University Hospitals Bristol and Weston NHS Foundation Trust

February 2025 Published Papers

Including:

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

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 January 2025
Data up to December 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.

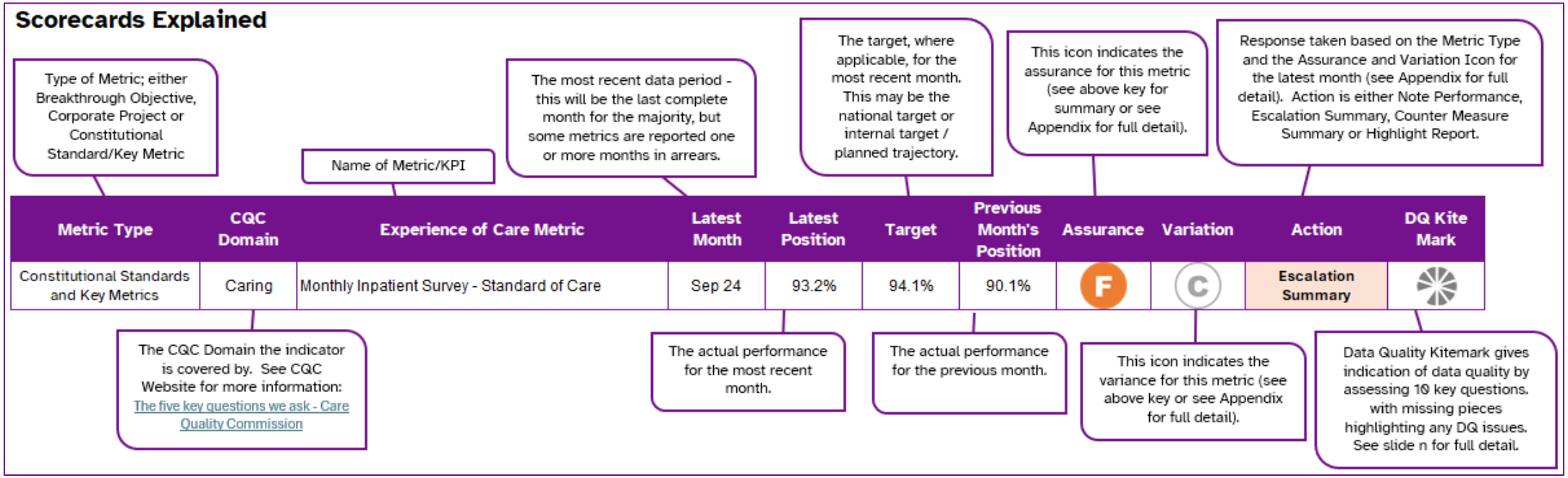
Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (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



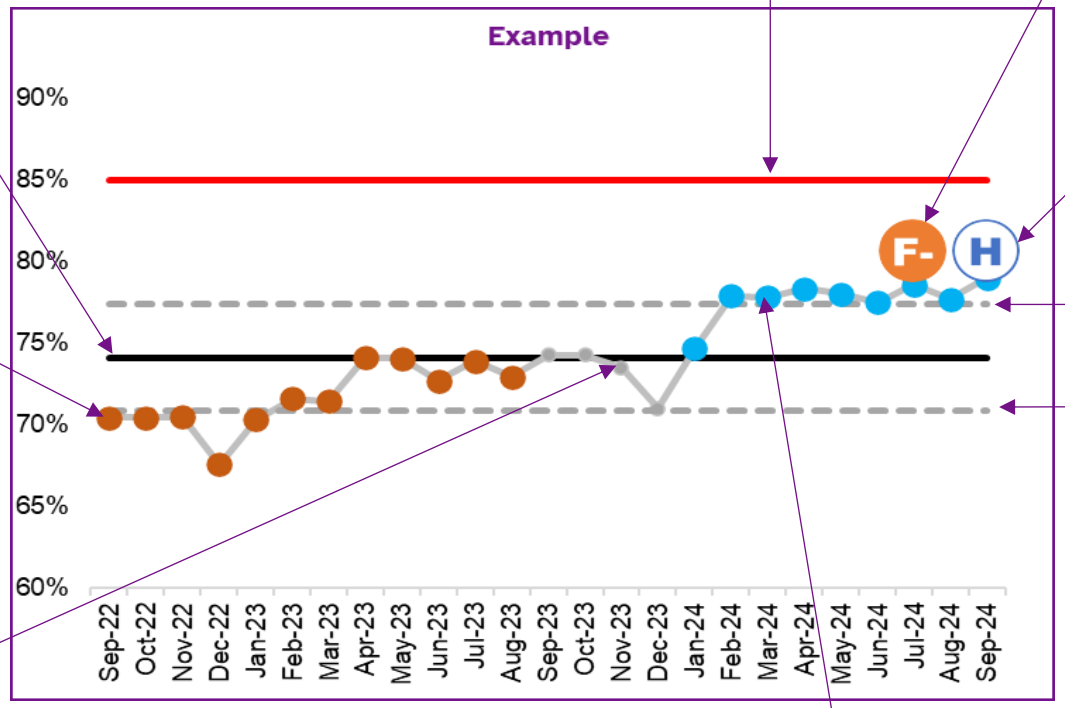
Statistical Process Control (SPC) Charts

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 **L**ow 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 **C**ommon **C**ause due to **Unstable Variation** (highs and lows)

Now, Metric has **Improving Variation** due to consistent **H**igher 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.

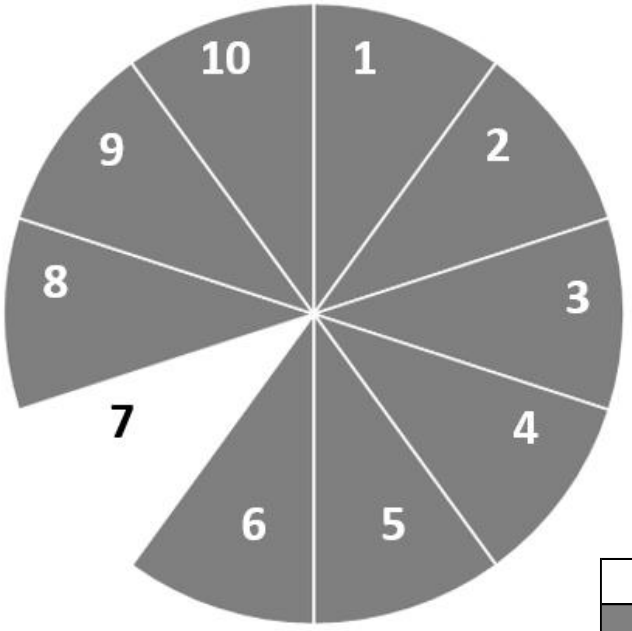
Metrics that fall into the **blue categories** above will be labelled as **Note Performance**. The SPC charts and accompanying narrative will not be included in this iteration.

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:

Improving Experience of care through better communication objectives have in December 2024 achieved:

•Throughout the Medicine Divisions wards "What Matters to you" 'pocket guides' disseminated and the first meeting held of Experience of Care champions held.

• In Specialised Services a pilot of bedside handover on C705 ward in Bristol Heart Institute. A further stratification of communication metric data by ward has been undertaken to understand key trends.

•At Weston General Hospital, patient surveys were undertaken on discharge experience to provide data to help drive improvement. Discharge information boards have been created to go above patient beds for consistency of communication.

Patient Safety:

The implementation of Martha's Rule was launched in Bristol Children's Hospital on 6th January 2025. Three Martha's Rule calls have been made at the time of writing, all three children were seen and assessed by the Children's Critical Care Outreach Team and managed appropriately. Informal initial feedback about experiences of the process for Martha's Rule in the Children's Hospital has been mainly positive. Analysis and learning from these cases is planned for early February. In adult services, progress continues as part of a joint project with North Bristol Trust to test approaches to the three elements of Martha's Rule. This includes reaching out to community groups such as African Voices and Bristol Deaf Partnership to help us build an accessible and inclusive process. We are also exploring digital opportunities to enable people whose first language is not English to make a Martha's Rule call in their first language, which is detected and auto-translated to English for the receiver and the initial response is translated back to the person's first language.

During December 2024 there were 167 falls which equates to 4.865 per 1,000 beddays, in line with the trust target and showing normal variation. There were 11 falls with moderate or severe physical and/or psychological harm which is indicating special cause variation. Initial review of the special cause variation has identified some characteristics of some of the falls that are infrequent but co-incided during the month of December contributing to the special cause variation. These are described in the highlight report.

The trust had one case of MRSA in December 2024. Year to date there have been seven cases recorded. UHBW remain within the national upper quartile of MRSA blood stream infections. A relaunch of the new streamlined MRSA management pathway is from 20th January 2025, as part of the delivery of the quality improvement outcomes has begun, with key actions for improvement related to screening, assessment and decolonisation.

Executive Summary

Our People:

- Overall vacancies increased to 3.0% (384.4 FTE) compared to 2.7% (343.9 FTE) in the previous month.
- Turnover remained static at 11.1%.
- Sickness absence reduced to 4.5% compared to 4.6% the previous month (updated figures).
- Appraisal compliance reduced to 81.0% December compared to 83.3% in November. Increases were seen in three divisions, with reductions in the remaining six.
- Agency usage is at 0.6% (73.8 FTE) against a target of 1.0% maximum.

As part of the Pro Equity Corporate Project all Divisions now have a Pro-Equity plan in place reviewed as part of the Executive Divisional Strategy Deployment Review process . A multi-disciplinary workshop has reviewed findings on sexual safety, anti-racism and anti-ableism, 3 subgroups have been set up and have commenced work on outline plans. A peer review of the plans is scheduled for 25th February, and we aim to have a consolidated plan for pro-equity in place by end of March, which will also include our staff survey benchmarked data for 2024/25.

Medical Workforce Corporate Priority Project: Premium spend rate reduction negotiations continue with highest cost agency placements. Action will now focus on scoping locum bank rate alignments across the region. Resident Doctor Rota Review has progressed at the Children's Hospital, PICU and Paediatrics, Cardiac Surgery are priority areas. The outline case for the Locally Employed Doctors Medical Rotation is complete.

Executive Summary

Timely Care:

Bed occupancy remains high in December (BRI: 104.6% and Weston 99.7%) 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 December, the Trust reported 54 patients waiting more than 65 weeks for treatment. The Trust continues to develop and implement strategies to address the remaining number of 65ww in dental services with the aim of eliminating within Q4.

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

At the end of December, performance against the diagnostic six week wait standard was reported as 83.0% against the operational planning trajectory of 93.1%, a deterioration from November (87.0%). The impact of diagnostic recovery plans in train continue to be reviewed to ensure year-end delivery.

Performance against the ED 4-hour standard in December dropped to 70.0% from 71.7% in November (74.5% YTD) against a system and NHSE ambition of 78%. Performance against the ED 12-hour standard also deteriorated to 7.0 % (November, 5.4%) against the national target of 2%.

During December, the average daily number of patients in hospital with No Criteria to Reside (NCtR) remained at 183 (also 183 in November), this equates to 20.8% of total available beds (17.5% at BRI and 27.9% at Weston) compared with 21.0% in November (17.1% at BRI and 29.9% at Weston).

Theatre utilisation fell slightly below the NHSE set target of 81% in December, reporting 80.8% and outpatient DNA rates have increased to 6.6% (5.8% in November), noting that a drop in performance against both measures is typical at this time of year and full recovery is anticipated.

Our Resources:

In December, the Trust delivered a £150k surplus against the plan of break-even. The cumulative YTD position at the end of the month is a net deficit of £6,168k (£6,318k net deficit last month) against a breakeven plan. The Trust is therefore £6,168k adverse to plan. The cumulative YTD net deficit is 0.6% of total operating income.

Significant operating expenditure variances in the year-to-date position include: the shortfall on savings delivery; premium pay pressures and over-establishment mainly relating to nursing and medical staff; higher than planned pass-through costs (matched by additional patient care income) and the impact of unfunded non-pay inflation.

YTD pay expenditure is c3% higher than plan on medical staffing in the Women's & Children's Division and nursing costs continue to cause overspends across Surgery, Specialised and Women's & Children's Division with continuing high nursing pay costs in total across substantive, bank and agency staff. Agency expenditure in month is £754k, compared with £990k in November. Bank expenditure in month is £4,069k, compared with £4,311k in November. Total operating income is higher than plan by £25,755k. The shortfall in ERF of £3,401k is offset by higher than planned pass-through payments, additional commissioner funding and additional other operating income.

Matrix Summary – Constitutional Standards and Key Metrics

December 2024			Assurance					
			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
Variance	H L	Special Cause - Improvement	•Percentage Agency Usage •Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	•Cancer - 28 Day Faster Diagnosis •Cancer 62 Day Referral To Treatment •Cancer 31 Day Diagnosis To Treatment •Essential Training Compliance •Staffing Fill Rate - Combined	•Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours		•Diagnostics Percentage Under 6 Weeks (15 Key Tests) •Theatres - Touchtime Utilisation	
	C	Common Cause	•Pressure Injuries Per 1,000 Beddays •Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	•Friends and Family Test Score - ED •Hospital Standardised Mortality Ratio (HSMR) •Sickness Rate •Workforce Turnover Rate	•Monthly Outpatient Survey - Overall Experience •Formal Complaints Responded To Within Trust Timeframe •Informal Complaints Responded To Within Trust Timeframe •Falls Per 1,000 Beddays •CDiff Healthcare Associated Cases •ED Percentage Spending Over12 Hours in Department •ED Percentage Spending Under 4 Hours in Department	•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 •Outpatient DNA Rate	•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			•Total Number of Patient Falls Resulting in Harm		•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

Principal Related Risk: 1. Quality

Experience of Care

Our Vision

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

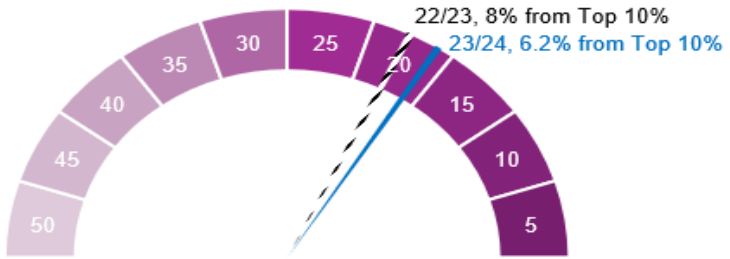
Our Goal

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

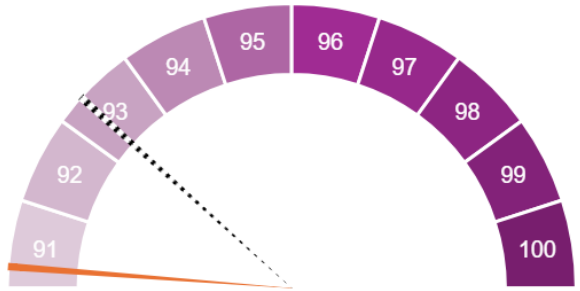
Vision Metrics

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



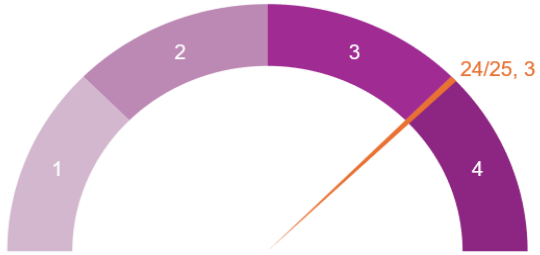
Annual

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



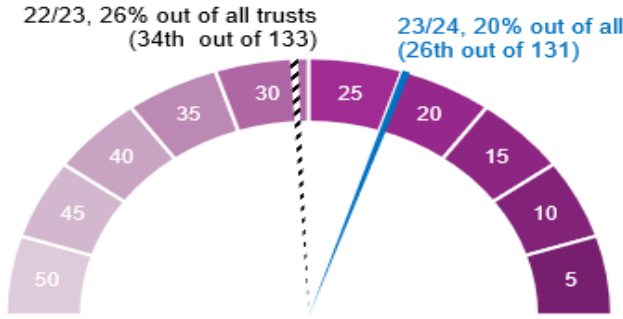
Monthly

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



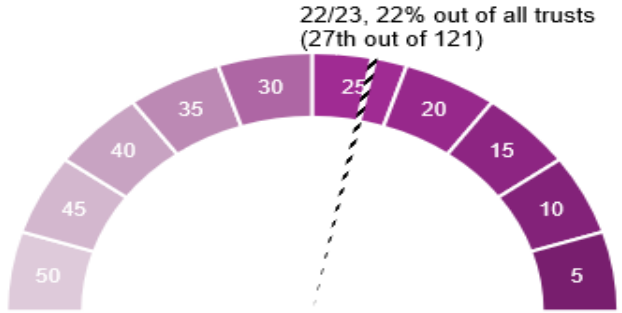
Monthly

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



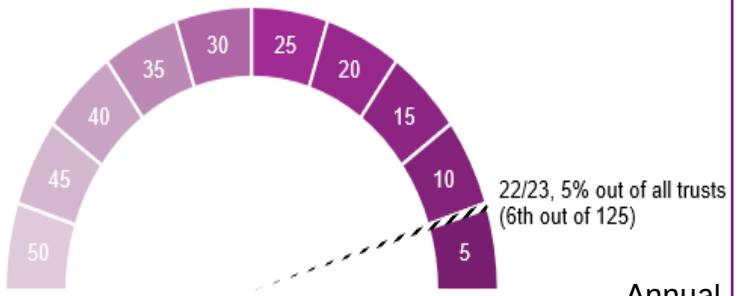
Annual

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

The number displayed represents the maximum of that segment

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	Dec 24	83.9	88.0	83.7	F-	C	Counter Measure Summary	
Constitutional Standards and Key Metrics	Caring	Monthly Inpatient Survey - Overall Experience	Dec 24	92.4%	94.1%	92.9%	F	C	Escalation Summary	
	Caring	Monthly Outpatient Survey - Overall Experience	Dec 24	95.1%	97.5%	98.4%	?	C	Escalation Summary	
	Caring	Friends and Family Test Score - ED	Dec 24	86.3%	85.0%	86.3%	P	C	Note Performance	
	Caring	Patient Complaints - Formal	Nov 24	24	No Target	45	n/a	L	Note Performance	
	Caring	Formal Complaints Responded To Within Trust Timeframe	Nov 24	74.0%	90.0%	59.0%	F	C	Escalation Summary	
	Caring	Informal Complaints Responded To Within Trust Timeframe	Nov 24	81.9%	90.0%	87.4%	?	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	

