

Meeting of the Board of Directors in Public on Friday 27th May 2022

Report Title	Integrated Quality & Performance Report
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1. Report Summary
To provide an overview of the Trust's performance on quality and access standards.
2. Key points to note <i>(Including decisions taken)</i>
Please refer to Executive Summary for an overview. A new Appendix on Health Inequalities has been added this month on pages 85-88. This was an action from the April Quality Outcomes Committee and also addresses some of the requirements from national policy including The Delivery Plan for Tackling the COVID-19 backlog of elective care . Future development will also include Trust actions in response to the Core20Plus5 approach .
3. Risks If this risk is on a formal risk register, please provide the risk ID/number.
None
4. Advice and Recommendations <i>(Support and Board/Committee decisions requested):</i>
This report is for Assurance.
5. History of the paper Please include details of where paper has <u>previously</u> been received.
Quality and Outcomes Committee 24 May 2022

Integrated Quality & Performance Report

Hartles Rachel
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May 2022

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Executive Summary

Reporting Month: April 2022

Activity volumes for all elective and non-elective admissions were under plan for April and below the pre-pandemic level seen in April 2019. Improvements to flow and associated benefits anticipated from the extension of discharge to assess community capacity in the local health care system is a critical enabler to supporting all aspects of performance recovery in 2022/23, where currently several NHS constitutional standards are not being met (*Datix Risk ID 801 - Risk that one or more standards of the NHS Oversight Framework are not met*).

In urgent care, 4 hour response times in the Emergency department was at 61.5% and the BRI benchmarked position for the end of Quarter 4 was one of the most challenged nationally. Ambulance handover delays remain above the South West average, although the volume of 12 hour trolley waits improved by 15% from the previous month. Poor flow continues to impact on performance and an average of 147 beds were occupied over the period with patients assessed as having no criteria to reside. The Trust Every Minute Matters Programme has launched and plans are in place to improve weekend discharge and focus on quality of discharge reviews before 12pm on weekdays. Community capacity is also being ramped up by October to support improvement in flow as part of system wide recovery plans.

In planned care, the Trust remains focused on interventions to reduce the volume of patients waiting over two years for treatment. At the end of April the Trust was 13 patients worse than the operating plan trajectory of 336. Weekly forecasting is in place as part of recovery plans to deliver agreed targets for end of June 2022. Referral to treatment time performance was 58.7% against the national 92% standard in April and the scale of recovery is illustrated by a waiting list that is 58% higher than two years ago, with an additional risk that outpatient referrals are not yet at pre-pandemic levels.

Diagnostic performance remained steady in April although is still well below constitutional standard at 57.9% within 6 weeks, with endoscopy capacity being a key constraint. Cancer performance for 62 day and 104 day treatment was within trajectory although two week wait performance dropped to 66.5% and has been skewed by skin pathway capacity constraints. Outsourcing of outpatient Dermatology capacity has since been agreed to support future recovery. There has also been some positive progress this month in reducing overdue follow up appointments by more than 10% following waiting list validation activity on the Weston site as part of the Digital Convergence programme.

COVID bed occupancy returned to normal planning parameters of less than 5% bed occupancy in April. If this can be sustained, there is every chance of improved activity and performance in future months, especially because benefits will begin to be realised from removing social distancing in many areas and a renewed focus on productivity. Changes to social distancing requirements follows the release of national Infection, Prevention and Control guidance released by NHS England and NHS Improvement in the middle of April.

Reporting Month: April 2022

Safe

Caring

Successes	Priorities
• In the newly published National Audit of Inpatient Falls report for 2020/2021 the Trust has performed better than peers nationally in providing good post fall management including equipment used, medical assessment within 30 minutes and analgesia provided. • There were no category 3, 4 or unstageable pressure injuries reported during April. In addition, there was a reduction in sacral-coccygeal pressure injuries. The Tissue Viability Study Day in April was well attended and excellent feedback was received.	• Wards continue to work at staffing levels below their agreed establishment throughout April, as the Internal Critical Incident continued. The impact on staff well-being cannot be underestimated as many staff are moved from their base wards at very short notice and moved to cover other wards and support the ED queue, this is undertaken through a balance of risk. • A business case for a further 108 International Nurses has been agreed with recruitment progressing. • A system wide Health Care Support Worker recruitment event is planned for 19th May with significant Trust representation. • A review and refresh of the current retention strategy is underway to ensure that staff see UHBW as where they wish to work, undertake further development and continue their careers. • The Dementia, Delirium and Falls Lead is working with the Care of the Elderly Consultants to review the number of patient transfers out of hours, with a known dementia / delirium diagnosis. This will help understand the impact and inform risk reduction for vulnerable patients.

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Reporting Month: April 2022

Safe

Caring

Opportunities

- Recommendations for strengthening components of the Multi-factorial risk assessment (MFRA) for patients at risk of falls and compliance with care plans from the National Inpatient Audit for Falls are being addressed by the Dementia, Delirium and Falls steering group. The new Team lead will undertake a QI project to improve compliance.
- Medicines management: A new audit database has been built which will facilitate the collection of Weston medication audit data going forward.
- Following publishing of the second Ockenden report into Maternity Services at Shrewsbury and Telford NHS Trust, the Non-Executive Directors visited St Michael's site on the 10th May where they were able to speak with front line staff providing an opportunity to recognise successes and ongoing challenges.

Risks & Threats

- The continued level of COVID- 19 transmission coupled with a high level of staff absence has caused significant staff shortages across all wards and departments, this has been managed on a whole site basis.

New or increased patient safety risks:

There was one new/ emerging risk in the Patient Safety domain for April 2022. Datix ID 6016

- Risk that Phillips V60, V60 plus and V680 ventilators potentially will shut down leading to a complete loss of ventilation. Following a new National Patient Safety Alert this risk has been identified, actions outlined in the alert have been taken to mitigate the risk which is expected to be closed within the required timescales. Score 10

Update on risk 5787 previously reported:

- Risk that patient procedures and operations may be cancelled when there is severe disruption to supplies of non-pay consumables. The NHS Supply Chain disruptions are affecting a wider range of consumables required for care delivery posing an increased risk to patient safety and restoration of planned care. Mitigation is at local and system level. The risk score is now increased 16 to reflect this.

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Reporting Month: April 2022

Responsive

Effective

Successes

- Over 28,000 patients have been allocated with an N-code to support clinicians in identifying lower risk caseloads that might be appropriate to PIFU or discharge.
- Validation of waiting lists in Weston have reduced the overdue follow up backlog from 101,419 in March to 90,473 in April.
- Cancer standards: the subsequent radiotherapy, subsequent chemotherapy, and 28 day faster diagnosis following GP referral standards were all compliant in March. The Trust also remains below its given maximum number of 'long waiting' (<62 day) patients on a GP suspected cancer pathway.
- DrDoctor went live on the 6th April with non-face to face video consultations.
- All patients over 104 week waits have been contacted by the Trust to identify preferences for future treatment including willingness to consider treatment at alternative providers if clinically appropriate.
- An Artificial Intelligence tool is being piloted to establish risk on surgical waiting lists based on length of wait (relating to mortality, surgical complications and post-op complications). This will help to inform future surgical triage decisions to improve patient outcomes.
- The Trust has developed a demographic profile of the waiting list to inform the elective recovery health inequalities strategy.

Priorities

- Appointment type Medway configuration work to be finalised in May to support further integration of the DrDoctor application, enabling the use of appointment reminder functions.
- Delivery of 104 week wait reductions for patients on a referral to treatment pathway by end of June 2022. The Trust operating plan is to reduce the 346 patients recorded in March down to 197, with 29 remaining at the end of March 2023 all due to patient choice reasons only. Current position shows that we are currently off track to deliver the 197 end of June position by 13 (end of April trajectory of 336 against actual of 349).
- All 104ww patients have been contacted to identify any patients that would be willing to accept treatment at an alternative provider, 83 patients have been identified and a mutual aid request has been sent to the regional team for expediting.
- Ensuring all cancer patients are treated in a clinically safe timescale during the ongoing emergency pressures and over winter, and secondly to maintain performance against the 'ongoing' cancer standards for numbers waiting (once clinical priority has been taken into account).
- Plans for the implementation of the quick question functionality to be reviewed in the June Outpatient programme board.

Reporting Month: April 2022

Responsive

Effective

Opportunities

- Reduction of social distancing has supported divisions with the identification of further operational capacity.
- The Trust has invited NHSE's intensive support team into UHBW to review our management of our patient tracking lists (PTL) to identify if there are any improvements required to support our recovery of long waiting process and our booking in order practices. Consideration during this visit will also help the Trust develop a NON-RTT PTL process. The visit is planned for 25th May 2022.
- Mutual aid with Liverpool Heart and Chest Hospital is working successfully to provide more timely treatment for appropriate thoracic surgery patients, including cancer patients.
- The Trust has initiated a review of productivity measures to inform future recovery plans.

Risks & Threats

- Continued risk that community phlebotomy non-recurrent posts will not be funded through system funding or planning rounds. This has the potential to add further operational pressure to specialities.
- Risk to delivering national targets for 104 week wait reductions. The Trust has a strategy for delivering agreed reductions by end of June but there are several constraints to overcome including elective inpatient beds, theatre staff, restrictions in independent sector options due to pricing, restricted mutual aid opportunities due to competing priorities at other Trusts and ongoing clinical prioritisation of higher risk patients who have not waited as long but have higher risk of coming to harm without treatment.
- There is an ongoing impact on cancer waiting time standard compliance due to the pandemic and system emergency pressures. The increase in these impacts since January 2022 has caused further (for duration of the period of heightened prevalence) deterioration in performance. Some surgical specialities are considering mutual aid however this is dependent on other providers being in a better position, which is unlikely. These issues particularly affect cancer pathway patients at low clinical risk from delay. (Datix Risk ID 42).

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Reporting Month: April 2022

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

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

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

April 2022

Y Achieved

Standards:	For this section, two measures are reported: Healthcare Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA). HOHA cases include patients where C.Difficile is detected from Day 3 after admission. COHA cases include patients where C.Difficile is detected within 4 weeks of discharge from hospital. The limit of Clostridium Difficile cases for 2022/2023 as set by NHS England is 89. This limit will give a trajectory of approximately 7.4 cases a month.
Performance:	In April there were six cases identified as HOHA. Zero COHA case reported. Each case requires a review by our commissioners before determining whether it will be Trust apportioned if a lapse in care is identified. Hospital Onset Healthcare Associated (HOHA) C-Difficile cases are attributed to the Trust after patients have been admitted for two days (day 3 of admission). Therefore, this financial year to date we have had 6 clostridium difficile HOHA and COHA cases for 2022/23 which means we are currently below our trajectory for this year.
Commentary:	Underlying issues: Further post-infection reviews are scheduled to deal with each of the remaining outstanding quarters in 20/21. Increased cases have been identified across both Bristol and Weston sites. Actions taken: - Increased environmental auditing within areas of increased rates is taking place. - A structured collaboration commenced in September 2021 across the BNSSG provider organisations facilitated by the CCG and a regional NHSE/I quality improvement collaborative is being established. - An updated IPC education plan in clinical departments has begun. - Increased environmental auditing within areas of increased rates is taking place.
Ownership:	Chief Nurse

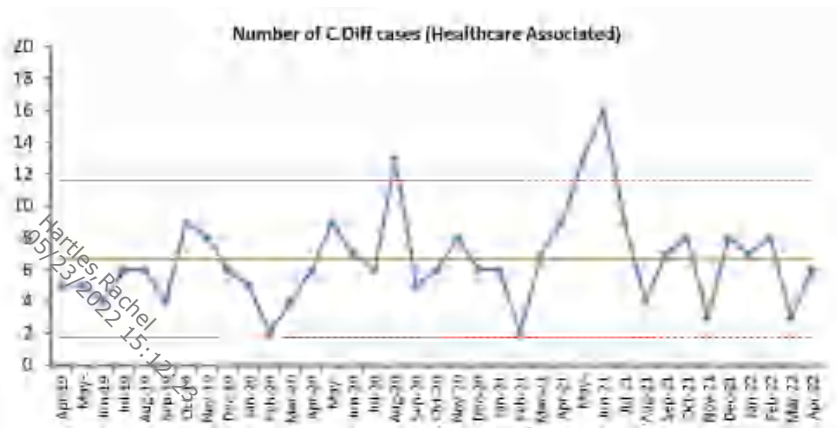
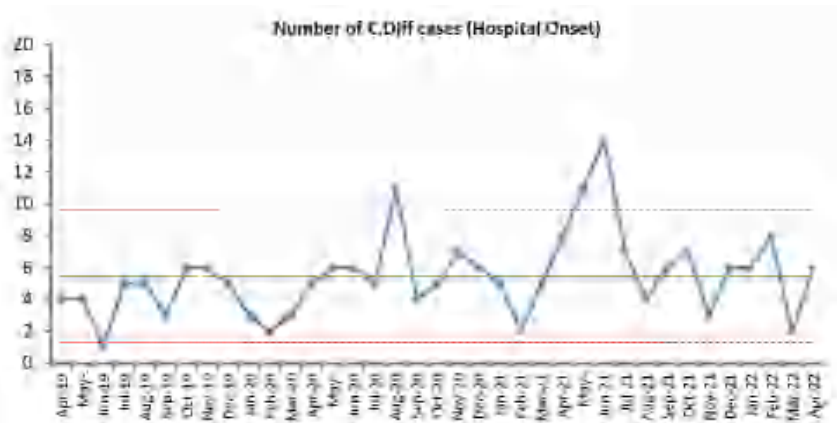
	Apr-22		2021/2022		2020/2021	
	HA	HO	HA	HO	HA	HO
Medicine	1	1	32	31	25	24
Specialised Services	1	1	16	12	18	14
Surgery	1	1	13	13	11	11
Weston	1	1	19	14	12	8
Women's and Children's	2	2	12	12	12	10
Other (Bristol)	0	0	3	0	3	0
TOTAL	6	6	95	82	81	67

HA = Healthcare Associated, HO = Hospital Onset

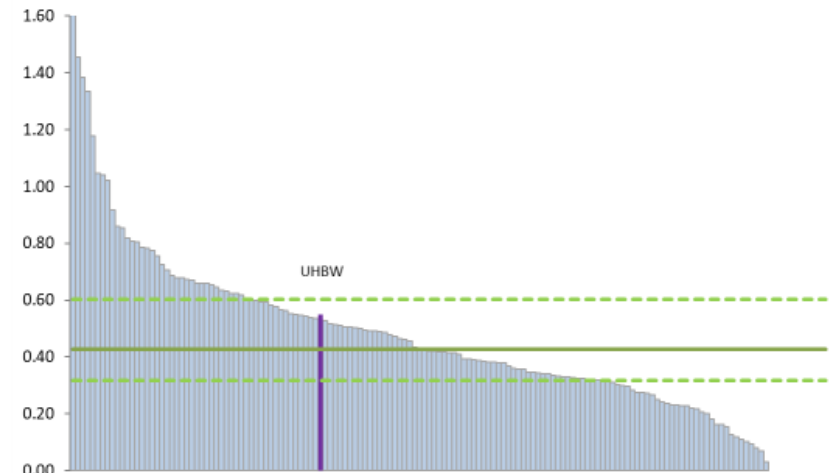
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Infection Control – C.Difficile

April 2022



Benchmarking - C.Diff Rate Per 1000 Beddays - Apr 21 to Mar 22



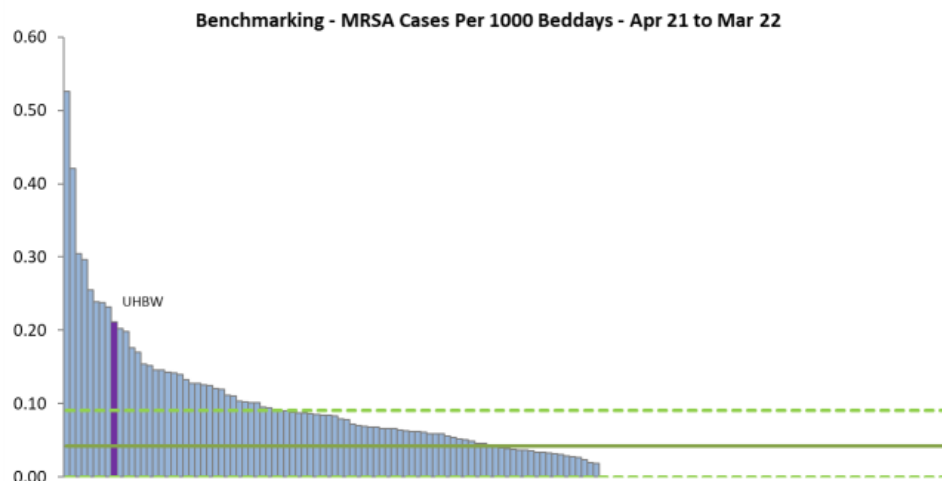
Infection Control - MRSA

April 2022

Y Achieved

Standards:	The standard is to have zero Trust Apportioned MRSA cases. This is Hospital Onset cases only.
Performance:	There was no new case of MRSA bacteraemia in UBHW in April 2022. There were seven cases reported in the financial year 2021/22.
Commentary:	Actions: - The vascular access group was restarted in March to help reduce levels of bacteraemia. A regional collaborative led by NHSE/I for improved vascular device management linked to reduced levels of bacteraemia has commenced. - An improvement plan is to be developed.
Ownership:	Chief Nurse

	Apr-22	2021/2022	2020/2021
Medicine	0	6	0
Specialised Services	0	0	1
Surgery	0	0	0
Weston	0	0	1
Women's and Children's	0	1	2
TOTAL	0	7	4

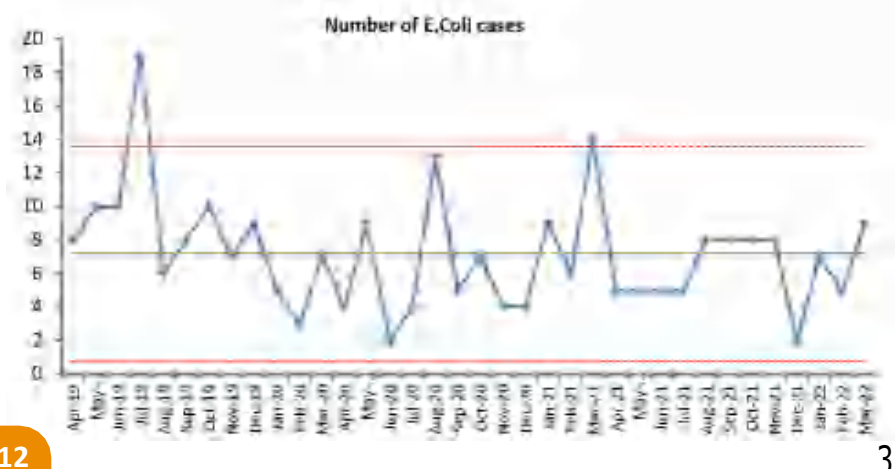


April 2022

N Not Achieved

Standards:	Enhanced surveillance of Escherichia coli (E.coli) bacteraemia is mandatory for NHS acute trusts. Patient data of any bacteraemia are reported monthly to Public Health England (PHE). As a result in the national rise in E.coli bacteraemia rates, a more in-depth investigation into the source of the E.coli bacteraemia are initially undertaken by a member of the Infection Prevention and Control team. Reviews include identifying whether the patient has a urinary catheter and whether this could be a possible source of infection. If any lapses in care are identified at the initial review of each case, a more complete analysis of the patient's care is carried out by the ward manager through the incident reporting mechanism. There is a time lag between reported cases and completed reviews. An annual limit of E.coli cases has now been confirmed with NHS England as 119 for 2022/23. This would give a trajectory of approximately 9.9 cases per month.
Performance:	There were 13 Hospital Onset cases in April.
Commentary:	Underlying issues: - The community prevalence of E.coli cases has been noted to be increasing throughout this year. - Hepatobiliary was identified as the potential source of E. coli bacteraemia in one of the cases. The potential source of infection for one of the cases was upper urinary tract and the potential source of two other cases was lower urinary tract. The potential source of infection for two cases was gastrointestinal or intraabdominal collection. The source of infection for the other seven cases has not been identified. None of the cases were identified as urinary catheter related. A catheter use / prevalence survey across the Trust and an audit of compliance with best practice is planned. - This year we have had 13 E.coli cases for 2022/23 which means we are above our trajectory of 9.9 cases a month.
Ownership:	Chief Nurse

	Apr-22	2021/2022	2020/2021
Medicine	5	19	27
Specialised Services	2	16	16
Surgery	3	15	21
Weston	1	18	9
Women's and Children's	2	7	8
TOTAL	13	75	81



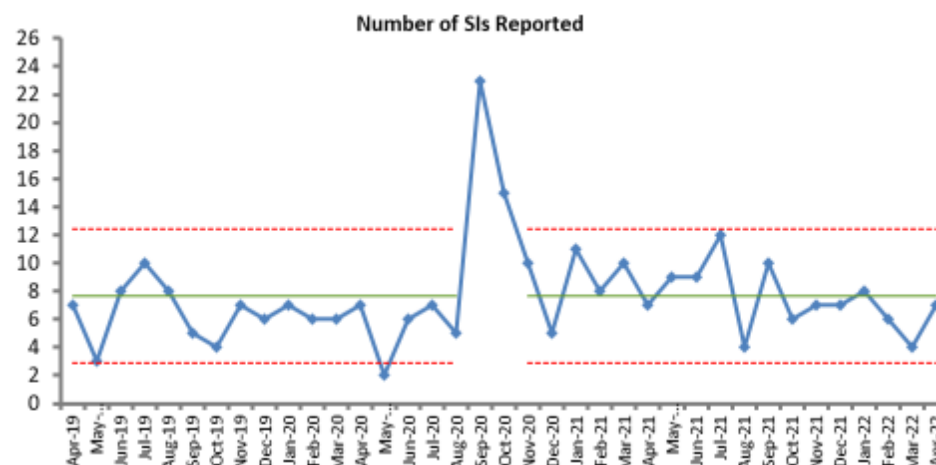
Serious Incidents (SIs)

April 2022

N/A No Standard Defined

Standards:	UHBW is committed to identifying, reporting and investigating serious incidents and ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence. Serious Incidents (SIs) are identified and reported in accordance with NHS Improvement's Serious Incident Framework 2015.
Latest Data:	Seven serious incidents were reported in April 2022: two in the Divisions of Medicine, Surgery and Women's & Children's and one in Weston Division. These serious incidents comprised: two Treatment Delay, two Sub-Optimal care of the Deteriorating Patient, one Diagnostic incident including failure to act on test results, one Pressure injury and one Maternity/Obstetric Incident. There were no new Healthcare Safety Investigation Branch (HSIB) maternity investigations or never events declared in April 2022.
Commentary:	In 2022/23, the new Patient Safety Incident Response Framework is to be implemented and an initial scoping exercise including stakeholder workshops have commenced. 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

	Apr-22	2021/2022	2020/2021
Medicine	2	29	31
Specialised Services	0	8	6
Surgery	2	9	13
Trust Services	0	0	1
Weston	1	22	50
Women's and Children's	2	19	8
Other/Multiple Divisions	0	1	0
TOTAL	7	88	109



Harm Free Care – Inpatient Falls

April 2022

N Not Achieved

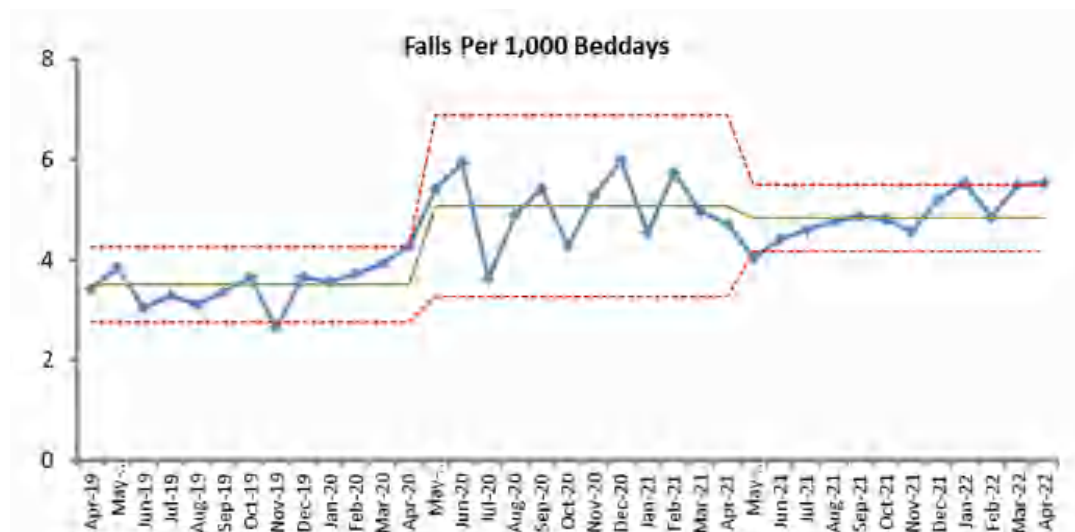
Standards:	To reduce and sustain the number of falls per 1,000 bed days below the UHBW threshold of 4.8 and to reduce and sustain the number of falls resulting in moderate or higher level of harm to two or fewer per month.
Performance:	During April, the rate of falls per 1,000 bed days was 5.54 across UHBW. There were 179 falls in total (117 in our Bristol Hospitals and 62 in the Division of Weston). There was no moderate harm and one fall with major harm (Division of Surgery) reported in April 22.
Commentary:	The continued operational pressures and staff shortages across the Trust remains, alongside the numbers of patients requiring enhanced care observation. The Divisions continue to manage those patients at risk of falls and review and investigate these falls as timely as possible to ensure learning is obtained and shared. The National Audit of Inpatient Falls report for 2020/2021 is now available for UHBW. With recommendations for strengthening components of the Multi-Factorial Risk Assessment (MFRA) for patients at risk of falls and compliance with care plans. The Trust has performed better than peers nationally in providing good post fall management including equipment used, medical assessment within 30 minutes and analgesia provided. The Dementia, Delirium and Falls (DDF) team lead is leaving the Trust towards the end of July and a member of the team is retiring in the beginning of July. Recruitment plans are being discussed as well as examining plans to ensure the level of service across Bristol and Weston sites are equitable. Actions: • Falls continues to be on the Trust Risk register and on each Divisions Risk Register. • A planned review of staffing and skill levels within the dementia, delirium and falls team is being done, as the requests for support for Weston site has increased for training, education as well as compliance with MFRA and care plans. • The Dementia, Delirium and Falls Lead continue to provide falls related training along with members of the team in conjunction with the Simulation Team. • The recommendations from the National Inpatient Audit for Falls was discussed at the Dementia, Delirium and Falls steering group in May 2022 and plans for improving MFRA and care plan completion rates were discussed. The new DDF Team lead will be tasked with leading a QI project to facilitate divisional teams to improve compliance.
Ownership:	Chief Nurse

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Harm Free Care – Inpatient Falls

April 2022

	Apr-22	
	Falls	Per 1,000 Beddays
Diagnostics and Therapies	3	-
Medicine	72	9.66
Specialised Services	22	4.20
Surgery	17	3.81
Weston	62	7.81
Women's and Children's	2	0.28
Other/Not Known	1	-
TRUST TOTAL	179	5.54
<i>Bristol Subtotal</i>	<i>117</i>	<i>4.80</i>



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Harm Free Care – Pressure Injuries

April 2022

Y Achieved

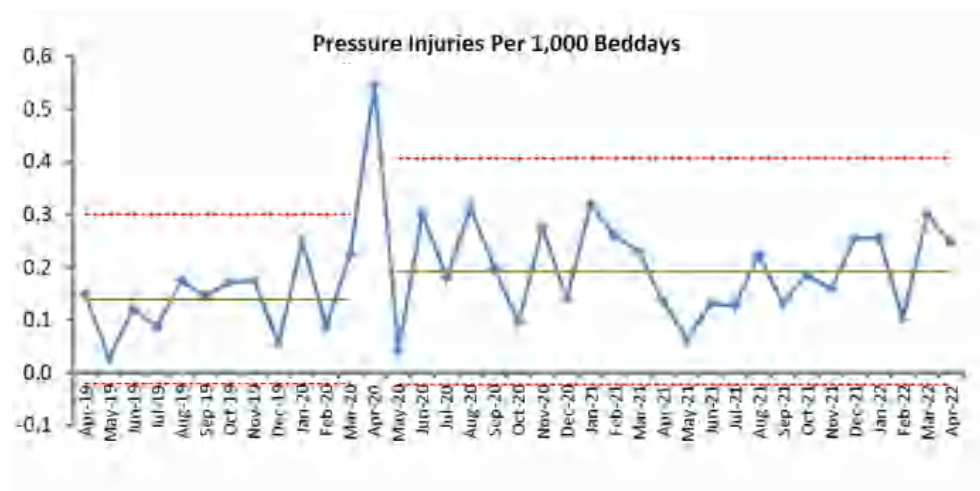
Standards:	Pressure Injuries are classified as Category 1,2,3 or 4 depending on depth and skin/tissue loss, with category 4 the most severe. For this measure category 2, 3 and 4 are counted. There is an additional category referred to as “Unstageable”, where the final categorisation cannot be determined when the incident is reported. The Tissue Viability Team has agreed that these will be reported as Category 3 pressure injuries within this measure. The aim is to reduce and sustain the number of hospital acquired pressure injuries per 1,000 beddays below an improvement goal of 0.4. In addition there should be no Category 3 or 4 injuries.
Performance:	During April 2022, the rate of pressure injuries per 1,000 beddays was 0.248 across UHBW. Across UHBW there were a total of eight Category 2 pressure injuries: • Four in Weston Division (2x heel, coccyx and elbow), • Two in Surgery Division (medical device related: nostril secondary to NG tube and elbow secondary to a sling). • One in Medicine Division (coccyx) • One in Specialised Services (coccyx). There were no category 3, category 4 or unstageable pressure injuries reported in April.
Commentary:	Six out of the eight patients were elderly with multiple co-morbidities and three of these patients were receiving end-of-life care at time of tissue viability nurse review. There was a reduction in sacral-coccygeal pressure injuries. There were two injuries which developed on elbows however the themes for both were different with one being in part due to EOL skin changes and the other secondary to a medical device. Actions (all sites): • Re-circulation of the Critical Care Pressure Relief Pathway to aid staff with appropriate pressure re-distribution aids to be used underneath medical devices. • Ongoing 15-minute micro teaching sessions offered to staff: tailored 1:1 sessions on the ward for individual staff members or small groups. • Tissue Viability Study Day in April – excellent feedback from staff in attendance on the study day. Work is now underway for the next tissue viability study day in November. Actions (Weston specific): • Tailored tissue viability training sessions booked with Weston ED to support with first line dressing choices and to re-emphasise the importance of timely skin checks and documentation of skin damage on admission to ED. • Face to face monthly one hour pressure ulcer training sessions for staff across all wards. • Division wide ward based Linet pressure relieving mattress education and training delivered by Linet Clinical Advisor. • Division-wide ward-based heel off-loading equipment education and training delivered by Frontier Medical Clinical Advisor. • Circulation of a Mattress Selection Flowchart for Weston Division to support staff with choosing the appropriate pressure relieving mattress. • Monthly auditing of the appropriate use of Linet pressure relieving mattress equipment across the division.
Ownership:	Chief Nurse

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Harm Free Care – Pressure Injuries

April 2022

	Apr-22	
	Injuries	Per 1,000 Beddays
Diagnostics and Therapies	0	-
Medicine	1	0.13
Specialised Services	1	0.19
Surgery	2	0.45
Weston	4	0.50
Women's and Children's	0	0.00
Other/Not Known	0	-
TRUST TOTAL	8	0.248
<i>Bristol Subtotal</i>	4	0.16



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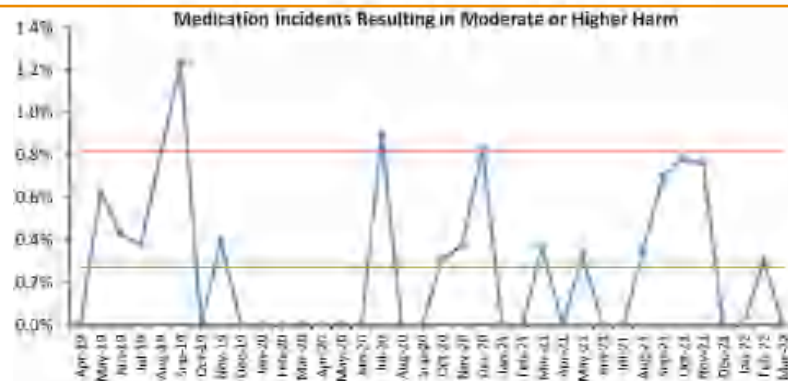
March/April 2022

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 were zero moderate or greater harm incident out of 280 medication incidents reported Trust wide in March. Omitted doses data was not collected last month so the update for two months is: - In March there were two omitted doses of critical medicine out of 104 patients audited (1.92%). - In April there were two omitted doses of critical medicine out of 188 patients audited (1.06%).
Commentary:	The recorded omitted doses in March were: - Drug administered but administration not signed, and - Antiepileptic medication not on the ward, so not given. This was ordered urgently. It was available in the emergency department, but a supply was not sought. The omitted doses in April were: - Antiepileptic not administered. This was ordered urgently but is also available widely as stock on several wards, so a supply could have been obtained using the drug finder. - An antiviral agent was omitted. The omitted doses were found on routine review of the drug chart, so doses were ordered for urgent supply. The medicine had not been ordered from pharmacy or sourced from elsewhere. Actions: - A new audit database has been built which will allow Weston to collect and input audit criteria each month in future. The number of patients audited in both March and April was very low. This is partly due to clinical work pressures and priorities and also due to new staff not being aware of the need to carry out the omitted doses audit. Renewed instructions on completion of the data collection will be delivered to the pharmacy team within the next two weeks.
Ownership:	Medical Director

Hartley Rachael
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	Mar-22		
	Moderate or Higher harm	Total Audited	Percentage
Diagnostics and Therapies	0	21	0.0%
Medicine	0	46	0.00%
Specialised Services	0	62	0.00%
Surgery	0	39	0.00%
Weston	0	24	0.00%
Women's and Children's	0	88	0.00%
Other/Not Known	0	0	-
TRUST TOTAL	0	280	0.00%



April 2022

N Not Achieved

Standards:	Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%, which was set by Bristol and has been adopted by Weston.
Performance:	April 2022 overall compliance for Core Skills (mandatory/statutory) training increased to 81% from 80% compared to the previous month, across the eleven programmes.
Commentary:	There were no reductions in compliance on any individual programme overall, however compliance on some individual programmes remains below 81%. This represents the first increase in overall compliance since August 2021. Since the launch of Kallidus Learn 10,700 users (of 14,800) accessed various training activities. Notably, 54,000 eLearning programmes were launched, with 33,700 lessons completed. There were no reductions in any programmes and there were increases in six programmes, with Fire Safety, Infection Prevention and Control, NHS Conflict Resolution, and Safeguarding Children training all increasing by 2%. Extracting those subjects with the lowest compliance: 1. Information governance overall compliance is 77%; the Medical & Dental staff group have the lowest compliance rate at 42% compared to the highest staff group Estates & Ancillary at 87% 2. Moving & Handling overall compliance is 64%; the Medical & Dental staff group have the lowest compliance rate at 45% compared to AHPs with the highest compliance rate at 86% 3. Resuscitation overall compliance is 62%; the Estates & Ancillary staff group have the lowest compliance rate at 29%, compared to AHPs who have the highest compliance rate at 75%. Compliance for nursing and midwifery (key target audience) compliance is 65%. Overall compliance for remaining Essential Training increased to 82% from 81% in the previous month. NEWS2 (National Early Warning Score) training is essential training for all doctors and nurses working in adult services, compliance for this subject will be reported from the end of May 2022 when the training will be factored into overall compliance.
Ownership:	Director of People

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Nurse Staffing Levels

April 2022

N/A No Standard Defined

Standards:	It is an NHS England requirement to publish and report monthly safer staffing levels to the Trust Board. High level figures are provided here and further information and analysis is provided in a separate more detailed report to the Board. The data is reported against Registered Nurse (RN) and Unregistered Nursing Assistant (NA) shifts.
Performance:	The report shows that in April 2022 (for the combined inpatient wards) the Trust had rostered 303,724 expected nursing hours, against the number of actual hours worked of 264,544 giving an overall fill rate of 87.1%.
Commentary:	Issues: • Wards have continued to work at staffing levels below their agreed establishment throughout April as the Trust's declared Internal Critical Incident. The impact on staff well-being cannot be underestimated as many staff are moved from their base wards at very short notice and moved to cover other wards and support the Emergency Department queues. Staff also moved between the Bristol and Weston sites to help ensure patient safety is maintained across the Trust. • The international recruitment programme continues to bring in new recruits each month, however there is a variable delay between arriving and officially joining the staffing numbers. • The Band 5 RN vacancy level has improved this month to 12.5% compared to 15.3 % in March with turnover decreasing to 17.6% across the Trust. • The impact of COVID-19 infection on staff sickness and absence in April has been excessive this has been reflected in Trust fill rate for shifts for registered and non-registered staff to 87%, however this does not reveal lower fill rates on specific wards on specific days. • This month the low staffing situation has been exacerbated with the requirement to ensure extra capacity areas have been regularly utilised during the month due to operational pressure, this has also reduced the pool of available staff to cover ward shifts. • Both the level of 'lower than expected staffing incidents and red flag incident decreased in April compared to March 2022. Actions: • Additional oversight and support for nurse staffing has been required by Heads of Nursing and Deputy Chief Nurses to ensure the balance of safe staffing is achieved across the Trust. • A business case for a further 108 International Nurses has been agreed with recruitment progressing. • All the Trusts incentives continued up until April 25th 2022 to encourage staff to work extra shifts where they felt able to do so. Some targeted incentives have continued these include the Allocate on Arrival incentive. • A system wide Health Care Support Worker recruitment event is planned for 19th May 2022 with significant Trust representation. • A review and refresh of the current retention strategy is underway to ensure that staff see UHBW as where they wish to work, undertake further development and continue their careers.
Ownership:	Chief Nurse

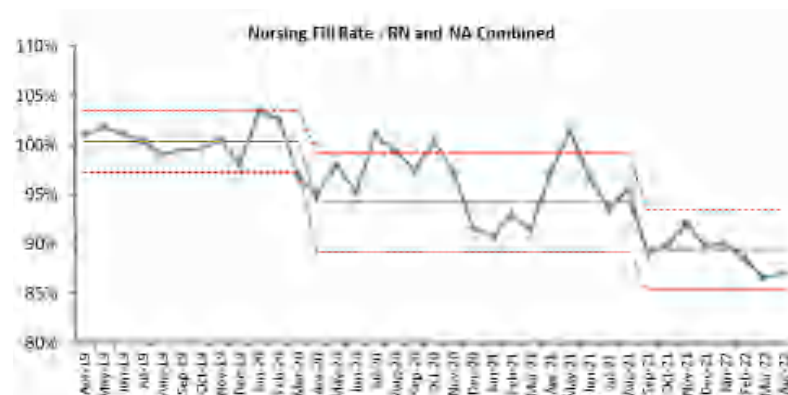
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Nurse Staffing Levels

April 2022

Staffing Fill Rates

	Mar-22		
	Total	RN	NA
Medicine	94.2%	91.6%	97.7%
Specialised Services	93.2%	83.6%	122.8%
Surgery	86.8%	83.3%	95.6%
Weston	88.1%	80.7%	96.4%
Women's and Children's	77.6%	80.8%	62.7%
TRUST TOTAL	86.6%	83.5%	93.4%



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Venous Thromboembolism (VTE) Risk Assessment

April 2022

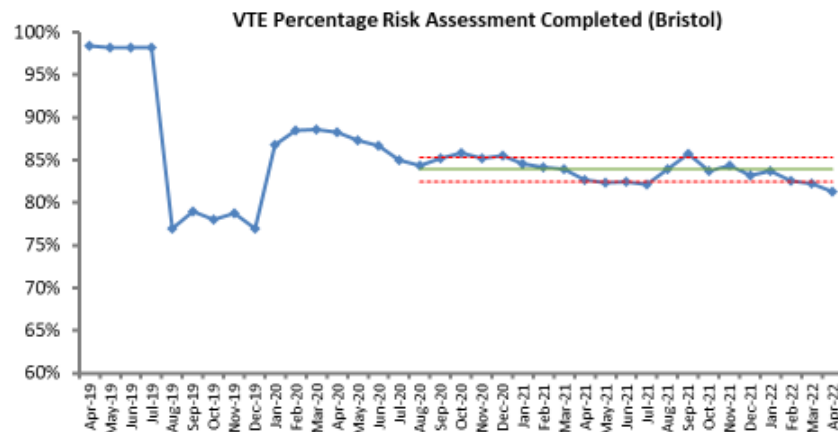
N Not Achieved

Standards:	Venous Thromboembolism (VTE) is a significant cause of mortality and disability in England. At least two-thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and the administration of appropriate thromboprophylaxis. The expectation for UHBW was to achieve 95% compliance, with an amber threshold to 90%.
Performance:	Compliance for April 2022 was 81.3% and has remained around this level for recent months (82.2% for March 2022). This is data for Bristol sites only and is below the 95% target.
Commentary:	Previous compliance results highlight the ongoing need for improvement in VTE risk assessment completion which is significantly below the national target. Following implementation of digital risk assessments and the alignment of Low Molecular Weight Heparin (LMWH) in Weston, there is now unity across UHBW; and digital risk assessments have several advantages including: • VTE risk assessments completed in full including name and date of person completing • VTE risk assessment can be completed and accessed anywhere, even when the drug chart cannot be located. • Compliance data available in real time, with performance reports according to ward or speciality at the click of the button. However, further integrated digital roll out has been delayed and this has resulted in digital VTE risk assessments standing alone within Careflow, which has generated a significant barrier to compliance. The merging of the Careflow systems in April now means that the VTE risk assessments completed on either site can be viewed by any clinician within the trust. This allows for more complete history when completing VTE assessments and improves workflow when patients are transferred between sites. Actions: • There are VTE Quality Improvement (QI) projects ongoing in Haematology, Oncology, Trauma & Orthopaedics, Medicine and Surgery led by speciality consultants; and there is evidence that speciality specific focused effort can improve compliance in the short term, but this improvement is transient. • It is very unlikely that sustained consistent compliance >95% will be achieved without an integrated digital system. In the meantime, to optimise VTE risk assessment compliance as much as possible, changes need to be led by and performance owned within the individual specialities and divisions. • Following a scoping exercise relating to the challenges faced with improving VTE risk assessments within UHBW; a meeting took place in May with the Trust VTE Leads, Patient Safety Lead, Patient Safety Improvement Lead, and the Medical Director Team to discuss the focus for further improvement work pending the implementation of an electronic prescribing system in the longer term. This has resulted in a number of new actions being taken forward.

Hartles Rachel
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Venous Thromboembolism (VTE) Risk Assessment

April 2022



Division	SubDivision	Number Risk Assessed	Total Patients	Percentage Risk Assessed
Diagnostics and Therapies	Chemical Pathology	2	2	100.0%
	Radiology	21	21	100.0%
Diagnostics and Therapies Total		23	23	100.0%
Medicine	Medicine	1,419	2,097	67.7%
Medicine Total		1,419	2,097	67.7%
Specialised Services	BHOC	2,156	2,279	94.6%
	Cardiac	276	453	60.9%
Specialised Services Total		2,432	2,732	89.0%
Surgery	Anaesthetics	15	15	100.0%
	Dental Services	74	112	66.1%
	ENT & Thoracics	188	278	67.6%
	GI Surgery	729	917	79.5%
	Ophthalmology	272	273	99.6%
	Trauma & Orthopaedics	128	145	88.3%
Surgery Total		1,406	1,740	80.8%
Women's and Children's	Children's Services	34	46	73.9%
	Women's Services	1,270	1,457	87.2%
Women's and Children's Total		1,304	1,503	86.8%
Grand Total		6,584	8,095	81.3%

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Friends and Family Test (FFT)

April 2022

N/A No Standard Defined

Standards:	The FFT question asks "Overall, how was your experience of our service?". The Trust collects FFT data through a combination of online, postal survey responses, FFT cards and SMS (for Emergency Departments and Outpatient Services). There are no targets set.
Performance:	The Trust received 4,724 FFT responses in April 2022, which represents a 21% decrease in the number of responses received in March (5,714). See table below for the performance summary. In terms of ED FFT performance in April 2022: - BRI ED score has increased to 75% (from 67% in March). - BRCH ED score has seen a small decrease to 84% (from 86% in March). - Weston ED reports a score of 81%, a small increase from the score of 77% in March. - BEH ED score remains high at 96% (from 96% in March).
Commentary:	FFT scores for inpatients, day cases, maternity and outpatients are extremely positive and broadly consistent with March figures. In response to the lower than (long-term) average FFT scores for the BRI ED and Weston ED, weekly reports are sent from the Patient Experience Team to ED divisional leads with their FFT data for the previous week so that data can be reviewed in a more timely manner.
Ownership:	Chief Nurse

		Positive Response	Total Response	Total Eligible	% Positive	Response Rate
Inpatients	UHBW	718	762	2,780	94.3%	27.4%
Day Cases	UHBW	372	373	1,972	99.7%	18.9%
Outpatients	UHBW	2,181	2,345		94.2%	
A&E	BRI	214	288	4,063	75.4%	7.1%
	BRHC	217	260	2,969	83.5%	8.8%
	BEH	166	175	1,940	96.0%	9.0%
	Weston	272	340	2,998	80.7%	11.3%
	UHBW	869	1,063	11,970	82.4%	8.9%

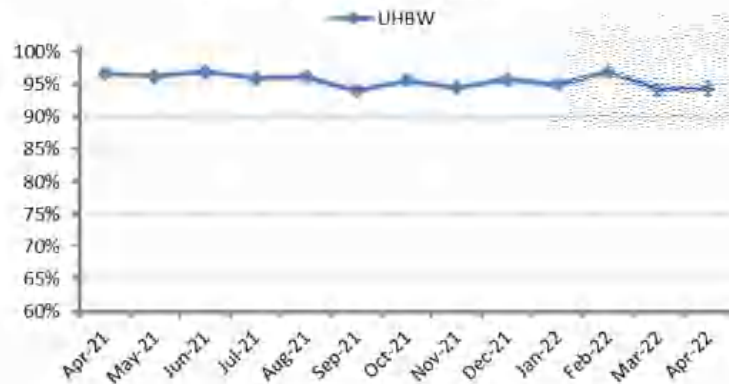
		Positive Response	Total Response	Total Eligible	% Positive	Response Rate
Maternity	Antenatal	40	42	183	97.6%	23.0%
	Birth	55	56	357	98.2%	15.7%
	Postnatal (ward)	43	43	346	100.0%	12.4%
	Postnatal (community)	39	40	170	97.5%	23.5%
	UHBW	177	181	1,056	98.3%	17.1%

TOTAL RESPONSES	4,724

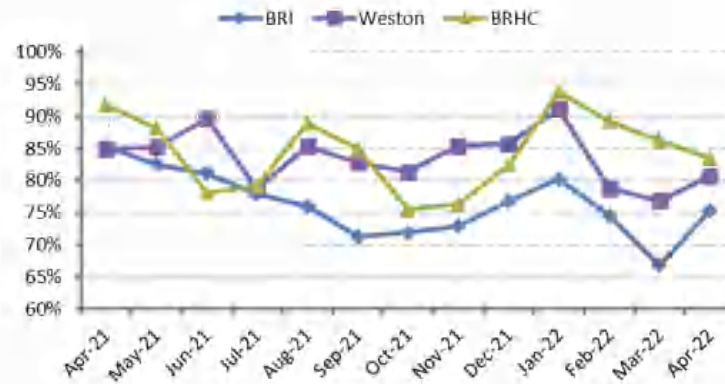
Friends and Family Test (FFT)

April 2022

Inpatient (excluding Day Case) Scores



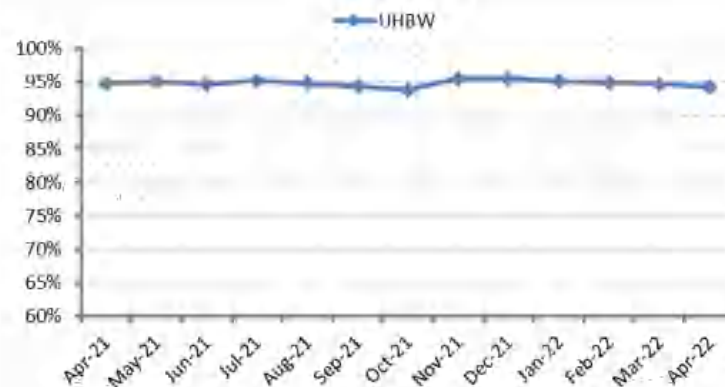
Emergency Department Scores



Maternity Services Scores



Outpatient Scores



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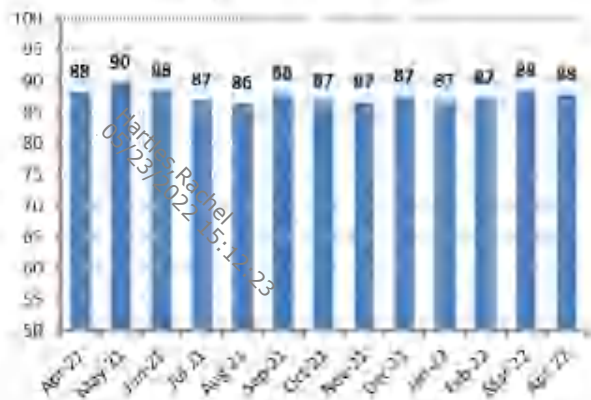
Patient Surveys

April 2022

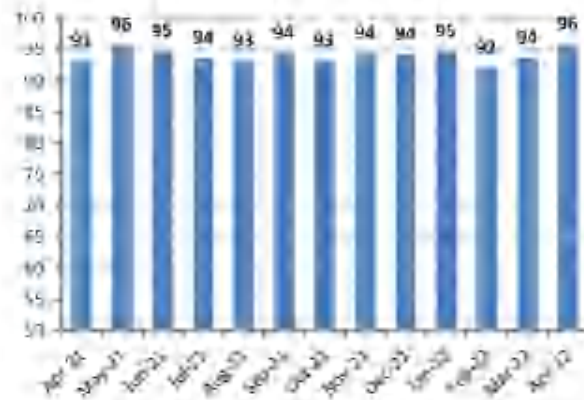
Y Achieved

Standards:	For the inpatient and outpatient postal survey, five questions relating to topics our patients have told us are most important to them are combined to give a score out of 100. For inpatients, the target is to achieve a score of 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target score of 90 or over. This is now an integrated score across Bristol and Weston. In previous months the survey results were reported separately.
Performance:	For April 2022: - Inpatient score was 88 (March was 88). - Kindness and understanding score was 96 (March was 94). - Outpatient score was 92 (March was 91).
Commentary:	Please note that reporting for monthly patient survey data for Bristol hospital sites and Division of Weston has been integrated from April 2022. Data from 2021/22 has also been integrated to give comparable trend data. Therefore, there is now a single set of metrics for the Trust. Divisional level metrics are reported quarterly through the Patient Experience Group (PEG) and Quality Outcomes Committee (QOC). April 2022 scores exceeded the minimum targets.
Ownership:	Chief Nurse

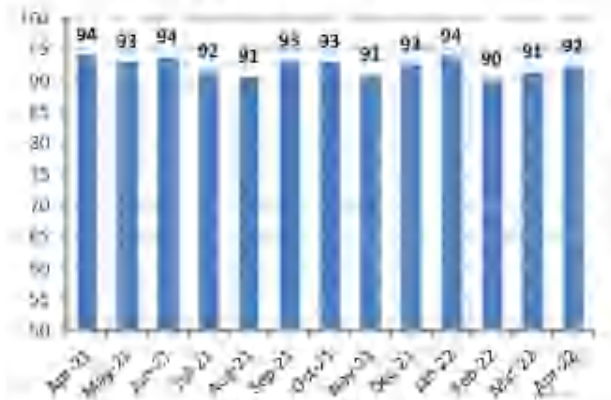
Inpatient Tracker Score



Kindness & Understanding Score



Outpatient Tracker Score



Patient Complaints

April 2022

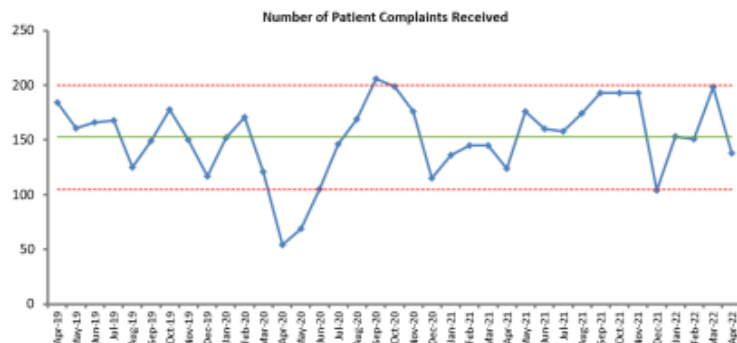
N Not Achieved

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 April 2022: • 138 Complaints were received (12 Formal and 126 Informal). • Responses for 57 Formal and 72 Informal complaints were sent out to complainants. • 63% of formal complaints (36 out of 57) were responded to within the agreed timeframe, representing a deterioration in performance compared with 68% reported in March 2022, and still significantly below the 95% target. • Divisions returned 75% (43 out of 57) of formal responses to the PSCT by the agreed deadline, which is the same as reported in March. This is the deadline for responses to be returned to PSCT; seven working days prior to the deadline agreed with the complainant. • 92% of informal complaints (66 out of 72) were responded to within the agreed timeframe, which is a notable improvement on the 86.1% in March, and the best monthly performance since July 2021. • There were eight complaints where the complainant was dissatisfied with our response, which represents 8.5% of the 94 first responses sent out in February 2022 (this measure is reported two months in arrears).
Commentary:	Performance for the overall response time for formal complaints continues to reflect operational pressures across the organisation. 17 of the 21 breaches were attributable to delays within the divisions, with three breaches due to delays in the Patient Support & Complaints Team (PSCT) and one due to a delay during the Executive signing process. The dissatisfied metric of 8.5% does not achieve the Trust's target of no more than 8% of complainants advising us that they were unhappy with our response to their complaint. Analysis of the reasons for complainant dissatisfaction continues to be closely monitored by the PSCT Manager. NB: At the time of submitting this report, this data had not yet been validated by Divisions
Ownership:	Chief Nurse

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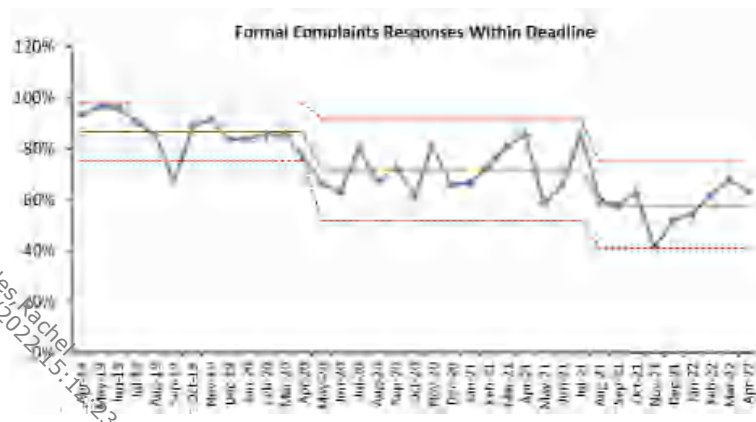
Patient Complaints

April 2022



Complaints Received

	Apr-22	2021/2022	2020/2021
Diagnostics and Therapies	11	103	56
Medicine	37	414	385
Specialised Services	18	260	190
Surgery	34	504	406
Trust Services	0	30	56
Weston	18	227	250
Women's and Children's	17	389	273
Estates and Facilities	3	50	49
TOTAL	138	1977	1665



Responses Within Deadline

	Apr-22	
	% Within Deadline	Total Responses
Diagnostics and Therapies	0.0%	2
Medicine	58.8%	17
Specialised Services	100.0%	4
Surgery	77.8%	9
Trust Services	100.0%	1
Weston	27.3%	11
Women's and Children's	83.3%	12
Estates and Facilities	100.0%	1
TOTAL	63.2%	57

Emergency Care – 4 Hour Standard

April 2022

N Not Achieved

Standards:	Measured as length of time spent in the Emergency Department from arrival to departure/admission. The national standard is that at least 95% of patients should wait under 4 hours. There is also an expectation that no patient will wait more than 12 hours in ED after a decision to admit has been made, called “Trolley Waits”. There is also an expectation that no Ambulance Handover will exceed 30 minutes.
Performance:	Trust level 4 hour performance for April was 61.5% across all four Emergency Departments (15,234 attendances and 5,864 patients waiting over 4 hours). There were 809 patients who had a Trolley wait in excess of 12 hours. In April there were 2,231 ambulance handovers in excess of 15 minutes which was 81% of all handovers. In April there were 2,766 ambulance handovers in excess of 30 minutes which was 62% of all handovers.
Commentary:	Bristol Royal Infirmary: Performance against the 4 hour standard in April has deteriorated further to 42.2% despite average daily attendances dropping from 209 attendances per day in March to 196 attendances per day. 12 hour trolley wait breaches remain high at 504 and average ambulance handover delays at 99 hours lost per day. This reflects the highly challenging picture in across the local health and care system. The primary drivers of breaches is workforce shortages and the availability of supporting services in the wider health and care system. A particular challenge is the high numbers (>100 per day) of patients who are medically fit for discharge (MFFD) but whose discharge is delayed due to the lack of system capacity to support their social care needs out of hospital. The Trust is progressing a range of initiatives to reduce overcrowding, ambulance queueing and long waits including: • Community Pharmacy Consultation Service (CPCS) app was launched in April helping patients who attend ED to book pharmacy consultations • The Trust is also progressing redesign of clinical pathways (chest pain, surgical patients, early pregnancy) to reduce ED attendances. • Medical Same Day Emergency Care: SDEC helps avoids overnight admissions. Recruitment is ongoing to expand from 5 to 7 day service. • Escalation capacity and reverse queuing is routinely used to support the additional bed demand. • Redirection of minor illness/injury to GPs, Urgent Treatment Centres and community pharmacy is fully embedded in our practice. ...continued over page

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Emergency Care – 4 Hour Standard

April 2022

Commentary (continued):

Bristol Eye Hospital:

Performance improved in April to 97.2%, compared to 94.8% in March, with attendances of 1,949 which is slightly less than the 2,029 for the month before. There were 55 four-hour breaches with the reasons for breach being: 32 doctor delay, 16 diagnostic delay, 7 clinical having treatment to avoid admission, though 1 was admitted. Of those 55 four-hour breaches, 5 had a long nurse triage time over 1 hour which would have contributed to the wait time.

Doctor staffing continues to be challenging due to sickness and annual leave. The department has had 1 nurse retire and have successfully recruited 1 full time and 1 part time nurse to our outstanding vacancies; however the impact of this will not been seen for a while as they will need a lot of 1:1 supervision for the first 18 months.

The department continues to await the outcome of the planning round submission for permanent technician support (3.5 whole time equivalents requested). In the meantime one technician has been seconded to the post and bank technicians used to fill the outstanding post.

Weston General Hospital:

Weston's performance against the 4 hour standard for April has further decreased at 54.3% vs 59.6% in March. Challenges around staffing and capacity to see patients when high numbers of patients continue to be bedded in the Emergency Department overnight awaiting an inpatient bed. Overall the daily average has decreased in month however 12 hour breaches remain high with 366 in month vs 361 in March.

The Trust remained in Internal Critical Incident and the Weston Division in OPEL 4 throughout the month. Escalation beds were in regular use, whilst also trying to ensure the right patients were in the right ward avoiding outliers as much as possible. Covid positive patients remain cohorted on Waterside ward which is becoming slightly easier to manage with the demand of positive cases reducing. The daily average for Medically Fit for Discharge patients average remains high at 75 patients per day.

Projects on going at the front door to support de-escalation. Redirection work on going with further developments planned to take place mid-June where the impact will be monitored and reported.

Ownership

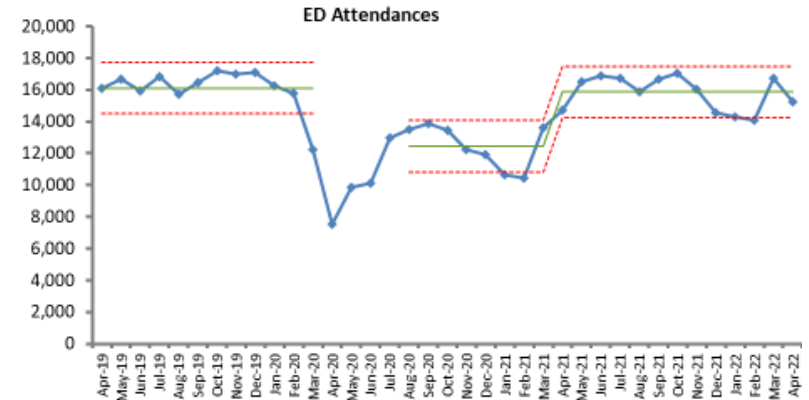
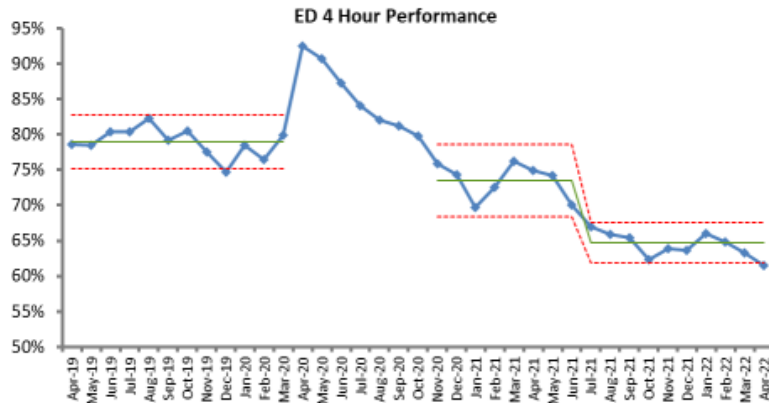
Chief Operating Officer

4 Hour Performance	Apr-22	2021/2022
Bristol Royal Infirmary	42.2%	50.4%
Bristol Children's Hospital	81.1%	78.0%
Bristol Eye Hospital	97.2%	97.0%
Weston General Hospital	54.3%	67.3%

Total Attendances	Apr-22	2021/2022
Bristol Royal Infirmary	5,878	74,852
Bristol Children's Hospital	3,644	47,205
Bristol Eye Hospital	1,949	22,325
Weston General Hospital	3,763	45,841

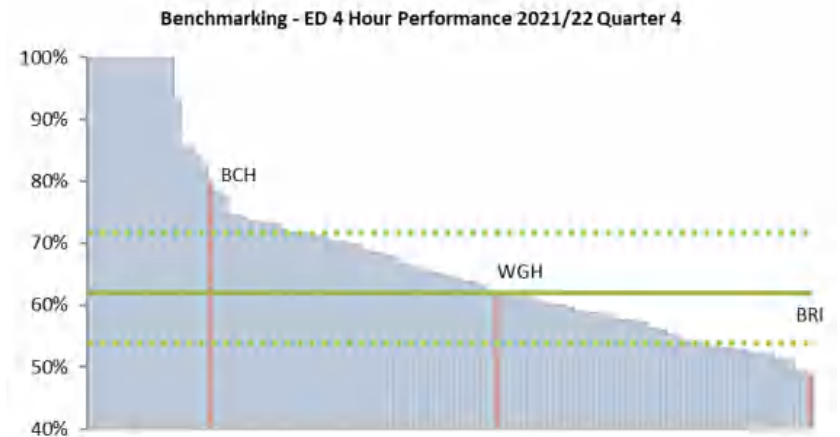
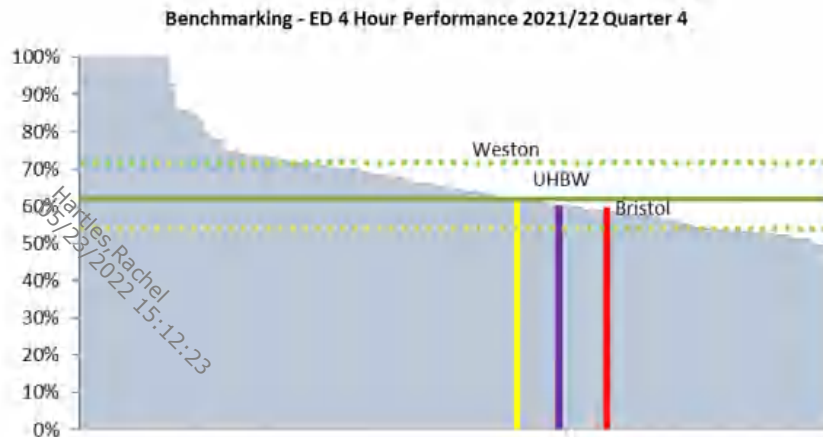
Emergency Care – 4 Hour Standard

April 2022



Note:

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



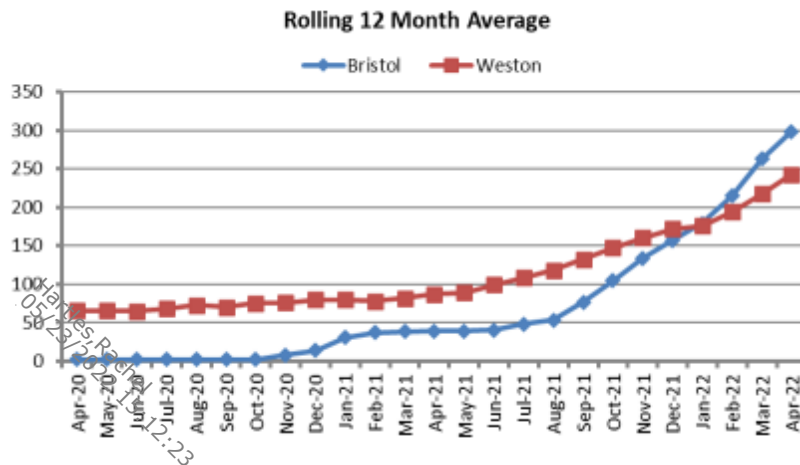
Emergency Care – 12 Hour Trolley Waits

April 2022

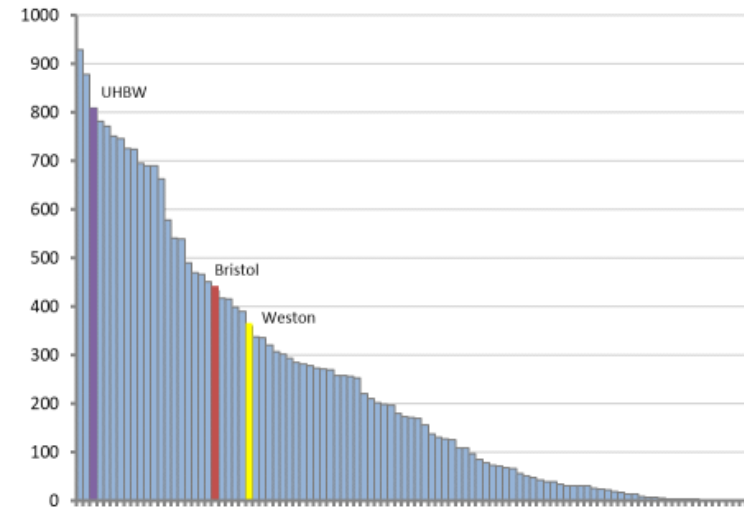
12 Hour Trolley Waits

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

	2020/2021												2021/2022												22/23
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Bristol	0	0	0	0	0	0	3	66	79	211	82	18	9	4	12	91	69	276	337	415	363	472	514	591	443
Weston	0	1	7	58	68	6	84	135	168	257	113	84	62	24	134	164	188	180	257	291	313	304	330	361	366
UHBW	0	1	7	58	68	6	87	201	247	468	195	102	71	28	146	255	257	456	594	706	676	776	844	952	809



Benchmarking - 12 Hour Trolley Waits - April 2022



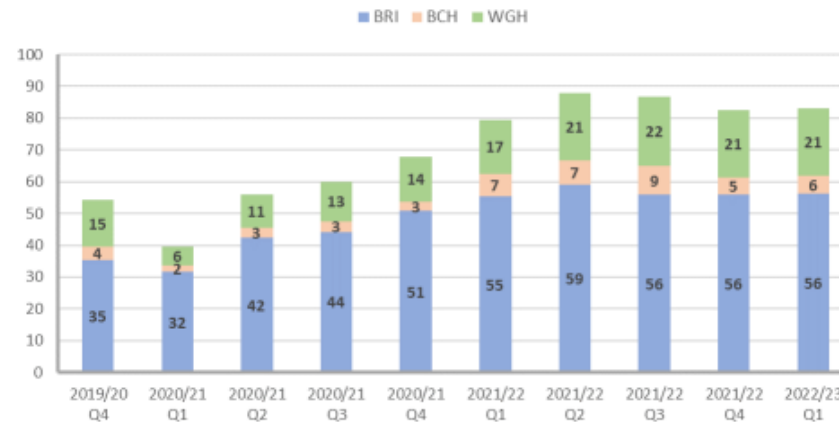
Emergency Care – Ambulance Handovers

April 2022

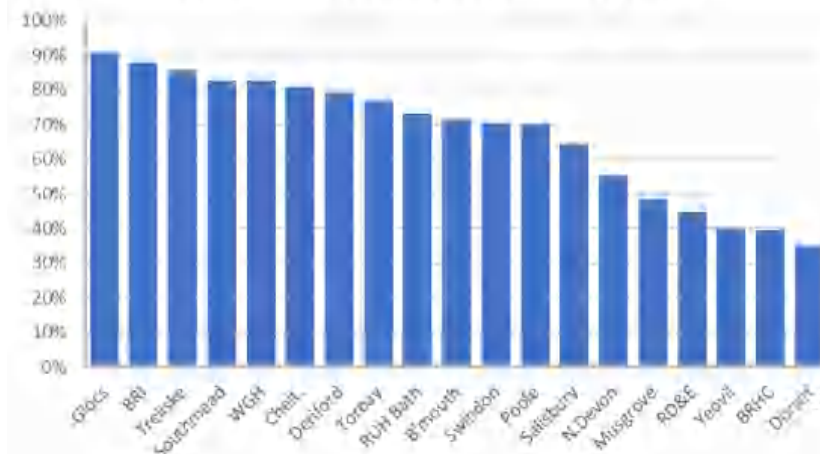
This data is supplied by the South Western Ambulance Service NHS Foundation Trust (SWASFT).

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

UHBW Handovers In Excess of 15 Minutes (Average Per Day)



Percentage of Handovers Over 15 Minutes - April 2022



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Emergency Care – Ambulance Handovers

April 2022

	Total Handovers - South West - April 2022						
	Total Handovers	Over 15 Mins	% Over 15 Mins	Over 30 Mins	% Over 30 Mins	Over 1 Hour	Over 2 Hours
BRISTOL ROYAL HOSP FOR CHILDREN	339	134	39.5%	42	12.4%	8	0
BRISTOL ROYAL INFIRMARY	1,718	1,512	88.0%	1,271	74.0%	938	594
CHELTENHAM GENERAL HOSPITAL	454	367	80.8%	266	58.6%	155	67
DERRIFORD HOSPITAL	1,877	1,485	79.1%	1,210	64.5%	867	610
DORSET COUNTY HOSPITAL	1,256	440	35.0%	220	17.5%	106	32
GLOUCESTER ROYAL HOSPITAL	1,834	1,663	90.7%	1,478	80.6%	1,192	881
GREAT WESTERN HOSPITAL	1,652	1,160	70.2%	840	50.8%	582	334
MUSGROVE PARK HOSPITAL	1,912	928	48.5%	421	22.0%	229	86
NORTH DEVON DISTRICT HOSPITAL	1,166	644	55.2%	275	23.6%	92	26
POOLE HOSPITAL	1,538	1,077	70.0%	684	44.5%	438	244
ROYAL BOURNEMOUTH HOSPITAL	1,659	1,187	71.5%	890	53.6%	596	354
ROYAL DEVON AND EXETER WONFORD	2,597	1,162	44.7%	281	10.8%	47	16
ROYAL UNITED HOSPITAL - BATH	1,903	1,389	73.0%	997	52.4%	688	422
SALISBURY DISTRICT HOSPITAL	890	574	64.5%	375	42.1%	230	111
SOUTHMEAD HOSPITAL	2,227	1,839	82.6%	1,210	54.3%	725	440
TORBAY HOSPITAL	1,626	1,251	76.9%	886	54.5%	610	387
TRELISKE HOSPITAL	1,687	1,447	85.8%	1,308	77.5%	1,128	924
WESTON GENERAL HOSPITAL	709	585	82.5%	414	58.4%	286	187
YEOVIL DISTRICT HOSPITAL	1,062	427	40.2%	124	11.7%	10	1
SOUTH WEST TOTAL	28,106	19,271	68.6%	13,192	46.9%	8,927	5,716

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Delayed Discharges (No Criteria to Reside)

April 2022

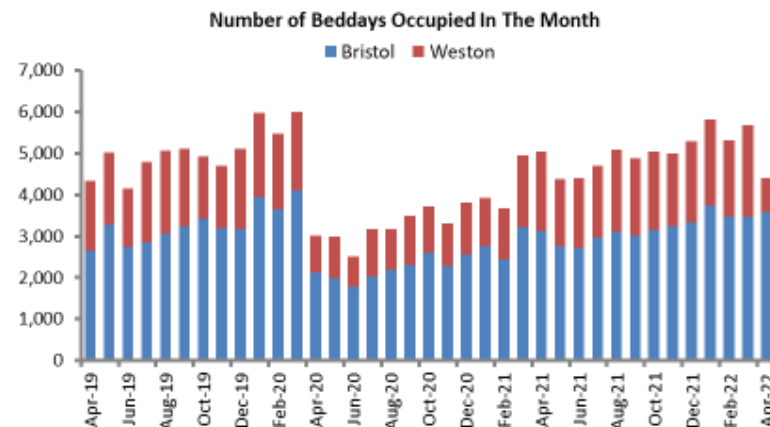
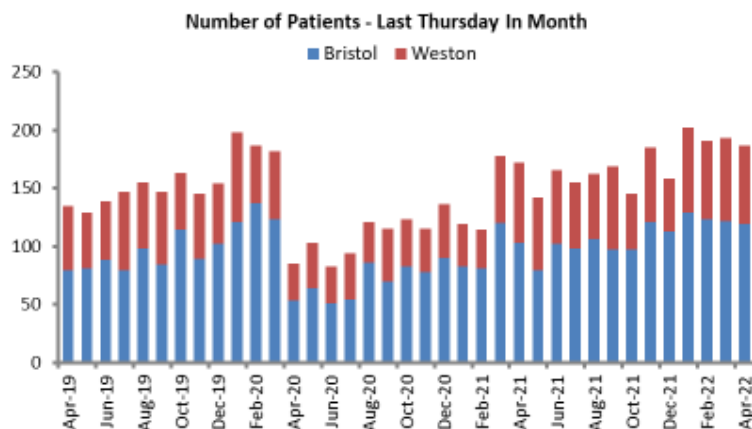
N/A No Standard Defined

Standards:	Patients who are medically fit for discharge should wait a minimal amount of time in an acute bed. Pre-Covid, this was captured through Delayed Transfers of Care (DToC) data submitted to NHS England. This return has been discontinued but the Trust continues to capture delayed discharges through its No Criteria to Reside (NCR) lists. These are patients whose ongoing care and assessment can safely be delivered in a non-acute hospital setting, but the patient is still in an acute bed whilst the support is being arranged to enable the discharge. Patients are transferred through one of three pathways; at home with support (Pathway 1), in community based sub-acute bed with rehab and reablement (Pathway 2) or in a care home sub-acute bed with recovery and complex assessment (pathway 3).
Performance:	At the end of April there were 187 NCR patients in hospital. There were 4,408 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 NCR patients.
Commentary:	In April 2022, the demand across all the pathways in Bristol and Weston continued to exceed capacity in the community: • Pathway 1: In the BRI there were 31 patients who did not meet the reason to reside waiting for a P1. Work ongoing with Sirona to provide more notice of P1 slots in advance with the aim that the Integrated Discharge Service (IDS) can attempt earlier discharges for patients who have family support. However, short notice discharge dates persisted April so opportunities were limited. Issues persisted with lack of capacity in the community for Bristol patients in particular, this has been raised with the CCG. In Weston there were 19 patients awaiting P1 (9 more than in March). Work ongoing around opportunities with the discharge support grant and increased engagement with the discharge MDT meetings. • Pathway 2: In the BRI there were 22 patients waiting at the end of April. Work continues with therapies to review patient needs to ensure that they are discharged on the most appropriate pathway. Capacity continues to not be able to keep up with demand. In Weston there were 22 P2's (7 more than in March 2022). Continued P2 capacity challenges in North Somerset. Work ongoing with discharge Multi Disciplinary Teams (MDT's) to seek to return home where safe. • Pathway 3: Work is ongoing around transitional beds to further reduce P3 waits for both sites. Community capacity constraints remain with homes being shut due to covid. In the BRI there were 26 patients waiting for a P3 bed. In Weston there were 14 patients awaiting P3. Ongoing bed and home closures limiting discharges. Needs continue to be relatively high meaning smaller base of potential beds to call upon.
Ownership:	Chief Operating Officer

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Delayed Discharges (No Criteria to Reside)

April 2022



Bristol: Current Breakdown of Medically Fit For Discharge (MFFD) Patients, 19th May 2022

Pathway	Number of Patients	Percentage	7+ Days on Latest Pathway	14+ Days on Latest Pathway	21+ Days on Latest Pathway
Pathway 1	53	26.1%	10	3	0
Pathway 2	42	20.7%	24	6	1
Pathway 3	53	26.1%	29	16	9
Awaiting Decision	38	18.7%	4	1	1
Awaiting Referral	6	3.0%	1	0	0
Other	11	5.4%	7	4	2
Total	203		75	30	13

Pathway 1 – patients awaiting package of care

Pathway 2 – requiring rehabilitation or reablement

Pathway 3 – Nursing or Residential home required

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Referral To Treatment

April 2022

N Not Achieved

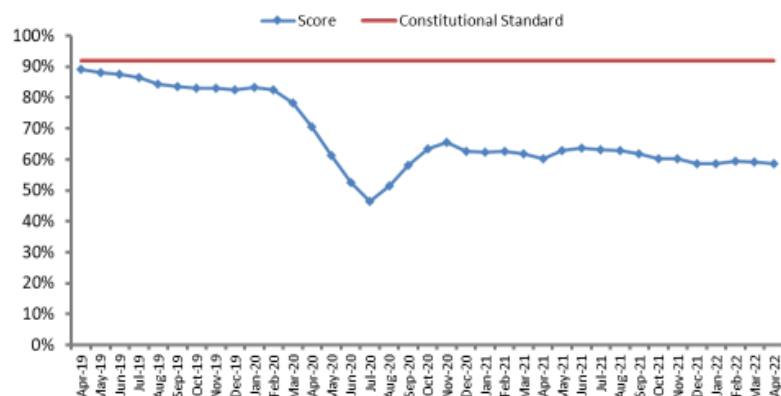
Standards:	The number of patients on an ongoing Referral to Treatment (RTT) pathway and the percentage that have been waiting less than 18 weeks. The national standard is that over 92% of the patients should be waiting under 18 weeks. A recovery trajectory was submitted to NHS England for 2022/23. The end of April target list size was 53,304.
Performance:	At end of April, 58.7% of patients were waiting under 18 weeks. The total waiting list was 57,019 and the 18+ week backlog was 23,579. So the end of April position for total list size exceeded the recovery trajectory. Comparing the end of April 2020 with the end of April 2022: - the overall wait list has increased by 20,807 patients. This is an increase of 58%. - the number of patients waiting 18+ weeks increased by 12,925 patients. This is an increase of 121%.
Commentary:	The focus of discussions with divisions and wider system partners is to clear patients who are currently 104 weeks wait where possible by the end of March 2022 and eradicate any 104ww patient by end of June 2022. This will require focus on transferring suitable patients to the independent sector, making the best use of internal capacity by ensuring full utilisation is maximised and to bolster additional capacity through Glanso and waiting list initiatives. In addition, using the CCG to make use of mutual aid arrangements allowing transfer to another specialist centre for treatment due to the lack of bed/HDU capacity to bring these patients in for treatment. The requirement from NHSE and the local CCG is to demonstrate that we have explored all options for our long waiting patients to be treated before end of March 2022 with the back-stop position of June 2022 where we should have no 104ww patients. The largest increases in waiting list size, when compared with April 2020, are in Ophthalmology (4,621 increase, 117%), Adult ENT & Thoracics (3,821 increase, 233%) and Dental Services (4,368 increase, 52% increase). The largest volumes of 18 +week backlog patients at the end of April are in Dental (7,309 patients), Ophthalmology (2,681), ENT & Thoracics (2,552) and Paediatrics (3,464).
Ownership:	Chief Operating Officer

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Referral To Treatment

March/April 2022

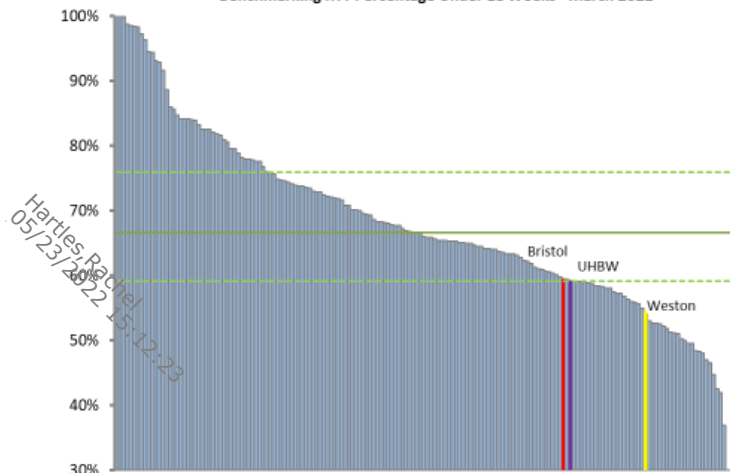
Referral To Treatment - Percentage Under 18 Weeks



Referral To Treatment - Total on Waiting List



Benchmarking RTT Percentage Under 18 Weeks - March 2022



	Apr-22		
	Under 18 Weeks	Total Pathways	Performance
Diagnostics and Therapies	405	472	85.8%
Medicine	5,365	7,899	67.9%
Specialised Services	3,885	5,422	71.7%
Surgery	17,492	32,717	53.5%
Women's and Children's	6,277	10,492	59.8%
Other/Not Known	16	17	-
TRUST TOTAL	33,440	57,019	58.6%

Referral To Treatment – Long Waits

April 2022

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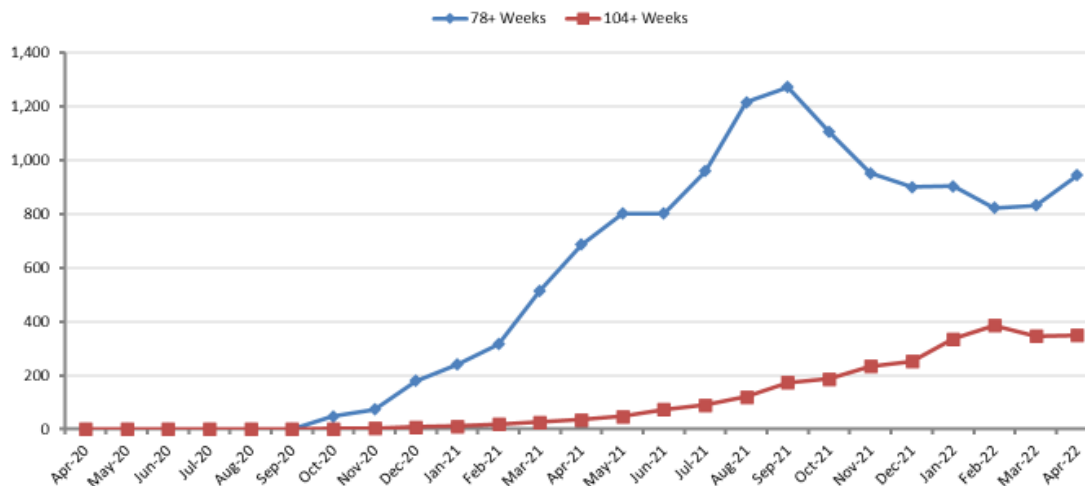
Standards:	Pre-Covid, the expectation was that no patient should wait longer than 52 weeks for treatment. As part of the Elective Recovery Programme Trusts were required to submit plan that eliminated patients waiting 104+ weeks (2+ years) for treatment by the end of June 2022. UHBW's submitted trajectory has 336 patients waiting 104+ weeks by end of April 2022 and 197 by end of June 2022.
Performance:	At the end of April 4,362 patients were waiting 52+ weeks. At the end of April, 349 patients were waiting 104+ weeks, which is 13 patients above the recovery trajectory of 336.
Commentary:	The trend has been upwards for 52 week waiters over the past few months. This is due to the volume of long waiters in the lower weeks wait cohort tipping into the 52+ week cohort whilst divisions try to date the longer waiting patients. It is still extremely difficult to date the longer waiting patients who are waiting for routine operations when there is a lack of capacity due to the continual high demand of higher clinical priority patients, emergency and cancer admissions. This has been further exacerbated by the critical incident position across the Trust and the Omicron variant. The demand and capacity modelling and trajectory setting for the next 3 months, which are being finalised, will demonstrate the short falls in our capacity to recover against the demand. Clinical prioritisation of patients who are on the waiting list without a "to come in" date continues with processes in place to ensure this is now business as usual. 93.8% of the patients who are 52+ weeks on the RTT admitted waiting list have now been clinically prioritised. We are currently making use of the increased capacity within the independent sector and our long waiting patients who meet the criteria to have a transfer of care to the Independent Sector. NHS England, and local commissioners, continue to request weekly reporting of patients waiting 104+ week, as part of the drive to reduce the 104-week breaches by the end of March 2022 and eradicate them by end of June 2022. There is also a requirement to ensure that any 104ww patient who is awaiting an outpatient appointment is given a date before the end of March and seen before the end of April. Weekly analysis and exception reporting is underway, alongside clinical validation of the waiting list however the volumes of patients who have been clinically prioritised as requiring treatment within a month against the Royal College of Surgeons guidelines, still outweigh the capacity we have available to be able to offer this cohort a TCI date which currently doesn't give assurance that we will be able eradicate the 104-week breaches within this timescale. All data sets are shared on a weekly basis with NHSE via a waiting list minimum data set (WLMDs) and weekly meetings are now set up with the CCG and NHSE where the requirement is to provide assurance on a patient level basis what the next steps are with each of our long waiting patients.
Ownership:	Chief Operating Officer

	52+ Weeks	78+ Weeks	104+ Weeks
Diagnostics and Therapies	0	0	0
Medicine	386	45	1
Specialised Services	149	13	5
Surgery	3,009	695	290
Women's and Children's	818	191	53
TOTAL	4,362	944	349

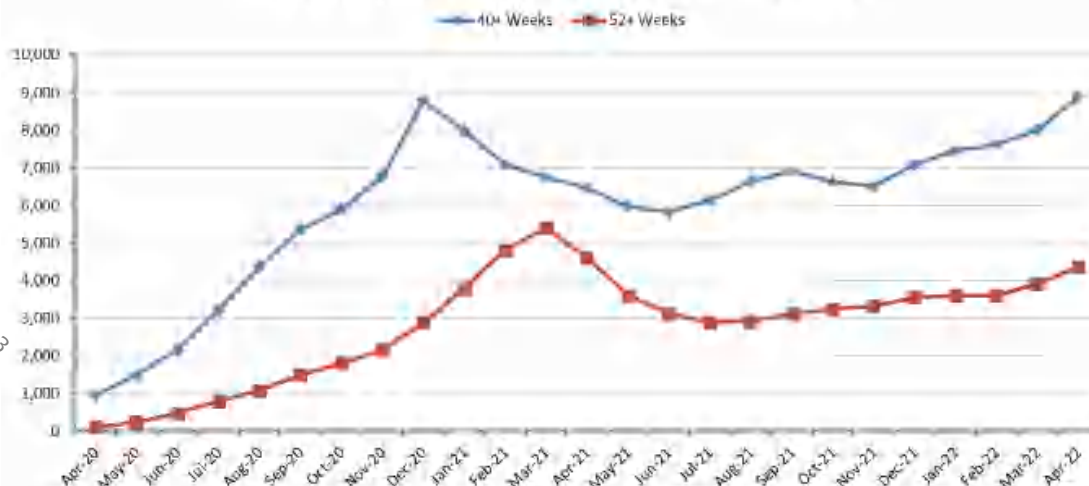
Referral To Treatment – Long Waits

April 2022

Number of Ongoing Pathways Over 78 and Over 104 Weeks at Month End



Number of Ongoing Pathways Over 40 and Over 52 Weeks at Month End



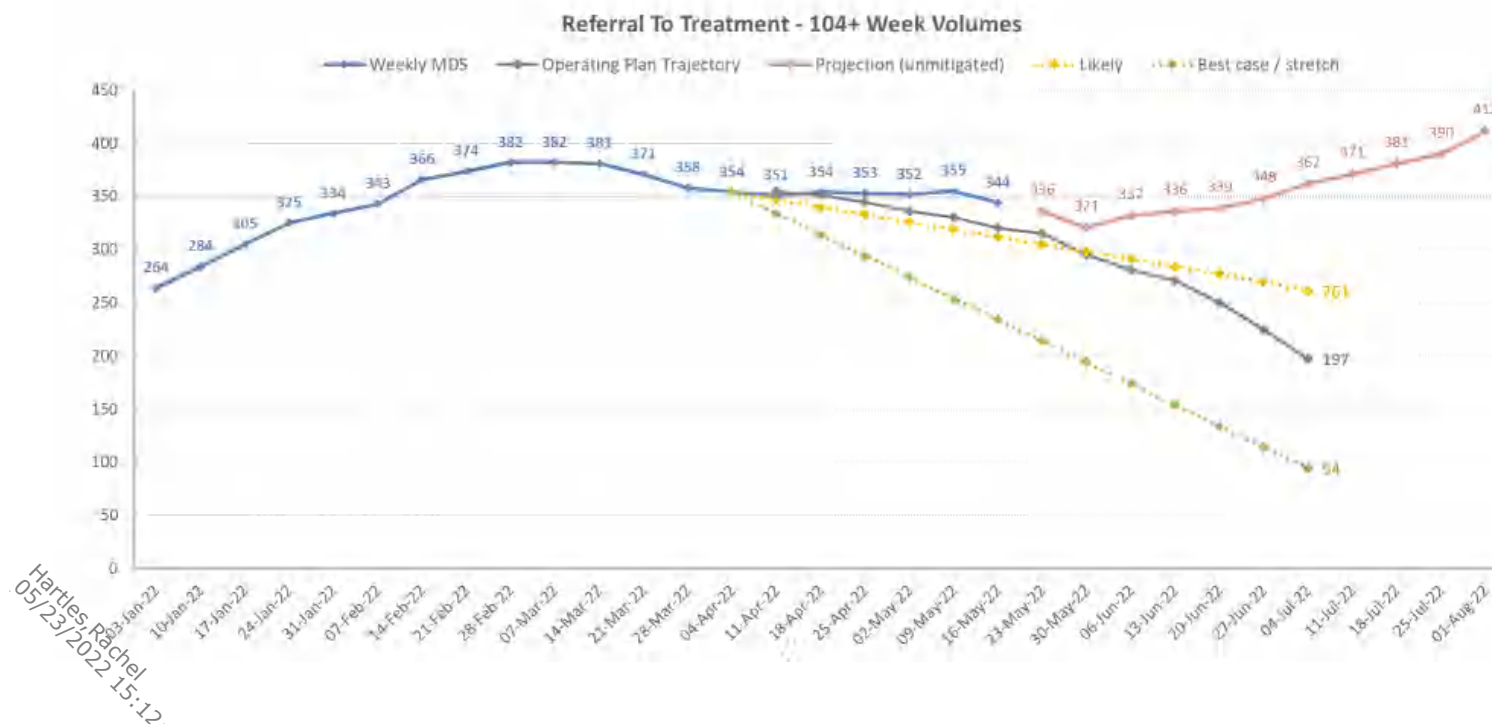
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Referral To Treatment – Long Waits

As At: 15th May 2022

104 Week Trends

Latest Data: Based on position as at end of Sunday 15th May 2022



"Projection (Unmitigated)" – Number of currently Undated RTT patients who will exceed 104 weeks wait.

"Likely" – divisional and corporate assessment of position following mitigations, e.g. future capacity still to be booked.

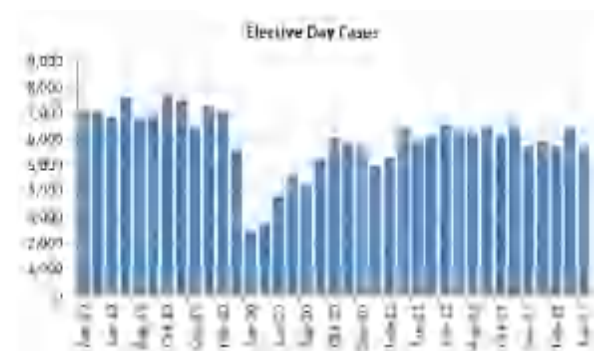
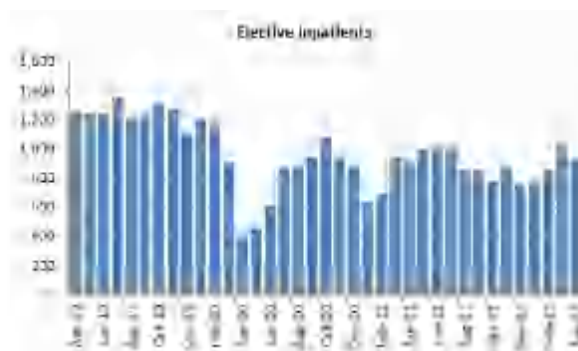
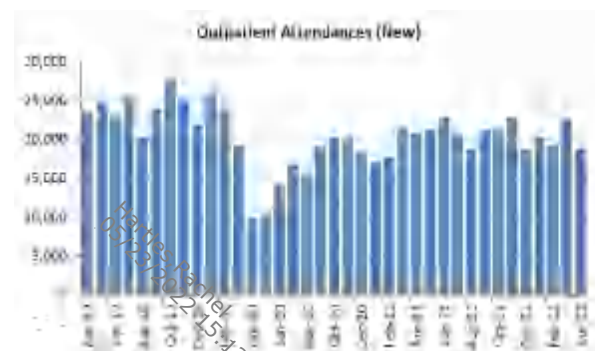
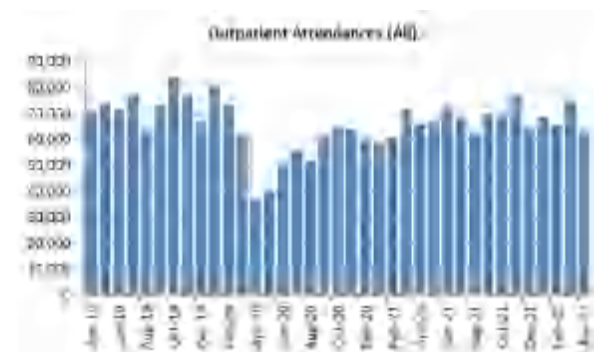
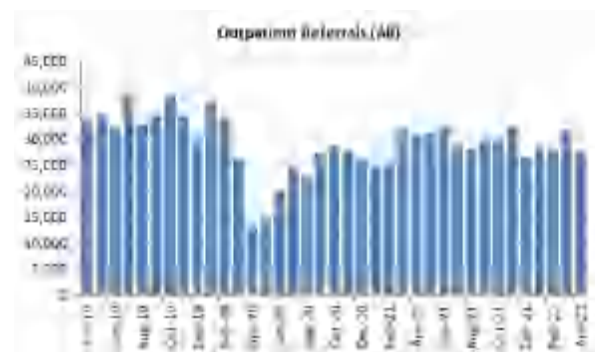
"Best case/stretch" – divisional and corporate assessment of position if all mitigations were implemented

"Operating Plan Trajectory" – nationally submitted trajectory for second half of 2020/21, called "H2".

Elective Activity and Referral Volumes

April 2022

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

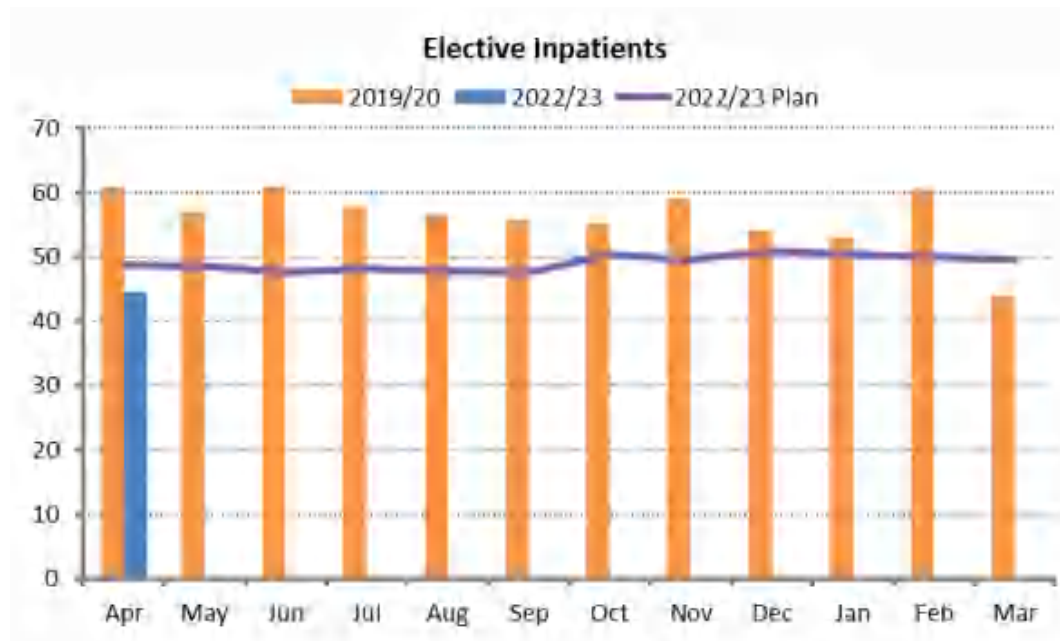


The above data is sourced from the Patient Administration Systems (PAS) and is not the final contracted activity that is used to assess restoration or Business As Usual (BAU) levels.

