University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday, 09 July 2024 in St James' Court, Bristol, 13.45-16.45

AGENDA

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS
Preliminary Business				
1.	Apologies for Absence	Information	Chair	13.45 25 mins
2.	Declarations of Interest	Information	Chair	
3.	Patient Story	Information	Patient and Public Involvement Lead	
4.	Minutes of the Last Meeting- **Tuesday, 14 May 2024**	Approval	Chair	
5.	Matters Arising and Action Log	Approval	Chair	
Strategic				
6.	Chief Executive's Report (verbal)	Information	Chief Executive	14.10 10 mins
7.	Chair's Report	Information	Chair	14.20 10 mins
8.	Patient First Strategic Priority Projects Update	Information	Executive Managing Director, Weston General Hospital	14.30 15 mins
9.	Carbon Reduction Plan	Approval	Chief Financial Officer	14.45 10 mins
Quality and Performance				
10.	Quality and Outcomes Committee – Chair's Report	Information	Chair of the Quality and Outcomes Committee	14.55 10 mins
11.	Six-Monthly Nurse Staffing Report	Information	Chief Nurse and Midwife	15.05 5 mins
BREAK – 15.10 TO 15.20				

We are supportive respectful innovative collaborative. We are UHBW.

University Hospitals Bristol and Weston NHS Foundation Trust

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS
12.	Integrated Quality and Performance Report	Information	Chief Operating Officer/Chief Nurse and Midwife/Chief People Officer/Chief Medical Officer	15.20 10 mins
13.	Medical Appraisal and Revalidation Board Report	Approval	Chief Medical Officer	15.30 5 mins
14.	Learning From Deaths Quarterly Report – Q4	Information	Chief Medical Officer	15.35 5 mins
Financial Performance				
15.	Finance, Digital & Estates Committee Chair's Report	Information	Chair of the Finance, Digital & Estates Committee	15.40 10 mins
16.	Monthly Finance Report	Information	Chief Financial Officer	15.50 10 mins
People Management				
17.	People Committee Chair's Report	Information	Chair of the People Committee	16.00 10 mins
18.	Freedom to Speak Up 6 Monthly Update	Information	Director of Corporate Governance	16.10 10 mins
Governance				
19.	Emergency Preparedness, Resilience and Response (EPRR) Annual Report	Information	Chief Operating Officer	16.20 10 mins
20.	Audit Committee Chair's Report	Information	Chair of the Audit Committee	16.30 5 mins
21.	Well Led Action Plan Update	Information	Director of Corporate Governance	16.35 10 mins

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NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS
22.	Register of Seals	Information	Director of Corporate Governance	16:45 5 mins
23.	Governors' Log of Communications	Information	Director of Corporate Governance	
Concluding Business				
24.	Any Other Urgent Business – *Verbal Update*	Information	Chair	
25.	Date and time of next meeting • **Tuesday, 10 September 2024**	Information	Chair	

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th July 2024

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

1. Purpose

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

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

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

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

In this patient story we will hear from Sonah (son–uh) the founder and Director of Black Mothers Matter.

In sharing her story, Sonah will draw on the experiences of black mothers to reflect on the wider social experience they have in maternity care. Sonah will highlight what matters to black mothers, where progress locally is recognised referencing current work to address equity at UHBW and where an additional focus can bring most impact.

This story is set in the context of the MBRRACE-UK Saving Lives, Improving Mothers' Care report for 2023. The report highlighted the inequity experienced by global majority women in maternity care.

In March 2024 the Care Quality Commission's UHBW Main Site Inspection report, carried out as part of CQC's national maternity services inspection programme, highlighted the following area of outstanding practice.

"Senior leaders had attended the 'Black Maternity Matters' course supporting midwives to reduce the inequitable maternity outcomes faced by Black mothers and their babies. The course was a six-month anti-racism education and training programme, examining a range of topics including unconscious biases and the role of the individual in perpetuating unsafe systems of care for Black women."

The Trust's focus on advancing health equity is further supported by a Diversity and Inclusion lead midwife, working with local organisations such as Black Mothers Matter and Caafi Health (an organisation that helps communities in Bristol get the health and care services they need) to gather feedback, insight and learning from local groups about their experience of maternity care and applying this to Quality Improvement projects and teaching on mandatory study days.

This role extends to collaborating with other specialists and organisations to ensure health equity is a priority in all areas of maternity care to improve the outcomes and experience of global majority women, birthing people and their families.

In parallel to this. existing Enhanced Care Community Maternity Support Workers, funded by NHSE Local Maternity Systems, aim to improve early engagement of women and will be co-designing and testing the concept of a new early pregnancy clinic and resource pack offering tailored care to meet a woman's individual needs.

For more information about Black Mothers Matter click here:
https://www.blackmothersmatter.org

For more information about the MBRRACE report click here:
https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2023/MBRRACE-UK_Maternal_Report_2023_-_Lay_Summary.pdf

3. Strategic Alignment

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

4. Risks and Opportunities

None.

5. Recommendation

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

6. History of the paper

Please include details of where paper has previously been received.

N/A

University Hospitals Bristol and Weston NHS Foundation Trust

BOARD OF DIRECTORS (IN PUBLIC)

Minutes of the meeting held on Tuesday, 14 May 2024 at 13.45 – 16.45 in St James' Court, Canon Street, Bristol

Present

Board Members

Name	Job Title/Position
Martin Sykes	Vice Chair and Non-Executive Director (Chair)
Stuart Walker	Interim Chief Executive
Arabel Bailey	Non-Executive Director
Sue Balcombe	Non-Executive Director
Rosie Benneyworth	Non-Executive Director
Paula Clarke	Executive Managing Director, Weston General Hospital
Neil Darvill	Chief Digital Information Officer
Jane Farrell	Chief Operating Officer
Emma Glynn	Associate Non-Executive Director
Marc Griffiths	Non-Executive Director
Susan Hamilton	Associate Non-Executive Director
Neil Kemsley	Chief Financial Officer
Rebecca Maxwell	Interim Chief Medical Officer
Roy Shubhabrata	Non-Executive Director
Emma Wood	Chief People Officer & Deputy Chief Executive

