University Hospitals Bristol and Weston NHS Foundation Trust

Board of Directors (in Public)

Meeting of the Board of Directors to be held in Public on Thursday 29 July 2021 at 11.00 – 14.00 Video Conference
AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
Preliminary Business				
1.	Apologies for Absence – *Verbal update*	Information	Chair	11.00
2.	Declarations of Interest – *Verbal update*	Information	Chair	11.02
3.	Patient Story	Information	Chief Nurse	11.05
4.	Minutes of the Last Meeting • 27 May 2021	Approval	Chair	11.25
5.	Matters Arising and Action Log	Approval	Chair	11.27
6.	Chief Executive's Report	Information	Chief Executive	11.30
7.	Committee Chair Reports • Quality and Outcomes Committee • Audit Committee • Finance & Digital Committee • People Committee • Charity Committee	Assurance	Chairs of the Committees	11:40
Strategic				
8.	Healthier Together Sustainability and Transformation Partnership Update	Information	Chief Executive	11:45
9.	Board Assurance Framework (Quarter 1) (a) Strategic Risk Register (b) Corporate Objectives Update	Assurance	Chief Executive	11:50
10.	2021/22 Operational Plan	Information	Director of Strategy & Transformation and Director of Finance & Information	11:55
11.	Weston Integration update	Assurance	Director of Strategy and Transformation	12:00
12.	Transforming Care Programme Board Report Quarter 1	Information	Director of Strategy & Transformation	12:10

NO.	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
	Break			12:20
Quality and Performance				
13.	Integrated Quality & Performance Report	Assurance	Deputy Chief Executive and Chief Operating Officer, Chief Nurse, Medical Director, Director of People	12:25
14.	CQC Informal Feedback and Action Plan progress update	Assurance	Chief Nurse	12:35
15.	Learning from Deaths and Medical Examiner Annual Report	Assurance	Medical Director	12:40
16.	Quarterly Maternity Perinatal Quality Surveillance Matrix	Assurance	Chief Nurse	12:45
17.	Safeguarding Annual Report	Assurance	Chief Nurse	12:50
18.	Quality Account 2020/21	Approval	Chief Nurse	12:55
19.	Patient Experience Report Quarter 4	Information	Chief Nurse	13:00
20.	Patient Complaints Report Quarter 4	Information	Chief Nurse	13:05
21.	Revalidation Annual Report	Approval	Medical Director	13.10
People Management				
22.	Resolving Conduct Concerns Policy	Approval	Director of People	13:15
23.	Bi-Annual Equality and Diversity Report	Information	Director of People	13:20
24.	National Staff Survey Results	Information	Director of People	13:25
Research and Innovation				
25.	NIHR Clinical Research Network Annual Plan and Annual Report	Information	Medical Director	13:30
Finance				
26.	Finance Report	Assurance	Director of Finance and Information	13:35
Governance				
27.	Appointment of a Trustee to Above & Beyond	Approval	Chief Executive	13:40
28.	Emergency Preparedness Annual Report	Assurance	Deputy Chief Executive, Chief Operating Officer	13:45
29.	Governors' Log of Communications	Information	Director of Corporate	13:50

NO.	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
			Governance	
30.	Register of Seals Report Quarter 1	Information	Director of Corporate Governance	
Concluding Business				
31.	Any other urgent business	Information	Chair	13:55
32.	Date of next meeting: **30 September 2021**	Information	Chair	

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University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

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

1. Report Summary

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

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

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

2. Key points to note
(Including decisions taken)

The Covid-19 pandemic has set an unprecedented challenge to the delivery of our services. We have adapted by delivering new service models and by working together have prioritised those with greatest need. In this patient story we will hear from Henry, a 28 year old who has been in our care throughout the pandemic.

One month prior to his 27th birthday Henry was diagnosed with a rare sarcoma of the prostate – an uncommon condition most often associated with younger children. In recounting his experience of care Henry will talk about how he has dealt with his cancer diagnosis, the treatment and care he has received and the impact this has had on him. He will reflect on the challenges he has faced in receiving treatment and care during Covid-19 and the value he derived from knowing a "community of physicians" (choreographed by Dr Adam Dangoor) was looking after his interests. Henry will also offer a personal reflection on the emotions that surface as a young man being treated alongside older people and the importance of age-appropriate services.

Henry will focus on key aspects of his care including how, on the eve of lockdown in March 2020, he commenced an 8 month intensive course of chemotherapy. He will reflect on the value video-conferencing has brought to him in being able to avoid waiting rooms and have "scary conversations" with his consultant at home and conversely, the challenge of not being able to have the direct support of his family in hospital as a result of visiting restrictions.

Throughout his story Henry will share the aspects of care that really matter to him,

including:

- the value he placed on the compassion shown by the medical and nursing teams – something that reminds us that the way in which we deliver treatment and care really does make a difference.
- the importance of the care environment and the impact the quality of the physical environment and food on ward D603 had on how he felt about his care.
- The need to support family members at a time when the anxiety associated with cancer is exacerbated by visiting restrictions.
- The importance of sustaining his own health and wellbeing through appropriate psychological support services

By way of further context, during 2021 the Trust is planning a significant patient experience project exploring in-depth the experience of cancer care over recent months. This work will help inform where the focus of attention will be in further developing cancer services in the trust. Henry has expressed an interest in taking part in this work so that his experiences will impact on what we do next.

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

The risks associated with this report include:
N/A

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

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

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

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

University Hospitals Bristol and Weston NHS Foundation Trust

Minutes of the Board of Directors Meeting held in Public

Thursday 27 May 2021, 11:00-13:30, by videoconference

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

Present

Board Members

Name	Job Title/Position
Jayne Mee	Interim Chair of the Board
Robert Woolley	Chief Executive
David Armstrong	Non-Executive Director
Sue Balcombe	Non-Executive Director
Julian Dennis	Non-Executive Director
Bernard Galton	Non-Executive Director
Jane Norman	Non-Executive Director
Martin Sykes	Non-Executive Director
William Oldfield	Medical Director
Matt Joint	Director of People
Mark Smith	Deputy Chief Executive and Chief Operating Officer
Neil Kemsley	Director of Finance and Information
Paula Clarke	Director of Strategy and Transformation
Deirdre Fowler	Chief Nurse
Matt Joint	Director of People

In Attendance

Name	Job Title/Position
Eric Sanders	Director of Corporate Governance
Mark Pender	Head of Corporate Governance
Rob Field	For Item 3, Patient Story
Alex Nestor	Deputy Director of People
Sarah Windfeld	Head of Nursing, Midwifery and Women's Services, for Item 15
Dr Sneha Basude	Clinical Governance Lead for Women and Children's for Item 15
Trish Garland	Corporate Governance Administrator (minutes)

The Chair opened the Meeting at 11:00

01/05/21	**Welcome and Introductions/Apologies for Absence**	
	Jayne Mee, Interim Chair of the Trust, welcomed the Board and members of the public to the meeting. Jayne had been appointed to the role of Interim Chair of the Trust to cover the Trust Chair, Jeff Farrar, who had been temporarily appointed to the Interim Chair of the BNSSG Integrated Care System for a six month period. The meeting today was being recorded and would be available online for the next two weeks. Apologies for absence had been received from Steven West, Non-Executive Director.	

02/05/21	**Declarations of Interest**	
	There were no new declarations to note.	
03/05/21	**Patient Story**	
	Matthew Areskog, Patient Experience Manager, introduced Rob Field to the Board. Rob wanted to share his story with the Board to highlight mainly the communication issues experienced by the family when his father-in-law was in hospital. Rob explained how his father-in-law, Brian, had been under the care of the Trust, firstly in the Bristol Royal Infirmary, from December 2020 to March 2021, before being transferred to South Bristol Community Hospital. Brian and his wife Sylvia lived together in Bristol; Rob and Brian's daughter Alison lived in Hampshire. Brian had mild dementia and Sylvia was physically disabled so each required different types of support. Brian was admitted to hospital in 2020 with respiratory infection, and it was noted that his dementia compounded this. Antibiotics were prescribed for a couple of weeks and it was assumed that Brian was suffering from a urinary tract infection. During Brian's stay in the hospital, the COVID visiting restrictions were in place and originally a phone call was made to the family each day to provide an update. The day after Brian's admission a doctor called to say Brian was very poorly; the doctor then started discussing the DNR notice, but there was no discussion with the family in particular; the call was on speaker phone and Brian's wife Sylvia became very upset at this point. The next day the Occupational Health therapist called and emphasised what was needed for Brian at home; given the previous day's conversation regarding the DNR notice, this caused great confusion and uncertainty in the family. The Occupational Health therapist confirmed they would not have called if not hopeful for the outcome of Brian's treatment. After this it was left to the family to call the ward each day, but it was difficult to speak to a member of staff who was aware of Brian's situation; the speech and language therapist was more helpful. The care he received was very good - this was an 85-year old who had never been in hospital before and was in really good health previously. Once Brian was stable he was then transferred to South Bristol Community Hospital for rehabilitation, but the delirium was really affecting him. The rehabilitation was really good and Brian left the hospital feeling much better. The communications side was really difficult; there were still COVID restrictions with no visiting allowed; the family were informed they could ring at any time but it was often difficult to get an answer and the family rarely spoke to a medic – on one occasion it took 22 attempts to get a call answered. Alison, Brian's daughter, was able to manage Brian's wellbeing but Brian was very confused and had no capacity. The family felt there had been an over-enthusiastic use of laxatives and that a catheter had been used with no clear explanation of why this was needed. If visits had been allowed the family would have been aware of this instead of finding out these things by chance. The family was not given any information regarding what clothes and personal possessions Brian would need for his stay in rehabilitation and there was an assumption that the family would do the patient's laundry, but this was not possible due to the location; it should not be assumed that families lived close to the hospital. It was left to the family to organise a COVID vaccination for Brian, although staff were aware that the plan was for Brian to move to a care home. Once Brian had moved to the care home, Oakhill, he had to isolate for 2 weeks due to arriving from the hospital. After this Sylvia and Alison were only	

	allowed to visit through a pod visit, but this was difficult. Since then 2 visits with lateral flow testing beforehand had taken place. There was not much information available for Brian in the care home regarding guidance around visiting and changes in the guidelines etc. A capacity assessment had now been undertaken and a best interest meeting was due to be held later in the week with the social worker to determine Brian's pathway. The family felt that Brian was so now removed from his normal daily routine he would likely have to stay in residential care. It was felt that his time in the care home had negatively impacted Brian's physical progress, as there was no continuation of the occupational therapy support. Communication was difficult for Brian as he is partially deaf and combined with the dementia and staff wearing masks this made things very difficult. During Brian's stay at the Bristol Royal Infirmary, the family discovered the 'Message to my loved ones' service, and through this were able to send Brian a weekly message and photo. Rob stated that this was an excellent service with an acknowledgment sent to provide assurance that the message had been sent to the patient. The family were then informed that it was possible to undertake virtual visits and this was really successful. Two of the visits had been facilitated by Tony Watkin, Patient Involvement Lead for the Trust, who had been really helpful in helping Brian to engage with his family; Sylvia felt much better after seeing and talking to Brian. The family wanted to thank the Patient Voluntary Services Team for their support and in particular to thank Tony Watkin for coming in to help with the virtual visits when he was meant to be on annual leave. Rob again referred to the poor communication issues experienced during Brian's stay in hospital and mentioned that it was only due to the fact that he was on sick leave and recovering from surgery, that he had been able to have time to keep pursuing issues that were necessary to resolve for Brian. It was appreciated that hospital staff have to get things done for patients when possible but it was suggested that a mutually agreed time for telephone calls would work much better. Rob thanked all the staff that had been involved in Brian's care since he had been admitted in December 2020. Jayne Mee, Interim Chair, thanked Rob for the patient story today and the fact that he had been so honest about the issues encountered. Deirdre Fowler, Chief Nurse, thanked Rob for the Patient Story today and gave assurance that this would be shared with staff in the Trust. The benefits and support that carers and families can provide for patients in the rehabilitation process was emphasised. The National Carers Week would take place on 7 – 13 June. Sue Balcombe, Non-Executive Director, wanted assurance that the wards had updated leaflets regarding communication during the pandemic; the suggestion of pre-booked slots for telephone calls should be explored. **Action: Ensure updated communication/leaflets were available on the wards; explore whether pre-booked phone slots would be feasible**. Matthew Areskog, Patient Experience Manager, thanked Rob Field for the positive feedback regarding the 'Message to my loved one' service and the virtual visits; it was confirmed this would continue and staff were being given further training to undertake this, with further funding from NHS England provided. The Board thanked Rob Field for joining the meeting today; the Board would ensure the learning from the Patient Story today would be cascaded through	**Chief Nurse**

	the teams in the Trust. Rob Field reiterated his thanks for the care Brian had received in the Trust. **Action: Head of Corporate Governance to write on behalf of the Board to thank Tony Watkin, Patient Involvement Lead, for the support he had provided for Brian Field and his family.** *Rob Field left the meeting*.	**Head of Corporate Governance**
04/05/21	**Minutes of the previous meeting**	
	The Board reviewed the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust Board held in public on 31 March 2021. **Members of the Board RESOLVED to approve as a true and accurate record the above minutes.**	
05/05/21	**Matters arising and action log**	
	Board Members received and reviewed the action log. Updates on completed actions were noted, and others were discussed as follows: **Emergency Preparedness Report** *The Emergency Preparedness Annual Report to be reviewed at the Audit Committee*. This report would be presented to the Audit Committee in July. It was noted that Jayne Mee, Interim Chair, had taken on the Non-Executive Director lead responsibility for Emergency Preparedness, and a successful meeting had taken place between her with John Wintle, the Resilience Manager for the Trust. **Action ongoing**. **Integration update** *Review the Weston integration plan to see what areas could be accelerated*. This was on the agenda. **Action ongoing**. **Patient Complaints Report** *The Patient Complaints Report to be updated to show year-on-year trends going forward and to be presented at the Quality and Outcomes Committee*. This would be presented at the July meeting. **Action ongoing**. **Six-monthly Safe Staffing Report** *To include the consultant workforce data in the Six-monthly Staffing Report going forward*. This would be included in the September report. **Action ongoing**. **Safe Working Hours Guardian Report** *Implementation programme for the roll-out of e-rostering to be provided to the Board including timeframe*. Matt Joint, Director of People, mentioned that a paper regarding Safe Working Hours had been presented at the People Committee. The timelines had been reset and would be delivered by March 2022. There had been delays due to the pandemic. **Action closed.** **Members resolved to note the updates against the action log.**	
06/05/21	**Chief Executive's Report**	
	Robert Woolley, Chief Executive, provided a verbal update on the following key issues:	

- It was acknowledged that incidence of COVID-19 in the community had reduced and the Trust was focused on restoration, particularly elective activity and the recovery programme.
- The Board was informed that Bristol, North Somerset and South Gloucestershire had been designated as an elective accelerator for the region.
- The Trust was continuing to acknowledge the extraordinary experience that staff had been through during the pandemic. The Pause, Reflect and Recover Programme continued, and recently hampers of goodies had been distributed to all the wards and departments in the Trust, which had been very well received.
- The two 'staff only' dining facilities in Bristol and Weston would be refurbished and extended in the coming weeks.
- A great deal of work was underway regarding the cultural values of the organisation. The Board was encouraged to complete the survey related to this and to cascade to colleagues. A series of focus groups would be held with staff about what they would like to see reflected in the values, vision and culture of the organisation to ensure full alignment across all staff groups in Bristol and Weston.
- As part of the recovery from the pandemic, the Executive Directors and Non-Executive Directors would visit wards and departments across the Trust; this had been paused due to the Infection Control restrictions imposed during the pandemic and there had been good staff feedback regarding the proposed visits. Jayne Mee, Interim Chair, stated that she had in the past few weeks undertaken some visits in various parts of the Trust and emphasised how good it was to meet staff and listen to their experiences, particularly during the pandemic.
- It was noted that in the Queen's Speech on 11 May the Health and Care Bill was formally announced, the biggest set of reforms for the NHS for almost a decade, with the intention to put Integrated Care Systems on a statutory footing. A great deal of work was ongoing to understand what this meant in practice, with a number of concerns to be resolved such as how the independence of the NHS was preserved and how this would affect sovereign organisations. The Government had allocated funding to clear the backlog of care but there was no formal change for social care that affected the hospital directly.
- The Trust had accelerated its work in response to the CQC inspection of Medicine at Weston General Hospital and the action plan would be reviewed later in the meeting. Following the removal by Health Education England of the F1 doctors from the Department of Medicine in Weston General Hospital in April 2021, the Trust had mitigated the loss of the trainees but was in ongoing discussions with Health Education England about the potential restoration of trainees for the next rotation.
- Congratulations were given to Professor Jane Blazeby, Professor of Surgery at the University of Bristol and Consultant Surgeon in the Trust, who had become a Fellow of the Academy of Medical Sciences, a great credit to Jane and her team, and added prestige for the Bristol Health Partners Academic Health Science Centre (AHSC), with surgical research being one of the key themes in the AHSC programme.
- The Board were informed that Guy Bailey, Cardiac Anaesthetist, had sadly unexpectedly died. Guy had worked in the Bristol Royal Hospital for Children since 2007. There was further sad news with the announcement that Charles Wakeley, Clinical Radiologist, who had

	only recently retired, had died after suffering from a brain tumour. The Board passed on their condolences to the families. Jayne Mee, Interim Chair, thanked Robert Woolley for the update today and stated that the Board's thoughts were with Guy's and Charles' families. Jane Norman, Non-Executive Director, queried what the timescale was for appraisal compliance, considering what staff had endured. Robert Woolley, Chief Executive, referred to the national guidance that some routine processes should be relaxed given the pressures caused by the pandemic. The Senior Leadership Team would be driving recovery and focus with the target set at 85% by the end of September. Jayne Mee, Interim Chair, mentioned this had been discussed at the recent People Committee; Bernard Galton, Chair of the People Committee, mentioned that compliance was reviewed regularly by the Committee and greater focus would be given going forward. Sue Balcombe, Non-Executive Director, queried whether there were plans to relax the restrictions in the hospital regarding social distancing given the huge impact this had on capacity. Mark Smith, Deputy Chief Executive and Chief Operating Officer, noted that one of the key assets in the accelerator programme was Infection and Prevention Control and the Trust would be part of a regional pilot to look at this. Deirdre Fowler, Chief Nurse, stated that a discussion had taken place recently at the Senior Leadership Team meeting regarding the Quality Impact Assessment presented by Martin Williams, Consultant Microbiologist. It had been decided that on the balance of risk, to ensure treatment was received while minimising the risk of transmission, there would not be any further removal of beds subject to triggers, e.g. outbreaks or community prevalence. This was being monitored by the Infection and Prevention Control Team and the Clinical Site Teams. David Armstrong, Non-Executive Director, mentioned the articles in the media regarding hospital acquired COVID and deaths with information sourced from Freedom of Information requests; it was queried whether the Trust submitted or withheld requests for this information. Robert Woolley, Chief Executive, replied that the Trust responded as it was the legal duty to do so and assured the Board that the Trust always respond to Freedom of Information requests. It was confirmed that a partial response for information had been submitted, in the belief this information was available to the media from other sources. The Board was reminded that the Trust had been transparent about the impact of COVID – it was one of the first Trusts to undertake Root Cause Analysis and Serious Incident investigations following the outbreak in Weston General Hospital in May 2020, with the findings made public in September 2020. The Trust remained transparent about the impact of COVID on patients and staff. **Members resolved to receive the Chief Executive's Report for information**.	
07/05/21	**Healthier Together Sustainability and Transformation Partnership Update**	
	Robert Woolley, Chief Executive, presented a brief update on the Integrated Care System. Jeff Farrar, Interim Chair of the ICS, had set out the objectives in the paper circulated. Robert Woolley, Chief Executive, informed the Board that he had been designated as the Senior Reporting Officer for the community diagnostic hubs bid; very rapid work had been undertaken to establish a diagnostic hub in BNSSG by October. The proposition proposed was the possibility of establishing a modular hub at Weston General Hospital and this looked the	

	most likely option to progress. The bid had been submitted just over a week ago and a response was awaited from NHS England and the Treasury. There was a longer term strategy to develop diagnostic capacity in the community as part of the recovery from the pandemic. It was noted that the Clinical Commissioning Group would be considering proposals on 1 June for the transformation of stroke services as briefed to the Board previously. This would then proceed to a public consultation. Jayne Mee, Interim Chair, informed the Board that the Non-Executive Directors would be attending workshops on the Integrated Care System development on 22 June and 22 July and several Non-Executive Directors had volunteered to be on the various work streams that were being set up for this. Robert Woolley stated that this was important to demonstrate that plans were in place for the development of the Integrated Care System besides reflecting the leadership that the Trust was providing into this. Bernard Galton, Non-Executive Director, mentioned that at the People Committee it had been agreed for the System-wide People Committee agenda and minutes to be circulated to ensure discussions at this meeting could be aligned and supported in the Trust. Sue Balcombe, Non-Executive Director, mentioned the nurse supply work was very important and particularly the emphasis around retaining staff, and the Trust's flexibility to support this. **Members resolved to receive the Healthier Together Sustainability and Transformation Partnership Update for assurance**.	
08/05/21	**Integration update**	
	Jayne Mee, Interim Chair, welcomed Paula Clarke, Director of Strategy and Transformation, who had returned to post from her secondment to the National Vaccination Programme. Paula Clarke commented on the importance of progress with the integration programme that had been impacted by the pandemic. Since the report had been issued good progress had been made in re-engagement with the teams. Highlights from the report were noted below: • The gynaecology and resuscitation services had moved forward with integration; • Very positive sessions had been held with teams who were reviewing timelines to see how integration could be accelerated; • Teams were visiting each other's areas to ensure a greater understanding of the timeline for the integration plan and this plan would be brought to the Board meeting in due course; • Progress had been made with the Urology Business Case, a service transfer, to ensure the service remained at Weston General; Hospital for the local population; • The progress made with corporate services was robust and was close to being complete, as a formal part of the post-transaction plan; • The communications and digital services integration was underway and progressing well. Focus was needed to ensure teams felt part of a single unit and the Executive walk arounds and staff focus groups being held would help to progress this. The opportunities available to staff within the organisation were being highlighted alongside the re-establishment of the Healthy Weston Partnership Board to ensure the overall vision of the integration.	

	Matt Joint, Director of People, remarked on the good response to the staff survey and reminded the Board of the Blue Goose cultural work being undertaken. The draft Trust values would be available in September and would be shared widely and feedback sought after this. Neil Kemsley, Director of Finance and Information, mentioned the digital convergence of the clinical systems – the main shift had taken place in September 2020 regarding Medway in Weston General Hospital. The Trust was now working towards April 2022 in terms of the alignment of Bristol and Weston onto a single system; meanwhile several clinical systems had been aligned between the sites. A revised business case would be presented at the Finance and Digital Committee in July and this would set out the timeline for the complete alignment. Martin Sykes, Non-Executive Director, stated that it was positive to see the integration being reinvigorated and the vision being set out for the staff and public to see. David Armstrong, Non-Executive Director, mentioned the digital convergence target date now being April 2022 and that this was subject to a number of dependencies. He asked what the level of risk was associated with this. Neil Kemsley, Director of Finance and Information, informed the Board that further information regarding this was in the Finance and Digital Committee Report, particularly regarding the resourcing for the Weston programme in the next 12 months. It was acknowledged that the Medway version now at Weston General Hospital was a superior version to the Medway version in Bristol so the alignment for this particular item was for Bristol to be upgraded. It was explained that the target date of April 2022 had been set due to the wider issues affecting the Trust and not solely Weston General Hospital. **Action: Further information regarding the Integration's digital convergence to be provided at the Finance and Digital Committee in July**. Jane Norman, Non-Executive Director, asked what was the most concerning issue regarding the Integration that the Board could help progress. Paula Clarke, Director of Strategy and Transformation, mentioned the CQC and regulatory issues and in light of this the importance to maintain focus on the vision for the integration and to remind people of the progress already made. **Members resolved to receive the Integration Update for assurance**.	**Director of Finance and Information**
09/05/21	**CQC Report and Action Plan for Weston**	
	Deirdre Fowler, Chief Nurse, provided an update on the findings from the CQC Report and Action Plan for Weston since the visit to the medical wards on 11 March 2021 as below: • The report found that in relation to the medical wards staff demonstrated good and compassionate care; • Areas that needed to improve were documented in the action plan; there were nine 'must do' and seven 'should do' recommendations received in the report published on 12 May. • On 29 March following a series of assurances the CQC confirmed that it was satisfied with the actions and evidence produced; • The action plan had been shared with the CQC and the Executive team would be meeting monthly with the CQC to ensure there was ongoing engagement with progress reports to provide continuing assurance to	

	the CQC regarding actions taken. Jayne Mee, Interim Chair, commented that this was a very comprehensive action plan with many actions already in progress when the feedback from the CQC was received. Sue Balcombe, Non-Executive Director, requested an update on the nursing vacancies and overseas recruitment. Deirdre Fowler, Chief Nurse, informed the Board that 60 new nurses were expected to start in the Weston Division by September 2021; 12 had already started in post. The Government's decision to add India to the red list had impacted the recruitment plans but it was anticipated that 47 nurses would be in place by the autumn. The Trust was working with Health Education England and various agencies to source nurses from other areas. Martin Sykes, Non-Executive Director, queried whether there had been discussions with the regulators about the balance of risks and managing risks in the best way, e.g. patients having to travel long distances to receive treatment and the fill rate for nurses and junior doctors. Deirdre Fowler, Chief Nurse, assured the Board that a robust governance process was in place to ensure patients were treated locally and a detailed report was provided at the Quality and Outcomes Committee each month. There was reduced bed occupancy in Weston General Hospital with bank agency in use although this was not ideal. Julian Dennis, Non-Executive Director, noted that in the report several timescale dates had passed but there was no comment to show if the action had been achieved. Deirdre Fowler, Chief Nurse, stated that the progress report had recently been presented to the Executive team and would be updated to show compliance with timescales. **Action: CQC Action Plan for Weston updates to be shared with the Board**. **Members resolved to receive the CQC Report and Action Plan for Weston General Hospital for assurance**.	**Chief Nurse**
10/05/21	**Integrated Quality & Performance Report**	
	Mark Smith, Deputy Chief Executive and Chief Operating Officer, updated the Board regarding the following points: • The accelerator programme was briefly summarised. The Trust was one of several centres participating in a national pilot scheme, which was an opportunity for the BNSSG Integrated Care System to collaborate and improve the elective recovery work, in particular the low complexity, high volume specialities such as Ear, Nose and Throat (ENT). This was being led jointly with North Bristol NHS Trust, with a series of meetings being held each week, the meetings being structured similar to the Gold, Silver and Bronze incident command meetings. There was an associated capital allocation and if over-performance occurred against the baseline for 2019/20, the Trust would be eligible for the Elective Recovery Fund. • Internally, the restoration programme was being governed by the Restoration Oversight Group who would oversee the totality of restoration. It was emphasised that this was also about staff recovery and wellbeing, not just the elective recovery. • The hospital had increased its activity, experiencing a very busy time similar to the pressures normally seen in the winter. • There had been a significant reduction in COVID infection with currently only four potential cases in the Trust. It was thought this might increase in the autumn.	

	• There was good news regarding recovery – in the first month the Trust had exceeded the national trajectory of 70% with theatres returning to normal capacity. • An improved position with 12 hour breaches was noted, with a marked improvement in the BRI site and also improvement at Weston General Hospital. • There were ongoing significant issues with ambulance handovers, and the Board was informed that a meeting would be held with South West Ambulance Service NHS Foundation Trust (SWAST) to identify what options there were to make improvements. • The Emergency Departments across the Trust were extremely busy, particularly the Children's Emergency Department and work was ongoing across the organisation to improve flow. William Oldfield, Medical Director provided an update to the Board as below: • The mortality indicator remained as expected which showed no deterioration in the quality of care. • A significant amount of work was underway to look at Never Events, particularly around wrong site nerve blocks. The acute teams were developing protocols for this and a summit was scheduled for early July for all surgical teams to review surgical never events to improve care going forward. A similar event had been held several years ago and had been extremely successful. • There had been some incidents regarding medicines management, one related to the transcription of a drug chart, and the second incident was due to omitted doses due to a lack of availability on the ward. A significant amount of education had taken place with staff about how to access drugs out of hours. Matt Joint, Director of People, provided the following updates: • It was noted that staff turnover had increased slightly and a greater focus on retention was underway. • Vacancies and sickness were still extremely low. • A focus on wellbeing and flexible working to improve retention was ongoing. • The Board was informed that the HR team were in touch with the recruited nurses unable to travel from India due to the red list restrictions. Jayne Mee, Interim Chair, mentioned the pastoral care support being provided by the Trust was excellent. **Action: An update on the Restoration and Recovery work to be provided at the Quality and Outcomes Committee**. **Members resolved to receive the Integrated Quality and Performance Report for assurance**.	**Deputy Chief Executive, Chief Operating Officer**
11/05/21	**Committee Chair Reports**	
	Quality and Outcomes Committee Julian Dennis, Non-Executive Director and Chair of the Quality and Outcomes Committee, informed the Board that Mark Goninon, Deputy Chief Nurse for Weston, attended the recent meeting and provided an informative update regarding Weston General Hospital, including the process in place around	

	Governance. Sarah Windfeld attended to talk about the Maternity Incentive Scheme. ***Finance and Digital Committee*** Martin Sykes, Non-Executive Director and Chair of the Finance and Digital Committee, informed the Board that a very good presentation had been highlighted at the last meeting regarding external strategic items from NHSX, and how this linked to internal projects. The issue of safety regarding cyber-attacks was discussed with assurance provided about what was in place to prevent this. A good review of the year was undertaken with a great list of successes, such as the Microsoft Office 365 rollout, upgrades to Medway, X-rays across sites and the team was commended for this. Regarding finance it was a forward looking meeting, with a plan drawn up for the coming year although there was uncertainty around the second half of year; the team was commended for the plan considering some guidance for the latter part of the year was not yet available. The efficiency programme was discussed regarding the Integrated Care System frameworks and how the efficiency programme could be reframed going forward. ***People Committee*** Bernard Galton, Non-Executive Director and Chair of the People Committee informed the Board that a lengthy discussion regarding recruitment and retention had taken place at the recent meeting. A task force had been set up to progress this. The support for the nurses on the red list was mentioned. The Diversity and Inclusion Plan and the Wellbeing Action Plan were discussed and a Women's Network was due to be set up. Alistair Johnstone, the Guardian of Safe Working Hours had attended the meeting and provided the regular Guardian update for the Trust. There had been an excellent presentation about how the vaccination hub had been set up and delivered. Appraisals were an ongoing challenge. ***Acute Services Review Programme Board*** Martin Sykes, Non-Executive Director, reported that the recent meeting followed the usual format to get updates for projects underway. This Board had been set up between UHBW and NBT (North Bristol Trust) to improve service for patients, and the stroke service success was a result of this collaboration. The national guidance was promoting provider collaboratives and a discussion had been held on how to move forward in light of the guidance. There had been a good presentation from the local maternity system, a good example of collaborative working but there was some frustration about navigating governance systems to get things approved; it was hoped to align governance groups to progress quicker when joint projects were being developed. Jayne Mee, Interim Chair, mentioned that Jane Norman, Non-Executive Director, was also now part of this Board. **Members resolved to receive the Committee Chair Reports for assurance**.	
12/05/21	**Financial Plan 21/22**	
	Neil Kemsley, Director of Finance and Information, reported that the financial plan was produced from guidance and allocations received at the end of March; the full operational plan would be presented at Board at the end of June and was aligned with the system financial plan submitted on 6 May. Further points noted were: • The system revenue plan was referred to – sections 2 and 3 – this was a balanced plan and it was stated that all financial risks identified were	

	mitigated in delivering the plan proving a strong position from a system perspective. • The system capital plan – there was an allocation of £121m in terms of annual allocation of capital; UHBW would spend approximately £85m of this. Section 1.5 set out the objectives of the plan, with the importance of supporting the restoration plan and the integration plan included. • The investment priorities for the Trust, a combination of externally funded service developments, were listed. The £5m of internal investment agreed by Senior Leadership Team last week was referred to. • Section 4.16 referred to the external service development proposals and potential issue of the ability of the STP to agree funding going forward. The savings programme for 2021/22 was mentioned and the Trust was confident regarding this with a strong platform for the 2022/23 target. Jayne Mee, Interim Chair, commended Neil Kemsley and the team for the excellent Finance Plan. Julian Dennis, Non-Executive Director, agreed that the Finance Plan was an excellent plan but sought clarification regarding the key risks figure of £5m. Neil Kemsley, Director of Finance and Information, confirmed this figure was the list of schemes set out in Table 2 of the paper; the absence of certainty in current funding streams was highlighted; but if funding changed this approach had been taken to ensure awareness. **Members resolved to approve the financial plan for 2021/22.**	
13/05/21	**Freedom to Speak Up Annual Report**	
	Eric Sanders, Freedom to Speak Up Guardian, presented the Freedom to Speak Up Annual Report and highlighted the following: • It was reported that the National Guidance office had published a new Freedom to Speak Up index for 2020/21, with a score being given to every Trust based on staff survey results; the Trust had improved slightly and considering the previous year with the pandemic and the merger this was felt to be positive. • Two metrics from the annual staff survey were referred to – firstly 63.5% of staff reported that they were confident that the organisation would address their concern, and 69% not feeling confident that they would be supported if they spoke up. • The index report provided a breakdown and showed significant discrepancies in groups of staff who felt able to speak up. Greater focus was needed to encourage staff to speak up when necessary. • The Trust continued to deliver against the strategy, which included raising awareness regarding speaking up. Kate Hanlon was now in post as Deputy Guardian and there were 80 Freedom to Speak Up advocates working across the Trust to promote this. One of the advocates, Jordan Reid, had done some great work to promote speaking up in her area, with a suggestions box in place for staff to share ideas, and this had proved popular. • Key changes to note were the introduction of the new speaking up training which was now included as essential training - the Trust was one of the first in the South West to commit to this. Compliance would be reported from August. • The listening training for managers would be promoted widely and the	

	Board was committed to undertaking this training. The Organisational Development team were also promoting this training. The Board was asked to think how the cultural changes and Blue Goose work were being implemented throughout the organisation to support a culture of speaking up. Jayne Mee, Interim Chair, Non-Executive Director with responsibility for Freedom to Speak Up, commented that Eric Sanders and Kate Hanlon had worked tirelessly and had made great progress; it was felt that staff recognised the importance of being able to speak up; it was important to ensure investment to this area. The Chair thanked Eric and Kate for their excellent work. **Action: Head of Corporate Governance to write on behalf of the Board, to thank Eric Sanders and Kate Hanlon, for their great work to promote the Freedom to Speak Up campaign.** David Armstrong, Non-Executive Director, queried the appropriate forum for discussion of funding commitment for the Freedom to Speak Up campaign. Bernard Galton, Non-Executive Director, stated that this should continue to be presented at the People Committee with an annual report for the Board. Jayne Mee, Interim Chair, mentioned linking this with the Blue Goose work. Jane Norman, Non-Executive Director, congratulated Eric Sanders and his team on the mainly positive report and the confidence this showed amongst staff. Eric Sanders, Freedom to Speak Up Guardian, mentioned the advocates in the Weston Division would be actively engaged with the changes and improvements planned in the Weston Division and would be encouraged to share their thoughts and experiences with the new Managing Director in the Weston Division. Eric Sanders thanked the Board for the positive feedback. **Members resolved to receive the Freedom to Speak Up Annual Report for assurance**.	**Head of Corporate Governance**
14/05/21	**Hepatobiliary Service Peer Review on HPP**	
	William Oldfield provided a summary of the Hepatobiliary Service Peer Review. This external review had been conducted in 2020 following patient safety concerns raised in 2018 by a senior consultant. It had not been possible to substantiate these concerns at that time therefore the external review had been commissioned from the Royal College of Surgeons of England (RCS) who visited the Trust in February 2020. The case notes of individual patients had been reviewed and interviews were undertaken with the entire team and various stakeholders. The RCS then wrote to the Trust and confirmed that there were no patient safety issues but they had identified several deficiencies in the service related to data collection, organisation of staffing and working relationships. The Trust fully accepted the report and had constructed an action plan approved by the RCS with continuing engagement regarding progress of the plan. The RCS recently confirmed the action plan was approved and would remove the Trust from the monitoring process. The CQC and GMC had been kept updated. Jayne Mee, Interim Chair, thanked William Oldfield, Medical Director, for the report and confirmed that this had been approved. Jane Norman, Non-Executive Director, queried the internal concerns that instigated this process. William Oldfield, Medical Director, explained the individual that raised the concerns had been a party to the entire review	

	process and kept fully informed as the review progressed. Robert Woolley, Chief Executive, stated that the review had been an exemplary piece of work and congratulated William Oldfield, Medical Director, and his team for the work undertaken and the successful outcome.	
15/05/21	**Ockenden Assurance and Assessment**	
	Sarah Windfeld, Head of Nursing for Midwifery and Women's Services, was joined by Dr Sneha Basude, Clinical Governance Lead for Women's and Children's, to provide an update on the Ockenden Assurance and Assessment. The Ockenden Report had been published in 2020 after the investigation undertaken at Shrewsbury and Telford Hospitals and this had resulted in every Trust in the country being required to undertake an immediate assessment into maternity services. A thorough challenge and assurance process had been undertaken in the Trust and had involved Executive and Non-Executive Directors, and users of the services. The assessment had been reviewed with the Regional Chief Midwife who had altered some of the ratings; when the review had been submitted the Regional Chief Midwife had stated that the Trust was 71% compliant, with 3 areas only partially compliant. The Trust was now 91% compliant with 2 areas assessed as amber for leadership – this was regarding the lack of consultant midwife role in the Trust – it was noted that this was similar to the whole South West region. The Trust was amber for risk assessment and this had been rectified by undertaking risk assessment when booking patients and also at 36 weeks. Dr Sneha Basude, Clinical Governance Lead for Women's and Children's, confirmed that re-auditing would be undertaken and the use of an evidence portal was now in place. Evidence sharing would be undertaken going forward. Julian Dennis, Non-Executive Director, queried why there was no consultant midwife in the Trust. Sarah Windfeld, Head of Nursing for Women's and Children's replied this role had previously been in place and had been jointly funded by NBT and the UWE (University of the West of England). It was stated that the remit of this role varied nationally but was mainly focused on research and there was no concern that this role was not being covered in the Trust due to the configuration of the department. There was a good research team in the department and the unit had recently appointed education trainees and professional midwifery advocates were in place. The team had a good working relationship with medical colleagues. Deirdre Fowler, Chief Nurse, informed the Board that although it would be appropriate to explore whether a consultant midwife role was required in the Trust, she stated that it would be more beneficial to have a greater number of Band 6 midwives in post. **Action: Explore whether the Trust required a consultant midwife role**. Sue Balcombe, Non-Executive Director, stated that in her role as the Maternity Safety Champion, she had taken part in a 'Check and Challenge' Panel and had had been impressed by the honesty the Trust UHBW midwife team showed; the compliance had been rigorous and a positive experience to ensure learning was shared across the system. **Members resolved to receive the Ockenden Assurance and Assessment Report for assurance**.	**Chief Nurse**
16/05/21	**Transforming Care Q4 report**	
	Paula Clarke, Director for Strategy and Transformation, presented the Transforming Care Quarter 4 Report. It was noted that the Senior Leadership Team had discussed and prioritised Transforming Care priorities for 2021/22	

	with a focus on restoration including system projects. Transformation capacity had been appropriately directed towards supporting response to the pandemic and achievements were highlighted, particularly in the vaccination programme. Going forward, the ability for staff to have the opportunity to participate in Quality Improvement programmes and training was emphasised, with greater accessibility via online training. Partnership working was also developing with greater involvement with the University of Bristol into a formal leadership and management qualification. Julian Dennis, Non-Executive Director, mentioned there was no reference to 'delivering best value' in the report. Paula Clarke, Director of Strategy and Transformation, stated that no resource had been specifically dedicated to this but would clarify this. **Action: Head of Corporate Governance to write to the Transforming Care team, on behalf of the Board, to thank them for their great work in response to the pandemic and their involvement with the vaccination programme.** **Members resolved to note the Transforming Care Q4 Report for information**.	**Head of Corporate Governance**
17/05/21	**Capital Investment Policy**	
	Neil Kemsley, Director of Finance and Information, asked the Board to approve the Capital Investment Policy to the Board. The merger of the organisation reflected the Trust's turnover to accommodate guidance from NHSEI; this had been approved by the Capital Steering Group, the Senior Leadership Team and the Finance and Digital Committee. The document would be updated shortly once the Single Oversight Framework was implemented. **The Board agreed to approve the Capital Investment Policy**.	
18/05/21	**Quality Account update**	
	Deirdre Fowler, Chief Nurse, stated that the Executive Directors recently agreed that it would be appropriate to bring the Quality Account to the Public Board meeting in July 2021. The date agreed was appropriate as this would enable engagement with stakeholders. The Board agreed that the Quality Account should be submitted at the slightly later date than originally planned and that this was of paramount importance to ensure engagement with the stakeholders. **Members resolved to note the Quality Account update for information**.	
19/05/21	**Research and Innovation Report**	
	William Oldfield, Medical Director, presented the Research and Innovation Report as below: • This was the annual report for the previous financial year and it was acknowledged that this had been a unique year for research – the Trust had been one of the highest recruiting areas for vaccine trials in the UK. • The Trust had now taken over the University Clinical Research Centre and this had been converted to a new facility, the basis for the clinical research bid due to be submitted to NIHR later in the year. • Vaccine development would be a priority going forward with the Trust having a major role in this. • Non-COVID research had paused due to the pandemic, and this would be restarted in the coming months. • The team was in the process of submitting the first stage of a clinical	

	research facility bid, with the full application hopefully submitted in October. • The Trust had recently been awarded Academic Health Science Centre status, a successful year for Research and Innovation with the Trust established as a major research centre. Jane Norman, Non-Executive Director, congratulated William Oldfield and the Research and Innovation team for their great work and queried whether it would be possible to include benchmarking against other Trusts in future reports. William Oldfield, Medical Director, acknowledged this would be useful. **Action: Benchmarking against other Trusts to be included in the Annual Report for Research and Innovation**. **Members resolved to note the Research and Innovation Report for information**.	**Medical Director**
20/05/21	**Provider Licence Self-Certifications**	
	Eric Sanders, Director of Corporate Governance, informed the Board that the Provider Licence Self-Certifications report was required to be updated annually. All risks had been noted. **Members agreed to approve the Provider Licence Self-Certifications Report**.	
21/05/21	**Annual Review of Code of Conduct for Board of Directors (including Fit and Proper Persons Self-Certification)**	
	Eric Sanders, Director of Corporate Governance, informed the Board that the Annual Review of Code of Conduct for the Board of Directors (including Fit and Proper Persons Self-Certification) had been completed with no issues to highlight. **Members agreed to approve the Annual Review of Code of Conduct for the Board of Directors (including Fit and Proper Persons Self-Certification) for information**	
22/03/21	**Governors Log of Communications**	
	Eric Sanders, Director of Corporate Governance, presented the Governors Log of Communications to the Board as below: • A response had been submitted to the question regarding the digital transformation. • A response to the aerosol/infection transmission question was due to be submitted. • No response to date had been given to the question regarding training for different levels and types of management roles in the Trust. **Members resolved to receive the Governors Log of Communications for information.**	
23/05/21	**Register of Seals**	
	Eric Sanders, Director of Corporate Governance, updated the Board regarding the use of the Register of Seals as below: The Register of Seals had been used twice recently, once regarding the PPE storage in the TK Maxx Unit in the Galleries Shopping Centre and latterly for the purchase of St. James Court. **Members resolved to note the Register of Seals for information**.	

24/05/21	**Any Other Urgent Business** No items were raised.	
	Jayne Mee, Interim Chair, on behalf of the Board, thanked Mark Pender, Head of Corporate Governance, for all his great work over the previous years and wished Mark all the best in his new role. Matt Joint, Director of People, would be leaving the Trust shortly to take up a new appointment at Frimley Park Hospital; Matt was thanked for the great work carried internally and also externally with the local system; the learning academy, and the focus on diversity and inclusion. The Board wished Matt all the best in his new role and welcomed Alex Nestor as interim Director of People. The Chair closed the meeting at 1.30pm and thanked Members for attending and the members of the public who had viewed the meeting via YouTube.	
25/05/21	**Date of next meeting: 29 July 2021 via video conference**.	

University Hospitals Bristol and Weston NHS Foundation Trust

Public Trust Board of Directors Meeting
29 July 2021
Action Log

Outstanding actions from the meeting held on 27 May 2021					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Due date**	**Action Update**
1.	03/05/21	**Patient Story** Ensure updated communication/leaflets were available on the wards; explore whether pre-booked phone slots would be feasible.	Chief Nurse	July 2021	**Suggest action closed** Hard copy information leaflets removed during pandemic but signposted as available on request. Staffing does not facilitate this at present but work in progress. This action arose from the patient's family frustration at numerous unanswered telephone calls.
2.	03/05/21	**Patient Story** A written formal thanks to be written on behalf of the Board to Tony Watkin, Patient Involvement Lead, for the work he had undertaken to support the patient Brian Field and his family.	Head of Corporate Governance	July 2021	**Suggest action closed** Tony Watkin had worked when he was meant to be on annual leave to facilitate virtual visits with the patient's family.
3.	08/05/21	**Integration update** Further information regarding the Integration's digital convergence to be provided at the Finance and Digital Committee in July.	Director of Finance and Information	July 2021	**Work in Progress** Verbal update to be provided.
4.	09/05/21	**CQC Report and Action Plan for Weston** CQC Action Plan for Weston updates to be shared with the Board.	Chief Nurse	July 2021	**Suggest action closed** This would enable the Board to be aware of progress made/underway. This was on the agenda for the July meeting.
5.	10/05/21	**Integrated Quality and Performance Report** An update on the Restoration and Recovery work to be provided at the next Quality and Outcomes Committee meeting.	Deputy Chief Executive/Chief Operating Officer	June 2021	**Suggest action closed** An update had been provided at the Quality and Outcomes Committee meeting in June.
6.	13/05/21	**Freedom to Speak Up Annual Report** A written formal thanks to be written on behalf of the Board to Eric Sanders and Kate Hanlon for their great	Head of Corporate Governance	July 2021	**Suggest action closed** Completed.

		work to promote the Freedom to Speak Up campaign.			
7.	15/05/21	**Ockenden Assurance and Assessment** Explore whether the Trust required a consultant midwife role.	Chief Nurse	July 2021	**Suggest action closed** This would be considered in future ICS conversations. Although there were no concerns at the lack of this role in the department, it was thought this role could be beneficial at a system level.
8.	16/05/21	**Transforming Care Q4 Report** A written formal thanks to be written on behalf of the Board to the Transforming Care team for their response to the pandemic and their involvement with the vaccination programme.	Head of Corporate Governance	July 2021	**Suggest action closed** Completed.
9.	19/05/21	**Research and Innovation Report** Benchmarking against other Trusts to be included in the Annual Report for Research and Innovation.	Medical Director	July 2021	**Work in Progress** Verbal update to be provided.
10	05/03/21	**Emergency Preparedness Annual Report** The Emergency Preparedness Annual Report to be reviewed at the Audit Committee.	Head of Corporate Governance	July 2021	**Suggest action closed** Completed. Emergency preparedness report scheduled to be considered by the Audit Committee in July.
11	08/03/21	**Integration Update** Review the Weston integration plan to see what areas could be accelerated.	Director of Finance and Information	May 2021	**Work in Progress** Verbal update to be provided.
12	13/03/21	**Patient Complaints Report** The Patient Complaints Report to be updated to show year-on-year trends going forward and to be presented at the Quality and Outcomes Committee.	Chief Nurse	July 2021	**Work in Progress** Team capacity has not allowed progression – work ongoing.
13	14/03/21	**Six-monthly Safe Staffing Report** To include the consultant workforce data in the Six-monthly Staffing Report going forward.	Chief Nurse	September 2021	**Work in Progress** Report to be updated when next presented in September.
Closed actions from the meeting held on 27 May 2021					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
14	17/09/20	**Safe Working Hours Guardian Report** Implementation programme for the roll-out of e-	Director of	November	**Completed**

		rostering to be provided to the Board including timeframe.	People	2020	

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**Chief Executive Report**
Report Author	**Mark Smith, Deputy Chief Executive**
Executive Lead	**Mark Smith, Deputy Chief Executive**

1. Report Summary

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

2. Key points to note
(Including decisions taken)

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

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

The risks associated with this report include:
N/A

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

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

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

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

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Embracing change
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APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – JULY 2021

1. INTRODUCTION

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

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

3. STRATEGY AND BUSINESS PLANNING

The group received an update on the approach and delivery to the restoration programme and supported a commitment to non-recurrent resource for the programme.

The group received an update on the Weston integration programme and **approved** the programme re-set, noting financial proposals would be presented in September.

The group **approved** the Transforming Care priorities for 2021/2022.

4. RISK, FINANCE AND GOVERNANCE

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

The group **approved** Divisional Operating Plans narratives, next steps and timelines.

The group **approved** the 2021/2022 capital programme and noted the Capital Programme Steering Group would progress actions for finalising the detailed schemes within the allocations.

The group **approved** funding proposals for major medical and operational capital 2021/2022, noting further work required for some schemes.

The group **supported** the business case for the transfer of management of Weston General Hospital urology services from UHBW to North Bristol Trust, following staff consultation on 1 October 2021.

The group **received** an update on the BNSSG Stroke Programme.

The group **approved** the decision for the Trust to bid for the Thrombotic Thrombocytopenic Purpura (TTP) service.

The group **approved** proposals for Health Education England Continuing Professional Development 2021/2022 investment plans.

The group **approved** the development of the Trust action plan for implementation of the 6 key actions to ensure diversity of workforce increased year on year.

The group **approved** a recommendation that locally employed Associate Specialists be included in the choice exercise to transition to the new national 2021 contract.

The group **approved** a recommendation to ensure outcome measures and data collection was in place for all specialties.

The group **approved** options for bed base reconfiguration in the Bristol adult divisions, noting that it had not been possible to arrive at any option that would meet the requirement to restore elective capacity. The position and decision would be reviewed at the end of this financial year.

The group **approved** an option to increase the international nurse recruitment ambitions, noting that the Director of Finance would be reviewing costings further prior to final decision.

The group **approved** a Standard Operating Procedure around compliance with Test and Trace requirements to self-isolate.

The group **noted** the success of the hospital vaccination hub and the project closure.

The group **noted** the summary feedback letter following a core services inspection from the Care Quality Commission on 8-9 June 2021.

The group **noted** the progress made following the Care Quality Commission inspection at Weston General Hospital and the intention to close the current action plan and move remaining legacy actions into a single integrated Weston CQC action plan.

The group **noted** the action plan submitted following the Care Quality Commission focussed inspection of the Emergency Department of the Bristol Royal Infirmary in February 2021.

The group **noted** the progress made following the Care Quality Commission inspection of the Weston General Hospital Emergency Department in July 2020 and the intention to move remaining legacy actions into a single integrated Weston CQC action plan.

The group **received** an update regarding changes to the national quarterly staff survey reporting.

The group **approved** amended Terms of Reference for the Risk Management Group.

The group **approved** the Quality Accounts 2020/2021 for onward submission to the Trust Board.

The group **approved** the Annual Complaints Report 2020/2021 for onward submission to the Trust Board.

The group **approved** the Emergency Preparedness, Resilience and Response Annual Report for onward submission to the Trust Board.

The group **approved** proposed principles for agile and flexible working.

The group **noted** an update on the values and leadership behaviours review.

The group **approved** the recommendation for the temporary road closure of Terrell Street to enable work to install an extension to the district heating network.

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

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

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

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

The group **received** an update on progress of the Strategic Capital Programme prior to submission to the Trust Board.

The group **received** two Internal Audit Reports with limited assurance (Fire Safety and Weston Division Governance).

Reports from subsidiary management groups were **noted,** including updates from the Senior Leadership Team Delivery Group, Cancer Steering Group, Clinical Quality Group, Trust Research Group, Risk Management Group, Weston Integration Programme Board and the Cellular Pathology Performance Group.

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

5. RECOMMENDATIONS

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

Robert Woolley/Mark Smith
Chief Executive
July 2021

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Meeting of the Board of Directors in Private – 29 July 2021

Reporting Committee	**Quality & Outcomes Committee – meeting held on 16 July 2021**
Chaired By	**Julian Dennis, Non-Executive Director**
Executive Lead	**Mark Smith, Deputy Chief Executive and Chief Operating Officer** **Deirdre Fowler, Chief Nurse and Midwife** **William Oldfield, Medical Director**

For Information

The meeting considered a range of quality and access information and the following was highlighted and discussed:

- The Committee heard Chris Bourdeaux, Chief Clinical Information Officer, regarding the challenges the Trust had faced in improving venous thromboembolism (VTE) assessment compliance, with delays to implementation of the Electronic Patient Record impacting completion. It was noted however that learning from areas with outstanding performance, despite this challenge, was needed.

- The Deputy Chief Executive and Chief Operating Officer updated the Committee on restoration and recovery, explaining that staff were fatigued and with current pressures from non-elective care a graduated view of what accelerator work would be undertaken. A proposal had been agreed by Business SLT in response to the 3rd wave of COVID-19. The reconfiguration would result in impacts on the surgical team's ability to address waiting lists. As a result, conversations with the Trust's Estates team were underway to investigate what options exist in year "the art of the possible".

- The Medical Director advised the Committee that NHSEngland/Improvement (NHSE/I) had advised Trusts to cease undertaking prospective harm review panels and instead continue to review harm using root cause analysis and the serious incident process, though caveated that this situation would likely develop with a focus on bulk analysis of cases.

- The Medical Director also advised the Committee that the number of inquests had begun to rise post COVID-19 pandemic. Training had recently been held for staff in the medicine division on how to prepare for an inquest and this had been positively received. This would be rolled out to other divisions.

- The Learning from Deaths paper was received by the Committee, with 87% of deaths noted to have been reviewed by the Coroner following a significant amount of work undertaken by the intensive care unit team. The Committee queried the variance in use of ventilator reporting across the country, and it was explained that this was due to different approaches in reporting with some Trusts only including those ventilated in intensive care.

- The Maternity Perinatal Quality Surveillance Matrix was received by the Committee, alongside a contemporary updated flagging a backlog in induction of labour. The need for a system resolution was acknowledged.

- The Committee considered the monthly Root Cause Analysis and nurse safe staffing reports for assurance. Concerns regarding safer staffing were raised by the Chief Nurse as well as a fear that challenged nursing ratios could increase adverse impact on patients and impact negatively on staff wellbeing. Regular monitoring, mitigation and escalation was noted to be in place to avoid harm.

- Finally, both Strategic and Corporate Risks were reviewed by the Committee.

For Board Awareness, Action or Response

- The Committee reviewed the integrated quality and performance report, and it was reported that the Emergency Departments in the BRI and the Children's Hospital were both incredibly busy alongside an increase in COVID-19 admissions. Continued pressures were noted to be impacted elective procedures. It was noted that the outpatient improvement work was continuing at pace, and that mortality indices were doing well, but there was an increasing number of clostridium difficile cases both within the Trust and nationally. **The Committee reflected on the importance of system working and shared risk to ensure the best care for patients.**

- The EPRR Annual Report was noted by the Committee, prior to its review at Audit Committee and subsequently Trust Board. The Committee challenged whether the report detailed how the Trust would respond to the impact of climate change, i.e. extreme weather such as short bursts of heavy rain. It was agreed that this would be taken forward and reviewed by the risk team. **The Committee received the report for assurance and endorsed that it proceed to Trust Board for final approval and wanted a note of thanks to John Wintle for his work on Business Continuity and EPRR**.

- The Quality Account was also noted by the Committee, prior to its review at Audit Committee and subsequently Trust Board. The Committee challenged whether VTE should have been included in the forthcoming year's priorities, however the Chief Nurse provided assurance that the continued focus on VTE would continue, monitored by the Committee, irrespective of the Quality Account. **The Committee received the report for assurance and endorsed that it proceed to Trust Board for final approval**

- The Committee received a presentation on the new approach to Patient Safety Incident Response, noting that this was a very different to previous approached. The Committee endorsed the approach, expressing that it felt much more valuable, and would consider whether an extraordinary Committee meeting to discuss was needed.

- The Deputy Chief Executive and Chief Operating Officer noted that the new NHSE/I had published the new single oversight framework and would write out to QoC members as part of the review process that is undertaken when this is a new framework is published.

Key Decisions and Actions

N/A

Date of next meeting:	**26 August 2021**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors on 29 July 2021

Reporting Committee	**Audit Committee – July 2021 Meeting**
Chaired By	**David Armstrong, Non-Executive Director**
Executive Lead	**Neil Kemsley, Director of Finance and Information**

For Information

- The Committee received and noted the following four internal audit reports:
  - Care Quality Commission (Weston Action Plan)
  - Estates Management of Contractors
  - Divisional Governance/Management (Weston Division)
  - Limited Assurance Follow-Up – Fire Safety
- The Emergency Planning, Resilience and Response Annual Report was presented and the Resilience Manager attended the meeting to outline how business continuity plans were identified, in terms of need, and how they were developed and tested. The Committee were assured that there was a robust process in place.
- The risks and benefits of the integration with Weston were considered as part of the regular quarterly update. The challenges, given the pandemic and the operational pressures were discussed. It was noted that further conversations were being progressed about the timeline for the integration of services and the potential impact of the Healthy Weston programme.
- The Committee received regular updates on the following:
  - Losses and special payments
  - Single tender actions
  - Clinical audit forward plan
  - Committee Chair reports to describe the work of the other Board Committees including the Quality and Outcomes Committee, People Committee and the Finance & Digital Committee
- The Committee received assurance on the processes and actions to improve compliance with the declarations of interests, gifts and hospitality, and policy management. Good progress against the declarations process was noted, with the introduction of a new system, Declaflow, supporting the enhanced monitoring and reporting of compliance.
- Assurance on the procedural document management processes was provided and discussed by the Committee. Procedural documents included strategy, policy, standard operating procedures and clinical guidelines. A number of areas for improvement were identified including the procurement of a new Document Management System, which would reduce the current administrative burden and enhance the accessibility of documents, particularly for clinical staff, and enhanced reporting so that compliance could be monitored more effectively. The Committee asked for an update report at every meeting so progress could be monitored.

For Board Awareness, Action or Response
• The Audit Committee undertook a detailed review of the Strategic and Corporate Operational Risk Registers. The Committee welcomed the refreshed strategic risk register which better reflected the strategic risk profile and context within which the Trust was operating. The risks related to fire safety compliance were considered alongside the recent internal audit report, and the update from the Director of Estates and Facilities. The Committee asked for further clarity on the timescales to address the required actions. • The Committee received confirmation that controls were now in place to address the recommendations from the External Auditors following their review of the annual report and accounts. It was noted that KPMG, the incoming external auditors, would undertake a baseline assessment which would consider the controls implemented. • The Committee agreed the approach to undertaking its self-assessment which included using the HFMA's template questionnaire. The survey would be completed over the summer and the outcomes reported to the Committee and Board in October.
Key Decisions and Actions
There are no key decisions or actions to report to the Board.
Additional Chair Comments

Date of next meeting:	**26 October 2021**

Meeting of the Board of Directors on 29 July 2021

Reporting Committee	**Finance and Digital Committee**
Chaired By	**Martin Sykes, Non-Executive Director**
Executive Lead	**Neil Kemsley, Director of Finance and Information**

For Information

Digital

The Committee received an updated digital report to the meeting which highlighted the upgrade of Medway (v4) to Careflow (v5). This would support the implementation of new functionality particularly around clinical noting. The next steps to procure a new electronic prescribing system (ePMA) were discussed. The Committee agreed to have updates at each meeting on the ePMA project to provide greater oversight of the progress of the business case.

The risks to digital services were discussed, and in particular the risk relating to the possible failure of the Uninterruptable Power Supply (UPS) to computer room 1. The logistics to enable this to happen and the timescales were discussed and noted. The need for enhanced clinical engagement were also considered given the scale of change being implemented in relation to the digital strategy.

The Committee received a full briefing on the Trust's approach to cyber security, including the layers of protections in place, the internal and external assurances provided and the interface with the national systems.

Finance

The Committee received the finance report in a revised format which was welcomed by the Committee. The key points to note included:

- A net surplus of £0.387m was being reported against a plan of break-even at the end of month 3.
- The divisional position were broadly reporting an underspend against budget, even with a shortfall on the delivery against the annual savings target.
- Pay pressures were noted in Women's and Children's, Medicine and Weston Divisions, which were linked to known issues around substantive recruitment and the operational pressures being faced by the Trust.
- A two year savings plan was being developed to provide a longer term consideration of efficiency and productivity improvements. This was being supported through work with a number of peer Trusts to identify schemes which could be implemented at UHBW, in addition to looking at the Getting it right first time (GIRFT) information and other benchmarking data.

For Board Awareness, Action or Response

A full Business Case for a new electronic prescribing system would be developed and would be progressed through the decision making process.

The Committee considered the strategic and operational risks from a finance perspective and noted the mitigations in place.

A strategic review of capital would be presented to the Board in September, this

would include the options with respect to the pace and impact of the digital strategy.
Key Decisions and Actions
No key decisions or actions to report.
Additional Chair Comments

Date of next meeting:	**27 July 2021**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public –29 July 2021

Reporting Committee	**People Committee – meeting held on 27 July 2021**
Chaired By	**Bernard Galton, Non-Executive Director**
Executive Lead	**Alex Nestor, Interim Director of People**

For Information

The meeting considered a range of people and organisational development reports and the following were highlighted and discussed:

- The Integrated Quality and Performance Report was received, with Committee members informed that substantial conversations regarding quality had taken place the day prior at Quality and Outcomes Committee. The impact of staffing on patient flow was noted. Despite all of the current challenges: improvements in appraisal compliance were noted in 5 out of 8 divisions, with a 3% increase in Medicine, though the closure of the compliance gap by September was felt unlikely. A decreasing number of attendances at resuscitation training were noted and therefore actions to address were underway. The Committee agreed that exit interview data should be received at the next meeting, and sought clarity regarding the replacement for the Friends and Family Test. This would be provided following the meeting.

- A strategic discussion around long term workforce plans generated from the annual Operating Planning Process for 2021/22 took place, and while the need for the inclusion of social demographics and a roadmap for the future were flagged, the work underway and progress were acknowledged.

- Dr Tejas Netke, one of the Trust's junior doctors, attended the meeting to share a project that she had developed during her intercalation year. This focused on engaging medical management in organisational structures and key policies and how this could provide opportunities for personal development and lead to change and transformation. The Committee praised and welcomed the presentation with enthusiasm and encouraged sharing across the Trust and beyond.

- The psychological and physical exhaustion of staff was noted with concern, and the Committee discussed wellbeing and how the Trust was assessing the provision of support offered over the last year and the staff response to this. This feedback would be incorporated into a business case to continue and develop the wellbeing offer.

- The update regarding values was acknowledged with plans underway to test and design further with staff at end of august/ beginning of September. The Board would then further view at a seminar in September.

- A report summarising the existing, transitional and future strategy for leadership and development was received highlighting that funding for an external leadership development programme had been secured. A plan and roadmap would be received by the Senior Leadership Team in September, and the Committee encouraged that following this review that the update progress to the Council of Governors.

- Finally, both Strategic and Corporate Risks were reviewed by the Committee.

For Board Awareness, Action or Response

- The Committee were provided with an update on the recruitment activity underway across the Trust, with a particular focus on the overseas nurse programme and medical recruitment at Weston. The Committee had a number of questions in response and ultimately felt the report provided limited assurance. **Conversations would continue outside the Committee.**

- An update was received regarding diversity and inclusion alongside the bi-annual Equality, Diversity and Inclusion Report. The Committee praised the all-encompassing and comprehensive report and encouraged understanding all facets of EDI, not just those highlighted by the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). **The Committee received the report for assurance and endorsed that it proceed to Trust Board for final approval**

- The Freedom to Speak Up Guardian updated on the increasing concerns raised in Quarter 1, with a majority coming from the Weston site and in relation to attitudes and behaviours. The complexity of cases, and as result, longer resolution times were highlighted, however another 10 champions were noted to have been inducted, with 86 champions overall. The Committee acknowledged the complexity in addressing concerns related to culture, policy and behaviour but reinforced that until addressed, concerns would continue. This conversation continued into the agenda item regarding the new Resolving Conduct Concerns Policy which had been led by the Head of HR Services but created through collaboration with a task and finish group, staff side and other organisations. **The Committee approved the policy and endorsed that it proceed to Trust Board for final approval**

Key Decisions and Actions

N/A

Date of next meeting:	**28 September 2021**

Meeting of the Board of Directors on 29 July 2021

Reporting Committee	**Charity Committee**
Chaired By	**Jayne Mee, Interim Chair**
Executive Lead	**Paula Clarke, Director of Strategy and Transformation**

For Information

The Committee:

- considered a summary of fund balances as at 30 June 2021 and asked for support to be given to staff to access the charitable funds.
- received and noted an update on the investments held by the charity.

For Board Awareness, Action or Response

The Committee:

- received a report from Paul Kearney, Chief Executive of Above & Beyond, on their plans to change the name of the Charity to better reflect their role in supporting the whole of UHBW, following the merger between UH Bristol and WAHT.
- received assurances about the communications and engagement plans to support the proposed merger of the Weston Charity with Above & Beyond. This included how Above & Beyond would work with fund holders, support staff to promote fundraising and to access charitable funds, and how they would work collaboratively with existing charitable partners to support Weston General Hospital.
- considered the revised terms of reference for the Committee and recommended their approval by the Board.
- received an update on the plans to merge the Weston Charity with Above & Beyond, and noted that all of the regulatory and statutory requirements had been met, that the documentation to support the transfer had been agreed, and transition plans including those relating to communications and engagement were being developed. A final decision would now be required by the Trustees of Above & Beyond and the Board, acting as the Corporate Trustee for the Weston Charity.

Key Decisions and Actions

The Committee approved a bid for matched funding from the Arts Programme Director for £10k to support the Weston Arts and Health Week 17th – 26th September 2021.

Additional Chair Comments

Date of next meeting:	**September 2021**

University Hospitals Bristol and Weston NHS Foundation Trust

Terms of Reference – Charity Committee

Document Data	
Corporate Entity	Charity Committee
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Robert Woolley, Chief Executive
Document Owner	Director of Corporate Governance
Approval Authority	Board of Directors
Review Cycle	12 months
Next Review Date	

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision (Major/Minor)**	**Description of Revisions**
18/03/2020	1	Director of Corporate Governance	Major	Initial draft for comment
12/07/2021	2	Director of Corporate Governance	Minor	Annual review. Logo change

Contents

1. Constitution of the Committee

1.1. The Trust is the Corporate Trustee of the group of charitable funds registered with the Charity Commission under the charity registration number 1057589 in the name of Weston Health General Charitable Fund.

1.2. The Board of Directors, acting as the Corporate Trustee, hereby resolves to establish a Committee to be known as the Charity Committee.

1.3. Its constitution and terms of reference shall be as set out below, and will be subject to amendments approved by the Corporate Trustee.

2. Stakeholder Assessment

2.1. The Stakeholders of the Charity Committee are identified below:

Internal (accountable to)

- Corporate Trustee (Board of Directors)

Internal (peer)

- None

Internal (reporting to CC)

- Fund Budget Holders

External

- Charity Commission
- Investment Brokers
- External Audit

Stakeholder Analysis

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

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

2.4. **Requirements from CC** - Explains what the Charity Committee is required to do based on the requirements of the stakeholder.

2.5. **Inputs into CC** - Explains what needs to be provided into the Charity Committee to allow it to fulfil the requirements of the stakeholder.

Internal Stakeholder Community					
Stakeholder	**Requirements from CC**		**Inputs to CC**		**Section Reference**
	General	Formal Deliverables	General	Formal Deliverables	
Corporate Trustee (Board of Directors)	Oversee the running of the Charity	CC Chair Report (after each meeting) CC Annual Report		Charity Strategy Approve Terms of Reference	3.1 8.1
Fund Budget Holders				Update on expenditure and plans	7.1

External Stakeholder Community					
Stakeholder	**Requirements from CC**		**Inputs to CC**		**Section Reference**
	General	Deliverables	General	Deliverables	
External Audit	Guidance on possible scope of annual audit			Audit Report Management Letter of Representation	7.1.5
Investment Brokers	Guidance on investment portfolio			Report on investments to each meeting	7.1.9
Charity Commission	Meet good governance in the Charity Governance Code			Annual self-assessment of compliance in the CC annual report	4.1 7.2

3. Purpose

3.1. The purpose of the Charity Committee is to:

3.1.1. Oversee the operation of the Weston Health General Charitable Fund to ensure it is managed and operated in accordance with the governing documents and comply with relevant legislation and guidance from the Charity Commission, Fundraising Regulator and Information Commissioners Office.

3.1.2. Review the operation of the Charity, providing assurance to the Corporate Trustee on the development and delivery of the Charity's Strategy.

3.1.3. Provide assurance to the Corporate Trustee on the efficient and effective running of the Charity's activities and to oversee the implementation of an infrastructure appropriate to the efficient and effective running of the Charity.

3.1.4. Oversee the smooth and compliant transition of the funds held in trust to a charitable partner

4. Authority

4.1. The Committee is authorised to ensure that the Charity acts within the terms of its Declaration of Trust, appropriate legislation, Charity Commission guidance and should provide the Corporate Trustee with assurance that the Charity is properly governed and well managed across its full range of activities.

4.2. The Committee is authorised to seek any information it requires from any employee of the Trust. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain legal or other independent professional advice and to secure the attendance of advisors with such expertise that it considers necessary.

4.3. The Committee is authorised by the Corporate Trustee to make decisions

within its terms of reference, including matters specifically referred to it by the Corporate Trustee.

4.4. The Committee may establish sub-committees for a specific purpose. For example a Fundraising Appeals Committee.

5. Membership and attendance

5.1. The membership of the Charity Committee is appointed by the Board of Directors from amongst the Executive and Non-Executive Directors of the Board and shall consist of not less than five members.

5.2. The usual members of the Committee will be:

- Three Non-Executive Directors one of whom will chair the Committee.
- Director of Finance
- Director of Strategy and Transformation

5.3. In the absence of the appointed Committee Chair, another Non-executive will chair the meeting.

5.4. The following officers are expected to attend meetings of the Committee at the invitation of the Chair:

- Financial Controller
- Director of Corporate Governance
- Investment Brokers (as required)
- Fund Budget Holders (as required)

5.5. The Committee can request the attendance of any other director or senior manager if an agenda item requires it.

5.6. Attendance at meetings is essential. In exceptional circumstances when an Executive Director member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf.

6. Quorum

6.1. The quorum necessary for the transaction of business shall be three members including at least the Committee Chair and the Director of Finance (or their nominated deputy).

6.2. A duly convened meeting of the Charity Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable as set out in these terms of reference.

7. Duties

7.1. The Charity Committee shall discharge the following duties on behalf of the Board of Directors:

7.1.1. To ensure that best practice is followed in terms of guidance from the Charity Commission, and professional financial and investment advisers, where appropriate.

7.1.2. To ensure that appropriate policies and procedures are in place, consistent with the purposes of the Funds.

7.1.3. To review investment income and the arrangements with the investment brokers at regular intervals.

7.1.4. To review the Scheme of Delegation for charitable funds on a regular basis and recommend changes where appropriate.

7.1.5. To agree Fund budget holders proposals for income and expenditure on an annual basis or more frequently if appropriate.

7.1.6. To ensure that a separate register of interests is compiled for both Trustees and Fund budget holders, and that it is reviewed and updated on a regular basis.

7.1.7. To approve fundraising policies in conjunction with the Director of Finance, ensuring compliance with statutory requirements.

7.1.8. To ensure that any proposals for equipment purchases are consistent with Funds' objectives and overall Trust Business Plans.

7.1.9. To oversee the management of investments. The committee will ensure the investment brokers are aware of the overall objectives for the use of charitable and non-charitable funds and of the risk considerations.

7.1.10. To ensure that information from Investment brokers is received in a timely manner and that the service is market tested at regular intervals.

7.1.11. To ensure that all research monies paid into charitable funds meet the criteria for charitable status as specified by the Charity Commission.

7.1.12. To review the number of funds on an annual basis and undertake a programme of rationalisation, where appropriate.

7.1.13. To approve any requests to set up new funds and cost centres.

7.1.14. To decide the bases of apportionment for investment income and administration costs respectively.

7.1.15. To arrange an annual audit or inspection of the Funds as required.

7.2. The Charity Committee will seek to ensure that all donations, sponsorship, legacies and other income that may be received by the Charity is given on terms that permit flexibility in its use, consistent with overall requirements of the Charity Commission and other bodies set out in this document. Where necessary it will seek advice from the Charity Commission.

8. Reporting and Accountability

8.1. The Chair of the Charity Committee shall report to the Board of Directors on the activities of the Committee.

8.2. The Chair of the Charity Committee shall make whatever recommendations to the Board deemed by the Committee to be appropriate (on any area within the Committee's remit where disclosure, action or improvement is needed).

9. Administration

9.1. The Trust Secretariat shall provide administrative support to the Committee.

9.2. Meetings of the Charity Committee shall be called by the Trust Secretariat at the request of the Committee Chair.

9.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting.

9.4. Supporting papers shall be made available to Committee members no later than three working days before the date of the meeting.

9.5. A member of the Trust Secretariat shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and those in attendance.

9.6. Draft Minutes of meetings shall be made available promptly to all members of the Committee.

10. Frequency of Meetings

10.1. The Committee will meet four times a year and will be set in advance as part of the planning of the Board of Directors/Corporate Trustee and Committee meetings annual calendar of business. The meetings will be scheduled to enable timely reporting to the Corporate Trustee meeting.

10.2. Further meetings can be called at the request of the Committee Chair.

10.3. Decisions may be taken by written resolution upon the agreement of the majority of members of the Committee in attendance, subject to the rules on quorum.

11. Review of Terms of Reference

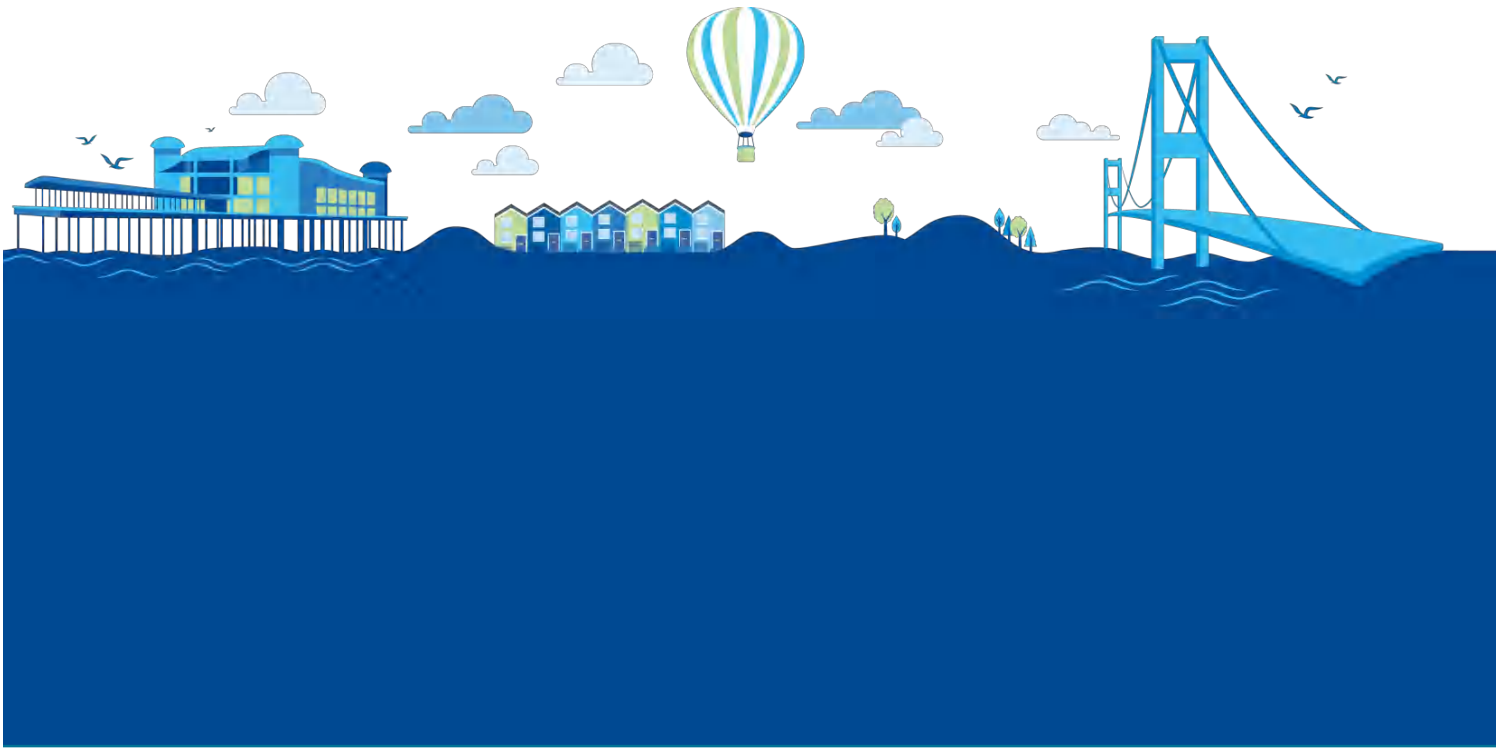
11.1. The Committee shall, at least once a year, review its own performance and Terms of Reference to ensure it is operating at maximum effectiveness.

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Healthier Together Integrated Care System (ICS) monthly update

July 2021



1. Introduction

This monthly report provides an update on ongoing work in relation to the Healthier Together partnership – our Integrated Care System (ICS) for Bristol, North Somerset and South Gloucestershire.

Topics highlighted may vary from month to month. If you would like to receive an update on a specific area of system working, please let us know.

This month's report covers:

- Progress on our Integrated Care System development
- ICS Chair advert
- New diagnostic scanners for BNSSG
- Trauma and adversity informed system
- Healthier Together Support network for staff
- Community Phlebotomy Service
- Integration of Bristol Health Partners Academic Health Science Centre (AHSC) within the ICS
- Urgent and Emergency Care Collaborative
- Healthier Together transformation report and 'campaign maps'

2. Progress on our integrated care system development

The Health and Care Bill is now working its way through Parliament with its second reading having taken place on 14 July 2021. The content is largely as anticipated based on the guidance to-date, but we'll be reviewing this in detail and are expecting further updated guidance over the coming weeks.

As well as the Design Framework last month, we've now also seen the publication of the Employment Commitment from NHSEI. This document sets out guidance around the proposed changes and how employees will be supported through the transition period.

Over recent weeks we've had feedback on our draft ICS Memorandum of Understanding (MOU) and supporting frameworks from the Healthier Together Executive Group and Partnership Board. Our ICS MOU focuses on principles for how we work in partnership, and formalises our ways of working together as an ICS for the benefit of the population of BNSSG.

As a reminder, our ICS MOU:

- Memorialises **how we work together** as Healthier Together partners **and with the people and communities** we serve
- Describes our **shared vision, values, and principles**
- Defines how we intend to **evolve and build on the work we do in partnership** to achieve our system ambition
- Details how we want to **make decisions, resolve disagreements, manage risk, and manage conflicts**

We are now working with constituent organisations to gather further feedback on our ICS MOU before signing off by Partnership Board in the autumn.

3. ICS Chair advert

On 27 July, NHS England/Improvement (NHSE/I) published a national advert for 17 ICS Chair roles, including the Chair for Bristol, North Somerset and South Gloucestershire (BNSSG).

The advert went live at 3pm and the microsite can be accessed via this link:

> Non-executive opportunities in the NHS » Bristol, North Somerset and South Gloucestershire Integrated Care System (ICS), Chair (england.nhs.uk)

The 17 ICS Chair roles have been advertised nationally and the local appointment processes will be coordinated regionally. Key stages in the appointment process will include:

- Selection Panel (i.e. stakeholder engagement session)
- Interview Panel.

The NHSE/I Regional Director will chair the Interview Panel and agree the composition of the Selection Panel and Interview Panel.

We understand that the recruitment and appointment processes will be designed to promote Equality, Diversity and Inclusion, including in determining the membership of the Interview Panel. We have suggested that local representatives for both of these Panels be drawn from the Partnership Board membership.

The adverts are due to go close 23.59 on Tuesday 17 August. Selection processes are planned to be completed by 15 October 2021.

4. New diagnostic scanners for BNSSG

Significant additional diagnostic capacity is being introduced across BNSSG. This includes a new MRI scanner and three new CT scanners across the system. The investment will improve patient waiting times and help with recovery, following the capacity loss associated with the Covid-19 pandemic.

The new MRI scanner is sited at Cossham Hospital and has been brought in as part of the national programme to replace ageing scanners. It will produce better quality, faster scans that should make diagnosis of diseases even easier. A CT scanner has been installed at Cossham as well.

This additional capacity has been procured as part of the Adapt and Adopt Programme and will significantly help achieve the ambitious recovery targets that have been set in BNSSG. The scanner will help bring diagnostic capacity back to pre-Covid levels as soon as possible.

An additional CT scanner, the first to be sited at South Bristol Community Hospital, is expected to be put in place over the summer and funding has just been secured for another CT scanner at Weston General Hospital.

5. Trauma and adversity informed system

The BNSSG Executive Group agreed to support recommendations from the Mental Health and Learning Disabilities and Autism Steering Group for developing Trauma - Informed Practice within the ICS.

Research shows a range of positive impacts where trauma and adversity-informed ways of working have been established including Psychological safety; Recovery and empowerment; Organisational processes; Staffing and Safeguarding.

> *"A trauma-informed approach will seek to provide long-term, reliable support. Instead of isolation and disempowerment, it will seek to bring people together, rebuilding relationships, and giving all members of the community a voice in planning for recovery. And, where there has been loss, it will support people to grieve and come to terms with a changed future."*
>
> *(Centre for Mental Health, 2020)*

The recommendations supported by the Executive Group included:

- Supporting the development of a Trauma and Adversity Informed Plan for the system; and,
- Adopting a set of principles for the development of trauma informed practice in BNSSG (see link below)

Item 5.3 BNSSG Principles for Trauma

6. Healthier Together Support Network for staff

A new and exciting service has just launched for health and care staff in Bristol, North Somerset and South Gloucestershire.

Funded by national government, the 'Healthier Together Support Network' has been set up in response to the extraordinary pressure our teams have been under during the COVID-19 pandemic.

As part of the service a team of clinical psychologists now offer:

- **For all staff:** psychological assessments and 1:2:1 therapy for work-related trauma
- Training workshops, webinars and explainer videos on wellbeing related subjects. You can read details on the 'Help for me' section of the Healthier Together Support Network web pages. You can book on these free courses now.
- **For managers:** 1-hour consultations with a trained psychologist to help plan steps that can be taken to support individuals or rebuild team relationships, plus training workshops and collated resources. You can read details on the 'Help for my team' section of the Healthier Together Support Network web pages.
- **For leaders:** the offer of joining a leadership meeting to run a facilitated session, helping people to reflect on the impact of recent experiences on staff wellbeing and plan ahead. See the 'Help for my team' pages.

This service has been set up to complement existing wellbeing services that may be offered by individual organisations across the system.

For more information see the Healthier Together Support Network web pages, where you can also see a handful of staff tell their stories about how they have been affected by and are coping with work since the pandemic hit.

7. Community Phlebotomy Service

A new, improved community phlebotomy (blood samples) service is now live across much of BNSSG, with changes to the service expected to improve patient safety and streamline the process of samples being taken, analysed, and acted upon.

It means some hospital specialties are now able to request blood tests using the online ICE system, so that patient results go direct to consultants. Work will continue to ensure all remaining specialties go live with this new approach in the autumn.

Previously, General Practice colleagues took responsibility for the phlebotomy procedure, interpretation, communication and risk-holding associated with a patient's results.

This new approach has come about by colleagues working together to seek improvements for patients, starting by addressing the governance and funding issues with input from primary care, local trusts, public, CCG and the Local Medical Committee. GP practices will now be reimbursed for taking blood tests on behalf of secondary care.

For patients, safety is improved with results going to the person who can interpret them best.

It also means better care as the whole process is streamlined and care is more often delivered closer to home, particularly in the case of outpatients whose follow-up blood tests are more likely to be done locally and then communicated by video or phone call, removing the need for repeat hospital visits.

For more information please contact Dr Geeta Iyer.

8. Integration of Bristol Health Partners Academic Health Science Centre (AHSC) within the ICS

The Partnership Board has approved recommendations to make best use of the academic research, implementation and evaluation activities undertaken by Bristol Health Partners (BHP) Academic Health Science Centre (AHSC) to support the work of the Healthier Together ICS.

The proposed approach aims to optimally integrate the excellence in research, innovation and service transformation undertaken by the AHSC with the aims and objectives of the ICS.

Key recommendations include:

- Bristol Health Partners Executive Group should act as a new Research and Innovation Steering Group for BNSSG ICS. The R&I Steering Group would initially report to the Healthier Together Executive Group and continue reporting to the Bristol Health Partners AHSC Board, who would have ultimate control of the Partnership's budget and work programme.

- Through a seminar session, the BNSSG ICS Partnership Board should consider the vision for research and innovation in the ICS to drive the work of a new R&I Steering Group.

- Bristol Health Partners AHSC representatives should continue and expand involvement in ICS programme steering groups, and specific programmes and projects, to ensure that current and planned research and innovation activities align with the work of the ICS.

- The AHSC will work with the ICS People Steering Group to develop proposals for innovation in health and care workforce education and development.

9. Urgent and Emergency Care Collaborative

The Urgent Care Steering Group (USCG) commissioned a review of the urgent and emergency care programme.

The primary objectives were to understand why our current approach was not delivering anticipated outcomes and to recommend a new approach to the delivery of the Healthier Together (HT) Urgent and Emergency Care (UEC) strategy.

The review reported to UCSG in June. A key recommendation from the review that is now being taken forward is the unification of the UEC improvement and transformation portfolio to be delivered by a new Urgent and Emergency Care Collaborative (UEC Collaborative).

The UEC collaborative will be multi-professional, bringing together clinical and managerial leads from across the system, including the VCSE sector.
The UEC collaborative will split the portfolio into defined work packages, make connections and identify and manage interdependencies. The collaborative will oversee the development of a BI dashboard which will be consistently reviewed and developed to ensure the programme is driven by the data.

A UEC Collaborative hub will coordinate delivery of the UEC portfolio through multi-professional delivery networks will be established – charged with delivery of defined work packages, using the model of the NHS 111 First programme.

Setting up the UEC collaborative hub will be the priority, and this will be done in parallel with initiation of the delivery networks below:

- Minor illness and injury
- System navigation (based on existing Think 111 programme)
- System management

Second phase implementation will follow for

- Targeted populations: high impact/ intensity users
- Specialised network care
- Integrated Care Partnerships UEC model for localities (based on current community urgent care delivery group

10. Healthier Together Transformation Report and 'campaign maps'

Healthier Together programme managers have produced 'campaign maps' to provide a visualisation of forward plans for each of the Healthier Together transformation steering groups (copy attached below). These will be updated regularly and circulated quarterly.

Campaign Maps MASTER.xlsx

Key achievements highlighted in the Healthier Together transformation reports, in addition to those described elsewhere in this report, include:

- **Social prescribing -** The Elemental Social Prescribing platform has been rolled out to all PCNs; the aim is to have it installed on all GP practice computers by the end of July.
- **Elective Accelerator Pay harmonisation -** People Steering Group ratified an agreement to support the BNSSG's Accelerator pilot in respect of pay rates for additional hours worked by UHBW, NBT and Sirona staff. Across all organisations there is a variation in both Agenda for Change WLI rates and Medical Extra Contractual rates, so it has not been possible for all organisations to agree a single rate for Accelerator across BNSSG, however, variation in the rates has been reduced through the collaboration of all partners.
- **Employee Value –** Created virtual work experience materials, including flyer, social media ads and 11-page workbook.
- **Annual Health Checks for people living with learning disabilities -** 69% of people with learning disabilities in BNSSG have received Annual Health Checks and Health Action Plans (our goal was 67%).
- **Learning Disabilities & Autism Keyworker Pilot –** BNSSG has gained funding for a Keyworker Pilot to support young people with the most complex needs (initially those at risk of admission or in hospital) to ensure they receive appropriate personalised, integrated community support.
- **Improving support for minority ethnic groups living with Learning Disabilities and Autism -** Our new engagement programme to improve support for people with Learning Disability and/or Autism from minority ethnic communities has begun, supported by Autism Independence.
- **Community Mental Health -** Target Operating Model and associated supporting documents (finance and response process) have been released to shadow Integrated Care Partnerships (ICPs) to develop place-based models of community mental health support.
- **Suicide Prevention -** launched our Zero Suicide prevention initiative; a new BNSSG service for people bereaved by suicide; and BNSSG's real-time suicide surveillance approach.
- **Urgent care -** A mental health 111 model has been developed for a local pilot.
- **Health Inequalities –** The CSU are pseudonymising the waiting list data to enable analysis using a wide range of attributes linked to health inequalities.
- **Digital Health -** Supporting people with Learning Disabilities: all 30 self-care app licences now deployed and users engaged in self-care activities.

The Healthier Together Office – If you have any questions or would like to see a specific topic covered in the next update, please contact bnssg.healthier.together@nhs.net.

Meeting of the Board of Directors in Public on Thursday 29th July 2021

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

1. Report Summary

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

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

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

2. Key points to note

There are **12** risks on the Strategic Risk Register; this is summary of the action taken to manage the risks during the last financial quarter :

<u>Points to note:</u>

- 3 new risks
  - 5277 - Education Strategy
  - 5317 - Integrated Care System
  - 5369 - Service model for WGH
- 1 risk increased
  - 416 - Financial Strategic Plan
- 2 risks closed
  - 2640 - Commissioning of Services
  - 2643 - STP System Strategy

3. Risks

See attached appendix.

4. Advice and Recommendations:

This report is for **ASSURANCE**

5. History of the paper

Executive Directors Meeting	30/06/2021
Risk Management Group	13/07/2021
Senior Leadership Team	21/07/2021
F&DC and QOC (relevant risks)	26/04/2021
Audit Committee	26-27/04/2021
Trust Board	29/07/2021

Alignment with Strategic Priorities

The Trust has identified 6 strategic priorities to support delivery of its vision.

The annual corporate objectives have been formulated to support the delivery of the strategic priorities. The RAG ratings against the achievement of the 2020/21 corporate objectives is shown in the second column.

The strategic risks identified that may have an impact of the achievement of the strategic priorities, are noted in the third column.

STRATEGIC PRIORITIES	Corporate Objective RAG*	STRATEGIC RISKS
1 – **Our Patients**: We will excel in consistent delivery of high quality, patient centred care, delivered with compassion.		5369
2 – **Our People**: 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.		737, 2646, 2694, 5277
3 – **Our Portfolio**: We will consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focussing on core areas of excellence and pursuing appropriate, effective out of hospital solutions.		2642
4 – **Our Partners**: We will lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve.		3472, 5317
5 – **Our Potential**: We will be at the leading edge of research and transformation that is translated rapidly into exceptional clinical care and embrace innovation.		2633, 2741, 2992
6 – **Our Performance:** 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.		416

Taken from Document – 4.40a Corporate Objectives 2021-22 v1.0 13Jul2021

Risks to Enabling Strategies

STRATEGY	RISKS
Communications Strategy	Nil
Digital Strategy	2633
Estates Strategy	2642
Financial Strategy	416
People Strategy	737, 2646, 2694, 5277
Quality Strategy	5369
Research Strategy	2741
Sustainability Strategy	3472
Transformation Strategy	2992
Trust Strategy	5317

Themes of Strategic Risks

- Workforce Recruitment
- Workforce Retention
- Leadership capacity
- Trust Finances
- Research Activity
- Transformation Activity
- Sustainability Agenda
- Trust Estate
- Trust Digitisation
- System/Provider Collaboration

Good practice suggests that Board committees should use the BAF as a tool for delivering their responsibilities.

Considering the following prompts when reviewing strategic risks could be beneficial:

- Are there any identified gaps in assurance?
- Are mitigating plans in place?
- Is there good evidence that risks are being effectively managed?
- What specific action is the committee to commission for review at its next meeting?

New Risks

New Strategic Risks		
5277	**Risk that the objectives of the Trust wide multi-disciplinary education strategy are not delivered**	**12**
	Education is one of the key strategic enablers as part of a University Teaching Hospital alongside that of research and clinical services. In 2019 a Trust wide multi-disciplinary education strategy was approved with a vision and aligned strategic priorities. Education is one of the Trust's core responsibilities and essential to ensuring our commitment to developing our people and, in turn, providing outstanding and safe clinical services. The education strategy encompasses an action plan for the oversight and coordination of education across the Trust. This activity has also supported the creation of new models of education and investment business cases.	
5317	**Risk that the Integrated Care System Implementation reduces the Trusts decision making powers**	**12**
	The ICS is developing and objectives are being worked up currently and through this work system level risks will be identified to the achievement of its objectives. Delivery of the Trust priorities and objectives will be impacted by the changes (positive & negative) and this will require a consequent review of existing risks and identification of new risks, however the biggest know current risk is the changes to the Trusts decision making powers and the impact of the system capital expenditure limits (CDEL) on the Trust.	
5369	**Risk that the Trust is unable to deliver a suitable service model for Weston General Hospital**	**16**
	If the Trust is unable to design and deliver a suitable service model for Weston General Hospital the ambitions and vision around the integration of clinical services across Bristol and Weston and Healthy Weston may not be achieved and services across the Weston campus may be unsustainable and non-compliant with CQC Regulations.	

Existing Risks

Quarterly update on existing Risks		
416	**Risk that the Trust fails to achieve the objectives of its financial strategic plan**	**15**
↑	The Trust Board approved the 2021/22 Financial Plan at its meeting on 27 May 2021. The plan included an initial risk assessment including strategic financial risks. The risk has been updated accordingly to align with the approved financial plan. The Trust's Strategic Capital Review was formally concluded and signed-off at Strategic SLT on 02 June 2021. However, at the time of writing, national planning regarding the revenue financial regime beyond 30 September 2021 remains outstanding. However, national planning guidance is expected this Summer and its is hoped this guidance will enable a credible refresh of the Trust's revenue Long Term Financial Plan and Financial Strategy by the Autumn.	
737	**Risk that the Trust is unable to recruit sufficient numbers of substantive staff**	**16**
↔	The Trust's nurse agency supply which is the most significant volume of the Trust's agency use continues to be managed through a neutral vendor who has contractually responsibility to ensure that agency workers comply with the mandatory NHS employment checks. The Trust's AHP agency supply which is relatively small is also now managed through a neutral vendor who has is also contractually responsibility to ensure that agency workers comply with the mandatory NHS employment checks. The Trust's use of non-clinical agency is minimal in light of NHSE controls which came into place in September 2019 to restrict the use of non-clinical agency usage.	

	In the past quarter the Trust has appointed a new neutral vendor for the provision of medical agency workers who will take over supply from August 2021 and as a result provide increase assurance over employments checks. Currently the Weston supply of medical agency staff is through a neutral vendor and the Bristol supply through a master vendor.	
2633	**Risk that Trusts IM&T Systems fail to deliver the required levels of efficiencies**	**8**
⇔	The Digital Hospital Programme Board's remit includes ensuring that the systems within the Digital Hospital Programme can enable clinical efficiencies. To that end the Board has recently reviewed challenges with the Electronic Document Management System and Scanning Bureau turnaround times. An investment proposal to make improvements is expected in July. The Board has also requested an outline business case on viable options for the Trust to return to using an EPMA solution. The Board is due to review its Terms of Reference in light and will consider whether any changes are necessary to ensure the Programme is owned and managed by all divisions.	
2642	**Risk that the Trust is unable to invest in modernising the Trust estate**	**6**
⇔	The rapid review of the strategic programme was completed in April 2021. Schemes were assigned categorisation for delivery: • Category 1 - Years 1-2 (additional ward capacity staff wellbeing, medical education) • Category 2 - Years 2- 4 (BEH, dermatology, NICU, StMH level E, endoscopy) • Category 3 - Years 3 - 5+ (UEAC, Theatres, BHOC expansion, BRHC expansion. The Category 1 schemes are now actively being designed or delivered, the Category 2 & 3 schemes are being scored against key priority metrics and moderation will be undertaken by the senior management teams to determine the sequencing of the programme.	
2646	**Risk that the Trust has insufficient leadership capacity**	**12**
⇔	A proposal for senior leadership development is being re-worked and will further support the work undertaken in partnership with Co-create. Senior leaders continue to access the systems leadership programme, a new cohort has recently commenced. OD are working in collaboration with the Education and Learning team to develop a renewed approach to the Organisational Leadership and management offer: In collaboration with the Education and learning team, a contract has been secured with NSU media who will provide digital Leadership and management solutions which will go live in the autumn.	
2694	**Risk that Trust is unable to retain members of the substantive workforce**	**12**
⇔	A corporate culture and people plan has been developed focused on work programmes in response to the staff survey. This will be monitored through People and Education Group and People Committee. This is supported by divisional culture and people plans which are in place and managed by divisional leadership teams. These plans will be further supported by the introduction of the quarterly staff survey cycle which commences in July 2021 focusing on gaining the views of our staff who work in the bank. The values review programme is underway and a status update will be provided by the end of July as we go into the 'design' phase of the programme ahead of roll-out in the autumn.	
2741	**Risk that Research and Innovation is not adequately supported**	**9**
⇔	Work to develop and submit grants is ongoing: four pump priming grants which should ultimately lead on to NIHR grant submissions have been awarded, three NIHR RfPB grants are through to full application stage and we have submitted grants totaling £1.45m to NIHR.	

2992	**Risk that benefits of transformation, improvement and innovation are not realised**	**6**
⟷	The QI training programs are now fully restored following the pause due to Covid. In April 2021 six divisional teams commenced QI Gold and the QI Bronze and Silver training capacity will be expanded from September 2021 to recover the training trajectory. The number of QI faculty members has grown to 45 to support, coach and mentor staff undertaking improvement projects. Feedback from the managers' survey and the leading and supporting improvement survey, will inform development of the leading for change modules in the Leadership and Management Development Programme. Feedback from the staff diagnostic tool survey will inform the development of the QI programme in extending its reach and addressing barriers to improvement and the 2021/22 Transforming Care priorities have been discussed and agreed with SLT.	
3472	**Risk that the Trust fails to make a positive impact on combatting climate change**	**10**
⟷	The Trust is developing the climate risk framework to ensure Trust risks are fully captured. Delivery and reporting of the Sustainability team is aligned across Bristol and Weston, with combined data reported for Travel, Waste and Energy. The Healthier Together sustainability and health group is established and links to the regional NHSE/I Greener NHS and ICS sustainability SROs and reports to the Health and Wellbeing Board. Coffee cup recycling with the 'For Cups Sake!' recycling scheme started in June. Metal recycling is being trialed in Weston theatre areas, electric vehicle charging points have been installed and the cycle to work scheme have been extended. The Salix funded heat de-carbonisation phase 2 de-steaming is underway and is progressing with the feasibility and tendering of upgrades for Weston district heating efficiency, LED, solar photovoltaics (PV), insulation and BMS progressing. The review of the sustainable procurement gap analysis against ISO 20400 is complete, further actions required were identified.	

Risks Closed

Closed Strategic Risks	
2640	**Risk that services are not commissioned at levels of forecasted demand**
	Risk closed in light of changes to the commissioning of services through ICS and any updates will be picked in in risk 5317.
2643	**Risk that the STP fails to deliver a system strategy**
	This risk has been superseded by risk 5317

The current and target assessments of risks are shown below:

Risk ID	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/211	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22		Target
416	9	9	9	9	9	9	9	9	15		4
737	12	12	12	12	16	16	16	16	16		6
2633	4	4	8	8	8	8	8	8	8		4
2642	6	6	6	6	6	6	6	6	6		6
2646	12	12	12	12	12	12	12	12	12		6
2694	12	12	12	12	12	12	12	12	12		4
2741	9	9	9	9	9	9	9	9	9		6
2992	9	9	9	9	9	6	6	6	6		6
3472			10	10	10	10	10	10	10		5
5277									12		4
5317									12		4
5369									16		4

The current scores are summarised in the following heat map:

Likelihood	Impact				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Very Likely					
4 Likely			2646	737, 5369	
3 Possible			2741,	2694, 5277, 5317	416
2 Unlikely			2642, 2992	2633	3472
1 Rare					

Q1 Strategic Risk Register							Inherent				Controls			Assurance			Current Assessment				Action Plan		Target				Review	
ID	Domain	Origin	Strategy	Assurance	Executive	Principal Risk Description	C	L	S	Risk level	Key Controls	Adequacy	Gaps in Controls	Form of Assurance	Level	Gaps in Assurance	C	L	S	Risk level	Action Details	Due date	C	L	S	Risk level	Next Review	Status
416	Financial	External	Financial Strategy	Finance and Digital Committee	Director of Finance & Information	If the Trust's planned income and expenditure position of break-even or better is not delivered, or If the cost of capital schemes increase beyond that provided for in the Trust's Strategic Capital Programme, or If external regulation is imposed regarding the use of the Trust's cash resources (this may include the requirement to share resources within an STP or restrictions on the use of cash surpluses) Then less cash will be available to fund the Trust's Strategic Capital Programme Resulting in the requirement to identify additional cash funding sources (via charitable partners or NHSEI) and/or reduce the cost of the Strategic Capital Programme through scheme deletion, deferral or reduction in scope.	Catastrophic	Likely	20	Very High Risk	Periodic review and update of the Strategic Capital Programme and the underpinning five year revenue Long Term Financial Plan (LTFP). Effective reporting, monitoring and review of operational plan to identify issues requiring a financial recovery plan. Established contract monitoring and commissioner dialogue to minimise external factors arising from contracting issues. Established working relationship with Charitable partners to manage donations Fully worked up schemes in advance with experienced staff input, control of tenders and costs and effective monitoring and reporting of costs. A managed contingency reserve. Engagement at a national level regarding any proposed external regulation A comprehensive, committed capital programme proceeding at pace.	Adequate	Revised national financial framework remains in development.	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) Regular Reporting to the Finance Committee and Trust Board. Monthly Pay Controls Group, Non Pay Controls Group and Nursing Controls Group scrutiny of Divisions performance. 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. Delivery of the capital programme, including the prioritisation and allocation of strategic capital.	Second Line Assurance - Risk and Compliance		Catastrophic	Possible	15	Very High Risk	Deliver the action plan out lined in the 2020/21 business planning paper approved at Finance Committee to improve the underlying position. Once national framework is in place, work with STP partner to maintain control over Trust cash reserves.	10/31/2021	Catastrophic	Unlikely	10	High Risk	10/1/2021	Action Required Risks
737	Workforce	External	People Strategy	People Committee	Director of People	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 and effectiveness of services may suffer, Resulting in increased reliance on other staff members and increased chance of 'Burnout' and a negative experience of working for UHBW.	Major	Very Likely	20	Very High Risk	A new Tactical Recruitment Group has been set up including senior clinical leadership across the Trust to drive clinical recruitment across the newly merged organisation. A robust 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. Divisional position reviewed through monthly exec scrutiny.	Inadequate	The nursing vacancy position remains a challenge in some hard to fill areas such as Care of the Elderly, T&O, Oncology & Haematology. Turnover in nursing remains high. Ongoing challenges exist with Radiographers, Sonographers, Neurophysiology and Audiology, where there is a national and international shortage. Each of these roles remain on the national shortage occupation list. A dedicated D&T recruitment manager is in post to give key recruitment input to these hard to recruit to roles. 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. This results in ongoing vacancy rates. Ongoing gaps in consultant posts such as Dermatology, Stroke Services and Acute Medicine continue to challenge service delivery. The new Weston Division has significant vacancy rates across all clinical roles.	Monitoring achievement of Strategic Workforce Plan objectives though People Committee. Divisional performance is monitored monthly at Performance and Operational Reviews. Monitoring of controls by People Committee.	Second Line Assurance - Risk and Compliance		Major	Likely	16	Very High Risk	Develop mutually beneficial relationships across the BNSSG healthcare economy and beyond to increase workforce supply. 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. Introduce new roles and innovative T&C's to attract new junior doctors in training. 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. Develop the scope of the apprenticeship provision, to include a wider number of job roles, levels and progression pathways. Ongoing European head hunters now being used to target hard to recruit to nursing and medical vacancies. Success being reviewed on a quarterly basis.	3/31/2022 12/31/2021 12/31/2021 12/31/2021 12/31/2021 12/31/2021	Moderate	Unlikely	6	Moderate Risk	10/1/2021	Action Required Risks
2633	Quality	External	Digital Strategy	Finance and Digital Committee	Director of Finance & Information	If the Trusts IT Systems do not support increased efficiency for clinical teams, Then documenting and accessing clinical information may take more time than previously, Resulting in inability to deliver effective care, decreased engagement with the Trusts digitisation programme and increased potential for the development of local 'work arounds'.	Major	Very Likely	20	Very High Risk	Harnessing the CCIO team and their clinical networks to engage and collaborate widely across clinical users. This is now further supported by establishing Digital Hospital Programme Committee Applying best practice management and operational disciplines and controls to IT operations.	Inadequate	The Trusts Digital Strategy is not yet approved.	Routine departmental assurance by programme management office for all digital and IM&T projects and activities reported to IM&T Management Group. EPRR Annual Report to the Board.	Third Line Assurance - Independent		Major	Unlikely	8	High Risk	July Digital Hospital Programme Board to consider business cases for Electronic Document Management and EPMA. September /October Trust Board to consider capital and revenue investments required to increase pace and scope of implementing the Trust's digital strategy and associated programmes of work.	7/30/2021 11/12/2021	Major	Rare	4	Moderate Risk	10/1/2021	Action Required Risks

Q1 Strategic Risk Register							Inherent				Controls			Assurance			Current Assessment				Action Plan		Target				Review	
ID	Domain	Origin	Strategy	Assurance	Executive	Principal Risk Description	C	L	S	Risk level	Key Controls	Adequacy	Gaps in Controls	Form of Assurance	Level	Gaps in Assurance	C	L	S	Risk level	Action Details	Due date	C	L	S	Risk level	Next Review	Status
2642	Business	Internal	Estates Strategy	Audit Committee	Chief Operating Officer	If the Trust has restricted system capital and is unable to invest, is unable to access to clinical areas due to operational pressures or has insufficient internal project management resources, Then the estate may not be modernised and developed in line with the aspirations of the strategic plan, Resulting in an environment with facilities that do not support improved efficiencies in patient care, streamlined pathways, improvements in patient experience and a deterioration in staff engagement.	Major	Very Likely	20	Very High Risk	Medium Term Financial Plan. Strategic Capital Plan and Operational Plan. Planned preventative maintenance budget. Trust Capital Group Chaired by Divisional Director, Surgery, receives monthly status reports on Capital Projects from Divisions and Assistant Director of Estates. SED Programme Board to oversee all SEDP schemes, chaired by Director of Strategy and Transformation. Financial Control Procedures, including the scheme of delegation and Standing Financial Instructions in place. Approved Five year Medium Term Capital Programme. Delivery of the capital programme, including the prioritisation and allocation of strategic capital. Delivery of the Operational plan without significant deterioration in the underlying run rate to ensure availability of strategic capital is available for future investment.	Adequate		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.	Moderate	Unlikely	6	Moderate Risk	Undertake review of projects in strategic investment programme and develop business cases to bring them to a similar state of development. Capital projects re-prioritisation exercise to coincide with the revision to the Medium Term Capital Programme.	9/30/2021 7/31/2021	Moderate	Rare	3	Low Risk	10/1/2021	Action Required Risks
2646	Workforce	Internal	People Strategy	People Committee	Director of People	If the Trust has insufficient management and leadership capacity, Then the our strategic objectives may be negatively affected, Resulting in decreased capacity to maintain financial and operational sustainability.	Major	Very Likely	20	Very High Risk	Funding has been secured to scope the talent management agenda and to develop an organisational framework. Work with external consultant to develop a best practice framework.	Inadequate	Further development of the Talent Management Framework is required.	Assurance reports to the Remuneration, Nominations and Appointments Committee and SLT. Divisional Performance reviews and the People Committee will provide the governance for this risk.	Second Line Assurance - Risk and Compliance	Divisional level analysis of succession plan not in place at present, therefore there is an 'unknown' risk. The risk of not funding the executive leadership programme will impact on the ability to provide leadership capacity at the senior level of the organisation.	Moderate	Likely	12	High Risk	Support the transition of the Management development programme to the Education team, working in partnership to review develop and design the cultural programme of work. As part of the TI&I strategy the Transformation Team are developing some QI for Leaders training, this will be developed during Q4 with a view to a launch in April. The development of a new Leadership training modules focussing on how to lead change are in development in Q4 of 2020/21 Two modules will launch initially, which are likely to be 'managing resistance to change' and 'creating the conditions for change'. It is anticipated that the training will give managers the tools to lead change more effectively in their area of work. working in collaboration with the Education team to develop and deliver revised L&M organisational offer	9/30/2021 9/30/2021 9/30/2021 12/31/2021	Moderate	Unlikely	6	Moderate Risk	10/1/2021	Action Required Risks
2694	Workforce	Internal	People Strategy	People Committee	Director of People	If the factors that contribute to a decrease in the staff annual engagement score are not improved, Then the workforce may be disengaged and chose to move to other organisations, Resulting in increased turnover, absence and other workforce KPI's.	Moderate	Likely	12	High Risk	People Strategy, focus on improving key cultural elements of: - Staff Engagement - Bullying and Harassment - Recognition - Performance Management - Diversity and Inclusion - Workplace Wellbeing - Leadership and management development. All workstreams have detailed action plans to ensure improvements are in place. This is supported by 3 sub-groups: - Wellbeing Steering Group - Workforce Diversity & Inclusion Group - Culture & People Group These groups feed into the People and Education group, and ultimately feed into the People Committee.	Adequate		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 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	The recognition framework will be reviewed and aligned following the merger with proposal complete in July 2021 and implementation by September 2021 Support the delivery and implementation of staff values. Work collaboratively with stakeholders to ensure alignment across the organisation Provide support to the external supplier Blue Goose Engage the transition plan to embed the new Trust values Weston Currently access happy app however the division needs to align to the Trust reporting system for monitoring review and reporting to mirror all divisions Following suspension during COVID 19 to deliver Quarter 2 Staff Survey (previously known as Staff Friends and Family test) Extend Annual Staff Survey Contract with provider the picker organisation. The contract is due for renewal in August 2021 however has an option for a year extension. The proposal is to extend the current contract until a review of the NHS England option to uptake the NHS People Pulse. The immediate action is to secure an extension	9/30/2021 9/30/2021 8/6/2021 8/6/2021 8/13/2021	Major	Rare	4	Moderate Risk	10/1/2021	Action Required Risks

Q1 Strategic Risk Register							Inherent				Controls			Assurance			Current Assessment				Action Plan		Target				Review	
ID	Domain	Orders	Strategy	Assurance	Executive	Principal Risk Description	C	L	S	Risk level	Key Controls	Adequacy	Gaps in Controls	Form of Assurance	Level	Gaps in Assurance	C	L	S	Risk level	Action Details	Due date	C	L	S	Risk level	Next Review	Status
																					Set robust plan to deliver Staff Survey 2021 which will be live from October 2021 until December 2021 This stage of the survey will include : .Data verification .Preparation for IT launch date .Communication plan	9/30/2021						
																					Plan and execute 'You said, we did' week.	9/30/2021						
																					Embed the Supporting Positive Behaviours Framework	10/1/2021						

Q1 Strategic Risk Register							Inherent				Controls			Assurance			Current Assessment				Action Plan		Target				Review	
ID	Domain	Origin	Strategy	Assurance	Executive	Principal Risk Description	C	L	S	Risk level	Key Controls	Adequacy	Gaps in Controls	Form of Assurance	Level	Gaps in Assurance	C	L	S	Risk level	Action Details	Due date	C	L	S	Risk level	Next Review	Status
2741	Quality	Internal	Research Strategy	Quality and Outcomes Committee	Medical Director	If financial pressures, service pressures or failure to recognise the value of research cause it to be deprioritised, Then the Trust will be unable to sustain research activity, Resulting in loss of reputation, income and ability to attract and retain highly skilled and motivated staff. limitation of patient choice, loss of potential to offer novel and/or cutting edge treatments and inability to contribute to the evidence to improve patient care.	Moderate	Likely	12	High Risk	Memorandum of agreement with University of Bristol. Joint Posts and Clinical Networks. Research Standing Operating Procedures. Process in place for corrective and preventative actions where breaches of GCP/protocol are identified to support learning by PI/CI and research team. Regular review of research recruitment on a trust-wide level. Key Performance Indicators at divisional level (bed holding only) finalised for regular divisional review. Appropriate study selection to maximise fit with patient pathways and minimise high resource use at times of clinical pressure. Research grants, Research Capability Funding, commercial and delivery income maintained. SPAs recognised in consultant job plans. Experienced and dedicated research teams to support delivery of clinical research. NIHR award £21m over 5 years for Biomedical Research Centre to Trust and UoB partnership. Call for BRC2 expected April 2021 and bid will be submitted for renewal. New Clinical Director and substantive Chief Operating Officer to Local Clinical Research Network. Review of impacts of research and engagement with SLT, board and divisional management teams to demonstrate value of research in NHS. Regular interaction with comms team to maintain visibility of research in as part of every day business.	Adequate		Reporting structures for divisional research committees/groups to Trust Research Group. Regular reports to divisions and the Board on KPI reviews (Trust-wide & divisional). Internal and External Audits and inspections. Process in place to identify and address poor performance within R&I Dept.	Second Line Assurance - Risk and Compliance	No clear mechanism for protecting time for non-medical PIs who do not hold funded research role recruiting to National Institute of Health Research portfolio trials not in place.	Moderate	Possible	9	High Risk	Continue to work with our researchers, with the RDS and with trials units to encourage them to submit high quality applications to NIHR funding streams. NIHR project grants draw in Research Capability Funding. Therefore increasing the number and value of NIHR project grants will lead to an increase over time of RCF. Drawing in successful grants also increases the research activity of the trust.	3/31/2022	Moderate	Unlikely	6	Moderate Risk	10/1/2021	Action Required Risks
2992	Business	Internal	Quality Strategy	Quality and Outcomes Committee	Director of Strategy & Transformation	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 and improvement priorities embedded into annual Trust and Divisional operating plans. Regular updates on Transforming Care programme to Strategic SLT and Public Trust Board Staff engagement embedded in planning service improvement and transformation work. Transformation and other service improvement leads networked across the divisions. Working in partnership with the Academic Health Science Network to train a cohort of improvement coaches. Quality Improvement Academy established 2017 and "dosing plan" for training developed. Digital Hospital programme a priority within the Transformation programme with Digital Hospital Committee aligning actions into clinical safety and operational decisions. Transformation, Improvement and Innovation strategy approved by Trust Board, and delivery of actions reported to People Committee six monthly for assurance	Adequate		Reporting to Transformation Board & Senior Leadership Team. Evidence of wide range of innovation and improvement programmes completed/underway including good response to programmes such as Bright Ideas, Trust Recognising Success awards , Quality Improvement Hub, QI annual forum and achievement of local / national awards. Audit and inspections. Quarterly Transformation reports to the Trust Board and six monthly updates to be provided through governance structure to People Committee Benefits realisation plans in place for all Transformation projects. Routine departmental assurance by programme management office for all digital and IM&T projects and activities reported to IM&T Management Group.	First Line Assurance - Operational	Lack of an Improvement and Innovation strategy. Scale of QI Programme for larger transformation projects. Securing sufficient capacity to deliver 'Dosing' strategy.	Moderate	Unlikely	6	Moderate Risk	Grow the scope of the QI Academy offer in the line with the dosing strategy, including the development of a QI foundation programme and QI for Senior Leaders programme Develop plans for online and virtual training for staff during Covid-19 period Develop and approve Digital Strategy	3/31/2024	Moderate	Unlikely	6	Moderate Risk	10/1/2021	Action Required Risks
3472	Environmental	External	Sustainability Strategy	Audit Committee	Chief Operating Officer	If the Trust fails to educate and drive changes in how we deliver our services, in the behaviour and the ways of working of staff, contractors and in the supply chain, Then it will be unable to contribute to making a positive impact on combatting climate change, Resulting in the environmental and health impacts from the delivery of our services and reputational damage.	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. Sustainability team established, 2 posts left to be recruited. 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.	Reports to SLT and Trust Board.	Second Line Assurance - Risk and Compliance	None noted.	Catastrophic	Unlikely	10	High Risk	Develop proactive stakeholder engagement and communication plan	12/31/2021	Catastrophic	Rare	5	Moderate Risk	10/1/2021	Action Required Risks

Q1 Strategic Risk Register							Inherent				Controls			Assurance			Current Assessment				Action Plan		Target				Review	
ID	Domain	Origin	Strategy	Assurance	Executive	Principal Risk Description	C	L	S	Risk level	Key Controls	Adequacy	Gaps in Controls	Form of Assurance	Level	Gaps in Assurance	C	L	S	Risk level	Action Details	Due date	C	L	S	Risk level	Next Review	Status
5277	Workforce	Internal	People Strategy	People Committee	Director of People	If the Trust is unable to create the required workforce capacity and capability the the Education Strategy will not be fully realised impacting staff recruitment and retention.	Major	Very Likely	20	Very High Risk	Associate Director of Education and DME part of SLT with a governance structure fully implemented as part of the People Portfolio and strategy. Education priorities part of the operating plans with KPIs and reporting into business cycles . A UHBW SRO of the BNSSG Learning Academy enabling cross sytem working and high visibility of education. Matrix working with aligned portfolios such as transformation , research, clinical services , OD and recruitment thereby ensuring less silo working. Partnership working with a range of education providers, HEE, Local Authority , Skills for Health/Care. A staff engagement and communication strategy. Central oversight of corporate education investment/finances and the NHS contract. Review and implmentatation of a Trust Services education structure able to provide the foundations for the education strategy.	Adequate	To be added		Second Line Assurance	Risk and Compliance	Major	Possible	12	High Risk	Develop an integrated, robust governance framework that supports the monitoring, visibility and quality assurance of education. Establish an equitable, technology enhanced model for the oversight, coordination and delivery of outstanding education. Consistently achieve high compliance and staff engagement in relevant essential training. Invest in the education of new roles , skills and competencies for future focused transformational models of care Expand the synergy between education, patient safety and the Quality Improvement Academy. Increase opportunities for knowledge sharing and reward and recognition schemes. Develop an equitable and transparent funding model for education Ensure all trainees receive an excellent and supportive clinical placement Develop shared governance processes with external education providers Create inclusive opportunities for career development and progression Proactively support flexible, supply routes into the NHS and workforce retention strategies Secure an apprenticeship model that becomes known as a national centre of excellence.	8/30/2021	Major	Rare	4	Moderate Risk	10/1/2021	Being Assessed (Draft)
5317	Business	External	Trust Strategy	Audit Committee	Director of Strategy & Transformation	If a conflict arises between the objectives and plans of the ICS and those of the Trust, Then the Trust may have a limited ability to make some investment and service funding decisions, Resulting in non-achievement of the Trust's Strategy in relation to delivery of specialised and tertiary services, the service mix not being optimal and impacting on the quality of care and recruitment and retention of staff and potential non-compliance with regulatory standards such as CQC and JAG accreditation.	Major	Very Likely	20	Very High Risk	Chief Executive is a member of the Healthier Together Chief Execs Group who are directly involved in shaping the ICS for BNSSG. The Trust is a member of a number of System working groups where ICS development is discussed. BNSSG System is actively developing an ICS development plan which will be submitted to NHSE/I in July. Members of the Trust are involved in these workshops and are SROs for various aspects of the plan. As a subset of this plan, UHBW & NBT are also working to form a 'provider collaborative' as part of the wider ICS. Adopting an approach of pro-active planning and willingness to show flexibility with regard to emerging national picture, based on the assumption that guidance won't change significantly for Acute providers and that there is likely to be a good degree of latitude in terms of how local Systems manage the delivery. Responsive process to ensure appropriate governance arrangements can be put in place to underpin ICS working.	Inadequate	Awaiting further national guidance (due July 2021) which is expected to provide more clarity on Integrated Care Systems. Legislative proposal for Integrated Care Systems to be considered by parliament summer 2021. It is too early in the process to know exactly what the ICS will look like. Until this is clearer, we will not know what the impact will be on individual organisations and their sovereignty, and therefore their ability to execute plans agreed prior to the creation of the ICS.	Board reporting vis the Healthier Together Update Report and via the CEO Update. Board Seminar on the development of the system MoU - June 2021	Second Line Assurance	Risk and Compliance	Major	Possible	12	High Risk	Approval of the system Memorandum of Understanding. Approval of the system enabling frameworks Inclusion of system performance metrics into the performance reporting to the Board and Committees to address the new System Oversight Framework coming into force from 1 April 2022 (expected in line with legislative timeline)	9/30/2021 9/30/2021 3/31/2022	Major	Rare	4	Moderate Risk	10/1/2021	Action Required Risks
5369	Business	Internal	Trust Strategy	Audit Committee, Quality and Outcomes Committee	Director of Strategy & Transformation	If the Trust is unable to design and deliver a suitable service model for Weston General Hospital, Then the ambitions and vision around the integration of clinical services across Bristol and Weston and Healthy Weston may not be achieved, Resulting in services across the Weston campus being unsustainable and non-compliant regulatory requirements.	Major	Very Likely	20	Very High Risk	Enhanced leadership in place for the Weston Division including a Managing Director, Deputy Medical Director and Deputy Chief Nurse. Clear alignment of the Weston Division Improvement Plan with the second stage of the Healthy Weston Programme. System incident response governance arrangements in place. Recruitment plans for nursing and medical staff. CQC improvement plan in place and being overseen by the Weston Division and through the Executive oversight arrangements. Integration Programme Board in place and overseeing clinical service integration and associated risks. System vision for WGH developed and submitted to regulators.	Inadequate	Further work underway to develop the proposals for the future service model at WGH as part of Healthy Weston	Monthly reporting to the Board of Directors by the Managing Director. Weston focused quality metrics developed and to be reviewed monthly. Monthly IPB meetings and reports.			Major	Likely	16	Very High Risk	Outcome of the second stage of the Healthy Weston Programme to be developed and considered by the system and Trust.	9/30/2021	Major	Unlikely	8	High Risk	10/1/2021	Action Required Risks

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on 29 July 2021

Report Title	**Corporate Objectives 2021/22**
Report Author	**Executive Directors**
Executive Lead	**Robert Woolley, Chief Executive**

1. Report Summary

The purpose of this paper is to provide an update to the Board on the delivery of the Trust's Corporate Objectives for Quarter 1.

2. Key points to note
(Including decisions taken)

The attached document provides the Q1 update on progress in delivering the Trust Annual Corporate Objectives for 2021/22. This report should be read in conjunction with the Q1 Corporate and Strategic Risk Registers.

Each objective has also been allocated with a Lead Assurance Committee in order to maintain oversight.

Following approval at Business SLT and Trust Board in April 2021, the objectives have been reviewed further and rationalised, resulting in a small number of objectives being removed (but absorbed where appropriate) and some re-allocated to a different lead Executive Director.

As part of this review, our objectives were shared with and jointly considered with colleagues at NBT. This process will continue as our provider collaboration develops, with a view to including a number of joint objectives in 2022/23.

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

The risks associated with this report include:
None

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

- This report is for **Assurance.**

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

Senior Leadership Team	**21 July 2021**
Quality and Outcomes Committee	**26 July 2021**
People Committee	**27 July 2021**
Finance Committee	**27 July 2021**

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

CORPORATE OBJECTIVES 2021/2022

Mission:

To improve the health of the people we serve by delivering exceptional care, teaching and research, every day.

VISION:

Grow our specialist hospital services and our position as a leading provider in south west England and beyond
Work more closely with our health and care partners to provide more joined up local healthcare services

Plan Owner
Paula Clarke
Version Number / Date
v1.0 13Jul2021

KEY: Strategic Objectives 2019 - 2025			
Specialist & Regional Services	Local acute services and integrated care	Education and workforce	Research and innovation

Grey: Not due to start yet
Red: Not started and behind schedule / not achieved
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Strategic priority	Objective	Lead Assurance Committee	Linked Assurance Committee (who may also need to consider impact)	Goal *[measureable goals for the organisation]*	Measure *[How the initiatives will be measured for success]*	Initiative *[Top level initiatives that will deliver the objectives and goals]*	Risk *[What are the risks to delivery of the objective]*	Timeline	Q1 update	RAG Rating	Exec owner
Our Patients: We will excel in consistent delivery of high quality, patient centred care, delivered with compassion.	1. To develop a consistent approach to quality across the Trust, embedded in systems not people to support retaining our CQC Outstanding rating.	QOC		•Completion and embedding all historic and current actions relating to previous CQC inspections	• Outstanding rating retained. • Any future CQC inspections assure us of progress made	• Restart of Delivering Best Care reviews, including extending these into WGH. • Participation in and learning from CQC transitional monitoring arrangements during the current pandemic.	•If planned improvement work at WGH does not deliver quality improvements by 31/3/2022, and if current Bristol CQC core services ratings are not retained or improved, UHBW's CQC 'outstanding' rating will be at risk.	Q1-Q4	Unannounced CQC core services inspection 8/9 June (medical care in Bristol and Weston, plus outpatient care in Weston) followed by corporate Well-led inspection 22-24 June. Positive CQC feedback about medical care in Bristol and outpatients in Weston, but Section 31 notice served in respect of medical care in Weston - concerns about insufficient numbers of medical and nursing staff, lack of clinical leadership in medicine, and unsafe use of escalation areas. Initial urgent assurances provided to CQC 11 June, including temporary cessation of use of escalation areas; followed by weekly progress reports to CQC commencing 21 June. Our understanding is that the Trust's 'period of grace' in respect of service ratings has ended, in which case ratings assigned to Weston General Hospital would form part of the calculation of the Trust's organisational rating. Draft inspection report anticipated in July. CQG, SLT and QOC have received the updates on the following CQC plans in June: legacy CQC actions from WAHT (pre-merger), Weston ED inspection July 2020, and BRI ED inspection February 2020. All Weston-related CQC actions will now be moved into a single co-ordinated improvement plan to provide the Board with a clearer view of outstanding tasks and to support oversight/ownership by Weston Division. Deputy Chief Nurse leading a new initiative for ward accreditation - plans for DBC reviews to be considered in this context (note that DBC tools were also widely used by wards and departments as part of preparation for the June core services inspection). The Trust participated in a transitional monitoring review of outpatient services earlier in Q1 - opportunity to share examples of innovation arising from the Trust's response to the pandemic - very positive CQC feedback. Rated amber at Q1 because although progress is being made, some Weston CQC actions are behind schedule, and also in view of Section 31 notice arising from June core services inspection at Weston.		CN
				Delivery of UHBW year 1 priorities of the national patient safety strategy: • Be ready to transition to new Patient Safety Incident Response Framework by March 2022. • Further develop UHBW just and restorative culture. • Patient Safety training and development in line with National Patient Safety curriculum. • Meaningful involvement of patients and families in improving patient safety in UHBW.	• Board approved patient safety incident response plan in place • Trained patient safety incident investigators in place • Delivery of programme of patient safety update training to clinical staff in Weston. % attendance. • HEE level 1 national patient safety training available. Compliance measurement not required nationally until 2022/23 • Readiness assessment completed and involvement plan in place.	• Develop Board approved Patient Safety Incident Response Plan. • Identify, recruit and develop trained, objective patient safety investigation specialists. • Deliver a programme of patient safety development in Weston to mirror existing provision in Bristol. • Level 1 HEE training "essentials of patient safety" available for all UHBW staff. • Review existing patient safety training and development in UBHW and align with HEE principles in the interim. • Conduct "readiness for involvement" assessment and develop involvement plan.	• If resource to deliver the patient safety elements of the Board approved Quality Strategy 2021-2025 is not approved, then the strategy will not be delivered resulting in sub-optimal patient safety risk reduction for patients and families and increased risk to CQG outstanding rating or regulatory action.	Q1 - Q4	Situational analysis to inform patient safety incident response plan planned for Q2. Patient Safety Development training programme commenced in Weston to support further development UHBW safety culture and a just and restorative culture. HEE patient safety syllabus launched and level 1 training for all NHS staff awaited from HEE. UHBW incident investigation training reviewed to be more in line with HSIB approach. UHBW patient safety training reviewed and being cross referenced with HEE syllabus. Senior nursing resource in place to lead readiness for involvement assessment during Q2.		
			People Committee	• Ensure the workforce is fit for purpose to enhance post-Covid restoration and recovery	• Recruitment and retention metrics • Recovery metrics	•Develop a non-medical workforce strategy with focus on international recruitment in the short term and more sustainable mid-long term workforce solutions	•Our workforce requirement does not match the demand and therefore risk that recovery programme is not optimised	Q1-Q4	Nursing and midwifery workforce strategy planning event with key stakeholders and Heads of Nursing took place on 30th June 2021. This included: scoping current recruitment plans in place and future requirements, opportunities for the development of an increased multi professional / skilled workforce: Non registered Nursing staff, Associate Nurses , and Advanced Practitioners. Staff development was also discussed in order to seek to improve in order to enhance the sustainability of the workforce. Planning for Nursing Workforce strategy document to articulate to all levels of staff underway ensuring that the vision and impact is considered both Trust wide and across the system .		
	2. Provide the physical estate and facilities to respond flexibly to the impact of Covid 19, and deliver our strategic objectives including additional and remodelled clinical space to keep both patients and staff safe and meet increased clinical need.	Board	• QOC	• Produce refresh of the 10 year estates strategy to underpin the strategic capital programme and inform system estate agenda. - Complete review of strategic capital programme. - Reset prioritised programme into 2021/22 and deliver against key milestones. - make progress on the approval of prioritised business cases within the programme. • Make progress with implementation of the Sustainability strategy • Further development and delivery of Culture and Arts Strategy	• Revised estates strategy approved by Board • Complete review of strategic capital programme and refresh of the Programme and business cases approval against agreed timescales. • Progress against year 1 metrics in Sustainability Strategy • Completion of construction against prioritised schemes and programmes within the 1 year timeframe.	• Delivery of revised estates strategy. - Completion of review. - Reset of programme, including contents, governance and prioritisation. - Financial strategy underpinning the programme agreed. - Prioritised business cases progressing against overall timeline. • Operational Capital schemes agreed and delivered in year to align with strategic programmes. • Delivery of key sustainability initiatives: - Sustainable development policy - Clean air hospital - including Travel strategy, car parking policy, Clean Air Zone response - Sustainable waste - Sustainable Procurement – Sustainable procurement policy (consortium wide), Sustainability Impact Assessment of all business cases >£1m - Carbon Neutral – Complete installation of low carbon heat network de-steaming site, carbon neutral plan	• Changed financial operating regime from a capital and revenue perspective. • Divisional capacity to progress assessment and development of business cases. • Operational impact during construction	Q1 - Q4	• Strategic Capital Programme Review complete and approval to close down the review phase approved at SSLT June 2021 • Strategic Capital Programme is transitioning from review phase to mobilisation phase. Programme Structure and Governance are being reviewed and reset to align to this delivery phase and in recognition that the resource requirements for this programme across both the Clinical and Corporate Divisions work are considerable. • Category 1 schemes prioritised, approved and scheduled. Working Groups in place or being established for all schemes to develop business cases, although some are more mature than others. Some risk that all schemes may not deliver in full in-year. • Divisional prioritisation of Category 2 and Category 3 schemes complete and submitted to SEDPB 6th July for consideration and moderation. Aiming for SSLT sign off of priority order August 21. • Funding decisions relating to category 2 and category 3 schemes are dependent upon production of a Trust 5 Year Capital Plan which details the financial envelope available for the programme. Development of the 5 Year Capital Plan is dependent upon clarity from NHSEI regarding the National financial regime for CCGs and provider Trusts. A final system five year capital submission is required in mid-October 2021, and the Trust will be producing its 5 year Capital Plan in September 2021.		D S&T
	3. Ensure Weston General Hospital remains at the heart of the community, improving the resilience of services and meeting the needs of its local people.	Board	• QOC • People Committee	• Achieve a successful transition into UHBW, including implementation of clinical service models and integration of services.	• Measurable progress made against benefit delivery and risk mitigation reported into relevant Board committees. • Vision and values for UHBW developed with staff. • Healthy Weston service change benefits monitored.	• Reset the Weston Integration Programme • Support benefits plan delivery and oversee realisation through the IPB Programme Benefits and Strategic Change workstream. • Weston Services integrated across sites against agreed milestones • Clinical integration, including use of clinical practice groups to integrate services. • Drive workforce productivity, recruitment and retention initiatives through the Workforce and OD workstream. • Support cultural integration with work on values and behaviours via third party provider.	• Lack of capacity of the Divisional Teams to realise the benefits plan - Transformation team to support delivery. • Delays to the integration schedule, due to Covid, may adversely affect the resilience of some clinical services.	Q1 - Q4	• Programme Reset decision to extend for a further 6-12 months. • Corporate integration workstream closed, with follow up review in 6 months. • 4 high priority medical specialities going through focussed workshop based integration process – plan to complete integrations for remaining divisions by 1st April 2022. • Retention group being established by Acting Director of People (in additional to Recruitment Taskforce Steering Group) to increase organisational focus. • New shared values component of the cultural integration work is gathering pace, with extensive survey and focus groups taking place. • Healthy Weston benefits review completed.		D S&T

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				• develop and integrate the working of the intensive care services at Weston General Hospital, including the development of a critical care transfer team. • extend and develop Ophthalmology services at Weston General Hospital.	• New ICU model and transfer team in place • Ophthalmology at Weston model in place	• New integrated ICU and ophthalmology models in place across both sites	• Impact of Covid on available capacity and demand requirements. • Delays due to Covid response.	Q4	Integration plans presented to July Division of Surgery Board and now progressing through IPB and Division of Weston.		COO
	4. To transform outpatient services to meet the aspirations outlined in the Long Term Plan	QOC		To develop more responsive, patient-centred outpatient services including: 1. reducing unnecessary follow ups. 2. expand our offer of non-face-to-face alternatives to outpatient attendances. 3. Make the best use of technology to redesign our services.	Constitutional standards and defined KPIs related to follow-up waiting times and non Face-to-Face activity.	• Expansion of the use of Attend Anywhere platform for video consultation. • Further develop use of Advice & Guidance supported by roll out of electronic triage. • Capitalise on digital technologies including implementation of Medway Outcome, Medway Clinical Notes and Fluency dictation software. • Conclude pilot of community phlebotomy hub in South Bristol Community Hospital, with a review of the service informing Phase 2 of the implementation plan. • Undertake workshops with clinical teams to consider re-design of outpatient model, including opportunities to integrate care.	Risk related to integration of clinical systems and pathways.		Progress note: The Trust is consistently delivering >30% of outpatients as NF2F. This was 3% pre-pandemic. We are delivering 650 video consultations per week. 89% of patients have stated that they are happy to have a video consultation again. A&G services have increased from 9 pre-pandemic to more than 50 services. A&G requests are approaching 2,000 per month. Community phlebotomy service pilot at SBCH concluded. The system has supported the roll out of a community wide phlebotomy service to go live from 1st July 2021. Concerns escalated from divisions about readiness to support go live, in particular, relating to red drugs management Change of approach for outpatient redesign programme supported by SLT DG. The Trust is pursuing a workshop approach and is focussing efforts on a small number of high impact interventions such as PIFU, outpatient waiting list validation and community phlebotomy. PIFU task and finish group established with transformation support. Focus on extending the use beyond our baseline of 20,000 PIFU pathways per annum.		COO
Our People: 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.	5. Culture: investing in our people to create a culture that fulfils the Trust's potential at every level	People Committee		Improve staff engagement score Improved related HR KPI's including sickness and turnover Improve internal pipeline of talent and ensure staff feel they are given the opportunity to realise their potential.	Values and Leadership behaviours are developed into a meaningful employee values proposition that becomes the golden thread in all of our staff communication. Staff survey of 7.6 or above and upper quartile for the ten survey themes. Increased staff engagement as measured through the staff survey. Focus on leadership and management development, communications and staff support to build staff engagement, increase retention and reduce bullying and harassment.	Working with an external organisation who are developing an outline plan to launch values and leadership behaviours Implement focused interventions on those areas of staff engagement impacted covid, and by ensuring a robust approach to OD interventions ensuring we create opportunities to listen and respond to staff Develop an internal framework for Talent Management for junior levels in a way that is consistent with the planned (postponed) HPS scheme.	•Lack of stakeholder engagement •Effective staff engagement if the current COVID operational challenges remain in place	Q1 - Q4	• The outline plan to develop and review meaningful employee values and behaviours with the external provider has been developed and launched in Quarter 1. The first stage of the programme of work will be to engage and explore with staff across the organisation providing staff with a range of opportunities to contribute to the creation of new values • The Annual Staff Survey 2020 detailed reporting has led to the development of both organisational and local divisional Cultural and people plans to set priorities and actions to support focussed OD interventions.		
				Equality, Diversity & Inclusion To deliver the year three plan for Diversity and Inclusion realising our ambition to be 'committed to inclusion in everything we do'.	Improved indicators for Diversity and Inclusion	Develop a meaningful D&I Framework, to launch the national reciprocal mentoring scheme, work in partnership with divisions.	Effective staff engagement if the current COVID operational challenges remain in place		Quarter 1 has seen the development of a robust assurance and delivery plan for the Equality Diversity and Inclusion agenda. There have been a number of key successes in the period including ; relaunch of the ED&I steering group introduction of Cultural Awareness training as well as Senior leadership programmes of work and a commitment to the national reciprocal mentoring programme as well as working in partnership with Bristol City council to engage with the Stepping Up Diversity Leadership programme		DOP
				Restoration and Recovery To deliver the staff 'reset' plan to effectively mobilise the workforce as we move into the post-covid environment	Increased staff engagement as measured through the staff survey Improved related HR KPI's including sickness and turnover	Ensuring staff are supported including wellbeing from a psychological and physical perspective, team working in the new world, working from home/more flexibly, agility and performance management			During qtr 1 programme of events delivered across the organisation: • Pause – celebrating the efforts of our staff and saying 'thank you'. • Reflect – opportunity for staff to share their experiences about COVID-19 • Rebuild – review of learning from the reflection and feedback past 12 months to respond and develop plans in order to support the Trust team to rebuild ourselves and our future. Supported by a continuous focus on the wellbeing and agility of our staff, services and teams with positive action and practical support		
	6. **Staff health, safety and wellbeing**: Support the health, safety and wellbeing of staff by establishing stability and sustainability within Avon Partnership Occupational Health Service.	People Committee		APOHS • Broaden the APOHS Income base in order to contain OH costs to NHS Partners • Develop a 5 year business strategy for APOHS	Achievement of KPIs with the agreed SLA Increased income, reduced CPH to Partner Customer satisfaction reports Retained external contracts Improved immunisation compliance.	Develop a proactive plan of business development. Implement agreed approach to prevent front line staff taking up their new post in UHBW without an immunisation review/update.	Non-achievement of KPIs Competing priorities and activity demands impacted by Covid capability Competitive market for OH service provision Limited engagement from System partners		• APOHS - funding secured for 2021/22. APOHS Board have agreed that for 2021/22 the team need time to stabilise, seek efficiencies and deliver against KPI's. • Meeting set up with BNSSG People Programme Lead to explore promoting APOHS to ICS Partners. •SLT met and approved the Immunisation revised process, awaiting confirmation from NBT before implementing changes.		DOP
	7. Education: develop exceptional people for exceptional careers	People Committee		Implement the renewed apprenticeship business model inclusive of work experience, traineeships and T Levels		Implement a consistent apprenticeship offer across Bristol and Weston sites. Identify available inclusive BNSSG career pathways made possible through apprenticeships. Develop a T level Strategy that support supply routes	Divisional pressures for staff release Availability of clinical placements	Q4	Apprenticeship model for contracting opportunities supported. Monthly contract meetings in place with education providers and divisions. It is of note operational and workforce pressures is impacting on staff feeling able to support apprenticeships in the workplace. T levels offer a longer term access route for access to health careers - again engagement with the team has been challenging with further mitigations being sought		DOP
				Implement a new Trust wide multi-disciplinary management development and customer services training	Increased level s of management and customer care training uptake for both internal and external opportunities Enhanced levels of staff motivation and recovery	Engagement process to inform development Utilisation of available training funds for securing external consultancy /training opportunities Develop a coaching framework that promotes a coaching culture Map BNSSG management/leadership for areas of synergy and learning	Divisional pressures for staff release Availability of clinical placements		New customer care provision in place through a hybrid of on line and face to face methods. This has been piloted through estates and facilities with positive evaluations - scope to further extend offer and marketing of the opportunity. Leadership/management development programme being developed with sign off planned for September SLT. Leadership portal externally procured for launch in Sep 2021- supported through SLT. Aim to share reviewed portfolio of leadership and management development programmes by Sep 2021; this will include an integrated offer for both internal and external provision and with staff engagement. .		
				Implement a new model for the leadership and governance of PGME across all sites	100% trainees to have an identified education supervisor and clinical supervisor	Business case for proposed investment Implementation of a devolved framework for PGME leadership across Weston and Bristol sites	Improved HEE monitoring events Increased trainee satisfaction		New medical education structure through SLT with funding made available through education. One DME successfully appointed for both Bristol and Weston. From July to August a number of deputy posts will be advertised with identified objectives. Further work required for clarity of oversight of medical education governance and Weston.		
				Increase clinical placement capacity and quality for under graduate students	Increase adult nursing clinical placements by 50 Increase number of AHP clinical placements by 10 Increased levels of student satisfaction	Implement the BNSSG HEE funded clinical placement expansion targets Identify and implement new models of supervision models such as CLiP. Partner with UWE and UoB for innovative clinical placement solutions	Inability to fully recruit to funded project leads Rapidly changing service configuration		UG clinical placement project KPIs in place for adult nursing, childrens and OT. The number of additional adult nursing placements (50) have not been identified due to a number of emerging factors - workforce, service re configuration and university alignment. This has been escalated to HEE and UWE Bristol and with other ICS/organisations across the SW similar outcomes are being found. Current HEE bid for additional funding for extending clinical placement being coordinated through BNSSG Learning Academy. CLiP project lead in place and working across UHBW and NBT for introducing new model of placement supervision.		

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	8. Resourcing: develop and implement a Strategic Workforce Plan to respond to the workforce challenges To become an outstanding employer of choice which attracts, recruits and retains a rich diversity of people across the organisation	People Committee		**Recruitment** Maximise the Trust's advertising Brand, becoming a national & International Employer of Choice to ensure we have a productive workforce that is as diverse as the community that we serve.	Vacancy targets met Reduced Bank and Agency use/spend Improved staff retention Improved time to hire and candidate experience.	Deliver a pipeline of international adult recruits to the organisation. Deliver an updated solution for the provision of bank and agency doctors for the Trust which is aligned across Weston sites. Work to create a collaborative approach to the recruitment of Health Care Support Workers. Explore bank collaboration to maximise the benefits of the BNSSG partnership model. Roll out the national digital passporting system for the mandated suite of employment checks.	Risk that the pandemic may restrict the ability of international recruits to migrate to the UK. Risk of not recruiting sufficient substantive staff to meet workforce demands.	Q3 / Q4	HCSW recruitment, on boarding and development part of a national work stream. A team of additional x5 12 month posts have been supported to be part of education teams to focus on retention and visibility of the HCSW role. ACP, Nursing Associate and Physician Associate wide working groups are now re-instated with good representation . Aim to enhance a coordinated response able to steer funding, workforce planning, recruitment and retention priorities. Training Needs Analysis to be completed by each division by end of June 21 (outstanding W& C, Surgery). Each TNA to be reviewed as part of developing a trust wide oversight of education priorities. Aim to ensure education core to workforce priorities. HEE CPD TNA completed with sign off from SLT July 21 with central reporting to HEE planned by 30th July 2021.		DOP
				Strategic Workforce Planning Review the existing Workforce strategy and produce an annual workforce plan	Improved rigour to workforce planning with a robust annual workforce plan in place Indicative training and education plan Routine report to People Committee	Review existing Workforce Strategy and target for 2019/2020 to 2024/2025. Identify workforce 'gaps' and associated vacancies by profession to support and prioritise interventions. Work with education team to undertake a TNA and consider the impact of the returns. Review WRES and DES data priorities and identify any required activities to address underrepresentation in specific professional areas, roles and levels of seniority.	Divisional service pressures restrict engagement and delay activities		Operating Planning process 21/22 concluded in Q1 with agreed workforce plan. Vacancy review underway with specific priority area (nursing) subject to workforce planning summit and actions Strategy review work to commence with HRBP's August 21 onwards. This will dovetail with outputs from Education lead TNA		
	9. People Systems: maximise the beneficial use of technology to improve how we manage our people	People Committee	Finance & Digital Committee	**Trust e-rostering:** Create a single solution of HealthRoster for all staff groups across both sites. This will provide increased support to all staffing decisions across clinical services using the system **Nurse / AHP / HCS e-rostering:** Establish robust Safe Staffing assurance, backed up by forecast acuity and dependency monitoring via SafeCare. AHP (Allied Health Professional) and HCS (Health Care Scientist) e-rostering to be rolled out across the Trust.	Improved / accurate annual leave and, study leave recording Reduced sickness absence through improved oversight and reporting Improved alignment of resources to clinical demand. Safe staffing assurance and correct staffing on wards in line with the expected acuity and dependency of patients.	Merge the Weston Allocate Database with Bristol to provide one single system for e-rostering, Temporary Staffing management, payroll services and operational day-to-day staffing visibility. Align the Safe Staffing and KPI reporting for Weston with Bristol to provide one report.	Risk the merge of the Allocate database could disrupt normal staffing operations leading a reduction in capacity and or delays in allocating temporary staff to critical assignments. NHSE/I have mandated all clinical teams are expected to be on an e-rostering system by 2021. The bid last year was delayed due to the Weston merger. Risk to delivery if the bid is not approved for 2021/22 Risk that safe staffing assurance is not monitored each shift.		*Allocate commissioned to support the role out of medical e-rostering following the quick upload of junior doctors to create a super Covid rota in order to manage resource availability during the pandemic. Allocate has been further engaged to continue to work with the Trust to push forward the medical e-rostering roll out. Harmonisation implementation with Weston postponed due to extreme operational pressures. With original planned system merger postponed due to significant operational pressures, the Allocate HealthRoster System merge to create one database across the Trust was completed successfully without any major operational impact in May 2021.The license base was increased to support the planned rollout of both sickness monitoring to all staff groups and to fully develop AHP/HCS rostering. Awaiting confirmation of capital and revenue bids to start both projects. These cannot commence unless the supporting revenue structures are in place. Review of SafeCare to commence July 2021 to support the safe Staffing across both Trusts., this will include scoping options for other staff groups to make best use of the software.		
				eJob Planning Implement e-job planning for all Consultants **Medical e-Rostering** Implement e-rostering for medical staff, creating efficiencies and sustainable workforce solutions to the management of safe working	Roll out of e-job planning for Consultants and SAS Associates Implementation of medical e-rostering (including a locum bank) for all grades of medical & dental staff	Improved oversight of Consultant job plans. Reduced locum spend. Improved/accurate annual leave and study leave recording. Reduced sickness absence through improved oversight and reporting. Safer working hours.	Risk of delay to the medical e-rostering implementation will prevent the Trust having a clear understanding of medical staffing levels, an ability to manage staffing gaps, and realise the productivity and efficiency benefits (emerging risk to be entered onto Datix)	Q3/4	Re-engagement with Allocate. 2 x demos to explore reporting, system structure and functionality. Next steps - discuss with Allocate implementation plan and assess Weston's current use of the system. Review of the roll out implementation plan to review usage in live Divisions/Depts and then plan for the remaining areas roll out. Allocate have been further engaged to continue to work with the Trust to push forward the medical e-rostering roll out.		DOP
				Electronic absence recording	Improved, accurate sickness absence reporting Reduced reporting time Increased ability to report on trends against workforce activity.	Scope resource, costs and timeline for rolling out HealthRoster where not currently in place. End workspace recording for covid absence End weekly payroll return	Inaccurate absence reporting, particularly for medics Under reporting of absence Trustwide		Scoping work has commenced to enable the Trust to start to develop a workforce intelligence hub, reporting on staffing information entered into HealthRoster. This will provide the Trust with a more robust tool to report staffing activity both internally and externally. Growth of this will be dependent on the successful bid for the sickness monitoring and AHP/HCS projects.		
				Learning Management System (LMS) Secure one LMS across Weston and Bristol sites that aligns with BNSSG partners	Electronic pass porting of training records Improved staff access to the Trust's training offer Enhanced functionality of reporting	BNSSG business case development for possible capital/resource implications Options appraisal of available LMS Participate in BNSSG procurement process Transfer of data to one integrated LMS	Improved pass porting of training records reducing repetition of training Improved value for money KPI for essential training	Not known	Cost approved through OPP. Out to advert for band 7 project lead with IMT and T involvement. Project plan in place and shared as part of BNSSG Learning Academy programmes of work. 6 week delay in procurement of extended Kallidus contract that was outside of education control; mitigations in place. Head of Education part of national work stream with NHS/I and Kallidus input.		
				Digital Learning Strategy Develop and implement a consistent, sustainable digital learning strategy that is inclusive of all staff groups.	Improved staff access to training Increased induction and care certificate compliance High quality staff feedback /evaluations on training Increased utilisation of on line resources	Review existing digital e learning content. Work in partnership with colleges and universities for digital upskilling programmes/offers. Implement an increasingly blended on boarding and care certificate process. Increase digital learning offer for post graduate medical education.	Staff competency and equipment access for digital learning Staff release time		New AV and IT equipment made available at education centre in Bristol and additional lap tops at both Weston and Bristol sites made available for staff loan. Part of working group with digital teams to explore enhanced functionality of 365. Process in place for E Learning Development . BNSSG bid submitted for digital upskilling development through the Institute of Technology- awaiting outcome.		
	10. To develop a Strategic Nursing Workforce Plan which is successfully translated into Divisional Plans against which recruitment, Education and Organisational Development deliver an improved pipeline of resource and ensures improved retention of Nursing staff.	People Committee	QOC	To achieve reduction of N&M vacancies to a position of vacancies recruited to turnover by year end. Improvement of retention rates. Define professional career pathway for all nursing staff to include Nursing Associates and Advanced Clinical Practitioners .	Trust wide Nursing workforce plan in place . Reduction in Monthly Turnover report by Division, Reduction in Monthly vacancy achieved , improved annual staff survey results	Delivery of a Nursing workforce plan which includes a variety of recruitment initiatives, Career development and Organisational development initiatives in order to ensure improved retention of all nursing staff .	If there is an increase in demand for the number of nurses required and increase in turnover of staff then the recruitment plans in place may not deliver the required increase of staff leading to an increase in vacancies. If education and organisational development support is not able to be provided this may lead to increased turnover of staff and a reduction of satisfaction within the staff survey.	Q1-Q4	Workforce planning workshop held in June 2021 Chaired by the Chief Nurse, with key stakeholders in Nursing, Education, Resourcing and Workforce Planning to discuss key risks with the demand and supply of the N&M workforce and agree ambitions for new roles, career pathways, increased international recruitment, marketing and attraction, and retention intiatives such as flexible working and flexible retirement options. Activity is is underway in response to the signficant challenegs, with a view of an overarching Nursing Workforce Strategy being developed.		DOP
	11. Policies, Process and Customer Service	People Committee	QOC	•Improve non-pay elements of staff reward package •Integrate terms and conditions of Bristol and Weston staff as far as possible in context of TUPE •Lead implementation of new SAS doctor contract if approved by staff referendum	•To improve the overall value of staff reward without incurring significant costs •To reduce agency/locum spend and reliance on enhanced pay rates by improving establishment	•Conclude procurement of benefits platform •Obtain Trust approval to proceed with early access to earnings system •Obtain Trust approval to proceed with electric car salary sacrifice scheme	Failure to procure appropriate platform. Unable to secure appropriate supplier of earnings system.		The procurement for the benefits platform needs to be revisited due to the insolvency of the preferred supplier. A Weston Terms & Conditions Group has been convened to review, redesign and effectively monitor local T&Cs with a view to standardising, where appropriate, contractual arrangements across both sites. The SAS contract will be implemented in August once an agreement has been made regarding locally employed associate specialists.		