Elective Activity – Restoration

April 2022

Activity Per Day, By Month and Year

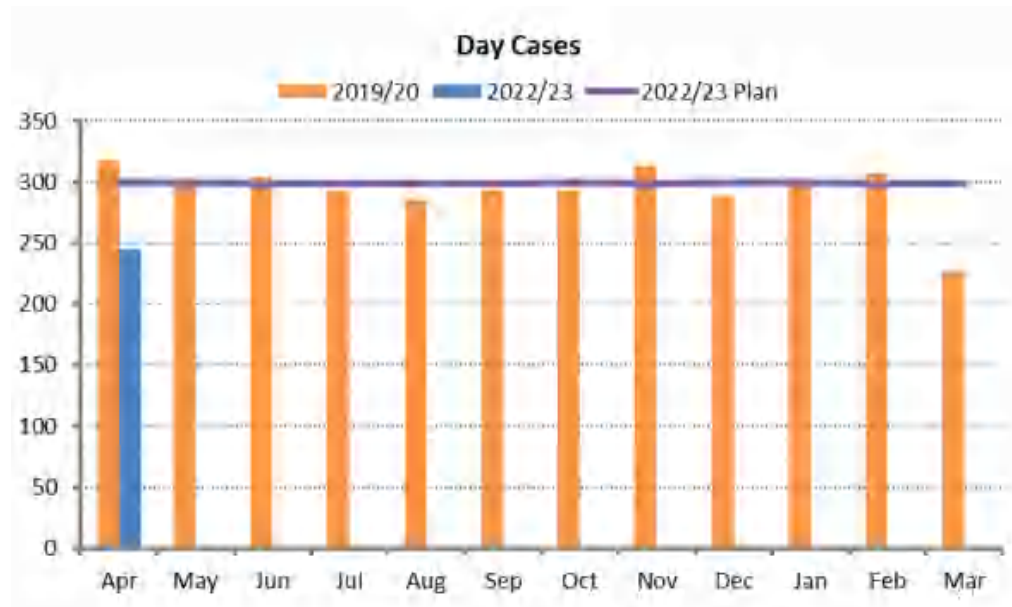


		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	Actual Activity Per Day	61	57	61	58	57	56	55	59	54	53	60	44
2021/22	Actual Activity Per Day	45	51	44	45	39	38	36	39	35	38	41	44
2022/23	Actual Activity Per Day	45											
	Planned Activity Per Day	49	49	48	48	48	48	50	50	51	50	50	50
2022/23 Activity: % of Plan		91%											
2022/23 Activity: % of 2019/20		73%											

Elective Activity – Restoration

April 2022

Activity Per Day, By Month and Year



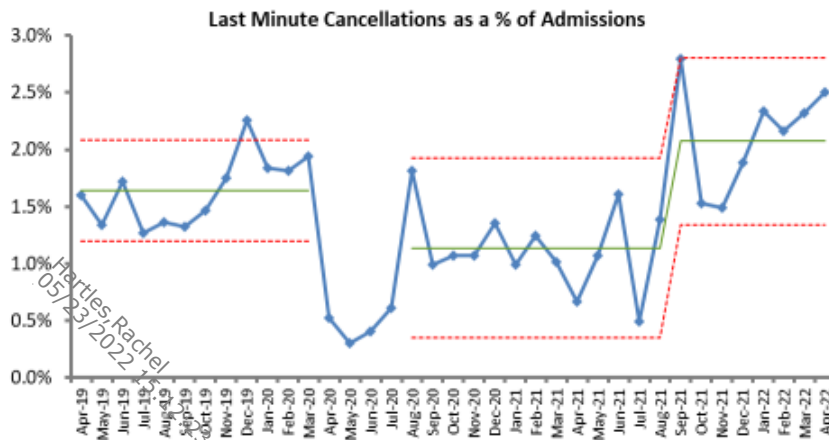
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	Actual Activity Per Day	318	302	303	292	286	294	294	313	288	301	307	226
2021/22	Actual Activity Per Day	279	300	280	265	275	272	268	276	253	280	266	259
2022/23	Actual Activity Per Day	245											
	Planned Activity Per Day	300	299	298	299	299	298	299	299	300	299	299	299
2022/23 Activity: % of Plan		82%											
2022/23 Activity: % of 2019/20		77%											

Cancelled Operations

April 2022

N Not Achieved

Standards:	For elective admissions that are cancelled on the day of admission, by the hospital, for non-clinical reasons: (a) the total number for the month should be less than 0.8% of all elective admissions (b) 95% of these cancelled patients should be re-admitted within 28 days
Performance:	In April, there were 159 last minute cancellations, which was 2.5% of elective admissions. Of the 152 cancelled in March, 121 (80%) had been re-admitted within 28 days.
Commentary:	The largest volumes were in Cardiac/Cardiology (34), Ophthalmology (24) General Surgery (24) and Paediatrics (21). The most common cancellation reasons were: Rescheduled/Postponed (37), No Theatre Staff (23), Ran out of Operating Time (22) and Other Emergency Patient Prioritised (19).
Ownership:	Chief Operating Officer



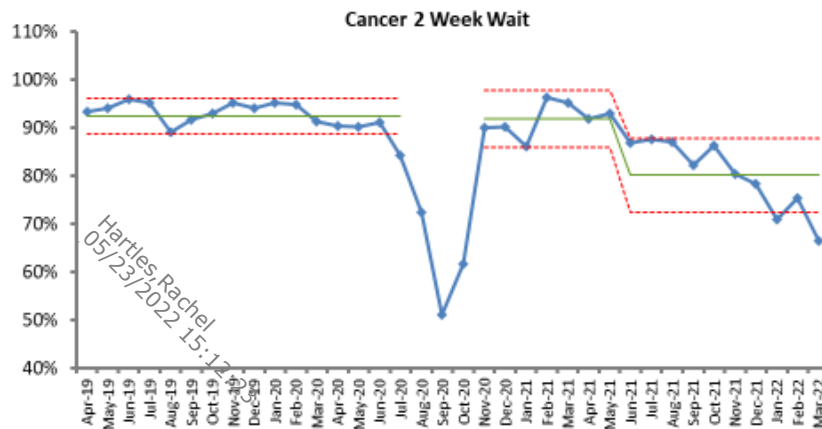
	Apr-22		2021/2022	
	LMCs	% of Admissions	LMCs	% of Admissions
Medicine	19	2.41%	24	0.29%
Specialised Services	40	1.50%	288	1.05%
Surgery	71	3.72%	672	3.16%
Weston	5	0.00%	92	0.76%
Women's and Children's	24	2.84%	237	2.29%
Other/Not Known	0	-	0	-
TRUST TOTAL	159	2.51%	1313	1.65%

Cancer Two Week Wait

March 2022

N Not Achieved

Standards:	Urgent GP-referred suspected cancer patients should be seen within 2 weeks of referral. The national standard is that 93% of patients should be seen within this standard
Performance:	For March, 66.5% of patients were seen within 2 weeks. This is combined Bristol and Weston performance. Overall performance for Quarter 1 was 90.4%. Overall performance for Quarter 2 was 85.7%. Overall performance for Quarter 3 was 81.8%. Overall performance for Quarter 4 was 70.6%.
Commentary:	The standard was non-compliant in March (66.5% against a 93% standard). It is expected that compliance will continue to be challenging until all precautions and restrictions related to Covid are lifted. Covid sickness in clinical teams, and to a lesser extent, amongst patients, has severely limited capacity. Dermatology in particular has had very high levels of sickness, and is a high volume speciality, meaning the impact on the overall position is especially noticeable.
Ownership:	Chief Operating Officer



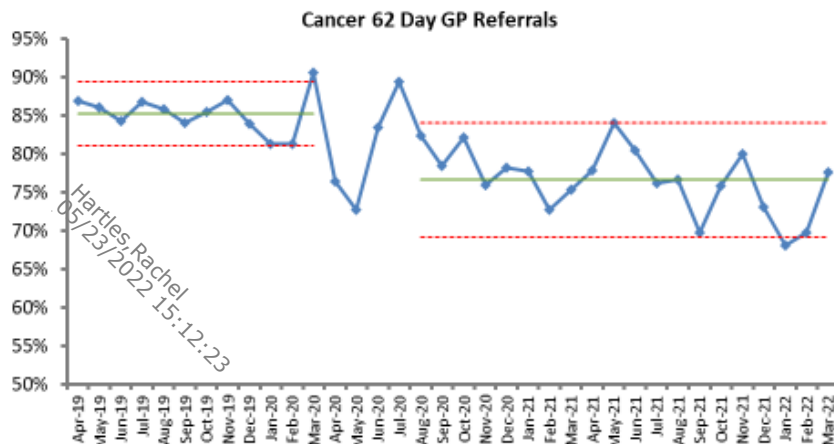
	Under 2 Weeks	Total Pathways	Performance
Other suspected cancer (not listed)	3	3	100.0%
Suspected children's cancer	21	22	95.5%
Suspected gynaecological cancers	168	199	84.4%
Suspected haematological malignancies	9	9	100.0%
Suspected head and neck cancers	405	446	90.8%
Suspected lower gastrointestinal cancers	253	342	74.0%
Suspected lung cancer	39	42	92.9%
Suspected skin cancers	287	750	38.3%
Suspected upper gastrointestinal cancers	128	161	79.5%
Grand Total	1,313	1,974	66.5%

Cancer 62 Days

March 2022

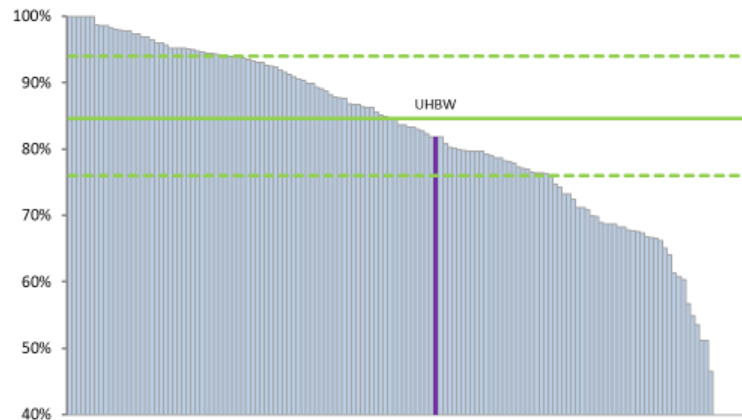
N Not Achieved

Standards:	Urgent GP-referred suspected cancer patients should start first definitive treatment within 62 days of referral. The national standard is that 85% of patients should start their definitive treatment within this standard.
Performance:	For March, 77.6% of patients were seen within 62 days. This is combined Bristol and Weston performance. The overall Quarter 1 performance was 80.9%. The overall Quarter 2 performance was 74.1%. The overall Quarter 3 performance was 76.5%. The overall Quarter 4 performance was 72.2%.
Commentary:	The standard was non-compliant in March (77.6% against an 85% standard). The impact of the Covid pandemic on all areas of capacity continues to be at the root of the majority of potentially avoidable target breaches. Achieving compliance with the 85% standard remains unlikely in the short term, as Covid continues to impact the health service. It should be noted that patients who have been infected with Covid (even asymptotically) require 7 weeks' recovery time prior to undergoing major surgery, and with the high prevalence of the disease this means high numbers of patients are medically deferred for this period. Therefore recovery may be slower than following other 'waves'. The majority of patients continue to be treated within clinically safe timescales with clinical safety review embedded into waiting list management practice.
Ownership:	Chief Operating Officer

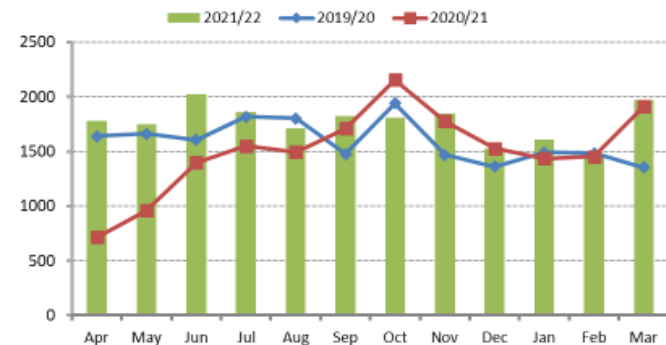


	Within Target	Total Pathways	Performance
Breast	0.5	0.5	100.0%
Gynaecological	2.5	6.0	41.7%
Haematological	9.0	10.0	90.0%
Head and Neck	8.5	13.5	63.0%
Lower Gastrointestinal	5.0	11.0	45.5%
Lung	16.5	23.0	71.7%
Other	4.0	4.0	100.0%
Sarcoma	1.5	2.5	60.0%
Skin	39.5	43.0	91.9%
Testicular	0.0	0.5	0.0%
Upper Gastrointestinal	8.0	8.0	100.0%
Urological	0.5	1.0	50.0%
Grand Total	95.5	123.0	77.6%

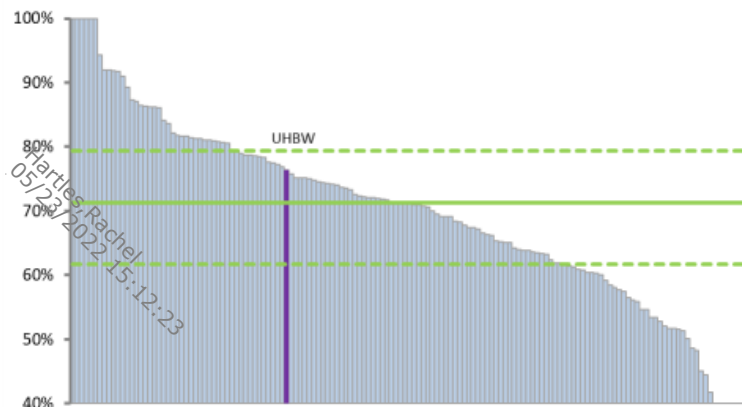
Benchmarking - 2 Week Wait Performance - 2021/22 Quarter 3



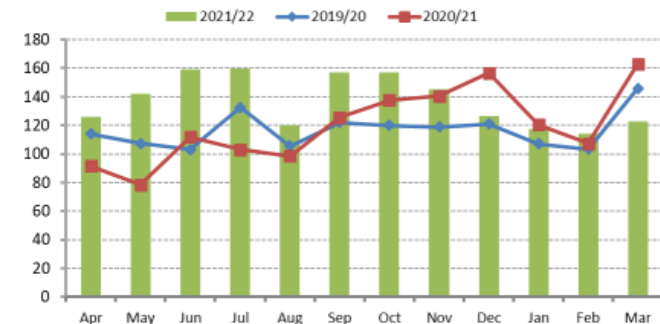
2 Week Wait - Patients Seen



Cancer 62 Day Performance - 2021/22 Quarter 3



62 Day - Patients Treated



Cancer – 28 Day Faster Diagnosis

March 2022

N Not Achieved

Standards:	The standard measures time from receipt of a suspected cancer referral from a GP or screening programme to the date the patient is given a cancer diagnosis, or told cancer is excluded, or has a decision to treat for a possible cancer. This time should not exceed 28 days for a minimum of 75% patients. The standard is reported separately for GP referred and screening referred patients.
Performance:	In March the Trust delivered 76.0% against the GP referred standard and 37.6% against the screening standard. Overall compliance was 73.8%.
Commentary:	The GP referred standard retained compliance. The screening standard, which has a low denominator and is mostly composed of colorectal patients, continues to be non-compliant. This standard has been heavily impacted by patient choice (patients require invasive tests with bowel preparation, and are asymptomatic so often choose to defer these), and by operational pressures on endoscopy services due to the Omicron wave. Loss of endoscopy capacity due to clinician sickness through Covid has impacted this month as delayed patients were seen. Were the standards combined (as is the intention of NHS England for later this financial year), the Trust would be compliant overall.
Ownership:	Chief Operating Officer

Month	Measure	Number Within 28 Days	Total Patients	Percentage Compliance
Nov-21	GP Referred	1,298	1,715	75.7%
	Screening	71	94	75.5%
	Combined	1,369	1,809	75.7%
Dec-21	GP Referred	1,071	1,362	78.6%
	Screening	38	48	79.2%
	Combined	1,109	1,410	78.7%
Jan-22	GP Referred	1,036	1,458	71.1%
	Screening	39	77	50.6%
	Combined	1,075	1,535	70.0%
Feb-22	GP Referred	975	1,240	78.6%
	Screening	27	47	57.4%
	Combined	1,002	1,287	77.9%
Mar-22	GP Referred	1,282	1,687	76.0%
	Screening	38	101	37.6%
	Combined	1,320	1,788	73.8%

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Snapshot taken: 8th May 2022

Standards:	This is not a constitutional standard but monitored by regulators in conjunction with the 62 day standard for cancer treatment after a GP referral for suspected cancer. Trusts are expected to have no patients waiting past day 104 on this pathway for inappropriate reasons (i.e. those other than patient choice or clinical reasons). The Trust has committed to sustaining <10 waiters for 'inappropriate' reasons.
Performance:	Prior to the Covid-19 outbreak the Trust consistently had 0 patients waiting over 104 days for inappropriate reasons (i.e. those other than patient choice, clinical reasons, or recently received late referrals into the organisation). As at 8 th May 2022 there were 2 such waiters. This compares to a peak of 53 such waiters in early July 2020.
Commentary:	The Trust is aiming to sustain minimal (<10) waiters over 104 days on a GP referred cancer pathway for 'inappropriate' reasons. The number of such waiters remains below this threshold. Avoiding harm from any long waits remains a top priority and is closely monitored. During this period of limited capacity due to the Covid outbreak, appropriate clinical prioritisation will adversely affect this standard as patients of lower clinical priority may wait for a longer period, to ensure those with high clinical priority are treated quickly. This is because cancer is a very wide range of illnesses with differing degrees of severity and risk and waiting time alone is not a good indicator of clinical urgency across cancer as a whole. An example of this is patients with potential thyroid cancers awaiting thyroidectomy, who have been clinically assessed as safe to wait for several more months (and most of whom will not ultimately have a cancer diagnosis), but who have exceeded the 104 day waiting time.
Ownership:	Chief Operating Officer

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Cancer – Patients Waiting 62+ Days

Snapshot taken: 8th May 2022

Standards:	This is one of the metrics being used by NHS England (NHSE) to monitor recovery from the impact of the Covid epidemic peak. NHSE has asked Trusts to return to/remain below 'pre-pandemic levels'. NHSE defines this as 180 patients for UHBW. Note that the 62 day constitutional standard is based on patients who start treatment. This additional measure reviews the patients waiting on a 62 day pathway prior to treatment or confirmation of cancer diagnosis.
Performance:	As at 8 th May the Trust had 179 patients waiting >62 days on a GP suspected cancer pathway, against a baseline of 180.
Commentary:	The Trust remains below the 'pre-Covid' baseline and the position has improved in recent weeks. This position is difficult to maintain due to the pressures on the healthcare system and ongoing impact of Covid on services. Every effort is being made to minimise long waiting patients and, of those who do wait longer, ensure there is a low risk of harm from the delay.
Ownership:	Chief Operating Officer

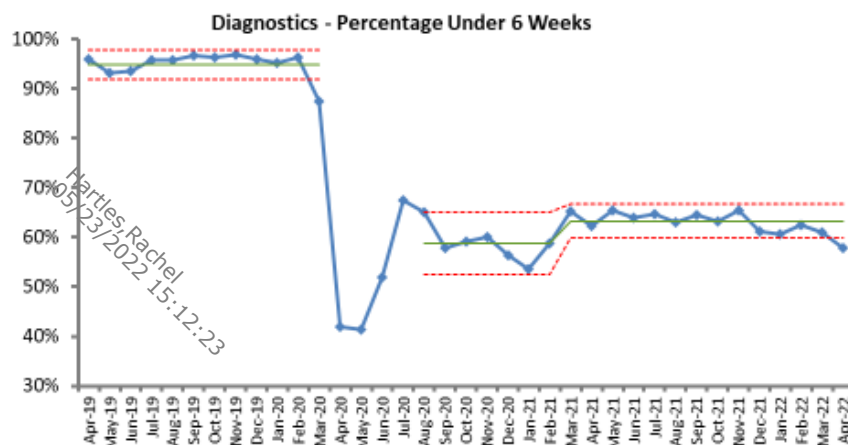
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Diagnostic Waits

April 2022

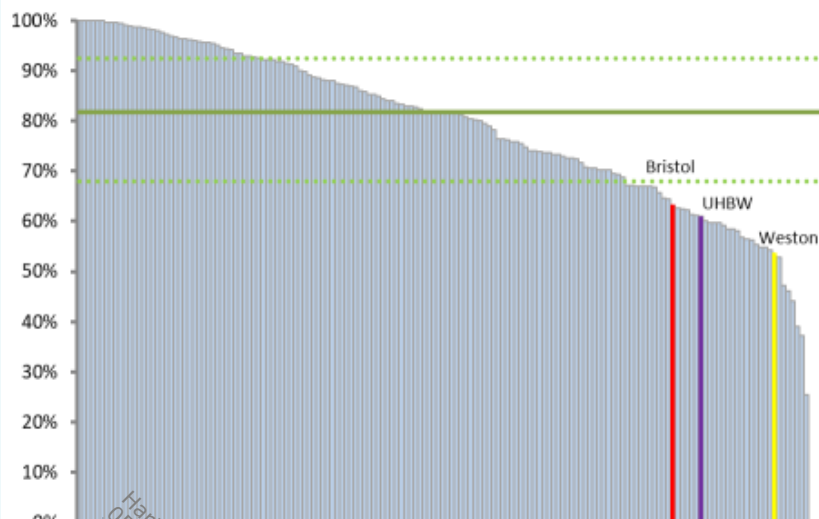
N Not Achieved

Standards:	Diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is that 99% of patients referred for one of the 15 high volume tests should have their test carried-out within 6 weeks, as measured by waiting times at month-end.
Performance:	At end of April, 57.9% of patients were waiting under 6 week, with 16,521 patients in total on the list. This is Bristol and Weston combined.
Commentary:	Diagnostic activity levels are being held overall, but pressure points are Endoscopy (where additional insourcing and use of independent sector lists is offset by loss of QDU capacity due to escalation), Adult MRI (Cardiology) and Cardiac MRI (where additional reporting capacity is being investigated to recover backlogs) and echo (predominantly at Weston, where long wait reviews are in place with Bristol and additional capacity is being investigated within the Independent Sector). There are also some niche constraints in MRI Paediatric GA pathway where mutual aid opportunities are being looked into within the SW region and Wales, but which rely on the provision of anaesthetists. Recovery plans for long waiting patients over 52 weeks have also been completed this period and are currently being reviewed by NHS England and NHS Improvement. The Trust is also aiming to ensure all patients are waiting less than 26 weeks for a diagnostic test by March 2023 (i.e. to eliminate long waiters).
Ownership:	Chief Operating Officer



	Apr-22		
	Under 6 Weeks	Total Pathways	Performance
Diagnostics and Therapies	7,240	9,811	73.8%
Medicine	96	162	59.3%
Specialised Services	1,279	4,127	31.0%
Surgery	629	2,019	31.2%
Women's and Children's	320	402	79.6%
Other/Not Known	0	0	-
TRUST TOTAL	9,564	16,521	57.9%

Benchmarking - Percentage Under 6 Weeks - March 2022

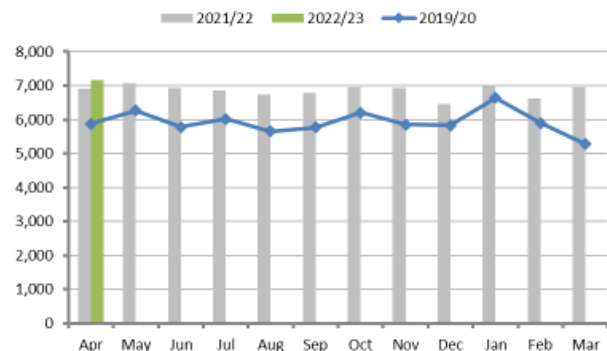


END OF APRIL 2022 BREAKDOWN

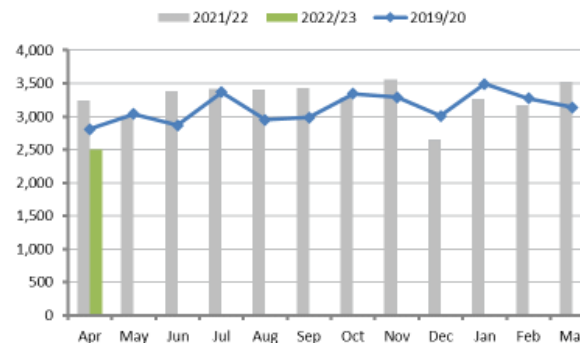
Modality	6+ Weeks	13+ Weeks	Total On List	% Under 6 Weeks
Audiology - Audiology Assessments	28	2	563	95.0%
Cardiology - echocardiography	2,234	1,245	3,278	31.8%
Colonoscopy	622	491	909	31.6%
Computed Tomography	328	100	2,090	84.3%
Cystoscopy	4	0	12	66.7%
DEXA Scan	212	15	683	69.0%
Flexi sigmoidoscopy	225	196	310	27.4%
Gastroscopy	607	427	892	32.0%
Magnetic Resonance Imaging	989	639	2,766	64.2%
Neurophysiology - peripheral neurophysiology	11	0	162	93.2%
Non-obstetric ultrasound	1,656	643	4,785	65.4%
Respiratory physiology - sleep studies	41	41	71	42.3%
Grand Total	6,957	3,799	16,521	57.9%

April 2022

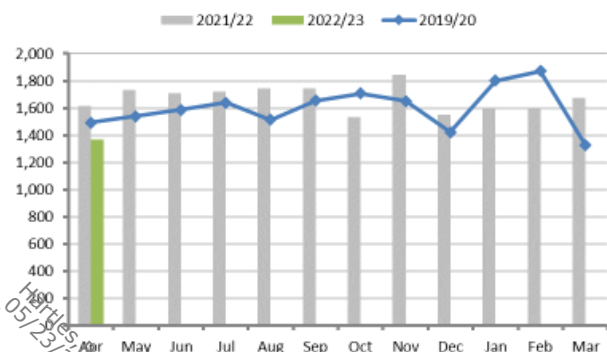
Computed Tomography (CT)



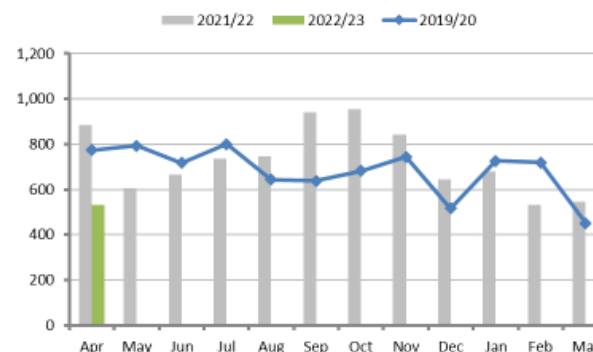
Magnetic Resonance Imaging (MRI)



Echocardiography



Endoscopy (Gastroscopy, Colonoscopy, Flexi Sig)



2022/23 as a Percentage of 2019/20

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Computed Tomography	122%											
Magnetic Resonance Imaging	89%											
Echocardiography	91%											
Endoscopy	69%											

Outpatient Measures

April 2022

N Not Achieved

Standards:	There are three outpatient measures covered in this section. - Proportion of outpatient consultations that are non face-to-face (including ones that are delivered by video, as opposed to telephone). The target is to have at least 25% delivered as non face-to-face. - Advice and Guidance (A&G) is a service within the electronic Referral Service (eRS) which allows a clinician to seek advice from another, providing digital communication between two clinicians: the “requesting” clinician and the provider of a service, the “responding” clinician. The aim is for a minimum of 12 advice and guidance requests to be delivered per 100 outpatient new attendances (i.e. 12%) - Patient Initiated Follow-Up (PIFU) is one possible outcome following an outpatient attendance. This gives patients and their carers the flexibility to arrange their follow-up appointments as and when they need them rather than the service booking a follow-up. The target is to have 5% of all outpatient attendances moved or discharged to a PIFU pathway.
Performance:	In April: 21% of outpatient attendances were delivered non face-to-face. Of these, 7.8% were delivered as a video consultation. - There were 1,330 Advice & Guidance Responses sent out, which was 7.2% of all New outpatient attendances. - There were 2,471 outpatient attendances that were outcome as PIFU, which was 3.9% of all outpatient attendances.
Commentary:	The roll out of Long Term Condition (LTC) PIFU pathways is in progress with specialities and was agreed in the March Outpatient Programme board meeting. New templates for recording activity will be available in May. Non face-to-face activity is reflective of divisions increasing face to face activity to tackle backlogs. New provider DrDoctor went live this month and represents a significant improvement in functionality for patients and clinicians. The programme aims to achieve delivery of 5% non face-to-face as video. Advice and Guidance request activity has reduced November to April and this is reflective of extending waiting times for responses and increasing backlogs of requests. There are a number of resourcing challenges faced across the trust impacting on delivery. The system's Healthier Together programme has identified the priority specialities for A&G service development for 2022/23.
Ownership:	Chief Operating Officer

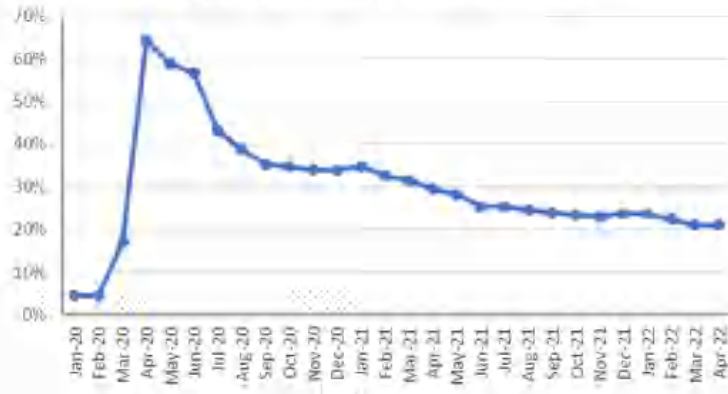
	Non Face To Face		Non Face To Face (Video)		Advice & Guidance		Advice & Guidance Responses		Patient Initiated Follow-Up	
	Total	% of All Attendances	Total	% of All Non Face To Face	Total Responses	% of New Attendances	Responses Within 7 Days	% Responses Within 7 Days	Total PIFU'ed Outcomes	% of All Attendances
Diagnostic & Therapy	1,288	17.2%	255	19.8%	40	1.1%	40	100.0%	539	7.2%
Medicine	3,105	39.5%	337	10.9%	275	11.8%	177	64.4%	384	5.0%
Specialised Services	5,369	44.1%	199	3.7%	271	10.9%	269	99.3%	217	1.8%
Surgery	1,587	7.5%	24	1.5%	195	3.6%	154	79.0%	559	2.7%
Women's & Children's	1,913	13.6%	219	11.4%	549	11.9%	464	84.5%	772	5.5%
TOTAL	13,265	21.1%	1,034	7.8%	1,330	7.2%	1,104	83.0%	2,471	3.9%

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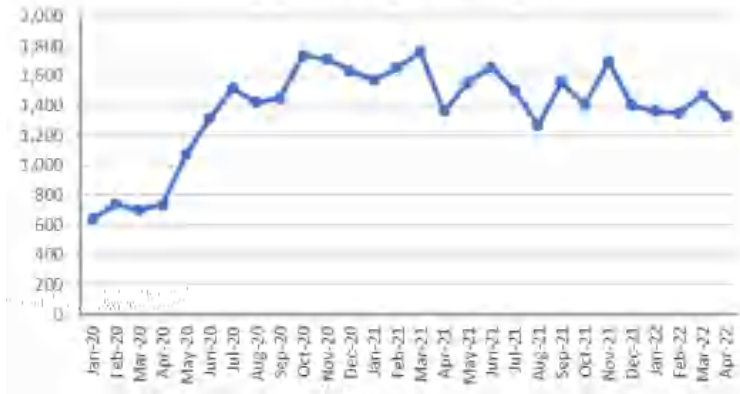
Outpatient Measures

April 2022

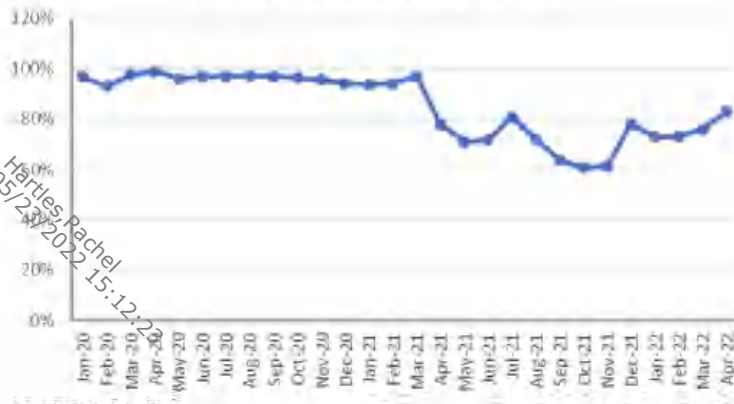
Outpatient Attendances - % Non Face To Face



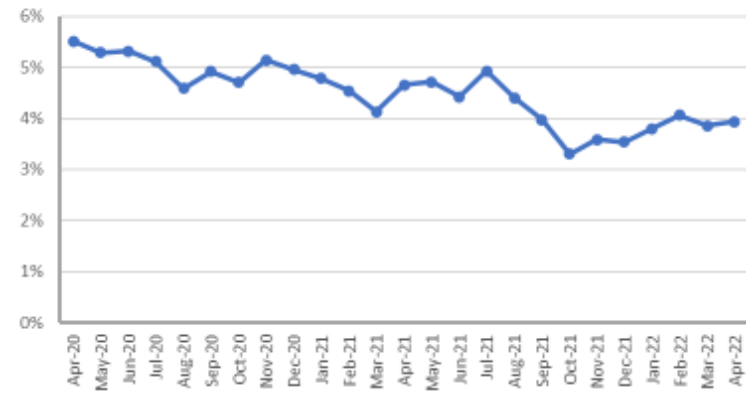
Number of Advice and Guidance Responses



Percentage of A&G Responses in 7 Days



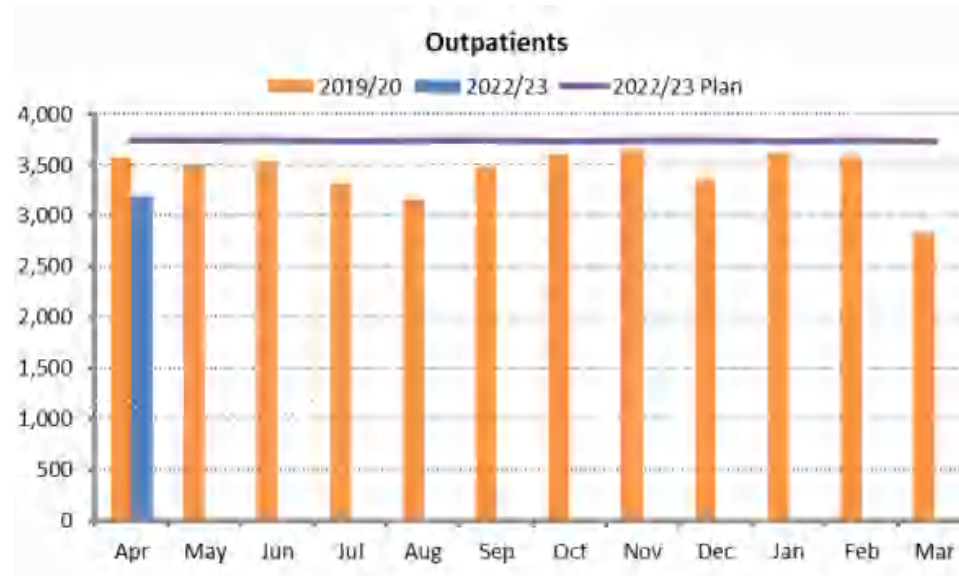
Percentage of Attendances with PIFU Outcome



Outpatient Activity – Restoration

April 2022

Activity Per Day, By Month and Year – Outpatient Attendances



		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	Actual Activity Per Day	3,568	3,507	3,544	3,327	3,162	3,487	3,604	3,657	3,343	3,615	3,584	2,835
2021/22	Actual Activity Per Day	3,457	3,655	3,478	3,239	3,108	3,373	3,424	3,638	3,167	3,571	3,384	3,383
2022/23	Actual Activity Per Day	3,201											
	Planned Activity Per Day	3,745	3,745	3,745	3,745	3,745	3,745	3,745	3,745	3,745	3,745	3,745	3,745
2022/23 Activity: % of Plan		85%											
2022/23 Activity: % of 2019/20		90%											

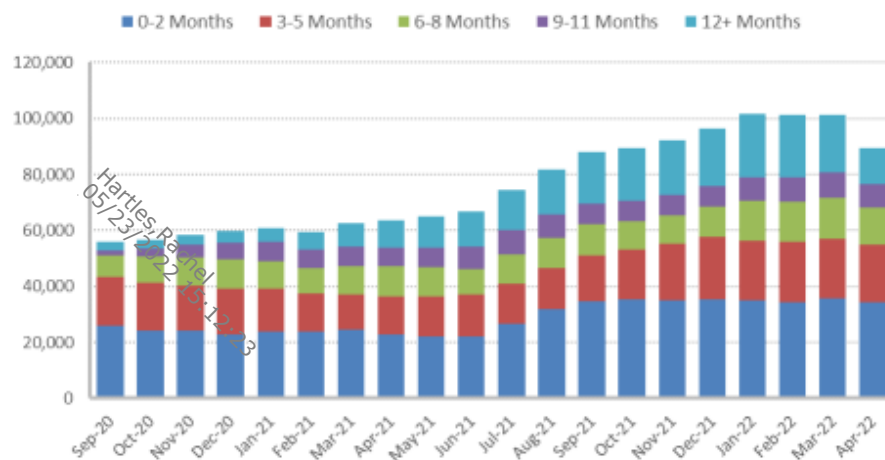
Outpatient Overdue Follow-Ups

April 2022

N Not Achieved

Standards:	This measure looks at referrals where the patient is on a "Partial Booking List" at Bristol, which indicates the patient is to be seen again in outpatients but an appointment date has not yet been booked. Each patient has a "Date To Be Seen By", from which the proportion that are overdue can be reported. Datix 2244 Risk that long waits for Outpatient follow-up appointments results in harm to patients.
Performance:	Total overdue at end of April was 89,591 of which 34,730 (39%) were overdue by 9+ months and 13,032 (15%) were overdue by 12+ months.
Commentary:	- A large validation project in Weston has completed in April which has reduced the backlog position. - 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. - UHBW has commenced the validation of Outpatient waiting lists, 28,000 patient records have now been given N-codes. - NHSE/I has requested trust plans to achieve 15% validation of Outpatient waiting lists by the end of Q2. - Areas of largest areas of backlog seen in Sleep, Ophthalmology, T&O and Respiratory. Discussions in progress with specialities to review the use of PIFU. Sleep recovery may be affected by risk relating to CPAP/BIPAP machine supply issues and recall (Datix ID 5422)
Ownership:	Chief Operating Officer

Overdue Follow-Ups By Number of Months Overdue



	6+ Months		12+ Months		Total Overdue
	Number	Percentage	Number	Percentage	
Diagnostics & Therapies	2,945	26%	383	3%	11,362
Medicine	9,630	41%	5,072	22%	23,297
Specialised Services	4,055	36%	747	7%	11,204
Surgery	15,696	43%	6,055	17%	36,353
Women's and Children's	2,381	33%	766	10%	7,323
Other	23		9		52
UHBW TOTAL	34,730	39%	13,032	15%	89,591

Mortality – SHMI (Summary Hospital-level Mortality Indicator)

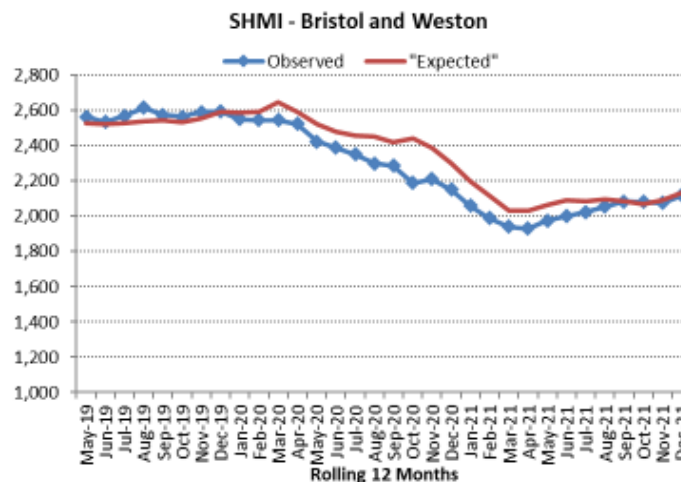
December 2021

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. This data is now provided by NHS Digital as a single figure from UHBW. SHMI is derived from statistical calculations of the number of patients expected to die based on their clinical risk factors compared with the number of patients who actually died. There is no target. A SHMI of 100 indicates these two numbers are equal, but there is a national statistically acceptable range calculated by NHS Digital and a SHMI that falls within this range is “as expected”.
Performance:	The Summary Hospital Mortality Indicator for UHBW for the 12 months January to December 2021 was 99.3 and in NHS Digital’s “as expected” category. This is slightly below the overall national peer group of English NHS trusts of 100.
Commentary:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to speciality level if required and investigating any identified alerts.
Ownership:	Medical Director

Rolling 12 Months To:	UHBW		
	Observed Deaths	"Expected" Deaths	SHMI
Mar-21	1,940	2,030	95.6
Apr-21	1,930	2,030	95.1
May-21	1,975	2,065	95.6
Jun-21	2,000	2,090	95.7
Jul-21	2,025	2,085	97.1
Aug-21	2,055	2,095	98.1
Sep-21	2,085	2,085	100.0
Oct-21	2,080	2,070	100.5
Nov-21	2,075	2,090	99.3
Dec-21	2,120	2,135	99.3

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



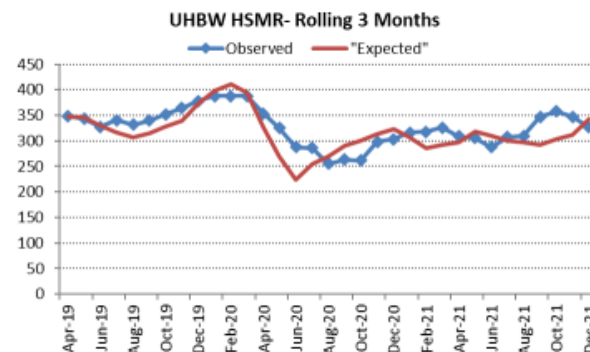
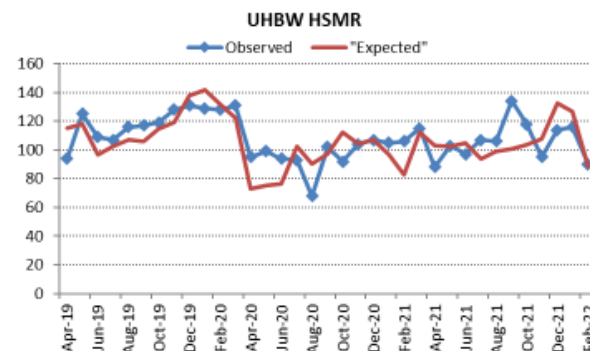
Mortality – HSMR (Hospital Standardised Mortality Ratio)

February 2022

P Partially Achieved

Standards:	Reported HSMR is from CHKS (Capita Health Knowledge System) and is subject to annual rebasing. HSMR data published by the Dr Foster unit is rebased more frequently so figures will be different, although our position relative to other Trusts will be the same.
Performance:	HSMR within CHKS for UHBW solely for the month of February 2022 was 101.5, meaning there were more observed deaths (90) than the statistically calculated expected number of deaths (89). Single monthly figures for HSMR are monitored in UHBW as an “early warning system” and are not valid for wider interpretation in isolation. The rolling 3 month HSMR (Dec21 to Feb22) is below 100, at 92.0.
Commentary:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to speciality level if required and investigating any identified alerts.
Ownership:	Medical Director

	UHBW		
	Observed	"Expected"	HSMR
Mar-21	115	112	102.5
Apr-21	88	103	85.6
May-21	103	103	100.5
Jun-21	97	105	92.6
Jul-21	107	94	114.4
Aug-21	106	99	107.2
Sep-21	134	101	133.2
Oct-21	118	104	114.0
Nov-21	95	108	88.4
Dec-21	114	133	86.0
Jan-22	116	127	91.7
Feb-22	90	89	101.5



Fractured Neck of Femur (#NOF)

April 2022

P

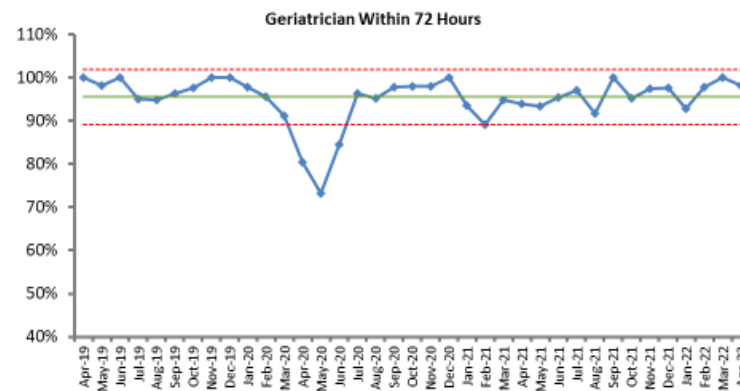
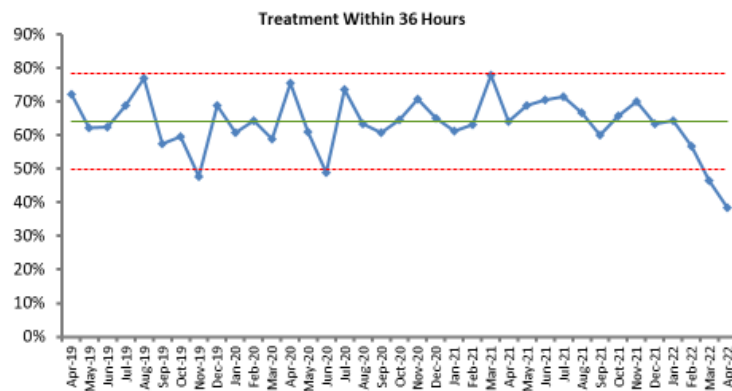
Partially Achieved

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 April, there were 52 patients eligible for Best Practice Tariff (BPT) across UHBW (23 in Bristol and 29 in Weston). - For the 36 hour standard, 39% achieved the standard (20 out of 52 patients) - For the 72 hour standard, 98% achieved the standard (51 out of 52 patients)
Commentary:	This was a very poor month for performance. The trauma list was exceptionally busy, peaking at 30 patients on the list. This position was exacerbated by a bank holiday and reduced operating due to staffing gaps in theatres. There is continued difficulty in time to theatre in Bristol, mostly driven by the increase in general trauma demand to theatres for Fracture NOF patients and an inability to stand up more trauma theatres due to the necessity to maintain cancer theatre capacity and also a lack of available inpatient beds. Challenges to be addressed in Bristol: - Difficulty accessing theatres to ensure consistent #NOF theatre – also challenges with theatre and anaesthetic staffing which is impacting on overall theatre capacity. This predominantly effects our ability to utilise extra theatres for trauma in the event of cancellations. - Difficulty starting on time in theatre and also some anecdotal reports that theatre efficiency is being lost at the end of the day due to staffing pressures and a reticence to start cases in case they overrun. - Lack of beds in the right area to have patients seen quickly. This is exacerbated by outliers in the T&O wards which cause our own T&O patients to outlie into other surgical beds. Actions being taken in Bristol: - Theatre capacity being actively monitored and prioritised on a weekly basis across all specialties. - Any last minute cancellation from another specialty is usually then backfilled by trauma surgeons. - Extra shifts are offered to orthogeriatric consultants on bank holidays / long weekends. Reasons patients missed the expected level of care in Weston: - Lack of theatre capacity was the main reason for breaching surgery time this month. Weston only has eight designated trauma theatre lists available Monday to Friday and shared lists on weekends. - Difficulties with prompt start in theatres and other short notice urgent cases needing priority which often causes short notice cancellations to the planned trauma lists. Actions being taken in Weston - Use of emergency (CEPOD) lists where possible for extra capacity when trauma lists are full or limited. The Orthopaedic team are pro-active in cancelling lists or fracture clinics where possible for either providing additional theatre capacity or ensuring that a radiographer is present. - Managerial team to discuss how extra physiotherapy staffing can be provided at 7 days/week - Substantive Ortho-geriatrician now in post Monday-Friday at Weston.
Ownership:	Medical Director

Hartles Rachel
05/23/2022 15:12:23

Fractured Neck of Femur (NOF)

April 2022



		36 Hours		72 Hours	
	Total Patients	Seen In Target	Percentage	Seen In Target	Percentage
Bristol	23	2	9%	22	96%
Weston	29	18	62%	29	100%
TOTAL	52	20	38.5%	51	98.1%

Hartles Rachel
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Mixed Sex Accommodation Breaches

April 2022

A *Achieved*

Standards:	There should be no clinically unjustified Mixed Sex Accommodation (MSA) breaches. There are some clinical circumstances where mixed sex accommodation can be justified. These are mainly confined to patients who need highly specialised care. Therefore, the description of an MSA breach refers to all patients in sleeping accommodation who have been admitted to hospital: A breach occurs at the point a patient is admitted to mixed-sex accommodation outside the guidance.
Performance:	Twelve reported Mixed Sex Accommodation breaches occurred during April 2022; all of which took place in Theatre Recovery. None of these were avoidable breaches. Cases have continued to decrease since the February high of 35 breaches, with incidents reducing by 60% in comparison to March (300 breaches). Prior to any mixed sex accommodation breach there is a full review of all patient areas.
Commentary:	Actions being taken • Support Theatre recovery staff to report all MSA breaches. • Invitation sent to the CCG to review reporting processes.
Ownership:	Chief Nurse

Hartles Rachel
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April 2022

N/A No Standard Defined

Standards:	The Perinatal Quality Surveillance Matrix (PQSM) provides additional quality surveillance of the maternity services at UHBW and has been developed following the recommendations made by the Ockenden report (2020) into maternity care at Shrewsbury and Telford Hospital Trust.
Performance:	• There were nine reported incidents related to workforce in April. Themes: delayed Induction Of Labour /non-compliance with BAPM standards (British Association of Perinatal Medicine) standards for Neonatal nursing)/ staffing levels and capacity. • In UHBW, the induction of labour (IOL) rate for April was increased to 34.5% with sporadic capacity issues with the flow of inductions (to match increasing demand). This rise reflects the reduced Lower Section Caesarean Section (LSCS) rate. • The LSCS rate in April was 35.1%, down from 35.9% in March. The emergency rate was also slightly reduced in April at 20.1% from 20.4% in March. • Lack of appropriate capacity to manage the current and increasing number of planned (“elective”) caesarean sections remains an issue. • No serious incidents were reported to the Trust or HSIB in April. • In April, maternity and neonatal services received 12 written compliments. All were for Neonatal Intensive Care Unit (NICU), with themes of clinical care/help and support/attitude of staff. • April received five formal complaints; all were for maternity. Themes were clinical care/ attitude and communication with patients /delayed procedures/lost test results.
Commentary:	Threats: • Risk to Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) compliance. The IT connectivity issues and capacity constraints within the community midwifery teams. This has been escalated and is on the risk register. • Multi-professional emergency and foetal monitoring training target of 90% is affected by staffing pressures, often COVID-19 related. Additional study days are run to support clinicians’ opportunity to attend. MIS was relaunched on the 6th May having been suspended since the 23rd December which has helped with extra time to catch up on perinatal reviews using the perinatal review tool. The revised submission date is now 5th January 2023. • Sickiness rates in doctors’ rotas - no change from last month regarding consultants acting down to cover and cross cover to maintain safe service. • NICU improved to 58.8% of nurses qualified in speciality (QIS) trained (against the BAPM standard 70%). Recruitment plan in progress. We have 10 nurses currently undertaking the QIS training. • An assessment of the requirements to continue the roll-out of Continuity of Carer (CoC) as default model of care by April 2023 has suggested that an additional 16.1 WTE midwives would be required. However, further roll-out is currently paused following the publication of the Ockenden Review and pending the agreed national response to the recommendations pertaining to CoC.

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April 2022

**Commentary
(continued):**

- Birthrate Plus review has been undertaken which has recommended that UHBW need an additional 1 midwife to meet the current demand and acuity. This will be confirmed following a meeting with the Birthrate plus team on the 7th of June.
- Ockenden report has suggested the continual roll out of CoC should be suspended if safety cannot be assured with regards to staffing. UHBW have risk assessed and are able to continue with 4 teams. Two teams have been paused until staff have been recruited to fill newly vacant posts. Recruitment is on-going.
- The Continuity of Carer (CoC) programme presently sits at 48%, with BAME at 63.6% and IMD 1(most deprived) at 78.0%. This has reduced from last month due to suspension of two teams.

Actions:

- There is a monthly forum to share staff concerns with the Maternity and Neonatal Safety Champions and actions are fed back to staff. The current themes align with the data and include staffing, capacity, equipment, and level E refurbishment.
- In response to the second Ockenden report into maternity services at Shrewsbury and Telford NHS Trust, nearly all non-executive directors visited St Michaels site on the 10th May and were shown around the unit and were able to speak with front line staff. This gave them an opportunity to be made aware of our successes and challenges. The Regional Maternity team are visiting St Michael's to undertake an Ockenden response review the end of May.

Ownership:

Chief Nurse

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April 2022

UHBW Perinatal Quality Surveillance Matrix

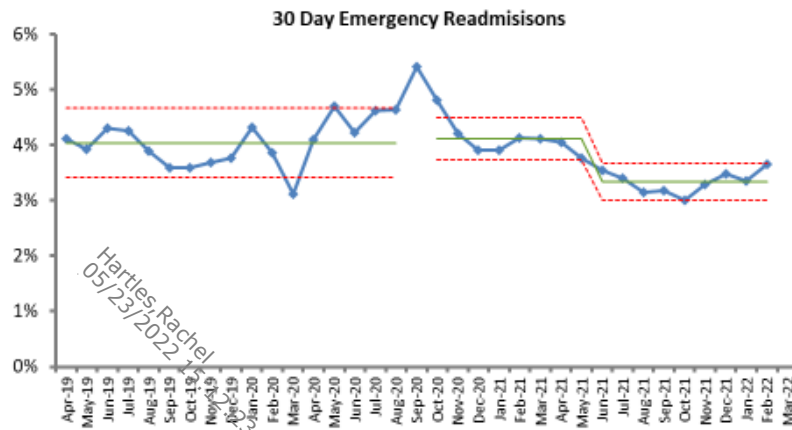
	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Number of babies born alive at ≥ 22 to 36+6 weeks gestation	37	31	38	24	44	29	26	22	18	36	21	30
Number of women who gave births all gestations from 22+0 weeks	429	415	466	429	429	449	432	419	357	368	399	367
Induction of Labour rate %	30.7%	30.6%	26.6%	27.8%	26.8%	26.6%	24.4%	31.0%	35.4%	26.3%	28.7%	34.5%
Unassisted Birth rate %	49.0%	51.2%	46.7%	46.9%	49.2%	45.0%	45.4%	45.3%	47.2%	44.9%	47.1%	47.3%
Assisted Birth rate %	15.6%	14.8%	15.2%	20.5%	14.5%	17.5%	16.9%	12.4%	14.9%	16.0%	17.0%	17.6%
Caesarean Section rate (overall) %	35.5%	34.0%	38.1%	32.6%	36.3%	37.6%	37.7%	42.3%	37.8%	39.1%	35.9%	35.1%
Elective Caesarean Section rate %	14.0%	15.8%	13.9%	14.9%	14.3%	12.2%	15.3%	17.4%	16.0%	16.8%	15.5%	15.0%
Emergency Caesarean Section rate %	21.5%	18.2%	24.0%	17.7%	21.7%	25.3%	22.4%	24.9%	21.8%	22.3%	20.4%	20.1%
Total number of perinatal deaths	6	0	2	1	1	4	11	6	6	1	5	3
Number of late fetal losses 22+0 to 23+6 weeks excl TOP	0	0	0	0	0	1	1	0	0	0	0	0
Number of stillbirths (≥ 24 weeks excl TOP)	2	2	1	0	1	2	4	4	2	0	1	2
Number of neonatal deaths - 0-6 Days	1	0	1	1	0	0	1	1	4	0	1	1
Number of neonatal deaths - 7-28 Days	3	0	0	0	0	1	5	1	0	1	3	0
Suspected brain injuries in inborn neonates (no structural abnormalities)	2	0	0	0	0	1	0	0	1	0	0	0
Number of maternal deaths (MBRRACE)	0	0	0	0	0	0	0	0	0	0	0	
Number of women who received level 3 care	1	0	1	1	1	1	2	0	1	1	1	0
Continuity of Care (overall percentage)	45.9%	46%	44.4%	48.3%	47%	40%	43%	45%	48%	49%	54%	48%

Heather Rachel
05/04/2022 15:12:23

February 2022

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 February, there were 12,269 discharges, of which 449 (3.7%) had an emergency re-admission within 30 days.
Commentary:	This data set is one month in arrears as it is reported against the month of discharge (as opposed to the month of readmission). So a month has to elapse before the Trust knows how many patients were re-admitted within this 30 day period. For this month, the convergence of Bristol and Weston Careflow systems meant that the rules for identifying 30 day readmissions had to be re-built and reviewed to ensure consistency of approach across organisations. This was not completed in time for inclusion of latest data (March discharges) in this month's IQPR. So data quoted is the same as last month's IQPR (February discharges). The data is expected to be ready for inclusion in next month's IQPR.
Ownership:	Chief Operating Officer



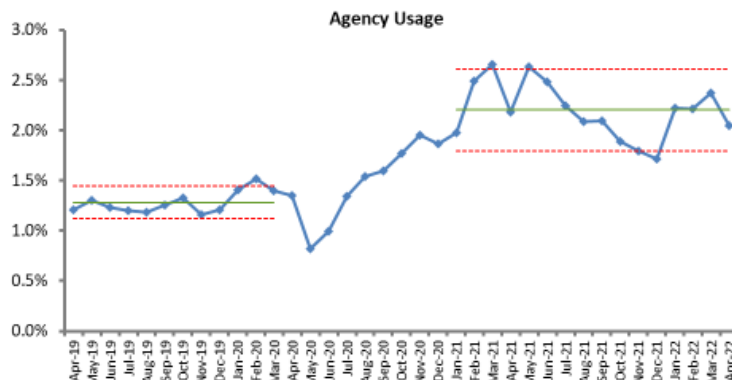
	Feb-22		
	Readmissions	Total Discharges	% Readmitted
Diagnostics and Therapies	1	25	4.0%
Medicine	168	2,082	8.1%
Specialised Services	28	2,716	1.0%
Surgery	74	2,226	3.3%
Weston	133	1,714	7.8%
Women's and Children's	45	3,506	1.3%
Other/Not Known	0	0	-
TRUST TOTAL	449	12,269	3.7%
<i>Bristol Subtotal</i>	<i>316</i>	<i>10,555</i>	<i>3.0%</i>

Workforce –Agency Usage

April 2022

N Not Achieved

Standards:	Usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets (including Weston) for 2020/21. The maximum agency usage rate has been set at 1.8%.
Performance:	Agency usage reduced by 74.1 FTE to 2.0%. There was an increase in only one division, with the largest increase seen in Diagnostic and Therapies, increasing to 1.7 FTE from 1.5 FTE in the previous month. There were reductions in seven divisions, with the largest reduction seen in Weston, reducing to 57.8 FTE from 72.8 FTE in the previous month.
Commentary:	Actions taken to mitigate agency usage and encourage bank use instead are: - Following the success of auto-enrolment of medical new starters to the Bank this is now being rolled out to all staff including clinical nursing staff to increase the pool of available Bank staff to drive down agency usage. - There were 56 new starters across the bank in April, including 31 re-appointments. 24 of these staff joined non-clinical bank roles, comprising 11 administrators and 9 cleaning and catering assistants. - Active recruitment continues to substantive medical roles in the Weston Division to drive down the demand for high-cost agency workers. - Deep dive of Bank incentives being undertaken to ensure that these are tactically deployed to drive down agency usage but also costs managed. - Temporary agreement of payment for travel time to encourage Bank workers to pick up Bank shifts on the Weston site. - New model of Bank A&C recruitment being piloted during May to fast-track applicants into post. - New summer recruitment campaign going live in May supported through social media to grow the Bank and reduce agency reliance.
Ownership:	Director of People



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April 2022

P Partially Achieved

Standards:	Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The target is to have less than 15% turnover.
Performance:	Turnover for the 12 month period increased to 15.2% in April 2022 compared with 15.1% (updated figures) for the previous month. - Four divisions saw an increase whilst three divisions saw a reduction in turnover in comparison to the previous month. - The largest divisional increase was seen within Trust Services, where turnover increased by 0.6 percentage points to 17.0% compared with 16.4% the previous month. - The largest divisional reduction was seen within Medicine, where turnover reduced by 0.3 percentage points to 15.0% compared with 15.3% the previous month. - Four staff groups saw an increase whilst five staff groups saw a reduction in turnover in comparison to the previous month. - The largest staff group increase was seen within Allied Health Professionals, where turnover increased by 0.3 percentage points to 15.7% compared with 15.4% the previous month. - The largest staff group reduction was seen within Estates and Ancillary, where turnover reduced by 0.3 percentage points to 18.9% compared with 19.2% the previous month.
Commentary:	The People teams are progressing a number of programmes of work to address colleague experience and improve retention: - An integrated programme of work has commenced in partnership with an external consultancy company to introduce a resolution framework designed to reduce conflict and improve resolution at a local level. The organisation is currently undertaking a deep dive to establish a baseline position and develop an implementation plan which will follow the findings report due for completion at the end of May. The expansion of Bullying and Harassment resources continues to be a priority with the development of a new eLearning module aimed at managers and a witness guide for bystanders and these resources will run alongside the review. - As part of the Winter Wellbeing programme to prioritise staff wellbeing and help boost morale, 5,000 individuals received a gift and 250 teams have received plants that have been distributed to staff rest areas, and over 100 staff accessed massage sessions, yoga, and mindfulness workshops. - An extension of pastoral and wellbeing support to international recruits is in development in partnership with BNSSG system partners which supports the wellbeing and EDI agenda. - A paper reviewing, analysing and triangulating the turnover and exit data across UHBW has been completed and will be presented to People Committee on the 26th May 2022. This paper represents a 'stock take' of where we are currently, where we have gaps and where we need to continue to develop our staff offers. This paper will go on to inform the newly convened UHBW Recruitment and Retention Group which will meet for the first time in May 2022.

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April 2022

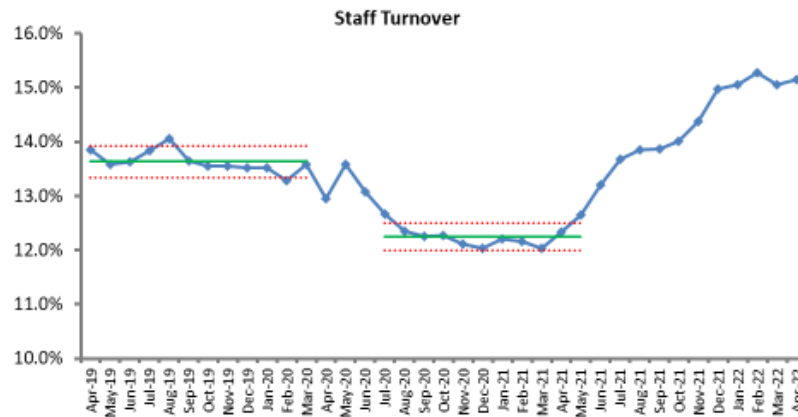
Commentary (continued)

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- Overall, there is a significant amount of data collected from leavers and the report referred to above highlights this data; however, this report also highlights that we now need to drill down into this data, understand it on a more individual level and move from asking 'why did you leave' to 'how can we help you choose to stay'.
- A recommendation from the paper is to understand exactly what the generic issues (e.g., career development) mean in relation to different workforce groups, and how to improve their experience.
- The Deputy Chief Nurse and Associate Director HR Operations will work together over the next few months to establish retention priorities in relation to the Nursing workforce, using the People Strategy priorities as a framework for setting actions to improve retention of Nurses.

Ownership:

Director of People



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Workforce – Vacancies

April 2022

A Achieved

Standards:	Vacancy levels are measured as the difference between the budgeted Full Time Equivalent (FTE) establishment and the actual Full Time Equivalent substantively employed figures, represented as a percentage, The Trust target is to have less than 7.0% vacancy.
Performance:	Overall vacancies reduced to 5.6% compared to 7.6% in the previous month. - The largest divisional increase was seen in Medicine where vacancies increased to 123.0 FTE from 96.6 FTE in the previous month. - The largest divisional reduction was seen in Women's and Children's, where vacancies reduced to -52.3 FTE from 117.7 FTE the previous month. However, the division as well as Trust Services are over-established following the new year budget amendment. - All staff groups made a reduction in vacancy, mainly due to new financial year budget adjustments. - The largest staff group reduction was seen in Nursing, where vacancies reduced to 304.5 FTE from 427.5 FTE the previous month. Registered Nursing reduced by 125.0 FTE.
Commentary:	Key updates to address our vacancy rate in the current period are as follows: - A large scale recruitment event for HCSW's across the BNSSG ICS is taking place on the 19th May. This provides a showcase opportunity for local recruitment and career pathways for our entry level roles. Around 400+ candidates are expected to attend to be interviewed with an aim of getting the Trust to a zero-vacancy position for this staff group. - On 18 May 2022 Senior Leadership Team (SLT) reviewed and supported a paper collating a trust-wide position on expanding new and advanced roles for 2022/2023. This provides a request for 49 Trainee Nurse Associates and 54 other types of roles (e.g. Advanced Clinical Practitioners, Physician Associates, etc). Subject to funding, this will provide a new skill mixes within the clinical workforce and a pipeline for domestic development of key roles e.g. Nurses. - The Talent team have sent letters to all year 3 Student Nurses who started back on placement 25th April, promoting newly qualified roles at UHBW. These are followed up with non-competitive supportive "Career Conversations" which result in employment offers. - The Trust has been given financial support from NHSE/I to recruit an additional 18 Medical Support Workers, the Trust is working with NBT to work through a collaborative approach to this recruitment. 268 international nurses have now arrived in the Trust of which 177 have secured their NMC PIN as part of the 21/22 plan. The Trust have now commenced the recruitment of the 22/23 plan of 219 additional nurses approved by SLT. - The international nurse recruitment team are currently working with NBT on collaborative recruitment initiatives including OSCE provisions and aligning our relocation offerings. A pilot A&C careers event is taking place on 24th May to support the Surgery Division's hard to recruit to admin and clerical roles. This will be evaluated for potential rollout to the wider Trust.
Ownership:	Director of People

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Workforce – Staff Sickness

April 2022

P Partially Achieved

Standards:	Staff sickness is measured as a percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2021/22, including Weston. The target is to have a maximum 6.1% sickness rate. The red threshold is 0.5 percentage points over this.
Performance:	Sickness absence reduced to 6.4% compared with 7.3% in the previous month, based on updated figures for both months. This figure is now combined with Covid Related absence, which is new for this month's reporting. Historic data has not been re-based in time for inclusion this month, hence no trend/SPC chart has been produced. There were no increases within any divisions, Women's and Children's division remained static. There were reductions within seven divisions, the largest divisional reduction was seen in Weston reducing to 8.1% from 8.5% compared to the previous month.
Commentary:	Sickness combined with Covid Absence was not calculated in previous months. Medical and Dental currently has the lowest staff group absence rate of 2.6% whilst Nursing and Midwifery Unregistered has the highest staff group absence rate of 10.9%. Actions taken to mitigate sickness absence include: • A review of our psychological services has commenced aiming to align these services to support staff accessing at the point of need. Stage 1 of the psychological review has been undertaken and identified five key areas of focus, this has been developed into a plan and is supported by the psychological leads working group across all service providers. • A process review of obtaining equipment and/or reasonable adjustments in support of our colleagues who require them is now underway. The aim of this review is to streamline processes across both Bristol and Weston sites and involve key teams within the HR function with the aim of placing the employee at the forefront of this process. This will increase accessibility and simplify the sign off processes alongside ensuring equity in access and funding. • The Supporting Attendance Policy review is underway with colleague engagement groups scheduled in order to hear what is needed from the policy going forward. Engagement sessions with staff side, line managers and other key stakeholders will also be undertaken as part of this collaborative review. This review will focus particularly on the targets that are set through the existing attendance management processes with a view to modernising this approach in line with our UHBW Supportive value and our People Strategy. • A paper proposing a relaunch of the medical e-rostering and e-job planning rollout was supported at SLT on 18/5/22; a successful rollout will improve the recording of Medical staff absence and give us better data in order to understand the absence picture and inform interventions.
Ownership:	Director of People

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Workforce – Appraisal Compliance

April 2022

N Not Achieved

Standards:	Staff Appraisal is measured as a percentage of staff excluding consultants who have had their appraisal signed-off. The target is 77%.
Performance:	Overall appraisal compliance reduced to 68.6% from 69.9% compared to the previous month. There was an increase in one division, and reductions in seven divisions. The only divisional increase was within Specialised Services, increasing to 73.2% from 72.7% in the previous month. The largest divisional reduction was within Facilities and Estates, reducing to 79.8% from 85.2% in the previous month. Two divisions, Facilities and Estates as well as Diagnostics and Therapies remain above the new KPI target.
Commentary:	During April an exercise was taken to add all Weston based employees onto Kallidus Perform replacing ESR Manager Self Service. The organisational development Q1 strategic action plan for appraisal included: • Successful alignment of online appraisal across UHBW in Q1 ensuring equitable access for all colleagues. • The development of a Trust wide review of appraisal to improve the quality and focus of conversations on wellbeing, and personal development. The plan and updates to be executed from Q1 -Q3 2022
Ownership:	Director of People



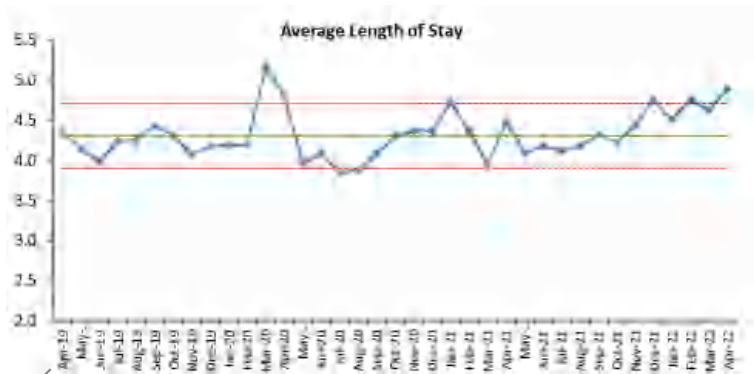
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Average Length of Stay

April 2022

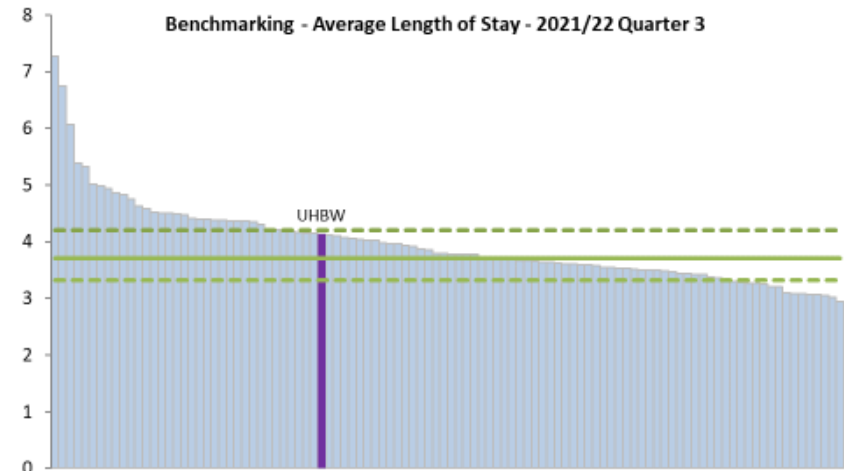
N/A No Standard

Standards:	Average Length of Stay is the number of beddays (1 beddays = 1 bed occupied at 12 midnight) for all inpatients discharged in the month, divided by number of discharges.
Performance:	In April there were 31,831 discharges at UHBW with an average length of stay of 4.88 days.
Commentary:	Current assumptions around length of stay are being reviewed as part of the 2022/23 operating plan submissions and demand & capacity reviews.
Ownership:	Chief Operating Officer



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	Apr-22
Medicine	6.7
Specialised Services	6.9
Surgery	5.1
Women's and Children's	0.0



April 2022

YTD Income & Expenditure Position

- Net I&E deficit of £3,007k against a planned deficit of £2,545k (excluding technical items).
- Total operating income is £547k adverse to plan due to lower than planned other operating income of £1,109k (relating mainly to research and education).
- Operating expenses are £58k adverse to plan primarily due to higher pay expenditure (£685k adverse), the shortfall in CIP delivery of £1,057k (of which £839k relates to system transformation savings), offset by lower than planned depreciation expenditure of £638k.
- Technical and financing items are £130k favourable to plan.

Key Financial Issues

- *Savings delivery below plan* – Savings delivery is £857k or 45% of plan. Full year forecast delivery is £10,380k or 47% of plan of which recurrent savings are £4,007k, 20% of plan.
- *Capital expenditure below CIEL* – expenditure is 20% of plan in April. Conclusion of the re-prioritisation process in early June and delivery against agreed schemes must be achieved to ensure effective use of capital resources.
- *Pay costs higher than plan* – pay expenditure must be maintained within divisional and corporate budgets to enable delivery of the financial plan.
- *Forecast overspend against divisional budgets* – assessment of gap between budget and forecast expenditure to be completed by end of Q1, including the development of recovery plans where overspend is not acceptable.

Strategic Risks

- Agreeing a system approach to future financial targets and allocation of system envelopes – on-going.
- Assessment and implications of the financial arrangements relating to the Healthy Weston – pending.
- Continue to understand the risks and mitigations associated with the new capital regime; and how the CIEL limit and system prioritisation could restrict future strategic capital investment – on-going.
- Understanding the implications of not delivering the financial plan, the impact this may have on future investment opportunities and the ability to maintain autonomy – pending.

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April 2022

Trust Year to Date Financial Position

	YTD		
	Plan	Actual	Variance Favourable/ (Adverse)
	£000's	£000's	£000's
Income from Patient Care Activities	75,666	76,228	561
Other Operating Income	9,059	7,950	(1,109)
Total Operating Income	84,725	84,178	(547)
Employee Expenses	(50,976)	(51,661)	(685)
Other Operating Expenses	(32,172)	(32,163)	(11)
Depreciation (owned & leased)	(3,664)	(3,426)	638
Total Operating Expenditure	(86,812)	(86,270)	(542)
PDC	(244)	(161)	83
Interest Payable	(1,037)	(1,037)	0
Interest Receivable	29	85	56
Other Gains/(Losses)	0	0	0
Net Surplus/(Deficit) inc technicals	(2,739)	(3,204)	(465)
Remove Capital Donations, Grants, and Donated Asset Depreciation	194	197	3
Net Surplus/(Deficit) inc technicals	(2,545)	(3,007)	(462)

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

Key Facts:

- The position at the end of April is a net deficit of £3,007k, £463k worse than the planned deficit of £2,545k.
- Pay expenditure is £51,661k in April, c£1m lower than the January and February average and c£1,500k higher than the Q3 average.
- Agency expenditure is broadly in line with plan at £2,642k in April and consistent with previous months at 5% of total pay costs.
- Operating income is adverse to plan by £547k, due to an adverse position on 'Other Operating Income'. This is driven by lower than expected income levels for research, education and NHS recharges.
- Income from Patient Care Activities is £561k favourable to plan.
- CIP achievement is 45%. £857k has been achieved against a target of £1,914k, a shortfall of £1,057k.
- Additional costs of Covid-19 are £919k in April, a reduction of £498k from £1,417k in March.

Care Quality Commission Rating - Bristol

The Care Quality Commission (CQC) published their latest inspection report on 4th November 2021. Full details can be found here:

<https://www.cqc.org.uk/provider/RA7>

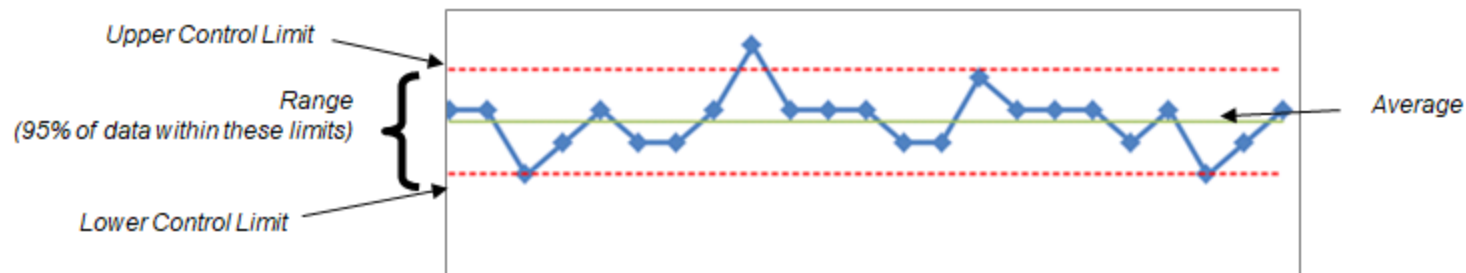
The overall rating was GOOD, and the breakdown by site is shown below:

Rating for acute services/acute trust

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

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

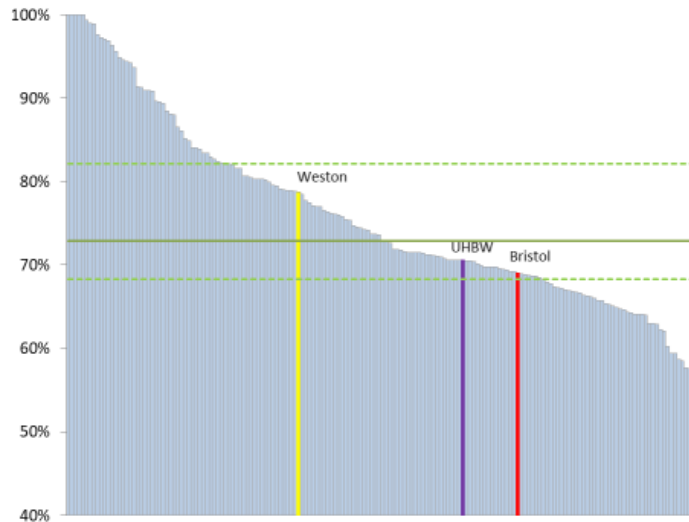


The blue line is the Trust's monthly data and the green solid line is the monthly average for that data. The red dashed lines are called "control limits" and are derived from the Trust's monthly data and is a measure of the variation present in the data. If the process does not change, then 95% of all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

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

Explanation of Benchmarking Charts

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



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

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

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

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

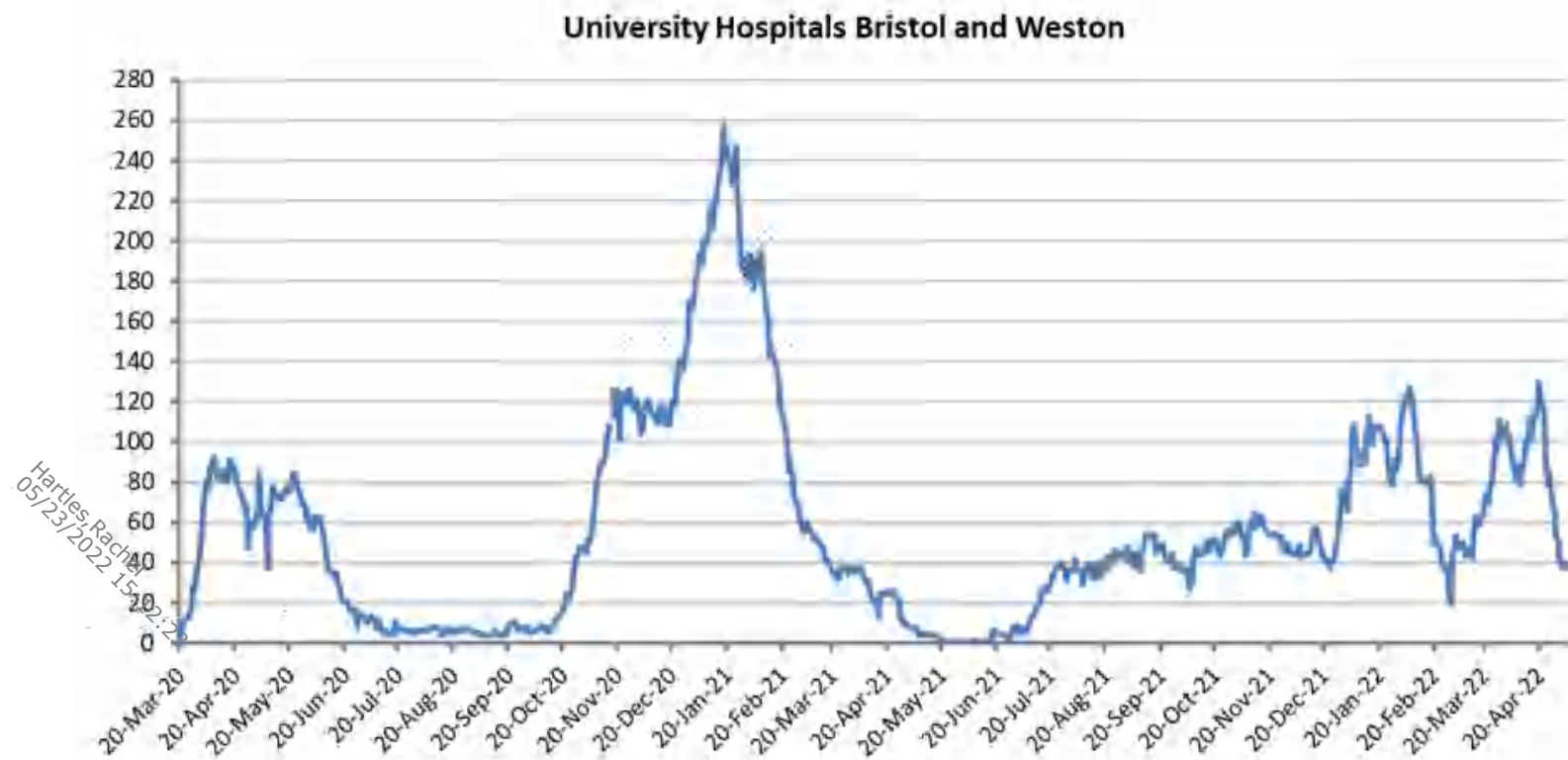
The separate performance for Bristol and Weston Trusts is shown as the vertical red and yellow bars respectively. The combined performance (UHBW) is the vertical purple bar.

Appendix – Covid19 Summary

Source:	COVID-19 NHS Situation Report
Publication Date:	Published data, 12 th May 2022, from https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/
Ownership:	Chief Operating Officer

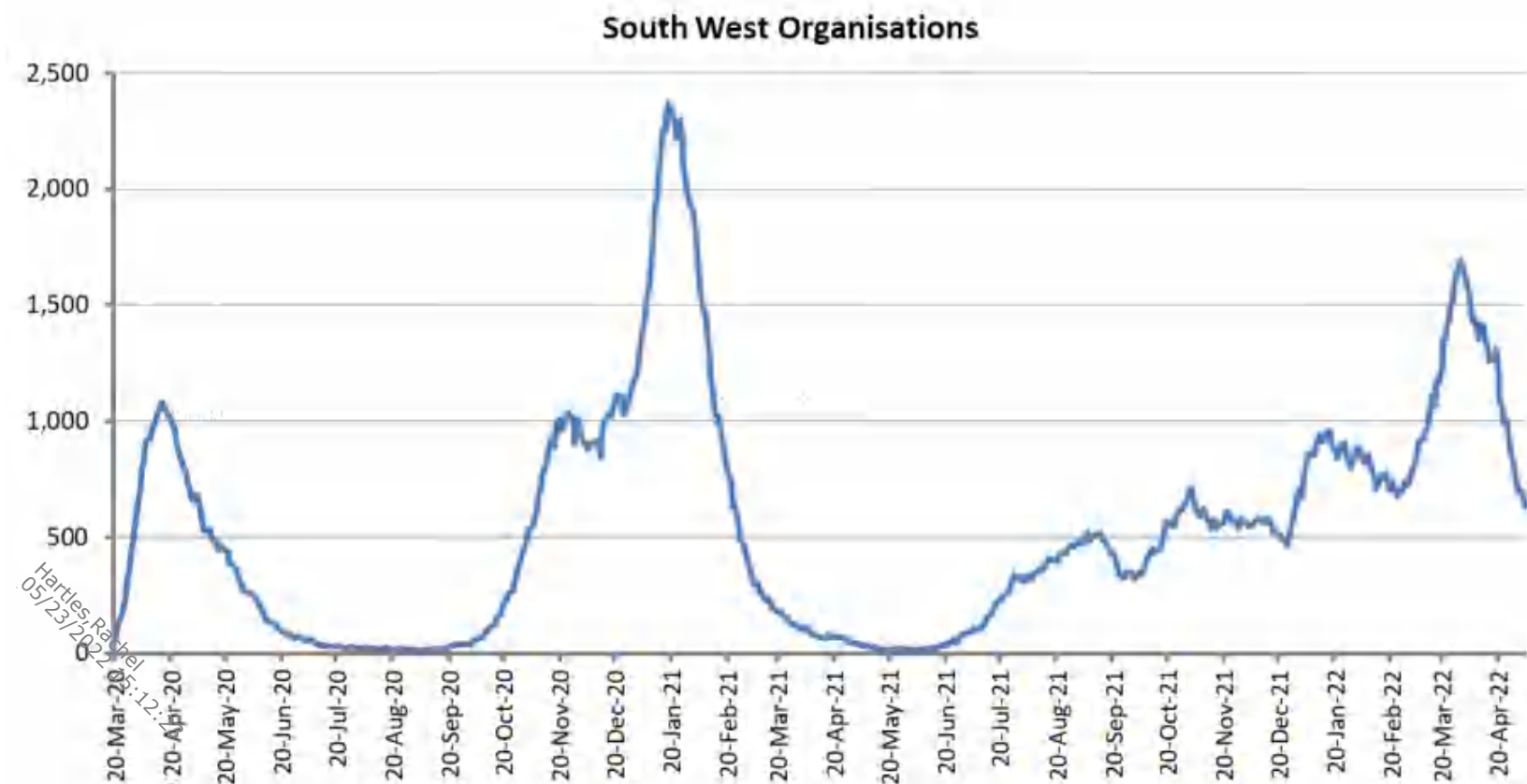
Bed Occupancy

Total beds occupied by confirmed Covid-19 patients as at 8am each day. Data from the “COVID-19 NHS Situation Report”. Data up to 5th May 2022.



Appendix – Covid19 Summary

Source:	COVID-19 NHS Situation Report
Ownership:	Chief Operating Officer



Appendix – Covid19 Summary

Source:	COVID-19 NHS Situation Report. Retrieved on 17 th May 2022.
Commentary:	The Trust undertakes rapid action when any cases are identified to prevent further spread with the dissemination of the Infection Prevention and Control Covid outbreak pack to ensure all cases are managed consistently with outbreak meetings set up and conducted in line with the Hospital Outbreak of infection policy.
Ownership:	Chief Nurse

Month	Inpatients Admitted With Covid-19	Inpatients Diagnosed With Covid-19 Following Admission				
		Community Onset	Hospital-Onset Indeterminate Healthcare-Associated	Hospital-Onset Probable Healthcare-Associated	Hospital-Onset Definite Healthcare-Associated	TOTAL Diagnosed Following Admission
May-20	37					313
Jun-20	16					75
Jul-20	6	5	1	0	1	7
Aug-20	8	9	0	0	1	10
Sep-20	13	17	0	0	0	17
Oct-20	47	107	6	6	5	124
Nov-20	176	157	22	12	23	214
Dec-20	203	94	27	22	35	173
Jan-21	414	159	31	25	19	234
Feb-21	156	88	22	19	22	151
Mar-21	75	17	7	3	10	37
Apr-21	38	7	2	3	12	24
May-21	2	3	0	0	0	3
Jun-21	13	7	1	1	0	9
Jul-21	124	72	5	1	5	83
Aug-21	130	64	13	6	5	88
Sep-21	149	66	10	3	19	103
Oct-21	174	74	7	5	15	101
Nov-21	189	68	3	4	11	91
Dec-21	194	75	16	14	16	122
Jan-22	269	129	37	24	45	235
Feb-22	216	75	33	13	25	144
Mar-22	181	124	33	29	36	226
Apr-22	201	108	46	37	64	255
	3,036					2,844

- 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 – Staff Vaccination Summary

Source:	These figures are based on those published by NHS England . These statistics include vaccinations administered across all settings in England (within Hospital Hubs and other Local Vaccination Service sites such as GP practices and Vaccination Centres).
Timeframe:	For information the COVID-19 Booster and Flu Vaccination Programme started in late-September 2021. The National NHS Flu and COVID-19 booster data starts from December 2021. The 2021/2022 flu vaccination season finished on the 31 st March 2022.
Commentary:	NHS England and NHS Improvement have set out the following three priorities for the year ahead: 1. Continued access to COVID-19 vaccination; • As a minimum, all acute trusts are expected to deliver vaccinations to staff and patients. 2. Delivery of an autumn COVID-19 vaccination campaign if advised by JCVI; and 3. Development of detailed contingency plans to rapidly increase capacity, if required. The Programme Team will also continue to evolve and improve the services' processes, share success and address challenges in partnership with the Bristol, North Somerset and South Gloucestershire (BNSSG) Vaccination Programme.
Ownership:	Chief Nurse/Director of People

Note:

The national data for May had not been published in time for inclusion in this month's IQPR.

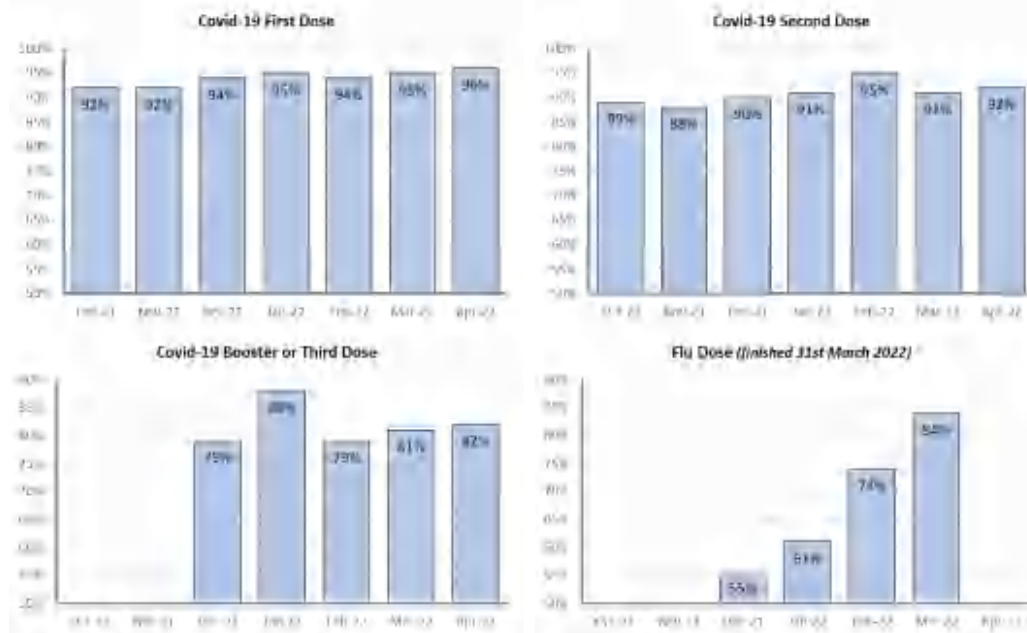
So the Staff Vaccination Summary and Immunisation Summary appendices are the same as last month's IQPR.

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Appendix – Immunisation Summary

Monthly Trends

The monthly totals below are the percentages quoted in previous month's IQPRs. April 2022 is current/latest percentage figures.



Divisional Uptake

The divisional totals for Covid19 Booster/Third Dose are shown below. Note these figures include only those who have had their vaccination through the UHBW Hospital Hub.

Division	COVID-19 Booster or Third dose uptake as a % of all staff
Diagnostics And Therapies	73%
Facilities And Estates	45%
Medicine	101%
Specialised Services	89%
Surgery	71%
Trust Services	34%
Weston	80%
Women's And Children's	65%

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Appendix – Health Inequalities

Source:	CareFlow PAS. Deprivation deciles are based on the Index of Multiple Deprivation 2019 (IMD 2019), which is the official measure of relative deprivation. Decile 1 represents the most deprived and Decile 10 represents the least deprived.
Timeframe:	Based on waiting list census as at May 2022.
Commentary:	Health inequalities are avoidable, unfair and systematic differences in health between different groups of people (Kings Fund, 2020). The NHS Health Inequalities Improvement Dashboard is currently being developed nationally and will provide key information for strategic indicators relating to health inequalities all in one place. This includes the five priority areas for narrowing health inequalities in the 2021-22 planning guidance and data for the five clinical areas in the Core20Plus5 approach. It will also include a public facing dashboard. The Delivery Plan for Tackling the COVID-19 backlog of elective care puts reducing inequalities at the core of recovery plans and performance monitoring and the Trust Health Inequalities Working Group has focused on establishing a dashboard to inform a “fair recovery” which is at the core of the NHS approach. Initial lines of enquiry from the data to inform our priorities for reducing health inequalities in elective recovery are: 1. How can the Trust reduce variation in the average length of wait in the most deprived areas (23.79 weeks) and the least deprived areas (22.25 weeks)? 2. How can the Trust reduce variation in the average length of wait and DNA rates for black, Asian and minority ethnic groups / people of colour? 3. How can the Trust reduce variation in the average length of wait for those with a recorded disability (26.1 weeks) compared to those without (22.63 weeks)? The Trust has commissioned an independent baseline assessment to inform the future strategy for improving patient experience and health equality. This will be presented to a Board seminar in the Summer of 2022. The Trust has agreed a quality priority for developing a Health Inequalities Strategy informed by the findings of the baseline review. Further work is also underway to develop insight into how the Trust can mitigate digital exclusion in its access policies and procedures. This will specifically include an analysis of who is accessing face to face, telephone and video consultations, split by age, ethnicity and Index of Multiple Deprivation. Improvement priorities for the next period are: 1. To complete the Public Health Action Support Team (PHAST) baseline assessment for July Board seminar. 2. To develop a clinically led improvement plan in response to the insights provided for the baseline data from the waiting list analysis, including drill down into specialty level opportunities where there are opportunities for dialogue on ways to improve access for groups who may be more disadvantaged.

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Commentary (continued):

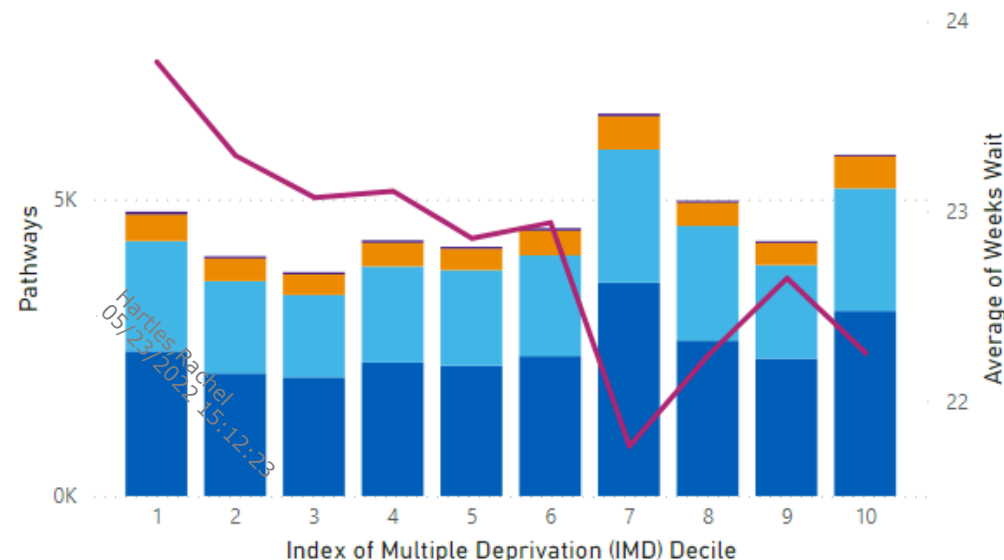
- To further develop the Trust “waiting well” Quality Priority. This builds upon the deployment of My Planned Care to support patients while they wait, and will include the co-design of commitments the Trust will agree with patients to support patients and their carers to wait well and other initiatives to take positive action that supports reduction in health inequalities.
- To complete initial findings from piloting artificial intelligence to support surgical triage of waiting lists (C2Ai) so that the risk of mortality, surgical complications or post-operative complications is not exacerbated by length of wait. This has potential to include analysis of demographic information and social determinants of health following the pilot phase.
- Continuing to work in partnership with the BNSSG partners in the Integrated Care System to support broader objectives in reducing health inequalities through population health management.

Ownership:

Chief Nurse/Deputy Chief Executive and Chief Operating Officer

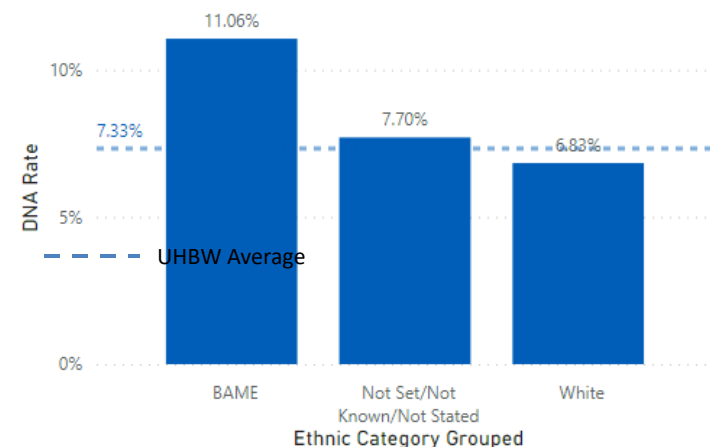
Index of Multiple Deprivation (IMD) Decile

Wait Bands ● <18 Weeks ● 18-51 Weeks ● 52-103 Weeks ● 104+ Weeks ● Average of Week...