In Attendance

Matthew Areskog	Head of Experience of Care and Inclusion (for Item 12: Experience of Care Strategy)
Sarah Dodds	Deputy Chief Nurse (Nursing)
Emily Judd	Corporate Governance Manager (minutes)
Mark Pender	Head of Corporate Governance
Verity Tebby	Patient Story
Chris Swonnell	Associate Director of Quality and Compliance (for Item 12: Experience of Care Strategy)
Tony Watkin	Patient and Public Involvement Lead (for Item 3: Patient Story)
Sarah Windfeld	Director of Midwifery and Nursing (for Item 14: Maternity Assurance Report)

The Chair opened the Meeting at 13.45

Minute Ref.	*Item*	*Actions*
01/05/24	**Welcome and Apologies for Absence**	
	Martin Sykes, Vice-Chair, welcomed members of the Board to the meeting. Martin informed attendees that the meeting would be recorded and published on the Trust's YouTube account for public access following the meeting. Furthermore, Martin advised Board members that should a fire occur, all attendees must follow the fire safety precautions of the meeting venue and follow signs to the nearest exit.	

Minute Ref.	*Item*	*Actions*
	Apologies of absence were received from: • Bernard Galton, Non-Executive Director; • Deirdre Fowler, Chief Nurse and Midwife. Martin noted that Sarah Dodds, Deputy Chief Nurse, was attending the meeting to deputise for Deirdre Fowler.	
02/05/24	**Declarations of Interest**	
	There were no new declarations of interest relevant to the meeting to note.	
03/05/24	**Patient Story**	
	Tony Watkin, Patient and Public Involvement Lead introduced the Patient Story from Verity Tebby. In this story, Verity talked about her sister, Sarah Crowley, and shared an account of the care that her sister had received at the Trust whilst waiting for surgery for a liver lesion. In sharing her story, Verity asked the Board to reflect on the stress both her late sister and family were placed under whilst waiting for surgery; dealing with the practical, emotional and psychological impact of a series of cancellations; and as her sister's prognosis deteriorated, personally researching the treatment options available to Sarah and raising funding towards the treatment. Verity stressed the importance of transparent and clear lines of communication between clinicians, other healthcare staff, patients and next of kin at a time of intense anxiety. Verity challenged the Board to take practical steps to improve practice and lobby for change where there were blocks in doing so. Martin Sykes, Chair, thanked Verity for the emotive story and opened the meeting to questions from the Trust Board. Stuart Walker, Interim CEO, acknowledged the powerful story and the honest reflection of Sarah's family experience. Stuart apologised on behalf of the organisation for the delays in Sarah's care and for the experience that she encountered. Stuart said the Trust would do everything in its power to prevent a recurrence. **RESOLVED that the Patient Story be received and noted for information**.	
04/03/24	**Minutes of the Last Meeting – Tuesday 12th March 2024**	
	The Board reviewed the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust Board held in public on Tuesday 12th March 2024. **RESOLVED that the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust Board held in public on Tuesday 12th March 2024 be approved as a true and accurate.**	
05/05/24	**Matters Arising and Action Log**	
	10/03/24 Trust Secretariat to add an item to the next Finance, Digital and Estates Committee agenda to discuss ageing radiology equipment. The Trust Secretariat had added an additional item to the March meeting of the Finance, Digital and Estates Committee agenda to discuss the ageing equipment. Neil Kemsley said it was discussed and agreed to hold a session later in the year about how capital funding was prioritised in respect of the replacement of equipment. **Action closed.**	

Minute Ref.	*Item*	*Actions*
	19/03/24 Director of Corporate Governance to amend the Modern Slavery and Human Trafficking Statement 2023/24 to include social care. Director of Corporate Governance to provide an update at July's meeting. **Action ongoing.** **RESOLVED that the updates against the action log be noted.**	
06/05/24	**Chief Executive's Report**	
	Stuart Walker, Interim Chief Executive, provided a verbal update on the following key issues: • As part of the ongoing negotiations with Junior Doctors, the Trust received a letter from NHS England asking for all organisations to work towards improving the working lives of doctors in training. It was noted that the Chief Medical Officer and Chief People Officer would undertake an assessment against the improvements suggested, and that many of the requirements were already in place within the Trust. • The Trust had been allocated additional Foundation Programme Trainees Doctors. • Stuart thanked the teams involved for the system delivered report in relation to the Priorities and Operational Planning Guidance 2024/25 which was positively received regionally and nationally. • During a power outage at the Trust's Bristol city centre sites on Friday 7 May, a Major Incident had been declared at UHBW. Stuart thanked the huge efforts from colleagues, local emergency services and system partners, and said the Trust was able to step down from Major Incident to Internal Critical Incident and return to business as usual within 48hrs, maintaining the safety of patients, visitors and staff throughout. The lessons learned would be shared with the Trust Board. • Stuart informed the Trust Board that Martin Williams would be standing down from the Director of Prevention Control role and thanked Martin for his efforts and contributions to the Trust. • The Annual UHBW Recognising Success Awards would be taking place later that week. During the ensuing discussion the following points were made: Rosie Benneyworth, Non-Executive Director asked about the Integrated Care System strategy development and whether funding and prioritisation would change how effective it would be for the region going forward. Stuart said he was clear on the aspirations for the wider system and noted that the Trust would have to deliver on priorities. As an example, one of the mechanisms for achieving change in how healthcare is delivered was based on UHBW forming a hospital group structure to prevent duplication of services with more of a shift towards putting prevention first. Arabel Bailey, Non-Executive Director asked for further information on the Shared Data and Planning Platform (SDPP) that the Integrated Care System was developing. Neil Darvill, Chief Digital Officer, explained that national guidance advised Integrated Care Systems to develop a system wide approach to sharing information in order to realise the benefits of integrated care,	