Experience of Care

Mental Health across UHBW Highlight Report

Our 12 to 18 month goal:

To have a robust infrastructure to support the Mental Health (MH) care of patients, ensuring the safety of patients & staff, by September 2025

Latest Month	January 2025
Project status	**Project timeline on track**
Related Principle Risk	1. Quality

Key progress in last month

- MH Charter reviewed & updated timelines provided
- Project Priorities agreed (*Agency Registered Mental Nurse (RMN) reduction; Restrictive Practice reduction*)
- Guidance for 1:1 MH Care (ie Mental Health Support Workers (MHSW) v RMN booking) developed.
- Model agreed (Aligned Services) for Single Managed Service (SMS) for UHBW & North Bristol Trust Liaison Psychiatry Services (LPS) (inc. Weston)
- Project Driver diagram completed: mini-project charters identified

Metrics in box

Weekly data for RMN usage to be collated

Metrics in box

monthly data for Restrictive Practice incidents to be collated

Key aims for next month

Review Mental Health Act (MHA) Policy

Establish 5 key 'mini-charters' (MH Safer Spaces; MHA Compliance; MH Training; MH Management- Trustwide model; UHBW MH Strategy, all ages- to align with Integrated Care Board (ICB) & NBT)

Complete Gap analysis of MH Services across UHBW

Agree process for delivery of function of 'MH Harm reduction' strand

Roll-out 1:1 MH Guidance Standard operating procedure (SOP) with Training

High Level Roadmap

•Dec 24- MH Project Charter commenced

•Mar 25- MHA Policy Completed

•Apr 25- LPS SMS Completed

•Apr 25 –MH Strategy Completed

•Mar 25- 20% reduction in RMN usage;

with further 20% reduction per month

Key risks and challenges

•Breadth of project & prioritisation

•Funding required to deliver MH training Trust wide ('MH Module' & 'Suicide Prevention')

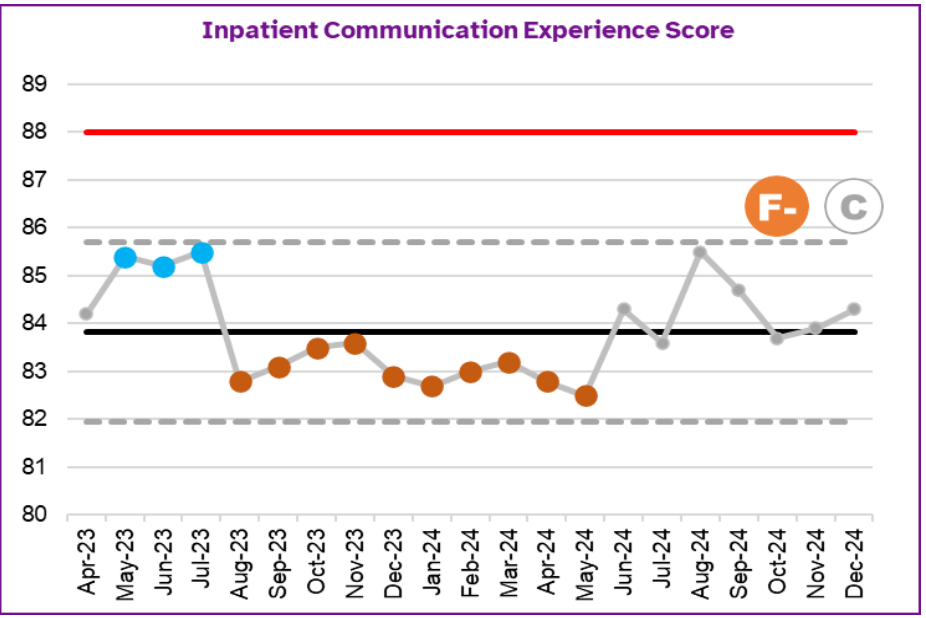
•Substantial future funding required for ward/bay adaptations to provide 'MH Safer' spaces.

Overall project achievements /Impact achieved

Recruitment of Project Lead & defined Project Management Team established: *Charter formally commenced*

Experience of Care

Monthly Inpatient Survey - Communication Counter Measure Summary



Inpatient Communication Experience Score

Latest Month
Dec-24

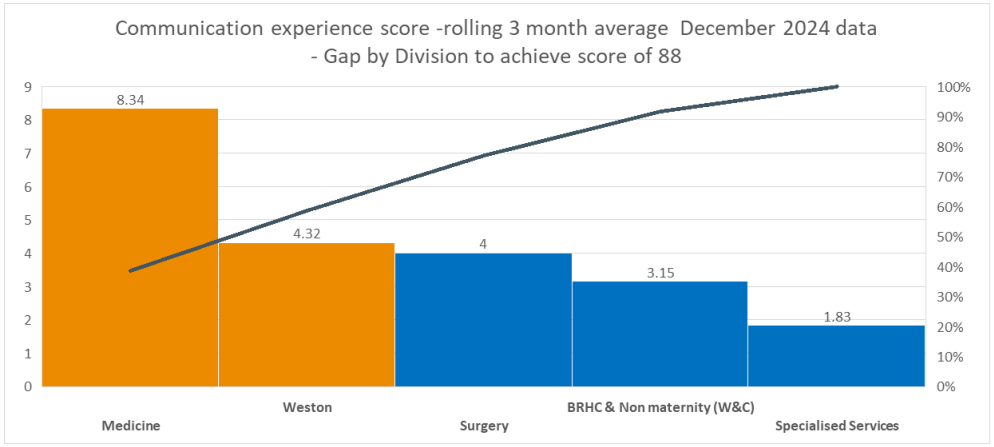
Target
88.0

Latest Month's Position
84.3

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

Risk
No risk on Board Assurance Framework

Stratified data



Note: Maternity = 88.5 rolling 3 month average in December 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

No new key progress due to festive period and new year operational pressure. December's IQPR update:
•Weston, Medicine and Specialised have reduced the gap to achieving target.
•What Matters to you 'pocket guides' disseminated throughout Medicine wards and the first meeting held of Experience of Care champions held.
• Pilot of bedside handover on C705 ward in Bristol Heart Institute. Further stratification of communication metric data by ward to understand key trends.
• At Weston General Hospital, patient surveys were undertaken on discharge experience to provide data to help drive improvement. Discharge information boards have been created to go above patient beds for consistency of communication.

Next actions

• Medicine embedding a new communication needs sheet on A522 (key countermeasure from A3 project) and implementing a "This is me" form which helps to get to know the young patient better (a first draft is being shared with the Youth Involvement Group for feedback on content).
• Specialised Services will be reviewing the pilot of bedside handover and introducing a new Experience of Care Champion role.
• Weston will be introducing a discharge communication flow chart and focusing on increasing the proportion of staff completing Accessible Information Standard training.

Experience of Care

Monthly Inpatient and Outpatient Survey – Overall Experience Escalation Summary

Monthly Inpatient Survey – Overall Experience

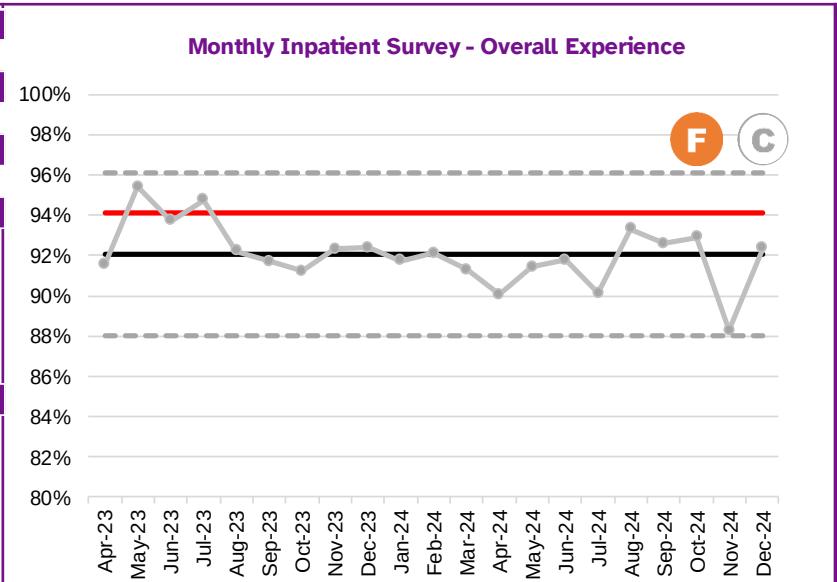
Latest Month
Dec-24

Target
94.1%

Latest Month's Position
92.4%

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

Corporate Risk
5942 - Risk that patients' communication requirements are not identified, and care is suboptimal or delayed (12)
1702 - Risk that the Trust does not meet the communication needs of patients with a disability or sensory impairment (AIS) (12)



Summary

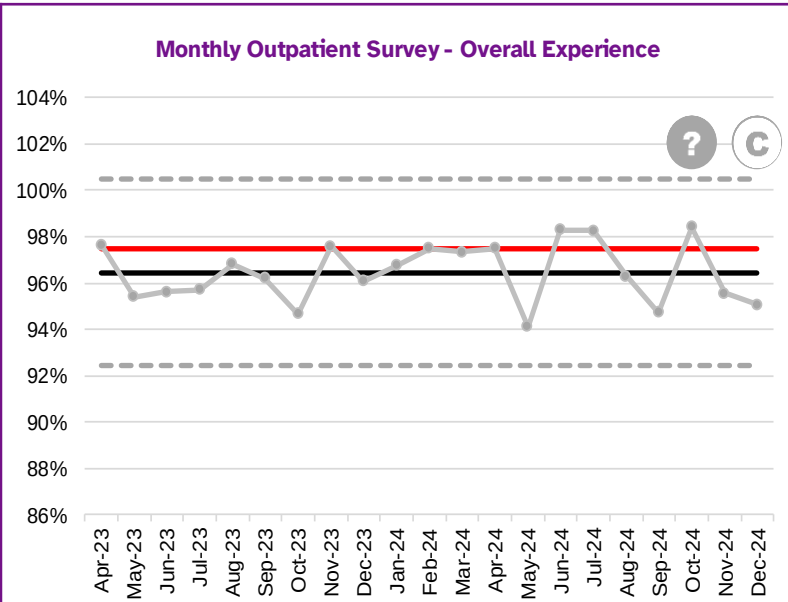
Please note that latest month's data will change as more surveys are received. Therefore, the latest month's data should be treated with caution.

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
Dec-24

Target
97.5%

Latest Month's Position
95.1%

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

Corporate Risk
5942 - Risk that patients' communication requirements are not identified, and care is suboptimal or delayed (12)
1702 - Risk that the Trust does not meet the communication needs of patients with a disability or sensory impairment (AIS) (12)

Summary

The mean for outpatient survey score is above 96% with relatively few patients indicating that their experience is less than 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

Formal Complaints Responded To Within Trust Timeframe

Latest Month

Nov-24

Target

90%

Latest Month's Position

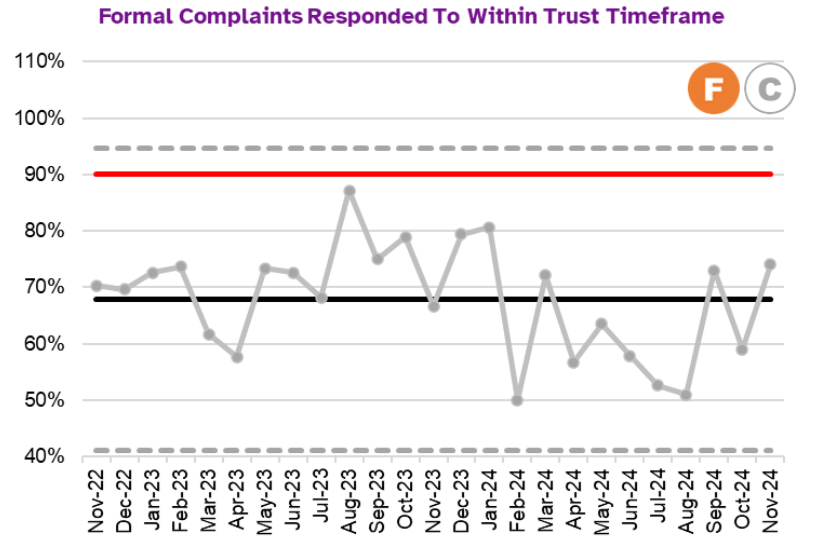
74.0%

Performance / Assurance

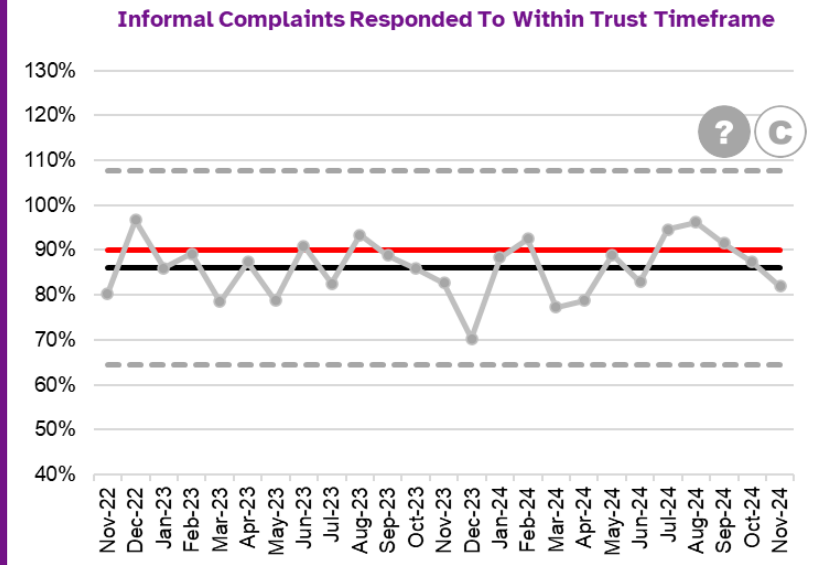
Common Cause (natural/expected) variation where last six data points are less than target where down is deterioration.

Corporate Risk

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



Informal Complaints Responded To Within Trust Timeframe



Informal Complaints Responded To Within Trust Timeframe

Latest Month

Nov-24

Target

90%

Latest Month's Position

81.9%

Performance / Assurance

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

Corporate Risk

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

Summary

In November 2024:

- 196 new complaints were received (24 formal, 134 informal and 38 PALS Concerns).
- 97% of complaints and concerns received in November were acknowledged in line with national guidance (within three working days).
- Responses for 46 formal and 83 informal complaints were sent out to complainants in November and 34 PALS concerns were sent out.
- 82% of informal complaints were responded to by the agreed deadline (below the target of 90%).
- 74% of formal complaints were responded to by the agreed deadline (below the target of 90%).

The majority of complaints continue to be resolved via the informal pathway.

Of 45 first formal complaints responded to in October (reported two months in arrears), four complainants told us they were unhappy with our response (8.9%, which is marginally above our target of 8%).

The Trust increasingly encourages rapid informal resolution of complaints wherever possible. This provides an explanation for the overall reduction in formal resolution over time. Complaints investigated formally are increasingly those which are complex in nature, which is also a contributory factor to the Trust's recent performance in relation to meeting investigation timescales.