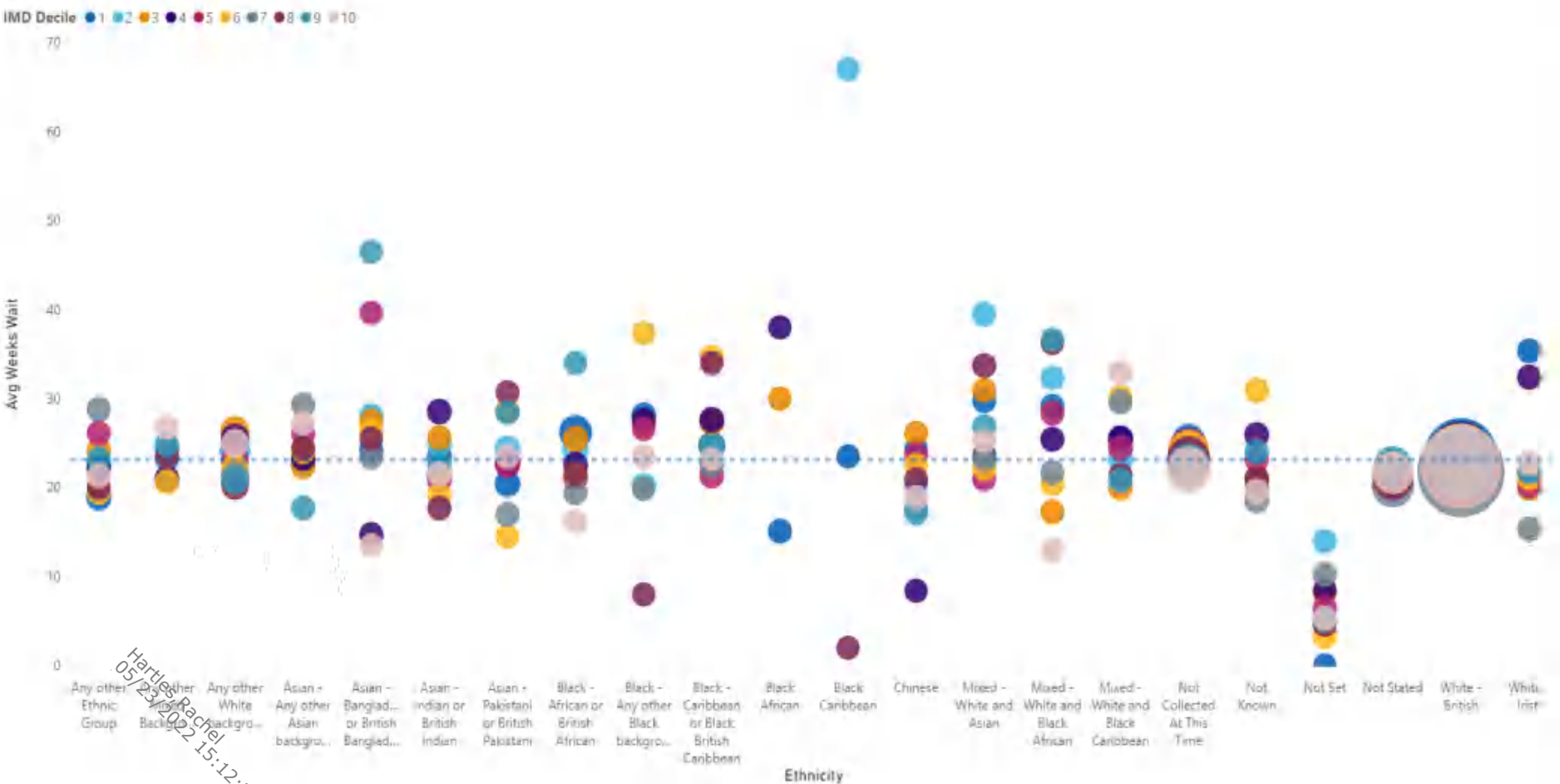


DNA Rate, Appointments

BY ETHNIC CATEGORY GROUPED



Appendix – Health Inequalities

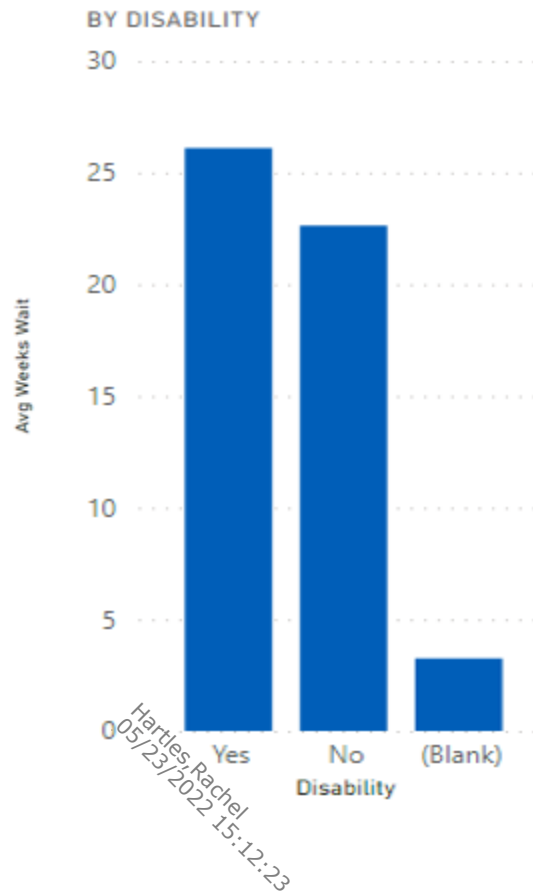


UHBW Average

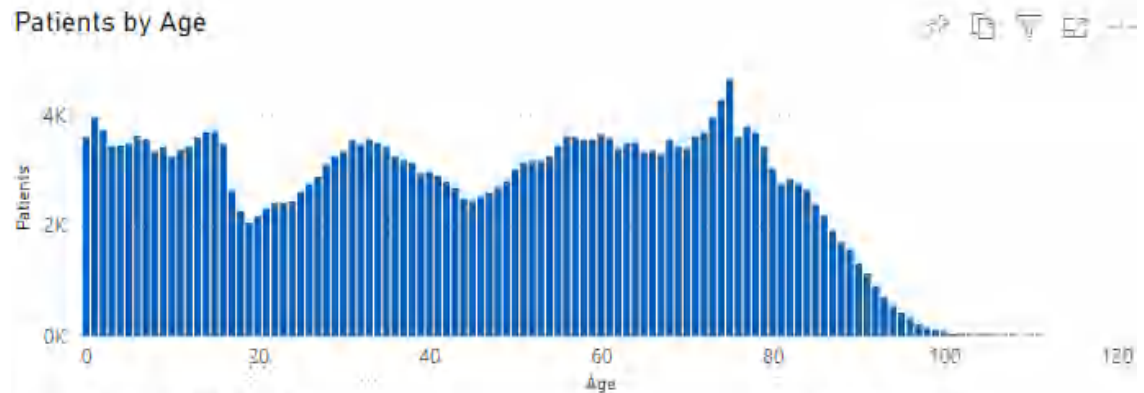


Size denotes number of pathways in each IMD decile

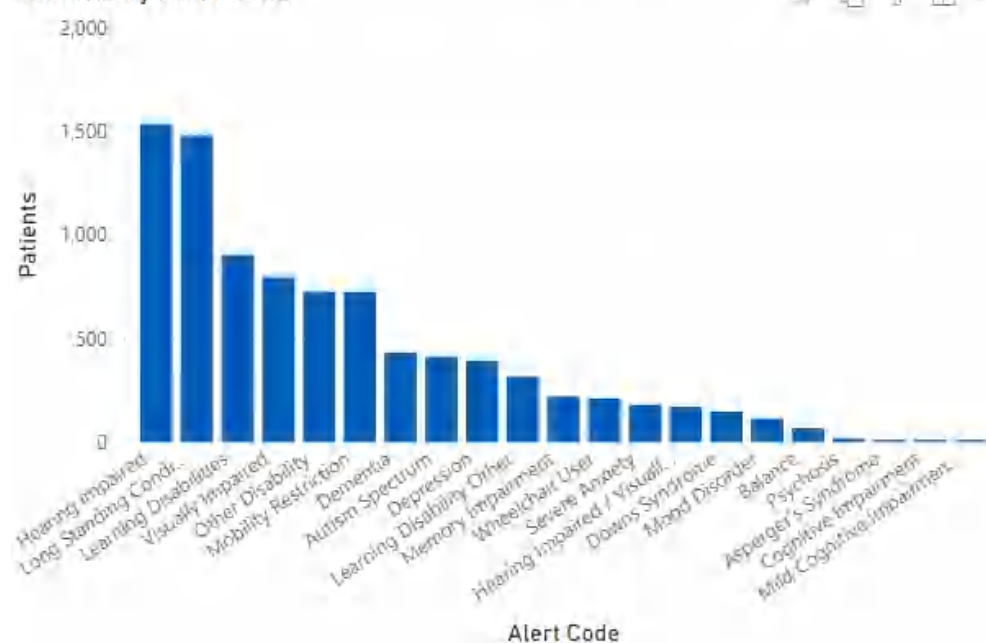
Appendix – Health Inequalities



Patients by Age



Patients by Alert Code



Appendix – Trust Scorecards

INTEGRATED PERFORMANCE REPORT – (TRUST TOTAL)																	 University Hospitals Bristol and Weston NHS Foundation Trust			
SAFE DOMAIN																				
C	Measure	2022-23 Rate	2022-23 Rate	2021-22	2020-21	2019-20	2018-19	2017-18	2016-17	2015-16	2014-15	2013-14	2012-13	2011-12	2010-11	2009-10	2008-09	2007-08		
Infection Control																				
DA01	MRSA Hospital Onset Cases	7	0	0	0	1	0	0	0	0	2	3	0	1	0	1	2	4		
DA02	MSSA Hospital Onset Cases	41	3	5	4	0	4	3	4	5	1	4	2	5	3	7	10	11		
DA03	CDiff Hospital Onset Cases	82	6	11	14	7	4	6	7	3	6	6	8	2	6	17	16	16		
DA03A	CDiff Healthcare Associated Cases	95	6	13	16	9	4	7	8	3	8	7	8	3	6	20	19	18		
DA06	EColi Hospital Onset Cases	75	13	5	5	5	8	8	8	8	2	7	5	9	13	21	18	21		
Patient Falls																				
AB01	Falls Per 1,000 Beddays	4.03	5.54	4.04	4.41	4.53	4.70	4.37	4.1	4.57	5.2	5.54	4.05	5.5	5.54	4.74	4.86	5.01		
	Numerator (Falls)	1801	179	126	134	144	149	147	154	144	163	173	145	183	179	440	461	501		
	Denominator (Beddays)	373117	32302	31155	30415	31367	31283	30207	32072	31479	31351	31233	29895	33280	32302	92857	94902	94408		
AB06A	Total Number of Patient Falls Resulting in Harm	35	1	1	2	4	4	2	1	1	6	1	2	4	1	10	8	5		
Pressure Injuries																				
DE01	Pressure Injuries Per 1,000 Beddays	0.114	0.248	0.064	0.132	0.128	0.224	0.132	0.187	0.159	0.255	0.256	0.1	0.3	0.248	0.162	0.2	0.222		
	Numerator (Pressure Injuries)	65	8	2	4	4	7	4	6	5	8	8	3	10	8	15	19	21		
	Denominator (Beddays)	373117	32302	31155	30415	31367	31283	30207	32072	31479	31351	31233	29895	33280	32302	92857	94902	94408		
DE02	Pressure Injuries - Grade 2	53	8	1	3	4	5	3	5	4	7	6	3	8	8	12	16	17		
DE03	Pressure Injuries - Grade 3	11	0	1	1	1	2	1	1	1	1	1	0	2	0	3	2	4		
DE04	Pressure Injuries - Grade 4	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0		
Serious Incidents																				
S02	Number of Serious Incidents Reported	89	7	9	9	12	4	10	6	7	7	8	6	4	7	26	20	18		
S01	Total Never Events	2	0	0	0	1	0	1	0	0	0	0	0	0	0	2	0	0		
Medication Errors																				
WA01	Medication Incidents Resulting in Harm	0.37%	-	0.37%	0%	0.0%	0.4%	0.1%	0.15%	0.15%	0%	0%	0.4%	0%	-	0.36%	0.51%	0.11%		
	Numerator (Incidents Resulting in Harm)	11	0	1	0	0	1	2	3	3	0	0	1	0	0	3	6	1		
	Denominator (Total Incidents)	3667	0	271	258	292	248	285	382	394	361	299	330	280	0	825	1137	909		
WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.36%	1.06%	0%	0.6%	0.34%	1.1%	0.44%	0.1%	0%	0%	0.7%	1.92%	1.06%	-	0.41%	0.24%	1.01%		
	Numerator (Number of Incidents)	13	2	0	3	0	1	3	1	1	0	0	2	2	2	4	2	4		
	Denominator (Total Audited)	3603	188	447	501	440	265	273	225	338	278	135	158	104	188	978	841	397		
Omitted Doses is Bristol only																				

Appendix – Trust Scorecards

		INTEGRATED PERFORMANCE REPORT - TRUST TOTAL																NHS University Hospitals Bristol and Weston NHS Foundation Trust			
		21/22	22/23	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	21/22	22/23	21/22	22/23	21/22	22/23
VTE Risk Assessment																					
N01	Adult Inpatients who Received a VTE Risk Assessment	83.3%	81.8%	82.3%	82.5%	82.1%	83.9%	85.7%	83.7%	84.3%	83.2%	83.8%	82.8%	82.2%	81.3%	83.9%	83.8%	82.8%	81.8%		
	Numerator (Number Risk Assessed)	85085	6584	7137	7251	7201	7091	7417	7016	7398	6816	6784	6569	7393	6584	21709	21230	20746	6584		
	Denominator (Total Patients)	102202	8095	8671	8794	8769	8449	8654	8380	8774	8189	8099	7956	8990	8095	25872	25343	25045	8095		
VTE Data is Bristol only																					
Nurse Staffing Levels ("Fill Rate")																					
RP01	Staffing Fill Rate - Combined	92.5%	87.1%	101.5%	96.9%	93.6%	95.6%	89%	89.9%	92.2%	89.8%	90.1%	88.6%	86.6%	87.1%	92.7%	90.6%	88.4%	87.1%		
	Numerator (Hours Worked)	33502.20	26454.4	300816	284844	285636	288962	263605	276499	277810	282203	280381	253025	273197	264544	838203	836512	806604	264544		
	Denominator (Hours Planned)	3621399	303724	296455	294105	305258	302404	296280	307464	301316	314390	311348	285546	315542	303724	903942	923170	912437	303724		
RP02	Staffing Fill Rate - RN Shifts	88.3%	85.4%	97.7%	92.7%	87.9%	88.7%	84.4%	86.7%	89.1%	86.8%	86%	85%	83.5%	85.4%	87%	87.5%	84.8%	85.4%		
	Numerator (Hours Worked)	2213205	177267	199598	187080	184059	184918	174331	185524	185886	189697	186980	167746	181617	177267	543308	560108	536343	177267		
	Denominator (Hours Planned)	2505201	207596	204360	201866	209391	208549	206611	213872	208721	217364	217493	197421	217502	207596	624552	639957	632416	207596		
RP03	Staffing Fill Rate - NA Shifts	101.9%	90.8%	109.9%	106%	106%	110.9%	99.6%	97.2%	99.3%	96.4%	99.5%	96.8%	93.4%	90.8%	105.5%	97.6%	96.5%	90.8%		
	Numerator (Hours Worked)	1137015	87276.4	101218	97763.7	101576	104044	89274.3	90974.6	91924.3	93505.8	93401	85278.9	91580.9	87276.4	294895	276405	270261	87276.4		
	Denominator (Hours Planned)	1116197	96127.9	92095	92238.5	95866.7	93855.2	89669	93591.6	92595	97025.7	93854.7	88125.3	98040.6	96127.9	279391	283212	280021	96127.9		

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Appendix – Trust Scorecards

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL																							
CARING DOMAIN																							
ID	MEASURE	11/22	12/22	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1
Patient Surveys (Bristol)																							
P01D	Patient Survey (Bristol) - Patient Experience Tracker Score			88	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88	88	#N/A
P01G	Patient Survey (Bristol) - Kindness and Understanding			94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	94	#N/A
P01H	Patient Survey (Bristol) - Outpatient Tracker Score			92	92	92	92	92	92	92	92	92	92	92	92	92	92	92	92	92	92	92	#N/A
Patient Surveys (Weston)																							
P02D	Patient Survey (Weston) - Patient Experience Tracker Score			85	84	82	81	83	85	82	86	82	86	87	82	86	87	82	84	86	86	86	#N/A
P02G	Patient Survey (Weston) - Kindness and Understanding			92	95	90	92	92	92	94	94	95	93	95	92	93	95	91	93	94	94	94	#N/A
P02H	Patient Survey (Weston) - Outpatient Tracker Score			94	85	90	92	88	95	88	90	95	92	87	90	95	92	90	92	92	92	92	#N/A
Patient Complaints (Number Received)																							
T01	Number of Patient Complaints	1977	138	176	160	158	174	193	193	193	104	153	151	198	138	525	490	502	138	525	490	502	138
T01C	Patient Complaints - Formal	517	12	46	51	50	45	24	27	39	32	61	53	40	12	119	98	154	12	119	98	154	12
T01D	Patient Complaints - Informal	1460	126	130	109	108	129	169	166	154	72	92	98	158	126	406	392	348	126	406	392	348	126
Patient Complaints (Response Time)																							
T03A	Formal Complaints Responded To Within Trust Timeframe	87.9%	87.7%	87.1%	87.1%	85.6%	86%	87.6%	88%	88.4%	88.2%	88.2%	88.2%	88.2%	88.2%	88.2%	88.2%	88.2%	88.2%	88.2%	88.2%	88.2%	88.2%
	Numerator (Responses Within Timeframe)	573	36	42	58	77	51	46	34	29	36	44	58	51	36	174	99	153	36	174	99	153	36
	Denominator (Total Responses)	653	57	72	68	90	65	80	54	70	69	81	94	75	57	255	193	250	57	255	193	250	57
T03B	Formal Complaints Responded To Within Divisional Timeframe	73.4%	75.4%	62.5%	72.7%	76.7%	70.6%	72.5%	72.2%	70%	76.8%	69.1%	73.4%	76%	75.4%	73.3%	73.1%	72.8%	75.4%	73.3%	73.1%	72.8%	75.4%
	Numerator (Responses Within Timeframe)	670	43	45	64	69	60	58	39	49	53	56	69	57	43	187	141	182	43	187	141	182	43
	Denominator (Total Responses)	913	57	72	88	90	85	80	54	70	69	81	94	75	57	255	193	250	57	255	193	250	57
T05A	Informal Complaints Responded To Within Trust Timeframe	88.4%	88.7%	88.4%	87.8%	88.9%	88.7%	88.4%	87.8%	88.2%	88.4%	88.4%	88.4%	88.4%	88.4%	88.4%	88.4%	88.4%	88.4%	88.4%	88.4%	88.4%	88.4%
	Numerator (Responses Within Timeframe)	676	66	67	43	52	52	49	51	71	66	59	46	68	66	153	188	173	66	153	188	173	66
	Denominator (Total Responses)	763	72	71	49	56	60	57	58	79	78	66	53	79	72	173	215	198	72	173	215	198	72
Patient Complaints (Dissatisfied)																							
T04C	Percentage of Responses where Complainant is Dissatisfied	9.11%	-	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%	9.11%
	Numerator (Number Dissatisfied)	76	0	7	9	7	9	8	2	5	7	9	8	0	0	24	14	17	0	24	14	17	0
	Denominator (Total Responses)	838	0	72	88	90	85	80	54	70	69	81	94	0	0	255	193	175	0	255	193	175	0

Appendix – Trust Scorecards

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL CARING DOMAIN

ID	Measure	7/1/21	7/2/21 YTD	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	21/22 Q3	21/22 Q3	21/22 Q3	21/22 Q3	21/22 Q3	21/22 Q3	21/22 Q3	21/22 Q3	21/22 Q3	21/22 Q3	21/22 Q3	21/22 Q3
Friends and Family Test (Inpatients and Day Cases)																											
P03A	Friends and Family Test Admitted Patient Coverage	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%
	Numerator (Total FFT Responses)	18610	1135	1930	1960	1870	1635	1787	1373	1523	1352	1580	1021	1357	1135	5292	4248	3955	1135	17552	16555	14860	4752	30.1%	25.7%	26.6%	23.9%
	Denominator (Total Eligible to Respond)	67156	4752	5994	6332	5989	5782	5781	5701	5717	5137	4949	4546	5365	4752	17552	16555	14860	4752	96.9%	96.9%	97%	96.1%	5084	4103	3825	1090
P04A	Friends and Family Test Score - Inpatients/Day Cases	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
	Numerator (Total "Positive" Responses)	17993	1090	1882	1917	1801	1592	1691	1325	1463	1315	1512	1005	1308	1090	5084	4103	3825	1090	9248	8235	7392	2134	21.0%	18.1%	17.1%	15.1%
	Denominator (Total Responses)	18520	1134	1926	1959	1852	1634	1762	1362	1522	1351	1566	1020	1356	1134	5248	4235	3942	1134	96.9%	96.9%	97%	96.1%	5084	4103	3825	1090
Friends and Family Test (Emergency Department)																											
P03B	Friends and Family Test ED Coverage	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%
	Numerator (Total FFT Responses)	12161	1063	774	1086	782	1139	848	1335	1243	1051	1161	1037	1168	1063	2759	3629	3366	1063	96444	95429	93486	11970	7.6%	10.2%	10.1%	8.9%
	Denominator (Total Eligible to Respond)	138397	11970	11898	12542	12385	11557	12502	12799	11990	10640	10405	10494	12587	11970	96444	95429	93486	11970	83.3%	82.5%	85.3%	82.4%	2298	2977	2866	869
P04B	Friends and Family Test Score - ED	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%
	Numerator (Total "Positive" Responses)	10176	869	660	904	613	971	714	1071	1015	891	1046	873	947	869	2298	2977	2866	869	2758	3609	3358	1054	21.0%	18.1%	17.1%	15.1%
	Denominator (Total Responses)	12111	1054	771	1080	779	1134	845	1331	1231	1047	1158	1036	1164	1054	2758	3609	3358	1054	96.9%	96.9%	97%	96.1%	5084	4103	3825	1090
Friends and Family Test (Maternity)																											
P03C	Friends and Family Test MAT Coverage	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%	10.2%
	Numerator (Total FFT Responses)	1355	181	138	217	40	146	111	5	273	96	92	48	127	181	297	374	267	181	4241	4127	3507	1056	7%	9.1%	7.6%	17.1%
	Denominator (Total Eligible to Respond)	15875	1056	1359	1341	1408	1399	1434	1401	1392	1334	1100	1159	1248	1056	96444	95429	93486	11970	83.3%	82.5%	85.3%	82.4%	2298	2977	2866	869
P04C	Friends and Family Test Score - Maternity	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
	Numerator (Total "Positive" Responses)	1332	177	133	215	38	145	107	4	271	96	91	47	126	177	290	371	264	177	290	371	264	177	21.0%	18.1%	17.1%	15.1%
	Denominator (Total Responses)	1351	180	138	217	40	146	108	5	273	96	92	48	127	180	294	374	267	180	96.9%	96.9%	97%	96.1%	5084	4103	3825	1090
Friends and Family Test (Outpatients)																											
P04D	Friends and Family Test Score - Outpatients	94.9%	94.2%	95%	94.7%	95.2%	94.8%	94.4%	93.9%	95.5%	95.5%	95.1%	94.9%	94.8%	94.2%	94.7%	94.9%	95%	94.2%	94.7%	94.9%	95%	94.2%	94.7%	94.9%	95%	94.2%
	Numerator (Total FFT Responses)	31167	2181	2549	2910	1958	2523	3330	3022	2935	2023	3381	1942	2864	2181	7811	7980	8187	2181	8246	8411	8621	2315	94.7%	94.9%	95%	94.2%
	Denominator (Total Eligible to Respond)	32858	2315	2682	2440	2057	2660	3579	3220	3073	2118	3554	2046	3021	2315	8246	8411	8621	2315	96.9%	96.9%	97%	96.1%	5084	4103	3825	1090

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INTEGRATED PERFORMANCE REPORT - TRUST TOTAL														
RESPONSIVE DOMAIN														
Measure		2022	2021	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010
Emergency Department Performance														
B01	ED Total Time in Department - Under 4 Hours	96.74%	95.51%	95.24%	94.99%	94.91%	94.81%	94.74%	94.68%	94.61%	94.54%	94.47%	94.40%	94.33%
	Numerator (Number Seen In Under 4 Hours)	127045	9370	12260	11825	11202	10481	10903	10630	10255	9284	9450	9134	10589
	Denominator (Total Attendances)	190223	15234	16523	16871	16738	15901	16654	17041	16049	14578	14317	14090	16738
B06	ED 12 Hour Trolley Waits	98.1%	8.0%	98.1%	98.1%	98.1%	98.1%	98.1%	98.1%	98.1%	98.1%	98.1%	98.1%	98.1%
		18	140	18	140	18	140	18	140	18	140	18	140	18
Emergency Department Clinical Indicators														
B02	ED Time to Initial Assessment - Under 15 Minutes	81.5%	71.5%	81.5%	81.5%	81.5%	81.5%	81.5%	81.5%	81.5%	81.5%	81.5%	81.5%	81.5%
	Numerator (Number Assessed Within 15 Minutes)	35034	2144	3920	3599	3407	3164	2718	2646	2644	2541	2583	2116	2220
	Denominator (Total Attendances Needing Assessment)	41980	2825	4427	4082	3808	3768	3358	3260	3297	3235	3130	2802	2835
B03	ED Time to Start of Treatment - Under 60 Minutes	92.5%	85.1%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%
	Numerator (Number Treated Within 60 Minutes)	86759	6420	8389	7474	6928	7029	7135	6596	6922	6921	7471	6630	6875
	Denominator (Total Attendances)	179463	14333	15824	15936	15599	15005	15518	15733	15284	13841	13643	13291	15581
B04	ED Unplanned Re-attendance Rate	1.0%	1.8%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
	Numerator (Number Re-attending)	5453	433	527	520	494	435	441	528	472	421	366	377	474
	Denominator (Total Attendances)	190223	15234	16523	16871	16738	15901	16654	17041	16049	14578	14317	14090	16738
B05	ED Left Without Being Seen Rate	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
	Numerator (Number Left Without Being Seen)	5775	379	295	480	526	484	597	727	487	397	384	401	758
	Denominator (Total Attendances)	190223	15234	16523	16871	16738	15901	16654	17041	16049	14578	14317	14090	16738
Referral To Treatment Ongoing														
A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	-	-	61.8%	63.4%	63.1%	62.0%	61.8%	60.7%	60.3%	58.6%	58.7%	59.5%	59.7%
	Numerator (Number Under 18 Weeks)	0	0	31263	32579	33280	33914	33165	32353	32131	31208	31662	32309	32555
	Denominator (Total Pathways)	0	0	49791	51198	52718	53855	53697	53743	53328	53253	53909	54305	55021
A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	-	-	34.5%	31.1%	29.6%	29.5%	31.0%	32.0%	33.0%	35.5%	35.9%	36.0%	39.2%
A06A	Referral To Treatment Ongoing Pathways Over 78 Weeks	-	-	802	802	960	1217	1272	1105	952	900	903	824	833
A06B	Referral To Treatment Ongoing Pathways Over 104 Weeks	-	-	48	73	90	120	173	187	235	252	336	386	346
Referral To Treatment Activity														
A01A	Referral To Treatment Number of Admitted Clock Stops	30226	2144	2671	2930	2746	2504	2583	2394	2631	2162	2227	2322	2144
A02A	Referral To Treatment Number of Non Admitted Clock Stops	113401	8127	10149	11045	9996	8069	9331	9565	10536	8030	8742	8444	8127
A09	Referral To Treatment Number of Clock Starts	140873	9414	12419	13667	12501	11535	11737	12029	12077	9892	10584	10568	9414

Appendix – Trust Scorecards

		INTEGRATED PERFORMANCE REPORT – TRUST TOTAL														NHS			
		RESPONSIVE DOMAIN														University Hospitals Bristol and Weston NHS Foundation Trust			
		2017-18	2018-19	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	21/07/17	21/07/18	21/07/19	21/07/20
Diagnostic Waits																			
A05	Diagnostics Under 6 Week Wait (15 Key Tests)	-	-	85.34%	63.83%	61.61%	83.08%	64.47%	83.37%	85.4%	61.14%	80.55%	62.57%	60.95%	57.89%	-	-	-	-
	Numerator (Number Under 6 Weeks)	0	0	9301	9197	9123	8617	9057	8937	9357	8881	9175	9738	10124	9564	0	0	0	0
	Denominator (Total Waiting)	0	0	14234	14387	14119	13661	14049	14125	14307	14525	15154	15576	16610	16521	0	0	0	0
A05J	Diagnostics 13+ Week Wait (15 Key Tests)	-	-	19.9%	19.59%	19.45%	20.32%	20.86%	22.43%	20.61%	21.89%	21.38%	21.5%	20.3%	22.99%	-	-	-	-
	Numerator (Number Over 13 Weeks)	0	0	2833	2819	2746	2776	2930	3169	2949	3180	3240	3349	3372	3799	0	0	0	0
	Denominator (Total Waiting)	0	0	14234	14387	14119	13661	14049	14125	14307	14525	15154	15576	16610	16521	0	0	0	0
Cancer 2 Week Wait																			
E01A	Cancer - Urgent Referrals Seen In Under 2 Weeks	82.4%	-	81.1%	82.2%	87.1%	89.3%	87.3%	86.4%	86.1%	76.3%	71%	75.4%	68.5%	-	81.7%	81.8%	70.5%	-
	Numerator (Number Seen Within 2 Weeks)	17444	0	1631	1755	1634	1490	1500	1561	1484	1194	1140	1110	1313	0	4624	4239	3563	0
	Denominator (Total Seen)	21179	0	1753	2022	1864	1711	1822	1807	1846	1525	1605	1472	1974	0	5397	5180	5051	0
Cancer 31 Day																			
E02A	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	95.4%	-	96.1%	96.2%	97.2%	96.1%	97.7%	93%	89.9%	89.5%	91.1%	89.6%	93.5%	-	97%	90.9%	91.4%	-
	Numerator (Number Treated Within 31 Days)	3323	0	274	330	311	269	302	294	266	256	246	259	259	0	881	816	764	0
	Denominator (Total Treated)	3557	0	285	343	320	280	308	316	296	286	270	289	277	0	908	898	836	0
E02B	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	89.7%	-	100%	100%	99.1%	99.3%	100%	100%	98.7%	100%	97.3%	99.3%	99.3%	-	99.8%	99.6%	98.7%	-
	Numerator (Number Treated Within 31 Days)	1793	0	155	157	157	145	151	155	154	164	143	148	152	0	453	473	443	0
	Denominator (Total Treated)	1806	0	155	157	158	146	151	155	156	164	147	149	153	0	455	475	449	0
E02C	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	85.1%	-	81.1%	81.2%	80.7%	80.1%	80%	80%	81.2%	80%	81.2%	80%	82.1%	-	82.8%	86%	76.4%	-
	Numerator (Number Treated Within 31 Days)	570	0	47	52	51	52	49	44	48	43	50	40	55	0	152	135	145	0
	Denominator (Total Treated)	670	0	50	57	55	59	57	50	57	50	68	50	67	0	171	157	185	0
Cancer 62 Day																			
E03A	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	6%	-	94%	90.5%	76.2%	76.7%	62.7%	75.8%	82%	79.1%	66.1%	63.7%	77.6%	-	74%	76.4%	71.3%	-
	Numerator (Number Treated Within 62 Days)	1254.5	0	121	128	121.5	92	109.5	119	116	92.5	80	79.5	95.5	0	323	327.5	255	0
	Denominator (Total Treated)	1651	0	144	159	159.5	120	157	157	145	126.5	117.5	114	123	0	436.5	428.5	354.5	0
E03B	Cancer 62 Day Referral To Treatment (Screenings)	5.2%	-	11.4%	57.1%	80.7%	11.7%	11.2%	66.7%	71.1%	55.6%	71.1%	60%	55.8%	-	52.9%	47.1%	47.8%	-
	Numerator (Number Treated Within 62 Days)	44.5	0	3	5.5	6.5	5	2	4	1.5	2.5	4.5	3	2.5	0	13.5	8	10	0
	Denominator (Total Treated)	88.5	0	7	9.5	7.5	12	6	6	6.5	4.5	11.5	5	4.5	0	25.5	17	21	0
E03C	Cancer 62 Day Referral To Treatment (Upgrades)	81.1%	-	81%	81.4%	80.7%	91.1%	81.2%	97.7%	91.1%	85%	80.7%	75%	71.9%	-	89.4%	88.8%	77.2%	-
	Numerator (Number Treated Within 62 Days)	614.5	0	50.5	64.5	56.5	54	49	50	51.5	50	47	45	48.5	0	159.5	151.5	140.5	0
	Denominator (Total Treated)	722	0	55.5	75.5	63	58	57.5	57	56.5	61	54.5	60	67.5	0	178.5	174.5	132	0

Appendix – Trust Scorecards

INTEGRATED PERFORMANCE REPORT - BEST TOTAL															
RESPONSIVE DOMAIN															
NHS															
University Hospitals Bristol and Weston NHS Foundation Trust															

Last Minute Cancelled Operations

F01	Last Minute Cancelled Operations - Percentage of Admissions
	Numerator (Number of LMCs)
	Denominator (Total Elective Admissions)
F02	Cancelled Operations Re-admitted Within 28 Days
	Numerator (Number Re-admitted Within 28 Days)
	Denominator (Total LMCs)

1313	159	72	115	34	91	192	98	104	115	149	135	165	159	1313	159
79837	6347	6721	7149	6871	6553	6866	6413	6974	6094	6385	6251	7114	6347	20290	6347
899	121	39	57	21	22	61	155	81	76	82	127	118	121	104	121
1129	152	40	69	108	31	81	178	97	94	99	142	130	152	220	152

Green To Go/Fit For Discharge (BRISTOL Only)

AQ06A	Medically Fit For Discharge - Number of Patients (Acute)
AQ06B	Medically Fit For Discharge - Number of Patients (Non Acute)
AQ07A	Medically Fit For Discharge - Beddays (Acute)
AQ07B	Medically Fit For Discharge - Beddays (Non-Acute)

-	-	79	102	92	106	87	77	121	113	129	123	122	187	-	-
-	-	0	0	0	0	0	0	0	0	0	0	0	0	-	-
-	-	2759	2721	2972	3113	3014	3152	3243	3335	3745	3473	3475	4408	-	-
-	-	0	0	0	0	0	0	0	0	0	0	0	0	-	-

Outpatient Measures

R03	Outpatient Hospital Cancellation Rate
	Numerator (Number of Hospital Cancellations)
	Denominator (Total Appointments)
R05	Outpatient DNA Rate
	Numerator (Number of DNAs)
	Denominator (Total Attendance + DNAs)

129922	10975	8793	11259	11146	10690	10751	10756	11390	10380	11265	10928	13425	10975	32587	10975
1202123	95439	91815	103665	101160	91621	103563	100109	111593	95111	101103	97506	113500	95439	296544	95439
54643	4981	4687	5457	5959	4973	5685	5384	6106	5327	5530	5184	5872	4981	16617	4981
885592	67879	71018	77475	73890	67240	75316	74180	83262	69124	73806	70276	80092	67879	216446	67879

Overdue Partial Booking (Bristol)

R22N	Overdue Partial Booking Referrals
	Numerator (Number Overdue)
	Denominator (Total Partial Booking)
R22R	Overdue Partial Bookings (9+ Months)
	Numerator (Number Overdue 9+ Months)
	Denominator (Total Partial Booking)
R22H	Overdue Partial Bookings (12+ Months)
	Numerator (Number Overdue 12+ Months)
	Denominator (Total Partial Booking)

41.6%	49.5%	33.9%	34%	36.6%	40.5%	42.6%	42.5%	43.2%	44.6%	48.2%	47.7%	48.6%	49.5%	39.9%	49.5%
759002	89591	49301	49825	55628	61574	65732	65410	67976	71860	76655	76434	79637	89591	182334	89591
1849006	181119	145451	146681	152049	152058	154470	154005	157486	161010	158904	160094	163758	181119	458577	181119
9.3%	11.8%	7.7%	8.2%	8.6%	9%	9.2%	9.4%	9.3%	9.3%	11%	10.7%	10.9%	11.8%	8.9%	11.8%
171143	21406	11199	12019	13022	13691	14215	14417	14659	15047	17460	17086	17859	21406	40928	21406
1849006	181119	145451	146681	152049	152058	154470	154005	157486	161010	158904	160094	163758	181119	458577	181119
6%	7.2%	4.2%	4.9%	5.4%	6%	6.3%	6.5%	6.4%	6.4%	7.4%	7%	6.9%	7.2%	5.9%	7.2%
110245	13032	6165	7247	8226	9067	9756	9944	10106	10378	11718	11174	11248	13032	27049	13032
1849006	181119	145451	146681	152049	152058	154470	154005	157486	161010	158904	160094	163758	181119	458577	181119

Appendix – Trust Scorecards

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL															
EFFECTIVE DOMAIN															
ID	Measure	21/22	22/23	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22
21/22 Q1 21/22 Q2 21/22 Q3 21/22 Q4 22/23 Q1															
Mortality															
X04	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	87.3	-	89.8	89.7	87.1	88.1	87.0	88.5	89.5	89.4	-	-	-	-
	Numerator (Observed Deaths)	18345	0	1975	2000	2025	2055	2085	2080	2075	2120	0	0	0	0
	Denominator ("Expected" Deaths)	18745	0	2055	2090	2085	2095	2085	2070	2090	2135	0	0	0	0
X02	Hospital Standardised Mortality Ratio (HSMR)	100.5	-	100.5	92.6	114.4	107.2	133.2	114	88.4	86	91.7	101.5	-	-
	Numerator (Observed Deaths)	1168	0	103	97	107	106	134	118	95	114	116	90	0	0
	Denominator ("Expected" Deaths)	1161.8	0	102.5	104.8	93.5	98.9	100.6	103.5	107.5	132.5	126.5	88.7	0	0
Fracture Neck of Femur (NOF)															
U02	Fracture Neck of Femur Patients Treated Within 36 Hours	50.7%	4.7%	53.8%	58%	64.7%	63.2%	64.1%	57%	55%	50%	50%	41.4%	45.8%	46.7%
	Numerator (Treated Within 36 Hrs)	147	2	14	14	11	12	13	9	11	11	12	12	12	2
	Denominator (Total Patients)	290	23	26	25	17	19	27	18	20	22	24	29	34	23
U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	90.9%	35.7%	95.7%	90%	98.1%	94.7%	100%	94.6%	100%	97%	94.7%	96.8%	100%	95.7%
	Numerator (Seen Within 72 Hrs)	281	22	25	23	16	18	27	17	20	22	22	28	34	22
	Denominator (Total Patients)	290	23	26	25	17	19	27	18	20	22	24	29	34	23
U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	70.3%	4.7%	61.8%	52%	66.7%	67.8%	67.1%	65%	65%	67%	65%	64.3%	75.7%	8.7%
	Numerator (Number achieved BPT)	146	2	14	13	11	11	13	9	11	11	12	13	12	2
	Denominator (Total Patients)	290	23	26	25	17	19	27	18	20	22	24	29	34	23
Emergency Readmissions															
C01	Emergency Readmissions Percentage	1.4%	-	1.0%	1.8%	1.3%	1.7%	1.4%	1.1%	1.5%	1.9%	1.8%	2.5%	-	0%
	Numerator (Re-admitted in 30 Days)	3863	0	435	390	382	334	325	295	358	299	299	316	0	0
	Denominator (Total Discharges)	161255	0	13778	14032	13991	13513	13794	13389	13945	12726	12577	12341	13928	0
Stroke Care															
O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	55.7%	-	64.7%	64.8%	58.4%	55.1%	58.5%	51.5%	54.5%	61.5%	51.2%	57.9%	52.6%	-
	Numerator (Achieved Target)	229	0	19	18	19	15	21	17	18	20	12	19	19	0
	Denominator (Total Patients)	404	0	39	28	32	27	36	33	33	32	23	28	36	0
O02	Stroke Care: Percentage Spending 90+ Time On Stroke Unit	53.7%	77.8%	62%	66.8%	63.6%	66.7%	74.5%	68.8%	58.7%	54.4%	55.3%	57.4%	58.2%	77.8%
	Numerator (Achieved Target)	369	7	32	33	35	18	35	35	27	25	25	29	32	7
	Denominator (Total Patients)	579	9	50	48	55	27	47	51	46	46	38	43	55	9

Appendix – Trust Scorecards

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL																	 University Hospitals Bristol and Weston NHS Foundation Trust			
WELL-LED DOMAIN																				
ID	Measure	21/22	22/23 YTD	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	
Bank and Agency Usage																				
AF11A	Percentage Bank Usage	-	-	4.05%	5.15%	5.80%	7.20%	5.70%	5.70%	5.41%	6.41%	5.89%	5.92%	6.34%	5.25%	-	-	-	-	
	Numerator (Bank wte)	0	0	552.21	574.41	655.6	833.54	587.41	591.17	613.62	613.65	673.48	675.59	731.9	597.39	0	0	0	0	
	Denominator (Total wte)	0	0	11160.6	11163.1	11189.7	11429.3	11252.4	11292.1	11335.5	11335.8	11441.8	11411.2	11549.9	11386.6	0	0	0	0	
AF11B	Percentage Agency Usage	-	-	2.53%	2.46%	2.25%	2.05%	2.1%	1.68%	1.78%	1.71%	2.22%	2.21%	2.38%	2.05%	-	-	-	-	
	Numerator (Agency wte)	0	0	293.62	276.8	251.31	238.33	236.02	212.91	203.34	194.3	254.06	252.3	274.31	233.34	0	0	0	0	
	Denominator (Total wte)	0	0	11160.6	11163.1	11189.7	11429.3	11252.4	11292.1	11335.5	11335.8	11441.8	11411.2	11549.9	11386.6	0	0	0	0	
Turnover																				
AF10	Workforce Turnover Rate	-	-	12.7%	13.2%	11.7%	11.8%	13.0%	14%	14.8%	15%	15.1%	15.3%	15.1%	15.2%	-	-	-	-	
	Numerator (Leavers in last 12 months)	0	0	1099.6	1145.43	1188.94	1204.66	1213.97	1229.95	1264.87	1314.78	1325.46	1348.96	1327.11	1332.28	0	0	0	0	
	Denominator (Average Staff in Post)	0	0	8689.73	8678.28	8691.24	8700.47	8751.06	8782.27	8804.04	8775.31	8806.01	8826.92	8812.54	8791.26	0	0	0	0	
Vacancy																				
AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	-	-	4.3%	7.4%	7.3%	7.3%	7.3%	7.3%	7.4%	7.4%	7.5%	7%	7.6%	5.7%	-	-	-	-	
	Numerator (Vacancy wte, Funded minus actual)	0	0	534.8	821.88	871.8	861.83	818.56	822.74	834.57	846.11	885.13	912.16	865.82	632.1	0	0	0	0	
	Denominator (Actual WTE)	0	0	10849.6	11133.8	11154.6	11219.1	11247.5	11310.7	11353.1	11373.9	11399.4	11395.5	11409.5	11187.9	0	0	0	0	
Staff Sickness																				
AF02	Sickness Rate	4.1%	6.4%	3.6%	3.9%	4%	4.2%	4.3%	4.8%	4.8%	4.5%	4.1%	4%	4.1%	6.4%	4.1%	4.7%	4.1%	6.4%	
	Numerator (Total WTE Days Lost)	156985	19977.5	11403	11947.8	12669	12440.4	13743.5	15674.3	15214.3	14788.6	13318.3	11745.4	13289.5	19977.5	38852.9	45677.2	38353.2	19977.5	
	Denominator (Total WTE Days)	3798329	313528	319464	308512	318912	319164	310729	323982	315563	325937	324179	294304	326222	313528	948805	965482	944705	313528	
Staff Appraisal																				
AF03	Workforce Appraisal Compliance (Non-Consultant)	-	-	10.1%	97.0%	10.3%	10.1%	97.2%	10.8%	10.1%	10.3%	10.3%	10.6%	10.4%	10.7%	-	-	-	-	
	Numerator (In-Date Appraisals)	0	0	7106	7159	7091	6994	7151	6965	7242	7066	7157	7182	7304	7123	0	0	0	0	
	Denominator (Total Staff)	0	0	10286	10248	10228	10233	10339	10423	10446	10403	10400	10424	10446	10390	0	0	0	0	

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Harriet Barclay

INTEGRATED PERFORMANCE REPORT - TRUST TOTAL																	 University Hospitals Bristol and Weston NHS Foundation Trust			
USE OF RESOURCES DOMAIN																				
ID	Measure	21/22	22/23 YTD	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	
Average Length of Stay																				
J03	Average Length of Stay (Spell)	4.38	4.88	4.09	4.18	4.12	4.18	4.33	4.22	4.44	4.75	4.51	4.75	4.63	4.88	4.21	4.46	4.63	4.88	
	Numerator (Total Beddays)	364347	31831	29903	29853	30340	28933	30184	29231	31103	31643	28517	30164	33354	31831	89457	91977	92035	31831	
	Denominator (Total Discharges)	83120	6518	7306	7143	7363	6920	6973	6929	7008	6663	6319	6345	7205	6518	21256	20600	19869	6518	

Meeting of the Board of Directors in Public on Friday 27 May 2022

Report Title	CQC Action Plan Update
Report Author	Chris Swonnell, Head of Quality & Patient Experience
Executive Lead	Deirdre Fowler, Chief Nurse

1. Report Summary

The updated composite CQC action plan lists all actions relating to UHBW CQC inspections since January 2021. The plan also includes any actions from the CQC's inspection of the Emergency Department at Weston General Hospital which were outstanding at the point when they were last reviewed by the Board in June 2021.

In future, the Trust will hold one consolidated CQC action plan, i.e. there will not be separate action plans for each CQC inspection, but instead, any new actions from CQC inspections will be incorporated into the single consolidated plan.

A previous draft of the composite action plan was reviewed at the March 2022 meeting of the Quality & Outcomes Committee (QOC). A number of actions were recommended to the committee for closure, however QOC requested further work on the plan before closure would be considered. QOC asked that an updated action plan be brought back to the Board in May for assurance, after which QOC will review the detail of the plan at its June meeting and will consider items for closure that point.

The attached governance framework for the CQC action plan was approved by QOC in March and is attached for information; the framework will now be implemented, following the updates to the action plan requested by QOC.

2. Key points to note (Including decisions taken)

Progress against plan

Overall progress against actions is summarised below. Further information regarding the status of action from individual inspections and services can be found in the dashboard section of the plan.

The full plan and the individual actions per inspection can be found at Appendix 1. Currently, the action plan relates to core services in the Divisions of Medicine and Weston, plus corporate Well-led actions.

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The current status of the 141 actions in the plan is as follows:

	May 22	
Closed	34	24%
Recommend to close (evidence supports completion)	21	15%
Complete (awaiting evidence to support)	45	32%
On track	3	2%
Behind schedule but significant progress made	12	9%
Behind schedule	26	18%
Total actions	141	

34 actions have previously been closed with the agreement of QOC.

Following review, a further **21 actions will be recommended for closure** at the June meeting of QOC.

Latest assessment is that a further **45 actions can potentially be closed pending evidence to support completion**. These are generally actions where the Trust's CQC support team has been advised that actions have been completed, but evidence to support this is awaited.

3 actions are on track. This includes actions which have been agreed since the time of the original inspection plans.

12 actions are technically behind schedule, however there is evidence of significant progress towards completion. The assessment of the CQC support team is that it should be possible to move these actions to complete/closed in the near future.

This leaves **26 actions (18% of the total) which are 'behind schedule'**, where limited information has been provided about progress and/or where the underlying concern remains despite intervention (an example of the latter would be staff appraisal compliance). For ease of reference, 'Behind schedule' actions are highlighted in a separate tab within the action plan.

17/26 behind schedule actions reside in Weston Division, which partly reflects the fact that CQC's inspections during the time since merger have focussed significantly on Weston. Of these 17 actions, 10 are for Medical Care, 5 are for the Weston Emergency Department, and 2 are for outpatients.

Of the remaining 9 behind schedule actions, 5 are for Medical Care in Bristol, 2 relate specifically to monitoring air quality at the BRI Emergency Department, and 2 relate to corporate 'Well-led' actions.

In respect of common themes, 7/26 behind schedule items relate to staff training and appraisal, 4 relate to incident investigation and learning, 2 relate to medicines management and 2 relate to Freedom to Speak Up.

Governance framework

The attached framework (Appendix 2) formalises a pattern of quarterly reporting to the Board via sub-committees / lead groups. As part of this governance framework, Divisional Boards are responsible for agreeing and implementing actions in response to CQC core clinical service inspection findings. Divisions will discharge this responsibility through appropriate senior managers, wards, teams and departments (this may include representatives from corporate services).

Immediate next steps

- Implement attached Governance framework
- Seek closure of the 21 'recommend to close' items at June QOC
- Seek further evidence to assess whether any further actions can also be recommended for closure at June QOC (particularly those currently categorised as 'complete (awaiting evidence to support)').
- Seek urgent clarification regarding the 26 'behind schedule' actions: what next steps are and revised timescales for completion
- Having completed the above, advise the Board of predicted completion dates for each of the respective inspection plans with the composite document

Future development of the CQC action plan

The intention is to develop the CQC action plan to become a more flexible and dynamic document to include improvement actions identified through other forms of CQC engagement outside of inspections, e.g. informal monitoring visits.

3. Risks

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

Risk 3763 – risk of non-compliance with CQC standards

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

Standard Operating Procedure (SOP)

UHBW GOVERNANCE AND ASSURANCE STRUCTURE FOR ACTIONS TAKEN IN RESPONSE TO CARE QUALITY COMMISSION INSPECTION REPORTS AND EXCEPTIONS RAISED

SETTING	Trust-wide
FOR STAFF	Divisional Boards, Executive Directors, Corporate Leads
ISSUE	CQC compliance

Purpose

The purpose of this SOP and accompanying flowchart is to provide clarity about organisational expectations for monitoring the progress of actions agreed following CQC inspections.

Context

Following a CQC inspection, the Trust will receive a formal report which may include required actions to enable the Trust to continue to meet CQC standards/regulations (things which the Trust 'must do') and recommendations for improving practice (things which the Trust 'should do'). In addition to this, the Trust may identify additional improvement actions based on learning from the inspection, which are over and above the formal requirements and recommendations set out by the CQC. The CQC will advise a date by which the Trust is required to confirm any actions it is taking in response to inspection findings. The agreed actions need to be implemented in a timely way.

The Trust will hold **one** consolidated CQC action plan, i.e. there will not be separate action plans for each CQC inspection, but instead, any new actions from CQC inspections will be incorporated into the single consolidated plan.

Governance and assurance structure (flowchart)

The CQC action plan will consist of actions relating either to core clinical services (as per CQC regulations) or to the Well-led quality domain, owned respectively by Divisional Boards and Executive Directors.

The CQC action plan will be held by the corporate Quality Team and made available to Divisions and corporate leads via a Teams site.

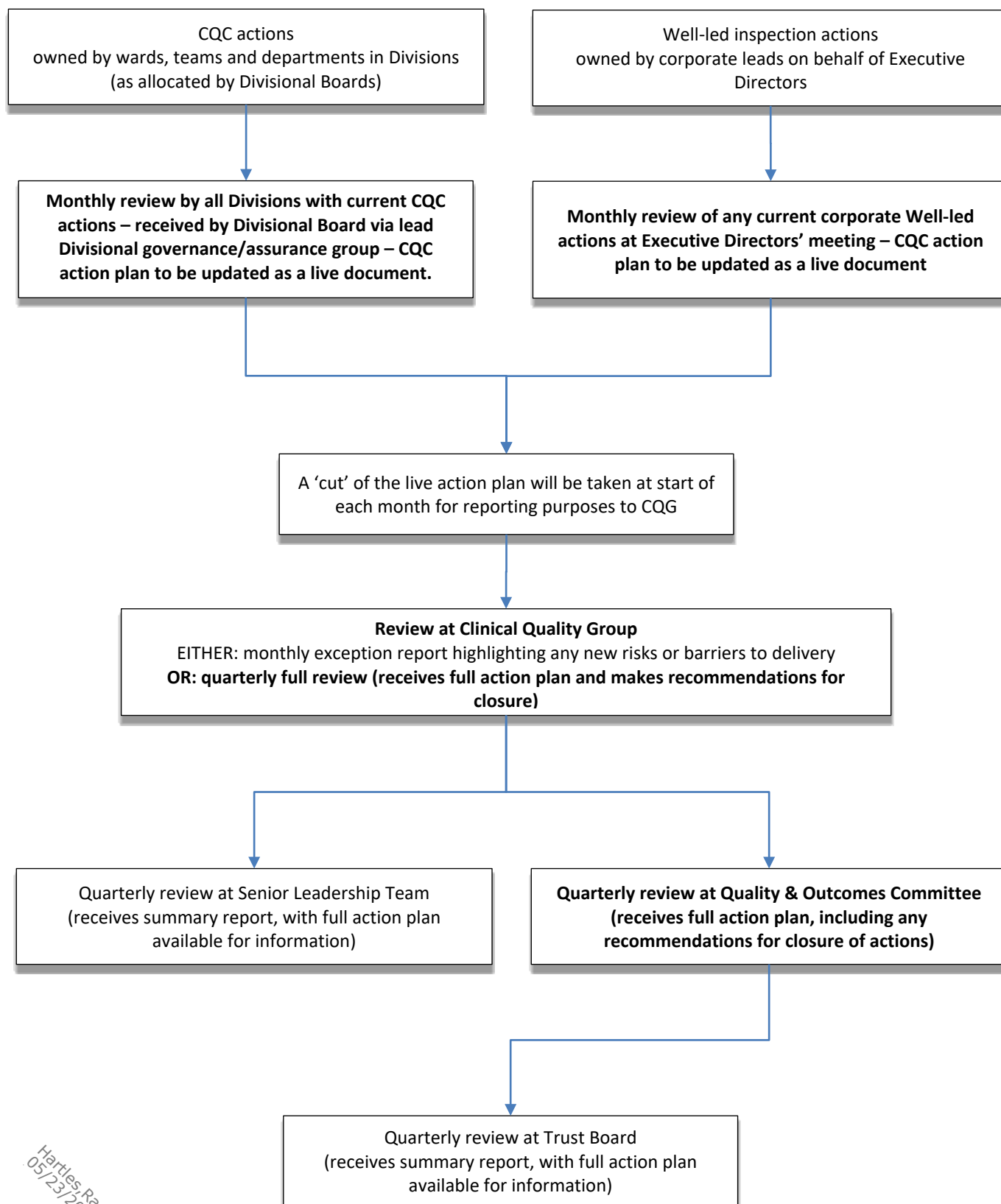
Divisional Boards are responsible for agreeing and implementing actions relating to CQC core clinical services. They will discharge this responsibility through appropriate senior managers, wards, teams and departments (this may include representatives from corporate services).

Executive Directors are responsible for agreeing and implementing actions relating to Well-led actions. They will discharge this responsibility through appropriate corporate leads, and in some instances through representatives from clinical Divisions.

The flowchart on page 2 describes the process for monitoring the implementation of actions relating to CQC inspections, including seeking closure of completed actions.

The cornerstones of this process are monthly detailed review at Divisional Boards and Execs and quarterly scrutiny at Clinical Quality Group and Quality & Outcomes Committee.

UHBW governance and assurance structure for actions taken in response to Care Quality Commission inspection reports and exceptions raised



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CQC inspection composite plan

This composite plan lists all actions relating to UHBW CQC inspections since January 2021. The plan also includes any actions from the CQC's inspection of the Emergency Department at Weston General Hospital which were outstanding at the point when they were last reviewed by the Board in June 2021.

Overall position

This section provides an overall summary of progress against actions

	May 22	
Closed	34	24%
Recommend to close (evidence supports completion)	21	15%
Complete (awaiting evidence to support)	45	32%
On track	3	2%
Behind schedule but significant progress made	12	9%
Behind schedule	26	18%
Total actions	141	

Individual inspections

This section provides a summary of progress against actions across the individual services inspected.



Actions classified as 'behind schedule'

Well Led

Status: Behind schedule

Count of ID						
Source/Event (e.g. name of inspection)	ID	Details of requirement / recommendation	Actions to address gaps	Target date for completion	Lead	Exec
June 2021	2021/06/WL/1.5	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services and to provide ensure high quality, sustainable care at all locations. To do this, the trust must ensure systems or processes must be established and operated effectively to ensure compliance. (Regulation17 (1), (2), (a), (b), (e), (f). Specific issue highlighted by CQC: compliance with staff appraisal had dropped considerably during the pandemic.	Develop and implement a plan to improve mandatory training and appraisal compliance	01/04/2022	Training lead	Director of People
	2021/06/WL/2.2	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f). Specific issue highlighted by CQC: Trust senior leaders recognised that work towards the full integration of services was not as advanced as would have been hoped - some senior staff were disappointed with progress and the way in which integration had	Review lessons learnt from integration activities and share these through the programme to ensure further integration projects make necessary changes	28/02/2022	Programme Director	Director of Strategy and Transformation

Urgent and Emergency Care

Status: Behind schedule

Count of ID						
Source/Event (e.g. name of inspection)	ID	Details of requirement / recommendation	Required action	Target date for completion	Lead	Exec
Bristol Emergency Department Inspection (Feb 2021)	21-05/UAEB/8.1	Check and risk assess the quality of air and vehicle emissions in the area where ambulances are required to wait. As ambulances are required to leave their engines running for their crews and patient safety and comfort, this causes emissions into a very built-up small area with little opportunity for the polluted air to dissipate. Act if possible, should the air quality be considered as a risk to people	Develop plan for risk assessment / monitoring air quality.	44347	Andy Headon and Green Travel Manager	Chief Operating Officer / Deputy CEO
	21-05/UAEB/8.2	Check and risk assess the quality of air and vehicle emissions in the area where ambulances are required to wait. As ambulances are required to leave their engines running for their crews and patient safety and comfort, this causes emissions into a very built-up small area with little opportunity for the polluted air to dissipate. Act if possible, should the air quality be considered as a risk to people	Share findings with SWAST and explore potential solutions.	44408	Andy Headon and Green Travel Manager	Chief Operating Officer / Deputy CEO

Status: Behind schedule

Count of ID						

Source/Event (e.g. name of inspection)	ID	Details of requirement / recommendation	Actions to address gaps	Target date for completion	Lead	Exec
Weston Emergency Department Inspection (July 2020)	20-07/UAEW/2.1	Ensure all registered health staff have completed level three safeguarding for children training.	Divisional safeguarding lead to liaise with paediatric safeguarding team to identify and agree a process of delivery whilst staff are unable to complete face to face Level 3 training (in line with the Trust's 'blended' approach to delivering training which will take time to agree and roll out).	44526	Head of Nursing	Chief Nurse
	20-07/UAEW/3.2	Ensure there is an effective mechanism where all staff in the department learn from incidents that occur within the department and externally. Ensure that governance meetings provide a framework for discussions about serious incidents and include themes and lessons learned. Consider mechanisms to share information from governance meetings with all staff in the department.	Six-monthly spot check audits to be initiated to check with staff learning from recent RCA/ SI; this will be reported to the specialty (medicine) governance group.	44526	Head of Nursing	Chief Nurse
	20-07/UAEW/5.1	Ensure that all staff receive adequate supervision, mentorship and appraisal, and ensure that this is documented.	Spot check audit of staff satisfaction/ support to be undertaken	44526	Head of Nursing	Director of People / Chief Nurse / Medical Director
	20-07/UAEW/5.2	Ensure that all staff receive adequate supervision, mentorship and appraisal, and ensure that this is documented.	Continue to ensure that annual appraisals take place in a timely manner, achieving 95% compliance. Appraisal trajectory to be agreed and monitored monthly through the specialty (medicine) governance group.	44526	Divisional HR Business Partner	Director of People / Chief Nurse / Medical Director

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	20-07/UAEW/12	Address the cause of a lack of joined up working between the emergency department and the acute medical physicians.	Re-introduce a fortnightly ED/Physicians cabinet to discuss issues and develop joint working.	44470	Clinical Chair	Medical Director

Medical Care

Status	Behind schedule

Count of ID Source/Event (e.g. name of inspection)	ID	Details of requirement / recommendation	Actions to address gaps	Target date for completion	Lead	Exec
Bristol Medical services (June 2021)	21-06/MEDB/2	The trust must ensure medical staff receive and complete mandatory training in line with trust targets.	Specialties have been asked to book prospective dates to address non-compliance and to flag any barriers to accessing the training (training capacity or releasing workforce to attend)	44866	HR Business Partners, Divisional Triumvirate	Director of People
	21-06/MEDB/3	Review level three safeguarding adult training and ensure all staff who require this training are identified.	Training need being assessed	01/11/2022	HR Business Partners, Divisional Triumvirate	Director of People
Hartles Rachel 05/23/2022 15:12:23	21-06/MEDB/6	Ensure staff receive regular appraisal.	Specialties have been asked to book prospective dates to address non-compliance. Ward managers are required to update HoN on appraisal recovery actions and account for any non-compliant appraisals.	Trust target is 85% by end of December 21. Reported position in October 21 suggests this cannot be achieved so the target time has been stretched (in Division) to end of September 22	HR Business Partners, Divisional Triumvirate	Director of People

	21-06/MEDB/9.1	Review effectiveness of the Freedom to Speak up process to ensure staff are confident to raise concerns.	Expand upon the Supporting Positive Behaviours toolkit with new resources aimed at supporting Bystanders, Teams with a bullying culture, and looking at behaviour change to address bullying behaviours (Q3-4 21/22)	44652	FTSU advocate, Divisional Triumvirate	Director of Corporate Governance
	21-06/MEDB/9.4	Review effectiveness of the Freedom to Speak up process to ensure staff are confident to raise concerns.	Work with the Comms Team to plan a campaign to effectively promote the toolkit (Q3-4 21/22).	01/04/2022	FTSU advocate, Divisional Triumvirate	Director of Corporate Governance

Status	Behind schedule

Count of ID Source/Event (e.g. name of inspection)	ID	Details of requirement / recommendation	Actions to address gaps	Target date for completion	Lead	Exec
Weston Medical Services Inspection (March 2021)	21-03/MEDW/1.7	MD1 - Ensure there is enough staff to safely care for patients at all times. MD3 - Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.	Continued recruitment to consultant posts.	31/11/2021	Deputy Medical Director (AH)	Medical Director
	21-03/MEDW/3.2	MD4 - Ensure incidents are investigated without delay and demonstrate learning is shared to mitigate the risk of reoccurrence. SD4 - Consider how to improve staff reporting of incidents.	Contact any member of the Division that has a responsibility for risk or incident management and that does not have a Datix account, request that they sign up for an account immediately (action agreed at Risk Management Group, list to be provided by Head of Risk Management).	44526	Divisional Director	Chief Operating Officer
	21-03/MEDW/3.3	MD4 - Ensure incidents are investigated without delay and demonstrate learning is shared to mitigate the risk of reoccurrence. SD4 - Consider how to improve staff reporting of incidents.	Assurance audits of safety briefs to commence to help identify whether there is a need to improve the sharing of Trust, divisional and local safety messages arising from reported incidents.	44531	Head of Quality & Patient Safety	Chief Nurse
	21-03/MEDW/3.5	MD4 - Ensure incidents are investigated without delay and demonstrate learning is shared to mitigate the risk of reoccurrence. SD4 - Consider how to improve staff reporting of incidents.	Develop an additional 'You said, we did' feedback system for staff in response to reported incidents to augment the existing electronic feedback from managers to reporters from Datix.	44652	Head of Quality & Patient Safety	Chief Nurse
Weston Medical Services Inspection (June 2021)	21-06/MEDW/7.2	(blank)	Circulate SOP and posters to be shared with ward and department managers and managed through divisional governance.	44651	Head of Nursing	Chief Nurse
	21-06/MEDW/9	Ensure that for patients lacking capacity to make their own decisions a capacity assessment has been completed to provide a clear audit trail of decisions made.	Undertake an audit to establish compliance	44652	Head of Nursing	Chief Nurse

	21-06/MEDW/13	Ensure that checks to ensure patients have the correct medicines (medicines reconciliation) follow national best practice.	Electronic recording of KPI national standards need to be merged across both sites.	44653	Pharmacy Lead/Dir. of Pharmacy	Medical Director
	21-06/MEDW/15	Ensure that medicines storage areas are only accessible to authorised staff and are within an appropriate temperature range.	Ambient temperature is currently not being routinely monitored in clinic areas – systems to aid this needs to be implemented across the site	44743	Pharmacy Lead/Dir. of Pharmacy	Medical Director
	21-06/MEDW/16	Consider how electronic records could be made less visible when not in use.	Further communication via management to remind staff of the importance of IG compliance	44592	Divisional Triumvirate	Weston Managing Director
	21-06/MEDW/17	Consider the suitability of moving patients late at night.	Create an SOP to support the safe movement of patients at night	44652	Divisional Triumvirate	Weston Managing Director

Outpatients

Status	Behind schedule

Count of ID Source/Event (e.g. name of inspection)	ID	Details of requirement / recommendation	Actions to address gaps	Target date for completion	Lead	Exec
Weston Outpatients inspection June 2021	21-06/OUTW/1	The trust must ensure referral to treatment time performance is in line with national standards. Not all referral to treatment times were meeting national standards (Regulation 9 (1) Person-centred care.	Use of accelerator funding to create waiting initiative lists/clinics to reduce waiting lists where appropriate.	44681	Deputy Divisional Manager	Weston Managing Director
	21-06/OUTW/2	The trust should consider how data about medical staffing is collated to be able to easily provide information about the number of medical staff working in the service, the vacancy or turnover rates, sickness rates, and the level of bank and locum staff.	All medical staffing will be moved to Allocate, so all data will be pulled in the same way as we currently do with Nursing staff.	44651	Deputy Divisional Manager	Weston Managing Director

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ID	Source/Event (e.g. name of inspection)	Requirement or recommendation?	Details of requirement / recommendation	Assurance / mitigation of risk	Actions to address gaps	Target date for completion	Lead	Exec	Status:	Evidence / update provided (May 2022)
2021/06/WL/1.1	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services and to provide ensure high quality, sustainable care at all locations. To do this, the trust must ensure systems or processes must be established and operated effectively to ensure compliance. (Regulation17 (1), (2), (a), (b), (e), (f). Specific issue highlighted by CQC: staff spoke of not seeing senior representatives of the Trust in their workplace	Exec walkarounds/Adhoc NED programme in place. Weston Divisional clinical governance function. Enhanced clinical leadership in Weston Division. Enhanced escalation of speaking up concerns to Executives. Campaign Plan. Plan for additional winter bed capacity. FTSU report includes staff feedback and challenges about resolving concerns	Actions: - develop a robust Executive/SLT engagement programme - reintroduce quarterly staff 'pulse' survey to measure staff experience - introduce clinical accreditation programme from March 2022, including Exec/SLT input - Patient First programme will also include element of engagement.	31/03/2022 Extended to 31/12/2022	Deputy Chief Nurse (SD)	Chief Nurse and (Midwife)	Behind schedule but significant progress made	Significant progress made: • Thematic analysis of executive engagement walkabouts (undertaken Oct 21 - Feb 22) completed by Head of Quality and Patient Safety and reported to Chief Nurse. • 49 Walkabouts are scheduled for 1st March – 31st December 2022. SOP drafted to guide further walkarounds. • Clinical ward accreditation commenced in March 2022 with Senior Nurses taking part and Heads of Nursing. • Executive team joined clinical ward accreditation rota to complete 15 step challenge • Quarterly staff pulse survey recommenced in April 2022.
2021/06/WL/1.2	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services and to provide ensure high quality, sustainable care at all locations. To do this, the trust must ensure systems or processes must be established and operated effectively to ensure compliance. (Regulation17 (1), (2), (a), (b), (e), (f). Specific issue highlighted by CQC: staff spoke of not seeing senior representatives of the Trust in their workplace	Exec safety walkarounds/Adhoc NED programme in place. Weston Divisional clinical governance function. Enhanced clinical leadership in Weston Division. Enhanced escalation of speaking up concerns to Executives. Campaign Plan. Plan for additional winter bed capacity. FTSU report includes staff feedback and challenges about resolving concerns	Develop a NED engagement programme to improve visibility.	31/03/2022	Head of Corporate Governance	Director of Corporate Governance	Recommend to close (evidence supports completion)	A NED site visit engagement programme has now been created and implemented. Content of the programme will align with key assurance items through the year and be flexible to changing organisational needs. Enhanced escalation of concerns to executives has led to a reduction in the number of stuck concerns. Evidence reviewed to support closure - Copy of NED site visit document with department contacts
2021/06/WL/1.3	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services and to provide ensure high quality, sustainable care at all locations. To do this, the trust must ensure systems or processes must be established and operated effectively to ensure compliance. (Regulation17 (1), (2), (a), (b), (e), (f). Specific issue highlighted by CQC: CQC were not assured that the process for tracking patient safety metrics at Weston General Hospital allowed for the recognition of immediate safety risks and how to mitigate future safety risks; delays to serious incident investigations and the closure of incidents.	Exec safety walkarounds/Adhoc NED programme in place. Weston Divisional clinical governance function. Enhanced clinical leadership in Weston Division. Enhanced escalation of speaking up concerns to Executives. Campaign Plan. Plan for additional winter bed capacity. FTSU report includes staff feedback and challenges about resolving concerns	Develop and deliver an action plan to improve risk and incident management, and clinical governance systems in Weston, specifically to highlight immediate safety risks and to ensure incidents were investigated and actions completed	30/02/2022	Deputy Chief Nurse (Weston) supported by corporate Heads of Quality	Chief Nurse	Complete (awaiting evidence to support)	Final report of review of governance arrangements in Weston General Hospital received from Audit South West. Management response/action plan agreed; response covers the aspects of the issues identified by CQC. Patient Safety team in place with a tracker for logging all SI, PSSIs and RIRs completed or investigations outstanding. Reports from this tracker is presented at Weston Quality & Safety Group, EDGE, Surgery and Medicine Governance Groups. Incident closure within 30 days remains consistently at 69-77% for Q1-Q4 of 21/22. Post merger the number of incidents reported has significantly increased by 61%. The 30% that remain open tend to fall within the 12 hour breaches and hospital acquired Covid, which are managed and assessed by the central flow team.
2021/06/WL/1.4	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services and to provide ensure high quality, sustainable care at all locations. To do this, the trust must ensure systems or processes must be established and operated effectively to ensure compliance. (Regulation17 (1), (2), (a), (b), (e), (f). Specific issue highlighted by CQC: serious concerns amongst staff about the escalation of violence and aggression on staff working in the BRI ED (reference to February 2021 inspection).	Exec safety walkarounds/Adhoc NED programme in place. Weston Divisional clinical governance function. Enhanced clinical leadership in Weston Division. Enhanced escalation of speaking up concerns to Executives. Campaign Plan. Plan for additional winter bed capacity. FTSU report includes staff feedback and challenges about resolving concerns	Deliver the violence and aggression reduction work programme;	Ongoing	Training lead	Director of People	Recommend to close (evidence supports completion)	Funding has supported additional bespoke violence and aggression sessions; planned throughout 2022 to cater to specific violence and aggression scenarios and concerns. There are 4 bespoke sessions - 'Dynamic Awareness and De-escalation', 'Handling Difficult Telephone Calls', 'Breakaway', and 'Restraint and Restrictive Physical Interventions' (RPI). The first three are now offered to all staff, the last is to a smaller clinical audience. We have a total mix of 139 of these PMVA sessions on offer on Kalidus from March through to December 2022, both here and at Weston. This offer will never be 'completed' as PMVA will be an ongoing topic after 2022 and more sessions will be required. However, despite the range of provision take-up remains challenging due to clinical pressures. Since the beginning March about a dozen staff have taken up 'Breakaway' training, and about 35 have done RPI – however sessions are running under capacity. Recommendation to close - for specilfc concerns related to V&A in the Bristol ED, please see the Medicine Urgent & Emergency plan.

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2021/06/WL/1.5	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services and to provide ensure high quality, sustainable care at all locations. To do this, the trust must ensure systems or processes must be established and operated effectively to ensure compliance. (Regulation17 (1), (2), (a), (b), (e), (f)). Specific issue highlighted by CQC: compliance with staff appraisal had dropped considerably during the pandemic.	Exec safety walkarounds/Adhoc NED programme in place. Weston Divisional clinical governance function. Enhanced clinical leadership in Weston Division. Enhanced escalation of speaking up concerns to Executives. Campaign Plan. Plan for additional winter bed capacity. FTSU report includes staff feedback and challenges about resolving concerns	Develop and implement a plan to improve mandatory training and appraisal compliance	01/04/2022	Training lead	Director of People	Behind schedule	SLT have been regularly monitoring. ICI has extended the deadline. A simplified form has been introduced to aid appraisal completion alongside the new Values being embedded into this to ensure alignment across all sites. Information on the appraisals and training forming part of the workforce report The amended deadline for appraisal compliance was end of March 2022, as agreed by SLT in December 2021. The Trust remains behind this target as at end of March 2022, although significant progress has been made in Estates and Facilities. This remains a risk for the organisation despite the governance of monthly executive reviews. In recent weeks the Kalidus system has been updated to ensure automated notifications which significantly improved the Essential Training position along with Weston adopting on-line appraisals on 25th April.
2021/06/WL/2.1	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f)). Specific issue highlighted by CQC: the vision, strategy and values of the organisation had not been reviewed and updated following merger.		Enhanced communication of the Trust's vision and strategy to staff in Weston through a programme of engagement events	31/03/2022	Strategy and Business Planning team, Weston Medical Director	Director of Strategy and Transformation	Behind schedule but significant progress made	A communication and engagement plan is being developed to recognise the progress made with the Trust strategy at its mid point, and build a stronger message around the total UHBW vision and new values. This will progress March/April 2022 and will also be aligned with Healthy Weston comms and engagement planning /implementation (commenced 14th Feb 2022). <i>Update awaited</i> <i>Prompt:</i> <i>Has this happened? What is the evidence? What has the impact been? Also, current action describes communication of the vision and strategy - clarify whether this includes reviewing the strategy following merger</i>
2021/06/WL/2.2	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f)). Specific issue highlighted by CQC: Trust senior leaders recognised that work towards the full integration of services was not as advanced as would have been hoped - some senior staff were disappointed with progress and the way in which integration had been managed		Review lessons learnt from integration activities and share these through the programme to ensure further integration projects make necessary changes	28/02/2022	Programme Director	Director of Strategy and Transformation	Behind schedule	Will be reflected in Board 18 months post-merger report planned for March 2022 Board meeting due to delay with completion of Internal Audit review <i>Update awaited</i>
2021/06/WL/2.3	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f)). Specific issue highlighted by CQC: medical leadership was facing significant challenges brought about by integration.		Review and enhance medical leadership to support integration	31/03/2022	Medical Director (Weston)	Medical Director	Complete (awaiting evidence to support)	Additional leadership in place. Further work undertaken by MD Team to understand the leadership/development needs of clinical staff. Outline programme part of MD OPP. MD Team also supporting an additional PA (also in OPP) for a coaching and mentoring role for consultants has increased dramatically during the pandemic. <i>Update awaited</i>
2021/06/WL/2.4	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f)). Specific issue highlighted by CQC: not all staff felt safe or secure about speaking up; some staff did not feel listened to.		Promotion of speaking up across Weston through the Champion Network, newsletters, email communications and visibility of the FTSU Guardian	31/03/2022	Deputy Guardian of Safe Working	Director of Corporate Governance	Complete (awaiting evidence to support)	Monthly meetings with FTSU champions in Weston, quarterly with wider champion network. Guardian visits undertaken at SBCH; medical records. Presentations to international nurse induction and Digital Services. Staff Pulse survey on speaking up to be scheduled in 2022. Management/leadership training offer under review <i>Update awaited - demonstrate impact</i>

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2021/06/WL/2.5	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f)). Specific issue highlighted by CQC: staff expressed concern about reduction of bed base coupled with rising demand; trolley waits.		Enhanced and more visible planning to address risks from increased demand for beds, including winter plan	31/03/2022	Deputy Chief Operating Officer – Urgent Care	Chief Operating Officer	Behind schedule but significant progress made	Capacity tracker and bed modelling under monthly review via Demand and Capacity Group. Recovery structure now in place using Control Centre methodology to manage capacity mitigations / business cases throughout the year. <i>Update awaited</i> <i>Prompt:</i> <i>Describe progress of Proactive Hospital and Every Minute Matters. How is capacity planning communicated to staff.</i> <i>Impact of actions?</i>
2021/06/WL/2.6	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f)). Specific issue highlighted by CQC: the inspection team found that the pharmacy service across the Trust was not integrated, with different leadership and governance		Complete the Pharmacy integration ensuring senior leadership visibility onsite in Weston	04/10/2021	Divisional Director, Diagnostic & Therapies	Chief Operating Officer	Closed	Reported to QOC in December 21 Pharmacy service merged on 4th October 2021, providing a single Chief Pharmacist (Director of Pharmacy) lead role across UHBW to ensure both sites follow the same UHBW governance process. Associate Director of Pharmacy Weston, Senior Band 8c role as part of the new integrated service. Evidence reviewed to support closure - Pharmacy organisational chart for structure post service integration.
2021/06/WL/2.7	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f)). Specific issue highlighted by CQC: medicines optimisation strategies had yet to be aligned following merger.		Align Medicines Optimisation Strategies	31/03/2022	Divisional Director, Diagnostic & Therapies	Chief Operating Officer	Recommend to close (evidence supports completion)	All strategic decisions are now taken as a unified approach across Bristol and Weston. Medicines Optimisation Strategy is now aligned not only at a UHBW level but a BNSSG ICS level. Some examples but not limited to; - Outsourced Outpatient Pharmacy contract currently provided by Boots in Bristol and Lloyds in Weston. This is currently out to tender for a single provider across UHBW to commence in April 2023. - Aseptic Services review ITT about to be launched for an external consultancy to provide and options appraisal and OBC for Pharmacy Aseptic Services supporting the needs of Bristol and Weston. - Weston Pharmacy stock control and dispensing software integrated with Bristol to provide a single UHBW system in November 2021. - Rotational training and B6 Pharmacist roles between sites Evidence reviewed to support closure - Copy of presentation to D&T Board and 'optimisation' poster
2021/06/WL/2.8	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f)). Specific issue highlighted by CQC: increasing numbers of patients were fit for discharge but with no onward place to be discharged to, and no evidence of progress towards resolution.		Work with system partners to further develop and refine Decision to Admit (DTA) criteria and processes and to understand wider systems issues in terms of discharge. Internal work will focus on the Every Minute Matters campaign. (new action added May 2022)	01/10/2022	Medical Director	Exec tri - COO, MD, CNO	On track	Work has progressed at a system level to further develop and refine the D2A (now known as Home First) Business Case with an associated system-wide performance improvement trajectory in development. It should be noted that despite system partners providing more community and care packages than ever previously, that work is yet to result in a reduction in the number of patients awaiting prescription of, or commencement of, community packages of care who are still residing in the Acute Trust. The organisation is also working internally on the Every Minute Matters campaign to ensure that all possible internal efficiencies are delivered in patient discharge planning and delivery. Furthermore work between the two Acute Trusts (UHBW and NBT), based in the Acute Provider Collaborative, is also progressing – both to ensure that we have a common understanding of the current system drivers/solutions to discharge block, but also to ensure that we both utilise our own resources to their most efficient. That work is also leading to the future development of a joint Clinical Strategy aligning our joint future clinical service aspirations with population need and system resources. The next step from that is a second Clinical workshop, being held in June 2022, following on from the prior Joint Clinical Strategy Workshop held in November 2021.

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2021/06/WL/2.9	June 2021	Req (Must do)	The trust must seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. To do this, the trust must ensure people are supported to speak up and raise concerns and that these are listened to and appropriate action taken. The trust must ensure that staff in all areas of the organisation are supported to develop their cultural intelligence and ensure a fully inclusive culture (Regulation17 (2) (e), (f)). Specific issue highlighted by CQC: statistically significant differences in WRES scores between white and BAME staff; concerns about lack of equitable treatment of BAME staff; micro-aggressions, etc.		Deliver the action plans to improve WRES and WDES compliance	31/03/2021 Extended to 31/06/2022	Head of Organisational Development	Director of People	Behind schedule but significant progress made	The WRES plan is integrally linked to the EDI strategy delivery plan and includes the: • EDI advocate programme • System recruitment overhaul work- including disparity ratios alongside good practice • Refreshing of the BAME network There has been a significant resource issue for the delivery of this work for a number of months therefore the planned activity for this work has slipped. An interim EDI Manager commenced in post on the 7th February and work as re-started. The updated position and look forward plan will be presented in the bi-annual report in April. The Bi-annual report details the plan for WRES and WDES as part of the strategic action plan. This includes the updated staff survey results and will be presented at People Committee in May. A detailed paper on WRES and WDES (national request has not been received) will be presented at People Committee in July along with gender pay gap. This will support the model employer and race disparity paper that has been developed and will go to PEG in April/People committee in May 2022.
2021/06/WL/3	June 2021	Req (Must do)	All premises and equipment used by the service provider must be properly maintained. (Regulations 15 (1) (e)). Specific issue highlighted by CQC: leaks (e.g. roof leaks in corridor at St Michael's Hospital - buckets and towels being used), including raw sewage coming into buildings; some areas of estate described by staff as "embarrassing".	Operational capital programme. Backlog maintenance review. Medical equipment function. Maintenance contracts. Staff can report issues through on-line CAFM system 'Agility' and Estates helpdesk can be contacted by phone to escalate critical problems.	Deliver the Campaign plan action to address the top 10 divisional estates issues	31/03/2022	Director of Estates and Facilities	Chief Operating Officer	Complete (awaiting evidence to support)	Issues with the leak in the gynaecology block at St. Michaels have been completed. This was in relation to a steam leak within the plant room which caused excess humidity. Leak was repaired and issue resolved. Issues related to 'raw sewage' was in clinical genetics department. There is a proposal to relocate this department so that a significant refurbishment can be undertaken in the area. There have been no sewage leaks in that area since January 2022. Full drainage survey of St. Michaels has been commissioned and any remedial works from recommendations will be completed. Problems are directly linked to the misuse of drains. Estates working with clinical colleagues to try and improve the misuse of drains through campaigns, posters, frequency of bin collections and education. All the items remaining on the 'campaign plan' are not related to maintenance and repair. There are some long standing issues around space requirements and also longer term capital projects.
2021/06/WL/4	June 2021	Req (Must do)	All premises and equipment used by the service provider must be properly maintained. (Regulations 15 (1) (e)). Specific issue highlighted by CQC: CQC noted a significant backlog of estates work	Operational capital programme. Backlog maintenance review. Medical equipment function. Maintenance contracts	Deliver the Operational Capital Programme 2021/22 to address backlog maintenance issues	31/03/2022	Director of Estates and Facilities	Chief Operating Officer	Complete (awaiting evidence to support)	Strategic Infrastructure programme in place to spend circa 50m over the next 5-7 years to improve estate infrastructure. This will be prioritised using a combination of risk profile and strategic programme enabling works. Estates backlog maintenance reviewed and submitted as part of the ERIC return 21/22. Backlog maintenance figure for UHBW has reduced in 21/22 from 75m to 69m.
2021/06/WL/5	June 2021	Rec (Should do)	The trust should ensure staff are involved in the development of the trust's values of the organisation.	Blue Goose (external agency) commissioned to support the development of new values. Engagement with all staff via surveys and focus groups, with over 6000 responses. Final set of values agreed and communicated out to all staff. Immersion plan developed and being developed to communicate and start to embed the new values	Final set of values agreed and communicated out to all staff. Immersion plan developed and being developed to communicate and start to embed the new values	01/01/2022		Director of People	Closed	Final set of values agreed and communicated out to all staff. Immersion plan developed to communicate and start to embed the new values. Work continues in this area Evidence reviewed to support closure - wide communication of values and the development of tools and guidance for staff and managers.
2021/06/WL/6	June 2021	Rec (Should do)	The trust should consider strategies to improve the representation of staff from black and minority ethnic groups on the board and in senior leadership roles. Continue focus on improving career progression for these groups.	All Board and senior manager roles are promoted to target the widest possible audience. Annual Board evaluation considers Board diversity and actions to address identified gaps. D&I Strategy is considering how to support the development of all managers and promoting Diversity	Introduce Associate NED roles to support wider diversity on the Board	31/03/2022 Extended to 01/06/2022	Head of Corporate Governance	Director of Corporate Governance	Complete (awaiting evidence to support)	Nominations Committee approved the approach to recruitment and timeline for 2x NED and 2x Associate NED roles on 10 February 2022. NED and associate NED recruitment focused on improving Board diversity and final stages of appointments are in process. Plan to have starters in place for 1 June 2022. Governors responsible for the appointments have received training on NED recruitment and how to improve Board diversity. Suggest closure once recruitment is completed.

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Source/Event (e.g. name of inspection)	Requirement or recommendation?	Details of requirement / recommendation	Current actions / mitigation	Required action	Target date for completion	Lead	Exec	Status:	Evidence / update provided (May 2022)
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Have safe and sufficient numbers of all grades of medical staff to meet the recommendations of the Royal College of Emergency Medicine. The department did not have enough consultants to meet the recommendations for caring for the number of patients it saw and the expanded size and footprint of the environment. There were insufficient numbers to be able to expand into a fully operational same-day emergency care pathway to reduce demand for overnight beds. There were some night shifts where the junior doctors' rotas (primarily middle grade) were not fully covered and this required the use of locum doctors if available and consultants to remain past their shift or start earlier than planned	Divisional Workforce group / HRBPs develop and drive initiatives to improve recruitment and retention and right-size workforce. Risk 3040 (mitigations) • ED Capacity and Demand work, leading to departmental workforce review and recommendations for expansion to Divisional team and Trust Executive. • Agreement as a priority to increase middle grade staffing (3 wte) to achieve 2 middle grades per night shift at weekends and then 7 days a week. Proactive recruitment campaigns. • Development of ED regular locum bank. Application for enhanced rates of pay for Locum staff to TPAG • Centralisation of rota writing and day to day rota management to Divisional rota coordinator, with consultant overview. Clinical supervision. Daily 2 week look ahead and escalation process. • Departmental wellbeing programme. • Robust Monitoring of extended waits to be seen through live ED tracking and daily reports. ED Workforce Group in place	Expand medical workforce to include • SDEC, • 8A ENP, • GPs in Minors. • 2nd Middle Grade on night shift (make substantive)	01/10/2021	Chris Atkinson – Divisional Director Emma-Kate Reed - Clinical Chair	Medical Director	Recommend to close (evidence supports completion)	Action linked to ED staff feedback to CQC at follow-up focus-groups (re. workforce). - Fully recruited to consultant body establishment - 21 staff (14.5 wte) - RCEM 24+ (plus SDEC) - MD Team - 4 new posts (two appointed, and two assessed). The Medical Director will pick up further conversations around staffing with the CQC as part of routine engagement. Further work needs to reflect retention strategies as well as recruitment.
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Have safe and sufficient numbers of all grades of medical staff to meet the recommendations of the Royal College of Emergency Medicine. The department did not have enough consultants to meet the recommendations for caring for the number of patients it saw and the expanded size and footprint of the environment. There were insufficient numbers to be able to expand into a fully operational same-day emergency care pathway to reduce demand for overnight beds. There were some night shifts where the junior doctors' rotas (primarily middle grade) were not fully covered and this required the use of locum doctors if available and consultants to remain past their shift or start earlier than planned		Establish Workforce sub group for ED	16/04/2021	Acute Care Senior Triumvirate	Medical Director	Closed	Reported to QOC in December 21 Group established. First meeting 7/4/21. Evidence reviewed to support closure - Workforce group standing agenda and Terms of Reference
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Have safe and sufficient numbers of all grades of medical staff to meet the recommendations of the Royal College of Emergency Medicine. The department did not have enough consultants to meet the recommendations for caring for the number of patients it saw and the expanded size and footprint of the environment. There were insufficient numbers to be able to expand into a fully operational same-day emergency care pathway to reduce demand for overnight beds. There were some night shifts where the junior doctors' rotas (primarily middle grade) were not fully covered and this required the use of locum doctors if available and consultants to remain past their shift or start earlier than planned	<u>Consultants</u> Maternity leave locum cover and Military deployment locum cover utilised	<u>Consultants</u> Expand the medical workforce to enable SDEC to be established and delivered.	01/06/2021 Extended to 01/07/22	Sufi Husain, Deputy Divisional Director	Medical Director	Behind schedule but significant progress made	Same Day Emergency Care (SDEC) vision document has been approved (seen at SLT). Full business case currently being worked up. Going to Divisional Board in May and SLT in June. Currently operating a five day SDEC service (other than by exception)
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Have safe and sufficient numbers of all grades of medical staff to meet the recommendations of the Royal College of Emergency Medicine. The department did not have enough consultants to meet the recommendations for caring for the number of patients it saw and the expanded size and footprint of the environment. There were insufficient numbers to be able to expand into a fully operational same-day emergency care pathway to reduce demand for overnight beds. There were some night shifts where the junior doctors' rotas (primarily middle grade) were not fully covered and this required the use of locum doctors if available and consultants to remain past their shift or start earlier than planned	<u>Middle grades</u> • Proactive recruitment campaign in place and ongoing, • Recruit video and website • Long term agency locum use • Locum night shifts. Risk 3855 (mitigations) • ED are using other staff groups as an alternative to fill middle grade 2nd night shift gaps. • ACPs can offer three nights a month & ST3 tier can offer three nights a month, • Increasing SHO numbers to four on nights.	<u>Middle grades</u> Improve recruitment and retention and support BRI ED to become employer of choice by: • Explore global health expansion • CESR training programme, • 2nd Middle Grade on night shift	01/06/2021 Extended to 01/09/2022	Duncan Courtney, ED consultant / Lizzie Martin, ED consultant	Medical Director	Behind schedule but significant progress made	Continuing to try and recruit to our new establishment of 20.5. We advertised for our new CESR posts and had 4 applicants for interview on 27/1/22. We advertised our 80:20 posts at the recent EMTA conference and are hopeful that this will improve our recruitment for August 2022. In the interim, vacant shifts are reliant on adhoc cover
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Provide care and treatment in a safe way for patients by ensuring there is flow through the emergency department. In growing and unprecedented numbers in this organisation, patients were waiting on ambulances in queuing systems which had the potential to be unsafe. Some patients were waiting on trolleys for more than 12 hours after a decision had been made to admit them to a hospital bed.	Trust inpatient escalation plan in place, including boarding. BNSSG Ambulance Divert SOP in place, BNSSG system management calls in place. Daily Triumvirate meetings in place (Assistant Directors of Ops for UHBW and NBT with SWAST Deputy County Commander) to review system pressures and recommend divert actions according to Trust positions.	Revamped performance and quality governance structure to drive improvement actions at both Trust and System level: • Whole System Operational Group for Urgent Care (System Level urgent Care initiatives) • Pro-active Hospital Programme: delivery group for cross-divisional flow initiatives) • Quality & Performance Review: Front Door performance and improvement group	26/04/2021	Lucy Parsons, Deputy Chief Operating Officer	Chief Operating Officer / Deputy CEO	Closed	Action linked to ED staff feedback to CQC at follow-up focus groups (re. flow) Reported to QOC in December 21 Whole System Operational Group in place. Proactive Hospital has launched, staffing resource approved and will be recruited to. Quality & Performance Review established Evidence reviewed to support closure - WSOG agendas, action logs, fast flow and performance reports, access and flow dashboards

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Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Provide care and treatment in a safe way for patients by ensuring there is flow through the emergency department. In growing and unprecedented numbers in this organisation, patients were waiting on ambulances in queuing systems which had the potential to be unsafe. Some patients were waiting on trolleys for more than 12 hours after a decision had been made to admit them to a hospital bed.	Escalation process in place; admissions overflow areas in use	Division will continue with Daily SitReps established during wave three internal critical incident and standing midday huddle to ensure that escalation actions are agreed and enacted in a timely way during operational pressures	01/03/2021	Chris Atkinson, Divisional Director	Chief Operating Officer / Deputy CEO	Closed	Action linked to ED staff feedback to CQC at follow-up focus groups (re. flow) Reported to QOC in December 21 Medicine SitRep meeting moved to 8.15am with expected attendance by all specialities. Silver and duty matron of the day (per rotas) huddles at 12.30pm as required Evidence reviewed to support closure - evidence of Sitrep meeting notes and escalation issues
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Provide care and treatment in a safe way for patients by ensuring there is flow through the emergency department. In growing and unprecedented numbers in this organisation, patients were waiting on ambulances in queuing systems which had the potential to be unsafe. Some patients were waiting on trolleys for more than 12 hours after a decision had been made to admit them to a hospital bed.	ED escalation checklist; Incident Triage area. Supporting SOPs established - Incident Triage area, Redirection, Direct admission, Admission overflow / Medicine Extra capacity, Boarding. Risk 910 (mitigations) Establishment of front door frailty service, • Expansion of A413 capacity and opening 24/7, • Increase in take cover by acute physicians, • New super team structure to support take, • RATting (Rapid Access Triage and Treatment) is in place during core hours and space is available, • SHINE (patient safety checklist) is fully embedded into the department, • CSM attend ED and expedite ED transfers to reduce pressure in the department, • Opening of old majors 'admission overflow area' to allow movement of patients out of ED who are waiting for a bed	Establish monthly ED Performance group and Fast Flow Working Group	29/04/2021	Sufi Husain, DDD	Chief Operating Officer / Deputy CEO	Closed	Action linked to ED staff feedback to CQC at follow-up focus groups (re. flow) Reported to QOC in December 21 Group established, first meeting 23/7/21. ED Performance Group ToR and Standing Agenda reviewed Evidence reviewed to support closure - ED Performance Group ToR and Standing Agenda
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Take action to protect staff and other patients as much as possible from incidences of violence and aggression. Ensure staff feel fully trained and have the tools, experience and support to be able to feel safe and protected. Staff said they felt scared and anxious about their safety at times and the experience and skills of those around them to deescalate or prevent violence and aggression.	Warning letters are sent to patients who display unacceptable behaviour towards staff and a RED card procedure is followed if a patient physically assaults staff or whose behaviour is deemed unsuitable. Close working relationships with security services and early alerts recognition. Security has additional presence for the ED only on night shifts and a presence in Majors	<i>Actions have been progressed via a separate BRI ED V&A action plan, the remaining elements of which need to be distilled and added to this plan</i>	Need to reset trajectory based on remaining actions	Hayley Long, Head of Nursing, Angela Bezer, DHON	Director of People	Behind schedule but significant progress made	Outstanding task to map findings from Audit South West report in order to support closure of this action
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Make sure the patient waiting area in the minors' treatment unit is maintained and established to the standards of hygiene and patient safety for which it is being used in the current pandemic. There were torn seats which meant chairs could not be effectively cleaned. The arrangements for seating and social distancing were inadequately maintained, and there were no particular changes in safety arrangements in times of overcrowding.	Risk 4523 (mitigations): • All staff adhere to PPE and non-clinical staff wear a facemask and all patients are given a facemask on entry. • Handwashing facilities available in the department. • In the process of reviewing available space to expand the waiting area or move to a different waiting area. Capital work proposals have now moved to the design stage with plans to look at use of expanding the waiting footprint and using Perspex screening to allow patients to sit back-to-back which would allow the space to considerably expand to up to 28 pts. • Visual prompts for patients reminding of social distancing. • Restricted visitors in the waiting room. • Communications to the wider public for the use of PPE. • Streaming – this reduces patients in the waiting room as they are sent to other areas. • Redirection work being considered as part of Trustwide group to look at how we can reduce attendances / patients time in the waiting area. • Security on site to remind patients to wear masks and monitor visitors. • Six available chairs in the waiting room have been marked out to show social distancing rules. • Where possible patients are called through to old obs unit cubicles to reduce the number of patients waiting in the waiting area.	Implement Phase 1 of capital programme - Creation of 4 additional trolley spaces in ED - Creation of 3 additional escalation beds - Creation of Interview room in ED for mental health patients	31/08/2021	Sufi Husain, DDD	Chief Operating Officer / Deputy CEO	Closed	Reported to QOC in December 21 Phase 1 works completed 24/8/21. Evidence reviewed to support closure - ED fast flow area plans and evidence of change in department
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Make sure the patient waiting area in the minors' treatment unit is maintained and established to the standards of hygiene and patient safety for which it is being used in the current pandemic. There were torn seats which meant chairs could not be effectively cleaned. The arrangements for seating and social distancing were inadequately maintained, and there were no particular changes in safety arrangements in times of overcrowding.		Implement Phase 2A of capital programme; Expand Minors waiting area capacity to 24 socially distanced spaces and upgrade airflow and ventilation system	01/03/2021 Extended to 01/04/22	Sufi Husain, DDD	Chief Operating Officer / Deputy CEO	Recommend to close (evidence supports completion)	Works completed Evidence reviewed to support closure - email confirmation or works complete and Divisional newsletter highlighting work done.
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Make sure the patient waiting area in the minors' treatment unit is maintained and established to the standards of hygiene and patient safety for which it is being used in the current pandemic. There were torn seats which meant chairs could not be effectively cleaned. The arrangements for seating and social distancing were inadequately maintained, and there were no particular changes in safety arrangements in times of overcrowding.		Implement Phase 2C of capital programme; Creation of 4 Additional clinical spaces adjacent to fast flow and upgrade airflow and ventilation system	29/03/2021 Extended to 01/09/22	Sufi Husain, DDD	Chief Operating Officer / Deputy CEO	Recommend to close (evidence supports completion)	Works completed Evidence reviewed to support closure - email confirmation or works complete and Divisional newsletter highlighting work done.
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Make sure the patient waiting area in the minors' treatment unit is maintained and established to the standards of hygiene and patient safety for which it is being used in the current pandemic. There were torn seats which meant chairs could not be effectively cleaned. The arrangements for seating and social distancing were inadequately maintained, and there were no particular changes in safety arrangements in times of overcrowding.		Undertake a formal waiting room risk assessment	29/03/2021	ED Matron	Chief Nurse	Closed	Reported to QOC in December 21 Assessment undertaken Evidence reviewed to support closure - Copy of risk assessment

Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Make sure the patient waiting area in the minors' treatment unit is maintained and established to the standards of hygiene and patient safety for which it is being used in the current pandemic. There were torn seats which meant chairs could not be effectively cleaned. The arrangements for seating and social distancing were inadequately maintained, and there were no particular changes in safety arrangements in times of overcrowding.		Replace social distancing signage and establish programme of daily checks.	29/03/2021	ED AGM	Chief Nurse	Closed	Reported to QOC in December 21 Signage replaced and weekly rota established to review Evidence reviewed to support closure - Copy of weekly rota and visual inspection
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Make sure the patient waiting area in the minors' treatment unit is maintained and established to the standards of hygiene and patient safety for which it is being used in the current pandemic. There were torn seats which meant chairs could not be effectively cleaned. The arrangements for seating and social distancing were inadequately maintained, and there were no particular changes in safety arrangements in times of overcrowding.		Posters and digital display re covid risk assessment	31/03/2021	ED AGM	Chief Nurse	Closed	Reported to QOC in December 21 Poster and signage in place Evidence reviewed to support closure - Copies of posters and slides
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Make sure the patient waiting area in the minors' treatment unit is maintained and established to the standards of hygiene and patient safety for which it is being used in the current pandemic. There were torn seats which meant chairs could not be effectively cleaned. The arrangements for seating and social distancing were inadequately maintained, and there were no particular changes in safety arrangements in times of overcrowding.		Reupholster waiting room seating	29/03/2021	ED AGM	Chief Nurse	Closed	Reported to QOC in December 21 Works completed Evidence reviewed to support closure - Copy of invoice
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Make sure the patient waiting area in the minors' treatment unit is maintained and established to the standards of hygiene and patient safety for which it is being used in the current pandemic. There were torn seats which meant chairs could not be effectively cleaned. The arrangements for seating and social distancing were inadequately maintained, and there were no particular changes in safety arrangements in times of overcrowding.		Establish Fast Flow working group with focus on Fast Flow strategy	29/03/2021	Sufi Husain, Deputy Divisional Director / ED Triumvirate	Chief Operating Officer / Deputy CEO	Closed	Reported to QOC in December 21 Fast Flow group in place. Evidence reviewed to support closure - Fast flow working group ToRs and action log
Bristol Emergency Department Inspection (Feb 2021)	Req (must do)	Make sure the patient waiting area in the minors' treatment unit is maintained and established to the standards of hygiene and patient safety for which it is being used in the current pandemic. There were torn seats which meant chairs could not be effectively cleaned. The arrangements for seating and social distancing were inadequately maintained, and there were no particular changes in safety arrangements in times of overcrowding.		Consideration of long-term redirection arrangements	15/04/2021	Lucy Parsons, Deputy COO	Chief Operating Officer / Deputy CEO	Recommend to close (evidence supports completion)	Redirection from ED is now business as usual process. Ongoing discussions with CCG, Sirona and primary care to expand redirection destinations (expanded hours and criteria). Re-direction to Urgent Treatment Centre (UTC) working well. Information reviewed on an ongoing basis. Picked uped specifically in specialty review with ED 17/05/22. Evidence reviewed to support closure - Specialty review document; evidence of good update of UTC through reporting mechanisms Work continues in partnership with CCG on implementation of national ED screening tool (EDST).
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Consider how to address the perception in the staff team in the emergency department that there was limited executive visibility, recognition, understanding and support. Look at options for more virtual contact with staff teams if executive or director visits are on hold during the pandemic.	Increased visibility of Exec's in the department. NED visit to medicine which included ED. Head of Nursing and Deputy Head of Nursing frequently in the department to support the staff ,especially during times of escalation and when ambulances Queuing. Divisional Tri meeting with ED Tri in place fortnightly in the diary as a regular meeting so that ED tri can raise concerns.	Re-establish programme of Executive visits including virtual visits to existing ED management and staff briefing	30/06/21 - as part of a wider organisational wide plan for Executive visits/visibility.	Chris Atkinson DD / Emma-Kate Reed, Clinical Chair / Hayley Long, Head of Nursing	Chief Operating Officer / Deputy CEO	Recommend to close (evidence supports completion)	Action linked to ED staff feedback to CQC at follow-up focus groups (re. leadership) Regular informal visits by Execs since inspection although no formal programme in place. The Divisional leadership team are in agreement that these informal visits are more beneficial, providing visible support to staff at a time of significant ongoing operational pressure. Therefore recommend closure from this plan.
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Consider how to address the perception in the staff team in the emergency department that there was limited executive visibility, recognition, understanding and support. Look at options for more virtual contact with staff teams if executive or director visits are on hold during the pandemic.		Increase formal touchpoints between Divisional and Departmental leadership teams to improve awareness and that escalations and SLT/Trust responses are clearly - Division of Medicine Urgent Care Board (fortnightly) - Daily Sitreps and Huddles	01/03/2021	Christine Atkinson DD / Emma-Kate Reed, Clinical Chair / Hayley Long, Head of Nursing	Chief Operating Officer / Deputy CEO	Recommend to close (evidence supports completion)	Action linked to ED staff feedback to CQC at follow-up focus groups (re. leadership) Urgent care board and daily sit-reps in place. Tri to Tri meetings and specialty reviews have been introduced to increase touch points. Other informal contact has been as beneficial within the department. Evidence reviewed to support closure - Example specialty review
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Address with staff the failures and lapses in practice around infection prevention and control we identified. This included the failure to wear or have masks covering the face at all times, a lack of good hand cleansing at all times, and the safe disposal of clinical waste in staff areas.	Staff communication methods in place regarding PPE requirements, provision of PPE and PPE guidance.	Include in divisional newsletter to raise awareness	30/04/2021	Hayley Long	Chief Nurse	Closed	Reported to QOC in December 21 A reminder to staff on PPE requirements and to challenge non compliance was included in the April 21 newsletter Evidence reviewed to support closure - Copy of newsletter
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Address with staff the failures and lapses in practice around infection prevention and control we identified. This included the failure to wear or have masks covering the face at all times, a lack of good hand cleansing at all times, and the safe disposal of clinical waste in staff areas.		Track updates from the walk arounds through the Divisional Quality Assurance Committee	27/04/21 (next meeting). A separate action plan is in progress with IPC	Hayley Long	Chief Nurse	Complete (awaiting evidence to support)	Updates reported through the QAC. IPC team do monthly walkaround with the CNS and Matron. Proving useful and helpful to staff.

Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Address with staff the failures and lapses in practice around infection prevention and control we identified. This included the failure to wear or have masks covering the face at all times, a lack of good hand cleansing at all times, and the safe disposal of clinical waste in staff areas.		Include in regular staff communications	01/03/2021	ED Triumvirate	Chief Nurse	Closed	Reported to QOC in December 21 Included in staff comms since March and is now included in safety briefings Evidence reviewed to support closure - Copy of comms and safety briefings
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Address with staff the failures and lapses in practice around infection prevention and control we identified. This included the failure to wear or have masks covering the face at all times, a lack of good hand cleansing at all times, and the safe disposal of clinical waste in staff areas.		Routine walk around between Matron and IPC teams and development of local ED IPC action plan	02/03/2021	ED Matron	Chief Nurse	Complete (awaiting evidence to support)	Updates reported through the QAC. IPC team do monthly walkaround with the CNS and Matron. Proving useful and helpful to staff.
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Address with staff the failures and lapses in practice around infection prevention and control we identified. This included the failure to wear or have masks covering the face at all times, a lack of good hand cleansing at all times, and the safe disposal of clinical waste in staff areas.		Establish a programme of spot checks to provide real-time feedback to staff and identify broader IPC themes and corrective actions	01/04/21 - undertaken weekly	ED Matron	Chief Nurse	Complete (awaiting evidence to support)	Updates reported through the QAC. IPC team do monthly walkaround with the CNS and Matron. Proving useful and helpful to staff.
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Revisit the handover process for nurses when patients are transferred from the emergency department to a ward. These was no paper record of a patient handover which sometimes meant it would need to be repeated or recreated if different staff were involved in the final move of the patient.		Review internal Nursing Handover processes	08/04/2021	Hayley Long, HON (in conjunction with divisional HoN) ED Matron	Chief Nurse	Recommend to close (evidence supports completion)	Handover pilot completed. A sticker has been designed and rolled out for use with ED and AMU. Planned for wider adoption across other wards including Weston, and Weston ED. Evidence reviewed to support closure - copy of sticker and pilot review results
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Check and risk assess the quality of air and vehicle emissions in the area where ambulances are required to wait. As ambulances are required to leave their engines running for their crews and patient safety and comfort, this causes emissions into a very built-up small area with little opportunity for the polluted air to dissipate. Act if possible, should the air quality be considered as a risk to people.		Develop plan for risk assessment / monitoring air quality.	31/05/2021	Andy Headon and Green Travel Manager	Chief Operating Officer / Deputy CEO	Behind schedule	Report received from Atmotech in Jan 2022. Monitoring to be extended for 3 more months with a phase 2 approach of expanding the monitoring to other areas. Most recent update from estates is that there is an alternative to running ambulance engines whilst queuing (Shorelines/Hock up).
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Check and risk assess the quality of air and vehicle emissions in the area where ambulances are required to wait. As ambulances are required to leave their engines running for their crews and patient safety and comfort, this causes emissions into a very built-up small area with little opportunity for the polluted air to dissipate. Act if possible, should the air quality be considered as a risk to people.		Share findings with SWAST and explore potential solutions.	31/07/2021	Andy Headon and Green Travel Manager	Chief Operating Officer / Deputy CEO	Behind schedule	Findings shared. SWAST have arranged for monitors to be installed in the Ambulance waiting area and data will be shared. SWAST fully involved in all discussion regarding the solution to improving air quality. SBAR being prepared (May 22) to further outline current issues (highlighted as part of ED specialty review).
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Undertake a review of the safety of identity lanyards worn by staff to determine if these meet health and safety requirements or pose a ligature risk.	Distinctive lanyard purchased to denote substantive staff during pandemic and times of significant staff shortages (balanced dynamic risk assessment)	Obtain and consider health and safety guidance re need to revert back to standard lanyards	30/04/2021	ED Triumvirate	Director of People	Closed	Reported to QOC in December 21 Individualised lanyards with two 2nd generation break points agreed with Trust V&A lead and in use. Evidence reviewed to support closure - email confirming use of new lanyards
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Review the clinical and performance risks the department is facing so these, as recorded in the risk register, reflect the crisis in these areas at the current time.	Urgent Care operational group in place (but stood down during pandemic). Minor Injury/illness redirection policy in place. Risk 5067 (mitigations) There is currently an adult escalation framework which is followed and in addition, the following actions are being taken: • There are limited pathways in place such as chest pain clinic. • There is a surgical SDEC. • Adult ED have a redirection process. • Medical division to pilot an SDEC. • ED have an escalation checklist when crowding occurs and there is boarding in some inpatient areas. • Escalation capacity is opened when staffing allow	12-hour performance added to Trust Scorecards and daily reports	15/02/2021	Linda Wadey, Head of BI	Chief Operating Officer / Deputy CEO	Closed	Reported to QOC in December 21 Scorecard added Evidence reviewed to support closure - Copies of scorecard including new measure
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Review the clinical and performance risks the department is facing so these, as recorded in the risk register, reflect the crisis in these areas at the current time.		Overcrowding risk to be central objective through Urgent Care and Quality performance reviews	26/04/2021	Chris Atkinson, Divisional Director / Angela Bezer, DHON	Chief Operating Officer / Deputy CEO	Closed	Reported to QOC in December 21 Fast Flow waiting room relocated to larger space (capacity expanded from 8 to 16). Re-direction SOPs in place Evidence reviewed to support closure - Copies of SOPs and evidence from fast flow working group
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Review the clinical and performance risks the department is facing so these, as recorded in the risk register, reflect the crisis in these areas at the current time.		Re-establish ED Specialty reviews	20/04/2021	Chris Atkinson, DD	Chief Operating Officer / Deputy CEO	Recommend to close (evidence supports completion)	Reported to QOC in December 21 Specialty reviews re started and ongoing. Evidence reviewed to support closure - Specialty review document for ED (May 22)
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Review the clinical and performance risks the department is facing so these, as recorded in the risk register, reflect the crisis in these areas at the current time.		Ensure 12-hour breach performance is included within the performance board report monthly	25/02/2021	Sufi Husain, DDD	Chief Operating Officer / Deputy CEO	Closed	Reported to QOC in December 21 Performance included in performance report Evidence reviewed to support closure - copy of report
Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Review the clinical and performance risks the department is facing so these, as recorded in the risk register, reflect the crisis in these areas at the current time.		Re-establish monthly departmental risk review meeting and establish Fast Flow working group	30/04/2021	ED Triumvirate	Chief Operating Officer / Deputy CEO	Closed	Reported to QOC in December 21 New meeting structure effective May 2021 Evidence reviewed to support closure - minutes of meetings

Bristol Emergency Department Inspection (Feb 2021)	Rec (should do)	Review the clinical and performance risks the department is facing so these, as recorded in the risk register, reflect the crisis in these areas at the current time.		Re-establish ED performance meeting	30/03/2021	ED Triumvirate	Chief Operating Officer / Deputy CEO	Closed	Reported to QOC in December 21 Meeting series effective from 10th May Evidence reviewed to support closure - minutes of meetings

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Urgent and emergency services (Weston)

ID	Source/Event (e.g. name of inspection)	Requirement or recommendation?	Details of requirement / recommendation	Current assurance / mitigation of risk	Actions to address gaps	Target date for completion	Lead	Exec	Status	Evidence / update provided (May 2022)
20-07/UAEW/1.1	Weston Emergency Department Inspection (July 2020)	Req (must do)	Ensure that staff employed in the emergency department are supported to complete regular mandatory training, and compliance is accurately captured.	Since merger, Weston Division now has access to detailed data enabling non-compliance to be identified and addressed with individual members of staff. Work is ongoing to integrate systems and processes for essential training as part of the Trust merger and the wider procurement of a regional Learning Management System. Monthly HR drop-in surgeries is underway, with essential training topics dedicated to each session to help recovery.	Continue to monitor and report training figures monthly through the specialty (medicine) governance group.	26/11/2021	Divisional HR Business Partner	Director of People	Complete (awaiting evidence to support)	The ED has recently appointed a band 7 practice educator with a focus to provide ED specific education to the nursing workforce and ensure staff are supported to complete mandatory and statutory training. Staff failing to complete are identified and supported appropriately to become compliant. Scorecards are generated each month outlining the medicine department's performance (including ED) against workforce KPIs. These scorecards are distributed to nursing and management teams. Comprehensive workforce reports are presented to Divisional Board on a monthly basis. These reports include key issue and planned remedial actions. Kalidus has also merged to give better visibility for all mandatory training information. Evidence received to date - Scorecards, evidence of reporting to Board and Kalidus reports. <i>Prompt:</i> <i>Further evidence required to demonstrate that staff are up to date with statutory and mandatory training.</i>
20-07/UAEW/1.2	Weston Emergency Department Inspection (July 2020)	Req (must do)	Ensure that staff employed in the emergency department are supported to complete regular mandatory training, and compliance is accurately captured.	Staff are proactively booked and rostered onto mandatory training update days where face to face teaching is required. Staff compliance with on-line updates is monitored routinely by managers and individuals reminded of requirements and appropriate action taken if out of date	Staff will continue to be released for training according to capacity and in line with budget allocation. This is monitored through rostering KPIs on a monthly basis.	26/11/2021	Head of Nursing	Chief Nurse	Closed	Reported to QOC in December 21 Nursing control exception report includes rostering KPIs which provide an overview of shift/rota cover, leave, etc. These are monitored monthly by the Weston nursing controls group, where exception reporting against the KPIs is undertaken. Staff are undertaking training in additional hours a t present due to the demands on the service, this is supported by management where appropriate. Evidence reviewed to support closure - Copies of nursing control reports, shifts and rotas
20-07/UAEW/2.1	Weston Emergency Department Inspection (July 2020)	Req (must do)	Ensure all registered health staff have completed level three safeguarding for children training.	Established Safeguarding leads are working collaboratively with educational leads to determine a consistent approach to deliver safeguarding training across Bristol and Weston sites. Safeguarding children training is in place and is being delivered. Divisional workforce reports/scorecards produced and reviewed by Divisional Board and Specialty Governance meeting. Weston staff cannot currently book onto update days via Kalidus; they need to use ESR or complete a training log – this is currently being reviewed by the Trust training department in relation to all mandatory training. A training recovery plan is being developed by the Safeguarding Team in conjunction with the Trust Training Team who are reviewing all mandatory training. Existing divisional risk 3917 (previously WAHT risk 327 – opened 2014) relates.	Divisional safeguarding lead to liaise with paediatric safeguarding team to identify and agree a process of delivery whilst staff are unable to complete face to face Level 3 training (in line with the Trust's 'blended' approach to delivering training which will take time to agree and roll out).	26/11/2021	Head of Nursing	Chief Nurse	Behind schedule	Training and compliance being monitored by Safeguarding Lead (DHoN). Ward Managers and Matrons will be contacted regularly to ensure compliance. Also reported through Divisional Governance Safeguarding Children Level 3 training - New starter training is now achieved via eLearning supported by local information delivered as part of Corporate Induction. Weston based staff can now book training via the new Kalidus. Compliance for subsequent updates can be achieved by attendance at themed updates delivered via Teams or face to face, completion of Professional Practice logs or eLearning training . Safeguarding Adults Level 3 training -New starter training currently follows a blended model of face to face and e learning. Weston based staff can now book training via the new Kalidus. Additional dates to deliver face to face sessions in Weston are currently being arranged. Going forward all adults level 3 training will be delivered as eLearning, supported by specific local information as part of Corporate Induction. <i>Prompt:</i> <i>Need to understand current performance and trajectory for improvement.</i>
20-07/UAEW/2.2	Weston Emergency Department Inspection (July 2020)	Req (must do)	Ensure all registered health staff have completed level three safeguarding for children training.	Established Safeguarding leads are working collaboratively with educational leads to determine a consistent approach to deliver safeguarding training across Bristol and Weston sites. Safeguarding children training is in place and is being delivered. Weston staff cannot currently book onto update days via Kalidus; they need to use ESR or complete a training log – this is currently being reviewed by the Trust training department in relation to all mandatory training. A training recovery plan is being developed by the Safeguarding Team in conjunction with the Trust Training Team who are reviewing all mandatory training. Existing divisional risk 3917 (previously WAHT risk 327 – opened 2014) relates.	Training figures to be reported and monitored monthly through the specialty (medicine) governance group.	26/11/2021	Head of Nursing	Chief Nurse	Closed	Reported to QOC in December 21 Safeguarding compliance figures widely circulated. Evidence reviewed to support closure - Evidence of reporting to divisional quality , safety and governance.

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20-07/UAEW/2.3	Weston Emergency Department Inspection (July 2020)	Req (must do)	Ensure all registered health staff have completed level three safeguarding for children training.	Established Safeguarding leads are working collaboratively with educational leads to determine a consistent approach to deliver safeguarding training across Bristol and Weston sites. Safeguarding children training is in place and is being delivered Weston staff cannot currently book onto update days via Kalidus; they need to use ESR or complete a training log – this is currently being reviewed by the Trust training department in relation to all mandatory training. A training recovery plan is being developed by the Safeguarding Team in conjunction with the Trust Training Team who are reviewing all mandatory training. Existing divisional risk 3917 (previously WAHT risk 327 – opened 2014) relates.	Review ESR to establish correct target audience and agree this with corporate safeguarding team.	26/11/2021	Head of Nursing	Chief Nurse	Complete (awaiting evidence to support)	Discussed with Safeguarding lead for Weston and this has been completed. Since the action was agreed, Kalidus has merged so Weston staff are on the same system as Bristol based staff Evidence reviewed to support closure - verbal assurance. Roll out of Kalidus system and communications. To be validated by Trust Safeguarding Lead.
20-07/UAEW/3.1	Weston Emergency Department Inspection (July 2020)	Req (must do)	Ensure there is an effective mechanism where all staff in the department learn from incidents that occur within the department and externally. Ensure that governance meetings provide a framework for discussions about serious incidents and include themes and lessons learned. Consider mechanisms to share information from governance meetings with all staff in the department.	EDGE (ED Governance Event) meeting in place (although impacted by COVID). 'Hot Topic' (learning from specific incidents, trends, etc.) is a standing agenda item. Evidence that -incidents, SIs, and RCAs are standing agenda items at the Divisional Quality & Safety Group and the Medicine specialty governance group. Learning reviewed and disseminated through EDGE. Information available in a shared folder on the K drive, and a copy is placed in staff room communication folder.	Incident reporting will be reported monthly to the specialty (medicine) governance group; sharing of RCAs and SIs will also be presented at the meeting.		Head of Nursing	Chief Nurse	Recommend to close (evidence supports completion)	Incidents, SIs, and RCAs are standing agenda items at the Emergency Department Governance Meeting (EDGE) and also at the Divisional Quality & Safety Group. Evidence reviewed to support closure - TOR/agendas/minutes of both EDGE and Divisional Quality and Safety Group. Minutes provide evidence of discussion and dissemination of learning.
20-07/UAEW/3.2	Weston Emergency Department Inspection (July 2020)	Req (must do)	Ensure there is an effective mechanism where all staff in the department learn from incidents that occur within the department and externally. Ensure that governance meetings provide a framework for discussions about serious incidents and include themes and lessons learned. Consider mechanisms to share information from governance meetings with all staff in the department.	EDGE (ED Governance Event) meeting in place (although impacted by COVID). 'Hot Topic' (learning from specific incidents, trends, etc.) is a standing agenda item. Evidence that -incidents, SIs, and RCAs are standing agenda items at the Divisional Quality & Safety Group and the Medicine specialty governance group. Learning reviewed and disseminated through EDGE. Information available in a shared folder on the K drive, and a copy is placed in staff room communication folder.	Six-monthly spot check audits to be initiated to check with staff learning from recent RCA/ SI; this will be reported to the specialty (medicine) governance group.	26/11/2021	Head of Nursing	Chief Nurse	Behind schedule	Daily safety briefings across all wards and Trust safety bulletin sent to all areas monthly. EDGE Meetings in place that take place monthly. RCA and SI Report highlighted and discussed in full for learning. All actions are reviewed and updated monthly. Proposal of use of LASER in Weston division. Formal audit/survey yet to be undertaken.
20-07/UAEW/4.1	Weston Emergency Department Inspection (July 2020)	Req (must do)	Ensure there is an effective mechanism where all staff are aware of national patient safety alerts to ensure patients receive care in line with that recommended in these national alerts.	Following merger, Weston Division now follows corporate processes relating to national patient safety alerts, coordinated through MEMO and Trust's Patient Safety Team. CAS alerts are reported and monitored through the Divisional Quality & Safety Group via the existing Patient Safety report; in line with other Divisions. The Divisional Governance Team are developing a report specific for Weston to numbers of CAS applicable, number completed, number requiring a response. This work should be completed by the end of June 21. Trust wide policy for management of CAS alerts approved (Apr 21). This will further align processes across the Trust	New and ongoing CAS alerts to be monitored through the weekly Divisional sit rep meeting prior to sending out to all teams.	26/11/2021	Head of Nursing	Chief Nurse	Recommend to close (evidence supports completion)	The Divisional Sit rep meetings are no longer in place. CAS alerts are reported and monitored through the Divisional Quality & Safety Group via the existing Patient Safety report; in line with other Divisions. Evidence reviewed to support closure - Evidence confirms that CAS alerts are routinely reported to Divisional Quality and Safety Group.
20-07/UAEW/4.2	Weston Emergency Department Inspection (July 2020)	Req (must do)	Ensure there is an effective mechanism where all staff are aware of national patient safety alerts to ensure patients receive care in line with that recommended in these national alerts.	Following merger, Weston Division now follows corporate processes relating to national patient safety alerts, coordinated through MEMO and Trust's Patient Safety Team. CAS alerts are reported and monitored through the Divisional Quality & Safety Group via the existing Patient Safety report; in line with other Divisions. The Divisional Governance Team are developing a report specific for Weston to numbers of CAS applicable, number completed, number requiring a response. This work should be completed by the end of June 21. Trust wide policy for management of CAS alerts approved (Apr 21). This will further align processes across the Trust	Internal process of sign off from Weston specialities to be established; compliance monitored monthly through Divisional Governance Group.	26/11/2021	Head of Nursing	Chief Nurse	Recommend to close (evidence supports completion)	Current process is in alignment with Bristol site with monthly and adhoc patient safety alerts and bulletins that are cascaded to all clinical staff. CAS alerts are reported and monitored through the Divisional Quality & Safety Group via the existing Patient Safety report; in line with other Divisions. Evidence reviewed to support closure - Evidence confirms that CAS alerts are routinely reported to Divisional Quality and Safety Group.
20-07/UAEW/5.1	Weston Emergency Department Inspection (July 2020)	Req (must do)	Ensure that all staff receive adequate supervision, mentorship and appraisal, and ensure that this is documented.	Patient Safety Sister and Practice Development Nurse roles were introduced as a result of the WAHT inspection; one of the main aspects of these roles is to support and develop staff (and to help develop the process by which to do so). A competency framework with supporting guidance has been developed for nursing staff. All new nursing staff now have a mentor identified to work with and support them for their first six months in post. Record of staff and mentors in place including relevant induction element training record	Spot check audit of staff satisfaction/ support to be undertaken	26/11/2021	Head of Nursing	Director of People / Chief Nurse / Medical Director	Behind schedule	ED nursing staff moved into teams to ensure adequate supervision and mentorship from band 7 and 6s. Newly appointed band 7 educator to support staff with training and development. Closer monitoring of training and appraisal KPIs. Improved process for securing external training for staff. New starters supported with recommended supervisory time and allocated band 5 mentor to support competencies. Formal audit/survey yet to be undertaken.