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				•Developing a Resolution Focussed Culture	•To improve staff experience and realise a reduction in the number of formal cases and length of time taken to reach resolution •To ensure a fully embedded learning culture across the organisation	•Revised policies to reflect and facilitate a resolution focussed culture •Increase access to mediation across the organisation •To source the provision of relevant training to underpin the project •Refreshing existing staff benefits and marketing new initiatives	•Lack of stakeholder engagement •Lack of funding for resourcing and training		Task & Finish Group established and running fortnightly, through this group a review of the Disciplinary Policy has taken place and this will be presented at SPF on the 20th July then to People Committee on 27th July 2021. A pilot has commenced within Estates & Facilities which aligns the commissioning of investigations to that of a 'Just Culture' thus enabling more opportunity to resolve issues informally and learn from incidents. The procurement process for the roll out of a Resolution Framework and associated training has commenced. A bank Case Investigator job description has been developed and recruitment will soon take place.		DOP
Our Portfolio: We will consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focussing on core areas of excellence and pursuing appropriate, effective out of hospital solutions.	12. Consolidate and grow our specialist services portfolio	QOC	Finance & Digital Committee (Investment Committee)	• Develop the Genomics Medicines Service Alliance (GMSA) business plan, working with the NBT Genetic Laboratory Centre and Royal Devon and Exeter Trust.	Recruitment successful and business plan agreed by National Genomics Team	The South West has been recognised as a Genomic Medicine Service Alliance Centre between NBT / UHBW and RD&E. The priority activities are: 1. Recruiting to the regional GMSA team. 2. Producing a SW GMSA business plan and obtaining agreement from the National Genomics Team	• Inability to fill core team posts. • Low consultant numbers in UHBW Clinical Genetics team to support programme.	Q3	• GMSA Clinical Director and Programme Director Appointed, other roles in recruitment. • Business plan agreed with NHSE: • SW GMSA are leading the national Monogenic Diabetes project • SW have funding for 2 SW only projects, BRCA, Community Paediatrics. • SW have funding for a number of other national projects, being led by other GMSAs (pathology, DPYD, Lynch, FH, Sudden Cardiac Death, nursing & midwifery)		MD
				Develop an integrated regional system for children's health care Improve consistency of and access to specialist services for children across the south-west and build the reputation of the Trust as a lead provider nationally.	Act as host provider for networks for existing networks in the division and new networks from 20/21 (paediatric critical care, surgery in children, children's cancer and TYA, and fetal networks)	• Realise benefits of leadership through Congenital Heart Disease and Neonatal networks and formalisation of further Networks models. • Work with NHSE to develop an overarching children's network framework for the South West.	NHSE funding has still not yet been confirmed for some of the network team roles within the new surgery in children and children's critical care networks, and for all roles in the children's/TYA cancer, and fetal networks	Q2	• SLA and MoU with NHSE Specialised Commissioning agreed • CHD, Critical Care, Neonates, Fetal medicine networks established •Progress made in the establishment of the new Children's Teenager and Young Adult Cancer Network as follows: - CD and manager recruited and about to take post. Lead nurse and admin support to be recruited. -NHSE engagement and ownership of the networks agenda has increased significantly – continue to work closely to ensure delivery of the SLA and consistency across the Networks. -The networks report into the W&C Board quarterly with updates. Formal governance lines are into NHSE and their own Boards. -A programme board has been established by NHSE for W&C networks – to meet quarterly; W&C rep requested at the Board to ensure on-going alignment.		D S&T
				• Complete the Full business case for NICU services across Bristol working with NBT, the ODN and commissioners.	• NICU FBC completed and approved through Boards • Agreement on cross-city model for service delivery	• Establishment of a Joint Service Partnership Board • Development of a new cross-city model for NICU, support via ASR • Development of a Full Business Case	Cost of the enabling capital scheme for the NICU Project is now estimated to be greater than the OBC assessment. Financial implications of the service change to be finalised with NBT and will require further consideration by both Boards.	Q3	A new NICU Service Joint Partnership Board has been established between NBT and UHBW, with membership from NICU teams and corporate services staff. The Board will oversee a programme that focuses on two key workstreams: virtual integration of services where there is an agreed benefit in advance of reconfiguration and conclusion of a project Full Business Case. This programme aligns to Healthier Together strategic priorities and the joint Trust Acute Services Review Programme. A funding application to the Neonatal Critical Care Review to support the capital scheme has been unsuccessful. Capital funding for 2022/23 for the project remains under review and at risk.		D S&T
				• Agree the future model for dental teaching programme and renew our relationship with University of Bristol.	• Agreed next steps for future of dental teaching programme in place.	• Clarity of future dental teaching programme	Loss of dental SIFT impacts on the financial position of the Trust	Q1 2021/22	•Paper to Board June 2021. •Establish 'Transformation Board'. •Regular updates to Board going forward.		DOF
				• Develop a plan for improving the Cardiovascular Research Unit (CRU) with UoB to support our ongoing joint commitment to develop Bristol as a centre of excellence for teaching, research and clinical care.	Agreed plan in place for CRU improvements to support our joint commitment to research and the Biomedical Research Centre (BRC) renewal bid.	Working Group with UoB to agree options for CRU improvements to support the BRC renewal bid. Option to extend BHI as a new space deemed unfeasible so an alternative model focussed on redeveloping the existing space on level 7 to be considered.	Changes in financial conditions impacting on UoB and UHBW capital	Q4	Business Case to go to September CPSG.		DOF
				• Continue development of chimeric antigen receptor T-cell (CAR-T) treatment	• Increase in resourcing, following opening of additional physical bed as per CAR-T business plan. • Progress reconfigurations with BHOC to create additional 2 - 3 beds identified in business plan, ahead of any wider capital bid.	• Be at the forefront of development of CAR-T services and innovation nationally. • Designated centre for SW region	• Next stage of physical bed expansion contingent on relocation of Apheresis unit with BRI precinct. • Current funding source appears secure. Significant future changes to commissioning arrangements could impact on programme.	Q3	Increased capacity on D703 Haematology ward via capital project to provide an additional bed to enable increased CAR-T activity as per business model. CAR-T extended to include other eligible patient cohorts, including in treatment of Multiple Sclerosis and Mantle Cell Lymphoma. Development of ambulatory care model for Melphalan Autograph patients to release bed days with plan to extend model to lympho-depleting chemotherapy work up for CAR-T therapy that will further reduce 5 bed days for these patients.		D S&T
				• Collaborate with NBT to develop and present our planned developments for a city-wide approach to critical care. • Develop the wider clinical and operational collaboration between the units,	• An agreed plan with commissioning teams for ECMO and broader bed expansion. • Greater standardisation and collaboration between UHBW and NBT. • Successful delivery of enablers (eg alignment of clinical information systems)		Uncertainty regarding the national financial framework and commissioning landscape that will be in place from end of July 2020.	Q3	• Joint case of need for City wide expansion requirement developed and presented to commissioners. • FBC BRI bed expansion in development with detailed design work and costing ongoing with BAM contractors. • Clinical collaboration group across UHBW/NBT established, date sharing as part of CPG approach completed. • ECMO working group established to define a Bristol clinical model.		D S&T
	13. Improve how we manage growing acute demand inside and outside our hospitals	Board	QOC	• Improve ED access standards. • 12 hour and ambulance handovers • Develop a capacity and demand model that accurately predicts the bed need, including ICU • Develop winter plan	• SDEC and other initiatives to be measured through agreed KPIs reported to UCSG • Rebuild the adult acute floor, creating space for well designed urgent care pathways and the co-location of acute services such as Same Day Emergency Care (SDEC). •ork with system partners to determine the right model of referral into the EDs, noting that this may include the provision of an Urgent Treatment Centre across our front door. • Complete business case to expand our critical care capacity to ensure that we have the requisite capacity to meet the needs of our elective services. • Develop our plans to expand our theatres and endoscopy facilities. • Use our demand and capacity modelling to determine the optimal size and configuration of our acute bed base to ensure timely access to specialist services. • Divisional winter plans •Deliver timely and appropriate discharge from hospital inpatient settings and seek to deliver an improvement in average length of stay with a particular focus on stays of more than 14 and 21 days •Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments	• Various estates plans have been drawn up for development of the acute floor and are being circulated for clinical consultation. • Winter summit being planned to bring together cross Divisional plans for reducing admissions and LOS.	• Capacity and finance to deliver initiatives in a timely way	Q1 - Q4	New operational process and validation process introduced to reduce reportable 12 hour trolley wait breaches in BRI and Weston. Demand and Capacity Group chaired by Asst DP is overseeing new approach to bed modelling across all Divisions. Seasonal / winter planning has commenced, reporting into Demand and Capacity Group Medical SDEC ICP proposal signed off and currently being recruited into. Ongoing data analysis work with NHSE/I national team to further explore SDEC opportunities within Medicine and Surgery. UEC capital works 2 year plan is underway. Additional ED space in place, next step is additional trolleys for medical assessment. BNSSG project group to deliver City Centre UTC has commenced, with needs assessment complete and approved by UCSG. Interim planning has commenced to provide minor illness service out of hours for adults and children on BRI site. Exercise to reconfigure Bristol adult bedbase for the next 18 months to 2 years has commenced and will report into SLT for final sign off. Discharge to assess business case for BNSSG is in development and due for submission to Healthier Together Exec on 5 August. 111 First Programme Group active across BNSSG, various actions to support direction away from ED.		COO

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				• Working with system partners, we will take a system position on commissioning of out of hospital care using the demand and capacity tool developed by the Out of Hospital Delivery Group.	• Reduced Medically Fit For Discharge (MFFD) patients • Improved LOS	• Working with partners on enhanced discharge pathways for patients with complex needs. • Development of new MDT approach for people with complex needs, including agreement for joint funding between CCG and LAs.	• Patients with complex needs attract long LOS due to need to commission bespoke services for them.	Q4	New demand and capacity tool for all D2A pathways has been developed by the University of Bath and BNSSG CCG. This is informing the BNSSG D2A business case which will go to HT Exec on 5 August asking for circa £7M investment in out of hospital capacity.		COO
Our Partners: We will lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve.	14. Extend acute collaborative partnerships	Board	QOC	• Provide leadership within the Healthier Together Acute Care Collaboration to support service resilience risks and reduce variation. .	• Ongoing participation and leadership to ACC and links to ASR. • Agreed actions for Clinical Practice Group model progressed within nominated specialties. • Clinical Sponsorship Board with NBT fully established.	• We will work with system partners to deliver comprehensive integrated stroke services, from specialist acute care to rehabilitation and recovery at home. • We will work with system partners to review the configuration of MSK services, including trauma, to ensure they are responsive to the needs of patients. • Implement a Clinical Sponsorship Board with NBT to align clinical strategies that ensure high quality and consistent clinical services offer for local and regional populations	• Ensuring impact on aligned services are accounted for in preferred option. • Recruitment challenges in Stroke	Q4	ASR infrastructure and governance in place and clinical sponsorship board re-established. ACC and ASR closely aligned with organisational participation across both programmes.		D S&T
				• Progress an Acute Services Review in partnership with North Bristol Trust to establish Bristol as the regional centre for excellence for service, teaching and research and fully realise the benefits of collaborative working for our local and regional populations.	• Delivery of Acute Services Review with defined milestones.	•First phase priorities agreed as Stroke, NICU and Critical Care, followed by Cancer, Genomics, Diagnostics and Maternity.	Capacity to design and deliver programme		ASR workstreams underway - good progress in stroke, critical care and NICU.		
				•Understand and interpret our role as an organisation and jointly with NBT in developing Provider Collaborative arrangements, both as a specialist and non-specialist provider.	• Governance Framework and formal provider collaboration programme established	• Develop commitment and co-design through Exec to Exec and Board to Board	Communicating "what this means to me" for our teams		Clear direction of travel established for UHBW/NBT provider collaboration arrangements in response to national developments.		
	15. Improve how we work with primary and community provider partners and the charitable sector for the benefit of patients	Board	• QOC • Finance & Digital Committee	Realise benefits of SBCH bed transfer in partnership with Sirona	• Successful delivery of transfer on 1st April 2021 • Expected benefits delivered throughout 2021/22	• Delivery of service transfer of SBCH beds to Sirona • Lessons learned review with Sirona	Sirona ability to consistently staff beds to full capacity and impact on UHBW access to beds inhibiting internal flow	Q1	SBCH beds transferred to Sirona on 1st April 2021 as planned. There are ongoing discussions to work though issues identified post transfer, to reflect on the transfer and to identify lessons learned. The Business Transfer Agreement has been agreed and is being prepared for signature, the Licence to Occupy agreement and ULPA to follow, ahead of post transfer governance at July/August SLT and Board meetings.		D S&T
				• Using Connecting Care as the platform, we will communicate with primary care networks (PCNs) when our patients are admitted to hospital to start planning the best discharge for them from day 1. • Deliver advice and guidance services for GPs and Outpatient transformation • We will work with PCNs to improve referral routes into hospital, which in turn will ensure patients have a reduced length of stay and improved outcomes by getting to the right service, first time. • We will expand our work with both adult and paediatric patients who use our services the most frequently "High Impact Users"), ensuring that they have access to new pathways of care which better meet their needs first time.	Value stream mapping for each D2A pathway to ensure KPIs being met for each part of the pathway.	• Establishment of Community based ICBs to make discharge decisions for patients with complex needs. • Social workers moved out of the hospital to enable them to complete assessments remotely.		Q3	• Connecting Care rolled out and well used across the Trust. • Improved referral routes in for GPs communicated. • New High Impact Admissions Group will start under the Proactive Hospital once improvement leads have been recruited. • Community based ICBs in place. • Social Workers in-reaching where needed.		COO
				Work with charitable partners to support delivery of our corporate objectives and provide opportunities for our staff to improve the care they deliver.	• Charitable partners policy approved and Charities Forum established and operational. • Regular engagement with charities over capital programme and charitable contributions agreed as part of programme refresh. • Location of and timescales for Maggie's Centre agreed.	• Agree a charitable partners policy and establish a new Charities Forum. • Work with A&B to support development of future fundraising strategy focused on Patient Experience • Optimise the potential for charitable support for our strategic and operational capital plans and education opportunities. • Progress development of a Maggie's Centre for holistic care, as part of SCCS programme.	Impact of Covid on charitable activities	Q3 Q3 Q4 Q4	Initial discussions commenced commenced on developing charities policy, and scoping a charities forum. Key areas of focus for fundraising and ways of working between A&B and UHBW staff discussed and agreed in principle. Bids being developed for charitable funding for education. Ongoing discussions regarding charitable support for strategic and operational capital plans. Maggie's confirmed their intent to proceed with a Maggie's Bristol on UHBW site, initial planning to commence Q2		D S&T
	16. Work within the Healthier Together Integrated Care System to develop the opportunities associated with the new ICS structure and apply the learning from transformational changes rapidly implemented in response to the pandemic, agreeing and implementing system and organisational solutions that maximise impact for our populations.	Board		Clear links and representation at key HT meetings. System programmes clearly linked into Clinical Strategy Delivery Group (CSDG) programme plan. Transformation Programme reflecting system and organisational priorities Support for the development of the BNSSG ICSs to meet the expectations set out in the H1 planning guidance.	Representation at System Change and other System Transformation forums. Impact of System-led transformational changes within the organisation understood and supported Clear links back into and understanding within UHBW of ICS new ways of working, and priorities, what this means to us and how we support and influence. 3 projects with PCN agreed and action plans in place to deliver against set milestones.	Understand and interpret ICS changes and implications for the organisation. Ensure clear links back into the organisation from System meetings via CSDG and Core Planning Group. Provide support for System wide Transformation programmes with UHBW influencing outcomes and clearly understanding impact on organisation. Work with NBT to ensure joint programmes are established where beneficial. Ensure internal transformation programme reflects broader System priorities and joint working is supported where needed	•Breadth and volume of agenda •Complexity of the System • Uncertainty over application and implications of ICS changes.	Q2	• UHBW staff working as part of system wide ICS development Teams, including SRO roles for Governance, provider collaboration and Performance workstreams. • Regular attendance at System Change meetings focussed on System Transformation agenda and approach to transformation across BNSSG. • Commissioning & Planning Team representation at Bristol Integrated Locality Partnerships Board (shadow ICPs) to help identify PCN projects that could be worked on with general practice partners.		D S&T
				• Further develop our regional collaborative working through Bristol Health Partners and the Bristol AHSC.	• Strong unified presentation across all BHP organisations at the AHSC designation interview. •Output of HITs compared to plan.	•Disseminate HIT project prioritisation outcome and support HITs to initiate and deliver projects.	•Clinical pressures as a result of COVID reduce ability of staff to engage with HITs	Review quarterly	Discussions about where to position the AHSC in relation to the ICS have taken place, with a proposal made for it to become a formal R&I subgroup of the ICS NHS statutory body. Decision expected end Q2		MD
Our Potential: We will be at the leading edge of research and transformation that is translated rapidly into exceptional clinical care and embrace innovation.	17. Develop our people and our culture to enable improvement and innovation in our services.	Board	People Committee	• Continue to develop and deliver our Transforming Care programme to support achievement of our strategic ambitions. • Provide our staff with improvement skills and capabilities through our QI Academy and create an environment that makes it easy to innovate within the organisation through our QI Hub and Bright Ideas. • Develop relationships with external partners to identify opportunities to grow and spread our QI approach, and explore potential commercial opportunities.	• Delivery of Transformation priorities. • Delivery of year 2 of dosing strategy. Metrics to include: • Number of people attending QI training programmes • Number of people using the QI Hub • Number of people submitting to Bright Ideas. • New relationships and projects developed.	• Agree Transformation priorities 2021/22, focussing on service restoration. • Establish additional capacity for delivering training across organisation, through face to face and online delivery methods. • Rebrand the QI programme to a continuous improvement approach that is accessible to the whole organisation with appropriate communications. • Explore QI training opportunities to the South West Deanery • Consolidate relationship with UoB Centre for Innovation and Entrepreneurship, providing exciting student placements • Deliver QI module of UoB MSc and PG Cert for Healthcare Management	• Timing and speed of Post Covid recovery may impact on capacity of organisation to deliver transformation priorities. • Impact of Covid on recommencing training and ability for teams to release staff could reduce numbers trained in 2021/22	In line with project/ programme timelines Q2 Q3 Q2 Q4 Q4	Transforming Care programme approved by SLT 23/6/21, initially focusing on service restoration. Benefits and tracker being developed. System transformation priorities being discussed through ASR, including hospital at home. Additional capacity for QI Bronze to commence Sep 2021. QI Gold programme cohort 2 underway with 6 division undertaking projects. Rebranding will align with work to develop Trust values. Discussions ongoing with SW Deanery to provide QI bronze training. Scoping opportunities with Centre for Innovation and Entrepreneurship (CfIE) for student placements. Developing student handbook for QI unit, delivering unit Mar 2022.		D S&T

KEY: Strategic Objectives 2019 - 2025			
Specialist & Regional Services	Local acute services and integrated care	Education and workforce	Research and innovation

Grey: Not due to start yet
Red: Not started and behind schedule / not achieved
Amber : Commenced but behind schedule / risk of not achieving
Blue: Commenced and on-plan
Green: Complete

Strategic priority	Objective	Lead Assurance Committee	Linked Assurance Committee (who may also need to consider impact)	Goal *[measureable goals for the organisation]*	Measure *[How the initiatives will be measured for success]*	Initiative *[Top level initiatives that will deliver the objectives and goals]*	Risk *[What are the risks to delivery of the objective]*	Timeline	Q1 update	RAG Rating	Exec owner
	18. Continue to grow our research portfolio and reputation for excellence	Board		BRC2 - secure funding for a further 5 years, embedding existing themes and expanding into new areas of research excellence with our partners.	• UHBW shortlisted • Minimum funding of £23m awarded in May 2022.	• Bid team comprising key UoB and UHBW individuals leading preparation of a high quality bid due by 20 October 2021.		Q4	Outline bid for £45m submitted; awaiting outcome. Full bid Due October 2021.		MD
				Secure funding for 5 years to fund CRF infrastructure that will underpin BRC2 work and expand in other areas of experimental and early phase research, springboarding from nascent CRF already in operation	Minimum funding of £3m awarded in January 2022.	• Bid team comprising key UoB and UHBW individuals leading preparation of a high quality bid due by 29th September 2021.		Q4	Bid in preparation for £5m. Deadline September 2021, with outcome in Q4.		
				Submit high quality project and programme grants, primarily to NIHR, that will generate grant income and research capability funding that can be reinvested to generate new grant outputs and increase our research capacity.	•Number of grant submissions/awards. •Value of RCF awarded	• Identify research active/interested staff and support to develop links with mentors/trials units, signpost to funding opportunities and assist in grant development as appropriate. - pump prime NIHR grant applications through A&B/RCF funding scheme	• Lack of capacity both in the R&I core team to support high quality grant applications and in clinical staff to develop grants.	Ongoing	NIHR grants totalling £1.45m submitted. Four pump priming grants awarded and should lead to NIHR grant submissions. Three NIHR-RfPB grants are through to full application stage.		
				Actively manage a portfolio of research that has breadth and depth and is relevant to our patient population across the Trust .	• Contribute to relevant Local Clinical Research Network's achievement of high level objectives	• Support delivery units to open and maintain a research portfolio that has breadth and depth across the Trust and is relevant to our patient population. •Provide targeted financial support to ensure continuity where necessary.	• Lack of capacity both in the R&I core team to support reopening and in clinical research and support staff to deliver recruitment.	Ongoing	Slow recovery of previously paused studies reopening due to clinical pressures across the Trust. However increase in number of new studies opening across most specialties. Clinical pressures and potential covid wave may impact recruitment activity.		
	19. Use technology and our digital capabilities to transform where and how we deliver care, education and research and maximise the opportunity provided by our successful appointment as a Global Digital Exemplar site.	Finance & Digital Committee	QOC	• Complete refresh of clinical digital strategy as an enabler to delivery of the clinical strategy incorporating priorities identified from the review of the Trust strategy to respond to Covid requirements. • Implementation of new delivery and governance structure through the Digital Hospital Programme Board Implementation of modules identified as a priority within Covid impact review, along with year two projects within the overall strategy. •Create solutions for non face-to-face interactions and ways of working, both clinically and non-clinically and assess high impact AI opportunities	• Refresh of strategy completed and approved • New structures in place and delivering agenda - settled format for reporting between DHPB and D&FC • Modules delivered in line with agreed scope, associated Measures of Success, KPIs, Benefits and budget within specified timelines. • Delivery of Phase 2 of Medway Integration.	•Weston/Bristol - Medway Phase 2 • Careflow Connect • Clinical Workspace • Medway Upgrade • Medway Server Refresh • Vitals Upgrade • Transfer of Care • Medway Ordercomms • ED Digitalisation • Clinical Information Digitalisation	• Alignment to the current Clinical Strategy to drive the digital agenda. • Limited/inconsistent clinical ownership of the Portfolio of Work. • Inconsistent/limited level of Clinical Engagement across the Programme Portfolio. • Limited resources available to deliver the Portfolio Pipeline i.e. Demand significantly outweighs Supply.	Q4	• The re-baselined Digital Hospital Programme Roadmap was approved at the Digital Hospital Programme Board in May 2021 as well as the revised governance model. Active planning with System C is due to commence in July 2021. The key critical path items being progressed are the Medway Upgrade (v5) [July 2021] on the Bristol site and the convergence of the two instances of Medway into one [April 2021]. • Ongoing collaboration to deliver the identified system-wide priorities across BNSSG continues. • The planning for the trust-wide rollout of N365 is in progress. A working group is now set up and the project board is due to be set up imminently having identified the project SRO. • The Trust's Digital Strategy was discussed at the Trust Board seminar in June 2021; actions to refresh the strategy were discussed and will be progressed accordingly by appropriate clinical and non-clinical colleagues. Further update planned for September or October 2021.		DOF
Our Performance: 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.	20. Achieve Annual financial plan for the Trust and contribute to the delivery of the required ICS trajectory. For UHBW, this will include delivery of the merger financial benefits and the restoration of the underlying health of the UHB financial position.	Finance & Digital Committee	QOC	• Deliver financial position as determined in final plans for the year, using post-Covid version of plan, incorporating changed context. • Complete refresh of Medium Term Capital Plan and links to revised LTFM • Deliver financial benefits as per the merger business case, subject to any changes resulting from the wider Plan reset. • Implement recovery plans to achieve restoration of underlying financial surplus across the Trust.	•Delivery of financial plan as reported in monthly reports to Finance and Digital Committee and Trust Board. •Reporting to include delivery of merger benefits and divisional delivery of financial recovery plans. •Refreshed MTCP and LTFM approved by SLT and Trust Board	A refreshed Trust savings plans incorporating operational efficiency, GiRFT, model hospital and procurement opportunities.	• Uncertainty regarding the national financial framework to be in place from end of H1 2021/22. • Ongoing operational disruption as a result of the impact of Covid. • Assessment of emerging risks of ICS financial frameworks.	Q4	Q1 financial plan delivered by all partners. H2 plan to Finance & Digital Committee and Trust Board in September.		DOF
	21. Support the delivery of the ICS financial plan	Finance & Digital Committee		• Contribute to development of new contracting and commissioning models to drive system innovation. • Delivery of ICS financial revenue and capital plan.	• Active participation in developing new models. New contracting arrangements in place against agreed timescales. • Delivery of ICS financial plan as reported through internal and system governance	• Re-introduction of the ICS financial recovery plans, incorporating system Covid impact. • Increased visibility of ICS financial performance within the organisation.	•Uncertainty regarding the national financial framework to be in place from end of H1 2021/22. •Ongoing operational disruption as a result of the impact of Covid.	Q4	Q1 financial plan delivered by all partners.		DOF
	22. Ensure our services are responsive and achieve all constitutional access standards	QOC		• To reduce the size of the RTT incomplete waiting list to pre-Covid level. • To eradicate waits of 52 weeks or more for treatment. • To reduce waiting times for diagnostic investigations. • Cancer 62D standard. • To meet four hour standard performance in our EDs	Constitutional standards	Relaunch of the urgent care programme of work, focusing on delivery of SDEC and system work on suppression / diversion of minors attendances.	Lack of traction on scheme to divert activity elsewhere means risk of crowding and clinical incidents, in particular related to inability to offload ambulances in a timely way.	Q4	Progress update at June 2021: •RTT incomplete waiting list has grown to 49,791 and the 18 week backlog is 18,528. • 52 week backlog exceeded 5,000 patients in March 2021, but is showing signs of month-on-month reductions • Diagnostic waits are 65.3% of patients waiting more than 6 weeks against a national standard of 99%. • Cancer 62 day for April 2021 was 77.8% compared to the national standard of 85%. The majority of breaches relating to capacity, patient choice and medical deferrals. Other cancer indicators have shown signs of improvement. • 4 Hour performance deteriorated following restoration of levels of ED attendance and constraints on inpatient capacity associated with IPC precautions.		COO

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**2021/22 Operating Plan Summary**
Report Author	**Evelyn Elliott, Head of Commissioning and Planning** **Jeremy Spearing, Deputy Director of Finance**
Executive Lead	**Paula Clarke, Director of Strategy and Transformation and Neil Kemsley, Director of Finance and Information**

1. Report Summary

The purpose of the paper is to:

- Provide an overview of the Trust delivery plans for 2021/22 including a high level summary drawing out high value / high impact items
- Identify the key risks associated with delivery of the plans

2. Key points to note
(Including decisions taken)

Through the 2021/22 Operating Plan process, investment of circa £30m has been made to support the Trust deliver more sustainable and higher quality services whilst also looking to increase elective activity recover back to 2019/20 levels.

In addition there is an approved capital plan of £78.5m, which aims to deliver investment in Trust Infrastructure, digital services, medical equipment, and strategic capital schemes.

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

The main risk to the 2021/22 operating plan is workforce and the level of emergency and non-elective pressures faced by the Trust, as early as in Summer 2021.

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

- This report is for **Information.**

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

N/A	

2021-22 Operating Plan Summary

1. Introduction

The purpose of the paper is to:

- Summarise the approach taken to developing the operating plan for 2021-22, both internally and externally as a system;
- Provide an overview of the Trust delivery plans for 2021/22;
- Identify the key risks associated with delivery of the plans;

2. Summary of Operating Plan in 2021-22

2.1 Planning Approach and Principles

Planning for 2021/22 has been very challenging due to the uncertainty of the environment we have been planning in, both as a result of Covid, and the change in national planning and financial guidance. In particular the new national planning guidance has accelerated system working, and the Trust was required to submit plans that were aggregated at a system level.

The overarching principle adopted across all elements of planning process was that 2021/22 is a year of consolidation and recovery following the disruption experienced in 2020/21 . It was also agreed that it is a year to focus on the delivery of objectives not delivered in 2020/21, rather than generating significant new objectives for 2021/22.

A key focus and priority of both system and internal plans has been developing plans to recover elective activity, and this work is continuing through the accelerator programme.

2.2 Summary of plan

The 2021/22 plan is a break-even income and expenditure plan. Whilst 2021/22 is primarily a year of consolidation, through the OPP process significant investment has been agreed to support key developments and mitigate risks identified.

Recurrent investment has been approved by the Trust to support delivery of activity, this includes funding the workforce required for capital builds that have now been completed:

- New ward beds BHI (12 beds)
- Cath Lab expansion (5th cath. lab)
- BHOC reconfiguration (refurbished space and additional treatment capacity)
- GICU/CICU additional beds (5 additional adult ICU beds)

In addition external funding of £3.2m has been agreed with NHS England Specialised Commissioning to host the Regional Retrieve service. This work was accelerated due to Covid and has supported the Covid response by undertaking transfers of adult critical care patients in the region to support the management of capacity.

As described in the Financial Plan approved by the Board in May 2021, and as detailed in section 7, the Trust has committed investment to support the mitigation of risks across the Trust including:

- Further investment in the Weston Integration programme
- Increased investment in the security team in ED

- Funding to support the Clinical site teams
- Additional investments in divisional management teams (D&T / Surgery/HR/ Weston)
- Medical staff (e.g. Haemostasis Consultant, Critical care consultant)

Investment has also been agreed to support clinical services to improve sustainability including the BMT service, clinical genetics and paediatric safeguarding as detailed in section 7.

As a result of Covid and to support the restoration of activity, there has been an investment in infection control weekend working and maintenance of new Covid equipment.

Non-recurrent investment has been agreed to fund schemes to support elective activity restoration, this has included waiting lists, increased opening hours for CSSD, and insourcing of endoscopy.

2021/22 Capital planning has been challenging due to the Capital and Cash Regime changes implemented in April 2020, this has meant that the Trust's Capital expenditure in 2021/22 is limited to a capital envelope (CDEL) of £54.3m. In addition there is funding of £24.2m, outside this envelope, which increases the total Trust capital plan to £78.5m.

In April 2021, the Trust had £50.5m of slipped schemes, therefore work was required to review the slipped schemes and understand what could be potentially deferred. In total, schemes to the value of £38.7m from the 2020/21 slippage have been approved to continue this year with the balance of schemes deferred into 2022/23. A risk based approach was adopted by Divisions in completing this assessment.

Key capital schemes approved for 2021/22 include:

- £4.6m to support fire improvement
- £5.6m to support Digital services (plus additional £2.5m for Weston IT)
- £23.7m to support strategic capital schemes which include; Adult GICU expansion, BHI Ward Beds, Medical Education, Staff Well-being (including a staff Well-being hub), high risk infrastructure.
- £6.2m Bristol and Weston Urgent EC
- £16.5m Salix Decarbonisation scheme
- £10.6m Infrastructure investment
- £14.7m Medical equipment investment

Further information is provided in section 3.

3. 2021/22 Capital Programme

The 2021/22 Capital Plan of £84.7m was approved by the Trust Board in May. The Trust's net capital expenditure plan after slippage is £84.7m. A revised capital plan was agreed by the Trust's Senior Leadership Team in June. The revised capital plan is £78.5m and is summarised in the table overleaf.

Table 1: 2021/22 Capital Plan

		2021/22 Revised Plan		
		STP Envelope £m	Outside of Envelope £m	Total Plan £m
Strategic schemes				
	Slippage brought forward	3.606	-	3.606
	BHI beds	6.000	-	6.000
	Infrastructure	10.600	-	10.600
	Other	3.500	-	3.500
	Decarbonisation	-	16.549	16.549
Total Strategic scheme		**23.706**	**16.549**	**40.255**
Major medical				
	Slippage brought forward	10.279	-	10.279
	Current year allocation	3.861	-	3.861
	Donated schemes	-	0.517	0.517
Total Major medical		**14.140**	**0.517**	**14.657**
Fire Improvement				
	Slippage brought forward	2.692	-	2.692
	Current year allocation	1.934	-	1.934
Total Fire Improvement		**4.626**	**-**	**4.626**
Digital services				
	Slippage brought forward	2.251	-	2.251
	Current year allocation	3.555	-	3.555
	Weston IT	-	2.500	2.500
Total Digital services		**5.806**	**2.500**	**8.306**
Operational capital				
	Slippage brought forward	10.862	-	10.862
	Current year allocation	2.705	-	2.705
	Weston UEC	1.800	-	1.800
	Bristol UEC		4.393	4.393
	Donated schemes	-	0.273	0.273
Total Operational capital		**15.367**	**4.666**	**20.033**
Estates replacement				
	Slippage brought forward	7.991	-	7.991
	Current year allocation	2.125	-	2.125
	Computer Room 2	1.254	-	1.254
Total Estates Replacement		**11.370**	**-**	**11.370**
Gross Capital programme		**75.015**	**24.232**	**99.247**
Over programming / forecast slippage into 2022/23		(20.722)		(20.722)
Net Capital programme		**54.293**	**24.232**	**78.525**
Slippage %		28%		

4. Workforce Plan

4.1 Impact of national guidance and system approach

The Trust submitted the required workforce plans to BNSSG to the agreed timetable. Narrative information was also submitted to the system to articulate the Trust plan and respond to the requirements in the national guidance, specifically addressing national Priority A; Supporting the health and wellbeing of staff and taking action on recruitment and retention.

- A1 – Looking after our people and helping them to recover
- A2 – Belonging in the NHS and addressing inequalities
- A3 – Embed new ways of working and delivering care
- A4 – Grow for the future

The output of both the numerical workforce plan and narrative plans were combined by BNSSG for a system response to NHSEI in line with the national timetable of 3rd June.

4.2 Summary of Trust plan

The Trust plan reflects the following high level workforce changes this year;

- Funded establishment (demand) is planned to increase by 2.3% (258 fte) in 2021/22. The majority of this increase is due to approved developments.
- The planned increase in workforce numbers (supply) is 1.5% (177 fte) at Quarter 2. This takes account of vacancies that might be filled, as well as temporary staffing requirements and overtime.
- Supply is currently over budget by 202 fte (1.8%) against the planned funded establishment.
- Recruitment and retention of staff remains a key workforce priority for 2021/22 across all Divisions, particularly in nursing for bed holding divisions.

4.3 Capacity Constraints and Enablers

To support delivery of the workforce plans the following constraints and mitigations have been identified:

- Registered nursing, midwifery and health visiting staff – planned expansion in numbers of 185 WTE. There is pressure created by high vacancy rates in some divisions (Weston and Medicine), however there is an ongoing programme of recruitment in identified 'hot spot areas' as well as significant programme of international recruitment (150 new recruits from overseas in 21/22).
- AHP roles – expansion of 11 WTE – Existing vacancies in specific professions and hard to recruit professions such as radiography and endoscopy. Adopt and adapt programme providing increased radiographer numbers. There are planned targeted recruitment campaigns and specific apprenticeship programmes and further development to resource gaps.
- Consultants - Expansion of 28 though some recruited to as hosted services such as Retrieve. There are known recruitment difficulties in specific specialisms and divisions.

There are ongoing targeted programmes, Recruitment, Retention Premia's in place and joint appointments across Bristol and Weston developed and advertised.

Key risks and challenges to the workforce plan include:

- Risk that there are insufficient numbers of doctors in training to safely cover rotas
- Risk that continuity and effectiveness of services may suffer through inability to recruit
- Risk that use of agencies who are non-compliant with national pricing caps does not reduce
- Risk that the Trust has insufficient leadership capability
- Risk that Trust is unable to retain members of the substantive workforce
- Risk that staff experience work related stress as a result of the pandemic

Therefore to manage these risks, there will be;

- Further refining and updating of workforce numbers to reflect further agreed schemes and changes in agreed funding.
- Scrutiny of numbers at professional and divisional level to identify potential resourcing issues that require targeted support or alternate approaches e.g. role substitution/new roles/new ways of working
- Scrutiny of numbers related to Phase 3/recovery work and identification of resourcing in those particular areas resourced via overtime, fixed term contracts, bank and agency
- Development of high level mobilisation plan as part of the ongoing recruitment and resourcing programmes of work within Human Resources
- Ongoing discussions and development of plans with system partners in BNSSG including retention work programme

5. Activity Plan

5.1 Summary of System and Trust Approach

The Trust wide Indicative Activity Plan (IAP) was submitted as part of the system wide activity plan on 25th May 2021. The activity plan for the Trust has been profiled for the whole of the 2021/22 financial year, although the system wide submission largely focused on the monthly activity trajectory for Months 1 to 6 (April to September 2021). Current expectations are that there will be a national requirement for a revised activity plan for the second half of the financial year.

The activity plan for elective points of delivery including elective inpatients, outpatients and diagnostics is capacity based only to inform the expected levels of recovery that are possible given the ongoing constraints to business as usual operations due to COVID related Infection, Prevention and Control restrictions and other COVID related factors affecting productivity in outpatients, theatres and diagnostics.

The activity plan for urgent care points of delivery is based on a hospital site assessment of A&E attendances and non-elective admissions, and largely plans for a return of 19/20 pre-pandemic levels by the end of July 2021.

The activity plan has been stress tested via the Trust Demand and Capacity Group to ensure that supply side capacity for beds, theatre sessions, outpatient clinics and diagnostics can accommodate the levels of activity proposed. This has then subsequently been triangulated with workforce plans and financial planning assumptions. A summary of the activity plan in volume terms compared with 2019/20 actual activity is provided in the table below.

Table 2: 2021/22 Activity Volumes

Activity volumes	2019/20 Actual	2020/21 Actual	2021/22 Plan Including Accelerator Schemes	2021/22 Plan Including Accelerator Schemes v 2019/2020 Actual	2021/22 Plan Including Accelerator Schemes v 2019/20 Actual % Change
Accident & Emergency	195,767	141,458	196,589	822	0.4%
Day Cases	74,529	53,106	74,257	-272	-0.4%
Elective Inpatients	14,252	10,157	13,047	-1,205	-8.5%
Emergency Inpatients	63,039	49,607	59,734	-3,305	-5.2%
Non-Elective Inpatients	20,985	19,954	21,263	278	1.3%
Outpatients	872,129	678,258	809,129	-63,001	-7.2%
Grand Total	**1,240,701**	**952,540**	**1,174,019**	**-66,682**	**-5.4%**

5.2 Independent Sector Utilisation

A key component of in year recovery is utilisation of Independent Sector (IS) capacity where possible and safe to do so. During the early phase of the pandemic response in the Spring and Summer of 2020, 100% of IS capacity was made available to support the NHS. Since then, the NHS has introduced the Increasing Capacity Framework, designed for Trusts and Commissioners to more easily call off IS capacity from a nationally managed procurement framework. However, under this arrangement there is no guaranteed amount of NHS activity that has to be made available by IS providers, and given the size of private waiting lists, this has reduced the capacity available to the NHS. The capacity available from IS providers locally for the NHS including UHBW is approximately at 20% of total IS capacity.

UHBW has worked with the BNSSG healthcare system and IS providers to agree priority areas for accessing IS capacity as follows:

- Cardiology, Cardiac Surgery, MRI and CT at the Spire;
- Endoscopy at the Nuffield;
- Non obstetric ultrasound at Practice Plus;
- Cataracts at Newmedica;
- A mix of short stay surgical activity and day case activity at Somerset Surgical Services;
- Dermatology at Queen's Square; and
- Endoscopy at Inhealth.

List uptake and utilisation of IS agreed activity is monitored in conjunction with system partners and there will be opportunities throughout the year to increase IS activity throughput, depending on overall utilisation and contract management elsewhere within the local healthcare system.

5.3 Accelerator Programme

UHBW is part of the BNSSG healthcare system elective accelerator programme initiative which is aiming to restore elective activity above and beyond the levels of activity delivered in 2019/20, with the primary focus on restoration between July and September 2021.

The Accelerator Programme PMO is coordinating the development of business cases and delivery of plans to go further than the 25th May activity plan submission, and the impact by point of delivery in volume terms based on a system plan submission at 15th June 2021 is shown in the table below.

Table3: Accelerator Programme Indicative Activity Plan Stretch – part of System Plan submission

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Total outpatient attendances (all TFC; consultant and non consultant led)	0	0	125	1232	1739	4706
Total outpatient attendances (all TFC; consultant and non consultant led) - Face to face	0	0	125	1232	1739	4706
Consultant-led first outpatient attendances (Spec acute)	0	0	37	264	288	504
Consultant-led first outpatient attendances with procedures (Spec acute)	0	0	16	43	53	75
Consultant-led follow-up outpatient attendances (Spec acute)	0	0	71	788	1271	4029
Consultant-led follow-up outpatient attendances with procedures (Spec acute)	0	0	0	0	185	2777
Total number of Specific Acute elective spells in the period	0	0	36	342	453	455
Total number of Specific Acute elective day case spells in the period	0	0	36	298	402	406
Total number of Specific Acute elective ordinary spells in the period	0	0	0	44	51	49

5.4 Key risks and challenges

There are a number of risks and challenges to the delivery of the Indicative Activity Plan which will continue to be managed through established performance management governance processes within the Trust.

The main risks to delivery of the plan are:

- An increase in the number of non-elective and emergency admissions above the Indicative Activity Plan volumes, which will displace capacity for elective recovery;
- A further peak in COVID related demand, particularly if a third wave develops over the Autumn and Winter of 2021, impacting on green pathway capacity;
- An increase in the number of new outpatient referrals, which is significant because the Indicative Activity Plan for elective care is based largely on capacity, and therefore the materialisation of pent up demand could further affect the backlog position that the Trust is currently holding.
- Workforce supply causing significant vacancies, and workforce availability due to absence (sickness and self-isolation).

6 Performance

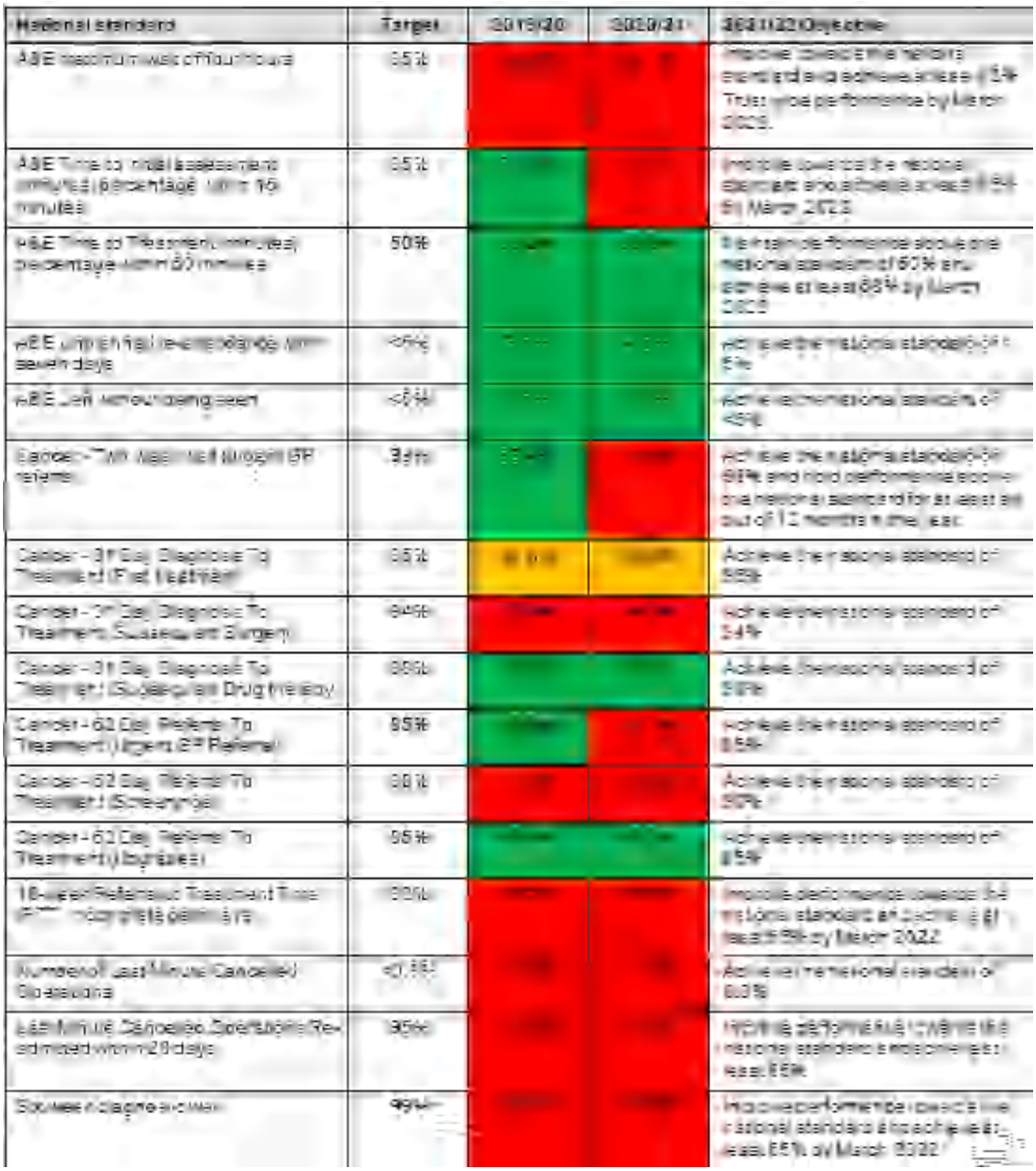
6.1 Impact of national guidance and system approach

National Operating Planning guidance has focused largely on recovery of activity volumes to pre-pandemic 2019-20 levels as the key performance directive for the NHS. In response to this the Trust has produced a Programme Mandate and Brief for Restoration, Recovery and Renewal, which documents the current risks the Trust is holding with regards to backlogs and capacity constraints, and a programme of work to deliver recovery objectives in 2021/22.

6.2 Summary of Performance Targets and Objectives

The national planning guidance has not been explicit about specific performance trajectory requirements against constitutional standards in 2021/22. The Trust targets therefore remain unchanged in terms of delivering against constitutional standards, but given the impact on performance during the pandemic, some prudent objectives for recovery have been proposed. The table below shows the objective in 2021/22 for recovery towards the national constitutional standards, and the programme mandate and brief outlines several related objectives for recovery in the areas of urgent care, planned care, cancer, outpatients and diagnostics.

Table 4: Objectives in 2021/22 Against the National Constitutional Standards



National standard	Target	2019/20	2020/21	2021/22 Objective
A&E maximum wait of four hours	95%			Improve performance towards standard and achieve at least 91% Trust-wide performance by March 2022.
A&E Time to initial assessment (median) (percentage seen within 15 minutes)	95%			Improve towards the national standard and achieve at least 95% by March 2022.
A&E Time to Treatment (median) (percentage seen within 60 minutes)	50%			Maintain performance above the national standard of 50% and achieve at least 68% by March 2022.
A&E unplanned re-attendances within seven days	<5%			Achieve the national standard of 5%.
A&E Left Without being seen	<5%			Achieve the national standard of <5%.
Cancer - 2 Week Wait from GP referral	93%			Achieve the national standard of 93% and hold performance above the national standard for at least 10 out of 12 months in the year.
Cancer - 31 Day Diagnosis To Treatment (First Treatment)	96%			Achieve the national standard of 96%.
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94%			Achieve the national standard of 94%.
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug Therapy)	98%			Achieve the national standard of 98%.
Cancer - 62 Day Referral To Treatment (Urgent GP Referral)	85%			Achieve the national standard of 85%.
Cancer - 62 Day Referral To Treatment (Screening)	90%			Achieve the national standard of 90%.
Cancer - 62 Day Referral To Treatment (Upgrades)	85%			Achieve the national standard of 85%.
18-week Referral to Treatment Time (RTT - Incomplete pathways)	92%			Improve performance towards the national standard and achieve at least 85% by March 2022.
Number of Last Minute Cancelled Operations	<0.8%			Achieve the national standard of 0.8%.
Last Minute Cancelled Operations Re-admitted within 28 days	95%			Achieve the national standard and achieve at least 95%.
Outpatient diagnostics	99%			Improve performance towards the national standard and achieve at least 95% by March 2022.

The above national standards remain subject to the outcome of the Clinically-Led Review of NHS Access Standards. Following the launch of this programme in March 2019, the review set out to test new access standards in mental health services, cancer care, elective care

and urgent and emergency care to see whether they can be used safely and improve patient experience and outcomes. An interim report was published in October 2019 and the COVID-19 response has delayed the publication of the final recommendations of this review.

6.3 Summary of Bed Modelling and Key Mitigations

There have been a number of changes and loss to the bed base as part of risk assessments to maintain social distancing and IPC precautions.

To offset this loss of inpatient bed capacity the Trust has a number of development schemes in progress including:

- 5 new beds adjacent to A700 and 4 new beds adjacent to A800 have been created by converting open plan office space. The A701 beds have been opened, but the A801 beds will be used for a short period for decant to undertake works on A800
- There is scope to create an additional 10 beds in a second stage of conversion of ancillary services adjacent to A700 and A800. These works are anticipated to be completed by the end of the calendar year.
- 12 new beds have been created on the Weston site by converting part of Quantock outpatients into ward beds. These works summer 2021; the opening of these beds contingent upon staffing.
- There is scope to create between 16 and 24 additional beds on the site adjacent to the BHI that was planned to accommodate the cardiac research unit. Assuming this scheme is approved to proceed, these beds will be created by February 2023.
- Modular wards are being explored on the Weston site to support decant for ward refurbishment.

Bed modelling and planning will continue throughout 2021/22 under the direction of the Bed Modelling Testing Group and supported by the Trust wide Demand and Capacity Group. Further mitigations continue to be developed in partnership with providers and commissioners in the BNSSG healthcare system.

7. 2021/22 Revenue Financial Plan

The Trust's 2021/22 Financial Plan has been agreed by Business SLT and was approved by Finance & Digital Committee and Trust Board in May 2021. It is a break-even income and expenditure plan and includes significant revenue investments of over £30m. In summary, the key, high impact investments are:

- £2.6m for category 1 unavoidable cost pressures, that are corporately funded:
  - £0.4m Clinical Site Team towards out of hours operational management
  - £0.4m increased security in ED to support frontline staff
  - £0.4m immigration surcharges to support overseas recruitment
  - £0.3m investment in operational management posts, in D&T and Weston
  - £0.3m on clinical posts e.g. Lung cancer CNS, Haemostasis Consultant

- £5.0m for category 2 quality and safety related investments such as
  - £0.5m Weston integration
  - £0.5m Consultant posts and additional programmed activities
  - £0.4m ITU outreach service
  - £0.4m Clinical genetics review

    - £0.4m Organisational development and wellbeing initiatives
    - £0.2m Emergency Nurse Practitioners
    - £0.2m Enhanced staffing for Cardiac HDU

- £13.4m for category 4 non-recurrent investments to deliver additional activity via waiting list initiatives and insourcing

- £ 8.4m for category 5a recurrent investments to deliver additional activity including
    - £3.2m for adult ITU retrieval service
    - £2.6m for adult ITU Phase 1 expansion
    - £1.6m for BHOC and Cath Lab expansion.

A number of further investments of £0.19m have been agreed since the approval of the 2021/22 Financial Plan, for example, further support to the flu vaccine programme.

The BNSSG STP/system has put further recurring investment decisions on hold until national guidance is provided by NHSEI on the financial regime from 1st April 2022. Work is underway to also understand the change in the recurring expenditure position of the system, and once the financial regime and funding picture is communicated, the underlying or recurring deficit of the system. An initial assessment of the underlying position undertaken in March 2021 quantified the underlying system deficit at c£80m or 3.4% of funding based on the previously submitted Long Term Plan. The completion of the system underlying deficit will be reviewed by the system Directors of Finance in due course.

8. Recommendation

Through the 2021/22 Operating Plan process, investment of circa £30m has been made to support the Trust deliver more sustainable and higher quality services whilst also looking to increase elective activity recover back to 2019/20 levels.

The main risk to the 2021/22 operating plan is workforce and the level of emergency and non-elective pressures faced by the Trust, as early as in summer 2021.

The Trust Board is asked to note this report for information.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29th July 2021

Report Title	**Integration Progress Report**
Report Author	**Robert Gittins, Programme Director**
Executive Lead	**Paula Clarke, Director of Strategy and Transformation**

1. Report Summary

This report sets out the progress being made with the clinical and corporate integration programme for University Hospitals Bristol and Weston NHS Foundation Trust. Clinical and corporate teams across the Trust continue to work together to provide integrated services for patients.

It was reported in the last integration update to the Public Board that Clinical services integration had been delayed due to the impact of Covid19 and other operational challenges and that a 'review and reset' exercise was being undertaken to safely and sustainably accelerate progress. This review has been completed, with approval of Trust Board, to reset the integration timetable with a revised target completion date of October 2022. The financial implications of extending the transitional period up to the full and final integration will be considered in September 2021.

2. Key points to note

(Including decisions taken)

Board members should note:

- The Integration Report and the progress being made on integration against the reset schedule.

3. Risks

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

Corporate risk, 4539 states that 'Trust core activities and performance are adversely affected by the allocation of resources required to manage service level integration'

4. Advice and Recommendations

*(Support and Board/Committee decisions requested)***:**

- This report is for **Assurance**

The Board is asked to note the Integration Report and the progress being made on integration against the reset schedule.

5. History of the paper

Integration Programme Board	**July 21**
SLT	**July 21**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public
Integration Progress Report
29th July 2021

1. Report Summary

This report sets out the progress being made with the clinical and corporate integration programme for University Hospitals Bristol and Weston NHS Foundation Trust. Clinical and corporate teams across the Trust continue to work together to provide integrated services for patients.

It was reported in the last integration update to the Public Board that Clinical services integration had been delayed due to the impact of Covid19 and other operational challenges and that a 'review and reset' exercise was being undertaken to safely and sustainably accelerate progress. This review has been completed, with approval of Trust Board, to reset the integration timetable with a revised target completion date of October 2022. The financial implications of extending the transitional period up to the full and final integration will be considered in September 2021.

2. Clinical Services Update

70% of all clinical services have now commenced or completed the integration process in line with the reset timetable. The following 9 clinical services have completed the process and are operating as a single UHBW clinical team:

- Sexual Health
- Laboratory Services
- Therapies
- Paediatrics
- Audiology
- Resuscitation
- Site Coordination & Patient Flow
- Integrated Discharge Service (IDS)
- Cancer Personalised Care and Support teams

Work with both the medical and surgical divisions is now being accelerated. Workshops have taken place for two of the priority specialties in Medicine (ED and Acute Medicine), and further sessions planned shortly with Care of the Elderly and Respiratory teams.

In August, formal service integration commenced for the following surgical services with dual reporting arrangements, ahead of full integration in in late September / October when these services will be managed by the UHBW Surgical Division:

- Critical Care
- Anaesthesia.

- Pre-Op
- Ophthalmology

The Division of Surgery expects to complete the integration of all their services by February 2022, ahead of schedule.

In September, following the conclusion of the staff consultation process, Pharmacy will become a single integrated service, as will Gynaecology.

Progress is also being made on the proposed management hub model that will ensure operational grip, day to day support and provide leadership for working with local partners to integrate hospital and community services within the place of Weston, following full integration and transition from the Division of Weston next year.

Good progress is being made working with partner providers for sustainable delivery of some clinical services at WGH including Microbiology. Discussions at an advanced stage with North Bristol NHS Trust (Severn Pathology) and Public Health England (PHE) over service reconfiguration that would see an Essential Services Laboratory (ESL) remain on the Weston site, supported by the regional laboratory capacity and expertise of specialist partners.

The planned service transfer of the Weston Urology service to North Bristol NHS Trust (NBT) management has now been approved by both Trust Boards, and will to go ahead on 1st October 2021, following the satisfactory conclusion of joint consultation with the 20 staff affected. The Urology services will continue to be delivered by NBT from Weston General Hospital. We are working closely with NBT to ensure posters/banners are visible within the department at Weston General after the 1st October go-live and that website copy is updated accordingly so the public can access up-to-date accurate information about the service and the new provider, alongside assurances of the continued delivery of high-quality local care.

3. Recruitment

When the Trust approved the business case for merger, it was recognised that a key enabler of improvement at Weston General would be recruitment of more substantive staff across the clinical professions. The five year plan to achieve this is being supported by dedicated recruitment and retention resources.

The Trust has developed a targeted campaign for recruiting nurses to Weston General Hospital. The comprehensive recruitment package includes information relating to benefits, work-life balance and relocation assistance for the candidate and their family. A high quality promotional video to showcase nursing roles in the Weston Division has been launched and is being followed by a significant social media campaign: https://www.uhbwcareers.nhs.uk/love-weston.

As part of the wider recruitment plan for the Trust, we are also pleased to say that following a strict quarantine procedure, a group of 21 international nurses have commenced work at Weston General, with a further cohort group through pre-employment checks.

There is a national shortage across a range of medical specialties, and we are competing for talent with other local and national Trusts. As part of our approach, we are in the process of building a compelling offer for clinicians to come to Weston and / or work across both sites, including creating a video to showcase medical roles at Weston, a full page national advertisement and sustained international recruitment. Offers for permanent and interim Medical positions have been accepted and are currently subject to pre-employment checks before starting. This includes appointing to one fixed term and four permanent consultant posts, plus one specialty doctor.

4. Corporate Trust Services Integration

Integrating corporate services is an important building block of our approach to developing a new and common approach across University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). It's been reported previously that 19 out of 21 corporate services have completed their integration process and are operating as single Trust Services and work continues to ensure these teams share learning as they become used to working together.

Integrating our digital services teams across the Trust has presented a significant challenge, given the scale and complexity of the workforce. Staff consultations on the proposed changes have now been completed and the leadership of the service are in the process of completing the implementation. This is an important underpinning step in our digital convergence programme at Weston General. The remaining team to integrate is Communications, with the staff consultation on changes commencing early next month.

5. Communication and Engagement

A roadmap of our integration story has been completed and tested with staff, now taking into account the feedback received to ensure it is accessible and easy to understand, prior to wider sharing. The roadmap is a visual aid which outlines the key milestones of our merger and working towards our collective vision. It will be a live document which will be updated and developed as we continue to make progress on our journey, and will be used for sharing within the different stakeholder groups; staff, patients and public as well as other stakeholders such as partner organisations, and health scrutiny committee members. It serves as a helpful reminder of everything that has been achieved – the challenges, the celebrations and the benefits – and also the direction of travel for the organisation, guiding us in our mission and supporting us to realise our vision.

To support service changes, the Communications team share with staff important information regarding services as they become single Trust-wide teams – ensuring staff understand the changes and how they affect them.

6. Developing a shared set of UHBW Values

As part of our values engagement process, our staff have been sharing their thoughts on what our future values should be as a new organisation operating in a changed NHS context. We have had over 2,400 responses so far to the online survey, and have also conducted extensive staff focus groups across all our sites.

Our shared Values matter, as they help us to build a strong, united future as a single Trust. They will bind us together and guide how we act individually and collectively to make the experience of working at UHBW, and that of our patients, better. Ensuring that staff at Weston Hospital engage fully in this process remains a priority.

Once we have all the information in from our surveys and focus groups, there will be the opportunity to consider the themes that have emerged, with a launch event in the Autumn to explore and celebrate our shared values as a single Trust.

7. Digital Convergence

The Trust has a 5 year programme of digital convergence for both its corporate and clinical systems. As part of this programme, we have successfully implemented the Bluespier Theatres system at Weston General, which will enable staff to deliver more effective and integrated theatre management, resourcing and scheduling across the Trust.

The Philips Intensive Care patient IT system has now gone live at Weston, providing clinical teams with advanced clinical decision support software, structured documentation and analysis tools to provide integrated care across the Trusts critical care services.

Improving communication and collaboration between multi-disciplinary teams across care communities has a beneficial impact upon clinical care and clinical outcomes. To enable this, the Trust is rolling out the CareFlow Connect product at Weston General over the next six months, starting with clinical engagement later this month.

Plans also continue apace with the merger of our patient administration system (Medway), with preparations for initial testing this month, ahead of the go live in April 2022.

Our Communications team have supported the roll out of these technology projects publicizing the implementation arrangements and drop in sessions for staff to find out more about the systems and their real-life benefits.

8. Healthy Weston

The Healthy Weston Partnership Board has recently reviewed the early impact of the changes agreed in the Healthy Weston programme from October 2019. The majority of this work is now complete, with remaining actions rescheduled for the next 6-12 months due to the adverse impact of Covid on hospital activities.

As part of the Healthy Weston Partnership Board's work to define the long-term design and vision for services in North Somerset, a Clinical Design and Delivery Group chaired by the UHBW deputy Medical Director has had its first meeting, with representation from across Health and social care partners.

The North Somerset Health Overview and Scrutiny Panel (HOSP) has also undertaken at its July meeting in public a review one year after the start of the implementation of the Healthy Weston changes.

9. Recommendations

This report is for Assurance.

The Board is asked to note the Integration Report and the progress being made on integration against the reset schedule.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on 29th July 2021

Report Title	**Transforming Care Programme Board Report**
Report Author	**Melanie Jeffries, Transformation Programme Manager**
Executive Lead	**Paula Clarke**

1. Report Summary	
This Transforming Care update provides highlights of the key transformation and improvement work that has progressed during Quarter 1 (April - March 2021), including new projects undertaken as part of the Trust Covid 19 response	
2. Key points to note *(Including decisions taken)*	
• Transforming Care Programme 2021/22 approved by Business Senior Leadership Team on 23rd June 2021	
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**	
The risks associated with this report include: • None	
4. Advice and Recommendations *(Support and Board/Committee decisions requested)***:**	
• This report is for **INFORMATION** • The Board is asked to **NOTE** the report	
5. History of the paper **Please include details of where paper has <u>previously</u> been received.**	
Strategic SLT	7th July 2021

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Quarter 1 Transforming Care programme report

This Transforming Care update provides highlights of the key transformation and improvement work that has progressed during quarter 1 (April – June 2021).

The SPORT report below (Appendix 1) provides further detail of initiatives.

2020/21 Transforming Care programme

The following programme was approved by Business Senior Leadership Team on 23rd June 2021:

Alignment with Trust Strategic Priorities	Programme	Purpose
Our Patients Our People Our Partners	Restoration programme	Trust-wide programme comprising a range of initiatives to support delivery of high quality care and efficient patient pathways and recover waiting times by reducing backlogs. Including: (1) Proactive hospital (2) Planned Care (3) Redesign of Outpatients (4) Theatres (5) Urgent Care (6) Cancer (7) Demand & Capacity (8) Staff Wellbeing
Our Patients Our People Our Portfolio	Improving management of Medicine Division inpatient bed base	Configure the Division bed base to effectively meet the needs of patients requiring medicine specialties care. Whilst, attracting and retaining talented health professionals across all disciplines.
Our People	Advanced Care Practitioner (ACP) workforce	To support the development and oversight of Trust-wide Advanced Clinical Practitioner strategy, including Operational, Education, Workforce work-streams.
Our People	Leadership and Management Development	Develop a Trust-wide collaborative leadership and management programme for staff. This will involve oversight of both internal and external opportunities and in collaboration with transformation, clinical and non-clinical teams.
Our Potential	Transformation, Improvement and Innovation Strategy	Delivery of Year 2 action plan, to build Trust-wide improvement capacity and capability, and develop a Trust-wide continuous improvement culture.
Our Patients Our People Our Partners	Healthy Weston	Complete delivery of the four priority areas.

In addition to this programme it was agreed the Transformation team will re-establish

dedicated Divisional resource, 7.5 hours per week clinical divisions, 8 hours a month Trust services/Estates and Facilities. Divisional Transformation resource is used to build improvement capability though coaching, or supporting staff with the delivery of small to medium sized improvement projects.

Proactive Hospital

Proactive Hospital was launched in May 2021, having been in planning phase in the preceding eight months. Proactive Hospital is a model of working that improves quality and efficiency by supporting agile improvements to the way we assess, admit and discharge patients through our hospitals.

Improvements have been prioritised to support the delivery of four key drivers:
efficient arrival, swift assessment, seamless admission and transfer and prompt discharge.

Proactive Hospital coaches will be recruited to support staff involved to develop their improvement capability and promote the development of a continuous improvement culture, with funding provided via the 2021/22 OPP.

Until coaches are in post to support full mobilisation of Proactive Hospital, the transformation team will support the following initial priority projects:

Efficient arrival	Improving the speed of ambulance handovers by reducing second handovers
Swift assessment	Led by the frailty team, likely focus on early identification of patients suitable for frailty in-reach team in Emergency Department (ED) – to be agreed by team in July 2021
Seamless admission and transfer	'Tap to Transfer' – optimising the use of Medway system to signal when beds are ready, improving flow from ED to assessment units
Prompt discharge	Working group to commence in October 2021, when new Assistant Director of Operations – Discharge Services, is in post

COVID 19 response

Transformation team resource was allocated to support the following area of work:

- **Hospital entrances and exits**

  A project was commenced in April 2021 to standardise all Trust hospital entrances and exits, in relation to Infection prevention and control equipment and communication.

  Work has included involving patients' with visual and auditory impairment in co-designing requirements, as well as site visits by a range of UHBW staff. Each patient entrance was reviewed to implement improved Personal Protective Equipment stations, more effective communication as well as more efficient flow in and out.

  The standardised entrances will be live from July 2021, once in place the managed access security guards will be stood down.

Quality Improvement (QI) and Bright Ideas

- **QI Gold**

  The second QI Gold programme commenced in April. Five of the six training days have been completed, with an additional catch up session for attendee's unable to attend.

  Each of the projects are working with their allocated mentors to plan and deliver the identified improvements.

QI Gold project		Key Update
Estates & Facilities	Scoping a digital management system for facilities, estates and capital projects	• Staff survey and focus group planned for July • Feedback collected will be used to ensure correct solution is designed
Diagnostics & Therapies	Improving Urgent ED CT scan turnaround times	• Diagnostic phase completed to understand the problem • Initial focus is the requesting scans phase of the process
Trust Services	Improvements in corporate induction and essential training	• Scoping and design of improvements underway • Engagement with team completed • Managing significant risk of scope creep to ensure project remains deliverable
Medicine	Implementing a tele monitoring pathway for CPAP patients	• Team decided to focus on different project, as initial submission was not ready to take forward. • Scoping and design of improvements underway
Weston	Improving the colorectal pathway – outpatients and endoscopy	• Focus on implementing a straight to test pathway for two week wait patients.
Surgery	Development of a unified comprehensive pre-habilitation programme	• Staff survey commenced • Patient survey planned • Pre-habiliation digital note launched

- **QI Forum**

  The QI Forum is being moved online for 2021/22. A week of improvement focused events and presentation is planned for 12th -16th July 2021.

  The purpose of the QI forum is to share and celebrate the wide range of Quality Improvement initiatives completed across our organisation

- **Bright Ideas**

  A decision has been made to delay the next Bright Ideas competition until Autumn 2021, allowing time for previous winners to have support to complete their ideas.

Bright Idea winner	Key updates
Developing films to support parents, children and young people on their cancer journey	• Short films to provide essential information needed following a cancer diagnosis • Storyboard for video developed. • Aim for video to be completed by September 2021
Digital 'Prepare for Surgery'	• Repurpose the current 'Prepare for Surgery' appointment into a digital format to ensure it can be accessed by pre- operative patients • Decision 'Prepare for Surgery' video is of benefit outside of pandemic restrictions, enabling access by more patients than a scheduled appointment • Links with QI Gold pre-habilitation project • Script completed
Prescribed supplements bedside magnet	• Magnets ready to be ordered • Aim is to launch in Medicine Division on 1st August 2021, with support from Matrons and Dietetics service
Video safety netting in CED	• Obtaining further quotes to ensure best value • May need to reduce quantity of videos to stay within allocated budget • Team of Junior Doctors developing the content of the planned videos

Appendix 1: Transforming Care – Progress Summary Q1 April - June 2021/22	
Successes	**Priorities**
Patient fridge magnet reminder for biologics	• Magnets ready to be ordered

• Transforming Care priorities for 2021/22 approved
• Decommissioning of Bristol and Weston Hospital vaccination hubs and restoration of Education/Library services
• Improving management of medicine division inpatient bed base project, recommendation made following diagnostic phase
• experience based design tool for patient involvement in medicine bed project piloted, to gather information on five key phases of admission
• Restoration oversight group programme management established
• Proactive Hospital launched and priority improvements agreed
• Transforming care priority 2020/21 Critical Care Outreach business case funded for six month proof of concept
• One year funding for proactive hospital coaches, to support delivery of the new model of working
• Infection control champion role launched
• Funding and design for staff rest areas in Bristol BRI Level 9 restaurant (design awaiting sign off) , and Weston Rafters restaurant completed, prior to handover of project
• Patient safety Improvement lead commenced
• Weston discharge processes diagnostic completed, and priority improvements agreed
	• Development of Patient Safety Improvement programme, in collaboration with the Head of Quality
	• Hospital at home/OPAT project
	• Delivery of the diagnostic clinical validation project, to meet NHS England requirements
	• Development of Trust-wide theatre efficiency programme
	• Redesign of outpatients:
	  ▪ Community Phlebotomy pathways
	  ▪ Patient initiated follow up (PIFU) implemented in at least three specialties
	• Recruitment of proactive hospital coaches
	• Establishment of Clinical Genetics development programme, which will focus on:
	  • Optimising our highly skilled workforce in Genetics
	  • Building on the successes in improving the delivery of quality care
	  • Enhancing the patient/family experience
	• Transformation Team Annual Report 2020/21
	• Development of Quality Improvement (QI) for Leaders training, which will form part of an Integrated Leadership and Management Development programme
	• Delivery of Weston Discharge Improvement project

Opportunities	**Risks and Threats**
• Submission to South West Severn Deanery to be their QI training provider • Use networks - Shelford Transformation, Severn Networks Trusts, Beneficial changes, Taunton Improvement team – to research methods and tools, to develop our approach for evaluating return on investment (ROI) in our improvement projects • Early adopter of Microsoft 365. Supporting Digital services to understand impact on users, enabling the transformation team to develop skills to be super users, as work with a range of staff across the organisation, and optimise new functionality to deliver our work	• Impact of restoring services on operational teams, and their capacity to engage with Transforming Care priorities • Ability to provide Transformation resource for all the priorities • Ability to maintain delivery of projects at pace, as operational and transformation capacity becomes stretched

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Public Board on 29th July 2021

Report Title	**Integrated Quality & Performance Report**
Report Author	**James Rabbitts, Head of Performance Reporting** **Rob Presland, Associate Director of Performance** **Anne Reader, Head of Quality (Patient Safety)** **Deborah Tunnell, Associate Director of HR Operations**
Executive Lead	**Overview and Access – Mark Smith, Deputy Chief Executive and Chief Operating Officer** **Quality – Deirdre Fowler, Chief Nurse/ William Oldfield, Medical Director** **Workforce – Alex Nestor, Interim Director of People** **Finance – Neil Kemsley, Director of Finance**

1. Report Summary

To provide an overview of the Trust's performance on Quality, Workforce, Access and Finance standards.

2. Key points to note
(Including decisions taken)

Please refer to Executive Summary for an overview.

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

Not applicable as this report is for information and assurance only, although risks referenced within the main body of the report.

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

- This report is for **Assurance.**

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

Quality and Outcomes Committee	**26 July 2021**
People Committee	**27 July 2021**

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University Hospitals Bristol and Weston NHS Foundation Trust

Integrated Quality & Performance Report

July 2021

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NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: June 2021

Executive Summary

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: June 2021

Performance against NHS constitutional standards remained extremely challenging during the month of June (*Datix Risk ID 801 - Risk that one or more standards of the NHS Oversight Framework are not met*). Attendances at the A&E departments were up 5% from the same point in 2019 and 8% above plan, with Trust wide performance against the national 4 hour standard reducing to 70.1%. Emergency admissions continue to be suppressed against normal levels, but there have been increased pressures on flow due to increasing COVID numbers, difficulties in staffing some wards and, on average, 147 beds being occupied by patients medically fit for discharge. Urgent care pressures have contributed towards a downturn in elective activity in the month, with day case and elective inpatient volumes adversely affected. In spite of this, there was a third consecutive month of improvement for patients waiting greater than 52 weeks, with the list size reducing by 14% from the previous month. Outpatient activity also remained above plan and most diagnostic modalities were at or above plan. Unscheduled care demand and increasing occupancy of COVID patients remain as substantive threats to recovery.

There were 146 12 hour trolley wait breaches in June where patients were delayed from being admitted to a Ward from a decision to admit. Performance was adversely affected by the temporary loss of 12 COVID positive beds on the Weston site and restrictions on the use of escalation areas, with the Weston site contributing towards 92% of the total breaches in the month. This partially contributed towards increased pressure on the BRI adults site where ambulance handovers delays greater than 30 minutes continued to be exceptionally high. A BNSSG ambulance handover improvement plan is in development and national support is being provided to assist with resolving immediate problems and preparing for the Winter. The deliverability of in year schemes to accelerate recovery of elective activity has proven to be challenging given the context of the urgent care pressures described, but these initiatives continue to move into the implementation phase where delivery is not compromised. The current status of waiting lists is as follows:

- Referral to Treatment patients waiting 52+ weeks. At the end of June there were 3,114 patients waiting over a year for the start of treatment, which is the third consecutive month of improvement. However, overall referral to treatment waiting list size continues to increase and is currently 10,331 patients higher at the end of June when compared to March 2020 (pre-pandemic). Patients waiting over two years is also on an upwards trajectory with 72 patients waiting at the end of June and a risk of further breaches due to the lack of elective pathways in specialties such as orthopaedics and prioritisation of P1-3 patients which has delayed more routine P4 patients in specialties such as Colorectal Surgery and Urology;
- Diagnostic waiting lists, where 63.9% were waiting within the 6 week standard. Whilst diagnostic activity continues to exceed recovery trajectories and in many cases is performing better than at the same point last year, this is not sufficient to recover the backlog of waiting lists. 13 week breaches remain the current area for improvement and several waiting list initiatives are now scheduled to take place over the summer;
- Outpatients, where 70,406 patients currently have a partial booking follow up status showing as overdue. This position continues to remain stable and independent advice on the best strategy to risk stratify and reduce the backlog of patients has now been received for both the Bristol and Weston sites. These recommendations are currently being reviewed by the Trust Outpatient leads and a plan will be developed for the remainder of the financial year including opportunities to increase patient initiated follow up; and
- Patients on a cancer pathway, where 7 out of 9 cancer standards were achieved in the most recent reporting period, including all of the 31 day decision to treat standards. The number of patients waiting >62 and >104 days on a 62 day GP referred suspected cancer pathway are at pre pandemic levels.

Over the coming weeks attention will move towards management of the next COVID surge, Winter planning and also developing a sustainable multi-year elective recovery plan following the expected release of national guidance outlining the required pace of change in August.

SPORT

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: June 2021

Safe | **Caring**

Successes	Priorities
• Consistently high scores across our maternity , in-patient and emergency department Friends and Family Test indicators despite the continued significant operational pressures June suggest the majority of patients have a good experience from their interactions with our staff and the services we provide. • Early indications of improvements in electronic VTE risk assessment compliance in Trauma and Orthopaedic wards in Bristol are being seen (currently around 90-94%) as a result of a doctor-led quality improvement project. The project is currently ongoing.	• In response to an increase in C difficile cases in Q1, the anti- microbial stewardship team has now restarted focusing on areas where C difficile is identified to ensure and support compliance with antibiotic prescribing guidance. In addition the frequency of environmental audits in these areas has increased to ensure high standards of cleanliness are maintained. • To resume interactive pharmacy and consultant led VTE prevention and treatment teaching for doctors in training in Bristol and Weston sites.

Safe | Caring

Opportunities	Risks & Threats
• To repeat the omitted doses of critical medication spot check audit in Weston General Hospital by the end of August, pending the implementation of regular audits from October 2021. • To increase response rates for emergency department Friends and Family Test feedback we will put in place text feedback (SMS) to increase response rate for the ED in Bristol Eye Hospital. This should provide additional opportunities to learn and improve from patient experience feedback.	Existing known risks: • The past month has seen highly pressured demand on both emergency services and in-patient areas across the Trust which has required close management of safe staffing to be balanced across all areas. The number of lower than expected staffing incidents reported more than doubled this month which is reflective of staff being encouraged to report these incidents to ensure clear visibility. There was also a significant increase in the number of red flag incidents reported. Each of these incidents is reviewed, investigated and feedback provided by the head of nursing. • There are several wards who have consistently worked at staffing levels below their agreed establishment; In order to provide support to the wards, the practice education facilitators and the well-being nurses are ensuring visibility and providing advice and support in order to enhance staff morale. Key new risks in the quality and patient safety domains: • Emerging risk 5351: Risk that the withdrawal of Phillips ventilator devices could affect patient safety and delay provision of devices to new patients requiring home ventilatory support. The patient safety risk to existing patients is very low but it affects devices used by 10,000 patients in our sleep and home NIV services. There have been no reported deaths globally as a result of this issue. A replacement programme is being put in place focussing on highest risk patients first, and the national advice is to continue using these devices until alternatives are provided. The emerging greater risk is to the timely provision of devices for patients who are already waiting to commence treatment. The current risk score is 16, the risk will follow the Trust's risk escalation process.

SPORT

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: June 2021

Responsive | **Effective**

Successes	Priorities
• Achievement of 8 out of 10 cancer standards in May 2021, including all four subsequent treatment standards, the first appointment standard, and both 28 day faster diagnosis standards. • The RTT month-end position associated with over 52-week waiters has reduced by a further 504 between May and June. • The Trust has been successful in obtaining additional in year revenue and capital to support the acceleration of elective activity, some of which will improve future ways of working beyond the life of the accelerator programme. • The Trust has been successful in obtaining national funding to be an early adopter for increasing capacity under the national community diagnostic hub programme, enabling the delivery of additional CT scan activity from August. • The Trust is continuing to meet national Elective Recovery Fund gateway criteria including ongoing focus on data quality improvements of waiting list minimum data set submissions across RTT and diagnostics.	• Ensuring all cancer patients are treated in a clinically safe timescale throughout any 'third wave' of Covid over the summer, and secondly to maintain performance against the 'ongoing' cancer standards for numbers waiting (once clinical priority has been taken into account). • The Medway upgrade was deployed over the weekend of 17th July, there now commences a period of cross checking data from the back-up taken on 16th July to check that RTT pathways are reflecting the correct wait time. This is purely for assurance purposes as a configuration note highlighted a possible issue in waiting times increase for some ERS referrals. • The mandated Diagnostic waiting list clinical prioritisation program has been launched by NHSE/I and a Trustwide working group is working through the requirements to ensure all patients on a diagnostic waiting list have been clinically prioritised by the end of August 2021. • Deployment date of 1st July retained by the BNSSG system despite concerns raised regarding medicines management issues identified in the Community phlebotomy standard operating procedure (Datix Risk ID: 4715 Departmental). The SOP conforms to formulary/shared care arrangements. It has become apparent that this is not a reflection of customary practice across trust Specialities. The risk is being managed internally and with the BNSSG system. • Increasing pressure on Advice and Guidance services to be raised with BNSSG CCG. Review of Dermatology Advice & Guidance service currently in progress (Datix Risk ID: 5347 Departmental). • Outpatient follow up waiting list deconstruction completed. Recommendations under review by outpatient steering group for agreement of next steps in waiting list back log management. • Improvement plan in support of urgent care recovery and to mitigate increasing demand (Datix Risk ID 423 risk that demand for inpatient admissions exceeds capacity)

Responsive | Effective

Opportunities	Risks & Threats
• There is an opportunity to commence testing of the new functionality within Careflow following the recent upgrade from Medway. The initial focus will be on the outpatient worklist function in order to implement mandatory review dates for patients who are placed on-hold. • Further opportunities to accelerate elective activity recovery via the Accelerator programme which can be isolated from the impact of increasing urgent care demand (e.g. relocation of the Eye diagnostic hub, productivity improvement focus in areas such as patient did not attend rates). Outpatient activity in general remains a key area of opportunity and continues to be explored.	• Cancer performance over the summer is being impacted by rising demand in several specialities, likely due to 'pent up' demand from the winter months when some patients were unwilling to come forwards with symptoms. • Rising emergency pressures, the likelihood of a 'third wave' of Covid equivalent to the demand seen in a 'bad winter' and staff being required to isolate, all risk the recovery of the cancer standards over the summer. This is particularly impacting patients of low clinical risk, as those of highest clinical priority are rightly prioritised as capacity becomes more limited (Datix Risk ID 42). • There is a risk that the RTT position will deteriorate further in Weston due to workforce caused by isolation requirement, lack of anaesthetic cover, insufficient nursing and therapies staff and summer holidays which is likely to result in further 104 week wait breaches. • Increase in appointment slot issues (ASIs) dropping off waiting lists at 6 months, following a spike in Covid cases (Datix Risk ID: 4516 Divisional). Increases in Orthopaedics, ENT, Sleep and Genetics are being followed up with Divisions and additional safety nets being put in place within informatics systems. • Increasing pressure and waiting times for advice and guidance. Increasing concern regarding the sustainability of advice and guidance services in the face of increasing demand, alongside sustained referral and backlog demand. Work ongoing with commissioners to implement demand management initiatives such as temporary advice and guidance closures if required. • Ongoing requirement to improve data quality of patient tracking lists, especially given national scrutiny and requirement to achieve 95% confidence levels by December 2021 (Datix Risk ID 5191)

Well-Led

Successes	Priorities
• A successful campaign to assist EU staff in applying for settled status post BREXIT finished on 30th June 2021. Staff fed back that the information provided was helpful and informative. • Launch of the Healthier Together Support Network, providing a rapid and confidential access to local psychological support services for all health and social care staff . • Four permanent Consultants were appointed to the Weston Division in the month of June; an ED Consultant, two Upper GI Surgery Consultants and a Radiology Consultant.. • The Trust welcomed a further 18 International Nurses in the month of June taking the total to 60 nurses arriving with the Trust since the end of April, all of whom have since successfully passed their OSCE assessments and will receive an NMC registration imminently.	• To increase capacity for Patient Safety training sessions across the coming months, to ensure greater access. • A full review of staff recognition is in place, including Long Service badges/ Long Service Awards/ Divisional recognition / the annual Recognising Success event / Retirement. • Roll out of the new quarterly Staff Survey replacing the Friends and Family Test. It will include the nine engagement questions contained in the annual Staff Survey. The online survey being run in Q2 is offered to staff who have zero hour contracts on the Bank. • Developing a business case for consideration by the Trust's Senior Leadership Team to increase the ambition for international nurse recruitment and support the Trust's Trainee Nurse Associate programme.

Well-Led

Opportunities	Risks & Threats
• Roll-out of the Prevention and Management of Violence and Aggression (PMVA) provision continues to extend the range of provision and access, with enrolments to the 'Handling Difficult Telephone Calls' being particularly high. • A reciprocal mentoring programme combined with the launch and rollout of Equality, Diversity & Inclusion Advocates presents an opportunity for sustained cultural change and reaching the ambition of the Trust becoming an inclusive employer of choice. • Recruitment of a new Wellbeing Screening Nurse hosted by Avon Partnership Occupational Health Service and funded by Above & Beyond to provide onsite health assessment and additional expertise for the benefit of staff. • The renewed Allocate contract provides improved access to rostering data; this is being scoped to start the build for a staff data warehouse, providing improved staff metrics across a number of workforce priorities. • Women's and Children's are keen to progress medical e-rostering roll out. Allocate accelerator funding is being explored to support implementation.	• As the 'Speak Up' core training goes live in August as part of Trust compliance reporting, current completion rates indicate it will not achieve the Trust's 90% compliance target. • The Trust has a large amount of employees with fixed term contracts overdue for review and/or extension. This creates a risk of redundancy obligations for the organisation & turnover of talent. • Appraisal compliance remains at risk across all Divisions. • Ongoing increased use of high cost, non-framework nurse agency supply due to significant operational pressures. • Increased demand for bank and agency staff with the significant rise of staffing gaps due to the increased number of staff self-isolating. • Lack of affordable accommodation both in Bristol and Weston impacting on the Trust's ability to support both national and international new starters arriving.

Dashboard

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: June 2021

CQC Domain	Metric	Standard Achieved?
Safe	Infection Control (C. diff)	N
	Infection Control (MRSA)	Y
	Infection Control (E.Coli)	N/A
	Serious Incidents	N/A
	Patient Falls	Y
	Pressure Injuries	Y
	Medicines Management	P
	Essential Training	P
	Nurse Staffing Levels	N/A
	VTE Risk Assessment	N
Caring	Patient Surveys (Bristol)	Y
	Patient Surveys (Weston)	P
	Friends & Family Test	N/A
	Patient Complaints	N

CQC Domain	Metric	Standard Achieved?
Responsive	Emergency Care - 4 Hour Standard	N
	Delayed Transfers of Care	N/A
	Referral To Treatment	N
	Referral to Treatment – 52 Weeks	P
	Cancelled Operations	N
	Cancer Two Week Wait	Y
	Cancer 62 Days	N
	Cancer 104 Days	N/A
	Diagnostic Waits	N
	Outpatient Measures	P
	Outpatient Overdue Follow-Ups	N
Effective	Mortality (SHMI)	Y
	Mortality (HSMR)	Y
	Fracture Neck of Femur	P
	30 Day Emergency Readmissions	N

CQC Domain	Metric	Standard Achieved?
Well-Led	Bank & Agency Usage	P
	Staffing Levels – Turnover	P
	Staffing Levels – Vacancies	N
	Staff Sickness	P
	Staff Appraisal	N
Use of Resources	Average Length of Stay	N/A
	Performance to Plan	N/A
	Divisional Variance	N/A
	Savings	N/A

N	Not Achieved
P	Partially Achieved
Y	Achieved
N/A	Standard Not Defined

Infection Control – C.Difficile

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021

N *Not Achieved*

Standards:	A limit of cases for UHBW was not set for 2020/21 and has yet to be set for 2021/2022. The limit is usually based on the previous financial year's outturn, which requires all cases to have undergone commissioner validation prior to reaching a confirmed year end position. A limit of 72 cases for UHBW (57 for Bristol plus 15 for Weston based on 2019/2020) as a whole for 2020/21 would give a trajectory of 6 cases a month. Healthcare Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA) C.Difficile cases are attributed to the Trust. HOHA cases include patients where C.Difficile is detected from Day 3 after admission. COHA cases include patients where C.Difficile is detected within 4 weeks of discharge from hospital.
Performance:	There were sixteen cases of C. difficile attributed to UHBW in June 2021. Of the sixteen cases, fourteen were HOHA and two were COHA. Each case requires a review by our commissioners before determining whether it will be Trust apportioned if a lapse in care is identified. Hospital Onset Healthcare Associated (HOHA) C. difficile cases are attributed to the Trust after patients have been admitted for two days (day 3 of admission.)
Commentary:	First sets of data including post infection reviews have been sent to the commissioners for the outstanding reviews Q4 19/20 and Q1 20/21 – this is for cases across the Trust. Further post-infection reviews will be scheduled to deal with each of the remaining outstanding quarters in 20/21. Increased cases have been identified across both Bristol and Weston sites Actions taken: • Increased environmental auditing within areas of increased rates • Anti- microbial stewardship now restarted focusing on areas where C difficile identified to ensure and support compliance with guidance
Ownership:	Chief Nurse

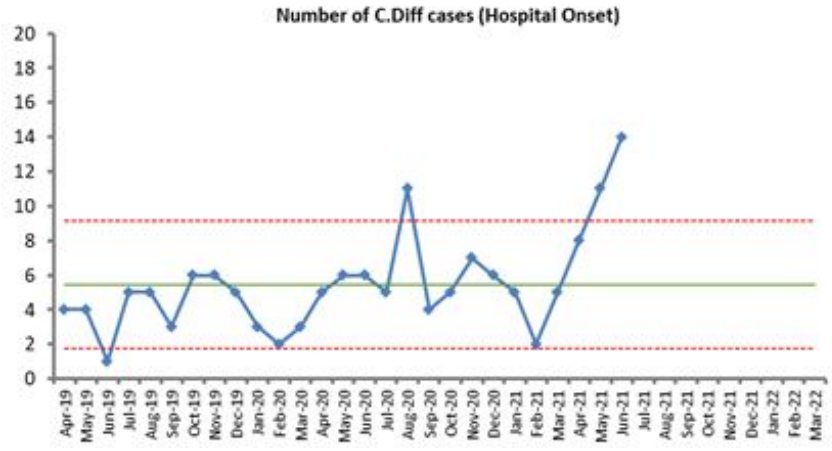
	Jun-21		2021/2022		2020/2021	
	HA	HO	HA	HO	HA	HO
Medicine	6	6	12	12	25	24
Specialised Services	3	3	8	8	23	18
Surgery	1	1	4	4	11	11
Weston	4	3	10	7	12	8
Women's and Children's	1	1	2	2	7	6
Other (Bristol)	1	0	2	0	3	0
TOTAL	**16**	**14**	**38**	**33**	**81**	**67**

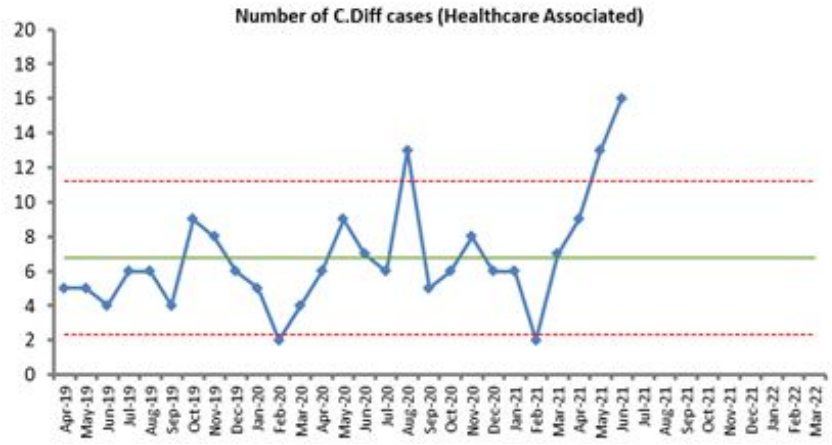
HA = Healthcare Associated, HO = Hospital Onset

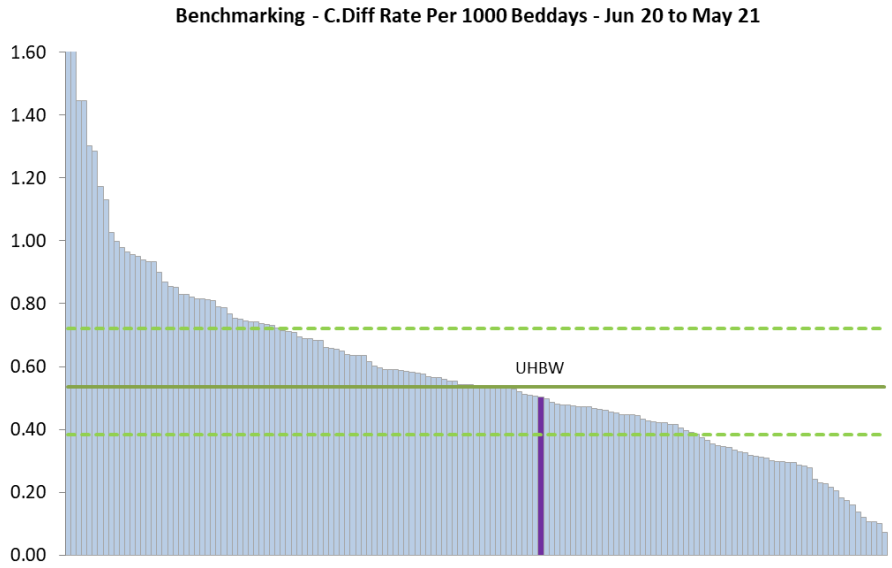
Infection Control – C.Difficile

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021







Infection Control - MRSA

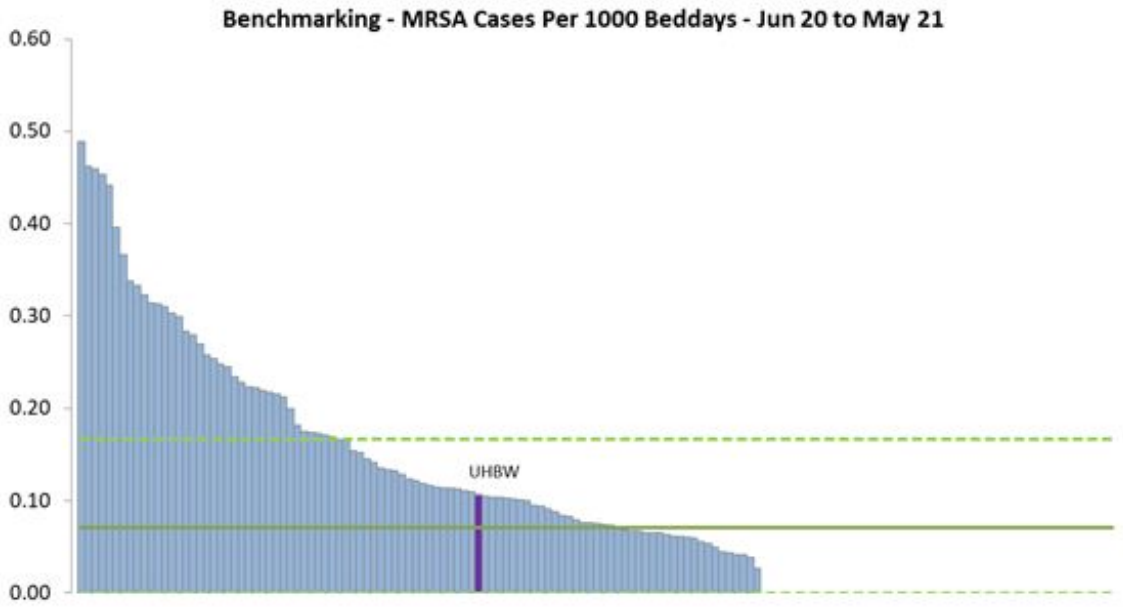
NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

Y *Achieved*

Standards:	No Trust Apportioned MRSA cases. This is Hospital Onset cases only.
Performance:	There were no new cases of MRSA bacteraemia in UBHW in June 2021.
Commentary:	There have been no Hospital Onset cases in the first three months of 2021/22. There were four reported MRSA cases for the whole 2020/21.
Ownership:	Chief Nurse

	Jun-21	2021/2022	2020/2021
Medicine	0	0	0
Specialised Services	0	0	1
Surgery	0	0	0
Weston	0	0	1
Women's and Children's	0	0	2
TOTAL	**0**	**0**	**4**



Infection Control – E. Coli

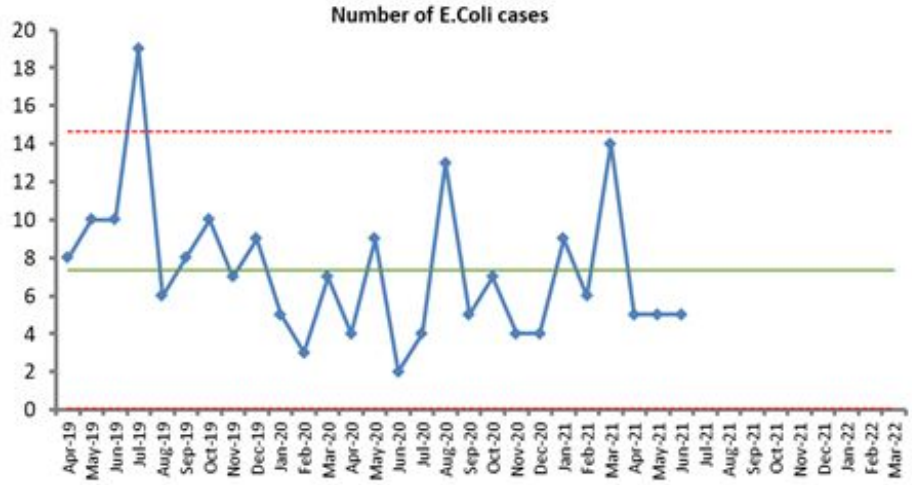
University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

N/A *No Standard Defined*

Standards:	Enhanced surveillance of *Escherichia* coli *(E.coli)* bacteraemia is mandatory for NHS acute trusts. Patient data of any bacteraemias are reported monthly to Public Health England (PHE). As a result in the national rise in *E.coli* bacteraemia rates, a more in-depth investigation into the source of the *E.coli* bacteraemias is initially undertaken by a member of the Infection Prevention and Control team. Reviews include identifying whether the patient has a urinary catheter and whether this could be a possible source of infection. If any lapses in care are identified at the initial review of each case, a more complete analysis of the patient's care is carried out by the ward manager through the incident reporting mechanism. There is a time lag between reported cases and completed reviews.
Performance:	There were five Hospital Onset cases in June, giving 15 cases year-to-date.
Commentary:	Urinary tract infections were identified as the source of the E.coli bacteraemia in one of the five identified. None of the cases were identified as urinary catheter related. Gastro-intestinal/intra-abdominal collection was identified as the source of infection for one of the identified cases case and hepatobiliary being the source of one of the 5 cases for June 2021.
Ownership:	Chief Nurse

	Jun-21	2021/2022	2020/2021
Medicine	2	3	27
Specialised Services	1	5	17
Surgery	1	4	21
Weston	1	3	9
Women's and Children's	0	0	7
TOTAL	**5**	**15**	**81**



Serious Incidents

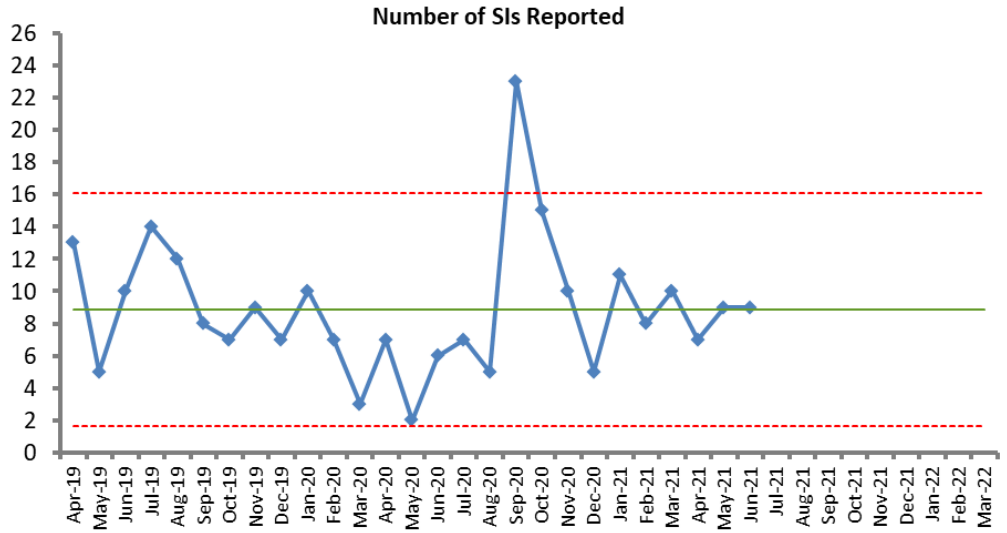
University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

N/A *No Standard Defined*

Standards:	UHBW is committed to identifying, reporting and investigating serious incidents and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence. Serious Incidents (SIs) are identified and reported in accordance with NHS Improvement's Serious Incident Framework 2015. In 2021, a new Patient Safety Incident Response Framework is to be implemented in UHBW in 2021/22 following learning from early adopters.
Latest Data:	Nine serious incidents were reported in June 2021; three each in the Divisions of Medicine & Specialised Services and one each in the Divisions of Surgery, Weston & Women's & Children's.
Commentary:	The nine incidents comprised: two unstageable pressure ulcers, one unexpected death, one pregnancy following the replacement of a contraceptive implant, two lost to follow-up, one unsafe discharge, one chemotherapy toxicity, one obstetric emergency (met HSIB criteria). There were no Never Events reported in the month of June 2021. Underlying issues: • The outcomes and improvement actions of all serious incident investigations will be reported to the Quality and Outcomes Committee (a sub-committee of the Board) in due course.
Ownership:	Chief Nurse

	Jun-21	2021/2022	2020/2021
Medicine	3	7	31
Specialised Services	3	4	6
Surgery	1	6	13
Trust Services	0	0	1
Weston	1	2	50
Women's and Children's	1	6	8
TOTAL	**9**	**25**	**109**



Harm Free Care – Inpatient Falls

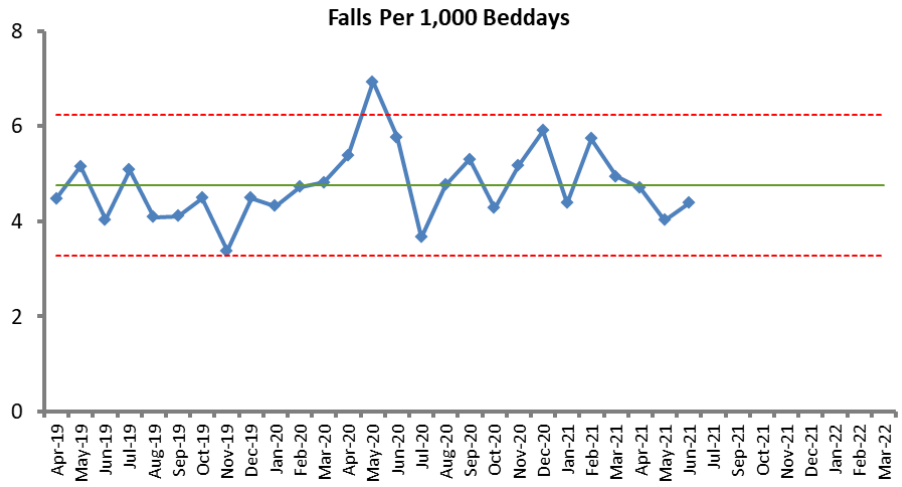
NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

Y *Achieved*

Standards:	To reduce and sustain the number of falls per 1,000 bed days below the UHBW threshold of 4.8 and to reduce and sustain the number of falls resulting in moderate or higher level of harm to two or fewer per month.
Performance:	During June 2021, the rate of falls per 1,000 bed days was 4.38 across UHBW and remains within the statistical process control limits. The rate in Weston is similar to last month at 3.70. There were 134 falls (108 in our Bristol Hospitals and 26 in the Division of Weston) in UHBW in June 2021. Three falls were initially reported in June as resulting moderate and above harm but one of these has since been reassessed as causing negligible harm. One of the remaining two occurred in Weston and one in the BRI.
Commentary:	The number of falls throughout the trust has remained similar over the past 3 months. Actions: • The amended Falls Policy which will provide consistent practice has been approved. • The training for the education programme for pre and post falls care involving the SIM team, the manual handling and falls team has started with a programme roll out across a number of targeted wards to begin with. • An audit has been undertaken looking at Enhanced Care Observation (ECO) levels at the time of falls between April and June 2021 which identified that the majority of patients who sustained an inpatient fall were on ECO 1. These results will be discussed within the Falls Steering Group in order to action future falls prevention work. • Joint working across NBT and UHBW falls team including sharing of good practice and learning is underway.
Ownership:	Chief Nurse

	Jun-21	
	Falls	Per 1,000 Beddays
Diagnostics and Therapies	2	-
Medicine	66	8.37
Specialised Services	21	4.33
Surgery	15	3.88
Weston	26	3.70
Women's and Children's	4	0.58
TRUST TOTAL	134	4.38
Bristol Subtotal	*108*	*4.59*



Harm Free Care – Pressure Injuries

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

Y *Achieved*

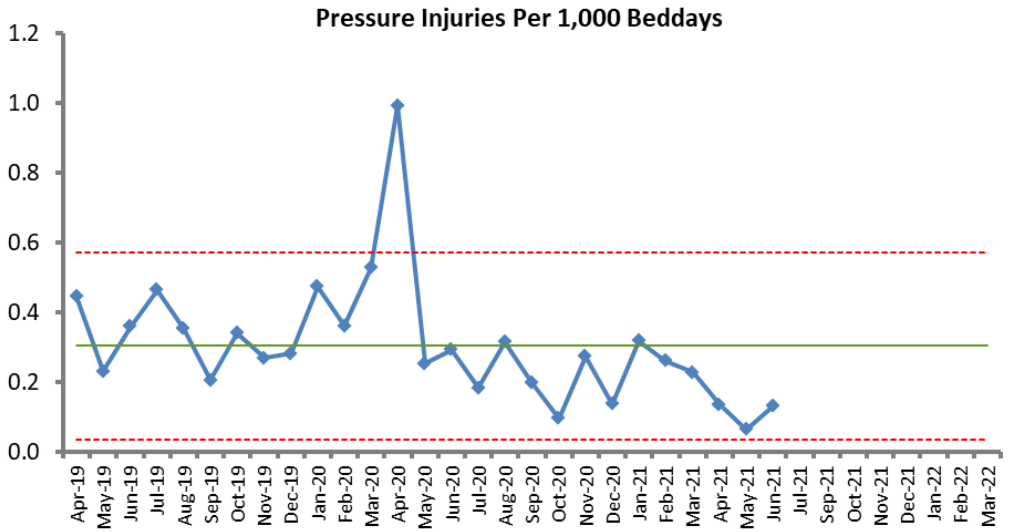
Standards:	To reduce and sustain the number of hospital acquired pressure injuries per 1,000 beddays below an improvement goal of 0.4. Pressure Injures are classified as Category 1,2,3 or 4 depending on depth and skin/tissue loss, with category 4 the most severe. For this measure category 2,3 and 4 are counted. There is an additional category referred to as "Unstageable", where the final categorisation cannot be determined when the incident is reported. However the Tissue Viability Team has agreed that these will be reported as Category 3 pressure injuries within this measure. This has been implemented from this month and will be in place going forward. Whilst there is no clear national or local guidance on how unstageable injuries are reported, the rationale for this change is to draw alignment across Serious Incident reporting, Pressure Injury KPIs and across system partners & North Bristol Trust.
Performance:	During June 2021, the rate of pressure injuries per 1,000 beddays was 0.131 across UHBW. There were three category 2 pressure injuries, two in Surgery Division and one in Weston Division. A theme has been identified with each of these injuries developing to the sacral coccygeal area. In Medicine Division there was one unstageable pressure injury (heel) which evolved from a deep tissue injury. An investigation is underway for the unstageable pressure injury.
Commentary:	Actions, all sites: • Monthly face to face pressure ulcer training re-commenced from July 2021 and open to all clinical staff. • Implement bi-monthly tissue viability champion nurse meetings to support evidence based wound care practice. • A reminder to staff via the monthly training sessions and tissue viability newsletter regarding pressure damage risks to the sacral coccygeal area. • UHBW Tissue Viability Team Twitter Account – set up as another platform to deliver key messages to staff. • Trust wide launch of new tissue viability care pathways, including *Moisture Associated Skin Damage*, *Dressing Selection*, *Leg Ulcer* and *Skin Tear* Pathways in July 2021. • Poster campaign for Emergency Department nurses and wards to highlight the importance of removing leg bandages to perform skin checks within six hours of patient admission. Review of campaign impact in two months to evaluate practice improvement. • Re-introduction of face to face study days in Bristol and Weston from October 2021. Weston Hospital Specific Actions: • Monthly face to face pressure ulcer training re-commenced from July 2021 and open to all clinical staff. • Embedding best practice in use of heel 'off-loading' equipment for vulnerable patients. • Pressure Injury RCA findings to be shared at Ward Sister Governance meetings to encourage division wide learning from serious incidents.
Ownership:	Chief Nurse

Harm Free Care – Pressure Injuries

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

	Jun-21	
	Injuries	Per 1,000 Beddays
Diagnostics and Therapies	0	-
Medicine	1	0.13
Specialised Services	0	0.00
Surgery	2	0.52
Weston	1	0.14
Women's and Children's	0	0.00
TRUST TOTAL	4	0.131
Bristol Subtotal	*3*	*0.13*



Medicines Management

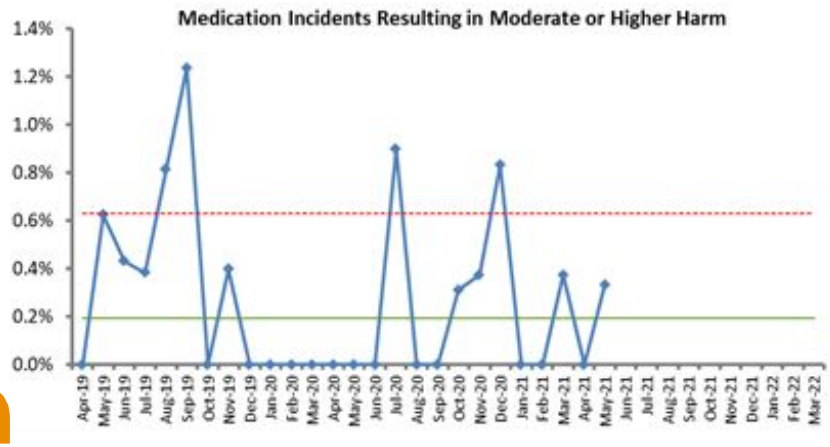
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

May/June 2021

P *Partially Achieved*

Standards:	Number of medication errors resulting in moderate or greater harm to be below 0.5%, with an amber tolerance to 1%. Please note this indicator is a month in arrears. Percentage of non-purposeful omitted doses of critical medicines to be below 0.75% of patients reviewed in the month.
Performance:	There was one moderate harm incidents out of the 301 reported medication incidents in May (0.33%) across UHBW. This was in Bristol division of Medicine. There were three omitted doses of critical medicine out of 496 patients audited in June (0.61%) across Bristol sites. Data on omitted doses for Weston will be collected on a regular basis from October.
Commentary:	The major harm incident occurred when a patient was admitted to the observation unit where they developed sudden left side weakness. A drug chart had not been written for the patient. Thrombolysis could not be administered because the records were unclear about when the patient had last taken their anticoagulant. The patient had to be transferred for clot retrieval because thrombolysis could not be given. This incident is undergoing root cause analysis investigation. The omitted doses reported in June involved two drugs which were not available on the ward; the first is a medicine used after transplant to prevent rejection, and the second was a restricted antibiotic. In both cases the medicines were ordered urgently and given. The third omitted dose occurred because a drug could not be obtained from the patient's bedside medicine locker as the locker was malfunctioning and would not open. Further doses were ordered urgently from pharmacy while the locker was fixed. Actions: • To continue to promote the urgent requesting of medicines from pharmacy by Careflow in Bristol • A repeat omitted doses spot check audit is planned to be completed in Weston by the end of August.
Ownership:	Medical Director

	May-21		
	Moderate or Higher harm	Total Audited	Percentage
Diagnostics and Therapies	0	0	-
Medicine	1	59	1.69%
Specialised Services	0	51	0.00%
Surgery	0	34	0.00%
Weston	0	30	0.00%
Women's and Children's	0	58	0.00%
Other/Not Known	0	69	-
TRUST TOTAL	**1**	**301**	**0.33%**



Essential Training

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

P *Partially Achieved*

Standards:	Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%, which was set by Bristol and has been adopted by Weston.
Performance:	In June 2021, Essential Training overall compliance remained static at 85%, compared with the previous month (excluding Child Protection Level 3).
Commentary:	June 2021, overall compliance for Core Skills (mandatory/statutory) training remained static compared with the previous month, at **85%** across the eleven programmes. There were increases in compliance of two of the core programmes, however Resuscitation compliance remains low at 66% and Information Governance fell by one percentage point on the month to 80%. Overall compliance for 'Remaining Essential Training' is at 90%, which now includes both Bristol and Weston. • The Resuscitation team are increasing resource at Bristol and Weston, and reducing training times through shorter skills testing, and use of ward-based assessors to assess competency in lieu of full refreshers. • Volunteer essential training is to be delivered through eLearning to improve compliance in 8 core skills, and achieve the Volunteer Certificate. • Greater focus upon pass-porting Manual Handling records is in place, supported by eLearning and remote delivery as an alternative to face to face delivery.
Ownership:	Director of People

Essential Training	Jun-21	KPI
Equality, Diversity and Human Rights	91%	90%
Fire Safety	82%	90%
Health, Safety and Welfare (formerly Health & Safety)	91%	90%
Infection Prevention and Control	83%	90%
Information Governance	80%	95%
Moving and Handling (formerly Manual Handling)	81%	90%
NHS Conflict Resolution Training	89%	90%
Preventing Radicalisation	90%	90%
Resuscitation	66%	90%
Safeguarding Adults	88%	90%
Safeguarding Children	88%	90%

Essential Training	Jun-21	KPI
UHBW NHS Foundation Trust	85%	90%
Diagnostics & Therapies	90%	90%
Medicine	81%	90%
Specialised Services	85%	90%
Surgery	83%	90%
Women's & Children's	83%	90%
Trust Services	88%	90%
Facilities & Estates	92%	90%
Weston	84%	90%

Nurse Staffing Levels

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

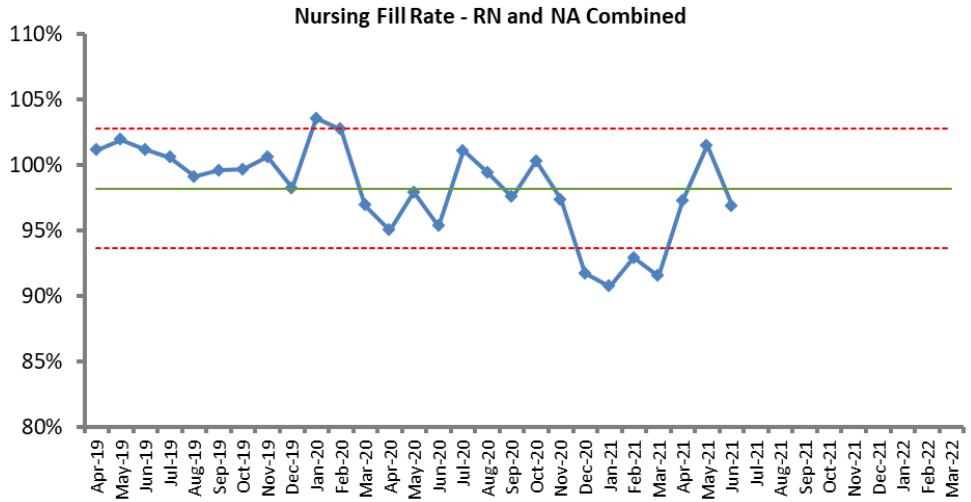
N/A *No Standard Defined*

Standards:	It is an NHS England requirement to publish and report monthly safer staffing levels to the Trust Board. High level figures are provided here and further information and analysis is provided in a separate more detailed report to the Board. The data is reported against Registered Nurse (RN) and Unregistered Nursing Assistant (NA) shifts.
Performance:	The report shows that in June 2021 (for the combined inpatient wards) the Trust had rostered 294,105 expected nursing hours, against the number of actual hours worked of 284,844 giving an overall fill rate of 97%.
Commentary:	The combined figures for UHBW in June 2021 show that the trust had 91% cover for RN's on days and 95% RN cover for nights. The unregistered level of 100% for days and 113% for nights reflects the activity seen in June 2021. Underlying issues: • The past month has seen highly pressured demand on both emergency services and in-patient areas across the Trust which has required close management of safe staffing to be balanced across all areas. The number of lower than expected staffing incidents reported more than doubled this month which is reflective of staff being encouraged to report these incidents to ensure clear visibility. There was also a significant increase in the number of red flag incidents reported. Each of these incidents are reviewed, investigated and feedback provided by the head of nursing. • There are several wards who have consistently worked at staffing levels below their agreed establishment; In order to provide support to the wards, the practice education facilitators and the well-being nurses are ensuring visibility and providing advice and support in order to enhance staff morale. • A decision on the 11th June 2021 was made by the Trust not to open any additional bed capacity at Weston due to the current position with nurse staffing. The extra escalation areas in Bristol have not been able to be opened on a regular basis due to the inability to provide nurse staffing. • Due to the increased number of registered nurse vacancies in order to maintain safe staffing; the use of temporary agency staff has increased. The Trust has been working closely with the neutral vendor to support an increase in fill rate; however with the current supply the use of non-framework agencies has been required. Actions: • The international nurse recruitment and training programme is well underway with the first cohorts of staff progressing through their examination and obtaining their professional registration. The pipeline of registered nurses both national and international due to start over the next three months will make significant progress and impact on the number of vacancies across the Trust.
Ownership:	Chief Nurse

Nurse Staffing Levels

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021



Staffing Fill Rates	Jun-21		
	Total	RN	NA
Medicine	104.3%	99.7%	109.9%
Specialised Services	102.4%	90.9%	138.5%
Surgery	96.4%	91.8%	107.4%
Weston	97.4%	86.3%	110.5%
Women's and Children's	89.6%	93.2%	73.5%
TRUST TOTAL	**96.9%**	**92.7%**	**106.0%**

Venous Thromboembolism Risk Assessment

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

N *Not Achieved*

Standards:	Venous Thromboembolism (VTE) is a significant cause of mortality and disability in England. At least two thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and the administration of appropriate thrombo-prophylaxis. From 2010, Trusts have been required to report quarterly on the number of adults admitted as inpatients in the month who have been risk assessed for VTE on admission to hospital using the criteria in the National VTE Risk Assessment Tool. The expectation for UHBristol was to achieve 95% compliance, with an amber threshold to 90%.
Performance:	In our Bristol hospitals, since August 2019, the VTE risk assessment is completed electronically for individual patients using the Medway system and combined with cohort assessments for low risk groups; for June 2021 the combined figure is 82.5% which has remained fairly static throughout 2020/21 and remains below the lower control limit. In Weston General Hospital the previous paper based data collection system ceased at the end of March 2020.
Commentary:	At the time of the launch of digital VTE risk assessments; there was an expectation that a fully digital integrated system was imminent, whereby VTE risk assessments would be incorporated into admission or prescribing. However, there have been recurrent delays with the full digital roll out which has resulted in VTE risk assessment remaining as a standalone task in Medway. This is seen as the biggest barrier to achieve the expected compliance. See next slide for a table of actions and initiatives.
Ownership:	Medical Director

Venous Thromboembolism Risk Assessment

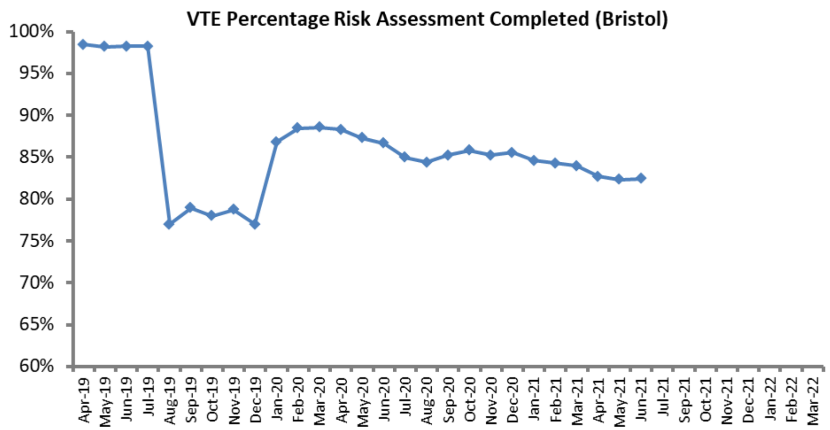
June 2021

Initiative	How this will make a difference	Completion date
Commence programme of patient safety update training in Weston for all clinical staff to raise awareness of current VTE risk and mitigation required	Clinical staff are aware of risk and need to support prescribers to improve compliance with documented VTE risk assessment.	Commenced May 2021 and ongoing.
Recommence HA VTE reviews across UHBW. (There is a time lag for to identify VTEs within 90 days of discharge.)	It will provide assurance that patients are not coming to harm from lack of recording a VTE risk assessment and potentially identify any new learning and improvement opportunities.	Started in Q1. Learning from HA VTE reviews in Q1 to date to be reported by end of August 2021.
Repeat spot check VTE risk assessment audit at Weston	It will provide on-going assurance that thrombo-prophylaxis is being prescribed.	August 2021
Reintroduce Face to Face VTE teaching for new doctors on induction and existing doctors at every opportunities in both Bristol and Weston sites.	It will re-engage doctors in training in the latest evidence base for VTE prevention and management (including the apparent thrombo-philic effect of Covid) and the practicalities of recording risk assessments.	Commencing August 2021
Standardise Low Molecular Weight Heparin and drug chart across Bristol and Weston hospitals and use as a vehicle for additional VTE training in Weston.	As above	August 2021
Introduce electronic VTE risk assessments in Weston Medway system.	There will be one system for recording VTE risk assessments across UHBW with close to real time compliance information for teams.	November 2021
VTE has been formalised as a work stream of our patient safety improvement programme. In addition a doctor led QI project is underway in T & O.	Improve VTE risk assessments pending electronic prescribing.	To be confirmed once programme refreshed post Covid.

Venous Thromboembolism Risk Assessment

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021



The table below shows June's Bristol data based on the admitting specialty.

Division	SubDivision	Number Risk Assessed	Total Patients	Percentage Risk Assessed
Diagnostics and Therapies	Chemical Pathology	[illegible]	[illegible]	100.0%
	Radiology	[illegible]	[illegible]	100.0%
Diagnostics and Therapies Total		[illegible]	[illegible]	[illegible]
Medicine	Medicine	[illegible]	[illegible]	[illegible]
Medicine Total		[illegible]	[illegible]	[illegible]
Specialised Services	BHOC	[illegible]	[illegible]	[illegible]
	Cardiac	[illegible]	[illegible]	[illegible]
Specialised Services Total		[illegible]	[illegible]	[illegible]
Surgery	Adult ITU	[illegible]	[illegible]	100.0%
	Anaesthesia	[illegible]	[illegible]	100.0%
	Dental Services	[illegible]	[illegible]	[illegible]
	ENT & Thoracic	[illegible]	[illegible]	[illegible]
	GI Surgery	[illegible]	[illegible]	[illegible]
	Ophthalmology	[illegible]	[illegible]	[illegible]
	Trauma & Orthopaedics	[illegible]	[illegible]	[illegible]
Surgery Total		[illegible]	[illegible]	[illegible]
Women's and Children's	Children's Services	[illegible]	[illegible]	[illegible]
	Women's Services	[illegible]	[illegible]	[illegible]
Women's and Children's Total		[illegible]	[illegible]	[illegible]
BRISTOL TOTAL		7,251	8,794	82.5%

Safe

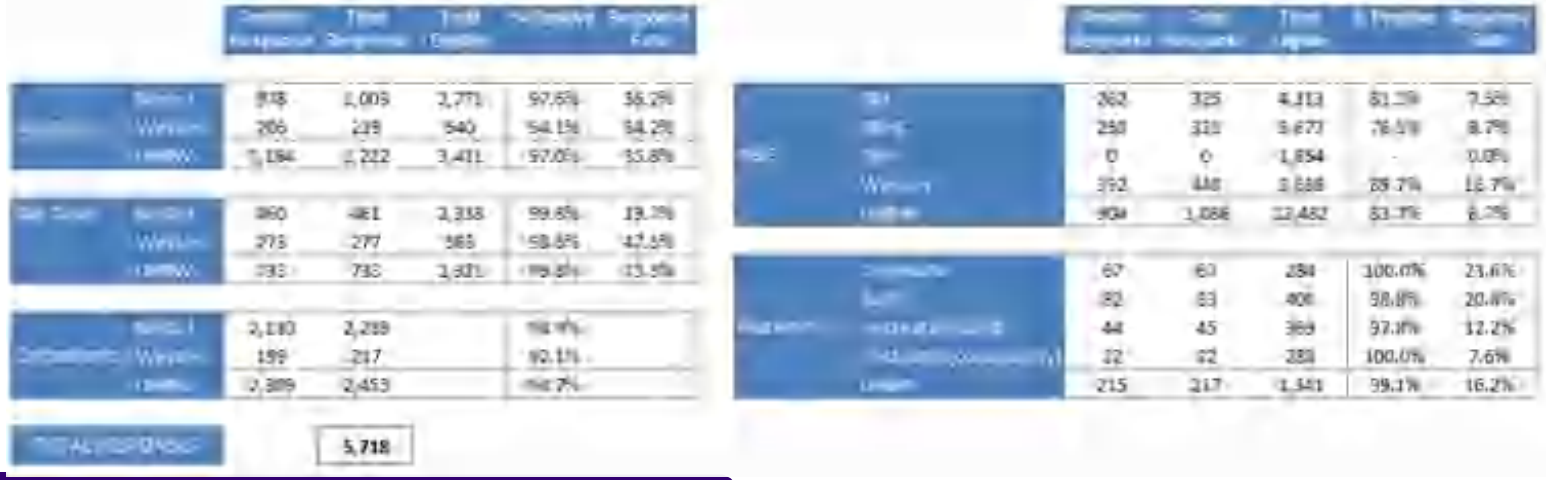
Friends and Family Test (FFT)

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021

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

Standards:	The FFT question asks "Overall, how was your experience of our service?". The proportion who reply "Good" or "Very Good" are classed as Positive Responses, and this is expressed as a percentage of total responses where a response was given. The Trust fully integrated the FFT approach across Bristol and Weston hospitals as of April 2021. FFT data are collected through a combination of online, SMS (for Emergency Departments and Outpatient Services), postal survey responses and FFT cards. There are no response rate targets set.
Performance:	We received 5,718 FFT responses in June 2021, which represents a positive 3.2% increase from the number received in May 2021 (5,539). • Day Case FFT scores are extremely positive across the Trust. • The inpatient FFT score for Bristol hospitals is 97.6% and the score for Division of Weston is 94.1%. • Emergency Department FFT scores for the BRI and BRHC ED have deteriorated for the fourth consecutive month and now stand at 81.1% for the BRI, 78.1% for BRHC. • The Emergency Department FFT score for Weston is 89.7%, the strongest performance in the year to date. • The outpatient FFT score for Bristol hospitals is 94.9% and for Division of Weston 92.1%; • Maternity FFT scores remain extremely positive. Response rates for postnatal ward and community need to increase and there are plans in development to achieve this (see below).
Commentary:	The Patient Experience Team have: • Met with Bristol Eye Hospital and we will put in place text feedback (SMS) to increase response rate for the ED; • Arranged a meeting with the Head of Midwifery to review how to increase response rate for postnatal ward and community maternity services.
Ownership:	Chief Nurse



	818	1,005	1,771	97.6%	56.7%
	266	239	540	94.1%	44.3%
	1,084	1,222	3,411	97.0%	55.8%
	360	481	2,333	99.6%	19.7%
	275	277	565	58.8%	47.5%
	733	733	3,631	99.8%	15.5%
	2,180	2,299		98.4%	
	199	217		92.1%	
	2,389	2,453		98.7%	
		5,718			

	262	325	4,313	81.1%	7.5%
	258	330	5,677	78.5%	8.7%
	0	0	1,854	-	0.0%
	392	448	3,838	89.7%	10.7%
	904	1,086	22,482	83.7%	6.7%
	67	67	284	100.0%	23.6%
	82	83	408	98.8%	20.8%
	44	45	369	97.8%	12.2%
	22	22	288	100.0%	7.6%
	215	217	1,341	99.1%	16.2%

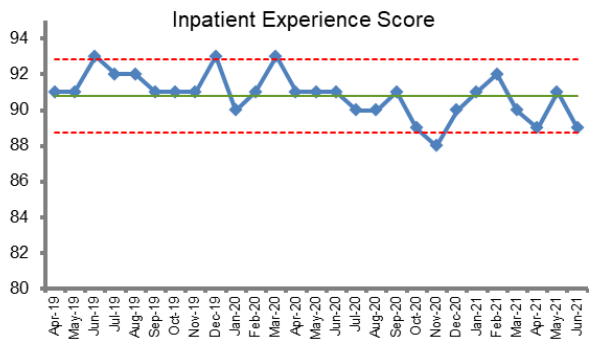
Patient Surveys (Bristol)

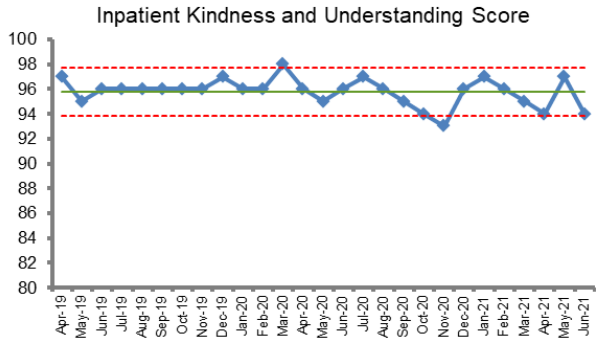
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021

Y ***Achieved***

Standards:	Please note this data relates to Bristol hospitals only. Data for Division of Weston is reported on the following page. For the inpatient and outpatient postal survey, five questions about topics our patients have told us are most important to them are combined to give a score out of 100. For inpatients, the target is to achieve a score of 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target score of 90 or over.
Performance:	For June 2021: • Inpatient score was 89 (May was 91) • Outpatient score was 96 (May was 93) • Kindness and understanding score was 94 (May was 97)
Commentary:	The latest (June) data exceeded the target thresholds.
Ownership:	Chief Nurse





Patient Surveys (Weston)

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021

P ***Partially Achieved***

Standards:	Please note this data relates to Division of Weston only. Following the successful extension of the postal survey programme, this is the first time postal survey data for patients seen at Weston General Hospital (WGH) has been reported. For the inpatient and outpatient postal survey, five questions about topics our patients have told us are most important to them are combined to give a score out of 100. For inpatients, the Trust target is to achieve a score of 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target score of 90 or over.
Performance:	For June 2021: • Inpatient score was 85 (May was 85) • Outpatient score was 85 (May was 94) • Kindness and understanding score was 96 (May was 93)
Commentary:	The drop in outpatient score is entirely driven by a significant drop is the 'waiting time for appointment' measure within the overall tracker score; this was 59, a significant drop from 80 in May 2021. Other outpatient measures (communication / respect and dignity) have remained consistent during quarter 1 2021/22. Further analysis reveals that 23% of patients reported that they waited more than 30 minutes for their appointment to start (after the stated appointment time), compared to 5% in May. Note that the sample size is small and this may skew the results on a monthly basis.
Ownership:	Chief Nurse

Patient Complaints

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021

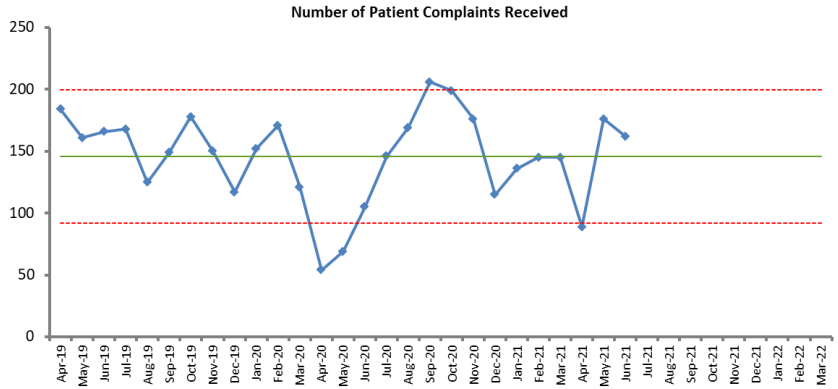
N ***Not Achieved***

Standards:	For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe, with a lower tolerance (Red) of 85%. In addition the requirement is for divisions to return their responses to the Patient Support & Complaints Team (PSCT) seven working days prior to the deadline agreed with the complainant. Of all formal complaints responded to, less than 8% should be re-opened because complainant is dissatisfied, with an upper tolerance of 12%.
Performance:	• In June, 162 complaints were received; 26 formal and 136 informal • In June, 88 formal complaints were responded to. Of these, 65.9% (58 out of 88) were responded to within the agreed timeframe. • Divisions returned 71.6% (63 of 88) of formal responses to the PSCT by the agreed deadline, compared with 63% in May and 93% in April. This is the deadline for responses to be returned to PSCT; seven working days prior to the deadline agreed with the complainant. • 87.8% of informal complaints (43 of 49) were responded to within the agreed timeframe in June 2021, compared with 94.4% in May and 91.2% in April2021. • There were five complaints reported in June 2021 where the complainant was dissatisfied with our response, which represents 9.1% of the 55 first responses sent out in April 2021 (this measure is reported two months in arrears).
Commentary:	The formal complaints Response Time standard of 65.9% shows an improvement on the 57% reported in May 2021 but still significantly below the 95% target. 25 of the 29 breaches were attributable to delays within the divisions, three were due to delays during Executive sign-off and one was due to delays during the checking process by the Patient Support & Complaints Team (PSCT). There were 15 breaches for the Division of Weston, eight for the Division of Medicine, two each for the Divisions of Specialised Services and Women & Children and one each for Estates & Facilities and Diagnostics & Therapies. The Divisions of Surgery and Trust Services had no breaches, with 100% of their responses being sent to complainants by the agreed date. It should be noted that neither of the two breaches for Women & Children were due to delays attributable to the division, who would otherwise have also achieved 100%. For the Response Time for informal complaints, there were three breaches for the Division of Specialised Services and one each for Weston, Surgery and Medicine. Note: At the time of submitting this report, this data had not yet been validated by Divisions.
Ownership:	Chief Nurse

Patient Complaints

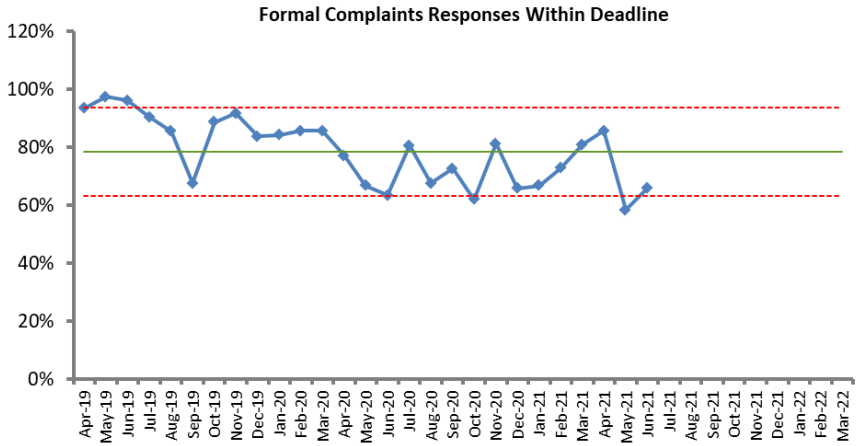
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021



Complaints Received

	Jun-21	2021/2022	2020/2021
Diagnostics and Therapies	12	18	56
Medicine	34	86	385
Specialised Services	24	76	190
Surgery	35	99	406
Trust Services	8	10	56
Weston	16	48	250
Women's and Children's	30	80	273
Estates and Facilities	3	10	49
TOTAL	**162**	**427**	**1665**



Responses Within Deadline	Jun-21	
	% Within Deadline	Total Responses
Diagnostics and Therapies	50.0%	2
Medicine	65.2%	23
Specialised Services	80.0%	10
Surgery	100.0%	14
Trust Services	100.0%	1
Weston	11.1%	18
Women's and Children's	88.9%	18
Estates and Facilities	50.0%	2
TOTAL	**65.9%**	**88**

Emergency Care – 4 Hour Standard

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

N *Not Achieved*

Standards:	Measured as length of time spent in the Emergency Department from arrival to departure/admission. The national standard is that at least 95% of patients should wait under 4 hours. Due to the Covid pandemic, trajectories for 2021/22 have not been agreed with NHS Improvement. There is also an expectation that no patient will wait more than 12 hours in ED after a decision to admit has been made, called "Trolley Waits". There is also an expectation that no Ambulance Handover will exceed 30 minutes.
Performance:	Trust level 4 hour performance for June was 70.1% across all four Emergency Departments (16,871 attendances and 5,046 patients waiting over 4 hours). There were 146 patients who had a Trolley wait in excess of 12 hours (12 in Bristol and 134 at Weston). Between 1st April and 30th June 2021 there were 3,650 Ambulance Handovers that exceeded 30 minutes across all departments. This represents 28% of all Handovers.
Commentary:	**Bristol Royal Infirmary:** Performance against the 4 hour standard was 54.3% which is a continued deterioration from 57.5% in May as attendances continued to average 215 per day which is unprecedented for this time of year (c.f. 179 per day in March). 12 hour trolley waits have increased from 9 to 12 breaches in April reflecting the challenges in staffing escalation capacity and capacity in the community to support discharges. Achieving flow remains a key enabler to minimising overcrowding, ambulance queueing and long waits. Incident Triage Area, Ambulance Queuing and Admissions Overflow Standard Operating Procedures (SOPs) have been established along with increased nursing and medical staffing to support decompressing ED and reducing patient safety risks. A same day emergency care (SDEC) unit has been established in July to support admission avoidance and decompress the emergency department in July following a successful pilot in Spring which diverted over 13 patients and avoided 4.6 admissions per day. The Trust is actively recruiting to enable the unit to expand from a 5 day to a 7 day service. Walk-in activity has continued to escalate resulting in frequent overcrowding in the Fast Flow waiting area which is a known driver of violence and aggression, poor patient experience and reduced infection control and prevention. Walk-in demand has been especially pronounced on Mondays and Tuesdays. Redirection to the Urgent Treatment Centre (UTC) at South Bristol hospital resumed in May in recognition of increasing minor illness/injury demand. However due to high demand across the system, redirection is periodically halted if demand at the UTC becomes high. Messaging to the public to raise awareness of alternatives to Emergency Department attendance has been used through social media as well as a system led radio campaign. The flow challenges have been exacerbated by the following factors: • Workforce shortages, particularly nursing, has meant that inpatient escalation beds could not consistently be staffed • The delay in restoration of primary and community care services has driven an increase in activity to ED which is significantly above usual averages for May as well as ability to discharge patients.

Emergency Care – 4 Hour Standard

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

Commentary:	**Bristol Royal Hospital for Children:** 4 hour performance was 79.32% in June with 4,464 attendances compared to June 2020 - 94% with 2,233 attendances and 2019 - 93% with 3,535 attendances. Attendances continue to rise, we saw our highest attendance of 207 patients in one day. We have seen an increase in 4 hour breaches due to availability on the ward. During our busy times with the high volumes of attendances social distancing within the waiting area is a significant problem, we continue to use outpatients area where possible but more patients presenting are of respiratory symptoms. We are experiencing more work force shortages due to school children having to self-isolate and parents needing to look after them and staff being messaged to self-isolate, this is putting extreme pressure on the department. We are working with the wider system to help decrease ED attendances. **Weston General Hospital:** During the month of June 21 ED attendances increased for the 4th consecutive month. The department saw an increase in walk in attendances although Ambulance arrivals were down from those in May. Performance against the 4 hour target deteriorated to 72.4% in June (down from 77.03% in the month of May). The conversion rate was 21.42% in June (down from 23.27% in May). There has been a significant increase in the number of 12 hour trolley waits - at 134 in June compared to 24 in May – this is largely attributed to the CQC mandated closure of 12 beds on Waterside and the removal of escalation beds in GEMs and the Day Case Unit. This has reduced the Weston core bed base to 230 beds from the pre pandemic core stock of 256 beds (excluding ITU), which is a reduction of 26 beds, in addition to the loss of 13 escalation beds. The Division has continued with its streaming and redirection work at the front door. Flow throughout the division has been challenging – the number of patients who are Medically Fit for Discharge has also been consistently high, with an average of 56 patients, particularly due to lack of Pathway 2 and Pathway 3 capacity, with 1,677 bed days lost in June.

Emergency Care – 4 Hour Standard

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

Commentary:	**Bristol Eye Hospital:** Attendances are slightly decreased this month, with 1859 in June compared with 1867 in May. Performance decreased again this month with 43 four hour breaches, 5 of which were under 4 hrs and 10 minutes. Performance in June was 97.7 % versus 98.1% in May. Five patients were admitted from ED to the ward, none of whom breached. Staffing continues to be difficult. A locum was employed to cover the multiple rota gaps, however the post became vacant unexpectedly creating further staffing issues. Medics are being requested to cover, cancelling other commitments, which will affect other performance metrics. On several occasions consultants have been required to act down to cover absent registrars. In addition, the ED Sister post becomes vacant soon and recruitment is underway. The planned rollout of a new electronic patient went live from 14 June, Initially lengthening processes in ED and therefore impacting on patient waiting times. Breaches increased from 5 in the week before rollout to 20 in the first week. However breach volumes returned to 5 or 6 per week by the fourth week after rollout. The intention is that ultimately it will improve efficiency , especially now the department is paper light. An ED dashboard. has been developed with the Business Intelligence Team and is ready to be published. This will help visibility, in real time, as patients get closer to 4 hours .
Ownership:	Chief Operating Officer

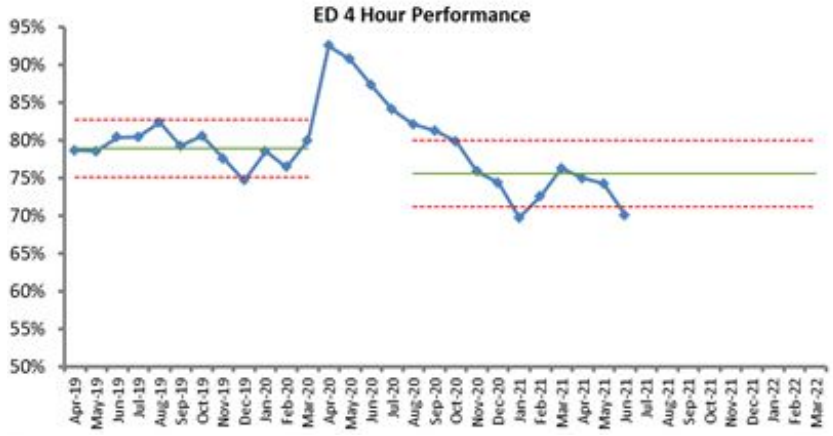
4 Hour Performance	Jun-21	2021/2022
Bristol Royal Infirmary	54.3%	57.9%
Bristol Children's Hospital	79.3%	85.6%
Bristol Eye Hospital	97.7%	98.0%
Weston General Hospital	72.4%	73.5%

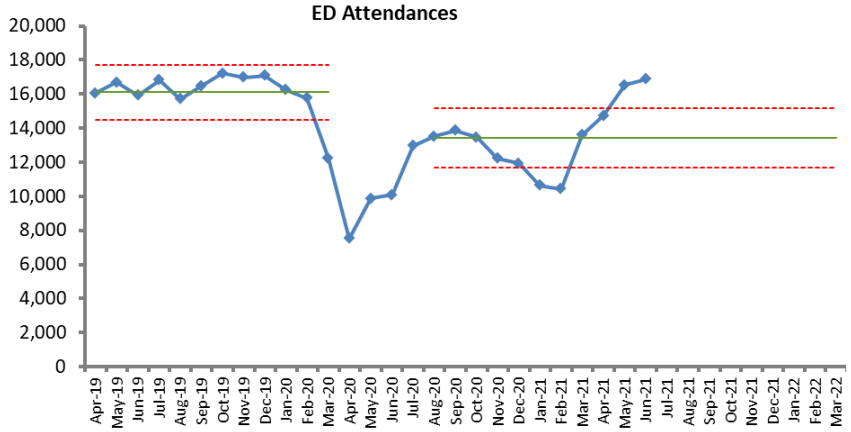
Total Attendances	Jun-21	2021/2022
Bristol Royal Infirmary	6,443	19,192
Bristol Children's Hospital	4,464	11,529
Bristol Eye Hospital	1,859	5,528
Weston General Hospital	4,105	11,868

Emergency Care – 4 Hour Standard

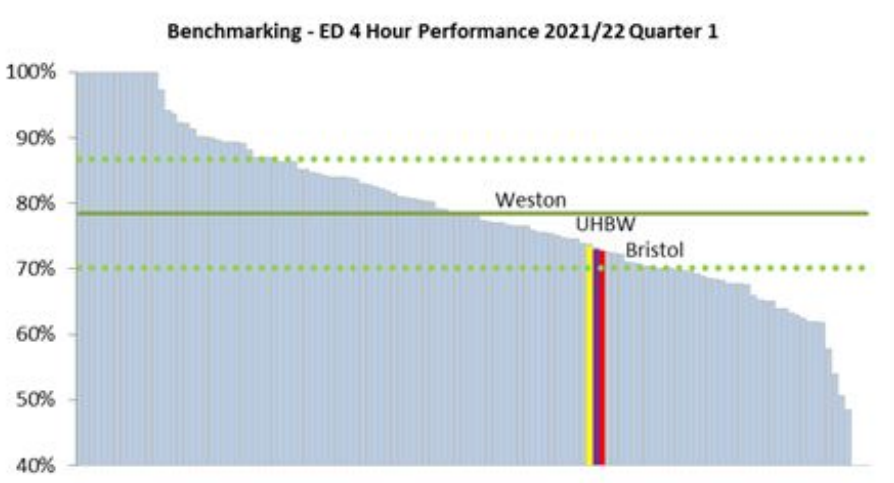
University Hospitals Bristol and Weston NHS Foundation Trust

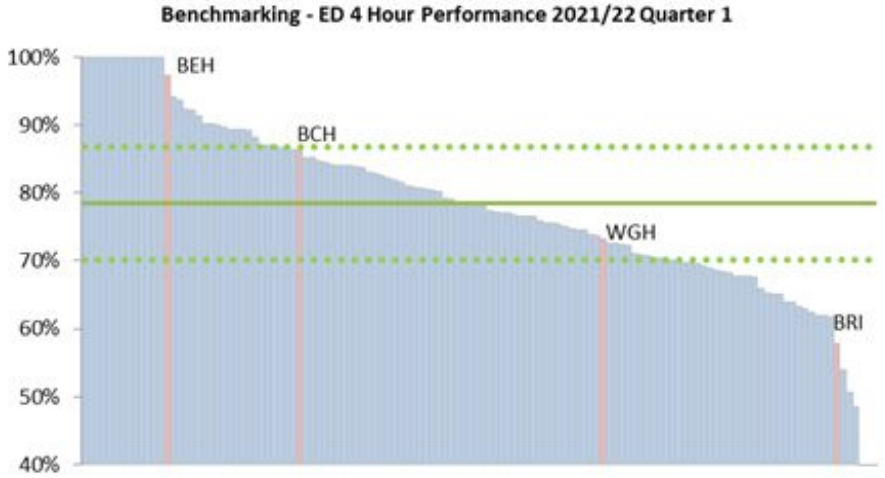
June 2021





Note:
The above charts are now Bristol and Weston data for all months. The Benchmarking chart below is for Type 1 EDs, so for UHBW it excludes the Eye Hospital.