Patient Safety

Principal Related Risk: 1. Quality

Patient Safety

Our Vision

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

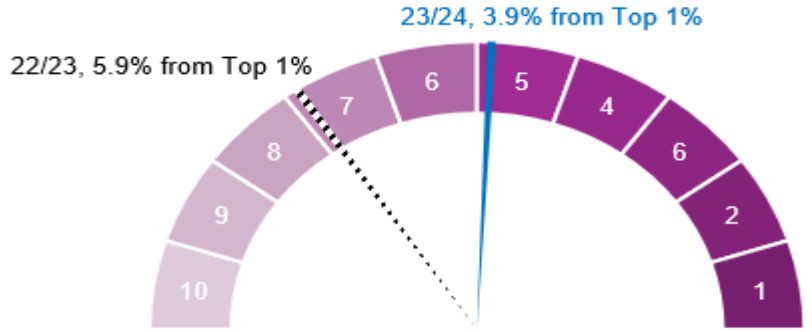
Our Goal

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

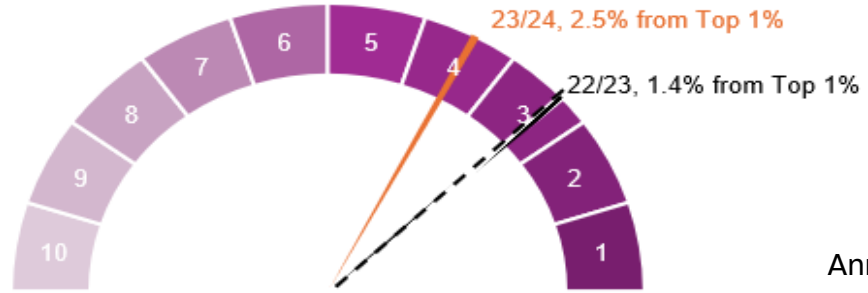
Vision Metrics

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



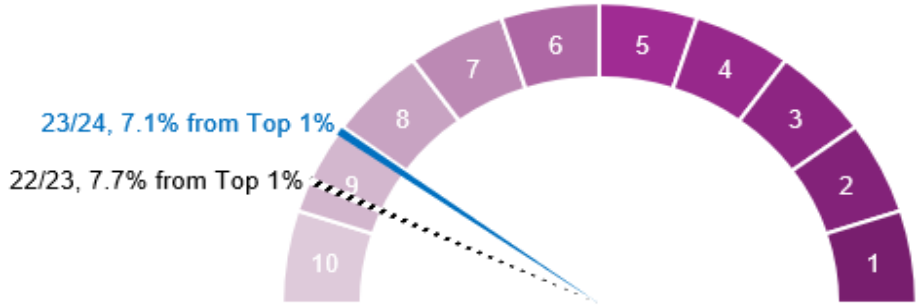
Annual

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



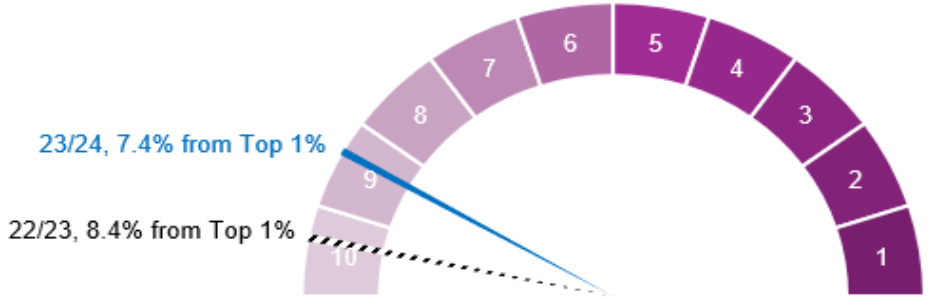
Annual

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

The number displayed represents the maximum of that segment

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	Nov 24	3.9	4.8	3.9	?	C	Escalation Summary	
	Safe	Total Number of Patient Falls Resulting in Harm	Nov 24	5	2	7	?	H	Escalation Summary	
	Safe	CDiff Healthcare Associated Cases	Nov 24	8	9	5	?	C	Escalation Summary	
	Safe	MRSA Hospital Onset Cases	Nov 24	1	0	0	F	C	Escalation Summary	
	Safe	Adult Inpatients who Received a VTE Risk Assessment	Nov 24	75.5%	90%	75.5%	F-	L	Escalation Summary	
	Safe	Pressure Injuries - Grade 3 or 4	Nov 24	1	0	1	F	C	Escalation Summary	
	Safe	Pressure Injuries Per 1,000 Beddays	Nov 24	0.12	0.40	0.12	P*	C	Note Performance	
	Safe	Staffing Fill Rate - Combined	Nov 24	102.7%	100%	104.6%	P	H	Note Performance	
	Safe	Mixed Sex Accommodation Breaches	Dec 24	8	0	10	F	C	Escalation Summary	
	Effective	Fracture Neck of Femur Patients Treated Within 36 Hours	Dec 24	51.4%	90%	56.8%	F-	C	Escalation Summary	TBC
	Effective	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	Dec 24	94.6%	90%	84%	?	H	Note Performance	TBC
	Effective	Fracture Neck of Femur Patients Achieving Best Practice Tariff	Dec 24	48.6%	No Target	40.9%	n/a	C	Note Performance	TBC
	Effective	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	Aug 24	91.0	100	91.4	P*	L	Note Performance	
	Effective	Hospital Standardised Mortality Ratio (HSMR)	Sep 24	80.4	100	76.9	P	C	Note Performance	
	Effective	Maternity Services Perinatal Quality Surveillance Matrix (PQSM)	Dec 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	January 2025
Project status	**Project timeline on track**
Related Principle Risk	1. Quality

Key progress in last month

- The focus in December has been planning the next three priority projects for the deteriorating patient improvement programme:

-improving recording of escalation, review and response to patient deterioration

-improving escalation pathways

-developing safe processes for determining and implementing revised escalation thresholds when individual patients require this.

We are working with North Bristol Trust to scope opportunities for collaboration and alignment and potentially standardise revised escalation thresholds.

Key aims for next month

- Finalise stakeholder mapping and project planning for improvement priority projects for Escalation and Response.
- Commence audit for Modified Obstetric Early Warning Score (MOEWS) in non-obstetric settings (previously delayed due unavailability of staff to complete).
- Divisions to commence updates on progress via Exec Divisional SDRs.

High Level Roadmap

- February 2025 – commence project working group meetings.
- March 2025 – completion of audit for Modified Obstetric Early Warning Score (MOEWS) in non-obstetric settings to support evaluation.

Key risks and challenges

- Substantial resource required for process of data collection (manual audit) (Risk 3452).
- Reduced capacity of the Patient Safety Improvement Team resulting in an inability to maintain progression and delivery of projects (Risk 3452).
- 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) (Risk 588).
- CareFlow Vitals Sepsis NICE module (aligned to 2024 NICE update) not available until 2026 (Risk 7919).
- 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 Leads limits effective adoption of 2024 NICE Sepsis Guidance (Risk 7919).

Overall project achievements /Impact achieved

- Between Aug – Oct 2024, 378 patients were sampled across adult inpatient areas and adult EDs. 175 patients required screening for sepsis; of these, 37 (21%) had documented evidence of sepsis screening (on the UBHW Screening Tool and Pathway, based on 2024 NICE guidance).
- 74 of the 175 patients (who required screening) were identified as 'high risk' of having or developing sepsis and required the delivery of the Sepsis Six; of these, 14 (19%) patients had documented evidence of the delivery of the Sepsis Six (on the UHBW Screening Tool and Pathway, 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 North Bristol Trust (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	January 2025
Project status	**Project timeline off track**
Related Principle Risk	1. Quality

Key progress in last month

- Patients/families/lay partners identified to be involved in co-design of an inclusive and accessible process and resources that works best for them. Initial meetings with commenced
- Ongoing development of a communications plan, with draft content underway for leaflets, videos, stickers and posters
- Martha's rule launched in Bristol Royal Hospital for Children
- UHBW (Adults) commenced drafting a digital wellness questionnaire
- Ongoing exploration with telecommunication accessible options for calls to be taken from patient, families and carers, including people who don't have English as a first language
- UHBW digital resources have been allocated from Business Intelligence (BI), digital clinical specialist , systems development, and business analyst teams
- Medicus Electronic Patient Record (EPR) records and available data sense checked against NHSE reporting requirements – amendment requests in process

Key aims for next month

- Agree measurement strategy
- Finalise communications plan.
- Identify medical leads
- Confirm ward areas for testing
- With BI explore data extraction options using Medicus
- Develop staff training
- Approval for developed patient questionnaire for baseline awareness

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 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
- Aiming to have first data from test ward in February 2025

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 Patient Administration System (PAS) for use within the inpatient hospital bed base.

Latest Month	January 2025
Project status	**Project timeline on track**
Related Principle Risk	1. Quality

Key progress in last month

- **Process Mapping/Standard Operating Procedures (SOPs):** team to continue to complete mapping and progress SOP work
- **Clinical Configuration:** Continue with final clinical configuration in Live system. Outputs of mitigations and testing has been reviewed to ensure system is configured with any additional requirements
- **Training:** Workstream critical path items based upon option chosen by CMM board develop and make available some training material to end users and progress the elearning
- **Resource:** onboard and embed additional resources to sure up plan, 3.0 Whole Time Equivalent (WTE) additional temp pharmacy staff onboarded other resources still outstanding
- **Go Live Planning:** Ongoing development of go live plans with Divisions, initial dates and sites to be presented to the CMM board in January
- **Business Continuity Plan (BCP) /Business As Usual (BAU**): Resilience hardware testing to be rescheduled. BCP workstream lead to be agreed
- **Communications:** animation to be released and engagement sessions to begin, - engagement sessions being planned in for February, animation to be released at the end of January
- **Technical/Hardware (HW**): finish deploying additionally identified hardware and order the next batch of HW, additional HW audit to complete in January.
- **Clinical Safety:** Hazard workshops are now in progress with the first workshop being well attended.
- Continue to build confidence in the project and the business, review and agree Paediatric position – ongoing but improving
- Continue to improve the governance and control mechanisms to support workstreams delivering on time – ongoing but improving

Key aims for next month

- **Process Mapping/SOPs:** team to continue to complete mapping and progress 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 develop and make available some training material to end users
- **Resource:** onboard and embed additional resources to sure up plan
- **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
- **Communications:** animation to be released and engagement sessions to begin,
- **Technical/Hardware:** finish deploying additionally identified hardware and order the next batch of Hardware
- **Clinical Safety:** Hazard workshops to be progressed
- Continue to build confidence in the project and the business,
- Increased work to be undertaken around Paediatrics in drug file and protocol build
- Continue to improve the governance and control mechanisms to support workstreams delivering on time
- Run go no go, process and stress test current plan and position to highlight gaps and risk along with any critical path items and to provide additional assurance to Digital Senior Leadership Team (SLT) and business that plan is solid.

High Level Roadmap

- Go live agreed for May 2025, with Western hospital being the first area to go live with CMM

Key risks and challenges

- Resource and the ability to onboard it swiftly, to provide the push needed to go live in May, confidence remaining in the programme to ensure the business has the confidence to go live,

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.

Patient Safety

Harm Free Care – Inpatient Falls Escalation Summary

Falls Per 1,000 Bed days

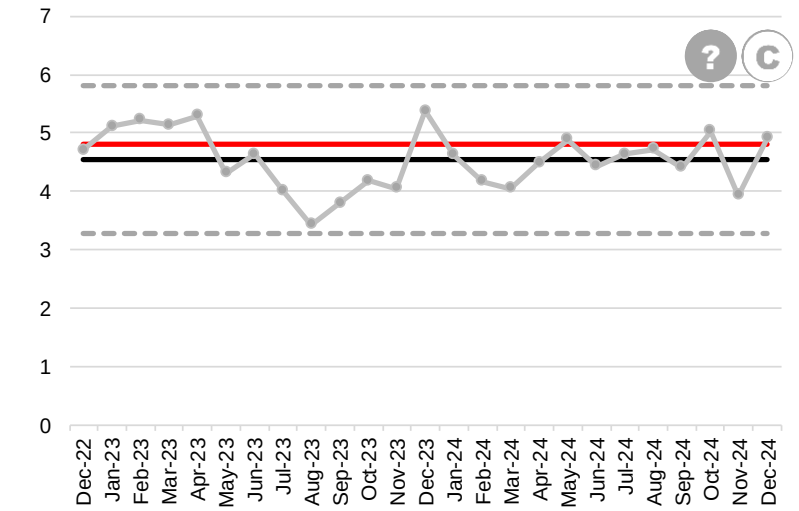
Latest Month
Dec-24

Target
4.8

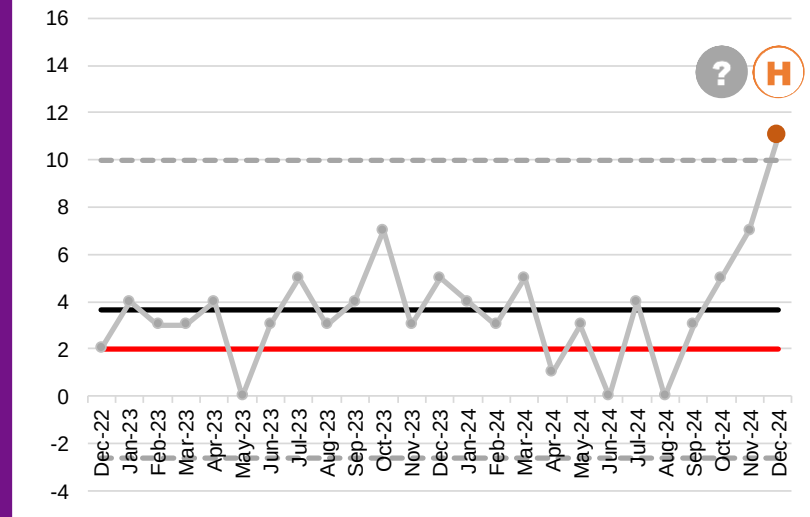
Latest Month's Position
4.9

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

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



Total Number of Patient Falls Resulting in Harm



Latest Month
Dec-24

Target
2

Latest Month's Position
11

Performance / Assurance
Special Cause Concerning Variation High, where up is deterioration and last six data points are both hitting and missing target, subject to

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

Summary

During December 2024, there were 167 falls, which equates to 4.865 per 1000 beddays and is in line with the trust target of 4.8 per 1000 bed days. There were 120 falls at the Bristol site and 47 falls at the Weston site. There were 11 falls with moderate or severe physical and/or psychological harm.

An initial review of the special cause variation of falls with harm identified two of these involved children and one occurred in an outpatient setting, both of which are unusual. A further incident occurred in a previous month but the harm associated with it was identified in December following imaging and is therefore included in December's figures. In addition, since April 2024 when we started recording physical and psychological harm related to incidents separately as required by NHSE Learning From Patient Safety Events system (LFPSE), December was the first month when an incident was recorded that was assessed as being associated with low physical harm but moderate psychological harm and is therefore included in the figures..

Risk of falls continues to remain on the divisions' risk registers as well as the Trust risk register. Actions to reduce falls, all of which have potential to cause harm, is provided below.

Actions:

- Learning: In December, Weston General Hospital and Women's and Children Division shared their learning from their analyses of falls incidents at the Dementia, Delerium and Falls Group. They shared some patient stories and learning themes: environmental factors- distance from bed to bathroom, a significant number of unfilled staffing shifts and a high number of patients requiring enhanced care observation.
- Audit: We are participating in the National Audit of Inpatient Falls, The next audit is expanding to include head injury, spinal injury or any fracture from an inpatient fall as well as hip fractures. This may provide new national and local insights when published.
- Improvement: Improving completion and use of the Multi Factorial Risk Assessment (MFRA) document. Following a programme of education and support to increase awareness of completing the MFRA a reaudit is planned for February 2025. 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.
- The Dementia Garden Project is embedded in the 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 education sessions 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
Dec-24

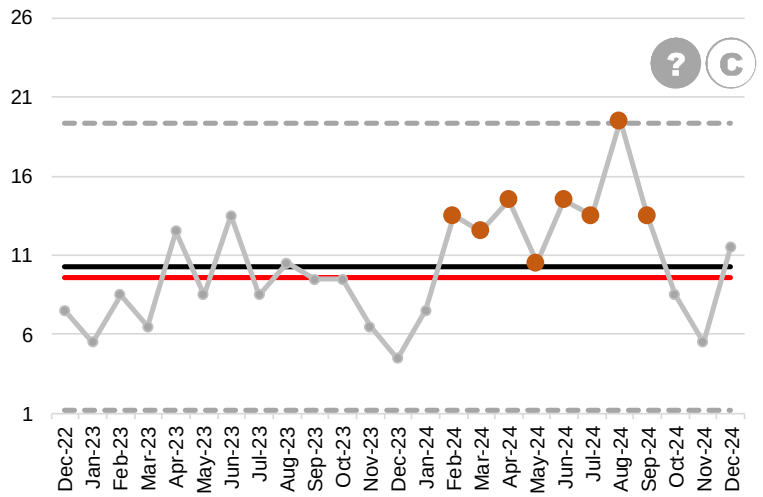
Target
9.08

Latest Month's Position
11

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

Corporate Risk
Risk 3216 - Risk that the Trust will breach the NHSE Limits for cases of clostridiodes difficile (12)

CDiff Healthcare Associated Cases

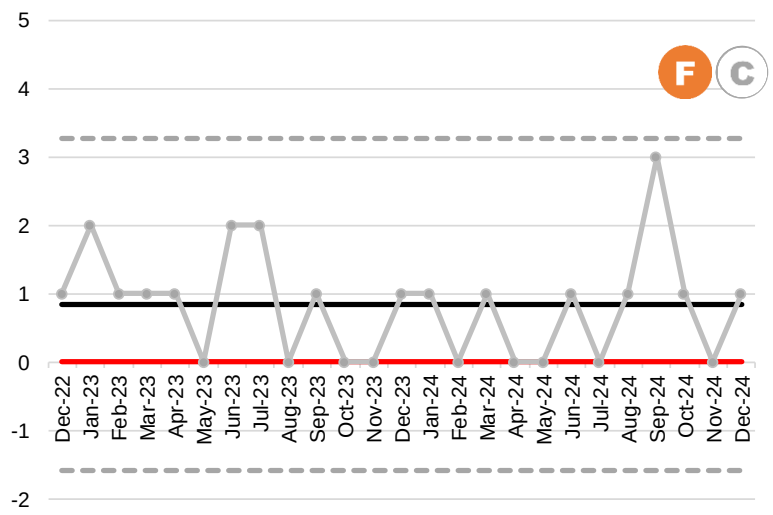


Summary

The trust had 11 cases of C. Diff apportioned in December 2024 The break down for the month is 10 HOHA and 1 COHA. Year to date is now running at 107 cases. It is noted that the NHS England position both nationally and regionally is showing an increased incidence of cases. UHBW is in the mid-range of national incidence. Ongoing quality improvement work continues e.g. improvements in screening for C. Diff, isolating patients who have diarrhoea, clinical equipment cleaning standards

MRSA Hospital Onset Cases

MRSA Hospital Onset Cases



Latest Month
Dec-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.

