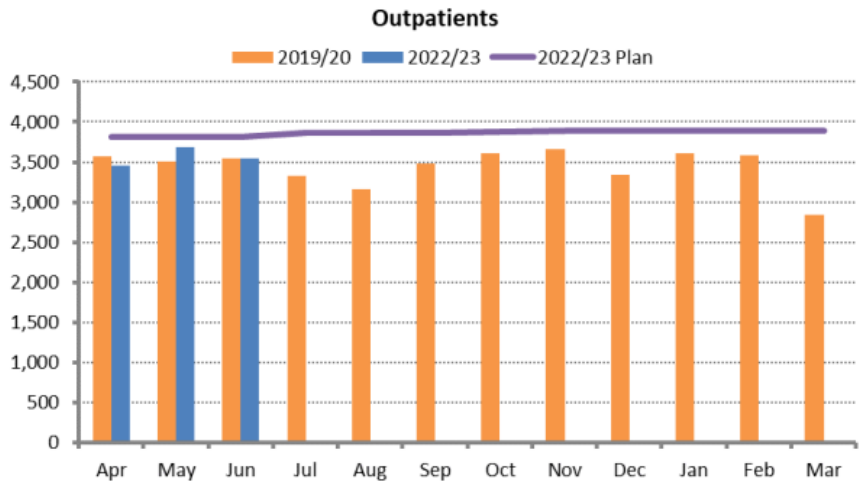


Outpatient Activity – Restoration

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

Activity Per Day, By Month and Year – Outpatient Attendances



		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	Actual Activity Per Day	3,568	3,507	3,544	3,327	3,162	3,487	3,604	3,657	3,343	3,615	3,584	2,835
2021/22	Actual Activity Per Day	3,457	3,655	3,478	3,239	3,108	3,373	3,424	3,638	3,167	3,571	3,384	3,383
2022/23	Actual Activity Per Day	3,451	3,690	3,545									
	Planned Activity Per Day	3,820	3,820	3,820	3,862	3,860	3,860	3,874	3,889	3,896	3,893	3,896	3,886
2022/23 Activity: % of Plan		90%	97%	93%									
2022/23 Activity: % of 2019/20		97%	105%	100%									

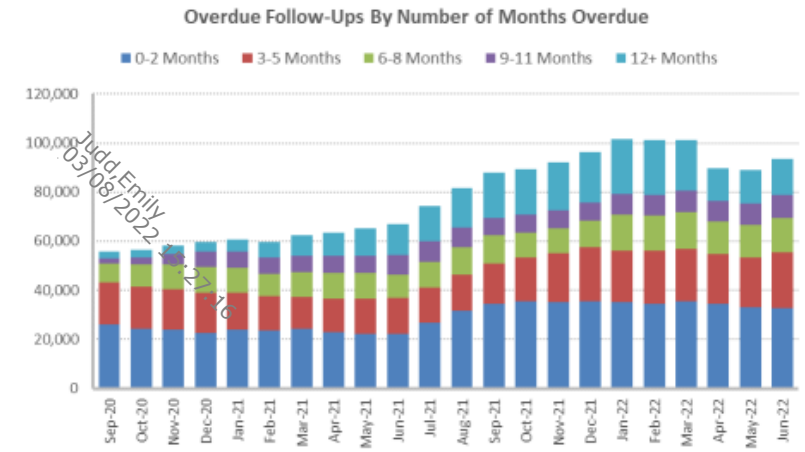
Outpatient Overdue Follow-Ups

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

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 June was 93,513 of which 38,250 (41%) were overdue by 6+ months and 14,615 (16%) were overdue by 12+ months.
Commentary:	• 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. June has seen a rise in overdue follow ups to 93,513 (Datix ID 2244) • UHBW has commenced the validation of Outpatient waiting lists, 32,355 patient records have now been given priority code ("N codes") 23,191 patients have been identified as N4 or lower priority. • The Outpatient programme board has agreed a pilot into the use of the DrDoctor Quick question functionality to message patients waiting on overdue follow up back logs to validate if patients still require appointments and to add patients to PIFU pathways where clinically appropriate. Volunteer specialities are being identified and engaged with the process • NHSE/I are reconsidering plans to validate outpatient waiting lists an update to this position is anticipated at the end of this month. • Areas of largest areas of backlog seen in Sleep, Ophthalmology, Audiology, ENT, 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



	6+ Months		12+ Months		Total
	Number	Percentage	Number	Percentage	Overdue
Diagnostics & Therapies	4,502	35%	418	3%	12,741
Medicine	10,805	43%	5,621	23%	24,882
Specialised Services	4,518	38%	1,214	10%	11,981
Surgery	16,076	44%	6,490	18%	36,839
Women's and Children's	2,331	33%	862	12%	7,032
Other	18		10		38
UHBW TOTAL	**38,250**	**41%**	**14,615**	**16%**	**93,513**

Mortality – SHMI (Summary Hospital-level Mortality Indicator)

University Hospitals Bristol and Weston NHS Foundation Trust

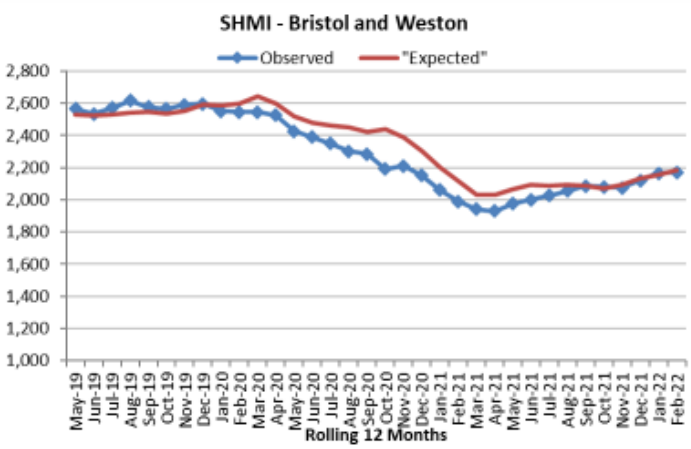
February 2022

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. This data is now provided by NHS Digital as a single figure from UHBW. SHMI is derived from statistical calculations of the number of patients expected to die based on their clinical risk factors compared with the number of patients who actually died. There is no target. A SHMI of 100 indicates these two numbers are equal, but there is a national statistically acceptable range calculated by NHS Digital and a SHMI that falls within this range is "as expected".
Performance:	The Summary Hospital Mortality Indicator for UHBW for the 12 months March 2021 to February 2022 was 99.3 and in NHS Digital's "as expected" category. This is slightly below 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 diagnosis group level if required and investigating any identified alerts.
Ownership:	Medical Director

	UHBW		
Rolling 12 Months To:	Observed Deaths	"Expected" Deaths	SHMI
May-21	1,975	2,065	95.6
Jun-21	2,000	2,090	95.7
Jul-21	2,025	2,085	97.1
Aug-21	2,055	2,095	98.1
Sep-21	2,085	2,085	100.0
Oct-21	2,080	2,070	100.5
Nov-21	2,075	2,090	99.3
Dec-21	2,120	2,135	99.3
Jan-22	2,165	2,155	100.5
Feb-22	2,170	2,185	99.3

Note: Nov-21 represents 12 month period Dec-20 to Nov-21



Mortality – HSMR (Hospital Standardised Mortality Ratio)

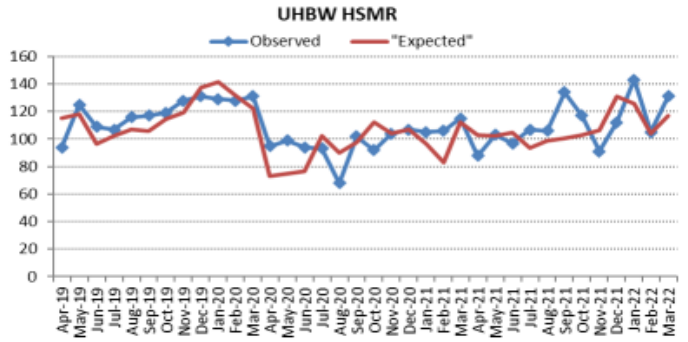
University Hospitals Bristol and Weston NHS Foundation Trust

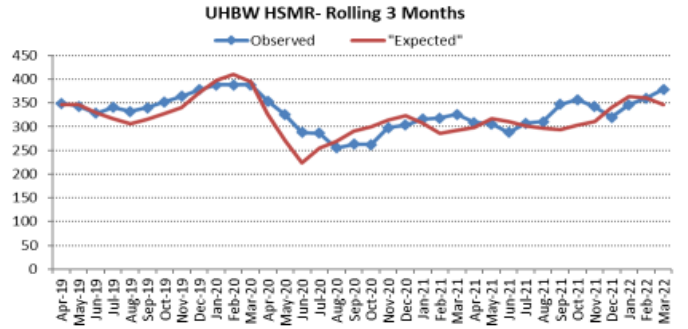
March 2022

N *Not 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 March 2022 was 112.2, meaning there were more observed deaths (131) than the statistically calculated expected number of deaths (117). 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 March 2022 for UHBW was 102.5.
Commentary:	Please note that NHS Digital do not provide April data until May data is available because of their end of year processing. Therefore the latest month reported is March 2022. Also note that March's data has altered from what was reported last month. This is because HSMR is sourced from national data and is not "frozen" at month-end. The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to diagnosis group level if required and investigating any identified alerts.
Ownership:	Medical Director

	UHBW		
	Observed	"Expected"	HSMR
Apr-21	88	103	85.6
May-21	103	103	100.5
Jun-21	97	105	92.6
Jul-21	107	94	114.4
Aug-21	106	99	107.2
Sep-21	134	101	133.2
Oct-21	117	103	113.4
Nov-21	91	106	85.5
Dec-21	112	131	85.4
Jan-22	143	126	113.7
Feb-22	105	104	100.9
Mar-22	131	117	112.2





Fractured Neck of Femur (#NOF)

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

N *Not 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 June, there were 44 patients eligible for Best Practice Tariff (BPT) across UHBW (21 in Bristol and 23 in Weston). • For the 36 hour standard, 64% achieved the standard (28 out of 44 patients). • For the 72 hour standard, 100% achieved the standard.
Commentary:	Underlying issues (Bristol): • 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. This difficulty is compounded by recent staffing issues in theatres resulting in the trauma team being unable to stand up extra trauma lists in place of cancelled cancer cases. • Difficulty accessing theatres to ensure consistent #NOF theatre – also challenges with theatre and anaesthetic staffing which is impacting on overall theatre capacity. This predominantly effects our ability to utilise extra theatres for trauma in the event of cancellations. • Difficulty starting on time in theatre and also some anecdotal reports that theatre efficiency is being lost at the end of the day due to staffing pressures and a reticence to start cases in case they overrun. • Lack of beds in the right area to have patients seen quickly. This is exacerbated by outliers in the Trauma & Orthopaedic (T&O) wards which cause our own T&O patients to outlie into other surgical beds. Actions taken (Bristol): • 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. • Poor results discussed in T&O Governance & Silver trauma steering group meeting so ideas for improvement could be discussed. • Restart of "Automatic Send" so each theatre should be sending for their first patient without any delay. • Trauma Standard Operating Procedure (SOP) signed off to allow the allocation of a "Golden Patient", enabling a prompt start. Reasons patients missed the expected level of care at Weston: • Lack of theatre capacity was the main reason for breaching surgery time this month. • Weston only has 8 designated trauma theatre lists available Monday to Friday and shared lists on weekends. • Difficulties with prompt start in theatres and other short notice urgent cases needing priority which often causes short notice cancellations to the planned trauma lists. *…continued over page*

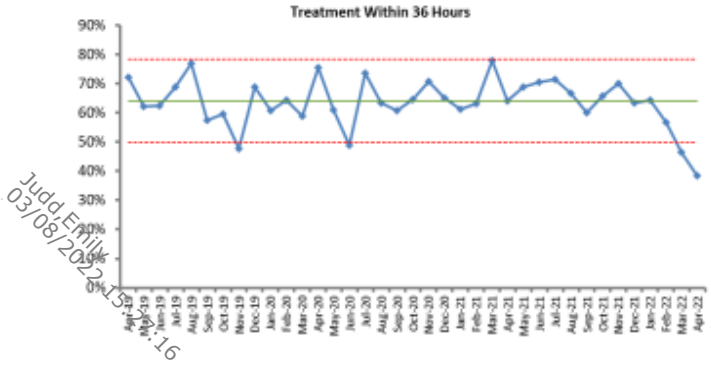
Fractured Neck of Femur (#NOF)

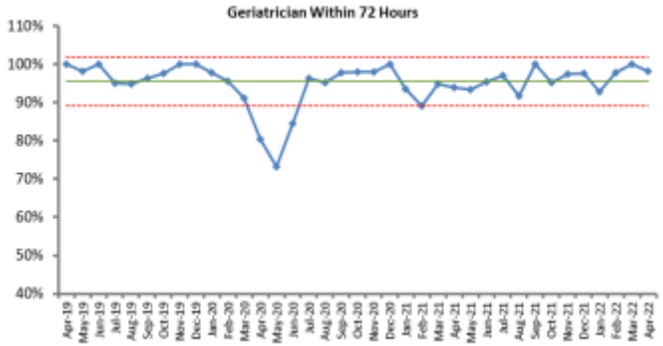
University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

Commentary (continued):	Actions taken (Weston): • Use of emergency (CEPOD) lists where possible for extra capacity when trauma lists are full or limited. The Orthopaedic team are pro-active in cancelling elective lists or fracture clinics where possible for either providing additional theatre capacity or ensuring that a radiographer is present.
Ownership:	Medical Director

		36 Hours		72 Hours		Best Practive Tariff	
	Total Patients	Seen In Target	Percentage	Seen In Target	Percentage	Achieved All Elements	Percentage
Bristol	21	11	52%	21	100%	11	52%
Weston	23	17	74%	23	100%	16	70%
TOTAL	**44**	**28**	**63.6%**	**44**	**100.0%**	**27**	**61.4%**





Mixed Sex Accommodation Breaches

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

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:	There were two Mixed Sex Accommodation breaches in June 2022, involving 8 patients. Both incidents occurred on the Stroke ward. Prior to any breach there is a full review of all inpatient areas. None of these were avoidable breaches and so none were reported in the national return.
Commentary:	Actions being taken: • Escalation bed capacity areas remain open • Continue to support staff to report all breaches
Ownership:	Chief Nurse

Maternity Services

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

N/A ***No Standard Defined***

Standards:	The Perinatal Quality Surveillance Matrix (PQSM) 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:	Three incidents were reported as moderate harm and are being investigated. Two were reported to the Healthcare Safety Investigation Branch (HSIB); however, one family did not consent to a HSIB investigation, and the other does not meet the revised threshold as the baby's MRI scan did not show hypoxic ischaemic encephalopathy (HIE). Both cases will be reviewed internally, and any learning shared with staff, the Local Maternity System (LMS), and through quarterly report to the Trust Board when available.
Commentary:	Underlying issues (Threats): • There remains a risk to achievement of compliance for the Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST). This is due to IT connectivity issues and capacity constraints within the community midwifery teams. This specifically relates to evidence of recording of carbon monoxide at 36 weeks of pregnancy, against which measure we need to achieve 80%. This has been escalated and is on the risk register (3643). The Division has an advert out for a band 2 to support a pilot of additional intensive administrative support for one of the teams, to understand whether this improves the situation. The second risk to CNST compliance is multidisciplinary obstetric emergency training, where there is a target of 90% in all relevant staff groups; this has been affected by staffing pressures, mainly from covid, with staff being redeployed from the study day to work clinically. Additional study days are run to support clinicians' opportunity to attend. Plans are in place to be compliant by the end of the reporting period. • Sickness rates in medical rotas – there has been no change from last month regarding consultants acting down to cover and cross cover to maintain safe service, and this is stable and low overall. Sickness within midwifery and neonatal nursing teams is higher and it is challenging to find cover, with beds/cots closed to maintain safety and Neonatal Intensive Care Unit (NICU) babies transferred out where safe and possible. Where necessary, regular numbers of induction of labour have been reduced day to day, which causes delays. All delays are risk assessed daily with obstetric and neonatal consultants in charge of delivery suite/NICU. • An assessment of the requirements to continue the roll-out of Continuity of Carer (CoC) as default model of care by April 2023 has suggested that an additional 16.1 WTE midwives would be required. The Continuity of Carer programme presently sits at 41% achievement, with BAME at 61.4% and IMD1 (most deprived) at 75%. UHBW risk assesses staffing and recruitment regularly and can continue with four teams safely at the current time. Two teams have been paused until staff have been recruited to fill newly vacant posts. Recruitment is on-going. • Further roll-out is currently paused following the publication of the Ockenden Review and pending the agreed national response to the recommendations pertaining to Continuity of Carer (CoC). *…continued over page*

Commentary *(continued)*:	Underlying issues (successes): • The lack of appropriate capacity to manage the current and increasing number of planned ("elective") caesarean sections, the Trust have agreed to fund a five day all day elective caesarean lists. Roles will need to be recruited to. We aim to have the sessions covered by the end of the financial year. • There was a Regional Maternity Team visit St Michael's to undertake an Ockenden response review at the end of May (the "Insight" visit). This was very successful with some lovely feedback into the safe culture of our teams. Areas to focus on are: 1. Co-production with our communities including the Maternity Voices Partnership (MVP), 2. Evidence of continuous risk assessments in pregnancy and place of birth, 2. Shared decision making. Actions taken: • 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, equipment, and the planned Level E refurbishment. • Ockenden implementation board to be established in September 2022, to enable oversight of progress with actions from the final report.
Ownership:	Chief Nurse

UHBW Perinatal Quality Surveillance Matrix

June data will be available for next month's report.

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Number of babies born alive at >=22 to 36+6 weeks gestation	31	38	24	44	29	26	22	18	36	22	35	31
Number of women who gave births all gestations from 22+0 weeks	415	466	429	429	449	432	419	357	369	422	416	396
Induction of Labour rate %	30.6%	26.6%	27.8%	26.8%	26.6%	24.4%	31.0%	35.4%	26.3%	28.1%	36.5%	29.8%
Unassisted Birth rate %	51.2%	46.7%	46.9%	49.2%	45.0%	45.4%	45.3%	47.2%	45.1%	46.9%	46.8%	48.6%
Assisted Birth rate %	14.8%	15.2%	20.5%	14.5%	17.5%	16.9%	12.4%	14.6%	15.9%	16.5%	17.2%	13.8%
Caesarean Section rate (overall) %	34.0%	38.1%	32.6%	36.3%	37.6%	37.7%	42.3%	37.8%	39.0%	36.6%	36.0%	37.6%
Elective Caesarean Section rate %	15.8%	13.9%	14.9%	14.3%	12.2%	15.3%	17.4%	16.0%	16.7%	16.5%	15.3%	15.5%
Emergency Caesarean Section rate %	18.2%	24.0%	17.7%	21.7%	25.3%	22.4%	24.9%	21.8%	22.3%	20.0%	20.7%	22.1%
Total number of perinatal deaths	0	2	1	1	4	11	6	6	1	5	3	3
Number of late fetal losses 22+0 to 23+6 weeks excl TOP	0	0	0	0	1	1	0	0	0	0	0	1
Number of stillbirths (>=24 weeks excl TOP)	2	1	0	1	2	4	4	2	0	1	2	1
Number of neonatal deaths : 0-6 Days	0	1	1	0	0	1	1	4	0	1	1	1
Number of neonatal deaths : 7-28 Days	0	0	0	0	1	5	1	0	1	3	0	0
Suspected brain injuries in inborn neonates (no structural abnormalities)	0	0	0	0	1	0	0	1	0	0	0	0
Number of maternal deaths (MBRRACE)	0	0	0	0	0	0	0	0	0	0	0	0
Number of women who recieved level 3 care	0	1	1	1	1	2	0	1	1	1	0	2
Continuity of Carer (overall percentage)	46%	44.4%	48.3%	47%	40%	43%	45%	48%	49%	54%	48%	49%

Workforce –Agency Usage

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

N *Not Achieved*

Standards:	Usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets (including Weston) for 2020/21. The maximum agency usage rate has been set at 1.8%.
Performance:	Agency usage for June was 2.3% (264.8 FTE). This was an increased of 31.1 FTE. There were increases in four divisions, with the largest increase seen in Medicine, increasing to 90.4 FTE from 69.8 FTE in the previous month. There were reductions in two divisions, with the largest reduction seen in Women's and Children's, reducing to 18.5 FTE from 20.7 FTE in the previous month.
Commentary:	Actions taken to mitigate agency usage and encourage bank use instead are: • There were 84 new starters across the bank in June, including 38 re-appointments. 23 of the total new starters joined non-clinical bank roles, comprising 12 administrators, 10 cleaning and catering assistants and 1 porter. • Active recruitment continues to substantive medical roles in the Weston Division to drive down the demand for high-cost agency usage. • A pilot is underway to invite partners of the Trust's international nurses to apply for Bank roles in administration, cleaning & catering and healthcare support work at the Trust. So far, 25 applications have been received. • The Trust is currently offering paid travel time for clinical staff as an incentive to encourage staff to pick up bank shifts at Weston to reduce agency reliance. • The Bank team continue to promote 'Allocate on arrival' shifts for clinical staff which carry a 30% rate increase in an effort to increase bank fill and reduce agency reliance. • Working with BNSSG partners the Trust has approved rate increases for Tier 1 agency staff to bring nursing agency rates in line with Wales to drive agency nurse supply back to lower cost agency providers. • Recruitment to the bank has increased in frequency with rolling adverts going out for non-clinical bank roles and bi-weekly interviews taking place to increase bank supply and drive down the high cost agency usage.
Ownership:	Director of People