Minute Ref.	*Item*	*Actions*
	including health improvement, reduced health inequalities and more efficient commissioning. Neil noted that UHBW would have access to a single, consolidated data set, which could be used to make better decisions for its patients and the region. **RESOLVED that the Chief Executive's report be received and noted for information**.	
07/05/24	**Annual Financial Plan and Operating Plan**	
	Neil Kemsley, Chief Financial Officer, introduced the Operating Plan Summary for 2024-25 to the Board and noted the following key updates: • Under delegated authority from the Trust Board, the Finance, Digital and Estates Committee approved the Trust's 2024/25 Operating Plan ahead of its submission to NHS England on 2nd May 2024. • The Trust had aligned its approach to both planning and the system submission with North Bristol NHS Trust (NBT). • The Trust was one of three Trusts within the South West to have submitted a plan to NHS England. • In 2024/25, investment decisions in the Trust's clinical services totalled £46.9m and included around £4m investment in the opening of new beds, which should reduce the likelihood of future cancellations, and £25m in supporting elective recovery. New areas of investment for 2024/25 included targeted lung health checks, safer staffing within children's services and growing an in-house nursing strategy. • The Trust's financial plan assumed a savings delivery of £41.2m and a savings target at 4.6% at a system level, which was a step-up compared to previous years. • A summary of key risks and challenges to the delivery of the Trust plans had been detailed in the report, were in relation to savings delivery, tackling high volumes of patients with "No Criteria To Reside", and supporting operational recovery and productivity across clinical services and corporate support functions. • Neil thanked Rebecca Dunn, Director of Business Development and Improvement, for the development of the Operating Plan. • Jane Farrell, Chief Operating Officer, added that activity plans had been implemented against national standards and the trust was confident that the activity could be delivered in support of the financial performance. During the ensuing discussion the following points were made: Rosie Benneyworth, Non-Executive Director, asked about the potential negative impact of cost savings on patient safety and queried how robust the processes were to ensure patient safety was not compromised. Sarah Dodds, Deputy Chief Nurse, explained that Quality and Equality Impact Assessments (QEIA) were taking place by a panel of senior medical and nursing staff, the Patient Equity Team, and with oversight from the Chief Nurse and Midwife, and the Quality and Outcomes Committee.	

Minute Ref.	*Item*	*Actions*
	RESOLVED that the Annual Financial Plan and Operating Plan be received and noted for information.	
08/05/24	**Annual Sustainability Strategy and Annual Sustainability Reporting**	
	Neil Kemsley, Chief Financial Officer introduced the Annual Sustainability Strategy and Annual Sustainability Report for 2022-2023 to the Board. • Most emissions within the supply chain were beyond the Trust's direct control due to the complexities of the large supply chain. The Annual Report for 2023-2024 was expected to be ready in July 2024 and an update on the feasibility for achieving the target of net zero carbon by 2030 would be addressed in this and reported to the Trust Bord in July. • This year, the Trust, along with North Bristol NHS Trust and the wider Integrated Care System partners, published its first Green Plan. The Green Plan set out the ambitious goals that the Trust was working to achieve, and the Trusts were aligned in their sustainability outcomes, aiding partnership and collaboration. • Within the Integrated Care System's capital plan there was a £3m allocation to support the green agenda. During the ensuing discussion the following points were made: Roy Shubhabrata, Non-Executive Director, asked what the consequences would be if the Trust did not meet the 2023 carbon neutral target. Neil explained there would be a financial trade-off in terms of how the Trust decided to invest the capital and revenue. Another factor that Neil considered was in relation to staff recognition and how important staff believed achieving the 2030 target was. Neil confirmed that for the next annual report, details around progressing the targets would be included within the report, and discussed at the Finance, Digital and Estates Committee. Emma Glynn, Associate Non-Executive Director, queried how the Trust would be measuring progress against the net zero supplier roadmap and social value requirements that were introduced in April 2022 for all NHS procurements. Neil agreed to include this level of detail in the next annual report. Arabel Bailey, Non-Executive Director, asked to understand the path to measuring supply chain emissions more accurately, given that it was the largest source of the Trust's carbon footprint. Arabel continued to query why only a low number of staff had signed up to the new "Greener Together" staff engagement programme which was a digital platform to encourage, educate and reward staff for taking sustainable action at work and home. Neil agreed to include this level of detail in the next annual report and liaise with the Director of Communications to explore mechanisms to push the Greener Together Programme to staff. Marc Griffiths, Non-Executive Director suggested that more could be done around training initiatives for staff in relation to sustainability and the Greener Together approach. Neil agreed to link the sustainability team with Marc Griffiths to see if this could be developed. **Action: Neil Kemsley, Chief Financial Officer, to progress the next Annual Sustainability report to include data around measuring the**	

Minute Ref.	*Item*	*Actions*
	Trust's carbon footprint targets, widely advertising the "Greener Together" Programme to UHBW staff via Comms and exploring the potential for a new training module for staff in this area. **RESOLVED that the Annual Sustainability Strategy and Annual Sustainability Reporting be received and noted for information**.	**Chief Financial Officer**
09/05/24	**Patient First Strategic Priority Projects Update**	
	Paula Clarke, Executive Managing Director for Weston General Hospital introduced the Patient First Strategic Priority Projects Update to the Board. Paula highlighted the following: • This was the first Patient First update report for 2023/24 that demonstrated measurable improvements against the six strategic priorities that the Board agreed in the previous year (Experience of Care, Patient Safety, Our People, Timely Care, Innovate and Improve, Our Resources). • Of the twenty-four projects within these core pillars, two project timeline metrics and five project target metrics were assessed as red at the end of April 2024. • In 2023/24 twelve projects had been completed or moved to business as usual. • The project priorities had been refreshed for 2024/25 and several projects had been carried over from the previous year with new priorities. • The deployment of Patient First management operating system was progressing well, and agreement of divisional priorities had been completed for six of the divisions, with teams in Estates and Facilities and Medicine operating the new approach on the ground. Positive feedback from the teams demonstrated that they had delivered small projects well which had made the biggest impact on a day-to-day basis. During the ensuing discussion the following points were made: Rosie Benneyworth, Non-Executive Director, thanked Paula for the clear report and asked for an update on how the transfer to the new national learning from patient safety events system (LFPSE) in April 2024 had progressed and whether people were confident to report events on the new system. Becky Maxwell, Interim Chief Medical Officer, agreed that the project intended to develop the patient safety culture and said that it was early days in terms of reporting this data, but assured the Board that it was being monitored. Sue Balcombe, Non-Executive Director, asked how data within the report was being delivered and received by divisions. Paula explained that divisions were able to easily track their progress against the actions via a one-page dashboard and were able to track how their projects and actions were contributing to the Trust's overall 24 projects. Eventually a divisional scorecard and improvement board would be displayed around wards to make projects more visible, and divisions would continue to join monthly meetings with the Executive Team to review progress, constraints and any emerging new priority issues.	