Emergency Care – 12 Hour Trolley Waits

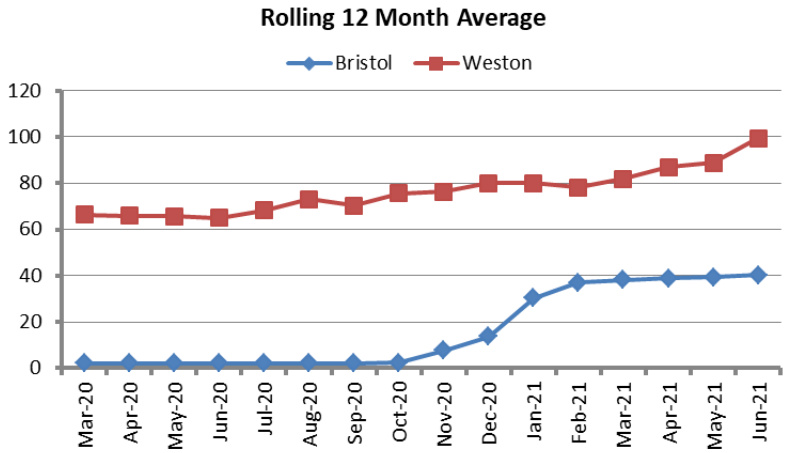
University Hospitals Bristol and Weston NHS Foundation Trust

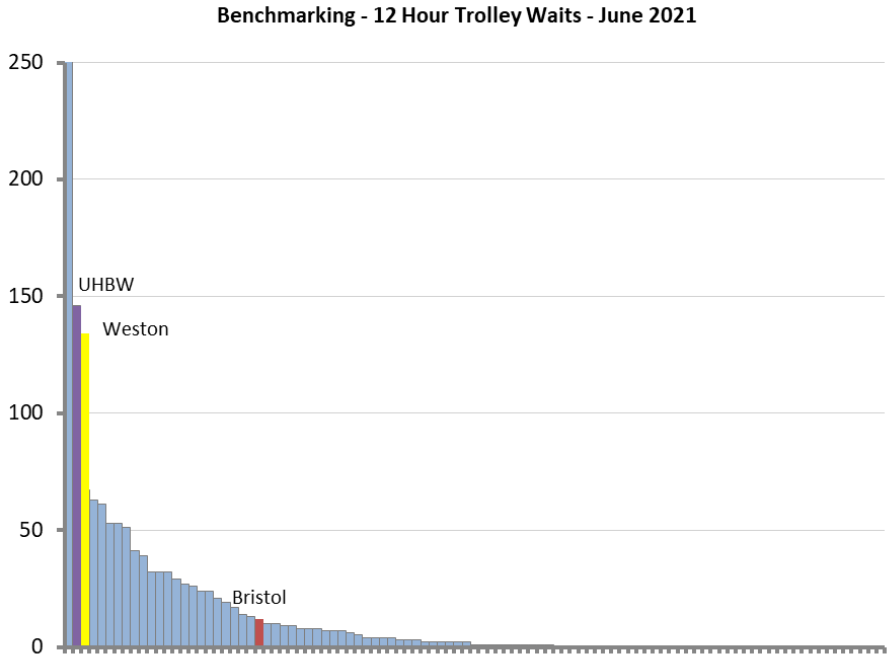
June 2021

12 Hour Trolley Waits

A supporting measure for Emergency Care is the "12 Hour Trolley Wait" standard. For all patients admitted from ED, this measures the time from the Decision To Admit (within ED) and the eventual transfer from ED to a hospital ward. The national quality standard is for zero breaches. Datix ID 5067 Risk that patients will come to harm when they wait over 12 hours to be admitted to an inpatient bed

	2020/2021												2021/2022											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Bristol	0	0	0	0	0	0	3	66	79	211	82	18	9	4	12									
Weston	0	1	7	58	68	6	84	135	168	257	113	84	62	24	134									
UHBW	0	1	7	58	68	6	87	201	247	468	195	102	71	28	146									





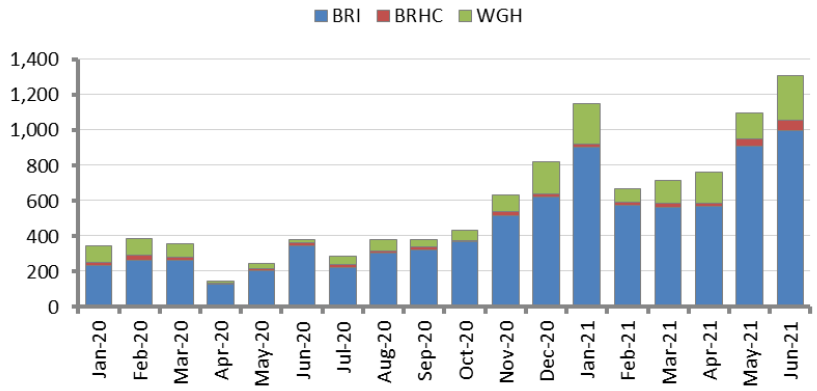
Emergency Care – Ambulance Handovers

University Hospitals Bristol and Weston NHS Foundation Trust

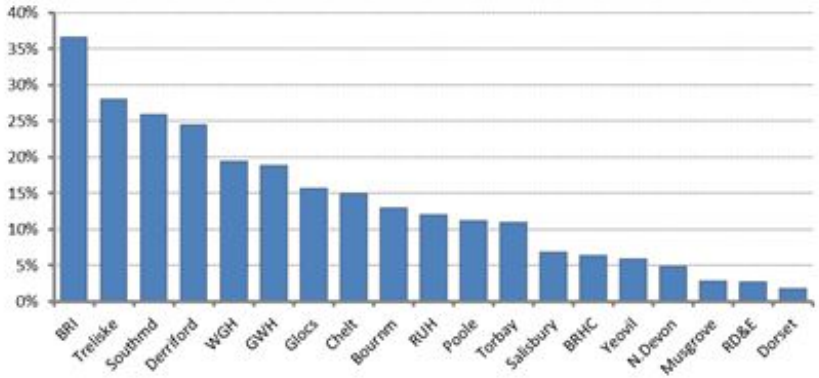
Quarter 1 2021/22

This data is supplied by the South Western Ambulance Service NHS Foundation Trust (SWASFT).
The Handover Time is measured from 5 minutes after the ambulance arrives at the hospital and ends at the time that both clinical and physical care of a patient is handed over from SWASFT staff to hospital staff. This time is not just the time that a verbal handover is conducted; it also includes the time taken to transfer the patient to a hospital chair, bed or trolley.

UHBW Chargeable Ambulance Handovers In Excess of 30 Minutes



Percentage of Handovers Over 30 Minutes (1st April to 30th June)



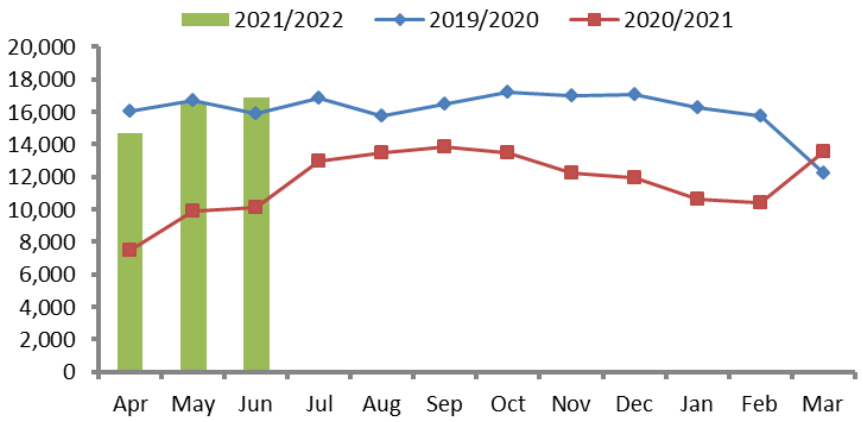
Hospital					

Emergency Care – Supporting Information

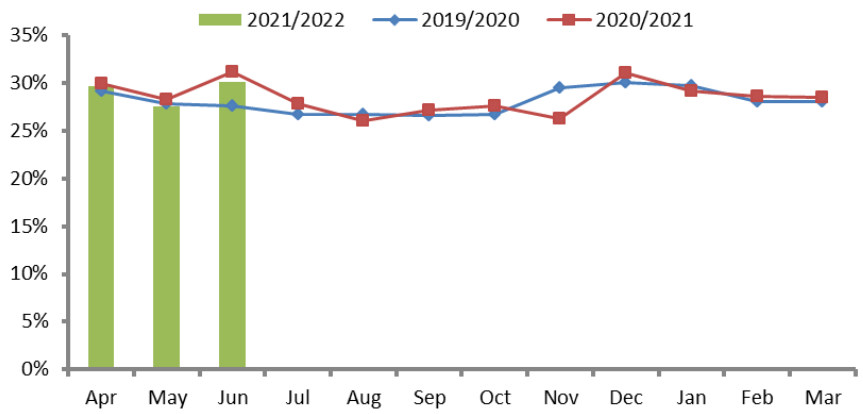
University Hospitals Bristol and Weston NHS Foundation Trust

May 2021

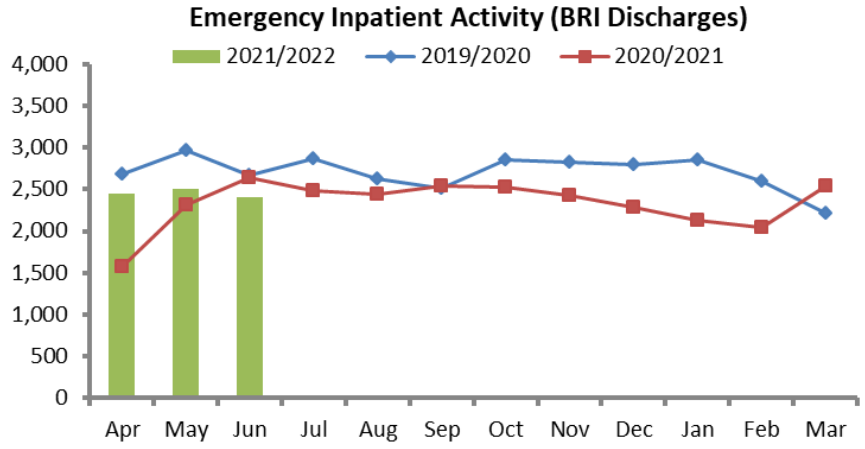
Emergency Department Attendances (UHBW)



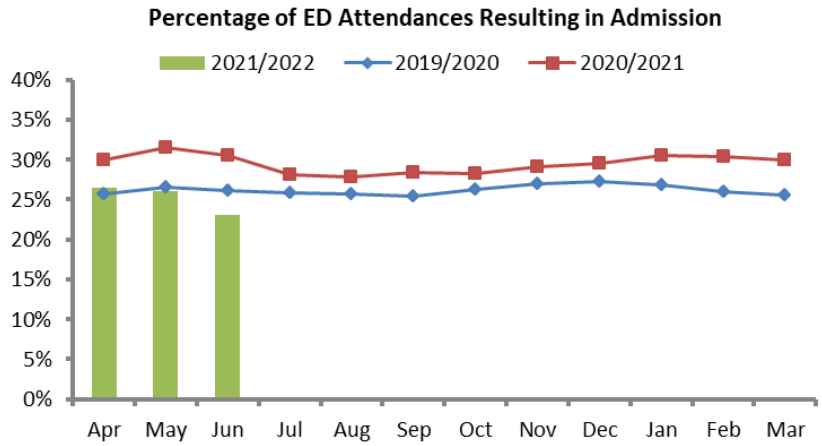
Percentage of Emergency BRI Spells - Patients Aged 75+



Emergency Inpatient Activity (BRI Discharges)



Percentage of ED Attendances Resulting in Admission



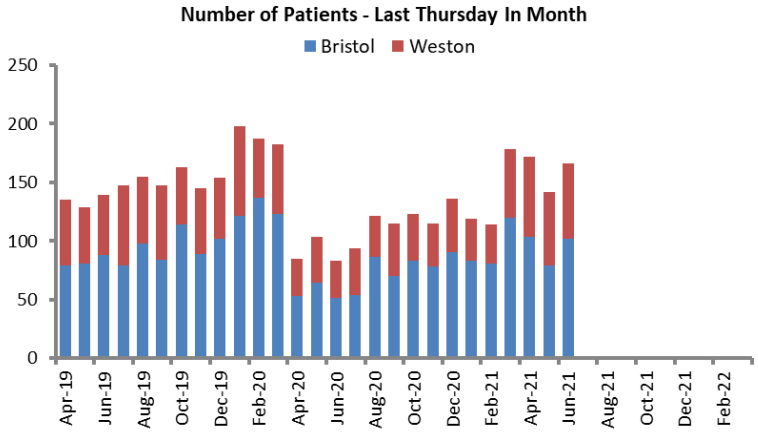
Delayed Discharges

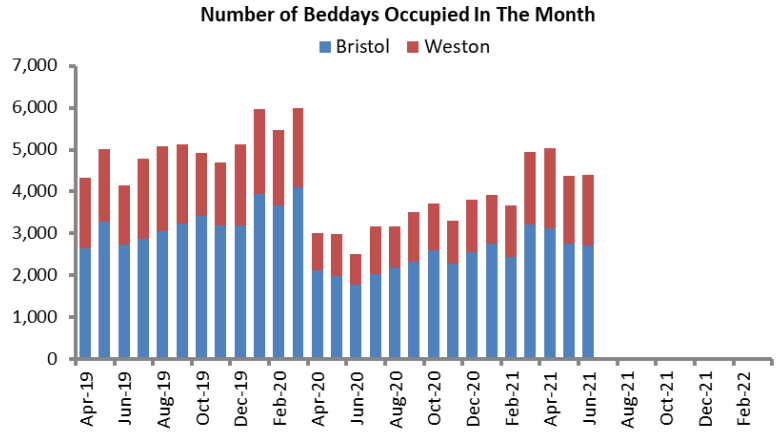
University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

N/A *No Standard Defined*

Standards:	Patients who are medically fit for discharge should wait a minimal amount of time in an acute bed. Pre-Covid, this was captured through Delayed Transfers of Care (DToC) data submitted to NHS England. This return has been discontinued but the Trust continues to capture delayed discharges through its Medically Fit For Discharge (MFFD) lists. These are patients whose ongoing care and assessment can safely be delivered in a non-acute hospital setting, but the patient is still in an acute bed whilst the support is being arranged to enable the discharge. Patients are transferred through one of three pathways; at home with support (Pathway 1), in community based sub-acute bed with rehab and reablement (Pathway 2) or in a care home sub-acute bed with recovery and complex assessment (pathway 3).
Performance:	At the end of June there were 166 MFFD patients in hospital: 102 in Bristol hospitals and 64 at Weston. There were 4,398 beddays consumed in total in the month (1 bedday = 1 bed occupied at 12 midnight). This means, on average, 147 beds were occupied per day by MFFD patients.
Commentary:	Throughout June 2021, the demand across all the pathways in Bristol exceeded capacity : • Pathway 1: referrals continued to exceed the number of slots available due to increasing demand. • Pathway 2: overall capacity remained limited in June 2021 and the waiting list for P2 patients increased. This is due to the temporary reduction in beds at South Bristol Community Hospital being extended until August 2021. Sirona's extensive recruitment programme is underway. • Pathway 3: New P3 contracts have been issued to care homes in Bristol (with particular focus on patients requiring complex dementia care) in an effort to meet demand. The benefits of the new contracts are starting to be realised as the waiting lists for P3 patients appear to be improving.
Ownership:	Chief Operating Officer





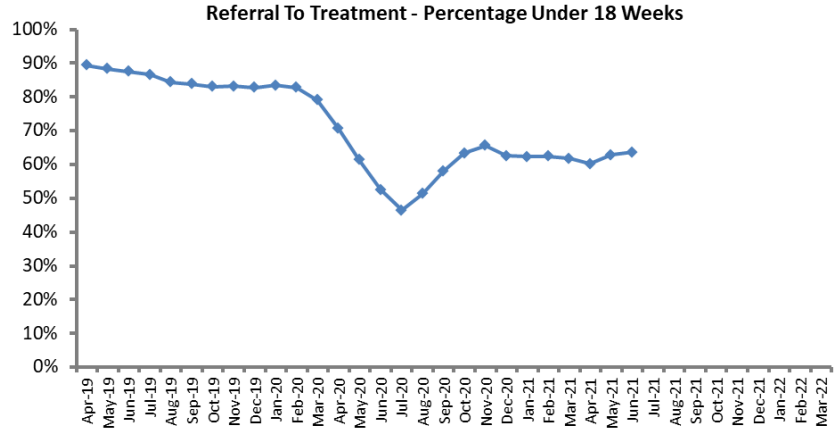
Referral To Treatment

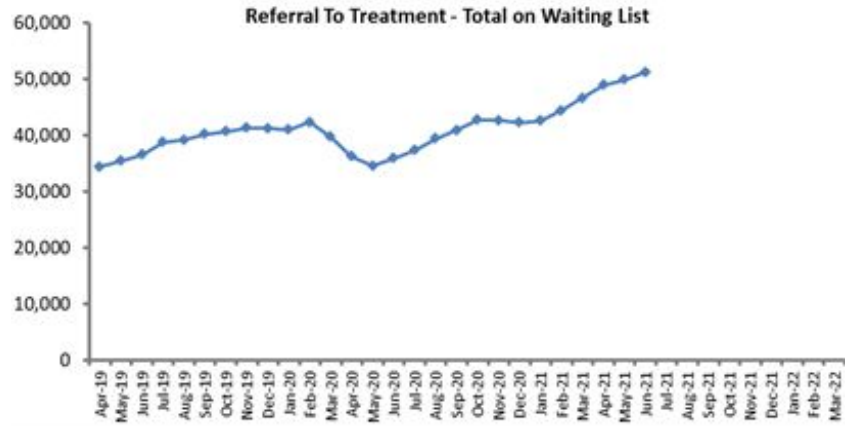
University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

N *Not Achieved*

Standards:	The number of patients on an ongoing Referral to Treatment (RTT) pathway and the percentage that have been waiting less than 18 weeks. The national standard is that over 92% of the patients should be waiting under 18 weeks.
Performance:	At end of June, 62.8% of patients were waiting under 18 weeks. The total waiting list was 51,198 and the 18+ week backlog was 18,619. Compared the end of March 2020 with the end of June 2021: • the overall wait list has increased by 11,495 patients . This is an increase of 29%. • the number of patients waiting 18+ weeks increased by 10,330 patients. This is an increase of 125%.
Commentary:	The focus of discussions with divisions and wider system partners is on restoring of activity and clinically prioritising waiting lists. This will involve demand management, ensuring full utilisation of the available capacity in the independent sector and full utilisation of the extra lists that have been arranged through waiting list initiatives. Some Divisions have agreed a temporary enhanced rate for WLI initiatives and weekend lists have been arranged. A longer term plan around rate of pay for staff to do extra during the evening / weekends has been agreed to support accelerator recovery. The largest Bristol increases in waiting list size are In Ophthalmology (4,430 increase), Adult ENT & Thoracics (1,598). The Weston list has increased by 1,483 over the same time period. The largest Bristol volumes of 18 +week backlog patients at the end of June are in Dental (4,031 patients), Ophthalmology (2,545), ENT & Thoracics (1,873) and Paediatrics (1,696). Weston has 4,105 patients waiting 18+ weeks at the of June.
Ownership:	Chief Operating Officer

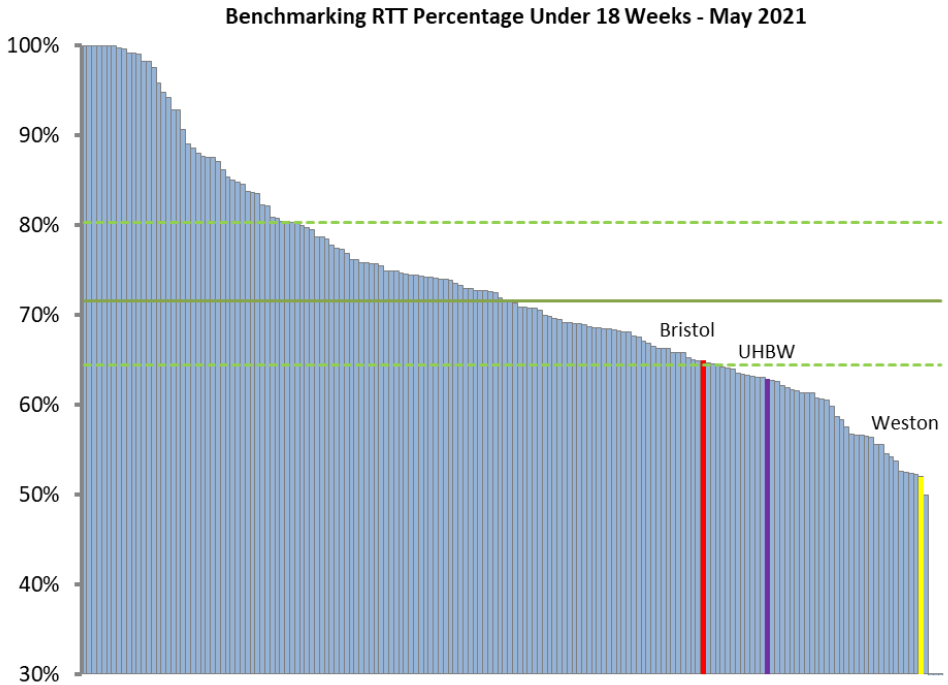




Referral To Treatment

University Hospitals Bristol and Weston NHS Foundation Trust

May/Jun 2021



	Jun-21		
	Under 18 Weeks	Total Pathways	Performance
Diagnostics and Therapies	284	284	100.0%
Medicine	4,129	4,958	83.3%
Specialised Services	3,179	4,605	69.0%
Surgery	15,535	25,822	60.2%
Weston	4,349	8,594	50.6%
Women's and Children's	5,212	7,191	72.5%
Other/Not Known	0	0	-
TRUST TOTAL	32,679	51,198	63.8%
Bristol Subtotal	28,330	42,604	66.5%

Referral To Treatment – 52 Weeks

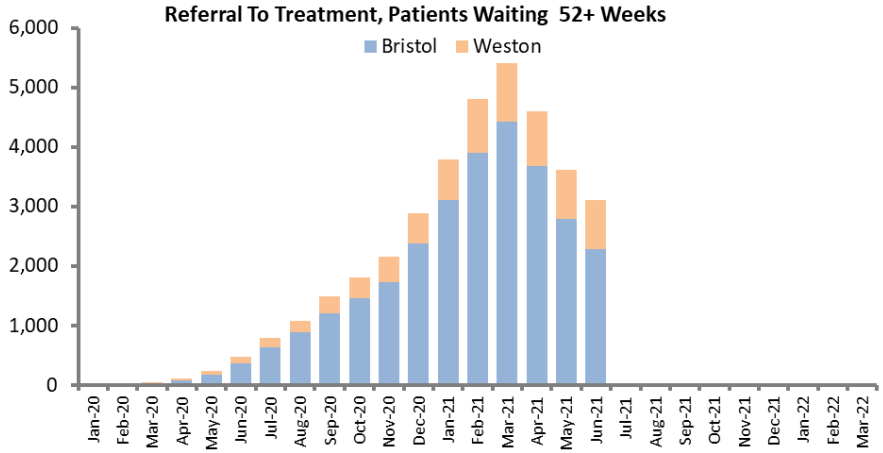
University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

N *Not Achieved*

Standards:	No patient should wait longer than 52 weeks for treatment
Performance:	At end of June 3,114 patients were waiting 52+ weeks; 2,288 across Bristol sites and 826 at Weston.
Commentary:	Patients who are 52+ week breaches reduced by 504 patients from end of May to End of June being the third month of reduction however it is too early to tell if this is a downward trend due to the level of backlogs caused by the Covid-19 pandemic. However this third month of reduction demonstrates the importance of waiting list initiatives to reduce our backlog position. The demand and capacity modelling and trajectory setting for the next 6 months, which are being finalised, will demonstrate the short falls in our capacity to recover against the demand. Patients who have been clinically prioritised as urgent ("P2" prioritisation code, treatment within 1 month) is challenging but continues to be the focus when prioritising our patients for treatment and where capacity allows, long waiting patients will be added to the list. However , the Trust is still seeing an unprecedented number of breaches for more routine treatment which is likely to continue to grow. Clinical prioritisation of patients who are on the waiting list without a "to come in" date continues with processes in place to ensure this is now business as usual. 93% of the patients who have been waiting 18+ weeks have now been clinically prioritised with 0.6% of those being assigned a P2 status. Offers of dates will be made for treatment in the independent sector where clinicians have practicing privilege rights, insourcing arrangements and waiting list initiatives. Previous challenges of theatre closures is becoming less of an issue as theatres are almost back to full capacity, however the challenge of distancing restrictions, the increases in Covid cases and lack of ward beds continues to be an issue for routine patients. NHS England, and local commissioners, continue to request weekly reporting of patients waiting 78+ and 104+ week, as part of the drive to reduce the overall numbers waiting over a year. Weekly analysis and exception reporting is underway, alongside clinical validation of the waiting list however the volumes of patients who have been clinically prioritised as requiring treatment within a month against the Royal College of Surgeons guidelines, still out way the capacity we have available to be able to offer this cohort a TCI date.
Ownership:	Chief Operating Officer

	52+ Weeks	78+ Weeks	104+ Weeks
Diagnostics and Therapies	0	0	0
Medicine	21	3	0
Specialised Services	249	72	5
Surgery	1,613	399	28
Weston	826	251	38
Women's and Children's	405	77	2
TOTAL	**3,114**	**802**	**73**
Bristol	*2,288*	*551*	*35*

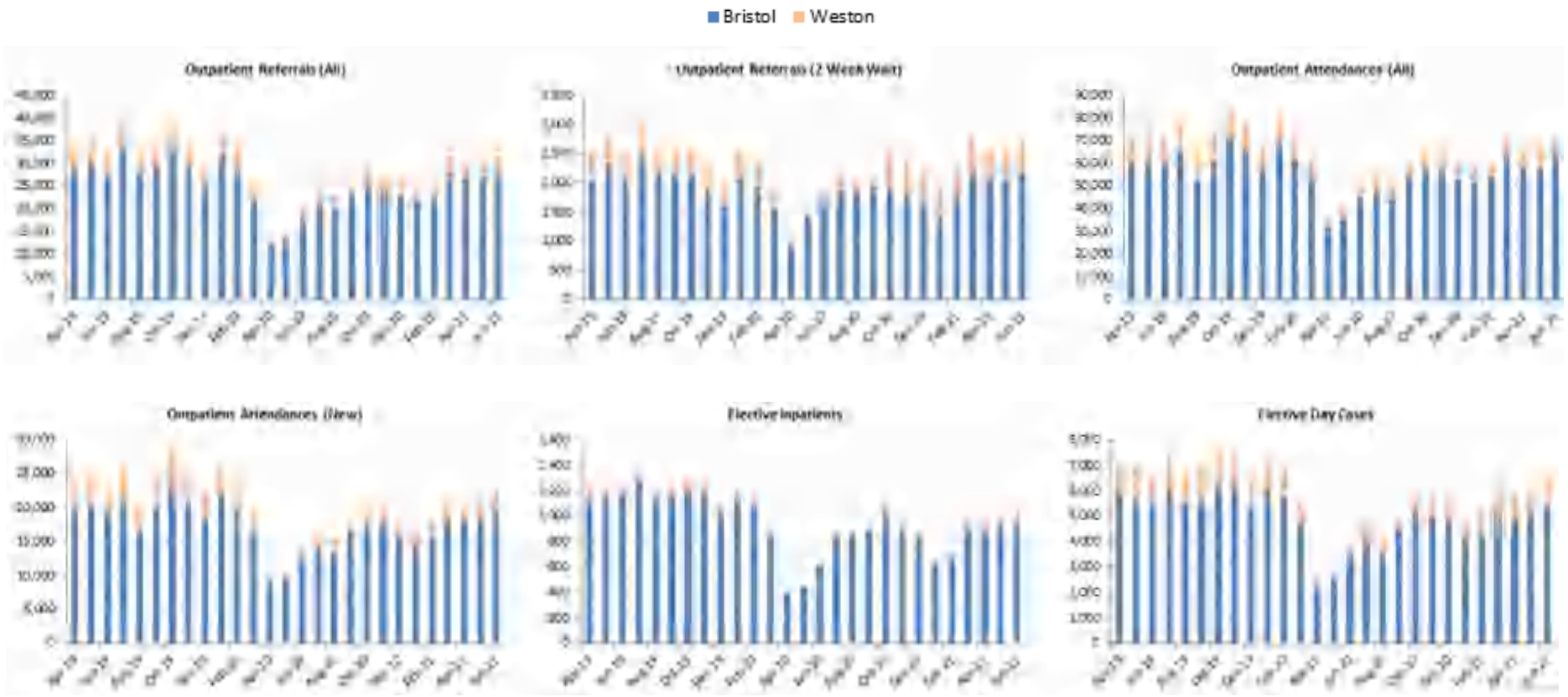


Elective Activity and Referral Volumes

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

BRISTOL AND WESTON PLANNED ACTIVITY AND REFERRALS APRIL 2019 TO JUNE 2021



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

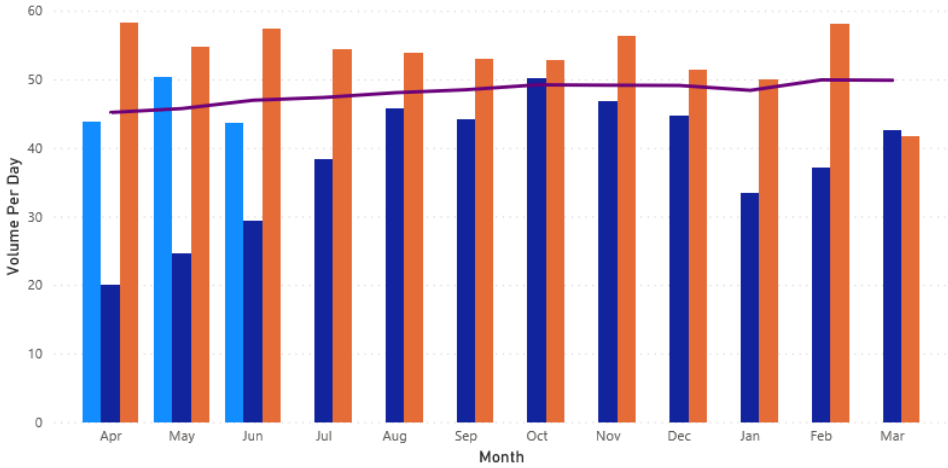
Elective Activity – Restoration

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

Activity Per Day, By Month and Year

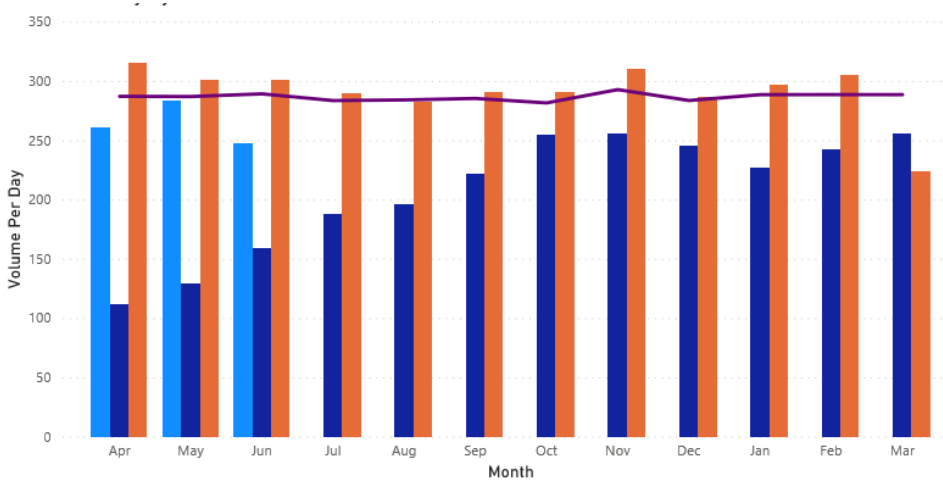
Elective Inpatients



		Apr	May	Jun
2021/22	Actual Activity Per Day	44	50	44
	Planned Activity Per Day	45	46	47
2019/20	Actual Activity Per Day	58	55	57

2021/22 Activity: % of Plan	98%	109%	94%
2021/22 Activity: % of 2019/20	76%	91%	77%

Elective Day Cases



		Apr	May	Jun
2021/22	Actual Activity Per Day	261	284	247
	Planned Activity Per Day	287	287	289
2019/20	Actual Activity Per Day	315	300	301

2021/22 Activity: % of Plan	91%	99%	85%
2021/22 Activity: % of 2019/20	83%	95%	82%

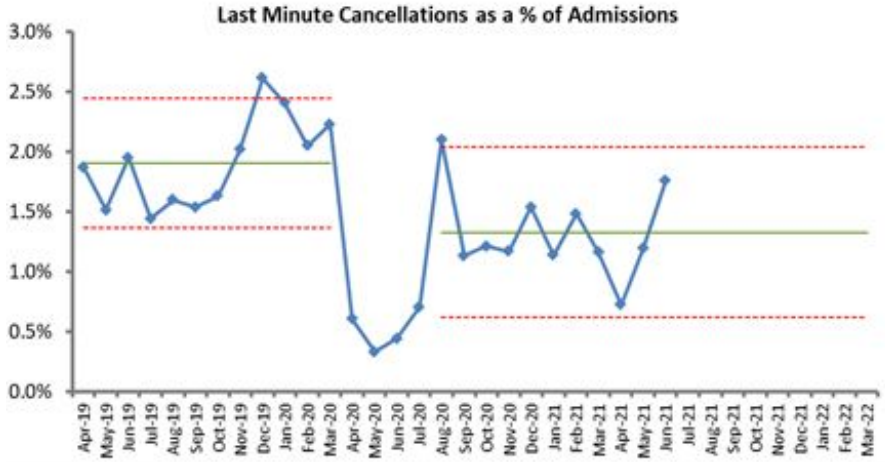
Cancelled Operations

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021

N *Not Achieved*

Standards:	For elective admissions that are cancelled on the day of admission, by the hospital, for non-clinical reasons: (a) the total number for the month should be less than 0.8% of all elective admissions (b) 95% of these cancelled patients should be re-admitted within 28 days
Performance:	In June, there were 112 last minute cancellations, which was 1.8% of elective admissions. Of the 69 cancelled in May, 57 (83%) had been re-admitted within 28 days.
Commentary:	April saw last minute cancellations fall below the target of 0.8% of elective admissions for the first time sine July 2020. Performance deteriorated in May to 1.2% (below the red threshold), but deteriorated again in June to 1.8%. The most common cancellation reasons for June were "Other Emergency Patient Prioritised" (31), No Beds Available (26), No Theatre Staff (9) and "AM List Over-ran" (6). The largest Bristol volumes were in Cardiac (25), Paediatrics (20), Ophthalmology (19) and ENT & Thoracics (15). National reporting of Cancelled Operations was suspended from Quarter 4, so there is no current benchmarking data.
Ownership:	Chief Operating Officer



	Jun-21		2021/2022	
	LMCs	% of Admissions	LMCs	% of Admissions
Medicine	6	0.81%	6	0.29%
Specialised Services	25	1.10%	63	0.95%
Surgery	52	2.63%	109	1.97%
Weston	4	1.09%	9	0.89%
Women's and Children's	25	2.51%	39	1.33%
Other/Not Known	0	-	0	-
TRUST TOTAL	**112**	**1.76%**	**226**	**1.24%**

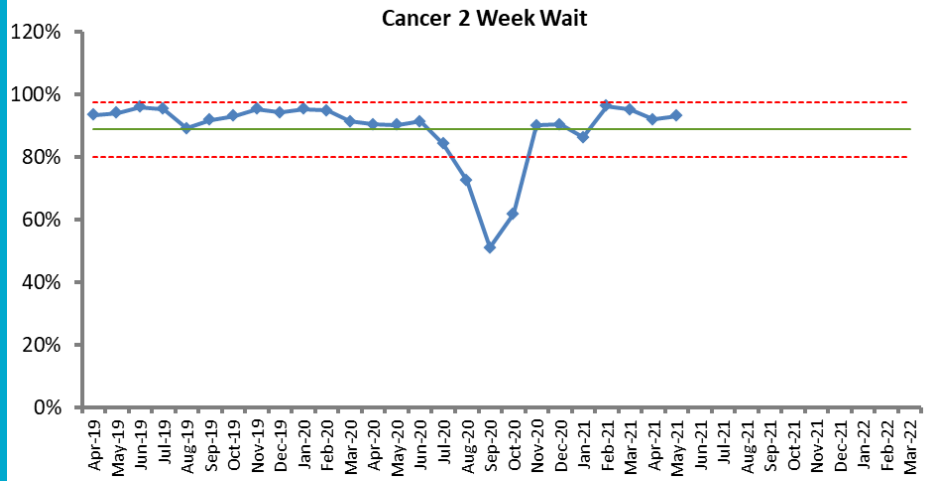
Cancer Two Week Wait

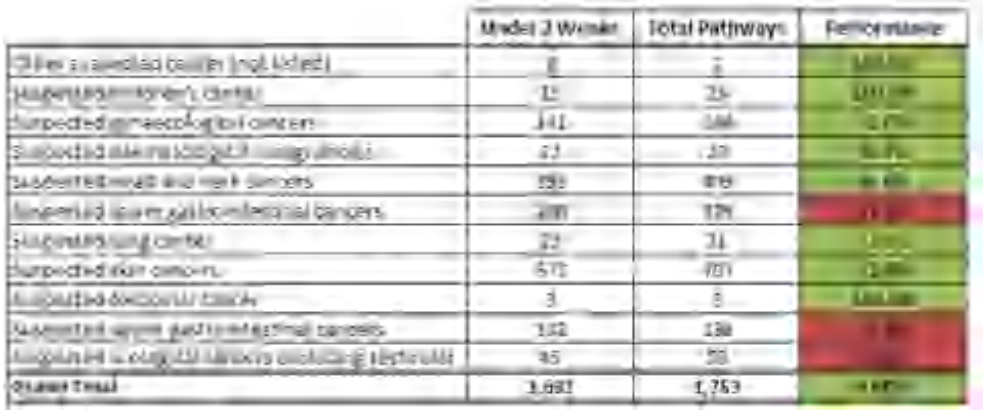
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

May 2021

Y *Achieved*

Standards:	Urgent GP-referred suspected cancer patients should be seen within 2 weeks of referral. The national standard is that 93% of patients should be seen within this standard
Performance:	For May, 93.0% of patients were seen within 2 weeks. This is combined Bristol and Weston performance.
Commentary:	The standard was compliant in May. It is expected that compliance will continue to be challenging until all precautions and restrictions related to Covid are lifted. Regional changes to the colorectal pathway and surges in demand (the latter likely due to patients preferring not to present during the winter Covid peak) are also affecting performance against the standard at present.
Ownership:	Chief Operating Officer





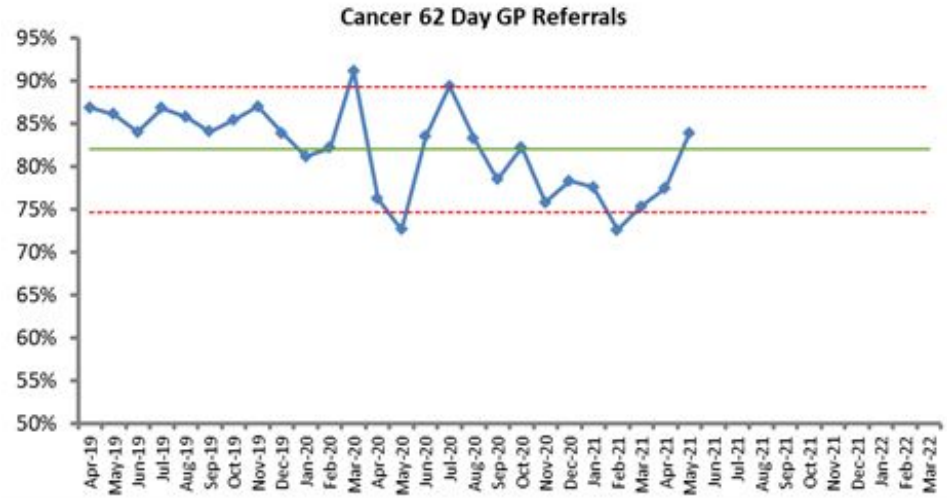
Cancer 62 Days

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

May 2021

N *Not Achieved*

Standards:	Urgent GP-referred suspected cancer patients should start first definitive treatment within 62 days of referral. The national standard is that 85% of patients should start their definitive treatment within this standard. Datix ID 4060 Risk that delayed cancer outpatients and diagnostics during the Covid 19 Pandemic will affect cancer performance and outcomes
Performance:	For May, 83.8% of patients were seen within 62 days. This is combined Bristol and Weston performance.
Commentary:	The standard was non-compliant in May (84% against an 85% standard). The majority of breaches were due to the impact of the Covid pandemic on capacity, patient choice, and medical deferrals. Achieving compliance with the 85% standard remains unlikely in the short term, particularly in light of rising emergency pressures and staff being obliged to isolate. The current forecast of a forecast of a Covid 'third wave' equalling a 'bad winter' in terms of demand on acute hospitals would make it very challenging to achieve this standard during that period. Patients continue to be treated within clinically safe timescales with clinical safety review embedded into waiting list management practice.
Ownership:	Chief Operating Officer

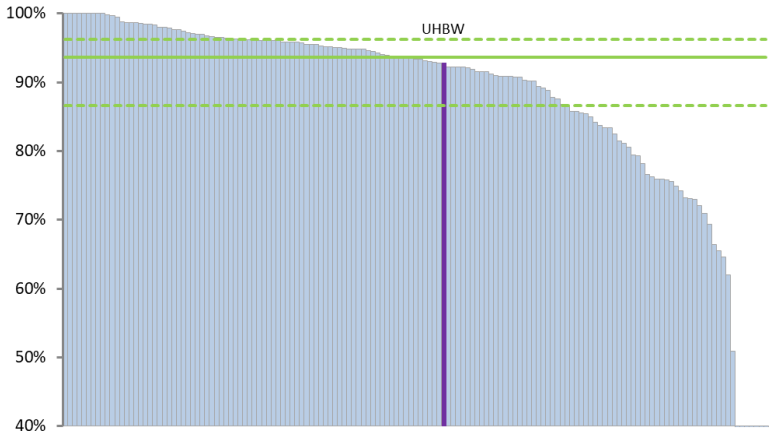


	Within Target	Total Pathways	Performance
Breast	2.0	2.0	
Gynaecological	6.4	8.5	
Haematological	1.0	2.5	
Head and Neck	9.5	11.5	
Lower Gastrointestinal	7.5	11.0	
Lung	15.0	17.0	
Other	1.5	1.5	
Sarcoma	0.5	1.5	
Skin	37.5	61.0	
Upper Gastrointestinal	9.0	10.5	
Urological	10.0	14.0	
Grand Total	119.0	142.0	

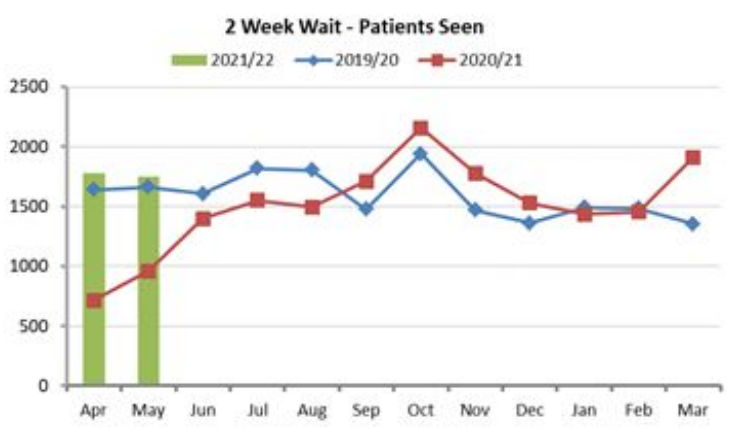
Cancer – Additional Information

University Hospitals Bristol and Weston NHS Foundation Trust

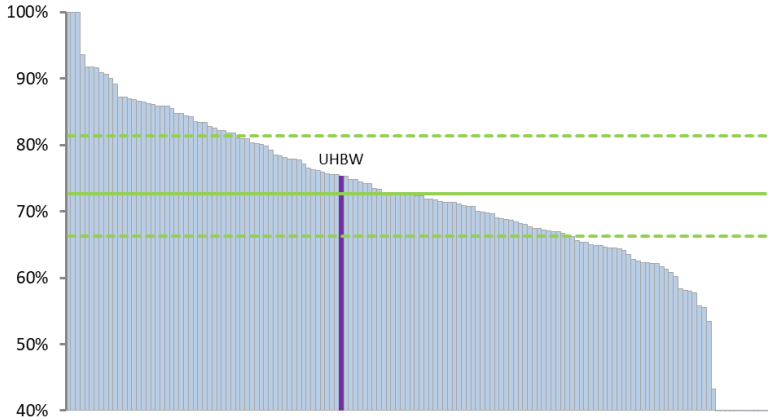
Benchmarking - 2 Week Wait Performance - 2020/21 Quarter 4



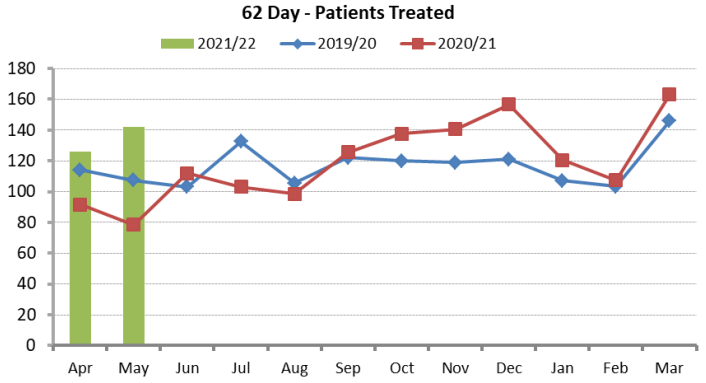
2 Week Wait - Patients Seen



Cancer 62 Day Performance - 2020/21 Quarter 4



62 Day - Patients Treated



Cancer 104 Days

University Hospitals Bristol and Weston NHS Foundation Trust

Snapshot taken: 11th July 2021

Standards:	This is not a constitutional standard but monitored by regulators in conjunction with the 62 day standard for cancer treatment after a GP referral for suspected cancer. Trusts are expected to have no patients waiting past day 104 on this pathway for inappropriate reasons (i.e. those other than patient choice or clinical reasons). The Trust has committed to sustaining <10 waiters for 'inappropriate' reasons.
Performance:	Prior to the Covid-19 outbreak the Trust consistently had 0 patients waiting over 104 days for inappropriate reasons (i.e. those other than patient choice, clinical reasons, or recently received late referrals into the organisation). As at 11th July 2021 there was 1 such waiter. This compares to a peak of 53 such waiters in early July.
Commentary:	The Trust is aiming to sustain minimal (<10) waiters over 104 days on a GP referred cancer pathway for 'inappropriate' reasons. The number of such waiters remains low and stable. Avoiding harm from any long waits remains a top priority and is closely monitored. During this period of limited capacity due to the Covid outbreak, appropriate clinical prioritisation will adversely affect this standard as patients of lower clinical priority may wait for a longer period, to ensure those with high clinical priority are treated quickly. This is because cancer is a very wide range of illnesses with differing degrees of severity and risk and waiting time alone is not a good indicator of clinical urgency across cancer as a whole. An example of this is patients with potential thyroid cancers awaiting thyroidectomy, who have been clinically assessed as safe to wait for several more months (and most of whom will not ultimately have a cancer diagnosis), but who have exceeded the 104 day waiting time.
Ownership:	Chief Operating Officer

Cancer – Patients Waiting 62+ Days

University Hospitals Bristol and Weston NHS Foundation Trust

Snapshot taken: 11th July 2021

Standards:	This is one of the metrics being used by NHS England (NHSE) to monitor recovery from the impact of the Covid epidemic peak . NHSE have asked Trusts to return to/remain below 'pre-pandemic levels'. NHSE defines this as 180 patients for UHBW. Note that the 62 day constitutional standard is based on patients who start treatment. This additional measure reviews the patients waiting on a 62 day pathway prior to treatment or confirmation of cancer diagnosis.
Performance:	As at 11th July the Trust had 176 patients waiting >62 days on a GP suspected cancer pathway, against a baseline of 180.
Commentary:	The Trust is slightly below the 'pre-Covid' baseline (with the aim being to remain below). The number of waiters is expected to rise in the summer due to the usual significant seasonal increase in demand associated with the Trust's large skin service. The 180 figure is an average across the year, so exceeding it over summer is not a problem provided it is balanced by significantly better performance over the winter months. Currently the Trust is aiming to remain below the 180 figure however this is proving increasingly difficult to maintain in the face of rising demand across a number of specialities, due to 'pent up' demand from earlier in the year (when patients were reluctant to come forwards with symptoms) now adding to the usual monthly demand for cancer services.
Ownership:	Chief Operating Officer

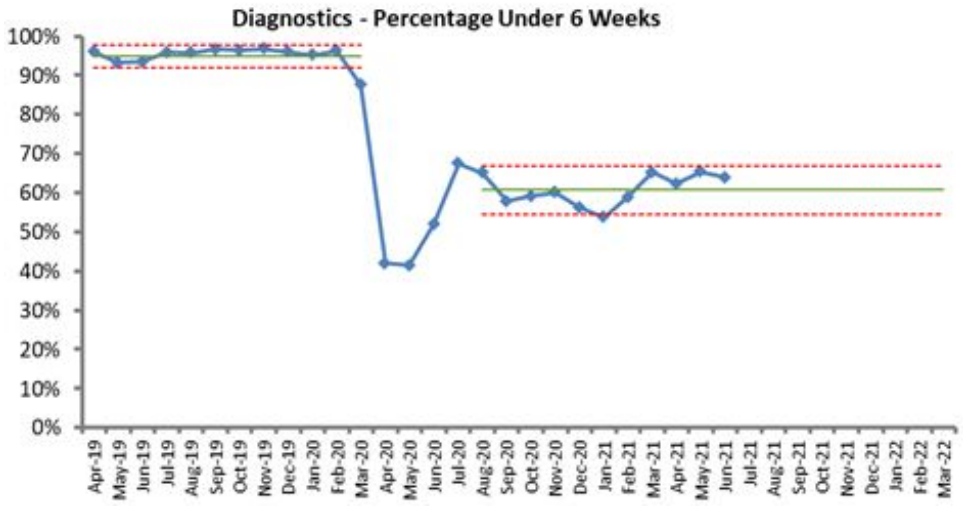
Diagnostic Waits

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

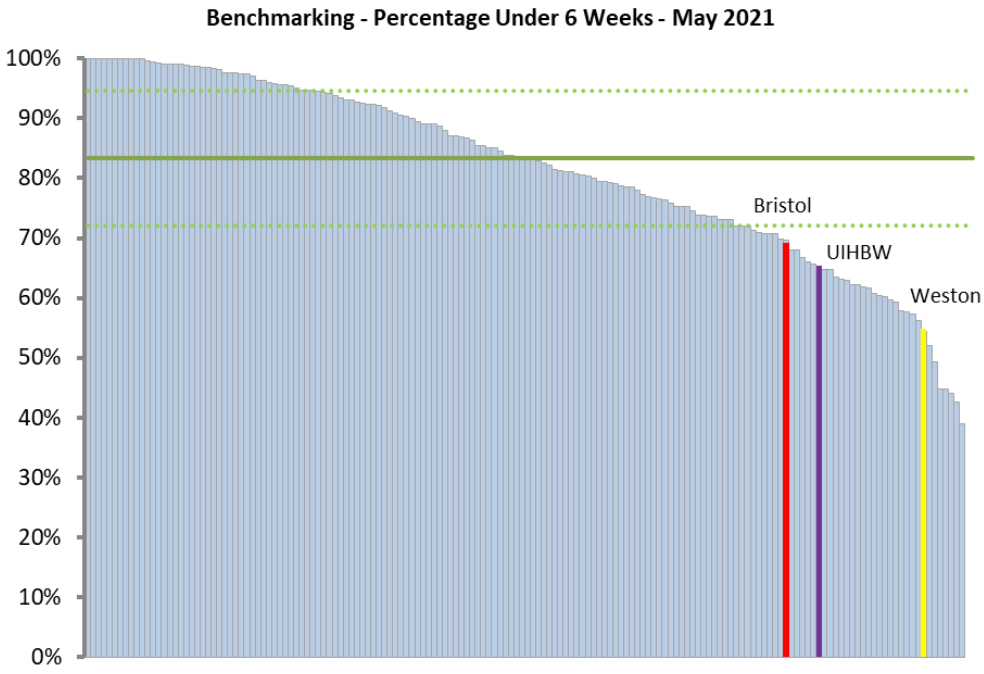
N *Not Achieved*

Standards:	Diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is that 99% of patients referred for one of the 15 high volume tests should have their test carried-out within 6 weeks, as measured by waiting times at month-end.
Performance:	At end of June, 63.9% of patients were waiting under 6 week, with 14,387 patients in total on the list. This is Bristol and Weston combined.
Commentary:	• Short term staffing issues in Paediatric Radiology during June to August will affect 6 week breach performance. Mitigations in place including clinical meeting postponement and seeking locum support. MRI Cardiac Paediatric and MRI paediatric remain key performance challenges. • Data Quality issues in the Weston data for Endoscopy have now been resolved, with the next area of focus on echo cardiography and Cystoscopy. Weston echo cardiography recovery plan in development and to be submitted via Accelerator programme. • National diagnostic waiting list validation exercise launched. Priority to review modalities where 50% waiting over 6 weeks by end of August, and then remainder of the list by end of December. This has slipped nationally by 1 month on the first stage validation. • Non obstetric ultrasound outsourced capacity procurement expected to be awarded by 10th August , additional activity mobilised by September. • CT scanner "early adopter" agreed for Weston demountable scanner (capacity increase although future location TBC) c. 500 additional scans per month from August.
Ownership:	Chief Operating Officer



	Jun-21		
	Under 6 Weeks	Total Pathways	Performance
Diagnostics and Therapies	5,178	8,541	60.6%
Medicine	76	205	37.1%
Specialised Services	1,240	2,260	54.8%
Surgery	471	1,354	47.6%
Weston	2,006	3,847	52.1%
Women's and Children's	224	356	62.9%
Other/Not Known	11	0	-
TRUST TOTAL	9,197	14,387	63.9%
Bristol Subtotal	7,189	10,540	68.2%

Diagnostic Waits



WESTON	6+ Weeks	Total On List	% Under 6 Weeks	13+ Weeks
Audiology - Audiology Assessments	2	30	93.3%	0
Cardiology - echocardiography	866	1,168	25.9%	564
Colonoscopy	139	202	31.2%	130
Computed Tomography	0	371	100.0%	0
Cystoscopy	335	439	23.7%	255
DEXA Scan	305	411	25.8%	176
Flexi sigmoidoscopy	21	39	46.2%	17
Gastroscopy	90	174	48.3%	70
Magnetic Resonance Imaging	1	410	99.8%	0
Non-obstetric ultrasound	80	603	86.7%	0
Grand Total	**1,839**	**3,847**	**52.2%**	**1,212**

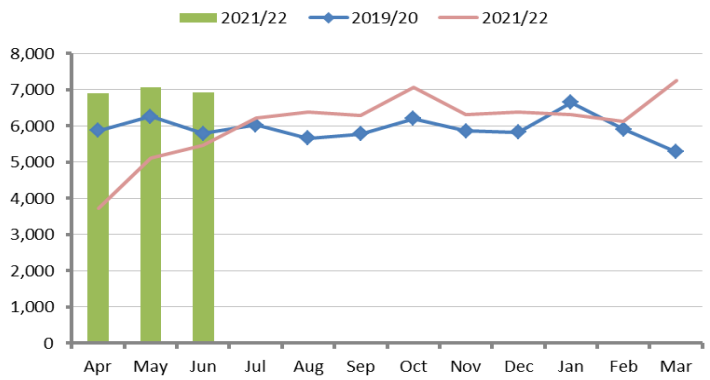
BRISTOL	6+ Weeks	Total On List	% Under 6 Weeks	13+ Weeks
Audiology - Audiology Assessments	1	355	99.7%	0
Cardiology - echocardiography	434	1,413	69.3%	7
Colonoscopy	382	551	30.7%	306
Computed Tomography	280	1,329	78.9%	184
Cystoscopy	4	8	50.0%	0
DEXA Scan	137	376	63.6%	89
Flexi sigmoidoscopy	142	224	36.6%	100
Gastroscopy	286	531	46.1%	209
Magnetic Resonance Imaging	814	2,316	64.9%	458
Neurophysiology - peripheral neurophysi	2	138	98.6%	0
Non-obstetric ultrasound	856	3,278	73.9%	243
Respiratory physiology - sleep studies	13	21	38.1%	11
Grand Total	**3,351**	**10,540**	**68.2%**	**1,607**

Diagnostic Activity – Restoration

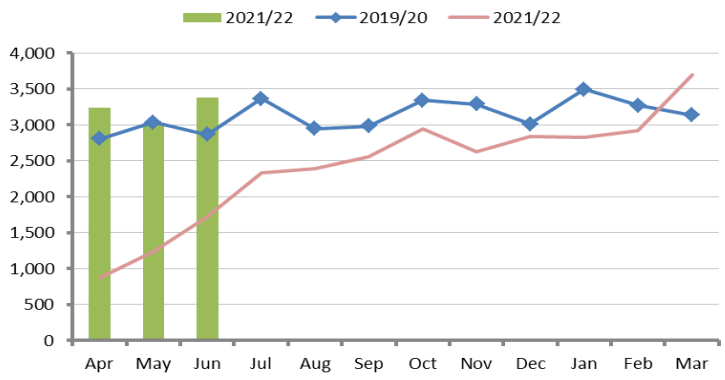
University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

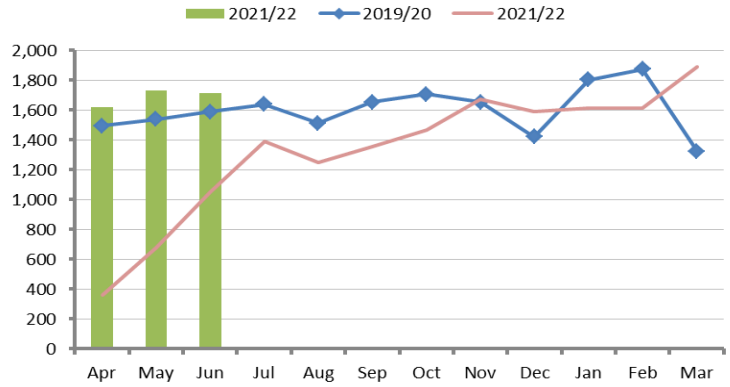
Computed Tomography (CT)



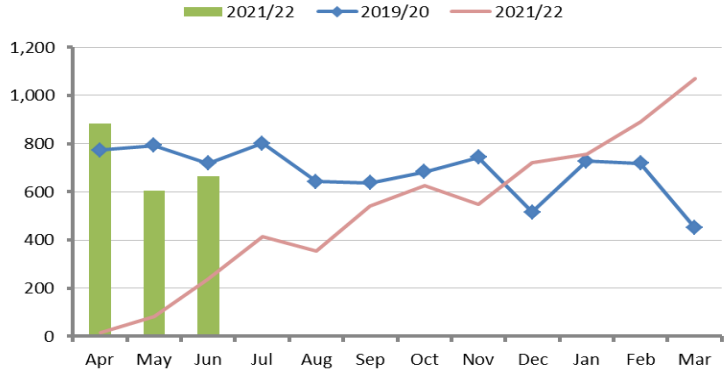
Magnetic Resonance Imaging (MRI)



Echocardiography



Endoscopy



2021/22 as a Percentage of 2019/20

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Computed Tomography	118%	113%	120%									
Magnetic Resonance Imaging	115%	99%	118%									
Echocardiography	108%	113%	108%									
Endoscopy	114%	76%	92%									

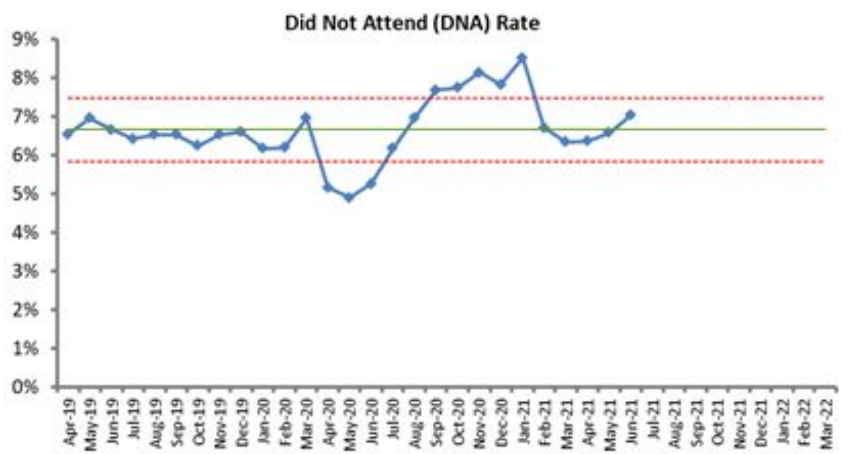
Outpatient Measures

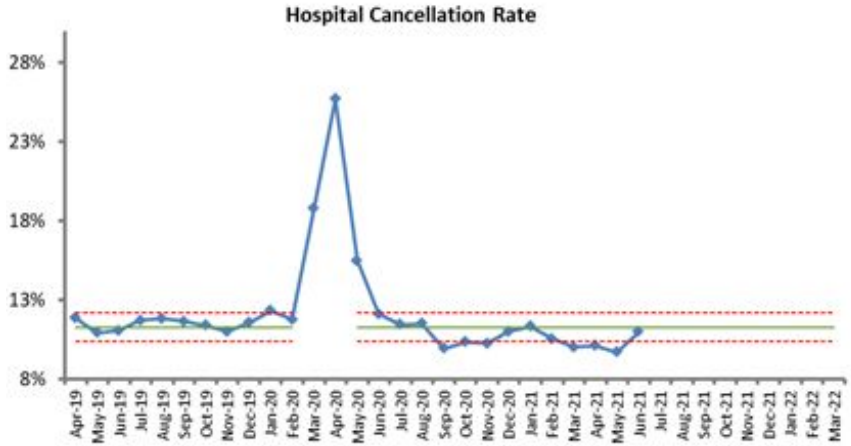
NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021

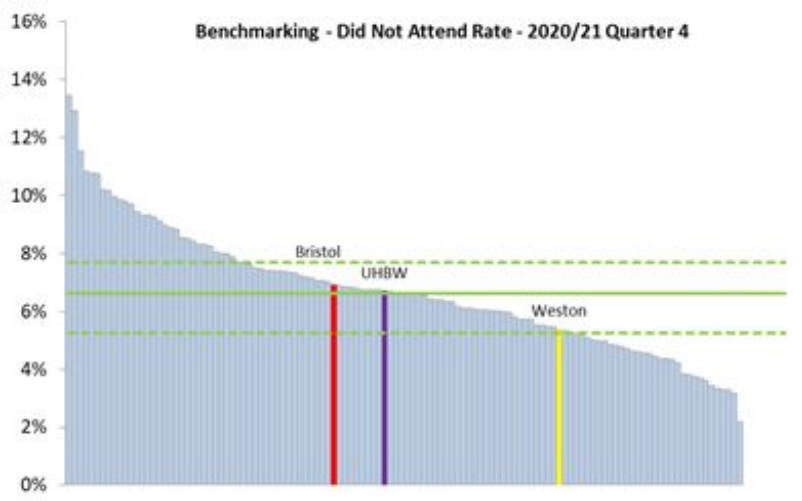
P *Partially Achieved*

Standards:	The number of outpatient appointments where the patient Did Not Attend (DNA), as a percentage of all attendances and DNAs The Hospital Cancellation Rate is the number of outpatient appointments cancelled by the hospital, as a percentage of all outpatient appointments made. The DNA Target at Trust level is to be below 6.7%, with an amber tolerance of between 6.7% and 7.2%. For Hospital Cancellations, the target is to be on or below 9.7% with an amber tolerance from 10.7% to 9.7%.
Performance:	In June, the DNA Rate was 7.0% across Bristol and Weston, with 5,429 DNA'ed appointments. The hospital cancellation rate was 11.0% with 11,411 cancelled appointments
Commentary:	• Acceleration of Outpatient activity is in progress. Cancellation rates are tracking below the trust average rates 10.6% • DNA rates reduced to 6.6 % in May and then rose slightly to 7.0% in June following a spike in January relating to the peak of COVID cases. • Discussions are in progress with divisions to access early restoration funds to reduce DNA and Cancellation rates.
Ownership:	Chief Operating Officer

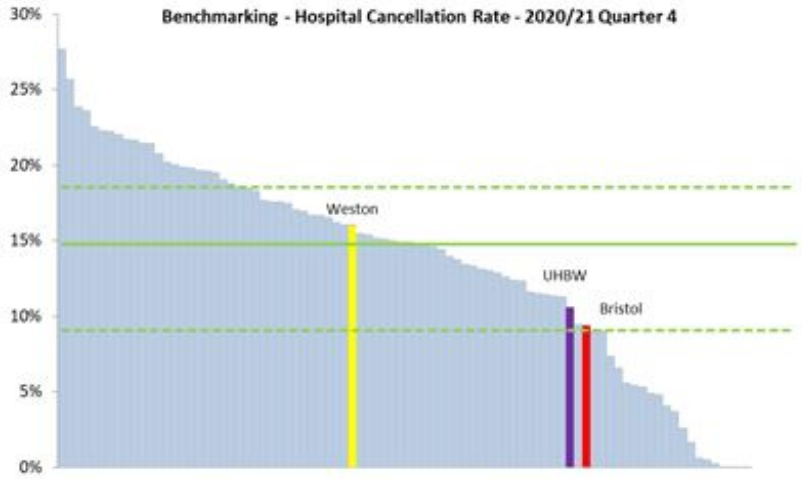




Outpatient Measures



	Jun-21	
	DNAs	DNA Rate
Diagnostics and Therapies	382	5.1%
Medicine	898	10.6%
Specialised Services	573	4.7%
Surgery	1,625	7.1%
Weston	648	6.4%
Women's and Children's	1,303	8.0%
Other/Not Known	0	-
TRUST TOTAL	**5,429**	**7.0%**
Bristol Subtotal	*4,781*	7.1%



	Jun-21	
	Cancellations	Rate
Diagnostics and Therapies	465	5.2%
Medicine	1,335	11.9%
Specialised Services	2,703	16.1%
Surgery	2,848	9.0%
Weston	1,834	13.5%
Women's and Children's	2,226	10.1%
Other/Not Known	0	-
TRUST TOTAL	**11,411**	**11.0%**
Bristol Subtotal	*9,577*	10.6%

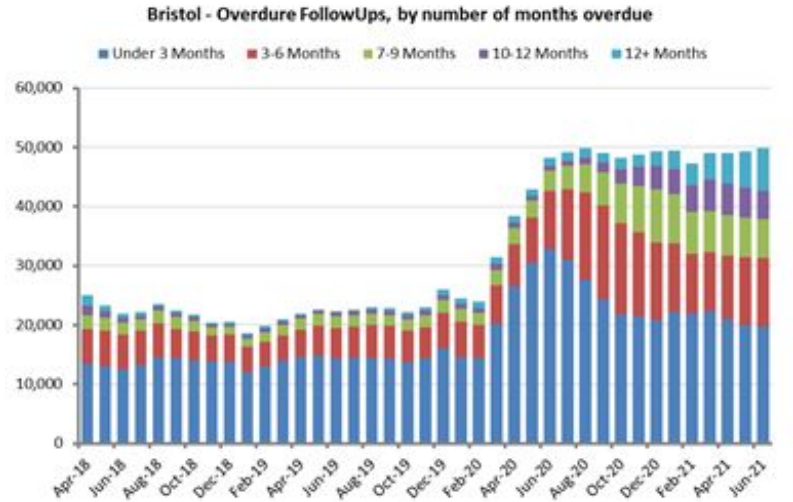
Outpatient Overdue Follow-Ups

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

N *Not Achieved*

Standards:	This measure looks at referrals where the patient is on a "Partial Booking List" at Bristol, which indicates the patient is to be seen again in outpatients but an appointment date has not yet been booked. Each patient has a "Date To Be Seen By", from which the proportion that are overdue can be reported. Datix 2244 Risk that long waits for Outpatient follow-up appointments results in harm to patients.
Performance:	Total overdue at end of June was 70,406 of which 19,848 (28%) were overdue by 9+ months. Note that the Weston Data Quality Improvement Group reviewed the reporting of follow-ups and made a decision to use data direct from the Medway Patient Administration System, rather than validation spreadsheets maintained locally. This means historic trend data cannot be presented in a way that is consistent with the current methodology. Source Group have been commissioned to risk stratify the UHBW overdue follow up backlog and advise upon improvement priorities.
Commentary:	• Outpatient restoration activity has exceeded the 2021/22 plan delivering 106% in May 21 and has dropped during June to 99% this is 84% of 2019/20 activity. Clinical capacity is not sufficient to manage follow up backlog demand as well as the ongoing new demand. Capacity is being focussed on the delivery of the most clinically urgent cases. • Areas of largest areas of backlog seen in Sleep, Ophthalmology, T&O and Respiratory. Discussions in progress with specialities to review the use of PIFU
Ownership:	Chief Operating Officer



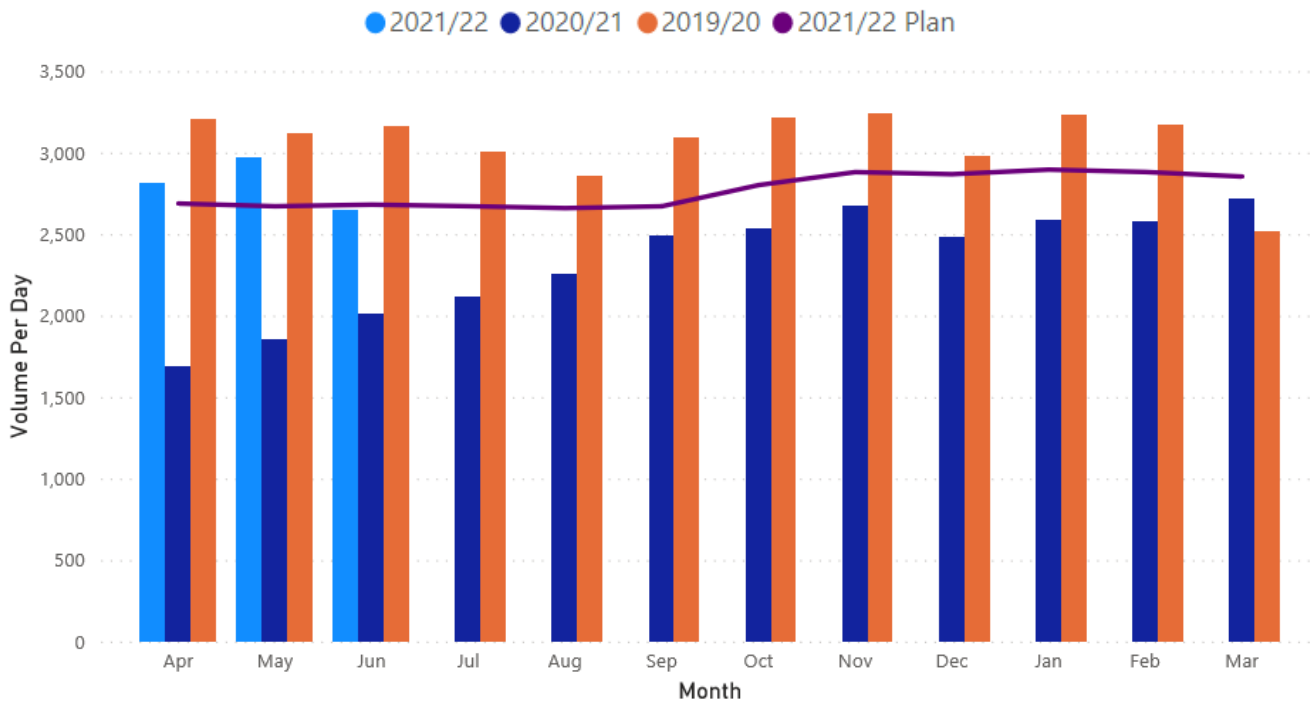
	Under 3 Months	3-11 Months	12+ Months	Total
Diagnostics & Therapies	1,864	0	1	1,865
Medicine	10,820	1,088	4,557	16,465
Specialised Services	4,899	231	749	5,879
Surgery	16,653	2,585	3,084	22,673
Weston	12,705	2,444	5,378	20,527
Women's and Children's	4,022	351	156	4,529
UHBW TOTAL	50,963	7,257	12,631	70,851
Bristol Ambulant	37,859	4,774	7,931	50,564

Outpatient Activity – Restoration

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

Activity Per Day, By Month and Year – Outpatient Attendances



		Apr	May	June
2021/22	Actual Activity Per Day	2,818	2,975	2,648
	Planned Activity Per Day	2,687	2,671	2,681
2019/20	Actual Activity Per Day	3,209	3,120	3,161

2021/22 Activity: % of Plan	105%	111%	99%
2021/22 Activity: % of 2019/20	88%	95%	84%

Mortality – SHMI (Summary Hospital-level Mortality Indicator)

University Hospitals Bristol and Weston NHS Foundation Trust

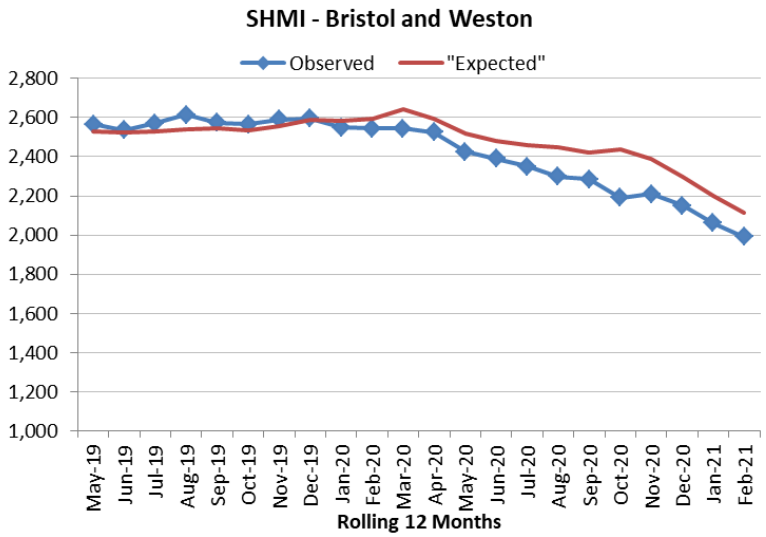
February 2021

A *Achieved*

Standards:	Mortality indicators are used as alerts to identify something that needs closer investigation. This indicator is published nationally by NHS Digital and is six months in arrears. The most recent data is for the 12 months to November 2020 and is now provided by NHS Digital as a single figure from UHBW. SHMI is derived from statistical calculations of the number of patients expected to die based on their clinical risk factors compared with the number of patients who actually died. There is no target. A SHMI of 100 indicates these two numbers are equal, but there is a national statistically acceptable range calculated by NHS Digital and a SHMI that falls within this range is "as expected".
Performance:	The Summary Hospital Mortality Indicator for UHBW for the 12 months to February 2021 and was 94.1 and in NHS Digital's "as expected" category. This is lower than the overall national peer group of English NHS trusts of 100.
Commentary:	Actions: The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to speciality level if required and investigating any identified alerts.
Ownership:	Medical Director

	UHBW		
Rolling 12 Months To:	Observed Deaths	"Expected" Deaths	SHMI
May-20	2,425	2,520	96.2
Jun-20	2,390	2,480	96.4
Jul-20	2,350	2,460	95.5
Aug-20	2,300	2,450	93.9
Sep-20	2,285	2,420	94.4
Oct-20	2,190	2,440	89.8
Nov-20	2,210	2,390	92.5
Dec-20	2,150	2,300	93.5
Jan-21	2,060	2,200	93.6
Feb-21	1,990	2,115	94.1

So Jan-21 represents 12 month period Feb-20 to Jan-21



Mortality – HSMR (Hospital Standardised Mortality Ratio)

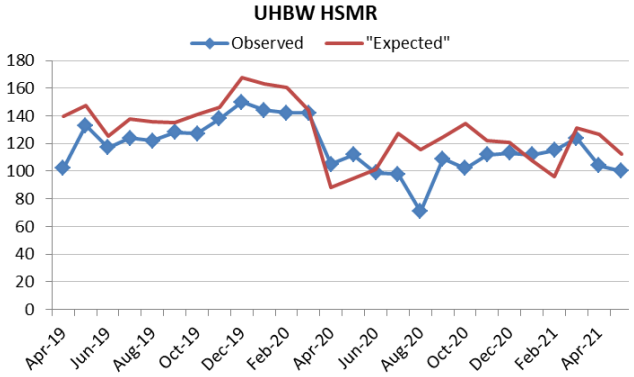
University Hospitals Bristol and Weston NHS Foundation Trust

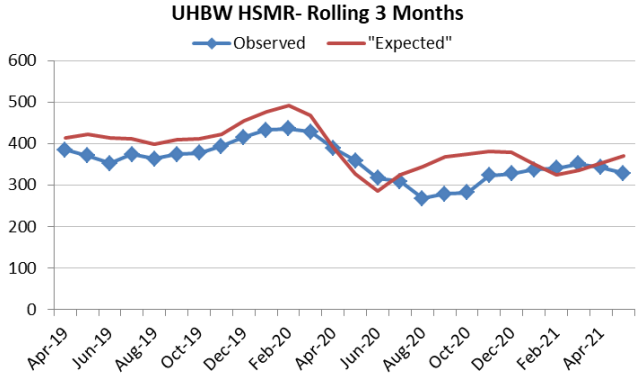
February 2021

A *Achieved*

Standards:	Reported HSMR is from CHKS (Capita Health Knowledge System) and is subject to annual rebasing. HSMR data published by the Dr.Foster unit is rebased more frequently so figures will be different, although our position relative to other Trusts will be the same.
Performance:	HSMR within CHKS for UHBW for the solely the month of May 2021 is 89, meaning there were fewer observed deaths (100) than the statistically calculated expected number of deaths (112.3). Single monthly figures for HSMR are monitored in UHBW as an "early warning system" and are not valid for wider interpretation in isolation. Further investigation within CHKS shows UHBW to below the national peer for HSMR data to May 2021 shows the Trust figure for the 12 months is 88.7 against a national peer figure of 90.0.
Commentary:	Actions: The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to speciality level if required and investigating any identified alerts.
Ownership:	Medical Director

	UHBW		
	Observed	"Expected"	HSMR
Jun-20	99	102	97.4
Jul-20	98	128	76.8
Aug-20	71	115	61.6
Sep-20	109	124	87.6
Oct-20	102	135	75.7
Nov-20	112	122	91.5
Dec-20	113	121	93.5
Jan-21	112	108	103.9
Feb-21	115	96	119.4
Mar-21	124	131	94.6
Apr-21	104	126	82.3
May-21	100	112	89.0





Fractured Neck of Femur (NOF)

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021

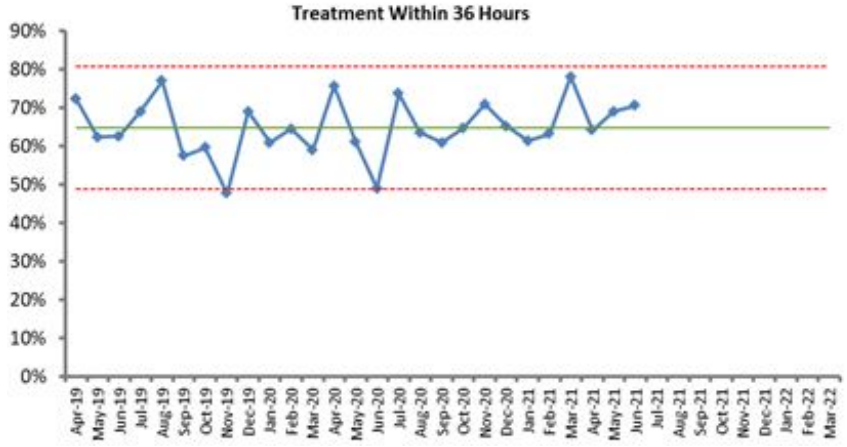
P *Partially Achieved*

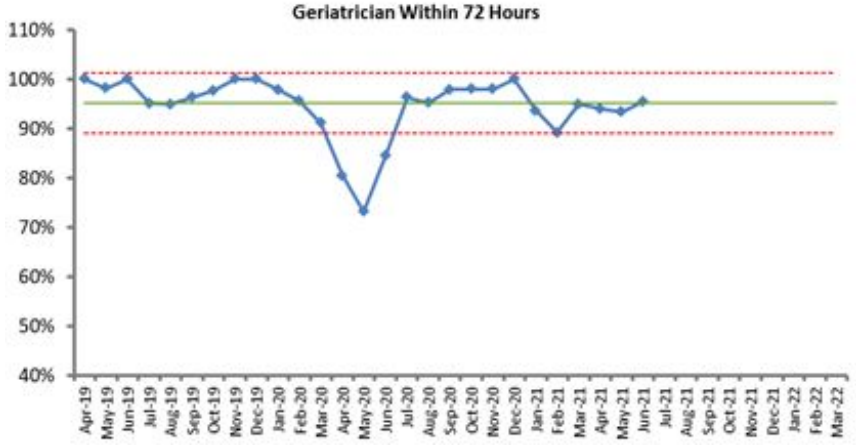
Standards:	Fractured neck of femur best practice comprises eight elements, all of which need to be provided within relevant time scales to demonstrate care provided to individual patients has met best practice standards. Two of the eight individual criteria are monitored in this report: time to theatre within 36 hours and ortho-geriatrician review within 72 hours. Both standards have a target of 90%.
Performance:	In June 2021, there were 44 patients eligible for Best Practice Tariff (BPT) across UHBW: 25 in Bristol and 19 in Weston. Overall Best Practice Tariff performance was achieved for 31 out of 44 patients in June (70%). 71% (31 patients) received surgery within 36 hours and 96% (42 patients) had ortho-geriatrician review within 72 hours.
Commentary:	Challenges to be addressed in Bristol: • Availability of specialist surgeon is still a challenge. • Difficulty accessing theatres to ensure consistent #NOF theatre • The BRI is witnessing an increase of demand on the trauma service as a result of national lockdowns being eased. • Inability to address peaks in #NOF demand. Actions being taken in Bristol: • GIRFT (Getting It Right First Time) review completed, awaiting feedback from report. • Reinvigoration of the Silver Trauma meetings to address the ongoing issues with access to theatre. • Theatre capacity being actively monitored and prioritised on a weekly basis across all specialties. • Formal job planning completed and actioned to provide multi-specialist trauma cover each day. • Additional trauma lists have been stood up on bank holidays and on any dropped elective list to ensure maximum capacity. Challenges to be addressed in Weston: • Access to theatre due to other trauma or shared operating theatres especially at weekends • Availability of specialist surgeon due to fracture type complication or specialist surgery kit required • Unavoidable medical issues preventing timely surgery • No additional cover for Orthogeriatrician annual leave/sickness • For June, two patients who were not admitted onto the orthopaedic ward did not have a MUST/nutritional assessment completed. Difficult to maintain good practice care when these patients are outliers within the hospital. Actions being taken in Weston • Continue to allow full day trauma operating to allow for prioritisation of these patients on trauma lists. Provide short notice additional theatre capacity and allow extra surgeon availability when demand is required. • Re-advertise vacant Orthogeriatrician post • Weston has re-invigorated the direct admit overnight pathway for #NOF patients to support other units in area. • Monitor outliers on medical wards and escalate to divisional managers to support "pulling" outlier patients to the orthopaedic ward
Ownership:	Medical Director

Fractured Neck of Femur (NOF)

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021





		36 Hours		72 Hours	
	Total Patients	Seen In Target	Percentage	Seen In Target	Percentage
Bristol	25	14	56%	23	92%
Weston	19	17	89%	19	100%
TOTAL	**44**	**31**	**70.5%**	**42**	**95.5%**

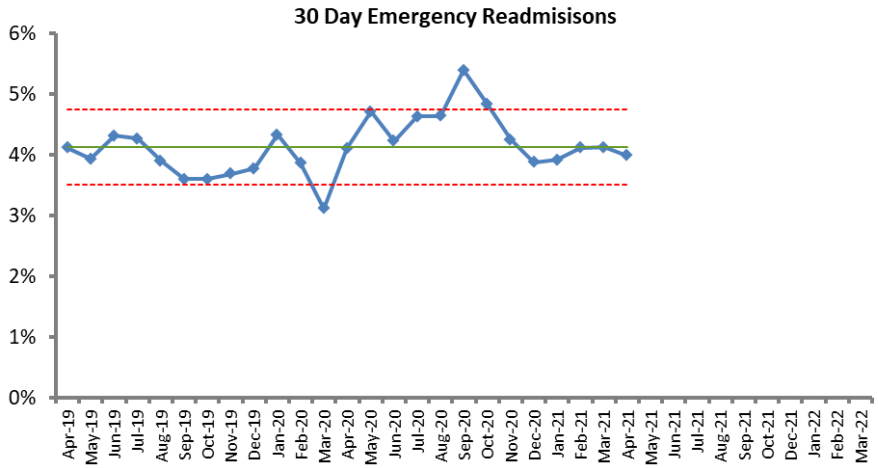
Readmissions

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

May 2021

N *Not Achieved*

Standards:	This reports on patients who are re-admitted as an emergency to the Trust within 30 days of being discharged. This can be in an unrelated specialty; it purely looks to see if there was a readmission. The target for the Trust is to remain below 2017/18 total of 3.62%, with a 10% amber tolerance down to 3.26%.
Performance:	In May, there were 13,669 discharges, of which 507 (3.7%) had an emergency re-admission within 30 days.
Commentary:	The review of Readmission methodologies across the two Trusts has not concluded due to other priorities. However, during 2021/22 the aim is for Readmissions to be managed and reviewed as part of the "Proactive Hospital" group which is being established. The aim of the group is to "deliver timely emergency and elective care by the optimal specialty in the ideal clinical location. All treatments go ahead as planned; no patient will have to queue for a bed or stay in hospital longer than is right for them." There are four strands: 1) Efficient Arrival, 2) Swift Assessment, 3) Seamless Admission and Transfer, and 4) Prompt Discharge. Readmissions will be reviewed as part of a balancing measure to ensure discharges are safe and do not generate inappropriate readmissions.
Ownership:	Chief Operating Officer



	May-21		
	Readmissions	**Total Discharges**	**% Readmitted**
Diagnostics and Therapies	0	22	0.0%
Medicine	215	2,418	8.9%
Specialised Services	33	2,618	1.3%
Surgery	110	2,491	4.4%
Weston	79	2,035	3.9%
Women's and Children's	70	4,085	1.7%
TRUST TOTAL	**507**	**13,669**	**3.7%**
Bristol Subtotal	*428*	*11,634*	*3.7%*

Workforce – Bank and Agency Usage

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

P *Partially Achieved*

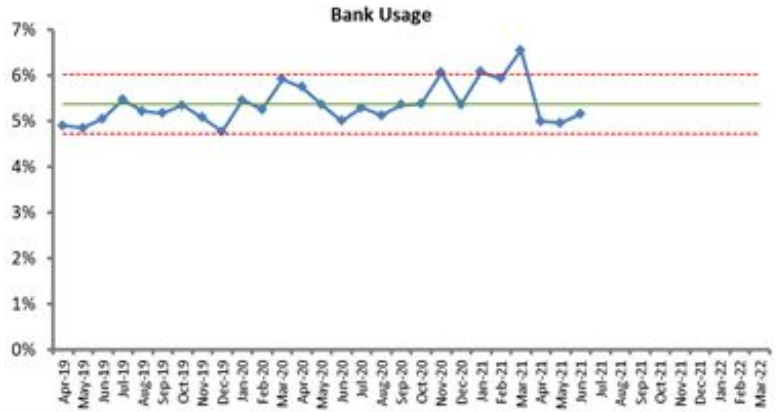
Standards:	Usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2018/19. The red threshold is 10% over the monthly target.
Performance:	In June 2021, total staffing was at 11,163 FTE. Of this, 5.1% was Bank (574 FTE) and 2.5% was Agency (277 FTE).
Commentary:	**Bank usage** increased by 22.2 FTE. There were increases in six divisions, with the largest increase seen in Facilities and Estates, increasing to 95.2 FTE from 79.6 FTE in the previous month. There were reductions in two divisions, with the largest reduction seen in Weston, reducing to 105.6 FTE from 121.0 FTE in the previous month. **Agency usage** reduced by 16.8 FTE. There were increases in five divisions, with the largest increase seen in Weston, increasing to 85.0 FTE from 73.5 FTE in the previous month. There were reductions in three divisions, with the largest reduction seen in Facilities and Estates, reducing to 5.2 FTE from 43.5 FTE in the previous month. • The Trust Staff Bank saw 211 new starters/re-appointments during Q1 of whom 129 have completed at least one shift since registering. • There have been six applications from the summer Bank recruitment campaign for Nursing Assistants. The campaign is now targeting non-clinical staff. • A new supplier has been appointed for the provision of medical agency locums across Bristol and Weston, commencing in August 2021. • A new incentive for bank shifts for registered nurses is in place with the aim of incentivising bank shifts in areas with high vacancy levels. • Work has commenced with BNSSG partners to commence a procurement process for the appointment of a new provider of nurse agency supply.
Ownership:	Director of People

Workforce – Bank and Agency Usage

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

Bank	June FTE	June Actual %	KPI
UHBW NHS Foundation Trust	**574.4**	5.1%	**5.5%**
Diagnostics & Therapies	14.5	1.2%	2.0%
Medicine	116.7	8.3%	10.0%
Specialised Services	71.3	6.2%	6.0%
Surgery	88.4	4.7%	5.3%
Women's & Children's	50.1	2.3%	1.2%
Trust Services	32.8	2.9%	4.5%
Facilities & Estates	95.2	10.2%	8.0%
Weston	105.6	8.7%	10.0%



Agency	June FTE	June Actual %	KPI
UHBW NHS Foundation Trust	**276.8**	2.5%	**1.7%**
Diagnostics & Therapies	0.0	0.0%	0.9%
Medicine	83.1	5.9%	2.2%
Specialised Services	27.9	2.4%	1.0%
Surgery	33.4	1.8%	1.0%
Women's & Children's	32.0	1.4%	0.6%
Trust Services	10.2	0.9%	0.0%
Facilities & Estates	5.2	0.6%	3.9%
Weston	85.0	7.0%	5.2%

Workforce – Turnover

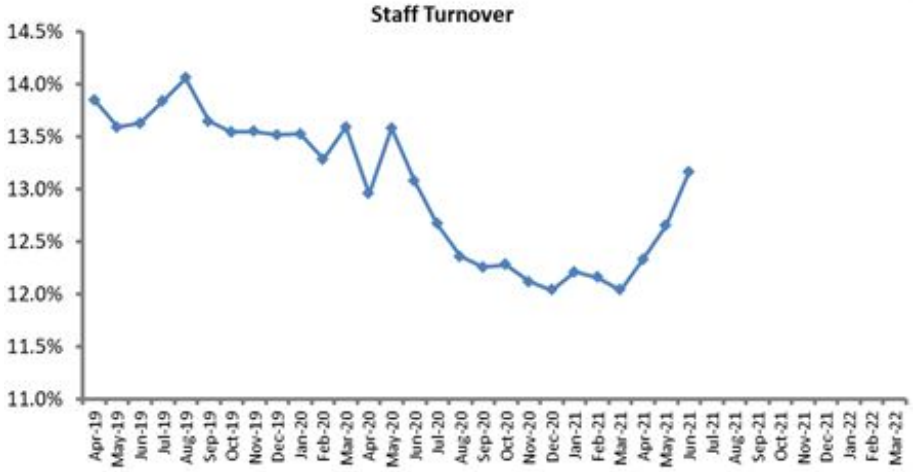
NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

P *Partially Achieved*

Standards:	Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.3% by the end of 2018/19. The red threshold is 10% above monthly trajectory.
Performance:	In June 2021, there had been 1142 leavers over the previous 12 months, with 8679 FTE staff in post on average over that period; giving a turnover of 1142 / 8679 = 13.2%.
Commentary:	Turnover for the 12 month period increased to 13.2% in June 2021 compared with 12.7% in the previous month. One division saw a reduction whilst seven divisions saw increases in turnover in comparison to the previous month. The largest divisional reduction was seen within Medicine, where turnover reduced by 0.3 percentage points compared with the previous month. Diagnostics and Therapies had the largest divisional increase, rising from 11.6% to 12.8%. • The EU staff Settled Status campaign has now finished. There have been no known resignations directly relating to this risk. • The Trust continues to work with BNSSG System partners across Health and Social Care with initiatives to retain staff. • The flexible working and flexible retirement options developed through the NHSE/I Retention Programme are to be reviewed with the view of further promoting them across the Trust. • An Exit Process Review Group has been re-established with a view to reviewing the current exit processes in line with BNSSG STP initiatives/shared learning such as the implementation of 'stay conversations'.
Ownership:	Director of People

Turnover	Jun-21	KPI
UHBW NHS Foundation Trust	13.2%	**12.3%**
Diagnostics & Therapies	12.8%	11.0%
Medicine	18.7%	18.0%
Specialised Services	14.4%	13.5%
Surgery	13.0%	12.1%
Women's & Children's	10.3%	9.6%
Trust Services	10.3%	9.7%
Facilities & Estates	14.7%	13.3%
Weston	13.8%	13.8%



Workforce – Vacancies

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

N *Not Achieved*

Standards:	Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.
Performance:	In June 2021, funded establishment was 11,255 FTE, with 822 FTE as vacancies (7.4%).
Commentary:	Overall vacancies increased to 7.4% compared to 4.9% in the previous month. The notable change is due to an expected increase in funded establishment. During month three, Finance allocate a large proportion of the funded monies available for developments, cost pressures and other commitments which therefore converts to additional funded establishment. Separately, funded establishment has also been added for divisional Covid-19 cost centres. Previously, these would have only had staff in post FTE, therefore reducing the vacancy position. The largest divisional increase was seen in Surgery, where vacancies increased to 206.4 FTE from 124.6 the previous month. This is due to large investments for two developments in the division. The largest divisional reduction was seen in Diagnostics and Therapies, where vacancies reduced to 34.1 FTE from 45.7 FTE the previous month. This was also expected, due to funding having been removed this month for the financial year. The over-establishment within the division of Women's and Children's has the effect of lowering the overall total vacancy position for the Trust. • The active recruitment to cover clinical fellow and middle grade gaps in General Medicine in the Weston Division for August has seen positive outcomes in June, with x9 Clinical Fellows ST1/2 and x4 ST3+ appointed. • Targeted marketing of medical roles across the Trust is underway through a number of international job boards, with a particular focus on the Weston Division. • Scoping of the role of Medical Support Worker is underway with supported funding from Health Education England. • An Expression of Interest has been submitted to join the Health Education England Global Health Partners Framework to support the Trust's ambition for international health partnerships.
Ownership:	Director of People

Vacancy	Jun-21	KPI
UHBW NHS Foundation Trust	7.4%	6.2%
Diagnostics & Therapies	2.8%	5.5%
Medicine	10.7%	6.5%
Specialised Services	9.5%	5.5%
Surgery	10.4%	4.5%
Women's & Children's	-0.5%	5.0%
Trust Services	4.6%	4.9%
Facilities & Estates	11.3%	9.1%
Weston	14.8%	11.0%

Workforce – Staff Sickness

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

P *Partially Achieved*

Standards:	Staff sickness is measured as a percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2018/19. The red threshold is 0.5% over the monthly target.
Performance:	In June 2021, total available FTE days were 308,845 of which 11,831 (3.8%) were lost to staff sickness.
Commentary:	Sickness absence increased to 3.8% compared with 3.6% in the previous month. This figure now contains Long Covid sickness. It does NOT include Medical Suspension reporting. There were increases within seven divisions; the largest divisional increase was seen in Specialised Services, increasing by 1.0 percentage points to 4.0% from 3.0% the previous month. There were reductions within one division; the largest divisional reduction was seen in Medicine, reducing by 0.4 percentage points to 3.5% from 3.9% the previous month. Medical Suspension continues to be the method used to record short-term Covid absences. During June, 1.3% of available FTE was lost to Medical Suspension compared to 1.1% in May: 0.4% Covid Sickness, 0.9% Covid Isolation/Shielding. Long Covid accounts for 0.1% of the sickness absence. • Both Men's Health Week and British Nutrition Foundation Healthy Eating Week are being promoted across all Trust communication channels. • Engagement of 30+ colleagues from Estates has been seen, with the delivery of a session promoting mental health support access for men. • A new video has been shared via social media for Wellbeing Wednesday, encouraging colleagues to switch-off from work and promoting a healthy work/life balance. • Preventative and targeted support of musculoskeletal (MSK) and physical wellbeing is being enhanced through the provision of a new Manual Handling Guide for individuals and line managers. The Guide is being promoted across Divisions. • A new wellbeing library book scheme funded by Above and Beyond is launched, providing staff with guidance on a range of wellbeing topics.
Ownership:	Director of People

Sickness	Jun-21	KPI
UHBW NHS Foundation Trust	3.8%	**3.7%**
Diagnostics & Therapies	3.0%	2.8%
Medicine	3.5%	4.0%
Specialised Services	4.0%	3.3%
Surgery	3.7%	4.0%
Women's & Children's	3.9%	3.6%
Trust Services	2.9%	3.1%
Facilities & Estates	4.9%	5.3%
Weston	5.1%	4.1%

Workforce – Appraisal Compliance

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

N *Not Achieved*

Standards:	Staff Appraisal in measured as a percentage of staff excluding consultants who have had their appraisal signed-off. The target is 85% Trust-wide.
Performance:	In June 2021, 7,159 members of staff were compliant out of 10,248 (69.9%).
Commentary:	Overall appraisal compliance increased to 69.9% from 69.1% compared to the previous month. All divisions are non-compliant. There were increases in five divisions, and reductions in the remaining three divisions. The largest divisional increase was within Diagnostic & Therapies, increasing to 76.9% from 73.6% in the previous month. The largest divisional reduction was seen within Weston where compliance reduced to 64.4% compared with 69.9% in the previous month. Following the implementation of the interim appraisal programme in place to close the appraisal compliance gap by September 2021, the following actions are being undertaken: • A review of the Divisional trajectories with ongoing compliance tracking. • Implementation of on-line appraisal functionality in the Division of Weston. • Alignment of the Appraisal Policy with Pay Progression requirements.
Ownership:	Director of People

Appraisal (Non-Consultant)	Jun-21	May-21	KPI
UHBW NHS Foundation Trust	69.9%	69.1%	**85.0%**
Diagnostics & Therapies	76.9%	73.6%	85.0%
Medicine	59.0%	56.0%	85.0%
Specialised Services	82.1%	83.2%	85.0%
Surgery	54.8%	52.3%	85.0%
Women's & Children's	73.4%	72.7%	85.0%
Trust Services	77.5%	75.5%	85.0%
Facilities & Estates	75.2%	75.7%	85.0%
Weston	64.4%	69.9%	85.0%

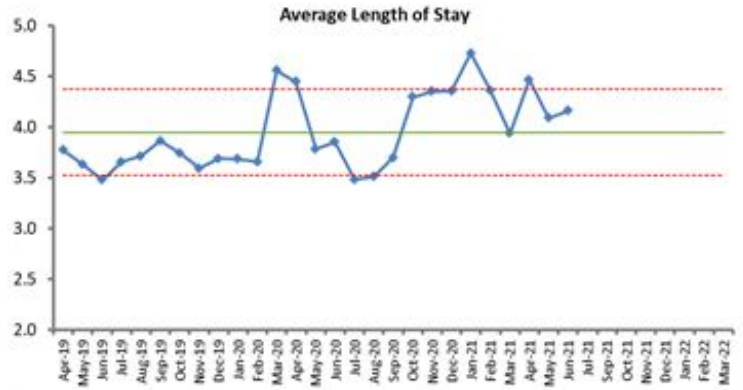
Average Length of Stay

NHS University Hospitals Bristol and Weston NHS Foundation Trust

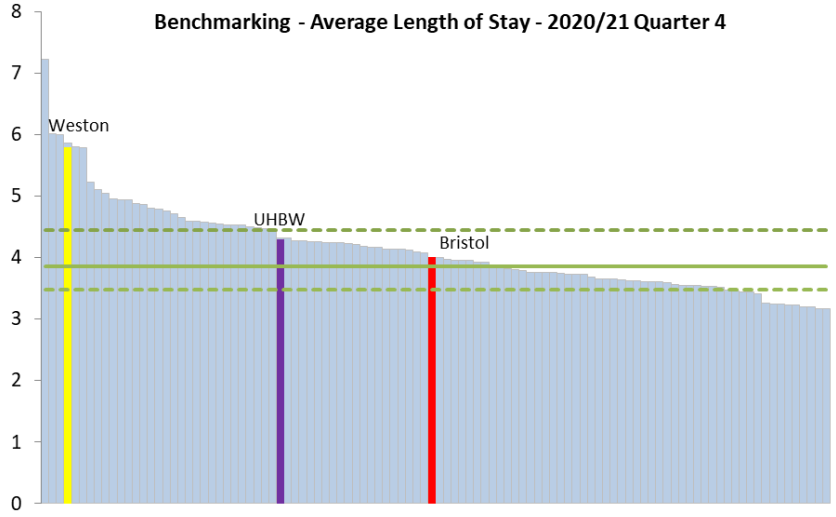
June 2021

N/A *No Standard*

Standards:	Average Length of Stay is the number of beddays (1 beddays = 1 bed occupied at 12 midnight) for all inpatients discharged in the month, divided by number of discharges.
Performance:	In May there were 7,173 discharges at UHBW with an average length of stay of 4.16 days.
Commentary:	Current assumptions around length of stay are being reviewed as part of the pathway reconfigurations resulting from the Covid pandemic.
Ownership:	Chief Operating Officer



	Jun-21
Medicine	4.4
Specialised Services	7.3
Surgery	4.2
Weston	6.5
Women's and Children's	2.3



Finance – Executive Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021

YTD Income & Expenditure Position	• Net surplus of £387k against a plan of break-even (excluding technical items). • Total operating income is £1,516k favourable to plan mainly due to higher than planned Elective Recovery Fund (ERF) income of £2,835k offset by lower than planned other operating income of £1,062k. • Operating expenses are £1,487k adverse to plan. Excluding technical items, operating expenses are £931k adverse to plan and is primarily due lower than planned savings delivery (£2,061k adverse) offset by slower than planned pay costs linked to investments.
Key Financial Issues	• The Trust's financial position includes estimated ERF income and matching costs of £7,835k pending a system decision regarding the allocation of ERF. • The level of ERF earnable by the Trust will reduce over the next quarter due to challenges with workforce and bed availability impacting on activity delivery as seen in June. • Savings delivery of £1,578k or 44% of the plan. The savings forecast outturn indicates a shortfall in delivery of £8,002k. Although this will impact on the Trust's financial performance against plan it is not expected to lead to non-delivery overall. More significantly, the indicative recurrent savings delivery of £3,757k will have a material impact on the Trust's underlying position going in to 2022/23.
Strategic Risks	• Although these are not expected to have an impact in this financial year, further work is required to develop understanding and mitigating strategies on the following: • Agreeing an STP approach to future financial targets given UHBW's need to service past borrowing; • Understanding the risks and mitigations associated with the new capital regime; and how the CDEL limit could restrict future strategic capital investment • Re-assessing the implications of the financial arrangements relating to the merger and how that may have altered by changes in the national financial regime.

Finance – Financial Performance

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

Trust Year to Date Financial Position

	Month 3			YTD		
	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's
Income from Patient Care Activities	79,303	84,116	4,813	227,607	230,184	2,577
Other Operating Income	12,660	14,936	2,277	34,189	33,127	(1,062)
Total Operating Income	**91,963**	**99,052**	**7,090**	**261,796**	**263,311**	**1,516**
Employee Expenses	(47,832)	(47,518)	314	(143,495)	(142,228)	1,267
Other Operating Expenses	(36,610)	(41,251)	(4,641)	(99,822)	(102,258)	(2,436)
Depreciation (owned & leased)	(2,413)	(2,498)	(85)	(7,238)	(7,556)	(318)
Total Operating Expenditure	**(86,855)**	**(91,267)**	**(4,412)**	**(250,555)**	**(252,042)**	**(1,487)**
PDC	(1,072)	(1,072)	(1)	(3,215)	(3,215)	(1)
Interest Payable	(190)	(174)	16	(571)	(541)	30
Interest Receivable	0	0	0	0	0	0
Other Gains/(Losses)	0	(12)	(12)	0	(12)	(12)
Net Surplus/(Deficit) inc technicals	**3,846**	**6,527**	**2,681**	**7,455**	**7,501**	**46**
Remove Capital Donations, Grants & donated asset depreciation	(3,846)	(6,462)	(2,616)	(7,455)	(7,114)	341
Net Surplus/(Deficit) exc technicals	**0**	**65**	**65**	**0**	**387**	**387**

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

Key Facts:

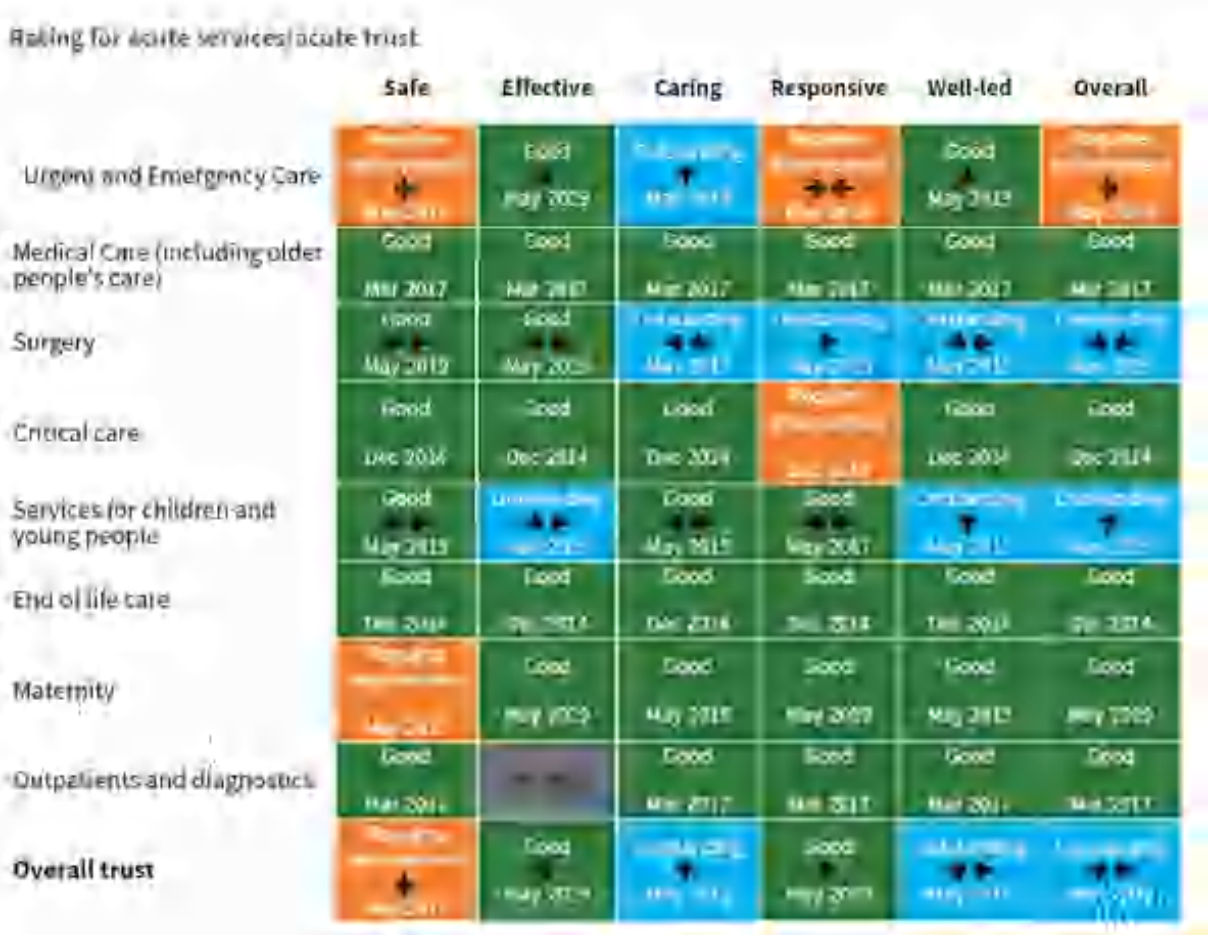
- The actual position for June is a net surplus of £65k against a plan of breakeven.
- YTD the position is £387k favourable to the planned breakeven position.
- Pay expenditure is favourable to plan at £1,267k or 0.8% YTD.
- High agency usage continues predominantly driven by vacancies and sickness.
- Agency expenditure at the end of Q1 is £7,597k, representing 5% of total pay.
- Elective activity decreased in June by 11-13% compared to May. In addition, productivity also fell with a reduction in activity per working day across elective inpatients, day cases and outpatients.
- Income earned from the Elective Recovery Fund (ERF) in Q1 is £7,835k, £2,835k ahead of plan.
- Other operating income is adverse to plan by £1,062k due to slower than planned pick up in commercial income.
- CIP achievement is 44%. £1,578k has been achieved against a target of £3,609k.
- Additional costs of Covid-19 are £2,867k in Q1 and show a month-on-month reduction.

Care Quality Commission Rating - Bristol

University Hospitals Bristol and Weston NHS Foundation Trust

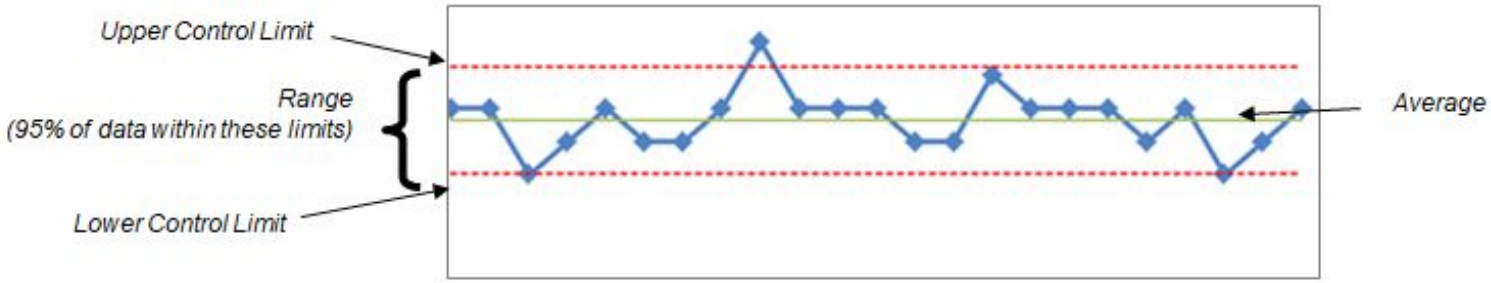
The Care Quality Commission (CQC) published their latest inspection report on 16th August 2019. Full details can be found here: **https://www.cqc.org.uk/provider/RA7**

The overall rating was OUTSTANDING, and the breakdown by category is shown below:



Explanation of SPC Charts

In the previous sections, some of the metrics are being presented using Statistical Process Control (SPC) charts. An example chart is shown below

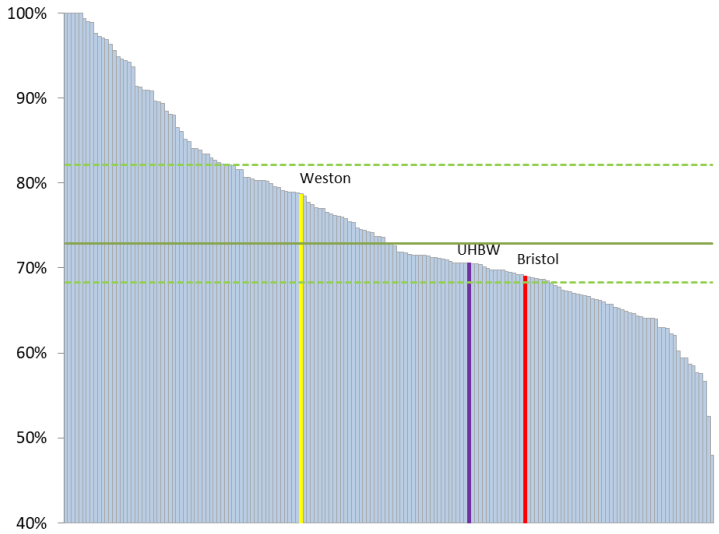


The blue line is the Trust's monthly data and the green solid line is the monthly average for that data. The red dashed lines are called "control limits" and are derived from the Trust's monthly data and is a measure of the variation present in the data. If the process does not change, then 95% of all future data points will lie between these two limits.

If a process changes, then the limits can be re-calculated and a "step change" will be observed. There are different signals to look for, to identify if a process has changed. Examples would be a run of 7 data points going up/down or 7 data points one side of the average. These step changes should be traceable back to a change in operational practice, changes to flow, patient choice or demand changes; they do not occur by chance.

Explanation of Benchmarking Charts

In the previous sections, some of the metrics have national benchmarking reports included. An example is shown below:



Each vertical, light-blue bar represents one of the (approx.) 140 acute Trusts in England.

The horizontal solid green line is the median Trust performance, i.e. 50% of the Trusts are above this line and 50% are below.

The horizontal dotted green lines are the upper and lower quartile Trust performance, i.e.

- 25% of Trusts are above the Upper Quartile line and 75% are below.
- 25% of Trusts are below the Lower Quartile line and 75% are above.

The separate performance for Bristol and Weston Trusts is shown as the vertical red and yellow bars respectively. The combined performance (UHBW) is the vertical purple bar.

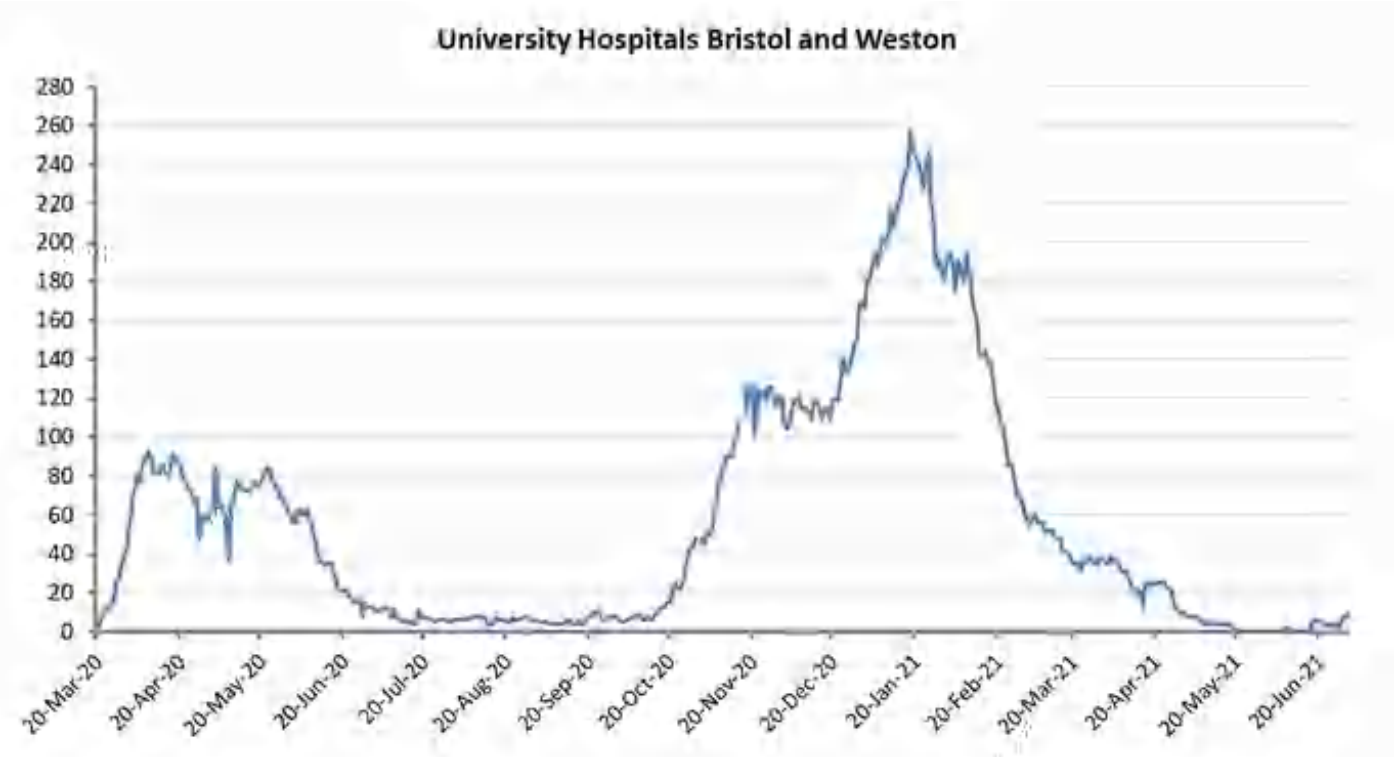
Appendix – Covid19 Summary

University Hospitals Bristol and Weston NHS Foundation Trust

Source:	COVID-19 NHS Situation Report
Publication Date:	Published data, 8th July 2021, from https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/
Ownership:	Chief Operating Officer

Bed Occupancy

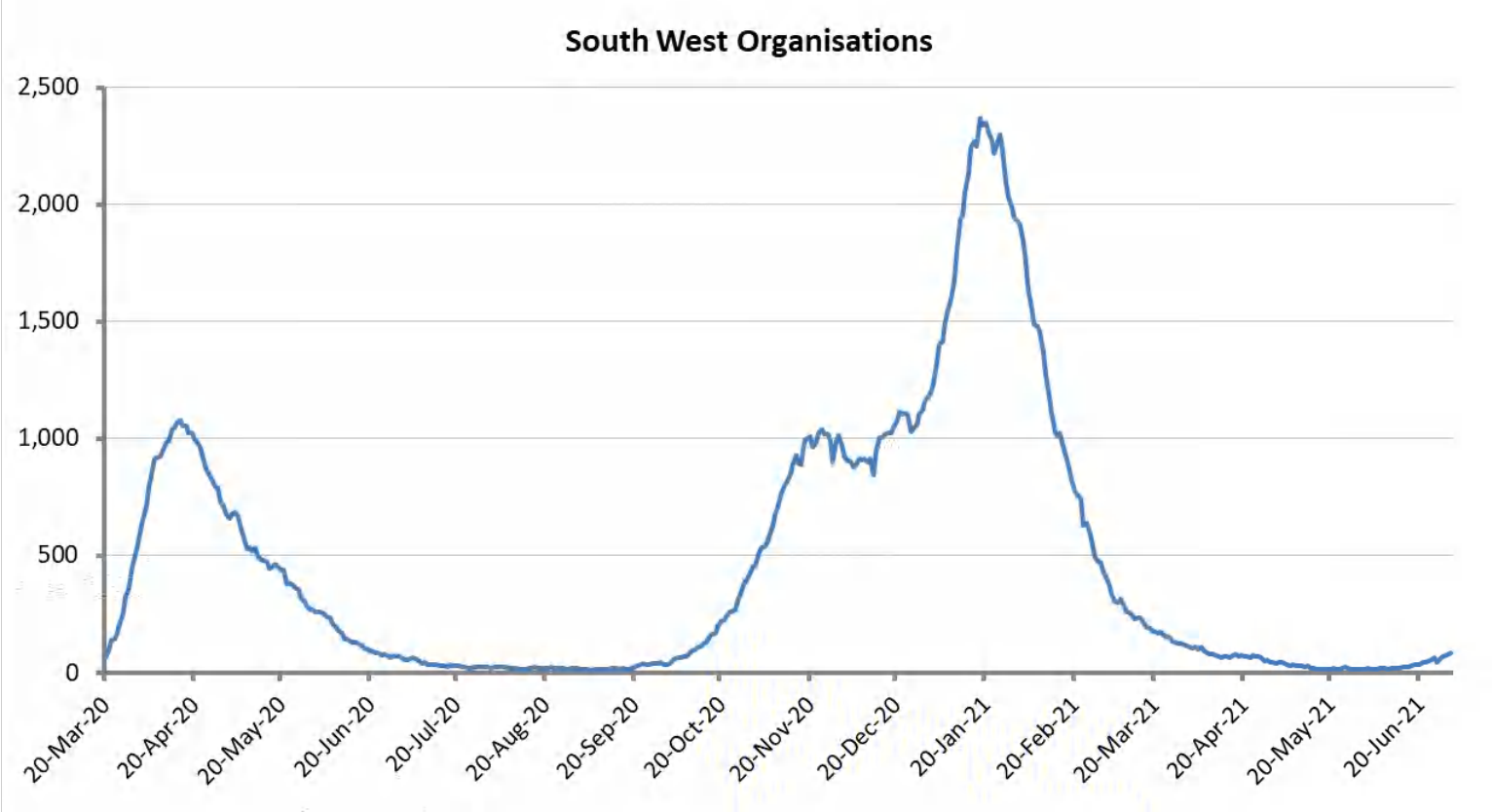
Total beds occupied by confirmed Covid-19 patients as at 8am each day. Data from the "COVID-19 NHS Situation Report". Data up to 1st July 2021.



Appendix – Covid19 Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Source:	COVID-19 NHS Situation Report
Publication Date:	Published data, 8th July 2021, from https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/
Ownership:	Chief Operating Officer



Appendix – Covid19 Summary

University Hospitals Bristol and Weston NHS Foundation Trust

Source:	COVID-19 NHS Situation Report
Publication Date:	Retrieved on 20th July 2021 from https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/
Commentary:	Daily monitoring and reporting of all Covid -19 results is reviewed and approved by an Executive Director. The Trust undertakes rapid action when any cases are identified to prevent further spread with the dissemination of the Infection Prevention and Control Covid outbreak pack to ensure all cases are managed consistently with outbreak meetings set up and conducted in line with the Hospital Outbreak of infection policy.
Ownership:	Chief Nurse

Month	Inpatients Admitted With Covid-19	Inpatients Diagnosed With Covid-19 Following Admission				
		Community Onset	Hospital-Onset Indeterminate Healthcare-Associated	Hospital-Onset Probable Healthcare-Associated	Hospital-Onset Definite Healthcare-Associated	TOTAL Diagnosed Following Admission
May-20	37					[illegible]
Jun-20	16					[illegible]
Jul-20	[illegible]	5	1	0	1	7
Aug-20	[illegible]	9	0	0	1	10
Sep-20	[illegible]	17	0	0	0	17
Oct-20	[illegible]	127	6	5	5	134
Nov-20	[illegible]	157	32	18	23	234
Dec-20	[illegible]	144	27	22	35	178
Jan-21	[illegible]	159	31	25	19	234
Feb-21	[illegible]	88	32	19	22	151
Mar-21	[illegible]	17	7	3	10	37
Apr-21	[illegible]	7	2	3	12	[illegible]
May-21	2	0	0	0	0	1
Jun-21	[illegible]	7	1	1	0	[illegible]
	1,209					[illegible]

- Community-Onset: a positive specimen date less than or equal to 2 days after hospital admission or hospital attendance;
- Hospital-Onset Indeterminate Healthcare-Associated: a positive specimen date 3-7 days after hospital admission;
- Hospital-Onset Probable Healthcare-Associated: a positive specimen date 8-14 days after hospital admission;
- Hospital-Onset Definite Healthcare-Associated: a positive specimen date 15 or more days after hospital admission

Appendix – Trust Scorecards

NHS University Hospitals Bristol and Weston NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
SAFE DOMAIN

NHS University Hospitals Bristol and Weston NHS Foundation Trust

ID	Measure	20/21	21/22 YTD	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1
Infection Control																			
DA01	MRSA Hospital Onset Cases	4	0	0	0	1	1	0	0	1	0	0	0	0	0	1	1	1	0
DA02	MSSA Hospital Onset Cases	45	13	3	2	5	1	3	6	5	9	2	4	5	4	10	10	16	13
DA03	CDiff Hospital Onset Cases	67	33	5	11	4	5	7	6	5	2	5	8	11	14	20	18	12	33
DA03A	CDiff Healthcare Associated Cases	81	38	6	13	5	6	8	6	6	2	7	9	13	16	24	20	15	38
DA06	EColi Hospital Onset Cases	81	15	4	13	5	7	4	4	9	6	14	5	5	5	22	15	29	15
Patient Falls																			
AB01	Falls Per 1,000 Beddays	5.14	4.36	3.66	4.76	5.3	4.28	5.18	5.9	4.38	5.73	4.94	4.7	4.02	4.38	4.6	5.1	5	4.36
	Numerator (Falls)	*1698*	*399*	*100*	*136*	*160*	*134*	*151*	*171*	*124*	*154*	*152*	*139*	*126*	*134*	*396*	*456*	*430*	*399*
	Denominator (Beddays)	*330253*	*91522*	*27319*	*28557*	*30205*	*31336*	*29161*	*28979*	*28301*	*26872*	*30746*	*29584*	*31351*	*30587*	*86081*	*89476*	*85919*	*91522*
AB06A	Total Number of Patient Falls Resulting in Harm	23	8	1	1	1	4	3	1	3	3	2	5	1	2	3	8	8	8
Pressure Injuries																			
DE01	Pressure Injuries Per 1,000 Beddays	0.279	0.109	0.183	0.315	0.199	0.096	0.274	0.138	0.318	0.26	0.228	0.135	0.064	0.131	0.232	0.168	0.268	0.109
	Numerator (Pressure Injuries)	92	10	5	9	6	3	8	4	9	7	7	4	2	4	20	15	23	10
	Denominator (Beddays)	330253	91522	27319	28557	30205	31336	29161	28979	28301	26872	30746	29584	31351	30587	86081	89476	85919	91522
DE02	Pressure Injuries - Grade 2	84	8	5	9	6	0	8	4	8	7	7	4	1	3	20	12	22	8
DE03	Pressure Injuries - Grade 3	5	2	0	0	0	0	0	0	1	0	0	0	1	1	0	0	1	2
DE04	Pressure Injuries - Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Serious Incidents																			
S02	Number of Serious Incidents Reported	109	25	7	5	23	15	10	5	11	8	10	7	9	9	35	30	29	25
S01	Total Never Events	6	1	1	0	2	1	2	0	0	0	0	1	0	0	3	3	0	1
Medication Errors																			
WA01	Medication Incidents Resulting in Harm	-	-	0.9%	0%	0%	0.31%	0.37%	0.83%	0%	0%	0.37%	0%	0.33%	-	-	-	-	-
	Numerator (Incidents Resulting In Harm)	0	0	3	0	0	1	1	2	0	0	1	0	1	0	0	0	0	0
	Denominator (Total Incidents)	0	0	335	274	284	323	269	241	257	229	268	293	301	0	0	0	0	0
WA03	Non-Purposeful Omitted Doses of the Listed Critical Medi	0.46%	0.22%	0.49%	0.15%	0.54%	0.63%	0.68%	0.36%	1.43%	0.19%	0.35%	0%	0%	0.61%	0.39%	0.58%	0.46%	0.22%
	Numerator (Number of Incidents)	26	3	4	1	3	3	3	1	3	1	2	0	0	3	8	7	6	3
	Denominator (Total Audited)	5638	1382	825	675	557	479	442	281	210	521	576	439	447	496	2057	1202	1307	1382

Omitted Doses is Bristol only

Appendix – Trust Scorecards

NHS University Hospitals Bristol and Weston NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL SAFE DOMAIN																		
ID	Measure	20/21	21/22 YTD	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1
VTE Risk Assessment																			
N01	**Adult Inpatients who Received a VTE Risk Assessment**	**85.4%**	**82.5%**	**85%**	**84.4%**	**85.3%**	**85.8%**	**85.2%**	**85.5%**	**84.6%**	**84.3%**	**84%**	**82.7%**	**82.3%**	**82.5%**	**84.9%**	**85.5%**	**84.3%**	**82.5%**
	Numerator (Number Risk Assessed)	77073	21400	6566	6151	7104	7525	7089	6925	6250	6217	7332	7012	7137	7251	19821	21539	19799	21400
	Denominator (Total Patients)	90252	25942	7726	7287	8333	8770	8317	8095	7386	7377	8732	8477	8671	8794	23346	25182	23495	25942
	VTE Data is Bristol only																		
Nurse Staffing Levels ("Fill Rate")																			
RP01	**Staffing Fill Rate - Combined**	**95.8%**	**98.5%**	**101.1%**	**99.4%**	**97.6%**	**100.3%**	**97.4%**	**91.7%**	**90.7%**	**92.9%**	**91.5%**	**97.2%**	**101.5%**	**96.9%**	**99.4%**	**96.4%**	**91.7%**	**98.5%**
	Numerator (Hours Worked)	3472575	868901	302850	296436	286125	306243	295331	294407	288541	266423	292106	283241	300816	284844	885411	895982	847070	868901
	Denominator (Hours Planned)	3623484	881850	299683	298223	293298	305348	303349	321059	318057	286794	319187	291290	296455	294105	891204	929756	924037	881850
RP02	**Staffing Fill Rate - RN Shifts**	**92.7%**	**94.3%**	**97.2%**	**94.9%**	**95.4%**	**98.6%**	**96.7%**	**89.4%**	**88.6%**	**89.9%**	**87.5%**	**92.4%**	**97.7%**	**92.7%**	**95.9%**	**94.8%**	**88.6%**	**94.3%**
	Numerator (Hours Worked)	2310640	573446	199195	194533	191444	206329	200175	199025	194810	176959	192919	186768	199598	187080	585172	605529	564687	573446
	Denominator (Hours Planned)	2492525	608276	204937	204886	200675	209358	207114	222595	219755	196821	220486	202050	204360	201866	610498	639066	637062	608276
RP03	**Staffing Fill Rate - NA Shifts**	**102.7%**	**108%**	**109.4%**	**109.2%**	**102.2%**	**104.1%**	**98.9%**	**96.9%**	**95.3%**	**99.4%**	**100.5%**	**108.1%**	**109.9%**	**106%**	**107%**	**99.9%**	**98.4%**	**108%**
	Numerator (Hours Worked)	1161934	295454	103655	101903	94680.3	99914.8	95156.2	95381.5	93731.3	89463.7	99187.8	96472.6	101218	97763.7	300239	290452	282383	295454
	Denominator (Hours Planned)	1130958	273574	94745.6	93337.7	92622.9	95990.9	96235.3	98464.4	98302.4	89972.7	98700.3	89240.1	92095	92238.5	280706	290691	286975	273574

Appendix – Trust Scorecards

NHS University Hospitals Bristol and Weston NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
CARING DOMAIN

NHS University Hospitals Bristol and Weston NHS Foundation Trust

ID	Measure	20/21	21/22 YTD	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1
Patient Surveys (Bristol)																			
P01D	Patient Survey (Bristol) - Patient Experience Tracker Score			90	90	91	89	88	90	91	92	90	89	91	89	-	-	-	-
P01G	Patient Survey (Bristol) - Kindness and Understanding			97	96	95	94	93	96	97	96	95	94	97	94	96	94	96	95
P01H	Patient Survey (Bristol) - Outpatient Tracker Score			93	92	94	92	94	93	94	94	95	95	93	96	93	93	94	95
Patient Surveys (Weston)																			
P02D	Patient Survey (Weston) - Patient Experience Tracker Score												84	85	85				-
P02G	Patient Survey (Weston) - Kindness and Understanding												92	93	96				93
P02H	Patient Survey (Weston) - Outpatient Tracker Score												90	94	85				89
Patient Complaints (Number Received)																			
T01	Number of Patient Complaints	1665	427	146	169	206	199	176	115	136	145	145	89	176	162	521	490	426	427
T01C	Patient Complaints - Formal	546	103	58	61	90	51	65	24	49	32	43	31	46	26	209	140	124	103
T01D	Patient Complaints - Informal	1119	324	88	108	116	148	111	91	87	113	102	58	130	136	312	350	302	324
Patient Complaints (Response Time)																			
T03A	Formal Complaints Responded To Within Trust Timeframe	71.5%	68.4%	80.4%	67.4%	72.6%	61.9%	81%	65.8%	66.7%	72.7%	80.9%	85.5%	58.3%	65.9%	73.5%	69.1%	72.5%	68.4%
	Numerator (Responses Within Timeframe)	*442*	*147*	*41*	*31*	*53*	*39*	*47*	*48*	*46*	*32*	*38*	*47*	*42*	*58*	*125*	*134*	*116*	*147*
	Denominator (Total Responses)	*618*	*215*	*51*	*46*	*73*	*63*	*58*	*73*	*69*	*44*	*47*	*55*	*72*	*88*	*170*	*194*	*160*	*215*
T03B	Formal Complaints Responded To Within Divisional Timeframe	76.7%	74%	90.2%	71.7%	68.5%	71.4%	84.5%	67.1%	63.8%	77.3%	87.2%	92.7%	62.5%	71.6%	75.9%	73.7%	74.4%	74%
	Numerator (Responses Within Timeframe)	*474*	*159*	*46*	*33*	*50*	*45*	*49*	*49*	*44*	*34*	*41*	*51*	*45*	*63*	*129*	*143*	*119*	*159*
	Denominator (Total Responses)	*618*	*215*	*51*	*46*	*73*	*63*	*58*	*73*	*69*	*44*	*47*	*55*	*72*	*88*	*170*	*194*	*160*	*215*
T05A	Informal Complaints Responded To Within Trust Timeframe	93%	91.5%	93.1%	88.4%	90.9%	89.2%	93.9%	93.2%	97.6%	94.6%	88.7%	91.2%	94.4%	87.8%	90.8%	92.1%	92.9%	91.5%
	Numerator (Responses Within Timeframe)	*686*	*162*	*67*	*61*	*70*	*74*	*92*	*55*	*40*	*35*	*55*	*52*	*67*	*43*	*198*	*221*	*130*	*162*
	Denominator (Total Responses)	*738*	*177*	*72*	*69*	*77*	*83*	*98*	*59*	*41*	*37*	*62*	*57*	*71*	*49*	*218*	*240*	*140*	*177*
Patient Complaints (Dissatisfied)																			
T04C	Percentage of Responses where Complainant is Dissatisfied	7.12%	9.09%	9.8%	2.17%	9.59%	20.64%	1.72%	5.48%	2.9%	13.64%	2.13%	9.09%	-	-	7.65%	9.28%	5.63%	9.09%
	Numerator (Number Dissatisifed)	*44*	*5*	*5*	*1*	*7*	*13*	*1*	*4*	*2*	*6*	*1*	*5*	*0*	*0*	*13*	*18*	*9*	*5*
	Denominator (Total Responses)	*618*	*55*	*51*	*46*	*73*	*63*	*58*	*73*	*69*	*44*	*47*	*55*	*0*	*0*	*170*	*194*	*160*	*55*

Appendix – Trust Scorecards

NHS University Hospitals Bristol and Weston NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
CARING DOMAIN

NHS University Hospitals Bristol and Weston NHS Foundation Trust

ID	Measure	20/21	21/22 YTD	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1
Friends and Family Test (Inpatients and Day Cases)																			
P03A	Friends and Family Test Inpatient Coverage	17%	26.6%	-	-	-	-	-	11.6%	15.4%	19.1%	21.5%	20.8%	32.2%	-	-	11.6%	19%	26.6%
	Numerator (Total FFT Responses)	*3442*	*3152*	*0*	*0*	*0*	*0*	*0*	*620*	*662*	*913*	*1247*	*1222*	*1930*	*0*	*0*	*620*	*2822*	*3152*
	Denominator (Total Eligible to Respond)	*20211*	*11857*	*0*	*0*	*0*	*0*	*0*	*5330*	*4295*	*4790*	*5796*	*5863*	*5994*	*0*	*0*	*5330*	*14881*	*11857*
P04A	Friends and Family Test Score - Inpatients	98.4%	97.7%	-	-	-	-	-	97.4%	99.1%	99.1%	98.1%	97.7%	97.7%	-	-	97.4%	98.6%	97.7%
	Numerator (Total "Positive" Responses)	*3346*	*3064*	*0*	*0*	*0*	*0*	*0*	*592*	*648*	*895*	*1211*	*1182*	*1882*	*0*	*0*	*592*	*2754*	*3064*
	Denominator (Total Responses)	*3400*	*3136*	*0*	*0*	*0*	*0*	*0*	*608*	*654*	*903*	*1235*	*1210*	*1926*	*0*	*0*	*608*	*2792*	*3136*
Friends and Family Test (Emergency Department)																			
P03B	Friends and Family Test ED Coverage	7.4%	6.4%	-	-	-	-	-	8.5%	6.6%	6.6%	7.8%	6.2%	6.5%	-	-	8.5%	7.1%	6.4%
	Numerator (Total FFT Responses)	*1971*	*1311*	*0*	*0*	*0*	*0*	*0*	*572*	*407*	*401*	*591*	*537*	*774*	*0*	*0*	*572*	*1399*	*1311*
	Denominator (Total Eligible to Respond)	*26539*	*20496*	*0*	*0*	*0*	*0*	*0*	*6760*	*6126*	*6034*	*7619*	*8598*	*11898*	*0*	*0*	*6760*	*19779*	*20496*
P04B	Friends and Family Test Score - ED	92.4%	86.6%	-	-	-	-	-	91.9%	93.5%	92%	92.5%	88%	85.6%	-	-	91.9%	92.7%	86.6%
	Numerator (Total "Positive" Responses)	*1811*	*1131*	*0*	*0*	*0*	*0*	*0*	*524*	*375*	*367*	*545*	*471*	*660*	*0*	*0*	*524*	*1287*	*1131*
	Denominator (Total Responses)	*1959*	*1306*	*0*	*0*	*0*	*0*	*0*	*570*	*401*	*399*	*589*	*535*	*771*	*0*	*0*	*570*	*1389*	*1306*
Friends and Family Test (Maternity)																			
P03C	Friends and Family Test MAT Coverage	15.8%	12.2%	-	-	-	-	-	5%	16.3%	31%	10.4%	7.4%	16.7%	-	-	5%	19.1%	12.2%
	Numerator (Total FFT Responses)	*240*	*98*	*0*	*0*	*0*	*0*	*0*	*18*	*62*	*119*	*41*	*29*	*69*	*0*	*0*	*18*	*222*	*98*
	Denominator (Total Eligible to Respond)	*1523*	*805*	*0*	*0*	*0*	*0*	*0*	*362*	*381*	*384*	*396*	*392*	*413*	*0*	*0*	*362*	*1161*	*805*
P04C	Friends and Family Test Score - Maternity	99%	96.5%	-	-	-	-	-	94.4%	97.4%	99.5%	100%	96.7%	96.4%	-	-	94.4%	99.2%	96.5%
	Numerator (Total "Positive" Responses)	*381*	*192*	*0*	*0*	*0*	*0*	*0*	*17*	*74*	*205*	*85*	*59*	*133*	*0*	*0*	*17*	*364*	*192*
	Denominator (Total Responses)	*385*	*199*	*0*	*0*	*0*	*0*	*0*	*18*	*76*	*206*	*85*	*61*	*138*	*0*	*0*	*18*	*367*	*199*
Friends and Family Test (Outpatients)																			
P04D	Friends and Family Test Score - Outpatients	95.7%	94.9%	-	-	-	-	-	95.1%	96.4%	96%	95.6%	94.8%	95%	-	-	95.1%	96%	94.9%
	Numerator (Total FFT Responses)	*8482*	*4879*	*0*	*0*	*0*	*0*	*0*	*2233*	*1701*	*2151*	*2397*	*2330*	*2549*	*0*	*0*	*2233*	*6249*	*4879*
	Denominator (Total Eligible to Respond)	*8861*	*5140*	*0*	*0*	*0*	*0*	*0*	*2349*	*1765*	*2240*	*2507*	*2458*	*2682*	*0*	*0*	*2349*	*6512*	*5140*

Appendix – Trust Scorecards

NHS University Hospitals Bristol and Weston NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
RESPONSIVE DOMAIN

NHS University Hospitals Bristol and Weston NHS Foundation Trust

ID	Measure	20/21	21/22 YTD	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1
Emergency Department Performance																			
B01	ED Total Time in Department - Under 4 Hours	80.09%	72.98%	84.05%	82.09%	81.24%	79.82%	75.84%	74.35%	69.72%	72.56%	76.27%	74.93%	74.2%	70.09%	82.43%	76.79%	73.14%	72.98%
	Numerator (Number Seen In Under 4 Hours)	*112178*	*35117*	*10900*	*11092*	*11253*	*10740*	*9263*	*8865*	*7413*	*7570*	*10364*	*11032*	*12260*	*11825*	*33245*	*28868*	*25347*	*35117*
	Denominator (Total Attendances)	*140062*	*48117*	*12969*	*13512*	*13851*	*13455*	*12213*	*11924*	*10633*	*10433*	*13588*	*14723*	*16523*	*16871*	*40332*	*37592*	*34654*	*48117*
B06	ED 12 Hour Trolley Waits	1440	245	58	68	6	87	201	247	468	195	102	71	28	146	132	535	765	245
Emergency Department Clinical Indicators																			
B02	ED Time to Initial Assessment - Under 15 Minutes	81.1%	88.5%	82.3%	79.7%	76.6%	73.6%	81.7%	78.7%	80.3%	82.2%	77.7%	88.8%	88.5%	88.1%	79.5%	77.8%	79.9%	88.5%
	Numerator (Number Assessed Within 15 Minutes)	*53673*	*11004*	*5241*	*5145*	*5014*	*4689*	*4748*	*4499*	*4167*	*4030*	*4838*	*3485*	*3920*	*3599*	*15400*	*13936*	*13035*	*11004*
	Denominator (Total Attendances Needing Assessment)	*66150*	*12440*	*6368*	*6456*	*6543*	*6374*	*5814*	*5715*	*5190*	*4905*	*6227*	*3926*	*4430*	*4084*	*19367*	*17903*	*16322*	*12440*
B03	ED Time to Start of Treatment - Under 60 Minutes	68%	51.8%	65.4%	63.1%	58.3%	63.7%	70.1%	65.6%	68.5%	66.8%	64%	57.5%	52.4%	46.2%	62.6%	66.4%	66.2%	51.8%
	Numerator (Number Treated Within 60 Minutes)	*91353*	*24152*	*8362*	*8364*	*5861*	*8490*	*8455*	*7731*	*7158*	*6813*	*8507*	*8289*	*8389*	*7474*	*22587*	*24676*	*22478*	*24152*
	Denominator (Total Attendances)	*134421*	*46597*	*12793*	*13259*	*10048*	*13319*	*12062*	*11776*	*10442*	*10203*	*13290*	*14409*	*16009*	*16179*	*36100*	*37157*	*33935*	*46597*
B04	ED Unplanned Re-attendance Rate	4.5%	4.5%	4.4%	4.4%	4.4%	4.5%	5.4%	4.7%	4.9%	4.3%	4.6%	4.2%	4.7%	4.6%	4.4%	4.9%	4.6%	4.5%
	Numerator (Number Re-attending)	*6243*	*2164*	*567*	*589*	*612*	*609*	*654*	*565*	*525*	*448*	*630*	*619*	*773*	*772*	*1768*	*1828*	*1603*	*2164*
	Denominator (Total Attendances)	*139970*	*48116*	*12847*	*13512*	*13973*	*13456*	*12216*	*11925*	*10636*	*10438*	*13592*	*14723*	*16523*	*16870*	*40332*	*37597*	*34666*	*48116*
B05	ED Left Without Being Seen Rate	1%	1.7%	1.2%	1.2%	1.3%	1.2%	1%	1.1%	1%	1%	1%	1.2%	1.5%	2.3%	1.2%	1.1%	1%	1.7%
	Numerator (Number Left Without Being Seen)	*1442*	*818*	*152*	*158*	*174*	*161*	*121*	*135*	*103*	*104*	*140*	*181*	*244*	*393*	*484*	*417*	*347*	*818*
	Denominator (Total Attendances)	*140062*	*48117*	*12969*	*13512*	*13851*	*13455*	*12213*	*11924*	*10633*	*10433*	*13588*	*14723*	*16523*	*16871*	*40332*	*37592*	*34654*	*48117*
Referral To Treatment Ongoing																			
A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	-	-	46.5%	51.4%	58.1%	63.4%	65.6%	62.6%	62.3%	62.5%	61.7%	60.1%	62.8%	63.6%	-	-	-	-
	Numerator (Number Under 18 Weeks)	*0*	*0*	*17319*	*20216*	*23729*	*27022*	*27942*	*26416*	*26493*	*27685*	*28721*	*29401*	*31263*	*32579*	*0*	*0*	*0*	*0*
	Denominator (Total Pathways)	*0*	*0*	*37270*	*39363*	*40827*	*42654*	*42624*	*42222*	*42523*	*44314*	*46538*	*48902*	*49791*	*51198*	*0*	*0*	*0*	*0*
A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	25077	11330	796	1077	1500	1809	2164	2891	3790	4807	5409	4598	3618	3114	3373	6864	14006	11330
Referral To Treatment Activity																			
A01A	Referral To Treatment Number of Admitted Clock Stops	27415	8127	2319	2202	2731	3583	3658	2817	2022	1966	2478	2526	2671	2930	7252	10058	6466	8127
A02A	Referral To Treatment Number of Non Admitted Clock Stops	88000	30997	5680	5366	6944	9106	9178	9730	8935	8583	10237	9803	10149	11045	17990	28014	27755	30997
A09	Referral To Treatment Number of Clock Starts	116667	38404	9347	8902	11150	12913	11900	10997	10312	11047	12990	12311	12419	13674	29399	35810	34349	38404
Diagnostic Waits																			
A05	Diagnostics 6 Week Wait (15 Key Tests)	-	-	67.49%	65.09%	57.78%	59.09%	60.08%	56.28%	53.65%	58.86%	65.15%	62.3%	65.34%	63.93%	-	-	-	-
	Numerator (Number Under 6 Weeks)	*0*	*0*	*8093*	*8285*	*8623*	*8628*	*8761*	*8563*	*7544*	*8388*	*9413*	*8738*	*9301*	*9197*	*0*	*0*	*0*	*0*
	Denominator (Total Waiting)	*0*	*0*	*11991*	*12728*	*14925*	*14602*	*14582*	*15215*	*14062*	*14252*	*14448*	*14025*	*14234*	*14387*	*0*	*0*	*0*	*0*

