NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Public Board Meeting

Schedule	Tuesday 14 November 2023, 10:30 AM — 1:15 PM GMT
Venue	Lecture Theatre, The Academy, Weston General Hospital, Grange Road, Uphill, Weston Super Mare, BS23 4TQ
Organiser	Rachel Hartles

Agenda

	1. Welcome and Apologies for Absence For Information - Presented by Jayne Mee	
	2. Declarations of Interest For Information - Presented by Jayne Mee	
10:30 AM	3. Patient Story For Information - Presented by Deirdre Fowler	(20 mins)
	4. Minutes of the Previous meeting	
10:50 AM	5. Matters Arising and Action Log For Approval - Presented by Jayne Mee	(5 mins)
10:55 AM	6. Chief Executive's Report For Information - Presented by Eugine Yafele	(10 mins)
11:05 AM	7. Quality and Outcomes Chair's Report For Assurance - Presented by Sue Balcombe	(5 mins)
11:10 AM	8. Performance Report For Assurance - Presented by Jane Farrell, Deirdre Fowler, Emma Wood and Stuart Walker	(15 mins)
11:25 AM	9. Maternity Assurance Report For Assurance - Presented by Deirdre Fowler	(10 mins)

11:35 AM	10. National Care Survey Results For Assurance - Presented by Deirdre Fowler	(15 mins)
	10.1. Urgent and Emergency Care	
	10.2. Annual Cancer Patient Experience Survey	
	10.3. Annual Inpatient Survey	
11:50 AM	11. Learning from Deaths 2022/23 Annual Report For Assurance - Presented by Stuart Walker	(10 mins)
12:00 PM	12. Safeguarding Annual Report For Assurance - Presented by Deirdre Fowler	(10 mins)
12:10 PM	Break	(10 mins)
12:20 PM	13. Finance, Digital & Estates Committee Chair's Report For Assurance - Presented by Martin Sykes	(5 mins)
12:25 PM	14. Trust Finance Report For Assurance - Presented by Neil Kemsley	(10 mins)
12:35 PM	15. People Committee Chair’s Report For Assurance - Presented by Bernard Galton	(5 mins)
12:40 PM	16. Quarter 2 Freedom to Speak Up Report For Assurance - Presented by Eric Sanders	(10 mins)
12:50 PM	17. Board Assurance Framework: Strategic Risk Register	(5 mins)

12:55 PM	18.	Audit Committee Chair's Report For Assurance - Presented by Jane Norman	(5 mins)
1:00 PM	19.	Capital Investment Policy For Approval - Presented by Neil Kemsley	(5 mins)
1:05 PM	20.	Governor's log of communications For Assurance - Presented by Eric Sanders	(5 mins)
1:10 PM	21.	Any Other Urgent Business For Information - Presented by Jayne Mee	
	22.	Date of Next Meeting: Tuesday, 09 January 2024 For Information - Presented by Jayne Mee	

University Hospitals Bristol and Weston NHS Foundation Trust

BOARD OF DIRECTORS (IN PUBLIC)

Meeting to be held on Tuesday, 14 November 2023 at 10.30 – 13.15 in Lecture Theatre, The Academy, Weston General Hospital

AGENDA

NO	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS
Preliminary Business				
1.	Welcome and Apologies for Absence	Information	Chair	10.30
2.	Declarations of Interest	Information	Chair	
3.	Patient Story	Information	Patient and Public Involvement Lead	
4.	Minutes of the Last Meeting – 12th September 2023	Approval	Chair	
5.	Matters Arising and Action Log	Approval	Chair	
6.	Chief Executive's Report	Information	Chief Executive	10 .55
Quality and Performance				
7.	Quality and Outcomes Chair's Report	Assurance	Chair of the Quality and Outcomes Committee	11.10
8.	Performance Report	Assurance	Chief Operating Officer; Chief Nurse and Midwife; Chief People Officer; Chief Medical Officer	11.15
9.	Maternity Assurance Report	Assurance	Chief Nurse and Midwife	11.25
10.	National Care Survey Results a. Urgent and Emergency Care b. Annual Cancer Patient Experience Survey c. Annual Inpatient Survey	Assurance	Chief Nurse and Midwife	11.30
11.	Learning from Deaths 2022/23 Annual Report	Assurance	Chief Medical Officer	11.50
12.	Safeguarding Annual Report	Assurance	Chief Nurse and Midwife	12.00
BREAK – 12.15 -12.25				
Financial Performance				
13.	Finance, Digital & Estates Committee Chair's Report	Assurance	Chair of the Finance and Digital Committee	12.25
14.	Trust Finance Report	Assurance	Chief Financial Officer	12.30

NO	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS
People Management				
15.	People Committee Chair's Report	Assurance	Chair of the People Committee	12.40
16.	Quarter 2 Freedom to Speak Up Report	Assurance	Director of Corporate Governance	12.45
Governance				
17.	Board Assurance Framework: Strategic Risk Register	Assurance	Director of Corporate Governance	12.55
18.	Audit Committee Chair's Report	Assurance	Chair of the Audit Committee	13.05
19.	Capital Investment Policy	Approval	Chief Financial Officer	13.10
20.	Governor's log of communications	Assurance	Director of Corporate Governance	13.15
Concluding Business				
21.	Any Other Urgent Business	Information	Chair	
22.	Date of Next Meeting: **Tuesday, 09 January 2024**	Information	Chair	

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 14th November 2023

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

1. Purpose

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

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

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

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

In this story we will meet Paul. Paul is the uncle of a teenage boy receiving care at the Bristol Royal Hospital for Children (BRHC). Paul's nephew was transferred to the BRHC from Musgrove Park Hospital, Taunton for investigations and the subsequent successful removal of a spinal tumour. In sharing his story, Paul will describe how the team at the hospital created a safe and supportive climate for his nephew and family at a "terrifying time". He will share some of the small, nuanced touches the team made that shone and exemplified the "remarkable" personal and individual care his nephew received; how the team "saw his nephew as a human being"; how these touches supported his nephew through some of the most challenging and frustrating moments; and, how this instilled a confidence in the family that his nephew was being cared for both clinically and emotionally at all times, 24/7.

In addition, Paul will share his insight on the importance of understanding and responding to the unique level of information each family may seek about the likely course of a medical condition of a loved one and, how getting this right can ease the anxiety of speculation.

Finally, Paul will note he is part of a Bristol based team who, in partnership with the hospital and the Grand Appeal, have created a paediatric digital diary for patients within the Seahorse Paediatric Intensive Care Unit to aid psychological recovery and to keep families connected. Paul will reflect on how his own lived experience has brought new insight into this work and, on a personal level, how his experience

has strengthened the bond with his nephew for the future.

Divisional representatives will be at the meeting and have provided this supporting statement:

We know it is a challenge for families to match their adjustment and understanding to the speed of the medical journey and treatment decisions they are given. Often as families are processing the information the story is changing and they have questions, difficulties remembering information and anxieties at times the team are not there. Finding ways to record information, questions, explore feelings and find ways to cope with the adjustment is a challenge for us and highlighted by Paul's story. We've been lucky to start a project in PICU with Paul whose experience has become part of the project's development and led us to look at how the PICU diary can be extended out but also explore the gap we have for young people themselves to have a place to go to record their own journey, questions, feelings, key contacts and treatments to help them adjust in their own time with our help.

We are aware that strong partnerships with young people, families and our charity partners can help us do this better.

3. Strategic Alignment

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

4. Risks and Opportunities

None.

5. Recommendation

This report is for Information

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

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

N/A

University Hospitals Bristol and Weston NHS Foundation Trust

BOARD OF DIRECTORS (IN PUBLIC)

Minutes of the meeting held on Tuesday 12th September 2023 at 13.45 – 16.45 in Lecture Theatre 1, the Education Centre, UHBW.

Present

Board Members

Name	Job Title/Position
Jayne Mee	Chair
Eugine Yafele	Chief Executive
Arabel Bailey	Non-Executive Director
Sue Balcombe	Non-Executive Director
Rosie Benneyworth	Non-Executive Director
Paula Clarke	Executive Managing Director, Weston General Hospital
Neil Darvill	Chief Digital Information Officer
Jane Farrell	Chief Operating Officer
Deirdre Fowler	Chief Nurse and Midwife
Bernard Galton	Non-Executive Director
Marc Griffiths	Non-Executive Director
Emma Glynn	Associate Non-executive Director
Susan Hamilton	Associate Non-executive Director
Neil Kemsley	Chief Financial Officer
Jane Norman	Non-Executive Director
Stuart Walker	Chief Medical Officer
Martin Sykes	Non-Executive Director

In Attendance

Mark Pender	Head of Corporate Governance (minutes)
Alex Nestor	Deputy Chief People Officer
Eric Sanders	Director of Corporate Governance
Tony Watkin	Patient and Public Involvement Lead (for Item 3: Patient Story)
Lindsey	For Item 3: Patient Story
Matthew James	Associate Director of Estates (for Item 8: Healthier Together ICS Green Plan)
Caroline Walker	Pharmacy Transformation Programme Manager for item 9: Pharmacy Technical Services Outline Business Case)
Martin Williams	Director of Infection Prevention and Control (for item 12: Annual Infection Prevention Control Report)
Rebecca Mann	Well-Led Team (Observer)
Will Crookes	The Value Circle Consultant (Observer)
Apologies	
Roy Shubhabrata	Non-Executive Director
Emma Wood	Chief People Officer

The Chair opened the Meeting at 13.45

Minute Ref.	*Item*	*Actions*
01/09/23	**Welcome and Apologies for Absence**	
	Jayne Mee, Trust Chair, welcomed members of the Board to the meeting. Jayne informed the Board that the meeting would be recorded and published on the Trust's YouTube account for public access following the meeting. Apologies of absence had been received from Emma Wood, Chief People Officer (Alex Nestor, Deputy Chief People Officer, deputising) and Roy Shubhabrata, Non-Executive Director.	
02/09/23	**Declarations of Interest**	
	There were no new declarations of interest relevant to the meeting to note.	
03/09/23	**Patient Story**	
	Lindsey, a patient who underwent surgery for bowel cancer at Weston General Hospital, attended the meeting to share her personal experience of care at University Hospitals Bristol & Weston NHS Foundation Trust, including a summary of the impact of the care she received. Lindsey informed the Board that earlier in the year she had received a diagnosis of bowel cancer and had a right hemi-colectomy at Weston General Hospital on the 25th of April. The care of Mr Krishna and team had been outstanding; however, the nursing care was not. Lindsey felt she had been put at significant risk and did not receive the level of care and compassion that she would expect in her experience as a former Chief Nurse at the Trust. Lindsey's main fear on admission was that low staffing levels might compromise the nursing care, but although she felt her care was compromised, the ward she was on appeared to be well staffed. She was admitted to the ward at teatime and had a comfortable post-operative night. She recalled observations being done before lights out and again in the morning, but not in between, which surprised her given she had been in surgery for 6 hours. That morning was the start of a distressing 24 hours for Lindsey as there were a myriad of issues: she was offered high fibre breakfast when on fluids only; consistently poor Infection Prevention & Control practice was evident, with hand washing between patients not taking place; she experienced delays in pain relief with her having to wait four hours; there was no checking of identity for controlled drugs; and a general lack of care and compassion. None of the nurses appeared to know or understand anything about her other than what operation she had undergone. Then came a very difficult night. Whilst the ward was well staffed there clearly was an issue with a very unwell patient. Lindsey's 6-bed area had a dedicated support worker, but she did nothing and did not appear to escalate any issues to the registered nurses and ignored another patient in pain and who was vomiting. Lindsey felt she needed to manage her own infusion and the support worker made hourly records, documenting that she was sleeping comfortably. This was untrue.	

Minute Ref.	*Item*	*Actions*
	For the remainder of her admission issues relating to safety, care and compassion continued, but to a lesser degree. Two days after discharge Lindsey tested positive for COVID which she felt was due to the consistently poor IPC she had observed on the ward. This meant that she had to spend a week in isolation at home whilst she was at her most vulnerable, unable to receive support. In summary, her concerns related to: • Patient Safety – patients placed at significant risk due to unsafe IPC practice, medicines management, infusion management etc. • Lack of care & compassion from nursing staff. • Lack of knowledge of the patients and little application of evidence-based practice. • Care was task orientated with little application of person-centred care or a holistic approach. During the ensuing discussion the following points were made: • Sue Balcombe, Non-Executive Director, expressed her anger and disappointment at Lindsey's experience, as the nursing profession had let her down. Sue wondered whether the training nurses received was enough and questioned where the ward sister or other managers on the ward were. Lindsey responded that she felt a back-to-basics approach was required, and ward mangers needed to walk the ward and be much more visible. Lindsey confirmed that she had been asked to work with the Trust to ensure sustained improvement was achieved, although this could be done without her. • Paula Clarke, Executive Managing Director Weston General Hospital, thanked Lindsey for her courage in telling her story, which was very uncomfortable for the Board to hear, and which Lindsey had every right to be angry about. Paula apologised to Lindsey for the care she had received and assured the Board that the Trust was on a journey of continuous improvement, but there was not a quick fix. Lindsey commented that she did not believe the issues she experienced were endemic across the Trust. • Deirdre Fowler, Chief Nurse and Midwife, apologised to Lindsey on behalf of the nursing profession for the care she received and confirmed that remedial work was ongoing. Leadership needed to be front and centre in changing culture and leadership development would be key to this. • Eugine Yafele commented that it had been difficult to listen to Lindsey's experiences, which undermined the improvements that had recently been celebrated at Weston. Ward sisters were key in the provision of safe and compassionate patient care, and he agreed that a simple back to basics approach, where compassion and making time to listen to patients would go a long way to addressing the issues reported. At the conclusion of the discussion the hair thanked Lindsey for sharing her story with the Board. **RESOLVED that the Patient Story be received and noted for information**.	

Minute Ref.	*Item*	*Actions*
04/09/23	**Minutes of the Last Meeting**	
	The Board reviewed the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust Board held in public on 15th June 2023. It was reported that in the 6th bullet point on page 10 of the minutes, 'voluntary services' should be replaced with 'psychological services', and this amendment was accepted by the Board. **RESOLVED that subject to the amendment above amendment, the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust Board held in public on 15th June 2023 be approved as a true and accurate record.**	
05/09/23	**Matters Arising and Action Log**	
	Board Members received and reviewed the action log. Updates on completed actions were noted, and others were discussed as follows: <u>08/06/23 - Eric Sanders to confirm whether the moral injury of the workforce has been captured within the risk registers.</u> It was reported that the risk registers had been reviewed and although there was a corporate risk related to workplace stress (ID: 793), there was no specific mention of a risk of moral injury in any risk. The risk team would follow this up with HR and frontline teams to ensure that this risk was assessed. It was agreed that this action could be CLOSED. <u>14/06/23 - Due diligence to return to the Board in September to support the proposal from the Safer Nursing Care Tool (SNCT) assessment.</u> It was reported that a solution had been achieved for CED winter 2023 and conversations were ongoing regarding the recurrent solution for PICU. ACTION ONGOING. <u>15/06/23 - Mandie Townsend to confirm what had driven the monthly commercial income figures in figure D of the report and whether it was related to vaccinations.</u> It was reported that there had been a surge of commercial trials income in 21/22 due to the COVID vaccine trials. These were the first few commercial covid vaccine trials available and the Trust had recruited a high number of participants. The drop off in 22/23 reflected those studies closing and new vaccine trials having smaller target numbers for recruitment. 2022/23 income was still higher than in pre-COVID times as the Trust had continued to deliver vaccine trials in adults, which was not routinely done previously. It was agreed that this action could be CLOSED. **RESOLVED that the updates against the action log be noted.**	
06/09/23	**Chief Executive's Report**	
	Eugine Yafele, Chief Executive, provided a verbal update on the following key issues: **Lucy Letby Verdict:** Eugine commented on the appalling crimes committed by Lucy Letby, and whilst there were now better processes in place To protect all patients, there was a need to guard against complacency as it was unlikely any process would have stopped her. There was a need to continue to develop an open and compassionate	

Minute Ref.	*Item*	*Actions*
	culture, where patient safety was everyone's business and where people felt able to speak up and raise concerns. Concerns needed to be acted upon and the organisation needed to keep being curious and learn from such events. **Industrial Action:** Further industrial action was planned by the BMA, with consultants due to take industrial action on 19th and 20th September and Junior Doctors on 2nd and 3rd October. This would add to the cumulative impact of the industrial action already taken place this year. **Reinforced Autoclaved Aerated Concrete (RAAC) -** Eugine reported that the Trust had responded to Government's enquiry regarding RAAC in May and confirmed that the Trust did not have a risk in relation to RAAC. **Urgent and Elective Care for Winter:** It was reported that the Trust was well on its way to meeting its waiting time expectations and whilst closing the gap was becoming harder, work was continuing in this area. In respect of urgent care, Eugine was pleased to report that the BNSSG system was top of England for emergency care access, although it was not at the 95% target. During the ensuing discussion the following points were made: • The Chair thanked the team for maintaining safe services during the recent industrial action and highlighted the fact that staff well-being was critical during this time. • Rosie Benneyworth, Non- Executive Director, referenced the update on the ICS Strategy contained in the CEO report, particularly in respect of the focus on prevention and early intervention, and asked where the ownership of this was within the Trust. Eugine responded that prevention was a key element in managing demand, and the Chair commented that this would be taken account of as part of the forthcoming refresh of the Trust's strategy. After further discussion it was **RESOLVED that the Chief Executive's report be received and noted for information**.	
07/09/23	**Response to the Verdict in the trial of Lucy Letby**	
	Eric Sanders, Director of Corporate Governance, introduced a report that summarised the Trust's response to the letter received from NHS England on 18 August 2023 relating to the verdict in the trial of Lucy Letby and the specified actions contained within. The following points were highlighted: • The Trust had a range of mechanisms in place to support staff and patients to have a voice. • There were a range of reports which were regularly presented to the Board and its Committees which shared this feedback. It was recommended that the Board seek further assurance as to the impact and embeddedness of the actions agreed following consideration of the feedback. • Further work was required to ensure that all staff understood the different routes to speak up, and to ensure they had confidence that the Trust would listen and act promptly. In addition, continued work	

Minute Ref.	Item	Actions
	was required to understand and address the cultural barriers in existence across the Trust which stopped some staff speaking up. • The Trust had a robust approach to ensuring that all Directors were Fit and Proper Persons (FPP) and it complied with the regulations. The new guidance relating to FPP would now be reviewed and processes updated. All Directors met the regulatory requirements relating to Fit and Proper Persons. During the ensuing discussion the following points were made by Board members: • Bernard Galton, Non-Executive Director, commented that this was an extreme and shocking case which highlighted the importance of Freedom to Speak Up (FTSU) at all levels. He suggested a 'big conversation' could be held with staff to raise awareness of FTSU and highlight the importance of acting on concerns raised. • Arabel Bailey, Non-Executive Director, highlighted the importance of triangulating information and asked whether there was a place where all the feedback could be pulled together and assessed. • Emma Glynn, Associated Non-Executive Director, commented that there might be too many routes for raising concerns / points of escalation, which could cause confusion and delay, and Eric Sanders responded that efforts to improve triangulation had been on going but this had not been landed yet. The Patient First initiative was changing this. Alex Nestor added that there had been an increase in employee relations cases as a result of Letby. • Stuart Walker, Chief Medical Officer, commented that FTSU was just one part of a suite of safety metrics available to the Trust which would help to identify if there was a serious issue such as Letby. There was no lack of data, and the key was to ensure there were effective escalation processes and triangulation in place. • Eugine Yafele, Chief Executive, responded to the comment about there being too many points of escalation, and suggested that it was better to have as many as possible, as this helped build confidence amongst staff that they were being listened to. He would therefore be reluctant to narrow down the options, but work would need to be done to consider how well the various processes were connected. After further discussion it was **RESOLVED that the report and the challenge outlined within it be noted.**	
	Healthier Together ICS Green Plan	
	Matthew James, Associate Director of Estates, attended the meeting to present the Healthier Together ICS Green Plan. It was noted that NHS England guidance required for all Trusts to have a "Green Plan" and previously UHBW had the "Sustainable Development Strategy 2020 – 2025". It was proposed that this should be superseded with the joint BNSSG ICS Green Plan. It was reported that the joint ICS Green Plan set out ambitions for environmental and social sustainability, most notably the Trust's plans for net zero greenhouse gas emissions by 2030. These ambitions had previously agreed by the board when the Trust declared a climate emergency in 2018. This new plan expanded on previous ambitions to	

Minute Ref.	*Item*	*Actions*
	cover topics such as air pollution, social value in procurement and biodiversity net gain. During the ensuing discussion the following points were made: • The Chair questioned how achieving the ambitious targets set out in the plan would be funded, and Matthew reported that this would be allocated at system level with a proposal that 10% of capital funding be allocated to the sustainability agenda. • The impact of travel and transport on the sustainability agenda was discussed, and it was noted that patient travel was a huge contributory factor to carbon output. It was suggested that virtual appointments / consultations could help reduce this impact to some degree. • Marc Griffiths, Non-Executive Director, expressed his disappointment with section 23.1 of the plan relating to academic partners, which he felt did not capture the contribution academic partners could make to the sustainability agenda. Matthew agreed to take this point away to ensure academic partners were properly engaged with. • Susan Hamilton, Associate Non-Executive Director, commented that the plan touched all the Trust's other strategies, and suggested that ideas from patients and staff on how to meet the sustainability targets could prove useful. Arabel Bailey, Non-Executive Director, agreed and suggested that there could be some quick wins in respect of single use plastics etc which the Trust could implement now. After further discussion it was **RESOLVED that the ambition, intent, and proposals for delivery of the joint ICS Green Plan be approved by the Board.**	
08/09/23	**Pharmacy Technical Services Outline Business Case**	
	Caroline Walker, Pharmacy Transformation Programme Manager, attended the meeting to present the Pharmacy Technical Services Outline Business Case. It was reported that the outline business case detailed the requirement to transform pharmacy technical services across the BNSSG ICS and presented the preferred option, which had been derived from a full options appraisal undertaken by a specialist external consultancy firm. The preferred option (option 4c of the Outline Business Case Options Appraisal) was for UHBW and NBT to establish and operate a new, fully MHRA licensed off-site aseptics and technical services hub, supported by existing on-site spokes at both Trusts to deliver the required capacity. The intention was to develop the outline business case into a full business case to bid for capital funding from NHSE with a Capital Departmental Expenditure Limit (CDEL) uplift for the BNSSG ICS. It was noted that should the business case be endorsed by the Board it would require final sign off by the Council of Governors. During the ensuing discussion the following points were made:	

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	• Martin Sykes, Non-Executive Director, confirmed that the Finance, Digital and Estates Committee had considered the outline business case and had endorsed it for approval by the Board. He suggested that the savings in staff time needed to be confirmed as being real or notional in the full business case. • Several Non-Executive Directors expressed their support for the outline business case as an ambitious and innovative proposal. The likelihood of securing funding from NHSE was questioned, and whilst it was acknowledged that timescales were tight, key stakeholders were being engaged with and this was a priority for the system. **RESOLVED that the development of the outline business case into a full business case to present to NHSE in order to bid for national funding and regional CDEL uplift for the transformation of pharmacy aseptic and technical services, in line with the preferred option, be endorsed and recommended to the Council of Governors for approval.**	
09/09/23	**Quality and Outcomes Chair's Report**	
	Sue Balcombe, Non-Executive Director, introduced the Quality and Outcomes Committee Chair's Report and summarised the contents of the meeting held in July 2023. **RESOLVED that the Quality and Outcomes Chair's Report be received and noted for assurance.**	
10/09/23	**Performance Report**	
	Jane Farrell, Chief Operating Officer, introduced the Performance Report to provide an update on the key performance metrics for 2022/23 and the Trust's Leadership priorities. It was noted that the full Integrated Quality and Performance Report (IQPR) had been included within the Document Library for Board members' reference. Jane highlighted that by the end of July 2023, no patients were waiting over 104 weeks and the Trust continues to maintain zero 104-week Referral To Treatment (RTT) breaches, with no patient waiting longer than 104 weeks since February 2023. The recent periods of industrial action had made progress towards elimination of other care backlogs more challenging, with the number of patients reported to be waiting over 78 weeks rising to 248 in May and subsequently falling to 215 in June and further reducing to 203 by the end of July. The Trust anticipated a sustained reduction from September and continued to work towards an elimination of patients waiting over 78 weeks in Q3 2023/24. It was noted that Fractured neck of femur performance was not where it should be. Deidre Fowler, Chief Nurse and Midwife, highlighted that there were six hospital onset hospital acquired cases and two community onset hospital acquired cases of C.difficile reported in July. There were also two cases of MRSA bacteremia in July. The Infection Prevention and Control team were working with procurement to agree a peripheral venous catheter (PVC) insertion pack to be used Trust wide, with its implementation to include enhanced training across the organisation about Aseptic Non Touch Technique (ANTT) practice. Rosie Benneyworth, Non-Executive	

Minute Ref.	*Item*	*Actions*
	Director, commented on the lack of hand washing reported during the patient story, and it was agreed that this needed to be re-enforced with staff. Alex Nestor, Deputy Chief People Officer, reported that there had been a reduction in staff turnover but sickness absence had increased during July. It was suggested that the two could be linked. **RESOLVED that the Performance Report be received and noted for assurance.**	
11/09/23	**Annual Infection Prevention Control Report**	
	Martin Williams, Director of Infection Prevention and Control, attended the meeting to present the Annual Infection Prevention Control Report. Matin highlighted the following key points: • The report included a self-assessment summary approved by the DIPC of compliance with the 10 criteria with the IP&C code of practice, that the organisation was obliged to deliver. All 10 were acknowledged to be compliant. • Input for the report had been received from colleagues in the Safety Department, Occupational Health, IP&C, Facilities, Estates, Pharmacy, Decontamination, with specific elements of the report being written by them. The IP&C Annual Report had threads through each clinical pathway for every patient across the whole of UHBW. • The performance figures for Healthcare Acquired Infections (HCAI) infections, namely C.diffiicle and MRSA, where the Trust had exceeded the NHSE set limits. • The impact of SARS-CoV-2 and the pandemic continued through 2022/23 with significant impact on the services within UHBW. During the ensuing discussion the level of staff vaccinations was questioned, and Martin commented that whilst there was vaccination fatigue setting in, the numbers were still encouraging. The Trust would need to work hard for the coming winter vaccination season to ensure this was maintained. The Chair noted that the specialist ventilation room at Weston General Hospital was out of action due to an estates issue, and Martin agreed to pick this issue up outside of the meeting. **RESOLVED that the annual summary of organisational performance for Infection Prevention and control in UHBW across the year be noted, and the Annual Report for Infection Prevention and Control for 2022/23 be approved.**	
12/09/23	**National Institute for Health and Care Research (NIHR) Clinical Research Network West of England (CRN WE) Annual Plan and Annual Report**	
	Stuart Walker, Chief Medical Officer, introduced the Annual Plan and Report of the National Institute for Health and Care Research (NIHR) Clinical Research Network West of England (CRN WE), which was hosted by UHBW. With a £15.9m annual budget, the CRN WE supported patients, the public and health and care organisations across the West of	

Minute Ref.	*Item*	*Actions*
	England to participate in high-quality research, thereby advancing knowledge and improving care. **RESOLVED that the National Institute for Health and Care Research (NIHR) Clinical Research Network West of England (CRN WE) Annual Plan and Annual Report be approved.**	
13/09/23	**Finance & Digital Committee Chair's Report**	
	Martin Sykes, Non-Executive Director introduced the Finance & Digital Committee Chair's Report. He reported that the committee had seen good progress in respect of the Digital Strategy, and had reviewed the financial recovery plan, key risks and the arrangements for medium term financial planning. **RESOLVED that the Finance, Digital & Estates Committee Chair's Report be received and notes for assurance.**	
14/09/23	**Trust Finance Report**	
	Neil Kemsley, Acting Chief Financial Officer introduced the Trust Finance Report and reported that as of 31st July 2023 the Trust's net income and expenditure position was a net deficit of £9.4m, against a planned deficit of £5.8m. The adverse position against plan of £3.6m was due to higher than planned operating expenditure driven by the estimated financial impact of industrial action of £2.6m, and the shortfall on savings delivery of £1.0m. The Trust had delivered savings of £6.1m year to date, £1.0m behind plan. All services were being supported to identify 100% of their recurrent savings target by the end of September. The value of elective activity was £3.5m (or 1%) ahead of plan in the period including over-performance on pass-through drugs and devices of £1.8m despite the impact of industrial action. **RESOLVED that the Trust Finance Report be received and noted for assurance.**	
15/09/23	**People Committee Chair's Report**	
	Bernard Galton, Non-Executive Director, introduced the People Committee Chair's Report and summarised the contents of the meeting held in July 2023. An update was also provided on the BNSSG ICB People Committee, which was becoming more effective now that the ICB's new Chief People Officer was now in post. **RESOLVED that the People Committee Chair's Report be received and noted for assurance.**	
16/09/23	**Audit Committee Chair's Report**	
	Jane Norman, Non-Executive Director, introduced the Audit Committee Chair's Report and summarised the contents of the meeting which took place in July 2023.	

Minute Ref.	*Item*	*Actions*
	RESOLVED that the Audit Committee Chair's Report be received and noted for assurance.	
17/09/23	**Framework of quality assurance for responsible officers and revalidation**	
	Stuart Walker, Chief Medical Officer, introduced the annual board report and statement of compliance in respect of the framework of quality assurance for responsible officers and revalidation. This was presented to Board to provide assurance regarding appraisal and revalidation activity at UHBW and confirm compliance with the Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) prior to its submission to NHE England. It was reported that overall, it had been a good year for revalidation and appraisal, with compliance and revalidation recommendations at UHBW in line with other similar sized organisations. During the ensuing discussion the question of the appraisal of clinical academics jointly employed by UHBW and the University of Bristol was discussed, and it was confirmed that these members of staff were appraised. A further piece for work in respect of the alignment of these appraisals between the two organisations to ensure they were in line with the Follett principles would be undertaken by a new strategic group which was being established between the two organisations. **RESOLVED that the annual board report and statement of compliance in respect of the framework of quality assurance for responsible officers and revalidation be approved for submission to NHS England.**	
18/09/23	**Register of Seals**	
	Eric Sanders, Director of Corporate Governance, presented the register of seals for the period June to August 2023. The seal had been applied once during this period. **RESOLVED that the Register of Seals be received and noted for information.**	
19/09/23	**Governors' Log of Communications**	
	Eric Sanders, Director of Corporate Governance, presented the Governors' log of communications for the information of the Board. **RESOLVED that the Governors' Log of Communications be received and noted for information**.	
20/09/23	**Any Other Urgent Business**	
	The Chair reminded those present that the Annual Members Meeting would commence at 5.15pm, and all were welcome to stay. There were no further items of urgent business to discuss, and the Chair thanked everyone for attending and closed the meeting.	
21/09/23	**Date of Next Meeting:** Tuesday 14 November 2023	

University Hospitals Bristol and Weston NHS Foundation Trust

Public Trust Board of Directors Meeting on Tuesday, 14 November 2023
Action Log

Outstanding actions from the meeting held in September 2023					
No.	**Minute reference**	**Detail of action required**	**Executive Lead**	**Due Date**	**Action Update**
1.	**14/06/23**	Due diligence to return to the Board in September to support the proposal from the Safer Nursing Care Tool (SNCT) assessment.	Chief Nurse and Midwife / Chief Financial Officer	September 2023	**Action Ongoing** November Update The case for investment in PICU is being considered as part of a wider on-going assessment of key risks. If prioritised internally, the potential for recurring investment will need to be addressed as part of the system planning process for 2024/25. In the meantime we will continue to identify and implement appropriate mitigations. September Update: A solution has been achieved for CED winter 2023 and conversations are ongoing regarding the recurrent solution for PICU.
Closed actions from the meeting held in September 2023					
No.	**Minute reference**	**Detail of action required**	**Action for**	**Due Date**	**Action Update**
1.	**08/06/23**	Eric Sanders to confirm whether the moral injury of the workforce has been captured within the risk registers.	Director of Corporate Governance	September 2023	**ACTION CLOSED** September Update: The risk registers have been reviewed and although there is a corporate risk related to workplace stress (ID: 793), there is no specific mention of a risk of moral injury in any risk. The risk team will follow this up with HR and frontline teams to ensure that this risk is assessed.

2.	**15/06/23**	Mandie Townsend to confirm what had driven the monthly commercial income figures in figure D of the report and whether it related to vaccinations.	Deputy Medical Officer	September 2023	**ACTION CLOSED** September Update: There was a surge of commercial trials income in 21/22 due to the COVID vaccine trials. These were the first few commercial covid vaccine trials available and we were recruiting high numbers of participants. The drop off in 22/23 reflects those studies closing and new vaccine trials having smaller target numbers for recruitment. Our 22/23 income is still higher than in pre-COVID times as we have continued to deliver vaccine trials in adults, which we weren't routinely doing previously.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 14 November 2023

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

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

Chief Executive's Report

Background

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

National Topics of Interest

Thirlwall Inquiry

On 21 August 2023, after a trial at Manchester Crown Court, Lucy Letby was sentenced to life imprisonment and a whole life order on each of 7 counts of murder and 7 counts of attempted murder. The offences took place at the Countess of Chester Hospital, part of the Countess of Chester Hospital NHS Foundation Trust.

The Government announced that a Public Inquiry would be held, under the Inquiries Act 2005, to identify learning from the events at the Countess of Chester Hospital. The court of appeal judge Lady Justice Thirlwall has been appointed to lead the public inquiry. The inquiry will investigate 3 broad areas:

A. The experiences of the Countess of Chester Hospital and other relevant NHS services, of all the parents of the babies named in the indictment.

B. The conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby while she was employed there as a neonatal nurse and subsequently, including:

(i) whether suspicions should have been raised earlier, whether Lucy Letby should have been suspended earlier and whether the police and other external bodies should have been informed sooner of suspicions about her

(ii) the responses to concerns raised about Lucy Letby from those with management responsibilities within the trust

(iii) whether the trust's culture, management and governance structures and processes contributed to the failure to protect babies from Lucy Letby

C. The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture.

The Inquiry Terms of Reference can be found at the link below:

Thirlwall Inquiry: terms of reference - GOV.UK (www.gov.uk)

All Trusts with neonatal units will be contacted for evidence.

Industrial Action

Since the last written report of 12th September, the Trust has overseen the following Industrial Action:

- Junior Drs: 20th – 23rd September and 2nd – 5th October
- Consultants: 19th – 20th September and 2nd – 5th October

- Radiographers: 3rd – 4th October

Having successfully re-balloted Junior Doctors for further industrial action, the BMA now has a mandate to continue strike action until 29 February 2024. As their mandate for Consultant strike action expires in December, they are now re-balloting this staff group for a further mandate, the result of which is expected on or shortly after 18 December 2023. The BMA are also separately balloting SAS Doctors for strike action for the first time, with the result also expected around 18 December. This follows an indicative ballot in which 88% of respondents said they were prepared to strike. For either staff group a successful ballot would grant a strike mandate through to mid-June 2024. The HCSA are also balloting SAS Doctors with the result expected around 15 November, though they have previously coordinated all strike action with the BMA.

The BMA have not yet announced further dates of strike action. Having announced that talks with the government would take place in the week of 23 October 2023, it is likely that further strike action would not be declared before these talks have had an opportunity to progress. The Society of Radiographers have also not yet announced further strike action or an intention to re-ballot, with their mandate expiring at the end of December.

The impact on our patients, and delays in their treatment, remain a concern but we are assured that we have provided safe care for our In-Patients during periods of action. There are delays in Out-Patient appointments and elective operations as a consequence of the strikes, but the Operational teams continue to programme our recovery agenda. We recognise that this adds stress to our patients and their families. Equally our staff are feeling increasingly tired covering gaps and catching up with cancelled services. We continue to work with NHSE, NHS Providers and NHS Employers to encourage a National solution to the remaining disputes.

Strategy and Culture

<u>UHBW Clinical Strategy</u>

We are progressing the development of a new clinical strategy for UHBW which will build on Embracing Change, Proud to Care, published in 2019, and the work the Divisions did at that time to support their clinical services. The new strategy will work with the Integrated Care System Strategy published this summer, NBT's Clinical Strategy, published in Jan 2023, and the Joint Clinical Strategy that is in development between ourselves and NBT. Whilst it's a complex picture, we are keen for UHBWs clinical services to have a single place where our ambition for the next 3-5 years can be brought together. Over the autumn and up until Christmas we are engaging widely with Divisional leadership teams, clinical and professional leads and others, in order to ensure that our new clinical strategy is reflective of the views of our expert staff. We will be drawing in information on population health and what our services users have told us they want to see. A draft document is expected early in 2024 with publication likely to be in the Spring.

<u>Planning for 2024/25</u>

This time of year always involves a good deal of work throughout our organisation, and with the system, to develop what is required to meet expected access targets, mitigate known risks and achieve savings requirements in the coming financial year. This work has commenced, and, in a similar way to last year, UHBW will be involved in the

development of a system plan for Bristol, North Somerset and South Gloucestershire for 2024/25. Guidance from NHS England will support BNSSG's plan; this is expected this side of Christmas, but has not yet been received.

New Children's Research Unit

We are proud to have worked in partnership with Bristol and Weston Hospitals Charity to establish a brand-new dedicated research facility for children and young people within the Bristol Royal Hospital for Children. BWHC's support has enabled us to convert the old medical records library into a state-of-the-art research facility, with two bay beds and two consultation rooms, plus supporting areas for patients and staff. The area looks fantastic with a beautiful array of art works (including an interactive digital art wall for patients to engage with), in line with the theme of its name, the Coral Reef. The grand opening of the unit is on 8th November, and we look forward to welcoming patients through the facility very soon!

Operational Delivery

Tiering update

On 25 September, NHSE wrote to the Trust to acknowledge progress that has been made in reducing the 78ww backlog and 62 day cancer recovery. It was confirmed that NHSE, at a national level, would be continuing the tiering approach through 2023/24 for both elective recovery and cancer. It was confirmed that from 2 October 2023, UHBW would be placed in Tier 2 for elective (RTT). Providers in Tier 2 are managed through the regional NHSE infrastructure.

PIDMAS

On 31 October, the Trust participated in a national initiative called PIDMAS which is intended to reduce waiting times by encouraging patients to move providers to find more timely access to treatment. The Trust contacted 2,700 eligible patients who have waited over 40 weeks on an RTT pathway. In the first 48 hours, the Trust has received approximately 120 requests to move provider. These requests will be subject to admin validation (to confirm eligibility) and clinical validation (to confirm suitability to move providers). The Trust will be supported by the ICB and NHSE in the identification of alternative providers.

Recommendation

The Board is asked to note the report.

Eugine Yafele
Chief Executive

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Trust Board in Public on 14 November 2023

Reporting Committee	**Quality and Outcomes Committee – September 2023 meeting**
Chaired By	**Sue Balcombe, Non-Executive Director**
Executive Lead	**Deirdre Fowler, Chief Nurse and Midwife**

For Information

The committee were briefed on a number of strategic issues which were or could impact on the Trusts ability to maintain quality and safety. This included the monitoring of the paediatric pathology service, the impact of ongoing industrial action for patients including repeat cancellations, and on staff wellbeing, and feedback following coroners' cases.

The committee received the Quarter One Complaints and Experience of Care reports. It was noted that the number of complaints was now stable, but the considerable backlog remains a concern. The committee were really pleased to hear that the PALs drop-in service is now recommencing at the BRI and that the service has now moved away from the call back service to avoid delays. The experience of care report is largely positive with more divisions setting up Experience of Care Groups and the metrics for kindness and understanding remain consistent.

In terms of safer staffing, it was noted that the fill rate is 98%, turnover for Band 5 nurses is much improved, and the use of incentives for bank staff is working well with a reduction in Tier4 agency. Theatre staffing remains an issue however the committee received assurance re.the management plan.

The Annual Pharmacy Report was received and provided a high level of assurance re. the required standards. Issues relating to the re-tendering of the out-patient dispensary, workforce pressures, and storage of medicines were discussed. The contribution that effective pharmacy services have on the timely discharge of patients was particularly noted.

The committee discussed the progress and challenges in delivering against the performance standards. The recruitment of an ortho-geriatrician for Weston and consultants in Dentistry were particularly welcomed. The committee were briefed on the NHSE priorities for recovery and the action planned to meet them.

The impact of ongoing industrial action on the ability to sustain improvement in performance in August was noted. Assurance regarding the faster diagnosis standard was provided. The priority placed on the system delivery of patient flow (including timely discharge) was discussed and good progress noted.

University Hospitals Bristol and Weston NHS Foundation Trust

For Board Awareness, Action or Response
The committee wished to escalate two specific concerns to the Trust Board-: the importance of the operating theatres to the Trusts ability to meet its performance targets and the impact that concerns regarding the physical estate and staffing levels are having on theatre utilisation. There are an increasing number of estates issues being identified which are having an effect on our ability to maintain high levels of Infection, Prevention and Control assurance - for example in theatres and St Michaels.
Key Decisions and Actions
The committee supported the proposal to close four actions on the CQC composite action plan.
Additional Chair Comments
None

Date of next meeting:	**Tuesday 31st October 2023**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Quality and Outcomes Committee on 31st October 2023

Reporting Committee	**Quality and Outcomes Committee**
Chaired By	**Sue Balcombe, Non-Executive Director**
Executive Lead	**Deirdre Fowler**

For Information

The committee received an excellent presentation outlining the significant amount of work being undertaken to ensure that the urgent and emergency services pathway is working optimally. This includes improvements to ambulance handovers and further expansion of Same Day Emergency Care at both Weston and Bristol to pull patients away from ED and prevent unnecessary hospital admissions. Transformation programmes including Every Minute Matters, Transfer of Care Hubs, Active Hospitals and increased use of criteria led discharge are all actively contributing to the patient journey and timely discharge of our patients.

The Quarter Two progress against the Trusts Quality objectives was well received and noted that the Patient First metrics would be used to monitor progress in future.

The first of the new style Patient Safety report was considered in line with the new national Patient Safety Programme. The committee was advised that the new national strategy means that Trusts will no longer automatically provide coroners with detailed investigation reports prior to the hearing, and this is likely to cause concern for coroners. Patient Safety training compliance continues to improve.

The Safer Staffing fill rate this month was 96%. The continued high levels of vacancies and lower fill rates in the Childrens division continues to be a concern. The committee was briefed on the pipeline of recruits and actions being taken to mitigate the risk.

The committee received the Quarter Two legal report and noticed the significant increase in the number of coroners hearings and the resource impact this will have as clinicians are called as witnesses. There continues to be a high number of requests from staff for healthcare legal advice due to the increasing number of complex discharges.

The annual Clinical Audit Report was received, and the committee noted the good level assurance regarding the audit process and increased number of audits demonstrating compliance with NICE standards.

In terms of performance the committee was briefed regarding the sustained increased in non-elective demand, which together with industrial action has had an impact on the Trusts ability to maintain its elective performance. It was noted that the proactive transformation work across the hospital has helped to mitigate some of the impact on the elective programme.

University Hospitals Bristol and Weston NHS Foundation Trust

For Board Awareness, Action or Response
An issue with the current Datix system has been identified as more detailed incident coding is required to identify systemic risks and in order for the Trust to meet the new national requirements for submitting data as STEIS and NRLS are replaced. The committee was advised that work is underway to try to resolve this issue and the national team have been informed. Nurse staffing level in the Childrens Division.
Key Decisions and Actions
The committee approved the Trusts Winter Plan for adults and will receive the Childrens Services Winter Plan at the November meeting.
Additional Chair Comments
None

Date of next meeting:	**28th November 2023**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 14th November 2023

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

1. Purpose	
To provide an overview of the Trust's performance on quality, access and workforce standards.	
***2.* Key points to note** *(Including any previous decisions taken)*	
Please refer to Executive Summary	
3. Strategic Alignment	
This report aligns to the objectives in the domains of "Quality and Safety", "Our People", "Timely Care" and "Financial Performance".	
4. Risks and Opportunities	
Risks are listed in the report against each performance area and in a summary.	
5. Recommendation	
This report is for Assurance	
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**	
Quality and Outcomes Committee	31 October 2023

University Hospitals Bristol and Weston NHS Foundation Trust

Performance Report

Month of Publication: October 2023
Data up to: September 2023

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

INTRODUCTION

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

Performance Report

Reporting Month: September 2023

EXECUTIVE SUMMARY

Quality and Safety

The Summary Hospital Mortality Indicator for UHBW for the 12 months June 2022 to May 2023 was 95.0 and in NHS Digital's "as expected" category. This is below the overall national peer group of English NHS trusts of 100. HSMR within CHKS for UHBW solely for the month of June 2023 was 114.3, meaning there were 15 more observed deaths (119) than the statistically calculated expected number of deaths (104). 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 June 2023 for UHBW was 103.2, above the National Peer of 100.4.

There were nine reported cases for Clostridium Difficile in September. The breakdown for these are three COHA and six HOHA. This is higher than the projected monthly figure of 7.3 within the 4-week period. The trust year to date figures show as 60. There was one reported case of MRSA bacteraemia in September. This brings 2023/24 year to date figures currently to six in total. First stage of improvement work is underway with adult Emergency Department's with lead senior doctor involvements to review practice with a QI approach.

The new Trust VTE Lead commenced in role 1st October 2023. The new VTE Lead role will provide the leadership, clinical expertise and prioritisation needed to make a step change in progress of actions related to improvements with VTE prevention. First priority is to re-establish the VTE and Anticoagulation Group (ToR drafted and stakeholder analysis undertaken), to ensure correct membership, governance and reporting structure of VTE.

At Bristol sites 26 patients were eligible for Best Practice Tariff in September 23. 6/26 (23%) patients received surgery within 36 hours. 26/26 (100%) received an ortho-geriatrician review within 72hours. 6/26 (23%) achieved all the targets for the BPT. Trauma SOP has now been signed off to allow the allocation of a "Golden Patient", enabling a prompt start. At Weston 25 patients eligible for BPT for fractured Neck of Femur,17/25 patients had surgery within 36 hrs of admission - 68%, 14/25 patients had an Ortho-geriatrician assessment within 72hrs of admission - 56%, 7/25 patients achieved all at the targets required for BPT. 8 patients missed time to surgery due to lack of flexible theatre space or patients requiring more medical support prior to surgery, 11 patients missed time to ortho-geriatrician assessment. This was due to no cover at weekends and caseload pressures during the week for the one individual responsible for this service.

Performance Report

Reporting Month: September 2023

EXECUTIVE SUMMARY

Our People

In summary, the Performance data for September shows the following:

- Overall vacancies reduced to 4.1% (490.5 FTE) compared to 5.2% (623.7 FTE) in the previous month. In relation to Nursing and Midwifery there continues to be a healthy pipeline of Internationally Educated Nurses (IENs) joining the Trust over the next six months and this month the Trust received the biggest cohort of IENs to date, with 54 arrivals. 773 IENs have now arrived at the Trust since the beginning of the programme.
- The significant over establishment for unregistered nurses is at band 4 and is due to the large number of newly qualified nursing staff awaiting their NMC PINs. 32 substantive Healthcare Support Workers (HCSW) started in the Trust and another 107 have been offered. 31 Bank HCSW started in the Trust during September and another 82 have been offered.
- Turnover for the 12-month period reduced to 12.7% compared to 13.1% for the previous month. Six divisions saw a reduction whilst one division saw an increase in turnover, and one remained static in comparison to the previous month.
- Sickness absence increased to 4.7% compared with 4.6% the previous month. There were reductions within three division but the largest divisional increase was seen within Weston General Hospital, increasing by 1.5 percentage points to 6.6%, compared to 5.1% in the previous month. Health Assured 24/7 Employee Assistance Programme launched on 6 September via internal communications channels and introductory sessions to optimise awareness. The Supporting Attendance Policy has been amended to remove mandatory HR presence at all meeting stages meaning managers are able to meet with colleagues who have high levels of absences in a quicker timescale and more informal and supportive way.
- Overall appraisal compliance increased to 76.6%, compared with 76.2% in the previous month. There were increases within four divisions and Specialised Services remains above the new KPI target.
- Core skills training compliance remains static at 90.2%. Remaining Essential Training improved again to 90%, with Fluids and Nutrition again making the largest gain to 80.1%. Education are developing the creation of CPD certificates that will reflect CPD hours and learning outcomes. These will be automatically issued by Kallidus upon completion of core skills initial training or updates. Although initially designed to meet Dental CPD regulations, these certificates may also be used by other staff to evidence training in a personal portfolio.
- Agency usage has reduced further to 1.3%, nearing the target of a maximum of 1.1%. System work continues at ICB level to drive the supply of lower cost framework nursing agency supply with a renewed focus on developing a plan to deliver cap compliant agency supply.
- Bank usage at month six is at 6.5%, a reduction of 0.9% (116.4 FTE). There were 86 new starters across the Bank in September and monthly recruitment is due to commence for the admin and clerical bank, this will include a monthly advert followed by an assessment centre.

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

EXECUTIVE SUMMARY

Timely Care

Industrial Action continued to have an impact on workforce resilience and access during September. In addition, the increase in non-elective demand experienced in August prevailed throughout September, reflected in an increase in bed occupancy (BRI 93.5% July to 101% Sept; WGH 89% July to 93.8% Sep), No Criteria To Reside patients and a commensurate impact on flow and thereby non-elective performance. There is clear evidence that the aggregate of the multiple flow improvement schemes, including Every Minute Matters, delivered demonstrable length of stay improvements in the first half of the year (BRI 12.5%; WGH 18%) but these bed benefits outstripped by the increase in demand, exceeding 2023/24 operational planning assumptions. This impacted both planned and urgent and emergency performance, albeit marginally in the overall scheme of things as outlined below. In urgent and emergency care for example, whilst there has been marginal deterioration across the last two months against key flow metrics, the scale of overall improvement Month 1-6 has been largely maintained, and recovery and delivery at year end still within our grasp. Key headlines are below.

Planned Care - At the end of September 2023, no patients were waiting over 104 weeks and the Trust continues to maintain zero 104-week Referral To Treatment (RTT) breaches, with no patient waiting longer than 104 weeks since February 2023.

The Trust had largely held the significant progress in reducing the number of patients waiting over 78 weeks in the last 6 months of 2022/23, bringing the number down from 877 in December 2022 to 166 in March 2023, now 287 in September. Whilst September reflects another incremental deterioration in performance in recent months, the overall numbers remain relatively static and our position in keeping with the national context where the compounding impact of recurrent Industrial Action has inhibited progress against full elimination. The other area of note is the narrowing of the range of specialties that have care backlogs over 78 weeks to those that have been recognised by NHSE as being particularly complex or nationally challenged, e.g. Paediatric Dental and Corneal Graft.

Up until June 2023, the Trust were on track to achieve the national ambition of no patients waiting longer than 65 weeks by end of March 2024. The impact of Industrial Action has predictably contributed towards a deterioration and, at the end of September 2023, the number of patients waiting longer than 65 weeks increased to 2,183 against an operating plan trajectory of no more than 1,260. Work continues to recover and ameliorate the impact of Industrial Action to deliver the national ambition.

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Performance Report

Reporting Month: September 2023

EXECUTIVE SUMMARY

Timely Care (continued)

Through 2022/23, the Trust made sustained progress in reducing the number of patients on a cancer pathway waiting over 62 days. The number of patients waiting over 62 days was reduced from a peak of 416 patients in August 2022 to 178 patients in March 2023. This reflected achievement of the 62-day baseline set for the Trust by NHS England. During 2023/24, alongside other planned care pathways and targets Industrial Action has had a commensurate impact on Cancer and the number of patients waiting over 62 days. At the end of May the number of patients waiting 62 days or longer had increased to 238 and volumes have fluctuated in the months since (179 June, 233 in July, 222 August). Due to the continued impact of Industrial Action, at the end of September, the position had deteriorated to 270 patients. Efforts will continue to mitigate against any impact and the Trust continue to work towards the target of 160 by March 2024.

The Faster Diagnosis Standard measures from receipt of a suspected cancer referral from a GP or screening programme to the date the patient is given a cancer diagnosis, told that cancer is excluded, or has a decision to treat for a possible cancer. Performance against the trajectory was met during March 2023 but has deteriorated in the five months since, with August reporting 56% (April: 60%, May: 61.5%, June 61.6%, July 59.5%). The performance has been impacted by a combination of Industrial Action and the impact of the Trust being unable to cease the mutual aid support being provided to Somerset NHS FT for dermatology. Compliance with the 75% standard by the end of the financial year is still attainable, dependent on impact of future industrial action and on the provision of mutual aid to Somerset for dermatology ceasing at the end of October.

At the end of April 2023, the Trust reported that 71.8% of patients were waiting less than six weeks for a diagnostic test. Improvement had been made each month since and, at the end of July, the position had improved to 78%. During August and September, the Trust's focus on the recovery of other areas predictably impacted the diagnostic six-week wait standard and performance at the end of September deteriorated to 74.9%, against the operating planning trajectory of 77.8%. However, the Trust remain on track to deliver the ambition that 83.3% of patients will be waiting six weeks or less for their diagnostic test by March 2024.

Across the key emergency department and flow measures, September saw a marginal deterioration in performance compared to previous months. This is broadly due to slower flow through the hospitals driven largely by the increased bed occupancy rate (BRI 101% / WGH 92% in September compared to BRI 93.5% and Weston 89% in July). The Length of Stay (LoS) benefits (13.8% reduction in LoS) derived from initiatives such as Every Minute Matters, SDEC development and the Transfer of Care Hubs mobilisation, have been subsumed by an 18% increase in Non-elective admissions.

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Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

EXECUTIVE SUMMARY

Timely Care (continued)

During September, 67.2% of attendances spent less than 4 hours in an emergency department (ED), from arrival to discharge or admission, compared to 75.3% in July and 71% in August. This was largely driven by "exit block" out of the emergency departments resulting from the increased bed occupancy / non-elective described above. Work is underway to recover this position during October, and will mean the Trust remains on-track to achieve the March 2024 target of 76% of patients waiting less than 4 hours in ED.

The number of patients spending 12 hours or more in ED during September was reported as 2.8%, against the target of 2%. Whilst this was a deterioration from August (2.1%), significant improvement has been made against this standard over the last few months and the Trust continues to progress actions to deliver and sustain the NHSE year-end target (2%).

The proportion of ambulance handovers in excess of 15 minutes had been improving between January 2023 and July 2023, with a much-improved position of 48.6% reported in July (62% in June). During August and September, this position predictably deteriorated (70.3% in September) because of the impacts of the constrained flow, particularly noticeable on the BRI site where handover performance and been so significantly better in July. A similar performance was noted for ambulance handovers in excess of 30 minutes, with September reporting 38.8.% compared with August (37.1%), July (17.1%), June (27.3%) and May (45%). Whilst at Trust level ED attendances are currently tracking above 2019/20 levels, 'Ambulance conveyed' arrivals as a sub-set of attendances are up c 18% compared to the same period last year.

During September, the average daily number of patients in hospital with no criteria to reside (NCTR) increased to 142 (130 in August), with the deterioration held mainly in Bristol D2A Pathway 3, where there are significant flow constraints related to Bristol Local Authority with no immediate solutions. Ongoing improvement had been achieved over several months leading up to September and a range of schemes implemented are expected to continue to have a positive impact on this standard, including the ongoing establishment of the two Transfer of Care Hubs, within which c85% of the 33 WTE new UHBW staff are now in post.

Performance Report

Reporting Month: September 2023

EXECUTIVE SUMMARY (continued)

Financial Position

At the end of September there is a net I&E deficit of £12,419k against a deficit plan(excluding technical items) of £6,202k. Total operating income is £15,579k favourable to plan due to higher than planned income from activities of £12,097k and higher than planned other operating income of £3,482k. Operating expenses are £23,676k adverse to plan due to higher pay expenditure (£14,913k) and non-pay expenditure (£8,844k). Depreciation is broadly in line with plan. The estimated cost of industrial action for May to September (at £3,223k) remains unfunded. Technical and financing items are £2,153k favourable to plan mainly due to interest receivable.

The key issues underlying the financial position are recurrent savings delivery below plan – Internal CIP delivery is £8,938k or 95% of plan of which recurrent savings are £3,773k, 40% of plan. Failure to achieve the annual target of £27m (including transformational savings) in full will result in the Trust failing to meet the financial plan. Delivery of elective activity recovery below plan – elective activity must be delivered in line with plan. Failure to do so will result in a loss of income of up to c£30m which may result in the Trust not achieving its financial plan. Corporate mitigations not delivered in full – non-recurrent mitigations of c£25m must be achieved to support delivery of the plan. Failure to deliver the financial plan – failure to deliver the actions and therefore the financial plan of break-even will constitute a breach of statutory duty and will result in regulatory intervention.

Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

SUMMARY SCORECARD – FINANCIAL YEAR 2023/24

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

			Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Infection Control: C.Diff Cases (Hospital Attributable)	Risks: 800 and 4651	Actual	12	8	13	8	10	9	-	-	-	-	-	-
		Trajectory	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3
Infection Control: MRSA Cases (Hospital Onset)	Risks: 800 and 4651	Actual	1	0	2	2	0	1	-	-	-	-	-	-
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Fracture NOF: Theatre Within 36 Hours		Actual	53.6%	44.4%	48.3%	61.9%	68.0%	45.1%	-	-	-	-	-	-
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Fracture NOF: Geriatrician Review Within 72 Hours		Actual	42.9%	47.6%	40.0%	38.1%	48.0%	78.4%	-	-	-	-	-	-
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
VTE Risk Assessment	Risk: 720	Actual	82.0%	82.8%	82.6%	84.0%	84.7%	82.5%	-	-	-	-	-	-
		Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Workforce: Agency Usage	Risk: 674	Actual	1.7%	1.7%	1.7%	1.6%	1.5%	1.3%	-	-	-	-	-	-
		Trajectory	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
Workforce: Turnover	Risk: 2694	Actual	14.3%	14.1%	13.8%	13.4%	13.1%	12.7%	-	-	-	-	-	-
		Trajectory	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%
Workforce: Staff Sickness		Actual	4.1%	4.1%	4.2%	4.4%	4.6%	4.7%	-	-	-	-	-	-
		Trajectory	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Workforce: Staff Vacancy	Risk: 737	Actual	4.2%	6.1%	6.3%	6.2%	5.2%	4.1%	-	-	-	-	-	-
		Trajectory	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%

			Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Summary Hospital Level Mortality Indicator (SHMI)		Actual	100.4	98.0	98.9	97.5	95.8	95.0	-	-	-	-	-	-
		Trajectory	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

SUMMARY SCORECARD – FINANCIAL YEAR 2023/24

DOMAIN: "Timely Care"

			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Referral To Treatment 78+ Weeks	Risk: 801	Actual	182	248	215	203	245	287	-	-	-	-	-	-
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Referral To Treatment 65+ Weeks	Risk: 801	Actual	1,549	1,599	1,765	1,933	2,222	2,183	-	-	-	-	-	-
		Trajectory	1,950	1,910	1,870	1,670	1,470	1,260	1,050	840	630	420	210	0
Cancer 62+ Days	Risk: 801	Actual	218	238	179	233	222	270	-	-	-	-	-	-
		Trajectory	180	178	176	174	172	170	168	166	166	164	162	160
Cancer Treated Within 62 Days	Risk: 801	Actual	68.2%	66.7%	66.0%	69.0%	64.8%	-	-	-	-	-	-	-
		Trajectory	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Diagnostics: Percentage Waiting Under 6 Weeks	Risk: 801	Actual	71.8%	73.5%	76.8%	78.0%	75.9%	74.9%	-	-	-	-	-	-
		Trajectory	72.9%	73.4%	74.7%	75.6%	76.8%	77.8%	79.1%	79.9%	80.4%	81.2%	82.3%	83.3%
Diagnostics: Number Waiting 26+ Weeks	Risk: 801	Actual	358	294	191	188	146	311	-	-	-	-	-	-
		Trajectory	411	357	281	188	102	9	0	0	0	0	0	0
Emergency Department: Percentage Spending Under 4 Hours	Risks: 910 and 4700	Actual	70.7%	67.5%	72.1%	75.3%	71.0%	67.2%	-	-	-	-	-	-
		Trajectory	61%	61%	62%	63%	64%	65%	67%	68%	70%	72%	73%	76%
Emergency Department: Percentage Spending Over 12 Hours	Risks: 910 and 4700	Actual	4.7%	5.0%	3.1%	0.9%	2.1%	2.8%	-	-	-	-	-	-
		Trajectory	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Emergency Department: Handovers Under 15 Minutes	Risks: 910 and 4700	Actual	28.0%	25.1%	38.0%	51.4%	31.5%	29.7%	-	-	-	-	-	-
		Trajectory	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%
Emergency Department: Handovers Under 30 Minutes	Risks: 910 and 4700	Actual	63.0%	55.0%	72.7%	82.9%	62.9%	61.2%	-	-	-	-	-	-
		Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Every Minute Matters: Timely Discharges (12 Noon)	Risk: 423	Actual	18.3%	19.4%	19.9%	19.4%	17.8%	19.7%	-	-	-	-	-	-
		Trajectory	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%
Every Minute Matters: Discharge Lounge Use (BRI and Weston)	Risk: 423	Actual	22.3%	22.1%	21.9%	26.2%	27.3%	30.7%	-	-	-	-	-	-
		Trajectory												

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Final Quarter 1 Position

CORPORATE RISKS

ID	Corporate Risks, Projected Mitigation	22/23		2023/24				2024/25				2025/26				26/27
		Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
801	NHS System Oversight Framework	20	20	20	→		8									
2244	Long waits for Outpatient follow-up appointments	20	20	20	12	12	→	4								
910	Patients in ED do not receive timely and effective care	20	16	16	→			6								
972	Fire Safety Regulations	16	16	16	16	16	→									4
1035	Cancelled operations, breached performance targets cancelled	16	16	16	→	4										
2264	Delays in commencing induction of labour	16	16	16	16	16	4									
588	Patient deterioration is not identified and responded to	15	15	15	15	15	→		5							
856	Emotional and mental health needs of children and YP	15	15	15	15	15	→	8!								
5477	Nurse staffing levels	15	15	15	12	12	6									
1595	Mental health patients in Adult ED for prolonged periods	20	12	12	→			8!								
422	Patients and staff experience V&A	12	12	12	→		6									
674	Agency use - national pricing caps	12	12	12	→			4								
793	Staff experience work-related stress	12	12	12	12	9!										
1598	Patients suffer harm or injury from preventable falls	12	12	12	12	12	→	9!								
2639	Staff compliance with appraisal requirements	12	12	12	9	9	6									
2695	Robust governance processes	9	9	12	12	12	6									
5520	Health inequalities exacerbated for patients on waiting list	12	12	12												
6502	Industrial action impact on patient safety	10	20	9	5											
921	Staff compliance with their Essential Training	9	9	9	6											
2614	Patients being cared for in extra capacity locations	10	10	8	6	4										
720	VTE prevention and management	8	8	8	→		4									
291	Critical IT equipment fails	8	8	8*												
		← History →			← Prediction →											

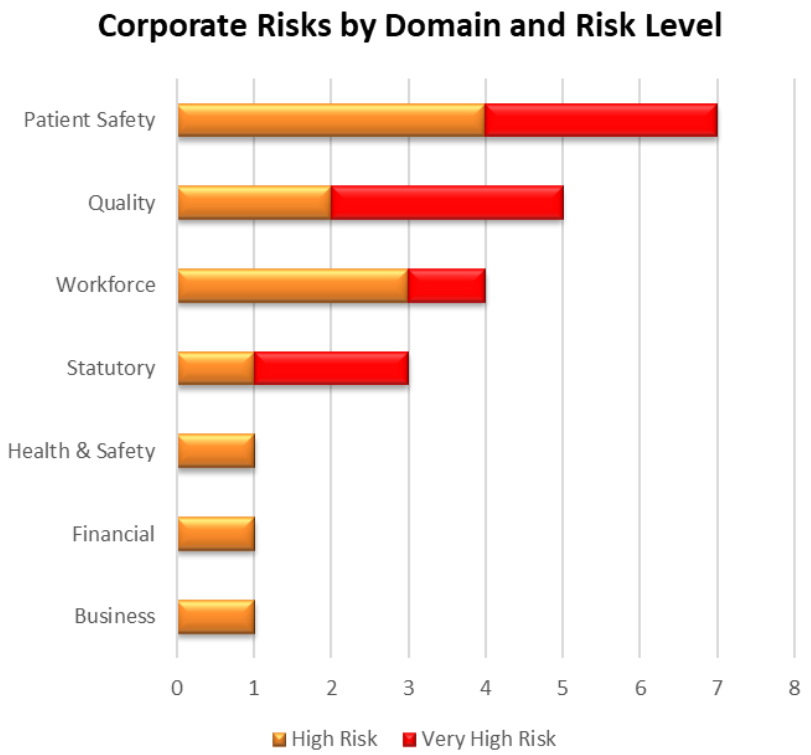
*denotes that the risk has achieved its target
! denotes that the target assessment is above tolerance

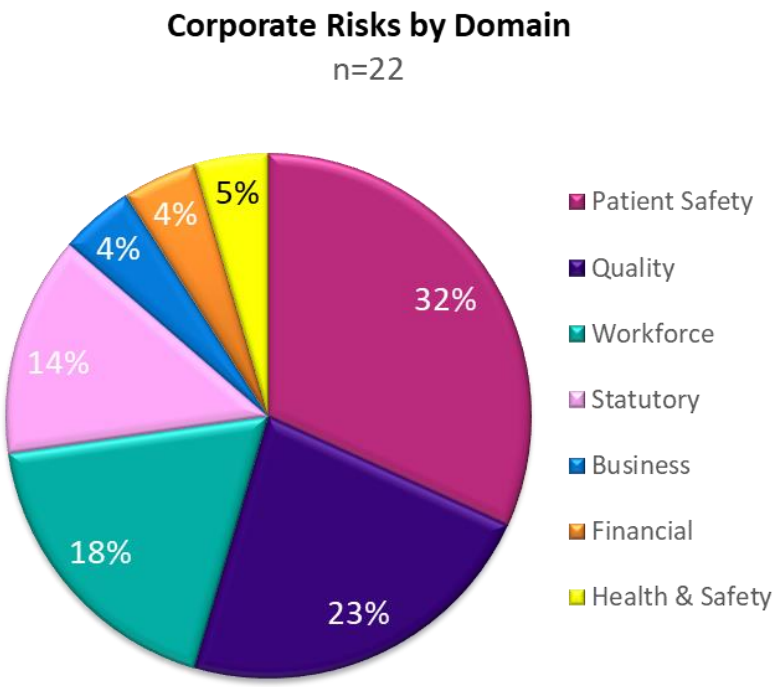
Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Final Quarter 1 Position

CORPORATE RISKS





Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2023

STANDARD	QUALITY AND SAFETY: MORTALITY - SHMI (Summary Hospital-level Mortality Indicator)
Background:	Mortality indicators are used as alerts to identify something that needs closer investigation. This indicator is published nationally by NHS Digital and is six months in arrears. This data is now provided by NHS Digital as a single figure from UHBW. SHMI is derived from statistical calculations of the number of patients expected to die based on their clinical risk factors compared with the number of patients who actually died. There is no target. A SHMI of 100 indicates these two numbers are equal, but there is a national statistically acceptable range calculated by NHS Digital and a SHMI that falls within this range is "as expected".
Performance:	The Summary Hospital Mortality Indicator for UHBW for the 12 months June 2022 to May 2023 was 95.0 and in NHS Digital's "as expected" category.
National Data:	UHBW's total is below the overall national peer group of English NHS trusts of 100.
Actions:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to diagnosis group level if required and investigating any identified alerts.

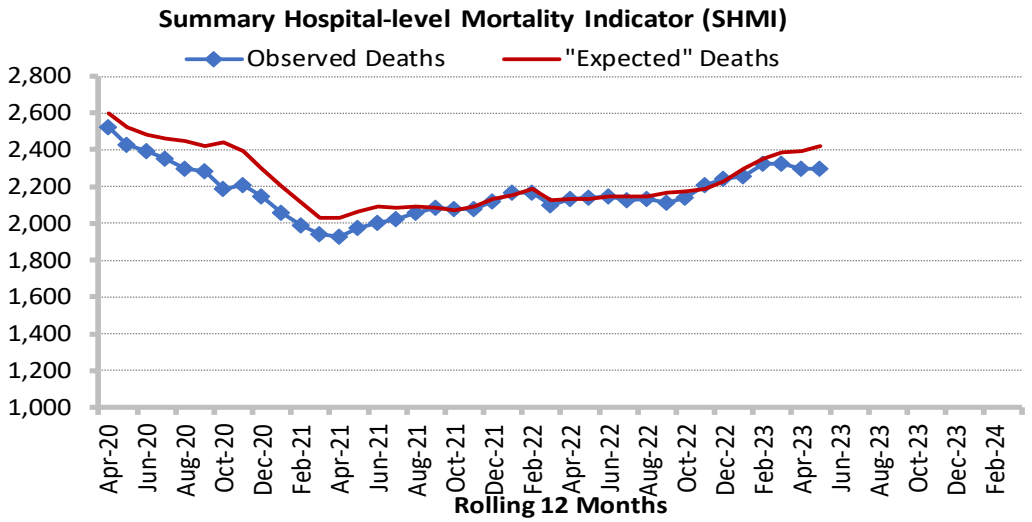
Rolling 12 Months To:	Observed Deaths	"Expected" Deaths	SHMI
Jun-22	2,150	2,145	100.2
Jul-22	2,125	2,145	99.1
Aug-22	2,135	2,150	99.3
Sep-22	2,110	2,165	97.5
Oct-22	2,140	2,175	98.4
Nov-22	2,205	2,190	100.7
Dec-22	2,240	2,230	100.4
Jan-23	2,255	2,300	98.0
Feb-23	2,325	2,350	98.9
Mar-23	2,325	2,385	97.5
Apr-23	2,295	2,395	95.8
May-23	2,300	2,420	95.0

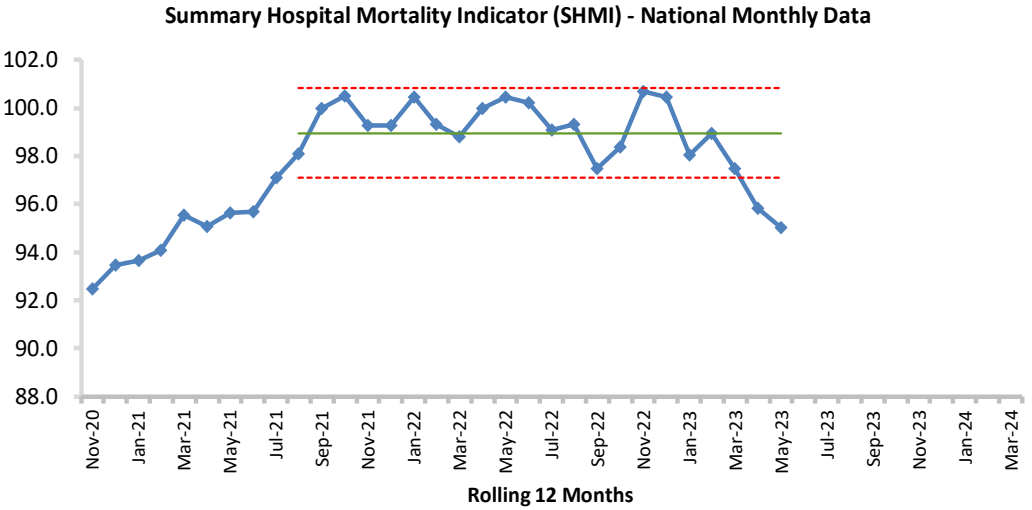
Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2023

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





Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: June 2023

STANDARD	QUALITY AND SAFETY: MORTALITY - HSMR (Hospital Standardised Mortality Ratio)
Background:	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. Single monthly figures for HSMR are monitored in UHBW as an "early warning system" and are not valid for wider interpretation in isolation.
Performance:	HSMR within CHKS for UHBW solely for the month of June 2023 was 114.4, meaning there were 15 more observed deaths (119) than the statistically calculated expected number of deaths (104). Single monthly figures for HSMR are monitored in UHBW as an "early warning system" and are not valid for wider interpretation in isolation.
National Data:	The HSMR for the 12 months to June 2023 for UHBW was 103.2, above the National Peer of 100.4.
Actions:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to diagnosis group level if required and investigating any identified alerts.