Minute Ref.	*Item*	*Actions*
	Arabel Bailey, Non-Executive Director, asked how the effectiveness of the leadership training was being measured. Emma Wood, Chief People Officer explained that the leadership training was new for the Trust due to a gap in this area for managers in the past. In terms of measuring the success, the triangulation of data would be key and made up of staff survey results and manager feedback, Freedom to Speak Up matters, and employee relation matters. This data was usually available around autumn and helped to determine any teams that needed additional support and would provide HR with the opportunity to track progress over the coming year. In response to a query from Susan Hamilton, Associate Non-Executive Director, Paula explained that Patient First training cohorts were identified by the continuous improvement team working with Divisions and based on balancing the continuous improvement team capacity with the ambition and pace divisions want in their improvement journey. **RESOLVED that the Patient First Strategic Priority Projects Update be received and noted for information**.	
10/05/24	**Digital Strategy**	
	Neil Darvill, Chief Digital Information Officer, introduced the Digital Strategy to the Board. Neil highlighted the following: • Following approval of the text for the Digital Strategy at the Public Board meeting in March, the final version of the Digital Strategy had been finalised and included emphasised information on sustainability and equality of access as requested by the Board. • An annual plan would need to be agreed as the first deployment stage of the strategy and Digital Services were working with the Business Planning Team and Finance and Estates to develop the business case and to identify the best priorities. This plan would be presented to the Finance, Digital and Estates Committee for approval. During the ensuing discussion the following points were made: In response to a comment from Rosie Benneyworth, Non-Executive Director, around making sure the Trust had enough capability and capacity to deliver the strategy, Neil said the strategy would focus on a smaller number of key themes to reinforce some of the risks and concerns around patient safety. During the planning process, the new Digital Governance Oversight Group would approve the key priorities and implement them safely by offering strong user support and training. Marc Griffiths, Non-Executive Director, asked what role the Digital Champions would take as the strategy developed. Neil said the governance had already changed significantly which had allowed senior divisional leadership to contribute to digital solutions and the governance of projects moving forward would be clinically lead for clinical systems. **RESOLVED that the Digital Strategy be received and noted for information**.	
11/05/24	**Quality and Outcomes Chair's Report**	

Minute Ref.	*Item*	*Actions*
	Sue Balcombe, Chair of the Quality and Outcomes Committee presented the Chair's Report from March 2024 meeting of the committee. Sue highlighted the following: • The Committee received a Deep Dive into End-of-Life Care (EOL) and the Trust's Palliative Care Service which highlighted significant challenges around the delivery of the service over five-days and optionally over seven-days. The Committee was also informed that at a system level the priority was to support moving the service forward to ensure equitable access to care was provided. • The Committee received an update position on the Trust's Composite CQC Action Plan and it was agreed to close six actions leaving one residual action pertaining to Venous Thromboembolism (VTE). • The Committee considered the Trust's progress against the Niche report response to "Baby J" with a focus on a review of the learning and actions, and the Committee supported the recommendation to close fifteen out of the sixteen residual actions. **RESOLVED that the Quality and Outcomes Chair's Report be received and noted for information.**	
12/05/24	**Experience of Care Strategy 2024-2029**	
	Matthew Areskog, Head of Experience of Care and Inclusion, and Chris Swonnell, Associate Director of Quality and Compliance, introduced the new Experience of Care Strategy for 2024-2029. The following was highlighted to the Board: • The development of the Experience of Care Strategy formed one of the projects on the Patient First priority list. • As well as patients, carers and communities, more than twenty senior leaders across UHBW had contributed to the development of the strategy's themes and would play a pivotal role in the delivery phase. • A detailed three-year delivery plan had been developed for 2024-2027 which would be refreshed at the end of year three to establish the priorities for the final two years. • Matthew outlined how the strategy would shift the organisation to follow a life-course approach, from birth through to end of life and the patient journey from the very first contact with UHBW through to the transfer of care back home and/or to other health and care providers. • The strategy followed the "Picker Principles of Person-Centred Care". During the ensuing discussion the following points were made: Roy Shubhabrata, Non-Executive Director, commended the new strategy and queried how the measures of success could be carried through to the strategy milestones to monitor the progress of achieving the goals. Following on from this, Roy asked about how the strategy would capture the views from underrepresented groups of the community. Matthew explained that by using the national core competency framework, the Trust could work with targeted community organisations that represented those	

