University Hospitals Bristol and Weston NHS Foundation Trust

December 2024 Published Papers

Including:

University Hospitals Bristol and Weston NHS Foundation Trust Quality and Performance Report

We have aligned our Patient First Priorities with our Quality and Performance Report and this report will now be presented slightly differently.

We are supportive respectful innovative collaborative. We are UHBW.

University Hospitals Bristol and Weston NHS Foundation Trust

Integrated Quality and Performance Report

Month of Publication November 2024
Data up to October 2024

Contents

Introduction: Delivering Our Strategy

A difference that matters is our Trust Strategy and is delivered though our Patient First approach.

The following report highlights our progress against delivering our strategic priorities.

The report also highlights how we are performing against our constitutional and key metrics.

Key to KPI Variation and Assurance Icons

Assurance						Variation				
P*	P	?	F	F-	No icon	H	L	C	H	L
Consistently Passing Target	Meeting or Passing Target for at least Six Months	Inconsistent Passing and Falling Short of Target	Falling Short of Target for at least Six Months	Consistently Falling Short of Target	No Assurance Icon as No Specified Target	Special Cause of Improving Variation due to Higher or Lower Values		Common Cause Variation - No Significant Change	Special Cause of Concerning Variation due to Higher or Lower Values	

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

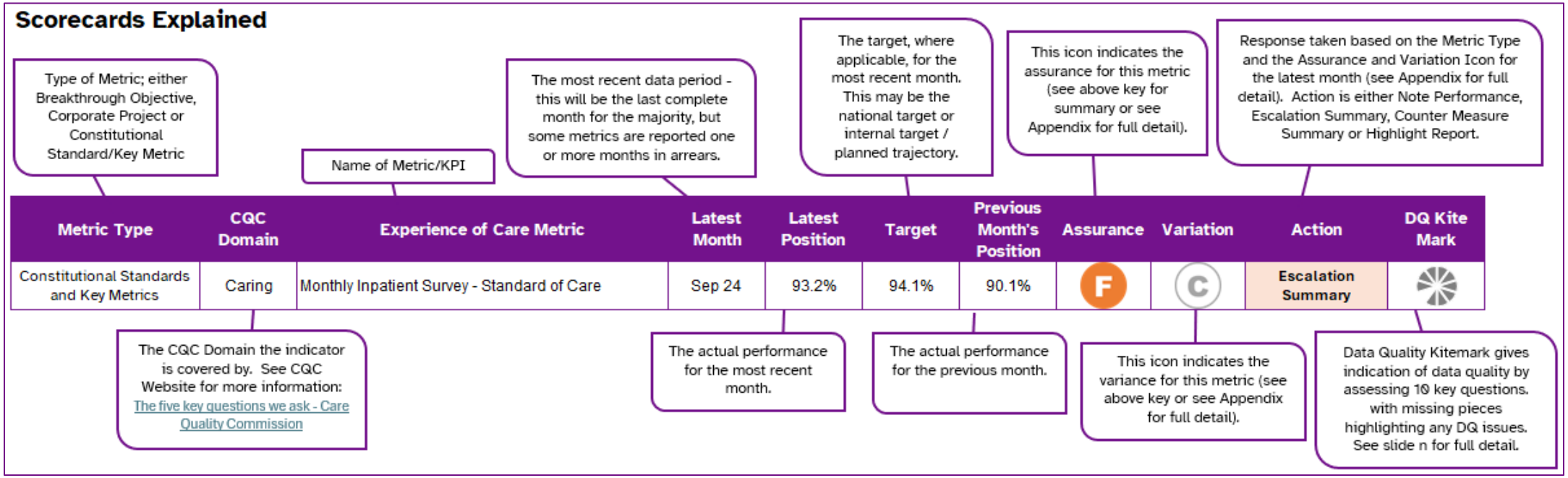
Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Escalation Rules: SPC charts for metrics are only included in the IQPR where the combination of icons for that metric has triggered a Business Rule – see Appendix for full detail.

Further Reading / Other Resources

The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link:
NHS England » Making data count

Scorecards Explained



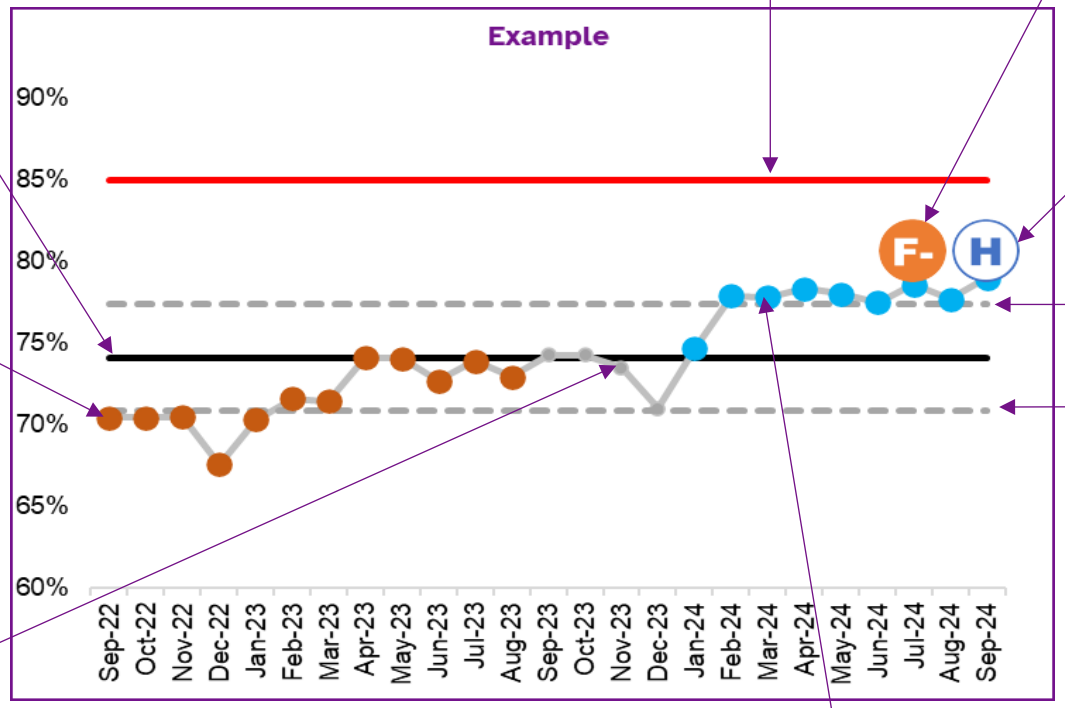
Statistical Process Control (SPC) Charts

Average line, the sum of all data points divided by the number of data points

Target line, this will influence the Assurance indicator

Assurance Icon

Variance Icon



Metric started with **Concerning Variation** due to consistent Low numbers

Upper and Lower Control Limits are a *standard deviation* above and below the average (black line). This is a measurement of statistical significance. A larger standard deviation (grey dotted lines further apart) indicates more variation in the data.

Metric then shifted to Common Cause due to **Unstable Variation** (highs and lows)

Now, Metric has **Improving Variation** due to consistent Higher than average results

Business Rules and Actions

Assurance						Variation			
P*	P	?	F	F-	No icon	H	L	C	H	L
Consistently Passing Target	Meeting or Passing Target for at least Six Months	Inconsistent Passing and Falling Short of Target	Falling Short of Target for at least Six Months	Consistently Falling Short of Target	No Assurance Icon as No Specified Target	Special Cause of Improving Variation due to Higher or Lower Values		Common Cause Variation - No Significant Change	Special Cause of Concerning Variation due to Higher or Lower Values	

SPC charts for metrics are only included in the IQPR where the combination of icons for that metric has triggered a Business Rule – see *Appendix* for full detail.

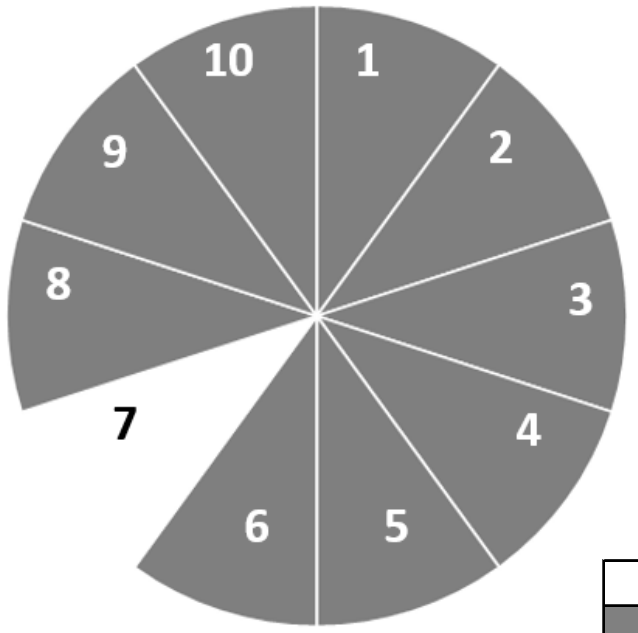
Metrics that fall into the **blue categories** above will be labelled as **Note Performance**. The SPC charts and accompanying narrative will not be included in this iteration.

Metrics that fall into the **orange categories** above will be labelled as **Counter Measure Summary** if they are a corporate project, or **Escalation Summary** if they are regulatory metrics.

Counter Measure Summary	Escalation Summary	Highlight Report
• Improvements to the Project. • Top Contributors and Key Risks. • Stratified Data. • Key Progress. • Further Actions needed.	• Summary of Metric Performance. • Further Actions Needed to Aid Performance. • Assurance and Timescales for Improvement.	• Provided for Strategic Priorities when project either not in the measurement stage, or metrics are in development.

Data Quality (DQ) Kitemark

A Kite Mark has been assigned to each metric in the report. This has been created by assessing the source system against relevant criteria listed below.
A point has been assigned for each of the criteria met. The maximum score is ten. There are ten segments in the Kite Mark image and the corresponding segments are shaded grey based on those that have been met.
The ordering of the criteria has been kept consistent so users can see which criteria are met/unmet.



Key	
	Yes
	No

Number	Question
1	Data electronically captured.
2	KPI definition documented.
3	Information processes documented
4	Data does not have significant proportion of missing values.
5	Data included in divisional reports.
6	Validation processes built into the system*
7	Data captured in a timely fashion (noting that different measures will work to different timescales)
8	Subject to audit and / or benchmarking
9	System training and SOPs in place.
10	Input from appropriate experts into collection/validation processes where required.

Executive Summary

Experience of Care:

UHBW and NBT are currently conducting a joint peer review of complaints handling structures, processes and performance measures, seeking to identify opportunities for closer alignment between the two Trusts as part of preparation for corporate enabler work to support the development of pathfinder single managed services in our new hospital Group.

The outpatient survey scores are consistently scoring >95% with patients indicating that their experience is very good. The Trust is making use of Dr Doctor to give patients the ability to manage their clinic appointment through the patient portal. This means for many patients they will be able to cancel, reschedule and book appointments directly through the Dr Doctor patient portal or NHS App.

Patient Safety:

The number of falls in October 2024 (175) is more than September 2024 (146) with a rate just above the target of 0.48 per 1,000 beddays. There were five falls with harm in October 2024, this is higher than the previous month (three) and above the improvement goal of two or fewer. Both charts are showing common cause variation. Information about quality improvement workstreams underway is provided in the relevant slide.

There was one event of a mixed sex breach which occurred in theatre recovery area in Bristol Royal Infirmary, affecting two patients. This is above the target of 0 and the chart is showing common cause variation. This is also a large reduction in the number of mixed sex breaches from previous months. Information about improvement workstreams relating to maximising bed availability is provided in the relevant slide.

A small but emerging theme of device related pressure injuries has been identified in October , with two of the pressure injuries this month being secondary to NIV or CPAP masks. A working group with input from Tissue Viability Nurses, Respiratory Physios has been set up as an action following the After- action Review (AAR) for the Category 3 device related injury. This group will be looking at NIV mask care plans to ensure parity across Bristol and Weston and procurement of under nose masks, not previously stocked in Weston.

There were eight Clostridioides Difficile cases for the month of October The cases are Hospital Onset Hospital Acquired (HOHA) with no Community Onset (CO) HA, this gives us a year-to-date total currently at 91 (61 HOHA and 30 COHA) against a target of 9.08. Improvement actions for clinical care delivery and in relation to the estate have been identified as detailed in this report.

There has been one apportioned case of Methicillin Resistant Staph Aureus bacteraemia's for the month of October. This now brings the Trust year to date total to six cases against a target of zero. Actions have been identified to increase the visibility of Infection Prevention & Control status on the ward view boards and to provide additional staff guidance for the screening and management of MRSA in ward areas, details outlined in the relevant slide.

Executive Summary

Patient Safety (continued):

October in Maternity has been UHBWs busiest month of 2024 so far, both in terms of new maternity bookings (446), triage attendances (609), and births (409). New triage process (allocation of two midwives) launched in late September has seen an immediate and significant improvement in length of time patients are waiting before their initial review.

Bristol sites: Fracture Neck of Femur Best Practice Tariff (BPT) achievement was 15% for October 2024 this was due to only four out of 26 patients undergoing surgery within 36 hours. Theatre capacity is being actively monitored and prioritised on a weekly basis across all specialties. At Weston 19/21 - 90% met all the requirements for BPT in October 2024.

Our People:

Overall vacancies reduced to 2.3% (292.2 FTE) compared to 3.2% in the previous month. Turnover reduced to 11.1% compared to 11.4% the previous month. Sickness absence increased to 4.7% compared to 4.2% in the previous month.

Appraisal compliance increased to 79.9% compared to 79.7% in September, with increases in 7 divisions. In response to Staff Survey feedback, to improve compliance and quality of appraisal, a programme of work has been in place to identify the root causes aligned to the A3 thinking Patient First approach. An anonymous quality of appraisal feedback form was launched which has seen positive reviews and feedback on the appraisal form process and quality of the conversation.

Statutory and Mandatory training has remained unchanged at 90.7%.

Agency usage remains at 0.6% (78.1 FTE) against a target of 1% maximum. It remains a priority focus area as reflected in the Patient First Corporate Projects, with increased focus on reducing medical usage.

Executive Summary

Timely Care:

Bed occupancy remains high in October (BRI: 107.2% and Weston 99.1%) which, when coupled with high non-elective demand, continues to impact non-elective services, although good progress has been noted against a number of performance measures.

At the end of October, the Trust reported 57 patients waiting more than 65 weeks for treatment , an improvement from the end of September (73x 65ww). The Trust have met with NHSE to describe the current challenges within Orthodontics; the only specialty exceeding our 65ww elimination commitment. NB: cornea graft dispensation remains. In terms of Orthodontic elimination forecast, this remains subject to further work in partnership with NHSE.

All three core cancer waiting times standards were met during September, maintaining the performance reported across 2024/25 which is anticipated to continue through the remaining months of the year.

In October, performance against the diagnostic six week wait standard was reported as 86.2% against the operational planning trajectory of 91.1%, an improvement from September (83.3%). The impact of diagnostic recovery plans in train are currently under review to ensure year-end delivery.

Performance against the ED 4-hour standard in October dropped slightly to 66.4% (September, 68.7%). When combined with the system type-3 footprint this increases to 73.3% for October (75.4% YTD) against a system and NHSE ambition of 78%.

During October, the average daily number of patients in hospital with No Criteria to Reside (NCtR) had increased to 191 (171 in September), this equates to 21.9% of total available beds (19.4% September).

Our Resources:

The Trust's net income and expenditure position at the end of October is a deficit of £6.4m against a break-even plan. The net deficit is 0.9% of total operating income. The adverse position against plan of £6.4m is primarily due to the shortfall on the delivery of savings and elective inpatient activity not achieving planned levels, offset by planned corporate mitigations.

Year to date, the Trust delivered savings of £16.5m, £7.2m behind plan. The year-end forecast for savings delivery is £32.5m with £26.8m on a recurring basis, against a target of £41.2m.

The value of elective activity for outpatient, day case and inpatient delivery points improved by £0.6m to £3.4m behind plan year to date.

The Trust delivered capital investment of £13.3m year to date against a plan of £21.2m.

The Trust's cash position was £88.1m as at the 31st October 2024, £7.5m higher than plan.

Matrix Summary – Constitutional Standards and Key Metrics

Assurance

Variance		October 2024	P* Consistently Passing target (target outside control limits)	P Passing target	? Passing and Falling short of target subject to random variation	F Falling short of target	F- Consistently Falling short of target (target outside control limits)	No icon No Target
H	L	Special Cause - Improvement	•Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	•Cancer - 28 Day Faster Diagnosis •Cancer 62 Day Referral To Treatment •Staffing Fill Rate - Combined	•ED Percentage Spending Over12 Hours in Department •Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours		•Diagnostics Percentage Under 6 Weeks (15 Key Tests) •Outpatient DNA Rate •Theatres - Touchtime Utilisation	
C		Common Cause	•Pressure Injuries Per 1,000 Beddays •Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	•Essential Training Compliance •Friends and Family Test Score - ED •Hospital Standardised Mortality Ratio (HSMR) •Percentage Agency Usage •Sickness Rate •Workforce Turnover Rate	•Cancer - 31 Day Diagnosis To Treatment •CDiff Healthcare Associated Cases •ED Percentage Spending Under 4 Hours in Department •Falls Per 1,000 Beddays •Informal Complaints Responded To Within Trust Timeframe •Monthly Outpatient Survey - Overall Experience •Total Number of Patient Falls Resulting in Harm	•Formal Complaints Responded To Within Trust Timeframe •Last Minute Cancelled Operations - Percentage of Admissions •Mixed Sex Accommodation Breaches •Monthly Inpatient Survey - Overall Experience •MRSA Hospital Onset Cases •Pressure Injuries - Grade 3 or 4	•Fracture Neck of Femur Patients Treated Within 36 Hours •Inpatient Communication Experience Score •Median Discharge Time •No Criteria To Reside Occupancy •Workforce Appraisal Compliance (Non-Consultant)	•ED 12 Hour Trolley Waits •ED Attendances (Trust Total) •Fracture Neck of Femur Patients Achieving Best Practice Tariff •Patient Complaints - Formal
H	L	Special Cause - Concern					•Adult Inpatients who Received a VTE Risk Assessment •No Criteria To Reside - Beds Occupied	
n/a		Not SPC - Run Chart Only		•Total RTT Pathways 52+ Weeks		•Total RTT Pathways 65+ Weeks		

Experience of Care

Experience of Care

Our Vision

Together, we will deliver person-centred, compassionate and inclusive care every time, for everyone.

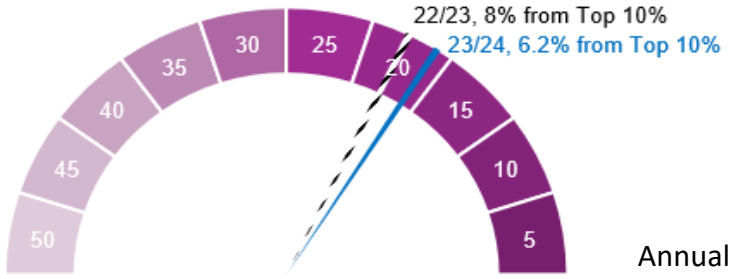
Our Goal

We will be in the top 10% of NHS organisations for providing an outstanding experience for all our patients as reported by them and as recognised by our staff.