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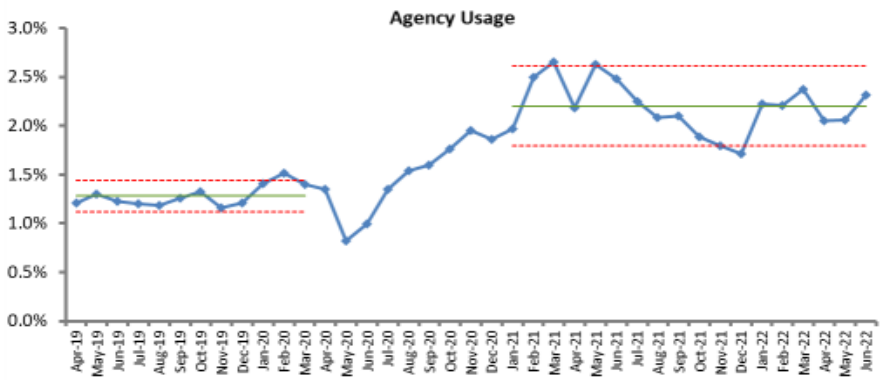


Workforce – Turnover

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

P *Partially 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 target is to have less than 15% turnover.
Performance:	Turnover for the 12 month period remained static at 15.3% in June 2022 compared with updated figures for the previous month. • Five divisions saw an increase whilst three divisions saw a reduction in turnover in comparison to the previous month. • The largest divisional increase was seen within Trust Services, where turnover increased by 0.7 percentage points to 17.9% compared with 17.2% the previous month. • The largest divisional reduction was seen within Facilities and Estates, where turnover reduced by 0.8 percentage points to 16.8% compared with 17.6% the previous month. • Six staff groups saw an increase whilst three staff groups saw a reduction in turnover in comparison to the previous month. • The largest staff group increase was seen within Additional Clinical Services, where turnover increased by 0.9 percentage points to 18.7% compared with 17.7% the previous month. • The largest staff group reduction was seen within Nursing and Midwifery Unregistered, where turnover reduced by 0.9 percentage points to 17.0% compared with 17.9% the previous month. Band 5 Registered Nurse turnover is 18% in June 22.
Commentary:	There are several work programmes progressing to address colleague experience and improve retention: • The exit process task and finish group has successfully drafted a new staff feedback policy, process and questionnaire, which was been circulated for comment to all relevant stakeholders. The feedback window has now closed, work is now in progress to assimilate the feedback and as soon as this has been completed, the policy will be implemented. • A Retention strategy and action plan specific to Nursing and Midwifery is being developed by the Deputy Chief Nursing Officer and the Associate Director of HR Operations, to be instigated by the end of July. This strategy is based on the 4 People Strategy pillars; uses the findings of the exit interview / retention paper presented to People Committee in May 2022; incorporates the 'high impact retention actions' requested by NHS England by letter on 11/7/22; and will be cross-checked against the findings of a Nursing and midwifery retention self-assessment tool which was launched by NHS England in early July. • HR Services are continuing to review a monthly divisional report which will highlight key risks relating to ER casework and leavers feedback. This will be using relevant data from HR systems and will aid the early identification of hotspot areas. • The Trust-wide values programme of work continues to be a priority, embedding a sense of belonging and ensuring staff continue to be engaged with the Values they developed including: • Working in collaboration with the Communications team to embed the values and behaviours by focusing on exploring each value every two months. The current value being explored is `we are respectful` which has been utilised through all our media platforms of the Trust and our communities. *…continued over page*

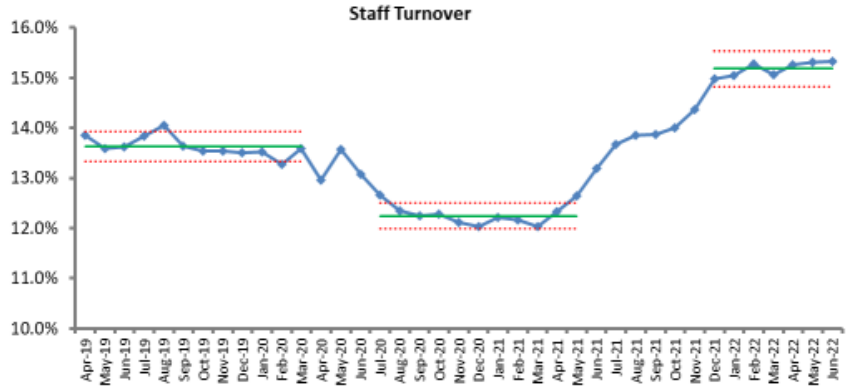
Workforce – Turnover

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

P *Partially Achieved*

Commentary (continued):	• Utilising the 'leaders connected' platform to bring the values and behaviours to life and into action for our leaders who are being developed. In the new leadership behaviours will see a short video from the Chief Executive, Eugine Yafele sharing his vision for the value 'We are Respectful'. • Values and Leadership behaviours training continues to be available. • Quarterly People Pulse Survey launched 1st July. We will continue to use this platform to measure the impact of the new values and leadership behaviours. • The corporate Workplace Wellbeing team commenced a review into the Nurse Wellbeing Lead role to support delivery of the Trust Nursing Retention Plan 2022/23 through provision of 1:1 support and signposting to new starters, newly qualified and overseas nurses particularly in wards with a high level of vacancies, absence or incidents. The review and subsequent recommendations, to conclude in Q2, aims to to ensure equity and consistency of mutual goals and accountability across all Divisions and to address gaps in funding in Divisions without local resource. • A review of our psychological services has commenced aiming to align these services to support staff accessing at the point of need. An informal advisory group has been established to connect psychological wellbeing service leads and developments are underway to include a Peer Support Training model and Suicide Prevention/Postvention resources.
Ownership:	Director of People



Workforce – Vacancies

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

N *Not Achieved*

Standards:	Vacancy levels are measured as the difference between the budgeted Full Time Equivalent (FTE) establishment and the actual Full Time Equivalent substantively employed figures, represented as a percentage, The Trust target is to have less than 7.0% vacancy.
Performance:	Overall vacancies increased to 8.3% (953.5 FTE) compared to 8.0% (912.5 FTE) in the previous month. • The largest divisional increase was seen in Weston where vacancies increased to 148.2 FTE from 125.0 FTE in the previous month. • The largest divisional reduction was seen in Trust Services, where vacancies reduced to 7.1 FTE from 25.5 FTE the previous month. • The largest staff group reduction was seen in Admin and Clerical, where vacancies reduced to 172.7 FTE from 177.5 FTE the previous month. • The largest staff group increase was seen in Medical and Dental, where vacancies increased to 25.5 FTE from 0.8 FTE the previous month. • Consultant vacancy has increased to 43.9 FTE (6.2%) from 30.7 FTE in the previous month, this step change is largely down to a budget amendment in month 3.
Commentary:	Key updates to address the vacancy rate in the current period are as follows: • A new Overseas Pastoral Support and Relocation Managers has started in the Trust's Talent team to support the additional demand for international nurses being recruited to the organisation. • An additional Overseas Pastoral Support and Relocation Manager has been recruited as a six-month pilot to support the onboarding of international medical graduates with the aim of reducing time to hire, improving candidate experience and improving retention. • The Trust is in the process of applying for additional GMC Sponsorship Scheme status to be able to offer non-GMC registered doctors a fast track route to employment (this is currently only offered in two specialties within the Women's and Children's Division). • 70 of the newly qualified children's nurse offer holders have been given the opportunity to commence employment early at Bristol Royal Hospital for Children in a Band 3 or 4 role before they receive their NMC PIN in the autumn with the aim of providing more support to the wards – results to follow. • 20 international nurses joined the Trust during June, taking the total nurses arrived since the start of the programme up to 302 of which 202 have now received their NMC PIN. • The Trust participated in a mass recruitment event with BNSSG partners for Healthcare Support Workers in May. Out of this event, 15 now have start dates booked for July so far. • The Radiology team are in the process of introducing linked progression roles starting at Radiography Assistant roles through to becoming qualified Radiographers, this work will be in collaboration with the Education team to assist with linking in with local schools and colleges.
Ownership:	Director of People

Workforce – Staff Sickness

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

A *Achieved*

Standards:	Staff sickness is measured as a percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2021/22, including Weston. The target is to have a maximum 6.1% sickness rate. The red threshold is 0.5 percentage points over this.
Performance:	Sickness absence increased to 5.6% compared with 5.1% in the previous month, based on updated figures for both months. This figure is now combined with Covid Related absence. • There were increases within seven divisions, the largest divisional increase was seen in Surgery increasing to 5.9% from 5.2% the previous month. • There were no reductions within any division, Medicine division remained static compared to the previous month. • There were increases within eight staff groups, the largest staff group increase was seen in Healthcare Scientists, increasing to 4.2% from 2.8%. • There was only one staff group reduction within Estates and Ancillary reducing to 8.2% from 8.3% compared to the previous month.
Commentary:	• The Supporting Attendance Policy review is continuing to receive feedback from focus groups with staff and relevant staff networks. Work continues regarding a case conference approach to supporting colleagues with complex health needs and reviewing reasonable adjustments. This work is in partnership with the ABLE+ network. • HR Services held Supporting Attendance clinics across May and June enabling colleagues to drop in and discuss any wellbeing needs or concerns that they had. Feedback from those sessions has been collated and will be considered when reviewing the policy. • At present, managers are unable to record menopause-related sickness absence as a primary reason on HealthRoster, this may be updated by Allocate in the future. Meanwhile, in September HRIS propose to pilot menopause absence recording as a subsection to prevalent codes as advised by colleagues experiencing menopause. • The long-term sickness review meeting guide was updated in June to signpost to the inclusive workplace wellbeing offer. A review of workplace wellbeing content within other HR guides is planned for Q2.
Ownership:	Director of People

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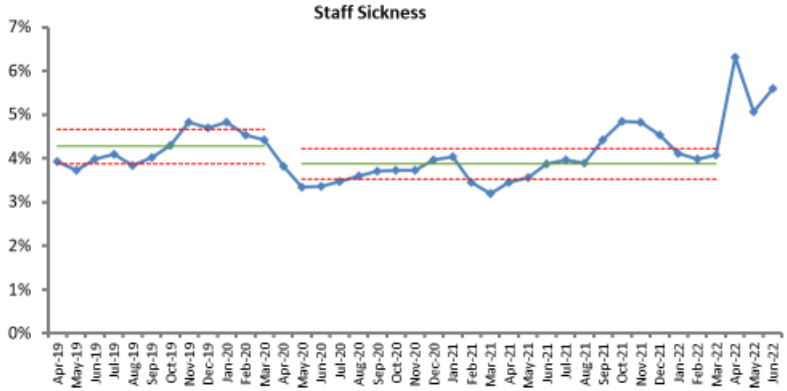


Workforce – Appraisal Compliance

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

N *Not Achieved*

Standards:	Staff Appraisal is measured as a percentage of staff excluding consultants who have had their appraisal signed-off. The target is 77%.
Performance:	Overall appraisal compliance reduced to 70.2% from 70.8% compared to the previous month. • There were increases in four divisions, and reductions within four divisions. • The largest divisional increase was within Facilities and Estates, increasing to 84.4% from 82.5% in the previous month. • The largest divisional reduction was within Diagnostic and Therapies, reducing to 73.2% from 77.9% in the previous month. • Only Facilities and Estates remain above the new KPI target, reducing by two divisions.
Commentary:	During April 22 an exercise was taken to add all Weston based employees onto Kallidus Perform replacing ESR Manager Self Service. A trust wide review to improve the quality of appraisal conversations with a focus on personal development, wellbeing, and talent is in place which will impact positively on compliance. A detailed project plan is in place leading up to an anticipated launch of a new appraisal form in September 2022, this plan will include the delivery of the pay progression agenda. The delivery plan is underway with the following achievements to date: • Bi-weekly sprint meeting with key stakeholders, • Trust Wide Appraisal Survey, • Alignment of online appraisal Division of Weston, • External benchmarking and • Appraisal workshop and Focus Groups.
Ownership:	Director of People

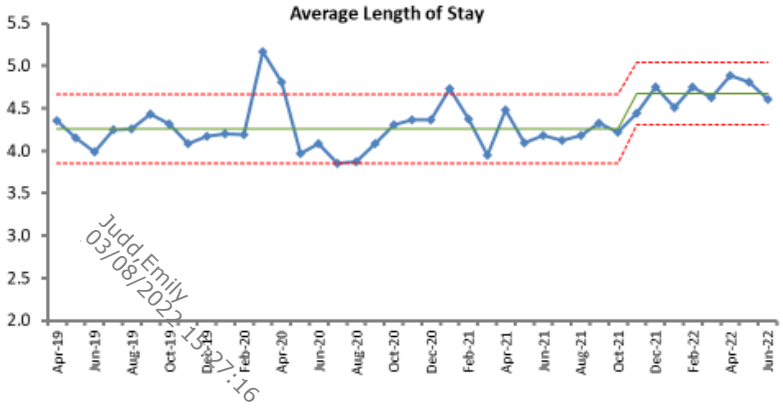
Average Length of Stay

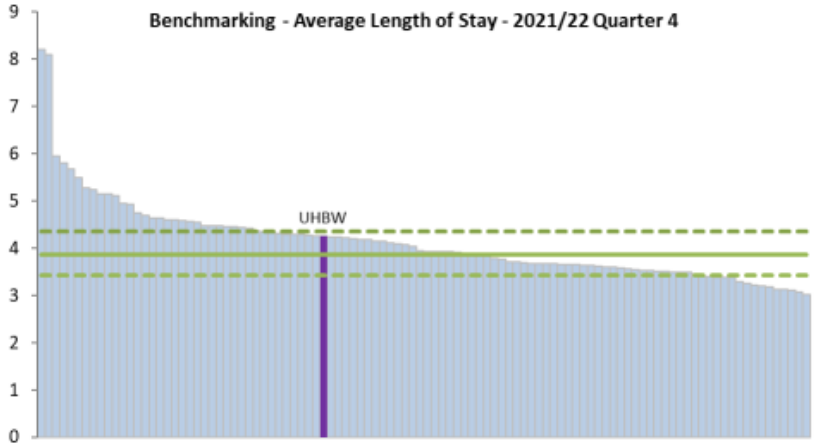
University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

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 June there were 31,487 discharges at UHBW with an average length of stay of 4.61 days.
Commentary:	Current assumptions around length of stay are being reviewed as part of the 2022/23 operating plan submissions and demand & capacity reviews.
Ownership:	Chief Operating Officer





Finance – Executive Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2022

YTD Income & Expenditure Position	• Net I&E deficit of £6,865k against a planned deficit of £3,874k (excluding technical items). • Total operating income is £1,038k favourable to plan due to higher than planned income from patient care activities of £2,526k. • Operating expenses are £4,300k adverse to plan primarily due to higher pay expenditure (£5,666k adverse), the shortfall in Trust CIP delivery of £1,271k, offset by lower than planned depreciation expenditure of £331k and lower than planned other non-pay expenditure of £2,286k. • Technical and financing items are £271k favourable to plan.
Key Financial Issues	• *Savings delivery below plan* – Trust-led CIP delivery is £2,726k or 68% of plan. Full year forecast delivery is £10,952k or 73% of plan of which recurrent savings are £5,365k, 36% of plan. • *Lower than planned elective activity* – if overall elective activity continues below plan there will be a reduction in ESRF income which could contribute to the Trust not meeting its plan. • *Pay costs higher than plan* – pay expenditure must be maintained within divisional and corporate budgets with enhanced pay rates ending from July. • *Forecast overspend against divisional budgets* – divisional forecasts will be monitored monthly and recovery plans developed where overspends are not acceptable.
Strategic Risks	• Agreeing an approach to future financial targets and allocation of system envelopes – on-going; • Assessment and implications of the financial arrangements relating to Healthy Weston – pending completion of a Full Business Case/(s); • Continue to 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 – on-going. • Understanding the implications of not delivering the financial plan, the impact this may have on future investment opportunities and the ability to maintain autonomy- pending.

Finance – Financial Performance

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

Trust Year to Date Financial Position

	Month 3			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	78,798	80,568	1,770	230,144	232,671	2,526
Other Operating Income	9,059	8,688	(371)	27,176	25,689	(1,488)
Total Operating Income	**87,857**	**89,257**	**1,400**	**257,321**	**258,359**	**1,038**
Employee Expenses	(49,040)	(51,827)	(2,786)	(150,992)	(156,658)	(5,666)
Other Operating Expenses	(33,071)	(33,047)	24	(97,768)	(96,733)	1,035
Depreciation (owned & leased)	(3,470)	(4,456)	(986)	(9,262)	(8,931)	331
Total Operating Expenditure	**(85,582)**	**(89,330)**	**(3,748)**	**(258,021)**	**(262,322)**	**(4,300)**
PDC	(1,037)	(1,037)	0	(3,112)	(3,112)	0
Interest Payable	(244)	(402)	(158)	(732)	(728)	4
Interest Receivable	29	139	109	88	322	234
Other Gains/(Losses)	0	(19)	(19)	0	(19)	(19)
Net Surplus/(Deficit) inc technicals	**1,023**	**(1,393)**	**(2,416)**	**(4,456)**	**(7,499)**	**(3,043)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	194	264	70	582	634	52
Net Surplus/(Deficit) exc technicals	**1,217**	**(1,129)**	**(2,346)**	**(3,874)**	**(6,865)**	**(2,991)**

See the Trust Finance Performance Report for full details on the Trust's financial performance.

Key Facts:

- The position at the end of June is a net deficit of £6,865k, £2,991k higher than the planned deficit of £3,874k.
- Pay expenditure is £51,827k in June, c£1,400k lower than May. YTD expenditure is adverse to plan by £5,666k, mainly due to enhanced rates of pay, the cost of escalation capacity, F1 junior doctors costs and international recruitment costs.
- Agency expenditure in month is £3,127k, c£800k higher than May and c£500k higher than plan. Overall, agency expenditure has increased from 5% to 6% of total pay costs.
- Operating income is favourable to plan by £1,038k. The adverse position on 'Other Operating Income' is driven by lower than expected income levels for research, education and non-patient care activities.
- Income from Patient Care Activities is £2,526k favourable to plan.
- Trust-led CIP achievement is 68% of plan. £2,726k has been achieved against a target of £3,997k, a shortfall of £1,271k.
- Additional costs of Covid-19 are £568k, a reduction of £137k from £705k incurred in May.

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th August 2022

Report Title	**Learning from Deaths Annual Report 21/22**
Report Author	**Rebecca Thorpe, Alice Hillyard**
Executive Lead	**Medical Director**

1. Report Summary

The report describes the structures of the learning from deaths programme across the Trust and introduces the newly embedded Medical Examiner's office.

It also looks at the mortality data across the year across several metrics and reviews themes and outlying areas. Themes identified as part of scrutiny processes are reviewed and actions taken detailed.

The report will summarise work planned for 2022/23.

2. Key points to note

(Including decisions taken)

- Ongoing investigations into incidents involving intra-hospital transfers and Weston Sepsis protocols have resulted in education programmes and revisions to SOPs.
- Medical Examiner feedback with comments from families is communicated to care areas to share learning - this includes compliments where teams have shown great compassion to families and patients. Other feedback includes families experiencing problems reaching wards by phone and problems in care for outliers.
- Delays in escalation to end of life care is also a theme but less prevalent than previous years.
- Autism is now also a mandatory review category from April 2022.
- Collaboration with NBT to review effectiveness of processes

3. Risks

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

The risks associated with this report include:
No new risks to 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	26 July 2022

University Hospitals Bristol and Weston
NHS Foundation Trust

LEARNING FROM DEATHS

2021 – 2022 ANNUAL REPORT

Authors: Dr Rebecca Thorpe, Associate Medical Director,
Alice Hillyard, Dawn Shorten

INTRODUCTION

This report covers the Learning from Deaths for the year 2021/22.

This has been an exceptional year with the healthcare system still responding to the COVID-19 pandemic. The Learning from Deaths programme has also undergone a period of significant change with a new Mortality Lead, Trust Medical Director and changes in divisional mortality leads. Furthermore the Medical Examiner (ME) role has been embedded within the Trust and moved to "business as usual."

This report will lay out the figures relating to the programme, the structure and governance processes and analyse the themes that have emerged in year.

This report covers learning from adult deaths across the Trust and a separate Child Death Review (CDR) report will be shared by the CDR lead.

FIGURES AND ANALYSIS

During 2021/ 22 all adult deaths were reviewed by the Medical Examiners. The number of deaths overall was higher than in 2020/2021 (1286) this is may have been caused by patients not being admitted to hospital during the pandemic. Furthermore, anecdotally we know that patients are presenting with more progressed disease and in emergency circumstances at a higher rate than in 2019.

The increased numbers of patients dying had also been remarked on as a theme by the Intensive Care Unit who review all deaths under their care. They noted that this work had become much more significant in the past year and particularly in quarter four.