Corporate Risk
Risk 6013 - Risk that the Trust exceeds its NHSE/I limit for Methicillin Resistant Staphylococcus aureus bacteraemia's

Summary

The trust had one MRSA case in December 2024. Year to date is seven cases. UHBW remain with a higher incidence of MRSA blood stream infections within the national upper quartile. The relaunch of the streamlined MRSA management pathway starts on 20th January 2025, as part of the delivery of quality improvements with key actions and targeted education e.g. improvement in MRSA screening, assessment and decolonisation. A 'deep dive' review of the seven cases to date has identified the risk factors that require action are all incorporated in the existing quality improvement project.

Patient Safety

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

Adult Inpatients Who Received A VTE Risk Assessment

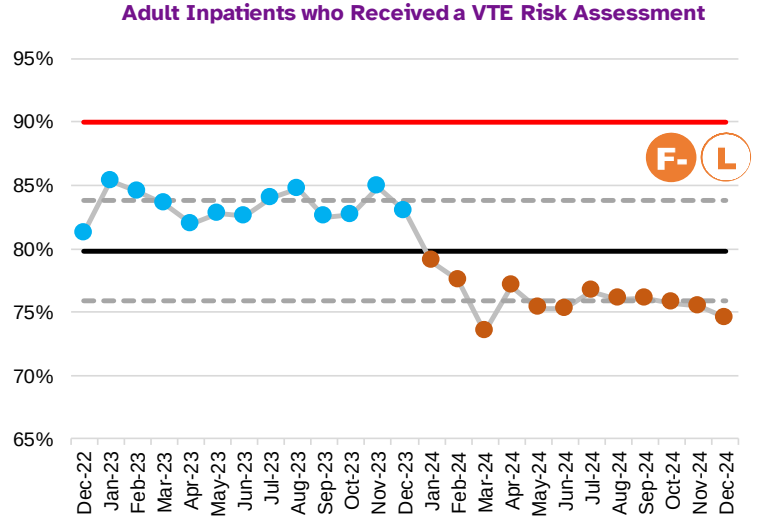
Latest Month
Dec-24

Target
90.0%

Latest Month's Position
74.5%

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

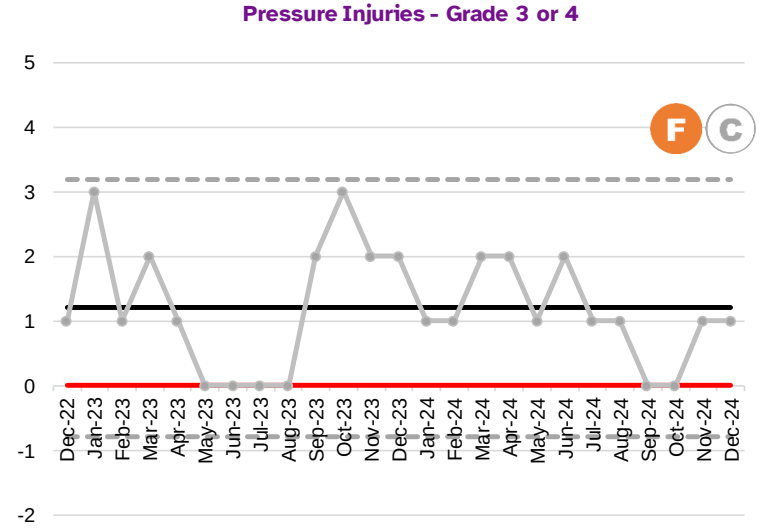
Corporate Risk
No Corporate Risk



Summary

- VTE risk assessment completion remains unchanged, however local auditing shows that the % of patients receiving VTE prophylaxis (with or without a complete risk assessment) is over 90%
- On 16th Jan NHSE published the national data for the first 2 quarters of 2024/5. The key results showed:
- England did not achieve the 95% NHS Standard Contract threshold. Of the 3.1 million admitted inpatients aged 16 and over for whom data was reported in this collection, 2.8 million (89%) were risk assessed for VTE on admission.
- In Q1 2024/25, the percentage of admitted inpatients aged 16 and over at the time of admission risk assessed for VTE was 89% for NHS acute care providers and 88% for independent sector providers. NHS acute care providers carry out 97% of all VTE risk assessments.
- No regions achieved the 95% NHS Standard Contract operational standard in Q1 2024/25
- In the Southwest, UHBW remains in the lower end of the table of comparable trusts but significantly better than the worst performers, with the range in the region for NHS acute providers ranging from 30%-97%.

Pressure Injuries – Grade 3 or 4



Latest Month
Dec-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.

Corporate Risk
No Corporate Risk

Summary

Across UHBW there were three category 2 pressure injuries. One each in Surgery (heel), Medicine (sacrum) and Weston (ear, secondary to high flow oxygen strap). There was one category 3 pressure injury in Children's. This injury was to the left mandible (jaw area) secondary to a hard collar in situ.

Offloading / preventative measures were found not to have been in place prior to injuries developing in three out of the four incidents. Pressure Ulcer Care Plan compliance was inconsistent in all of the injuries.

Actions:

- 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.
- Targeted "on-spot" training about importance preventative measures to be used for patients at risk and those with medical devices in-situ.
- 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

Patient Safety

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

Mixed Sex Accommodation Breaches

Mixed Sex Accommodation Breaches

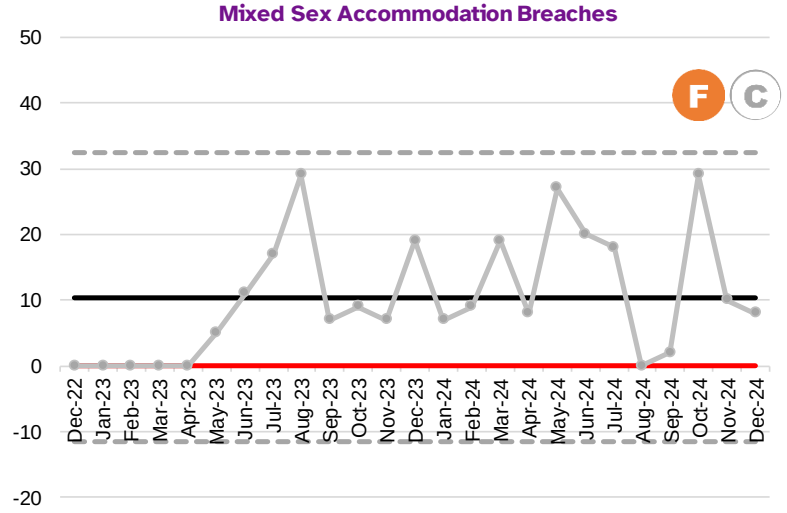
Latest Month
Dec-24

Target
0.00

Latest Month's Position
8.00

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

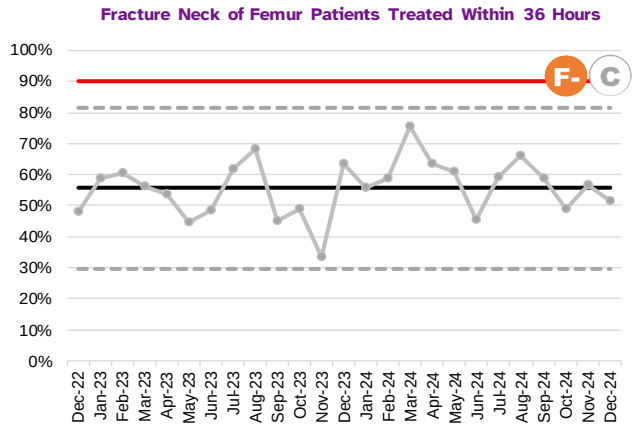
Corporate Risk
No Corporate Risk



Summary

- In December 2024 there were two events of mixed sex breaches, affecting eight patients.
- Both events occurred in theatre recovery, Bristol Royal Infirmary. These patients experienced mixed sex breaches as a result of a delay in transfer to inpatient wards, due to overall bed capacity.
- There is continued flow and discharge improvement projects to enable earlier bed availability, via the Every Minute Matters programme.
- Clinical leads continue to undertake ongoing review of clinical areas to ensure consistent compliance with NHSE Delivering Same Sex Accommodation guidance.
- Task and finish group continues to work through a full Equality Impact Assessment to review the Managing Single Sex Accommodation Compliance SOP. Aims include providing training to staff to assist in applying this guidance in practice, whilst ensuring that they are inclusive and sensitive to the needs of all of our communities. A proposal for an e-learning module has been approved by the Learning and Workforce Development Board, and is now starting to be built, working alongside community partners.
- Continued monitoring of temporary escalation spaces is underway, ensuring compliance with NHSE Delivering Same Sex Accommodation guidance.

Fracture Neck of Femur Patients Treated Within 36 Hours



Latest Month
Dec-24

Target
90%

Latest Month's Position
51%

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

Corporate Risk
No Corporate Risk

Summary

Weston:
18 patients were eligible for best practice tarriff
15/18 had surgery within 36hrs (83%)
16/18 had ortho-geriatician assessment within 72hrs (88%)
12/18 received care that met all the targets required (67%)
Reasons for delays in Weston:

- Surgery - delay to diagnosis, theatre space, specialist hip surgeon required
- Ortho-geriatrician review- one patient missed assessment due to Christmas bank holidays falling on the days of the single clinician and patient discharged before assessment could take place. One patient seen but over the 72hrs time due to weekend/bank holidays.
- Other targets missed - Additional patients missing pre-op assessment test for delirium and cognitive impairment (4AT) (unknown reason), additional patient missing post -op 4AT (unknown reason), missing nutritional screening MUST (unknown reason)

Bristol:
19 patients were eligible for best practice tarriff
6/19 had surgery within 36hrs (32%)
19/19 had ortho-geriatician assessment within 72hrs (100%)
6/19 received care that met all the targets required (32%)

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.

- "Delay in induction" incidents have reduced in Q3 to 29 incidents from 163 in Q2 (although there were only 17 in Q1). The reduction of incidents in Q3 may in part be contributed to by improved staffing within maternity services facilitating flow. There are also plans develop the triage area in maternity services to provide more space to accommodate women requiring induction of labour.
- There have been no poor outcomes relating to delayed induction of labour in December. This risk is being mitigated by enhanced monitoring of women awaiting induction either with a daily review in the maternity Day Assessment Unit or remotely via a call by a midwife.
- A deep dive audit on delayed induction of labour is being finalised and will be presented to identify whether there is any additional learning to be taken forward.

Our People

Principal Related Risk: ?

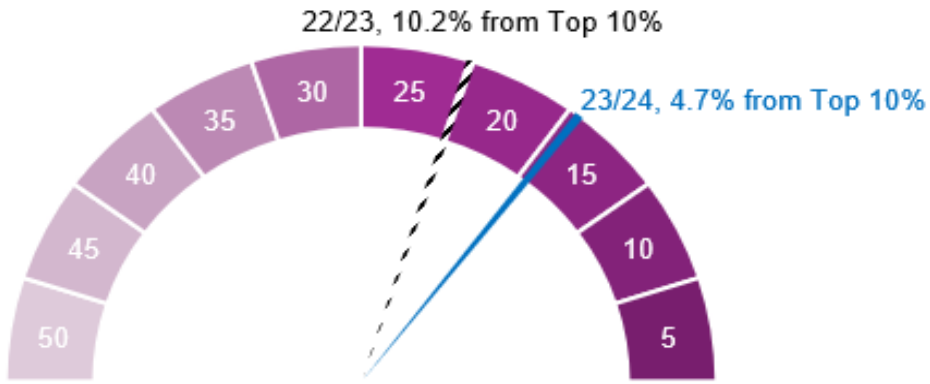
Our People

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

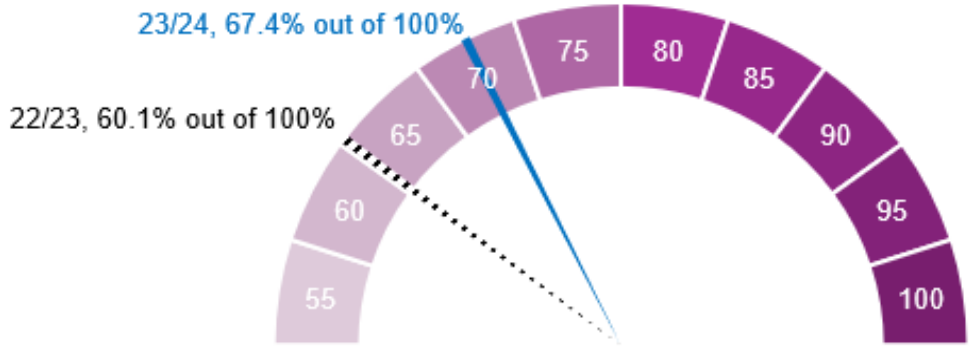
Vision Metrics

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

The number displayed represents the maximum of that segment

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	Dec 24	0.6%	1.0%	0.6%	P*	L	Note Performance	
	Well-Led	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	Dec 24	3.0%	5.0%	2.7%	P*	C	Note Performance	
	Well-Led	Sickness Rate	Dec 24	4.5%	4.9%	4.6%	P	C	Note Performance	
	Well-Led	Workforce Appraisal Compliance (Non-Consultant)	Dec 24	81.0%	85.0%	83.3%	F-	C	Escalation Summary	
	Well-Led	Workforce Turnover Rate	Dec 24	11.1%	12.0%	11.1%	P	C	Note Performance	
	Well-Led	Essential Training Compliance	Dec 24	90.4%	90.0%	90.4%	P	H	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	January 2025
Project status	**Project timeline off track**
Related Principle Risk	2. Workforce

Key progress in last month

Policies

Annual leave policy drafted and being tested with divisional colleagues

Medical Workforce Systems (Healthroster, Locum's Nest and E-job planning system)

- Women's and Children's use of Healthroster has increased
- Loop app usage tracking commenced, currently at 10%

Long Term Plan

- Locally Employed Doctors Medical Rotation outline plan shared and updated. Finalising rotation.
- Trust Medical Workforce Risks report reviewed, 92 risks identified, this is basis for conversation with Divisions. - (see next months aims)

Key aims for next month

Reduce Premium Spend

- Set up medical agency controls meeting
- Carry on scoping locum bank rate alignments across the region

Resident Doctor Rota Review

- Agree principles for over & underpayments
- Establish protocol for costing and approving rota changes

Medical Workforce Systems (Healthroster, Locum's Nest and E-job planning system)

- Loop app roll out to continue with focus on Weston and Diagnostic and Therapies
- Complete Healthroster implementation in 11 remaining departments excluding Women's & Children's

Long Term Plan

- Present Locally Employed Doctors rotation paper at Business Delivery Group and Learning and Development Board. Create recruitment microsite and documentation.
- Identify priority Medical Workforce Risks by Division to shape speciality action planning.
- High Impact priority corporate actions identified via workshop, to inform project plan.