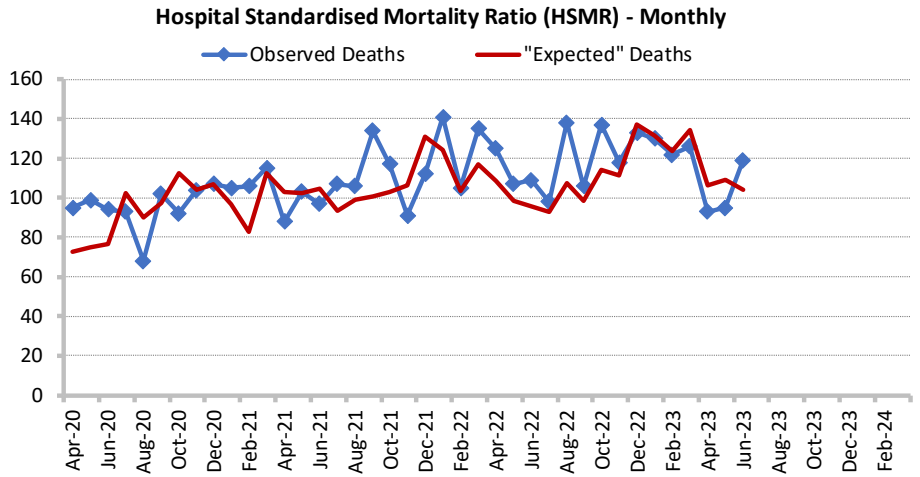
Month	Observed Deaths	"Expected" Deaths	HSMR
Jul-22	98	92.9	105.5
Aug-22	138	107.5	128.4
Sep-22	106	98.5	107.6
Oct-22	137	113.9	120.3
Nov-22	118	111.5	105.8
Dec-22	133	137.0	97.1
Jan-23	130	131.8	98.6
Feb-23	122	123.7	98.6
Mar-23	126	134.3	93.8
Apr-23	93	106.4	87.4
May-23	95	109.0	87.2
Jun-23	119	104.0	114.4

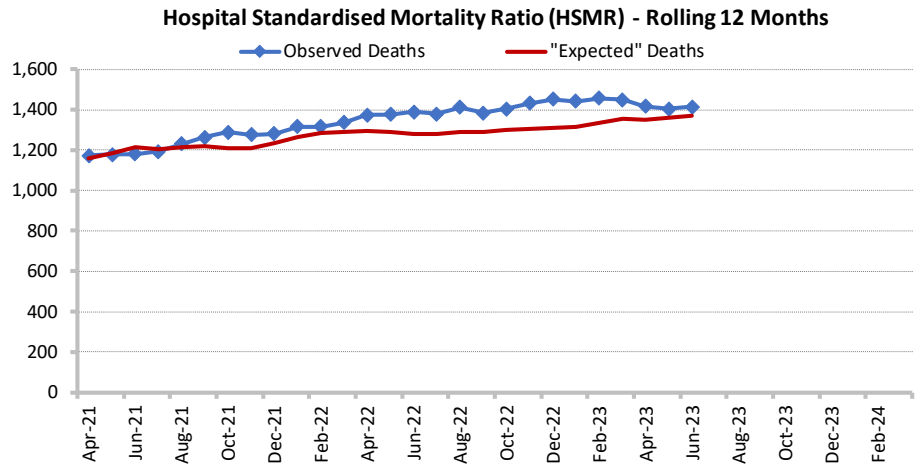
Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: June 2023

STANDARD	QUALITY AND SAFETY: MORTALITY - HSMR (Hospital Standardised Mortality Ratio)





Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	QUALITY AND SAFETY: INFECTION CONTROL– C.DIFFICILE AND MRSA
Background:	For this section there are two infections reported: C.difficile and methicillin-resistant Staphylococcus aureus (MRSA). Infections are reported in two different categories for infections associated with hospital care: 1. Hospital Onset – Healthcare Associated (HOHA). Patient is an inpatient in an acute trust and has 3 or more days between admission and a positive specimen. 2. Community Onset – Healthcare Associated (COHA). Patient returns a positive specimen within 28 days of discharge from an elective or emergency hospital admission. For C.difficile, two measures are reported: HOHA and COHA. For MRSA it is the HOHA cases only. The limit of C.difficile cases for 2023/24 as set by NHS England is 88. This limit will give a maximum monthly number of approximately 7.3 cases. For MRSA the expectation is to have zero cases.
Performance:	There were nine reported cases for Clostridium Difficile in September. The breakdown for these are three COHA and six HOHA. This is higher than the projected monthly figure of 7.3 within the 4 week period. The trust year to date figures show as 60. There was one reported case of MRSA bactereamia in September. This brings 2023/24 year to date figures currently to six in total.
National Data:	See next page.
Actions:	**C.Difficile** There are numerous potential causes of Clostrdium difficile infection and the most important ones are antibiotic prescribing and appropriate standards of cleanliness including commodes and toilet areas. Cleaning standards are generally compliant in low risk (FR2) areas but in the high risk areas (FR1) full compliance has not been achieved consistently. This is actively scrutinised by the Operational Infection Control Group with Divisions, and the Facilities team. • With the transition to the Patient Safety Incident Response Framework in UHBW will retain C.dfficile reviews as an important focus, but in an improved and more responsive format. • The Infection Prevention and Control team (IPC) will continue regular sluice auditing. • Each Division has a schedule of monthly 'walk arounds' with an IPC nurse and the matron for the Division to review and consider IPC related practice. • The monthly clinical ward audits from August will include a section for the ward manager to review the sluice and commodes formally and report this as part of their quality schedule for the ward. **MRSA** Progress with vascular access improvement work continues. The Infection Prevention and control team are working with procurement to agree a Peripheral Venous Catheter (PVC) insertion pack to be used Trust wide, with its implementation to include enhanced training across the organisation about Aspetic non-touch technique (ANTT) practice. The outcomes of ANTT auditing is awaited. Page 44 of 245 *...continued over page*

Performance Report

Reporting Month: September 2023

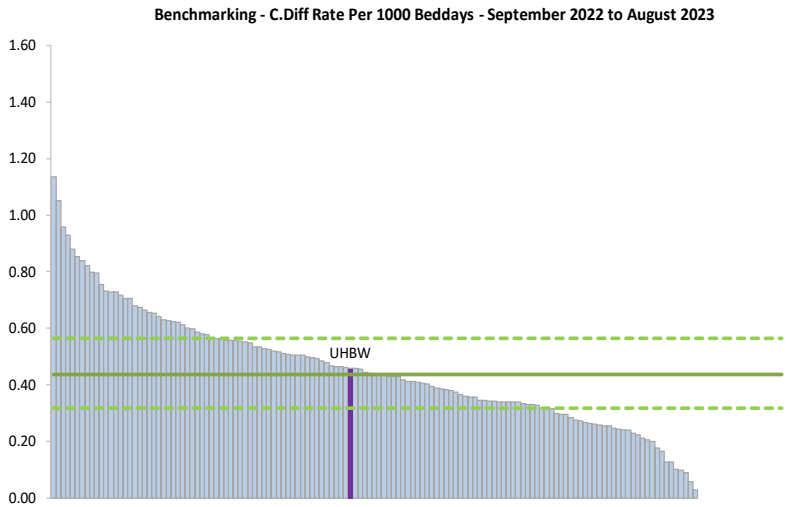
STANDARD	QUALITY AND SAFETY: INFECTION CONTROL– C.DIFFICILE AND MRSA
Actions (continued):	• First stage of improvement work is underway with adult Emergency Department's with lead senior doctor involvements to review practice with a Quality Improvement (QI) approach. • Policy and guidance documents around Central venous catheters (CVC) and Peripheral venous catheters (PVC) care have been reviewed, updated and are in the process of cascade to clinical teams.
Risks:	800: Risk that Trust operations are negatively impacted by (COVID-19) pandemic 4651: Risk that Covid -19 is transmitted between patients and staff within the Trust

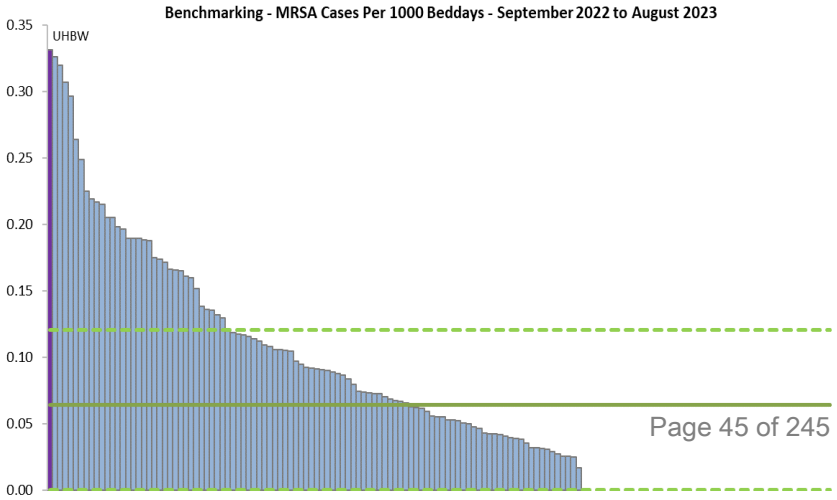
C.Difficile

	Sep-23		2023/2024		2022/2023	
	HOHA	COHA	HOHA	COHA	HOHA	COHA
Medicine	3	0	15	4	23	4
Specialised Services	1	1	8	6	8	3
Surgery	0	0	2	1	11	1
Weston	0	2	10	5	27	7
Women's and Children's	2	0	6	1	8	3
Other	0	0	0	2	1	4
UHBW TOTAL	**6**	**3**	**41**	**19**	**78**	**22**

MRSA

	Sep-23	2023/2024	2022/2023
Medicine	0	1	1
Specialised Services	0	0	1
Surgery	1	2	2
Weston	0	2	1
Women's and Children's	0	1	2
Other	0	0	0
UHBW TOTAL	**1**	**6**	**7**



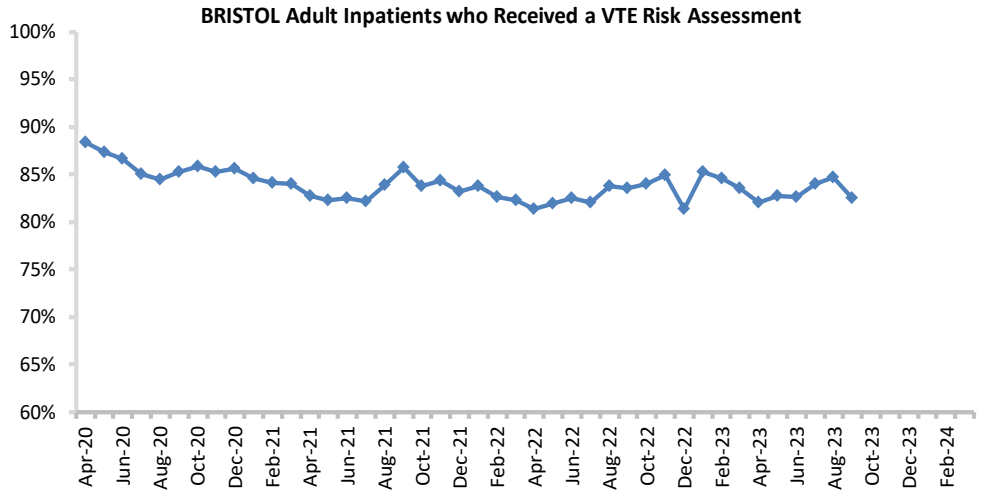


Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	QUALITY AND SAFETY: VENOUS THROMBOEMBOLISM (VTE) RISK ASSESSMENT
Background:	Venous Thromboembolism (VTE) is a significant cause of mortality and disability in England. At least two-thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and the administration of appropriate thromboprophylaxis. The expectation for UHBW was to achieve 95% compliance, with an amber threshold to 90%.
Performance:	VTE Risk Assessment compliance remains below expected levels.
Actions:	The new Trust VTE Lead commenced in role 1st October 2023. The new VTE Lead role will provide the leadership, clinical expertise and prioritisation needed to make a step change in progress of actions related to improvements with VTE prevention and support the transfer to business-as-usual (BAU). • First priority is to re-establish the VTE and Anticoagulation Group (ToR drafted and stakeholder analysis undertaken), to ensure correct membership, governance and reporting structure of VTE. • Collaboration with CareFlow Medicines Management (CMM) project group will recommence to ensure the VTE risk assessment (RA) process within CMM meets NICE guidance, and that force function for completion of initial VTE RA is in place to support with improvements to compliance. Interdependencies with pregnant patients in non-obstetric settings needs to be scoped as part of this. • Work will commence on reviewing the VTE data metrics to establish agreed cohorts and exclusions for VTE risk assessment compliance, which will enable accurate data for IQPR/reporting. • Hospital Acquired VTE (HAVTE) processes to be reviewed, with a plan to align closer to the PSIRF model of learning.
Risks:	Corporate Risk 720: Risk that VTE risk assessments are not completed



Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

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

Division	SubDivision	Number Risk Assessed	Total Patients	Percentage Risk Assessed
Diagnostics and Therapies	Radiology	26	26	100.0%
	Therapies	1	1	100.0%
Diagnostics and Therapies Total		**27**	**27**	**100.0%**
Medicine	Medicine	2,140	2,854	75.0%
Medicine Total		**2,140**	**2,854**	**75.0%**
Other Division	Other Directorate	4	4	100.0%
Other Division Total		**4**	**4**	**100.0%**
Specialised Services	BHOC	2,083	2,186	95.3%
	Cardiac	366	526	69.6%
Specialised Services Total		**2,449**	**2,712**	**90.3%**
Surgery	Anaesthetics	30	30	100.0%
	Dental Services	116	138	84.1%
	ENT & Thoracics	266	354	75.1%
	GI Surgery	926	1,198	77.3%
	Ophthalmology	355	362	98.1%
	Trauma & Orthopaedics	125	206	60.7%
Surgery Total		**1,818**	**2,288**	**79.5%**
Women's and Children's	Children's Services	30	41	73.2%
	Women's Services	1,245	1,422	87.6%
Women's and Children's Total		**1,275**	**1,463**	**87.1%**
Grand Total		**7,713**	**9,348**	**82.5%**

Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	QUALITY AND SAFETY: FRACTURE NECK OF FEMUR (#NOF)
Background:	Fractured neck of femur best practice comprises eight elements, all of which need to be provided within relevant time scales to demonstrate care provided to individual patients has met best practice standards. Two of the eight individual criteria are monitored in this report: time to theatre within 36 hours and ortho-geriatrician review within 72 hours. Both standards have a target of 90%.
Performance:	In September, there were 51 patients eligible for the Best Practice Tariff (BPT): 26 in Bristol and 25 in Weston. For the 36hr time to surgery standard, 23/51 patients (45%) achieved the standard. For the 72-hour time to Ortho-geriatric assessment, 40/51 patients (78%) achieved the standard.
Actions:	Weston: • 8 patients missed time to surgery due to lack of flexible theatre space or patients requiring more medical support prior to surgery. • 11 patients missed time to ortho-geriatrician assessment. This was due to no cover at weekends and caseload pressures during the week for the one individual responsible for this service. Bristol: • Theatre capacity being actively monitored and prioritised on a weekly basis across all specialties. • Poor results discussed in T&O Governance & Silver trauma steering group meeting so ideas for improvement could be discussed. • Actively re-patriating patients to WGH to avoid breaches. • Trauma SOP signed off to allow the allocation of a "Golden Patient", enabling a prompt start.
Risks:	924: Risk that there is a delay in hip fracture patients accessing surgery within 36 hours of admission. 1834: Risk of failure to achieve best practice tariff and good quality care for patients with #NOF

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

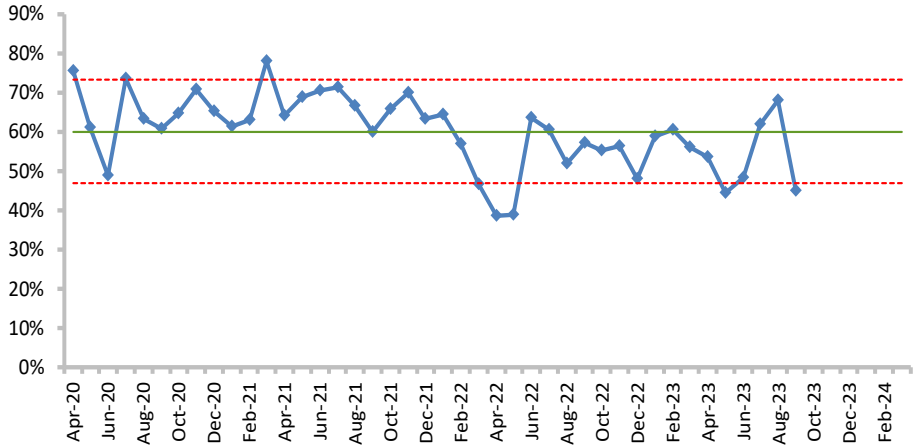
Reporting Month: September 2023

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

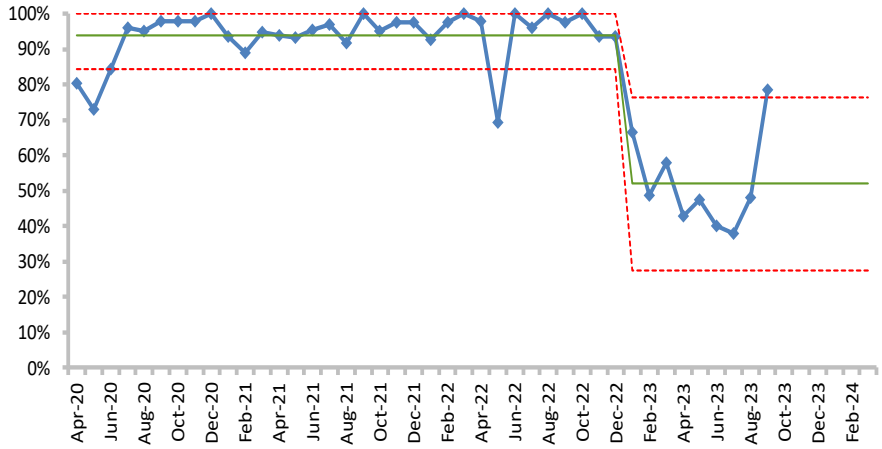
Sep-23

		36 Hours		72 Hours	
	Total Patients	**Seen In Target**	**Percentage**	**Seen In Target**	**Percentage**
Bristol	26	6	23%	26	100%
Weston	25	17	68%	14	56%
TOTAL	**51**	**23**	**45.1%**	**40**	**78.4%**

Fracture Neck of Femur Patients Treated Within 36 Hours



Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours



Performance Report

Reporting Month: August/September 2023

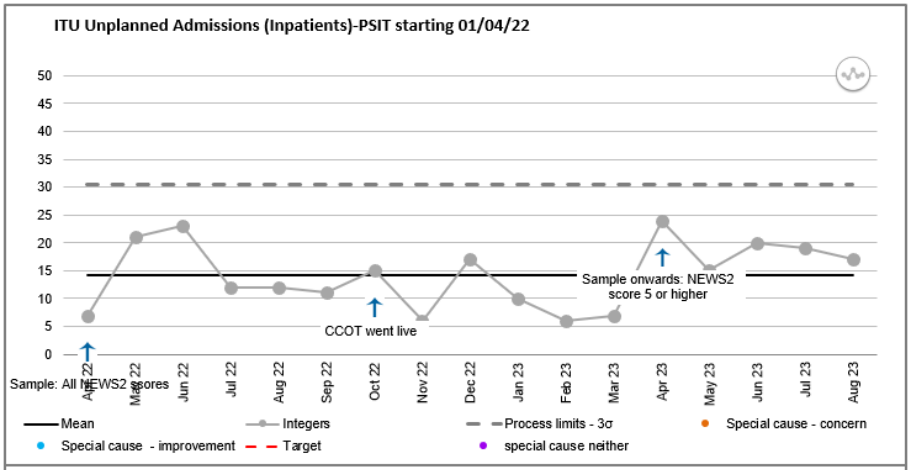
STANDARD	QUALITY AND SAFETY: DETERIORATING PATIENT
Background:	Delayed recognition and response to patient deterioration is nationally recognised as one of the significant causes of avoidable harm. This is a long-term improvement programme (to March 2025) with several workstreams reported in more detail as part of the Patient First Deteriorating Patient corporate project. The programme includes: implementation of an adult critical care outreach team across the BRI main site (already in place in Weston General Hospital), a refresh of e-observations monitoring of patients' vital signs and supporting resources, use of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) and monitoring pregnant patients in non-maternity settings. The number of cardiac arrests in general adult wards and unplanned adult ITU admissions are the proxy outcome indicators for prompt recognition and response to patient deterioration.
Performance:	Improvement goals to be confirmed.
National Data:	N/A
Actions:	<u>Critical Care Outreach Team (CCOT)</u> Next steps: • Evaluate impact of adding proactive CCOT reviews triggered by raised NEWS2 scores <u>ReSPECT and ReSPECT PLUS</u> Next steps: • Publish RESPECT SOP to support a standardised process Trust wide • Embed UHBW-wide RESPECT form at Weston General Hospital • Continue ReSPECT PLUS (which is also known as BNSSG-ReSPECT) work to achieve a digitalised ICB-wide ReSPECT form <u>Maternity and Obstetric Early Warning Score (MOEWS) Next steps:</u> • Scoping adding the MOEWS module to E-Vitals • Maternity Practice Education Facilitators to develop MOEWS education for non-maternity clinical teams • Implementation of MOEWS charts to monitor pregnant patients in non-maternity in-patient settings • Development of updated sepsis pathway in maternity

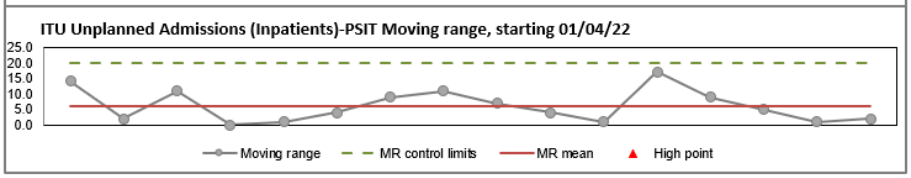
Performance Report

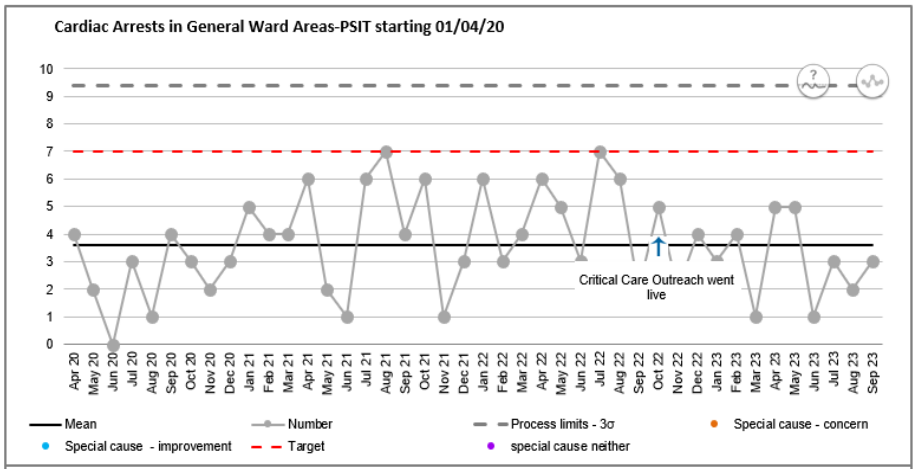
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

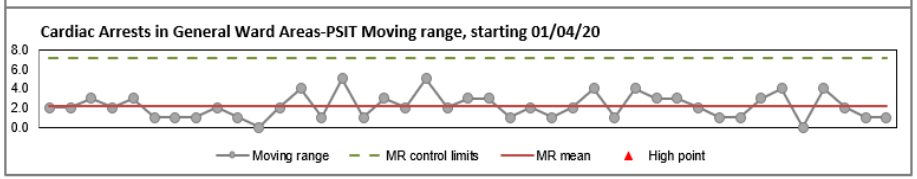
Reporting Month: August/September 2023

STANDARD **QUALITY AND SAFETY: DETERIORATING PATIENT (continued)**







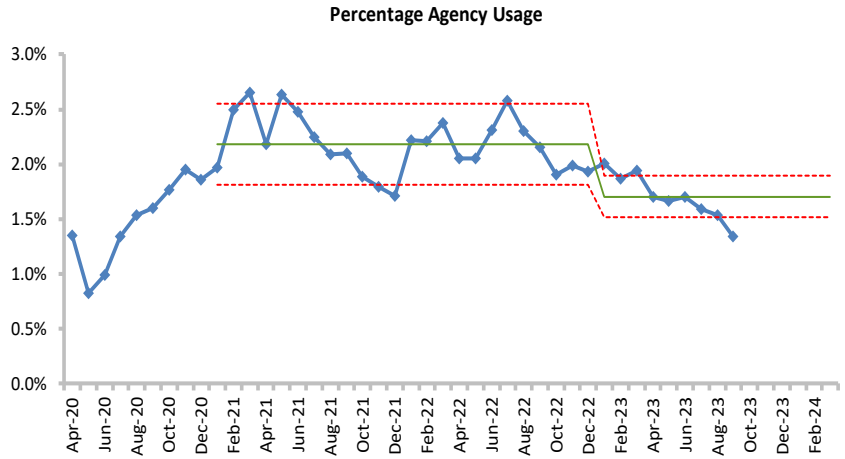


Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	OUR PEOPLE: WORKFORCE AGENCY USAGE
Performance:	Agency usage reduced by 23.7 Full Time Equivalents (fte) to 1.3% (168.4 fte). There were increases within three divisions. The largest divisional increase was seen in Weston General Hospital, where usage increased to 16.9 FTE from 15.6 FTE in the previous month. There were reductions within four divisions. The largest divisional reduction was seen within Medicine, where usage reduced to 65.5 FTE from 80.9 FTE in the previous month.
Actions:	• There were 86 new starters across the Bank in September. • System work continues at Integrated Care Board (ICB) level to drive the supply of lower cost framework nursing agency supply with a renewed focus on developing a plan to deliver cap compliant agency supply. • Strict controls are also now in place internally to control agency usage and review through a Patient First approach led by the Deputy Chief Nurse. • Ongoing work continues to encourage the UHBW Bank as the employer of choice for temporary workers with an increased Band 5 Bank Registered Nursing (RN) rate and an improved bank experience in clinical areas. • The Trust continues to encourage "block bookings" to reduce the use of last minute, non-framework reliance. • Active recruitment continues to substantive medical roles in the Weston Division to drive down the demand for high-cost agency usage. • The Trust continues to offer school hour and twilight shifts in a small number of clinical areas within the division of Medicine as a pilot to reduce the number of unfilled shifts, this is in place for both registered and unregistered nursing workers.
Risks:	Corporate Risk 674: Risk that use of agencies who are non-compliant with national pricing caps does not reduce



Performance Report

Reporting Month: September 2023

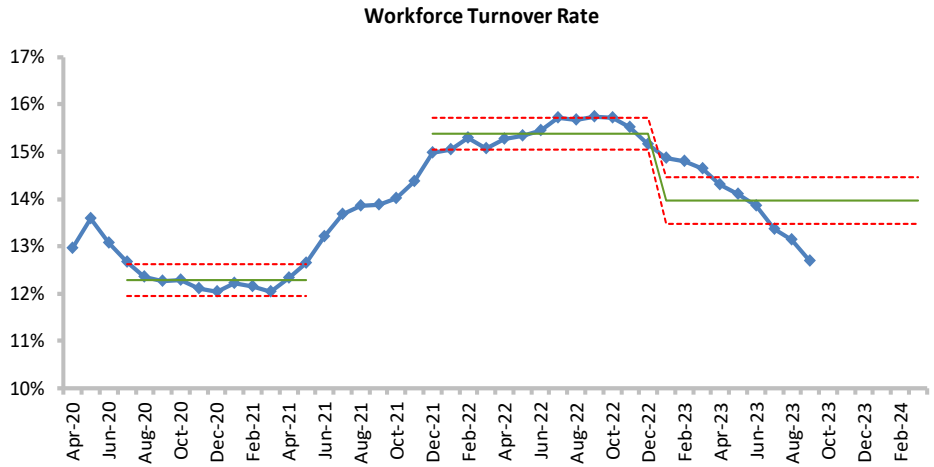
STANDARD	OUR PEOPLE: WORKFORCE STAFF TURNOVER
Performance:	Turnover for the 12-month period reduced to 12.7% compared to 13.1% (updated figures) for the previous month. • Six divisions saw a reduction whilst one division saw an increase in turnover, and one remained static in comparison to the previous month. • The largest divisional reduction was seen within Diagnostics and Therapies, where turnover reduced by 1.06 percentage points to 14.58% compared with 15.64% the previous month. • The largest divisional increase was seen within Trust Services, where turnover increased by 0.2 percentage points to 11.9% compared with 11.7% the previous month. • Eight staff groups saw a reduction and one staff group saw an increase in comparison to the previous month. • The largest staff group reduction was seen within Allied Health Professionals, where turnover reduced by 1.67 percentage points to 13.87% compared with 15.55% the previous month. • The largest staff group increase was seen within Additional Professional Scientific and Technic, where turnover increased by 0.65 percentage points to 14.13% compared with 13.48% the previous month. • Turnover rate for Band 5 nurses in September is 14.2% (compared with 14.7% for August).
Actions:	Work taking place to reduce turnover is as follows: • Engagement: The report summarising the programme of work to understand the key drivers for colleagues providing feedback, and to benchmark nationally with the top percentile of NHS Trusts, was finalised. Key recommendations have been implemented for the 2023 Staff Survey campaign, including: a new managers toolkit, videos from our senior leaders, messaging on payslips, better advertised pop up events, more creative communications, etc. • Staff Survey 2023: Data submission was completed and confirmed by Picker, ready for launch on 2 October 2023. Key communications have been created ahead of the launch, with promotion of the Staff Survey beginning in mid-September with Newsbeat articles, updated HRWeb page, and communications to our HRBP Community. • Recognition: A recognition brochure has been developed highlighting our recognition offer. This will be shared with stakeholders for review. • Exit interview data is being reviewed by Workplace Wellbeing team to address related themes/trends. • Leavers feedback uptake calculation has been reviewed to highlight headcount based completion rates, this has reduced the completion rate to 40%. Whilst this is higher than average (benchmarking with other trusts undertaken), it is lower than desired. Work to separate the KPI into Divisional uptake data is underway so that targeted improvement measures can be implemented. • Respecting Everyone roadshows are underway and the policy goes live in November, the aim of this is to reduce levels of conflict and bullying and harassment thus reducing turnover.
Risk:	Strategic Risk 2694: Risk that Trust is unable to retain members of the substantive workforce

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	OUR PEOPLE: WORKFORCE STAFF TURNOVER

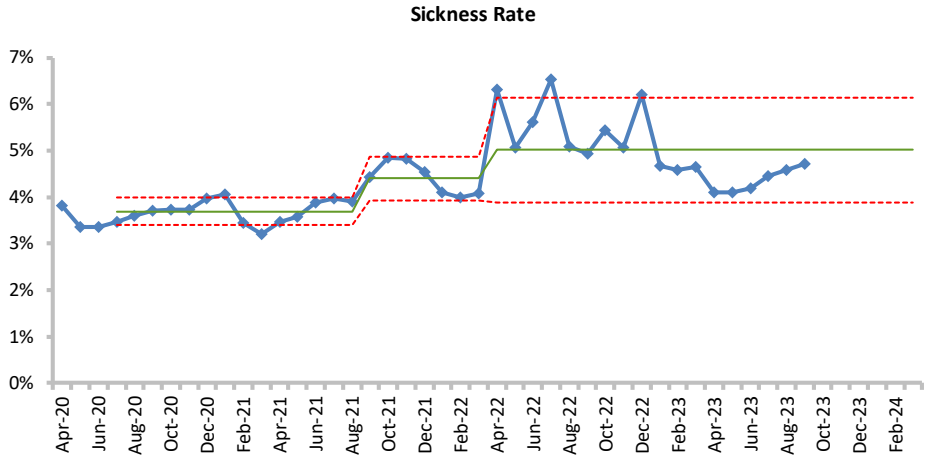


Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	OUR PEOPLE: WORKFORCE STAFF SICKNESS
Performance:	Sickness absence increased to 4.7% compared with 4.6% the previous month, based on updated figures for both months. This figure is now combined with Covid Related absence. There were reductions within three divisions. The largest reduction was seen in Medicine, where sickness reduced by 0.4 percentage points to 4.2%, compared to 4.6% in the previous month. There were increases within all other divisions. The largest divisional increase was seen within Weston General Hospital, increasing by 1.5 percentage points to 6.6%, compared to 5.1% in the previous month. There were reductions within two staff groups. The largest staff group reduction was seen within Nursing and Midwifery Registered, reducing to 6.3% from 6.9% compared to the previous month.
Actions:	Work taking place to reduce sickness absence is as follows: • Health Assured 24/7 Employee Assistance Programme launched on 6 September via internal communications channels plus 15 introductory sessions to teams and services to optimise awareness and signposting to colleagues seeking in-the-moment and structured counselling. • An overview of the Government funded 'Maximus' - Access to Work Mental Health programme was presented to Wellbeing Advocates, Managers, Wellbeing and Network Leads on 6 September. • Workplace Wellbeing and Violence Reduction teams committed to closer collaboration and providing practical and emotional wellbeing support to colleagues experiencing violence and aggression in the workplace – at the place of need and within a short timescale as possible. • The Supporting Attendance Policy has been amended to remove mandatory HR presence at all meeting stages therefore managers are able to meet with colleagues who have high levels of absences in a quicker timescale and more informal and supportive way. • Reasonable adjustment passport has been reviewed and will be relaunched in January. • Sickness absence rates are particularly high and over target in Estates and Facilities and a specific action plan has been implemented to deliver a targeted reduction in absence rates



Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	OUR PEOPLE: WORKFORCE STAFF VACANCY
Performance:	Overall vacancies reduced to 4.1% (490.5 FTE) compared to 5.2% (623.7 FTE) in the previous month. The largest divisional increase was seen in Trust Services where vacancies increased to -11.6 FTE (over-established) from -18.1 FTE (over-established) in the previous month. The largest divisional reduction was seen in Women's and Children's, where vacancies reduced to 27.9 FTE from 98.3 FTE the previous month. The largest staff group reduction was seen in Nursing, where vacancies reduced to 269.9 FTE from 328.5 FTE the previous month. There were no staff group vacancy increases this month. Consultant vacancy has reduced to 24.7 FTE (3.1%) from 33.8 FTE (4.3%) in the previous month. Unregistered nursing vacancies can be broken down as follows: **Band** / **Vacancy** AfC Band 2 — 90.2 FTE AfC Band 3 — 65.9 FTE AfC Band 4 — -192.1 FTE The band 4 over establishment is due to the large number of newly qualified nursing staff awaiting their NMC PINs. Once these staff become fully qualified and have received their PIN, this should reduce the band 4 over establishment, reduce the registered nursing vacancy position, and increase the unregistered nursing vacancy position, which is a much more accurate reflection of the nursing vacancy position.
Actions:	Work taking place to reduce the vacancy rate during September is as follows: • The Trust received the biggest cohort of Internationally Educated Nurses (IEN) to date, with 54 arrivals. • The Trust held 86 virtual interviews and made 42 offers to support the ambitious IEN target for 2023. • 773 IENs have now arrived at the Trust since the beginning of the programme, with an additional 51 due to arrive in October. • Work has continued to organise and promote the Newly Qualified Nurse Expos planned for October and November in Bristol and Weston. The first event will take place on the 9th October at the Bristol site for both Adult and Children's nurses. • The Trust held an Open Day for the Pre-Operative Department in September. Five nurses attended the event and two have interviews arranged for October. • The Pastoral Team delivered the Safeguarding Recruitment Event on the 8th of September. As a result, three nurses were interviewed, and one candidate has been offered a developmental role. • A successful mass recruitment event for Healthcare Support Workers (HCSW) took place and resulted in 87 offers and another 36 candidates added to a talent pool. Following a marketing campaign, 480 candidates signed up for the event of which 292 attended on the day. This was the second HCSW hiring event organised by the Trust. • 32 substantive HCSW started in the Trust and another 107 have been offered. 31 Bank Healthcare Support Workers (HCSW) started in the Trust during September and another 82 have been offered.

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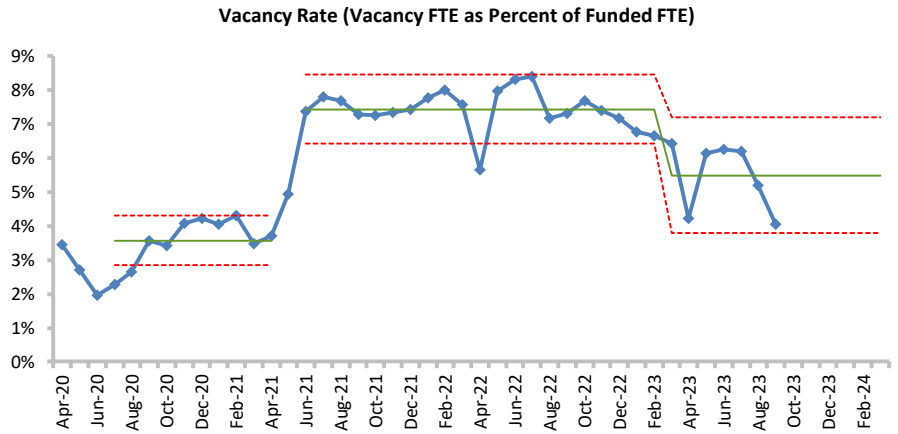
Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	OUR PEOPLE: WORKFORCE STAFF VACANCY
Actions (continued):	• The Trust has recruited 21 candidates onto the Trainee Nursing Associate (TNA) programme of which 11 joined the Trust in September and are due to start the educational programme in October. • 18 Registered Nurse Degree Apprentices and 31 Accelerated Registered Nurse Degree Apprentices started in the Trust and are due to embark on their nursing apprenticeship in October. • 36 substantive Allied Health Professionals and 31 substantive Healthcare Scientists joined the Diagnostics and Therapies division in September. • One Internationally Educated Occupational Therapist started in the Trust and another was offered and is due to start in the coming months. This is part of the continued collaborative AHP international recruitment with the ICB system partners. • One Internationally educated Radiographer joined The Trust and four additional Radiographers have been appointed and are due to start in November. The Trust has secured funding from NHS England for two additional internationally educated Radiographers, bringing the total to 17 which will arrive before the end of this year. • Two clinical fellows started in Weston and a further two clinical fellows and one consultant were cleared for start dates in October. • In the month of September, the Trust offered two further non-consultant grade doctor and six consultants across the Weston site. 11 clinical fellows and two consultants are currently going through pre-employment checks for the Weston site to support rota gaps. • The Pastoral team welcomed nine International Medical Graduates (IMG's) to the Bristol site and two to the Weston site in September.
Risks:	Strategic Risk 737: Risk that the Trust is unable to recruit sufficient numbers of substantive staff



Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	REFERRAL TO TREATMENT (RTT) LONG WAITS
Performance:	At the end of September: • 5,813 patients were waiting 52+ weeks against the Operating Plan trajectory of 5,135. • 2,183 patients were waiting 65+ weeks against the Operating Plan trajectory of 1,260. • 287 patients were waiting 78+ weeks. • 0 patients were waiting 104+ weeks. For 2023/24 the Operating Plan assumes that no patients will be waiting over 78 weeks. The next national ambition is to have no patients waiting 65+ weeks by the end of March 2024. NB: dispensation for industrial action continues to inform the revision of in-year trajectories
National Data:	For August 2023, across all of England, 5.2% of the waiting list was waiting over 52 weeks. UHBW's performance was 9.1% (6,134 patients) which places UHBW as the 12th highest Trust out of 169 Trusts that reported RTT wait times.
Actions:	• At the end of September 2023, there were no patients waiting over 104+ weeks. This is a sustained position, with February 2023 being the last time a patient was reported waiting 104 weeks or longer. • The Trust continues to work towards the elimination of any patient waiting longer than 78 weeks and had shown improvement throughout 2022/23. Industrial action and higher presentation of trauma cases in paediatric services have contributed towards a deterioration in the reported position at the end of August, when there were 245 patients waiting in excess of 78 weeks. This position has deteriorated further in September, with the number of patients waiting 78 weeks or longer increasing to 287. The Trust continues to work towards reducing long waits through specific initiatives including the expansion of insourcing in clinical genetics and dental specialties where there are recognised national challenges. • Of the 287 patients waiting 78 weeks or longer at the end of September, 9 related to cornea grafts. There is currently a national shortage of cornea graft material which is contributing to delays in treating these patients. There is a nationally led process to allocate graft material to Trusts based on the clinical priority and length of waiting time but graft material. • As part of the 2023/24 Annual Planning Process (APP), clinical divisions have developed plans to move towards the national ambition of no patient waiting longer than 65 weeks by end of March 2024. The number of patients waiting in excess of 65 weeks at the end of September was 2,183 which shows a deterioration against the operational planning trajectory of 1,260 This is in part due to the deterioration in clearance of the 78+ week waits due to industrial action. Actions being taken to reduce the number of long waiting patients includes: • Dental services have additional Independent Sector capacity under contractual agreements with both Nuffield and Spire to support their recovery in Cleft services. The service are also insourcing using KPI Health for paediatric dental clinics and extractions which commenced mid-January, with schedules being provided each month. The contract agreement with KPI Health has been extended for 2023/2024. • The Trust is in the process of establishing insourcing arrangements for outpatient services in oral surgery, oral medicine, gynaecology, sleep, respiratory medicine and dermatology. Page 58 of 245 *...continued over page*

Performance Report

Reporting Month: September 2023

STANDARD	REFERRAL TO TREATMENT (RTT) LONG WAITS
Actions (continued):	• Within General Surgical Specialties, the service has been working with Somerset Surgical Services (SSS) to support provision of additional treatment to be undertaken on the Weston site. • The dental service will be undertaking interviews on 5th October for an additional Orthodontics consultant to increase the capacity within this service. • Patients currently waiting for treatment dates are being contacted to ask if they would accept treatment at an alternative provider. Should patients consent, each patient is added to NHS England Digital Mutual Aid system (DMAS). • The Trust continues to bolster additional capacity through other insourcing providers and waiting list initiatives. • Paediatric Urology Consultants agreed to additional treatment lists and had booked patients into dates during July with the plan to ensure that there will be no Paediatric Urology patients waiting 78 weeks or longer at the end of July. However, due to BMA industrial action the patients who were booked on industrial action dates had to be cancelled and, although additional lists were arranged in August, due to continued industrial actions and summer holidays, these dates were also stood down and were not rescheduled until October. • Due to further industrial action during September and the number of trauma cases that the service has experienced, as anticipated, there were 43 patients waiting in excess of 78 weeks, nine of whom were waiting for Urology treatment, twelve for ENT and eleven waiting for Plastic Surgery treatment. • Where patients are too complex for transferring outside of the organisation for treatment under mutual aid arrangements, theatre schedules are under review via a theatre improvement programme to ensure that suitable capacity is available for the longest waiting patients. This continues to be a challenge due to the high volume of cancer cases, inpatient capacity, rest restraints (including High Dependency) and staff shortages.
Risk:	Corporate Risk 801: Risk that the six oversight themes within the NHS Oversight Framework for 2023/24 are not met

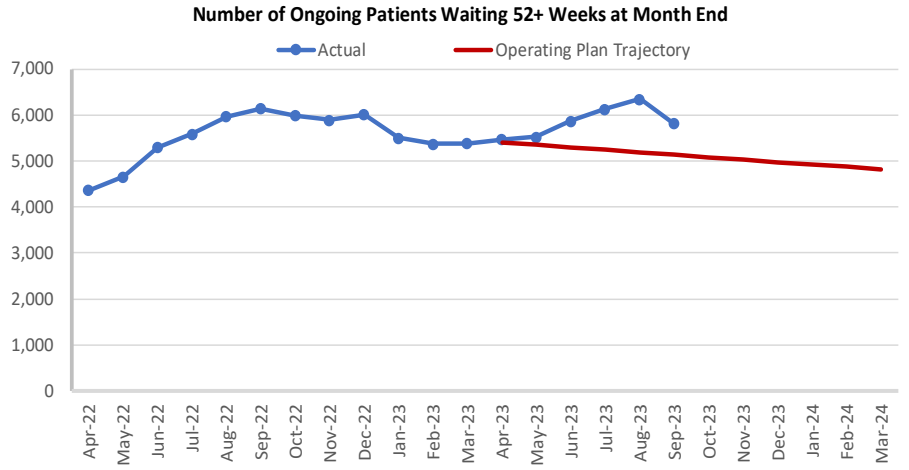
Performance Report

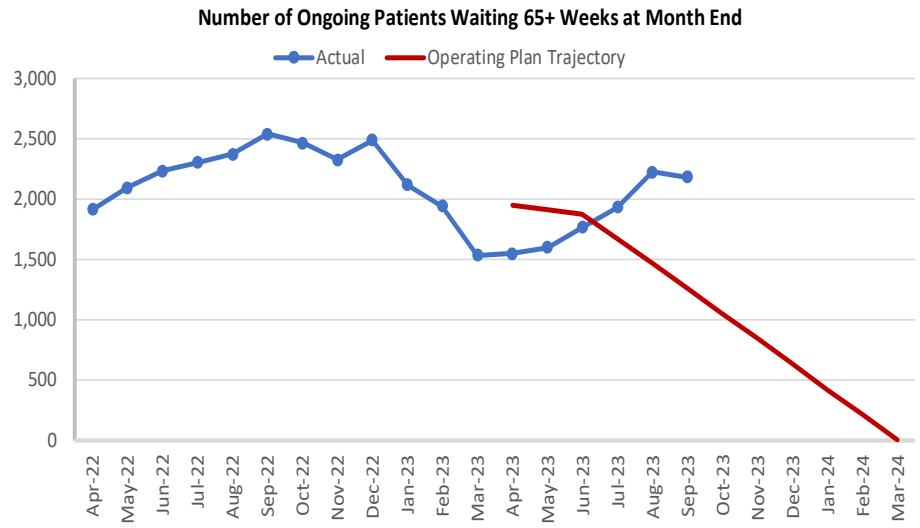
University Hospitals Bristol and Weston NHS Foundation Trust

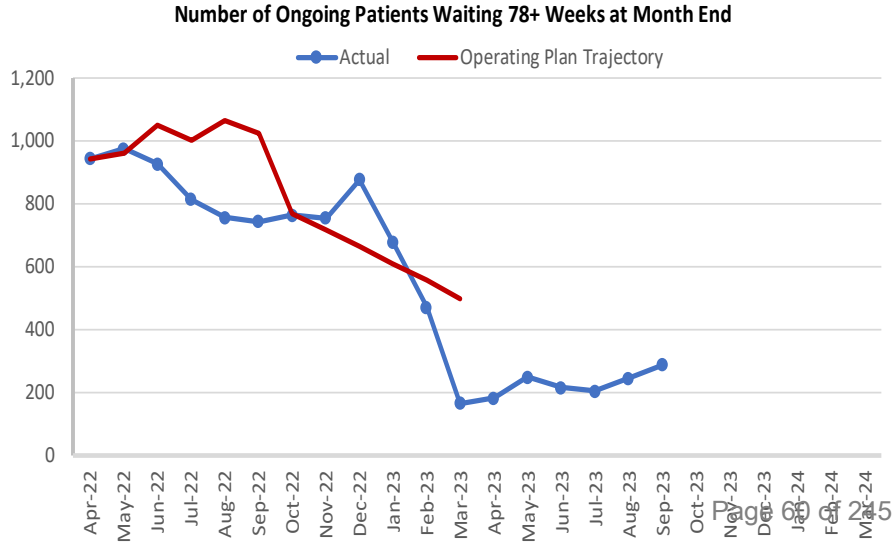
Reporting Month: September 2023

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

	Sep-23		
	52+ Weeks	65+ Weeks	78+ Weeks
Diagnostics and Therapies	0	0	0
Medicine	1,113	316	0
Specialised Services	222	83	31
Surgery	3,579	1,427	211
Women's and Children's	899	357	45
Other	0	0	0
UHBW TOTAL	**5,813**	**2,183**	**287**







Performance Report

Reporting Month: Aug/Sep 2023

STANDARD	CANCER WAITING TIMES
Performance:	At the end of September, the Trust had 270 patients waiting 62+ days on a GP suspected cancer pathway. The Trust has an operating planning trajectory of not exceeding 170 patients at the end of September 2023, reducing to 160 by March 2024. The performance for patients treated within 62 days of an urgent GP referral is reported a month in arrears. For August, 64.8% of patients were seen within 62 days. The national constitutional standard remains at 85%. The "Faster Diagnosis Standard" (FDS) is also reported a month in arrears, and this measures time from receipt of a suspected cancer referral from a GP or screening programme to the date the patient is given a cancer diagnosis, or told cancer is excluded, or has a decision to treat for a possible cancer. This time should not exceed 28 days for a minimum of 75% patients. The Trust's improvement trajectory returns to 75% by March 2024. Performance in August was 56.0% against the improvement trajectory of 69.0%.
National Data:	National data for patients treated within 62 days of an urgent GP referral is shown on the next page. Latest national data for quarter 1 2023/24 shows UHBW at 67.1% against an England average of 59.6%. This puts UHBW 47th out of 142 Trusts.
Actions:	The Trust was compliant with the trajectory for patients waiting 62+ days on a GP suspected cancer pathway at the start of July, but that since deteriorated with the impact of industrial action. Performance is in a repeating pattern of improving and then falling sharply following each period of industrial action. At the end of September, the number waiting 62+ days was 270, an increase from the position reported at the end of August (222) when industrial action was particularly impactful due to coinciding with school holidays and thus limiting opportunities to replace lost activity. The Trust continues to strive to reduce the number of long waiting patients, working towards the operational planning target of no more than 160 patients waiting 62+ days by the end of March 2024. Actions focus on replacing activity lost to industrial action and continue to concentrate on reducing waits in gynaecology, lower GI and skin through use of locums, outsourcing and additional permanent capacity where required. Performance against the Faster Diagnosis Standard was met during March 2023 but has deteriorated in the five months since, with August reporting 56% (June 61.6%, July 59.5%). The performance has been impacted by a combination of industrial action and the impact of the Trust being unable to cease the mutual aid support being provided to Somerset NHS FT for dermatology. Recovery to compliance with the 75% standard by the end of the financial year is still attainable although increasingly challenging, dependent on impact of future industrial action and the provision of mutual aid to Somerset for dermatology ceasing at the end of October. Actions to improve the position include ensuring prompt first appointments in high volume specialities and reducing waiting times for key diagnostic tests such as hysteroscopy, CT, ultrasound and endoscopy. As referenced above, the predicted under-performance against trajectory due to ongoing issues in dermatology is being supported by NHS England. *...continued over page*

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: Aug/Sep 2023

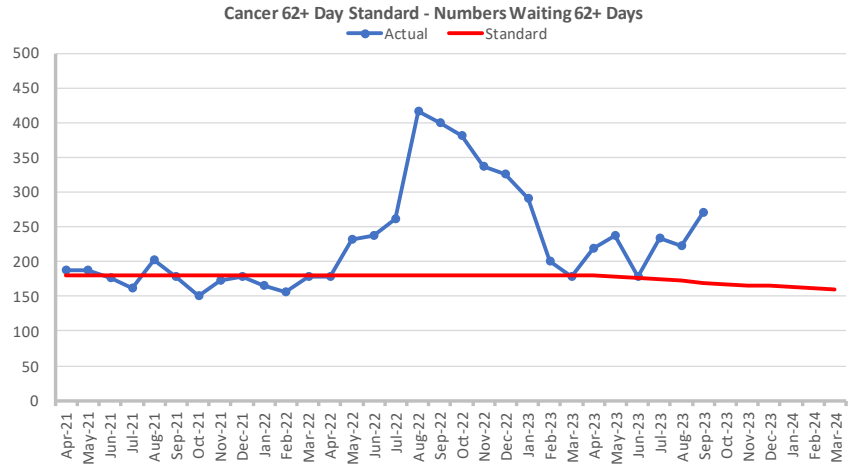
STANDARD	CANCER WAITING TIMES
Actions (continued):	During August, the Trust continued to achieve the subsequent radiotherapy and subsequent chemotherapy treatment standards. The faster diagnosis standard for screening was also achieved. Performance against the other retrospective standards remains non-compliant due to the impact of industrial action. The Trust continues to work towards delivering its improvement action plan although progress on most actions is being negated by the impact of industrial action where, for example, additional capacity is being used to replace that lost to strikes, rather than as intended to improve the position. More additional capacity through use of insourcing is planned for autumn in the two most challenged areas (dermatology and gynaecology) which should help address this. Rising demand in the Gynaecology service is also a confounding factor, with a 21% rise in demand in July and a 25% rise across the year overall. This rising demand is a national issue, due to societal changes in attitudes to HRT, and further national guidance on managing these patients is expected in the next months. Patient safety is at the heart of all performance management in cancer and is being maintained.
Risk:	Corporate Risk 801: Risk that the six oversight themes within the NHS Oversight Framework for 2023/24 are not met

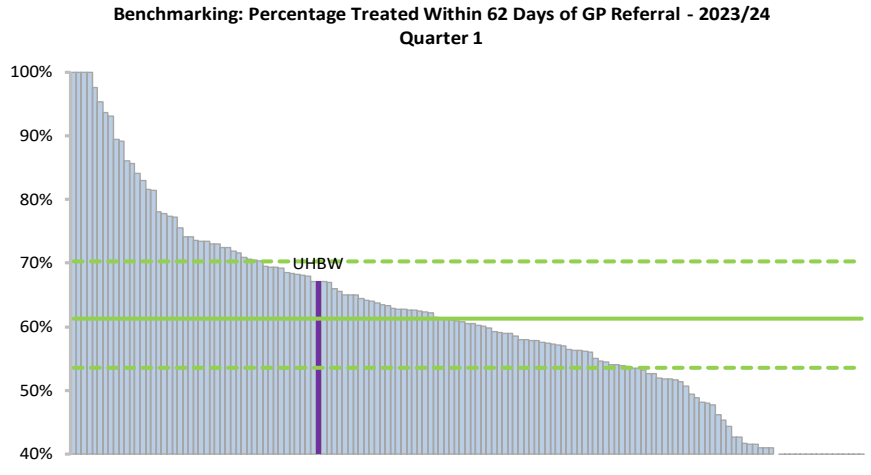
Performance Report

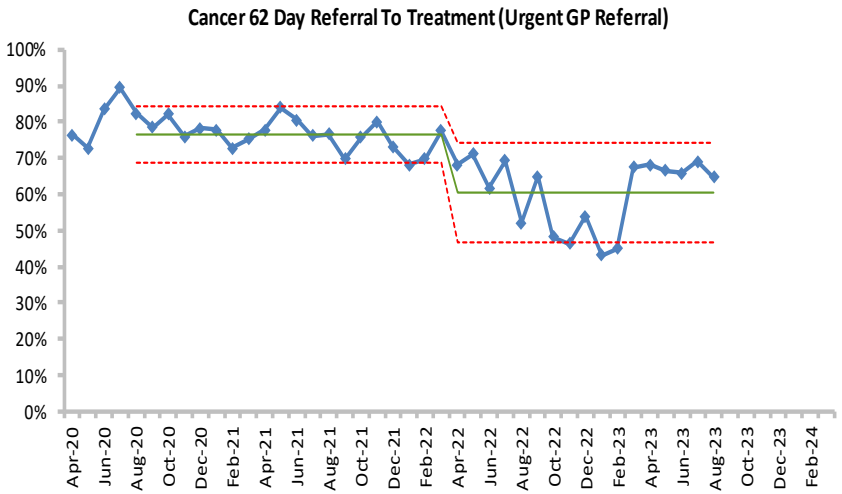
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

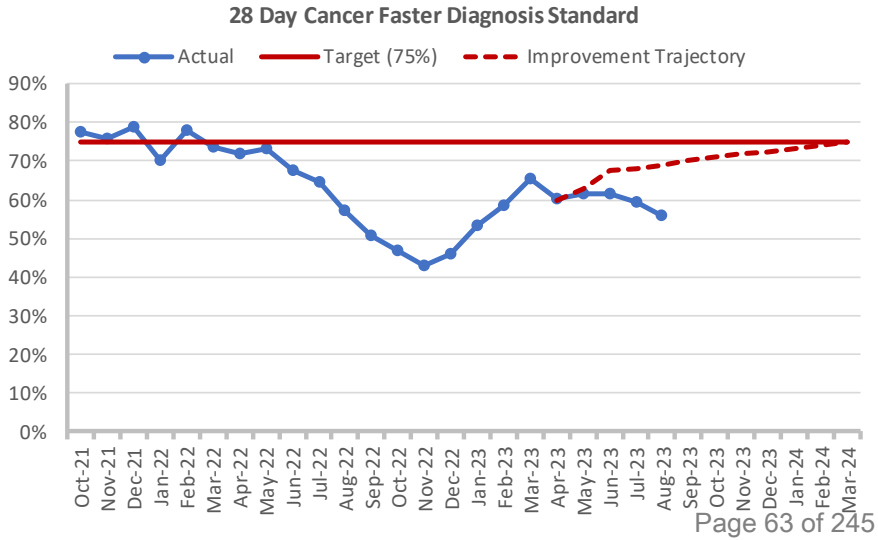
Reporting Month: Aug/Sep 2023

STANDARD **CANCER WAITING TIMES**









Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	DIAGNOSTIC WAITING TIMES
Performance:	The ambition set as part of the Trust's operational planning submission is that 83.3% of patients will be waiting under six weeks by end of March 2024. As at the end of September, 74.9% of patients had been waiting under 6 weeks, against a performance trajectory of 77.8%. At the end of September 2023, there were a total of 311 patients waiting 26+ weeks which is 2.3% of the waiting list. The target for end of September was nine and an expectation to have zero patients waiting 26+ weeks by October 2023. At the end of September 2023, there were a total of 1072 patients waiting 13+ weeks which is 7.8% of the waiting list. The target for end of September was 737 and an expectation to have zero patients waiting 13+ weeks by March 2024.
National Data:	For August 2023, the England total was 71.5% of the waiting list under six weeks. UHBW's performance was 75.9% which places UHBW 86th of 156 Trusts that reported diagnostic wait times.
Action/Plan:	• At the end of September, diagnostic performance against the six week wait standard was reported as 74.9% against the operational planning trajectory of 77.8%. Whilst September 2023 saw a slight deterioration in performance, it is noted that most modalities improved in performance from August 2023. During September, performance deteriorated slightly within Echocardiography and Non-obstetric ultrasound, but most notably in Sleep Studies. • For the first time in 11 months, patients waiting more than 13 and 26 weeks has not reduced. The Trust had planned to clear all patients waiting over 26 weeks by October 2023, there is now significant risk that this target will not be achieved due to challenges in the Sleep Service, ongoing capacity pressures and continued industrial action across all diagnostic modalities. • Endoscopy (adults) performance against the six-week standard improved to 55.4% in September, an 18% improvement since March 2023. Due to the ongoing capacity challenges and industrial action, long waiters in Endoscopy (adults) did not reduce for the first time since October 2023. Ongoing challenges remain, with actions in place to mitigate risk wherever possible. • Challenges in Non-obstetric ultrasound have previously been noted as potential risks to overall diagnostic performance, particularly in reducing to zero patients waiting over 13 weeks by March 2024. This modality did see a deterioration in performance in September, and the Division is currently reviewing all opportunities which may help to improve performance in this service. • Performance and long waiters in Sleep Studies poses the most significant risk and challenge to diagnostic performance. The service is using additional capacity with the support of Locum doctors and insourcing to improve performance and waiting times for patients and mutual aid from other providers is also being explored. The new patient demand in this service is exceptional and the service has temporarily closed to all out of area referrals. The issues in this service are considerably complex and will require extensive and sustained actions across key areas including; review of the pathways and referral criteria and sustained additional capacity across all staffing groups to recover. Service-wide demand and capacity modelling is being undertaken over Quarter 3 and the Division of Medicine is currently developing recovery trajectories. *...continued over page*

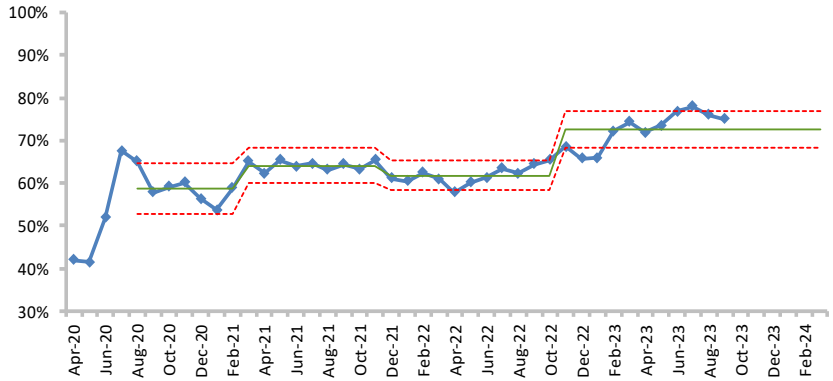
Performance Report

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

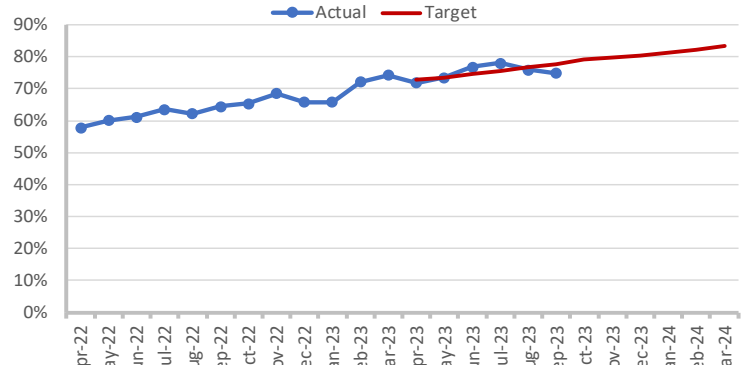
Reporting Month: September 2023

STANDARD	DIAGNOSTIC WAITING TIMES
Action/Plan (continued):	• Modality-level diagnostic trajectories and plans for 23/24 are in place across the Trust. The other key risks to diagnostic performance and improvement are industrial action and complex patients needing general anaesthetic or theatre slots where capacity is more limited and prioritised for the most clinically urgent patients and the growing waiting list in the Sleep Service. The Trust continues to utilise transferred capacity and outsourcing to the independent sector which are integral to the diagnostic recovery plans for 23/24.
Risk:	Corporate Risk 801: Risk that the six oversight themes within the NHS Oversight Framework for 2023/24 are not met

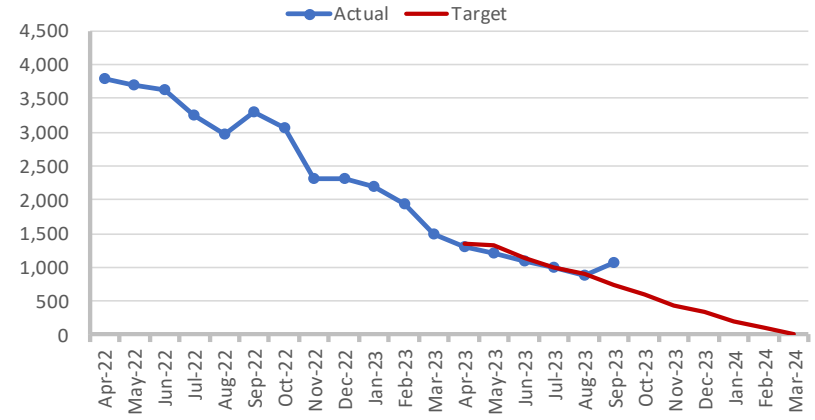
Diagnostics Under 6 Week Wait (15 Key Tests)



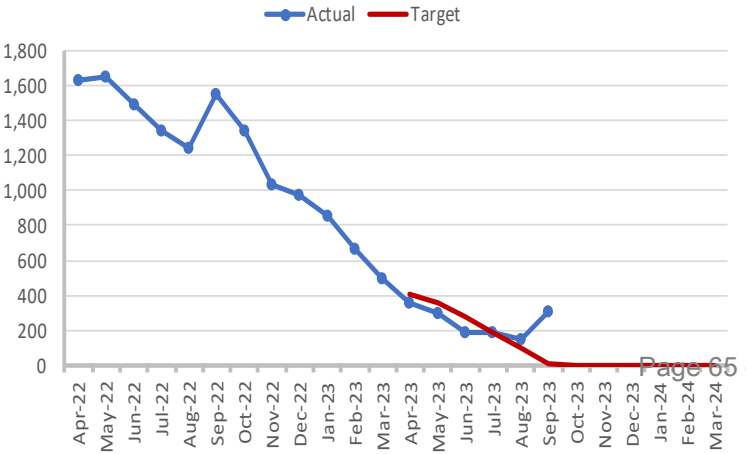
Diagnostics Percentage Waiting Under 6 Weeks



Diagnostics Numbers Waiting 13+ Weeks



Diagnostics Numbers Waiting 26+ Weeks



Performance Report

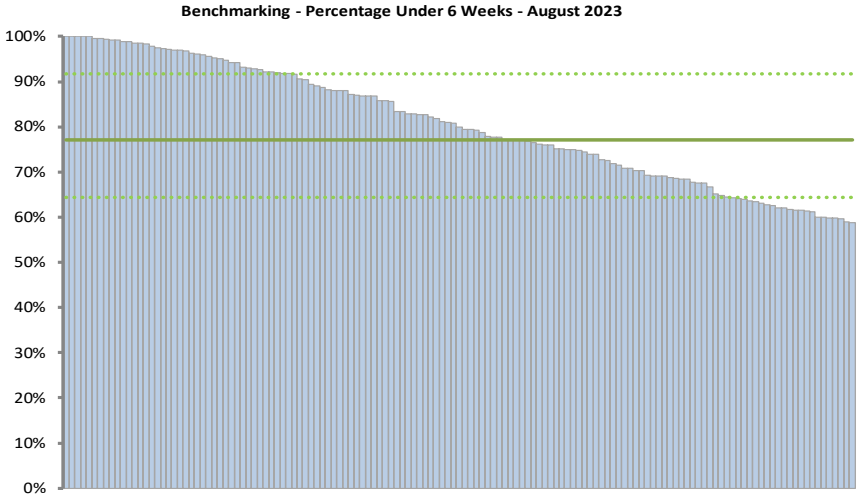
NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD **DIAGNOSTIC WAITING TIMES**

End of September 2023

Modality	Total On List	Under 6 Weeks			13+ Weeks		26+ Weeks	
		Number	Percentage	Mar24 Target	Number	Percentage	Number	Percentage
Audiology Assessments	414	23	94%	97%	0	0%	0	0%
Colonoscopy	418	196	53%	53%	141	34%	44	11%
Computed Tomography (CT)	1,846	110	94%	81%	22	1%	0	0%
DEXA Scan	700	308	56%	68%	63	9%	1	0%
Echocardiography	1,793	438	76%	85%	5	0%	0	0%
Flexi Sigmoidoscopy	139	67	52%	53%	44	32%	15	11%
Gastroscopy	483	218	55%	55%	128	27%	26	5%
Magnetic Resonance Imaging (MRI)	2,587	291	89%	95%	162	6%	49	2%
Neurophysiology	194	11	94%	99%	1	1%	0	0%
Non-obstetric Ultrasound	4,967	1,611	68%	83%	327	7%	1	0%
Sleep Studies	232	181	22%	51%	179	77%	175	75%
Other	0	0			0		0	
UHBW TOTAL	**13,773**	**3,454**	**74.9%**	**83.3%**	**1,072**	**7.8%**	**311**	**2.3%**



Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS & WAITS IN A&E FROM ARRIVAL TO DISCHARGE, ADMISSION OR TRANSFER
Performance	**Waits in ED from arrival to discharge, admission or transfer** The total time spent in the emergency department (ED) measures from arrival time to discharge/admission time. There are two standards reported: 1. The "4 Hour Standard". This is the standard that has been reported in previous years and had a constitutional standard of 95%. For 2023/24, Trusts are required to return performance to 76% by March 2024, i.e. 76% of ED attendances should spend less than 4 hours in ED. 2. The "12 Hour Standard". This standard has a new definition from April 2023 related to the proportion of patients attending ED who wait more than 12 hours from arrival to discharge, admission or transfer, with an operational standard of no more than 2%. Note: both these standards apply to all four emergency departments in the Trust. During September, 67.2% of attendances spent less than 4 hours in an emergency department (ED), from arrival to discharge or admission. This is ahead of the operational planning trajectory of 64.8% for September. The September performance for the "12 Hour Standard" showing a deterioration to 2.8% (compared to 2.1% in August). Both metrics have been impacted by increased bed occupancy during September of 101% BRI and 92% Weston (compared to 93.5% and 89% respectively in July). The links between occupancy and four hour performance are well established, for example in 2022 Health Foundation analysis found a 1% increase in occupancy decreases the probability of achieving the four hour target by 9.5%. Additionally, outlier beddays increased in August and September compared to July, which essentially means patients are not being cared for on the right specialty ward and their specialty team is completing safari ward rounds to review them, both of which adds to inefficiency and LOS. **12 Hour Trolley Waits** This metric is for patients who are admitted from ED, and measures from the Decision To Admit (DTA) time to the Admission Time. This is a standard that has been reported in previous months and will continue to be reported in 2023/24. During September, there were 193 12 Hour Trolley Waits: 89 in Bristol and 104 at Weston, which is a deterioration from the 112 reported in August, again linked to the flow constraints resulting from increased occupancy. **Ambulance Handovers** Following handover between ambulance and ED the ambulance crew should be ready to accept new calls within 15 minutes. The two metrics reported are the number and percentage of handovers that are completed within15 or 30 minutes. The current improvement targets are that 65% of handovers should be completed within 15 minutes and 95% within 30 minutes. Of the 3,876 ambulance handovers in September: • 1,151 ambulance handovers were within 15 minutes which was 29.7% of all handovers • 2,371 ambulance handovers were within 30 minutes which was 61.2% of all handovers
National Data	There are 19 hospitals in the South-West that the Ambulance Service report data for. For September 2023, overall number of handovers over 15 minutes was 75.9% across these hospitals. The chart on page 20 shows the distribution: Weston was 3rd highest at 88%, BRI was 14th highest at 72% and BRHC was 4th lowest at 59%. ED 4 hour national performance is shown on page 17.