Appendix – Trust Scorecards

NHS University Hospitals Bristol and Weston NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
RESPONSIVE DOMAIN

NHS University Hospitals Bristol and Weston NHS Foundation Trust

ID	Measure	20/21	21/22 YTD	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1
Cancer 2 Week Wait																			
E01A	Cancer - Urgent Referrals Seen In Under 2 Weeks	81.9%	92.5%	84.2%	72.5%	51.1%	61.8%	90%	90.2%	86.2%	96.2%	95.1%	91.9%	93%	-	68.6%	78.9%	92.8%	92.5%
	Numerator (Number Seen Within 2 Weeks)	*14845*	*3263*	*1306*	*1085*	*873*	*1332*	*1601*	*1379*	*1238*	*1401*	*1820*	*1632*	*1631*	*0*	*3264*	*4312*	*4459*	*3263*
	Denominator (Total Seen))	*18125*	*3529*	*1551*	*1497*	*1709*	*2157*	*1778*	*1528*	*1437*	*1456*	*1913*	*1776*	*1753*	*0*	*4757*	*5463*	*4806*	*3529*
Cancer 31 Day																			
E02A	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	95.1%	93%	96%	98.4%	95.6%	97.8%	97%	95.5%	94%	92.2%	94%	89.9%	96.1%	-	96.7%	96.7%	93.4%	93%
	Numerator (Number Treated Within 31 Days)	*2971*	*532*	*217*	*246*	*262*	*270*	*260*	*298*	*249*	*259*	*328*	*258*	*274*	*0*	*725*	*828*	*836*	*532*
	Denominator (Total Treated)	*3125*	*572*	*226*	*250*	*274*	*276*	*268*	*312*	*265*	*281*	*349*	*287*	*285*	*0*	*750*	*856*	*895*	*572*
E02B	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	99.4%	98.9%	100%	98.8%	98.5%	99.3%	99.2%	99.3%	99.2%	100%	100%	97.4%	100%	-	99%	99.3%	99.8%	98.9%
	Numerator (Number Treated Within 31 Days)	*1516*	*267*	*116*	*166*	*128*	*140*	*129*	*151*	*124*	*137*	*158*	*112*	*155*	*0*	*410*	*420*	*419*	*267*
	Denominator (Total Treated)	*1525*	*270*	*116*	*168*	*130*	*141*	*130*	*152*	*125*	*137*	*158*	*115*	*155*	*0*	*414*	*423*	*420*	*270*
E02C	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	84.1%	86%	89.1%	92.3%	92.9%	91.5%	82.9%	80%	89.2%	64.6%	81.1%	78%	94%	-	91.6%	85%	77.5%	86%
	Numerator (Number Treated Within 31 Days)	*492*	*86*	*41*	*48*	*52*	*43*	*34*	*36*	*33*	*31*	*43*	*39*	*47*	*0*	*141*	*113*	*107*	*86*
	Denominator (Total Treated)	*585*	*100*	*46*	*52*	*56*	*47*	*41*	*45*	*37*	*48*	*53*	*50*	*50*	*0*	*154*	*133*	*138*	*100*
Cancer 62 Day																			
E03A	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	78.7%	80.8%	89.3%	83.2%	78.5%	82.2%	75.8%	78.3%	77.6%	72.6%	75.3%	77.5%	83.8%	-	83.3%	78.7%	75.3%	80.8%
	Numerator (Number Treated Within 62 Days)	*1130.5*	*217*	*92*	*82*	*98.5*	*113*	*106.5*	*122.5*	*93.5*	*78*	*123.5*	*98*	*119*	*0*	*272.5*	*342*	*295*	*217*
	Denominator (Total Treated)	*1436.5*	*268.5*	*103*	*98.5*	*125.5*	*137.5*	*140.5*	*156.5*	*120.5*	*107.5*	*164*	*126.5*	*142*	*0*	*327*	*434.5*	*392*	*268.5*
E03B	Cancer 62 Day Referral To Treatment (Screenings)	57.1%	48.4%	0%	85.7%	100%	100%	100%	27.3%	71.4%	28.6%	77.8%	52.9%	42.9%	-	70%	60%	59%	48.4%
	Numerator (Number Treated Within 62 Days)	*22*	*7.5*	*0*	*3*	*0.5*	*1*	*3.5*	*1.5*	*2.5*	*2*	*7*	*4.5*	*3*	*0*	*3.5*	*6*	*11.5*	*7.5*
	Denominator (Total Treated)	*38.5*	*15.5*	*1*	*3.5*	*0.5*	*1*	*3.5*	*5.5*	*3.5*	*7*	*9*	*8.5*	*7*	*0*	*5*	*10*	*19.5*	*15.5*
E03C	Cancer 62 Day Referral To Treatment (Upgrades)	86.8%	88.3%	89.4%	92.4%	90.4%	94%	88.2%	87.5%	80.7%	84.4%	76.7%	85.7%	91%	-	90.8%	89.9%	80.2%	88.3%
	Numerator (Number Treated Within 62 Days)	*583.5*	*98.5*	*42*	*54.5*	*51.5*	*55*	*41*	*56*	*46*	*62*	*74*	*48*	*50.5*	*0*	*148*	*152*	*182*	*98.5*
	Denominator (Total Treated)	*672.5*	*111.5*	*47*	*59*	*57*	*58.5*	*46.5*	*64*	*57*	*73.5*	*96.5*	*56*	*55.5*	*0*	*163*	*169*	*227*	*111.5*
Last Minute Cancelled Operations																			
F01	Last Minute Cancelled Operations - Percentage of Admissions	1.15%	1.24%	0.7%	2.09%	1.13%	1.21%	1.17%	1.54%	1.13%	1.48%	1.16%	0.72%	1.19%	1.76%	1.28%	1.3%	1.25%	1.24%
	Numerator (Number of LMCs)	*637*	*226*	*32*	*87*	*59*	*72*	*66*	*84*	*53*	*74*	*70*	*42*	*72*	*112*	*178*	*222*	*197*	*226*
	Denominator (Total Elective Admissions)	*55573*	*18213*	*4549*	*4154*	*5220*	*5951*	*5656*	*5463*	*4672*	*5001*	*6039*	*5803*	*6034*	*6376*	*13923*	*17070*	*15712*	*18213*
F02	Cancelled Operations Re-admitted Within 28 Days	83.4%	92.3%	76.5%	96.8%	98.8%	91.1%	93%	88.5%	83.1%	67.3%	81.5%	100%	97.5%	82.6%	95.4%	91%	78.4%	92.3%
	Numerator (Number Readmitted Within 28 Days)	*542*	*156*	*13*	*30*	*82*	*51*	*66*	*54*	*64*	*35*	*53*	*60*	*39*	*57*	*125*	*171*	*152*	*156*
	Denominator (Total LMCs)	*650*	*169*	*17*	*31*	*83*	*56*	*71*	*61*	*77*	*52*	*65*	*60*	*40*	*69*	*131*	*188*	*194*	*169*

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INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
RESPONSIVE DOMAIN

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Delayed Transfers of Care (DToC)																			
Q01A	Acute Delayed Transfers of Care - Patients	60	-	13	10	4	0	-	-	-	-	-	-	-	-	27	0	-	-
Q01B	Acute Delayed Transfers of Care - Beddays	1902	-	350	335	251	54	-	-	-	-	-	-	-	-	936	54	-	-
Q02A	Non-Acute Delayed Transfers of Care - Patients	18	-	0	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-
Q02B	Non-Acute Delayed Transfers of Care - Beddays	521	-	32	40	10	-	-	-	-	-	-	-	-	-	82	-	-	-
Green To Go/Fit For Discharge (BRISTOL Only)																			
AQ06A	Green To Go List - Number of Patients (Acute)	-	-	86	99	96	97	97	125	107	103	168	172	142	166	-	-	-	-
AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	8	22	19	26	18	11	12	11	10	0	0	0	-	-	-	-
AQ07A	Green To Go List - Beddays (Acute)	-	-	2582	2704	2973	3013	2745	3356	3572	3218	4540	5038	4384	4398	-	-	-	-
AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	588	464	528	698	564	458	340	445	398	0	0	0	-	-	-	-
Outpatient Measures																			
R03	Outpatient Hospital Cancellation Rate	12.2%	10.1%	11.5%	11.5%	9.9%	10.3%	10.3%	11%	11.3%	10.6%	10%	10.1%	9.7%	10.6%	10.9%	10.5%	10.6%	10.1%
	Numerator (Number of Hospital Cancellations)	*121436*	*27607*	*8785*	*8421*	*8785*	*9443*	*9607*	*9512*	*9866*	*9026*	*10100*	*9153*	*8877*	*9577*	*25991*	*28562*	*28992*	*27607*
	Denominator (Total Appointments)	*991907*	*272168*	*76680*	*73097*	*88393*	*91339*	*93649*	*86470*	*87155*	*85492*	*100767*	*90420*	*91369*	*90379*	*238170*	*271458*	*273414*	*272168*
R05	Outpatient DNA Rate	6.9%	6.7%	6.2%	7%	7.7%	7.7%	8.1%	7.8%	8.5%	6.7%	6.3%	6.4%	6.6%	7%	6.9%	7.9%	7.1%	6.7%
	Numerator (Number of DNAs)	*49604*	*14493*	*3625*	*3831*	*4848*	*5292*	*5610*	*5029*	*5383*	*4295*	*4807*	*4441*	*4623*	*5429*	*12304*	*15931*	*14485*	*14493*
	Denominator (Total Attendances+DNAs)	*717015*	*217636*	*58844*	*55092*	*63156*	*68473*	*69071*	*64312*	*63319*	*64094*	*75903*	*69929*	*70359*	*77348*	*177092*	*201856*	*203316*	*217636*
Overdue Partial Booking (Bristol)																			
R22N	Overdue Partial Booking Referrals	33.5%	34%	34.6%	35.2%	35.2%	34.7%	34.2%	35%	35.2%	34%	34.5%	34.2%	33.8%	33.9%	35%	34.6%	34.6%	34%
	Numerator (Number Overdue)	*569656*	*148227*	*49150*	*49821*	*49068*	*48149*	*48773*	*49352*	*49499*	*47199*	*49054*	*49008*	*49340*	*49879*	*148039*	*146274*	*145752*	*148227*
	Denominator (Total Partial Booking)	*1698619*	*436200*	*142016*	*141426*	*139371*	*138847*	*142817*	*141025*	*140442*	*138821*	*142381*	*143376*	*145793*	*147031*	*422813*	*422689*	*421644*	*436200*
R22R	Overdue Partial Bookings (9+ Months)	3.3%	7.7%	1.7%	1.9%	2.4%	3.1%	3.7%	4.6%	5.2%	5.8%	6.9%	7.3%	7.7%	8.2%	2%	3.8%	6%	7.7%
	Numerator (Number Overdue 9+ Months)	*55930*	*33707*	*2357*	*2753*	*3318*	*4252*	*5274*	*6422*	*7365*	*8102*	*9799*	*10475*	*11206*	*12026*	*8428*	*15948*	*25266*	*33707*
	Denominator (Total Partial Booking)	*1698619*	*436200*	*142016*	*141426*	*139371*	*138847*	*142817*	*141025*	*140442*	*138821*	*142381*	*143376*	*145793*	*147031*	*422813*	*422689*	*421644*	*436200*
R22H	Overdue Partial Bookings (12+ Months)	1.5%	4.3%	1%	1.1%	1.2%	1.3%	1.5%	1.8%	2.2%	2.6%	3.2%	3.6%	4.2%	4.9%	1.1%	1.5%	2.7%	4.3%
	Numerator (Number Overdue 12+ Months)	*26161*	*18643*	*1419*	*1569*	*1710*	*1808*	*2086*	*2557*	*3154*	*3627*	*4532*	*5220*	*6170*	*7253*	*4698*	*6451*	*11313*	*18643*
	Denominator (Total Partial Booking)	*1698619*	*436200*	*142016*	*141426*	*139371*	*138847*	*142817*	*141025*	*140442*	*138821*	*142381*	*143376*	*145793*	*147031*	*422813*	*422689*	*421644*	*436200*

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Mortality																			
X04	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	94.3	-	95.5	93.9	94.4	89.8	92.5	93.5	93.6	94.1	-	-	-	-	94.6	91.9	93.9	-
	Numerator (Observed Deaths)	*24875*	*0*	*2350*	*2300*	*2285*	*2190*	*2210*	*2150*	*2060*	*1990*	*0*	*0*	*0*	*0*	*6935*	*6550*	*4050*	*0*
	Denominator ("Expected" Deaths)	*26370*	*0*	*2460*	*2450*	*2420*	*2440*	*2390*	*2300*	*2200*	*2115*	*0*	*0*	*0*	*0*	*7330*	*7130*	*4315*	*0*
X02	Hospital Standardised Mortality Ratio (HSMR)	93.2	85.5	76.8	61.6	87.6	75.7	91.5	93.5	103.9	119.4	94.6	82.3	89	-	75.7	86.5	104.7	85.5
	Numerator (Observed Deaths)	*1272*	*204*	*98*	*71*	*109*	*102*	*112*	*113*	*112*	*115*	*124*	*104*	*100*	*0*	*278*	*327*	*351*	*204*
	Denominator ("Expected" Deaths)	*1365.5*	*238.7*	*127.6*	*115.3*	*124.4*	*134.7*	*122.4*	*120.9*	*107.8*	*96.3*	*131.1*	*126.4*	*112.3*	*0*	*367.3*	*378*	*335.2*	*238.7*
Fracture Neck of Femur (NOF)																			
U02	Fracture Neck of Femur Patients Treated Within 36 Hours	66.1%	67.6%	73.6%	63.4%	60.9%	64.6%	70.8%	65.1%	61.3%	63%	78%	64%	68.9%	70.5%	66.4%	66.9%	69.1%	67.6%
	Numerator (Treated Within 36 Hrs)	*358*	*94*	*39*	*26*	*28*	*31*	*34*	*28*	*19*	*29*	*46*	*32*	*31*	*31*	*93*	*93*	*94*	*94*
	Denominator (Total Patients)	*542*	*139*	*53*	*41*	*46*	*48*	*48*	*43*	*31*	*46*	*59*	*50*	*45*	*44*	*140*	*139*	*136*	*139*
U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Ho	92.1%	94.2%	96.2%	95.1%	97.8%	97.9%	97.9%	100%	93.5%	89.1%	94.9%	94%	93.3%	95.5%	96.4%	98.6%	92.6%	94.2%
	Numerator (Seen Within 72 Hrs)	*499*	*131*	*51*	*39*	*45*	*47*	*47*	*43*	*29*	*41*	*56*	*47*	*42*	*42*	*135*	*137*	*126*	*131*
	Denominator (Total Patients)	*542*	*139*	*53*	*41*	*46*	*48*	*48*	*43*	*31*	*46*	*59*	*50*	*45*	*44*	*140*	*139*	*136*	*139*
U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	59%	61.9%	69.8%	61%	52.2%	60.4%	64.6%	58.1%	61.3%	58.7%	69.5%	56%	66.7%	63.6%	61.4%	61.2%	64%	61.9%
	Numerator (Number achieved BPT)	*320*	*86*	*37*	*25*	*24*	*29*	*31*	*25*	*19*	*27*	*41*	*28*	*30*	*28*	*86*	*85*	*87*	*86*
	Denominator (Total Patients)	*542*	*139*	*53*	*41*	*46*	*48*	*48*	*43*	*31*	*46*	*59*	*50*	*45*	*44*	*140*	*139*	*136*	*139*
Emergency Readmissions																			
C01	Emergency Readmissions Percentage	4.41%	3.91%	4.62%	4.64%	5.39%	4.82%	4.25%	3.87%	3.91%	4.11%	4.12%	3.98%	3.71%	4.78%	4.9%	4.33%	4.05%	3.91%
	Numerator (Re-admitted in 30 Days)	*6036*	*1131*	*547*	*524*	*688*	*658*	*545*	*477*	*427*	*471*	*565*	*523*	*507*	*101*	*1759*	*1680*	*1463*	*1131*
	Denominator (Total Discharges)	*136884*	*28922*	*11831*	*11304*	*12766*	*13651*	*12830*	*12328*	*10912*	*11457*	*13729*	*13138*	*13669*	*2115*	*35901*	*38809*	*36098*	*28922*
Stroke Care																			
O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	61%	53.1%	51.4%	46.2%	48.6%	67.7%	71.7%	74.2%	66.7%	56.5%	58.5%	56.1%	48.7%	-	49%	71.3%	60.6%	53.1%
	Numerator (Achieved Target)	*250*	*51*	*18*	*12*	*18*	*21*	*33*	*23*	*20*	*13*	*24*	*32*	*19*	*0*	*48*	*77*	*57*	*51*
	Denominator (Total Patients)	*410*	*96*	*35*	*26*	*37*	*31*	*46*	*31*	*30*	*23*	*41*	*57*	*39*	*0*	*98*	*108*	*94*	*96*
O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	72.6%	58.7%	82.6%	91.4%	69.8%	75.6%	68.3%	64.6%	66.7%	54.5%	52.7%	58.9%	64%	45%	79.9%	69.3%	56.8%	58.7%
	Numerator (Achieved Target)	*393*	*84*	*38*	*32*	*37*	*34*	*41*	*31*	*20*	*18*	*29*	*43*	*32*	*9*	*107*	*106*	*67*	*84*
	Denominator (Total Patients)	*541*	*143*	*46*	*35*	*53*	*45*	*60*	*48*	*30*	*33*	*55*	*73*	*50*	*20*	*134*	*153*	*118*	*143*

Appendix – Trust Scorecards

University Hospitals Bristol and Weston NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
WELL-LED DOMAIN

ID	Measure	20/21	21/22 YTD	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1
Bank and Agency Usage																			
AF11A	Percentage Bank Usage	-	-	5.29%	5.12%	5.35%	5.37%	6.05%	5.35%	6.07%	5.93%	6.55%	4.99%	4.95%	5.15%	-	-	-	-
	Numerator (Bank wte)	*0*	*0*	*651.44*	*631.74*	*657.77*	*595.03*	*675.77*	*595.4*	*683.53*	*671.71*	*758.25*	*560*	*552.21*	*574.41*	*0*	*0*	*0*	*0*
	Denominator (Total wte)	*0*	*0*	*12327.3*	*12331.8*	*12298.9*	*11076.1*	*11165.2*	*11126.2*	*11253.9*	*11335.3*	*11582.2*	*11232*	*11160.6*	*11163.1*	*0*	*0*	*0*	*0*
AF11B	Percentage Agency Usage	-	-	1.21%	1.38%	1.75%	1.77%	1.95%	1.86%	1.97%	2.49%	2.66%	2.18%	2.63%	2.48%	-	-	-	-
	Numerator (Agency wte)	*0*	*0*	*149.62*	*170.64*	*215.35*	*195.62*	*218.18*	*207.2*	*221.92*	*282.54*	*307.47*	*245.28*	*293.62*	*276.8*	*0*	*0*	*0*	*0*
	Denominator (Total wte)	*0*	*0*	*12327.3*	*12331.8*	*12298.9*	*11076.1*	*11165.2*	*11126.2*	*11253.9*	*11335.3*	*11582.2*	*11232*	*11160.6*	*11163.1*	*0*	*0*	*0*	*0*
Turnover																			
AF10	Workforce Turnover Rate	-	-	12.7%	12.4%	12.3%	12.3%	12.1%	12%	12.2%	12.2%	12%	12.3%	12.7%	13.2%	-	-	-	-
	Numerator (Leavers in last 12 months)	*0*	*0*	*1080.09*	*1054.77*	*1052.86*	*1060.04*	*1050.79*	*1043.85*	*1061.5*	*1061.77*	*1049.15*	*1071.79*	*1099.6*	*1142.01*	*0*	*0*	*0*	*0*
	Denominator (Average Staff in Post)	*0*	*0*	*8525.3*	*8536.69*	*8591.86*	*8634.62*	*8671.86*	*8670.64*	*8693.68*	*8731.51*	*8714.32*	*8692.17*	*8689.73*	*8678.54*	*0*	*0*	*0*	*0*
Vacancy																			
AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	-	-	2.3%	2.7%	3.6%	3.4%	4.1%	4.2%	4.1%	4.3%	3.5%	3.7%	4.9%	7.4%	-	-	-	-
	Numerator (Vacancy wte, Funded minus actual)	*0*	*0*	*239.45*	*281.27*	*379.66*	*363.63*	*438.49*	*455.28*	*437.35*	*468.72*	*378.03*	*401.23*	*534.8*	*821.88*	*0*	*0*	*0*	*0*
	Denominator (Actual WTE)	*0*	*0*	*10557.9*	*10579.2*	*10616.2*	*10649.1*	*10709.8*	*10778.9*	*10785.8*	*10849.8*	*10894.5*	*10828*	*10849.6*	*11133.8*	*0*	*0*	*0*	*0*
Staff Sickness																			
AF02	Sickness Rate	3.6%	3.6%	3.5%	3.6%	3.7%	3.7%	3.7%	4%	4%	3.4%	3.2%	3.5%	3.6%	3.8%	3.6%	3.8%	3.6%	3.6%
	Numerator (Total WTE Days Lost)	*135412*	*33985.4*	*11025*	*11391.6*	*11363*	*11849.1*	*11466.5*	*12633.9*	*12941.5*	*10047.9*	*10396.8*	*10750.9*	*11403*	*11831.5*	*33779.7*	*35949.4*	*33386.2*	*33985.4*
	Denominator (Total WTE Days)	*3740392*	*939556*	*318330*	*315893*	*305946*	*317549*	*307597*	*318980*	*319702*	*291312*	*324625*	*311261*	*319464*	*308831*	*940169*	*944125*	*935639*	*939556*
Staff Appraisal																			
AF03	Workforce Appraisal Compliance (Non-Consultant)	-	-	64.1%	64.3%	65.5%	66.4%	67.2%	68.2%	66.4%	64.2%	64.9%	66.4%	69.1%	69.9%	-	-	-	-
	Numerator (In-Date Appraisals)	*0*	*0*	*6482*	*6484*	*6637*	*6747*	*6891*	*7005*	*6859*	*6728*	*6823*	*6905*	*7106*	*7159*	*0*	*0*	*0*	*0*
	Denominator (Total Staff)	*0*	*0*	*10116*	*10090*	*10128*	*10167*	*10247*	*10277*	*10337*	*10477*	*10510*	*10392*	*10286*	*10248*	*0*	*0*	*0*	*0*

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL
USE OF RESOURCES DOMAIN

ID	Measure	20/21	21/22 YTD	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1
Average Length of Stay																			
J03	Average Length of Stay (Spell)	4.03	4.23	3.48	3.51	3.69	4.29	4.35	4.35	4.72	4.36	3.93	4.46	4.09	4.16	3.56	4.33	4.31	4.23
	Numerator (Total Beddays)	*317717*	*90853*	*26599*	*26326*	*26723*	*31180*	*29087*	*28343*	*27360*	*26016*	*28069*	*31095*	*29921*	*29837*	*79648*	*88610*	*81445*	*90853*
	Denominator (Total Discharges)	*78741*	*21466*	*7639*	*7507*	*7234*	*7262*	*6690*	*6512*	*5793*	*5969*	*7134*	*6969*	*7324*	*7173*	*22380*	*20464*	*18896*	*21466*

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**CQC core services and well-led inspection June 2021**
Report Author	**Chris Swonnell, Head of Quality and Patient Experience**
Executive Lead	**Deirdre Fowler, Chief Nurse**

1. Report Summary

The Trust received a core services and well-led inspection from the CQC in June 2021. This cover sheet provides a brief summary of the CQC's initial findings and action being taken by the Trust in response.

2. Key points to note

(Including decisions taken)

On 24 May, the CQC notified the Trust of their intention to carry out the following inspections in June:

- A 'well-led' inspection from 22-24 June
- An unannounced core services inspection in Bristol and Weston prior to this

The Well-led inspection took place as planned and involved a series of staff interviews and focus groups. The core services inspection took place on 8th-9th June and focussed on the following:

- Medical care in Bristol and Weston
- Outpatients in Weston

The Trust received initial verbal feedback from the CQC at a meeting convened on 10th June, which was followed by the attached summary letter.

The CQC highlighted examples of a positive safety culture, including debriefs, ward rounds and use of early warning scores in the areas they inspected in the BRI. In Weston Outpatient services they found appropriate processes and training in place and found our staff to be passionate and enthusiastic.

They also commented on positive feedback from staff about direct ward and nursing leadership across both the BRI and Weston medical care wards and departments they visited, and they saw many examples of caring treatment and interactions with our patients during their inspection.

However, the CQC also requested urgent regulatory assurance in relation to the Weston site regarding staffing, patient risk assessment and use of escalation areas. The Trust took immediate action and provided the CQC with requested assurances on 11 June. In particular, immediate action was taken to decompress the Weston site and enable patients to be moved out of escalation areas.

The Trust has been providing CQC with weekly assurance reports – a pattern which will continue for the foreseeable future (potentially until such time as a re-inspection takes place – that inspection would be triggered by the Trust once we are sufficiently confident that the CQC's concerns have been addressed). Regular Weston-focussed engagement meetings are also taking place between the Trust and CQC, the latest of which took place on 21 July.

An action plan has been produced by the Division of Weston in response to the issues raised in the CQC's feedback letter; this will be formally reviewed by the Trust's Clinical Quality Group on 5 August. In the meantime, the CQC have advised that they will be issuing their draft inspection report in late July / early August (so this may have been received by the time the Board meets), at which point we will develop a broader action plan, incorporating any actions relating to the other elements of the inspection (and indeed, if there are further recommendation relating to medical care at Weston in the report).

Our understanding is that the report is likely to include an updated set of ratings for UHBW, which will be the first new ratings issued by the CQC since our organisational merger in April 2020.

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

3763 – Risk that the Trust may not meet standards to ensure compliance with CQC Regulations

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

- This report is for **INFORMATION and ASSURANCE**

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

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Sent – via email

Our reference: RA7

Chief Executive: Robert Woolley
University Hospitals Bristol and Weston NHS Foundation Trust.
Marlborough Street,
Bristol,
BS1 3NU

Date: 25 June 2021

CQC (Care Quality Commission) Reference Number: RA7

Dear Robert Woolley

Re: CQC inspection of University Hospitals Bristol and Weston NHS Foundation Trust.

Following the feedback meeting yesterday with myself, Garry Marsh, Odette Coveney, Nicola Evans and Hannah Watson I thought it would be helpful to give you written feedback, as highlighted, at this stage of the inspection. As you will appreciate, we have not concluded the inspection as we still have key members of the senior leadership team we are meeting with next week.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 24th June 2021 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

We wanted to thank you and the staff for their engagement with us during this part of the inspection process. Stuart Metcalf has been extremely helpful in working with us to ensure the logistics of both the onsite and virtual activities were effective.

Garry Marsh, an executive reviewer working with us, shared the diligent work undertaken by the IPC teams, not just in prioritising the risks associated with the pandemic but also in ensuring that business as usual areas were not impacted, the commitment from this team and their in reach in supporting others was noted.

Garry also spoke of the huge amount of energy within the patient experience team where it was clear the focus was not on meeting complaints recovery KPIs, rather to ensure these were of a high quality.

At the time of the feedback meeting we also raised three issues, firstly in respect of the integration of Weston General Hospital to the trust, we understand that this has been challenging, for a number of reasons, including the pandemic and acknowledge that the trust itself is not in the position it would have wanted to be in, in relation to the merger at this point in time.

Secondly, we were concerned to hear from staff that they have been told, by line managers to adopt a ‘Western work name’ as the pronouncing of their name was too difficult, this is not acceptable, individuals can only truly thrive in a work environment where they feel safe as themselves and belong rather than having to ‘fit in.’"

Thirdly, staff have raised concerns with us about the safety of some of the estate and have sent us photographs of buckets and towels gathering water in a corridor at St Michael's hospital and water coming in through the roof in main theatures of the Bristol Royal Infirmary. We were further told that St Michael’s also has leaking roofs in Gynaecological and office areas.

We note, from an email received yesterday that Dr Mark Smith felt he would like further opportunity to speak with us, to discuss the work that he, his team, and the Trust have done during the pandemic, he would also like to share with us work that has been done to support Divisional Management teams, we have asked if Dr Smith would be available to meet with us next week.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Ben Roe at NHS Improvement

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

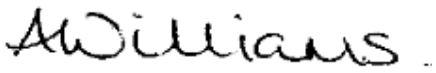
Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne

NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Amanda Williams

Head of Hospitals Inspection

c.c.

Jayne Mee - Chair of Trust

Ben Roe - NHS Improvement

John Scott - CQC regional communications manager

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29th July 2021

Report Title	**Learning from Deaths/ Medical Examiners Annual Report**
Report Author	**Mark Callaway, Deputy Medical Director**
Executive Lead	**William Oldfield, Medical Director**

1. Report Summary

These are the Annual Reports from the learning from Deaths process and the Medical Examiner for 2020/21. These reports look at the impact of the Covid -19 pandemic, integrate Weston into the system of reporting and learning and discuss the establishment of the medical examiner system.

2. Key points to note
(Including decisions taken)

The reports demonstrate a huge amount of effort on behalf of a large number of staff to provide a safe environment whilst adapting and learning from unprecedented pandemic.

It reports our overall mortality from Covid-19 as 26% on our general intensive care compared to a national average of 38%.

The medical examiner's report covers the introduction of this service into the acute sector.

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 risk identified

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.

N/A	

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

University Hospitals Bristol and Weston NHS Foundation Trust

Learning from Deaths

Annual Report

2020/2021

E Redfern

MP Callaway

W Oldfield

19th July 2021

Introduction

This report covers the learning from deaths for the year to date 2020/21. This has been an exceptional year with the impact of the Covid-19 pandemic on the delivery of healthcare. There have also been some major transitions in the method of certifying and reviewing death which have also been introduced during this period, with the introduction of the Medical Examiner system.

This year also represents the merger of UHBristol and Weston, whilst this report features primarily learning from death from UHBristol the integration of the Weston data has commenced and this will be fully integrated at the time of the Annual report.

Divisional Leads for Mortality UH Bristol

Medicine	Dr A Beale and Dr R Maxwell, now Dr Smithson
Surgery	Mr P Wilkerson
Spec Services	Dr Y Ismail

Divisional Leads for Mortality Weston

Weston	Dr A Edwards

General Intensive care Leads for Mortality

Dr K Oglesby and Dr S Gurney

Clinical Fellow

Dr A Dietrich

Medical Examiner

Dr D Crossley

Leads for Learning from Deaths

Dr E Redfern and Dr M Callaway

Business Manager

Ms A Hillyard

Report

This is a different Annual Report as it represents not only an integration of the new system to assess and certify deaths, the Medical Examiner, but the merger with Weston and the impact of the Covid -19 pandemic on the organisation. The figures of reported adult's deaths are broadly similar to the number of reported deaths in the previous years, but we have seen a reduction in the number of patients referred for Structured Case Note Review (SCNR). This was most noticeable in quarter 2, but this reduction represents the impact of two factors. Firstly this was at the beginning of the introduction and transition into the medical examiner system, and new system for the supervision and assessment of all adult deaths and secondly the impact of the Covid -19 pandemic and the impact on the delivery of health care. An example of this is represented by the marked reduction in the deaths from out of hospital cardiac arrests at UHBW, during this period. This represented the actions taken as part of the pandemic by the Ambulance Trust to take these patients to their local trust, rather than transferring these patients here, hence leading to an associated reduction in the admissions of this type of patient. The first, second and fourth quarters also so the maximum numbers of admissions of patients with Covid-19 in the first and second waves of the pandemic, and the deaths in these patients was reviewed, both on the critical care unit and in patients who died on the wards. This was not because these patients triggered the definitions that would have normally triggered a review, but because we were interested as an organisation to establish if appropriate support and escalation was being undertaken in these patients whom were approaching the end of their life and dying , as a result of this new disease. I am pleased to report, as documented in this report, that the majority of aspects of these patients care were excellent and appropriate intervention was present. This is really encouraging and is testament to the adaptability, professionalism and great care delivered by the staff of this organisation.

This report also documents areas of learning and improvement that have been identified as a result of these reviews.

All patients who were identified as dying of Hospital Acquired Covid-19 have been subject to a harm panel review to establish if the patient died of or with Covid-19, if the patient died of Covid-19 then this was recorded as a Serious Incident and the case subject to an RCA

	Quarter 1 (Apr – Jun 20)	Quarter 2 (July – Sept 20)	Quarter 3 (Oct – Dec 20)	Quarter 4 (Jan – Mar 20)	Totals
Total deaths (in Patients)	305	234	352	395	**1286**
OOHCA	10	6	11	0	**27**
Total excluding OOHCA	295	228	341	0	**1313**
Total SCNR identified	70 (23%)	2(1%)	22(6%)	34(8.6%)	**128(9.9%)**
Medicine	58	2	19	6	**85**
complete	43	0	1	0	**44**
pending	15	2	18	0	**35**
Surgery	4	0	0	6	**10**
complete	3	0	0	0	**3**
pending	1	0	0	0	**1**
Specialised Services	6	0	3	1	**10**
complete	6	0	0	0	**6**
pending	O	0	3	0	**3**
Weston	0	0	0	21	**21**
complete					
pending					
Number triggering MDO Review	0	0	0	0	**0**
Number of SI reports in the last episode of care related to patient death (Not Including the harm panel work)	0	6	0	0	**0**
Number of avoidable deaths	0	0	0	0	**0**

Number of Deaths in patients with Learning Difficulties	3	2	2	2	**6**

1. Medical Examiners

A new system overseeing the method of certification of death is being rolled out in England with a requirement to be assessing 100% of Adult deaths by April 2021. It was to be a statutory requirement but this time line has been put back. This system is dependent on the appointment of Medical Examiners (ME) who will review all adult deaths within acute providers and discuss each case with both the clinical team and next of kin prior to the issuing of a death certificate.

Since the beginning of the year 2020/21 the Medical Examiner system has been introduced, under the supervision of a project team commissioned by the Medical Directors of NBT and UHBW and lead by Dr James Calvert , Dr Emma Redfern and Dr M Callaway, supported by Charlotte Devereux as project manager. This was a unique project in the UK, as the aim was to introduce a single service covering all of the three acute providers, and appointing a lead Medical examiner and a lead medical examiners officer to co-ordinate the recruitment and co-ordinate of a team of Medical examiners across the three sites.

Dr David Crossley and Ms Charlotte Clews were appointed to these lead roles and have subsequently, recruited 11 medical examiners who have been trained and have started to review all adult in patient deaths with a view to achieving 100% coverage by the end of March. Currently the team are maintaining a trajectory to achieve this aim.

The Medical Examiner report for the year 2020-2021 is attached and confirms by March 2021 87% of applicable deaths were scrutinised by the Medical examiner team

This cross trust approach has been developed with full involvement and support of the local HM Coroner and her team

The medical examiner system is funded by NHSI and currently this project is on budget

The Medical examiner and the Medical examiners officer are now core members of the Mortality surveillance group at UHBW.

The feedback from the Medical Team into the learning from Deaths process is vital and allows co-ordination of the many interested agencies

ME referrals to the MD Office for Potential SCNR

Sixty Nine referrals from the ME office of deaths from 30/01/21 – 26/05/21

The ME office believed that 40 of these met the criteria for SJRs, however 5 have these have been only related to possible hospital acquired COVID. Therefore only 35 will be passed to the mortality leads.

These break down into:

- 21 for Western
- 6 for Medicine
- 6 for Surgery
- 1 for W&C
- 1 Specialised Services

Of the 35 SJRs:

- 3 relate to death during an elective procedure
- 2 relate to LD/MH
- 1 relates to maternal/neonatal death (This death being reviewed under HSIB process)
- 12 relate to concerns raised by clinical team of family (of these 4 either do not relate to the last hospital admission or the ME believes did not affect outcome)
- 17 relate to concerns raised by the ME or MEO (of these 1 relates to prehospital care)

Of those 19 who did not trigger a SCNR, 11 were referred for having possible hospital acquired COVID-19. The other 8 were outside the definition for a review and included : pressure sores on admission, review at stroke M&M, Hepatitis B notifiable to PHE, query on transfer, accommodation concern in the community, and possible CJD

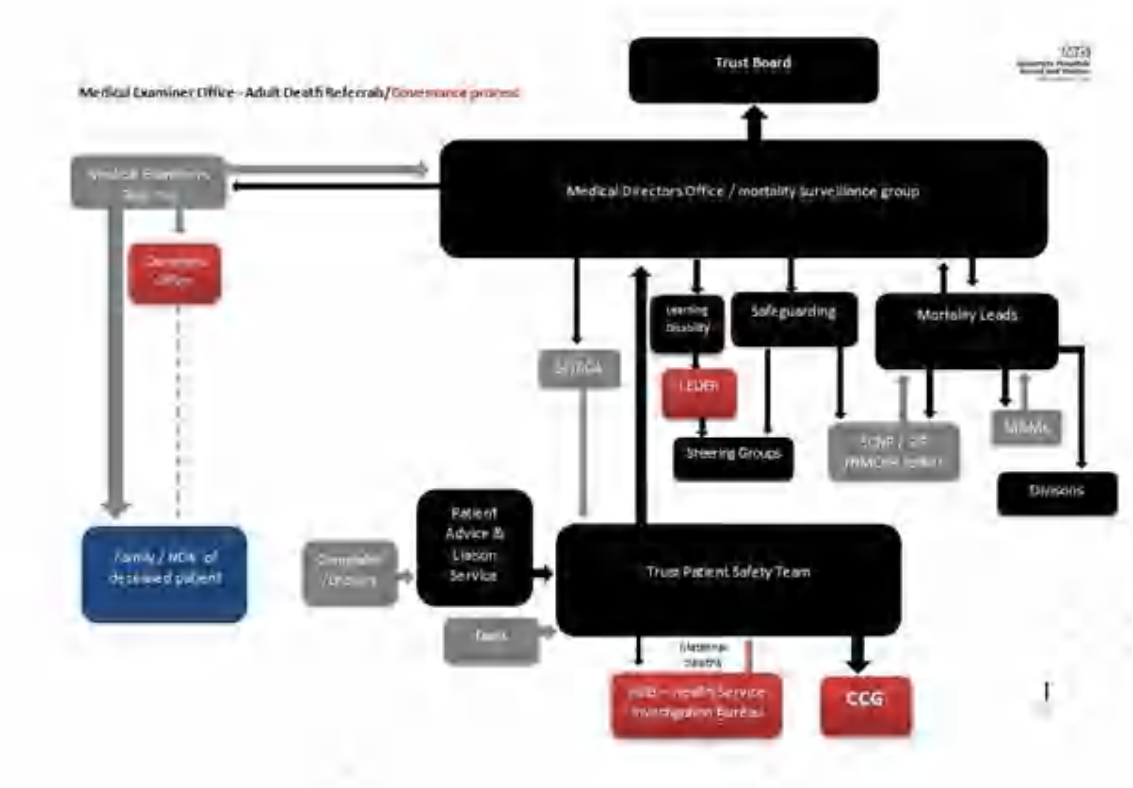


Figure 2. Flow Chart Illustrating the Governance of deaths identified by the medical examiner team in UHBW

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 and refers as follows:

1. **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

2. **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

The SCNRs are tracked on the Medway Report, Datix incidents by Patient Safety

The Safeguarding and Patient Safety follow up any valid concerns with community/system organisations and CCG.

2. Covid-19

This section represents all the work undertaken in patients who were admitted and subsequently dies of Covid-19

1. **Intensive Care Mortality First Wave (Dr Oglesby and Gurney)**

A piece of work was undertaken to review all the patients who died on the intensive care unit during the first wave of the pandemic from Covid-19, this work was undertaken by Dr Shorko, a post CCT Fellow and Dr S Gurney and Dr K Oglesby Consultants in ITU.

This comprehensive piece of work assessed all patients that died on the unit during the first wave of the pandemic and the final report was presented to the Mortality Surveillance group in December. The Standard mortality rate was 0.87 for the unit which represents a very impressive outcome for the management of this condition on our unit and represents a huge amount of hard work by the entire team; this is also supported by the mean value from SJNR, which was 4.3/5 which represents an excellent level of care. A Standard Mortality ratio of 0.87 means 5 people lived by being treated at out ITU when compared to a benchmarked ITU

Overall ICU COVID Admissions	39
Regional ICU Transfers In	4
Standardised Mortality Rate (number, UK rank)	0.87 (ICNARC data)

Figure 1. ICU Covid-19 admission in the first wave

Deaths	13
PCR positive (%, number)	77% (10)
Hospital Length of Stay (mean, range)	15.3 days (4-34)

ICU Length of Stay (mean, range)	13.4 days (1-34)
Prone Ventilated Days (mean, range)	7.1 days (2 – 15)
Renal Replacement Therapy (%, number)	69% (9)
Identified Coagulopathy (%, number)	46% (6)
Research Trial Enrolment (%, number)	46% (6)
Overall SJR Care Score (mean)	4.3

Figure 2. ICU Deaths during the first wave

Issue/Incident	**Type**	**Harm**
Endobronchial tube migration in prone position	3	Yes
Variable detail in consultant evening ward round notes	8	No
Incomplete clinical notes from transferring hospital	8	No
No available Nitric Oxide rig as all PICU/CICU systems in use	2	No
Recurrent clotting of RRT sets	3	No

Figure 3. Learning from deaths incident identified from the case review and feedback to all ITU staff via the Mortality and Morbidity meeting

2. **Second Wave BRI GICU COVID-19 Learning from Death Summary Report**

Background (Dr Oglesby and Gurney)

This report has been complied by Dr Kieron Oglesby and Dr Stefan Gurney, the mortality leads on the GICU and represents the data collected on the unit throughout the second wave, this piece of work represents a huge amount of effort on behalf of all the staff involved in caring for patients on this unit. It is really important to note that although our length of stay was a little longer than the national average the unit's mortality was much lower than the national average 23.6% compared to 38.1%.
I have included the learning points included in Dr Ogersby and Gurney report as it demonstrates the feedback and learning from death process in this unit

Period: 1st September 2020 – 31st March 2021 ("Second Wave")

Patient Cohort: All diagnoses of COVID-19 Pneumonitis ("Pandemic Influenza" as per ICNARC)

Locations: C604 (CICU) and A600 (GICU)

Resources: ICNARC reports on COVID-19 in critical care – CICU (21/5/21), GICU (19/5/21) and South West Critical Care Network (8/6/21)
South West Critical Care Network summary data (11/6/21)
GICU M&M – case reviews, monthly learning from death summaries and rolling action log

Quantitative Information

Admissions: 180 patients
Age (mean): 59.4 years-old (vs 59.3 years-old national)
Gender: 34% female (vs 34% national)
ADL Dependency: 80% independent pre-ICU (vs 88% national)
Severe Co-morbidity: 6.7% (vs 9.7% national)
APACHE II (mean): 14.2 (vs 14.5 national) [higher APACHE II score represents higher predicted mortality risk]
ICU Mortality Rate: 23.6% (vs 38.1% national)
ICU Duration (mean): 11.2 days (vs 8.9 days national)
Ventilated (or ECMO): 70% (vs 55% national)

Qualitive Interpretation

1 Caution is advised regarding strict and specific comparisons with other ICUs as to "performance" via ICNARC and similar datastreams

2 This is particularly relevant with regard to "COVID-19 performance" due to the significant variability in models of care, surge status and data reporting mechanisms

3 However, the outcome data (including mortality) should provide significant reassurance to all stakeholders that the "performance" of BRI ICU is *highly likely* to be well above average, both regionally and nationally

COVID-19 2nd Wave Mortality Processes

1 A rolling programme of COVID-19 learning has continued throughout the pandemic

2 This has been underpinned by the monthly M&M process of identifying learning themes – grouped into Systems, Communication, Guidelines and Education

3 Learning has been treated in 2 ways – 1) disseminated to the entire MDT through Learning From Death reports and 2) allocated to an Action Log with mitigating actions and assigned individuals

4 SJRs, via a specific M&M template, have been completed for all COVID-19 deaths in ICU, with independent case analysis from 2 ICU consultants, plus input from parent teams where relevant

COVID-19 2nd Wave Mortality Learning and Associated Action

1 Challenges in identifying availability of ICU beds for both elective and emergency work across critical care **->** new 0745 bed MDT meeting with decision-making tool

2 Communications and logistics for triage of incoming COVID patients from ED, wards and other centres **->** Admission SOP ratified with Careflow RAG-Tag triage, re-audit ongoing

3.Need for a "place of safety" to resuscitate and commence therapies prior to ICU bed availability **->** informal arrangements made for pandemic, formal SOP being drafted

4.Value of close joint working between Respiratory, Palliative Care and ICU **->** joint weekly Radiology meetings and rapid increase in SPCT input on ICU

5. Ventilation strategies for CT transfers, including breath holds **->** SOP pending, new ventilators purchased with rolling teaching session

6.Requirement for post-ICU follow-up, e.g. rehabilitation, psychological impact and physical consequences of critical illness **->** weekly ICU follow-up outpatient clinic now funded

7. Variability of prophylactic, enhanced and treatment anticoagulation, with particular reference to low-molecular weight Heparin dosing and titration of unfractionated Heparin infusions **->** rationalisation of guidelines, new protocol with use of Anti-Xa assays and 'Hot Topic' MDT teaching

8.Uptitration and subsequent weaning of therapeutic steroids for pneumonitis **->** new steroid guideline developed

9. Inconsistency in decision-making for admission to ICU, particularly for COVID patients on CPAP on A800 **->** agreed Resp-ICU policy regarding adverse features during trials off CPAP, consensus statement from ICU consultants

10. Delays in post-death verification and administrative processes **->** collaborative working with Medical Examiners' office to revise CIS forms and new agreed pathway

11. Need for revision of NG tube protocols, with assessment needed for lower threshold for bridling **->** guidelines updated and now in use in-situ

12. Potential for pressure area injury in prolonged episodes of prone ventilation **->** adaption of pre-existing guidelines to minimise risk, proning training embedded for both specialist and non-specialist staff

13. Awareness of risk of decompensation during transfers within critical care areas **->** new risk assessment tool

3. **Review of patients with Covid-19 as part of the National RCP learning from Deaths audit (Dr A Dietrich)**

This was a piece of work undertaken by Dr Alina Dietrich, a Clinical Education Fellow working with the MD team and Supporting Mortality. Dr Dietrich reviewed 57 cases of patients admitted Covid-19 during the first wave of the pandemic using the Structured Judgement Case Note Review (SCNR). Twenty eight patients who died and 29 patients who survived were reviewed, and these groups were recruited from patients who were escalated to critical acre and both died and survived and those patients who were not escalated to critical care and died and survived. The mean age of the patients reviewed was 68, with a range of 45-99. The study has been attached as an appendix but a summary of positive finding and the ongoing the learning points are listed below.

Positive findings

1. Prompt senior reviews and escalation decisions made in ED.
2. Most Respect forms completed within 24 hours.
3. Excellent family communication, senior led updates, especially during ITU admission.
4. Intensive physiotherapy input on wards.
5. Regular reassessment of ceiling of care, re- discussions with patients or NOK.
6. Most families offered one family visit for palliative patients

Learning Points

7. Complete Respect form on admission.
8. Escalation/ceiling of care discussion with patient/NOK.
9. Regular family updates on ward.
10. Facilitated family visits for palliative patients or long admissions.
11. Ensure ongoing community rehab/physio.
12. Involve palliative care earlier for symptom control

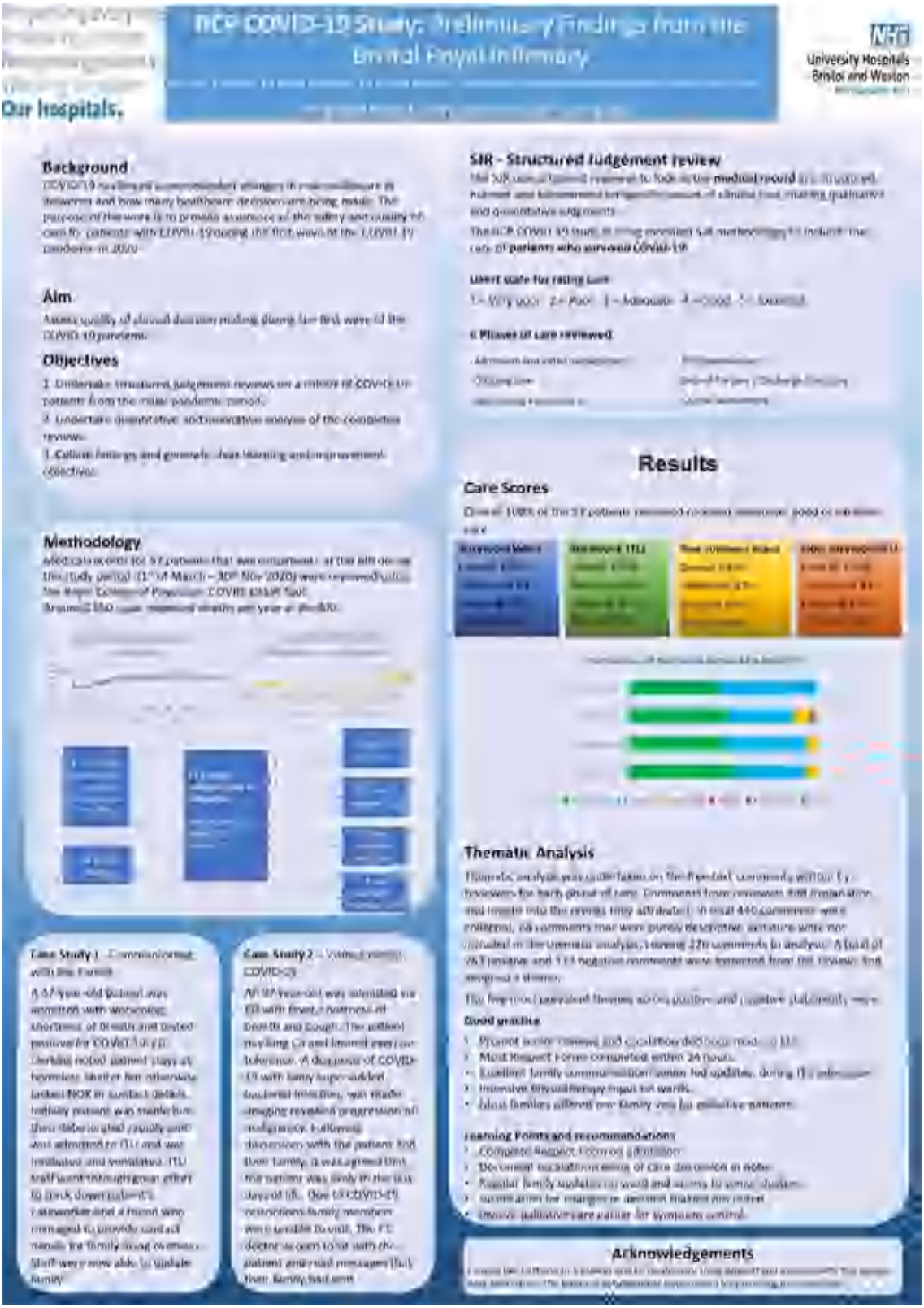


Figure 3. Poster documenting review of Patients with Covid -19

4. **Structure Judgement review of patients initially not escalated**

This piece of work was undertaken by Dr Beale. Dr Maxwell and Dr Redfern at the beginning of the pandemic and was presented as part of the last report, but is referred to hear for completeness. This work concluded that non escalation was the appropriate ceiling of care in the patients reviewed.

5. **Harm Panel Review**

All in patients who died of suspected hospital acquired Covid-19 as defined by the criteria defined by Public Health England were subject to a Harm panel review. This multidisciplinary panel has meet on 3 occasions and reviewed if the patient had died of Covid-19 or with Covid-19. If the patient was thought to have died of Covid-19 a Serious incident was declared and a Root Cause Analysis undertaken

COVID- 19 Harm Panel

The Covid -19 Harm panel has reviewed all cases where the patient has tested positive for COVID-19 8 days or more after admission and then died within 28 days of a positive test. Others have been included if very recent discharge.

- 4 harm panels (1 more to be scheduled)
- 110 cases discussed so far (65 Weston and 43 Bristol)
- 55 of those identified as having died “from” hospital acquired COVID (29 Weston and 26 Bristol)
- 31 cases have received individual RCAs with learning disseminated across the Trust.
- Remaining cases to be “cohorted” as per advice from the CCG. This is currently being worked through by the divisions and the patient safety team.

Conclusion.

This report represents a huge amount of hard work undertaken by a huge number of staff during unprecedented times, and demonstrates an ability to adopt and adapt to a very new and tough challenge, whilst maintaining the highest level of care for the patients treated.

It also represents, against this backdrop, the successful development and introduction of a new system to monitor and supervise the certification of a patient’s death.

Dr MP Callaway

19th July 2021

BNSSG Medical Examiners Report

Apr 20- Mar 21

David Crossley

Lead Medical Examiner

May 2021

Contents

Introduction

On behalf of the Medical Examiner (ME) service for BNSSG, I am delighted to provide the first annual report.

At the time of writing, the service is responsible for reviewing adult deaths occurring at University Hospitals Bristol and Weston NHS Trust (UHBW), and the North Bristol NHS Trust (NBT).

Despite the challenges of 2020-21, the Medical Examiners service was successfully launched and by the end of the year almost 90% of applicable deaths were being reviewed. Through these reviews we aim to achieve the three key components of the ME service, which are

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

In addition to the above, through our own review/scrutiny of care we aim to identify examples of good and poor care, be that individual medical practice or systemic processes. Any learning points are fed back to the Trusts via their governance systems.

It was intended that the ME service became a statutory requirement from the 1st April 2021 – a date understandably delayed by the political disruption of the combination of Brexit and the Coronavirus pandemic. The latter being a topical area that underlines how important the three main aims above are to continuing NHS improvement.

Regards,

Dr David Crossley
Lead Medical Examiner

About the Medical Examiner Service

Implementation of the ME service began in England and Wales in 2019 with the appointment of the National Medical Examiner and recruitment of national and regional teams.

For BNSSG, a project team laid the foundations, and the first appointment to the service was the Lead Medical Examiner post, in May 2020. This was followed by the appointment of a further 12 ME colleagues, undertaking between one and three sessions each. In terms of time, the ME service undertakes 21 sessions (equivalent of 2.1 whole time equivalents) per week. This recruitment was completed by mid-December 2020.

In parallel, our Lead Medical Examiner officer (Ms Charlotte Clews) was appointed in August 2020, and subsequently her team of 5 Medical Examiner Officers (MEO's) appointed. Between them they undertake the work of 5 whole time equivalents. We have offices in "The Sanctuary" at NBT, as part of the bereavement offices at the Bristol Royal Infirmary (BRI), and an office at Weston General Hospital (WGH).

Our team is currently assisted by a project support manager.

ME's are senior doctors who in the immediate period before the death is registered independently scrutinise the causes of death. MEO's are the continuity of the service, and are involved in all stages of the ME service from talking to attending physicians, advising on the wording of death certificates and explaining this to bereaved families, as well as answering any questions they may have.

The ME service provides an independent review of the patients case-notes pertaining to the last contact with healthcare services. The independence of the service was one of the main recommendations of the Francis Report (2013) which examined the failings in care at the Mid-Staffordshire NHS Foundation Trust between 2005 and 2009. ME's are not employed by the Trusts where they undertake review and scrutiny when performing the ME role, but by the National Medical Examiner Service.

How do we function?

To expand on the introductory comments about the ME service

"improving the experience of bereaved relatives through better communication around the death certification process and including their views of the care of their loved one"

-a core part of the medical examiner role is to provide bereaved people with clear information about the cause of death, and an opportunity to raise any concerns they may have about the care and treatment provided to the deceased person. This is through better communication around the death certification process, such as a detailed explanation of the terminology of the MCCD, and includes sourcing *their* views of the care of their loved one - be it good or bad. This is their opportunity to raise concerns that have historically had no clear forum. This aspect of our service has its roots in the 3rd Shipman enquiry (2003) and the Gosport enquiry of 2014.

"ensuring the Medical Certificate of Cause of Death (MCCD) is accurate"

-whilst every care is usually taken to ensure this is done correctly, it is a task historically delegated to the most junior member of the team. As this information is assessed by the Office for National Statistics and subsequently used to inform Public Heath interventions, inaccuracy leads to inappropriate healthcare planning and wasted resource.

"liaise with Her Majesties Coroner to ensure appropriate referrals are made"

-there is recognition that HM Coroner receives too many un-necessary referrals, and cases where Coronial input should be sought are not referred. We aim to signpost these cases more accurately to assist with the efficiency of the coronial service.

"In addition to the above, through our own scrutiny of care we aim to identify examples of good and poor care, be that individual medical practice or systemic processes. Any learning points are fed back to the organisation via trust governance systems."

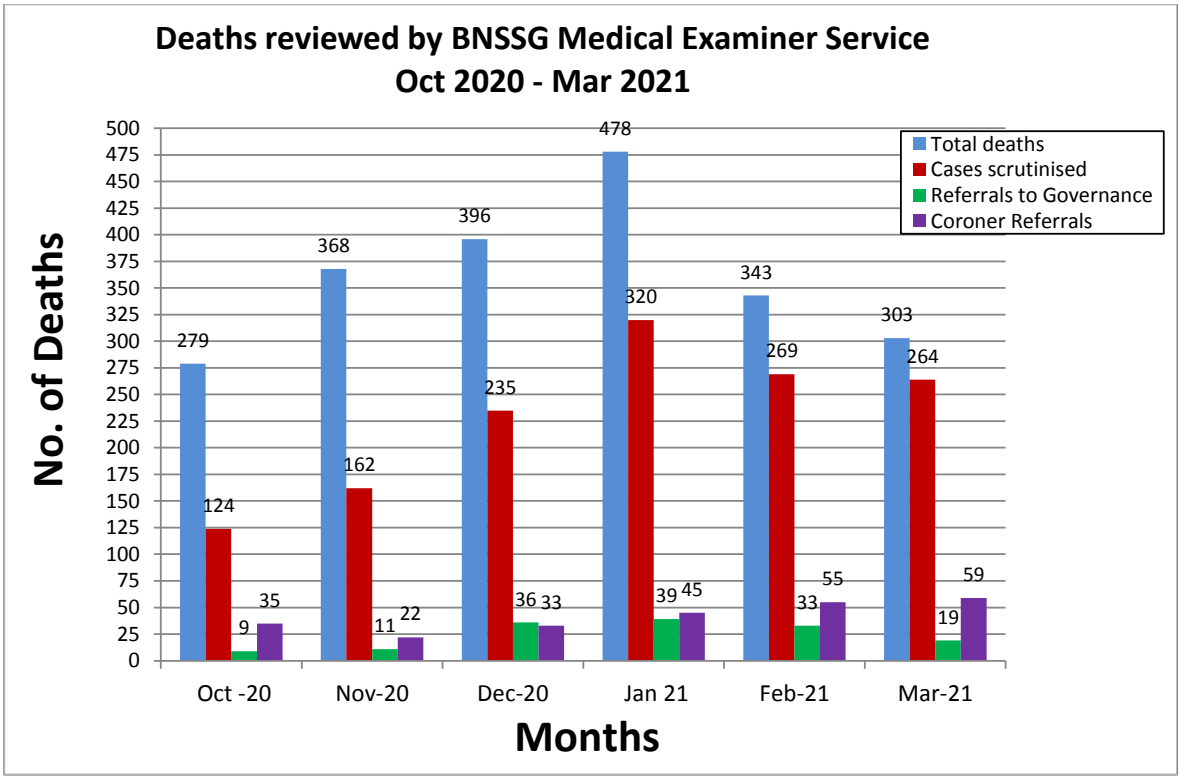
-the scrutiny of the care given to the deceased during their last admission/interaction with healthcare services is undertaken by a senior doctor acting independently of the Trust. This enables an unbiased review in order to identify examples of good and poor practice. Joint working between the ME service and the governance departments of both Trusts has ensured that a system exists so that ME service concerns are highlighted and brought to the attention of the Trust. Formal interactions are enabled by ME service attendance and input at the CEAC (Clinical Effectiveness and Audit Committee) at NBT and the MRG (Mortality Review Group) at UHBW. As well as the internal reporting, the ME service reports quarterly to the National Medical examiner service, and reports themes of concern to the Regional Medical Examiner which remain un-addressed following Trust governance review, should they arise.

Performance Statistics

The service has been continuing to build throughout the year with the aim of achieving 100% scrutiny. The data below commences when meaningful numbers of cases were starting to be scrutinised, showing that by March, just over 87% of total applicable deaths were scrutinised.

Of the cases referred to the Trusts governance departments, the majority were where the ME raised “significant concerns” about care quality. “Significant concerns” are a subjective assessment based on a proportional review of the case notes. It is intended that this highlights a more forensic review by the relevant governance department may be required. This is at the discretion of the Trust.

Cases referred to the coroner through the ME service are also scrutinised for learning points should there be a relevant hospital stay.



Deaths of health and social care workers with Covid-19

The safety of NHS and social care staff was paramount as they risked exposure to the virus in caring for patients. In England, an independent process was established in July 2020 for medical examiners to scrutinise the deaths of health service and adult social care staff that died after contracting Covid-19. This involves medical examiners considering whether there is a reason to suspect the death was a result of the person being exposed to Covid-19 at work, and reporting their conclusions to the National Medical Examiner's office. This process will remain in place for as long as it is required.

Feedback to date

Feedback has generally been positive, although this remains relatively "soft" data to date

- next of kin and families appreciated the opportunity to discuss the circumstances of their relative's death with an independent person, and the time taken to do this
- attending clinicians, especially junior doctors, appreciate medical examiners' support and developmental approach when completing MCCDs
- potential complaints are avoided because medical examiners detect concerns quickly and facilitate action before a complaint is made or positions become entrenched
- positive feedback from stakeholders such as coroners and registrars about the accuracy of notifications and MCCDs, and from other hospital services.
  One such example - Yvonne Dawes, Head of Statutory Registration, Bristol City Council, Coordinator of the After Death Working Group. "The establishment of the Medical Examiner system into the Bristol (BNSSG) area at the start of the pandemic has had an incredibly positive impact. Remarkably the new ME team achieved the fine balance of not interrupting systems that worked well by taking time to understand local individual agencies processes, whilst suggesting new ways of working to widespread benefit. Meeting virtually, our ME colleagues formed a core part of the After Death Working Group - a multi-agency public and private sector partnership set up at the start of the pandemic. Success is often about positive relationships and we work to achieve a dignified death to final resting place in 30 days. We created shared understanding and a supportive culture of practical mutual aid which we intend to continue going forward."

Going forwards

- Paediatric and Maternity Deaths at our acute Trust sites will be included as soon as possible

- A national ME database will be created (2021-22)

- A digitised MCCD will be developed (2021-22)

- The medical examiner system becomes statutory (expected April 2022)

- The system will “rollout” into the Community (ongoing). Initially focussing on Community Hospitals, Mental Health organisations and Hospices (2021-22), followed by General Practice. It is intended that over the next few years the ME service will scrutinise non-coronial deaths in ***all*** settings in our country.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Public Board 29th July 2021

Report Title	**Perinatal quality surveillance matrix**
Report Author	**Sarah Windfeld/Freya Mathewson**
Executive Lead	**Deirdre Fowler Chief Nurse and Midwife**

1. Report Summary

This report provides the board monthly oversight with regards to the safety matrixes of our maternity and neonatal services.

2. Key points to note
(Including decisions taken)

- CNST year 3 compliant, apart from Standard 1 which was partially compliant and action plan has been submitted to mitigate. Submission has been completed successfully.
- Continuity of carer at 46%. Having a National team visit on 27th July 2021to showcase the work.
- Monthly safety walk arounds with HoM/ Chief Nurse and Quality Patient Safety Manager
- Staffing incidents relate to NICU nurse staffing. Have had extra funding from the regional team to recruit 8 further nurses and have recruited to these posts.
- Achieve 121 care in labour by moving staff, to start twice daily bed manager safety huddles. Presently twice a day at 10 am and 4 p.m.
- Induction rate remains high and results in delayed inductions on a daily basis.
- More women having elective caesarean sections for maternal request.
- Positive engagement with HSIB with quarterly engagement feedback sessions

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

The risks associated with this report include:
3343 delayed elective LSCS
2264 delayed induction of labour
33/3623/988 NICU staffing/BAPM

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

- This report is for **Information.**

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

Divisional Quality Assurance Committee	
Women's Clinical Governance	

Meeting	
Quality and Outcomes Committee meeting	

Recommendation Definitions:

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

University Hospitals Bristol and Weston NHS Foundation Trust

UHBW perinatal quality surveillance matrix

	Jan-21	Feb-21	Mar-21	Q4 total	Apr-21	May-21	Jun-21	Q1 total	Jul-21	Aug-21	Sep-21	Q2 total	Oct-21	Nov-21	Dec-21	Year to date	Trend
Activity																	
Number of babies born alive at 16 to 23+6 weeks gestation	0	0	0	0	1	1	3	5									
Number of babies born alive at >=22 to 23+6 weeks gestation	0	0	0	0	1	1	0	2									
Number of babies born alive at 24 to 36+6 weeks gestation	29	27	24	80	27	37	28	92									
Number of women who gave births all gestations from 22+0 weeks	397	332	408	1137	411	431	401	1243									
Induction of Labour rate %	33.7%	29.0%	29.9	33.5	33.5	32.0	31	97									
Unassisted Birth rate %	47.6%	48.2%	52.0	50.2	53.5	46.5	50.9	151									
Assisted Birth rate %	18.2%	18.1%	16.0	17.5	16.2	17.1	15	48									
Caesarean Section rate (overall) %	25.6%	34.7%	31.4	34.0	30.0	36.4	35	101									
Elective Caesarean Section rate %	19.7%	21.1%	18.5	20.0	17.0	14.6	20	52									
Emergency Caesarean Section rate %	14.7%	13.6%	13.0	14.0	13.1	21.8	15	50									
Perinatal Morbidity and Mortality inborn																	
Total number of perinatal deaths	2	4	1	7	1	7	0	8									
Number of stillbirths 22+0 to 23+6 weeks excl TOP	0	0	0	0	0	0	0	0									
Number of stillbirths (>=24 weeks excl TOP)	0	3	0	3	0	3	2	5									
Number of neonatal deaths : 0-6 Days	0	1	0	1	0	1	0	1									
Number of neonatal deaths : 7-28 Days	2	0	1	3	1	3	0	4									
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (HSIB)	1	0	0	1	0	2	0	2									
Maternal Morbidity and Mortality																	
Number of maternal deaths (MBRRACE)	1	0	0	1	1	0	0	1									
Number of women who recieved level 3 care	0	0	1	1	2	1	0	3									
Insight																	
Number of datix incidents graded as moderate or above (total)	1	1	2	4	1	4	1	6									
Datix incident moderate harm (not SI)	0	0	1	1	0	0	0	0									
Datix incident SI (excl HSIB)	1	1	1	3	1	1	1	3									
New HSIB SI referrals accepted	1	0	0	1	1	2	0	3									
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									
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0									
Workforce																	
Minimum safe staffing in maternity services: Obstetric cover (Resident Hours) on the delivery suite	76	76	76	228	76	76	76	228									
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps	0	0	0	0	0	0	0	0									
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps	0	0	0	0	0	0	0	0									

Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)	0	0	0	0	0	0	0	0										
Minimum safe staffing in maternity services: neonatal medical workforce (rota gaps)	0	0	0	0	0	0	0	0										
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled bank shifts).	0	0	0	0	0	0	0	0										
Vacancy rate for midwives							4	0										
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained)																		
Vacancy rate for NICU nurses							0	0										
Datix related to workforce (service provision/staffing)	4	2	10	16	6	7	14	27										
MDT ward rounds on CDS (minimum 2 per 24 hours)	100%	100%	100%	100%	100	100	100	100%										
One to one care in labour (as a percentage)	100	100%	100%	100%	100	100	100	100%										
Number of times maternity unit attempted to divert or on divert	0	3	1	4	1	2	0	3										
Involvement																		
Service User feedback: Number of Compliments (formal)	10	20	12	42	30	40	36	106										
Service User feedback: Number of Complaints (formal)	3	4	3	10	5	0	6	11										
Staff feedback from frontline champions and walk-abouts (number of themes)	5	7	5	17	1	4	4	6										
Improvement																		
Progress in achievement of CNST /10	6	6	7	7	10	10	9	9										
Training compliance in maternity emergencies and multi-professional training (PROMPT)	94%	94%	92%	92%	92%	97%	94%	94%										
training compliance core competency 4. personalised care	n/a	n/a	n/a	n/a	61%		54%	57%										
Continuity of Carer (overall percentage)	36%	36%	36%	38%	38%	45.9%	46%	42%										

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	Safeguarding Adult and Children Annual Report for April 2020/ 2021(Incorporating Learning Disabilities and Prevent)
Report Author	Carol Sawkins. Safeguarding Lead Nurse
Executive Lead	Deidre Fowler. Chief Nurse and Executive Lead for Safeguarding

1. Report Summary

The Safeguarding Adult and Children Annual Report provides University Hospital Bristol and Weston, the Clinical Commissioning Group and Safeguarding Partners 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 decisions taken)

Safeguarding remains a key priority for the Trust and this annual report summarises key safeguarding activities, developments and achievements in this reporting period. The report also reflects the impact of the Covid 19 pandemic on both safeguarding activity and training.

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

The Safeguarding Steering and Operational Groups have maintained oversight of all safeguarding activity, including risks. The Trust has maintained compliance with CQC Regulation 13 'Protecting Service users from abuse' and no areas of risk have required escalation to the Board.

Full details of the aims and objectives of both safeguarding teams going forward are detailed in the work and audit plans for 2021/22.

3. Risks

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

The risks associated with this report include:

None

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.

Safeguarding Steering Group	Virtually
Quality and Outcomes Committee	24 June 2021

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Safeguarding Adult & Children Annual Report

(Incorporating Learning Disabilities and Prevent)

April 2020 – March 2021

Index

1. Introduction

Welcome to the University Hospitals Bristol and Weston NHS Foundation Trusts combined Safeguarding Children and Adults Annual Report reflecting the well-established integrated safeguarding approach followed across the Trust. This report includes safeguarding activity data from the Weston Division, for the first time, following the merger of the two Trusts in April 2020.

The Trust safeguarding agenda remains underpinned by shared governance, safeguarding work and audit plans, and supported by the safeguarding Executive leads with an experienced safeguarding team. Safeguarding is closely aligned with 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.

This reporting period has witnessed the unprecedented impact of the Covid 19 pandemic on all aspects of patient care within the Trust, including rapid and significant changes to the delivery of clinical care and patient flow. There has also been an increase in safeguarding risks, for both adults and children, from national and local restrictions and lockdowns, social isolation and changes in behaviours. Risks which have been compounded by school closures and reduced levels of face to face support available from partner agencies. This increase is reflected through the safeguarding data activity within this report

This report provides University Hospitals Bristol and Weston Trust Board, Bristol, North Somerset and South Gloucester Clinical Commissioning Group (BNSSG CCG) 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 summary and conclusion of this report describes the key priorities and areas identified for development for safeguarding in 2021/22.

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 (2018) and for adults, within the Care Act (2014), the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007). These arrangements are supported by the Named Professionals (Doctor, Nurse and Midwife), plus a team of experienced safeguarding nurses and administration staff.

Key governance arrangements comply with the statutory requirements of Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework (SAAF), which sets out the safeguarding roles and responsibilities of all individuals working in NHS funded care settings.

Assurance of continued compliance with the requirements of both Section 11 and the updated SAAF has been gained through completion of self- evaluations, which have been reviewed internally through the Safeguarding Operational and Steering Groups and reported externally to the BNSSG CCG and Safeguarding Partners.

UHBW Trust Board holds 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, provide expert advice, support and supervision to practitioners across all areas of the Trust.

The Safeguarding Steering Group reports annually to the Clinical Quality Group which in turn reports to the Quality and Outcomes Committee, the quality sub-committee of the Trust Board.

The Trust has two operational groups: one for Children's Safeguarding and one for Adult Safeguarding and Mental Capacity Act, which meet alternative months and report to the Safeguarding Steering Group and are responsible for the operational delivery of safeguarding across the Trust and delivery of an annual work and audit programme.

Safeguarding performance is monitored internally by the Trust Safeguarding Steering Group, chaired by the Chief Nurse and supported by senior representation from all Divisions.

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

Following the merger with the Weston site from April 2020, a complete review of safeguarding risks for adults and children was undertaken, including all Trust sites. The findings have been reviewed through the Safeguarding Operational and Steering Groups, and the Clinical Quality Group, with the recommendation that the Trust maintains compliance with CQC Regulation 13; 'Protecting Service users from abuse'.

Areas for improvement, including safeguarding training compliance (see section 9 of this report), continue to be considered internally and reflected through the safeguarding work and audit plans.

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

Compliance with Regulation 13 ensures 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.

4. Safeguarding Risks

The Safeguarding Steering Group and Safeguarding Operational Groups maintain oversight of all safeguarding Corporate, Divisional and Departmental risks entered onto Datix. Three safeguarding risks remain on the corporate risk register, two of which remain unchanged from the previous year's report.

The risk rating for the third corporate (risk ID 856), has increased from 12 to 15, as a result of the increase in numbers and complexity of children and young people with mental health concerns (particularly eating disorders) who require admission whilst waiting for a specialist Tier 4 mental health bed. This reflects the national acute shortage of Tier 4 beds; with the pre-existing capacity challenges being exacerbated by the significant adverse impact of the Covid pandemic now being seen on the mental health of children and young people. This concern has been escalated to the Keeping Bristol Safe Partnership Boards, the local Clinical Commissioning Group and NHS England Specialist Commissioning Team.

Table 1: Summary of Corporate Safeguarding Risks

<table>
<tr><th>Risk No</th><th>Summary of Risk</th><th>Current Risk Rating</th><th>Current Position and Key mitigating actions</th><th>Owners of Risk / Monitoring Group</th></tr>
<tr><td>856</td><td>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.</td><td>Risk Rating 15</td><td>This is an ongoing risk related to the number of children and young people being admitted to the BRHC as a place of safety, who do not require treatment for any physical health reasons.

During this reporting period, this risk has been reassessed and in light of the numbers and severity of CAMHS patients (particularly Eating Disorders) within the BRHC at the present time. This reflects the national picture and the adverse impact the Covid pandemic has had on mental health concerns.

Risk rating increased from 12 in previous report to current score of 15.

Lack of Tier 4 beds -escalated to Keeping Bristol Safe Partnership and NHS E (Specialist Commissioning). The commissioning of mental health services for children continues to be reviewed by NHS England locally and nationally.</td><td>Children's Governance & Mental Health Operational Group,

Safeguarding Steering Group.</td></tr>
<tr><td>921</td><td>Risk of not achieving 90% compliance for all Essential Training, which includes safeguarding training.</td><td>Risk Rating 12</td><td>If rates of compliance with Essential Training are not met and sustained, then staff may not have the skills, knowledge and experience to deliver effective care and treatment and maintain a safe working environment.

Level 1 & 2 Safeguarding Adults and Children training, primarily delivered via eLearning, has continued largely unchanged from previous years, following the Covid pandemic. Level 1 & 2 compliance training data at the end of this reporting period (31/3/21):

<table>
<tr><td></td><td>Adults</td><td>Children</td></tr>
<tr><td>Level One</td><td>90%</td><td>87%</td></tr>
<tr><td>Level Two</td><td>87%</td><td>85%</td></tr>
</table>

Level 3 training for adults and children has historically been delivered entirely as face to face training. Cancellation of all face to face training as a result of the Covid pandemic has been reflected in a decrease in Level 3 training compliance.

Safeguarding Training Compliance rates for Level 3 Children's and Adults Trainings at the end of this reporting period (31/3/21):

<table>
<tr><td></td><td>2019/2020</td><td>2020/2021</td></tr>
<tr><td>Level 3 Children's Core</td><td>Target Audience – 1903 staff

73%</td><td>Target Audience – 2023 staff

55%</td></tr>
<tr><td>Level 3 Children's Specialist</td><td>Target Audience – 379 staff

78%</td><td>Target Audience – 392 staff

58%</td></tr>
<tr><td>Level 3 Adults</td><td>52%</td><td>58%</td></tr>
</table>
</td><td>Executive Lead - Director of Workforce & Organisational Development.

Safeguarding Steering Group</td></tr>
</table>

			A post Covid Training recovery plan has been developed and will be reviewed by the Safeguarding Operational and Steering Groups prior to implementation.The Senior Leadership Team, Executive Lead Director of Workforce and Organisational Development and the local Clinical commissioning Group continue to maintain oversight of monthly training compliance reports.	
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).	Risk Rating 12	This risk relates to patients suffering from mental health disorders having a prolonged stay in ED and their condition could deteriorate in a busy and pressured environment. Patients affected include those detained under Section 136 (Mental Health Act) and those either awaiting assessment by AWP or allocation of a community bed. There are controls in place and good partnership working with AWP colleagues. The risk score has remained the same during this report period. Concerns about the increasing national picture of adolescent mental health attendances had potential to further exacerbate this risk. Risk review therefore increased to monthly in short term	Mental Health Operational Groups. Safeguarding Steering Group.

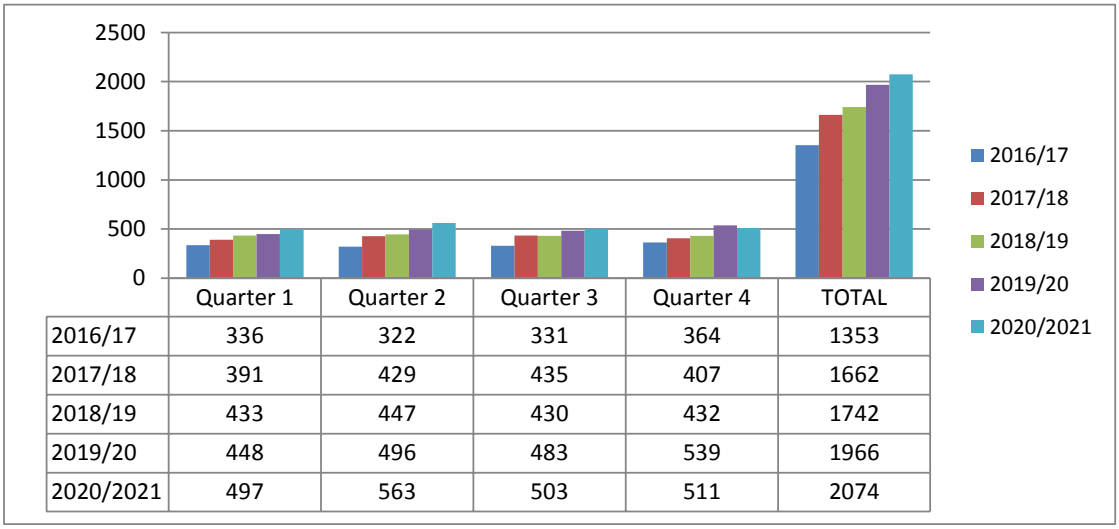
5. Summary of key safeguarding achievements

Merger and restructuring of Bristol and Weston Safeguarding and Learning Disabilities Teams, improved cohesion and resilience of service.	Partnership working with Sirona Care and Health towards a new Safeguarding Paediatrician Children's Hospital in reach service.	Safeguarding Service maintained throughout Covid Pandemic (Hospital Based). Development of safeguarding guidelines for Virtual Clinics.
Significant progress towards complete alignment of safeguarding governance, systems, and processes across all Trust sites.	Safeguarding training and matrices updated to reflect changes in legislation, guidance and best practice, (including the Intercollegiate Document for Adults), contextual safeguarding, and Adverse Childhood Experiences.	Implementation of Bristol Emergency Department safeguarding process; including weekly review meetings, into Weston Emergency Department.
Active participation in Covid multi-agency safeguarding response - supporting a system wide responsive approach with early identification of emerging risks.	Appointment of second Named Doctor (children); and new Named Doctor (adults) appointed, to support the clinical teams in the management of complex and high risk cases.	Changes in practice required for 'Liberty Protection Safeguards '(LPS) legislative changes continue to be reviewed, to be supported by LPS implementation lead.

6. Safeguarding Children Activity Data

The safeguarding children's activity data continues to reflect a year on year increase, both in terms of volume and complexity of cases (See Table two and Table three). This has been sustained despite the unprecedented challenges faced by frontline clinical staff during the Covid pandemic. This is a positive reflection of staff awareness of the safeguarding process, highlighting that safeguarding has remained a key priority throughout this exceptionally challenging year.

Table 2: Number of contacts made to the Safeguarding Children's Nursing Team



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
2016/17	336	322	331	364	1353
2017/18	391	429	435	407	1662
2018/19	433	447	430	432	1742
2019/20	448	496	483	539	1966
2020/2021	497	563	503	511	2074

Table 3: Annual RAG Rated Cases

Rating	Red	Amber	Green	Number of Contacts
2019/20	59	229	1459	1966
2020/21	64	370	1764	2074

6.1 Safeguarding Referrals to Children's Social Care

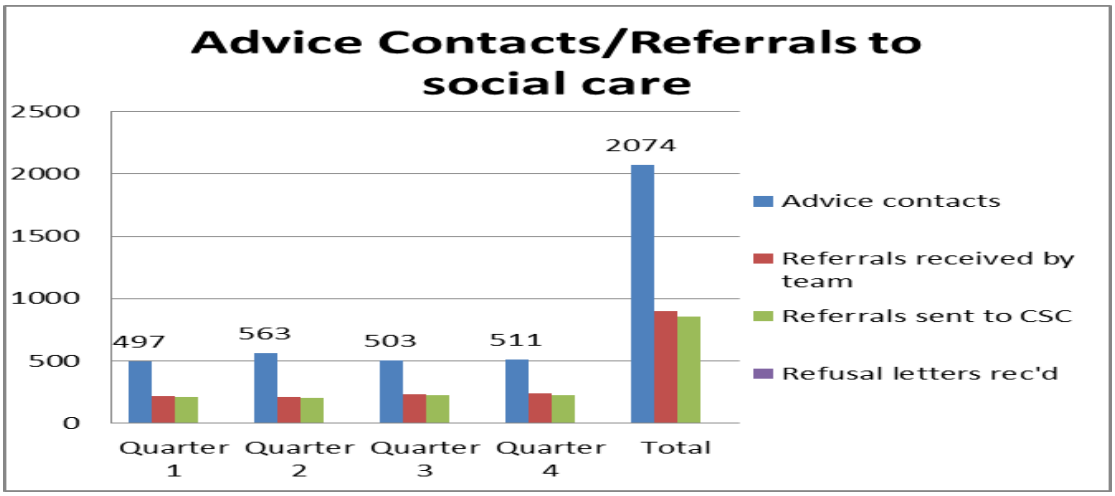
Safeguarding referrals to Children's Social Care are sent, from all sites, via the Safeguarding team. This enables the team to:

- Review the quality of the information recorded in 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 Bristol Multi Agency Threshold Guidance - Working together to get the Right Help at the Right Time for the Right Duration (BSCB 2018).
- Collect and collate data for analysis purposes and onward reporting to the Child Protection Operational and Safeguarding Steering 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 relatively stable during this reporting period (Table 4) Out of the total of 858 safeguarding referrals sent to Children's Social Care, only 7 were considered to not require any further social care investigation or intervention. This is a significant positive finding, providing assurance of the effectiveness of the Trust's internal safeguarding screening process.

In the case of referrals not sent to Children's Social Care, the majority were 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.

Table 4: Number of Referrals Received and Sent to Children's Social Care

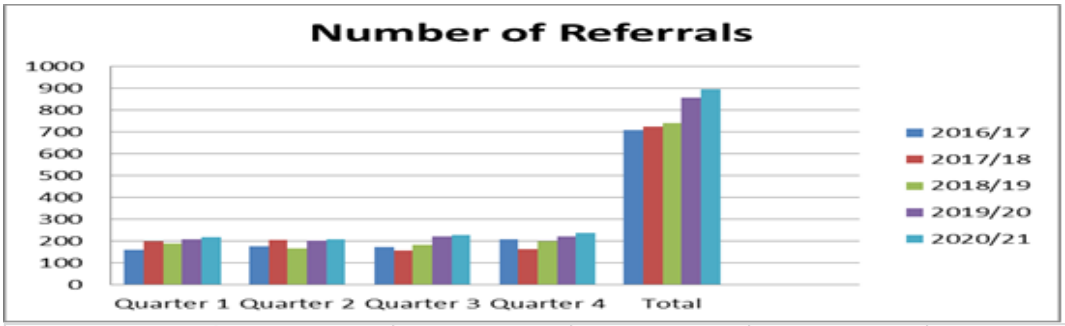


As evidence emerges about the impact of the Covid pandemic, there is increasing concern, locally and nationally, of potential increasing safeguarding risks for children at a time of reduced professional surveillance.

This was reflected, in the first half of this reporting period, with a decrease in the number of safeguarding referrals being received by Children's Social Care from partner agencies - in particular, and as anticipated from education.

It has therefore been reassuring to note that staff within the Trust have continued to maximise upon all health contacts to safeguard children, with the number of referrals to Children's Social Care remaining relatively stable (Table 5). The total number of annual referrals has also remained stable in the face of the reduction in elective patient activity, and flow across all hospital sites as a result of the pandemic.

Table 5: Number of Annual Safeguarding Referrals



Referrals made by Quarter / Year					
	2016/17	2017/18	2018/19	2019/20	2020/21
Quarter 1	162	199	191	209	219
Quarter 2	178	206	167	204	210
Quarter 3	172	157	183	223	229
Quarter 4	208	163	199	222	239
Total	708	726	740	858	897

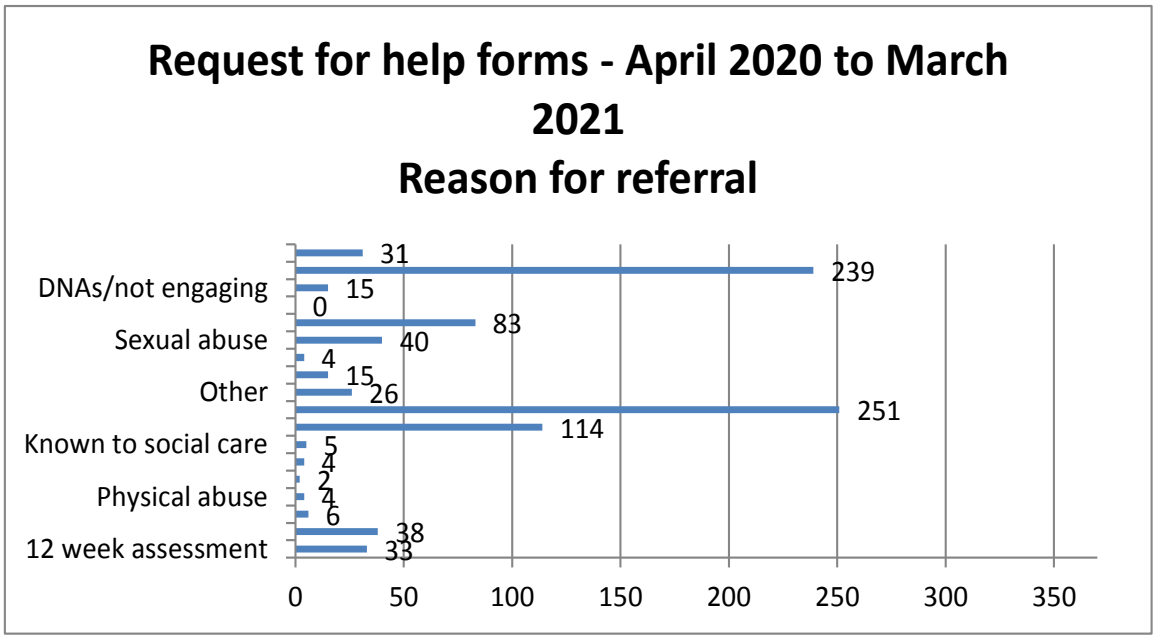
Safeguarding referrals continue to be made from a range of areas across the Trust, with the Sexual Abuse Referral Centre and Midwifery Services continuing as the two areas with the highest referral rates within the Trust.

Activity data from the Division of Weston has been included in this report for the first time and has as anticipated, had a minimal impact on the overall total number of safeguarding referrals; as children under the age of 16 years are not admitted to the Weston site. Activity date from the Seashore Centre (ambulatory day care unit), is currently reflected within the Emergency Department data activity.

A breakdown of the reasons for the safeguarding referrals remains broadly in line with previous years (Table 6).Of particular note, the number of referrals for children and young people with mental health concerns increased from 4 in the previous report, to 15 in this reporting period. Nationally there are increasing concerns about the impact of the Covid pandemic on children and young people's mental health, including in presentations of eating disorders.

This increase in demand has exacerbated the pre-existing challenge of the lack of Tier 4 mental health provision for children and young people. This has resulted in a number of prolonged admissions for children, often requiring a significant level of restrictive intervention, whilst waiting for a more suitable mental health placement (Datix No 856)

Table 6: Reason for referral



6.2 Safeguarding in the Emergency Departments

The Trust Emergency Departments, including at the Bristol Royal Infirmary, Bristol Royal Hospital for Children, Bristol Eye Hospital and Weston General Hospital, complete 'Social Care Notification forms', recognising the time limited contact with a child and family, as opposed to the more detailed Trust wide Request For Help' form.

This safeguarding referral process was introduced into the Weston Emergency Department in May 2020, and includes a weekly safeguarding meeting, between the safeguarding and Emergency Department teams, to review the notification forms, update on the local outcomes, and share any learning.

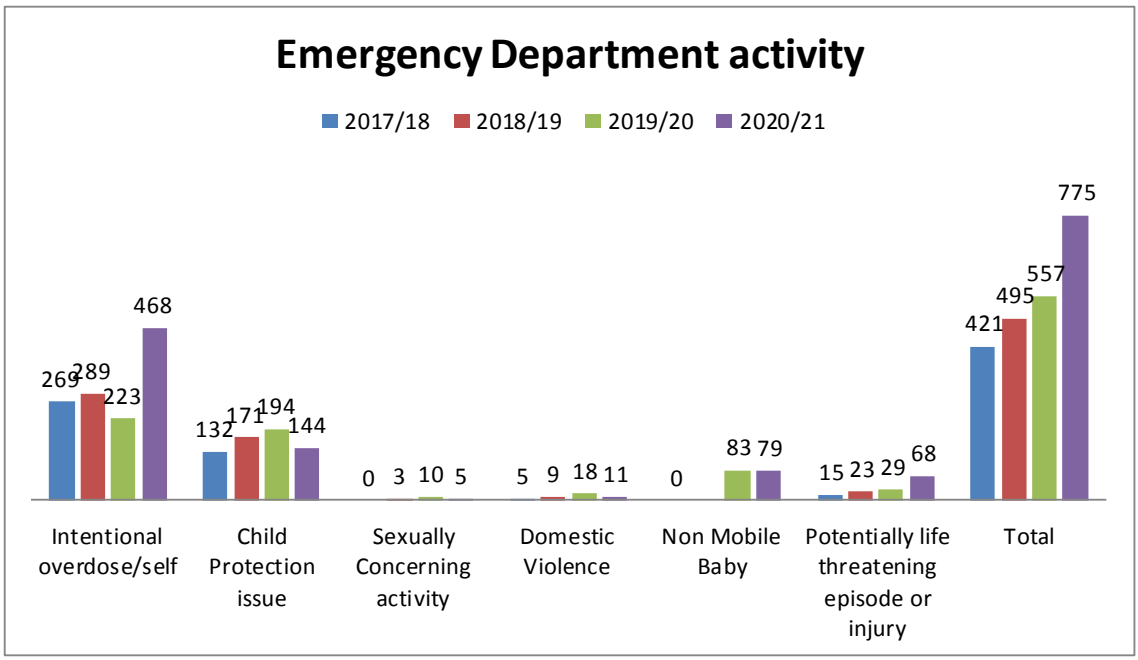
The overall referral data for the Emergency Departments has increased significantly during this reporting period (see Table 7).The Weston referral data was impacted upon by the closure of the Emergency Department for a period of approximately 6 weeks.

Table 7: Emergency Department Social Care Notifications

	2016/17	2017/18	2018/19	2019/20	2020/21
BRHC ED	1326	1360	1301	1493	1762
BRI ED	616	779	709	745	756
Weston ED	Pre-merger	Pre-merger	Pre-merger	Pre-merger	496
Annual Total	**1942**	**2139**	**2010**	**2238**	**3014**

The major contributory factor, in the overall increase (greater than 50%) in Emergency Department safeguarding activity, is the number of children and young people attending the Emergency Departments with mental health concerns (Table 8). This includes presentations with intentional overdose and self-harm. This is a very concerning finding, which is being reflected nationally and thought to be a consequence of the Covid pandemic.

Table 8: Emergency Department Referral Categories



This reporting period has also seen an increase, both locally and nationally, in gang related activity- including knife crimes. This is an area of concern which is currently the subject of a thematic review by the Keeping Bristol Safe Partnership, to which the Trust is contributing. The Trust is also part of a pilot project with Barnardo's called ROUTES.

Staff are able to make a referral to the project for any young person thought to be at risk of or involved in gang related activity. Barnardo's are able to provide the young person with support from a youth worker.

6.3 Safeguarding, Midwifery and the Unborn Baby

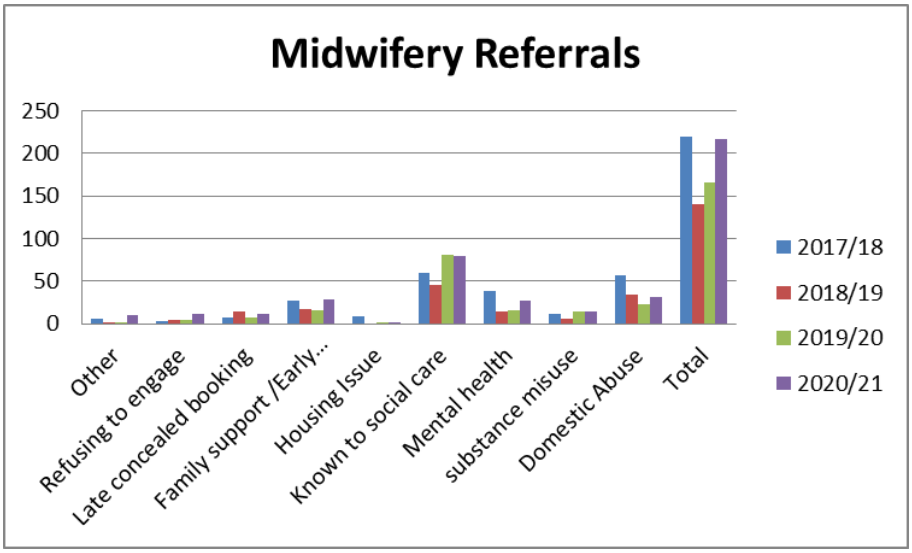
The Midwifery service to mothers and babies, for up to ten days post-delivery, has been successfully continued throughout the Covid pandemic, including home visits and face to face contacts. Midwives have continued to make safeguarding referrals for unborn babies due to a range of concerns about potential parental risk factors, with an increase in Domestic Abuse referrals seen in the first two quarters of this reporting period (See Table 9).

Information is emerging about increased risks for victims of Domestic abuse and their children, resulting from the pandemic's social isolation, exacerbated by potential financial and/or home schooling pressures.

There are also emerging concerns locally, for women who have not engaged in ante-natal care, and, although this is likely to be very small numbers, this has resulted in tragic outcome for the mother and/or baby.

In cases of high risk there may be 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 9: Referrals for Unborn Babies



At the beginning of this reporting period, concerns were raised nationally about a possible increased risk of babies becoming victims of Abusive Head Trauma as a result of the increase family pressures from the pandemic.

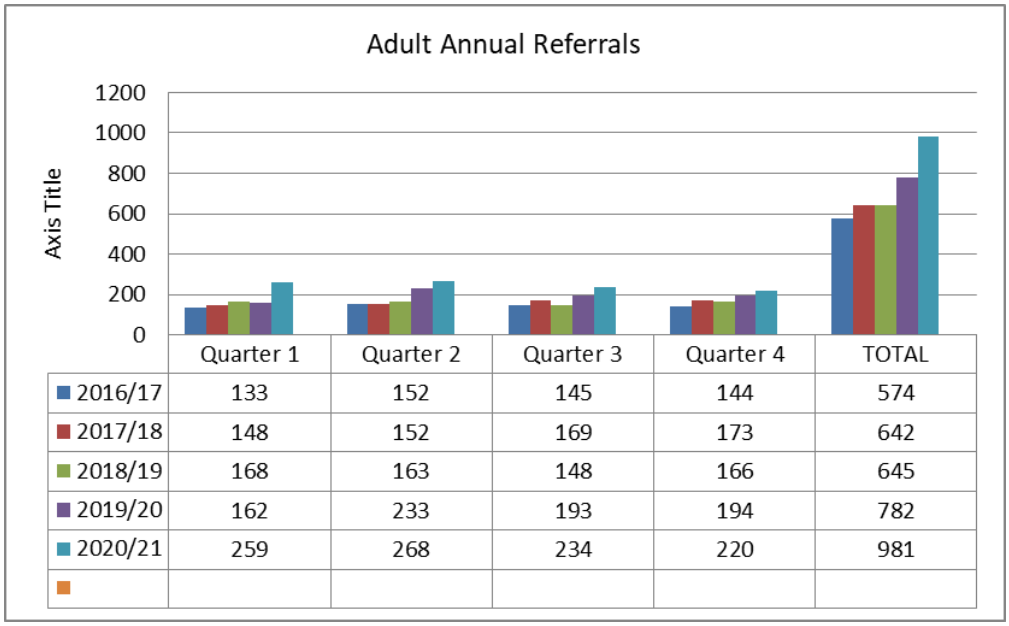
Midwifery services have fully implemented 'ICON', a national campaign to educate parents about baby's crying patterns and empower them with positive coping mechanisms. The aim of the campaign is to reduce harm resulting from babies being shaken

7. Safeguarding Adults Activity Data

The safeguarding adult's activity data in this reporting period reflects a significant increase in the number of safeguarding referrals (Table 10), in spite of reduced patient flow and cancellation of elective activity.

This is a positive reflection of staff awareness of their safeguarding role and responsibilities throughout the pandemic.

Table 10: Number of Referrals Received

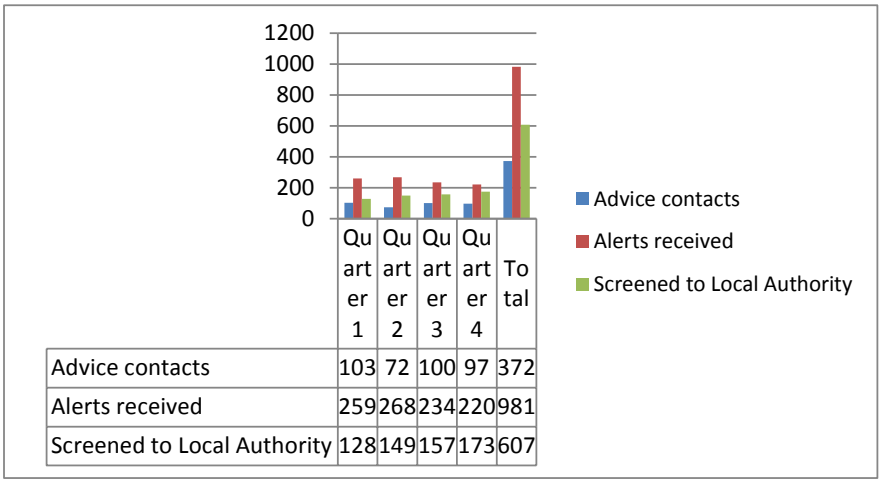


	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
2016/17	133	152	145	144	574
2017/18	148	152	169	173	642
2018/19	168	163	148	166	645
2019/20	162	233	193	194	782
2020/21	259	268	234	220	981

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

As in previous years, significant numbers of alerts received do not meet the agreed threshold for referring to the relevant Local Authority for a safeguarding investigation (Table 10). Focusing on staff knowledge and awareness of safeguarding thresholds for referrals is an identified area for improvement in the next reporting period. Alerts not meeting the threshold continue to be risk assessed, and redirected to other appropriate service including housing, domestic violence support, or local authority care needs assessments.

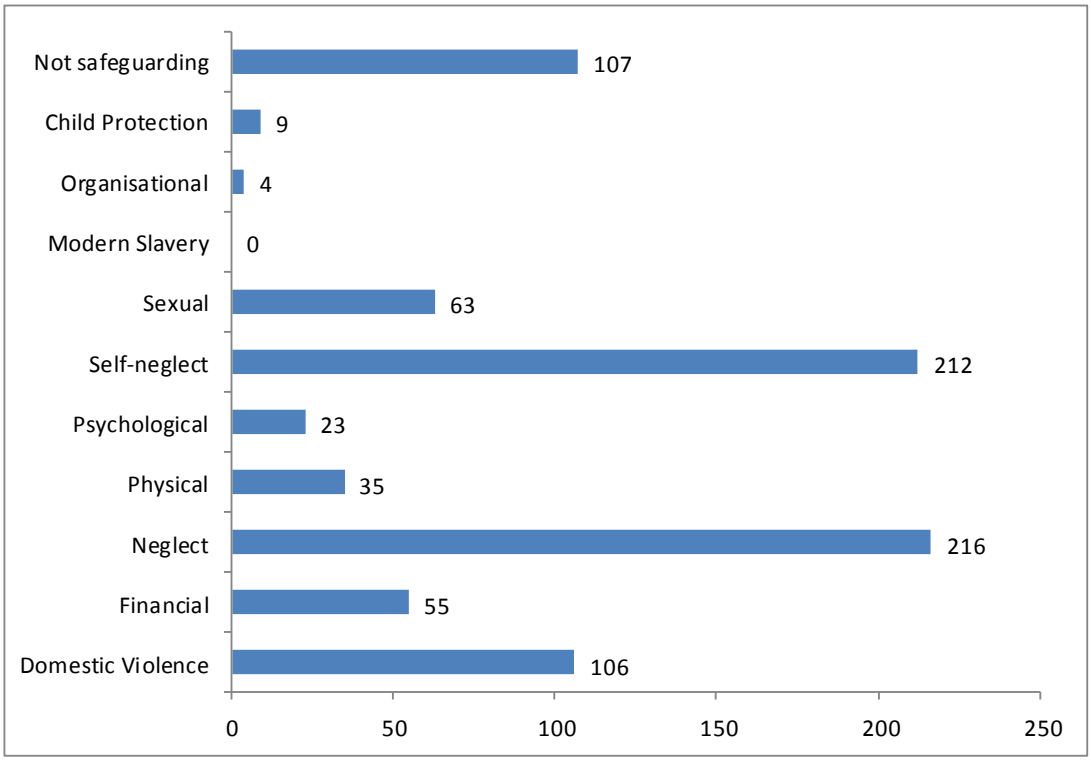
Table 11: Number of Contacts / Referrals screened prior to sending to Local Authority



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Advice contacts	103	72	100	97	372
Alerts received	259	268	234	220	981
Screened to Local Authority	128	149	157	173	607

The Safeguarding nursing team continues to record the number of requests for advice and support from staff across the Trust. Contacts include advice sought in relation to the application of the Mental Capacity Act, Deprivation of Liberty Safeguards, and safeguarding and complex case queries. Of note advice has been sought in relation to the application of the emergency Coronavirus Act, for example in relation to authorisations to detain or restrict the movements of patients who are Covid positive, mental capacity and Covid testing.

Table 12: Category of referrals



Most referral categories remain in line with the previous year's reporting, with neglect, self-neglect and Domestic Abuse forming the largest categories and reflecting the national picture. Referrals for Domestic Abuse have fluctuated over the year and it is recognised that the pandemic has led to variations in patterns of reporting numbers; reducing during lockdowns, and increasing when restrictions are lifted.

There has been a 13% increase in the number of self-neglect referrals, which is consistent with the previous year's data and in line with the national picture. Overall a greater proportion of the self-neglect referrals have also been accepted and actioned by the Local Authority, with an increase in the severity of harm.
This is likely to be as a consequence of the reduction in access to people in their own homes and the reduced face to face protective contact, provided by a range of agencies as result of the pandemic.

7.1. Internal Safeguarding Alerts

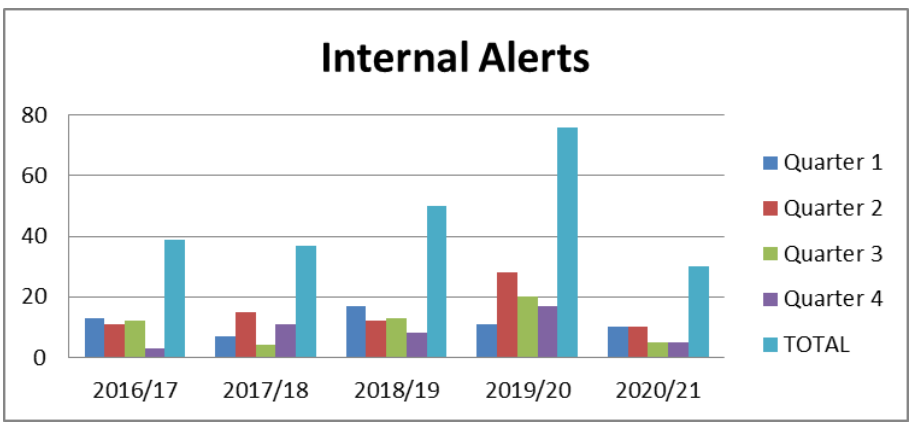
A Safeguarding Internal Alert is raised if it is alleged that the Trust may have caused harm to a patient through the omission or provision of care, underpinned by the Trust's responsibility to be open and transparent in line with the Duty of Candor. Alerts may be raised by practitioners within the Trust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

There has been a significant decrease in volume of internal cases recorded this year (Table 12) out of sequence with the previous pattern of a year on year increase.

The internal alert data for Weston Division continues to be recorded differently in this reporting period and Weston Division reported a total of 64 internal alerts this year. Work is underway to fully amalgamate data recording for the next reporting period. Weston Division internal alerts, including identified learning, is considered through the Safeguarding Operational and Steering Groups.

This picture is likely to be seen as a consequence of the Covid pandemic, with reduced patient flow and elective activity for the majority of this reporting period. Internal governance processes remain in place to monitor all safeguarding activity and incidents, including through the Safeguarding and Divisional Patient Teams, and the Safeguarding Operational and Steering Groups.

Table 13: Internal Safeguarding Alerts



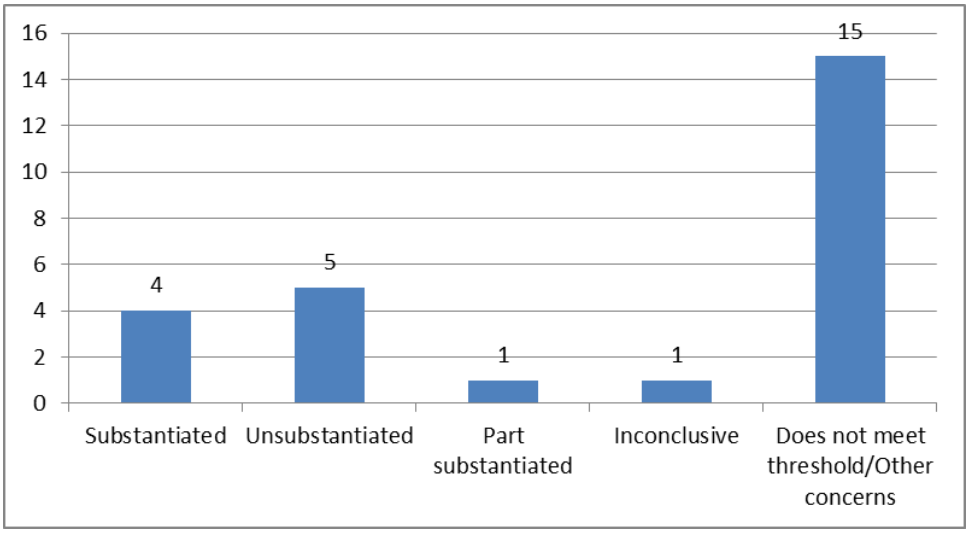
Of the internal referrals sent to the Local authority, 50% did not meet a threshold for a safeguarding investigation, or the local authorities were assured by the actions already taken by the Trust and no further intervention was required.

Of the internal cases this year, four were closed as Substantiated (Table 13), which is in line with the previous reporting period. Internal alerts are kept under careful scrutiny throughout the year and the following themes have been identified:

- Poor practice, including staff behaviours
- Discharge issues
- Absconding patients
- Pressure ulcers

These themes have been considered and learning actioned, through the Divisional Patient Safety teams and the Safeguarding Operational Groups, overseen by the Safeguarding Steering Group.

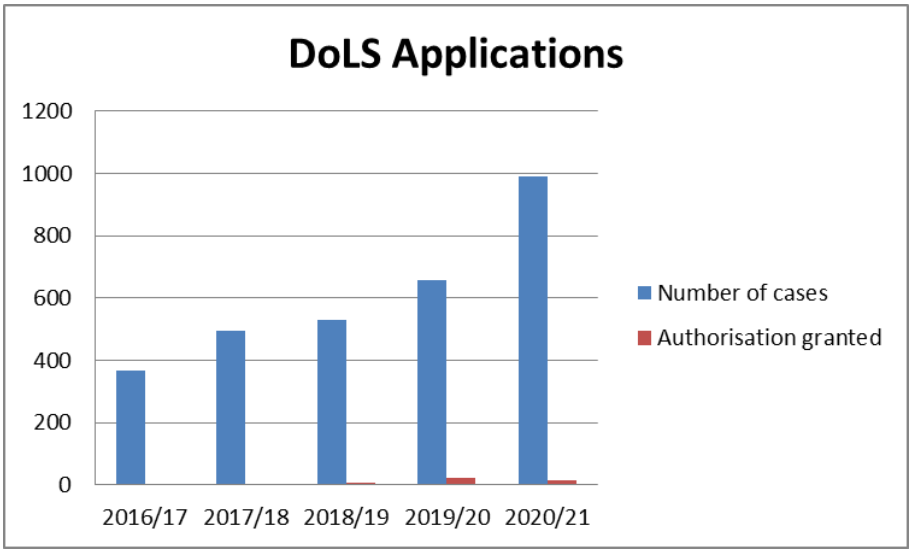
Table 14: Outcome of internal Safeguarding investigations



7.2 Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

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. The volume of DoLS applications continues to reflect a year on year increase (See Table 15).

Table 15: Deprivation of Liberty Safeguards (DoLS)



This reporting period has also seen an overall reduction in the number of DoLS applications to Local Authorities, progressing to a Standard authorisation. 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.

The majority of patients are discharged prior to assessment or authorisation by the Local Authority. The Care Quality Commission and the DoLS notification Team remain fully appraised of this situation through the routine reporting by the Safeguarding Team. 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).

During the Covid restrictions, Local Authorities have aimed to minimise face to face contacts, including those required to complete a DoLS assessment by independent assessors. The Trust has been able to support the assessment process by facilitating video and phone assessments with patients and families, as far as possible.

Arrangements for the planned changes to the Deprivation of Liberty Protection Safeguards (Mental Capacity (amendment) Act 2019 continue with the Code of Practice consultation, due to commence shortly. Implementation is now planned for April 2022.

The progress of the new LPS legislation continues to be monitored closely and funding has been agreed to support the implementation though the appointment of a new Named Doctor for adult safeguarding and an LPS implementation project lead, due to begin work at the beginning of the next reporting period.

8 **Learning Disability Services**

The Learning Disability nurse's provide advice, support and signposting to staff; identifying immediate reasonable adjustments, and providing direct patient support, aiming to facilitate a positive patient journey, in turn reducing patient anxiety and risks. The team are often the voice of the person with a learning disability who lacks capacity and without an advocate, supporting the application of the Mental Capacity Act (2005) to ensure safe decision making processes are followed, including best interest meetings/discussions.

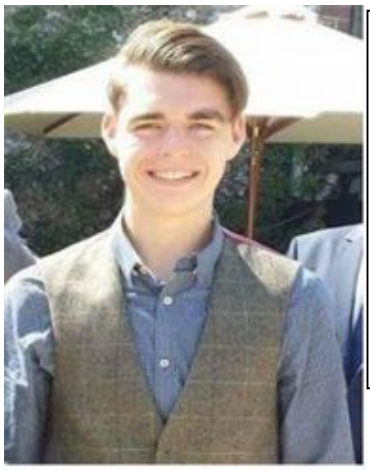
Following the merger in 2020 the Learning Disability team within the Weston Division joined forces with the BRI team, and both are now within the remit of the Safeguarding Team. The Deputy Lead Nurse for Safeguarding has taken on the operational management of the learning disability team. The merger has

enabled a fresh review of the UHBW learning disability service; case load, workforce and strengths and weaknesses. It is recognised that this is a time of change and opportunity from which the learning disability team will grow.

At the beginning of the reporting period, during the early stages of the Covid pandemic concerns were raised that people with a Learning Disability may be disproportionality adversely impacted by the virus. In response to these concerns, emergency Covid funding was identified to support a temporary increase in staffing within the Learning Disability team to provide an enhanced level of service, in partnership with Sirona Care and Health. It is hoped the funding will become permanent going forward to support the progressive work within the LD service, expanding their remit to include Autism only patients and to provide a seven day service across all sites.

It has been an exciting year and significant progress has been made in a number of areas of work, including:

- Consolidation of the Learning Disability team structure aiming to improve the patient experience. Strengthening of internal governance for LeDeR (Learning from Deaths Review), including regular reports to the mortality surveillance group and senior representation on the LeDeR steering group.
- During this reporting period the adult learning disability team have accepted referrals for 479 patients (186 in the Weston Division and 293 across Bristol sites) from a range of areas, including the Emergency Departments, inpatient areas and supporting outpatient appointments which have required additional planning to support patients to attend.
- Reasonable Adjustments, as defined within the Equality Act (2010) are small changes professionals can make to have a positive impact on the person, and have been a key focus of the team. For example through the provision of arts and crafts materials, noise reduction headphones and weighted blankets, (facilitated by Above and Beyond) to enable a positive patient journey. Small reasonable adjustments have been evidenced to have a significant positive impact on how a person with a learning disability perceives, accepts, and can access care and treatment.
- The trust is also currently working with BNSSG partners; to develop a system wide Learning Disability electronic ‘flag’ which will be follow the patient from GP to social care and to the acute provider trusts, this will replace the current Trust internal system, aiming to minimising the risk of people with a Learning Disability being ‘missed’.



Following the local death of Oliver McGowan; a young person with a mild learning disability and autism in 2018, a LeDeR investigation was completed. This has resulted in a system wide approach to develop a robust BNSSG wide action plan.

The Learning Disability Team have been fully engaged in this process, providing evidence and assurance of safe systems and processes within University Hospitals Bristol and Weston. Further work in relation to the action plan, including exploring options for mandatory Learning Disability training for health staff, will continue into the next reporting period

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9. 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.

In the first quarter of this reporting period, the Covid pandemic and associated restrictions resulted in the Trust decision to cancel all training which was delivered face to face. At the same time front line clinical areas were facing unprecedented challenges which understandably impacted upon their ability to release staff to attend mandatory training. The combination of these factors resulted in a significant adverse impact on safeguarding training compliance.

9.1 Level 1 and 2 Training Compliance

Safeguarding Level 1 and 2 training for both children and adults was incorporated into corporate clinical and non-clinical induction and update training. Compliance with Level 1 and 2 training has been affected to a lesser degree, as the option to provide staff with robust eLearning training was already established as a training option for staff. Some face to face delivery, including Clinical Induction, was later reinstated in this reporting period.

Training compliance for Level 1 & 2 at the end of this reporting period, is detailed in table sixteen below

Table 16: Level 1 and 2 Safeguarding Training Compliance

	March 2018	March 2019	March 2020	March 2021
Level 1 Safeguarding Adults	92%	93%	93%	90%
Level 1 Safeguarding Children	93%	96%	91%	87%
Level 2 Safeguarding Adults	86%	93%	95%	87%
Level 2 Safeguarding Children	91%	90%	93%	85%

9.2 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 2,100 staff post-merger). Staff in a more senior role must complete the more advanced level of Level 3 Specialist training (approximately 400 staff post-merger), which includes staff such as; Paediatric Consultants, Community Midwives and Paediatric Specialist Nurses (who are expected to undertake a lead role in safeguarding situations)

The Trust safeguarding Training Matrix states that staff in the Level 3 Core target audience must complete training within six months of starting employment and the Specialist target audience within twelve months.

Historically Level 3 Core and Specialist training has been delivered entirely face to face.In response to the challenges presented by the Covid pandemic a blended approach to training, i.e. half a day face to face training supported by e learning, was introduced, in an attempt to maintain training compliance. As Covid lookdown restrictions tightened, this approach was no longer considered to be safe. Consequently all face to face training was cancelled and compliance rates for both Level 3 Core and Specialist Training have dropped significantly.

End of year compliance for Level 3 Core and Specialist are detailed in Table 17.

Table 17: Level 3 Safeguarding Children Training Compliance

	March 2018	March 2019	*March 2020*	*March 2021*
Level 3 Safeguarding Children (Core)	79%	77%	*73%*	*55%*
Level 3 Safeguarding Children (Specialist)	83%	84%	*78%*	*58%*

9.3 Level 3 Safeguarding Training Compliance (Adult)

Work continues to ensure that the requirements of the Safeguarding Adults Training Guidance (Inter Collegiate Document) published in 2019, are fully reflected in the Trust safeguarding training matrix. In 2019 this resulted in an increase in the number of staff who required training which was reflected in an overall drop in compliance in that year (detailed in Table 18). A further review has taken place during this reporting period, and going forward, identified senior medical staff will be included into the Level 3 adults target audience.

The Covid pandemic and challenges of face to face training delivery, as described above, has similarly adversely impacted on Level 3 adults safeguarding training compliance detailed in table 18. The Trust has until 2021 to reach the required 90% target and compliance remains on track.

Table 18: Level 3 Safeguarding Adult Training Compliance

	March 2018	March 2019	March 2020	March 2021
Level 3 Safeguarding Adults	91%	88%	52%	58%

10 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.

Under the Prevent Duty, the health sector is required to ensure that healthcare staff are able to identify early signs of an induvial being drawn into radicalisation. Staff must be able to recognise keys signs of radicalisation and be confident in referring individuals to their organisational safeguarding lead, to ensure they receive the support and intervention they require.

During this reporting period the Prevent Training and Compentices Framework has been reviewed to promote a consistent approach to training and competency and to ensure that all NHS Trusts meet their legislative responsibilities to equip staff in relation to Prevent. In January 2021 ,the Trust provided representation to the NHS England Task and Finish group to review the current Prevent training and Competencies framework which will be aligned with the Safeguarding Adults (2018) and Children's(2019) Intercollegiate documents going forward.

Safeguarding training incorporates the required level of Prevent //WRAP, according to staff role and level of responsibility. The Covid Pandemic has also, therefore, had a negative impact on Prevent training compliance, detailed in table19.

Table 19: Prevent/WRAP Training Compliance

	March 2018	March 2019	March 2020	March 2021
Prevent training	90%	93%	94%	82%
WRAP training	68%	78%	77%	82%

The compliance target for both PREVENT and WRAP training is 90%. Work towards achieving the WRAP target will continue in the next reporting period, incorporated as part of the objectives to improve Level 3 safeguarding children's training.

The Trust is required to have a dedicated PREVENT lead, which has been incorporated within the remit of the Safeguarding Lead Nurse. The Trust has made no PREVENT referrals during this reporting period.

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

Child Safeguarding Practice Reviews (CPSR) for children and Safeguarding 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.

During this reporting period a number of Learning Briefs have been published by the local Partnership Boards to share local learning following Safeguarding Children Rapid reviews. The emerging themes and key learning for UHBW includes:

Injuries to Non- Mobile Babies

- The need for more inclusion and focus on fathers, partners and other carers –
- To identify underlying vulnerabilities or potential concerns. The need to improve the identification of cumulative risk factors
- The importance of seamless information sharing between services
- The need to reduce incidents on Acute Head Trauma in babies (Link to ICON in report)

Young People and Self – Harm: Contextual Abuse;

- Appropriate use of the Mental Capacity Act for 17 & 17 year olds seen in ED
- Age appropriate assessment, including use of HEADESSS

Serious Youth Violence / Contextual Safeguarding

Since 2018 there have been seven reported serious violence incidents involving young people who have been stabbed. (Link to Barnardos ROUTES pilot project)

A thematic review of Child Criminal Exploitation (CCE) was undertaken and has highlighted the need for a more in- depth cross border review, which will be commissioned in the next reporting period**.** The review will include knife crime in the context of CCE, County Lines and Gang activity.

One case review report has been published during this reporting period –'Martyn' (Bristol Safeguarding Adult Reviews.

Key learning for UHBW includes:

- The need for robust Mental Capacity Assessment in relation to 'unwise decisions'
- The impact of social isolation and the need for meaningful activity
- The risks of Mate Crime and substance misuse.

Learning from all safeguarding reviews is considered through the Safeguarding Steering and Operational Groups and actioned by the Divisions.

12. Report summary and objectives for 2021/22

The safeguarding agenda for both children and adults and the adults Learning Disability agenda 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.

The full safeguarding consequences of the Covid pandemic are not yet fully known and the Trust must remain fully engaged with partner agencies to ensure a responsive and system wide response continues as far as possible.

Safeguarding remains a key priority for the Trust and this annual report summarises the key safeguarding activities, developments and achievements in what has been an exceptionally challenging 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 2021/22 available on request.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**Quality Account 2020/21**
Author	**Chris Swonnell, Head of Quality & Patient Experience**
Executive Lead	**Deirdre Fowler, Chief Nurse**

1. Report Summary

The draft annual Quality Account for UHBW is presented here for approval following scrutiny by the Quality & Outcomes Committee. This is the first Quality Account for UBHW as a merged organisation.

2. Key points to note

(Including decisions taken)

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

In 2020/21, as per 2019/20, NHS trusts have not been required to obtain assurance from their external auditor on their Quality Account / Quality Report. Similarly, NHS foundation trusts were once again not required to include a Quality Report in their Annual Report – hence the document presented this year for UHBW is technically a Quality Account, not a Quality Report.

The draft annual Quality Account is presented here for final comment prior to scrutiny by Quality & Outcomes Committee ahead of formal Board approval (and publication) later in July and publication in early August. The Quality Account is presented in complete form, with the exception of the signatures of the Chief Executive and Chief Chair at Appendix B which will be added following Board approval.

Please note:

- The report has not yet been proof-read – this will happen between Board approval and publication
- Requests for expanded narrative from the Bristol City Council People Scrutiny Commission (Appendix A part d) were received too late for incorporation in this year's report but will be factored into the 2021/22 report next year.

The Board has previously received an SBAR summary explaining the timeline for the publication of this year's Quality Account.

3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **Approval.**
5. History of the paper **Please include details of where paper has previously been received.**

Senior Leadership Team	21/7/21
Quality and Outcomes Committee	26/7/21

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University Hospitals Bristol and Weston
NHS Foundation Trust

Quality Account 2020/21

Contents

Part 1

1.1 Statement on quality from the Chief Executive

The year 2020-21 has been unprecedented and one that has affected us all, as the world responded to COVID-19. The global pandemic has changed all of our lives and forced us to adapt at home, at work, and in the way we interact with friends, family and colleagues. Face masks, social distancing and video calls have all become a new way of life. As I write this introduction to our annual Quality Account, restrictions are easing and we are beginning to see the positive impact of the vaccination programme.

For our staff at the Trust, together with the wider NHS, the focus of 2020/21 has been on our response to the pandemic and I am immensely proud of the way all of our staff have risen to the monumental challenge and continued to provide high quality care to our patients and adapted to ensure the safety of our patients and staff at our hospitals. In line with national guidance we reconfigured our wards, introduced enhanced PPE (personal protective equipment), moved to video and telephone consultations for routine appointments where appropriate and where a physical examination is not needed, and also needed to restrict visiting.

We cannot underestimate the significant impact the pandemic has had on our ability to deliver services. This has included the need to reschedule or postpone planned appointments, such as surgery, and I do not under-estimate the impact this has had on patients and their relatives. A priority for 2021-22 will be to work through the backlog of patients who are waiting, as quickly and safely as possible. I would like to thank our patients and their relatives for their understanding and support.

Whilst COVID-19 has dominated the headlines and been the major focus for the NHS, it is not all that has happened during the past 12 months – not least we became a new and bigger organisation. At the very start of the year Weston Area Health NHS Trust and University Hospitals Bristol NHS Foundation Trust merged to become University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). When the merger was agreed none of us could have imagined that the merger date would fall just weeks into a global pandemic.

Uniting the Trusts increases our diversity, capacity and resilience, and provides a unique opportunity to bring together the things that make the Weston and Bristol hospitals great places to work and receive care and the merger will make an even better and stronger organisation for the future.

In January 2021, our Board approved a new Quality Strategy which sets out a vision for quality over the next four years. Our strategy represents a key step on our ongoing journey to becoming one of the outstanding centres for care delivery, healthcare teaching, research and innovation. Our ambition is to deliver the safest care with the best patient experience in the NHS and, in that context, I commend our 2020/21 Quality Account to you. As ever, my thanks go to those who have prepared and contributed to this report, including Healthwatch, our commissioners and our governors. I am pleased to confirm that the Board of Directors has reviewed this 2020/21 Quality Account and I confirm that it is an accurate and fair reflection of our performance.

Robert Woolley
Chief Executive

Part 2

Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

2.1.1 Update on quality objectives for 2020/21

In view of the merger of University Hospitals Bristol NHS Foundation Trust (UH Bristol) with Weston Area Health NHS Trust (WAHT) on 1st April 2020 to form University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), it was agreed that the Trust's quality objectives for 2020/21 would focus on four areas where UH Bristol did not fully achieve its goals in 2019/20:

- Improving compliance with VTE (Venous thromboembolism) assessment
- Improving the availability of information about physical access to our hospitals to ensure patients and visitors know how to get to services in the easiest possible way, particularly patients with disabilities.
- Improving patient experience through roll out of the Trust's outpatients strategy and guiding principles
- Supporting and developing the participation of lay representatives in Trust groups and committees

It was agreed that these quality objectives would apply across the merged organisation and further that any outstanding annual quality objectives for WAHT would be taken forward via the annual operating plan for the newly created Weston Division.

It should be noted that these objectives were agreed prior to the COVID-19 pandemic, however by the start of the financial year 2020/21, the UK was experiencing the first wave of the pandemic, resulting in dramatic changes for the NHS workforce and the provision of healthcare services, which further confirmed the decision not to set more adventurous quality ambitions for the year.

A progress report is set out below, including a reminder of why we selected each theme, our improvement objective/s and an overall 'RAG' (Red/Amber/Green) rating of the extent to which we achieved each ambition.

Objective 1	**Improving compliance with VTE (Venous thromboembolism) assessment**
Rationale and past performance	Venous Thromboembolism (VTE) is a significant cause of mortality and disability in England. At least two thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and the administration of appropriate thrombo-prophylaxis. Since 2010, Trusts have been required to report quarterly on the number of adults admitted as inpatients in the month who have been risk assessed for VTE on admission to hospital using the criteria in the National VTE Risk Assessment Tool. The expectation for UHBW was to achieve 95 per cent compliance. Previously, VTE assessment compliance has been measured from paper records when patients are discharged; we recognise that this has not provided a true measure of VTE assessment compliance rates. Use of an

	electronic VTE risk assessment in Medway was implemented in our Bristol hospitals in August 2019. Compliance initially improved markedly to 79%, then fell away, before returning to a similar level by the end of 2019/20. We recognised that compliance needed to be optimised by support from divisions / specialities / consultants. Current significant barriers included variable use of the Medway system, and of mobile computer devices for ward rounds. Extreme pressures on capacity in the Trust were and remain a key issue, as was a culture that VTE risk assessment was a low priority for staff.
What did we say we would do?	Compliance had been particularly poor in the wards responsible for acute admissions. These areas are a challenge due to the high turnover of patients, multiple members of staff involved and other tasks to be completed on admission. A number of new initiatives led by key clinicians had commenced and we expected this to translate into improvements in the efficiency and completion of VTE risk assessments. We planned to incorporate digital VTE risk assessment into routine pre-operative assessment to improve compliance for elective surgical patients, and lastly we said we would explore the potential to appoint a dedicated VTE prevention nurse.
Measurable target/s for 2020/21	Although our target continues to be to meet the national standard, which requires at least 95 per cent of appropriate inpatients to have a VTE risk assessment, we did not anticipate this would happen until such time as there is a digital fully integrated system with a force function (a force function means that staff cannot complete a subsequent step of a process without completing a preceding step).
How did we get on?	Performance in Bristol has remained essentially static during 2020/21 and below our target, achieving 85.4% for the year as a whole compared to 87.4% in 2019/20. In Weston General Hospital the previous paper-based data collection / audit process ceased at point of merger and has yet to be replaced by a reliable alternative; a spot check audit in December 2020 showed 63% compliance. At the time of the launch of digital VTE risk assessments, there was an expectation that a fully digital integrated system was imminent (Electronic Prescribing and Medicines Administration was in use in the Bristol Haematology and Oncology Centre and the Bristol Heart Institute), whereby VTE risk assessments would be incorporated into admission or prescribing. However, there have been recurrent delays with the full digital roll out which has resulted in VTE risk assessment remaining as a standalone task in Medway (the Trust's patient administration system). This is seen as the biggest barrier to achieve the expected compliance. There were however some positive developments towards the end of the financial year: • The Trust's VTE group has reconvened and is working with our digital CICOs (Chief Clinical Information Officers), digital pharmacists and Medway team to find digital ways to optimise compliance with VTE risk assessments (including by linking with the Careflow workspace); the digital CICOs will also be working to continue to highlight the unacceptable delays in the full digital roll out due to supplier issues with the aim to achieve a solution, realistic timelines and ensure it remains an achievable goal. • A consultant VTE lead for Weston has been identified (subject to confirmation) who will link in with the Bristol VTE lead to identify and

	develop improvement opportunities. • A Quality Improvement project is underway to improve VTE risk assessment in Trauma and Orthopaedics on the Bristol site. Furthermore, there were no Serious Incidents in 2020/21 associated with VTE risk assessment and prescribing of VTE thrombo-prophylaxis.
RAG rating	Red – We did not make the progress we had been seeking in Bristol, and more robust asssurance is needed relating to the consistent use of VTE risk assessments at Weston General Hospital. Achieving improvements in VTE risk assessment will continue to be a focus for the Trust in 2021/22, driven through our VTE group working with the Digital Hospital Programme Board.

Objective 2	**Improving the availability of information about physical access to our hospitals to ensure patients and visitors know how to get to services in the easiest possible way, particularly patients with disabilities.**
Rationale and past performance	The hospitals which make up the Trust's Bristol site have grown and developed over the past hundred years. We receive consistent feedback that our estate can be challenging to navigate, particularly for patients and visitors with a physical disability. In 2019/20 we successfully secured charitable funding to enable the Trust to partner with an organisation called AccessAble.
What did we say we would do?	In 2020/21, working with AccessAble, we planned to create a detailed web-based access guide for patients and the public, providing visual and descriptive information about our Trust estate, including Weston General Hospital (WGH).
Measurable target/s for 2020/21	We said that success would be measured by implementation of the project, including production of a 'recommendations matrix' to guide future decisions about how and where we could improve access, subject to future funding.
How did we get on?	The delivery of this project experienced significant delays as a result of COVID-19 restrictions. AccessAble eventually commenced surveys of our hospital sites in central Bristol in October 2020 with a plan to begin surveys at Weston General Hospital the following month. In total, 63 of the 230 planned site surveys were completed in Bristol before surveying was once again paused due to the pandemic. At the time of writing, survey work is scheduled to re-start in the second quarter of 2021/22 with a projected formal launch of the completed Access Guides in the public domain by the end of the financial year 2021/22 (see quality objectives for 2021/22). This work is generously funded by Above and Beyond and the Weston General Hospital Charitable Fund.
RAG rating	Amber – Limited progress was made with site surveys due to the COVID-19 pandemic, however additional charitable funding was secured to enable the project to be extended into Weston General Hospital

Objective 3	**Improving patient experience through roll out of the Trust's outpatients strategy and guiding principles**
Rationale and past performance	We continue to recognise the inconvenience and stress caused to patients when there are delays to communication and booking of next steps following an outpatient clinic attendance. From a Trust operational perspective, delays in sending out the clinic letter also result in failure to meet the national seven-day clinic letter turnaround target. Missing or incorrect outcomes and delays in booking next steps increase the risk of breaching referral and treatment targets and the possibility of the patient coming to harm. The real time outpatients (RTOP) initiative was designed to allow all of the

	administrative tasks relating to a patient's clinic appointment to take place on the day of the visit. This means that patients would leave the clinic knowing what the next step in their treatment is, and when that will take place. It was designed to significantly reduce waste within the system by shortening the turnaround time for clinic letter production, enabling diagnostics, follow- up and 'to come in' (TCI) dates to be booked in a more timely manner. Finally, it would enable the appointment outcome, next steps on the patient pathway, and discharge (if applicable) to be confirmed as correct, known as validation in real time. In 2019/20, we took important steps towards implementing RTOP into a number of hospital specialties, however various factors limited progress, e.g. staff vacancies and sickness, IT systems, winter pressures, etc.
What did we say we would do?	During 2020/21, we said we would take a new approach to RTOP, incorporating it into our broader strategic approach to the outpatients programme, reflective of overall national strategy and the guiding principles of BNSSG CCG for the delivery of outpatients. We said that this strategy would include further digitisation of outpatient pathways, to include improvements in the production of letters, clinical triage, outcomes, patient communications and appointment bookings. We said that this would include a review of outpatient service delivery in Weston General Hospital and alignment of service access where possible.
Measurable target/s for 2020/21	Our targets were to: • Achieve seven day turnaround for all appropriate letters in specialities where real-time outpatients is implemented. • Improve the number of letters that are dictated checked and approved within 24 hours of the clinic appointment. • Reduce the number of letters sent out 14 days after clinic. • Reduce the number of missing outcomes (at the end of each appointment, an outcome must be recorded on the Trust patient administration system Medway; this is how the next step for the patient is booked) and the time spent by staff validating outcomes each month. • Reduce the 'Did not attend' rate for outpatient clinics. • Achieve seven day turn around for advice and guidance requests.
How did we get on?	We made huge progress in the delivery of outpatient services, although not in the way we had originally envisaged due to the pandemic. As part of the Trust's response to COVID-19, we took the opportunity to redesign elements of outpatient pathways, deploying e-RS (electronic referral service) advice and guidance. This service allows GPs and consultants to discuss and plan referrals making the most out of outpatient referrals. We have also deployed non-face-to-face video conferencing services, enabling patients to 'attend anywhere'. This deployment has been Trust-wide and at scale, representing significant improvements in the digitisation of the outpatient pathway and improved communication with patients and primary care. During 2020/21, non-face to face outpatient activity was rapidly scaled up so that around 30 per cent of outpatient consultations are now undertaken either by the phone or video (this is the equivalent of the NHS target by 2024). More than 1,900 clinical users of the Attend Anywhere system delivered over 28,000 virtual consultations 2020/21. This means that UHBW is one of the most rapidly growing users of virtual consultations in the South West region. Following feedback from our clinicians, the programme established a clinical reference group to deliver top tips and education to support clinicians to make the most of this new way in delivering patient care. Programme leads have also

	worked with the Trust's patient experience team to promote inclusivity and improve delivery of the service to inpatients and patients with communication needs. Patient feedback has been central to the development of the new service and over 9,000 patients have responded about their experience of virtual consultations. These views have supported the development of evidence for the effectiveness of video consultations in clinical practice and allowed reflection on future developments to reduce health care inequalities in patients accessing care in virtual settings (as well as reinforcing that virtual consultations are not the best way of meeting the needs of every patient). This feedback has led to a published paper 'The impact of increased outpatient telehealth during COVID-19: Retrospective analysis of patient survey and routine activity data from a major healthcare system in England.' (International Journal of Health Planning and Management, April 2021). This research has been used to inform the growing national body of evidence supporting the use of virtual consultations. Patient views have demonstrated that virtual consultations are an affective methodology for delivering patient care, however we have also learnt that virtual consultations are not for all patients and need to be balanced with the option of patients choosing face to face care when appropriate. The sustainability of this rapid redesign of outpatient delivery will be reviewed with the CCG and Healthier Together Programme for 2021/22.
RAG rating	Green – The goals we set ourselves at the start of the year no longer apply due to the pandemic, however Outpatient services have been successfully redesigned in response to COVID-19 with significantly improved patient experience ratings

Objective 4	**Supporting and developing the participation of lay representatives in Trust groups and committees**
Rationale and past performance	This objective set out to influence and develop the practice of lay partner involvement in UHBW as part of a growing move in the NHS to develop the concept and practice of patient leadership. This represented a continuation of a journey which commenced in 2016 with the patient and community leadership programme, "Healthcare Change Makers", which was a collaboration between UH Bristol, North Bristol NHS Trust and Bristol Community Health, with additional input from the local Clinical Commissioning Group and Healthier Together, with facilitation provided by the Centre for Patient Leadership and The King's Fund. In 2019/20, prior to merger, we completed a mapping exercise to identify which UH Bristol groups, formal networks, and committees had "lay representatives" on them and, in doing so, identified new opportunities for lay representation, including maternity services and the Learning Disabilities Steering Group.
What did we say we would do?	During 2020/21 we said we would: • Ensure that all of our lay representatives have attended our new training session • Develop and run a six-monthly update training and support programme • Develop an internal communications plan to more effectively publicise and promote the value of working with lay representatives and the processes for recruitment/training

	• Update our internal guidance for staff who are considering recruiting lay representatives • Undertake a mapping exercise of lay representation and networks at Weston General Hospital, including the existing Patient Council, with a view to implementing our new training there • Explore opportunities to partner with local health and social care providers so that UHBW training can be shared across organisations.
Measurable target/s for 2020/21	Our targets for 2020/21 were: • For all Trust lay representatives to attend introductory training • To develop and deliver an internal communications plan, to be launched in Quarter 3 2020/21 • To design and launch a half-yearly training update programme by the end of 2020/21
How did we get on?	At the beginning of 2020/21 we launched this work by holding a workshop with existing lay representatives and other colleagues to identify opportunities to improve the support and development we offer people in such roles. The workshop concluded that, whilst participants felt they understood their role, were respected and had influence, there were opportunities for improvements in the support offered (particularly emotional support), the connectivity between lay representatives (peer sharing) and the diversity of participants. Unfortunately, during the first quarter of the year the impact of COVID-19 resulted in the pausing of further work in relation to this objective including the recruitment of lay representatives to the Trust Learning Disabilities Steering Group in partnership with the Carers Support Centre and discussions with the former Patient Council at Weston General Hospital. This pause extended throughout 2020/21, apart from some planning activity to ensure we are well placed to make progress on this area of work in 2021/22; significantly, this includes capitalising on the potential that the delivery of the National Patient Safety Strategy offers the Trust in respect of modelling the new approach to lay representation that we originally set out to achieve.
RAG rating	Red – This objective is being carried forward to 2021/22

2.1.2 Quality objectives for 2021/22

In view of the fact that we anticipate that 2021/22 will be a year characterised largely by recovery and the restoration of services following the pandemic, the Trust has once again chosen a relatively small set of corporate quality objectives. We are carrying forward our objectives relating to the implementation of AccessAble and the development of lay representation in our organisation. Last year's VTE risk assessment objective will also continue to be a key patient safety focus for us in 2021/22, albeit not as a formal quality objective.

To our existing objectives, we are adding three new ones: firstly, a key objective to deliver the first year of the Trust's plan for implementing the NHS Patient Safety Strategy; secondly an objective focussing on improving the experience of patients with a Learning Disability; and thirdly, an objective aimed at improving patient experience of discharge from hospital.

Objective 1	**Delivering the NHS Patient Safety Strategy**
Rationale and past performance	In July 2019, NHS Improvement published the first ever national patient safety strategy, setting the direction of travel for patient safety in the NHS in England for the foreseeable future. The strategy recognises that: • Patient safety has made great progress since the publication of "To err is human" 20 years ago but there is much more to do. • The NHS does not yet know enough about how the interplay of normal human behaviour and systems determines patient safety. • The mistaken belief persists that patient safety is about individual effort. People too often fear blame and close ranks, losing sight of the need to improve. More can be done to share safety insight and empower people – patients and staff – with the skills, confidence and mechanisms to improve safety. • Getting this right could save almost 1,000 extra lives and £100 million in care costs each year from 2023/24. The potential exists to reduce claims provision by around £750 million per year by 2025. Addressing these challenges will enable the NHS to achieve its safety vision; to continuously improve patient safety. To do this, the NHS will build on two foundations: a patient safety culture and a patient safety system. Three strategic aims will support the development of both: 1. improving understanding of safety by drawing intelligence from multiple sources of patient safety information (Insight) 2. equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement) 3. designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement).
What will we do?	In 2020/21, we will deliver Year 1 of UHBW priorities to implement the national strategy. To do this we will: 1. Be ready to transition to new Patient Safety Incident Response Framework from March 2022 by: • Conducting a thematic situational analysis on which to base a UHBW incident response plan • Developing a UHBW patient safety incident response plan • Identifying, recruiting and developing trained, objective patient safety

	investigation specialists (note: achievement is reliant on access to Healthcare Safety Investigation Branch patient safety incident investigation training commissioned by NHS Improvement). 2. Further develop UHBW just and restorative culture by: • Delivering a programme of patient safety development in Weston to mirror existing provision in Bristol • Reviewing patient safety approach in UHBW to mitigate risk of blame culture. 3. Provide patient safety training and development in line with the National Patient Safety curriculum. Specifically: • Level 1 Health Education England training "essentials of patient safety" will be made available for all UHBW staff (note: compliance reporting is not required until 2022/23) • We will review existing patient safety training and development in UBHW and align with Health Education England principles in the interim. 4. Meaningfully involve patients and families in improving patient safety in UHBW. Specifically, in 2021/22 we will: • Conduct a "readiness for involvement" assessment and develop our involvement plan.
Measurable target/s for 2021/22	1. Revised interim patient safety approach in place: • Bristol and Weston patient safety update aligned and focusing on safety culture, safety systems, continuous improvement, human factors awareness and sharing learning from incidents by end Q1. • Moving towards patient safety incident investigations adopting HSIB principles and format by end Q2 2. Thematic situational analysis completed by end of Quarter 2. 3. Readiness for involvement assessment completed and plan in place by end of Quarter 2. 4. Measurement of the percentage attendance for patient safety update training for clinical staff in Weston by the start of Quarter 3. 5. Patient safety incident response plan drafted by end Quarter 3, with Board approval by the end of Quarter 4. 6. Trained patient safety incident investigators in place by end of Quarter 4.
How progress will be monitored	Through quarterly reporting to: Patient Safety Group, Clinical Quality Group and Senior Leadership Team.
Board sponsors	Chief nurse and medical director
Implementation lead	Head of quality and patient safety

Objective 2	**Improving the availability of information about physical access to our hospitals to ensure patients and visitors know how to get to services in the easiest possible way, particularly patients with disabilities.**
Rationale and past performance	The hospitals which make up the Trust's Bristol site have grown and developed over the past hundred years. We receive consistent feedback that our estate can be challenging to navigate, particularly for patients and visitors with a physical disability. In 2019/20 we successfully secured charitable funding to enable the Trust to partner with an organisation called AccessAble to survey our estate and produce on-line Access Guides. Work to achieve this objective

	commenced in 2020/21 but was paused as a result of the COVID-19 pandemic.
What will we do?	In 2021/22, working with AccessAble, we will re-commence the surveying of over 230 locations and create detailed web and app-based access guides for patients and the public, providing visual and descriptive information about our Trust estate, including Weston General Hospital.
Measurable target/s for 20221/22	Success will be measured by implementation of the project, including production of a 'recommendations matrix' to guide future decisions about how and where we could improve access, subject to future funding.
How progress will be monitored	Via the Patient Inclusion and Diversity Group, reporting to Patient Experience Group
Board sponsor	Chief nurse
Implementation lead	Patient and public involvement lead

Objective 3	**Supporting and developing the participation of lay representatives in Trust groups and committees**
Rationale and past performance	This objective sets out to influence and develop the practice of lay partner involvement in UHBW as part of a growing move in the NHS to develop the concept and practice of patient leadership. This represents a continuation of a journey which commenced in 2016 with the patient and community leadership programme, "Healthcare Change Makers", which was a collaboration between UH Bristol, North Bristol NHS Trust and Bristol Community Health, with additional input from the local Clinical Commissioning Group and Healthier Together, with facilitation provided by the Centre for Patient Leadership. At the beginning of 2020/21 we launched this work by holding a workshop with existing lay representatives and other colleagues to identify opportunities to improve the support and development we offer people in such roles. The workshop concluded that, whilst participants felt they understood their role, were respected and had influence, there were opportunities for improvements in the support offered (particularly emotional support), the connectivity between lay representatives (peer sharing) and the diversity of participants. Whilst the impact of COVID-19 resulted in the pausing of significant progress in relation to this objective there has been some activity to ensure we are well placed to make progress on this area of work in 2021/22. Significantly, this includes capitalising on the potential that the delivery of the National Patient Safety Strategy offers the Trust in respect of modelling the new approach to lay representation that we originally set out to achieve (see Objective 1 above).
What will we do?	During 2021/22 we will: • Devise and launch a new support and development package for lay representatives including refreshed recruitment materials • Develop an internal communications plan to more effectively publicise and promote the value of working with lay representatives and the processes for recruitment/training • Update our internal guidance for staff who are considering recruiting lay representatives • Increase the number of opportunities for lay representatives to join the organisation as volunteers • Develop and support the former Weston General Hospital Patient Council as a corporate patient feedback resource

	• Explore opportunities to partner with local health and social care providers so that UHBW training can be shared across organisations. • Support the implementation of the National Patient Safety Strategy as it relates to lay representation
Measurable target/s for 2020/21	Our targets for 2021/22 are: • For all Trust lay representatives to attend at least one training, support and development activity • To develop and deliver an internal communications plan, to be launched in Quarter3 2021/22 • To have recruited at least four new lay representatives to Trust groups • To have mapped out an implementation plan to deliver that part of the National Patient Safety Strategy as it relates to lay representation
How progress will be monitored	Via quarterly reports to the Patient Experience Group
Board sponsor	Chief nurse
Implementation lead	Patient and public involvement lead

Objective 4	**Improving the experience of patients with a learning disability**
Rationale and past performance	Research shows that people with learning disabilities have poorer health and receive poorer healthcare than people without learning disabilities. Patients with a learning disability who access services provided by our Trust should expect to be cared for and communicated with by staff skilled in recognising complex care needs in both inpatient and outpatient environments. We want to ensure patients with a learning disability and the people who care for them feel engaged and listened to, and that they have a voice in how we plan and deliver services. Legislation requires that public bodies, including providers of health and social care, monitor their performance in identifying and addressing these issues. https://digital.nhs.uk/services/general-practice-gp-collections/service-information/learning-disabilities-observatory UHBW has submitted data to NHS Digital as a newly merged organisation, leading to the development of a robust improvement plan where shortfalls in service provision were identified. UHBW is also committed to learning from the recommendations of an independent review into the death of Oliver McGowan, a young man with a mild learning disability and autism who had received care from numerous agencies across Bristol, North Somerset and South Gloucestershire. The Trust currently employs a small team of learning disability nurses who advise, support and signpost staff with enquiries; they carry out some clinical assessments but do not currently offer any regular in house training.
What will we do?	We will: • Hold a learning disability 'Health Matters' interactive virtual learning event in the first quarter of the year; external and internal speakers will be invited as well as a carer with lived experience and a person with autism; invitations will be sent to all staff within the organisation, as well external professionals nationally/locally and carers/people with a learning disability.