Turning the Dial

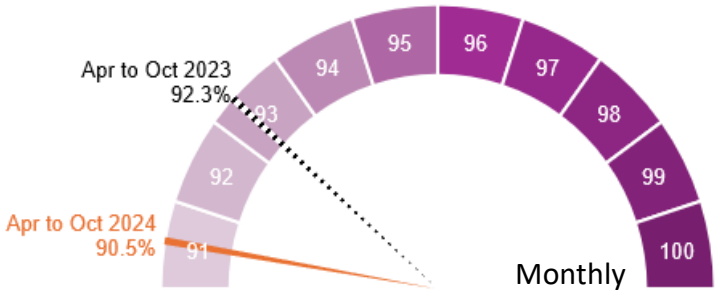
Vision Metrics

To be in top 10% of non-specialist acute Trusts for 'staff recommend this organisation for treatment of a friend or relative'



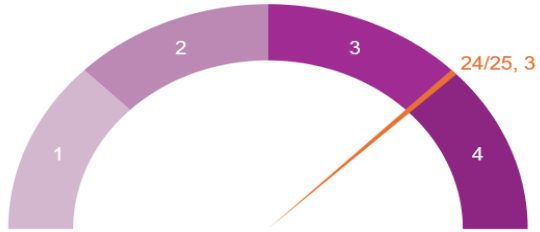
Annual

≥98% of inpatients and maternity will rate their care as good or above (2024/25 Target – 94.1%)



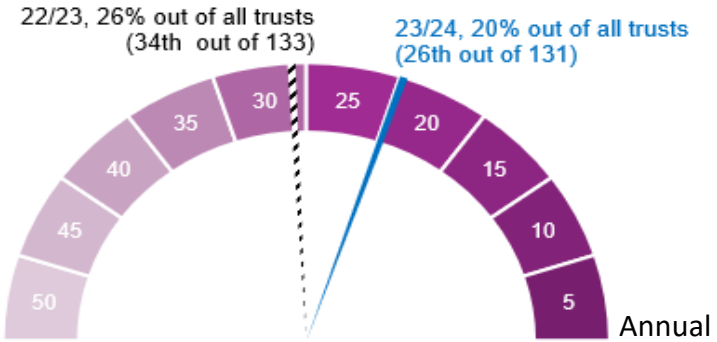
Monthly

Feedback is representative of the patients we care for by undertaking a minimum of 4 community outreach events per year aligned to the Core20Plus5 health inequality areas



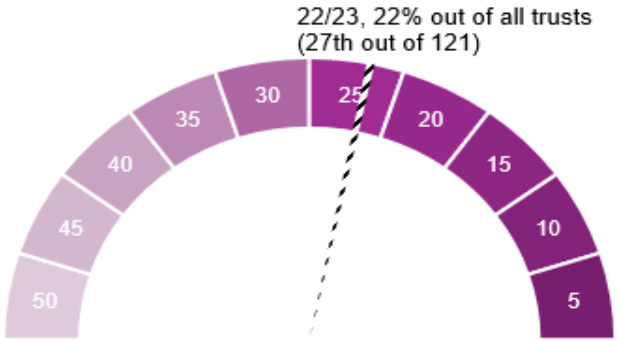
Monthly

To be in top 10% of non-specialist acute Trusts for overall patient experience in national **inpatient** survey



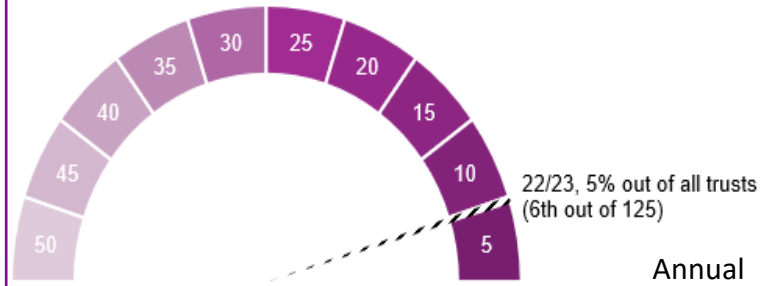
Annual

To be in top 10% of non-specialist acute Trusts for overall patient experience in national **maternity** survey



Annual

To be in top 10% of non-specialist acute Trusts for overall patient experience in national **child and young person** survey



Annual

Experience of Care

Scorecard

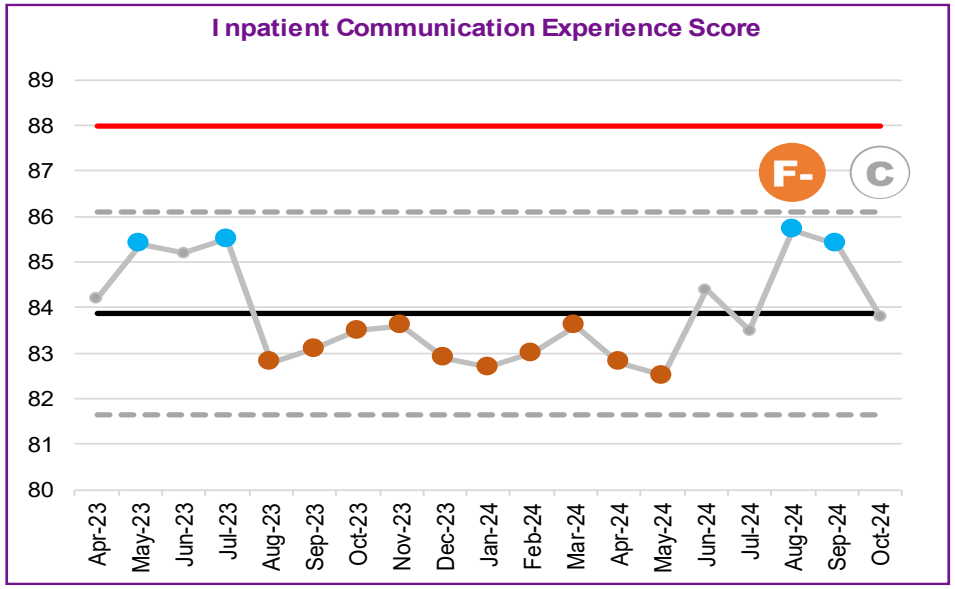
Metric Type	CQC Domain	Experience of Care Metric	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action	DQ Kite Mark
Corporate Project*	Caring	Mental Health across UHBW	Project in Development							
Breakthrough Objective*	Caring	Inpatient Communication Experience Score	Oct 24	83.8	88.0	85.4	F-	C	Counter Measure Summary	
Constitutional Standards and Key Metrics	Caring	Monthly Inpatient Survey - Overall Experience	Oct 24	90.5%	94.1%	93.1%	F	C	Escalation Summary	
	Caring	Monthly Outpatient Survey - Overall Experience	Oct 24	98.1%	97.5%	95.0%	?	C	Escalation Summary	
	Caring	Friends and Family Test Score - ED	Oct 24	86.1%	85.0%	88.8%	P	C	Note Performance	
	Caring	Patient Complaints - Formal	Sep 24	26	No Target	32	n/a	C	Note Performance	
	Caring	Formal Complaints Responded To Within Trust Timeframe	Sep 24	73.0%	85.0%	51.0%	F	C	Escalation Summary	
	Caring	Informal Complaints Responded To Within Trust Timeframe	Sep 24	91.5%	85.0%	96.2%	?	C	Escalation Summary	

*Strategic Priority

Assurance						Variation			
P*	P	?	F	F-	No icon	H	L	C	H	L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation		Common Cause (natural) Variation	Concerning Variation	

Experience of Care

Monthly Inpatient Survey - Communication Counter Measure Summary



Inpatient Communication Experience Score

Latest Month

Oct-24

Target

88.00

Latest Month's Position

83.8

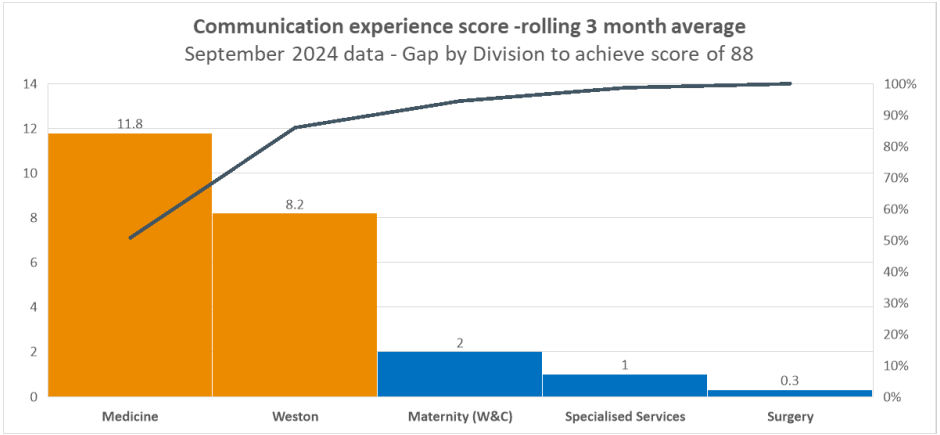
Performance /

Common Cause (natural/expected) variation, where target is greater than upper limit and down is deterioration.

Risk

Principle Related Risk: 1. Quality

Stratified data



Note: Bristol Royal Hospital for Children scored 88 in September 2024

Improvement work in progress

Breakthrough Objective:

Improve Experience of care through better communication

Project: On track

Divisional priority project for:

- Medicine
- Specialised Services
- Weston

Top contributors to addressed

- Limited resources around communication needs
- Communication needs differ between patient demographics
- Lack of communication training
- Note: A3 thinking continues to identify specific contributors on ward areas

Key Risks to achieving improvement

- Improvement in participating wards alone will not turn the dial sufficiently to achieve Trust-wide target

Key progress

•Amended Trust-wide metric from rolling 3 months to single month reporting to improve data specificity
•Bristol Heart Institute (BHI) ward average exceeds communication experience target
•Specialised Services created Handover SOP to improve communication
•Improvement in 3 lowest scoring wards at Weston and Uphill recent implementation of What Matters To You (WTMY)
•Hospital communication booklet shared digitally with all inpatient wards in Division of Medicine.
•Action plan created for A801 as a result of staff survey

Next actions

•Specialised Services leads attending journal club for junior medics education around WMTY and commence communication workshops for BHI staff
•Weston focus on remaining wards where Patient Feedback Hub data demonstrates poorer scores and monthly 'Back to Floor' will focus on improving processes for meeting specific communication needs
•Ensure there is an "Experience of Care champion" for each ward and department in Division of Medicine
•Collaboration with Medicine Quality and Patient Safety Team with Communication experience focus.

Experience of Care

Monthly Inpatient and Outpatient Survey – Overall Experience Escalation Summary

Monthly Inpatient Survey – Overall Experience

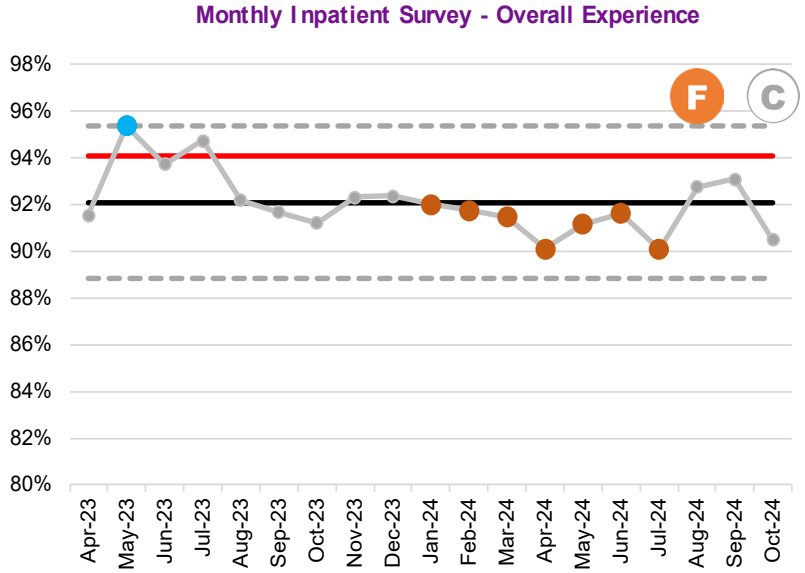
Latest Month
Oct-24

Target
94.1%

Latest Month's Position
90.5%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration.

Risk
No risk in current Board Assurance Framework



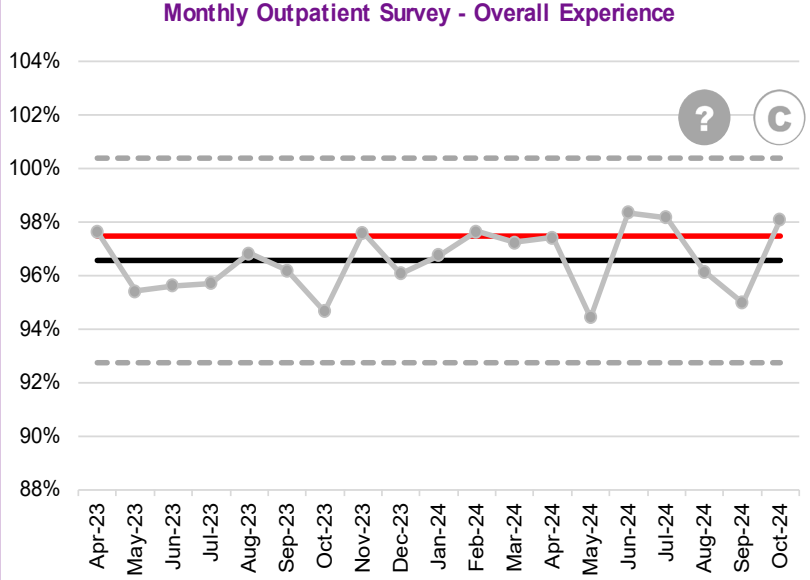
Summary

Improving inpatient experience is a Patient First priority. The breakthrough objective focuses on improving communication between patients and staff because we know this is the biggest driver of overall inpatient experience.

Year one delivery of the Experience of Care Strategy 2024-2029 is underway and focuses on improvements to experience on the patient journey and across the life course. It is expected that delivery of the strategy goals and milestones will support an improvement towards target for this metric.

Actions;
- Continue to deliver breakthrough objective to improve communication experience
- Continue to deliver year one of Experience of Care Strategy

Monthly Outpatient Survey – Overall Experience



Latest Month
Oct-24

Target
97.5%

Latest Month's Position
98.1%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Risk
No risk in current Board Assurance Framework

Summary

The outpatient survey scores are consistently scoring >95% with relatively few patients indicating that their experience is less than good or very good. From previous analysis of survey results, patients are generally satisfied with their clinic experience on the day. However, there are opportunities for improvement associated with how responsive the Trust's administrative functions are to patients' phone calls.

Actions:
In the short term, the Trust is making use of Dr Doctor to give patients the ability to manage their clinic appointment through the patient portal. This means for many patients they will be able to cancel, reschedule and book appointments directly through the Dr Doctor patient portal or NHS App.

In the longer term, the Trust has established the Outpatients 2025 task and finish group, to consider how best to improve the responsiveness of our services. The group is considering our telephony systems, our administrative staffing model and the scope to utilise technology to improve patient experience.

Experience of Care

Patient Complaints - Responses Escalation Summary

Formal Complaints Responded To Within Trust Timeframe

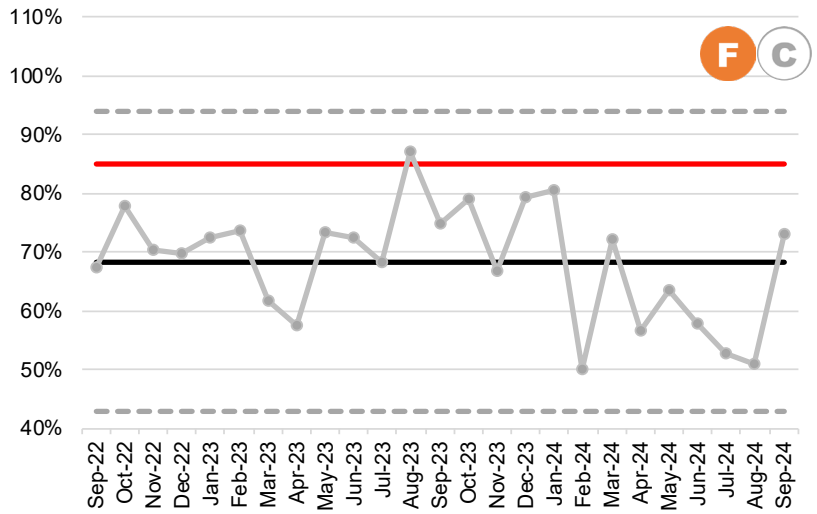
Latest Month
Sep-24

Target
85%

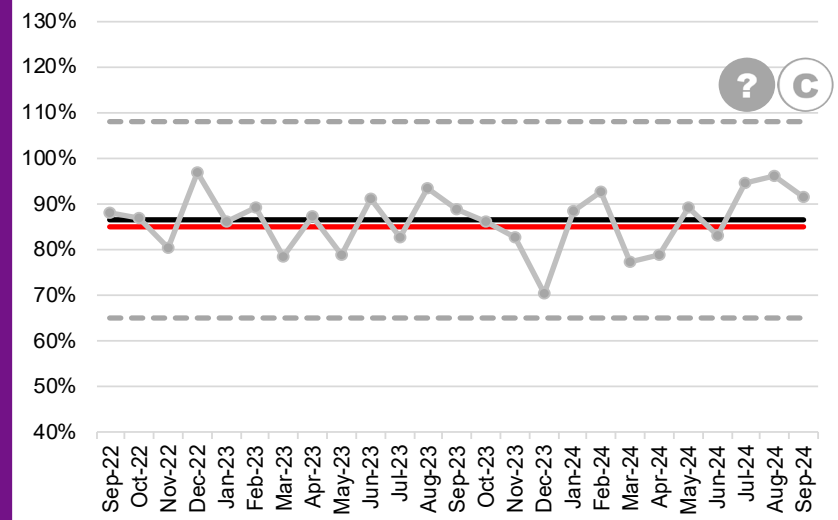
Latest Month's Position
73.0%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration.

Risk
Corporate Risk 2680 - Complainants experience a delay in receiving a call back (12)



Informal Complaints Responded To Within Trust Timeframe



Latest Month
Sep-24

Target
85%

Latest Month's Position
91.5%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Risk
Corporate Risk 2680 - Complainants experience a delay in receiving a call back (12)

Summary

The Trust's performance in timely handling of informal complaints had been above target throughout Quarter 2 of 2024/25.

The majority of complaints received by the Trust are handled via the informal resolution process. The remaining complaints, handled by formal resolution, are increasingly complex, sometimes requiring extended time for investigations to be completed.

September performance for formal resolution recovered to above the mean. Performance is currently measured from the point in time when complaints are sent to divisions for investigation. UHBW and NBT are currently conducting a joint peer review of complaints handling structures, processes and performance measures, seeking to identify opportunities for closer alignment between the two Trusts as part of preparation for corporate enabler work to support the development of pathfinder single managed services in our new hospital Group.

Patient Safety

Patient Safety

Our Vision

Together, we will consistently deliver the highest quality, safe and effective care to all our patients.

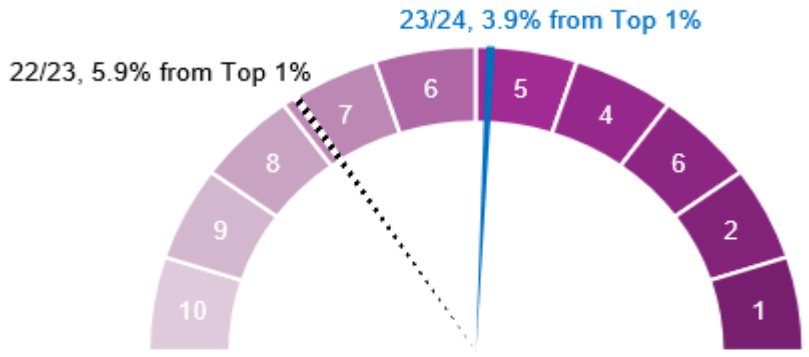
Our Goal

Building on the many things we do well to keep our patients safe, we will continue to develop a 'no blame' and 'just' culture and make improvements to how care is delivered to make it even safer for patients.