Performance Report

Reporting Month: September 2023

STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E
Actions:	No Criteria to Reside (NCTR) bed days have also increased which will be contributing to reduced flow. No Criteria to Reside bed days associated with community waits have increased for the sixth consecutive week, corresponding to levels last seen in December 2022. There are significant constraints in flow associated with staffing in Bristol City Council Pathway 3, and Pathway 1 is also constrained across all LA's. Non recurrent funding has been agreed to purchase "bridging capacity" in home care to support patients moving from Sirona's Pathway 1 caseload whilst ongoing arrangements for their care are put in place by social care colleagues. • 329 patients were seen in Surgical SDEC (BRI) in September, a slight increase compared to August (324). Admission rate for SDEC attendances in September was 22.2%, a 3.1% decrease compared to August. • 570 patients were seen in Weston SDEC in September, a 10% improvement compared to 518 in August. Admission rate for SDEC attendances in September was 6.1%, a 1.5% decrease compared to August. A range of initiatives are being progressed across adult services to reduce overcrowding, ambulance queueing and long waits including: • 'check and challenge' events are being planned for November at BRI and Weston Emergency Departments, working with SWASFT to ensure that all appropriate clinical pathways are being accessed at the earliest opportunity as alternatives to conveyance to ED / hospital, and delays to handovers are minimised. • Two workshops have been held in September to support the co-design of new UHBW Internal Professional Standards relating to the patient journey from arrival to the hospital to the point of admission or discharge from ED. The outputs of the workshops are being collated to inform a draft set of new standards, which will be supported by a series of continuous improvement projects. • BRI are conducting a trial pathway to admit non-ambulant expected patients via medical SDEC to support decompression of ED majors. The initial pilot enabled a proportion of patients who would otherwise have been admitted, to be converted to Same Day Emergency Care. • A new triage process has been piloted in the minors end of ED at the BRI and formal evaluation is currently underway. Early findings suggest that the effectiveness of proposed process was significant impacted during periods of over-crowding due to increased presentation of higher acuity patients. • Weston Same Day Emergency Care (SDEC) surgical pathways are now available through an enhanced staffing model. Across an eight-day period there has been an estimated 72 hours of ED clinician time saved; and 36 patients have been streamed out of the Emergency Department and seen direct by specialty teams. • A new Emergency Department Observation Unit has launched in Weston in September, with four patient spaces. This aims to decompress ED for patients who are likely to be able to be discharged from the department but who do need longer than four hours for their treatment needs to be met. Initial data is showing that the unit has been regularly exceeding the initial target of eight patients per day. • A new 'Care Traffic Control' dashboard has now been developed by the clinical site management team; aiming to give greater oversight of patient flow, supporting site teams to minimise delays and enable swift admissions from ED.
Risks:	Corporate Risk 910: Risk that patients in ED do not receive timely and effective care 4700: Risk that a patient may deteriorate whilst being held in the ambulance bay

Performance Report

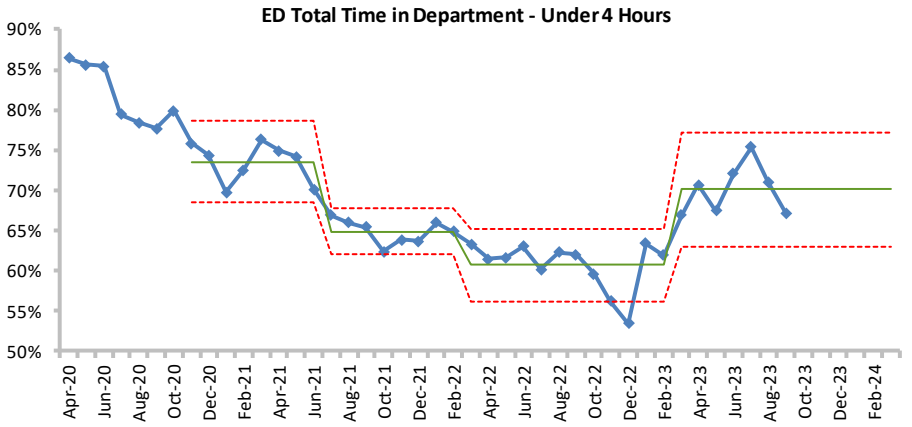
University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD **EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E**

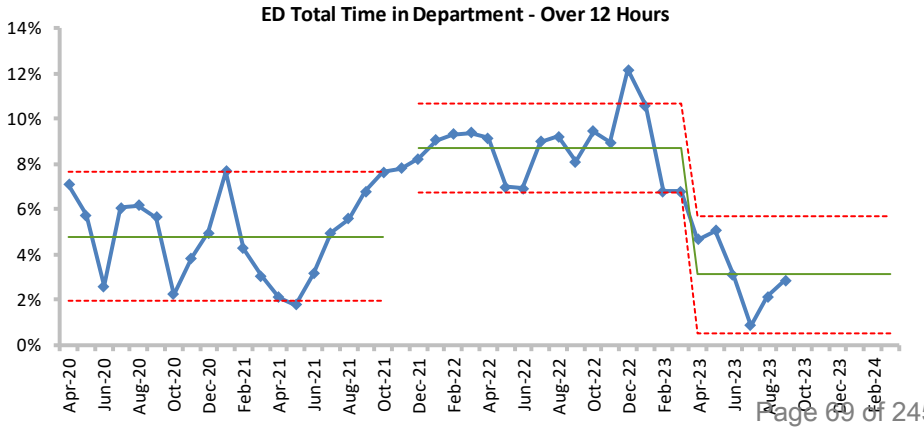
Patients Who Spend Under 4 Hours In ED (Arrival to Discharge/Admission)

4 Hour Performance	Sep-23	2023/24	2022/23
Bristol Royal Infirmary	53.75%	58.33%	46.14%
Bristol Children's Hospital	77.12%	82.72%	71.14%
Bristol Eye Hospital	94.9%	95.78%	95.97%
Weston General Hospital	65.02%	65.72%	55.05%
UHBW TOTAL	**67.2%**	**70.57%**	**60.94%**



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

12 Hour Performance	Sep-23	2023/24	2022/23
Bristol Royal Infirmary	3.1%	3.7%	12%
Bristol Children's Hospital	0.9%	0.7%	2%
Bristol Eye Hospital	0%	0%	0%
Weston General Hospital	5.5%	5.9%	15%
UHBW TOTAL	**2.8%**	**3.1%**	**8.7%**



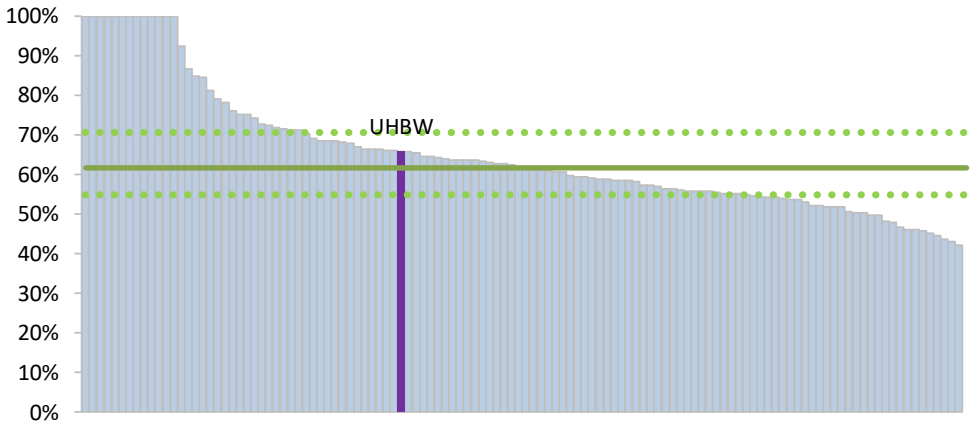
Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

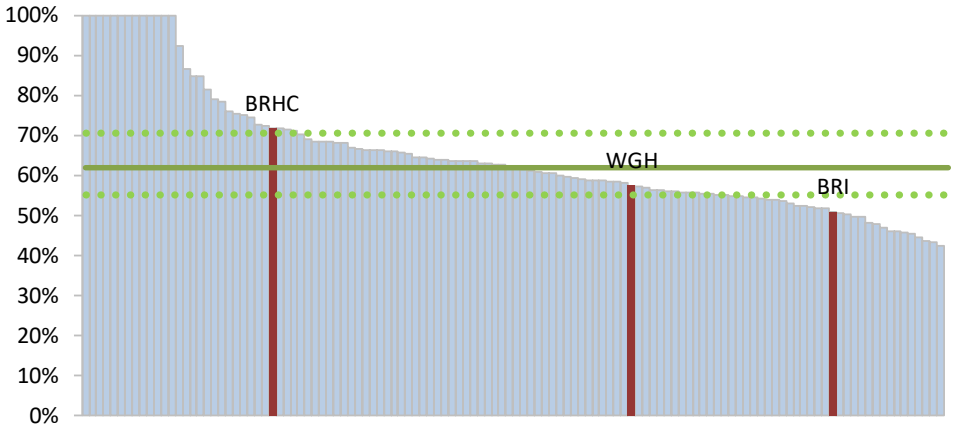
Reporting Month: Quarter 1

STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E

Benchmarking - Type 1 ED 4 Hour Performance 2023/24 Quarter 1



Benchmarking - Type 1 ED 4 Hour Performance 2023/24 Quarter 1



Performance Report

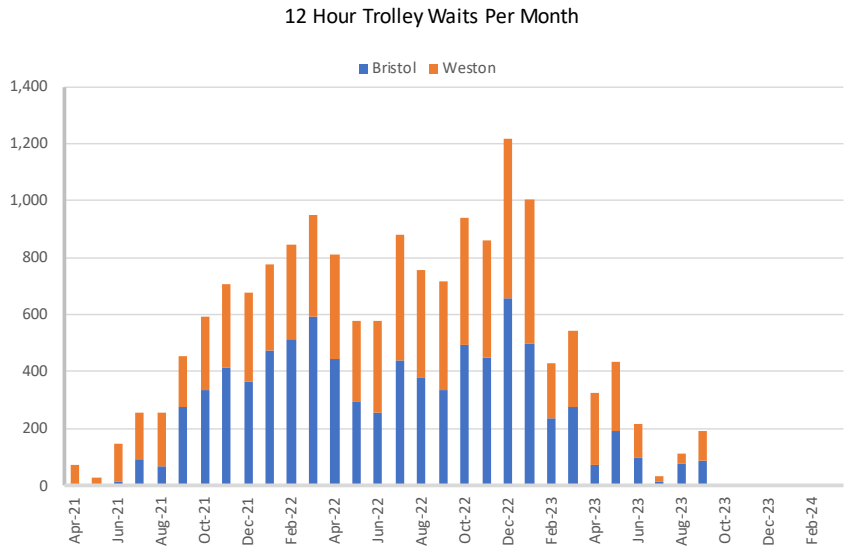
University Hospitals Bristol and Weston NHS Foundation Trust

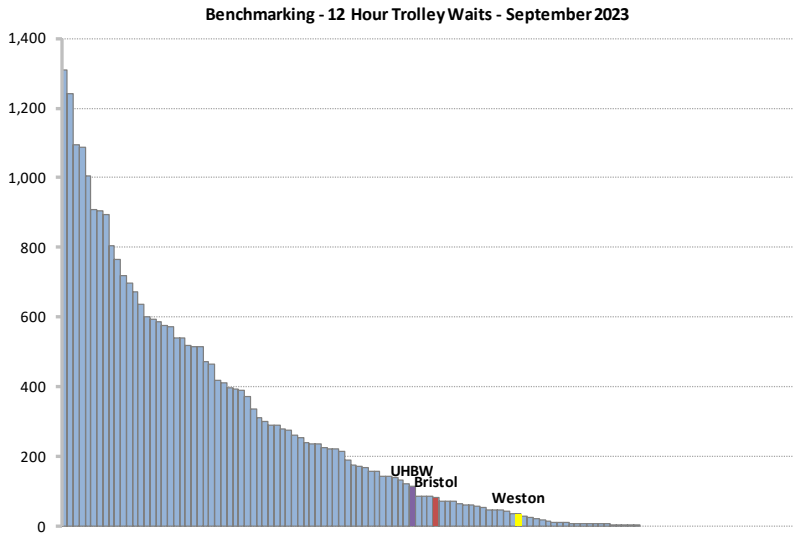
Reporting Month: September 2023

STANDARD **EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E**

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

	2022/2023												2023/2024											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Bristol	443	297	257	437	379	334	496	449	659	500	235	278	74	192	95	11	79	89						
Weston	366	282	319	441	379	383	445	413	558	506	192	267	250	243	119	23	33	104						
UHBW	**809**	**579**	**576**	**878**	**758**	**717**	**941**	**862**	**1217**	**1006**	**427**	**545**	**324**	**435**	**214**	**34**	**112**	**193**						





Performance Report

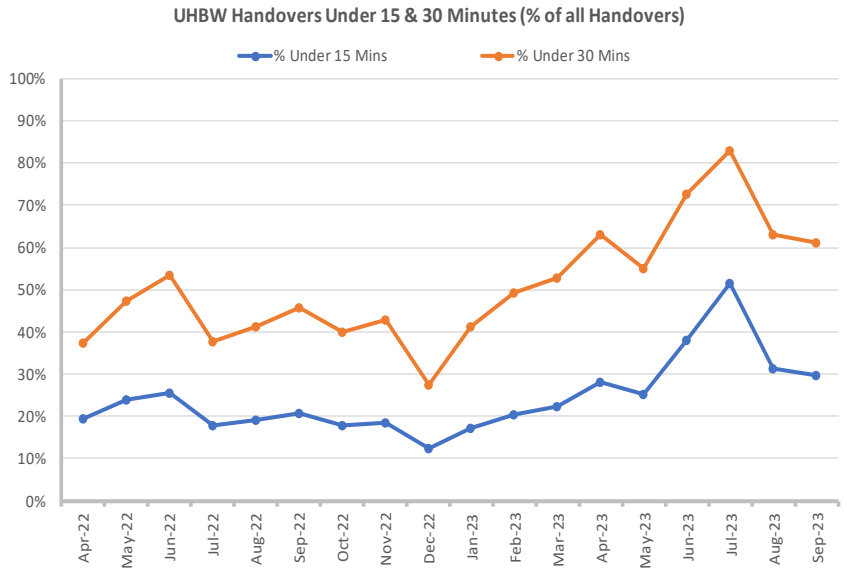
NHS University Hospitals Bristol and Weston NHS Foundation Trust

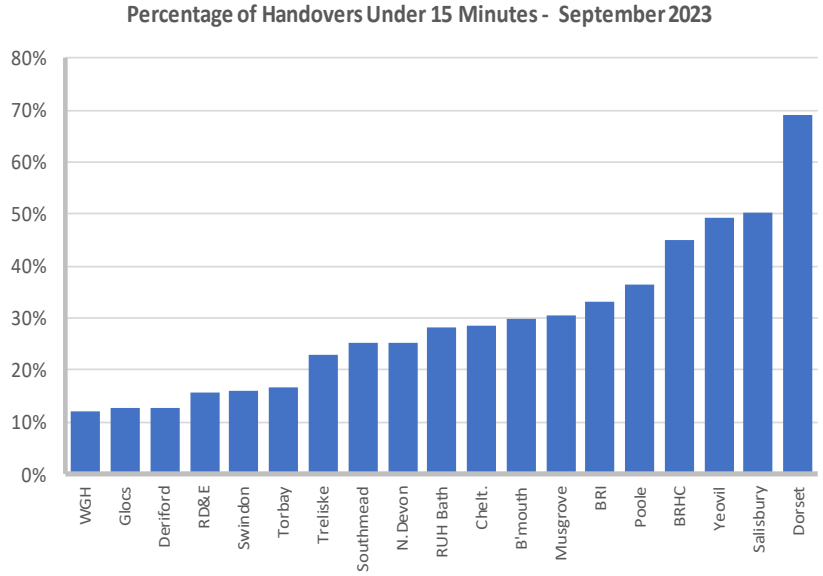
Reporting Month: September 2023

STANDARD **EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E**

Ambulance Handovers

	Sep-23				
	Total Handovers	**Under 15 Mins**	**% Under 15 Mins**	**Under 30 Mins**	**% Under 30 Mins**
Bristol Royal Infirmary	2,452	828	33.8%	1,505	61.4%
Bristol Children's Hospital	462	206	44.6%	381	82.5%
Weston General Hospital	962	117	12.2%	485	50.4%
UHBW Total	**3,876**	**1,151**	**29.7%**	**2,371**	**61.2%**





Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	EVERY MINUTE MATTERS
Background:	The Every Minute Matters (EMM) programme has four work streams. **1. Implementation of the SAFER bundle – including Estimated Date of Discharge EDD:** A bundle of principles that advocates best practice in optimising flow. It includes early senior review, flow of patients from admission units to downstream wards before 10am, timely discharges and daily review of all patients with a length of stay greater than seven days. **2. Proactive Board Rounds:** Focuses on implementing daily board rounds with a consistent structure that proactively progresses adult patients towards safe, timely discharge through effective multidisciplinary collaboration. **3. Criteria to Reside - Using the MCAP tool:** Comprises 11 nationally defined criteria to ensure patients who require acute care are in the most appropriate bed. The criteria identify where patients no longer require acute care and can be discharged safely to their home or within the community. MCAP is the digital system that determines whether a patient is in the right bed for their care, whether there is a delay in their pathway, and what their next care location should be. **4. Optimising use of the Discharge / Transition Lounge:** Optimising the use of the discharge lounge so that it is embedded as a routine part of the inpatient pathway - freeing acute beds early for new unplanned admissions and elective activity.
Performance:	Three metrics are reported as the high-level priorities: 1. Percentage of patients with a “timely discharge” (before 12 noon). September had 22.9% discharged before 12 noon (19.6% in August). The SAFER bundle standard is to achieve 33%, though we are reviewing this as there is no longer evidence that this produces a "best in class" outcome. Using the Patient First methodology, the focus is on timely discharge to identify actions which will bring the discharge curve forwards. 2. Percentage of patients discharged via the BRI or Weston Discharge Lounges. In September 30.7% of eligible discharges went through the Weston or BRI Discharge Lounges, compared to 27.3% in August. This was 668 patients, averaging 31.8 patients per working day– our highest this year. a. BRI achieved 32.0%, with 461 patients. This averages to 22.0 patients per working day. b. Weston achieved 28.0% with 207 patients. This averages to 9.9 patients per working day. 3. At the end of September there were 157 No Criteria To Reside (NCTR) patients in hospital: 82 in Bristol and 75 in Weston 4. During September, the daily average number of patients with no criteria reside was 142. This is equivalent to saying 142 beds, on average, were occupied each day by NCTR patients.

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD	EVERY MINUTE MATTERS - TIMELY DISCHARGE

Actions:	• Active Hospitals due to launch in November 2023, with focus on six ward of getting up and dressed in the morning and eating main meals at a table.
	• Weekend discharges: new workstream underway to establish a weekend discharges baseline review to include staffing, clinical pathways and operational services available during weekdays vs weekends.
	• Discharge lounge usage: new task and finish group commenced to support operationalisation of 24/7 model in BRI. In future membership will be expanded to include ward-based teams and WGH discharge lounge representatives. This group will be responsible for communication, data monitoring and improvement actions relating to discharge lounge usage.
	• Key Priorities for next year's Every Minute Matters (EMM) programme identified, including:
	  ○ Evolution of oversight and data reporting to ensure decision making is data driven (using Patient First methodology).
	  ○ Ensuring that clearly defined metrics are in place, developed, implemented and communicated.
	  ○ Plans to strengthen links between Digital Hospital Programme Board with EMM programme to ensure operational and clinical joint working relating to digital solutions.
	  ○ Alignment of EMM with other programmes including clinical accreditation and Home First.
	  ○ Develop and initiate EMM roll out plans for BRHC.
	• Value stream mapping for 'to take away' medications: Timed observations completed on A524 in BRI in September. Reviewed data from Pharmacy Informatics to aid in value stream mapping calculations. Analysis of data and observations is underway.
	• Tap to Transfer (digital bed management): pilot launched in September to use Tap to Transfer for inpatient-to- inpatient transfers within medicine. Next phases in planning stage.
	• Scoping working underway to determine any opportunities for improvement in bed turnaround / bed idle times.
	• Criteria Led Discharge (CLD), additional pathways now being explored in acute medicine wards.
	• Work underway to align, where possible, criteria for admission for no criteria to reside wards to support timely flow.
	• Scoping work completed to review ward criteria SOPs. Findings to be presented in October for further discussion and agreement of next steps.
	• Proactive Board Rounds: observation of all current adult board rounds almost complete, focused action plan to be put in place at a divisional level. Continue joint working with Home First team to ensure consistency and embedding of processes.

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

Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

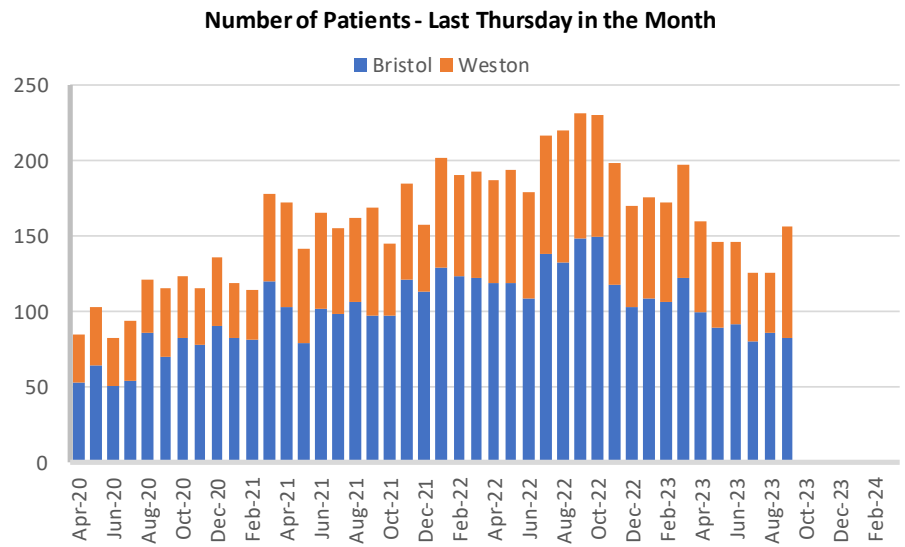
STANDARD	EVERY MINUTE MATTERS - NO CRITERIA TO RESIDE (NCTR) AND TRANSFER OF CARE HUB (ToCH)
Actions:	A programme of continuous improvement is in place, managed through the Trust's Integrated Discharge Group, which mirrors the Every Minute Matters core principle of respecting patients' time. This includes actions to reduce the number of people waiting in hospital for onward care, and the number of days they are delayed for. • Reduction in NCTR length of stay (particularly for the longest waiting patients), through weekly multi-disciplinary team (MDT) escalation reviews. • Establishing two Transfer of Care Hubs with system partners at BRI and Weston, with c85% of new UHBW colleagues in post, and partner colleagues coming in to post over the coming weeks and months. • A significant focus on the Transfer of Care Hubs is on transformation and improvement, with the following initiatives underway: ○ Pan BNSSG pathway redesign workshops conclude at the end of October and will result in findings being shared and a programme of improvement agreed on by all Transfer of Care hub partners (statutory and voluntary sector). ○ Learning and support from Barnsley Local Authority (cited as the best nationally for hospital discharge). Work is underway to frame the improvement actions we want to implement across BNSSG based on a recent visit to Barnsley. ○ Acute therapies and discharge team workshops (UBW and NBT joint events) to align and describe our acute Trust approaches to discharge and working with partners in the Transfer of Care Hubs. ○ Implementation of the D2A winter plan, including additional bridging capacity in Pathway 1 and spot purchased beds on Pathways 2 and 3. ○ Further PDSA cycles of the navigation process, taking learning from the recent UHBW event at Weston and NBT event at Southmead – the aim is to engender a "homefirst" approach across all teams and reduce reliance on bed-based acre on discharge.
Risks:	6789 and 6788: Risk that a Bristol and Weston location for Transfer of Care Hub site will not be found 6874: Risk that ways of working are not changed ToCH partners will operate in silo impeding the teams ability to discharge patients.

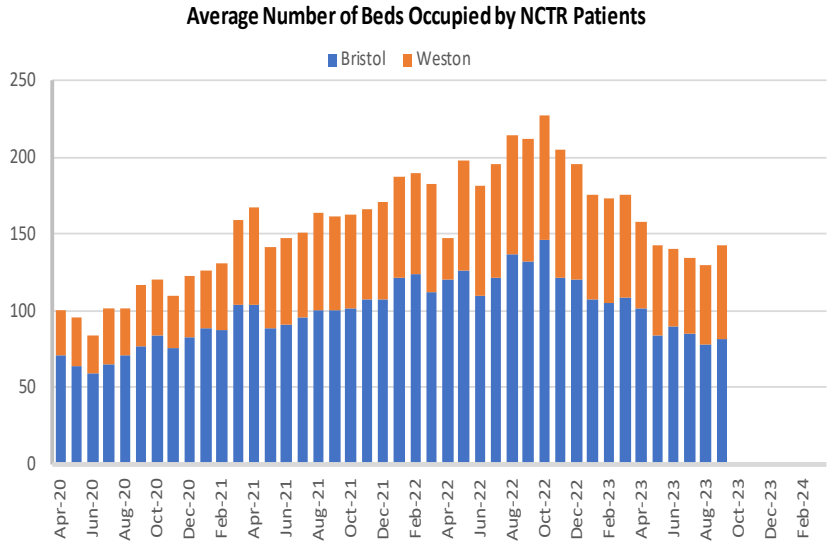
Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

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





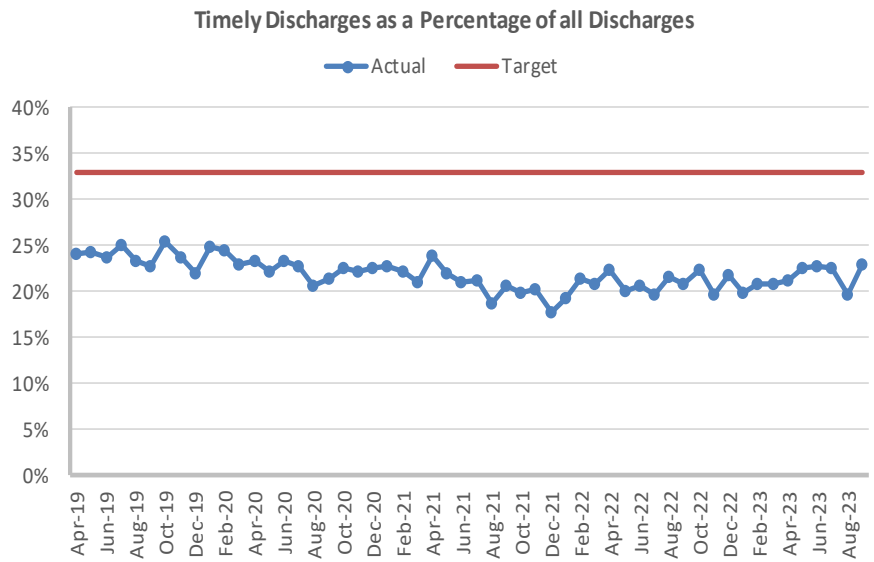
Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD **EVERY MINUTE MATTERS - TIMELY DISCHARGE**

Timely Discharge (Before 12 Noon)



Summary of High Volume Specialties - September 2023

	Total Discharges	% Before Noon
Cardiac Surgery	96	12.5%
Cardiology	339	18.9%
Clinical Oncology	78	30.8%
Colorectal Surgery	92	12.0%
ENT	105	24.8%
Gastroenterology	119	14.3%
General Medicine	672	22.3%
General Surgery	242	17.4%
Geriatric Medicine	211	50.2%
Gynaecology	133	31.6%
Ophthalmology	85	32.9%
Paediatric Surgery	91	35.2%
Paediatrics	207	18.4%
Thoracic Medicine	126	22.2%
Trauma & Orthopaedics	194	22.7%
Upper GI Surgery	43	20.9%
UHBW TOTAL	**3,836**	**22.9%**

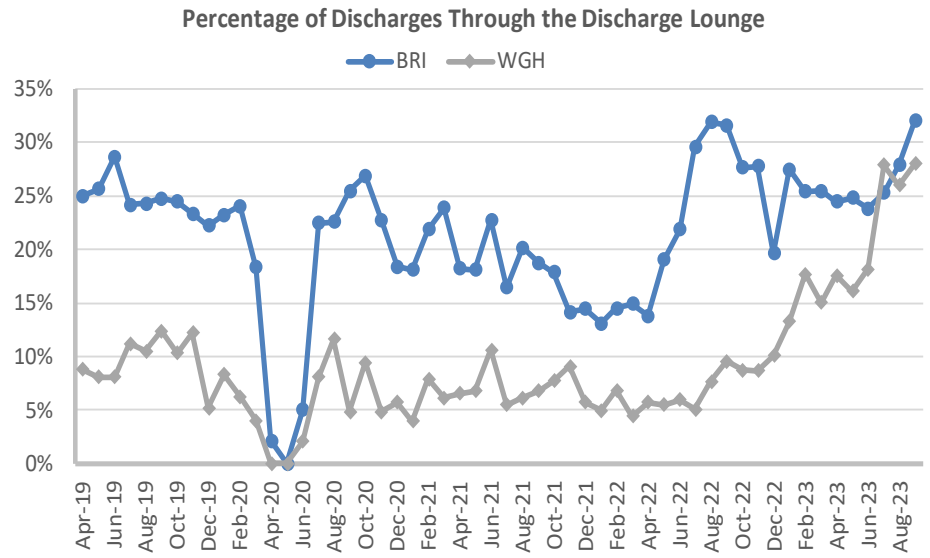
Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

STANDARD **EVERY MINUTE MATTERS - TIMELY DISCHARGE**

Discharge Lounge Use Summary



Summary of High Volume Specialties - September 2023

	BRI	WGH	TOTAL
Accident & Emergency	2.3%	12.5%	3.8%
Cardiac Surgery	79.2%	-	79.2%
Cardiology	53.0%	33.3%	51.9%
Colorectal Surgery	20.7%	37.5%	22.7%
ENT	10.6%	-	10.6%
Gastroenterology	12.9%	37.5%	30.1%
General Medicine	30.2%	22.6%	25.2%
General Surgery	8.7%	30.6%	16.9%
Geriatric Medicine	48.4%	41.2%	47.8%
Hepatobiliary and Pancreatic Surgery	40.5%	-	40.5%
Maxillo Facial Surgery	14.3%	-	14.3%
Thoracic Medicine	20.3%	16.3%	18.6%
Thoracic Surgery	20.5%	-	20.5%
Trauma & Orthopaedics	23.4%	48.2%	36.4%
Upper GI Surgery	39.1%	33.3%	37.9%
UHBW TOTAL	**32.0%**	**28.0%**	**30.7%**

Performance Report

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: September 2023

FINANCIAL SUMMARY

YTD Income & Expenditure Position	• Net I&E deficit of £12,419k against a deficit plan of £6,202k (excluding technical items). • Total operating income is £15,579k favourable to plan due to higher than planned income from activities of £12,097k and higher than planned other operating income of £3,482k. • Operating expenses are £23,676k adverse to plan due to higher pay expenditure (£14,913k) and non-pay expenditure (£8,844k). Depreciation is broadly in line with plan. • The estimated cost of industrial action for May to September (at £3,223k) remains unfunded by NHSE. • Financing items are £2,062k favourable to plan mainly due to interest receivable.
Key Financial Issues	• *Recurrent savings delivery below plan* – Internal CIP delivery is £8,938k or 95% of plan, of which recurrent savings are £3,773k, 40% of plan. Failure to achieve the annual target of £27m (including transformational savings) in full will result in the Trust failing to meet the financial plan. • *Delivery of elective activity recovery below plan* – elective activity must be delivered in line with plan. Failure to do so will result in a loss of income of up to c£30m, resulting in the Trust not achieving its financial plan. At M6, the value of elective activity is £2.8m behind plan. • *Corporate mitigations not delivered in full* – non-recurrent mitigations of c£25m must be achieved to support delivery of the plan. At M6, the corporate mitigations are on track. • *Failure to deliver the financial plan* – failure to deliver the actions and therefore the financial plan of break-even will constitute a breach of this statutory duty and will result in regulatory intervention.
Strategic Risks	• Assessment and implications of the financial arrangements relating to Healthy Weston 2 Phase 2 – pending completion of the business case; • Understanding the operational risks and mitigations associated with the Trust's legacy estate and how the CDEL limit and system prioritisation restricts future strategic capital investment – pending completion of the ICB and Trust draft medium term capital plan in November 2023; • Understanding the implications of the Trust's recurrent revenue deficit of c£60m, i.e. the requirement to present a medium-term financial plan in November 2023 to address the Trust's recurrent deficit and the impact this will have on future clinical strategy and Trust autonomy.

Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: September 2023

TRUST YEAR TO DATE FINANCIAL POSITION

Trust Year to Date Financial Position

	Month 6			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	84,761	86,452	1,691	502,075	514,172	12,097
Other Operating Income	8,416	9,866	1,450	54,781	58,263	3,482
Total Operating Income	**93,177**	**96,318**	**3,141**	**556,856**	**572,435**	**15,579**
Employee Expenses	(55,954)	(59,472)	(3,518)	(338,342)	(353,255)	(14,913)
Other Operating Expenses	(32,473)	(34,346)	(1,873)	(202,412)	(211,256)	(8,844)
Depreciation (owned & leased)	(3,078)	(2,995)	83	(17,684)	(17,603)	81
Total Operating Expenditure	**(91,505)**	**(96,813)**	**(5,308)**	**(558,438)**	**(582,114)**	**(23,676)**
PDC	(1,037)	(1,037)	0	(6,222)	(6,223)	(1)
Interest Payable	(221)	(224)	(3)	(1,326)	(1,375)	(49)
Interest Receivable	250	546	296	1,500	3,732	2,232
Other Gains/(Losses)	0	(97)	(97)	0	(120)	(120)
Net Surplus/(Deficit) inc technicals	**664**	**(1,307)**	**(1,971)**	**(7,630)**	**(13,665)**	**(6,035)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	238	154	(84)	1,428	1,246	(182)
Net Surplus/(Deficit) exc technicals	**902**	**(1,153)**	**(2,055)**	**(6,202)**	**(12,419)**	**(6,217)**

Key Facts

- The position at the end of September is a net deficit of £12,419k against a deficit plan of £6,202k. The adverse position against plan of £6,217k, a deterioration from last month of £2,055k.
- The adverse variance is due to the estimated cost of industrial action for May to September at £3,223k, a shortfall on Elective Recovery Funding of £2,700k, a shortfall on savings delivery of £2,601k offset by interest receivable at £2,232k.
- YTD, the Trust has spent £3,715k on costs associated with Internationally Educated Nurses (IENs).
- Pay expenditure in September is £2,843k lower than last month, overall, broadly in line with last month, excluding the medical pay award. Additional staffing costs of covering the industrial action (£538k), were offset by lower bank and agency costs.
- Agency expenditure in month is £2,080k, compared with £2,333k in August. Bank expenditure in month is £3,416k, compared with £3,742k in August.
- YTD, pay expenditure is £14,913k above plan, due mainly to costs of industrial action (£3,957k), medical pay award (£3,000k) and a higher number of substantive staff in post.
- Total operating income is £3,141k higher than plan in August. c£1,700k is as a result of income from commissioner investments being higher than planned and c£1,500k relates to various sources of other operating income.
- The financial position of the clinical divisions deteriorated by £1,450k in September to a YTD overspend against budget of £9,861k or 2.2%. Excluding the cost of industrial action, this reduces to £6,006k or 1.3%. Estates and Facilities improved, ending the month £599k or 1.8% over budget, excluding industrial action.
- Surgery (£569k), Women's & Children's (£345k) and Medicine (£223k) had the largest deterioration during the month.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Trust Board of Directors in Public on Tuesday 14th November 2023

Report Title	**Maternity Perinatal Quality Surveillance Matrix with Maternity Incentive Scheme (MIS) Monthly Update**
Report Author	**Sarah Windfeld Director of Midwifery and Nursing, Jo Mockler Quality and Patient Safety Manager**
Executive Lead	**Deirdre Fowler Chief Nurse and Midwife**

1. Purpose

This report provides the trust board with monthly oversight regarding the safety metrics of the maternity and neonatal services for the month of September 2023.

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

Work towards year 5 CNST standards now progressing. Safety standard 6 (Saving Babies Lives Care Bundle 3) and safety standard 8 (training) identified as posing significant capacity and funding implications. Completion of all standards is essential to meet to ensure CNST compliance.

Implementation of the Maternity IT system Badgernet went live on the 26th of September.

With effect from the 1st of October 2023 the Healthcare Safety Investigation Branch (HSIB) will be known as the Maternity and Newborn Safety Investigations programme (MNSI).

3. Strategic Alignment

This report forms part of the divisional reporting requirement which supports the delivery of safer maternity care. This reflects the Trusts priority of Patient Safety within the Patient First True North Strategy.

4. Risks and Opportunities

Risk (3553) of not achieving CNST standards due to new Saving Babies LIVES Care Bundle and new training requirements.

Work with North Bristol Trust on implementing 3-year delivery plan is an opportunity for more equity of service for women in BNSSG.

5. Recommendation

This report is for Assurance

Board is asked to note this report for information and assurance.

6. History of the Paper

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

Quality Outcomes Committee	31st October 2023

Maternity Perinatal Quality Surveillance Matrix with Maternity Incentive Scheme (MIS) Monthly Update

1. Purpose

1.1. This report provides the trust board with monthly oversight regarding the safety metrics of the maternity and neonatal services for the month of September 2023. It also provides any progress with the implementation of Ockenden Immediate and Essential Actions (IEAs) recommendations and progress/concerns relating to the current Maternity Incentive Scheme (MIS) year.

2. Context/Background

2.1. This report is a standing agenda item as per the recommendations set out in the Maternity Incentive Scheme (MIS) Year 5 and the NHS England report, *Implementing a revised perinatal quality surveillance model.*

3. Healthcare Safety Investigation Branch (HSIB)

There were 3 x new HSIB referral during September.

MI-033285 - Early neonatal death. Baby transferred to UHBW NICU from Swindon (initially for therapeutic cooling) following a traumatic birth, care withdrawn on day 6. This case was also subsequently reported by Swindon (ref: MI-033318) – Swindon referral to be progressed to investigation – UHBW referral closed.

MI-033191 - HIE/Therapeutic Cooling. Decision for Category 1 EMC for fetal distress, delay in utilising 2nd theatre out-of-hours, baby born in poor condition, therapeutic cooling commenced, this was subsequently discontinued, and the Baby was transferred to PICU to start ECMO, airlifted to Leicester for ongoing care. – Case accepted by HSIB

MI-033913 - Intrapartum stillbirth. Mother on low-risk pathway, attended on 3 occasions for early labour assessment over the course of a week. Intrapartum stillbirth diagnosed on last admission. – Case accepted by HSIB

There are 4 x active HSIB investigation ongoing, these are:

MI-030250 / Datix 213315 – Maternal Death

MI-030084 / Datix 224302 – HIE/Therapeutic Cooling

MI-029754 / Datix 223909 – HIE/Therapeutic Cooling

Draft report for **MI-027213** / Datix 218689 – Intrapartum Stillbirth received on the 20th of September and circulated for comments.

4. Trust PSII

1 x Trust PSII accepted by central investigation team on the 25/09/2023

Datix 226882 – Mother identified with hypernatremia during labour, and neonatal hypernatremia diagnosed following birth. Evidence of a stroke seen on the baby's MRI. Care concerns identified relating to the management of fluid balance during labour.

5. SWOT

Strengths	Deputy Divisional Director of Midwifery and Nursing appointed. Interview dates planned for Band 7 Quality and Patient Safety Gynae Lead, and Band 6 Quality and Patient Safety Midwife Additional funding secured (initially until March 2024) for a Band 6 (wte 0.5) Bereavement Midwife to support the Snowdrop team.
Weaknesses	Band 6 Quality and Patient Safety Midwife vacancy. Band 7 Quality and Patient Safety Nurse (Gynae) vacancy from 18th August. Compliance for obstetric training remains below target. Training booked for all staff and reassurance that 90% compliance will be met by January 2024.
Opportunities	Shared saving babies lives 3 workstream with North Bristol Trust to unify fetal growth surveillance pathway. LMNS plan to review PPH rates in conjunction with North Bristol Trust, with aim to identify local learning opportunities. HSIB maternity programme to move under CQC from October 2023.
Threats	Saving Babies Lives Care Bundle 3 published which has implications for scan capacity and will need discussion with obstetrics and Diagnostic and Therapies Division about investment in capacity including issues around physical space, extended hours, staffing, additional equipment, and training of staff (re uterine artery Dopplers). The new training requirements specified within MIS safety action 8 post require a significant increase in the volume of training provided - (from 2 days to 5 days per clinician). Gaps in QPS team due to staff movement. Challenging Midwifery staffing levels due to vacancies and sickness over the summer period.

6. PQSM

See attached.

7. Perinatal Mortality

In 2021 the adjusted extended perinatal mortality rate was 6.69 (5.01 excluding congenital abnormalities).

The **crude** extended perinatal mortality rate for October 2022 to September 2023 was 6.25.

8. Ockenden Immediate and Essential Actions (IEA's)

IEA	Completed and evidenced	Blue (Completed, not yet evidenced)	Green	Amber	Red	Total actions
1	0	10	0	0	0	10
2	1	10	0	0	0	11
3	2	3	0	0	0	5
4	1	2	4	0	0	7
5	1	0	4	2	0	7
6	0	0	0	3	0	3
7	7	0	3	0	0	10
8	0	0	12	5	0	17
9	0	0	4	0	0	4
10	2	0	3	1	0	6
11	0	0	5	0	0	5
12	0	4	0	0	0	4
13	2	1	0	2	0	5
14	4	0	0	4	0	8
15	0	0	0	1	0	1
TOTAL	20	30	35	18	0	103

We currently have no IEA's that require immediate remedial action (red).

There are currently 20 completed and evidenced actions.

There are currently 30 Blue actions which means the action is completed pending evidence review and sign off.

There are currently 35 Green actions which means the action is on target, evidence to be collated.

There are currently 18 Amber actions which means that some action is still required, breakdown of outstanding Amber actions as follows:

IEA5: Clinical Governance – Incident Investigation and Complaints

IEA **5-3** Audit actions arising from a SI investigation which involve a change in practice must be audited to ensure a change in practice has occurred.

IEA **5-4** Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred. A Clinical Effectiveness Committee has been set up to monitor IEA 5-3 and 5-4.

IEA6: Learning from Maternal death

IEA **6-1** and IEA **6-2** There Ongoing discussion to decide if an independent panel looking into Maternal deaths needs to be set up by region.

IEA **6-3** Learning from reviews must be introduced within 6 months of the panel. - A Clinical Effectiveness Committee has been set up.

IEA8: Complex Antenatal Care

IEA **8-1** Ensure women referred for Consultant led care are seen by the right clinician at their initial appointment, at the right point in their pregnancy – There is improvement work ongoing in Antenatal Clinic with focus on right Consultant.

IEA **8-9** and IEA **8-10** Agree definition of formal risk assessment – LMS Response group has discussed this and is looking at how we evidence the risk assessments. Implementing Badger Net Sept 2023 which should address this.

IEA **8-11** Evidence that all women have a discussion at each appointment reviewing intended place of birth. An audit needs to be performed to evidence.

IEA **8-12** Develop, implement and embed into practice formal evidence of ongoing risk assessments throughout pregnancy- Awaiting Badger Net

IEA10: Labour and Birth

IEA **10-6** Centralised CTG monitoring systems. Ontrack to implement with Badger Net in September.

IEA13: Bereavement Care

IEA **13-1** Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.

IEA **13-4** National Bereavement Care Pathway - Signed up and action plan in place to implement by July 2023

IEA14: Neonatal Care

IEA **14-3** Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks' gestation taking place at a maternity unit with an onsite NICU. Action plan in place, some progress seen although remains inconsistent at present.

IEA **14-4** Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. Scoring tool being developed by the network, unable to provide evidence until tool approved and in use.

IEA **14-5** Each Network must report to commissioners annually what measures are in place to prevent units working in isolation. Southwest ODN developing template for the units in Southwest. Implementation due early 2024.

IEA **14-8** Sufficient appropriately trained consultants, tier 2 staff and nurses available in line with national service spec. There are 4 nights per week where we do not meet BAPM standards for number of middle grade staff. Action plan in place for investment and recruitment. Funding now available for nurses and recruitment commenced and unit should meet BAPM standards this year. Significant improved achieved during last 18 months, going from 0% compliant to being compliant 80% of the time. A case for another full time equivalent funded post needs to be made.

IEA15: Supporting Families

IEA **15-1** Clear pathways for families to get psychological support – Currently updating triage process to align with changes in Community services mental health and Perinatal mental health and have shared UHBW pathway documents for wellbeing triage clinics. Women's Psychological Heath Services and Liaison Psychiatry with the Perinatal Mental Health Services single point of entry.

9. Maternity Incentive Scheme

Work towards year 5 CNST standards now progressing. Safety action 6 (Saving Babies Lives Care Bundle 3) and safety action 8 (Training) identified as posing significant capacity and funding implications (see risk 3553, current score 16). Completion of all standards is essential to meet to ensure CNST compliance.

10. Quality and Improvement

PERIPrem progress made to identify optimal delivery rooms for pre-term deliveries, and audit ongoing to monitor temperature control of pre-term infants following birth.

Atain data for the start of Q2 shows admission rates to NICU of term infants remains within tart of 5%.

11. Recommendations

This report is for assurance.

NHS University Hospitals Bristol and Weston NHS Foundation Trust

UHBW perinatal quality surveillance matrix

	Jan	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Year to date average	Trend
Activity														
NICU admission rate at term (excluding surgery and cardiac) % target 5%	4%	5.7%	3.8%	2.90%	2.30%	2.10%	3.50%	Data pending	Data pending				0	
Number of babies born alive at >=22 to 26+6 weeks gestation (for regional team LMNS)	2	1	2	0	2	2	2	1	5				2	
Number of babies born alive at >=24 to 36+6 weeks gestation (MBRRACE)	30	20	25	29	26	32	38	25	34				29	
Number of women who gave birth all gestations from 22+0 weeks	377	333	367	337	385	362	351	365	345				358	
total number of registerable births from 22/40	386	337	371	341	389	371	359	368	356				364	
Induction of Labour rate %	40.2%	36.2%	33.4%	37.0%	32.6%	37.2%	40.1%	32.1%	30.7%				35.5%	
Unassisted Birth rate %	45.3%	47.2%	41.2%	51.3%	44.7%	43.9%	46.8%	40.2%	46.0%				45.2%	
Assisted Birth rate %	17.1%	17.8%	15.4%	13.5%	15.9%	15.4%	13.6%	16.0%	13.6%				15.4%	
Caesarean Section rate (overall) %	37.6%	35.0%	43.4%	33.4%	39.3%	40.7%	39.6%	43.8%	40.2%				39.2%	
Elective Caesarean Section rate %	17.4%	15.7%	18.9%	12.6%	18.0%	18.3%	15.3%	20.9%	18.8%				17.3%	
Emergency Caesarean Section rate %	20.2%	19.3%	24.5%	20.8%	21.3%	22.4%	24.2%	22.8%	21.4%				21.9%	
Perinatal Morbidity and Mortality inborn														
Total number of perinatal deaths (excluding late fetal losses)	4	3	1	1	4	1	1	0	3					
Number of late fetal losses 16+0 to 23+6 weeks excl TOP	5	0	5	6	7	3	2	3	0					
Number of stillbirths (>=24 weeks excl TOP)	1	0	0	0	2	1	0	0	1					
Number of neonatal deaths : 0-6 Days	1	3	1	1	0	0	0	0	1					
Number of neonatal deaths : 7-28 Days	2	0	0	0	2	0	1	0	1					
PMRT grading C or D themes in report	0	0	0	2	0	2	0	1	1					
Suspected brain injuries in term (37+0) inborn neonates (no structural abnormalities) (HSIB referral)	1	0	0	1	0	0	2	1	1					
Maternal Morbidity and Mortality														
Number of maternal deaths (MBRRACE)	1	0	0	1	0	0	0	0	0					
Direct causes	0	0	0	1	0	0	0	0	0					
Indirect causes	1	0	0	0	0	0	0	0	0					
number of women who received enhanced maternal care on CDS	22	28		27	27	27	Data pending	Data pending	Data pending					
Number of women who received level 3 care (ITU or CCU) * not pregnancy related	1	0	1	1	0	0	1	1	1					
Insight														
Number of datix incidents graded as moderate or above (total)	1	1	1	0	2	1	2	2	4					
Datix incident moderate harm (not PSII, excludes HSIB)	0	0	0	0	0	1	2	1	2					

Datix incident PSII (excludes HSIB)	0	1	0	0	0	0	0	1	0				
New HSIB referrals accepted	1	0	0	0	1	0	3	0	2				
Outlier reports (eg. HSIB/NHSR/CQC) or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0	0	0	0				
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0				
Workforce													
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained) BAPM standard is 70%	65%	57%	54%	55%	52.2%	52.8%	57.0%	Data pending	Data pending				
Datix related to workforce (service provision/staffing)	13	3	8	10	6	6	5	10	23				
Consultant Led MDT ward rounds on CDS (minimum 2 per 24 hours) day staff	100%	100%	100%	100%	100%	100%	100%	100%	100%				
Consultant Led MDT ward rounds on CDS with day to night staff handover	0%	86%	87%	83%	87%	87%	81%	87%	85%				
One to one care in labour (as a percentage)* excludes BBAs	100%	100%	100%	100%	100%	99.7%	99.7%	100%	98.5%				
Compliance with supernumerary status for labour ward coordinator	100%	100%	100%	100%	100%	100%	100%	100%	100%				
Number of times maternity unit attempted to divert or on divert	1	0	1	0	2	0	0	0	1				
in-utero transfers													
in-utero transfers accepted													
in-utero transfers declined	3	1	1*						5				
ex-utero transfers													
ex-utero transfers accepted	1	0	1	0	16	14	Data pending	Data pending	Data pending				
ex-utero transfers declined	1	0	3	0	0	0	Data pending	Data pending	Data pending				
NICU babies transferred to another unit due to capacity/staffing	2	0	1	1	0	0	Data pending	Data pending	2				
attempted baby abduction	0	0	0	0	0	0	0	0	0				
Number of consultant non-attendance to 'must attend' clinical situations	0	0	0	0	0	0	0	0	0				
Involvement													
Friends and family Test score (response rate % who rated 'very good' or 'good') NICU	100%	100%	100%	100%	100%	100%	100%	No Responses Recorded	Data pending				
Friends and family Test score (response rate % who rated 'very good' or 'good') maternity	98.3%	98.6%	100%	97.7%	98.9%	98.5%	97.6%	100%	Data pending				
Service User feedback: Number of Compliments (formal)	25	15	15	9	36	25	13	26	14				
Service User feedback: Number of Complaints (formal)	5	4	5	3	3	3	1	1	3				
Staff feedback from frontline champions and walk-abouts (number of themes)				3	4	4	0	0	3				
Improvement													
Progress in achievement of CNST /10	10	10	10	10	10	Analysis of new standards in progress	Analysis of new standards in progress	Work towards new standards in progress	Work towards new standards in progress				

Training compliance in maternity emergencies and multi-professional training (PROMPT) midwives* includes NBLS	95%	94%	93%	95%	94%	89%	88%	91%	93%				
Training compliance in maternity emergencies and multi-professional training (PROMPT) obstetricians* includes NBLS	77%	70%	77%	82%	76%	49%	49%	48%	65%				
Training compliance in maternity emergencies and multi-professional training (PROMPT) anaesthetists	91%	89%	78%	88%	81%	72%	70%	74%	47%				
Training compliance in maternity emergencies and multi-professional training (PROMPT)maternity care assistants* includes BNLS	85%	85%	78%	76%	77%	58%	61%	62%	74%				
Training compliance annual local NBLS (NICU) nurses	57%				82%	80%	85%	Data pending	Data pending				
Training compliance annual local NBLS (NICU) doctors	91%					91%	97%	Data pending	Data pending				
Training compliance fetal wellbeing day midwives	89%	89%	88%	89%	79%	58%	58%	61%	61%				
Training compliance fetal wellbeing day doctors	79%	79%	79%	83%	75%	40%	40%	33%	32%				
Training compliance core competency 4. personalised care			85%		89%	90.4%	90.3%	90.3%	90.4%				
Continuity of Carer (overall percentage)	37%	40%	39%	35%	36%	42%	36.5%	39.8%	41.5%				
Trust Level Risks (number shared with LMNS)* score 12 or >	9	9	9		14	15		12	17				

Meeting of the Trust Board of Directors in Public on Tuesday 14 November 2023

Report Title	**Summary of recently published National Patient Survey Results for UHBW**
Report Author	**Matthew Areskog, Head of Experience of Care and Inclusion**
Executive Lead	**Professor Deirdre Fowler, Chief Nurse and Midwife**

1. Purpose

To summarise the findings and provide assurance to Board on improvement activity relating to three recently published National Patient Survey Results for UHBW (Urgent and Emergency care (UEC), Cancer care and Inpatient care).

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

2022 National Urgent and Emergency Care Survey (patients seen Sep 2022)

Despite the increased demand on urgent and emergency care in 2022, the BRI Emergency Department (ED) received a positive set of results in the survey which were above the national average in almost all 'sections' of the survey. For overall experience of care, the BRI ED ranks 9th out of 122 Trusts with a score of 8.1 out of 10, a result within the top 10% nationally.

WGH ED did not meet the eligibility criteria to participate in the National Survey as they are not open 24/7, however a local survey was undertaken that mirrored the national survey question set. WGH ED results in the 2022 local survey show a fall in the score for the overall experience of care question to 77.5% (from 84% in the 2021 results). This is likely attributable to high demand on the service during this period which has resulted in longer waiting times to be seen, i.e. many of the questions that have a lower score in 2022 (compared to 2021) have a theme of 'waiting'. Please note that Friends and Family Test data from 2023/24 (to date) suggests an improvement in this position for WGH ED with scores above the national FFT benchmark for EDs.

The briefing report is found at Appendix A. An experience of care improvement plan is in place for BRI ED and WGH ED and can be found as an appendix to the report.

2022 National Cancer Experience Survey (patients seen April to June 2022)

Patients scored the Trust 8.9 out of 10 for the 'overall experience of care' question. This result places UHBW 60th out of 131 Trusts (where 1st is the top rating) and in line with the national average. This is a similar position to the 2021 results.

The results indicate themes of good practice across UHBW, including care planning to meet patient's needs, care quality and treatment and the quality of staff.

The lower scoring areas relate to the themes of providing clear and timely treatment related information (in particular on long-term side-effects), providing more information to inform treatment decision and involvement in research opportunities. In addition access to support from GP practices, community and voluntary services scored comparatively low.

The briefing report is found at Appendix B. An experience of care improvement plan is in place for cancer care and support services and can be found as an appendix to the report.

2022 National Inpatient Survey (patient admissions during November 2022)

In terms of the 'overall experience' question, UHBW ranks 34th out 133 Trusts with a score of 8.3 out of 10 which is an encouraging and positive improvement on our 2021 results (where the Trust ranked 56th with a score of 8.2). This result places UHBW amongst the highest scoring Trusts in the South West region. UHBW receives an overall report for the Trust as a whole; however, the report provides a breakdown by hospital site where there are enough responses (in this case the BRI and WGH). Looking at the results at this level reveals a positive increase in the overall experience score for WGH, which ranked 112th out of 230 hospital sites that were part of NHS Trusts that participated - a performance that is now in line with the national average (compared to 157th in the 2021 results).

The main areas for improvement identified from the results are similar to the priority areas in the action plan created following the publication of the 2021 results. These are listed below. The report (Appendix C) provides detail on the improvement work planned for these areas.

- Improving communication and support pre/post discharge;
- Ensuring patients get help to wash and keep clean when they need it
- Improving the quality and choice of food to meet the nutritional needs of patients.

Improving experience of care for inpatients is a Patient First strategic priority area and some Divisions (subject to ‘Catch-ball’) will therefore have this as an area of focus over the next 12-18 months.

Benchmarking
A summary of national survey performance for UHBW can be found on page three.

3. Strategic Alignment

This work aligns to the True North Experience of Care strategic priority. In particular for inpatient services which are in scope as part of the Breakthrough Objective to focus on improved communication with patients and between staff.

4. Risks and Opportunities

In many cases, National Patient Survey responses (and in our local surveys) are not representative of the patient population that UHBW serves and we know from national evidence and the data we do have that the experience of some groups are poorer, i.e. there are inequalities in experience of care. The True North Experience of Care priority will focus on understanding and improving the experience of all groups in the diverse local population.

5. Recommendation

This report is for **Assurance**. The Board is asked to note the findings of the National Patient Survey reports and associated action plans (the corporate monitoring of which takes place via Experience of Care Group).

6. History of the paper

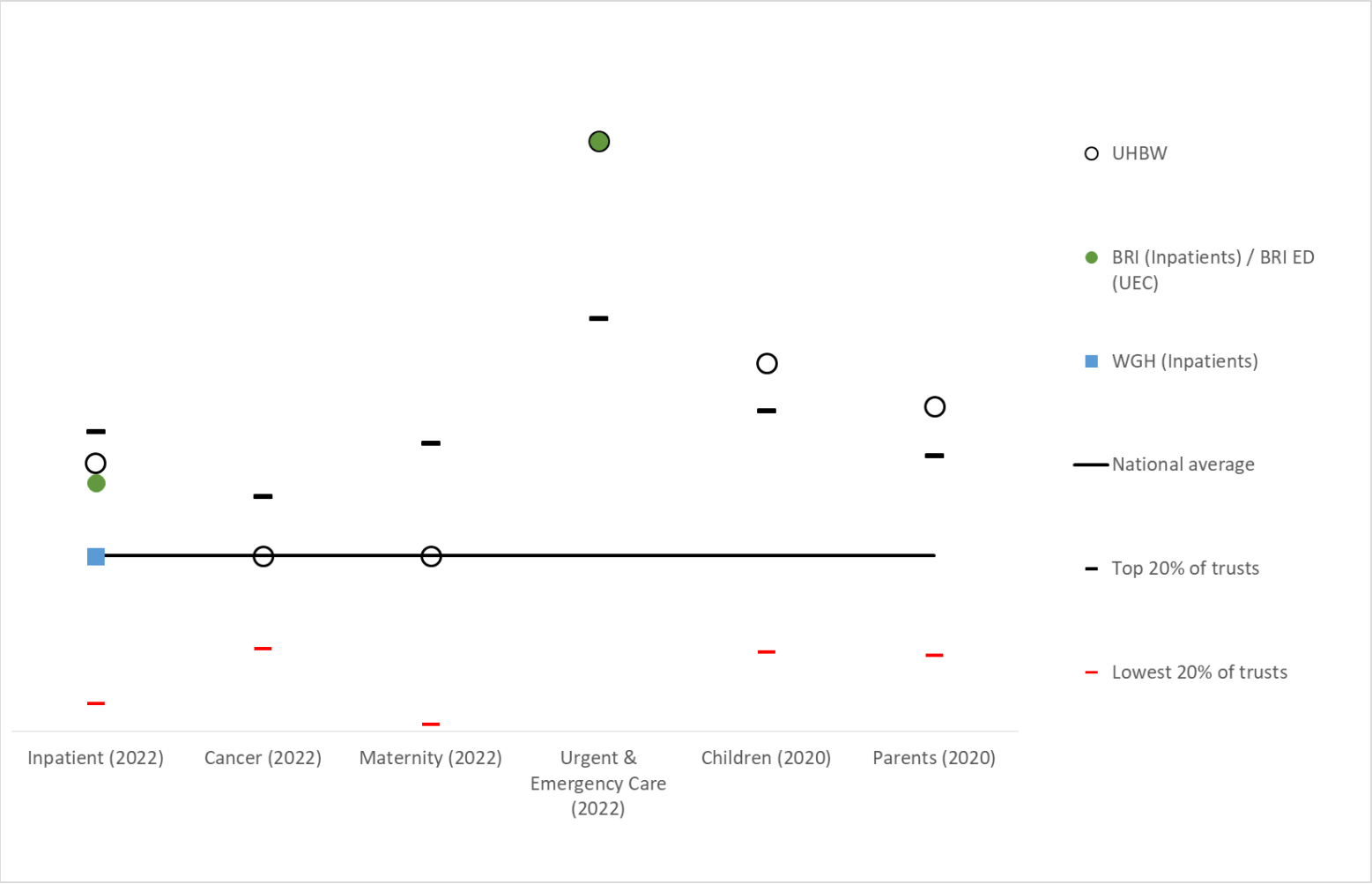
Please include details of where paper has <u>previously</u> been received.

Experience of Care Group	17/08/2023 (Urgent Care Survey), 21/09/2023 (Cancer Survey), 19/10/2023 (Inpatient Survey).
Clinical Quality Group	04/10/2023 (Urgent Care & Cancer Survey), 01/11/2023 (Inpatient Survey).

National Patient Survey Benchmarking

What does this tell us?

UHBW performs in the top 10% of Trusts nationally in the National Urgency and Emergency Care Survey (BRI ED) and in the top 30% of Trusts for the Inpatient survey. UHBW performs in line with the national average in the Cancer and Maternity experience surveys. In the 2020 Children and Young People survey (this survey is next due to take place in 2024), UHBW performed in the top 20% of Trusts.
The next surveys to be published (both in November) are the 2022 National Under-16 Cancer Experience Survey and the 2023 National Maternity Survey results.



Appendix A: Briefing report for the 2022 National Urgent and Emergency Care (UEC) Patient Survey Results for BRI ED and 2022 Local UEC Patient Survey Results for WGH ED

1. National Survey methodology and national context

The National Urgent and Emergency Care (UEC) Survey takes place every two years and is part of the Care Quality Commission's (CQC) national survey programme. In total, 122 NHS trusts participated in the 2022 survey. Patients were eligible to receive a questionnaire if they were aged 16 years or older and had attended a Type 1 or Type 3 Emergency Department[1] during September 2022. The data is for University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and primarily covers attendances at the Bristol Royal Infirmary Emergency Department (BRI ED)[2].

A questionnaire was sent by post to 1250 patients that had attended the Bristol Royal Infirmary ED, with 196 responses received; a 16% response rate compared to 23% nationally[3]. Separately, a local survey with the same question set was run for patients seen at Weston General Hospital emergency department (WGH ED) and these results are covered separately in this report[4]. Results for the local WGH ED survey are not comparable with the national survey due to the demographic weighting (on age and sex) that is applied by CQC to scores on the national set of results.

At a local and a national level, demand on urgent and emergency care services was escalating and remained high for sustained periods during 2022. At a national level, the survey results show that patient's experiences or urgent and emergency care was worse in 2022 than in 2020 with a decline seen for all questions evaluating care. Although people surveyed remained broadly positive about their interactions with staff, the 2022 results show a decline in positivity for every question asked where a historical comparison is available.

2. Headline results for BRI ED

The BRI ED achieved the following headline results in the survey:

- 9th out of 122 Trusts for overall experience (8.1) which is top 10% performance (compared to 25th highest score in the 2020 results). *Please note the score of 8.1 is lower than the score of 8.5 achieved in the 2020 results which mirrors the decline in experience seen at a national level.*
- The overall experience score was second highest in the South West region and second highest for large city-centre acute trusts.
- The highest experience score nationally for the 'Care and Treatment' section (i.e. a group of questions)
- The 3rd highest experience score nationally for the 'Respect and Dignity' section
- Better than the national average for 11 questions:
    - Q10. Were you kept updated on how long your wait would be?
    - Q11. While you were waiting, were you able to get help with your condition or symptoms from a member of staff?
    - Q17. Did you have confidence and trust in the doctors and nurses examining and treating you?

[1] Type 1 Departments are defined as "consultant led 24 hour service with full resuscitation facilities and designated accommodation for patients".
[2] Just three patients in the survey sample had attended the Bristol Royal Hospital for Children Emergency Department.
[3] The response rate calculation excludes questionnaires that could not be delivered.
[4] Weston General Hospital emergency department does not fall into the type 1 or type 3 department criteria for this survey

- Q21. While you were in A&E, did staff help you with your communication needs? (e.g. any language needs or communication needs related to a disability, sensory loss or impairment).
- Q23. Were you given enough privacy when being examined or treated?
- Q24. If you needed attention, were you able to get a member of medical or nursing staff to help you?
- Q30. Do you think the hospital staff did everything they could to help control your pain?
- Q33. Were you able to get suitable food or drinks when you were in A&E?
- Q44. After leaving A&E, was the care and support you expected available when you needed it?
- Q46. Overall, did you feel you were treated with respect and dignity while you were in A&E?
- Q47. Overall patient experience

- There were no questions we score worse than the national average
- Results were about the same as other Trusts for the remaining 26 questions

The full set of results is available from the NHS Surveys website here

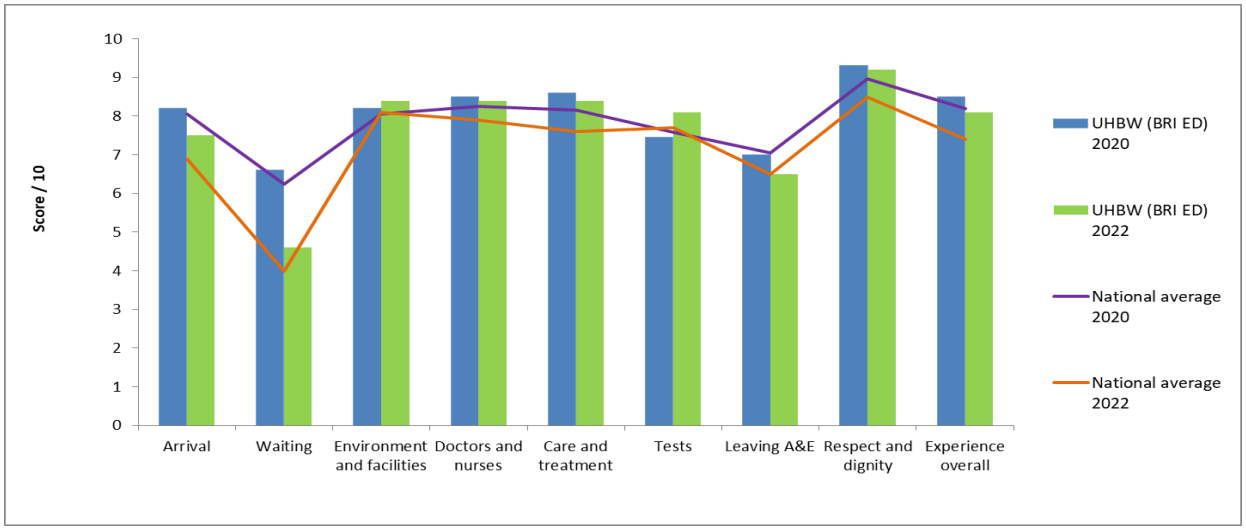
3. Analysis of the BRI ED survey results

Chart 1 shows the key touchpoints of an "average" patient experience journey at the BRI ED for patients attending in September 2022 (i.e. the period covered by the national survey). These touchpoints are calculated in sections based on the average of a cohort of related question scores in the survey.

In every section of the care pathway, the 2022 results for BRI ED are above the national average, with the exception of the 'leaving A&E' section where BRI ED performs in line with the national average.

There has been a decline in the UHBW experience scores for almost every section of the care pathway. Whilst these declines are evident, in most cases, the rate of decline is less than that seen at a national level from 2020 to 2022 (indicated by the gap between the purple and orange lines in the chart below). The exceptions to this are 'environment / facilities' and 'tests' both of which improved from 2020 to 2022. The most significant section decline from 2020 to 2022 (as mirrored nationally) relates to the experience of waiting which correlates to higher demand on urgent and emergency care services during 2022.

Chart 1: Key touchpoints in the BRI Emergency Department patient journey



4. Benchmarking for BRI ED

The following section compares BRI ED performance in the 2022 National UEC survey to other Trusts nationally and regionally using the overall experience of care question. In the 2022 National UEC survey, BRI ED patients gave the Trust an overall experience rating of 8.1 out of 10. This compares to a national average on this survey question of 7.4 and puts BRI ED in the top 10% of trusts nationally (Chart 2 overleaf). This places BRI ED 9th out of 122 Trusts.

Chart 2: Overall experience rating question score – UHBW vs national profile

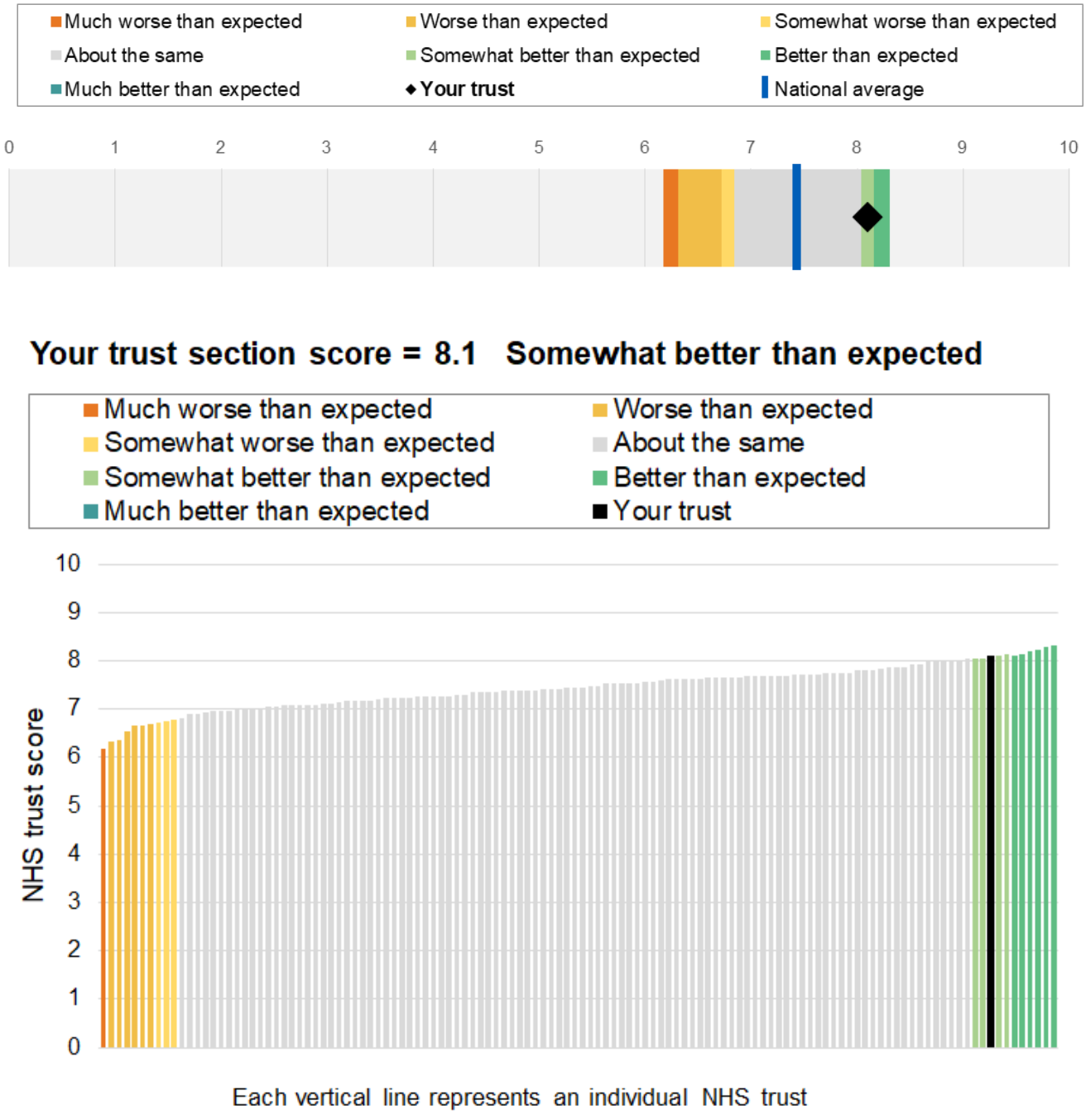
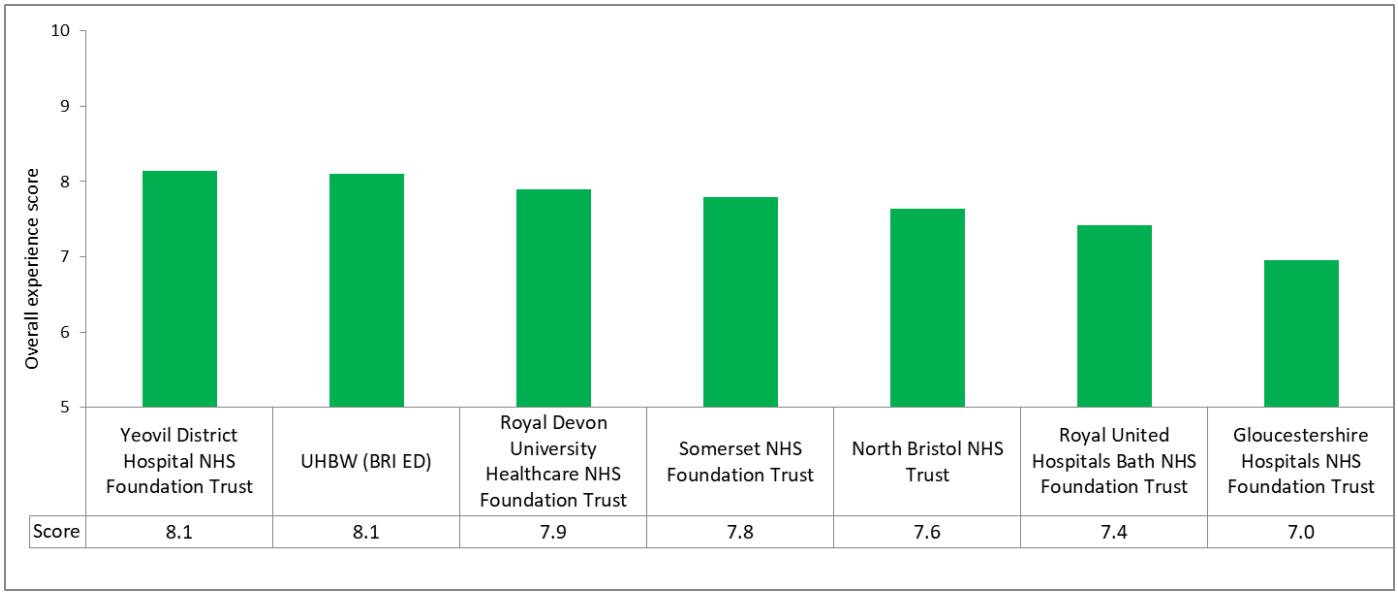


Chart 3 (below) shows that the overall experience score for BRI ED was second highest in the South West region.

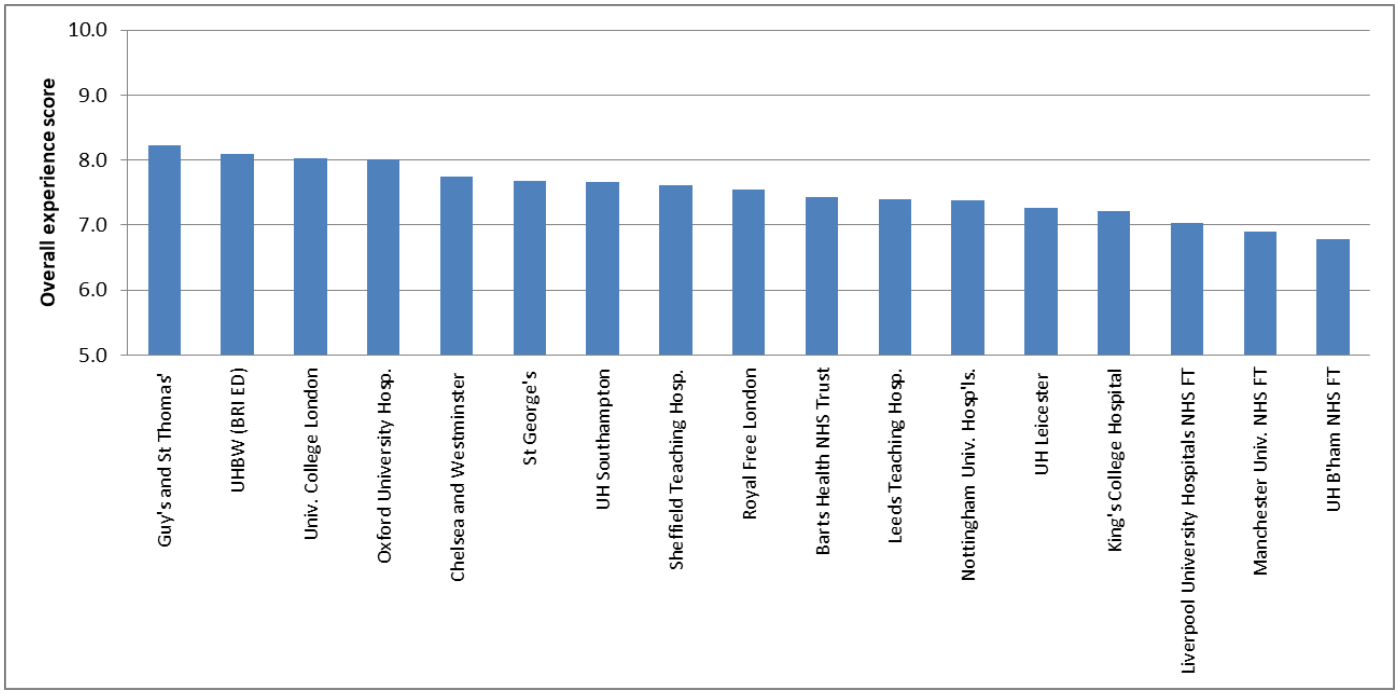
Chart 3: Comparison of overall patient experience rating question score for geographically neighbouring trusts



	Yeovil District Hospital NHS Foundation Trust	UHBW (BRI ED)	Royal Devon University Healthcare NHS Foundation Trust	Somerset NHS Foundation Trust	North Bristol NHS Trust	Royal United Hospitals Bath NHS Foundation Trust	Gloucestershire Hospitals NHS Foundation Trust
Score	8.1	8.1	7.9	7.8	7.6	7.4	7.0

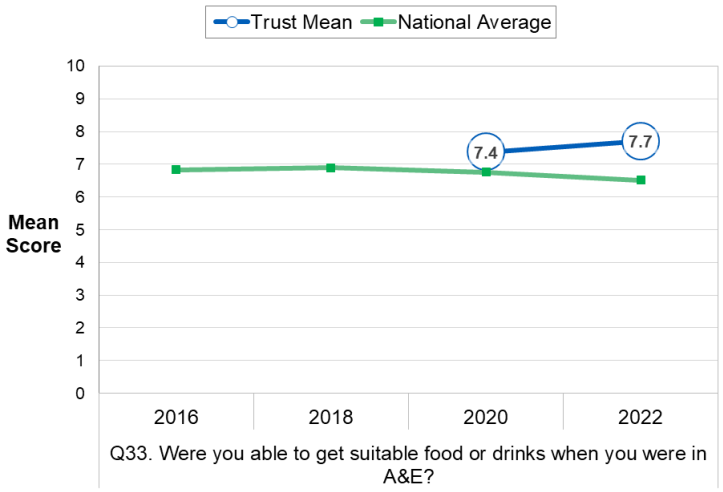
Chart 4 (below) shows that the overall experience score for BRI ED was the second highest for large acute city-centre trusts.