	• Ensure that identified staff from across the Trust from a range of disciplines complete the Oliver McGowan pilot tier one and two training programme (20 Tier 2 training places are available for UHBW). Tier 1 training is designed for all staff including volunteers who have limited contact with people with a learning disability/Autism; Tier 2 is a blended all day face to face/online event, aimed at staff who have clinical involvement with people with a learning disability/autism. The pilot for both tiers will run until November 2021. The 20 staff chosen to attend Tier 2 training are from a wide spectrum of professions within our organisation. The pilot also provides an opportunity for UHBW to influence the national mandatory training proposal. • Establish and expand a new network of Learning Disabilities Champions across the Trust who will identify early in a patient's journey their care needs and the resources needed to meet those needs. • Participate in a BNSSG system-wide pilot project to develop and implement a robust system to record Reasonable Adjustments; this will support staff to identify people with a learning disability and ensure they receive equitable care and treatment. • Undertake reviews of the Emergency Department (BRI/BRCH/BEH & Weston) environments for patients with sensory impairments and/or learning disabilities; this will be a peer review with North Bristol NHS Trust, led by the patient experience team and with service user engagement, with the aim of identifying improvements aimed at reducing anxiety and distress for patients and their carers. • Develop with the ED team prompt cards to assist in our out-of-hours attendance and management of people with a learning disability. • With the help of our clinicians, carry out a retrospective audit of ReSPECT forms for people with a learning disability during the Covid-19 pandemic, looking at the use of the Mental Capacity Act (2005) and best interest decision making; any learning will be shared and used to improve practice. • Develop a standard operating procedure (SOP) for adding learning disability alerts to our Medway patient administration system; this will ensure that patients who present with a learning disability will have an alert flag on their hospital record which correctly reflects their diagnoses and any requirements for reasonable. • Organise an autism whole day event with invited speakers including those with lived experience (although at present the Trust does not currently have a commissioned autism service, we recognise that people with a learning disability can also have an autism diagnoses - having an awareness event will allow staff to engage and take learning to further support positively this cohort of patients). • Work collaboratively with BNSSG partners to carry out an 'end to end' review of the patient pathway followed by Oliver McGowan to ensure lessons are learned. • Make a bid to our hospital charity 'Above and Beyond' for equipment and resources to improve the experience of people with a learning disability, such as noise reducing headphones, sensory distraction equipment and communication books. • Relaunch the learning disability group at Weston General Hospital; this is a multidisciplinary group with an agenda led by service users and their carers.
Measurable	Our target is to deliver each of the commitments set out above.

target/s for 2021/22	
How progress will be monitored	Via Learning Disability Steering Group and BNSSG Learning Disability/Autism provider network
Board Sponsor	Chief Nurse
Implementation lead	Head of Safeguarding & Learning Disability Services

Objective 5	**Improving patient experience of discharge from hospital**
Rationale and past performance	A well organised and timely discharge for patients is an important element of their hospital journey. We know from patient feedback that receiving a safe, coordinated and planned discharge helps patients and their families to leave hospital feeling as if they have been well looked after, and well prepared to adapt back to their home environment. Discharging our patients earlier in the day also supports the flow of patients across the organisation, enabling UHBW to deliver a proficient, safe and appropriate admission pathway for patients. We have previously set annual quality objectives relating to improving discharge (most recently in 2016/17), but we recognise that there is more work to do.
What will we do?	During 2021/22, we will: • Focus in particular on releasing time for staff to be able to deliver improvements in discharging patients from hospital. We will undertake diagnostic work, through a time in motion study, by observing our nursing staff, quantifying time undertaken on non-value-adding tasks, enabling the teams to be freed up to plan and deliver an improved discharge experience for our patients. • Create qualitative channels (via questionnaires and focus groups) to encourage staff to identify efficiency savings in the way they perform their duties in order to create additional capacity to progress safe and timely patient discharges. • Work in partnership with local Healthwatch to better understand patients' experiences of discharge from hospital and to co-design service improvements. We also envisage that this will, by its nature, be an iterative objective and that further ideas and initiatives will emerge and be explored as the year progresses.
Measurable target/s for 2020/21	Success will be measured in the achievement of the plans described above, and specifically in achieving a measurable improvement in timely discharge from hospital.
How progress will be monitored	Delivery of the time in motion study and identified recommendations for delivery will be monitored through the Productive Hospital Steering Group, and Restoration Oversight Group. Co-production activity with local Healthwatch will be monitored via Patient Experience Group.
Board sponsors	Chief nurse and chief operating officer / deputy chief executive
Implementation leads	Deputy chief operating officer Improvement lead, Transformation Team Assistant chief nurse

2.2.2 Participation in clinical audits and national confidential enquiries

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

During 2020/21, 58 national clinical audits and four national confidential enquiries covered NHS services that University Hospitals Bristol and Weston NHS Foundation Trust provides. During that period, University Hospitals Bristol and Weston NHS Foundation Trust participated in 82 per cent (45/55) of national clinical audits and 33 per cent (1/3) of the national confidential enquiries of which it was eligible to participate in. Five national audits and two confidential enquiries were cancelled or postponed due to Covid-19, while some other national audits suspended mandatory data submissions but continued to collect data where participating units were able to provide it.

Table 1 lists the national clinical audits and national confidential enquiries that University Hospitals Bristol and Weston NHS Foundation Trust was eligible to participate in during 2020/21 and whether it did participate:

Table 1

Name of audit / programme	Participated
Acute, urgent and critical care	
Case Mix Programme (CMP) – Intensive Care	Yes
Emergency Medicine QIPs – Fractured Neck of Femur	Yes
Emergency Medicine QIPs – Pain in Children	Yes
Emergency Medicine QIPs – Infection Control	Yes
Major Trauma Audit (TARN)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Emergency Laparotomy Audit (NELA)	Yes †
Perioperative Quality Improvement Programme (PQIP)	Yes †
Sentinel Stroke National Audit programme (SSNAP)	Yes
Society for Acute Medicine Benchmarking Audit (SAMBA)	No *
Blood and infection	
Mandatory Surveillance of Healthcare Associated Infections (HCAI)	Yes
National Comparative Audit of Blood Transfusion – Perioperative Paediatric Anaemia	No *
NHS Provider Interventions with Suspected / Confirmed Carbapenemase Producing Gram Negative Colonisations / Infections	No *
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes
Cancer	
UK Registry of Endocrine and Thyroid Surgery	No
National Audit of Breast Cancer in Older People (NABCOP)	Yes
National Bowel Cancer Audit (NBOCA) – part of NGICP[1]	Yes
National Lung Cancer Audit (NLCA)	Yes
National Oesophago-Gastric Cancer (NAOGC) – part of NGICP[1]	Yes
National Prostate Cancer Audit (NPCA)	Yes

Elderly care	
Fracture Liaison Service Database (FLS) – part of FFFAP[2]	Yes
National Audit of Inpatient Falls (NAIF) – part of FFFAP[2]	Yes
National Hip Fracture Database (NHFD) – part of FFFAP[2]	Yes
Vertebral Fracture Sprint Audit – part of FFFAP[2]	Yes
National Audit of Dementia (NAD)	No *
National Joint Registry (NJR)	Yes
End of life care	
National Audit of Care at the End of Life (NACEL)	Yes
Heart	
Adult Cardiac Surgery (ACS) – part of NCAP[3]	Yes †
Cardiac Rhythm Management (CRM) – part of NCAP[3]	Yes
Myocardial Ischaemia National Audit Project (MINAP) – part of NCAP[3]	Yes †
National Audit of Cardiac Rehabilitation (NACR)	Yes †
National Audit of Percutaneous Coronary Interventions (PCI) – part of NCAP[3]	Yes †
National Congenital Heart Disease (CHD) – part of NCAP[3]	Yes
National Heart Failure Audit (NHF) – part of NCAP[3]	Yes
Long term conditions	
British Association of Urological Surgeons (BAUS) Female Stress Urinary Incontinence Audit	No ‡
BAUS Cytoreductive Radical Nephrectomy Audit	No *
Cleft Registry and Audit Network (CRANE)	Yes
National Asthma Audit – part of NACAP[4]	Yes †
National COPD Audit – part of NACAP[4]	Yes
National Early Inflammatory Arthritis Audit (NEIAA, formerly NCAREIA)	Yes †
National Diabetes Core Audit (NDA)	Yes †
National Diabetes Foot Care Audit (NDFA) – part of NDA	Yes
National Diabetes Inpatient Audit (NaDIA) – part of NDA	No *
National Pregnancy in Diabetes Audit (NPID) – part of NDA	Yes
National Ophthalmology Audit (NOD)	Yes
UK Cystic Fibrosis Registry	Yes
Inflammatory Bowel Disease programme / IBD Registry	No
Women's & Children's Health	
Antenatal and Newborn National Audit Protocol 2019 to 2022	Yes
National Audit of Seizures / Epilepsies in Children / Young People (Epilepsy 12)	Yes
National Maternity and Perinatal Audit (NMPA)	Yes
National Neonatal Audit Programme (NNAP)	Yes
National Paediatric Diabetes Audit (NPDA)	Yes †
Neurosurgical National Audit Programme	Yes
Paediatric Intensive Care Audit Network (PICANet)	Yes
Confidential enquiries/outcome review programmes	
Child Health Clinical Outcome Review Programme	No *
Learning Disabilities Mortality Review Programme (LeDeR)	Yes
Medical and Surgical Clinical Outcome Review Programme	No *

* National decision to close or postpone audit during 2020/21
† Data collection remained open, but without mandatory submission requirement
‡ No publication of 2020 data, to be replaced with an NHS Digital national registry
[1] NGCIP: National Gastro-Intestinal Cancer Programme
[2] FFFAP: Falls and Fragility Fractures Audit Programme
[3] NCAP: National Cardiac Audit Programme
[4] NACAP: National Asthma and COPD Audit Programme

Of the above national clinical audits and national confidential enquiries, those which published reports during 2020/21 are listed in Table 2 alongside the number of cases submitted to each, where known. Where relevant, this is presented as a percentage of the number of registered cases required by the terms of that audit or enquiry. Due to variation in sample selection and publication dates, these cases may be from time periods earlier than 2020/21.

Table 2

Name of audit / programme	
Acute, urgent and critical care	
Case Mix Programme (CMP)	3784 (100%)
Major Trauma Audit (TARN)	68-79%*
National Emergency Laparotomy Audit (NELA)	226*
National Audit of Seizure Management in Hospitals (NASH3)	27 (98%)
Sentinel Stroke National Audit programme (SSNAP)	739 (100%)
Society for Acute Medicine Benchmarking Audit (SAMBA) – Jan 2020 data	Unknown
Blood and infection	
Surgical Site Infection Surveillance Service	730*
Cancer	
National Bowel Cancer Audit (NBOCA)	158 (120%)**
National Lung Cancer Audit (NLCA)	299 (92%)
National Oesophago-Gastric Cancer (NOGCA)	125 (85-100%
Elderly care	
Fracture Liaison Service Database (FLS)	Unknown
National Hip Fracture Database (NHFD)	532 (100%)
National Joint Registry (NJR)	474*
Heart	
Cardiac Rhythm Management (CRM)	918*
Myocardial Ischaemia National Audit Project (MINAP)	840 (73%)
National Audit of Percutaneous Coronary Interventions (PCI)	1857 (100%)
National Congenital Heart Disease Audit (NCHDA)	Unknown
National Heart Failure Audit (NHF)	815*
Long term conditions	
National Asthma Audit	312*
National COPD Audit	839
National Early Inflammatory Arthritis Audit (NEIAA, formerly NCAREIA)	Unknown
National Diabetes Foot Care Audit (NDFA)	Unknown
National Pregnancy in Diabetes Audit (NPID)	Unknown

Women's & Children's Health	
Antenatal and Newborn National Audit Protocol	5199*
National Neonatal Audit Programme (NNAP)	459*
National Paediatric Diabetes Audit (NPDA)	475*
Neurosurgical National Audit Programme	725*
Paediatric Intensive Care Audit Network (PICANet)	2206 (99%)
Confidential enquiries/outcome review programmes	
Learning Disabilities Mortality Review Programme (LeDeR)	Unknown
Maternal, Newborn and Infant Clinical Outcome Review Programme	Unknown

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

The outcomes and proposed actions from completed projects are usually reviewed by the Trust Clinical Audit Group. Throughout 2020/21 and as a result of the pandemic, this group was stood down for clinical and operational reasons. Usually processes will resume during 2021/21.

2.2.3 Participation in clinical research

UHBW leads and collaborates in world-class clinical research that contributes to the evidence that guides the services offered by the NHS. As a key partner in Bristol Health Partners Academic Health Science Centre (AHSC), we work closely alongside our university, NHS and city council partners in the region to improve health and service delivery in Bristol, North Somerset and South Gloucestershire.

Our role at the forefront of translational and clinical research is enabled through substantial infrastructure funding awarded by the National Institute for Health Research (NIHR) to fund the Applied Research Collaborative (ARC West) and the Biomedical Research Centre (Bristol BRC). We also hold a significant number of NIHR career development awards and project and programme grants. Added to this is a research portfolio funded by our partners in the charitable and industry sectors. Above and Beyond, the official charity supporting the work of all our hospitals provides significant funding to pump prime small research projects, which are designed to lead onto NIHR grants. The whole spectrum of work is supported and facilitated by the Bristol-based arm of the NIHR Research Design Service South West (RDS-SW) and the UK Clinical Research Collaboration- registered Bristol Trials Centre (BTC). We also host and work in close partnership with the NIHR Local Clinical Research Network (CRN West of England) to deliver a balanced portfolio of research to our local and specialist patient population.

Over the last year, our excellent working relationships with partner organisations in the CRN West of England have been cemented through the work we have done to deliver COVID-19 Urgent Public Health (UPH) research, both to develop licensed vaccines at-pace and to identify effective treatments for patients suffering from COVID-19. Internally within the trust we reconfigured the medical research leadership and research delivery team support for the UPH in-patient research and recruited a team of research staff to deliver vaccine trials, including very early phase research. This allowed us to maximise effectiveness during this difficult time, recruiting 3,614 participants into COVID-19 UPH research. Alongside this where possible, research teams continued to recruit to our most important non COVID research, ensuring that patients continued to have access to potentially life-saving or -changing specialist trials.

The number of patients receiving relevant health services provided or subcontracted by UHBW in 2020/21 that were recruited during that period to participate in research approved

by a research ethics committee was 6,377. This compares with 7,011 in 2019/20.

2.2.4 CQUIN framework (Commissioning for Quality and Innovation)

The practical operation of CQUIN (both CCG and specialised) for NHS providers was suspended in 2020/21 due to the COVID-19 pandemic. During this time, NHS providers were not required to carry out CQUIN audits or submit CQUIN performance data.

2.2.5 Care Quality Commission registration and reviews

University Hospitals Bristol and Weston NHS Foundation Trust is required to register with the Care Quality Commission (CQC). Its status at the end of the year 2020/21 was 'registered without compliance conditions'. The CQC did not take enforcement action against the Trust during 2020/21.

UHBW received three focussed CQC inspections during the course of 2020/21, as follows:

- Focussed inspection of Emergency Department at Weston General Hospital in July 2020
- Focussed inspection of Emergency Department at Bristol Royal Infirmary in February 2021
- Focussed inspection of Medical care at Weston General Hospital in March 2021

Following these inspections the CQC highlighted various requirements and recommendations to improve quality care, in response to which the Trust has taken prompt action. No new service ratings were assigned by the CQC as part of these inspections and, at the time of writing, UHBW's overall CQC rating continues to be 'Outstanding'.

2.2.6 Data quality

UHBW submitted records in two separate flows for Bristol and for Weston during 2020/21 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES), which are included in the latest published data.

The percentage of records for UHBW:

- which included the patient's valid NHS number was: 99.6 per cent for admitted patient care; 99.8 per cent for outpatient care; and 98.1 per cent for accident and emergency care.
- which included the patient's valid general practice code was: 99.2 per cent for admitted patient care; 99.9 per cent for outpatient care and 99.0 per cent for accident and emergency care.

(Data source: NHS number, Trust statistics. GP Practice: NHS Information Centre, SUS Data Quality Dashboard, April 2020 – March 2021 extracted 21/04/2021. Data was compiled separately for Bristol and Weston from respective submissions of CDS and ECDS to SUS, but has been aggregated locally to provide UHBW totals)

UHBW completed 107 of 110 mandatory requirements in the 2021/22 Data Security and Protection Toolkit and submitted an Improvement Plan to NHS Digital to achieve the remaining requirements. NHS Digital approved this Improvement Plan and UHBW's Data Security and Protection Toolkit Assessment is "Standards Not Fully Met – Plan Agreed".

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

In February 2021, the Trust commissioned an External Clinical Coding Audit in Bristol to fulfil the DS&P Toolkit requirement. The audit reviewed a total of 200 episodes from the Specialities of Thoracic Surgery, Hepatobiliary and Pancreatic Surgery, Upper Gastroenterology, Paediatric Surgery and Paediatric Gastroenterology. The episodes audited were randomly selected from April – September 2020 data. The audit focussed on primary diagnoses and procedures as well as completeness of codes including comorbidities. These percentages achieved meet the mandatory level of attainment for an Acute Trust in line with HSCIC's Data Quality Standard 1 and exceed that for Standard 3 Training.

The following levels of accuracy were achieved:

- Primary diagnosis accuracy: 93.0 per cent
- Primary procedure accuracy: 91.6 per cent

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

Weston also commissioned an external audit (in November 2020, which looked at October 2020 activity) and their levels of accuracy were:

- Primary diagnosis accuracy: 95.0 per cent
- Primary procedure accuracy: 92.0 per cent

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

- The data quality programme involves a regular data quality checking and correction process. This involves the use of daily reports by the Medway support team that have identified errors and queries in Medway. Some errors are corrected centrally, but may involve users across the Trust in the correction (this includes staff in clinical Divisions checking with the patient for their most up to date demographic information).

- The Bristol clinical coding team have a plan in place to follow through on the recommendations from the Bristol External Audit to improve the quality of coding:

    - Implement an effective internal audit programme to achieve and record improved accuracy rates
    - Prioritise a programme of clinical validation of clinical coded data
    - Support protected in-house mentoring sessions for novice Coders

- Recommendations from Weston coding audit:

    - Initiate a training session to all clinical coders based on the coding errors identified in this audit (Comorbidities/More detailed study of the operation documentation)
    - Promote collaborative working between coders and clinicians in all specialties

2.3 Mandated quality indicators

In February 2012, the Department of Health and NHS Improvement announced a new set of mandatory quality indicators for all Quality Accounts and Quality Reports. The Trust's performance in 2020/21 (or, in some cases, latest available information which predates this) is summarised in the table below. The Trust is confident that this data is accurately described in this Quality Account.

Table 3

Mandatory indicator	UHBW Most Recent	National average	National best	National worst	UHBW Previous
Venous thromboembolism risk assessment	77.9% 2019/20 Q3 (UHB)	95.0%	100%	71.6%	85.3% 2019/20 Q2
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over). Total Cases	26.2 2019/20 (UHB)	37.4	0.0	143	27.0 2018/19
Rate of patient safety incidents * reported per 1,000 bed days	76.3 Oct19-Mar20 (UHB)	50.7**	110.2**	15.7**	76.7 Apr19-Sep19
Percentage of patient safety incidents* resulting in severe harm or death	0.39% Oct19-Mar20 (UHB)	0.33%**	0.0%**	1.49%**	0.40% Apr19-Sep19
Responsiveness to inpatients' personal needs	70.0 2019/20 (UHB)	67.1	84.2	59.5	71.3 2018/19
Percentage of staff who would recommend the provider	83.3% 2020 survey	73.2%	91.7%	49.7%	85.4% 2019 survey
Summary Hospital-level Mortality Indicator (SHMI) value and banding	93.6 (Band 2 "As Expected") Feb20-Jan21	100.0	73.4	119.4	98.4 (Band 2 "As Expected") Feb19-Jan20
Percentage of deaths with specialty code of 'palliative medicine' or diagnosis code of 'palliative care'	33% Feb20-Jan21	37%	62%	7%	35% Feb19-Jan20
Emergency readmissions within 30 days of discharge: age 0-15	10.5% 2019/20 (UHB)	12.6%	2.2%	56.7%	10.2% 2018/19
Emergency readmissions within 30 days of discharge: age 16 or over	13.1% 2019/20 (UHB)	10.5%	1.9%	37.7%	13.3% 2018/19

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

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

Part 3

Review of services in 2020/21

3.1 Patient Safety

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

During 2021/22 we will be preparing a new framework for responding to patient safety incidents aligned with the new NHS Patient Safety Strategy launched in July 2019, but implementation delayed due to the COVID-19 pandemic.

3.1.1 Our Patient Safety Improvement Programme 2019-2021

#DeliveringSaferCare

Our current Patient Safety Improvement Programme commenced in 2019 prior to the merger with Weston Area Health Trust in April 2020, but will be refreshed during 2021-22 as a UHBW wide programme. The purpose of the Trust's Patient Safety Improvement Programme is to provide a framework and structure to take forward quality and safety improvements across the trust, focus on internal and external improvement opportunities identified from systematic learning and new developments. The programme underpins the Trust's commitment to continuous improvement and is aligned with the UHBW Quality Strategy 2021-2025.

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

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

Our Patient Safety Improvement Programme was largely paused in 2020-21 due to the impact of the COVID-19 pandemic. However our Transformation Team led work in UHBW on a national adoption and spread COVID Oximetry@ home project. This rapid project developed as a result of national learning from Wave 1 of the pandemic and enabled patients with COVID-19 to be monitored at home using pulse oximetry. This enabled patients with COVID-19 who could safely self-isolate at home to do so whilst, ensuring those with early signs of deterioration and reduced oxygen levels (silent hypoxia) to be admitted to hospital earlier for respiratory support to given them a better chance of a good outcome. For UHBW this meant ensuring patients recovering from COVID-19 could be monitored following discharge from hospital for signs of a reversal in their recovery.

World Patient Safety Day 17 September 2020

We were also able to participate in the second World Patient Safety Day on 17th September 2020 which had a focus on health worker safety recognising that working in stressful environments during the pandemic makes health workers more prone to errors which can lead to patient harm. Our focus was necessarily on a virtual awareness campaign including thank you messages to staff and supported by socially distanced access to resources for staff about raising concerns and speaking up about staff safety.

3.1.2 Freedom to Speak Up

The Trust has a Freedom to Speak Up Guardian (FTSUG) to whom all staff can raise concerns. To support the work of the Guardian at the point of merger with Weston Area Health NHS Trust, a full-time Deputy FTSUG was appointed on 1 April 2020. To help raise awareness of speaking up and provide more local support for staff to raise concerns a network of more than 80 FTSU champions have been recruited from across the Trust. Since November 2020, in-house training has been provided for champions in association with the psychological services team.

Individuals who raise concerns are supported by the Guardian or Deputy Guardian and receive feedback following investigations into their concerns. The impact of the coronavirus pandemic and the merger with Weston Area Health NHS Trust were evident in the increase in the numbers of concerns raised via the FTSU Guardian in 2020/21 (112 concerns compared to 55 the previous year). Half of the concerns for the year were raised from the division of Weston, with the remainder of concerns split fairly evenly across the remaining divisions. Concerns were heard from all staff groups, except dentists, though the majority of concerns are raised by admin and clerical and nursing staff.

Most of the concerns raised relate to attitudes and behaviours (45 per cent) with the next highest category policies, procedures and processes (37 per cent). There were 12 quality and safety concerns raised in the year. Where there are concerns relating to quality or safety, these are escalated to the Chief Nurse or Medical Director to investigate and take appropriate action. Just over 40 per cent of concerns referenced the pandemic.

The FTSUG is not the only one mechanism through which staff can raise concerns. The Trust also has the following groups or processes which can support staff, alongside an external employee assistance programme:

- Joint Union offices
- Occupational health
- Employee services
- Safeguarding team
- Patient Safety team
- Staff governors
- Staff networks (ABLE+, BAME, LGBT)

Alongside posters and other materials around the Trust which describe what speaking up is and how to contact the FTSUG, regular communications about speaking up in the weekly all staff newsletter, and FTSUG updates to different teams and departments, the introduction of mandatory Speak Up training for all staff from 1 February 2021 will further increase awareness of the FTSU programme and the role of the Guardian.

The challenge remains in recognising the role of leaders and managers in driving improvement in staff experience and wellbeing and therefore speaking up – and appropriately investing in development and support in this area as part of a wider programme of cultural change.

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

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

The Trust has two Guardians of Safe Working for Junior Doctors - Dr Alistair Johnstone for the Bristol hospitals and Mr John Probert for the Weston site. Guardian of Safe Working for Junior Doctors reports are published by the Trust at https://www.uhbw.nhs.uk/p/about-us/reports-and-publications

3.1.4 Never Events

There were six never events reported in our Trust in 2020/21:

- Misconnection of oxygen tubing to an air flowmeter in Weston General Hospital Emergency Department (July 2020)
- Wrong site new block in Weston General Hospital Emergency Department (September 2020)
- Retained laparoscopic retrieval bag Bristol Children's Hospital theatres (September 2020)
- Wrong site nerve block Weston General Hospital theatres (October 2020)
- Retained suture needle Bristol Children's Hospital theatres (identified November 2020- historic incident from 2019)
- Wrong site excision of basal cell carcinoma (adjacent lesion excised), NHS patient but private provider (November 2020)

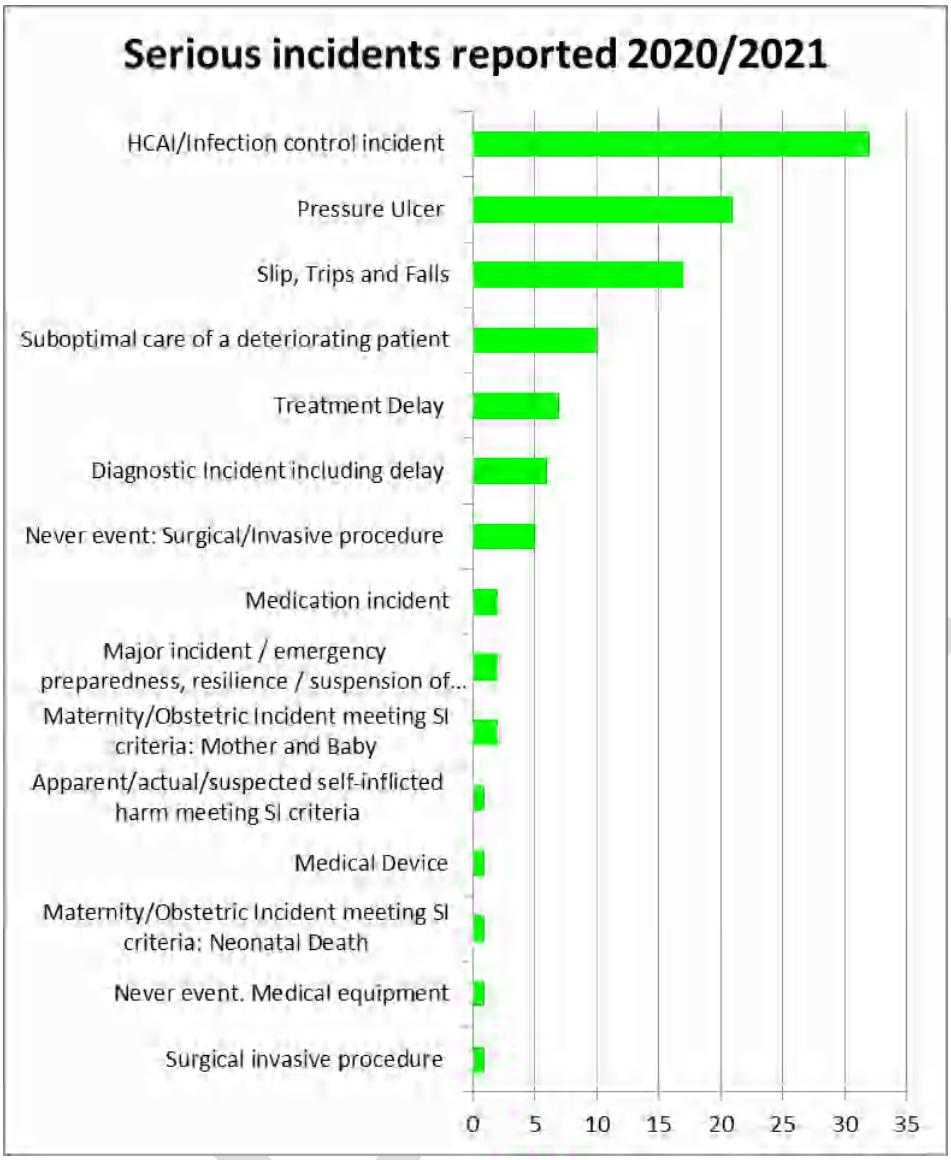
Investigations from all six never events have been completed. Examples of improvements we have made as a result of our investigations include:

- Work across Bristol and Weston sites to strengthen the "Stop before you block" check before a nerve block embedded in a single fractured neck of femur pathway as part of our improvement programme work on reducing the risk of invasive procedure never events.
- A refreshed structure in the Bristol Royal Hospital for Children's theatres for oversight and learning from reported incidents. Introduction of revised scrub policies and practices. Specimen handling processes have been reviewed with a pilot of new practices in place.
- Review of barriers to prevent misconnection of oxygen tubing to air flowmeters by introducing electric nebulisers in Weston General Hospital to enable airflow meters to be permanently removed from wall air outlets

3.1.5 Serious incidents

The purpose of identifying and investigating serious incidents, as with all incidents, is to understand what happened, learn and share lessons, and take action to reduce the risk of a recurrence. The decision that an event should be categorised as a serious incident is usually made by an executive director. Throughout 2020/21, the Trust Board was informed of serious incidents via its monthly quality and performance report. The total number of serious incidents reported for the year was 109 for UHBW, compared to 73 in 2019/20 for UH Bristol and 30 for Weston Area Health NHS Trust. Two serious incidents were requested to be downgraded. A breakdown of the categories of the 109 serious incidents is provided in Figure 1 below.

Figure 1



Healthcare associated infections were the most frequently reported serious incident in 2020/21 involving patients who died following hospital onset COVID-19. A total of 25 cases were identified Wave 1 of the pandemic , 18 of which related to an outbreak at Weston General Hospital in April/May of 2020. Seven further cases were also identified relating to early in Wave 2 of the pandemic which were reported as serious incidents, with further reviews of cases of patients who died later on in Wave 2 currently on-going.

There was an increase in hospital acquired grade 3 pressure ulcers and unstageable pressure ulcers in 2020/21 some of which related to pressure from equipment such as oxygen tubing causing tissue damage on patients' faces when in the prone position to maximise respiratory function. These were mainly seen during Wave 1 of the pandemic with a significant reduction in Wave 2 due to changes in practice as a result of learning.

Inpatient falls where patients suffered a fractured neck of femur reduced to 17 across UHBW in 2020/21 (compared with 16 in UH Bristol and seven for Weston Area Health NHS Trust in

2019/20). Falls improvement work has recommenced in 2021/22 aligning risk assessments and prevention care planning across Bristol and Weston sites.

There will be continued focus on more improvement work on early recognition and response to deterioration in patients' condition in 2021/22 as part of our deteriorating patient work stream aligned with national priorities. We have introduced the Vitals e-observations system in Weston General Hospital and are refining roles within the system in Bristol sites to reduce the risk of user error. A bid to fund a critical care outreach team in Bristol has been made to establish a more reliable system for responding to deteriorating patients similar to that already in place in Weston General Hospital.

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

3.1.6 Learning from serious incidents and Never Events

Internally, we have local and Trust-wide systems to learn from serious incidents and Never Events, including safety briefs, Learning After Significant Event Recommendations (LASER) posters, governance and specialty meetings, clinical audit days, newsletters, and safety bulletins. We also share learning from incidents within patient safety update sessions for staff and will be introducing patient safety updates in Weston General Hospital in 2021/22.

3.1.7 Duty of Candour

We continue to comply with the statutory and regulatory requirements for Duty of Candour as evidenced in each of our serious incident investigation reports. Local audits in 2020/21 for non-serious incidents that have caused moderate or higher level of harm have identified a need to improve and align across divisions the recording of all aspects of duty of candour.

3.1.8 Overview of monthly board assurance regarding the safety of patients 2020/21

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

Table 4

Quality measure	Data source	Actual 2019/20	Target 2020/21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2020/21
Infection control and cleanliness monitoring								
Number of MRSA Bloodstream Cases	National Infection Control data (PHE)	4	0	1	1	1	1	4
Number of *Clostridium difficile* Cases	National Infection Control data (PHE)	41	< 57	19	22	18	15	41
Number of MSSA Cases	Infection Control system (MESS)	48	< 25	7	10	9	17	43
Serious incidents and Never Events								
Number of Serious Incidents Reported	Local SI Log	73	No set target	15	35	30	29	109
Total Never Events	Local SI Log	4	0	0	3	3	0	6
Patient falls								
Falls Per 1,000 Bed days	Datix/Medway	4.52	< 4.80	6.05	4.6	5.1	5.0	5.14
Total Number of Patient Falls Resulting in Harm	Datix	26	< 24	4	3	8	8	23
Pressure ulcers developed in the Trust								
Pressure Ulcers Per 1,000 Bed days	Datix/Medway	0.182	< 0.40	0.494	0.232	0.168	0.268	0.279
Pressure Ulcers - Grade 2	Datix	49	No set target	34	20	15	23	87
Pressure Ulcers - Grade 3 or 4	Datix	5	0	4	0	0	1	5
Venous Thromboembolism (VTE)								
Adult Inpatients who Received a VTE Risk Assessment*	Medway	87.4%	≥ 95%	87.3%	84.9%	85.5%	84.3%	85.4%
Medicines								
Medication Incidents Resulting in Harm	Datix	0.33%	< 0.5%	0%	0.25%	0.53%	0.15%	0.24%
Non-Purposeful Omitted Doses of the Listed Critical Medication**	Monthly local pharmacy audit	0.41%	< 0.75%	0.47%	0.39%	0.58%	0.46%	0.46%
Staffing levels								
Nurse staffing fill rate combined	National Unify return	100.3%	No set target	96.1%	99.4%	96.4%	91.6%	95.8%

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

3.2 Patient experience

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

3.2.1 National patient surveys

Each year, the Trust participates in the Care Quality Commission's national patient experience survey programme. These national surveys reveal how the experience of patients at UHBW compares with other NHS acute trusts in England. The results of each national survey, along with improvement actions / learning, are reviewed by the Trust's Patient Experience Group and the Quality and Outcomes Committee of the Trust Board.

The most recently published national survey results affecting UHBW are listed below. Please note that national survey results are generally published around ten months after the participating patients attended hospital.

- In the 2019 National Inpatient Survey for Bristol hospitals, four of the scores were better than the national average to a statistically significant degree;
- Our 2019 National Cancer Patient Experience Survey results were particularly positive for Weston General Hospital, with 20 questions scoring above the national average;
- In the 2019 National Maternity Survey, we achieved a "better than national average" rating for the experience that women have at our St Michael's Hospital during their labour and birth – including the best score nationally on women being treated with respect and dignity during this time.
- In the 2018 national children's survey, the Bristol Royal Hospital for Children received an overall hospital experience rating from both children and parents that was amongst the best 20 per cent of trust scores nationally.

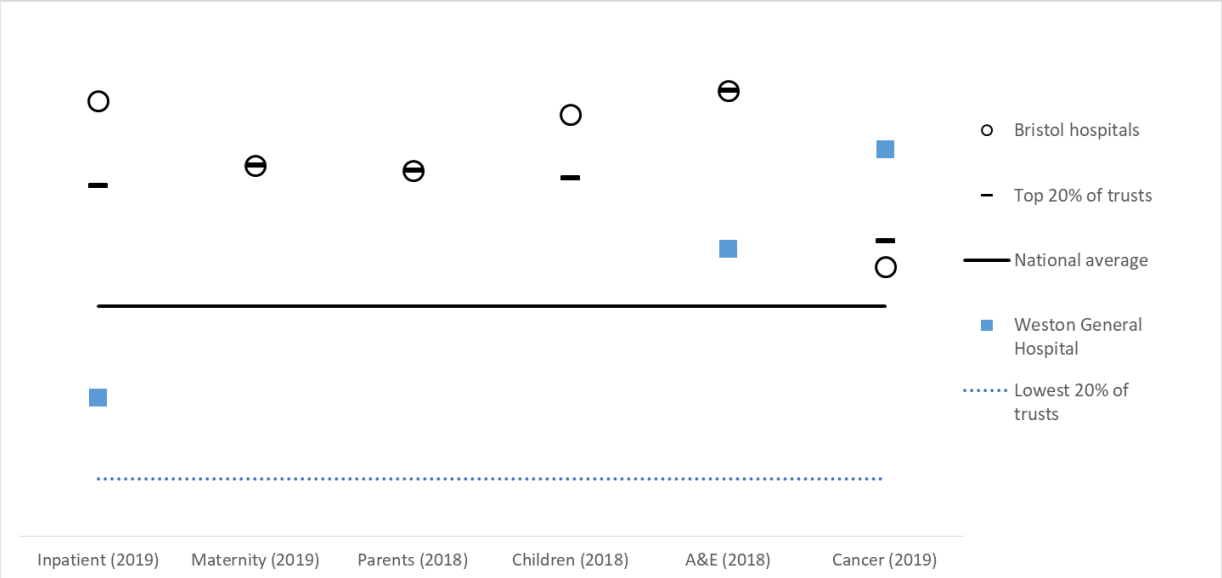
Table 5 below summarises the number of scores that UHBW had above, below, or in line with the national average in each of the most recent set of national survey results released.

Table 5

		Comparison to national average	
	Date patients attended	Above (better)	Below (worse)
2019 National Cancer Survey Bristol hospitals Weston General Hospital	April – June 2019	 5 20	 0 0
2018 National Children's Survey	November – December 2018	6	1
2019 National Maternity Survey	February 2019	6	0
2019 National Inpatient Survey Bristol Hospitals Weston General Hospital	July 2019	 4 0	 0 0
2018 National Accident and Emergency Survey (Bristol only)	September 2018	4	0

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

Figure 2: Overall experience of patients at UHBW relative to national benchmarks[1]



Source: UHBW Patient Experience Team analysis of Care Quality Commission data

3.2.2 UHBW patient survey programme

UHBW has a comprehensive local survey programme to ensure that ongoing and timely feedback from patients forms a key part of our quality monitoring and improvement processes**.** Our extensive patient feedback processes provide us with important insights from patients and people who visit our hospitals about what we are doing well and how we can continually improve our services.

The Trust continues to receive very positive feedback from service-users in our monthly postal surveys (Figure 3). Over the 2020/21 financial year, 97 per cent of inpatient survey respondents and 98% of outpatient survey respondents seen at Bristol hospitals rated the care they received as excellent, very good, or good. Praise for our staff remains by far the most frequent form of feedback that we receive.

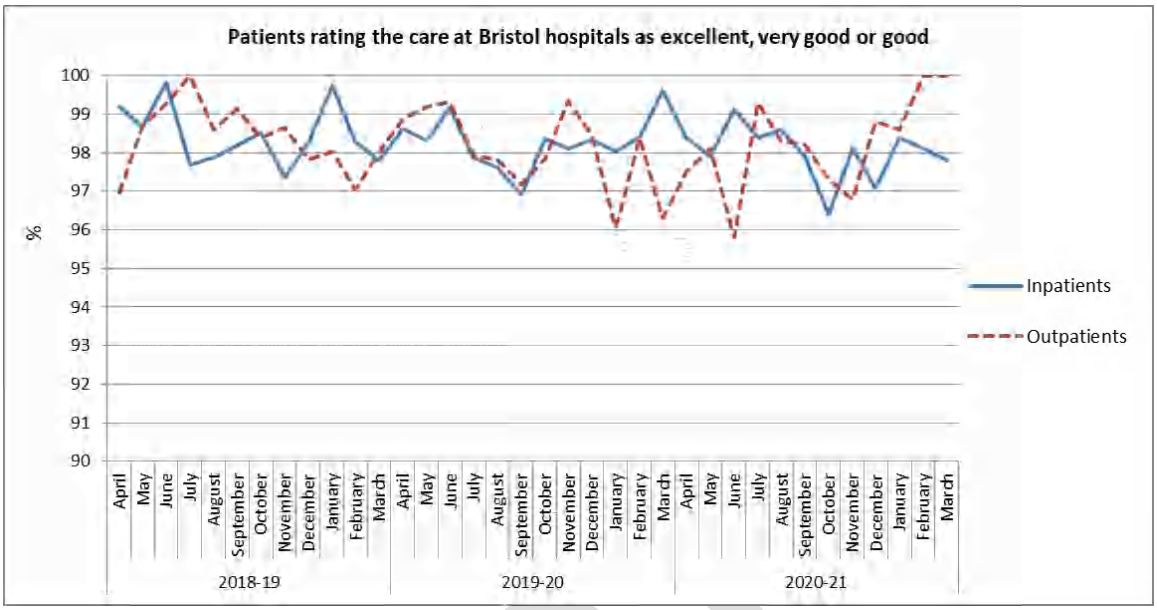
Patients seen at Weston General Hospital were offered the opportunity to provide feedback as part of an exit paper survey (which has now ceased due to the extension of the postal survey programme – see note below).

A sub-set of the results from this survey is shown in Table 6 below for the period September 2020 to March 2021. Note that the survey was paused from April 2020 to August 2020 due to the pandemic. Scores for this year have been broadly comparable to 2019/20 however the number of responses is low which has been driven by a high number of 'blue' COVID wards

[1] This is based on the national survey question that asks patients to rate their overall experience. We have indexed (=100) each score to the national average to ease comparability. This overall question is not included in the national maternity survey and so we have constructed this score based on a mean score across all of the survey questions. Weston General Hospital does not participate in the national children's survey, national A&E survey, or the national maternity survey. Please note that the 2020 National Maternity Survey and 2020 was cancelled for all Trusts by the CQC in response to the COVID-19 pandemic. UHBW did not participate in the voluntary National Cancer Experience Survey 2020.

during the period which resulted in a temporary suspension of the paper-based survey as a necessary infection control and prevention measure.

Figure 3



Source: UHBW postal survey

Table 6: Weston Patient Survey data

Attendance Type / Question	2019/20	2020/21 (Sep - Mar)
Inpatients		
Q2. Did you feel we listened to you?		
Responses	2729	325
Score (%)	91.4%	89.2%
Q5. Did we treat you with dignity and respect?		
Responses	2727	326
Score (%)	96.7%	96.0%
Q8. What did you think of the ward overall?		
Responses	2695	320
Score (%)	93.2%	92.5%
Day cases		
Q2. Did you feel we listened to you?		
Responses	2479	608
Score (%)	99.1%	99.4%
Q5. Did we treat you with dignity and respect?		
Responses	2470	611
Score (%)	99.5%	100%
Q8. What did you think of the ward overall?		
Responses	2478	609
Score (%)	97%	100%

At end of 2020/21 we extended our patient survey programme to Weston General Hospital, in doing so creating a consistent and robust approach to listening to the voice of patients across our hospitals.

Patient Experience of 'Virtual Clinics'

During the past year, there has been a growing body of local survey work taking place across the Trust to understand the quality and suitability of remote outpatient services, known as 'Virtual Clinics' in more depth. The most significant source of feedback has been a Trust-wide survey asking patients to share their experience of Virtual Clinics; this survey received 8,810 responses from the launch in June, up to 31 March 2021.

Patients are selected for virtual consultations by clinicians at the Trust based upon technical and clinical suitability to the electronic medium. Individuals are deselected if they are deemed to be lacking support to use the technology or if a detailed physical or otherwise intimate examination is required. Therefore this data is based on those who were able to access the service.

Some key headlines from this data are:

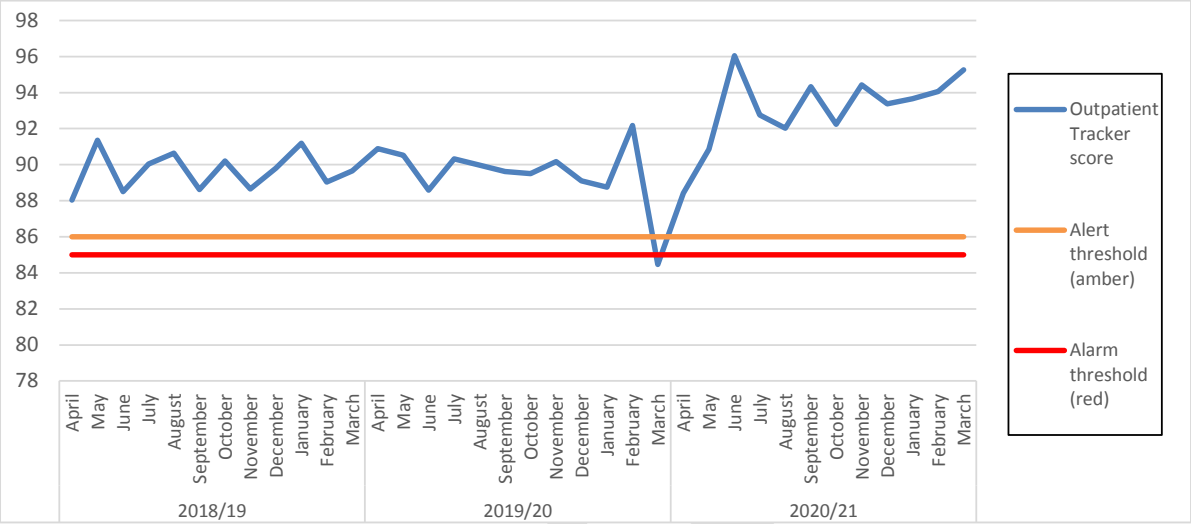
- 97 per cent of respondents reported they were given all the information they needed about the video consultation process / system before their appointment
- 87 per cent rated the process of booking as 'excellent' or 'good'
- 89 per cent rated the quality of the sound as 'excellent' or 'good' with 89 per cent rating the quality of the picture as 'excellent' or 'good'
- 39 per cent of respondents preferred having their consultation by video; when asked what they would prefer post-pandemic, this drops to 31 per cent
- Approximately a third of respondents had no preference between face to face and video consultation

The impact of the introduction of Virtual Clinics during 2020/21 as a result of the Trust's rapid reconfiguration of Outpatient services in response to COVID-19 can be clearly seen in our Outpatient experience tracker score below.

The tracker score dipped in the March 2020 survey, which was completed by patients attending clinics the day before the Government's announced the first COVID-19 lockdown. However, since the introduction of Virtual Clinics, the scores have continued to improve over subsequent months as staff and services adjusted to the new ways of working, and since June 2020 have been trending above their long-term average (see Figure 4).

The positive increase in the tracker score continued throughout Quarter 4 and ended the year on a score of 95/100 in March 2021. This is a considerable and sustained benefit in delivering Outpatient services as part of a new model which appears to be offering a very positive experience for a large cohort of patients.

Figure 4: Outpatient Experience Tracker Score (Trust-level)



3.2.3 Family Communications Support during COVID-19

As a key part of the Trust's response to the pandemic, the Patient Experience and Voluntary Services Team created a package of person-centred services established by to support communication between patients and those important to them during the pandemic, at a time when visiting restrictions were in place in our hospitals. Two of these services are described below.

Message to My Loved One

Since November 2020, family members and friends have been able to send messages for patients staying in our hospitals to a dedicated email, or leave a message on an answerphone. These messages are then sensitively presented and delivered to wards across our hospitals.

Up to 31 March 2021, 725 messages were received, the majority of which come via email from family and friends, with the remaining via telephone message. The service has been well received by patients and those important to them and has offered a communication bridge during the time that visiting restrictions were in place.

Virtual Visiting

Not all patients have their own IT devices, or were able to use either their own or ward devices, to make contact with those important to them at home or in the community during the periods of restricted visiting during 2020/21. The Trust's 'Virtual Visiting' service, launched in December 2020, has enabled patients and those important to them to remain connected during the patient's stay in hospital. The service is delivered through the Trust's 'Attend Anywhere' system using iPads (Attend Anywhere is the same system used to deliver virtual outpatient clinics). The vast majority of patients being supported by this service have been an inpatient for at least 72 hours, have no access to their own IT devices, are unable to use Trust devices without significant support and have had no, or very limited, contact since being in hospital with those important to them.

Facilitated virtual video visits are available in the BRI, BHOC and Weston General Hospital. There have been over 200 virtual visits since launch.

3.2.3 Patient and Public Involvement

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

The impact of the COVID-19 pandemic (both on our clinical services and on the Trust's Patient Experience and Voluntary Services Team, most of whom were redeployed to support family communications) meant that PPI activities were significantly reduced in 2020/21. Nevertheless, some highlights from this activity during the year were:

- The design and delivery of online Haemoglobinopathy patient focus groups to inform developments in the Clinical Nurse Specialist role, the scope of psychological support services and the role the hospital plays in community based services;
- The design and delivery of patient focus groups to inform the content and production of a cancer fatigue self-care workbook for use by patients as part of their rehabilitation process;
- The delivery of patient focus groups in collaboration with members of the former Weston General Hospital Patient Council to bring a patient voice into the design of the redeveloped Quantock Ward at Weston General Hospital;
- Working with Maternity Services to re-start plans to deliver focus groups with mothers and partners to explore experiences of an induced labour as part of a national initiative to reduce neo-natal deaths;
- Supporting the Trust's Manual Handling Team to explore the experiences of larger patients who attend our hospitals as part of a safety improvement initiative;
- Supporting colleagues in the UHBW Simulation Centre to develop a training simulation for staff to explore issues connected with the care of patients who are transgender;
- Developing and delivering PPI for the Trust's Transformation Team

3.2.4 Equality and diversity

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

- Working with AccessAble to survey hospital sites in order to provide patients and carers with detailed information about physical access arrangements to our hospitals - enabling them to plan their journeys better (after a pause this work will continue to completion in 2021/22 – see section 2.1 of this report for details);
- Embedding the new provider of our spoken language interpreting services across the Trust, including Weston General Hospital, ensuring consistency of service for our patients;
- Supporting carers in the role they have as partners in care by providing clarity on visiting arrangements during times of restrictions;
- Providing advice on how to best access the views of community groups as part of a successful HIV research grant application;
- Launching the Trust's "Cultural Awareness for an Inclusive Workplace" training sessions;
- Approving the adoption of the Sunflower Lanyard Scheme as a mechanism to support people with hidden disabilities (after a pause this work will continue to completion in 2021/22)

3.2.5 Complaints received in 2020/21

In 2020/21, 1,665 complaints were reported to the Trust Board, compared with 1,674 in 2019/20. The majority of the complaints (1,119 or 67.2 per cent) were investigated via informal resolution, with the remaining 546 addressed through the formal complaints process.

In addition, the Patient Support and Complaints Team dealt with 1,419 other enquiries, including compliments, requests for support and requests for information and advice; this represents a significant 57.1 per cent increase on the 903 enquiries dealt with in 2019/20. The team also received and recorded an additional 502 enquiries which did not proceed after being recorded (a decrease on the 618 reported in 2019/20). In total, the team received 3,586 separate new enquiries into the service in 2020/21; an increase of 12.3 per cent on the 3,195 reported the previous year.

In 2020/21, the Trust had nine complaints referred to the Parliamentary and Health Service Ombudsman (PHSO), representing a further 35.7 per cent decrease on the 14 cases referred the previous year; which was in itself a 54.8 per cent decrease on the 31 cases reported in 2018/19. During the same period, five cases were closed by the PHSO. Of these five cases, none were 'upheld'; none were 'partly upheld'; one was 'not upheld' following a full investigation; three fell into the category designated by the PHSO whereby they carried out an initial review but then decided not to investigate and closed their file, citing 'no further action'. The final case was closed without a full investigation, with the sum of £200 paid to the complainant to cover the cost of some scans carried out on a private basis, at the suggestion of the PHSO as a "quick resolution". At the end of the year 2020/21, 13 cases were still under investigation by the PHSO.

617 complaints were responded to via the formal complaints process in 2020/21 and 71.5 per cent of these (441) were responded to within the agreed timescale. This is a significant deterioration on the 88 per cent achieved in 2019/20, which does not meet the Trust target of 95 per cent. A total of 739 complaints were responded to in 20120/21 via the informal complaints process and 92.7 per cent of these (685) were responded to within the agreed timescale, an improvement on the 89.3 per cent achieved the previous year.

The Trust continues to deal with a higher proportion of complaints via the informal process, which means that these issues are being dealt with as quickly as possible and by the specialty managers responsible for the service involved.

At the end of the reporting year, 6.1 per cent of complainants had expressed dissatisfaction with the formal response they had received. This represents a total of 40 of the 653 first formal responses sent out during the reporting period and compares with 9.1 percent in 2019/20 and 9.5 per cent in 2018/19.

3.2.6 Learning from the experience of patients

Our approach to listening to experience of patients is grounded in the Trust's belief that we must learn from what people tell us in order to make improvements to the way services are designed and delivered. Over the past year, there have been many examples across our hospitals where this has happened. Some of these examples are listed below.

- Following a complaint from a patient who underwent an angioplasty at Bristol Heart Institute (BHI), filming of a new Cardiac Rehabilitation Phase 1 film has been completed by the Division of Specialised Services, specifically for the BHI. This is in addition to the existing film for patients who needed rehabilitation following a cardiac arrest, which caused confusion for the complainant as it did not apply to him.

- Following receipt of a complaint about how difficult and painful it had been for a patient to have a naso-gastric (NG) tube inserted, the Division of Surgery updated teaching sessions (including the clinical skills refresher update) to incorporate consideration of individual patient circumstances which may require more input from the medical team and an amended plan which supports the NG policy.
- The Health Psychologist team in Oncology have held video-conferencing patient focus groups with patients to explore the impact of fatigue as a result of treatment for cancer. The conversations have focussed on what works best for patients in the context of self-management in respect of fatigue and has challenged a suggestion that a "fatigue workbook" offers the best solution. Patients suggested there be more emphasis on signposting to existing support through community based partners, the use of web-based patient stories and facilitated peer support groups as alternatives. This work is on-going.
- The Haemglobinopathy Team have held video-conferencing patient focus groups with patients to inform the development of psychological services and the role of the Clinical Nurse Specialists for patients who have Sickle Cell and Thalassemia. The patient-informed developments will include a greater emphasis on awareness raising and training for staff who support patients outside of the immediate Haemoglobinopathy Team so their needs are more widely understood, and the development of a peer support network to complement the existing health and well-being support provided by psychological services.
- The Children's Disability team undertook their regular review of the hospital passport scheme, opening a short survey on experiences to over 600 existing passport users as well as to non-users via the hospital Facebook page. The response was predominantly positive but highlighted three key areas for development including 1) enhancing staff training around implementation of reasonable adjustments, 2) administration challenges for families and staff around completing and updating the passport and 3) further raising the profile of the scheme to reach families who may not yet be aware of it. These themes will be addressed through the service work plan, working alongside our parent carer representatives to tackle these challenges.

3.2.7 Overview of monthly board assurance regarding patient experience

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

Table 7: Patient Experience Quality Metrics

Quality measure	Data source	Actual 2019/20	Target 2020/21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2020/21
Monthly patient surveys								
Patient Experience Tracker Score	Monthly postal survey	91	≥ 87	91	90	90	91	91
Kindness and Understanding	Monthly postal survey	96	≥ 90	96	96	94	96	96
Outpatient Tracker Score	Monthly postal survey	90	≥ 85	91	93	93	94	93
Friends and Family Test (response rate)*								
Inpatient response rate	Friends and Family Test	35.5%	≥ 30%	No data*	No data*	12.1%	19.7%	15.9%
ED response rate	Friends and Family Test	16.6%	≥ 15%	No data*	No data*	8.5%	9.9%	9.2%
Maternity response rate	Friends and Family Test	26.5%	≥ 15%	No data*	No data*	No data*	10.1%	10.1%
Friends and Family Test (score)*								
Inpatient Score	Friends and Family Test	98.7%	≥ 90%	No data*	No data*	93.1%	96%	95%
ED Score	Friends and Family Test	84%	≥70%	No data*	No data*	91.6%	92.6%	92.1%
Maternity Score	Friends and Family Test	97.6%	≥92%	No data*	No data*	94.4%	96.5%	95.5%
Patient complaints								
Number of Patient Complaints	Patient Support and Complaints Team	1,674	No set target	228	521	490	426	1,665
Formal Complaints Responded To Within Trust Timeframe	Patient Support and Complaints Team	88%	≥ 95%	71.3%	73.4%	69.1%	72.5%	71.5%
Informal Complaints Responded To Within Trust Timeframe	Patient Support and Complaints Team	89.3%	≥ 95%	97.9%	90%	92.1%	92.9%	92.7%
Percentage of Responses where Complainant is Dissatisfied	Patient Support and Complaints Team	9.1%	< 8%	2.8%	7.7%	11.5%	3.5%	6.1%

*Note: The Friends and Family Test (FFT) was relaunched nationally on 1st December 2020 having been paused since February 2020 due to the pandemic. This explains the lack of data available for Quarter 1 and Quarter 2.

3.3 Clinical effectiveness

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

3.3.1 Understanding, measuring and reducing patient mortality

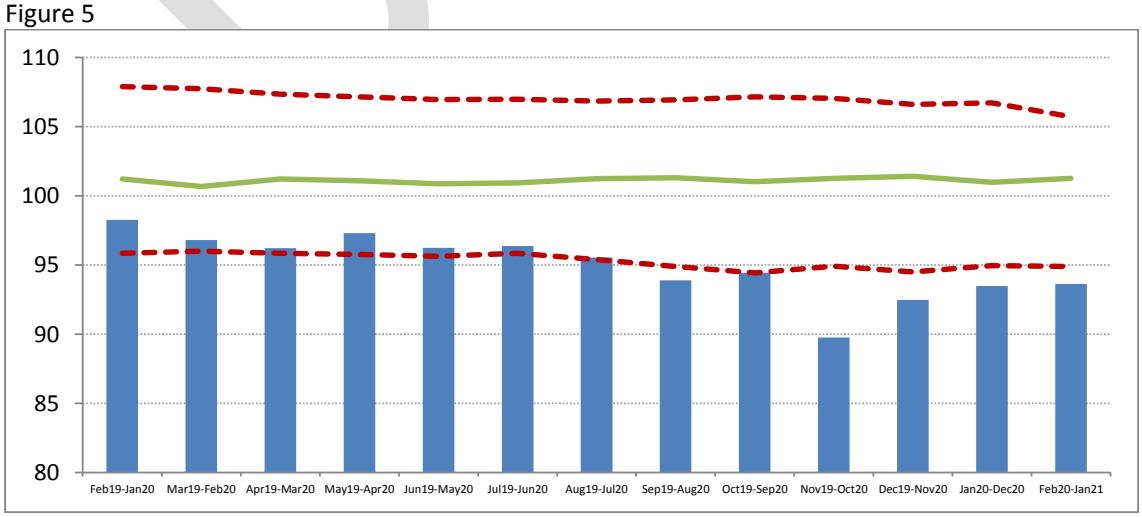
The Trust continues to monitor the number of patients who die in hospital and those who die within 30 days of discharge. This is done using the two main tools available to the NHS to compare mortality rates between different hospitals and trusts: Summary Hospital Mortality Indicator (SHMI) produced by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

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

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

In Figure 5, the blue vertical bars represent UHBW SHMI data, the green solid line is the median for all trusts, and the dashed red lines are the upper and lower quartiles (top and bottom 25 per cent). Comparative data from February 2020 to January 2021 shows that the Trust remains in the 'as expected' category. In this period the Trust had 2,060 deaths compared to 2,200 expected deaths; a SHMI score of 93.6.

Figure 5



Source: CHKS benchmarking

The latest HSMR data available (published February 2021) shows 105 patient deaths at UHBW, compared to 93 expected deaths: an HSMR of 113.

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

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3.3.2 Learning from deaths (local mortality review)

During the period of April 2020 to March 2021, 1,259 of University Hospitals Bristol NHS Foundation Trust patients died. This comprised the following number of deaths that occurred in each quarter of that reporting period:

- 295 in the first quarter
- 228 in the second quarter
- 341 in the third quarter
- 395 in the fourth quarter.

By 31 March 2021, 67 case record reviews have been carried out in relation to 1,259 deaths. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 52 in the first quarter
- 0 in the second quarter
- 4 in the third quarter
- 11 in the fourth quarter

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

Internal processes

The Learning from Deaths process has undergone significant changes this year with the full establishment and embedding of the Medical Examiners (ME) team across the region. The ME team reviews all adult deaths (within acute providers) and discusses each case with both the

clinical team and next of kin prior to the issuing of a death certificate. Any cases where they feel further review would be of benefit is referred into the Medical Director team. If the case meets the criteria it will trigger a Structured Case Note Review (SCNR), undertaken by the mortality leads within the relevant Division. A further assessment and in-depth review is then carried out with learning fed back into the Division and back into the mortality surveillance group.

The mortality surveillance group continues to align closely with the Learning Disabilities Mortality Review (LeDeR) process. All deaths in patients with learning difficulties are cross referenced with the LeDeR team.

With the introduction of Medical Examiners, there have been significant changes in the Learning from Deaths process, and as such, a piece of work is being conducted in summer 2021, in collaboration with both the lead Medical Examiner and the Divisions to clearly lay out and consolidate the process of SCNR and learning from deaths. This will lay solid foundations for the Trust and Medical Examiners as the ME team develops relationships with other organisations and considers next steps in terms of reviewing community deaths.

3.3.3 Overview of monthly board assurance regarding clinical effectiveness

The table below contains key quality metrics providing assurance to the Trust Board each month regarding the clinical effectiveness of the treatment we provide. Where there are no nationally defined targets, or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable. Some clinical effectiveness metrics and targets in Table 8 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2019/20" may vary slightly from the equivalent data in our 2019/20 Quality Report due to finalisation of provisional data.

Table 8

Quality measure	Data source	Actual 2019/20	Target 2020/21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2020/21
Mortality								
Summary Hospital Mortality Indicator (SHMI)	NHS Digital	102.1	< 100	96.6	94.6	91.9	93.6	94.4
Hospital Standardised Mortality Ratio (HSMR)	CHKS	89.9	No set target	111.4	74.5	86.3	107.5	92.2
Re-admissions								
Emergency Readmissions Percentage		3.88%	< 3.26%	4.35%	4.90%	4.33%	4.05%	4.41%
Fracture Neck of Femur								
Patients Treated Within 36 Hours	National Hip Fracture Database	63.3%	≥ 90%	61.4%	66.4%	66.9%	69.1%	66.1%
Patients Seeing Orthogeriatrician > 72 Hours	National Hip Fracture Database	97.0%	≥ 90%	79.5%	96.4%	98.6%	92.6%	92.1%
Patients Achieving Best Practice Tariff	National Hip Fracture Database	57.4%	≥ 90%	48.8%	61.4%	61.2%	64.0%	59.0%
Stroke Care								
Percentage Receiving Brain Imaging Within 1 Hour	Medway PAS & Radiology Information System	56.2%	≥ 80%	61.8%	49.0%	71.3%	60.6%	61.0%
Percentage Spending >90% Time On Stroke Unit	Medway PAS & Radiology Information System	73.5%	≥ 90%	83.1%	79.9%	69.3%	56.8%	72.6%

3.4 Performance against national priorities and access standards

3.4.1 Overview

The NHS Oversight Framework outlines the approach taken by NHS England and NHS Improvement to oversee organisational performance and identify where organisations may need support. The framework describes the measures that are used to assess performance. There are several waiting time standard measures relevant to organisations providing hospital services, including:

- Percentage of patients admitted, transferred, or discharged from A&E within four hours
- People with urgent GP referral having first definitive treatment for cancer within 62 days of referral
- Patients waiting 18 weeks or less from referral to hospital treatment
- Patients waiting six weeks or less for a diagnostic test

The national standards are:

- 95 per cent of patients should be admitted, transferred, or discharged from A&E within four hours
- 85 per cent of people referred by their GP should have their first definitive treatment for cancer within 62 days of referral
- 92 per cent of patients should wait 18 weeks or less from referral to hospital treatment
- 99 per cent of patients should wait six weeks or less for a diagnostic test

3.4.2 Referral to Treatment (RTT)

The national standard for Referral to Treatment (RTT) is 92 per cent. This has not been achieved for the whole of 2020/21.

At the end of March 2020 the overall waiting list size for routine patients was at 39,703 with 8,289 patients waiting over 18 weeks compared to March 2021 where the waiting list size was 46,3538 and the over 18 week backlog position was 17,817.

The backlog growth in the main related to the COVID pandemic with step-down of capacity to support the pressures in the hospital relating to admitted COVID patients. This was further exacerbated with winter pressures and the added pressures relating to periods of the year where critical incidents and decompression activities resulted in the temporary closure of theatres and the step-down of all patients requiring routine treatment, whether as an in-patient admission or an outpatient attendance.

Across the Trust all services have seen backlog increases and patients waiting longer for an appointment or treatment. The largest areas of growth have been seen in Dental services, Ophthalmology, Cardiac, Trauma and Orthopaedic (T&O) in both adult and paediatric areas. The Dental and Ophthalmology growth was a result of step-down of theatres from four to one in the Bristol Eye Hospital and the suspension of dental treatments due to the guidance received during the pandemic relating to the use of air-flow equipment. Furthermore, staff have been re-deployed to support ward and other pressured areas within the Trust during the pandemic. The T&O growth has occurred from patients referred into the Referral Assessment Service (RAS) and the lack of clinic capacity to book an appointment slot for these routine patients. Overall the waiting list as a whole has increased by 6,835, with 3,457 of those over 18 weeks relating to

Weston Hospital patients, who are now included in the overall UHBW position following integration.

With the COVID pandemic, the winter pressures and step down of many of the lower priority routine patients, the focus for the Trust is to continue with the national clinical prioritisation programme and to identify capacity to treat those patients who have been clinically prioritised as P2 - require treatment within one month. However, recovery of RTT performance is expected to be difficult given the volume of more urgent patients, especially those on cancer pathways that require the majority of the capacity that is available.

The Trust's commitment to achieve zero 52 week breaches has not been achieved and in March 2020, the Trust reported 31 patients who have waited for 52 weeks or more for treatment. This compares to 4,424 patients in March 2021 who have waited more than 52 weeks.

The NHS Constitution states that patients are entitled to start first definitive treatment within 18 weeks. However, given the current backlogs and priority within all services to treat patients who are more clinically urgent such as cancer patients and emergency admissions, ensuring equality of access within routine services is likely to be extremely challenging over the coming months. Every effort is continuing to be made with partners in the BNSSG health care system to maximise capacity, including within Independent sector providers, where patients will be transferred if capacity is available and a transfer is deemed safe and clinically appropriate to do so.

3.4.3 Accident & Emergency four hour maximum wait and 12 hour trolley waits

The Trust did not meet the national 95 per cent standard for the number of patients discharged, admitted or transferred within four hours of arrival in our emergency departments. Annual performance for all sites combined was 80.1 per cent. For the four emergency departments (EDs):

- The Bristol Royal Hospital for Children (BRHC) ED achieved the 95 per cent standard in one month during 2020, and achieved 92.32 per cent for the year
- The Bristol Eye Hospital (BEH) ED achieved the 95 per cent standard in all 12 months, and achieved 98.57 per cent for the year
- The Bristol Royal Infirmary (BRI) ED did not achieve the 95 per cent standard in any month of 2020/21, and achieved 70.17 per cent for the year
- The Weston General Hospital ED did not achieve the 95 per cent standard in any month of 2020/21, and achieved 77.49 per cent for the year.

March 2020 saw a significant reduction in ED attendances due to the COVID-19 pandemic and activity remained suppressed throughout the year. April 2020 to March 2021 averaged 11,672 attendances per month, a decrease of 4,425 from the average of the previous year.
Overall A&E attendances between 2019/20 and 2020/21 were:

- 27 per cent down across all four sites
- 18 per cent down at the BRI
- 36 per cent down at the BRHC
- 27 per cent down at the BEH
- 33 per cent down at Weston

Although A&E attendances were suppressed, challenges to flow were experienced throughout the year due to Emergency Department and inpatient ward reconfiguration to stream patients during the COVID pandemic, which significantly affected bed capacity, productivity and ambulance handover performance. The Trust recorded 1,440 twelve hour trolley wait breaches

(against a national standard of zero) which was an increase of 619 from the previous year. 459 were at the BRI and 981 were in Weston.

3.4.4 Cancer

The COVID pandemic has affected the Trust's delivery of cancer standards in terms of compliance throughout the year, however the Trust has maintained services despite the challenging circumstances, with patient safety at the forefront of delivery. Every cancer patient treated outside the 62 or 31 day standards is assessed for potential harm as a result of their additional waiting time, with only one patient during the year identified with potential harm as a result of the extra time waited. The Trust's cancer performance has been reported in an integrated way (across its Bristol and Weston sites) since the point of merger in April 2020.

The Trust achieved the 62 day GP referral to treatment standard in one out of 12 months in the period. During the early part of the year (the first wave of COVID) the main impacts were from high numbers of patients choosing to delay investigations/treatments and from the closure of the elective endoscopy service in line with national infection control guidance. In the latter part of the year (impacted by the second wave of COVID), the impact was greater on surgical diagnostics and treatments due to the high numbers patients admitted during this period. Despite the challenges during this period, the Trust has continued to treat the majority of patients within 62 days of a GP suspected cancer referral, with the percentage treated in this timescale remaining above 70 per cent in every month.

The Trust achieved the two week wait standard for first appointment following GP suspected cancer referral in two months out of twelve. This standard was heavily impacted by the suspension of the endoscopy service (endoscopy being a common first appointment type following cancer referral) and by patients choosing to delay their appointments. Endoscopy capacity has continued to be a limiting factor throughout the year particularly when the need for pre-procedure isolation periods for patients are considered. There was a marked deterioration in performance against the standard in September and October due to a surge in Dermatology demand which exceeded capacity, with options to increase capacity limited by the necessary COVID precautions. The surge in demand was a combination of the usual seasonal increase over summer, combined with patients who had chosen to defer appointments becoming more willing to attend as COVID rates had reduced, and with patients assessed via the telephone due to the pandemic needing further appointments for face to face assessment. The service resolved these issues and this resulted in a significant improvement in compliance from November which was sustained for the remainder of the year.

The 31 day decision to treat to treatment standards have performed better overall than the earlier pathway standards. The 31 day first definitive treatment standard was achieved in four out of 12 months. This reflects the Trust's success in maintaining cancer treatments almost as normal between the first and second waves despite the ongoing restrictions associated with the pandemic. The subsequent oncology standards have retained compliance for every month of the year. The subsequent surgery standard was not compliant in any month during the year due to the impact of the pandemic on surgical capacity (including bed capacity for patients post-operatively), in the context of a standard with a low denominator where small numbers of breaches are sufficient to cause non-compliance.

The introduction of monitoring against the 28 day faster diagnosis standard was deferred nationally to the 2021-22 financial year. The Trust has continued to collect and validate data for the standard and remains ready for its formal introduction. The Trust is already compliant with the national threshold of 75 per cent.

Ensuring equality of access is a priority for the Sustainability and Transformation Partnership's cancer working group going into the next financial year. There is limited data at present to fully assess cancer standard attainment across different patient groups and the BNSSG healthcare system is working to obtain this and identify any areas for improvement. This work has started with lung cancer, due to the national drop in referrals and diagnoses during the pandemic, which has been far greater in lung than other cancer types. A specific working group is in place to investigate and implement recommendations for improvement. This can then be used as model for similar work on other cancer types. The Trust has always acted on an ad hoc basis to address any apparent issues with equality of access to cancer care that have arisen, for example, in the previous financial year where improvement plans were links were designed with the commissioners for prisoners' health. The Trust now has contacts in place who can rapidly resolve any issues with arranging attendance by people in prison who require cancer investigations or treatment.

3.4.5 Diagnostic waiting times

The NHS constitutional standard for 99 per cent of patients waiting for a diagnostic test within 6 weeks was not met at any point during the year. Month end performance for diagnostic waiting times varied between 41.3 per cent at the start of the COVID pandemic and recovered to a maximum of 67.49 per cent in July 2020, but ended the year with 65.2 per cent waiting under 6 weeks for a diagnostic test. Annual performance was 62.3 per cent.

April and May 2020 saw a marked deterioration in performance. This was affected by a change in behaviours where patients opted to delay appointments during the first wave of the pandemic, in addition to restrictions on routine referrals, periodic closures of services such as diagnostic endoscopy and lower productivity due to the introduction of Infection Prevention and Control standards in diagnostic imaging, physiology and endoscopy.

The diagnostic tests where performance has been most adversely affected by backlogs as at the end of March 2021 were:

- Adult endoscopy (31.16% under six weeks)
- Echocardiography (60.13% under six weeks)
- Dexa scans (37.25% under six weeks)

Diagnostic activity recovered well in the second half of the year and is operating close to normal levels in areas such as CT, adult MRI and endoscopy, although backlogs remain in areas such as CT Cardiac, endoscopy and adult ultrasound. Recovery has been supported by outsourced activity to the Independent Sector and a partnership with North Bristol NHS Trust and UK Biobank to increase adult MRI capacity. Waiting lists have also been validated and data cleansed to ensure patients are correctly on new and planned surveillance waiting lists respectively. An extension of the principles introduced via the national elective waiting list clinical validation and prioritisation exercise is also being implemented by the end of August 2021.

3.4.6 Outpatients

In response to the Long Term Plan, UHBW has created an outpatients redesign programme to support the development of services in line with the national vision and incorporating learning from the real time outpatients programme. This plan has been developed in conjunction with the BNSSG Healthier Together Programme which has involved patients in co-designing the future strategy. Work has commenced to undertake a self-assessment with each Division in UHBW to create strategies that support a tailored change programme for specialities holding outpatients.

During the COVID response non-face to face activity has been rapidly scaled up. 30 per cent of outpatient consultations are now undertaken either by the phone or using the video consultation platform Attend Anywhere. This achieves the national target of 30 per cent by 2024 outlined within the long term plan. There are now over 1,905 clinical users of the Attend Anywhere system, delivering over 28,124 virtual consultations this year. Patient feedback surveys have been central to the development of the new service and over 9,000 patients have responded about their experience of virtual consultations. These views have supported the development of evidence for the effectiveness of video consultations in clinical practice and allowed reflection on future developments to reduce health care inequalities in patients accessing care in virtual settings.

To support referral management during the COVID response, Advice and Guidance has been progressed from the nine pilot specialities in 2019/20 to 54 specialities in 2020/21. Over 21,725 advice and guidance responses have been provided. Plans are in progress to review the sustainability of this rapid redesign of outpatient delivery with the CCG and Healthier Together Programme for 2021/22.

Work has been progressed with our community providers to develop new outpatient models of care. A community phlebotomy hub has been successfully piloted in South Bristol Community Hospital, supported and staffed by our community partner Sirona Health and Care. Patient feedback from the delivery of this model has informed the development of a BNSSG primary care community phlebotomy model with the view of supporting patients to access care as close to home as possible. Plans are in progress to review the proposed model and longer term sustainability of the service.

To support patients attending outpatient departments for face to face care changes were required to support social distancing. New processes were developed and risk assessments were undertaken. Patient communications have been reviewed to provide patients with information on how to access care during the pandemic. Work has been undertaken to develop a number of new appointment letters, text message reminders and patient leaflets. DNA (Did Not Attend) rates have risen in 2020/21 and are largely attributed to the patient concerns of accessing care during the pandemic. The Trust is in the process of reviewing non-attendance to understand patient's reasons for not attending further.

At the peak of COVID hospital cases, outpatient activity was cancelled to support the urgent care and patient flow pathways. Outpatient clinical activity was clinically reviewed and reprioritised, with only essential outpatient activity undertaken. As a result, the Trust now has large follow up and new outpatient patient back log. Plans are being developed to advance the use of waiting list validation and patient initiated follow up to reduce waiting list backlogs.

3.4.7 Important events since the end of the financial year

The COVID-19 pandemic continues to have an impact on our capacity because of the need to maintain social distancing in ward and outpatient areas. This has meant that the Trust has reduced some of its bed capacity and has limited the numbers of patients that can be safely managed within outpatient waiting areas. There also continues to be an impact on our workforce related to changes to the model of care offered to our patients as part of the Trust's response to the pandemic.

The loss of capacity has resulted in a lower level of activity being delivered compared to pre-pandemic levels. The level of day case, elective inpatient, diagnostic, and outpatient activity that is being delivered continues to be monitored. To oversee the restoration of activity to pre-pandemic levels, the Trust established the Restoration Oversight Group in April 2021.

In May 2021, our local healthcare system was successful in its bid to participate in the NHS elective accelerator initiative. This accelerator initiative is an opportunity for systems to rapidly develop plans to increase activity levels above pre-pandemic levels to reduce the care backlogs that have formed because of the COVID-19 pandemic. The intention of this initiative is threefold: to reduce waiting times, to learn from the experience of other accelerator systems, and to increase activity levels whilst safeguarding the wellbeing of our patients and workforce.

Table 9: Performance against national standards

National standard	Target	2017/18	2018/19	2019/20	2020/21
A&E maximum wait of four hours	95%	86.5%	86.3%	80.4%	80.1%
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	97.7%	95.6%	97.2%	81.1%
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	52.2%	49.3%	50.2%	68.0%
A&E Unplanned re-attendance within seven days	<5%	2.8%	3.3%	3.6%	4.5%
A&E Left without being seen	<5%	1.9%	1.7%	1.6%	1.0%
Cancer - Two week wait (urgent GP referral)	93%	94.3%	95.3%	93.4%	81.9%
Cancer - 31 Day Diagnosis To Treatment (First treatment)	96%	95.8%	97.2%	95.8%	95.1%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94%	92.0%	96.1%	92.5%	84.1%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	98%	98.6%	98.4%	98.6%	99.4%
Cancer - 62 Day Referral To Treatment (Urgent GP Referral)	85%	81.7%	85.6%	85.5%	78.7%
Cancer - 62 Day Referral To Treatment (Screenings)	90%	74.8%	66.7%	71.1%	57.1%
Cancer - 62 Day Referral To Treatment (Upgrades)	85%	85.4%	83.7%	86.6%	86.8%
18-week Referral to Treatment Time (RTT) incomplete pathways	92%	89.6%	89.0%	83.2%	61.7%
Number of Last Minute Cancelled Operations	<0.8%	1.19%	1.31%	1.73%	1.15%
Last Minute Cancelled Operations Re-admitted within 28 days	95%	94.2%	93.4%	92.9%	83.4%
Six week diagnostic wait	99%	98.3%	96.7%	95.2%	65.2%

APPENDIX A – Feedback about our Quality Account

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

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

In reading and commenting on this Quality Account we must remember the dramatic changes and pressures that arose during this 12 month period. The onset of the COVID pandemic occurred alongside the early months of the integration of Weston Area Health NHS Trust with University Hospitals Bristol NHS Foundation Trust. In addition, subsequent changes to funding for Trusts and use of wider resources such as private hospitals all had to be incorporated in service planning.

Despite the significant changes and pressures brought about by the COVID-19 pandemic over the past year, the Council of Governors at UHBW FT has continued to be well supported and informed in our roles at the Trust; we are therefore, happy to offer a commentary as requested. We have maintained a very full schedule of meetings and discussions online throughout this time, which has allowed us to continue to monitor activity at the Trust and explore key issues in some depth.

The pandemic has been a significant factor in causing many of the delayed or limited outcomes that are reported here; while there is also clear evidence of impressive adaptability and innovation in response to COVID. On-going commitment to learning and action in response to all feedback and investigations is also demonstrated.

Governor involvement with Quality and Performance at UHBW FT

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

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

At the bi-monthly Public Board Meetings (streamed via YouTube during 2020/21) Governors have the opportunity to witness the Board of Directors discussing all their regular agenda topics, including quality and performance. Governors also meet informally every two months, followed by a joint meeting with the Non-executive Directors at which we can raise specific topics or concerns that we want to pursue in greater depth. The Chair and all NEDs at the Trust are fully supportive of the governors offering both comment and challenge in this way, and our questions are always handled in an open, engaged atmosphere.

Quality Improvement Activity

An extensive range of quality improvement (QI) activities have been developed at the Trust in recent years, supported by ongoing development of the Quality Improvement Academy.

This Quality Account reports on the four quality objectives set for 2020/21, which were focussed on areas where the Trust did not fully achieve its goals in 2019/20, and demonstrates clearly the positive and negative effects of the adaptations brought about by the COVID pandemic.

In setting quality objectives for 2021/22 the Trust is, fittingly, planning to concentrate on a relatively small number of priority areas during a year of recovery and restoration. These objectives are all highly relevant and the Governors particularly welcome the inclusion of those relating to Learning Disabilities and Discharge.

Review of Services

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

While the pandemic led to a pausing of the Patient Safety Improvement Programme at the Trust there is clear evidence of a commitment to maintaining high standards of patient safety and clinical effectiveness, along with a readiness to acknowledge and learn from all adverse events and comments. In May 2020, Weston General Hospital became one of the first in the country to experience serious problems with Hospital Acquired COVID and had to stop taking admissions until it was under control. The measures that were implemented there became a model for other hospitals to follow and enabled admissions to recommence in a very short time.

UHBW underwent a massive adjustment of inpatient wards and treatment areas to take account of social distancing and other COVID safeguarding practices during this 12 month period. This resulted in a substantial reduction in numbers of beds, while every task related to patient care took longer and required a greater intensity of staff input. Outpatient and diagnostic services all had to be halted, reduced or adapted and many staff members had to be redeployed while others were becoming victims of COVID themselves. The implementation of these changes had to happen quickly and offered significant levels of challenge within the Trust's buildings that vary considerably in age and layout.

Among the many challenges acknowledged in this section there are some impressive examples of innovation such as the COVID Oximetry @ home project, the introduction of 'Virtual Clinics' for outpatients, the 'Message to My Loved One' service and Virtual Visiting. Support from appropriate technology and a huge commitment from staff have enabled these projects to achieve considerable success and impressive feedback from patients and their families.

It has not been possible to use many of the usual local measures of clinical and managerial performance while the changes required by COVID have been in place. Similarly, performance against national priorities and access standards has inevitably been significantly affected. However, the governors feel that UHBW has adapted effectively to meet the challenges presented to them by the pandemic and remains totally committed to offering the best possible service to their patients.

Topics of special interest to the Council of Governors during 2020/21

- Management of the COVID pandemic itself and all required changes at the Trust.

- Integration of Weston General Hospital post-merger.
- Staffing.
- Wider integration and transformation of healthcare services via the Integrated Care System.

Within our information-gathering and discussion about these topics, we have been keen to seek assurance that the Trust had been continuing to apply all possible priority and resource to the action plans that have been agreed under these headings; whilst accepting that delays have been inevitable during the pandemic.

The key staffing issues that we have pursued are staffing deficits at Weston General Hospital, continuing development of the Freedom to Speak Up service, the need to develop a comprehensive programme for training and development in management and leadership at the Trust, and a firm commitment to tackling bullying and harassment at the Trust.

We have also asked for regular updates on the impact of the pandemic on all aspects of staff wellbeing, have had access to the regular video messages to staff from the Chief Executive and been pleased to hear about all the measures that the Trust has put in place to support staff.

The Governors have been impressed by the way in which UHBW has adapted for, and coped with, the new challenges presented to them by the COVID crisis. We feel strongly that all involved have excelled in their commitment and performance and deserve our very sincere thanks.

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

Dear UHBW,

Thank you for this opportunity for respond to your Quality Account 2020/21.

We have read the Trust's summary of their performance over this past year and have been impressed by the resilience demonstrated. We look at this account with an interest in your culture of learning and see how future priorities reflect the issues that you and others have heard from patients. We also seek assurance that these improvements are sufficiently challenging and state how they will be measured.

We are pleased to see the RAG rated electronic VTE assessment compliance is continuing as a high priority in 2021/22. We welcome the Consultant VTE Lead in Weston and dedicated nurse appointments and the recognition that a transfer into the digital patient administration system is important. We must assume that the higher compliance rates that have occurred in 2020/21 are in acute admissions, as no serious incidents have been reported related to VTE assessments.

We are pleased that you have carried over 'Supporting and developing the participation of Lay representatives in Trust groups and committees' into 2021/22. As in 2019/20, we look forward to hearing how you have been able to represent diversity in these roles, by including people with protected characteristics.

We are interested to hear more details of the key additional objectives that are missing from the draft account we reviewed, but we applaud the commitment to implementing the NHS Patient Safety Strategy. This coproduced work will draw out insights from patients and staff, encourage their involvement and include them in a design of programmes that deliver effective and sustainable change.

The first new objective, focussing on improving the experience of patients with a Learning Disability is welcomed, particularly in the light of the LeDeR policy 2021. This national programme will include work to improve services for autistic people from late 2021 and UHBW may wish to consider this as a future priority?

The second new objective aims at improving patient experience of discharge from hospital. Healthwatch heard from patients in 2020 that this is an important issue to them and as a result also intend to evaluate the patient experience in a 2021 Healthwatch Bristol project. You may be interested in a collaborative approach in this research piece?

We note there is reference to providing translation of alternative spoken languages for patients who do not speak English. We feel there should also be a recognition that some patients may need sign language, and in Bristol where there is a population of patients who are both deaf and blind, Gypsy, Roma and Traveller and Refugees there could be a need to make further adjustments so that people can access equal care.

It is a comfort to know that UHBW is one of the most rapidly growing users of virtual consultations in the Southwest, and good that it is also being recognised that this does not meet the needs of every patient. Your scores from the patient survey combined three answers into one category which may create a misleading picture, but overall, the feedback is very positive. What may be helpful to hear is narrative of the patient experience recorded by an independent organisation and of course the viewpoint from staff.

Finally, we would like to extend our heartfelt thanks to your whole staff team for their efforts and tireless dedication to patients, having managed to work with Covid-19 for over a year now. They are to be congratulated on their achievements and this account reflects their hard work.

Yours sincerely

Georgie Bigg — Vicky Marriott

Chair of Trustees — Area Manager

Healthwatch Bristol North Somerset and South Gloucestershire

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

This statement on the University Hospitals Bristol and Weston NHS Foundation Trust's Quality Account 2020/21 is made by Bristol, North Somerset & South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG).

BNSSG CCG welcomes University Hospitals Bristol and Weston NHS Foundation Trust's Quality Account, which provides a review on the overall quality and performance of the provider during 2020/21. The data presented has been reviewed and is in line with data provided throughout year, predominantly via the monthly Integrated Performance Report (IPR), our discussion with the providers and more recently through the monthly quality assurance meetings.

BNSSG CCG acknowledges that the period under review has been one of the most challenging as we respond and adapt to the onset and management of the COVID-19 pandemic, affecting a wide range of performance indicators. For UHBW, this is also the first Quality Account of the combined provider, incorporating Weston Area Health NHS Trust.

UHBW identified four quality objectives for 2020/21 for the newly merged organisation. BNSSG CCG notes that progress has understandably been variable, and significantly disrupted by the necessary response to COVID-19.

Objective One – 'Improving Compliance with VTE (Venous thromboembolism) Assessment' is rated as Red. VTE risk assessment has been a regular themed line of enquiry for the CCG, as performance has been below the national expected standard of 95%. Electronic/digital solutions are being actively explored and the CCG acknowledges that no serious incidents have been reported related to VTE. The planned review of all Hospital Associated Thrombosis (HAT's) would strengthen local assurance processes.

Objective 2 – Improving the Availability of Information about Physical Access to Hospitals is rated as Amber. UHBW engaged the external company AccessAble, to survey 230 areas, unfortunately progress has been affected by COVID-19 restrictions, but the CCG recognises the efforts to restart this process with the aim of promoting a positive experience for all patients accessing UHBW services.

Objective 3 – Improving Patient Experience through the roll out of the Trust's Outpatients Strategy and Guiding Principles is rated as Green. As part of the response to COVID-19, the plan for non-face to face outpatient initiatives at UHBW was expedited, leading to the commendable delivery of 28,000 virtual consultations. Patient feedback has been collected which will support the development of this approach and has led to the publication of a paper, sharing UHBW's experience with the wider health care community. The CCG welcomes the rapid development of this initiative in what has been extremely challenging circumstances for the trust.

Objective 4 – Supporting and developing the participation of Lay Representatives is rated as Red. An initial workshop was held in early 2020/21 with existing lay representatives which identified further opportunities to develop and support those undertaking this important role. The CCG notes that progress has been affected by COVID -19 and welcomes the further focus planned for 2021/22.

Additionally, the CCG commends the addition of the of three new quality objectives for 2021/22 with a focus on improving the experience of patients with a learning disability, and delivering the plan for implementing the new NHS Patient Safety Strategy. The transition and introduction of the new Patient Safety Incident Response Framework (PSIRF) during 2022 will be a challenge, but also a great opportunity to work with partners across Bristol, North Somerset and South Gloucestershire to achieve a more connected approach to improving quality. The CCG will support UHBW by working to promote a collaborative approach to PSIRF across the BNSSG system.

Whilst the rate of falls per 1,000 bed days has increased during 2020/21, compared to 2019/20, it is recognised that a reduction in Neck of femur fractures has been achieved. An overall increase in pressure injuries was reported during 2020/21, some of which related to medical devices. The overall number of Grade 3 or 4 has remained static at 5 each year. The CCG will continue to facilitate and host the BNSSG Pressure Injury Steering Group, to share learning and the adoption of best practice across the system.

The Trust is reporting an increase in Clostridium difficile cases during 2020/21, MRSA assigned cases are static at 4, and a reduction in MSSA bacteraemia cases is noted. We would encourage

the provider to consider adding a narrative on their approach to the management of healthcare associated infections in next year's report.

We welcome and thank the trust for its continuing engagement in national audits and national enquiries, contributing to national datasets and associated guidance. The CCG also wishes to acknowledge and extend its thanks for the trust's outstanding contribution to the body of research on COVID-19, both in the development of vaccines and new treatments.

BNSSG CCG reiterates that 2020/21 has been one of the most challenging for the NHS and our local providers. Patient experience through the Friend and Family Test has shown an improvement for both ED and maternity at UHBW. We note the areas that have been identified by the Trust for further improvement and we look forward to working with the Trust in 2021/22 to achieve these improvements.

Michael Richardson
Deputy Director of Nursing and Quality
NHS Bristol, North Somerset & South Gloucestershire CCG

d) Statement from Bristol City Council People Scrutiny Commission

University Hospitals Bristol and Weston NHS Foundation Trust Draft Quality Account 2020/21

The Health Scrutiny Committee (Sub-Committee of the People Scrutiny Commission) discharges the statutory health scrutiny function for Bristol City Council. The Committee received a copy of the University Hospitals Bristol and Weston NHS Foundation Trust Draft Quality Account 2020/21 on the 22 June 2021.

Due to time constraints it was agreed that the Health Scrutiny Committee would not request a briefing or meet to discuss the report. Instead Members of the Committee would provide comments to the Chair, Councillor Graham Morris. This would form the Committee's statement to the Trust, detailed in this letter;

- Members noted that most acronyms were explained, although it was recommended that this should be extended to all acronyms which included BAUS (within the context of BAUS Renal Colic Audit) on p.14 and 'DNA' rates on p.43.
- The Committee noted the Trust's performance within the mandated quality indicators, which included some above national average performance, and recommended there be some commentary with regard to how performance related to the national average and also the national best; and how the Trust could reach the national best, including Clostridium difficile rate per (total) of 0 (reference p.20).
- It was noted and acknowledged that this was a draft report and that there were incomplete sections, as illustrated on p.2, and Members looked forward to reading the completed version, and especially the proposed section on Quality Objectives for Learning Difficulties and Discharge. Meanwhile it was recommended that attention be focused on missing data, which included 'Total Number of Patient Falls Resulting in Harm in 'Table 4' (reference p.27).
- Also with reference to 'Table 4', Members recommended commentary on the reasons staffing levels were lower compared to the previous year (reference p.27).
- The Committee noted the key quality metrics providing assurance to the Trust Board monthly regarding the clinical effectiveness of treatment provided, and recommended some

commentary for 'Table 8', specifically with regard to the reason the figures related to 'Fracture Neck of Femur (Patients Treated Within 36 Hours)' were low, and also an explanatory note about what 'Patients Achieving Best Practice Tariff' referred to (reference p.38).

- The Committee noted and understood how COVID-19 had affected ability to meet the national 95% standard for the number of patients discharged, admitted or transferred within four hours of arrival in emergency departments. It was recommended that it would be of value if further commentary could provide the reasons why the Bristol Royal Hospital for Children and Bristol Eye Hospital Emergency Departments had a greater measure of success than the Bristol Royal Infirmary and the Weston General Hospital Emergency Departments (reference p.40).
- The Committee commended the successful bid to participate in the NHS elective accelerator initiative; Members felt the report would benefit from further commentary about this, with an explanation how the initiative would be focused (for example, on all backlogs or specific procedures?), and to provide detail on existing plans to reduce waiting times, and those in the pipeline. This was a key point Members felt would be of public interest (reference p.44).

The Committee thanked the Trust for the opportunity to consider the draft report. Councillor Morris and the Committee would like to thank the University Hospitals Bristol and Weston Trust for its fantastic efforts during the worst of the pandemic. It was no surprise that not all the targets were achieved due to the impact of the global pandemic but, importantly, the report demonstrated clear plans with regard to how the Trust would progress, particularly with plans to reduce the waiting lists which had understandably increased.

The Committee's comments are made within the context of supporting the Trust's priorities and being a 'critical friend' to help enable positive outcomes.

Yours sincerely,

Dan Berlin
Scrutiny Advisor

e) Statement from North Somerset Health Overview and Scrutiny Panel

Thank you for sharing your Quality Account with us to review and for supporting this with a briefing, which we found incredibly helpful.

It's clear that the pandemic has affected all of our lives significantly and our health partners have been working incredibly hard to keep us safe and to care for us. As a panel we wanted to pass on our thanks to you and your colleagues for the tough job you have been doing over the last year and for all that you've achieved. We are very grateful to you all.

We've read your Quality Account and as a panel we agree fully with your priorities for the forthcoming year and we particularly welcome the focus on improving the experience of care for patients with learning disabilities and the focus on improving experience for patients discharged from hospital. These are areas that deeply impact some of our communities and we'd therefore ask that UHBW considers accelerating these plans.

Kind regards

Cllr. Ciaran Cronnelly
Chair of North Somerset's Health Overview and Scrutiny Panel

f) Statement from South Gloucestershire Health Scrutiny Committee

A statement has not been provided by the South Gloucestershire Health Scrutiny Committee on this occasion.

APPENDIX B – Statement of Directors' Responsibilities

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

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

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2020 to March 2021
    - papers relating to Quality reported to the board over the period April 2020 to March 2021
    - feedback from commissioners
    - feedback from governors
    - feedback from local Healthwatch organisations
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the national inpatient survey
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with the annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Jayne Mee, Interim Chair
29th July 2021

Robert Woolley, Chief Executive
29th July 2021

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**Quarter 4 Patient Experience & Involvement Report**
Author	**Matthew Areskog, Patient Experience Manager**
Executive Lead	**Deirdre Fowler, Chief Nurse**

1. Report Summary

The Quarterly Patient Experience Report provides a comprehensive review of patient survey data and Patient and Public Involvement activities being carried out at the Trust.

2. Key points to note
(Including decisions taken)

The Trust's postal survey data (which was only available for Bristol hospitals in 2020/21) shows that patients continued to report a positive experience of inpatient services throughout 2020/21 despite the challenges presented by the COVID-19 pandemic.

During the pandemic, a significant proportion of outpatients have been seen via 'Virtual Clinics' (telephone or video-based). Our survey data suggests that these changes continue to be received positively by many patients. However, we also need to better understand the impact of virtual clinics on particular groups in the population, including those who are digitally excluded and have plans emerging to do this.

Patient and public involvement activity continues to grow across Divisions and networks hosted by the Trust including scoping out a new model of family engagement in the South West Regional NICU Network.

The approach to delivering the Friends and Family Test (FFT) was standardised across Bristol and Weston hospitals during Q4.

Integration of the Division of Weston into the Trust's patient experience programme, specifically, was completed in readiness for Q1 2021/22.

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

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

- This report is for **Assurance.**

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

Patient Experience Group	20/5/21
Senior Leadership Team	23/6/21
Quality and Outcomes Committee	24/6/21

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Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

University Hospitals Bristol and Weston NHS Foundation Trust

Quarterly Patient Experience and Involvement Report

Incorporating patient survey data up to and including Quarter 4 2020/21

1. Overview of patient-reported experience and involvement

Successes	Priorities
The Trust's postal survey data (which currently covers the Bristol hospitals) shows that patients continued to report a positive experience of inpatient services throughout 2020/21 despite the challenges presented by the COVID-19 pandemic. During the pandemic, a significant proportion of outpatients have been seen via Virtual Clinics. Our postal survey data suggests that these changes continue to be received positively by many patients. The approach to delivering the Friends and Family Test has now been standardised across Bristol and Weston hospitals. This includes extending SMS (text) patient feedback functionality to patients seen in the Outpatient and the Emergency Department in the Division of Weston. We can evidence a month on month increase in the volume of patient feedback received via FFT since the relaunch in December 2020. Patient and Public Involvement activity continues to grow across Divisions and networks hosted by the Trust including scoping out new model of family engagement in the SW Regional NICU Network.	Integration of the Division of Weston into the Trust's patient experience programme, specifically, extending the current Bristol hospitals' postal survey process for inpatients and outpatients which will be completed in Quarter 1 2021/22. Growing our understanding of outpatient virtual clinic experience by analysing the Virtual Clinic survey by key demographic groups (we will be reporting on this in Quarter 1 2021/22). As part of this, scoping how to undertake further engagement with those who are digitally excluded in order to understand access barriers (see risks and threats) by working with the Outpatient Services Manager. Establishing a close relationship with the individuals that made up the now dissolved Weston Patient Council as part of the overall Trust's Patient and Public Involvement approach. In doing so, work with those individual to deliver My Journey (mystery shopping) activities at Weston General Hospital.
Risks & Threats	**Opportunities**
Outpatient experience continues to be broadly positive, however, we need to better understand the impact of virtual clinics on particular groups in the population, including those who are digitally excluded and those with a sensory impairment. We must prioritise engagement with these groups of patients in order to reduce the risk of widening health inequalities. The volume of feedback from the Division of Weston in Q4 was proportionately low in comparison to Bristol hospitals. The extension of the FFT process (in Q4) and UHBW's postal survey programme (from Q1 2021/22) to Weston Division should result in an increase in the volume of feedback, and therefore the robustness of our understanding of experience of care at Weston. However, this will need carefully monitoring. For FFT specifically, it will require ownership and a focus on embedding the new process by managers and staff across wards and departments.	The pandemic has created a 'pause' in the roll out of the rapid-time patient feedback touchscreens and system. Taking learning from other organisations, the Patient Experience Team is developing a project plan to integrate all patient experience data at the Trust into a single repository using the IQVIA real-time feedback system. Patient feedback data will be accessible by staff across the Trust on a user profile basis (i.e. based on organisational structure). This change will ensure that patient feedback is seen by teams and departments in a timely way which will support quality and service improvement activity. This approach will also engender a culture of transparency and local ownership.

2. About this report

This report provides an analysis of patient-reported experience and also summarises patient and public involvement activities being carried out at the Trust.

3. Patient and Public Involvement

The Trust's Patient and Public Involvement (PPI) programme is gaining momentum with the PPI Lead increasingly supporting both corporate and divisional initiatives, including:

- The design and delivery of the 'My Journey' patient experience evaluation model in the Division of Weston;
- Scoping a new model of family engagement in the SW Regional NICU Network that will offer transferable learning to other Trust hosted networks;
- Re-starting the process to recruit lay representatives to the Trust's Learning Disability Steering Group;
- Supporting the design and delivery of a Learning Disability Pride Health Matters event in June';
- Re-launching the Trust's Patient Inclusion and Diversity Group;
- Re-launching the Trust's Carers Strategy Group;
- Co-ordinating the re-start of the AccessAble Access Guide survey work at Bristol hospitals and its extension to Weston General Hospital.

4. Patient Surveys: Patient experience scores for Bristol hospitals (postal survey data)

The charts in this section of the report show data from the Trust's postal survey programme for Bristol hospitals. These surveys were extended to the Division of Weston from April 2021 and analysis of this vital dataset will feature in the Q1 2021/22 report.

Despite the considerable challenges and pressures faced across the Trust during 2020/21, inpatient-reported experience has remained consistently positive during the Covid-19 pandemic. Please see Charts 1 and 2 overleaf.

When reviewing the data over the year, it is evident that at the point in which the second wave of Covid-19 created additional demand on services (due to a rising number of inpatients) there was a corresponding dip in patient reported experience. However, it should be noted that the temporary dip in the kindness and understanding score and the inpatient tracker score remained above the alert threshold. This provides the Trust with assurance that despite the considerable challenges faced by staff, they continued to afford patients an excellent experience of care.

Chart 1: Kindness & Understanding Score (Trust-level / inpatients)

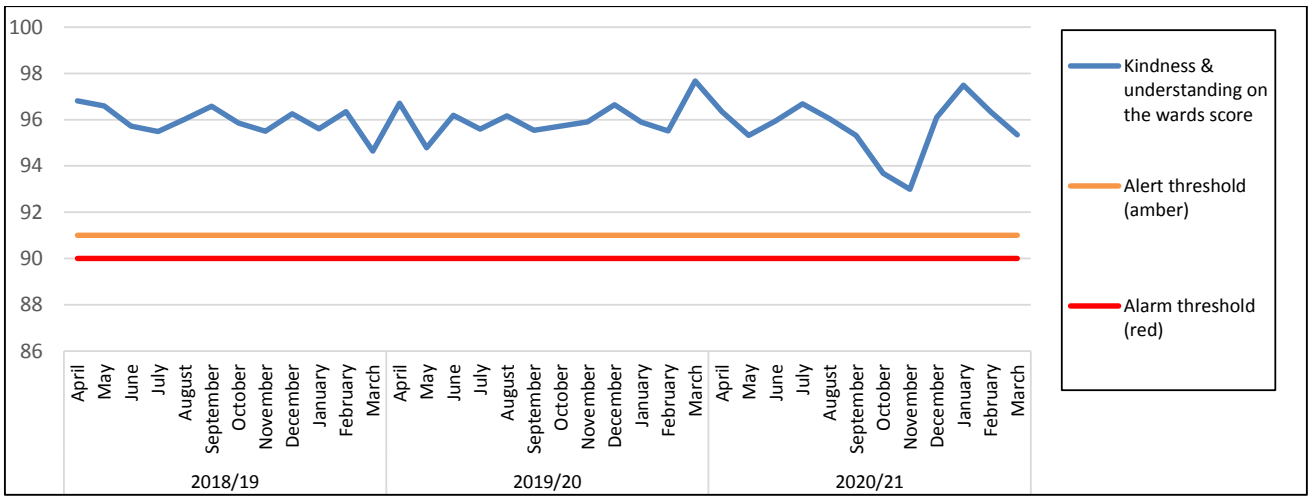
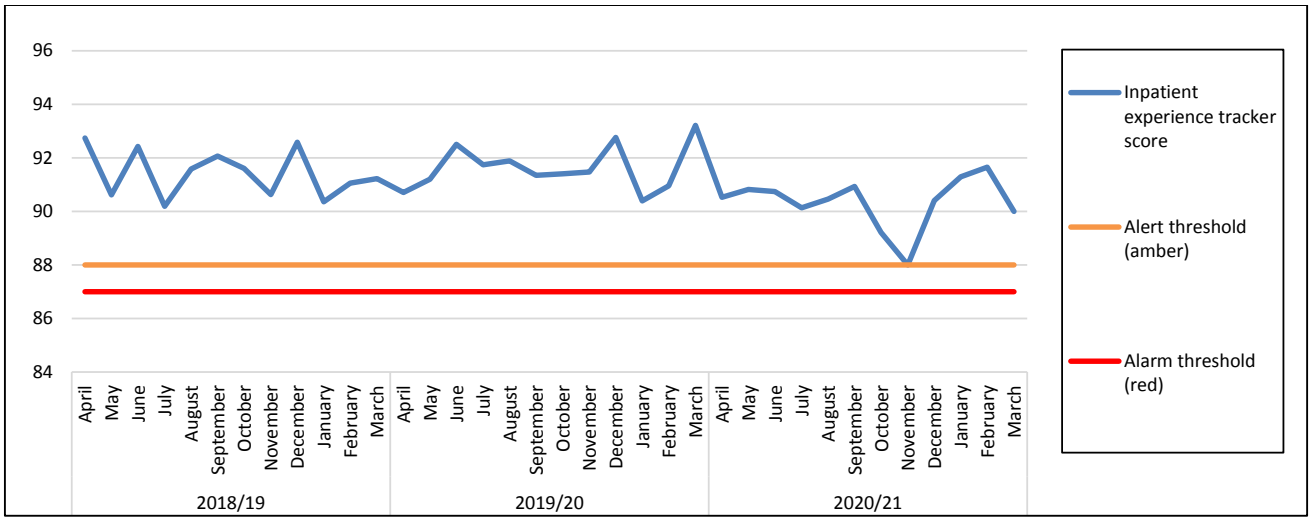


Chart 2: Inpatient Experience Tracker Score (Trust-level)



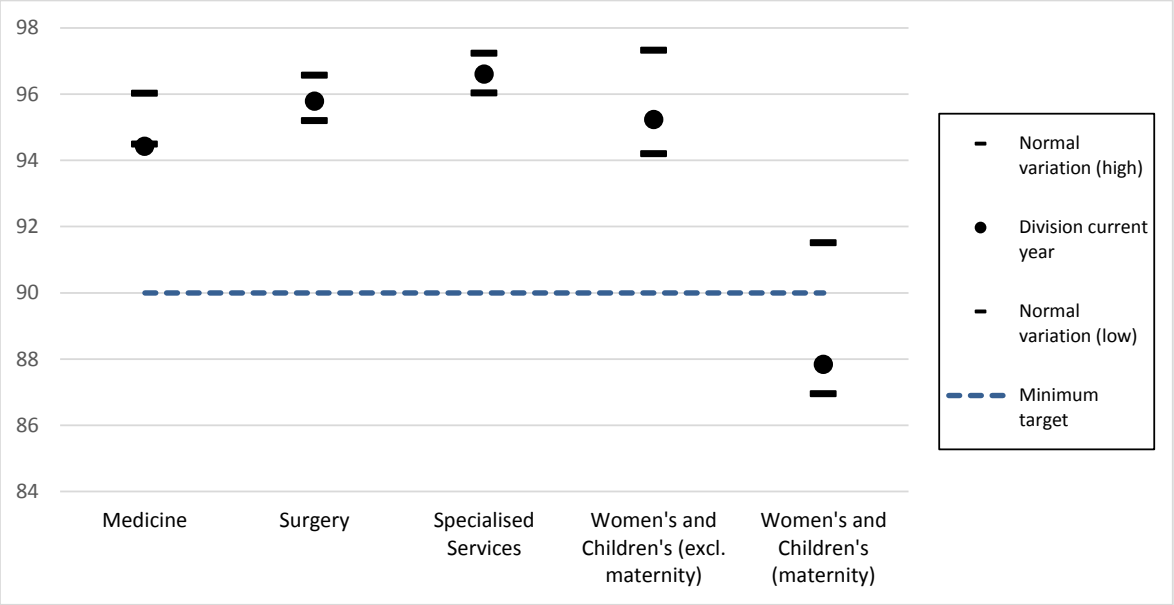
It is difficult at present to establish a reliable picture of patient-reported experience below Trust-level due to the impact of Covid-19 on our surveys[1]. However, with caution, we have been able to examine inpatient-reported experience at a Divisional-level - by aggregating the data for 2020/21 and comparing this to the long-term trend score for each Division (Charts 3 and 4).

The maternity "kindness and understanding" score (Chart 3) was below the minimum target for 2020/21. The score, which is in line with national norms for postnatal wards, tends to fluctuate around this level and is typically lower than other inpatient wards. The score dipped slightly during the pandemic but has recovered during Quarter 4 to 90/100, now above the long-term average of 89/100. During this year, there have been significant periods of time where women have been unable to have their partners with them on the wards due to visiting restrictions. The Head of Midwifery in Maternity (HoM), Sarah Windfeld, believes fluctuations in the score during this time can be explained in part by these restrictions. Partners are now able to be at induction and to be on the ward to visit for a period of two hours a day. If women have severe emotional issues then we assess and at times

[1] The response rates have been lower, leading to smaller sample sizes. At the time of producing this report, there has been a 22% reduction in the volume of patient feedback via postal surveys during 2020/21 compared to 2019/20. A number of hospital services were also temporarily reconfigured, disrupting our ability to aggregate data over several months (which we have to do to get a reliable result at ward level).

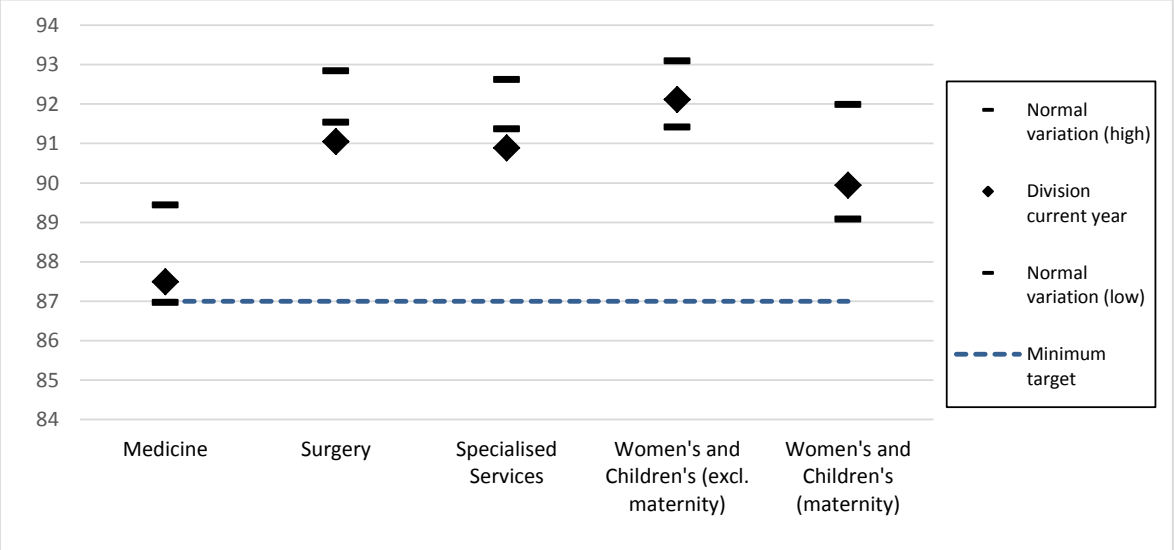
allow a partner to stay longer if we can facilitate with a side room. Partners are now also able to come to all scans and ante natal appointments. A range of ante natal education videos are in development.

Chart 3: Divisional kindness and understanding scores April to March 2020/21. *The year-to-date mean score for each Division is shown as a diamond, with two lines around this showing the historical variation in the score over time (the "standard deviation"); therefore you would expect the current score, represented by the diamond, to sit somewhere between these two dots.*



Our inpatient experience tracker scores (Chart 4) have remained very positive, with most Divisions broadly in line with their long-term average score once normal fluctuation in the data is taken in to account. Whilst the average scores for some Divisions do appear lower than the long term averages, it is important to note that the variation for each Division is no more than 1 point and therefore the differences are negligible. Given the pressures experienced across the Trust during the year, this data indicates these pressures have not translated into a demonstrably different experience for inpatients when compared to previous years.

Chart 4: Divisional inpatient experience tracker scores April to March 2020/21.



By aggregating the survey data between April and March 2020/21, the sample sizes are now large enough to build a picture of inpatient hospital experience during the pandemic (Charts 5 and 6). Please note that Bristol Eye Hospital has been excluded from this analysis due to the significantly lower volume of survey responses when compared to the previous financial year.

South Bristol Community Hospital (SBCH) continued a long-term trend in our data and remained a negative outlier in respect of the inpatient experience tracker score (Chart 6). The long-term range for this score at SBCH is 79 – 87 based on historical data. Patient experience scores do vary between different types of specialty and treatment. SBCH specialises in rehabilitation services which presents unique challenges for both staff and patients.

The Patient Experience Team met with representatives from Sirona Care & Health in March 2021 as part of the safe transfer of beds on ward 100 and ward 200. Sirona took ownership of these beds from 1 April 2021 and in order to provide context, we provided information and reports relating to feedback from SBCH patients and staff, plus feedback from external stakeholders, such as Healthwatch Bristol in recent years. SBCH data will not feature in our reporting going forwards.

Chart 5: Hospital-level kindness and understanding scores 2020/21.

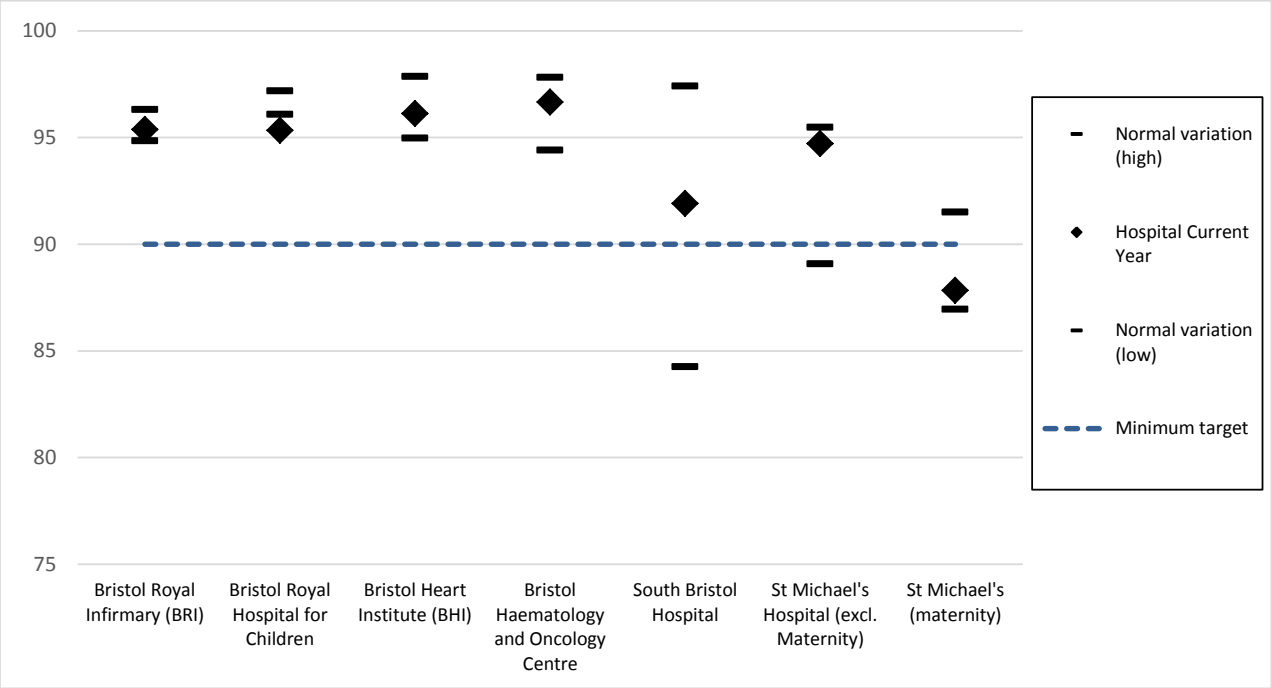


Chart 6: Hospital-level inpatient experience tracker scores 2020/21.

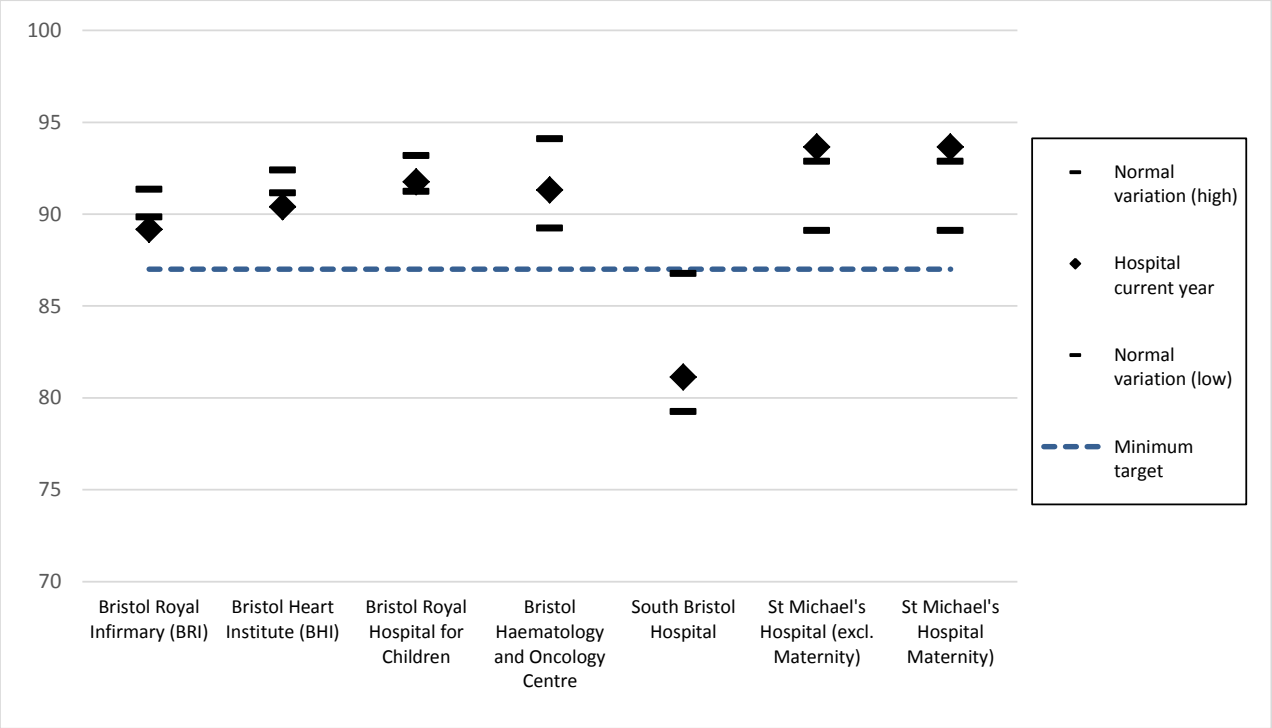
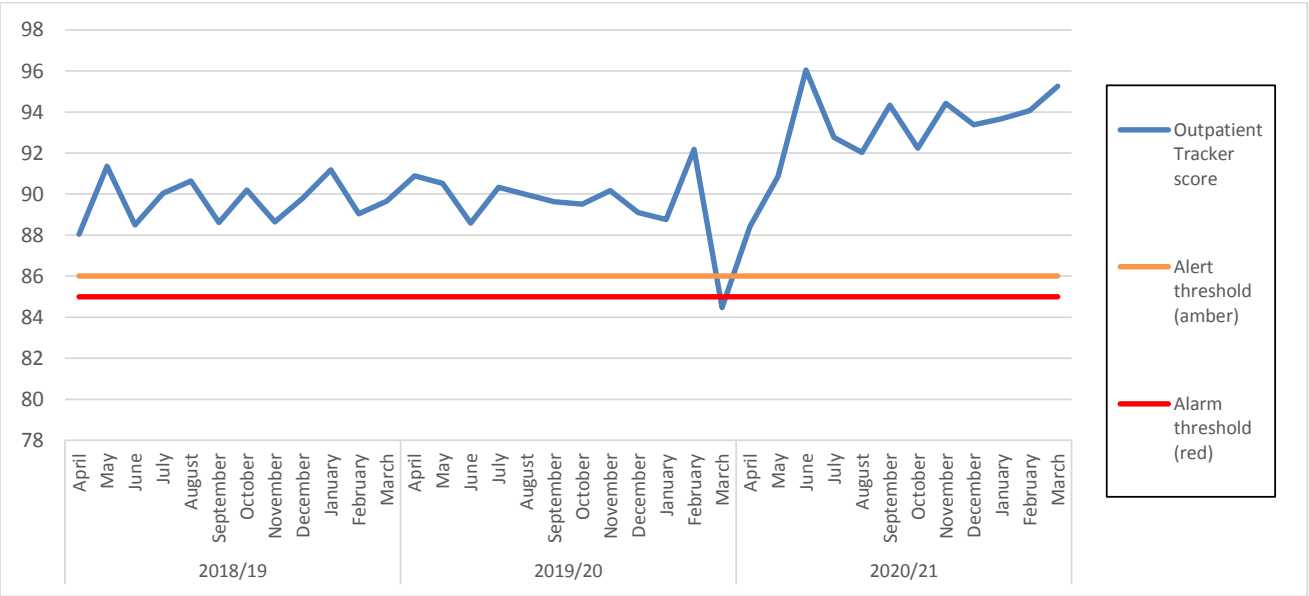


Chart 7: Outpatient Experience Tracker Score (Trust-level)



The impact of the introduction of Virtual Clinics during 2020/21 as a result of the Trust's rapid reconfiguration of Outpatient services in response to Covid-19 can be clearly seen in our Outpatient experience tracker score.

The tracker score dipped in the March 2020 survey, which was completed by patients attending clinics the day before the Government's announced the first Covid-19 lockdown. However, since the introduction of Virtual Clinics, the scores have continued to improve over subsequent months as staff and services adjusted to the new ways of working, and since June 2020 have been trending above their long-term average (see chart 7 above).

The positive increase in the tracker score continued throughout Quarter 4 and ended the year on a score of 95/100 in March 2021. This is a considerable and sustained benefit in delivering Outpatient services as part of a new model which appears to be offering a very positive experience for a large cohort of patients.

Patient Experience of 'Virtual Clinics'

During the past year, there has been a growing body of local survey work taking place across the Trust to understand the quality and suitability of remote outpatient services, known as 'Virtual Clinics' in more depth. The most significant source of feedback has been a Trust-wide survey asking patients to share their experience of Virtual Clinics; this survey received 8,810 responses from the launch in June, up to 31 March 2021.

Patients are selected for virtual consultations by clinicians at the Trust based upon technical and clinical suitability to the electronic medium. Individuals are deselected if they are deemed to be lacking support to use the technology or if a detailed physical or otherwise intimate examination iss required. Therefore this data is based on those who were able to access the service.

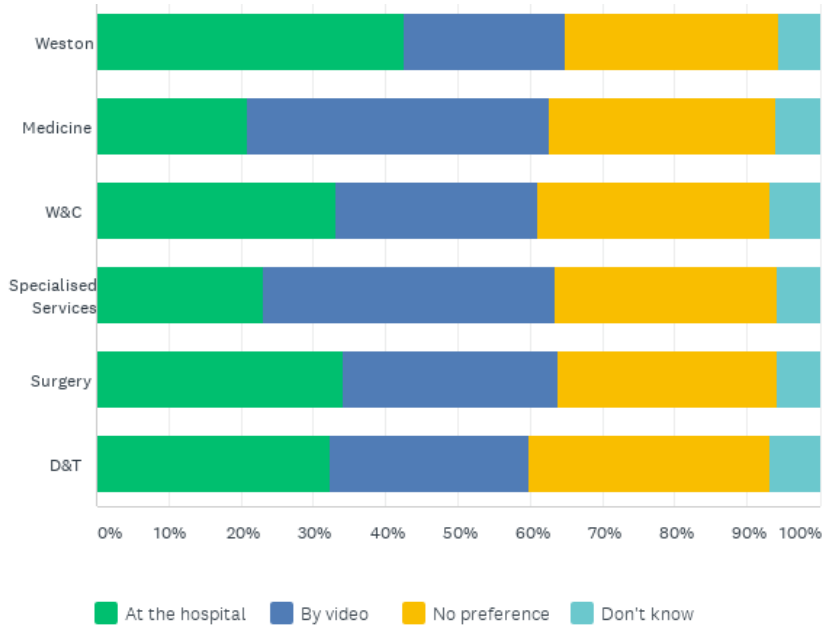
Some key headlines from this data are:

- 97% of respondents reported they were given all the information they needed about the video consultation process / system before their appointment
- 20% of respondents did not know who to contact if they had a problem in accessing the video consultation. There is significant variation across the Divisions in relation to this question as shown in table 1 overleaf. To illustrate this point, 13% of patients seen by the Division of Weston stated they did not know who to contact if they had a problem in accessing the video consultation, compared to 24% in Division of Surgery. This indicates some scope to improve the consistency of pre appointment information provided to patients across the Trust.
- 87% rated the process of booking as 'excellent' or 'good'
- 89% rated the quality of the sound as 'excellent' or 'good' with 89% rating the quality of the picture as 'excellent' or 'good'
- 39% of respondents preferred having their consultation by video; when asked what they would prefer post-pandemic, this drops to 31%
- 23% of respondents would have preferred the consultation face to face, when asked what they would prefer post-pandemic, this rises to 32%
- Approximately a third of respondents had no preference between face to face and video consultation
- There is significant variation by Division when looking at the preference of patients as to whether they would prefer face to face vs video consultations in a 'post-pandemic' situation as shown in Chart 8 overleaf.

Table 1 - Virtual Clinic Survey (2020/21) Q5 - Did you know who to contact if you had a problem in accessing the video consultation?

Division	Yes	No	Total
	87%	13%	
Weston	873	134	1,007
	80%	20%	
Medicine	1,036	253	1,289
	79%	21%	
W&C	2,466	663	3,129
	85%	15%	
Specialised Services	514	90	604
	76%	24%	
Surgery	1,043	322	1,365
	81.97%	18%	
D&T	1,073	236	1,309
	80%	**20%**	
Total Respondents	**7,005**	**1,698**	**8,703**

Chart 8: Virtual Clinic Survey (2020/21) - Q12 – After the pandemic is over, if there was a choice, do you think you would prefer to have the outpatient appointments face-to-face at the hospital or continue to have them by video?



Evaluation of this large dataset of patient feedback suggests that for those who had experience of accessing virtual clinics during the past year, they generally welcomed the changes that the Trust has made to the delivery of outpatient services but there is clearly variation across our hospitals. It is important to note that the Trust clearly states through its Standard Operating Procedure that the need and/or preference for a remote or hospital-based appointment will vary between individuals and situations.

A redesigned survey to understand patient experience of virtual clinics was launched at the end of January 2021. This new survey includes a key set of demographic questions which will allow analysis by age, ethnicity, disability and sexual orientation. This evidence base will be key in determining whether the experience of patients varies between diverse groups in our local communities. An analysis of this data will be presented in the Quarter 1 2021/22 report, to allow response volumes to build over the coming months.

During Quarter 4, revised guidance was issued for staff working in Outpatient services to highlight some of the reasons why patients may find it difficult to access Virtual Clinics, and to highlight some practical solutions to remove barriers – such as the use of spoken and non-spoken language interpreters. This must remain an ongoing priority for the Trust to ensure those who are currently digitally excluded are supported to access Virtual Clinics with additional support measures in place. In doing so, the Trust has the opportunity to work in partnership with patients, carers, with the local healthcare system and the Voluntary and Community Sector to better understand what steps can be taken to ensure the service is inclusive and mitigate the risk of amplifying health inequalities.

5. Patient Surveys: Division of Weston

Patients seen at Weston General Hospital are offered the opportunity to provide feedback as part of an exit paper survey which was established by Weston Area Health NHS Trust prior to merger. This data is shown in Table 2 below for the period September 2020 to March 2021. Note that the survey was paused from April 2020 to August 2020 due to the pandemic. A sub-set of questions from the survey is shown here. Scores for this year have been broadly comparable to 2019/20, however, the number of responses is low which has been driven by a high number of 'blue' Covid wards during the period which resulted in a temporary suspension of the paper-based survey as an infection control and prevention measure.

Good progress is being made in aligning the patient experience programme in the Division of Weston with the overall corporate programme. The Friends and Family Test processes are now integrated and the next step is the extension of the monthly postal survey approach into the Division of Weston. We anticipate that this work will be completed in Quarter 1 2021/22. This will improve the volume and robustness of patient feedback, and enable direct comparisons to be made between patient experience at Bristol and Weston

Table 2: Weston Patient Survey data

Attendance Type / Question	2019/20	2020/21 (Sep - Dec)
Inpatients		
Q2. Did you feel we listened to you?		
Responses	2729	325
Score (%)	91.4%	89.2%
Q5. Did we treat you with dignity and respect?		
Responses	2727	326
Score (%)	96.7%	96.0%
Q8. What did you think of the ward overall?		
Responses	2695	320
Score (%)	93.2%	92.5%
Day cases		
Q2. Did you feel we listened to you?		
Responses	2479	608
Score (%)	99.1%	99.4%
Q5. Did we treat you with dignity and respect?		
Responses	2470	611
Score (%)	99.5%	100%
Q8. What did you think of the ward overall?		
Responses	2478	609
Score (%)	97%	100%

6. Patient surveys: Friends and Family Test

The Friends and Family Test (FFT) is a national patient survey mandated by NHS England. The Friends and Family Test (FFT) was relaunched nationally on 1st December 2020 having been paused since February 2020 due to the pandemic. FFT was reintroduced to the Trust at a time of considerable operational pressure. We therefore worked in a proportionate way, taking into account the significant pressures on ward staff during this period and some of the restrictions in place on 'blue' Covid wards due to IPC guidelines. Where possible, methods such as online, SMS or postal surveys are being prioritised to avoid unnecessary burden on staff.

During Quarter 4 (the first full quarter since launch), we received 11,170 responses We have seen a steady increase in the FFT responses on a monthly basis since the relaunch with 2,927 responses in January, 3,787 in February, and 4,458 in March.

The FFT question has changed to "Overall, how was your experience of our service?". FFT data for Quarter 4 is shown below (Table 3). Please note that as this is a new question, it is not valid to compare results to data previously collected and therefore no historic data is shown in this report. We will build data over time and include analysis of trends when we are able to do so.

Table 3: Friends and Family Test Data – Quarter 4 2020/21

Attendance type by Division/Site	Response rate	FFT score*
Inpatients		
Medicine	12.8%	94.7%
Surgery	26.7%	97.5%
Specialised Services	25.1%	95.5%
Women's and Children's	29.8%	96.9%
Weston	2.7%	100.0%
Trust total	**19.7%**	**96%**
Emergency Department		
Bristol Royal Infirmary	8.1%	89.8%
Children's Hospital	12.9%	95.5%
Weston	No data	No data
Trust total	**9.9%**	**92.6%**
Outpatients		
Bristol	10.5%	95.9%
Weston	0.8%	100.0%
Trust total	9.4%	96.0%
Maternity		
St Michaels Hospital	10.1%	96.5%
Day case		
Bristol	13.1%	99.0%
Weston	32.7%	100.0%
Trust total	**17%**	**99.4%**

*The FFT score is calculated as those reporting their overall experience of care as 'very good' or 'good' divided by the total number of responses

We have successfully integrated the Friends and Family Test approach across our hospitals from 1st April 2021. We expect this approach to improve response rates in the Division of Weston and in doing so provide increasingly useful data on the experience of patients for quality assurance and improvement.

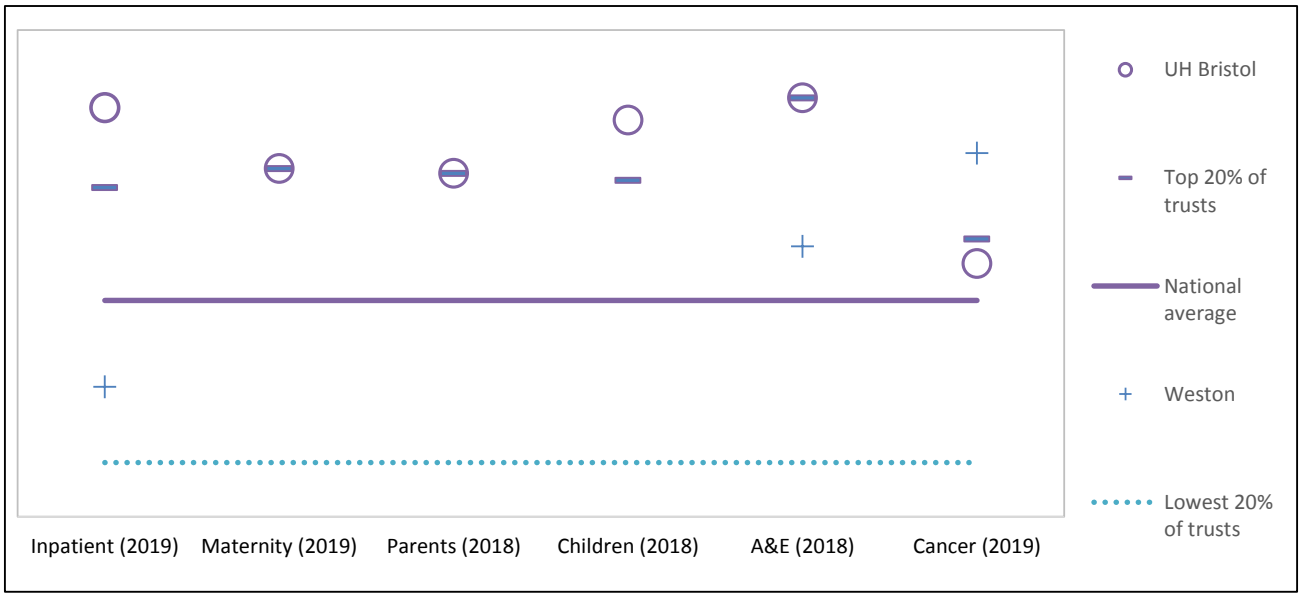
7. Patient Surveys: national benchmarks

The Care Quality Commission's national patient survey programme provides a comparison of patient-reported experience across NHS trusts in England. The data currently available pre-dates the UH Bristol / Weston Area Health Trust merger. Chart 9 overleaf shows that UH Bristol (as-was) tended to perform around or above the top 20% of trusts nationally in these surveys; whilst Weston Area Health NHS Trust (WAHT) performed broadly in line with the national average. There were particularly strong performances for UH Bristol in the national inpatient and Children's surveys, and for WAHT in the 2019 National Cancer Survey.

The results of each national survey, along with improvement actions / learning, are reviewed by the Trust's Patient Experience Group and the Quality and Outcomes Committee of the Trust Board.

The next national survey data that is due to be published will be for the National Urgent Care Survey (2020) and will be available in September 2021.

Chart 9: Overall experience relative to national benchmarks[2]



[2] This is based on the national survey question that asks patients to rate their overall experience. We have indexed (=100) each score to the national average to ease comparability. This overall question is not included in the national maternity survey and so we have constructed this score based on a mean score across all of the survey questions. Weston Area Health Trust does not participate in the national children's survey, national A&E survey, or the national maternity survey. Please note that the 2020 National Maternity Survey was cancelled for all Trusts by the CQC in response to the COVID-19 pandemic.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**Quarter 4 Complaints Report**
Report Author	**Tanya Tofts, Patient Support and Complaints Manager**
Executive Lead	**Deirdre Fowler, Chief Nurse**

1. Report Summary

	Q4	
Total complaints received	**426**	↓
Complaints acknowledged within set timescale	**73.5%**	↓
Complaints responded to within agreed timescale – formal investigation	**72.5%**	↑
Complaints responded to within agreed timescale – informal investigation	**92.9%**	↑
Proportion of complainants dissatisfied with our response (formal investigation)	**3.5%**	↓

2. Key points to note

(Including decisions taken)

Improvements:

- In Q4, the Divisions of Women & Children, and Surgery continued to perform strongly in respect of meeting deadlines for complaint responses.
- The vast majority of complaints were dealt with informally, leading to quick resolution.
- Levels of dissatisfaction with formal complaints responses have been lower than (i.e. better than) the Trust's target for 13 out of the last 17 months
- Complaints about staff attitude and communication reduced for the second consecutive quarter.
- Complaints related to the contract security staff, employed by the Trust during the pandemic, reduced in Q4.
- Complaints about Dermatology reduced significantly in Q4 (from 23 complaints down to only 7).
- New Complaints/PALS/Bereavement Coordinator successfully appointed for the Division of Weston.

However:

- In Q4, the Trust's ability to conduct timely complaints investigations continued to be significantly impacted by wider divisional operational capacity in the face of the ongoing pandemic. Of particular note is the significant reduction in formal complaints responded to within the agreed timeframe by the Division of Weston where only a third of responses were sent out on time for the second consecutive

quarter. The Division of Medicine also struggled with timely responses in Q4, with 64% of responses meeting the agreed deadline; however, this was a marked improvement on the 40% reported in Q3.

- The volume of complaints being received by the Trust post-merger, coupled with staff sickness in the corporate complaints team, has resulted in a backlog of cases waiting to be assigned to a PSCT Complaints Officer and shared with Divisions for investigation. This backlog is being closely monitored by the PSCT Manager and the Head of Quality and a plan has been put in place to clear the backlog by the end of Q1 2021/22.
- Similarly, not all complaints were acknowledged in a timely way during Q4 – again, the recovery trajectory is for the end of Q1.

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

Risk 2680 - Risk that delays to complaints caseworkers contacting patients causes complainant dissatisfaction

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.

Patient Experience Group	20/6/21
Senior Leadership Team	23/6/21
Quality and Outcomes Committee	24/6/21

University Hospitals Bristol and Weston NHS Foundation Trust

Complaints Report

Quarter 4, 2020/2021

(1 January 2021 to 31 March 2021)

Author: Tanya Tofts, Patient Support and Complaints Manager

Quarter 4 Executive summary and overview

	Q4	
Total complaints received	426	↓
Complaints acknowledged within set timescale	73.5%	↓
Complaints responded to within agreed timescale – formal investigation	72.5%	↑
Complaints responded to within agreed timescale – informal investigation	92.9%	↑
Proportion of complainants dissatisfied with our response (formal investigation)	3.5%	↓

Successes

- In Q4, the Divisions of Women & Children and Surgery continued to perform strongly in respect of meeting deadlines for complaint responses.
- The vast majority of complaints were dealt with informally, leading to quick resolution.
- Levels of dissatisfaction with formal complaints responses have been lower than (i.e. better than) the Trust's target for 13 out of the last 17 months
- Complaints about staff attitude and communication reduced for the second consecutive quarter.
- Complaints related to the contract security staff, employed by the Trust during the pandemic, reduced in Q4.
- Complaints about Dermatology reduced significantly in Q4 (from 23 complaints down to only 7).
- New Complaints/PALS/Bereavement Coordinator successfully appointed for the Division of Weston.

Opportunities

- Opportunity for significant improvement in complaints performance in Weston Division following recruitment to roles in the new divisional complaints, PALS and bereavement team

Priorities

- To support divisions to return to pre-pandemic levels of compliance with the important target of sending out 95% of complaint responses by the time agreed with the complainant.
- To re-open the PSCT 'drop in' service in the Bristol Royal Infirmary as soon as this can safely be done in 2021 once lockdown restrictions and hospital visiting arrangements are eased.
- Urgent review of overdue complaints responses in Weston Division

Risks & Threats

- In Q4, the Trust's ability to conduct timely complaints investigations continued to be significantly impacted by wider divisional operational capacity in the face of the ongoing pandemic. Of particular note is the significant reduction in formal complaints responded to within the agreed timeframe by the Division of Weston where only a third of responses were sent out on time for the second consecutive quarter. The Division of Medicine also struggled with timely responses in Q4, with 64% of responses meeting the agreed deadline; however, this was a marked improvement on the 40% reported in Q3.
- The volume of complaints being received by the Trust post-merger, coupled with staff sickness in the corporate complaints team, has resulted in a backlog of cases waiting to be assigned to a PSCT Complaints Officer and shared with Divisions for investigation. This backlog is being closely monitored by the PSCT Manager and the Head of Quality and a plan has been put in place to clear the backlog by the end of Q1 2021/22.
- Similarly, not all complaints were acknowledged in a timely way during Q4 – again, the recovery trajectory is for the end of Q1.

1. Complaints performance – Trust overview

The Trust is committed to supporting patients, relatives and carers in resolving their concerns. Our service is visible, accessible and impartial, with every issue taken seriously. Our aim is to provide honest and open responses in a way that can be easily understood by the recipient.

During Quarter 4 (Q3) of 2020/21, the Trust received 426 complaints, a reduction on the 490 received in Q3 and similar to the 444 received during the same period a year ago. The service has remained very busy, receiving 381 other enquiries in addition to the 426 complaints.

1.1 Total complaints received

The Trust received 426 complaints in Q4. This total includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1] but does not include concerns which may have been raised by patients and dealt with immediately by front line staff. Figure 1 provides a long-term view of complaints received per month.

In figures 1 to 5, the point at which Weston Area Health NHS Trust (WAHT) merged with University Hospitals Bristol NHS Foundation Trust (UH Bristol) is indicated by a green diamond-shaped marker.

Figure 1: Number of complaints received

[1] Informal complaints are dealt with quickly via direct contact with the appropriate department, whereas formal complaints are dealt with by way of a formal investigation via the Division.

Figure 2: Numbers of formal v informal complaints

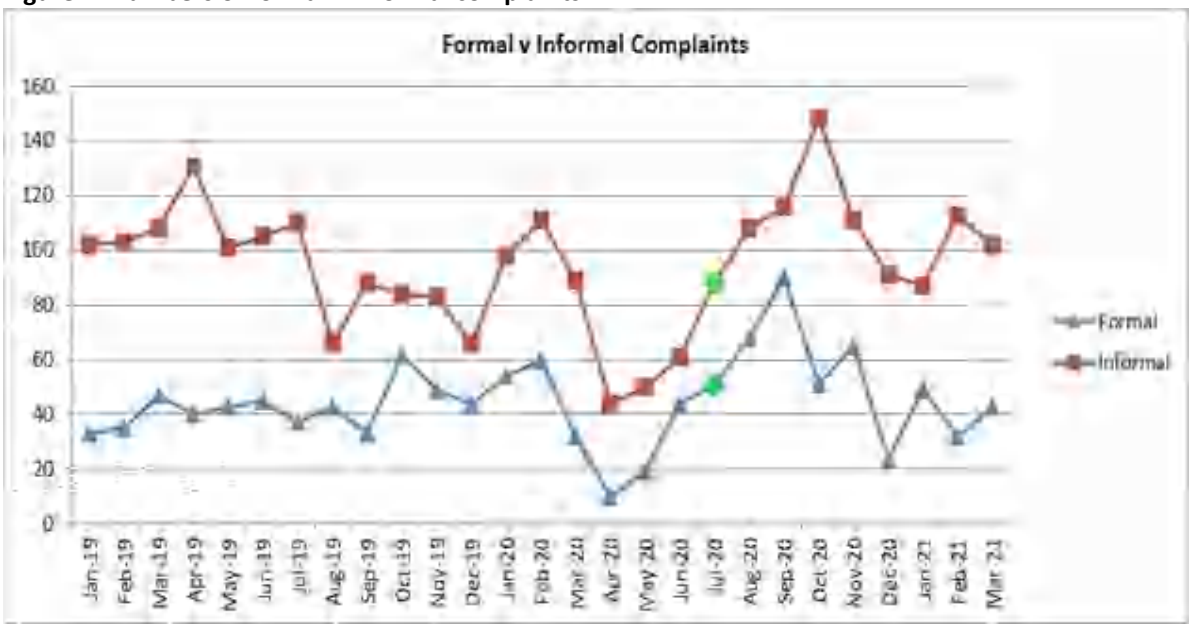


Figure 2 (above) shows complaints dealt with via the formal investigation process (124) compared with those dealt with via the informal investigation process (302), over the same period. We continue to deal with a higher proportion of complaints via the informal process, which means that these issues are being dealt with as quickly as possible and by the specialty managers responsible for the service involved.

1.2 Complaints responses within agreed timescale

Whenever a complaint is managed through the formal resolution process, the Trust and the complainant agree a timescale within which we will investigate the complaint and write to the complainant with our findings, or arrange a meeting to discuss them. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days.

When a complaint is managed through the informal resolution process, the Trust and complainant also agree a timescale and this is usually 10 working days.

During Q4, divisions were given longer timescales for responding to complaints, in order to help mitigate the impact of the additional operational pressures on them due to the Covid-19 pandemic. With the exception of the Division of Women & Children (who adhered to the usual timescales), divisions were given 15 working days to respond to informal complaints and 45 working days for formal complaints.

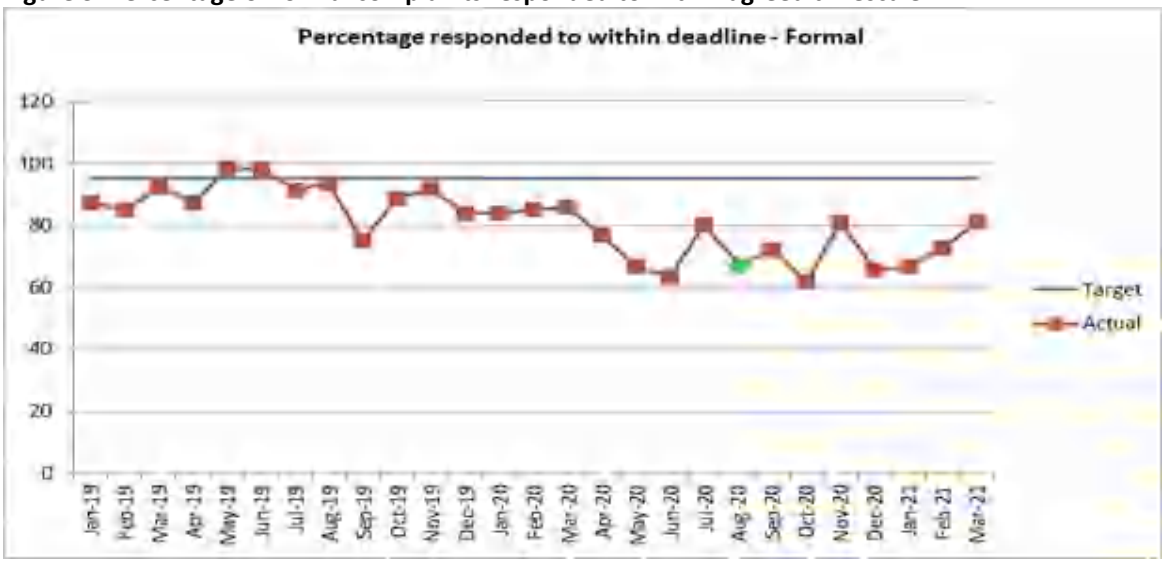
1.2.1 Formal Investigations

The Trust's target is to respond to at least 95% of complaints within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant. In Q4 2020/21, 72.5% of responses were sent to complainants within the agreed timescale. This represents 40 breaches out of the 160 formal complaint responses which were sent out during the

quarter[2]. This is a slight improvement on the 69.1% reported in Q3, although still significantly below the Trust target of 95%.

Figure 3 shows the Trust's performance in responding to complaints since January 2019. Please see section 3.3 of this report for details of where these breaches occurred and at which part of the process they were delayed.