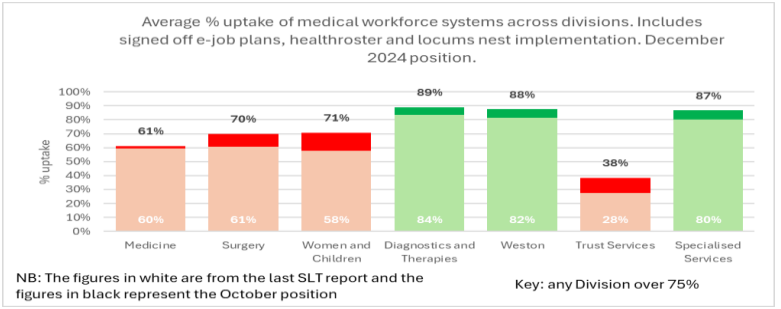
High Level Roadmap

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
- Risk of fixed term contract not being renewed in 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	January 2025
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 and these have been reviewed as part of the Executive Divisional Strategy Deployment Review process
- We have held a multi-disciplinary workshop to review our findings with sexual safety, anti-racism and anti-ableism and to set up subgroups to commence work on the 'deep dive' analysis
- We have identified four key workstreams and allocated leads: HR, recruitment, Learning and Development, Culture and Trauma Informed. Each workstream lead is analysing their feedback with the aim of having an outline plan end of February

Key aims for next month

- Each subgroup to meet to analyse their data and develop an outline plan
- Pro-Equity Assurance group to receive a detailed update on the progress made and the changes to the subgroups in response to the data analysis.

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. Completed
- Collectively review the thematic analysis from Sexual Safety, Anti-Racism and Anti-Ableism to identify themes by the end of January 2025. Completed in initial workshop in December, follow up session on 13th 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

Dec-24

Target

85%

Latest Month's Position

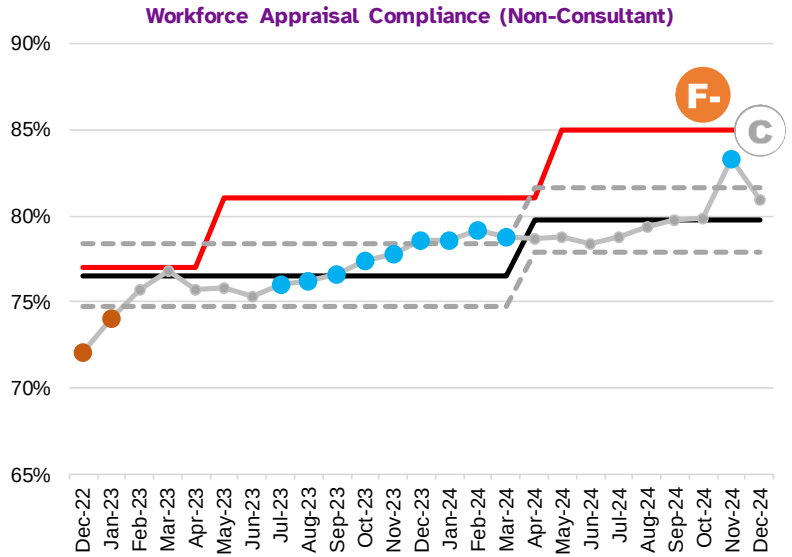
81.0%

Performance / Assurance

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

Corporate Risk

No Corporate Risk



Summary

Early indications from Staff Survey 2024 preliminary results show a positive increase in all measures related to appraisal. Although compliance measures in the survey had one of the most improved questions, performance remains below the provider average.

Timely Care

Principal Related Risk: 6. Capacity and Performance

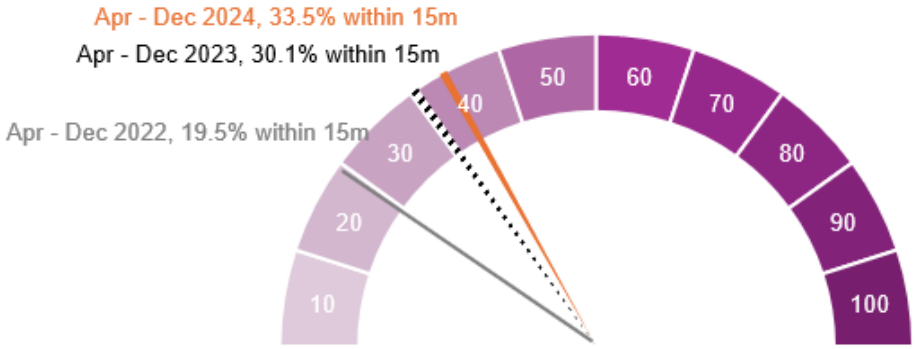
Timely Care

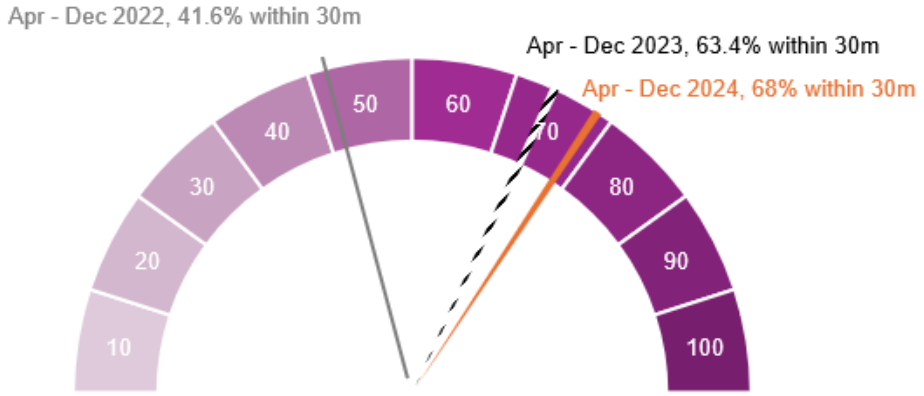
Our Vision	*Together, we will provide timely access to care for all patients, meeting their individual needs.*
Our Goal	*By streamlining flow and reducing variation, we will eliminate avoidable delays across access pathways.*

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





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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	Dec 24	7.0%	2.0%	5.4%	?	C	Counter Measure Summary	
	Responsive	Theatres - Touchtime Utilisation	Dec 24	80.8%	81.0%	81.8%	F-	H	Counter Measure Summary	
	Responsive	Outpatient DNA Rate	Dec 24	6.6%	5.0%	5.8%	F-	C	Counter Measure Summary	
Breakthrough Objective*	Responsive	Median Discharge Time	Dec 24	15:34	13:30	15:30	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

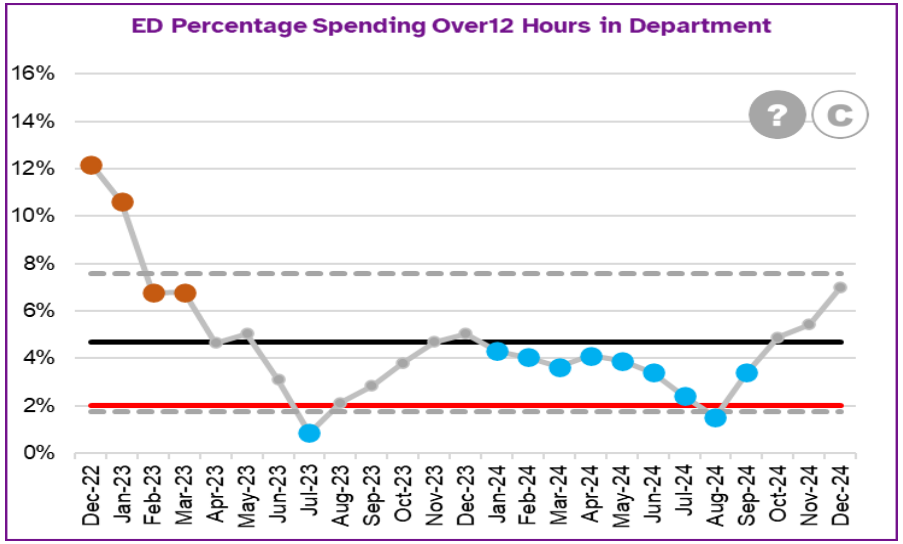
Scorecard

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	Dec 24	1022	1257	1180	P	n/a	Note Performance	
	Responsive	Total RTT Pathways 65+ Weeks	Dec 24	54	0	58	F	n/a	Escalation Summary	
	Responsive	Diagnostics Percentage Under 6 Weeks (15 Key Tests)	Dec 24	83.0%	93.1%	87.0%	F-	H	Escalation Summary	
	Effective	Cancer - 28 Day Faster Diagnosis	Nov 24	77.2%	77.0%	77.1%	P	H	Note Performance	
	Effective	Cancer - 31 Day Diagnosis To Treatment	Nov 24	96.5%	96.0%	98.3%	P	H	Note Performance	
	Effective	Cancer 62 Day Referral To Treatment	Nov 24	74.3%	70.0%	76.1%	P	H	Note Performance	
	Responsive	Last Minute Cancelled Operations - Percentage of Admissions	Dec 24	2.9%	1.5%	2.9%	F	C	Escalation Summary	
	Responsive	ED Percentage Spending Under 4 Hours in Department	Dec 24	62.3%	71.8%	64.8%	?	C	Escalation Summary	
	Responsive	ED 12 Hour Trolley Waits	Dec 24	695	No Target	530	n/a	C	Note Performance	
	Responsive	ED Attendances (Trust Total)	Dec 24	17953	No Target	18761	n/a	C	Note Performance	
	Responsive	No Criteria To Reside - Beds Occupied	Dec 24	183	105	183	F-	H	Escalation Summary	
	Responsive	No Criteria To Reside Occupancy	Dec 24	20.8%	13.0%	21.0%	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

Proactive Hospital Counter Measure Summary



ED Percentage Spending Over12 Hours in Department

Latest Month

Dec-24

Target

2.0%

Latest Month's Position

7.0%

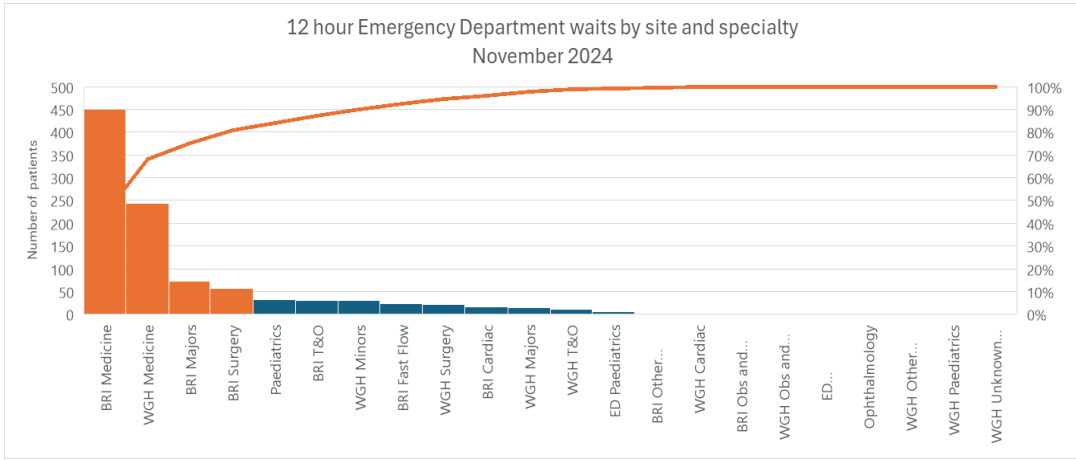
Performance / Assurance

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

Risk

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

Stratified data



Improvement work in progress

Project: On track

Divisional priority project for:

- Medicine
- Weston
- Specialised Services
- Diagnostics and Therapies

Top contributors to addressed

- Embedding Every Minute Matters
- Access to non-admitting pathways (Same Day Emergency Care (SDEC)/NHS@Home)
- Cross-divisional approach to 12-hour improvement actions

Key Risks to achieving improvement

- Emergency Department (ED) attendance rate
- Operational pressures
- Inpatient adult bed capacity
- Adherence to Getting It Right First Time (GIRFT) acute care standards across specialties

Key progress

- ED to CT scan pathway review progressing with workshop planned in January to review root causes
- ED to pathology pathway review progressing with data collection and visits planned for January 2025
- Relaunch of ED to specialty referrals process in line with GIRFT acute care standards underway to inform plan to improve specialty referrals
- Weekend discharges improvement work started - initial audit completed in Medicine

Next actions

- Further analysis of 12-hour performance within divisions underway
- Urgent Care Leads operational group meetings to be refreshed
- Review Key Performance Indicator (KPI)'s for winter schemes and review impact of schemes
- Continue to progress ED pathway reviews and review of GIRFT acute care standards

Timely Care

Theatres Touchtime Utilisation and Average Cases per List Counter Measure Summary

Theatres - Touchtime Utilisation

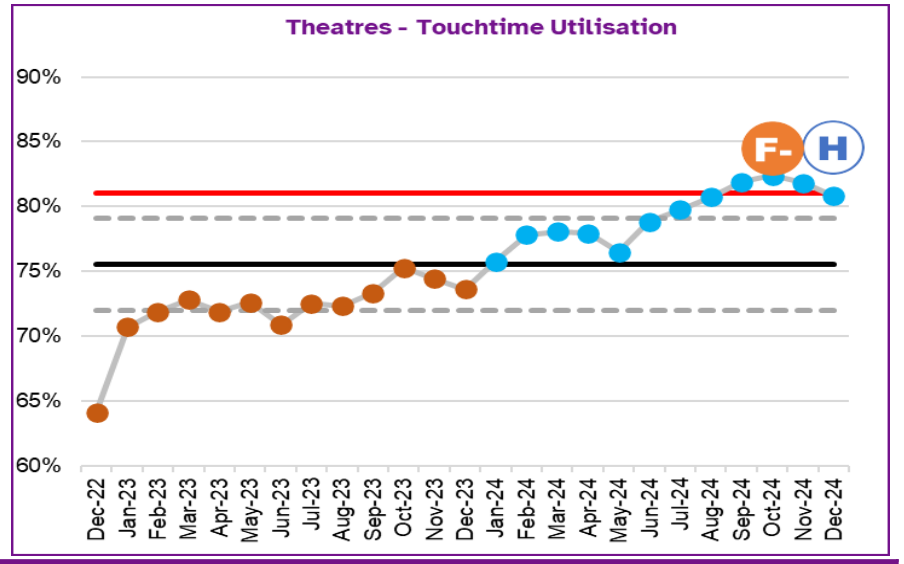
Latest Month
Dec-24

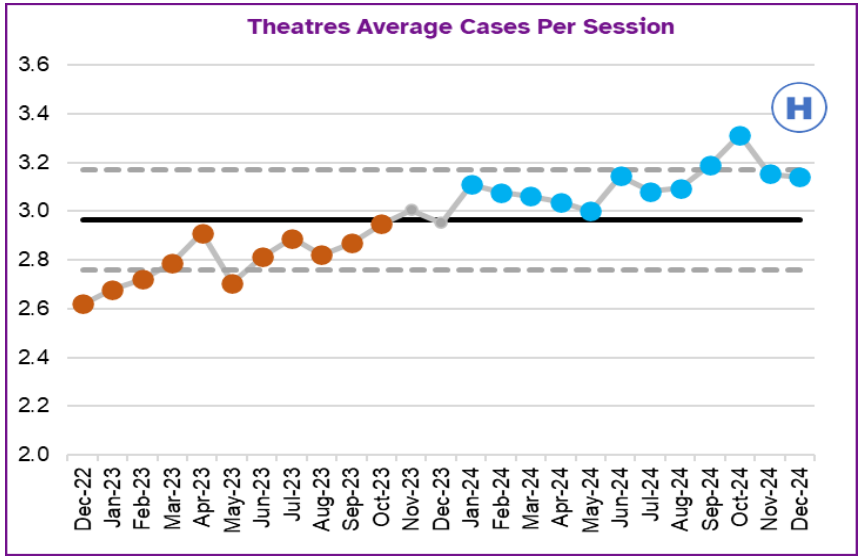
Target
81.0%

Latest Month's Position
80.8%

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

Corporate Risk
No Corporate Risk





Theatres Average Cases Per Session

Latest Month
Dec-24

Target
N/A

Latest Month's Position
3.14

Performance / Assurance
Not Applicable

Corporate Risk
No risk on Board Assurance Framework

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

- Continued short notice booking
- Lack of emergency (CEPOD) capacity causing emergency work to break into elective capacity in BRI and STMH.
- Lack of timely pre-assessment of patients to ensure that they are fit and health optimised prior to surgery.
- Lack of transparency and reporting around patient pre assessment status

Key Risks to achieving improvement

- Decentralised booking teams and lack of standardised processes, management and Key Performance Indicator's (KPI)
- Continued short notice theatre list booking
- Decentralised pre assessment services and variable processes.
- Staffing shift patterns impacting ability to cover extended theatre lists

Key progress

- The avoidance of the routine drop in performance for December demonstrates that the positive changes made as part of the theatre improvement work are now embedded as business as usual.
- December utilisation was 80% compared to 72% in 2023.
- BDH has continued to sustain a 20% improvement in capped utilisation.
- Trustwide audit into surgical cancellations on the day to ensure accurate recording and reporting is on track to start in Jan 25
- A new pre-operative demand, capacity and performance tracking tool is being developed

Next actions

- Review theatre improvement programme plan to incorporate new requirements for 25/26 including all aspects of the perioperative pathway that impact on theatre performance.
- Continue to collaborate with Business Intelligence (BI) to produce a pre assessment dashboard
- Identify reporting to track procedure room activity & identify capacity for appropriate Right Procedure Right Place cases to move out of theatres
- Continue 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.