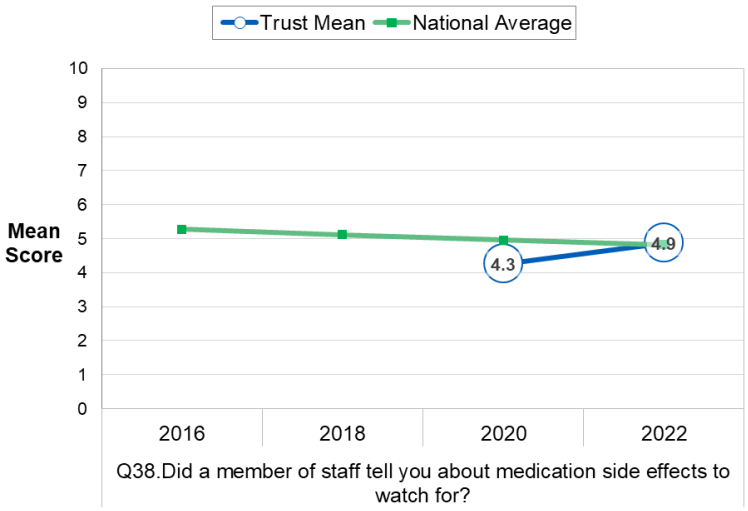
Chart 4: Comparison of overall patient experience rating score (out of 10) for large acute city-centre trusts



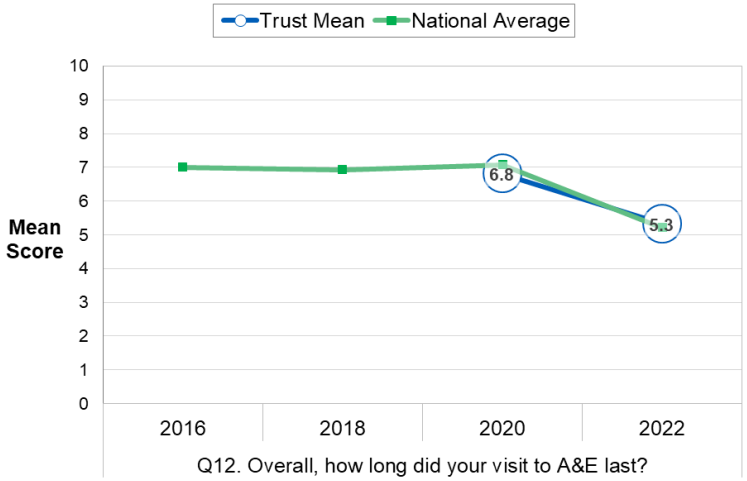
5. Trends over time for BRI ED

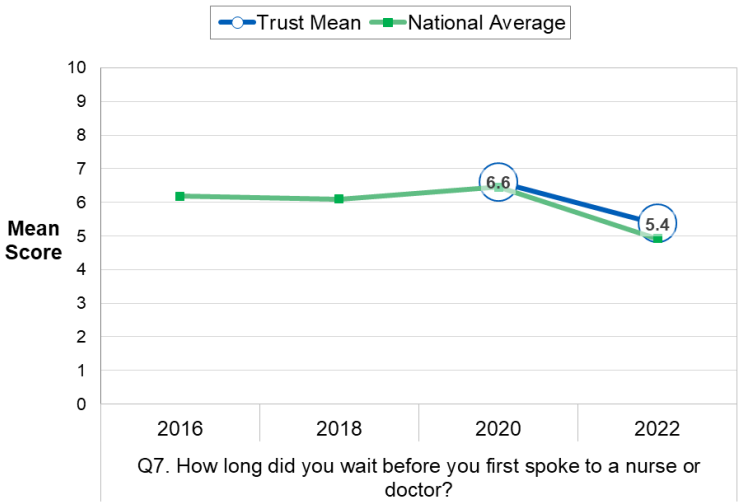
Statistically significant increases

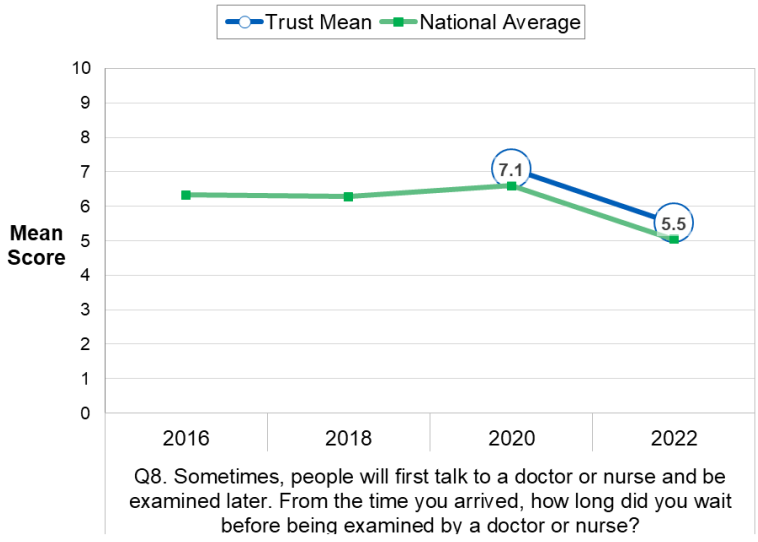


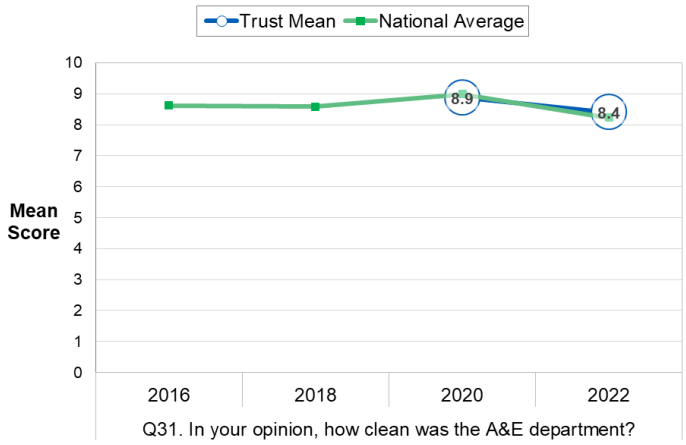


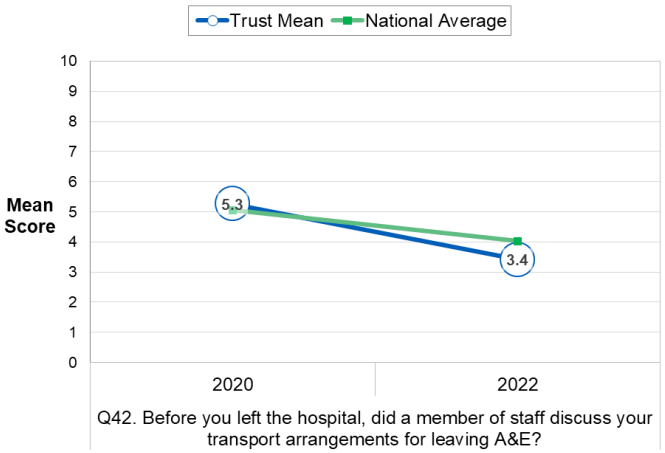
Statistically significant decreases











6. Local Weston General Hospital Emergency Department survey

Weston General Hospital (WGH) Emergency Department did not meet the inclusion criteria (Type 1 or Type 3 departments) for inclusion in the National UEC Survey. However, the Trust commissioned Patient Perspective, who administers many of the National Surveys on our behalf, to run a local survey for patients seen at WGH ED, which mirrored the approach and question set used for the National UEC survey. The full set of results for WGH ED are available from the Experience of Care & Inclusion team via experience@uhbw.nhs.uk

Questions which scored 5% percentage points higher or lower in 2022 than in 2020 for WGH ED are shown in the table below. It is important to note, when interpreting these local results, that there has been a decline for the majority of questions in from 2020 to 2022 in terms of UEC experience at a national level.

Q#	Question text	2020	2022	Difference	Trend
Q6	Were you given enough privacy when discussing your condition with the receptionist?	80.0%	72.0%	-8.0%	↓
Q7	How long did you wait before you first spoke to a nurse or doctor? This does not include staff screening for coronavirus at the entrance to A&E.	71.0%	53.6%	-17.4%	↓
Q8	Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	70.0%	54.4%	-15.6%	↓
Q11	While you were waiting, were you able to get help with your condition or symptoms from a member of staff?	63.0%	43.5%	-19.5%	↓
Q12	Overall, how long did your visit to A&E last?	72.0%	58.9%	-13.1%	↓
Q16	If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	69.0%	62.3%	-6.7%	↓
Q24	If you needed attention, were you able to get a member of medical or nursing staff to help you?	82.0%	72.4%	-9.6%	↓
Q31	In your opinion, how clean was the A&E department?	94.0%	87.3%	-6.7%	↓
Q33	Were you able to get suitable food or drinks when you were in A&E?	67.0%	73.9%	6.9%	↑
Q37	Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	88.0%	94.4%	6.4%	↑

Q38	Did a member of staff tell you about medication side effects to watch for?	47.0%	57.4%	10.4%	↑
Q43	Did hospital staff discuss with you whether you may need further health or social care services after leaving A&E (e.g. services from GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?	65.0%	78.2%	13.2%	↑
Q46	Overall, did you feel you were treated with respect and dignity while you were in A&E?	93.0%	87.7%	-5.3%	↓
Q47	Overall, how good was your experience (0=very poor, 10= very good)?	84.0%	77.5%	-6.5%	↓

Analysis of the local survey results shows that the majority of questions (24 out of 37) scored within 5% of the performance of BRI ED. The questions where there were notable variations in score are shown below - a difference of +/- 5%. There was stronger performance at WGH ED for 6 out of the 13 questions. For all questions, a higher score is positive.

For the overall experience question, BRI ED scored 79.4% compared to WGH ED score of 77.5% which is a relatively small difference. Please note these are both unweighted for age / sex and are therefore not comparable to the published national survey results for BRI ED in the previous sections of this report.

Survey Question	BRI ED	WGH ED	Variance
Q10. Were you kept updated on how long your wait would be?	28.2%	19.3%	8.9%
Q11. While you were waiting, were you able to get help with your condition or symptoms from a member of staff?	60.7%	43.5%	17.2%
Q12. Overall, how long did your visit to A&E last?	53.0%	58.9%	-5.9%
Q16. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	70.8%	62.3%	8.5%
Q21. While you were in A&E, did staff help you with your communication needs? (e.g. any language needs or communication needs related to a disability, sensory loss or impairment).	81.6%	65.0%	16.6%
Q24. If you needed attention, were you able to get a member of medical or nursing staff to help you?	81.1%	72.4%	8.7%
Q27. If you had any tests, did a member of staff explain why you needed them in a way you could understand?	74.6%	67.5%	7.1%
Q32. While you were in A&E, did you feel threatened by other patients or visitors?	91.6%	97.8%	-6.2%
Q38. Did a member of staff tell you about medication side effects to watch for?	48.5%	57.4%	-8.9%
Q42. Before you left the hospital, did a member of staff discuss your transport arrangements for leaving A&E?	33.9%	42.9%	-9.0%
Q43. Did hospital staff discuss with you whether you may need further health or social care services after leaving A&E (e.g. services from GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?	72.9%	78.2%	-5.3%
Q44. After leaving A&E, was the care and support you expected available when you needed it?	80.4%	73.5%	6.9%
Q45. If you had contact with care and support services after leaving A&E, did the health or social care staff have information about your visit?	51.4%	60.4%	-9.1%

Whilst it is not possible to make comparisons between the local survey results and the National UEC benchmarking dataset, there remains useful learning to take forward in WGH ED, both in terms of areas where there is a positive experience of care, and other areas for improvement. These results have been shared with the WGH ED management team. As part of sharing the results and reflecting on the findings, it is recommended that the BRI ED and WGH ED staff explore opportunities to work together to share good practice and learning.

7. Sentiment analysis for patient comments for BRI ED and WGH ED

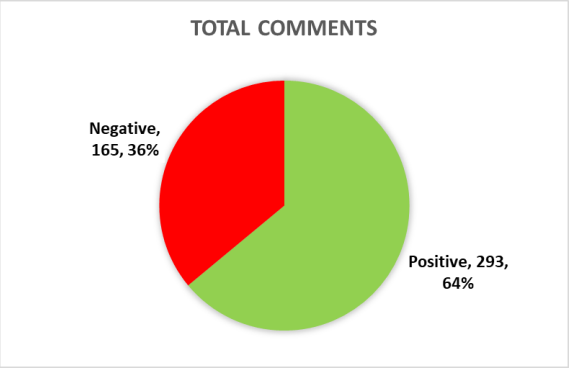
An analysis of each free-text comment received as part of the 2022 UEC Survey has been undertaken for the BRI ED and WGH ED. The full free-text analysis (split BRI ED and WGH ED) is available from the Experience of Care & Inclusion team via experience@uhbw.nhs.uk . There were 579 comments in total:

- 213 comments were about pathways of care (of which 37% were positive, 63% were negative);
- 163 comments were about staff (of which 81% were positive, 19% were negative);
- 159 comments were about care and treatment (of which 56% were positive, 44% were negative);
- 242 comments were about place (environment) (of which 86% were positive, 14% were negative);
- 2 comments were categorised as 'other'.

Just over half of the comments were positive in sentiment in the 2022 results, compared to two thirds in the 2020 results which correlates to the decline in overall experience seen from the 2020 results to the 2022 results both locally and nationally. There has been a significant increase in negative comments regarding waiting times, reflecting the increased demands and pressures on UHBW UEC services during the period of this survey.

Chart 5: Total comments by sentiment by year of survey

2020



2022

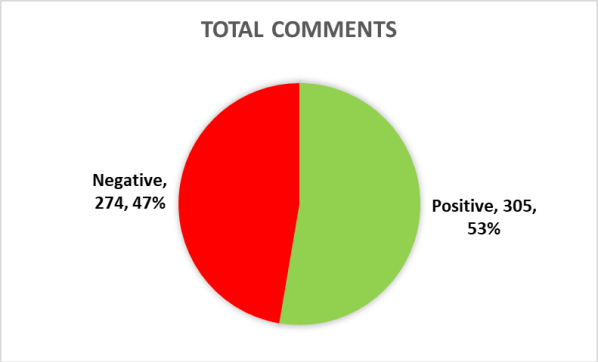
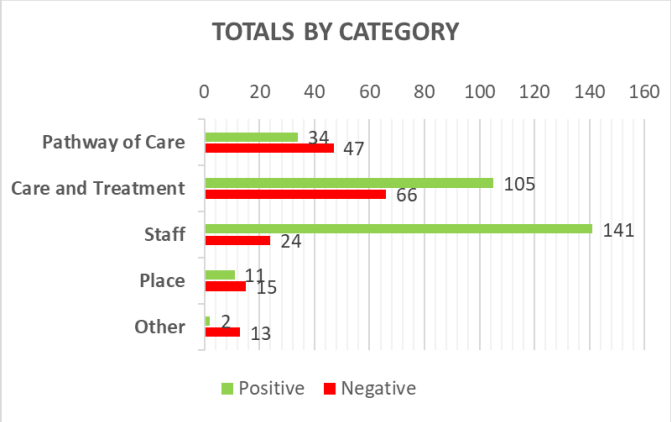


Chart 6: Sentiment analysis of comment categories

2020



2022

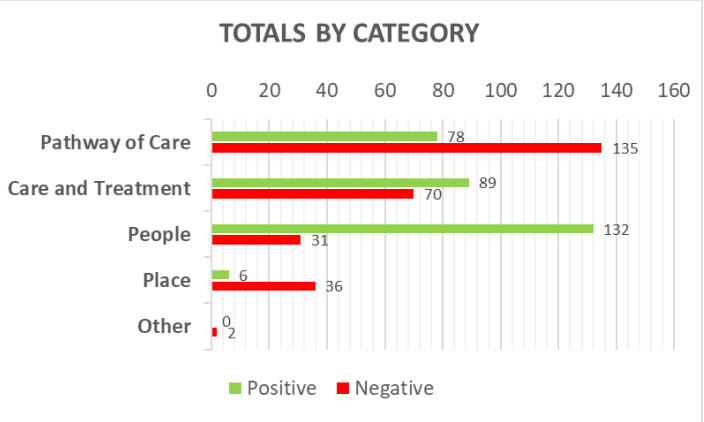
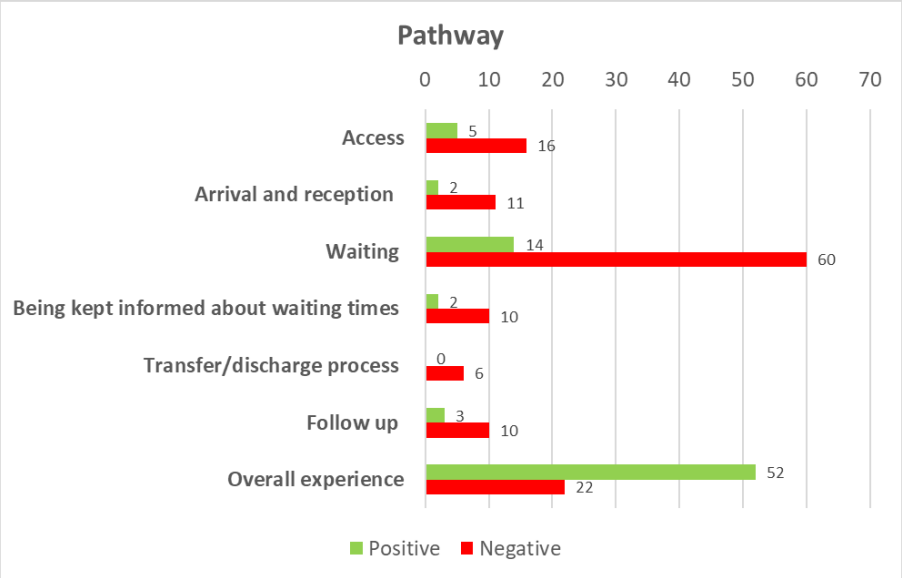


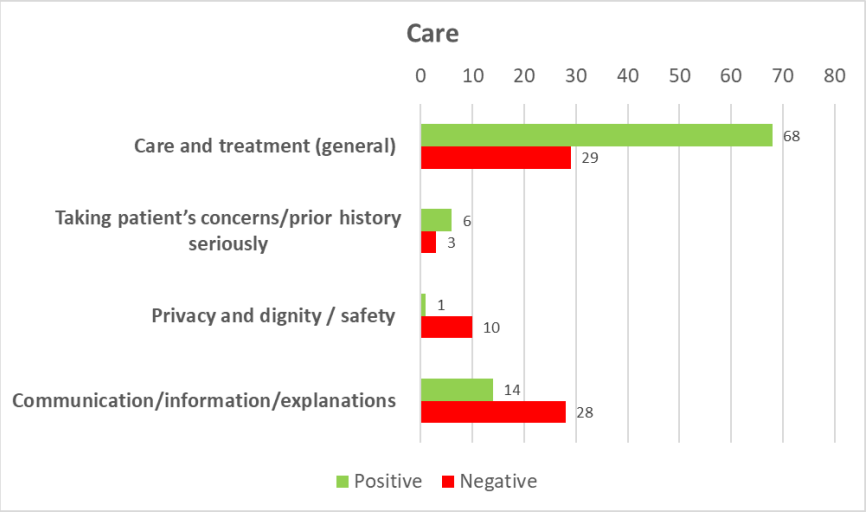
Chart 7: Pathway of care sentiment analysis



"All staff I dealt with were compassionate and helped me hugely. The only negative was when I arrived to be told there was a 10+ hour wait to be seen, which was hugely distressing and made me unsure what to do. Fortunately I was helped significantly faster than that." (BRI ED).

"I was in A&E for 14 hours before given a bed. Almost all of that time I was left in a chair. Finally, a CT scan revealed double pneumonia and I was put on a ward. I was told I was to go to the corridor, but a nice sister in charge helped me get to a ward. Overall, a very poor experience. Not even offered any food in that initial 14 hours!" (WGH ED).

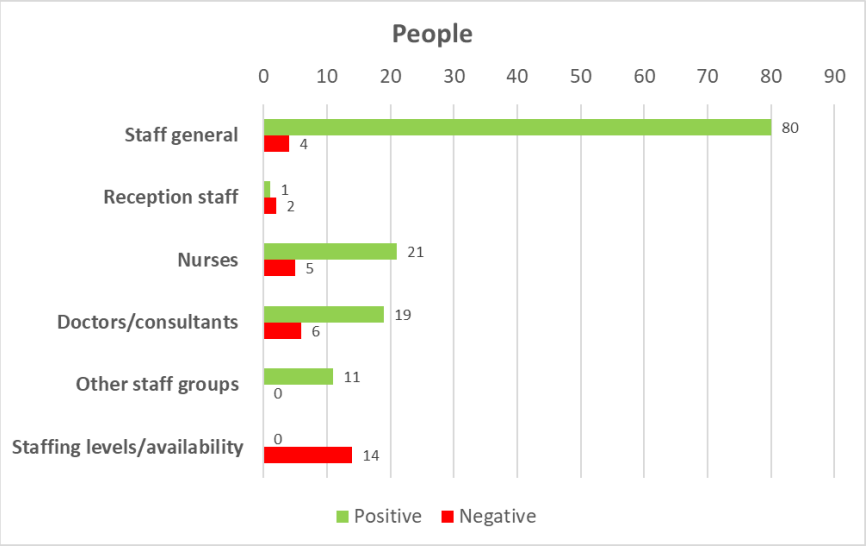
Chart 8: Care and treatment sentiment analysis



"My experience with the ambulance paramedics was first class. All nurses and doctors were respectful and gave me the medical attention without fault." (BRI ED).

"I was diagnosed with inoperable pancreatic cancer by the professionals during my 13 hour stay at A&E but this was not communicated to me or my husband that first day. I was informed of my condition the following morning by a consultant while I was alone. Although if anyone had asked, I knew my husband would be with me later that morning. I found this very traumatic." (BRI ED).

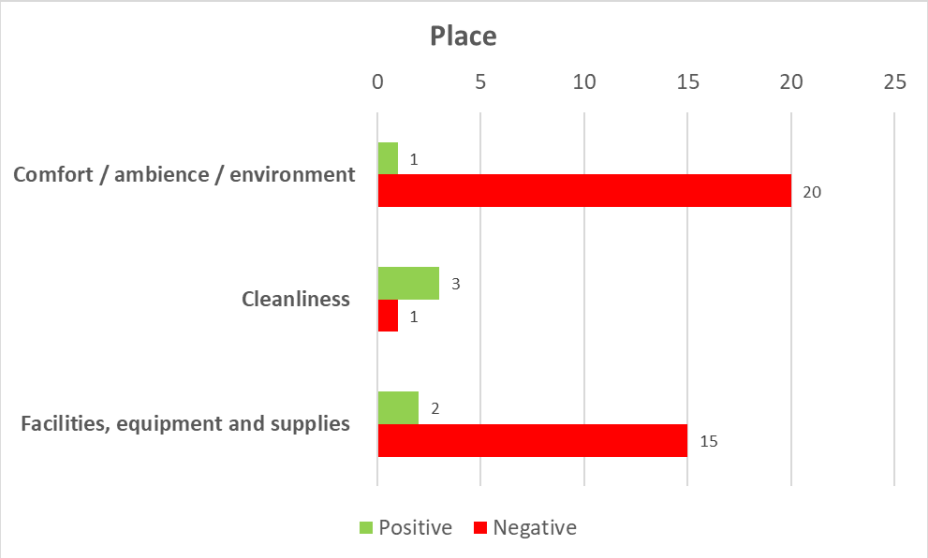
Chart 9: People (staff) sentiment analysis



“Just a massive thank you for the patience, care, communication and kindness of all the staff I encountered. The nurse and my doctor were calming, informative and made me feel like my health truly mattered to them. The care I received from the receptionist through to the pharmacy (which my doctor walked me to) was amazing!” (WGH ED).

“Just to say 'thank you'! I was dealt with in the A&E Department swiftly and given adequate pain relief. All nurses and doctors were friendly and attentive! Thank you!” (BRI ED).

Chart 10: Place (environment) sentiment analysis



“Admitted to A&E on a Bank Holiday (Queen's funeral). Not an ideal day as very busy. Staff very kind, but obviously pushed. Kept in overnight on a trolley in the department. Uncomfortable but grateful.” (WGH ED).

8. Improvement activity

The BRI ED Leadership Team has produced a Patient Experience action plan for the BRI ED which is attached as Appendix A1 to this report. The action plan reflects learning from the 2022 National UEC survey results as well as incorporating themes from the Trust's ongoing patient experience programme, primarily gathered via the Friends and Family Test (FFT).

The BRI ED team have been early-adopters in using the Patient Experience Hub to access regular feedback from their patients and focus on improvements that can be made based on what patients have said would make their experience better. Examples of improvements that have been made are providing healthier food and drink choices in the vending machines; improving the signage throughout the department; providing toilet raisers and grab rails to improve facilities; addressing the temperature issues in the waiting room; and offering food provision for fast flow patients.

In addition, BRI ED has worked with Bristol Autism Support Service and people living with Autism to identify areas that would enhance patient experience. This has resulted in the creation of a sensory suite for people with a Learning Disability or Autism as alternate to waiting room, an improved colour scheme and lighting, availability of fiddle/twiddle toys and ear defenders, additional artwork, communication booklets and access to iPads.

The WGH ED Leadership Team has produced a Patient Experience action plan for the Weston ED which is attached as Appendix A2 to this report. The action plan reflects learning from the 2022 National UEC survey results as well as incorporating themes from the Trust's ongoing patient experience programme, primarily gathered via the Friends and Family Test (FFT).

The Weston ED action plan includes objectives to improve the experience whilst waiting in the department, a focus on improving privacy and dignity, upgrades to the environment and facilities including a plan to install a shower, an additional toilet and reclining chairs, as well as a plan to implement a 'you said, we did' information board in the waiting area.

9. Summary and next steps

The BRI ED received a positive set of results in the 2022 National UEC Survey which were above the national average in almost all 'sections' of the survey. For overall experience of care, the BRI ED ranks 9th out of 122 Trusts, within the top 10% nationally. However, it should be noted there has been a decline in the overall experience question and a decline in almost all sections of the care pathway from the 2021 results which may be attributable to high demand and pressure on the service during this period. This decline is mirrored in the results at a national level.

The WGH ED results in the 2022 local UEC survey show a fall in the overall experience of care question to 77.5% (from 84% in the 2021 results). It clear when reviewing the results at question level, that the fall may be attributable to high demand on the service during this period which has resulted in longer waiting times to be seen, i.e. many of the questions that have a lower score in 2022 (compared to 2021) have a theme of 'waiting'.

Next steps

- National UEC Survey and local UEC Survey results have been shared with BRI and WGH ED Leadership teams and have been presented to Experience of Care Group (17/8/23) and Clinical Quality Group (4/10/23);

- The BRI ED management team and Weston ED management team have produced Patient Experience action plans for their respective departments which are live documents that will be reviewed regularly;
- Ongoing patient feedback data via the Friends and Family Test (FFT) for both BRI ED and WGH ED will continue to be shared weekly with the departments in order that they monitor experience of care and ensure that improvement actions and associated benefits to patients are being realised;
- The next National UEC (and local WGH ED survey) will be undertaken relating to patients attending ED in September 2024 which will provide a further opportunity to listen to patients about their experience of care.

Report author: Matthew Areskog, Head of Experience of Care & Inclusion.

Report date: 26th October 2023 (Original report 18th September 2023).

NHS
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NHS Foundation Trust

BRI ED Patient Experience Action plan- 2023/2024

No.	AREA FOR IMPROVEMENT	ACTIONS	WHEN	BY WHO	PROGRESS	STATUS	Completed Date
1	**Improves required to improve accessibility to the Emergency service for patients that require assistance**	Lack of facilities for those with mobility issues – requiring toilet raisers in waiting room toilet facilities	23/01/2023	Tina Johnson/Kelly Membery	Working in conjunction with OT and Frailty Team, comms to staff re equipment and High Raiser toileting equipment available in disabled SDEC toilet	Completed	01/01/2023
2	**Patient complaints and IQVIA feedback re lack of facility for healthy choices in vending machines.**	Meet with Rachel Liston (Specialist Dietician for Food policy)	22/11/2023	Tina Johnson/Kelly Membery	Email to Operations Manager and Director of Facilities regarding opportunity to work together on aim for food provision for patients staff and visitors.	Completed	11/11/2022
3	**Waiting room environment feels unsafe "Terrifying" at night**	Discussion with Head of security	23/11/2023	Tina Johnson/Kelly Membery	17/03/23 Email from head of arts Programme. "We have a new Arts Programme Manager joining the team next month. Once they're with us I'm keen to look into best practice of ED waiting areas (and other similar environments) in creating calming and uplifting environments. We would then look to find an artist to develop some ideas and work with you and the ED team to put a bid into the Charity to get some bespoke artwork created and installed for ED Regular security patrols and monitoring of CCTV in security hub	In progress	
4	**Poor patient experience for those presenting with visual impairment.**	Discussion with patient experience team Sammy Moxey		Tina Johnson/Kelly Membery	Initial meeting with Bristol Sight Loss Council 09/01/23	Completed	
		"Secret shopper" pt experience visitation from Bristol sight loss council.	23/11/2023	Tina Johnson/Kelly Membery	Series of meetings arranged for Feb/March for visitation and video interview for PEF dissemination. First draft of audio trail completed - once recording completed will be uploaded to the UHBW website as well as the Sight Loss Council accessibility site. Braille buttons are available on the internal lift doors - but not external. Braille stickers to be accessed via the Bristol Sight loss society. Work stream re communication in reception for those that attend with Visual impairment (VI) and how to assist appropriately as well as highlight to team. Door frames in the waiting room all one colour - red tape applied to the door frames - head height 3 inches thickness for easier access for VI. Communication to Team re info on connect for translation of discharge summaries into large print (size 16 or above in Arial font) and accessing braille summaries.	In progress	
5	**Inadequate facilities for LD in waiting room (Sept 22)**	Development of sensory cubicle (Cubicle 10 Fast Flow) with dimmable lighting, trolley of sensory equipment - fiddle toys, ear defenders, communication aids. (posters displayed in majors and fast flow depicting available items stored in reception to avoid theft)		Tina Johnson/Kelly Membery/ Fiona Spence/BASS	~~Supplies purchased for Sensory trolley~~ Communication booklets printed Posters displayed BASS (Bristol Autism Society) visit Jan 23 for advice Arts and Culture department contacted re artwork for walls	Completed	23/06/2023

BRI ED Patient Experience Action plan- 2023/2024

No.	AREA FOR IMPROVEMENT	ACTIONS	WHEN	BY WHO	PROGRESS	STATUS	Completed Date
6	**Relatives room in poor repair**	Relatives room to be refurbished		Tina Johnson/Kelly Membery	Painting of walls, purchase of comfortable seating, hot drink facilities and china cups. Inappropriate use by MH team requiring Digi lock code to ensure availability for Resus relatives and the bereaved.	Completed	12/03/2023
7	**Inadequate facilities for patients attending whose first language is not English**		23/12/2023	Tina Johnson/Kelly Membery	Patient EDI Manager arranging visits to Somali Autism services for engagement in reach. Update from Patient EDI Manager - contact made with Somali autism services to arrange a visit to the department (to establish links for transition from Paeds to adult services). Arts dept arranging welcome signage in several	In progress	
8	**Poor signage for Front Door services**	Review signage across Level 3 footprint - ED Fast Flow, ED Majors, Medical SDEC, X-RAY, Exit routes	Ongoing Trust initiative	Lorna Gregory/ Rebecca Rowntree	ED Specialty Manager and Assistant General Manager have a small work group looking at signage	In progress	
9	**Patients complaining of lack of entertainment during long waits**	Facilitating ED Volunteer service - first volunteer in post 01/01/23	23/08/2023	Tina Johnson/Kelly Membery	"Boredom breakers" Sudoku and colouring etc. in Relatives and waiting room. Enquiries into hospital radio in waiting room. Increased supply of 'twiddlemuffs' for dementia patient	Completed	03/09/2023
10	**Security hub in A300 ED Majors entrance - not a welcoming entrance for patients, relatives and other UHBW staff.**	ITA relocation project incorporates the swap between the Security hub and the PFC desk for the provision of improved welcome.	31/08/2023	Tina Johnson/Lorna Gregory/ Jennifer Jones/ED Lead B7 team	Phase 4 of reconfiguration ED - move Frailty team into HIUT office, security into Frailty office, Reception/Welcome desk to take over Security Hub. Security to relocate by the 04/08/23	Completed	23/09/2023
11	**Improve signage in A300 Majors - majority of patients attend by ambulance to this areas but relatives and visitors have minimal direction**	Review of signage under way by working party between ED and SDEC.	31/09/23	Tina Johnson/Lorna Gregory/ Jennifer Jones/ED Lead B7 team	Review of signage under way by working party between ED and SDEC. 14/03/23 Meeting with lead for Equality, Diversity and Inclusion re signage in top 4 languages spoken in Bristol : English, Polish, Urdu and Somali. 10/03/23 Visit from A.D. from Sight loss society for application of Braille to lift buttons. 20/03/23 Red tape on waiting room doors for visually impaired service users to aid door frame identification.	In progress	
12	**Information required re identification of the staff team, uniforms for patients and relatives**	New staff board required for A300 Majors & Fast Flow to show ED team on shift	31/09/23	ED lead B7 team	02/08/23 - Recent change of uniform for PFC team, ED Admin team to create posters including this uniform and display in dept.	Completed	23/07/2023
13	**Implementation of a "you said, we did" information board (Majors and Fast flow waiting room)**	Introduce a new board to ED Majors to detail this information for patients, relatives and staff	31/09/23	Sarah Waite	Work with UHBW Communications Team for a new board. New board has arrived - need to finalise layout. Template available W/C 1st November 2023	In progress	
14	**Temperature in waiting room was very cold for patients waiting to be seen**	Review heating in areas to ensure suitable level for patients	31/08/2023	Tina Johnson/Kelly Membery	Heating has been fixed (flagged on IQVIA data) The continues opening of door as patients enter, unfortunately unavoidable due to flow through the dept. Temperature to be monitored. Two air condition controls exposed in the waiting room - covers ordered so lock the units so they can not be tampered with.	Completed	
15	**High Impact Users Team (HIUT)suspect poor patient experience within the ED for their client group**	Focus group in January 23 - regular users of the service were invited to share feedback in a face to face (or telephone forum) to gain valuable insight into improvements that could be made within the department.	01/01/2023	Sarah Burn and HIIUT	Consultation taking place with HIU team and managers regarding the team name which we are hoping to change. Current name can be seen as negative to users. Review of personal support plans to better reflect clients as an individual, including how they are formulated. A wider Trust message to help highlight compassion and accepting people as individuals. Continue collaboration work with clients to enable a positive relationship with the team and to help improve their hospital experience.	In progress	
16	**Lack of pillows available in the department**	Monthly order complete department to receive 25 pillows each month	01.09.2022	Tina Johnson	Pillows on rolling order	Completed	30/11/2023
17	**No waiting time update available in the waiting rooms**	BI team to create a more accurate report to show the average waiting times in the department to be seen. This will be displayed in the waiting room. More screens required to display report to ensure patients and visitors are aware of potential delays on arrival and whilst they wait.	01.08.2022	Owen Lloyd-Jones	One screen in waiting room has been damaged and removed. waiting for new order of screens. BI have provided a report which is in test mode to confirm data accurate before being rolled out in the waiting room area.	In progress	
18	**Equality and Diversity ED working group**	Monthly meeting to take place with reps across the department	23/12/2023	Tina Johnson/Kelly Membery	Support sought from Patient EDI Manager with the new working group	In progress	

University Hospitals Bristol and Weston NHS Foundation Trust

Weston ED Patient Experience Action plan - 2023/2024

No	CATEGORY AND FEEDBACK	ACTIONS	BY WHO	PROGRESS	STATUS	Due Date
1	**THE PATHWAY OF CARE** **- Delays with ambulance offload** **- Long waits in department** **- Lack of information on wait times**	Tap to transfer focus week in Weston Hospital to support nursing staff in using this system more efficiently. This identification of empty beds electronically will enable ED to mobilise quicker improving flow and bed availability in the department.	**Jess Wickham Weeks**	**Initiative supported by action lead who came across from Bristol. On review the clinical site and operational team in Weston has seen a marked improvement in the use of tap to transfer in Weston.**	**Complete**	Aug-23
2		GEMBA walk (walk around to review flow and pathways to grasps condition of workplace and identify areas for improvement) Focusing on the beginning to end journey, looking for any wastes; time, man power, machines, materials, methods Then reviewing model in abnormal conditions (stress test)	**Sarah Jenkins**	**Discussed progress with Associate Director of Operations, she would like to complete this before we hit winter pressures and is looking at putting a team together to compete this project.**	**In Progress**	**Nov-23**
3		Perfect week in ambulance handover to improve the process of handing over and offloading timely (15 min handover and offload target)	**Sarah Jenkins**	**Associate Director of Operations to mirror the work done in BRI ED as the improvements seen were immediate following 'the perfect week'. Associate Director of Operations to facilitate with SWAST, ops, ED as this is a collaborative piece of work**	**In Progress**	Nov-23
4		Implementation of an effective ED observation unit which will improve flow through the department and support admission avoidance and overcrowding in the department/waiting room	**Charlotte King/ Jo Poole**	**Project in progress to create a ED observation unit within the ED footprint. This requires input from ED, clinical site, IPC team, Divisional management, estates and finance. ED consultant and band 7 lead identified and actions being worked through.**	**Complete**	**Sep-23**
5		Waiting times for triage and to be seen by a clinician to be displayed on electronic screens in waiting areas and within the department. These are to be updated hourly by the ED reception team based on Careflow data.	**Charlotte King/ Emma Louise Woods**	**Existing screens within the department utilised, reconfigured and now display the updated information required.**	**Completed**	Jul-23

No	CATEGORY AND FEEDBACK	ACTIONS	BY WHO	PROGRESS	STATUS	Due Date
6	**CARE AND TREATMENT** **- Lack of privacy at reception** **- Unable to obtain help whilst waiting** **- Delays in pain relief post triage**	Plan to staff the ED waiting room with a HCSW when there is overcrowding and a number of DTAs in the waiting room due to unavailability of beds. This will provide oversight of patients in the waiting room and ensure observations are completed and escalated where required. It will also ensure the comfort of these patients is improved by providing them with refreshments and updates as require. Any medication requests or reviews can also be escalated timely to a registered nurse to support efficient pain relief administration.	**Charlotte King/ Jo Poole**	**HCSW added to the ED roster and escalated as required by the ED band 7 nurse in charge**	**Completed**	Jun-23
7		Barriers to be purchased and installed in reception to ensure queue of patients are kept at a distance from the reception desk to improve privacy when booking in. Seating also to be rearranged to maximise privacy and confidentiality.	**Charlotte King/ Emma Louise Woods**	**Barriers arrived and installed. New seating purchased and in place**	**Complete**	Feb-23
8		Education team to add importance of accurate assessment and management of pain to the topic of the month. Audit of cas cards to ensure pain relief discussed/ reviewed and offered (if appropriate) at triage.	**Cheryl Smith/ Caroline Bool**	**Action sent to ED Practice Educator and ED lead band 7 22/8/23**	**In Progress**	Nov-23
9	**PEOPLE** **- Unable to get the attention of a staff member when required** **- Doctor or nurse did not discuss anxieties or concerns with patients** **- Patients did not always feel they treated with respect and dignity** **- Staff not always identifiable** **- Staff did not always listen to what patients had to say**	Information posters have been designed to be displayed in each patient bed space in majors and minors. These include information regarding visiting, patient journey, amenities available and who to ask for (NIC) if you have any queries/ concerns. We have also included the direct dial numbers for each end of the department for relatives to contact the right area.	**Caroline Bool**	**Posters have been created and sent to the print room to ensure signs are IPC compliant.**	**Complete**	Sep-23
10		New staff boards to be located between minors and majors within the ED. This board is to display all clinical staff working in the department. The posters of different uniforms and who wears them will also be displayed here, along with the Divisional management team to support escalation of concerns for patients and staff.	**Caroline Bool**	**Photographs of the clinical have now been completed and are awaiting printing. Board and clip frames ordered and installed.**	**Complete**	Sep-23
11		Implementation of a "you said, we did" information board into the ED waiting room. This board is to detail this information for patients to inform them of how we have improved our service as a result of their feedback.	**Caroline Bool / Emma Louise Woods**	**New board on order for waiting room. Monthly meetings to be set up to discuss friends and family feedback, along with complaints received to provide actions and information for this board**	**In progress**	Oct-23

No	CATEGORY AND FEEDBACK	ACTIONS	BY WHO	PROGRESS	STATUS	Due Date
12		The department is nearly recruited to establishment and we are committed to investing in our established workforce to retain and develop them. Patient feedback is to be included within the monthly matron update and bedside teaching for doctors, nurses, AHPs and admin staff is to be completed around the Trust Values and expectations of behaviours towards each other and our patients. Spot checks will then be undertaken to ensure staff are aware of the Trust Values and how we demonstrate these at work.	**Charlotte King**	**Monthly matron updated adapted to include patient feedback and complaint themes from July 2023. Values awareness Week planned for the 4th September and a quarterly audit to be designed following delivery of this.**	**Complete**	Sep-23
13	**PLACE** **- No wash facilities** **- Uncomfortable wait in ambulance** **- Delay to move to ward, spent long time in a chair whilst waiting** **- Transport arrangements not always discussed** **- Lack of privacy during examination/treatment** **- Drop in cleanliness of department**	Plan to install a shower and additional toilet in the ED to ensure patients spending extended periods of time in the department are able to wash.	**Charlotte King**	**Estates have reviewed department and identified most appropriate place to install shower and toilet in ED. ED Matron to complete feasibility request for estates work and submit for Capital funding. Risk on ED risk register.**	**In Progress**	Jan-24
14		Purchase repose mattresses for patients required to wait in ambulances for extended periods of time. Ensure hot meals and refreshments taken out to patients on ambulances at times of escalation. Utilise cohort space early when department full as patients can transfer to a chair/more comfortable trolley in a more timely manner.	**ED band 7 team**	**Close working with SWAST to ensure patients are transferred onto repose on RATTing. Early escalation to HALO to utilise cohort space to improve patient experience and comfort. Additional meals ordered for escalation patients.**	**Complete**	Jan-23
15		Order additional reclining chairs for 'fit to sit' and escalation areas to ensure patients comfort is a priority.	**Caroline Bool/ Emma Louise Woods**	**Action sent to ED lead band 7 and ED Team Leader. Funding stream to be identified.**	**In Progress**	Nov-23
16		Additional privacy screens ordered to support the maintenance of privacy and dignity during examination and treatment.	**Charlotte King**	**Screens arrived and in use**	**Complete**	Feb-23
17		Review cleanliness audit for ED and actions required	**Charlotte King**	**ED cleanliness audit result for August 2023 is 98%. Work required to replace celling tiles, escalated to estates and work planned. Results shared with ED band 7s for monitoring.**	**Complete**	Aug-23
18		Information regarding support in arranging transport home to be displayed in the waiting room for ED and within the bedside posters. Nursing staff reminded that this is part of the discharge planning.	**Caroline Bool/ Emma louise Woods**	**Awaiting posters to return from print room and be displayed in bed spaces. Poster to be added to information board I waiting room.**	**Complete**	Oct-23

Appendix B - Briefing Report for the 2022 National Cancer Patient Experience Survey Results

1. National Survey methodology

The annual National Cancer Patient Experience Survey ("NCPES") is commissioned and managed by NHS England. The survey was overseen by a National Cancer Patient Experience Advisory Group. This Advisory Group set the principles and objectives of the survey programme and guided questionnaire development. The survey provider, Picker, was responsible survey for designing, running and analysing the survey.

The sample for the survey included all adult NHS patients (aged 16 and over), with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2022. The fieldwork for the survey was undertaken between November 2022 and February 2023.

The questionnaire was redeveloped for the 2021 National Cancer Patient Experience Survey and there is now trend data available to have year on year comparisons which is included in this year's reporting for the first time.

This is the second time the survey has been carried out after the University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) 2020 merger of University Hospitals Bristol NHS Foundation Trust (UH Bristol) and Weston Area Health Trust (WAHT) and therefore offers a view of cancer patient experience across the whole geographical footprint of the Trust. Please note that for Bristol hospital sites, the results reflect cancer care across all wards and departments – not just the Bristol Haematology and Oncology Centre.

In total, 589 patients returning a completed questionnaire, giving a response rate of 51%, which was similar to the response rate nationally (53%). The full set of results can be accessed via the NCPES website here.

2. Results summary

Patients scored the Trust 8.9 out of 10 for the 'overall experience of care' question. This means UHBW ranks as the 60th out of 131 Trusts (where 1st is the top rating). Patients gave an average rating for overall experience of care of 8.9 which places UHBW in line with the national average.

We score better than most Trusts for three questions:

- Patient received all the information needed about the diagnostic test in advance (95%);
- Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right (89%);
- The whole care team worked well together (92%).

We score worse than most Trusts for one question, *compared to no questions in the 2021 results;*

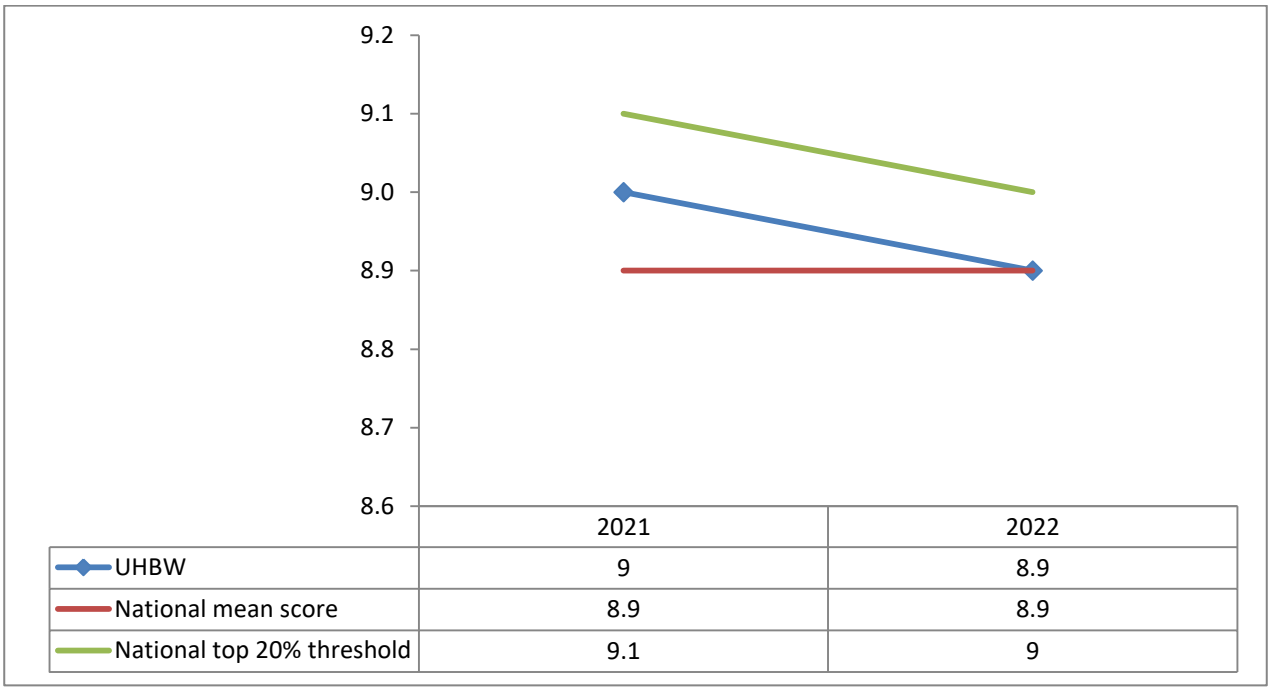
- Patient felt the length of time waiting for diagnostic test results was about right (74%).

Results were about the same as other Trusts for the remaining questions.

3. Trust comparison and results over time

This is the first year where trend data is available to have year on year comparisons. There are no questions where the 2022 score is significantly higher or lower than the 2021 score for UHBW. Chart 1 shows survey respondents' overall cancer care ratings between 2015 and 2022. This indicates that the 2022 results for UHBW (represented by the blue diamond) appear to represent a 'middle-ground' of the previous results of UH Bristol (as was – represented in red) and Weston Area Health Trust (represented as green) pre-merger.

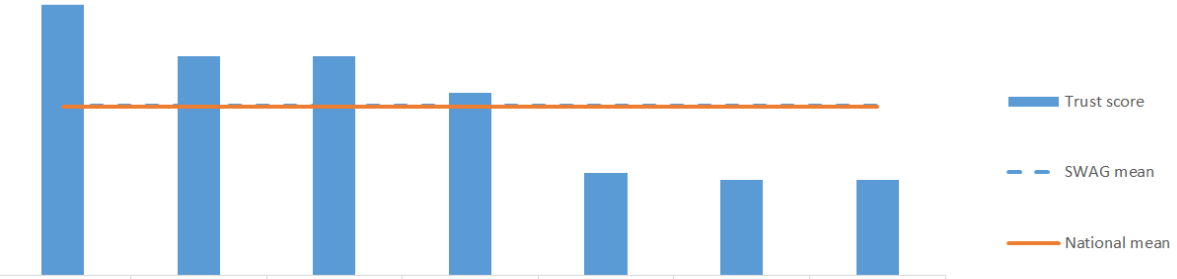
Chart 1: Overall experience rating for cancer care



	2021	2022
UHBW	9	8.9
National mean score	8.9	8.9
National top 20% threshold	9.1	9

Chart 2 (below) compares the overall care rating score between organisations in the Somerset Wiltshire Avon and Gloucestershire Cancer Alliance group (SWAG). This shows that patients in the South West tend to rate their care in line with the national average. In 2022, UHBW performed around the middle of this cohort, with Gloucestershire Hospitals NHS Foundation Trust performing best.

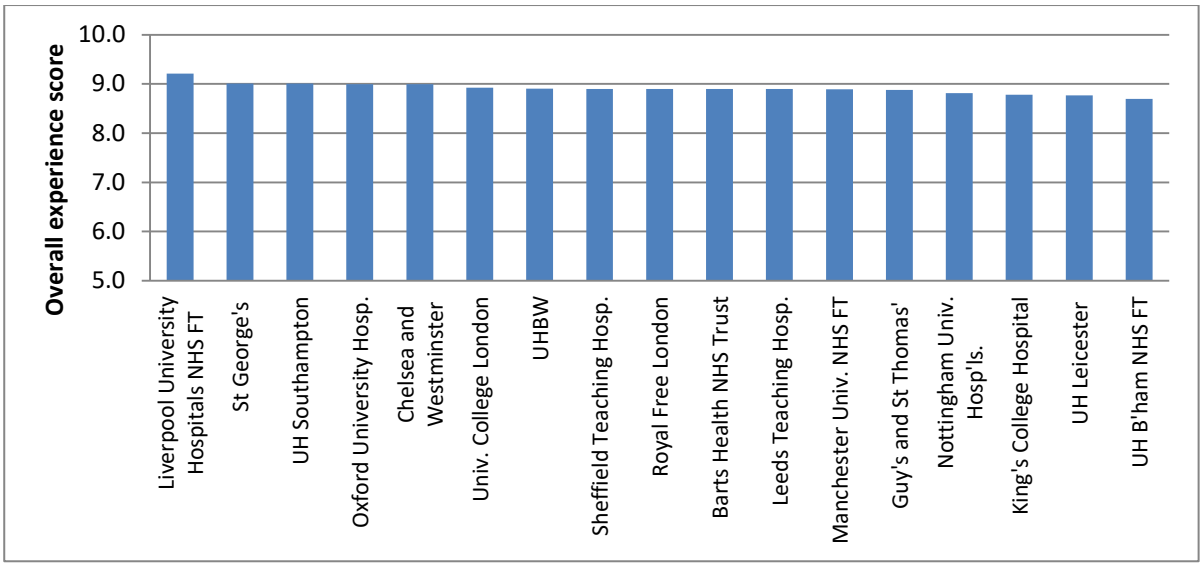
Chart 2: Overall Patient Care Ratings for the SWAG Cancer Alliance



	Gloucestershire Hospitals	RUH Bath	Salisbury NHS FT	UHBW	Somerset	Yeovil District Hospital	North Bristol Trust
Trust score	9.0	9.0	9.0	8.9	8.8	8.8	8.8
SWAG mean	8.9	8.9	8.9	8.9	8.9	8.9	8.9
National mean	8.9	8.9	8.9	8.9	8.9	8.9	8.9

Chart 3 (below) shows that the overall experience score for UHBW was in line with other large acute city-centre trusts.

Chart 3: Comparison of overall patient experience rating score (out of 10) for large acute city-centre trusts



Analysis by question

UHBW's best and worst comparator scores (i.e. those with greatest % variance when compared with the national average), are displayed in Table 1 (below) and Table 2 (overleaf). These comparisons can help provide some useful context and help differentiate between areas of national or local good practice or concerns.

Table 1: UHBW top performing questions (compared to the national average).

Ques No	Question Text	UHBW Score (Case mix adjusted)	National Score	Variance
Q43[1]	Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	89.1%	78.0%	11.1%
Q53	After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	36.2%	31.1%	5.1%
Q29	Patient was offered information about how to get financial help or benefits	71.8%	67.5%	4.4%
Q54	The right amount of information and support was offered to the patient between final treatment and the follow up appointment	82.5%	78.2%	4.3%
Q49	Care team gave family, or someone close, all the information needed to help care for the patient at home	62.2%	57.9%	4.2%
Q39	Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	82.0%	78.3%	3.7%
Q55	Patient was given enough information about the possibility and signs of cancer coming back or spreading	66.1%	62.4%	3.6%
Q36	Hospital staff always did everything they could to help the patient control pain	87.7%	84.3%	3.4%
Q42_4	Patient completely had enough understandable information about progress with hormone therapy	75.7%	72.5%	3.2%
Q42_1	Patient completely had enough understandable information about progress with surgery	88.1%	84.9%	3.2%

[1] This question score was also above the upper expected range of 86% for this question score nationally

Table 2: UHBW lowest performing questions (compared to the national average).

Ques No	Question Text	UHBW Score (Case mix adjusted)	National Score	Variance
Q07[2]	Patient felt the length of time waiting for diagnostic test results was about right	73.9%	78.4%	-4.5%
Q12	Patient was told they could have a family member, carer or friend with them when told diagnosis	72.1%	75.9%	-3.8%
Q50	During treatment, the patient definitely got enough care and support at home from community or voluntary services	47.7%	51.3%	-3.5%
Q24	Patient was definitely able to have a discussion about their needs or concerns prior to treatment	68.4%	71.1%	-2.7%
Q41_4	Beforehand patient completely had enough understandable information about hormone therapy	76.5%	78.8%	-2.3%
Q22	Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	77.8%	80.0%	-2.2%
Q13	Patient was definitely told sensitively that they had cancer	71.6%	73.5%	-2.0%

Many of the best scores for UHBW mainly related to themes around care planning, information-giving and advice. This included a member of the care team helping the patient to create a care plan, reviewing the patients care plan with them as well as patients receiving all of the information needed about the diagnostic test in advance and patients finding advice from the main contact person helpful.

Other high scoring scores (compared to the national average) were around the length of wait at the clinic / day unit for treatment, the care team working together and having a main contact in the team and receiving the right amount of information and support between final treatment and follow up appointment.

Looking at our absolute scores, not comparisons, will often give the clearest indication of what is working well at UHBW and where we should be focused on service improvements. Table 3 and Table 4 show the actual highest and lowest UHBW % scores. Table 4 also identifies some themes amongst the lowest absolute scores.

Table 3: The absolute **highest** UHBW scores: 11 scores ≥ 90%

Q. no.	UHBW %	National average % range	Question
26	98	97-100	Care team reviewed the patient's care plan with them to ensure it was up to date
5	95	90-95	Patient received all the information needed about the diagnostic test in advance
9	95	93-97	Enough privacy was given to the patient when receiving diagnostic test results
19	95	94-97	Patient found advice from main contact person was very or quite helpful
25	95	90-96	A member of their care team helped the patient create a care plan to address any needs or concerns
17	93	88-95	Patient had a main point of contact within the care team
56	92	87-92	The whole care team worked well together

[2] This question score was also below the lower expected range of 75% for this question score nationally

27	91	87-93	Staff provided the patient with relevant information on available support
37	90	84-92	Patient was always treated with respect and dignity while in hospital
38	90	84-92	Patient received easily understandable information about what they should or should not do after leaving hospital
41-1	90	86-93	Beforehand patient completely had enough understandable information about surgery

Table 4: The **lowest** UHBW scores: 7 scores < 60%

Q. no.	UHBW %	National average % range	Question	Themes
23	**50**	46-58	Patient could get further advice or a second opinion before making decisions about their treatment options	Treatment related information
48	**56**	48-58	Patient was definitely able to discuss options for managing the impact of any long-term side effects	
58	**46**	33-53	Cancer research opportunities were discussed with patient	
51	**45**	38-51	Patient definitely received the right amount of support from GP practice during treatment	Care from the GP practice
52	**22**	17-24	Patient had a review of cancer care by GP practice	
50	**48**	44-59	During treatment, the patient definitely got enough care and support at home from community or voluntary services	Support while at home from community or voluntary services
53	**36**	23-40	After treatment, the patient definitely could get enough emotional support at home form community or voluntary services	

4. Free-text-comments

NCPES 2022 provided the opportunity for patients to share their views on their experience of care via free-text questions which asked about aspects that were good about patient care, aspects that could have been improved and any other comments that patients wanted to share. Patient feedback included:

What could be improved?

- *"There could be better communication between departments."*
- *"With so many staff involved in care, it could be much more joined up."*
- *"Communication between different teams and different hospitals."*
- *"From my experience the care in hospital was very good but since leaving hospital the aftercare & communication between GP & Cancer team has been poor."*
- *"Numerous mentions of the stress and anxiety caused by car parking challenges; administration processes and outpatient appointment booking phone lines not being answered."*

What was good about your care?

- *"I cannot fault the clinical and emotional care I have (and still am) received."*
- *"I am very happy with all my help to overcome my cancer and everyone I met gave me time to listen."*
- *"The care and treatment. I had could not have been better. First class."*
- *"Excellent & thorough by every member of staff. All through Covid, which was tough, I felt very safe*."
- *"I received thoughtful, swift, caring and supportive care within the three hospitals that saw me."*

The chart overleaf (Chart 4) shows these comments broken down by topic / theme area and have been grouped by good / positive comments (in green), areas for improvement (in blue) and other comments (in grey).

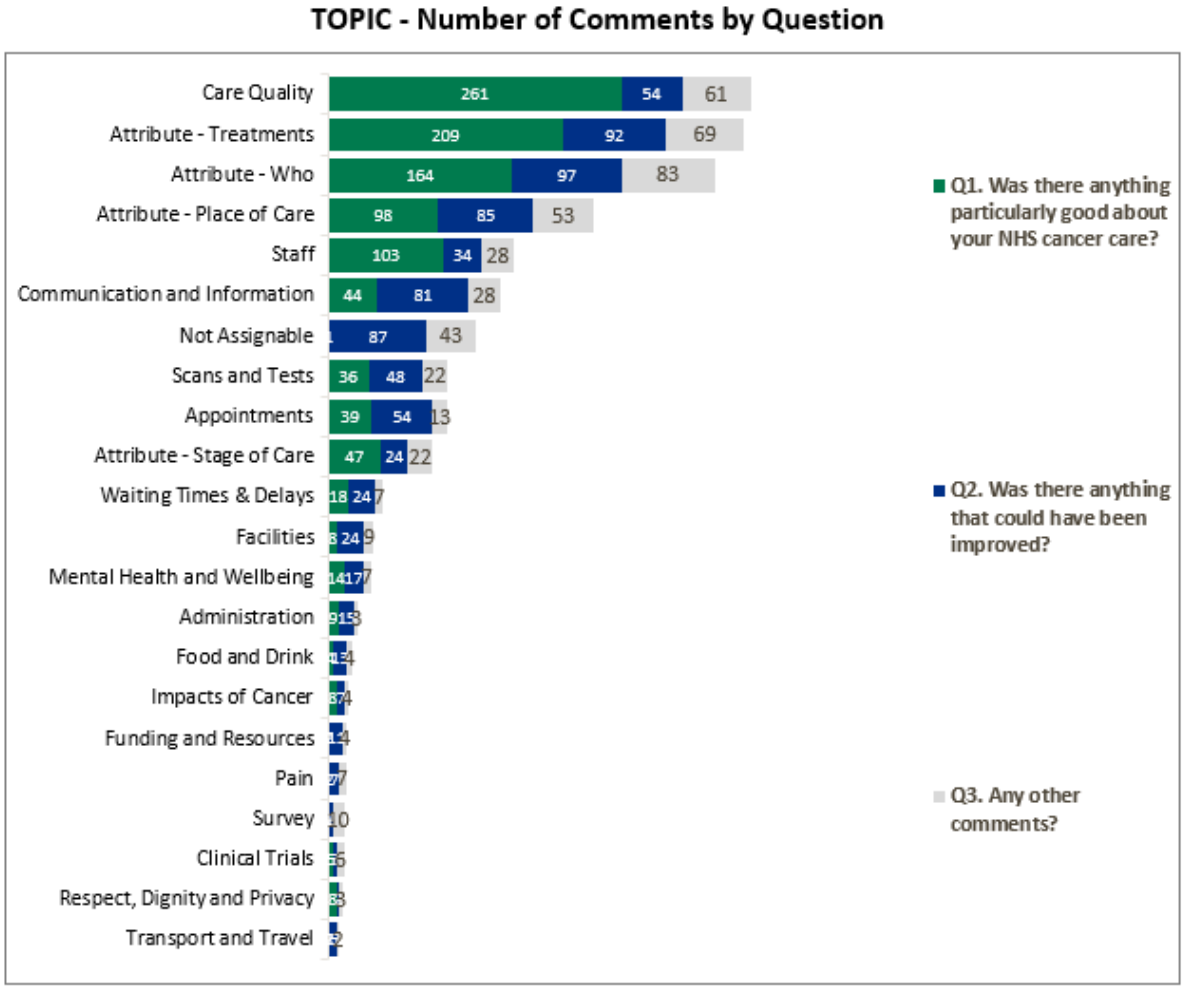
This analysis reveals:

The top five themes of comments (by volume) relate to care quality; treatments; the staff delivering care; the environment (place of care) and staff in general;

- 69% of comments (261/376) relating to **care quality** were positive, with 14% relating to areas for improvement and 20% shared under 'any other comments';
- 56% of comments (209/370) relating to **treatment** were positive, with 25% relating to areas for improvement and 19% shared under 'any other comments';
- 48% of comments (164/344) relating to **staff delivering care** were positive, with 28% relating to areas for improvement and 24% shared under 'any other comments';
- 42% of comments (98/236) relating to the **environment** were positive, however, 36% related to areas for improvement and 22% shared under 'any other comments';
- 62% of comments (103/165) relating to all **staff** were positive, with 21% relating to areas for improvement and 17% shared under 'any other comments'.

The theme with the highest proportion of comments relating to areas for improvement was communication and information. 53% (81/153) of comments, suggesting required improvements.

Chart 4: Free-text comments by topic and sentiment



5. Demographic observations

The report this year has also provided detail on results presented by different demographic groups including age, gender, ethnicity, Indices of Multiple Deprivation (IMD) and respondents with additional 'long term conditions'. This enables us to gain further insight into the potential correlation between different patient demographics and the impact on their reported cancer patient experience.

Looking at the demographic detail in Table 5 (below), the largest groups of survey respondents were over 65, identifying as male or female; White British and from the least deprived areas locally.

Table 5: Demographics of UHBW NCPES 2022 respondents.

	Age	Gender	Ethnicity	Deprivation
Respondents	under 35 - suppressed 5% (29) 35 – 44 — 5% 11% (60) 45-54 — 35% 24% (129) 55 -64 31% (172) 65-74 26% (143) 75-84 — 60% 3% (14) 85+	57% (318) female 37% (207) male 6% (30) – not given / prefer not to say	87% (513) white British 6% (36) not given 3% (17) 'other' White 1% (6) Black, Asian and all other ethnic groups (inc. mixed and multiple)	IMD quintiles[3] 1 – 71 (most deprived) — 27% 2 – 82 3 – 99 — 18% 4 – 147 5 – 158 (least deprived) — 55%

[3] IMD - Indices of Multiple Deprivation – is widely used data-sets in the UK, used to classify the relative deprivation of small geographical areas. Multiple components of deprivation (e.g. crime rates, education, housing, income, employment, health etc) are weighted and compiled into a single figure. IMD is divided into 5 quintiles, 1 being the most deprived areas and 5 being least deprived.

The fact that 87% of respondents identified as 'White British' is so significant, it required closer scrutiny. Was this ethnicity response rate relative to the ethnicity profile of the original survey sample? i.e. was the sample similarly made up of 87% White British patients? See Table 6 (below).

Table 6: 2022 NCPES sample and corresponding response rates:

Ethnicity category		**2022 sample**	**2022 responses**	**% response rate**
A	White British	954 (74%)	513	54%
B	White Irish	11 (78%)	*	*
C	White other	43	17	40%
D	Mixed white and black Caribbean	4	*	*
E	Mixed white and black African	1	*	*
F	Mixed White and Asian	5	*	*
G	Mixed other	5	*	*
H	Asian Indian	3	*	*
J	Asian Pakistani	2	*	*
K	Asian Bangladeshi	3 (4%)	*	*
L	Asian other	6	*	*
M	Black Caribbean	14	6	43%
N	Black African	9	*	*
P	Black other	3	*	*
R	Chinese	1	*	*
S	Any other ethnic group	4	*	*
Z	Not stated	123	36	29%
(blank)		98	*	*
Small number / supressed results, from all these groups to prevent patient identification.			17	
Total:		(1289) **NCPES adjusted sample 1146**	**589**	**51%**

Table 6 shows us that 78% of the original 2022 sample (all people, aged 16 and over, with a cancer diagnosis, discharged from a cancer-related day-case or inpatient episode of care, over a 3 month period at UHBW) were identified as White and only 56 people (4% of 1289) were identified with any other ethnicity.

Whilst the response rate for people from Black and Minority Ethnic (BAME) groups is 40% in this survey, the overall 'White' response rate was a bit higher at 54%. This perhaps raises much bigger questions:

- Why is the 'sample' not more representative of our diverse Bristol population?
- Are diverse communities accessing primary care, cancer screening and cancer services at UHBW?
- Why is the recording of ethnicity data still so poor in the NHS and in UHBW?

In NCPES 2022, respondents were asked if they also had a 'long term condition' (LTC). Table 7 (overleaf) details the number of respondents that self-identified as also living with one or more LTC. From the data below we can see that some people are living with multiple co-morbidities.

Table 7: No. of respondents with long term conditions

Long term condition	Number	% of total respondents (589)
Breathing problem, such as asthma	100	17%
Blindness or partial sight	13	2%
Dementia or Alzheimer's disease	suppressed	suppressed
Deafness or hearing loss	89	15%
Diabetes	56	10%
Heart problems, such as angina	47	8%
Joint problems, such as arthritis	156	26%
Learning disability	suppressed	suppressed
Mental health condition	31	5%
Neurological condition	26	4%
Other long-term condition[4]	70	12%
Total:	588	99%

The feedback from people with other LTCs, and cancer, is challenging to read. It gives the impression (see some of the detail in Table 8), when compared to the wider cancer population who said they didn't have additional LTCs, that this cohort were less well informed and felt less supported, and therefore had a poorer overall cancer patient experience.

It is important that we try to recognise and understand the disparity between the experiences of patients from different demographic groups, in order that we develop processes and services that can be responsive, accessible and inclusive to meet these different needs.

From the limited feedback in this survey, Table 8 (below): identifies some of the potential demographic variations in cancer patient experience.

Table 8: Demographic variations in cancer patient experience

<table>
<tr><th>Demographic</th><th>Initial observations</th></tr>
<tr><td>Age</td><td>Overall, for the majority of questions, people under 64, scored their experiences lower than those over 75 who, generally rated their experiences more highly. Specifically, the greatest difference was seen between Under 45 and Over 75:
<table>
<tr><th>Question</th><th>Under 45</th><th>Over 75</th></tr>
<tr><td>Patient felt the length of time waiting for diagnostic test results was about right</td><td>62%</td><td>83%</td></tr>
<tr><td>Patient found it very or quite easy to contact their main contact person</td><td>63%</td><td>87%</td></tr>
<tr><td>Patient was definitely involved as much as they wanted to be in decisions about their treatment</td><td>57%</td><td>82%</td></tr>
<tr><td>Patient was definitely able to have a discussion about their needs or concerns prior to treatment</td><td>40%</td><td>71%</td></tr>
<tr><td>Patient was always involved in decisions about their care and treatment whilst in hospital</td><td>40%</td><td>86%</td></tr>
</table></td></tr>
<tr><td>Gender</td><td>Overall, there was a fairly consistent level of scoring of experience between people who identified as male or female. A couple of notable exceptions included:
<table>
<tr><th>Question</th><th>Male</th><th>Female</th></tr>
<tr><td>Referral for diagnosis was explained in a way the patient could understand</td><td>58%</td><td>71%</td></tr>
<tr><td>Patient had confidence and trust in all of the team looking after them during their stay in hospital</td><td>87%</td><td>74%</td></tr>
<tr><td>Patient was always involved in decisions about their care and treatment whilst in hospital</td><td>80%</td><td>64%</td></tr>
<tr><td>Beforehand patient completely had enough understandable information about hormone therapy</td><td>88%</td><td>69%</td></tr>
</table></td></tr>
</table>

[4] Autism will be added as a separate condition in the 2023 survey

Ethnicity

The responses were so few for people of Black and Minority Ethnic groups, all the scores were suppressed[5] and not available for comparison.
Comparison is available between those that identified as White and those that chose not to disclose their ethnicity. There were a couple of significant disparities identified:

Question	White	Not given
Cancer diagnosis explained in a way the patient could completely understand	75%	62%
Patient was told they could go back later for more information about their diagnosis	83%	69%
Patient was offered information about how to get financial help or benefits	74%	45%
Patient was always involved in decisions about their care and treatment whilst in hospital	72%	58%
Patient was always offered practical advice on dealing with any immediate side effects of treatment	73%	57%
Patient definitely received the right amount of support from their GP practice during treatment	45%	21%

Deprivation

Overall, there was a moderate variation in levels of experience, mainly within a 0-10% difference in scores across all quintiles. There are a couple of notable exceptions:

Question	More deprived	Less deprived
Patient found it very or quite easy to contact their main contact person	74%	87%
Patient as offered information about how to get financial help or benefits	55%	77%
During treatment, the patient definitely got enough care and support at home from community or voluntary services	29%	49%

Long term conditions

Overall people living with other long-term conditions score their experiences lower, than those with no other long term conditions.

Question	LTC	No LTC
Patient only spoke to primary care professional once or twice before cancer diagnosis	72%	82%
Patient was definitely able to discuss options for managing the impact of any long-term side effects	51%	64%
During treatment, the patient definitely got enough care and support at home from community and voluntary services	40%	60%
Patient definitely received the right amount of support from their GP practice during treatment	42%	55%

6. Improving cancer services at UHBW

There is much to learn for UHBW, from the 2022 NCPES results.

Given the context, that this feedback was collected in 2022 from patients who were experiencing their cancer diagnosis and care during the later stages of the pandemic and while most services were still 'recovering' and managing backlogs, there are a lot of positive reflections and evidence that many services have been sustained despite these challenges. That should be acknowledged.

There are still areas of concern, and it is evident that communication between departments and between hospitals can still be improved. This will certainly be a continued focus for future work.

UHBW has maintained and consolidated the gradual improvements of recent years, but we remain expectant of further future improvement.

[5] Score suppression - where there are fewer than 10 responses for a particular question, that score is suppressed, to prevent potential patient identification.

At the centre of this ambition is the Trust's NCPES improvement plan, which has driven the positive and sustained trend in our survey results since 2015. The Trust's NCPES rolling improvement plan has been updated initially by the Lead Cancer Nurse following publication of the 2022 results and will be further developed following more detailed service-level analysis and discussion in Bristol and Weston with the clinical teams across UHBW, to incorporate specific actions relating to shared learning opportunities across UHBW (see Appendix B1).

There have been continued delays in making progress towards the two main 'bigger tickets' items in the improvement plan. It is still recognised that they are required to bring the anticipated real 'step-change' improvement.

- UHBW is still committed to having a cancer support 'Maggie's Centre' built on-site in Bristol. The establishment of the 'Maggie's Bristol' was understandably paused and delayed during the pandemic, but is back on track now, with complex design and pre-planning discussions underway and a provisional construction plan anticipated for 2025/26. The Trust should be receiving plans to review and approve by the end of 2023.