Minute Ref.	Item	Actions
	groups based on the available research through ongoing improvement projects running in the organisation. In response to a query from Rosie Benneyworth, Non-Executive Director, Matthew confirmed that he would explore and consider whether the measures of success within the strategy would be able to pick up the Trust's success of its involvement with communities that it needed to engage with in a different way. Jane Farrell, Chief Operating Officer, asked how the Board could support the team to bring the key elements of the strategy to the next stage of delivery. Matthew said the everybody had a role to play in bringing the strategy to life, and due to the number of strategies being launched by the Trust, it would be helpful if key messages were not lost in communication. It was noted that the Communications Teams would be considering how to get the key messages from the strategy out into the organisation. Arabel Bailey, Non-Executive Director, considered the amount of work that the people on the ground would need to undertake, and asked whether the team believed that the strategy could be delivered. Chris explained that the team had considered the strategies' key priorities against the new Patient First framework which would appear in the Trust's Quality Account. Matthew noted that the milestones had not been set for the entirety of the strategy and explained that there would be a pause halfway through the term to assess what had been achieved with the potential for re-prioritising of the key ambitions. It was noted that annual check-ins would take place, aligning to the Patient First objectives. Sue Balcombe, Non-Executive Director, shared a concern that services and teams could become rigid in how they responded to the strategy, due to the patient being at the centre of the strategy. Sue queried how this would be monitored. Matthew responded that in support of this, the "What Matters to You" toolkit would be rolled out to all patient areas within the Trust which would help to recognise that patients will have some of the solutions as people with lived experiences. Chris noted that the "What Matters to You" conversation would also help to ease the overall pressures on services by dealing with patient concerns sooner, as opposed to concerns developing into a patient complaint further down the line. Susan Hamilton, Associate Non-Executive Director commended the strategy and offered support for the end-of-life care aspect of it. Paula Clarke, Executive Managing Director, Weston General Hospital, welcomed the new strategy and queried whether the Trust was utilising its relationships with locality partnership boards and whether advanced training around lived experiences could be filtered into the training for Healthcare Professionals, who could influence shared decision making once in post. Matthew said relationships with locality partnership boards would be taken forward with Director of Business Development and Improvement. Marc Griffiths, Non-Executive Director responded to the training for Healthcare Professionals and acknowledged that more could be done generally, however noted that end-of-life care was developing and there would be an opportunity to promote this profession as a viable career option. Marc offered support to Matthew in terms of taking this forward.	

Minute Ref.	*Item*	*Actions*
	In response to a query from Emma Glynn, Associate Non-Executive Director, Matthew said the baselines for measuring the success of percentage increases needed to be determined, however acknowledged that more information could be added before publicising the strategy to make this clearer. Martin Sykes, Chair, thanked Matthew and Chris for the strategy and wished them luck for taking it forward. **The Board APPROVED the Experience of Care Strategy for 2024-2029, taking into account the comments raised above.**	
13/05/24	**Integrated Quality Performance Report**	
	Jane Farrell, Chief Operating Officer, introduced the Performance Report of the key performance metrics within the NHS Oversight Framework for 2023/24 and the Trust Leadership priorities. It was noted that the full Integrated Quality and Performance Report (IQPR) had been included within the Document Library for Board members' reference. The key points around timely care for year-end included: • Elective recovery had exceeded delivery at the end of the financial year and remained on-track for 2024/25 expectations. • Cancer performance had achieved the 62-day baseline set for the Trust by NHS England. • Diagnostics and Therapies saw a significant increase and growth in echocardiology which was affecting elective capacity and recovery and the reasons behind this was being investigated and responded to. • Workforce challenges in Audiology had also impacted Diagnostics performance in March and recovery was ongoing which would be seen going forward. • Performance in the Emergency Department (ED) had met the standards set out by NHS England, and Jane noted the effort to deliver this which was a testament of the hard work carried out by the teams involved. The lessons learned from this work were being embedded which was predicting an increase in overall week on week sustainable improvement. Rebecca Maxwell, Interim Chief Medical Officer, highlighted key points around quality and safety which included: • The Hospital Mortality Indicator for the month of December 2023 was 75.9, meaning there were 35 fewer observed deaths than expected. • The Hospital Mortality Indicator for the 12 months between December 2022 to November 2023 was 92.5 and in the as expected category. Emma Wood, Chief People Officer & Deputy Chief Executive, highlighted key points around people which included: • The Trust was awarded bronze status of the North Somerset Healthy Workplaces Award for the workplace wellbeing provision. • Turnover, vacancies, and sickness performance had all remained on track, however agency usage for doctors was an area of focus so this form part of the Patient First priorities.	

Minute Ref.	*Item*	*Actions*
	• The Trust's Bank team continued work with the Acute Provider Collaborative to progress the concept of a Collaborative Bank across UHBW and North Bristol NHS Trust. • The final arrival of internationally educated nurses landed in April which would conclude the recruitment programme due to lack of national funding. During the ensuing discussion the following points were made: Roy Shubhabrata, Non-Executive Director queried the data in relation to white ethnic group having the lowest Did Not Attend (DNA) rate, versus nearly half the rate for the black ethnic group, and whether there were known inequalities for these patients. Jane acknowledged that this was only the second month of capturing this data, however noted that as the data matured it would be used to understand what was going on in this area. Stuart Walker, Interim CEO, noted that this was a national picture. Rosie Benneyworth, Non-Executive Director asked about timely care within the ED and whether the team had the data to see how patients could be managed elsewhere in terms of acuity and referred to a new study in relation to this. Stuart considered whether patients coming to the ED were sicker than some of the narrative being publicised and noted that a study assessing the acuity tool in EDs had not yet publicised. Emma Glynn, Associate Non-Executive Director asked about the Trust's process for work visas coming to an end and whether it would impact vacancy rates. Emma Wood responded that visas were being renewed by the Trust once nurses had reached the end of their repayment clause in their contracts. Each Division had spoken to nurses coming to the end of the repayment clause and the Trust had an idea of the number of leavers. In terms of workforce planning, the organisation had prepared for this workforce gap whilst it grew its own by using retention programmes such as "Stay and Thrive". Emma Glynn asked about "No Criteria to Reside" and Jane advised that a system led working group was developing hospital specific targets that would include community hospitals which would provide a clear picture of the challenges in this area. **RESOLVED that the Integrated Quality Performance Report be received and noted for information**.	
14/05/24	**Maternity Assurance Report**	
	Sarah Windfield, Director of Midwifery and Nursing introduced the Maternity Assurance Report including the maternity serious incidents report and highlighted the following key points to members of the Board. • The Board received an oversight with regards to all moderate harm or above incidents, and any incidents which met the criteria to be referred to the Maternity and Newborn Safety Investigations programme. It was noted that action plans were in place and being progressed for all incidents. • The compliance for the level 3 safeguarding training target had made progress over the last month.	