Turning the Dial

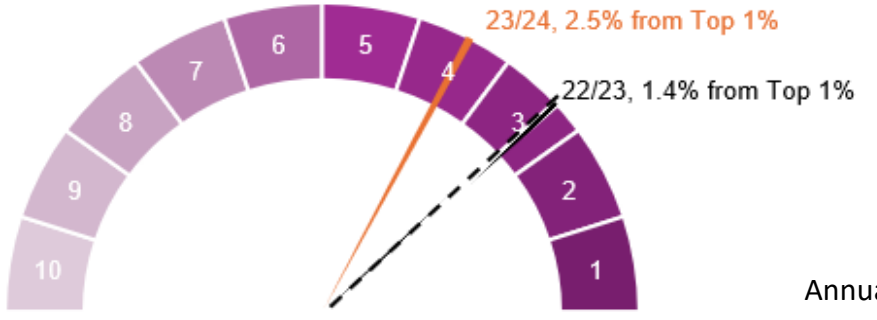
Vision Metrics

To be within 1% of the best non specialist acute Trust for staff involved in error/near miss/incident treated fairly



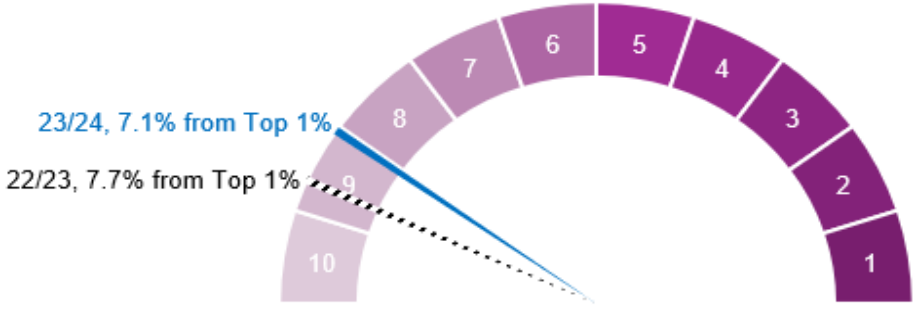
Annual

To be within 1% of the best non specialist acute Trust for encourages us to report errors, near misses or incidents



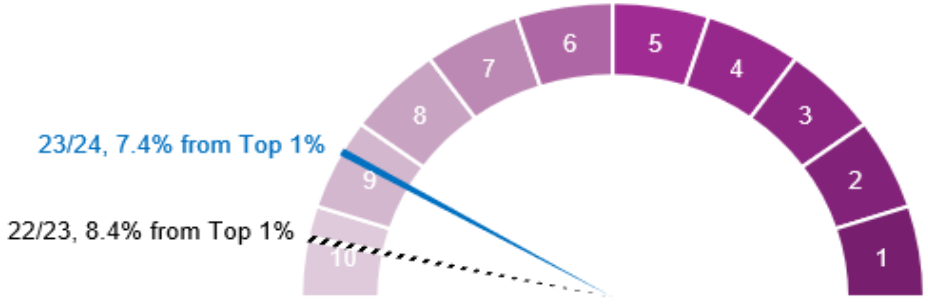
Annual

To be within 1% of the best non specialist acute Trust for ensure errors/near misses/incidents do not repeat



Annual

To be within 1% of the best non specialist acute Trust for feedback given on changes made following errors/near misses/incidents



Annual

Patient Safety

Scorecard

Metric Type	CQC Domain	Patient Safety Metric	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action	DQ Kite Mark
Corporate Project*	Safe	Deteriorating Patient - Adult Care Settings	**Highlight Report Provided**							
	Safe	Implementation of Martha's rule	**Highlight Report Provided**							
	Safe	Careflow Medicines Management	**Highlight Report Provided**							

***Strategic Priority**

Assurance						Variation		
P*	P	?	F	F-	No icon	H L	C	H L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation	Common Cause (natural) Variation	Concerning Variation

Patient Safety

Scorecard

Metric Type	CQC Domain	Patient Safety Metric	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action	DQ Kite Mark
Constitutional Standards and Key Metrics	Safe	Falls Per 1,000 Beddays	Oct 24	5.0	4.8	4.4	?	C	Escalation Summary	
	Safe	Total Number of Patient Falls Resulting in Harm	Oct 24	5	2	3	?	C	Escalation Summary	
	Safe	CDiff Healthcare Associated Cases	Oct 24	8	9	13	?	C	Escalation Summary	
	Safe	MRSA Hospital Onset Cases	Oct 24	1	0	3	F	C	Escalation Summary	
	Safe	Staffing Fill Rate - Combined	Oct 24	103%	100%	102%	P	H	Note Performance	
	Safe	Adult Inpatients who Received a VTE Risk Assessment	Oct 24	76%	90%	76%	F-	L	Escalation Summary	
	Safe	Pressure Injuries Per 1,000 Beddays	Oct 24	0.20	0.40	0.00	P*	C	Note Performance	
	Safe	Pressure Injuries - Grade 3 or 4	Oct 24	2	0	0	F	C	Escalation Summary	
	Effective	Mixed Sex Accommodation Breaches	Oct 24	2	0	18	F	C	Escalation Summary	
	Effective	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	Jun 24	93.0	100	93.5	P*	L	Note Performance	
	Effective	Hospital Standardised Mortality Ratio (HSMR)	Jul 24	77.2	100	97.2	P	C	Note Performance	
	Effective	Fracture Neck of Femur Patients Treated Within 36 Hours	Oct 24	49%	90%	20%	F-	C	Escalation Summary	TBC
	Effective	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	Oct 24	100%	90%	100%	?	H	Note Performance	TBC
	Effective	Fracture Neck of Femur Patients Achieving Best Practice Tariff	Oct 24	49%	No Target	20%	n/a	C	Note Performance	TBC
	Effective	Maternity Services Perinatal Quality Surveillance Matrix (PQSM)	Oct 24	n/a	n/a	n/a	n/a	n/a	Narrative	n/a

Assurance						Variation			
P*	P	?	F	F-	No icon	H L	C	H L	
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation	Common Cause (natural) Variation	Concerning Variation	

Patient Safety

Deteriorating Patient – Adult Care Settings Highlight Report

Our 12 to 18 month goal: Deteriorating Patient – Adult Care Settings

Increase effective and timely recognition, escalation and response of potentially deteriorating patients, including the recognition of sepsis by March 2025.

Latest Month	November 2024
Project status	**Project timeline on track**
Related Principle Risk	1. Quality

Key progress in last month

- On-going floor walking in September to engage with clinical staff to further embed the new Sepsis Screening Tool and Pathway in clinical practice.
- The new "Recognition, Treatment, and Management of Sepsis" standard operating procedure based on the 2024 NICE Guidance has been approved and published on MyStaff app.
- August sepsis data collection onwards is based on new triggers for sepsis screening in the 2024 NICE Guidance. Sepsis data is now visible to the Divisions.
- The Patient Safety Improvement Team are working with BRI and Weston Emergency Departments (ED) to support sepsis data collection (EDs have commenced own auditing processes) and test change ideas to improve timeliness of screening and treatment for patients at high risk of sepsis.
- The sepsis data is being used to support the wider Escalation and Response A3 thinking project.

Key aims for next month

- Identify improvement priorities for Escalation and Response.
- Monitor data from August 2024 in anticipation of fluctuation in compliance with audit standards due to change with NICE Guidance.

High Level Roadmap

- August 2024 – implementation of Sepsis NICE 2024 guidance.

Key risks and challenges

- Substantial resource required for process of data collection (manual audit).
- Reduced capacity of the Patient Safety Improvement Team resulting in an inability to maintain progression and delivery of projects.
- Vitals 4.3 upgrade is delayed; therefore, there is an inability to optimise the system to offer improved functionality as an enabler to recording clinical observations of deteriorating patients (e.g., Sepsis NICE, Maternity Early Warning Score (MEWS).
- CareFlow Vitals Sepsis NICE module (aligned to 2024 NICE update) not available until 2026.
- Risk that data publication for reporting and escalation purposes is not timely and impedes ability to identify opportunities for improvement.
- Risk that lack of UHBW Sepsis Lead limits effective adoption of 2024 NICE Sepsis Guidance

Overall project achievements /Impact achieved

- Between August – September 2024, 250 patients were sampled across adult inpatient areas and ED. 106 patients required screening for sepsis; of these, 19 (18%) had documented evidence of sepsis screening (on UBHW tool, based on 2024 NICE guidance).
- 40 of the 106 patients (who required screening) were identified as ‘high risk’ of having or developing sepsis and required the delivery of the Sepsis Six; of these, 7 (17.5%) patients had documented evidence of the delivery of the Sepsis Six (on UHBW tool, based on 2024 NICE guidance).

Patient Safety

Implementation of Martha's Rule Highlight Report

Our 12 to 18 month goal: Implementation of Martha's Rule

To implement:

- an accessible and inclusive system across UHBW and NBT for patients, families, carers and advocates to access a 24/7 rapid review from a critical care outreach team
- a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily.

Latest Month	November 2024
Project status	**Project timeline off track**
Related Principle Risk	1. Quality

Key progress in last month

- The Clinical Lead for Martha's Rule for BRI site and Weston started in post November 2024
- The Improvement Lead Role has been recruited to and the staff member starts on 9th December 2024.
- We started submitting data to NHSE -(initially minimal for adult areas)
- Attended learning events: Gloucestershire Hospitals (pilot site), Health Innovation West of England Community of Practice.

Key aims for next month

- Agree measurement strategy
- Develop communications plan
- Identify patients/families/lay partners to be involved in co-design of an inclusive and accessible process and resources that works best for them.
- Set up two x sub-groups to develop and test processes related to the two aims
- Brief and identify support for newly identified ward staff (Medicine and Specialised Services so far) to participate in the implementation of Martha's Rule in adult areas Bristol/Weston

High Level Roadmap

- Engage stakeholders including patient, family and community representatives
- Interrogate existing data and agree measurement strategy
- Identify test areas and testing strategy
- Develop, test and iterate process for 24/7 receiving and responding to Martha's Rule calls and Critical Care Outreach Team review of patients.
- Develop, test and iterate structured process for documented daily wellness conversations with patients/families.
- Develop communications resources
- Spread, adapt/adopt and embed.

Key risks and challenges

- Capacity to deliver at pace until fixed term roles recruited to.
- Capacity for divisions to engage with this project in addition to the other Patient First Projects.
- Risk that pressure to deliver results in a process that has not been co-designed and sufficiently tested or has unintended consequences of increasing rather than reducing inequitable access.
- Volume of NHSE data requirements results in a focus on collecting data rather than delivering project aims

Overall project achievements and impact

- To be added as project progresses

Patient Safety

Careflow Medicine Management (CMM) Highlight Report

Our 12 to 18 month goal: Careflow Medicine Management

Improve patient care and reduce the risk to patients relating to the prescription of medicines through implementation of an electronic prescribing module within the Careflow PAS for use within the inpatient hospital bed base.

Latest Month	November 2024
Project status	**Project timeline off track**
Related Principle Risk	1. Quality

Key progress in last month

- Formal sign off new project plan and timeframe at CMM Programme Board (11th November). Board ran over time, decision out of committee has been requested for formal approval by the 18th November.
- Process Mapping/Standard operating procedures (SOP) – Additional sessions held gaps and mitigations work progressed risk removed around impact on future workstreams such as testing and training. Development of SOPs where mitigation approval received.
- Clinical Configuration – Continue with final clinical configuration in Live system. Outputs of mitigations and testing to be reviewed to ensure system is configured with any additional requirements.
- Training – Gain approval for superuser training strategy from CMM Programme Board. Update material with any outputs from testing. Expected on the 18th November.
- Testing – User Acceptance Testing Cycle 2 has been re-scheduled, 02/12/24 to the 13/12/24.
- Go Live Planning – Ongoing development of go live plans with Divisions.
- Business Continuity Plan (BCP)/Business As Usual (BAU) – Resilience hardware testing to be rescheduled. BCP workstream lead to be agreed.
- Comms – CMM animation to be finalised. Talking heads video and further stakeholder engagement sessions to be scheduled for the new year now the project has a firm date.
- Technical/Hardware – Install additional hardware in all Intensive Care Units (ICU). Review output of hardware survey and potential funding presented to the board further hardware review closer to go live to be done as part of assurance work.
- Clinical Safety – Finalised and approve (formal approval on the 18th Nov) clinical risk management plan. Hazard workshops have been rescheduled and have now started formally and will run into February 2025.

Key aims for next month

- Process Mapping/SOPs – team to continue to progress mapping and SOP work
- Clinical Configuration – Continue with final clinical configuration in Live system. Outputs of mitigations and testing to be reviewed to ensure system is configured with any additional requirements
- Training – progress training workstream critical path items based upon option chosen by CMM board
- Testing – produce testing report and resolve any issues uncovered as part of test cycles
- Go Live Planning – Ongoing development of go live plans with Divisions
- BCP/BAU – Resilience hardware testing to be rescheduled. BCP workstream lead to be agreed
- Comms – Comms plan to be produced and stakeholder engagement sessions to be scheduled
- Technical/Hardware – continue to deploy additionally identified hardware
- Clinical Safety – Hazard workshops to be progressed
- Continue to build confidence in the project and the business
- Continue to improve the governance and control mechanisms to bring the project back on track

High Level Roadmap

- Project replanning in progress. Metrics to be redeveloped in line with new plan and go live date, once agreed.

Key risks and challenges

- Collaborative replanning of the project is underway between Digital Services and all Divisions. This will extend the project timeframe into 2025. Confidence building in the teams and the business to deliver

Overall project achievements /Impact achieved

- Stronger governance, leading to stability, and confidence in the project, teams and the business in delivering CMM safely on time and on budget. work still to be done but the project is heading in the correct direction.

Patient Safety

Harm Free Care – Inpatient Falls Escalation Summary

Falls Per 1,000 Bed days

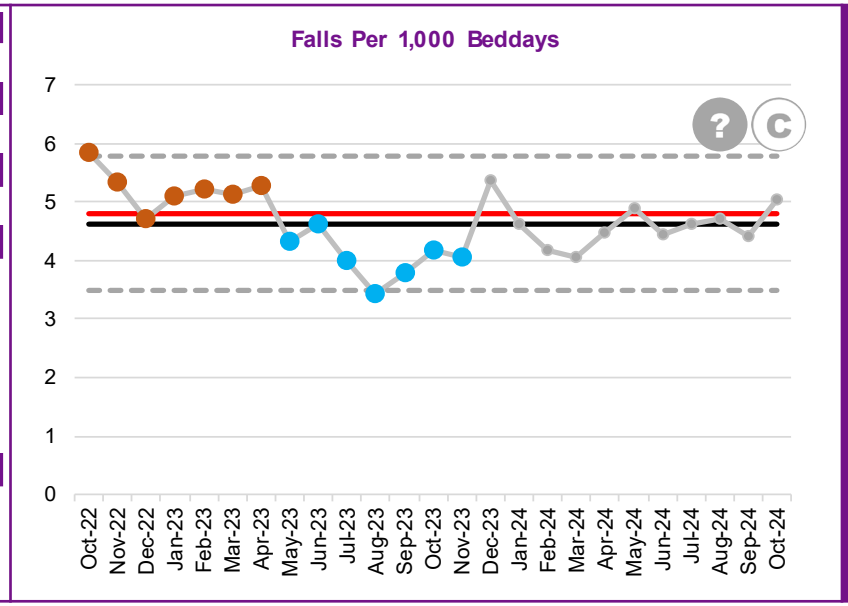
Latest Month
Oct-24

Target
4.8

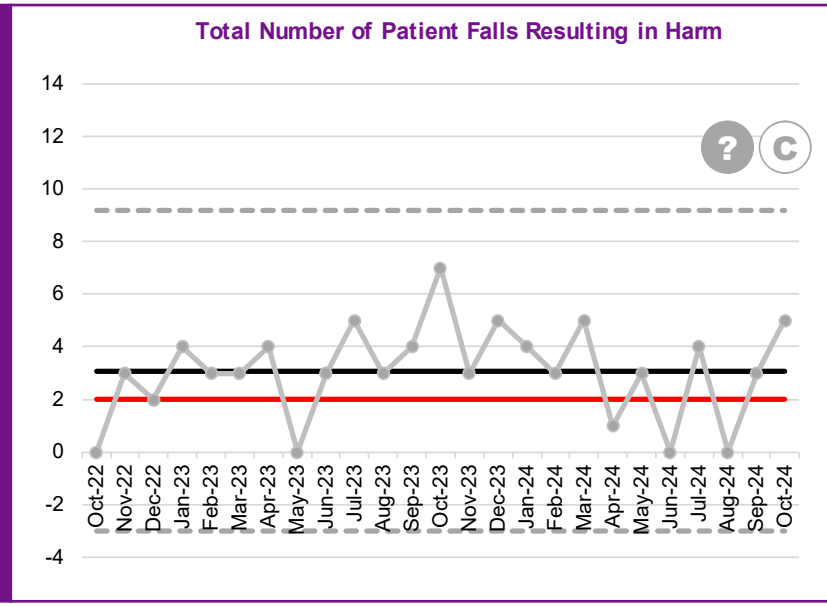
Latest Month's Position
5.0

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Risk
Corporate Risk 1598 - Patients suffer harm or injury from preventable falls (12)



Total Number of Patient Falls Resulting in Harm



Latest Month
Oct-24

Target
2

Latest Month's Position
5

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Risk
Corporate Risk 1598 - Patients suffer harm or injury from preventable falls (12)

Summary

During October 2024: There have been 175 falls, which per 1000 bed days equates to 5.051, this is above the trust target of 4.8 per 1000 bed days. There were 122 falls at the Bristol site and 53 falls at the Weston site. There has been 5 falls with moderate, severe or fatal harm.

The number of falls in October 2024 (175) is more than September 2024 (146). There are five falls with harm in October 2024, this is higher than the previous month (3). Risk of falls continues to remain on the divisions' risk registers as well as the Trust risk register.

Actions:

Steering group: The Dementia Delirium and Falls steering group continues to meet monthly. In October the divisions of surgery and medicine provided an update, including patient stories and shared learning. Medicine division presented a thematic review of falls with harm with actions identified. Update of actions to be discussed at steering group in January 2025.

Dementia, Delirium and Falls Team (DDF): The DDF team are participating in the National Audit of Inpatient Falls. The DDF team are leading on three Quality Improvement projects: 1. Reviewed and updated Multi Factorial Risk Assessment document to help improve completion and use of the document. Updated document is available on My Staff App. The Team are providing education support across the trust for increasing awareness of completing the MFRA. Re audit use of MFRA scheduled for January 2025. 2. The Multi Factorial Risk Assessment document has been reviewed and updated to embed Personalisation, Prediction, Prevention and Participation in falls prevention and management across the trust. 3. Improving mobilisation and preventing deconditioning in hospitals. The Dementia Garden Project is embedded in BRI and Weston hospital sites. The aim of the Dementia garden project is to promote activity, engagement and wellbeing and improve patient experience.

Training: The DDF Steering Group provides an Education Component. Bitesize education sessions are delivered to the group on relevant topics. The DDF team continue to deliver 'in-place' and simulation-based training for staff across the trust.