- The refurbishment and expansion of facilities at Bristol Haematology and Oncology Centre (BHOC). Unfortunately, there has been further delay in progressing the refurbishment of ward D603 in BHOC. Funded by Bristol and Weston Hospitals Charity, plans are now being developed and progressed to deliver a series of improvement projects, including upgrading the Side Rooms, the aesthetics of the ward and renovating the family and patient room. There has been limited progress made with the major BHOC expansion plans. The Trust has commissioned Archus and Laing O'Rourke to undertake future capacity, demand modelling, and develop the business case and provisional designs options for the necessary expansion of services. This remains a critical priority to meet the ever-increasing demand and facilitate a positive step change in patient experience.

A summary of the NCPES results was presented to the UHBW Cancer CNS / AHP Group on 12/9/23; UHBW Cancer Steering Group on 18/9/23, Experience of Care Group on 21/9/23 and Clinical Quality Group on 4/10.23.

The Improvement plan is being developed with input from clinical teams across the Divisions. The clinical teams (as individual tumour sites, e.g. breast, colorectal, lung, gynae etc) are currently reviewing their site-specific NCPES results and working collaboratively across Bristol and Weston sites, identifying priority areas for improvement and planning actions accordingly. Completion of actions and progress will be monitored through this governance route. There is also collaboration with colleagues at North Bristol NHS Trust and across Somerset Wiltshire Avon and Gloucestershire Cancer Alliance (SWAG) to review and progress improvements to shared pathways.

7. Validating our NCPES improvement plan

The intention is to triangulate the themes from the 2022 NCPES results with the ongoing feedback received from the national cancer Quality of Life Survey, identifying priority areas for further exploration. This can then be fed into the newly formed SWAG patient and public voice (PPV) group, enabling focussed deep-dive conversation to unpick the true current and personalised priorities behind the data, to ensure planned improvement activity is prioritised appropriately.

Report date: 26th October 2023 (original version 8th September 2023).
Authors: Ruth Hendy, Lead Cancer Nurse.
Anna Horton, Experience of Care Coordinator.

Ref	Work-stream / actions	Progress	Responsible leads	Timescale
1	<u>New cancer support centre</u> The Trust is working with external partners to develop a new cancer support centre for our patients with cancer. The charity 'Maggie's' will design, fundraise and build a cancer 'wellbeing centre' on-site at 'Maggie's Bristol'. The charity Penny Brohn UK has agreed to work in partnership with 'Maggie's' to deliver some holistic services on site.	Strategic Outline Case for 'Maggie's Centre' at UHBW – approved and supported at Capital Programme Board / SLT / Trust Board April 2019. 'Maggie's Bristol' approved by Maggie's Board of Directors May 2019. PROCESS PAUSED/ DELAYED DUE TO PANDEMIC. RESUMMED, 2022 2022 - Architect and landscape-designer appointed for 'Maggie's Bristol' build. Heads of Term's approved. Project Board established. Initial land searches completed.	Paula Clarke, Director of Strategy and Transformation Jane Farrell, Chief Operating Officer Ruth Hendy, Lead Cancer Nurse	2023 – Design, pre-planning, launch fundraising 2024 /25– planning permissions, enabling and construction 2025/26 – completion, fit-out and move in
2	<u>Refurbishment of ward D603</u> Ward D603 in the Bristol Haematology and Oncology Centre is in need of refurbishment. The refurbishment will significantly improve patient and staff experience on the ward.	Previous plans were delayed due to lack of suitable ward decant facilities. Funding is now being provided by Bristol and Weston Hospitals Charity. A stepped approached towards D603 refurbishment is planned, including upgrading the Side Rooms, the ward aesthetics and the patient and family room.	Owen Ainsley, Divisional Director Jamie Cargill, Deputy Director of Nursing	This was previously unable to progress due to lack of decant facility and then the impact of COVID. Remains a high risk for the Trust. New plans are being finalised.
3	<u>Additional capacity proposal (Phase V)</u> Recognising the need for a more comprehensive and longer-term Trust plan for the delivery of cancer services, an Executive Trust Group will be set up to review these services and the Bristol Haematology and Oncology build.	Unfortunately, the previous scheme (2021) was not prioritised for Trust Capital investment and had high costs associated with it due to the complexity of expanding capacity on the BHOC site. UHBW has identified the development of the BHOC estate as a priority within the Trust's current capital investment programme. Archus and Laing O'Rourke have been commissioned to work with the team in BHOC, by undertaking capacity & demand healthcare modelling, and developing feasibility options and designs. It	Carly Palmer. Associate Director Capital Sophie Baugh, Deputy Divisional Director	Ongoing

		remains a critical priority scheme given the unprecedented change within Haematology and Oncology services (including Radiotherapy) and these changes have dramatically altered the delivery of care.		
	Work-stream / actions	**Progress**	**Responsible leads**	**Timescale**
4	Identified further Clinical Nurse Specialist capacity required, to specifically allow support for patients whilst going through oncological treatment (as well as surgery) – application to Macmillan for 2 years funding and then for posts to be funded by UHBW • Breast Cancer Band 6 2.0wte – Division of Specialised Services • Non-melanoma skin cancer – Division of Specialised Services	Provisional funding proposal SBARs to Macmillan to gauge support Full funding applications to Macmillan Progress longer term Divisional 'pick-up' funding solution	Ruth Hendy, Lead Cancer Nurse Ruth Hendy, Lead Cancer Nurse Jamie Cargill Deputy Head of Nursing, Specialised Services	Oct '23 Dec '23 2024/25
5	Shared learning & review of results across UHBW, with associated actions to increased consistent cancer patient experience across Bristol and Weston. Including focus on • Treatment related information • Awareness of, provision and access to support when at home	Reports with clinical teams across UHBW for further review. Collaborative 'MS Teams' calls in the dairy with all teams, to discuss priorities and planned actions Follow up calls, to provide assurance of progress.	Amanda Bessant Deputy Lead Cancer Nurse / Cancer Matron Weston	Completed July / Aug.'23 Sept / Oct. '23 Jan'24
6	Progress NHS E Cancer Improvement Collaborative (CIC) project to 'improve the experience of cancer care for those with pre-existing conditions' (learning disability, autism, mental health, dementia, sensory impairment)	Application for BNSSG ICS system project for Cohort 5 of the NHS E CIC Application to SWAG Health Inequalities fund for money to support this project Project launch and scoping	Ruth Hendy, Lead Cancer Nurse Ruth Hendy and Fiona Spence UHBW Patient EDI Manager	Successful July '23 Successful, Aug '23 London, 7/9/23

		Patient engagement activity to identify priority actions Development of cancer services 'reasonable adjustments' toolkit, to support equitable access	As above As above	Oct'23-Jan'24 Feb- April'24
	Work-stream / actions	**Progress**	**Responsible leads**	**Timescale**
7	Work with the SWAG Cancer Alliance Patient and Public Voice (PPV) Team to triangulate NCPES results with focus group discussion and Quality of Life survey results.	Feedback to SWAG PPV lead Link in with SWAG PPV engagement activity	Ruth Hendy Amanda Bessant	Completed Sept. '23 Oct.'23 -Feb'24
8	Further unpick the ethnicity profile of the NCPES sample and corresponding response rate, to develop a strategy to improve future feedback from more diverse groups	Feed back to the national NCPES team, about ethnicity data, survey access and understanding of the value of NCPES Understand the NCPES data the correlation with referral / access to UHBW cancer services Link in with BNSSG ICS / public health colleagues, to feed NCPES data into strategies to increase diverse access to cancer services	Ruth Hendy Ruth Hendy Ruth Hendy	Sept '23 Dec'23 Jan'24
9	Improve awareness of and access to support available to people at home; from primary, community and voluntary services.	NCPES feedback to BNSSG ICS Cancer Programme Board – agree plan to address Engage with Caafi Health, Healthwatch and other community partners to develop strategy	Ruth Hendy Glenda Beard GP and BNSSG ICS Cancer Lead	Oct. '23 Oct.'23 – March'24

Appendix C - Briefing report for the 2022 National Adult Inpatient Survey Results

1. Purpose of this report

This report provides a summary of how well the Trust performed in the Care Quality Commission's (CQC) 2022 National Adult Inpatient Survey. The full benchmarking report prepared by Ipsos Mori on behalf of the CQC can be found on the NHS Surveys website here.

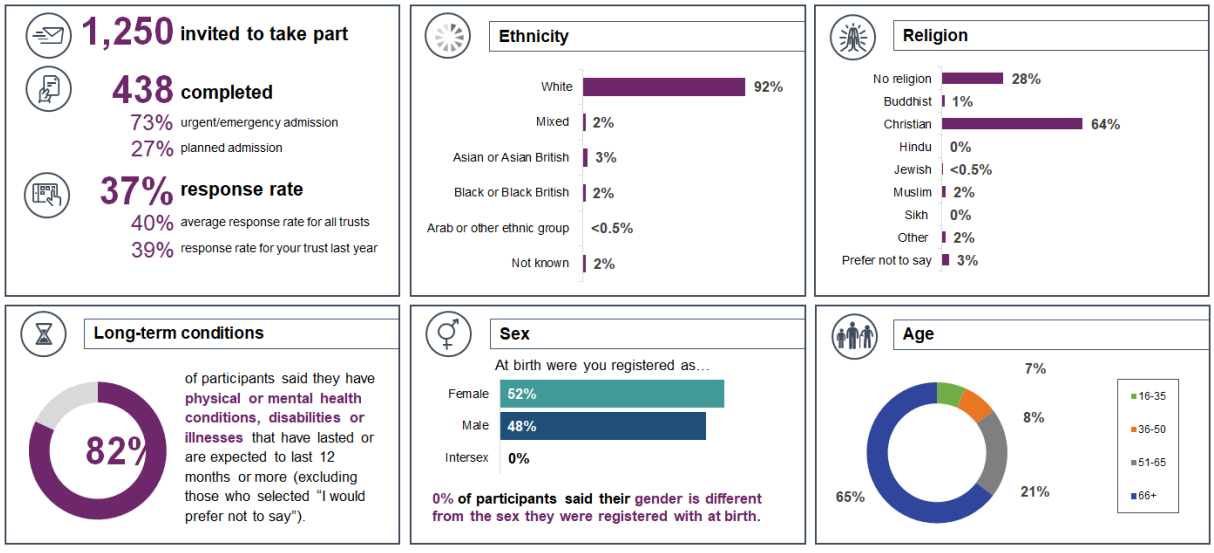
2. Background

The Adult Inpatient Survey is an annual survey that all English acute trusts participate in. It forms part of the NHS Patient Survey Programme which is commissioned by CQC as the independent regulator of health and adult social care in England.

Patients were eligible to participate in the Adult Inpatient Survey if they were aged 16 years or over, had spent at least one night in hospital during November 2022, and were not admitted to maternity or psychiatric units. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between January and May 2023.

The survey was conducted using a push-to-web methodology (offering both online and paper completion). The 2022 results are comparable with data from the 2021 survey (unless a question has changed).

Who took part in the survey?



The percentage of feedback from Black, Asian and Minority Ethnic (BAME) people to the survey was 7.5% which is an increase from the 2021 survey, with only 3% of survey respondents belonging to a BAME community. This is an encouraging improvement. The proportion of BAME patients who stayed as an inpatient in our hospitals during the same period was 6.8% so it is reasonable to suggest that the feedback is broadly representative of the patient demographic for this particular survey. Better understanding the experience of marginalised communities is a challenge shared by the majority of NHS providers. At UHBW, the Patient First Experience of Care priority will aim to reduce this disparity.

3. Headline survey results

The 2022 results show that we score **somewhat better** than the national average for one question - '*After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone*?'.

Results were **about the same** as other Trusts for the remaining 44 questions. There were **no** questions where we score worse than the national average.

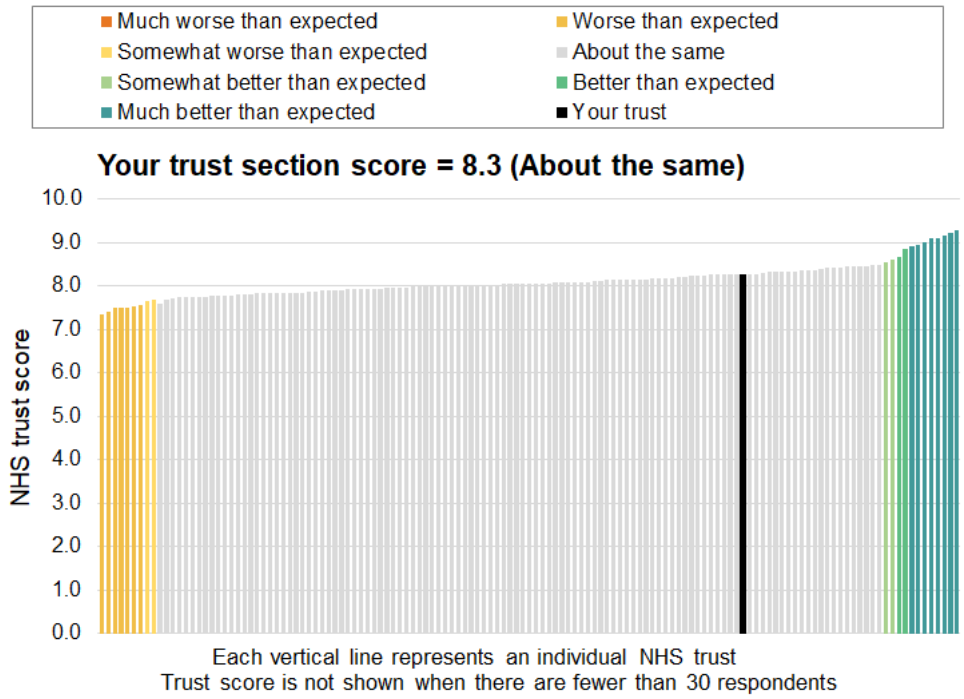
In absolute terms, scores increased for 21 questions when compared to the 2021 results and scores decreased for 13 questions. However, there were no questions where the survey results for UHBW saw a **statistically significant** increase or decrease compared to the 2021 results.

Bristol Royal Infirmary (BRI) saw a very small increase in overall experience rating compared to the 2021 results. However, the increase at Weston General Hospital (WGH) was more significant, with WGH now ranking 112th out of 230 hospital sites that were part of NHS Trusts that participated - a performance that is in line with the national average. The 2021 results for WGH were below the national average (157th out of 230 hospital sites) so this improvement in the 2022 results is to be recognised and celebrated. Responses from Bristol Haematology and Oncology Centre (BHOC), Bristol Heart Institute (BHI) and Bristol Eye Hospital (BEH) were too low to be included in hospital site-level analysis.

Overall experience of care rating

In terms of the 'overall experience' question, UHBW ranks 34th out 133 Trusts with a score of 8.3/10.0 which is an encouraging and positive improvement on our 2021 results (where the Trust ranked 56th with a score of 8.2). This places UHBW amongst the highest scoring Trusts in the South West region.

Chart 1: Overall experience rating, ranked by NHS Trust performance (UHBW score is represented by the black line).



4. Analysis

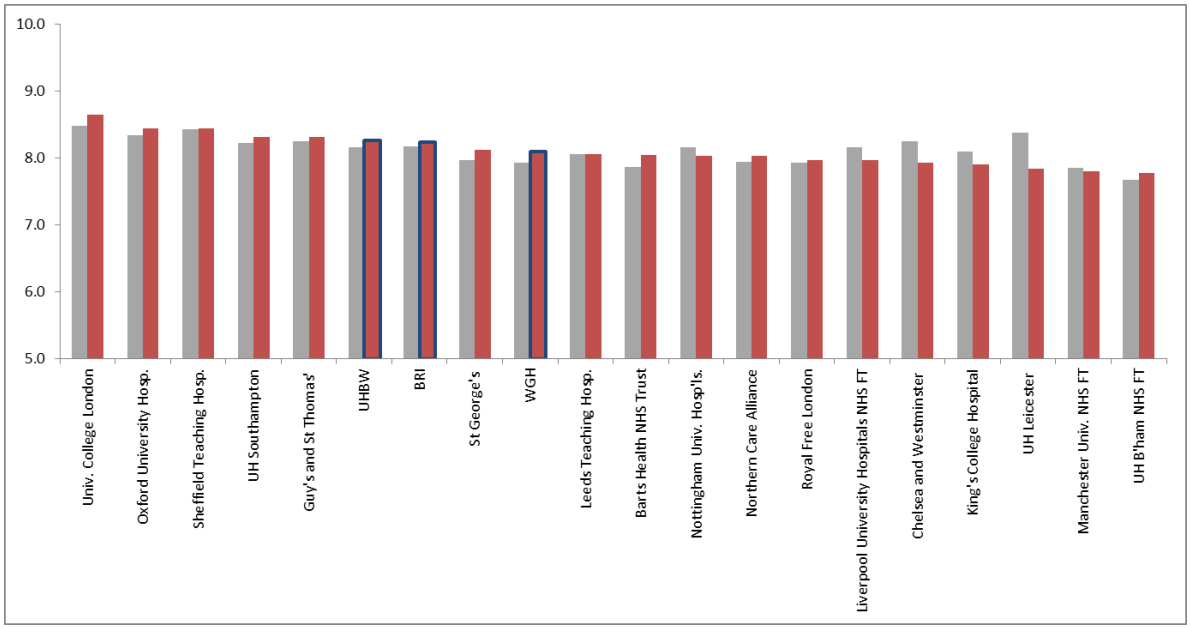
4.1. Benchmarking regionally and nationally

Charts 2 and 3 below compare the overall ratings between geographically neighbouring trusts. These charts contain the overall UHBW score, and include the Bristol Royal Infirmary (BRI) and Weston General Hospital (WGH) displayed separately. Responses from Bristol Haematology and Oncology Centre (BHOC), Bristol Heart Institute (BHI) and Bristol Eye Hospital (BEH) were too low to be included in hospital site level analysis.

Chart 2: Overall patient experience rating amongst geographical neighbouring trusts from the 2021 and 2022 Adult Inpatient Survey – UHBW is in the mid-range of Trusts in the region for overall patient experience. *Please note there is no 2021 score for Royal Devon University Healthcare NHS Foundation Trust because of the merger between what was Royal Devon & Exeter NHS Foundation Trust and North Devon NHS Trust during that period.*

	Royal Devon University Healthcare NHS Foundation Trust	Royal United Hospitals Bath NHS Foundation Trust	North Bristol NHS Trust	University Hospitals Bristol and Weston NHS Foundation Trust	Bristol Royal Infirmary	Weston General Hospital	Somerset NHS Foundation Trust	Yeovil District Hospital NHS Foundation Trust	Gloucestershire Hospitals NHS Foundation Trust
2021 score		8.2	8.3	8.2	8.2	7.9	8.2	8.0	7.8
2022 score	8.5	8.3	8.3	8.3	8.2	8.1	8.1	7.9	7.8

Chart 3: Overall patient experience rating amongst large city acute trusts from the 2021 and 2022 Adult Inpatient Survey –UHBW ranks 6th amongst the 18 large city-centre acute Trusts nationally (shown in the chart below) for overall experience.



4.2. Section 'pathway' trends

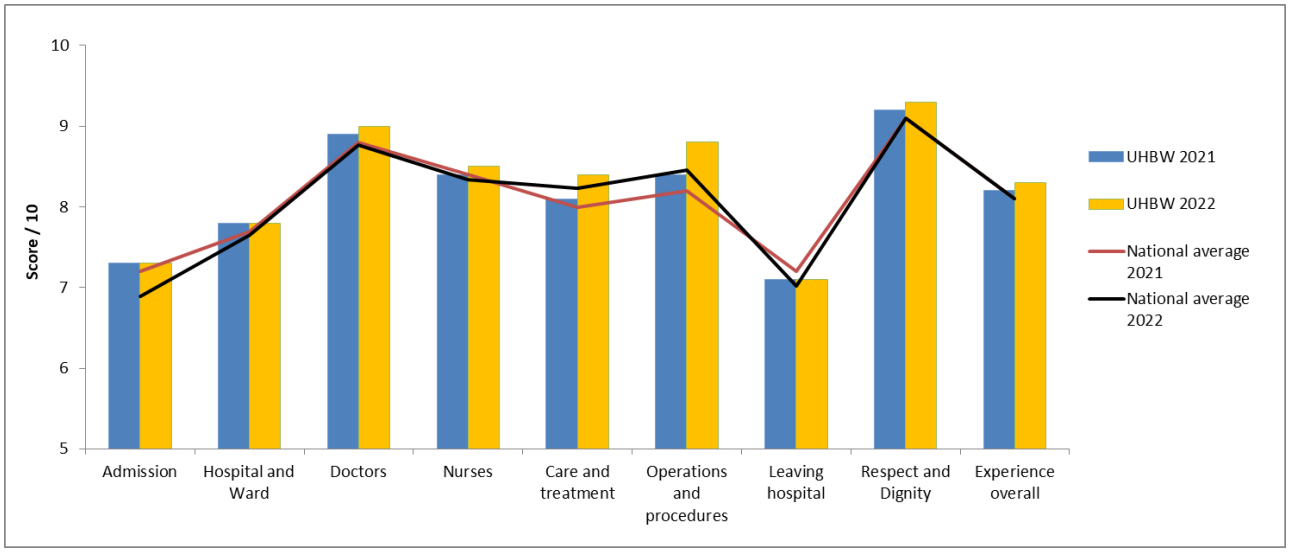
Chart 4 below represents overall scores for each of the section headers within the survey. Sections are groups of questions relating to the same overall theme and they are, to some extent, chronologic in terms of the patient journey during an inpatient stay. The chart compares UHBW section scores to the national average for each section and to results for UHBW from 2021.

There has been an improvement in inpatient experience when comparing November 2021 to November 2022 in six out of the nine sections of the patient pathway. The largest improvements relate to 'Care and Treatment' and 'Operations and procedures'.

In most sections of the survey, patients seen at UHBW reported an experience that was better than the national average. Two areas of comparative strength (as indicated by the larger gaps between the national average line in black and UHBW bar in yellow) was experience of admission of aspects of operations and procedures. Patient reported experience of discharge from UHBW hospitals is in line with the national average.

The chart also conveys the decrease in inpatient experience at a national level relating to admission and discharge, i.e. the gap between the national average red line (2021) and the black line (2022).

Chart 4: UHBW section scores from the 2021 and 2022 Adult Inpatient Survey compared to the national average



4.3. Best and worst performance compared to the trust average (nationally)

The top five and bottom five questions below are calculated by comparing the UHBW results to the average score from all trusts across England.

Where patient experience is best

- ✓ Food outside set meal times: patients being able to get hospital food outside of set meal times, if needed
- ✓ Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital
- ✓ After the operation or procedure: patients being given an explanation from staff of how their operation or procedure went
- ✓ Help with eating: patients being given enough help from staff to eat meals, if needed
- ✓ Involvement in decisions: patients being involved in decisions about leaving hospital, if they wanted to be

Where patient experience could improve

- o Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital
- o Quality of food: patients describing the hospital food as good
- o Further health or social care services: patients being given information about further health or social care services they may need after leaving hospital
- o Help to wash and keep clean: patients getting enough help to wash and keep clean
- o Equipment and adaptations in the home: hospital staff discussing if any equipment or home adaptations were needed when leaving hospital

Please note the topics above relating to improvements needed in the experience of discharge suggest this is an issue at BRI and WGH although feedback is poorer in this area for WGH.

4.4. Comparison to previous results from 2020 and 2021

There were no questions where the 2022 survey results for UHBW saw a statistically significant increase or decrease compared to the 2021 results. However, the information below displays the questions in the 2022 survey results for UHBW where there was a statistically significant increase or decrease in the score when compared to the 2020 results.

There has been a statistically significant decrease in the 2022 patient experience score in eight out of the 46 questions on the survey compared to the 2020 results and a statistically significant increase in two of the questions. Further analysis will take place to understand whether this trend is mirrored in the national results.

The key themes of patient experience where UHBW scores have decreased to a statistically-significant degree are around poor / a lack of communication, discharge planning and patient-perceived staffing levels and the impact of this on both relational and personal aspects of care.

Significant Increase	Point change
Q37. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	+0.8
Q18. When doctors spoke about your care in front of you, were you included in the conversation?	+0.3

Significant Decrease	Point change
Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	-1.5
Q39. Thinking about any medicine you were to take at home, were you given any of the following?	-1.1
Q22. In your opinion, were there enough nurses on duty to care for you in hospital?	-0.8
Q42. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	-0.7
Q9. Did you get enough help from staff to wash or keep yourself clean?	-0.6
Q26. Did you feel able to talk to members of hospital staff about your worries and fears?	-0.5
Q8. How clean was the hospital room or ward that you were in?	-0.4
Q46. During your hospital stay, were you ever asked to give your views on the quality of your care?	-0.3

5. Sentiment analysis for patient comments

An analysis of each of the 905 free-text comments received as part of the 2022 National Adult Inpatient Survey has been undertaken. There were 329 (36%) comments about staff, 268 (30%)about care and treatment, 165 (18%) about pathway of care and 143 (16%) about the hospital environment and facilities.

Just over half (54%) of the comments overall were positive in the 2022 results which is a similar profile compared to the 2021 results.

Two thirds of comments about staff and just over half the comments about care and treatment were positive. However, three quarters of comments on the hospital environment and facilities and just over half of comments on aspects of the pathway of care were negative.

A further breakdown of themes and a selection of patient feedback can be found in charts 5 – 9 below.

Chart 5: Total comments by sentiment

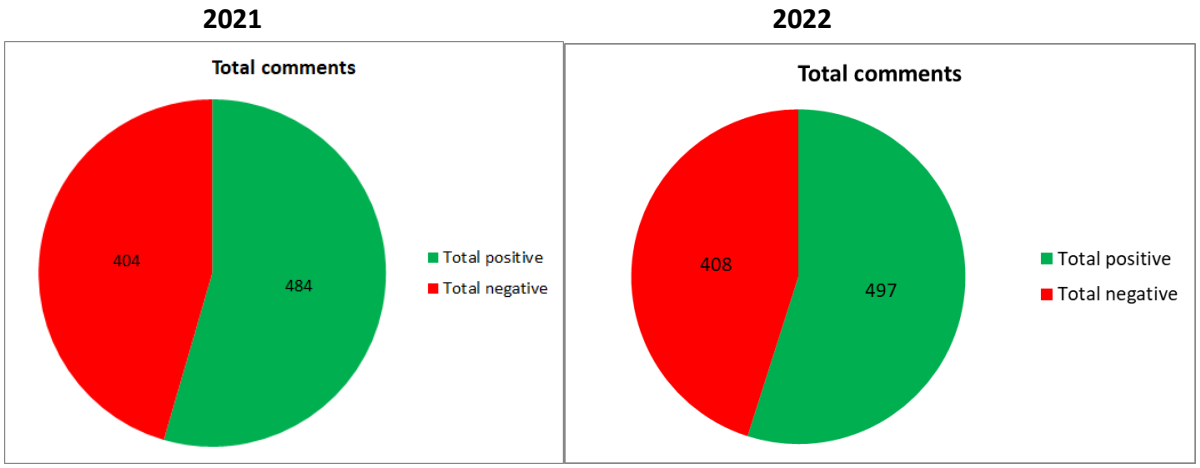


Chart 6: Pathway of care sentiment analysis

- 'Times wasted waiting for pills and medication from hospital pharmacy on discharge. Nearly 5 hours after time given meant just hanging around when bed could be used for others.'
- 'More information to my family (*needed*) also more information (*needed*) on the virtual ward package I was given, as I was just given the box to take home.'

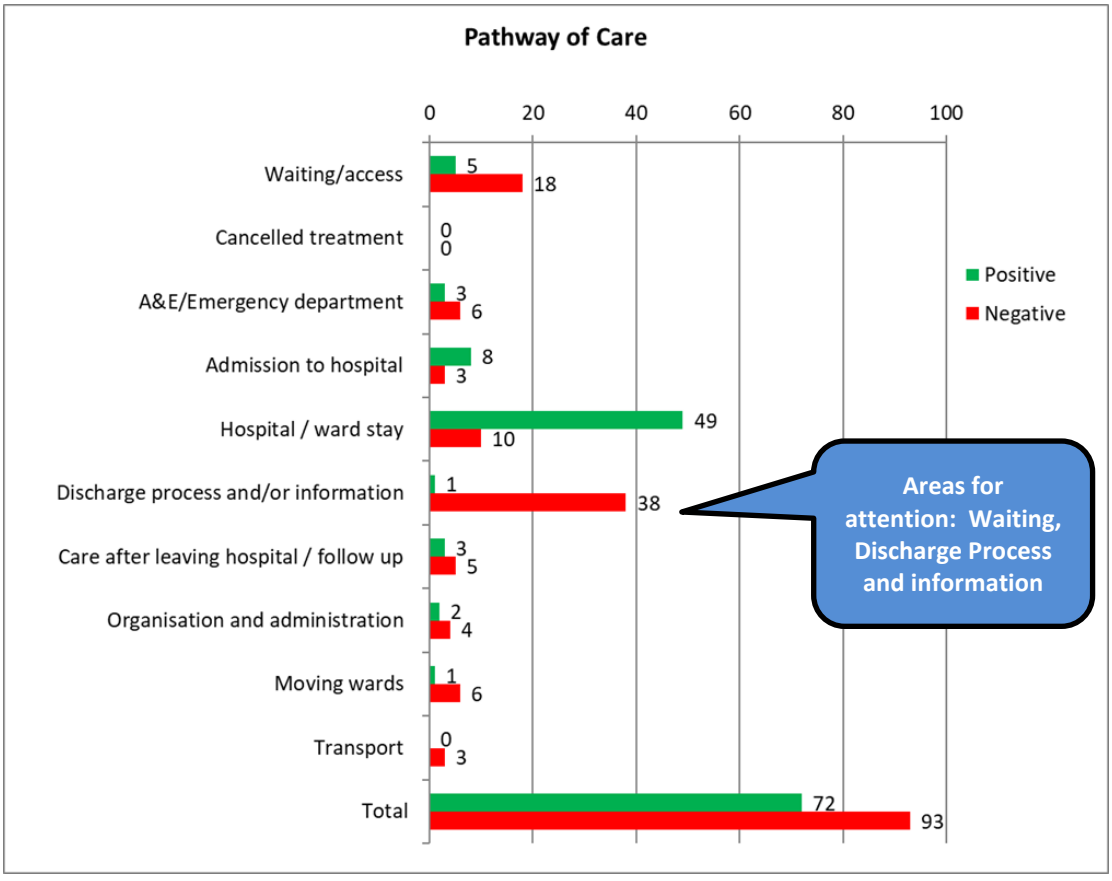


Chart 7: Care and treatment sentiment analysis

- 'I felt I could have had more explanation about what to expect, I was quite afraid and scared to ask. Perhaps some better communication or asking me directly how much I wanted to know would have been helpful.'
- 'I did get a little upset at having tests then no one tells you the results unless there was a problem , you are left thinking " I presume the tests were ok because I have not heard anything different".'

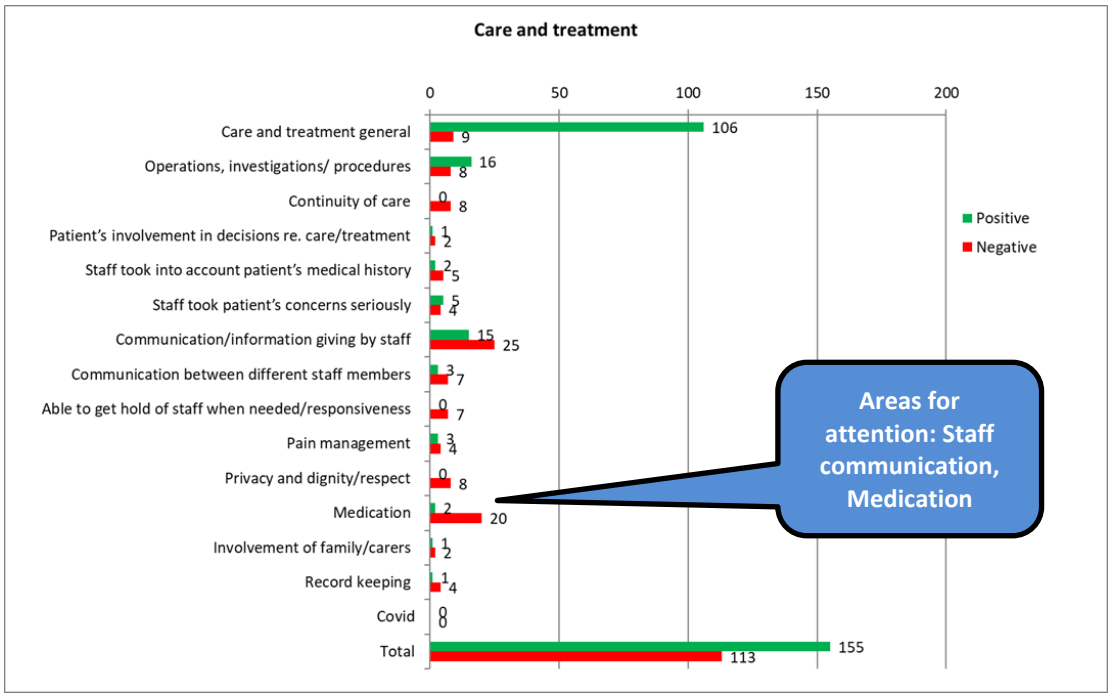


Chart 8: Comments relating to staff sentiment analysis

- 'Relentless care and kindness, I was surprised at the warmth and total care offered, particularly by the nurses.'
- 'Some staff were abrupt. I was given no information about how to operate night lights / bed settings / call bell & no idea what to expect throughout the course of the day/ night. As a result I felt disempowered & vulnerable'

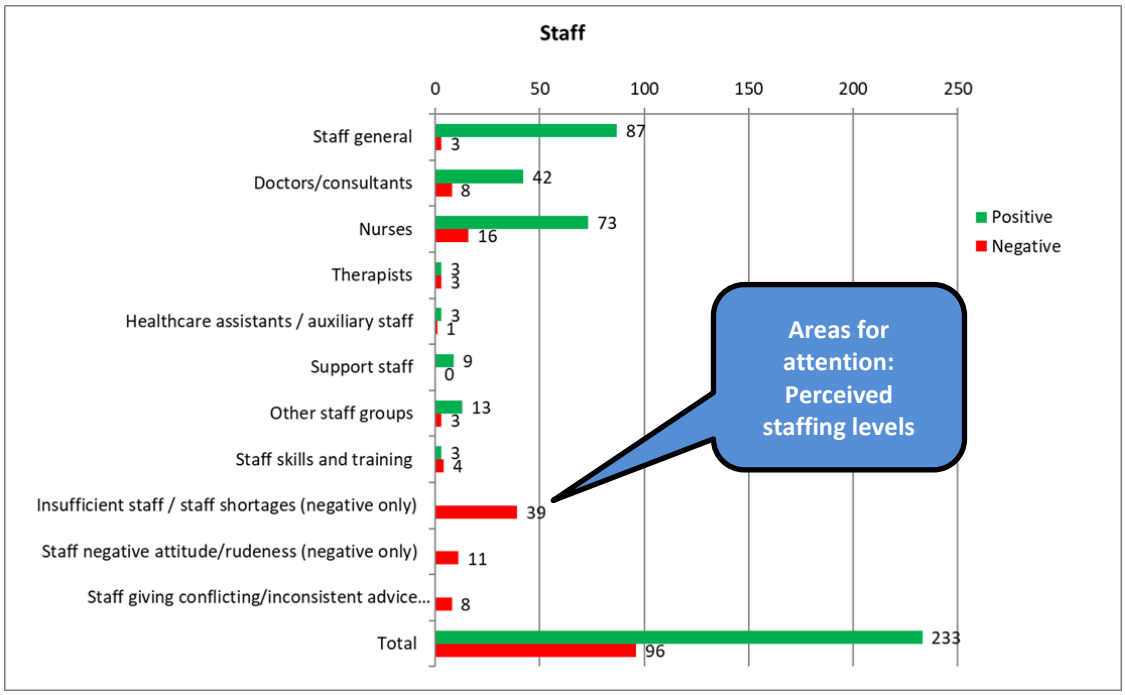


Chart 9: Hospital environment and facilities sentiment analysis

- 'Lack of some equipment i.e. washing bowls a problem.'
- 'The ward was very cold at night and there was not enough blankets'
- 'The food was truly awful, inedible for me, this did not help my recovery. In the end, I went to M&S in the BRI to buy some proper tasting food. Other patients seemed to be able to eat the food, but I struggled.'
- 'Noise - nurses moving heavy equipment throughout the night from upstairs. '
- '2am staff chatting and giggling. Too much lighting at night.'

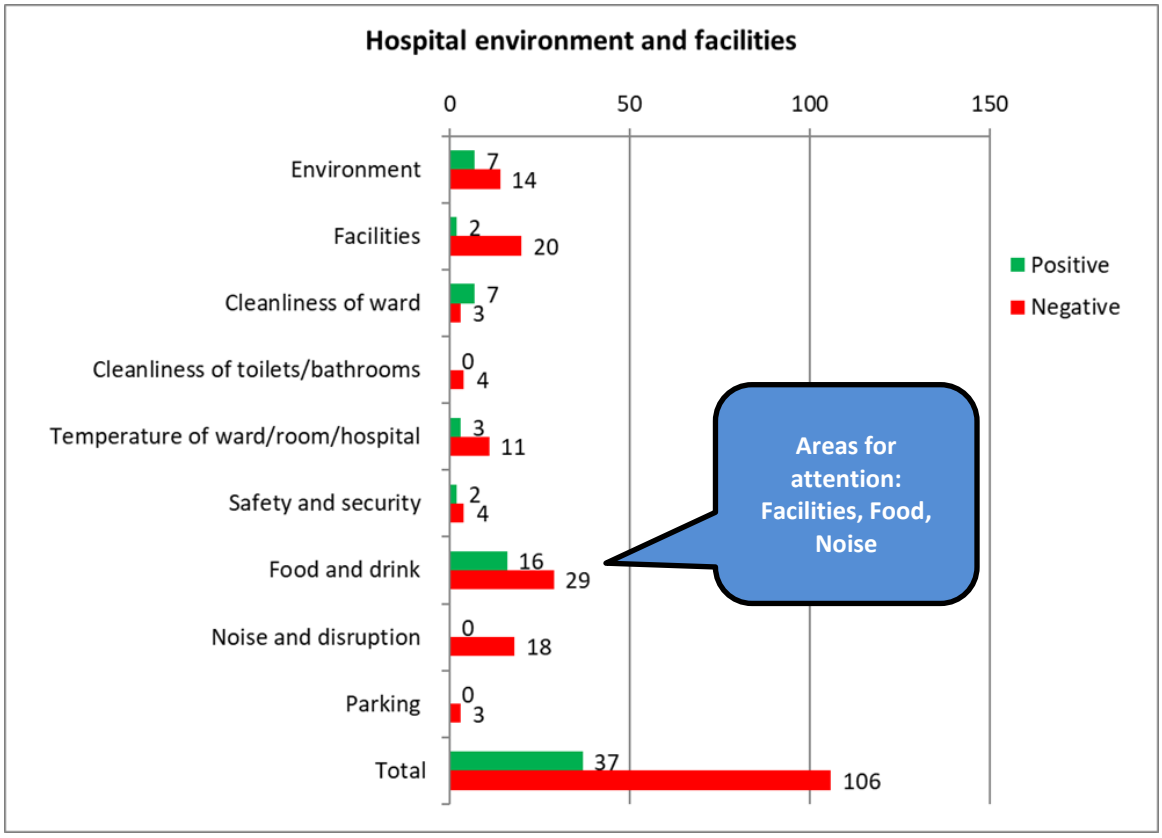
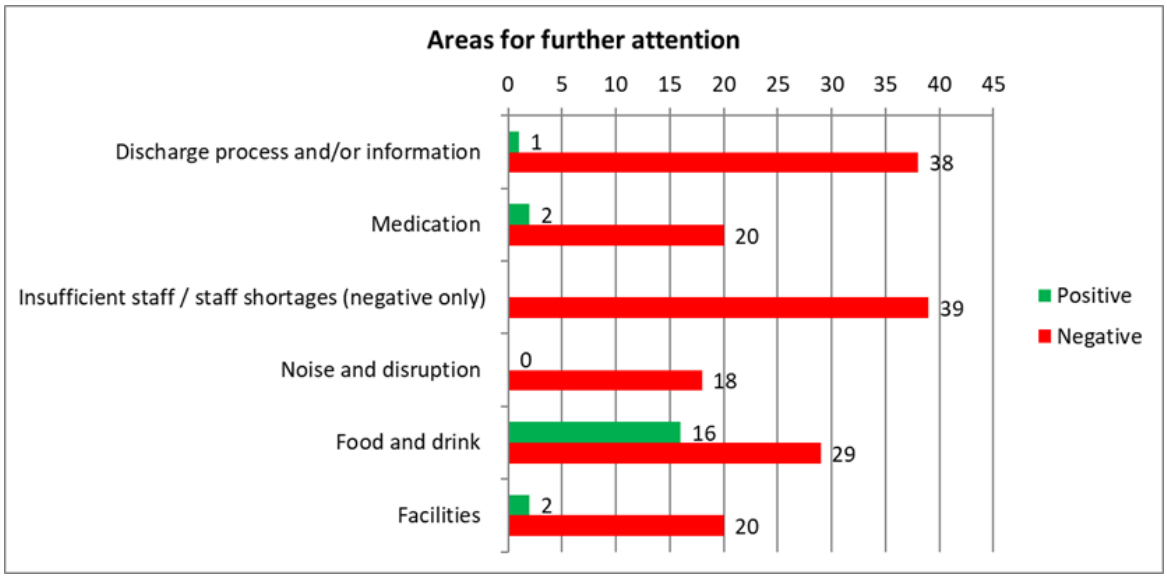


Chart 10: Summary of themes with the highest number of negative comments



6. Hospital site-level analysis (BRI and WGH)

This section compares and contrasts results for the Bristol Royal Infirmary (BRI) and Weston General Hospital (WGH) displayed separately. Responses from Bristol Haematology and Oncology Centre (BHOC), Bristol Heart Institute (BHI) and Bristol Eye Hospital (BEH) were too low to be included in hospital site-level analysis.

At **WGH**, the following **two** questions scored **better** than most Trusts:

- 'During your time in hospital, did you get enough to drink?';
- 'To what extent did you understand the information you were given about what you should or should not do after leaving hospital?'.

At **WGH**, the following three questions scored **worse** than most Trusts:

- 'Were you offered food that met any dietary needs or requirements you had?';
- 'Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?';
- 'After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?'.

At **BRI**, the following **two** questions scored **better** than most Trusts:

- 'When doctors spoke about your care in front of you, were you included in the conversation?';
- 'After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?'.

At **BRI**, there were **no** questions which scored **worse** that most Trusts.

Comparison between WGH and BRI (shown where the performance gap is >=0.5 points and not listed above)

- At WGH, patients were more likely to report that they felt they had to wait a long time to get a bed on a ward after they arrived at the hospital;
- Patients at WGH were more likely to report that they were prevented from sleeping at night by noise from other patients;
- Patients at BRI were more likely to report they were involved in decisions about their care and treatment and were given the right about of information about their condition or treatment;
- Patients at BRI were more likely to report the were able to talk to members of hospital staff about their worries or fears when they needed to;
- Before operations or procedures, patients at BRI were more likely to say that hospital staff were able to answer questions they had;
- Patients at BRI were more likely to that hospital staff involved family or carers in discussions about leaving hospital.

7. Improvement opportunities

The main areas for improvement identified from the results are broadly similar to the areas of focus in the action plan that was created following the publication of the 2021 results. These are:

- A continued focus on **improving support pre and post discharge**, involving patients and their families in discharge planning, more efficient medication to take away (TTA) processes and working with health and social care and wider community partners to ensure patients right support in place at home. Please note the data suggests this is an issue at BRI and WGH although feedback is poorer in this area for WGH.

  Current position: Every Minute Matters programme has now celebrated a year of success in ensuring that 'Each day in hospital actively supports our patients' progress so that no patient is in hospital longer than they need to be'. The workstreams focus on two areas: 1) Proactive Patient Care (ward-based efficiency in patients with criteria to reside) and 2) Proactive Discharges (ward-based efficiency in patients with no criteria to reside). As part of these workstreams there are a variety of projects being undertaken to support our patients discharge from hospital. These include improving communication for patients as part of a structured and standardised proactive board round, improving timelessness of discharges at weekends and use of the discharge lounge through an increased operating model and structure. The discharge lounge is working towards operating as a 24/7 model from Mid-November 2023 and will have bed spaces in order to make the lounge more accessible and comfortable to a wider patient group. Lastly, criteria led discharge is beginning to be rolled out within certain areas of the hospital. This approach aims to improve team communications regarding discharge planning. It ensures that the entire team, including the patient, is aware of what needs to occur before a patient can leave the hospital.

  Two new Transfer of Care Hubs are being implemented to support patients with discharge planning from admission through leaving hospital and into the community; one Hub at the Bristol Site and one at Weston General Hospital. The Transfer of Care Hub will bring together our community partners (Sirona), Local Authorities and Voluntary Sector colleagues across BNSSG to create a new team from multidisciplinary backgrounds.

  The Transfer of Care Hub brings together, Acute Trust Case Managers, Patient Flow Coordinators, Social Workers, Local Authority Discharge Coordinators, Sirona Case Managers, Community OT's, the Homeless Team, Voluntary Services and Flow and Discharge Coordinators. The aim is to be co-located and work collaboratively and holistically to support patients to get 'Home First', focussing the patient at the centre of discharge discussions. Working together provides the opportunity to use collective skills, knowledge and services to maximise patient independence and ensure discharge expectations are realised.

  The Transfer of Care Hubs have introduced a new Therapy role which remit is to investigate the opportunity for a therapy role in the Transfer of Care hub which runs to the end of 2023/24. This role specifically focusses on supporting patients waiting to leave hospital to make sure they do not decondition, liaising with ward therapy teams to ensure the infrastructure and equipment is ready in time for discharge to promote independence.

  The Transfer of Care Hubs have been involved in system workshops to decipher the BNSSG Transfer of Care Hubs operating model. Some of the outputs include an action to create BNSSG

action cards which have clearly defined roles and responsibilities, detailing when and who is the most appropriate person to liaise with the patient, their family and / or carer throughout each stage of their hospital stay so we can provide a consistent expectation for what will happen before and after they leave hospital. Timescales for creation and roll-out are to be agreed with system partners.

- A renewed focus on meeting personal care needs, in particular ensuring **patients get help to wash and keep clean** when they need it.

  Current position: Healthcare Support Workers (HCSW) play a vital role in meeting the personal care needs of patients. In November 2022 (the month this survey relates to) there were 160 FTE B2 HSCW vacancies across the Trust. Following a period of intensive and successful recruitment, this reduced to 90 FTE vacancies as at September 2023. Recruitment for HSCW is ongoing.

  There are a number of existing Divisional initiatives in place that are on focussing on the fundamentals of nursing care standards and 'getting back to basics' of nursing care. These projects include meeting the personal care and hygiene needs of patients. These include:

  - The roll-out of the 'What Matters To You' (WMTY) approach which is a conversation tool to ensure that the areas that matter most to patients each day directly shape the care they receive. Wards at Weston were the first to pilot this approach in early 2023 and are now in the embedding phase. Weston held a 'lunch and learn' on WMTY for other Divisions across the Trust via MS Teams. Divisions of Medicine, Surgery and Specialised are now beginning to pilot WMTY in specific wards, with a view to a full roll-out to all inpatient areas.

  - A renewed focus on the fundamentals of nursing care (a 'getting back to basics' approach) with expected standards of care communicated by and with ward teams in Divisions of Medicine, Surgery, Weston and Specialised Services. This includes a specific focus a meeting the hygiene needs of patients. To support this, Practice Education Facilitators (PEFs) are supporting a HCSW study day which includes meeting the personal care and hygiene needs of patients and this topic is also included as part of new Registered Nursing staff induction.

  - The 'Active Hospitals' programme is being rolled out in some ward areas which is focussed on encouraging patients to be mobile, to meet their personal care and hygiene needs (with support), dressed in their own clothes and sitting up for meals.

  - All Divisions will be monitoring feedback via the Patient Experience Hub (IQVIA) on a monthly basis and reviewing feedback on whether patients feel they had the right support for washing and keeping clean. IQVIA provides the ability to 'drill-down' to ward level and therefore Divisions will target improvement efforts to the areas of comparatively poor performance.

- Improving **the quality and choice of food** to better support meeting the nutritional needs of patients.

  Current position: Catering and Dietetics teams have developed a robust large scale patient food tasting process that occurs every day - involving a wide range of staff in clinical areas.

The re-procurement of the Trust's food supplier is complete with an agreed contract for 2 years with an optional further 2 years agreed with the supplier 'Apetito'. Patient feedback from the monthly inpatient survey suggests the quality of patient food has improved (from the patient perspective) since the transition from TVF (April 23) to Apetito (May 23). The patient-rated quality of hospital food improved from 66% in April to 72% in July. Separate patient food surveys, run by the Catering service, also provide feedback to influence food quality. There is a plan to move to these surveys to the Patient Experience Hub (IQVIA) to provide greater interpretation of data.

The Nutrition and Hydration group (NHSG) monitor the data and their work plan has a key objective to improve learning from patient feedback. This links with another work plan EDI objective to engage community partners in hospital food development and being part of wider events such as Black History Month to ensure a culturally inclusive offer.

Patient involvement in food tasting continues to feature as part of the Trust's approach to quality assurance and improvement. There is a food tasting element to the Patient-Led Assessments of the Care Environment (PLACE) visits which were recently completed.

There has been improvement in patient-reported experience on whether they were disturbed by **noise at night by staff** members from a score of 7.7 in 2021 to 8.2 in 2022. UHBW now performs in line with the national average. This topic was a priority focus in the action plan from the 2021 results and therefore this is a positive sign that the improvement efforts are being felt by patients.

Improving experience of care for inpatients is a Patient First strategic priority area. There is a particular focus within this on improving communication with patients and between staff, based on the common themes arising in patient feedback. Some, but not all Divisions will focus on Experience of Care as one of their priority areas. This will be negotiated through a process known as 'Catch-ball' and will be based on where the data suggests there is biggest room for improvement. Any action plan(s) developed by Divisions to improve experience of inpatient care will be reviewed and recorded by the Experience of Care & Inclusion team. In doing so, opportunities to share learning and improvement approaches across Divisions will be pro-actively explored.

Whilst the National Adult Inpatient Survey is useful as a way of comparing patient experience between trusts, the small sample sizes and delay in publishing the results make it less useful as a timely data source for measuring improvement. To address this, the Trust has an ongoing patient experience programme that supports ongoing monitoring (via survey feedback) of patient experience down to ward-level. This feedback is available across all Divisions, Specialities and Ward areas via the Patient Experience Hub (IQVIA system).

These results have been shared with Divisional Triumvirates and were reported to the Experience of Care Group on 19/10/23 and Clinical Quality Group (CQG) on 1st November 2023.

Author: Matthew Areskog, Head of Experience of Care & Inclusion.

Report date: 1st November 2023 (Original report date 10th October 2023).

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 14th November 2023

Report Title	**Learning from Deaths Annual Report 22/23**
Report Author	**Rebecca Thorpe, Associate Medical Director**
Executive Lead	**Stuart Walker, Chief 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 data and actions for 2022/23.

2. Key points to note

(Including decisions taken)

ALL adult deaths at UHBW were scrutinised by the Medical Examiner service in 2022/2023

Themes of concern:

- Harm including deaths in patients being transferred between UHBW sites, in particular surgical cases between Weston and Bristol
- Harm from delayed/missed interpretation of investigation results
- Feedback from families about communication around
  - End of life and RESPECT
  - Sharing information with next of kin
- Problems with access to insertion of chest drains on Weston site

A deep dive was conducted into our increasing HSMR despite reassuring SHMI include and the following concerns were identified:

a. Periods of operational pressure represented by higher than average risk adjusted LoS,

b. Palliative care coding has a particular impact on HSMR (more palliative care coding results in a lower HMSR). UHBW coding is inline with the national average but our review has identified areas where coding could be improved

Deep Dive into perinatal mortality rates complete, actions now being decided.

Recognition of BNSSG Learning Disability mortality processes by NHSE as exemplary

End of life feedback review scheduled as part of the ReSPECT audit and deteriorating patient workstream.

Newly appointed mortality lead at Weston and SJRs not completed for nearly a year - new candidate commenced in June 2023 and plan made to address backlog.

Under PSIRF, SJRs could be submitted to inquests, and therefore shared with families, so Mortality Group process has been updated to give assurance of each SJR rather than hearing summaries and themes from SJRs.
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.**

Clinical Quality Group	**September 2023**

University Hospitals Bristol and Weston NHS Foundation Trust

LEARNING FROM DEATHS

2022/23 ANNUAL REPORT

Annual Report – Learning From Deaths 2022/23

Authors - **Dr Rebecca Thorpe, Trust Mortality Lead**
- **Dawn Shorten, CMO Mortality Administrator**

INTRODUCTION

This report covers the Learning from Deaths for the year 2022/23.

This report will cover data relating to the programme, the programme group structure and governance processes and analyse themes that have emerged in the year.

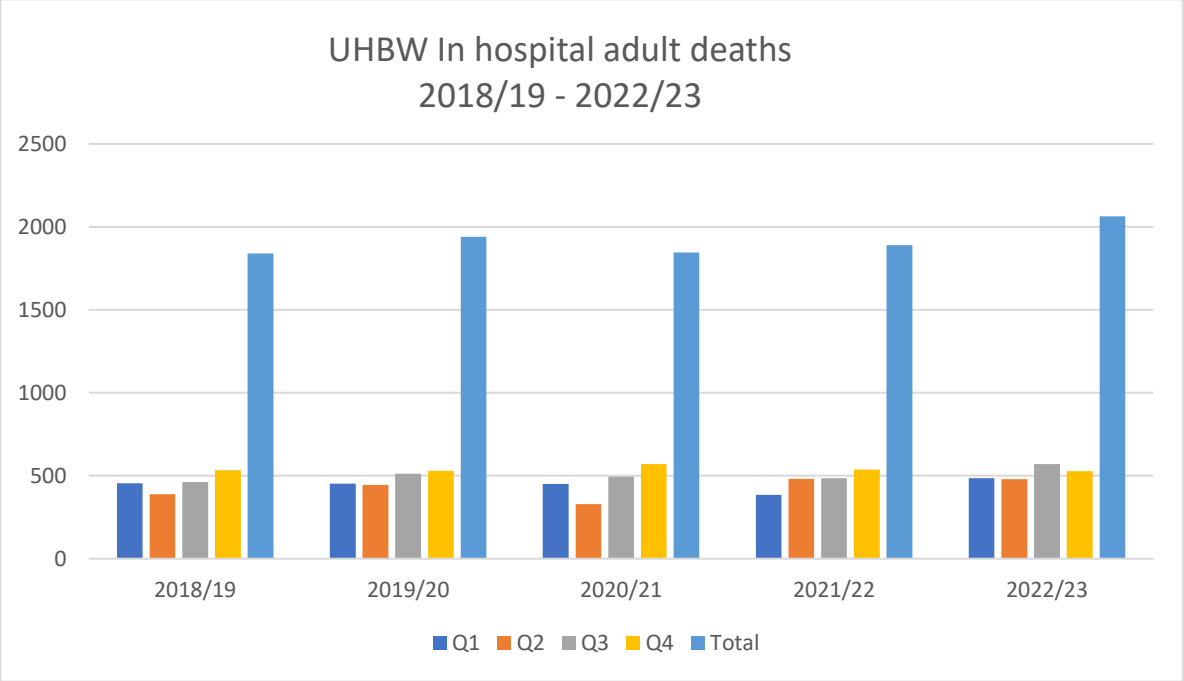
This report covers learning from adult deaths across the Trust and a separate Child Death Review (CDR) report will be shared by the CDR lead.

During 2022/ 23 all UHBW in-hospital adult deaths were reviewed by the Medical Examiners.

Contents **page**

FIGURES AND ANALYSIS

Numbers for overall in-hospital deaths were higher this year than for the preceding 4 years. This was predicted nationally as a result of the impact of the pandemic on delays to elective care. 100% of all UHBW deaths were reviewed by the medical examiners.



Scrutiny of SHMI and HMSR figures has been undertaken in the Quality Intelligence group which monitors benchmarking alerts, see data below.

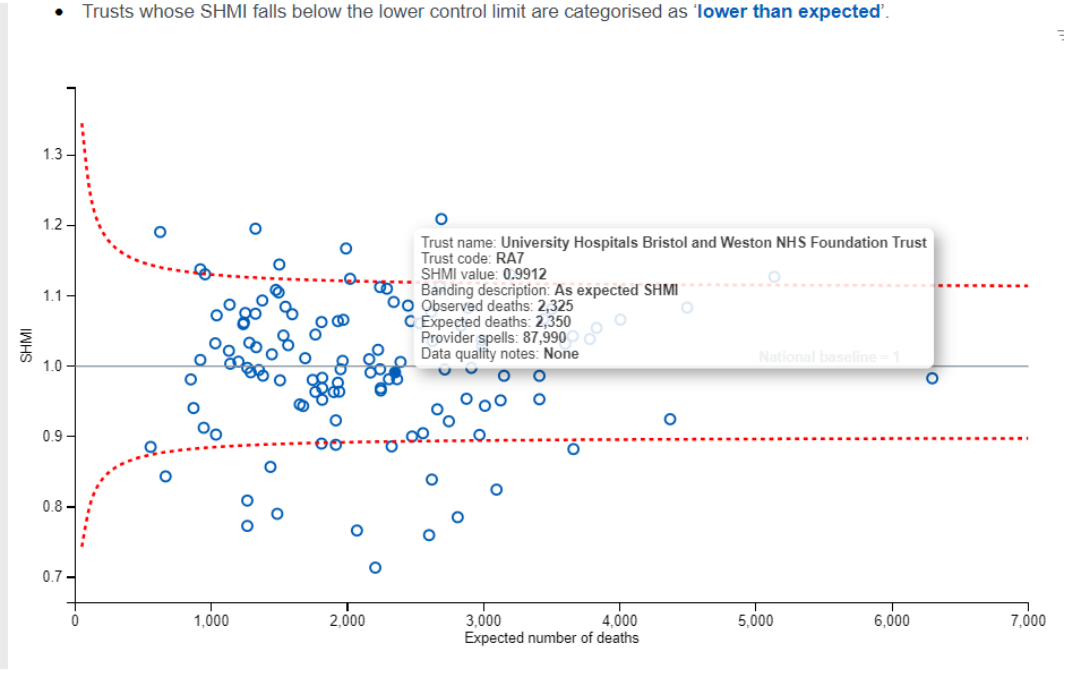
Summary Hospital-level Adult Mortality data annually 2022 –2023

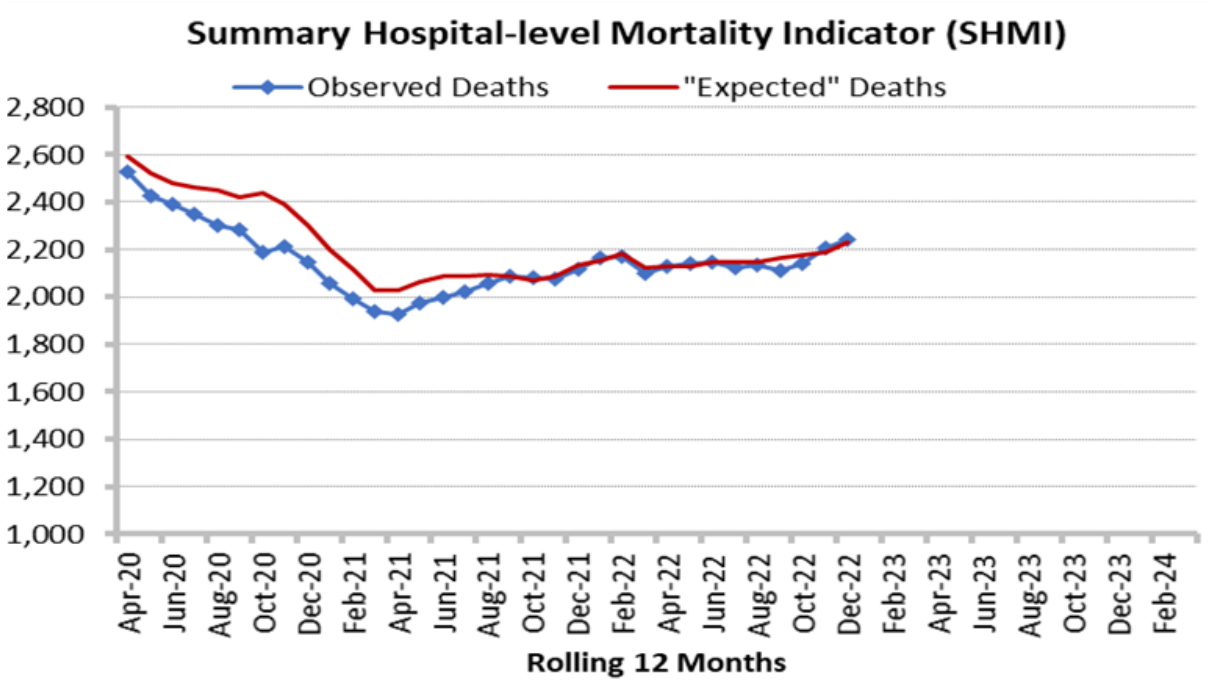
Mortality indicators are used as alerts to identify something that needs closer investigation. This indicator is published nationally by NHS Digital and is six months in arrears. This data is now provided by NHS Digital as a single figure from UHBW. SHMI is derived from statistical calculations of the number of patients expected to die based on their clinical risk factors compared with the number of patients who 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”.

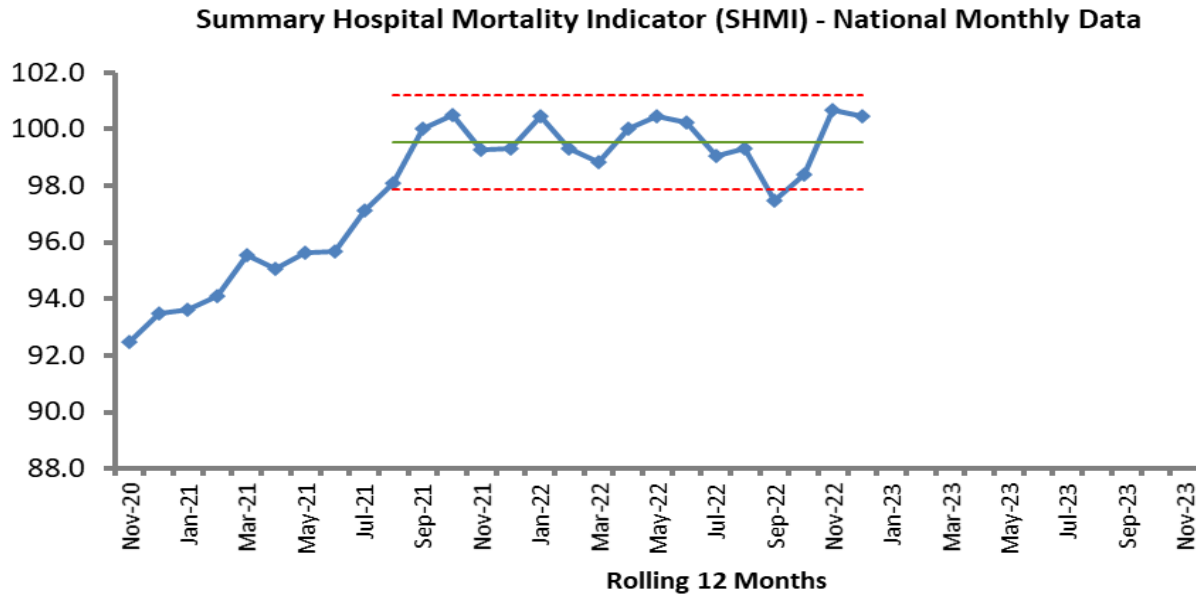
The Summary Hospital Mortality Indicator for UHBW for the 12 months January 2022 to December 2022 was 100.4 and in NHS Digital's "as expected" category.

Rolling 12 Months To:	Observed Deaths	"Expected" Deaths	SHMI
Apr-22	2,130	2,130	100.0
May-22	2,140	2,130	100.5
Jun-22	2,150	2,145	100.2
Jul-22	2,125	2,145	99.1
Aug-22	2,135	2,150	99.3
Sep-22	2,110	2,165	97.5
Oct-22	2,140	2,175	98.4
Nov-22	2,205	2,190	100.7
Dec-22	2,240	2,230	100.4
Jan-23	2,255	2,300	98.0
Feb-23	2,325	2,350	98.9
Mar-23	2,325	2,385	97.5

The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to diagnosis group level if required, and investigating any identified alerts.





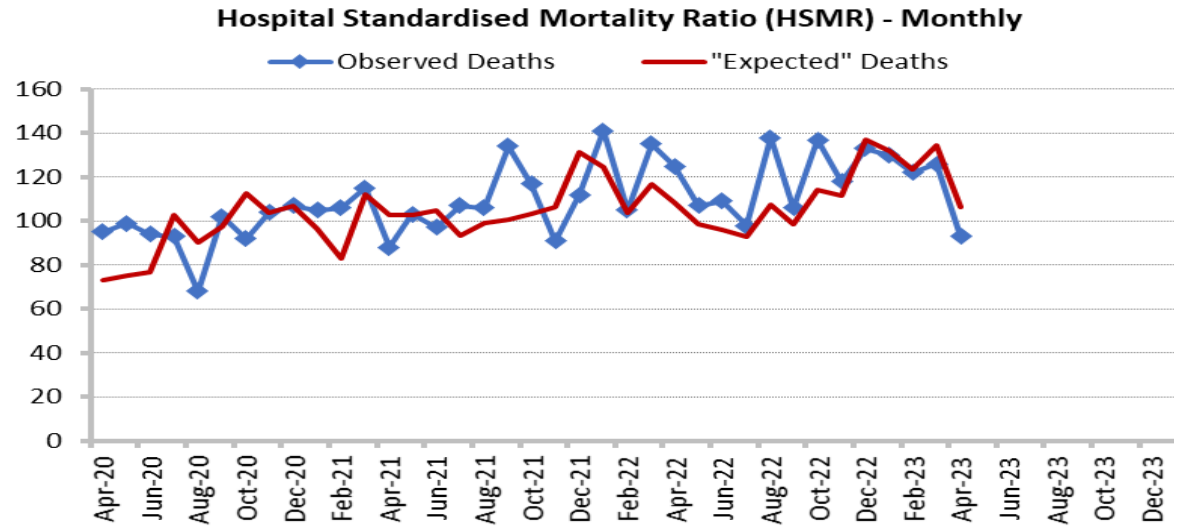


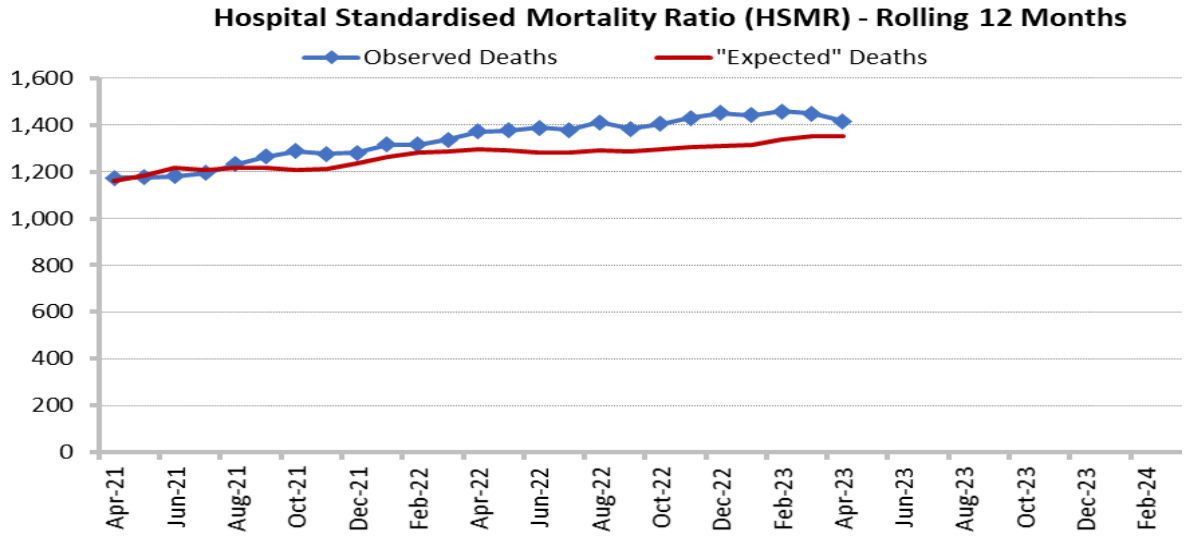
Hospital Standardised Mortality Ratio

The following two graphs show UHBW HSMR. A deep dive was conducted into our increasing HSMR despite reassuring SHMI include and the following concerns were identified:

- Periods of operational pressure represented by a higher than average risk adjusted Length of Stay (LoS),
- Palliative care coding has a particular impact on HSMR (more palliative care coding results in a lower HMSR). UHBW coding is in-line with the national average but our review has identified areas where coding could be improved

More detail on the deep dive can be found in the Thematic review section later in this report





UHBW in-hospital adult deaths per quarter

Winter pressures began early in the year with summer also being busier than usual. The autumn demand for emergency services was unprecedented, resulting in long waits for ambulances in the community and extended queues for admittance to ED.

For this period the healthcare system was experiencing the after effects of the COVID-19 pandemic with a steep increase in the number of high acuity attendances in emergency care, reflected in the peak in the number of deaths in the 3rd quarter.

This was predicted nationally as a result of the impact of the pandemic on primary care and elective services through the preceding years coupled with a seasonal peak in COVID and severe respiratory infections.

The winter period was followed by spells of industrial action from nurses and Junior Drs, again negatively impacting elective and emergency care capacity.

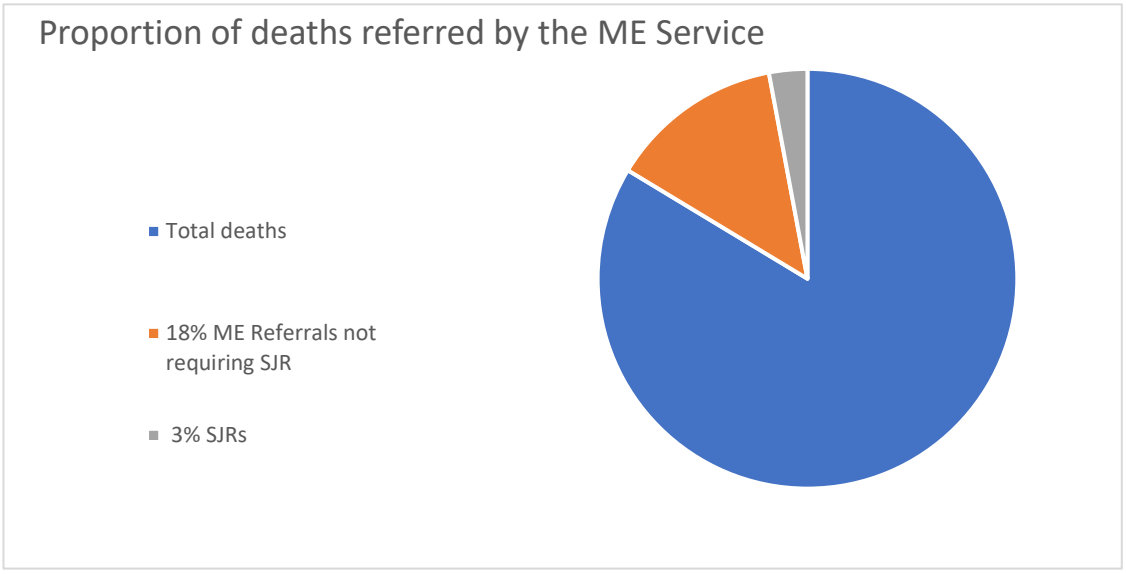
2022-23	Q1	Q2	Q3	Q4	Total
Medicine	338	342	421	403	1504
Surgery	68	60	73	63	264
Specialised	80	77	75	62	294
Weston	# now included with clinical divisions				
Other			1		1
Total	486	479	570	528	**2063**

Note: Weston site data is now fully integrated into UHBW clinical division data.

Medical Examiner Referrals

Of the 1504 total adult Trust deaths 294 (19%) were flagged as of possible concern by the Medical Examiners (ME) . These were 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 in governance and processes (appendix 1).

The ME process is intended to identify any issues that may be missed through standard monitoring processes, taking note of feedback from families and carers when discussing the medically certified cause of death.



Of the 294 referrals, 53 (18% of referrals, or 3% of deaths overall) initially met the criteria for a Structured Judgement Review – the approved process developed by the Royal College of Physicians for conducting reviews in treatment/care as part of the learning from deaths process. Upon examination 4 were found to have not met the criteria for mental health or Learning disability and so the outcome was 49. As well as assessing the care and treatment given to the patient during each phase of care, the SJR also gives an indicator of the avoidability of the death of the patient during the last spell of care.

The criteria for requesting an SJR are as follows:

- **Concern raised around care / treatment**
- **Indication of a serious learning disability / autism / serious mental Illness**
- **An elective admission**
- **Patient under 18**

For this period SJRs were not requested for patients where other patient safety processes or coronial referrals were taking place unless mandatory criteria indicated. This however changes from April 2023 as the new Patient Safety Investigation and Review Framework moves away from Root Cause Analyses towards thematic reviews and the SJR becomes a more significant source of narrative in cases where the patient has died.