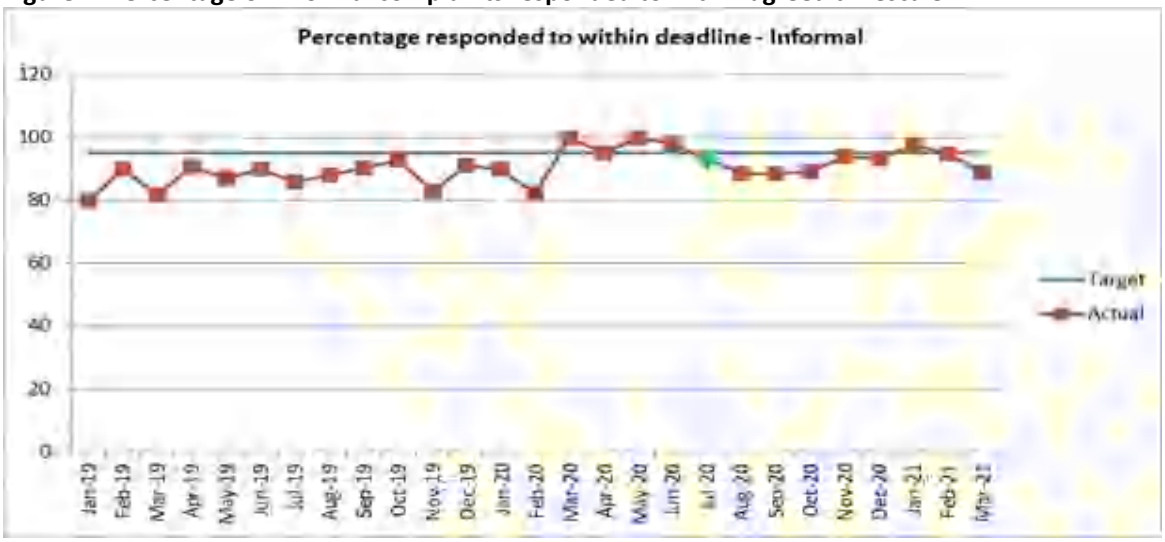
Figure 3: Percentage of formal complaints responded to within agreed timescale



1.2.2 Informal Investigations

In Q4 2020/21, the Trust received 302 complaints that were investigated via the informal process. During this period, the Trust responded to 140 complaints via the informal complaints route and 92.9% (130) of these were responded to by the agreed deadline, a marginal improvement on the 92.1% reported in Q3. Figure 4 (below) shows performance since January 2019, for comparison with formal complaints.

Figure 4: Percentage of informal complaints responded to within agreed timescale



[2] Note that this will be a different figure to the number of complainants who *made* a complaint in that quarter.

1.3 Dissatisfied complainants

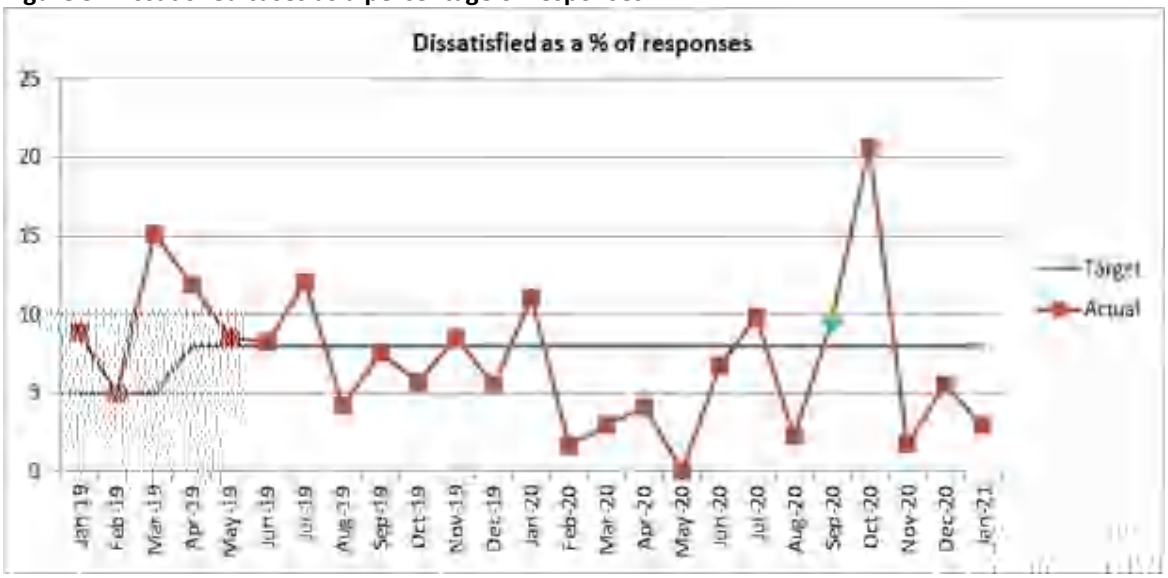
The Trust's target is that no more than 8% of complaints responses should lead to a dissatisfied response.

This data is reported **two months in arrears** in order to capture the majority of cases where, having considered the findings of our investigations, complainants tell us they are not happy with our response.

In Q4 2020/21, we are able to report dissatisfied data for November and December 2020 and January 2021. Of the 200 complainants who received a first response from the Trust during those months, seven have since contacted us to say they were dissatisfied. This represents 3.5% of the 200 first responses sent out during that period and compares favourably with the 11.5% reported in Q3.

Figure 5 shows the monthly percentage of complainants who were dissatisfied with aspects of our complaints responses since January 2019. This data includes dissatisfied cases for the Division of Weston since June 2020, relating to responses sent out in April 2020, as this is reported two months in arrears.

Figure 5: Dissatisfied cases as a percentage of responses



2. Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of eight major categories, or themes. Table 1 provides a breakdown of complaints received in Q4 2020/21 compared with Q3.

Complaints decreased in the majority of categories in Q4, with the exception of 'Information & Support' and 'Facilities & Environment', which saw slight increases. The top three categories of 'clinical care', 'appointments and admissions' and 'attitude and communication' accounted for 73.7% (314/426) of all complaints received, as detailed in Table 1 below.

Table 1: Complaints by category/theme

Category/Theme	Number of complaints received in Q4 (2020/21)	Number of complaints received in Q3 (2020/21)
Clinical Care	122 (28.6% of total complaints) ↓	144 (29.4% of total complaints) ↓
Attitude & Communication	113 (26.5%) ↓	134 (27.3%) ↑
Appointments & Admissions	79 (18.5%) ↓	103 (21%) ↓
Information & Support	45 (10.6%) ↑	32 (6.5%) ↓
Facilities & Environment	33 (7.8%) ↑	31 (6.3%) ↓
Discharge/Transfer/Transport	17 (4%) =	17 (3.5%) ↓
Documentation	11 (2.6%) ↓	14 (2.9%) ↑
Access	6 (1.4%) ↓	15 (3.1%) ↑
Total	**426**	**490**

Each complaint is also assigned to a more specific sub-category, of which there are over 100. Table 2 lists the most commonly reported sub-categories, which together accounted for 79.6% of the complaints received in Q4 (339/426).

There are some significant increases in several sub-categories. Of particular note are the increases in complaints about lost personal (patient) property, incorrect entries in patient notes and medication errors. Where themes or trends have been identified in these areas, the appropriate divisions have been asked to comment in section 3 of this report. The largest percentage decrease was seen in complaints about 'clinical care (nursing/midwifery)'.

Table 2: Complaints by sub-category

Sub-category	Number of complaints received in Q4 (2020/21)	Q3 (2020/21)	Q2 (2020/21)	Q1 (2020/21)
Cancelled/delayed appointments and operations	69 (10.4% decrease compared with Q3) ↓	77	93	31
Clinical care (Medical/Surgical)	68 (8.1% decrease) ↓	74	115	33
Communication with patient/relative	42 (5% increase) ↑	40	34	18
Lost personal property	21 (133.3% increase) ↑	9	10	12
Clinical care (Nursing/Midwifery)	20 (39.4% decrease) ↓	33	29	12
Attitude of medical staff	16 (5.9% decrease) ↓	17	17	7
Discharge arrangements	15 (25% increase) ↑	12	19	10
Failure to answer phones / failure to respond	15 (25% decrease) ↓	20	14	6
Attitude of Nursing/Midwifery	14 (17.6% decrease) ↓	17	17	12
Clinical information request	13 (62.5% increase) ↑	8	7	3
Infection control / infectious disease enquiry	10 (42.9% increase) ↑	7	13	7
Information about patient	10 (42.9% increase) ↑	7	9	2
Incorrect entry in notes	9 (125% increase) ↑	4	2	2
Confidentiality	9 (28.6% increase) ↑	7	2	1
Medication incorrect / not received	8 (100% increase) ↑	4	3	2

Figures 6-9 (below) show the longer term pattern of complaints received since January 2019 for a number of the complaints categories and sub-categories reported in Tables 1 and 2.

Figure 7 shows that complaints about 'cancelled/delayed appointments and operations' began to climb significantly from May 2020 and followed this trajectory until there was a significant reduction in the latter part of Q3.

Figures 8 and 9 show an increase in complaints about 'attitude and communication', which peaked in November 2020. The increase in complaints reported in this category was raised as a concern during the December 2020 meeting of the Trust's Quality and Outcomes Committee, which prompted a detailed review by the Patient Support & Complaints Manager. This is being closely monitored and, whilst no particular trends or themes have been identified in respect of particular departments or services, complaints in this category are 48.7% higher than for the same period one year ago. The Division of Surgery has the highest percentage of 'attitude and communication' complaints overall, with 25.7% (29 of 113) of all complaints in this category. However, as a percentage of each division's own complaints, Trust Services has the highest percentage in this category at 33.3% or seven of the 21 complaints they received. The number of complaints in this category was very similar across inpatient (47) and outpatient (42) services.

There was, however, a further 15.7% decrease Trustwide in complaints in this category in Q4 and this reduction was reflected across all divisions, with the exception of Women & Children, which saw a small increase.

Trends in categories and sub-categories of complaints are explored in more detail in the individual divisional details from section 3.1.1 onwards.

Figure 6: Clinical care – Medical/Surgical

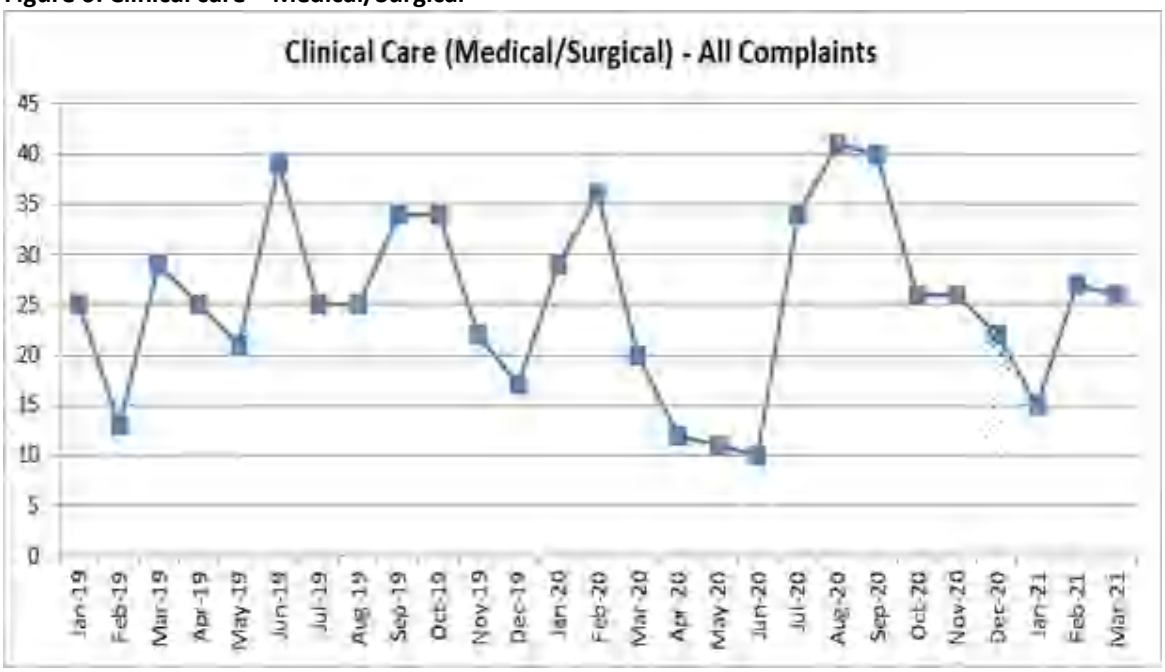


Figure 7: Cancelled or delayed appointments and operations

Figure 8: Communication with patient/relative

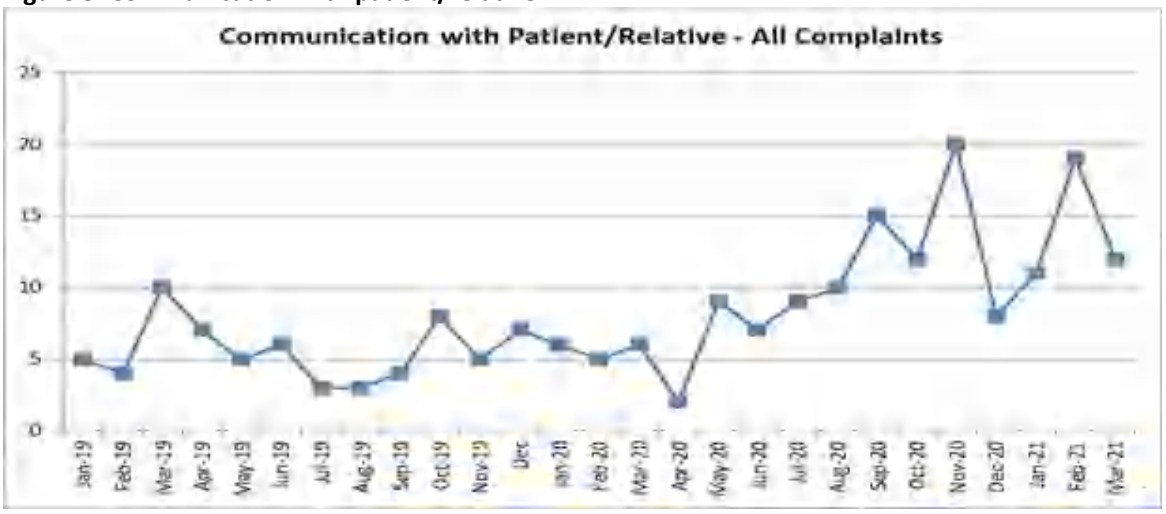


Figure 9: Attitude and Communication

3. Divisional Performance

3.1 Divisional analysis of complaints received

Table 3 provides an analysis of Q4 complaints performance by Division. In addition to providing an overall view, the table includes data for the three most common reasons why people complain: concerns about appointments and admissions; and concerns about staff attitude and communication. Data for the Division of Trust Services (21 complaints) is not included in this table but is summarised in section 3.1.7 of the report.

Table 3	**Surgery**	**Medicine**	**Specialised Services**	**Women & Children**	**Diagnostics & Therapies**	**Weston**
Total number of complaints received in Q4	108 (121) ↓	103 (115) ↓	48 (63) ↓	73 (76) ↓	8 (23) ↓	65 (64) ↑
Number of complaints about appointments and admissions	41 (49) ↓	7 (18) ↓	11 (21) ↓	8 (9) ↓	2 (3) ↓	10 (3) ↑
Number of complaints about staff attitude and communication	29 (32) ↓	27 (31) ↓	14 (19) ↓	17 (15) ↑	1 (6) ↓	18 (20) ↓
Number of complaints about clinical care	21 (29) ↓	30 (36) ↓	14 (16) ↓	38 (29) ↑	2 (6) ↓	20 (28) ↓
Area where the most complaints have been received in Q4	Bristol Eye Hospital (BEH) – 23 (32) Bristol Dental Hospital (BDH) – 29 (32) Queens Day Unit – 9 (6) ENT – 8 (14) Oral & MaxFax Surgery – 10 (12)	Emergency Department (BRI) (inc. A413 EMU) – 37 (39) Dermatology – 7 (23) Unity Sexual Health – 6 Ward A800 – 6 (0) Ward A522 – 5 (2)	**BHI (all) – 35 (46)** **BHOC (all) – 10 (16)** (plus two for Clinical Genetics and one for Clinical Trials Unit) BHI Outpatients – 12 (31) BHOC Outpatients – 6 (6) Ward C708 – 5 (5)	**BRHC (all) – 42 (40)** Paediatric Neurology / Neurosurgical – 7 (3) Children's ED – 6 (2) Carousel Outpatients – 4 (7) Caterpillar Ward – 4 (1) **StMH (all) – 31 (34)** NICU – 7 (0) Gynae Outpatients – 6 (4)	Radiology – 5 (13)	Accident & Emergency – 18 (15) Hutton Ward – 5 (3) Kewstoke Ward – 5 (2) Outpatients (Quantock) - 4
Notable deteriorations compared with Q3	No notable deteriorations	Ward A800 – 6 (0)	No notable deteriorations	NICU – 7 (0) Paediatric Neurology / Neurosurgical – 7 (3)	No notable deteriorations	No notable deteriorations
Notable improvements compared with Q3	ENT – 8 (14) BEH – 23 (32)	Dermatology – 7 (23)	BHI Outpatients – 12 (31)	No notable improvements	Radiology – 5 (13) Speech & Language Clinic Rooms – 0 (6)	Harptree Ward – 0 (4) Steepholm Ward – 0 (3)

3.1.1 Division of Surgery

The Division of Surgery received 108 new complaints in Q4; a small reduction on the 121 received in Q3. Of these 108 complaints, 47 were in respect of outpatient services and 42 were about inpatient services. The largest number of complaints received by the Division was again recorded under the category of 'appointments and admissions' (38%), with the majority (33 of 41) being about cancelled or delayed appointments and operations. There was a noticeable increase in complaints about 'Information & Support', which includes concerns raised about patient, hospital or clinical information not being provided in a timely manner. Complaints in this category increased from 4 in Q3 to 15 in Q4.

The Division achieved 96.8% against its target for responding to formal complaints within the agreed timescale in Q4, compared with 90.2% in Q3, and 97.1% for informal complaints, the same percentage that was reported in Q3. It should be noted that there was one breach of deadline for the division in respect of formal complaints and this was due to a delay in in the Patient Support and Complaints Team – if not for this, the Division would have achieved 100%. Please see section 3.3 Table 22 for details of where in the process any delays occurred.

Table 4: Complaints by category type

Category Type	Number and % of complaints received – Q4 2020/21	Number and % of complaints received – Q3 2020/21
Appointments & Admissions	41 (38% of total complaints) ↓	49 (40.5% of total complaints) ↓
Attitude & Communication	29 (26.9%) ↓	32 (26.4%) ↑
Clinical Care	21 (19.4%) ↓	29 (24%) ↓
Information & Support	15 (13.9%) ↑	4 (3.3%) ↑
Discharge/Transfer/ Transport	1 (0.9%) ↓	2 (1.7%) ↓
Access	1 (0.9%) ↓	2 (1.7%) ↑
Documentation	0 (0%) ↓	2 (1.7%) =
Facilities & Environment	0 (0%) ↓	1 (0.7%) ↓
Total	**108**	**121**

Table 5: Top sub-categories

Category	Number of complaints received – Q4 2020/21	Number of complaints received – Q3 2020/21
Cancelled or delayed appointments and operations	33 ↓	34 ↓
Clinical/hospital/patient information	14 ↑	4 ↑
Clinical care (medical/surgical)	11 ↓	14 ↓
Communication with patient/relative	7 =	7 ↑
Failure to answer phone/ Failure to respond	6 ↓	7 ↑
Appointment administration issues	6 ↓	11 ↑
Attitude of medical staff	5 ↓	7 ↑
Clinical care (dental)	5 =	5 =

Table 6: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
The Division received 29 complaints about Bristol Dental Hospital (BDH) in Q4. This represents 26.9% of all complaints received by the Division. Of these 29 complaints, 15 were recorded under the category of 'appointments and admissions' and there were five each for 'attitude and communication' and 'clinical care'. Nine complaints were received for Child Dental Health (CDH).	A number of the complaints were in relation to patients who reported they had not received letters asking them to call us for an appointment to be made. CDH is not yet back to pre-Covid capacity, and there was further reduced capacity due to workforce challenges.	This was investigated with the company who post letters for the Trust (Synertec) and no delays were reported. Some letters were sent via Royal Mail, who were experiencing delays, so the call back time was extended. Additional weekend clinics have been happening and a consultant returned from maternity leave late last year, resulting in more appointments being made available.
A total of 23 complaints were received about Bristol Eye Hospital (BEH) in Q4. Of the 23 complaints received, 10 were about cancelled or delayed appointments/operations; six were in respect of 'attitude and communication' and four were about 'clinical care'.	For a large part of Q3 and 4, BEH theatres were closed due to the second Covid wave and staff needed to be redeployed into ITU and wards on the main BRI site. Outpatient appointments were also reduced due to the need to redeploy staff and also due to Covid-related absences. Inevitably this led to cancelled or delayed care. It is possible that the stress that the workforce was under in Q4 has contributed to complaints relating to attitude, communication and clinical care.	Theatres and clinics have now been restored, although continue to be impacted by social distancing. Waiting List Initiatives are in place, which partly compensate for lost capacity. Work is underway to find a new location for the Diagnostic Hub (diagnostic testing centre). Transformation resource is in place to improve theatre efficiency, specifically focusing on cataracts, with the aim of increasing throughput. All complaints relating to communication, attitude and clinical care are discussed with the individuals concerned where they remain employed by UHBW. Individuals are asked to reflect on behaviour where appropriate, to prevent similar incidences. Training is offered where required and if it is available.
Nine complaints were received for the Queen's Day Unit in Q4, with eight being in respect of Endoscopy and one for the waiting list team.	Extremely high volume of calls due to very high volume of patients on the waiting list, which has severely increased due to the pandemic.	Increased administrative support has been provided, with two whole time equivalents appointed to the bookings team in March 2021. The management team regularly monitor the call handling in the bookings team and produce a monthly call handling report to ensure the appropriateness and timeliness of calls. Recruitment is also

		underway for one additional whole time equivalent to the endoscopy Pre-Assessment nursing team due to the increase in demand and pressures on the team. It will be reiterated to all staff that they ensure clear communications and actions to the patients if, for an unforeseen circumstance, the patients has had to be cancelled last minute. An in-patient bleep has been implemented, which takes out clinical calls to the phone line, freeing it up for the outpatient incoming calls.

Current divisional priorities for improving how complaints are handled and resolved:

The Division has not identified any problems in the investigation journey of their complaints. They continue to manage all complaints in a timely way, ensuring patients' concerns are addressed appropriately.

Priority issues we are seeking to address based on learning from complaints.

The Division proactively monitors any themes and trends identified as a result of complaints received. For example, a trend was identified in a previous report in respect of complaints received about Covid-19 measures in place to protect staff and patients in the ENT Outpatient Clinic. As a result of this, a number of steps were taken to ensure improved communication between staff and patients around face covering and social distancing in the waiting area was improved. This led to a notable reduction in complaints received by the service in Q4 and offers assurance that the Division manages complaints in a ways that enables trends to be identified and acted upon at an early stage.

Figure 10: Surgery – formal and informal complaints received

Figure 11: Surgery – Appointments and admissions

3.1.2 Division of Medicine

The Division of Medicine received 103 new complaints in Q4; a slight reduction on the 115 received in Q3. The largest number of complaints received by the Division was recorded under the category of 'clinical care' (29.1%), with more than half (16 of 30) being about 'clinical care (medical/surgical)'. There was a noticeable decrease in complaints about cancelled or delayed appointments/operations decreasing from 15 in Q3 to seven in Q4. Complaints about lost patient property increased to the highest number recorded since March 2016 when complaints were first recorded on Datix.

The Division achieved 64.3% against its target for responding to formal complaints within the agreed timescale in Q4, a significant improvement on 39.4% reported in Q3, although still below the 95% target. For informal complaints, the Division achieved 88.9& for responding within the agreed timescale; again an improvement compared with 84.9% in Q3. Please see section 3.3 Table 22 for details of where in the process any delays occurred.

Table 7: Complaints by category type

Category Type	**Number and % of complaints received – Q4 2020/21**	**Number and % of complaints received – Q3 2020/21**
Clinical Care	30 (29.1% of total complaints) ↓	36 (31.3% of total complaints) ↓
Attitude & Communication	27 (26.2%) ↓	31 (27%) ↑
Information & Support	14 (13.6%) ↑	6 (5.2%) ↓
Facilities & Environment	11 (10.7%) ↑	9 (7.8%) ↑
Discharge/Transfer/ Transport	10 (9.7%) ↑	7 (6.1%) ↓
Appointments & Admissions	7 (6.8%) ↓	18 (15.7%) ↑
Documentation	4 (3.9%) ↓	7 (6.1%) ↑
Access	0 (0%) ↓	1 (0.8%) ↓
Total	**103**	**115**

Table 8: Top sub-categories

Category	Number of complaints received – Q4 2020/21	Number of complaints received – Q3 2020/21
Clinical care (medical/surgical)	16 ↓	17 ↓
Lost personal property	9 ↑	5 ↑
Communication with patient/relative	8 ↑	7 ↑
Attitude of nursing staff	8 ↑	7 ↑
Discharge arrangements	8 ↑	5 ↓
Clinical care (nursing/midwifery)	7 ↓	13 ↑
Cancelled or delayed appointments and operations	7 ↓	15 ↑
Infection Control / Infectious disease enquiry	5 ↑	2 =

Table 9: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
There has been a marked increase in the number of complaints received about lost patient property, with the majority for the Divisions of Medicine and Weston. In Q4, there were nine complaints about this issue for Medicine, five of which were about property lost in the BRI Emergency Department (ED).	Due to the increasing pressure in the ED and the fact that the department operates out of A300 and the old ED estate, patient property has been an issue and the speed in which patients are moved from ED to the wards is having an impact on this.	The process of ensuring patient property remains with the patient is being reviewed and a LASER poster (Learning After Significant Event Recommendation) is being shared within the division to highlight the issue of lost and missing property.
In Q4, there were 30 complaints with a primary category of 'clinical care'. Over half of these complaints (16) were for the BRI Emergency Department with the remainder spread across a variety of inpatient and outpatient settings.	The ED is seeing increased numbers of patients, which is being described as the numbers of patients that would typically be seen in the winter. The team has also seen an increase in patients with mental health issues, which has been very challenging and the correct redirection of patients has resulted in an increase in complaints.	Due to the increased number of patients being seen in the ED, and across the Division of Medicine, the Trust wellbeing team are working with all teams and providing support. The senior nursing team in the Division of Medicine (Matrons and Sisters) is being supported to undertake coaching and leadership courses to build resilience and enable reflection on what staff have been through during the pandemic. It is anticipated that these two measures to support staff wellbeing, will in turn help to

		reduce the number of complaints being received, particularly in the ED, by staff who are struggling to cope with the increased workload and pressures caused by the pandemic, which can understandably impact on the level of service they are able to offer our patients.

Current divisional priorities for improving how complaints are handled and resolved:

- The importance of 'nipping issues in the bud' has been shared with the teams.
- Responding to informal complaints is a priority in the division.

Priority issues we are seeking to address based on learning from complaints.

- The division is pulling together some customer service training for staff in the division.
- A LASER poster (Learning After Significant Event Recommendation) has been produced, to share with staff, about the loss of patient property.

Figure 12: Medicine – formal and informal complaints received

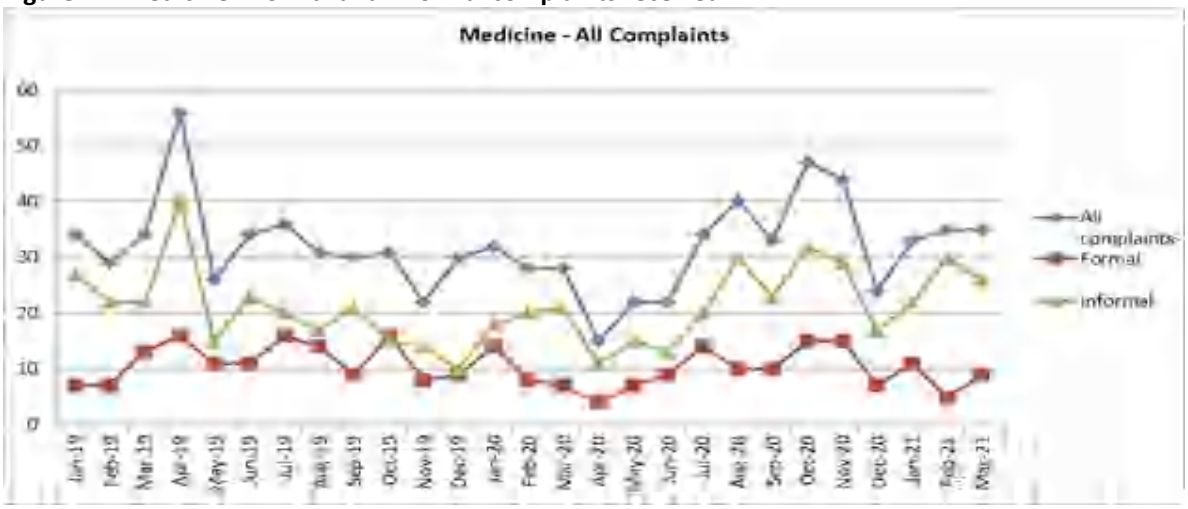
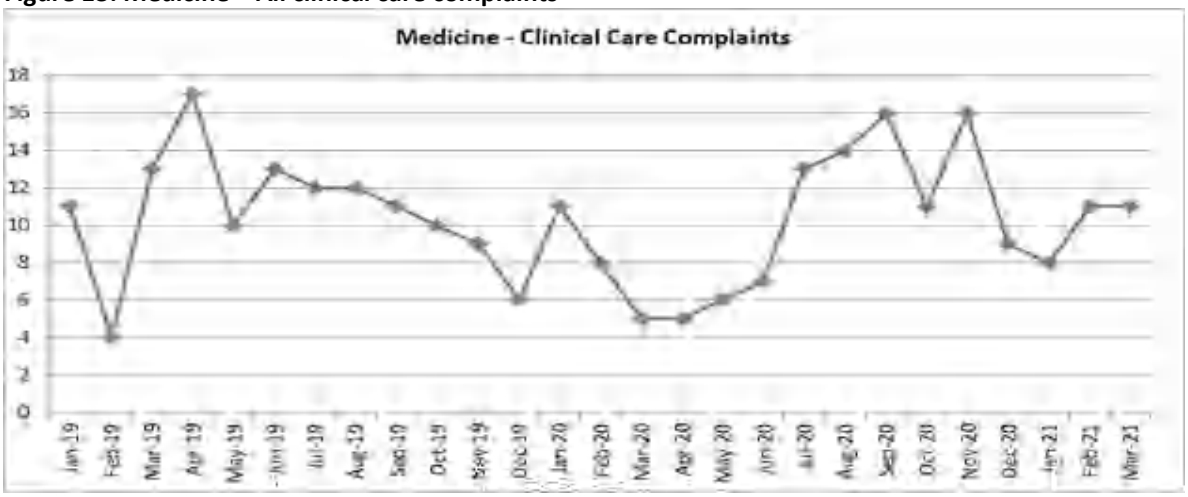


Figure 13: Medicine – All clinical care complaints



3.1.3 Division of Specialised Services

The Division of Specialised Services received 48 new complaints in Q4; a decrease on the 63 received in Q3. Of these complaints, 35 were for the Bristol Heart Institute (BHI], compared with 46 in Q3; and 10 were for the Bristol Haematology & Oncology Centre (BHOC), compared with 16 in Q3. In addition, there were two complaints for Clinical Genetics and one for the Clinical Trials Unit.

The largest number of complaints received by the Division was recorded under the category of 'attitude and communication' (29.2%), with the majority (8 of 14) being about communication with the patient/relative or between staff. There was a noticeable decrease in complaints about 'appointments and admissions', from 21 in Q3 to 11 in Q4. There was also a significant (61.3%) reduction in complaints received for BHI Outpatients, from 31 in Q3 to 12 in Q4.

The Division achieved 77.8% against its target for responding to formal complaints within the agreed timescale in Q4, compared with 78.6% in Q3, and 100% for informal complaints, compared with 95% in Q3. Please see section 3.3 Table 22 for details of where in the process any delays occurred.

Table 10: Complaints by category type

Category Type	Number and % of complaints received – Q4 2020/21	Number and % of complaints received – Q3 2020/21
Attitude & Communication	14 (29.2% of total complaints) ↓	19 (30.2%) ↑
Appointments & Admissions	11 (22.9%) ↓	21 (33.3%) ↑
Clinical Care	11 (22.9%) ↓	16 (25.4%) ↑
Information & Support	4 (8.3%) ↑	2 (3.2%) ↓
Discharge/Transfer/ Transport	4 (8.3%) ↑	2 (3.2%) =
Documentation	3 (6.3%) ↑	1 (1.5%) =
Facilities & Environment	1 (2.1%) ↓	2 (3.2%) ↓
Access	0 (0%) =	0 (0%) ↓
Total	**48**	**63**

Table 11: Top sub-categories

Category	Number of complaints received – Q4 2020/21	Number of complaints received – Q3 2020/21
Cancelled or delayed appointments and operations	11 ↓	17 ↑
Clinical care (medical/surgical)	8 ↓	9 ↓
Failure to answer phone/ Failure to respond	4 ↓	6 =
Communication with patient/relative	7 =	7 ↑
Discharge arrangements	4 ↑	1 ↓

Table 12: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
The Division received 12 complaints for the Outpatient Department at the BHI. This represents a quarter of all complaints received. Complaints were recorded under a number of categories, including 'appointments and admissions', 'attitude and communication' and 'documentation'.	Whilst there were no consistent themes emerging, the complaints received were as follows: Three complaints related to chasing MRI and heart monitor results; two relate to chasing new medication and sharing of information with GPs; two were about clinic letters sent out with inaccuracies (both letters sent by same Registrar); and there was one complaint each about - a member of staff requiring guidance on their return to work, a patient who had been discharged from the service but had requested a review, a patient chasing a telephone appointment which had not gone ahead, and one complainant was chasing paperwork to be sent to the DVLA, which is undertaken by consultants as part of their private work.	Investigations into each complaint showed that delayed results had been sent to the patients' GPs and letters were resent to GPs where appropriate. The registrar who sent inaccurate letters has discussed with their Medical Supervisor and plan put in place going forward to check that all records and all letters are accurate. Appointments were made or rescheduled as necessary and a reminder was sent to the consultant who needed to complete the DVLA paperwork.
Complaints received about the BHOC Outpatients Department, whilst not high in terms of numbers (6), they do represent 60% of all complaints received by BHOC. The complaints are recorded under a variety of categories, including communication with patient/relative and appointment issues.	The complaints made have been investigated and no themes or trends were identified. The complaints included the misdiagnosis of the spread of metastatic cancer; concerns about brachytherapy treatment; and delayed results for an MRI scan.	No themes were identified but all complaints have been thoroughly investigated and action taken as appropriate. Two of the six complaints did not proceed to investigation due to patient consent not being returned.

Current divisional priorities for improving how complaints are handled and resolved:

Issues through Q4 and into Q1 relate to staff movement/leavers leaving gaps in the Specialised Services Management Team, particularly with the BHOC team and BHI matron team. This has resulted in an impact on ability to investigate and respond in timely fashion. All vacancies have been recruited to and once in post, the Division should improve on its ability to investigate and respond in timely fashion.

Priority issues we are seeking to address based on learning from complaints.

- Accuracy of clinic letters and documentation – reminder to be added to Divisional Patient Safety/Patient Experience newsletter.
- Details of Kallidus online training for 'Handling Complaints with Confidence' to be added to newsletter.
- Communication with families and patients on wards to be included in Ward Safety Briefs and newsletter.
- Improvement to be made to discharge process from ward; including discharge summaries, and communication with family.

Figure 14: Specialised Services – formal and informal complaints received

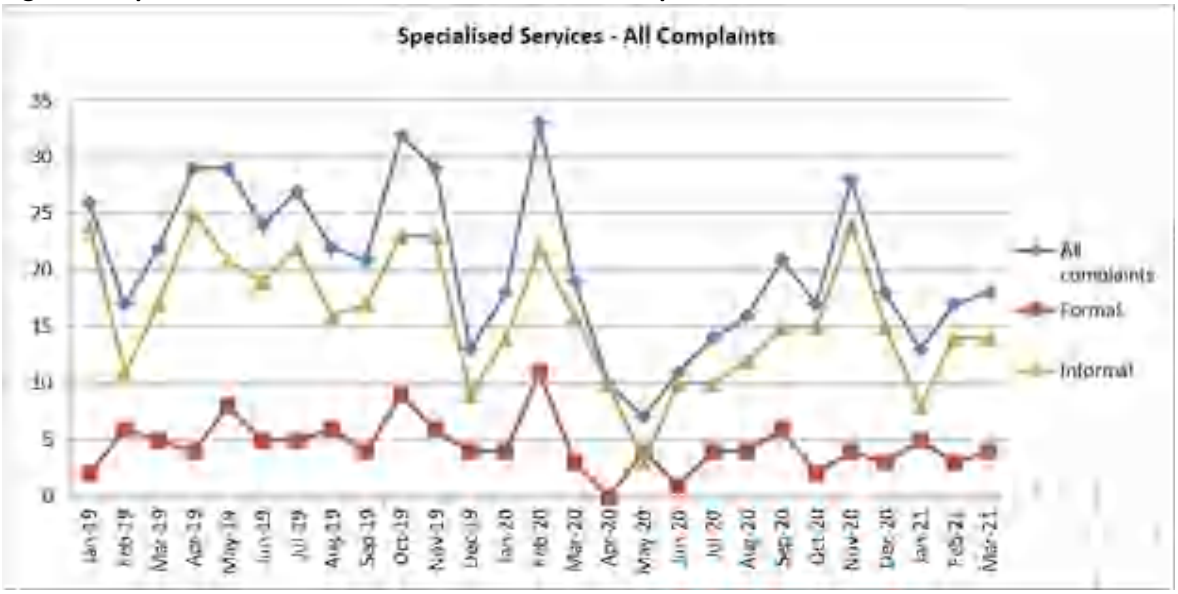


Figure 15: Complaints received by Bristol Heart Institute

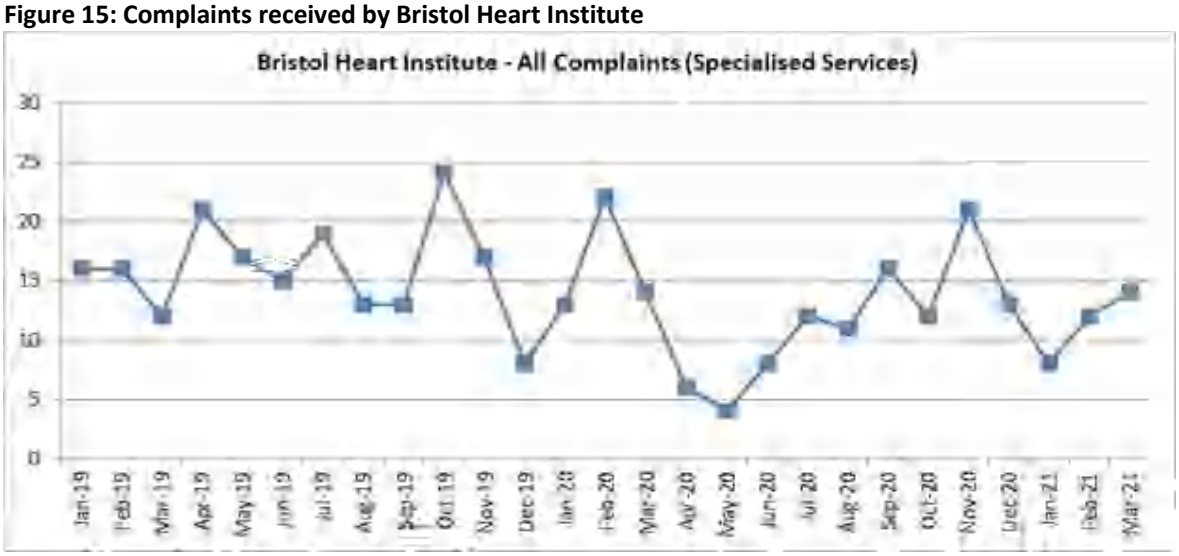
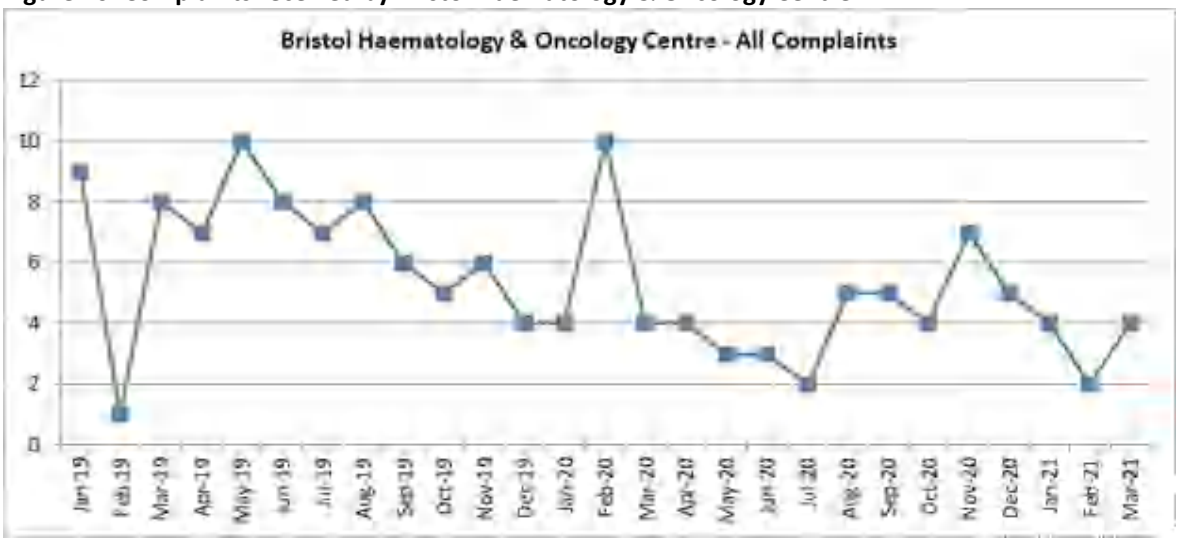


Figure 16: Complaints received by Bristol Haematology & Oncology Centre



3.1.4 Division of Women's and Children's Services

The Division of Women & Children received 73 new complaints in Q4; a similar number to the 76 received in Q3. Of these complaints, 42 were for Bristol Royal Hospital for Children (BRHC), compared with 40 in Q3; and 31 were for St Michael's Hospital (StMH), compared with 34 in Q3.

Complaints recorded under the primary category of 'clinical care' accounted for more than half of all complaints received by the Division in Q4 (38 of 73). Numbers of complaints in all other categories remained similar to the previous quarter. There was a 70% reduction in complaints received about visiting restrictions, following an increase in these complaints due to restrictions imposed by Covid-19 national guidance.

The Division achieved 92.5% against its target for responding to formal complaints within the agreed timescale in Q4, compared with 94.4% in Q3, and 100% for informal complaints for the second consecutive quarter. It should be noted that none of the three breaches of deadline in respect of formal complaints were due to complaints by the division. Please see section 3.3 Table 22 for details of where in the process any delays occurred.

Table 13: Complaints by category type

Category Type	Number and % of complaints received – Q4 2020/21	Number and % of complaints received – Q3 2020/21
Clinical Care	38 (52.1% of total complaints) ↑	29 (38.2%) ↓
Attitude & Communication	17 (23.3%) ↑	15 (19.7%) ↓
Appointments & Admissions	8 (11%) ↓	9 (11.8%) ↓
Access	4 (5.5%) ↓	10 (13.2%) ↑
Documentation	4 (5.5%) ↑	2 (2.6%) ↑
Information & Support	2 (2.6%) ↓	8 (10.5%) ↑
Discharge/Transfer/ Transport	0 (0%) ↓	1 (1.3%) ↑
Facilities & Environment	0 (0%) ↓	2 (2.6%) ↑
Total	**73**	**76**

Table 14: Top sub-categories

Category	Number of complaints received – Q4 2020/21	Number of complaints received – Q3 2020/21
Clinical care (medical/surgical)	21 ↑	14 ↓
Clinical care (nursing/midwifery)	9 ↓	13 ↓
Cancelled or delayed appointments and operations	7 ↑	5 ↓
Communication with patient/relative	5 ↓	9 ↑
Attitude of nursing staff	4 ↑	2 =
Attitude of medical staff	4 ↑	1 ↓
Incorrect entry in notes	4 ↑	0 =
Visiting hours/restrictions	3 ↓	10 ↑

Table 15: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
BRHC 23 of the 38 'clinical care' complaints received by the division were for BRHC. These accounted for over half of all complaints they received. The majority of these (17) were recorded under 'clinical care (medical/surgical)'. Of those 17 complaints, four were for the Children's Emergency Department; there were three each for Paediatric Gastroenterology and Paediatric Neurology; and two for Starlight Ward.	**BRHC** During Q4 the Division does recognise that the number of complaints received has escalated, and clinical care has become the predominant reason for this. The Division has been unable to identify a specific reason for this, and there is no specific theme that can be seen, for which action can be taken.	**BRHC** Whilst it has not been possible to identify an all-encompassing action to address the complaints made about clinical care, the Division is actively monitoring the complaints received, to ensure trends are not being overlooked. Individual actions are taken where appropriate, including arranging appointments when this has not been forthcoming, having direct telephone calls between the clinician and complainant to ensure clear explanations are provided and reflective discussions so that individuals can learn from the feedback received.
StMH St Michael's received 15 complaints about 'clinical care', representing almost half of all complaints received by the hospital in Q4. Seven of these were about 'clinical care (nursing/midwifery)' and four were for 'clinical care (medical/surgical)'.	**StMH** No themes have been identified in these complaints. The patients dealt with are often complex and this can lead to high levels of anxiety in patients, due to the nature of the service.	**StMH** All complaints have been reviewed and medicines and pain relief guidelines have been reiterated to all midwifery staff. The clinic letter in respect of the complaints for Reproductive Medicine has been reviewed with the staff involved.

BRHC Seven complaints were received for Paediatric Neurology/Neurosurgical, compared with three in Q3. Four of these complaints were about 'clinical care (medical/surgical)'; two were in respect of a lack of a follow-up appointment; and one was about communication. **StMH** Nine complaints were received about 'attitude and communication'. There were three complaints each for 'attitude of medical staff', 'attitude of nursing/midwifery' and 'communication with patient/relative'.	**BRHC** The neurology/neurosurgical teams treat some very complex patients, many of whom are also under the care of other specialties, or require input from other specialties. Where this is the case, there can sometimes be delays in follow up appointments due to input needed from elsewhere, which is not always clearly communicated to families. **StMH** Again, no themes have been identified and patients are unhappy with care at times from all disciplines.	**BRHC** The specific cases for which complaints were received, have been addressed on an individual level and appointments were arranged as appropriate. Explanations were also provided accordingly. The General Manager for Neurosciences and Cardiac is aware of the increase in complaints within this specialty and is closely monitoring this, alongside the Divisional Complaints Coordinator so that any trends can be identified and acted upon. **StMH** Complaints are always discussed with the staff involved and staff are urged to write their reflections. The Patient Safety Group has written guidelines for Venefor infusion as a result of a complaint. The Trust's Head of Midwifery is cross-city working with the Head of Midwifery in North Bristol to improve communication.
BRHC There was a spike in the number of complaints received by the hospital at the end of the quarter, with the highest monthly total since February 2020. Of the 22 complaints received in March 2021, five complaints were received for Paediatric Neurology/Neurosurgery; three for the Children's Emergency Department; and two each for Paediatric Cardiology, Paediatric Orthopaedics and Starlight Ward (E700).	**BRHC** The spike at the end of March cannot be definitely explained but may be partially impacted by the slow lifting of Covid-19 restrictions and therefore an increase in patient/parent expectations. That said, from the complaints made, there were genuine concerns raised and there were times when the patient experience fell below the standard expected.	**BRHC** The BRHC continues to monitor the feedback received and takes action where possible, to help prevent the same difficulties from reoccurring. Where this is applicable across the hospital, it is shared more widely. The teams and General Managers also continue to observe for trends and themes, and will take appropriate action as soon as these become apparent, to prevent the issue from escalating.

Current divisional priorities for improving how complaints are handled and resolved:

BRHC

The BRHC has a robust policy for handling and resolving complaints, and actions are taken as necessary to address the concerns that are raised. Our priority is to continue to provide the best service and care we can to our patients and their families by fully investigating and responding to the feedback we receive in a constructive manner, whilst recognising that, despite the best efforts of those involved, inevitably there will be occasions when we don't get it right.

Priority issues we are seeking to address based on learning from complaints.

BRHC

- Monitoring the increase in the number of complaints received as a whole, to identify if this is a blip or is indicative of a wider problem.
- Particularly monitor the feedback received for the Children's Emergency Department and Neurology/Neurosciences and address any trends identified.

Figure 17: Women & Children – formal and informal complaints received

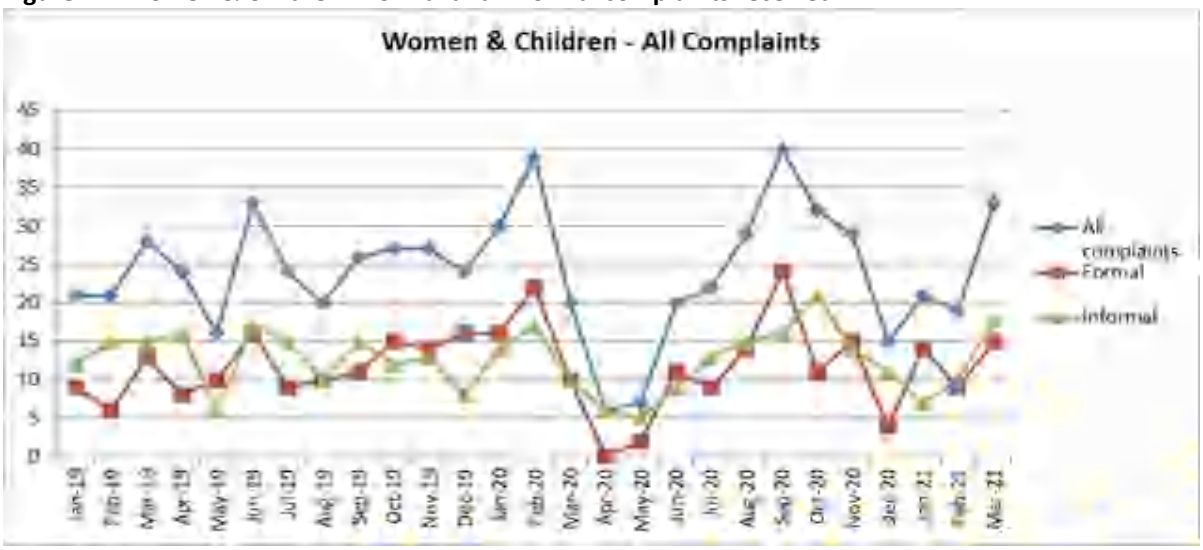


Figure 18: Complaints received by Bristol Royal Hospital for Children

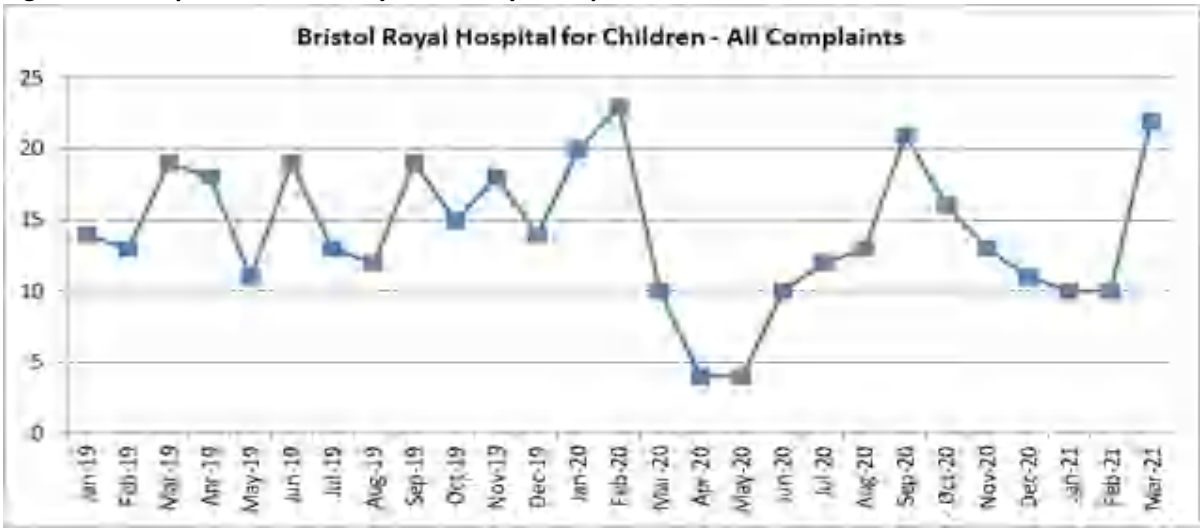


Figure 19: Complaints received by St Michael's Hospital

3.1.5 Division of Diagnostics & Therapies

The Division of Diagnostics & Therapies received eight new complaints in Q4; a significant reduction on the 23 received in Q3. There were no notable increases or decreases or any areas of concern identified in terms of themes or trends. The Division achieved 100% against its target for responding to formal complaints within the agreed timescale in Q4 for the fourth successive quarter, and 100% for informal complaints, compared with 95% in Q3.

Table 16: Complaints by category type

Category Type	Number and % of complaints received – Q4 2020/21	Number and % of complaints received – Q3 2020/21
Appointments & Admissions	2 (25% of total complaints) ↓	3 (13.1%) ↓
Clinical Care	2 (25%) ↓	6 (26.1%) ↑
Information & Support	2 (25%) ↓	5 (21.8%) ↑
Attitude & Communication	1 (12.5%) ↓	6 (26.1%) =
Facilities & Environment	1 (12.5%) =	1 (4.3%) ↑
Discharge/Transfer/ Transport	0 (0%) =	0 (0%) ↓
Documentation	0 (0%) ↓	1 (4.3%) ↓
Access	0 (0%) ↓	1 (4.3%) =
Total	**8**	**23**

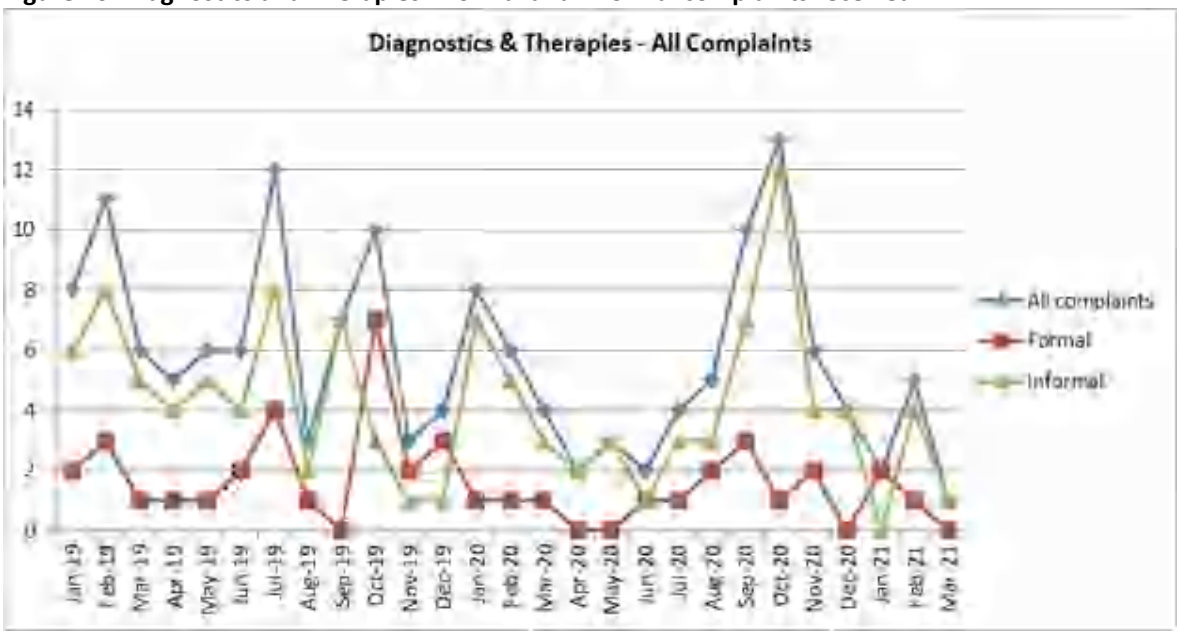
Current divisional priorities for improving how complaints are handled and resolved:

In Q4, the division achieved 100% compliance in responding to formal and informal complaints within the timeframe. As such, we have not identified any areas of concern when dealing with and investigating complaints. We aim to continue this standard of timely response into the next quarter.

Priority issues we are seeking to address based on learning from complaints.

- Improved communication with maternity services and ultrasound regarding the partners of patients being able/not able to attend scans; and
- Ensure robust means of communicating and documenting patients who are under the care of the mental health midwives within the ultrasound department.

Figure 20: Diagnostics and Therapies – formal and informal complaints received



3.1.6 Division of Weston

The Division of Weston received 65 new complaints in Q4; a similar number to the 64 received in Q3. The highest number of complaints received were those recorded under the category of 'clinical care' (20), closely followed by 'attitude and communication' (18). There were 12 complaints about 'facilities and environment' and 10 related to 'appointments and admissions'.

The largest number of complaints received by one department was 18 (27.7%) for the Accident & Emergency Department. There was a marked increase in complaints received about 'lost personal property', with the highest number reported since the merger of the trusts in April 2020. Complaints about 'clinical care (medical/surgical)' decreased for the third quarter in succession.

The Division achieved 31.3% against its target for responding to formal complaints within the agreed timescale in Q4, compared with 30% in Q3, and 82.4% for informal complaints, a slight deterioration on the 86.7% reported in Q3. Please see section 3.3 Table 22 for details of where in the process any delays occurred.

Table 17: Complaints by category type

Category Type	**Number and % of complaints received – Q4 2020/21**	**Number and % of complaints received – Q3 2020/21**
Clinical Care	20 (30.8% of total complaints) ↓	28 (43.8% of total complaints) ↓
Attitude & Communication	18 (27.7%) ↓	20 (31.3%) ↑
Facilities & Environment	12 (18.5%) ↑	5 (7.8%) ↓
Appointments & Admissions	10 (15.4%) ↑	3 (4.7%) ↓
Discharge/Transfer/ Transport	2 (3.1%) ↓	4 (6.3%) ↓
Information & Support	2(3.1%) =	2 (3.1%) ↓
Access	1 (1.4%) =	1 (1.5%) ↑
Documentation	0 (0%) ↓	1 (1.5%) ↓
Total	**65**	**64**

Table 18: Top sub-categories

Category	Number of complaints received – Q4 2020/21	Number of complaints received – Q3 2020/21
Communication with patient/relative	13 ↑	8 =
Clinical care (medical/surgical)	11 ↓	20 ↓
Lost personal property	10 ↑	3 ↓
Cancelled or delayed appointments and operations	10 ↑	3 ↓
Diagnosis issues	3 ↑	1 ↓
Clinical care (nursing/midwifery)	3 =	3 ↓

Table 19: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
The Division has seen a marked increase in complaints about lost patient property in Q4. Of the 10 complaints recorded, five were about personal property that went missing in the Emergency Department; three were for Hutton Ward; and one each for Kewstoke and Cheddar Wards. These 10 complaints make up the majority of the 12 recorded under 'facilities and environment', making this the category with the highest increase in complaints for the Division compared with the previous quarter.	Bedding can often hide patient property, i.e. rings that have slipped off and glasses. Prior to Covid-19 infection control, bedding would be gently shaken out to reveal any misplaced property but this action has ceased. Patients have not been able to hand property to their visiting family members due to Covid-19 restrictions not allowing visitors and wards do not have a safe for property or a robust system for storing valuable items. There is a property disclaimer for all wards but these are not routinely completed, meaning that there is no evidence available to indicate whether or not a patient had the item on admission. Patients also sometimes ask family members to bring property in when visiting, which would bypass the property disclaimer process that should take place on admission.	The Divisional Complaints Coordinator is exploring the possibility of displaying leaflets and posters, alerting patients and their relatives to leave valuables at home, including bank cards and cash, and bringing only essentials onto the ward. All staff to be reminded of the importance of ensuring that a disclaimer has been completed and signed if personal property is brought in by the patient. Staff also to be reminded of the importance of items of sentimental value to patients and the anguish this can cause if these items are lost. Head of Nursing to look into whether a lockable safe can be placed on each ward.

The department with the highest number of complaints in Q4 was the Emergency Department (ED) with 18 complaints. Of these 18 complaints, 10 were about 'clinical care' and five related to lost patient property.	Communication between doctors and patients continues to feature in these complaints. This could be due to language barriers or cultural differences, including where English is not the first language of a doctor or a patient. There can also be an issue with patients' expectations of care in an ED, which can sometimes be unrealistic, with many people attending for issues that a not urgent or an emergency. As above, there are issues with property disclaimers not being completed and scanned onto the system, resulting in difficulties locating lost property.	These complaints are monitored and further training on empathy/bedside manner might be appropriate for the doctors in question. All staff on ED to be reminded of the importance of completing patient property disclaimers for all patients admitted to the department. This should be done even where the patient has no property with them, so that there is evidence of this if required at a later date. As above, the possibility of displaying posters stating ED processes regarding property is being explored by the Divisional Complaints Coordinator, in order to manage patient expectations.
The Division continues to experience problems with the timeliness of their formal complaint responses, with less than a third being issued within the timescale agreed with the complainant in Q4. Approximately 45 of these delayed responses have been outstanding for some considerable time and discussions are taking place for a specific plan to deal with these.	Staff turnover in respect of complaints management in the division was high during Q4, along with the team administrator being on maternity leave. The new Complaints Coordinator is now in the role; however, she has inherited over 60 outstanding and overdue complaint investigations and responses, in addition to the new enquiries and complaints coming into the division.	Following discussion around the various options for managing the backlog of overdue complaint responses, the senior divisional management team have put a plan in place whereby each overdue complaint has been allocated to an appropriate specialty manager or matron, who has contacted the complainant to update them and agree a new deadline for the Trust to respond. The results of this plan will be reported in the next quarterly complaints report, although positive outcomes are already being reported.

Current divisional priorities for improving how complaints are handled and resolved:

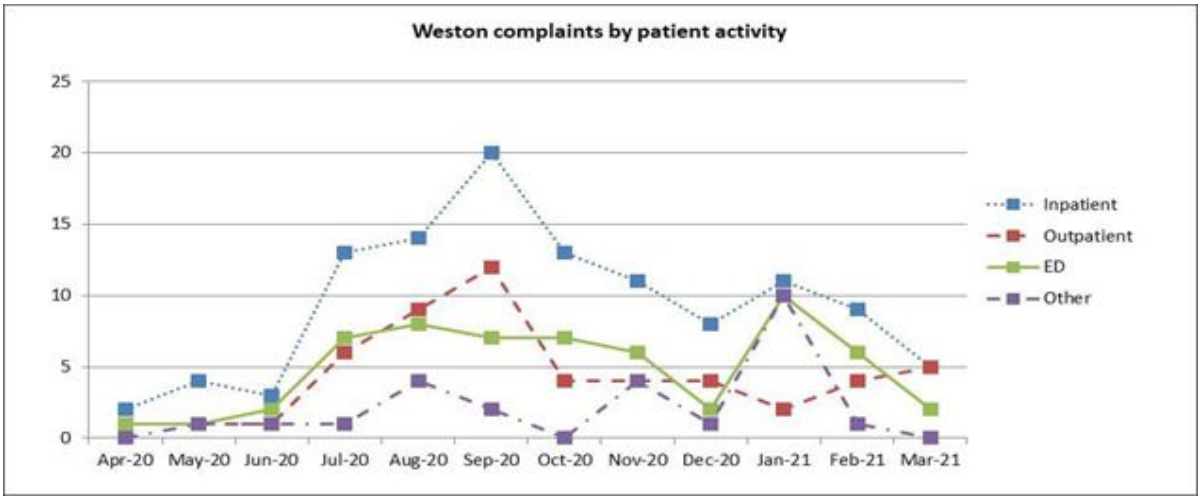
The processing of all new complaints for the division is considered a priority and is managed in a timely manner with open communication between the co-ordinator and the investigators, to ensure the flow of information is accurate, supportive and within given timescales.

Priority issues we are seeking to address based on learning from complaints.

- Monitor complaints about the attitude, empathy and listening skills of doctors about whom complaints are received;
- Improve communication between staff and patients/relatives/carers in order to meet patients' expectations; Divisional Coordinator is exploring ways in which this can be done, including displaying posters in the ED outlining why patients should and should not attend and the pathway through the department. Similar plans are being considered for posters in wards in respect of personal property, with the emphasis on patients not keeping valuable items in hospital with them and also acting as a reminder for staff to complete disclaimer forms.
- Improve lost property processes, to include training of staff regarding property disclaimers where necessary.

Figure 21: Division of Weston - formal and informal complaints received

Figure 22: Division of Weston – complaints by patient area



3.1.7 Division of Trust Services

The Division of Trust Services, which includes Estates & Facilities, received 21 new complaints in Q4; a decrease on the 28 received in Q3.

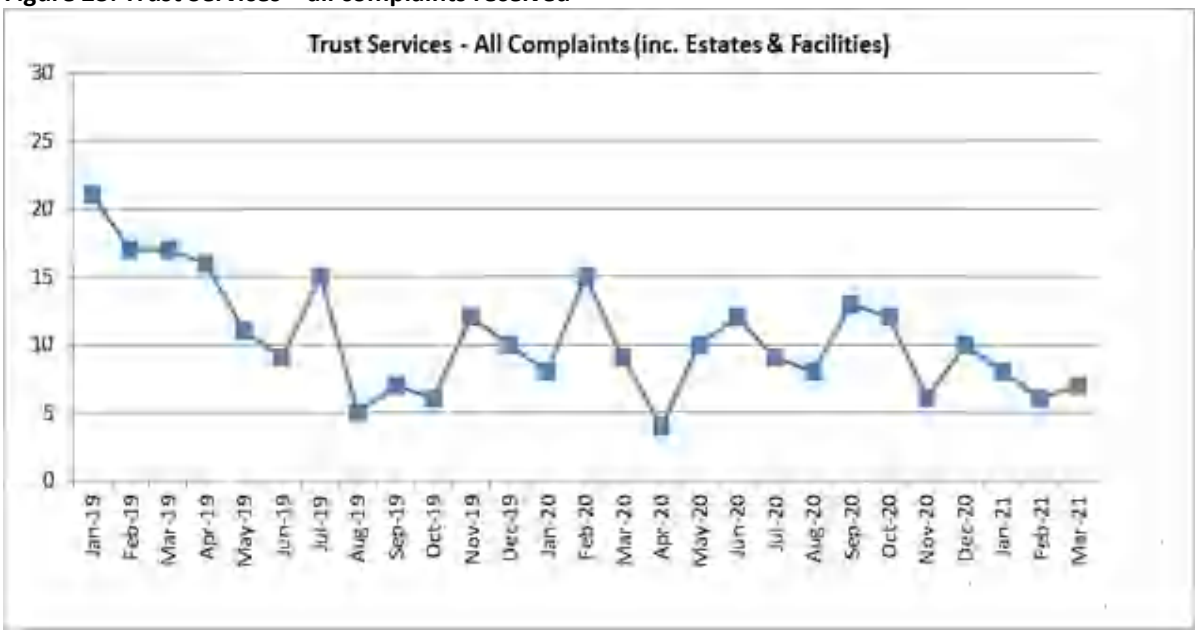
The largest number of complaints received by the Division was recorded under the category of 'facilities and environment' (38.1%), with complaints split between 'catering choice/quality', 'smoking' and 'security'.

The Division achieved 42.9% against its target for responding to formal complaints within the agreed timescale in Q4, compared with 71.4% in Q3, and 89.5% for informal complaints; an improvement on the 80% achieved in Q3. Please see section 3.3 Table 21 for details of where in the process any delays occurred.

Table 20: Complaints by category type

Category Type	Number and % of complaints received – Q4 2020/21	Number and % of complaints received – Q3 2020/21
Facilities & Environment	8 (38.1% of total complaints) ↓	11 (39.2% of total complaints) ↓
Attitude & Communication	7 (33.3%) ↓	11 (39.2%) ↑
Information & Support	6 (28.6%) ↑	5 (17.9%) =
Access	0 (0%) =	0 (0%) ↓
Appointments & Admissions	0 (0%) ↓	0 (0%) =
Clinical Care	0 (0%) =	0 (0%) =
Discharge/Transfer/ Transport	0 (0%) =	1 (3.7%) ↓
Documentation	0 (0%) =	0 (0%) ↓
Total	**21**	**28**

Figure 23: Trust Services – all complaints received



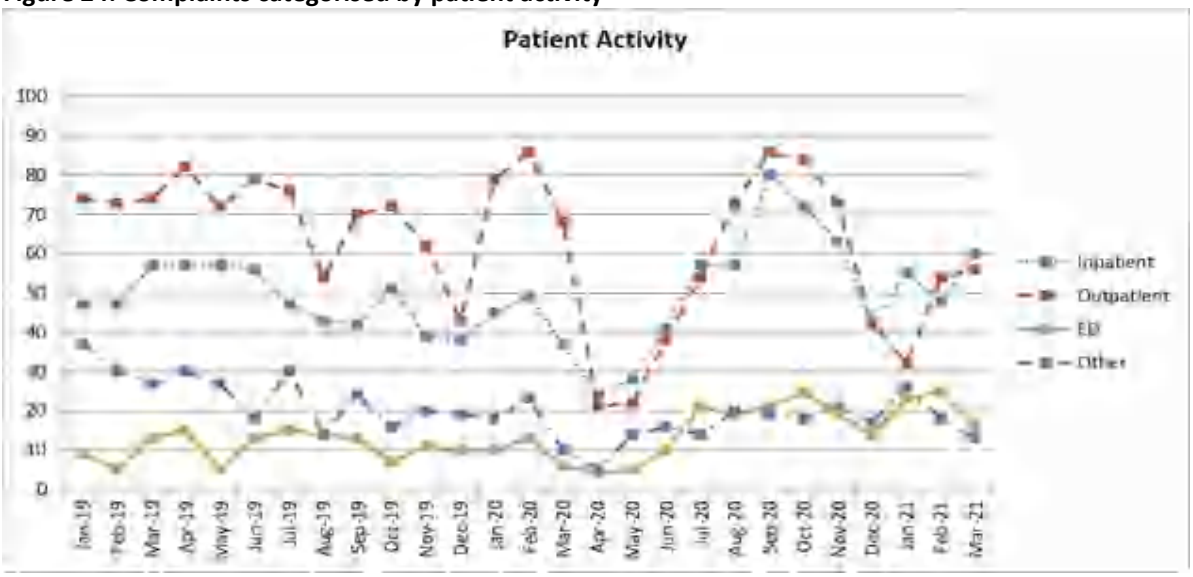
With effect from May 2020, Estates & Facilities complaints have been reported separately, as well as being included in the data produced for Trust Services. Figure 23 above shows all complaints received for Trust Services, including Estates & Facilities.

3.2 Breakdown of complaints by inpatient/outpatient/ED status

In order to more clearly identify the number of complaints received by the type of service, Figure 24 below shows data differentiating between inpatient, outpatient, Emergency Department and other complaints. The category of 'other' includes complaints about non-clinical areas, such as car parking, cashiers, administration departments, etc.

In Q4, 33.3% (*40.6%) of complaints received were about outpatient services, 38.3% (36.2%) related to inpatient care, 15% (11.8%) were about emergency patients; and 13.4% (11.4%) were in the category of 'other' (as explained above). ** Q3 percentages are shown in brackets for comparison.*

Figure 24: Complaints categorised by patient activity



3.3 Complaints responded to within agreed timescale for formal resolution process

All divisions, with the exception of Diagnostics & Therapies, reported breaches of formal complaint deadlines in Q4, with a total of 44 breaches reported Trustwide. This is an improvement on the 60 breaches reported in Q3, which was the highest number of breaches recorded since this report commenced.

The Division of Weston reported 22 breaches of deadline, Medicine reported 10, there were four breaches each for Specialised Services and Trust Services (including one for Estates & Facilities), Women & Children had three breaches and Surgery had just one. It should be noted that none of the breaches for the Divisions of Surgery and Women & Children were due to delays by the Divisions. Please see Table 22 below for details of where in the process the delays occurred/who the breaches were attributable to.

In Q4, the Trust responded to 160 complaints via the formal complaints route and 72.5% (116) of these were responded to by the agreed deadline, against a target of 95%, compared with 69.1% in Q3 and 73.4% in Q2.

Table 21: Breakdown of breached deadlines – Formal

Division	Q4 2020/21	Q3 2020/21	Q2 2020/21	Q1 2020/21
Weston	22 (68.8%)	28 (70%)	19 (55.9%)	2 (33.3%)
Medicine	10 (35.7%)	20 (60.6%)	14 (36.8%)	5 (26.3%)
Specialised Services	4 (22.2%)	3 (21.4%)	0 (0%)	3 (33.3%)
Trust Services	4 (57.1%)	2 (28.6%)	1 (14.3%)	1 (50%)
Women & Children	3 (7.5%)	3 (5.6%)	2 (6.5%)	5 (20.8%)
Surgery	1 (3.2%)	4 (9.8%)	9 (23.1%)	11 (33.3%)
Diagnostics & Therapies	0 (0%)	0 (0%)	0 (0%)	0 (0%)
All	**44 breaches**	**60 breaches**	**45 breaches**	**27 breaches**

(So, as an example, there were 10 breaches of timescale in the Division of Medicine in Q4, which constituted 35.7% of the 28 complaint responses which were sent out by that division in Q4).

Breaches of timescale in respect of formal complaints were caused either by late receipt of draft responses from Divisions which did not allow adequate time for Executive review and sign-off; delays in processing by the Patient Support and Complaints Team (PSCT); delays during the sign-off process itself; and/or responses being returned for amendment following Executive review.

Table 16 shows a breakdown of where the delays occurred in Q4. During this period, 54 breaches were attributable to the Divisions, three were caused by delays in the Patient Support & Complaints Team, two occurred during the Executive sign-off process and one was due to a delay in another Trust providing input for a response.

Table 22: Source of delay

Breach attributable to	Surgery	Medicine	Specialised Services	Women & Children	Diagnostics & Therapies	Trust Services	Weston	All
Division	0	9	2	0	0	4	22	**37**
PSCT	1	0	0	2	0	0	0	**3**
Execs/sign-off	0	1	2	1	0	0	0	**4**
Other Trust	0	0	0	0	0	0	0	**0**
All	**1**	**10**	**4**	**3**	**0**	**4**	**22**	**44**

3.3.1 Complaints responded to within agreed timescale for informal resolution process

All breaches of informal complaint timescales are attributable to the Divisions, as the Patient Support & Complaints Team and Executives do not contribute to the time taken to resolve these complaints. In Q4, the Trust responded to 140 complaints via the informal complaints route (compared with 240 in Q3) and 92.9% of these were responded to by the agreed deadline; a marginal improvement on the 92.1% reported in Q3.

Table 23: Breakdown of breached deadlines - Informal

Division	Q4 2020/21	Q3 2020/21	Q2 2020/21	Q1 2020/21
Medicine	4 (11.1%)	1 (11.1%)	11 (22.9%)	0 (0%)
Weston	3 (17.6%)	2 (13.3%)	2 (6.1%)	1 (20%)
Trust Services	2 (10.5%)	4 (20%)	3 (20%)	2 (9.5%)
Surgery	1 (2.9%)	2 (2.9%)	3 (4.2%)	0 (0%)
Diagnostics & Therapies	0 (0%)	1 (5%)	0 (0%)	0 (0%)
Specialised Services	0 (0%)	2 (5%)	0 (0%)	0 (0%)
Women & Children	0 (0%)	0 (0%)	0 (0%)	0 (0%)
All	**10**	**12**	**19**	**3**

4. Learning from complaints

All feedback is welcome, as it creates an opportunity to better understand, and to improve the care and treatment we provide to our service users. All complaints are investigated, learning is identified and any necessary changes to practice are made. Actions resulting from complaints are monitored and reviewed by our Divisions; the Patient Support and Complaints Team also monitor progress.

Below are some examples of actions taken by the Trust in response to complaints during Q4 2020/21.

A complaint was received regarding the rushed discharge of a patient from South Bristol Community Hospital (SBCH), including the patient having to be readmitted several hours later, mistakes on the discharge summary and the patient's family not knowing who to contact for help and advice. As a direct result of this complaint, the division implemented the use of a business-style card to be given to patients on discharge, containing contact details for the specific ward, for help and advice in the first 24 hours post-discharge. (Medicine)

Following the discharge of a patient from the Bristol Heart Institute (BHI), her daughter went through the paperwork her mother had been sent home with and discovered a completed ReSPECT form. The form included a statement that the patient did not want to be resuscitated and included DNR and DNACPR orders. Despite the form stating that this had been discussed with the patient by a doctor, this took the family completely by surprise. As a result of this complaint, the Head of Nursing discussed this with the specific staff involved on this occasion to ensure that they understood the correct process for completing the ReSPECT form. In addition, an article was published in the divisional Patient Safety, Governance and Complaints Newsletter and on the Bristol and Weston intranet pages, reminding all staff of the correct process. (Specialised Services)

A complaint was received for Bristol Royal Hospital for Children (BRHC) about a number of problems experienced by the family of a young patient who fell and broke his arm. He had been referred to the 'hot' fracture clinic at BRHC and his parents were told to expect a call which they never received; an appointment letter was sent to the wrong address and contained the wrong first name for the patient; when they did attend the appointment, they felt rushed; a follow-up call was not responded to despite several messages being left; and when a doctor did finally call, he contradicted the advice given to them at the appointment. As a result of this complaint, the doctor who originally saw the patient was asked to reflect on his communication and approach in order to embed learning in his future practice; the Paediatric Trauma & Orthopaedics team contacted the local minor injuries unit that had referred the patient to BRHC to provide them with up to date information about the 'hot' clinic (including timeframes and expectations for parents); and work was undertaken with the administrative team to ensure that name and address details are always cross-checked and parents' calls are returned promptly. (Women & Children)

5. Patient Support & Complaints Team activity

5.1 Information, advice and support

In addition to dealing with complaints, the Patient Support and Complaints Team are also responsible for providing patients, relatives and carers with help and support. A total of 298 enquiries were received in Q4, a decrease on the 346 received in Q3. This figure includes 29 concerns recorded by the Patient Advice & Liaison Service (PALS) in Weston, compared with 26 recorded in Q2. As reported in Q3, the Division of Weston continued to divert calls and emails to the PALS service to the corporate complaints team in Bristol during Q4, so many cases that had previously been recorded as 'concerns' were recorded as informal (or occasionally formal) complaints.

The Patient Support and Complaints Team also recorded and acknowledged 83 compliments received during Q4 and shared these with the staff involved and their Divisional teams. This is a reduction on the 106 compliments reported in Q3, but does not include compliments received and recorded elsewhere within the divisions.

In addition to the enquiries detailed above, in Q3 the Patient Support and Complaints Team recorded 137 enquiries that did not proceed, compared with 126 in Q3. This is where someone contacts the department to make a complaint or enquiry but does not leave enough information to enable the team to carry out an investigation (and the team is subsequently unable to obtain this information), or they subsequently decide that they no longer wish to proceed with the complaint.

Including complaints, requests for information or advice, requests for support, compliments and cases that did not proceed, the Patient Support and Complaints Team continues to deal with an increasingly high volume of activity, with a total of 944 separate **new** enquiries in Q4. In addition, the Division of Weston directly recorded 29 concerns.

5.2 Acknowledgement of complaints by the Patient Support and Complaints Team

The NHS Complaints Procedure (2009) states that complaints must be acknowledged within three working days. This is also a requirement of the NHS Constitution. The Trust's own policy states that complaints made in writing (including emails) will be acknowledged within three working days and that complaints made orally (via the telephone or in person) will be acknowledged within two working days.

In Q4, 234 complaints were received in writing (181 by email, 36 via website feedback and 17 letters) and 183 were received verbally by telephone. Nine complaints were also received in Q4 via the Trust's 'real-time feedback' service. Of the 426 complaints received in Q4, 73.5% (313/426) met the Trust's standard of being acknowledged within two working days (verbal) and three working days (written). This reduction, compared with 98.8% in Q3 was due to a combination of the overall high volume of enquiries coming into the Patient Support and Complaints Team and the long-term sickness of two members of the service, including its full time administrator. A recovery plan has been agreed and implemented which should see a recovery to normal levels of performance (98%+) from July 2021 onwards.

5.3 PHSO (Ombudsman) cases

During Q4, the PHSO notified the Trust of its interest in two new complaints, for which copies of the complaint file and medical records have been sent to them.

One case was closed by the PHSO during Q4, when the Trust agreed to make a payment of £200 to the patient to cover the cost of some scans that she paid for privately. The PHSO suggested this as a quick resolution of the case, rather than them carrying out a full investigation.

There are currently 13 cases that are open with the PHSO whilst they decide whether or not to carry out a full investigation or for which a decision is awaited following their investigation.

6. Severity of Complaints

Since April 2019, the Patient Support & Complaints Team has been recording the severity of complaints received by the Trust using a system of categorisation proposed by researchers at the London School of Economics. This severity rating is based on the nature of the complaint as first described to the Trust by or on behalf of the patient; not after the issues have been investigated. This ensures that the rating is reliable and independent of the outcome of the investigation.

We know from NHS data that Trusts with high levels of incident reporting have fewer instances of severe harm to patients, i.e. organisations with cultures that encourage reporting when things go wrong, learn and provide safer care. The LSE research suggests a similar pattern of data associated with patient complaints, i.e. Trusts who receive high levels of low level severity complaints receive lower levels of high severity complaints, again indicating that a culture of openness to receiving and learning from complaints is associated with safer and higher quality care. Put another way, receiving complaints should not be viewed as a bad thing *per se*; it depends what the complaint is about. A practical example of each of these categories is shown in Table 24 below.

As we build our dataset, we hope that this will enable us to begin to differentiate between higher and lower performing areas within the Trust (in terms of the severity of complaints reported) and to use the information to explore opportunities for quality improvement.

Table 24: Examples of severity rating of complaints

	Low severity	**Medium severity**	**High severity**
Clinical problem	Isolated lack of food or water	Patient dressed in dirty clothes	Patient left in own waste in bed
Clinical problem	Slight delay administering medication	Staff forgot to administer medication	Incorrect medication administered
Management problems	Patient bed not ready on arrival	Patient was cold and uncomfortable	Patient relocated due to bed shortage
Management problems	Appointment cancelled and rescheduled	Chasing departments for an appointment	Refusal to give appointment
Relationship problems	Staff ignored question from patient	Staff ignored mild patient pain	Staff ignored severe distress
Relationship problems	Staff spoke in condescending manner	Rude behaviour	Humiliation in relation to incontinence

In Q4, the Trust received 426 complaints, all of which have been severity rated by the Patient Support & Complaints Team. Of these 426 complaints, 208 were rated as being low severity, 194 as medium and 24 as high.

Figure 25 below shows a breakdown of these severity ratings by month since April 2019. The significant drop shown for April and May 2020 reflects the much lower numbers of complaints (50 and 53 respectively) received during those months due to the Covid-19 pandemic.

In July 2020, the corporate Patient Support and Complaints Team commenced the management of complaints for the Division of Weston and therefore started recording the severity of their complaints at the same time. Figure 25 therefore includes severity ratings for the Division of Weston's complaints from July 2020 onwards, indicated by the larger triangular markers.

Figure 25: Severity rating of complaints

Since recording of the severity of complaints commenced in April 2019 (24 months), the number of complaints received by severity is shown below, with the average per month across that period shown in brackets:

- High severity – 199 (av. 8)
- Medium severity – 1,330 (55 av.)
- Low severity – 1,901 (79 av.)

A breakdown by Division is shown in Table 25 below.

Table 25: Severity rating of complaints by Division (all complaints received in Q4 2020/21)

Division	High Severity	Medium Severity	Low Severity	Totals
Specialised Services	8 (16.7%)	17	23	**48**
Women & Children	6 (8.2%)	47	20	**73**
Medicine	6 (5.8%)	36	61	**103**
Weston	4 (6.2%)	31	30	**65**
Surgery	1 (0.9%)	52	55	**108**
Trust Services	0 (0%)	10	11	**21**
Diagnostics & Therapies	0 (0%)	4	4	**8**
Totals	**25 (5.9%)**	**197**	**204**	**426**

*i.e. 16.7% of complaints received by the Division of Specialised Services in Q4 of 2020/21 were rated as high severity – this compares, for example, with 0.9% of complaints about the Division of Surgery.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Thursday 29th July 2021 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title										
A Framework of Quality Assurance for Responsible Officers and Revalidation - Board Report and Framework of Compliance										
Sponsor and Author(s)										
Dr Anne Frampton, Associate Medical Director for Revalidation										
Intended Audience										
Board members		Regulators		Governors		Staff		Public		

Executive Summary

Purpose

The Framework for Quality assurance for responsible officers and revalidation sets out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer, and
c) act as evidence for CQC inspections.

The statement of compliance is incorporated within this report for sign off by the board before submission to NHSE/I

Key issues to note

- On 1st April 2020 UHBristol and WHAT merged to form the new designated body of UHBW. This is the first board report covering the new designated body of UHBW.
- The new DB had 1016 connections at end of March 2021
- Due to the merger and disruption of the covid-19 pandemic comparisons with previous years regarding appraisal rates are hard to make.
- Some appraisal activity did continue, and an interim report was presented to the people committee in Nov 2020 to assure them of the progress being made. Early indications are that appraisal rates in 2021 are significantly higher than in 2020 (April appraisal rate approximately 90% to date).
- A new QA process was successfully implemented.
- Additional training was commissioned and has been successful in recruiting additional appraisers as well as providing updates for current appraisers.

Overall conclusion:
The new designated body of UHBW was successfully created on 1st April 2020 with more than 1000 doctors attached.
Actions from last year have been completed with the exception of a review of patient feedback

which has stalled due to the pandemic and a the ability to input performance data directly into appraisal (a review of which is underway)
e anticipate that appraisal compliance in 2021/2 will be significantly improved as long as there is no further significant impact from the covid-19 pandemic.

Recommendations

For agreement and sign off of the compliance statement prior to submission to NHSE/I

Members are asked to:

- Ratify the Report.

Impact Upon Board Assurance Framework

Impact Upon Corporate Risk

Implications (Regulatory/Legal)

Equality & Patient Impact

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval		For Information	

Date the paper was presented to previous Committees

Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

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

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

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

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

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

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

Designated Body Annual Board Report

Section 1 – General:

The board of University Hospitals Bristol and Weston (UHBW) can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: No AOA submission was completed in 2020/21 as this was cancelled due to Covid-19

Action from last year: None

Comments:

A draft AOA submission was completed this year as it was in 2020/1. The number of doctors connected to UHBW on 31st March 2021 was 1016 (compared to 806 on 31st March 2020 attached to UHBristol).

Appraisal was suspended with immediate effect nationally on 19th March 2020 and reinstated but in a supportive form in July 2020. At the same time the GMC suspended the ability of RO's to recommend revalidation. Many doctors (30%) therefore had missed approved appraisals in 2020 and a significant number appraised but were delayed (25%). The expectation for 2021 is that all appraisals will go ahead as planned. To encourage doctors to appraise and have a supportive meeting with their appraiser, we marked a second missed appraisal due to covid as non-approved (doctors due in Jan/ Feb/ March)- but with the only action taken being that we brought forward their 2021/2 appraisal dates to April/ May/ June so that in effect they did not go significantly longer than 2 years between appraisals.

On 31st March 2021

There were 1016 doctors connected to UHBW designated body.

Of these

Complete 1(a) = 394

Complete 1(b) = 250

Incomplete approved (2) =304

Incomplete not approved (3) = 68

In 2020/1 we have a new designated body (UHBW) with RO William Oldfield; these figures now include doctors previously under the separate designated bodies of WHAT and UHBristol

Action for next year:

Doctors whose appraisals were not approved missed last year have been contacted to ensure that they meet with their appraisers early in 2021. Early indications are that appraisal rates are significantly increased already

compared to 2020 and so we anticipate improved compliance in 2021. Appraisal rate for April 2021 is running at around 90%.

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

Action from last year: Nil

Comments: William Oldfield remains RO for the newly formed body of UHBW, having previously been RO for UHBristol. WAHT is no longer a DB and no longer has its own RO. NB Dr Oldfield is stepping down from his post as medical director at UHBW in September and so a new RO will be in place in time for the next report.

Action for next year: Appoint a new RO to UHBW DB

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

Yes

Action from last year: To develop the team structure to provide additional administrative support and time

Comments: The current UHBW Band 4 post is under review to up band to a Band 5. This was under review last year but delayed due to covid-19. Outcome awaited. In addition, funding was agreed for 2x internal appraiser training courses agreed which have been highly successful in attracting new appraisers.

Action for next year: Confirm up banding of post and establish regular funding for external appraiser update training to maintain a pool of appraisers and support their CPD.

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

Action from last year: None

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

Action for next year: Nil

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

Action from last year: To update the Appraisal and Revalidation Policy to reflect the merger of UHB and Weston to form UHBW

Comments: This has been updated to reflect both the implementation of Fourteen Fish and the merger with Weston and has been uploaded to the DMS and approved by the people committee.

Action for next year: Nil

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

No Peer review took place in 2020/1 due to covid, however there were outstanding actions from the previous year as outlined below:

Action from last year:

*To introduce the use of the PROGRESS tool to QA appraisals in UHBW- complete

*To review the use of MPIT forms- complete

*To review data supplied to doctors in preparation for appraisal including complaints and audit data – a review of this has taken place but a robust plan for implementing is yet to be agreed.

*To review the opportunities for patient feedback (on hold due to Covid-19)

Comments: All actions from last year completed except patient feedback which was on hold due to covid and will be progressed this year. QA process undertaken and results shared with appraisers.

A piece of work is underway to continue to look at data supplied to doctors and how we might achieve this locally in UHBW. This is being led by the AMD for appraisal and one of the other AMDs.

Action for next year:

*To review the opportunities for patient feedback (on hold due to Covid-19)

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

Action from last year: Nil

Comments: Yes, these doctors are attached and are supported in maintaining their portfolios. All have access to Fourteen Fish and an appraiser, as well as supporting material, to ensure they are aware of their

requirements. They are all contacted on an individual basis by the AMD for Revalidation and Appraisal and an individualised plan is made for each depending on their own circumstances.

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

Action for next year: Nil

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: An additional QA process will be put in place this year to further enhance this process and identify any gaps.

Comments: Yes, appraisals are all reviewed prior to revalidation to ensure full scope of practice is covered. In addition there is close liaison with local private sector providers to ensure appropriate information transfer. There is a regular complaints feed into the appraisal process and a regular feed of low level concerns at divisional level. The new appraisal formal and the QA process has highlighted the need for robust summaries as not all information is now uploaded to portfolios. This has been completed and fed back to appraisers and monitored.

Action for next year: continue with QA process.

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

Action from last year: Nil

Comments:

Action for next year: Nil

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

Action from last year: To update the UHBW policy to include the merger with Weston General Hospital

Comments: Approved by People committee and uploaded to the DMS

Action for next year: Nil

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

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

Comments: Due to covid-19 this review has not taken place, though we have actively recruited a number of new appraisers in 2020/1. Action to be carried over to this year.

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

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

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

Comments: Yes, this was instigated in 2019 and continues this year and the appraisal system has been updated to allow appraisers to receive feedback on the quality of their appraisals. In addition 6-8 annual events are held across the 2 sites to ensure access for appraisers from both organisations. A record of attendance of these events is maintained and access to material discussed at the events is made available to all appraisers on the workspace on the Trust intranet. Topics included feedback from GMC / updates from NHSE and Wellbeing and Support

Action for next year: To continue this process and develop according to needs of appraisers

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

Action from last year: QA process to be initiated

Comments: A QA process has been commenced and report generated and submitted to the medical director. This has also been shared with appraisers.

Action for next year: continue with this process

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 3 – Recommendations to the GMC

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

Action from last year: Nil

Comments: Revalidation recommendations were halted by the GMC for a period in 2020 and re-instated in the summer.

In 2020-21

102 positive revalidation recommendations were made from 2nd July when revalidation was re-opened until 31st March 2021.

There were no deferrals and no non-engagement recommendations made in 2020/1

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

Action from last year: Nil

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

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

Action for next year: No new actions identified

Section 4 – Medical governance

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

Action from last year: Nil

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

Action for next year: Nil

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

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

Comments: Recommendations for revalidation are based on triangulation of information from appraisal, complaints and reports from clinical chairs regarding soft concerns. Currently UHBW has no method of automatically providing audit, GIRFT or other data directly to doctors for their appraisals and they are expected to access this information themselves. A report on this by one of the AMD team is being considered currently to review options.

Action for next year: Continue to review and refine this process.

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

Action from last year: Nil

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

Action for next year: Nil

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year:

Comments: Measurement and Key performance indicators comprise:

- The number of Speaking Up concerns raised.

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

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

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

Action for next year: none identified

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

Action from last year: To ensure MPITs are uploaded into the doctor's record on Fourteen Fish to make them visible to the AMD easily.

Comments: This action is completed. In addition RO's in other organisations are contacted promptly when concerns regarding a doctor need to be shared when the doctor moves posts.

Action for next year: No new action identified

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

Action from last year: Nil

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

Action for next year: No specific action

Section 5 – Employment Checks

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

Action from last year:

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

Action for next year:

Section 6 – Summary of comments, and overall conclusion

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

- On 1st April 2020 UHBristol and WHAT merged to form the new designated body of UHBW. This is the first board report covering the new designated body of UHBW.
- The new DB had 1016 connections at end of March 2021
- Due to the merger and disruption of the covid-19 pandemic comparisons with previous years regarding appraisal rates are hard to make.
- Some appraisal activity did continue, and an interim report was presented to the people committee in Nov 2020 to assure them of the progress being made. Early indications are that appraisal rates in 2021 are significantly higher than in 2020 (April appraisal rate approximately 90% to date).
- A new QA process was successfully implemented.
- Additional training was commissioned and has been successful in recruiting additional appraisers as well as providing updates for current appraisers.

Overall conclusion:

The new designated body of UHBW was successfully created on 1st April 2020 with more than 1000 doctors attached.

Actions from last year have been completed with the exception of a review of patient feedback which has stalled due to the pandemic and a the ability to input performance data directly into appraisal (a review of which is underway)

We anticipate that appraisal compliance in 2021/2 will be significantly improved as long as there is no further significant impact from the covid-19 pandemic.

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

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

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

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

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

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

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29th July 2021

Report Title	**Resolving Conduct Concerns Policy**
Report Author	**Naomi Adams, Head of HR Services**
Executive Lead	**Alex Nestor, Interim Director of People**

1. Report Summary

This report outlines the changes made to the UHBW Disciplinary Policy following recommendations made to for all NHS Trusts in relation to their formal procedures set out in 2019 by Baroness Dido Harding, Chair of NHS Improvement following an independent review.

In this report the main and significant changes are highlighted for review and discussion by members of the People Committee. Discussion and feedback is requested.

2. Key points to note

(Including decisions taken)

The main changes are as follows;

- The Policy no longer uses the term disciplinary; this has been replaced with concerns and the need to resolve concerns.
- The process surrounding suspension has been reviewed and re-written to include a risk assessment process, escalation via reporting of lengthy suspensions, placing emphasis on alternatives to suspension in a bid to avoid wherever possible, a new authorisation of suspension process and a clear direction to return an employee to work if suspended as soon as is possible.
- Reinforced emphasis on support.
- The option at both informal and formal resolution processes to implement supportive training and/or performance processes has been included and emphasised.
- The requirement for an Investigating Officer to make a recommendation as to training/interventions that would support resolution and improvement as opposed to warnings.
- The word sanction has been removed.
- The situation or concerns are now investigated as opposed to the individual or person.
- Increased emphasis on governance and escalation of delays.
- Support for employees is now emphasised throughout.
- A 'cooling off' period has been refreshed and emphasised.
- Significant and increased emphasis on informal resolution with the line manager including no formal investigations to be commissioned without having discussed the concerns with the employee/s involved at an informal setting.
- Support for employees altered from being possible to being actively encouraged.

- A complete refresh of the language used in the policy to revise punitive or contentious terminology and replace this with neutral phraseology and supportive terms.
- Refreshed guidance and templates to support new policy.

The new policy is attached as an appendix.

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

This review has taken place to reduce risks associated with suspensions and investigations.

This report and policy review relates to risk number 3263.

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.

Staff Partnership Forum	**20th July 2021**
People Committee	**27th July 2021**

University Hospitals Bristol and Weston NHS Foundation Trust

Resolving Conduct Concerns Policy

Document Data			
Document Type:	Policy		
Document Reference	7799		
Document Status:	Approved		
Document Owner:	Head of HR Services		
Executive Lead:	Director of People		
Approval Authority:	Staff Partnership Forum		
Review Cycle:	24 months		
Date Version Effective From:	31 July 2021	**Date Version Effective To:**	30 Jun 2023

What is in this policy?

This policy contains guidance for managers on dealing with conduct issues through both formal and informal means. It aims to ensure that all employee conduct matters are dealt with fairly and consistently with resolution in mind, by setting a clear process for resolving issues of concern appropriately at all levels of seriousness.

The Trust's Workforce Diversity & Inclusion Strategy sets out the ambition to be 'committed to inclusion in everything we do'. Ensuring dignity and respect for patients and staff is a core principle within this strategy, and promoting equality, diversity and human rights while challenging any form of inequality, discrimination and harassment is central to the Trust's Values.

This Trust will not tolerate discrimination, harassment or bullying under any circumstances and particularly because of a protected characteristic. This is supported by the Trust's commitment to the Equality Act 2010 and its Public Sector Equality Duties as defined by the Act.

Our Human Resources policies are written with this commitment as a guiding principle, to ensure that the policies and their application are inclusive and supportive for all of our staff.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions (Job title only)**	**Type of Revision**	**Description of Revision**
Jan 2010	1	Director of Workforce & OD	Policy review	
Jan 2013	2	Director of Workforce & OD	Policy review	Policy review
May 2015	3	Director of Workforce & OD	Policy review	Policy review
Oct 2018	4	HR Consultant	Major	New policy template and full restructuring. Additional guidance on terms of reference for investigations and other minor changes.
July 2021	5	Head of HR Services	Major	Full policy and process restructure including Just Culture

Sign off Process and Dates	
Groups consulted	**Date agreed**
Resolution Culture Task & Finish Group	08/07/2021
Policy Group	06/07/2021
Staff Partnership Forum	20/07/2021
People Committee	27/07/2021
Policy Assurance Group	Click here to enter a date.
	Click here to enter a date.

Table of Contents

1. Introduction

University Hospitals Bristol & Weston NHS Foundation Trust's (the Trust or UHBW) Resolving Conduct Concerns Policy aims to ensure that all matters regarding conduct or matters of concern with employees are dealt with fairly, consistently and with resolution at the heart of the process. UHBW is a learning organisation and recognises the importance of resolving issues of concern early and quickly, maximising opportunities to improve and learn from experiences of individuals and circumstances that arise in the course of service delivery.

The policy is compliant with legislation contained within the Employment Rights Act 1996 and the Employment Act 2008 and has taken due account of the ACAS Code of Practice on Disciplinary and Grievance Procedures.

Alternative resolutions other than formal investigations and processes will be used wherever possible in the first instance. This is in line with the UHBW ethos of learning and continuous improvement and recommendations made to for all NHS Trusts in relation to their formal procedures set out in 2019 by Baroness Dido Harding, Chair of NHS Improvement following an independent review.

2. Purpose

The Policy and Procedure provides a framework to manage concerns about someone's conduct in a fair and timely way whilst addressing these issues with a view to improvement and resolution.

It is the Trust's policy to ensure that any concern with regards to the conduct or actions of employees is resolved with fairly and as informally as possible ensuring that steps are taken to establish the facts and to give employees the opportunity to reflect and respond at the earliest opportunity.

3. Scope

This policy and procedure applies to all employees of the Trust including Bank Staff. The only exception will be that of Medical and Dental Staff in relation to professional misconduct where these matters will be dealt with in accordance with the Trust's Medical and Dental Policy for Managing Capability Concerns.

Separate procedures exist for dealing with performance and capability due to ill health. For these issues managers should refer to:

- Supporting Performance Policy
- Supporting Attendance Policy

4. Definitions

4.1 Informal Resolution

This is where actions to address concerns and support improvement are agreed between an employee and their manager. This does not include a formal investigation, and will not result in formal warnings or dismissal. It may include a resolution discussion, initial fact-finding, reminders or improvement plans etc. See section 6 for more detail.

4.2 Formal Resolution

This is where formal resolution of concerns is sought via an investigation of circumstances and facts commissioned by a senior manager, and can result formal training improvement recommendations which may or may not be supported by formal warnings or in the most serious of cases dismissal if allegations are proven and alternative outcomes are not possible. See section 8 for full details.

4.3 Suspension/Exclusion

This is when an employee is removed from their place of work on full pay, pending an investigation of an incident or their conduct.

4.4 Resolution Hearing

This is a formal hearing held as a result of a formal investigation finding that there is a case for the member of staff to answer. The aim of this hearing is to resolve the concerns in a manner that ensure improvement both for the individual concerned and address any system concerns or training requirements as appropriate.

4.5 Resolution Outcomes

This is a possible outcome of a resolution hearing where concerns relating to the conduct of an employee has been proven, and includes but is not exclusively, formal warnings, downgrading, and dismissal. See section 10 for full details.

4.6 Commissioning Manager

This is the senior manager who decides in partnership with expert advice from HR Services whether an investigation should be undertaken, and by whom it should be investigated. They will set the terms of reference for the investigation, and also consider whether adjustments such as temporary redeployment or in the most serious and rare incidences if suspension is appropriate. In most cases the commissioning manager will receive the investigation report, determine whether a resolution hearing is required and will chair this hearing if required. The commissioning manager should generally be determined with reference to the required levels of authority and in conjunction with expert advice from HR Services (Appendix F).

4.7 Investigating Officer

This is the manager that has been appointed by the commissioning manager to formally investigate an incident or concern. In many cases this will be the employee's line manager, but in situations where the line manager is already involved, the commissioning manager will nominate another manager to fulfil this role. The investigating officer may be an external investigator or a member of the HR Services Team if this is deemed appropriate in exceptional circumstances.

5. Duties, Roles and Responsibilities

5.1 Line managers

(a) To handle conduct issues professionally, sensitively and confidentially, and to remain a source of support and guidance to their member of staff

(b) To ensure the member of staff's Health and Wellbeing is considered and the correct support put in place e.g. referral to Occupational Health, counselling or other external support.

(c) To make every effort to handle conduct issues in a resolution focussed with the best interests of the employee at the Trust in mind.

(a) To review any incidents or concerns and carry out an initial fact-finding exercise to better understand what led to the event.

(b) To ensure that the employee is aware of the details of the incident at the earliest appropriate stage.

(c) To ensure that the employee is aware they can be supported at meetings by a union representative, friend or colleague.

5.2 Commissioning Managers

(a) To consider the information provided regarding the incident by the line manager and to decide the next steps In conjunction with expert advice from HR Services.

(b) To appoint an investigating officer in a timely fashion where formal resolution is to be sought.

(c) To consider whether suspension is necessary and carry out a Suspension risk assessment and gain approval from the Head of HR Services, HR Business Partner and Divisional Director or nominated deputies if suspension is deemed appropriate.

(d) To set the terms of reference for the investigation with support from HR Services.

(e) To review any suspension and decide whether they need to continue. To write to an employee if their suspension has exceeded 28 calendar days, to advise on the period of extension and the reasons for it.

(f) To review the progress of the investigation ensuring timescales are adhered to.

5.3 Investigating officers

(a) To ensure that incidents are investigated fully ensuring that all mitigating factors, system and environmental factors are reviewed when compiling reports and making recommendations.

(b) To investigate and establish the facts of the case.

(c) To comply with the terms of reference as provided by the commissioning manager.

(d) To conclude investigations within four weeks (or other timescale as specified in the terms of reference) wherever possible and to escalate barriers to timely completion to the Divisional Board.

5.4 Chair of a resolution hearing

(a) To conduct the resolution hearing in accordance with section 9 of this policy.

(b) To report cases requiring external referral to the Head of HR Services and Head of Profession as appropriate (see sections 5.2, 5.3 and 10.9).

5.5 HR Services

(a) To support and advise managers throughout the process, attending meetings and hearings as necessary.

(b) To ensure that investigations are undertaken in accordance with this policy and the terms of reference as provided by the commissioning manager and escalate through appropriate reporting channels where this is not possible.

(c) To encourage and support the investigating officer to conclude the investigation within the specified timescale and escalate through appropriate reporting channels where this is not possible.

(d) To support with the review of suspensions on a regular basis and within the 28 day review timeframe with a view to bringing an employee back to work as soon as is possible

5.6 Employees involved in an investigation

(a) To engage with the process as fully as possible giving all facts, context and mitigation relevant in order to establish appropriate resolution. This means attending any meetings as needed and giving as much notice as possible if they need to rearrange.

(b) Produce a statement as part of the investigation when requested

(c) Inform the investigating officer of anybody whom they wish to be interviewed as part of the investigation.

6. Policy Statement and Provisions

6.1 Key Provisions

The Trust's resolution procedure is based on the following principles:

- The protection and safety of staff, patients and the public is the Trust's overriding priority.
- Concerns should be dealt with fairly, consistently and with resolution at the heart of the process.
- Employees may be accompanied by a union representative, friend or colleague at formal meetings.
- No employee will normally be dismissed for a first breach of conduct standards except in the case of gross misconduct, when the outcome will be dismissal without notice or any post-employment notice pay (see Appendix E). Informal resolution will always be used in the first instance unless in the most serious of cases this is not possible.
- Impartiality will be maintained by all those involved in any part of the process. A resolution hearing will not be conducted by anyone who has been actively involved in the investigation.
- Pay progression will be deferred where formal warnings have been applied.

6.2 Safeguarding

Safeguarding procedures are not limited to allegations involving significant harm or the risk of significant harm to a child or vulnerable adult. The Safeguarding leads for Adults and Children need to be notified at the outset in respect of any allegation that an employee has:

- Behaved in a way that has harmed a patient, or may have harmed a child or vulnerable adult, whether or not this person is a patient;
- Possibly committed a criminal offence against or related to a child or vulnerable adult, whether or not this person is a patient;
- Behaved towards a child or vulnerable adult in a way that indicates that they are unsuitable to work with children or vulnerable adults.

The Trust has a legal duty to refer to the Disclosure and Barring Service relevant information where there is a concern relating to harm or the risk of harm to children or vulnerable adults.

Further information on safeguarding can be found in the Safeguarding Policy.

6.3 Professional Bodies

The Trust requires employees in registered professions to adhere to their standards of professional practice, and their relevant codes of professional conduct will be referenced in line with this policy.

The relevant external body for professional staff will be notified of professional misconduct cases if a formal warning results from a resolution process. The professional body may take action in addition to action taken by the Trust. The Trust has a duty to report instances of professional misconduct to certain statutory bodies e.g. Nursing and Midwifery Council. Reporting is done with the relevant Head of Profession's approval within the division.

The professional body should be informed either after an appeal has been heard where the final outcome has been given or at the end of the appeal deadline. In some cases the Trust may inform the relevant professional body at the beginning of an investigation if appropriate, after discussion with the relevant professional lead (see Appendix F).

If the nurse or midwife is subject to an internal resolution procedure, they will be able to apply to renew their registration as long as they fulfil all the revalidation requirements. However, if this internal resolution procedure includes concerns about the nurse or midwife's fitness to practise, these should be raised in the appropriate way at that time. This would fall outside of the revalidation process.

6.4 Support for Employees

Employees can be accompanied at investigation meetings by a union representative or a colleague. Other support such as a personal friend or family member may also be considered. Only union representatives can formally represent the employee or answer questions on their behalf. The Trust encourages employees to seek support throughout the process.

Meetings may be rearranged if the employee's companion is not available on the first date offered, however this must not be unduly delayed and a second meeting should be proposed to be held as soon as possible.

6.5 Informal Resolution

On most occasions concerns can be dealt with agreed actions to improve conduct or behaviours, appropriate support and/or training. Employees should be aware that a pattern of behaviour following informal resolution could mean that the formal resolution process may be needed.

The manager should meet informally with the employee to discuss the matter with the employee, providing support and encouragement to improve their behaviour. The aim of the meeting should be to agree joint standards and plan improvement over an agreed timescale, where appropriate. The manager must write to the employee to confirm the discussion and support/training offered in the form of an Improvement Plan. Alternatively, this meeting could establish facts and circumstances that require further investigation via formal resolution, in such circumstances the formal resolution process should be followed.

Improvement Plans should be live working documents for the employee to refer back to in support of improvement, it is not anticipated that these documents will be required or retained for longer than six months.

6.6 Suspension

Suspension is a last resort. It is normally carried out by either the line manager or the commissioning manager and must be authorised by the Head of HR Services, HR Business Partner and Divisional Director or nominated deputies following a suspension risk assessment.

If it is necessary to remove an employee from the workplace for the protection of an employee, a patient or the public, or the allegation is of such a serious nature that it is not acceptable for the employee to remain on duty; the employee may be sent home immediately and a 'cooling off' period invoked. This must be followed as soon as possible by a formal suspension risk assessment and authorisation process, the 'cooling off' period will not normally last for more than 48 hours.

a) Support for Employees

When an employee is suspended, they must be informed in writing of any support that the Trust offers, the conditions of suspension and the length of time they can expect to be away from the workplace.

An employee that is suspended should be supported throughout the process. They should be nominated a senior member of staff and a member of the HR Services team to remain in contact with. They should be informed of the process that will be taking place and informed regularly of progress the investigating officer is making.

If it becomes apparent that the suspension is going to remain in place for longer than 28 calendar days, the commissioning manager should write to the employee to advise on the period of extension and the reasons for the delay in concluding the investigation. The suspension should also be escalated to the Divisional Board with explanation of the barriers to completion of the process or returning the employee to work.

b) Ending a Suspension Early

The commissioning manager should regularly review whether it is appropriate for a suspension to continue, taking cues from the investigating officer if further information comes to light that is material to the decision to suspend.

The commissioning manager should in each review consider whether a return to work for the employee is possible this should be done in collaboration with expert advice from HR Services. In such a situation, the investigating officer must discuss with the employee how a return to work might be supported and then write to the employee notifying them of the end of their suspension.

c) Bank and other work during Suspension

The line manager must ensure that the Temporary Staffing Bureau is advised if a member of staff is on suspension. The employee who has been suspended must not undertake work for the Trust or other NHS employers during their normal work hours with the Trust, including bank, agency and locum work.

d) Annual Leave during Suspension

The suspending manager should ask the employee during the suspension meeting whether they have any annual leave booked that might fall within the suspension period. This information should be passed on to the investigating officer, and investigation meetings should not be arranged to take place on dates of the employee's annual leave. This is in order to ensure that the employee is able to prioritise periods of rest as they would if they were in the workplace.

If an employee is on suspension and wishes to book new annual leave, the Trust actively encourages employees to take frequent rest breaks in the form of annual leave; therefore no employee whom is suspended shall be prevented from booking annual leave as a result of their suspension. All annual leave bookings will be dealt with in accordance with the Trust's Annual Leave policy.

e) Sickness during Suspension

If an employee is unwell during the period of suspension and has a GP fit note to verify this, then the absence will be recorded and paid as sickness absence as opposed to suspension, and managed in accordance with the Trust's Supporting Attendance Policy.

7. Investigation

See Appendix G if the case relates to a member of medical and dental staff.

See section 4 for individual duties and responsibilities.

The investigating officer will normally be the line manager of the individual with whom the concern has arisen. However if the line manager has been involved in the incident then an investigating officer will be appointed by the commissioning manager, in discussion with HR Services and/or the divisional HR Business Partner.

The investigation should begin as soon as possible, and should be completed without undue delay. The process of investigation should take no longer than four workings weeks wherever possible. If the investigation is going to take longer than this then the employee should be informed in writing with the reasons for the delay.

7.1 Informal Resolution Meeting/Fact Find

When concerns or an incident comes to light, the line manager (or other appropriate person) should undertake an informal resolution meeting before a full investigation is commissioned, in order to determine:

- The employee's perspective.
- The basic facts of the situation. This may include gathering statements and examining documentary evidence such as Datix reports, patient records etc.
- Whether a formal investigation is required, or whether informal resolution is appropriate.

- For clinical incidents, managers should refer to the Staff Support and Being Open Policy, which covers the relationship between incident reporting and Resolution processes.
- Whether fraud or corruption is suspected, in which case the Local Counter Fraud Specialist should be contacted, in line with the Countering Fraud and Bribery Policy.
- Whether a safeguarding referral is appropriate (see section 5.2)
- Whether suspension is appropriate or necessary (see section 7).

7.2 Terms of Reference

If, once an informal resolution meeting has been held, concerns of a serious or repeated nature or concerns that cannot be resolved through informal resolution action remain, the line manager should discuss the concerns with the appropriate senior manager within the division (with reference to Appendix F). If the senior manager commissions an investigation, they must prepare the terms of reference with expert advice from HR Services. This will set out clearly the investigating officer's remit and the deadline for the investigation.

The commissioning manager will identify an appropriate investigating officer, with expert advice from their HR Services, taking into consideration:

- The seriousness and complexity of the allegation;
- Whether the line manager is personally involved in the matter or any other potential investigating officer is too closely associated with the people involved in it;
- Whether there is any conflict of interest.

If new concerns come to light during the investigation, it may be appropriate for the commissioning manager to amend the terms of reference in order to avoid any confusion about the scope of the investigation (the investigating officer would need to write to the employee regardless). This does not however mean that the informal resolution process should not be used to address these concerns in the first instance.

7.3 Procedure

See Appendix B for flow chart.

Once they are provided with the terms of reference, the investigating officer will:

(a) Write to the employee inviting them to an investigation meeting, outlining the concerns and informing them that they can have support at the meeting. The employee will receive notice of the investigation meeting in order to arrange representation; the employee can expect the investigation meeting to take place within one week of received notification of the concerns.

(b) Arrange a venue for the investigation meeting and also, provide a note taker. HR Services may be able to support note taking in some circumstances such as where an external or independent investigator is commissioned however usually, this responsibility will sit with the Division that the investigation takes place in. The

notes are not a verbatim record of the meeting but should be sent to the employee as soon as possible after the meeting to be reviewed and signed for accuracy. In some circumstances it may be appropriate to for the Trust to use a digital recording device in order to provide a full transcription. This must only be done with the agreement of all parties in advance of the hearing. Recordings will be transcribed and stored as appropriate and in line with GDPR Regulations.

(c) Meet with all witnesses and obtain a verbal account of the incident and request a written statement, ideally within 48 hours of the incident happening, and collect relevant documents, equipment or any other material relevant to the case.

(d) Having gathered the relevant facts, present their findings in an investigation report outlining the full circumstances of the case making recommendations as to whether training or support to improve conduct and performance is more appropriate that a Resolution Hearing. This recommendation should be discussed with the commissioning manager prior to the convening of a resolution hearing, if required, the process can be referred to the Supporting Performance Policy at this point.

(e) Should the case go to a resolution hearing, present a summary of their findings at that meeting.

7.4 Next Steps

Upon receiving the completed investigation report, the commissioning manager will:

(a) Read the submitted investigation report and determine whether:

(i) The case should proceed to a resolution hearing;
(ii) The employee should undertake training or any other informal recommendations or restrictions that may be put in place (see section 10.2)
(iii) There is no case to answer and no further action will be taken (see section 10.1).
(iv) The case should be referred to the Supporting Attendance Policy for ongoing support and training.

(b) If they decide the case should proceed to resolution hearing, to determine who should chair the panel in line with the levels of authority necessary depending on the severity of the matter (see section 9). The commissioning manager can chair the hearing themselves.

(c) To decide whether it is appropriate to end the suspension prior to a hearing (see section 7.3)

(d) If proceeding to a resolution hearing, to share the investigation report with the employee and their chosen Trade Union representative as early as is practicable.

8. Resolution Hearing

In order for a formal resolution outcome to be considered, a resolution hearing is required. The hearing will be organised by the chair of the panel, whom will be appropriately authorised or will have delegated responsibility to issue a warning or other outcome (See Appendix xx).

This manager will not have been actively involved in the investigation, but may have been the suspending manager, the commissioning manager, or the manager who received the investigation report (if these are not the same person).

The chair of the panel will in conjunction with expert advice from HR Services:

- Select who should be on the panel to support them, depending on the severity or complexity of the case or the staff group the employee belongs to;
- Formally invite the employee to a resolution hearing, giving as much notice as possible, including the following information:
  - The requirement of the employee to attend the hearing;
  - The date, time and place of the hearing;
  - The precise details of the concerns relating to the employee;
  - The right of the employee to be accompanied by a Trade Union representative, or other person not acting in a legal capacity;
  - The names and job titles of the individuals attending the hearing;
  - A request for details of the employee's representative (if any) at the hearing, witnesses to be called and documents to be produced;
  - Whether the allegation could be considered gross misconduct, and whether dismissal is a possible outcome of the resolution hearing.
- Send out two copies of the investigation report to the employee with the invitation letter.
- Organise a note taker for the hearing; this note taker will usually be sourced from the Division in which the case originates however in exceptional circumstance, HR Services may be able to provide support.
- Lead the hearing and follow the process as set out in Appendix C;
- Make a decision in line with section 10 of this policy, after consultation with the other members of the panel;
- Confirm the outcome of the hearing to the individual in writing.

The panel should also include an HR professional and if required a clinical or subject matter expert or independent member of the panel. All panel members will participate in the decision making process in order to give a balanced outcome.

A third panel member is required for any hearing where the outcome may be dismissal on the grounds of conduct.

Before the hearing, the employee should:

- Produce evidence or a statement in response to the investigation report for the panel to consider, which should be received by the chair no fewer than two working days prior to the hearing.
- Let the organiser know as soon as possible if they cannot attend;
- Organise Trade Union representation, friend or colleague, if required, and give them a copy of the investigation report.

8.1 Conduct of the Hearing

See Appendix C for flow chart.

Further details of the appeal process can be found by referring to the Appeals Policy. Non Attendance at a hearing

If an employee fails to attend a hearing without notification or without significant mitigation, the decision may be taken for the hearing to go ahead in their absence. The chair of the panel, with the counsel of the other panel members, will decide whether to proceed with the hearing.

A union representative may present the case in the absence of the employee, if needed, and only if all parties agree.

Resolution hearings may in most circumstances be rearranged once if the employee or their representative is unable to attend, providing they have given prior warning and reasonable information as to their inability to attend. At the second attempt, the hearing will take place and a decision will be made in their absence unless there are highly exceptional circumstances.

9. Outcomes and Resolution

9.1 No case to answer

If, following either a full investigation or a formal hearing, the manager receiving the investigation report or chairing the panel decides that there is no case to answer on the presented allegations, they should write to the employee to confirm the decision and end the resolutions process. Care should be given to ensure the wellbeing of the employee following what has likely been a distressing and stressful period of time.

9.2 Informal Outcome with Recommendations

Following either a full investigation or a resolution hearing, the manager receiving the investigation report or chairing the panel may decide that while the concerns may be substantiated, a resolution hearing, outcome or warning is not warranted. They should write to the employee to confirm this decision and the nature of the informal outcome, and inform them that if further similar incidents arise within the next 12 months, the evidence gathered may be considered alongside a future investigation. The letter will remain live on the employee's file for 12 months.

9.3 Formal Warnings

Formal warnings can only be applied following a resolution hearing.

When a warning is given, the panel should have considered all the facts available, any mitigation provided, and be confident that a fair and consistent decision has been made in light of the concerns, evidence and Investigating Officer recommendations presented.

The employee's pay progression will be deferred for 12 months whenever a formal warning is applied. The chair must refer to the Pay Progression Policy and seek advice from HR Services.

(a) First Written Warning

Where conduct or performance have fallen below acceptable standards or have not been resolved informally or where the concern is more serious, the employee may be given a first written warning.

The warning will set out the nature of the concerns, the consequences of any further concerns, specifying, if appropriate, what improvement is required and over what time period and notification that further incidents could result in a final warning and ultimately dismissal.

There can be recommendations made by the panel in reference to training or supporting performance, where appropriate.

This warning letter will remain live on the employee's file for a period of 12 months.

(b) Final Written Warning

Where conduct is extremely serious or conduct continues to fall significantly below acceptable standards and previous resolution efforts have not resulted in sufficient improvement the employee may be given a final written warning.

The final written warning will set out the nature of the concerns, specifying, if appropriate, what improvement is required over what time period and will state that any further misconduct may lead to dismissal.

There can be recommendations made by the panel in reference to training or supporting performance where appropriate.

This warning letter will normally remain live on the employee's file for a period of 12 months. However, for serious misconduct, this may be extended up to a maximum of 24 months.

(c) Downgrading/Transfer

In certain circumstances it may be necessary to apply further formal resolution measures in addition to a final written warning or as an alternative to dismissal. This includes downgrading or transfer (permanent or temporary) without protection of earnings. Any downgrading will always be within one band or equivalent of the employee's existing post.

(d) Dismissal

If all resolution stages have been followed and the misconduct continues or where there have been a number of instances of less serious offences, or where an incident is so serious it constitutes gross misconduct (see Appendix E), then the employee will be dismissed. Dismissal for **misconduct** will be with the appropriate notice period (or exceptionally post-employment notice pay) of one week's notice for each completed year of continuous service up to a maximum of twelve weeks. A dismissal for **gross misconduct** will be a summary dismissal without notice or post-employment notice pay.

In considering dismissal as an option, the following must be examined:

- Whether the resolution procedure has been complied with and, if it has not, that there are good and justifiable reasons for deviating from it;
- Whether other available courses of action have been considered and discounted;
- Where appropriate, the dismissal is consistent with previous practice within the Trust and is a reasonable course of action;
- All the evidence relied upon is available and sufficiently clear to justify the decision.

In certain circumstances, where a registered health professional employee is dismissed from the Trust, the relevant professional body should be informed by the dismissing Chair. This should be done after the appeal deadline or after the final outcome has been made.

10. Appeals

Following a formal resolution outcome (including dismissal) , an employee can appeal against the decision. The right to appeal will be given in writing in the outcome letter from the resolution hearing, including a copy of the Trust's Appeals Policy (under which any appeal will be conducted).

An appeal must be to the nominated manager as stated in the resolution hearing outcome letter, and must be received by them no later than ten working days following the employee's receipt of the written confirmation of the hearing outcome.

For appeals against dismissal, the appeal should be addressed to the Head of HR Services, University Hospitals Bristol & Weston NHS Foundation Trust, Level 4C Whitefriars, Lewins Mead, Bristol, BS1 2NT or email HRServices@UHBW.nhs.uk marking for the attention of Head of HR Services.

The employee should include in their written appeal the following:

- The reasons for appeal;
- If they feel that due process in the hearing was not followed;
- If they feel that there was evidence/mitigation that was not considered.

11. Referrals

In some circumstances, the Trust has a legal duty to refer individuals to the Disclosure and Barring Service (DBS). Where the outcome of a hearing is to dismiss or transfer the employee from a post

working with children or vulnerable adults, and that their action or inaction caused or risked harm to a child or vulnerable adult, the Chair of the hearing must report the case to the Head of Employee Relations. Advice about making DBS referrals can also be sought from the Trust's Lead Safeguarding Nurse (see section 5.2).

Where the employee is a professional registrant, the hearing chair must consider whether a referral to the professional body is appropriate and discuss this with the relevant professional lead (see section 5.3).

Referrals will be made once any line of appeal is exhausted.

12. Records and Time Limits

All records and associated papers are confidential and will be kept on the employee's central personal file in HR Services.

Written warnings will remain on the individual's personal file for the period of the sanction and may be disclosed as part of employment references. At the end of this time the record will be disregarded for most purposes.

All written documents/records and proceedings relating to matters dealt with under this policy are, and must remain, confidential, with the exception of meeting the Trust's duties to make referrals to the DBS (see section 10.9) or to professional bodies.

13. Standards and Key Performance Indicators

13.1 Applicable Standards

Applicable standards include all areas covered by this policy, where specific standards will be used to monitor compliance, including all standards staff are expected to follow and reach in order to comply with this policy. For example, this might include regulatory requirements.

13.2 Measurement and Key Performance Indicators

These are any specific, measurable targets or objectives which will be used to ensure compliance with the policy, to ensure performance in relation to this policy is monitored.

14. References

ACAS Code of Practice on Disciplinary and Grievance Procedures

Maintaining High Professional Standards in the Modern NHS

15. Associated Internal Documentation

Alcohol and Prohibited Substance Misuse Policy

Appeals Policy

Counter Fraud and Bribery Policy - UHBW

Pay Progression Policy

Starting Salary and Incremental Pay Progression Policy – Weston Staff protected under TUPE

Managing Capability Concerns of Medical and Dental Staff - UHBW

Safeguarding Patients Policy

Social Media for Personal Use Policy

Staff Conduct Policy

Staff Support and Being Open Policy

Supporting Attendance Policy

Supporting Performance Policy

16. Appendix A – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this policy. Please ensure any possible means of monitoring this policy to ensure all parts are fulfilled are included in this table. **The first line is an example for you and should be removed prior to submission**.

Objective	Evidence	Method	Frequency	Responsible	Committee
Monitoring of incidents to identify learning.	Incident reports from Datix Incident Reporting System.	Data extraction from incident reporting system.	Quarterly, Annually and Ad hoc as required.	Divisional Health and Safety Leads/Divisional H&S (site/service) Advisors	Trust Health and Safety Committee/Divisional H&S Forums.

17. Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Head of HR Services
Is this document: A – replacing the same titled, expired policy, B – replacing an alternative policy, C – a new policy:	A
If answer above is B: Alternative documentation this policy will replace (if applicable):	[DITP - Existing documents to be replaced by]
This document is to be disseminated to:	All staff
Method of dissemination:	[DITP – Method of Dissemination]
Is Training required:	Yes for investigating Officers
The Training Lead is:	Head of HR Services

Additional Comments
[DITP - Additional Comments]

18. Appendix C – Equality Impact Assessment (EIA) Screening Tool

Further information and guidance about Equality Impact Assessments is available here:
http://nww.avon.nhs.uk/dms/download.aspx?did=17833

Query	Response
What is the main purpose of the document?	
Who is the target audience of the document? 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 in relation to your response.
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	

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		By ensuring early resolution and informal line management intervention.
Will it promote and protect human rights?			

On the basis of the information/evidence so far, do you believe that the document will have a positive 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

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 Impact Assessment.

Is a full equality impact assessment required? YES / NO

Date assessment completed:

Person completing the assessment:

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**Bi-Annual Report: Diversity and Inclusion**
Report Author	**Harjinder Bahra – Equality, Diversity and Inclusion Manager**
Executive Lead	**Alex Nestor – Acting Director of People**

1. Report Summary

The Trust has produced its first bi-annual equality, diversity and inclusion integrated performance report. The purpose of the bi-annual report is to ensure that the Trust has developed a robust assurance and delivery plan that mitigates risk on compliance with our public sector equally duty across all protected characteristics and responding to findings from staff surveys, Equality Delivery System (EDS2), Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap.

The bi-annual report sets-out both corporate and divisional progress against the Trust's 2020/25 diversity & inclusion strategy for Q3 and Q4 of 2020/21, forward plan for WRES and WDES and also the strategic action plan for 2021/22

2. Key points to note
(Including decisions taken)

The Board is asked to receive the report for assurance

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

Risk 285: Risk that the Trust fails to ensure equity of experience for all staff.

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

- This report is for **Assurance.**

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

People & Education Group	7 July 2021
EDI Steering Group	8 July 2021
People Committee	27th July 2021

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

"The last year has been incredibly challenging for all our staff who have continued to provide passionate and dedicated care to our patients and each other.

As one of the largest Trust in the country, employing over 13,000 staff, I cannot emphasise enough how crucial equality, diversity and inclusion are to our wellbeing and aspirations.

The publication of this bi-annual report is an important step showing the progress we are making on our five-year strategy to become inclusive in everything we do.

We have a long way to go, and on behalf of the Trust Board, I can give you our pledge to do whatever it takes to complete this journey."

Alex Nestor, Acting Director of People

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NHS Foundation Trust

Workforce Equality, Diversity and Inclusion

Bi-annual Integrated Equality, Diversity and Inclusion Performance Report (October 2020 – March 2021)

June 2021

Draft report sign-off pathway and glossary

Report author - Harjinder Bahra, Trust Equality, Diversity and Inclusion Manager			
Sign-off pathway for the bi-annual EDI integrated performance report			
1	Support	People and Education Group	7 July 2021
2	Feedback	EDI Steering Group	8 July 2021
3	Assurance	People Committee	27 July 2021

Glossary	
EDI	Equality, Diversity and Inclusion
D&I	Diversity and Inclusion
WRES	Workforce Race Equality Standard
EDS2	Equality Delivery System (version 2)
WDES	Workforce Disability Equality Standard
GPG	Gender Pay Gap

Executive Summary

Our Vision

Our vision is to be '**inclusive in everything we do**'. We aim to do that through a programme of change initiatives that realises the following benefits:

- A culture of inclusion and engagement at University Hospitals Bristol and Weston for all staff
- Valuing and empowering staff to ensure better outcomes for individuals, the organisation and patients
- Ensuring talent is maximised in the organisation
- Our Leadership teams represent the community we serve
- An inclusive approach to development, education and promotion
- Greater innovation; as research shows that diverse teams are more likely to increase organisational effectiveness

Our Ambition

Our ambition is to become an inclusive employer of choice. We aim to achieve this through:

- Leadership and cultural transformation
- Accountability and assurance
- Positive action and practical support
- Monitoring progress and benchmarking

About this report

This is the Trust's first bi-annual equality, diversity and inclusion integrated performance report. The purpose of the bi-annual EDI report is to ensure that the Trust has developed a robust assurance and delivery plan that realises our vision and ambition by mitigating risk by:

- Compliance with the public sector equally duty for all protected characteristics
- Responding to findings from staff surveys
- Using the Equality Delivery System (EDS2) as a cultural of care barometer
- Embedding the Workforce Race Equality Standard (WRES) and adopting the Model Employer framework
- Embedding the Workforce Disability Equality Standard (WDES)
- Addressing Gender Pay Gap

The bi-annual EDI report sets-out both corporate and divisional progress against the Trust 5-year D&I strategy in Q3 and Q4 of 2020/21. The report also sets-out the forward plans for WRES, WDES and Trust staff networks together with the strategic action plan for 2021/22

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NHS Foundation Trust

Key successes on Trust equality, diversity and inclusion action plan

The following slides set-out some of the key successes the Trust has made in the last six months on its five-year EDI strategy.

Key Successes

Senior Leadership Team EDI Summit 4 Nov 2020

Successful and well attended EDI seminar with keynote speech by Habib Naqvi, national WRES lead. Divisional updates on EDI activities since the launch of the Trust 5-year EDI strategy and action plan for 2020/21.

Black History Month Webinar 22 Oct 2020

Black History Month was supported with a wide range of online activities. The well-attended webinar was address by RCN Regional Director, Lucy Muchina, and also by top British athlete and inspirational speaker, Vernon Samuels.

LGBT History Month Event 24 Feb 2021

Very successful and generative event with over 60 people attending including the exec team with commitment to work with Freedom Youth (local LGBT organisation) and ShoutOut Radio.

National Reciprocal Mentoring Programme

Trust successfully bid to be part of the national 18-month Reciprocal Mentoring for Inclusion programme.

Stepping Up Diversity Leadership Programme 2021

Three Trust-funded staff members have successfully enrolled onto Bristol Council's award winning Stepping Up Diversity Leadership Programme.

Cultural Awareness Training

New two-hour workshop, 'Cultural awareness for an inclusive workplace', was launched with positive feedback. Workshop focuses on exploration of 'You' and 'your place in the world' with the aim of creating a positive culture in the workplace.

Equality, Diversity and Inclusion Steering Group

Relaunched EDI steering group with new terms of reference, governance pathways and refreshed membership that includes divisional EDI leads and the creation of operational EDI leads for local EDI reporting.

Trust EDI Lead

A permanent EDI lead has been appointed to deliver the Trust 5-year diversity and inclusion strategy, support and build divisional and corporate EDI capacity including staff networks and EDI Advocates

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Update on Trust equality, diversity and inclusion action plan Sept 2020 to March 2021

The following slides set-out the high level progress the Trust has made in the last six months on its five-year EDI strategy.

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update

KPIs	No	Action	Who	When	Progress	RAG
PSED EDS4.1 DPP6	1	Reciprocal Mentoring (RM). The Trust successfully bid to be part of the national 18-month RM for Inclusion programme.	EDI Manager Barnard Galton Sam Chapman	May 21	• Productive on-boarding day (3 Feb) • RM has potentially better outcomes for mentoring relationships and co-production across the Trust	
EA2010 PSED WRES WDES EDS2	2	Trust Staff Networks: Supporting and developing them to become sustainable with a wider reach and impact across all protected characteristics.	EDI Manager Staff Networks Chairs Jeff Farrar Matt Joint	Apr 21	• Draft feasibility report completed and options being considered including protected time for developing and running the networks • Networks currently developing a 12 month action plan framework	
PSED EDS4.1 DPP6	3	Stepping Up Diversity Leadership Programme 2021. The award winning programme is aimed at developing a diverse range of future leaders from BAME communities, women, people with disabilities and wider protected groups.	Divisional Directors HRBP's	Feb 21	• For the 2021 cohort, between 4 and 6 Trust staff have applied to join the programme • Offer on the programme is subject to shortlisting and interview outcome	
WRES WDES PSED EA2010 EDS2	4	Trust-wide capacity-building for divisional EDI Leads and EDI Advocates	EDI Manager Divisional EDI leads Divisional EDI Advocates HRBPs	Mar 21	• EDI Leads and Advocates support pack in progress • EDI capacity-building training and development tools in development	

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update

KPIs	No	Action	Who	When	Progress	RAG
EA2010 PSED BSS1 BSS2 BSS3 BSS4	5	Develop an EDI Inclusive Leadership Programme for Divisional EDI Leads & Advocates. This programme will provide robust baseline capacity-building on legal compliance, equality analysis and practical application of embedding EDI in all Trust activities and functions including equality of opportunity in career progression and development across all protected groups.	EDI Manager Head of Education Head of L&D Staff Networks Divisional EDI leads Divisional EDI Advocates	April 21 onwards	Ongoing support for Divisional EDI Leads & Advocates is already in place. In parallel, a wider scoping and feasibility study is underway to determine EDI capacity-building needs, programme content and delivery mechanisms.	
APP2	6	Support for line-managers to have 'meaningful' EDI conversations in Appraisals. There is a clear juxtaposition between, 'what have you done to improve EDI in the Trust?' and 'how can I support your pathway to EDI in the Trust'.	EDI Manager Oonagh McNeil	Feb 21	Draft guidance currently being developed.	
EDS4.3	7	Cultural Awareness Training.	EDI Manager Mike Sheppard	Ongoing	Training has been well received with 567 having completed it - ongoing promotion	
EDS3.1 DPP1	8	Building EDI into our Recruitment processes.	EDI Manager Peter Russell	April 21	Scoping and feasibility study underway to develop focused interventions.	
EDS3.3 APP2 DSS1	9	Building EDI into Talent Management as part of the Talent Management pilot in Estates to harnesses the talent that is lying dormant in our staff across all protected groups.	EDI Manager Faye Beddow	April 21	Scoping and feasibility study underway to develop focused interventions.	

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update

KPIs	No	Action	Who	When	Progress	RAG
EDS4.1 DSS1	10	Review Lift As You Climb pilot and develop an up scaled programme with self-sufficient management system allowing the mentor and mentee to contact directly.	EDI Manager Alex Millar	Feb 21	Review of the Lift As You Climb pilot has been completed and the self-service management system is currently being tested for functionality and integrity. The pilot has been well received and a number of inspirational staff have registered as mentors. The full programme should go live in Feb 21.	
EDS3.6 PSED	11	Celebrating and Valuing the Contribution of all our staff. OD has developed a comprehensive EDI communications plan for 2021 that is in the process of being implemented that showcases the diversity and richness of contribution by Trust staff. There will be particular focus on national and international events e.g. LGBT Month (Feb), Black History Month (Oct) and Disability Month (Dec) and also on festivals (e.g. Diwali) as well as celebration and awareness days/weeks e.g. men's health week.	EDI Manager OD team Staff Networks Divisional EDI Leads Divisional EDI Advocates Comms team	Ongoing 2021	Activities around LGBT Month are at the planning stage with a half-day LGBT conference taking place on 24 Feb (virtual conference).Planning around other events is also in progress.	

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update

KPIs	No	Action	Who	When	Progress	RAG
PSED DSS1 APP2	12	Equality of opportunity. The Trust is committed to understanding the barriers to equality of opportunity for career progression and development for all staff across all protected characteristics.	EDI Manager Staff Networks Divisional EDI leads Divisional EDI Advocates	2021-22	Scoping and feasibility study underway to develop focused interventions by understanding key barriers, hot spots and pressure points to EDI in the Trust.	
WDES PSED EDS3.6	14	Improving our WDES & LGBT staff data collection on ESR. The Trust recognises that there are genuine EDI barriers that prevent some staff from registering their disability and/or sexual orientation on ESR. This is a complex area with issues of trust, safety, confidentiality and inclusion needing to be addressed at an individual, team and organisational level. The Trust is committed to cultural change where staff from all protected groups feel safe, supported, valued and respected.	EDI Manager Lorna Hayles LGBT+ Staff Network Chair ABLE+ Staff Network Chair	2021-22	The learning from the WRES Cultural Change pilot, particularly, the diagnostics, gathering of quantitative and qualitative data, will be directly applicable to addressing some of the EDI barriers faced by our LGBT and disabled staff.	

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Trust Equality, Diversity & Inclusion Action Plan 2021/22

KPIs	No	Action	Who	When	Progress	RAG
PSED DSS1 APP2	12	Equality of opportunity. The Trust is committed to understanding the barriers to equality of opportunity for career progression and development for all staff across all protected characteristics.	EDI Manager Staff Networks Divisional EDI leads Divisional EDI Advocates	2021-22	Scoping and feasibility study underway to develop focused interventions by understanding key barriers, hot spots and pressure points to EDI in the Trust.	
WRES DPP3 DPP4 DPP5 PSED	13	WRES Cultural Change Programme. The pilot involves deep-dive diagnostics on the WRES data, focus group facilitation and reviewing access to leadership development among other interventions. The learning from this programme will be applied across all protected characteristics to help the Trust build a more representative workforce.	EDI Manager Lorna Hayles Sam Chapman National WRES Team	Feb 21	The programme initiation meeting is set for Feb 21.	
WDES PSED EDS3.6	14	Improving our WDES & LGBT staff data collection on ESR. The Trust recognises that there are genuine EDI barriers that prevent some staff from registering their disability and/or sexual orientation on ESR. This is a complex area with issues of trust, safety, confidentiality and inclusion needing to be addressed at an individual, team and organisational level. The Trust is committed to cultural change where staff from all protected groups feel safe, supported, valued and respected.	EDI Manager Lorna Hayles LGBT+ Staff Network Chair ABLE+ Staff Network Chair	2021-22	The learning from the WRES Cultural Change pilot, particularly, the diagnostics, gathering of quantitative and qualitative data, will be directly applicable to addressing some of the EDI barriers faced by our LGBT and disabled staff.	

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update

KPIs	No	Action	Who	When	Progress	RAG
EA2010 PSED	15	EDI visibility on HRWeb. EDI Landing Page to be reviewed and refreshed.	EDI Manager Alex Millar	Jan 21	The EDI landing page on HRWeb has been refreshed with continued development throughout 2021 so it becomes a robust resource for all staff on Equality, Diversity and Inclusion.	
EA2010 PSED	16	EDI visibility on Public Website (external). EDI publications to be migrated from UHB to UHBW new website.	EDI Manager Tasmeen Warr John Kirk	Jan-Feb 21	Discussions are taking place on the timeframe when this can be achieved.	
EDS4.2 EA2010 PSED WRES WDES	17	Bi-annual EDI performance framework report. Develop a bi-annual EDI performance framework report to enable robust local reporting and targeted interventions that goes to People Committee and all governance routes within the Trust.	EDI Manager Sam Chapman	May 21	Draft outline of the framework report is in progress. The final report to be presented to the People Committee on 25 May 2021.	

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update

KPIs	No	Action	Who	When	Progress	RAG
EA2010 PSED WRES WDES EDS2	18	Mystery Shopper - testing the assumptions. The Trust is committed to EDI for staff, students, volunteers and patients. However, we need to test how this works in practice. Therefore, in parallel with the BAME Student Placement Pilot (see action point 27), the Trust is developing a programme that will journal the EDI experience of placement students from other protected characteristics (e.g. LGBT, disability, religion or belief, pregnancy and age) in clinical and educational settings.	EDI Manager Head of Education Head of L&D Head of Medicine Edu. Divisional EDI leads	April 21 onwards	Scoping and feasibility study is underway in advance of the design stage which will include 'safe and confidential space' for honest dialogue for students and supervisors to share about their respective experience of EDI in these settings/relationships.	

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update

KPIs	No	Action	Who	When	Progress	RAG
EA2010 PSED WRES WDES EDS2	19	Positive Action and Practical Support on EDI Over the next 12 months, the Trust's focus will be to achieve high visibility on EDI internally (intranet) and externally (public website), with increased focus through our communication channels including Voices, Newsbeat, leaflets, webinars, focused EDI masterclasses and capacity building workshops.	EDI manager Tasmeen Warr John Kirk Staff Network chairs Divisional EDI Leads/Advocates Head of L&D Head of Education	2020-21	EDI landing page on HRWeb refreshed. Focused interventions and messages are being developed as part of the Trust New EDI Offer to all staff, Divisional EDI Leads/Advocates as detailed throughout this report.	

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update

KPIs	No	Action	Who	When	Progress	RAG
EA2010 PSED WRES WDES EDS2	20	The Trust is committed to supporting Staff Networks to become sustainable with increased visibility, membership, wider reach and impact across all protected characteristics.	EDI Manager Staff Network Chairs Jeff Farrar Matt Joint	Feb 21	A draft scoping and feasibility study for making Staff Networks sustainable is near completion for wider circulation and engagement.	
WRES WDES PSED EA2010	21	Access to facilities and room at Weston to enable staff based at Weston to attend Staff Network meetings virtually.	EDI Manager Staff Network Chairs Julian Newberry Mark Kellinger	Jan 21	An agreement is in place to provide a IT/Webcam equipped room to ensure that staff based at Weston can participate in all Staff Network meetings.	
WRES WDES PSED EA2010 EDS2	22	Increased visibility of Staff Networks on HRWeb.	EDI Manager Staff Network Chairs Alex Millar	Jan 21	Access to Staff Networks' landing page has been moved to HRWeb top menu below 'Staff Services'. Staff Network pages on HRWeb have also been refreshed with continued development throughout 2021 to become a robust resource for staff.	
WRES WDES PSED EA2010	23	Library facilities and support for Staff Networks to develop areas of expertise and resource.	EDI Manager Thomas Osborne Staff Network Chairs	Mar 21	Further dialogue on hold due to covid vaccine being rolled out from the academy building.	

B	R	A	G
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Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update

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B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

Trust Equality, Diversity & Inclusion Action Plan 2021/22

Progress update

KPIs	No	Action	Who	When	Progress	RAG
WRES WDES PSED EA2010 EDS2	26	The Trust has committed itself to a number of local, regional and national partnership working for 2020/22 these include attending, contributing and co-producing EDI interventions that benefit local people, staff and patients.	EDI Manager	2021/22	Attending and contributing to: • Bristol Race Equality Strategic Leaders Group • Bristol, North Somerset And South Gloucestershire CCG EDI Leads Network • North Bristol City Council stakeholder EDI Leads Network • SWE Leadership Academy • NHSI EDI Programmes	
WRES PSED EDS2	27	BAME Student Support in Practice | A Collaborative Approach Pilot - led by UWE. This is a 18-month pilot that will focus on the EDI experience of BAME students when on formal work experience placement.	EDI Manager Head of Education Head of L&D	Phase 1 10 Feb 21	The Project Initiation Document (PID) published. BAME Student Support in Practice | A Collaborative Approach workshop taking place on 10 Feb	
WRES PSED EDS2	28	BAME Medical Students Pilot This project is led by University of Bristol with a focus on addressing racial harassment and bias in medical teaching.	EDI Manager Education Learning & Development	Phase 1 Feb 21	On-boarding and induction meeting have had to be cancelled due to Covid pressures. They are being rescheduled.	

B	R	A	G
On Plan	Not Achieved	Risks Slippage	Completed

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Trust Staff Networks

Staff networks play a key role in meeting the objectives set in the Trust's 5 year EDI strategy. Currently the Trust has three staff networks and would like to grow these in the future.

The following slides set-out the current status of Trust staff networks with a forward plan to make them sustainable with greater reach and impact across the Trust.

Staff Networks

The value of staff networks

Staff networks play a key role in delivering on the Trust 5-year EDI strategy. Staff networks, bring an insight into organisational culture and are invaluable at creating solutions, enhancing motivation and making the Trust a place where people feel authentic with a sense of belonging as part of the **'many voices – one community'** at the Trust. Currently the Trust has three staff networks these are:

ABLE+ (supporting staff with physical, sensory or mental impairments)

LGBT+ (supporting lesbian, gay, bisexual and trans staff)

BAME (supporting staff from the Black, Asian and ethnic minority communities)

Contribution by staff networks

Despite the lack of protected time and resource, the three staff networks have made a positive, but limited impact by:

- Supporting members from under-represented and disadvantaged individuals/group in the workplace
- Contributing to the development and implementation of the Trust 2020/25 EDI strategy
- Playing an active part in celebrating the valuable contribution of our diverse staff
- Contributing to the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard WDES and LGBT reporting pathways and action plans
- Celebrating key events such as LGBT history month, Black history month and Disability history month

Staff Networks

Staff networks forward plan

In April 2021, the BAME staff network chair stepped down. The absence of an expression of interest leads to an opportunity to review the network by resourcing this on a temporary basis from the Trust EDI Manager who will become acting chair of the BAME staff network providing support to the network half a day per week until new elections can be arranged.

This will allow this temporary dedicated resource to deliver a forward plan for June to end of August 2021. This will allow a period of assessment on the impact on the BAME staff network in terms of sustainability, reach and meaningful contribution to the delivery of the Trust people strategy, 5-year EDI strategy and compliance with public sector equality duty.

This review will also enable understanding as to what resource is required to enable a strategic decision to be made as to how/if this is replicated across other networks to enable these to also work more effectively.

The learning from the BAME staff network pilot running from June to end of August 2021 will be used to:

- Inform requirements for other networks- both those established and those proposed
- Develop an approach to go through the appropriate governance given it is likely to involve a financial investment

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Divisional equality, diversity and inclusion action plan update

The Trust comprises of eight divisions. Each division has developed a EDI action plan which is being imbedded with support from divisional EDI leads, operational EDI leads and HR Business Partners. The following slides set-out the progress and forward planning the eight divisions have made on the Trust five-year D&I strategy.

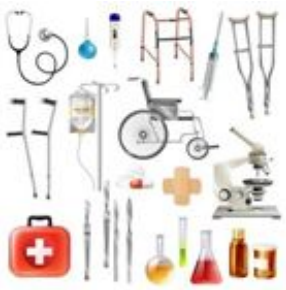
Divisional equality, diversity and inclusion action plan update

Each division has developed an equality, diversity and inclusion action plan

Estates and Facilities

Women's & Children's Services

Surgery



Diagnostics and Therapies

Specialised Services

Trust Services

Weston

Medicine

Diagnostics and Therapies Division

Our progress in the first year

Three things we feel proud to have done and made progress on since May 2019

1. We have strongly encouraged our staff to complete the cultural awareness on line training and are pleased to report that to date 108 D&T staff members have completed the course (out of 340 across the Trust)

2. We have rolled out D&I appraisal objectives for all D&T Managers. The initiative has had sponsorship and support from Divisional Board, Divisional Workforce Committee and has been communicated widely across D&T including a feature in our monthly HR update

3. We have successfully appointed two D&I Leads (one from Radiology and one from Pharmacy) to take on a dual role for the Division meaning more insight and support for our D&I agenda

Our D&I plan going forward

Three priorities we will deliver for the remainder of 2020/2021

1. Continue to promote Cultural Awareness training across the Division, encouraging all staff and mandating Divisional Board and Heads of Service to complete it by the end of 2020/2021 (we now receive regular monthly reports to track progress)

2. Divisional Leaders have expressed interest in the reverse mentoring scheme which we are in the process of facilitating

3. Utilise our two D&I reps to increase awareness and understanding of D&I issues within the Division

Our D&I plan going forward

What are we doing differently or going to do differently as a leadership team?