Patient Safety

Infection Control – C.Difficile and MRSA Escalation Summary

C.Difficile Healthcare Associated Cases

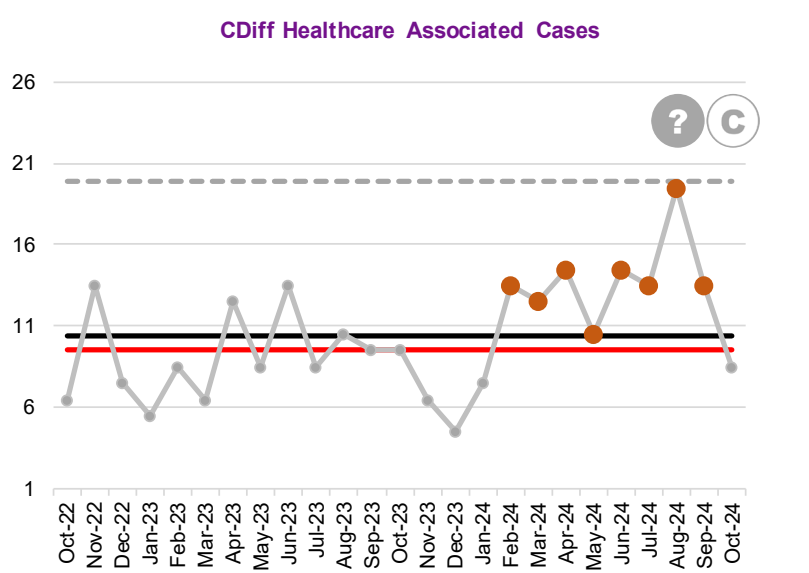
Latest Month
Oct-24

Target
9.08

Latest Month's Position
8

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Risk
No risk in current Board Assurance Framework

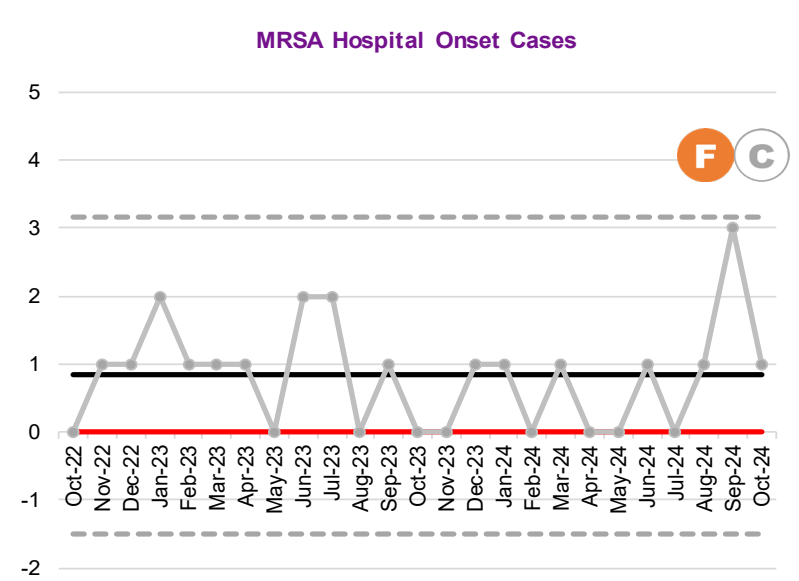


Summary

Clostridioides Difficile cases for the month of October are eight. The cases are Hospital Onset Hospital Acquired (HOHA) with no Community Onset (CO) HA, this gives us a year-to-date total currently at 91 (61 HOHA and 30 COHA).

The C-Diff quality improvement group chaired by the Director of Nursing for Weston General Hospital, with the support of the Continuous Improvement Team and Infection Prevention & Control are collaborating on the cross Divisional working group for C Diff. The diagnostic phase is 'coming to a close'. There are some areas for improvement in terms of actions for clinical care delivery but also in relation to the estate.

MRSA Hospital Onset Cases



Latest Month
Oct-24

Target
0

Latest Month's Position
1

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration.

Risk
Corporate Risk 6013 - Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia's (12)

Summary

There has been one apportioned case of Methicillin Resistant Staph Aureus bacteraemia's for the month of October. This now brings the Trust year to date total to six cases.

The MRSA Quality Improvement Group is chaired by the Director of Nursing for Surgery, with the support of the Continuous Improvement Team and Infection Prevention & Control is a collaborative cross-divisional working group for MRSA Quality Improvement (QI). The diagnostic phase is 'coming to a close' some "Just Do It" and "quick wins" have been identified. The short-term actions are:

1. Delivery of a simplified and updated MRSA management pathway document with ward-based updates
2. Updated simplified prompt guide for the 'right MRSA patient to screen' supported by ward- based training updates
3. Updated and simplified 'How to decolonise' an MRSA colonised patient effectively
4. Updated Ward-view Board (from 21.10.24) with infection prevention and control columns added to flag significance of infections such as MRSA.

Patient Safety

Venous Thromboembolism Risk (VTE)Assessment and Pressure Injuries – Grade 3 or 4 - Escalation Summary

Adult Inpatients Who Received A VTE Risk Assessment

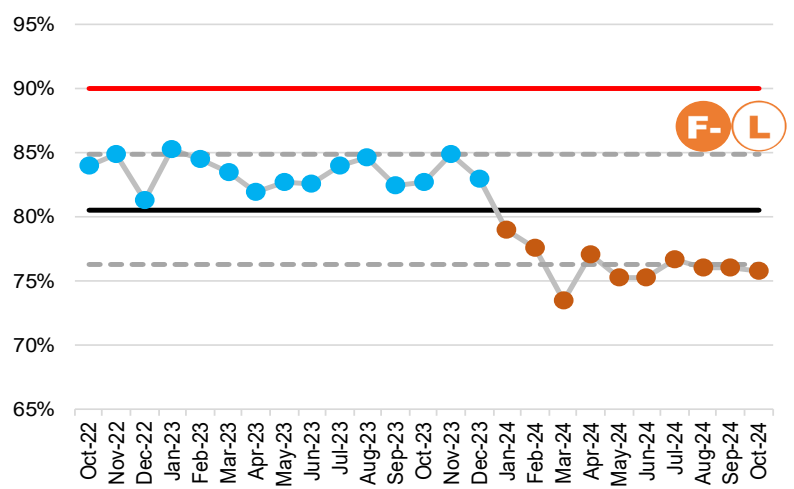
Latest Month
Oct-24

Target
90.0%

Latest Month's Position
75.7%

Performance / Assurance
Special Cause Concerning Variation Low, where down is deterioration and target is greater than upper limit.

Risk
Corporate Risk 589 - Patient deterioration is not recognised and responded to (15)



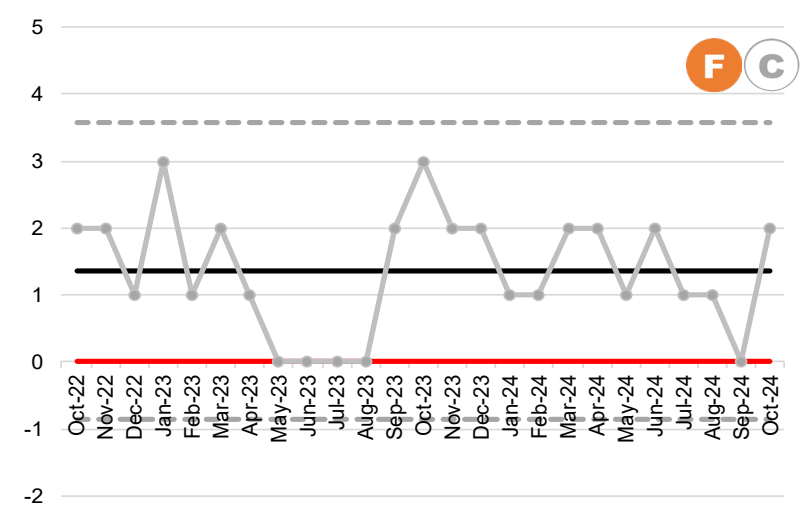
Summary

- VTE risk assessment compliance has remained unchanged since the report was updated in Dec 2023
- Work continues to close the gaps in control in risk 720 and these have largely been completed.
- A QI project is underway to address compliance on Careflow- however improvement is not anticipated to be significant until the launch of CMM
- Audits completed by the pharmacy team provide some assurance that despite Risk Assessments not always being completed- a much larger proportion of patients do have a VTE prophylaxis prescribed and this is in line with recommendations

Actions:
The VTE action plan is ongoing and includes actions related to guidelines, reporting, governance, CMM and safety

Assurance and Timescales for Improvement:
Manual audits provide some assurance
CMM is due to be rolled out sometime in the new year and should improve compliance
Work with individual teams continues to try to mitigate risks where possible

Pressure Injuries – Grade 3 or 4



Latest Month
Oct-24

Target
0

Latest Month's Position
2

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration.

Risk
Corporate Risk 528 - Patients suffer harm or injury from preventable pressure damage (9)

Summary

During October 2024, the rate of pressure injuries per 1,000 bed-days was 0.201 across UHBW.
Across UHBW there were six category 2 pressure injuries. One each in Surgery, Medicine and Specialised Services (all sacral-coccygeal). There was one device related category 2 in the Children's Hospital (chin, secondary to CPAP mask). There were two category 2 pressure injuries in Weston, both sacral coccygeal. There was one device category 3 pressure ulcer in Weston Division (nasal bridge, secondary to NIV mask). There has been an increase in category 2 pressure injuries during October, with these numbers last seen in May 2024. Four out of the six were sacral coccygeal which continues to be the most prominent location for pressure damage occurrence. A small but emerging theme of device related injuries has been identified, with two of the pressure injuries this month being secondary to NIV or CPAP masks.

<u>Actions - All sites:</u>

- Increased push in training to encourage wards to use preventative measures underneath devices to prevent risk of pressure damage occurrence.
- A working group with input from Tissue Viability Nurses (TVN), Respiratory Physios has been set up as an action post After action Review (AAR) for the Category 3 device related injury. This group will be looking at NIV mask Care Plans to ensure parity across Bristol and Weston and procurement of under nose mask, not previously stocked in Weston.
- TVN initiated Pressure Ulcer Care Plan monthly audit in Surgery, Weston and Medicine. Results submitted to Divisions at end of each month.
- Work with Divisional Matron leads to support with improvements to Pressure Ulcer Care Plan compliance.
- Ongoing biannual face-to-face study days for staff across UHBW.
- Monthly study days in Weston to roll out leg bandaging and update staff on pressure ulcer prevention, dressing selection and wound management.
- Ongoing engagement with TV champions on wards to support good pressure prevention practice, including support, feedback, and wellbeing incentives.
- Monthly Tissue Viability newsletters focusing on key themes each month and delivering key messages to staff.

Patient Safety

Mixed Sex Accommodation Breaches and Fractured Neck of Femur Patients Treated Within 36 Hours - Escalation Summary

Mixed Sex Accommodation Breaches

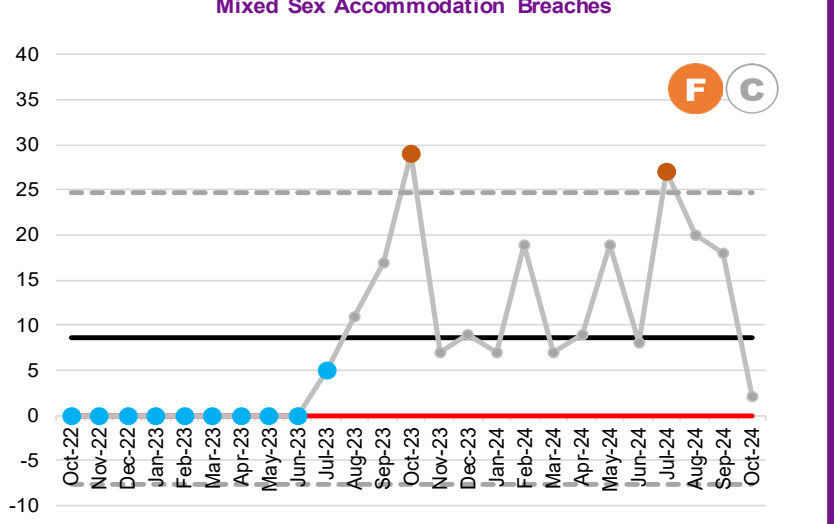
Latest Month
Oct-24

Target
0

Latest Month's Position
2

Performance /
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration.

Risk
No risk in current Board Assurance Framework



Summary

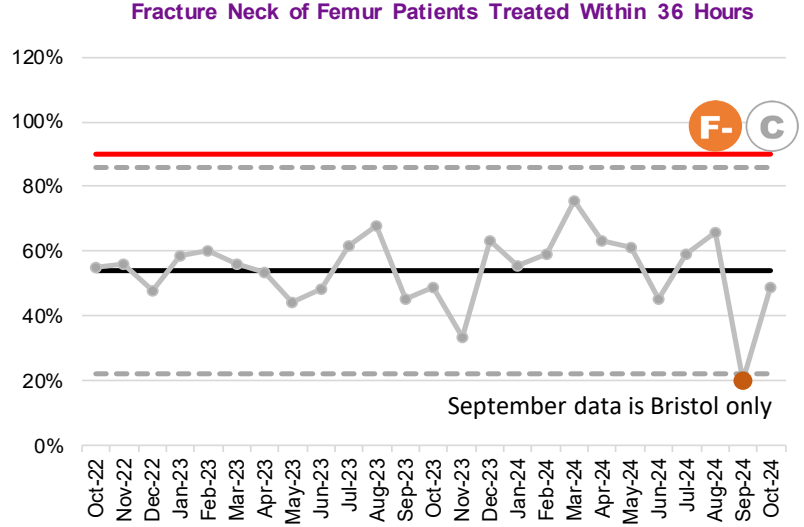
- There was one event of mixed sex breaching which occurred in theatre recovery in Bristol Royal Infirmary, affecting two patients. These patients experienced mixed sex breaches because of a delay in transfer to inpatient wards, due to overall bed capacity and demand.
- There has been a large reduction in the number of mixed sex breaches from previous months.

Actions:

- Continue flow and discharge improvement projects to enable earlier bed availability, via the Every Minute Matters Programme
- Clinical leads to undertake continual review of clinical areas to ensure consistent compliance with NHSE Single Sex Accommodation guidance.

Assurance and Timescales for Improvement:
Task & finish group working through a full Equality Impact Assessment to review how the NHSE Single Sex Accommodation guidance is applied in practice; developing training for staff to assist in applying this guidance in practice, being inclusive and sensitive to all the needs of our communities. Content for training will be completed by Spring 2025.

Fracture Neck of Femur Patients Treated Within 36 Hours



Latest Month
Oct-24

Target
90%

Latest Month's Position
49%

Performance / Assurance
Common Cause (natural/expected) variation, where target is greater than upper limit and down is deterioration.

Risk
No risk in current Board Assurance Framework

Summary

BRI- Number of Hip # Patients qualifying for Best Practice Tariff (60YRS) (Hip#, Femoral shaft & Distal Femur #) = 26.
Predicted BPT for October 2024= 4/26 15%
Patients who underwent surgery within 36 hours = 4/26 15%
Ortho-Geriatric Review within 72 Hrs of admission= 26/26 100%
Physio Assessment on the day or day after surgery= 26/26 100%

Weston - Number of Hip # Patients qualifying for Best Practice Tariff (60YRS) (Hip#, Femoral shaft & Distal Femur #) = 21
19/21 - 90% had surgery within 36hrs of admission
Two patients had their surgery delayed; One required medical support needed prior to surgery, One due to the lack of theatre space due to other trauma
21/21 - 100% had Ortho-geriatrician assessment within 72hrs of admission
Overall, 19/21 - 90% met all the requirements for BPT

Actions (BRI):
- Theatre capacity is being actively monitored and prioritised on a weekly basis across all specialties.
- Poor results discussed in T&O Governance and Silver Trauma Steering Group meeting so ideas for improvement could be discussed.
- Actively re-patriating patients to WGH to avoid breaches.
- Trauma SOP signed off to allow the allocation of a "Golden Patient", enabling a prompt start.
- Restart of automatic send.
- Theatre Utilisation continues to be monitored each month

Patient Safety

Maternity Services
Perinatal Quality Surveillance Matrix (PQSM)

Risk: Corporate Risk 2264 - Delays in commencing induction of labour (16)

Summary

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.

October has been UHBWs busiest month of 2024 so far, both in terms of new maternity bookings (446), triage attendances (609), and births (409).

New triage process (allocation of two midwives) launched in late September has seen an immediate and significant improvement in length of time patients are waiting before their initial review.

Our People

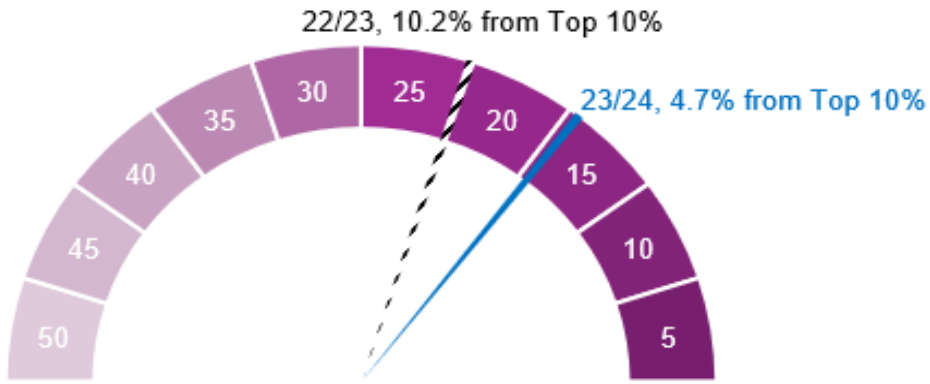
Our People

Our Vision	*Together, we will make UHBW the best place to work.*
Our Goal	*We will improve the employment experience of all our colleagues to retain our valuable people.*

Turning the Dial

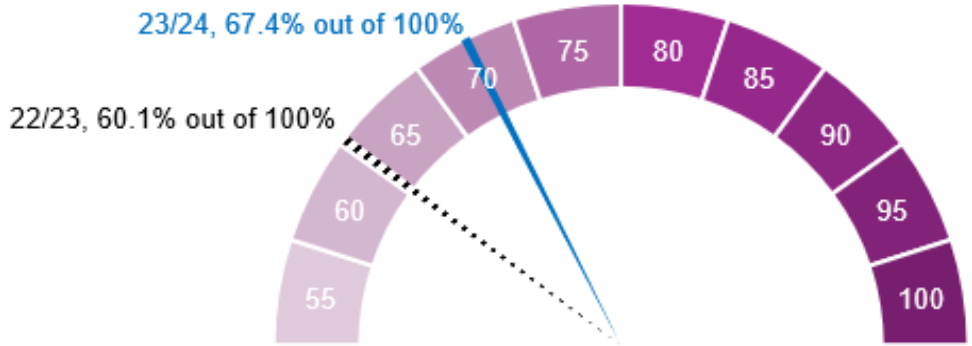
Vision Metrics

We will be in the top 10% of NHS organisations for staff recommending us as a place to work



Annual

A 5% improvement year on year in staff recommending us as a place to work



Annual

Our People

Scorecard

Metric Type	CQC Domain	Workforce Metric	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action	DQ Kite Mark
Corporate Project*	Well-Led	Medical Workforce Programme	Highlight Report Provided							
	Well-led	Delivering Pro-Equity Promise	Highlight Report Provided							
Constitutional Standards and Key Metrics	Well-Led	Percentage Agency Usage	Oct 24	0.6%	1.0%	0.6%	P	C	Note Performance	
	Well-Led	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	Oct 24	2.3%	5.0%	3.2%	P*	C	Note Performance	
	Well-Led	Sickness Rate	Oct 24	4.7%	4.9%	4.2%	P	C	Note Performance	
	Well-Led	Workforce Appraisal Compliance (Non-Consultant)	Oct 24	79.9%	85.0%	79.7%	F-	C	Escalation Summary	
	Well-Led	Workforce Turnover Rate	Oct 24	11.1%	12.0%	11.5%	P	C	Note Performance	
	Well-Led	Essential Training Compliance	Oct 24	90.7%	90.0%	90.7%	P	C	Note Performance	

*Strategic Priority

Assurance						Variation				
P*	P	?	F	F-	No icon	H	L	C	H	L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation		Common Cause (natural) Variation	Concerning Variation	

Our People

Medical Workforce Programme Highlight Report

Our 12 to 18 month goal

To develop a strategic and Trust wide approach to the recruitment, deployment and configuration of the medical staff to support them and to enable the delivery of the Clinical Strategy.