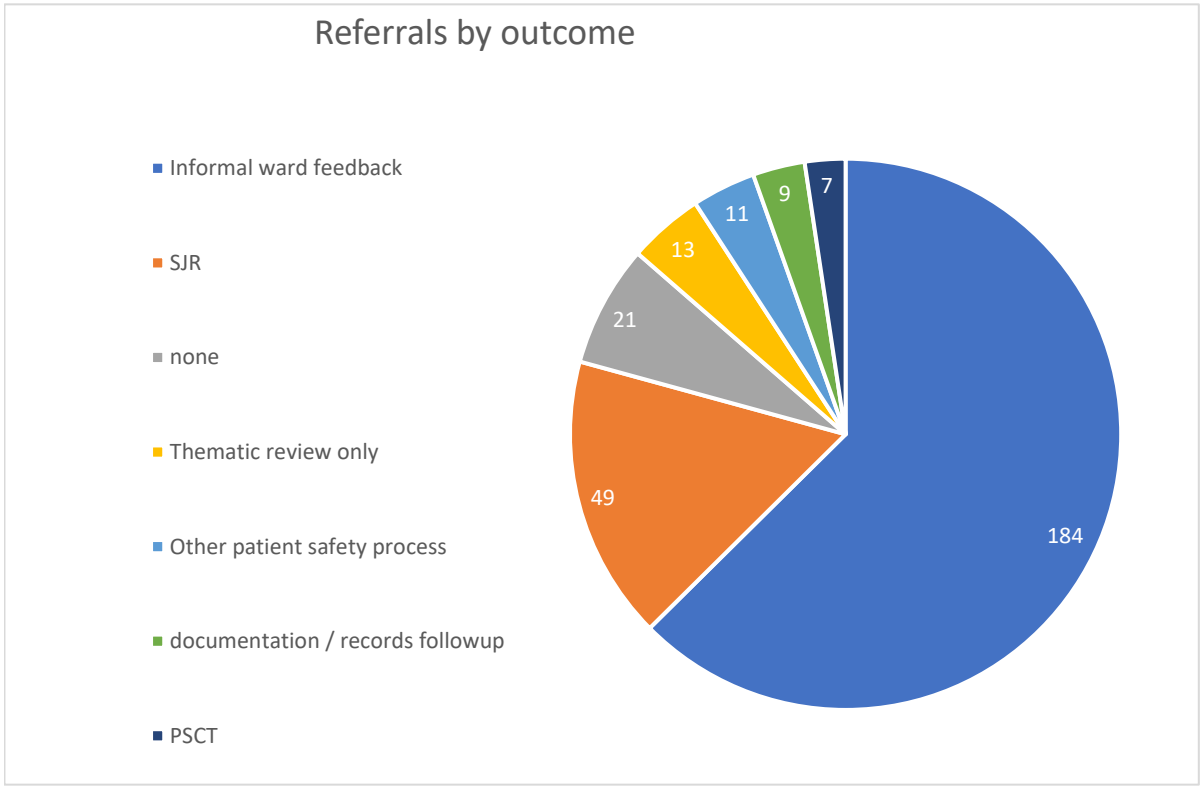
Medical Examiner referrals triaged by outcome

Of the 294 Medical Examiner referrals to feedback with their concerns or comments from families 21 required no further action and 24 were Coroner Referrals, none of which progressed to inquest.

The majority of referrals were assessed as requiring informal feedback, 184 were copied to the wards and clinical areas with requests for sharing learning as appropriate.

36 were complimentary of the care given :

"The care on ITU was absolutely amazing"
"Iona was lovely and went way beyond expectations spending a lot of time with my Dad"
"I cannot fault the care Anna has received this admission - it was absolutely fantastic from everyone, including the Macmillan team, the cleaner, ward clerk (a brilliant, wonderful guy!), the coffee shop staff and all the HCPs. As I work in an NHS hospital myself, I can judge a good ward and they are doing an amazing job! Anna had a good rapport with the staff and felt really safe and well looked after so in the end decided she wanted to stay on the ward for EOL care - that really says it all."



Process followed	Number
Ward/Clinical Area feedback	184
SJR	49
none	21
Thematic review only	13
Other patient safety process	11
documentation/records follow-up	9
PSCT	7
Total	294

Referrals by theme

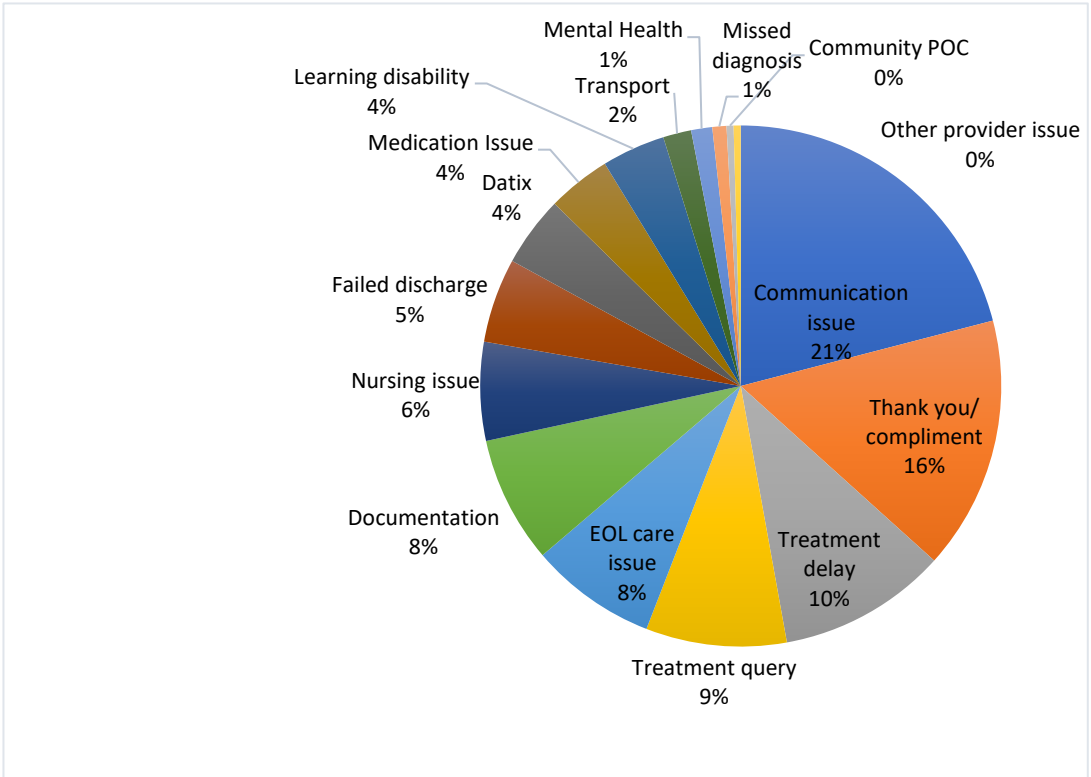
By far the most common theme emerging from the referrals was communication – telephone access to ward staff and information was cited – particularly over the winter pressures.

Some communication issues also involved the understanding around expectations for end of life treatment or processes and how these are communicated. A programme of teaching to nursing around communication and end of life care has commenced in relevant areas. End of life care out of hours and on weekends was noted in a number of comments which were subject to a review by the End of Life group and the Deteriorating Patient Group.

The End Of Life group now monitor all feedback and this is helping to support the expansion of the service and improve communication with families around EOL processes and best care.

Some feedback expressed concerns around the availability of nurses on the wards, much of this occurred around the time of winter pressures; the nursing directors reviewed staffing and at the times of the feedback there were issues with fully staffing the wards which are now resolved.

Fig. Referrals by theme

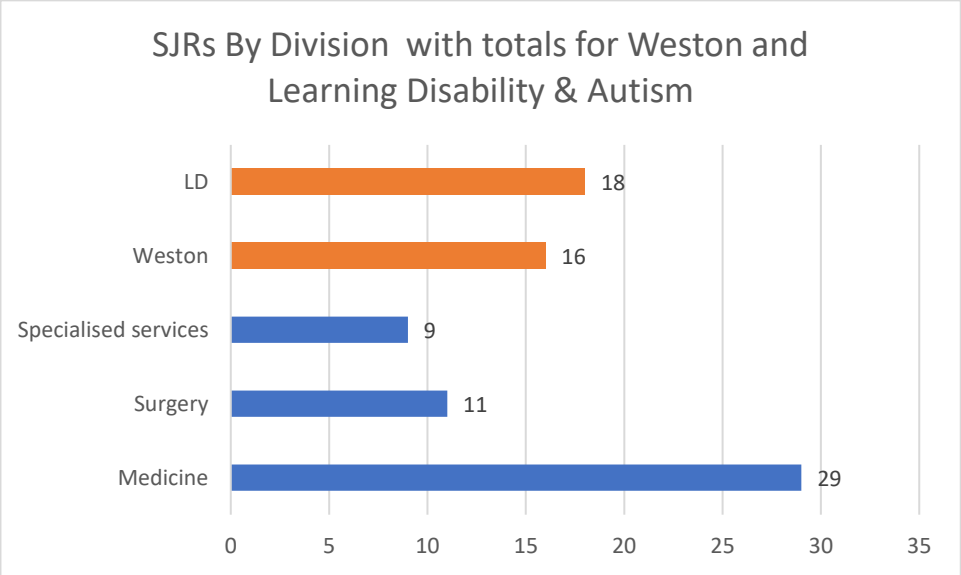


Positive feedback and thanks from families are also fed back to clinical areas to recognize the compassion and kindness of nurses and clinicians in caring for patients and supporting their families through the traumatic experience of bereavement.

Structured Judgement Reviews

Fig 1. Structured Judgement Reviews (SJRs) by division

78% of patient deaths take place within the Medicine Division which is reflected in the proportion of deaths requiring an SJR; 59% of sjrs were completed within the division - 29 were requested out of a Divisional total of 1504 deaths. Of the 49 SJRs requested from across the Trust 16 were for patients cared for in Weston, representing 32% of the overall total, with 3 of those referrals being for mandatory LD/MH category patients.
36% of the total number of SJRs were mandatory category Learning Disability or Mental Health reviews.



SJR Outcomes

Phase of care scores
The majority of structured judgement reviews assessed care as good with prompt reviews and treatment, and those rated as adequate fell within accepted prescribed parameters of appropriate care. Of the 53 referred for SJR, 2 cases were assessed to have received poor care; one due to delayed administration of medication following an NSTEMI, the other case was of an 80 year old fractured neck of femur patient who deteriorated post operatively and senior review was delayed, the patient had a completed Respect form and was not for resuscitation. Learning was shared with the appropriate teams at Mortality and Morbidity review meetings (M&Ms).

Avoidability scores
The majority of reviews gave ratings of 4 and above (4= highly unlikely to be unavoidable 5 = unavoidable) . 2 patients were rated as 3 for avoidability (less that 50:50 - probably avoidable) and both were elderly frail patients undergoing surgery, one had deteriorated in general condition awaiting elective surgery, the other raised learning points around delay to senior review, senior assessment of imaging on admission, and decisions around commencing anti-coagulants prior to surgical assessment

Fig. % Overall care ratings

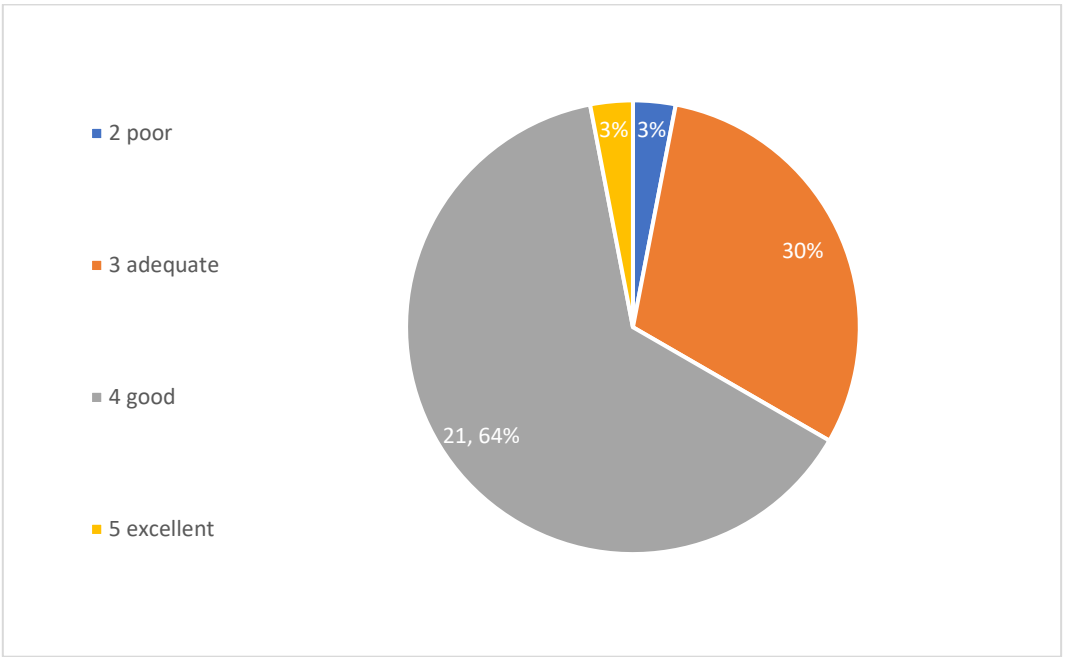
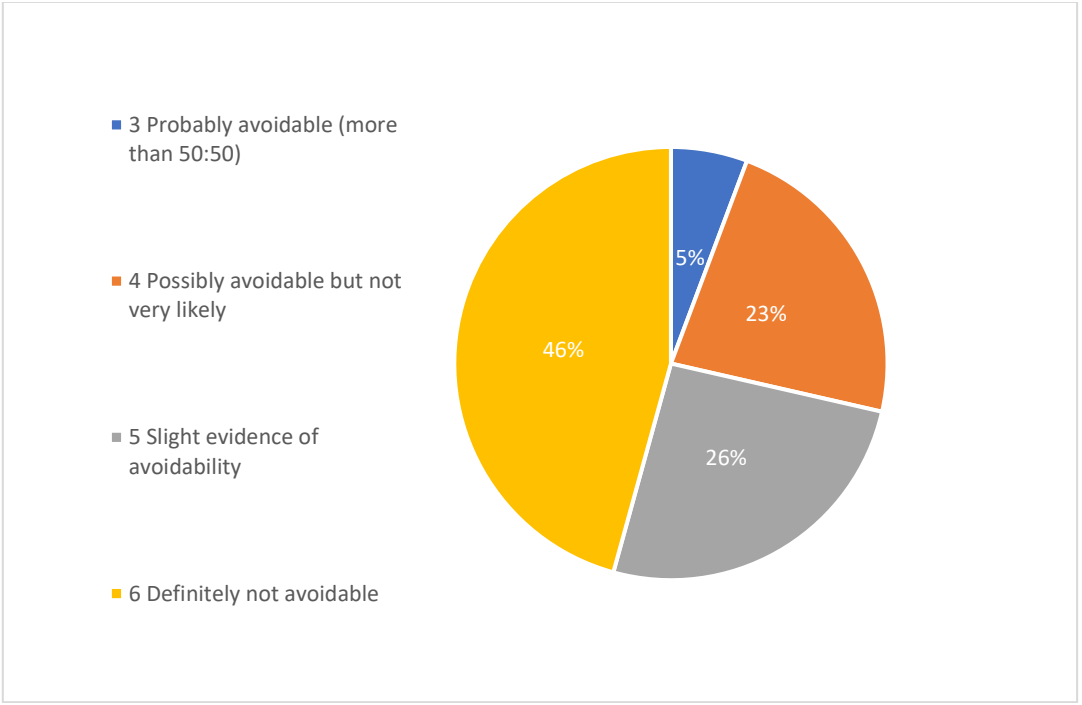


Fig % Avoidability ratings



Mortality Lead Summaries

Learning Disability and Autism - LEDER Reviews

This year saw the introduction of Autism as a category for mandatory review

A total of 18 deaths were reported by the Trust Learning Disability and/or Autism team onto the LeDeR platform (22 deaths reported in 2021/22). 12 deaths were within UHB and 5 within WGH. Only 2 deaths of autistic people were recorded during 2022/23, this is in line with local data. There were 64 deaths reported across BNSSG, with 59% of patients with a learning disability dying in acute hospitals. Key findings from the Structured Judgement Review (SJR) are shared with the mortality surveillance group, lead clinician, Matron, Deputy Head of Nursing and ward sister. The specialised SJR is also shared with the external LeDeR reviewer supporting a comprehensive review. The key findings and any actions required are included on the divisional reports presented by the divisional leads at the learning disability and/or autism steering group.

On average, due to reduced staffing levels within the learning disability and or autism team during 2022/23 the SJR took between 2- 4 months to complete following the date of death. The key findings were most commonly linked to poor understanding and completion of Mental Capacity Act (2005) assessment and MCA documentation.

The primary cause of death most often recorded was aspiration pneumonia followed closely by pneumonia and then sepsis; this is in line with national data.

In 2023/24 the process for completing an SJR on patients with a learning disability and/or autism has improved to include a medical overview, this may lead to an increased review period. Recruitment within the learning disability and /or autism team has proved successful; duration between date of death and SJR completion by the specialist team will reduce.

Medicine Division

There was no dedicated mortality lead until the role was finally appointed to in February 2023. Mortality referral for this time were managed by the Clinical Chair who responded to concerns and issues within the division. The themes prevalent in the division reflected Trust wide themes around frailty. Recognition and communication for deteriorating patients is improving and there is a good referral rate to palliative care, especially as teaching was limited last year due to funding issues.

Specialised Services Division

The cases where referrals were made were also subjected to M&M discussions, including cases where the threshold for an SJR was not considered to have been reached. In those cases where SJRs were completed trust wide themes of frailty and transfer issues were noted. A number of highly detailed M&Ms were conducted with teams from ICU, CICU with a wide range of specialist input.

Surgery Division

The total number of Structured Judgmental Reviews (SJRs) completed in Surgery at the Bristol Royal Infirmary (BRI) site have remained low. Scrutiny of these reports has allowed focus on potential recurring themes. One such theme is the issues surrounding the transfer of patients from the Weston General Site to BRI for urgent out of hours surgical care. There is currently a lack of capacity to staff an emergency theatre at the Weston site from 1800 in the evening until 0800 in the morning. Current inpatients or those presenting to the Weston site who require urgent surgical intervention during these hours are referred to the emergency surgical team at the BRI, and if deemed appropriate, then transferred to BRI for surgical intervention. Issues have arose with communication between the referring hospital and long delays for ambulance transfers. Ongoing work is focusing on potential strategies to facilitate this process including fostering closer working relationships between surgical teams on the different sites as well sourcing dedicated support to ensure timely transfer of these critically unwell patients.

Intensive Care Medicine

The department conducts highly detailed and robust M&M meetings and has an action log for any issues arising in care. Themes arising are listed below:

- Weaning from Intra-aortic balloon support (IABP)
- Haematology/Oncology Prognostication
- Transfers in (predominantly WGH to BRI)
- Refractory shock in the context of overdose
- Group A Strep toxic shock
- Documentation of percutaneous tracheostomy
- Deaths within 24hours
- Cardiogenic Shock
- Escalations from different areas of ICU
- Delivering care in the extremes of body habitus
- Pacing wires in GICU

Weston General Hospital Site

The Weston Hospital site had been without a mortality lead for the whole of this period so there have been delays in investigating some deaths at the Weston site. A mortality lead, Dr Michael Haley was appointed in May and took up the post in June and addressed the backlog. The number of outstanding reviews were reduced by 80% within the month. A summary of themes and actions is noted below:

Urgent Care - A thematic review was conducted looking into early identification and treatment of sepsis, identified barriers to completing sepsis 6 and prompted ongoing quality improvement project on this, led by consultant and ED Matrons. This included regular teaching sessions to improve staff awareness and adherence to protocols.

Acute Medicine and Urgent Care - Some deaths highlighted by the medical examiner identified need for further training in chest drain insertion to ensure skills present on site at all times. Practical skills sessions arranged for middle grade urgent care and medical doctors to improve chest drain insertion competency.

Care of Elderly Medicine - Identified term frailty being used but not well defined, led learning on identification and classification of frailty syndromes.

Stroke Medicine - Stroke Unit governance review identified patients with large intracerebral haemorrhage were sometimes palliated early, after neurosurgical specialist advised patient would not be for surgery. This was a decision that was made by on call medical teams and the highlighted lack of 24/7 stroke specialist cover. Promoted awareness of Salford ABC haemorrhage bundle and supported implementation of new BNSSG stroke pathway promoting admission to centralised hyperacute stroke unit.

Nursing feedback - Lead nurses at Weston met to discuss feedback on communication problems among the IENs and devise a plan of action to tackle this issue, collating details on complaints related to communication to develop a plan accordingly. The team continued with the End-of-life study day that included a communication interactive ice-breaker and a SIM on breaking bad news using the SPIKES model. Communication is also part of the KICK study day, which involves various activities such as description, listening, open questioning, summarising, and checking understanding. The Fundamentals of Care working group also contributed to this project, to develop further study

sessions or microteach on communication if needed, that can be used across UHBW. Currently, the IEN workforce team conducts monthly workshops that include SIM sessions on topics such as breaking bad news, dealing with difficult patients, and discussing patients' issues with MDT. The IEN PEFs will keep delivering the ward readiness programme, which involves a SIM session focused on deteriorating patients and escalation.

End of Life steering group

The End of Life steering group meets quarterly and is well attended by Divisional, Corporate and Lay representatives with a patient or carer end of life story presented at each meeting for sharing and learning. The focus for improvement is managed through a workplan which is aligned to the national end of life framework, objectives over the past year have included delivery of bespoke education programmes for wards and departments by the end of life practice educators, creation of improved carers comfort facilities, and improving feedback from a more diverse and representative group .

A thematic review of reported incidents is undertaken at each meeting with the top reported groups being tissue viability, clinical assessment, and medication. In recognition of the risk and the significant pressures of capacity on the specialist palliative care teams additional funding has been agreed for one year which will hopefully assist with a more robust 5 day a week nurse and medical service to be provided. There is an on-call specialist Palliative care consultant available at the weekend.

The addition of the Medical Examiner's office attendance to the group has enabled an improved understanding of the medical examiner's role, along with thematic experience of care feedback gained from family and carers which is shared with staff.

Women's and Childrens Division

Perinatal Deaths

Perinatal Deaths are reported to the Perinatal Mortality Review Team Board which is administrated by the Patient Safety team with Women's and Childrens Division which reviews all deaths and risks, reporting regularly via the Perinatal Mortality Review Tool on the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE – UK) database. The Trust is 100% compliant with reporting requirements.

The PMRT (perinatal mortality review tool) report from MBRACE – UK for 2021 key messages are:
For all deaths:
1. UHBW stabilised & adjusted stillbirth rate is 4.03 per 1,000 total births. This is around the average for similar Trusts & Health Boards.
2. UHBW stabilised & adjusted neonatal mortality rate is 2.67 per 1,000 live births. This is around the average for similar Trusts & Health Boards.
3. UHBW stabilised & adjusted extended perinatal mortality rate is 6.69 per 1,000 total births. This is around the average for similar Trusts & Health Boards.

A deep dive is ongoing within the neonatal team, safety teams and intelligence/coding teams about unexpectedly higher perinatal mortality rates which has revealed that some perinatal deaths were recorded as "stillbirths" when it would have been more appropriate to code them as perinatal deaths (NOT still births) during the period of concern. Ongoing discussions to consider resubmitting data for previous year and forward.

Thematic Reviews

The Learning from Deaths Process included several thematic reviews/harm panels this year.

1. **Transfer-related Harm**
   This was trust wide but predominantly involved issues around surgical patients requiring transfer from Weston sites to Bristol. The main areas of concern identified were around:
   - clinical decision making prior to decision to transfer to BRI.
   - end of life planning and discussions with patient and next of kin prior to decision to transfer.
   - availability of transfers service including SWAST, Retrieve and patient transport.
   - impact of lack of access to theatres at Weston overnight

2. **RESPECT related concerns**
   23 referrals noted family feedback around End-of-Life care. Many of the issues were communication related and did not achieve the threshold for structured judgement reviews. Family feedback that discussions 'could have been handled better' or 'should have taken place sooner' was noted and passed on to the teams. The need for family involvement was also a theme. This feedback will be included in an End of Life thematic review which will be under the RESPECT+ workstream, the review has been delayed due to industrial action and will happen in May and will feed into the Deteriorating Patient Group.

3. **Missed/delayed interpretation radiology results**.
   A thematic review was undertaken into missed diagnostics, focussing initially on Trust wide radiology results not acted upon. The review was undertaken on 28th November and was used as a learning theme at January's Clinical Quality Group. A number of hotspots were identified in the trust – BRI AMU, STAU and SDEC and Weston AMU. With the support of digital teams, some helpful solutions have been shared with divisions which should allow clinical teams to choose the best solution for them based on the way their teams work.

Changes to Coronial Process

Preparation has been made around communications for the introduction of the new Patient Safety Investigation Framework (PSIRF) whereby the Structured Judgement Review will become more significant as a source of information on individual cases as Root Cause Analyses are replaced by thematic reviews and service reviews.

Appendix 1 – UHBW Mortality Governance Process

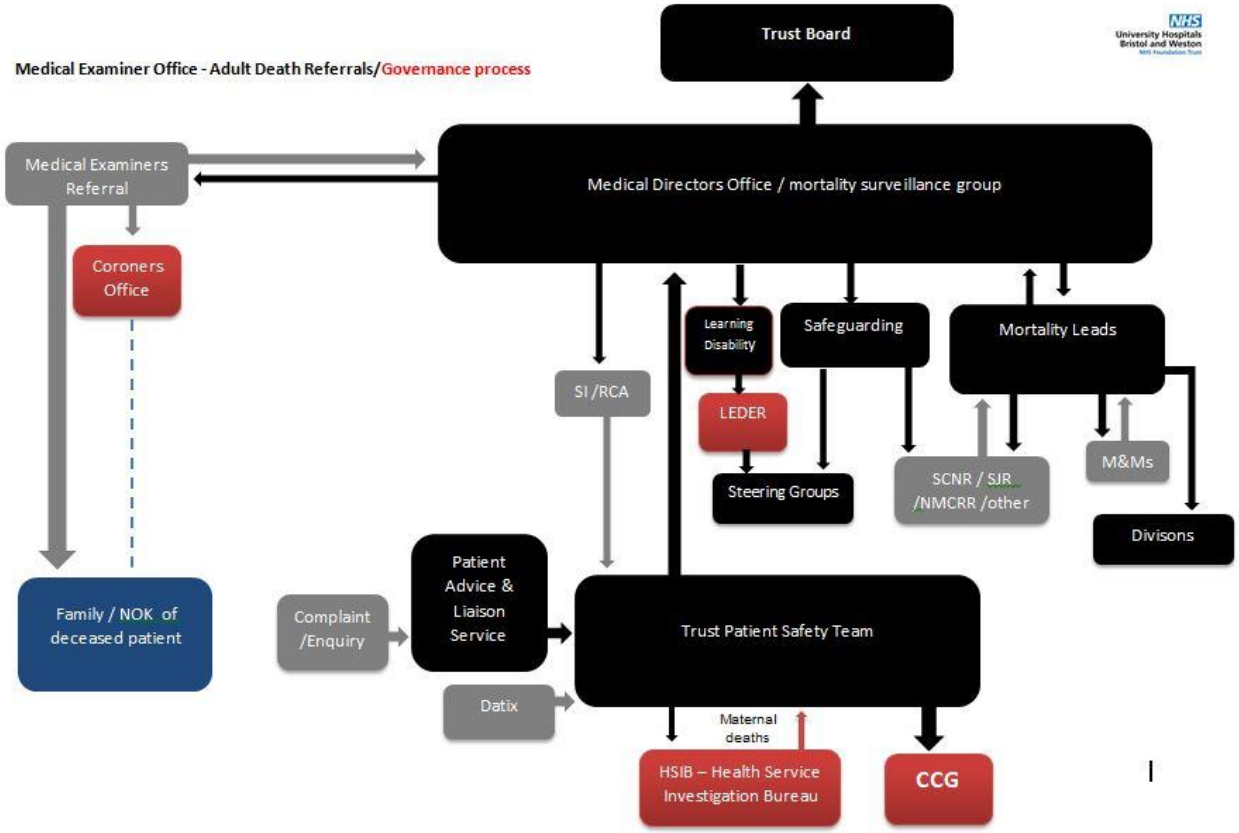


Figure 2. Flow Chart Illustrating the Governance of deaths identified by the medical examiner team in UHBW

Medical Examiner Office
1. ME Reviews Notes,
2. ME speaks with NOK, advises family to contact PALS if they wish to file a complaint
3. Contacts Coroner if necessary
4. ME Office refers concerns raised and mandatory reporting categories to MD Office

Medical Directors Office - Reviews the referral from the ME refers as follows:

Care issue:
Issue with care in Trust meeting requirement for SCNR – to Mortality Lead (LD, Mental Health, Div and ITU)
Issue with external organisation prior to admission – refer to Patient Safety Team checks incident logged on Datix – reports to CCG

Notifiable patients:
Safeguarding concerns raised – refer to Safeguarding Team
Learning Disability (LeDeR) – refer to Learning Disability Team
Maternal or Neonatal Death – Contact Patient Safety Women's Services to refer to HSIB
Patient 18 years or under – refer to Children's Mortality Lead (for CDR process - not yet under ME remit).

Once referred - The Mortality Leads, Safeguarding Team and Patient Safety report back to MD Team to confirm status of concerns and processes followed
SJRs / SCNRs are tracked on the Careflow Report, Datix incidents by Patient Safety
The Safeguarding and Patient Safety follow up any valid concerns with community/system organisations and CCG.

Appendix 2

BNSSG Medical Examiners Report

April 2022- March 2023

Dr. David Crossley

Lead Medical Examiner for BNSSG

June 2023

Contents

Introduction

On behalf of the medical examiner service for Bristol, North Somerset and South Gloucestershire (BNSSG), I am delighted to provide our third annual report.

The national medical examiner system is a key component of the Department of Health and Social Care's "Death Certification Reform Programme for England and Wales". It also forms part of the NHS Patient Safety Strategy and the NHS Long Term Plan in England, and is a key element of the quality and patient safety agenda in Wales. The BNSSG service is one of 128 medical examiner offices, the largest in the South-West, and one of the largest in England and Wales.

We are considered "business as usual" in terms of the scrutiny of adult deaths at University Hospitals Bristol and Weston NHS Trust (UHBW), and the North Bristol NHS Trust (NBT), ensuring the three key components of the medical examiner service are met-

-improving the experience of bereaved relatives through better communication around the death certification process, and including their views of the care of their loved ones
-ensuring the Medical Certificate of Cause of Death (MCCD) is accurate
-liaising with His Majesties Coroner to ensure appropriate referrals are made

The main focus of the service nationally is to enable all bereaved people to benefit from independent scrutiny of non-coronial deaths, provide a forum to include *their views* about the care of their loved ones - be it good or bad, and to support the NHS and beyond to learn from this scrutiny to improve the quality of care. We are currently rolling our service out to the community.

Regarding the learning from our scrutiny – currently our service interacts with the governance teams at both Trusts, via the Mortality Review Group (MRG) at UHBW, and the Clinical Effectiveness and Audit Committee (CEAC) at NBT.

Regards,

Dr David Crossley, Lead Medical Examiner for BNSSG

About the Medical Examiner Service in BNSSG

Implementation of the medical examiner service began in England and Wales in 2019 with the appointment of the national medical examiner and recruitment of national and regional teams.

Our service was established in May 2020. It was developed in the footprint of the (at that time) putative Integrated Care System, rather than the conventional individual Trust model. Initially the team consisted of 5.4 whole time equivalent medical examiner officers (MEO's, six persons), and 20 sessions (two whole time equivalents) of medical examiners (ME's, 12 persons). These figures included the lead MEO and lead ME roles, and gave the capacity to undertake scrutiny in the acute trusts.

In May 2022, royal assent for the Health and Care Act paved the way for the statutory medical examiner system, with a ministerial statement in April 2023 setting out the pathway towards implementing the full statutory medical examiner system from April 2024, to cover all deaths (not just those occurring in acute trusts).

As we prepare for this community expansion, our workforce has been increased to 8.4 MEO's and 28 sessions of ME time. Extra office space has been provided at the Frenchay site of NBT for our "community team" of 3 MEO's and the 8 sessions of ME time. We have purchased the "EMIS" computer system to allow seamless record sharing with community healthcare providers so that patient information is available for community note scrutiny.

As we are currently in a non-statutory phase, a legal basis for the scrutiny of patient notes in community settings was required to be made by the national medical examiner's team. Their submission to the Confidentiality Advisory Group in 2021 was supported, and therefore health and care organisations in England are able to share records of deceased patients for the purpose of medical examiner scrutiny in the period prior to the service becoming statutory.

Any concerns or themes identified by the ME service are shared with the trusts governance department(s), and they in turn report back actions both proposed and taken. The role of the lead ME is to report onwards to the national ME (following discussion with the responsible medial director) where actions or escalations taken are thought inadequate or insufficient.

Continued…

This escalation process has not been required in BNSSG. Escalation is via the lead ME's quarterly report to the national ME (via the Regional ME). A similar process is in preparation for community issues with the ICS' governance lead.

Performance Statistics

During this year in England and Wales there were approximately 577,000 deaths, of which around 8500 occurred in BNSSG. Of these 8500 deaths, just under half occurred in the two acute trusts and the remainder in the community.

Our service has now been reliably scrutinising applicable cases (adult deaths in the two acute trusts), achieving 99.9% scrutiny of the 4146 applicable deaths. We interacted with the bereaved in 83% of cases (national average 96%).

Appropriate signposting of cases to HM Coroner is an important part of the medical examiner service. In BNSSG, during this year our rate of coronial referral was 17.6% (national average 8%).

The discrepancies in the figures for "interaction with the bereaved" and the "rate of coronial referral" between BNSSG and the national figures is due to a conscious decision to review ALL deaths, and NOT to exclude coronial cases from our scrutiny (which is the national steer). This approach is supported/actively encouraged by the Senior Coroner for Avon, and her request is that we extend this way of working to the community (again – not the national steer).

The referral rate to Trust governance for further investigation was 9.7% of cases scrutinised at NBT (202 referrals out of 2070 deaths), and 16.5% of cases scrutinised at UHBW (344 referrals out of 2076 deaths). The national average for governance referral was 10%.

Most of the issues that medical examiners identify will be considered and addressed at local level through existing clinical governance arrangements. Only one trend has been escalated to medical director level, with plans clearly being implemented to prevent recurrence.

We have maintained a timely service throughout all the Junior Doctors strikes to date.

Deaths of health and social care workers with Covid-19

The BNSSG service was part of the review deaths of health and adult social care staff that died with COVID-19 in England, which was concluded in this year. This discreet process differed from normal medical examiner scrutiny, particularly in that most reviews were retrospective. The key question medical examiners were required to consider was whether there was reason to suspect the health or care worker ***may*** have acquired COVID-19 through employment. Medical examiners were not asked to determine that COVID-19 was definitely acquired through employment, nor whether the infection was avoidable. Regional medical examiners wrote to the employers of those individuals so they could consider whether they had an obligation under RIDDOR to report the death to the Health and Safety Executive. In addition, medical examiners reported that 347 deaths had been notified to the coronial service, and the coroner appropriate to the registered address of the deceased was either investigating or considering investigation.

Local progress highlights

- We are actively engaged with local faith leaders, and have modified protocols to ensure urgent release of bodies where faith requirements are that burial should be facilitated promptly. An “on-call” service is planned for when we become statutory for issues that occur “out of hours” – mainly (but not exclusively) to ensure that these religious requirements are appropriately met.

- In the general practice community, we have presented to BNSSG Primary Care Networks to publicise our service. The Local Medical Committee Director (Dr Lee Salkeld) is one of several general practitioners to be piloting our service. In addition, we have liaised with the Avon and Wiltshire Mental Health Partnership, Sirona Care & Health, and both St Peters and Weston Hospices.

- We hold a monthly governance meeting at which Trust colleagues have presented on issues such as sudden cardiac death, safeguarding and LeDeR to promote our understanding of their issues. As part of this meeting we have also undertaken an audit of cases to support a wider review of ME service practice and process.

Continued…

- Maternity/new-born deaths at NBT are now covered by our service.

- The protocol for deaths occurring in the “Retrieve” service for the south west was written by the UHBW Retrieve lead assisted by the BNSSG lead ME and MEO. This protocol was subsequently used as template for all such services across the country.

- The south west lead for organ donation (NBT based) and the lead ME have co-authored a protocol to facilitate interaction with coroners and remove delays for organ retrieval in the south west.

Where next?

- Our community roll-out is our priority for 2023-4. We will test the draft community ME process with 3 GP pilot practices (each from a different Primary Care Network) over the coming months. Our goal is full rollout for the 1st April 2024.

- The NHS Business Services Authority is developing a medical examiner case management system in England and Wales. It is a bespoke system which is being built specifically for the programme and will be used for communication in both the acute trusts and community alike. It will take the place of the current “Cremation Certificate” system.

- A digital MCCD for England and Wales will integrate with the aforementioned medical examiner case management system (pilots are currently running in Wales).

dc june 2023

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Trust Board of Directors in Public on Tuesday 14th November 2023

Report Title	**Safeguarding Annual Report (Adults &Children) 2022-23**
Report Author	**Carol Sawkins, Associate Director of Safeguarding**
Executive Lead	**Deirdre Fowler, Chief Nurse and Midwife**

1. Purpose

The Safeguarding Children and Adults Annual Report provides the Trust Board, with assurance that the Trust continues to fulfil its statutory and regulatory responsibility to safeguard the welfare of children and adults across all areas of service delivery.

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

The Trust has maintained compliance with CQC Regulation 13 'Protecting Service users from abuse and neglect', ensuring that those who use the Trust services are safeguarded and that staff are suitably skilled and supported.

The safeguarding adult's activity data has shown a significant increase in this reporting period, with a 21% increase from the previous year, with key areas being Neglect and Self Neglect.

The safeguarding Children's and Maternity data continues to reflect a sustained year on year increase, with key areas for Children being Family Support or parental risk factors; and Maternity known to Social Care or Domestic Violence.

The weekly safeguarding review meeting, with the safeguarding and Emergency Department teams has been replicated in Weston Emergency Department. Some concerns remain in relation to the timelessness of safeguarding concerns being raised by Weston ED and many of the referrals continue to be completed retrospectively. This concern is reflected as a trust risk and will continue to be an area of focus.

A Safeguarding Internal Alert is raised if it is alleged that the Trust may have caused harm to a patient through the omission or provision of care, underpinned by the Trust's responsibility to be open and transparent in line with the Duty of Candor. There has been a decrease in the number of internal cases recorded this year.

There has been a significant increase in number of DoLS applications over the last two years, reflecting the anticipated increase in activity following the merger with Weston General Hospital. The majority of DoLS applications are made by the Division of Medicine and Weston, in line with expected practice. The number of DoLS authorised remains very small.

A Safeguarding training recovery plan has been developed and whilst some progress has been made, the Trust has yet to reach pre Covid compliance levels or the required 90% target (Table 18). This remains an area of concern for the Trust.

3. Strategic Alignment

This report aligns to the Trust strategic direction by delivering a robust service to ensure all our patients and staff kept safe from harm, and are at the heart of everything that we do.

The Safeguarding activity aligns directory with our Patient Safety and Our People priorities.

4. Risks and Opportunities

Three safeguarding risks remain on the Corporate risk register:

- Risk No 856 - Risk that the emotional and mental health needs of children and young people admitted to the Children's Hospital (for mental health reasons only), may not be fully met as the Hospital is not a provider of mental health services.
- Risk No 921 - Risk of not achieving 90% compliance for all Essential Training, which includes safeguarding training.
- Risk No 1595 - Risk that if patients suffering from mental health disorders spend prolonged time in ED their condition could deteriorate. Patients affected are those detained under S 136 (Mental Health Act).

These risks remain unchanged from previous years

5. Recommendation

This report is for **Assurance.**

The Board is asked to approve the report as evidence that the Trust is fulfilling its statutory safeguarding duties and responsibilities and is thereby fulfilling its contractual duty to safeguard children and adults.

6. History of the paper

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

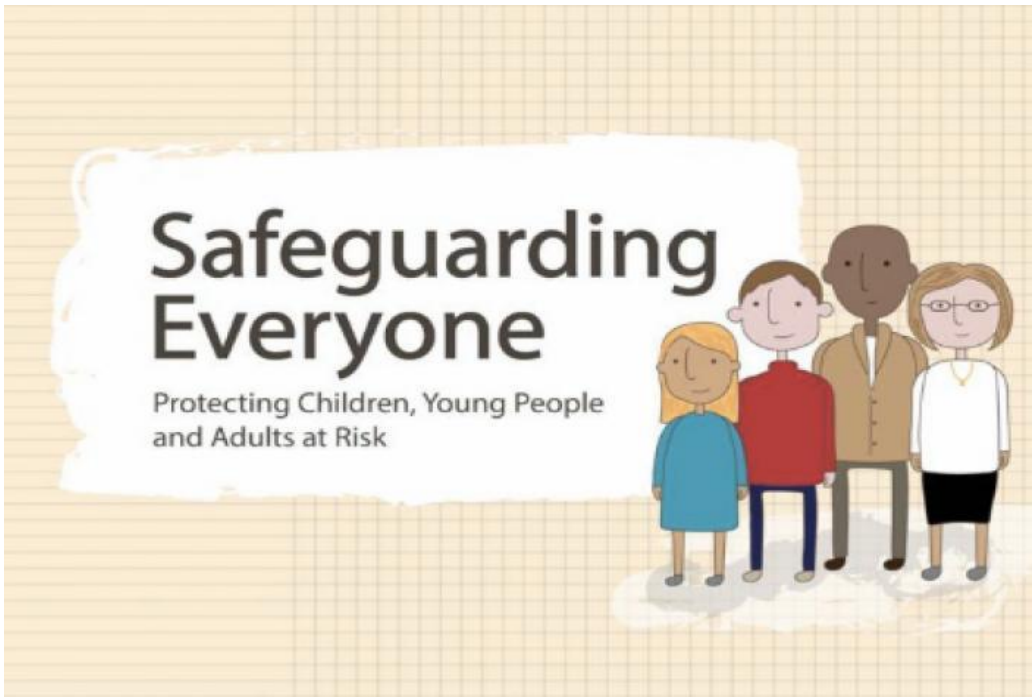
Clinical Quality Group	4th October 2023

University Hospitals Bristol and Weston NHS Foundation Trust

Annual Report

Safeguarding Adult & Children

(Incorporating Mental Capacity Act & Prevent)



April 2022 – March 2023

Prepared by Carol Sawkins Head of Safeguarding (Adults & Children)

Index

1. Introduction

Welcome to the University Hospitals Bristol and Weston NHS Foundation Trust Safeguarding Children and Adults Annual Report, incorporating the Mental Capacity Act and PREVENT. The Trust has a well-established integrated (adults, children and unborn babies) safeguarding approach, underpinned by robust governance arrangements, safeguarding work and audit plans, and supported by the safeguarding Executive leads with an experienced safeguarding team.

The Trust safeguarding team are committed to supporting staff in understanding safeguarding, and embedding this as 'everyone's business', improving outcomes and providing an integrated and consistent approach across all areas of the Trust.

This report provides University Hospitals Bristol and Weston Trust Board, Bristol, North Somerset and South Gloucester Integrated Care Board (BNSSG ICB) and the Local Safeguarding Partners with a summary of key activities during this reporting period, and assurance that the Trust continues to fulfil its statutory responsibilities to safeguard the welfare of children and adults across all areas of service delivery.

The Trust safeguarding agenda is underpinned by the Trust values, aiming to ensure that a culture exists where safeguarding is everyone's business and areas for learning and improvement are continually identified. The summary and conclusion of this report describes the key priorities and areas identified for development for safeguarding in 2023/24.

2. Summary of current arrangements for Safeguarding and Assurance within University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)

The Trust's safeguarding arrangements are defined in a range of statutory governance frameworks, for children those defined within Section 11 of the Children Act 2004 underpinned by Working Together to Safeguarding Children (2020) and for adults, within the Care Act (2014), the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007)/ Liberty Protection Safeguards (2019). These arrangements are supported by the Named Professionals (Doctor, Nurse and Midwife), plus a team of experienced safeguarding nurses and administration staff.

Safeguarding roles, duties and responsibilities of all National Health Service (NHS), including the Trust, are laid out in the NHS England 'Accountability and Assurance Framework (SAAF). The SAAF was reviewed during this reporting period (July 2022), and the Trusts safeguarding arrangements remain in line with the update framework.

Assurance of compliance with the requirements of Care Quality Commission (CQC) Regulation 13: Protecting service users from abuse and neglect, continues to be monitored through the Safeguarding Assurance and Operational Groups and reported externally to the BNSSG ICB and Safeguarding Partners.

UH Bristol & Weston Trust Board hold ultimate accountability for ensuring that safeguarding responsibilities for both children and adults are met, with the Chief Nurse as Executive Lead for Safeguarding.

A team of experienced safeguarding professionals, including the Named Professionals and Safeguarding Duty Consultants (for children) provide expert advice, support and supervision to practitioners across all areas of the Trust.

The Safeguarding Assurance Group reports annually to the Clinical Quality Group which in turn reports to the Trust Board.

Safeguarding performance is monitored internally, supported by quarterly safeguarding activity reports, annual work and audit plans, reviewed by the Trust Safeguarding Assurance and Operational Groups, chaired by the Deputy Chief Nurse and supported by senior representation from all Divisions.

3. Safeguarding and Care Quality Commission (CQC) Regulation 13

The Trust has maintained compliance with CQC Regulation 13 'Protecting Service users from abuse and neglect', ensuring that those who use the Trust services are safeguarded and that staff are suitably skilled and supported. Demonstrating safeguarding leadership and commitment at all levels of the organisation and remaining fully engaged in local accountability and assurance structures.

The Head of Safeguarding is accountable for ensuring compliance with regulation 13, reporting regularly to the Safeguarding Operational Groups, the Safeguarding Assurance Group, and annually to the Clinical Quality Group (CQG).

4. Safeguarding Risks

The Safeguarding Assurance and Operational Groups, which include senior Divisional representatives, maintains oversight of safeguarding Corporate, Divisional and Departmental risks entered onto Datix. Three safeguarding risks remain on the Corporate risk register:

- Risk No 856 - Risk that the emotional and mental health needs of children and young people admitted to the Children's Hospital (for mental health reasons only), may not be fully met as the Hospital is not a provider of mental health services.
- Risk No 921 - Risk of not achieving 90% compliance for all Essential Training, which includes safeguarding training.
- Risk No 1595 - Risk that if patients suffering from mental health disorders spend prolonged time in ED their condition could deteriorate. Patients affected are those detained under S 136 (Mental Health Act).

These risks remain unchanged from previous years. Further details in relation to key safeguarding risks are reference in the activity sections of this report.

5. Summary of key safeguarding achievements

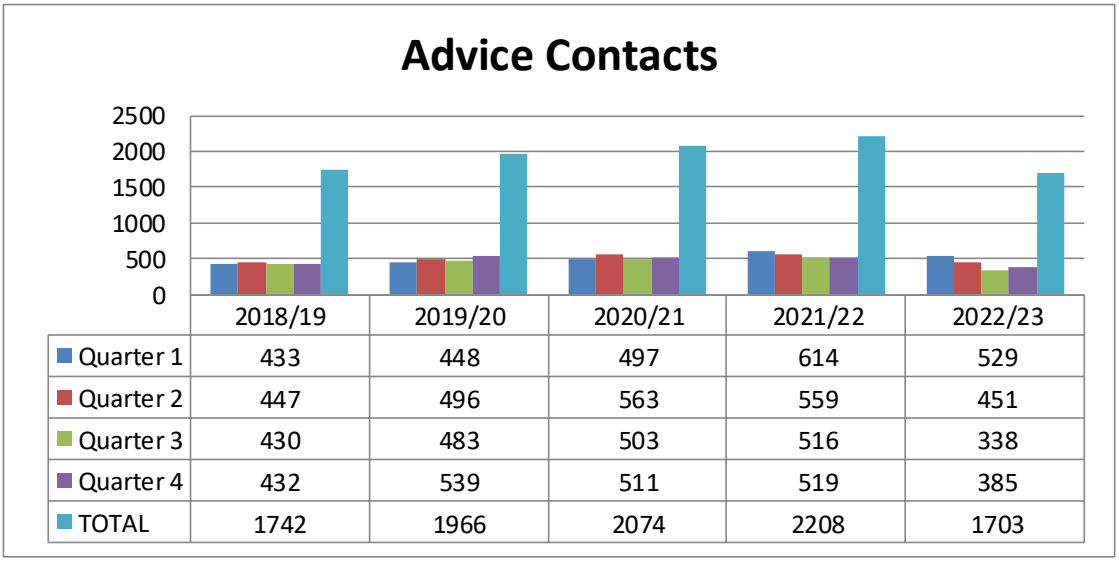
Robust safeguarding annual work and audit plans completed, providing assurance of a range of safeguarding arrangements.	Implementation of a new Safeguarding Duty Consultant role (for children), providing medical expertise and advice to support the management of safeguarding children in BRHC	Development and implementation of SOP to support women with a Learning Disability/ Autism (LD/ASD) presenting to midwifery services.
Implementation of Child Protection Information Sharing alerts system into all ED's, following successful pilot of system in Children's ED. Evidenced through audit.	Appointment of new Named Doctor's for Safeguarding Children and Adults and an increased safeguarding midwifery provision to support safeguarding unborn babies.	Strengthening and expanding the Hospital IDSVA service (provided by Next Link), to include Unity Sexual Health and Midwifery Services (as a pilot)., as well as ED.
A number of staff successfully completed specialist training to enable them to deliver safeguarding supervision in Divisions.	Formal safeguarding Partnership agreement developed with North Bristol Trust to support joint working and cross cover arrangements across BNSSG.	Maintained compliance with regulatory and commissioning requirements, including positive feedback from Section 11 Audit (Children Act 2004)

6. Safeguarding Children Data

Calls to the safeguarding team for advice and support are a useful reflection of staff knowledge of the safeguarding process and of support resources available to them. The data continues to reflect a sustained year on year increase, both in numbers and complexity of cases. Table one reflects children's activity data only, with Midwifery activity data being reported separately for the first time in this report (see section 8). For comparison purposes the total number of advice contacts, inclusive of midwifery data is 2222 contacts in total, an average of 9 calls per working day.

During this reporting period the safeguarding team has been under unprecedented capacity pressures, due to the significant and on- going recruitment challenges. This data provides reassurance that robust safeguarding children's practice continues, despite the decreased visibility of the safeguarding team in clinical areas. Recruitment of suitably experienced and knowledgeable staff into the safeguarding arena is an area of concern both nationally and locally.

Table 1: Number of contacts made to the Safeguarding Children's Nursing Team



	2018/19	2019/20	2020/21	2021/22	2022/23
Quarter 1	433	448	497	614	529
Quarter 2	447	496	563	559	451
Quarter 3	430	483	503	516	338
Quarter 4	432	539	511	519	385
TOTAL	1742	1966	2074	2208	1703

NB Contacts to the safeguarding midwives for advice and support during this reporting period have been recorded separately for the first time. Midwifery activity data is detailed in Section 8 of this report.

Further analysis of contact data, quantified according to the complexity of the case and the amount of time required to support staff (detailed in table 2). This data supports the identification of areas for service development; such as supervision provision, thematic or targeted training including for thresholds for referrals, and signposting to other services such as Next Link.

Table 2: RAG Rated Cases per Quarter

	Green	Amber	Red	Annual Total
2018-19	907	269	65	1241
2019-20	1541	272	84	1895
2020-21	1786	263	70	2119
2021-22	1673	453	82	2208
2022-23	1164	415	124	1703

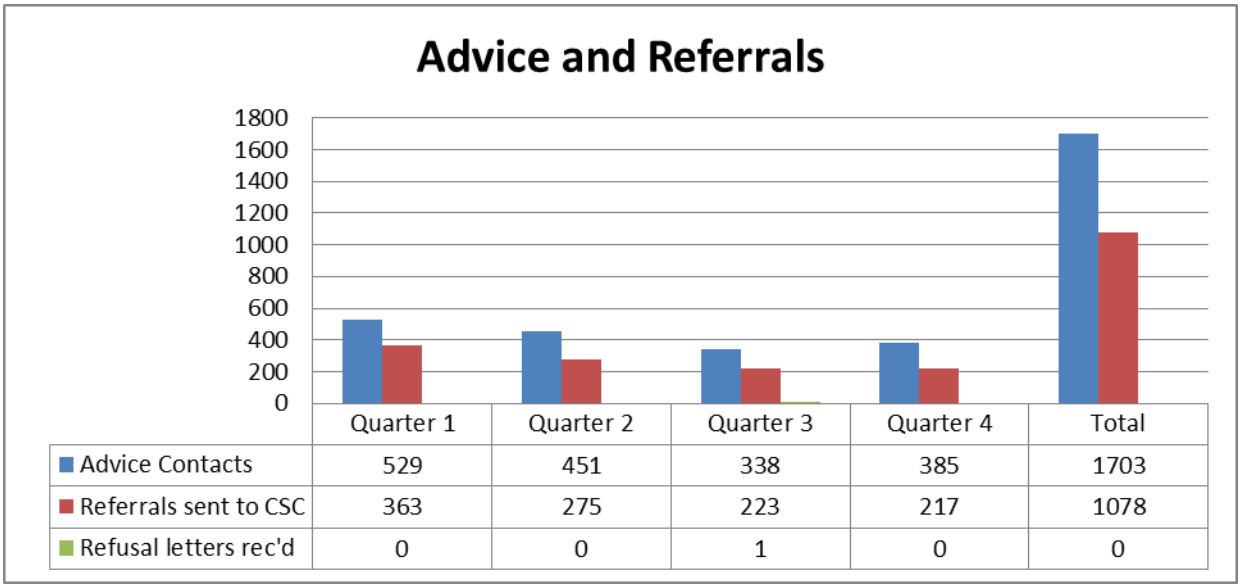
6.1 Safeguarding Referrals to Children's Social Care

All safeguarding referrals to Children's Social Care continue to be sent via the Safeguarding team. This process enables the team to:

- Review the quality of the information recorded on the referral, ensure relevant information is included and the risk is clearly articulated.
- Ensure referrals are in line with the threshold for Social Care involvement as set out in the Keeping Bristol Safe Multi Agency Threshold Guidance.
- Collect and collate data for analysis purposes and onward reporting to the Safeguarding Assurance and Operational Groups.
- Monitor and identify trends/concerns and take necessary action.
- Provide direct feedback to practitioners.

The number of onward referrals to Children's Social Care has remained in line with previous years, with approximately 35% of the advice contacts continuing to result in a referral to Children's Social Care Team (Table 3).

Table 3 Number of Advice Contacts & Referrals Sent to Children's Social Care



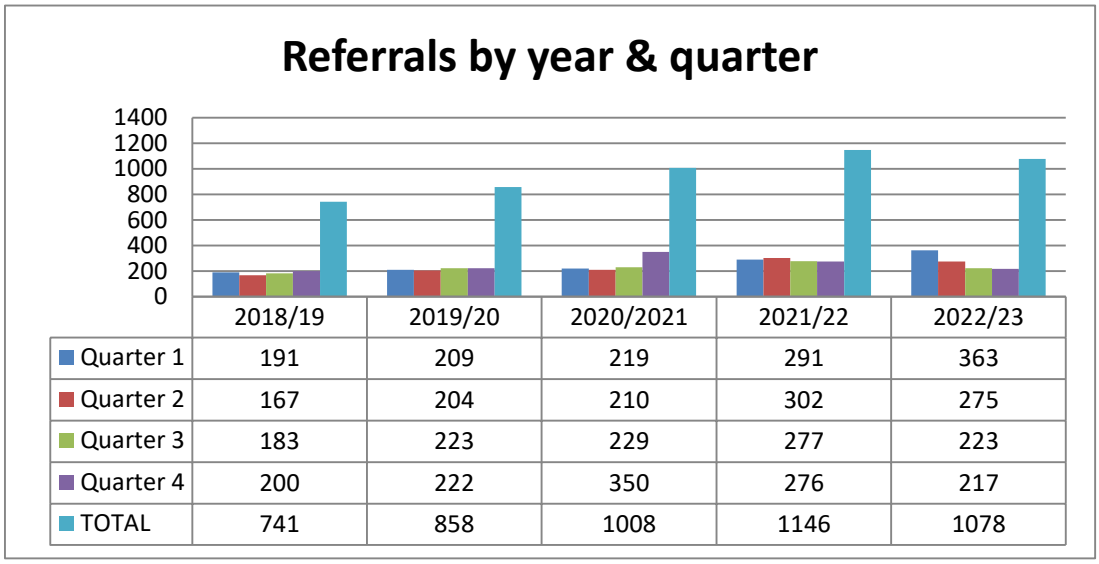
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Advice Contacts	529	451	338	385	1703
Referrals sent to CSC	363	275	223	217	1078
Refusal letters rec'd	0	0	1	0	0

Only one refusal letters was received , meaning that almost 100% of referrals sent onwards to Children's Social Care by the safeguarding team were deemed to be appropriate and in line with expected thresholds. This indicates that the quality assurance process of reviewing all safeguarding referrals prior to sending them to Children's Social Care is effective in reducing the number of inappropriate referrals. The majority of referrals not sent to Children's Social Care, are shared with other healthcare providers such as GP, School Health Nurse, Health Visiting services or other services that are better situated to assist in addressing the concerns.

Of the total of 1078 safeguarding children's referrals, 427 referrals were completed by the Sexual Abuse Referral Centre (SARC). This is in line with expected practice, as the SARC is the referral centre for the South West.

Midwifery services also continue to make a significant number of referrals, 253 in this reporting period, in line with previous years and expected practice.

Table 4: Annual Safeguarding Children Referral Data

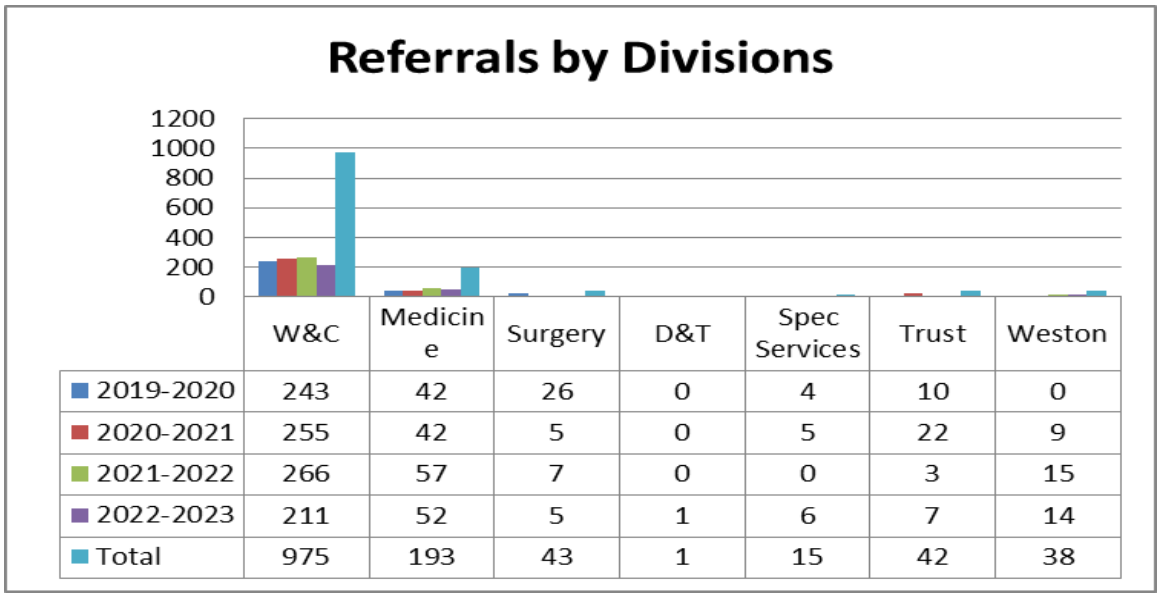


	2018/19	2019/20	2020/2021	2021/22	2022/23
Quarter 1	191	209	219	291	363
Quarter 2	167	204	210	302	275
Quarter 3	183	223	229	277	223
Quarter 4	200	222	350	276	217
TOTAL	741	858	1008	1146	1078

Analysis of the annual data, (post the impact of the Covid pandemic) reflects that the anticipated increase in safeguarding children's inpatient activity as a result of the merger with Weston General Hospital (which includes the Seashore Children's Centre) did not materialised . There has been no significant increase, either in the number of safeguarding referrals made (table 4) or in the number of advice contacts to the team (table 3).

As expected the majority of the safeguarding referrals continue to be made by Women's and Children's Division (table 5). Excluding Midwifery and SARC referral data

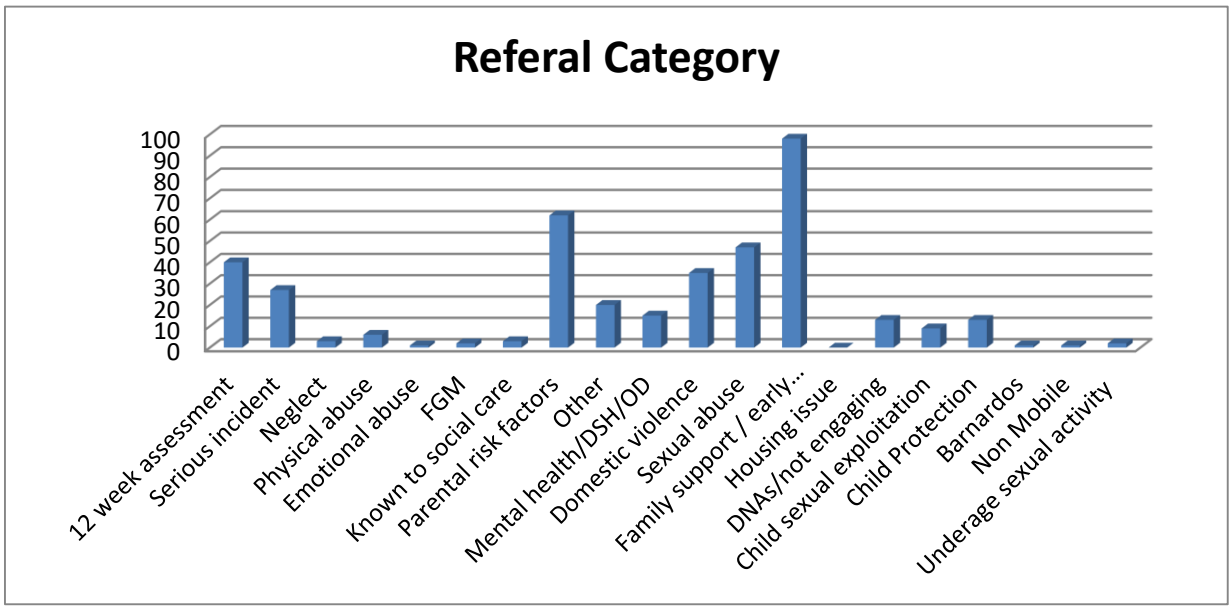
Table 5: Safeguarding Children Divisional Referral Data



	W&C	Medicine	Surgery	D&T	Spec Services	Trust	Weston
2019-2020	243	42	26	0	4	10	0
2020-2021	255	42	5	0	5	22	9
2021-2022	266	57	7	0	0	3	15
2022-2023	211	52	5	1	6	7	14
Total	975	193	43	1	15	42	38

A breakdown of reasons for referrals (excluding SARC and midwifery) is detailed in table 6.

Table 6 Referral Category



The safeguarding children's activity data (inpatient and Emergency Department) continues to reflect increasing numbers and complexity of children and young people presenting with mental health concerns, including self- harming behaviours, dysregulated behaviours and disordered eating. In line with the picture nationally, which may be linked to the impact of Covid and the associated social isolation and missed schooling.

A small number of children were admitted to hospital whist waiting for a suitable mental health bed (Tier 4) or Local Authority placement. Placing children with significant mental health presentations in an acute health care setting has resulted in a number of challenges, including increasing incidences requiring several staff to maintain the safety of one patient, frequent episodes of restrictive interventions, children absconding from hospital and physical assaults to staff. As well as a potential adverse impact on the child, other inpatient children and their families.

There continues to be a lack of suitable Tier 4 mental health provision both locally and nationally and the situation has been escalated to BNSSG ICB, NHS England and the Local Safeguarding Children's Partnership Board. New escalation processes have been introduced to manage the situation, as safely as possible and is reflected as a risk for the trust. (Datix risk no 856)

Incidents relating to Restrictive Interventions for children and young people continue to be reported and monitored via the Safeguarding and Mental Health Operational Groups.

7. Safeguarding in the Emergency Departments

Following the merger with Weston General Hospital, the safeguarding team have successfully standardised and centralised the safeguarding referral process. All of the Emergency Departments (ED) (Bristol Royal Infirmary, Weston General Hospital and Bristol Royal Hospital for Children) now complete the same Social Care Notification form. Activity data is detailed in table 7.

A weekly safeguarding review meeting, with the safeguarding and Emergency Department teams has also been introduced into Weston Emergency Department .The meeting reviews notification forms, updates on the local outcomes and shares learning.

Some concerns remain in relation to the timelessness of safeguarding concerns being raised by Weston ED and many of the referrals continue to be completed retrospectively. This concern has been escalated

internally during this reporting period, is reflected as a trust risk and will continue to be an area of focus in the next reporting period.

Table 7: Emergency Department Social Care Notifications

Social Care Notifications					
	2018/19	**2019/20**	**2020/21**	**2021/2022**	**2022/2023**
BRHC ED	1301	1493	1762	1957	1734
BRI ED	709	745	756	594	590
Weston ED	-	-	496	651	557
Total	2010	2238	3014	3202	2881

After the initial increase in activity in the 2020/21 data (post-merger) activity has remained relatively consistent. In this reporting period, activity date has dropped slightly for each of the ED's.

The decrease in activity, may in part be due to the impact of the full implementation of the Child Protection Information System (CP-IS) into all ED's, following a robust quality assurance audit process. CP-IS is a national data base of children and young people who are in care (CIC) or subject to a Child Protection Plan (CPP). The CP-IS will automatically share information with the allocated social worker, when a child has attended any unscheduled care setting. This electronic system means that ED staff no longer have to complete Social Care Notification forms, saving valuable time and increasing the accuracy of information sharing.

The Children's ED has been part of a joint project with Sirona Public Health Nurse to improve sharing of information about children's attendance between acute and community services. This has been an area of concern highlighted in national and local Serious Case Reviews and more recently in the Child M case review (see section 13)

This reporting period has seen an increase in the numbers of children presenting with life threatening injuries, including falls from open windows, near drownings and injuries from farm tractors. In particular concerns have been noted from the Children's Hospital ED and the Paediatric Trauma Team, in relation to children presenting with significant injures resulting from accidents involving E scooters. The minimum legal age for children using E scooters should be 16 years, children cared for the in the Paediatric Trauma Pathway are under the age of 16 years. Concerns for individual children have been followed up through a safeguarding route, and the broader concern is being considered as potential public health issue, through the South West Trauma network.

8 Safeguarding, Midwifery and the Unborn Baby

A significant number of safeguarding referrals continue to be made by the Community Midwifery Team's across Bristol and Weston. The midwives are providing care to an increasing number of challenging and complex cases including; domestic Abuse, substance misuse, late/ concealed pregnancies and mother's with significant mental health concerns involving Family Court proceedings. This is in line with the national post Covid picture.

The number of families already known to Children's Social care has also increased over the last two years; in part this may be due to the absorption of midwifery activity from Weston General Hospital. Parts of North Somerset and Weston include areas in which social deprivation is particularly high. To support this

increase in demand, safeguarding and midwifery resources have been realigned, to provide an increased level of support for midwifery services.

Referrals for unborn babies are made due to concerns about potential parental risk factors which may result in occasions where babies have to be removed from their mothers following a multi- agency safeguarding process. Midwives continue to be supported by a robust system of safeguarding supervision.

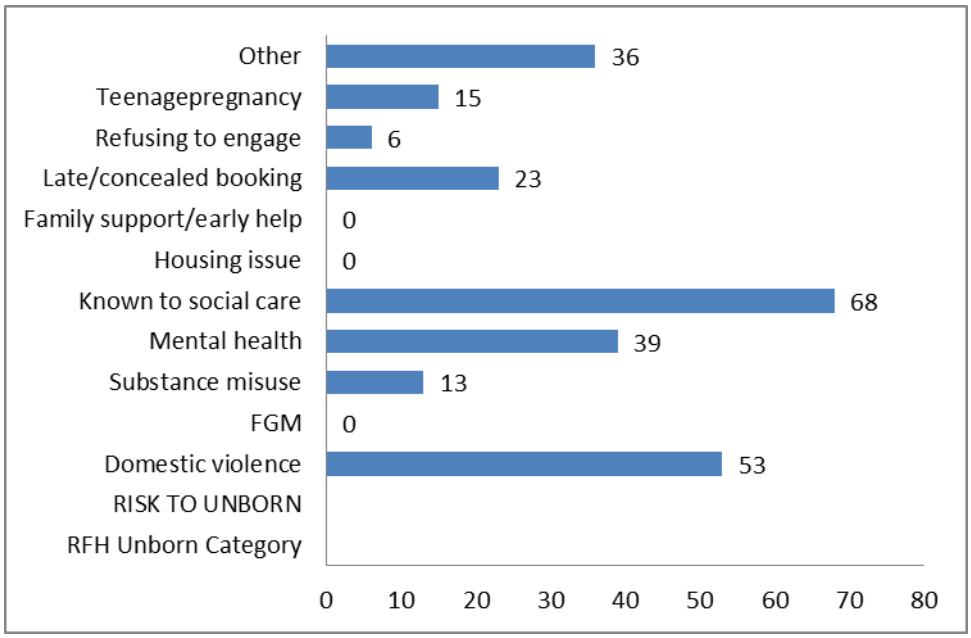
Table 8: Number of contacts made to the Safeguarding Midwifery Team

Quarter 1	131
Quarter 2	130
Quarter 3	142
Quarter 4	116
Total	**519**

Women can choose to book and deliver their babies in UHBW or North Bristol Trust and if significant safeguarding concerns are raised, communication can be hindered by the two separate IT booking systems, locally developed midwifery terminology and practices. This is being actively addressed following the Ockenden Report as well as the recommendations of a local case review (Child M see section 13). Both Trusts are working together, to move towards a single maternity booking system in 2023.

Women are routinely asked screening questions about domestic abuse, as pregnancy is recognised to be a potential trigger time and high risk for women. Over the last few years the Trust has been working with domestic abuse services locally to review the support available to women. This has resulted in a pilot project with Next Link, providing an Independent Domestic and Sexual Abuse Violence Advisor (IDSVA) specifically to support pregnant women. The impact of the IDSVA project will be reviewed going forward.

Table 9: Referrals for Unborn Babies



Total Number of Midwifery Safeguarding referrals = 253

Questions are also asked about Female Genital Mutilation (FGM) at booking appointments and at other stages during antenatal care in line with best practice guidance and the requirements of the national information sharing data base (FGM-IS). Female babies will also have an alert placed on their Carefow records.

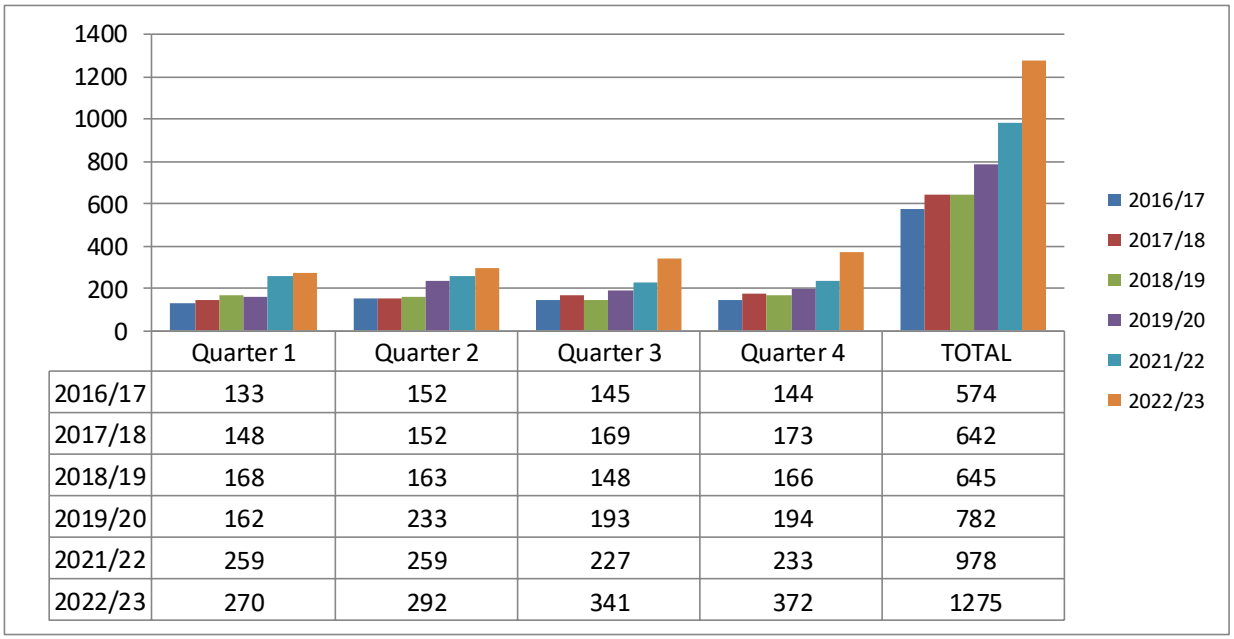
Midwives also continue to support the 'ICON' programme, a national campaign to educate parents about baby's crying patterns and empower them with positive coping mechanisms. The aim of the campaign is to reduce risks and instances of Abusive Head Trauma resulting from babies being shaken. There have been two children's case reviews during this reporting period (detailed in Section13) relating to very young babies with significant non accidental injuries.