Timely Care

Outpatient Did Not Attend Rate (DNA) Counter Measure Summary

Outpatient DNA Rate

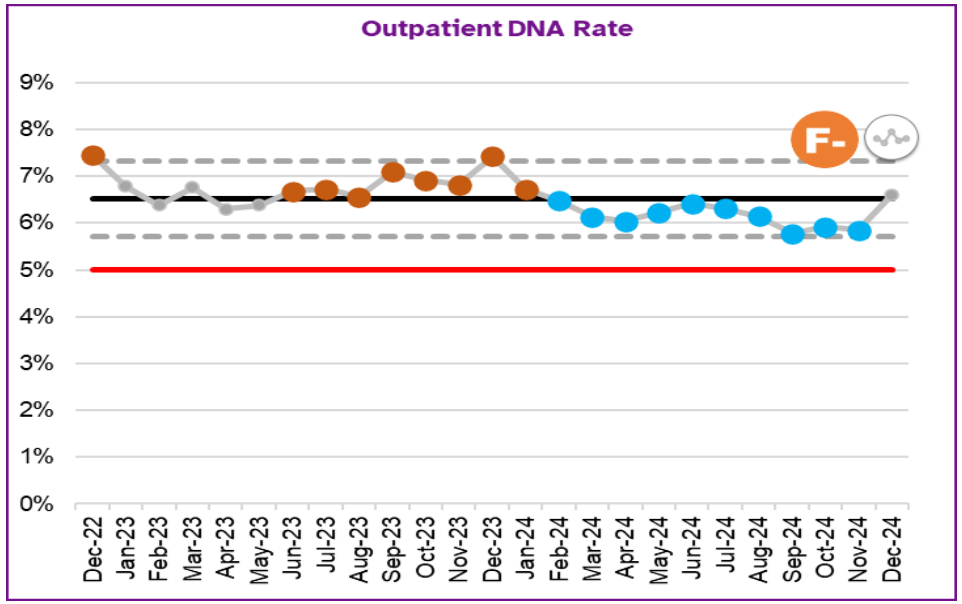
Latest Month
Dec-24

Target
5.0%

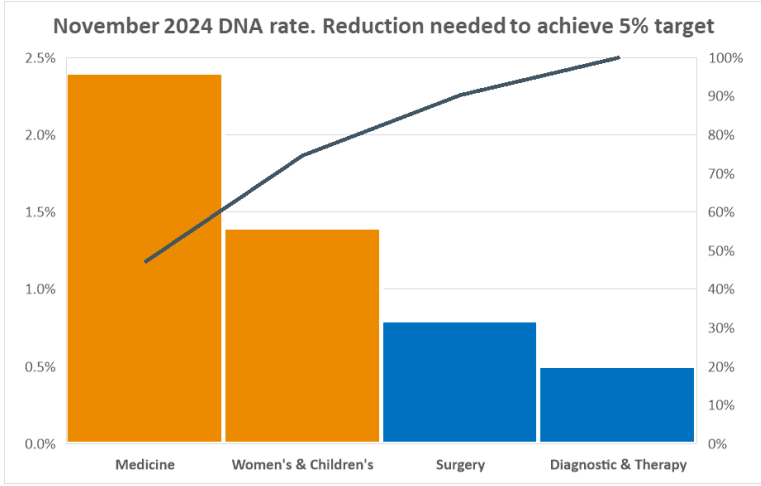
Latest Month's Position
6.6%

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

Corporate Risk
Add Risk 5520 - that health inequalities are exacerbated if positive action is not taken for patients on waiting lists (12)



Stratified data



Orange = top contributors.

Divisions that can make most contribution to overall Trust target

Note:

Specialised Services achieved 5 % target in November

DNA rate was 4.3%

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.
- Lack of technical means 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

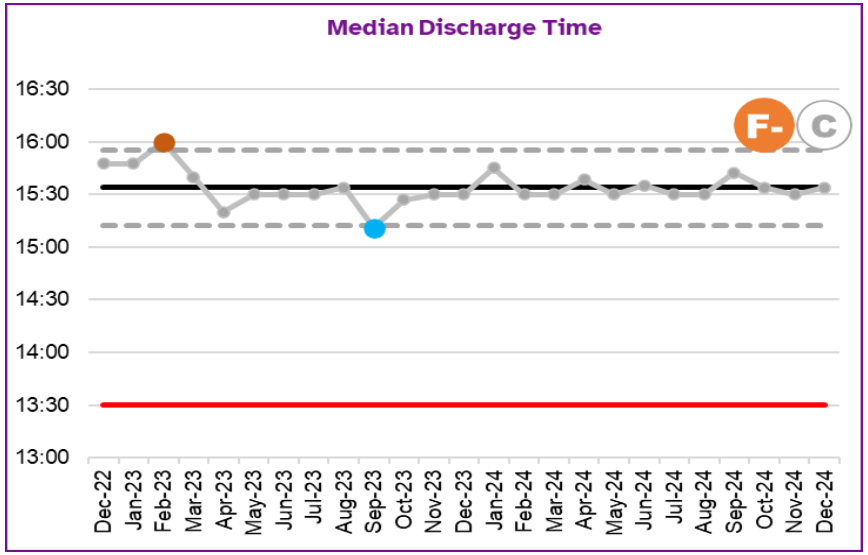
- DrDoctor digital letters expected to increase by 6,000 per month in 6-12 weeks
- Appointment notifications and reminders are now available in the NHS App. Impact expected in 6-12 weeks
- Seasonal increase in DNA rate in December 6.6% (0.8% less than Dec 23)
- D&T 6.7% (+1.2%)
- Medicine 8.7% (+1.3)
- Specialised 4.9% (+0.6%)
- Surgery 6.4% (+0.6%)
- Women's and Children's 7.1% (+0.7%)

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

Dec-24

Target

13:30

Latest Month's Position

15:34

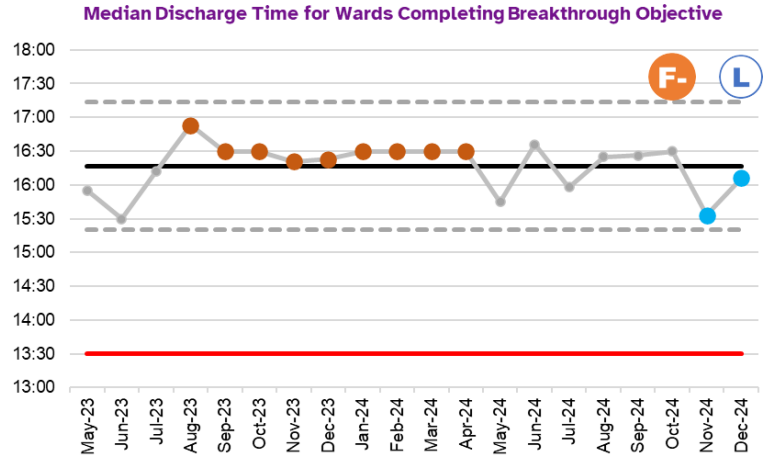
Performance / Assurance

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

Corporate Risk

Corporate Risk 423 - Inpatient admissions exceeds bed capacity (20)

Stratified data -December 2024



Wards completing A3 thinking for breakthrough objective:

- A900
- A512/525
- C808
- A528

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

Key Risks to achieving improvement

- Staff capacity and consistency to engage with change

Key progress

- Ongoing support to Weston Division with rapid review events, using learning from December Trustwide inpatient reviews
- Solution to launch Wardview (digital whiteboard) at Weston agreed, and implementation plan being formulated
- Weekend Planning project launched across Divisions, with aim to increase weekend discharges
- Roll out of Criteria Led Discharge toolkit
- Weston discharge lounge refocus continues, current A3 project in progress
- Direct referral process for Pathway 1 has been successfully launched and is now business as usual

Next actions

- Progress division-specific project work on Weekend Planning
- GEMBA (go and see) to focus on ward recording of discharge time
- Identify quality improvement measures relating to safety and experience of discharges
- Understand impact of direct pathway 1 referrals with Therapies re-audit of time taken to complete referral
- Request for Divisional implementation of Criteria Led Discharge pathway

Timely Care

RTT 52 and 65 Week Waits Escalation Summary

Total RTT Pathways 52+ Weeks

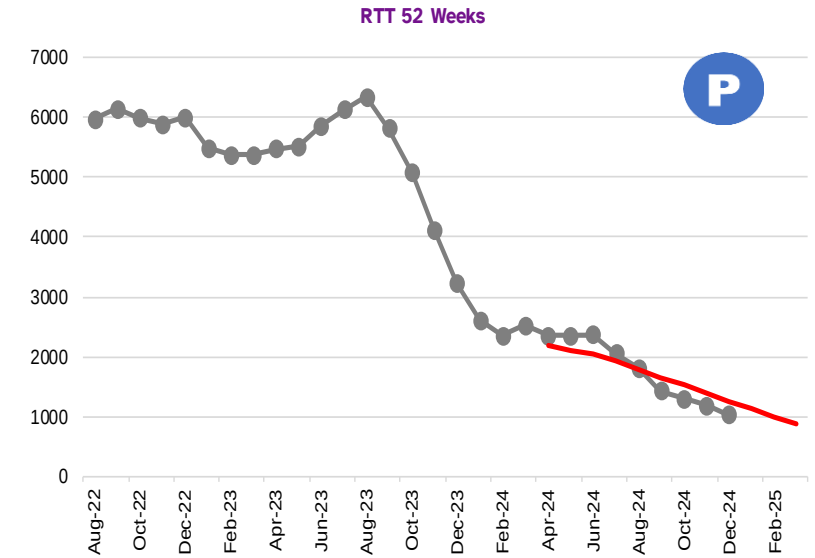
Total RTT Pathways 52+ Weeks

Latest Month
Dec-24

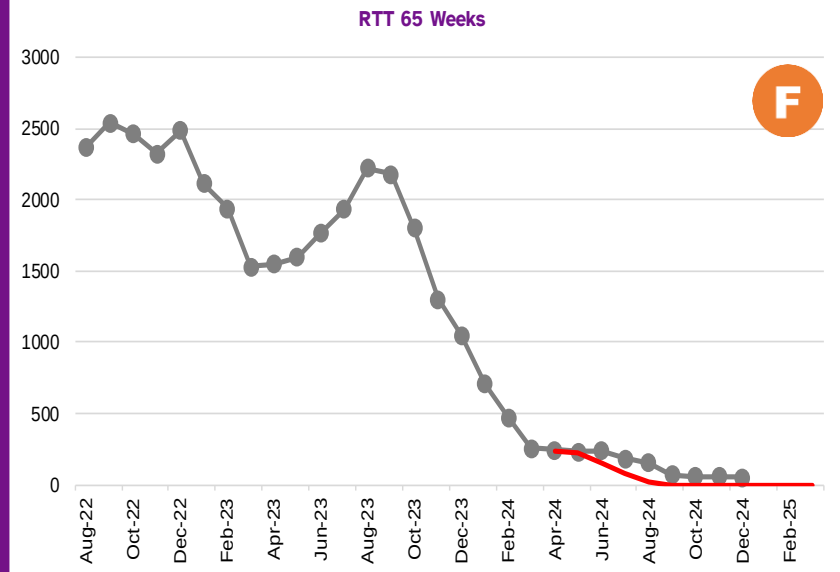
Target
1257

Latest Month's Position
1022

Corporate Risk
Risk 801 - Elements of the NHS Oversight Framework are not met (12).



Total RTT Pathways 65+ Weeks



Total RTT Pathways 65+ Weeks

Latest Month
Dec-24

Target
0

Latest Month's Position
54

Corporate Risk
Risk 801 - Elements of the NHS Oversight Framework are not met (12).

Summary

- At the end of December there were no 78ww+ patients waiting for treatment.
- At the end of December, the Trust reported 54 patients who were waiting more than 65 weeks for treatment (37 in Dental services and 17 Cornea Graft) which is an improvement from the end of November (58).
- NHS Blood and Transport (NHSBT) have now advised that the Trust are able to request Cornea graft material for patients who will breach 65ww in January. There are currently 26 patients who would otherwise breach 65ww in January.
- The Trust continues to work towards elimination of 65ww in Dental services and to develop strategies to expedite the treatment of these patients in a sustainable way. Insourcing arrangements had been established for outpatient services in Paediatric Dentistry and Orthodontics with a plans for both to commence in January 2025. Insourcing for Orthodontics has resulted in additional capacity with two suitable Orthodontists and already 46 patient appointments have been secured and patients booked into dates in January. We have additional dates secured for Orthodontics in February and March which will further provide both new appointment clinics and on-going brace adjustments.
- 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.
- Additionally, the Trust bolsters additional capacity through other insourcing providers and waiting list initiatives.

Timely Care

Diagnostics Patients Under 6 Weeks and Last Minute Cancelled Operations Escalation Summary

Diagnostics Patients Waiting Under 6 Weeks

Diagnostics Percentage Under 6 Weeks (15 Key Tests)

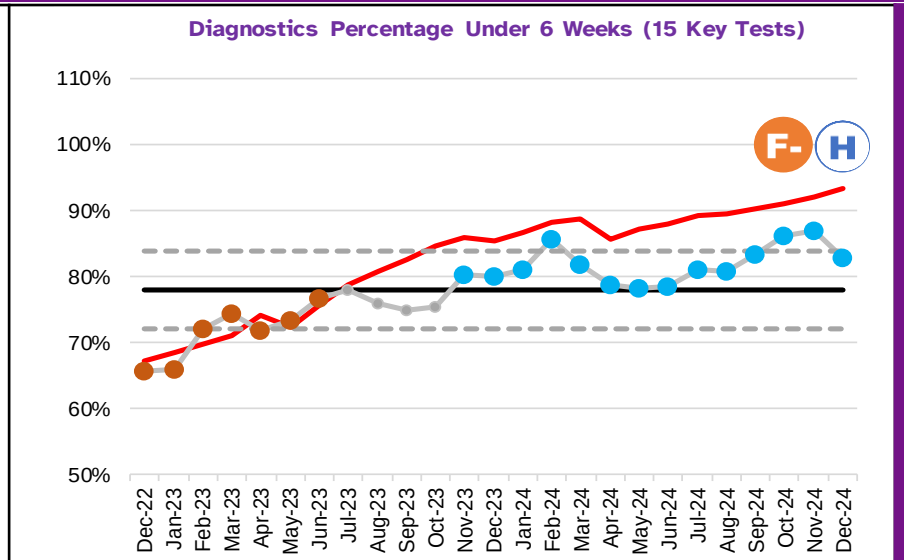
Latest Month
Dec-24

Target
93.1%

Latest Month's Position
83.0%

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

Corporate Risk
Risk 801 - Elements of the NHS Oversight Framework are not met (12).



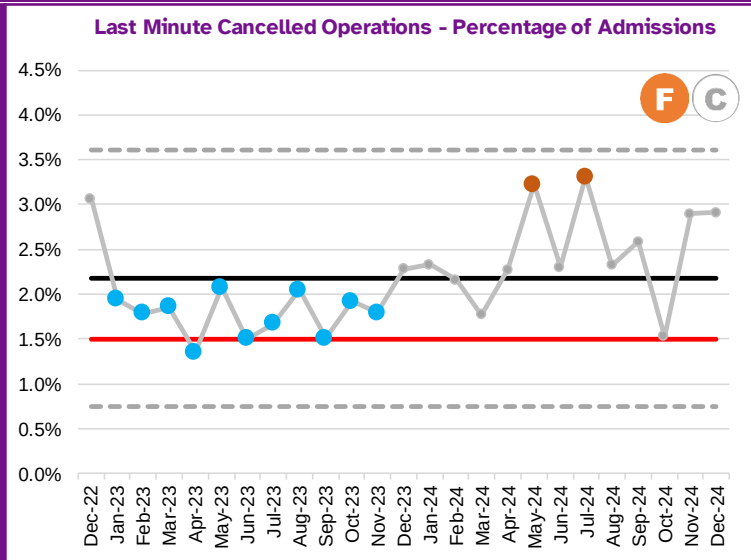
Summary

At the end of November 2024, the England total was 79.46% of the waiting list under six weeks. UHBW's performance at the end of November was 87.0% which places UHBW 81st of 157 Trusts that reported diagnostic wait times. Significant progress has been made in reducing wait times for long-waiting patients. The number of patients waiting over 13 weeks decreased from 694 at the end of March 2024 to 423 by the end of December, while those waiting over 26 weeks dropped dramatically from 206 to just 7 during the same period.

Notable successes include Sleep Studies, DEXA, and Paediatric Audiology, which are consistently meeting the national six-week waiting time standard of 99%. Additionally, Adult Gastroscopy has achieved NHS England's 2024/25 year-end target of 95%. However, challenges persist in high-volume modalities such as Cardiac MRI, Cardiac CT, and Paediatric MRI. These were exacerbated by short-term PACS integration issues, which led to hospital-initiated cancellations across all imaging modalities in early December. Further disruption occurred due to cancelled Echocardiography lists at the Community Diagnostic Centre, significantly impacting scanning capacity. Staffing shortages within both clinical and booking teams further contributed to the decline in overall diagnostic six-week wait performance in December.