Minute Ref.	*Item*	*Actions*
	• There was an opportunity to progress the development of a new incident review tool, which aimed to improve the timeliness of initial incident reviews. • Due to ongoing concerns relating to the quality of data captured within "BadgerNet", the team were assessing the information available to women regarding their pregnancy. • There had been an increase in staffing levels related Datix incidents during March. • A deep dive relating to postpartum haemorrhage (PPH) rates would be presented to the Quality and Outcomes Committee, as the Trust was an outlier in this area. • The frequency of reporting maternity updates to the Trust Board would change to a quarterly basis with urgent issues being escalated to the Quality and Outcomes Committee. • The Care Quality Commission (CQC) action plan for maternity was being monitored by the maternity governance group with good progress being made. In response to a query relating to "BadgerNet" from Arabel Bailey, Sarah confirmed that learning was being shared with other Trusts via a national group. Arabel noted that the data being presented to the Board was richer than previously received, likely because of the new system, but she suggested that it was difficult to interpret and compare with other Trusts. Sarah agreed to include this level of benchmarking information within the next maternity report. **RESOLVED that the Maternity Assurance Report be received and noted for information**.	
15/05/24	**Learning From Deaths Quarterly Reports – Q3**	
	Rebecca Maxwell, Interim Chief Medical Officer, introduced the Learning From Deaths Quarterly Reports for quarter 3. • Compared to the previous year a considerable drop in the number of in-hospital Trust deaths had been reported. • Several positive feedback referrals were received that praised the care given at Weston General Hospital. • All deaths for the quarter were rated 4 or above for avoidability. • The key learning points and recommendations from the Mortality Surveillance Group were good. **RESOLVED that the Learning From Deaths Quarterly Reports for Q3 be received and noted for information**.	
16/05/24	**Finance, Digital and Estates Committee Chair's Report**	
	Martin Sykes, Non-Executive Director and Chair of the Finance, Digital & Estates Committee updated the Board on the last meetings held in March 2024 and April 2024. Key points included: • The draft financial plan for 2024/25 was reviewed by the Committee. • The Committee received an update on the Trust Sustainability Programme.	

Minute Ref.	*Item*	*Actions*
	• The Committee received an update on the Digital Strategy and an update on digital projects including the latest opportunities and risks. • The Committee received a presentation on the Building Safety Act 2022 and considered potential impacts on the Trust's capital projects. **RESOLVED that the Finance, Digital and Estates Committee Chair's Report be received and noted for information**.	
17/05/24	**Monthly Finance Report**	
	Neil Kemsley, Chief Financial Officer, informed the Board of the Trust's overall financial performance from 1st April 2023 to 31st January 2024 (month 12). Key points included: • The Trust's outturn net income and expenditure position for 2023/24 was a surplus of £41k against the plan of break-even for the year. It was noted that the reported position was subject to external audit which would be reported to the Audit Committee in June. • Divisional financial performance ended in a £12.1m deficit and Divisions would prioritise recurrent CIP schemes to deliver the 2024/25 efficiency challenge of £41m. • It was noted that the Trust had significantly invested in its workforce over the last 12 months. • At year-end the Trust's cash balance remained strong at £96.7m. • The challenges going into the new financial year were outlined, such as the elective income falling behind plan by £17,100k which largely related to industrial action. Martin Sykes thanked the finance teams on their work relating to the year-end accounts. **RESOLVED that the Monthly Finance Report be received and noted for information**.	
18/05/24	**People Committee Chair's Report**	
	Marc Griffiths, Non-Executive Director updated the Board on the last meeting held in March in the absence of Bernard Galton, Committee Chair. Key points included: • The Committee approved the KPIs for 2024/25. • The Committee was informed that NHS England would be taking a strong line with organisations unable to forecast a break-even budget which would result in demands to reduce headcount. • The Committee discussed initiatives to improve the internal career routes for nurses to retain staff. • There was a presentation from the Director of Communications outlining the progress that has been made on implementing the new Communications Strategy. • The Committee discussed the general shortage of staff with Diagnostics and Therapies and how the Trust was maximising the resources across sites.	

Minute Ref.	*Item*	*Actions*
	• It was agreed that the item referred to the Committee from the Quality and Outcomes committee in relation to food hygiene training was an operational issue and would be forwarded to the People Learning Development Group for monitoring. **RESOLVED that the People Committee Chair's Report be received and noted for information**.	
19/05/24	**Audit Committee Chair's Report**	
	In the absence of Jane Norman, Chair of the Audit Committee, who had now left the Trust, Martin Sykes updated the Board on the last meeting held in April. Key points included: • The Committee spent some time discussing the Board assurance framework and ensuring there was clarity over some risks. • The Head of Internal Audit Opinion was expected to be another positive response and it was highlighted that many other Trusts were not able to maintain the significant assurance that the Trust had, which was to be commended. • Further information on the number of obsolete and under review documentation as well the Trust's plan to decrease this was requested for the next meeting. **RESOLVED that the Audit Committee Chair's Report be received and noted for information**.	
20/05/24	**Annual Review of Directors' Interests**	
	Mark Pender, Head of Corporate Governance, presented the Annual Review of Directors' Interests to the Board and highlighted the purpose of the report which was to provide assurance that the Trust was compliant with regulatory requirements to maintain an up-to-date register of all interests for the Board of Directors. **RESOLVED that the Annual Review of Directors' Interests be received and noted for information**.	
21/05/24	**Governor's Log of Communications**	
	Mark Pender, Head of Corporate Governance, presented the Governors' Log of Communications for the information of the Board and highlighted that since the previous report one question had been added to the log around digitisation, and five questions had been answered on the log. **RESOLVED that the Governor's Log of Communications be received and noted for information**.	
22/05/24	**Any Other Urgent Business**	
	There were no items of urgent business for discussion.	
23/03/24	**Date of Next Meeting:** Tuesday 9th July 2024	