The safeguarding midwifery senior nurse has worked closely with the Sirona Learning Disability nurses to develop and implement a Standard Operating Procedure (SOP) to support women with a Learning Disability /Autism (LD/ASD) to access midwifery care safely. The SOP has also been adopted in North Bristol Trust.

9. Safeguarding Adults Activity Data

The safeguarding adult's activity data has shown a further significant increase in this reporting period, with a 21% increase from the previous year (Table 10). This follows the merger with Weston General Hospital, indicating that the new centralised safeguarding adult's process has been robustly embedded across all sites of the trust.

Table 10: Number of Referrals Received

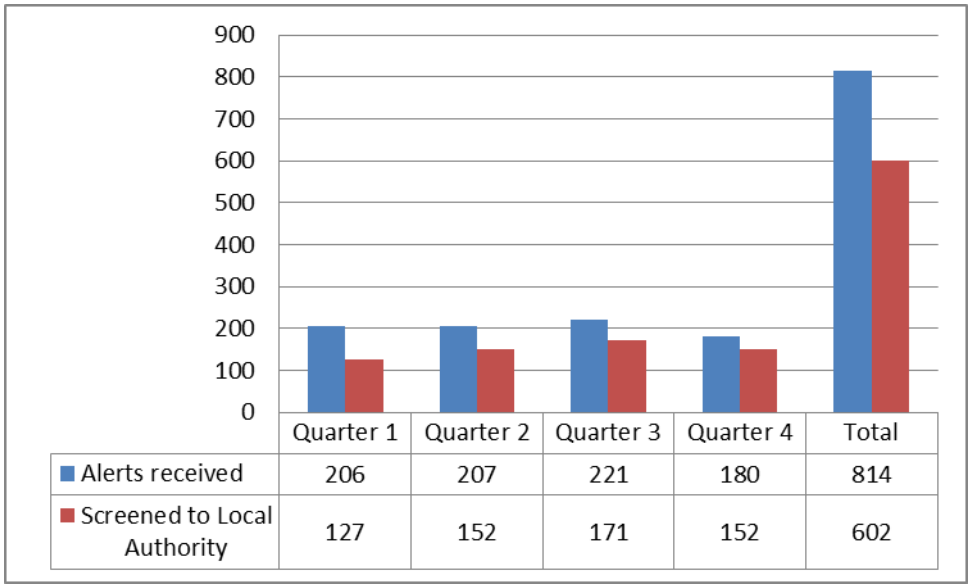


	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
2016/17	133	152	145	144	574
2017/18	148	152	169	173	642
2018/19	168	163	148	166	645
2019/20	162	233	193	194	782
2021/22	259	259	227	233	978
2022/23	270	292	341	372	1275

The quality assurance process, previously described in relation to safeguarding children's referrals, is mirrored for safeguarding adults. This process ensures that onward referrals are in line with the Keeping Bristol Safe Adults Partnership Board Threshold Guidance and the Care Act 2014.

During this reporting period, 74% of alerts received met the agreed threshold for referring to the relevant Local Authority for a safeguarding investigation (Table 11). This is an improvement on previous years. Alerts not meeting the threshold have been risk assessed and redirected to other appropriate services, such as housing, domestic violence support, or local authority care needs assessments.

Table 11: Number of Contacts / Referrals screened prior to sending to Local Authority

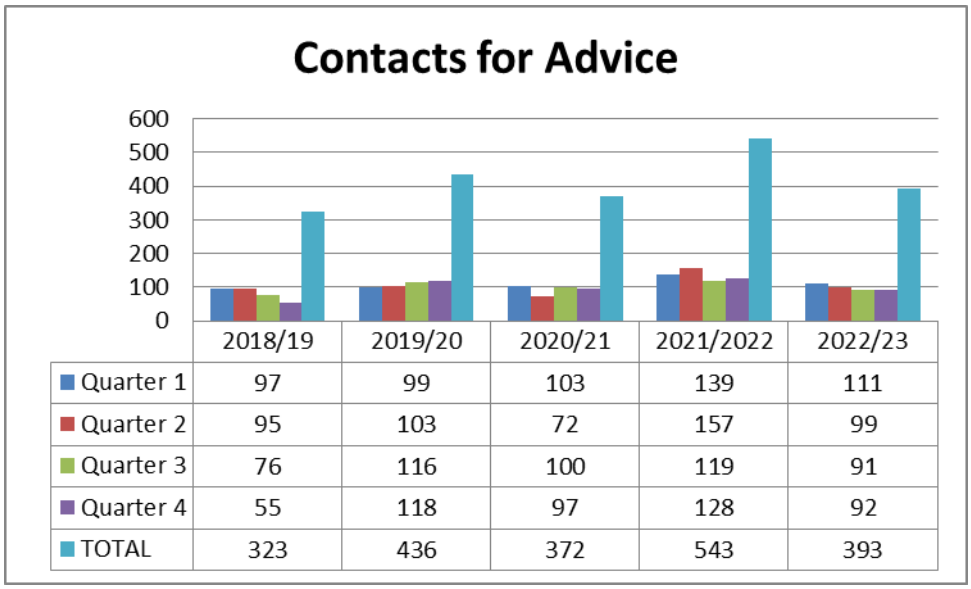


	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Alerts received	206	207	221	180	814
Screened to Local Authority	127	152	171	152	602

The Safeguarding nursing team continues to record the number of requests for advice and support from staff across the Trust (table 12). Contacts include advice sought in relation to the application of the Mental Capacity Act and Deprivation of Liberty Safeguards as well as Safeguarding queries.

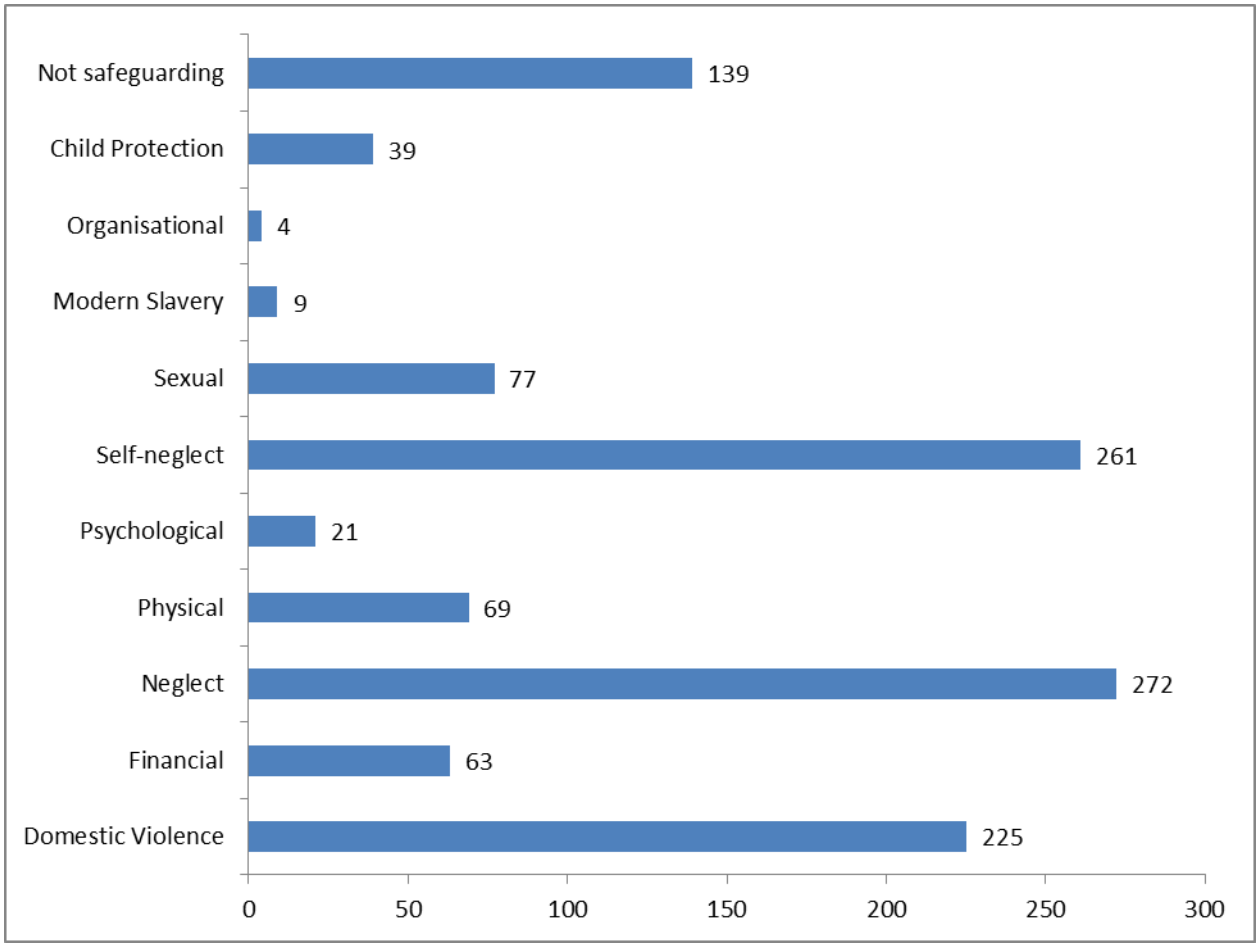
There has been a reduction in the number of advice contacts to the safeguarding team during this reporting period. This may be as a result of the previously described recruitment challenges, decreased capacity and visibility of the safeguarding team. Plans to support recruitment into the safeguarding team continue. It is reassuring, therefore that the number of safeguarding referrals has increased significantly this year (Table 11).

Table 12: Number of Contacts for advice



	2018/19	2019/20	2020/21	2021/2022	2022/23
Quarter 1	97	99	103	139	111
Quarter 2	95	103	72	157	99
Quarter 3	76	116	100	119	91
Quarter 4	55	118	97	128	92
TOTAL	323	436	372	543	393

Table 13: Category of referrals



Categories for referrals remain in line with previous years and the national picture, with self- neglect and neglect predominating. In response to this, the safeguarding team has been working with the Bristol Keeping Safe Partnership to strengthen the multi- agency response to self- neglect.

The trust has contributed to two Safeguarding Adults Review (SAR) Self Neglect Thematic Reviews (Bristol and North Somerset Safeguarding Adults Boards) considering a total of five adults who have recently died as a result of self- neglect (see section13). The reviews considered the complexity of self-neglect and the challenges faced by an acute trust in addressing this.

Identified learning includes the need ensure that self- neglect concerns are considered through the lens of safeguarding , especially when there is a risk to life, and the requirement to promote staff knowledge and confidence in the application of the Mental Capacity Act (2005) in the context of refusal of care. The reviews also highlight the additional challenges and risks faced by some adults, to access health care. Work is underway within the trust, to implement a newly developed adult ‘Did Not Attend’ Policy; this is reflected in the safeguarding work plan for the next reporting period.

Domestic violence referrals continue to form a significant referral category. Internal arrangements to support the Multi Agency Risk Assessment Conference (MARAC) have been reviewed alongside North Bristol Trust (NBT) and a partnership approach agreed. The new approach aims to streamline the information sharing process, recognising the capacity challenges faced by both safeguarding teams. This has been underpinned by a new safeguarding partnership agreement with NBT, signed by both trusts Executive Leads / Chief Nurse. The impact of this approach will be reviewed in the next reporting period.

The safeguarding team continues to make a referrals to the MARAC for patients who are deemed to be high risk and choose not to engage with the IDVAS service

The trust hosts Next Link Independent and Sexual Violence Advisors in the Emergency Department, Unity Sexual Health and now also in Midwifery Services. A research project is also underway in conjunction with two charities, Macmillan Cancer Support and 'Standing Together Against Domestic Abuse', to consider options to support patients in the trust with a cancer diagnosis. The project involves training to increase staff awareness of the risks of domestic abuse. The impact of project will be evaluated going forward.

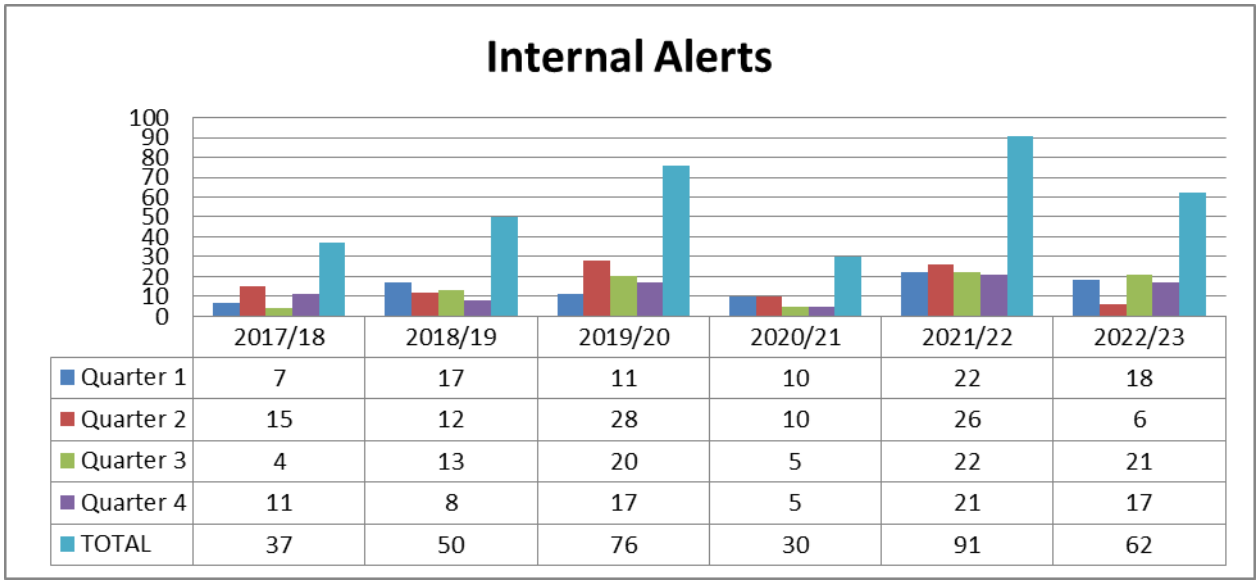
In response to increasing concerns that potential increased vulnerabilities of families staying in BNSSG designated Asylum hotels may not be fully considered, as staff may not know the addresses, a new safeguarding (Careflow) alert has been created. The new alerts are linked to the addresses of the designated Asylum hotels- thereby prompting staff to consider potential associated risks.

9.1. Internal Safeguarding Alerts

A Safeguarding Internal Alert is raised if it is alleged that the Trust may have caused harm to a patient through the omission or provision of care, underpinned by the Trust's responsibility to be open and transparent in line with the Duty of Candor. Alerts may be raised by practitioners within the Trust or by other agencies or individuals.

There has been a decrease in the number of internal cases recorded this year.

Table 14: Internal Safeguarding Alerts

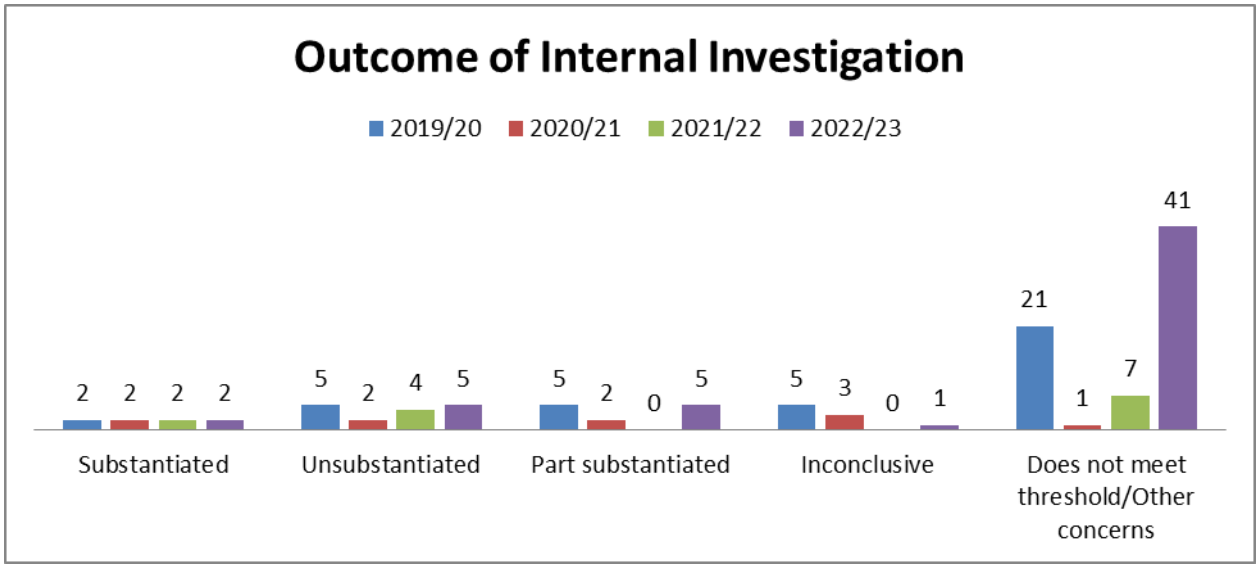


	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Quarter 1	7	17	11	10	22	18
Quarter 2	15	12	28	10	26	6
Quarter 3	4	13	20	5	22	21
Quarter 4	11	8	17	5	21	17
TOTAL	37	50	76	30	91	62

Approximately a quarter of the internal referrals sent to the Local authority did not meet a threshold for a safeguarding investigation, or the local authorities were assured by the actions already taken by the Trust and no further intervention was required. The number of internal cases substantiated remains in line with previous reporting period; some cases remain open under investigation, awaiting outcome decisions from the local authority.

The numbers of internal alerts, outcomes, emerging themes or concerns, are robustly monitored by the Safeguarding Team, Divisional Patient Safety Teams and the Safeguarding Assurance and Operational Group's. Learning outcomes are incorporated into staff training updates.

Table 15: Outcome of internal Safeguarding investigations



There have been two key themes for learning from internal investigations, also repeated in previous annual findings:

- Issues relating to discharge/ discharge communication, the majority of the concerns were thought to result from poor practice issues. The concerns were all investigated by Divisions and subsequently closed by the Local Authority, who were reassured by the actions taken internally by the trust to address poor practice and identify the learning.

- Hospital acquired pressure injuries, triggering concerns about possible neglect. Of particular concern is a pressure injury which resulted in significant harm to a patient. This case is currently being fully investigated by the Division and the final report will be presented to the Safeguarding Adults Review Group (a sub group of the Keeping Bristol Safe Adults Partnership Board). Learning will be addressed though the Safeguarding Assurance and Operational Groups and included into next year's annual report.

10. Mental Capacity Act and Deprivation of Liberty Safeguards (Dols) / Liberty Protection Safeguarding (LPS)

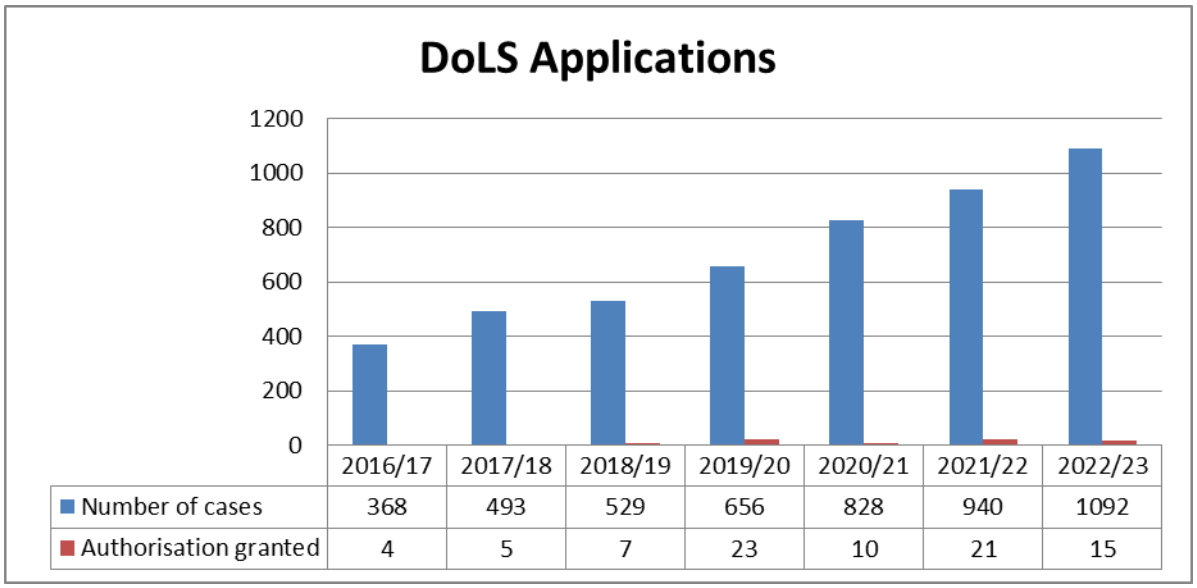
The Deprivation of Liberty Safeguards (DoLS), within the Mental Capacity Act, provides a protective legal framework for those vulnerable / at risk people who are deprived of their liberty. DoLS applications continue to be quality assured by the safeguarding team, prior to sending onwards to the relevant Local Authority DoLS team.

The number of DoLS authorised remains very small. The Trust continues to care for and detain patients, as it is in their best interests to do so, following the least restrictive option and in line with the Mental Capacity Act measures. This stance continues to mirror the current position of NHS Trusts, both locally and nationally, which is also reflected in the Trust risk register (Datix Risk no 690).

The planned changes to the Deprivation of Liberty Safeguards framework, part of the Mental Capacity (amendment) Act 2019, originally due for implementation in 2019, were delayed due to the Covid pandemic. Implementation planned for April 2022 has now also been deferred to beyond the term of the current government. The safeguarding team submitted a detailed response to the government consultation for the new MCA Code of Practice which will underpin the legislative changes. Final publication of the Code has also now been postponed.

There has been a significant increase in number of DoLS applications over the last two years, reflecting the anticipated increase in activity following the merger with Weston General Hospital. The majority of DoLS applications are made by the Division of Medicine and Weston, in line with expected practice

Table 16: Deprivation of Liberty Safeguards (DoLS)



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Number of cases	368	493	529	656	828	940	1092
Authorisation granted	4	5	7	23	10	21	15

Safe and effective MCA practice is essential in protecting our patient's human rights, safety and wellbeing. Staff MCA knowledge has been highlighted as an area for improvement in a recent independent MCA/DoLS audit (undertaken by South West Auditors) and in the findings of the Self- Neglect Thematic Reviews (section13). Staff MCA knowledge will be reflected as a new/ pending risk and updated in the safeguarding work plan going forward.

MCA/DoLS training will also continue to focus on raising awareness of the 'passive patient' who meets the criteria for a DoLS application, even if they are not objecting or trying to leave. There are likely to be patients, within the trust, who fall into this category and could be considered to be illegally detained if the appropriate legislative process has not been implemented. This concern is also reflected as a risk on the risk register (Datix no 690).

11. Safeguarding Children and Adult Training

The provision and delivery of both children and adults safeguarding training remains a key priority, ensuring that all staff are provided with the appropriate training for their role and responsibilities. The Trust performance standard is currently 90% compliance with all levels of safeguarding training. All levels of training remain in line with the requirements of the Adults (2018) and Children's (2019) Intercollegiate Documents

11.1 Level 1 and 2 Training Compliance

Safeguarding Level 1 and 2 training for both children and adults is available as e learning training, supported by face to face level 2 training delivered as part of corporate clinical induction. The required 90% target has been achieved successfully, recovering following the dip last year seen as part of the impact of the Covid pandemic. (Table 17).

Table 17: Level 1 and 2 Safeguarding Training Compliance

	March 2020	March 2021	March 2022	March 2023
Level 1 Safeguarding Adults	93%	90%	88%	96%
Level 1 Safeguarding Children	91%	87%	87%	96%
Level 2 Safeguarding Adults	95%	87%	83%	90%
Level 2 Safeguarding Children	93%	85%	82%	90%

11.2 Level 3 Core and Specialist Training (Children)

All staff who work regularly with children, young people or the unborn baby must complete Level 3 Core training as a minimum (approximately 2,200 staff). Staff in a more senior role must complete the more advanced level of Level 3 Specialist training (approximately 450 staff), including staff such as; Paediatric Consultants, Community Midwives and Paediatric Specialist Nurses who are expected to undertake a lead role in safeguarding situations.

Level 3 training was historically delivered as face to face training, and so has been adversely affected by the Covid pandemic. Training (including update training) is now delivered via a blended approach (face to face an eLearning).

A training recovery plan has been developed and whilst some progress has been made, the trust has yet to reach pre Covid compliance levels or the required 90% target (Table 18). This remains an area of concern for the trust which is monitored robustly internally through the Safeguarding Assurance and Operational Group, with input from all Divisional leads. Level 3 training compliance also remains an area of risk, reflected in Datix no 921.

Table 18: Level 3 Safeguarding Children Training Compliance

	March 2020	March 2021	March 2022	March 2023
Level 3 Safeguarding Children (Core)	73%	55%	46%	61%
Level 3 Safeguarding Children (Specialist)	78%	58%	53%	54%

11.3 Level 3 Safeguarding Training Compliance (Adult)

Safeguarding Adults Level 3 training primarily includes senior front line clinical staff, primarily Band 7 nursing staff and Consultants working in adult specialist and inpatient areas. The target audience includes approximately 400 staff. The trust has yet to reach the required 90% target and this remains an area of concern for the trust which is monitored robustly internally through the Safeguarding Assurance and Operational Group, with input from all Divisional leads. Level 3 training compliance also remains an area of risk, reflected in Datix no 921

Table 19: Level 3 Safeguarding Adult Training Compliance

	March 2020	March 2021	March 2022	March 2023
Level 3 Safeguarding Adults	52%	58%	54%	53%

12 Prevent, including training

The Counter-Terrorism and Security Act requires that specified bodies, including health, have a legal duty to "have due regard to the need to prevent people from being drawn into terrorism". As part of these statutory requirements, underpinned by the NHS Commissioning Standards, the Trust is required to train staff so they know what PREVENT is and how to escalate concerns regarding people who may be at risk of radicalisation.

Safeguarding training incorporates the required level of PREVENT/WRAP according to staff role and level of responsibility. Compliance is reported as part of the Trust monthly Essential Training report.

Table 20: Prevent/WRAP Training Compliance

	March 2020	March 2021	March 2022	March 2023
Basic Prevent Awareness Training (BPAT)	94%	82%	88%	86%
Workshop to Raise Awareness of Prevent (WRAP)	77%	82%	86%	94%

The compliance target for both PREVENT and WRAP training is 90%. Work towards achieving the BPAT target will continue in the next reporting period. The Trust is required to have a dedicated PREVENT lead, which has been incorporated within the remit of the Head of Safeguarding.

The Trust made one PREVENT referral during this reporting period, following a concern from ITU regarding the possible radicalisation of an inpatient. This was well managed under the PREVENT process with input from the Home Office. The Head of Safeguarding has also represented the Trust through one Channel Panel process.

13. Child Safeguarding Practice Reviews * Safeguarding Adult Reviews and Domestic Homicide Reviews

*Serious Case Reviews are now referred to as 'Child Safeguarding practice Reviews', reflecting the requirements of the updates statutory guidance 'Working Together to Safeguarding Children (2018).

Child Safeguarding Practice Reviews (CPSR) for children and Serious Adult Reviews (SAR) are undertaken as part of a statutory multi-agency investigation process:

- following the death or serious harm of a child or an adult (with care and support needs), as the result of abuse or neglect,
- and there have been concerns about the way in which agencies have worked together and lessons can be learnt.

Domestic Homicide Reviews (DHR), are conducted following the death of an individual over the age of 16 years of age as a result of violence within a relationship, either from a partner of another member of the household they live in.

The safeguarding team has contributed information (scoping requests, full chronologies and Individual Management Reviews) within the required time frame in response to the all requests received in this reporting period.

The following local case reviews have been published:

Table 21: Case Reviews published 2022/23

Child Safeguarding Practice Review / Rapid Reviews (previously known as Serious Case Reviews – SCR)	Domestic Homicide Reviews(DHR)	Safeguarding Adults Review (SAR)
Bristol Learning Brief published following Rapid Review – 'Bruising in Non- Mobile Babies	Bristol Joint DHR/SAR – Caroline died in 2018 (complex history, self- neglect and domestic abuse)	Bristol Self Neglect Thematic Review – Charles and Bridget.
South Glos – Baby M (3 month old baby with non- accidental injuries		N Somerset – Self Neglect Thematic Review – Stan, Charlotte and Phillip
South Glos – Family A (Mother convicted of murder of partner /father of children)		

Learning and associated actions resulting from these DHR /SCR / SAR s is included and monitored via the Safeguarding Assurance and Operational Groups, underpinned by the safeguarding work and audit plans.

Key learning for UHBW includes:

- Increase staff knowledge and competence in relation Mental Capacity Act implementation, particularly in relation to complex cases of self- neglect.
- Awareness of the risks of self- neglect, need for risk based assessments and joined up multi-agency planning.
- Consideration of adult vulnerabilities (cognitive impairments, domestic abuse etc) as part of risk assessment for follow up of missed health appointments (Did Not Attend policy).
- Awareness of increased vulnerabilities of babies, risk of significant injuries and death/ the importance of preventative programs for abusive head trauma (ICON)
- Promote awareness of Domestic Abuse Act 2021, recognising children as victims of domestic abuse need for joined up multi- agency planning.

Local case reviews underway during this reporting period, including a Domestic Homicide Review (DHR) and a Safeguarding Adults Review (SAR), have again highlighted that children and young people attending our ED's do not always have a HEEADSSS (Home, Education, Eating, Activities, Drugs, Sexuality, Suicide, Safety) completed. The aim of the tool is to support a holistic assessment and raising staff awareness of the tool will remain a key objective for 2023/24.

14. Report summary and objectives for 2023/24

The safeguarding agenda for both children and adults is constantly changing and it is essential that the Trust continues to develop a proactive approach to ensure that safeguarding practice remains up to date and in line with new guidance and best practice.

Safeguarding remains a key priority for the Trust and this annual report summarises the key safeguarding activities, developments and achievements in this reporting period. The report aims to provide assurance that the Trust is fulfilling its statutory safeguarding duties and responsibilities and is thereby fulfilling its contractual duty to safeguard children and adults.

Full details of the aims and objectives of both safeguarding teams going forward are detailed in the work and audit plans for 2023/24 available on request

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Trust Board of Directors in Public on Tuesday 14th November 2023

Reporting Committee	**Finance Digital and Estates Committee – September meeting**
Chaired By	**Martin Sykes, Non-executive Director**
Executive Lead	**Neil Kemsley Chief Financial Officer/ Neil Darvill, Joint Chief Digital Information Officer**

For Information

Finance

The committee noted the month 5 financial position that remained in deficit against plan, albeit with a relatively small negative movement in month. Savings plans were delivering reasonably well against target, but unfortunately with a significant proportion being 'non-recurrent' and hence failing to reduce the Trust's underlying deficit.

Progress on the development of the Trust in-year financial recovery plan and forecast out turn was noted. Good progress was being made on in-year 'grip and control' however, significant uncertainty around national allocations (e.g. elective recovery fund) were making year-end projections extremely difficult to refine.

The committee approved a proposal for the costing methodology to be used in an upcoming national costs collection exercise.

Digital

The committee reviewed progress on the rollout of the current digital strategy. A number of notable successes were noted (go-live of the Badgernet digital maternity and the roll out of digital outpatient letters for example).

The medicines management (digital prescribing) project remained behind schedule. The committee were informed that high-level meetings between the Trust and System-C had recently taken place but were not assured that these had yet helped to resolve outstanding issues.

The committee received an update from the Trust Cyber Security Manager detailing the governance and processes in place the manage cybersecurity. Recommendations from recent audits were presented, together with associated action plans. The committee requested an update on the Trust business continuity and escalation processes, were an attack to breach the Trust defences.

Estates

The committee received an update and assurance on the actions being taken to

University Hospitals Bristol and Weston NHS Foundation Trust

improve fire safety across the Trust. Robust governance and escalation was noted and the committee were assured that the processes are in place and operating.

The 2023 fire safety audit (authorised engineer (fire)) was presented and the committee noted that a number of recommendations had been made and incorporated into the Fire Safety Improvement Programme. The actions and timescales for these recommendations were noted by the committee.

A report on space utilisation was provided for information, including an update on the progress with usage of Chapter House. Progress was noted and opportunities for further realignment of Chapter House and the Dental Hospital were discussed.

For Board Awareness, Action or Response

The updated financial forecast outturn will be finalised in October.

It is clear from the ongoing fire assessment work that further capital and revenue investment may be required. This has the potential to be in excess of the Trust budget allocations and may need to be escalated regionally.

Key Decisions and Actions

Approved the costing methodology for the upcoming national costs collection exercise.

Additional Chair Comments

Date of next meeting:	27th October

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Trust Board of Directors in Public on Tuesday 14th November 2023

Report Title	**M6 Trust Finance Performance Report**
Report Author	**Jeremy Spearing, Director of Operational Finance**
Executive Lead	**Neil Kemsley, Chief Financial Officer**

1. Purpose

To inform the Trust Board of the Trust's overall financial performance from 1st April 2023 to 30th September 2023 (month 6).

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

The Trust's net income and expenditure position is a net deficit of £12.4m against a planned deficit of £6.2m. The adverse position against plan to date of £6.2m is due to: a shortfall on Elective Recovery Funding (ERF) of £2.7m; the estimated cost of industrial action of £3.2m; the shortfall on savings delivery of £2.6m; and better than planned interest receivable income of £2.2m.

The Trust delivered savings of £8.9m year to date, £2.6m behind plan.

The value of elective activity covering inpatient, day case and outpatient points of delivery, was £2.8m behind plan compared with £1.4m behind plan at the end of August.

The Trust delivered capital investment of £15.6m year to date.

The Trust's cash balance was £106.3m as at the 30th September 2023.

3. Strategic Alignment

This report is directly linked to the Patient First objective of 'Making the most of our resources'. Achieving break-even ensures our cash balances are maintained and therefore we can continue to support the Trust's strategic ambitions subject to securing CDEL cover.

4. Risks and Opportunities

416 – Risk that the Trust fails to fund the strategic capital programme. Unchanged risk score of 20 (very high).

5. Recommendation

This report is for Assurance. The Board is asked to note the Trust's financial performance for the first half of the financial year.

6. History of the paper

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

N/A

University Hospitals Bristol and Weston NHS Foundation Trust

Trust Finance Performance Report

Reporting Month: September 2023

Executive Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: September 2023

YTD Income & Expenditure Position	• Net I&E deficit of £12,419k against a deficit plan of £6,202k (excluding technical items). • Total operating income is £15,579k favourable to plan due to higher than planned income from activities of £12,097k and higher than planned other operating income of £3,482k. • Operating expenses are £23,676k adverse to plan due to higher pay expenditure (£14,913k) and non-pay expenditure (£8,844k). Depreciation is broadly in line with plan. • The estimated cost of industrial action for May to September (at £3,223k) remains unfunded by NHSE. • Financing items are £2,062k favourable to plan mainly due to interest receivable.
Key Financial Issues	• *Recurrent savings delivery below plan* – Internal CIP delivery is £8,938k or 95% of plan, of which recurrent savings are £3,773k, 40% of plan. Failure to achieve the annual target of £27m (including transformational savings) in full will result in the Trust failing to meet the financial plan. • *Delivery of elective activity recovery below plan* – elective activity must be delivered in line with plan. Failure to do so will result in a loss of income of up to c£30m, resulting in the Trust not achieving its financial plan. At M6, the value of elective activity is £2.8m behind plan. • *Corporate mitigations not delivered in full* – non-recurrent mitigations of c£25m must be achieved to support delivery of the plan. At M6, the corporate mitigations are on track. • *Failure to deliver the financial plan* – failure to deliver the actions and therefore the financial plan of break-even will constitute a breach of this statutory duty and will result in regulatory intervention.
Strategic Risks	• Assessment and implications of the financial arrangements relating to Healthy Weston 2 Phase 2 – pending completion of the business case; • Understanding the operational risks and mitigations associated with the Trust's legacy estate and how the CDEL limit and system prioritisation restricts future strategic capital investment – pending completion of the ICB and Trust draft medium term capital plan in November 2023; • Understanding the implications of the Trust's recurrent revenue deficit of c£60m, i.e. the requirement to present a medium-term financial plan in November 2023 to address the Trust's recurrent deficit and the impact this will have on future clinical strategy and Trust autonomy.

Reporting Month: September 2023

Successes	Priorities
• Delivery of capital investment of £15.6m at the end of September. • The Trust's cash position remains strong at £106.3m. • BPPC continues to be maintained with 90% of invoices by value and 90% by volume paid within 30 days.	• Formal FD&E Committee and Board review of the Trust's forecast outturn (FOT) assessment to determine if the Trust will need to invoke the NHSE protocol. • Delivery of the Division's financial recovery plans. • The COO Team is forecasting elective recovery performance to 31 Match 2024 to inform the ERF forecast. • The COO Team is assessing the operational and financial benefits arising from the Systems Urgent & Emergency Care (UEC) investments against the UEC saving requirement of £7,850k. • Divisions and Corporate Services to ensure recurrent CIP schemes are fully identified to deliver the 2022/23 recurrent CIP shortfall and the 2023/24 recurrent target. • Delivery of the Trust's non-recurrent corporate mitigations. • Development of the Trust's revenue Medium-Term Financial Plan and Medium-Term Capital Plan. • Securing national capital funding for to the Trust's capital plan.
Opportunities	**Risks & Threats**
• NHS England have confirmed it is reducing the threshold to earn additional Elective Recovery Funding (ERF) for all systems by 2% and will pay 84% of systems planned ERF in recognition of the financial impact of industrial action in April. • Ensure the full impact of industrial action continues to be identified in the event that national funding becomes available to support the additional costs and lost income.	• The financial positions of the Trust's Divisions deteriorate further and potentially undermine the delivery of the Trust's FOT. • Workforce supply challenges in hard to fill vacant posts and staff absences continues to impact on the Trust's ability to meet emergency and elective demand. • Below plan elective recovery during Winter given system challenges with patient flow. • Recurrent under-delivery on the Trust's savings program will result in a significant deterioration in the Trust's underlying deficit by c£10m. • CDEL, the recurring revenue deficit of the Trust at c£60m and the system at c£98m is likely to constrain the Trust's strategic capital plans over the next three to five financial years.

Income & Expenditure Summary

NHS University Hospitals Bristol and Weston NHS Foundation Trust

September 2023

Trust Year to Date Financial Position

	Month 6			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	84,761	86,452	1,691	502,075	514,172	12,097
Other Operating Income	8,416	9,866	1,450	54,781	58,263	3,482
Total Operating Income	**93,177**	**96,318**	**3,141**	**556,856**	**572,435**	**15,579**
Employee Expenses	(55,954)	(59,472)	(3,518)	(338,342)	(353,255)	(14,913)
Other Operating Expenses	(32,473)	(34,346)	(1,873)	(202,412)	(211,256)	(8,844)
Depreciation (owned & leased)	(3,078)	(2,995)	83	(17,684)	(17,603)	81
Total Operating Expenditure	**(91,505)**	**(96,813)**	**(5,308)**	**(558,438)**	**(582,114)**	**(23,676)**
PDC	(1,037)	(1,037)	0	(6,222)	(6,223)	(1)
Interest Payable	(221)	(224)	(3)	(1,326)	(1,375)	(49)
Interest Receivable	250	546	296	1,500	3,732	2,232
Other Gains/(Losses)	0	(97)	(97)	0	(120)	(120)
Net Surplus/(Deficit) inc technicals	**664**	**(1,307)**	**(1,971)**	**(7,630)**	**(13,665)**	**(6,035)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	238	154	(84)	1,428	1,246	(182)
Net Surplus/(Deficit) exc technicals	**902**	**(1,153)**	**(2,055)**	**(6,202)**	**(12,419)**	**(6,217)**

Clinical Divisions YTD Financial Position – Variance to Budget

Division	M6 YTD Variance Favourable/ (Adverse) £000's	M5 YTD Variance Favourable/ (Adverse) £000's	Increase/ (Decrease) in Variance £000's	M5 YTD Variance exc. Industrial Action Favourable/ (Adverse) £000's	M6 YTD Variance exc. Industrial Action as % of Budget
Diagnostics & Therapies	(754)	(705)	(49)	(753)	-1.5%
Medicine	(1,452)	(1,229)	(223)	(449)	-0.6%
Specialised Services	(190)	25	(215)	192	0.2%
Surgery	(2,667)	(2,098)	(569)	(1,900)	-2.0%
Weston	(1,323)	(1,274)	(49)	(397)	-1.4%
Women's & Children's	(3,475)	(3,130)	(345)	(2,699)	-2.5%
Clinical Divisions Total	**(9,861)**	**(8,411)**	**(1,450)**	**(6,006)**	**-1.3%**
Estates & Facilities	(647)	(782)	135	(599)	-1.8%
Total	**(10,508)**	**(9,193)**	**(1,315)**	**(6,605)**	**-1.4%**

Key Facts:

- The position at the end of September is a net deficit of £12,419k against a deficit plan of £6,202k. The adverse position against plan of £6,217k, a deterioration from last month of £2,055k.
- The adverse variance is due to the estimated cost of industrial action for May to September at £3,223k, a shortfall on Elective Recovery Funding of £2,700k, a shortfall on savings delivery of £2,601k offset by interest receivable at £2,232k.
- YTD, the Trust has spent £3,715k on costs associated with Internationally Educated Nurses (IENs).
- Pay expenditure in September is £2,843k lower than last month, overall, broadly in line with last month, excluding the medical pay award. Additional staffing costs of covering the industrial action (£538k), were offset by lower bank and agency costs.
- Agency expenditure in month is £2,080k, compared with £2,333k in August. Bank expenditure in month is £3,416k, compared with £3,742k in August.
- YTD, pay expenditure is £14,913k above plan, due mainly to costs of industrial action (£3,957k), medical pay award (£3,000k) and a higher number of substantive staff in post.
- Total operating income is £3,141k higher than plan in August. c£1,700k is as a result of income from commissioner investments being higher than planned and c£1,500k relates to various sources of other operating income.
- The financial position of the clinical divisions deteriorated by £1,450k in September to a YTD overspend against budget of £9,861k or 2.2%. Excluding the cost of industrial action, this reduces to £6,006k or 1.3%. Estates and Facilities improved, ending the month £599k or 1.8% over budget, excluding industrial action.
- Surgery (£569k), Women's & Children's (£345k) and Medicine (£223k) had the largest deterioration during the month.

Savings – Cost Improvement Programme

September 2023

Division	YTD					Forecast Outturn				
	Plan £'000	Recurring £'000	Non-Recurring £'000	Total £'000	Variance (Fav/(Adv)) £'000	Plan £'000	Recurring £'000	Non-Recurring £'000	Total £'000	Variance (Fav/(Adv)) £'000
Diagnostics & Therapies	1,235	242	1,241	1,483	248	2,383	569	2,300	2,869	486
Medicine	900	480	585	1,065	165	2,112	903	1,160	2,064	(49)
Specialised Services	774	548	461	1,009	234	1,658	1,170	896	2,065	408
Surgery	1,439	244	457	701	(737)	2,932	540	892	1,432	(1,500)
Weston	251	361	84	445	194	510	594	159	753	242
Women's & Children's	1,875	976	1,267	2,243	368	3,787	2,029	2,463	4,492	705
Estates & Facilities	504	169	347	516	13	1,028	389	560	950	(79)
Finance	122	123	0	123	0	245	245	0	245	0
HR	67	50	34	84	16	135	100	67	167	32
Digital Services	308	4	82	86	(222)	574	8	185	193	(381)
Trust HQ	285	76	109	184	(101)	569	151	217	368	(201)
Corporate	696	500	500	1,000	305	1,391	1,000	1,000	2,000	609
OP Transformation & Demand Management	938	0	0	0	(938)	1,875	0	0	0	(1,875)
Divisional Sub Totals	**9,393**	**3,773**	**5,165**	**8,938**	**(455)**	**19,200**	**7,698**	**9,899**	**17,597**	**(1,603)**
Urgent & Emergency Care Transformation Plans	**2,617**	**470**	**0**	**470**	**(2,146)**	**7,850**	**766**	**0**	**766**	**(7,084)**
Grand Totals	**12,009**	**4,243**	**5,165**	**9,408**	**(2,601)**	**27,050**	**8,464**	**9,899**	**18,363**	**(8,687)**

Key Points:

- The Trust's 2023/24 savings target is £27,050k. This includes £7,850k attributable to Urgent & Emergency Care Transformation Plans.
- Urgent & Emergency Care Transformation savings were planned to begin delivery from July 2023.
- At the end of September, the Trust had achieved savings of £9,408k, or 78% against a plan of £12,009k, resulting in a shortfall of £2,601k.
- The current year forecast outturn for 2023/24 is £18,363k against a plan of £27,050. £7,084k of the shortfall currently assumes under delivery of Urgent & Emergency Care Transformation savings, pending assessment.
- The recurring forecast outturn for 2023/24 is £8,464k resulting in a recurring savings shortfall of £18,586k.
- At month 6, all areas apart from Finance & Weston, had a shortfall against their recurring plans and five of the divisions had a shortfall against their non-recurring plans.
- Currently, 54% of the forecast identified savings are non-recurrent, which will result in a deterioration of the Trust's recurring revenue deficit of c£60m at the plan stage by c£10m. A significant step change in the identification and delivery of savings is paramount to securing the full delivery of CIP on a recurring basis to avoid increasing the Trust's recurring revenue deficit.

Appendix 1 – Action Log

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Summary of Recovery Actions

Ref	Date	Description of Action	Action Owner	Date Due	Committee Month	Status	Revised date	Update
014	Jun-21	Present the Trust Five Year Financial Strategy	OpDoF	Oct-21	November	Open	TBC	Pending - will be completed in alignment with BNSSG timelines
030	May-22	Include a summary of the ICS financial position	HoFFP	TBC		Open	TBC	Reporting of the ICS financial position currently under discussion
044	Jul-22	Review and address increased costs for patient transport services. (Trust Services)	HoFMI	Aug-22	September	Open	TBC	Subject to system wide procurement of non-emergency patient transport during Q4 - system process not yet concluded (March 2023)
055	Dec-22	HFMA H - Rollout revised financial training programme	HoFFP	Apr-23	May	Open	Q4 2023/24	Planning for the financial training programme commenced in Q2 as planned, with design and rollout over the next 2 quarters.

Key:

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

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the People Committee on 28th September 2023

Reporting Committee	**People Committee – 28 September 2023**
Chaired By	**Bernard Galton**
Executive Lead	**Emma Wood**

For Information

The meeting focussed on items relating to the People Strategy pillars: Inclusion and Belonging and New Ways of Working together with emerging strategic items.
Agenda items included:

- Workforce Risk Report
- Guardian of Safe Working Hours quarterly report
- Education Update
- Allied Health Professionals Strategy
- KPI report and Deep Dive into Women's and Children's Division HR metrics and people issues.

For Board Awareness, Action, or Response

The ongoing industrial action continues to have a significant impact on The Trust with further strikes announced for Consultants, Junior Doctors, and radiographers.
The meeting was informed that The Strikes (Minimum Service Level) Act became law on 20 July 2023, although this will have no impact on current strike action. However, it now gives the Secretary of State the Powers to set out standards that fall within health and social care.
An update was provided on Case Management and whilst significant progress has been made to improve the time taken to deal with employee relations cases there remains a high number of sensitive and complex cases to work through. In the aftermath of the Letby conviction extra measures have been put in place to ensure all cases are dealt with thoroughly and compassionately.
The move of HR teams to St James Court has now been completed which has enabled the creation of a Home First team on the 9th floor of the BRI building.
The Guardians of safe working hours reported that exceptions reports were down, and that positive work continues to cleanse the medical workforce data.
Locum Nest is beginning to be rolled out across the Trust. The Locum Nest App will connect qualified doctors with temporary work opportunities within UHBW.
The Education update gave the Committee the opportunity to assess progress against the ambitious strategy introduced earlier this year. The Committee was pleased to note that the Education Team is now fully resourced, and that leadership and management mandatory training is now taking place although it was not clear how much of a backlog remained.
Dr Vimal Sriram, the Director of Allied Health Professions, gave an excellent presentation on the Recruitment and Retention plan for AHPs. The plans are ambitious and not yet fully resourced.
It is always interesting to get a deep dive presentation from Divisional HR Business Partners and this time we heard about the workforce issues and successes within Women's and Children's Division where vacancies and turnover continue to be challenging.

University Hospitals Bristol and Weston NHS Foundation Trust

Key Decisions and Actions
A further update on Case Management and on Team Development Plans was asked for at the next meeting. Locums Nest is still in the early stages of implementation, but a more detailed update was requested for the November meeting, and it was agreed to look at the scheduling of Guardian Reports to ensure the most up to date reports are reviewed by the Committee Whilst progress is being made on delivery of the Education Strategy more details were requested on the backlog of managers yet to receive mandatory leadership and management training. Resourcing of the AHP strategy will need to be closely monitored to ensure milestones are met. Further work needs to be undertaken to establish the low take up of Bank staff in Women's and Children's Division when there are significant vacancies.
Additional Chair Comments
Hopefully there will be less apologies for the November meeting.
Update from ICB Committee
I attended the ICB meeting held on 26th September. In addition to the standard Agenda Items there was an excellent deep dive into Social Care workforce issues and future recruitment and retention plans. The issues and challenges are significant, and it was helpful to see them in set out in detail alongside those facing the NHS.

Date of next meeting:	**30 November 2023**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors on 14 November 2023

Report Title	**Freedom to Speak Up Q2 2023/24 Report**
Report Author	**Eric Sanders, Freedom to Speak Up Guardian** **Kate Hanlon, Deputy Freedom to Speak Up Guardian** **Zakira Takolia, Deputy Freedom to Speak Up Guardian**
Executive Lead	**Emma Wood, Director of People**

1. Purpose

To update the Board of Directors on the work of the Freedom to Speak Up Guardian.

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

- Whilst the number of concerns increased to 20, compared to 13 in Q1, the overall trend is a decline in the number of concerns raised.
- The themes from concerns remains similar to previous quarters. This includes fairness in recruitment and progression, team dynamic and working relationships, particularly between managers and colleagues, including concerns around bullying/harassment (10%) and use of discriminatory language.

3. Strategic Alignment

Freedom to Speak Up supports delivery of the Trust Strategy and People Strategy, by encouraging an open culture where staff can share concerns and ideas for improvement, and they are heard by managers and leaders. The Patient First approach is about continuous improvement, and for this to be successful we need all our staff to share their ideas, and thus the two areas must work closely to support achievement of all our strategic goals.

4. Risks and Opportunities

The risks associated with this report include:

- The reputation of the Trust and confidence in the Freedom to Speak Up process are affected by concerns not being addressed quickly enough (Risk 5906)
- Managers not taking ownership of issues/concerns identified by staff and not finding a route for monitoring and resolution leading to a loss of trust in local escalation.

5. Recommendation

This report is for **Information.**

The Board is asked to:

- Note the concerns raised and the themes that are being reported.

• Consider how it is tracking cultural change in the organisations such that all staff feel able to speak up and are heard.
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**
N/A

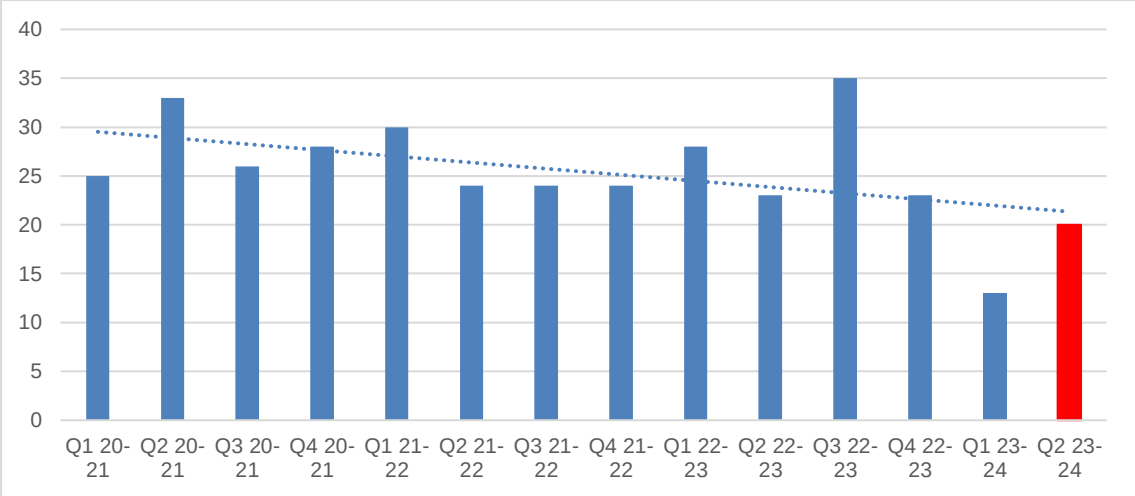
Q2 Freedom to Speak Up Update

1. Introduction

1.1. The purpose of this report is to update the Board of Directors on Freedom to Speak Up (FTSU) activities at UHBW over the past quarter, including an assessment of cases; actions against the current Freedom to Speak Up strategy and recommendations for further improvement in speaking up.

2. Assessment of cases

2.1. In relation to the number of concerns that have been raised, the chart below provides data by quarter from April 2021 to date. It shows that the overarching trend is a decline in the number of concerns raised.



2.2. In Q2, 20 concerns were raised compared to 13 in the previous quarter. Most of the concerns were raised by staff in admin/clerical and registered nurses/midwives.

2.3. There were similar themes identified in the concerns raised as per previous quarters. This included fairness in recruitment and progression, team dynamic and working relationships, particularly between managers and colleagues, including concerns around bullying/harassment (10%) and use of discriminatory language. Of note is that two concerns were raised relating to misogynistic language.

2.4. Themes of concerns raised via walk rounds in the quarter (inpatient and outpatient areas in Medicine and Bristol Royal Hospital for Children) included pressure of staffing shortages, rota pressures and poor behaviours.

2.5. In the quarter, the Trust responded to NHS England following the conclusion of the Letby trial on specified actions about how it supports staff and patients to speak up. The response highlighted the numerous routes and reporting mechanisms – and the information staff have access to about how to speak up and who can support them to do so. It is acknowledged that there is more work to do around tackling barriers to speaking up and sharing learning. This will be taken into the refresh of the FTSU strategy planned to be completed by March 2024.

3. Raising awareness of Speaking Up

3.1. The FTSU Guardian and Deputy Guardian, with support of the Champions, continue to attend Trust induction and induction for the Internationally Educated Nurses who are joining the Trust to ensure they are aware of the service.

3.2. Walkarounds were undertaken in the Medicine Division (Bristol Royal Infirmary) and Bristol Royal Hospital for Children, to visit inpatient and outpatient areas. The Guardians also participate in the Ward Accreditation visits.

3.3. The quarterly Champion meeting had a focus on sharing the FTSU annual report and feedback from the Board, discussing the response to the Lucy Letby trial and verdict and the impact on staff and how we could better utilise the different routes to speaking up, and to introduce Arabel Bailey, our new Non-Executive Director lead for FTSU.

3.4. The Deputy Guardian and several of the Champions attended a conference hosted by AWP on 15 September 2023. The conference, which was open to all Champions and Guardians from across BNSSG was an opportunity to understand the challenges and understand how to tackle barriers/share learning and experience. Similar themes were raised from all the organisations who attended.

3.5. Guidance for students around who and how to contact FTSU was published in September and similar advice for agency staff was recirculated during October (which was Speak Up month).

4. Forward Look

4.1. The FTSU team are finalising a new Manager's Guide to speaking up which will link to the new Leadership and Management Training and also to the Speak Up, Listen Up and Follow Up training available on Kallidus.

4.2. A case study relating to concerns raised around the treatment of bank staff is being finalised and will be published in Q3.

4.3. The FTSU Strategy will be refreshed in Q3 and presented to the People Committee and Board before the end of the Financial Year.

4.4. Work is progressing on the project to triangulate data across the Trust to help identify areas where further targeted work is required. This is work is aligned with Patient First, and is seeking to triangulate data from sources including the annual staff survey, patient safety, FTSU, patient experience, safe staffing levels etc. In the spirting of data triangulation, an Executive level task and finish group, which included a multidisciplinary membership, was convened to look at data in a specific service area where concerns had been raised. The first meeting considered all the data points mentioned above and agreed an action plan to address to concerns raised. The Task and Finish Group will continue to meet regularly to oversee delivery of the plan and improvements in the service area.

4.5. Kate Hanlon, Deputy FTSU Guardian, is taking a 6-month break to travel. I would like to thank Kate for the fantastic work she has done in the role and the support she has provided to lots of colleagues from across the Trust. To provide cover, we are pleased to welcome Zakira Takolia to the team. Zakira brings a wealth of experience in advocacy and for supporting colleagues to the role.

5. Recommendations

5.1. The Board is asked to:

- Note the concerns raised and the themes that are being reported.
- Consider how it is tracking cultural change in the organisations such that all staff feel able to speak up and are heard.

Meeting of the Board of Directors in Public on Tuesday 14 November 2023

Report Title	**Q2 Strategic Risk Register**
Report Author	**Sarah Wright, Head of Risk Management & IG**
Executive Lead	**Chief Executive**

1. Purpose

This report, denoted as part B within the Trust's Board Assurance Framework, serves as the key instrument for facilitating a comprehensive examination and communication of the Trust's approach to strategic risk management.

Within the broader context of the Trust's risk governance, this report focuses on the critical aspect of strategic risk, delving into the various elements that underpin our approach to identifying, assessing, and mitigating risks that could potentially impact our long-term objectives.

This report informs the Trust Board of Directors of how the Trust is proactively addressing challenges and opportunities to the achievement our strategic vision.

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

There are 13 risks on the Strategic Risk Register.

The key changes for the quarter are:

- 2 risks moved from the Corporate Risk Register
  - 291 – IT infrastructure
  - 801 – NHS System Oversight Framework
- 1 risk de-escalated from the Strategic Risk Register to divisional level
  - 2741 - Research is not adequately supported

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

- Risks assessed against the statutory domain have increased in prevalence in both the strategic and corporate risk registers. Strategic risks assessed against the domains of Patient Safety and Environmental are fewest, with no risks in the domain of Quality, Reputational or Health and Safety at strategic level.

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

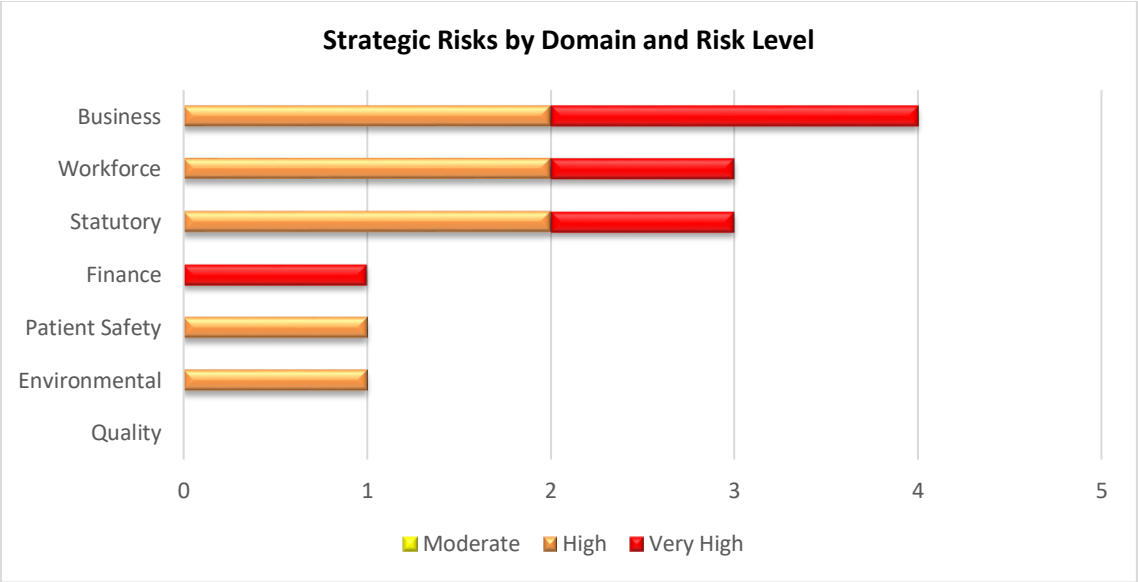
- The risk profile section includes a chart to map the projected achievement of the target risk score over time. This chart will help support review of risk actions and key milestones in mitigating risk and align decision-making on planned mitigations within our risk appetite and tolerance to approach and manage risks to an acceptable level.

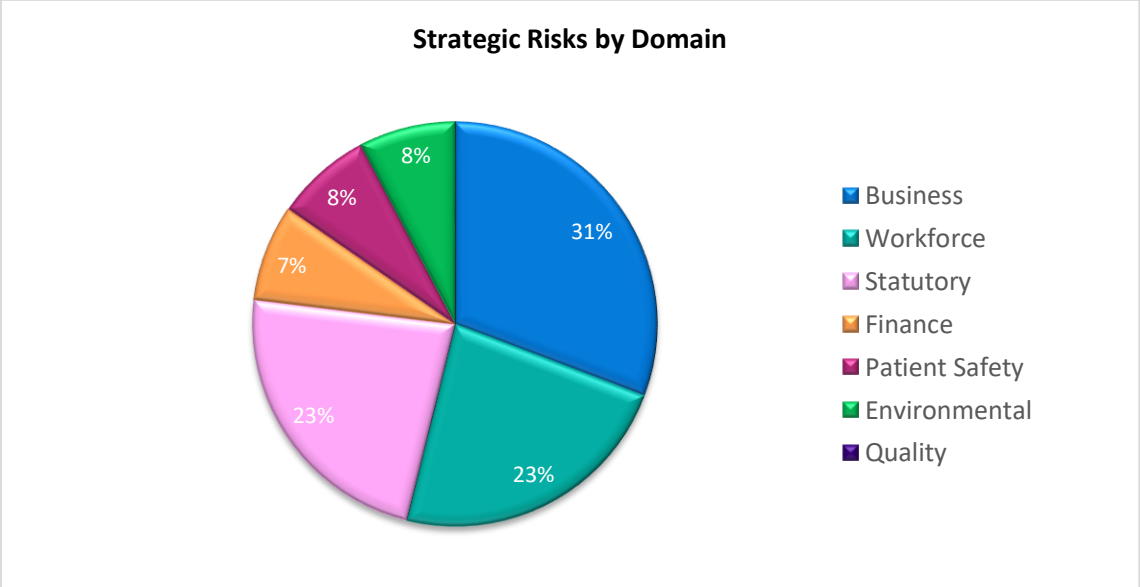
- The narrative to describe changes to the risks in the quarter is ordered in line with the domains so that similar risks can be considered together.

3. Strategic Alignment
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)*.
4. Risks and Opportunities
See attached report
5. Recommendation
This report is for Approval
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**

Executive Directors	25/10/2023
Audit Committee	31/10/2023
Trust Board	14/11/2023
Finance & Digital Committee (relevant risks)	28/11/2023
Quality and Outcome Committee (relevant risks)	28/11/2023
People Committee (relevant risks)	30/11/2023

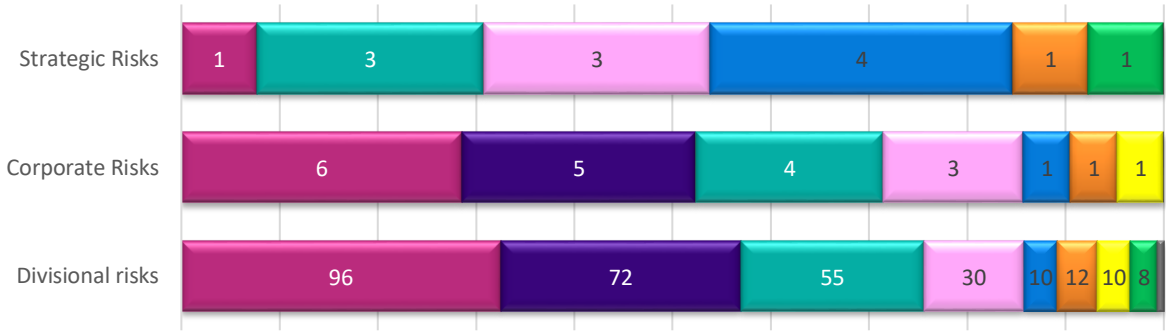
Risk Profile: **Strategic Risks**





	2022/23			2023/24	
Domain	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Patient Safety	1	1	1	1	1
Quality	-	1	-	-	-
Workforce	2	2	3	3	3
Statutory	2	2	2	2	3
Business	4	4	4	3	4
Finance	2	2	2	2	1
Environmental	1	1	1	1	1

Comparison of Risk Domains across Risk Levels



	Divisional risks	Corporate Risks	Strategic Risks
Patient Safety	96	6	1
Quality	72	5	0
Workforce	55	4	3
Statutory	30	3	3
Business	10	1	4
Financial	12	1	1
Health & Safety	10	1	0
Environmental	8	0	1
Reputational	2	0	0

ID	Strategic Risks, Timescale for Planned Mitigation	22/23	2023/24					2024/25				2025/26			
		Q4	Q1		Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
801	Meet the elements of the NHS Oversight Framework	20	20	NEW	20	→	8								
423	Demand for inpatient admission exceeds available bed capacity	20	20	↔	20	→	→	→	→	8					
416	Fail to fund the Strategic Capital Programme	20	20	↔	20	20	8								
737	Unable to recruit sufficient substantive staff	16	16	↔	16	→	→	→	→	→	→	→	→	TBC	
291	IT infrastructure doesn't meet needs of a digital hospital	8	8	NEW	15	15	15	→	→	6					
3763	May not meet standards to comply with CQC Regulations	12	12	↔	12	12	→	→	→	8					
3115	Clinical decision making based upon incomplete information	12	12	↔	12	12	→	→	→	→	4				
2694	Unable to retain substantive workforce	12	12	↔	12	8									
2642	Unable to develop and modernise the Trust estate	12	12	↔	12	12	8	8							
3472	Fails to meet sustainable development strategy commitments	10	10	↔	10	→	→	→	→	→	→	5			
5032	National patient safety strategy requirements are not delivered	16	9	↔	9	9	→	6							
2992	Transformation, improvement and innovation benefits not realised	9	9	↔	9	9	6								
285	Fail to have a fully diverse workforce	9	9	↔	9	9	→	→	→	→	→	→	→	4	
2741	Research and Innovation is not adequately supported	6	6	↔	6*	De-escalated									

KEY

* Risk has met the target score

Target scores are outlined in black

ID	*DRAFT* Alignment to True North Strategic Priorities Strategic Risks	Score	Experience of Care	Patient Safety	Our People	Timely Care	Innovate and Improve	Our Resources
801	NHS System Oversight Framework 2021/22	20	✓			✓		✓
423	Demand for inpatient admission exceeds available bed capacity	20				✓		
416	Fail to fund the Strategic Capital Programme	20						✓
737	Unable to recruit sufficient substantive staff	16			✓			
291	IT infrastructure not resilient for digital hospital needs	15						✓
3763	May not meet standards to comply with CQC Regulations	12	✓	✓				
3115	Clinical decision making based upon incomplete information	12					✓	✓
2694	Unable to retain substantive workforce	12			✓			
2642	Unable to develop and modernise the Trust estate	12						✓
3472	Fails to meet sustainable development strategy commitments	10						✓
5032	National PS Strategy	9		✓				
2992	Transformation, improvement and innovation benefits not	9					✓	
285	Fail to have a fully diverse workforce	9			✓			

Alignment to be finalised in collaboration with the Patient First Team

New Strategic Risks		
291	**Risk that the Trust's IT infrastructure is not resilient to meet the needs of a fully digital hospital**	**15**
CDIO **Business**	With the arrival of the CDIO, a review of Digital Services' Governance arrangements has commenced, to underpin strategy development and align to risks. Risk 291 has been updated to describe the strategic risk posed to the organisation. Specific infrastructure and operational risks are being assessed and will be linked to this risk where applicable. Programmes of work to address the gaps identified from this strategic risk will be monitored through the Digital Hospital Programme Board. Due to the strategic nature of this risk, it has therefore been transferred from the Corporate Risk Register to the Strategic Risk Register. *This risk is linked to strategic 3115 (clinical decision-making) and corporate 292 (cyber-attack)*	
801	**Risk that elements of the NHS Oversight Framework are not met**	**20**
COO **Statutory**	The NHS System Oversight Framework comprises many elements all of which are risk assessed independantly and are sat at various levels across the trust's risk registers. Due to the strategic nature of this risk, it has therefore been transferred from the Corporate Risk Register to the Strategic Risk Register. This will allow escalation of any significant operational risks to the corporate risk register whilst maintaining an overview of the level and nature of support required across the system. This will provide the Trust Board of Directors with oversight of the mitigation to address the capacity risks as effectively as possible. Trust segmentation ranges from 1 to 4; trusts in segment 1 are consistently high performing across the six oversight themes. Trusts in segment 4 are in actual or suspected breach of the NHS provider licence with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support. Segment 2 is the default for ICBs or Trusts unless criteria for moving to another segment are met. UHBW currently sits at Tier 2. *This risk is linked to strategic 423 - Bed Capacity, corporate 1035 - Cancelled Ops, corporate 2244 - Outpatient Waits, Divisional risks (for escalation to the Corporate Risk Register Q3) 2687 – Cancer waiting times and 5596 – RTT*	

Q2 Update – Strategic Risks		
3115	**Risk that clinical decision making may be based upon incomplete information**	**12 ↔**
CMO **Patient Safety**	The Digital Outpatients project has completed phase 1, project closure and lessons learnt are being prepared. Digital letters are being sent to patients via the Dr Doctor Portal at BEH with all outpatient letters planned for digital distribution via Dr Doctor in October. Patients will be given the choice whether to continue receiving a paper copy or to just access it digitally on Dr Doctor. Early analysis shows 50% of patients would prefer this method rather than post, which promises savings for the Trust. The Digital Maternity Solution (Badgernet) is now live at NBT and UHBW. The CareFlow Medicines Management Project has encountered delays due to integration with CareFlow and the project is replanning the Go-lives. A senior escalation meeting with the CDIO and System C's senior healthcare provider team took place in early September to discuss remedies in ensuring the trust can be given a robust delivery plan. The CMM project cannot progress until the Trust receives resolution dates for outstanding issues with sufficient assurance from System C that they can be delivered. Peer to Peer image sharing is no longer possible with RUH and other Trusts using Different PACS software to UHBW. A regional peer to peer solution that enabled easy image sharing with RUH was deactivated in March 2023. The Diagnostic Convergence Programme is paused pending a proposed digital strategy for a region wide PACS and then to adopt CareFlow Order Communications. Draft risks are being raised on Datix regarding the risks associated with operating two instances of PACS, RIS and ICE. A decision is expected this quarter on whether the original project should proceed. Further planned mitigations include • Agreement of the Go-live for Careflow Medicines Management (CMM) • Decision on whether ICE PACS & RIS Merger project should proceed • Develop the Digital Strategy *This risk is linked to strategic 291 (IT infrastructure), strategic 737 (recruitment), strategic 2694 (Retention), corporate 793 (Workplace stress), corporate 5477 (Nurse Staffing).*	

3763	Risk that the Trust may not meet standards to ensure compliance with CQC Regulations	12 ↔
CNM Statutory	During the last quarter the Trust's clinical accreditation programme has continued to provide a foundation for inspection readiness, supplemented by targeted spot-checks. The Trust has yet to receive its anticipated maternity inspection, but in the meantime a mock inspection has taken place, led by a head of midwifery from another NHS Trust - key findings are currently being translated into an action plan. Self-assessments against the CQC's new quality statements (KLOE replacements) have continued for maternity services, end of life care, critical care and theatres; self-assessments will then be paused awaiting full publication of the CQC's new Single Assessment Framework in the autumn/winter (including service-specific detail behind the generic CQC quality statements). The Trust is currently participating in a Well-led external assessment (significant overlap between CQC well-led and the NHSE well-led framework). The Quality & Outcomes Committee has continued to monitor progress with a small number of residual actions from previous CQC inspections and monitoring visits which are now being followed up via Divisional Review meetings with the aim of closure. The Sexual Assault Referral Centre has received an excellent inspection report (note that SARC inspections are not formally rated) following its June inspection, with inspectors highlighting exemplar care. A CQC monitoring visit to theatres in Bristol and Weston took place in October.	

5032	Risk that national patient safety strategy requirements are not delivered in UHBW	9 ↔
CNM Statutory	We transferred to the Patent Safety Incident Response Framework on 1st July 2023. The first reports under PSIRF into UHBW corporate quality governance systems will occur in October/November 2023. Significant preparatory work has been undertaken to draft a new patient safety learning framework. Further work is underway with the Head of Human Factors and the new Head of Clinical Learning and Development to draft a framework for discussion at the quality away day in November. As reported last quarter, we had met the milestones for progress in transferring to the national Learning From Patient Safety Events system. However, the software upgrades we received from RL Datix in August and September are not fit for purpose to enable LFPSE transfer. There is now an increased risk that we may not be in a position to transfer to LFPSE within the national timeframe of April 2024, or that any transfer would force a compromise in system configuration. A compromised Datix configuration without stakeholder involvement and a significant training and education programme would risk a reduction in incident recording and a reduction in the meaningful data and information about the safety of our services to enable us to act to reduce risk to patients. Risk 5826 (LFPSE) has been reframed and the score has been increased to 12 and escalated via the Clinical Quality Group and Trust Services' Divisional Board. Work on the engagement and involvement framework for patient safety in conjunction with our patient safety partners is behind plan and will not be completed by the end of Q2 2023/24. The revised projected date is the end of Q3 2023/24. Our Deteriorating Patient corporate project under Patient First is aligned with the Trust's Patient Safety True North and was presented to the Senior Leadership Team in August. Clarity on some details is still to be worked through. Interviews for a Human Factors Fellow to work alongside the Head of Human Factors are due to take place in October. The Human Factors Faculty development is on track. Discussions on new methods to understand our safety culture are underway, with outputs to be considered alongside quantitative data sources to help us identify signals that may need further investigation and areas that my need further support.	