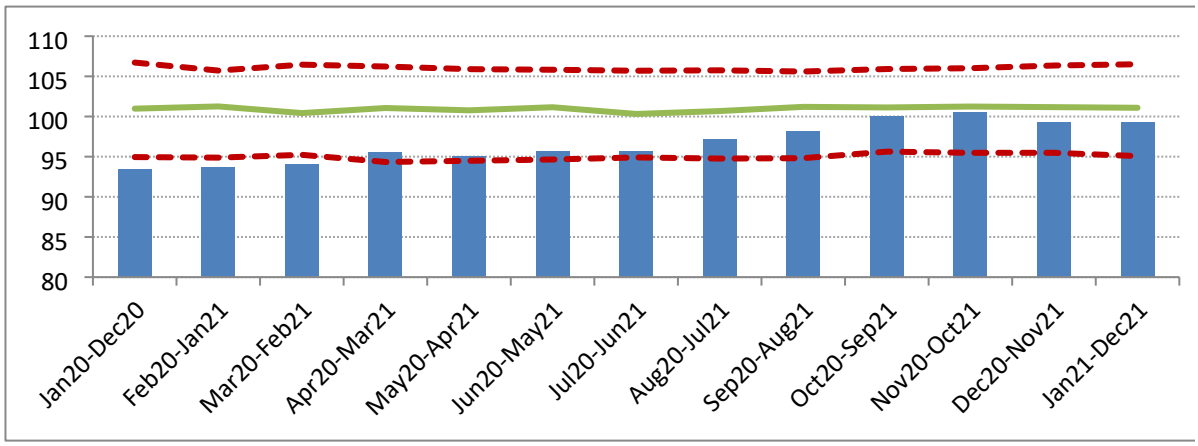
Figure 1: Trust deaths per quarter

	Q1	Q2	Q3	Q4	
Medicine	138	220	228	362	
Surgery	31	38	32	42	
Specialised	72	64	51	87	
Weston	123	130	147	5	
W&C	19	16	34	23	
Total	**383**	**468**	**492**	**519**	**1862**

Please note in Quarter four the Weston data was fully amalgamated with the rest of the Trusts and therefore the deaths have been redistributed by clinical area to the division they would correspond with (mostly medicine). Therefore the Weston Q4 deaths are only five.

On comparing the Summary Hospital-level Mortality Indicator (SHMI) data with other local Trusts it appears UHBW has continued to see fewer deaths than the England average. However the rate of deaths compared to admissions has increased over the course of the year whilst the averages have remained static.

Figure 2: Summary Hospital-level Mortality data 202 by month:



The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. In the chart above, the blue vertical bars are UHBW data, the green solid line is the Median for all Trusts, the dashed red lines are the Upper and Lower Quartiles. In simple terms, the SHMI 'norm' is a score of 100 – so scores of less than 100 are indicative of trusts with lower than average mortality.

Overall across the year January 2021 to December 2021the Trust achieved a SHMI score of 99.4

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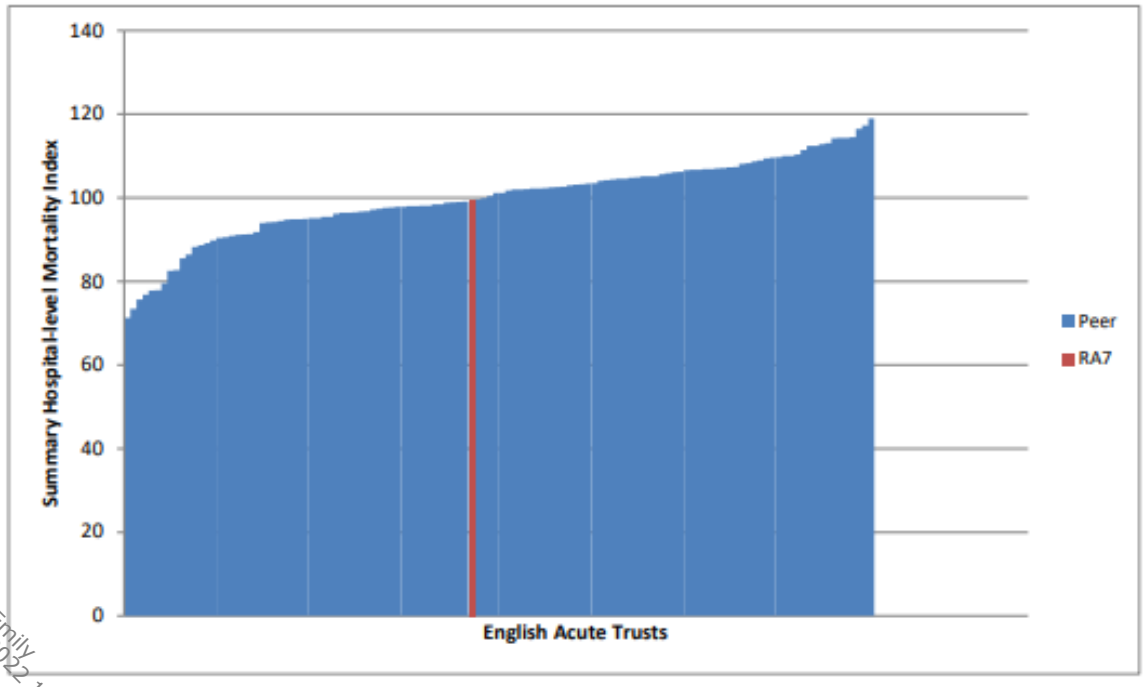
Figure3: Summary Hospital-level Mortality data annually

Cases	Observed Deaths	Expected Deaths	SHMI	Excess Deaths
83314	2122	2134.7	99.4	-12.7



The clinical areas that had the highest SHMI scores across the Trust are:

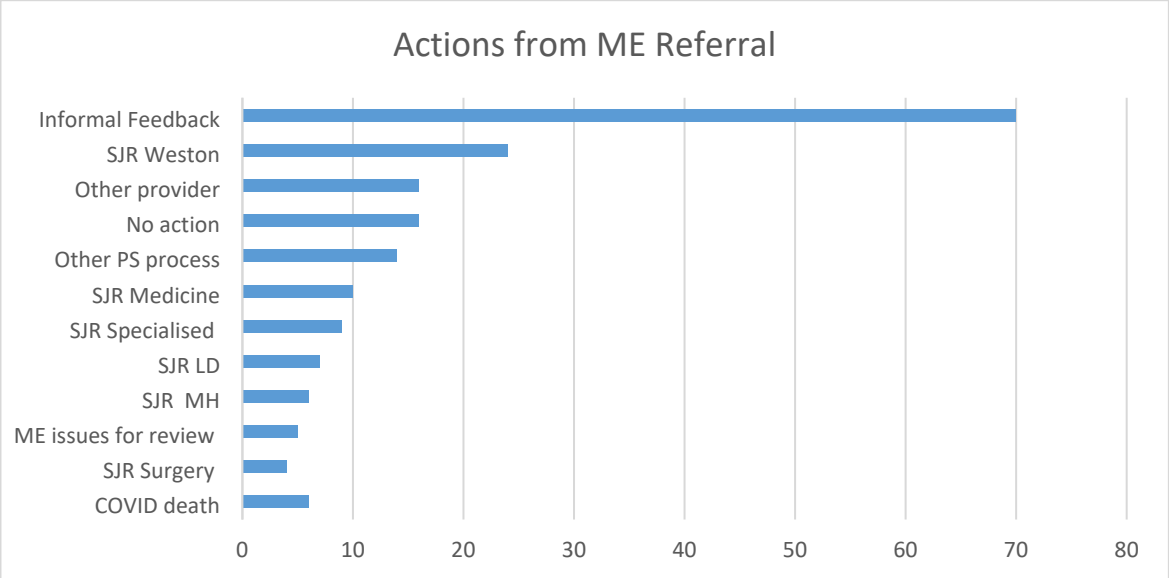
Area	Anticipated number of deaths	Actual number of deaths
Disease of veins and lymphatics	3.1	10
Other perinatal conditions (not pregnancy related conditions)	13	38
Complication of device; implant; or graft	13	26
Lung disease due to external agents	12	24

The programme team will seek to review this data along with NBT as part of our work with the “Better Tomorrow” programme (see section work initiated for 2022/23).

Of the total adult Trust deaths 187 (10%) were flagged as of possible concern by the Medical Examiner. These are then reviewed and triaged by the Medical Director Team so that each case can be taken forward though the most appropriate process. The triage process is described below in the governance and processes.

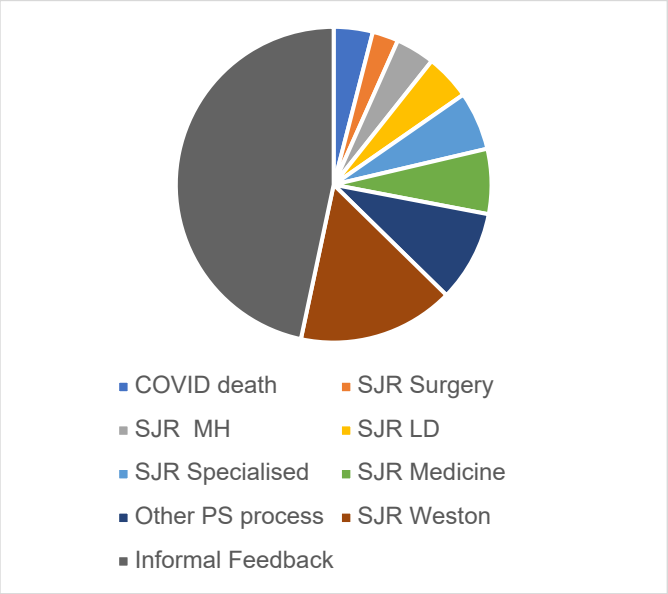
The ME team were only fully operational in January 2021 and therefore have refined their processes and training throughout the year. A breakdown of the actions resulting from the cases identified can be found below:

Figure 4: ME referrals Triaged by Outcome



Figures 5 and 6: Trust Actions Resulting from ME Referrals

Resulting action	number
COVID death	6
SJR Surgery	4
ME issues for review	5
SJR MH	6
SJR LD	7
SJR Specialised	9
SJR Medicine	10
Other PS process	14
No action	16
Other provider	16
SJR Weston	24
Informal Feedback	70
Total	**187**



Most of the actions generated for the Trust were to informally pass feedback to clinical areas for future learning and reflection, for examples see the themes identified section.

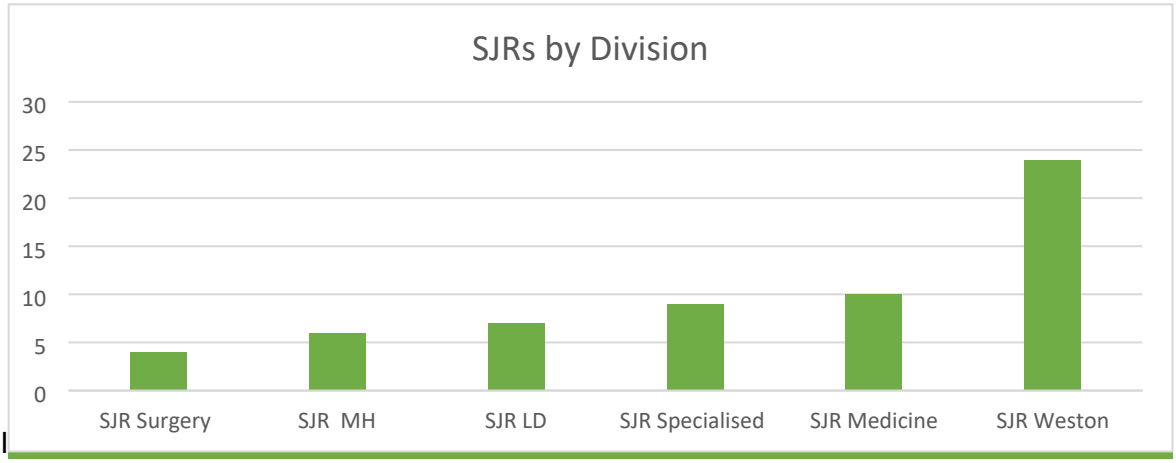
It should be noted that some cases require multiple actions, only the top action per case has been included in this data.

Of the cases that required further action a disproportionate volume related to Weston patients. By way of partial mitigation, it should be noted that the lead Medical Examiner is a Weston based consultant who has previously held several patient safety roles. He undertakes a high proportion of the reviews and is acutely aware of the processes and issues in the division and may be identifying concerns that a more generalist reviewer might not. However, referrals are still only made when there is a clinical concern regarding the case or when the family have significant issues to raise about care and therefore this high number cannot be overlooked.

Though the numbers are small there are some patterns which can be correlated with other known ongoing issues at Weston. Of the cases for SJR:

- Four cases relate to delayed administration of antibiotics in cases of possible sepsis. This has commenced work with the Emergency Department which is described in the themes section.
- Four cases clearly highlight continuity of consultants as a possible area of concern, this a known challenge in Weston's Medical teams which the Medical Leadership team have done significant work to tackle, with improved rota structures, increased staffing consistency and regular audit.
- Three cases suggest the patient's death was not avoidable but that the threshold for moving the patient to end of life care appeared too high/aggressive. These cases will be passed to the End of Life Steering Group and the Palliative Care lead at Weston to support ongoing learning.
- Three referrals state that assessing the patients care was made difficult by poor-quality documentation and note keeping.

Figure 7: SJRs by Divison



For further information and to allow for comparison the divisions have an approximate bed base as follows:
Weston 257
Medicine 240
Surgery 162 (including 11 beds within the eye hospital)
Specialised Services 85

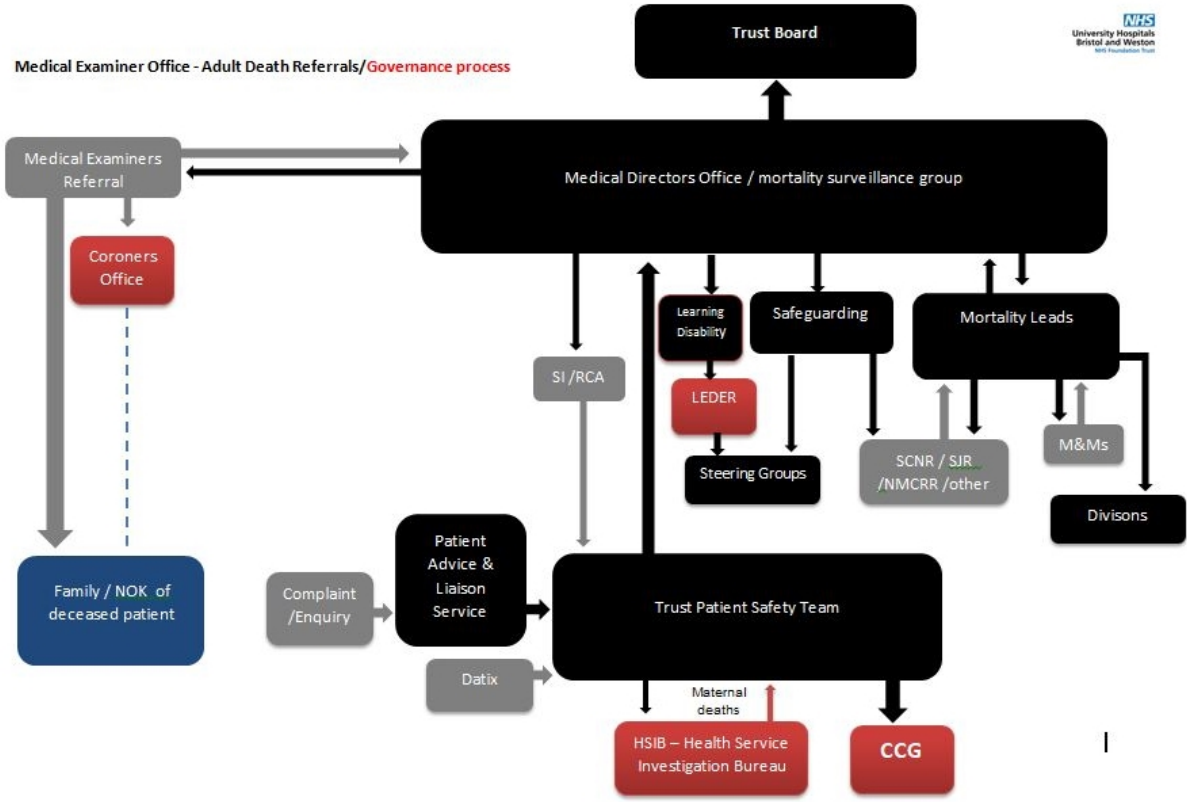
GOVERNANCE & PROCESSES

Changes to the team:
The team and processes have evolved during 2021/22. In September Professor Mark Callaway stepped down as Mortality Lead for the Trust and was replaced by Dr Rebecca Thorpe, newly appointed Associate Medical Director with a portfolio covering Patient Safety. Dr Thorpe chairs the Patient Safety Group and the Mortality Steering Group which has enabled the links between the two programmes to develop and mature.

The Trusts Learning from Death policy was updated this year and is now due for review in 2024. Mr. Paul Wilkerson, Mortality Lead for Surgery has also updated the e-learning to support clinicians to complete Structured Case Note reviews (SCNRs) the updated training can be found here: **https://360.articulate.com/review/content/a751b1b8-8d26-4eef-b7d6-dfbde7e4b51a/review**.

As highlighted above the pan-Bristol Medical Examiner team has been at full establishment during the year, reviewing all adult deaths across the Trust (and NBT) and liaising with families and clinical teams to create a medical cause of death certificate. The lead Medical Examiner and lead Medical Examiner officer attend the Mortality Surveillance Group and the teams work closely together. From 1st April 2023 The Medical Examiners will become statutory and their remit has begun to expand into the community.

Figure 8: Learning from Deaths Governance Structure



The governance process remains broadly unchanged this year although the process has been improved to make sure that the “softer” themes are more widely shared even if they do not trigger a Structured Case Note review.

1. The Medical examiner reviews all hospital adult deaths. Cases that might be of concern are reported weekly to the Medical Director office.

2. The cases are triaged:
   a. Cases where the feedback can be done informally to the clinical teams, i.e. concerns about communication etc. that would not have affected the outcome to the patient. This feedback is often positive.
   b. Cases that require review.
   There are several mandatory criteria which trigger a SCNR:
   (i) Deaths after an elective procedure
   (ii) Deaths where the family raise concerns about the overall care
   (iii) Patients with learning disabilities who have died (undertaken by Learning Disabilities team)
   (iv) Patients who have died with a history of severe mental illness, this is defined as patients receiving on-going care from secondary mental health services or were detained under the Mental Health Act 2007 at the time of their death (undertaken by MH team)
   (v) Patients aged between 16-18 years
   (vi) Patients who die and have triggered a serious incident review.
   (vii) Deaths that occur following an alert that has been raised with the organisation
   (viii) Patients who have died within 30 days of discharge from hospital

3. Cases that require review are passed to the divisional mortality lead to either undertake the SCNR or identify an appropriate clinician to do so. Different divisions

have different processes, but cases may also be discussed at Mortality and Morbidity meetings (M&Ms) or other divisional forums so that learning can be shared.

4. If the case triggers another patient safety process (such as a Serious incident Review) an SCNR is not completed to avoid duplication of work

5. Themes and learning are shared within the division by the mortality lead and then across the Trust via the Mortality Steering Group.

Child Deaths

The Child Death Review (CDR) process is followed for all children that die under the age of 18 years, regardless of the cause of death. The process runs from the moment of a child's death and occasionally commences earlier in cases where death is inevitable. Once all relevant information has been gathered, a Child Death Review Meeting (CDRM) will be arranged. This is the multi-professional meeting attended by professionals directly involved in the care of that child during life and those involved in the investigation after death. The focus of the CDRM is on local learning. The CDR process concludes with an anonymised secondary review by the Child Death Overview Panel (CDOP). This review is informed by an analysis form completed after the CDRM and focuses more on system-wide learning. The Child Death Review Statutory and Operational Guidance (England) is available for download from the government website. Specific local guidance about the CDR process can be found on the UHBW intranet. A link to the current CDR Standard Operating Policy can be found in the appendices.

Risks:

There are currently three ongoing risks associated with the programme which should be noted:

Description	Score	Mitigating actions
No mortality lead is currently appointed in Weston	Moderate	An interim lead was in place until March 2022. All SRJs until this point have therefore been completed. A process has been put in place where SJRs are shared with the clinical directors for medicine and surgery within the division who will identify suitable clinicians to complete the reviews.
No single second screening process results in some cases being missed.	Low	Medical Examiner reviews all adult deaths CDR process reviews all child deaths Some other key clinical areas (i.e LD[1] and ITU) review all deaths regardless of whether they receive a referral Patient Safety teams liaise with Dr Thorpe regarding incidents raised to them. Report in place to try and capture deaths within 30 days of discharge.

[1] [1] All LD deaths receive a LD specialised review under NHS England LeDeR framework, in 2022 this will include Autism. Key themes identified through LeDeR are shared with the mortality group.

Some Medical Examiner referrals require improvement. Specifically 1. it is sometimes difficult to establish the area of concern. 2. In some cases, the language used in the referral is overly informal or emotive,	Low	ME referrals are triaged by the Medical Director Team who clarify areas of uncertainty and amend any language before sharing more widely. The Medical Director team feed back to the ME suggested areas of improvement. The Medical Director team have attended the ME team meeting to present on how referrals could be improved.