20-07/UAEW/5.2	Weston Emergency Department Inspection (July 2020)	Req (must do)	Ensure that all staff receive adequate supervision, mentorship and appraisal, and ensure that this is documented.	Appraisal figures form part of the workforce reports presented to Divisional Board Monthly. These reports contain 'key recovery plans' for elements within the report As with essential training, the divisional HR team has recommended reminders for overdue appraisals; this was paused during the winter due to the Covid Pandemic and therefore reduction in available staff. The corporate workstream to develop appraisals to align across both campuses is progressing, with a new appraisal form, updated policy and new training module all in the draft / pilot stages. Some elements of the pre-merger Weston form are being retained as they are preferable to the previous Bristol version, which is a positive message to share with staff when the new information is communicated. The Division has put forward development ideas to the Education team to be part of the roll out of the new training.	Continue to ensure that annual appraisals take place in a timely manner, achieving 95% compliance. Appraisal trajectory to be agreed and monitored monthly through the specialty (medicine) governance group.	26/11/2021	Divisional HR Business Partner	Director of People / Chief Nurse / Medical Director	Behind schedule	Appraisal figures form part of the workforce reports presented to Divisional Board Monthly. These reports contain 'key recovery plans' for elements within the report. ED nursing staff moved into teams to ensure adequate supervision and mentorship from band 7 and 6s. These senior nurses are responsible for completing meaningful appraisals from staff to identify and support learning needs. The band 7 of each team reports monthly to the matron with their appraisal compliance and teams development needs. Slow improvement since November. As with essential training, the divisional HR team has recommended reminders for overdue appraisals. Working with managers, going through the lists of outstanding appraisals to make sure that the ESR records are updated and supporting managers to diaries a discussion with their employees. Weston staff are now on the Kalidus system which will further help improve compliance <i>Prompt:</i> Need to understand current performance and trajectory for improvement.
20-07/UAEW/6	Weston Emergency Department Inspection (July 2020)	Rec (should do)	Take further steps to improve the quality and quantity of training for junior doctors.	ENP teaching also takes place on the BRI site, there is an open invitation for Weston ED to attend, however so far this has seen limited attendance	Specific dedicated teaching time identified within the emergency department.	28/11/2021	Clinical Chair	Medical Director	Closed	Reported to QOC in December 21 14hr clinical educator time is now being provided from the BRI. The junior Drs/ENPs receive 1:1 shop floor teaching weekly. ENP in-house monthly evening sessions are being provided . Open invitation to ENPs. Evidence reviewed to support closure - various teaching agendas/programmes. Emails of positive feedback
20-07/UAEW/7.1	Weston Emergency Department Inspection (July 2020)	Rec (should do)	Take further steps to ensure all equipment in the emergency department is maintained and not used past its finite life date. Furthermore, leaders should consider ways to ensure the risk of staff using this equipment unknowingly is mitigated.	Agreement during/post inspection that Weston equipment would be prioritised for maintenance, especially any long-standing items past their finite date (agreed with Head of MEMO). Work being undertaken through the Medical Devices Management Group to align Weston to the current equipment maintenance programme.	Identify a lead within the emergency department	26/11/2021	Head of Quality and Patient Safety	Chief Operating Officer	Complete (awaiting evidence to support)	ED Matron has oversight of equipment in ED and another Matron has been appointed as medical devices lead for the Division. <i>Prompt:</i> Clarification of role would be useful. Evidence of improvement/impact required
20-07/UAEW/7.2	Weston Emergency Department Inspection (July 2020)	Rec (should do)	Take further steps to ensure all equipment in the emergency department is maintained and not used past its finite life date. Furthermore, leaders should consider ways to ensure the risk of staff using this equipment unknowingly is mitigated.	Agreement during/post inspection that Weston equipment would be prioritised for maintenance, especially any long-standing items past their finite date (agreed with Head of MEMO). Work being undertaken through the Medical Devices Management Group to align Weston to the current equipment maintenance programme.	Ensure an equipment log is maintained and a competency log is completed for all staff.	26/11/2021	Head of Quality and Patient Safety	Chief Operating Officer	Complete (awaiting evidence to support)	Reported to QOC in December 21 Weston Division incorporated into Trust wide equipment/maintenance log. Currently equipment replacement is focused on high risk items (none at WGH at point of writing) Evidence reviewed to support closure - Evidence of equipment log received from MEMO. <i>Prompt:</i> Need to determine whether we have addressed the 'competency' aspect
20-07/UAEW/8	Weston Emergency Department Inspection (July 2020)	Rec (should do)	Improve compliance with the escalation process to procure and escalate requests for agency and locum staff to make sure all shifts are covered.	ED Specialty manager reviews medical rotas and prospectively escalates gaps to Temporary Staffing Bureau, also informing ED Clinical lead. escalate short notice gaps to on call manager. It is felt that this process is not as robust and straight forward as the previously process and that the Divisional process should be further reviewed with TSB to address concerns. This will be completed by the Deputy Divisional Director as a priority, with completion by the end of April 2021. Additional administrative support for the coordination of the rota has been agreed	Establish a clear and robust process to enable staff to acquire additional doctors in and out of hours.	26/11/2021	Clinical Chair	Director of People / Chief / Nurse Medical Director	Complete (awaiting evidence to support)	Reported to QOC in December 21 Rota coordinator in post. Process for TSB to engage locums for in and out of hours. Evidence reviewed to support closure: - Daily staffing huddles and weekly compliance reports to CQC <i>Prompt:</i> Need to confirm the process and that this has addressed the issues
20-07/UAEW/9	Weston Emergency Department Inspection (July 2020)	Rec (should do)	Consider and mitigate the risk created by the high workload of the clinical lead.	Since the inspection, additional support has been agreed with the Bristol site; this includes a Consultant support post for eight months. Two consultants are also supporting the department one day a week, with a specific focus on clinical leadership and support. Educational support is also being provided by a consultant (1 PA from Bristol ED). Consultant recruitment monthly meeting in place with Clinical Chair Recruitment team including talent acquisition staff and Employee Services to discuss progress with Consultant recruitment role by role.	Recruit to substantive consultant posts	26/11/2021	Clinical Chair	Medical Director	Behind schedule but significant progress made	Additional 2 consultants appointed, clinical lead increased time in job plan for management responsibility in line with BRI ED lead. Middle grade appointments made. <i>Awaiting update</i>

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20-07/UAEW/10.1	Weston Emergency Department Inspection (July 2020)	Rec (should do)	Consider ways in which the oversight of nursing competencies and training needs analysis can be improved.	Originally identified as an action from WAHT Warning Notice action plan. Internal review noted that a training needs analysis had been completed, but monitoring arrangements were unclear. The emergency department has produced and agreed a training and supervision policy/guideline. Each nurse has a competency booklet which is signed off by the Educator when achieved. Competencies are aligned to RCN requirements and will be updated in line with any national updates (infrequent); this will be the responsibility of the ED Matron/Senior Sister. The senior sister for ED meets with the educator monthly to discuss numbers achieved. This will be monitored via 1:1 documentation.	Agreement that all staff are signed off by the Matron when training is completed.	26/11/2021	Head of Nursing	Chief Nurse	Closed	Reported to QOC in December 21 Trainijg is signed off by the ED Practice Educator and recorded on the ED database. Evidence reviwed to support closure: - records and database reviewed
20-07/UAEW/10.2	Weston Emergency Department Inspection (July 2020)	Rec (should do)	Consider ways in which the oversight of nursing competencies and training needs analysis can be improved.	Originally identified as an action from WAHT Warning Notice action plan. Internal review noted that a training needs analysis had been completed, but monitoring arrangements were unclear. The emergency department has produced and agreed a training and supervision policy/guideline. Each nurse has a competency booklet which is signed off by the Educator when achieved. Competencies are aligned to RCN requirements and will be updated in line with any national updates (infrequent); this will be the responsibility of the ED Matron/Senior Sister. The senior sister for ED meets with the educator monthly to discuss numbers achieved. This will be monitored via 1:1 documentation.	Process for reviewing and updating competencies to be established.	26/11/2021	Head of Nursing	Chief Nurse	Closed	Reported to QOC in December 21 Competencies booklet created (previously reviewed as evidence). All staff are signed off by the ED Practice Educator and recorded on the ED database. Competencies reviewed whenever national training standards change (infrequently). Evidence reviwed to support closure: - Competancy booklet and systems
20-07/UAEW/10.3	Weston Emergency Department Inspection (July 2020)	Rec (should do)	Consider ways in which the oversight of nursing competencies and training needs analysis can be improved.	Originally identified as an action from WAHT Warning Notice action plan. Internal review noted that a training needs analysis had been completed, but monitoring arrangements were unclear. The emergency department has produced and agreed a training and supervision policy/guideline. Each nurse has a competency booklet which is signed off by the Educator when achieved. Competencies are aligned to RCN requirements and will be updated in line with any national updates (infrequent); this will be the responsibility of the ED Matron/Senior Sister. The senior sister for ED meets with the educator monthly to discuss numbers achieved. This will be monitored via 1:1 documentation.	Progress to be reported and monitored through medicine governance group	27/11/2021	Head of Nursing	Chief Nurse	Complete (awaiting evidence to support)	Competency progress monitored within ED (evidenced by department spreadsheet). Education training will be a standing agenda item at the medicine governance group.
20-07/UAEW/11.1	Weston Emergency Department Inspection (July 2020)	Rec (should do)	Implement training for reception staff in the recognition of seriously ill patients.	This has been discussed with reception staff and they are clear about actions they need to take to support critically ill patients and the process for escalation. Weston ED reception have the RED phone number to call for immediate assistance if they are worried about someone. Discussed with Bristol site but no specific learning identified.	ED Sister/ Matron to obtain and review Bristol learning.		Head of Nursing	Chief Nurse	Recommend to close (evidence supports completion)	Mitigation (availability/use of red phone) suitable. This has been discussed with reception staff and they are clear about actions they need to take to support critically ill patients and the process for escalation. Weston ED reception have the RED phone number to call for immediate assistance if they are worried about someone. No further action undertaken
20-07/UAEW/11.2	Weston Emergency Department Inspection (July 2020)	Rec (should do)	Implement training for reception staff in the recognition of seriously ill patients.	This has been discussed with reception staff and they are clear about actions they need to take to support critically ill patients and the process for escalation. Weston ED reception have the RED phone number to call for immediate assistance if they are worried about someone. Discussed with Bristol site but no specific learning identified.	Weston team will seek to source action cards to assist front desk		Head of Nursing	Chief Nurse	Recommend to close (evidence supports completion)	Mitigation (availability/use of red phone) suitable. This has been discussed with reception staff and they are clear about actions they need to take to support critically ill patients and the process for escalation. Weston ED reception have the RED phone number to call for immediate assistance if they are worried about someone. No further action undertaken
20-07/UAEW/12	Weston Emergency Department Inspection (July 2020)	Rec (should do)	Address the cause of a lack of joined up working between the emergency department and the acute medical physicians.	Some ED / Medicine meetings took place but stopped during Covid. Starting in September new meetings with clinical leads ED and acute medicine consultants will take place (plus registrars to be invited every two weeks).. Meetings will focus on the interface between ED and acute Medicine – “what could we have done better for this patient” spirit of cooperation and relationship building with auditable learning points to be disseminated to departments.	Re-introduce a fortnightly ED/Physicians cabinet to discuss issues and develop joint working.	01/10/2021	Clinical Chair	Medical Director	Behind schedule	Occasional meetings took place but generally stood down during COVID. A new meeting with clinical leads in ED and acute medicine consultants (plus Registrars to be invited every two weeks) commenced in September 2021. Focus on the interface between ED and acute Medicine – “what could we have done better for this patient” spirit of cooperation and relationship building with auditable learning points to be disseminated to departments. Clinical Leads meeting in place, 3 meetings since September 2021. <i>Awaiting update</i>

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Medical care (Bristol)

ID	Source/Event (e.g. name of inspection)	Requirement or recommendation?	Details of requirement / recommendation	Current assurance / mitigation of risk	Actions to address gaps	Target date for completion	Lead	Exec	Status	Evidence / update provided (May 2022)
21-06/MEDB/1	Bristol Medical services (June 2021)	Req (Must do)	The trust must ensure patients in interim beds have access to equipment and have privacy in line with the trust standard operating procedure. For example, access to electrical sockets, call bells and privacy screens. The trust must ensure boarding patients and those in the same bay can be safely accessed should urgent treatment be needed.	Boarding SOP in place. Risk assess Boarding completed Risk assessment for use of extension leads in place. Dignity screens now in place on all of the wards (order arrived/work undertaken subsequent to the CQC visit)	Request has been submitted to Estates to assess options for fixed power points (to replace extension leads)	01/05/2022	Head of Nursing	Chief Nurse	Behind schedule but significant progress made	Risk assessments undertaken in areas requiring additional power sockets (part of recognised Boarding risk). It will not be possible or cost effective to have fixed power points in all areas. The SOP for boarding that was written for medicine is being reviewed and amended to reflect trustwide boarding processes. Once established, processes (including the use of the patient leaflet that is associated with boarding) need to be audited. Further discussion on approach needed at heads of nursing meeting 12th May 2022. As further assurance this could be added to the CQC ward and department checklist.
21-06/MEDB/2	Bristol Medical services (June 2021)	Req (Must do)	The trust must ensure medical staff receive and complete mandatory training in line with trust targets.	Training compliance reported monthly to Divisional Board and to Divisional workforce Committee. Specialty updates regarding actions and prioritising at Specialty Reviews	Specialties have been asked to book prospective dates to address non-compliance and to flag any barriers to accessing the training (training capacity or releasing workforce to attend)	01/11/2022	HR Business Partners, Divisional Triumvirate	Director of People	Behind schedule	Sessions available to staff. Essential training compliance for medical staff is behind trajectory (currently 57%) and is not showing an increase. Essential training compliance against medical staff is a particular issue with medical staff showing as levels of non-compliance for every essential training course. Consultant appraisal compliance is above target at 91.7% (April 22) The new learning system is now live and more functional than before. it is hoped that the system will be easier for managers to navigate and to monitor the compliance of their teams. Callum McCourt from the Education team has attended the Ward Sisters Meeting and Specialty Managers meeting to train managers on how to utilise the new system and make best use of its functionality. <i>Prompt:</i> <i>Need to understand current performance and trajectory for improvement</i>
21-06/MEDB/3	Bristol Medical services (June 2021)	Rec (Should do)	Review level three safeguarding adult training and ensure all staff who require this training are identified.	Safeguarding team are working with ED to provide group training in the department to improve compliance. HRBPs are working with teams to assess the requirement for training across the Division	Training need being assessed	01/11/2022	HR Business Partners, Divisional Triumvirate	Director of People	Behind schedule	Training is being provide in ED for staff who cannot leave the shop floor, SG level 3 children remains an issue. <i>Prompt:</i> <i>Need to understand current performance and trajectory for improvement. Also note that this action is for for the Division as a whole rather than ED alone</i>
21-06/MEDB/4	Bristol Medical services (June 2021)	Rec (Should do)	Review the environment on the endoscopy unit to ensure infection and prevention control standards are met and the premises are suitable for their intended use.	Immediate issue to do with restricted access dirty/clean linin addressed at time of inspection. The plans to upgrade the service/ environment are part of a long-term strategic capital programme bid.	N/A	N/A	N/A	N/A	N/A	
21-06/MEDB/5	Bristol Medical services (June 2021)	Rec (Should do)	Consider confidentiality in relation to personal information being on display in ward areas.	Digital Ward view board contains patient information that is displayed on each ward	Options being considered via IG group	01/11/2022	IG lead, Deputy Head of Nursing	Chief Nurse	Complete (awaiting evidence to support)	Reminder sent out to staff post inspection regarding awareness of leaving notes/information in view. Digital ward view boards are standard in all of the wards in adult services. The working assumption is that this refers to white boards. It is felt that the risk to patient safety outweighs any information governance risk. <i>Prompt:</i> <i>Need to determine whather the IG team are in agreement</i>
21-06/MEDB/6	Bristol Medical services (June 2021)	Rec (Should do)	Ensure staff receive regular appraisal.	Appraisal figures reported monthly to Board. Also reported to Divisional workforce Committee. Current compliance 69.8% (Oct 21) Specialty updates regarding actions and prioritising at Specialty Reviews. Inconsistent data so working with HRIS and Training Team to understand differences – may be due to timing of reports (the difference is circa 10% each month) further work to take place. Deep dive' appraisal data (identifies 'completed' appraisals that have taken place but are awaiting a single party's sign off on E-appraisal system) has been analysed and communicated to relevant managers – this ensures appraisals that have taken place can be correctly documented as complete. At present, these 'completed' appraisals account for 7% of out of date appraisals. Appraisal recovery actions are discussed and agreed at Divisional Workforce Committee, as is our divisional datix risk for inadequate appraisal compliance. Barriers to completion include:- double sign off, only one line manager identified on the system so reliant on ward sister to update system	Specialties have been asked to book prospective dates to address non-compliance. Ward managers are required to update HoN on appraisal recovery actions and account for any non-compliant appraisals.	Trust target is 85% by end of December 21. Reported position in October 21 suggests this cannot be achieved so the target time has been stretched (in Division) to end of September 22	HR Business Partners, Divisional Triumvirate	Director of People	Behind schedule	From June 2021 until March 2022, there has been an average increase in appraisal compliance of around 2% per month. In March 2022, appraisal compliance was 68.2%. Based on this data, if compliance were to increase at the same rate, the trajectory for reaching 85% compliance would be May 2023. However, the following actions are being taken to improve compliance with the aim of reaching the target of 85% by September 2022. • A large audit of the inpatient wards to assign staff to the correct cost centres following substantial ward moves. This will improve the accuracy of the appraisal compliance data sent to managers. The audit is also looking at ensuring that the correct supervisors are assigned to staff. In many cases, the supervisor will be a Band 6 to ensure that that Ward Manager does not have to sign off every appraisal. • Managers to be sent an appraisal compliance report every month for their teams. To date this has either not happened, or the data has been inaccurate due to staff being assigned to the wrong cost centres. • Where either the manager or the individual have not signed off their appraisal, they are to be contacted directly to ask them to update this on the system. • Appraisal compliance will continue to be monitored through Quality and Performance meetings with the Head of Nursing with managers accounting for overdue appraisals.

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21-06/MEDB/7	Bristol Medical services (June 2021)	Rec (Should do)	Review the need to reinstate a dedicated older person assessment unit which was repurposed due to COVID-19.	Plan developed as part of a review of the medical bed base following first wave pandemic. Phase 1 of implementation includes OPAU Nursing team being expanded and trained in requirements for OPAU Consultant workforce in place Therapies workforce in place	Re-established OPAU as a bed base. Further development of nursing workforce required (previous team skills dispersed and left posts)	01/03/2022	Operational teams	Chief Operating Officer	Recommend to close (evidence supports completion)	'Phase 1' re-opening of the Older Person's Assessment Unit (OPAU) based on A400 took place on Tuesday 3 May. The model of care provided on the OPAU will be via a phased approach: • Phase 1: Patients to be admitted via ED or SDEC 24 hours a day, 7 days a week. • Phase 2: Patients to be admitted via ED or SDEC 24 hours a day, 7 days a week. Patients to be admitted via direct referrals from GP's and/or SWAST within the hours of 08:00 – 16:00. • Phase 3: As per phase 1 and 2 but receiving direct referrals from GP's/SWAST 24 hours a day, 7 days a week.
21-06/MEDB/8.1	Bristol Medical services (June 2021)	Rec (Should do)	Review effectiveness of wellbeing initiatives to support morale of staff at all levels.	Benefits and research supporting the role of the Nurse Well-Being advocate role included within Wellbeing Nurse Business case which has now been approved and recruited substantively. • Safety Brief message to staff weekly from wellbeing nurses thanking them for all they are doing, sharing information about support, initiatives, events etc. • Link in with clinical psychology to engage wards to undertake huddle training and implement during shifts to support staff as believe this will also link into team morale • WB nurses visit all new starters a few time- helps them feel welcomed and valued, allows message of support to be heard at beginning of employment at BRI • WB nurses trying to engage staff to join listening ear events • Hosted divisional Schwarz round 'why I come to work' • WB nurses working closely with Psychological Health services to ensure staff have access to drop ins at ward level when on duty • Tea rounds by WB nurses or SLT-thanking staff, sharing information about WB and self-care • WB nurses piloting development days for band 6 team on 522- a chance for the nurses to spend a day shadowing another MDT member for their own professional CPD and experience. • WB nurses working with wellbeing advocates to embed star of the month on wards. Peer to peer celebrating and sharing success of their colleagues - would like to divisionally recognise this with a star pin badge for each months winners to be given by senior nurse	• Provide wobble rooms for wards that would like one.	01/04/2022	Wellbeing Lead	Director of People	Complete (awaiting evidence to support)	Well being nurses substantively funded in the division as of December 2021. Wobble room located on Level 9 in the BRI. Outpatient Wellbeing Nurse appointed in April 22. <i>Prompt: Need to consider the effectiveness of the initiatives. Is there evidence that this had made a difference to staff wellbeing?</i>
21-06/MEDB/8.2	Bristol Medical services (June 2021)	Rec (Should do)	Review effectiveness of wellbeing initiatives to support morale of staff at all levels.	Benefits and research supporting the role of the Nurse Well-Being advocate role included within Wellbeing Nurse Business case which has now been approved and recruited substantively. • Safety Brief message to staff weekly from wellbeing nurses thanking them for all they are doing, sharing information about support, initiatives, events etc. • Link in with clinical psychology to engage wards to undertake huddle training and implement during shifts to support staff as believe this will also link into team morale • WB nurses visit all new starters a few time- helps them feel welcomed and valued, allows message of support to be heard at beginning of employment at BRI • WB nurses trying to engage staff to join listening ear events • Hosted divisional Schwarz round 'why I come to work' • WB nurses working closely with Psychological Health services to ensure staff have access to drop ins at ward level when on duty • Tea rounds by WB nurses or SLT-thanking staff, sharing information about WB and self-care • WB nurses piloting development days for band 6 team on 522- a chance for the nurses to spend a day shadowing another MDT member for their own professional CPD and experience. • WB nurses working with wellbeing advocates to embed star of the month on wards. Peer to peer celebrating and sharing success of their colleagues - would like to divisionally recognise this with a star pin badge for each months winners to be given by senior nurse	•WB nurses to have a designated calm room for staff to come to if need support in confidence away from their clinical area				Complete (awaiting evidence to support)	Well being nurses substantively funded in the division as of December 2021. Wobble room located on Level 9 in the BRI. Outpatient Wellbeing Nurse appointed in April 22. <i>Prompt: Need to consider the effectiveness of the initiatives. Is there evidence that this had made a difference to staff wellbeing?</i>
21-06/MEDB/9.1	Bristol Medical services (June 2021)	Rec (Should do)	Review effectiveness of the Freedom to Speak up process to ensure staff are confident to raise concerns.	FTSU advocate in Medicine Embed mandatory Speak Up training across UHBW. Improve reach and diversity of speaking up champion network. Share 'positive change' initiatives through champions to encourage staff to raise issues/suggestions in their areas. PHS continue to offer support to teams to build positive working relationships through provision of team check in sessions and leaders consultation slots.	Expand upon the Supporting Positive Behaviours toolkit with new resources aimed at supporting Bystanders, Teams with a bullying culture, and looking at behaviour change to address bullying behaviours (Q3-4 21/22)	01/04/2022	FTSU advocate, Divisional Triumvirate	Director of Corporate Governance	Behind schedule	Awaiting update

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21-06/MEDB/9.2	Bristol Medical services (June 2021)	Rec (Should do)	Review effectiveness of the Freedom to Speak up process to ensure staff are confident to raise concerns.	FTSU advocate in Medicine Embed mandatory Speak Up training across UHBW. Improve reach and diversity of speaking up champion network. Share 'positive change' initiatives through champions to encourage staff to raise issues/suggestions in their areas. PHS continue to offer support to teams to build positive working relationships through provision of team check in sessions and leaders consultation slots.	Work with HR to align SPB work with planned Restorative framework (Q3-4 21/22)	01/04/2022	FTSU advocate, Divisional Triumvirate	Director of Corporate Governance	Behind schedule but significant progress made	The division now have 12 FTSU champions. As well as cascading of process to be followed and signposting, the division will be working with the FTSU team who manage these advocates to look to increase the number via means of recruitment and promotion of the role. Role and process to be included in divisional newsletter to ensure all staff are aware. Recent examples of cases where the use of FTSU has helped address working relationship have proved beneficial and improvements seen. Well being nurses are now actively working with the champions to provide drop in sessions for staff to speak up.
21-06/MEDB/9.3	Bristol Medical services (June 2021)	Rec (Should do)	Review effectiveness of the Freedom to Speak up process to ensure staff are confident to raise concerns.	FTSU advocate in Medicine Embed mandatory Speak Up training across UHBW. Improve reach and diversity of speaking up champion network. Share 'positive change' initiatives through champions to encourage staff to raise issues/suggestions in their areas. PHS continue to offer support to teams to build positive working relationships through provision of team check in sessions and leaders consultation slots.	Increase access to manager training by creating eLearning version	01/04/2022	FTSU advocate, Divisional Triumvirate	Director of Corporate Governance	Complete (awaiting evidence to support)	Listen up training for managers is on Kalidus and will be discussed at the monthly quality and performance meeting with the sisters. Compliance against mandatory Speak Up training has increased: Medicine - 24% (Aug 21) to 47% (Mar 22).
21-06/MEDB/9.4	Bristol Medical services (June 2021)	Rec (Should do)	Review effectiveness of the Freedom to Speak up process to ensure staff are confident to raise concerns.	FTSU advocate in Medicine Embed mandatory Speak Up training across UHBW. Improve reach and diversity of speaking up champion network. Share 'positive change' initiatives through champions to encourage staff to raise issues/suggestions in their areas. PHS continue to offer support to teams to build positive working relationships through provision of team check in sessions and leaders consultation slots.	Work with the Comms Team to plan a campaign to effectively promote the toolkit (Q3-4 21/22).	01/04/2022	FTSU advocate, Divisional Triumvirate	Director of Corporate Governance	Behind schedule	Awaiting update
21-06/MEDB/10	Bristol Medical services (June 2021)	Rec (Should do)	Consider ways to improve executive team engagement with staff.	Continue with exec and non-exec visits to wards and departments when offered	Invite execs to join senior team 'tea trolley' rounds (informal opportunity to visit wards and talk/listen to staff)	On-going	Divisional Triumvirate	Director of Corporate Governance	Recommend to close (evidence supports completion)	Informal Exec visits happen in the division and are actively encouraged. For example, the director of strategy (who is the division's Exec 'buddy') visited ED in April and fed back to the matron at the time. The chief nurse visits the wards and departments on a regular basis. Also see Well Led plan re. Exec and Non-Exec visits.

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Medical care (Weston)										
ID	Source/Event (e.g. name of inspection)	Requirement or recommendation?	Details of requirement / recommendation	Current assurance / mitigation of risk	Actions to address gaps	Target date for completion	Lead	Exec	Status	Evidence / update provided (May 2022)
21-03/MEDW/1.1	Weston Medical Services Inspection (March 2021)	Req (must do)	MD1 - Ensure there is enough staff to safely care for patients at all times. MD3 - Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.	Nursing workforce Safe staffing meetings held minimum twice daily with oversight by Head of Nursing. Monthly review of Trust-wide safe staffing triangulated with quality metrics and incidents Practice Educator Facilitators in post across Wards, ITU / ED / Theatres, working alongside staff. On-site Matron at weekends. Critical Care outreach team providing additional oversight of unwell patients. Electronic observations implemented October 2020. 17 Aspirant nurses (3rd year student nurses employed in January 2021). Fully recruited to nursing assistant vacancies. Nursing staff conversion rate (i.e. interview to actually starting) is 90% across UHBW as a whole	21/22 UHBW International Nurse Recruitment Programme. Recruit 40 International Nurses during April – October 2021.	26/11/2021	Deputy Chief Nurse (MG)	Chief Nurse	Complete (awaiting evidence to support)	Reported to QOC in December 21 20 RN's are now in the workforce numbers; 4 more are arriving in the UK week commencing 25th October. We continue to work with NHSP (our international recruitment partner to recruit more international nurses). National recruitment campaigns continue with rolling adverts for Weston General Hospital; and individual departments <i>Prompt: what was the final number. Need to clarify whether Target of 74 was acheived</i>
21-03/MEDW/1.2	Weston Medical Services Inspection (March 2021)	Req (must do)	MD1 - Ensure there is enough staff to safely care for patients at all times. MD3 - Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.	Nursing workforce Safe staffing meetings held minimum twice daily with oversight by Head of Nursing. Monthly review of Trust-wide safe staffing triangulated with quality metrics and incidents Practice Educator Facilitators in post across Wards, ITU / ED / Theatres, working alongside staff. On-site Matron at weekends. Critical Care outreach team providing additional oversight of unwell patients. Electronic observations implemented October 2020. 17 Aspirant nurses (3rd year student nurses employed in January 2021). Fully recruited to nursing assistant vacancies. Nursing staff conversion rate (i.e. interview to actually starting) is 90% across UHBW as a whole	Start 20 New Registered Nurses during April – October 2021.	26/11/2021	Deputy Chief Nurse (MG)	Chief Nurse	Closed	Reported to QOC in December 21 September recruitment pipeline had 33 RN's identified at various stages of the recruitment pathway. Target was considered met although recruitment continues.
21-03/MEDW/1.3	Weston Medical Services Inspection (March 2021)	Req (must do)	MD1 - Ensure there is enough staff to safely care for patients at all times. MD3 - Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.	Nursing workforce Safe staffing meetings held minimum twice daily with oversight by Head of Nursing. Monthly review of Trust-wide safe staffing triangulated with quality metrics and incidents Practice Educator Facilitators in post across Wards, ITU / ED / Theatres, working alongside staff. On-site Matron at weekends. Critical Care outreach team providing additional oversight of unwell patients. Electronic observations implemented October 2020. 17 Aspirant nurses (3rd year student nurses employed in January 2021). Fully recruited to nursing assistant vacancies. Nursing staff conversion rate (i.e. interview to actually starting) is 90% across UHBW as a whole	Increase International Nurse Recruitment as part of 3 year programme (2022/23).	30/12/2022	Deputy Chief Nurse (MG)	Chief Nurse	On track	UHBW currently reviewing and business cases being drafted to explore ongoing (rolling) international recruitment programme. April 22 initial tranche of 70 International Nurses agreed for UHBW. Full business case continuing to be developed.
21-03/MEDW/1.4	Weston Medical Services Inspection (March 2021)	Req (must do)	MD1 - Ensure there is enough staff to safely care for patients at all times. MD3 - Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.	Nursing workforce Safe staffing meetings held minimum twice daily with oversight by Head of Nursing. Monthly review of Trust-wide safe staffing triangulated with quality metrics and incidents Practice Educator Facilitators in post across Wards, ITU / ED / Theatres, working alongside staff. On-site Matron at weekends. Critical Care outreach team providing additional oversight of unwell patients. Electronic observations implemented October 2020. 17 Aspirant nurses (3rd year student nurses employed in January 2021). Fully recruited to nursing assistant vacancies. Nursing staff conversion rate (i.e. interview to actually starting) is 90% across UHBW as a whole.	Develop a comprehensive recruitment and retention nursing workforce strategy for Weston.	26/11/2021	Deputy Chief Nurse (MG)	Chief Nurse	Closed	Reported to QOC in December 21 Recruitment, Retention, Wellbeing group in place since May 21. Recruitment and retention strategy in place. Individual actions being progressed through the recruitment and retention group. Evidence reviewed to support closure - copy of workforce strategy

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21-03/MEDW/1.5	Weston Medical Services Inspection (March 2021)	Req (must do)	MD1 - Ensure there is enough staff to safely care for patients at all times. MD3 - Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.	Medical workforce The Trust has continued to proactively seek mitigations for managing the Trust-wide medical workforce A standard operating procedure has been agreed and approved by the consultant body. This SOP outlines the mechanism for allocation and recording of consultant responsibility for wards / patients and the monitoring mechanism for professional standards. It also describes the process for junior doctor allocation where there is sickness or where there are vacancies. Wards have an identified named consultant responsible to the area, which is clearly identified on the Board. Weekly Wednesday afternoon 'junior doctor clinics' commenced early February 2021; where juniors are encouraged to attend to feedback and issues and concerns but also to receive information on current challenges. This supportive clinical discussion group is led by the Deputy Medical Director. Mechanism in place to gather real time feedback from junior doctors via the Trust 'Happy App' – commenced early February 2021. This should help identify and address and specific themes. End of placement surveys will continue to be conducted to provide further insight into staff wellbeing.	Undertake monthly audits of consultant documented attendance at ward/boards rounds.	01/04/2022	Deputy Medical Director (AH)	Medical Director	Complete (awaiting evidence to support)	Audit conducted monthly from April 21 - December 21. The audit focused on a) whether patients were seen within 14 hours of admission, b) whether patients were seen face to face by a consultant twice weekly as part of a ward round and c) whether the named consultant was clear in the notes and consistent on midway. Subsequent to this work, a Trust wide Internal Audit was undertaken by Audit South West. An action plan was agreed and is being taken forward by the Deputy Medical Director
21-03/MEDW/1.6	Weston Medical Services Inspection (March 2021)	Req (must do)	MD1 - Ensure there is enough staff to safely care for patients at all times. MD3 - Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.	Medical workforce Weekly Wednesday afternoon 'junior doctor clinics' commenced early February 2021; where juniors are encouraged to attend to feedback and issues and concerns but also to receive information on current challenges. This supportive clinical discussion group is led by the Deputy Medical Director. Mechanism in place to gather real time feedback from junior doctors via the Trust 'Happy App' – commenced early February 2021. This should help identify and address and specific themes. End of placement surveys will continue to be conducted to provide further insight into staff wellbeing. Current focus is on responding to concerns in real time through the Happy App. Further work required to triangulate with Datix reports of medical staff shortages or rota gaps and other concerns, feedback from rota coordinator and exception reports via GOSW.	Continue roll out/use of Happy App and establish process to triangulate with other data sources (e.g. incidents).	26/11/2021	Deputy Medical Director (AH)	Medical Director	Closed	Reported to QOC in December 21 Happy App is just one of the many tools used to better understand the workforce. Happy app continues to be a useful tool and is being rolled out. Evidence reviewed to support closure - Evidence of data reviewed and viewed in context with other sources.
21-03/MEDW/1.7	Weston Medical Services Inspection (March 2021)	Req (must do)	MD1 - Ensure there is enough staff to safely care for patients at all times. MD3 - Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.	Medical workforce Appointment made to a joint Gastro/Acute Medic post. Out to recruitment for further acute medics and care of the elderly consultants (five posts). Job plans for respiratory posts are being discussed and agreed and then out to recruit (four combined posts across both sites). This is the third cycle of recruitment for these posts.	Continued recruitment to consultant posts.	31/11/2021	Deputy Medical Director (AH)	Medical Director	Behind schedule	This work is ongoing. Weekly Recruitment meetings in place to support ongoing consultant recruitment. Currently 8 x Consultants in post (2 x locum CoE, 2 x Fixed term Acute Medicine, 1 x Substantive Stroke, 1 x Gastro, 2 x Endocrine). 1 x Agency Gastro and 1 x Agency Acute also in post. Staff Grade Stroke/Coe support in place. Staffing is at a safe levels. Significant gaps in all specialties. CoE, Resp, Acute and Gastro. Still trying to recruit into unfilled and agency gaps. There is no change in the recruitment at consultant level from November with no change in cover. All posts are still out to advert and being actively chased via the weekly recruitment meetings. Registrar tier is now at establishment (3 doctors awaiting visas via the IMG route but posts filled) Ongoing junior doctor recruitment for August with >140 applicants for 34 posts.
21-03/MEDW/1.8	Weston Medical Services Inspection (March 2021)	Req (must do)	MD1 - Ensure there is enough staff to safely care for patients at all times. MD3 - Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.	Medical workforce SDEC established; ~10 patients per day come through the process which alleviates front door pressure. Geriatric Emergency Medicine Service (GEMS) now in place and operating. Ongoing discussion with Pier Health and Sirona regarding establishing a frailty unit; this is part of Healthy Weston work..	Re-design plans will focus on: - Admission avoidance, SDEC, Frailty - Offering an Integrated Frailty Hub and joint EDC frailty posts 72 hour front door model This long term programme is part of the wider integration of services, which has been delayed by the pandemic. It is contingent on wider systems working in some places, such as outputs from 'Healthy Weston'.	01/04/2022	Deputy Medical Director (AH)	Medical Director	Complete (awaiting evidence to support)	Reported to QOC in December 21 Plans in place which links into Healthy Weston 2 and further integration realignment of services. This long term programme is part of the wider integration of services, which has been delayed by the pandemic. It is contingent on wider systems working in some places, such as outputs from 'Healthy Weston 2'. Evidence reviewed to support closure - plans and vision document and presentation for services Weston. Healthy weston communications and involvement work. <i>Prompt: Work will be ongoing but need to determine whether it is complete from the plan point of view</i>

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21-03/MEDW/1.9	Weston Medical Services Inspection (March 2021)	Req (must do)	MD1 - Ensure there is enough staff to safely care for patients at all times. MD3 - Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.	Therapy workforce In November 2020, therapy services across both sites merged. A new management structure is in place and service leads for speech and language therapy, nutrition and dietetics, occupational therapy and physiotherapy have been agreed and are also 'pathways leads' (in line with the BRI). A divisional lead therapy post has been appointed to and this role will lead the changes within the Division. Since merger the pathway leads have been reviewing staff numbers where there have been significant issues. Pathway leads are working together and are already sharing staff across both sites where needed. Speech and Language Therapy sent BRI staff to Weston to support a significant gap in January 2021. Weston staff are also spending time at the BRI site in specific pathways to start making contact and sharing good practice.	Review all the Pathways of Care that operate at BRI and Weston across Therapies. Each pathway lead will review processes in relation to referrals, documentation and datasets around performance. WTE staff numbers within pathways will be reviewed and figures compared to national guidance where available.	26/11/2021	Head of Adult Therapies	Chief Nurse	Behind schedule but significant progress made	Work has progressed as part of integration process. Recruited 8a Therapist - corporate workforce review to be undertaken <i>Awaiting update</i>
21-03/MEDW/1.10	Weston Medical Services Inspection (March 2021)	Req (must do)	MD1 - Ensure there is enough staff to safely care for patients at all times. MD3 - Ensure there is adequate cover and support for the medical workforce at all times, including out of hours to be assured a safe service can be provided to patients which is subject to audit in order to provide assurance.	Therapy workforce In November 2020, therapy services across both sites merged. A new management structure is in place and service leads for speech and language therapy, nutrition and dietetics, occupational therapy and physiotherapy have been agreed and are also 'pathways leads' (in line with the BRI). A divisional lead therapy post has been appointed to and this role will lead the changes within the Division. Since merger the pathway leads have been reviewing staff numbers where there have been significant issues. Pathway leads are working together and are already sharing staff across both sites where needed. Speech and Language Therapy sent BRI staff to Weston to support a significant gap in January 2021. Weston staff are also spending time at the BRI site in specific pathways to start making contact and sharing good practice.	Introduce a wider rotation for Band 5 & 6 staff to allow all rotational staff to rotate across both sites, this will also allow for a flexible workforce within Therapies.	26/11/2021	Head of Adult Therapies	Chief Nurse	Behind schedule but significant progress made	Work has progressed as part of integration process. Recruited 8a Therapist - corporate workforce review to be undertaken <i>Awaiting update</i>
21-03/MEDW/2	Weston Medical Services Inspection (March 2021)	Req (must do)	MD2 - Ensure all staff receive the required amount of supervision for their role to enable them to practice safely.	All junior doctors are now allocated a supervisor at the start of each post. In addition, each clinical staff group has a named educational lead. These leads are also part of the wider UHBW medical education hub and have the opportunity to meet regularly. Progress monitored through educational work based assessments and weekly educational meetings. Division of Medicine visiting on a rolling basis to review and re-design service models. Care of the Elderly consultant providing weekly educational ward and board rounds. Ongoing work as part of integration of medical services across Weston and Bristol sites. Opportunity for care of the elderly consultant clinics in Bristol to be attended by COE IMT and SpR from Weston. Joint teaching opportunities in Weston and Bristol across medicine and surgery established. Access to MDT, X-ray, meetings and grand rounds.	Agree further mutual consultant support from the BRI.	26/11/2021	Deputy Medical Director (AH)	Medical Director	Recommend to close (evidence supports completion)	3 x Consultants offering CoE support from BRI covering wards, design of new model and supervisory support. Staffing at safe levels however there is a need to fill into agency/locum gaps. Further clinical leadership has been put in place. There is a weekly to session to which all consultants are invited to discuss and agree what we need to do where there are areas of concern the following week. Most of the time it can be resolved by moving people and tweaking the cover, but if not the cover is discussed with Clinical Director, who is Bristol based, but will often also help to cover when particularly stretched. Evidence reviewed to support closure - consultant cover rotas and discussions with clinical lead
21-03/MEDW/3.1	Weston Medical Services Inspection (March 2021)	Req & Rec	MD4 - Ensure incidents are investigated without delay and demonstrate learning is shared to mitigate the risk of reoccurrence. SD4 - Consider how to improve staff reporting of incidents.	Trust policy is that every reported incident is looked at every working day by the divisional and corporate patient safety teams in addition to an expected review and management by the ward/department manager. The Datix extract provided to the CQC following their inspection of Medicine provides assurance that all incidents had been reviewed apart from four incidents reported shortly before the data extract and all the incidents with status of "under review" had immediate learning and actions documented. There is already and existing UHBW wide mechanism of sharing learning from incidents that includes Weston which is the safety bulletins and safety brief messages. There are also local safety messages, screen savers and safety huddles in place in Weston General Hospital. Assurance audits will take place to understand the effectiveness of these learning mechanisms reaching front line staff. Individual incident feedback is via their line manager either directly or at the ward daily safety brief and an email from Datix to their UHBW email. If the staff member has not activated their Datix account or does not access their UHBW email, this will not happen. How to activate Datix account was in Day 1 merger FAQ document and, for new staff, and is part of the patient safety session of corporate induction which has been delivered in Weston since April 2020. A spot check notes audit by senior nurses of a random sample of 25 patients with long admissions (21+days) across five wards identified 13 events that could have or did lead to harm for patients and should be reported as incidents. 11/13 were reported. In the March audit, the two events occurred	Audit of incident reporting will continue to take place every three months.	01/04/2022	Head of Quality & Patient Safety	Chief Nurse	Complete (awaiting evidence to support)	Audits completed and provide assurance that incidents are reported on Datix when they occur. Formalising formal report before sign off.

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21-03/MEDW/3.2	Weston Medical Services Inspection (March 2021)	Req & Rec	MD4 - Ensure incidents are investigated without delay and demonstrate learning is shared to mitigate the risk of reoccurrence. SD4 - Consider how to improve staff reporting of incidents.	Trust policy is that every reported incident is looked at every working day by the divisional and corporate patient safety teams in addition to an expected review and management by the ward/department manager. The Datix extract provided to the CQC following their inspection of Medicine provides assurance that all incidents had been reviewed apart from four incidents reported shortly before the data extract and all the incidents with status of “under review” had immediate learning and actions documented. There is already and existing UHBW wide mechanism of sharing learning from incidents that includes Weston which is the safety bulletins and safety brief messages. There are also local safety messages, screen savers and safety huddles in place in Weston General Hospital. Assurance audits will take place to understand the effectiveness of these learning mechanisms reaching front line staff. Individual incident feedback is via their line manager either directly or at the ward daily safety brief and an email from Datix to their UHBW email. If the staff member has not activated their Datix account or does not access their UHBW e mail, this will not happen. How to activate Datix account was in Day 1 merger FAQ document and, for new staff, and is part of the patient safety session of corporate induction which has been delivered in Weston since April 2020. A spot check notes audit by senior nurses of a random sample of 25 patients with long admissions (21+days) across five wards identified 13 events that could have or did lead to harm for patients and should be reported as incidents. 11/13 were reported. In the March audit, the two events occurred	Contact any member of the Division that has a responsibility for risk or incident management and that does not have a Datix account, request that they sign up for an account immediately (action agreed at Risk Management Group, list to be provided by Head of Risk Management).	26/11/2021	Divisional Director	Chief Operating Officer	Behind schedule	Awaiting update <i>Prompt:</i> Need to clarify who is leading this action as previous DD has left post.
21-03/MEDW/3.3	Weston Medical Services Inspection (March 2021)	Req & Rec	MD4 - Ensure incidents are investigated without delay and demonstrate learning is shared to mitigate the risk of reoccurrence. SD4 - Consider how to improve staff reporting of incidents.	Trust policy is that every reported incident is looked at every working day by the divisional and corporate patient safety teams in addition to an expected review and management by the ward/department manager. The Datix extract provided to the CQC following their inspection of Medicine provides assurance that all incidents had been reviewed apart from four incidents reported shortly before the data extract and all the incidents with status of “under review” had immediate learning and actions documented. There is already and existing UHBW wide mechanism of sharing learning from incidents that includes Weston which is the safety bulletins and safety brief messages. There are also local safety messages, screen savers and safety huddles in place in Weston General Hospital. Assurance audits will take place to understand the effectiveness of these learning mechanisms reaching front line staff. Individual incident feedback is via their line manager either directly or at the ward daily safety brief and an email from Datix to their UHBW email. If the staff member has not activated their Datix account or does not access their UHBW e mail, this will not happen. How to activate Datix account was in Day 1 merger FAQ document and, for new staff, and is part of the patient safety session of corporate induction which has been delivered in Weston since April 2020. A spot check notes audit by senior nurses of a random sample of 25 patients with long admissions (21+days) across five wards identified 13 events that could have or did lead to harm for patients and should be reported as incidents. 11/13 were reported. In the March audit, the two events occurred	Assurance audits of safety briefs to commence to help identify whether there is a need to improve the sharing of Trust, divisional and local safety messages arising from reported incidents.	01/12/2021	Head of Quality & Patient Safety	Chief Nurse	Behind schedule	Audit completed and reported to Patient Safety Group. <i>Awaiting update</i>
21-03/MEDW/3.4	Weston Medical Services Inspection (March 2021)	Req & Rec	MD4 - Ensure incidents are investigated without delay and demonstrate learning is shared to mitigate the risk of reoccurrence. SD4 - Consider how to improve staff reporting of incidents.	Trust policy is that every reported incident is looked at every working day by the divisional and corporate patient safety teams in addition to an expected review and management by the ward/department manager. The Datix extract provided to the CQC following their inspection of Medicine provides assurance that all incidents had been reviewed apart from four incidents reported shortly before the data extract and all the incidents with status of “under review” had immediate learning and actions documented. There is already and existing UHBW wide mechanism of sharing learning from incidents that includes Weston which is the safety bulletins and safety brief messages. There are also local safety messages, screen savers and safety huddles in place in Weston General Hospital. Assurance audits will take place to understand the effectiveness of these learning mechanisms reaching front line staff. Individual incident feedback is via their line manager either directly or at the ward daily safety brief and an email from Datix to their UHBW email. If the staff member has not activated their Datix account or does not access their UHBW e mail, this will not happen. How to activate Datix account was in Day 1 merger FAQ document and, for new staff, and is part of the patient safety session of corporate induction which has been delivered in Weston since April 2020. A spot check notes audit by senior nurses of a random sample of 25 patients with long admissions (21+days) across five wards identified 13 events that could have or did lead to harm for patients and should be reported as incidents. 11/13 were reported. In the March audit, the two events occurred	Deliver programme of patient safety updates for existing clinical staff by the end of Q3 2021/22.	26/11/2021	Head of Quality & Patient Safety	Chief Nurse	Complete (awaiting evidence to support)	Patient safety update training for all clinical staff commenced on May 2021; this includes Divisional themes from incident reporting and shared learning and actions taken in response to key risks identified from reported incidents. <i>Prompt:</i> Need to understand Weston staff attendance and further detail before recommend to close

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21-03/MEDW/3.5	Weston Medical Services Inspection (March 2021)	Req & Rec	MD4 - Ensure incidents are investigated without delay and demonstrate learning is shared to mitigate the risk of reoccurrence. SD4 - Consider how to improve staff reporting of incidents.	Trust policy is that every reported incident is looked at every working day by the divisional and corporate patient safety teams in addition to an expected review and management by the ward/department manager. The Datix extract provided to the CQC following their inspection of Medicine provides assurance that all incidents had been reviewed apart from four incidents reported shortly before the data extract and all the incidents with status of “under review” had immediate learning and actions documented. There is already and existing UHBW wide mechanism of sharing learning from incidents that includes Weston which is the safety bulletins and safety brief messages. There are also local safety messages, screen savers and safety huddles in place in Weston General Hospital. Assurance audits will take place to understand the effectiveness of these learning mechanisms reaching front line staff. Individual incident feedback is via their line manager either directly or at the ward daily safety brief and an email from Datix to their UHBW email. If the staff member has not activated their Datix account or does not access their UHBW email, this will not happen. How to activate Datix account was in Day 1 merger FAQ document and, for new staff, and is part of the patient safety session of corporate induction which has been delivered in Weston since April 2020. A spot check notes audit by senior nurses of a random sample of 25 patients with long admissions (21+days) across five wards identified 13 events that could have or did lead to harm for patients and should be reported as incidents. 11/13 were reported. In the March audit, the two events occurred	Develop an additional ‘You said, we did’ feedback system for staff in response to reported incidents to augment the existing electronic feedback from managers to reporters from Datix.	01/04/2022	Head of Quality & Patient Safety	Chief Nurse	Behind schedule	This will be considered as part of the response to the National Patient Safety Strategy. <i>Awaiting update</i> <i>Prompt:</i> <i>Timescale/detail to be established</i>
21-03/MEDW/4	Weston Medical Services Inspection (March 2021)	Req & Rec	MD6 - Ensure management of behaviours in accordance with professional standards. SD8 - Evaluate and consider the extent to which the culture of working environment is having a detrimental effect on staff and establish a plan to improve culture onwards.	The configuration of medical wards and the resulting changes to responsible doctors occurred during the Covid-19 pandemic due to urgent operational necessity to cohort in accordance with infection control. Subsequently, the ward bed base has been returning to the pre-existing configuration as the number of patients with Covid-19 has reduced. A standard operating procedure has been written, discussed and agreed with the medical consultants to explicitly describe the responsibilities both immediately after admission and whilst the patient remains an inpatient. Compliance audits will take place in Quarters 1 and 2. If there is evidence of continued noncompliance from individuals, this will be addressed under the Trust’s Disciplinary policy and Managing behaviours in accordance with ‘Maintaining High Professional Standards’ policy. The Trust is currently exploring the use of an external agency (Blue Goose) to help facilitate a programme of cultural change.	Undertake audits of SOP.	01/04/2022	Deputy Medical Director (AH)	Medical Director	Complete (awaiting evidence to support)	Audit conducted monthly from April 21 - December 21. The audit focused on a) whether patients were seen within 14 hours of admission, b) whether patients were seen face to face by a consultant twice weekly as part of a ward round and c) whether the named consultant was clear in the notes and consistent on midway. Subsequent to this work, a Trust wide Internal Audit was undertaken by Audit South West. An action plan was agreed and is being taken forward by the Deputy Medical Director.
21-03/MEDW/5.1	Weston Medical Services Inspection (March 2021)	Req (must do)	MD7 - Review the risk register to ensure all risks are recorded and given priority to match their degree of seriousness.	The risk culture in Weston was identified as immature in comparison to Bristol Divisions early on in the integration programme. Staff and managers in the division of Weston have therefore needed to adopt new ways of working and engage with the risk management process. The Divisional Management Board of the Weston Division have invested in the implementation of a monthly ‘Divisional Risk Management Group’ to oversee risk governance within the division and to ensure that all risk records are adequately described, assessed and moderated and that current and planned mitigation is recorded and having the intended effect. The Head of Risk Management attends this meeting in a supportive capacity to provide help and advice and to facilitate risk escalation to the Trusts Senior Leadership Team as appropriate. eLearning and other supporting training documentation have been shared with the Divisional Governance team in the absence of face to face training (due to Covid-19 restrictions). Template reports, process flow maps and dashboards have been provided for owners and handlers of risks.	Provision of ongoing support to Divisional management to identify improvements and to further embed and establish Trust processes and implement Divisional action plan to address gaps in compliance with the Trust’s Risk Management Policy.	26/11/2021	Head of Risk Management & Information Governance	Director of Corporate Governance	Closed	Reported to QOC in December 21 Strong relationship with the Datix and Risk Management team which continues to support the implementation of changes required within the Division. Patient Safety Lead and Clinical Chair have reviewed all risks on the Division’s risk register that are under the status “Being Assessed (Draft)”. There were >300 open at one stage, following the review there are now 31 open. support is ongoing.

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21-03/MEDW/5.2	Weston Medical Services Inspection (March 2021)	Req (must do)	MD7 - Review the risk register to ensure all risks are recorded and given priority to match their degree of seriousness.	The risk culture in Weston was identified as immature in comparison to Bristol Divisions early on in the integration programme. Staff and managers in the division of Weston have therefore needed to adopt new ways of working and engage with the risk management process. The Divisional Management Board of the Weston Division have invested in the implementation of a monthly 'Divisional Risk Management Group' to oversee risk governance within the division and to ensure that all risk records are adequately described, assessed and moderated and that current and planned mitigation is recorded and having the intended effect. The Head of Risk Management attends this meeting in a supportive capacity to provide help and advice and to facilitate risk escalation to the Trusts Senior Leadership Team as appropriate. eLearning and other supporting training documentation have been shared with the Divisional Governance team in the absence of face to face training (due to Covid-19 restrictions). Template reports, process flow maps and dashboards have been provided for owners and handlers of risks.	Formalise a rota for a 'departmental risk deep dive', which will involve speciality and departmental managers presenting risks for discussion and challenge.	26/11/2021	Head of Nursing	Director of Corporate Governance	Complete (awaiting evidence to support)	Completed and rota in place, the stand alone Specialty I Risk Meetings are in place and reporting in toto Risk Management Group which reports into Divisional Board. Review of the Departmental risks on a rolling basis in place with planned close scrutiny planned ahead of specialty integration. Evidence in the form of Governance Review Action Tracker
21-03/MEDW/5.3	Weston Medical Services Inspection (March 2021)	Req (must do)	MD7 - Review the risk register to ensure all risks are recorded and given priority to match their degree of seriousness.	The risk culture in Weston was identified as immature in comparison to Bristol Divisions early on in the integration programme. Staff and managers in the division of Weston have therefore needed to adopt new ways of working and engage with the risk management process. The Divisional Management Board of the Weston Division have invested in the implementation of a monthly 'Divisional Risk Management Group' to oversee risk governance within the division and to ensure that all risk records are adequately described, assessed and moderated and that current and planned mitigation is recorded and having the intended effect. The Head of Risk Management attends this meeting in a supportive capacity to provide help and advice and to facilitate risk escalation to the Trusts Senior Leadership Team as appropriate. eLearning and other supporting training documentation have been shared with the Divisional Governance team in the absence of face to face training (due to Covid-19 restrictions). Template reports, process flow maps and dashboards have been provided for owners and handlers of risks.	Review and agree risk management training provision/method of delivery (training provision had initially been delayed due to Covid-19-19 and related travel restrictions).	01/04/2022	Head of Risk Management & Information Governance	Chief Operating Officer	Complete (awaiting evidence to support)	Weston Division training in regards to Risk Management is as per Trust policy. There is a risk as some staff cannot access Connect where the training packages are held. This issue will be concluded once both sites are on one domain April 2022. Patient Safety Lead in Weston provides bespoke training (using trust wide template) to new speciality managers/matrons/ward sisters as required.
21-03/MEDW/6.1	Weston Medical Services Inspection (March 2021)	Req (must do)	MD8 - Ensure all information is handled in line with information governance requirements.	The Trust has an established 'Information Risk Management Group' (IRMG) that is responsible for the oversight of the information governance agenda as a mainstream discipline and as a part of daily risk management. The IRMG supports the Trust to manage information risk in accordance with the Data Security and Protection Toolkit and other applicable and appropriate practices. It is chaired by the SIRO who is the Director of Finance and Information, the Deputy Chair is the Medical Director in the role of Caldicott Guardian and its membership includes Divisional Directors and senior managers of the clinical divisions. The IRMG receives reports of all information governance related incidents, risks, complaints, details of their root cause and their associated action plans. Divisions submit focussed report to each IRMG and have an opportunity to raise any queries or concerns regarding compliance with information governance and data protection standards and legislation.	Improve Divisional attendance at IRMG; clarify who should be attending and whether a deputy can be assigned.	26/11/2021	Divisional Director	Chief Operating Officer	Complete (awaiting evidence to support)	It has been agreed that the Deputy Divisional Manager will attend IRMG in place of the Divisional Director <i>Prompt:</i> <i>Would be good to see attendance and how any information is fed back to the Division</i>

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21-03/MEDW/6.2	Weston Medical Services Inspection (March 2021)	Req (must do)	MD8 - Ensure all information is handled in line with information governance requirements.	The Trust has an established 'Information Risk Management Group' (IRMG) that is responsible for the oversight of the information governance agenda as a mainstream discipline and as a part of daily risk management. The IRMG supports the Trust to manage information risk in accordance with the Data Security and Protection Toolkit and other applicable and appropriate practices. It is chaired by the SIRO who is the Director of Finance and Information, the Deputy Chair is the Medical Director in the role of Caldicott Guardian and its membership includes Divisional Directors and senior managers of the clinical divisions. The IRMG receives reports of all information governance related incidents, risks, complaints, details of their root cause and their associated action plans. Divisions submit focussed report to each IRMG and have an opportunity to raise any queries or concerns regarding compliance with information governance and data protection standards and legislation.	Improve training compliance for Information Governance across the Weston Division: - o HR Surgery in July will focus on IG as the statutory/mandatory topic. - o Utilise the weekly HR bulletin to raise awareness	26/11/2021	Weston Triumvirate	Chief Operating Officer	Complete (awaiting evidence to support)	Evidence supplied in terms of the specified actions (HR bulletins and Surgery agenda reviewed). <i>Prompt:</i> Need to understand current training compliance and whether actions have made a difference
21-03/MEDW/6.3	Weston Medical Services Inspection (March 2021)	Req (must do)	MD8 - Ensure all information is handled in line with information governance requirements.	The Trust has an established 'Information Risk Management Group' (IRMG) that is responsible for the oversight of the information governance agenda as a mainstream discipline and as a part of daily risk management. The IRMG supports the Trust to manage information risk in accordance with the Data Security and Protection Toolkit and other applicable and appropriate practices. It is chaired by the SIRO who is the Director of Finance and Information, the Deputy Chair is the Medical Director in the role of Caldicott Guardian and its membership includes Divisional Directors and senior managers of the clinical divisions. The IRMG receives reports of all information governance related incidents, risks, complaints, details of their root cause and their associated action plans. Divisions submit focussed report to each IRMG and have an opportunity to raise any queries or concerns regarding compliance with information governance and data protection standards and legislation.	IG training will be a focus in the re-launched HR programme for specialty managers, sisters and matrons	26/11/2021	Weston Triumvirate	Chief Operating Officer	Closed	Reported to QOC in December 21 Evidence that IG training is in the HR Programme
21-03/MEDW/7	Weston Medical Services Inspection (March 2021)	Req (must do)	MD9 - Ensure laboratory results are sent to the consultant who ordered the tests.	Most medical patients are admitted through the acute medical take. The acute physicians are responsible for the admission of the patients with the patients being transferred to speciality teams as needed. Hence the acute physician receives the bulk of the laboratory tests. The SOP 'interim ward cover on medical base wards and outline wards' states that when a patient moves between wards, and hence consultant, the named consultant will also be changed on Medway to ensure laboratory test are returned to the correct consultant. Additional checks now done as part of ward rounds; consultant name is changed on system when patient transfers from acute care after 48-72 hours.	An audit will be carried out to ensure the consultant is correct on Medway as outlined in the SOP 'interim ward cover on medical base wards and outline wards'.	01/04/2022	Deputy Medical Director (AH)	Medical Director	Complete (awaiting evidence to support)	Audit conducted monthly from April 21 - December 21. The audit focused on a) whether patients were seen within 14 hours of admission, b) whether patients were seen face to face by a consultant twice weekly as part of a ward round and c) whether the named consultant was clear in the notes and consistent on medway. Subsequent to this work, a Trust wide Internal Audit was undertaken by Audit South West. An action plan was agreed and is being taken forward by the Deputy Medical Director.
21-03/MEDW/8.1	Weston Medical Services Inspection (March 2021)	Rec (should do)	SD1 - Consider how to address the perception on medical wards that there was limited senior and executive visibility, recognition, understanding and support.	The Weston Divisional leadership team has been based on site since before 1 April 2020. IPC and social distancing measures during the pandemic have reduced opportunities for engagement and face to face staff meetings. In recognition of the demands on the Divisional team, additional corporate leadership was added in January with the deployment of DMD and DCN time to WGH. Executive Directors have maintained a roster of on-site presence at WGH. Again, IPC and social distancing measures during the pandemic have reduced opportunities for large scale staff engagement, with some mitigation through regular video briefings. Regular walk rounds now in place. An appointment of a hospital Managing Director has been made. The role will provide senior operational oversight and support to Weston's leadership team. To commence in post from 1st June 2021. Also the role of Medical Director for Weston has been agreed. Forums now held every two weeks and include different days and times including evening and weekends (under review currently) . Work underway with Communication team to help make feedback and actions more visible to staff.	Continue the monthly open staff forum with the Triumvirate and the wider Weston senior leadership team; increasing frequency/changing days/time as required.	26/11/2021	Weston triumvirate	Deputy Chief Executive / Chief Operating Officer	Complete (awaiting evidence to support)	Staff forum stood down due to low attendance. Rebranding and restart face to face sessions to be planned. Joint specialties meetings being attended by senior team. Divisional Tri walk rounds and staff focused sessions in rafters being held. the Tri have time in their diaries to attend team meetings, • Posters have been placed around the Trust showing who is who of the management team • Time is scheduled for the wellbeing team to base themselves in rafters to speak to staff and highlight the support available • time is blocked out so that they can walk around the wards • all senior managers to complete listening up training. • staff stories to come to SMT on a rotational basis • wellbeing advocates being recruited for each ward. • Trust Senior Nurse / AHP Q&A sessions monthly

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21-03/MEDW/8.2	Weston Medical Services Inspection (March 2021)	Rec (should do)	SD1 - Consider how to address the perception on medical wards that there was limited senior and executive visibility, recognition, understanding and support.	The Weston Divisional leadership team has been based on site since before 1 April 2020. IPC and social distancing measures during the pandemic have reduced opportunities for engagement and face to face staff meetings. In recognition of the demands on the Divisional team, additional corporate leadership was added in January with the deployment of DMD and DCN time to WGH. Executive Directors have maintained a roster of on-site presence at WGH. Again, IPC and social distancing measures during the pandemic have reduced opportunities for large scale staff engagement, with some mitigation through regular video briefings. Regular walk rounds now in place. An appointment of a hospital Managing Director has been made. The role will provide senior operational oversight and support to Weston's leadership team. To commence in post from 1st June 2021. Also the role of Medical Director for Weston has been agreed. Forums now held every two weeks and include different days and times including evening and weekends (under review currently) . Work underway with Communication team to help make feedback and actions more visible to staff.	Develop a 'You said we did' approach to feedback staff initiatives taken in response to their feedback.	12/10/2021	Weston triumvirate	Deputy Chief Executive / Chief Operating Officer	Complete (awaiting evidence to support)	Reported to QOC in December 21 Posters all over the site, protected walk about session in all senior teams diaries to visits all areas on the hospital site. Close monitoring of Weston Superstars and linking with the administrators for ongoing engagement and communications. "you said we did" spreadsheet created and actioned. Rafter and rest areas completed following requests. Also there is a dedicated email for staff queries, concerns and recommendations.
21-03/MEDW/9.1	Weston Medical Services Inspection (March 2021)	Rec (should do)	SD2 - Develop systems so staff feel able to contribute their ideas and escalate concerns without fear of retribution.	Processes/systems are in place to enable staff to contribute ideas and raise concerns: - o Happy App - o Staff forums - o Datix/incident reporting - o Freedom to Speak Up process 50% of all UHBW FTSU feedback is from Weston so process is known and used) - o Trainee end of placement feedback The use of these methods has developed over the last year and will continue to do so.	Improve roll out and uptake of Happy App; raise awareness through HR bulletins and other established methods.	01/12/2021	Weston triumvirate	Director of Corporate Governance	Closed	Reported to QOC in December 21 HR bulletins evidenced
21-03/MEDW/9.2	Weston Medical Services Inspection (March 2021)	Rec (should do)	SD2 - Develop systems so staff feel able to contribute their ideas and escalate concerns without fear of retribution.	Processes/systems are in place to enable staff to contribute ideas and raise concerns: - o Happy App - o Staff forums - o Datix/incident reporting - o Freedom to Speak Up process 50% of all UHBW FTSU feedback is from Weston so process is known and used) - o Trainee end of placement feedback The use of these methods has developed over the last year and will continue to do so.	Set up email inboxes for ideas and concerns - Email ideas. Weston@Concerns. Weston@	01/12/2021	Weston triumvirate	Director of Corporate Governance	Complete (awaiting evidence to support)	Reported to QOC in December 21 Email address created and used widely <i>Prompt:</i> <i>Can we evidence how well used?</i>
21-03/MEDW/10.1	Weston Medical Services Inspection (March 2021)	Rec (should do)	SD3 - Improve communications channels so staff are fully aware of the hospital and department's vision, or changes to the service.	Communication channels in place to allow information sharing o Screensavers, Staff forums, Facebook group, HR Bulletins (weekly), HR Surgery/s, Newsbeat, Weston Intranet. These will continue to be used and adapted. Chair's briefing and HMAc now in place. Forums now held every two weeks and include different days and times including evening and weekends (under review currently) . Work underway with Communication team to help make feedback and actions more visible to staff.	Re-establish monthly Hospital Medical Advisory Committee to include updates from Medical Director, Deputy Medical Director and Clinical Chair to consultant body.	26/11/2021	Deputy Medical Director (AH)	Medical Director	Complete (awaiting evidence to support)	HMAc in place where all consultants invited, Medical Consultants Forum to be re-established by Jim Portal. Dates to be confirmed
21-03/MEDW/10.2	Weston Medical Services Inspection (March 2021)	Rec (should do)	SD3 - Improve communications channels so staff are fully aware of the hospital and department's vision, or changes to the service.	Communication channels in place to allow information sharing o Screensavers, Staff forums, Facebook group, HR Bulletins (weekly), HR Surgery/s, Newsbeat, Weston Intranet. These will continue to be used and adapted. Chair's briefing and HMAc now in place. Forums now held every two weeks and include different days and times including evening and weekends (under review currently) . Work underway with Communication team to help make feedback and actions more visible to staff.	Continue the monthly open staff forum with the Triumvirate and the wider Weston senior leadership team; increasing frequency/changing days/time as required and according to staff feedback.	01/12/2021	Weston triumvirate	Chief Operating Officer	Complete (awaiting evidence to support)	Staff forum stood down due to low attendance. Rebranding and restart face to face sessions to be planned. Joint specialties meetings being attended by senior team. Divisional Tri walk arounds and staff focused sessions in rafters being held. the Tri have time in their diaries to attend team meetings, • Posters have been placed around the Trust showing who is who of the management team • Time is scheduled for the wellbeing team to base themselves in rafters to speak to staff and highlight the support available • time is blocked out so that they can walk around the wards • all senior managers to complete listening up training. • staff stories to come to SMT on a rotational basis • wellbeing advocates being recruited for each ward. • Trust Senior Nurse / AHP Q&A sessions monthly

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21-03/MEDW/11	Weston Medical Services Inspection (March 2021)	Rec (should do)	SD7 - Provide support to staff so they can merge their emails and use one system.	WAHT originally subscribed to the NHS Mail service, a single system used across many other subscriber organizations within the NHS. In common with many larger Trusts that wanted to maintain direct control over email services, UH Bristol maintained its own Microsoft Exchange-based email system. The lack of 'peer-level' security has been a barrier to unrestricted direct communication between Exchange and NHS Mail. UHBW has now migrated its Exchange email service from being locally hosted to a cloud-based service within Microsoft's secure boundary. Having completed this migration, which involved over 14,000 accounts, the Trust has applied for certification by NHS Digital as having peer-level security with NHS Mail. It is hoped that this process will be completed by the end of August '21 and from that point on there will be no further reason for any UHBW staff to continue use of NHS Mail (secure transfer of patient information has been a barrier) Staff will then be encouraged to adopt the use only of UHBW's Exchange service and migrate any content required from their NHS mail account.	Agree certification by NHS Digital as having peer-level security with NHS Mail.		Chief Information Officer	Director of Finance & Information	Closed	Reported to QOC in December 21 Single email launched and completed
21-06/MEDW/1.1	Weston Medical Services Inspection (June 2021)	Req (Must do)	Ensure that there are enough numbers of nursing staff, with the right skills to meet patients' needs at all times.	Leadership and flow meeting daily, attended by all wards, ED, duty matron and ops matron in post, Rostering KPIs reviewed, Vacant shifts escalated daily, Ongoing recruitment plans to support	Establish specialty pathways to help ensure that patients go to the correct wards. This will be completed once Healthy Weston 2 outcomes are established.	Ongoing	Head of Nursing	Chief Nurse	Complete (awaiting evidence to support)	Currently all patients are being managed through Leadership and Flow meeting. All Patients are allocated and treated with the correct number of nursing staff based on acuity.
21-06/MEDW/1.2	Weston Medical Services Inspection (June 2021)	Req (Must do)			Create a Divisional Training Needs Analysis, to understand the gaps in educational requirements.	01/04/2022	Divisional Triumvirate	Chief Nurse	Complete (awaiting evidence to support)	Deputy Head of nursing created training training needs of staff, which was reviewed in April when new educational budget is available to ensure that the nursing workforce has adequate skills to support safe and effective patient care. Outcome of review is that there are gaps within learning in end of life and deteriorating patient training. <i>Prompt: What are we doing to address gaps identified</i>
21-06/MEDW/2	Weston Medical Services Inspection (June 2021)	Req (Must do)	Ensure there is always adequate cover and support for the medical workforce, including out of hours. To develop and implement an audit in order to provide assurance.		Recruitment to Medical staff vacancies	30/03/2022	Clinical Chair	Medical Director	Complete (awaiting evidence to support)	Daily and weekly staffing huddles and CQC submissions in place and ongoing. Dr rota's reviewed daily.
21-06/MEDW/3	Weston Medical Services Inspection (June 2021)	Req (Must do)	Ensure the management of consultant behaviours is in accordance with professional standards and that patients are seen by the appropriate consultant within 24 hours of admission.	SOP in place. Electronic board round, figures Significant delays reported through Datix	Amend current audit to capture 24 hrs consultant review information	01/02/2022	Clinical Chair	Medical Director	Recommend to close (evidence supports completion)	Audit amended to capture the required information (submitted to CQC as part of weekly assurance reporting. Evidence reviewed to support closure - Audit tool and data submissions
21-06/MEDW/4	Weston Medical Services Inspection (June 2021)	Req (Must do)	Ensure that areas used by patients are suitably risk assessed and have the right environment and equipment to meet patient's needs. This includes the escalation areas, discharge lounge and waterside unit.	GEMS and Discharge Lounge no longer used as escalation area. Waterside now operating as adult inpatient covid ward. RNS in MDU help out DL	Review and update escalation SOP	01/01/2022	Deputy Head of Nursing	Chief Nurse	Complete (awaiting evidence to support)	SOP writtenand ratified. This includes use of Pharmacy trolley.
21-06/MEDW/5	Weston Medical Services Inspection (June 2021)	Req (Must do)	Ensure the management of outlier patients are safe and ensure appropriate medical oversight.	Rota coordinator assigns staff to Leadership and flow meeting to help get patents to right area. Outlier SOP in place and continuous audit underway. Weekly huddles with consultants in place to ensure adequate cover is maintained at all times.	Review the Outlier SOP	01/02/2022	Clinical Chair	Medical Director	Complete (awaiting evidence to support)	Outlier SOP reviewed. CareFlow Connect and Workspace now live which gives further visibility to active consultant and ability to change consultant. Evidence in consultant ward cover weekday/rota email. This goes out to all consultants and Jrs daily.
21-06/MEDW/6	Weston Medical Services Inspection (June 2021)	Req (Must do)	Ensure that venous thromboembolism (VTE) risk assessments are completed and recorded according to trust policy and appropriate prescribing of medicines or compression is in place.		Move to electronic VTE Risk Assessment in line with other Divisions.	01/12/2021	Clinical Chair	Chief Nurse	Closed	Reported to QOC in December 21 November 21 the switch from paper to electronic assessments has been made for the Weston Division using CareFlow Workspace.
21-06/MEDW/7.1	Weston Medical Services Inspection (June 2021)	Req (Must do)	Substances hazardous to health must be stored securely.	SOP in place	Implementation of a Health and Safety Inspection Log and Quarterly spot check audits to be undertaken.	31/03/2022	Head of Nursing	Chief Nurse	Complete (awaiting evidence to support)	Inspection template available for use. Plan to roll out in the Weston division from Jan 22 but awaiting confirmation that this has been done <i>Prompt: Need audit results</i>
21-06/MEDW/7.2	Weston Medical Services Inspection (June 2021)	Req (Must do)			Circulate SOP and posters to be shared with ward and department managers and managed through divisional governance.	31/03/2022	Head of Nursing	Chief Nurse	Behind schedule	<i>Awaiting update</i>
21-06/MEDW/8.1	Weston Medical Services Inspection (June 2021)	Req (Must do)	Ensure incidents are investigated without delay and appropriate action and learning is shared to mitigate the risk of reoccurrence.	Patient Safety reporting framework. Reported in meetings. Tuesday sit rep meetings	Create a Patient Safety Action SITREP Log to support traction of incidents	01/12/2022	Head of Nursing	Chief Nurse	Complete (awaiting evidence to support)	Commenced for use on the 7th December 21. HON, DHON, Clinical Chair and Patient Safety Team present at weekly meetings. Actions assigned.
21-06/MEDW/8.2	Weston Medical Services Inspection (June 2021)	Req (Must do)			Implement the use of LASER for learning	01/12/2022	Head of Nursing	Chief Nurse	Complete (awaiting evidence to support)	Patient safety teams ensuring that all RCAs have an action for the author to complete a LASER and to be shared with Division
21-06/MEDW/9	Weston Medical Services Inspection (June 2021)	Req (Must do)	Ensure that for patients lacking capacity to make their own decisions a capacity assessment has been completed to provide a clear audit trail of decisions made.	MCA Policy and Mental Capacity Assessment Flowchart	Undertake an audit to establish compliance	01/04/2022	Head of Nursing	Chief Nurse	Behind schedule	Awaiting update
21-06/MEDW/10.1	Weston Medical Services Inspection (June 2021)	Req (Must do)	Ensure governance systems work effectively to support leaders to make sustainable proactive improvements.		Act on findings/ recommendations from internal governance review	30/07/2022	Head of Nursing	Chief Nurse	On track	Audit reported and management response/action plan agreed. Further work to be supported by Heads of Quality as necessary
21-06/MEDW/10.2	Weston Medical Services Inspection (June 2021)	Req (Must do)			Review and update Terms of Reference for main Divisional Quality and Safety Group (and sub groups)	01/12/2021	Head of Nursing	Chief Nurse	Recommend to close (evidence supports completion)	All TORs have been completed and signed off for use. Evidence reviewed to support closure - Divisional Quality and Safety Board and Sub Group TOR

21-06/MEDW/11	Weston Medical Services Inspection (June 2021)	Req (Must do)	Ensure that medical staff attend mandatory training to achieve the trust compliance level.		Establish a monthly KPI Review meeting to report on any exceptions around rostering KPI, Essential training and financial spend.	30/01/2022	Deputy Head of Nursing	Chief Nurse	Complete (awaiting evidence to support)	KPIs are reported monthly Divisional Board, Minutes and agends supplied as evidence <i>Prompt: Need to determine whether there was a separate group established other than Board</i>
21-06/MEDW/12	Weston Medical Services Inspection (June 2021)	Rec (Should do)	Ensure that checks to ensure patients have the correct medicines (medicines reconciliation) follow national best practice.	The pharmacy team currently follow a medicines reconciliation process that follows best practice. In order to increase our responsiveness to meet national KPI standards, extra pharmacists and pharmacy technicians have been recruited to fill this requirement.	Alignment of Weston and Bristol policies to ensure consistency of approach between Sites.	01/04/2022	Pharmacy Lead/Dir. of Pharmacy	Medical Director	Complete (awaiting evidence to support)	Alignment of main policies and procedures complete <i>Prompt: Are there any that are outstanding</i>
21-06/MEDW/13	Weston Medical Services Inspection (June 2021)	Rec (Should do)	Ensure that checks to ensure patients have the correct medicines (medicines reconciliation) follow national best practice.	The pharmacy team currently follow a medicines reconciliation process that follows best practice. In order to increase our responsiveness to meet national KPI standards, extra pharmacists and pharmacy technicians have been recruited to fill this requirement.	Electronic recording of KPI national standards need to be merged across both sites.	02/04/2022	Pharmacy Lead/Dir. of Pharmacy	Medical Director	Behind schedule	Awaiting update
21-06/MEDW/14	Weston Medical Services Inspection (June 2021)	Rec (Should do)	Ensure that patients who may lack mental capacity to make decisions about their medicines are supported to receive medicines in their best interest.	Covert medicines policy	Review of policy to ensure it's in alignment with Bristol.	30/01/2022	Head of Nursing	Chief Nurse	Closed	Reported to QOC in December 21 Trust wide usage of Covert Medicines Policy in place following review in Sept 21.
21-06/MEDW/15	Weston Medical Services Inspection (June 2021)	Rec (Should do)	Ensure that medicines storage areas are only accessible to authorised staff and are within an appropriate temperature range.	Works orders are in place to ensure medicines storage areas are only accessible to authorised staff. The temperature ranges of fridges are currently monitored as per Medicines Policy.	Ambient temperature is currently not being routinely monitored in clinic areas – systems to aid this needs to be implemented across the site	01/07/2022	Pharmacy Lead/Dir. of Pharmacy	Medical Director	Behind schedule	Awaiting update
21-06/MEDW/16	Weston Medical Services Inspection (June 2021)	Rec (Should do)	Consider how electronic records could be made less visible when not in use.		Further communication via management to remind staff of the importance of IG compliance	31/01/2022	Divisional Triumvirate	Weston Managing Director	Behind schedule	Awaiting update
21-06/MEDW/17	Weston Medical Services Inspection (June 2021)	Rec (Should do)	Consider the suitability of moving patients late at night.	Link to hospital at night work currently underway	Create an SOP to support the safe movement of patients at night	01/04/2022	Divisional Triumvirate	Weston Managing Director	Behind schedule	Awaiting update

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Outpatients (Weston)

ID	Source/Event (e.g. name of inspection)	Requirement or recommendation?	Details of requirement / recommendation	Current assurance / mitigation of risk	Actions to address gaps	Target date for completion	Lead	Exec	Status	Evidence / update provided (May 2022)
21-06/OUTW/1	Weston Outpatients inspection June 2021	Req (Must do)	The trust must ensure referral to treatment time performance is in line with national standards. Not all referral to treatment times were meeting national standards (Regulation 9 (1) Person-centred care.	Consistent waiting list validation processes are in place.	Use of accelerator funding to create waiting initiative lists/clinics to reduce waiting lists where appropriate.	30/04/2022	Deputy Divisional Manager	Weston Managing Director	Behind schedule	Contact has been made with 17 insourcing providers to instigate an agreement for diagnostic imaging - approx. 50% were unable to provide a service; awaiting a response from the other 50% (April 22). Update awaited
21-06/OUTW/2	Weston Outpatients inspection June 2021	Rec (Should do)	The trust should consider how data about medical staffing is collated to be able to easily provide information about the number of medical staff working in the service, the vacancy or turnover rates, sickness rates, and the level of bank and locum staff.		All medical staffing will be moved to Allocate, so all data will be pulled in the same way as we currently do with Nursing staff.	31/03/2022	Deputy Divisional Manager	Weston Managing Director	Behind schedule	Allocated implemented but no further information provided. Update awaited

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Meeting of the Board of Directors in Public on Friday 27th May 2022

Report Title	Ockenden v2 (March 2022) – Initial Review Findings
Report Author	Jessica Whitton, Deputy Divisional Director Emma Grzyb-Yung, CDS (delivery suite) Matron Ingrid Henderson, Patient Safety Lead, Women's Services
Executive Lead	Deirdre Fowler, Chief Nurse, and Midwife

1. Report Summary

In 2017, Donna Ockenden was asked to review Maternity Services in the Shrewsbury and Telford Hospitals Trust by the Secretary of State. The inquiry covered incidents relating to neonatal and maternal deaths and poor outcomes in the service between 2000 and 2019.

The first Ockenden report was published in December 2020 and included seven Immediate and Essential Actions (IEA). An amount of national money was made available to Trusts to support implementation of the immediate actions, and UHBW received recurrent funding (£97,923) to support recruitment of three additional midwives specifically to enable the Trust to meet the staffing levels recommended by 'Birthrate Plus', the midwifery workforce assessment tool. Additional requests for funding to support the introduction of consultant ward rounds with the incoming night-team and additional fetal monitoring midwifery lead time was not supported/funded at that time. Within the BNSSG Local Maternity System (LMS), North Bristol Trust received additional funding to reflect its lower level of midwifery establishment. Further changes were made to strengthen the governance structure within the BNSSG LMS, and to improve the visibility of, and regularity of reporting on maternity services to the Trust Boards of NBT and UHBW. A multidisciplinary quarterly perinatal quality surveillance group was established by the LMS to improve reporting, shared learning and transparency across both Trusts. This group includes representation from the Maternity Voices Partnership (MVP) and a non-executive director (NED) from both NBT and UHBW.

UHBW were compliant with 10 of the 12 clinical priorities in the Ockenden 1 report reported to Trust Board on March 31st 2022 and partially compliant with 2 .

The full, second Ockenden report was published at the end of March 2022 and builds significantly on the summary of the first report. The final full report identifies 15 themes and a series of further recommendations, including 66 for provider Trusts. The themes identified are:

- Workforce planning and sustainability
- Safe staffing
- Escalation and accountability
- Clinical governance – leadership
- Clinical governance – incident investigation and complaints
- Learning from maternal deaths
- Multidisciplinary training
- Complex antenatal care
- Pre-term birth
- Labour and birth

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We are
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respectful
innovative
collaborative.
We are UHBW.

- Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday, with reference to guidance such as the National Bereavement Care Pathway
- Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU
- Neonatal providers must ensure enough appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit

For a number of these requirements, action is already underway, but there are several that will require new project work, and/or investment, to realise. This will be managed at Trust and LMS level, with support of the Southwest Neonatal Operational Delivery Network (ODN) and Health Education England (HEE). Further support will be provided by a regional task and finish group. A LMS task and finish group was set up to support the implementation of the draft Ockenden report, which meets monthly, and will be extended to support the actions raised in the final report.

Regional visits by NHSEI (NHS England and NHS Improvement) will take place in late May/early June 2022, to review the performance of providers and commissioners against the requirements, and to reflect on the report and actions that need to be taken.

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

The full Ockenden Report has been reviewed by the UHBW maternity and neonatal services to assess the current situation and any gaps for investment/development. There are areas where the Trust will need to develop action plans to change systems or reporting structures or where investment will be required in systems and/or staff. There is likely to be national money available to support this, but it cannot be guaranteed that sufficient funding will be allocated to UHBW to meet the requirements identified.

A regional structure is being established to support prioritisation and completion of actions.

Action plans will be managed collaboratively within the BNSSG LMS, with support of HEE (Health Education England and the SW Neonatal ODN).

An internal governance structure is in place to ensure regular and timely reporting of the Trust's position to the Division of Women's & Children's Services, the Trust Executive, and to the Trust Board.

The current status of the 92 questions that form the Ockenden 2 review is:

- Green (complete) - 43
- Amber (in progress) - 32
- Red (to be started) - 5
- White – action required by national team - 12

3. Risks

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

The risks associated with this report include:(These risks have not yet been formally assessed but will need to be in due course) The risks associated with the review process that is underway are that: • Embedded systems and processes may need to change, which will involve the need for IM&T and Business Intelligence (BI) support • There may need to be investment in additional midwifery, neonatal and obstetric staffing • There will be a need to purchase a centralised CTG monitoring system for St Michael’s Hospital which integrates fully with the new maternity data system (which is in the process of being procured city wide) and with the additional infrastructure required to enable integration within the Central Delivery Suite • Review of clinical pathways as recommended may result in identification of further actions to be taken • The relatively good position of the services provided by UHBW in respect of recruitment, retention, and service provision may result in national funding being prioritised for other less secure maternity and neonatal systems	
4. Advice and Recommendations <i>(Support and Board/Committee decisions requested):</i>	
• This report is for Assurance.	
5. History of the paper Please include details of where paper has <u>previously</u> been received.	
Women’s governance	16/5/22
Women and Children’s Quality Assurance Committee	20/05/2022

Meeting of the Board of Directors in Public on Friday 27th May 2022

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

1. Report Summary

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

2. Key points to note (Including decisions taken)

Perinatal Quality Surveillance Matrix (PQSM)/MIS compliance

Continued implementation towards full compliance with MIS safety standards year 4 continue. MIS reinstated submission date moved to 5th Jan 2023.

Strengths: implementation of Continuity of Carer (CoC) presently 48%, with BAME at 63.6% and IMD 1(most deprived) at 78%. As part of our continual risk assessment four CoC teams continue to run, two teams have been paused until staff have been recruited to fill newly vacant posts. Ockenden report has suggested the continual roll out of CoC should be suspended if safety cannot be assured with regards to staffing. UHBW have risk assessed and can continue with 4 teams.

UHBW maternity services are achieving 10 out of 11 MSDS (Maternity data Safety Standards quality metrics. Personalised care and support plan use is unable to be recorded due to insufficient numbers in the data set. The personalised care plans are being revised by the LMS (Local Maternity System) as they are deemed not fit for purpose, as women/midwives are not using the tool as intended.

Challenge: The perinatal mortality review tool (PMRT) during MIS suspension- the patient safety team continued to review all cases within timescale and engage with families. However, the team did not maintain completion of reports as allowed from MIS during the suspension. There is a plan to be 100% compliant by the end of the reporting period.

UHBW is not compliant with the 90% target for all staff groups to have completed Obstetric emergency and fetal monitoring training annually. Extra sessions are being scheduled. All midwives are booked on sessions and will be compliant at the end of the reporting period. There is a plan for all new doctors to do training when they start the new rotation in August.

SBLCBv2 (Saving babies lives version 2). It has been a challenge to complete all the audits required due to capacity constraints in the Quality and Patient Safety Team. New team members are now recruited and there is a plan to reinstate audits by the end of June. .

A risk associated with a potential failure of MIS clinical negligence scheme for trusts (CNST) is the IT connectivity issues and capacity constraints within the community midwifery teams. The Trust I M and T team are helping to resolve this issue MIS allows for manual audit but expects data to be entered electronically

Improvement work

The fetal monitoring week, on the 28th of March, to raise awareness with staff involved with interpreting cardiotocographs (CTGs) was very well attended and received great feedback from staff

The LMS has funded 1.2 wte bereavement midwives and the recruitment of these posts is in progress. There is also funding for an administrative post and consultant lead.

Following release of the 2021 National Maternity Survey the UHBW results **were worse** than most trusts for 3 questions, which relate to care at home and were **somewhat worse** than most trusts for 2 questions relating to women being involved in decision making about their care and information given about mental health after having a baby. In response to this, a MDT (multi-disciplinary team) meeting was held and an action plan drafted to develop and make improvements. From this a monthly 'women's experience group' has been re-instated with MVP (maternity voices partnership) representation to take and monitor actions and improvements. North Bristol NHS Trust (NBT) have been asked to join the group due to the crossover of the services and women giving birth at UHBW but being cared for by NBT community midwives and vice versa.

Following a recent Neonatal GIRFT (Getting It Right First Time) review, a plan is being developed to review all under 27-week premature babies, whose admission to St. Michaels was declined in utero. This is to review reasons why the mothers did not give birth at St. Michaels and whether it was CDS (central delivery suite) and /or NICU capacity constraints. UHBW NICU is an outlier for refusals of babies with extreme prematurity which impacts on babies not being born in the right place. The plan will include how we record these requests for admission.

There will also be a review of all extreme premature births who require advance resuscitation as UHBW NICU is an outlier for resuscitation events where the baby has required adrenaline and cardiac massage.

ATAIN (Avoiding term admission to the neonatal unit) Q3 audit: 52% of all term admissions had a primary cause aligned to ATAIN themes. Actions from the reviews were

- Review of o2 saturation monitors on CDS (availability)
- Production of neonatal encephalopathy guideline (support of babies staying on Transitional care for observations to reduce NICU admission)

Learning from incidents: There was one incident reported in March as moderate harm or above. The learning from this incident is that the risk form at booking has been updated to be easier for administrative staff to see the referrals that are required to specific consultant specialist clinics.

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

1. Staffing- the number of staff that have been off with covid and the challenges to ensure staff replaced.
2. Transitional Care- Identification of the need for extra equipment e.g., a second resuscitaire and pulse oximeter monitors
3. Pressure to admit babies on the transitional care ward at the limit of the transitional care criteria.
4. Post-natal and ante natal ward refurbishment

Escalation:

- Lack of appropriate capacity to manage the current and increasing number of planned ("elective") caesarean sections
- Sporadic capacity issues with the flow of inductions (to match increasing demand)
- Ongoing lack of appropriate antenatal scan capacity to manage implementation of some specific scan pathways for large or small for gestational age (LGA/SGA) babies in line with RCOG guidance, due to difficulties with recruitment and retention of sonographers
- Ockenden safety action recommends two MDT consultant led ward rounds on CDS day and night. Presently the Consultant undertakes two ward rounds during the day, but the Consultant is not present at the ward round at night. A regional bid for funding (Ockenden funding) was unsuccessful. Alternative rostering arrangements being reviewed.
- GIRFT (Getting it right first time) review highlighted the need to recruit to medical and neonatal nursing NICU establishment. NICU do not meet BAPM (British Association of Perinatal Medicine) standards for staffing or neonatal nurses qualified in speciality (QIS). Funding obtained and plan in progress to recruit 15.3 wte Band 5 Nurses and 6, Band 6 nurses. Ten nurses undertaking QIS training.
- Birthrate Plus (midwifery workforce assessment tool) review has been undertaken and the draft results will be discussed with the Birthrate Plus team on the 7th of June to confirm any deficit of midwifery numbers.

Areas of excellence

UHBW midwifery, neonatal and obstetric teams have and continue to show remarkable resilience during these testing Covid times. Staff have shown exemplary teamwork and professionalism, being flexible to ensure safety of services during staffing absence, with often last-minute changes to working patterns. Services maintained throughout pandemic. The value of our proactive practice educational facilitators (PEFs) has proven immensely successful in supporting rotational midwives and new starters and junior staff, ultimately this will reduce turnover at a time when every member of staff counts.

Excellent engagement with the executive team. In response to Ockenden two, the Trust Chair and non-executive directors visited St Michaels site on the 10th May and were shown around the unit and were able to speak with front line staff. This gave them an opportunity to be made aware of our successes and challenges. The Regional Maternity team are visiting St Michael's and Weston General Hospital to undertake an Ockenden Insight visit at the end of May.

3. Risks

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

The risks associated with this report include

1. **3343 - delayed elective LSCS (Lower Segment Caesarean Section)**
2. **2264 - delayed induction of labour**

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

4. Advice and Recommendations

(Support and Board/Committee decisions requested):

- This report is for **Assurance**.

5. History of the paper

Please include details of where paper has previously been received.

Women's governance group	16/05/2022
Quality Assurance Committee	20/05/2022

	Jan	Feb-21
Activity		
Number of babies born alive at ≥ 22 to 36+6 weeks gestation	29	33
Number of women who gave births all gestations from 22+0 weeks	397	396
Induction of Labour rate %	32.9%	29.8%
Unassisted Birth rate %	48.4%	46.9%
Assisted Birth rate %	17.7%	18.1%
Caesarean Section rate (overall) %	33.9%	35.0%
Elective Caesarean Section rate %	14.7%	15.6%
Emergency Caesarean Section rate %	19.2%	19.4%
Perinatal Morbidity and Mortality inborn		
Total number of perinatal deaths	2	4
Number of late fetal losses 22+0 to 23+6 weeks excl TOP	0	0
Number of stillbirths (≥ 24 weeks excl TOP)	0	3
Number of neonatal deaths : 0-6 Days	0	1
Number of neonatal deaths : 7-28 Days	2	0
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (HSIB)	1	0
Maternal Morbidity and Mortality		
Number of maternal deaths (MBRRACE)	1	0
Number of women who recieved level 3 care	0	0
Insight		
Number of datix incidents graded as moderate or above (total)	1	1
Datix incident moderate harm (not SI)	0	0
Datix incident SI (excl HSIB)	1	1
New HSIB SI referrals accepted	1	0
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0

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<u>Coroner Reg 28 made directly to Trust</u>	0	0
<u>Workforce</u>		
<u>Minimum safe staffing in maternity services: Obstetric cover (Resident Hours) on the delivery suite</u>	76	76
<u>Minimum safe staffing in maternity services: Obstetric middle grade rota gaps(SR 9WTE)</u>	0	0
<u>Minimum safe staffing in maternity services: Obstetric Consultant rota gaps</u>	0	0
<u>Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)</u>	0	0
<u>Minimum safe staffing in maternity services: neonatal medical workforce (rota gaps) tier 1.</u>	0	0
<u>Minimum safe staffing in maternity services: neonatal medical workforce (rota gaps) tier 2. (0.9 WTE)</u>		
<u>Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled bank shifts).</u>		
<u>Vacancy rate for midwives</u>		
<u>Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained) BAPM standard is 70%</u>		
<u>Vacancy rate for NICU nurses</u>		
<u>Datix related to workforce (service provision/staffing)</u>	4	2
<u>MDT ward rounds on CDS (minimum 2 per 24 hours)</u>	100%	100%
<u>One to one care in labour (as a percentage)</u>	100	100%
<u>Number of times maternity unit attempted to divert or on divert attempted baby abduction</u>	0	3
	0	0
<u>Involvement</u>		
<u>Service User feedback: Number of Compliments (formal)</u>	10	20
<u>Service User feedback: Number of Complaints (formal)</u>	3	4
<u>Staff feedback from frontline champions and walk-about (number of themes)</u>	5	7
<u>Improvement</u>		
<u>Progress in achievement of CNST /10</u>	6	6
<u>Training compliance in maternity emergencies and multi-professional training (PROMPT)</u>	94%	94%
<u>Training compliance fetal wellbeing day</u>		
<u>training compliance core competency 4. personalised care</u>	n/a	n/a

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	Continuity of Carer (overall percentage)	36%	36%

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Perinatal quality surveillance matrix

Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
24	27	37	31	38	24	44	29
407	410	429	415	466	429	429	449
37.2%	33.7%	30.7%	30.6%	26.6%	27.8%	26.8%	26.6%
51.9%	53.5%	49.0%	51.2%	46.7%	46.9%	49.2%	45.0%
16.2%	15.9%	15.6%	14.8%	15.2%	20.5%	14.5%	17.5%
31.9%	30.6%	35.5%	34.0%	38.1%	32.6%	36.3%	37.6%
15.5%	13.3%	14.0%	15.8%	13.9%	14.9%	14.3%	12.2%
16.4%	17.3%	21.5%	18.2%	24.0%	17.7%	21.7%	25.3%
1	1	6	0	2	1	1	4
0	0	0	0	0	0	0	1
0	0	2	2	1	0	1	2
0	0	1	0	1	1	0	0
1	1	3	0	0	0	0	1
0	0	2	0	0	0	0	1
0	1	0	0	0	0	0	0
1	2	1	0	1	1	1	1
2	1	4	1	3	0	2	2
1	0	0	0	0	0	1	1
1	1	1	1	0	0	1	1
0	1	2	0	1	0	0	0
0	0	0	0	0	0	0	0

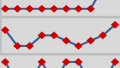
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0	0	0	0	0	0	0	0
76	76	76	76	76	76	76	76
0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0
							7
			0				
10	6	7	14	28	15	26	19
100%	100	100	100	100	100%	100%	100%
100%	100	100	100	100	100%	100%	100%
1	1	2	0	2	2	1	1
0	0	0	0	0	0	0	0
12	30	40	36	36	31	5	23
3	5	0	6	6	7	7	4
5	1	4	4	7	4	4	4
7	10	10	9	9	8	8	7
92%	92%	97%	94%	94%	90%	80%	80%
							72.2%
n/a	61%		54%	56%	63.8%	64%	64.7%

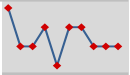
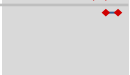
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36%	38%	45.9%	46%	44.4%	48.3%	47%	40%

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Nov-21	Dec-21	Year to date average	Trend
26	22	30	
432	419	423	
24.4%	31.0%	29.8%	
45.4%	45.3%	48.3%	
16.9%	12.4%	16.3%	
37.7%	42.3%	35.5%	
15.3%	17.4%	14.7%	
22.4%	24.9%	20.7%	
11	6		
1	0		
4	4		
1	1		
5	1		
0	0		
0	0		
2	0		
2	1		
1	0		
1	0		
0	1		
0	0		

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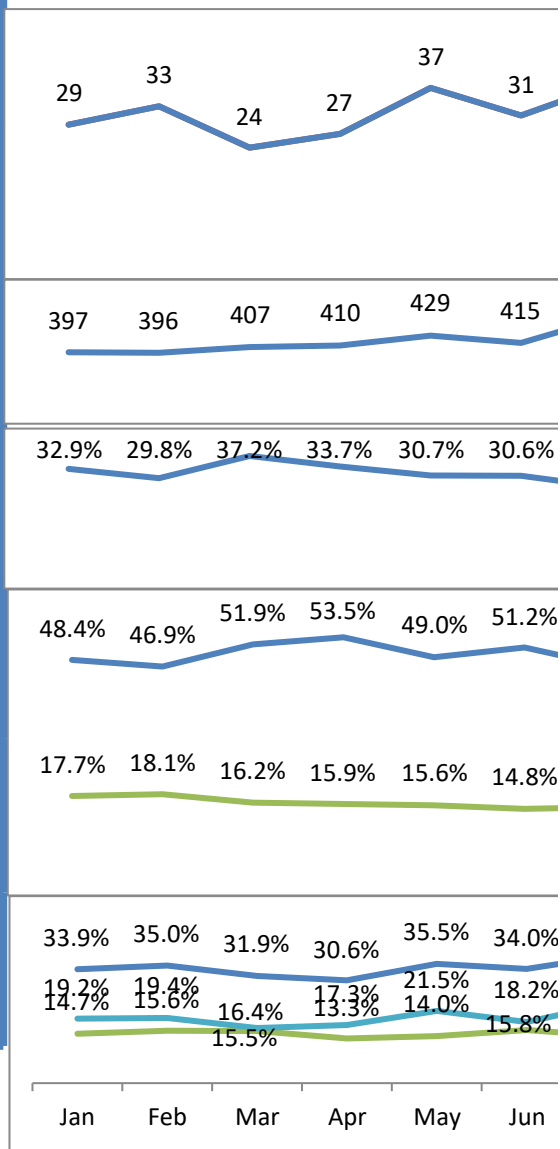
0	0	
76	76	
7.7WTE	7.7WTE	
0	0	
0	0	
0	0	
0.6WTE	0.6WTE	
3	7	
53%	53%	
13	18	
100%	100	
100%	100	
1	0	
0	0	
24	19	
8	6	
3	4	
7	7	
90%	79.6%	
72%	77%	
60%	64%	

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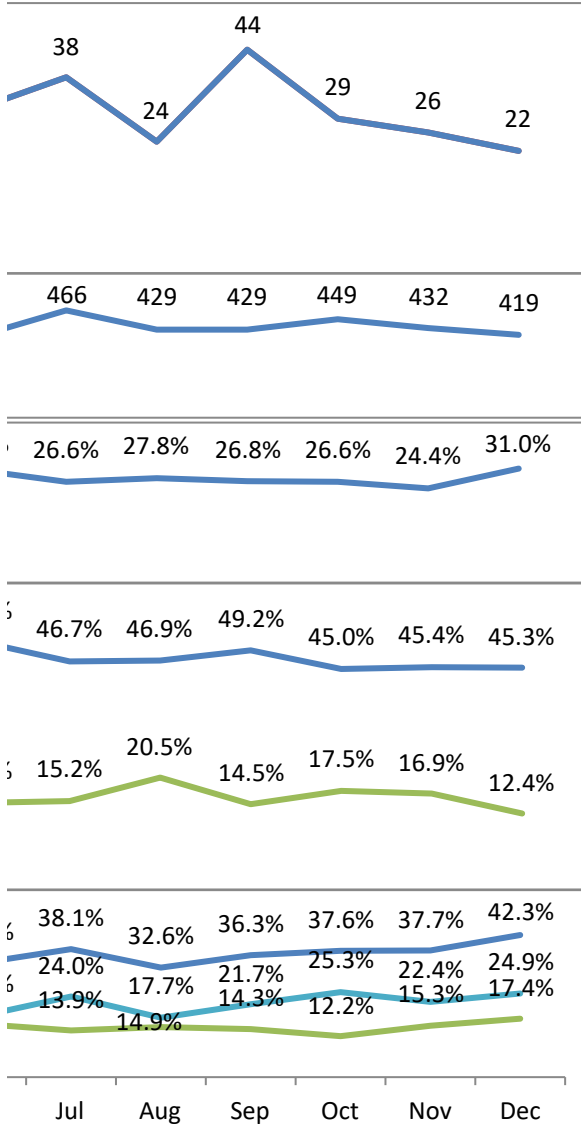


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	Average
Premature Births	30
All Births from 22/40	423
IOL Rate	30%
Unassisted BR	48%
Assisted BR	16%
LSCS	35%
ELSCS	15%
EmLSCS	21%

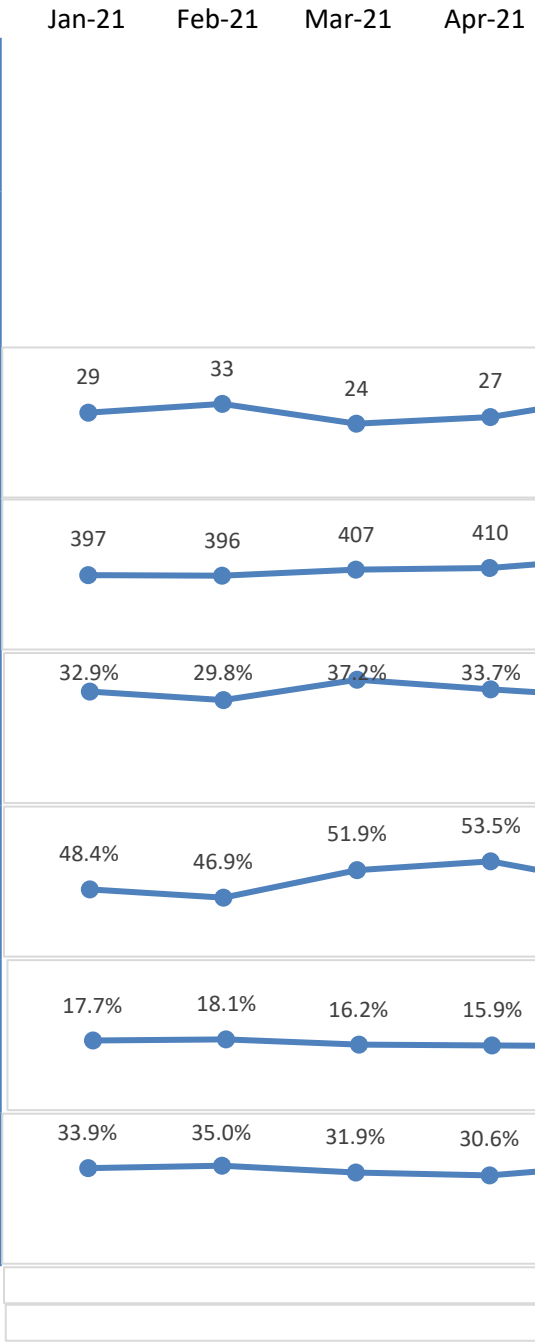


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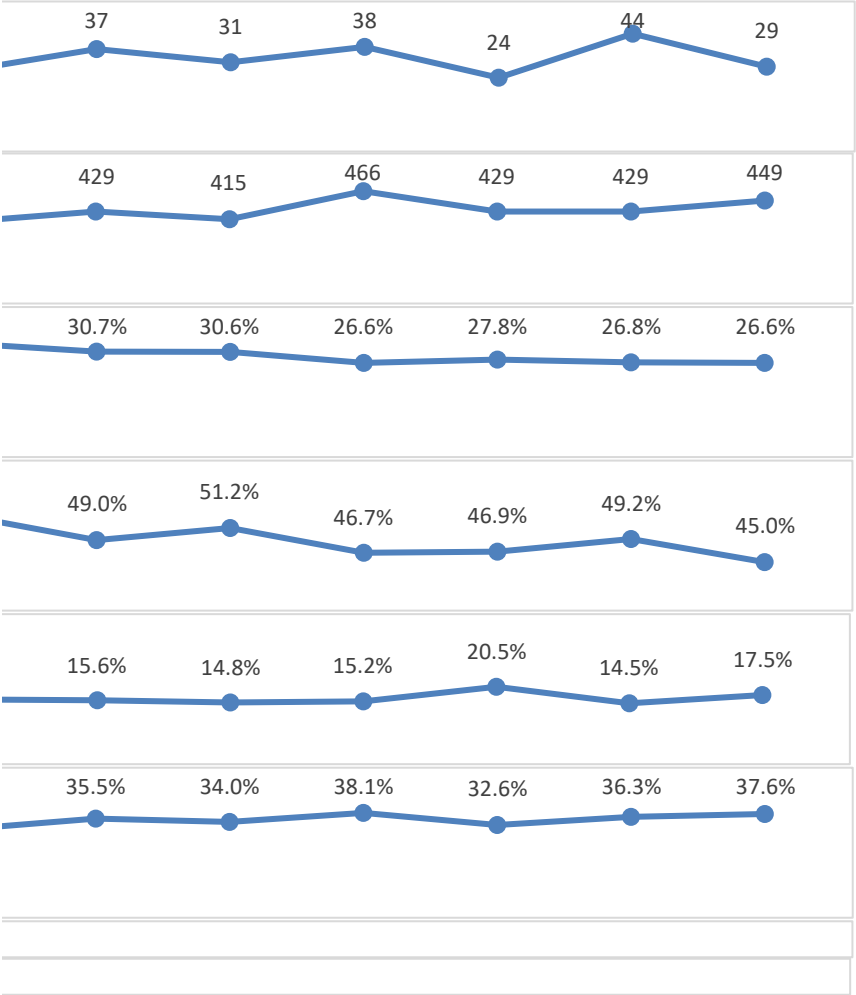
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LSCS	35%
ELSCS	15%
EmLSCS	21%



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May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21

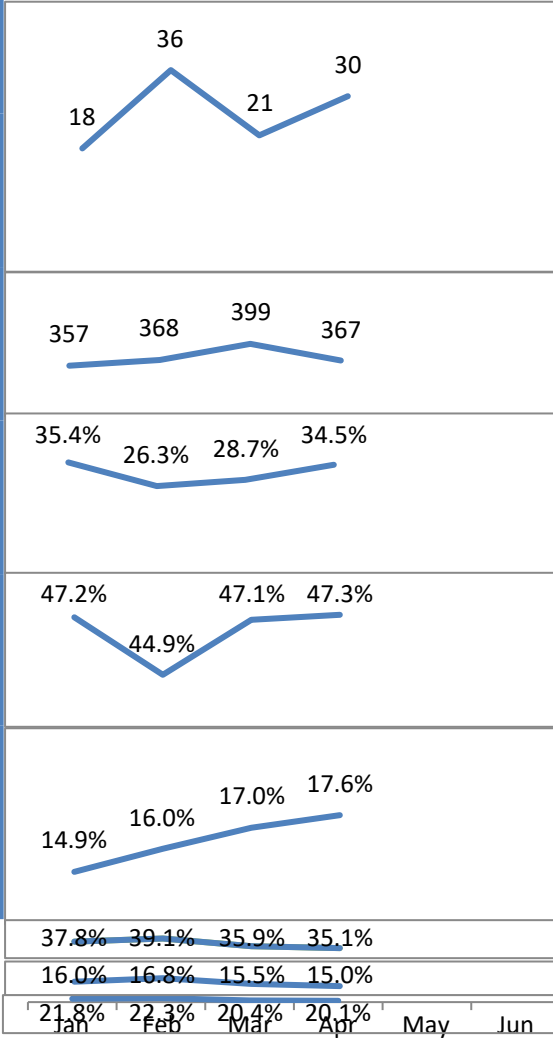


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 University Hospitals Bristol and Weston NHS Foundation Trust	UHBW perinatal quality surveillance matrix														
		Jan	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Year to date average	Trend
Activity															
Number of babies born alive at >=22 to 36+6 weeks gestation	18	36	21	30										26	
Number of women who gave birth all gestations from 22+0 weeks	357	368	399	367										373	
Induction of Labour rate %	35.4%	26.3%	28.7%	34.5%										31.2%	
Unassisted Birth rate %	47.2%	44.9%	47.1%	47.3%										46.6%	
Assisted Birth rate %	14.9%	16.0%	17.0%	17.6%										16.4%	
Caesarean Section rate (overall) %	37.8%	39.1%	35.9%	35.1%										37.0%	
Elective Caesarean Section rate %	16.0%	16.8%	15.5%	15.0%										15.8%	
Emergency Caesarean Section rate %	21.8%	22.3%	20.4%	20.1%										21.2%	
Perinatal Morbidity and Mortality inborn															
Total number of perinatal deaths	6	1	5	3											
Number of late fetal losses 22+0 to 23+6 weeks excl TOP	0	0	0	0											
Number of stillbirths (>=24 weeks excl TOP)	2	0	1	2											
Number of neonatal deaths : 0-6 Days	4	0	1	1											
Number of neonatal deaths : 7-28 Days	0	1	3	0											
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (HSIB)	1	0	0	0											
Maternal Morbidity and Mortality															
Number of maternal deaths (MBRRACE)	0	0	0	0											
Number of women who recieved level 3 care	1	1	1	0											
Insight															
Number of datix incidents graded as moderate or above (total)	2	0	1	0											
Datix incident moderate harm (not SI)	0	0	0	0											
Datix incident SI (excl HSIB)	0	0	0	0											
New HSIB SI referrals accepted	2	0	0	0											
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0											
Coroner Reg 28 made directly to Trust	0	0	0	0											
Workforce															
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained) BAPM standard is 70%	47%	47%	59%	58.80%											
Datix related to workforce (service provision/staffing)	18	18	15	9											
MDT ward rounds on CDS (minimum 2 per 24 hours) day staff	100%	100%	100%	100%											
MDT ward rounds on CDS with day to night staff handover	0%	0%	0%	0%											
One to one care in labour (as a percentage)	100	100%	100%	100%											
Number of times maternity unit attempted to divert or on divert attempted baby abduction	1	2	0	0											
	0	0	0	0											
Involvement															
Service User feedback: Number of Compliments (formal)	5	17	13	12											
Service User feedback: Number of Complaints (formal)	2	0	3	5											
Staff feedback from frontline champions and walk-about (number of themes)	4	3	4	4											
Improvement															
Progress in achievement of CNST /10	7	7	8	8											
Training compliance in maternity emergencies and multi-professional training (PROMPT) midwives	1	78%	82%	77%											
Training compliance in maternity emergencies and multi-professional training (PROMPT) obstetricians	1	54%	61%	52%											
Training compliance in maternity emergencies and multi-professional training (PROMPT) anaesthetists	1	71%	75%	73%											
Training compliance in maternity emergencies and multi-professional training (PROMPT) maternity care assistants	62%	72%	72%	66%											
Training compliance fetal wellbeing day midwives	79%	61%	67%	71%											
Training compliance fetal wellbeing day doctors	69%	38%	44%	43%											
training compliance core competency 4. personalised care	65%	66%	66%	69%											
Continuity of Carer (overall percentage)	48%	49%	54%	48%											

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Premature Births	26
All Births from 22/40	373
IOL Rate	31%
Unassisted BR	47%
Assisted BR	16%
LSCS	37%
ELSCS	16%
EmLSCS	21%



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Take a screenshot with windows key+Shift+S t

Use Ctrl-V to paste.