University Hospitals Bristol and Weston NHS Foundation Trust

Public Trust Board of Directors Meeting on Tuesday, 09 July 2024
Action Log

Outstanding actions from the meeting held in May 2024					
No.	**Minute reference**	**Detail of action required**	**Executive Lead**	**Due Date**	**Action Update**
1.	**08/05/24**	Neil Kemsley, Chief Financial Officer, to progress the next Annual Sustainability report to include data around measuring the Trust's carbon footprint targets, widely advertising the "Greener Together" Programme to UHBW staff via Comms and exploring the potential for a new training module for staff in this area.	Chief Financial Officer	July 2024	**Action ongoing** This item will now come to the September meeting of the Board.
2.	**19/03/24**	Director of Corporate Governance to amend the Modern Slavery and Human Trafficking Statement 2023/24 to include social care.	Director of Corporate Governance	July 2024	**Suggest action is closed** The Modern Slavery and Human Trafficking Statement 2023/24 has been updated and published in the Trust's website.
Closed actions from the meeting held in May 2024					
1.	**10/03/24**	Trust Secretariat to add an item to the next Finance, Digital and Estates Committee agenda to discuss ageing radiology equipment.	Trust Secretariat	May 2024	**Action Closed** May Update The Trust Secretariat had added an additional item to the March meeting of the Finance, Digital and Estates Committee agenda to discuss the ageing equipment.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9 July 2024

Report Title	**Joint Chair Activity Report**
Report Author	**Ingrid Barker, Joint Chair**
Executive Lead	**Ingrid Barker, Joint Chair**

1. Purpose

The report sets out information on key items of interest to the Trust Board, including the Joint Chair's attendance at events and visits as well as details of the Joint Chair's engagement with Trust colleagues, system partners, national partners and others during the reporting period.

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

The Trust Board receives a report from the Joint Chair to each meeting of the Board, detailing relevant engagements undertaken and important changes or issues affecting University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and North Bristol NHS Trust (NBT) and the external environment during the previous month.

In addition to the activity listed in the report, during the Joint Chair's first month in post the Communications teams in both Trusts undertook valuable work to agree a 'first 100 days' joint communications approach to support her visibility across both Trusts.

3. Recommendation

- This report is for **Information**

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

N/A

Joint Chair Activity Report

The report sets out information on key items of interest to the Trust Board, including the Joint Chair's attendance at events and visits as well as details of the Joint Chair's engagement with Trust colleagues, system partners, national partners and others during the reporting period.

1. Joint Chair Activity at University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)

1.1. Connecting with our Trust Colleagues:

The Joint Chair undertook a variety of visits during May, before her employment contract started, and June 2024, in support of a planned induction programme, including to gain insight to:

- the Children's Hospital with Martin Gargan, Clinical Chair, Fiona Jones, Divisional Director, Rachel Hughes and Beth Shirt, Directors of Nursing;
- the Bristol Royal Infirmary Emergency Department and Same Day Emergency Care Unit with Rebecca Maxwell, Interim Chief Medical Officer, Clare Holmes, Clinical Chair, Lisa Galvani, Divisional Director and Angela Bezer, Director of Nursing (Division of Medicine);
- Hey Groves Theatres with Ashley Livesey, Divisional Director and Sarah Chalkley, Director of Nursing (Division of Surgery);
- Weston General Hospital, specifically the Emergency Department, SDEC, Seashore, Kewstoke and Hutton Wards, and OPAU;
- the Bristol Heart Institute, specifically Catheter Laboratories, Cardiac Critical Care Unit and Cardiac Surgery, with Rachel Protheroe, Clinical Chair, Owen Ainsley, Divisional Director, Jamie Cargill and Helen Bishop, Directors of Nursing (Division of Specialised Services;
- the Dental Hospital, with Ashley Livesey, Divisional Director, and Mark Stevens, Deputy Divisional Director (Division of Surgery);
- introduction meeting with Lead Governor, Mo Phillips;
- introduction meeting with Council of Governors;
- induction meetings with Executive Directors and Non-Executive Directors;
- UHBW Board Day where the Board of Directors came together to sign off the Annual Report and Account, as well as hold discussions on the Infected Blood Enquiry and a Digital update.

2. Joint Chair Activity at North Bristol NHS Trust (NBT)

2.1 Connecting with NBT Trust Colleagues:

The Joint Chair undertook a variety of visits during June 2024, in support of a planned induction programme, including to gain insight to:

- the Emergency Department, Acute Medical Unit and Same Day Emergency Care with Ella Chaudhuri, Clinical Director, Ben Hewlett, Divisional Operations Director, Annie Langford, Divisional Director of Nursing, and Anna Bell, ED Ward Manager;
- the Research and Development team with Helen Lewis-White, Deputy Director of Research and Development;
- the Transfer of Care Hub with Cathy Daffada, Associate Director for Integrated Discharge;
- the Women's and Children's Health Division with Jane Mears, Clinical Director and Julie Northrop, Divisional Director of Midwifery and Nursing;
- Ward 9b, Medical Division - Complex Care - with Lalu Abraham, Senior Sister and Shelley Panayiotou, Registered Nurse;
- Cossham Estate Midwifery and Dialysis Unit with Joanna Karolewska, Community Midwife and Lisa Ford, Clinical Matron for Renal and Dialysis Services;
- Pathology Labs with Dave Fisher, Director of Pathology;
- Brunel Atrium with Volunteers and Move Makers, with Bwalya Treasure, Volunteer Service Manager and Jill Randall, Move Maker Volunteer Manager.

2.2 Southmead Hospital Charity Event

The Joint Chair attended the Southmead Hospital Charity "Evening of Thanks" on 11 June 2024.