THEMES IDENTIFIED

Several Trustwide themes have been identified and acted upon during the course of the year.

1. Communication with families and information sharing

Challenges communicating with the wards is a consistent theme in the feedback the Trust receives through the Mortality Review process, being included in 9% of all referrals. This was particularly difficult for families when visiting was restricted during the pandemic but remains the most common negative feedback received. Often families do not wish to raise a formal complaint and are very sympathetic to the pressures staff are under but are anxious that other people have a better experience.

"Spoke to son who stated that communication was 'appalling' it was almost impossible to get through to the ward and speak to a doctor or nurse. He dialed in more than 25 times on one occasion and in the end called his father directly"

"Daughter raised concerns about poor communication with the family from the treating team. They were told they were only allowed to see him if he became poorly (he was dying) and felt they were not updated."

All concerns like this are passed directly onto the senior ward staff and also shared with divisional nursing staff. Patients are encouraged to contact Patient Complaints and Support Team if they would like to receive a formal response to their concerns. This theme is also discussed at the End-of-Life Steering Group, chaired by Sarah Dodds, Deputy Chief Nurse.

The Programme will work in 2022/23 to strengthen its links with the Patient experience teams so that this feedback can positively contribute to the ongoing work that they are undertaking.

"Numerous attempts to transfer/get action regarding the patient's rib fractures which were too complicated for WGH to attempt a regional block. The transfer was delayed and required multiple calls. The gentleman died from his underlying malignancy – but things could have been less painful for him. He needed either a thoracic opinion, or acute pain procedure both of which required transfer to BRI."

2. Transfers and transport

Since the winter of 2021 there have been a number of cases identified though incident reporting and mortality reviews where patients experienced delays in emergency transfer between hospital sites. This is due to the significant pressure the ambulance service is under. Calls from hospitals are usually classed as "category two" by South West Ambulance Service Trust as the patient is considered to already be in a place of safety. Due to the geographical distance between the sites this particularly impacts Weston patients who require transfer to Bristol for acute interventions, but also impacts transfers from South Bristol Community Hospital and St Michael's Hospital.

The Medical Director team and central Patient Safety team have scheduled a harm panel to review the incidents thematically, establish root causes and begin an options appraisal for mitigations to avoid future harm.

3. Medical outliers

Because of the huge operational pressures the Trust is under across all sites optimal bed placement is very challenging and there are a very high numbers of patients being cared for in areas that do not specialise in their area of need. This particularly impacts medical patients.

1. Continuity of care - different team most days 2. Medical outlier despite concerns that this was inappropriate for care 4. Documentation indicating serious pain but minimal analgesia 5. Absence of clear diagnosis. Postgraduate Doctor feels strongly that the patient was let down

This can result in patients receiving sub-optimal care as the Medical doctors care for patients spread over a wide area without the specialist Allied Health Professional and nursing staff that would support them in medical wards. This also has a significant negative impact of the staff who are unable to deliver the high quality, very responsive, care they would wish to as well as having to spend significant time moving between areas.

The programme will aim to strengthen its links with operational colleagues in 2022/23 to support the significant work of the clinical site team to optimise patient placement.

4. Positive feedback across all sites

A significant amount of the feedback the Trust receives is hugely positive. This is shared directly with the clinical area and staff themselves if they are identifiable.

Weston: “Spoke with [sister] who stated the care on the ward was excellent - all staff especially the consultant who spent time explaining and keeping her up to date with her brothers’ condition.”

Bristol: "The staff were 'bloody marvellous'! Just terrific - hard to articulate - facilitated visiting, making sure family were looked after, providing cups of tea, looked after especially, who was the most upset - comforting and compassionate. Cannot imagine it being done better anywhere else. The care was outstanding!

This feedback is often gratefully received and the process should consider whether there are opportunities or benefits to formalising this feedback so that it can be more widely received.

5. COVID-19

COVID – 19 has remained an ongoing theme across the Learning from Deaths Programme during 2021/22 with the response continuing to evolve alongside national policy.

Harm panels to review patients who had died of hospital acquired COVID took place in March, May, and August 2021. A clinical team discussed all patients who had died after

testing positive for COVID-19 on day 7 or later of an inpatient stay. The panel sought to conclude whether the patient died “of” or “with” COVID-19. In cases where the patient was judged to have died “of” COVID duty of candour processes were completed and investigations undertaken.

Since August 2021 the process has been shared with the divisional patient safety teams. Cases where patients have died of hospital acquired COVID-19 are highlighted by the Medical Examiner and shared with the Patient Safety Teams to review and undertake the appropriate processes.

6. Delayed administration of antibiotics

“Missed one hour target of IV antibiotics - and only gave one applicable medication. Second med noted to be appropriate at midnight - but not given until 0800 next day.”

Several cases were identified of high-risk Sepsis patients attending the Emergency Department in Weston but not receiving antibiotics within the one hour stipulated in national guidance. Although it was not felt that this delay changed the outcome for any of the patients identified NICE guidance states that failure to treat red flag sepsis patients increases mortality by 7% per hour treatment is delayed.

The central Patient Safety Team have therefore been working closely with Dr Dowds, Clinical Lead, to deliver service development and education. Nurse educators are going into the ED to do focused training on screening and treatment for sepsis. The nurse RAT (rapid assessment and triage) model is also being rolled out in Weston ED to bring in line with BRI ED.

7. Possible theme of Afro-Caribbean families and end of life discussion

“The family had a long discussion where they explained they felt [the patient] was being 'left to die', and the son said that he felt as though he was 'negotiating for his

At the beginning of the year the Trust received four referrals which seemed to indicate a possible pattern relating to Afro-Caribbean families being unhappy when a patient was moved to end of life care. This was discussed at the End-of-Life Steering Group and with the Patient Experience manager to consider as part of future training. In each case the wards contacted the individual families to discuss the case.

8. Other providers

As the ME team have only been operating across the Acute Trusts in 2021/2022 they have had limited avenues to share concerns raised by families with other organisations. This has resulted in concerns being raised with UHBW in the first instance. A process has been agreed this year that any concerns not relating to the Trust be returned to the ME team so that they can be escalated to the regional Medical Examiner.

WORK INITIATED FOR 2022/2023

Work with NBT and "better tomorrow"
Work has already begun to further evolve the Learning from Deaths processes over the next year. Regionally work has commenced to align the processes and share the learning between NBT and UHBW more closely. A group has been established with mortality leads from both Trusts and an agreement reached that to engage together with the national "Better Tomorrow" programme.

To this end a self-assessment has been undertaken to identify common strengths and areas for improvement and an initial meeting held with the national leads. BNSSG Integrated Care System would be the first muti-Trust project for the programme.

Closer links with Quality Intelligence Group and data:
Until now the Mortality Surveillance Group have predominantly reviewed qualitative data, exploring individual cases for learning, and identifying themes in an ad-hoc manner. During 2022/23 the group will seek to consider more quantitative data, linking more closely with Stuart Metcalfe, Head of Audit and Clinical Effectiveness, to identify trends using the CHKS (a provider of healthcare intelligence) data already available to the Trust.

APPENDICIES

Further related reporting:

Local Medical Examiner Annual Report 2021/11

NBT and UHBW Medical Examiners R

National Medical Examiner Annual Report 2021/11

https://www.england.nhs.uk/publication/national-medical-examiner-reports/

Bristol Royal Hospital for Children Annual Report on Child Deaths from 2020

BRHC Annual Report on Child Dea

Child Death Review Standard operating policy.

CDR SOP V4 Final.pdf

Current May 2022

Meeting of the Board of Directors in Public on Tuesday August 9th 2022

Report Title	**Maternity Perinatal Quality Surveillance Matrix (PQSM) Quarterly Update Report/ Clinical Negligence Scheme for Trusts update**
Report Author	**Sarah Windfeld / Ingrid Henderson**
Executive Lead	**Deirdre Fowler, Chief Nurse and Midwife**

1. Report Summary

This report provides the Trust Board with quarterly oversight with regards to the safety matrixes of UHBW maternity and neonatal services for the months of May and June 2022. This report is a standing agenda item as per the recommendations set out in the Maternity Incentive Scheme (MIS) Year 4 and the NHS England report, *Implementing a revised perinatal quality surveillance model*.

2. Key points to note

(Including decisions taken)

Perinatal Quality Surveillance Matrix (PQSM)/MIS compliance

Continued implementation towards full compliance with MIS (Maternity Incentive scheme) safety standards year 4 continue. MIS reinstated submission date moved to 5th January 2023.

Strengths:

- Implementation of Continuity of Carer (CoC) presently 41%, with BAME at 61.4% and IMD 1(most deprived) at 75%. As part of our continual risk assessment, four CoC teams continue to run and two teams have been paused until staff have been recruited to fill newly vacant posts.
- UHBW maternity services are achieving 10 out of 11 MSDS (Maternity data Safety Standards) quality metrics. Personalised care and support plan use is unable to be recorded due to insufficient numbers in the data set. This will increase with further roll out and relaunch of the care plans.
- 100% compliant in the use of the perinatal mortality reporting tool in Quarter 1.
- 11 newly qualified midwives and 2 Band 6 midwives to start in September 2022. 3 newly qualified midwives to start in January 2023.
- 11 NICU nurses to start in September/October 2022 and a further 5 international nurses to start in December 2022.

Challenges:

- UHBW is not compliant with the 90% target for all staff groups to have completed Obstetric emergency and fetal monitoring training annually. Extra sessions are being scheduled. All midwives are booked on sessions and will be compliant at the end of the reporting period unless pulled to cover clinical work. There is a plan for all new doctors to do training when they start the new rotation in August.
- SBLCBv2 (Saving Babies Lives Care Bundle version 2) - Carbon monoxide (CO) screening audits restarted, with a requirement to achieve 80% CO screening offered and recorded at booking and at 36 weeks of pregnancy for all women. There is variation across the community midwifery teams with compliance, although compliance is improving. Audit results have been escalated to senior teams to raise awareness amongst all maternity staff.
- There is a risk associated with a potential failure of MIS clinical negligence scheme for trusts (CNST) due to IT connectivity issues and capacity constraints within the

community midwifery teams. The Trust IM&T team are helping to resolve this issue. MIS allows for manual audit but expects data to be entered electronically.

Improvement work:

- Following feedback from our patient survey, we are improving the patient information leaflets and posters on display in ward areas with reference to 'welcome to the ward', expectations for self-help following birth such as mobilisation after caesarean section and process for discharge. Posters displayed in ward areas have been improved to add pictures next to QR codes to aid understanding when English is not their first language, or literacy is challenging.
- Funding has been allocated to provide a full day elective caesarean section list Monday through to Friday which will greatly improve our elective work and plans are being developed to implement this.

Learning from incidents:
There were two incidents related to perinatal care reported in May which have warranted further investigation.

- Incident 182464. Patient had a post-partum haemorrhage. This was reported as a no harm incident but is being investigated. No care provision issues have been noted on initial review. Appropriate emergency care provided Patient required examination under anaesthetic following secondary PPH, placental cotyledon found slightly adhered in the uterus.

- Incident 182336 - delayed assessment of a baby with a bilious vomit. This was reported as a near miss incident which has been investigated. The final draft report has been shared with Central Patient Safety Team, reviewed by Executive team for divisional investigation, not declared a Serious Incident (SI).

- There were no SIs reported to Healthcare Safety Investigation Branch (HSIB) in May. There were three SIs reported in June, two were new HSIB cases.
    - Incident 185461 - The family have declined HSIB investigation, this is being investigated internally.
    - Incident 186513 - baby required therapeutic cooling after unexpected poor condition at birth requiring ventilation support. The MRI was reported as normal, HSIB have declined subsequently to take the case.

Both cases will be reviewed internally, and any learning shared with staff, Local Maternity System and through quarterly report to the trust board when available.

- The third incident (184665) involved a premature baby who suffered an extravasation injury from a longline in right arm due to seepage of total parental nutrition (TPN). After Executive review, this was downgraded as it is a known complication. Specialist review believes the TPN has caused a 'chemical burn', there is no known documented case of this happening before. Baby is having physiotherapy and appears to be making a slow recovery.

Safety walk-arounds: Staff concerns shared monthly with the Maternity and Neonatal Safety Champions and actions fed back to staff, current themes continue to include:

1. Staffing- the number of staff that have been off with covid and the challenges to ensure staff are replaced.

2. Post-natal and ante-natal ward refurbishment
3. NICU regularly have staff and patient toilets out of order, this means both patients and staff must leave the unit and use the facilities on the floor below. This has been resolved.

Escalation:

- Sporadic capacity issues with the flow of inductions (to match increasing demand)
- Ongoing lack of appropriate antenatal scan capacity to manage implementation of some specific scan pathways for large or small for gestational age (LGA/SGA) babies in line with RCOG (Royal College of Obstetricians & Gynaecologists) guidance, due to difficulties with recruitment and retention of sonographers
- Ockenden safety action recommends two MDT consultant led ward rounds on CDS (Central Delivery Suite) day and night. Presently the Consultant undertakes two ward rounds during the day, but the Consultant is not present at the ward round at night. A regional bid for funding (Ockenden funding) was unsuccessful. Alternative rostering arrangements are being reviewed.

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

The risks associated with this report include

1. 3343 - delayed elective LSCS (Lower Segment Caesarean Section)
2. 2264 - delayed induction of labour
3. 5652 - Risk that St Michael's Hospital (STMH) cannot offer an induction of labour (IOL) at 41 weeks as recommended by NICE guidelines
4. 33/3623/988 - NICU staffing/BAPM (British Association of Perinatal Medicine)
5. 3553 Risk that the trust will not achieve CNST safety standards
6. 4810 Risk that if the trust does not achieve continuity of carer we will not achieve CNST safety standards
7. 3643 Risk that patient care will be compromised if remote IT access is not improved to provide a reliable accessible secure system

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

- This report is for **Assurance**

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

Women's leadership meeting	28/07/2022

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Trust Board of Directors in Public – 9 August 2022

Reporting Committee	**Finance & Digital Committee – meeting held on 26 July 2022**
Chaired By	**Jayne Mee, Chair**
Executive Lead	**Neil Kemsley, Director of Finance and Information**

For Information

Digital Services Report

The Committee received the digital services report and briefing. Of note, was the successful go live of Vitals e-observations across the Children's Hospital. Other go-lives were Medilogik Endoscopy at Weston and the Topcon ophthalmology image system. It was noted that the infection prevention and control system had been delayed by the supplier and would now take place next week.

The Committee acknowledged that it appeared progress was being made with scanning and digitisation, but it would be good to see what our targets were. Non-Executives had recently visited the Eye Hospital and feedback from the consultants was that space was being taken up by paper records. Due to the sheer volume of scanning for current and old records it meant that we were unable to make inroads as quickly as we would like across the Trust.

Referring to the residual systems operating on the old Weston network domain that continued to cause disruption, from an assurance point of view it seemed that this should be on the risk register and it was asked if further project management was needed. In response, it was noted these were in the diagnostic space i.e., ICE (order comms), CRIS radiology information system, PACS image store and pathology and for various reasons these are technically difficult to merge. It was dependent on third-party organisations. It was hoped these components would be resolved in the Autumn with the remaining shared resources migrated by the end of the year.

The Committee asked about the uptake of electronic patient noting. They were advised that we have not always managed to get people to adopt new digital ways of working. It was recognised this was now an issue and it was suggested a managed approach be taken. The Executive team will give thought on how to take this forward.

Finance Report

The Committee received a brief update on the month 2 finances which were behind plan. The main drivers are the impact of international recruitment campaign, the non-availability of F1 doctors at Weston, CIP delivery and enhanced rates of pay.

The key priority for the finance team is the development of a financial recovery plan to give assurance that we will achieve our forecast outturn for the year.

The Committee were presented with the 2023/2023 Operating Plan summary and members were briefed. The paper would be presented to the August Board for final sign-off.

It is clear that a whole system approach will be required to deliver the plan. Whilst the Trust will play its part in full (for example with local savings and efficiency programmes) it will be heavily reliant upon the success of whole system solutions as well.

For Board Awareness, Action or Response

Note the increased financial risk being borne by the Trust and the increased reliance on whole system delivery of strategies to mitigate this risk.

Key Decisions and Actions

None

Additional Chair Comments

None

Date of next meeting:	**27 September 2022**

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th August 2022

Report Title	Trust Finance Performance Report
Report Author	Jeremy Spearing, Director of Operational Finance
Executive Lead	Neil Kemsley, Director of Finance & Information

1. Report Summary

The purpose of this report is to inform the Board of the financial position of the Trust for the period April to June 2022.

The Trust's net income and expenditure position is a deficit of £6.9m, £3.0m worse than the planned deficit of £3.9m. The adverse position against plan is primarily due to unachieved Trust CIP, enhanced/premium rates of pay and unfunded costs associated with the Trust's international recruitment program and Weston Foundation 1 posts.

The Trust delivered CIP savings of £2.7m in quarter 1, £1.3m worse than plan. Currently only 36% or £5.4m of the Trust's savings plans are recurrent. The year to date and forecast position is a significant concern and without action to recover the position, the Trust's recurrent deficit and financial challenge going into 2023/24 will increase significantly.

The value of elective activity undertaken headed in the wrong direction in June compared with May 2022, pre-pandemic 2019/20 activity levels and the recently submitted 2022/23 plan. This is a significant concern given the scale of investment approved by SLT to deliver elective recovery and earn Elective Services Recovery Funding (ESRF). The Q1 position will increase the challenge from the BNSSG ICS and NHSE regarding the Trust's deteriorating productivity i.e., spending more and doing less elective activity.

2. Key points to note

(Including decisions taken)

The Board is asked to note the adverse financial position of the Trust and the following recovery actions to mitigate the position:

- Led by the Director of Finance & Information, the development of a financial recovery plan, with the objective of achieving the best possible financial position to take into 2023/24.
- For all Divisions to continue to prioritise the delivery of their operating plans, including the elective performance recovery targets we have committed to as an organisation.
- For all Divisions and corporate services to recover the shortfall in CIP delivery to date and ensure recurrent CIP schemes are fully identified by September; and

• For all Divisions to continue to assess the impact of the investments made since April 2020 and consider unwinding, or re-purposing these, where the expected benefits have not been realised.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
Risk that the Trust does not delivery the in-year financial plan – ID5375 Risk that the Trust fails to fund the Trust's strategic capital programme - ID416
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]**
Senior Leadership Team	20th July 2022
Finance & Digital Committee	25th July 2022

University Hospitals Bristol and Weston NHS Foundation Trust

Trust Finance Performance Report

Reporting Month: June 2022

Executive Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: June 2022

YTD Income & Expenditure Position	• Net I&E deficit of £6,865k against a planned deficit of £3,874k (excluding technical items). • Total operating income is £1,038k favourable to plan due to higher than planned income from patient care activities of £2,526k. • Operating expenses are £4,300k adverse to plan primarily due to higher pay expenditure (£5,666k adverse), the shortfall in Trust CIP delivery of £1,271k, offset by lower than planned depreciation expenditure of £351k and lower than planned other non-pay expenditure of £2,286k. • Technical and financing items are £271k favourable to plan.
Key Financial Issues	• *Savings delivery below plan* – Trust-led CIP delivery is £2,726k or 68% of plan. Full year forecast delivery is £10,952k or 73% of plan of which recurrent savings are £5,365k, 36% of plan. • *Lower than planned elective activity* – if overall elective activity continues below plan there will be a reduction in ESRF income which could contribute to the Trust not meeting its plan. • *Pay costs higher than plan* – pay expenditure must be maintained within divisional and corporate budgets with enhanced pay rates ending from July. • *Forecast overspend against divisional budgets* – divisional forecasts will be monitored monthly and recovery plans developed where overspends are not acceptable.
Strategic Risks	• Agreeing an approach to future financial targets and allocation of system envelopes – on-going; • Assessment and implications of the financial arrangements relating to Healthy Weston – pending completion of a Full Business Case/(s); • Continue to 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 – on-going. • Understanding the implications of not delivering the financial plan, the impact this may have on future investment opportunities and the ability to maintain autonomy- pending.