Latest Month	November 2024
Project status	**Project timeline off track**
Related Principle Risk	2. Workforce

Key progress in last month

Reduce Premium Spend
- Rate reduction negotiations underway with highest cost placements

Resident Doctor Rota Review
- Rota review has commenced in W&C's and discussions have taken place with Surgery & Medicine to prioritise certain rota's

Medical Workforce Systems (Healthroster, Locum's Nest and E-job planning system)
- Significant progress in signed off job plans on the system in Women's and Children's division, increase of 10%.
- Healthroster implementation at 75% for absence and leave recording, an increase of 24%

Long Term Plan
- Long Term Medical Workforce Plan drafted
- LED Rotation, posts identified for Bristol, Weston and SS rotation with effect from August 2025

Key aims for next month

Reduce Premium Spend
- Confirm rate reduction plan for all agency locums
- Carry on scoping locum bank rate alignments across the region

Resident Doctor Rota Review
- Produce workforce data for priority rota's to enable deep dive into service requirements, training needs, resources & minimum staffing numbers.
- Begin review of general paediatrics and hospital@night for the Children's Hospital

Medical Workforce Systems (Healthroster, Locum's Nest and E-job planning system)
- Completion of Locum's Nest implementation plus reporting to divisions on activity/spend
- Women's and Children's Healthroster roll out to continue across the division

Long Term Plan
- Update project plan at medical Leaders 25th November
- Understand feasibility of placement capacity (18) across ICS for the medical apprenticeships

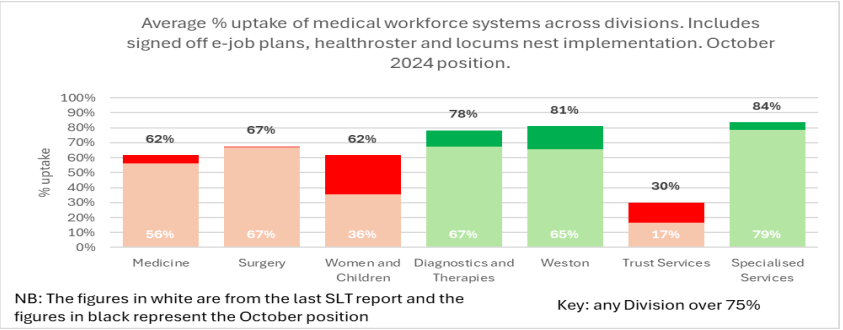
High Level Roadmap

System Delivery and Associated Policies Implementation of Locums Nest, Health Roster, Loop and Ejob planning Trust wide,	Q4
Reducing Short Term Agency Delivery of NHSE Medical Agency Plan removal of off-framework agencies and implementation of rate card	Q2
Long term Plan Identify priorities and gaps, business case for investment, development of LED Medical Workforce	Q4
Resident Doctor Rota Review Populate workforce data per rota (funding, budget, training posts, absence rates, locum cost etc) / Review contracted rota pattern	Q2

Key risks and challenges

- Absence levels within the medical E-rostering team
- Structure/models/resource is different across different divisions and therefore levels of support vary
- Scale of work is significant

Overall project achievements /Impact achieved



Our People

Pro-Equity Promise Highlight Report

Our 12 to 18 month goal: Pro- Equity Promise

In order to deliver our True North People, ambition to be in the top 10% of organisations for staff recommending us as a place to work, with a 5% year on year improvement, we are going to establish our Pro-Equity approach.

Latest Month	November 2024
Project status	**Project timeline on track**
Related Principle Risk	2.Workforce

Key progress in last month

- All Divisions have a Pro-Equity plan in place
- We have published our Anti-Racist community commitment
- As of Friday 8 November, 37 colleagues have attended across 6 workshops for anti-ableism
- The Pro-Equity Assurance group have approved a timeline for each working group with key deliverables to ensure the programme is on track, see high level roadmap

Key aims for next month

- Complete the anti-ableism workshops (end of November)
- Finalise the Trauma informed framework to deliver Pro-Equity
- Run an action planning workshop with our stakeholders to co-create the plan (10th December)
- Launch our new sexual safety guidance (first week December)

High Level Roadmap

- Design a Pro-Equity framework that is trauma informed to ensure effective communication and engagement with the Pro-Equity agenda (this will include Anti-Sexism, Anti-Racism and Anti-Ableism) by the end of October 2024. Completed
- Run Pro-Equity Workshops (Sexual safety, Anti-Racism, Anti-Ableism) from July – end of December 2024.
- Collectively review the thematic analysis from Sexual Safety, Anti-Racism and Anti-Ableism to identify themes by the end of January 2025.
- Rationalise and prioritise the themes into clear plans for action, aligned to national requirements, best practice and group model working by the end of February 2025.
- Integrated plan for Pro-Equity by the end of March 2025.

Key risks and challenges

- Engagement on anti-racism and anti-ableism might bring to light concerning practices across the Trust, and we may see an increase in Employee Relation cases

Overall project achievements / Impact achieved

- A pro-equity trauma informed communication and engagement plan has been developed.
- We have published our Anti-Racist community commitment

Our People

Workforce Appraisal Compliance Escalation Summary

Workforce Appraisal Compliance (Non-Consultant)

Latest Month

Oct-24

Target

85%

Latest Month's Position

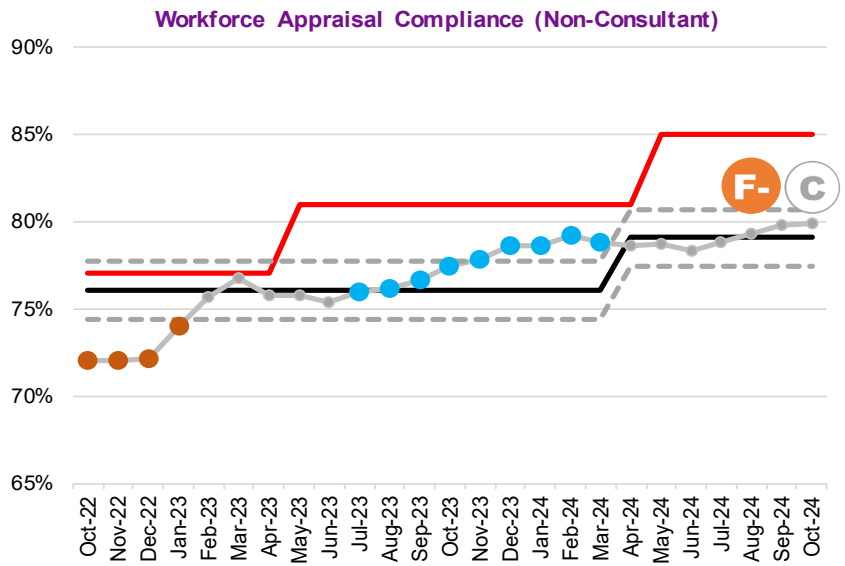
79.9%

Performance / Assurance

Common Cause (natural/expected) variation, where target is greater than upper limit down is deterioration.

Risk

Corporate Risk 2639 - Staff not receiving an annual appraisal (12)



Summary

- Overall appraisal compliance increased to 79.9% compared with 79.7% in the previous month.
- There were increases within 7 divisions and a reduction in the other division.
- The largest divisional increase was seen within Weston General Hospital, increasing to 86.2% from 83.8% in the previous month.
- The only divisional reduction was within Surgery, where compliance reduced to 74.0% from 76.5% in the previous month.
- Weston General Hospital, has met the new KPI target of 85.0% this month.

- In response to Staff Survey feedback to improve compliance and quality of appraisal a programme of work has been in place to identify the root causes aligned to the A3 thinking patient first approach.
- Supporting the A3 exploration, 1400 colleagues were involved in providing feedback and as a result a more tailored, flexible and agile Appraisal form was introduced in Q1 with much positive feedback.
- Q2 the implementation of an anonymous quality of appraisal feedback form was launched. The form has seen positive reviews and feedback on the form process and quality of the conversation.
- Although the appraisal programme of work was completed in June 2024 there have been some software changes from Kallidus which are currently being explored. The impact of the advance tool may have a positive impact on compliance this will be realised by the end of Q3.

- Programmes of work as a result of Staff Survey feedback are in place
- Assurance measure will be realised in compliance rates, and Staff Survey 2024 measures in Q4.

Timely Care

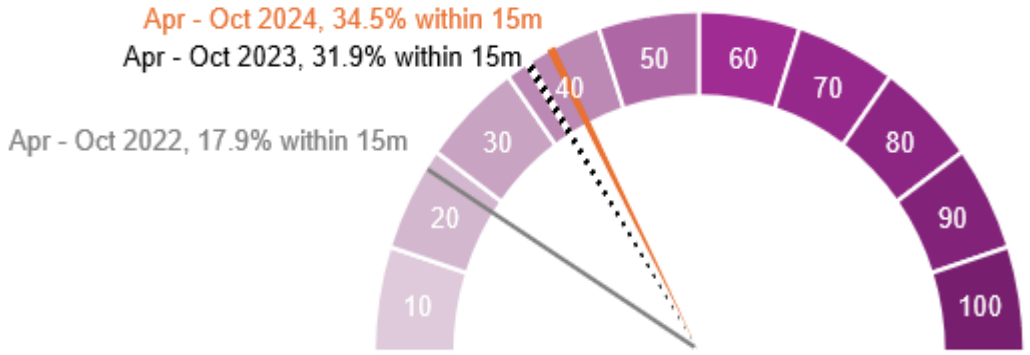
Timely Care

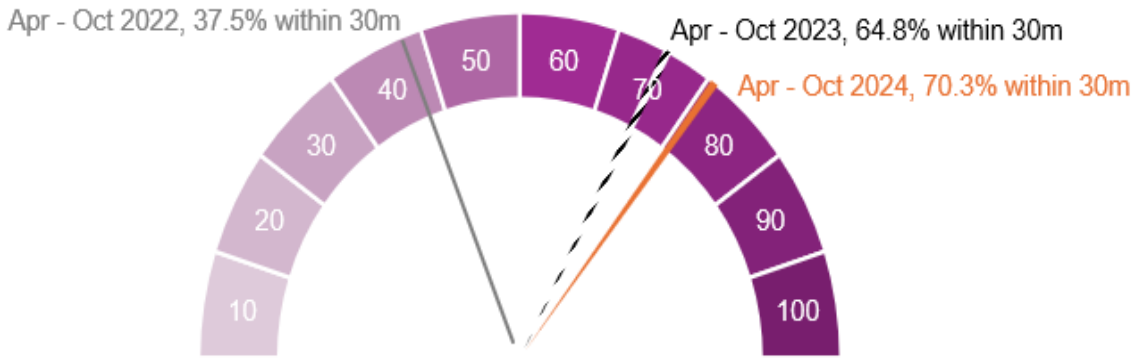
Our Vision	*Together, we will provide timely access to care for all patients, meeting their individual needs.*
Our Goal	*By streamlining flow and reducing variation, we will eliminate avoidable delays across access pathways.*

Turning the Dial

Vision Metrics

We will make a 10% year on year improvement in ambulance handover times as a measure of improved patient flow through our hospital





Timely Care

Scorecard

Metric Type	CQC Domain	Experience of Care Metric	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action	DQ Kite Mark
Corporate Project*	Responsive	ED Percentage Spending Over12 Hours in Department	Oct 24	4.9%	2.0%	3.4%	?	L	Note Performance	
	Responsive	Theatres - Touchtime Utilisation	Oct 24	82.3%	81.0%	81.9%	F-	H	Counter Measure Summary	
	Responsive	Outpatient DNA Rate	Oct 24	5.9%	5.0%	5.8%	F-	L	Counter Measure Summary	
Breakthrough Objective*	Responsive	Median Discharge Time	Oct 24	15:33	13:30	15:43	F-	C	Counter Measure Summary	

*Strategic Priority

Assurance						Variation				
P*	P	?	F	F-	No icon	H	L	C	H	L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation		Common Cause (natural) Variation	Concerning Variation	

Timely Care

Scorecard

Metric Type	CQC Domain	Experience of Care Metric	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action	DQ Kite Mark
Constitutional Standards and Key Metrics	Responsive	Total RTT Pathways 52+ Weeks	Oct 24	1296	1521	1425	P	n/a	Note Performance	
	Responsive	Total RTT Pathways 65+ Weeks	Oct 24	57	0	72	F	n/a	Escalation Summary	
	Responsive	Diagnostics Percentage Under 6 Weeks (15 Key Tests)	Oct 24	86.2%	91.1%	83.3%	F-	H	Escalation Summary	
	Effective	Cancer - 28 Day Faster Diagnosis	Sep 24	77.0%	77.0%	77.6%	P	H	Note Performance	
	Effective	Cancer - 31 Day Diagnosis To Treatment	Sep 24	96.1%	96.0%	98.1%	?	C	Escalation Summary	
	Effective	Cancer 62 Day Referral To Treatment	Sep 24	71.4%	70.0%	75.8%	P	H	Note Performance	
	Responsive	Last Minute Cancelled Operations - Percentage of Admissions	Oct 24	1.5%	1.5%	2.6%	F	C	Escalation Summary	
	Responsive	ED Percentage Spending Under 4 Hours in Department	Oct 24	66.4%	71.8%	68.7%	?	C	Escalation Summary	
	Responsive	ED 12 Hour Trolley Waits	Oct 24	440	No Target	261	n/a	C	No Target	
	Responsive	ED Attendances (Trust Total)	Oct 24	18485	No Target	17014	n/a	C	No Target	
	Responsive	No Criteria To Reside - Beds Occupied	Oct 24	191	105	171	F-	H	Escalation Summary	
	Responsive	No Criteria To Reside Occupancy	Oct 24	21.9%	13.0%	19.4%	F-	C	Escalation Summary	

Assurance						Variation				
P*	P	?	F	F-	No icon	H	L	C	H	L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation		Common Cause (natural) Variation	Concerning Variation	

Timely Care

Theatres Touchtime Utilisation and Average Cases per List Counter Measure Summary

Theatres - Touchtime Utilisation

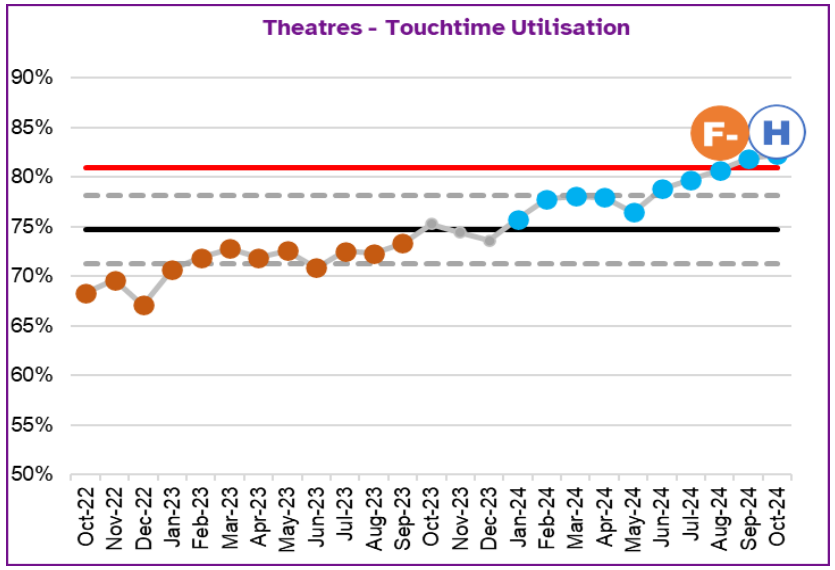
Latest Month
Oct-24

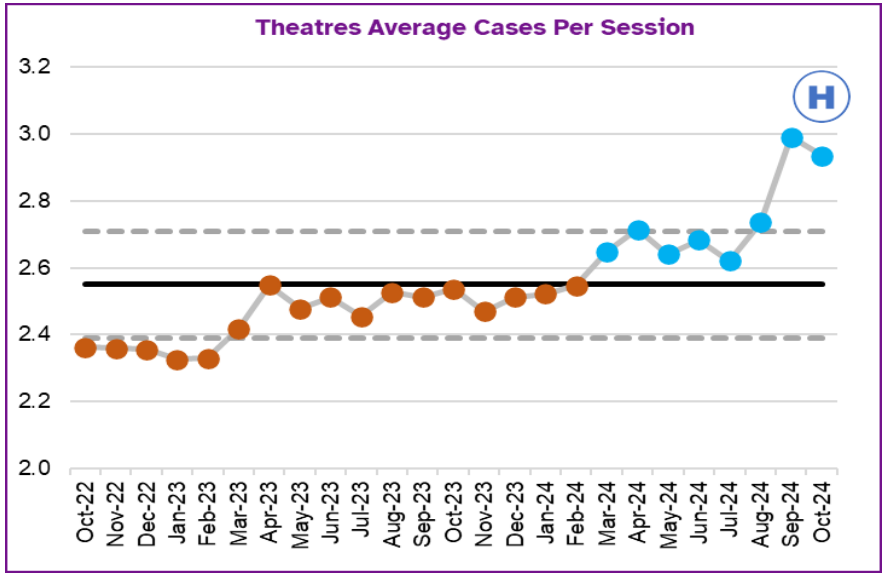
Target
81.0%

Latest Month's Position
82.3%

Performance / Assurance
Special Cause Improving Variation High, where up is improvement but target is greater than upper limit.

Risk
Principle Related Risk :6. Capacity and Performance





Theatres Average Cases Per Session

Latest Month
Oct-24

Target
N/A

Latest Month's Position
2.93

Performance / Assurance
Not Applicable

Risk
Corporate Risk 910 - That patients in BRI ED do not receive timely and effective care (20)

Improvement work in progress

Corporate Project:
Improving Theatres Productivity and Efficiency

Project: On track

Divisional priority project for:
- Weston
- Women and Children
- Surgery

See Appendix for Capped Touchtime example

Top contributors to addressed

- Adherence to best practice for planning and scheduling theatre activity (e.g. 6-4-2 processes).
- Lack of timely pre-assessment of patients to ensure that they are fit and health optimised prior to surgery.

Key Risks to achieving improvement

- Decentralised booking teams and lack of standardised processes, management and KPI's
- Continued short notice theatre list booking
- Decentralised pre assessment services and variable processes.
- Staffing shift patterns impacting ability to cover extended theatre lists
- Lack of traction & engagement in pre assessment improvement workstream

Key progress

- Trust wide utilisation continues to improve (Aug: 79%, Sept: 81%, Oct 81%) and exceed our planned improvement trajectory.
- All theatre areas show steady and sustained monthly improvement except SBCH and WGH. BDH utilisation is still low at 70%, however it has steadily increased from 47% in April.
- New process implemented to reduce unused pre assessment clinic slots
- Agreement to review BRI theatre staffing, shift patterns, capacity and future demand

Next actions

- Review and start to implement the new British Association of Day Surgery (BADS) metrics which now include outpatient procedures.
- Review processes for recording and coding outpatient procedures in line with new requirements.
- Complete validation and data quality work on pre-assessment clinic and slot utilisation to provide transparency and agree clinical criteria for telephone and face-to-face appointment types.
- Review admin capacity for the booking of theatre lists to ensure the appropriate level of resources is available.