Efforts to equalise waiting lists between Bristol and Weston are ongoing. Enhanced bank rates have been introduced for Adult MRI, supported by plans to outsource a mobile diagnostic van to Weston General Hospital from February to March 2025. CT Cardiac outsourcing began in late November and will continue through the remainder of 2024/25. Additionally, an agreement has been reached with St Joseph's to conduct 60 Cardiac MRI scans per week, prioritising patients with the longest waits and ensuring faster access to diagnostic services.

Last Minute Cancelled Operations



Last Minute Cancelled Operations - Percentage of Admissions

Latest Month
Dec-24

Target
1.5%

Latest Month's Position
2.9%

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

Corporate Risk
Risk 1035 - Risk that BNSSG and tertiary catchment populations do not have access to sufficient critical care beds (12).

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 which includes the development of a dashboard to provide divisions with data concerning the timeliness of validation at specialty level. The dashboard is expected to be available and in operational use from January 2025.

The Continuous Improvement Team are also supporting a review of the project charter with a specific focus on peri-operative practice and a refocussing of improvement efforts towards hospital-initiated clinical cancellations for operation not needed, or patient not fit, where there may have been opportunities to optimise the health of patients in advance of their surgery to avoid cancellation.

Timely Care

Emergency Department Metrics Escalation Summary

ED Percentage Spending Under 4 Hours in Department

ED Percentage Spending Under 4 Hours in Department

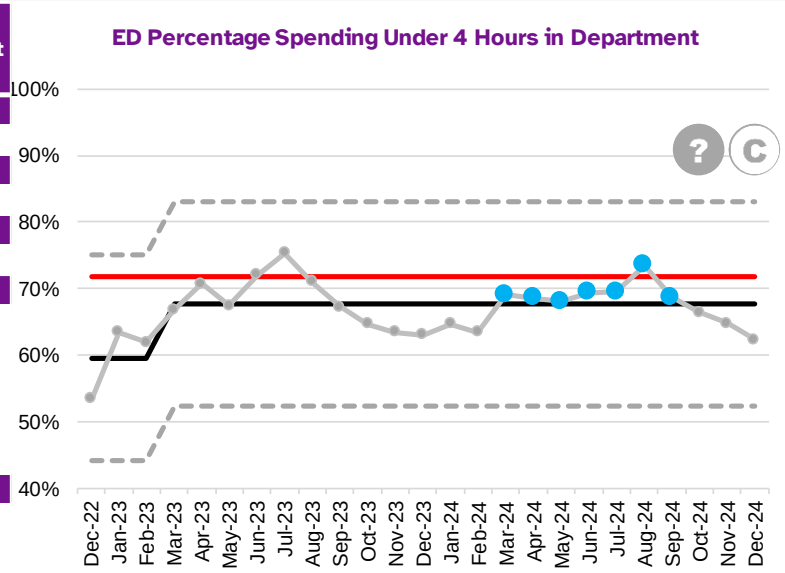
Latest Month
Dec-24

Target
71.8%

Latest Month's Position
62.3%

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

Corporate Risk
Risk 7769 - Patients in the Trust's EDs may not receive timely and effective care (20).



Bristol Royal Infirmary (BRI):

Attendances: Type 1 attendances to the front door decreased in December to 6,556 from 6,786 in November. Fast Flow and Surgery Performance Groups both showed a reduction in ED attendances in comparison to a slight increase in attendances seen in Majors.
4 Hour performance: 46% (November, 47%)
12 Hour performance: 10.23% (9.64% November). 43% of Medicine admitted patients had a 12 hour wait. This is monitored as a Proactive Hospital project through Medicine Strategy Deployment Review.
Ambulance handover delays: Despite an overall reduction in Type 1 ED attendances, there was an increase of 104 ambulance conveyances to the site in December, an average of 70 arrivals per day. There was an increase in ambulance handover delays in December, up to 1530 hours with 31.8% of ambulance handovers breaching 60 minutes. The main reason for reported handover delays was physical capacity.
Time to be seen: 24.15% of patients attending BRI ED were seen within 60 minutes in December, in comparison to 22.33% in November.
Time to triage: 51.45% of patients attending BRI ED were triaged within 15 minutes in December, in comparison to 55.71% in November.

Summary

Bristol Royal Hospital for Children (BRHC):

- Attendances: 4,745 patient attendances in December 2024 (average of 153 per day); a decrease from November (172 average attendances per day).
- 4-Hour performance: 73.53% (November 75.67%).
- 12-Hour performance: breach working group is ongoing and have been successful in driving down 12-Hour breaches since inception in September 2024. There were 22 x 12-Hour breaches in December 2024, compared with 94 x 12-Hour breaches in December 2023, (a reduction of 72 overall, or 76.60%).

Weston General Hospital (WGH):

- Attendances: Attendances remained stable in December in comparison to November with 4,535 attendances-an average of 146 per day (149 in November). Overall, the greatest number of attendances was in the minor group at 57% of all attendances. This is consistent with overall attendance patterns throughout 2024/25.
- 4 Hour Performance: 58% (November 66%).
- 12 Hour Performance: 13% (7% November). Increased impact of Infection Prevention and Control (IPC) on the inpatient bed base throughout December affected performance against both this and the 4-hour standards.
- There were 944 ambulance handovers in December, an increase of 89 against November. Lost ambulance hours increased in December to 678 from 308 in November.

Timely Care

No Criteria to Reside – Beds Occupied and Occupancy Escalation Summary

No Criteria To Reside - Beds Occupied

No Criteria To Reside - Beds Occupied

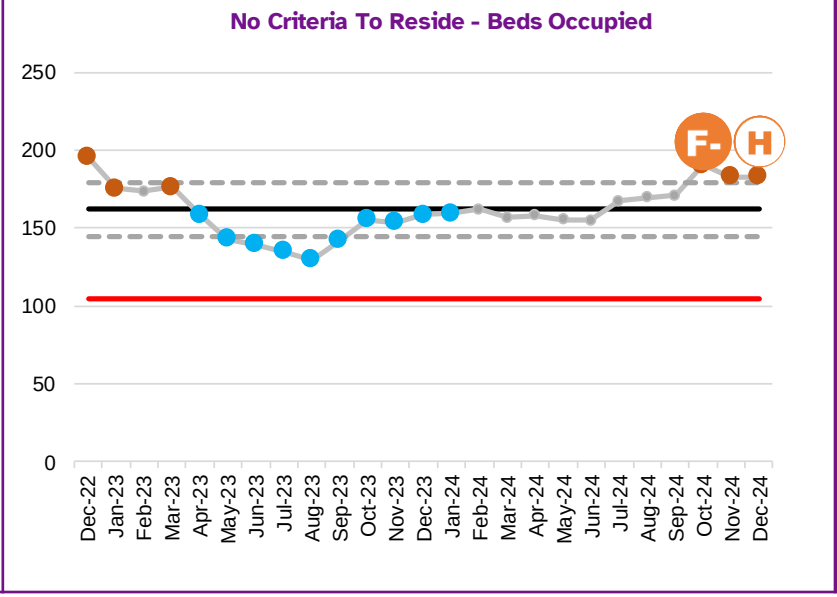
Latest Month
Dec-24

Target
105

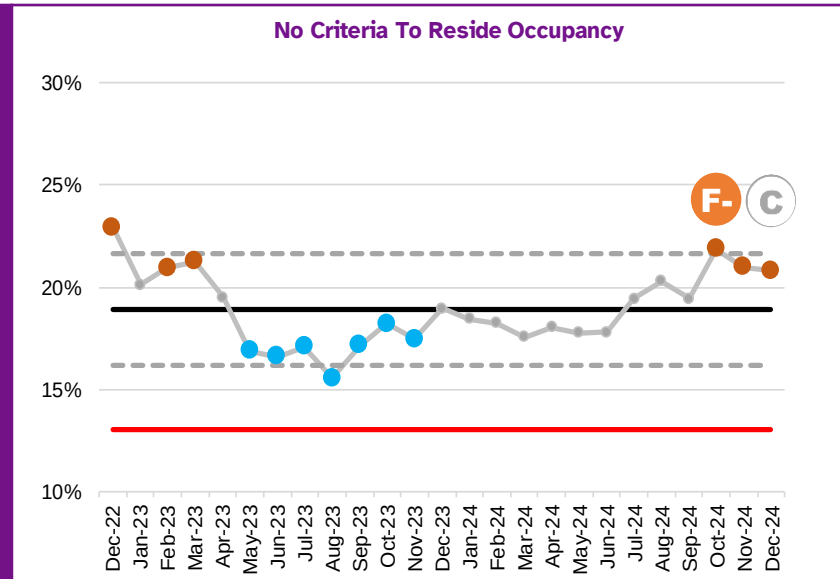
Latest Month's Position
183

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

Corporate Risk
Corporate Risk 423 - Risk that demand for inpatient admission exceeds available bed capacity (20). Corporate Risk 2614 Risk that patient care and experience is affected due to being cared for in extra capacity locations (15)



No Criteria To Reside Occupancy



No Criteria To Reside Occupancy

Latest Month
Dec-24

Target
13.0%

Latest Month's Position
20.8%

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

Corporate Risk
Corporate Risk 423 - Risk that demand for inpatient admission exceeds available bed capacity (20).
Corporate Risk 2614 Risk that patient care and experience is affected due to being cared for in extra capacity locations (15)

Summary

No Criteria to Reside (NCTR) numbers fluctuated in December ranging from 183 patients to 212, largely driven by an increase in non-elective admissions and poor discharge profile. Whilst length of stay (LoS) for patients on a P1 And P2 pathway reduced compared with November, the LoS increased for P0 and P3 patients

All system partners reported higher levels of sickness which will have impacted on discharges and capacity in the community remains limited.

Actions:

- Focus on internal and external delays using new coding structure continues with ongoing staff training.
- Version 2 of the Transfer of Care form implemented on 11th Nov. A much shorter referral form for Pathway 1 results in saving clinical time.
- Implementing a “Home for Christmas” initiative to support earlier discharges, initial focus on End of Life patients.
- 99 patients were discharged prior to their package of care start date with family support **saving 274 bed days**, highest performance to date.

Timescales for Improvement and Assurance:

- Achievement of the 25% reduction in LoS in December for P2 patients.
- 25% reduction in LoS across all patients 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

Principal Related Risk: Fire Safety

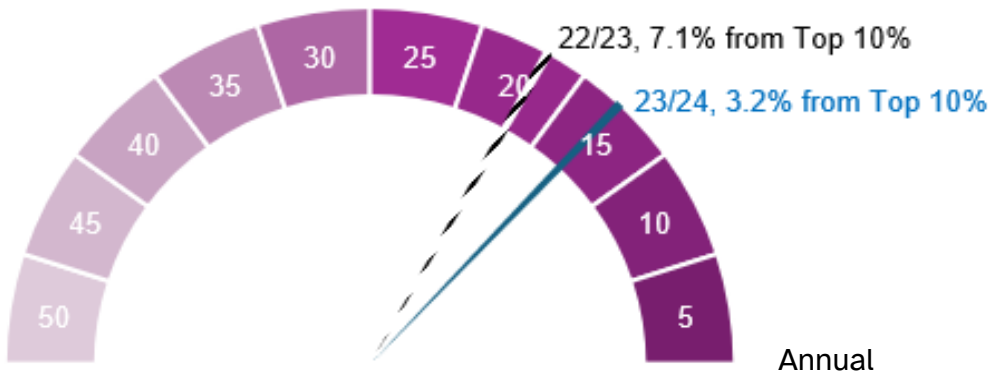
Innovate and Improve

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

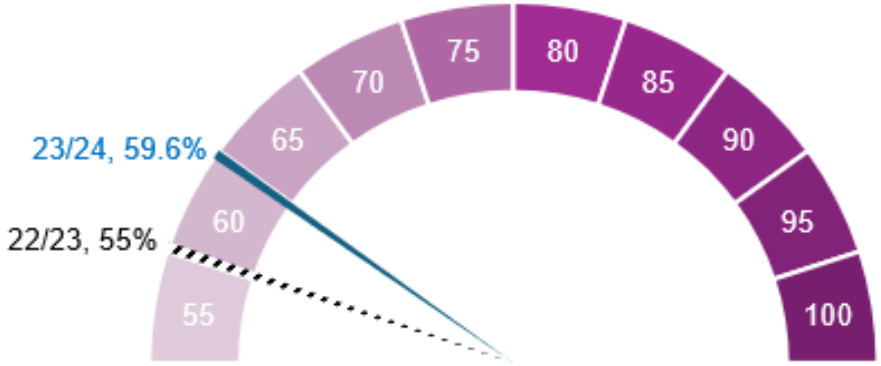
Vision Metrics

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

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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	January 2025
Project status	**Project timeline on track**
Related Principle Risk	5.Fire Safety

Key progress in last month

- 25/26 Capital prioritisation draft programme based on hazard and consequences submitted for review
- Neonatal Intensive Care Unit (NICU) contractor installed new fire doors as part of initial NICU fire improvement project
- NICU Fire Safety Project RIBA Stage 2 design and programme agreed at Strategic Estate Development Programme Board and at NICU Fire Safety Project team
- Fire alarm survey and updated report including floor plans for St. Michaels Hospital received for review
- Connect Lighting completed emergency lighting review and risk assessment for priority buildings – reports received for review.
- Damper survey for all priority buildings reports received for review
- Draft Authorised Engineer fire safety audit action plan submitted for review
- Fire Safety Engineer job description submitted for matching
- Planned Preventative Maintenance (PPM) fire safety programme submitted to Fire Improvement Group

Key aims for next month

- Fire door training – competency of trade staff to complete fire door inspections and repairs to fire doors following PPM's
- Recruit band 6 Estates Officer to work with Authorised Person (Fire Safety Maintenance)
- PPM compliance – statutory and mantuary compliance improvements to be presented at FIG
- Continue fire alarm gap analysis across clinical buildings
- Compartmentation lines within buildings – review to establish if walls provide 60- or 30-minute protection or not (review to be overseen by fire engineers)
- Works on SharePoint risk/action/project tracker to allow clear visibility and accountability across multiple existing reports and survey information.
- Development of fire risk assessment process for individual departments using Zetasafe; to be undertaken by Fire safety Advisors
- BAF - Datix fire risk entries to be reviewed and rationalised
- Review latest Fire Risk Assessment from fire engineers – King Edward Building

High Level Roadmap

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

Key risks and challenges

- Potential for significant fire – harm to staff, patient and visitors plus loss of building/s
- Potential for enforcement action due to extent of legacy issues and time to address physical estate
- Scope of works will require multi-year capital investment and require ICS support
- Scope of projects includes 'unknown' elements could impact budgets/cause delays
- Building Safety Act gateways cause delays to fire improvement works within year
- Availability of legacy information, interconnectivity and complexity of buildings has the potential to cause delays in projects and/or decision making

Overall project achievements

- Incremental understanding of the estate and the challenges ahead to improve fire safety
- Moving into the next phase – from significant surveying focus to delivery of physical improvements

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	January 2025
Project status	**Project timeline on track**
Related Principle Risk	5.Fire Safety

Key progress in last month

- Started providing support to dependent patient wards without evacuation plan to complete the fire evacuation template
- Updated fire evacuation floor plans started to be issued for priority clinical buildings
- Fire safety advisors attending wardens to complete on-site training for fire wardens
- Meetings held with Security and Helideck to look at improvements in ensuring final fire exit doors and evacuation routes are regularly inspected and reported upon to Fire Safety Manager
- Fire Safety Manager attendance at Medicine divisional Health and Safety meeting to provide an overview of the requirements for additional fire wardens, fire warden monthly checklist and fire evacuation.

Key aims for next month

- Development of single matrix for divisional reporting and Strategy Deployment Review's
- Production of updated fire evacuation floor plans and ward level plans to continue to be produced following fire strategy plans
- Divisional fire evacuation plan workshops to help with template and guidance document
- Set-up group fire warden walk-arounds instead of 1-2-1 with Fire safety Advisers for areas like Emergency Departments
- Provide divisions with summary chart for those areas with and without evacuation plans plus those areas that require updating their evacuation plans
- Fire Safety Advisers continue to support wards with completing their evacuation plans
- Focus on improving attendance on evacuation training

High Level Roadmap

- 'Red' fire safety information boards installed in all location - March 25
- Bespoke fire evacuation floor plans installed on fire 'Red' boards for all locations - March 25
- All locations to complete fire evacuation plan on new template following issued guidance - June 25
- All locations to ensure 95% staff trained on updated fire evacuation plan - October 25
- All locations to conduct fire evacuation exercise/drill to test evacuation plan - December 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
- Only 50 staff attended fire evacuation training in 2024

Overall project achievements /Impact achieved

- All Very High Dependent areas have a fire evacuation plan
- Template and guidance issued
- Workshops set-up

Our Resources

Principal Related Risk: 3. Financial

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.