SPORT

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: June 2022

Successes	Priorities
• Delivery of capital investment of £6,809k in the period 1st April 2022 to 30th June 2022. • The Trust's cash position remains strong at £160,116k. • Submission of the Trust's 2021/22 audited annual accounts and annual report to NHSEI. • Submission of the Trust's 2022/23 Financial Plan. • Submission of responses to the key lines of enquiry per the Julian Kelly letter dated 20th May 2022.	• Development of a Trust financial recovery plan. • Divisions to continue to prioritise the delivery of their operating plans, including monthly monitoring of divisional forecast against budget and development of recovery plans where required. • Divisions and Corporate services to recover the shortfall in CIP delivery and ensure recurrent CIP schemes are fully identified. • Continue to assess the benefits impact of investments made since April 2020 and consider unwinding or re-purposing. • Finalise the capital re-prioritisation process to ensure conclusion in July.
Opportunities	**Risks & Threats**
• Significant opportunity to align the productivity improvements being driven by the Accelerator Programme and the Restoration Oversight Group. • Removal of Covid-19 infection control measures supporting improvement in elective recovery and Covid-19 cost reduction.	• Workforce supply challenges to fill existing and new vacant posts and staff absences 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. • Lower than required elective recovery will result in a reduction in Elective Services Recovery Funding (ESRF) which may result in the Trust and system not achieving it's financial plan of break-even. • Under-delivery on the Trust's recurrent savings programme and continuation of enhanced pay rates may contribute to the Trust not achieving its break-even financial plan. • 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

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

Trust Year to Date Financial Position

	Month 3			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	78,798	80,568	1,770	230,144	232,671	2,526
Other Operating Income	9,059	8,688	(371)	27,176	25,689	(1,488)
Total Operating Income	**87,857**	**89,257**	**1,400**	**257,321**	**258,359**	**1,038**
Employee Expenses	(49,040)	(51,827)	(2,786)	(150,992)	(156,658)	(5,666)
Other Operating Expenses	(33,071)	(33,047)	24	(97,768)	(96,733)	1,035
Depreciation (owned & leased)	(3,470)	(4,456)	(986)	(9,262)	(8,931)	331
Total Operating Expenditure	**(85,582)**	**(89,330)**	**(3,748)**	**(258,021)**	**(262,322)**	**(4,300)**
PDC	(1,037)	(1,037)	0	(3,112)	(3,112)	0
Interest Payable	(244)	(402)	(158)	(732)	(728)	4
Interest Receivable	29	139	109	88	322	234
Other Gains/(Losses)	0	(19)	(19)	0	(19)	(19)
Net Surplus/(Deficit) inc technicals	**1,023**	**(1,393)**	**(2,416)**	**(4,456)**	**(7,499)**	**(3,043)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	194	264	70	582	634	52
Net Surplus/(Deficit) exc technicals	**1,217**	**(1,129)**	**(2,346)**	**(3,874)**	**(6,865)**	**(2,991)**

Key Facts:

- The position at the end of June is a net deficit of £6,865k, £2,991k higher than the planned deficit of £3,874k.
- Pay expenditure is £51,827k in June, c£1,400k lower than May. YTD expenditure is adverse to plan by £5,666k, mainly due to enhanced rates of pay, the cost of escalation capacity, F1 junior doctors costs and international recruitment costs.
- Agency expenditure in month is £3,127k, c£800k higher than May and c£500k higher than plan. Overall, agency expenditure has increased from 5% to 6% of total pay costs.
- Operating income is favourable to plan by £1,038k. The adverse position on 'Other Operating Income' is driven by lower than expected income levels for research, education and non-patient care activities.
- Income from Patient Care Activities is £2,526k favourable to plan.
- Trust-led CIP achievement is 68% of plan. £2,726k has been achieved against a target of £3,997k, a shortfall of £1,271k.
- Additional costs of Covid-19 are £568k, a reduction of £137k from £705k incurred in May.

Savings – Cost Improvement Programme

University Hospitals Bristol and Weston NHS Foundation Trust

June 2022

Divisional Finance Report June – 2022/23 Savings Programme Summary including 2021/22 recurring shortfall carry forward

Division	2021/22 Programme c/f		Progress to Date					Total Variance to date (inc. 2021/22 shortfall)	Forecast Outturn					Forecast Outturn			Recurring Variance inc. 2021/22 recurring shortfall
			2022/23 Programme						2022/23 Programme					2022/23 Programme			
				Actual					Current Year					Recurring Full Year			
	2021/22 Recurrent shortfall	2021/22 Shortfall Variance to date	Plan	Recurring	Non-Recurring	Total	Variance Fav / (Adv)		Plan	Recurring	Non-Recurring	Total	Variance Fav / (Adv)	Balance to FYE	Total Recurring	Variance Fav / (Adv)	
Financial Performance	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Diagnostics & Therapies	(1,401)	(350)	336	13	334	347	11	(339)	1,384	90	1,380	1,471	87	132	222	(1,162)	(2,563)
Medicine	(1,197)	(299)	584	173	102	275	(309)	(608)	1,777	958	415	1,372	(405)	30	988	(789)	(1,986)
Specialised Services	(1,513)	(378)	435	164	336	500	65	(313)	1,788	623	1,044	1,666	(122)	50	673	(1,115)	(2,629)
Surgery	(2,177)	(544)	581	184	62	246	(335)	(879)	2,514	1,079	388	1,467	(1,047)	663	1,743	(771)	(2,949)
Weston	(798)	(200)	541	314	116	430	(111)	(310)	1,666	808	464	1,271	(395)	41	849	(817)	(1,616)
Women's & Children's	(2,176)	(544)	773	303	280	583	(190)	(734)	2,900	1,266	1,009	2,275	(625)	-	1,266	(1,634)	(3,811)
Estates & Facilities	27	7	239	69	155	224	(16)	(9)	907	259	619	878	(29)	174	433	(474)	(447)
Trust Services	(991)	(248)	269	53	67	121	(149)	(397)	1,062	282	270	552	(510)	60	342	(720)	(1,711)
Corporate	(1,500)	(375)	238	-	-	-	(238)	(613)	953	-	-	-	(953)	-	-	(953)	(2,453)
Divisional Sub Totals	**(11,728)**	**(2,932)**	**3,997**	**1,273**	**1,453**	**2,726**	**(1,271)**	**(4,203)**	**14,951**	**5,365**	**5,587**	**10,952**	**(3,999)**	**1,150**	**6,515**	**(8,436)**	**(20,164)**
System Transformational Plans	-	-	**1,317**	-	-	-	**(1,317)**	**(1,317)**	**7,366**	-	-	-	**(7,366)**	-	-	**(7,366)**	**(7,366)**
Grand Totals	**(11,728)**	**(2,932)**	**5,313**	**1,273**	**1,453**	**2,726**	**(2,588)**	**(5,519)**	**22,317**	**5,365**	**5,587**	**10,952**	**(11,365)**	**1,150**	**6,515**	**(15,802)**	**(27,530)**

Key Points:

- The Trust's 2022/23 savings target is £22,317k. This includes £7,366k attributable to system transformation savings.
- At the end of June, the Trust had achieved savings of £2,726k, or 51% against a plan of £5,313k, resulting in a shortfall of £2,588k.
- £1,317k of the £2,588k shortfall is due to non-achievement of system savings.
- The Trust has a recurrent shortfall from the 2021/22 savings programme of £11,728k, resulting in a £2,932k shortfall to date. Therefore the total variance to date is £5,519k.
- The recurring forecast outturn for the 2022/23 plan is a shortfall of £15,802k and including the 2021/22 shortfall is £27,530k.
- At the end of June, all divisions have a shortfall against their recurring plans and all but the Division of Diagnostics and Therapies has a shortfall against their non-recurring plans.
- Currently 51% of forecast savings are non-recurrent, which is a concern .

Action Log & Developments

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Summary of Recovery Actions

Ref	Date	Description of Action	Action Owner	Date Due	Committee Month	Date Close	Status	Revised date	Update
014	Jun-21	Present the Trust Five Year Financial Strategy	OpDoF	Oct-21	November		Open	Nov-22	Plan to be presented at November Committee
021	May-22	Complete assessment of the gap between divisional budgets and forecast expenditure by end of Q1, including development of recovery plans where required.	HoFMI	Jun-22	July		Closed		Divisions will continue to update Forecast outturn v budget which will be monitored each month.
022	May-22	Re-establish the medical workforce group to include review in GIRFT.	HoFMI	Jul-22	August		Closed		Medical staff Advisory group now set up with Stu Walker as chair
023	May-22	Review corporate savings in Medicines including Procurement, CMU contracts and contract variances.	HoFMI	Aug-22	September		Open		
024	May-22	Develop divisional pipelines and convert to actual savings plans. Divisions to have implemented 2% savings on a recurrent basis by the year end.	HoFMI	Mar-23	Monthly Update		Open		Ongoing pipeline progress will be reported to cost savings delivery group each month to monitor progress
025	May-22	Continue work to develop and deliver productivity improvements and relaunch the Trust's approach to productivity.	HoFMI	Jul-22	August		Open	October	Trust relaunch of productivity programme event planned for September – will be led by Mark Smith. Preparations will be finalised during july and August
026	May-22	Savings programme governance has also been recently reviewed and the application of this will be reinforced across the trust	HoFMI	Mar-23	Quarterly Review		Closed		Governance process raised at Cost savings delivery group in June – all necessary document now updated – ongoing application in divisions
027	May-22	Conclude the Capital re-prioritisation exercise.	HoFFP	Jul-22	August		Open		
028	May-22	Establish robust Capital monitoring and reporting processes, including realistic assessment of FoT.	HoFFP	Sep-22	October		Open		
029	May-22	Re - establish BPPC Recovery Plan to support improvement towards national 95% target.	HoFFP	Sep-22	October		Open		Plan to be included in July report
030	May-22	Include a summary of the ICS financial position	HoFFP	TBC			Open		Reporting of the ICS financial position currently under discussion
031	May-22	Review and create mitigations for medical staff adverse variances within W&C and Weston divisions - cease enhanced rates of pay , increase recruitment of permanent staff.	HoFMI	Jul-22	August		Closed		Women's and Children's and Weston have reported the actions they are taking to address in divisional Finance Committee reports
032	May-22	Review and create mitigations for overspend on pay within E&F - cease premium rates of pay in line with approved timetable	HoFMI	Jul-22	August		Open		Not yet resolved
033	Jun-22	Review usage of traditional passthrough drugs now on block arrangements with clinical teams at BHOC.	HoFMI	Aug-22	September		Open		
034	Jun-22	Review W&C junior doctor rotas , action to recruit permanent staff in cardiac surgery to reduce premium costs, enhanced costs to cease in line with trust plan.	HoFMI	Aug-22	September		Open		
035	Jun-22	On going recruitment drive to reduce premium costs, tighter controls on junior doctor rotas, pay enhancements to cease in line with Trust timetable, review of junior staffing numbers on wards.	HoFMI	Sep-22	October		Open		
036	Jun-22	Development of a financial recovery plan	DoFI	Nov-22	December		Open		
037	Jun-22	Divisions and Corporate services to recover the shortfall in CIP delivery and ensure recurrent CIP schemes are fully identified	HoFMI	Sep-22	October		Open		
038	Jun-22	Continue to assess the benefits impact of investments made since April 2020 and consider unwinding or re-purposing.	HoFMI	Mar-23	Quarterly Review		Open		

Key:

Role	Description	Name
DoFI	Director of Finance & Information	Neil Kemsley
OpDoF	Operational Director of Finance	Jeremy Spearing
HoFMI	Head of Financial Management & Improvement	Dean Bodill
HoFFP	Head of Finance - Financial Performance	Kate Herrick

NHS
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Meeting of the Trust Board of Directors in Public – 26th July 2022

Reporting Committee	**Audit Committee**
Chaired By	**David Armstrong, Non-Executive Director**
Executive Lead	**Neil Kemsley, Director of Finance and Information**

For Information

The Focus of this meeting was primarily on:

- Board Assurance Framework (Strategic and Operational Risks)
- Estate and Facilities (Status and Risks)
- Development of Standard Operating Procedures
- Counter Fraud (Annual Report and Interim Progress Report)
- 8 Internal Audit Reports (details on request)
- Audit South-West (ASW) Briefing Paper on Cyber Security

Other standing items, as required by our Annual Business Cycle, were covered by the Committee and were noted for **Information** (Risk Management Group Minutes), **Assurance** (Integration Report, KPMG Progress Report, ASW Annual Report, Losses & Special Payments Report) or **Approval** (Single Tender Actions, AC Terms of Reference update), as required.

For Board Awareness, Action or Response

- Chair and other Committee members expressed concern that the detailed Risk Registers were not included as part of the main documentation pack this month. It was agreed that these are essential for understanding Risk Mitigation and the well-being of our Risk Management process and would be included in future

- The Risk Register for E&F details mitigation activities which are almost always 'preparatory.' That is to say -focused on recruitment, planning, insight gathering etc etc. Whilst this is partly explained by the considerable number of personnel changes within the team and the need to establish a fresh perspective on priorities, it is nonetheless a significant concern.

- The Chair raised a general point that the Chair and Committee Members must be involved before decisions are taken which result in significant changes to: -
    - The AC agenda
    - Annual Business Cycle (ABC)
    - Content of documentation provided to the Committee

  since all of the above have been developed, collegiately, over a significant period of time to meet the needs of the Committee. It was note that the presentation of the BAF and the Integration Reports provided less insight than the Committee expected and required.

- Work to release a SOP document to describe how exposure to Asbestos should be managed is now 2 years overdue. The Committee asked for this to be addressed in advance of the next meeting

- The Trust has no mandated Risk Management Training. Whilst the AC understands the importance of controlling 'mandated' training, the committee challenged whether Risk Management Training is not in fact critical for some key roles, if we wish to establish an effective RM culture.

- The Committee received a brief on the status of the SOP (newly introduced standing agenda item on the ABC). The SOP is one of the key mechanisms by which "Management Intent" is defined, communicated, trained and implemented within the Trust and is often central to both the origin and resolution of Serious Incidents. The Committee learned of activities to improve the IT infrastructure, management of obsolete documentation and to support SOP Owners with their responsibilities in this regard.

- The Committee recognised the excellence of the Counter Fraud team and especially the quality of the Annual and Interim CF reports

- The Internal Audit report on Rota Management and e-rostering raised a number of concerns with respect to how these activities are project managed and reported. However the Internal Audit report highlighted key areas of concern and the committee supported the recommended actions and completion dates

- The Committee agreed four proposed changes to the Internal Audit Plan (details on request)

Key Decisions and Actions
• To consider how Technology might help address Trust concerns with respect to both Staff Shortages and our Cost Improvement programme by identifying new ways of working. • It was noted that the risk associated with maternity (Risk 2264 - Risk that delays in commencing induction of labour increases perinatal morbidity and mortality) is not aligned with the feedback that members of the committee had heard at a recent NED visit to this area and Board seminar. It was agreed that the risk mitigations should be reviewed and revised, as necessary, by the maternity team. • The E&F were asked to consider how the various 'fire compliance programmes' might be expedited by considering alternative approaches to procurement, staffing, clinical engagement etc • It was agreed that the Cyber Security briefing provided by ASW should also be considered by the Finance and Digital Committee • To consider analysing risk in terms of our key enablers (People, Technology, Digital, Finance, E&F etc) to provide a simpler mapping to our Committees and ownership within the Trust
Additional Chair Comments
None

Date of next meeting:	**27th October 2022**

NHS
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NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th August 2022

Report Title	**Annual Report Medical Appraisal and Revalidation**
Report Author	**Dr Anne Frampton**
Executive Lead	**Stuart Walker**

1. Report Summary

This report is the covers the NHSE Annual Board report and statement of compliance regarding appraisal and revalidation.

This forms part of the mandatory reporting on appraisal compliance to NHSE

2. Key points to note

(Including decisions taken)

Following the disruption to appraisal and revalidation caused by the covid-19 pandemic the emphasis in the last 12 months has been to get appraisal and revalidation embedded back into usual business as normal for clinical teams.

What has become apparent is that there are still many doctors struggling with workload and wellbeing, and this has been borne out in delays for some doctors in re-engaging with appraisal. To support this the new appraisal format has been embedded with more emphasis on well-being and less on evidence gathering however this brings its own challenges in terms of assurance for revalidation.

There remain a number of doctors who are having revalidation delays due to appraisal activity and/ or collection of feedback.

Overall compliance for the year was 88% though appraisal rates overall were generally higher for consultants and SAS grades and slightly lower for bank and locum doctors as a result of these groups being harder to reach and confirm their appraisal status especially if they were using a non UHBW portfolio. This is considerably improved from 2018/19 -the last year unaffected by the pandemic where the overall appraisal rate was 78%.

Actions for last year were completed apart from a review of appraiser numbers which has been carried forward to this year. 2022/3 will see the return of peer review visits and a resumption of the AOA report. The main challenge for the year ahead will be to continue to engage with those handful of doctors struggling to get back to appraisal post covid.

3. Risks

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

The risks associated with this report include:

NA

4. Advice and Recommendations

(Support and Board/Committee decisions requested):

• This report is for **Approval.** • The board is requested to approve this report and sign the statement of compliance for return to NHSE
5. History of the paper **Please include details of where paper has previously been received.**
N/A

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of University Hospitals Bristol NHS Foundation Trust (UHBW) can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

> **Action from last year**: To appoint a new RO after Dr William Oldfield stepped down as medical director and RO for UHBW in September 2021.
>
> **Comments**: Dr Emma Redfern acted as interim MD and RO from September 2021 until February 2022. In February 2022 Prof Stuart Walker was appointed as the new substantive MD and RO for the organisation.
>
> **Action for next year**: Nil

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

> Yes
>
> **Action from last year**: Confirm up banding of the admin support post to a band 5, and establish regular funding for external appraiser update training to maintain a pool of appraisers and support their CPD.
>
> **Comments**: This has been completed and the administrative support post has been up banded. Additionally regular externally accredited appraiser training is supported and increases the pool of new appraisers. 2 external sessions were booked in 2021/2 with a further 2 planned for 22/3. Up to 14 places are available at each of these sessions.
>
> An appraiser survey in 2021 noted that a large percentage of appraisers did not receive remunerated time in their job plan for appraisals.
>
> **Action for next year**: Work with clinical chairs to understand the barriers to this and implement appropriate remuneration for all appraisers in line with the trust job planning guidance.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: None

Comments: Fourteen Fish has now been rolled out over the Weston campus as well as the Bristol campus and an accurate record of all doctors with a prescribed connection to the organisation is maintained. Due to the size of the designated body and the high turnover at clinical fellow level this is a considerable administrative task, and requires triangulation with HR, ESR and new DB connections.

Action for next year: Continue

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None

Comments: The Appraisal and Revalidation policy was updated in Feb 2021 and is due for review again in 2023

Action for next year: Review revalidation policy in Feb 2023 and update as required.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: No peer review process took place in 2021 due to the covid 19 pandemic.

Comments: Actions identified internally included reviewing the opportunities and processes for collecting patient feedback as this was a frequent reason for deferral of revalidation. A workshop was held with appraisers in 2021 exploring the options for this and working through the updated GMC guidance.

Action for next year: Peer review visit planned in October 2022

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Nil

Comments: Yes, these doctors are attached and are supported in maintaining their portfolios. All have access to Fourteen Fish and an appraiser, as well as supporting material, to ensure they are aware of their requirements. They are all contacted on an individual basis by the DMD for Revalidation and Appraisal and an individualised plan is made for each depending on their own circumstances.

For clinical fellows our compliance has increased significantly, and we have good visibility of locum and bank doctors.

Action for next year: Continue

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater

emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: continue with the QA process for appraisal

Comments: Yes, appraisals are all reviewed prior to revalidation to ensure full scope of practice is covered and there is an additional check built into the appraisal system to require doctors to declare if they undertake private practice.

In addition, there is close liaison with local private sector providers to ensure appropriate information transfer. There is a regular complaints feed into the appraisal process and a regular feed of low-level concerns at divisional level.

The new appraisal formal and the QA process has highlighted the need for robust summaries as not all information is now uploaded to portfolios. The new change to the appraisal template for 2022/3 is welcomed as this will provide a better balance of information and verbal reflection and support appraisers better in providing a balanced summary of the meeting.

Feedback from doctors is that they prefer the new format and find it less onerous to complete.

Action for next year: continue with the QA process and monitor the change with the new appraisal format.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Nil

Comments: there are a few doctors who find it difficult to engage with appraisal and who require multiple attempts and reminders to complete an annual appraisal. Where a doctor has not completed an appraisal in year (other than approved missed appraisals) the appraisal date is bought forward to the beginning of the next year to ensure that the length of time between appraisals is minimised. As an organisation we have not to date actively used the REV 6 notification option for non-appraisers, preferring instead to try to engage them locally, particularly during the pandemic where other factors are often relevant to not appraising. However now that we are returning to business as usual, we should consider using this route where we are finding it difficult to engage doctors locally.

Action for next year: Implement a quarterly revalidation and appraisal review meeting to highlight those doctors where we are struggling to engage

them locally and where no other reason for not undertaking appraisal has been identified and agree issuing of REV 6 notifications.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Nil

Comments: The Appraisal and Revalidation policy was updated in Feb 2021 and is due for review again in 2023. It was approved by the people committee and uploaded to the DMS.

Action for next year: Review the Appraisal and Revalidation policy in Feb 2023

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: to review both the number of appraisers and the number of appraisals undertaken to ensure that this remains the case post-merger

Comments: this piece of work was not completed in 2021 and will be carried over. However we do not currently have concerns about the number of trained appraisers in the organisation

Action for next year: Action from 2021 carried forward.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: To respond to feedback from appraisers to continue to refine and develop the content to meet their needs.

Comments: Yes, this was instigated in 2019 and continues this year and the appraisal system has been updated to allow appraisers to receive feedback on the quality of their appraisals. In addition, 6-8 annual events are held across the 2 sites to ensure access for appraisers from both organisations. A

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

record of attendance of these events is maintained and access to material discussed at the events is made available to all appraisers on the workspace on the Trust intranet. Topics included feedback from GMC / updates from NHSE and Wellbeing and Support

Action for next year: continue to develop this process.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: To continue with the QA process and share the report with the MD Comments: The previous QA report was shared with the medical director prior to his departure in Sep 2021. We have now instigated a quarterly appraisal and revalidation review meeting which will be the route through which this information is shared in the future as well as an opportunity to focus on any significant appraisal and revalidation issues arising. The first meeting was in June 2022. Action for next year: Develop and refine this process

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: UHBW	
Total number of doctors with a prescribed connection as at 31 March 2022	1081
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	948
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2022	133
Total number of agreed exceptions	28

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None

Comments: 214 recommendations were made to the GMC in 2021/2. Of these 29 were requests for deferrals and 2 of these deferrals were second deferrals.