Timely Care

Outpatient Did Not Attend Rate Counter Measure Summary

Outpatient DNA Rate

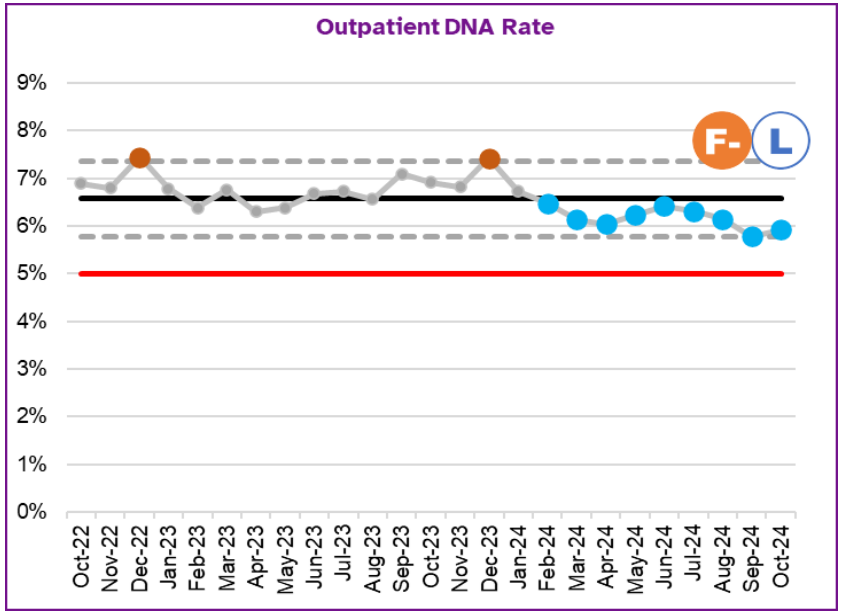
Latest Month
Oct-24

Target
5.0%

Latest Month's Position
5.9%

Performance / Assurance
Special Cause Improving Variation Low, where down is improvement but target is less than lower limit.

Risk
Principle Related Risk :6. Capacity and Performance



Improvement work in progress

Corporate Project:
Improving Outpatient Productivity and Efficiency

Project: On track

Divisional priority project for:
- Medicine
- Specialised Services

Top contributors to addressed

- Lack of timely and clear communication with patients concerning outpatient appointments.
- Do not have processes to support rescheduling of outpatient appointments that are responsive to patients' needs. .

Key Risks to achieving improvement

- DrDoctor functions support patients to cancel appointments that are not convenient for them
- Process variation in the management of clinic builds and booking of appointments may limit ability to introduce patient-led booking and rescheduling.
- Capacity within digital services to manage ongoing support to DrDoctor programme

Key progress

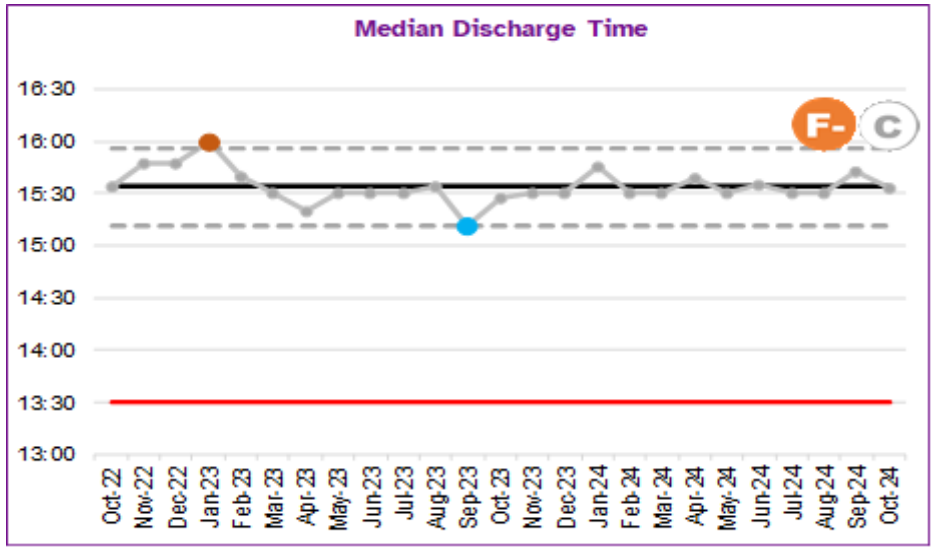
- Interoperability between DrDoctor and Careflow has been progressed.
- Review first 100 specialities currently not using DrDoctor automated appointment reminders completed
- Bristol Royal Hospital for Children now live with DrDoctor digital letters Impact expected in 4-12 weeks

Next actions

- Further 100 specialities currently not using DrDoctor automated appointment reminders selected for improvement
- Continued work with divisions to benchmark practice against Getting It Right First Time (GIRFT) guidelines. There are now 21 specialty specific handbooks that have been published providing best practice guidelines and case studies.
- Missed Appointments GIRFT guidance circulated to divisions
- Review of specialities with fixed booking and the potential expansion Patient Initiated Follow-Up (PIFU) pathways.

Timely Care

Median Discharge Time Counter Measure Summary



Median Discharge Time

Latest Month

Oct-24

Target

13:30

Latest Month's Position

15:33

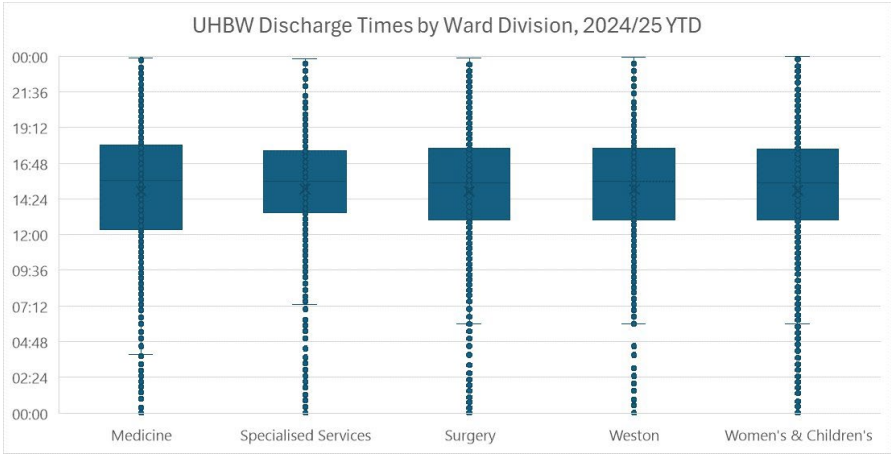
Performance / Assurance

Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration.

Risk

Principle Related Risk: 6. Capacity and Performance

Stratified data -September 2024



Improvement work in progress

- Ready for Discharge Breakthrough objective
- Every Minute Matters (EMM) programme of work
- Golden Patient

Project: On track

Divisional priority project for:

- Medicine
- Weston

Top contributors to addressed

- Discharges not identified early in the day
- Inconsistency of board round process and outputs
- Lack of visibility of patients needing progression of care and/or discharge
- Discharge summaries not completed in a timely way
- Low use of discharge lounge at Weston

Key Risks to achieving improvement

- Staff capacity and consistency to engage with change

Key progress

- Continued rollout of Golden Patient
- Home First delivering P1 direct referral training to support understanding of this pathway
- EMM strategy review and prioritisation of projects to include:P0 discharge delays review, improved Proactive Board Round reporting to support visibility of progression of patient care and/or discharge, Weekend Discharges
- Live P0 discharge data under review with ward teams to identify any themes or recurring challenges
- Review of current Leadership & Flow(L & F) meetings process underway with the Clinical site Team
- Focus on timely proactive board round reporting to support improvements to Leadership & Flow meetings
- Supporting BRHC with work to increase usage of their Discharge waiting area on Puzzlewood
- Rollout of Wardview at Weston paused pending the resolution of a technical issue

Next actions

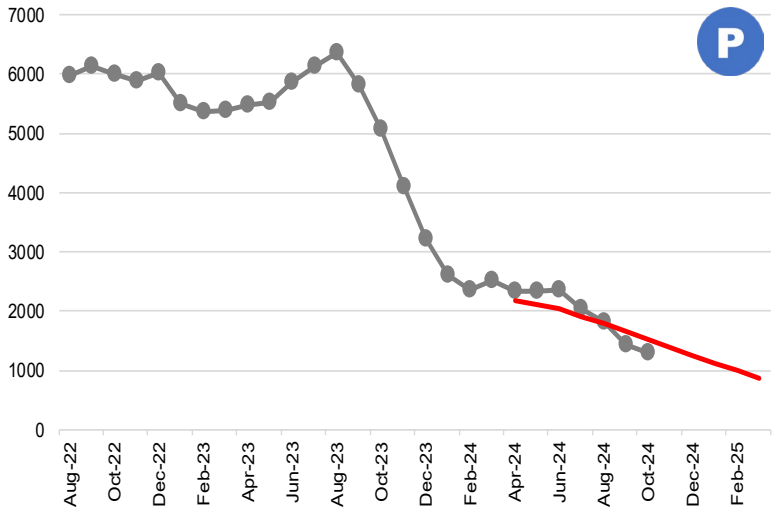
- Follow-up P0 discharge review
- Support the site team in evolving the Leadership & Flow meetings
- Work with the ward teams to improve timely completion of proactive board round reporting
- Weekend discharge data analysis to inform scoping of project work to start in January 2025

Timely Care

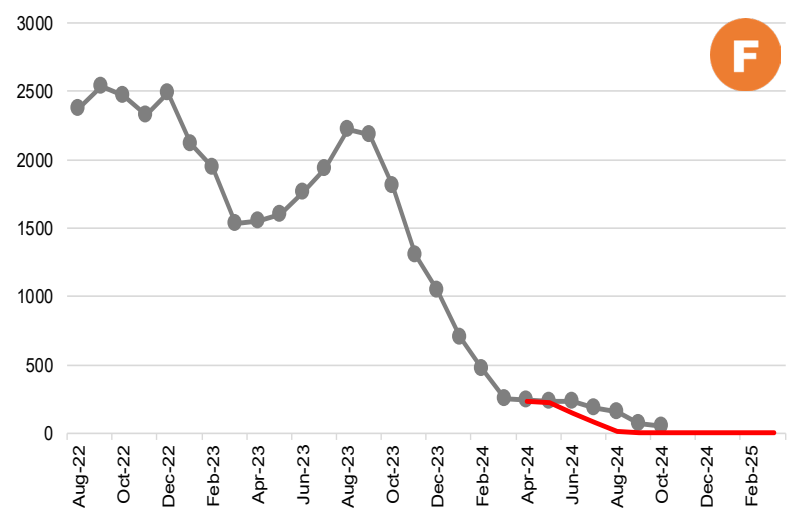
RTT 52 and 65 Week Waits Escalation Summary

Total RTT Pathways 52+ Weeks

Latest Month
Oct-24
Target
1521
Latest Month's Position
1296
Risk
Corporate Risk 7182 - Non-compliance with routine elective treatment within 65 weeks (12)



Total RTT Pathways 65+ Weeks



Latest Month
Oct-24
Target
0
Latest Month's Position
57
Risk
Corporate Risk 7182 - Non-compliance with routine elective treatment within 65 weeks (12)

Summary

- At the end of October, no patients were waiting 78+ weeks and the last time the Trust reported a 78+ww breach was the end of August 2024.
- Whilst there is a continued national shortage of cornea graft material, the Trust had received sufficient allocation of material to date all associated 78ww cornea patients in October. Further allocation of cornea graft material has been requested for patients who will breach 78ww in November and the Trust have sufficient capacity to treat those patients should allocation of material be made available. NB: as per NHSE guidance, cornea graft breaches are monitored but excluded from planning assumptions.
- At the end of October, the Trust reported 57 patients who were waiting more than 65 weeks for treatment (24 Cornea Graft; 32 Dental and 1 Gastroenterology), an improvement from the end of September (73x 65ww+). The Trust have recently met with NHS England to describe the challenges relating to the elimination of 65ww in Orthodontics (the remaining Dental challenge, November onwards) and work continues to develop strategies to expedite the treatment of these patients in a sustainable way.
- Insourcing arrangements have been established for outpatient services in Paediatric Dentistry and Orthodontics. Additionally, the Dental service has recently recruited an additional Orthodontics Consultant who commences in May 2025 and a Paediatric Cleft locum to increase the capacity within these services. The Trust have requested that Independent Sector Provider colleagues reach out to their network to identify any additional Orthodontic consultants who may be available for a period of up to 18 months to support clinic appointments and on-going brace adjustments to further support the recovery of this service.
- The Dental service continue to use additional Independent Sector capacity under contractual agreements with Spire to support their recovery in cleft services whilst there has been a consultant gap in this service.
- The Trust continues to bolster additional capacity through other insourcing providers and waiting list initiatives.

Timely Care

Diagnostics Patients Under 6 Weeks and Cancer 31 Day Standard Escalation Summary

Diagnostics Patients Waiting Under 6 Weeks

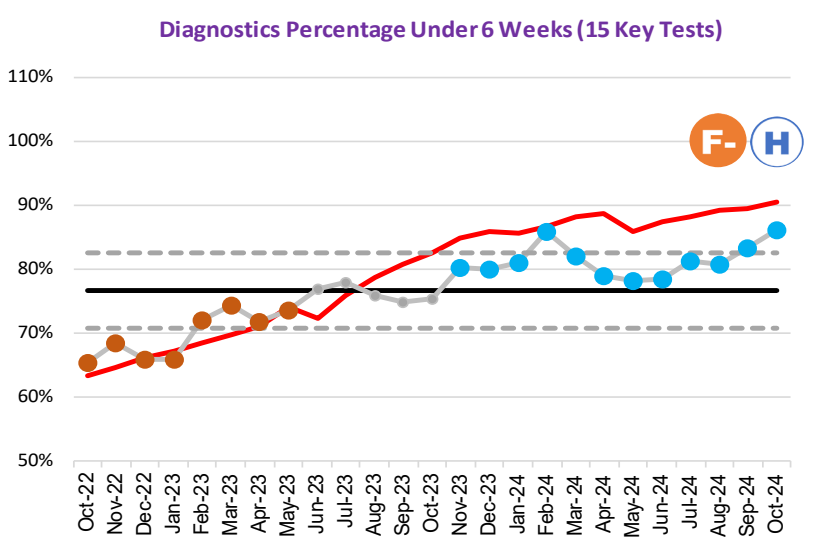
Latest Month
Oct-24

Target
91.1%

Latest Month's Position
86.2%

Performance / Assurance
Special Cause Improving Variation High, where up is improvement but target is greater than upper limit

Risk
No risk in current Board Assurance Framework



Summary

For September 2024, the England total was 76.5% of the waiting list under six weeks. UHBW's performance was 83.3% which places UHBW 76th of 158 Trusts that reported diagnostic wait times.

At the end of October, performance against the six week wait standard was reported as 86.2% against the operational planning trajectory of 91.1%.

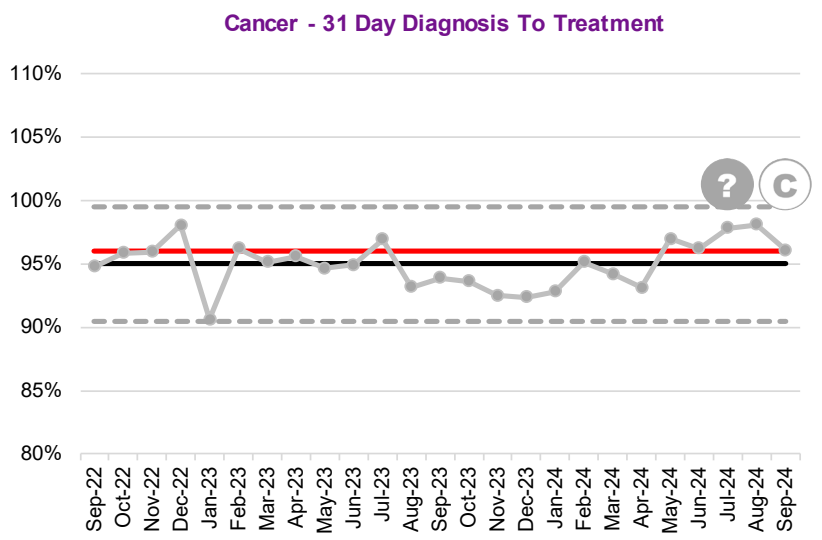
Considerable efforts have been made to improve performance for long wait patients and the number waiting over 13 weeks have improved from 694 at end of Mar-24 to 466 at end of October. The number of patients waiting 26+ weeks have reduced from 206 to 11 over the same time period.

Improvements in performance for October are noted across all modalities, with the exception of MRI and CT Cardiac. Recovery plans for MRI and CT are underway and actions are in place to recover which are yielding some positive results with further recovery in these services expected through the remaining months of 2024/25.

Recovery plans within Audiology (adults) have continued to improve performance during October and improvement to the national target is expected by Q3 24/25 with the use of additional capacity to supplement the core capacity which has been maintained.

Modality-level diagnostic trajectories and plans for 24/25 are agreed across the organisation and the Trust continues to utilise insourcing and transferred capacity and outsourcing to the independent sector which are all integral to the 24/25 diagnostic recovery plans.

Cancer – 31 Day Diagnosis To Treatment



Latest Month
Sep-24

Target
96%

Latest Month's Position
96.1%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Risk
Corporate Risk 5532 - Non-compliance with the 31 day cancer standard (12)

Summary

The 31 Day Standard reports number of patients treated within 31 days of the decision to treat. For September, 96% of patients were treated within 31 days. The national constitutional standard is 96%.

The Trust continues to comply with the 31-day standard and has done for the past five months and expects to continue to do so. No specific actions are required other than ongoing waiting list management as part of business as usual. The standard should be rated 'P' next month, when we expect six consecutive months of compliant performance.

Timely Care

Last Minute Cancellations and ED Percentage Spending Under 4 Hours in Department - Escalation Summary

Last Minute Cancelled Operations

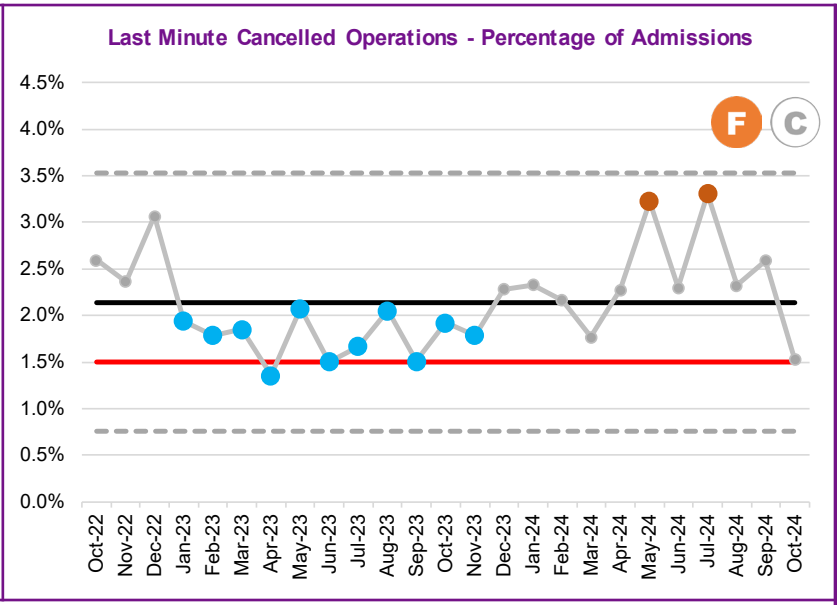
Latest Month
Oct-24

Target
1.5%

Latest Month's Position
1.5%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration.