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Meeting of the Trust Board on Friday 27 May 2022

Report Title	6 Monthly Nurse Safe Staffing Report Nursing, Midwifery and Allied Health Professionals
Report Author	Andy Landon - Clinical Informatics Sarah Dodds – Deputy Chief Nurse Sarah Windfeld- Head of Midwifery Vimal Sriram – Head of Allied Health Professionals
Executive Lead	Deirdre Fowler – Chief Nurse and Midwife

1. Report Summary

The aim of this paper is to provide assurance to the Trust Board on how the Trust has managed nursing, midwifery and AHP safe staffing across all inpatient wards, in line with Developing Workforce Safeguards.¹ The full assessment of nurse safe staffing should include an evidence-based review using the Safer Nursing Care Tool (SNCT) of all inpatient areas, emergency departments, outpatients, theatres, day case and clinical nurse specialists however, this has been delayed due to the COVID- 19 pandemic. SNCT will be utilised in July, consequently analysed and reported on in the next 6 monthly report to the Trust Board.

Each Professional group has a separate section within the overall report which details the National Quality Board² expectations of right staff, right skills, right place and time.

The significant impact of the level of infectivity and isolation requirements of the Omicron COVID -19 variant on staffing absence impacted adversely across all professions. Fill rates on wards were depleted and management of daily staffing needed additional oversight and out of hours support to ensure that risk was managed across both Bristol and Weston sites. This required daily deployment of staff and movement across all areas and the redeployment of staff from specialist and non-ward roles to support the wards.

In addition to impact on staff, some quality metrics deteriorated which appear to be a direct correlation with staffing fragility, this has been scrutinised throughout via the Trust Quality and Outcomes committee.

Across all professions it is recognised that there is more to do to improve the retention of staff; supporting staff health and well-being has been vital over the past 6 months and the Retention improvement plan is being reviewed and refreshed to ensure that UHBW is where staff want to work, undertake further development and

¹ [Developing workforce safeguards.pdf \(improvement.nhs.uk\)](https://improvement.nhs.uk/documents/developing-workforce-safeguards.pdf)

² [Microsoft Word - how to ensure the right people right skills right place right time FINAL \(england.nhs.uk\)](https://www.england.nhs.uk/wp-content/uploads/2021/07/microsoft-word-how-to-ensure-the-right-people-right-skills-right-place-right-time-final.pdf)

continue their careers. Work is also required to ensure a more sustainable pipeline and develop more resilience in our nursing, midwifery and AHP workforce.

The evaluation demonstrates that staffing in all professional groups did not meet the required levels over the last 6 months, risks were mitigated on a dynamic basis but the consequence was seen to impact staff and patient quality metrics.

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

Nursing

- Over the past 6 months the Trust has consistently been unable to meet the planned levels of nursing staff on the wards, this has undoubtedly affected staff resilience and staff morale. The use of incentives for staff has been used to increase staff cover and leaders have been clear of the importance of monitoring staff well-being and resilience.
- The number of Band 5 Registered Nurse vacancies have remained high over the past 6 months despite recruitment with vacancies in March 2022 at 16.3 % and Band 5 turnover at 15.7%
- There was a noted correlation with a reduced Registered Nurse fill rate and an increase in the number of hospital acquired cases of MRSA and an increase in the number of falls and pressure ulcers over the past 6 months.
- The opening of additional capacity within the Trust was required to support the overcrowded Emergency Department. Quality Impact Assessments were undertaken to support the decision making for increasing boarding (extra beds in non-designated spaces) on wards and offloading of ambulances into queuing areas, balanced against the risk of opening these areas based on the availability of safe staffing.
- Staff feedback and the current turnover of staff illustrate that there is much more to do with retention; exit interview data is one element being analysed and will be part of the retention improvement plan and new People strategy.
- The value of Practice Educators and Professional Nurse advocates is evident and a full benefits assessment is underway to plan for substantive posts.
- Investment in Nursing associates is required to augment the registered nurse workforce and a business case for a further 108 International nurses has progressed through business planning.
- In July 2022, the Trust will be undertaking a full evidence-based assessment of Nurse staffing levels across the Trust using the Safer Nursing Care tool.

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We are
supportive
respectful
innovative
collaborative.
We are UHBW.

Midwifery

- The landmark publication of the Ockendon Reports in December 2020 and March 2022 are addressed to assure the Trust that the Midwifery services are responding appropriately to the recommendations outlined in these two reports
- UHBW received funding from the Neonatal Network for 10 WTE Neonatal Intensive Care Unit (NICU) nurses to help improve the staffing to meet British Association of Perinatal Medicine (BAPM) NICU standards.
- Within the last 6 months, one to one care to women in labour has been maintained 100% of the time. Over the reported period there has been a recognisable increase in the acuity of the patients, in addition there has also been a rise in induction rates and caesarean section rates.
- The impact of the pandemic on the midwifery workforce has been at its greatest over the past 6 months. However, due to the flexibility of staff, on call rotas, the use of bank staff ongoing recruitment and retention initiatives, the service is able to maintain patient safety
- The licence for the acuity tool for both the wards and the delivery suite has been purchased which will allow improved daily decision making on staffing requirements, based on the acuity of the patients but also demonstrate a long-term view of activity and acuity.
- A full Birth Rate Plus audit (the nationally recognised workforce assessment of Midwifery staffing) has been undertaken with the results being published in May 2022.

Allied Health Professionals

- COVID related and Non COVID absences have resulted in around 70-75% staffing levels against establishment with AHP turnover currently at 15.9%
- There continues to be some difficulty in recruiting and retaining AHP staff across the divisions. This mirrors the regional and national picture in recruiting staff in specific professions such as Radiographers and Occupational Therapists.
- The Trust wide Head of AHPs started in December 2021, reporting to the Chief Nurse and Midwife and provides professional support and oversight to AHP professional groups across the divisions as well as working with partners across the BNSSG system.
- A planned review of pathways and services by July 2022 will help consolidate gains from integrated working across Bristol and Weston sites as well as identifying further skill missing opportunities. WTE staff numbers within pathways will be reviewed and skill-mix compared to national guidance/data where available.
- Recruitment of Practice Educators within professional groups to be considered (therapies, diagnostic radiography, therapeutic radiography etc.) to provide hands-on supervision and support for new starters.
- Plan to facilitate cross-organisational working within BNSSG to assist recruitment, provide additional training opportunities, a common preceptorship framework and

career progression opportunities which will facilitate retention of the best talent within UHBW.	
3. Risks If this risk is on a formal risk register, please provide the risk ID/number.	
The risks associated with this report include: ID 5477 Risk that nurse staffing levels will not be met The current rating has been escalated to 20 due to the omicron variant wave and the level is very high risk ID Risk 737 unable to recruit staff - score 16 level is very high risk ID Risk 2694 unable to retain staff - score 12 level is high risk	
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 <u>previously</u> been received.	
Quality and Outcomes Committee	24 th May 2022

Report on Nurse, Midwifery and Allied Health Professionals (AHP's) Staffing Levels UHBW (October 2021- March 2022).

May 2022 Trust Board

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Part 1: Nurse Staffing

1.0 Introduction

Following publication of the Francis Report 2013¹ and the subsequent “Hard Truths” (2014)² document, NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery and care staff levels. These include:

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

The NHS Improvement “Developing Workforce Safeguards” (October 2018)³ has several recommendations that Trusts should include and report on, the Trust has utilised these recommendations to produce this report.

In November 2021, the Trust undertook a gap analysis against the Developing Workforce Safeguards and an action plan has been devised and is underway. Further National guidance was released in November 2021 (Winter 2021 preparedness: nursing and midwifery safer staffing NHS 2021) when the Trust benchmarked and planned for the Winter surge of COVID–19. The implications and levels of infectivity of the Omicron variant led to a significant challenge to all staffing groups across the Trust which meant that the management of daily staffing needed additional oversight from the Deputy Chief Nurses and out of hours support to ensure that risk was managed across both Bristol and Weston sites. This required daily deployment of staff and movement of staff across all areas.

¹ [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541234/Report_of_the_Mid_Suffolkshire_NHS_Foundation_Trust_Public_Inquiry_-_GOV.UK_(www.gov.uk).pdf)

² [NHS England » Guidance issued on Hard Truths commitments regarding the publishing of staffing data](https://www.nhs.uk/england/guidance/issued-on-hard-truths-commitments-regarding-the-publishing-of-staffing-data)

³ [Developing workforce safeguards.pdf \(improvement.nhs.uk\)](https://www.improvement.nhs.uk/documents/developing-workforce-safeguards.pdf)

Scope

This report is a factual review of the past 6 months safe staffing review for Nursing on inpatient wards, Maternity services and Allied Health Professionals. A full 6 monthly safe staffing review of all inpatient areas, theatres, day case, outpatients, and clinical nurse specialists has been delayed due to the impact of the COVID-19 pandemic on staffing resource and the several ward re-locations and specialty changes which have taken place.

This report does include the significant challenges to all professions safe staffing that have occurred during the past 6 months where there has been sustained pressure and impact from the pandemic, this included a surge in Children's Respiratory Syncytial Virus (RSV), substantial increase in Adult and Children's Mental Health attendances and the impact of Elective restoration work.

The report aims to provide the Trust Board with assurance that staffing has been managed during this time in line with National COVID recommendations⁴, with close oversight by the Chief Nurse and Midwife and the Incident Management structure which was in place.

The report is presented in three parts identifying the key elements to each profession: -

- Nursing
- Midwifery
- Allied Health Professionals.

Where possible the Nursing and Midwifery components have been separated out into specific reports however, many data sources group Nursing and Midwifery together and where it is not possible to report separately it will be reported as Nursing and Midwifery in this report.

Nursing

- Any significant changes that have occurred in nurse staffing establishments and skill mix in the last six months and any risks on the corporate risk register related to nurse staffing.
- Assurance regarding safe staffing of wards over the last six months, including Care Hours Per Patient Per Day and Weighted Activity Unit data.
- The impact on staffing due to the pandemic and Workforce planning for the future.

2.0 NQB Expectations: A triangulated Approach to Staffing Decisions.

- The NQB three expectations (right staff, right skills, right place and time) support an approach to determining safe staffing levels based on patients' needs, acuity and risks, monitored from 'ward to board'. This triangulation approach to staffing decisions, rather than making judgments based solely on numbers or ratios of staff to patients, is supported by the CQC.

⁴ https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/12/C0833_advice-on-acute-sector-workforce-models-during-COVID-with-apps_10dec.pdf

2.1 NQB Expectation One: Right Staff

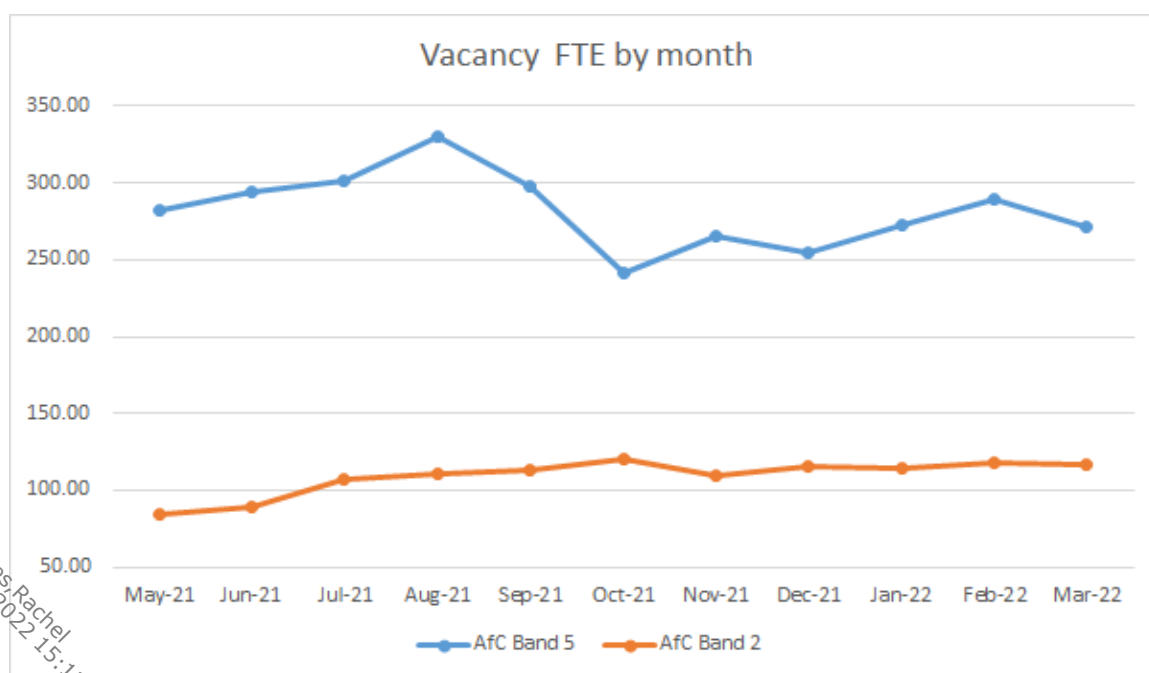
Principles of Safe Staffing for Inpatient Wards: -

- As detailed in appendix 1 these are the triggers that indicate when a nurse staffing review is needed with any ad hoc reviews triggered would be in addition.

Nursing Vacancies

- The COVID-19 pandemic has undoubtedly led to an increase in Nurse vacancies, with the current Band 5 registered Nurse vacancy rate in March 2022 at 15.3% (279 W.T. E)
- The volume of Nurse vacancies across all Divisions in the Trust has required intensive collaborative work between the recruitment, clinical and education teams to plan and prepare for increased numbers of new recruits. In September 2021, the impact of the international recruitment programme and recruitment of newly qualified nurses started to reduce the vacancy level. However, there has been a gradual increase in vacancies as the turnover rate has increased. A detailed analysis is underway of exit interviews undertaken to action key issues highlighted, along with some focus groups with staff. To further mitigate the increased turnover the Trust is enhancing the retention offers across all the staff groups.
- A variety of methods are used to recruit Registered Nurses including regular advertising on NHS jobs, specialist adverts, recruitment open days both Trust wide and for specific departments, participation at national recruitment events and a programme of International Nurse recruitment.
- The input of the non-registered nursing education team has been pivotal in engaging and supporting the workforce and is now seeing a reduction in turnover for this group of staff. A System-wide Recruitment Day is planned for Health Care Support Workers in May. This is supported by NHS England will be a fantastic opportunity to highlight the roles available for health and social care and hopefully fill the current vacancies across the Divisions.

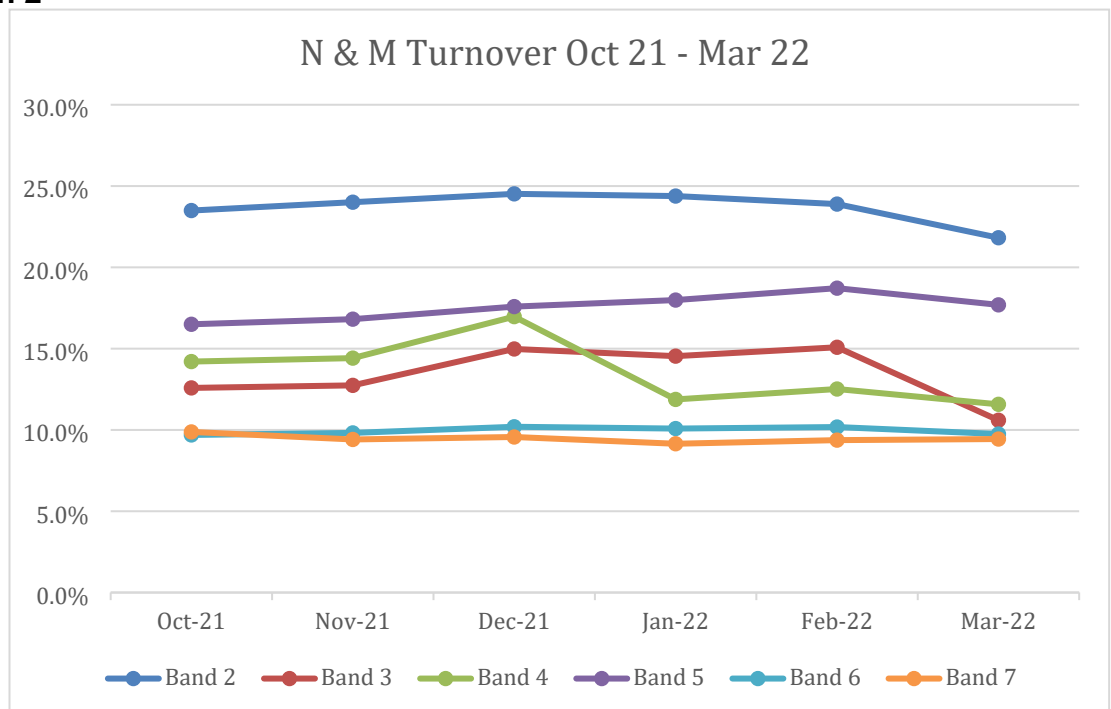
Graph 1



Nursing and Midwifery Turnover.

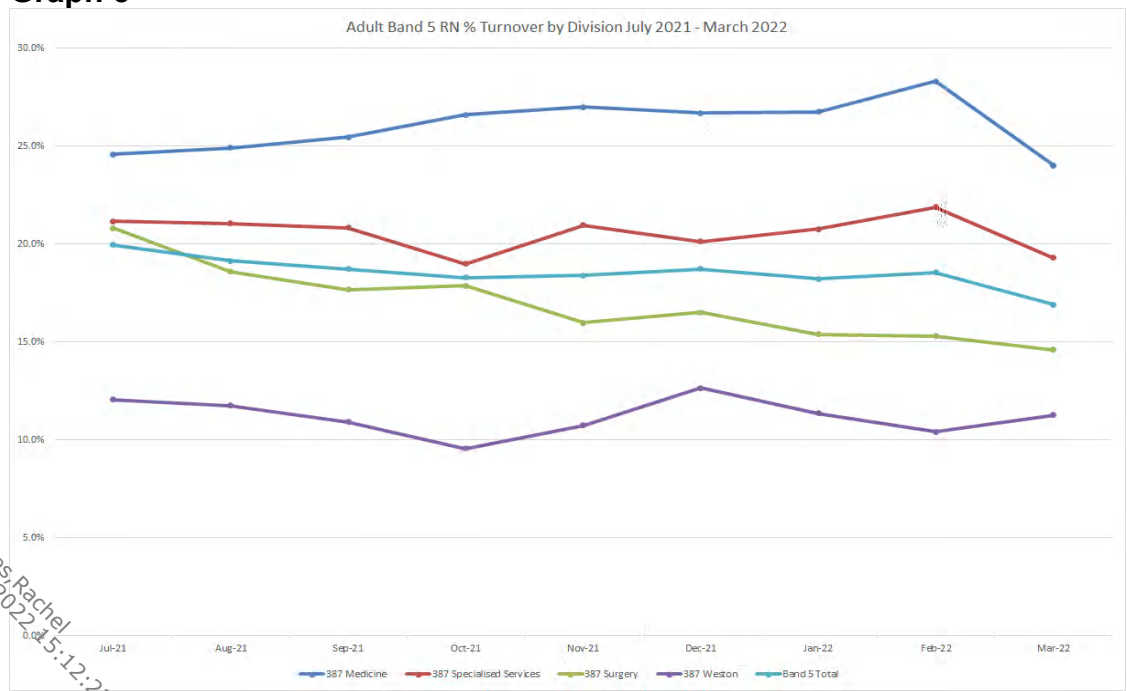
- The turnover in bands 6 and 7 remained relatively static whilst for bands 3 and 4 the turnover has reduced. It should be noted that all the newly qualified and international recruits start on a band 4. The band 5 turnover rate, however, steadily increased for the first 5 months but was reduced in March 2022.

Graph 2



- The adult band 5 Registered Nurse is a large component of the adult nursing ward workforce, and the graph below illustrates the change in turnover during the previous 9 months for each division (Midwives start on Band 5). For the first time in March a slight reduction in all the adult divisions is shown, with the continued effect of the international recruitment programme beginning to show some dividends.

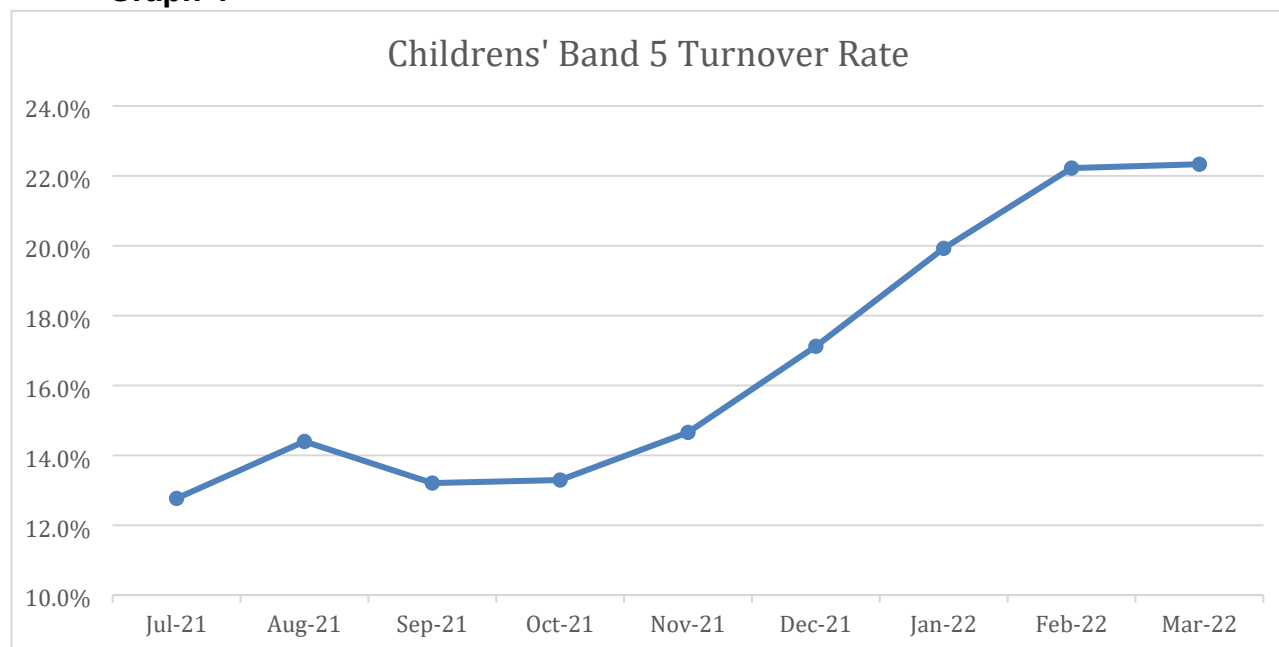
Graph 3



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- Childrens Nursing has seen a marked change in the turnover, this illustrates a steep increase in turnover since October 2021 that has continued despite the ongoing recruitment initiatives. Some of the turnover relates to the post initial pandemic movement with staff leaving to travel and seek career development for specialist roles. In addition, this was the first year that saw the impact of the reduced number of local university intakes for newly registered nurses who usually start in February each year.

Graph 4



Divisional Staffing reviews

The following summarises the changes that have taken place as part of divisional reviews:

Unit Area	Service Review and Changes Made	WTE
Medicine	There have been some additional capacity areas which have required consistent staffing. A516: - Review of bed base and boarding capacity took place, and the discharge lounge was moved to a different site with A516 becoming a 6 bedded escalation area co located to A515. Staffing 1 RN and 1NA 24/7. 2 reverse queuing areas have been introduced in the ED (Emergency Department) to support ambulance offloads, this is staffed through bank and agency or the adult divisions on the BRI (Bristol Royal Infirmary) site. Service Change: Same Day Emergency Care Unit (SDEC): - Providing a service to stream patients to the correct location and help reduce crowding in ED 5 days a week with a plan to expand in the future to a 7-day service with increased hours or 8-10pm. Initially piloted as Band 6 posts to enhance recruitment. Introduction of the OPAT (Outpatient Parenteral Antimicrobial Therapy) team, supplying care to patients in	Band 5- 5.2 wte Band 2 – 5.2 wte Band 5 3 RN's and 1 NA Band 7 1 WTE Band 6 5 WTE Band 2 3 WTE Band 7 x 1 WTE

	their own home. This is a 7-day service running during the day from 9 - 5. This is currently funded through Sirona.	Band 6 7 WTE
Specialised Services	There were no funded establishment changes made. Escalation areas required staffing overnight due to constant use of 8 bed spaces	Band 5 – 5.2 wte Band 2 – 2.6 wte
Surgery	There have been some ward reconfigurations, but no funded changes required as part of this	
Childrens	Review of all areas took place during the staffing review, some temporary changes in support roles for the wards/winter pressure and paediatric accelerator funding (e.g., Increase in outreach nurses, emergency department mental health practitioners and paediatric vascular access roles) - Theatre matron as a 6-month pilot post with accelerator funding to provide overall leadership in Theatre department - Additional Meadow Ward/day case band 5 nurses	Band 8a 1.0 wte for 6 months Band 5 1.0 wte for 6 months
Weston	Temporary changes in the nurse staffing with the Emergency Department establishment have been approved to include the following: - Nursing Assistants (NA's) have been increased from 3 to 5 NA's per long day shift, and from 1 to 2 NA's on the Twilight shift. - Additional staff, RN's, and NA's, to oversee patients in the cohort areas/ ambulance bay. Extra staff needed are 2 RN's LD, 1 NA LD, 1 RN night, 1 RN twilight, 1 NA night. - Knightstone ward opened in February and is currently used for elective recovery. Staff required are 2 RN's LD and night and 1 NA LD and night. These RN vacancies are currently covered by consistent Agency staff and the NA covered by Bank.	Band 2 - 7.91 wte Band 5 – 7.79 wte Band 2 – 5.14 wte Band 5 – 10.4 wte Band 2 – 5.2 wte

New standards, legislation and/or professional guidelines that affect the staffing in Nursing.

A 2nd review and gap analysis of the Royal College of Nursing workforce standards (2021) was undertaken and presented in November 2021, this showed that the Trust was compliant with 36 of the required standards with a further 6 being partially compliant with actions almost complete. A further review will be undertaken in the next 3 months in order to assess compliance.

Model Hospital Nursing Benchmarking - Care Hours Per Patient Day (CHPPD)

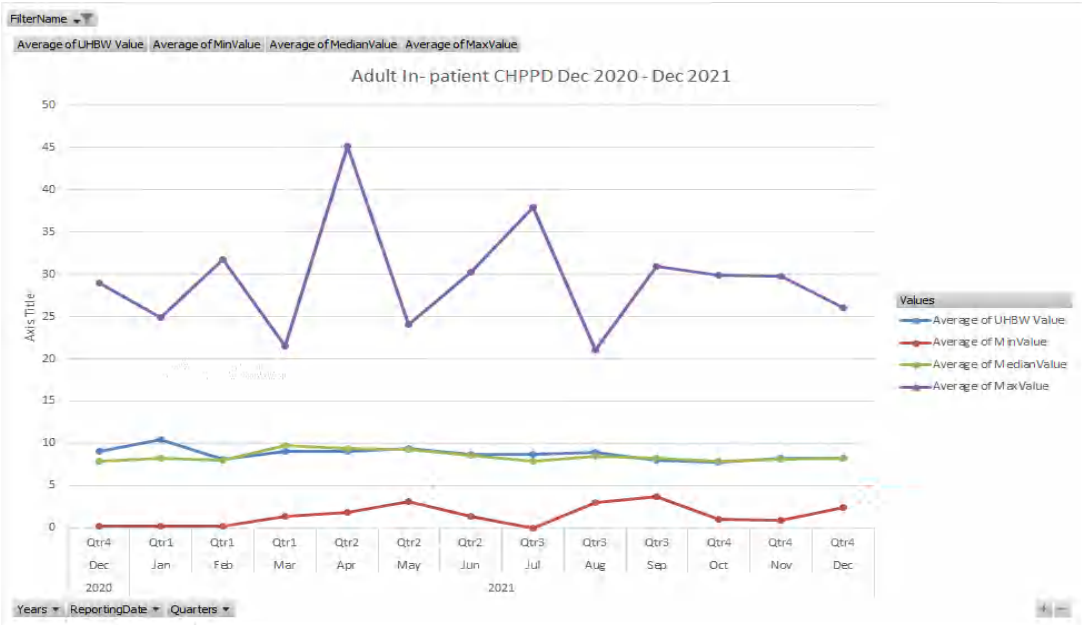
- CHPPD as a measure of actual nursing resource deployment for the period December 2020 – December 2021. For this report CHPPD is shown in three key graphs (Model Hospital data). In each graph the UBHW level, national medial average, maximum and minimum reported levels are shown.

Adult In-patient Wards CHPPD (except ITU areas)

These areas include all the adult general medical and surgical ward, assessment areas, and specialist wards in Bristol and Weston.

- For the majority of the year the UHBW level compares well with the national medial average for this group

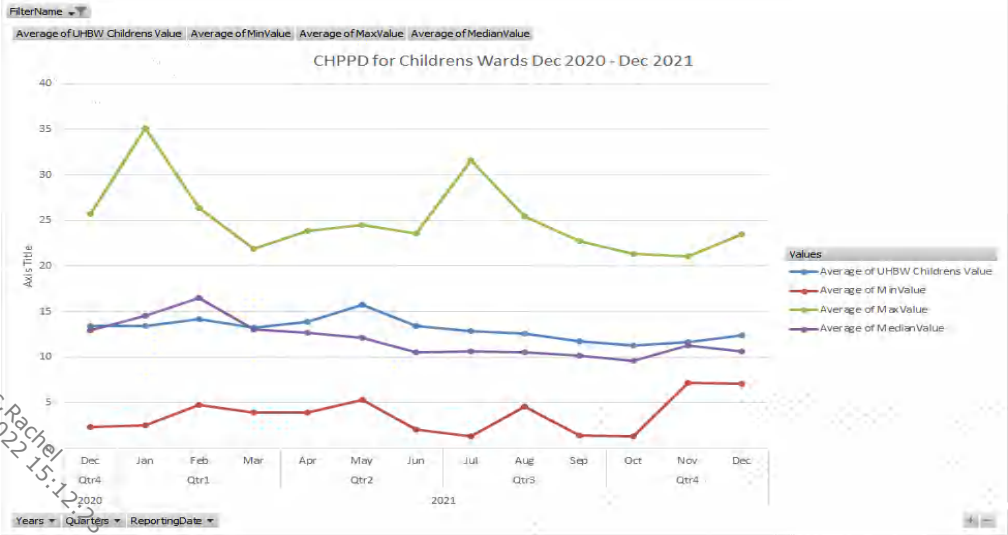
Graph 5



Children In-Patient Wards CHPPD (except ITU areas)

- For the in-patient children's wards, the CHPPD is detailed below. This sits above the median average most likely due to the specialist nature of the wards in the Childrens hospital.

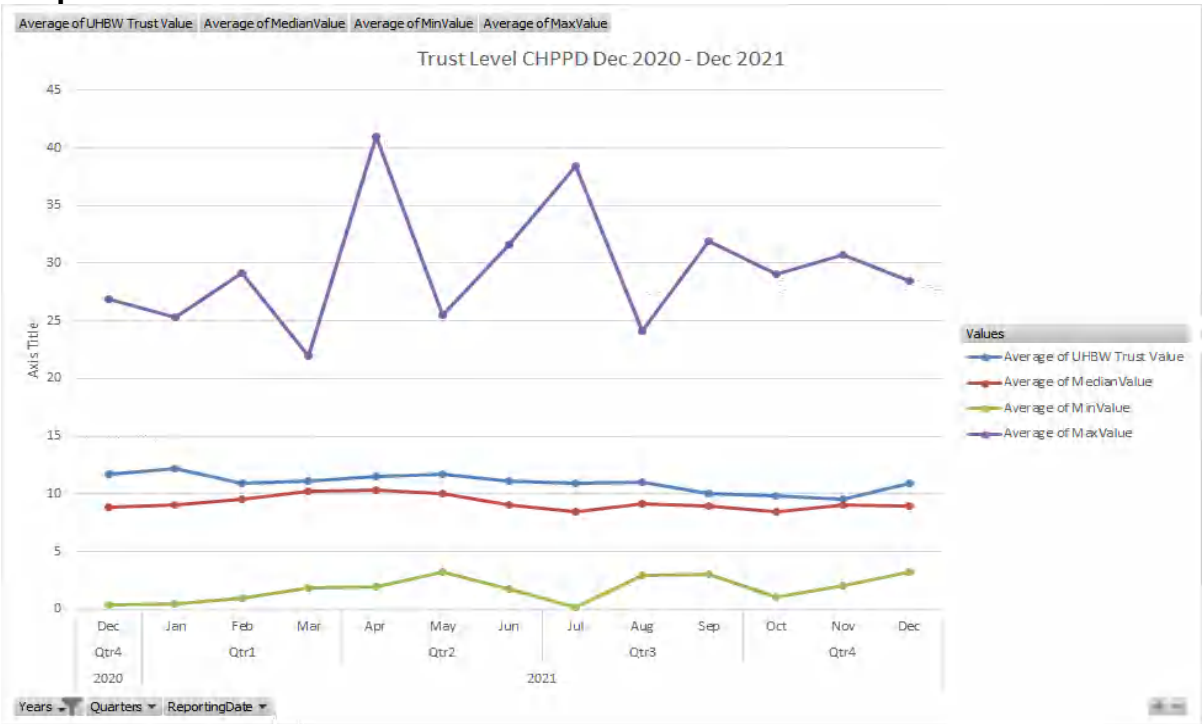
Graph 6



Trust Level CHPPD

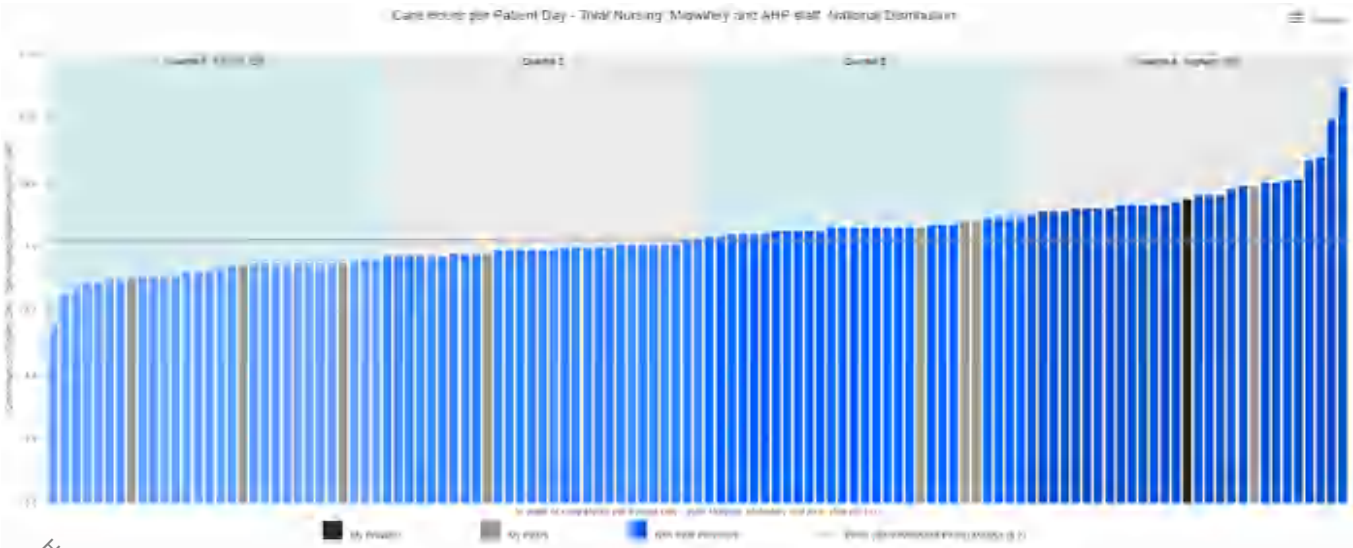
- The Trust level CHPPD trends above the medial average across the year, usually about 1 – 2 CHPPD points above. This graph includes all inpatient areas including all the Trusts' ITUs and Midwifery units across both sites.

Graph 7



- The graph below taken from the Model Hospital shows UHBW benchmarks well and sits in the middle of the 4th Quartile. The Trust has previously been in the top 10 nationally for CHPPD. Please note this graph includes both Nursing and Midwifery.

Graph 8



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Model Hospital Nursing Benchmarking – WAU (Nursing and Midwifery)

- The graph below shows the total staff cost for UHBW nursing and Midwifery staff per Weighted Activity Unit for the financial year 20/21, this is the most up to date information available. The peer group used is the Model Hospital recommended peer group. This metric includes both substantive and temporary staff.
- For the financial year 2020 – 2021 the Bristol and Weston sites are now combined (and UHBW sits in quartile 3 for cost per WAU. The headline WAU is now £939, in the previous years the WAU for Bristol was £819 and Weston £1127. UHBW sits in the middle of the recommended peer group and spends less on staff per unit of activity than a number of Trusts both nationally and within our peer group (model hospital recommended).
- The continued use and improvement of e-rostering for Nurses and Midwives together with the planned Safer Nursing Care Tool Assessment (SNCT) exercise will provide the evidence that the Trust nursing spend is correct at a divisional level. Following the SNCT assessment, the Trust will undertake a full refresh of the SafeCare system to support day to day operational resource management. This continues to enhance the understanding of nursing costs and reasons behind budget spend and creates a greater visibility of critical staffing shortages.

Graph 9



Details of the planned acuity and dependency review.

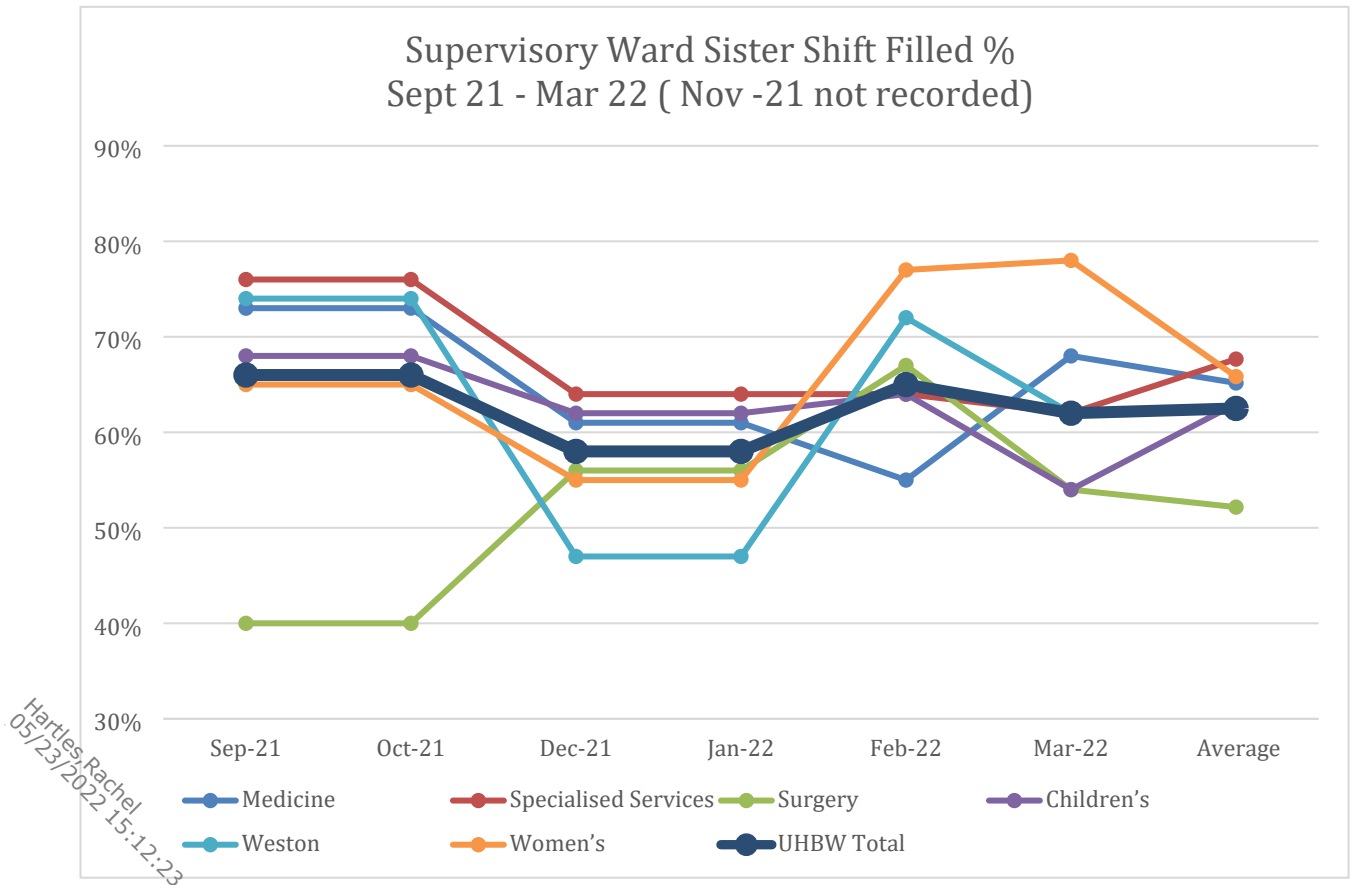
- The nursing establishments have been reviewed and amended to manage the Covid pandemic to ensure patient safety. Undertaking a full evidence review to support these changes has not been possible however, the Trust will be carrying out a full evidence-based review using the mandated Safer Nursing Care Tool (SNCT) to support the agreed funded establishments. This will encompass all adult and children's inpatient wards and Emergency Departments with refreshed training underway for staff. The audit programme will run in July 2022 and the results will be reported in the next 6 monthly report.

- It is recognised that the SNCT data cannot solely be the tool used to recommend staffing establishments, the role of professional judgement and local intelligence cannot be underestimated and should be applied to increase confidence in recommended staffing levels and provide assurance.

Supervisory Ward Sister Role.

- The Trust recognises the essential role of the ward sister in leading the ward team, setting the level of expected care, professional leadership and overall ward and staff management. This position was made supervisory in line with national guidance to allow Ward sisters ringfenced time to achieve this. All ward establishments were also set up to ensure that the role could continue throughout the year.
- During the Pandemic this role has been pivotal in maintain staff morale and in supporting ward teams to continue to provide excellent care.
- Over the the past months the Trust has been reporting the level of supervisory ward sister time due to the number of occasions the Ward Sister has been required to work in the ward numbers to 'act down' in order to ensure patient safety.
- The expected level of fill for Supervisory Ward Sister shifts is 100% each month. The graph below shows the actual level for the past 7 months (there were no figures reported for November). This shows that for some Divisions the level dropped below 50% but has consistently been below 80%.

Graph 10



2.2 NQB Expectation Two: right skills

Workforce planning for the future

The Trust recognises and is committed to ensuring that staff have the appropriate training and competencies to support patient care. This is supported by a plan to invest in new roles to enhance the current workforce model. The Non-medical workforce planning group meets monthly to maintain close oversight of the workforce metrics and workforce planning for the future.

Nursing Associates

- The introduction of Nursing Associates aims to bridge the gap between Health Care Support Workers and Registered Nurses, providing a clear career pathway into the latter role. This is a registered role with the Nursing and Midwifery Council focussed on supporting Registered Nurses to spend more time using their skills and knowledge to focus on complex clinical duties and leading decisions in the management of patient care.
- The first cohort of Registered Nursing Associates graduated in March 2022, and the scope of practice has now been developed to support their role. In view of the decreasing numbers of available registered nurses and in recognition of the opportunities this role will bring, a further 50 Trainee Nursing Associate (TNA) places were approved in August 2021. We currently have 71 TNA's across Adult and Paediatric areas. Future funding for these roles will require further review of the staffing skill mix within the Divisions.

Advanced Clinical Practitioners (ACP)

- Advanced practice roles are vital to delivering high-quality, safe complex patient care throughout UHBW. To support and co-ordinate the development of roles across the Trust, an Advanced Practice Steering Group has been established, chaired by a Medical Consultant, there is representation from each division as well as advanced practitioner representation on the steering group which meets every two months.
- Three subgroups feed into the steering group and have representation from multiple professionals from all divisions and advanced practitioners in each subgroup. The underpinning philosophy of all the groups is to support multi-professional advanced practice across the Trust to enhance the delivery and quality of patient care.
- The Trust wide steering group has recently extended its remit to include all advanced practice and over the past year the Trust has seen the number of trainee ACP's increase to 24.
- The Trust organised a successful regional ACP conference to celebrate the role and impact on patient care in UHBW, as well as to raise awareness of the role and its contribution to workforce transformation, with 80 delegates attending.

• The Trust has received funding from Health Education England to support training for some ACP's this year and has been planning how to optimise any further funding opportunities.

- The ACP steering group has undertaken some detailed work over the past 6 months looking at the value and benefits of advanced practice which will further augment the current workforce model and ensure robust plans for the future. Progression of this work is happening as a Trust wide plan as part of the operating plan process.

Nursing Degree Apprenticeships

- Health Education England announced additional national funds for organisations able to support a registered nursing degree apprenticeship (RNDA). The Trust has agreed to support a fully funded initial cohort of 8 staff to undertake the RNDA programme commencing in September 2022. This is an attractive opportunity for staff and the Trust is currently exploring a solution as to how this might be progressed to provide a sustainable opportunity for suitable applicants currently working within UHBW.

Health Care Support Worker

- A significant reduction in vacancies was achieved following the NHS England funding received (November 2020) to accelerate Healthcare Support Worker (HCSW) recruitment, and to address the ongoing challenges of COVID-19 and winter pressures. The additional funding enabled a team for a fixed term period to be appointed; they are now in place and are starting to make a difference to the previous high turnover rates experienced in this staff group. A BNSSG recruitment day supported by NHSE/I is currently being developed with the objective of attracting individuals to the role across BNSSG.
- More work continues to be needed however to ensure that a clear pathway of progression for staff is in place, the Trust has recently reviewed the competencies for Band 3 HCSW who now will be developing skills ensuring role enrichment. The dedicated HCSW development team are leading on this programme of work, along with the education team to ensure that they are well trained and prepared for the wards and departments that they join.

International Recruitment

- International nursing recruitment in the first year has seen 248 arrivals of which 184 have passed their Objective Structured Clinical examination (OSCE), 176 have the NMC pins; we have also seen the arrival of 4 displaced nurses joining our workforce. Following a review of the vacancy, recruitment and retention situation, the Trust has approved the recruitment of 108 international nurses from May 2022 to August 2022. This has once again been supported with NHS England funding.
- The team of Nursing and Human Resource leads manage the international nursing process, providing pastoral support, ensuring education and preparation for their OSCE and a bespoke 'ward ready' programme prepares them for joining the wards with more support provided by the clinical digital specialists and the practice education facilitators on the wards and department.

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Practice Education Facilitators

- The team of Practice Educators who are in place across the Trust are key to supporting the staff on the wards and in supporting the transition of the International Nurse recruits into the ward and theatre environments. Many of the posts are funded by Health Education England and this funding has been approved for a further year. An impact and benefits review is underway to plan for the future provision of funding for these roles.

Professional Nurse Advocates (PNA)

- The PNA is a new professional clinical leadership and advocacy role introduced to deploy the Advocating for Education and Quality Improvement (A-EQUIP) model for Registered Nurses. The role supports staff through a continuous improvement process that builds personal and professional clinical leadership, improves the quality of care delivered and supports professional revalidation. The training is a Masters level 7 Module with a national qualification in leadership and advocacy.
- This is a clinical model of restorative supervision for nurses in England that equips PNA-trained staff to listen and understand the challenges fellow colleagues and teams are facing, and to provide and deliver quality improvement initiatives in response.
- The national guidance from NHSE/I (2021)⁵ suggests one PNA per clinical team / ward, with an aim to embed approximately 6,600 PNA's across England, equivalent to 1:20 PNA by 2025. The current numbers supported by UHBW are 19 with a plan being developed over the next 3 years to increase the numbers which will go some way to achieve the recommended number. The outcomes and benefits of the programme will be shared across the Trust.

Retention Plan

With the current level of both Registered Nurse and Health Care Support Worker vacancies and the increased turnover seen, the Trust recognises that there is much more to do with staff retention. Each Division has been focussing over the past 6 months on supporting the health and wellbeing of staff which has been extremely challenged due to the staffing pressures seen across all services.

The refreshed Trust wide nurse retention plan will be part of the new people strategy which provides some clear and stretching objectives to ensure that UHBW is where staff want to work, undertake further development and continue their careers.

Statutory and Mandatory Training compliance.

- Due to the COVID-19 pandemic and the pressure on maintaining staffing levels on the wards in order to ensure patient safety, on some occasions training including statutory and mandatory training has had to be suspended.
- Below are the current levels by Division for Staff Nurses and Health Care Support Workers. The new learning management system will allow more detailed reports in the future.

⁵ [B0799-national-professional-nurse-advocate-implementation-guide-with-links.pdf \(england.nhs.uk\)](#)

Table 1

Division	UK 11 Core Skills		Remaining Essential Statutory and Mandatory Training	
	RN & RCN	All HCSW	RN & RCN	All HCSW
Diagnostic and Therapies	86%	64%	53%	78%
Medicine	87%	88%	88%	89%
Specialised Services	90%	88%	92%	89%
Surgery	86%	85%	90%	87%
Weston	88%	87%	70%	60%
Women's and Children *excl Midwives	88%*	84%	91%	87%
Trust (AHP and N & M)	87%	86%	87%	87%

Appraisal compliance

The Nursing, Midwifery and AHP leaders all recognise the importance of the appraisal process to support and guide staff to progress their careers and improving the quality of care they provide. Due to the pressures of staffing and the impact of the pandemic compliance has dropped as illustrated below; The divisions are managing their recovery plans for improvement. Maternity support workers are not included in this table due to reporting constraints.

Table 2

Staff Group	%
Nursing (RN and RCN)	69.4%
HealthCare Support Workers	68.8 %
Total Compliance for AHP and Nursing and Midwifery	69.6%

2.3 NQB Expectation Three – Right Place and Time

The past 6 months has continued to bring many challenges for ensuring that staff are in place to cover wards, theatres and departments. There has been unprecedented demand to manage the increased pressures within the Emergency Department, which has needed Quality Impact Assessments to support the decisions to increase the number of 'Boarding Patients' that can be safely cared for on the wards, an increase in escalation beds and the staffing of new areas for queuing of patients awaiting beds in the Emergency Departments across both Bristol and Weston.

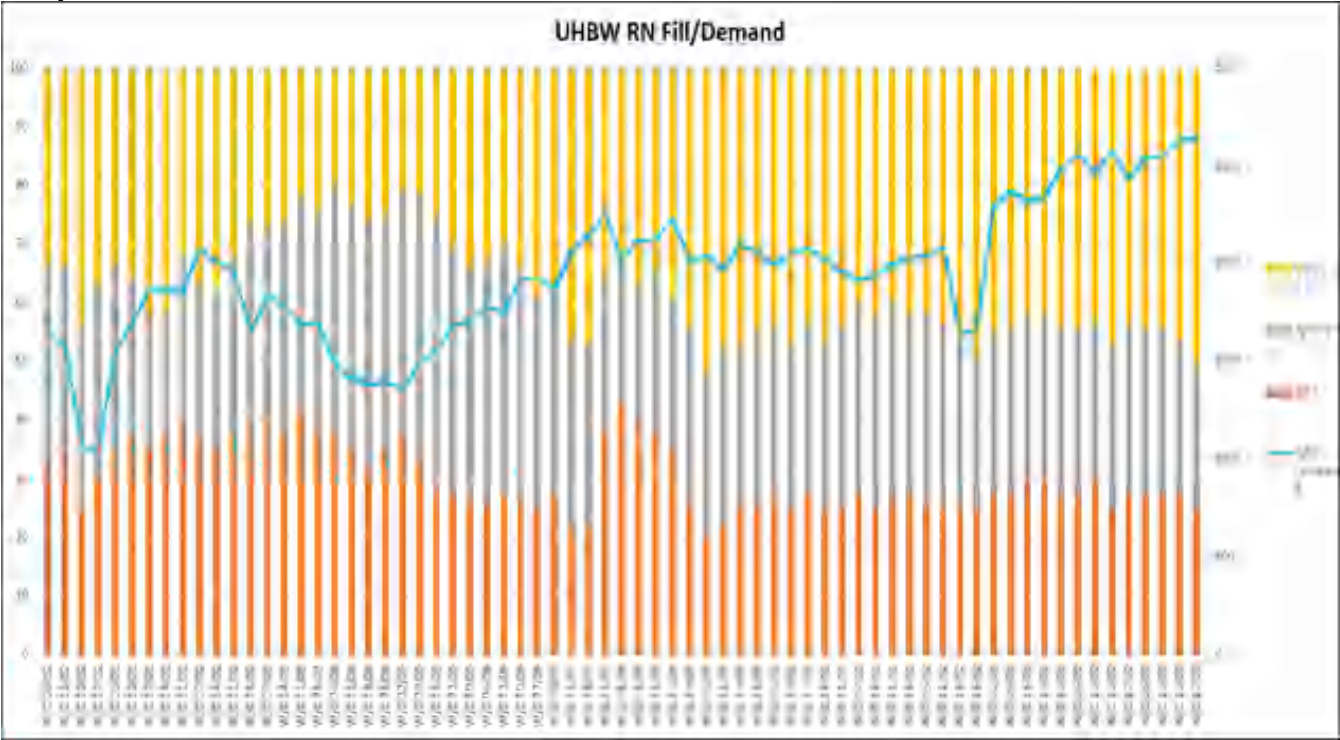
The level of infectivity of the Omicron variant meant that nursing teams were stretched substantially and the impact of this continued reduction of substantive staff in place cannot be underestimated. For a period staff were redeployed from some corporative services and

Divisions reviewed all non-ward-based roles to release staff to provide cover for wards in order to maintain safety.

Use of Temporary staff

The Trust has a proactive staff bank in place which has continued to recruit both registered and non-registered staff. A bank incentive was in place for all staff for some months over the winter period, this was of value as the demand for Registered Nurses increased significantly from January to March as noted below. Most of these incentive shifts have now ceased apart from for some key hotspot areas and the continuation of the ‘Allocate on Arrival’ shift for both Registered Nurses and Health Care Support Workers which has limited uptake.

Graph 11



Nursing and Midwifery Staff Experience and Satisfaction

Staff are encouraged to feedback on staffing through a variety of means, these include alerting and discussing with their line manager, via freedom to speak up ambassadors, via staff side representatives, reporting via the Datix incident reporting system, and opportunities for feedback through visibility of senior Nurse and Midwifery staff and executive walk abouts along with Senior Nursing staff conducting clinical quality accreditation visits to wards and departments. There is also the national staff survey. Results from the national staff survey of 2021 showed that a low percentage of Nursing, Midwifery and Health Care Support Workers felt that there were enough staff in the organisation for them to do their job properly. It also indicated that their personal health and wellbeing was affected by their work.

Staff have fed back that they value investment in the format of training and education. An example of action taken includes a development framework for the Band 6 ward nurses has been implemented which includes both local learning opportunities, university courses and National NHS Leadership academy resources.

Nursing Fill rates and comparisons

The Trust continues to submit monthly returns to the Department of Health via the NHS national staffing return. This return details the overall Trust position on actual hours worked versus expected hours worked for all inpatient areas, the percentage fill rate for Registered Nurses (RN) and Nursing Assistants (NA) for day and night shifts, together with the overall Trust percentage fill rate. This includes care hours per patient per day (CHPPD).

A detailed report on nurse staffing is received and reviewed monthly at the Quality and Outcomes Committee, the Non-Executive chaired sub-committee of the Board. This report gives a detailed breakdown of any staffing variances by ward/ department and Division. It includes detailed information regarding NICE (2014)^[1] staffing red flags that have been reported, the reasons and any actions that have been taken.

The graph and table below show 6 monthly staffing fill rates for inpatient ward areas.

Key issues to note:

- The total average fill rate for RN and NA staffing has remained within a range of 87% - 92 %. This is lower than in all the previous months of the pandemic. The full effect of the Omicron Covid variant, the reduced restrictions in public environments and the continued exclusion of staff with Covid symptoms for a full week has contributed to a reduced fill rate. The impact felt by the ward staff on this continued shortfall on each shift cannot be underestimated.
- The average RN Day fill rate for the Trust has remained below 90% for the whole 6-month period. This is on occasion supplemented by Ward sisters and Clinical Nurse Specialists supplying some additional support to wards.
- The average RN night fill rate follows a similar pattern to the day fill rate however it is marginally higher to ensure that there is sufficient nursing resource to cover the increased bed escalation requirements and any unexpected staff absences. The overall fill rate for RNs at night has not exceeded 100% in any month.
- The average NA Day fill rate has also decreased to below 100% in most months due to the staffing absence level created by the pandemic and increased vacancies. This has previously trended above 100% in all months.
- The NA night fill rate continues to be consistently above the planned staffing levels for nights. This is driven by the requirement to cover most of the Enhanced Care Observation assignments due to generally having less staff on duty at night. The fill rate above 100% has been maintained through this 6-month period. It should be noted that the fill rate is usually above 110% whereas for this period it is consistently below this level.

RAG rating for Fill Rate	Red	Amber	Green	Blue
Thresholds (75% is the national red flag level)	< 75%	76%- 89%	90%-100%	101%>

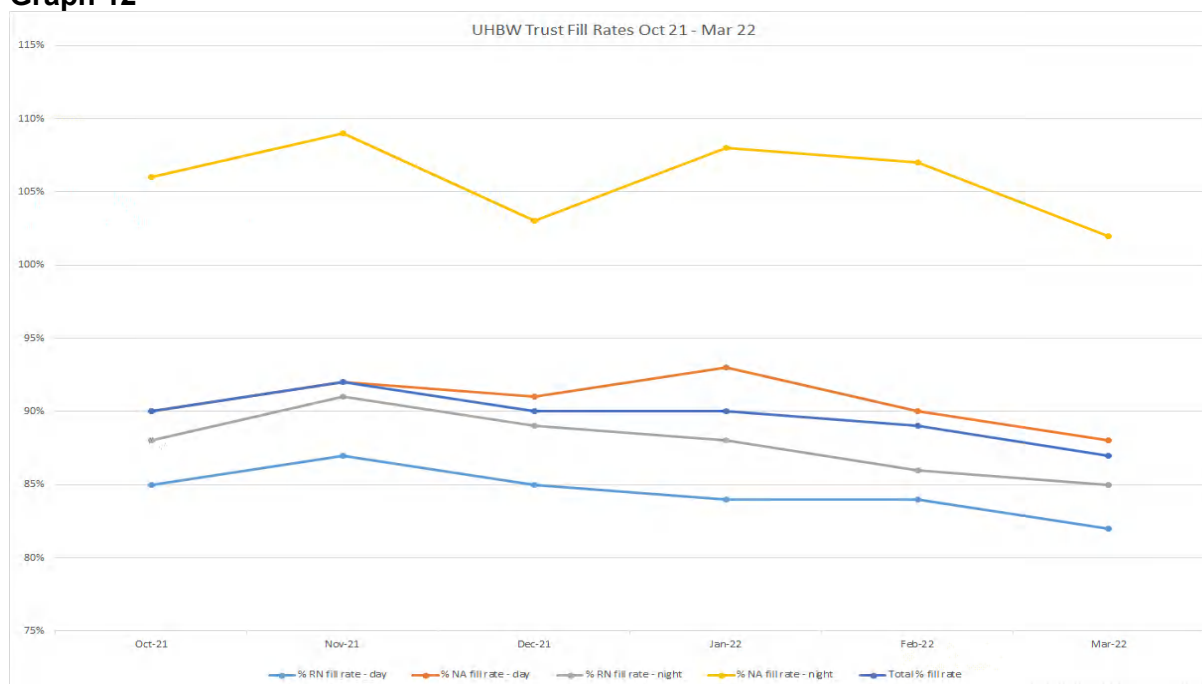
Note: the red rating has been set at 75% to be in line with the national guidance that states that:

- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 33 hours of Registered Nurse time, a red flag event would occur if 5:45 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).

Table 3

UHBW Trust Position (Nursing and Midwifery)	% RN fill rate - day	% NA fill rate - day	% RN fill rate - night	% NA fill rate - night	Total % fill rate
Oct-21	85%	90%	88%	106%	90%
Nov-21	87%	92%	91%	109%	92%
Dec-21	85%	91%	89%	103%	90%
Jan-22	84%	93%	88%	108%	90%
Feb-22	84%	90%	86%	107%	89%
Mar-22	82%	88%	85%	102%	87%
Trust 6 month Average	85%	91%	88%	106%	90%

Graph 12

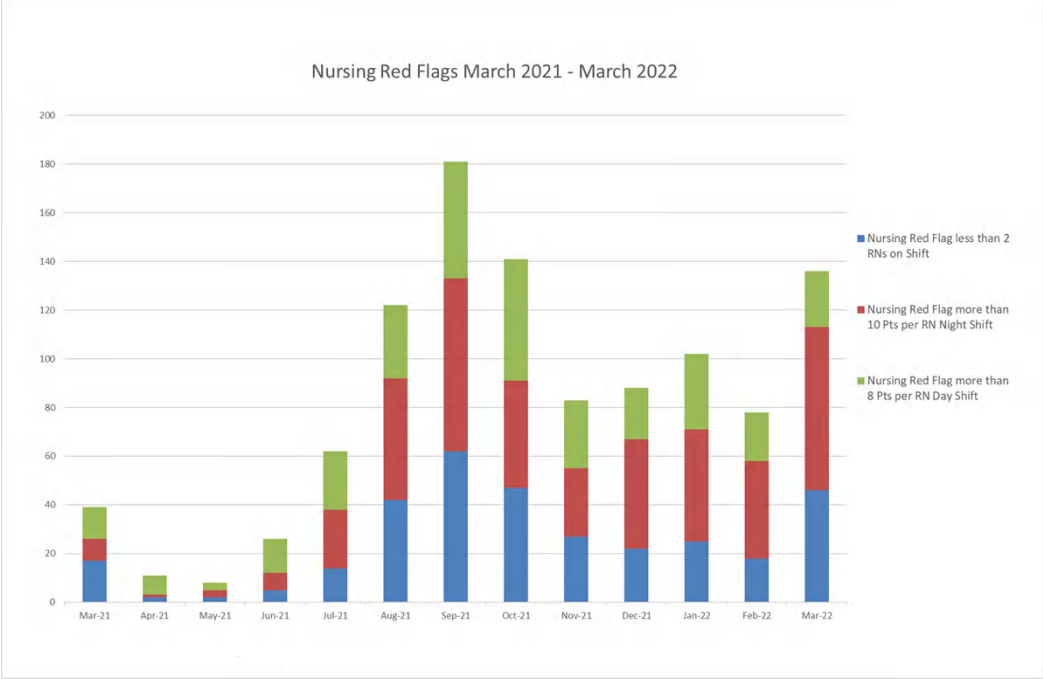


Nursing Red Flags and low staffing incidents

Since August 2021 there has been a significant increase in red flag incidents across the Trust. This has occurred in all divisions. All staff are encouraged to report concerns about staffing levels and this increase is a direct result of the pressure the nursing staff has been under. The largest increase has been seen in the red flag incident of more than 10 patients per RN night shift where on occasions RN staffing numbers have been up to 14 patients per RN on a night shift. The reasons for this include the impact of the Omicron Covid variant, increasing turnover and vacancy levels as staff leave and the subsequent impact of a

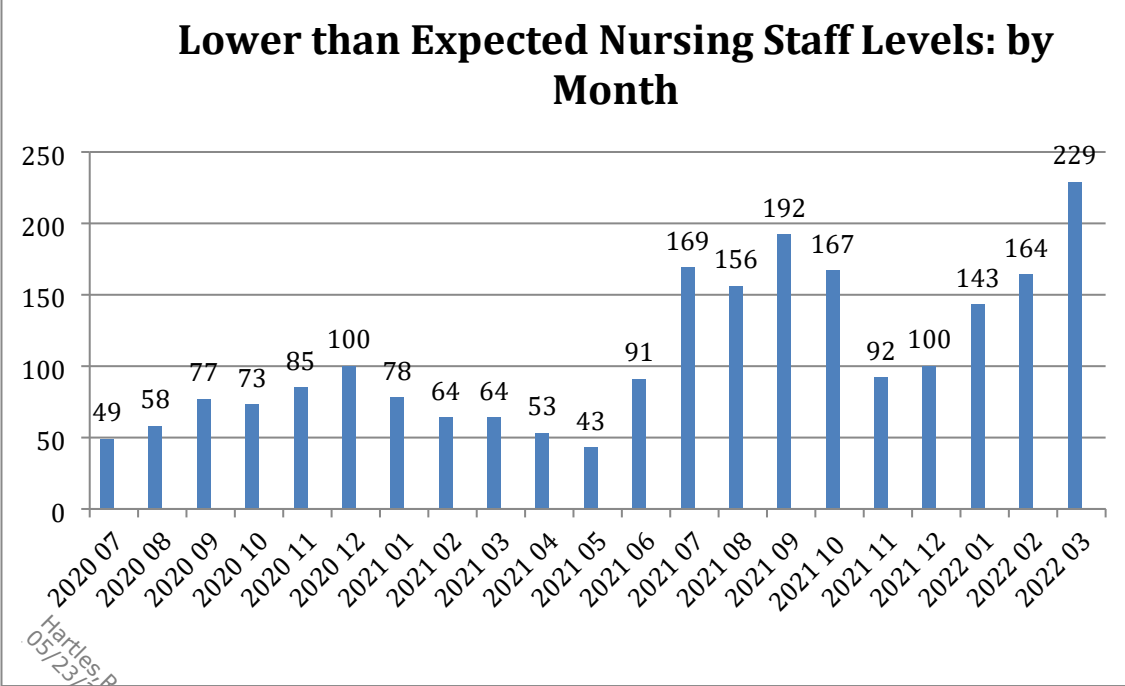
reduced skill mix because of the number of newly qualified and internationally registered nurses joining the numbers.

Graph 13



The number of ‘lower than expected’ staffing incidents reached the highest ever seen in March 2022 during the peak of the Omicron surge. The Heads of Nursing reviewed all the incidents and are also monitoring and triangulating the impact of these incidents on Nurse sensitive key quality outcomes.

Graph 14



Hartles Rachel
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3.0 Triangulation measuring and improving - Performance against key quality metrics. Patient outcomes

Carers and patient feedback

The impact of the pandemic on patients and carers during their hospital stay is clear particularly with the reduction in visiting throughout the past 2 years. The Trust has been flexible with visiting in line with the national Infection control guidance and when there has been no visiting the use of an IPAD by volunteers and ward staff for virtual visiting has been used. Feedback received via the comments within the friends and family test feedback from patients specifically shows that nursing staff are consistently busy throughout the day and night with a few occasions whereby patients felt that there were insufficient staff to provide prompt care for them.

Complaints

Tracking complaints provides an insight into the relationship between patients and staff and is acknowledged as a nurse sensitive indicator. For this reporting period, the level of complaints for nursing areas shows a reducing picture for formal and informal complaints between Quarter 3 and Quarter 4 of 2021/22. The comparison between formal and informal complaints also reduced from 22% to 17% in Quarter 4.

Table 4

Year	Quarter	Month	Patient Complaints	Formal Complaints	Informal Complaints
	2021/2022 Q2 Total		490	113	377
	2021/2022 Q3	Oct-21	176	26	150
		Nov-21	165	37	128
		Dec-21	89	30	59
	2021/2022 Q3 Total		430	93	337
	2021/2022 Q4	Jan-22	99	26	73
		Feb-22	110	20	90
		Mar-22	144	11	133
	2021/2022 Q4 Total		353	57	296

Infection control metrics

Infection rates are a key marker of quality care, the Trust tracks incidence of MRSA, MSSA and Clostridium Difficile to ensure that these are kept within acceptable trajectories as much as possible. The presence of these infections can potentially cause significant harm to patients, increase their length of stay and make caring for them more difficult.

There were six cases of MRSA in the 6-month period from October 21 to March 22 compared to one case in the previous 6 months. MSSA cases across the Trust have increased slightly and in the case of Clostridium Difficile the levels have decreased compared to February 21–September 21.

The infection control team and all Divisional matrons attend the monthly Operational Infection Prevention Control Group and are working through a Clostridium Difficile and MRSA improvement plan with learning gained from the regional collaborative working groups.

Falls and Pressure ulcers

The number of falls and the number of pressure ulcers have increased over the past 6

months, the Heads of Nursing continue to monitor these outcomes against lower than expected safe staffing incidents reported.

Table 5

		Integrated Performance Report - FY2023 Q4																						Overall Summary	
		Report Period: Q4 2023		Department: General Practice																					
		Metric: Patient Satisfaction		Target: 85%		Actual: 82%		Variance: -3%		Trend: Stable		Risk: Low		Action: Monitor		Status: On Track		Next Review: Dec 2023		Overall Score: 82%		Overall Rating: Good		Overall Trend: Positive	
		Metric: Patient Satisfaction		Target: 85%		Actual: 82%		Variance: -3%		Trend: Stable		Risk: Low		Action: Monitor		Status: On Track		Next Review: Dec 2023		Overall Score: 82%		Overall Rating: Good		Overall Trend: Positive	
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		Metric: Patient Satisfaction		Target: 85%		Actual: 82%																			

Regulatory requests for nurse staffing information

There was a Trust Care Quality Commission (CQC) inspection in June 2021 and one of the regulatory requirements identified specifically relating to nurse staffing was:

CQC inspection (June 2021)	Weston Medical	(Must do)	Ensure that there are enough nursing staff, with the right skills to meet patients' needs at all times. Regulation 18 (1) Staffing.

The Trust has supplied both written and verbal assurance to the CQC through regular engagement meetings to update on the recruitment, retention and staffing plans for nurse staffing at Weston. The turnover of Registered Nurse staff is decreasing, and the percentage of Registered Nurse vacancies at Weston is at the lowest it has been in the past year due to the international recruitment programme and some targeted specialist recruitment programmes.

Nurse Staffing Risks held on the corporate risk registers

There are 3 specific nurse staffing risks which are held on the Corporate risk register as below:

- **ID 5477 Risk that nurse staffing levels will not be met**
The current rating was increased to 20 due to the impact of the most recent omicron variant wave and the level is very high risk
- **ID Risk 737 unable to recruit staff** - score 16 level is very high risk
- **ID Risk 2694 unable to retain staff** - score 12 level is high risk

5.0 Nursing Recommendations

The last 6 months have continued to be an extraordinarily challenging time due to the pandemic, with the reconfiguration of beds required on a regular basis and staff adjusting to new environments and teams. An increase in absence was particularly noted over the past 3 months due to the Omicron Covid variant and also due to sickness for non-Covid related reasons, coupled with an increase in turnover and demand for the use of temporary staff.

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

The Trust Board is recommended to review the safe staffing report to note and support the following:

- Over the past 6 months the Trust has consistently not been able to meet the planned levels of Nursing and Midwifery staff on the wards, this has undoubtedly affected staff resilience and staff morale. The use of incentives for staff has been used to increase staff cover but leaders have been clear of the importance of monitoring staff well-being and resilience.
- The impact of staffing on patient quality outcomes at ward level will continue to be monitored through the monthly reporting to the Quality and Outcomes Committee. There was a noted correlation with a reduced Registered Nurse fill rate and an increase in the number of hospital acquired cases of MRSA and an increase in the number of falls and pressure ulcers over the past 6 months.
- The opening of additional capacity within the Trust was required to support the overcrowded Emergency Department, Quality Impact Assessments were undertaken to support the decision making for increasing boarding on wards and offloading of ambulances into queuing areas, balanced against whether it is safe to open these areas based on the availability of safe staffing.
- Staff feedback and the current turnover of staff illustrate that there is much more to do with retention; exit interview data is one element being analysed and will be part of the improvement plan and People strategy.
- In order to enable skills development, recruitment and retention of the existing workforce, the Trust has continued for a further year the Practice Education Facilitators posts. A benefits review is underway to assess these posts as part of the decision for considering substantive contracts in the next year.
- There will be a continued requirement for Trainee Nursing Associates to augment the Registered Nurse shortfall which continues to occur, and it will be necessary to review the numbers of registered nurses in areas in order to facilitate this.
- The current business plan for continuation of International Nurse recruitment in 22/23 will provide 108 more nurses to support the current turnover of Band 5 nurses. Further work is planned to assess and mitigate the current nursing establishment

vacancy.

- Future workforce plans include commitment to and progression of the training of Advanced Clinical Practitioners and the use of Non-Medical Consultants as key roles to ensure that UHBW is prepared for the future NHS workforce plans.
- In July 2022, the Trust will be undertaking a full evidence-based assessment of Nurse staffing levels across the Trust using the Safer Nursing Care tool. This will support the Divisional safe staffing reviews being undertaken by the Chief Nurse and Midwife and will be reported to the Trust Board in November 2022.

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Appendix 1:

University Bristol and Weston NHS Foundation Trust principles for initiating a nurse staffing review (2014)

As a minimum a staffing and skill mix ratio review will be undertaken annually for each clinical area.

OR when there is:

- A significant change in the service e.g. changes of specialty, ward reconfiguration, service transfer.
- A planned significant change in the dependency profile or acuity of patients within a defined clinical area e.g. demonstrated by sustained high acuity/dependency scores or an increased enhanced care requirement.
- A change in profile and number of beds within defined clinical area.
- A change in staffing profile due to long term sickness, maternity leave, other leave or high staff turnover.
- If quality indicators in the key performance indicators a failure to safeguard quality and/or patient safety.
- A Serious Incident (SI) where staffing levels was identified as a significant contributing factor.
- If concerns are raised about staffing levels by patients or staff.
- Evidence from benchmark group that UHBW is an outlier in staffing levels for specific services.

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Appendix 2:

Care Hours per Patient Per Day and How it's calculated

CHPPD was developed, tested and adopted by the NHS to provide a single consistent way of recording and reporting deployment of staff on inpatient wards/ units. The metric produces a single figure that represents both staffing levels and patient requirements, unlike actual hours alone. The data gives a picture of how staff are deployed and how productively they are used. It is possible to compare a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals. If a wide variation between similar wards is found it is possible to drill down and explore this in more detail.

Every month, the hours worked during day shifts and night shifts by Registered Nurses and MMidwives and by Health Care Support Workers are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day. This figure is reported monthly to NHSI.

The care hours per patient day required to deliver safer care can vary in response to local conditions, for example the layout of wards or the dependency and care needs of the patient group it serves. Therefore, higher levels of CHPPD may be completely justifiable and reflect the assessed level of acuity and dependency. Lower levels of CHPPD may also reflect organisational efficiencies or innovative staffing deployment models or patient pathways.

Weighted Activity Unit

Weighted Activity Unit (WAU) is defined as a 'common currency' to describe an amount of clinical activity, with a weighting applied that takes account of case mix and complexity. It is used in the Model hospital, following the work undertaken by Lord Carter, as a method of viewing NHS operational productivity and comparing this between Trusts.

A WAU is a quantity of any types of clinical activity including inpatients, outpatients, diagnostic testing and others. The national average cost is taken of each clinical activity and divided by 3,500 to say how many WAUs that clinical activity is 'worth'. The national average cost of a procedure comes from reference costs. One WAU equates to £3,500 'worth' of healthcare services.

Slightly different methodologies are used to calculate all staff cost per WAU (weighted activity unit) metrics at Trust level and for individual clinical service lines.

A simple calculation is used for staff cost per WAU metrics at clinical service line level, using data from ESR (the Electronic Staff Record) for costs:

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Part 2: Midwifery Staffing

1.0 Introduction

This section of the report details the specific requirements and actions taken by Midwifery Services to ensure that all mothers and babies are given quality care in a safe and secure environment.

- These are tailored to the unique client group and include ongoing actions and initiatives currently being undertaken in response to the Francis Report 2013^[1], Hard Truths 2014^[2] and the Developing Workforce Safeguards (October 2018)^[3]. The landmark publication of the Ockendon Reports in December 2020 and March 2022 are also addressed to assure the Trust that the Midwifery services are responding appropriately to the recommendations outlined in these two reports.

Midwifery

- In December 2020 the first Ockenden Report into the maternity services in Shrewsbury and Telford was published (Ref: ISBN 978-1-5286-2304-9, HC1081 2020-21). Following this all Trusts were able to bid for funding to close their gap between their current Midwifery establishment and their latest Birth rate Plus recommended establishment.
- UHBW had already taken steps to fund some of this gap and NHS England provided the remaining funding for a further 3 WTE Midwives, this was received in January 2022.
- The Trust has also provided funding for a 0.8 WTE specialist maternal medicine Midwife and 0.4 WTE to increase specialist mental health Midwives.
- UHBW received funding from the Neonatal Network for 10 WTE Neonatal Intensive Care Unit (NICU) nurses to help improve the staffing to meet British Association of Perinatal Medicine (BAPM) NICU standards. The Trust expects further funding this year to bring the NICU services above the BAPM threshold. Instances where these standards are not met are always reported as Nursing Red Flag events.
- Within the last 6 months, one to one care to women in labour has been maintained 100% of the time. This has been achieved by the flexibility of the Midwifery staff to ensure the one to one standard is achieved. Actions taken include:-
 - moving to work in different areas than they are rostered,
 - use of specialist Midwives working clinically,
 - an on-call system for the hospital,
 - calling in the on-call continuity teams to delivery suite,
 - review of staffing and capacity at twice daily flow meetings.

All these working practices are supported by the Royal College of Midwifery representatives.

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- Over the period October 2021–March 2022 there has been a recognisable increase in the acuity of the patients, in addition there has also been a rise in induction rates and caesarean section rates as a result of National safety initiatives to reduce the still birth and neonatal death.
- In view of these, two main initiatives have started.
 - A full Birth Rate Plus audit (the nationally recognised workforce assessment of Midwifery staffing) has been undertaken with the results being published in May 2022.
 - A scoping exercise has been completed with the Divisional finance team to assess the workforce requirements to implement continuity of care as the default position for all women by 2023. This has demonstrated that to achieve the goal and to continue to ensure safe staffing across the whole of the maternity service an extra 16 WTE Midwives would be required.
- The Pandemic has affected the Midwifery and neonatal workforce much more in the past few months than at the start of the Pandemic in 2020, with many more staff being affected with the virus. This has resulted in: -
 - closed NICU cots at times impacting on clinical care due to staff shortages which resulted in delays to inductions of women where it is known that babies will require NICU admission. (Inductions are reviewed on a daily basis and where appropriate some women may be transferred to other units in the locality),
 - the occasional night with only a Born Before Arrival (BBA) service in the community Midwifery service and closure of the alongside Midwifery led unit,
 - With increased junior neonatal medical staff shortages, the newborn examinations (NIPE) on the postnatal wards have been covered by appropriately trained Midwives.

2.0 NQB Expectations: A triangulated Approach to Staffing Decisions.

- The NQB three expectations (right staff, right skills, right place and time) support an approach to determining safe staffing levels based on patients' needs, acuity and risks, and are monitored from 'ward to board'. This triangulation approach to staffing decisions, rather than making judgments based solely on numbers or ratios of staff to patients, is supported by the CQC.

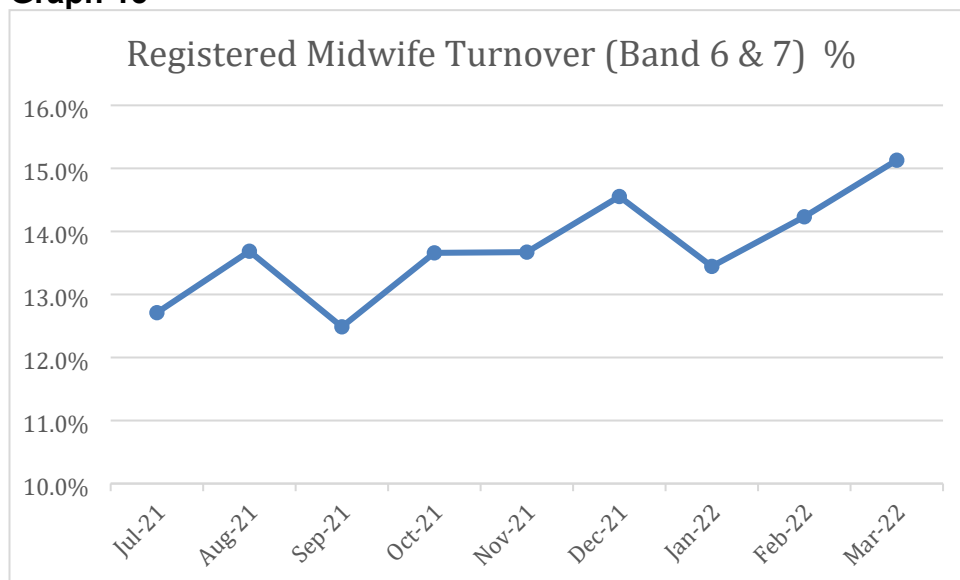
2.1 NQB Expectation One: Right Staff

- As well as undertaking the Birth rate Plus workforce assessment tool to ensure the service has the required Midwifery staffing, the Local Maternity System (LMS) has funded the Trust to acquire the license for the acuity tool for both the wards and the delivery suite which will allow improved daily decision making on staffing requirements, based on the acuity of the patients but also demonstrate a long-term view of activity and acuity in the unit. The tool has been implemented on the delivery suite, week commencing 18th April 2022 and results will be reported in the next 6 monthly report.
- The 2nd Ockendon report, published 30th March 2022, has recommended that the

national roll out of Continuity of Carer (a woman is cared for by a team of up to 8 Midwives in the antenatal period, intra partum and post-natal period) should not continue unless a unit has safe staffing established. UHBW has already stated that it cannot achieve Continuity of Carer as the default for all women by 2023, unless there is significant investment in the workforce numbers. There are currently 4 teams set up and working well however, 2 teams have had to return to traditional working temporarily due to staff leaving and retirements.

- There are 8 WTE vacancies in April 2022 in the Midwifery establishment, NHS England have provided specific funding for recruitment and retention with targeted activities. This includes a: -
 - Dedicated Midwifery Retention Midwife working across the whole acute and community-based Midwifery services
 - Practice Educator facilitators (PEF) roles, also part funded externally by the Local Maternity System. These roles have been invaluable in supporting new Midwifery staff and recently qualified Midwives to the unit evidenced by very positive feedback from staff.
 - Retention strategies have included giving extra supernumerary time to new staff, funding staff for external study days and reward schemes.
 - Midwifery has now 10 Professional Midwifery advocates who are very proactive and support Midwives in their practice. Midwifery turnover is regularly reported separately but is shown below for band 6 and band 7 (15.1%) compared to the latest staffing turnover in Women's services of 13.2%

Graph 15



The other key recommendations from Ockenden 30th March 2022 related to Midwifery staffing are identified below and the Trust will develop a dedicated action plan to deliver the expected outcomes: -

- Specific training and specialisation for labour ward coordinating Midwives.
- Take on the responsibility for the funding of the Practice Education Facilitators role.
- Training and development of a team of high dependency care Midwives, providing at least one HDU-trained Midwife per shift on Central Delivery Suite.

2.2 NQB Expectation Two: right skills

- Midwifery staff in UHBW all have rotational contracts and rotate in the hospital from delivery suite to the wards every year to maintain essential and advanced skills in all areas of practice.
- The Practice Development Midwives and new PEF Midwives have developed a training package with multidisciplinary input and attendance to ensure that staff keep their clinical skills up to date and practice effectively.
- Training compliance is monitored monthly and currently Midwifery compliance for obstetric emergency training is at 77%. The required standard for CNST is an overall compliance of 90% which was achieved last financial year. Currently, the compliance has been affected by Covid sickness and the need to cancel some training days to cover clinical shifts.
- A foetal monitoring and escalation focus week took place week of 28th March 2022 to highlight challenges that staff have with cardiotocograph (CTG) interpretation, escalation, human factors, civility saves lives and psychological safety as well as how to remove these barriers. This was supported by the Local Maternity System (LMS) who funded resources for staff. It was very well attended and received great feedback; further sessions are planned. Midwives are now running new-born examination clinics at the weekend to provide greater flexibility to mothers, this is with funding from the neonatal medical budget.
- There is currently an ongoing review of the Midwifery Assistants/ Midwifery Support Worker job descriptions and skills in line with the NHS Maternity Support Worker Competency, Education and Career Development Framework, to ensure that staff have the right skills and competencies and are being rewarded for their work appropriately.
- A regional piece of work is being led by the Regional Chief Midwife to assess how to encourage more Midwives to take on leadership courses to ensure succession planning for Senior Midwifery roles. All Midwifery Matrons at UHBW have completed or are participating in leadership courses this year.
- UHBW neonatal service continues to work in collaboration with UWE to deliver the post graduate neonatal course.

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2.3 NQB Expectation Three – Right Place and Time

- A twice daily flow meeting is held within women's services to ensure safe staffing is maintained by moving staff in line with patient activity. Bank Midwives are used to fill short term gaps and there is a hospital Midwife on call each night, at weekends and bank holidays both day and night. They can be called as part of the escalation plan for Maternity services. In addition, there are community Midwives on call each day and night to cover home births, they can also be called into the hospital as required.
- There are clear guidelines for the situation of either a lack of Midwives, lack of Midwifery beds or both which are invoked where indicated and overseen by the Midwifery manager on call each day and night. Specialist Midwives, Matrons and the practice development team are also used to work clinically if required. Where necessary onward escalation to the Head of Midwifery and Chief Nurse is expected to ensure safety of both the mother and baby.
- When community staff have been required to self isolate, Midwives have undertaken booking clinics virtually to ensure continuity in the antenatal/post-natal period.
- The majority of Midwives work full 12-hour shifts. A recent listening event with Midwifery staff raised some concerns about their rosters and working patterns. Therefore, part of the retention funding obtained from NHS England is being used to pilot self-rostering. This will be evaluated in the Autumn.

Midwifery Fill rates and comparisons

RAG rating for Fill Rate	Red	Amber	Green	Blue
Thresholds (75% is the national red flag level)	< 75%	76%- 89%	90%-100%	101%>

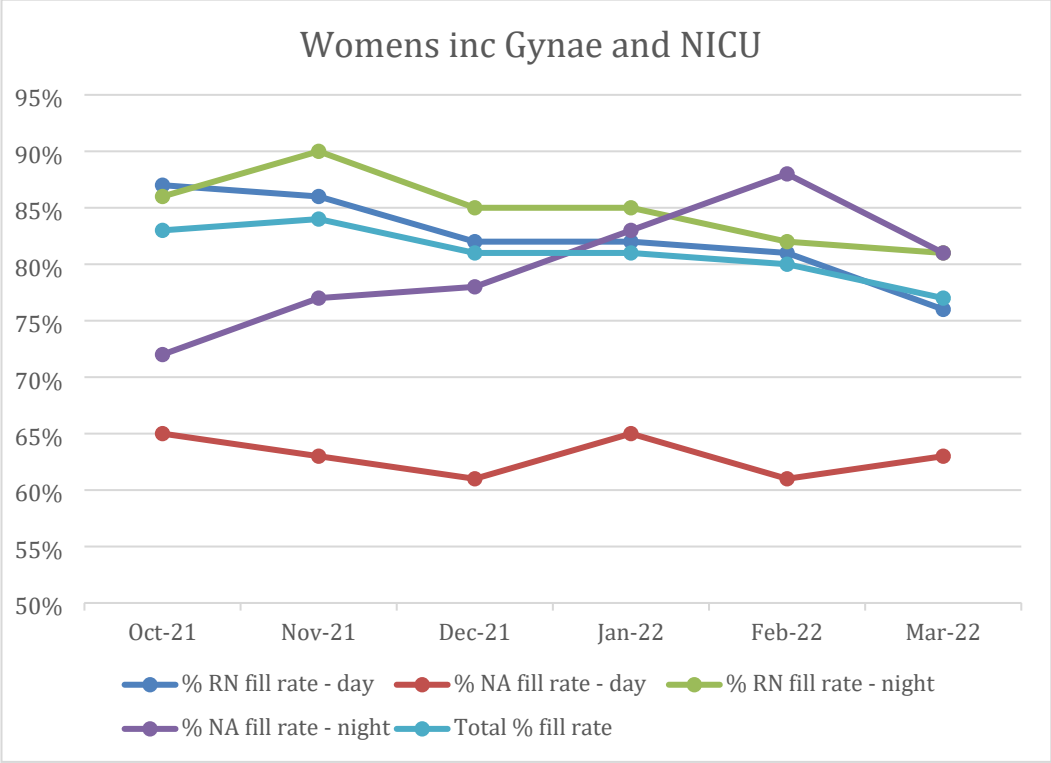
Note: the red rating has been set at 75% to be in line with the national guidance that states that:

A shortfall of more than 8 hours or 25% (whichever is reached first) of registered Midwife time available compared with the actual requirement for the shift. For example, if a shift requires 33 hours of registered Midwife time, a red flag event would occur if 5:45 hours or less of registered Midwife time is available for that shift (which is the loss of more than 25% of the required registered Nurse or Midwife).

Table 6

Womens inc Gynae and NICU	% RN/RM fill rate - day	% NA fill rate - day	% RN/RM fill rate - night	% NA fill rate - night	Total % fill rate
Oct-21	87%	65%	86%	72%	83%
Nov-21	86%	63%	90%	77%	84%
Dec-21	82%	61%	85%	78%	81%
Jan-22	82%	65%	85%	83%	81%
Feb-22	81%	61%	82%	88%	80%
Mar-22	76%	63%	81%	81%	77%
Trust 6 month Average	82%	63%	85%	80%	81%

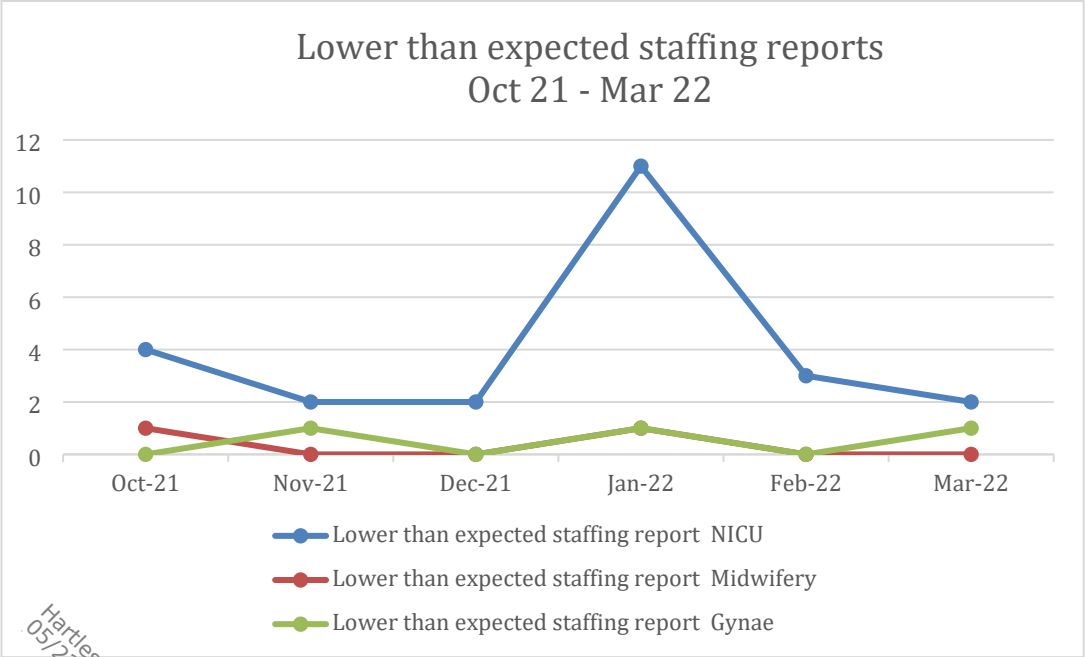
Graph 16



Midwifery Red Flags and low staffing incidents

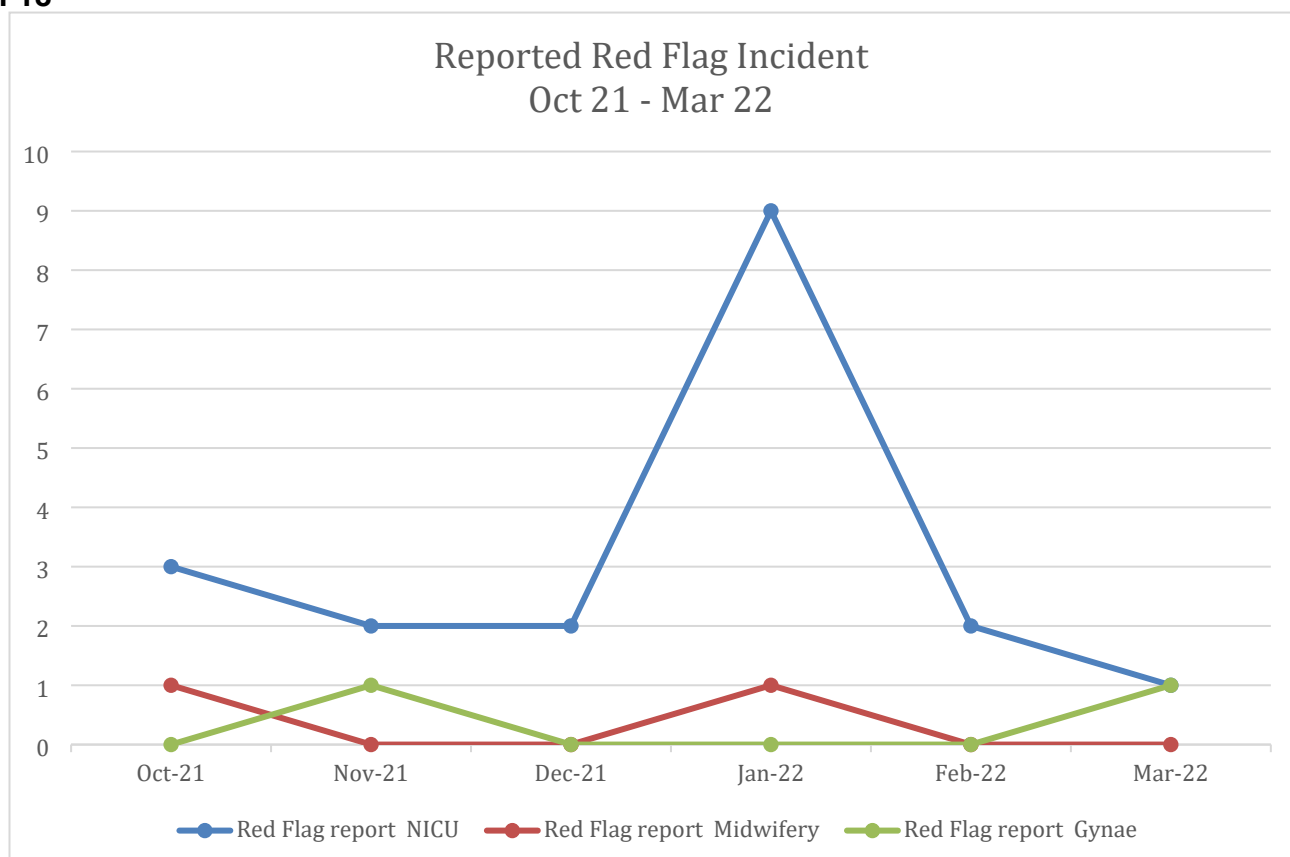
- There were 23 reported incidents related to workforce in the last 6 months (themes: delayed Induction of Labour/ non-compliance with BAPM standards/ staffing levels and capacity).
- Each of these incidents is reviewed by the Head of Midwifery.
-

Graph 17



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Graph 18



- Board Level champion patient safety visits take place monthly, and outputs are fed back to staff and reported on the Maternity perinatal quality surveillance dashboard.

3.0 Triangulation measuring and improving - Performance against key quality metrics. Patient outcomes

One to one midwifery care was achieved 100% when a woman is in labour, during the last 6 months.

Table 7

Domain	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
One-to-one care in labour (as a percentage)	100%	100%	100%	100%	100%	100%

Continuity of Carer is achieved for the women booked by UHBW Midwives at 53.7%, with it being achieved for 54.2% of BAME women and IMD 1 (most deprived) at 81.2%.

A new triage system has been introduced which ensures that patients presenting to the delivery suite are seen in a timely manner dependent on their clinical picture. This has achieved improved flow on the delivery suite.

Patient Complaints

- In line with the new reporting format the level of complaints for Women's Services are

now available. There has been a total of 13 (28%) formal complaints and 33 (72%) informal complaints over the past 6 months. This shows a good percentage of issues are mitigated at the informal stage.

Statutory and mandatory Training

- The level of compliance to Statutory and mandatory training for ward level Midwives is shown below along with the ward RN level for comparison.

Table 8

Division	UK 11 Core Skills	Remaining Essential Statutory and Mandatory Training
Midwives	81%	90%
Trust Ward level RN.'s	87%	87%

Midwifery Staffing Risks held on the corporate risk registers

Risk Number	Details	Risk Level	Score
33	Risk that inadequate nursing levels in line with BAPM standards 2011 will affect neonatal outcomes	Departmental	12
998	Risk that neonates are transferred out to alternative NICU units due to lack of cot capacity	Departmental	12
3623	Risk that extreme pre-term babies will have a sub-optimal outcome due to inability to deliver in a tertiary centre	Departmental	12
4810	Risk that if the trust does not achieve continuity of carer we will not achieve CNST safety standards	Departmental	12
5401	Risk that there will not be enough Midwives and obstetric staff to run a safe maternity service due to the impact of covid	Departmental	10
3697	Risk that there is not a Deputy Head of Midwifery and Nursing for Women's services	Departmental	8

5.0 Midwifery Recommendations

- The Birth rate Plus results will be published in May 2022 indicating the suggested level of staffing for all areas. The report and action plans will go to the Divisional Board and be reviewed by the Head of Midwifery and Chief Nurse and Midwife, and it is recommended that the Trust Board reviews the report and supports the investment in the Midwifery workforce as required.