Both second deferrals were discussed with the GMC ELA prior to the second deferral being made (both doctor's initial deferrals had been made in a different organisation and both were due to lack of appraisal activity). Both doctors moved on from UHBW prior to the next revalidation recommendation becoming due and, in both cases, the DMD discussed the cases directly with the ROs of the new designated body to make them aware of the circumstances and action plan in place.

No doctors received a non-engagement recommendation.

Action for next year: none identified

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Nil

Comments: All doctors are contacted a minimum of 6 and then 4 months prior to revalidation to outline any remaining requirements and a plan to ensure they are met. In addition, the DMD for Revalidation and Appraisal will scan all doctors up to a year in advance of revalidation to pick up any who are looking as if they may fall short of requirements. Doctors in whom a deferral may be made are all contacted and given an explanation and a plan to work to ensure revalidation is not deferred on a second occasion.

All doctors are contacted as soon as the recommendation for revalidation has been made to make them aware.

Action for next year: no additional actions identified

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Nil

Comments: UHBW has an active patient safety, audit and effectiveness culture overseen by the Quality team at the Trust. The work of this team is outlined in the UHBW Quality Strategy

Action for next year: none identified

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: To explore the possibility of making performance data directly available to doctors for their appraisal

Comments: Recommendations for revalidation are based on triangulation of information from appraisal, complaints and reports from clinical chairs regarding soft concerns. Currently UHBW has no method of automatically providing audit, GIRFT or other data directly to doctors for their appraisals and they are expected to access this information themselves.

Action for next year:

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Nil

Comments: The Trust has a freedom to speak up policy last updated in March 2020 which reports to the Board and People committee and links to the grievance policy, disciplinary policy, serious incident policy and dignity at work policy.

Additional training for case investigation has been rolled out this year and a new responsible officer advisory group has been set up which oversees cases going through one of the trust/ GMC processes.

Action for next year: continue to develop the ROAG group as a vehicle for overseeing the capability/ conduct and FTP cases.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: none identified

Comments: Measurement and Key performance indicators comprise:

• The number of Speaking Up concerns raised.

The outline of all concerns will be recorded, and outcomes monitored by the Board and People Committee to identify any key themes or issues patterns/similarities so as to maintain a safe learning culture within the Trust.

• National staff survey indicators relating to staff feeling secure about raising concerns about unsafe clinical practice and having confidence in the organisation to address the concern

Action for next year: none identified

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: No new actions

Comments: Yes, all new starters have an MPIT TOI form completed and uploaded onto the appraisal system. Exceptions are doctors who transfer from HEE where the ARCP outcome is used for this process. Any concerns are flagged to the DMD directly.

There are regular triangulation meetings with NBT and the Spire and Nuffield hospitals to ensure relevant information can be shared between organisations.

Any doctor moving from UHBW where there is a concern is discussed directly with the new RO as well as submitting an MPIT form

Action for next year: No new actions identified

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Nil

Comments: The Trust has a strong equality and diversity ethos and policies covering bias and discrimination

Action for next year: Nil

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: none identified

Comments: This action is completed by the HR team. A request from the Spire private hospital for this information to support emergency placement of doctors in 2020 allowed us to review the robustness of this process. Information was available for all doctors attached to UHBW as requested by the Spire.

Action for next year: none identified

Section 6 – Summary of comments, and overall conclusion

Following the disruption to appraisal and revalidation caused by the covid-19 pandemic the emphasis in the last 12 months has been to get appraisal and revalidation embedded back into usual business as normal for clinical teams.

What has become apparent is that there are still many doctors struggling with workload and wellbeing, and this has been borne out in delays for some doctors in re-engaging with appraisal. To support this the new appraisal format has been embedded with more emphasis on well-being and less on evidence gathering however this brings its own challenges in terms of assurance for revalidation.

There are also still a number of doctors who are having revalidation delays due to appraisal activity and/ or collection of feedback.

Overall compliance for the year was 88% though appraisal rates overall were generally higher for consultants and SAS grades and slightly lower for bank and locum doctors as a result of these groups being harder to reach and confirm their appraisal status especially if they were using a non UHBW portfolio. This is considerably improved from 2018/19 -the last year unaffected by the pandemic where the overall appraisal rate was 78%.

Actions for last year were completed apart from a review of appraiser numbers which has been carried forward to this year, and 2022/3 will see the return of peer review visits and a resumption of the AOA report. The main challenge for the year ahead will be to continue to engage with those handful of doctors struggling to get back to appraisal post covid.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th August 2022

Report Title	**NIHR CRN Annual Report 2021/22 (hosted body report)**
Report Author	**Ifan Jones, Chief Operating Officer CRN WE**
Executive Lead	**Professor Stuart Walker, Executive Medical Director**

1. Report Summary

The Clinical Research Network West of England (CRN WE) is submitting the Annual 2021/22 Highlight Report for Host Trust Board approval.

The report highlights a selection of regional successes in delivering research in challenging circumstances following the pandemic. 84,691 participants were recruited in total across the region into 596 studies. With its annual budget of £14.7M, the CRN WE funded and supported research in a variety of settings including NHS trusts (7), GP practices (154), care homes (12), schools (17) and many others. Participation in research allows access to cutting edge treatments to those taking part with the results of the research going on to benefit countless other lives across the West of England, the UK and beyond.

2. Key points to note

(Including decisions taken)

Clinical Research Networks were asked to only submit a 1 page Highlight Report for 21/22 in contrast to previous years where the report covered CRN activities more comprehensively. It should be noted therefore that this Highlight Report only covers a fraction of the work of the CRN.

The report highlights:

- Continued success in the delivery of COVID vaccine in a coordinated regional model
- The forming of a number of Continuous Improvement Groups (with members from multiple organisations) with the aim of building on successes from the pandemic
- Developmental work supporting Social Care research within the region
- Examples of projects from over £700k invested in increasing research in under-served areas.
- The important work of the Direct Delivery Team in introducing research to new out-of-hospital settings
- Our very well received inaugural Research Awards
- Successes in collecting feedback from individuals participating in research

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 report reflects on performance in 21/22. The challenge will be maintaining these successes and building on them in 22/23.

Not a risk with the report per se but it should be noted that delays at DHSC level in approving 22/23 CRN objectives has unfortunately led to a delay writing the CRN WE 22/23 Annual Plan as this is a collaborative endeavour with our Partner Organisations.

4. Advice and Recommendations

(Support and Board/Committee decisions requested):

- This report is for **Approval.**

5. History of the paper Please include details of where paper has previously been received.	
CRN WE Executive Management Group	17/07/2022
CRN WE Partnership Group Meeting	15/07/2022

2021/22 CRN West of England Highlight Report

Early in the pandemic, the CRN West of England (CRN WE) led a highly successful regional model which included upskilling all District General Hospitals to deliver on COVID Vaccine trials. With regional leadership and coordination, this collaborative endeavour continues to recruit well and provide opportunities to participants across our geography. The locally led ComFluCOV study went on to quickly inform clinical guidelines nationally.

Recognising the benefits of collaborative working, CRN WE has established a number of continuous improvement groups, with membership from across Partner Organisations, to embed innovative working practices learnt during the pandemic, and has expanded this methodology into other areas. Examples of this work include a group to collaboratively attract industry into the region and the co-production of an engagement event for research partners. CRN WE continues to work collaboratively across the regional NIHR infrastructure, including as part of a new collaborative group focused on coordinating and co-producing equality, diversity and inclusion (EDI) projects.

Supporting social care research remains an important focus. Working with Research in Practice, an organisation promoting evidence-based social care, and the local Research Design Service, CRN WE held an event connecting key regional stakeholders in social care. The event was well received with attendees ranging in roles including social workers, occupational therapists, service directors and a diversity of researcher roles.

This year, CRN WE funded around £700k of projects aiming to increase research in under-served areas. Many of these projects supported specific disease areas such as critical care and diabetes. Other projects supported EDI more generally, including a funding pilot for an embedded EDI Project Officer in a mental health trust, which has provided important insights into different approaches to better serve under-served communities in research delivery and will inform further posts in 2022/23.

In response to the Transforming Research Funding, CRN WE expanded its existing Direct Delivery Team (DDT). This team, made up of research nurses and Clinical Research Practitioners (CRP), continues to work on studies across a range of non-hospital settings, including local authority, community and primary care, and we shared our expertise with other LCRNs commissioning DDTs for the first time. This agile workforce was instrumental to the success of regional vaccine trial delivery, centralising and leading on the pre-screening element of the Vaccine Taskforce trials. For a CRN WE led study in primary care, AvonCAP GP, the team influenced study design in championing the role of CRPs in the recruitment pathway, which has led to CRP involvement and healthy participant recruitment. This team has also been crucial to the delivery of the nationally-importance PANORAMIC Trial. Their support has enabled a CRN WE site to be one of the pioneering and highest recruiting sites for the second arm of the trial.

In March 2022, CRN WE held its inaugural Research Awards, recognising the hard work and achievements of those working within research in the region. The initiative received 162 nominations across nine categories, with a virtual ceremony live-streamed to individuals and teams across the region and now viewed over 850 times on YouTube.

This year, CRN WE received 1,924 Participant in Research Experience Survey (PRES) responses, an increase of 71% from 2020/21 and 67% greater than the 1,155 ambition. Staff have trialed new initiatives to increase both the number and representativeness of responses,

including better promotion of the online survey, business cards and posters, and a PRES champion initiative within delivery teams at one CRN WE Partner Organisation to help embed PRES as a standard part of the participant journey.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th August 2022

Report Title	**Review of Board Committees Terms of Reference**
Report Author	**Eric Sanders, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary

As part of its own self review, the Board Committees consider their own terms of reference on a regular basis to ensure they remain fit for purpose and cover the correct remit for the Committee.

The Audit Committee and the Quality and Outcomes Committee have recently reviewed their term of reference and these are now presented to the Board of Directors for approval (appendices 1 and 2).

2. Key points to note

(Including decisions taken)

Following discussion between the Director of Corporate Governance and the Chair of the Committees, and review by the respective Committees at the July meetings, the following amendments are proposed for approval:

Audit Committee (appendix 1):

- Amendments to the external stakeholder table to reflect the requirement around clinical audit
- Amendments to paragraph 7.6.2 around clinical audit being received via periodic internal audit report
- Amendments to paragraph 7.3.10 regarding Emergency Preparedness Resilience and Response (EPRR) which seeks to clarify that the Committee will seek assurance around the robustness of the Trust's EPRR framework and specifically impact on operations (Audit Committee will focus on estates and legal compliance)

Quality and Outcomes Committee (appendix 2):

- Amendments to the external stakeholder table to reflect the requirement around clinical audit
- Amendments to paragraph 7.10 around clinical audit
- Amendments to paragraph 7.21 regarding Emergency Preparedness Resilience and Response (EPRR) which seeks to clarify that the Committee will seek assurance around the robustness of the Trust's EPRR framework and specifically impact on operations (Audit Committee will focus on estates and legal compliance)

3. Risks

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

The risks associated with this report include:

- Risks to the robust governance of the Trust and the Committee's capacity to effectively support the Board in its governance function.

4. Advice and Recommendations

(Support and Board/Committee decisions requested):

This report is for **APPROVAL.** The Board is asked to consider and if appropriate approve the proposed revised terms of reference of the following Board committees: • Audit Committee (appendix 1) • Quality and Outcomes Committee (appendix 2)

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

Quality and Outcomes Committee	28th June 2022
Audit Committee	26th July 2022

University Hospitals Bristol and Weston NHS Foundation Trust

Terms of Reference – Audit Committee

Document Data	
Corporate Entity	Audit Committee
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Director of Corporate Governance
Document Owner	Director of Corporate Governance
Approval Authority	Board of Directors
Review Cycle	12 months
Next Review Date	October 2021

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision (Major/Minor)**	**Description of Revisions**
16/02/2011	1	Trust Secretary	Draft	Draft for consideration by the members of the Audit and Assurance Committee
08/03/2011	2	Trust Secretary	Draft	Draft for consideration by the Audit and Assurance Committee
04/05/2011	3	Trust Secretary	Draft	Draft for consideration by the Audit Committee on 09 May 2011
09/05/2011	4	Trust Secretary	Draft	Revisions by Audit Committee
26/05/2011	5	Trust Secretary	Draft	For Approval by Trust Board of Directors
26/05/2011	6	Trust Secretary	Approved version	Approved by the Trust Board of Directors
01/09/2015	7	Trust Secretary	Major	Revised terms of reference for consideration by the Audit Committee 9th September 2015
05/10/2016	8	Trust Secretary	Minor	Revised terms of reference for consideration by the Audit Committee 18 October 2016.
10/10/2017	9	Deputy Trust Secretary	Moderate	Revisions to a) Clarify existing practice, b) Ensure terms of reference reflect ICSA guidance/best practice. c) Reflect input from the Internal and External Auditors, d) Reflect input from the Chair [and the members] of the Committee e) Include minor grammatical corrections.
28/11/2018	10	Trust Secretary and AC Chair	Moderate	Inclusion of Context Section & Stakeholder Analysis. Re-organisation of Section on Duties Clarification re key deliverables
27/10/2021	11	Head of Corporate governance	Minor	Reviewed post-merger and titles updated.
23/05/2022	12	Director of Corporate Governance	Minor	Clarify the role of the committee in relation to Clinical Audit and Emergency, Planning, Resilience and Response. Changes aligned with those made to the Quality and Outcomes Committee ToR.

Contents

1. Constitution of the Committee

1.1. The Audit Committee (AC) is a statutory Committee established by the Board of Directors to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for Governance, Assurance and Risk Management.

2. Context

Stakeholder Community

2.1 The Audit Committee's primary responsibility is to the Board of Directors, as detailed above. However, in order to discharge these responsibilities appropriately the AC must work in close partnership with a number of internal and external Stakeholders. These Stakeholders influence the work of the AC by:

- establishing external benchmark standards and requirements
- providing insights on current and emerging risks
- providing / receiving assurance on the suitability and efficacy of the Trust's approach.

2.2 The Stakeholders of the Audit Committee are identified below:

Internal (accountable to)

- Board of Directors
- Council of Governors
- Accounting Officer (CEO of the Trust)
- Director of Finance and Information

Internal (peer)

- People Committee
- Quality and Outcomes Committee
- Finance & Digital Committee

Internal (reporting to AC)

- Internal Audit (sub-contracted)
- Local Counter Fraud Specialist (sub-contracted)
- Local Security Management Specialist
- Clinical Audit
- Freedom to Speak Up Guardian

External

- External Audit
- National Audit Office
- HM Treasury
- Freedom to Speak Up National Guardian
- NHS Counter Fraud Authority
- Cabinet Office

Stakeholder Analysis

2.3 The Terms of Reference and the responsibilities of the AC are critically dependent on an accurate understanding of the Stakeholder community and their associated requirements, especially any deliverables that are required, either from or by the AC.

2.4 The following table provides an analysis of the requirements and dependencies associated with the AC's Stakeholder Community.

2.5 **Requirements from AC** - Explains what the Audit Committee is required to do based

on the requirements of the stakeholder.

2.6 **Inputs into AC** - Explains what needs to be provided into the Audit Committee to allow it to fulfil the requirements of the stakeholder.

Internal Stakeholder Community					
Stakeholder	**Requirements from AC**		**Inputs to AC**		**Section Reference**
	General	Formal Deliverables	General	Formal Deliverables	
Board of Directors	Feedback on emerging risks	AC Chair Report (after each meeting) AC Annual Report Feedback on the risk management process and specifically the risks held within the BAF and Trust Risk registers Feedback on the overall Annual Report, including the Quality Report	Identification of emerging risks Recommendations for Internal Audit Approve Terms of Reference	Quality Report	7.3 7.10 7.11 8.8 8.11
Council of Governors	Updates at Governors Constitution Focus Group	Recommendation to appoint, re-appoint or remove the external auditor Performance evaluation of the External Auditors Audit Committee draft Terms of Reference for consultation	None	Authorisation to appoint agreed external auditor	7.5 7.12
Accounting Officer	None	Submission for Annual Governance Statement	None	Draft Annual Report (for AC review) Identification and status of Trust Hosted Services (annually)	7.3
Director of Finance and Information	None	None	Identification of emerging risks (Finance, IT) Recommendations for Internal Audit	Accounting Policies Draft Annual Accounts Inputs to Annual Report including FD Report, Accounting Policies, TACs Summarisation Schedules, Single Estimates) Losses and Special payments report (each mtg)	7.7

Internal Stakeholder Community					
				Single Tender Report (each mtg)	
People Committee	None	Results of relevant Internal Audits	Chair's Report (each mtg)	None	7.3.7
Quality and Outcomes Committee	None	Results of relevant Internal Audits	Chair's Report (each mtg)	None	7.3.7
Finance & Digital Committee	None	Results of relevant Internal Audits	Chair's Report (each mtg)	None	7.3.7
Internal Audit (sub-contracted)	Requirements for Internal Audit (including Freedom to Speak Up issues) Feedback on Reporting	None	None	Internal Audit Plan (annual) Internal Audit Reports (each mtg) Progress Report (each mtg) Head of Internal Audit Opinion (for reference in the Annual Governance Statement – part of the Annual Report)	7.4
Local Counter Fraud Specialist (sub-contracted)	None	None	None	Annual Plan Annual Report Progress report (each mtg)	7.8
Local Security Management Specialist	None	None	None	Progress report (each mtg)	7.8
Clinical Audit (more regular reports via QOC)	None	None	None	~~Annual Clinical Audit Report~~Internal audit report	7.6
Freedom to Speak Up Guardian	None	None	None	Annual Report	7.9

External Stakeholder Community					
Stakeholder	**Requirements from AC**		**Inputs to AC**		**Section Reference**
	General	Deliverables	General	Deliverables	
External Audit	Guidance on possible scope of annual audit Informal communication on external audit activities (Without Executives present)			Audit Report (ISA 260 Report) Trust Accounts Consolidation Schedules Management Letter of Representation, Quality Report Management representation letter Assurance Report on the Trusts Quality Report	7.5

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External Stakeholder Community					
				Report to the Council of Governors on Trusts Quality Report (annually)	
NHSI	None	Escalation in those instances where the services of the External Auditor are terminated in disputed circumstances. Escalation where exceptional, serious and improper activities have been revealed by the Committee, if insufficient action has been taken by the Board of Directors after being informed of the situation.	None	NHS Code of Governance	7.13 7.14
National Audit Office	None	None	None	Code of Audit Practice	7.1
HM Treasury	None	None	None	Audit and risk assurance committee handbook	7.1
Freedom to Speak Up National Guardian	None	None	None	Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts	7.9
NHS Counter Fraud Authority	None	None	None	Counter Fraud Standards for NHS Providers	7.8
Cabinet Office	Compliance with Civil Contingencies Act (2004)	None	None	Report on legislative and regulatory compliance Annual EPRR Report	7.3.10

3. Responsibilities

3.1 As stated above, the purpose of the Audit Committee is to ensure the suitability and efficacy of the Trust's provisions for Governance, Assurance and Risk Management. The activities of the AC are therefore focused on the Policies and Processes of the Trust:

- Definition
- Implementation
- Outcomes

and especially on the approach to Enterprise Risk Management, that is the identification and management of Operational and Strategic Risks which might impact on the Trust's principle objectives.

3.2 The **primary responsibilities** of the Audit Committee are therefore to:

1. Review and seek assurance of the Trust's approach to Risk Management and internal control
2. Monitor and review the effectiveness of the internal audit function,
3. Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process
4. Seek assurance about Clinical Audit activity

3.3 In addition, the AC has specific responsibilities which it undertakes on behalf of the Board with respect to:

5. Integrity of Financial Reporting
6. Activities to Identify and Counteract Fraud
7. Ensuring the effectiveness of the Freedom to Speak Up Policy

3.4 Finally, the AC must:

8. Communicate and report effectively to all its Stakeholders

3.5 Each of these responsibilities is covered in more detail in section 7. The performance of the Audit Committee is most clearly evidenced by the degree of Stakeholder Satisfaction.

4. Authority

4.1 The Committee is authorised by the Board to investigate any activity within its terms of reference and to seek any information it requires from any officer of the Trust and to call any employee to be questioned at a meeting of the Committee as and when required.

4.2 This will include, but is not limited to:

- Evaluating the integrity of the financial statements of the Trust, any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them
- Independently and objectively monitor, review and report to the Board on the adequacy of the policies and processes for governance, assurance, and risk management
- Facilitate the effective implementation of an internal and external audit plan, and so the development, maintenance and implementation of Trust Policies and Processes
- Obtain whatever professional advice it requires (as advised by the Trust Secretary);

4.3 Since the Audit Committee is a Non-executive Committee of the Board of Directors it has no executive powers, other than those specifically delegated in these Terms of Reference.