Risk
No risk in current Board Assurance Framework

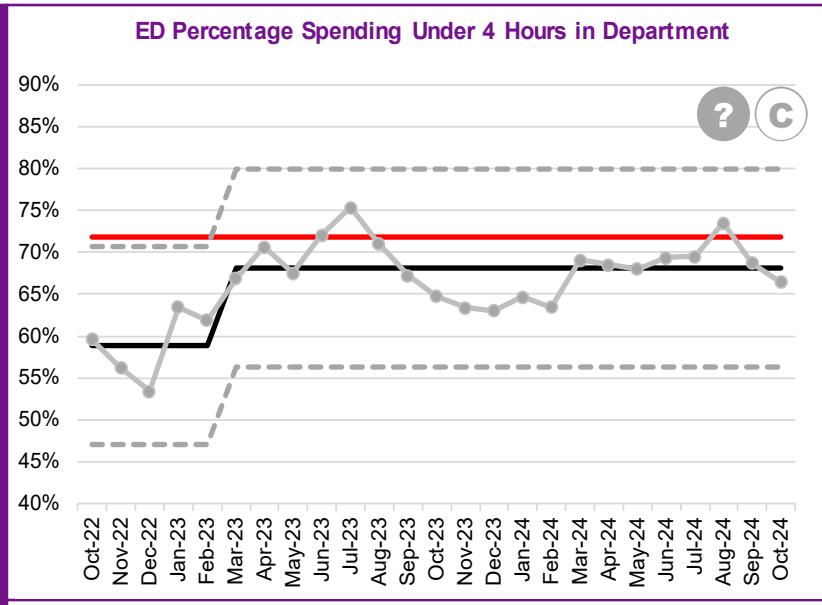


Summary

Actions for reducing last minute cancellations are being delivered by the Trust's Theatre Productivity Programme. As part of this Programme, the Theatre Improvement Delivery Group and Planned Care Group are continuing to work on the data quality associated with this metric.

Whilst performance has improved in October, it is noted that some of the biggest drivers of last-minute cancellations are due to availability of beds in Bristol Haematology and Oncology Centre (BHOC) and postponement of procedures in endoscopy. Both areas are subject to review.

ED Percentage Spending Under 4 Hours in Department



Latest Month
Oct-24

Target
71.8%

Latest Month's Position
66.4%

Performance / Assurance
Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.

Risk
Corporate Risk 910 - That patients in BRI ED do not receive timely and effective care (20)

Summary

BRI: 4-hour performance unchanged from September (49.5%) despite an increase in attendances in October (231 per day) vs September (222 per day) and an increase of 7% compared with October 2023.

A number of mitigating actions are being taken, including the Division of Medicine reviewing Medicine-admitted 12-hour waits as a priority project through Strategy Deployment Review (SDR), which has identified a number of actions to reduce the proportion of patients waiting in the department.

BRHC: 4-hour performance 82.8% in October (83.2% September), noting an increase in attendances in October (140 per day) vs September (124 per day) and an increase of 0.4% compared with October 2023.

Children's ED successfully expanded into Carousel outpatients in early November 2024. This new area comprises of 6 observation beds, with an additional 4 seated patients. The old observation ward is now a designated minor injuries and illness area, overseen by the nurse practitioners. There is a continued focus on improving the 12- hour breach position with a working group meeting weekly to focus on improvements to reduce overall waits.

Weston: 4-hour performance 64.9% in October (72.8% September), noting a slight increase in attendances in October (148 per day) vs September (146 per day) and an increase of 8% compared with October 2023.

Various actions are being taken including a review of 12-hour performance and development of KPIs relating to specialty reviews in ED, with an anticipated performance recovery in November.

Timely Care

No Criteria to Reside – Beds Occupied and Occupancy Escalation Summary

No Criteria To Reside - Beds Occupied

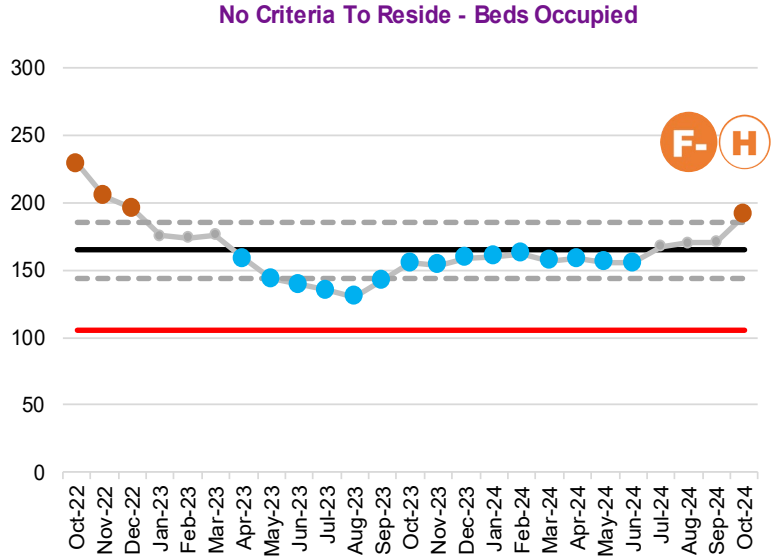
Latest Month
Oct-24

Target
105

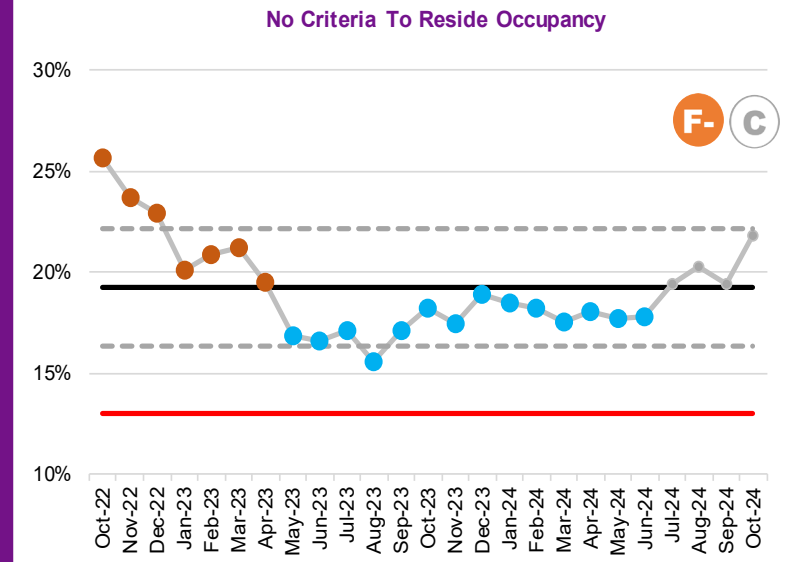
Latest Month's Position
191

Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration.

Risk
No risk in current Board Assurance Framework



No Criteria To Reside Occupancy



Latest Month
Oct-24

Target
13.0%

Latest Month's Position
21.9%

Performance / Assurance
Common Cause (natural/expected) variation where down is improvement.

Risk
No risk in current Board Assurance Framework

Summary

No Criteria to Reside (NCtR) numbers have risen during October across both sites, whilst length of stay (LoS) for NCtR patients has continued to improve across all pathways. The rise in NCtR is driven by the increase in non-elective admissions rather than a deterioration in LoS.

Actions:

- 10th September implementation of a more detailed coding structure for all NCtR patients to provide greater granularity which will provide us with better visibility of delays either internal or external.
- Operational processes are in development to manage this new data to reduce delays with a refreshed escalation plan to minimise non-value adding days in patients' pathways.
- To support delivery of the 15% NCtR ambition for BNSSG there is a requirement to increase community bedded capacity by an additional 18 P3 beds and 11 P2 beds. Funding to be finalised.
- The Home First Team has prioritised supporting the Trust to deliver improvements in timely discharge through the Golden Patient initiative to support length of stay and flow improvements.

Assurance and Timescales for Improvement

- 25% reduction in LoS across all patient pathways by end of March 2025 compared to 22/23 baseline.
- Reduce the number of NCTR patients to 13% of useable bed base (core adult bed base).

Innovate and Improve

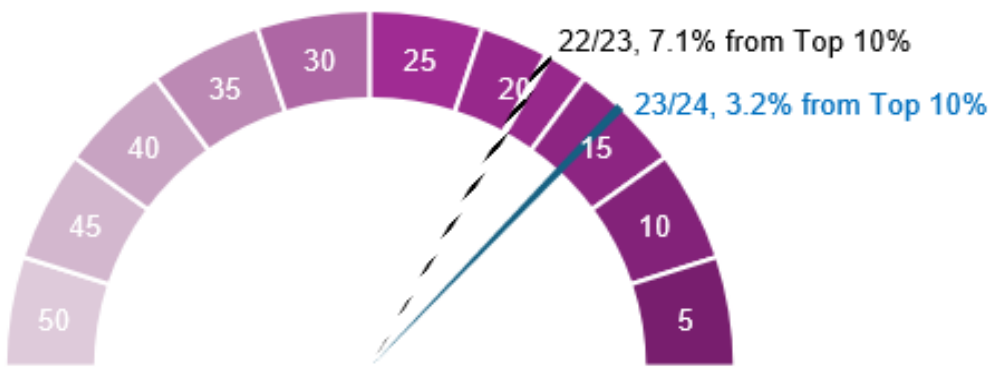
Innovate and Improve

Our Vision	*Together, we will drive improvement every day, engaging our staff and patients in research and innovative ways of working to unlock our full potential.*
Our Goal	*We will be in the top 10% of NHS organisations for our staff stating they can easily make improvements in their area of work.*

Turning the Dial

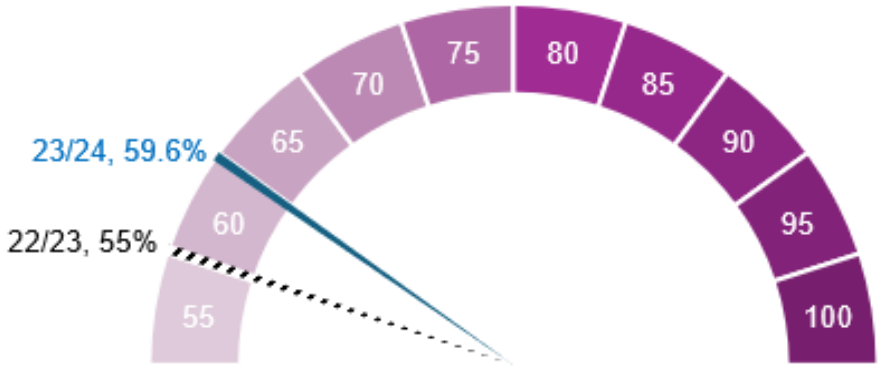
Vision Metrics

We will be in the top 10% of NHS organisations for staff reporting they are able to make improvements



Annual

A 2% improvement year on year in staff reporting they are able to make improvements



Annual

Innovate and Improve

Scorecard

Metric Type	CQC Domain	Innovate and Improve Metric	KPI	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action	DQ Kite Mark
Corporate Project*	Safe	Fire Safety Programme	**Highlight Report Provided**								TBC
	Safe	Fire Evacuation Readiness and Compliance	**Highlight Report Provided**								TBC

***Strategic Priority**

Assurance						Variation			
P*	P	?	F	F-	No icon	H L		C	H L
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation		Common Cause (natural) Variation	Concerning Variation

Innovate and Improve

Fire Safety Programme Highlight Report

Our 12 to 18 month goal

To have sufficient understanding and confidence in ongoing fire safety across the UHBW Estate that fire safety compliance and improvement can return to Business as Usual.

Latest Month	November 2024
Project status	**Project timeline on track**
Related Principle Risk	5.Fire Safety

Key progress in last month

- Two-day fire risk assessment (FRA) of St.Michaels Hospital (StMH) undertaken by fire engineers (re-assessment) Summary of StMH FRA visit presented at Fire Improvement Group (FIG)
- Fire Door Strategy paper agreed at FIG
- Fire Door Inspection standard operating procedure; draft reviewed at FIG and further amendments to include Institute of Healthcare Engineering and Estate Management (IHEEM) information and represent at FIG
- Fire Risk Assessment Strategy paper agreed at FIG
- Guidance from fire engineers on the treatment of Isolation Rooms agreed at FIG
- Fire Evacuation programme agreed at FIG
- FRA and Fire Strategy Programme agreed at FIG
- Planned Preventative Maintenance (PPM) fire compliance programme agreed at FIG
- Façade recommendation and prioritisation programme agreed with fire engineers – priority buildings – order placed
- StMH evacuation lift conversion decision made; all four central lifts to be converted – programme to be developed

Key aims for next month

- Continuing upgrade of StMH's existing emergency lighting on levels D and E
- Survey of compartmentation and dampers continuing
- Continue works on SharePoint risk/action/project tracker to allow clear visibility and accountability across multiple existing reports and survey information.
- Developing further programme for improvement of fire compliance regarding statutory and mandatory PPM's across the estate for FIG.
- Development of fire risk assessment process for individual departments using Zetasafe; to be undertaken by Fire safety Advisors
- Datix fire risk entries to be reviewed and rationalised
- Review latest FRA's from fire engineers
- Continue works on Priority Risk Matrix across building s with completed fire strategies and FRA's.
- Development of data for capital allocation for 25/26 – meeting date agreed for first week in December.

High Level Roadmap

- Multi-year project that will require substantial resources – human and capital

Key risks and challenges

- Potential for significant fire during improvement Programme – loss of building
- Potential for enforcement action during fire improvement Programme; extent of the legacy issues and the time required to address physical elements
- Scope of works will require multi-year capital investment and require ICS support
- Scope of improvement works 'unknown' elements impact budgets/cause delays
- Building Safety Act gateways cause delays to fire improvement works within year
- Availability of legacy information and complexity of buildings potential to cause delays in works and/or decision making

Overall project achievements /Impact achieved

Incremental understanding of the estate and the challenges ahead to improve fire safety

Innovate and Improve

Fire Evacuation Readiness and Compliance Highlight Report

Our 12 to 18 month goal

Achieve comprehensive fire evacuation preparedness across all wards, departments, and clinics by ensuring 100% compliance with evacuation plans, training, and annual exercises by 01/12/2025.

Latest Month	November 2024
Project status	**Project timeline on track**
Related Principle Risk	5.Fire Safety

Key progress in last month

- Fire safety advisers allocated wards to work with to develop suitable and sufficient fire evacuation plans
- Very high dependency wards without evacuation plan targeted initially
- Fire evacuation floor plans being produced for priority clinical buildings and wards/clinics - standardised template
- Currently, 28 areas lack fire evacuation plans, and 155 require updates and training, leaving the Trust vulnerable.

Key aims for next month

- Development of single matrix for divisions
- Update fire evacuation plan template and guidance, plus issued to all locations - Nov 24

High Level Roadmap

- 'Red' fire safety information boards installed in all location - Mar 25
- Bespoke fire evacuation floor plans installed on fire 'Red' boards for all locations - Mar 25
- All locations to complete fire evacuation plan on new template following issued guidance - Jun 25
- All locations to ensure 95% staff trained on updated fire evacuation plan - Oct 25
- All locations to conduct fire evacuation exercise/drill to test evacuation plan - Dec 25

Key risks and challenges

- Suitable facilities to maintain clinical care for progressive horizontal evacuation to be effective
- Physical restrictions on evacuation routes
- Ability of clinical staff to be released for evacuation training and fire drills

Overall project achievements /Impact achieved

Our Resources

Our Resources

Our Vision

Together, we will reduce waste and increase productivity to be in a strong financial position to release resources and reinvest in our staff, our services and our environment.

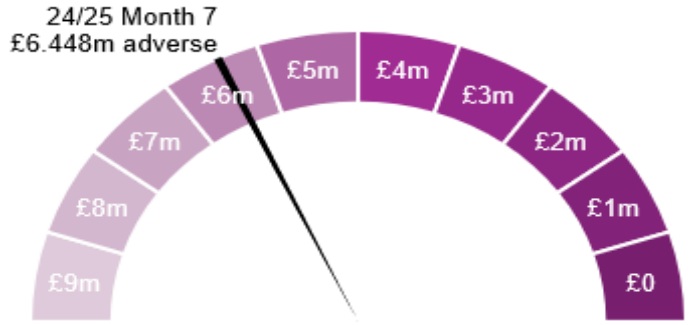
Our Goal

To play our part, along with health and care partners across the Bristol, North Somerset and South Gloucestershire Integrated Care System, in restoring financial balance on a sustainable basis.

Turning the Dial

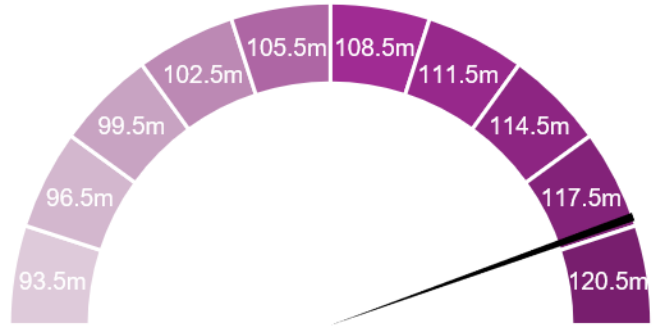
Vision Metrics

To eliminate the underlying deficit within the timeline set out within the System Medium Term Financial Plan



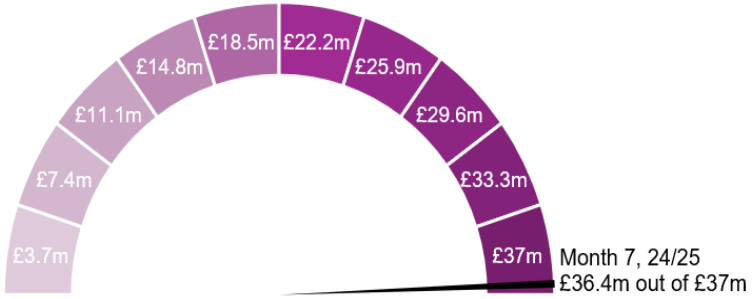
Monthly

We will treat more patients with elective care needs, exceeding 2019/20 activity levels.



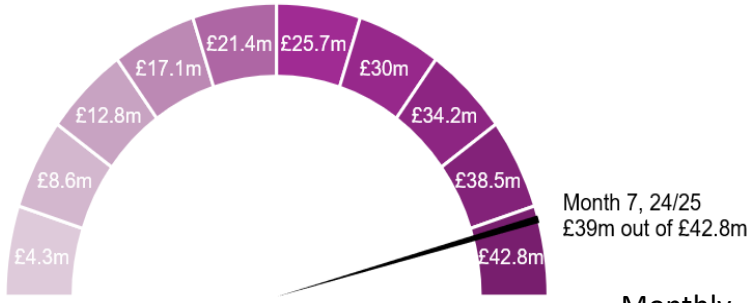
Monthly

Day Cases



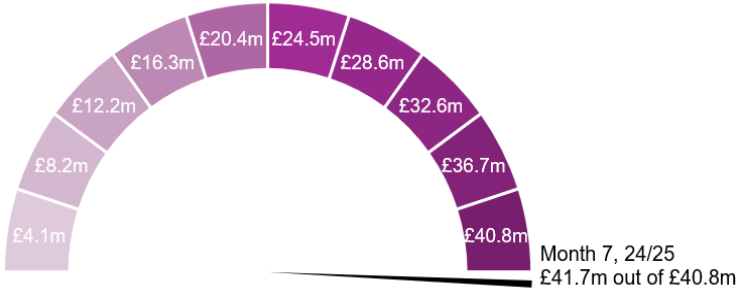
Monthly

Elective Inpatients



Monthly

Outpatients



Monthly

Our Resources

Scorecard

Metric Type	CQC Domain	Our Resources Metric	KPI	Latest Month	Latest Position	Target	Previous Month's Position	Assurance	Variation	Action	DQ Kite Mark
Corporate Project*	Well-Led	Driving Productivity and Financial Improvement	**Highlight Report Provided**								
Breakthrough Objective*	Well-Led	To reduce waste in our processes by March 2025	Paused								

***Strategic Priority**

Assurance						Variation			
P*	P	?	F	F-	No icon	H L	C	H L	
Consistently Passing Target	Meeting or Passing Target	Passing and Falling Short of Target	Falling Short of Target	Consistently Falling Short of Target	No Specified Target	Improving Variation	Common Cause (natural) Variation	Concerning Variation	

Our Resources

Driving Productivity and Financial Improvement Highlight Report

Our 12 to 18 month goal

To deliver high quality patient care in a financially sustainable manner. Ensuring that productivity and value is maximised within our services. Supporting transformation of processes and pathways, resulting in excellent patient outcomes within our available financial resources. Delivering 25/26 Cost Improvement Programme (CIP) targets on a recurring basis.