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Part 3: Allied Health Professionals (AHP's) Staffing

1.0 Introduction

This is a new style of report for assessment of Allied health Professional's staffing levels and is part of the requirements of the Developing workforce safeguards compliance.

Allied Healthcare Professionals (AHPs)

- Any significant changes that have occurred in Allied Healthcare Professionals staffing establishments and skill mix in the last eight months and any risks on the corporate risk register related to Allied Healthcare staffing.
- Assurance regarding safe staffing over the six months, including Weighted Activity Unit information.
- Notable recent national guidance that impacts on safe staffing for Allied Health Professionals both on Adult and Children.

NQB Expectations: A triangulated Approach to Staffing Decisions.

- The NQB three expectations (right staff, right skills, right place and time) support an approach to determining safe staffing levels based on patients' needs, acuity and risks, monitored from 'ward to board'. This triangulation approach to staffing decisions, rather than making judgments based solely on numbers or ratios of staff to patients, is supported by the CQC.

2.0 NQB Expectation One: Right Staff

Principles of Safe Staffing for AHP's in UHBW.

The Trust currently employs 679 (574.51 WTE) registered Allied Health Professionals (Bands 5-8D) and are aided by 131 (109.4 WTE) support workers and assistants (Bands 2-4) from the professions of:-

- Occupational Therapy,
- Physiotherapy,
- Diagnostic Radiography,
- Therapeutic Radiography,
- Nutrition and Dietetics,
- Speech and Language Therapy,
- Operating Department Practitioners and
- Orthoptics

They are an integral part of the multi-disciplinary team and work across all divisions within the Trust. AHP's provide clinical care for patients within outpatient, inpatient and community settings. The Trust also provides a prosthetics and orthotics service which is outsourced in adult and children's services, also employing psychologists who are not included in this report.

The current AHP staffing turnover is at 15.9%, vacancies within the specialties vary and more detailed reporting is expected to be available in future reports.

For the purposes of this report, the following terms have been used:

- **Adult Therapies (ists)** – Occupational Therapists (OT), Speech and Language Therapists (SLT), Physiotherapists (PT) and dieticians working in the divisions of Diagnostics and Therapies, Surgery, Medicine and Weston.
- **Childrens Therapies (ists)** – OTs, SLTs, PTs and dieticians working within the women and children's division.

The following summarises the changes that have taken place as part of the divisional reviews:

Unit Area	Service Review and Changes Made	WTE
Adult Therapies	Staff have completed training at Guys and St. Thomas' Hospital for ECMO (Extra Corporeal Membrane Oxygenation) beds in the BRI (Bristol Royal Infirmary).	2.0 WTE
Childrens' Therapies	Band 8A, Paediatric dietician for national pilot project supporting Obesity strategy.	0.5 WTE
	Band 7 Dieticians to cover Gastroenterology (until March 2022) and Band 6 Dietician to support community waiting list backlog.	2 WTE band 7 and 0.5 WTE band 6
	Band 6 PT (Bronchiolitis) and Band 3 rehab assistant posts until June 2022 through accelerator funding.	1.0 WTE each
	Band 7 OT Gene therapy for children with muscular atrophy (new service).	0.2 WTE
	Paediatric Long Covid MDT band 7 OT (until June 2022).	0.4 WTE
Therapeutic Radiography	Two Therapeutic Radiographer apprentices (March 2022).	2.0 WTE
	Radiotherapy Late Effects Radiographer (Macmillan funded 2 year project).	1.0 WTE
Operating Department Practitioners	3 trainee ODP apprenticeships	3.0 WTE

Impact of COVID-19:

- Staffing hours lost during the COVID-19 pandemic have been due to staff shielding, staff being diagnosed with COVID-19 and staff having to isolate due to being in contact with a COVID-19 positive person. Where possible staff continued to work from home when not directly involved in front-line care as well as offering out-patient appointments through video conference calls.
- During the Trust Internal Critical Incident from December 2021 until March 2022 - Study leave was cancelled when it could be however, during March staff were encouraged to take booked annual leave as they were reporting feeling tired and burnt out.

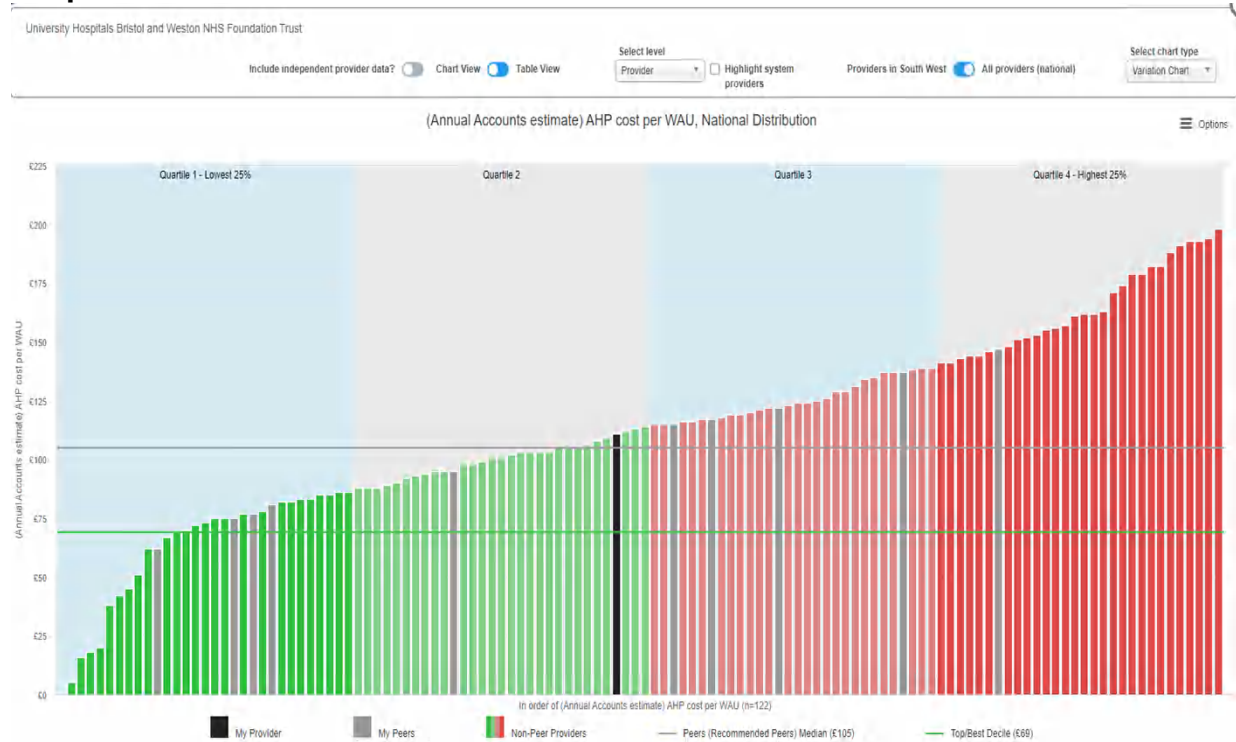
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- COVID-19 risk assessments were undertaken with all staff to ensure that they were allocated to work in areas appropriate to their risk level.

Model Hospital AHP Benchmarking and WAU

The WAU for AHP's has remained consistent from the previous year. UBHW currently has a WAU of £111, this compares favorably with the national median value of £114.

Graph 19



Care pathway reviews

- Adult Therapies staff from UHBW are involved in the Discharge to Assess Pathway reviews and contributed to the development of the new Single Referral Form for BNSSG to facilitate patient discharge and flow and adult therapies staff supported the BNSSG Care Hotel when in use from January to March 2022.
- There is a plan for a review (before the end of July 2022) of all the pathways of care that operate at BRI and Weston across Adult Therapies. Pathway leads with support from the Head of AHPs will review processes in relation to referrals, documentation and datasets around experience, outcomes and performance. WTE staff numbers within pathways will be reviewed and skill-mix compared to national guidance/data where available.

2.2 NQB Expectation Two: right skills

Recruitment Strategy and planning

- Recruiting and retaining talented staff is a priority across the BNSSG system for the AHP workforce. Working in partnership with NBT (North Bristol Trust), different clinical rotations for Adult Therapies are being introduced (initially within critical care) with more opportunities for both adult and children rotations between NBT, UHBW and Sirona being explored; in addition international recruitment for radiographers is being explored. A clinical academic route for career progression for AHPs is also being explored within UHBW along with recruitment open days, apprenticeships, career clinics and workplace drop-in sessions.
- There are concerns with recruiting into Bands 6 and 7 in adult and children's therapies especially for Occupational Therapists and Dieticians. Issues remain in recruiting to posts within diagnostic radiography (there is currently over a 20% vacancy in radiographers at Band 5-7 level). Sonographer posts at Band 7 and 8A level are also difficult to recruit.
- There is a national shortage of Therapeutic Radiographers (currently at 8.8%) and this is resulting in difficulty in recruiting at UHBW with a high turnover among Radiology Assistant posts (Band 2). A majority of AHP staff who leave UHBW, do so, to gain further specialist skills, due to relocation to a different region, or due to lack of further career progression opportunities within the Trust.
- For recruitment within Adult Therapies Band 5 and 6 jobs are now advertised to include rotations between Bristol and Weston sites. All AHP professional groups also consider part-time and flexible working arrangements for recruitment and retention of staff.
- Adult Therapies have re-started a Recruitment Day and plan to include 'Live' feedback from students on placements (already in place in Therapeutic Radiography) to support recruitment initiatives across AHP services.
- Diagnostic Radiography is training apprentice radiographers and assistant practitioners.
- There are plans for investment in Practice Education Facilitator roles to co-ordinate and improve student placement experience within AHP professional groups with active recruitment from this group of students for working within UHBW being trialled with a fixed-term practice education facilitator role in Adult Therapies.

Retention Plans

- AHP's will inform the Nursing Midwifery and Allied Health Professionals strategy being developed in the Trust. Plans are in place to include the Four pillars of clinical practice, research and innovation, education and learning as well as leadership and talent management as part of clinical supervision and appraisal (already in place within Childrens' Therapies).
- Continue to provide flexible working arrangements and secondments and career breaks/unpaid leave in order to retain staff across all AHP groups.

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- Implement a robust preceptorship program for new starters at Band 5, as well as supporting the establishment a system wide AHP Council and AHP Faculty that staff within UHBW will be a part of.
- Diagnostic Radiography is developing a training programme for career progression of Band 2 radiography assistants to Band 3 roles (subject to funding and skill-mix).

Advanced Practice Opportunities

- The Trust supports and is keen to implement the advanced practice opportunities which exist for AHP's. The new role requests have been submitted from Adult Therapies as part of Trust wide ACP role expansion.

Workforce Planning for the Future

- Adult Therapies are undertaking a review of staff structures and skill-mix and using Model Hospital data to inform that the right workforce is available for the future. The Head of AHPs is also working with colleagues in the BNSSG system to identify and inform AHP future workforce planning issues across the system.

Statutory and Mandatory Training compliance

- The overall compliance among AHPs for UK core skills (EDI, Infection prevention and control, resuscitation, safeguarding, information governance etc.) is 87% and for remaining essential training (dementia awareness, clinical record keeping, harassment and bullying, patient safety etc.) is 84%.
- Some of the training non-compliance is due to the clinical operational pressures from COVID-19 and staff sickness absence during this time. Service managers are reviewing compliance levels to ensure all staff remain compliant with statutory and mandatory training using the new Kallidus learning platform.

Appraisal compliance

Staff Group	%
AHP's	76.4%

2.3 NQB Expectation Three: right place and time

Work is progressing to address the following as required:

- Staff rotations
- Seven Day and shift patterns working plans
- Joint working with nursing on wards

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AHP Staff Satisfaction Survey

The National staff survey for 2021 AHP results show that 'few staff felt that there was *enough staff at the organisation to do their job properly and staff were feeling burnt out and emotionally exhausted.*'

Staff Communication and Engagement

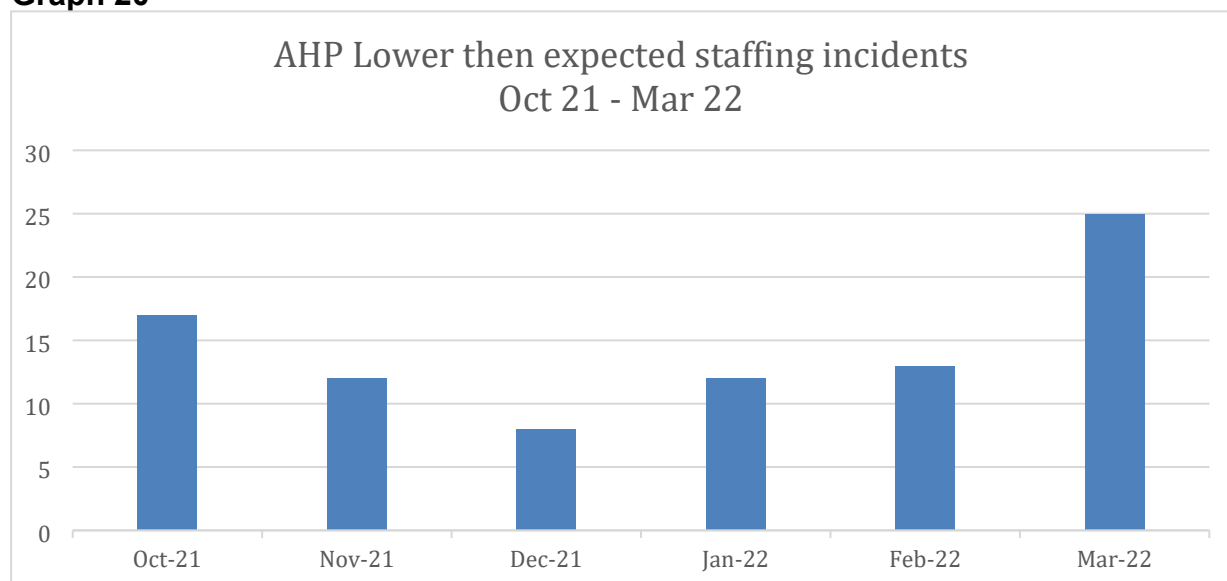
- The Head of AHPs hosts a monthly Allied Health Professional leads meeting. The meeting allows for cascade of information from Trust, BNSSG system, Southwest regional and National issues as well as discussing service (vacancy, recruitment and retention) and clinical care issues within different services. Every meeting has an invited speaker to talk about issues/new developments (first contact practitioners, regional clinical fellows, dementia/delirium/falls lead, advanced clinical practitioners) that could have an impact on AHP staff and service provision.
- AHP staff participate in the monthly Chief Nurse Question and Answer session to ask questions and cascade information from the Trust. Staff within Adult Therapies are involved in BNSSG system wide work on the discharge to assess (D2A) pathway, Childrens Therapies staff are involved with supporting first contact practitioners in nutrition and dietetics in the community and Diagnostic Radiography staff are engaged in system wide work on Community Diagnostic Centres.
- A number of posts are recruited and funded based on short-term funding and will need to translate into service level funding if services are expected to continue.

AHP low staffing incidents

- Where lower than expected staffing forms were submitted, they were assessed as near miss to minor actual harm impact only.
- The majority of reported incidents were reporting reduced Assistant cover or due to unforeseen service provision reduction due to the pandemic.

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Graph 20



AHP Staffing Risks held on the corporate risk registers

Risks involving AHP recruitment (737) on the Trust strategic risk register. In addition, leadership development (2646), education (5277), research (2741) and digital (2633) skills for all staff including AHPs are in the Trust strategic risk register.

Risk Number	Details	Risk Level	Score
737	Risk that the Trust is unable to recruit sufficient numbers of substantive staff	Strategic Risk Register	16
2646	Risk that the Trust has insufficient leadership capacity	Strategic Risk Register	20
5277	Risk that the objectives of the Trust wide multi-disciplinary education strategy are not delivered	Strategic Risk Register	20
2741	Risk that the Trust is unable to sustain research activity	Strategic Risk Register	12
2633	Risk that the Trust's IM&T Systems fail to deliver the required levels of efficiencies	Strategic Risk Register	20

5.0 AHP Recommendations

- The planned review of pathways and services will help consolidate gains from integrated working across Bristol and Weston sites. The review will include referrals, documentation, outcome and experience measures, research and digital capacity, skill-mix, new roles (advanced practitioners, non-medical consultants) and use of data and compare (where possible) with national guidance.
- Recruitment of Practice Educators within professional groups (therapies, diagnostic radiography, therapeutic radiography etc.) to be considered to provide hands-on supervision and support for new starters, competency development for non-

registered staff and international recruits as well as enhancing placement experience of pre-registration students – who are likely to be future staff at UHBW.

- Facilitate cross-organisational working within BNSSG to assist recruitment, provide additional training opportunities, a common preceptorship framework and career progression opportunities which will facilitate retention of the best talent within UHBW.

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Meeting of the Board of Directors in Public on Friday 27th May 2022

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

1. Report Summary	
The purpose of this report is to inform the Board of the financial position of the Trust for April 2022.	
2. Key points to note (Including decisions taken)	
The report has been abridged in the first reporting period of the new financial year to allow for completion of the 2022/23 budget setting process. The following sections are not included in the report for April: • SPORT • Divisional Position • Additional costs of Covid-19 • Action Log Full reporting will resume in June. The Trust's year to date net income and expenditure performance, excluding technical items, is a net deficit of £3,007k compared with a planned deficit of £2,545k. The position is driven by higher than expected pay expenditure and a shortfall on savings, offset by lower than planned depreciation. The Trust has delivered savings of £857k or 45% of the plan, a shortfall of £1,057k of which £439k relates to system transformation savings. The Trust's cash balance was £181,993k as at 30 April 2022.	
3. Risks If this risk is on a formal risk register, please provide the risk ID/number.	
A strategic risk assessment is provided in the Executive Summary.	
4. Advice and Recommendations (Support and Board/Committee decisions requested):	
• This report is for Assurance.	
5. History of the paper Please include details of where paper has <u>previously</u> been received.	
Finance & Digital Committee	26 th May 2022

Trust Finance Performance Report

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Reporting Month: April 2022

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Reporting Month: April 2022

YTD Income & Expenditure Position

- Net I&E deficit of £3,007k against a planned deficit of £2,545k (excluding technical items).
- Total operating income is £547k adverse to plan due to lower than planned other operating income of £1,109k (relating mainly to research and education).
- Operating expenses are £58k adverse to plan primarily due to higher pay expenditure (£685k adverse), the shortfall in CIP delivery of £1,057k (of which £439k relates to system transformation savings), offset by lower than planned depreciation expenditure of £638k.
- Technical and financing items are £139k favourable to plan.

Key Financial Issues

- *Savings delivery below plan* - Savings delivery is £857k or 45% of plan. Full year forecast delivery is £10,386k or 47% of plan of which recurrent savings are £4,607k, 20% of plan.
- *Capital expenditure below CDEL* - expenditure is 20% of plan in April. Conclusion of the re-prioritisation process in early June and delivery against agreed schemes must be achieved to ensure effective use of capital resources.
- *Pay costs higher than plan* – pay expenditure must be maintained within divisional and corporate budgets to enable delivery of the financial plan.
- *Forecast overspend against divisional budgets* – assessment of gap between budget and forecast expenditure to be completed by end of Q1, including the development of recovery plans where overspends are not acceptable.

Strategic Risks

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- Agreeing a system approach to future financial targets and allocation of system envelopes – on-going;
- Assessment and implications of the financial arrangements relating to the Healthy Weston – pending;
- Continue to understanding the risks and mitigations associated with the new capital regime; and how the CDEL limit and system prioritisation could restrict future strategic capital investment – on-going.
- Understanding the implications of not delivering the financial plan, the impact this may have on future investment opportunities and the ability to maintain autonomy- pending

Financial Performance – Income & Expenditure

April 2022

Trust Year to Date Financial Position

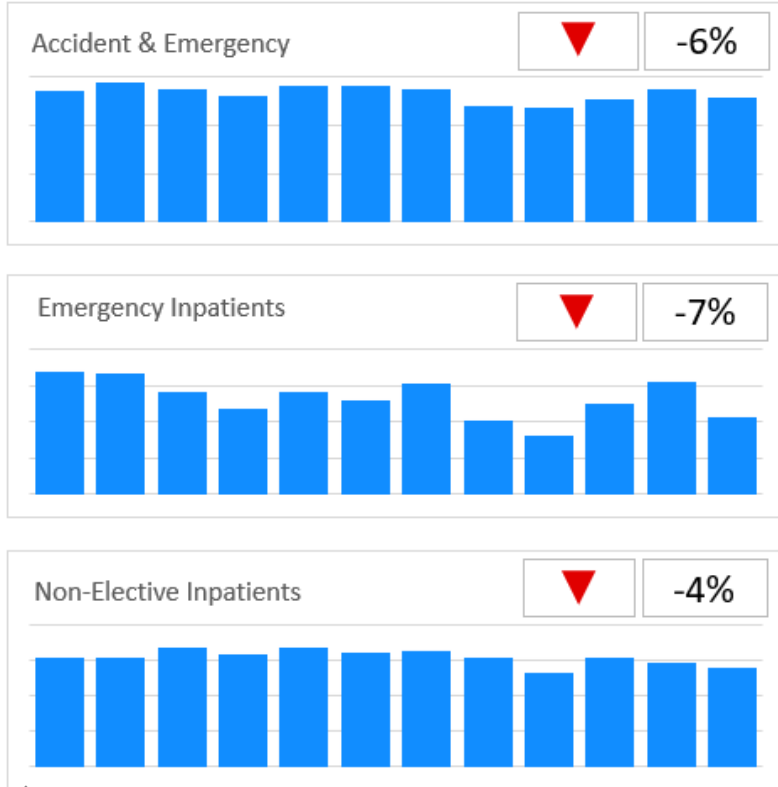
	YTD		
	Plan	Actual	Variance Favourable/ (Adverse)
	£000's	£000's	£000's
Income from Patient Care Activities	75,666	76,228	561
Other Operating Income	9,059	7,950	(1,109)
Total Operating Income	84,725	84,178	(547)
Employee Expenses	(50,976)	(51,661)	(685)
Other Operating Expenses	(32,172)	(32,263)	(91)
Depreciation (owned & leased)	(3,064)	(2,426)	638
Total Operating Expenditure	(86,212)	(86,270)	(58)
PDC	(244)	(161)	83
Interest Payable	(1,037)	(1,037)	
Interest Receivable	29	85	56
Other Gains/(Losses)	0	0	(0)
Net Surplus/(Deficit) inc technicals	(2,739)	(3,204)	(465)
Remove Capital Donations, Grants, and Donated Asset Depreciation	194	197	3
Net Surplus/(Deficit) inc technicals	(2,545)	(3,007)	(462)

Key Facts:

- The position at the end of April is a net deficit of £3,007k, £463k worse than the planned deficit of £2,545k.
- Pay expenditure is £51,661k in April, c£1m lower than the January and February average and c£1,500k higher than the Q3 average.
- Agency expenditure is broadly in line with plan at £2,642k in April and consistent with previous months at 5% of total pay costs.
- Operating income is adverse to plan by £547k, due to an adverse position on 'Other Operating Income'. This is driven by lower than expected income levels for research, education and NHS recharges.
- Income from Patient Care Activities is £561k favourable to plan.
- CIP achievement is 45%. £857k has been achieved against a target of £1,914k, a shortfall of £1,057k.
- Additional costs of Covid-19 are £919k in April, a reduction of £498k from £1,417k in March.

Actual Financial Position – Clinical Activity Volumes

April 2022



Key Points:

- We use calendar days to calculate the volume per day for non-elective points of delivery.
- Accident and emergency attendances per day are 6% lower in April compared with March. For the Trust overall, attendances are at 98% of pre-pandemic levels. However, the position by hospital site is very different with the Bristol Children's Hospital seeing 2% growth and the Eye Hospital being 16% lower. This is shown in Appendix 1.
- Emergency inpatient spells per day are 7% lower in April compared with March. Volumes are 16% lower YTD than pre-pandemic levels.
- Non-elective inpatient spells per day are 4% lower in April compared with March. Non-elective inpatients included maternity and non-emergency transfers.

Year to Date Volume

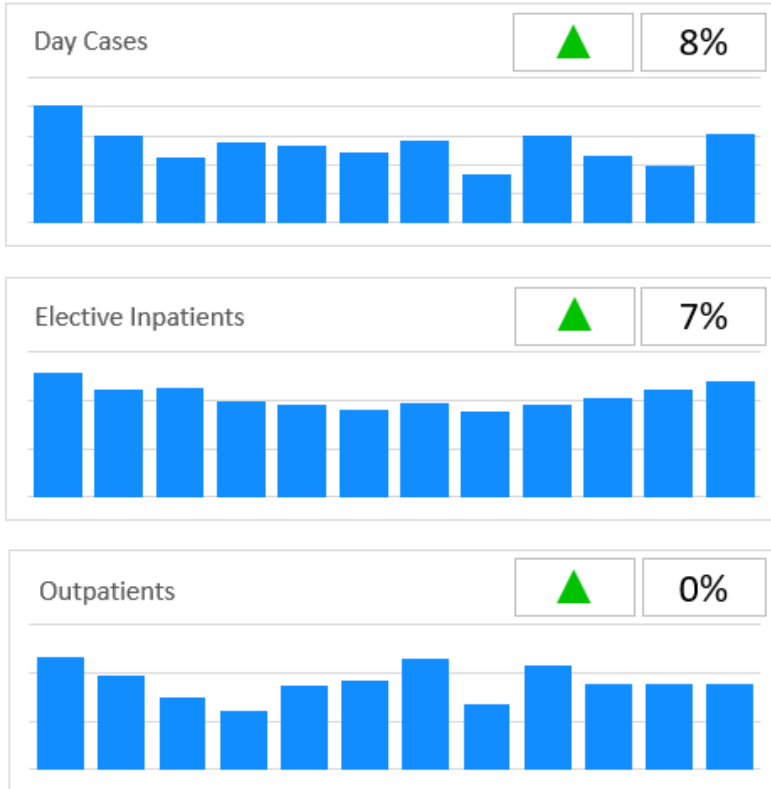
Board POD	2022/23 Actual Volume Per Day	2019/20 Actual Volume Per Day	2022/23 Planned Volume Per Day	2022/23 Actual / 2019/20 Actual	2022/23 Actual / 2022/23 Plan
Accident & Emergency	512	544	523	94%	98%
Emergency Inpatients	141	168	152	84%	93%
Non-Elective Inpatients	56	55	63	102%	89%

Current Month Volume

Board POD	2022/23 Actual Volume Per Day	2019/20 Actual Volume Per Day	2022/23 Planned Volume Per Day	2022/23 Actual / 2019/20 Actual	2022/23 Actual / 2022/23 Plan
Accident & Emergency	512	544	523	94%	98%
Emergency Inpatients	141	168	152	84%	93%
Non-Elective Inpatients	56	55	63	102%	89%

Actual Financial Position – Clinical Activity Volumes

April 2022



Key Points:

- We use working days to calculate the volume per day for elective points of delivery.
- Day cases per day are 8% lower in April compared with March. YTD volumes are 12% lower than pre-pandemic volumes and 6% lower than planned.
- Elective inpatients per day are 7% higher in April compared with March. YTD volumes are 22% lower than pre-pandemic volumes and 3% lower than planned.
- Outpatient attendances per day are broadly similar in March and April. YTD volumes are 5% lower than pre-pandemic volumes and 9% lower than planned.

Year To Date Volume

Board POD	2022/23 Actual Volume Per Day	2019/20 Actual Volume Per Day	2022/23 Planned Volume Per Day	2022/23 Actual / 2019/20 Actual	2022/23 Actual / 2022/23 Plan
Day Cases	281	318	300	88%	94%
Elective Inpatients	47	61	49	78%	97%
Outpatients	3,391	3,568	3,745	95%	91%

Current Month Volume

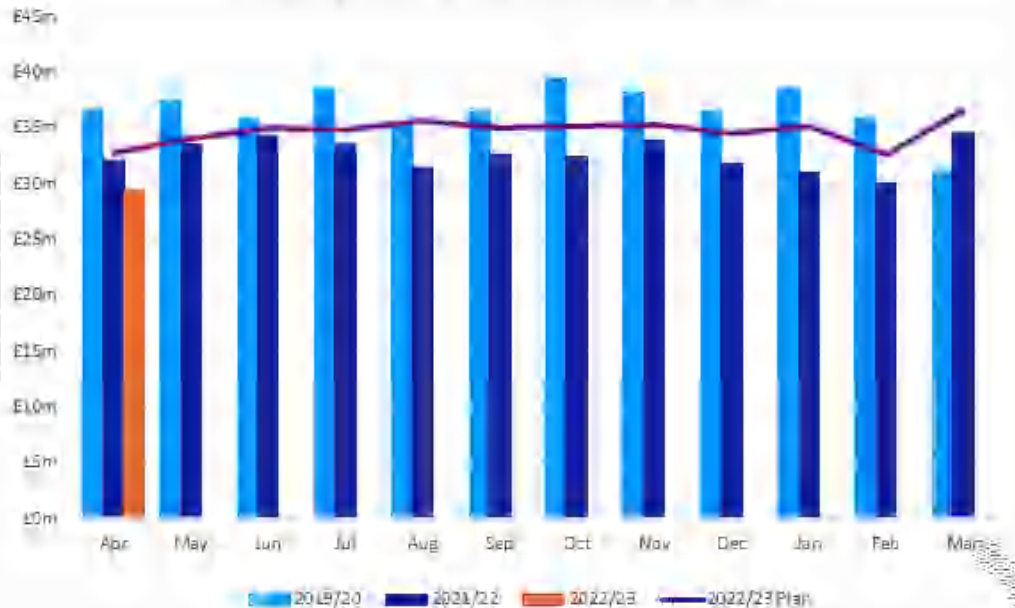
Board POD	2022/23 Actual Volume Per Day	2019/20 Actual Volume Per Day	2022/23 Planned Volume Per Day	2022/23 Actual / 2019/20 Actual	2022/23 Actual / 2022/23 Plan
Day Cases	281	318	300	88%	94%
Elective Inpatients	47	61	49	78%	97%
Outpatients	3,391	3,568	3,745	95%	91%

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Actual Financial Position – Clinical Income

April 2022

Value By Financial Year And Financial Month



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 April is £29.4m compared with £34.5m in March.
- The value of elective activity (including inpatients spells, day cases and outpatients) in April is £13.6m compared with £16.0m in March. The value of non-elective activity (including emergency inpatients and accident and emergency attendances) in April is £15.8m compared with £18.4m in March.
- There were 19 working days in April compared with 20 working days in March.

Year To Date Value

Board POD	2022/23	2019/20	2022/23	2021/23	2021/23
	Actual	Actual	Plan	Actual / 2019/20	Actual / 2021/23
	£000	£000	£000	Actual	Plan
Accident & Emergency	2,797	2,965	2,866	94%	98%
Day Cases	3,457	4,595	4,053	75%	85%
Elective Inpatients	3,694	5,582	4,197	66%	88%
Emergency Inpatients	10,586	12,129	11,432	87%	93%
Non-Elective Inpatients	2,464	3,115	3,041	79%	81%
Outpatients	6,437	8,291	7,171	78%	90%
Total	29,435	36,677	32,761	80%	90%

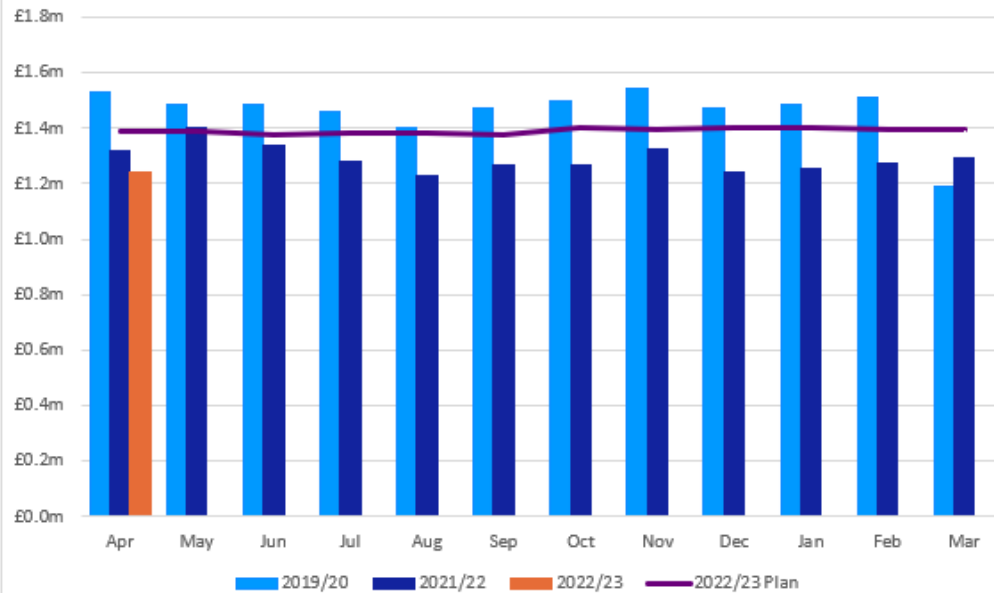
Current Month Value

Board POD	2022/23	2019/20	2022/23	2021/23	2021/23
	Actual	Actual	Plan	Actual / 2019/20	Actual / 2021/23
	£000	£000	£000	Actual	Plan
Accident & Emergency	2,797	2,965	2,866	94%	98%
Day Cases	3,457	4,595	4,053	75%	85%
Elective Inpatients	3,694	5,582	4,197	66%	88%
Emergency Inpatients	10,586	12,129	11,432	87%	93%
Non-Elective Inpatients	2,464	3,115	3,041	79%	81%
Outpatients	6,437	8,291	7,171	78%	90%
Total	29,435	36,677	32,761	80%	90%

Actual Financial Position – Clinical Income

April 2022

Value Per Day By Financial Year And Financial Month



Key Points:

- The value of elective activity per working day in April is 3% higher than March. The value of emergency activity per calendar day in April is 10% lower than March.
- Feedback from Divisions suggests that elective activity continues to be relatively low due to capacity constraints. High staff absence, due to sickness and isolation, has been cited as a key factor, as has high levels of emergency outliers. There are also difficulties discharging patients in the community.
- It is expected that these factors will also affect elective performance in May.

Year To Date Value Per Day

Board POD	2022/23 Actual £000	2019/20 Actual £000	2022/23 Plan £000	2022/23 Actual / 2019/20 Actual	2022/23 Actual / 2022/23 Plan
Accident & Emergency	93	99	96	94%	98%
Day Cases	182	230	213	79%	85%
Elective Inpatients	194	279	221	70%	88%
Emergency Inpatients	353	404	381	87%	93%
Non-Elective Inpatients	82	104	101	79%	81%
Outpatients	339	415	377	82%	90%
Total	1,243	1,530	1,390	81%	89%

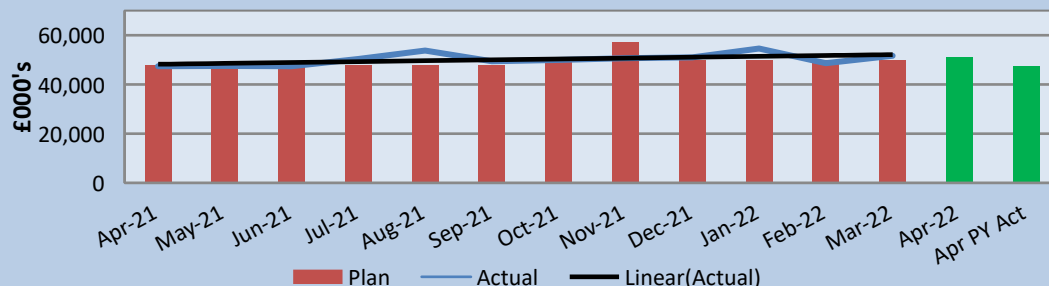
Current Month Value Per Day

Board POD	2022/23 Actual £000	2019/20 Actual £000	2022/23 Plan £000	2022/23 Actual / 2019/20 Actual	2022/23 Actual / 2022/23 Plan
Accident & Emergency	93	99	96	94%	98%
Day Cases	182	230	213	79%	85%
Elective Inpatients	194	279	221	70%	88%
Emergency Inpatients	353	404	381	87%	93%
Non-Elective Inpatients	82	104	101	79%	81%
Outpatients	339	415	377	82%	90%
Total	1,243	1,530	1,390	81%	89%

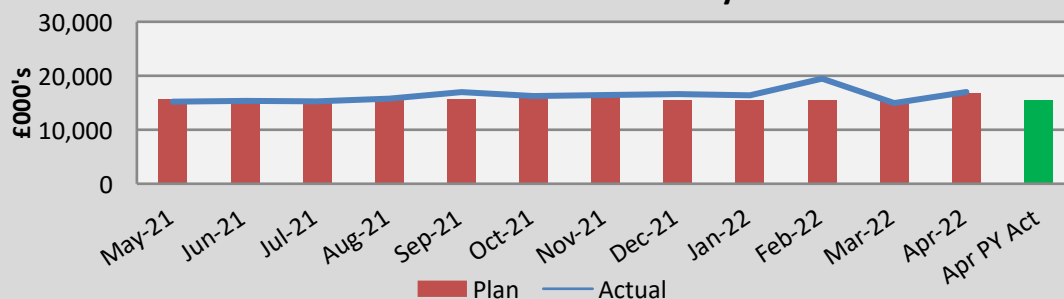
Financial Performance – Workforce Expenditure

April 2022

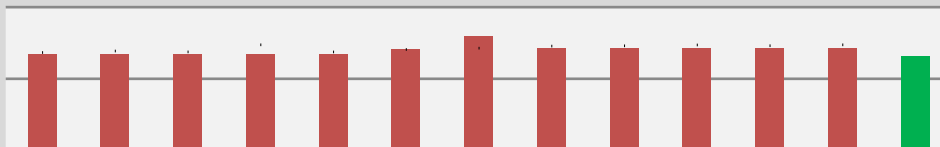
Run Rate: Total Pay Expenditure



Run Rate: Total Medical Pay



£000's



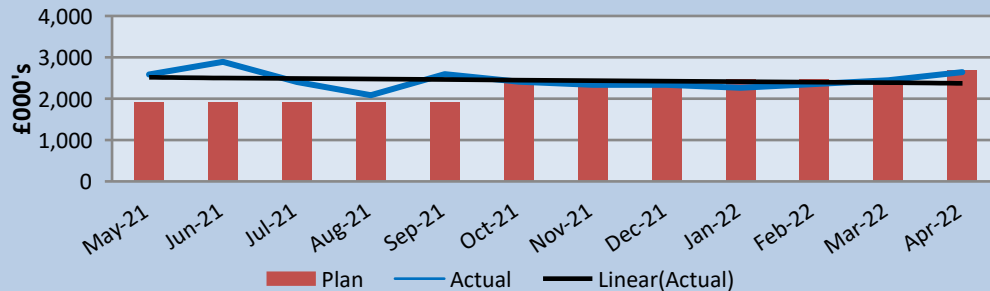
Key Points:

- Total pay expenditure in April is £51,661k, £1,140k lower than the January and February average. Expenditure was significantly lower in March due to the reduction in the holiday pay provision (£3,397k benefit in March).
- The main driver of the decrease can be attributed to the treatment of Clinical Excellence Awards which were paid in February elevating the pay costs in month. Substantive, bank and agency costs remain broadly consistent month-on-month.
- Total pay expenditure in April is £685k or 1.3% adverse to plan and continues the trend from 2021/22 (2021/22 pay expenditure was 1.3% adverse to plan).
- Agency expenditure in April is £2,642k compared with £2,446k in March and £2,354k in February.
- Nursing increased in month by £157k and medical agency reduced by £10k.
- Bank expenditure is £2,602k in April, lower than £3,638k in March and similar to £2,577k in February.

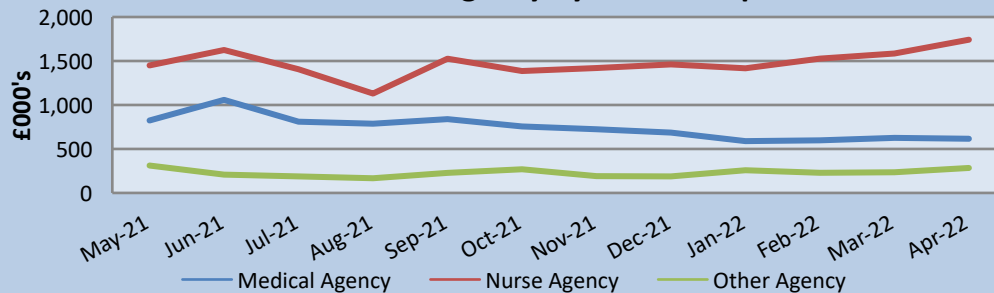
Financial Performance – Bank & Agency

April 2022

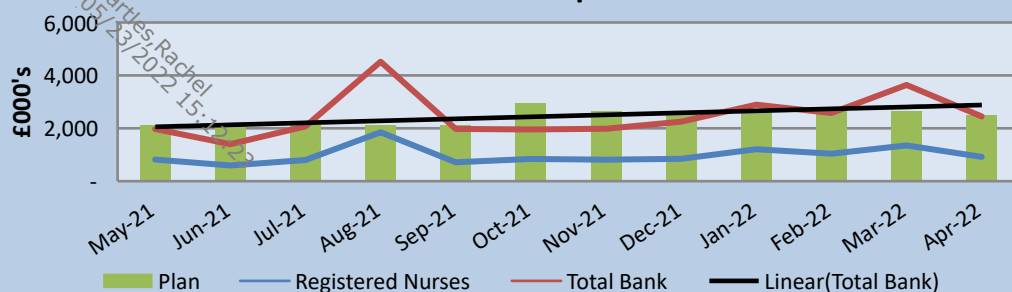
Run Rate: Agency Expenditure



Run Rate: Agency by Staff Group



Run Rate: Bank Expenditure



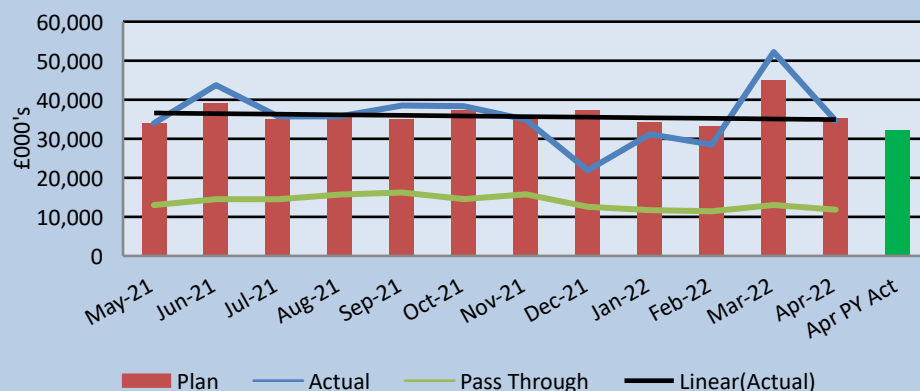
Key Points:

- Agency expenditure in April is £2,642k, £40k lower than plan and slightly higher than March (£2,446k).
- Agency as a % of total pay expenditure continues to represent 5% of total pay expenditure, following the trend set in 2021/22.
- Agency usage continues to be driven by vacancies across nursing and medical staffing. Sickness and the use of mental health nurses are also key drivers.
- Nurse agency shifts decreased by 598 or 13% compared with March. Average cost per shift increased by 19% compared with March.
- Medical agency spend is consistent with last month at £616k from £626k in March.
- Bank costs in April are £2,448k, down from £3,638k in March. This is mainly due to a 21% reduction in shifts. The reduced availability of enhanced payments is also a contributing factor.
- See Appendix 2 and 3 for further details on agency usage.

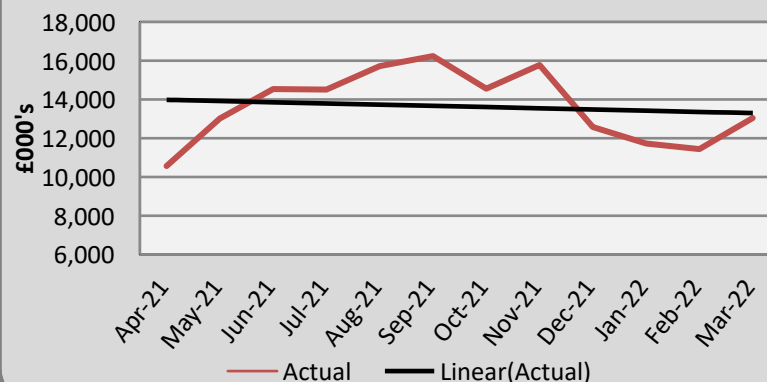
Financial Performance – Non Pay Expenditure

April 2022

Run Rate: Non Pay Expenditure



Run Rate: Pass-Through Drugs & Devices



	CURRENT YEAR			PRIOR YEAR		
Top 5 Favorable Variances	YTD Plan (£000's)	YTD Expenditure (£000's)	Variance (£000's)	YTD Plan (£000's)	YTD Expenditure (£000's)	Variance (£000's)
Research and development - non-staff	1,824	1,236	588	1,056	1,626	(770)
Supplies and services—clinical (excluding drugs cos)	6,781	6,356	425	7,385	6,160	1,225
Supplies and services - general	832	734	98	878	872	66
Clinical negligence	2,025	1,949	75	3,058	2,165	893
Premises - business rates payable to local authority	348	292	56	529	341	188
Total	11,810	10,567	1,243	11,687	11,163	524

	CURRENT YEAR			PRIOR YEAR		
Top 5 Adverse Variances	YTD Plan (£000's)	YTD Expenditure (£000's)	Variance (£000's)	YTD Plan (£000's)	YTD Expenditure (£000's)	Variance (£000's)
Operating lease expenditure	51	702	(651)	57	603	(546)
Premises - other	1,414	1,747	(333)	1,059	551	498
Establishment	1,392	1,598	(206)	1,448	1,353	95
Education and training -non-staff	185	764	(579)	256	72	184
Purchase of healthcare from NHS bodies	901	529	372	830	1,128	(298)
Total	3,983	5,225	(1,242)	3,154	3,910	(756)

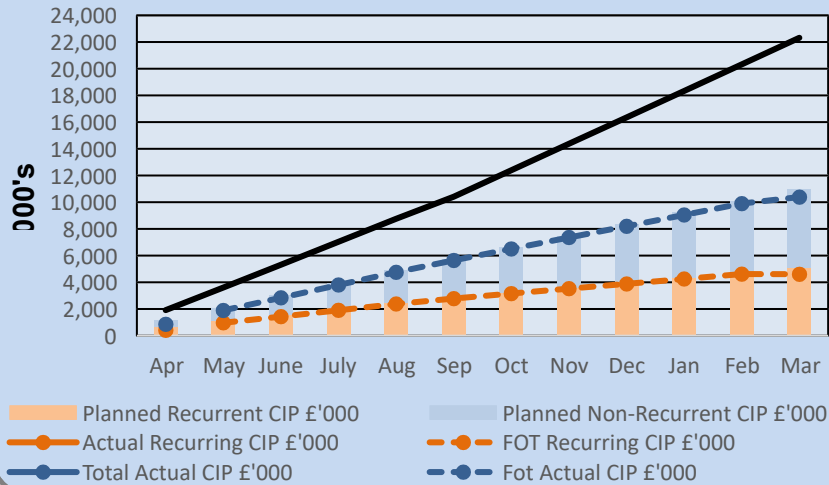
Key Points:

- Total non-pay expenditure in April is £32,183k, in line with the plan.
- Drug expenditure decreased in March to £12,860k from £13,358k in March, returning to a level similar to the average costs for Q4 2021/22.
- Clinical supplies and services is £425k lower than plan at the end of April despite the shortfall in CIP. This is driven by lower than expected activity levels.

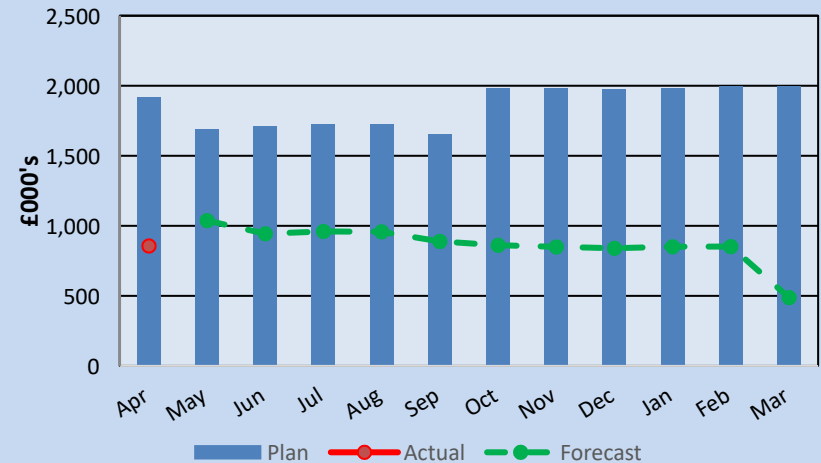
Savings – Cost Improvement Programme

April 2022

CIP: Planned Savings v Actual



2022/23 Savings Run Rate



Workstream	2022/23 Annual Target £'000's	Year to Date			Forecast Outturn £'000's
		Plan £'000's	Actual £'000's	Variance Fav/ (Adv) £'000's	
Nursing Pay & Productivity	1,009	23	57	(7)	1,009
Medical Pay & Productivity	539	41	41	-	539
Non Pay Productivity	3,970	681	666	(204)	3,832
HR Pay and Productivity	466	39	39	-	466
HR Pay and Productivity	435	37	37	(0)	435
Income, Finance & External	601	50	1	(49)	544
Medicines	30	3	0	(3)	0
Allied Healthcare Professionals Productivity	423	35	24	(11)	412
Estates & Facilities	852	95	95	-	852
Trust Services	276	20	20	(0)	276
Plans to be developed from Pipeline	4,014	334	-	(364)	-
System Transformational Savings	7,366	439	-	(439)	-
Weston Mergers - Nursing	336	67	67	-	-
Grand Total	22,317	1,914	857	(14,157)	10,386

Key Points:

- The Trust's 2022/23 savings target is £22,317k. This includes £7,366k attributable to system transformation savings.
- At the end of April, the Trust had achieved savings of £857k, or 45% against a plan of £1,914k, a shortfall of £1,057k.
- £439k of the £1,057k shortfall is due to non-achievement of system savings and £618k relates to Trust-led CIP.
- At the end of April, all divisions have a shortfall against their recurring and non-recurring plan.
- Currently 44% of forecast savings are non recurrent which is of concern.

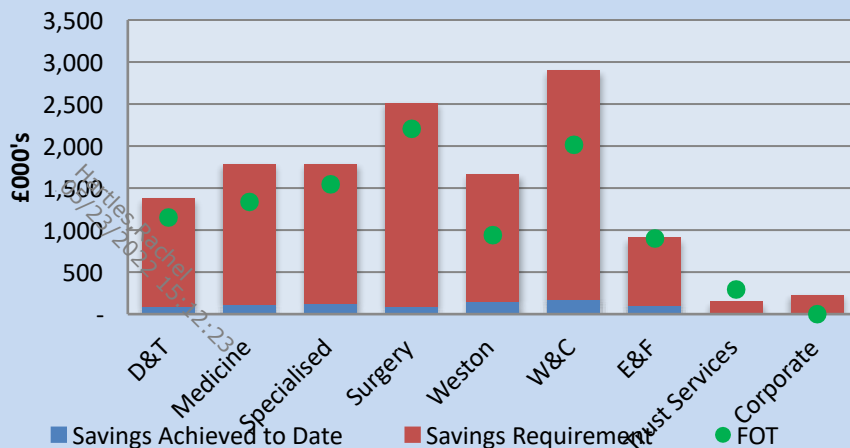
Savings – Divisional Position

April 2022

Division	2022/23 Annual Target £000's	Year to Date			Forecast Outturn £000's
		Plan £000's	Actual £000's	Variance Fav/ (Adv) £000's	
Diagnostics & Therapies	1,384	112	93	(19)	1,151
Medicine	1,777	241	109	(133)	1,336
Specialised Services	1,788	145	130	(15)	1,543
Surgery	2,514	211	91	(113)	2,205
Weston	1,666	139	149	(41)	940
Women's & Children's	2,900	305	167	(139)	2,015
Estates & Facilities	907	101	96	(5)	900
Finance	156	13	18	5	215
Human Resources	225	19	2	(17)	23
Trust Headquarters	339	30	2	(28)	33
Digital Services	342	29	1	(29)	23
Corporate	8,319	518	-	(510)	-
Total	22,317	15,515	857	(1,057)	10,386

Division	2022/23 Annual Target £000's	Full Year Forecast		
		Recurring £000's	Non Recurring £000's	Total £000's
Diagnostics & Therapies	1,384	90	1,060	1,151
Medicine	1,777	922	414	1,336
Specialised Services	1,788	602	944	1,545
Surgery	2,514	1,757	448	2,205
Weston	1,666	469	471	940
Women's & Children's	2,900	345	1,670	2,015
Estates & Facilities	907	281	619	900
Finance	156	62	153	215
Human Resources	225	23	-	23
Trust Headquarters	339	13	-	33
Digital Services	342	23	-	23
Corporate	8,319	-	-	-
Grand Total	22,317	4,607	5,779	10,386

2022/23 Savings Plans by Division



Recovery Actions:

- Re-establish the medical workforce group to include review in GIRFT.
- Review corporate savings in Medicines including Procurement, CMU contracts and contract variances.
- Work closer with NBT and BWPC to improve the non-pay workstream.
- Continue work to develop and deliver productivity improvements.
- Develop divisional pipelines and convert to actual savings plans.
- Target is for divisions to have implemented 2% savings on a recurrent basis by the year end.

Capital – Capital Programme Summary

April 2022

Key Points:

- A high-level, CDEL-compliant plan of £62,235k was submitted to NHSEI on 28th April in accordance with national guidance.
- The plan represents the UHBW share of the system capital envelope (£58,485k) plus £3,750k expected in donations. It is probable that there will also be additional funding available throughout the year to support nationally approved schemes.
- At the end of April total expenditure was £1,531k less than planned at £379k against a plan of £1,910k. This is due to a significant proportion of the programme currently being on pause whilst a re-prioritisation process is being concluded.
- A change in national reporting timetables also brought forward the Trust's closedown for April which reduces the spend captured in the month by one week.
- Expenditure on Major Strategic Schemes was extremely low in April. Given the volume of the programme this will need to substantially increase to assure delivery of the programme plan in year.
- Expenditure on Medical Equipment and Operational Capital is also low, reflecting the challenges of resourcing project managers to lead the programme areas. At the present time this is not expected to present a slippage challenge, however there is a risk of further delay if resources are not aligned in the coming month.

Capital Plan 2022/23	2022/23 NHSEI Plan £000's	YTD Plan £000's	YTD Actual £000's	Variance £000's
Strategic Schemes	20,621	687	48	(639)
Medical Equipment	7,369	247	150	(97)
Operational Capital	13,783	460	(36)	(146)
Fire Improvement	3,138	105	17	(98)
Digital Services	6,049	201	136	(65)
Estates Replacement & Infrastructure	6,303	210	55	(155)
Other	4,972	0	9	9
Total Capital Applications	62,235	1,910	379	(1,531)
Analysed as:				
Inside Envelope	58,485	1,598	379	(1,219)
Outside Envelope	3,750	312	0	(312)
Total Capital Applications	62,235	1,910	379	(1,531)

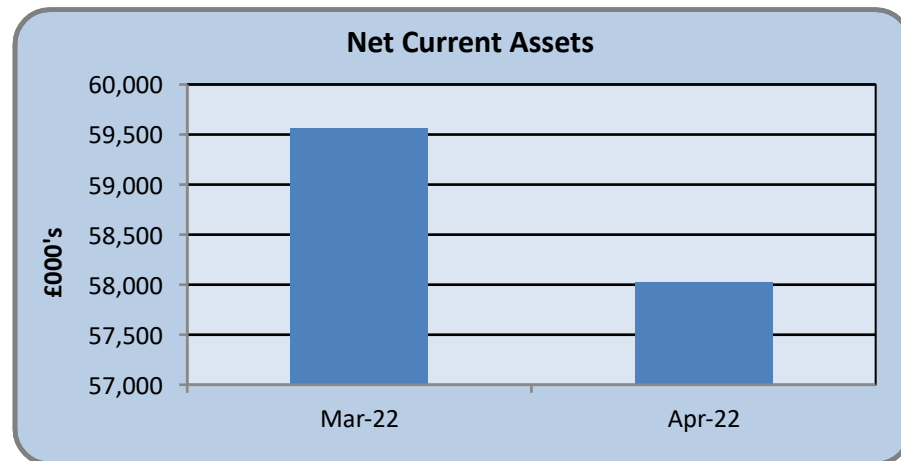
Actions:

- Conclude the re-prioritisation exercise by the w/c 6th June.
- Establish robust monitoring and reporting processes to provide early indication of slippage to enable resource to be utilised effectively.

Financial Position – Statement of Financial Position

April 2022

As at 31 March 2022 £000's		Actual Apr 2022 £000's	YTD Movement £000's
	Non-Current Assets		
554,486	Property, Plant and Equipment	552,655	(1,831)
10,788	Intangible Assets	10,603	(185)
1,906	Receivables	1,906	-
567,180	Total Non-Current Assets	565,164	(1,716)
	Current Assets		
13,580	Inventories	13,284	(296)
33,763	Trade and Other Receivables	32,469	(1,294)
155	PDC Dividend Receivable	155	-
168,091	Cash	181,993	13,902
215,589	Total Current Assets	227,901	12,312
	Current Liabilities		
(170,942)	Trade and Other Payables	(185,712)	(5,770)
(8,773)	Borrowings	(10,241)	(1,468)
(370)	Provisions	(370)	-
(8,940)	Other Liabilities	(15,868)	(7,928)
(188,025)	Total Current Liabilities	(211,991)	(23,966)
59,564	NET CURRENT ASSETS (LIABILITIES)	58,029	(1,535)
626,744	TOTAL ASSETS LESS CURRENT LIABILITIES	623,493	(3,251)
	Non-Current Liabilities		
(88,832)	Borrowings	(89,797)	(965)
(9,537)	Provisions	(1,524)	(8,013)
(98,369)	Total Non-Current Liabilities	(91,321)	(7,048)
572,375	TOTAL ASSETS EMPLOYED	569,171	(3,204)
323,158	Public Dividend Capital	323,158	-
160,191	Retained Earnings	157,167	(3,024)
88,941	Revaluation reserve	88,761	(180)
85	Other Reserves	85	-
572,375	Total Taxpayer's Equity	569,171	(3,204)



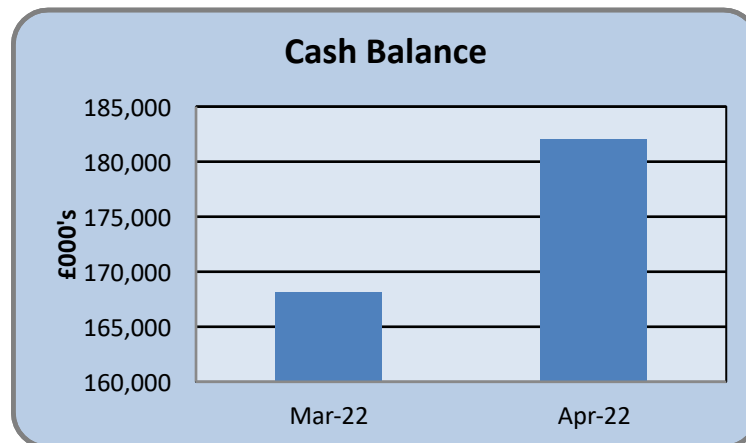
Key Points:

- Net current assets as at 31st March are £58,029k, a decrease of £1,535k on the 2021/22 closing year end position.
- The net current asset decrease is primarily driven by an increase in cash of £13,902k offset by a decrease in receivables of £1,294k, an increase in payables by £5,770k and increase in deferred income of £7,298 relating to Health Education England.
- Total Taxpayer's Equity has decreased by £3,204k, driven in part by the net income and expenditure deficit (including technical items).

Financial Position – Cash Flow

April 2022

As at 31 March 2022 £000's	Statement of Cash Flows	Apr-22 £000's
	Cash Flows from Operating Activities	
21,786	Operating Surplus/(Deficit)	(2,000)
30,300	Depreciation and Amortisation	2,621
13,035	Impairments and Reversals	-
-	Losses on Disposals	-
(17,178)	Income from Donations	2
(3,027)	(Increase)/Decrease in Assets	1,531
11,624	Increase/(Decrease) in Liabilities	15,872
56,541	Net Cash Generated from/(used in) Operations	18,094
	Cash Flows from Investing Activities	
90.00	Interest Received	85
(167,336)	Purchase of Assets	(18,000)
17,170	Receipt of Cash to Purchase Donated Assets	21
(100,000)	Net Cash Generated from / (used in) Investing Activities	(17,914)
	Cash Flows from Financing Activities	
11,023	Public Dividend Capital - Received	-
(18,334)	Loans	-
(1,150)	Interest Paid	-
(595)	Finance Lease	(45)
(13,815)	Public Dividend Capital - Paid	-
(7,005)	Net Cash Generated from/(used in) Financing Activities	(185)
(4,555)	INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	13,902
169,644	Cash at the Start of the Year	168,741
168,091	CASH & CASH EQUIVALENTS AT THE END OF THE PERIOD	183,643



Liquidity ratios	Acid test	Liquidity days
Draft target	2:1	30
Jan-22	1.3:2	20
Feb-22	1.3:2	19
Mar-22	1.3:0	17
Apr-22	1.3:1	16

Acid test - ability to meet short term debt

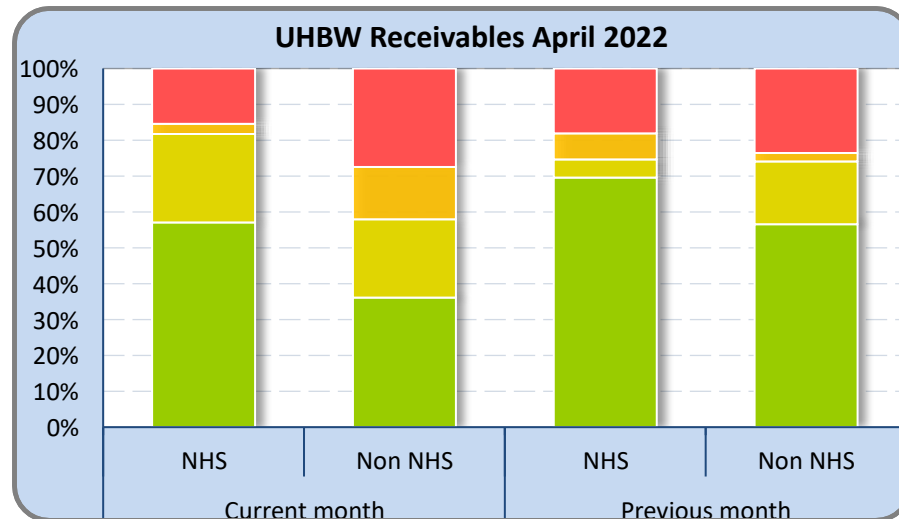
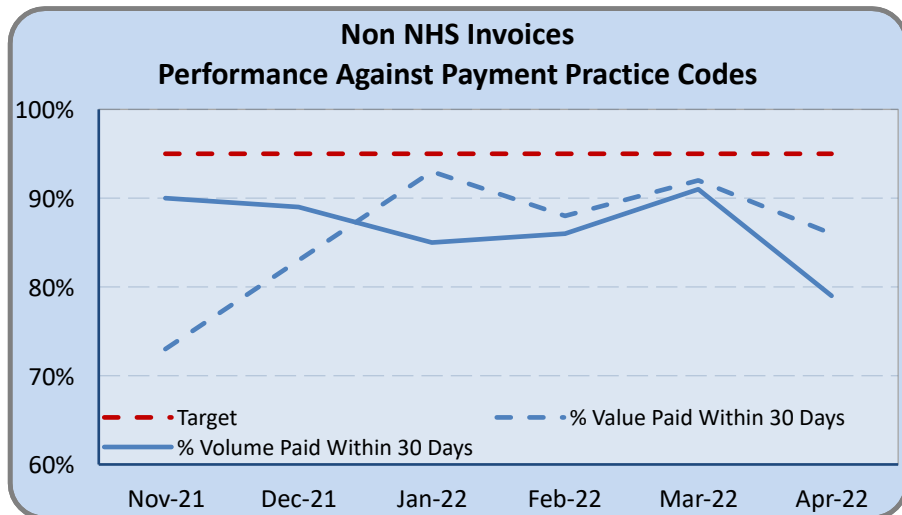
Liquidity days - no. days operating costs covered by cash reserves

Key Points:

- The cash balance at the end of March is £181,993k, £13,902k higher than the 2021/22 closing balance.
- The liquidity ratios show that although the Trust has a high cash balance, the Trust's ability to meet short term debt and the number of liquidity days is below the draft target, continuing the downward trend identified in Q4 2021/22.

Financial Position - Payment Performance

April 2022



Key Points:

- In March, 79% of invoices by volume and 86% by value have been paid within the 30 day target of the Better Payment Practice Code (BPPC).
- Deterioration in April was expected due to challenges with managing the year end and shorter timescales in month to allow alignment with revised national deadlines. Performance will be closely monitored in May to ensure a return to previous performance levels.
- The overall invoice receivable position of £31,582k has increased by £8,698k in month, driven predominantly by Q1 2022/23 invoices. The receivables balance is split £25,453k NHS and £6,129k non NHS, with over 60 day balances of £4,647k and £2,576k respectively.
- The 90+ day aged category has increased by £1,095k from last month.

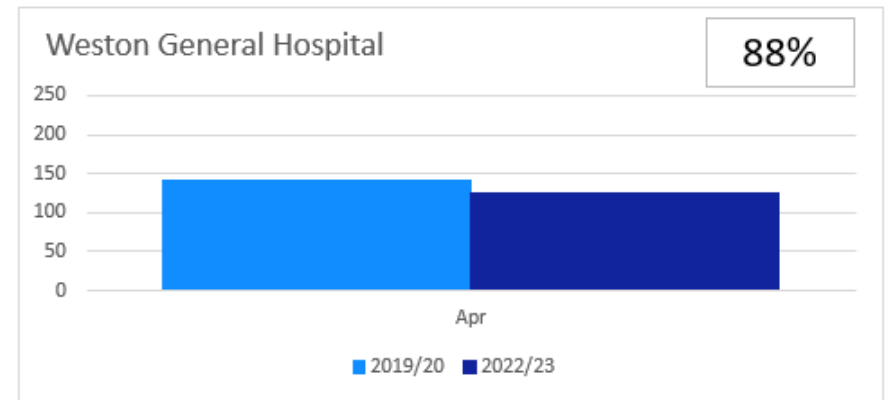
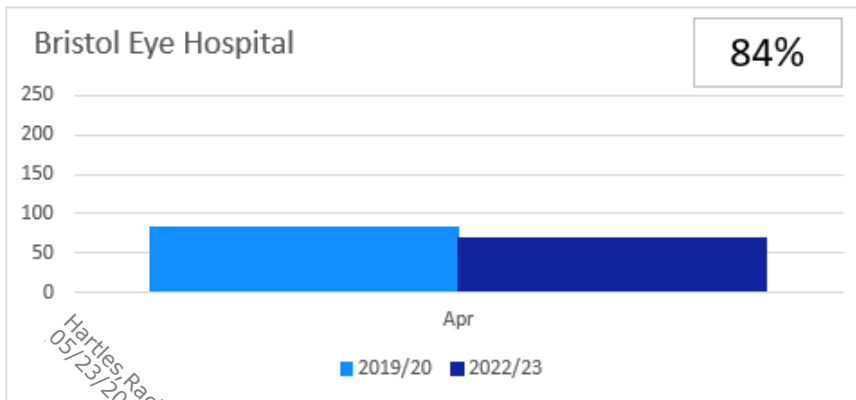
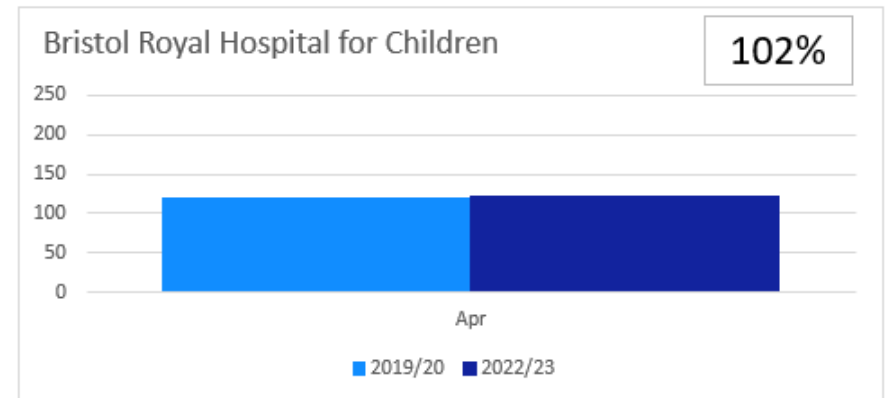
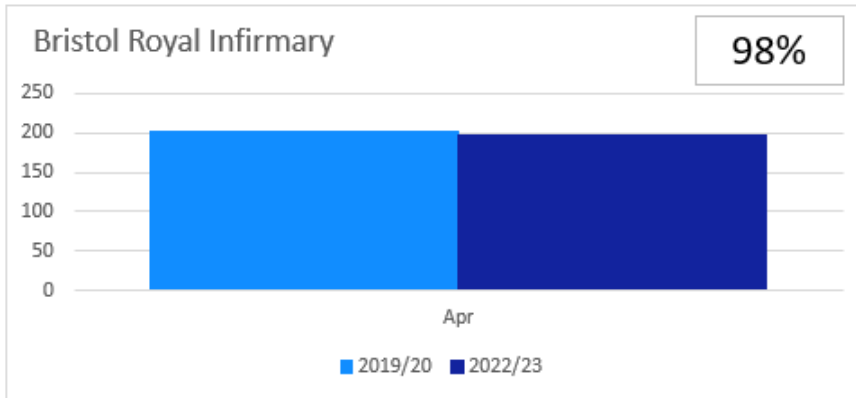
Days	Current Month (£000's)			Previous Month (£000's)			Movement (£000's)		
	NHS	Non NHS	Total	NHS	Non NHS	Total	NHS	Non NHS	Total
90+	3,926	1,682	5,608	2,899	1,614	4,513	1,027	0,069	1,095
60-90	0,721	0,894	1,615	1,164	0,161	1,326	(0,443)	0,733	0,290
30-60	6,276	1,338	7,614	0,812	1,199	2,011	5,465	0,139	5,603
0-30	14,530	2,215	16,745	11,159	3,876	15,035	3,371	(1,662)	1,709
Total	25,453	6,129	31,582	16,034	6,850	22,885	9,419	(0,721)	8,698

Recovery Actions:

- Review of the BPPC recovery plan to identify further actions to support the improvement in payment performance towards the national 95% target.

Appendix 1 – ED Activity by Site

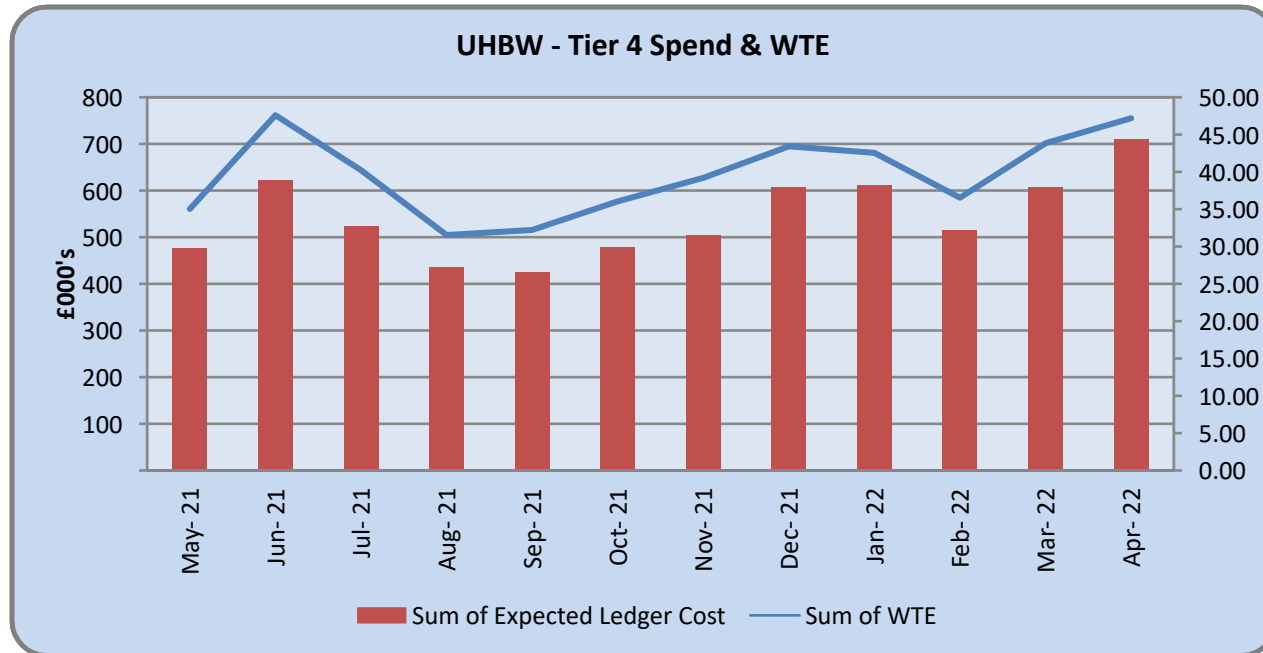
Accident & Emergency Attendances, Volume Per Day



Key Points

- The charts above indicate that the % of Accident and Emergency Attendances in 2021/22, compared with 2019/20, varies between hospitals. In both the Bristol Royal Infirmary and the Bristol Royal Hospital for Children, the number of attendances in 2021/22 is higher than the number in 2019/20.

Appendix 2 – Nurse Agency - Tier 4



- There was an increase in the use of Tier 4 across the Trust in April, rising from 43.84WTE (£608k) in March to 47.19WTE (£710k) in April.
- The highest increase was across the Medicine Division where usage increased by 3.06WTE from 14.99WTE (£206k) in March to 18.05WTE (£271k) in April.
- Usage across Surgery, Women's and Children's and Weston Divisions increased marginally, whilst Specialised Services reduced by 2.10WTE after high use in March and February.

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Appendix 3 – Reasons for Agency Usage

Top 10 Reasons for Agency Requests - Number of Shifts

Staff Group	Request Reason	November	December	January	February	March	April	Grand Total
Admin & Clerical	A&C Workload Need	58	73	75	88	138	216	648
	Additional Cover	14	3	21		28	1	67
	Staff Vacancy	13	12	20	22	31	13	111
Admin & Clerical Total		85	88	116	110	197	230	826
AHP	Additional Cover	15	9	2	25	38	46	135
	AHP/HCST/Med Staff Out of Hours		1					1
	Sickness Short Term Unplanned	3						3
	Staff Vacancy	146	157	148	98	126	111	786
AHP Total		164	167	150	123	164	157	925
Facilities	Additional Cover	336	325	361	390	382	281	2,075
	Extra Clinics					23		23
	Staff Vacancy	123	118					241
Facilities Total		459	443	361	390	405	281	2,339
Medic	Additional Cover	115	257	198	319	435	441	1,765
	Annual Leave					5		5
	Increased Acuity/Dependency	72	23	21				116
	Parental Leave				2			2
	Sickness Short Term Unplanned			2				2
	Staff Vacancy	562	373	383	258	209	73	1,858
Medic Total		749	653	604	579	649	514	3,748
Nursing	Additional Cover	76	133	119	157	151	219	855
	Covid UHBW	25	21	70	96	40	52	304
	ECO3 NA	85	108	74	48	97	66	478
	ECO4 RMN	201	178	286	421	392	235	1,713
	Extra Capacity Beds	26	46	42	135	102	65	416
	Increased Acuity/Dependency	145	92	60	113	54	29	493
	RMN Required	111	132	83	111	202	239	878
	Sickness Long Term Planned	44	50	61	46	35	57	293
	Sickness Short Term Unplanned	300	463	452	278	429	501	2,423
	Staff Vacancy	1,631	1,441	1,339	1,449	1,334	1,556	8,750
Nursing Total		2,871	2,740	3,022	2,998	3,250	2,885	17,766
Grand Total		4,325	4,291	4,253	4,200	4,665	4,067	25,604

Hartles Rachel
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Meeting of the Board of Directors in Public on Friday 27th May 2022

Report Title	SFI's Update – Extension to Temporary Amendments
Report Author	Kate Herrick, Head of Finance (Financial Performance)
Executive Lead	Neil Kemsley, Director of Finance and IT

1. Report Summary

The Trust's Standing Financial Instructions (SFI's) are planned for review in June 2022. This has been delayed from Q4 2021/22 due to operational challenges and to allow for further work initially planned for January and February 2022 to be completed. The work falls within several key areas:

Sections nine and ten of the SFI's refer to procurement and tendering. Significant work is in progress, in partnership with BWPC to review and align these sections to better support the needs of the organisation whilst ensuring sound financial governance and compliance with changing legislation. This is due to be finalised during June 2022.

Sections two, three, five and eighteen refer to budgeting, planning, reporting, contracting and capital investment. These sections require updating to reflect the Trust's changed approach following national changes to the financial regime and regulator requirements in these areas.

Sections fifteen and sixteen refer to patient property and losses and special payments. These sections will require review following the work to improve the processes to better support patients and staff. Given the operational pressures this work has taken longer than anticipated.

The SFIs are expected to be presented to the Board in 2022.

In advance of the full review, an amendment to the SFI's was agreed in November 2021 for a period of 6 months from 6th December 2021, to support the Trust to deliver the capital programme and activity recovery. The circumstances described in the SBAR continue to be relevant. A copy is attached for reference.

On the basis that the conditions described in the SBAR continue and the fact that there have been delays with the full review of the SFI's, it is proposed that the amendment approved in November 2021 is extended for a further 3 months, to 5th September 2022. This allows sufficient time for the review to be completed and pass through the governance process.

The amendment approved in November 2021 consists of the following:

1. The Trust waives the need to tender for goods or services that the Trust has recently been through a robust evaluation and selection process for.
2. The Trust should waive the need to tender for goods or services which BWPC considers could be procured using a compliant framework.
3. The threshold for which three written quotations are required should be raised from £5,000 to £10,000

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2. Key points to note <i>(Including decisions taken)</i>	
The request is to approve a continuation of the amended SFI's describes about for a period of 3 months from 6th June 2022. To provide assurance that no further extension will be requested the following timeline describes the next steps required to complete the review of the SFI's: • 23 May – 3 June – Review of sections two, three, five and eighteen refer to budgeting, planning, reporting, contracting and capital investment. • 6 June – 10 June – Review of sections fifteen and sixteen and updated based on progress against the controls programme. • 13 June – 17 June – Sections nine and ten to be reviewed by the Director of Procurement and proposal to be returned to the Trust by 17th June. • 4 July – 15 July – final review of amended SFI's and summary report prepared. • 25 July – Presentation of SFI's update to Finance & Digital Committee. • 9 August – Presentation of SFI's update at Public Board.	
3. Risks If this risk is on a formal risk register, please provide the risk ID/number.	
None	
4. Advice and Recommendations <i>(Support and Board/Committee decisions requested):</i>	
This report is for Approval • The Board is asked to approve that the extension of the amendment to the SFI's, agreed at the committee in November 2021, for a period of 3 months.	
5. History of the paper Please include details of where paper has <u>previously</u> been received.	
Finance & Digital Committee	16 th May 2022

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST STANDING FINANCIAL INSTRUCTIONS

May 2022~~September 2020~~

Approved at Finance Committee: ~~24th September 2020~~
Approved at Trust Board: ~~29th September 2020~~

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University Hospitals Bristol and Weston NHS Foundation Trust
Standing Financial Instructions

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University Hospitals Bristol and Weston NHS Foundation Trust
Standing Financial Instructions

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1 Introduction

1.1 Purpose and Content

- 1.1.1 These Standing Financial Instructions (SFIs) regulate the conduct of the Trust, its members, employees and agents in relation to all financial matters.
- 1.1.2 These Standing Financial Instructions explain the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law, the requirements of the Independent Regulator and best practice in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way the Trust manages public resources. They should be used in conjunction with the Standing Orders, Schedule of Matters Reserved to the Trust Board (appendix 1) and the Scheme of Delegation (appendix 2) adopted by the Trust.
- 1.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to **everyone** working for the Trust and its constituent organisations including trading units. They do not provide detailed procedural advice and should be read in conjunction with the relevant departmental guidance and the financial procedure notes (available on the intranet or via the Finance Department). All detailed financial procedures must be approved by the Director of Finance and Information.
- 1.1.4 These Standing Financial Instructions do not include applicable Regulator's guidance; the current version of all relevant guidance should be consulted. They also do not contain every legal obligation applicable to the Trust.
- 1.1.5 Each section in the Standing Financial Instructions clearly sets out its objectives and the financial responsibilities, policies and procedures relevant to it which must be complied with. When situations arise which are not specifically covered by this document, staff and Trust Board members are required to act in accordance with the spirit of the instructions as set out in the objectives.
- 1.1.6 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance and Information must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.
- 1.1.7 These Standing Financial Instructions have been reviewed by the Trust's Finance Committee and approved by the Trust Board. It is expected that all staff employed by the Trust will comply with these instructions at all times. **The failure to comply with the Trust's standing financial instructions and standing orders could result in disciplinary action up to and including dismissal.** Should any other guidance or departmental policies appear to conflict with these instructions, these Standing Financial Instructions will prevail. Any apparent conflict should be brought to the attention of the Director of Finance and Information.
- 1.1.8 If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the Director of Finance and Information. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance and Information as soon as possible. The Director of Finance and Information shall investigate and decide on the appropriate action to be taken. This will be reported to the next formal meeting of the Audit Committee for consideration.
- 1.1.9 These Standing Financial Instructions and associated scheme of delegation should be reviewed annually.

- 1.1.10 All references to NHS England and Improvement refer to the Independent Regulator of Foundation Trusts as established under the National Health Service Act 2006.

1.2 Responsibilities and Delegation

1.2.1 The Trust Board

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Schedule of Matters Reserved to the Trust Board at Appendix 1. Those aside, all executive powers are invested in the Chief Executive, who is the Accounting Officer.

The Board as a whole, and each member of the Board, is accountable for the financial performance of the Trust.

1.2.2 The Chief Executive and Director of Finance and Information

The Chief Executive and Director of Finance and Information will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Wherever the title Chief Executive or Director of Finance and Information is used in these instructions, it is deemed to include the deputies where they have been duly authorised by them to represent them.

The Chief Executive

The Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State and NHS England and Improvement, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

It is the responsibility of the Chief Executive to ensure that all staff are notified of and are required to understand their responsibilities within these instructions.

The Director of Finance and Information

The Director of Finance and Information is responsible for the implementation and monitoring of the Trust's financial policies and for ensuring any corrective action necessary to further these policies. In particular they will:

- provide financial advice to the Board, managers and other employees of the Trust
- design, implement and supervise systems of financial control
- prepare and maintain such accounts, certificates, financial estimates, records and reports as the Trust may require for the purpose of carrying out its statutory and other duties
- ensure that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time

The Director of Finance and Information requires that any officer who carries out a financial function does so in a manner and maintains records in a form that meets with their requirements.

The Director of Finance and Information shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of segregation of duties and internal checks. These procedures should be read as forming part of the Standing Financial Instructions.

1.2.3 All Trust Employees

All Trust Employees are responsible for:

- a) the security of the property of the Trust.
- b) avoiding loss.
- c) ensuring economy, efficiency and value for money in the use of public resources.
- d) complying with the Trust's Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

The scheme of delegation at appendix 2 contains all delegated authorities to nominated officers. Whilst these officers remain responsible for these authorities, should they delegate matters to other individuals within their organisational control, evidence should be maintained of this ensuring the understanding by the delegated officer of their associated responsibilities. This must be regularly reviewed.

All references in these instructions to 'employee' or 'officer' shall be deemed to include all salaried staff or those under contract to the Trust. This includes staff supplied using agency contracts even though the terms of supply may be covered in an agreement with the supplying organisation.

It is the responsibility of managers to ensure that both existing staff and new appointees within their management area know and understand their responsibility to comply with these instructions.

1.2.4 Hosting Arrangements

Where the Trust hosts an organisation with a separate management board, the financial transactions supporting the day to day business of the organisation shall be strictly in accordance with the Trust's Standing Financial Instructions, policies and procedures. Responsibility for decision making, planning and reporting will be delegated in accordance with the hosting agreement or as specified in the scheme of delegation.

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2 Planning, Budgets and Budgetary Control

2.1 Objective

- 2.1.1 To ensure the Trust Board is provided with the information required regarding the planning and development of the Trust's activities and finances to enable the Trust's Directors to fulfil their responsibilities. To provide assurance that the Trust exercises proper control of income and expenditure throughout the year. To inform budget managers of their delegated responsibilities.

2.2 Preparation and Approval of Annual Plans and Budgets

- 2.2.1 The Chief Executive will, with the assistance of, other Directors, compile and submit to the Trust Board an annual plan, strategic and operational plans required to support their accountability for the financial performance of the Trust. As a minimum this will meet the requirements laid down by NHS England and Improvement. The annual plan will contain a statement of the significant assumptions on which the plan is based and details of major changes in workload, delivery of services or resources required to achieve the plan.

- 2.2.2 Prior to the start of the financial year the Director of Finance and Information will, on behalf of the Chief Executive, prepare and submit a financial plan supporting the annual plan for approval by the Board. This will include:

- the expected level of income and the sources of that income
- the planned level of surplus or deficit
- how expenditure is to be managed in order to achieve the planned surplus or deficit
- the effect on the NHS England and Improvement's Finance Score as per the Oversight Framework
- the impact on the Trust's Statement of Financial Position
- cash flow and levels of borrowing
- the cost pressures faced by the Trust
- savings plans which need to be achieved
- potential risks which may affect the financial position of the Trust

The financial plan will

- be in accordance with the aims and objectives set out in the Trust's annual business plan
- accord with capacity and workforce plans
- be produced in accordance with principles agreed with the Senior Leadership Team as advised by the Director of Finance and Information.

- 2.2.3. The Director of Finance and Information is responsible for the preparation of the overall Trust budget within the total income receivable by the Trust, and in accordance with its agreed strategies and policies. Operational budgets shall be set at the beginning of each financial year by financial and operational managers in line with the Trust's approved budget.

- 2.2.4 Operational plans shall be compiled for each Division by the Clinical Chairs and Divisional Directors and for each corporate service area by the Head of Service. These plans should reflect the Trust's annual business plan and the budget, and will be approved by the Chief Executive.

- 2.2.5 Appropriate Trust employees shall provide the Directors with all financial, statistical and other relevant information, as required, in order to enable the compilation of plans and budgets.

2.3 Budgetary Delegation

- 2.3.1 The Chief Executive may delegate the management of budgets for defined services to the Clinical Chairs / Divisional Directors or Heads of Corporate Services responsible for the management of those services. Delegation and associated responsibilities must be clearly communicated. Control of budgets shall be exercised in accordance with these Standing Financial Instructions and supplementary guidance issued by the Director of Finance and Information.
- 2.3.2 Clinical Chairs, Divisional Directors and Heads of Corporate Service with budgetary responsibility must ensure that their budgets are structured appropriately to ensure effective budgetary control. Whilst accountable for the overall budget management, Clinical Chairs, Divisional Directors and Heads of Corporate Service are authorised to delegate the management of specific budgets to named budget managers. Delegation and associated responsibilities must be clearly communicated to these budget managers. It is the responsibility of the Head of Division/Corporate Service to ensure the budget structure and delegation to budget managers is maintained in line with organisational and staff changes.
- 2.3.3 The Chief Executive and delegated budget holders must not exceed the budgetary total set by the Trust Board, except as specified below:
- a) The Chief Executive may vary the budgetary limit of a Division or Service within the Trust's total budgetary limit.
 - b) Clinical Chairs, Divisional Directors and Heads of Corporate Services are permitted to authorise expenditure over the budget on individual budgets within their delegated areas provided this does not cause their delegated budget area to overspend or to exceed the financial limit set by (a) above.
- 2.3.4 Except where otherwise approved by the Chief Executive, taking account of advice of the Director of Finance and Information, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purposes shall transfer to the Trust's reserves, unless covered by the delegated powers of virement.
- 2.3.5 Non-recurring budgets must not be used to finance recurring expenditure unless authorised by the Director of Finance and Information.
- 2.3.6 Expenditure for which there is no provision in an approved budget and is not subject to funding under the delegated powers of virement, or approved procedures for new funding obtained during the year, may only be incurred if authorised by the Chief Executive.
- 2.3.7 Budget limits, individual and group responsibilities for the control of expenditure, exercise of virement, and achievement of planned levels of income and expenditure, shall be set out annually in a Resources Book approved by the Trust Board.

2.4 Budgetary Control and Reporting

- 2.4.1 The Director of Finance and Information is responsible for maintaining an effective system of budgetary control. All Trust staff responsible for the management of a budget or for incurring expenditure or collecting or generating income on behalf of the Trust must comply with these controls.
- 2.4.2 The Director of Finance and Information is responsible for providing financial information and advice to enable the Board, Chief Executive and other officers to carry out their budgetary responsibilities. This includes:

- a) monthly financial reports to the Board in a form approved by the Board containing:
 - i. income and expenditure to date against plan and forecast year-end position,
 - ii. the statement of financial position, changes in working capital and other material balances
 - iii. monthly cash flow monitoring of actual against plan and forecast year-end position,
 - iv. capital expenditure against plan and forecast year-end position,
 - v. achievement against the savings programme
 - vi. explanations of any material variances from plan,
 - vii. details of any corrective action where necessary and the Chief Executive's and/or Director of Finance and Information's view of whether such actions are sufficient to correct the situation,
 - viii. performance against NHS England and Improvement's Single Oversight Framework
- b) providing timely, accurate and comprehensible advice and financial information to all budget holders, covering the areas for which they are responsible,
- c) providing clear financial processes and procedures governing the operation of budgets,
- d) training and support to budget holders to allow them to undertake their financial responsibilities,
- e) investigation and reporting of variances from financial, activity and workforce budgets,
- f) monitoring of management action to correct variances,
- g) arrangements for the authorisation of budget transfers.

2.4.3 The Director of Finance and Information shall keep the Chief Executive and Board informed of the financial consequences to the Trust of changes in government policy, pay, terms and conditions, accounting standards and any other events affecting the current or future financial plans of the Trust.

2.4.4 All delegated budget managers are responsible for ensuring that:

- a) they check and validate all monthly budget statements,
- b) they fully understand their financial responsibilities and have received the required training and support to understand the financial information presented to them to fulfil these responsibilities,
- c) any likely overspending or reduction of income, which cannot be met by virement, is not incurred without the prior consent of the Head of Division/Service as per 2.3.3 (b) above,
- d) their delegated budget is only used in whole or in part for the purpose it was provided for, subject to the rules of virements,
- e) no permanent employees are appointed without the required approval as set out in section 8.3 and are provided for within the available resources and workforce establishment as approved by the Board,
- f) savings programme and income generation initiatives are implemented to achieve a balanced budget,
- g) all expenditure is approved and authorised in advance of commitment in line with these standing financial instructions and financial processes and procedures issued by the Director of Finance and Information.

2.4.5 The Chief Executive is responsible for authorising the implementation of savings programmes and income generation initiatives in accordance with the requirements of the Annual Business Plan to secure a balanced budget.

2.5 Capital Expenditure

2.5.1 The Director of Finance and Information shall keep the Chief Executive and Board informed of

the financial consequences to the Trust of changes in government policy, pay, terms and conditions, accounting standards and any other events affecting the current or future financial plans of the Trust.

- 2.5.2 The Director of Finance and Information is responsible for submitting to NHS England and Improvement all capital programme information required by them in line with their requirements and timescales.
- 2.5.3 The general rules applying to delegation, control and reporting above shall also apply to capital expenditure, (refer to section 18 for details relating to capital investment).

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3 Annual Accounts and reports

3.1 Objective

- 3.1.1 To ensure the production of the Trust's Annual Accounts and Report in accordance with statutory requirements.

3.2 General

- 3.2.1 The Director of Finance and Information, on behalf of the Trust, is responsible for the preparation and submission of financial reports and returns as required by NHS England and Improvement and other Government Departments in such form as they require and in accordance with their timetable.
- 3.2.2 The Director of Finance and Information, on behalf of the Trust, is responsible for the preparation and submission of the Trust's annual accounts as required by NHS England and Improvement, in such form as they require and in accordance with their timetable
- 3.2.3 The Trust's financial returns and annual accounts will be prepared in accordance with the accounting policies and guidance issued by NHS England and Improvement, the Trust's accounting policies, International Financial Reporting Standards and other accounting standards applicable at the time. The Director of Finance and Information is responsible for ensuring the Trust's accounting policies are reviewed annually, updated as required and approved by the Audit Committee.
- 3.2.4 The Trust's annual accounts must be audited and certified by an independent external auditor (see section 20) and the Director of Finance and Information is responsible for ensuring this happens in accordance with NHS England and Improvement's timetable.
- 3.2.5 The Trust's Director of Corporate Governance, on behalf of the Trust, is responsible for the preparation and submission of the Trust's Annual Report to NHS England and Improvement in such form as they require and in accordance with their timetable.
- 3.2.6 The Chief Nurse, on behalf of the Trust, is responsible for the preparation and submission of the Trust's Quality Report to NHS England and Improvement in such form as they require and in accordance with their timetable.
- 3.2.7 The Trust's annual report (including the quality report) must be audited and certified by an independent external auditor (see section 20) and the Director of Corporate Governance, is responsible for ensuring this happens in accordance with NHS England and Improvement's timetable.
- 3.2.8 The Trust's annual report and statutory accounts must be presented to the Trust Board for approval. They must be laid before Parliament, after which they cannot be changed. They must be made available for inspection by the public. The annual report and accounts and the auditor's report must be presented at a meeting of the Council of Governors in accordance with the NHS England and Improvement's timetable

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4 Research and Innovation

4.1 Objective

- 4.1.1 To provide specific instructions relating to research and innovation and reference to general financial instructions and processes governing this area.

4.2 General

- 4.2.1 The undertaking of research or clinical trials by Trust employees (substantive or honorary) within the Trust's premises shall be strictly in accordance with the Trust's policies and strategies on research management and governance and shall be subject to approval accordingly.
- 4.2.2 The Standing Financial Instructions apply equally when undertaking externally funded research activity within the Trust, particularly:
- Section 2 - Planning, Budgets and Budgetary Control
 - Section 8 - Payments of Trust Employees and Contractors
 - Section 9 - Procurement of Goods and Services
 - Section 10 – Tendering Procedure
 - Section 11 - Payment of Goods and Services Received
 - Section 12 - Stores and Receipt of Goods
 - Section 19 – Risk Management and Insurance
 - Section 22 – Acceptance of Gifts by Staff and Other Standards of Business Conduct
 - Section 24 – Retention of Documents
- 4.2.3 The principles governing probity and public accountability shall apply equally to work undertaken through externally funded research or clinical trials.

4.3 Research & Innovation Applications

- 4.3.1 All applications for research and innovation funding require approval from the Director of Finance and Information or a designated deputy. This applies to applications to both NHS funders, such the National Institute for Health Research, and to non-NHS organisations, such as charitable bodies and research councils.
- 4.3.2 All other documents* relating to Research & Innovation will require approval from the Director of Research & Innovation or a designated deputy, once all the necessary checks have been carried out, including finance checks where applicable.

**other documents include research contracts with funding bodies, collaboration agreements, commercial research contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments.*

4.4 Intellectual Property

- 4.4.1 The agreement covering any undertaking of research shall give cognisance to Trust policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the project.

5 NHS Contracts for the Provision of Healthcare Services

5.1 Objective

- 5.1.1 To ensure the Trust's contracts for the provision of healthcare services are properly planned and controlled and that all income relating to these agreements is properly accounted for.

5.2 Contracts for the provision of healthcare services

- 5.2.1 The Chief Executive is responsible for ensuring the Trust enters into suitable Commissioning Contracts with service commissioners for the provision of NHS services. Appropriate legal advice identifying the Trust's liabilities within the terms of the contract should be considered in discharging this responsibility. For 2020/21 block contracts have been introduced as part of the Department of Health and Social Care's Covid-19 response.

Where the Trust makes arrangements for the provision of services by non-NHS providers, the Chief Executive is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided.

- 5.2.2 In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance and Information regarding:

- standard NHS contractual terms and conditions
- costing and pricing of services
- payment terms and conditions
- amendments to contracts and extra-contractual arrangements

- 5.2.3 Agreements should be devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Where block contracts are not in place the Trust will use the National Tariff where appropriate and, for services not covered by the National Tariff, a local tariff agreed with the Commissioners.

- 5.2.4 All agreements should aim to implement the agreed priorities contained within the annual plan. National guidance on arrangements for contracting should be taken into account.

- 5.2.5 The Chief Executive shall ensure the contracting process is administered effectively and that appropriate service, quality, safety, clinical and financial input is provided.

- 5.2.6 The Director of Finance and Information is responsible for agreeing the financial details contained in service contracts.

- 5.2.7 NHS Contracts with commissioners for the provision of healthcare services can only be signed by the Chief Executive, Director of Finance and Information or Chief Operating Officer, without financial limit.

- 5.2.8 Service changes and developments initiated within the Divisions must be with the agreement of the Chief Executive or the Chief Operating Officer. The Director of Finance and Information must be informed to ensure appropriate financial scrutiny.

5.3 Service Agreement Monitoring and Reporting

- 5.3.1 The Director of Finance and Information is responsible for ensuring that systems and processes are in place to record patient activity, invoice and collect monies due under the agreements for the provision of healthcare services.
- 5.3.2 The Director of Finance and Information is responsible for reporting to the Board the Trust's actual contract activity and income due against the agreed contracts with an assessment of the financial impact of any contract under/over achievement.
- 5.3.3 The Director of Finance and Information is responsible for providing information to Clinical Chairs, Divisional Directors and Heads of Corporate Service for the actual contract activity and income due against the agreed contracts and the associated financial consequences for their service areas to facilitate financial management
- 5.3.4 The Director of Finance and Information is responsible for ensuring training and support to the Clinical Chairs, Divisional Directors and Heads of Corporate Service to be able to understand the contracts for their service areas and the information relating to activity and financial performance.
- 5.3.5 All Clinical Chairs, Divisional Directors and Heads of Corporate Service responsible for the management of service agreement income must ensure they understand and use the contract monitoring information for the financial management of their service areas.

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6 Banking and Cash Management

6.1 Objective

- 6.1.1 To ensure the effective management of the Trust's cash and to ensure it is properly controlled and safeguarded from loss and fraud.

6.2 General

- 6.2.1 The Director of Finance and Information is responsible for producing a Treasury Management Policy, in accordance with any relevant guidance from NHS England and Improvement, for Trust Board approval.
- 6.2.2 The Director of Finance and Information is responsible for the operation of the commercial bank and Government Banking Service accounts and for the management of accounts receivable, cash flow forecasting and investment of surplus funds. The Director of Finance and Information will ensure that these functions are properly managed and that information is provided to the Trust Board to support this.

6.3 Banking Arrangements

- 6.3.1 The Director of Finance and Information is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of bank accounts. This advice will take into account guidance/directions issued by NHS England and Improvement and Treasury requirements for NHS banking.
- 6.3.2 The Director of Finance and Information is solely authorised to open, operate and control any bank account where Trust funds are received or expended. All such accounts must be held in the name of the Trust. It is a disciplinary offence for any officer of the Trust outside of the organisational control of the Director of Finance and Information to operate such an account with a Trust name or from a Trust address.
- 6.3.3 All income relating to Trust business must be paid into the Trust's bank account. This includes all income from the sale of goods and services, disposal of items, vending machines and courses/lectures/other outside work undertaken in paid Trust time.
- 6.3.4 Donations are required to be managed via accounts operated by the Trust's charitable body. Such accounts must not be opened by employees. Any donations received must be managed in accordance with section 23.
- 6.3.5 If a member of staff wishes to set up a bank account with reference to the Trust and/or Trust address for a purpose other than that which has been explicitly prohibited in the sections above, they must write to the Director of Finance and Information for approval.
- 6.3.6 The Director of Finance and Information shall establish and approve procedural instructions on the operation of all commercial bank accounts, investment accounts and Government Banking Service.
- 6.3.7 The Finance Committee shall ensure proper safeguards are in place for security of the Trust's funds by:
- a) approving the Trust's commercial bankers, selected by competitive tender
 - b) approving a list of permitted 'relationship' banks and investment institutions
 - c) setting investment limits for each permitted investment institution
 - d) approving permitted types of investments /instruments
 - e) approving the establishment of new/ changes to existing bank accounts

- 6.3.8 The Director of Finance and Information is responsible for ensuring approved bank mandates are in place for all accounts and that these are updated regularly for any changes in signatories and authorised limits.
- 6.3.9 The Director of Finance and Information will review the banking needs of the Trust at regular intervals to ensure that they reflect current business patterns and represent value for money. Following such reviews, the Director of Finance and Information shall determine whether or not re-tendering for services is necessary. The Director of Finance and Information shall be responsible for organising and evaluating bank tendering processes. The Director of Finance and Information shall report the outcome of any tendering exercise for approval by the Finance Committee.
- 6.3.10 The Director of Finance and Information, on behalf of the Finance Committee, shall advise the Trust's commercial and relationship bankers in writing of the conditions under which each account shall be operated, the limits to be applied to any overdraft, the limitation on single signatory payments and the officers authorised to release money from and draw cheques or other payable orders on each account; this must contain the Chief Executive and Director of Finance and Information. The cancellation of any such authorisation shall be notified promptly to the bank.
- 6.3.11 Where a new banking relationship is suggested this must be pre-approved by the Director of Finance and Information before a proposal is made to the Finance Committee. The Finance Committee will consider the need for and potential benefit of the new relationship and sanction or reject the proposal. The Trust's bankers shall be notified by the Director of Finance and Information, on behalf of the Finance Committee of any alterations in the conditions of operation of the Trust's accounts that may be required by the Finance Committee.
- 6.3.12 The Director of Finance and Information is required to approve any direct debit or standing order payment arrangements. The Director of Finance and Information is responsible for the effective control of payments made from the Trust's bank account through bank transfers, cheques and payments by Bank Automated Credits (BACS).
- 6.3.13 The Director of Finance and Information may operate a credit/purchasing cards on behalf of the Trust which must be used in accordance with a written policy approved by the Finance Committee.

6.4 Cash Management

- 6.4.1 The Director of Finance and Information is responsible for managing and monitoring the cash flow of the Trust and ensuring that it has enough cash balances to meet all its commitments.
- 6.4.2 Any member of Trust staff aware of significant and unexpected delays in the receipt of cash or of significant unexpected or early payments that will have an effect on the Trust's cashflow position must inform the Director of Finance and Information or other Senior Finance Manager.
- 6.4.3 The Director of Finance and Information is responsible for providing assurance to the Trust Board and Finance Committee on the management of the Trust's cash position through monthly reporting.

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6.5 Investment of Temporary Cash Surpluses

- 6.5.1 Temporary cash surpluses shall be invested in line with the Treasury Management Policy, subject to the overall cash flow position and in line with any relevant guidance from NHS England and Improvement or HM Treasury.
- 6.5.2 The Director of Finance and Information is responsible for advising the Finance Committee on investments and shall report monthly to the Finance Committee concerning the performance of investments held.
- 6.5.3 The operation of investment accounts and the records maintained must be in accordance with detailed procedural instructions issued by the Director of Finance and Information and approved by the Finance Committee.
- 6.5.4 The Finance Committee shall:
 - a) approve a list of permitted investments institutions
 - b) set investment limits for permitted investment institutions
 - c) approve a schedule of permitted types of investments and financial instruments
- 6.5.5 Investments for purely speculative purposes are strictly prohibited'.

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7 Income

7.1 Objective

- 7.1.1 To ensure that income due is promptly assessed and collected and income received is promptly banked and fully accounted for.

7.2 Income Due

- 7.2.1 The Director of Finance and Information is responsible for designing and maintaining systems for the proper recording, invoicing and collection of all income together with systems for financial coding.
- 7.2.2 The Director of Finance and Information is responsible for the prompt banking of all monies received.
- 7.2.3 The Director of Finance and Information is responsible for the design and ordering of all receipt books, tickets, agreement forms, or other means of officially acknowledging or recording amounts received or receivable. They will be issued and controlled according to procedures established by the Director of Finance and Information and will be subject to the controls as are applied to cash (Section 14).
- 7.2.4 Cash payment for charges made by the Trust, for the provision of any goods or services, must not normally be accepted where the value of any single transaction is in excess of £10,000. Should this occur, the Head of Financial Services must be notified immediately to ensure the Trust complies with HM Revenue and Customs' regulations.
- 7.2.5 A contract or agreement must be in place for all income due to the Trust for the provision of goods or services to a third party. The nature of the contract or agreement will depend on the goods or services being provided. The Director of Finance and Information is responsible for signing all contracts and agreements with delegated responsibilities given within section 9 of the scheme of delegation (appendix 2).