5. Membership and attendance

5.1 Members of the Committee shall be appointed by the Board of Directors and shall number at least three.

5.2 All members of the Committee shall be independent Non-executive Directors.

5.3 The Committee should identify and agree with the Board of Directors the skills required

for Committee effectiveness. These skills will include governance, assurance and risk.

5.4 At least one member of the Committee should have recent and relevant financial experience sufficient to allow them to competently analyse the financial statements and understand good financial management disciplines.

5.5 The Chairs of the People, Finance & Digital and the Quality and Outcomes Committees will usually be members unless this does not meet the skills and experience requirements of the Committee.

5.6 Where the Chairs of the other Board Committees are not members (see above), then they will be invited to attend the meetings.

5.7 The Chair of the Board of Directors shall not be a member of the Committee and should limit his/her attendance to one meeting per annum to support the evaluation of the effectiveness of the Committee.

5.8 Only members of the Committee have the right to attend Committee meetings. However non-committee members may be invited to attend and assist the committee from time to time.

5.9 Members may nominate a deputy to attend where they are unavailable. The deputy must be agreed with the Chair of the Committee and must be an Independent Non-Executive Director of the Trust.

5.10 In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5.11 External Audit and Internal Audit representatives shall be invited to attend all meetings of the AC. At least once a year the Committee should meet privately with the External and Internal Auditors.

5.12 The Director of Finance & Information shall normally attend meetings.

5.13 The Chief Executive and other Executive Directors should be invited to attend as appropriate. The Chief Executive (or his/her nominated deputy) shall be required to attend the review of the Annual Governance Statement.

5.14 The Committee Secretary shall be the Director of Corporate Governance or his/her nominated deputy. The Director of Corporate Governance or his/her nominated deputy shall attend all meetings of the Committee.

6. Quorum

6.1 The quorum necessary for the transaction of business shall be three members, all of whom must be independent Non-Executive Directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7. Duties

7.1 The Committee shall undertake the duties detailed in the HM Treasury's Audit and Risk Assurance Committee Handbook, with reference to the NHSI Code of Governance and with regard to the National Audit Office Code of Audit Practice, see references in section 9. In addition the HFMA's NHS Audit Committee Handbook maybe taken into consideration to determine the governance of the Committee.

7.2 The following sections provide more detail of the specific duties, associated with the responsibilities of the Committee as outlined in section 3.

Review and seek assurance of the Trust's approach to Risk Management and internal control

7.3 The Committee shall

7.3.1 Review the establishment and maintenance of an effective system of integrated governance, assurance and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of both the organisation's Strategic and Operational Objectives; this includes a review of the Board Assurance Framework, Strategic and Operating Plans and the associated Trust Risk Registers.

7.3.2 Review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

7.3.3 Work with Internal and External Audit leadership teams to establish the level of compliance with External Legal and Regulatory Requirements and Trust Policies and Processes and to identify any associated risks.

7.3.4 Review any Governance, Assurance and Risk related disclosure statements, in particular the Annual Report, including the Quality Report and annual statements made by the Internal and External Auditors to ensure that any risks or gaps in controls are identified and appropriate actions are taken;

7.3.5 Review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications to the governance of the Trust. These will include, but not be limited to, any reviews undertaken by the Department of Health Arms-Length Bodies, Regulators, other Trust Committees as well as professional bodies with responsibility for the performance of staff or functions.

7.3.6 Review the scope and status of services hosted by our Trust on an annual basis to identify whether there are any emerging risks which might impact on the Trust's reputation

7.3.7 Review the work of other Committees within the organisation, whose work can help identify current and emerging risks and provide relevant assurance to the Audit Committee's own scope of work

7.3.8 Review the work of the Estates Leadership Team with respect to ensuring Regulatory and Legal Compliance, especially with respect to Emergency preparedness, Business Continuity and Safety (called up in ABC)

7.3.9 Receive regular reports from the Chair of the Risk Management Group (included in ABC).

7.3.10 Receive a report on legislative and regulatory compliance in relation to Emergency Planning, Resilience and Response, and the effectiveness of the governance framework which supports delivery in the Trust.

Monitor and review the effectiveness of the internal audit function

7.4 The Committee shall:

7.4.1 Ensure that there is an effective Internal Audit function that provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors;

7.4.2 Consider and approve the Internal Audit strategy and annual plan and ensure it has adequate resources and access to information, including the Board Assurance Framework, and ensure coordination between Auditors to optimise use of audit resource;

7.4.3 Ensure the function has adequate standing and is free from management or other restrictions;

7.4.4 Review promptly all reports on the Trust from the Internal Auditors including the Executive Management's responsiveness to the findings and recommendations of reports

7.4.5 Ensure the People, Quality and Outcomes and Finance & Digital Committees have full visibility of Audit reports that might impact on their work

7.4.6 Meet the Head of Internal Audit at least once a year, without management being present, to discuss their remit and any issues arising from the internal audits carried out. The Head of Internal Audit shall be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors and to the Committee;

7.4.7 Conduct a review of the effectiveness of Internal Audit services once every year

Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process

7.5 The Committee shall:

7.5.1 Consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor;

7.5.2 Work with the Council of Governors to manage the selection process for new auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this, and make any associated recommendations to the Council of Governors;

7.5.3 Receive assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts;

7.5.4 Approve the External Auditor's remuneration and terms of engagement including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted;

7.5.5 Agree and review the policy regarding the supply of non-audit services by the External Auditor and monitor that service, taking into account relevant ethical guidance;

7.5.6 Review and monitor the External Auditors' independence and objectivity and the effectiveness of the audit process annually. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work;

7.5.7 Meet the external auditor at least once a year, without management being present; to discuss their remit and any issues arising from the audit;

7.5.8 Discuss and agree with the External Auditors, before the audit commences, the nature and scope of the audit, as set out in the annual plan;

7.5.9 Discuss with the External Auditors their evaluation of audit risks and assessment of the Trust, and

7.5.10 Review all External Audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses;

Seek assurance about Clinical Audit activity

7.6 The Committee shall:

7.6.1 The Committee shall work with the Chair of the Quality and Outcomes Committee to review issues around clinical risk management and ensure that the Clinical Audit function is positioned to effectively identify and facilitate the mitigation of clinical risks.

7.6.2 The Committee will receive the ~~Clinical Audit Annual Plan and Annual Report and receive regular updates on progress made by clinical audit throughout the year~~assurance via a periodic internal audit report on the effectiveness of the clinical audit function and compliance with legislation, regulation and other national requirements.

Integrity of Financial Reporting

7.7 The Committee shall:

7.7.1 Ensure the integrity of the annual report, summary financial statements, and all other significant financial statements submitted by the Trust to external stakeholders. In reaching a view on the accounts, the Committee should consider:

- key accounting policies and disclosures
- assurances about the financial systems which provide the figures for the accounts
- the quality of the control arrangements over the preparation of the accounts
- key judgements made in preparing the accounts
- any disputes arising between those preparing the accounts and the auditors

7.7.2 Review these Financial Statements to identify significant issues and judgements and ensure actions are implemented as appropriate

7.7.3 Review the consistency of, and changes to, accounting policies both on a year on year basis and across the Trust and its subsidiary undertakings;

7.7.4 Review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the External Auditor; and

7.7.5 Review at each meeting, reports detailing:

- Losses and special payments
- Single Tender Actions (i.e. procurement without competition)

Activities to Identify and Counteract Fraud

7.8 The Committee shall:

7.8.1 Ensure that there is an effective Counter Fraud function that that meet the required NHS Counter Fraud Authority standards

7.8.2 Consider and approve the Counter Fraud strategy and annual plan and ensure it has adequate resources and access to information to undertake its activities

7.8.3 Undertake regular reviews of the work undertaken to counter fraud and to establish effective security arrangements of the Trust's assets

7.8.3 Undertake an Annual Review of the Board's Register of Interests (called up in

ABC)

7.8.4 Undertake an Annual Review of the Trust Wide Register of Interests, Gifts and Hospitality

7.8.5 Conduct a review of the effectiveness of Counter Fraud services every year

Ensuring the effectiveness of the Freedom to Speak Up Policy

7.9.1 The Committee shall monitor and receive assurance on compliance with the Trust's Freedom to Speak Up Policy and ensure that the policy allows for proportionate and independent investigation of such matters and appropriate follow-up action. This will be achieved by the Committee receiving an Internal Audit review of the Trust's arrangement for staff to raise issues on an annual basis.

Reporting to Board and other Stakeholders

7.10 The Committee Chair shall prepare and submit a written report after each Audit Committee for review and discussion at the proceeding Board of Directors meeting to:

- Provide assurance that an appropriate system of governance is in place
- Identify any emerging Risks associated with the Trust's System of Governance and its approach to Assurance and Enterprise Risk Management
- Inform the Board of any key decisions that have been taken or actions that have been placed

7.11 In addition, the Committee, having considered its effectiveness, will produce an Annual Report which will be developed in accordance with the Trust's requirements and will include:

- Details of how the committee is discharging its responsibilities.
- Reference to any non-audit services provided by the external auditors, and if so, how auditor objectivity and independence is safeguarded;
- Details of the full auditor appointment / contract termination processes (including the position of the Council of Governors with regard to the decisions taken) and the Committee's reasons for any decisions taken
- The signature of the Chair of the Audit Committee.

Reporting to Other Stakeholders

7.12 The Committee shall make necessary recommendations to the Council of Governors on areas relating to the appointment, re-appointment and removal of External Auditors, the level of remuneration and terms of engagement

The Chair of the Committee shall write to the Independent Regulator of NHS Foundation Trusts (NHS Improvement) in those instances where the services of the External Auditor are terminated in disputed circumstances.

Where exceptional, serious and improper activities have been revealed by the Committee, the Chair of the Committee shall write to NHS Improvement, if insufficient action has been taken by the Board of Directors after being informed of the situation.

8. Administration

8.1 The Committee shall meet a minimum of four times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require allowing the Committee to discharge all its responsibilities.

8.2 Meetings of the Committee shall be called by the Secretary of the Committee at the request of the Committee Chair. The Board of Directors, Chief Executive, External Auditors or Head of Internal Audit may request an additional meeting if they consider it necessary.

8.3 Trust Secretariat shall provide secretariat services to the Committee and shall provide appropriate support to the Chair and Committee members as required.

8.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting.

8.5 Supporting papers, detailing their purpose for inclusion and the actions / decisions that are expected of the Committee shall be made available no later than three working days before the date of the meeting.

8.6 The secretary shall minute the proceedings of all Committee meetings and maintain an "actions arising log". Draft minutes and the actions arising shall be issued promptly to the Chair of the Committee, for review, before formal issue

8.7 The secretary shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and minute them accordingly.

8.8 The Committee shall, at least once a year, review its own performance to ensure it is operating at maximum effectiveness. The Committee shall consider the use of the HFMA's Audit Committee Self-Assessment Checklist for this purpose.

8.9 All papers (notices, agendas, supporting papers and minutes) will be sent in electronic form, except where the recipient has specifically requested to receive documents in paper format.

8.10 The Director of Corporate Governance and Committee Chair shall develop and maintain an Annual Business Cycle detailing the standing agenda items required at each meeting throughout the year in order to discharge the duties detailed herein.

8.11 The Committee shall review its own terms of reference annually.

9. External References

HM Treasury - Audit and risk assurance committee handbook
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/512760/PU1934_Audit_committee_handbook.pdf

NHS Code of Governance
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/327068/CodeofGovernanceJuly2014.pdf

National Audit Office - Code of Audit Practice

https://www.nao.org.uk/code-audit-practice/

NHS Counter Fraud Authority – Standards for NHS Providers

https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Providers_2018.pdf?v=1.0

HFMA – NHS Audit Committee Handbook (available on request from the Trust Secretary)

University Hospitals Bristol and Weston NHS Foundation Trust

Terms of Reference – Quality and Outcomes Committee

Document Data	
Corporate Entity	Quality and Outcomes Committee
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Chief Nurse and Midwife Medical Director Deputy Chief Executive and Chief Operating Officer
Document Owner	Director of Corporate Governance
Approval Authority	Board of Directors
Review Cycle	12 months
Next Review Date	January 2023

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision (Major/Minor)**	**Description of Revisions**
16/03/2011	1	Trust Secretary	Major	Initial draft for comment
26/04/2011	2	Trust Secretary	Major	Incorporated committee Chair's comments
27/04/2011	3	Trust Secretary	Minor	Revisions following initial meeting of committee members
25/05/2011	4	Trust Secretary	Minor	Final consideration by the Quality and Outcomes Committee
26/05/2011	5	Trust Secretary	Minor	For approval by the Trust Board of Directors
27/03/2012	6	Trust Secretary	Minor	Revisions recommended by Quality and Outcomes Committee for approval by the Trust Board of Directors
27/09/2012	7	Trust Secretary	Minor	Revision to meeting regularity from bi-monthly to monthly (in months where there is a meeting of the Board of Directors) in accordance with the purpose of scrutinising the Quality and Performance report prior to each meeting of the Board of Directors
21/04/2015	8	Trust Secretary	Major	Complete review
18/05/2015	9	Trust Secretary	Minor	Incorporation of comments from Quality and Outcomes Committee held 30/04/15
17/05/2016	10	Trust Secretary	Minor	Change from 'Monitor' to 'NHS Improvement'; Section 2.1.1.
11/05/18	11	Deputy Trust Secretary	Minor besides change of quorum	Change of quorum from three members to two. This reflects agreement by the Chair of the Board that the quora for all Committees of the Board should be appropriately aligned. Update to attendee titles to reflect updated roles in the Trust. Minor changes for clarity and consistency of wording.
18/09/2018	12	Deputy Trust Secretary	Changes to remit to reflect the creation of a new People Committee to review workforce and people issues within the Trust.	Deletion of references to workforce overview which will now sit with the People Committee
17/09/2020	13	Head of Corporate Governance	Moderate	New Stakeholder analysis section added. Also updated for grammar and to reflect changes of titles.
20/10/2021	14	Head of Corporate Governance	Minor	Names removed from executive lead section and minor formatting undertake for visual ease.
28/01/2022	15	Head of Corporate Governance	Moderate	Change to Committee membership to include executive directors Increase of quorum from two to four Addition of NED champion responsibilities Addition to purpose and function in relation to Health Inequalities
23/05/2022	16	Director of Corporate Governance	Minor	Clarify the role of the committee in relation to Clinical Audit and Emergency, Planning, Resilience and Response. Changes aligned with those made to the Audit Committee ToR.

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1. Constitution of the Committee

1.1 The Quality and Outcomes Committee is a non-statutory Committee established by the Trust Board of Directors to support the discharge of the Board's responsibilities ensuring the quality of care provided by the Trust.

2. Purpose and function

2.1 The purpose of the Quality and Outcomes Committee is to ensure:

2.1.1 That the Board establishes and maintains compliance with health care standards including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professionals (including NHS Improvement);

2.1.2 To support the Trust to actively engage on quality of care with patients, staff and other relevant stakeholders and take into account as appropriate views and information from these sources;

2.1.3 That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and processes for escalating and resolving quality issues including escalating them to the Board where appropriate;

2.1.4 To support the Trust's objective to strive for continuous quality improvement and outcomes;

2.1.5 To support the objective that every member of staff that has contact with patients, or whose actions directly affect patient care, is motivated and enabled to deliver effective, safe, and person centred care in line with the NHS Constitution; and

2.1.6 To consider the operational and quality risks to the Trust's ability to achieve high quality care and continuous quality improvement.

2.1.7 To support the Trust's objective to reduce health inequalities amongst its patients and the community

2.2 To achieve this, the Committee shall:

2.2.1 Extend the Board's monitoring and scrutiny of the standards of quality, compliance and performance of Trust services and the workforce strategy which supports this;

2.2.2 Make recommendations to the Board on opportunities for improvement in the quality of services;

2.2.3 Support and encourage quality improvement where opportunities are identified.

2.3 The Committee shall discharge this function on behalf of the Board of Directors by:

2.3.1 Seeking and considering such additional sources of evidence upon which to base its opinion on the robustness of Board Assurance with regards to 'quality governance'; and

2.3.2 Working in consultation with the Audit Committee, People Committee and the Finance & Digital Committee, cross-referencing data and ensuring alignment of the Board assurances derived from the activities of each Committee.

3. Stakeholder Community

3.1 The Committee's primary responsibility is to the Board of Directors, as detailed above. However, in order to discharge these responsibilities appropriately the Committee must work in close partnership with a number of internal and external Stakeholders. These Stakeholders influence the work of the Committee by:

- establishing external benchmark standards and requirements
- providing insights on current and emerging risks
- providing / receiving assurance on the suitability and efficacy of the Trust's approach.

3.2 The Stakeholders of the Committee are identified below:

Internal (accountable to)

- Board of Directors
- Council of Governors

External

- NHS England and Improvement
- Care Quality Commission

Stakeholder Analysis

3.3 The Terms of Reference and the responsibilities of the Committee (QOC) are critically dependent on an accurate understanding of the Stakeholder community and their associated requirements, especially any deliverables that are required.

3.4 The following table provides an analysis of the requirements and dependencies associated with the Committee's Stakeholder Community.

3.5 **Requirements for QOC** - Explains what the Committee is required to do based on the requirements of the stakeholder.

3.6 **Inputs into QOC** - Explains what needs to be provided into the Committee to allow it to fulfil the requirements of the stakeholder.

Internal Stakeholder Community					
Stakeholder	Requirements for QOC		Inputs into QOC		Section Reference
	General	Formal Deliverables	General	Formal Deliverables	
Board of Directors	To advise on status, risks, opportunities associated with the key parameters listed in 2.1	Chair Report (after each meeting)	Approve Terms of Reference	None	7
Council of Governors	Updates at Governors Quality Focus Group and Council of Governors meetings	None	None	None	8.3, 8.4

External Stakeholder Community					
Stakeholder	Requirements for QOC		Inputs into QOC		Section Reference
	General	Formal Deliverables	General	Formal Deliverables	
NHS England and Improvement	None	Oversight of the Quality Report and Quality Account prior to Trust Board sign off.	None		7.2
	Emergency Preparedness, Resilience and Response (EPRR) Framework	Review of Annual Report prior to Trust Board sign off.			7.21 7.35.8
	NHS Long Term Plan			Equality and Diversity Annual Report	2.1.7, 7.17
Care Quality Commission		Organisational compliance with the CQC Fundamental Standards of Care.	None		7.1, 7.3, 7.35.3, 7.35.6
	Compliance with Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England 2006			Learning from Death regular reporting into the Committee	7.35.2
	Compliance with clinical audit requirements to support the review the effectiveness of services			Clinical Audit Annual Plan Clinical Audit Annual Report Clinical Audit escalation reports	7.10
Royal College of Physicians	Compliance with National Audit of Inpatient Falls Audit (NAIF) Report 2020)	None	None	Regular reporting into the Committee	7.7, 7.35.1
National Palliative and	Compliance with Ambitions	None	None	Regular reporting into	7.35.4

External Stakeholder Community					
End of Life Care Partnership	for Palliative and End of Life Care National Framework 2021-26			the Committee	
Resuscitation Council	Compliance with May 2020 Resuscitation Council Quality Standards in relation to acute, mental health and community trusts	None	None	Regular reporting into the Committee	7.35.7
Royal College of Nursing	Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff	None	None	Regular reporting into the Committee	7.15, 7.16, 7.35.9

4. Authority

4.1 The Quality and Outcomes Committee will:

4.1.1 Monitor, scrutinise and where appropriate, investigate any quality or outcome activity considered to be within its terms of reference;

4.1.2 Seek such information as it requires to facilitate this monitoring and scrutiny; and

4.1.3 Obtain whatever advice it requires, including external professional advice if deemed necessary (as advised by the Director of Corporate Governance) and may require Directors or other officers to attend meetings to provide such advice

4.2 The Quality and Outcomes Committee is a Non-Executive Committee and has no executive powers.

4.3 Unless expressly provided for in Trust Standing Orders, Trust Scheme of Delegation or Standing Financial Instructions the Quality and Outcomes Committee shall have no further powers or authority to exercise on behalf of the Trust Board of Directors.

5. Membership and attendance

5.1 The Quality and Outcomes Committee is appointed by the Trust Board of Directors and includes:

- One Non-Executive Director (who shall be the Committee Chair)
- Two further Non-Executive Directors
- Chief Nurse and Midwife
- Medical Director
- Deputy Chief Executive and Chief Operating Officer

5.2 Duly nominated deputies may attend in their Director's stead with the permission of the Committee Chair.

5.3 The following officers are expected to attend meetings of the Committee at the invitation of the Chair:

- Deputy Chief Operating Officer
- Head of Quality (Patient Experience and Clinical Effectiveness)
- Head of Quality (Patient Safety)

5.4 The Director of Corporate Governance shall attend from time-to-time to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance. Other officers shall be required to attend meetings of the Committee from time to time at the invitation of the Chair also.

6. Quorum

6.1 The quorum necessary for the transaction of business shall be not less than four members, two Non-Executive Directors and two Executive Directors.

6.2 Committee members may be represented at meetings of the Committee by a duly nominated delegate on no more than two successive occasions. Nominated delegates must be independent Non-Executive Directors.