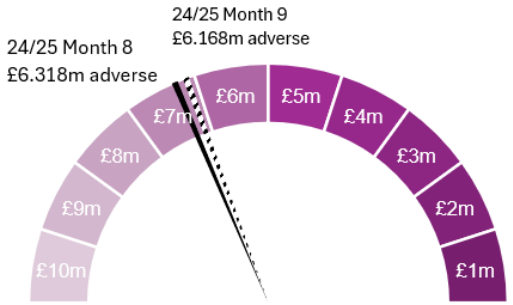
Our Goal

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

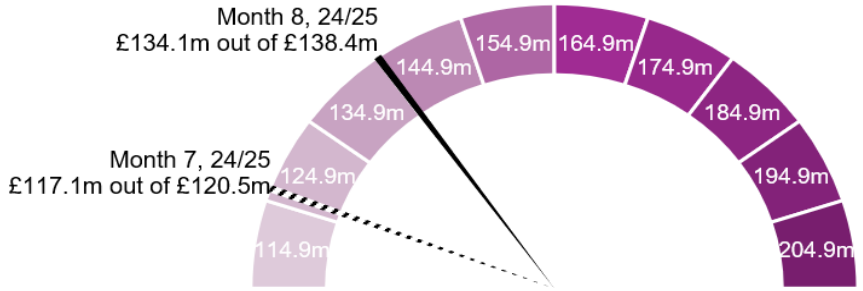
Vision Metrics

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



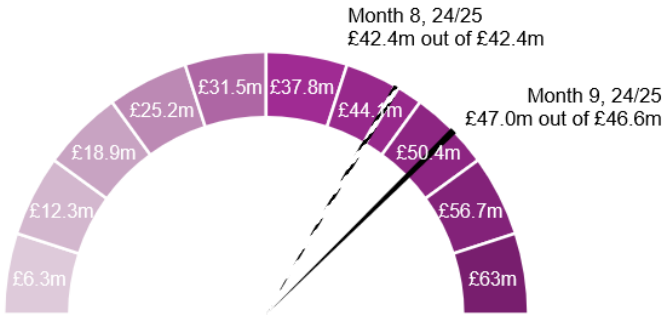
Monthly

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

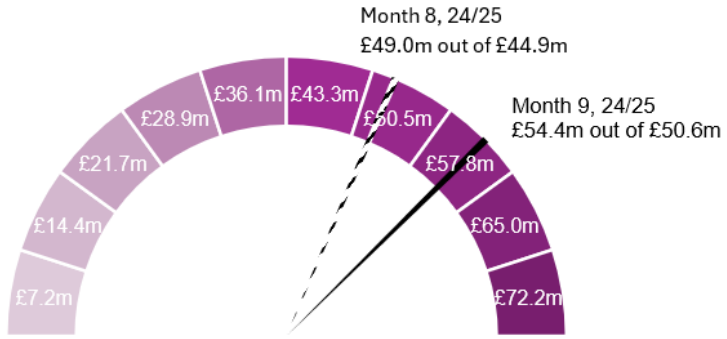


Monthly

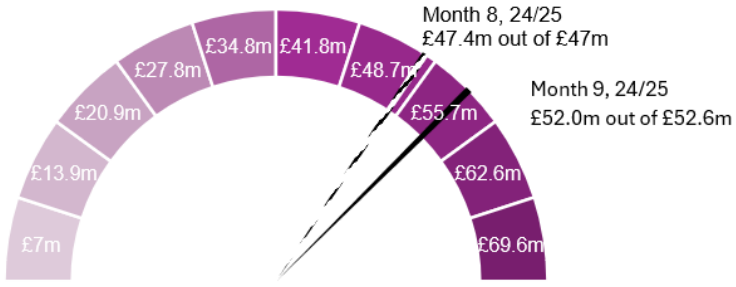
Day Cases



Elective Inpatients



Outpatients



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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	January 2025
Project status	**Project timeline on track**
Related Principle Risk	3.Financial

Key progress in last month

- Reduction in position on NHSE productivity metrics: Deterioration of improved productivity run rate performance metrics in month by 0.4%. YTD remains favourable.
- Further development and refinement of PFIG: Building on positive changes already in place, to increasing engagement and discussion at meetings, enhanced signposting of opportunities
- Continuation of FSIT hosted divisional workshops in month
- Continuation of delivery of agreed divisional financial control totals
- Signposting of National Cost Collection Index return data for 2023/24 financial year with organisation
- Communication of 2025/26 CIP Targets across the organisation

Key aims for next month

- Development of non pay workplan for 2025/26 in conjunction with BWPC and divisions. Formalising plans, areas of responsibility and commencing task and finish groups
- Review of medical pay controls as part of the optimising medical staffing group. Develop list of areas of focus and subsequent workplan
- Delivery of further CIP workshops across divisions
- Divisions sustaining improved run rate trajectories in line with control totals through winter months
- First cut 2025/26 CIP submissions to be received from divisions
- Assessment of trust wide forecast underlying financial position's
- Investigation of areas of opportunity from NCCI data presented in month

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

- 4.2% Productivity improvement @M7 vs 23/24 Financial year
- £30.4m Year end forecast savings achievement 24/25
- Year end trust financial forecast outturn favourable to majority of acute providers nationally

Our Resources

Leadership Priorities and Oversight Framework

December 2024

2024/25 YTD Income & Expenditure Position	• Net I&E deficit of £6,168k against a breakeven plan, an improvement of £150k from last month. • Total operating income is £25,755k ahead of plan due to higher than planned income from activities (£20,439k) and other operating income (£5,316k). The higher than planned position is primarily due to additional income received from ICB Commissioners and NHS England South-West Specialised Commissioning. • Total operating expenditure is £34,236k adverse to plan due to higher than planned non-pay costs of £18,536k and higher than planned pay expenditure of £15,700k. Higher than planned operating expenditure is due to higher than planned staff in post, the impact of non-pay inflation, higher than planned pass-through costs and the YTD shortfall in savings delivery.
Key Financial Issues	• *Recurrent savings delivery below plan* – YTD CIP delivery is £21,780k, behind plan by £8,895k or 29%. Recurrent savings YTD are £13,560k, an improvement of £908k in month. • *Delivery of elective activity below plan* – elective activity must be delivered in line with plan. The cumulative YTD value of elective activity is £3,401k behind plan, an improvement of £957k in December. • *Failure to deliver the financial plan* – failure to deliver the planned savings and failure to receive the planned level of ERF would constitute a breach of the statutory duty to break-even and will result in regulatory intervention. A forecast outturn assessment has been completed and as a system, and with further mitigations, the break-even plan remains achievable.
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 9			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	91,010	95,864	4,854	839,671	860,110	20,439
Other Operating Income	10,137	12,279	2,142	91,234	96,550	5,316
Total Operating Income	**101,147**	**108,143**	**6,996**	**930,905**	**956,660**	**25,755**
Employee Expenses	(62,113)	(64,686)	(2,573)	(561,933)	(577,633)	(15,700)
Other Operating Expenses	(34,274)	(39,008)	(4,734)	(326,582)	(345,029)	(18,447)
Depreciation (owned & leased)	(3,670)	(3,641)	29	(32,560)	(32,649)	(89)
Total Operating Expenditure	**(100,057)**	**(107,335)**	**(7,278)**	**(921,075)**	**(955,311)**	**(34,236)**
PDC	(1,210)	(458)	752	(10,890)	(10,125)	765
Interest Payable	(247)	(219)	28	(2,223)	(2,023)	200
Interest Receivable	292	437	145	2,628	4,305	1,677
Net Surplus/(Deficit) inc technicals	**(75)**	**568**	**643**	**(655)**	**(6,494)**	**(5,839)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	75	(418)	(493)	655	326	(329)
Net Surplus/(Deficit) exc technicals	**0**	**150**	**150**	**0**	**(6,168)**	**(6,168)**

Key Facts:

- In December, the Trust delivered a £150k surplus against the plan of break-even. The cumulative YTD position at the end of the month is a net deficit of £6,168k (£6,318k net deficit last month) against a breakeven plan. The Trust is therefore £6,168k adverse to plan. The cumulative YTD net deficit is 0.6% of total operating income.

- Significant operating expenditure variances in the year-to-date position include: the shortfall on savings delivery; premium pay pressures and over-establishment mainly relating to nursing and medical staff; higher than planned pass-through costs (matched by additional patient care income) and the impact of unfunded non-pay inflation.

- YTD pay expenditure is c3% higher than plan on medical staffing in the Women's & Children's Division and nursing costs continue to cause overspends across Surgery, Specialised and Women's & Children's Division with continuing high nursing pay costs in total across substantive, bank and agency staff.

- Agency expenditure in month is £754k, compared with £990k in November. Bank expenditure in month is £4,069k, compared with £4,311k in November.

- Total operating income is higher than plan by £25,755k. The shortfall in ERF of £3,401k is offset by higher than planned pass-through payments, additional commissioner funding and additional other operating income.

Appendix

Assurance and Variation Icons – Detailed Description

	ASSURANCE ICON	P*	P	?	F	F-	*No icon*
VARIATION 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

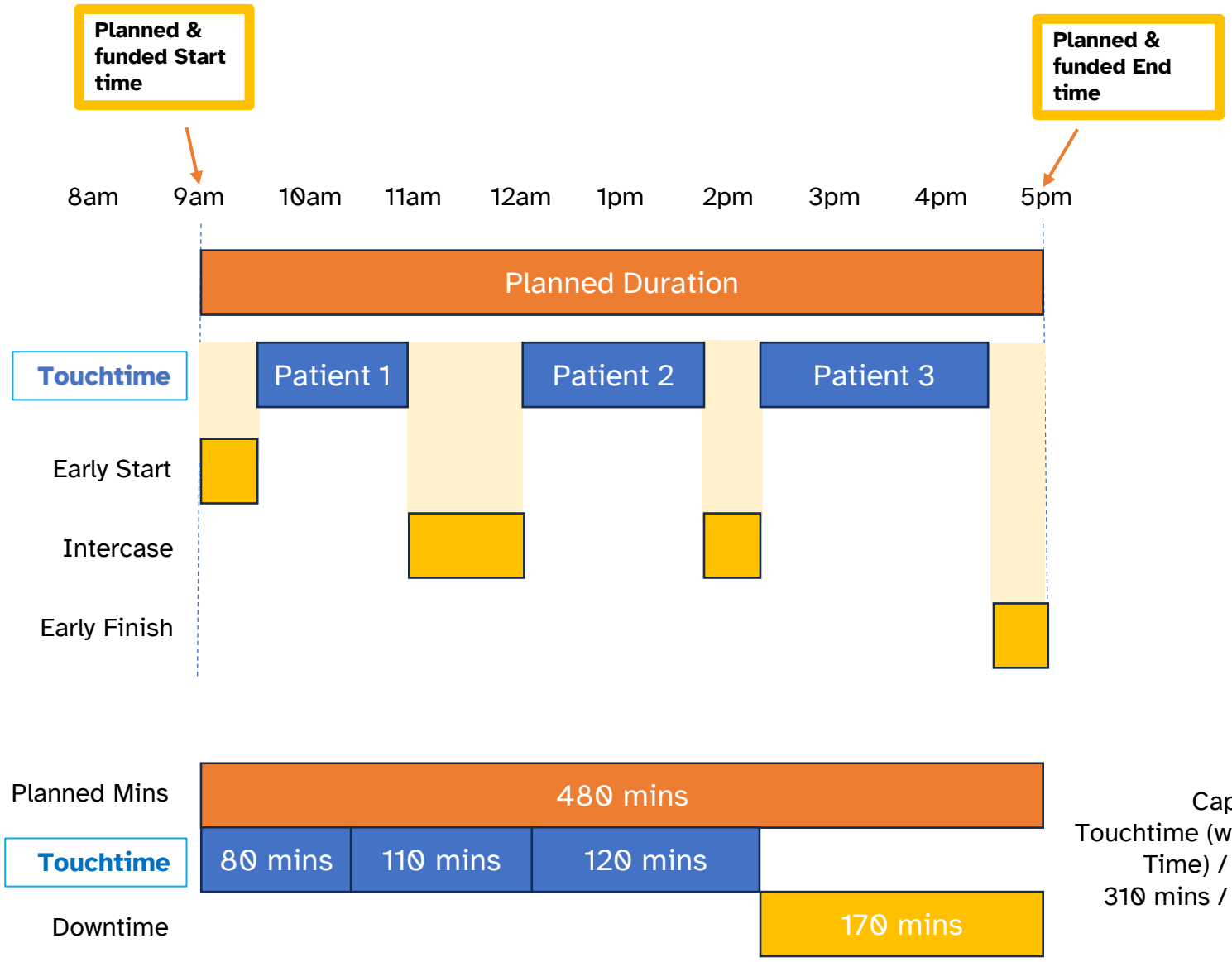
Theatre Utilisation
The total amount of touchtime within the planned and funded amount of operating time available. E.g. If a theatre list starts at 8.30am and ends at 5.30pm there is 9 hours of operating time available

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

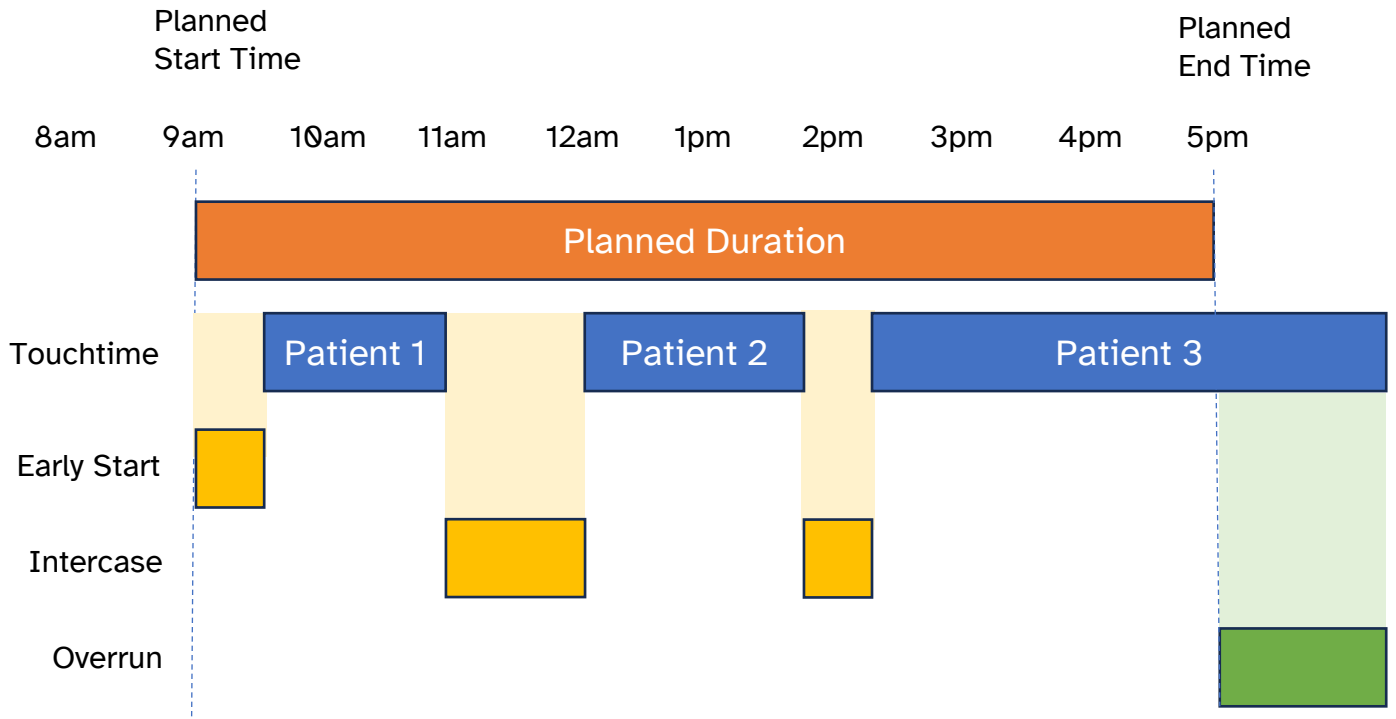
Return to Theatres Counter Measure Summary

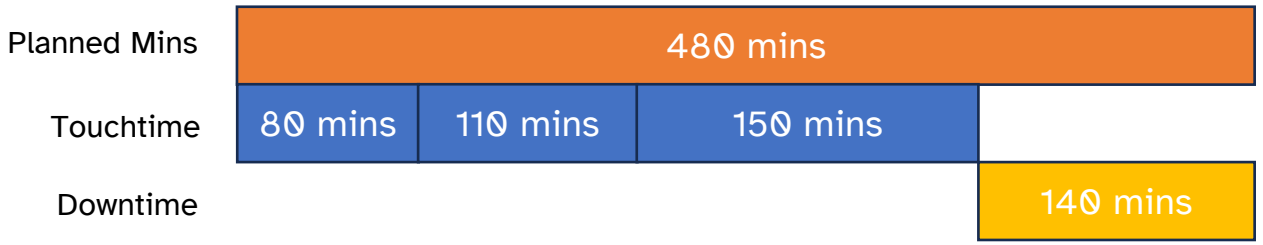


Capped Touchtime = Touchtime (within Planned End Time) / Planned Duration
310 mins / 480 mins = 64%

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%