423	**Risk that demand for inpatient admission exceeds available bed capacity**	**20 ↔**
COO Business	Benefits of the Every Minute Matters programme are being realised and assisting with the reduction in overall length of stay and improved use of the discharge lounge. The Getting Ready for Winter group is in place with Divisional representation, with all SOPs for boarding and escalation reviewed, along with staffing plans. Divisional Directors of Nursing will monitor quality outcomes on all wards and departments. A413 is to be opened from November to support bed capacity for the winter, this will have senior leadership and Matron support. The Discharge Lounge hours will be increased to 7 days per week, with a plan to open overnight in the next quarter. The Home First team is in place to support and expedite discharges. A robust winter plan is in place to support admission avoidance and early discharge. *This risk is linked to corporate risks 910 (Ambulance queue), 2614 (Extra Capacity), 801 (NHS Oversight Framework), 1035 (Cancelled ops) and 2244 (Outpatient Waits) as well as strategic risk 416 (Finance).*	
2642	**Risk that the Trust is unable to develop and modernise the Trust estate**	**12 ↔**
DOF Business	BWPC capacity challenges have delayed delivery to procure clinical equipment and support Estates Capital. The lack of focus and dedicated resource for the Estates Capital (Backlog) is putting risk of delivery of the £2.7million project in 2023 /2024. A review is underway of the national framework to identify the required procurement support and to identify, with the AD of Estates, the resource required to improve the situation. *This risk is linked to strategic 416 (Financial Plan), strategic 5317 (ICS Implementation).*	
2992	**Risk that benefits of transformation, improvement and innovation are not realised**	**9 ↔**
EMD Business	Key achievements this quarter comprise undertaking readiness assessments with divisions which includes a domain for workforce capacity; managerial and front line, commencement of catchball meetings with Medicine division and undertaking preparation meetings with all other divisions. The Executive Patient First Steering Group will monitor the progress of deployment against the agreed roadmap and continue to discuss organisational capacity to deliver business as usual alongside our improvement priorities. Communication and monitoring of the strategic priority projects commenced in August 2023 through the SLT Strategy Deployment Review. Our A3-thinking structured problem-solving approach continues, including clinical teams that have been awarded platinum through the ward accreditation programme. Capacity across the Trust to engage in Patient First deployment may be affected further should the Trust receive financial regulatory action. *This risk is linked to strategic risk 3115 (IM&T).*	

285	Risk that the Trust fails to have a fully diverse workforce	9 ↔
CPO Workforce	Key achievements this quarter include the celebration of both Windrush and Pride, trust wide and in the community. The completion and commitment to the NHS Rainbow Badge Phase 2 assessment and Bristol Women's Business Charter. Sharing locally our model employer data with Divisional HRBPs to align with our culture and people plan actions. The Bridges talent management programme continues to grow with the 4th Cohort starting in February 2024. A staff network review was undertaken and has a development plan in place. The NHS EDI improvement plan, aligned to six high impact actions, is in place with base line position for actions prepared for board presentation and planned governance for delivery. The EDI bi-annual report, submitted in September, provides an update of achievements in line with the EDI Strategic Action Plan. Using the Staff Survey 2023 EDI data, we will progress the improvement plan and provide a breakdown of Divisional EDI data We are delivering trust events for Black History Month, supporting the national theme `celebrating our sisters` with further messages and celebrations including aligning this with `it stops with me' campaign and red card to racism. *This risk is linked to strategic 737 (recruitment), strategic 2694 (Retention), corporate 793 (Workplace stress) and corporate 5477 (Nurse Staffing).*	

737	Risk that the Trust is unable to recruit sufficient numbers of substantive staff	16 ↔
CPO Workforce	Overall vacancies reduced to 5.2% (623.7 FTE) compared with 6.2% (742.4 FTE) in the previous month. The largest divisional increase was seen in Specialised Services where vacancies increased to 101.9 FTE from 100.0 FTE in the previous month. The largest divisional reduction was seen in Medicine, where vacancies reduced to 85.2 FTE from 115.0 FTE the previous month. The largest staff group reduction was seen in Medical, where vacancies reduced to -18.3 FTE (over established) from 60.3 FTE the previous month. The largest staff group increase was seen in Ancillary, where vacancies increased to 91.8 FTE from 90.3 FTE the previous month. • 37 new Internationally Educated Nurses (IEN) joined the Trust in the month of August. • Work was undertaken to organise and promote the Newly Qualified Nurse Expos in October in Bristol and Weston. • The campaign for the second Healthcare Support Worker (HCSW) hiring event went live in the month of August generating over 150 sign ups within the first two weeks. • The Trust recruited 21 candidates onto the Trainee Nursing Associate (TNA) programme, positions started in late September. • 20 out of the 40 candidates for the Registered Nurse Degree Apprenticeship (RNDA) are currently being onboarded and waiting to embark on their four-year journey in October to become a Registered Nurse. • 13 substantive Allied Health Professionals and nine substantive Healthcare Scientists joined the Diagnostics and Therapies division in the month of August, as well as one Bank Healthcare Scientist. • Work is also underway with ICB system partners to hold a Bristol based nurse recruitment event in November. • To address shortages in admin roles a mass recruitment event is being planned to take place in October. *This risk is linked to strategic 285 (Diverse Workforce), strategic 2642 (Estate Modernisation), strategic 2694 (Staff Retention) and strategic 2741 (Research).*	

2694	Risk that Trust is unable to retain members of the substantive workforce	12 ↔
CPO Workforce	In Quarter 1 the Pulse Survey engagement score remained consistent with the annual staff survey at 6.9 (out of 10). The Engagement Strategic Action plan and the local Culture and people plans 2023/24, are set out to deliver the priorities aligned to the People Strategy and associated KPIs where the milestones and actions are on track. The following areas have been identified as hotspots from the 2022 National Staff Survey results. Division of Weston: This priority area for 2022/23 has seen some positive improvements, particularly in terms of staff engagement. However, it remains that in comparison to other areas in the organisation, the division will continue to require support and expert advice intervention. Division of Surgery: Staff Survey 2022 results have demonstrated a significant decline in response rates and engagement scores. The development of the divisional culture and people plan will identify the hotspot areas requiring intervention which will be supported and delivered collaboratively. Medical and Dental Staff Group: This staff group inherently has the lowest response rate and engagement in the survey and outcomes. The development of a bespoke culture and people plan will identify the hotspot areas requiring intervention which will be supported and delivered collaboratively. In line with the milestones and actions set out in the People Strategy and Engagement Strategic Action plans the focus has been on the following actions to support mitigation of the risk: Engagement: A programme of work has been developed to understand the key drivers for colleagues providing feedback, and to benchmark nationally with the top percentile NHS Trust. Quarter 2 Pulse Survey: Launching 3rd – 30th July, measures the organisational engagement score, whilst also evaluating the annual check-in appraisal conversation. This feedback will be used to review and amend the annual check-in form in Q3, to better meet the needs of colleagues. Staff Survey 2023: Data review in place for Q2, prior to launch in Q3. Recognition: Launch of the Recognition Framework. *This risk is linked to strategic risks 737 (Recruitment) and 2741 (Research) and corporate risk 2639 (Appraisals)*	

416	Risk that the Trust fails to fund the Trust's Strategic Capital Programme	20 ↔
DOF Financial	The BNSSG Chief Finance Officers (CFOs) are yet to agree the capital planning principles and process that should apply and inform the capital prioritisation for 2024/25 and beyond. The BNSSG CFOs are aiming to agree this ahead of the System FED in November 2023. The significant CDEL (Capital Department Expenditure Limit) constraint for the System with the forward look CDEL likely to be lower than the providers depreciation, meaning capital expenditure plans can only deal with replacement and renewal of existing assets and not be available for new/strategic build. The Trust is currently modelling its 5-year Medium Term Revenue and Capital plan for review in November by the Executive Committee and the Finance, Estates and Digital Committee. This November update will also incorporate the BNSSG System agreement on capital prioritisation for 2024/25 onwards. *This risk is linked to strategic risk 2642 (Estate Modernisation), corporate risks 674 (High-Cost Agency) and 423 (Capacity).*	

3472	Risk that the Trust fails to meet its commitments under the Sustainable Development Strategy	10 ↔
DOF Environmental	The ICS Joint Green Plan was approved at Trust board, reaffirming the Trust's commitment. The team has recently expanded with the recruitment of an Energy Manager which will play a key role in our decarbonisation journey. Joint work with NBT is underway to develop a standard building specification for capital estates projects to ensure sustainability targets are met. The Trust has now abolished use of Desflurane, an inhalation anesthetic that emits significant greenhouse gases. A tender for waste management services which is key to forward our waste objectives has finally been released after 4 years of delay. 50% of our owned fleet is now electric vehicles. Electrical shorelines have been installed so ambulances queueing at Bristol can switch off their engines to reduce local air pollution.	

Risks for de-escalation		
2741	Risk that Research and Innovation is not adequately supported	6 ↔
CMO Financial	There has been strong commitment to research across the trust, resulting in a reduction in the assessment of this risk over 4 continuous quarters. The Research Department will visibility and good engagement with divisions, has increased capacity in grant development and secured new joint commercial research function with NBT. Small grants have been funded by the Research Capability Funding and Bristol and Weston Hospitals Charity each year and B&WHC has agreed to prioritise funding for studies leading to larger NIHR grants. Various training and development opportunities are overseen by the Research Facilitation and Grants Manager and continued oversight by the Research Department of the biomedical research centre is in place so that early phase research can be pulled through into later stage grants as appropriate. This risk has therefore been accepted as it falls below the Trust's tolerance levels and will be transferred to the divisional risk register for Trust Services.	

Strategic Risk Register Q2 2023/24

											Inherent				Controls			BAF Assurance			Current				Action Plan			Target					
ID	Opened	Domain	Origin of Risk	Proximity of Risk	BAF - Enabling Strategy	BAF - Assurance Committee	Executive Lead	Title	Description	Consequence	Likelihood	Rating	Level	Controls in place	Adequacy of controls	Gaps in controls	Form of Assurance	Level of Assurance	Gaps in Assurance	Consequence	Likelihood	Rating	Level	Action Driver	Action detail	Due date	Consequence	Likelihood	Rating	Level	Review date	Approval status
285	01/11/2011	Workforce	Internal	Is Currently an Issue	People Strategy	People Committee	Chief People Officer	**Risk that the Trust fails to have a fully diverse workforce**	If our Governance, recruitment and retention processes are not inclusive, accessible and wide-reaching, Then the Trust will not have a fully diverse workforce, Resulting in a negative impact on patients' clinical outcomes, patient & staff experience, recruitment and retention and reputational damage for the Trust.	Moderate	Likely	12	High Risk	We are mandated to report on the Workforce Race Equality Standards / Workforce Disability Equality Standards & Gender Pay Gap annually. Workforce Diversity & Inclusion strategy for 2020-25 is in place. The strategy supports delivery of Strategic objectives which are monitored by the Equality, Diversity and Inclusion Steering Group that feeds into People Learning and Development Group and People Committee. Bridges Talent Management programme running. Recruitment targets set for all Divisions to meet Model Employer ambitions and reduce Race Disparity Ratio. This is further supported by: -Anonymous recruitment framework -Trust Values -Staff development programmes -Freedom to Speak up framework	Inadequate	Trust focus on Race and Disability; may be detrimental to staff with other protected characteristics. Benefits not yet realised from the Staff Development programmes and targets in the divisions to support closing of the gaps associated with Model Employer and Race Disparity Ratio. Values not yet fully embedded and creating positive cultural change. Evidence suggests recruitment and promotion processes still favour staff from non-diverse backgrounds (less diversity seen in higher pay bands, than the rest of the Trust). Trust estate is not easily accessible for staff with mobility issues.	NHSE/I has oversight of our published data on Workforce Race Equality Standards / Workforce Disability Equality Standards & Gender Pay Gap Equality Act 2010 makes it illegal to discriminate against anyone based on their protected characteristics	Second Line Assurance - Risk and Compliance	None noted.	Moderate	Possible	9	High Risk	Policy & Processes (Start doing something)	Develop guidelines to include positive actions for recruitment at Band 8a+, designed to support the delivery of the Divisional Model Employer Targets.	30/06/2023	Minor	Unlikely	4	Moderate Risk	18/12/2023	Action Required Risks
																								Policy & Processes (Start doing something)	Delivering Supporting Positive Behaviours plan. Use knowledge gained from the TCM diagnostics to implement and embed a new approach to resolution. Detail as per EDI BRAG action plan.	30/06/2023						
																								Policy & Processes (Start doing something)	Co-ordinate the delivery of the key milestones, as laid out in the strategic action plan for 23/24	29/03/2024						
																								Policy & Processes (Start doing something)	Work with Network Chairs to create paper for SLT consideration into the process around releasing staff for network activities, including remuneration as required.	31/08/2023						
																								Policy & Processes (Start doing something)	Introduction of balanced shortlisting for BAME staff on all roles above Band 8a, as described in Q2 milestone Strategic plan 23/24 to achieve EDI Objective 9: We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves.	31/08/2023						
																								Policy & Processes (Start doing something)	Ensure annual reporting cycle in place to support Divisions to update against their plan and demonstrate positive actions taken to remove experience gap and meet model employer gap, as described in Q2 milestone in Strategic Plan 23/24 to achieve EDI Strategic objective 4: We will encourage shared learning by openly sharing our diversity data in a meaningful way.	31/08/2023						
																								Cultural work	In response to the review of the staff networks deliver the recommendations in line with the NHS Staff Network guidance.	30/11/2023						
																								Cultural work	Develop and deliver plan to respond to and measure actions in line with the EDI Improvement plan	29/03/2024						
																								Cultural work	Develop and deliver a robust plan to deliver the Black History month programme of work to include : Trust wide event 16th October Weekly focus throughout the month including red card to racism aligned to it stops with me campaign	31/10/2023						
																								Cultural work	Review current engagement with advocates improving the news letter and providing a `space` for advocates to share resources and best practices ideas including a share conversation space	31/10/2023						

Strategic Risk Register Q2 2023/24

											Inherent				Controls			BAF Assurance			Current				Action Plan			Target					
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																								Cultural work	To improve engagement and access Review and develop EDI Sharepoint	30/11/2023						
																								Cultural work	An EDI Brochure has been developed in readiness for launch in the autumn ensure a robust communication plan in place	30/11/2023						
																								Cultural work	Utilising the secondment of the EDI Coordinator role develop an engagement and communication plan to provide more visibility of the staff networks.	30/11/2023						
291	27/03/2008	Business	Internal	Is Currently an Issue	Digital Strategy	Finance, Digital & Estates Committee	Chief Financial Officer	**Risk that the Trust IT infrastructure is not resilient to meet the needs of a fully digital hospital**	If the Trust operates on an IT Infrastructure that includes out of date or aging equipment, software, or has single points of failure whilst continuing to progress its Digital Strategy. Then there is an increased likelihood of disruption to IT services due to failure or cyber attack Resulting in lack of resilience required for a fully digital Hospital and a failure to achieve strategic objectives	Minor	Possible	6	Moderate Risk	Centralised management of the management and replacement of Trust IT equipment. Disaster Recovery/Virtualisation/Backup in place: conducting simulated failover tests approximately 4 times a year. Regular randomised fail-and-restore testing is done on major systems. Maintenance and support contracts exist for all IT equipment. Temperature in main computer rooms monitored to assess whether below threshold using air conditioning. IM&T has a rolling programme of delivering extra equipment in the form of desktop and mobile laptops, iPad tablets, and iPod handheld devices for use in clinical areas with new Clinical systems. Cyber Security Working Group Established to track and manage progress addressing cyber threats.	Inadequate	The Trust has a large amount of shadow IT which is not managed centrally The Trust continues using old assets that are no longer supported and become increasingly difficult to manage within a modern infrastructure Incomplete asset Register makes it difficult to plan support for all systems UHBW investment in IT is comparatively low to neighbouring Trusts. Regular maintenance of IT infrastructure is not carried out in some areas due to reluctance to have planned downtime in clinical areas Trust's Data Centres are not sufficiently resiliant Not all Data backups are resilient Computer Room 2 environment is unfit for purpose. Weston Server's not on a cluster require manual restart should they fail (probably resulting in a longer restore time). Some departments in the Trust are reliant on IT Software that cannot run on supported server software and as a result are hosted on servers where the Operating System cannot be upgraded to current version. Incomplete Trust wide Information Asset		First Line Assurance - Operational		Catastrophic	Possible	15	Very High Risk	Policy & Processes (Start doing something)	Update and replacement of Description with Strategic Pillar risk on Infrastructure	24/10/2023	Minor	Possible	6	Moderate Risk	18/12/2023	Action Required Risks
416	01/11/2011	Financial	External	In the next 3-5 Financial Years	Financial Strategy	Finance, Digital & Estates Committee	Chief Financial Officer	**Risk that the Trust fails to fund the Trust's Strategic Capital Programme**	If the Trust's planned income and expenditure position of break-even or better is not delivered, or the cost and number of capital schemes increase beyond that provided for in the Trust's Strategic Capital Programme, or the Trust's share of system CDEL is reduced, Then the Trust's Strategic Capital Programme may not be affordable within the funding constraints, Resulting in the requirement to reduce the cost of the Strategic Capital Programme through scheme deletion, deferral or reduction in scope.	Catastrophic	Likely	20	Very High Risk	Periodic review and update of the Medium Term Capital Programme and the underpinning five year revenue Medium Term Financial Plan (MTFP). Effective reporting, monitoring and review of operational plan to identify issues requiring a financial recovery plan. Established contract monitoring and commissioner dialogue to minimise external factors arising from contracting issues. Established working relationship with Charitable partners to manage donations. Fully worked up schemes in advance with experienced staff input, control of tenders and costs and effective monitoring and reporting of costs. A managed contingency reserve. Engagement at a national level regarding any proposed external regulation. A comprehensive, committed capital	Adequate	Currently, there is great uncertainty regarding NHS revenue and capital funding. This, and the scale of the Trust's and the systems recurrent financial deficit, means there is potentially a significant impediment to the Trust in making future strategic capital and knock-on recurring revenue investment decisions. Therefore, significant risks to the Trust's strategic capital investment ambitions exist hence the risk score remains unchanged. The BNSSG system CFOs needs to agree the principles and and process that will apply to the system's capital prioritisation for 2024/25 onwards.	Detailed monthly submission of financial performance submitted to the Regulator, NHS Improvement. Strong statement of financial position. Liquidity metric of 1 (highest) and Use of Resources Rating of 1 (highest rating). Monthly reporting to the Finance & Digital Committee and Trust Board. Monthly Pay Controls Group, Non Pay Controls Group and Nursing Controls Group scrutiny of Divisions performance. 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance & Digital Committee and Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Delivery of the capital programme, including the prioritisation and allocation of strategic capital.	Second Line Assurance - Risk and Compliance		Major	Very Likely	20	Very High Risk	Policy & Processes (Do something differently)	The Trust will be constructing a Medium Term Financial Plan (MTFP) in September 2023 as a base case in order to recover the Trust's projected recurrent deficit of c£60m. The MTFP should ensure the Trust does not significantly deplete its accumulated cash balances and retains its cash balances for strategic capital investment. The Trust will also produce a Medium Term Capital Plan (MTCP) alongside the MTFP informed by a series of feasibility studies on strategic capital schemes.	30/11/2023	Major	Unlikely	8	High Risk	18/12/2023	Action Required Risks
423	18/09/2012	Business	Internal	Is Currently an Issue		Quality and Outcomes Committee	Chief Operating Officer	**Risk that demand for inpatient admission exceeds available bed capacity**	If demand for inpatient admission exceeds available bed capacity, Then increased occupancy will impacts on flow, Resulting in poor ED performance, increased staff workload and a negative patient experience. There will also be a knock on impact on the elective programme, including increased likelihood of cancellations.	Major	Very Likely	20	Very High Risk	Established D2A Board, chaired by Sirona COO, to oversee delivery of D2A business case, with Programme Director in place. Internal Integrated Discharge Group set up to work on UHBW actions to support across discharge pathways. Roll out of Every Minute Matters across adult services is progressing according to plan, and covers SAFER bundle, proactive board rounds, use of the discharge lounges and daily criteria to reside reviews.	Inadequate				Major	Very Likely	20	Very High Risk	Improve Environment (Estate)	Progression of BHI extension business case through to delivery.	31/03/2023	Major	Unlikely	8	High Risk	18/12/2023	Action Required Risks

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737	16/07/2014	Workforce	External	Is Currently an Issue	People Strategy	People Committee	Chief People Officer	**Risk that the Trust is unable to recruit sufficient numbers of substantive staff**	If the Trust is unable to recruit sufficient numbers of substantive staff and to fill specific staff groups/occupations where there is a limited supply, Then continuity, effectiveness and quality of services may suffer, impacting on patient care. Resulting in increased reliance on other staff members and likelihood of reliance on expensive agency cover, and increased chance of 'Burnout' and a negative experience of working for UHBW.	Major	Very Likely	20	Very High Risk	A Tactical Recruitment Group is established to drive clinical recruitment across the organisation. A clinical recruitment plan is being developed to target all hard to recruit to posts and areas which will then be managed through the Tactical Recruitment Group. A dedicated D&T recruitment manager is in post to give recruitment input to roles such as Radiographers, Sonographers, Neurophysiology and Audiology, where there is a national and international shortage. International nurse recruitment programme in place.	Inadequate	Turnover in nursing remains high. The nursing vacancy position remains a challenge in areas such as Care of the Elderly, T&O, Oncology & Haematology. Ongoing challenges exist with Radiographers, Sonographers, Neurophysiology and Audiology. The Trust is dependent upon Health Education England to allocate sufficient numbers of doctors in training. The number of doctors the Trust is allocated does not correlate with optimum staffing levels. Ongoing gaps in consultant posts such as Respiratory and Acute Medicine. The Weston Division has significant vacancy rates across all clinical roles especially across the medical staff groups which is creating a significant risk with rota gaps on the junior doctor rota.	Monitoring achievement of Strategic Workforce Plan objectives though People Committee. Divisional performance is monitored monthly at Performance and Operational Reviews.	Second Line Assurance - Risk and Compliance		Major	Likely	16	Very High Risk	Policy & Processes (Do something differently)	TRAC functionality now fully rolled out across medical recruitment and a full suite of medical KPI's introduced. Work ongoing to ensure that consultants more fully use the functionality available through TRAC.	31/12/2023	Major	Unlikely	8	High Risk	18/12/2023	Action Required Risks
																								Policy & Processes (Start doing something)	Strategic Workforce Planning for Junior Doctors. Introduce new roles and innovative T&C's to attract new junior doctors in training.	31/12/2023						
																								Policy & Processes (Start doing something)	Marketing & attraction – ongoing marketing plan for innovative campaigns using recruitment videos, targeted email shots, social media and recruitment microsites, all underpinned with a strong marketing brand.	31/03/2024						
																								Policy & Processes (Start doing something)	European head hunters now being used to target hard to recruit to nursing and medical vacancies. Success being reviewed on a quarterly basis.	31/03/2024						
																								Policy & Processes (Start doing something)	Partnership Working. Develop mutually beneficial relationships across the BNSSG healthcare economy and beyond to increase workforce supply.	31/12/2023						
801	10/07/2015	Statutory	Internal	Is Currently an Issue		Quality and Outcomes Committee	Chief Operating Officer	**Risk that elements of the NHS Oversight Framework are not met**	If Trust performance is unable to be adequately maintained, Then the Trust may fail to deliver the requirements of the NHS Oversight Framework, Resulting in increased regulatory scrutiny, loss or change in regulator segmentation and formal intervention including mandated support from NHS England.	Major	Very Likely	20	Very High Risk	The trust has established processes for monitoring and reporting performance, including mechanisms to address under-performance.	Inadequate	Metrics included within the IQPR Performance Report are under review throughout the year to ensure that all relevant measures are included. An example of this is the recent inclusion of ED 4 hour wait and Fractured Neck of Femur measures. A more comprehensive review is currently underway, which will lead to an updated version of the IQPR Performance Report in line with the Oversight Framework and Operational Planning Priorities. It is expected that the new report will be available by October 2023. Scorecards have been further developed to support the divisional performance reviews and the Performance Team and Business Intelligence Team are working closely with operational colleagues and colleagues from the				Major	Very Likely	20	Very High Risk		Weekly performance management of RTT, diagnostic and cancer waiting time standards through operational / PTL meetings (cancer, RTT and outpatients), fortnightly tacticals, and at a trust wide level the weekly planned care control centre. Performance oversight from the recovery delivery programme board at trust level, elective recovery operational group at system level, and weekly called with NHSEI as	31/03/2024	Major	Unlikely	8	High Risk	18/12/2023	Action Required Risks
																									Implementation of the delivery plans that have been approved through the annual planning process for 2023/24. This plans are linked to the delivery of waiting times standards defined in the priorities and operational planning guidance for 2023/24	31/03/2024						
2642	29/06/2018	Business	Internal	In the next 3-5 Financial Years	Estates Strategy	Finance, Digital & Estates Committee	Chief Financial Officer	**Risk that the Trust is unable to modernise and develop the existing estate due to restricted access to clinical areas**	If the Trust has restricted access to clinical areas due to operational pressures, Then the existing estate may not be modernised and developed in line with the aspirations of the strategic plan, Resulting in an environment with facilities that do not support improved efficiencies in patient care, streamlined pathways, improvements in patient experience and a deterioration in staff engagement.	Major	Very Likely	20	Very High Risk	Medium Term Financial Plan. Strategic Capital Plan and Operational Plan. Planned preventative maintenance budget. Trust Capital Group Chaired by Divisional Director, Surgery, receives monthly status reports on Capital Projects from Divisions and Assistant Director of Estates. SED Programme Board to oversee all SEDP schemes, chaired by Director of Strategy and Transformation. Financial Control Procedures, including the scheme of delegation and Standing Financial Instructions in place. Approved Five year Medium Term Capital Programme. Delivery of the capital programme, including the prioritisation and allocation of strategic capital. Delivery of the Operational plan without significant deterioration in the underlying run	Inadequate	Restricted access to clinical areas to deliver project improvements due to operational pressures	Monthly KPI report through Divisional Board on Reactive maintenance. Prioritisation of backlog maintenance through Capital Programme Steering Group Reports from Trust Capital Group to Capital Programme Steering Group. Reports from Phase 5 Programme Board to Capital Programme Steering Group. Chairs reports from Capital Programme Steering Group to Finance Committee. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Regular Reporting to the Finance Committee and Trust Board.	Second Line Assurance - Risk and Compliance	Lack of assurance that capital expenditure controls for delegated Divisional Capital are fully effective.	Major	Possible	12	High Risk		No open actions		Major	Unlikely	8	High Risk	18/12/2023	Action Required Risks
2694	13/08/2018	Workforce	Internal	In the next Financial Year	People Strategy	People Committee	Chief People Officer	**Risk that Trust is unable to retain members of the substantive workforce**	If staff are not engaged, motivated, involved and are not positive advocates Then staff turnover will be too high Resulting in a negative impact on organisational turnover retention and absence as well as other workforce KPIs, an increase in Agency costs, instability in the workforce, a negative impact	Major	Very Likely	20	Very High Risk	The People Strategy objectives and measures places staff experience at the heart of people programmes of work delivered via four pillars of: • Growing for the Future • New Ways of working • Inclusion and belonging • Looking after our people The Organisational Development strategic	Inadequate		The annual engagement score is monitored quarterly with annual targets to improve the annual score by 2025 to 7.5 (out of 10) Quarterly update to the the people committee and the Trust Board	Second Line Assurance - Risk and Compliance	Not achieving a score in the upper quartile nationally among peer Trusts.	Major	Possible	12	High Risk	Cultural work	The revision and implementation of the listening frame work to support quality conversations and bring confidence to placing listening into action	10/11/2023	Major	Unlikely	8	High Risk	18/12/2023	Action Required Risks

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									on staff wellbeing					The Organisational Development strategic priorities plan and local Divisional Culture and people plan set out to improve staff engagement and workforce KPIs with a focus on: • Staff Engagement: Recognition and Performance • Wellbeing • ED&I • Leadership and Management Development Immersion of new staff values and leadership behaviours throughout 2022/23 supporting engagement and sense of belonging, impact measurement through the annual survey cycle in Quarterly people Pulse Monthly HR/OD partnership meetings in place to review all plans which are then presented to the people management group and the supporting sub groups of wellbeing and Diversity and Inclusion. Each division has a workforce committee to provide assurance on this agenda Divisional Performance reviews monitoring progress against these KPI's											Cultural work	Develop and deliver a robust trust wide communication plan for the live period of Staff Survey to maximise engagement in the survey and actions taken as a result of the previous survey feedback.	24/11/2023						
																								Cultural work	To provide a more accessible and improved version of HRBP develop a revised Sharepoint site for staff engagement and experience aligned to Check in appraisal; recognition and engagement	30/11/2023						
																								Cultural work	Following the development of the brochure review with stakeholders prior to launch of the brochure	26/01/2024						
2992	28/12/2018	Business	Internal	In the next 3-5 Financial Years	People Strategy	People Committee	Executive Managing Director (Weston)	**Risk that benefits of transformation, improvement and innovation are not realised**	If sufficient priority is not given to developing the Trust's culture and the capacity and capability of staff for delivering transformation, improvement and innovation, Then staff in the organisation may not be able to support the scale and pace of change necessary to work in new ways and deliver the organisation's and system's strategies, Resulting in a partial or non-realisation of benefits, loss of reputation as an innovative organisation, poor performance, demotivation of staff, associated impact on recruitment and retention, and a reduced influence as a leader in our Local system.	Moderate	Possible	9	High Risk	Transformation, improvement and innovation strategy. Deploying the Patient First continuous improvement approach (via a quality management operating system) which will develop our organisational culture by aligning the deployment of our strategy with our improvement work, with focussed performance management to maximise delivery of our improvement priorities. This approach aligns to the recommendations of the NHS delivery and continuous improvement review published April 2023 Corporate improvement priorities agreed for 2023/24 with project charters completed (define phase of DMAIC), to be cascaded and embedded into divisional priorities through catchball (by September 2023). Transition plan developed for the current QI programme – running introductory Foundations for Improvement course for all staff, and retaining support for junior doctors in their QI projects (training, coaching, mentoring and appointment of QI fellows).	Inadequate	Commencing reporting of progress against improvement priorities at Trust level in August 2023 - SLT Strategy Deployment Review and reporting to the Board. Staff unable to be released to partake in training and/or deliver their improvements, due to operational pressures and industrial action	Reporting quarterly progress on Deployment of Patient First (strategic initiative) to Senior Leadership Team via SLT Strategy Deployment Review. Monthly Executive PF Steering Group gives overview of progress of deployment Quarterly reporting on Strategic Priority Projects to public Board (in development, due November 23) Evidence of wide range of innovation and improvement programmes completed/underway including good response to programmes such as Bright Ideas, Trust Recognising Success awards , Quality Improvement Hub, QI annual forum and achievement of local / national awards. Audit and inspections. Routine departmental assurance by programme management office for all digital and IM&T projects and activities reported to IM&T Management Group.	Second Line Assurance - Risk and Compliance		Moderate	Possible	9	High Risk	Policy & Processes (Start doing something)	Establish the Patient First Continuous Improvement approach. Remaining milestones: . Phase 3 strategy deployment: roll out PF to divisions from January 2023 . Phase 4 strategy deployment: roll out PF to front line staff from May 2023 . Develop roll out plan for the Patient First Improvement System for front line staff and divisional team (PFIS) Mar 2022. . Draft resource plan developed and presented to Executive Committee Dec 2022, to be discussed through 2023/24 annual planning process	31/03/2024	Moderate	Unlikely	6	Moderate Risk	18/12/2023	Action Required Risks
3115	07/03/2019	Patient Safety	Internal	Is Currently an Issue	Digital Strategy	Finance, Digital & Estates Committee, Quality and Outcomes Committee	Chief Financial Officer	**Risk that clinical decision making may be based upon incomplete information**	If Clinical information is held across multiple IT systems and paper record libraries Then clinicians may not have access to all necessary information to make the best decision regarding a patient's care Resulting in imperfect treatment, potentially causing harm to a patient or delays in their care.	Major	Possible	12	High Risk	Clinicians can access digital information held in Careflow and Evolve and can request paper notes if needed The Clinical workspace brings together information from multiple systems reducing the burden of multiple logins Connecting care brings together data from primary care, GP Practices and secondary and community care providers. Medical records monitor the performance of the scanning bureau to maintain service levels Training is available on the Trust's corporate clinical IT Systems	Inadequate	No Medicines Management system Digital Pathways not available for all clinical areas Many patient records remain on paper and need to be scanned into Evolve The scanning process includes an unavoidable period of time when records are not viewable because they are in transit or waiting to be scanned The scanning bureau is experiencing challenges with staff retention and recruitment Clinicians can find accessing information held by other organisations challenging		First Line Assurance - Operational		Major	Possible	12	High Risk	Policy & Processes (Start doing something)	Achieve national Minimum Digital Foundation target (including HIMSS L5) This requirement includes implementing Caeflow Medicines Management Converging on to single Order Coms, PACS and RIS Systems Transferring Paper Record to Evolve Electronic Document Management	29/03/2024	Major	Rare	4	Moderate Risk	18/12/2023	Action Required Risks
																								Tools & Technology	Implement CareFlow Medicines Management	29/03/2024						
3472	30/10/2019	Environmental	External	In the next 3-5 Financial Years	Sustainability Strategy	Finance, Digital & Estates Committee	Chief Financial Officer	**Risk that the Trust fails to meet its commitments under the Sustainable Development Strategy**	If the Trust fails to educate and drive changes in how we deliver our services, in the behaviour and the ways of working of staff, contractors and in the supply chain, Then the Trust may fail to meet its commitments under the Sustainable Development Strategy, Resulting in an inability to contribute to making a positive impact on combatting climate change and the associated environmental, health, financial, regulatory and reputational impacts.	Catastrophic	Possible	15	Very High Risk	Sustainability Strategy approved at Trust Board in September 2019. Sustainability Plan in place to support delivery of strategy objectives. A Sustainable Development Board with supporting governance structure and work streams to oversee delivery of the Sustainable Strategy has been approved by SLT and meets quarterly Sustainability team established Sustainability Implementation Group responsible for leading the Trust's work to become more sustainable; socially, environmentally and economically, across all areas	Inadequate	Until such time as the carbon neutrality target is delivered there will always be a risk that it will not be delivered as no one has control of future events. Therefore it will require an adaptive response to the changing climate emergency and mitigation will change over the period of delivery of the strategy. Carbon neutrality is not currently embedded in Trust decision making. Business cases do not consider net zero carbon target. Every procurement from 1st April 2022 is required to have minimum 10% social value/net zero weighting in scoring this is not currently controlled. Trust is required to have a Green Plan - this is currently achieved through the sustainable development strategy but is required to be updated into the green plan format and aligned with the ICS green plan.	Reports to SLT and Trust Board.	Second Line Assurance - Risk and Compliance	Carbon neutrality is not currently embedded in Trust decision making. Business cases do not consider net zero carbon target. Every procurement from 1st April 2022 is required to have minimum 10% social value/net zero weighting in scoring this is not currently controlled. Trust is required to have a Green Plan - this is currently achieved through the sustainable development strategy but is required to be updated into the green plan format and aligned with the ICS green plan.	Catastrophic	Unlikely	10	High Risk	Policy & Processes (Start doing something)	Identify ways to embed carbon neutrality in Trust decision making	31/07/2023	Catastrophic	Rare	5	Moderate Risk	18/12/2023	Action Required Risks
																								Policy & Processes (Do something differently)	Working with purchasing consortium to bring social value 10% weighting requirements into all tenders	30/06/2023						

Strategic Risk Register Q2 2023/24

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ID	Opened	Domain	Origin of Risk	Proximity of Risk	BAF - Enabling Strategy	BAF - Assurance Committee	Executive Lead	Title	Description	Consequence	Likelihood	Rating	Level	Controls in place	Adequacy of controls	Gaps in controls	Form of Assurance	Level of Assurance	Gaps in Assurance	Consequence	Likelihood	Rating	Level	Action Driver	Action detail	Due date	Consequence	Likelihood	Rating	Level	Review date	Approval status
3763	25/02/2020	Statutory	Internal	Is Currently an Issue		Quality and Outcomes Committee	Chief Nurse & Midwife	**Risk that the Trust may not meet standards to ensure compliance with CQC Regulations**	If the Trust is unable to meet the quality and safety requirements set out in CQC Regulations Then the CQC may determine that the Trust is in breach of regulatory requirements Resulting in new regulatory or enforcement action by the CQC.	Major	Very Likely	20	Very High Risk	Robust corporate quality and performance reporting to Board level. Consolidated CQC action plan to address outstanding inspection actions, with accompanying governance framework agreed by SLT/QOC. Clinical accreditation programme. Ongoing monitoring of compliance with CQC Regulations, including through self-assessment. CQC engagement in various forms including direct monitoring visits.	Inadequate	Outstanding actions relate to: - closing actions from previous CQC inspections - seeking lifting of Section 31 Enforcement Notice at Weston - addressing concerns raised by CQC in respect of clinical genetics accommodation at StMH - planning for future inspection readiness, incorporating new CQC regulatory framework The Clinical Accreditation Programme requires resource to effectively deliver its objectives and sustain the increasing volume of assessments. There is insufficient clinical operational resource and administrative resource identified to sustain the programme.				Major	Possible	12	High Risk	Policy & Processes (Do something differently)	To introduce the principles of the new CQC Inspection Framework, initially through the self-assessment programme.	31/12/2023	Major	Unlikely	8	High Risk	18/12/2023	Action Required Risks
5032	12/02/2021	Statutory	Internal	Is Currently an Issue	Quality Strategy	Quality and Outcomes Committee	Chief Nurse & Midwife	**Risk that the objectives of the national patient safety strategy are not implemented**	If additional funding or sufficiently skilled and experienced staff are not available to implement key patient safety roles, Then the Trust may be unable to support changes in culture, processes and practices associated with the implementation of the national patient safety strategy, Resulting in continuation of repeated occurrences of similar incidents, missed opportunities to reduce harm to patients, subsequent clinical negligence claims, potential regulatory action and a lack of a consistent just and restorative culture throughout the Trust negatively impacting on staff engagement and well-being.	Major	Very Likely	20	Very High Risk	There is some existing limited resource for managing patient safety in divisions and in the THQ team but this is insufficient to deliver on the new national requirements which include seniority and new comprehensive training requirements for expert investigators. UHBW model for responding to incidents changed to include a core team of expert investigators with more agile local learning responses in divisions. Investment in staff to support this new model secured and posts recruited to but some new staff yet to start. Patient Safety Partners recruited and inducted and are being supported to deliver their role. LFPSE compliant version of DatixWeb in test system and signed off by the national team, but needs further update before being suitable for deployment.	Inadequate	This is a Trust wide risk. Non-delivery is not an option The background information in this risk outlines the significant changes that need to be put in place across UHBW for which there is no existing resource.	Patient Safety Partners in place and being supported to carry out their role. Central Patient Safety Investigation Team in place, transfer to PSIRF completed, Board approved Patient Safety Incident Response Plan being implemented. UHBW incident management system (Datix) upgraded, reconfigured and integrated with national Learning from Patient Safety Events (LFPSE) system. Patient Safety Culture: NRLS benchmarking 2021/22 shows UHBW in top quartile indicating an open reporting culture. This national reporting will cease after March 2023.	First Line Assurance - Operational	Patient Safety Culture: responses to national Staff Survey questions about treating people fairly following an incident 2022/23 onwards (questions omitted in survey for 2021/22). Future safety culture/climate surveys. No more than a 15% drop in incident reporting numbers for no longer than 3 months on transfer to a LFPSE integrated version of Datix. Future reporting to the Board against PSIRF standards, progress against PSIRP and improvement work arising from insights from incident learning responses.	Moderate	Possible	9	High Risk	Policy & Processes (Do something differently)	Work with the Datix/Risk team to redesign the incident reporting system to support PSIRF	30/09/2023	Moderate	Unlikely	6	Moderate Risk	18/12/2023	Action Required Risks

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 14 November 2023

Reporting Committee	**Audit Committee – October 2023 meeting**
Chaired By	**Jane Norman, Non-Executive Director**
Executive Lead	**Neil Kemsley, Chief Financial Officer**

For Information

The Strategic and Corporate risk registers were reviewed. In respect of the Corporate Risk register, there were two risks recommended for escalation (cyber security and storage of medicines): three for de-escalation (VTE management, delays in induction of labour, and extra capacity during escalation); and two recommended for transfer to the strategic risk register (IT infrastructure and NHS system oversight framework). It was suggested that the de-escalation of the VTE management risk might be premature, and it was requested that this be checked. It was also requested that an analysis be undertaken the ascertain the proportion of predicted risk reductions that had been achieved over the past 12 months.

The committee received an update on the implementation of a new document management system (DMS) for Trust, which would greatly improve staff access to policies, procedures and guidance documents. It was noted that the system had gone live on 23rd October 223, and the ability for staff to be able to access procedural documents on mobile devices was particularly welcomed. The next phase of the project was for templates to be developed which would allow documents authors to create and approve procedural documents within the system itself.

The committee received the internal audit interim report, and the following four internal audit reports were considered:

- Management of Independent Sector Clinical Contracts – limited assurance
- Post-COVID Inquiry - satisfactory assurance
- Cyber Security - satisfactory assurance
- Risk Management Arrangements (Part 1) – significant assurance

It was noted that the follow up to the conflicts of interest review was proposed to be postponed until the new financial year to allow the new system for recording conflicts of interest to bed in. There would however be some interim audit work in this area to inform the end of year Head of Internal Audit Opinion.

The following reports were received and reviewed by the Committee:

- ASW Assurance (the Trust's Internal Auditors) Annual Report
- Review of Losses and Special Payments
- Review of Single Tender Actions

Date of next meeting:	**25 January 2024**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 14th November 2023

Report Title	**Capital Investment Policy (CiP)**
Author(s)	**Sarah Nadin, Deputy Director of Strategy and Transformation** **Annette Billing, Deputy Head of Commissioning and Planning, Trust Services**
Executive Lead	**Neil Kemsley, Chief Financial Officer**

1. Purpose

The Capital Investment Policy (CiP) sets out the governance arrangements for capital investments undertaken by the Trust. The purpose of this paper is to provide the Trust Board with an overview of the changes proposed to the CiP as part of the annual review cycle required for this document.

The Trust Board is asked to review and **approve** the changes to the Capital Investment Policy.

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

The main updates to the policy are listed below for ease of reference:

1. Amended the role of the Council of Governors in agreeing capital expenditure to align with the Trust Constitution. This role is to assure that Trust governance has been followed and adhered to for any application for significant transactions. This is defined in the policy as a capital investment over £30m.
2. Amended the Executive Lead from the Director of Strategy and Transformation to the Chief Financial Officer.
3. Updated the national context throughout by reference to the NHS England *Capital investment and property business case approval guidance for NHS trusts and foundation trusts* published in February 2023. This includes delegated limits for capital investment and property transactions and the external business case approval process.
4. Removed the definition and reference to high risk and major investments as per the national guidance.
5. Removed sections describing guidance which is readily available in national documents, in particular those repeating sections from the Better Business Case guidance. This enables the document to be a more focused and concise policy document that is easier to navigate.
6. Clarified the internal governance for strategic capital and digital capital schemes between £50k and £1m in line with the new Trust governance structure (Table 4, Section 7.1)
7. Proposed a move from a 12 month to a 36 month review cycle which the above changes would support. The policy may require review before this date if there are significant changes to the internal and external context in which the policy is applied.

As part of our broader work to align corporate processes across our acute provider collaborative the intention is to align our capital processes with North Bristol Trust. As and when this is finalised any implications will be reflected in further updates.

3. Strategic Alignment
The CiP policy underpins the delivery of the Trust's Patient First strategic priorities and aligns closely with the use of resources priority: **Our resources** Together, we will reduce waste and increase productivity to be in a strong financial position to release resources and reinvest in our staff, our services and our environment.
4. Risks and Opportunities
The policy mitigates risk by ensuring there is sufficient governance and assurance for the approval of capital investments, and supports the requirement to provide good value for money within the Capital Department Expenditure Limit (CDEL) set by HM Treasury. There is a future opportunity to align our capital policy and processes with North Bristol Trust.
5. Recommendation
This paper is for Approval The Trust Board is asked to approve the changes to the Capital Investment Policy.
6. History of the paper **Please include details of where paper has previously been received.**

Executive Director Committee	**11 October 2023**
Strategic Estates Development Programme Board	**12 October 2023**
Capital Programme Steering Group	**19 October 2023**
Finance, Digital and Estates Committee	**27 October 2023**

Attachment:

Revised Capital Investment Policy (clean version without tracked changes)

Capital Investment Policy

Document Data			
Document Type:	Policy		
Document Reference	19030		
Document Status:	For Approval		
Document Owner:	Deputy Director of Strategy and Business Planning		
Executive Lead:	Chief Financial Officer		
Approval Authority:	Trust Board of Directors		
Review Cycle:	13		
Date Version Effective From:	08/11/2023	**Date Version Effective To:**	07/11/2026

Introduction

This policy sets out the governance arrangements for capital investments undertaken by the University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). The policy takes into account the NHS Oversight Framework and the requirement to use the Fundamental Criteria/five case model when submitting business cases to NHSE. It should be noted that the Fundamental Criteria has been produced to supplement the HM Treasury Green Book Guidance and its aim is to streamline both business case content and approvals.

This policy will be subject to review by the Board of Directors every three years.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
24/06/2008	1		Draft	Draft considered at Trust Board on 1 July
11/05/2015	9	Director of Strategy & Transformation	Minor	Thresholds updated to reflect the Trust's 2015/16 planned turnover of £587m; removal of the reference to NHS Improvement's "Risk Evaluation for Investment Decisions" document; updated Annex 2 to reflect the 2015/16 capital prioritisation process.
12/10/2015	10	Director of Strategy & Transformation	Minor	Additional bullet point included in section 7.1 - 'The cost of the loan principal payments where relevant'
03/05/2017	11	Director of Strategy & Transformation	Minor	Update of section 7.2 to reflect the revised non-financial criteria for prioritisation.
31/07/2018	12	Director of Strategy & Transformation	Minor	Format changes to reflect Trust's standard template. Threshold updated to reflect the Trust's 2018/19 planned turnover of £690m. Update to section 8 to reflect the revised non-financial criteria for prioritisation.
30/06/2019	13	Director of Strategy & Transformation	Minor	Threshold updated to reflect the Trust's 2019/20 planned turnover of £727m. Update to section 8 to reflect the revised non-financial criteria for prioritisation.
21/04/2021	14	Director of Strategy & Transformation	Major	There is a supporting cover report to highlight the changes made to this policy – a few main changes are summarised below.

				Threshold updated to reflect the merged Trust's 2021/22 planned turnover of £1011.9m. Introduces the role of the Council of Governors New NHSE/I capital regime for 2021/22 explained in section 6 including the introduction of a capital departmental expenditure limit (CDEL) for 2021/22 and beyond. Referenced that requirement for external approvals will be established at start of the case and followed as required. Detail not added as currently unknown. Update to section 8 to reflect the revised financial and non-financial criteria. Revised SOC, OBC and FBC templates
07/03/2022	15.1	Director of Strategy & Transformation	Major	There is a supporting cover report to highlight the changes made to this policy – a few main changes are summarised below. Policy updated to align with the NHSE/I mandated Better Business Cases guidance in line with the HM Treasury Five Case Model. Single approval route for capital business cases based on financial values and gradation of Trust committees to apply a proportionate level of governance, assurance and oversight.

17/03/2022	15.2	Director of Strategy & Transformation	Major	Incorporate feedback from CPSG and SLT including: Greater clarity on approval route and governance for capital investments <£1m Greater clarity on approval and governance routes for Major Medical investments Inclusion of how to apply optimism bias in accordance with the Better Business Cases Guidance
21/03/2022	15.3	Director of Strategy & Transformation	Minor	Corrected typo on approvals table (p.19)
22/03/22	15.4	Director of Strategy & Transformation	Minor	Slight amends to wording in a few sections
30/03/22	16.0	Director of Strategy & Transformation	Major	Moved to approved status following Trust Board approval
02/10/23	17.1	Deputy Director of Strategy and Business Planning	Minor	Changed review cycle from annual to three years Exec lead changed to Chief Financial Officer Role of COG updated to be in line with constitution National policy context updated Removed sections outlining detail from national Better Business Case guidance Internal governance updated

Contents

Do I need to read this Policy?

All staff responsible for requesting, approving, managing,monitoring or reporting capital funds must read the whole policy.

1. Purpose

This policy sets out the governance arrangements for capital investments undertaken by the University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).

The policy takes into account the NHS Oversight Framework and the requirement to use the Fundamental Criteria/five case model when submitting business cases to NHSE. It should be noted that the Fundamental Criteria has been produced to supplement the HM Treasury Green Book Guidance and its aim is to streamline both business case content and approvals.

This policy will be subject to three year review by the Board of Directors.

2. Scope

The policy applies to capital investments by UHBW regardless of the source of funding. Charitably funded projects must be prepared and managed therefore in accordance with the policy.

3. Definitions

3.1 Capital Investment

Capital Investment refers to funds invested in the Trust with the understanding it will be used to purchase or create assets, rather than used to cover operating expenses.

3.2 Medium Term Capital Programme

The Medium Term Capital Programme (MTCP) aims to set out the Trust's Capital Investment plans for a period of up to ten years and with reference to the Trust's notified Capital Departmental Expenditure Limit (CDEL) from NHSE.

3.3 Strategic Investment

A strategic investment is defined as a scheme that enables the Trust's strategy.

4. Duties, Roles and Responsibilities

4.1. Council of Governors

Governors have responsibility to

(a) Approve any applications for mergers, acquisitions, separation or dissolution of the Trust; and

(b) To assure that Trust governance has been correctly followed and adhered to for any applications for significant transactions as outlined in the Trust constitution. This is defined as a capital investment over £30m.

4.2 Trust Board of Directors

The Board will provide oversight of the Finance, Digital and Estates Committee. It will have the final decision over all schemes (greater than £12m or 1% of the Trust's turnover).

The Board will approve the Capital Investment Policy every three years.

4.3 Finance, Digital and Estates Committee

The Finance, Digital and Estates Committee will take the role of **Capital Investment Committee** for the purposes of this policy. It will also consider all business cases as set out in Section 7.1, Table 4 and make recommendations for approval or rejection to the Board.

It will have delegated authority from the Trust Board for:

(a) Setting performance benchmarks and monitoring investment performance.

(b) Reviewing and revising the Capital Investment Policy for Board approval.

(c) Obtaining assurance that there is compliance throughout the Trust with the Capital Investment Policy.

(d) Approving business cases in line with Section 7.1.

(e) Reporting its approvals to the Trust Board, including an account of the cumulative value of schemes approved in-year.

(f) Delegates authority to CPSG to ensure capital investments meet the requirements as set out in Section 6.3.

4.4 Executive Directors Committee

(a) The Executive Directors Committee will have delegated authority to approve investments in line with Section 7.1, Table 4.1.

(b) It will report its approvals to the Finance, Digital and Estates Committee, including an account of the cumulative value of schemes approved in-year.

(c) The Executive Directors Committee may choose to delegate approval of capitalinvestments to the Capital Programme Steering Group.

4.5 Capital Programme Steering Group

(a) The Capital Programme Steering Group will report to the Executive Directors Committee.

(b) The Group will be responsible for co-ordinating the capital planning process and issuing internal guidance, ensuring that the appropriate initiation and risk assessment documentation is in place for proposed schemes. It will make recommendations about proposals to the Senior Leadership Team and the Finance and Digital Committee in line

with their respective approval rights. These recommendations will cover both approval of projects and the programming ofrelated expenditure. In line with Section 7.1, Table 4.

(c) The Group will approve capital investments in line with Section 7.1 and report its approvals tothe Executive Director Committee.

(d) The Capital Programme Steering Group will report performance against the capital programme both to the Finance and Digital Committee and the Executive Director Committee.

4.6 Strategic Estates Development Programme Board

(a) The Strategic Estates Development Programme Board will report to the Executive Directors Committee and will seek financial approval for the allocation of capital funding through the Capital Programme Steering Group, in line with the Trust's Capital Investment Policy.

(b) The Group will be responsible for overseeing the delivery of key objectives within the Estates Strategy, including the strategic capital programme within the Trust Capital Programme.

5. Policy Statement and Provisions

5.1 Investment Philosophy and Objectives

The Trust will invest in opportunities that are consistent with its purpose, vision and objectives.

The statutory and principal purpose of the Trust is the provision of goods and services for the health service in England.

In fulfilling its core purpose, the Trust's mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. When appropriate, the Trust will make investment decisions in line with the Trust's business and service intent as set out in the Trust's Clinical Strategy, as summarised below:

- We will excel in consistent delivery of high quality, patient centered care, deliveredwith compassion.
- We will invest in our staff and their wellbeing, supporting them to care with pride and skill, educating and developing the workforce for the future.
- We will consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focusing on core areas of excellence and pursuing appropriate, effective out of hospital solutions.

- We will lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve.
- We will be at the leading edge of research and transformation that is translated rapidly into exceptional clinical care and embrace innovation.
- We will deliver financial sustainability for the Trust and contribute to the financial recovery of our health system to safeguard the quality of our services for the future.
- The investment policy sets out the criteria which will be used by the Trust to evaluate capital investment decisions (defined in section 8).
- The Trust will also take into account the financial, strategic, quality, operational, regulatory and reputational risk and benefit when evaluating potential investment decisions.
- The Trust will not enter into any project that would result in a breach of the terms of its NHS provider licence

6. Capital Budget Setting

6.1 New Capital Regime

The capital regime introduced in 2020/21 essentially sets a limit to Integrated Care System (ICS) capital expenditure each year. The Capital Departmental Expenditure Limit (CDEL) represents the funding envelope for the year and each ICS will be expected to work together to manage their capital investment spending within this limit. This now means that although UHBW has built up cash reserves over the years, we now have a capital limit (CDEL) imposed on our spending.

All capital expenditure, however financed is scored against the CDEL, with the exception of charitable funds and certain grants as long as it falls within the same financial year.

Trusts are required to draw up capital investment plans and associated capital cash management plans in line with local investment priorities, agreed strategic plans and affordability constraints, and are required to agree these locally with ICS/ICB partners. Each ICS/integrated care board (ICB) and its partner trusts will need to agree an annual system capital plan, which will require all partners to be involved in capital planning and decision-making.

Leases

IFRS 16 on leases was implemented from 1 April 2022. For further guidance please refer to NHS England's Financial accounting updates – International Financial Reporting Standard 16 leases implementation.

- New leases and lease amendments within the scope of IFRS 16 will now score against capital budgets and providers will need to seek business case approval should business cases including lease expenditure exceed the delegated limits as set out in Table 4 above.

- For leases of property, plant and equipment and buildings, it is the capital element of the whole-life cost payable under the contract (excluding VAT) that is compared to the delegated limit. Any required enabling capital expenditure, eg alterations to premises to accommodate the equipment or, in the case of property, to make them suitable for the occupier's use should be included when considering the delegated limit.

6.2 The Medium Term Capital Programme

In line with the capital regime described above, the Board of Directors will approve both the size of the Medium Term Capital Programme, taking account of the approved long term financial plan, the allocated Trust CDEL and the budget allocation between classes of investment in the programme, which will include at a minimum:

(a) Major strategic projects;

(b) Medical equipment;

(c) Operational capital;

(d) Digital

(e) Fire Improvement; and

(f) Works replacement.

A capital planning process will be integrated into the annual planning process which will determine the approval route for each class of investment.

6.3 Business Case Requirements

All investment proposals are now required to be supported by relevant 5 case model business case documentation according to the value of the proposed investment as shown in **Table 1** below.

This business case process is to be followed for all types of business cases across the organisation including digital, estates and equipment.

Table 1 – Thresholds for Business Case Requirements

Scheme cost	Documentation required
<£50k	Short form business case
>£50k <= £1m (Operational Capital)	Business Planning Process should be followed for operational capital investments and major medical equipment, as part of the annual planning process`.
>£50k <= £3m (Major Medical)	
>£1m <= £3m	Business Justification Case (BJC) **OR** Strategic Outline Case (SOC), Outline Business Case (OBC) and (subject to OBC approval) a Full Business Case (FBC)
>£3m <= £5m	Strategic Outline Case (SOC), Outline Business Case (OBC) and (subject to OBC approval) a Full Business Case (FBC)
>£5m <= £12m	
>£15m	

Table 1: Thresholds for business case requirement

The development of business cases needs to align to the parallel development of estates design phases and approval for fees for design will be presented to and approved by CPSG.

Any project requiring financial support for production of the appropriate business case prior to scheme approval must have an approved Project Initiation Document.

The requirement for external approvals outside of the Trust will be established at the start of the process and the business case will be produced in accordance with these requirements. The detailed NHSE approval guidance can be found in the Capital investment and property business case approval guidance for NHS trusts and foundation trusts.

Detailed templates and guidance for each form of business case is available from the Deputy Director of Strategy and Business Planning, supported by the Commissioning

and Planning Team.

Table 2 – How to select the correct business case

Business Case	To be used for	Examples
Project Business Case Development stages: • Strategic Outline Case (SOC) • Outline Business Case (OBC) • Full Business Case (FBC)	Significant, complex or novel schemes requiring procurement. Schemes meeting the Trust's definition of a major and / or high risk and / or strategic scheme.	£12m expansion of GICU £18.6m Bristol cross-city NICU configuration
Business Justification Case (BJC) Detail related to size and complexity.	Single case for relatively small items of spend, which are NOT novel or contentious; and can be procured from an existing pre-competed arrangement (i.e. firm prices are available). Schemes with a capital cost threshold of a maximum of £3.0m.	£2m refurbishment of the Medical Education facilities in Dolphin House and Education Centre

The Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) should be considered as a suite of documents that collectively constitute the comprehensive business case for investment.

The Business Justification Case (BJC) is a 'lighter', single stage business case that is available for the support of smaller, less expensive spending proposals that are not novel or contentious and for which 'firm' process are available from a pre-competed arrangement, including framework contracts negotiated in accordance with EU/WTO rules and regulations.

There may be occasions when a scheme >£1m <= £3m does not meet the criteria for use of a Business Justification Case (e.g. scheme is considered contentious). In this circumstance, a SOC should be completed, even if the scheme is not considered to be strategic.

Construction / implementation / mobilisation of the scheme cannot start until a business case has been approved by the Trust.

6.4 Project Sponsor

Each capital investment proposal will require the support of a Senior Manager who will be the Project Sponsor / Senior Responsible Officer (SRO)

The SRO responsibilities include:

(a) ensuring that the terms of the Capital Investment Policy and other Trust policies are followed and that business cases follow the appropriate approval route (see section 7).
(b) key decision maker
(c) responsible for the project meeting its objectives and expected benefits
(d) responsible for ensuring Post Project Evaluation (PPE) will take place
(e) member of Project and / or Programme Board

The policy recommends that an Executive Director is assigned to projects / schemes requiring Finance, Digital & Estates Committee, Trust Board and / or Council of Governors approval. More often than not, this will be the Chief Operating Officer but there will be occasions when an alternative Executive Director is nominated. For projects/schemes requiring approval up to Executive Director Committee, the role of SRO may be delegated to a Divisional Director.

7. Approval route including regional and national requirements

7.1 Internal Trust approval route

For operational capital schemes >£50k <= £1m, and Major Medical equipment >£50k <= £3m, the approval route is via the Trust's annual planning process. CPSG will consider capital investments in-year, and outside of the Trust's annual planning process, on an exceptional basis only. Capital investments <£50k can be approved by Divisional Boards.

Table 1 shows the thresholds used to determine the internal approval route for all capital investment business cases. These approval routes are in the context of the Trust having a Long-term financial plan (LTFP) and a capital programme agreed by the Board, so there has already been a formal prioritisation process to get to the scheme into the wider programme before the detail is tested in the development of the business cases. It is also assumed that all business cases have the formal support of the relevant Divisional Board(s) prior to submission through the wider Trust approval route.

Table 4 – Internal Approval Route for ALL capital investment business cases

Threshold (capital expenditure including VAT £m)	Business Case Format*	Divisional Board	Trust Capital Group	Strategic Estates Development Programme Board	Capital Programme Steering Group	Digital Hospital Programme Board	Executive Director Committee	Finance, Digital and Estates Committee	Trust Board
<£50k	Short form business case	Yes							
>£50k <= £1m (Operational Capital, Estates)	Determined by annual planning process	Yes	Yes		Yes				
>£50k <= £3m (Major Medical)	Determined by annual planning process	Yes	Yes		Yes				
>£50k <= £1m (Strategic capital)	Autonomy to approve within budget allocation from CPSG	Yes		Yes					
>£50k <= £1m (Digital)	Autonomy to approve within budget allocation from CPSG	Yes				Yes			
>£1m <= £3m	BJC ***or*** SOC+ OBC+FBC	Yes		Yes	Yes				
>£3m <= £5m	SOC+OBC+FBC	Yes		Yes	Yes		Yes		
>£5m <= £12m	SOC+OBC+FBC	Yes		Yes	Yes		Yes	Yes	
>£15m[1]	SOC+OBC+FBC	Yes		Yes	Yes		Yes	Yes	Yes

[1] Council of Governors to assure Trust governance has been followed for capital investments over £30m.

7.2 External approval route

Where a business case falls below £25m the Trust Board can make investment decisions under our own governance arrangements as long as they fall within the Trust's CDEL as agreed with the BNSSG ICB.

All capital investment and property business cases that are equal to or exceed the delegated limits outlined below require NHS England and Department of Health and Social Care (DHSC) approval. A number of exceptions and alternative arrangements are in place for specific centrally funded schemes; these largely relate to capital investment as part of national programmes, as well as any transaction deemed to be novel, contentious, or repercussive.

Summary of Capital Delegated Limits

Capital Investment	NHS Trusts and FTs in financial distress	NHS FTs not in financial distress	Exceptions where approval is required irrespective of value
Non digital capital investment and property transaction business cases	£25m Capital Cost	£50m Capital Cost	Centrally funded schemes, eg: • Sustainability and Transformation Plan (STP) capital • frontline digitisation capital/revenue (see below) • New Hospitals Programme (NHP) • central programme allocations, eg mental health, RAAC, Targeted Investment Fund, diagnostics, etc • bespoke operational capital allocations to cover strategic priorities. Any transaction deemed to be novel,
Digital Business Cases self funded	£25m Capital Costs and £30m Whole Life Cost	£30m Whole Life Cost	
Electronic patient records (EPRs) partly or fully funded by the Frontline Digitisation Programme		All business cases partly or fully funded by the Frontline Digitisation Programme (NHS England Transformation Directorate) require approval	Where capital or revenue funding is provided by the Frontline Digitisation Programme, the business case will require approval in line with the process outlined in Table 3 below.

Note - NHS trusts and foundation trusts in financial distress are subject to the £25m capital delegated limit. Foundation trusts not in financial distress benefit from greater autonomy with higher capital delegated limits.

NHS England and DHSC define a foundation trust to be in financial distress if it or the ICB to which it belongs is:

- In the Recovery Support Programme (RSP), and therefore in segment 4 of the NHS Oversight Framework and/or in breach of its provider licence. If a foundation trust is in these categories when it submits the business case to NHS England, all subsequent stages of the business case will require approval (eg OBC and FBC)
- Even if the foundation trust/ICB moves into a different segment as the scheme progresses, or

- In receipt of DHSC revenue support from 1 April 2022 (received or planned).

NHS England and DHSC have a joint committee approval process in place that is designed to ensure there is one approval point for NHS England and DHSC, rather than sequential points, and therefore improve the timeliness of DHSC/NHS England approvals. The following table summarises the approvals required according to the investment or property transaction value:

External Approvals Table	Financial Value of the Capital Investment or Property Transaction	External Approving Committee	HMT Approval
Capital Investment and Property Transactions - Non Digital	£25m or greater but less than £50m	NHS England and DHSC Joint Investment Sub-Committee (JISC)	Not Required
	£50m or greater	NHS England and DHSC Joint Investment Committee (JIC)	Required
Capital investment– Digital – self-funded capital investment (see below for the Frontline Digitisation Programme)	£25m capital cost or £30m whole life cost but less than £50m	NHS England and DHSC JISC	Not Required
	£50m capital cost or £50m whole life cost	NHS England and DHSC JISC	Required
Capital investment – Electronic patient records (EPRs) partly or fully funded by the Frontline Digitisation Programme	Central frontline digitisation capital and revenue funding of less than £50m	NHS England Transformation Directorate – EPR Investment Board (EPRIB)	Not Required
	Central frontline digitisation capital and revenue funding of £50m or greater	NHS England Transformation Directorate – EPRIB, and NHS England and DHSC JIC	Not Required

7.3 Post approval of business cases

Business Justification Cases (BJC) and Full Business Cases (FBC) will be approved by the Trust subject to cost and time thresholds. This is to ensure that the scheme remains true to the original, approved proposal and investment objectives; continues to provide a value for money solution and delivers a timely solution that mitigates the operational and / or quality risks set out in the approved case.

Cost thresholds

A scheme is required to return to Capital Programme Steering Group (CPSG) for authorisation to proceed in the following circumstance(s):

(a) Forecasts an overspend of ≥10% of the total capital costs
(b) An underspend in the current financial year which forecasts slippage into future financial year(s) and poses a risk to the Trust's ability to meet its CDEL spending target

As set out in the Trust's Standing Financial Instructions (SFIs), a scheme is required to return to Trust Board for authorisation to proceed in the following circumstance(s):

(a) Forecasts an overspend of ≥£1.0m

Time thresholds

A scheme is required to return to Strategic Estates Development Programme Board (SEDPB) for authorisation to proceed in the following circumstance(s):

(a) Forecasts delays to the end delivery date of ≥ 12 weeks.
(b) Delayed end delivery date poses a material risk to operational performance / risk mitigation (e.g, scheme planned to deliver for winter delayed until spring)

8. Evaluation

Business cases will be evaluated against explicit financial and non-financial criteria outlined below.

8.1 Financial Criteria

All business cases for capital investment must;

- Clearly state the total revenue costs of the investment i.e. including direct operating costs and the indirect operating costs including associated financing costs for example capital charges and Trust corporate overheads;
- Clearly state the total non-revenue costs / transitional costs of the investment i.e. including direct operating costs and the indirect operating costs including associated financing costs e.g. capital charges and Trust corporate overheads;
- Understand the VAT implications of the capital investment.
- Understand the life cycle costs of the investment
- Understand and state the incremental impact of the investment on the Trust's primary financial statements. Statement of comprehensive income, statement of financial position and statement of cash flows.

Written letters of support are required from the BNSSG ICB and or Specialised Commissioning.

The Board may choose to waive the requirement for explicit ICS funding approval where it deems that exceptional circumstances apply. Such circumstances may include mitigation against significant strategic, statutory, regulatory, operational or reputation risks or a desired investment in a quality improvement. In this case, the Board will make the final investment decision itself.

8.2 Post project evaluation and benefits realisation

The Senior Responsible Officer is responsible for ensuring Post Project Evaluation (PPE) will take place to evaluate whether the project met its objectives and expected benefits.

The Management Case within the Full Business Case (FBC) must include details of the outline arrangements for Post Project Evaluation including:

(a) Expected timings for PPE
(b) Named individuals responsible for their delivery
(c) Target date for submission of PPE report to CPSG

9. Risk Management

The non-financial evaluation criteria include risk mitigation and therefore take into account the risk of not entering into a proposed investment.

The Trust will also take into account the risk and return (both financial and non-financial) of making a proposed capital investment. The risks will be fully identified and assessed according to the Trust's standard risk assessment tool. A sample due diligence checklist is attached at Appendix 4.

The Trust will seek to quantify the risks of a proposed investment in financial terms wherever possible. Business cases for major capital investment will include a quantified risk and mitigation assessment.

The Trust will actively monitor the performance of its investments and ensure that adequate risk mitigation is in place.

10. References

NHSE Capital investment and property business case approval guidance for NHS Trusts and Foundation Trusts, February 2023. NHS England » Capital investment and property business case approval guidance for NHS trusts and foundation trusts

Appendix 1 – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisionsassociated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Deputy Director of Strategy and Business Planning
This document replaces existing documentation:	No
Existing documentation will be replace by:	[DITP - Existing documents to be replaced by]
This document is to be disseminated to:	All Divisional Management Staff and those responsible for requesting managing monitoring or reporting on capital funds
Method of dissemination:	Available to download from FINWEB/DMS or on request from the Senior Financial Planning Accountant and Deputy Director of Strategy and Business Planning
Training is required:	No
The Training Lead is:	[DITP - Training Lead Title]

Additional Comments	None
[DITP - Additional Comments]	

Appendix 2 – Equality Impact Assessment

Query	Response
What is the main purpose of the document?	This policy sets out the governance arrangements for capital investments undertaken by the University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).
Who is the target audience of the document (which staff groups)? Who is it likely to impact on? (Please tick all that apply.)	Add ☑ or ☒ Staff ☑ Patients Visitors Carers Others

Could the document have a significant **negative** impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment.
Age (including younger and older people)		X	
Disability (including physical and sensory impairments, learning disabilities, mental health)		X	
Gender reassignment		X	
Pregnancy and maternity		X	
Race (includes ethnicity as well as gypsy travelers)		X	
Religion and belief (includes non-belief)		X	
Sex (male and female)		X	
Sexual Orientation (lesbian, gay, bisexual, other)		X	
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		X	
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		X	

Will the document create any problems or barriers to any community or group? ~~YES~~ / NO

Will any group be excluded because of this document? ~~YES~~ / NO

Will the document result in discrimination against any group? ~~YES~~ / NO

If the answer to any of these questions is YES, you must complete a full Equality ImpactAssessment.

Could the document have a significant **positive** impact on inclusion by reducing inequalities?	YES	NO	If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for people from all groups?		X	
Will it help to get rid of discrimination?		X	
Will it help to get rid of harassment?		X	
Will it promote good relations between people from all groups?		X	
Will it promote and protect human rights?		X	

On the basis of the information / evidence so far, do you believe that the document will have apositive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact				Negative Impact		
Significant	Some	Very Little	**NONE**	Very Little	Some	Significant

Is a full equality impact assessment required? ~~YES~~ / NO

Date assessment completed: 3 October 2023

Person completing the assessment: Deputy Director of Strategy and Business Planning

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 14th November 2023

Report Title	**Governors' Log of Communications**
Report Author	**Mark Pender, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Purpose
The purpose of this report is to provide the Board of Directors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous meeting. The Governors' Log of Communications is a means of channelling communications between the governors and the officers of the Trust.
2. Key points to note *(Including any previous decisions taken)*
Since the previous Board of Directors meeting held in public on 12th September: • One question has been added to the Governor's log relating to Oliver McGowan training. This question has also been answered and closed.
3. Strategic Alignment
N/A
4. Risks and Opportunities
None
5. Recommendation
This report is for Information
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**
N/A

Governors Log October 2023

ID	Governors questions reference number	Coverage start date	Governor Name	Governor Constituency (multi)	Origin	Title	Description	Executive Lead	Coverage end date	Response	Status	Secretariat Notes
261	285	18/09/2023	Ben Argo	Public Constituency	Governor Direct	Training	Please could you provide an update on the rollout of Oliver McGowan mandatory training on learning disabilities and autism?	Chief People Officer	16/10/2023		Assigned to Executive Lead	17/10- sent to Comms for approval before return to Governor

Meeting of the Trust Board in Public – 14 November 2023

Questions received from Page Nyame, a member of the public, relating to the Boots pharmacy in the BRI.

1. When did the Board first become aware of the current issues with the Pharmacy at the BRI?

   Answer: The relevant Executive Directors were informed on 19/07/2023.

2. When did the Board first become aware that the service provided by the Boots Pharmacy at the BRI was failing against its key performance indicators?

   Answer: The relevant Executive Directors were informed on 19/07/2023

3. How far below the KPIs is the Boots Pharmacy at the BRI currently performing (as at 7.11.2023)?

   Answer: Information for 07/11/2023 will be provided when it is available

4. What safeguards are in place to ensure that when performance falls below the KPI action is taken?

   Answer: Monthly meetings between UHBW and Boots reviewing KPIs

5. When will the Boots Pharmacy at the BRI be up for contract renewal?

   Answer: The current contract ends 31/03/2024

6. After what period of time, if service does not return to the performance standard required in the contract, will further action be taken regarding the Boots Pharmacy at the BRI? What action would be taken and when?

   Answer: The Trust has the right to serve performance notices if a KPI is not met for the previous month. In the event Boots accrues three or more Performance Notices within any rolling six-month period the Trust may issue Boots with a Critical Failure Notice. Notices are to be used when the Trust feels this is a necessary measure in order to gain additional focus and improvements in performance.

7. Please may the complaints report for 2021/2022 be provided online. It does not currently feature on Patient Advice and Liaison Service (PALS) and Complaints Team | University Hospitals Bristol NHS Foundation Trust (uhbristol.nhs.uk)

   Answer: this report has now been added to the Trust's website.

8. Please may the Quarterly Complaints Reports since March 2022 be provided. They do not currently feature on Patient Advice and Liaison Service (PALS) and Complaints Team | University Hospitals Bristol NHS Foundation Trust (uhbristol.nhs.uk)

   Answer: these reports have now been added to the Trust's website.