Latest Month	November 2024
Project status	**Project timeline on track**
Related Principle Risk	3.Financial

Key progress in last month

- Refreshed Productivity and Finance Improvement Group (PFIG) forum: Revised format and reporting into PFIG meeting. Updates now provided by workstream and divisional leads on trust wide initiatives
- Introduction of 5 year CIP pipeline: Shift of focus to longer term planning, enabling greater visibility of initiatives and support to aid and accelerate delivery.
- Improved position on NHSE productivity metrics: Continuation of improved productivity run rate performance metrics
- Medical Workforce Advisory Group (MWAG) planning discussions: Identification of key areas of focus and refreshed financial support.

Key aims for next month

- Further development and refinement of PFIG: Building on positive changes already in place, to ensure maximum value is added from meeting
- Refresh of trust workstreams: Review being undertaken to confirm areas of greatest opportunity to plan corporate resource allocation
- Continued development of workstream plans (new and existing): Programme Management Office (PMO) approach to developing high level outline workstream plans and subsequently detailed delivery actions
- Outputs of Finance Service Improvement Team (FSIT) Away Day: Further development and re-launch of FSIT support to organisation

High Level Roadmap

- Identifying financial improvement requirements for 25/26
- Establish workstreams to identify and support delivery across organisation
- Development of long term (5 Year) savings plans
- Use of productivity metrics to aid further improvements

Key risks and challenges

- Organisational capacity to take forward improvement initiatives (Pace of change)
- Ability of primary and social care partners to meet demand -No Criteria To Reside (NCTR) / Mental Health
- Scale of improvement required to match current funding allocations
- Physical estate restrictions hindering optimal use of resources
- Digital funding restrictions limiting transformation ability

Overall project achievements /Impact achieved

- 4.8% Productivity improvement @M5 vs 23/24 Financial year
- £32.5m Year end forecast savings achievement 24/25
- Year end trust financial forecast outturn favourable to majority of acute providers nationally

Our Resources

October 2024

2024/25 YTD Income & Expenditure Position	• Net I&E deficit of £6,448k against a breakeven plan, an improvement of £155k from last month. • Total operating income is £34,550k ahead of plan due to higher than planned income from activities (£30,485k) and other operating income (£4,065k). • Total operating expenditure is £42,875k adverse to plan due to higher than planned non-pay and depreciation costs at £11,367k and higher than planned pay expenditure at £31,508k. Financing costs combined are £1,509k favourable to plan. • c£30,000k of the variances for income from activities and pay are due to the pay award actioned in October. The plan will be re-aligned to reflect the changes in November.
Key Financial Issues	• *Recurrent savings delivery below plan* – YTD CIP delivery is £16,475k, behind plan by £7,156k or 30%. Recurrent savings are £10,790k, 46% of plan. • *Delivery of elective activity below plan* – elective activity must be delivered in line with plan. The cumulative YTD value of elective activity is £3.4m behind plan, an improvement of £0.6m in October. A continuation of the YTD performance could result in a total loss of income of c£4.0m and would result in the Trust failing to meet the financial plan. • *Failure to deliver the financial plan* – failure to deliver the savings and ERF requirement and therefore the financial plan of break-even will constitute a breach of this statutory duty and will result in regulatory intervention. A forecast outturn assessment will be undertaken in December using April to November actuals. The forecast outturn undertaken in September concluded , as a system, that the break-even plan remains deliverable.
Strategic Risks	• The scale of the Trust's recurrent deficit and CDEL constraint presents a significant risk to the Trust's strategic ambitions. Further work is required to develop the mitigating strategies, whilst acknowledging the Systems strategic capital prioritisation process will have a major influence and bearing on how we take forward strategic capital, including, for example, the Joint Clinical Strategy. This risk is assessed as high.

Our Resources

Trust Year to Date Financial Position

	Month 7			YTD		
	Plan	Actual	Variance Favourable/ (Adverse)	Plan	Actual	Variance Favourable/ (Adverse)
	£000's	£000's	£000's	£000's	£000's	£000's
Income from Patient Care Activities	93,247	115,948	22,701	636,543	667,028	30,485
Other Operating Income	9,886	12,607	2,721	69,202	73,267	4,065
Total Operating Income	**103,133**	**128,555**	**25,422**	**705,745**	**740,295**	**34,550**
Employee Expenses	(59,618)	(83,454)	(23,836)	(417,326)	(448,834)	(31,508)
Other Operating Expenses	(38,964)	(40,538)	(1,574)	(257,007)	(268,257)	(11,250)
Depreciation (owned & leased)	(3,459)	(3,420)	39	(23,763)	(23,880)	(117)
Total Operating Expenditure	**(102,041)**	**(127,411)**	**(25,370)**	**(698,096)**	**(740,971)**	**(42,875)**
PDC	(1,210)	(1,201)	9	(8,470)	(8,458)	12
Interest Payable	(247)	(223)	24	(1,729)	(1,584)	145
Interest Receivable	292	517	225	2,044	3,396	1,352
Net Surplus/(Deficit) inc technicals	**(73)**	**237**	**310**	**(506)**	**(7,322)**	**(6,816)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	73	(82)	(155)	506	874	368
Net Surplus/(Deficit) exc technicals	**0**	**155**	**155**	**0**	**(6,448)**	**(6,448)**

Key Facts:

- In October, the Trust delivered a £155k surplus against the plan of break-even. The cumulative YTD position at the end of the month is a net deficit of £6,448k (£6,603k at M6) against a breakeven plan. The Trust is therefore £6,448k adverse to plan. The cumulative YTD net deficit is 0.9% of total operating income.
- Significant variances in the year-to-date position include: the value of elective income behind plan by £3,437k, a shortfall on savings delivery of £7,156k and £4,339k of pay pressures relating mainly to nursing and medical staff.
- Income from Patient Care Activities and Employee Expenses overall show significant variances at the end of October due to the income received and cost related to the pay awards. The plan will be adjusted to reflect these changes in November.
- YTD, excluding the back-dated pay award, pay expenditure remains higher than plan as higher than planned medical staffing and nursing costs continue to cause concern across some divisions with continuing high pay costs in total across substantive, bank and agency staff.
- Agency expenditure in month is £828k, compared with £886k in September. Bank expenditure in month is £4,804k, compared with £4,308k in September.
- Total operating income is higher than plan by £34,550k. c£30m relates to the back-dated pay award. The shortfall in ERF is offset by higher than planned pass-through payments and additional other operating income.

Appendix

Assurance and Variation Icons – Detailed Description

VARIATION ICON	ASSURANCE ICON	P*	P	?	F	F-	*No icon*
		Consistently Passing target (target outside control limits)	Passing target	Passing and Falling short of target subject to random variation	Falling short of target	Consistently Falling short of target (target outside control limits)	No Target
H	Special Cause Improving Variation High, where up is improvement	Special Cause Improving Variation High, where up is improvement and target is less than lower limit.	Special Cause Improving Variation High, where up is improvement and last six data points are greater than or equal to target.	Special Cause Improving Variation High (where up is improvement) and last six data points are hitting and missing target, subject to random variation.	Special Cause Improving Variation High, where up is improvement but last six data points are less than target.	Special Cause Improving Variation High, where up is improvement but target is greater than upper limit.	Special Cause Improving Variation High, where up is improvement and there is no target.
L	Special Cause Improving Variation Low, where down is improvement	Special Cause Improving Variation Low , where down is improvement and target is greater than upper limit.	Special Cause Improving Variation Low, where down is improvement and last six data points are less than target.	Special Cause Improving Variation Low (where down is improvement) and last six data points are both hitting and missing target, subject to random variation.	Special Cause Improving Variation Low, where down is improvement but last six data points are greater than or equal to target.	Special Cause Improving Variation Low, where down is improvement but target is less than lower limit.	Special Cause Improving Variation Low, where down is improvement and there is no target.
C	Common Cause (natural/expected) variation	Common Cause (natural/expected) variation, where target is less than lower limit where up is improvement, or greater than upper limit where down is improvement.	Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is improvement, or less than target where down is improvement.	Common Cause (natural/expected) variation where last six data points are both hitting and missing target, subject to random variation.	Common Cause (natural/expected) variation where last six data points are greater than or equal to target where up is deterioration, or less than target where down is deterioration.	Common Cause (natural/expected) variation, where target is less than lower limit where up is deterioration or greater than upper limit down is deterioration.	Common Cause (natural/expected) variation with no target.
H	Special Cause Concerning Variation High, where up is deterioration	Special Cause Concerning Variation High, where up is deterioration but target is greater than upper limit.	Special Cause Concerning Variation High, where up is deterioration, but last six data points are less than target.	Special Cause Concerning Variation High, where up is deterioration and last six data points are both hitting and missing target, subject to random variation.	Special Cause Concerning Variation High, where up is deterioration and last six data points are greater than or equal to target.	Special Cause Concerning Variation High, where up is deterioration and target is less than lower limit.	Special Cause Concerning Variation High, where up is deterioration and there is no target.
L	Special Cause Concerning Variation Low, where down is deterioration	Special Cause Concerning Variation Low, where down is deterioration but target is less than lower limit.	Special Cause Concerning Variation Low, where down is deterioration but last six data points are greater than or equal to target.	Special Cause Concerning Variation Low, where down is deterioration and last six data points are both hitting and missing target, subject to random variation.	Special Cause Concerning Variation Low, where down is deterioration and last six data points are less than target.	Special Cause Concerning Variation Low, where down is deterioration and target is greater than upper limit.	Special Cause Concerning Variation Low, where down is deterioration and there is no target.

KEY
Note Performance
Patient First Metrics = Counter Measure Summary Constitutional Standards and Key Metrics = Escalation Summary

Theatres Touchtime Utilisation - Definitions

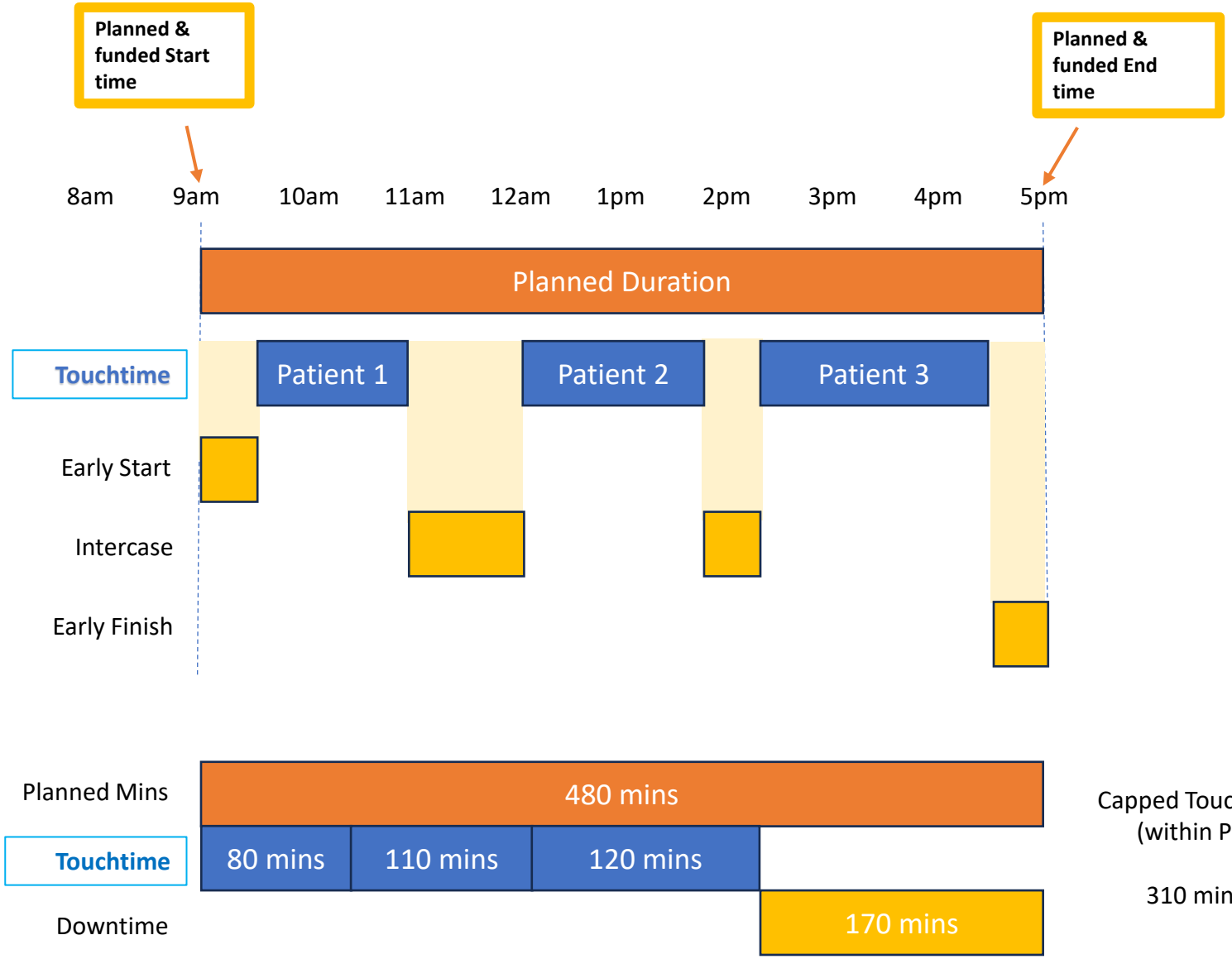
Return to Theatres Counter Measure Summary

Theatre Utilisation
The total amount of touchtime within the planned and funded amount of operating time available. E.g. If a theatre list starts at 8.30am and ends at 5.30pm there is 9 hours of operating time available

Touchtime
Starts when the patient enters the anaesthetic room and ends when the patient leaves theatre to go to recovery.

Capped Touchtime calculation
Individual touchtime for all patients on the theatre list is added together. This is then subtracted from the operating time available for that list and expressed as the percentage of the theatre list utilised.

Theatres Touchtime Utilisation: Capped Touchtime Example 1

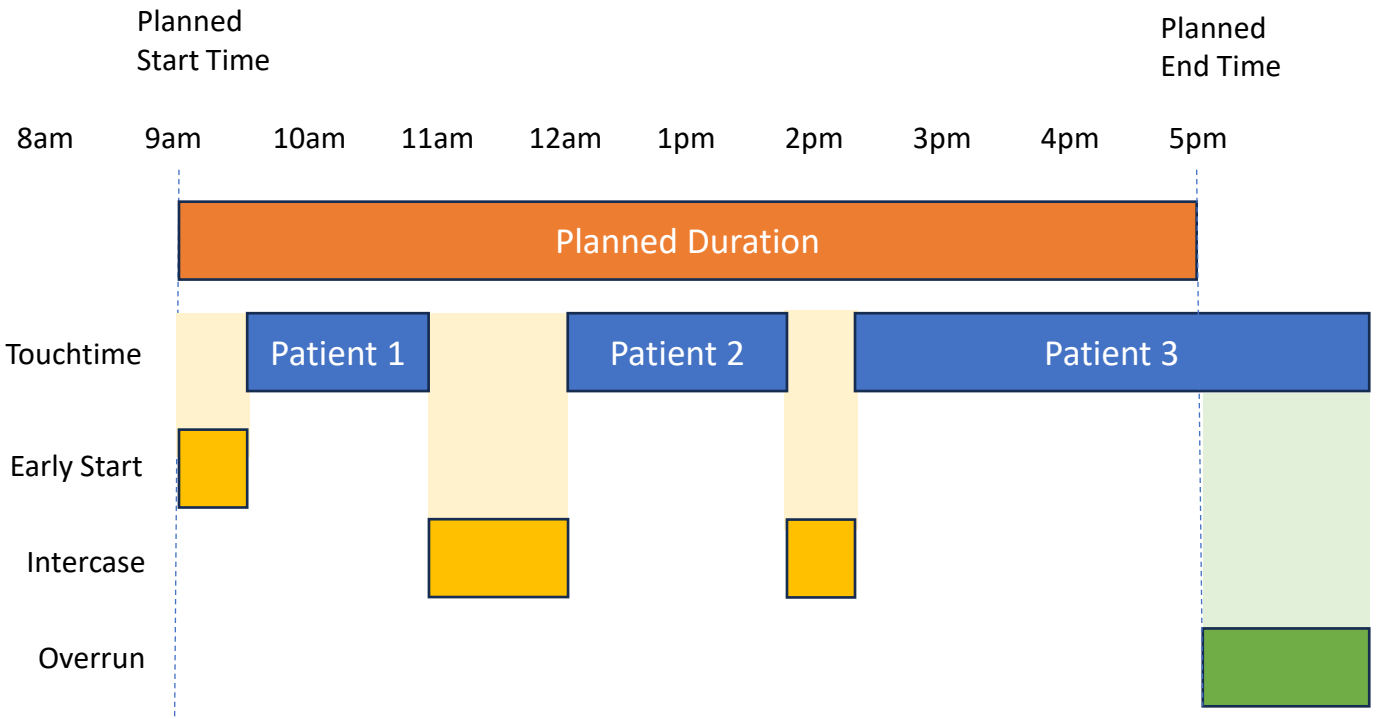


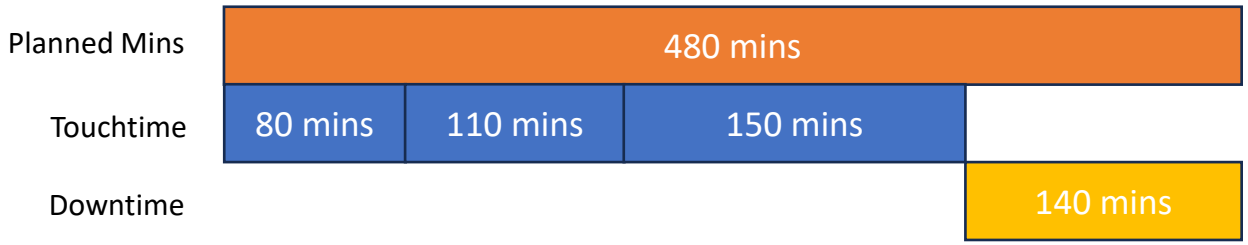
Return to Theatres Counter Measure Summary

Capped Touchtime = Touchtime (within Planned End Time) / Planned Duration
310 mins / 480 mins = 64%

Theatres Touchtime Utilisation: Capped Touchtime Example 2

Return to Theatres Counter Measure Summary





Capped Touchtime = Touchtime (within Planned End Time) / Planned Duration
340mins / 480 mins = 70%