Delegated Matter	Authority Delegated to
Agreeing / Signing agreement / contract	All require Director of Finance and Information agreement
- Hosting Arrangement	Director of Finance and Information or nominated deputy
- Research and Other Grant Applications	Director of Finance and Information or nominated deputy
- Staff Secondments	Service Manager
- Leases	Director of Finance and Information or nominated deputy
- Property Rentals	Below £5k per annum – Service Manager Above £5k and below £100k – Director of Estates and Facilities or nominated deputy Over £100k per annum - Director of Finance and Information or nominated deputy
- Residences	Residences Manager
- Peripheral Clinics and Provider to Provider arrangements	Below £25k per annum – Service Manager Above £25k and below £250k – Divisional/Corporate Director or nominated deputy Over £250k per annum - Director of Finance and Information or nominated deputy
- Trading Services	Below £25k per annum – Service Manager Above £25k and below £250k – Divisional/Corporate Director or nominated deputy Over £250k per annum - Director of Finance and Information or nominated deputy
- Other income generation	Below £25k per annum – Service Manager Above £25k and below £250k – Divisional/Corporate Director or nominated deputy Over £250k per annum - Director of Finance and Information or nominated deputy

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- 7.2.6 Employees responsible for agreeing the prices of goods and services provided by the Trust should ensure that they cover all costs, including overheads. Support should be sought from the finance department as required. Appropriate, independent professional advice shall be taken on matters of valuation. Prices and charges shall be reviewed at least annually. This paragraph applies equally to:
- the sale of goods and services
 - support to commercial research trials and projects
 - pricing of non-patient care service agreements with other bodies.
- 7.2.7 The Trust's price tariff for private patient treatment is set by the Director of Finance and Information. The pricing structure ensures that prices are at least equal to those charged to NHS Commissioners and ensures that public funds are not used to subsidise private patient activity. Any proposed variations to the Private Patient Tariff prices must be approved by the Director of Finance and Information before patients are advised of the cost of their treatment.
- 7.2.8 All Trust employees shall promptly inform the Director of Finance and Information of money due to the Trust arising from transactions which they initiate including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.
- 7.2.9 The notification of income due shall be as prescribed by procedures established by the Director of Finance and Information, ensuring sufficient details are included to enable the prompt payment by the debtor.
- 7.2.10 The Director of Finance and Information shall ensure that debtors are invoiced promptly on receipt of the advice of income due.
- 7.2.11 There must be clear separation of duties so that officers responsible for raising invoices or accounting for amounts due to the Trust shall not handle cash or cheques received by the Trust
- 7.2.12 The Director of Finance and Information shall take appropriate recovery action on all outstanding debts and no claims shall be abandoned except as in accordance with Section 16 - Losses and Special Payments.
- 7.2.13 Income from the disposal of assets, scrap material and items surplus to requirements shall be dealt with in accordance with Section 13 of these Instructions.

7.3 Income Received

- 7.3.1 All income received into the Trust must be collected, receipted and accounted for in accordance with the procedures established by the Director of Finance and Information. It is the responsibility of all Trust employees responsible for these duties to ensure they comply with these procedures. It is the responsibility of the Senior Managers responsible for areas where income is received to ensure that their staff are complying with these procedures.
- 7.3.2 All cash and cheques shall be banked intact promptly in accordance with the Director of Finance and Information's instructions. Disbursements shall not be made from cash received. Payment by debit or credit card may only be accepted by staff designated by the Director of Finance and Information. All transactions must be processed in accordance with the instructions approved by the Director of Finance and Information.
- 7.3.3 The opening of incoming post must be undertaken by officers working in pairs and all cash, cheques, and other forms of payment shall be entered immediately in an approved form of register and certified by both officers.
- 7.3.4 Every employee authorised to receive remittances in cash or other forms must keep up to

date a record of the amounts received in accordance with procedures approved by the Director of Finance and Information. This record must be reconciled with the amount held in accordance with these instructions. Any discrepancy shall be reported immediately to their senior manager and the Director of Finance and Information.

- 7.3.5 Official receipts shall be issued in all cases involving cash and only where especially requested by the payer for cheques, debit card etc.
- 7.3.6 All cash received, if not paid directly into the bank, shall be locked as soon as possible in the safe or cash box provided for the purpose, which shall be safeguarded as specified in Section 6.
- 7.3.7 Collections from cash tills, other coin boxes and from night safes shall be made at such intervals as shall be prescribed by or with the approval of the Director of Finance and Information. The opening of each such box or safe and the counting and recording of the contents shall be undertaken by two employees together. Both shall sign the record and the keys shall, at other times, be separately held by a senior officer.
- 7.3.8 The Director of Finance and Information shall ensure that all income received into the Trust's bank accounts are accounted for promptly – as per section 16.

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8 Payment of Trust Employees and Contractors

8.1 Objective

- 8.1.1 To ensure proper control over the appointment and payment of Trust employees and contractors.

8.2 Remuneration and Terms of Service of Directors

- 8.2.1 In accordance with Standing Orders and the 2006 Act, the Board shall establish a Remuneration, Nominations and Appointments Committee consisting of Non-Executive Directors to decide the remuneration and allowances and other terms of office of the Executive Directors, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

- 8.2.2 The Committee will:

- a) Agree appropriate remuneration and terms of service for the Chief Executive and other Executive Directors employed by the Trust including:
 - i. All aspects of salary (including any performance-related elements/bonuses)
 - ii. Provisions for other benefits, including pensions, cars, allowances, payable expenses and compensation payments
 - iii. Arrangements for termination of employment, including termination payments, and other contractual terms.
- b) Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors;
- c) Agree on the remuneration and terms of service of Executive Directors of the Board (and other senior employees) as ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;
- d) Monitor and assess the output of the evaluation of the performance of individual Executive Directors, and consider this output when reviewing changes to remuneration levels;
- e) Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

- 8.2.3 The Council of Governors will decide the remuneration and allowances and other terms of office of the Chair and Non-Executive Directors.

- 8.2.4 The Trust will pay allowances to the Chair and Non-Executive Directors in accordance with all relevant guidance.

8.3 Other Staff Remuneration and Appointments

- 8.3.1 The implementation of national pay directives relating to the remuneration of staff will be approved by the Chief Executive. Any local variation to these rates or implementation requiring local interpretation or negotiation requires Executive approval. This is delegated by the Chief Executive to Directors of People Workforce and Organisational Development and Finance and Information through the Trust Pay and Assurance Group (TPAG).

- 8.3.2 All Trust officers responsible for the engagement, re-engagement and regrading of

employees, either on a permanent or temporary contract, or for hiring agency staff or contractors, or agreeing to changes in any aspect of remuneration must comply with the scheme of delegation and act in accordance with the processes designated by the Director of People Workforce and Organisational Development. In particular such actions must be within the limit of their approved budget and funded establishment.

8.3.3 The Board shall delegate responsibility to the Director of People Workforce and Organisational Development. for ensuring:

- a) all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation
- b) processes are in place for dealing with variations to, or termination of, contracts of employment

8.3.4 The Directors of Finance and Information and People Workforce and Organisational Development, through TPAG, must be informed when a reward (monetary and non-monetary) is being proposed for staff in recognition of their work, other than for length of service, for the Trust which will not be processed through the payroll. This is to ensure consistency and that appropriate legislation is being complied with. It should be noted that such rewards may constitute a taxable benefit. Length of service rewards are made in line with the approved policy.

8.4 Notification of Information to Payroll

8.4.1 All Trust Officers responsible for the engagement and management of staff must inform the Director of Finance and Information's Payroll Department promptly and in the agreed form of full details in respect of:-

- a) Commencement of employment.
- b) Change to terms and conditions of employment or circumstance.
- c) Termination of employment.

8.4.2 On appointment, a properly authorised appointment form for Direct Hires or an e-Starter form for all staff recruited through ESR and such documents as required by the Director of Finance and Information and/or Director of People Workforce and Organisational Development shall be submitted to the Payroll Department immediately.

8.4.3 A properly authorised change of conditions e-form shall be submitted to the Payroll Department immediately a change in status of employment or personal circumstances of an employee is known.

8.4.4 A properly authorised termination of employment e-form and other relevant information shall be submitted to the Payroll Department immediately the effective date of an employee's resignation, retirement or termination is known. Where an employee fails to report for duty in circumstances which suggest that they have left without notice, the Payroll Department shall be informed immediately.

8.4.5 All absence due to sickness and other reasons as required shall be notified to the Payroll Department in the required form and timescales.

8.4.6 All documents used for payroll purposes such as time sheets and payment sheets must be in a form approved by the Director of Finance and Information and must be properly authorised.

8.5 Processing of Staff Payments

- 8.5.1 The Director of Finance and Information is responsible for:
- a) specifying timetables for the submission to the Payroll Department of properly authorised time records and other notifications
 - b) the final determination of pay and allowances
 - c) making payment on agreed dates
 - d) agreeing method of payment
- 8.5.2 The Director of Finance and Information will issue instructions regarding:
- a) Verification and documentation of data
 - b) The timetable for receipt of data, preparation of payroll and the payment of staff
 - c) Maintenance of subsidiary records for superannuation, income tax, national insurance, social security and other authorised deductions from pay
 - d) Security and confidentiality of payroll information
 - e) Checks to be applied to completed payroll before and after payment
 - f) Authority to release payroll data under the provisions of the Data Protection Act
 - g) Methods of payment for ALL staff by BACS
 - h) Procedures for payment of BACS and in an emergency cheques, or cash to staff
 - i) Procedures for recall of BACS
 - j) Pay advances and their recovery
 - k) Separation of the duties of initiating and making payments
 - l) A system to ensure the recovery from leavers of sums due by them to the Trust
 - m) Maintenance and regular reconciliation of adequate control accounts with appropriate internal check procedures
- 8.5.3 Appropriately nominated managers have delegated responsibility for:
- a) submitting properly authorised time records, and other notifications to the Payroll Department in accordance with agreed timetables
 - b) completing time records and other notifications in accordance with the Director of Finance and Information's instructions and in the form prescribed by the Director of Finance and Information
 - c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement.
- 8.5.4 Regardless of the arrangements for providing the payroll service, the Director of Finance and Information shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
- 8.5.5 The Director of Finance and Information shall pay salaries and wages on the currently agreed dates but may vary these when necessary due to special circumstances (e.g. Christmas and other bank holidays). Payments shall not normally be made in advance of the authorised normal pay date.

8.6 'Off Payroll' Arrangements

- 8.6.1 Off payroll arrangements relate to the payment of individuals for work undertaken on behalf of the Trust which is paid on receipt of invoice through personal services companies or as a sole trader rather than through the payroll. It does not include staff employed via employment agencies or those staff being seconded to the Trust, paid by another organisation which then recharges the Trust.
- 8.6.2 All senior staff must be on the payroll unless there are exceptional temporary circumstances,

which will require the Chief Executive's approval. This includes all Trust Board members, members of Divisional Boards and staff with significant financial responsibility.

- 8.6.3 All 'off payroll' engagements are required to comply with the relevant requirements of this section of the Standing Financial Instructions and with section 11. In particular:
- all staff are required to be issued with a Contract of Employment which complies with employment legislation
 - the terms of remuneration should be in line with national pay directives or locally Trust agreed variations. Payment outside of these terms requires Divisional Director and Human Resources approval.
- 8.6.4 The engagement of staff 'off payroll', gives rise to tax, national insurance and pension implications. It is the responsibility of Trust managers engaging the provision of such staff to ensure that the arrangements comply with the requirements of HM Revenue and Customs.
- 8.6.5 To comply with intermediaries' legislation all off payroll arrangements must be assessed to ensure compliance.
- 8.6.6 The Director of Finance and Information is responsible for ensuring there are detailed procedures in place to assist employing managers to assess and select the correct form of contractual relationship required (payable gross on invoice or subject to statutory deductions through PAYE) to comply with HM Revenue and Custom IR35 requirements.
- 8.6.7 All Trust officers responsible for procuring the provision of services by individuals not directly employed by the Trust must ensure that they comply with relevant Trust procedures and should seek guidance if required.

8.7 Travel and Subsistence

- 8.7.1 Payment of travel and subsistence costs incurred by staff on Trust business shall be made by the Payroll Department in accordance with the current regulations, subject to verification of claim details, upon receipt of the prescribed form, properly completed and authorised by an officer with delegated authorisation for this purpose.

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9 Procurement of Goods and Services

9.1 Objective

- 9.1.1 To ensure that proper control is exercised and value for money is obtained in the procurement of all goods and services on behalf of the Trust.

9.2 General

- 9.2.1 The Trust Board may enter into contracts on behalf of the Trust within the statutory powers delegated to it. The procedure for letting all contracts shall comply with these powers and Standing Financial Instructions. A contract or agreement must be in place for all goods, services and works procured by the Trust. The nature of the contract or agreement will depend on the goods or services being provided. The Director of Finance and Information is responsible for signing all contracts and agreements with delegated responsibilities given within section 10d of the scheme of delegation (appendix 2).
- 9.2.2 All contracts made shall endeavor to obtain best value for money by using the Trust's procurement service and processes established by the Director of Finance and Information. The Director of Finance and Information shall nominate a Trust officer who shall be responsible for overseeing and managing each contract on behalf of the Trust.
- 9.2.3 Goods, services and works shall only be ordered in line with the controls and systems established and approved by the Director of Finance and Information, which must comply with the financial limits and other principles set out in this section. These controls and systems cover all goods and services procured through the Trust's Electronic Requisitioning and Ordering System (EROS) and other processes agreed by the Director of Finance and Information
- 9.2.4 All employees must comply with the processes, systems and controls for procuring all goods and services established by the Director of Finance and Information which are available from the finance department.

9.3 EU Directives, Legislation and Guidance

- 9.3.1 The Trust shall comply with all European Union and Government Directives regarding public sector procurement and prescribed procedures for awarding all forms of contracts.
- 9.3.2 The Trust shall comply as far as is practicable with all guidance and advice issued by the Department of Health and Social Care and the independent regulator in respect of procurement, capital investment, estate and property transactions and management consultancy contracts.
- 9.3.3 No order shall be issued to any firm which has made an offer of gifts or rewards to Directors or employees – in line with Section 22.

9.4 Financial Limits

- 9.4 A minimum of three competitive tenders is required in accordance with the requirements of Section 10 for any purchase of goods or services over £25,000 (excluding VAT) including:
- a) a specification for equipment, goods, service contract, construction contract or other project
 - b) a period standing order, call-off contract, framework agreement or other purchase of goods or services where the aggregate value exceeds £25,000 in any year.

- 9.4.2 Where such purchases exceed £5,000 but are less than £25,000 a minimum of three competitive quotations in writing shall be obtained.
- 9.4.3 Where such purchases do not exceed £5,000, non-competitive quotations in writing may be obtained with value for money being demonstrated on all occasions. Best practice should be a minimum of three such quotations.
- 9.4.4 Before placing an order for goods or services, potential suppliers and the cost should be adequately investigated and evaluated in line with the Scheme of Delegation through the recommendation report prepared by the Trust's procurement service.

Recommendation Report Authorising Levels (excl. VAT)	Authority
£5,000 to £100,000	Director of Procurement, Divisional Finance Manager and Divisional Operations Director or Corporate Director
£100,000 to £1m	As above, plus the Director of Finance and Information
Above £1m	As above, plus Director of Finance and Information recommendation to Trust Board

All Exception Reports will be reviewed and authorised by the Director of Procurement, Divisional Finance Manager, Divisional Operations Director or Corporate Director and Director of Finance and Information.

- 9.4.5 Orders shall not be placed in a manner devised to avoid the financial thresholds specified by the Trust Board.
- 9.4.6 If the Trust's procurement service is asked to place orders outside these thresholds, they will refer the request back to the budget holder. The ordering of goods or services above £5,000 without three or more competitive quotes or £25,000 without three or more competitively priced tenders require approval as a Single Tender Action (STA) via the Trust's Single Tender Action procedure before placing the order. As part of the Trust's Covid-19 response the STA process for emergency Covid goods has been adapted to ensure there was no unnecessary delay.

For all orders above £5,000 that are not supported by competitive quotations, the case for proceeding must be submitted to the applicable authorising officers shown below to decide whether to approve as a Single Tender Action.

Value of Contract Per Annum (excl. VAT)	Authorising Officer
£5,000 to £24,999	Divisional Director and the Director of Procurement
£25,000 to £100,000	As above, plus the Director of Finance and Information
Above £100,000	As above, plus the Chief Executive or Trust Board

Covid-19 goods adaption

Value of Contract Per Annum (excl. VAT)	Authorising Officer
Less than £100,000	BWPC and Chair of the PPE/Equipment Group
Above £100,000	As above, plus Director of Finance and Information

- 9.4.7 For any procurement that takes place outside of the Trust's procurement service and/or the Trust's electronic requisitioning and ordering system, EROS, the processes referred to in 9.2.3 must be followed and the limits in 9.4.6 shall apply and follow the process agreed by the Director of Finance and Information.

9.5 Requisitioning

- 9.5.1 The Director of Finance and Information is responsible for establishing procedures regarding the requisitioning of goods and services on behalf of the Trust. This will include a list of managers authorised to requisition goods and services, including levels of authorisation.
- 9.5.2 No requisition or order shall be placed for items for which there is no provision in an authorised budget.
- 9.5.3 Requisitioners should comply with the Trust's procedures in the procurement of goods and services. They should always seek to obtain best value for money for the Trust and ensure that there are no conflicts of interest. In doing this the advice of the Trust's procurement service should be sought.
- 9.5.4 Requisitioning is required to be placed using the Trust's electronic requisitioning and ordering system EROS. It is recognised that the procurement of some goods and services is not supported by EROS. These cases are clearly defined within the process approved by the Director of Finance and Information. Only the goods and services defined within this policy are able to be procured outside of EROS and the prescribed process must be followed.
- 9.5.5 Access to the Trust's electronic requisitioning and ordering system, EROS, shall only be granted to budget holders and officers delegated by them through the Trust's Authorised signatory list.
- 9.5.6 Information regarding every order shall be notified to the finance department in an agreed format immediately after the order is issued via both the Trust's electronic requisitioning and ordering system EROS or the process approved by the Director of Finance and Information.
- 9.5.7 Official orders shall be consecutively numbered, Orders must have a unique purchase order number and be in a form approved by the Director of Finance and Information, and shall include such information concerning prices, discounts, and other conditions of trade as they may require. The order shall incorporate an obligation on the contractor to comply with the conditions printed thereon as regards delivery, carriage, documentation, variations, etc.
- 9.5.8 Orders requisitioned through the Trust's electronic requisitioning and ordering system EROS are required to be independently authorised by a second person. The receipt of the goods can therefore be carried out by one of these officers. All orders requisitioned outside of EROS must be certified by a separate person in accordance with the process approved by the Director of Finance and Information

9.6 Other

- 9.6.1 All contracts, leases, tenancy agreements and other commitments, which may result in a long-term liability, must be notified to the Director of Finance and Information for approval in advance of any commitment being made.
- 9.6.2 On completion of the procurement processes detailed within this section the signing of contracts and agreements to procure good and services on behalf of the Trust must be executed in line with the section 10d of the scheme of delegation

Delegated Matter	Authority
Contracts/ agreements following	Below £25k, service manager

tendering process above unless specifically referred to below:	Above £25k and below £100k, Divisional Director or Director of Purchasing and Supply Over £100k, Chief Operating Officer or Director of Finance and Information
Purchase of healthcare	Below £100k, Divisional Director Over £100k, Chief Operating Officer
Property leases	Director of Finance and Information
Leases – non property	Director of Finance and Information
Outsourcing services	Below £100k, Divisional Director Over £100k, Chief Operating Officer and Director of Finance and Information
Facilities contracts	Director of Estates and Facilities or nominated deputy
Estates maintenance contracts	Director of Estates and Facilities or nominated deputy
Capital construction based contracts	Director of Estates and Facilities or nominated deputy, following approval as per section 19

- 9.6.3 Where consultancy advice is being obtained or where supply of staff is being sought via an agency, the procurement of such skills must be in accordance with the latest guidance issued by the NHS Executive, the Department of Health and Social Care and NHS England and Improvement.

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10 Tendering Procedure

10.1 Objective

- 10.1.1 To ensure that major purchases are tendered in a manner which can be demonstrated to ensure fair competition and value for money and to comply with legislation. The Trust shall ensure that competitive tenders are invited for:
- the supply of goods, materials and manufactured articles
 - the provision of services including all forms of management consultancy services
 - the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens)

10.2 Requirements to Tender

- 10.2.1 The following instructions shall apply to any purchase over £25,000 as required by Section 9.4. The principles in this instruction apply equally to the tendering procedures operated by the Estates and Facilities Department (for capital construction contracts), Pharmacy (for drugs contracts) and the Procurement Department. Formal tendering procedures may be waived by the Chief Executive, where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care, in which event the said special arrangements must be complied with.
- 10.2.2 Formal tendering procedures may be waived by the Chief Executive in the following circumstances:
- a) in very exceptional circumstances where it is decided that formal tendering procedures would not be practicable and the circumstances are detailed in an appropriate Trust record.
 - b) where the requirement is covered by an existing contract
 - c) where national NHS agreements are in place
 - d) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
 - e) where specialist expertise is required and is available from only one source;
 - f) when the task is essential to complete a project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
 - g) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee.

- 10.2.3 Where the tendering procedures are waived under (a) above this must be reported and approved by the Trust Board before being actioned.

10.3 EU Directives Legislation, Guidance and Public Contract Regulations

- 10.3.1 EU procurement directives and UK procurement legislation governing procedures for awarding contracts by an NHS body shall have effect as if incorporated in these Standing Financial Instructions.
- 10.3.2 Contracts above specified thresholds must be advertised and awarded in accordance with EU and other directives and Government legislation. The Procurement Department will advise on these requirements.
- 10.3.3 The Trust should never enter into a contract which involves a contractor assessing and carrying out work on behalf of the Trust.

10.4 Selection of Suitable Firms to Invite to Tender

- 10.4.1 The Procurement Department shall ensure they source suitable suppliers to be invited to provide tenders or quotations for the supply of goods or services to the Trust. Suitability will include the technical and financial competence of the supplier.
- 10.4.2 The Estates and Facilities Department will refer to the relevant Register of Contractors (Constructionline) in considering suppliers suitable to be invited to provide tenders or quotations for their requirements.
- 10.4.3 All suppliers deemed suitable to be invited to submit quotations or tenders should comply with the Equality Act 2010, the Health and Safety at Work Act, procurement sustainability, fair and equitable trade policy and all other legislation concerning employment and the health, safety and welfare of workers and other persons. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.
- 10.4.4 The Director of Finance and Information may make or institute any enquiries deemed appropriate concerning the financial standing and financial suitability of approved contractors. The Directors with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

10.5 Health Care Services

- 10.5.1 The tendering limits and processes in these standing financial instructions apply equally to the supply of non SLA healthcare services. See Section 5 for SLA contracts.

10.6 Standard Selection Questionnaire

- 10.6.1 Statutory guidance states that the Trust may not include a pre-qualification stage in any procurement where the value of the goods and services is below the EU threshold, thus restricting the use of Selection Questionnaires. However, the Trust should ensure suitable assessment questions' relating to a potential supplier are asked making certain the questions are relevant to the subject matter of the procurement and proportionate.

For procurements above the EU threshold, the standardised set of selection questions should be followed as per the Crown Commercial Service guidance.

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10.7 Invitation to Tender

10.7.1 The Trust shall ensure:

- a) invitations to tender are sent to a sufficient number of firms to provide fair and adequate competition, unless this can be evidenced otherwise. In all cases a minimum of either:
 - i. three firms shall be invited to tender
 - ii. the most the market permits
- b) the firms invited to tender are deemed suitable as described above, having regard to their capacity to supply the goods or materials or to undertake the services or works required.
- c) the firms invited to tender are subject to the supplier selection questionnaire described above
- d) invitations to tender shall clearly state the date and time as being the latest time for the receipt of tenders.
- e) invitations to tender shall state that no tender will be accepted unless it meets the submission requirements of the Trust's e-tendering process or for manual tendering unless:
 - i. submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) by the latest date and time for the receipt of such tender and addressed to the Chief Executive or nominated manager.
 - ii. the tender envelopes / packages are free from any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

10.7.2 Before inviting tenders the appropriate officers shall compile a formal estimate of the probable expense of meeting the specification. Such estimates must quote the value of the relative item in the capital and/or revenue budget for the year approved by the Trust Board.

10.7.3 Every tender for goods, services or disposals shall include sections of the NHS Standard Contract Conditions as are applicable.

10.7.4 Every tender for building, engineering works, land and property transactions shall comply with the industry standards for such contracts.

10.7.5 In the case of IT procurements the requirements of relevant industry standards shall be followed.

10.8 Receipt and Safe Custody of Tenders and Records

10.8.1 Tenders received via the e-tendering system will be subject to the controls built into the system regarding the receipt and safe keeping of all tenders and records.

10.8.2 The date and time of receipt of each manual tender shall be endorsed on each unopened tender envelope/package.

10.8.3 The nominated employee shall be responsible for the receipt, endorsement and safe custody of manual tenders received until the time appointed for their opening.

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10.9 Opening Tenders

10.9.1 E-Tenders

Within three working days after the date and time stated as being the latest time for the receipt of tenders, they shall be unlocked and opened in the e-tendering system by two officers within the Procurement Department.

10.9.2 Manual Tenders

- a) Within three working days after the date and time stated as being the latest time for the receipt of tenders, they shall be opened in the presence of persons specified in the separate procedures for Capital and Procurement. In the case of JCT tenders, for capital projects, they shall be opened by:
 - Executive members of the Trust Board
 - Deputy Director of Finance – Governance and People
 - Deputy Chief Operating Officers
 - Deputy Director of People Workforce and Organisational Development
- b) Every tender received shall be stamped with the date of opening and initialed by the persons in Section 10.9.1 (a) above, who witnessed the opening.
- c) Every envelope shall be referenced to the tenderer and shall be retained with the tender documents.
- d) All pages of the tender documents containing the tender prices or making specific reference to terms and conditions stipulated by the tenderer shall be stamped in the presence of the persons witnessing the opening, with a uniquely identifiable stamp, which shall be held securely in the charge of a nominated officer.
- e) A record shall be maintained by the Nominated employee for each set of competitive tender invitations dispatched, which shall be initialed by the witnesses to the opening of tenders. The register shall contain the following information:
 - i. The names of all the firms invited
 - ii. In the case of building and engineering contracts, the estimate of the probable cost
 - iii. The names and the number of firms from which tenders have been received and the amount of each tender where applicable
 - iv. The date the tenders were opened
 - v. The persons present at the opening and their signatures
 - vi. Particulars of any anomalies
- f) Every price alteration appearing on the tender shall be initialed by two of those present at the opening.
- g) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

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10.10 Admissibility, Evaluation and Acceptance of Tenders

10.10.1 Admissibility

- a) If for any reason it appears that the tendering process has not been carried out on a strictly competitive basis no contract shall be awarded without the approval of the Chief Executive.
- b) Tenders received after the opening may not be considered unless it is agreed by the Chief Executive that there is adequate reason for the late arrival and that it is in the interest of the Trust to do so and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or the nominated officer or if the process of evaluation and adjudication has not started.
- c) If none of the tenders that were received in time are economically or in other ways acceptable, re- tendering to a new date shall be invited
- d) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

10.10.2 Evaluation

- a) The evaluation of Procurement Department and Pharmacy tenders are undertaken via a recommendation report and the thresholds laid out in section 9.4.4. For capital construction procurements a tender evaluation report will be approved in accordance with the scheme of delegation below.

Tender Evaluation Reports (excl. VAT)	Authority
£5,000 to £250,000	Director of Estates and Facilities or nominated Deputy
£250,000 to £1m	As above, plus the Director of Finance and Information
Above £1m	As above, plus Director of Finance and Information recommendation to Trust Board

- b) Necessary discussion and consultation with a tenderer to clarify the tender before the award of a contract need not disqualify the tender. However, if such discussions result in clarifications of the specification, which result in a tender price being reduced below what were previously lower prices of other tenderers, a contract shall not be awarded unless all the other tenderers have been given the benefit of any clarification to the specification that has resulted from the discussions, and an opportunity to re-tender if they wish. This is with the exception of a negotiated and competitive dialogue or innovation partnership procedure.

10.10.3 Acceptance

- a) The most economically advantageous tender, shall be accepted unless, for good and sufficient reasons which must be formally recorded, the Chief Executive decides otherwise. This is with the exception of a negotiated and competitive dialogue or innovation partnership procedure.
- b) No tender shall be accepted until the professional officer concerned has formally agreed that it is technically satisfactory.

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- c) No tender for building works which is in excess of the budget sum under 10.7.2 by more than 10% or £5,000, whichever is the greater, should be accepted without the approval of the Chief Executive.
- d) All tenders shall be treated as confidential and should be retained for inspection.

10.11 Form of Contract

- 10.11.1 a) Every contract including those for building and engineering works shall embody or be in the same terms and conditions of contract as those on the basis of which tenders were invited.
- b) Every contract for building and engineering works, which exceeds the sum of £150,000, shall be executed under the common seal of the Trust (except those executed under the JCT form of contract for minor works). The use of the common seal of the Trust shall be in accordance with Section 24 of the Scheme of Delegation.

10.12 Payment to Contractors by Instalments

- 10.12.1 a) Where contractors provide for payment to be made by instalments, the Director of Finance and Information shall keep a contract register to show the state of account on each contract, between the Trust and the contractor, together with any other payments and the related professional fees.
- b) Payment to contractors on account shall be made only on a certificate issued by the appropriate Estates Officer or Project Manager, Private Architect or other consultant nominated as Contract Administrator.

10.13 Variation of Contracts

- 10.13.1 Contract variations shall only apply to works or services, not goods. All contract variations must properly describe the additional work or services to be provided for the agreed additional cost.
- 10.13.2 Any contract variation must be considered and authorised in line with the scheme of delegation (appendix 2). Such variations or additional instructions must be issued prior to the commencement of the work in question, except in the case of an emergency when it must be issued on the next working day.
- 10.13.3 Any contract variation must not fundamentally change the scope of the procurement.
- 10.13.4 Contract variations are not subject to single tender actions.

10.14 Final Certificates and Accounts

- 10.14.1 a) The final payment certificate of any contract shall not be issued until the appropriate Contract Administrator, as in Section 10.12.1(b), has certified the accuracy and completeness of the value of the final account submitted by the contractor.

Any final account that is agreed at a figure in excess of the approved sum in the contract shall be reported to:

- i. The Chief Executive if in excess of 5%
- ii. The Trust Board if in excess of 10%

- b) The Director of Finance and Information may examine final accounts for contracts and

may make all such enquiries and receive such information and explanations as may be required in order to be satisfied of the accuracy of the accounts.

10.15 Competitive Tendering

- 10.15.1 The costs of support services may be tested by competitive tendering in accordance with appropriate legislation.
- 10.15.2 For each tendering exercise the following groups shall be set up:-
- a) Service specification group, comprising a nominee of the Chief Executive and a specialist technical officer who will obtain such support from Management Services as is required.
 - b) In-house tender group, comprising a nominee of the Chief Executive with technical support as necessary.
 - c) Evaluation team, comprising specialist support from the procurement department and a Director of Finance and Information representative.
- 10.15.3 All groups should work independently of each other. Individual officers may be members of more than one group, although no member of the in-house tender group may participate in evaluation of tenders.
- 10.15.4 The evaluation team shall make recommendations on the award of contracts to the Trust Board.
- 10.15.5 The price at which a tender is accepted becomes the new budget for the service and shall not be varied except for:-
- a) Subsequent changes in specification authorised by the Chief Executive (being a different person to the in-house contract manager) at prices to be negotiated by the Divisional Director.
 - b) Price variations allowed for in the contract.
- 10.15.6 Monitoring of performance against the contract shall be the responsibility of the nominated Trust officer utilising such advice as is appropriate.
- 10.15.7 The provisions of this section relating to tendering and contracting shall also be observed in competitive tendering.

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11 Payment for Goods and Services Received

11.1 Objective

11.1.1 To ensure that:

- a) Payments are only made for goods and services which have been ordered and received in accordance with these instructions, and are of the appropriate quality and quantity.
- b) Payments are only made once an invoice has been properly checked and authorised by a person with delegated responsibility.
- c) Contract invoices are paid in accordance with contract terms or otherwise in accordance with national guidance.
- d) Invoices and other valid claims are paid promptly

11.2 General

- 11.2.1 The Director of Finance and Information is responsible for the payment of all properly authorised invoices and claims.
- 11.2.2 The Director of Finance and Information is responsible for establishing procedures regarding the prompt notification of all monies payable by the Trust arising from transactions initiated by Trust officers. All Trust employees are responsible for complying with these procedures.

11.3 Verification and Payment

- 11.3.1 The Director of Finance and Information is responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by the Trust.

This system shall provide by certification or by compliance with an authorised computer system that:

- a) Goods and services have been ordered in accordance with Section 9
- b) Goods have been duly received, are in accordance with specification and order and that prices are correct
- c) Services have been satisfactorily executed in accordance with the order and that the charges are correct
- d) In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time records, that the rates of labour are in accordance with the appropriate rates, that the materials have been checked as regards quantity, quality and price, and that the charges for the use of vehicles, plant and machinery and other expenses have been examined and are reasonable
- e) The invoice is arithmetically correct
- f) The account has not been previously passed for payment or paid
- g) The account is in order for payment

- 11.3.2 The Trust will maintain an Authorised Signatory List of budget holders and officers delegated by them who are authorised to certify invoices.

- 11.3.3 The Director of Finance and Information shall ensure that all invoices and accounts are paid promptly having regard to:

- a) The Trust's cash flow
- b) The possibility of receiving a discount for early payment
- c) Current Department of Health and Social Care guidance on prompt payment.

- 11.3.4 Where an employee authorising invoices for payment relies upon other employees to do

preliminary checking they must ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

- 11.3.5 In the case of contracts for building or engineering works which require payment to be made on account during the progress of the work, the Director of Finance and Information shall make payment on receipt of a certificate from the appropriate technical consultant or officer. Without prejudice to the responsibility of any consultant or works officer appointed to a particular building or engineering contract, a contractor's account shall be subjected to financial and general examination by the person responsible to the Trust as Project Manager before the final certificate is issued.

11.4 Prepayments and commitments covering future financial years

- 11.4.1 Prepayments and commitments covering future financial years are only permitted where exceptional circumstances apply. In such instances: Prepayments are only permitted where the financial advantages outweigh the disadvantages;
- a) The appropriate employee must provide in writing, the case for a prepayment/future commitment, setting out all relevant circumstances of the purchase. This must include the effect on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments
 - b) The Director of Finance and Information will need to be satisfied with the proposed arrangements before contractual arrangements proceed
 - c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Executive Director or Chief Executive if problems are encountered.

11.5 Duties of Managers and Officers

- 11.5.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and Information and that:
- a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance and Information for approval in advance of any commitment being made
 - b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement. See also section 10
 - c) where consultancy advice is being obtained or where supply of staff is being sought via an agency, the procurement of such skills must be in accordance with the latest guidance issued by the NHS Executive, the Department of Health and Social Care and the independent regulator and in line with section 8.6
 - d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees other than:
 - I. isolated gifts of a trivial character or inexpensive branded seasonal gifts, such as calendars;
 - II. (conventional hospitality, such as lunches in the course of working visits; This provision needs to be read in conjunction with section 22.
 - e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance and Information on behalf of the Chief Executive
 - f) all goods, services, or works are ordered on an official order except purchases from petty

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cash

- g) verbal orders must only be issued by exception, by an authorised employee and only in cases of emergency or urgent necessity. These process for emergency ordering must be followed including the issue a confirmation order
- h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds laid out in section 9
- i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase
- j) changes to the Trust's Authorised Signatory List of budget holders and officers delegated by them authorised to certify invoices are notified to the finance department through the designated process;
- k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance and Information;
- l) petty cash records are maintained in a form as determined by the Director of Finance and Information;
- m) orders should be placed using either the Trust's electronic requisitioning and ordering system EROS or, where specifically permitted, the Trust's non EROS purchase to pay process as described in the applicable Trust policy.

11.5.2 The Chief Executive and Director of Finance and Information shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice and guidance issued by the Department of Health and Social Care and NHS England and Improvement. The technical audit of these contracts shall be the responsibility of the relevant Executive Director.

11.6 Imprests

11.6.1 The Director of Finance and Information may authorise advances on the imprest system for petty cash and other purposes as required. Individual payments from such imprests must not exceed an amount authorised by the Director of Finance and Information and must be properly reconciled to petty cash sheets, which are supported by vouchers showing details of the transaction.

11.7 Negotiation with Suppliers

11.7.1 Where there are ongoing disputes with suppliers that require compromise arrangements to resolve, these will be considered and approved as follows:

- £0 - £1,000 Deputy Director of Finance – Governance and People
- £1,001 - £25,000 Director of Finance and Information
- Over £25,000 Finance Committee

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12 Stores and Receipt of Goods

12.1 Objective

- 12.1.1 To ensure that all stockholdings of significant value are properly safeguarded and accounted for.

12.2 Control of Stores

- 12.2.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:
- a) kept to a minimum
 - b) subjected to annual stock take
 - c) valued at the lower of cost and net realisable value
- 12.2.2 Subject to the responsibility of the Director of Finance and Information for the systems of control, the overall control of stores shall be the responsibility of the appropriate Divisional Manager/Head of Trust Corporate Services function. This responsibility may be further delegated to a service manager or staff member provided this is clearly documented.
- 12.2.3 The Director of Pharmacy in Bristol and Lead Pharmacist in Weston is responsible for the control of pharmaceutical stocks.
- 12.2.4 The Director of Estates and Facilities is responsible for the control of fuel stocks (oil and coal).
- 12.2.5 The Operations Manager Clinical Engineering is responsible for the control of MEMO stocks
- 12.2.6 The Director of Finance and Information shall establish procedures and systems regarding the control of stores including receipting, issues, returns and losses. All staff responsible for the control of stores must comply with these procedures.
- 12.2.7 The responsibility for security arrangements and the custody of keys for all stores locations shall be clearly defined in writing by the designated employees and agreed with the Director of Finance and Information. Wherever practicable, stocks shall be marked as Trust property.
- 12.2.8 The Director of Finance and Information shall be informed of any variations in policy that are likely to result in any significant variation in overall stock levels.

12.3 Stocktaking

- 12.3.1 Stocktaking arrangements shall be agreed with the Director of Finance and Information and there shall be a rolling programme of physical check covering all items in store. The physical check shall involve at least one officer other than the designated responsible officer. The stocktaking records shall be numerically controlled and signed by the officers undertaking the check.
- 12.3.2 Any surpluses or deficiencies revealed on stocktaking shall be reported to the responsible officer for investigation. Evidence of such investigation shall be recorded and all confirmed surpluses or deficiencies shall be reported immediately to the Director of Finance and Information.
- 12.3.3 All responsible employees shall comply with the arrangements made by the Director of Finance and Information to certify stock values at the 31st March each year.

12.4 Losses and Slow-Moving Items

- 12.4.1 The responsible employee shall maintain a system approved by the Director of Finance and Information for reviewing slow moving and obsolete items at least annually and for the condemnation, disposal and replacement of all unserviceable items. They shall formally report to the Director of Finance and Information any evidence of significant overstocking and of negligence or malpractice.
- 12.4.2 Breakages, deteriorations due to overstocking and other losses of goods in stores shall be recorded as they occur, and a summary should be presented to the Director of Finance and Information at quarterly intervals. Tolerance limits shall be established for all stores subject to unavoidable loss, such as certain foodstuffs and natural deterioration of certain goods.
- 12.4.3 It is a duty of employees responsible for the custody and control of stores to notify all losses including those due to theft, fraud and arson, in accordance with Section 13 and 16 of these instructions.

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13 Fixed Asset Register and Security of Assets, Disposal and Accounting of Assets

13.1 Objective

- 13.1.1 To ensure that assets are properly safeguarded and accounted for.

13.2 Asset Register

- 13.2.1 The Director of Finance and Information is responsible for the maintenance of the Trust's register of assets and for arranging for a physical check of assets against the asset register to be conducted on a rolling three year programme.

- 13.2.2 The Director of Finance and Information must ensure the Trust maintains an asset register recording all fixed assets, including those used for the provision of Commissioner Requested Services, in accordance with the requirements of the Independent Regulator.

- 13.2.3 Additions to the fixed asset register must be clearly identified to an appropriate officer and be validated by reference to

- a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- b) stores, requisitions and payroll records for own materials and labour including appropriate overheads and
- c) lease agreements in respect of assets held under a finance lease and capitalised.

The Trust shall maintain an asset register of every relevant asset used for the provision of Commissioner Requested Services in accordance with the guidance issued by the Independent Regulator.

- 13.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, the responsible officer must notify the Director of Finance and Information, who will ensure that their value is removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

- 13.2.5 Assets that are leased by the Trust must not be disposed of.

- 13.2.6 The Director of Finance and Information shall approve procedures for reconciling the fixed asset balances in the financial ledger with the balances on the fixed asset register.

- 13.2.7 The value of each asset shall be maintained in accordance with the Trust's agreed accounting policies.

- 13.2.8 The value of each asset shall be depreciated over its expected asset life in accordance with the appropriate accounting standards and any guidance issued by Department of Health and Social Care.

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13.3 Security of Fixed Assets

- 13.3.1 The Chief Executive is responsible for the overall control of the Trust's fixed assets.
- 13.3.2 Asset control procedures (including fixed assets, donated assets, cash, cheques and negotiable instruments) must be approved by the Director of Finance and Information. These procedures shall make provision for
- a) recording the managerial responsibility for each asset
 - b) the identification of additions and disposals
 - c) the identification of all repairs and maintenance expenses
 - d) the physical security of assets
 - e) the periodic verification of the existence of, condition of and title to, assets recorded
 - f) identification and reporting of all costs associated with the retention of an asset
 - g) reporting, recording and safekeeping of cash, cheques and negotiable instruments; detailed in section 14.
- 13.3.3 All discrepancies revealed by the verification of physical assets to the fixed asset register shall be notified to the Director of Finance and Information.
- 13.3.4 Each employee has a responsibility for the security of the Trust's property and should ensure that equipment and property is secured when not attended and should report suspicious incidents and losses to their appropriate manager. It is the responsibility of Directors and senior managers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported to the Chief Executive.
- 13.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported in accordance with the procedure for reporting losses in section 16.
- 13.3.6 Where practical, purchased or donated assets should be marked as Trust property.
- 13.3.7 Where assets are loaned or leased to the Trust, responsible officers should ensure these are notified to the Director of Finance and Information in accordance with prescribed procedures. These assets must be clearly identified and must not be scrapped or otherwise disposed of. An inventory of such assets will be maintained but will not form part of the fixed asset register.

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13.4 Restrictions on the disposal of assets

- 13.4.1 A register of every relevant asset for the provision of Commissioner Requested Services is required to be maintained in accordance with requirements issued by the Independent Regulator.
- 13.4.2 If NHS England and Improvement has given notice to the Trust that it is concerned about the ability of the Trust to carry on as a going concern then the following shall apply.
- a) The Trust shall not dispose of the whole or any part of, or relinquish control over, any relevant asset except with the consent in writing of NHS England and Improvement
 - b) The Trust shall inform NHS England and Improvement of any proposals to dispose of, or relinquish control over, any relevant asset
 - c) Written consent from NHS Improvement shall not prevent the Trust from disposing of, or relinquishing control over, any relevant asset where:
 - I. NHS England and Improvement has issued a general consent, or
 - II. The Trust is required by the Care Quality Commission to dispose of a relevant asset.

13.5 Disposal of Assets

- 13.5.1 The Director of Finance and Information must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to Managers.
- 13.5.2 When a Department decides to dispose of a Trust asset, the Head of Department, or authorised deputy must comply with the Trust's procedures. In particular by:
- a) establishing whether it is needed elsewhere in the Trust; and if not
 - b) determining and advising the Director of Finance and Information of the estimated market value of the item, taking account of professional advice where appropriate.
- 13.5.3 In the event of a private sale (e.g. to a member of staff) the Head of Department should first follow the procedure in Section 13.5.1. If the private sale is more beneficial the Divisional Manager should be notified of the course of action. Advice should be sought from the Finance Department regarding the VAT liability of the proposed sale.

13.6 Condemnations

- 13.6.1 All unserviceable articles can only be condemned or otherwise disposed of by an officer authorised for that purpose by the Director of Finance and Information and in accordance with Trust procedures. In particular the condemnation must be appropriately recorded in line with these procedures identifying whether the articles are to be converted, destroyed or otherwise disposed of. All records shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance and Information.
- 13.6.2 The officer condemning the item shall establish whether or not there is evidence of negligence in use and shall report such evidence to the Director of Finance and Information who will take appropriate action.

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14 Security of Cash, Cheques and Other Negotiable Instruments

14.1 Objective

- 14.1.1 a) To ensure that cash, cheques, and similar documents of value are kept securely and properly controlled.
b) To design and securely control all controlled stationery e.g. receipt books, agreement forms, income books.

14.2 Cash

- 14.2.1 Cash handling represents an area of high risk, therefore it should be kept to a minimum with banking facilities used whenever possible. All staff responsible for collecting or holding cash must comply with these standing financial instructions and all detailed system procedures issued by the Director of Finance and Information, in order to protect themselves and prevent their integrity from being called into question.
- 14.2.2 The Senior Manager responsible for an area where cash is handled must ensure that all staff:
- are aware of their duty to comply with Standing Financial Instructions and the procedures issued by the Director of Finance and Information.
 - comply with the provisions of this section of the Standing Financial Instructions and cash handling procedures.
- 14.2.3 On every occasion when cash is transferred from the custody of one person to another it shall be the duty of the recipient to check it and of the other to obtain a written acknowledgement. Where this is not possible due to the cash being in sealed packets, the packets shall be counted and acknowledged unopened.
- 14.2.4 Cash handling procedures should always demonstrate segregation of duties. Where this is not possible, a Senior Manager must oversee the process including conducting regular checks to provide assurance.

14.3 Cash Expenditure

- 14.3.1 If a Manager considers it necessary for a member of staff to use cash to purchase goods or services on behalf of the Trust, where cheque payment or bank transfer is impractical, they must comply with the 'petty cash' procedures established by the Director of Finance and Information.
- 14.3.2 The Trust's money shall not, under any circumstances, be used for the encashment of private cheques or be used for private purposes.
- 14.3.3 Staff responsible for administering petty cash imprests must ensure that payments are only made in line with the petty cash procedure established by the Director of Finance and Information. Every payment must be recorded and authorised in accordance with these procedures with evidence supporting the transaction.
- 14.3.4 It is the responsibility of all staff authorised to hold cash to reconcile, at least once a week, the record of transactions with the amount actually in hand, in line with Trust procedures. It is the responsibility of their manager to review and make appropriate checks in line with Trust procedures. Any discrepancy or concerns must be reported to senior management and the Director of Finance and Information without delay.

14.4 Cash Income

- 14.4.1 Income received shall be handled and accounted for in accordance with the requirements of Sections 6.3 and 7.

14.5 Security of Cash

- 14.5.1 Staff involved in the handling of cash and their managers are responsible for ensuring that cash is kept securely and in accordance with the procedures issued by the Director of Finance and Information. They must ensure that they have notified the finance department of the cash handling within their area.
- 14.5.2 Safes and/or lockable cash boxes shall be provided for the custody of cash in all places where it is necessary for cash to be held. Coin-operated machines shall wherever possible be fitted with separately lockable compartments for cash.
- 14.5.3 Cash boxes holding cash shall not be left unattended at any time and shall be kept in a safe when not in use.
- 14.5.4 The loss of cash, cash boxes, safes or keys should be notified to the finance department immediately.

14.6 Unofficial Funds

- 14.6.1 The Trust shall not be liable in any circumstances for the loss of unofficial funds (funds not arising from Trust business). The holder of the key of a safe provided for the custody of official cash shall not accept unofficial funds for safe keeping.

14.7 Controlled Stationery

- 14.7.1 The Director of Finance and Information is responsible for approving the design of, and ordering, all controlled stationery such as receipt books, agreement forms, invoices or other means of recording monies received or receivable.
- 14.7.2 All controlled stationery shall be issued and kept securely in accordance with procedures established by the Director of Finance and Information. Any loss of controlled stationery must be reported to the Director of Finance and Information immediately.

14.8 Cheques

- 14.8.1 All blank cheques or other orders for payment shall be ordered only on the authority of the Director of Finance and Information, who shall make proper arrangements for their safe custody. They shall be subject to the same security precautions as are applied to cash. Any loss of cheques shall be reported to the Director of Finance and Information immediately.
- 14.8.2 Cheques are not permitted to be drawn to "cash" without the authority of the Director of Finance and Information.

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14.9 Movement of Cash

- 14.9.1 The Director of Finance and Information shall prescribe the system for the transporting of cash and shall be responsible for making all arrangements with any security company operating under a contract with the Trust. Cash in transit (including cash moved from one office or building to another on Trust premises) and the making up and paying out of cash payments shall be suitably safeguarded. When substantial amounts have to be moved, special security arrangements shall be made.
- 14.9.2 Any employee who has any indication that the safe custody of cash on the Trust's premises or in transit to or between premises may be at risk shall immediately notify the Director of Finance and Information and the Security Officer confidentially of the circumstances.

14.10 Transfer of Responsibilities for Cash, Cheques and Controlled Stationery

- 14.10.1 When an employee, whose duties include the holding of cash, cheques or controlled stationery hands over responsibility prior to leave or termination of appointment, both the outgoing and the incoming officer shall sign a handing over certificate stating:
- a) the composition of the cash
 - b) the consecutive numbers of the cheques or controlled stationery;
 - c) particulars of keys handed over
 - d) particulars of anything else being held for safekeeping
- 14.10.2 In the unavoidable absence of the outgoing employee, one or more other employee shall be appointed to carry out the hand-over to the incoming officer.
- 14.10.3 Where the responsibility for an imprest changes permanently, this fact shall be notified to the Director of Finance and Information. Hand-over certificates evidencing the change in responsibility should be retained within the area for future reference.
- 14.10.4 During any absence of the substantive holder of the key to a safe or cash box, the officer or officers appointed to act temporarily shall be fully accountable for the performance of such duties and shall be subject to these Standing Financial Instructions as though they were the substantive key holder.

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15 Patients' Property

15.1 Objective

- 15.1.1 To ensure that property of patients is properly safeguarded and fully accounted for.

15.2 Responsibilities

- 15.2.1 The Trust has a responsibility to provide safe custody for money or other personal property (hereafter referred to as 'property') handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital, or dead on arrival.
- 15.2.2 Staff shall be informed on appointment in writing by the appropriate departmental head or senior officers of their responsibilities and duties for the administration of the property of patients.
- 15.2.3 The Chief Executive shall be responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' monies and personal property brought into the Trust's premises, unless it is handed in for safe custody and a copy of the patients' property record is obtained as the official receipt.
- 15.2.4 Where possible patients should be advised to make their own arrangements for the safe custody of their property - outside of the hospital.
- These matters shall be drawn to patients' attention by means of:
- a) Notices and information booklets
 - b) Hospital admission documents and property records
 - c) The verbal advice of administrative and nursing staff responsible for admissions
- 15.2.5 The Director of Finance and Information must provide detailed written instructions on the collection, custody, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and patients transferred to other premises) for all staff whose duty it is to administer in any way the property of patients.
- 15.2.6 Every employee of the Trust into whose personal custody any money or other property of a patient is received must comply with the requirements of these instructions. Valuable items shall be dealt with in the same way as cash and therefore instructions in sections 6 and 14 will apply.
- 15.2.7 Except as provided below in section 15.3, refunds of property handed in for safe custody shall be returned to the patient, as required, by the employee who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate, and witnessed.

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15.3 Deceased patients

- 15.3.1 The disposal of property of deceased patients shall be effected by the Director of Finance and Information and in accordance with Department of Health and Social Care and Treasury guidance. Disposal to relatives shall be dependent on clarification of the lawful kin or other such person entitled to the possessions in question.
- 15.3.2 In all cases where property, including cash and valuables of a deceased patient is of a total value of more than £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments Act 1965), the production of a Grant of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of the property is £5,000 or less, forms of indemnity shall be obtained.
- 15.3.3 In respect of a deceased patient's property, if there is no will and no lawful kin, the property vests with the Crown, and particulars shall, therefore, be notified to the Treasury Solicitor, or to the Duchies of Lancaster and Cornwall, as appropriate.
- 15.3.4 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any cash of the estate held by the Trust shall be appropriated towards funeral expenses. No other expenses or debts shall be discharged out of the estate of a deceased patient.

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16 Losses and Special Payments

16.1 Objective

- 16.1.1 To ensure losses and special payments are correctly recorded and fully accounted for.

16.2 General

- 16.2.1 The Director of Finance and Information is responsible for establishing procedures for the recording of and accounting for losses and special payments.
- 16.2.2 The Director of Finance and Information shall maintain a losses and special payments register in which all losses shall be recorded without delay. Appropriate officers must undertake a review of systems and processes to reduce the risk of similar losses arising in the future and seek advice where they believe a particular case raises a point of principle.
- 16.2.3 For any loss the Director of Finance and Information shall consider whether any claim can be made against insurers and ensure this is pursued if appropriate.

16.3 Losses

- 16.3.1 Any employee discovering or suspecting a loss of any kind must immediately inform their Head of Department, who must ensure that their Divisional Director (or Head of Corporate Service in the case of Trust Services) is informed.

The Divisional Manager or Head of Service must appropriately inform the Chief Executive, Director of Finance and Information or Chief Internal Auditor. Employees may also report suspicions directly to the Chief Internal Auditor. Where a criminal offence (i.e. theft or arson) or loss due to fraud or corruption is suspected, the Chief Executive, Director of Finance and Information or Chief Internal Auditor must be informed immediately.

- 16.3.2 The Director of Finance and Information is responsible for ensuring the Trust has a 'Counter Fraud Plan' setting out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. Where loss due to fraud or corruption is suspected the Trust's countering fraud and bribery policy should be referred to.
- 16.3.3 Losses arising from accidental breakages, deteriorations due to overstocking and other losses of goods in stores should be recorded and notified as described in section 12.
- 16.3.4 All losses are required to be reported to the Audit Committee on a quarterly basis.

16.4 Write-Offs

- 16.4.1 The Trust Board shall approve a scheme of delegation for the approval and authorisation of write-offs within the limits of delegation granted to the Trust by NHS England and Improvement. Write offs includes the abandonments of claims and the charging of fruitless payments.
- 16.4.2 The Director of Finance and Information shall report to the Audit Committee a summary of write offs each quarter with details of all cases for which the Trust Board's specific approval is required.

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16.5 Special Payments

16.5.1 Special Payments include:

- Ex-gratia payments
- Compensation payments made under legal obligation
- Extra statutory or extra regulatory payments
- Extra contractual payments to contractors.

16.5.2 Ex gratia payments compensate patients, visitors and staff for the loss of personal effects or for incurring unnecessary expense in exceptional circumstances. The authority to make ex-gratia payments and the process for doing so is included in the procedures referred to in section 16.2.1. Key points can be summarised as:

- Ex-gratia payments for loss or damage to employees' or patients' personal effects should only be paid if there has been negligence on the part of the Trust or of any of its employees. Divisional Director/Head of Corporate Service must confirm that the loss occurred on Trust property and that there was negligence on the Trust's part which contributed to the loss. Reference should be made to Section 15, patient property.
- Accidental damage to an employee's clothes, etc., where no other person is involved does not qualify for compensation unless caused by defects in equipment or conditions which is the responsibility of the Trust and which could not reasonably have been foreseen or avoided by the employee. Accidental damage to staff's personal effects caused by a patient should be dealt with on the merits of the case.
- Reimbursement of unnecessary costs incurred, such as those associated with attending for treatment which is subsequently cancelled, will only be considered in exceptional circumstances and only reasonable expenses as defined in the policy will be considered.
- Ex-gratia payments are only made once properly authorised and reimbursement is limited to actual costs incurred. Receipts are required to support all claims, although reimbursement for amounts below £50 can be made without a receipt at the discretion of the Director of Finance and Information.
- Recommendations for ex-gratia payments should be made to the Director of Finance and Information in accordance with Trust procedures. Only the Director of Finance and Information or delegated deputy can authorise such payments.
- Ex-gratia payments are authorised in accordance with the following delegated limits:
 - Up to £1,000 Director of Finance and Information
 - £1,001 - £50,000 Chief Executive
 - Over £50,000 Trust Board

16.5.3 Personal injury cases will be dealt with in the following manner:

- Over 10,000 decided in conjunction with the NHS Resolution
- Up to £10,000 may be settled without legal advice with the approval of the Chief Executive or Director of Finance and Information or the Director of People Workforce and Organisational Development

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- 16.5.4 Public Liability cases will be dealt with in the following manner:
- Over £3,000 decided in conjunction with the NHS Resolution.
 - Up to £3,000 may be settled without legal advice with the approval of the Appropriate Divisional Director /Head of Corporate Services or Director of Finance and Information or Chief Executive
- 16.5.5 All Clinical Negligence Cases are handled and decided by the NHS Resolution on behalf of the Trust. Whilst NHS Resolution is administratively and financially responsible for all clinical negligence cases the legal liability remains with the Trust.
- 16.5.6 Severance payments or voluntary severance schemes require a supporting business case for submission to the Trust's relationship manager at NHS England and Improvement. NHS England and Improvement will then forward to HM Treasury for approval.
- 16.5.7 Special severance payments to staff outside contractual or statutory entitlements (including settlement of employment tribunal claims) in order to terminate employment need to be approved by HM Treasury before settlement is offered. There are no delegated limits for special severance payments, and all cases need to go to HM Treasury.
- 16.5.8 All applications for severance payments must be approved by the Director of People Workforce and Organisational Development and submitted by the Director of Finance and Information according to Trust procedures and in the appropriate form required by HM Treasury.
- 16.5.9 The Trust is required to obtain approval for time limited voluntary severance schemes, which obviates the need to make a submission for each individual non contractual or non-statutory payment made under the scheme.
- 16.5.10 All proposals for payment for maladministration and distress shall be dealt with in accordance with the Trust's policy. Divisional Directors shall sign off all payment requests for approval.
- 16.5.11 Delegated limits for approving maladministration and distress payments are as follows:
- Up to £1,000 Director/Deputy Director of Finance – Governance and People
 - £1,001 - £50,000 Chief Executive
 - Over £50,000 Trust Board
- 16.5.12 All extra contractual payments to contractors must be approved within the delegated limits
- | | |
|------------------------------|---|
| Up to £25,000 | Director of Finance and Information or Deputy Director of Finance – Governance and People |
| Between £25,000 and £100,000 | Chief Executive |
| Over £100,000 | Trust Board |
- 16.5.13 All special payments are required to be reported to the Audit Committee on a quarterly basis.

16.6 Insurance

- 16.6.1 There is a scheme available, administered by the NHS Resolution, through which the Trust insures. A small number of specified risks are not insurable through the NHS scheme and these may be insured commercially, see section 19. The Director of Finance and Information shall establish procedures so for reporting claims are made for all insured losses.

16.7 Bankruptcy and Liquidation

- 16.7.1 The Director of Finance and Information shall be authorised to take any necessary steps to

safeguard the Trust's interests in bankruptcies and company liquidations.

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17 External Borrowing and Public Dividend Capital

17.1 Objective

- 17.1.1 To ensure that external borrowing and public dividend capital is correctly approved, drawn and fully accounted for.

17.2 External Borrowings

- 17.2.1 The Trust can obtain a working capital facility from the commercial banking sector. Short term borrowing should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, comply with the Trust's Treasury Management Policy and all guidance issued by NHS England and Improvement.
- 17.2.2 The Director of Finance and Information shall be responsible for advising the Trust Board regarding the Trust's ability to repay public dividend capital (PDC) and long-term loan principal together with the payment of dividends on PDC and interest on such borrowings. The Director of Finance and Information shall also be responsible for reporting periodically to the Trust Board concerning the PDC debt and all loans or short term borrowings.
- 17.2.3 Any application for a loan or short term borrowing will only be made by the Director of Finance and Information or an officer designated for this purpose following approval by the Finance Committee, and in accordance with the Scheme of Delegation as appropriate.
- 17.2.4 The Director of Finance and Information shall maintain a schedule of employees (including specimens of their signatories) approved by the Finance Committee who are authorised to make short term borrowings on behalf of the Finance Committee. This must include the Chief Executive and Director of Finance and Information.
- 17.2.5 Any short-term borrowing must be with the authority of two employees identified in 17.2.4 one of which must be the Chief Executive or the Director of Finance and Information. The Board must be made aware of all short term borrowing at their next meeting.
- 17.2.6 The Director of Finance and Information will advise the Trust Board on the need for longer term borrowing. Following resolution of the Board, the Director of Finance and Information will make appropriate arrangements with the Independent Trust Financing Facility or other lender depending on the commercial arrangements available. All long term borrowing in respect of Strategic Capital Schemes must be consistent with the plans outlined in the current Medium Term Capital Programme approved by the Finance Committee.
- 17.2.7 The Director of Finance and Information must ensure that any loan application is made in accordance with the instructions issued by the lender and NHS England and Improvement. Records must be maintained and all interest and loan principal must be repaid in accordance with the lender's loan agreements.
- 17.2.8 Assets defined as Commissioner Requested Services (CRS) relevant assets shall not be used or allocated for borrowing; non-CRS relevant assets will be eligible as security for loans.

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18 Capital Investment and Private Financing

18.1 Objective

- 18.1.1 To ensure that the Trust has an appropriate policy to develop and deliver the Medium Term Capital Programme.

18.2 Capital Investment

- 18.2.1 The Trust Board shall approve the funding contained within the Trust's Medium Term Capital Programme as part of the annual budget approval process and any subsequent updates.

- 18.2.2 The Director of Finance and Information shall ensure that the Trust produces a Capital Investment Policy and this is reviewed annually and approved by the Trust Board.

- 18.2.3 The Chief Executive

- a) shall ensure that there is an adequate appraisal and approval process in place in line with the Trust's Capital Investment Policy, for determining capital expenditure priorities and the effect of each proposal upon business plans
- b) is responsible for the ensuring the effective management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost
- c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including, the servicing of loan interest, loan principal repayment and capital charges.

- 18.2.4 For every capital expenditure proposal the Chief Executive shall ensure;

- a) that a business case is produced in line with guidance issued by the Department of Health and Social Care or Independent Regulator and the Trust's Capital Investment Policy which sets out:
 - I. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to cost
 - II. the involvement of appropriate Trust personnel and external agencies
 - III. appropriate project management and governance arrangements.
- b) that the Director of Finance and Information has validated the capital costs and revenue consequences detailed in the business case.
- c) approval of each business case prior to tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with appropriate guidance and the Trust's Standing Orders.

- 18.2.5 For capital schemes requiring stage payments, the Director of Finance and Information shall issue procedures on their management.

- 18.2.6 The Director of Finance and Information shall ensure that all capital schemes are accounted for in accordance with HM Revenue and Custom guidance.

- 18.2.7 The Director of Finance and Information is responsible for the regular reporting of donations,

expenditure and commitments against the Trust's approved Medium Term Capital Programme via the Trust's Capital Programme Steering Group.

- 18.2.8 The approval of a Medium Term Capital Programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall ensure that there are procedures in place identifying managers responsible for each scheme, specifying:

- a) levels of authority to commit expenditure
- b) authority to proceed to tender

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Trust's Standing Orders.

- 18.2.9 Schemes must be tendered and managed in accordance with the requirements of Section 10.

- 18.2.10 Donations (cash and goods) received from charitable parties for the purposes of capital investment will require submission to and the approval of the Capital Programme Steering Group prior to acceptance. Any associated legal agreement containing obligations on the part of the Trust requires signature by the Director of Finance and Information or Director of Strategy and Transformation.

- 18.2.11 The Director of Finance and Information shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

18.3 Commercial / Private Finance

- 18.3.1 The Trust should give consideration to private finance when considering material capital procurement. When the Trust proposes to use private finance the following procedures shall apply:

- a) The Director of Finance and Information shall demonstrate that the use of commercial/private finance represents a balance of value for money compared with using the Trust's own finance and where appropriate, genuinely transfers risk to the private sector.
- b) The proposal must be specifically agreed by the Trust Board.

- 18.3.2 The Director of Strategy and Transformation is responsible for ensuring that:

- a) a programme of service delivery inspections is in place to ensure contract terms are monitored
- b) payments to the commercial partners are authorised in accordance with the contracted availability and performance factors
- c) clearly established dispute resolution procedures are in operation
- d) effective procedures for agreement of changes to service delivery
- e) the service is market tested in line with the contract

18.4 Leases

- 18.4.1 All proposals for finance or operating leases must be submitted to the Director of Finance and Information for advice and approval. Leasing proposals must demonstrate value for money. The Director of Finance and Information must sign all leases.

19 Risk Management and Insurance

19.1 Objective

- 19.1.1 To define the Trust's requirements for risk management and insurance.

19.2 Risk Management

- 19.2.1 The Chief Executive shall ensure that the Trust has robust risk management arrangements, in accordance with any requirements of NHS England and Improvement which must be approved and monitored by the Board.
- 19.2.2 The programme of risk management arrangements shall include:
- a) a process for identifying and quantifying risks and potential liabilities;
 - b) engendering among all levels of staff a positive attitude towards the management of risk;
 - c) governance processes to ensure all significant risks and potential liabilities are identified, managed including identifying responsibility, effective systems of internal control, action/mitigation, cost effective insurance cover, and decisions on the acceptable level of mitigated risk;
 - d) contingency plans to offset the impact of adverse events;
 - e) audit arrangements including; internal audit, clinical audit, health and safety review;
 - f) regular review of the Trust's risk management arrangements;
 - g) a clear indication of which risks shall be insured.
- 19.2.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by NHS England and Improvement.

19.3 Insurance

- 19.3.1 The Chief Executive, in conjunction with the Director of Finance and Information, is responsible for ensuring that adequate insurance cover is held in line with the Trust's risk management policy approved by the Board. This will include insuring through the risk pooling schemes administered by the NHS Resolution, self-insuring for some or all of the risks covered by the risk pooling schemes and purchasing insurance from commercial insurers. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.
- 19.3.2 Trust Officers are required to notify the Director of Finance and Information of all new risks or property which may require to be insured and of any changes that may affect risk or existing insurance.
- 19.3.3 All insurance policies must be approved by the Director of Finance and Information.
- 19.3.4 The Trust may purchase commercial insurance policies for risks not provided for under the Property Expenses Scheme (PES) and Liabilities to Third Parties Scheme (LTPS). This includes:
- a) Additional cover over and above the Trust's delegated limit under PES i.e. property (to the full reinstatement value of the property), contract works, fidelity, and business interruptions.
 - b) Providing cover for specific activities outside the LTPS i.e. non-clinical professional

indemnity, charitable trustees' liability, and Directors and Officers liability.

- c) All such insurance policies must be approved by the Director of Finance and Information.

19.3.5 Arrangements to be followed in agreeing insurance cover:

- a) Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Director of Finance and Information shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance and Information shall ensure that documented procedures cover these arrangements.
- b) Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance and Information shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance and Information will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.
- c) All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance and Information should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

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20 Audit and Counter Fraud

20.1 Objective

- 20.1.1 To ensure a systematic and effective review of the Trust's financial and management controls to give assurance that resources are used efficiently and safeguarded against misuse or fraud.

20.2 Audit Committee

- 20.2.1 In accordance with Standing Orders, the NHS Act 2006 and the NHS Foundation Trust Code of Governance as developed by the Regulator, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and membership consistent with relevant guidance issued by Regulators or the Department of Health and Social Care, including the NHS Audit Committee Handbook.

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

- Definition
- Implementation
- Outcomes

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

The primary responsibilities of the Audit Committee are therefore to:

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

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

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

Finally, the AC must:

8. Communicate and report effectively to all its Stakeholders

- 20.2.3 Where the Audit Committee considers there is evidence of ultra-vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Regulator via the Director of Finance and Information in the first instance.

20.3 Responsibilities of the Director of Finance and Information

- 20.3.1 The Director of Finance and Information is responsible for:
- a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function.
 - b) ensuring that the Internal Audit is effective and meets the NHS mandatory audit standards and any directions given by the Independent Regulator.
 - c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.
 - d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:
 - i. a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards
 - ii. major internal financial control weaknesses discovered
 - iii. progress on the implementation of internal audit recommendations
 - iv. progress against plan over the previous year
 - v. strategic audit plan covering the coming three years
 - vi. a detailed plan for the coming year
- 20.3.2 Director of Finance and Information or designated auditors are entitled without necessarily giving prior notice to require and receive:
- a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
 - b) access at all reasonable times to any land, premises or members of the Board or employees of the Trust;
 - c) the production of any cash, stores or other property of the Trust under a member of the Board or an employee's control; and
 - d) explanations concerning any matter under investigation.

20.4 Internal Audit

- 20.4.1 Internal Audit primarily provides an independent and objective opinion to the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust's objectives. Internal Audit will review, appraise and report upon:
- a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures
 - b) the adequacy and application of financial and other related management controls
 - c) the suitability and reliability of financial and other related management data
 - d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
 - i. fraud and other offences
 - ii. waste, extravagance, inefficient administration
 - iii. poor value for money or other causes
 - e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care and/or NHS England and Improvement.
- 20.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property of the Trust or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance and Information must be notified immediately.
- 20.4.3 The Chief Internal Auditor will normally attend the Audit Committee meetings and has a right

of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

- 20.4.4 The Chief Internal Auditor shall be accountable to the Chief Executive. The reporting system for internal audit shall be agreed between the Director of Finance and Information, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.
- 20.4.5 The Chief Internal Auditor is responsible for developing and maintaining an Internal Audit Strategy to provide an objective evaluation of, and opinion on, the effectiveness of the organisation's risk management, control and governance arrangements. The Chief Internal Auditor's opinion is a key element of the framework of assurance the Chief Executive needs to inform the completion of the Annual Statement on Internal Control. The delivery of this strategy will be realised through the delivery of considered and approved annual plans which will systematically review and evaluate risk management, control and governance of all the Trust's operations, resources, services and responsibilities for other bodies.
- 20.4.6 The Chief Internal Auditor will co-ordinate Internal Audit Plans and activities with line managers, external audit and other review agencies to ensure effective audit coverage is achieved and duplication of effort is minimised.
- 20.4.7 Internal Audit have the right to access all records, assets, personnel and premises of the Trust in the pursuit of information necessary to fulfil its responsibilities. In any instances of conflict this will be referred for resolution to the Director of Finance and Information, Chief Executive or Chair of Audit Committee as appropriate.
- 20.4.8 If the Chief Internal Auditor, Chief Executive, Director of Finance and Information or the Audit Committee consider that the level of Internal Audit resources or the terms of reference in any way limit the scope of Internal Audit, or prejudice the ability of Internal Audit to deliver a service consistent with the definition of internal auditing, they should advise the Board accordingly.
- 20.4.9 Internal Audit provides an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance. The service applies the professional skills of Internal Audit through a systematic and disciplined evaluation of the policies, procedures and operations that management put in place to ensure the achievement of the organisation's objectives, and through recommendations for improvement. Such consultancy work contributes to the opinion, which Internal Audit provides on risk management, control and governance.
- 20.4.10 Internal Audit must be sufficiently independent of the activities which it audits to enable auditors to perform their duties in a manner, which facilitates impartial and effective professional judgements and recommendations. Internal Audit will have no Executive responsibilities.
- 20.4.11 Internal Auditors must have an impartial, unbiased attitude, characterised by integrity and an objective approach to work, and should avoid conflicts of interest. Internal Auditors must declare any conflicts of interest to the Chief Internal Auditor. Any conflicts of interest encountered by the Chief Internal Auditor must be declared to the Director of Finance and Information.
- 20.4.12 The Director of Finance and Information is responsible for ensuring the Chief Internal Auditor is of sufficient status to facilitate the effective discussion and negotiations of the results of Internal Audit work with senior management.
- 20.4.13 Appointment at all levels within the Internal Audit team must endeavor to fulfil the four main

principles of the code of ethics for Internal Audit, integrity, objectivity, competency (i.e. professional qualifications, skills and experience) and confidentiality.

- 20.4.14 Within the parameters of the contract for the Internal Audit Service, the Chief Internal Auditor is responsible for ensuring the team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience to deliver the Internal Audit Plan in line with the NHS Internal Audit Standards. The team will undertake regular assessments of professional competence through an on-going appraisal and development programme (Personal Development Plans and Continuing Professional Development) with training provided where necessary,

20.5 External Audit

- 20.5.1 The External Auditor is appointed by the Council of Governors Representative at a general meeting of the Council of Member Representatives and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and reported to the Audit Committee and Council of Governors Representatives.
- 20.5.2 The Trust will ensure that the external auditor complies with the Audit Code for NHS Foundation Trusts at the date of appointment and on an on-going basis throughout the term of appointments.
- 20.5.3 The Council of Governors shall determine the terms of the contract for the provision of the External Audit.
- 20.5.4 The Audit Committee will receive and agree the External Auditor's annual plan.

20.6 Fraud and Corruption

- 20.6.1 In line with their responsibilities, the Chief Executive and Director of Finance and Information shall monitor and ensure compliance with relevant directions and guidance on countering fraud and corruption within the NHS.
- 20.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Fraud and Corruption Manual and relevant directions and guidance.
- 20.6.3 The Local Counter Fraud Specialist shall report to the Director of Finance and Information and shall work with staff in NHS Protect in accordance with the NHS Fraud and Corruption Manual.
- 20.6.4 The Local Counter Fraud Specialist will provide a written report to the Audit Committee, at least annually, on counter fraud work within the Trust.
- 20.6.5 Counter fraud specialists are entitled without necessarily giving prior notice to require and receive:
- a) access to all records, documents and correspondence relating to any relevant transactions, including documents of a confidential nature; (in which case, they shall have a duty to safeguard that confidentiality);
 - b) access at all reasonable times to any land, premises or members of the Board of Directors or employee of the Trust;
 - c) the production of any cash, stores or other property of the Trust under an employee's control;
 - d) explanations concerning any matter under investigation from any employee, agent or any

employees of third parties contracted to the Trust when acting on behalf of the Trust.

20.7 Security Management

- 20.7.1 The Chief Executive is responsible for ensuring compliance with directions issued by the Department of Health and Social Care relating to NHS security management
- 20.7.2 The Trust shall nominate a director at Board level who will have delegated responsibility for security management as required by the Department of Health and Social Care guidance on NHS security management.
- 20.7.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

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21 Information Management and Technology

21.1 Objective

- 21.1.1 To define responsibilities for the management of the Trust's Information Management and Technology Systems.

21.2 Responsibilities and Duties of the Director of Finance and Information

- 21.2.1 The Director of Finance and Information is responsible for the accuracy and security of the computerised financial data of the Trust:
- a) devising and implementing any necessary procedures to ensure appropriate protection of the Trust's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;
 - b) ensuring that appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
 - c) ensuring that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
 - d) ensuring that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are carried out.
 - e) ensuring procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.
- 21.2.2 The Director of Finance and Information is responsible for ensuring that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.
- 21.2.3 Where computer systems have an impact on corporate financial systems, the Director of Finance and Information shall seek assurance that
- a) systems acquisition, development and maintenance are in line with corporate policies including the Clinical Systems Strategy;
 - b) data produced for use with financial systems is adequate, accurate, complete and timely, and that there is an audit trail;
 - c) Director of Finance and Information staff has access to such data;
 - d) appropriate computer audit reviews are undertaken.

21.3 Responsibilities and Duties of Other Directors in Relation to Computer Systems of a General Application

- 21.3.1 The Legal Services Department (with support from the Chief Information Officer) shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. This describes the information regarding the Trust that is made publicly available.
- 21.3.2 For the implementation, upgrade or changes to computer systems used generally within the Trust, the responsible manager for the system will present a business case to the Joint IT Management Group and Clinical Systems Implementation Programme Board for approval.

21.4 Contracts for Computer Services with NHS Bodies or Outside Agencies

- 21.4.1 The Director of Finance and Information shall ensure that contracts for computer services for financial applications with another NHS body or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.
- 21.4.2 Where another NHS body or any other agency provides a computer service for financial applications, the Director of Finance and Information shall periodically seek assurances that adequate controls are in operation.

21.5 Risk Management

- 21.5.1 The Director of Finance and Information shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk (refer to Section 19.2). This shall include the preparation and testing of appropriate disaster recovery plans.

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22 Acceptance of Gifts by Staff and Other Standards of Business Control

22.1 Objective

- 22.1.1 To ensure that Trust staff comply with required standards of behaviour when using public funds.

22.2 General

- 22.2.1 The Chief Executive shall ensure that a Register of Interests, Gifts and Hospitality is established to formally record declarations of interests, gifts and hospitality made by Trust staff, and as the Accountable Officer has ultimate responsibility for ensuring the Trust has appropriate policies in place in respect of conflicts of interest and the acceptance of gifts or other benefits in kind conferring an advantage to a member of staff. These policies should be consistent with the Standards of Business Conduct for NHS Staff.
- 22.2.2 The Director of Corporate Governance of the Trust is responsible for implementing the Trust's Register of Interests, Gifts and Hospitality Policy across Clinical Divisions and Trust Headquarters, and ensuring all Trust employees are aware of these Trust policies and the restrictions in relation to accepting gifts, inducements, benefits in kind or other personal advantage that could be considered to be bribes under the Bribery Act 2010.

22.3 Gifts

- 22.3.1 Casual gifts offered by contractors or others may be construed to be connected with the performance of duties so as to constitute an offence under the Bribery Act 2010 and therefore all such gifts should be declined. Business articles with little intrinsic value (of less than £50 per gift) such as diaries, calendars, pens etc. need not be refused, nor small tokens of gratitude from patients or their relatives.
- 22.3.2 Any gift accepted of value greater than £50 should be declared in writing to the Trust Secretary via the Register of Interests, Gifts, and Hospitality. If several small gifts worth a total of over £100 are received by an individual from the same or closely related source in a twelve month period, these should also be declared on the Register of Interests, Gifts, and Hospitality.
- 22.3.3 Gifts offered to an individual where the value exceeds £50 should be declined. In exceptional circumstances and with the agreement of the line manager, the matter may be referred to the Trust Secretary for a decision as to whether the gift can be accepted.
- 22.3.4 Under no circumstances may staff accept cash or vouchers, even below the £50.00 threshold. Gifts of cash made to a ward or department are deemed to be charitable donations and should be dealt with as described in section 23. No further declaration is required.
- 22.3.5 All gifts to staff must be accepted in line with the Trust's Register of Interests, Gifts and Hospitality Policy.

22.4 Hospitality

- 22.4.1 Suppliers must not attempt to influence business decision making by offering hospitality to trust staff. Modest hospitality provided it is normal and reasonable in the circumstances may be accepted (e.g. lunches in the course of a working visit). If in doubt, advice should be sought from the employee's line manager or relevant Director.
- 22.4.2 Any offers of inappropriate hospitality should be notified to the Trust secretary for appropriate

action.

- 22.4.3 All hospitality to staff must be accepted in line with the Trust's Register of Interests, Gifts and Hospitality Policy.

22.5 Sponsorship

- 22.5.1 Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks approval in advance from their line manager. Approval must depend on whether acceptance will, or could be believed to, compromise current or future purchasing decisions in any way.
- 22.5.2 The sponsorship of Trust events by existing suppliers to the Trust is acceptable subject to informing the Trust Board Secretary of the agreement for recording the details in the Register of Gifts, Hospitality and Sponsorship. Where the sponsor does not have a contract for supplies or services with the Trust, the Procurement Department should be consulted. The Trust Director of Corporate Governance be informed. In all such cases there must be no favouritism shown to any one supplier in a way that could later be challenged by a competitor. Where this could be the case the same opportunity to sponsor events should be offered to the other interested parties.
- 22.5.3 Some suppliers offer training as a part of supplying equipment and this should be fully reflected through the contract entered into with the relevant organisation. In such cases no disclosure to the Trust Director of Corporate Governance is necessary.
- 22.5.4 The Trust shall not enter into commercial or charitable sponsorship arrangements which link such sponsorship to the supply of goods or services from any particular source.
- 22.5.5 Employees must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to concessionary agreements negotiated with companies by the Trust, or the NHS, or by recognised staff interests, on behalf of all staff for example, staff benefit schemes.

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23 Funds held in Trust

23.1 Objective

- 23.1.1 To ensure that the Trust's charitable funds are properly safeguarded and used for the benefit intended.

23.2 General

- 23.2.1 'Charitable funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the NHS, the objects of which are for the benefit of the NHS in England.
- 23.2.2 The charitable trusts associated with the University Hospitals Bristol and Weston NHS Foundation Trust are administered by the Trustees of **Bristol & Weston Hospitals Charity** (formerly Above & Beyond) (hereafter called the Trustees) ~~except for those associated with Weston Health General Charitable Fund which are administered by the Charity Committee (hereafter called the Committee).~~ The Trustees have their own systems of accounting and financial control and operate separate bank accounts to the Trust. Charitable funds should not be confused with those operated by the Trust for its exchequer funds.
- 23.2.3 All gifts, donations and proceeds of fund-raising activities which are intended for the Trust's benefit shall be handed immediately to either the Trustees or to the Trust's cashier for Bristol donations or the Finance Department for Weston donations who will bank the money and transfer funds as appropriate. Any charitable funds paid in through the Trust's cashier must be clearly identified as such to ensure it is separated from the Trust's exchequer funds. However the funds are passed to the charitable trusts, there must be clear instruction regarding the donor's intentions or the area to benefit.
- 23.2.4 The Director of Finance and Information shall be required to advise the Trust Board on the financial implications of any proposal for fund-raising activities which the Trust may initiate, sponsor or approve.
- 23.2.5 The Trustees will designate a fund advisor for each fund held who must comply with the written procedures issued by the charitable trusts regarding the use of these funds.
- 23.2.6 Expenditure of any funds held in trust shall be conditional upon:-
- a) the expenditure being within the terms of the appropriate fund
 - b) meeting the delegated limits which are:
 - <£1,000 approved by the designated fund advisor
 - >£1,000 approved by the charitable trusts in accordance with their scheme of delegation
 - assets or enhancements >£5,000 also requires approval in the first instance by the Trust's Capital Programme Steering Group
 - Expenditure can only be as prescribed by the approval given and can't exceed the value approved.
 - c) the prior approval of the Trust's Capital Programme Steering Group being obtained for items falling within the capital definition
 - d) being authorised by the fund advisor in writing, or by a person to whom the fund advisor has delegated authority having advised the Trustees in writing

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24 Retention of Documents

24.1 Objective

- 24.1.1 To ensure the Trust has appropriate arrangements for retaining documents to comply with legal responsibilities and to enable the effective operation of the Trust.

24.2 General

- 24.2.1 The Chief Executive shall be responsible for maintaining archives for all records, including electronic records, required to be retained in accordance with Department of Health and Social Care guidelines.
- 24.2.2 The documents held in archives shall be capable of retrieval by authorised persons.
- 24.2.3 Documents held in accordance with Department of Health and Social Care guidelines shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

Hartles Rachel
05/23/2022 15:12:23

Meeting of the Board of Directors in Public on Friday 27th May 2022

Report Title	SFI's Update – Charity Name Change
Report Author	Kate Herrick, Head of Finance (Financial Performance)
Executive Lead	Neil Kemsley, Director of Finance and Information

1. Report Summary	
This report updates the Board on changes to the Trust's Standing Financial Instructions (SFI's) and Scheme of Delegation (SoD). This is an interim review to reflect the change in the name of the charity from Above and Beyond to Bristol & Weston Hospitals Charity and is recommended for approval by the Trust Board at the Committee meeting in May.	
2. Key points to note (Including decisions taken)	
Following the merger of University Hospitals Bristol NHSFT (UHB) and Weston Area Health NHST (WAHT), the charity formerly supporting UHB, Above & Beyond, assumed responsibility for WAHT charitable funds. To reflect the merged organisation Above & Beyond changed its name to Bristol & Weston Hospitals Charity. The SFI's have been amended to reflect the name change and the dissolution of Weston Area Health General Charitable Fund.	
The changes relate to section 23.2.2 on page 64 of the SFI's and comprises of the following:	
• Removal of the reference to Weston Health General Charitable Fund • Insert Bristol & Weston Hospitals Charity (formerly Above & Beyond)	
3. Risks If this risk is on a formal risk register, please provide the risk ID/number.	
None	
4. Advice and Recommendations (Support and Board/Committee decisions requested):	
The Board is asked to:	
1. Approve the name change of the charity from Above & Beyond to Bristol & Weston Hospitals Charity and remove reference to Weston Area Health General Charitable Fund.	
5. History of the paper Please include details of where paper has <u>previously</u> been received.	
Finance & Digital Committee	16 th May 2022

Finance Committee – Standing Financial Instructions

1. Introduction

The Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) are required to be reviewed on an annual basis. Any changes must be considered by the Finance Committee before being recommended for approval at the Trust Board. The next review is planned for June. However, a request has been received from the CEO of Bristol & Weston Hospitals Charity for a change to be made to the SFI's to reflect the charity's name change from Above and Beyond to Bristol & Weston Hospitals Charity. The charity has stressed the urgency of the request to support its end of year processes and providing assurances to solicitors and auditors. As such, it is considered to delay until the full review of the SFI's in June and the ensuing governance process in July/August, would not be satisfactory.

The updated SFIs and supporting scheme of delegation are attached as a separate document. To enable the committee to review the proposed changes the additions are highlighted in green and deletions are in red font and crossed through.

2. Proposed Change

The changes relate to section 23.2.2 on page 64 of the SFI's and compromises of the following:

- Removal of the reference to Weston Health General Charitable Fund
- Insert Bristol & Weston Hospitals Charity (formerly Above & Beyond)

3. Scheme of Delegation

The scheme of delegation has been amended and is attached. The amendments reflect the changes discussed in section 2.

4. Next review

It is proposed to undertake a full review in June 2022 for approval at Finance & Digital Committee in July and Trust Board in August 2022.

The next revision will include changes following work with Bristol and Weston Procurement Consortium to review the procurement of goods and services thresholds in line with best practice.

5. Recommendation

The Finance Committee is asked to consider and approve the changes to the SFIs and Scheme of Delegation following for ratification by the Trust Board

5. Next Steps:

Following approval by the Trust Board the revised SFIs will be communicated to Bristol & Weston Hospitals Charity.

Hartles Rachel
05/23/2022 15:12:23

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

Where the title 'Executive' is used it is deemed to include their nominated deputy where they have been duly authorised by them to represent them

SFI REF	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
1. OVERALL RESPONSIBILITIES AND DELEGATION			
1a	Financial framework, policies and internal financial control systems. Maintain and update Trust's financial procedures.	Director of Finance and Information	SFIs section 1.2.3
1b	Requirement for all staff to be notified of and understand these instructions	Chief Executive, delegated to all managers	SFIs section 1.2.3
	Complying with the Trust's Standing Financial Instructions, Scheme of Delegation and financial procedures	All staff under contract to the Trust	SFIs section 1.2.5
2. PLANNING AND BUDGETS AND BUDGETARY CONTROL			
2a	Strategic and annual business plans	Chief Executive	SFIs section 2.2.1
	Annual (and longer term) financial plan and budget	Director of Finance and Information	SFIs section 2.2.3
	Divisional/Corporate Service operational plans and budgets	Clinical Chairs/Divisional Directors/Corporate Service Director	SFIs section 2.2.5
2b	Budget Management Responsibility		SFIs sections 2.3
	i. at individual cost centre level	Budget Manager or nominated deputy	
	ii. at departmental level	Departmental Manager or nominated deputy	
	iii. at divisional level	Clinical Chair / members of the Divisional Board as authorised by the Clinical Chair.	
	iv. at corporate service level	Director of Estates and Facilities or delegated deputy Chief Information Officer or delegated deputy Corporate Director or delegated deputy	
2c	Budget Virement/Transfer	Virements must be supported by appropriate paperwork and approved by the Senior Management Accountant	SFIs section 2.3
	i. Within a cost centre	Budget Manager and Department Manager	
	ii. Within a department/specialty between cost centres	Department Manager	
	iii. Between specialties/departments	Both department managers	

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

SFI REF		DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
2d	iv.	Between Divisions/Corporate Services below £5k	Both department managers	
	v.	Between Divisions/Corporate Services above £5k	Divisional Director / Director of Estates and Facilities / Chief Information Officer / Corporate Director by joint agreement	
	vi.	To and from Trust reserves	Director of Finance and Information or nominated deputy	
3. ANNUAL ACCOUNTS AND REPORTS				
4a		Preparation of annual accounts and associated financial returns for Board approval	Director of Finance and Information	SFIs section 3.2.1 - 2
4b		Preparation of Annual Report for Board approval	Director of Corporate Governance	SFIs section 3.2.5
4c		Preparation of Quality Report for Board approval	Chief Nurse	SFIs section 3.2.6
4. RESEARCH AND INNOVATION				SFIs Section 4
4a		Authorisation or research funding applications	Director of Finance or designated deputy for funding applications	
4b		Authorisation of commercial research contracts, site agreements, sub-contracts with participating organisations, contract variations and contract amendments.	Director of Research & Innovation or designated deputy	
4c		The West of England Clinical Research Network (CRN:WoE) Decision to provide additional funding to an NHS partner of the CRN:WoE following a request for financial support; Of £50,000 or below	West of England Clinical Research Network Executive Group	
		In excess of £50,000	West of England Clinical Research Network Partnership Group	
5. SERVICE AGREEMENTS NHS CONTRACTS FOR THE PROVISION OF HEALTHCARE SERVICES				
5a		Agreeing and signing NHS contracts for the provisions of healthcare services to NHS commissioners, other NHS providers or private organisations	Chief Executive, Deputy Chief Executive or Director of Finance and Information	SFIs section 5.2.7
5b		Agreeing changes and developments within existing contracts for healthcare services	Chief Executive, Deputy Chief Executive or Chief Operating Officer with Director of Finance and Information agreement	SFIs section 5.2.8
5c		Service agreement monitoring and reporting	Director of Finance and Information	
5d		Service agreement operational management	Clinical Chairs	

**UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST
SCHEME OF DELEGATION**

SFI DELEGATED MATTER REF		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
6. BANKING AND CASH MANAGEMENT			
6a	Opening, operating and controlling all bank accounts referencing the Trust's name or Trust address.	Director of Finance and Information	SFIs section 6.3.2
6b	Day to day operational management of the Trust's bank accounts	Deputy Director of Finance – Governance and People	SFIs section 6.3.6
6c	Determining when to subject commercial banking services to competitive tendering. Organising and evaluating the tender process.	Director of Finance and Information	SFIs section 6.3.9
6d	Approval of bank signatories	Chief Executive or Director of Finance and Information or nominated Senior Finance Manager	
6e	Approval of direct debit or standing order payment arrangements	Director of Finance and Information	SFIs section 6.3.12
6f	Operation of Trust credit/purchasing cards	Director of Finance and Information	SFIs section 6.3.13
6g	Investment of temporary cash surpluses	Director of Finance and Information	SFIs section 6.5
7 INCOME (SEE SECTION 5 FOR NHS CONTRACTS)			
7a	Setting of fees and charges		SFIs Section 7.2.6 – 7.2.8
	i. Private Patients	Director of Finance and Information or nominated deputy	
	ii. Overseas Visitors	Director of Finance or nominated deputy	
	iii. Property rental (excluding residences)	Director of Estates and Facilities	
	iv. Residences	Director of Estates and Facilities	
	v. Trading services	Divisional/Corporate Director or nominated deputy	
	vi. Other income generation	Divisional/Corporate Director or nominated deputy	
7b	Agreeing/signing agreement/contract	All require Divisional Finance Manager agreement	SFIs Section 7.2.5
	i. Hosting arrangements	Director of Finance or nominated deputy	
	ii. Research and other grant applications	Director of Finance or nominated deputy	
	iii. Staff secondments	Service Manager	
	iv. Leases	Director of Finance or nominated deputy	

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

SFI REF	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
7b	v. Property rentals (excluding residences)	Below £5k per annum, Service Manager Above £5k and below £100k per annum, Director of Estates and Facilities or nominated deputy Over £100k per annum, Director of Finance or nominated deputy	
	vi. Residences	Residences Manager	
	vii. Peripheral clinics and provider to provider arrangements	Below £25k per annum, Service Manager Above £25k and below £250k per annum, Divisional/Corporate Director or nominated deputy Over £250k per annum, Director of Finance or nominated deputy	
	viii. Trading Services	Below £25k per annum, Service Manager Above £25k and below £250k per annum, Divisional/Corporate Director or nominated deputy Over £250k per annum, Director of Finance or nominated deputy	
	ix. Other income generation	Below £25k per annum, Service Manager Above £25k and below £250k per annum, Divisional/Corporate Director or nominated deputy Over £250k per annum, Director of Finance or nominated deputy	
8. WORKFORCE AND PAYROLL			
8a	Remuneration and terms of service for Directors	Remuneration Committee	SFIs section 8.2.1
8b	Remuneration and allowances of Chair and Non- Executive Directors	Council of Governors	SFIs section 8.2.4
8c	Approval of implementation of national pay directives and local variations	Director of People Workforce and Organisational Development and Director of Finance and Information	SFIs section 8.3.1
8d	Approval of non-payroll rewards to staff	Director of People Workforce and Organisational Development and Director of Finance and Information	SFIs section 8.3.4
8e	Appointment of permanent staff (subject to any vacancy control process in place) or extension of fixed term contract		
	i. to funded established post	Budget holder or nominated deputy and divisional finance manager and HR advisor	
	ii. to post not within formal establishment	Divisional Director or nominated deputy and divisional finance manager and HR advisor	
8f	Granting of additional increments to staff outside of national terms and conditions	HR Business Partner	
8g	Banding of new posts or re-banding of existing posts	Divisional/Corporate Director with Trust review panel scrutiny	

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

SFI REF	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
8h	Authorisation and notification to payroll of all starters, leavers and changes of conditions for staff	Budget holder or nominated deputy	SFIs section 8.4.1 - 4
8i	Authorisation of all timesheets, overtime, unsocial, oncall, bank shifts and any other approved form to vary pay	Budget holder or nominated deputy	SFIs section 8.5.3
8j	Authorisation and notification to payroll of all absences from work including sickness, special leave, maternity leave, paternity leave, time off in lieu,	Line manager in accordance with agreed policies and processes	SFIs section 8.5.3
8k	Authorisation of medical staff leave of absence	Clinical Chair/Medical Director	SFIs section 8.5.3
8l	Approve annual leave applications and carry forwards to next year		
	i. within national or local Trust approved limits	Line Manager	SFIs section 8.5.3
	ii. outside of the limits above	Divisional/Corporate/Executive Director	SFIs section 8.5.3
8m	Approve staff departure		
	i. under compromise agreement	Director of People and the Director of Finance and Information	
	ii. under redundancy scheme	Divisional/Corporate/Executive Director and Director of Finance and Information	
8n	Early retirements in furtherance of efficiency or on ill health grounds.	Director of People and the Director of Finance and Information	
8o	Authorise benefits in kind	In accordance with Trust policies:	
	i. new or changes to authorised car users	Budget Manager or nominated deputy	
	ii. mobile phones/land lines	Divisional/Corporate/Executive Director	
8p	Authorisation of travel and subsistence claims	Line Manager	SFIs section 8.7.1
8q	Authorisation of relocation expenses	Director of Finance and Information	SFIs section 8.7.1
8r	Engaging staff to undertake work outside of the payroll (subject to contracting/procurement for consultancy work (excluding strategic capital projects)	Below £25k gross commitment – Divisional/Corporate Director Above £25k gross commitment – Chief Operating Officer or Corporate Executive Director Over £500k gross commitment – Chief Executive	SFIs section 8.6

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

SFI REF	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	ii. to fill a defined post using self-employed, limited company or umbrella professional services agency	For posts on the Trust Board, Divisional Board or those with significant financial responsibility – Chief Executive Other posts over £20 per day and/or over 6 months - Director of People Workforce and Organisational Development Other posts below £220 per day and less than 6 months – HR Business Partner	SFIs section 8.6.2 - 3
	iii. using agency or locum staff		
9 and 10. PROCUREMENT OF GOODS AND SERVICES INCLUDING CAPITAL SCHEMES (financial limits exclude VAT and the whole order/contract should be considered) All capital schemes must have been approved as per section 17 before orders/tenders are made) Goods/services will only be available for ordering via EROS once matters referred to under 9a to 9d have been followed – therefore staff requisitioning via EROS need only comply with 9e and 9f			
9a	Obtaining quotes/tendering for the provision of Goods and Services		SFI section 9.4
	i. Below £5k, best value to be demonstrated	Budget holder	
	ii. Between £5k and £25k, minimum three quotes to be obtained	Budget holder	
	iii. Over £25k and upto £1m, minimum three tenders to be obtained	Divisional/Corporate Director	
	iv. Over £1m, three tenders to be obtained	Trust Board	
9b	Procurement of main contractors and enabling works for estates based capital	<MOVED FROM SECTION 18>	SFI section 9.4
	iv. Below £5k, best value to be demonstrated	Requisitioner	
	v. Between £5k and £25k, three quotes to be obtained	Estates Manager	
	vi. Over £25k and up to £1m, three tenders to be obtained	Director of Estates and Facilities	
	vii. Over £1m	Capital Programme Steering Group	
9c	Recommendation Reports (BWPC)		SFI section 9.4.4
	i. Between £5k and £100k	Director of Procurement, Divisional Finance Manager and Divisional Operations Director	
	ii. Between £100k and £1m	As above plus Director of Finance and Information	
	iii. Over £1m	As above plus Director of Finance and Information recommendation to Trust Board	
9d i	Single tender actions – best value to be demonstrated		SFI section 9.4.6
	i. Between £5k and £25k	Divisional/Corporate Director and the Director of Purchasing and Supply	
	ii. Between £25k and £100k	As above plus Director of Finance and Information	
	iii. Over £100k	As above plus Chief Executive	
9d ii	Emergency Covid-19 Single tender actions adaptation		SFI section 9.4.6
	i. Upto £100k	BWPC and Chair of the PPE/Equipment Group	
	ii. Over £100k	As above plus Director of Finance and Information	

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

SFI REF	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
9e	Waiving of tendering and single tender action procedures	Chief Executive, reported to Audit Committee	SFI section 10.2.2 -3
9f	Tender Evaluation Reports (Capital Construction)		SFI section 10.10.2
	i. Between £5k and £250k	Director of Estates and Facilities or nominated deputy	
	ii. Between £250k and £1m	As above plus Director of Finance and Information	
	iii. Over £1m	As above plus Director of Finance and Information recommendation to Trust Board	
9g	Variations to approved capital schemes	<MOVED FROM SECTION 18>	SFI section 10.13
	i. Up to £250k	Capital Programme Steering Group	
	ii. Between £250k and £500k,	Senior Leadership Team	
	iii. Over £500k	Trust Board	
9h	Signing of contracts /agreements to procure good/services on behalf of the Trust	Following procurement processes described in 10a to 10c above	SFI section 9.6.2
	i. Contracts and agreements following tendering process above unless specifically referred to below:	Below £25k, service manager Above £25k and below £100k, Divisional Director/Director of Purchasing and Supply Over £100k, Chief Operating Officer/Director of Finance and Information	
	ii. purchase of healthcare	Below £100k, Divisional Director Over £100k, Chief Operating Officer	
	iii. property leases	Director of Finance and Information	
	iv. leases – non property	Director of Finance and Information	
	v. outsourcing services	Below £100k, Divisional Director Over £100k, Chief Operating Officer and Director of Finance and Information	
	vi. facilities contracts	Director of Estates and Facilities or nominated deputy	
	vii. estates maintenance contracts	Director of Estates and Facilities or nominated deputy	
	viii. capital estates based contracts	Director of Estates and Facilities or nominated deputy, following approval as per section 18	
9i	Requisitioning/ordering after procurement and contract/ agreement is in place:	Authorised requisitioner, ensuring segregation of duties from procuring and receipting	SFI section 9.5
9j	Receipting	Authorised receiptor, ensuring segregation of duties from procuring and ordering	SFI section 9.5
11 PAYMENT FOR GOODS AND SERVICES (FOLLOWING APPROPRIATE PROCUREMENT PROCESSES)			
11a	Authorisation of invoices for goods and services procured	<i>(applies to all procurement methods, not just EROS)</i>	SFIs section 11.3.1
	Where invoice price = order/quote	Budget holder or authorised signatory for the cost centre with regard to segregation of duties between ordering and approving in line with Trust procedures	
	ii. Where invoice price exceeds order/quote upto the lesser of 10% or £5,000	Budget holder	
	iii. Where invoice price exceeds order/quote over 10% or between £5,000 and £25,000	Divisional/Corporate Services Director	

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

SFI REF	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	iv. Where invoice price exceeds order/quote over 10% or over £25,000	Director of Finance and Information	
11b	Prepayments & commitments covering future financial periods	Director of Finance and Information or nominated deputy	SFIs section 11.4
11c	Receipting of goods and services procured via EROS	Budget holder or authorised receptor for the cost centre, with regard to segregation of duties between ordering and approving in line with Trust procedures.	SFIs section 11.3.1
11d	Maintaining the Trust's authorised signature list	Budget holder to review and advise Deputy Director of Finance - Governance and People to update	SFIs section 11.3.2
11e	Authorisation of expenditure reimbursement via petty cash in line with the Trust's policy.	Below £50 budget holder or nominated deputy Over £50, Divisional Manager	SFIs section 11.5
11f	Agreeing compromise arrangements with suppliers	Below £1k, Deputy Director of Finance- Governance and People Above £1k and below £25k, Director of Finance and Information Above £25k, Finance Committee	SFIs section 11.7
12 STORES AND STOCKS			
12a	System of stock control, receipting, issues, returns and losses	Director of Finance and Information	SFIs section 12.2.5
12b	Control of stores		
	i. Pharmaceutical	Director of Pharmacy in Bristol and Lead Pharmacist in Weston	SFIs section 12.2.3
	ii. Fuel stores	Director of Estates and Facilities	SFIs section 12.2.4
	iii. MEMO	The Head of Clinical Engineering	SFIs section 12.2.5
	iv. All other stores	Relevant Divisional/Corporate Services Manager	SFIs section 12.2.2
12c	Condemning and disposal of goods (excluding fixed assets – see section x)	All losses must be reported to the Director of Finance in accordance with section 14	
	i. Pharmaceutical Items	Director of Pharmacy	SFIs section 12.2.3
	ii. X-ray films	Head of Radiology	SFIs section 12.2.4
	iii. Computer equipment	Chief Information Officer	
	iv. All other goods with a current/estimate purchase price up to £1k	Relevant Divisional/Corporate Services Manager	SFIs section 12.2.2
	v. All other goods with a current/estimate purchase price between £1k and £25k	Divisional/Corporate Director or nominated deputy	
	vi. All other goods with a current/estimate purchase price over £25k	Director of Finance and Information	

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

SFI REF	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
13 FIXED ASSET REGISTER AND SECURITY OF ASSETS, DISPOSAL AND ACCOUNTING OF ASSETS			
13a	Maintenance of a fixed asset register	Director of Finance and Information	SFIs section 13.-2.1
13b	Authority to dispose of (sell or transfer to another organisation or scrap) a fixed asset	Director of Finance and Information	SFIs section 13.5
13c	Security of fixed assets and notification of loss or transfer to another department	Service Manager	SFIs section 13.3
16 LOSSES WRITE OFFS AND SPECIAL PAYMENTS (to be reported to the Audit Committee on a quarterly basis)			
16a	Maintenance of losses and special payments register	Director of Finance and Information	SFIs section 16 2.3
16b	Loss/damage due to theft, fraud, corruption or criminal activity	Chief Executive or Director of Finance and Information	SFIs section 16.2.3
16c	Write off of bad debts, abandoned claims and fruitless payments	Below £10k– Deputy Director of Finance - Governance and People Above £10k and below £100k– Chief Executive Over £100k – Trust Board	SFIs section 16 4.1
16d	Ex-gratia payments to compensate for loss or damage to personal effects or for out of pocket expenses	Below £1k – Deputy Director of Finance- Governance and People Above £1k and below £50k – Chief Executive Over £50k – Trust Board	SFIs section 16.5.2
16e	Personal Injury Claims		SFIs section 16.5.3
	• Up to £10,000	Director of People or Chief Executive or Director of Finance and Information – without legal advisor	
	• Over £10,000	Director of People or Chief Executive or Director of Finance and Information – in conjunction with NHS Litigation Authority	
16f	Public Liability Claims		SFIs section 16.5.4
	• Up to £3,000	Divisional/Corporate Director or Chief Executive or Director of Finance and Information – without legal advice	
	• Over £3,000	Divisional/Corporate Director and Chief Executive or Director of Finance and Information – in conjunction with NHS Litigation Authority	
16g	Compensation (no limit) payments made under legal obligation	Chief Executive and Director of Finance and Information	
16h	Maladministration and distress payments where there was no financial loss by the claimant.		SFIs section 16.5.10
	• Remedy up to £1,000;	Director of Finance and Information or Deputy Director of Finance – Governance and People	
	• Remedy between the value of £1,001 and £50,000;	Chief Executive	
	• Remedy over the value of £50,000.	Trust Board	

September 2020

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

SFI REF	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
16i	Cancellation of NHS debts - Up to £5,000 - Over £5,000	Deputy Director of Finance - Governance and People or Divisional Financial Manager Director of Finance or nominated deputy	
16j	Extra-contractual payments to contractors - Up to £25,000 - Between £25,000 and £100,000 - Over £100,000	Director of Finance and Information or Deputy Director of Finance- Governance and People Chief Executive Trust Board	SFIs section 16.5.11
17. EXTERNAL BORROWING AND PDC			
17a	Approval of short term borrowing	Finance Committee	SFIs section 17.2.4
17b	Approval of long term borrowing	Trust Board	SFIs section 17.2.6
17c	Application for borrowing	Director of Finance and Information	SFIs sections 17.2.3 and 17.2.7
18 CAPITAL INVESTMENT AND PRIVATE FINANCING			
18a	Approval of the Trust's Capital Investment Policy annually.	Trust Board	SFIs section 18. 2.2
18b	Business case approval – high risk schemes i. >1% of Trust turnover (£8.77m) ii. Between 0.25% and 1% of Trust turnover (between £2.19m and £8.77m) iii. Less than 0.25% of Trust turnover (less than £2.19m)	Outline and Full business case to be approved by Trust Board and Council of Governors Comprehensive business case to be approved by Trust Board and Council of Governors Short form business case to be approved by Trust Board and Council of Governors	Capital Investment Policy
18c	Business case approval – other schemes outside of high risk and less than 1% of trust i. > 0.5% of Trust turnover (between £4.84m and £8.77m) ii. Between 0.25% and 0.5% of Trust turnover (between £2.19m and £4.84m) iii. Less than 0.25% of Trust turnover (less than £2.19m)	Comprehensive business case to be approved by Finance Committee Comprehensive business case to be approved by Senior Leadership Team Short form business case to be approved by Capital Programme Steering Group	Capital Investment Policy
18d	Approval of Trust's Medium Term Capital Programme	Trust Board	
18e	Approval of all finance and operating leases	Director of Finance and Information	SFIs Section 18..3.3
18f	Private Finance Initiative	Trust Board	
18g	Management of the Trust's annual capital programme	Capital Programme Steering Group	Capital Investment Policy

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

SFI REF	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
18h	Feasibility fees given compliance with 18d and 18g	Capital Programme Steering Group	
19 RISK MANAGEMENT AND INSURANCE			
19a	Risk management arrangements	Chief Executive	SFIs section 19
19b	Insurance Policies		
	i. Arranging and ensuring adequate cover	Director of Finance and Information	SFIs section 19.3
	ii. Notifying Director of Finance of new or changed risks	All staff	SFIs section 19.3
20 AUDIT			
20a	Establishment of an internal audit function	Director of Finance and Information	SFIs section 20 3.1
20b	Appointment of External Auditors	Council of Governors	SFIs section 20.5.2
20c	Implementation of agreed internal and external audit recommendations	Divisional/Corporate Directors	
20d	Reporting of incidents to the police	Chief Executive, Director of Finance and Information, Chief Internal Auditor	SFIs Section 20.3
	▪ general	Appropriate departmental manager – need to inform Divisional Director or relevant Corporate Director as soon as possible. Also inform Local Security Management Specialist	
	▪ where a fraud is involved	Director of Finance and Information or Local Counter Fraud Specialist	Counter Fraud Policy
21 INFORMATION MANAGEMENT AND TECHNOLOGY			
21a	Security and accuracy of Trust computerised financial data	Director of Finance and Information	SFIs section 21.2.1
21b	Implementation of new and amendments to existing financial IT systems and approval of any Trust systems with an impact on financial	Director of Finance and Information	SFIs section 21.2.3
21c	Compliance with Freedom of Information Act	Director of Corporate Governance	SFIs section 21.3.1
21d	Implementation, upgrades or changes to general computer systems	Information Management and Technology Committee	SFIs section 21.3.2

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

SFI REF	DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
22 GIFTS HOSPITALITY AND SPONSORSHIP			
22a	Maintaining a register of gifts, hospitality and sponsorship	Director of Corporate Governance	SFIs section 22.2.2
22b	Acceptance of gifts		SFIs section 22.3
	i. Business articles less than £25 per gift	Receiving member of staff may accept with no requirement to register	SFIs section 22.3.1
	ii. Gifts over £25 but below £40 per gift or several small gifts of a value over £100 from same source over 12 month period	Receiving member of staff may accept with if declared and registered	SFIs section 22.3.2
	iii. Gifts over £40 per gift	Receiving member of staff should decline or seek Trust Secretary advice	SFIs section 22.3.3
22c	Acceptance of hospitality		SFIs section 22.4
	i. Modest hospitality if normal and reasonable in the circumstances	Receiving member of staff may accept but should refer to line manager or relevant Director if in doubt	SFIs section 22.4.1
	ii. Inappropriate hospitality offers	Member of staff should notify Director of Corporate Governance.	SFIs section 22.4.2
22d	Sponsorship		SFIs section 22.5
	i. Commercial sponsorship for attendance at conference or	Approval from line manager	SFIs section 22.5.1
	ii. Sponsorship of Trust events	Approval by Director of Corporate Governance, contractual agreement signed by Director of Finance and Information	SFIs section 22.5.2
22e	Acceptance of preferential rates or benefits in kind for private transactions with companies with which there have been or could be dealings with on Trust business	Not permissible by any member of staff unless a concessionary agreement negotiated by the Trust or NHS on behalf of all staff.	SFIs section 22.5.5
23 CHARITABLE FUNDS/DONATIONS			
23a	Administration of Trust's charitable funds	~~Bristol and Weston Hospitals Charity~~ Above and Beyond except those associated with- ~~Weston Area Health Trust~~ which ~~is~~ are administered by the Charity Fund Committee	SFIs section 23.2. 2
23b	Acceptance of donations of goods or cash from charitable bodies relating to capital defined expenditure	Trust's Capital Programme Steering Group	SFIs section 18.2.10
24 RETENTION OF DOCUMENTS			
24a	Retention of records and documents	Relevant Divisional/Corporate Director	SFIs section 24

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
25 OTHER DELEGATIONS NOT SPECIFICALLY REFERENCED IN THE STANDING FINANCIAL INSTRUCTIONS			
25a	Compliance with Freedom of Information Act	Director of Corporate Governance,	Freedom of Information Policy – December 2009
25b	Grievance procedure/appeals board procedures	Director of People Workforce and Organisational Development	Disciplinary Policy Managing Performance Policy Grievance Policy
25c	Dismissal	See Matrix	Disciplinary Policy and Procedure
25d	Authorisation of new drugs or significant change of use of existing drugs	Medicines Advisory Group - see specific guidelines and terms of reference of this committee	
	▪ Request for new drugs require authorisation before purchase	Senior Pharmacy Manager	
	▪ Orders placed to suppliers over £5,000 to be signed	Director of Pharmacy (Bristol)/Lead Pharmacist (Weston) or Pharmacy Purchasing Manager	
	▪ Pharmacy Payment Lists to be authorised ▪ Copy invoices over £10,000 and invoices from NHS bodies to be sent with the Payments Lists to Creditor Payments	Director of Pharmacy Bristol/Lead Pharmacist (Weston) or Pharmacy Purchasing Manager or Senior Pharmacy Clerical Officer	
	▪ Pricing agreements and quotations should be authorised	Director of Pharmacy Bristol/Lead Pharmacist (Weston) and Pharmacy Purchasing Manager	
	▪ Authorisation of coding slips for invoices and credits requirement payment to be	Senior Clerical Officer	
25e	Patients' & Relatives' Complaints :		
	▪ Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Nurse	
	▪ Responsibility for ensuring complaints relating to a division are investigated	Divisional Director and Head of Nursing / Midwifery	
	▪ Legal Complaints - Co-ordination of their management	Trust Solicitor	
25f	Relationship with the media	Director of Communications who reports to the Chief Executive	
25g	Infection Control and Prevention • Corporate Policy • Divisional and Clinical Delivery	Director of Infection Control and Prevention / Chief Nurse /Clinical Chairs	Standing Orders section 2.10

UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST

SCHEME OF DELEGATION

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
25h	Governance and Assurance Systems Corporate Risk Register Divisional Risk Registers Quarterly review of Risk Registers Reports on the Risk Registers quarterly Maintenance of the Assurance Framework Quarterly review of Assurance Framework Exception Reports on the Assurance Framework	Relevant Executive Directors Divisional Directors and Divisional Managers Risk Management Group Senior Leadership Team Director of Corporate Governance Senior Leadership Team Audit Committee	SFIs Section 19
25i	All proposed changes in bed allocation	Chief Operating Officer	
25j	Review of Fire Precautions	Fire Safety Manager	Fire Safety Policy and Fire Standards Procedures and Guidelines
	Review of all statutory compliance: legislation and Health and Safety requirements including control of substances hazardous to health regulations	Director of Estates and Facilities / Health and Safety Advisor	Control of Substances Hazardous to Health (COSHH) Policy
25k	Review of compliance with environmental regulations for example those relating to clean air and waste disposal	Director of Estates and Facilities	Operational Policy for Handling Disposal of Waste – August 2005
25l	Review of Trust's compliance with Data Protection Act	Chief Information Officer	Health Records Policy
25m	Review the Trust's compliance with the Access to Records Act	Chief Information Officer	Health Records Policy
25n	Allocation of sealing in accordance with standing orders	Director of Corporate Governance on behalf of the Chief Executive	
25o	The keeping of a Register of Sealing	Director of Corporate Governance on behalf of the Chief Executive	Section 8 Standing Orders
25p	Affixing the Seal	Chief Executive (or, should the Chief Executive not be available, another Executive Director not from the contract's originating department) and Director of Finance and Information or Deputy Director of Finance - Governance and People	
25q	Clinical Audit	Medical Director	
25r	Human Rights Act Compliance	Trust Solicitor	
25s	Equality and Diversity Schemes	Director of People Workforce and Organisational Development	
25t	Child Protection	Chief Nurse	Section 2.10 Standing Orders
26 In the case of a Major Incident			
26a	Commitment of resource in the event of a major incident	Executive Director on call	

Speeding up our Route to Market

S	Situation: There is an increased volume of procurement workload arising from the Trust's activity recovery programme and need to deliver the capital programme in the context of CDEL. Funding continues to be allocated in year by NHSEI for schemes with the expectation that they are delivered at pace. This includes additional capital funding for which there was already a challenge to deliver capital schemes by 31st March to meet the CDEL funding target. There is a need to ensure an efficient and effective procurement process to support the Trust. The current procurement governance structure places an emphasis on spot buying over the use of more efficient purchasing models. Contracts are tendered and let on a scheme by scheme basis. As a result, Trust delivery teams and BWPC are struggling to support the increased procurement requirements, with a risk to delivery of current and future projects. The current approach is also less responsive to operational requirements to meet funding opportunities. Currently the SFI's require all commitments / spend over a value of £5k whether in a single order or aggregation of a number of orders to be subject to a form of competition (<i>SFI 9.4.2</i>) unless a waiver (normally in the form of an STA) is granted to permit direct award. During 2020/21 497 STAs were raised exempting spend from the procurement process. All STAs are reported through to the Audit Committee and it should be noted that STAs are used for a number of reasons including where there is only one supplier. Best practice in this area is establish a suite of framework agreements/ call off contracts to manage repeat demands. However, currently the SFI's restrict the use of frameworks above an aggregate value of spend of £25k without using competition to demonstrate best value (<i>SFI 9.4.1</i>). This paper requests that the Trust changes it approach to the use of Frameworks / call off orders and proposes an approach to roll out the use of Frameworks across the Trust.
B	Background: UHBW's procurement policy has been established to promote delivery of best value for money and avoid corruption and waste. This is formalised within the SFI's which promote frequent market testing and use market forces to drive down the price of products, ensuring best value for money for the Trust. Whilst this policy has served the trust well for a number of years, it has resulted in a relatively inefficient procurement model that requires high levels of intervention and support without necessarily delivering value across the board. It is recognised that a different approach is required, however the immediate need is to create capacity within procurement to deliver the 2021/22 revenue and capital programmes and make wider scale changes. A further need to change the Trust's approach to procurement arises from the change in Government approach to Public Procurement post EU Exit. The Government has clearly

	set out its objectives (PPN 05/21, Outsourcing Playbook, and green paper transforming public procurement) for increasing management of contracts and of using public money to deliver Social Value outcomes. The implication of these changes is that they are unlikely to be deliverable within our current structure.
A	Assessment: We need to create capacity within the procurement process in a controlled way. 1 Follow a risk assessed approach to waiving tendering requirements We can segment our current spend into 3 groups: 1. Historic spend that has recently been through a robust evaluation and selection process (it is worth noting that most of our spend sits in this area) 2. Historic spend that has not been subject to reasonable evaluation and selection process 3. Spend which is new to the Trust. In order to deliver the level of procurement over the next six months there is a requirement to change our governance model. Historically this has been done reactively by increasing the number of orders being processed via the STA route. An alternative to this would be to take a more risk based approach by classing all group 1 spend as low risk and thereby waiver the requirement to tender. This would free up capacity to focus more time on groups 2 and 3. 2 Allow higher value frameworks into our commercial mix There are 3 ways that we can quickly increase our stock of frameworks / call offs to simplify our procurement process and free up capacity. 1. Authorise the use of NHS SC or other Government Frameworks as compliant procurement removing the need for using competition 2. When relevant to an approved commercial strategy, tender for longer term frameworks / call off contracts to reduce the need to frequently return to market 3. Seek opportunities to utilise other Trust's frameworks/ contracts where it is compliant to do so and they bring commercial advantage This would require a change to the Trust's SFIs 3 Carry out regular benchmarking and market testing to retain value Require that the BWPC category leads benchmark and/ or market test [10%] by value of all orders placed under frameworks or call offs to validate that the framework is still delivering value to the trust.
R	Recommendations: Recognising the need for a wider review of the Trust's SFIs and the procurement practice mandated within them, it is recommended that to be able to deliver the Trust's procurement needs in the next 6 months the Trust should:

	1. Waive the need to tender for goods or services that the Trust has recently been through a robust evaluation and selection process for. It should be left to BWPC to use their professional judgement to define 'recent'. 2. Waive the need for to tender for goods or services which BWPC considers could be procured using a compliant framework By adopting this approach, BWPC resource can be better utilised and less resource will be used on following an STA process. The Board is asked to: Note: The current challenges being faced by the Trust and BWPC in delivery of current and future procurement and commercial activity. Support: The proposal to adopt a risk assessed approach to waivering tender requirements. Agree: Agree the two recommendations above to simplify routes to market, supported by increased levels of monitoring by BWPC to test value. Recognise: That this needs to be part of a longer term plan to optimise our supply chains/ contract structures which will be reflected in further changes to the SFIs.