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

7. Duties

The Quality and Outcomes Committee shall discharge the following duties on behalf of the Trust Board of Directors:

Quality Strategy

7.1 Receive and assess the Board's Quality Strategy and provide an informed opinion to the Board on the suitability of the associated objectives; and

7.2 Monitor progress and achievement of the Board's Quality Strategy.

Annual Plan and Quality Report

7.3 Monitor the status of compliance with Care Quality Commission's Fundamental Standards of Care and Quality Objectives as set out in the Annual Plan; and

7.4 Review the Trust's Annual Quality Report prior to submission to the Trust's Board of Directors for approval.

Clinical and Service Quality, Compliance and Performance

7.5 Seek sources of evidence from existing Management Groups at divisional and sub-divisional level and Board Committees on which to base informed opinions regarding the standards of:

- Clinical and service quality;
- Organisational compliance with the CQC Fundamental Standards of Care and National targets and indicators as determined by the Risk Assessment Framework; and
- Organisational performance measured against specified standards and targets;

7.6 Review the Trust's declaration against the Single Oversight Framework (excluding financial

information) prior to submission to the Board of Directors for approval;

7.7 Review the Board Integrated Performance Report;

Action Plan Monitoring

7.8 Monitor progress of the quality-related action plans.

Benchmarking, Learning and Quality Improvement

7.9 Consider relevant regional and national benchmarking statistics when assessing the performance of the Trust;

7.10 Receive assurance on the delivery of the clinical audit programme in line with the clinical risks affecting the Trust. ~~Review the Annual Clinical Audit report;~~

7.11 Receive quarterly reports on complaints and patient experience;

7.12 Receive reports to monitor against action plans arising from Serious Untoward Incidents, complaints and never events to ensure: Trust-wide learning; actions have been completed; and ensure divisional intelligence and oversight;

7.13 To receive reports about patient experience and review the results and outcomes of local and national patient and staff surveys;

7.14 Receive and review quarterly reports on Infection Control;

7.15 Receive and review the annual report on Safeguarding;

7.16 Receive and review the annual report on Children's Services;

7.17 Receive and review the Equality and Diversity Annual Report;

7.18 Receive the monthly Nurse Staffing report on the information contained in the NHS national staffing return to ensure Trust-wide staffing levels remain safe;

7.19 Receive Quality Impact Assessment reviews for significant cost improvement schemes and their potential impact on quality, patient experience, patient safety and staff. The definition of significant will be determined by the Chief Nurse and Medical Director; and

7.20 Receive assurance regarding data quality assessment against the six national domains of data quality outlined in the Audit Commission's National Framework.

7.21 Seek assurance on the robustness of the Trust's Emergency Planning Resilience and Response (EPRR) framework including receiving the annual NHS England assurance report, and testing compliance of business continuity arrangements across the Trust.

Risk

7.30 Receive the Corporate Risk Register and review the suitability and implementation of risk mitigation plans with regard to their potential impact on patient outcomes.

Quality Governance

7.31 Identify any gaps in evidence or measures of quality utilised by the Board of Directors.

Procedural Documents and Corporate Record Keeping

7.32 Assess the suitability of Trust-wide relevant Procedural Documents in accordance with the Trust Procedural Document Framework (i.e., Board Quality Strategy);

7.33 Maintain and monitor a schedule of matters arising from agreed actions (for the Committee only) and performance-manage each action to completion; and

7.34 Maintain the corporate records and evidence required to support the Board Assurance Framework document.

Non-Executive Director Champion Roles

7.35 Following the release of NHS England/Improvement's publication entitled *"Enhancing Board Oversight: A New Approach to Non-Executive Director Champion Roles"* in December 2021 the following Non-Executive Director Champion Roles have been aligned with Committee:

7.35.1 Hip Fracture, Falls and Dementia NED Champion
7.35.2 Leading from Deaths NED Champion
7.35.3 Safety and Risk NED Champion
7.35.4 Palliative Care and End of Life NED Champion
7.35.5 Health and Safety NED Champion
7.35.6 Children and Young People NED Champion
7.35.7 Resuscitation NED Champion
7.35.8 Emergency Preparedness NED Champion
7.35.9 Safeguarding NED Champion

The Committee shall collectively undertake the statutory duties of these former roles.

8. Reporting and Accountability

8.1 The Chair of the Quality and Outcomes Committee shall report to the Board of Directors on the activities of the Committee.

8.2 The Chair of the Quality and Outcomes Committee shall make whatever recommendations to the Board deemed by the Committee to be appropriate (on any area within the Committee's remit where disclosure, action or improvement is needed).

8.3 Outside of the written reporting mechanism, the Committee Chair should attend the Council of Governors General meeting including the Annual Members Meeting, and be prepared to respond to any questions on the Committee's area of responsibility to provide an additional level of accountability to members.

8.4 Outside of the formal reporting procedures, the Governors' Quality Focus Group shall be informed by the Quality and Outcomes Committee via the Chair and Executive Leads, supported by the Trust Secretariat.

9. Administration

9.1 The Director of Corporate Governance shall provide administrative support to the Committee.

9.2 Meetings of the Quality and Outcomes Committee shall be called by the Director of Corporate Governance at the request of the Committee Chair.

9.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting.

9.4 Supporting papers shall be made available to Committee members no later than five working days before the date of the meeting.

9.5 A member of the Trust Secretariat shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and those in attendance.

9.6 Draft Minutes of meetings shall be made available promptly to all members of the Committee.

10. Frequency of Meetings

10.1 The Committee shall meet on a monthly basis, in advance of each meeting of the Board of Directors at which the Integrated Performance Report is to be considered, and at such other times as the Chair of the Committee shall require.

11. Review of Terms of Reference

11.1 The Committee shall, at least once a year, review its own performance and Terms of Reference to ensure it is operating at maximum effectiveness.

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Meeting of the Board of Directors on Tuesday 9 August 2022
and Meeting of the Council of Governors on Tuesday 9 August 2022

Report Title	**Proposed Changes to the Trust's Constitution**
Report Author	**Sarah Murch, Membership Manager**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary

The report sets out two proposed changes to the Trust's Constitution for approval by the Trust Board of Directors and the Council of Governors.

The changes have been discussed by governors at the Membership and Constitution Group who were fully supportive of the proposed changes and the previously agreed changes.

2. Key points to note

(Including decisions taken)

Background

One of the statutory duties of the Board of Directors and Council of Governors is to approve amendments to the Trust's Constitution. Governors review the Constitution annually through their Membership and Constitution Group and recommend changes to the Council of Governors and the Board for approval.

Key Points

At the last meeting of the Membership and Constitution Group on 13 July 2022, governors discussed and agreed the following proposed changes:

1. **A change to the Trust's minimum membership numbers**

Foundation Trusts state a figure for minimum membership numbers in each constituency class which they should aim to exceed. A reduction is proposed in the minimum membership numbers for UHBW to 100 per constituency class for every class except for the 'Rest of England and Wales' constituency class which will remain at 5.

The reasons for the proposed change are:

- to bring the numbers into line with the Trust's Membership Strategy 2020-23 which supports a reduction in the public membership numbers through a 3-year data cleansing exercise. The Trust already no longer meets the current minimum public membership numbers in the Constitution, and the gap will widen if the Trust continues with the data cleansing exercise as planned.

- to bring the Trust into line with other Foundation Trusts. A benchmarking exercise has been conducted looking at minimum membership numbers in other comparable large Foundation Trusts, the results of which were presented to the Membership and Constitution Group. There is little consistency, but most of these are considerably lower than UHBW's are currently. Many Trusts adopt a consistent approach across all public and staff constituency classes.

2. The second proposed change to the Trust Constitution is to make minor alterations to the **Code of Conduct for Governors** to bring the terminology up to date ('Chair' instead of 'Chairman')

The proposed changes are attached.

Reminder of prior changes: At the Council of Governors and Board of Directors meetings on 27 May 2022, governors and members of the Board approved two changes which had to be made at short notice and therefore took place outside the usual annual review of the Constitution.

1. A change to paragraph 24 - Composition of the Board of Directors – to allow for an increase from 7 Executive Directors to 8.
2. A change to the Board's standing orders to support electronic signature of documents.

These changes have now been made to the Constitution. The current version of the constitution can be viewed in its entirety on the Trust website at https://www.uhbw.nhs.uk/p/about-us/reports-and-publications.

Recommendation

Paragraph 40 of the Trust's constitution sets out the process for any required amendments and outlines that these may only be made if more than half of the Council of Governors vote to approve the amendments, as well as more than half of the Directors.

As a result, these changes are proposed to both the Trust Board and the Council of Governors on 9 August 2022 for their respective approval. Once authorised, NHSE will be advised of the change.

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 are no associated risks with this report.

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

- This report is for **Approval.**

The Board of Directors and the Council of Governors are asked to approve the proposed changes to the Constitution as outlined in the report.

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

Membership and Constitution Group	13 July 2022

Proposed Changes to UHBW Trust Constitution on p.23-24 – August 2022

ANNEX 1

THE PUBLIC CONSTITUENCIES

The Public Constituencies	**Area of each Public Constituency (as defined by Local Authority boundaries)**	**Minimum Number of Members**
Bristol	Bristol City Council	~~2271~~ 100
North Somerset	North Somerset District Council	~~1058~~ 100
South Gloucestershire	South Gloucestershire Council	~~1388~~ 100
Rest of England and Wales	Rest of England and Wales	5

~~The minimum number of members is based on 0.5% of the population in each Public Constituency as reported in the ONS 2016 based sub-national population data:~~

~~Rest of England and Wales – fixed value at 5 members~~

Judd,Emily
03/08/2022 15:27:16

ANNEX 2

THE STAFF CONSTITUENCIES

Classes within the Staff Constituency	**Individuals Eligible for Membership of that Staff Class**	**Minimum Number of Members in each Staff Class**
Medical and Dental Staff	Those individuals defined in paragraph 1 below.	~~1166~~ 100
Nursing and Midwifery Staff	Those individuals defined in paragraph 2 below.	~~3007~~ 100
Other Clinical Healthcare Staff	Those individuals defined in paragraph 3 below.	~~1313~~ 100
Non-Clinical Healthcare Staff	Those individuals defined in paragraph 4 below.	~~2289~~ 100

~~**The minimum number of members is based on 75% of the headcount of the eligible workforce in each Staff Constituency as at July 2018.**~~

ANNEX 8

COUNCIL OF GOVERNORS CODE OF CONDUCT

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

CODE OF CONDUCT FOR GOVERNORS

1. Introduction

1.1 ~~1.1~~ As defined by legislation, the Trust's Council of Governors have a formal role in the governance of the Trust, working with the Board of Directors to promote the success of the organisation for its members and the public. To support the proper discharge of the Council of Governors' statutory duties and to promote the success of the relationship between the Council of Governors and the Board of Directors, it is essential that Governors adopt high standards of personal conduct. Recognising this, this document sets out the Council's expectations for the way in which Governors will conduct themselves in all aspects of their role within the Trust.

2. ~~2.~~ Framework for Council of Governors

2.1 ~~2.1~~ The Trust operates within a legal, regulatory and governance framework which includes the NHS Act 2006, the Health and Social Care Act 2012, the Foundation Trust Code of Governance and the Trust's Constitution. The Constitution defines the composition of the Council of Governors and the arrangements for appointing (and, where necessary, removing) Governors. The Constitution's annexes include the Standing Orders for the Council of Governors and Board of Directors.

2.2 ~~2.2~~ This Code of Conduct is subject to the Constitution; nothing within this shall take precedence over or in any way amend the Constitution or any legal or regulatory requirements. This Code of Conduct is to be read in the context of that legal and regulatory framework.

3. ~~3.~~ Role of the Council of Governors

3.1 ~~3.1~~ The role of the Council of Governors is defined in law and in NHS ~~Improvement's~~ England's regulatory and governance framework. Although the role definition is not repeated here it is important as context for this Code of Conduct to recognise that good governance in the Trust depends upon active and constructive engagement between the Board of Directors and the Council of Governors. Adopting this approach will ensure that the Council of Governors is able to discharge its statutory duties, particularly in relation to:

3.1.1 ~~3.1.1~~ Holding the Non-Executive Directors individually and

collectively to account for the performance of the Board; and

3.1.2 ~~3.1.2~~ Representing the interests of the members as a whole and of the public

4. ~~4.~~ Board of Directors/Council of Governors Engagement

4.1 ~~4.1~~ The Constitution and supporting guidance commit the Board of Directors and the Council of Governors (as a whole and Governors individually) to engaging proactively and constructively with the Board of Directors, acting through the Chair~~man~~, Senior Independent Director and the Lead Governor where appropriate according to their roles.

4.2 ~~4.2~~ The Council of Governors will work with the Board of Directors for the best interests of the Trust as a whole, taking into account all relevant advice and information presented to, or requested by, the Council of Governors. The Council of Governors will not unduly delay responses to proposals or other reports from the Board of Directors, acting proactively to agree with the Board of Directors the information which the Council of Governors will need in order properly to discharge its statutory duties.

5. ~~5.~~ Conduct of Governors

5.1 ~~5.1~~ This section of the Code sets out the conduct which all Governors agree to abide by. These commitments are in addition to compliance with NHS Improvement's requirements, the Code of Governance and the Constitution.

5.1.1 ~~5.1.1~~ Personal Conduct

Governors agree that they will:

a) ~~a)~~ Act in the best interests of patients and the Trust as a whole in the delivery of services within relevant financial and operational parameters, seeking at all times to properly discharge their statutory duties;
b) ~~b)~~ Comply at all times with legal and regulatory requirements and with the Constitution, Standing Orders, relevant Terms of Reference, policies and guidance;
c) ~~c)~~ Be honest and act with integrity and probity at all times;
d) ~~d)~~ Respect and treat with dignity and fairness, the public; patients; relatives; carers; NHS staff and partners in other agencies;
e) ~~e)~~ Respect and value all Governors and Directors as colleagues;
f) ~~f)~~ Not seek to profit from their position as a Governor or in any way use their position to gain advantage for any person;
g) ~~g)~~ Accept responsibility for their actions and generally take seriously the responsibilities which are commensurate with the decision-making rights assigned to the Council of Governors through the legal and regulatory framework;
h) ~~h)~~ Ensure that the interests of the members as a whole and the public

are represented and upheld in decision making such that in accordance with the requirements of the Constitution and relevant policies, those decisions are not influenced by gifts or inducements or any interests outside the Trust;

i) ~~i)~~ Not be influenced in any way and not represent any outside interests which they may hold, including any membership of trade unions or political organisations;

j) ~~j)~~ Ensure that no person is discriminated against on grounds of religion or belief; ethnic origin; gender; marital status; age; disability; sexual orientation or socio-economic status;

k) ~~k)~~ Show their commitment to team working by working constructively with their fellow Governors and the Board of Directors as well as with their colleagues in the NHS and the wider community;

l) ~~l)~~ Not make, permit or knowingly allow to be made, any untrue; misleading or misrepresentative statement either relating to their own role or to the functions or business of the Trust;

m) ~~m)~~ At all times, uphold the values and core principles of the NHS and the Trust as set out in its Constitution;

n) ~~n)~~ Conduct themselves in a manner which reflects positively on the Trust and not in any manner which could be regarded as bringing it into disrepute;

o) ~~o)~~ Seek to ensure that the membership of the constituency from which they are elected/their appointing organisation is both properly informed and represented

p) ~~p)~~ At all times, uphold the seven principles of public life as set out by the Committee on Standards in Public Life (also known as the Nolan Principles) as below:

(i) ~~(i)~~ Selflessness: Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves; their family or friends or other interested parties.

(ii) ~~(ii)~~ Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

(iii) ~~(iii)~~ Objectivity: In carrying out public business, including making public appointments; awarding contracts or recommending individuals for awards or benefits, holders of public office should make choices on merit.

(iv) ~~(iv)~~ Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

(v) ~~(v)~~ Openness: Holders of public office should be as open as possible about all the decision and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

(vi) ~~(vi)~~ Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and

to take steps to resolve any conflicts arising in a way that protects the public interest.

(vii) ~~(vii)~~ Leadership: Holders of public office shall promote and support these principles by leadership and example.

q) ~~q)~~ ~~s~~Seek advice from the Chair~~man~~ or the Director of Corporate Governance~~Trust Secretary~~ on matters relating the Constitution, governance requirements or conduct, and have regard to the advice given to them.

5.1.2 ~~5.1.2~~ **Confidentiality**

Governors agree that they will:

a) ~~r)~~ Respect the confidentiality of the information they are made privy to as a result of their membership of the Council of Governors, except where information is made available in the public domain.

b) ~~s)~~ Understand, endorse and promote the Trust's Data Protection Policy in every aspect of their work. A copy of this policy will be provided to each Governor and training will be provided where necessary.

c) ~~t)~~ Make no public statements on behalf of the Trust or communicate in any way with the media without the prior consent of the Chair~~man~~ or a designated officer from the Trust's Communications Department.

5.1.3 ~~5.1.3~~ **Declaration of Interests**

Governors agree that:

a) ~~u)~~ It is essential for good corporate governance and to maintain public confidence in the Trust that all decision making is robust and transparent. To support this, the Constitution and the Trust's Policy on the Register of Interests, Gifts and Hospitality set out requirements for Governors to declare relevant interests (as defined in the Constitution).

b) ~~v)~~ Governors will declare interests on request from the Director of Corporate Governance~~Trust Secretary~~ or, as required by the Constitution, whenever they become aware of a potential conflict of interest in respect of a matter being considered by the Council of Governors. Governors should seek advice from the Director of Corporate Governance~~Trust Secretary~~ or the Chair~~man~~ where they are unsure as to whether an interest needs to be declared. Declared interests will be included in a Register of Interests, which will be published on the Trust website.

6. ~~6.~~ Participation in Meetings and in Training and Development

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6.1 ~~6.1~~ The Council of Governors will hold a number of meetings per year, the number to be determined by the Chair~~man~~. The schedule for these meetings and for other activities will be proposed by the Trust Secretari~~aty~~ and is subject to approval by the Council of Governors.

6.2 ~~6.2~~ It is expected that Governors will attend meetings of the Council of Governors and any committees to which they are appointed but it is accepted that there will be occasions on which Governors cannot attend, in which case they will give apologies for absence.

6.3 ~~6.3~~ The Constitution provides for the Council of Governors to remove any Governor from office where he/she fails to attend two consecutive Council of Governor meetings and where the Council is not satisfied that the absence was due to a reasonable cause and that the attendance record will be rectified.

6.4 ~~6.4~~ The Board of Directors has a statutory duty to take steps to ensure that the Governors are equipped with the skills and knowledge they need to discharge their responsibilities appropriately. A programme of training and development will be agreed with the Council of Governors and it is expected that Governors will participate in such activities unless, in reasonable circumstances, this is not possible.

7. ~~7.~~ Upholding this Code of Conduct

7.1 ~~7.1~~ Following approval of this Code of Conduct by the Council of Governors, individual Governors agree to comply with all of its content.

7.2 ~~7.2~~ Where possible or appropriate, any concerns about the conduct or performance of a Governor will be addressed under the leadership of the Chair~~man~~ through training, development or other means which are considered appropriate. Where such concerns exist the Chair~~man~~ will write to the Governor concerned to set out the concerns and the action agreed to rectify or otherwise address them.

7.3 ~~7.3~~ The Constitution provides for the circumstances in which a Governor can be removed from office, including where any Governor fails to comply with this Code of Conduct. It is for the Chair~~man~~ to propose removal from office if this is necessary after all other course of action, including training and development where relevant, have been exhausted. The Constitution provides for an independent review of evidence associated with such a proposal, reflecting the Foundation Trust Code of Governance. As required by the Constitution, it is for the Council of Governors to determine (in accordance with rules set out in the Constitution) whether any Governor should be removed from office following a proposal from the Chair~~man~~ and an independent review if one is commissioned~~.~~

Approved by the Council of Governors on 9 August 2022
Approved by the Board of Directors on 9 August 2022

To be reviewed not later than ~~March 2021~~August 2023

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

CODE OF CONDUCT FOR GOVERNORS

DECLARATION OF ACCEPTANCE

I confirm that I have received, read and understood the Code of Conduct for Governors (the Code).

I further confirm that I will comply with the provisions of the Code.

……
Signature of Governor

……
Name of Governor

Address for Governor

……
Date of signature

Please return the completed form to:

~~Membership Team,~~ University Hospitals Bristol and Weston NHS Foundation Trust, Trust Secretariat, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU ~~University Hospitals Bristol and Weston NHS Foundation Trust.~~

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University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th August 2022

Report Title	**Governors' Log of Communications Report**
Report Author	**Eric Sanders, Director of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary
The purpose of this report is to provide the Board of Directors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous meeting. The Governors' Log of Communications is a means of channelling communications between the governors and the officers of the Trust.
2. Key points to note
Since the previous Board of Directors meeting on 27 May 2022, one question has been added to the Governors' Log which relates to the quality of patient contact details and whether the Trust could improve records to improve the amount of 'no show' appointments.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
n/a
4. Advice and Recommendations
• This report is for **Information.**
5. History of the paper **Please include details of where paper has previously been received.**
n/a

We are
supportive
respectful
innovative
collaborative.
We are UHBW.

Governors' Log of Communications

03 August 2022

ID	Governor Name		
269	Charles Bolton	***Theme:*** Patient Records	***Source:*** Governor Direct

Query **03/08/2022**

How confident is the Trust about the quality of data it holds about patient contact details? Are there measures it could be taking which could improve this, and maybe help reduce the number of no-shows?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response

Status: *Pending Assignment*

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