1. Ensure that all leaders have a full understanding of D&I Divisional Action plan and how they can support the Trust's ambitions by setting the culture within their areas of responsibility – D&I updates are regularly given at the Divisional Workforce Committee and reported to Divisional Board

2. Dedicate time to discussing the issues at a senior level and listen to feedback from staff. We have 2 staff members due to present their staff stories at forthcoming Board meetings

3. Sponsor and closely monitor the progress of the Divisional D&I plan and the impact on our culture and working environments across the Division

Estates and Facilities Division

Our progress in the first year

Three things we feel proud to have done and made progress on since May 2019

1. Recognise and run a Black History event – 2020 Pledge wall
2. Promote Diversity and Inclusion at internal meetings – staff champions; team meetings
3. Carry out values based recruitment with a focus on removing unconscious bias

Our D&I plan going forward

Three priorities we will deliver for the remainder of 2020/2021

1. Recruit more D&I representatives from each hospital site
2. Work with Employee Services to review Employee Relations cases – use of sanctions
3. All managers/leaders/supervisors to complete Cultural Awareness for an Inclusive Workplace
4. D&I appraisal objective for estates and facilities staff

Our D&I plan going forward

What are we doing differently or going to do differently as a leadership team?

1. Complete talent management pilot in Estates and use outcomes to increase Diversity and Inclusion
2. Create a dashboard with current demographics/internal promotions/access to training and education
3. Diversity and Inclusion items on monthly Divisional Management Board agenda (not only Divisional Workforce Group)

Estates and Facilities Division – Some of our Pledges

Medicine Division

Our progress in the first year

Three things we feel proud to have done and made progress on since May 2019

1. Support of CESR & TNA programmes

We have supported these development programmes in our medical and nursing staff groups; our aim being to ensure we are offering progression pathways for all employees, regardless of their education/development background. Evidence has shown that these programmes have offered us the opportunity to develop existing employees who have gained relevant professional qualification overseas , but have not been able to progress through more standard routes. We see this as a hugely valuable way to value our hard working and highly skilled existing workforce.

2. Consultant Recruitment

D&I expectations - We have set an expectation that all consultant interview panels and/or focus groups should have BAME representation, with reasons clear stated to HR if recruiting panel agrees this is not appropriate or feasible. We also have recommended that all interview panels maintain gender equality at all times. All new consultant employees are encouraged to take on a leadership mentor . We utilise Women in Leadership BMA resources in our consultant packs, issued to all new consultants in post. This is also offered to all existing consultants. BAME representative role amongst consultant body has been introduced with key priorities being developed.

2. Graduate Scheme

Balanced Shortlisting Pilot & D&I Buddies - Division of Medicine recently took the lead on developing, recruiting and launching the UHBW Operational Management Graduate Scheme. We piloted balanced shortlisting during the recruitment process, in which BAME candidates were shortlisted first against essential criteria, then matched by the same number of non-BAME candidates, to ensure a completely balanced shortlist. We have also identified D&I buddies within the Trust for each of the new trainees, to ensure conversations with BAME colleagues are always ongoing.

Medicine Division

Our D&I plan going forward

Three priorities we will deliver for the remainder of 2020/2021

1. Divisional Diversity & Inclusion Advocate network

Aim to replicate the health & wellbeing advocate model within the division; the intention being that we develop a defined group of divisional colleagues with an interest in advocating for diversity and inclusion within their local teams and services. The central aim of this network is to establish a two way communication model in which key D&I initiatives are easily communicated locally across the division and advocates also have a feedback route upwards. D&I advocates would also be invited to nominate D&I representatives to attend divisional meetings ensuring that the focus on D&I is in everything they do in everything we do.

2. Pilot 'A fair experience for all' lay member model to narrow the gap in rates of disciplinary rates of BAME staff

To address the high numbers of BAME representation in disciplinary casework, we are planning to implement a 'pre-formal action check' model, as recommended in NHS England's suggestions for closing the ethnicity gap in rates of disciplinary action across the NHS workforce. We will look to nominate a trained lay member to review cases and challenges any perceived bias in the process before cases go to formal action.

3. Increase divisional participation in 'Lift as you Climb' and reverse mentoring schemes

Promote, encourage and support divisional participation in corporate-led mentoring schemes. These schemes offer our colleagues the opportunity to engage with senior colleagues in the organisation, outside of their day to day sphere of influence.

Our D&I plan going forward

What are we doing differently or going to do differently as a leadership team?

1. WRES Pilot

The division are pleased to be participating in the WRES pilot; this will allow the division to understand, plan, respond and proactively improve D&I across all areas. Of particular focus is the development opportunities and career progression for all. As well as equipping our workforce with the skills to thrive, creating a safe and respectful culture and working environment where everybody has a voice and their contribution is valued.

2. Quiet Leadership Programme

The division have started to explore the development of this programme which recognises the importance of having diversity in leadership styles to create high performing teams. This programme aims to deliver various skills and techniques that enable individuals to work together across all personality types with focus on empowering quieter members of teams.

3. D&I data in patient quality and safety data

The division's ambition is to begin to review key quality and safety data through a D&I lens ; initially this would be looking at clinic DNA rates across population groups in our patients to assess whether key themes can be identified and addressed. A longer term aspiration would be to monitor outcome data for different populations.

Surgery Division

Our progress in the first year

Three things we feel proud to have done and made progress on since May 2019

1. **Vulnerable Staff Risk Assessment:** Development & delivery
2. **Hosted International Student:** Underrepresentation of BME staff in non-medical management positions in the Division
3. **Leadership Action:** Positive Progress in Staff Experience

Factor	Staff Survey Question	2018	2019	Trend
Equality, Diversity & Inclusion	Organisation acts fairly: career progression	77%	84%	7%
	Disability: organisation made adequate adjustment(s) to enable me to carry out work	76%	77%	1%
	Experienced discrimination from manager/team leader or other colleagues	12%	10%	-2%
Bullying & Harassment	Experienced harassment, bullying or abuse from managers	17%	14%	-3%
	Experienced harassment, bullying or abuse from other colleagues	24%	25%	1%

Our D&I plan going forward

Three priorities we will deliver for the remainder of 2020/2021

1. **Vulnerable Staff Risk Assessment:**

- Engage with and support Trust review of Risk Assessment Guidance
- Line managers to review current adjustments: remain fit-for-purpose?

2. **Present Research Recommendations to Divisional Workforce Committee:**

- Improve mentorship – career and reverse
- Enhance line management training – addressing non-inclusive behaviours
- Improve the connection between management and BAME community

3. **Refresh Diversity & Inclusion Objectives:**

- Start the conversation

Our D&I plan going forward

What are we doing differently or going to do differently as a leadership team?

1. **Visible Commitment:** Hold self and others accountable and make D&I a personal priority
2. **Create a culture:** In which anyone can contribute to an important outcome
3. **Awareness of bias**: Personal blind spots and flaws in the system

Specialised Services Division

Our progress in the first year

Three things we feel proud to have done and made progress on since May 2019

1. Introduction of a Divisional Workforce Committee

2. All BAME or High Risk staff given opportunity for one to one meetings with line managers to complete a COVID-19 risk assessment, in order to feel supported during pandemic and enable interventions as required

3. Change to Divisional systems to capture D&I data e.g. applications for Divisional Training budget, monitoring Spotlight Award nominations and winners

Our D&I plan going forward

Three priorities we will deliver for the remainder of 2020/2021

1. Divisional Board commitment to hold D&I Listening Events (5th, 16th & 30th November)

2. Creating a Divisional D&I Action Group

3. Continued use of Divisional Culture and People Plan, which includes Diversity & Inclusion focus and underpins all the divisional workforce plans

Our D&I plan going forward

What are we doing differently or going to do differently as a leadership team?

1. Divisional Board members to have D&I objectives within their personal appraisals.
2. Continuous improvement around D&I based upon feedback provided by staff at Listening Events and Divisional Action Group.
3. Support and encourage all staff within the division to complete Cultural Awareness e-learning.
4. BAME observers at all interviews (following Medical model)
5. Divisional participation the D&I agenda;

- BNSSG High Potential Scheme (Band 8 or equivalent M&D)
- Lift as you climb
- Reverse Mentoring

Trust Services Division

Our progress in the first year

Three things we feel proud to have done and made progress on since May 2019

1. Representatives from each of the 5 areas of Trust Services
2. D&I representative part of Trust Services Star Performers awards
3. Piloted balanced shortlisting
4. Piloted interview panel constitution to include a active panel member from one of the protected characteristic groups

Our D&I plan going forward

Three priorities we will deliver for the remainder of 2020/2021

1. Recruit more D&I representatives
2. Further pilot balanced shortlisting
3. Review representation on shortlisting and interview panels
4. Review Recruitment statistics across the Division
5. Diversity and Inclusion objective to be included in appraisals
6. Identify how language acts as a barrier to good communication, recruitment and progression
7. Encourage all managers and staff to complete the online training: 'Nipping in the bud' and Cultural awareness for an inclusive workplace

Our D&I plan going forward

What are we doing differently or going to do differently as a leadership team?

1. Agree how D&I discussion can become part of routine discussion in all we do at all level
2. Work with the OD team to seek the views of staff about what the challenges really are (not just what we think they are)
3. Run a seminar on challenging our unconscious bias

Weston Division

Our progress in the first year

Three things we feel proud to have done and made progress on since May 2019

1. Developed a divisional Culture & People Plan with D&I as one of the key priorities and a number of actions and initiatives to drive D&I in the division

2. Launched the BAME & LGBT staff forums at Weston, enabling access for staff based here

3. Promotion of the Rainbow Badge scheme has begun, enabling staff to visibly display their commitment to D&I and their colleagues

Our D&I plan going forward

Three priorities we will deliver for the remainder of 2020/2021

1. Recruit a divisional D&I Lead and Diversity Champions – staff members who voluntarily lead on supporting the D&I agenda

2. Launch more staff forums on site at Weston, including Able+

3. Embed D&I objectives for all line managers as part of the appraisal process

Our D&I plan going forward

What are we doing differently or going to do differently as a leadership team?

1. Put aside dedicated space and time to receive opinions, feedback and suggestions from all staff groups, directly as an SMT – 'The Voice' forum launches November 2020

2. Ensure we role model in the foundations of D&I – complete our own cultural awareness e-learning, ensure our direct reports do the same.

3. Reach out to traditionally underrepresented employee groups - invite Staff Stories regularly at Divisional Board.

Women's and Children's Division

Our progress in the first year

Three things we feel proud to have done and made progress on since May 2019

1. Held 'See It My Way' listening event for all staff to hear lived experiences from staff working with a difference/protected characteristic

2. Terms of reference written for divisional Staff Forum and D&I Advocate role, both launching 5 Nov 2020

3. Somali Outreach worker recruited and embedded within the diabetes service, with other specialties keen to introduce similar roles to improve access, outcomes and patient/family experience

Our D&I plan going forward

Three priorities we will deliver for the remainder of 2020/2021

1. Midwifery: the next team to implement the continuity of carer pathway will target BAME community to improve outcomes in line with COVID response for maternity

2. Embed divisional Staff Forum and structure around D&I Advocates

3. Challenge our recruitment processes and advertising to target BAME applicants for nursing & midwifery roles, working collaboratively with our community & education providers

Our D&I plan going forward

What are we doing differently or going to do differently as a leadership team?

1. Continue to hold meetings in a virtual format wherever possible, in order to improve access for staff unable to attend on site

2. Apply learning from unconscious bias training pilot for senior nurses to enhance staff experience

3. Champion the D&I Advocates and the role they play in improving equality, diversity and inclusion

4. Equality impact assessment to be introduced into capital bids

University Hospitals Bristol and Weston NHS Foundation Trust

Workforce Race Equality Standard (WRES)

The WRES programme requires organisations employing the 1.3 million-strong NHS workforce to report against nine indicators of race equality; and supports continuous improvement through robust action planning to tackle the root causes of discrimination particularly in relation to Black, Asian and Minority Ethnic (BAME) staff.

The first full UHBW WRES data across all nine indicators of race equality as at 31 March 2021, will be collated and submitted to the national WRES team in July/August 2021.

The following slides set-out the Trust WRES 2020 data for University Hospitals Bristol (UHB) and University Hospitals Bristol and Weston (UHBW) 2020 staff survey.

The slides also set-out the Trust's WRES strategic forward plan 2021/22.

Merged Trust complexity on the WRES 2020 data

The Workforce Race Equality Standard (WRES) programme requires organisations employing the 1.3 million-strong NHS workforce to report against nine indicators of race equality; and supports continuous improvement through robust action planning to tackle the root causes of discrimination particularly in relation to Black and Minority Ethnic (BEM) staff.

Merged Trust complexity on the WRES data

The complexity of WRES data prior to the Trust merger makes benchmarking difficult.

- The WRES data is a snapshot taken on 31 March of each year
- The WRES indicators (1 to 4 and 9) represent data from University Hospitals Bristol (UHB) in 2020
- WRES indicators (5 to 8) represent data from the 2020 University Hospitals Bristol and Weston (UHBW) staff survey.
- The first full UHBW WRES data across all nine indicators of race equality as at 31 March 2021, will be collated and submitted to the national WRES team in July/August 2021
- A Trust report and action plan on the 2021 WRES data will follow in Q3 of 2021

KEY FINDINGS from the WRES data 2020

UHB (excluding Weston)

WRES indicator 1

% of staff in each of the Agenda for Change (AfC) Bands 1–9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce

Non-Clinical Staff

	White	BME	Unknown
Band 1	48.2%	45.9%	5.9%
Band 2	83.1%	11.1%	5.7%
Band 3	87.0%	9.9%	3.1%
Band 4	92.8%	5.6%	1.6%
Band 5	91.6%	7.2%	1.2%
Band 6	91.9%	6.8%	1.4%
Band 7	93.1%	4.6%	2.3%
Band 8A	96.0%	4.0%	0.0%
Band 8B	94.0%	4.0%	2.0%
Band 8C	95.7%	4.3%	0.0%
Band 8D	100.0%	0.0%	0.0%
Band 9	100.0%	0.0%	0.0%
VSM	100.0%	0.0%	0.0%

Clinical Staff - Non-Medical

	White	BME	Unknown
Band 1	65.0%	32.4%	2.6%
Band 2	80.1%	18.5%	1.4%
Band 3	85.8%	12.9%	1.3%
Band 4	92.9%	6.7%	0.4%
Band 5	79.6%	18.8%	1.6%
Band 6	89.1%	10.1%	0.8%
Band 7	94.5%	5.0%	0.5%
Band 8A	92.6%	6.5%	0.9%
Band 8B	96.6%	3.4%	0.0%
Band 8C	95.2%	2.4%	2.4%
Band 8D	85.7%	0.0%	14.3%
Band 9	100.0%	0.0%	0.0%
VSM	100.0%	0.0%	0.0%

Clinical Staff – Medical & Dental

	White	BME	Unknown
Consultants (including Senior Medical Staff)	80.0%	14.9%	5.0%
Non-consultant career grades	66.4%	26.7%	6.9%
Trainee grades	75.1%	16.1%	8.8%
Other	56.5%	8.7%	34.8%

KEY FINDINGS from the WRES data 2020

WRES indicator 2 (2020 UHB) **Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants**	**White staff are 1.48 times more likely to be appointed from shortlisting than BME staff.**
WRES indicator 3 (2020 UHB) **Relative likelihood of BME staff entering the formal disciplinary process compared to white staff**	**Relative likelihood of BME staff entering the formal disciplinary process is 2.06 times greater than white staff.**
WRES indicator 4 (2020 UHB) **Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff**	**Relative likelihood of white staff accessing non-mandatory training is 0.95 times greater**

WRES indicator 5 (Staff Survey) **% Staff experiencing harassment bullying or abuse from patients relatives or members of the public in last 12 months**	**UHB** **2019 %**	**UHBW** **2020 %**	**+/-**
BME: Trust	26.7	24.8	1.9
BME: Acute average	29.9	28.0	1.9
White: Trust	24.5	22.9	1.6
White: Average	28.2	25.4	1.2

KEY FINDINGS from the WRES data 2020

WRES indicator 6 (Staff Survey) % Staff experiencing harassment bullying or abuse from staff in the last 12 months	UHB 2019 %	UHBW 2020 %	+/-
BME: Trust	25.2	27.9	2.7
BME: Acute average	28.8	29.1	0.3
White: Trust	22.7	21.7	1.0
White: Average	25.8	24.4	1.4

WRES indicator 7 (Staff Survey) % Staff believing the organisation provides equal opportunity for career progression/promotion	UHB 2019 %	UHBW 2020 %	+/-
BME: Trust	68.9	71.4	2.5
BME: Acute average	74.4	72.5	1.9
White: Trust	89.7	88.6	1.1
White: Average	86.7	87.7	1.0

KEY FINDINGS from the WRES data 2020

WRES indicator 8 (Staff Survey) % Staff experienced discrimination from manager/team leader or other colleagues in last 12 months	UHB 2019 %	UHBW 2020 %	+/-
BME: Trust	14.9	18.3	3.4
BME: Acute average	13.8	16.8	3.0
White: Trust	5.2	5.5	0.3
White: Average	6.0	6.1	0.1

WRES indicator 9 (UHBW 2020) % difference between the organisation's board voting membership and its overall workforce	• 100 % of Voting Board Members are White • 0% of Voting Board Members are BME • 0% of Voting Board Members are of unknown/not stated ethnicity • 15.54% of the overall workforce are BME • Percentage difference between Voting Board Membership & overall workforce is –15.54% • Exec Board membership = 100% White

Trust WRES Strategic Forward Plan

The Trust is developing its strategic action plan to address some of the key WRES findings locally, regionally and nationally. This includes:

Overhaul of recruitment and promotion

At a Trust and system level, we are currently developing our response to the six high impact actions identified by the national EDI team as set out in the People Plan.

A regional action plan has a been developed (see appendix 1) and submitted to NHSE/I with individual organisations taking the lead on intervention to:

1. Address unfair treatment experienced by staff from diverse background who may be disadvantaged in recruitment and promotion practices,

2. Embed accountability and make workforce diversity an organisational priority by tackling institutional racism and reducing bias, and

3. Increase diversity of talent pools, particularly those from diverse ethnic backgrounds.

Trust Dataset Working Group

The Trust has set-up a dataset working group with membership comprising divisional EDI leads, HR business partners, HR information services, employment services and Trust EDI lead. The purpose of the working group is to undertake a detailed analysis of current data held by the Trust across a range of activities and functions with a view of developing a robust framework of current available data and future data requirements to deliver on the Trust D&I strategy and recruitment action plan.

WRES Model Employer Goals and Race Disparity Ratios

The Trust is committed to adopting the WRES Model Employer and develop its 5-year action plan. The Race Disparity Ratio is the difference in proportion of BAME staff at various AfC bands in a Trust compared to proportion of White staff at those bands. It is presented at three tiers:

1. bands 5 and below (‘lower’)
2. bands 6 and 7 (‘middle’)
3. bands 8a and above (‘upper’)

The Trust’s baseline target for their representation in bands 6 and above is the proportion who are in the workforce. At present BAME staff comprise 15.1% of the total workforce. The Trust projected race disparity ratios will be submitted to the national WRES team by 30 June 2021

Trust WRES Strategic Forward Plan

The Trust is developing its action plan to address some of the key findings locally, regionally and nationally from the WRES data. This includes:

Medical Workforce Race Equality Standard (MWRES)

The Trust has committed itself to an early adoption of MWRES. This is in recognition that 41 percent of the doctors in the NHS come from a BAME background. One of the key priorities for the national WRES team has been to develop a set of indicators that would enable ethnic variations in the experience of the medical workforce to be assessed. A bespoke set of WRES indicators have been developed for the NHS medical workforce. There are eleven indicators for the medical workforce. Four of the indicators reflect variation in career progression and pay, six represent medical staff perceptions of how they are treated by colleagues, employing organisations and patients, and one highlights the diversity of the councils and boards of medical institutions.

Systems support for BAME staff networks

In addition to the Trust developing a robust framework to make staff networks sustainable with greater reach and impact, the Trust is part of a systems approach to supporting BAME staff networks. The first meeting took place on 22 June with BAME staff network chairs and allies coming together to agree a framework of working on WRES and overhaul of recruitment and retention processes across Bristol, North Somerset And South Gloucestershire (BNSSG). Good practice and shared learning will feedback into the Trust's WRES priority areas.

Retaining our People – BNSSG Race Equality Talent Development Programme

A BAME talent development programme is in the process of going live that will support both the 6 key actions and help reduce the race disparity gap ratios. Through partnership working across our system and with regional and national teams, the goal of the programme is to:

- Increase engagement and retention of BAME colleagues across the BNSSG system, both clinical and non-clinical
- Increase the opportunity for BAME colleagues to achieve their potential within our organisations and wider system
- Build links with mainstream talent management colleagues and programmes to embed the race equality programme and equality, diversity and inclusion perspectives
- Increase the diversity of our Talent pipelines health & care professions; increasing leadership and management capability, representation and innovation

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Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) programme requires organisations employing the 1.3 million-strong NHS workforce to report against ten matrix indicators of disability equality; and supports continuous improvement through robust action planning to tackle the root causes of discrimination in relation to disabled staff.

The first full UHBW WDES data across all ten indicators of disability equality as at 31 March 2021, will be collated and submitted to the national WDES team in August 2021.

The following slides set-out the Trust WDES 2020 data for University Hospitals Bristol (UHB) and University Hospitals Bristol and Weston (UHBW) 2020 staff survey.

The slides also set-out the Trust's WDES strategic forward plan 2021/22.

Merged Trust complexity on the WDES data 2020

The Workforce Disability Equality Standard (WDES) programme requires organisations employing the 1.3 million-strong NHS workforce to report against **ten matrix indicators of disability equality;** and supports continuous improvement through robust action planning to tackle the root causes of discrimination in relation to disabled staff.

Merged Trust complexity on the WDES data

The complexity of WDES data prior to the Trust merger makes benchmarking difficult.

- The WDES data is a snapshot taken on 31 March of each year
- The WDES matrix indicators (1 to 3 and 9b to 10) represent data from University Hospitals Bristol (UHB) in 2020
- WDES matrix indicators (4 to 9b) represent data from the 2020 University Hospitals Bristol and Weston (UHBW) staff survey.
- The first full UHBW WDES data across all ten indicators of disability as at 31 March 2021, will be collated and submitted to the national WRES team in July/August 2021.

KEY FINDINGS from the WDES data 2020

WRES indicator 1 - UHB (excluding Weston)

% of staff in each of the Agenda for Change (AfC) Bands 1–9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce

Matrix 1a - Non-Clinical Staff (UHB 2020)						
	Disability		No Disability		Not Stated	
	No	%	No	%	No	%
Band 1	6	2.6	217	92.7	11	4.7
Band 2	22	3.1	558	78.9	127	18.0
Band 3	29	4.5	564	87.2	54	8.3
Band 4	19	3.7	465	90.1	32	6.2
Band 5	16	5.5	248	85.8	25	8.7
Band 6	7	4.0	156	89.7	11	6.3
Band 7	7	4.2	153	92.2	6	3.6
Band 8a	2	2.3	80	90.9	6	6.8
Band 8b	0	0.0	57	87.7	8	12.3
Band 8c	1	3.1	29	90.6	2	6.3
Band 8d	0	0.0	11	84.6	2	15.4
Band 9	0	0.0	13	86.7	2	13.3
VSM	0	0.0	9	90.0	1	10.0
Other	0	0.0	1	14.3	6	85.7

KEY FINDINGS from the WDES data 2020

Matrix 1b - Clinical Staff						
	Disability		No Disability		Not Stated	
	No	%	No	%	No	%
Band 1	3	1.6	173	92.5	11	5.8
Band 2	36	2.6	1203	88.7	117	8.6
Band 3	15	3.3	395	87.2	43	9.4
Band 4	7	2.6	240	89.8	20	7.4
Band 5	41	1.9	1937	92.7	110	5.2
Band 6	36	2.4	1332	91.9	80	5.5
Band 7	25	2.4	922	90.9	67	6.6
Band 8a	3	1.1	249	93.2	15	5.6
Band 8b	0	0.0	71	97.2	2	2.7
Band 8c	1	2.9	31	91.1	2	5.8
Band 8d	0	0.0	10	83.3	2	16.6
Band 9	0	0.0	3	100	0	0.0
VSM	0	0.0	2	100	0	0.0
Medical & Dental Staff, Consultants	7	1.1	532	85.39	84	13.4
Medical & Dental Staff, Non-Consultants career grade	3	1.0	262	87.63	34	11.3
Medical & Dental Staff, Medical and dental trainee grades	10	1.4	614	87.22	80	11.3
Other	2	6.2	21	65.63	9	28.1

KEY FINDINGS from the WDES data 2020

Metric 2

Metric 2 reports the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

The 2020 data shows that non-disabled staff were 1.57 times more likely to be appointed from shortlisting compared to disabled staff.

Metric 3

Metric 3 reports the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. This is based on a two-year rolling average from this year and the previous year.

Disabled staff are 3.22 times more likely than non-disabled staff to enter the formal capability process.

Metrics 4, 5, 6, 7, 8 and 9a - These metrics are part of the NHS Staff Survey UHBW 2020.

There are six questions in the Staff Survey that measure the Workforce Disability Equality Standard (WDES); out of the six questions there are two positive responses compared to last year. We compare more favourably to the average of Acute Trusts in 5 out of 6 questions.

LTC = Long Term Condition

KEY FINDINGS from the WDES data 2020

Metric 4 (Staff Survey) % Staff experiencing harassment bullying or abuse from patients relatives or members of the public in last 12 months	UHB 2019 %	UHBW 2020 %	+/-
LTC: Trust	27.7	28.0	**0.3**
LTC: Acute average	33.9	30.9	**3.0**
Without LTC: Trust	24.1	22.0	**2.1**
Without LTC: Average	27.3	24.5	**2.8**

Metric 5 (Staff Survey) % Staff experiencing harassment bullying or abuse from manager in the last 12 months	UHB 2019 %	UHBW 2020 %	+/-
LTC: Trust	17.4	17.4	
LTC: Acute average	19.7	19.3	**0.4**
Without LTC: Trust	9.0	9.1	**0.1**
Without LTC: Average	11.0	10.8	**0.2**

KEY FINDINGS from the WDES data 2020

Metric 6 (Staff Survey) % Staff experiencing harassment bullying or abuse from other colleagues in the last 12 months	UHB 2019 %	UHBW 2020 %	+/-
LTC : Trust	24.5	25.4	0.9
LTC: Acute average	28.1	26.9	1.2
Without LTC : Trust	16.7	16.0	0.7
Without LTC : Average	18.4	17.8	0.6

Metric 7 (Staff Survey) % Staff Experiencing Harassment bullying or abuse at work they or a colleague reported it	UHB 2019 %	UHBW 2020 %	+/-
LTC: Trust	51.0	50.4	0.4
LTC: Acute average	46.7	47.0	0.7
Without LTC: Trust	45.4	48.0	2.6
Without LTC: Average	45.6	45.8	0.2

KEY FINDINGS from the WDES data 2020

Metric 8 (Staff Survey) % Staff believe organisation provides equal opportunity for career progression or promotion	UHB 2019 %	UHBW 2020 %	+/-
LTC: Trust	84.1	80.7	**3.4**
LTC: Acute average	79.1	79.6	**0.5**
Without LTC: Trust	88.0	87.8	**0.2**
Without LTC: Average	85.6	86.3	**0.7**

Metric 9a (Staff Survey) % Staff felt pressure from manager to come to work despite not feeling well enough	UHB 2019 %	UHBW 2020 %	+/-
LTC: Trust	25.4	26.7	**1.3**
LTC: Acute average	32.7	33.0	**0.3**
Without LTC: Trust	17.5	20.5	**3.0**
Without LTC: Average	24.4	23.4	**1.0**

KEY FINDINGS from the WDES data 2020

Metric 9b

Metric 9b reports action taken to facilitate the voices of disabled staff at the Trust to be heard. At UHBW, a staff network called ABLE + has been actively involved in facilitating the voices and rights of disabled staff. In addition, UHBW has also launched a "reasonable adjustable support service' to help disabled staff access the support they need enabling them to work to the best of their ability. UHBW also has a robust Health and Wellbeing service available to all staff.

Metric 10 reports the percentage difference between the Trust Board's voting membership and the Trust's overall workforce, disaggregated.

	Disabled	Non-disabled	Unknown
Number of staff in overall workforce	298	10558	969
Total Board members - % by Disability	4%	92%	4%
Voting Board Member - % by Disability	4%	92%	4%
Non Voting Board Member - % by Disability	0%	0%	0%
Executive Board Member - % by Disability	0%	100%	0%
Non Executive Board Member - % by Disability	10%	80%	10%
Overall workforce - % by Disability	3%	89%	8%
Difference (Total Board - Overall workforce)	2%	2%	-4%
Difference (Voting membership - Overall Workforce)	2%	2%	-4%
Difference (Executive membership - Overall Workforce)	-3%	11%	-8%

Trust WDES Strategic Forward Plan

At a Trust and system level, we are developing our action plan to address some of the key WDES findings locally, regionally and nationally. This includes:

Supporting the ABLE Plus Staff Network

The Trust is currently scoping and reviewing how best to support staff networks to become sustainable with greater reach and impact for all disabled staff and other staff across all protected characteristics .

Wheelchair challenge

Following the Wheelchair Challenge in May 2021, the ABLE Plus staff network will be working with Estates and Facilities and the comms team to raise awareness of the physical obstacles that wheelchair staff and patients have to navigate within the hospital/work environment.

Reasonable adjustments resource room

A resource room is being identified in the Trust library where staff and managers can view accessibility aids and IT software solutions that can be purchased to make reasonable adjustments for disabled to remain in employment.

Training for EDI Advocates on disability

EDI Advocates play a crucial role in helping change the culture of the Trust. To facilitate culture change, EDI Advocates will be trained on all aspects of physical and sensory disability so that they can be voice and allies of disabled staff.

Overhaul of recruitment and talent development

At a Trust and system level, we are currently developing our response to WDES on recruitment of local disabled people and talent management programme for disabled staff.

Equality monitoring data on ESR

The Trust working with the ABLE Plus staff network will be running an internal campaign to raise awareness of what a disability is and encouraging staff to record their disability on ESR.

Policies and practice

The Trust will review policies such as absence management and reasonable adjustments to identify any gaps and make improvements.

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Equality Delivery System (EDS2)

EDS2 provides a compressive evidence-based approach to equality, diversity and inclusion for staff and patients. The following slides set-out the Trust's EDS2 self-assessment (RAG grades to be agreed) on workforce goals three and four. The evidence drawn upon for the rating should be read in conjunction with the whole Trust EDI reporting and governance pathways.

The slides also set out evidence to support goals one and two (patient care), governance for which resides with the Patient Inclusion and Diversity Group

Equality Delivery System (EDS2)

EDS2 – a framework for NHS organisations.

EDS2 is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.EDS2 is an equality, human rights and health inequalities reporting framework for the NHS containing four goals and 18 related outcomes.

The four goals are:

1. Better health outcomes.
2. Improved patient access and experience.
3. A representative and supported workforce.
4. Inclusive leadership.

EDS2 – an integrated approach to equality, diversity and inclusion

The Trust has developed a robust 5-year diversity and inclusion strategy that integrates EDS2 reporting framework and other key performance indicators

Determining the RAG rating:

RAG rating is determined by evidence showing how the Trust is meeting the health needs of **'none, some, most or all'** of the protected groups, so that:

- Red – Underdeveloped (people from all protected groups fare poorly compared with people overall or evidence is not available)
- Amber – Developing (people from only some protected groups fare as well as people overall)
- Green – Achieving (people from most protected groups fare as well as people overall)
- Purple – Excelling (people from all protected groups fare as well as people overall)

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EDS2 Goals One and Two

The Trust's Patient Inclusion and Diversity Group (PIDG), in 2019, agreed an approach for the self-assessment and validation of the Trust's performance in EDS2 Goals 1 and 2; to sample a cross-section of services and/or themes and in doing so, engage with patients, carers and staff to ensure the assessment was in the round. Due to the Covid-19 pandemic, this approach has not yet been undertaken, however there are plans to revisit this as soon as we are able to. In addition, there are clear actions in relation to our work in equality, diversity and inclusion for patients, carers and communities as part of the Patient Experience and Voluntary Services Team work plan for 2021/22.

Goal 1: Better health outcomes

1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	**Race** The Haemglobinopathy Team worked with the Afro-caribbean community in 2021 to promote and run patient focus groups with patients and carers to inform the development of psychological services and the role of the Clinical Nurse Specialists for patients who have Sickle Cell and Thalassemia. The patient informed developments will include a greater emphasis on awareness raising and training for staff who support patients outside of the immediate Haemoglobinopathy Team so their needs are more widely understood and, the development of a community based peer support network to complement the existing health and well-being support provided by psychological services. **Learning Disability** Members of North Somerset People First, a voluntary sector self-advocacy charity working for and led by the voices of people with a learning disability in North Somerset, attend the Weston General Hospital Learning Disabilities Group bringing a service user voice to the work of that group. This work is on-going. **Age** The Youth Involvement Group work is on-going and has positively impacted on service development in the Trust in a number of ways including: • Working with the Emergency Department to develop a process to support young people's wellbeing and implementation of HEADSSS (a Psychosocial interview tool for adolescents) • Contributing to the development of young people's involvement in staff recruitment and the increased formal requirement on teams to involve young people • Involvement of Young Governors at Board and a young person as a Equality, Diversity and Inclusion Advocate

Goal 1: Better health outcomes

1.2 Individual people's health needs are assessed and met in appropriate and effective ways

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	**Disability** The Trust continues to develop its approach to meeting the requirements of the NHS Accessible Information Standard to ensure that individuals who have additional communication needs and consistently asked about them and ensuring this is appropriately recorded and flagged on the patient record. Progress to date has included a clear policy, training for staff and flags on the 'Medway' system. The Trust recognises there is further work to do to ensure full compliance with the standard and a workshop is planned with key stakeholders in early August 2021 to take this work forward.

Goal 1: Better health outcomes

1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	**Young People's transition to adult services** Over the past 5 years we have worked together with young people (YP) to improve how they transition to adult services. This includes: - An on-going process of service specific feedback gained by service teams either through online surveys or informal discussion at the end of clinic sessions - Transition support evenings/sessions held by clinical teams including meeting new clinical team, exploring new environments and meeting other transferring YP - Annual verification survey of sample patient group run by Transition Delivery Group - limited responses were received over the two years of running the survey so process was discontinued. - Young representatives attending Transition Delivery Group – original plan unsustainable due to YP commitments and frequent changes in meeting structure but likely to be revisited in next 6 months as part of Youth Voice programme. - Dedicated focus groups with transitioning and transitioned YP As part of our engagement with the Transition Programme run by NHSE, we discussed the challenges with the Youth Involvement Group who noted it may be hard to feel comfortable evaluating a process when you are not sure what it should look like. This resulted in a pre-Covid plan to increase patient and family understanding of transition and 'skill up' families to be taking a more active role in the process and have a better understanding of what should occur. We hope this work will restart shortly and are revisiting a wider remit focus group for young people, this time online to improve access, to explore their further thoughts on how we might achieve this.

Goal 1: Better health outcomes

1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	

Goal 1: Better health outcomes

1.5 Screening, vaccination and other health promotion services reach and benefit all local communities

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	**Race / Sexual Orientation** Unity Sexual Health is a partnership led by UHBW. As part of service design and delivery, health promotion activity is targeted at communities at risk of poor sexual health. This includes the BAME communities and the LGBTQ community. A recent examples of targeted health promotion work in 2021 included the promotion of PrEP through targeted social media campaigning which resulted in an increase in PrEP uptake amongst these communities.

Goal 2: Improved patient access and experience

2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	**Carers** Our Carers Strategy Steering Group works closely with members of the Carers Liaison Centre, a voluntary sector organisation providing support, information and advice to Carers of any age living in the Bristol and South Gloucestershire area and, a Carers Lay Representative Group, to ensure Carers are seen as partners in care within UHBW. This includes a review of our visiting arrangements during the pandemic and our joint Carers Charter with North Bristol NHS Trust. We are currently working with this organisation to recruit lay people with caring responsibilities to the trust Learning Disability Steering Group. This work is on-going. **Disability** The Trust has commissioned AccessAble, an organisation that produced accessible information guides for public spaces, to produce on-line guides for all our service locations and public spaces to enable patients and their carers to make informed decisions about accessing our hospitals. This work is due for completion in 2021. **Physical and Sensory Impairment** The Bristol Sight Loss Council is a group of local people who have sight loss or experience visual impairment and who work closely with the Trust to promote sight loss awareness. In partnership with the Trust they have produced a video based sight loss training resource for staff, contributed to the Trust non-clinical customer service training video and advised the Trust on the design and provision of consistent signage and product placement in relation to Covid-19 at hospital entrances and exits. This work is on-going

Goal 2: Improved patient access and experience

2.2 People are informed and supported to be as involved as they wish to be in decisions about their care

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	**Religion / Belief** During 2019 and 2020, our Chaplaincy team has given a particular focus to our relationship with the Sikh and Hindi community to explore what matters to them in terms of receiving care and the importance that community places on respect and dignity. **Trans community** Members of the Trans community and their representatives work with the trust to ensure that the needs of Trans people are met when in our care. This work commenced in 2019 and is ongoing. This includes an initiative to promote the use of personal pronouns which is being piloted in Endoscopy services.

Goal 2: Improved patient access and experience

2.3 People report positive experiences of the NHS

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	**Disability** UHBW is a member of the Bristol Deaf Health Partnership which provides a single forum that fosters dialogue; enabling us to work together to understand and improve the experience of Deaf, hard of hearing and deaf blind people across the health community in Bristol. As a result of this work we have been able to develop and promote the wider use of video based BSL interpreting. This work commenced in 2018 and is ongoing. **Age** In 2020, The Children's Disability team undertook their regular review of the hospital passport scheme, opening a short survey on experiences to over 600 existing passport users as well as to non-users via the hospital Facebook page. The response was predominantly positive but highlighted three key areas for development: • enhancing staff training around implementation of reasonable adjustments • administration challenges for families and staff around completing and updating the passport • further raising the profile of the scheme to reach families who may not yet be aware of it These themes will be addressed through the service work plan, working alongside our parent carer representatives to tackle these challenges. **Patient experience by protected characteristics** The Trust's Patient Experience Group (PEG) on an annual basis received reported of patient experience analysed by key protected characteristic groups. These allow the Trust to understand any variation in experience of care and take targeted engagement work where appropriate. An example of this was in relation to experience of care for the Sikh community which was poorer when compared to the population accessing services as whole. This results in specific engagement work with the Sikh community to ask 'What matters to you'.

Goal 2: Improved patient access and experience

2.4 People's complaints about services are handled respectfully and efficiently

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	The Trust's Patient Support and Complaints Team has produced a learning disability leaflet, as well as supplies of the leaflet in the five most commonly spoken languages in the local area to ensure that information on how to raise a concern, compliant or compliment is accessible.

Goal 3: A representative and supported workforce

3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• The Trust's Recruitment Policy follows the NHS Employment Standards. Advertised posts are recruited to through the NHS Jobs website or the TRAC online recruitment system. • The systems do not allow shortlisting managers to have access to an applicant's personal details, although applicants may request a guaranteed interview those with a disability who are seeking employment. • The Trust has been accredited to use the Disability Confident Symbol (which has replaced the Double Tick disability symbol accreditation) in its recruitment literature, and has signed up to the Mindful Employer charter. • As of 31 March 2021, Trust workforce with substantive employment contract comprised of 12,054 (77.1% Female; 22.9 % Male; 71.9% White British; 24.7% BAME and Other White; 3.4% Not stated) • The recruitment and selection processes are currently subject to a comprehensive corporate and divisional review • The Trust is developing an action plan on the NHSE/I recruitment and promotion six priority areas • The Trust has acknowledged through its reporting against the relevant WRES that there is under-representation of BAME staff at senior levels, as well as a greater likelihood of white staff staff being appointed from shortlisting than BME staff, and is developing more detailed actions to address these issues. • The Trust is developing a WRES action plan including the five year Race Disparity Ratio action plan. • The Trust has set-up an EDI dataset working group to develop a comprehensive staff dataset for all protected characteristics particularly to address disability and sexual orientation data gaps • Currently, there is no staff data available on gender reassignment, marriage and civil partnership

Goal 3: A representative and supported workforce

3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• Equal pay has been set nationally as part of 'Agenda for Change' • The Trust allocates posts to pay bands – staff are placed in one of nine pay bands on the basis of their knowledge, responsibility, skills and effort needed for the job • The Trust has published its annual Gender Pay Gap report and action plan for the past four years • The Gender Pay Gap report 2020 will be published by 5 October 2021 • The the first full UHBW NHS FT Gender Pay Gap report 2021 will be published by 31 March 2022.

Goal 3: A representative and supported workforce

3.3 Training and development opportunities are taken up and positively evaluated by all staff

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• The Trust is diligent in ensuring that all staff are provided with training, learning and development opportunities • Further evidence can be found in the staff survey 2020 and divisional heat maps

Goal 3: A representative and supported workforce

3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• The Trust is diligent in ensuring that when at work, staff are free from abuse, harassment, bullying and violence from any source • The Trust has a bullying and harassment policy in place • The trust has a dedicated bullying and harassment lead that sits in OD • Further evidence can be found in the staff survey 2020 and divisional heat maps

Goal 3: A representative and supported workforce

3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• The Trust is diligent in ensuring that flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives: • There is a flexible working policy in place with a number of different flexible working options. • Further evidence can be found in the staff survey 2020 and divisional heat maps

Goal 3: A representative and supported workforce

3.6 Staff report positive experiences of their membership of the workforce

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• The Trust is diligent in ensuring that staff report positive experiences of their membership of the workforce along with a good working environment • Further evidence can be found in the staff survey 2020 and divisional heat maps

Goal 4: Inclusive leadership

4.1 Governing body members and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• Trust board members, divisional board members and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations. • Regular reports to the people committee and board on EDI progress and assurance • Trust chair and interim chair regular attendees and contributors at the Bristol Strategic Race Equality Leaders Group meetings • Interim Trust chair sponsor in the development of women's and also family and carers staff networks

Goal 4: Inclusive leadership

4.2 Papers that come before the governing body and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• Trust execs monitor EDI risks on a quarterly basis as part of the Risk Management Group • EDI risk registered on Datix (285) as: (1) Risk of non-compliance with the public sector equality duty and equalities legislation resulting in reputational damage, inequity of experience for all staff and potential legal action (2) Risk that the Trust fails to ensure equity of experience for all staff • Regular reports to the people committee and board on EDI risk, compliance and assurance • Review of risk is a standing item at the 6-wekly EDI steering group meeting • Trust has a robust EDI risk governance and reporting pathways that feed directly to the board via the people committee that is chaired by a board non executive director (NED) • SW regional standardised single equality impact assessment template and guidance being developed • At this point in time, however, the Trust cannot fully assure itself because we do not have full staff dataset across all protected groups

Goal 4: Inclusive leadership

4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

Grade	Protected characteristics that fare well (TBC)	Evidence drawn upon for the rating
Amber (Developing)	**Age** **Disability** **Gender Reassignment** **Marriage/Civil Partnership** **Pregnancy and maternity** **Race** **Religion or Belief** **Sex** **Sexual orientation**	• There is reasonable evidence to suggest that Trust middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination • Trust has developed a cultural awareness training that has been well received with xxx having completed the training so far • Further evidence can be found in the staff survey 2020 and divisional heat maps

University Hospitals Bristol and Weston NHS Foundation Trust

Gender Pay Gap 2020

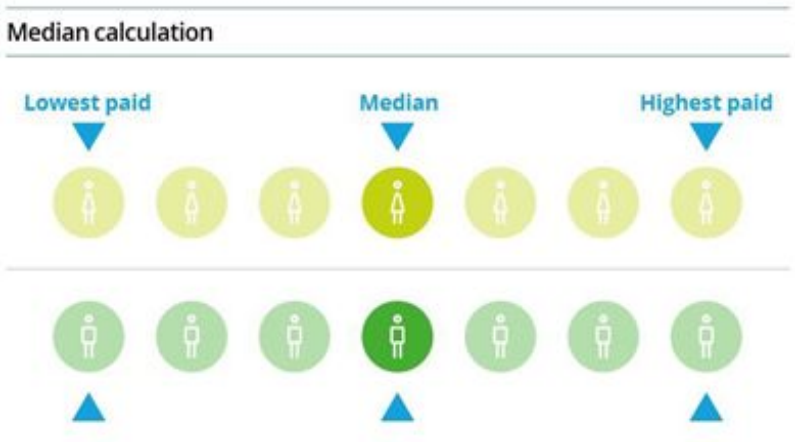
The following slides set-out gender pay gap 2020 figures for University Hospitals Bristol NHS Foundation Trust. The figures reported are on a 'snapshot date', which is 31st March 2020. The calculation methodology has been set out by the Government Equalities Office.

For 2021, the gender pay gap reporting will refer to University Hospitals Bristol and Weston NHS Foundation Trust.

Gender Pay Gap Update Report 2020

Since 2017, organisations with 250 or more employees are required to publish and report specific figures about their gender pay gap to show the pay gap between their male and female employees. The figures reported are on a 'snapshot date', which is 31st March each year for public sector organisations.

Distinguishing between median and mean



The median is the figure that falls in the middle of a range when the wages of all relevant employees are lined up from smallest to largest.

The median gender pay gap is calculated based on the difference between the middle employee in the range of male wages and the middle employee in the range of female wages.

The mean is calculated by adding up the wages of all relevant employees and dividing the figure by the number of employees.

The mean gender pay gap is calculated based on the difference between mean male pay and mean female pay.

Gender Pay Gap Update Report 2020

The gender pay gap report for 2020 has been generated using data collected from University Hospitals Bristol NHS Foundation Trust between 31 March 2019 and 1 April 2020.

This is due to the data collection methodology set by the Government Equalities Office, which requires data to be published by 30 March the following year.

Therefore, this report is the final gender pay gap report for University Hospitals Bristol NHS Foundation Trust.

2020 Gender Pay Gap findings

The continuing difference between men and women receiving bonus payments relates to historic national Clinical Excellence Awards. The outcomes from local awards demonstrate there is no ongoing bias towards male applicants but the continued payment of externally awarded bonus payments skews the figures.

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) was formed on 1 April 2020 following the merger of University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust. The first gender pay gap report for UHBW will be published by 30 March 2022.

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Risk, Compliance and Assurance

The following slides set-out a robust assurance and delivery plan that mitigates risk on compliance with our public sector equally duty across all protected characteristics and responding to findings from staff surveys, Equality Delivery System (EDS2), Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap.

Risk, Compliance and Assurance

The Equality Act 2010 makes it unlawful to discriminate against someone at work or wider society on the grounds of any of these nine characteristics: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion/belief, sex (gender) and sexual orientation. Other grounds include bullying and harassment or victimisation. In addition, public sector bodies, like NHS Trusts, also have a separate 'equality duty'.

Public Sector Equality Duty

The Trust, like all other public bodies, has a public sector equality duty which has three crucial aims to embed EDI in everything we do:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010

2. Advance equality of opportunity between people who share a protected characteristic and those who do not

3. Foster good relations between people who share a protected characteristic and those who do not

Risk, Compliance and Assurance

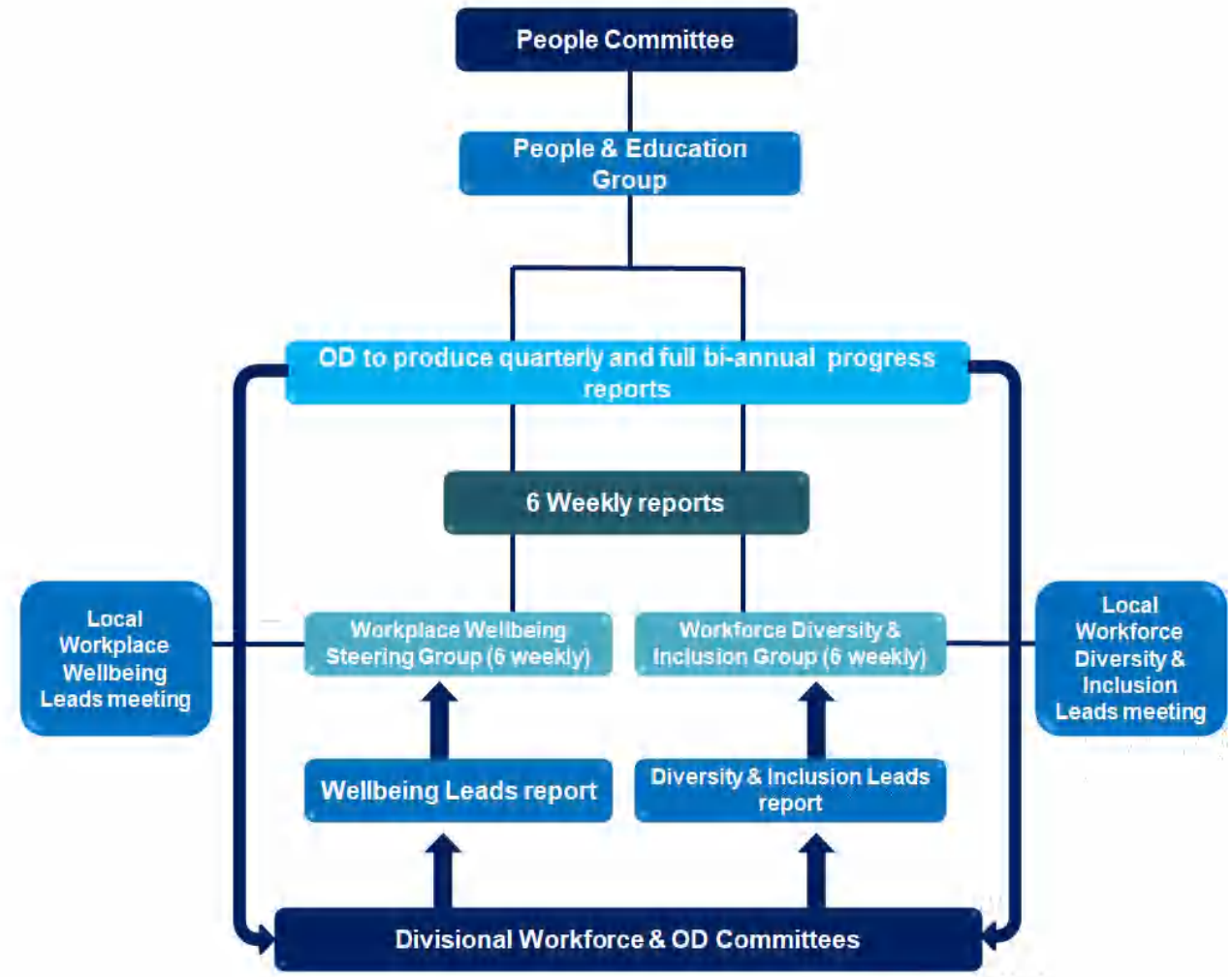
If our HR governance and recruitment processes are not more inclusive, accessible and wide-reaching, the Trust may fail to realise the benefits of the equality, diversity and inclusion strategy resulting in a negative impact on staff recruitment, poor staff retention and reputational damage for the Trust.

To mitigate risk on compliance, the Trust has developed a robust assurance and delivery plan to respond to our public sector equally duty across all protected characteristics including the findings from staff surveys, Equality Delivery System (EDS2), WRES, WDES and Gender Pay Gap. EDI risk is also registered on Datix as 285.

On Datix, Risk 285 is defined as:

‘Risk that the Trust fails to ensure equity of experience for all staff’

Workforce Equality, Diversity and Inclusion Governance Pathway



For risk assurance, Organisational Development has established a robust governance pathway for both workforce EDI and wellbeing.

Divisional and corporate EDI leads provide 6-weekly strategic updates on progress against the Trust 5-year D&I strategy to the EDI steering group, which is chaired by the head of OD.

In addition, operational EDI leads provide 6-weekly updates on local EDI activities and share best practice at the operation EDI group, which is chaired by the Trust EDI lead.

The People and Education Group provides challenge and/or support for assurance received by the People Committee, which feeds into the Trust Board and is chaired by a non executive director.

Mitigating compliance, inclusion and reputational risk

- Bullying and harassment
- Discrimination and victimisation
- Fair recruitment process at all levels
- Talent management
- Inclusive leadership at all levels
- Career development opportunities
- Valuing and celebrating staff diversity across all protected groups
- People policies and practices
- Health and wellbeing of all our staff

- Supported and representative workforce
- Developing partnerships at local, regional and national level
- Dignity and respect
- Being allowed to come to work as a whole person
- Career/personal development opportunities
- Values and leadership behaviours
- Embedding inclusion in everything we do
- UHBW – inclusive employer of choice

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Equality, Diversity and Inclusion Action Plan April 2021 to March 2022

The following slides set-out the strategic action plan for the next year. Progress and exceptions on the action plan will be monitored by the six-weekly EDI steering group with quarterly updates to the People Committee.

Equality, diversity and inclusion strategic objectives action plan 2021/22

Strategic Priorities: Leadership and Cultural Transformation.

KPIs	No	Objective	Who	When and How
Objective 1: As leaders we role model the Values and Leadership behaviours creating an environment that encourages feedback and where staff feel safe to challenge				
PSED EDS4.1 DPP6	1	In partnership with the national team launch the national reciprocal mentoring programme across divisions with recruitment of 20 mentor pairs across the Trust	EDI Manager Barnard Galton Sam Chapman	Launch at people committee in May; Commencement of programme by July 2021 The programme will continue for the duration of 2021/22
Objective 2: We are committed to inclusion in everything we do and this is evident in all our people policies and practices				
EA2010 PSED BSS1 BSS2&3	2	Develop leadership tools and support the development of the EDI advocates and divisional leads to have the knowledge, skills and abilities to embed EDI in everything we do.	EDI Manager Divisional EDI leads	EDI advocates in place by June 2021 with bitesize training videos and capacity-building EDI training throughout 2021/22
EDS3.1 DPP1	3	Ensure EDI is further embedded into our recruitment processes ensuring the diversity of our workforce increases year on year	EDI Manager Peter Russell	Year plan being developed to further improve recruitment practices which will include the creation of a EDI working group within Resourcing to take forward this agenda. Q1 focus on recruitment of overseas nurses and divisional recruitment processes.
Objective 3: We celebrate and value the contribution all of our staff make at all levels of the organisation				
EDS3.6 PSED	4	Develop an effective communication plan for sharing and promoting use of wellbeing resources and initiatives across the Trust that is embedded in to the UHBW cultural programme.	EDI manager Communications team Staff networks EDI leads	This has commenced with LGBT history month and will be ongoing throughout 2021/22.

Equality, diversity and inclusion strategic objectives action plan 2021/22

Strategic Priorities: Accountability and Assurance.

KPIs	No	Objective	Who	When and How
Objective 4: We will encourage shared learning by openly sharing our diversity data in a meaningful way.				
WRES WDES GPG DPP3 DPP4 DPP5 PSED EDS3.6	5	Develop a robust assurance and delivery plan to respond to our Public Sector Equalities Duties (PSED) across all protected characteristics.	EDI Manager HRIS team Workforce D&I Group	With effect from June, a business cycle will be in place to ensure effective reporting and alignment of all findings to inform integrated solutions. This will include but not be limited to; staff survey results, WRES, WDES, gender pay gap and staff network action plans
Objective 5: Our strategy is communicated at all levels reflecting our commitment to change.				
EA2010 PSED WRES WDES GPG	6	Ensure there is a robust reporting framework to communicate progress against the Trust's 5-year D&I strategy	EDI Manager Workforce D&I Group	With effect from May a bi-annual report will be in place to report on progress against the strategy and the business to ensure assurance and compliance (objective 5)

Equality, diversity and inclusion strategic objectives action plan 2021/22

Strategic Priorities: Positive Action and Practical Support.

KPIs	No	Objective	Who	When and How
Objective 6: Our Education Strategy focuses on inclusion and is a key enabler to delivering the vision supported by our Trust values.				
EA2010 PSED WRES WDES EDS2	7	Provide inclusive education that nurtures staff motivation and aspirational career development and values the individual and the teams that work together.	EDI Manager Senior Education Quality Manager Divisional EDI leads	Build on existing EDI dataset across all educational programmes for impact analysis and action including developing and supporting under-graduate medical students' EDI pathways at the Academy Continue to build on external partnerships including participate in the UWE-led project supporting students' EDI pathways in clinical practice placement.
Objective 7: Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible.				
EA2010 PSED WRES WDES EDS2	8	Ensure there are robust divisional plans in place to enable the effective delivery of the strategy at a local level and to ensure local solutions are embedded in response to the staff survey	EDI manager Divisional EDI leads Operational EDI leads Staff Network chairs HRBPs	With effect from June divisional EDI action plans in place EDI advocates support pack to launch in June 2021
Objective 8: Staff forums grow to become an increased staff voice who represent our workforce and the community we serve				
EA2010 PSED WRES WDES EDS2	9	Develop staff networks to have increased membership, greater reach and impact to support under-represented or disadvantaged staff across all protected characteristics.	EDI Manager Staff network chairs Jeff Farrar Matt Joint	Refreshed governance arrangements for staff networks and 12-month work plan to be in place by May 2021. This programme of work will be for the duration of 2021/22

Equality, diversity and inclusion strategic objectives action plan 2021/22

Strategic Priorities: Monitoring Progress and Benchmarking.

KPIs	No	Objective	Who	When and How
Objective 9: We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves.				
PSED EA2010 EDS2 WRES WDES	10	Ensure there is robust governance pathway across all divisions that reports into the corporate infrastructure and allows for a two way dialogue to monitor progress and share best practice	EDI Manager Divisional EDI leads Operational EDI leads	April onwards Relaunched EDI steering group with new terms of reference and six weekly reporting which will report into corporate governance for assurance Refreshed divisional EDI leads and operational leads reporting pathways which will report into corporate governance for assurance
Objective 10: We will seek opportunities to learn from others, developing our partnerships at a regional and national level.				
WRES WDES PSED EA2010 EDS2	11	The Trust to actively play a leading role in contributing and learning from EDI strategies, activities and policies in partnership locally, regionally and nationally for the benefit of our staff and patients.	EDI Manager	Membership at all regional and national forums ensuring best practice is adopted and shared. Learnings will be incorporated into the strategy plan as appropriate Partnership working has progressed with the development of a system wide EIA process commencing in July 2021

Equality, Diversity and Inclusion Key Performance Indicators (KPIs) Glossary

KPI	EQUALITY ACT 2010
EA2010	Protection against unlawful discrimination for the nine protected characteristics in the workplace
PSED	Public sector equality duty (the equality duty): • Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act. • Advance equality of opportunity between people who share a protected characteristic and those who do not • Foster good relations between people who share a protected characteristic and those who do not
KPI	**STAFF SURVEY**
BSS1	Not experience harassment, bullying, or abuse from patients/service users, their relatives or members of the public.
BSS2	Not experience harassment, bullying or abuse from mangers.
BSS3	Not experience harassment, bullying or abuse from other colleagues.
BSS4	Last experience of harassment/bullying/abuse reported
DSS1	Organisation acts fairly: career progression.
DSS2	Not experiences discrimination from patients/service users, their relatives or other members of the public.
DSS3	Not experiences discrimination from manger/team leader or other colleagues.
DSS4	Disability: organisation made adequate adjustment(s) to enable me to carry out work.
KPI	**GENDER PAY GAP**
GPG	Publish annual report with specific figures about gender pay gap, narrative and actions (if applicable)

Equality, Diversity and Inclusion Key Performance Indicators (KPIs) Glossary

KPI	PEOPLE PLAN
APP2	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.
DPP1	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.
DPP2	Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.
DPP3	Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce.
DPP4	51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes
DPP5	Support organisations to achieve the above goal, including establishing robust decision- tree checklists for managers, post-action audits on disciplinary decisions, and pre-formal action checks.
DPP6	Refresh the evidence base for action, to ensure senior leadership represents the diversity of the NHS, spanning all protected characteristics.
DPP7	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.
DPP8	Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.
DPP9	Prevent and tackle bullying, harassment and abuse against staff, and create a culture of civility and respect.
KPI	**WORKFORCE RACE EQUALITY STANDARD (WRES) INDICATORS**
WRES1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.
WRES2	Relative likelihood of staff being appointed from shortlisting across all posts.
WRES3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
WRES4	Relative likelihood of staff accessing non-mandatory training and CPD.
WRES5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

Equality, Diversity and Inclusion Key Performance Indicators (KPIs) Glossary

KPI	WORKFORCE RACE EQUALITY STANDARD (WRES) INDICATORS
WRES6	Percentage of staff saying they have experienced harassment, bullying or abuse from staff in the last 12 months
WRES7	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.
WRES8	Percentage of staff personally experiencing discrimination at work from their manager/team leader or another colleague in the last 12 months
WRES9	Percentage of difference between the organisations' Board voting membership and its overall workforce. (Note: Only voting members of the board should be included with considering this indicator.)
KPI	**WORKFORCE DISABILITY EQUALITY STANDARD (WDES) INDICATORS**
WDES1	Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.
WDES2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.
WDES3	Relative likelihood of Disabled staff compared to non-disables staff as entering the formal capability process, as measured by entry into the formal capability procedure.
WDES4	a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public; managers; other colleagues b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
WDES5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion
WDES6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
WDES7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

Equality, Diversity and Inclusion Key Performance Indicators (KPIs) Glossary

KPI	WORKFORCE DISABILITY EQUALITY STANDARD (WDES) INDICATORS
WDES8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
WDES9a	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation
WDES9b	Has your trust taken action to facilitate the voices of Disables staff in your organisation to be heard?
WDES10	Percentage difference between the organisations Board voting membership and its organisations overall workforce, disaggregated: • By voting membership of the board • By executive membership of the board
KPI	**EQUALITY DELIVERY SYSTEM 2 (EDS2)**
EDS2G3	**Goal 3: A representative and supported workforce**
EDS3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
EDS3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
EDS3.3	Training and development opportunities are taken up and positively evaluated by all staff
EDS3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source
EDS3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
EDS3.8	Staff report positive experiences of their membership of the workforce
EDS2G4	**Goal 4: Inclusive leadership**
EDS4.1	Governing body members and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
EDS4.2	Papers that come before the governing body and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
EDS4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**Staff Survey: Analysis report and emerging themes**
Report Author	**Samantha Chapman: Head of Organisational Development** **Oonagh McNeil: OD Manager**
Executive Lead	**Alex Nestor – Acting Director of People**

1. Report Summary

This paper sets out the analysis and comparator position of the Staff Survey 2020 results; in order to ensure OD priorities are evidenced based and responsive to the voice of the staff.

The paper sets out:

- Staff survey reporting 2020
- Response rates
- Staff Survey 2020 Highlights and priorities
- COVID 19 responses
- WRES/WDES Staff Survey Highlights
- Proposed Organisational Development priorities 2021/22

2. Key points to note
(Including decisions taken)

Trust Board are asked to:

- Note the report and support the further development of the OD priorities
- Receive an update against these priorities through the quarterly OD governance update

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

The risks associated with this report include:

793 Risk of continued absence due to work related stress
2694 Risk that the Trust's workforce is insufficiently motivated and engaged
285 Risk of non-compliance with the Public Sector Equality Duties and equalities legislation resulting in reputational damage and potential legal action
2646 Risk that the Trust has insufficient management and leadership capacity and capability

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.

People Committee	**26th March 2021**

Staff Survey: Analysis report and emerging themes

1.0 Introduction

Following the publication of the Staff Survey 2020 on March 11th 2021, this paper sets out the headlines from the results of the National Staff Survey 2020 including, the analysis and comparator position; in order to ensure OD priorities are evidenced based and responsive to the voice of the staff.

This paper sets out:

- Staff survey reporting 2020
- Response rates
- Staff Survey 2020 Highlights and priorities
- COVID 19 response
- WRES/WDES Staff Survey Highlights
- Organisational Development priorities 2020

2.0 Staff Survey reporting 2020

As a result of the merger the results are now representative of University Hospitals Bristol and Weston NHS Foundation Trust as a new organisation. Therefore; the staff survey results do not include a 5 year historical comparison of *organisational* data. This historical data is available at divisional level.

There are four key changes to the reporting information this year these are:

- There is no measure regarding personal development/appraisals as this theme was removed for 2020 and replaced by additional questions related to COVID-19
- Additional information and questions related to COVID-19 are included in the full report
- The free text for staff comments has been replaced by the following COVID-19 questions for 2020:
    - Thinking about your experience of working through the COVID-19 pandemic, what lessons should be learned from this time?
    - What worked well during COVID-19 and should be continued?
- Additional question in relation to the Freedom to Speak Up agenda

3.0 Response Rates

At the centre of increasing response rates is reassurance for staff and confidence in:

- Confidentiality of the survey
- Demonstration from the organisation both, corporately and locally that feedback in the survey has been listened to
- Providing time at work to complete the survey
- Quality of the data creates a picture of teams and services

One of the key enablers to the response rate is a comprehensive communication plan which was delivered across all mediums in partnership with the Trust communication team and included:

- All staff communications
- Direct communications with managers
- Articles in Newsbeat/Connect and Chief Executive Briefings and weekly introductions
- Branding of material
- A strong presence on social media

Table 1: Staff Survey response rate 2019 versus 2020

	Staff Survey 2019	**Staff Survey 2020**	**Variance year on year**
Staff survey response rate	55%	**53.5%**	-1.5%
Staff survey response count	5123	**6076**	+953
Acute Trust average response rate	47%	**45.4%**	-1.6%

Table 2: Staff Survey response rates and respondents 3 year comparator

Staff Survey Response rates 2018	**Staff Survey Response rates 2019**	**Staff Survey Response rates 2020**	**Staff Survey Number of Respondents 2018**	**Staff Survey Number of Respondents 2019**	**Staff Survey Number of Respondents 2020**
UHB	**UHB**	UHBW	**UHB**	**UHB**	UHBW
52.5%	55.2%		4813	5123	
Weston	**Weston**	53.5%	**Weston**	**Weston**	6076
36.9	41.3		627	700	

The Staff Survey 2020 response rate was 53.5%; 1.5% less than in 2019. The Trust remains ahead of the median response rate for Acute Trust which is 45%.

Although the impact of the COVID pandemic and our merger in 2020 may have affected the overall response rate, our ambition has been to significantly increase response rates has not been lost as the Trust has a higher number of respondents for 2020.

4.0 Staff Survey 2020 Highlights and Priorities

4.1 Ranking scoring results

The ranking scores below are provided by the Trusts external provider and represent a summary of our Acute ranking in the context of other Acute Trusts under contract with Picker.

Top five ranking Scores:

- 83% - If a friend or relative needed treatment staff would be happy with the standard of care provided by the organisation
- 82% - Diasability: the organisation made adequate adjustments to enable me to carry out my work
- 72% - Would recommended the organisation as a place to work
- 57% - In the last 3 months have not come to work when not feeling well enough to perform my duties
- 84% - Feel safe at work

Bottom five ranking scores:

- 52% - Team members often meet to discuss team effectiveness
- 46% - Are able to meet conflicting demands on my time at work
- 53% - Staff are satisfied with opportunities for flexible working patterns
- 66% - Of staff who experience physical violence reported it
- 81% - Of staff know who senior managers are

Top five areas most improved from the 2019 Staff Survey:

- 35% - Organisation definitely takes positive action on health and wellbeing
- 57% - In the last 3 months have not come to work when not feeling well enough to perform my duties
- 40% - There are enough staff in the organisation to do my job properly
- 53% - Staff satisfied with opportunities for flexible working patterns
- 25% - I have realistic time pressures

Least improved areas from 2019 Survey:

- 52% - Team members often meet to discuss team effectiveness
- 60% - In the last 12 months have not felt unwell due to work related stress
- 35% - Senior managers try to involve staff in important decisions
- 35% - Senior managers act on feedback
- 70% - Immediate managers can be counted on to help with difficult tasks

The remainder of this report uses benchmarking against the Acute Trust comparator best and average; AUKUH comparator data is currently unavailable. The Trust works closely with the Staff Survey Coordination Centre and the National OD Network to establish leaders of best practice to ensure shared learning and development of robust plans.

Table 3: Staff Survey themed results

The comparator results across the themes demonstrate the Trust is above the average or the same as the average for Acute Trust providers for eight out of the ten themes. In order to further distil the data the largest gaps within each theme have been analysed against the Acute Trust comparator to support the development of OD priorities. These areas are:

- Staff engagement
- Morale
- Team working
- Immediate managers
- Wellbeing
- Bullying and harassment (a priority due to unacceptable levels not in relation to Acute results)

It should be noted that apart from Team working all the priorities are above average Acute Trust scores however furthest in terms of scores from the acute best score.

4.2 Staff Engagement

Staff engagement is a key indicator of the culture of the organisation determined through nine questions measuring three themes:

Advocacy	Involvement	Motivation
Would Recommend the organisation as a place to work	Able to make improvements in the work of my team /dept.	Often/look forward to going to work
If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation	Opportunities to show initiative frequently in my role	Often/always enthusiastic about my job
Care of patients/service users is the organisations top priority	Able to make improvements that happen in my area of work	Time often/always passes quickly when I am working

Table 4: Staff engagement score 3 year comparator

Staff Engagement Score 2018	Staff Engagement Score 2019	Staff Survey Engagement Score 2020
UHB	**UHB**	UHBW
7.1	7.2	
Weston	**Weston**	7.1
6.7	6.7	

Table 5: Acute Trust staff engagement score comparator

Staff Engagement Score 2020	
UHBW	**7.1**
Acute Trust: Best	**7.6**
Acute Trust Average	**7.0**

Table 6: Three year comparison Divisional engagement scores

Division	2018	2019	2020	Division	2018	2019	2020
Women's and Children's	7.4	7.5	7.4	Estates and Facilities	6.8	6.9	6.8
Surgery	7.0	7.0	7.1	Finance	7.1	7.5	7.3
Medicine	7.3	7.2	7.1	HR	7.3	7.4	7.0
Specialised Services	7.2	7.3	7.3	R&I	7.8	7.5	7.5
Trust Services	7.2	7.3	7.1	Trust HQ	7.5	7.8	7.7
Diagnostic &Therapies	7.0	7.3	7.0	Weston	6.7	6.7	6.7

All Divisional engagement scores are in a negative position or remain unchanged compared to 2019 apart from the Division of Surgery.

The Trust consistently performs well in response to the engagement advocate questions and remains above average compared to other Acute Trust. In the 2020 results both motivation and involvement question have reduced from previous years but to a greater extent in the former.

The focus for staff engagement is therefore the 'motivation' theme, given the greatest reduction is question 2b 'Often/always enthusiastic about my job' alongside creating an environment where staff recognise that the organisation has listened and acted on feedback. This engagement indicator was further highlighted in a recent CIPD publication stating that improved engagement is consolidated in embedding a feedback loop into business as usual supported by ongoing campaigns such as 'you said… we did'. This approach has been embraced at UHBW and in previous years we have had bi-annual events across the organisation and locally in divisions. This approach will be embedded into our recovery plans and the work we commence in partnership with Blue Goose, who will play back key messages as part of the culture work commencing in April.

4.3 Morale

There are nine questions in the morale indicator; only two out of the nine questions have positive results compared to last year. We compare more favourably or the same as the average of acute Trust in 8 out of 9 questions.

Table 7: Staff Survey morale indicators benchmark with Acute Trust comparator

I am involved with changes that affect my work area/team/department	2019 %	2020 %	+/-
Trust	53.6	51.3	2.3
Acute average	52.2	50.3	2.1
Acute best	62.1	57.3	4.8

I receive the respect I deserve from my colleagues at work	2019 %	2020 %	+/-
Trust	72.4	71.2	1.1
Acute average	71.4	70.4	1.0
Acute best	81.9	82.1	0.3

I have unrealistic time pressures	2019 %	2020 %	+/-
Trust	21.9	24.4	2.5
Acute average	21.9	24.4	2.5
Acute best	31.2	33.8	2.6

I have a choice in deciding how to do my work	2019 %	2020 %	+/-
Trust	55.7	53.6	2.1
Acute average	53.9	54.3	0.4
Acute best	60.9	62.6	1.3

Relationships at work are strained	2019 %	2020 %	+/-
Trust	52.0	49.4	0.6
Acute average	44.1	45.5	1.4
Acute best	57.4	55.5	1.9

My immediate manager encourages me at work	2019 %	2020 %	+/-
Trust	72.2	69.4	2.8
Acute average	69.9	69.2	0.7
Acute best	79.4	77.3	2.1

I often think about leaving this organisation	2019 %	2020 %	+/-
Trust	23.7	23	0.7
Acute average	28.3	26.7	1.6
Acute best	19.6	16.9	2.7
I will probably look for a job in a new organisation in the next 12 months	**2019 %**	**2020 %**	**+/-**
Trust	17.6	18.6	1.0
Acute average	19.9	18.7	1.2
Acute best	14.5	11.2	3.3

As soon as I can find another job I will leave this organisation	2019 %	2020 %	+/-
Trust	11.3	11.6	0.3
Acute average	14.3	13.2	1.1
Acute best	8.7	7.5	1.2

4.4 Team working

There are two questions in the team working indicator:

- The team has a shared set of objectives
- The team I work in often meets to discuss the team's effectiveness

Both questions are below the average for acute Trust with the team effectiveness receiving a more negative response.

Table 8: Question 4h benchmark with Acute Trust comparator

The team I work in has a shared set of objectives	2019 %	2020 %	+/-
Trust	73.3	71.4	1.9
Acute average	72.0	71.6	0.4
Acute best	83.4	81.2	2.2

Although across Acute Trust comparators there has been a negative response in staff survey 2020, the scores for our organisation are comparative and in a more positive position than the Acute best benchmark.

Table 9: Question 4i benchmark with Acute Trust comparator

The team often meets to discuss the teams effectiveness	2019 %	2020 %	+/-
Trust	58.2	52.6	5.6
Acute average	60.3	56.7	3.6
Acute best	68.6	67.2	1.4

Although across the Acute Trust comparator there has been a negative response the scores for UHBW is significant in the context of the overall position.

4.5 Immediate Managers

There are five questions in the immediate manager's indicator; we have had a negative response to all questions compared to last year. We compare more favourably or the same as the average of acute Trust in 4 out of 5 questions.

Table 10: Staff Survey immediate manager questions benchmark with Acute Trust comparator

The support I get from my immediate manager	2019 %	2020 %	+/-
Trust	71.8	69.1	2.7
Acute average	69.4	69.1	0.3
Acute best	79.5	77.6	1.9

My immediate manager gives me clear feedback on my work	2019 %	2020 %	+/-
Trust	61.9	59.4	2.5
Acute average	61.4	60.6	0.8
Acute best	69.9	70.3	0.4

My immediate manager ask for my opinion before making decisions that affect my work	2019 %	2020 %	+/-
Trust	57.4	54.7	2.7
Acute average	55.4	54.5	0.9
Acute best	62.4	63.6	1.2

My immediate manager takes a positive interest in my health and wellbeing	2019 %	2020 %	+/-
Trust	71.0	70.3	0.7
Acute average	68.1	69.2	1.1
Acute best	77.8	76.9	0.9

My immediate manager values my work	2019 %	2020 %	+/-
Trust	75.0	72.4	2.6
Acute average	72.3	71.8	0.5
Acute best	80.2	79.5	0.7

Consistently across this theme we have negative results both in comparison to the benchmark group and the benchmark acute trust comparator.

4.6 Wellbeing

There are five questions in the wellbeing indicator; three out of the five questions have positive results compared to last year. We compare more favourably or the same as the average of acute Trusts in 4 out of 5 questions.

Table 11: Staff Survey wellbeing questions benchmark with Acute Trust comparator

Opportunities for flexible working patterns	**2019 %**	**2020 %**	**+/-**
Trust	50.0	52.8	2.8
Acute average	52.6	55.5	2.9
Acute best	62.0	64.9	2.9

Organisation takes positive action on health and wellbeing	**2019 %**	**2020 %**	**+/-**
Trust	32.3	35.0	2.7
Acute average	28.2	31.7	3.5
Acute best	45.4	51.1	5.7

In 12 months have you experienced MSK as a result of work	**2019 %**	**2020 %**	**+/-**
Trust	25.0	25.2	0.2
Acute average	29.7	28.8	0.9
Acute best	21.5	18.7	2.8

In the last 12 months unwell due to work related stress	**2019 %**	**2020 %**	**+/-**
Trust	35.9	40.0	4.1
Acute average	39.8	44.1	4.3
Acute best	31.3	32.6	1.3

In the last 3 months come to work despite not feeling well	**2019 %**	**2020 %**	**+/-**
Trust	52.7	42.2	10.5
Acute average	56.8	46.6	10.2
Acute best	48.0	38.3	9.7

Workplace wellbeing has been the main focus of the past 12 months and this is reflected in the positive feedback in the staff survey. The growth of wellbeing contribution over the past five years has been consistent as is illustrated the table below. The progress of this theme compared to other acute Trust is significantly positive.

Table 12: Five year comparison and movement of wellbeing theme

Year	Trust	Acute best	Acute average
2015	6.0	6.8	6.0
2016	6.2	6.8	6.1
2017	6.1	6.6	6.0
2018	6.0	6.7	5.9
2019	6.1	6.7	5.9
2020	6.3	6.9	6.1

4.7 Safe environment: Bullying and Harassment

There are three questions in the Bullying and Harassment indicator; two out of the nine questions have positive results compared to last year. We compare more favourably on all three questions than the average of acute Trust.

Table 13: Bullying and Harassment questions benchmark with Acute Trust comparator

In the last 12 months how many times have you experienced harassment bullying or abuse at work from patients /service users their relatives or other member of the public	**2019 %**	**2020 %**	**+/-**
Trust	25.4	23.2	2.2
Acute average	28.7	26.0	2.7
Acute best	23.4	18.0	5.4
In the last 12 months how many times have you experienced harassment bullying or abuse at work from managers	**2019 %**	**2020 %**	**+/-**
Trust	10.5	10.6	0.1
Acute average	13.1	12.6	0.5
Acute best	6.4	6.2	0.2
In the last 12 months how many times have you experienced harassment bullying or abuse at work from other colleagues	**2019 %**	**2020 %**	**+/-**
Trust	18.1	17.7	0.4
Acute average	20.3	19.8	0.5
Acute best	12.9	12.2	0.7

Almost a quarter of the respondents to the staff survey feel unsafe at work due to bullying and harassment, which is unacceptable. In terms of actual head count this would be 1397 of those surveyed.

5 COVID-19 Responses

The ten staff survey themes were broken down into the COVID-19 classification as at table 17. Please be reminded that the Staff Survey was live for responses between 6th October 2020 and 27th November 2020, this period was at the start of the national second wave of COVID-19.

Table 14: COVID-19 comparison of themed results

	All staff	Worked on a COVID19 ward or area	Redeployed	Required to work remotely from home	Shielding for self	Shielding for household member
Equality Diversity & Inclusion	9.2	9.0	9.0	9.3	8.9	8.9
Health and Wellbeing	6.3	5.9	5.9	6.7	6.3	6.6
Immediate Managers	6.8	6.7	6.7	7.1	6.8	6.8
Morale	6.3	6.1	6.2	6.5	6.4	6.4
Quality of care	7.4	7.3	7.2	7.3	7.5	7.6
Safe environment : Bullying and harassment	8.3	7.8	7.7	8.6	8.4	8.1
Safe environment : Violence	9.5	9.0	9.8	9.4	9.4	9.4
Safety Culture	6.9	6.8	6.7	6.8	6.7	6.6
Staff Engagement	7.1	7.0	7.0	7.3	7.1	7.0
Team Working	6.4	6.2	6.2	6.6	6.3	6.2

The variation in responses is clear in each category and classification, those working from home tended to have a more positive overall experience whereas the feedback expectedly indicates less positive for those working within the COVID-19 environment or being redeployed.

The free text questions are being analysed by the national co-ordination centre and will be provided thematically by the end of April.

6 Workforce race equality standard / Workforce Disability equality standard (WRES/WDES)

6.1 Workforce Race Equality Standard (WRES)

There are four questions in the Staff Survey that measure the Workforce Race Equality Standard (WRES); out of the four questions there are two positive responses compared to last year. We compare more favourably to the average of Acute Trusts in 2 out of 4 questions.

Table 15: WRES benchmark with Acute Trust comparator

% Staff experiencing harassment bullying or abuse from patients relatives or members of the public in last 12 months	**2019 %**	**2020 %**	**+/-**
BME: Trust	26.7	24.8	1.9
BME: Acute average	29.9	28.0	1.9
White: Trust	24.5	22.9	1.6
White: Average	28.2	25.4	1.2
% Staff experiencing harassment bullying or abuse from staff in the last 12 months	**2019 %**	**2020 %**	**+/-**
BME: Trust	25.2	27.9	2.7
BME: Acute average	28.8	29.1	0.3
White: Trust	22.7	21.7	1.0
White: Average	25.8	24.4	1.4
% Staff believing the organisation provides equal opportunity for career progression/promotion	**2019 %**	**2020 %**	**+/-**
BME: Trust	68.9	71.4	2.5
BME: Acute average	74.4	72.5	1.9
White: Trust	89.7	88.6	1.1
White: Average	86.7	87.7	1.0
% Staff experienced discrimination from manager/team leader or other colleagues in last 12 months	**2019 %**	**2020 %**	**+/-**
BME: Trust	14.9	18.3	3.4
BME: Acute average	13.8	16.8	3.0
White: Trust	5.2	5.5	0.3
White: Average	6.0	6.1	0.1

6.2 Workforce Disability Equality Standard (WDES)

There are six questions in the Staff Survey that measure the Workforce Disability Equality Standard (WDES); out of the six questions there are two positive responses compared to last year. We compare more favourably to the average of Acute Trusts in 5 out of 6 questions.

Table 16: WDES benchmark with Acute Trust comparator

% Staff experiencing harassment bullying or abuse from patients relatives or members of the public in last 12 months	**2019 %**	**2020 %**	**+/-**
LTC: Trust	27.7	28.0	0.3
LTC: Acute average	33.9	30.9	3.0
Without LTC: Trust	24.1	22.0	2.1
Without LTC: Average	27.3	24.5	2.8
% Staff experiencing harassment bullying or abuse from manager in the last 12 months	**2019 %**	**2020 %**	**+/-**
LTC: Trust	17.4	17.4	0
LTC: Acute average	19.7	19.3	0.4
Without LTC: Trust	9.0	9.1	0.1
Without LTC: Average	11.0	10.8	0.2
% Staff experiencing harassment bullying or abuse from other colleagues in the last 12 months	**2019 %**	**2020 %**	**+/-**
LTC : Trust	24.5	25.4	0.9
LTC: Acute average	28.1	26.9	1.2
Without LTC : Trust	16.7	16.0	0.7
Without LTC : Average	18.4	17.8	0.6
% Staff Experiencing Harassment bullying or abuse at work they or a colleague reported it	**2019 %**	**2020 %**	**+/-**
LTC: Trust	51.0	50.4	0.4
LTC: Acute average	46.7	47.0	0.7
Without LTC: Trust	45.4	48.0	2.6
Without LTC: Average	45.6	45.8	0.2
% Staff believe organisation provides equal opportunity for career progression or promotion	**2019 %**	**2020 %**	**+/-**
LTC: Trust	84.1	80.7	3.4
LTC: Acute average	79.1	79.6	0.5
Without LTC: Trust	88.0	87.8	0.2
Without LTC: Average	85.6	86.3	0.7
% Staff felt pressure from manager to come to work despite not feeling well enough	**2019 %**	**2020 %**	**+/-**
LTC: Trust	25.4	26.7	1.3
LTC: Acute average	32.7	33.0	0.3
Without LTC: Trust	17.5	20.5	3.0
Without LTC: Average	24.4	23.4	1.0

The WRES and WDES indicator information will be used to inform both corporate and local plans within the Workforce Diversity and Inclusion strategy.

7 Organisational Development priorities for 2021/22

The staff survey results are the greatest form of feedback and the priorities emerging from this enable the shaping of future corporate cultural plans supported by Divisional plans to target hotspot areas. COVID-19 has brought the practice and possibility of immediate culture change into a reality and has demonstrated that a greater shift in behaviour is possible as opposed to the incremental/ transactional change the Trust has seen during the past 3-5 years in this space.

Central to staff engagement is motivation; the indicator which is most compromised in the Trusts overall score; and increased only by staff's ability to be able to make their own decisions and make changes. The challenge now is to use this 'live' opportunity to make a difference that could potentially have a greater impact on culture resulting in outcomes that are outside of what we may have considered possible.

The programmes of work for the coming year need to reflect the cultural shift in the organisation due to the changes we have all made during the pandemic which have included working more flexibly, working from home, rotation of staff and teams, workforce ward reviews, governance arrangements and how the organisation can sustain the flattening of the decision making hierarchy. The agility of the organisation to manage change and the recognition of the cultural impact on the organisation, team's, individuals and ultimately patients should be captured to deliver a more inclusive and compassionate organisation.

A key element to sustaining our staff engagement is to recognise when there is a need to pause and recover. At this unprecedented time staff are focusing on the need to 'get through' and the OD response has therefore been entirely focused on wellbeing and more specifically psychological wellbeing interventions. There is a need to start to shift the 'get through' perspective to create a sense of belonging and togetherness. Shifting the focus from psychological safety to belonging/inclusion will encourage staff to be reminded of their huge contribution at this time whilst creating a sense of community/we are all in this together. Work has commenced to create this shift within the communications messages as we enter into the four week communications plan which commenced on March 15th 2021 with the launch of the 2020 Staff Survey results.

This programme of events will take place to Pause Reflect and Rebuild:

- **Pause** – celebrating the efforts of our staff and saying 'thank you'
- **Reflect** – an opportunity for staff to share their experiences about the COVID-19 pandemic
- **Rebuild** – review of what has been learned from the reflection and feedback on the past 12 months to respond and develop plans in order to support the Trust team to rebuild ourselves and our future

At the end of this four week plan the cultural programme of work will commence supported by Blue Goose. The timing of this is positioned to support and recognise the King's Fund *'path to recovery'* research which predicts the post-anniversary position of staff who are effectively 'poised' for reconstruction. The research considers that this is the maximised moment for the organisation to set clear expectations and reconstruct a new beginning.

King's Fund: Path to Recovery: February 2021.

Integral to our cultural and people planning will be the development and setting of staff restoration plans. Staff wellbeing will be at the centre of our plans and be the main driver to improve staff experience, support positive morale and improve staff retention.

In order to deliver this cultural agenda we need compassionate and inclusive leaders who are people centred in their decision making, supported by an organisational framework that authentically places our staff at the centre of the organisation.

Our key areas of focus will therefore be:

- Leading the programme of work; in partnership with Blue Goose; to fully review our Values and leadership behaviours; further developing our cultural integration as a newly merged organisation

- Continue to deliver our robust and holistic plan for wellbeing which includes:

  - Embedding the positive behaviours framework launched last year to support staff who are being bullied in the organisation

  - Team interventions which provide staff with a safe space to check in and 'hold' the space

- Building on the OD interventions in place for team development and working in partnership with the Education team to build and shape the new leadership offer

- Delivery of our strategy plan for equality, diversity and inclusion- focusing on the cultural influencing priorities including reciprocal mentoring and a detailed plan for WRES/WDES

- Working in partnership with the business to develop robust culture and people plans in response to the staff survey and staff experience during the pandemic, with an emphasis on listening and responding, and developing conversation frameworks

which demonstrate evidenced based ‘you said… we did’, which have a foundation in creating the space where action is reality

8 Trust Board are asked to:

- Note the report and support the further development of the OD priorities
- Receive an update against these priorities through the quarterly OD governance update

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**NIHR CRN Annual Plan 2021/22 (hosted body report)**
Report Author	**Dr Kyla Thomas and Ifan Jones**
Executive Lead	**Dr William Oldfield, Medical Director**

1. Report Summary

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

The plan sets out how the CRN WE intends to meet and exceed the High Level Objective ambition levels and National Priorities as set out in the 21/22 Performance and Operating Framework (POF). The POF forms part of the contract between University Hospitals Bristol & Weston NHS Foundation Trust and the Secretary of State for Health and Social Care to host the CRN WE.

2. Key points to note

(Including decisions taken)

In general, the main challenge for CRN WE for 21/22 is to maintain performance against COVID vaccine and treatment trials whilst re-establishing the non-COVID portfolio of studies. The budget for CRN WE was increased by £794k in 21/22 to facilitate this. Another important focus is to expand research into new non-hospital environments and an additional £758k was also provided in 21/22 to support this.

The High Level Objectives include ambitions to:

- Ensure commercial studies are delivered efficiently and to target
- Ensure both commercial and non-commercial studies nationally defined as 'Managed Recovery' meet their recruitment targets within year
- Ensure NHS organisations within the region remain engaged in research
- Ensure feedback from research participants is collected and acted on

3. Risks

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

The risks associated with this report include:

Recognising the importance of clinical research in tackling the pandemic and generally, the DHSC increased the national budget by £30M. £1.55M of this was awarded to the CRN WE taking the local annual budget to £14.5M.
The national funding allocation has previously been based on performance against High Level Objectives and other local performance measures. This did not happen in 21/22 due to the disruption caused by the pandemic. There is a risk that poor performance could lead to a cut in the CRN WE budget in future years.

4. Advice and Recommendations

*(Support and Board/Committee decisions requested)***:**

- This report is for **Approval.**

5. History of the paper Please include details of where paper has previously been received.	
CRN WE Partnership Group	**04/06/2021**

University Hospitals Bristol and Weston NHS Foundation Trust

Clinical Research Network
CRN West of England

2021/22 Annual Plan

Date of Annual Plan submission: 28/05/2021

Host Organisation Approval

Confirmation that this Annual Plan has been reviewed and agreed by the LCRN Partnership Group:	Yes
Date of the LCRN Partnership Group meeting at which this Annual Plan was agreed:	04/06/2021
Confirmation that this Annual Plan has been formally approved by the LCRN Host Organisation Board:	No
Date of the LCRN Host Organisation Board meeting at which this Annual Plan was (or will be) approved:	TBC Q1/Q2

If this Annual Plan has not been approved by the LCRN Host Organisation Board at the time of submission to CRNCC, then the LCRN Host Organisation Nominated Executive Director should provide that confirmation by email to the CRNCC once the Board has approved the Plan, to crncc.performance@nihr.ac.uk

University Hospitals Bristol and Weston NHS Foundation Trust

Section 1. Contract Compliance

Section 1 of the template should be used to provide the LCRN's RAG status against the mandatory requirements of the Performance and Operating Framework

RAG Status

Colours in the RAG column are automated. Please select Green, Amber or Red from the drop-down menu in column D and the colour will update automatically.

Green	Fully compliant with all mandatory requirements within 2021/22
Amber	Compliant with some but not all mandatory requirements within 2021/22
Red	Not compliant with any of the mandatory requirements within 2021/22

Plan Ref	POF Section		RAG	Comments
1.1	C.2.	General Management	Green	
1.2	C.3.	Financial Management	Green	
1.3	C.4.	CRN Specialties	Green	
1.4	C.5.	Research Delivery	Green	
1.5	C.6.	Information and Knowledge	Green	
1.6	C.7.	Communications	Green	
1.7	C.8.	Patient and Public Involvement and Engagement (PPIE)	Green	
1.8	C.9.	Health and Care Services Engagement	Green	
1.9	C.10.	Workforce Learning and Organisational Development	Green	
1.10	C.11.	Business Development and Marketing	Green	

Section 2: High Level Objectives									
Plan Ref	**Objective**		**Measure**	**Ambition**	**LCRN Target**	**How target has been determined and supporting rationale**	**Title of Project**	**Expected outcome(s) as a numbered list**	**Link (optional)**
2.1	Efficient Study Delivery	Deliver NIHR CRN Portfolio studies to recruitment target within the planned recruitment period	(1) Proportion of new commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period, at confirmed CRN sites	80%	N/A	N/A	- RDMs monitor studies within their division ensuring data points are correct. Red/amber studies will be raised with local Clinical Research Speciality Leads, Partners Organisations R&D and local Site Research Teams during routine meetings. Where a relevant local Community of Practice exists, best practice will be sought from other sites performing the same / similar studies.	Achieve ambition	
			(2) Proportion of commercial contract studies in the managed recovery process achieving or surpassing their recruitment target during	80%	N/A	N/A	- New processes developed to coordinate local Managed Recovery studies / deliverability assessments. RDMs are leading on this work given their existing relationships with local CIs within their division. - Internal reporting will maintain oversight on this	Achieve ambition	

			their planned recruitment period				metric at OMG and EMG (both of which include Partner Organisation representation). Site-level performance monitoring will be led by 'locality link' RDMs in regular engagement meetings with Partner Organisations.		
			(3) Proportion of non-commercial studies in the managed recovery process achieving or surpassing their recruitment target during their planned recruitment period	70%	N/A	N/A	As above	Achieve ambition	
2.2	Provider Participation	Widen participation in research by enabling the involvement of a range of health and social care providers	(1) Proportion of NHS Trusts recruiting into NIHR CRN Portfolio studies	99%	N/A	N/A	Target met. No planned projects.	Achieve ambition	
			(2) Proportion of NHS Trusts recruiting into NIHR CRN Portfolio	70%	N/A	N/A	Expect to meet target. No planned projects.	Achieve ambition	

			commercial contract studies						
			(3) Proportion of General Medical Practices recruiting into NIHR CRN Portfolio studies	45%	N/A	N/A	- Expect to meet target. 20/21 performance was 60.5% due to strong performance with a number of ongoing covid studies. Expect some of this activity to continue into 21/22. - Plan to improve our engagement with non-RSI GPs by developing and expanding on our embedded roles within CCGs.	Achieve ambition	
2.3	Participant Experience	Demonstrate to people taking part in health and social care research studies that their contribution is valued	Number of NIHR CRN Portfolio study participants responding to the Participant Research Experience Survey, each year	12,000	TBC	TBC	- There has already been discussion with POs on how best to maintain the momentum of the 2020-21 PRES success. Further recommendations are in the PRES 2020-21 report. - Meetings have been set up to work with ALSPAC (large local birth cohort study) in order for them to share a unique digital link with their cohorts, this will be finalised in Q1 - More will be done to make completing the PRES online even easier, with better promotion of the survey link	Achieve ambition	

							within POs, and consultation with Royal United Hospital on how they made a success of this in 2020-2021 - Regular contact with study delivery teams will be maintained, and we will return to the Poppy the PRES Penguin motif, by which we gamifed the process, and ensuring a prize of some description to the team with the most PRES returned - We will also explore running the 'It's OK to Say No' survey this year and the children's PRES (which this year counts towards the overall PRES count)		

Section 3: CRN National Priorities			
Plan Ref	**Priority Activity**	**Description of any planned contributions (where known)**	**Link (optional)**
COVID-19 Research			
3.1	Deliver new and existing activities relevant to the research response to the COVID-19 pandemic a) COVID-19 Vaccine studies b) COVID-19 Non-Vaccine studies	a) Continue with Regional Vaccine Model into 21/22. Earlier phases of this was based on a hub (dosing) and spoke (follow up) and skills exchange (staff from spokes gaining experience by working in hubs). Building on that foundation the model has grown to all DGHs recruiting/dosing themselves. Model going forward can now flex dependent on needs of individual trials. Plan to promote this regional model to pharma including expanding to non-COVID vaccine studies. b) Since the start of the pandemic weekly Urgent Public Health meetings have been held with CD, CRN WE team, R&D Management and relevant Clinical Leadership (i.e. vaccine / infectious diseases / respiratory). Plan to continue in 21/22 as required to focus on local performance in COVID-19 studies.	
Recovery, Resilience and Growth of Clinical Research			
3.2	Deliver the CRN activities in the DHSC Recovery, Resilience and Growth Programme	New processes developed to coordinate local Managed Recovery studies / deliverability assessments. RDMs are leading on this work given their existing relationships with local CIs / POs. Team is ready to contribute to further workstreams around the DHSC Recovery, Resilience and Growth Programme as it emerges.	
NIHR CRN Strategic Improvement Priorities			
3.3	Primary Care Research Engagement	- Local plan being developed with Primary Care Clinical Research Specialty Lead and GP Champions to locally enact elements of the recently released Primary Care Research Strategy. - With the expansion of the Direct Delivery Team we plan to create 'locality link' roles where team members will build an enhanced relationship with sites/PCNs to grow mutual understanding. - Plan to improve our engagement with non-RSI GPs by developing and expanding on our embedded roles within CCGs.	
3.4	Review and Refresh Research	The plan for the Direct Delivery Team includes a mix of Research Nurses (6 WTE) and	

	Delivery (including Direct Delivery Team)	Clinical Research Practitioners (10.5 WTE), most of which are already currently in post. We also have plans for specific Public Health and Social Care roles to improve engagement and promote expansion within those areas.	

Section 4: LCRN Initiatives

Section 4 of the template should be used to detail local initiatives and projects to be delivered in 2021/22, that the LCRN would like the CRNCC and other LCRNs to be aware of. Please include local network projects and activities, projects to be delivered in collaboration with other LCRNs (as part of regional LCRN-Supra-network collaborative activities or other LCRN collaborations), and projects to be delivered nationally/CRN-wide led locally by the LCRN. Projects to be delivered in collaboration with other parts of the NIHR and/ or other external organisations should also be included.

In the case of Supra-network projects or collaborative projects with other LCRNs the project should be included in the Annual Plan of each participating LCRN.

Plan Ref	Supra-network	POF section(s)	Title of Project	Expected outcome(s) as a numbered list	Link (optional)
4.1	Yes	C.4. CRN Specialties	SSS Supra Project: Development of a SoECAT completion resource for Investigators	1. Publication of SoECAT completion help resource - led by WU (WoE) with support from Supra LCRNs 2. Engage with Digital Learning Designer to help develop resource	
4.2	Yes	C.4. CRN Specialties	SSS Supra Project: Meeting Population Needs of Supra-Region and Research in Non-Traditional Settings During Early Engagement	1. Awareness of high prevalence conditions in Supra-Region and signposting Investigators to those LCRNs during early engagement meetings to target population needs 2. Highlight to other Study Support Services in Supra-Region non-traditional site types within individual LCRNs that have research experience for local investigators to contact when needed. 3. Discuss and plan how to streamline accessing sites within the South West Supra-Region following roll-out of outcomes 1 and 2. 4. Recording that SSS have highlighted opportunities for underserved participants in LPMS (or regions specific EC&E records)	

4.3	Yes	C.4. CRN Specialties	SSS Supranetwork Project: Create a set of working instructions for investigators wanting to deliver research in Non-NHS sites	SWP CRN leading with contribution from other members of the supraregion	
4.4	Yes	C.6. Information and Knowledge	BI Supra Project: Demographics	This is a pilot project, the objective is to establish whether it is possible to collect postcode data, merge with other data sources and use this to identify areas of greatest need. The project will therefore be evaluated on completion based upon the achievement of this objective through the report, and also on user acceptance from the partner organisations involved. It is likely that any measure of improvements in patient care or study delivery would have to be identified through a separate research study.	
4.5	Yes	C.6. Information and Knowledge	BI Supra Project: Rollout of redesigned LPMS	Partner organisations will be asked to evaluate the communications, training and other support they have received during the EDGE version 3 rollout.	
4.6	Yes	C.4. CRN Specialties	Implementation of the Primary Care National Framework	When the framework becomes available, we will collaborate to implement the recommendations and share ideas and learning.	
4.7	Yes	C.4. CRN Specialties	Development of PCN hub and spoke model template	A template for setting up Hub and Spoke model working across a PCN will be developed including recommended funding agreements, data sharing agreements and workforce recommendations in collaboration with CCG colleagues led by West of England	
4.8	Yes	C.4. CRN Specialties	Collate learning from vaccine delivery in Primary Care settings	TVSM have successfully delivered a vaccine trial in a PC setting. They will collate their learning from this to provide a guide for delivering studies of this nature in this setting in the future.	
4.9	Yes	C.11. Business Development and	Supra Industry Project: Shared Investigator Platform	1. Coordinated promotion of SIP across the supra-region in order to share best practice	

		Marketing	(SIP)	and aid site implementation. 2. Increased number of organisation and investigators set up on SIP across both primary and secondary care.	
4.100	Yes	C.11. Business Development and Marketing	Supra Industry Project: Commercial Costings	1. Standardised iCT validation across the supra regional network 2. Shared best practice and troubleshooting document 3. Increased number of study resource reviewers 4. Quicker, more consistent iCT validation.	
4.11	Yes	C.11. Business Development and Marketing	Supra Industry Project: Supra-network common ways of working	1. Understand how each network is set up and how internal processes are carried out. 2. Monthly supra-network calls to share and discuss new innovations and initiatives. 3. Jointly assess the local delivery of national processes such as site identification, site intelligence and Study Milestone Schedule. 4. Sharing of best practice and local intelligence from sponsor relationship calls	
4.12	Yes	C.10. Workforce Learning and Organisational Development (WLOD)	Supra WFD: Supporting virtual training and facilitation	1. Work with supra-regional workstream leads to identify topics/areas that would benefit from a virtual or blended learning approach. 2. Scope, define and agree projects to develop 3. Deliver agreed projects to defined project brief and evaluate impact	
4.13	Yes	C.10. Workforce Learning and Organisational Development (WLOD)	Supra WFD: Developing a workforce recovery and resilience package	1. Design a supportive wellbeing package that will aid senior research nurses and R&D leads to support recovery within their local workforce 2. Work with Subject Matter Experts (SMEs) to ensure the package is fit for purpose and can be delivered by local teams with minimal input 3. Host the wellbeing package in NIHR Learn and signpost	

				to other curated resources. 4. Evaluate feedback and impact	
4.14	Yes	C.10. Workforce Learning and Organisational Development (WLOD)	Supra WFD: Supporting the development of a research delivery workforce across primary care, community and social care settings	1. Understand and map the key skills, experience and attributes required to deliver research in primary care, community and social care settings 2. Agree and develop a strategy to ensure the required skills, experience and attributes are developed and maintained as part of a sustainable workforce 3. Create and curate a series of learning and development resources to support delivery of the strategy 4. Evaluate feedback and impact	
4.15		C.4. CRN Specialties	Social Care	1.Develop and approve job description/s to enable advertisement of posts in collaboration with RiPfA. 2. Strategic engagement with Directors of adult and children's social services 3. Engage with the local Principal Social Workers to plan collaborative working 4. Identification of local provider networks attached to local authorities in order to meet and scope potential opportunities for collaborative working. 5. Scoping with local researchers to understand their work and reach into adult social care practice in the West of England 6. From initial conversations develop a plan of activities to support the relationships.	
4.16		C.8. Patient and Public Involvement and Engagement (PPIE)	PPIE	1. Create a working group with contacts in POs to discuss ideas and needs of local PPIE and how we can best position the LCRN in order to generate a full PPIE plan within Q1/Q2. 2. Work on development of Research Champion (RC) programme locally, with possible collaboration with CRN	

				SWP, who are in a similar position of restarting the RC initiative. 3. Restart PRES, and liaise with previous PO working group to ascertain appetite for running 'OK to Say No' survey. Create report for 20-21 PRES findings and share with local POs, study teams and PPIE contact in RDS. 4. Create report for Somali Community Link work, organise celebration event and continue to inform Somali colleagues about results of project collaboration eg. contact per quarter to share how POs are addressing EDI in research based on barriers to participation reports findings. 5.	

Annex 1 [Reference only]: High Level Objectives Calculation Notes	
Efficient Study Delivery	Ambition value is either 70% (the 2020/21 value). 'New' indicates opened on or after 1 April 2021 and closed to recruitment on or before 31 March 2022
Provider Participation (A)	Ambition value is 99% (the 2020/21 value)
Provider Participation (B)	Ambition value is either 70% (the 2020/21 value) or the annual out-turn for 2020/21, whichever is lower
Provider Participation (C)	Ambition value is either 45% (the 2020/21 value) or the annual out-turn for 2020/21, whichever is lower
Provider Participation (D)	Ambition value is either 2,250 or the annual out-turn for 2020/21, whichever is lower
Participant Experience	Ambition value is either 12,000 or the annual out-turn for 2020/21, whichever is lower
Urgent Public Health	Ambition value 9 working days. This HLO was introduced in 2020/21. The Ambition value was determined by experience setting up Urgent Public Health Studies in early 2020/21
Recovery, Resilience and Growth (A)	Ambition value is the annual out-turn for 2020/21 + 10%. This is a new HLO, similar to HLO1 as appeared in the 2019/20 Performance and Operating Framework, and excludes recruitment to Urgent Public Health (UPH) studies and non-UPH COVID-19 related studies on the NIHR CRN Portfolio
Recovery, Resilience and Growth (B)	Ambition value is the annual out-turn for 2020/21 + 10%. This is a new HLO, similar to HLO1 as appeared in the 2019/20 Performance and Operating Framework, and excludes recruitment to Urgent Public Health (UPH) studies and non-UPH COVID-19 related studies on the NIHR CRN Portfolio

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**NIHR CRN Annual Report 2020/21 (hosted body report)**
Report Author	**Dr Kyla Thomas and Ifan Jones**
Executive Lead	**Dr William Oldfield, Medical Director**

1. Report Summary

The Clinical Research Network West of England (CRN WE) is submitting the Annual Report 2020/21 for Host Trust Board approval.

The report highlights regional successes in delivering research in the extremely challenging circumstances during the pandemic. 74,537 participants were recruited in total across the region, 1,898 of these into COVID vaccine trials and 32,294 into other COVID studies and trials. The results of this research have benefited countless lives in the UK and across the world.

2. Key points to note
(Including decisions taken)

The report highlights:

- The success of the Regional Vaccine Research Model which combined the expertise of vaccine research experienced sites with the research delivery capacity across all CRN WE acute sites. This delivered vaccine research per million on a scale second only to the Oxford region (covered by CRN Thames Valley and South Midlands).
- Successes in delivering COVID treatment trials across primary care and secondary care environments across the region.
- Doubling participation in our participant in research experience survey (PRES).
- Other events and innovations to meet the challenges faced over the last year.

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

The risks associated with this report include:
The report reflects on performance in 20/21. The challenge will be maintaining these successes and building on them in 21/22.

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

- This report is for **Approval.**

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

CRN WE Executive management Group	**28/06/2021**

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Recommendation Definitions:

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

Section 1. The LCRN's contribution to three Category 1A or Category 1B Priority studies of your choice

Throughout 2020/21 the CRN WE contributed to the successful delivery of the Vaccine Task Force research programme. 1,898 participants were recruited, meeting local targets across six different Covid -19 vaccine trials. The CRN WE also led the phase I/II and III Valneva trial (CPMS 47465) which successfully achieved its UK target.

A regional delivery model was developed in order to provide equity of access to Covid-19 vaccine trials across the CRN WE population. This approach allowed participants from across the region to participate in vaccine research whilst also harnessing the research capacity from all acute trusts in the region to deliver on the large scale vaccine trials. The model was developed and managed via the weekly UPH meetings (further details below).

For COV002 (CPMS 45551), staff from the CRN WE Core Team and vaccine research naive District General Hospitals (DGHs) were brought together to support the recruitment of the 1,202 participants at the two acute trusts in Bristol. The upskilling of DGH research staff allowed the Janssen ENSEMBLE 2 (CPMS 46804) to be set up to recruit participants from across the region with dosing in Bristol and follow up at their nearest DGH. The model was fully realised in subsequent trials where all DGH sites, with sufficiently developed skills and experience, were able to dose and follow up their local participants.

Every acute Trust in the region was set up as a recruiting site for RECOVERY (CPMS 45388). The CRN WE supported all arms of this platform study including early support of Dimethyl Fumarate. The CRN WE regularly surpassed the 10% regional target despite local disparities in case numbers. In collaboration with our local Biomedical Research Centre (BRC), the CRN WE organised and supported a delivery workshop. Best practice was shared and implemented, allowing sites with smaller caseloads to adapt techniques to improve recruitment. This work is being shared as a case study through the national Continuous Improvement programme. In-year, the CRN WE recruited 1,213 participants into this crucial platform study.

The opportunity to participate in the PRINCIPLE study (CPMS 45457) was advertised to all GP practices in the region by collaborating with our CCG colleagues. The local NHS 111

service worked in collaboration with the CRN to identify eligible participants self-referring via this route. In total 116 practices in the region recruited to the study. The CRN WE recruited 230 recruits in 2020/21 with 0.2% of Covid-19 cases in the region recruited into the study. The CRN WE facilitated two monthly meetings with recruiting sites to share best practice and recruitment strategies. Weekly communication was sent to sites via email and to offer additional support to sites. The CRN WE distributed information pertaining to study amendments and ensured these were implemented in a timely manner.

Section 2. Challenges recruiting to Urgent Public Health (UPH) Prioritised studies

Following our UPH Research Plan, at the start of the pandemic a UPH Group was quickly formed. Membership includes the local CRN Senior Leadership Team, R&D Management and Clinical Leadership covering UPH Research, Respiratory, Infectious Diseases and Primary Care. These meetings were held weekly throughout the peaks of the pandemic and provided timely senior oversight of the UPH portfolio including decision making regarding prioritisation of activities.

Assistant/Research Delivery Managers (A/RDMs) from all divisions rapidly adjusted workloads in order to support the local uptake of UPH studies. They were assigned new UPH studies on a rotation basis. Attending national meetings became a vital conduit for sharing intelligence to and from sites ensuring timely resolution of issues.

UPH trial recruitment was made difficult by research staff redeployment to clinical services earlier in the pandemic and later on by absence due to sickness/ self-isolation. As outlined in Section 3 (Workforce), our regional approach and regular communication allowed Partner Organisations to best mitigate the impacts of reduced staff capacity. For example, research staff from our Mental Health Trusts supported vaccine and other UPH studies across other organisations therefore adding crucial capacity to deliver the UPH portfolio.

Section 3. Workforce

Despite a challenging year, the CRN WE research community has been remarkable in the way in which they have stepped up to deliver and support our research portfolio. This has been supported by effective collaboration between the CRN WE and our Partner Organisations, with regular meetings and information sharing.

In the Core Team, one of the Research Delivery Managers stepped up into a vaccine lead role, supported by the new appointment of a Regional Vaccine Coordinator, hosted by one of our Partners. The West of England greatly benefited from our existing agile workforce (the WEReACH Team), who would ordinarily work across primary, community and social care. This team played a pivotal role in providing the necessary capacity for our sites to deliver on the vaccine trials.

The CRN WE played a significant role in the National Vaccine Trials Training Group. This group was led by the Chief Operating Officer (COO), and had representation from the Senior Workforce Lead, Workforce Development Lead, Senior Research Delivery Manager and

Vaccine Lead, and Executive Assistant. This group established a training matrix for different study roles in a matter of three weeks, reviewing existing materials and commissioning additional e-learning and other resources as needed. The South-West Supra-Regional Digital Learning Designer led the technical development of many of the new resources. This resource allowed staff across the region, and the nation, to develop the skills and knowledge necessary to deliver on vaccine trials in Q3 and Q4.

Throughout the pandemic, staff wellbeing has been a regular item on our R&D Management meeting agenda, with Partners discussing their staff's experience and supporting each other. We also invested in Mental Health First Aid training for our workforce across both the Core Team and embedded in Partner Organisations.

As we move forward with Managed Recovery and the Recovery, Resilience and Growth agenda, there is wide-spread concern across the CRN WE and all Partner Organisations about our staff and the demands placed on them. Following a difficult year, where many staff have delivered above and beyond, there is a need for pause, reflection and recovery, and it is important that the Clinical Research Network provides both the time and support for our colleagues if we are to retain a talented and high-performing workforce.

Section 4. Restart and Partner organisation engagement

In 2020/21, we held a number of speciality events aimed at supporting the restoration of the portfolio and encouraging new research and PIs/ CIs of the future. The first was focussed on Anaesthesia and Critical Care. The event was well attended (42 attendees) and the positive feedback showed there was interest for further events focused on specialties and restart. Similar events were delivered in Dermatology, Primary Care, and Reproductive Health & Childbirth. We also continued to facilitate five Communities of Practices (in Cardiovascular, Ophthalmology, Reproductive Health & Childbirth, Stroke, and Commercial Dementia).

In addition to a number of regular regional meetings with R&D Managers, the A/RDMs continued to meet regularly as locality links for the CRN WE Partner Organisations. These meetings enabled discussions around the restart of non-Covid research and fast escalation of any delivery issues. The A/RDMs, Clinical Director, COO and Deputy COO held reflection and business planning review meetings with each Partner Organisation to reflect on the year, share learnings and create focus for the year to come. In these meetings the R&D leads were very complimentary and thankful for the continuation of the locality meetings throughout the pandemic and in many cases the additional supportive increased contact which has led to strengthened relationships within the region.

Section 5. Patient and Public Involvement and Engagement (PPIE)

The Communications and Engagement Team have supported national campaigns, including promoting the Vaccine Registry and participating in awareness days, as well as proactively supporting recruitment to trials through engagement with local media and through social media channels. This has included greater involvement with the CRN WE led studies, such

as Valneva (CPMS 47465/48118) and ComFluCov (CPMS 48826). Our clinical vaccine leads, Professor Adam Finn and Dr Rajeka Lazarus, have readily engaged with the national and local media during the pandemic, often supported and facilitated by the CRN WE.

To support inclusive recruitment into vaccine trials, we co-designed projects with two local Somali groups; Bristol Somali Youth Voice and Bristol Somali Resource Centre, to engage with local Somali communities, promote participation in vaccine research, and to better understand perceived barriers to participation. We are currently collating the final reports from those projects, but we are already sharing our learning with research colleagues in the region, including colleagues in the NIHR Research Design Service, the NIHR BRC, University of Bristol and the University of the West of England.

In March 2021, the South-West Supra-Region held a public Q&A event over Zoom, an idea initiated and led by the CRN WE. The event involved a panel of four vaccine experts across the region, including two Chief Investigators, a Principal Investigator in Primary Care, and a lead Research Nurse. The event was chaired by a notable public figure who had participated in Com-COV (CPMS 48289). This event was attended by 250 people and post-event feedback was overwhelmingly positive.

The Participant in Research Experience Survey (PRES) for 2020/21 finished at the end of March 2021 with 1,126 responses, a notable increase from 621 in 2019/20. This is approximately 2% of participants in research between 20 August 2020 and 19 March 2021. Interim feedback from the vaccine studies was fed back to study teams and lead networks during the year. A higher response rate has no doubt been possible by the fact that efforts have focused on a smaller number of high-recruiting studies, such as vaccine studies, which also benefit from a simple participant pathway and generally healthy and digitally-literate participants.

Section 6. Selected non-COVID-19 LCRN achievement

The CRN WE has continued to recruit well into Public Health studies, a testament to the adaptability and versatility of our local study teams who continued existing work and produced new research during the pandemic. This was driven by the work of the Avon Longitudinal Study of Parents and Children (ALSPAC) birth cohort study team, who successfully completed their planned annual studies, delivered several new Covid-19 studies, and prepared for the launch of their next data collection clinic in September 2021.

The CRN WE has continued to focus on expanding support into social care settings.The Division 4 RDM continued to engage with the national ENRICH (Enabling Research In Care Homes) group and joined two sub-groups to help develop training and payment programmes in this area. In 2020/21 the CRN WE shared more research opportunities with care homes than ever before, a 166% increase from 2019/20 (including UPH study opportunities). This increase in opportunities led to some new interest from care homes who had previously not engaged with ENRICH.

The RSI Event for 2020/21 attracted GP Practices currently within our RSI scheme as well as some new sites/ care homes and hospices. It included speakers from six studies, four of which were non-Covid studies preparing to open to new sites. There was an update from the Primary Care Academic Collaborative (PACT) network aimed at Early Career GP Researchers. The CRN WE also promoted its new process and rates for paying Service Support Costs for studies opening post April 2021. The feedback from the event was positive with many sites commenting that the virtual event made it easier to attend.

The successful development funding award at Great Western Hospital (GWH) to support Reproductive Health & Childbirth research has led to significant portfolio study growth at the site. During the pandemic, the development funded Research Nurse has also proved invaluable in the setup of their participation in vaccine research, drawing on experience from the flu vaccination programme for Maternity services. At GWH, GCP training has now been embedded in routine training for all Midwives, the first of our Trusts to achieve this.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**Trust Finance Performance Report**
Report Authors	**Jeremy Spearing, Deputy Director of Finance** **Kate Herrick, Associate Director of Finance** **Dean Bodill, Head of Financial Management & Improvement**
Executive Lead	**Neil Kemsley, Director of Finance and Information**

1. Report Summary

The purpose of this report is to inform the Board of the financial position of the Trust for the period 1st April 2021 to 30th June 2021.

2. Key points to note

(Including decisions taken)

The Trust's year to date net income and expenditure performance, excluding technical items, is a net surplus of £0.387m compared with a plan of break-even. The overall position continues to be driven by slower than planned pick up in costs linked to the Trust's approved 2021/22 investments offset by the shortfall in savings delivery to date.

The Trust has delivered savings of £1.578m in quarter 1 compared with the plan of £3.609m.

The Trust has invested capital of £17.620m to date of which £7.114m relates to the Salix decarbonisation scheme.

The Trust's cash balance was £160.856m as at 30th June 2021.

3. Risks

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

The risks associated with this report include the following strategic financial risks. Although these are not expected to have an impact in this financial year, further work is required to develop understanding and mitigating strategies on the following**:**

- Agreeing an STP approach to future financial targets given UHBW's need to service past borrowing;
- Understanding the risks and mitigations associated with the new capital regime; and how the CDEL limit could restrict future strategic capital investment; and
- Re-assessing the implications of the financial arrangements relating to the merger and how that may have altered by changes in the national financial regime.

4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **Information.**	
5. History of the paper **Please include details of where paper has previously been received.**	
Finance & Digital Committee	**27th July 2021**

University Hospitals Bristol and Weston NHS Foundation Trust

Trust Finance Performance Report

Reporting Month: June 2021

Contents

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: June 2021

The Finance Performance Report replaces the Finance Director's Report. It considers best practice in presenting a transparent account of the Trust's current financial position and will shift the emphasis into future performance over the coming months as we develop the report. To ensure the report contains all of the relevant information necessary for the Finance & Digital Committee to understand the Trust's financial performance, the report will undergo periodic review at each quarter end. Actions to drive improved performance are detailed in Appendix 1.

Executive Summary

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Reporting Month: June 2021

YTD Income & Expenditure Position	• Net surplus of £387k against a plan of break-even (excluding technical items). • Total operating income is £1,516k favourable to plan mainly due to higher than planned Elective Recovery Fund (ERF) income of £2,835k offset by lower than planned other operating income of £1,062k. • Operating expenses are £1,487k adverse to plan. Excluding technical items, operating expenses are £931k adverse to plan and is primarily due lower than planned savings delivery (£2,061k adverse) offset by slower than planned pay costs linked to investments.
Key Financial Issues	• The Trust's financial position includes estimated ERF income and matching costs of £7,835k pending a system decision regarding the allocation of ERF. • The level of ERF earnable by the Trust will reduce over the next quarter due to challenges with workforce and bed availability impacting on activity delivery as seen in June. • Savings delivery of £1,578k or 44% of the plan. The savings forecast outturn indicates a shortfall in delivery of £8,002k. Although this will impact on the Trust's financial performance against plan it is not expected to lead to non-delivery overall. More significantly, the indicative recurrent savings delivery of £3,757k will have a material impact on the Trust's underlying position going in to 2022/23.
Strategic Risks	Although these are not expected to have an impact in this financial year, further work is required to develop understanding and mitigating strategies on the following: • Agreeing an STP approach to future financial targets given UHBW's need to service past borrowing; • Understanding the risks and mitigations associated with the new capital regime; and how the CDEL limit could restrict future strategic capital investment; and • Re-assessing the implications of the financial arrangements relating to the merger and how that may have altered by changes in the national financial regime.

SPORT

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: June 2021

Successes	Priorities
• Recovery of elective activity delivery beyond the thresholds set by NHSEI of 70% in April, 75% in May and 85% in June. • Delivery of ERF income of £7,835k, £2,835k ahead of plan. • The majority of Divisions are operating with largely immaterial variances to budget in percentage terms following the reset of budgets in June. • Delivery of capital investment of £17,620k in quarter 1.	• Further efforts to recruit into substantive nursing vacancies with an increased overseas recruitment campaign should help mitigate workforce supply challenges. • Options to increase bed capacity at the BRI are being explored at pace ahead of the Winter. An option appraisal has been presented and approved by the Trust's SLT. • Further work within the system to ensure efforts are co-ordinated and targeted at decompressing the acute hospital sites ahead of Winter. • The Trust is progressing its five year capital plan with system partners as required by NHSEI for submission in mid October. • The Trust must develop its CIP programme for 2022/23. Including recurrent savings not delivered in 2021/22, for conclusion the middle of Q4.
Opportunities	**Risks & Threats**
• The Trust is working closely with system colleagues to test and understand individual organisational underlying revenue financial positions to help inform planning and resource allocation for 2022/23. • The Trust/System position in 2021/22 may allow some non-recurrent flexibility that could help set stronger operational and financial foundations for 2022/23. • Significant opportunity to align the productivity improvements being driven by the Accelerator Programme and the Restoration Oversight Group.	• Workforce supply to fulfil vacant existing and new posts continues to impact on the Trust's ability to deliver ambitious elective activity recovery plans. • Substantive workforce availability due to the ongoing impact of the pandemic potentially resulting in additional absence such as self-isolation could continue to undermine elective activity recovery plans. • Increasing use of expensive (Tier 4) agency staffing throughout the Summer may have a material adverse impact on the Trust's financial plan. • Emergency and non-elective demand activity continues to displace elective activity delivery.

Financial Performance – Income & Expenditure

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

Trust Year to Date Financial Position

	Month 3			YTD		
	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's
Income from Patient Care Activities	79,303	84,116	4,813	227,607	230,184	2,577
Other Operating Income	12,660	14,936	2,277	34,189	33,127	(1,062)
Total Operating Income	**91,963**	**99,052**	**7,090**	**261,796**	**263,311**	**1,516**
Employee Expenses	(47,832)	(47,518)	314	(143,495)	(142,228)	1,267
Other Operating Expenses	(36,610)	(41,251)	(4,641)	(99,822)	(102,258)	(2,436)
Depreciation (owned & leased)	(2,413)	(2,498)	(85)	(7,238)	(7,556)	(318)
Total Operating Expenditure	**(86,855)**	**(91,267)**	**(4,412)**	**(250,555)**	**(252,042)**	**(1,487)**
PDC	(1,072)	(1,072)	(1)	(3,215)	(3,215)	(1)
Interest Payable	(190)	(174)	16	(571)	(541)	30
Interest Receivable	0	0	0	0	0	0
Other Gains/(Losses)	0	(12)	(12)	0	(12)	(12)
Net Surplus/(Deficit) inc technicals	**3,846**	**6,527**	**2,681**	**7,455**	**7,501**	**46**
Remove Capital Donations, Grants & donated asset depreciation	(3,846)	(6,462)	(2,616)	(7,455)	(7,114)	341
Net Surplus/(Deficit) exc technicals	**0**	**65**	**65**	**0**	**387**	**387**

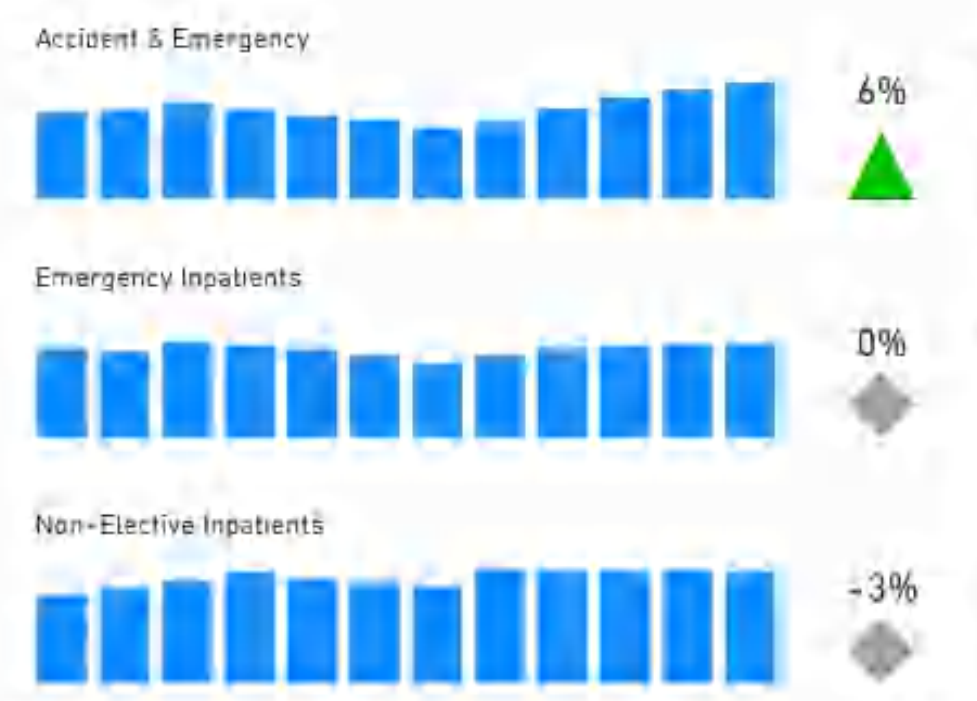
Key Facts:

- The actual position for June is a net surplus of £65k against a plan of breakeven.
- YTD the position is £387k favourable to the planned breakeven position.
- Pay expenditure is favourable to plan at £1,267k or 0.8% YTD.
- High agency usage continues predominantly driven by vacancies and sickness.
- Agency expenditure at the end of Q1 is £7,597k, representing 5% of total pay.
- Elective activity decreased in June by 11-13% compared to May. In addition, productivity also fell with a reduction in activity per working day across elective inpatients, day cases and outpatients.
- Income earned from the Elective Recovery Fund (ERF) in Q1 is £7,835k, £2,835k ahead of plan.
- Other operating income is adverse to plan by £1,062k due to slower than planned pick up in commercial income.
- CIP achievement is 44%. £1,578k has been achieved against a target of £3,609k.
- Additional costs of Covid-19 are £2,867k in Q1 and show a month-on-month reduction.

Financial Performance – Clinical Activity Volumes

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021



Key Points:

- We use calendar days to calculate the volume per day for non-elective points of delivery.
- Accident and emergency attendances per day were 6% higher in June compared with May and continues the upward trend in activity seen since January 2021. The volume per day is now higher than any previous month with Q1 year to date position back to pre-pandemic levels (Q1 June 2019).
- Emergency and non-elective inpatient spells have remained fairly static since March 2021. The Q1 year to date activity volumes per day are c90% of pre-pandemic volumes (Q1 June 2019).

Year To Date Volume

Ebero POD	Total Volume Per Day	Total Volume Per Day 21Ago	Total Planned Volume Per Day	Total Volume Per Day CY/Plan %	Total Volume Per Day CY/21Ago %
Accident & Emergency	1,593	1,590	1,533	104%	100%
Emergency Inpatients	482	490	489	99%	98%
Non-Elective Inpatients	111	124	116	96%	90%

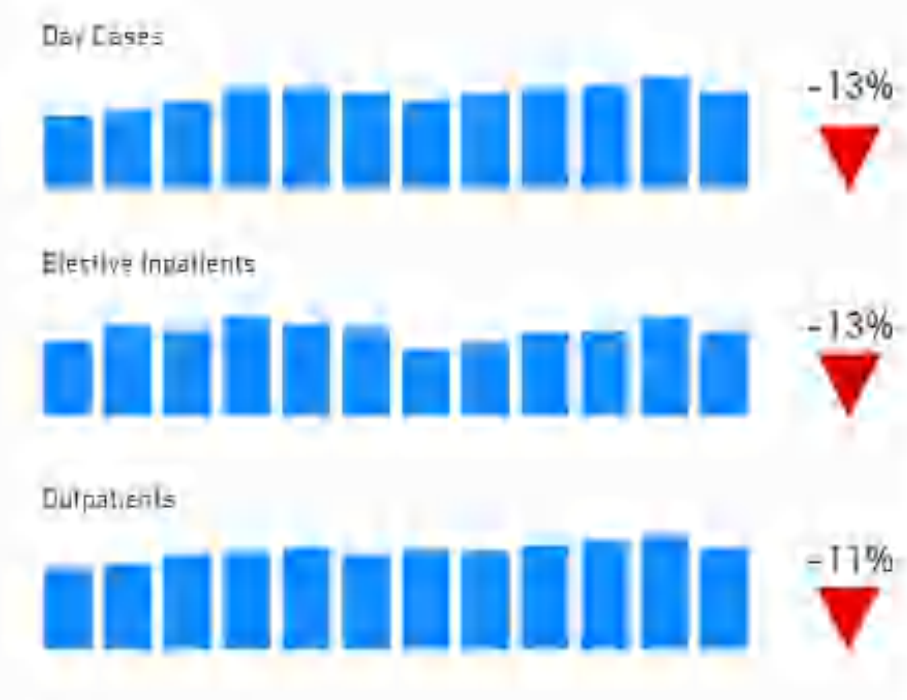
Current Month Volume

Ebero POD	Total Volume Per Day	Total Volume Per Day 21Ago	Total Planned Volume Per Day	Total Volume Per Day CY/Plan %	Total Volume Per Day CY/21Ago %
Accident & Emergency	636	529	513	110%	120%
Emergency Inpatients	152	159	161	94%	96%
Non-Elective Inpatients	37	42	38	96%	87%

Financial Performance – Clinical Activity Volumes

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021



Key Points:

- We use working days to calculate the volume per day for elective points of delivery.
- The volumes per day in June were lower than May for all three main elective points of delivery.
- Day cases and elective inpatients spells per day were 13% lower in June compared with May. Outpatient attendances per day were 11% lower.
- Elective volumes per day have been on an upward trajectory since January 2021 with May's figures the highest since the start of the pandemic. However, this trend has reversed in June.
- There are c4,000 outpatient attendances in June which don't have an outcome indicator meaning these are excluded from the figures presented here. It is likely that a significant proportion of these will be recorded as 'attended' by next month. If 75% have attended then June's volume per day will increase from 2,648 to 2,784 (6% lower than May).

Year To Date Volume

Board POD	Total Volume Per Day	Total Volume Per Day CYAgo	Total Planned Volume Per Day	Total Volume Per Day CY Plan %	Total Volume Per Day CY CYAgo %
Day Cases	792	917	961	82%	86%
Elective Inpatients	138	170	138	100%	81%
Outpatients	8,441	9,490	8,039	105%	89%

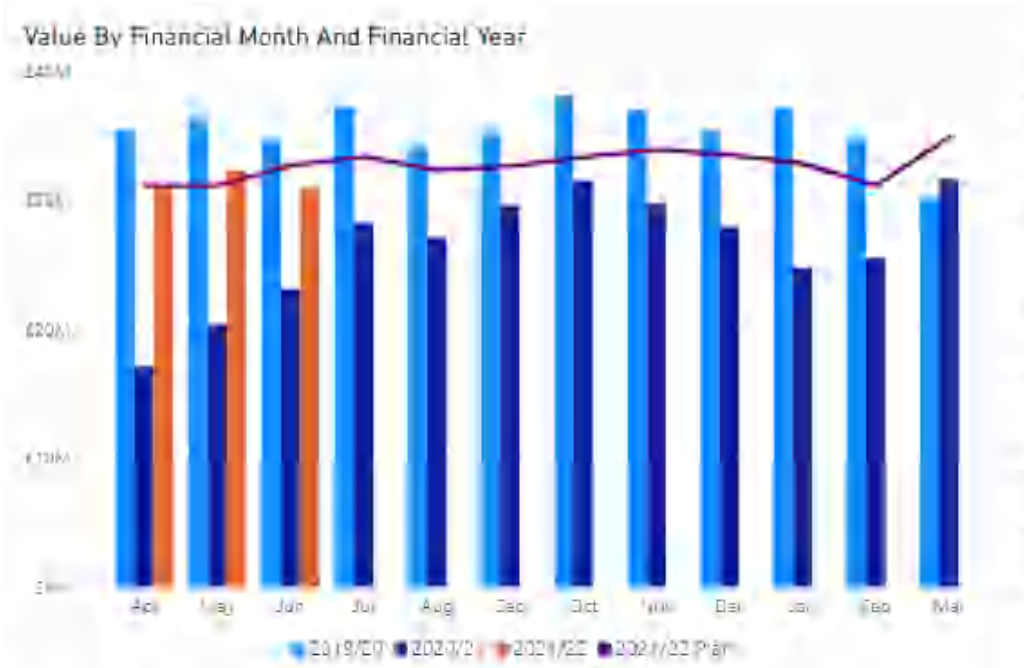
Current Month Volume

Board POD	Total Volume Per Day	Total Volume Per Day CYAgo	Total Planned Volume Per Day	Total Volume Per Day CY Plan %	Total Volume Per Day CY CYAgo %
Day Cases	247	301	259	95%	82%
Elective Inpatients	48	57	47	101%	84%
Outpatients	2,648	3,161	2,687	99%	84%

Financial Performance – Clinical Income

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021



Key Points:

- Payment by results has been suspended during the pandemic. To give a sense of casemix we have valued the activity we have delivered using the national tariffs.
- The value of activity for the main points of delivery in June was £31.0m compared to £32.3m in May.
- The value of elective activity (including inpatients spells, day cases and outpatients) in June was £14.3m compared to £15.0m in May. The value of non-elective activity (including emergency inpatients and accident and emergency attendances) in June was £16.7m compared to £17.3m in May.
- There were more working days in June, 22 compared to 19 in May, and fewer calendar days, 30 compared to 31 in May.

Year To Date Value

Board POD	Total Value (£000)	Total Value PYAgo (£000)	Total Planned Value (£000)	Total Value CY/PYAgo %	Total Value CY/Plan %
Accident & Emergency	7,978	8,067	7,851	99%	102%
Day Cases	10,860	12,550	11,154	87%	97%
Elective Inpatients	3,094	13,627	12,197	84%	106%
Emergency Inpatients	33,573	36,887	35,087	92%	97%
Non-Elective Inpatients	8,660	9,293	9,055	95%	96%
Outpatients	19,560	23,842	19,578	82%	100%
Total	**94,225**	**106,267**	**94,871**	**89%**	**99%**

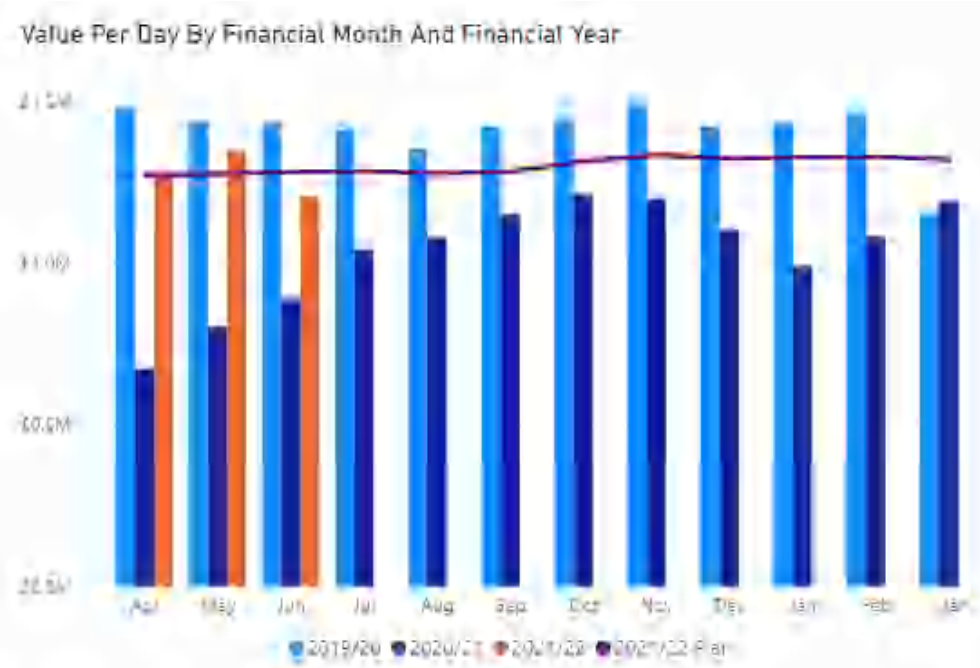
Year To Date Value

Board POD	Total Value (£000)	Total Value PYAgo (£000)	Total Planned Value (£000)	Total Value CY/PYAgo %	Total Value CY/Plan %
Accident & Emergency	8,744	8,645	8,613	104%	106%
Day Cases	3,697	4,004	4,041	92%	92%
Elective Inpatients	4,012	5,156	4,926	78%	89%
Emergency Inpatients	10,938	11,747	11,451	93%	96%
Non-Elective Inpatients	3,006	3,174	3,077	95%	102%
Outpatients	6,845	7,843	7,663	87%	89%
Total	**30,361**	**34,565**	**32,661**	**90%**	**93%**

Financial Performance – Clinical Income

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

June 2021



Key Points:

- Q1 year to date activity compared with Q1 2019 was at 87% for Day cases, 84% for elective inpatients and 82% for outpatients.
- Elective activity per working day (as an indicator for productivity) in June was over 10% lower than May and reverses the recent trend. This includes inpatient spells, day cases and outpatient attendances.
- Divisions have explained that elective activity was relatively low in June because of capacity constraints caused by high staff absence, due to ongoing vacancies, sickness and isolation.
- The expectation is that these factors will also adversely impact on July's elective activity delivery and productivity.

Year To Date Value

Board POD	Total Value Per Day (£'000)	Total Value Per Day PYAgo (£'000)	Total Planned Value Per Day (£'000)	Total Value Per Day CY/PYAgo %	Total Value Per Day CY/Plan %
Accident & Emergency	263	266	260	99%	101%
Day Cases	337	616	545	87%	98%
Elective Inpatients	643	769	955	84%	109%
Emergency Inpatients	1,117	1,215	1,157	92%	97%
Non-Elective Inpatients	292	307	299	95%	98%
Outpatients	995	1,173	963	82%	100%
Total	**3,822**	**4,348**	**3,821**	**88%**	**100%**

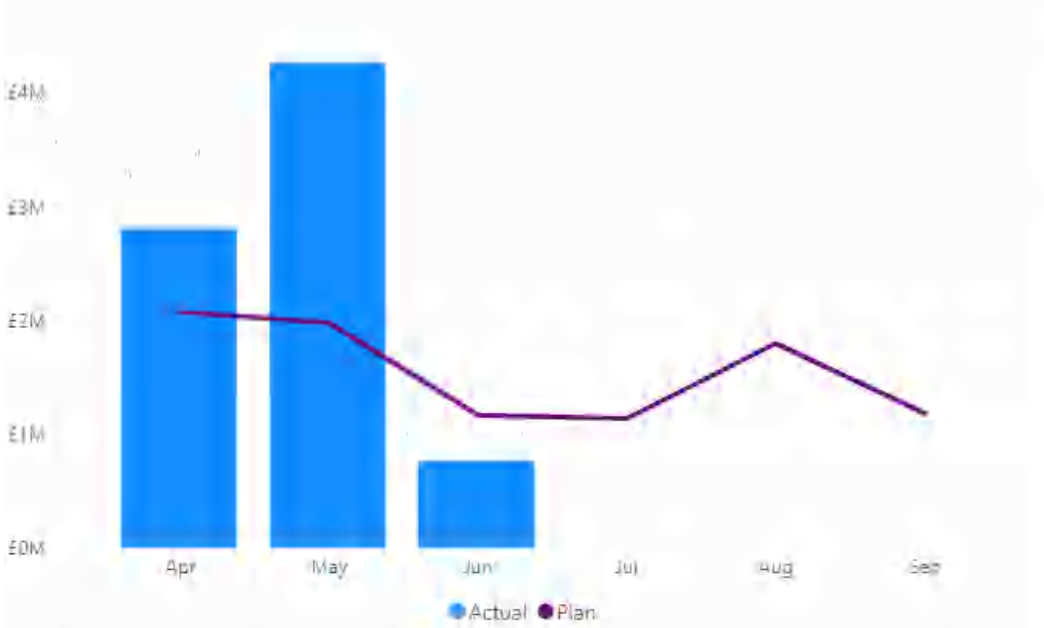
Current Month Value

Board POD	Total Value Per Day (£'000)	Total Value Per Day PYAgo (£'000)	Total Planned Value Per Day (£'000)	Total Value Per Day CY/PYAgo %	Total Value Per Day CY/Plan %
Accident & Emergency	21	188	87	134%	106%
Day Cases	164	200	184	82%	89%
Elective Inpatients	182	258	206	71%	89%
Emergency Inpatients	365	386	382	93%	96%
Non-Elective Inpatients	101	108	99	95%	102%
Outpatients	372	392	321	77%	94%
Total	**1,205**	**1,436**	**1,278**	**84%**	**94%**

Actual Financial Position – Clinical Income - ERF

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021



Month Name	2019/20 Actual (£'000)	2021/22 Actual (£'000)	Lower Threshold	Upper Threshold	2021/22 Elective Recovery Fund Plan (£'000)	2021/22 Elective Recovery Fund Estimate (£'000)
April	17,253	14,841	70%	85%	2,071	2,799
May	15,368	15,339	75%	85%	1,974	4,269
June	18,360	15,455	80%	85%	1,163	767
July	17,514		95%	100%	1,135	
August	16,315		95%	100%	1,794	
September	17,879		95%	100%	1,179	
Total	**102,690**	**45,635**	**85%**	**93%**	**9,315**	**7,835**

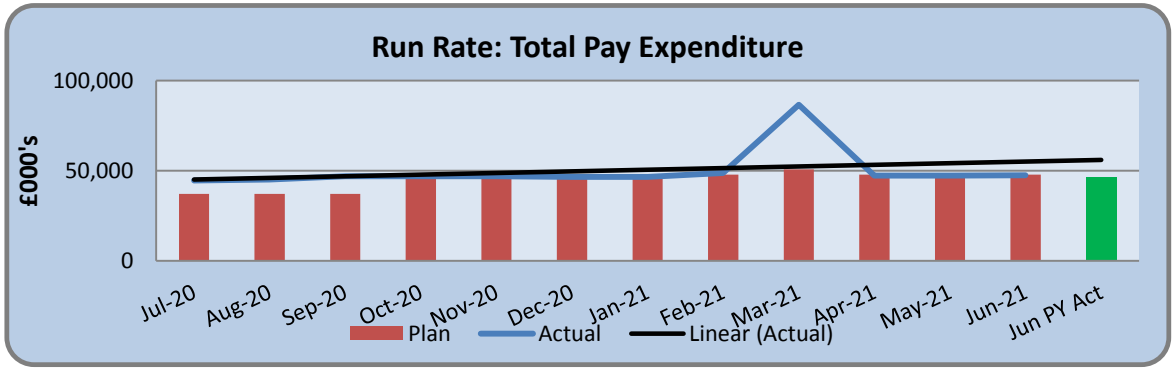
Key Points

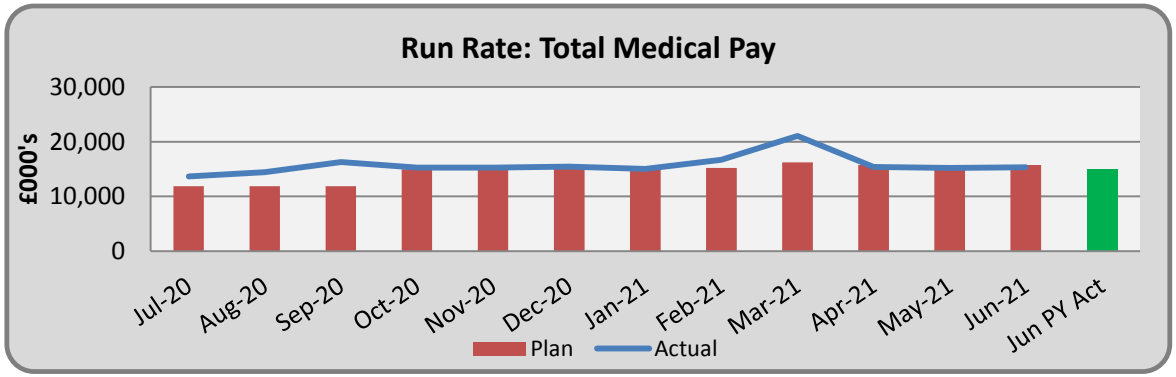
- The Elective Recovery Fund rewards systems with additional variable income in order to accelerate the return of elective activity to 2019/20 levels in value terms that exceeded a threshold of 70%, 75%, 80% and 85% for April, May, June and July respectively.
- The Trust has estimated ERF earnings at £7,835k for the Q1 year to date position, £2,835k ahead of plan. The Trust's estimate is subject to confirmation by NHSEI in due course.
- The very low level of ERF earned in June of £767k reflects the reduction in elective activity actual delivered and the increase in the lower threshold to 80% in June (from 70% in April and 75% in May) above which ERF is earned.
- NHSEI have changed the threshold from 1 July to 95% of 19/20 activity. NHSEI has also increased the level at which 120% of the national tariff is payable.
- The changes implemented by NHSEI means the Trust estimates ERF earnings of only £1m in Q2. This is significantly lower than our previous assessment, based on the original thresholds of £6.7m in Q2. These estimates include the impact of the Trust's accelerator programme.
- Elective capacity constraints described in the previous slide is likely to further reduce the ERF income earned in Q2.

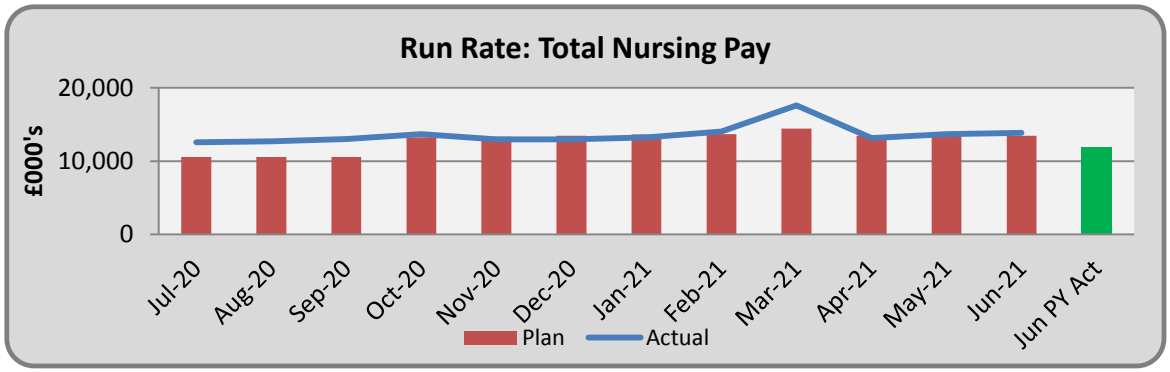
Financial Performance – Workforce Expenditure

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021







Key Points:

- Total pay expenditure in June is £47,518k, £314k favourable to plan and broadly in line with previous months.
- YTD expenditure is £1,267k favourable to plan mainly due to slower than planned pick up in costs linked to approved investments.
- Agency expenditure in June is £2,891k compared with £2,585k in May and £2,120k in April. Nursing and Medical agency expenditure increased in the month.
- Bank expenditure is demonstrating a downward trend in the first quarter.