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Meeting of the Board of Directors in Public on Friday 27th May 2022

Report Title	Freedom to Speak Up Annual Report 2021/22
Report Author	Eric Sanders, Freedom to Speak Up Guardian
Executive Lead	Emma Wood, Director of People

1. Report Summary

This report provides an overview of the activity that took place in 2021/22 across the Trust to deliver our commitment to Freedom to Speak Up – including actions taken to improve speaking up at UHBW, an assessment of the number and themes of concerns raised, learning and areas for improvement, and priorities for the next 12 months.

2. Key points to note

(Including decisions taken)

- The number of concerns raised via Freedom to Speak Up fell slightly in 2021/22, though concerns were heard from all staff groups, predominantly admin/clerical and nursing staff.
- Most of the concerns raised fall into three categories: working culture; pay and reward; and fairness and transparency in recruitment processes.
- The 2021 NHS Staff Survey shows there is work to do to ensure staff feel safe to raise concerns and feel their concerns will be addressed.
- Managers need training and support to listen up to help staff speak up to create positive workplace cultures in line with our Trust values.
- There is a significant opportunity through the Patient First programme to change the Trust's approach to listening to staff about concerns and opportunities for improvement, which will have a positive impact and support the Freedom to Speak Up programme at UHBW.

3. Risks

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

The risks associated with this report include:

There is a risk that learnings from concerns are not shared across the organisation and similar concerns continue to be raised, which may impact on the confidence of staff in the speaking up arrangements in the Trust. This could be addressed through investment and action in the areas of leadership and management development, people management and culture change.

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

18 May 2022

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Freedom to Speak Up annual report 2021/22

This report provides an overview of the activity that took place in 2021/22 across the Trust to deliver our commitment to Freedom to Speak Up – including actions taken to improve speaking up at UHBW, an assessment of the number and themes of concerns raised, learning and areas for improvement, and priorities for the next 12 months.

Background

The standard NHS contract requires that all trusts and foundation trusts employ a Freedom to Speak up (FTSU) Guardian. FTSU Guardians are now employed across the health and care sector, including in primary care, health charities, independent providers and arm's length bodies including health regulators.

At UHBW the FTSU Guardian is the Director of Corporate Governance, who is supported by a full-time Deputy Freedom to Speak Up Guardian. The role of the FTSU Guardians is to ensure patient safety and staff wellbeing by providing a mechanism for staff to speak up when they see or hear something that is not right. The FTSU Guardians not only provide support to staff who raise concerns, but also support the Board to develop a 'positive, compassionate, and inclusive' workplace culture in line with the vision set out in the NHS People Plan. The expectation of the National Guardian's Office (NGO) is that FTSU Guardians also play a proactive role in helping organisations 'learn from the opportunities that speaking up brings and tackle barriers to speaking up wherever they are'.

The FTSU Guardians report quarterly on concerns and themes, alternately to the Board or People Committee, and these reports are shared with the senior leadership team. The FTSU Guardian has regular access to both the executive lead for speaking up and the non-executive lead – positions which have changed in the year at UHBW. Externally, the FTSU Guardians link with the NGO via the South West regional FTSU Guardian network, which provides support and shares learning. Work continues with the FTSU Guardian at North Bristol NHS Trust to align FTSU policy and process along with staff training on speaking up.

This annual report provides an overview of:

- action taking to improve speaking up in line with the FTSU strategy
- areas of progress around speaking up in 2021/22
- concerns raised in the year including a breakdown by theme, division, and profession
- measuring speak up culture
- learning and improvement
- priorities for 2022/23.

ACTIONS AGAINST FTSU STRATEGY

The three objectives of the Trust's Freedom to Speak Up strategy set in 2019 focus on 1) raising awareness of speaking up; 2) building confidence in the process; and 3) ensuring that our corporate leadership and management training is informed by the feedback from the programme. Appendix 1 and 2 provide more detail. Highlights from this work include:

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1. *Awareness raising*

In meeting the objective to improve awareness of the Speaking Up programme, alongside regular corporate communications and updates via the speaking up champion network, the FTSU Guardians have completed training sessions with F1 and F2 doctors; midwives; graduate management trainees; presentations at HR surgeries for managers; international nurse induction; divisional board and departmental team meetings; and shared details about the FTSU process in volunteer and apprenticeship communications. It is essential that the FTSU Guardians continue to involve all staff groups in the promotion of the speaking up service, focusing on where staff may experience barriers in speaking up.

2. *Building confidence*

To meet the objective of hearing concerns promptly and providing feedback on outcomes wherever possible, feedback from individuals who have been involved in the Freedom to Speak Up process is now captured online via a short, anonymous survey managed by IQVIA. This provides a safer and more effective channel for capturing feedback from staff who have raised concerns, to understand if the process is working and if staff would feel confident to raise concerns again in the future.

In December 2021, the NGO published a case study from UHBW relating to concerns raised from student nurses working at the Trust. Examples of concerns which have moved to resolution via Freedom to Speak Up are provided in the quarterly updates to the Board/People Committee.

In 2021/22, 44 Freedom to Speak Up champions received in-house training, based on structure provided by the NGO – not only to provide more context around the importance of speaking up, but to help them to create positive working environments, and improve their listening skills to effectively support staff to speak up. Stories from champions about how they have brought about positive change in their own departments are shared with the network and through corporate channels.

3. *Training and support for managers and leaders*

The FTSU Guardians are involved in the development of the refreshed leadership and management development programme for managers in the Trust. Managers are now advised (via divisional cascades and corporate communications) to complete the 'Listen Up' training module produced by the NGO and Health Education England (which complements the mandatory speak up training module for all staff). Listen Up training compliance remains very low, with only 2% of the 2,285 line managers who have access to the training having completed it as of April 2022. The Board has committed to completing all three levels of training (Speak Up, Listen Up and the third module, Follow Up, which was released in April 2022).

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AREAS OF PROGRESS IN 2021/22

Among the objectives of the strategy, three areas of progress in the year have been:

1. *Resolving stuck concerns*

In reporting to the Board in 2021/22 the FTSU Guardian noted that some concerns were taking too long to resolve. Reasons concerns have remained open without resolution for a long time include, in the main, complex employee relations issues; issues around service delivery; estates issues; or cultural change work taking time to embed.

In October 2021, following conversations with the chief executive, it was agreed to bring a monthly report to the executive team to seek support to 'unlock' either specific concerns or thematic issues which had been raised through the Freedom to Speak Up process and to consider how to address the challenges. As a result, the executive team have early awareness of, and input into, complex issues raised through speaking up which cannot be resolved through the usual escalation process. The four concerns reported open in Q2 since the previous financial year were closed in Q4.

2. *Embedding Speak Up training and introducing Listen Up training for managers*

During Speak Up month in October 2021, the FTSU Guardians focused on encouraging all staff to complete their mandatory speak up training, which was introduced in the Trust in February 2021 with compliance recorded from August 2021. Reporting shows a significant increase in compliance (around 20 per cent) in the seven months between August and March, but it is clear there is more work to do to improve figures, particularly in the clinical divisions.

Division	Diagnostics and Therapies	Facilities and Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's and Children's	Weston
Aug 2021	26%	53%	24%	37%	26%	41%	29%	N/A
Mar 2022	51%	73%	47%	60%	46%	62%	50%	63%

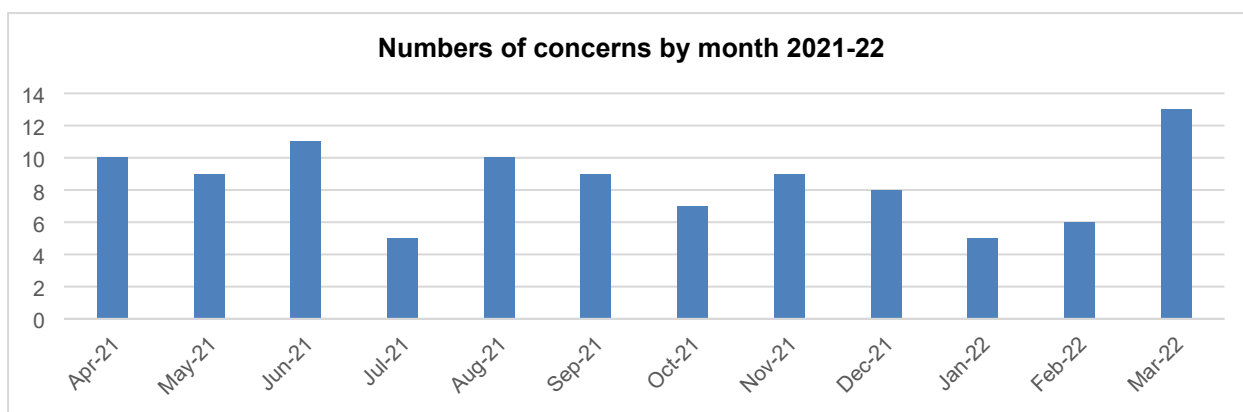
3. *Increasing the diversity of the FTSU champion network*

To ensure that the Freedom to Speak Up service is reaching as many staff in the organisation as possible, an assessment of the diversity of the 100-strong champion network was undertaken in March 2022. The results show that the network is largely reflective of the UHBW workforce by age, gender and banding – though the network is underrepresented in terms of BAME staff; staff working in B2 and Medical and Dental roles. See appendix 3 for more details.

ASSESSMENT OF CASES

Between April 2021 and March 2022, a total of 102 concerns were raised with the FTSU Guardians, compared to 112 in the previous financial year. The number of concerns raised appears to have stabilised with an average of 25 per quarter – and are more evenly spread across the divisions, though with the division of Weston still reporting more concerns than any other division. As a result, regular monthly meetings with the FTSU champions based at Weston General Hospital have continued to provide extra support to this group of staff.

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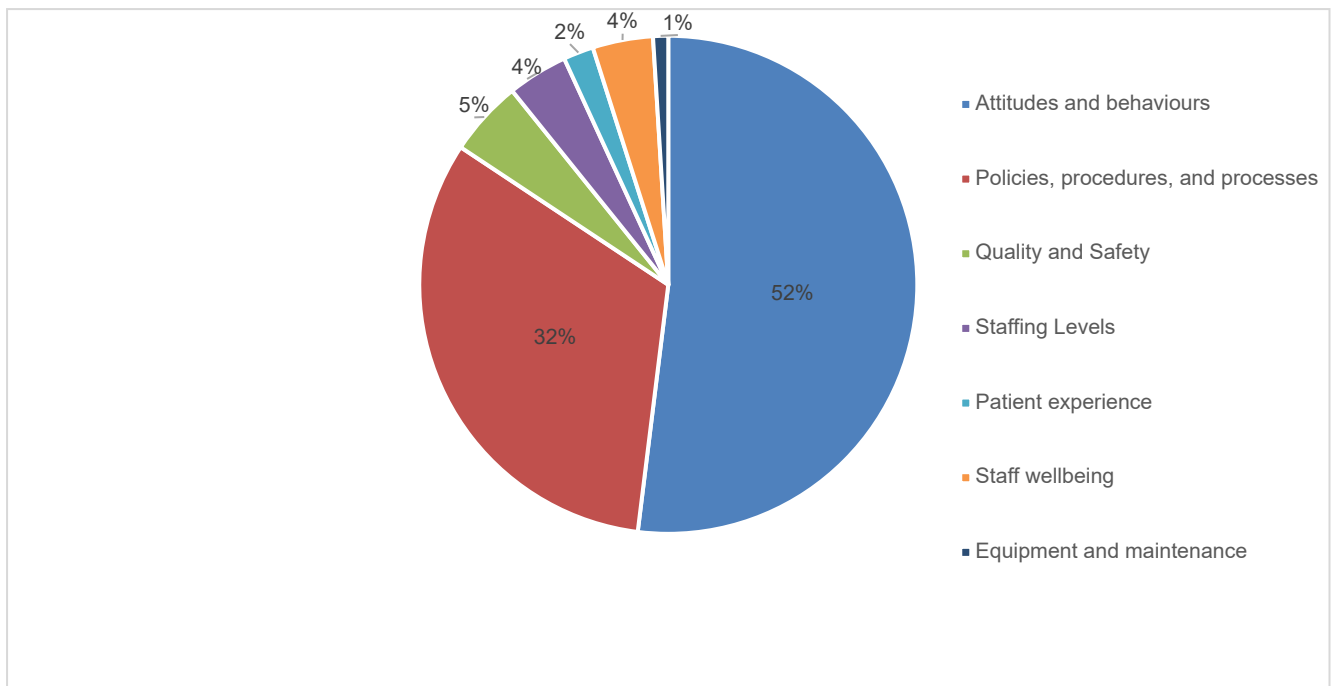
Concerns by division

Division	Number of concerns	Numbers of full time equivalent staff (at April 2021)	Concerns per 1,000 FTE	Number of FTSU staff champions
Diagnostics & Therapies	6	1,201.25	5.0	9
Medicine	10	1,217.81	8.2	12
Specialised Services	5	1,081.54	4.6	9
Surgery	11	1,810.11	6.1	11
Trust Services	13	1,076.56	12.1	24
Estates and Facilities	8	838.87	9.5	4
Weston	39	1,029.85	37.9	12
Women's & Children's	10	2,170.73	4.6	18

Themes of concerns

Looking at the themes of the concerns raised, the majority relate to attitudes and behaviours as per last year, with 23 (43 per cent) of these containing an element of bullying and harassment, which is an increase from 16 per cent last year. The number of cases relating to quality and safety remains low. Some cases involve different themes, but the overarching theme is recorded as the principal theme in this report.

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Within the overarching themes, there are three major themes which reoccur and account for a large proportion of the concerns shared with the FTSU Guardians, as follows:

- Concerns around working culture (including conflict between managers and employee or employee and colleagues, e.g. microaggressions; the lack of a resolution by a manager of issues escalated locally and a lack of action to tackle teams or departments with a 'poor reputation' e.g. those with consistently low staff survey results/high turnover/vacancies/sickness).
- Concerns around pay and reward (including the use of incentivised payments, consistency in their application; late or inaccurate staff pay; fairness of pay and leave allocation across job roles and sites).
- Concerns around fairness and transparency in recruitment processes and how staff are managed (including nepotism/cronyism; drawn out grievance or complaints processes and manager handling of employee performance).

The FTSU Guardians have been working with individuals and teams across the Trust to encourage and influence actions to tackle these common themes. Work is in progress, as follows:

- The Trust is currently conducting a wide-ranging review of additional rates of pay. Extensions to several other historic enhancements are also being reviewed and agreed, along with a number of revised incentive payments where there is continued high demand and/or significant vacancies.
- Work is ongoing to embed the new Trust values and leadership behaviours across the organisation in line with the People Strategy.
- A full review of leadership development across the Trust is underway to enhance the leadership training on offer to managers in the Trust so that managers have the right tools and the skills to manage their people.

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- External consultancy firm TCM is working within the Trust to move the organisation to a 'just and learning culture'.
- At the start of the new financial year, guidance around best practice recruitment was released to all recruiting managers.

Concerns by professional group

The FTSU Guardians have received concerns from a broad range of professional groups across the Trust in the year. Most cases were raised by administrative/clerical and nursing staff as per last year, and we have seen more engagement from doctors in the year. Looking at data from the NGO for 2020-21, nurses and midwives account for 28.9% of speaking up concerns, with admin, clerical and maintenance/ancillary staff accounting for 20.8%. It is pleasing to note that staff who speak up are largely comfortable to share their details in confidence with the FTSU Guardians; during 2020/21, only one case was reported anonymously.

Profession	Total
Administrative/clerical staff	40
Nurses	33
Cleaning/Catering/Maintenance/Ancillary staff	9
Healthcare Assistants	8
Allied Health Professionals	2
Other	3
Doctors	4
Midwives	1
Unknown	1
Anonymous	1
Total	102

MEASURING SPEAKING UP CULTURE

There are many metrics to consider when measuring a speaking up culture – two key indicators are feedback from those who have spoken up and feedback from the NHS staff survey.

Feedback from individuals speaking up

Once a case is closed a survey is sent to the person who spoke up asking questions about their experience of the FTSU process and if they would speak up again. When a case is closed by the Freedom to Speak Up Guardian, a confidential, anonymous survey is sent out to capture feedback on their experience and to seek any areas for improvement. Below are some comments and confidential feedback from staff who have used the speaking up services:

"I feel the speak up guardian did try their best, but I am dissatisfied with the response from the Trust"

"I feel the Trust will take things seriously if I do speak up and take things forward when necessary. My only concern would be that my concerns may not have been taken forward if other people in the department hadn't spoken out also"

"It is an essential and valuable service"

"I find it hard to believe that I went through the incidents I needed to speak up about, and then writing it all out, sharing it, all that anxiety only to realise that this was going to be a really bad career choice. I work in a small specialty and now work elsewhere but will have a professional relationship with the team for the foreseeable. The scope of the freedom to speak up work is within the trust, and I suppose if I had stayed I would be protected by that, but as someone who left, there was chance my career would be impacted."

"I feel it is important to speak up if something is not right."

"I think people are frightened to speak up because they feel their problem may be trivialized or not believed. I certainly felt like that before and so the problem continued for a long time, resulting in my leaving the post. I was met with kindness and compassion from the freedom to speak up team."

"I actually now feel empowered to speak up when I know there's a problem because the FTSU process has really shown that change can happen, even in a department that's been poorly managed for so long with systemic issues."

A total of 17 staff completed the survey in 2021/22. Of these, 15 answered 'yes' to the question "would you speak up again?"; 1 answered 'no' and 1 answered 'I don't know'.

Respondents are also asked to provide data on their protected characteristics so that we can better understand who is speaking up via the FTSU Guardians. Given the low response rate, the data does not reflect the reach of the service and has been withheld from this report to protect the identity of the respondents.

In the year, two individuals noted they had suffered detriment because of speaking up. The NGO states that there should be visible action on detriment for speaking up wherever this is reported. Work to update the FTSU policy to include a procedure for cases of detriment to be investigated is underway.

NHS staff survey feedback

The annual NHS staff survey contains questions on the NHS People Promise theme of 'we each have a voice that counts', and specifically four questions which reflect how staff feel about raising concerns in their organisation. There is a mixed picture here. While UHBW continues to score above the average figure for other acute/acute and community Trusts on all the questions, there is a decrease in confidence around staff feeling their concerns would be addressed and feeling safe to raise concerns compared to 2020, and this is reflected nationally. In the NGO survey of Guardians conducted in 2021, 62.8% of respondents said their organisation had a positive culture of speaking up, down five percentage points compared to the 2020 result.

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Staff Survey questions related to raising concerns (% agreeing / strongly agreeing with the following statements):	2020 UHBW	2021 UHBW	Average for acute / acute and community Trusts (2020 score)
I would feel secure raising concerns about unsafe clinical practice	73.5	74.8 ◆	73.6 (71.7)
I am confident that the organisation would address concerns about unsafe clinical practice	63.5	59.9 ◆	57.8 (59.2)
I feel safe to speak up about anything that concerns me in this organisation	69.6	66.4 ◆	60.8 (64.9)
I feel organisation would address any concerns I raised	Not asked in 2020	53.1	48.3

LEARNING AND IMPROVEMENT

Managers/leaders are asked to identify the changes made, lessons learnt and any transferable learning that results from FTSU concerns. They are responsible for ensuring the implementation of the learning relevant to their service area and for sharing transferable learning within appropriate forums/structures. The FTSU Guardians share themes and overall learning from cases with the Board/People Committee, Speaking Up summit partners (currently paused) and, since May 2022, with the People and Education Group, with a focus on thematic analysis and raising awareness of concerns with the wider HR community.

The series of Speaking Up Summits initiated by the FTSU Guardians, where individuals from across the Trust with an interest in encouraging the voice of staff (e.g. Heads of HR, Organisational Development, Staff Side, Patient Safety, Education), has been paused while work, led by the Organisational Development team, on culture considers what steps are required to drive forward improvement work.

Nationally, the NGO publishes Speaking Up reviews, which identify learning from organisations where the NGO has received information to suggest that speaking up had not been handled in accordance with good practice. The FTSU Guardians review the findings from speaking up cases published by the NGO for learning and have recommended the following actions for the Trust:

- Taking steps to promote a culture of visible and accessible leadership (**all leaders**)
 - Reviewing the effectiveness of the programme of work to challenge unwanted and/or unprofessional behaviours (**Organisational Development**)
 - Promoting and facilitating the use of mediation where appropriate and increasing capacity for mediation (**HR**)
- Aligning HR policies with new external resolution framework to ensure they are fair and supportive of all workers (including those speaking up) and have the confidence of its workforce, including effective training for workers in HR (**HR**)

- Taking appropriate steps to ensure matters arising from cases of speaking up are investigated within reasonable timescales and without undue delay (**FTSU Guardian – completed: ‘Escalation of FTSU concerns standard operating procedure’ updated to include timescales for investigation**)
- Updating FTSU policy to put in place procedure that would enable cases of detriment to be investigated effectively when they are reported (**FTSU Guardian**)

Most of these actions are still work in progress.

PRIORITIES FOR 2022/23

Updates on progress against the outstanding actions from the last financial year (above), and additional priorities for 2022/23 as identified below, will be included in quarterly reports to SLT and Board, and the People and Education Group:

- Create a template to support managers in both structuring their response to colleagues speaking up through the guardian route and for sharing learning.
- Complete a FTSU (Pulse) survey with all staff in the Trust to assess awareness of FTSU and feedback on the speaking up culture.
- Complete the FTSU review tool for NHS trusts and foundation trusts (last completed in June 2018) once the updated review tool is published by the NGO, which is imminent.
- Refresh the FTSU strategy after completion of the Board Self Review to link with key themes set out in the new People Strategy around inclusion and belonging; looking after our people; and new ways of working (developing compassionate and inclusive leaders).

Conclusion

- The Board is asked to consider and comment on the themes, trends and issues arising from this report.

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Appendix 1: Progress against the three objectives of the Freedom to Speak Up Strategy

	Data 2021/22	Description of changes in year and proposed areas of focus																																								
Awareness																																										
Compliance with corporate induction training	<table><tr><th>Division</th><th>Diagnostics and Therapies</th><th>Facilities and Estates</th><th>Medicine</th><th>Specialised Services</th><th>Surgery</th><th>Trust Services</th><th>Women's and Children's</th><th>Weston</th></tr><tr><td>Mar 2022</td><td>51%</td><td>73%</td><td>47%</td><td>60%</td><td>46%</td><td>62%</td><td>50%</td><td>63%</td></tr></table>	Division	Diagnostics and Therapies	Facilities and Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's and Children's	Weston	Mar 2022	51%	73%	47%	60%	46%	62%	50%	63%	20% increase in compliance against mandatory Speak Up training between August 2021 (first month of monitoring) and March 2022.																						
Division	Diagnostics and Therapies	Facilities and Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's and Children's	Weston																																		
Mar 2022	51%	73%	47%	60%	46%	62%	50%	63%																																		
Number of updates to staff and other workers in the Trust about speaking up	<table><tr><td>F1 and F2 training - 2 sessions</td><td>07/04/2021</td></tr><tr><td>Bite sized training for grad trainees</td><td>12/05/2021</td></tr><tr><td>Weston managers HR surgery</td><td>05/05/2021</td></tr><tr><td>Weston managers HR surgery</td><td>07/05/2021</td></tr><tr><td>Cardiac services team meeting</td><td>08/06/2021</td></tr><tr><td>Finance team briefing</td><td>07/07/2021</td></tr><tr><td>Specialised Services divisional workforce meeting</td><td>07/07/2021</td></tr><tr><td>St Michael's matrons meeting</td><td>30/09/2021</td></tr><tr><td>Women's and Children's Divisional Board</td><td>01/10/2021</td></tr><tr><td>BDH walkround</td><td>13/10/2021</td></tr><tr><td>Womens and childrens workforce board</td><td>26/10/2021</td></tr><tr><td>Clinical trials unit</td><td>02/12/2021</td></tr><tr><td>Central Delivery Suite B7s</td><td>02/12/2021</td></tr><tr><td>Community midwifery team</td><td>21/12/2021</td></tr><tr><td>Junior doctors forum Weston</td><td>26/01/2022</td></tr><tr><td>Digital Services team briefing</td><td>01/03/2022</td></tr><tr><td>SBCH walkround</td><td>08/03/2022</td></tr><tr><td>Medical records walkround</td><td>17/03/2022</td></tr><tr><td></td><td>Ongoing since Sept 2021</td></tr><tr><td>International nurse induction</td><td></td></tr></table>	F1 and F2 training - 2 sessions	07/04/2021	Bite sized training for grad trainees	12/05/2021	Weston managers HR surgery	05/05/2021	Weston managers HR surgery	07/05/2021	Cardiac services team meeting	08/06/2021	Finance team briefing	07/07/2021	Specialised Services divisional workforce meeting	07/07/2021	St Michael's matrons meeting	30/09/2021	Women's and Children's Divisional Board	01/10/2021	BDH walkround	13/10/2021	Womens and childrens workforce board	26/10/2021	Clinical trials unit	02/12/2021	Central Delivery Suite B7s	02/12/2021	Community midwifery team	21/12/2021	Junior doctors forum Weston	26/01/2022	Digital Services team briefing	01/03/2022	SBCH walkround	08/03/2022	Medical records walkround	17/03/2022		Ongoing since Sept 2021	International nurse induction		Face to face contact continued to be impacted by the pandemic – so more focus on virtual meetings. Monthly meetings for the Weston champion network continued in 2021/22. Despite operational pressures, in-house training of staff champions took place in April, June, July, September, October, December and February – supported by the psychological services team. Programme of presentations and walkround by FTSU Guardians to continue in 2022/23.
F1 and F2 training - 2 sessions	07/04/2021																																									
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International nurse induction																																										
Response to annual 'snapshot' survey relating to awareness of Speaking Up (targeted also to volunteers, agency workers, students and trainees)	Annual survey stood down due to Values survey work in 2021.	Pulse survey for 2022/23 to measure impact of speaking up.																																								

Number and location of Freedom to Speak Up staff champions across the Trust	Diagnostics & Therapies	9		Number of staff advocates increased from 80 to 99 in the year – champions are in all sites across the Trust. 44 champions trained in year. Aim to train remaining champions in 2022/23 and continue to recruit to replace staff turnover – with a focus on further increasing the diversity of the champion network.
	Medicine	12		
	Specialised Services	9		
	Surgery	11		
	Trust Services	24		
	Estates and Facilities	4		
	Weston	12		
	Women's & Children's	18		
Confidence				
Number of cases raised through the Raising Concerns phone line, email address and directly with the FTSU Guardian	102		Slight decrease in number of concerns raised compared to 2021/22. Number of concerns raised in Weston division remained higher than other divisions, but lower than previous year: 39 in 2021/22 compared with 56 in 2020/21	
Number of case studies completed and shared	One existing case study published by the National Guardian's Office: Supporting student nurses to speak up - National Guardian's Office		Two champion stories focused on positive change shared. Aim for 2022/23 to complete a further case study and story of positive change.	
Response to question in annual 'snapshot' survey relating to confidence in Speaking Up	N/A		Staff Survey shows	
Timelines for cases	102 opened in year 92 closed including 4 longstanding concerns from previous financial year 20 remain open into the new financial year		Escalation protocol created to involve executive support in resolving 'stuck' concerns.	
Feedback from those who have raised concerns (i.e. whether they would speak up again)	17 feedback forms returned from individuals who raised concerns and whose concerns were closed in the year.		New secure online feedback form created to improve access to providing confidential feedback.	
Supporting leaders and managers				
Take up of management (behaviours) training by division	No corporate management or leadership training took place in year due to the continued impact of Covid-19.		Recommendation remains to support investment in corporate management and development training for new and existing managers at all levels and from all backgrounds and experiences to understand their roles and responsibilities as managers	
Prevalence of 'hot spot' areas identified through Happy App data and annual Staff Survey	'Hot spot' areas identified through the Staff Survey, but no triangulation in year with data from summit partners.		Formation of a 'Culture Group', led by Organisational Development, in 2022/23 to triangulate data and support actions to address hot spot areas.	

Crafting a positive speaking up culture



Meel Tine Notari, Psychotherapy Administrator at Freedom to Speak Up advocate: Meel Tine described why she decided to help support her department to improve its culture and some of the actions. The staff and her colleagues are taking to bring about positive changes.

The first two most shared activities related to this are: [https://www.ftsu.org.uk/](#) or email [17342100@nhs.uk](#)

Why did you decide to become a Freedom to Speak Up advocate?

I joined the voluntary team in January 2019 and have 10 years' experience in patient safety. I was not aware of Freedom to Speak Up until I was asked to join the team. I had 2018 and 2019 in my mind, I was not aware of Freedom to Speak Up until I was asked to join the team. I had 2018 and 2019 in my mind, I was not aware of Freedom to Speak Up until I was asked to join the team. I had 2018 and 2019 in my mind, I was not aware of Freedom to Speak Up until I was asked to join the team.

What changes have you made to help improve safety and speak up to culture?

In the last year, we have made several changes to our culture. We have introduced a new policy on speaking up, which is now part of our induction. We have also introduced a new policy on speaking up, which is now part of our induction. We have also introduced a new policy on speaking up, which is now part of our induction.

What are the challenges you face in creating a positive speaking up culture?

One of the challenges we face is that some staff are still not comfortable with speaking up. We need to continue to work on this and ensure that all staff feel safe to speak up. We need to continue to work on this and ensure that all staff feel safe to speak up.

What advice would you give to other teams looking to improve their speaking up culture?

My advice would be to focus on building a culture of trust and openness. This is the foundation for any successful speaking up culture. We need to continue to work on this and ensure that all staff feel safe to speak up.

Whistleblowing and Ethics in Health and Social Care. Angie A. Ch <https://ed.oxfordcentral.proquest.com/view/116/116.html#:~:hl=detail&id=116104529849>



...a **function of the** ...

[illegible]

more than

...information without loss of brand loyalty, creating a compelling USP which
...advertising advocates turn us to my arm. I also analysed these firms in
...and wellbeing support which helped to get
...and help for support.

and adding the FTCD and ...
and meetings and ...
... and your speaking ...

...discussed a few things...
...to get more support and...
...in the last few months...

1. The **Business Stock** box = staff everywhere (all the time). The more

...helped to positively shape nurse, clinician and...
...example find your voice. This alone and suggestions from...
...in a room... or else... There is a freedom...
...and... and...

Let's look at some other factors that can affect the results of a survey. One factor is the way the questions are asked. For example, if you ask, "Do you support the death penalty?" you might get a different answer than if you ask, "Do you support the death penalty for people who have been convicted of a capital offense?"

I pledge to ...

100

will spread the work about the

Speak Up training so all staff understand they have a voice and

they will be heard!

Darren Lewis
Deputy HR Business Partner

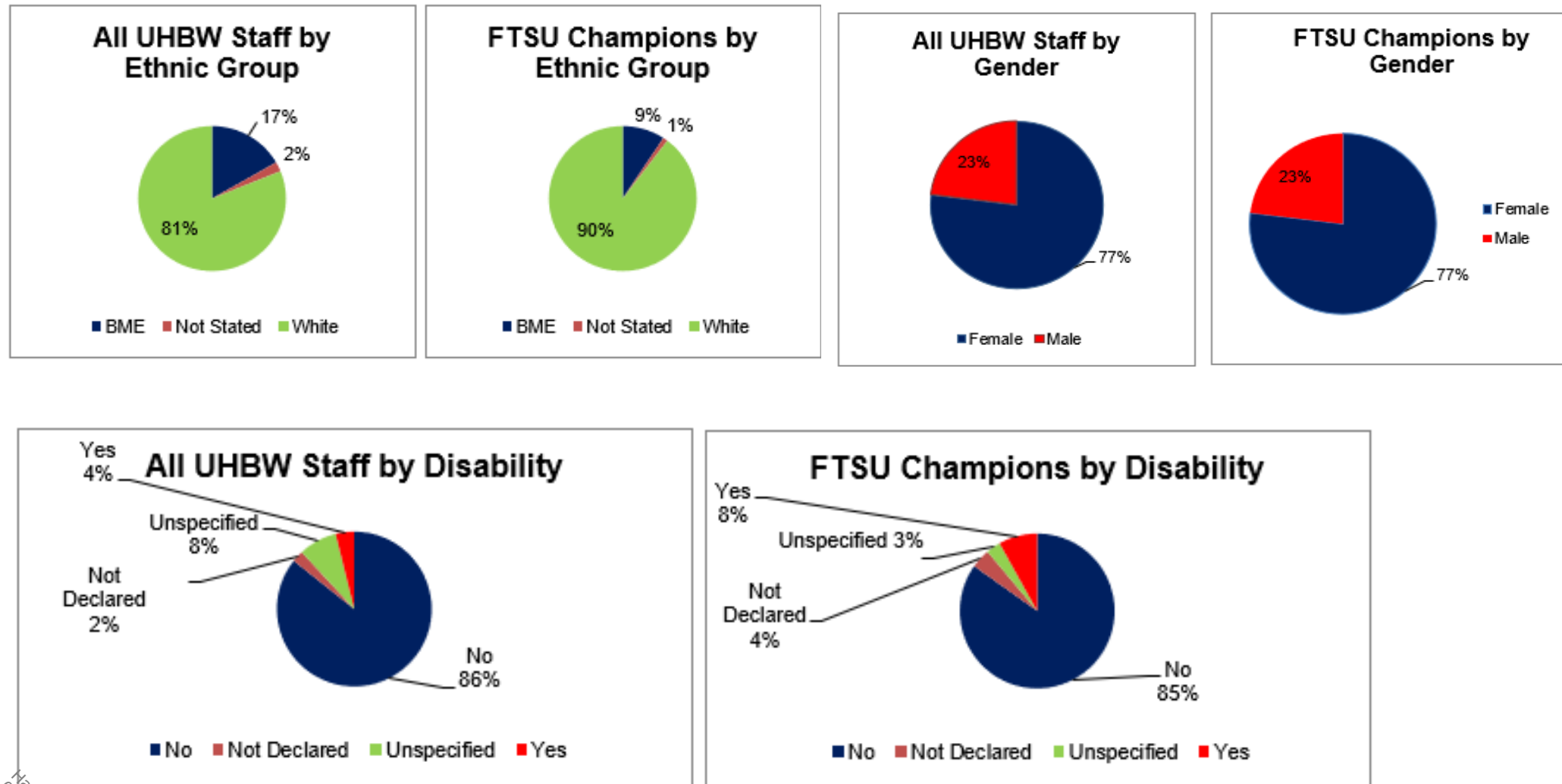
Women's & Children's Division

#SpeakUpPledge

#SpeakUpPledge

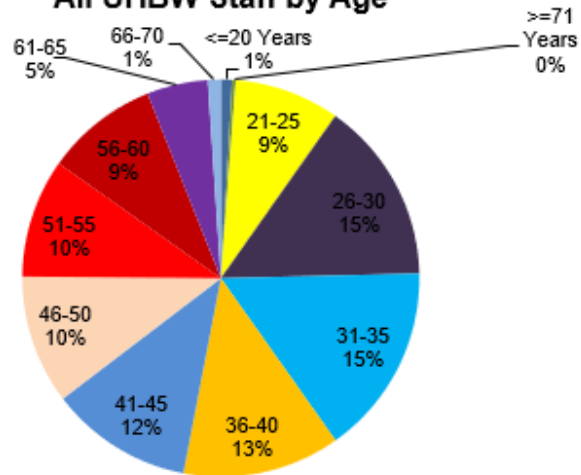


Appendix 3: Breakdown of diversity of FTSU staff champions compared to UHBW staff overall

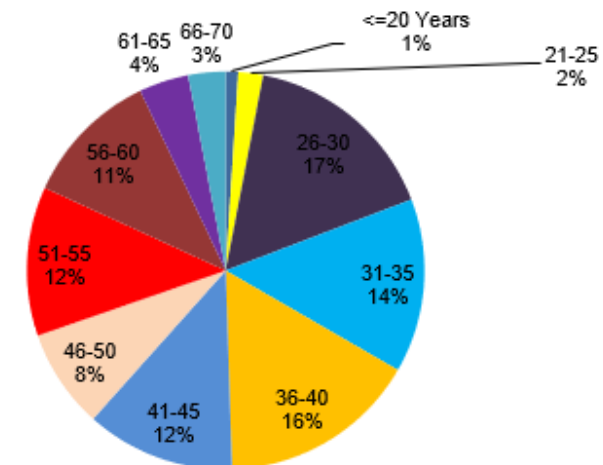


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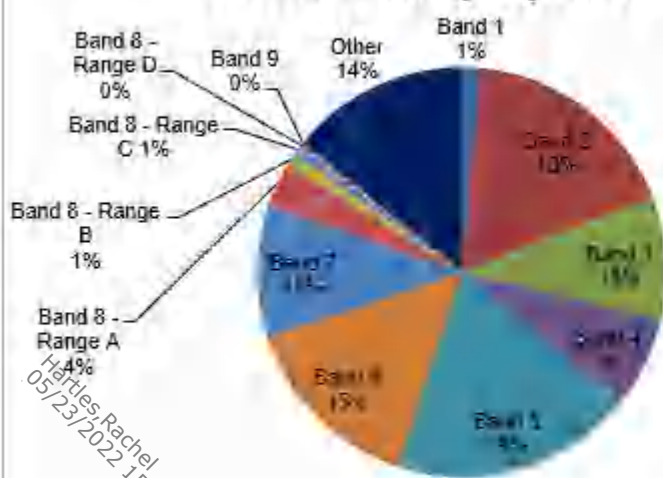
All UHBW Staff by Age



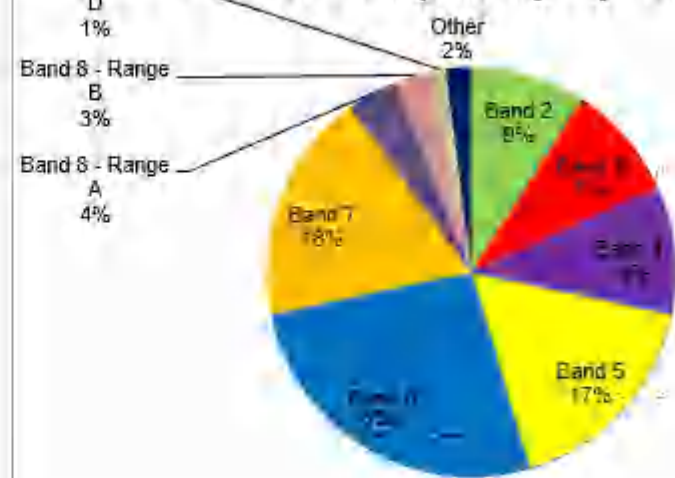
FTSU Champions by Age



All UHBW Staff by Pay Band



FTSU Champions by Pay Band



Meeting of the Board of Directors in Public on Friday 27th May 2022

Report Title	Freedom to Speak Up annual report 2021/22
Report Author	Eric Sanders, Freedom to Speak Up Guardian
Executive Lead	Emma Wood, Director of People

1. Report Summary	
This report provides an overview of the activity that took place in 2021/22 across the Trust to deliver our commitment to Freedom to Speak Up – including actions taken to improve speaking up at UHBW, an assessment of the number and themes of concerns raised, learning and areas for improvement, and priorities for the next 12 months.	
2. Key points to note <i>(Including decisions taken)</i>	
- The number of concerns raised via Freedom to Speak Up fell slightly in 2021/22, though concerns were heard from all staff groups, predominantly admin/clerical and nursing staff. - Most of the concerns raised fall into three categories: working culture; pay and reward; and fairness and transparency in recruitment processes. - The 2021 NHS Staff Survey shows there is work to do to ensure staff feel safe to raise concerns and feel their concerns will be addressed. - Managers need training and support to listen up to help staff speak up to create positive workplace cultures in line with our Trust values. - There is a significant opportunity through the Patient First programme to change the Trust's approach to listening to staff about concerns and opportunities for improvement, which will have a positive impact and support the Freedom to Speak Up programme at UHBW.	
3. Risks If this risk is on a formal risk register, please provide the risk ID/number.	
The risks associated with this report include: There is a risk that learnings from concerns are not shared across the organisation and similar concerns continue to be raised, which may impact on the confidence of staff in the speaking up arrangements in the Trust. This could be addressed through investment and action in the areas of leadership and management development, people management and culture change.	
4. Advice and Recommendations <i>(Support and Board/Committee decisions requested):</i>	
This report is for Assurance.	
5. History of the paper Please include details of where paper has previously been received.	
Senior Leadership Team	18 May 2022

Freedom to Speak Up annual report 2021/22

This report provides an overview of the activity that took place in 2021/22 across the Trust to deliver our commitment to Freedom to Speak Up – including actions taken to improve speaking up at UHBW, an assessment of the number and themes of concerns raised, learning and areas for improvement, and priorities for the next 12 months.

Background

The standard NHS contract requires that all trusts and foundation trusts employ a Freedom to Speak up (FTSU) Guardian. FTSU Guardians are now employed across the health and care sector, including in primary care, health charities, independent providers and arm's length bodies including health regulators.

At UHBW the FTSU Guardian is the Director of Corporate Governance, who is supported by a full-time Deputy Freedom to Speak Up Guardian. The role of the FTSU Guardians is to ensure patient safety and staff wellbeing by providing a mechanism for staff to speak up when they see or hear something that is not right. The FTSU Guardians not only provide support to staff who raise concerns, but also support the Board to develop a 'positive, compassionate, and inclusive' workplace culture in line with the vision set out in the NHS People Plan. The expectation of the National Guardian's Office (NGO) is that FTSU Guardians also play a proactive role in helping organisations 'learn from the opportunities that speaking up brings and tackle barriers to speaking up wherever they are'.

The FTSU Guardians report quarterly on concerns and themes, alternately to the Board or People Committee, and these reports are shared with the senior leadership team. The FTSU Guardian has regular access to both the executive lead for speaking up and the non-executive lead – positions which have changed in the year at UHBW. Externally, the FTSU Guardians link with the NGO via the South West regional FTSU Guardian network, which provides support and shares learning. Work continues with the FTSU Guardian at North Bristol NHS Trust to align FTSU policy and process along with staff training on speaking up.

This annual report provides an overview of:

- action taking to improve speaking up in line with the FTSU strategy
- areas of progress around speaking up in 2021/22
- concerns raised in the year including a breakdown by theme, division, and profession
- measuring speak up culture
- learning and improvement
- priorities for 2022/23.

ACTIONS AGAINST FTSU STRATEGY

The three objectives of the Trust's Freedom to Speak Up strategy set in 2019 focus on 1) raising awareness of speaking up; 2) building confidence in the process; and 3) ensuring that our corporate leadership and management training is informed by the feedback from the programme. Appendix 1 and 2 provide more detail. Highlights from this work include:

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1. *Awareness raising*

In meeting the objective to improve awareness of the Speaking Up programme, alongside regular corporate communications and updates via the speaking up champion network, the FTSU Guardians have completed training sessions with F1 and F2 doctors; midwives; graduate management trainees; presentations at HR surgeries for managers; international nurse induction; divisional board and departmental team meetings; and shared details about the FTSU process in volunteer and apprenticeship communications. It is essential that the FTSU Guardians continue to involve all staff groups in the promotion of the speaking up service, focusing on where staff may experience barriers in speaking up.

2. *Building confidence*

To meet the objective of hearing concerns promptly and providing feedback on outcomes wherever possible, feedback from individuals who have been involved in the Freedom to Speak Up process is now captured online via a short, anonymous survey managed by IQVIA. This provides a safer and more effective channel for capturing feedback from staff who have raised concerns, to understand if the process is working and if staff would feel confident to raise concerns again in the future.

In December 2021, the NGO published a case study from UHBW relating to concerns raised from student nurses working at the Trust. Examples of concerns which have moved to resolution via Freedom to Speak Up are provided in the quarterly updates to the Board/People Committee.

In 2021/22, 44 Freedom to Speak Up champions received in-house training, based on structure provided by the NGO – not only to provide more context around the importance of speaking up, but to help them to create positive working environments, and improve their listening skills to effectively support staff to speak up. Stories from champions about how they have brought about positive change in their own departments are shared with the network and through corporate channels.

3. *Training and support for managers and leaders*

The FTSU Guardians are involved in the development of the refreshed leadership and management development programme for managers in the Trust. Managers are now advised (via divisional cascades and corporate communications) to complete the 'Listen Up' training module produced by the NGO and Health Education England (which complements the mandatory speak up training module for all staff). Listen Up training compliance remains very low, with only 2% of the 2,285 line managers who have access to the training having completed it as of April 2022. The Board has committed to completing all three levels of training (Speak Up, Listen Up and the third module, Follow Up, which was released in April 2022).

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AREAS OF PROGRESS IN 2021/22

Among the objectives of the strategy, three areas of progress in the year have been:

1. *Resolving stuck concerns*

In reporting to the Board in 2021/22 the FTSU Guardian noted that some concerns were taking too long to resolve. Reasons concerns have remained open without resolution for a long time include, in the main, complex employee relations issues; issues around service delivery; estates issues; or cultural change work taking time to embed.

In October 2021, following conversations with the chief executive, it was agreed to bring a monthly report to the executive team to seek support to 'unlock' either specific concerns or thematic issues which had been raised through the Freedom to Speak Up process and to consider how to address the challenges. As a result, the executive team have early awareness of, and input into, complex issues raised through speaking up which cannot be resolved through the usual escalation process. The four concerns reported open in Q2 since the previous financial year were closed in Q4.

2. *Embedding Speak Up training and introducing Listen Up training for managers*

During Speak Up month in October 2021, the FTSU Guardians focused on encouraging all staff to complete their mandatory speak up training, which was introduced in the Trust in February 2021 with compliance recorded from August 2021. Reporting shows a significant increase in compliance (around 20 per cent) in the seven months between August and March, but it is clear there is more work to do to improve figures, particularly in the clinical divisions.

Division	Diagnostics and Therapies	Facilities and Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's and Children's	Weston
Aug 2021	26%	53%	24%	37%	26%	41%	29%	N/A
Mar 2022	51%	73%	47%	60%	46%	62%	50%	63%

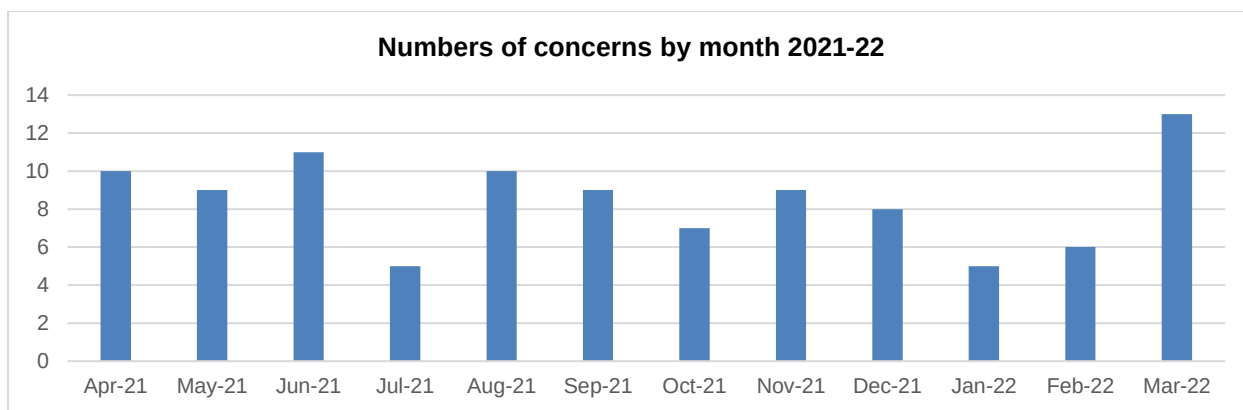
3. *Increasing the diversity of the FTSU champion network*

To ensure that the Freedom to Speak Up service is reaching as many staff in the organisation as possible, an assessment of the diversity of the 100-strong champion network was undertaken in March 2022. The results show that the network is largely reflective of the UHBW workforce by age, gender and banding – though the network is underrepresented in terms of BAME staff; staff working in B2 and Medical and Dental roles. See appendix 3 for more details.

ASSESSMENT OF CASES

Between April 2021 and March 2022, a total of 102 concerns were raised with the FTSU Guardians, compared to 112 in the previous financial year. The number of concerns raised appears to have stabilised with an average of 25 per quarter – and are more evenly spread across the divisions, though with the division of Weston still reporting more concerns than any other division. As a result, regular monthly meetings with the FTSU champions based at Weston General Hospital have continued to provide extra support to this group of staff.

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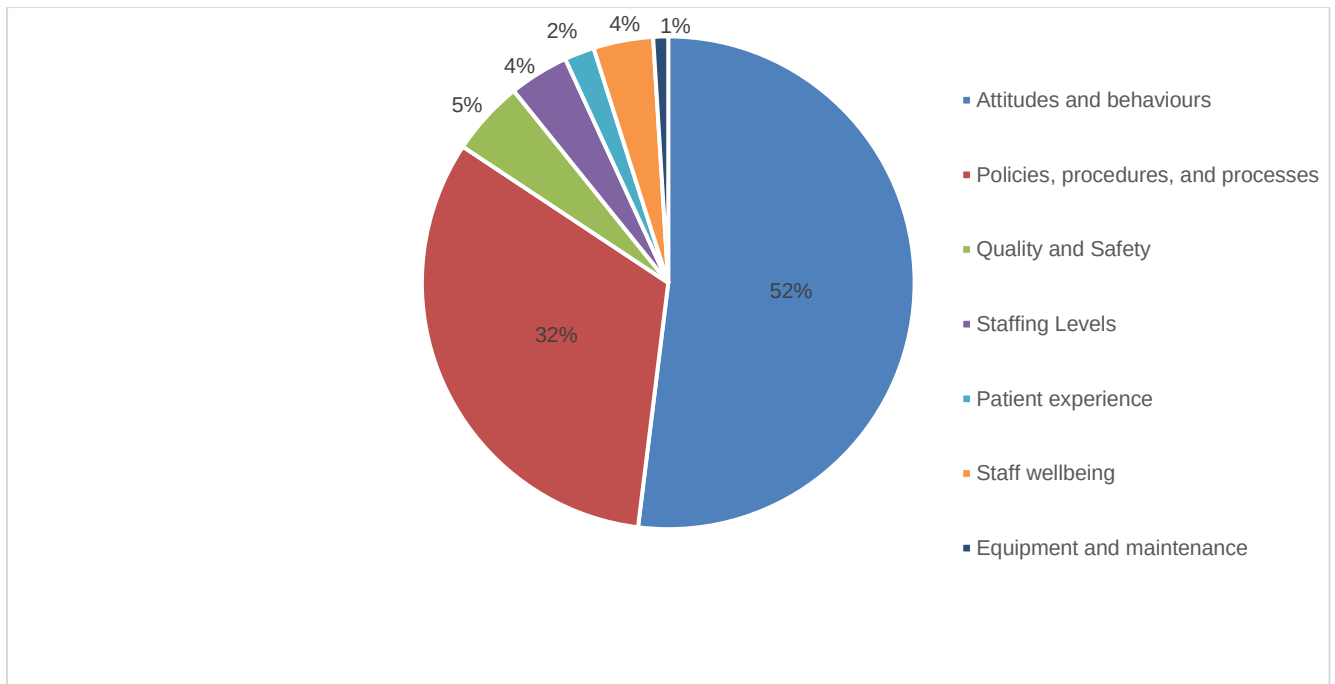
Concerns by division

Division	Number of concerns	Numbers of full time equivalent staff (at April 2021)	Concerns per 1,000 FTE	Number of FTSU staff champions
Diagnostics & Therapies	6	1,201.25	5.0	9
Medicine	10	1,217.81	8.2	12
Specialised Services	5	1,081.54	4.6	9
Surgery	11	1,810.11	6.1	11
Trust Services	13	1,076.56	12.1	24
Estates and Facilities	8	838.87	9.5	4
Weston	39	1,029.85	37.9	12
Women's & Children's	10	2,170.73	4.6	18

Themes of concerns

Looking at the themes of the concerns raised, the majority relate to attitudes and behaviours as per last year, with 23 (43 per cent) of these containing an element of bullying and harassment, which is an increase from 16 per cent last year. The number of cases relating to quality and safety remains low. Some cases involve different themes, but the overarching theme is recorded as the principal theme in this report.

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Within the overarching themes, there are three major themes which reoccur and account for a large proportion of the concerns shared with the FTSU Guardians, as follows:

- Concerns around working culture (including conflict between managers and employee or employee and colleagues, e.g. microaggressions; the lack of a resolution by a manager of issues escalated locally and a lack of action to tackle teams or departments with a 'poor reputation' e.g. those with consistently low staff survey results/high turnover/vacancies/sickness).
- Concerns around pay and reward (including the use of incentivised payments, consistency in their application; late or inaccurate staff pay; fairness of pay and leave allocation across job roles and sites).
- Concerns around fairness and transparency in recruitment processes and how staff are managed (including nepotism/cronyism; drawn out grievance or complaints processes and manager handling of employee performance).

The FTSU Guardians have been working with individuals and teams across the Trust to encourage and influence actions to tackle these common themes. Work is in progress, as follows:

- The Trust is currently conducting a wide-ranging review of additional rates of pay. Extensions to several other historic enhancements are also being reviewed and agreed, along with a number of revised incentive payments where there is continued high demand and/or significant vacancies.
- Work is ongoing to embed the new Trust values and leadership behaviours across the organisation in line with the People Strategy.
- A full review of leadership development across the Trust is underway to enhance the leadership training on offer to managers in the Trust so that managers have the right tools and the skills to manage their people.

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- External consultancy firm TCM is working within the Trust to move the organisation to a 'just and learning culture'.
- At the start of the new financial year, guidance around best practice recruitment was released to all recruiting managers.

Concerns by professional group

The FTSU Guardians have received concerns from a broad range of professional groups across the Trust in the year. Most cases were raised by administrative/clerical and nursing staff as per last year, and we have seen more engagement from doctors in the year. Looking at data from the NGO for 2020-21, nurses and midwives account for 28.9% of speaking up concerns, with admin, clerical and maintenance/ancillary staff accounting for 20.8%. It is pleasing to note that staff who speak up are largely comfortable to share their details in confidence with the FTSU Guardians; during 2020/21, only one case was reported anonymously.

Profession	Total
Administrative/clerical staff	40
Nurses	33
Cleaning/Catering/Maintenance/Ancillary staff	9
Healthcare Assistants	8
Allied Health Professionals	2
Other	3
Doctors	4
Midwives	1
Unknown	1
Anonymous	1
Total	102

MEASURING SPEAKING UP CULTURE

There are many metrics to consider when measuring a speaking up culture – two key indicators are feedback from those who have spoken up and feedback from the NHS staff survey.

Feedback from individuals speaking up

Once a case is closed a survey is sent to the person who spoke up asking questions about their experience of the FTSU process and if they would speak up again. When a case is closed by the Freedom to Speak Up Guardian, a confidential, anonymous survey is sent out to capture feedback on their experience and to seek any areas for improvement. Below are some comments and confidential feedback from staff who have used the speaking up services:

"I feel the speak up guardian did try their best, but I am dissatisfied with the response from the Trust"

"I feel the Trust will take things seriously if I do speak up and take things forward when necessary. My only concern would be that my concerns may not have been taken forward if other people in the department hadn't spoken out also"

"It is an essential and valuable service"

"I find it hard to believe that I went through the incidents I needed to speak up about, and then writing it all out, sharing it, all that anxiety only to realise that this was going to be a really bad career choice. I work in a small specialty and now work elsewhere but will have a professional relationship with the team for the foreseeable. The scope of the freedom to speak up work is within the trust, and I suppose if I had stayed I would be protected by that, but as someone who left, there was chance my career would be impacted."

"I feel it is important to speak up if something is not right."

"I think people are frightened to speak up because they feel their problem may be trivialized or not believed. I certainly felt like that before and so the problem continued for a long time, resulting in my leaving the post. I was met with kindness and compassion from the freedom to speak up team."

"I actually now feel empowered to speak up when I know there's a problem because the FTSU process has really shown that change can happen, even in a department that's been poorly managed for so long with systemic issues."

A total of 17 staff completed the survey in 2021/22. Of these, 15 answered 'yes' to the question "would you speak up again?"; 1 answered 'no' and 1 answered 'I don't know'.

Respondents are also asked to provide data on their protected characteristics so that we can better understand who is speaking up via the FTSU Guardians. Given the low response rate, the data does not reflect the reach of the service and has been withheld from this report to protect the identity of the respondents.

In the year, two individuals noted they had suffered detriment because of speaking up. The NGO states that there should be visible action on detriment for speaking up wherever this is reported. Work to update the FTSU policy to include a procedure for cases of detriment to be investigated is underway.

NHS staff survey feedback

The annual NHS staff survey contains questions on the NHS People Promise theme of 'we each have a voice that counts', and specifically four questions which reflect how staff feel about raising concerns in their organisation. There is a mixed picture here. While UHBW continues to score above the average figure for other acute/acute and community Trusts on all the questions, there is a decrease in confidence around staff feeling their concerns would be addressed and feeling safe to raise concerns compared to 2020, and this is reflected nationally. In the NGO survey of Guardians conducted in 2021, 62.8% of respondents said their organisation had a positive culture of speaking up, down five percentage points compared to the 2020 result.

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Staff Survey questions related to raising concerns (% agreeing / strongly agreeing with the following statements):	2020 UHBW	2021 UHBW	Average for acute / acute and community Trusts (2020 score)
I would feel secure raising concerns about unsafe clinical practice	73.5	74.8 ▲	73.6 (71.7)
I am confident that the organisation would address concerns about unsafe clinical practice	63.5	59.9 ▼	57.8 (59.2)
I feel safe to speak up about anything that concerns me in this organisation	69.6	66.4 ▼	60.8 (64.9)
I feel organisation would address any concerns I raised	Not asked in 2020	53.1	48.3

LEARNING AND IMPROVEMENT

Managers/leaders are asked to identify the changes made, lessons learnt and any transferable learning that results from FTSU concerns. They are responsible for ensuring the implementation of the learning relevant to their service area and for sharing transferable learning within appropriate forums/structures. The FTSU Guardians share themes and overall learning from cases with the Board/People Committee, Speaking Up summit partners (currently paused) and, since May 2022, with the People and Education Group, with a focus on thematic analysis and raising awareness of concerns with the wider HR community.

The series of Speaking Up Summits initiated by the FTSU Guardians, where individuals from across the Trust with an interest in encouraging the voice of staff (e.g. Heads of HR, Organisational Development, Staff Side, Patient Safety, Education), has been paused while work, led by the Organisational Development team, on culture considers what steps are required to drive forward improvement work.

Nationally, the NGO publishes Speaking Up reviews, which identify learning from organisations where the NGO has received information to suggest that speaking up had not been handled in accordance with good practice. The FTSU Guardians review the findings from speaking up cases published by the NGO for learning and have recommended the following actions for the Trust:

- Taking steps to promote a culture of visible and accessible leadership **(all leaders)**
 - Reviewing the effectiveness of the programme of work to challenge unwanted and/or unprofessional behaviours **(Organisational Development)**
 - Promoting and facilitating the use of mediation where appropriate and increasing capacity for mediation **(HR)**
- Aligning HR policies with new external resolution framework to ensure they are fair and supportive of all workers (including those speaking up) and have the confidence of its workforce, including effective training for workers in HR **(HR)**

- Taking appropriate steps to ensure matters arising from cases of speaking up are investigated within reasonable timescales and without undue delay (**FTSU Guardian – completed: ‘Escalation of FTSU concerns standard operating procedure’ updated to include timescales for investigation**)
- Updating FTSU policy to put in place procedure that would enable cases of detriment to be investigated effectively when they are reported (**FTSU Guardian**)

Most of these actions are still work in progress.

PRIORITIES FOR 2022/23

Updates on progress against the outstanding actions from the last financial year (above), and additional priorities for 2022/23 as identified below, will be included in quarterly reports to SLT and Board, and the People and Education Group:

- Create a template to support managers in both structuring their response to colleagues speaking up through the guardian route and for sharing learning.
- Complete a FTSU (Pulse) survey with all staff in the Trust to assess awareness of FTSU and feedback on the speaking up culture.
- Complete the FTSU review tool for NHS trusts and foundation trusts (last completed in June 2018) once the updated review tool is published by the NGO, which is imminent.
- Refresh the FTSU strategy after completion of the Board Self Review to link with key themes set out in the new People Strategy around inclusion and belonging; looking after our people; and new ways of working (developing compassionate and inclusive leaders).
- Link with the Patient First programme to change the Trust’s approach to listening to staff about concerns and opportunities for improvement.

Conclusion

- The Board is asked to consider and comment on the themes, trends and issues arising from this report.

Hartles Rachel
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Appendix 1: Progress against the three objectives of the Freedom to Speak Up Strategy

	Data 2021/22	Description of changes in year and proposed areas of focus																																								
Awareness																																										
Compliance with corporate induction training	<table><tr><th>Division</th><th>Diagnostics and Therapies</th><th>Facilities and Estates</th><th>Medicine</th><th>Specialised Services</th><th>Surgery</th><th>Trust Services</th><th>Women's and Children's</th><th>Weston</th></tr><tr><td>Mar 2022</td><td>51%</td><td>73%</td><td>47%</td><td>60%</td><td>46%</td><td>62%</td><td>50%</td><td>63%</td></tr></table>	Division	Diagnostics and Therapies	Facilities and Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's and Children's	Weston	Mar 2022	51%	73%	47%	60%	46%	62%	50%	63%	20% increase in compliance against mandatory Speak Up training between August 2021 (first month of monitoring) and March 2022.																						
Division	Diagnostics and Therapies	Facilities and Estates	Medicine	Specialised Services	Surgery	Trust Services	Women's and Children's	Weston																																		
Mar 2022	51%	73%	47%	60%	46%	62%	50%	63%																																		
Number of updates to staff and other workers in the Trust about speaking up	<table><tr><td>F1 and F2 training - 2 sessions</td><td>07/04/2021</td></tr><tr><td>Bite sized training for grad trainees</td><td>12/05/2021</td></tr><tr><td>Weston managers HR surgery</td><td>05/05/2021</td></tr><tr><td>Weston managers HR surgery</td><td>07/05/2021</td></tr><tr><td>Cardiac services team meeting</td><td>08/06/2021</td></tr><tr><td>Finance team briefing</td><td>07/07/2021</td></tr><tr><td>Specialised Services divisional workforce meeting</td><td>07/07/2021</td></tr><tr><td>St Michael's matrons meeting</td><td>30/09/2021</td></tr><tr><td>Women's and Children's Divisional Board</td><td>01/10/2021</td></tr><tr><td>BDH walkround</td><td>13/10/2021</td></tr><tr><td>Womens and childrens workforce board</td><td>26/10/2021</td></tr><tr><td>Clinical trials unit</td><td>02/12/2021</td></tr><tr><td>Central Delivery Suite B7s</td><td>02/12/2021</td></tr><tr><td>Community midwifery team</td><td>21/12/2021</td></tr><tr><td>Junior doctors forum Weston</td><td>26/01/2022</td></tr><tr><td>Digital Services team briefing</td><td>01/03/2022</td></tr><tr><td>SBCH walkround</td><td>08/03/2022</td></tr><tr><td>Medical records walkround</td><td>17/03/2022</td></tr><tr><td></td><td>Ongoing since Sept 2021</td></tr><tr><td>International nurse induction</td><td></td></tr></table>	F1 and F2 training - 2 sessions	07/04/2021	Bite sized training for grad trainees	12/05/2021	Weston managers HR surgery	05/05/2021	Weston managers HR surgery	07/05/2021	Cardiac services team meeting	08/06/2021	Finance team briefing	07/07/2021	Specialised Services divisional workforce meeting	07/07/2021	St Michael's matrons meeting	30/09/2021	Women's and Children's Divisional Board	01/10/2021	BDH walkround	13/10/2021	Womens and childrens workforce board	26/10/2021	Clinical trials unit	02/12/2021	Central Delivery Suite B7s	02/12/2021	Community midwifery team	21/12/2021	Junior doctors forum Weston	26/01/2022	Digital Services team briefing	01/03/2022	SBCH walkround	08/03/2022	Medical records walkround	17/03/2022		Ongoing since Sept 2021	International nurse induction		Face to face contact continued to be impacted by the pandemic – so more focus on virtual meetings. Monthly meetings for the Weston champion network continued in 2021/22. Despite operational pressures, in-house training of staff champions took place in April, June, July, September, October, December and February – supported by the psychological services team. Programme of presentations and walkround by FTSU Guardians to continue in 2022/23.
F1 and F2 training - 2 sessions	07/04/2021																																									
Bite sized training for grad trainees	12/05/2021																																									
Weston managers HR surgery	05/05/2021																																									
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	Ongoing since Sept 2021																																									
International nurse induction																																										
Response to annual 'snapshot' survey relating to awareness of Speaking Up (targeted also to volunteers, agency workers, students and trainees)	Annual survey stood down due to Values survey work in 2021.	Pulse survey for 2022/23 to measure impact of speaking up.																																								

Number and location of Freedom to Speak Up staff champions across the Trust	Diagnostics & Therapies	9		Number of staff advocates increased from 80 to 99 in the year – champions are in all sites across the Trust. 44 champions trained in year. Aim to train remaining champions in 2022/23 and continue to recruit to replace staff turnover – with a focus on further increasing the diversity of the champion network.
	Medicine	12		
	Specialised Services	9		
	Surgery	11		
	Trust Services	24		
	Estates and Facilities	4		
	Weston	12		
	Women's & Children's	18		
Confidence				
Number of cases raised through the Raising Concerns phone line, email address and directly with the FTSU Guardian	102		Slight decrease in number of concerns raised compared to 2021/22. Number of concerns raised in Weston division remained higher than other divisions, but lower than previous year: 39 in 2021/22 compared with 56 in 2020/21	
Number of case studies completed and shared	One existing case study published by the National Guardian's Office: Supporting student nurses to speak up - National Guardian's Office		Two champion stories focused on positive change shared. Aim for 2022/23 to complete a further case study and story of positive change.	
Response to question in annual 'snapshot' survey relating to confidence in Speaking Up	N/A		Staff Survey shows	
Timelines for cases	102 opened in year 92 closed including 4 longstanding concerns from previous financial year 20 remain open into the new financial year		Escalation protocol created to involve executive support in resolving 'stuck' concerns.	
Feedback from those who have raised concerns (i.e. whether they would speak up again)	17 feedback forms returned from individuals who raised concerns and whose concerns were closed in the year.		New secure online feedback form created to improve access to providing confidential feedback.	
Supporting leaders and managers				
Take up of management (behaviours) training by division	No corporate management or leadership training took place in year due to the continued impact of Covid-19.		Recommendation remains to support investment in corporate management and development training for new and existing managers at all levels and from all backgrounds and experiences to understand their roles and responsibilities as managers	
Prevalence of 'hot spot' areas identified through Happy App data and annual Staff Survey	'Hot spot' areas identified through the Staff Survey, but no triangulation in year with data from summit partners.		Formation of a 'Culture Group', led by Organisational Development, in 2022/23 to triangulate data and support actions to address hot spot areas.	

[illegible]

MWhistleblowing and Ethics in Health and Social Care. Angie A. Ch <https://ed.oxfordcentral.proquest.com/view/fulltext-link?detailaction=download&docID=4529849>



Trở lại với phần tiếp theo của bài học, chúng ta sẽ tiếp tục tìm hiểu về các thành phần của một bài báo và cách phân tích chúng.

...a healthy return home (Franklin) to Boston. I and this committee have already mentioned this...
my role as a Staff Room representative, some resolution has already been reached...
to speak until a number of students - including those of confidence in committee that they likely intend to...
speak or have proposed - wanted to learn how to participate here. I will then be offering an overview of the...
the situation for my department to help gain awareness of the student situation. It was also a good session that...
the situation for my department to help gain awareness of the student situation. It was also a good session that...

How have you raised awareness of your experiences?

I started by pulling up freedom to speak up posters in the office (and on my laptop). I also displayed these posters in my car. I also displayed these posters in my car. I also displayed these posters in my car.

department meetings and send out emails highlighting FTEU and what's going on in the office. It has really worked to have our department lead in this.

When customers have your number to help organize their lives, they'll be more likely to call you. I distributed a few thousand copies of the book and now I get calls from people who need help with their lives. In the last few months we've had

...in ideas and suggestions into the eye catching box. The ... and every week in the forum meeting ... and recognise su...

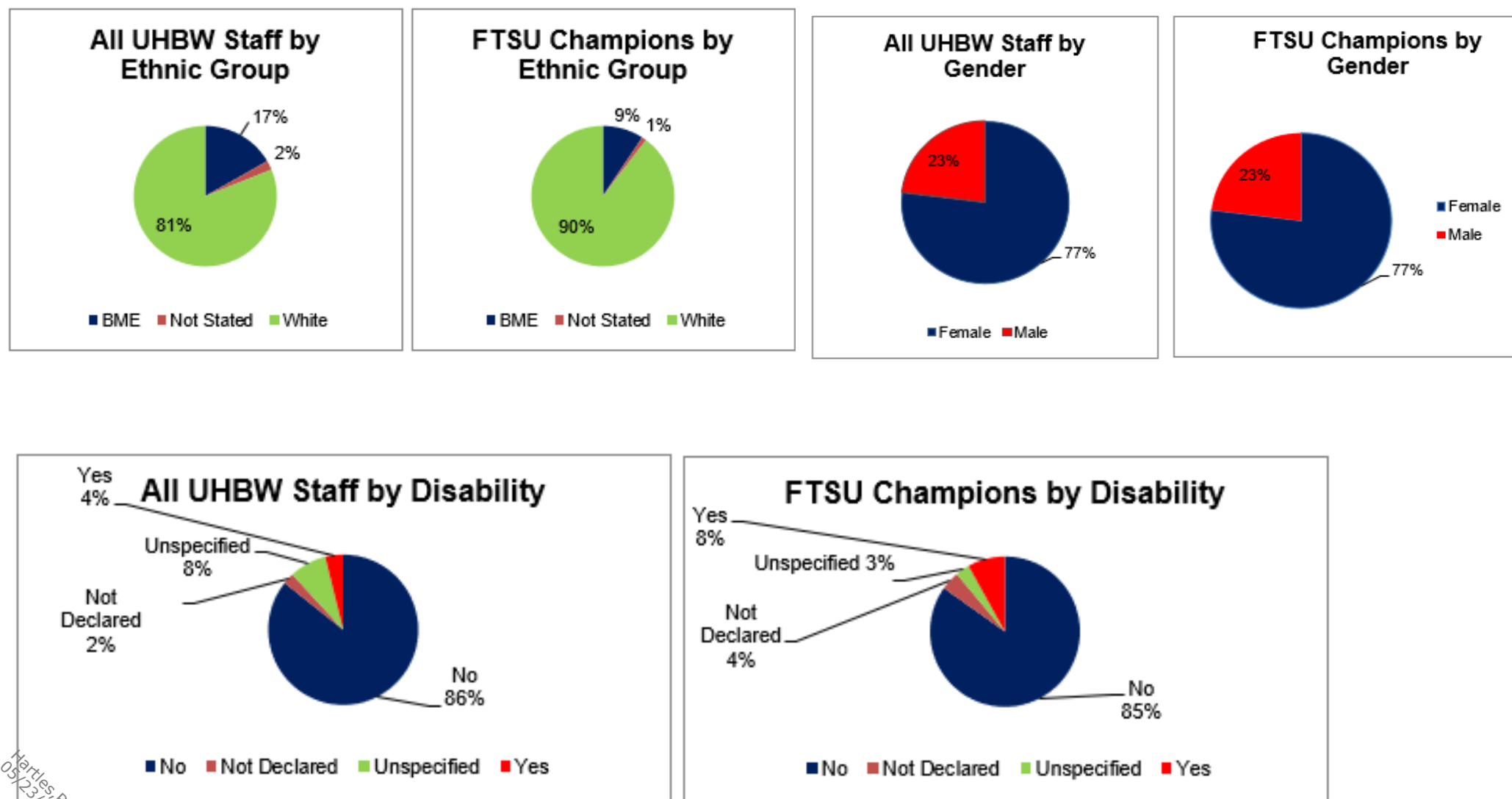
...the most common...
...positive body morale, behavior...
...make people feel even more valued. The class and suggestions...
...for unwavering and manured.

...and the ...

#SpeakUpPledge

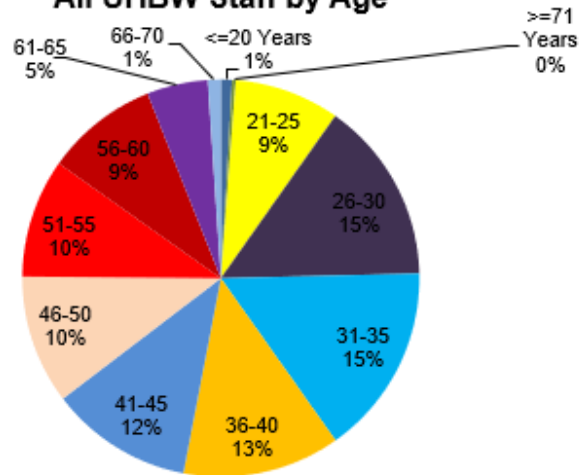


Appendix 3: Breakdown of diversity of FTSU staff champions compared to UHBW staff overall

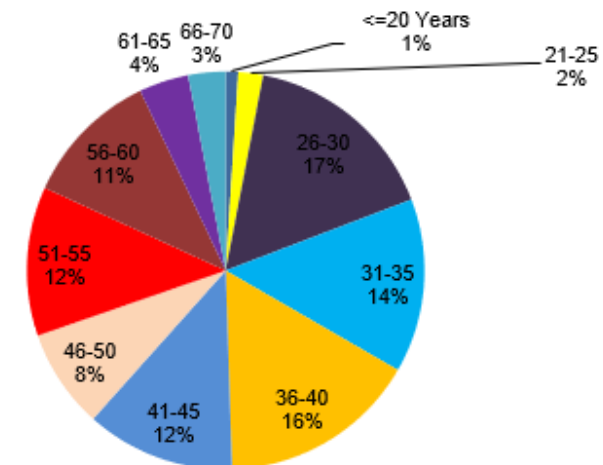


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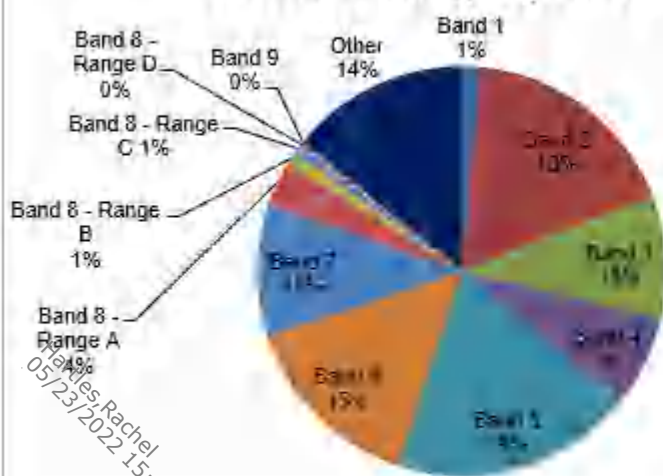
All UHBW Staff by Age



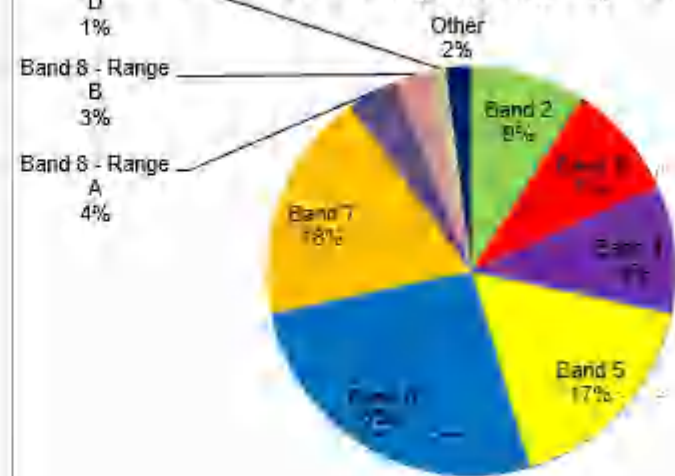
FTSU Champions by Age



All UHBW Staff by Pay Band



FTSU Champions by Pay Band



Meeting of the Board of Directors in Public on Thursday 27 May 2022

Report Title	Provider Licence Self-Certifications
Report Author	Eric Sanders, Director of Corporate Governance
Executive Lead	Eric Sanders, Director of Corporate Governance

1. Report Summary
To present the proposed self-certifications against the Provider Licence conditions for approval by the Board.
2. Key points to note <i>(Including decisions taken)</i>
NHS foundation trusts are required to self-certify, on an annual basis, whether or not they have: (1) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution); (2) the required resources available if providing commissioner requested services (CRS); (3) complied with governance requirements; and (4) have provided Governors with the necessary training This paper has been written by the Director of Corporate Governance to provide the Board with assurance that the Trust fully meets the NHS provider licence conditions.
3. Risks If this risk is on a formal risk register, please provide the risk ID/number.
The appendix identifies potential risks to compliance with the governance statement conditions and describes the identified mitigating actions.
4. Advice and Recommendations <i>(Support and Board/Committee decisions requested):</i>
• This report is for APPROVAL • The Board is asked to APPROVE the Trust's provider licence self certifications.
5. History of the paper Please include details of where paper has <u>previously</u> been received.
N/A

Provider Licence - Self-Certifications

1. Purpose

- 1.1. To provide evidence of compliance against the Provider Licence to support a decision by the Board.

2. Background

- 2.1. NHS foundation trusts are required to self-certify whether or not they have:

(1) complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution);

(2) the required resources available if providing commissioner requested services (CRS); and

(3) complied with governance requirements.

- 2.2. NHS Improvement issued guidance in 2018 which has been used to inform this paper and the appendices. The guidance can be access at the link below:

https://www.england.nhs.uk/wp-content/uploads/2020/08/Self-certification_2018_-_Consolidated_Guidance.pdf

3. Self-Certification Requirements

- 3.1. Providers need to self-certify the following after the financial year-end:

NHS provider licence conditions
The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
Publication of condition G6(3) self-certification Condition G6(4)
The provider has complied with required governance arrangements (Condition FT4(8))
The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. This only applies to foundation trusts that are providers of CRS. (Condition CoS7(3))
Governors have received the necessary training to ensure they are equipped with the skills and knowledge they need to undertake their role.

- 3.2. It is up to providers how they undertake the self- certification; however a number of templates have been provided which the Trust has used as the basis of the document in Appendix 1.

- 3.3. Trusts are required to state either “confirmed” or “not-confirmed” against each element of the licence condition, and if the Trust chooses “not-confirmed” must provide an explanation why.

- 3.4. Boards must sign off on self-certification no later than

- G6/CoS7(3): 31 May 2022
- G6(4)FT4: 30 June 2022

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3.5. To fulfil the requirement to publish the self-certification, the templates, proposed by NHS Improvement, will be completed and will be signed by the Chair and Chief Executive. These documents will then be added to the Key Publications section of the Trust's website.

4. Proposed Outcome

4.1. The Director of Corporate Governance has reviewed the statements and evidence sets and is proposing that the Board of Directors responds with "confirmed" for all elements. The evidence to support the response is outlined in Appendix 1.

4.2. For FT4, the Board is also required to consider any risks and mitigating actions for each element of the provider licence condition. These are described in Appendix 1.

4.3. The responses will be translated into the NHS Improvement template once agreed.

5. Recommendations

5.1. The Board of Directors is asked to consider the evidence aligned to each element of the provider licence conditions, which the Board is required to self-certify against, and confirm its response, noting the risks and mitigations.

Eric Sanders
Director of Corporate Governance

Hartles Rachel
05/23/2022 15:12:23

Appendix 1 – Provider Licence Self-Certification

		Proposed Response	Evidence	Risks	Mitigating Actions
FT4 - Corporate Governance Statement					
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	- Annual Governance Statement - Well-led Framework - External Review - Head of Internal Audit Opinion - Board Assurance Framework - Board annual effectiveness evaluation - Compliance with the Code of Governance - External audit of the annual report and accounts - Internal Audits including review of divisional governance and internal control systems e.g. risk management	The size and complexity of the organisation means there is a risk that good governance is not fully embedded in all divisions	- The Trust utilises its management and committee structures to ensure that good governance is embedded. This is complemented by the risk, performance and planning frameworks, which are overseen by the Senior Leadership Team - Guidance and advice is provided by the Director of Corporate Governance.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	- As above plus: - Alignment of performance reports to the Single Oversight Framework in the Quality and Performance Report	Guidance is not identified or implemented in a timely manner	- The Trust ensures that regular communications from NHSI, CQC and other key bodies are reviewed and acted upon. - Internal and external audit consider application of good governance during their audit programmes.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	- Governance structure - Board and Committee annual effectiveness reviews - Scheme of Reservation and Delegation and Standing Financial Instructions - Committee Terms of Reference - Reports from the Chairs of the Committees to the Board and Council of Governors, and its focus groups	Committee Terms of Reference are not fit for purpose/aligned with up to dates guidance on effective governance.	- Annual reviews of Committee Terms of Reference, with reference to relevant up to date guidance. - Stakeholder analysis included as part of the review process to ensure all internal and external requirements are identified and included in the Terms of Reference.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate	Confirmed	- Quality and Performance Report and Finance Report to Board each month - Annual Operating Plan and Budget (Trust and Divisional)	The Trust's internal control systems are not sufficiently robust to ensure compliance	The systems and processes are regularly tested through the internal and external audit programmes, and the robust approach to risk management

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		Proposed Response	Evidence	Risks	Mitigating Actions
	efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		• Standing Financial Instructions • Head of Internal Audit Opinion • Annual Governance Statement • Clinical Audit Programme and Reports • Financial Strategy • Committee Structure and Terms of Reference • External Audit of the Trust Annual Report and Accounts • Risk Management Strategy • Corporate and Divisional Risk Registers • Board Assurance Framework		
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	• Well-led Framework – External Review • Board Skills and Knowledge Review • Board Development Programme • Board member annual appraisals • Non-Executive Director and Executive challenge of proposals • Monthly Quality and Performance Report and finance report • Active engagement with Commissioners, local Health Scrutiny, Health & Well-being Boards and Healthwatch • Quality Governance Framework (safety, experience, outcomes and access)	• As above	• As above

		Proposed Response	Evidence	Risks	Mitigating Actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	- Board Skills and Knowledge Review - Remuneration, Nominations and Appointments Committee Terms of Reference and work programme - Management and Organisational Development Programmes - Divisional Performance Reviews - Senior Leadership Team oversight - Monthly and Six Monthly Nurse Staffing Reviews - Revalidation and appraisal processes (Medical and non-Medical) - Other workforce metrics included in the Quality and Performance Report	There is a risk of unforeseen changes at Board level which may impact on the requirements	- There are deputies in post and succession plans for all Executive Directors - The Board has appointed to all Non-Executive Directors roles
General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)					
1	Following a review for the purpose of paragraph 2(b) of licence condition G6 ¹ , the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	- Internal Audit and clinical audit work programmes - Annual Operating Plan reviews - Governance structure - Risk Management Strategy - Corporate Risk Register - Board Assurance Framework - Monthly Quality and Performance Report and Finance Report	N/A	N/A
Continuity of services condition 7 – Availability of Resources					
1	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	- Annual Operating Plan and Budget - Financial Strategy - Annual accounts and going concern statement	N/A	N/A
Training of Governors					
	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training	Confirmed	Seminar Programme	N/A	N/A

¹ “2. (b) regular review of whether those processes and systems have been implemented and of their effectiveness.”

		Proposed Response	Evidence	Risks	Mitigating Actions
	to its Governors as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.		• Induction programme • Access to external training via NHS Providers • Specific and targeted training and updates – quality, strategy, auditor appointment • Governor skills audit • Internal Audit of the support to Governors.		

Meeting of the Board of Directors in Public on Friday 27 May 2022

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 January 2022.
2. Key points to note <i>(Including decisions taken)</i>
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 <i>(Support and Board/Committee decisions requested):</i>
This report is for Information.
5. History of the paper Please include details of where paper has <u>previously</u> been received.
N/A

Hartles Rachel
 05/23/2022 15:12:23

We are
 supportive
 respectful
 innovative
 collaborative.
 We are UHBW.

Register of Seals

February 2022 – April 2022

Reference Number	Document	Date Signed	Authorised Signatory 1	Authorised Signatory 2	Witness
875	The surrender of the current lease between UHBW and Medirest for the level 9 DeliMarche restaurant and the extension of lease for Costa at level 2 BRI and Weston	30/03/2022	Smith, Mark	Kemsley, Neil	Sanders, Eric
874	Unit CG13 The Galleries Bristol – Underlease, Licence to Alter and Licence to Underlet	30/03/2022	Smith, Mark	Kemsley, Neil	Sanders, Eric
873	S278 agreement between UHBW, BCC and LDC (Old Hospital) Ltd relating to dedication of land to become highways. This will enable the provision of improved pavement access around the Old building site on Whitson Street and Lower Maudlin St	30/03/2022	Smith, Mark	Kemsley, Neil	Sanders, Eric
872	Underlease Local Partnership Agreement (uLPA) between UHBW and Community Health Partnerships, for the dental premises at SBCH	30/03/2022	Smith, Mark	Kemsley, Neil	Sanders, Eric
871	Lease and Licence to Underlet between UHBW and Community Health Partnerships, for the premises at Hampton House for the provision of Midwifery services	30/03/2022	Smith, Mark	Kemsley, Neil	Sanders, Eric
870	Renewal lease for Boots in Welcome Centre	30/03/2022	Smith, Mark	Kemsley, Neil	Sanders, Eric
869	Licence for Audiology space in North Bristol Trust, Thornbury	30/03/2022	Smith, Mark	Kemsley, Neil	Sanders, Eric

868	Deed of Surrender between the Trust and Honey Tree Nurseries terminating their lease agreement for a building, known as 'the Nursery Building' at the site of Weston hospital	31/03/2022	Kemsley, Neil	Fowler, Deirdre	Murch, Sarah
867	Heat connection agreement and master heat supply agreement of an area within the basement of Central Health Clinic to house mechanical plant to enable connection to Bristol City Council's heat network to supply heat to the building	05/04/2022	Smith, Mark	Kemsley, Neil	Hartles, Rachel
866	License to Occupy and Underlease between UHBW and Sirona for the premises at SBCH	23/02/2022	Clarke, Paula	Kemsley, Neil	Judge, Natasha
865	Legal Charges relating the Bristol General site	08/02/2022	Clarke, Paula	Kemsley, Neil	Judge, Natasha
864	Renewal of Lease for Unit 5A Whitefriars	23/02/2022	Smith, Mark	Woolley, Robert	Judge, Natasha

Hartles, Rachel
05/23/2022 15:12:23

Meeting of the Board of Directors in Public on Friday 27 May 2022

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 is a means of channelling communications between the governors and the officers of the Trust.	
2. Key points to note	
Since the previous public Board of Directors meeting on 30 March 2022, one question and one response has been added. There are no responses outstanding.	
3. Risks	
The risks associated with this report include: n/a	
4. Advice and Recommendations	
This report is for Information.	
5. History of the paper	
Please include details of where paper has <u>previously</u> been received.	
Governors' Quality Focus Group	20/5/22

ID

Governor Name

268

Annabel Plaister

Theme: Weston Emergency Department

Source: Governor Direct

Query

14/04/2022

It appears from the IQPR that in both January and February the Emergency Department at Weston General Hospital saw more patients per hour than the BRI ED. Whilst I totally understand that patients arriving at the BRI ED may have more complex and time consuming needs, I would like to seek assurance that the impact of these numbers on Weston ED is recognised. What support is Weston ED receiving to manage this amount of patients?

Division: Other

Executive Lead: Chief Operating Officer

Response requested: 14/04/2022

Response

11/05/2022

The Emergency Department at Weston is open from 08:00 to 22:00 seven days per week and sees on average 126 patients per day, which would be around 9 patients per hour during the 14 hours the department is open.

In comparison the Emergency Department in Bristol Royal Infirmary is open 24 hours per day, seven days per week and saw during 2021/22 an average of 205 patients per day, around 8.5 patients per hour.

Our capacity to see patients, in terms of our staffing models, are regularly reviewed against demand to ensure that our rotas support the numbers of patients attending at different times of the day.

It is correct that the data shows Weston as seeing slightly more patients per hour, as laid out below. Also shown below is the performance for the Jan and Feb 2022 as well as the whole year, and it is clear from this, that whilst performance is lower hoped, a higher percentage of patients attending Weston ED are being seen, treated and either admitted or discharged within 4 hours.

(Dashboard comparison stats have been provided to the governor who asked the question)

Status: Awaiting Governor Response

Handled by Rachel
05/23/2022 15:12:23

Meeting of the Board of Directors in Public on Friday 27 May 2022

Report Title	Proposed Changes to the Trust's Constitution
Report Author	Natashia Judge, Head of Corporate Governance
Executive Lead	Eric Sanders, Director of Corporate Governance

1. Report Summary

The report sets out two proposed changes to the Trust's Constitution for approval by the Trust Board and the Council of Governors.

2. Key points to note (Including decisions taken)

Background

One of the statutory duties of the Board of Directors and Council of Governors is to approve amendments to the Trust's Constitution. This was last updated following the Weston Merger in April 2020.

Key Points

Governors review the Constitution through the Membership and Constitution Focus Group and recommend changes to the Council of Governors and the Board for approval. At the last meeting on 11 March Governors were advised of an upcoming proposal to change the paragraphs regarding the signature of documents (*Standing Orders, Annex 6 of the Trust Constitution, Paragraph 9*). It was outlined that the proposed changes would have minimal impact on governors.

It is now also proposed that the Trust revise the composition of the Board of Directors (*paragraph 24*). The proposed changes are set out within the report.

The (current) Trust's constitution can be viewed in its entirety on the Trust website at <https://www.uhbw.nhs.uk/assets/1/20.04-uhbw-constitution.pdf>

Recommendation

Paragraph 40 of the Trust's constitution sets out the process for any required amendments and outlines that these may only be made if more than half of the Council of Governors vote to approve the amendments, as well as more than half of the Directors.

As a result, these changes are proposed to both the Trust Board and the Council of Governors on 27 May for their respective approval. Once authorised, NHSEI will be advised of the change.

3. Risks

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

There are no associated risks with this report.

4. Advice and Recommendations

(Support and Board/Committee decisions requested):

- This report is for **Approval**.

The Board is asked to approve the proposed changes to the Constitution as outlined in the report.

5. History of the paper

Please include details of where paper has previously been received – N/A

Proposed Changes to the Constitution

1. The composition of the Board of Directors (*paragraph 24*)

- 1.1. The first proposed change to the constitution is to the composition of the Board of Directors. The proposed change is to section 24.2.3 with an increase from 7 Executive Directors to 8. The rationale for the change is that the Trust may wish to expand the skills and experience of the Executive Directors to support the delivery of the strategy, for example through the appointment of an Executive Director with sole responsibility for Digital delivery. At present there is no scope to appoint an additional Executive Directors, which may impact on the ability to attract the best possible candidate to this role and to ensure that the Board is directly supported by Digital, or other, expertise.
- 1.2. The Board and Council of Governors should be cognizant of the good governance requirement, as recommended in the report titled "The Financial Aspects of Corporate Governance", commonly known as the Cadbury Report from 1992, which recommends that "the majority of non-executives on a board should be independent of the company." The proposal maintains that majority, with nine non-executives, including the chair, and eight executives.

Proposed version

24. Board of Directors – composition

24.1 The Trust has a Board of Directors, which comprises both Executive and Non-Executive Directors.

24.2 The Board of Directors comprises—

24.2.1 a Non-Executive Chairman,

24.2.2 up to 8 other Non-Executive Directors (one of whom may be nominated as the Senior Independent Director), and

24.2.3 up to 8 Executive Directors

24.3 One of the Executive Directors shall be the Chief Executive.

24.4 The Chief Executive shall be the Accounting Officer

24.5 One of the Executive Directors is the Finance Director

24.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)

24.7 One of the Executive Directors is to be a registered nurse or a registered midwife

24.8 The Board of Directors shall at all times be constituted so that the number of Non-Executive Directors (excluding the Chair) equals or exceeds the number of Executive Directors.

Hartles Rachel
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2. The signature of documents (*Standing Orders, Annex 6 for the Trust Constitution, Paragraph 9*)

- 2.1. The second proposed change to the standing orders is in order to support electronic signature of documents. The rationale for the change is to recognise that not all Deeds need to be signed under Seal, thus reducing the administrative burden on the Trust, and to support the electronic signature of documents, which will provide greater flexibility for document execution, and to support the Trust's sustainability ambitions to reduce the use of paper. The electronic system the Trust has procured will also provide an audit trail and support the secure storage of agreements, which will reduce the risks posed to the Trust.
- 2.2. The proposed wording has been drafted by the Trust's legal advisers, DAC Beacroft LLP, to ensure that the wording meets the legal duties on the Trust. For information, similar amendments are being proposed to the Board of North Bristol NHS Trust, to their Standing Orders, as a result of a joint project between the Secretariat teams of the two Trusts.

Proposed Version

10 SIGNATURE OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated Officer(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

10.3 Unless there is a requirement for sealing, the Chief Executive or nominated officers shall also be authorised, by resolution of the Board, to execute any agreement or other document (the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority) as a deed on behalf of the Trust by signing in the physical presence of an attesting witness. Before any deed relating to building, engineering, property, or capital is executed as a deed in this way, it must be approved and signed by the Finance Director (or an Officer nominated by him) and authorised and countersigned by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate).

10.4 Unless there is a specific requirement for a physical seal or wet ink signature, any signature under 10.1, 10.2 or 10.3 above may be provided in electronic form and shall not be invalid on this basis.

3. Recommendation

- 3.1. The Board is asked to approve the proposed changes to the Constitution as outlined in the report.

Hartley Rachel
 05/23/2022 15:12:23

We are
supportive
respectful
innovative
collaborative.
We are UHBW.