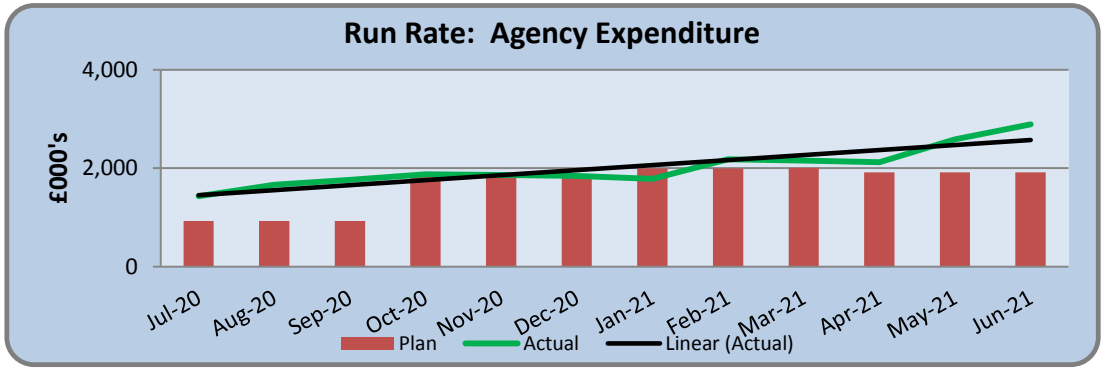
Recovery Actions:

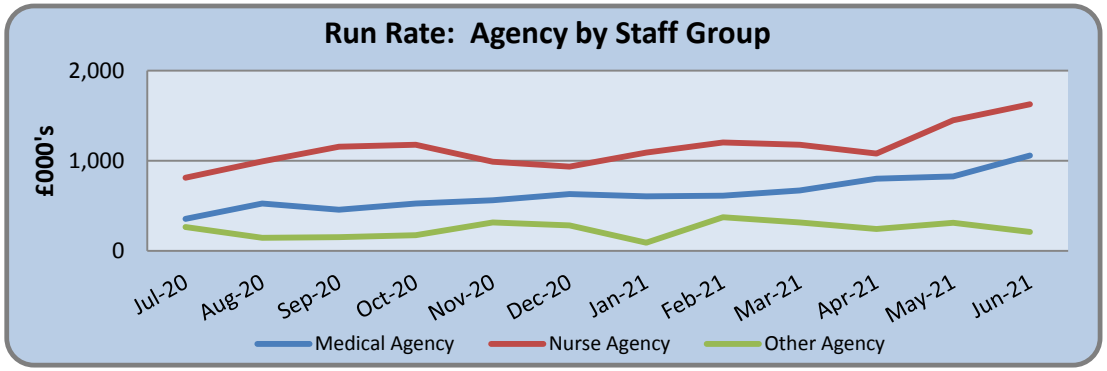
- Understand the drivers for the reduction in bank expenditure.
- Understand the drivers for the increase in agency costs in June, particularly Tier 4 usage and understand what further controls can be implemented to mitigate spend.
- The Trust will need to consider extending its recruitment campaign of overseas nurses.
- The Trust continues to implement plans to sustain medical staffing gaps in the Weston Division.

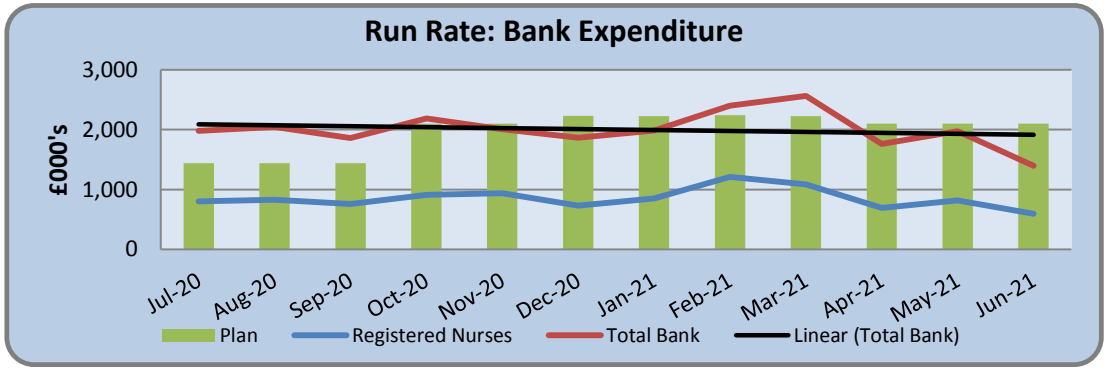
Financial Performance – Bank & Agency

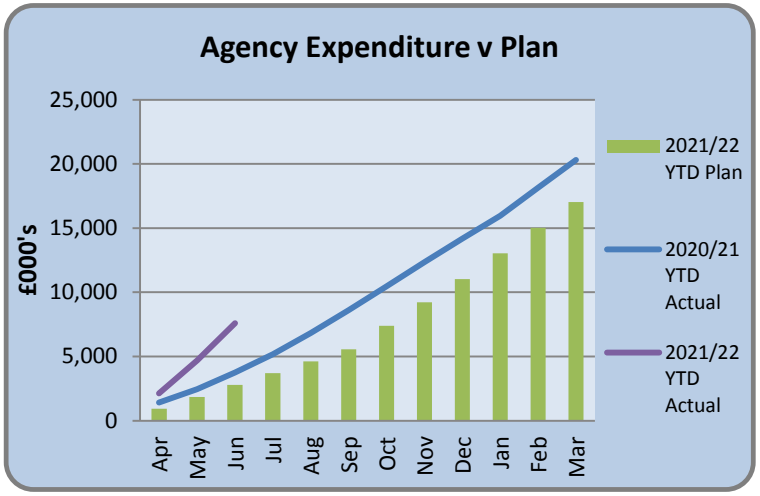
University Hospitals Bristol and Weston NHS Foundation Trust

June 2021









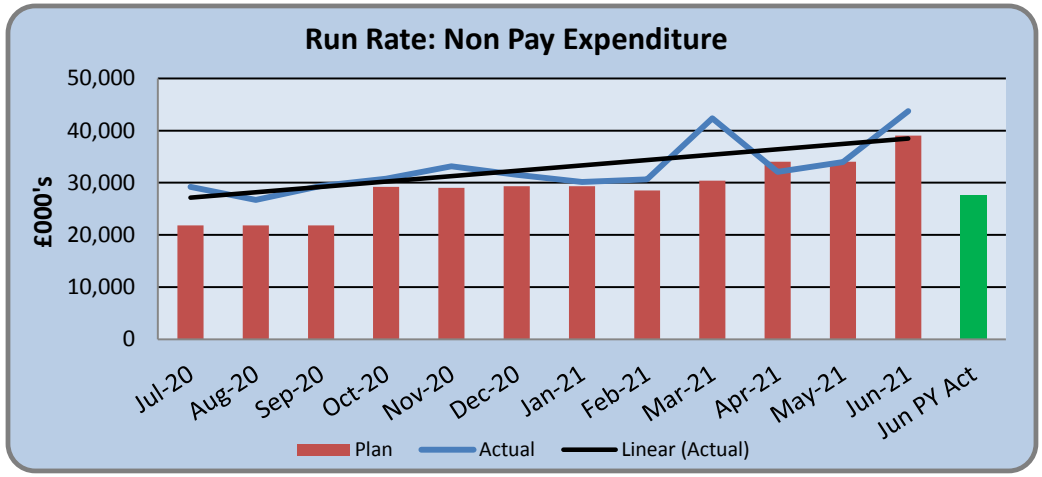
Key Points:

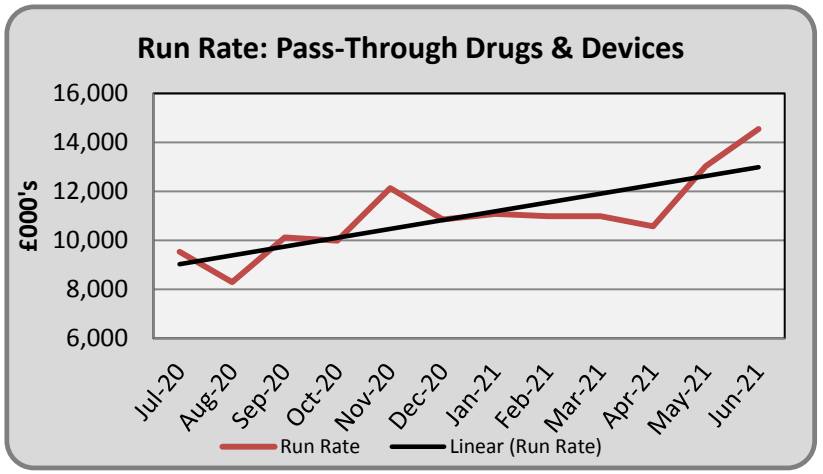
- Agency expenditure for June is £2,891k, £977k or 34% higher than plan. An increase of £306k from the previous month.
- YTD agency expenditure exceeds plan by £1,854k.
- Agency usage continues to be driven by vacancies, across nursing and medical staff groups. Sickness and use of mental health nurses are also significant factors for nursing.
- Nurse agency shifts has increased by 106 or 3% more shifts compared to the previous month. Tier 4 shifts have increased by 17%.
- Medical agency has increased by £234k, from £824k to £1,058k.
- Bank costs decreased in June from £1,974k to £1,399k.
- Early indications suggest that the vacancy and sickness levels are continuing into July so it is likely that current agency trends will continue.

Financial Performance – Non Pay Expenditure

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021





Top 5 Adverse Variances	CURRENT YEAR YTD Budget (£000's)	CURRENT YEAR YTD Expenditure (£000's)	CURRENT YEAR Variance (£000's)	PRIOR YEAR YTD Budget (£000's)	PRIOR YEAR YTD Expenditure (£000's)	PRIOR YEAR Variance (£000's)
Drugs	37,218	37,793	(576)	27,219	27,104	115
Purchase of healthcare - NHS	2,489	2,791	(302)	4,428	2,196	2,232
Operating lease expenditure	1,671	1,839	(169)	1,908	1,959	(51)
Consultancy	104	229	(125)	222	227	(5)
Audit Fees	37	56	(19)	36	40	(4)
Total	**41,519**	**42,709**	**(1,190)**	**33,813**	**31,526**	**2,287**

Top 5 Favourable Variances	CURRENT YEAR YTD Budget (£000's)	CURRENT YEAR YTD Expenditure (£000's)	CURRENT YEAR Variance (£000's)	PRIOR YEAR YTD Budget (£000's)	PRIOR YEAR YTD Expenditure (£000's)	PRIOR YEAR Variance (£000's)
Clinical Supplies & Services	22,155	20,104	2,051	19,597	13,760	5,837
Transport	1,218	684	534	750	1,105	(355)
Establishment	4,239	3,867	372	2,547	2,833	(286)
Purchase of healthcare - non-NHS	2,567	2,207	360	1,377	1,211	166
Supplies and services - general	2,574	2,287	287	2,424	2,975	(551)
Total	**32,754**	**29,149**	**3,605**	**26,695**	**21,884**	**4,811**

Key Points:

- YTD expenditure of £109,814k is £2,753k or 3% worse than plan. This is primarily due to the shortfall in savings delivery and expected costs associated with ERF.
- The increase in run rate of pass-through drugs and devices is primarily due to the use of Zolgensma at £3,200k YTD.
- Clinical supplies and services is £2,051k favourable to plan and reflects lower than planned elective activity levels.

Recovery Actions:

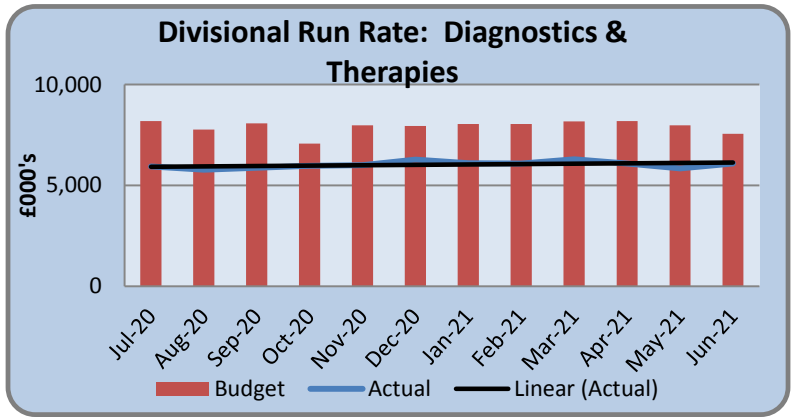
- Assessment of costs associated with the delivery of ERF income will be undertaken in month 4.

Financial Performance – Divisional Position

University Hospitals Bristol and Weston NHS Foundation Trust

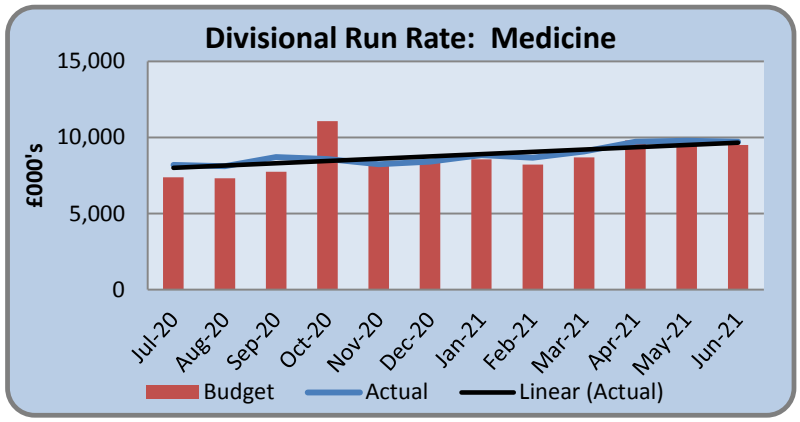
June 2021

	Diagnostics & Therapies		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	28	27	(1)
Other Activity Based Income	13	18	5
Other Operating Income	1,111	1,200	89
Total Operating Income	**1,152**	**1,245**	**93**
Nursing and Midwifery	(332)	(326)	6
Medical Staff - Consultants	(1,385)	(1,352)	33
Medical Staff - Others	(253)	(321)	(68)
Other Clinical Staff	(10,660)	(10,713)	(53)
Non Clinical Staff	(1,122)	(1,113)	9
Other Pay	(35)	0	35
Total Employee Expenses	**(13,787)**	**(13,825)**	**(38)**
Drugs	(1,517)	(1,734)	(217)
Clinical Supplies	(2,345)	(2,402)	(57)
Support Funding	0	0	0
Other Non Pay	(1,155)	(1,313)	(158)
Total Other Operating Expenses	**(5,017)**	**(5,449)**	**(432)**
Net Surplus/(Deficit)	**(17,652)**	**(18,029)**	**(377)**



Diagnostics & Therapies:

- Adverse variance £377k.
- Favourable variance on income ops due to increased commercial trial income.
- Adverse variance on drugs due to high tech homecare previously pass through.
- Adverse variance on cell path recharges due to higher than planned activity.
- No significant changes to note in run rate for either pay or non pay.



Medicine:

- Adverse variance £40k.
- Savings programme shortfall £145k.
- Adverse variance on other income due to lower than planned Covid trials and peripheral clinic income.
- Adverse variance on medical staff £367k mainly due to Weston pressures on and premium payments for medical Consultants.
- Favourable variance on non - pay lower than planned sleep devices expenditure and non pass through drugs spend.
- Increasing run rate trend on nursing re costs charged to division previously charged corporately.
- Pass through costs on devices lower in month by £500k.

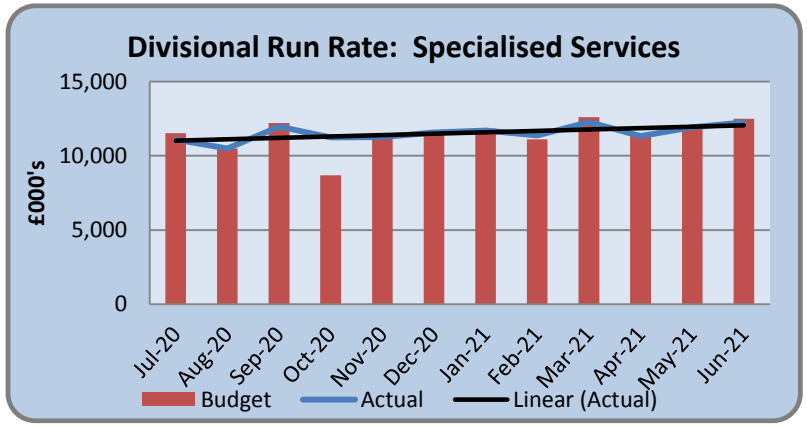
	Medicine		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	416	372	(44)
Other Activity Based Income	5	10	5
Other Operating Income	490	436	(54)
Total Operating Income	**911**	**818**	**(93)**
Nursing and Midwifery	(9,559)	(9,421)	138
Medical Staff - Consultants	(3,443)	(3,536)	(93)
Medical Staff - Others	(2,946)	(3,220)	(274)
Other Clinical Staff	(566)	(479)	87
Non Clinical Staff	(1,700)	(1,767)	(67)
Other Pay	0	0	0
Total Employee Expenses	**(18,214)**	**(18,423)**	**(209)**
Drugs	(8,608)	(8,360)	248
Clinical Supplies	(1,571)	(1,301)	270
Support Funding			0
Other Non Pay	(1,677)	(1,933)	(256)
Total Other Operating Expenses	**(11,856)**	**(11,594)**	**262**
Net Surplus/(Deficit)	**(29,159)**	**(29,199)**	**(40)**

Financial Performance – Divisional Position

NHS University Hospitals Bristol and Weston NHS Foundation Trust

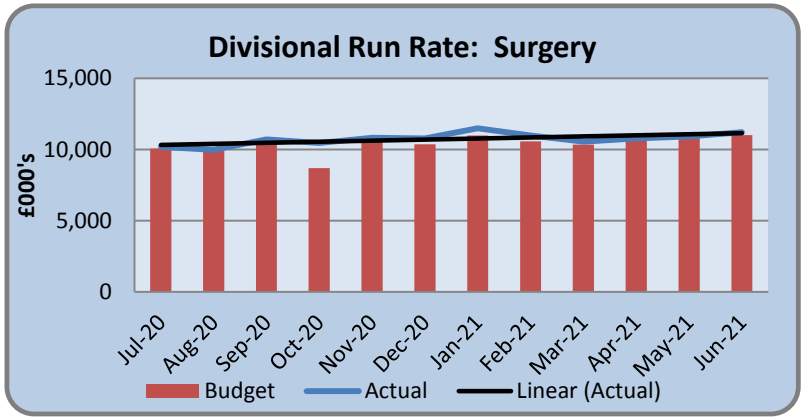
June 2021

	Specialised Services		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	691	691	0
Other Activity Based Income	420	198	(222)
Other Operating Income	779	852	73
Total Operating Income	**1,890**	**1,741**	**(149)**
Nursing and Midwifery	(6,473)	(6,500)	(27)
Medical Staff - Consultants	(3,655)	(3,540)	115
Medical Staff - Others	(2,013)	(2,082)	(69)
Other Clinical Staff	(1,840)	(1,882)	(42)
Non Clinical Staff	(1,527)	(1,465)	62
Other Pay			0
Total Employee Expenses	**(15,508)**	**(15,469)**	**39**
Drugs	(12,259)	(12,181)	78
Clinical Supplies	(6,079)	(5,733)	346
Support Funding			0
Other Non Pay	(4,119)	(3,868)	251
Total Other Operating Expenses	**(22,457)**	**(21,782)**	**675**
Net Surplus/(Deficit)	**(36,075)**	**(35,510)**	**565**



Specialised Services:

- Favourable variance to date £565k.
- Shortfall to date on savings programme £149k.
- Significant favourable variance on both drugs and clinical supplies, partly due to lower levels of activity this year compared to 2019/20 and reduced elective activity in June.
- Nursing run rate increasing as new ward beds have opened.
- Non pay run rate variable due to variability of pass through drugs and devices.
- Elective activity down in June compared to May.



Surgery:

- Favourable variance to date £243k.
- Shortfall on savings programme to date of £548k currently showing mainly under other non pay.
- Adverse variance on operating income due to lower BEH research activity.
- Large number of vacancies .
- Nursing run rate increasing over 2020/21 as ITU expansion now charged to the division, not corporately. High levels of vacancies being filled by agency staff and high levels of 1-1 care.
- Non pay run rate increasing and above 2020/21 rates as activity increase. However elective activity down in June compared to May.

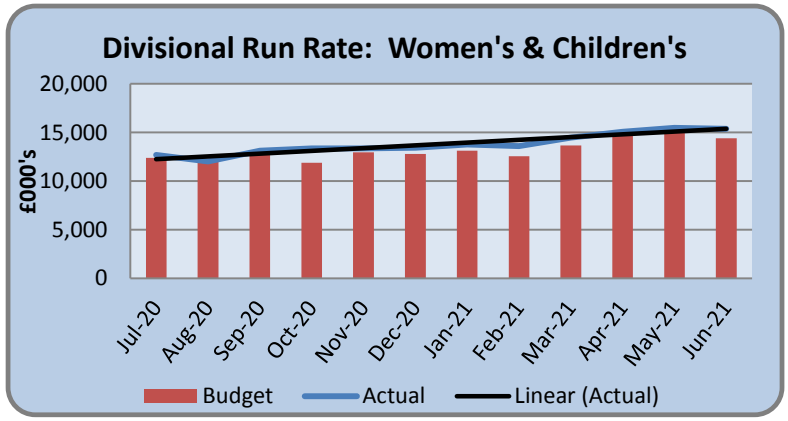
	Surgery		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	39	(29)	(68)
Other Activity Based Income	15	16	1
Other Operating Income	888	666	(222)
Total Operating Income	**942**	**653**	**(289)**
Nursing and Midwifery	(8,637)	(8,476)	161
Medical Staff - Consultants	(6,138)	(5,980)	158
Medical Staff - Others	(4,561)	(4,801)	(240)
Other Clinical Staff	(2,892)	(2,606)	285
Non Clinical Staff	(3,167)	(2,934)	233
Other Pay	28	0	(28)
Total Employee Expenses	**(25,367)**	**(24,797)**	**570**
Drugs	(3,469)	(3,355)	114
Clinical Supplies	(3,902)	(3,716)	186
Support Funding			0
Other Non Pay	(1,358)	(1,696)	(338)
Total Other Operating Expenses	**(8,729)**	**(8,768)**	**(38)**
Net Surplus/(Deficit)	**(33,155)**	**(32,912)**	**243**

Financial Performance – Divisional Position

University Hospitals Bristol and Weston NHS Foundation Trust

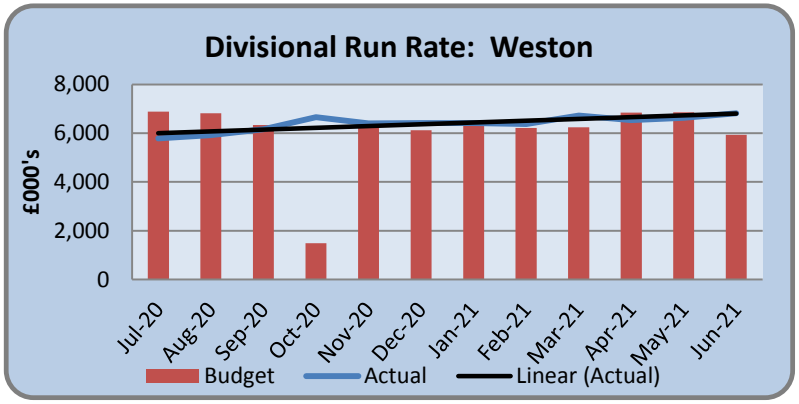
June 2021

	Women's & Children's		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	(18)	(18)	0
Other Activity Based Income	169	0	(169)
Other Operating Income	1,344	1,165	(179)
Total Operating Income	**1,495**	**1,147**	**(348)**
Nursing and Midwifery	(14,174)	(14,880)	(706)
Medical Staff - Consultants	(7,726)	(7,445)	281
Medical Staff - Others	(4,493)	(4,991)	(498)
Other Clinical Staff	(2,208)	(2,326)	(118)
Non Clinical Staff	(2,135)	(2,131)	4
Other Pay	189	0	(189)
Total Employee Expenses	**(30,547)**	**(31,773)**	**(1,226)**
Drugs	(9,632)	(9,623)	9
Clinical Supplies	(3,353)	(3,238)	115
Support Funding			0
Other Non Pay	(2,373)	(2,458)	(85)
Total Other Operating Expenses	**(15,358)**	**(15,319)**	**39**
Net Surplus/(Deficit)	**(44,410)**	**(45,945)**	**(1,535)**



Women's & Children's:

- Adverse variance of £1,535k.
- Income adverse £348k due private patient and research income.
- Savings programme shortfall £491k.
- Significant pay overspend for nursing including in PICU and ED with high levels of RMN expenditure support to mental health patients.
- Pay run rate consistent over past 4 months but is now significantly higher than in the early months of 2020/21 and 2019/20. This has contributed significantly to the pay overspend in Q1.
- Non pay run rate increased this month due to the treatment of two patients requiring Zolgensma.



Weston:

- An adverse variance to date of £337k.
- Significant shortfall on savings programme to date of £677k, particularly relating to a shortfall on savings plans linked to the merger.
- Significant pressure on other medical staff budgets due to the on-going staffing issues resulting in agency usage.
- Adverse variance on consultants due to premium payments and shortfall on merger savings plans.
- Pay run rate increasing partly due to medical staff pressures above.
- Non – pay budgets show small relatively small favourable variance and non – pay run rate showing small increase this month.

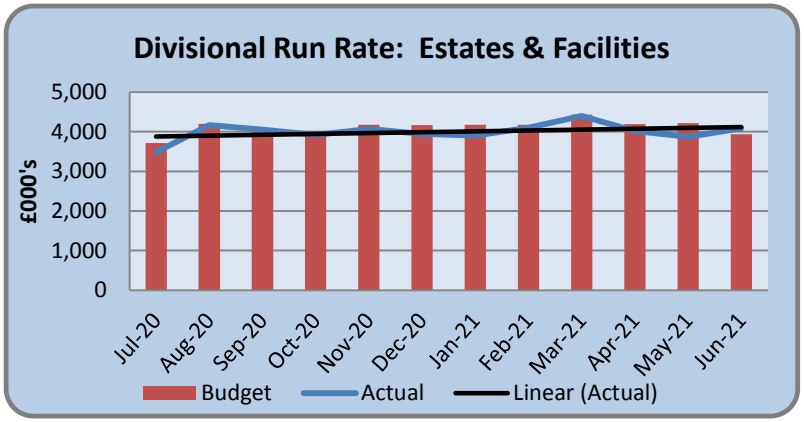
	Weston		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	(9)	257	266
Other Activity Based Income	39	0	(39)
Other Operating Income	567	495	(72)
Total Operating Income	**598**	**752**	**155**
Nursing and Midwifery	(7,752)	(7,439)	312
Medical Staff - Consultants	(2,897)	(3,429)	(532)
Medical Staff - Others	(2,832)	(3,286)	(454)
Other Clinical Staff	(918)	(964)	(46)
Non Clinical Staff	(1,679)	(1,487)	192
Other Pay	67	0	(67)
Total Employee Expenses	**(16,011)**	**(16,606)**	**(595)**
Drugs	(2,240)	(2,295)	(55)
Clinical Supplies	(1,101)	(1,142)	(42)
Support Funding			0
Other Non Pay	(887)	(688)	199
Total Other Operating Expenses	**(4,228)**	**(4,125)**	**103**
Net Surplus/(Deficit)	**(19,642)**	**(19,978)**	**(337)**

Financial Performance – Divisional Position

NHS University Hospitals Bristol and Weston NHS Foundation Trust

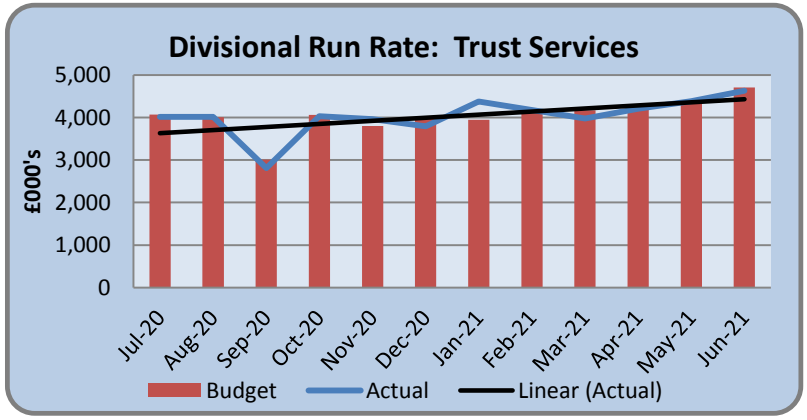
June 2021

	Estates & Facilities		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	0	0	0
Other Activity Based Income	0	0	0
Other Operating Income	1,086	1,078	(8)
Total Operating Income	**1,086**	**1,078**	**(8)**
Nursing and Midwifery	(1)	(2)	(1)
Medical Staff - Consultants	0	0	0
Medical Staff - Others	0	0	0
Other Clinical Staff	(2)	(1)	1
Non Clinical Staff	(7,119)	(7,040)	79
Other Pay			0
Total Employee Expenses	**(7,122)**	**(7,043)**	**79**
Drugs	0	0	0
Clinical Supplies	(107)	(107)	0
Support Funding	0	0	0
Other Non Pay	(6,198)	(5,897)	301
Total Other Operating Expenses	**(6,305)**	**(6,004)**	**301**
Net Surplus/(Deficit)	**(12,341)**	**(11,969)**	**372**



Estates & Facilities:

- Favourable variance to date £372k
- Significant favourable variance on energy due to the impact of the CHP programme savings initiative.
- Favourable variance on savings programme of £54k.
- Both pay and non pay run rates show only minor variability across months.



Trust Services:

- Favourable variance to date £116k.
- Main driver for favourable variance is a high number of vacancies in Finance and Digital services in particular.
- Shortfall on savings programme of £144k.
- Increase in non pay run rate due to immigration surcharges and education costs.
- Pay run rate increasing due to additional cost of management support to Weston Division.

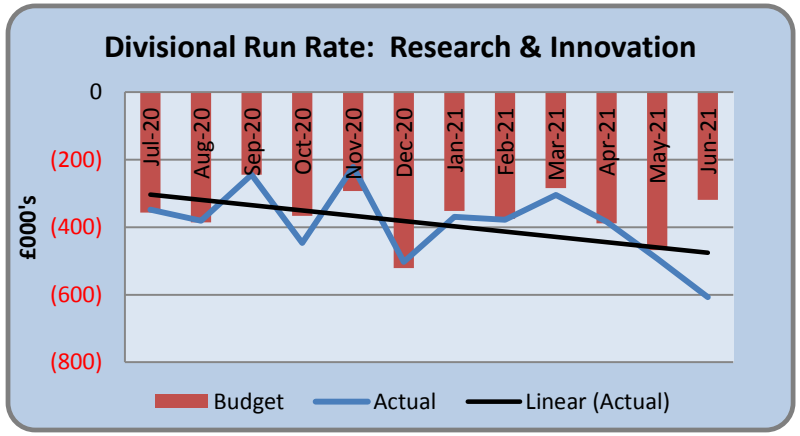
	Trust Services		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	0	0	0
Other Activity Based Income	0	0	0
Other Operating Income	1,297	1,215	(82)
Total Operating Income	**1,297**	**1,215**	**(82)**
Nursing and Midwifery	(1,534)	(1,511)	23
Medical Staff - Consultants	(389)	(419)	(30)
Medical Staff - Others	(306)	(276)	30
Other Clinical Staff	(213)	(229)	(16)
Non Clinical Staff	(8,483)	(8,274)	209
Other Pay	(17)	0	17
Total Employee Expenses	**(10,942)**	**(10,709)**	**233**
Drugs	(4)	(3)	1
Clinical Supplies	(118)	(59)	59
Support Funding	0	0	0
Other Non Pay	(3,577)	(3,672)	(95)
Total Other Operating Expenses	**(3,699)**	**(3,734)**	**(35)**
Net Surplus/(Deficit)	**(13,344)**	**(13,228)**	**116**

Financial Performance – Divisional Position

NHS University Hospitals Bristol and Weston NHS Foundation Trust

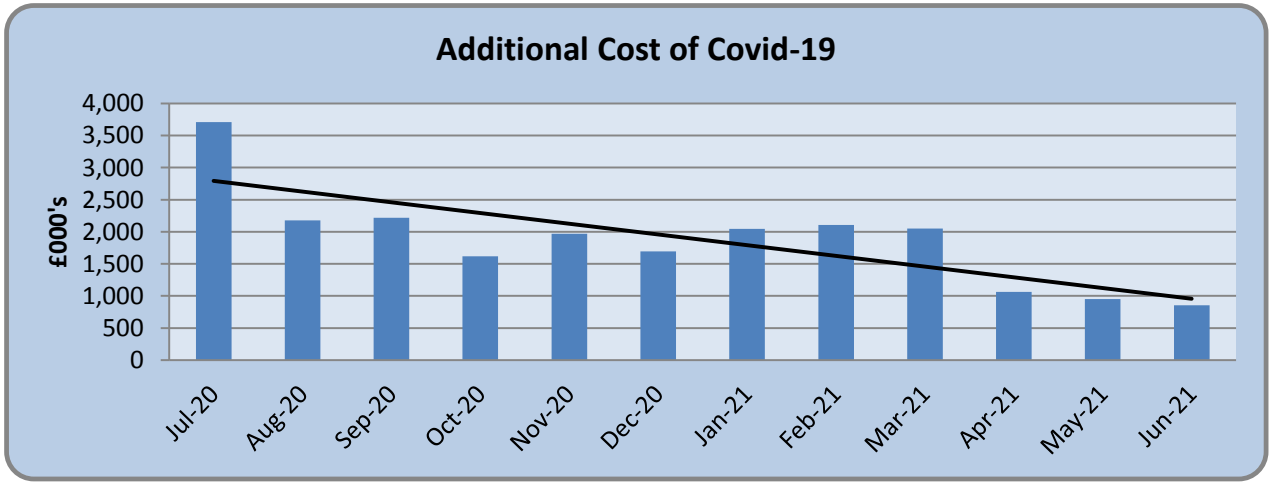
June 2021

	Research & Innovation		
	Plan £000's	Actual £000's	Variance Favourable /(Adverse) £000's
Activity Based Income SLA	0	0	0
Other Activity Based Income	0	0	0
Other Operating Income	8,484	7,800	(684)
Total Operating Income	**8,484**	**7,800**	**(684)**
Nursing and Midwifery	(265)	(241)	23
Medical Staff - Consultants	(141)	(98)	43
Medical Staff - Others	(30)	(25)	5
Other Clinical Staff	(28)	(13)	15
Non Clinical Staff	(787)	(836)	(49)
Other Pay	(111)	0	111
Total Employee Expenses	**(1,361)**	**(1,213)**	**148**
Drugs	0	0	0
Clinical Supplies	(558)	(3)	554
Support Funding	0	0	0
Other Non Pay	(5,389)	(5,099)	290
Total Other Operating Expenses	**(5,947)**	**(5,102)**	**845**
Net Surplus/(Deficit)	**1,176**	**1,485**	**309**



Research & Innovation:

- Favourable variance to date £309k.
- NIHR grant income and spend lower than planned.



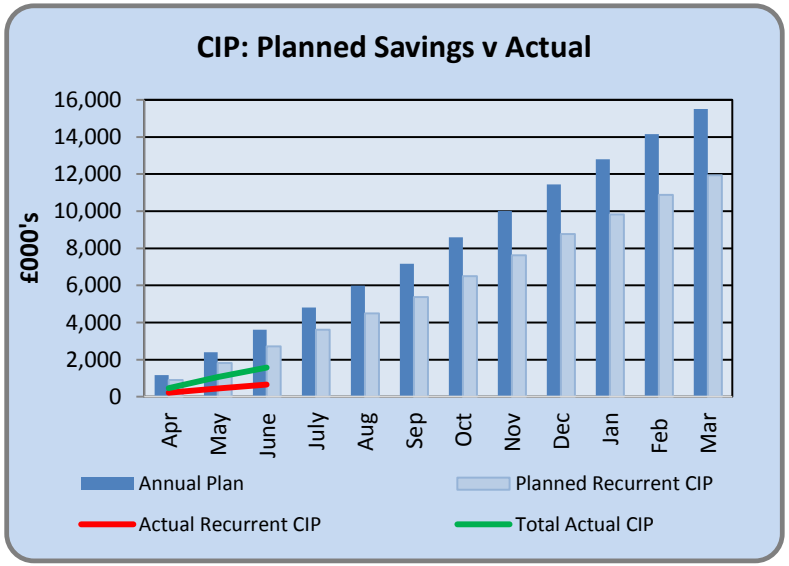
Covid-19 Expenditure:

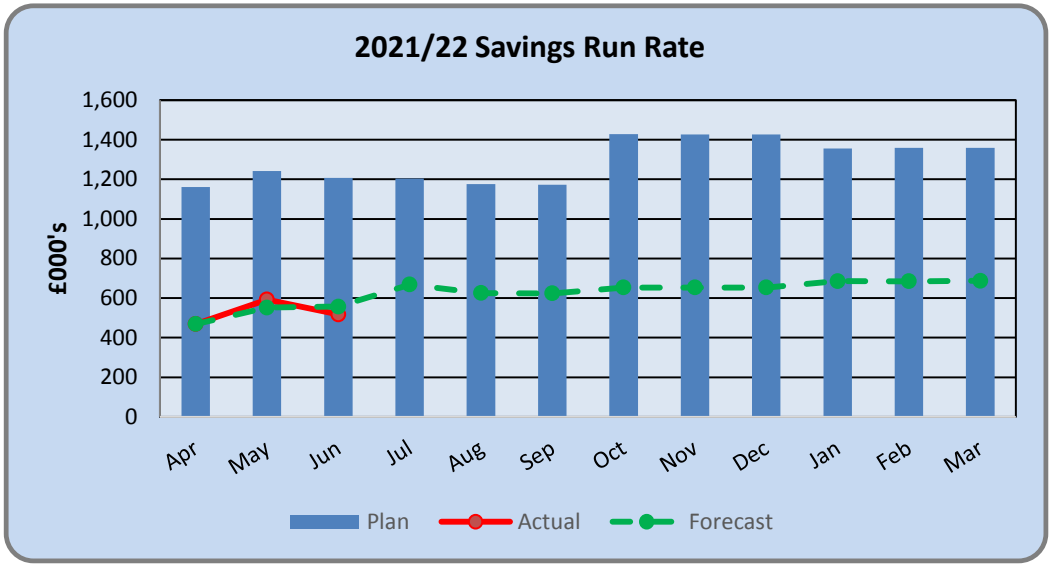
- Expenditure related to Covid-19 is £855k in June, against a forecast of c£1,000k.
- In comparison to previous months there is a downward trend.
- The expenditure is largely driven by non-pay costs including the provision of the vaccination hub.

Savings – Cost Improvement Programme

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2021





Workstream	2021/22 Annual Target £000's	M3 Year to Date Plan £000's	M3 Year to Date Actual £000's	M3 Year to Date Variance Fav/ (Adv) £000's	Forecast Outturn £000's
Nursing Pay	200	50	28	(23)	125
Medical Pay	65	25	20	(5)	45
Non-Pay & Procurement	3,890	1,018	995	(24)	4,035
Productivity	50	5	5	-	50
HR Pay and Productivity	18	4	-	(4)	18
Income, Fines and External	35	9	25	16	100
Medicines	499	111	149	38	696
Allied Healthcare Professionals	24	6	6	0	25
Estates & Facilities	805	258	258	-	805
Trust Services	364	93	93	-	364
Weston Merger	2,500	625	-	(625)	1,250
Plans to be developed from Pipeline	7,065	1,405	-	(1,405)	-
Total	**15,515**	**3,609**	**1,578**	**(2,031)**	**7,513**

Key Points:

- 2021/22 savings target is £15,515k.
- At the end of June the Trust has achieved savings of £1,578k against a plan of £3,609k; an underachievement of £2,031k.
- Divisions behind plan include Weston (£667k), Surgery (£548k), Women's and Children's (£491k), Specialised Services (£149k), Medicine (£145k) and Trust Services (£144k). Diagnostics & Therapies and Estates and Facilities have a favourable position of £59k and £54k respectively.
- Of the £2,031k adverse variance, £1,405k relates to plans to be developed from the savings pipeline and £626k is due to slippage on identified schemes.
- The full year forecast is £7,513k or 48%, £8,002k adverse to the plan of £15,515k. £3,757k is recurrent.
- Work is underway to identify additional projects which will deliver the required level of savings on a recurrent basis.

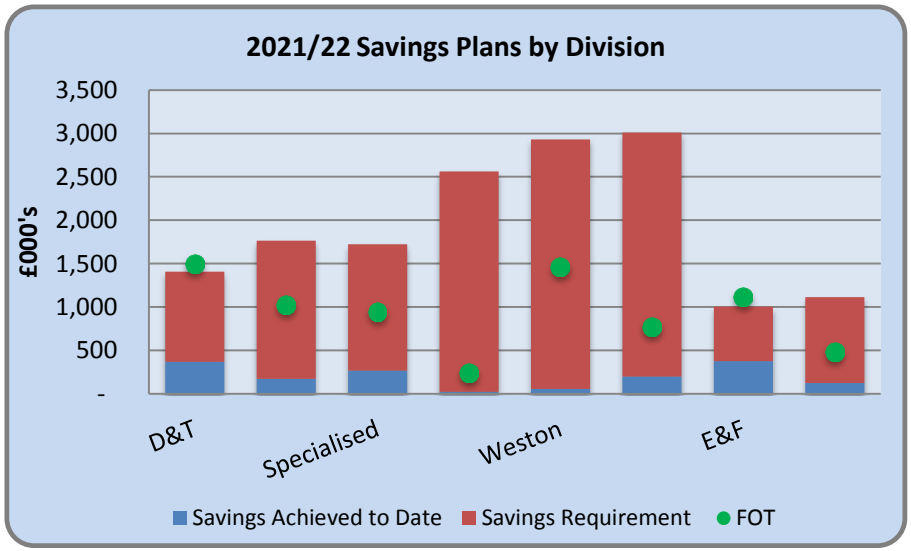
Savings – Divisional Position

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

Division	2021/22 Annual Target £000's	M3 Year to Date Plan £000's	Actual £000's	Variance Fav/ (Adv) £000's	Forecast Outturn £000's
Diagnostics & Therapies	**1,408**	307	366	**59**	**1,498**
Medicine	**1,765**	319	173	**(145)**	**1,023**
Specialised Services	**1,724**	415	266	**(149)**	**942**
Surgery	**2,561**	570	22	**(548)**	**235**
Weston	**2,930**	722	55	**(667)**	**1,456**
Women's & Children's	**3,009**	689	198	**(491)**	**769**
Estates & Facilities	**1,004**	321	375	**54**	**1,110**
Finance	**202**	47	23	**(24)**	**84**
Human Resources	**232**	52	23	**(28)**	**92**
Trust Headquarters	**387**	87	28	**(59)**	**113**
Digital Services	**292**	80	48	**(32)**	**136**
Misc Support Services	**0**	0	0	**0**	**56**
Total	**15,515**	**3,609**	**1,578**	**(2,031)**	**7,513**

Division	2021/22 Annual Target £000's	Forecast Outturn Recurring £000's	Non Recurring £000's	Total £000's
Diagnostics & Therapies	**1,408**	5	1,493	**1,498**
Medicine	**1,765**	584	438	**1,023**
Specialised Services	**1,724**	169	774	**942**
Surgery	**2,561**	179	56	**235**
Weston	**2,930**	1,420	37	**1,456**
Women's & Children's	**3,009**	202	566	**769**
Estates & Facilities	**1,004**	1,031	79	**1,110**
Finance	**202**	31	53	**84**
Human Resources	**232**	20	72	**92**
Trust Headquarters	**387**	10	102	**113**
Digital Services	**292**	50	85	**136**
Corporate	**0**	56	0	**56**
Total	**15,515**	**3,757**	**3,756**	**7,513**



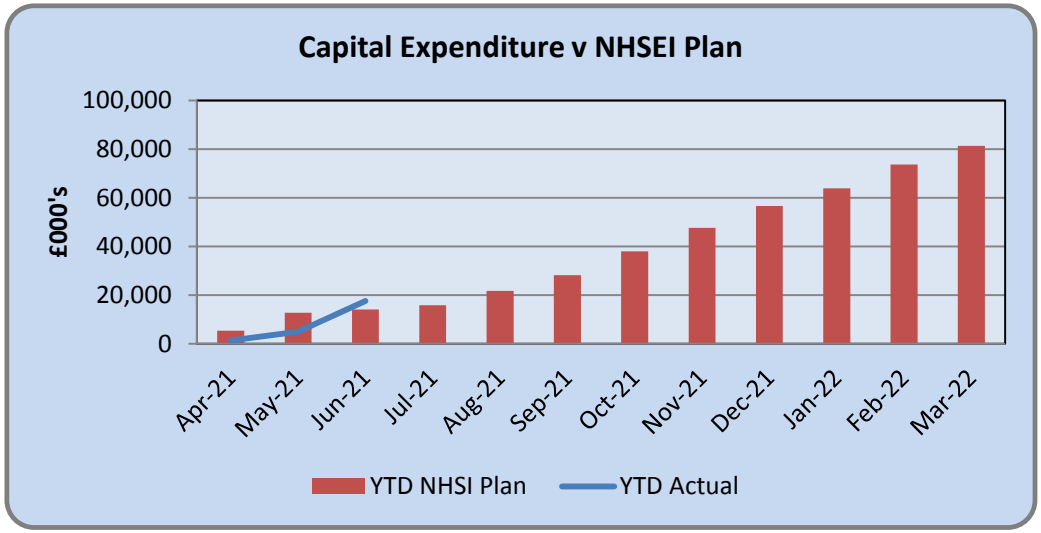
Recovery Actions:

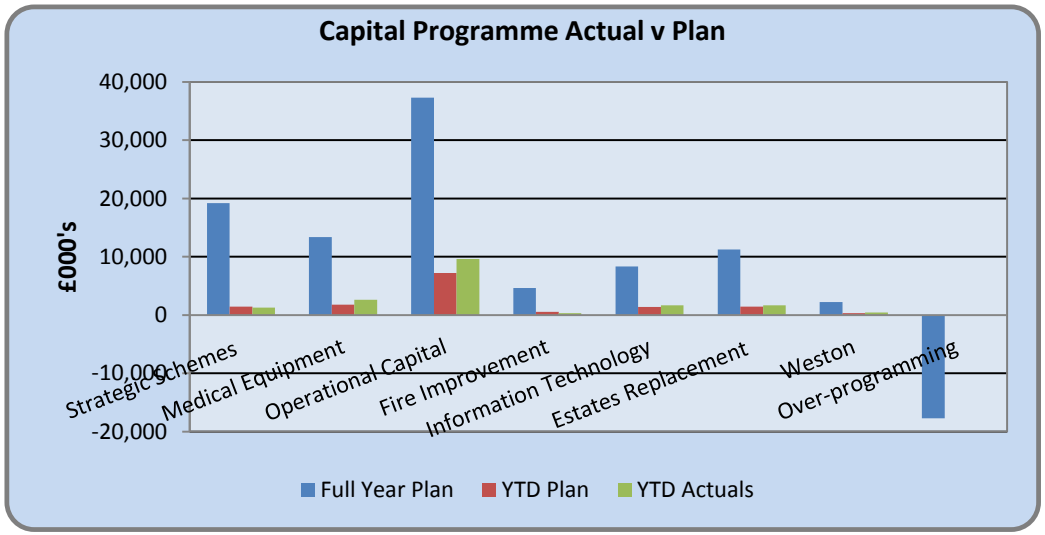
- The new payment regime means the focus must shift to cost reduction and removal of unwarranted variation.
- Urgent requirement to re-engage operational and clinical staff in delivering the Trust's required efficiency target of £15,515k.
- Greater accountability for the delivery of savings is required through the following groups: Cost Savings Delivery Board, Regular Divisional Savings Reviews, Working Smarter Forums, Drugs and Pharmacy Group, Medical Staffing and GIRFT.
- Developing transformation projects which will deliver recurrent savings.
- Re-establish Trust Non Pay Group and Task & Finish Groups.
- Paper to Finance & Digital Committee updating approach to developing the 2021/22 Savings Programme.

Capital – Capital Programme Summary

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021





Capital Plan 2021/22	Full Year Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
Inside STP Envelope:				
UHBW Funded	51,144	7,526	8,522	996
PDC Funded	3,149	500	960	460
Total Inside Envelope	**54,293**	**8,026**	**9,482**	**1,456**
Outside STP Envelope:				
PDC Funded	6,893	2,142	451	(1,691)
Grants/Donations	17,339	3,955	7,687	3,732
Total Outside Envelope	**24,232**	**6,097**	**8,138**	**2,041**
Total Capital Programme	**78,525**	**14,123**	**17,620**	**3,497**

Key Points:

- Internal plan of £78,525k recently agreed at SLT, and compliant with the system capital envelope. Further work is required to profile the plan across the year.
- YTD expenditure at the end of June is £17,620k, £3,497k ahead of revised NHSEI plan. The variance is primarily due to the Salix Decarbonisation project being ahead of plan.

Five Year Plan:

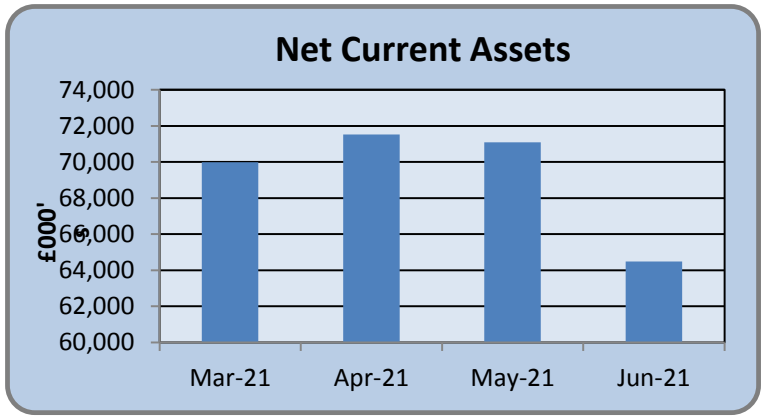
- The Trust has to submit a five year capital plan that is then prioritised by the system, to NHSEI in mid-October.
- The first submission is in July with revisions in August and September. The final submission is due in October.
- Early indications are that the five year plan will exceed the Trust's capital envelope (and therefore the system envelope) as a result of the Trust's strategic investment plans.

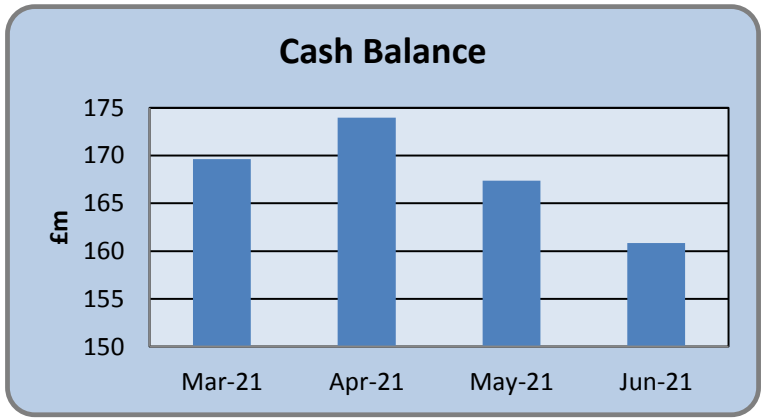
Financial Position - Balance Sheet

NHS University Hospitals Bristol and Weston NHS Foundation Trust

June 2021

As at 31 March 2021 £000's		Actual Apr 2021 £000's	Actual May 2021 £000's	Actual Jun 2021 £000's	YTD Movement £000's
	Non-Current Assets				
514,070	Property, Plant and Equipment	513,253	514,544	525,102	**11,032**
12,617	Intangible Assets	12,271	11,977	11,715	**(902)**
1,802	Receivables	1,802	1,802	1,802	**0**
528,489	**Total Non-Current Assets**	**527,327**	**528,323**	**538,620**	**10,131**
	Current Assets				
12,638	Inventories	12,396	12,036	12,118	**(520)**
32,845	Trade and Other Receivables	31,955	36,371	56,694	**23,849**
2,074	PDC Dividend Receivable	2,074	2,074	2,074	**(0)**
169,644	Cash	173,967	167,366	160,856	**(8,788)**
217,201	**Total Current Assets**	**220,392**	**217,846**	**231,741**	**14,540**
	Current Liabilities				
(126,680)	Trade and Other Payables	(124,094)	(125,191)	(148,211)	**(21,531)**
(6,818)	Borrowings	(6,923)	(7,093)	(6,283)	**535**
(853)	Provisions	(842)	(838)	(841)	**12**
(12,854)	Other Liabilities	(17,006)	(13,627)	(11,917)	**937**
(147,205)	**Total Current Liabilities**	**(148,865)**	**(146,749)**	**(167,251)**	**(20,046)**
69,996	**NET CURRENT ASSETS (LIABILITIES)**	**71,527**	**71,097**	**64,490**	**(5,506)**
598,485	**TOTAL ASSETS LESS CURRENT LIABILITIES**	**598,854**	**599,420**	**603,110**	**4,625**
	Non-Current Liabilities				
(56,097)	Borrowings	(56,125)	(56,093)	(53,268)	**2,829**
(4,325)	Provisions	(4,314)	(4,301)	(4,289)	**36**
(60,422)	**Total Non-Current Liabilities**	**(60,439)**	**(60,394)**	**(57,557)**	**2,865**
538,063	**TOTAL ASSETS EMPLOYED**	**538,415**	**539,026**	**545,553**	**7,490**
312,135	Public Dividend Capital	312,135	312,135	312,135	**0**
150,139	Retained Earnings	150,682	151,474	158,188	**8,049**
75,704	Revaluation reserve	75,513	75,332	75,145	**(559)**
85	Other Reserves	85	85	85	**(0)**
538,063	**Total Taxpayers' Equity**	**538,415**	**539,026**	**545,553**	**7,490**





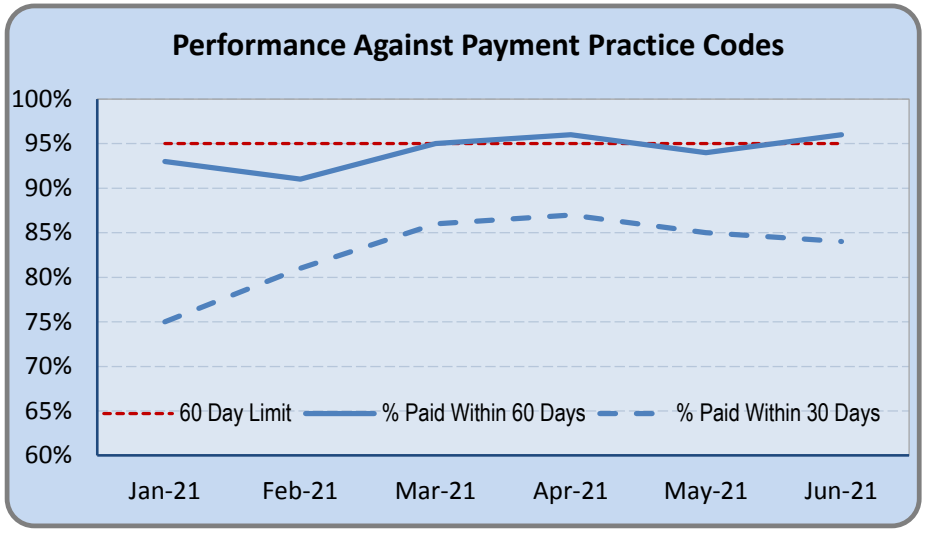
Key Points:

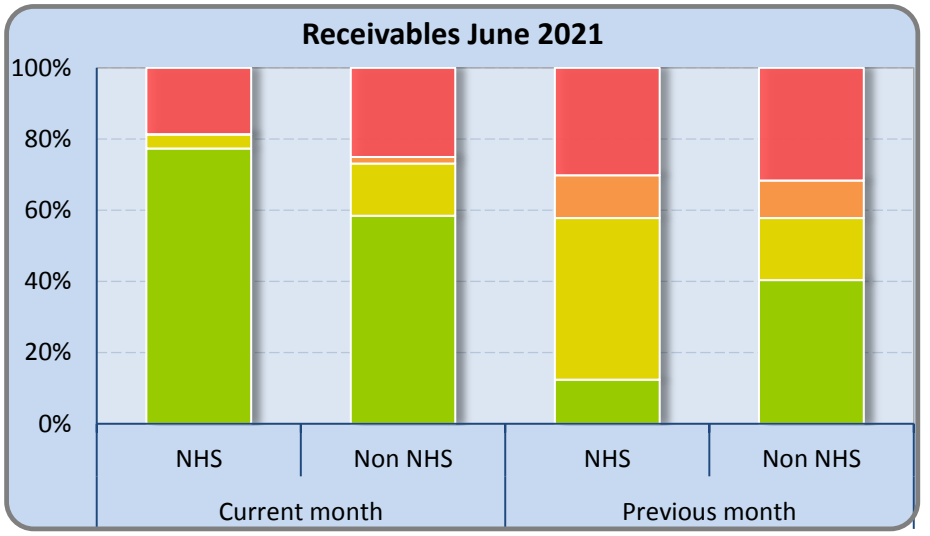
- Net current assets at the end of June are £64,490k. £6,607k lower than the previous month and £5,506k than the closing year end position.
- The deterioration in net current assets from 31st March 2021 is primarily driven by investment of retained cash balances in the capital programme with spend of £10,506k (excluding the Salix decarbonisation scheme).
- Total Taxpayer's Equity has increased by £7,490k, in line with the year to date surplus and grant received for the decarbonisation scheme.
- The cash balance at the end of June was £161m.

Financial Position - Payment Performance

University Hospitals Bristol and Weston NHS Foundation Trust

June 2021





Days	Current Month (£000's)			Previous Month (£000's)			Movement (£000's)		
	NHS	Non NHS	Total	NHS	Non NHS	Total	NHS	Non NHS	Total
90+	2,077	2,201	4,278	1,676	1,960	3,637	401	240	641
60-90	12	162	173	672	654	1,326	(660)	(493)	(1,153)
30-60	431	1,292	1,723	2,526	1,076	3,602	(2,095)	216	(1,879)
0-30	8,621	5,142	13,763	689	2,502	3,190	7,932	2,640	10,572
Total	**11,141**	**8,795**	**19,936**	**5,563**	**6,192**	**11,756**	**5,578**	**2,603**	**8,181**

Key Points:

- In June, 96% of invoices were paid within the 60 day Prompt Payments Code target and 84% within the 30 day Better Payment Practice Code.
- NHSEI are reviewing payment performances and will contact outlier trusts to understand the position
- The Trust currently pays all invoices on authorisation, regardless of payment terms. The Head of Transaction Services is looking at what further actions the Trust could take to improve the performance position.

Recovery Actions:

- The Trust will need to produce an action plan to recover payment performance above 85% against the Better Payment Practice Code as required by NHSEI.

Appendix 1 – Action Log & Developments

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Summary of Recovery Actions

Ref	Date	Description of Action	Action Owner	Date Due	Date Closed	Status	Revised date	Update
001	Jun-21	Understand the drivers for the reduction in bank expenditure.	ADFSC&I	Jul-21				
002	Jun-21	Understand the drivers for the increase in agency costs in June, particularly Tier 4 usage and understand what further controls can be implemented to mitigate spend.	ADFSC&I	Jul-21				
003	Jun-21	The Trust will need to consider extending its recruitment campaign of overseas nurses.	DoFI	Aug-21				
004	Jun-21	The Trust continues to implement plans to sustain medical staffing gaps in the Weston Division	DoFI	Aug-21				
005	Jun-21	Assessment of costs associated with the delivery of ERF income will be undertaken in month 4.	DDoF	Jul-21				
006	Jun-21	Urgent requirement to re-engage operational and clinical staff in delivering the Trust's required efficiency target of £15,515k.	HoFM&I	Aug-21				
007	Jun-21	Establish greater accountability for the delivery of savings is required through the following groups: Cost Savings Delivery Board, Regular Divisional Savings Reviews, Working Smarter Forums, Drugs and Pharmacy Group, Medical Staffing and GIRFT.	HoFM&I	Sep-21				
008	Jun-21	Develop transformation projects which will deliver recurrent savings.	HoFM&I	Jan-22				
009	Jun-21	Re-establish Trust Non Pay Group and Task & Finish Groups.	HoFM&I	Aug-21				
010	Jun-21	Paper to Finance & Digital Committee updating approach to developing the 2021/22 Savings Programme.	HoFM&I	Sep-21				
011	Jun-21	The Trust will need to produce an action plan to recover payment performance above 85% against the Better Payment Practice Code as required by NHSEI	HoFS	Sep-21				
012	Jun-21	Bridging of pay expenditure from March 2020, review and understand the pay variance against budget for Women's & Children's Division	HoFM&I	Sep-21				
013	Jun-21	Reassess the financial implications of the financial arrangements relating to the merger.	DDoF	Oct-21				
014	Jun-21	Present the Trust Five Year Financial Strategy	DDoF	Oct-21				

Summary of Future Developments/Amendments to the Report

Ref	Date	Description of Development	Action Owner	Committee Month
1	Jun-21	Inclusion of cashflow statement	HoFS	Aug-21
2	Jun-21	Further data on reason for agency cover and Tier 4 agency usage	ADFSC&I	Aug-21
3	Jun-21	Inclusion of a summary of the STP financial position	ADFSC&I	Oct-21

Key:

Role	Description	Name
DoFI	Director of Finance & Information	Neil Kemsley
DDoF	Deputy Director of Finance	Jeremy Spearing
HoFM&I	Head of Financial Management & Improvement	Dean Bodill
ADFSC&I	Associate Director of Finance - Strategic Change & Innovation	Kate Herrick
HoFS	Head of Financial Services	Catherine Cookson

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on 29 July 2021

Report Title	**Appointment of a Nominated Trustee on the Board of Trustees of Above & Beyond**
Report Author	**Eric Sanders, Director of Corporate Governance**
Executive Lead	**Robert Woolley, Chief Executive**

1. Report Summary

To propose a replacement to the Trust nominated Trustee on the governing body of Above & Beyond following the resignation of the Medical Director.

2. Key points to note

(Including decisions taken)

- The Trust is entitled to nominate a Trustee to the Board of Above & Beyond through the Deed of Understanding agreed as part of the move of Above & Beyond to independent status.
- This role has been undertaken by the Medical Director, but following his resignation, the Board needs to consider a replacement.
- It is proposed that the Chief Nurse take on this role when the Medical Director leaves.

3. Risks

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

The risks associated with this report include:

If Above & Beyond does not align its strategy with the Trust, there is a risk that the Trust is not able to maximise the opportunity from charitable funds to deliver its strategy and specifically support our staff and provide care to patients. The nominated Trustee provides this connection and provides clinical insight to inform the charity's strategy.

4. Advice and Recommendations

*(Support and Board/Committee decisions requested)***:**

- This report is for **Approval.**

The Board is asked to approve the nomination of Deirdre Fowler, Chief Nurse, to be a Trustee on the governing body of Above & Beyond.

5. History of the paper

Please include details of where paper has previously been received.

N/A	

Appointment of a UHBW nominated Trustee on the Board of Trustees of Above & Beyond

1. Purpose

1.1. To propose a replacement to the Trust nominated Trustee on the governing body of Above & Beyond following the resignation of the Medical Director.

2. Context

2.1. At the point of moving Above & Beyond to independent status, the Board of Directors agreed a Deed of Understanding, which provided the Trust the opportunity to nominate a Trustee to the Board of Above & Beyond. This is in section 2.1.4:

> 2.1.4 (…the Receiving Charity shall): confer on the NHS Foundation Trust the power to nominate a trustee to the board of the Receiving Charity; and

2.2. The Trust has nominated the William Oldfield, Medical Director, to be a Trustee on the Board of Above & Beyond and the Trustees approved Bill's appointment. Following his resignation, the Board now need to propose a new appointment to the Board.

2.3. In addition to the nominated Trustee, the Trust has an Executive lead for our charity relationships, the Director of Strategy and Transformation. That role is to coordinate strategic and operational discussions between the Trust and our charity partners, including ensuring alignment between fundraising and strategic projects.

3. Proposed Appointment

3.1. Following discussions, it is proposed that Deirdre Fowler, Chief Nurse, be the nominated Trustee on the Board of Above & Beyond. Above & Beyond have been keen to retain senior clinical input into their Board of Trustees and the proposed nomination would support this.

3.2. Deirdre Fowler has indicated her willingness to undertake the role when Bill steps down.

3.3. The Board of Above & Beyond will need to approve the appointment, if agreed by the Board of Director of UHBW.

4. Recommendation

4.1. The Board is asked to approve the nomination of Deirdre Fowler, Chief Nurse, to be a Trustee on the governing body of Above & Beyond.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**UHBW EPRR Annual Report**
Report Author	**John Wintle , Resilience Manager**
Executive Lead	**Mark Smith, Deputy Chief Executive/ Chief Operating Officer**

1. Report Summary

This report is to give assurance that the Trust is meeting its statutory civil protection duties under the Civil Contingencies Act, 2004 and NHSE/I contractual conditions of service in relation to Emergency Preparedness, Resilience and Response. This paper outlines activity over the past 12 months, and is to inform on the process undertaken in order to deliver a business continuity management system.

2. Key points to note

(Including decisions taken)

The Trust remains substantially compliant with the NHS England Core Standards for EPRR. In the previous financial year the Trust has continued to responded to the ongoing Covid-19 pandemic.

The report lists a summary of key risks as well as training and exercising undertaken over the time period. Priorities for this year in conjunction with Covid19 response and recovery include;

- Continued alignment of the new UHBW organisation into Trust's EPRR plans,
- Continuing to ensure delivery of training in the emergency departments for the on-going CBRN training programme.
- Support in the delivery of a shelter and evacuation training schedule Trust wide with certified fire advisors.
- Design and deliver a Trust wide business continuity training programme to support Trust preparedness and resilience
- Support to develop a system wide mass counter measure distribution plan, taking learning from mass vaccinations centres set up from Covid19 response
- Embed EPRR into the development of the new "Integrated care system" to shape future local, regional and national preparedness actions.

This report has been presented to the civil contingencies steering group where it has been agreed to be presented to Audit Committee before progressing to Public Board to fulfil the request of the committee to understand business continuity management.

3. Risks

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

The risks associated with this report include:

199 - Risk that incidents at Massed Gatherings event could cause disruption to Trust operational services

210 - Risk to Trust business and operations as a result of adverse weather conditions e.g. ice and snow

800 - Risk that Trust operations are negatively impacted by (COVID-19) pandemic

802- Risk that a heatwave could have adverse impact on UHBW business and operations

1909- Risk that the Trust is unable to respond to major or business continuity incidents in periods of extreme escalation

2031 - Risk that contaminated patient self-presenting to one of the Trusts Emergency Departments is not identified **2453-** Risk that outdated major incident plans would not deliver a coordinated network response to a major incident
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.**

Civil Contingencies Steering Group	**13 July 2021**
Quality and Outcomes Committee	**26 July 2021**
Audit and Assurance Committee	**26 July 2021**

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V0.1

Emergency Preparedness, Resilience and Response

Annual Report 2020 – 2021

Prepared by: **John Wintle,** Resilience Manager

Presented by: **Mark Smith,** Chief Operating Officer and Accountable Emergency Officer

Executive Summary

The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect the safe and effective operation of the Trust's services. These could be anything from severe weather to an infectious disease outbreak or a major transport accident.

Under the Civil Contingencies Act (2004), NHS organisations must show that they can effectively respond to emergencies and business continuity incidents while maintaining critical services to patients. This work is referred to in the health service as Emergency Preparedness, Resilience and Response (EPRR).

The Civil Contingencies Act 2004 (CCA) places a number of statutory duties on NHS organisations which are classed as either Category 1 or Category 2 responders.

Category 1 responders are those organisations at the core of an emergency response. As a Category 1 responder, University Hospitals Bristol and Weston NHS Foundation Trust (the Trust) is required to prepare for emergencies in line with its responsibilities under;

- The Civil Contingencies Act 2004,
- The Health and Social Care Act, 2012, and
- NHS England Core Standards for Emergency Preparedness Resilience and Response 2019.

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The NHS Core Standards for EPRR cover ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

In addition to the civil protection duties of the CCA 2004, the Trust must ensure it is compliant with Service Condition 30 of the NHS Standard contract (2020/2021) for Emergency Preparedness, Resilience and Response as outlined below:

- Comply with EPRR Guidance if and when applicable.
- Identify and have in place an Accountable Emergency Officer.
- Notify the Co-ordinating Commissioner as soon as reasonably practicable and in any event no later than 5 Operational Days following :

    a) The activation of its Incident Response Plan and/or Business Continuity Plan or;

    b) any risk or any actual disruption to Commissioner Requested Service (CRS) or Essential Services.

Part of the Trust is positioned centrally in what is known as a 'Core' city. This position places an even greater emphasis on there being robust up to date emergency plans in place. This report outlines the position of the Trust in relation to Emergency Preparedness, Resilience and Response and how the Trust will meet the duties set out in legislation and associated guidance, as well as any other issues identified by way of risk assessments and identified capabilities.

The Trust was rated sustainably compliant to the EPRR core standards in the annual assurance process for 2020/2021.

The impact of responding to the Covid19 worldwide pandemic has halted much of the business as usual activity for EPRR. The focus for the next year will be on ensuring the restoration of a solid base line from which to progress. This will be a datum point above the minimum requirements for NHSE/I core standards and shape UHBW as an exemplar of indicators of good practice to bench mark from.

Strategic priorities for 2021/2022

The new organisation	Continued alignment of the new UHBW organisation into Trust's EPRR plans.
NHSE/I Assurance process	Maintain substantial compliance in the 2021 EPRR assurance process
Training	Continuing to ensure delivery of training in the emergency departments for the on-going CBRN training programme. Support in the delivery of a shelter and evacuation training schedule Trust wide with certified fire advisors. Design and deliver a Trust wide business continuity training programme to support Trust preparedness and resilience
System working	Support to develop a system wide mass counter measure distribution plan, taking learning from mass vaccinations centres set up from Covid19 response.
Shaping the future	Embed EPRR into the development of the new "Integrated care system" to shape future local, regional and national preparedness actions.

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V0.1

Acronym's and Definitions

Acronym	Definition
AEO	Accountable Emergency Officer – at UH Bristol and Weston this is the Chief Operating Officer & Deputy Chief Executive
BCPG	Business Continuity Planning Group *(Internal Group)*
CBRN	Chemical, Biological, Radiological and Nuclear
CCSG	Civil Contingencies Steering Group *(Internal Group)*
EPRR	Emergency Preparedness, Resilience and Response
IRPG	Incident Response Planning Group *(Internal Group)*
ISO 22301	International Standardisation Organisation *(the International Standard for Business Continuity Management)*
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
NED	Non-Executive Director
OCMF	On Call Managers Forum *(Internal Group)*
SWASFT	South Western Ambulance Service NHS Foundation Trust

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V0.1

Contents

Title:	Emergency Preparedness Resilience And Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V0.1

1. Introduction

1.1 Purpose

This report outlines the Trust's EPRR activities during the period April 2020 to March 2021 that relate to the requirements of the Civil Contingencies Act 2004, its associated regulations, statutory and non-statutory guidance.

The report is presented to the University Hospitals Bristol and Weston NHS Foundation Trust Board in line with the requirements of the NHS Core Standards for Emergency Preparedness, Resilience and Response.

1.2 Background

The Civil Contingencies Act 2004 (CCA) sets out a single framework for civil protection in the United Kingdom. The CCA provides a statutory framework for civil protection at a local level and divides local responders into two categories depending on the extent of their involvement in civil protection work, and places a set of duties on each.

Category 1 responders are those organisations at the core of emergency response. Acute Trusts are identified as Category 1 responders and are subject to the full set of civil protection duties.

The Trust is therefore required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning,
- Put in place emergency plans,
- Put in place business continuity plans,
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency,
- Share information with other local responders to enhance co-ordination,
- Co-operate with other local responders to enhance co-ordination and efficiency.

In addition to the civil protection duties of the CCA 2004, the Trust must ensure it is compliant with Service Condition 30 of the NHS standard contract (2020/2021) for Emergency Preparedness, Resilience and Response as outlined below:

- Comply with EPRR guidance if and when applicable.
- Identify and have in place an Accountable Emergency Officer.
- Notify the Co-ordinating Commissioner as soon as reasonably practicable and in any event no later than 5 operational days following :
  a) The activation of its Incident Response Plan and/or Business Continuity Plan or;
  b) any risk or any actual disruption to Commissioner Requested Service (CRS) or Essential Services.

As a Category 1 responder, University Hospitals Bristol and Weston NHS Foundation Trust is required to prepare for emergencies in line with its responsibilities under;

The Health and Social Care Act, 2012, and

NHS England Core Standards for Emergency Preparedness Resilience and Response 2019.

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet. **(Appendix 1)**

The NHS Core Standards for EPRR cover ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

1.3 National and local Context

Across the NHS, the Covid-19 pandemic has resulted in continued pressure on all services and has highlighted the need for robust plans that are scalable, fit for purpose and that dovetail across the health and social care economy.

The majority of business as usual activity for the NHS stopped completely in the first quarter of 2020 as the NHS responded to the first wave of pandemic in the UK and the national lockdown. During this time the two organisations University Hospitals Bristol NHS Foundation Trust and Weston Area Heath NHS Trust merged to form the new organisation University Hospitals Bristol and Weston NHS Foundation Trust which brought unique challenges whilst responding to the nationally led pandemic.

Restoration of services and recovery from the first wave was the focus for the second quarter, whilst the NHS simultaneously prepared for the next wave of the pandemic. The outbreak at Weston Hospital resulted in its closure and the diversion of admissions into the wider health system, utilising the principles of the Avon and Somerset Health Community response plan and a system approach to the response.

The second wave of the pandemic hit the UK in the third quarter of 2020 with a second national lockdown implemented on November 4. As case rates exceeded that of the first wave, the demand for critical care beds resulted in mutual aid across regions with UHBW supporting across the south of England for critical care capacity.

Routine lateral flow testing for asymptomatic staff and the national vaccination programme began during this period.

The final quarter of 2020/2021 saw hospital admissions due to covid19 falling considerably across the UK with the vaccination programme targeting vulnerable groups of people and key workers. The government road map identified 19 July 2021

as the target date for easing all covid19 restrictions subject to a review of case rates, critical care pressures and deaths within 28 days of a positive Covid19 test result.

The impact on the EPRR work plan both nationally and locally was understood and accepted by NHSE/I, however, as the UK prepares to enter recovery a renewed focus and vigour for national and organisational preparedness is emerging with a move to retain collaborative working across the NHS. Within this approach regional and local system planning has been highlighted.

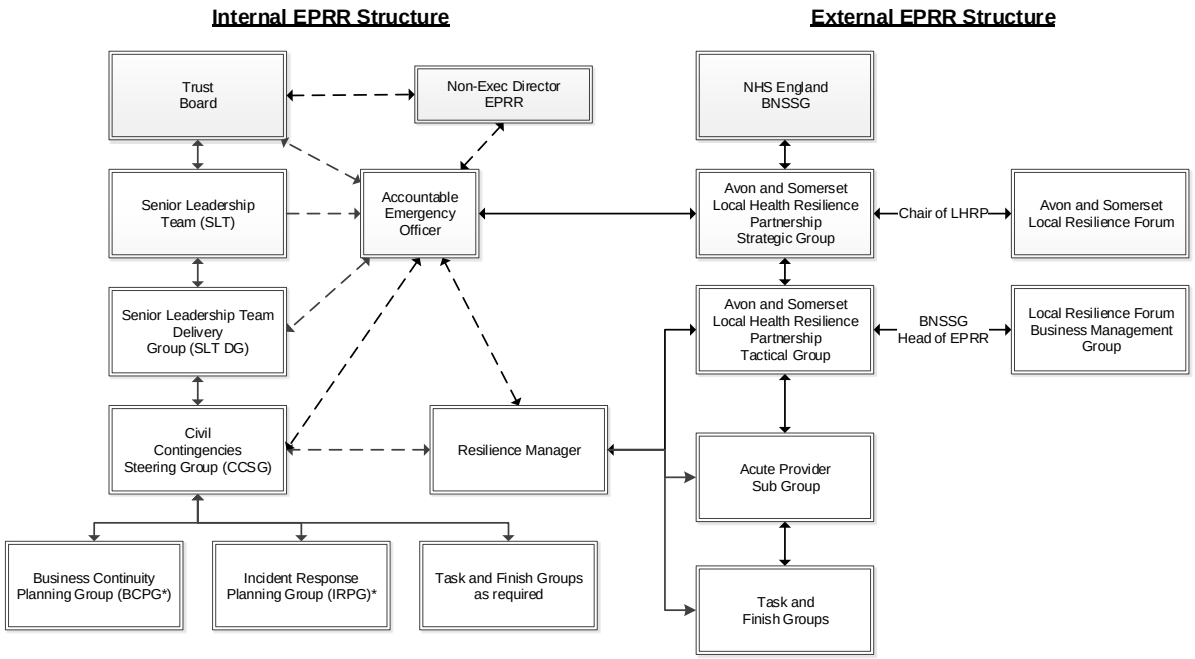
This focus gives an added importance to ensuring the Trust meets its statutory obligations and is able to provide high Standards of patient care when responding to incidents.

2. Governance and Assurance

EPRR within the Trust is overseen by the Deputy Chief Executive and Chief Operating Officer (COO) who acts as the Emergency Accountable Officer (AEO), supported by a Non-Executive Director (NED) to give impartial challenge to the organisation. There is a Resilience Manager at 1.0 WTE 8a, reporting to the Deputy Chief Operating Officer for Urgent Care, who will be supported by an EPRR Officer at band 5 1.0 WTE (currently out to advert).

The COO chairs the Civil Contingencies Steering Group which drives the EPRR agenda. Under this group are two substantive working groups chaired by the Resilience Manager.These are the Incident Response Planning Group and the Business Continuity Planning Group. The work of both groups was impacted by Covid19 and the Trust incident response, which required an all staff reaction

The diagram below represents the internal and external Emergency Planning, Resilience and Response (EPRR) governance structure.



*The incident response planning group did not meet in the financial year 2020/2021. The group is due to recommence 7 July 2021.*The Business continuity planning group recommenced meeting in Nov 2020 and has continued to meet quarterly since

In the 2020 NHS England EPRR Core Standards review the Trust was deemed to be substantially compliant for both the Bristol and Weston sites. This audit process was amended to account for the pressure due to Covid19 and required the Trust to complete a focused self-assessment against each of the core standards for EPRR concentrating on any gaps from the previous year. This self-assessment was subsequently reviewed by NHS England and the Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group and a final rating assigned. (**See Appendix 2** for BNSSG CCG system assurance outcomes).

3. Risk Assessment

This section details how the Trust is complying with the duty to undertake risk assessments for the purpose of informing contingency planning activities.

3.1 Community Risk Register

University Hospitals Bristol and Weston NHS Foundation Trust contributes to the development and maintenance of the Avon and Somerset Community Risk Register (CRR) by the Resilience Manager attending the NHS England Avon & Somerset Local Health Resilience Partnership (Tactical Group) where, amongst other areas, health related risks to the community are reviewed and updated.

3.2 Trust Risk Register

The Civil Contingencies Steering Group maintains an EPRR Risk Register for risks identified relating to EPRR. Risks assessed as scoring 12 or above are reviewed by the Trust Risk Management Group and Trust Board.

ID	Title	Description	Rating (inherent)	Controls in place	Adequacy of controls	Rating (current)	Rating (Target)
199	Risk that incidents at Massed Gatherings event could cause disruption to Trust operational services	If an incident occurred at massed gathering events in Bristol E.g. St Paul's Carnival, Bristol Balloon, Ashton Court, Maritime Festival, Bristol Half Marathon Then this could cause severe pressure on operational services Resulting in a major incident declaration impacting on the Trusts ability to operate normally	4= Moderate Risk	The Trust has in place Incident Response and Mass Casualty plans, these plans are exercised annually in line with the requirements of the Civil Contingencies Act 2004. The Trusts resilience manager receives notifications from the Safety advisory group of both Bristol city council and North Somerset council on planned events and the mitigations that will be in place.	Adequate	4 = Moderate Risk	4 = Moderate Risk

210	Risk to Trust business and operations as a result of adverse weather conditions e.g. ice and snow	If Adverse weather occurs including ice and snow then this can cause disruption to travel networks and infrastructure resulting in potential slips and falls or impact on the ability of staff and patients to travel to site	9= High Risk	Internal resources for gritting roads and paths within all sites. Relationship with Community Pay Back teams to provide additional gritting and snow clearance., Monitoring weather reports from the MET Office to flag any deterioration in weather and trigger severe weather plan (as appropriate), emergency access to Wessex 4x4 to provide 4x4 capability to for the purposes of saving life in times of adverse weather, The Trust has a severe weather plan in place.	Adequate	6 = Moderate Risk	6 = Moderate Risk
800	Risk that Trust operations are negatively impacted by (COVID-19) pandemic	If there is a national pandemic influenza outbreak (including any Novel Respiratory Disease such as COVID-19), Then there may be a significant increase in staff sickness rates at a time when activity is likely to increase and time pressures increase Resulting in the Trust being under severe pressure and operationally disrupted.	25 = Very High Risk	The Trust has a comprehensive Pandemic Influenza plan that was developed in consultation with PHE, other local health providers and internally the DIPC and communicable Disease planning group. This is being utilised for planning for the covid-19. A management group is overseeing the response reporting to ODG and SLT with a number of sub-groups managing specific work streams. Divisional leads have also been appointed to coordinate divisional planning and cascade information to staff. TOR for group attached. COVID-19 specific risks being reviewed by the group alongside specific action plans to close gaps and mitigate risks.	Adequate	12 = High Risk	9 = High Risk

802	Risk that a heatwave could have adverse impact on UHBW business and operations	Heatwave - Resulting in prolonged periods of raised temperatures within trust premises that may potentially impact on attendances, admissions, patient condition and staff working environment	9 = High Risk	The Trust has a heatwave plan that is updated annually following heatwave guidance from NHSE, Receive and assess Met Office weather reports and cascade to operational planning teams as necessary. Internal temperature monitoring in place and process for obtaining temporary air conditioning also in place.	Adequate	6 = Moderate Risk	6 = Moderate Risk
1909	Risk that the Trust is unable to respond to major or business continuity incidents in periods of extreme escalation	If there are extreme bed pressures in an extended period of a major or catastrophic internal or external incident then the Trusts business continuity response may be hampered resulting in delay to normal operations	12 = High Risk	Ensure effective and up to date business continuity plans/escalation plans to deliver a coordinated and timely response. Other work to reduce the impact also includes winter planning work and up to date and effective incident response plans.	Adequate	6 = Moderate Risk	6 = Moderate Risk
2031	Risk that contaminated patient self-presenting to one of the Trusts Emergency Departments is not identified	If Patent(s) self-presenting to Weston or the Adult or Children's Emergency Departments In Bristol are contaminated by an unknown substance (either chemical, biological, radiological or nuclear from a malicious incident or an industrial accident) and if the patient is not identified and decontaminated then they pose an increased risk to themselves as well as the other staff and patients within the department resulting in patient harm, staff harm and disruption to normal operations	5 = Moderate Risk	The Trust has a Chemical, Biological, Radiological and Nuclear (CBRN) response plan which covers the Adult and Children's ED in Bristol with a separate plan for the Weston site to account for the geographical and Estate differences. Key elements covered in these are: - Actions on identification and isolation of a potentially contaminated patient(s) - Contact details to access specialist advice - PPE for staff - Decontamination protocols including wet and dry decontamination processes - Quarterly training and maintenance for specialist CBRN kit	Adequate	3 = Low Risk	3 = Low Risk

2453	Risk that outdated major incident plans would not deliver a coordinated network response to a major incident	If a large scale incident were to happen then there is the risk of a lack of coordination across these networks if capacity was stretched beyond individual Trusts ability to respond. Whilst the Trust, and other neighbouring Trusts, have major incident plans the equivalent plans for the trauma, critical care and burns network are not up to date. Resulting in significant impact to trauma, critical care and burns services and delayed treatment.	9 = High Risk	The Trust is working with networks to inform local planning as well as supporting the networks develop and update their plans. Work includes support to a Burns network Emergo exercise, developing a casualty distribution plan with Severn trauma network and support to the critical care network in development of their plans.	Adequate	4 = Moderate Risk	4 = Moderate Risk

4. Maintaining Plans

This section details the activities undertaken to develop and maintain arrangements for responding to a major incident. Planning activities are ongoing, informed by identifying risks as per the above risk register and the guidance available from NHSE/I (**Appendix 3).**

4.1 Incident Response Plan

The Incident Response Plan (formerly the Major Incident Plan) has been reviewed to ensure the new organisation of UHBW is reflected. The plan is split into four parts to allow for individual updates to action cards and sites. This makes the plan iterative in its use but not affecting the overall response, responsibilities and command and control structure. A large part of the plan was reviewed the previous year (2019-2020) and focused on areas of the Trust previously not engaged in planning, with roles included for the bereavement team, clinical psychologists, psychiatry liaison, the resuscitation team and therapy services among others.

There is now a focused need to ensure that as part of the recovery from Covid19 impacts on the EPRR work programme, including training and exercising within the Trust is returned robustly and in place ongoing, to support organisational preparedness to implement the plan if required.

4.2 Severe Weather Plan

The severe weather plan was revised to ensure a Trust wide response, taking lessons learned and capabilities from the Covid19 response to create the formation of a logistics cell. This cell consists of a team from Human Resources, the Temporary Staffing Bureau and the Finance Department to manage requests seven days per week for staff transportation and accommodation, working with partners from Trust estates, residencies, Bristol Ambulance and local hotels at both Bristol and Weston. This concept allows key response staff to manage the response tactically whilst the logistics cell manage the continued supply of staff and goods across the Trust. The concept is

scalable and dovetails in to the local resilience forum concept of operations for a logistics cell in preparedness to the response to a wider emergency in Avon and Somerset.

4.3 Escalation plan

The Trust escalation plan was updated to include Weston Hospital, split into three parts to have one overarching strategic plan and site specific tactical plans for both Bristol and Weston. This work tried to include Covid19 however the fluidity and rapidly changing need for beds for Covid19 positive and non-covid19 patients proved to be a challenge, and as such the Covid19 escalation response was managed through separate ward and critical care plans. The inpatient escalation plan is reviewed six monthly with the latest review having commenced in June 2021. Once again a separate covid19 escalation plan that reflects the demand and identifies predetermined areas to surge into will exist outside of the business as usual adult inpatient escalation plan so that both will be reflective of the real time reality and can be used in both tandem and in isolation.

The following plans have expired whilst responding to covid19 and are the priority focus in recovery from the pandemic;

4.4 Shelter and Evacuation plan - Weston Division

The Trust has an in-date Shelter and Evacuation plan that identifies areas where patients can be moved to and that follows the principles of horizontal evacuation as per the Trust's and individual site's fire plans for Bristol sites.
Weston Hospital's whole-site evacuation plan has expired during the response to covid19 and is in need of review to update and include covid19 secure areas and a robust training programme to ensure all staff are aware of the process. The plan and capabilities to support a site evacuation needs to take account of the particular staffing challenges for the Weston site. The resilience manager is exploring the use of an "off the shelf" capability that requires minimal training and maintenance that uses familiar concepts of daily the activities of staff if deployed.

4.5 Mass countermeasure plan

Learning from system working as part of the Covid19 pandemic and the standing up of Mass vaccination Centres within UHBW and in the community, has highlighted the need for more integrated system planning. Health partners within BNSSG are scheduled to meet in early July to begin work on an integrated care system plan approach that will be localised per organisation. For UHBW this will follow the success of the concepts and locations used for the Trust mass vaccination programme.

4.6 Hazmat/CBRN response plan

This plan is a site specific response plan in the event of an incident involving the release and public exposure to hazardous materials (Hazmat) due to an accident or deliberate attack using Chemical, Biological, Radioactive or Nuclear materials (CBRN) . Each site plan reflects the geography and locations of key capabilities including emergency department opening times at Weston and the response outside of these hours.

New guidance issued November 2020 from the national ambulance resilience unit needs to be incorporated into the updated plan which is under review as of June 2021. This is scheduled for the Incident Response Planning Group 7 July to progress to Civil Contingencies Steering Group for sign off 13 July 2021.

5. Business and Service Continuity Planning

This section details the Trust's activities to develop, maintain and embed arrangements to ensure the continuity of service provision during an emergency or other disruption.

This standard for Business Continuity (BC) that has been adopted worldwide is known as ISO22301. NHS Specific supporting guidance is available to supplement the principles of the international standard **(Appendix 4)**

Over the course of 2020-21 there has been a continued focus on ensuring plans are updated to adhere to this standard, as well as being fit for operational use at the service delivery level. The template for BC plans across the Trust has been revised to include the requirements of this standard in addition to learning from incidents to ensure that clear escalation pathways and communication of disruptive incidents is embedded in all plans

BC Planning requirements are part of the annual NHSE/I EPRR assurance process, with UHBW rated as being substantially compliant. With the support of Divisional leads and the Business Continuity Planning Group, the ongoing review and updating of the plans is monitored by the Resilience Manager. Incidents and ongoing actions from debriefs are regularly reviewed by the group alongside other business continuity related agenda items.

The Trust will be audited in 2021-2022 by a third party appointed by the Executive team and the Trust audit committee to review the current position and provide recommendations for any gaps identified.

BC training and awareness is not currently included routinely as part of the Trust induction process. This is as a result of streamlining the induction in response to the pandemic and delivering training in the virtual space. The resilience manager is working with the corporate education team to explore options for embedding this going forwards. In addition, the resilience manager has commenced a clinical divisions project to increase awareness of staff already in post as a "catch all" exercise due to be completed August 2021. The focus will then move to non-clinical divisions for the remainder of 2021.

5.1 Aligning all plans to reflect the new UHBW organisation

The business continuity management system in place for UHBW ensures that all BC plans are reviewed as an ongoing piece with existing plans aligning to reflect the new UHBW organisation. This includes the removal of South Bristol Community Hospital inpatients bed responsibility but ensuring that the estate ownership is reflected in plans. The division of Weston BC planning alignment is included as part of the 2021-2022 EPRR work plan and the strategy for divisional declarations of preparedness.

5.2 Alignment of On Call structures post Trust merger

Prior to the creation of University Hospitals Bristol and Weston NHS Foundation Trust on 1st April 2020 work was undertaken to ensure the Trust's on call manager systems were aligned. Through 2020-2021a task and finish group was set up to align custom

and practice for on call manager teams, in particular the harmonisation of Weston's out of hours duty manager role to move to an on call role and to ensure that remuneration is mirrored across the Trust for on call managers'. A review of membership to the on call rota was undertaken to expand the team at Weston with the aim to move duty matrons from this rota in order to provide greater resilience to both the on-call manager and the duty matron rota.

5.3 EU Exit planning for "End of transition period"

Following the UK leaving the EU in early 2020, for the financial year the Trust had been planning for impacts related to the end of transition period and impacts of new border controls in place from 1 January 2021 and delays in supply chain. To support the planning for this, the Trust's previous EU Exit Planning Group was re- established. Specific work included re-assessing the Trust's supply chains for products and medicines which came through the EU, and developing mitigations for any deemed high risk. The end of transition period was managed and planned for as a business continuity incident using existing escalation and reporting structures internally, and aligned to national planning assumptions and national command and control.

UK Mutual aid was required on a single occasion to support UHBW cancer services due to a delay of equipment being held at the ports. The mitigation plans prepared ensured that targeted radio therapy procedures for outpatients continued with no impact to patients or cancelled appointments as a result. There were no other issues as a result of the end of the transition period for the financial year. The next key date being 30 June 2021 when the deadline for EU settled status passes. The workforce and communications cell of the Trust's EU exit planning group has continued to remain sighted on this date, has been following national guidance and monitoring our EU national workforce numbers. Actions undertaken include supporting applications for settled status, delivering workshops for staff and running communications regularly to staff to ensure the workforce remains robust.

6. Training and Exercising

Guidance set out by NHSE/I, stipulates that exercises must be carried out and provides a time frame for the type and frequency of exercises. See Table 1 below

Exercise type	Minimum Frequency	Undertaken
Communications exercise	6 monthly	Delivered 27th April 2021
Tabletop	12 monthly	Not required as completed in live incidents
Live play	3 yearly	Nov 2019
Command Post	3 Yearly	2020-2021

Table 1: EPRR exercises and frequency
(Adapted from NHS England, 2015)

The response to covid19 has fulfilled the command post and table top requirements where the Trust had in place command and control structures and an incident co-ordination centre at both Weston Hospital and Bristol.

Below is a summary of EPRR training and exercising which has taken place over the past year:

- Weston Hospital ED, BRI ED and the Children's ED Major Incident leads are supported by the Resilience Manager to facilitate regular training for ED personnel in both Major Incidents and decontamination of contaminated casualties. This training also includes training about safely donning and doffing the Powered Respirator Protective Suit (PRPS) which is a one piece, gas tight, chemical protective suit for use by emergency response personnel after a CBRN incident.
- On Call Managers continue to have a monthly forum to review on call matters; this forum has also been used as a training vehicle for sessions on "defensibly recording decisions" and "leadership in emergencies" training.
- Exercise "Swifty Chase" is a major incident communications cascade test that was designed in March 2021 and delivered at the end of April 2021 and is now on a six month cycle as a Trust wide exercise involving both Bristol and Weston switchboards.

7. Warning and Informing

As a Category One responder under the Civil Contingencies Act 2004 the Trust has a "duty, in partnership with others to warn and inform the public of emergencies".

The Trust Communications Team continues to work in partnership with NHS England and the CCG to inform and warn the public when circumstances warrant it. The Communications Team issue messages either directly or in collaboration with the CCG and Public Health England and are part of a local network of NHS Communications Teams. In the event of a major incident NHS England would ensure communications are coordinated and will link into the Trust communications department.

During the Covid-19 response this was implemented with the Trust communications department feeding into the regional and nationally coordinated communications response led by NHS England and Improvement.

8. Cooperation

This section details how the Trust would normally engage with regional EPRR planning groups noting that all of these planning groups were stood down as part of the health and multi-agency response to Covid-19 and replaced by incident response co-ordination groups into which the Trust was embedded.

6.1 Local Health Resilience Partnerships (LHRP)

The Local Health Resilience Partnership, chaired by NHS England, brings together all NHS organisations to ensure coordinated and joined up planning across Avon and Somerset.

There is a strategic group that would meet quarterly and is attended by the Accountable Emergency Officers (AEO) from all organisations in the Avon and Somerset area. The Deputy Chief Executive & Chief Operating Officer is the UHBW Accountable

Emergency Officer (AEO) supported by the Deputy Chief Operating Officer for Urgent Care. This group defines the strategic direction, the priorities and actively monitors the progress of the Tactical Planning Group.

For the Covid19 response this group became the strategic coordination group (Health Gold) and was the link to the local resilience forum strategic response group with CCG's generally representing health partners.

The Tactical Planning Group would also meet quarterly and would be attended by the Resilience Manager. It is this group that develops the Avon and Somerset local health community overarching emergency plans and delivers against the Strategic Group work programme.

This group became a hybrid model of a tactical co-ordination group in response to Covid and was split into an operational (Bronze) Co-coordinating group and Tactical (Silver) group to include Health and social care partners to deliver the strategic objectives required to preserve and protect life.

6.2 Local Health Resilience Partnership Sub-groups

There are normally a number of LHRP subgroups and task and finish groups; membership of these groups is dependent on the area of focus of the group. For example there is an acute provider sub-group focussing on planning and issues which solely affect acute hospitals. The Resilience Manager was the chair of this group until the group was stood down in response to Covid19 to focus on response actions.

6.3 Local Resilience Forum (LRF)

The LRF is a statutory planning group attended by Category 1, 2 and uncategorised responders in Avon and Somerset, as defined by the Civil Contingencies Act 2004. Health is normally represented by NHS England, which acts in the interests of all providers. This group also informs some of the planning activity undertaken by the LHRP.

For covid19 this group became the multi-agency co-ordinating response group and was a two tier response group: strategic (Chief Executive level) and Tactical (subject matter specialists such as public health and EPRR Professionals and CCG Director level attendees). UHBW was represented directly in these groups as part of the wider regional response and hybrid nature of the pandemic response.

9. Recent Major or Significant Events

The Trust has experienced the following emergency incidents and disruptive events whilst responding concurrently to the pandemic during the April 2020 to March 2021 period.

Title	Date
Weston Hospital Covid outbreak	25/05 -18/06/2021
Bristol Site Power Outage	19/08-20/8/2020
BRHC Loss of Theatres	21/09-25/09/2020
Critical Incident due to bed capacity	26/10-30/10/2020
Critical Incident due to bed capacity	Dec 2020
Weston Hospital Covid outbreak	31/12/2020 – 15/01/2021
EU Exit End of transition	Jan 2021
Bristol Eye Hospital mains water leak	11/02/2021
Digital Services disruption	31/03-1/04/2021

Debriefs have been undertaken as part of the EPRR policy with learning and lessons identified being used to improve the Trust's response.

10. Conclusions

2020/21 has been a year where the focus has been very much to respond to the worldwide pandemic of Covid19, mitigating the impacts to patients and supporting staff to deliver a sustained response with all but the minority of business as usual EPRR work put on hold..

Restoration of services and the "new normal" will require great focus for the organisation with EPRR being integral to having a resilient organisation.

EPRR Strategic Priorities for the upcoming year are:

- Maintain substantial compliance in the 2021 EPRR assurance process
- Continuing to deliver training in the emergency departments for the ongoing CBRN training programme
- Design and deliver a Trust wide business continuity training programme to support Trust preparedness
- Integrate Weston Hospital into the shelter and evacuation plan and support the delivery of a training schedule Trust wide with fire advisors.
- Support to develop a system wide mass counter measure distribution plan, taking learning from mass vaccinations centres set up from Covid19 response.
- Continued alignment of the new UHBW organisation into Trust's EPRR plans.
- Embed EPRR into the development of the new "Integrated care system" to shape future local, regional and national preparedness actions.

Preparing for Emergencies in the NHS in England

NHS

NHS Core standards for emergency preparedness, resilience and response guidance

NHS England and NHS Improvement

NHS Core standards for EPRR guidance

Publishing Approval Reference: 000719

Version number: 5.0

First published: 2013

Updated: June 2019

Prepared by: Emergency Preparedness Resilience and Response national

The NHS England Core Standards for EPRR may be referred to as the NHS Core Standards for EPRR in guidance documentation.

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact national EPRR team on england.eprr@nhs.net

Contents

1 Introduction

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

The NHS Core Standards for EPRR set out the minimum requirements expected of providers of NHS funded services in respect of EPRR.

1.1 Purpose

The purpose of the NHS Core Standards for EPRR are to:

- enable health agencies across the country to share a common approach to EPRR
- allow coordination of EPRR activities according to the organisation's size and scope
- provide a consistent and cohesive framework for EPRR activities
- inform the organisation's annual EPRR work programme.

2 Relevant legislation and guidance

The Civil Contingencies Act 2004 and the NHS Act 2006, as amended by the Health and Social Care Act 2012, underpin EPRR within health. Both Acts place EPRR duties on NHS England and the NHS in England.

Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS funded services to comply with the EPRR Framework and other NHS England guidance.

3 EPRR annual assurance process

The NHS England and NHS Improvement Board has a statutory requirement to formally assure its own and the NHS in England's, readiness to respond to emergencies. This is provided through the EPRR annual assurance process and assurance report. This report is submitted to the Department of Health and Social Care, and the Secretary of State for Health and Social Care.

As the NHS Core Standards for EPRR provide a common reference point for all organisations, they provide the basis of the EPRR annual assurance process.

Providers of NHS funded services complete an assurance self assessment based on these core standards. This assurance process is led by NHS England and NHS Improvement via the Local Health Resilience Partnerships (LHRP).

4 NHS Core Standards for EPRR

The NHS Core Standards for EPRR cover ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans

4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

The applicability of each domain and core standard is dependent on the organisation's function and statutory requirements.

An eleventh domain is only applicable to NHS Ambulance Trusts and covers the 'interoperable capabilities' they must have in place.

4.1 Governance

A policy statement, outlining the organisation's commitment to deliver EPRR, must be in place. This statement should be supported by an annual EPRR work programme to ensure all NHS Core Standards for EPRR are delivered.

Organisations must have an appointed Accountable Emergency Officer (AEO) who is a board level director and responsible for EPRR in their organisation. This person should be supported by a non-executive board member.

4.2 Duty to risk assess

Organisations should have provision in place to regularly assess the risks to the population it serves. This process should consider the community and national risk registers.

A supporting risk management system must be in place to ensure a robust method of reporting, recording, monitoring and escalating EPRR risks.

4.3 Duty to maintain plans

Appropriate and up to date plans must set out how the organisation plans for, responds to and recovers from major incidents, critical incidents and business continuity incidents. These should be developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.

4.4 Command and control

A robust and dedicated EPRR on call mechanism should be in place to receive notifications relating to EPRR. This facility should be 24 hours a day, 7 days a week, and provide the ability to respond or escalate notifications to executive level.

Personnel performing the on call function should be appropriately trained in major incident response.

4.5 Training and exercising

EPRR training should be carried out in line with a training needs analysis to ensure staff are competent in their role.

Arrangements must be exercised through, as a minimum, a:

- communications exercise every six months
- table top exercise once a year
- live exercise every three years
- command post exercise every three years.

4.6 Response

Staff trained in incident response should be available to respond to incidents from within an Incident Coordination Centre (ICC). This includes having processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings. These arrangements should also include an alternative ICC, should the primary location be affected by the incident itself or be unavailable at the time of response.

4.7 Warning and informing

Tested processes should be in place for communicating with partners and stakeholders, and warning and informing public and staff when responding to major incidents, critical incidents and business continuity incidents.

Organisations should also have an appropriate media strategy to enable communication with the public. This should include identification of and access to trained media spokespeople able to represent the organisation.

4.8 Cooperation

Arrangements should be in place to share appropriate information with stakeholders. This includes participation in Local Health Resilience Partnerships (LHRPs) to demonstrate engagement and co-operation with other responders.

4.9 Business continuity

Up to date business continuity plans setting out maintenance of critical activities when faced with disruption should be in place within each organisation. These planning arrangements should be aligned to current nationally recognised business continuity standards.

4.10 Chemical, Biological, Radiological, Nuclear (CBRN) and Hazardous Materials (HAZMAT)

Acute, specialist, mental health and community healthcare providers are required to have planning arrangement in place for the management of CBRN incidents. NHS Ambulance Trusts also share this requirement and their specific responsibilities in relation to CBRN are set out in ‘Interoperable capabilities’.

4.11 Interoperable capabilities

NHS Ambulance Trusts in England are required to maintain a set of specialist capabilities. These capabilities are nationally specified under the NHS England EPRR Framework.

These capabilities are interoperable between services. They must be maintained according to strict national standards to ensure they can be combined safely to provide an effective national response to certain types of incidents.

The interoperable capabilities include:

- Hazardous Area Response Teams (HART)
- Marauding Terrorist Firearms Attack (MTFA)
- Chemical Biological Radiological Nuclear (CBRN)
- Mass Casualty Vehicles (MCV)
- Command and control
- Joint Emergency Services Interoperability Principles (JESIP).

5 Reviews and updates

The NHS Core Standards for EPRR are subject to an annual review. This review includes minor amends and updates according to recent learning and changes in legislation and/or guidance.

A full review of the core standards occurs every three years, involving consultation with a working group. This was last conducted in 2018.

Any amendments/recommendations to future NHS Core Standards for EPRR can be directed to: england.eprr@nhs.net

Our Reference: 20201207-BNSSG

Lisa Manson, Director of Commissioning and EPRR AEO, BNSSG Clinical Commissioning Group

Leigh Clarke, Head of EPRR
NHS England and NHS Improvement, South West

Email: leigh.clarke2@nhs.net

By email

07 December 2020

Dear Lisa and Janette,

Reference: BNSSG System Emergency Preparedness, Resilience and Response (EPRR) confirm and challenge review meeting 26 November 2020.

Thank you for the time and effort you have taken in preparing for this year's light touch EPRR Core Standard Assurance process under what are really challenging times.

In August 2020 NHS England and NHS Improvement cascaded a letter outlining the Emergency Preparedness, Resilience and Response (EPRR) annual assurance process to be used this year. In response to the light touch assurance approach, BNSSG CCG submitted provider summaries and a system overview report on the 05 November 2020 covering the core areas requested.

This letter summarises our EPRR assurance confirm and challenge meeting held virtually on MS Teams on the 26 November 2020. In our meeting we reviewed and questioned you on your statement of assurance which focused on:

1. Progress made by organisations that were reported as partially or non-compliant in the 2019/20 assurance process
2. The process you have adopted to capture and embed learning from the first wave of COVID-19, and
3. Inclusion of progress and learning in winter planning preparations.

You outlined the method you had adopted to assess your own organisation and that of your system, summarising current levels of assurance as follows:

Organisation	2019	2020
BNSSG Clinical Commissioning Group	Full	Substantial
Avon and Wiltshire Partnership NHS Foundation Trust (AWP)	Partial	Substantial
North Bristol NHS Trust (NBT)	Substantial	Substantial

Organisation	2019	2020
University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)	Substantial	Substantial
Severnside	Partial	Substantial
Sirona care and Health	Substantial	Substantial

Organisations providing services to BNSSG but assessed by a lead CCG on your behalf include;

Organisation	Assessed by	2019	2020
E-Zec	BSW CCG	Full	Full
SWAST	Dorset CCG	Full	Full
Care UK (111)	NHSEI National	Non-Compliant	TBC[1]

Confirm and Challenge Outcome:

Through the submission of your report and additional commentary provided during the confirm and challenge process, you were able to address the queries raised by NHSEI. We support your self-assessment assurance level and those of your system providers with no changes required.

NHSEI observations and reflections:

The BNSSG System under the leadership of BNSSG CCG has supported its partners in improving and sustaining high levels of assurance across its providers.

It is clear to see that system partners have worked collaboratively, learning from one another to maintain a flexible and adaptable posture in response to the demands of the COVID-19 as you head into winter and the end of the EU Transition period.

Areas requiring further monitoring:

North Bristol NHS Trust: EPRR Resource – A newly recruited EPRR manager had to withdraw their application leaving NBT without a full time EPRR Manager. Other internal resources have been identified to maintain the current COVID-19 response with mutual aid support being provided by BNSSG CCG. NHSEI SW would request that you continue to monitor this situation and escalate any concerns until a longer-term solution is found.

[1] Please note that the NHSEI National Team have not yet released their report on Care UKs assurance this year. As soon as it is available it will be emailed to you.

Listed within your submission was a series of short to medium term concerns associated with the non-delivery of some business-as-usual activities e.g., LHRP work programme, training programmes and LRF/LHRP community risk assessment. In line with a decision by the LHRP Executive Group on the 20 November 2020 to reduce activity, NHSEI SW would request that you monitor and escalate any concerns/issues through current response structures and/or the NHSEI SW EPRR Team as appropriate.

Areas of concern:

None identified.

Next steps:

The outcome of the confirm and challenge assurance process will be communicated to Local Health Resilience Partnership Executive members and submitted to the NHS England and Improvement National Team as part of the South West's EPRR Core Standards assurance process.

Actions:

1. NHSEI SW to support BNSSG CCGs request to re-categorise Mental Health and Community Providers as Category 1 responders under the Civil Contingencies Act 2004.
2. BNSSG CCG to work with NHSEI SW to support the use of modular training packages via NHS Futures and to discuss wider training support as appropriate.
3. BNSSG CCG to confirm in response to this letter whether you would like to challenge any elements of the confirm and challenge process.

Thank you again for your time and openness in undertaking the annual EPRR confirm and challenge process especially considering the current pressures and challenges faced by your system and the wider NHS.

Yours sincerely,

Mr Leigh Clarke, Head of EPRR, NHS England and NHS Improvement, South West

Summary of Published Key Guidance for Health Emergency Preparedness, Resilience and Response (EPRR)

Preparing for Emergencies in the NHS in England

Summary of Published Key Guidance for Health, Emergency Preparedness, Resilience and Response (EPRR)

Version number: v 3.0

First published: March 2015

Updated: March 2019

Prepared by: NHS England EPRR

Classification: OFFICIAL

This material should be read in conjunction with the NHS England Emergency Preparedness Framework. All material forming the guidance is web based and prepared to be used primarily in that format. The web-based versions of the Guidance including underpinning materials have links to complementary material from other organisations and to examples of the practice of and approach to emergency planning in the NHS in England.

The web version of the guidance is available at http://www.england.nhs.uk/ourwork/eprr/

Introduction

- For the attention of all NHS emergency preparedness, resilience and response (EPRR) personnel.
- The following charts give an overview of the key EPRR guidance documents currently published. These lists are not exhaustive.
- For published documents, web-site links are imbedded in the charts. ‘Mouse over’ the boxes to see the links and click on the boxes to open the hyperlink (whilst viewed as a slideshow).
- For general queries, to request information about inaccessible documents, or to suggest amendments please contact NHS England (National) EPRR Team at England.eprr@nhs.net

Key:

- NHS England published guidance
- PHE published guidance
- DHSC published guidance
- new guidance under development
- NARU published guidance
- Cabinet Office and other published guidance
- DH or NHS England extant published guidance currently being updated

NHS England

Business Continuity

- NHS England Business Continuity Management Framework (2013)
- NHS England Business Continuity Management Toolkit
- Cabinet Office: Business Continuity (web-page)
- ISO 22301 Business Continuity Management Systems (BCMS) - Requirements
- ISO 22313 Business Continuity Management Systems - Guidance

Guidance and Framework

- NHS England Emergency Preparedness Framework
- NHS England Core Standards for Emergency Preparedness, Resilience and Response
- Mutual Aid Guidance

Exercising

- Off the Shelf Exercises
- Cabinet Office: Exercises and training

Incident Response

- Incident Response Plan - National

Evacuation and Sheltering

- Planning for the evacuation and sheltering of people in health sector settings
- Hospital Evacuation Plan
- Community Evacuation Plan

Key:

- NHS England published guidance
- PHE published guidance
- DHSC published guidance
- new guidance under development
- NARU published guidance
- Cabinet Office and other published guidance
- DH or NHS England extant published guidance currently being updated

NHS England

HAZMAT & CBRN

- Chemical Incidents – Planning for the management of self-presenters in healthcare settings
- Guidance for the initial management of self presenters from incidents involving hazardous materials
- UK Reserve National Stock for Major Incidents – How to access stock in England
- PGDs for Hazmat and CBRN incidents
- CBRN Incidents: A Guide to Clinical Management and Health Protection
- Ambulance service guidance on dealing with radiological incidents and emergencies (Mar 2010)
- Radiation Monitoring Units
- NHS Guidance - Incidents Involving Radioactivity (1998)
- NARU: Initial Operational Response

Mass Casualty & Major Incidents

- Concept of Operations for the Management of Mass Casualties
- Clinical Guidance for Major Incidents
- Planning for the psychological and mental health care of people affected by major incidents and disasters
- NARU: Clinical Guidance Medical Support Minimum Requirements for a Mass Casualty Incident (Oct 2014)

Key:

- NHS England published guidance
- PHE published guidance
- DHSC published guidance
- new guidance under development
- NARU published guidance
- Cabinet Office and other published guidance
- DH or NHS England extant published guidance currently being updated

NHS England

Pandemic Influenza

- Operating Framework – Response to Pandemic Influenza
- Roles and Responsibilities of CCGs in Pandemic Influenza
- Pandemic Influenza – NHS guidance on the current and future preparedness in support of an outbreak (January 2017)
- The UK Influenza Preparedness Strategy
- PHE Pandemic influenza response plan
- Health and Social Care Influenza Pandemic Preparedness and Response (Apr 2012)
- Responding to Pandemic Influenza: The Ethical Framework for Policy and Planning (Nov 2007)
- Pandemic Flu: Managing Demand and Capacity in Health Care Organisations (Surge) (May 2009)
- Pandemic Influenza: Guidance on the Management of Death Certification and Cremation Certification (Aug 2008)

Surge and Escalation

- Management of Surge and Escalation in Critical Care Services SOPs for Critical Care, Burns Services and ECMO

Key:

- NHS England published guidance
- PHE published guidance
- DHSC published guidance
- new guidance under development
- NARU published guidance
- Cabinet Office and other published guidance
- DH or NHS England extant published guidance currently being updated

Reference Materials

- Information on FFP3 Respirators
- Information for LHRPs
- A Plan for NHS Blood and Transplant and Hospitals to address Red Cell Shortages August 2016
- A Plan for NHS Blood and Transplant and Hospitals to address Platelet Shortages August 2016
- NHS Guidance on Planning for Disruption to Road Fuel Supply: Strategic National Guidance NHS Organisations (Nov 2008)
- PHE: Cold Weather Plan for England (October 2017)
- PHE: Heatwave Plan for England (May 2017)
- PHE: Flooding Advice
- National Risk Register (2017)
- The Central Government's Concept of Operations (April 2013)
- Lexicon of UK Civil Protection Terminology (February 2013)
- Emergency Response and Recovery (October 2013)
- Emergency Preparedness: Guidance on Part 1 of the Civil Contingencies Act 2004, its associated Regulations and non-statutory arrangements (March 2012)
- Expectations and Indicators of Good Practice Set for Category 1 and 2 Responders (October 2013)
- Recovery Guidance Common Issues and Recovery Plan Template (November 2008)
- The role of Local Resilience Forums (July 2013)
- Enhanced SAGE Guidance: A strategic Framework for the Scientific Advisory Group for Emergencies (SAGE) (October 2012)
- Provision of Scientific and Technical Advice in the Strategic Co-Ordination Centre (STAC) - Guidance to Local Responders (April 2007)
- Strategic Framework and Policy Statement on Improving the Resilience of Critical Infrastructure to Disruption from Natural Hazards (March 2010)
- Home Office: Guidance on Dealing with Fatalities in Emergencies (2004)
- National Recovery Guidance - Humanitarian Aspects - Mass Fatalities

Updates since previous version

Amendment	Date	Made by:
Management of surge and escalation in critical care services: standard operating procedure for Adult and Paediatric Burn Care Services in England and Wales	August 2015	NHS England EPRR
Updated list of documents included, based on Framework and Guidance Review Process. Updated links.	November 2015	NHS England EPRR
Updated all links and document titles	December 2017	NHS England EPRR
Links updated PGD's summarised Exercising Added	March 2019	NHS England EPRR

NHS
Commissioning Board

NHS Commissioning Board Business Continuity Management Framework (service resilience)

THE NHS CONSTITUTION
the NHS belongs to us all

NHS Commissioning Board Business Continuity Management Framework

Date	7 January 2013
Audience	• NHS Commissioning Board directors of operations and delivery • NHS Commissioning Board regional directors • NHS Commissioning Board area team directors • NHS Trust and NHS Foundation Trust chief executives • Ambulance Service chief executives • Clinical commissioning groups • Accountable emergency officers.
Copy to	• Members of local health resilience partnerships (LHRPs) • NHS Commissioning Board emergency planning leads • Strategic Health Authority emergency planning leads.
Description	Please read this document in the context of: • NHS standard contracts • the NHS Planning Framework • the NHS Commissioning Board Emergency Planning Framework (2013).
Cross reference and links	http://www.commissioningboard.nhs.uk/eprr/ Further links are listed in section 7.
Action required	NHS organisations and providers of NHS funded care must be able to maintain continuous levels in key services when faced with disruption from identified local risks such as severe weather, fuel or supply shortages or industrial action. All NHS organisations and providers of NHS funded care must contribute to co-ordinated plans for emergency preparation and service resilience through their local health resilience partnerships.
Timing	As new health EPRR arrangements are introduced (by April 2013).
Contact details	NHSCB.EPRR@nhs.net NHS Operations, Quarry House, Leeds LS2 7UE.

Contents

1. Introduction

1.1. The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe weather to an infectious disease outbreak or a major transport accident.

1.2. Under the Health and Social Care Act 2012, the NHS Commissioning Board must be 'properly prepared for dealing with an emergency' and must monitor and control all service providers to make sure they too are prepared.

1.3. Under the Civil Contingencies Act (2004), NHS organisations and sub-contractors must show that they can deal with these incidents while maintaining services to patients. This work is referred to in the health community as 'emergency preparedness resilience and response' (EPRR).

1.4. NHS organisations and providers of NHS funded care must therefore be able to maintain continuous levels in key services when faced with disruption from identified local risks such as severe weather, fuel or supply shortages or industrial action.

1.5. Business continuity management (BCM) gives organisations a framework for identifying and managing risks that could disrupt normal service.

1.6. An organisation's business continuity management system (BCMS) helps it to anticipate, prepare for, prevent, respond to and recover from disruptions, whatever their source and whatever part of the business they affect.

1.7. Disruptions can be caused by periods of severe pressure (for example, in winter), a long-term increase in demand for services, external emergencies and disasters, and internal system failures. Planning to tackle these effects goes way beyond the initial emergency response.

1.8. Business continuity management is an essential tool in establishing an organisation's resilience.

2. What is this document for?

2.1. This document highlights the need for business continuity management in NHS organisations. It lists the relevant standards and indicates the guidance organisations need to follow.

2.2. It also promotes joint working arrangements between NHS organisations when planning for and responding to disruptions. This partnership approach must focus on the best needs of patients, not the performance targets of each organisation.

2.3. All NHS organisations must use this framework and the associated core standards in order to align themselves with ISO 22301 and fulfil all assurance processes.

3. What are the business continuity requirements for providers of NHS funded care?

3.1. Some NHS organisations are identified under the Civil Contingencies Act (CCA) 2004 as 'category one' responders. This means they have a legal duty to develop robust business continuity management arrangements which will help them to maintain their critical functions if there is a major emergency or disruption. This could include, for example, an infectious disease outbreak, severe weather, fuel shortages, industrial action, loss of accommodation, loss of critical information, loss of communication technology (ICT) or supply chain failure.

3.2. Not all providers of NHS funded care are covered by the requirements of the CCA. But it is good practice for all of them to act as if they were.

3.3. Each NHS organisation is responsible for making sure it meets the legal requirements and core standards for business continuity set out in this document. This responsibility extends to services provided through partnerships or other forms of contractual arrangement.

3.4. The core standards in appendix 1 are the minimum standards which NHS organisations and sub-contractors **must** meet.

3.5. The accountable emergency officer in each NHS organisation is responsible for making sure these standards are met.

3.6. We will seek evidence that these standards are being met.

4. International and national standards

4.1. The main guidance for business continuity management is contained in:

a. **ISO 22301** Societal Security - Business Continuity Management Systems – Requirements[1]

b. **ISO 22313** Societal Security - Business Continuity Management Systems – Guidance

c. **PAS 2015** - Framework for Health Services Resilience[2].

4.2. In the past, organisations in the UK developed their business continuity management systems in line with BS25999. However, this standard has been replaced by ISO 22301.

4.3. ISO 22313 provides good practice, guidelines and recommendations based on the requirements of ISO 22301.

4.4. The aim of PAS 2015 is to provide a resilience framework for NHS organisations and all providers of NHS funded care

4.5. Other useful guidance includes:

a. ISO 27000 series – a set of standards relating to security management systems[3]

b. ISO 31000 series – a set of standards relating to risk management family of standards[4]

c. PD 25222 – guidance on supply chain continuity[5]

d. PD 25888 – guidance on recovery following a disruption[6]

e. PD25111 – guidance on the human aspects of business continuity[7]

f. NHS Commissioning Board Emergency Planning Guidance 2013

g. NHS Sustainable Development Unit Adaptation Guidance August 2012[8].

4.6 We will also publish a Business Continuity Management Toolkit in 2013 to help all NHS organisations develop their business continuity management system.

[1] http://www.iso.org/iso/catalogue_detail?csnumber=50038
[2] http://shop.bsigroup.com/en/ProductDetail/?pid=000000000030201297
[3] http://www.27000.org/index.htm
[4] http://www.iso.org/iso/catalogue_detail?csnumber=43170
[5] http://shop.bsigroup.com/en/ProductDetail/?pid=000000000030239218
[6] http://shop.bsigroup.com/en/ProductDetail/?pid=000000000030194308
[7] http://shop.bsigroup.com/ProductDetail/?pid=000000000030229830
[8] http://www.sdu.nhs.uk/documents/publications/Adaptation_Guidance_Final.pdf#search="adaptation"

5. The patient care pathway

5.1. The NHS is used by 62 million people in the UK. Its services cover everything from pre-birth screening to end-of-life care.

5.2. The NHS is a 'people-rich' organisation, employing 1.7 million staff across the UK.

5.3. Three million people are treated by the NHS every week. Each one of these people takes a specific care pathway through services delivered by a variety of NHS organisations and providers of NHS funded care.

5.4. NHS organisations and providers of NHS funded care must shift the focus of their business continuity management systems to that of a whole-system approach to the patient care pathway. Each organisation will play a part, but realistic resilience and continuity arrangements will only be achieved if we consider and understand the patient's whole journey.

5.5. NHS organisations and providers of NHS funded care will therefore need to recognise how their critical activities depend on each other and to align their plans with all partner organisations.

5.6. Some elements of ISO 22301 **must** be done in partnership with other health organisations, recognising the patient care pathway and the patient's needs throughout each stage. These are set out below.

Understanding the organisations and their context

5.7. NHS organisations and providers of NHS funded care should understand the functions, needs and issues of the partners who play connecting parts in the patient care pathway.

Understanding the needs and expectations of interested parties

5.8. 'Interested parties' will include patients, the wider community, other NHS organisations, the emergency services, local authorities and suppliers.

5.9. NHS organisations and providers of NHS funded care must identify all those who have an interest in their services and establish their needs and expectations.

5.10. They must then build these needs and expectations into their response and recovery arrangements.

Scope

5.11. NHS organisations and providers of NHS funded care must establish the scope of their business continuity management system, taking into account any internal and external dependencies, for example staffing, ICT, food, fuel and other supplies.

5.12. They should share the scope of their system with partner organisations and interested parties so that it is clear which services are and are not included.

Communications

5.13. NHS organisations and providers of NHS funded care should establish and maintain procedures for regular communications with partner organisations and other interested parties. This is particularly important during the planning stage for known disruptions such as winter weather.

5.14. Formal reporting and situation updates may also be required in the lead up to and during a disruption to create a local, regional and national overview of effects across the NHS. These arrangements should be tested to make sure each organisation can maintain the flow of information.

5.15. Plans should be developed and shared between organisations through Local Health Resilience Partnerships and Local Resilience Forums.

Warnings

5.16. NHS organisations and providers of NHS funded care should establish and maintain robust internal and external communication procedures for before, during and after a disruption. These procedures should include a system for alerting partner organisations and interested parties of any current or potential disruption to services.

Business impact analysis

5.17. NHS organisations and providers of NHS funded care should identify dependencies and supporting resources that help them deliver their critical activities effectively. This analysis should be a broad review using established organisational risk, capability and capacity processes. It should also include suppliers, partner organisations and other relevant interested parties. Any critical activities highlighted should form part of the organisational risk matrix.

Business continuity strategy

5.18. NHS organisations and providers of NHS funded care should identify what they require of partners and suppliers in order to implement their business continuity management strategy effectively.

Response

5.19. NHS organisations and providers of NHS funded care should develop their response plans in collaboration with partners and other directly-linked NHS organisations. In this way they can make sure the actions in their response arrangements do not have a negative effect on other organisations.

Business continuity plans

5.20. Business continuity plans should contain details of all internal and external dependencies and interactions, as well as details on how and under what circumstances key interested parties will be communicated with.

Recovery

5.21. NHS organisations and providers of NHS funded care should make sure the actions in their recovery arrangements do not have a negative effect on partner organisations.

5.22. They should develop recovery plans, including prioritised recovery timeframes, in collaboration with other directly-linked NHS organisations.

Exercising and testing

5.23. NHS organisations should aim to exercise and test their business continuity arrangements alongside partner NHS organisations. They should then share lessons learned and post-exercise reports with all interested parties.

6. Equality and diversity

6.1. Investing in a diverse NHS workforce enables us to deliver a better service and improve patient care in the NHS. Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense.

6.2. When putting arrangements in place to reflect this suite of documents, organisations should be mindful of their obligations under the Equality Act 2010. The Equality Duty ensures that public bodies consider the needs of all individuals in shaping policy, delivering services, and in relation to their own employees. It encourages public bodies to understand how different people will be affected by their activities on different people so that policies and services are appropriate and accessible to all and meet different people's needs.

7. References and information sources

This document should be read in the context of the following sources of information.

7.1. The Civil Contingencies Act 2004[9]

7.2. The Cabinet Office website[10]

7.3. The Health and Social Care Act 2012[11]

7.4. NHS Commissioning Board EPRR documents and supporting materials[12], including:

a. NHS CB Emergency Planning Framework (2013);

b. NHS Commissioning Board Command and Control Framework for the NHS during significant incidents and emergencies (2013); and

c. NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

7.5. National Occupational Standards (NOS) for Civil Contingencies – Skills for Justice[13].

7.6. ISO 22301 Societal Security - Business Continuity Management Systems – Requirements[14]

7.7. BSI PAS 2015 - Framework for Health Services Resilience[15]

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[9] http://www.legislation.gov.uk/ukpga/2004/36/contents

[10] http://www.cabinetoffice.gov.uk/ukresilience

[11] http://www.legislation.gov.uk/ukpga/2012/7/enacted

[12] www.commissioningboard.nhs.uk/eprr/

[13] http://www.skillsforjustice-nosfinder.com/epc/aboutnos.php

[14] http://www.iso.org/iso/catalogue_detail?csnumber=50038

[15] http://shop.bsigroup.com/en/ProductDetail/?pid=000000000030201297

8. Freedom of information

This document is available to the public.

9. Glossary

BCM	Business continuity management
BCMS	Business continuity management system
BS	British Standard
BSI	British Standard Institution
EPRR	Emergency preparation, resilience and response
CCA	Civil Contingencies Act (2004)
ISO	International Standards Organisation
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
NHS CB	NHS Commissioning Board
PAS	Publicly Available Specification
PD	Published document

APPENDIX 1 – CORE STANDARDS FOR BUSINESS CONTINUITY MANAGEMENT

These standards will be updated from time to time. The following extract is correct at the time of publication. To view the latest list of core standards, please see the NHS Commissioning Board Core Standards for Emergency Preparation, Resilience and Response Framework at www.commissioningboard.nhs.uk/eprr/

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Cat 1 responders				Cat 2	Not categorised			
		Acute trusts	Ambulance trusts	NHS CB area teams	NHS CB regional &	CCGs	Primary care	Other NHS organisatio	Community providers	Mental health
1	**All NHS organisations and providers of NHS funded care must nominate an accountable emergency officer who will be responsible for EPRR and business continuity management.**	X	X	X	X	X	X	X	X	X
3	**3. All NHS organisations and providers of NHS funded care must have plans setting out how they contribute to co-ordinated planning for emergency preparedness and resilience (for example surge, winter & service continuity) across the area through LHRPs and relevant sub-groups. These plans must include details of:**	X	X	X	-	X	X	X	X	X
3 . 1	director-level representation at the LHRP; and	X	X	X	-	X	-	X	X	X
4	**All NHS organisations and providers of NHS funded care must contribute to an annual NHS CB report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents. Reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys. They must be made through the organisations' formal reporting structures.**	X	X	X	X	X	X	X	X	X
4 . 1	Organisations must have an annual work programme to reduce risks and learn the lessons identified relating to EPRR (including details of training and exercises). This work programme should link back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X	X	X
4 . 2	Organisations must maintain a risk register which links back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X	X	X
5	**All NHS organisations and providers of NHS funded care must have plans which set out how they plan for, respond to and recover from disruptions, significant incidents and emergencies. Incident response plans must:**	X	X	X	X	Note[1]	Note 1	Note 1	Note 1	Note 1
5 . 5	include plans to maintain the resilience of the organisation as a whole, so that the Estates Department and Facilities Department are not planning in isolation.	X	X	-	X	-	-	-	X	X
5 . 28	Describe the alerting arrangements for external and self-declared incidents (including trigger points, decision trees and escalation/de-escalation procedures)	X	X	X	X	X	X	X	X	X

Note: 1. All NHS Organisations and providers of NHS funded care must maintain suitable incident response plans. However, the details in these plans will depend on the organisation's size and role. Providers of NHS funded care include:

- independent hospitals under contract to deliver NHS care;
- urgent care centres;
- nursing homes;
- residential and elderly mentally-impaired (EMI) homes; and
- patient care transport providers.

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS CB area teams	NHS CB regional &	CCGs	Primary care	Other NHS organisatio	Community providers	Mental health
5 . 31	Include 24-hour arrangements for alerting managers and other key staff, and explain how contact lists will be kept up to date.	X	X	X	X	X	X	X	X	X
5 . 40	Explain the process for completing, authorising and submitting NHS CB standard threat-specific situation reports and how other relevant information will be shared with other organisations.	X	X	X	X	X	X	X	X	X
5 . 42	Explain how to communicate with partners, the public and internal staff based on a formal communications strategy. This must take into account the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public'. Social networking tools may be of use here.	X	X	X	X	X	X	X	X	X
5 . 48	Explain the process of recovery and returning to normal processes.	X	X	X	X	X	X	X	X	X
5 . 51	Explain who will be responsible for managing escalation and surges.	X	X	X	X	X	X	X	X	X
5 . 52	Describe local escalation arrangements and trigger points in line with regional escalation plans and working alongside acute, ambulance and community providers.	X	X	X	X	X	X	X	X	X
6	**All NHS organisations must provide a suitable environment for managing a significant incident or emergency (an ICC). This should include a suitable space for making decisions and collecting and sharing information quickly and efficiently.**	X	X	X	X	Note[2]	Note 2	Note 2	Note 2	Note 2
7	**All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems. This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301. Organisations must:**	X	X	X	X	X	X	X	X	X
7 . 1	make sure that there are suitable financial resources for their BCMS and that those delivering the BCMS understand and are competent in their roles;	X	X	X	X	X	X	X	X	X
7 . 2	set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be made available to track costs;	X	X	X	X	X	X	X	X	X
7 . 3	develop business continuity strategies for continuing and recovering critical activities within agreed timescales, including the resources required such as people, premises, ICT, information, utilities, equipment, suppliers and stakeholders; and	X	X	X	X	X	X	X	X	X
7 . 4	develop, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery time objectives and timescales identified in the business impact analysis	X	X	X	X	X	X	X	X	X
	Business continuity plans must include governance and management arrangements linked to relevant risks and in line with international standards.	X	X	X	X	X	X	X	X	X
7 . 5	Each organisation's BCMS should be based on its legal responsibilities, internal and external issues that could affect service delivery and the needs and expectations of interested parties.	X	X	X	X	X	X	X	X	X
7 . 6	Organisations should establish a business continuity policy which is agreed by top management, built into business processes and shared with internal and external interested parties.	X	X	X	X	X	X	X	X	X
7 . 7	Organisations must make clear how their plan will be published, for example on a website.	X	X	X	X	X	X	X	X	X
7 . 8	The BCMS policy and business continuity plan must be approved by the relevant board and signed off by the Chief Executive.	X	X	X	X	X	X	X	X	X
7 . 9	There must be an audit trail to record changes and updates such as changes to policy and staffing.	X	X	X	X	X	X	X	X	X
7 . 10	The planning process must take into account nationally available toolkits that are seen as good practice.	X	X	X	X	X	X	X	X	X

Note: 2. Each NHS organisation is responsible for providing a suitable environment for managing a significant incident or emergency (an ICC). However, the exact specification of the ICC will depend on the organisation's size and role.

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS CB area teams	NHS CB regional &	CCGs	Primary care	Other NHS organisatio	Community providers	Mental health
	Business continuity plans must take into account the organisation's critical activities, the analysis of the effects of disruption and the actual risks of disruption.	X	X	X	X	X	X	X	X	X
7 . 11	Organisations must identify and manage internal and external risks and opportunities relating to the continuity of their operations.	X	X	X	X	X	X	X	X	X
7 . 12	Plans must be maintained based on risk-assessed worst-case scenarios.	X	X	X	X	X	X	X	X	X
7 . 13	Risk assessments should take into account community risk registers and at very least include worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment; • fuel shortages; • surges in activity; • IT and communications; • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites).	X	X	X	X	X	X	X	X	X
7 . 14	Organisations must develop, use and maintain a formal and documented process for business impact analysis and risk assessment.	X	X	X	X	X	X	X	X	X
7 . 15	They must identify all critical activities using a business impact analysis. This should set out the effect business disruption may have on the organisation and how this will be overcome, including the maximum period of tolerable disruption.	X	X	X	X	X	X	X	X	X
7 . 16	Organisations must highlight which of their critical activities have been put on the corporate risk register and how these risks are being addressed.	X	X	X	X	X	X	X	X	X
	Business continuity plans should set out how the plans will be called into use, escalated and operated.	X	X	X	X	X	X	X	X	X
7 . 17	Organisations must develop, use, maintain and test procedures for receiving and cascading warnings and other communications before, during and after a disruption or significant incident. If appropriate, business continuity plans should be published on external websites and through other information-sharing media.	X	X	X	X	X	X	X	X	X
7 . 18	Plans should set out: the alerting arrangements for external and self-declared incidents, including trigger points and escalation procedures;	X	X	X	X	X	X	X	X	X
7 . 19	the procedures for escalating emergencies to CCGs and the NHS CB area, regional and national teams;	X	X	X	X	X	X	X	X	X
7 . 20	24-hour arrangements for alerting managers and other key staff, including how up-to-date contact lists will be maintained;	X	X	X	X	X	X	X	X	X
7 . 21	the responsibilities of key staff and departments;	X	X	X	X	X	X	X	X	X
7 . 22	the responsibilities of the Chief Executive or Executive Director;	X	X	X	X	X	X	X	X	X
7 . 23	how mutual aid arrangements will be called into use and maintained;	X	X	X	X	X	-	X	X	X
7 . 24	where the incident or emergency will be managed from (the ICC);	X	X	X	X	X	-	X	X	X
7 . 25	how the independent healthcare sector may help if required; and	X	X	X	X	X	X	X	X	X
7 . 26	the insurance arrangement that are in place and how they may apply.	X	X	X	X	X	X	X	X	X

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**Governors' Log of Communications Report**
Report Author	**Sarah Murch, Membership Manager**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary

The purpose of this report is to provide the Board of Directors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous meeting. The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust.

2. Key points to note
(Including decisions taken)

Since the last public Board of Directors meeting in March, three additional questions have been added to the Governors' Log of Communications, and six responses received. All questions have now received responses and have been closed by governors.

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

n/a

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

- This report is for **Information.**

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

n/a	

Respecting everyone
Embracing change
Recognising success
Working together
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Governors' Log of Communications

21 July 2021

ID	Governor Name		
253	Charles Bolton	***Theme:*** Mental Health/Bed availibility	***Source:*** Governor Direct

Query **25/06/2021**

I understand that the Children's Hospital may be experiencing some pressure on bed availability due to a high number of admissions of young adults/older children with mental health issues arising from the pandemic. Is this the case and, if so, is there a strategy for addressing the situation?

Division: Women's & Children's Services ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **05/07/2021**

It is correct that the Children's Hospital has been experiencing greater numbers of admissions of children and young people with mental health needs, specifically and notably these have been presentations with anorexia nervosa.

We are providing data to the CCG in relation to these presentation. We have stood up a cross system surge and capacity project group with the CCG,AWP – Avon and Wiltshire Mental health partnership, inclusive of locality CAMHS Eating disorders leads, CAMHS operations lead and ourselves to address immediate actions and longer term solutions addressing this surge in numbers and acuity. Currently this approach is working well and we do not currently have higher numbers today as inpatients than is usual at this time of year – however this fluctuates regularly.

In addition, there are now twice weekly CAMHS escalation calls, cross system - social care, CCG, CAMHS, AWP, NBT, BRI & BRHC, reviewing all delayed discharges within acute hospital beds related to CAMHS.

Status: *Closed*

ID	Governor Name		
252	John Rose	***Theme:*** Sexual Health Services in Weston	***Source:*** From Constituency/ Members

Query **02/06/2021**

Can the Trust update the Governors on the running of the sexual health clinic at Weston General Hospital? It would appear that there has been a prolonged period where no consultant has been to Weston to run the clinic and this is causing concern to their patients.

Division: Other ***Executive Lead:*** *Medical Director* ***Response requested:*** 18/06/2021

Response **11/06/2021**

We are interviewing for the post of Genito-urinary Medicine (GUM) consultant for the WISH clinic later this month. In addition, we have successfully recruited a locum Sexual and Reproductive Health consultant who will start in August for six months.

To ensure our patients have continued to receive appropriate care and treatment in the interim. The Consultants and clinical team at the Bristol based Unity Sexual Health clinic have been supporting the nursing team in the WISH service by attending the clinic weekly and seeing patients as required, providing advice and support and where appropriate patients have been offered appointments in Bristol.

Status: *Closed*

ID	Governor Name		
251	John Rose	***Theme:*** Nosocomial infection by aerosol spread	***Source:*** From Constituency/ Members

Query **26/05/2021**

During the height of the COVID-19 pandemic, hospitals including ours made enquiries to determine the extent of transmission of the virus to patients while in hospital. Figures varied between 1 in every 7 patients and 1 in every 4. I find these figures quite alarming especially as some patients are likely to be immune response compromised. Recent research has pointed to aerosol spread of virus particles as a contributory factor in enclosed areas with inadequate ventilation (ventilation being the adequate supply of fresh or artificially purified air to all areas occupied).
The World Health Organisation published their advice on "Natural Ventilation For Infection Control in Healthcare Settings" updated in 2009 - ISBN 978 924 154785 7 and there may be more recent advice from NHS England.
1. Has UHBW carried out surveys to assess compliance with the WHO or more recent standards of ventilation in all occupied areas under its control and if so what are the findings?
2. If no surveys have been implemented I would like assurance that these will be carried out coupled with the establishment of an action plan.
3. Has the Trust recognised the risk of aerosol spread of COVID-19 and other airborne infections (T.B., Influenza, etc) and included this on its risk register?
I have attached information (2 documents) on aerosol infection spread and survey methods using carbon dioxide level monitoring to establish the effectiveness of ventilation. Levels of carbon dioxide give an indication of the build up of exhaled breath in occupied areas and thus an approximation of how effective the ventilation is.

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **02/06/2021**

1. Has UHBW carried out surveys to assess compliance with the WHO or more recent standards of ventilation in all occupied areas under its control and if so what are the findings?
There is a Trust ventilation safety Group managed through the Estates Department which includes clinical representation and IPC. There are Health Technical Memorandum (HTM's) produced by the Department of Health which describe the ventilation assurance for the hospital. As part of this compliance of the ventilation system is formally checked annually. This was carried out in 2020. There are a number of clinical areas where the ventilation systems, such as Theatre, must be fully compliant with specific air changes required per hour.
Throughout the pandemic we have been mindful of the issues around ventilation across the organisation. Each clinical area has been assessed against the current national (HTM O3-01). Certain parts of the older estate have poor ventilation, and efforts have been made to improve the situation. These have ranged from working with the estates department to increase the number of air changes in certain clinical areas, to simply opening windows.

2. If no surveys have been implemented I would like assurance that these will be carried out coupled with the establishment of an action plan.
Ventilation assurance is via the ventilation safety group. The ventilation compliance is monitored through this group with appropriate actions.

3. Has the Trust recognised the risk of aerosol spread of COVID-19 and other airborne infections (T.B., Influenza, etc) and included this on its risk register?
The critical issue with all infections is the way that transmission occurs. There remains some debate about aerosol versus droplet spread of SARS-CoV-2, although

ID **Governor Name**

it is clear that transmission is more likely to occur in areas with poor ventilation. The other factors that influence increased COVID-19 transmission include how close people are together (less than 2 metres apart), the density of people (the more people in a small space the greater the transmission risk) and the use of PPE to minimise the potential for transmission. Although efforts to improve the ventilation in certain clinical areas have been undertaken, it needs to be acknowledged that the levels of carbon dioxide (as a surrogate for ventilation) is primarily a function of the number of individuals occupying that space. In the older estate it is clear that there are too many beds in a number of the bays, meaning that patients are unable to maintain the required 2 meters to socially distance as mandated by Public Health England guidance. Individual beds have been identified, and plans to remove them from the overcrowded areas have been formulated to enable compliance with national guidance, and reduce the risk of transmission. These plans have been discussed at a senior level, but have to be balanced against other organisational priorities. These issues have been entered onto the risk register.

Status: *Closed*

ID	Governor Name		
250	John Chablo	***Theme:*** Digital Programme	***Source:*** Project Focus Group

Query **12/05/2021**

I am a little concerned about the progress of digital transformation within UHBW.
There seems to have been a number of issues which as governors we have been made aware of, but which still seem to be ongoing.
Of particular concern is the electronic prescribing and medicines administration (EPMA) system, which I believe was one of the first systems implemented as part of our Digital Exemplar program. We were informed a couple of years ago now that it had been stopped being used as there were a number of issues with it which required a software update, which would take a couple of months. I understand this is still not back in place as yet?
I recently attended a Digital Health Online Conference, and it appeared that there were a number of Trusts (including the new Digital Aspirants) using the System C software package, including EPMA, so what is the issue that we have with it?
I was also surprised to be told recently that Weston has a newer version of Medway which is not compatible with the version at the BRI? As we are developing a blueprint for digital excellence with System C for other trusts to use, should we not always be running the latest software version or even future versions that haven't been generally released? And why is the software not backward compatible? I appreciate the sensitivity and critical nature of the software, but shouldn't updates be implemented as soon as they are available, particularly in view of our Digital Exemplar status?
Can we be assured that the board is fully behind our digital transformation?

Division: Trust-wide ***Executive Lead:*** *Director of Finance* ***Response requested:***

Response **25/05/2021**

Due to a number of practical and technical reasons, over the last 15 months the digital hospital programme has experienced a number of delays however the programme has now been re-baselined and detailed planning is now in progress. The Trust is due to upgrade the current version of its Medway patient administration system on the Bristol site in July 2021, this will provide the foundation to progress the digitisation programme.

The Digital Hospital Programme Board which governs the delivery of the programme reviewed the current state of ePMA at the meeting held in May 2021 following concerns on the timelines for some of the core functionality required as outlined in the latest ePMA roadmap received from SystemC in March 2021.

UHB had worked with SystemC as a Development Partner to develop System C's ePMA product as part of the Global Digital Exemplar programme with a pilot launched in 2017. However, following an unsuccessful attempt to deploy the product more widely across the Trust in 2019, the Trust's fast follower (Whittington Trust) played a more active role in progressing the development of the product with System C with the Trust supporting as required. The Whittington's recent decision to progress an alternative product in early 2021 has further increased the concerns within UHBW about the timelines to realise a fully functioning ePMA product. The Board has now asked for an outline business case which will explore options on how to realistically achieve a suitable ePMA solution.

Currently, the Weston version of Medway is "ahead" of Bristol Medway due to its implementation of a later version in Sept 2020. On convergence of the two Medway systems (due to be completed in April 2022), the Trust will only operate one instance of Medway across its sites eliminating any compatibility issues. This approach has been validated as the most suitable approach with minimal risks to patient safety.

ID **Governor Name**

The Digital Hospital Programme Board is fully committed to the achievement of the Trust's digital transformation agenda. Furthermore, increased Trust Board oversight is provided by the Finance and Digital Committee (that has replaced the former Finance Committee). Board Seminars are being planned for later in the year to consider the refresh of the Digital Strategy and related resourcing implications.

Status: *Closed*

ID	Governor Name		
249	Carole Dacombe	***Theme:*** Bullying and Harassment	***Source:*** Project Focus Group

Query **12/05/2021**

The Governors are aware of the need to tackle the issues of bullying and harassment throughout the NHS, along with the challenges that this presents. We wish to seek assurance that UHBW has a comprehensive plan to tackle these issues throughout the trust - from awareness raising and prevention to the management of incidents when they occur. Has the required training in these issues been identified for all grades of staff?

Division: Trust-wide ***Executive Lead:*** *Director of People* ***Response requested:***

Response **27/05/2021**

To date, the priority has been to ensure appropriate support for the person(s) who feel they are being treated in an inappropriate way. Through consultation with stakeholders, the slogan 'Supporting Positive Behaviours' was adopted to de-stigmatise uptake of the resources. Below we outline the resources that comprise the Supporting Positive Behaviours framework:

1. A guide was written as a tool to help staff…
- acknowledge rather than ignore the impacts on them
- understand some of the reasons for others actions
- enhance confidence in speaking with the person/people (promoting an informal approach first)
- overviewing the support available through multiple channels.

The guide also includes a section for Managers of teams where bullying may be occurring, to help them…
- understand their role and responsibility
- know how to support staff
- acknowledge their own potential need for support

2. An e-learning session was created, presenting much of the self-help material from the above guide, but in an alternative medium for staff to access.
Since launch in March 2020, 917 staff have accessed this non-mandatory training session.

3. A second e-learning session was created with more of an emphasis on preventing negative behaviours between staff by introducing the concept of unconscious biases in all of our thinking. The session uses exercises to encourage the learner to consider how they may have beliefs about any colleagues (or people more generally) who they view as different to them, and how this has the potential to affect their behaviour/treatment of those people, without them being consciously aware. This session links heavily to the Equality Diversity and Inclusion agenda.
Since launch in July 2020, 1,015 staff have accessed this non-mandatory training session.

4. A workshop was developed for Managers, to support their learning of how to deal with conflict within their teams. The two hour session linked to the above content, but with more of an emphasis on how to support, resolve, signpost, escalate; as required of the situation. Unfortunately due to COVID-19, the delivery of

this session was impacted; meaning very few staff have as yet accessed it. Please see below.

5. In addition to existing channels of support (Trust Mediators, Freedom To Speak Up, Occupational Health etc), the procurement of an Employee Assistance Programme in 2020 has meant that all staff have 24/7 access to accredited counsellors able to support with matters including bullying and harassment.

6. The Organisational Development Team contributed to the updating of the existing Dignity at Work policy to ensure it reflected the above 'Supporting Positive Behaviours' approach. The re-launch of this policy has been delayed but is imminent.

7. Given the challenges and obstacles that surround this topic, a considered communications plan was designed to raise awareness of the new resources, whilst also attempting to normalise the topic; aiming to make it more acceptable for people to feel able to give informal feedback and seek informal resolution. Attached above is a poster which was used to help promote the work.

Work planned:

1. Delivery of the manager workshop (point 4 above) needs to be reviewed to see if it can resume as a face-to-face or live virtual option; or whether the content can appropriately be moved to an e-learning format.

2. Work is being explored to take a more preventative approach, by creating a support/learning resource for the person accused of (or self-suspecting) being a 'bully'. The intention here is that it can be offered as a tool for self-reflection and learning behaviour change when a grievance has been made…but also as a proactive tool that staff can self-access at any time in privacy.

3. Meetings are being held bi-monthly between the Freedom To Speak Up Guardians, members of Organisational Development and Employee Services to triangulate data (Staff Survey, Grievances, FTSU support requests, e-learning uptake) with the intention of better understanding how to provide more targeted responsive support in teams where there is an apparent culture of negative behaviour.

4. Work is being explored with the Learning Team to add a means of gathering feedback to the two e-learning sessions (points 2&3 in the above section), so that we can better understand the impact of these resources, and develop them in response to feedback.

Status: *Closed*

ID	Governor Name		
248	Carole Dacombe	***Theme:*** Training	***Source:*** Project Focus Group

Query **12/05/2021**

The Governors are aware that there are many different levels and types of management roles across the trust, all of which are integral to staff support and development. Is the trust committed to ensuring that managers at all levels are provided with the required knowledge, skills and confidence to fulfil these roles? Are the sources of all such training (internal and external) clearly identified?

Division: Trust-wide ***Executive Lead:*** *Director of People* ***Response requested:***

Response **27/05/2021**

The trust is currently understanding a review of its management and leadership development training for both clinical and non-clinical staff. To date two engagement workshops have been undertaken and further listening workshop through an external process are planned for May and June 2021. A Training Needs Analysis is currently being under taken as part of the OPP process of which leadership and management development is part.
The aim of the work is to develop a new one point of access for development that integrates internal and externally available training inclusive of apprenticeship pathways. This work is also aligning with ICS development.

In the interim development has been re-instated for appraisal training and bespoke offers led from education for management and customer service training.

Status: *Closed*

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Thursday 29 July 2021

Report Title	**Register of Seals Report**
Report Author	**Natashia Judge, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Report Summary

This report provides a summary of the applications of the Trust Seal made since the previous report in May 2021**.**

2. Key points to note
(Including decisions taken)

Standing Orders for the Trust Board of Directors stipulate that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the person who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust Seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing.

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

The risks associated with this report include:
N/A

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

- This report is for **Information**.

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

N/A

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University Hospitals Bristol and Weston NHS Foundation Trust

Register of Seals

May 2021 to July 2021

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
856	12/07/21	Lease formalising the occupation of Yatton's Children Centre, by the Women's and Children's Division, for the provision of maternity service. The Lease is between the Trust and North Somerset Council.	Mark Smith, Deputy Chief Executive and Chief Operating Officer	Neil Kemsley, Director of Finance & Information	Eric Sanders, Director of Corporate Governance