Attendees included Helen Lewis-White, Deputy Director of Research and Development, Sanjoy Shah, Deputy Chief Medical Officer, Donna Baber, Arts Programme Manager, Mario Teo, Consultant Neurosurgeon and Glyn Howells, Chief Finance Officer.

A wide variety of topics were discussed, including Charity-funded research, the Bristol ECMO Service, the Fresh Arts Programme and the Neurosurgery Robotic Microscope.

2.3 Clean Air Day Event

The Joint Chair attended the Clean Air Day event on 20 June 2024, with members of the Sustainability Team, led by Megan Murphy, Sustainability Manager.

3. Joint Chair Activity with Integrated Care System

3.1 Connecting with our Partners

The Joint Chair undertook introductory meetings with a number of partners as follows:

- Jeff Farrar, Chair of Bristol, North Somerset and South Gloucestershire Integrated Care Board
- Dave Perry, Chief Executive Officer, South Gloucestershire Council
- Jo Walker, Chief Executive Officer, North Somerset Council
- ICP Partnership Board Meeting

3.2 National and Regional Engagement

The Joint Chair will provide details verbally at the Trust Board meeting.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th July 2024

Report Title	**Patient First Strategic Priority Projects Report**
Report Author	**Melanie Jeffries, Continuous Improvement Programme Manager**
Executive Lead	**Paula Clarke, Executive Managing Director (WGH)**

1. Purpose

This report provides the first quarterly update on delivery of the Patient First strategic priority projects for 2024/5.

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

The purpose of the report is to provide assurance to the Board, and its committees, that strategic priority projects are delivering improvements to "turn the dial" on our True North goals and vision metrics (delivered over 3-5 years).

Appendix 1 summarises the progress in delivery of the Patient First strategic priority projects for 2024/25. In line with the data driven approach of Patient First, the metrics enable us to assess progress with project timelines and milestones being on or off track and to assess delivery of project targets against trajectory (either process or outcome metrics). Project target metrics continue to be reviewed and amended where required, to more accurately reflect the impact of the improvement work being undertaken and ensure we are continuously learning and adapting.

In June 2024 the following assessment has been made:

- 6 of the 18 True North vision metrics are red
- 2 of the 20 strategic priority project timelines are red.
- 3 of the 20 strategic priority projects have red target metrics
- 5 of the strategic priorities are in development, aiming for goals and metrics to be available for the September report.

It is noted which projects align to the IQPR and all projects are tracked through the monthly Senior Leadership Team Strategy Deployment Review. Board committees have also started to review projects relevant to their focus.

Deployment of the Patient First management operating system is progressing well:

- The Division of Medine are in preparation phase for deploying Patient First throughout the whole division. This will put in place tools and leadership mindsets and behaviours to streamline the governance of the division to release time and empower and support staff to continuously improve their services.
- Patient first for Teams training – this is progressing in Estates & Facilities and Medicine Divisions. The teams undergoing the training are included in Appendix 3 and 10 of the teams from cohorts 1& 2 have active improvement huddle boards up and running.

3. Strategic Alignment
This report gives assurance regarding the organisational steps being taken via the Patient First approach to deliver the Trust's strategic direction and progress in delivery of the Trust strategic priorities for 2024/25
4. Risks and Opportunities
• The strategic priority projects contribute to addressing all key areas of strategic and corporate risk across the Trust. • The Patient First approach provides an opportunity to prioritise our improvement work across the Trust to deliver in a more focused, transparent and effective way.
5. Recommendation
This report is for **Information.**
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**

Senior Leadership Team Strategy Deployment Review	Information taken from May and June meeting updates

Appendix 1: Progress of Strategic Priority Projects 2023/24 (attached)

Appendix 2

Glossary:

Strategic Initiative	Strategic programmes (our enabling strategies) with annual delivery plan, delivered by corporate services as BAU. May generate a future breakthrough objective or corporate project
Mission Critical project	Start and Finish Trust wide/complex project, must do can't fail. Temporary injection of resource, delivered by corporate teams and divisions.
Important Corporate Project	Start and Finish Trust wide/complex project. Temporary injection of resource, delivered by corporate teams and divisions.
Breakthrough Objective	12 month improvement priorities that focus improvement energy from floor to board, delivered by front line staff.

Appendix 3: Patient first for Teams training

Cohort 1:
Estates & Facilities Division

- Portering Bristol site
- Portering Weston site
- Capital and Space team
- Estates Officers
- Estates Operations

Cohort 2:
Medicine Division

- BRI Emergency Department
- Liaison Psychiatry
- A900 ward (gastroenterology/hepatobiliary)

Estates & Facilities Division

- Catering – Weston
- Catering - Bristol

Appendix 1: Strategic Priority Projects 2024/25: Progress report for Public Board July 2024

University Hospitals Bristol and Weston NHS Foundation Trust

Introduction

- This report presents the latest performance of the Trust's Strategic Priority projects
- The summary report for each Strategic Priority project is derived from the update report presented to the Senior Leadership Team Strategy Deployment Review by the Senior Responsible Officer (SRO), and latest updates from the SRO.
- It should be noted that some metrics are still under development, being led by the SRO.
- Where there is overlap with the IPQR, the detailed performance update is contained in the IPQR narrative to avoid duplication.
- The report includes a status for whether the project timeline is on or off track, and a 'turning the dial' status to show how much improvement has been made since the project baseline

Summary of Strategic Priorities

Strategic Priority	Project Type	Strategic Priority Project Title	Assurance	
Experience of Care *Exceptional patient experience*	Strategic Initiative	Experience of Care strategy Year 1 Delivery	Quality Outcomes Committee	QOC
	Breakthrough objective	Experience of care through better communication	Quality Outcomes Committee	QOC
Patient Safety *Excellent care, every time*	Strategic Initiative	Clinical Strategy Year 2	Quality Outcomes Committee	QOC
	Corporate Project	Implementing Careflow Medicines Management	Finance, Digital and Estates Committee	FDEC
	Corporate Project	Delivering our Deteriorating Patient Programme	Quality Outcomes Committee	QOC
Our People *Proud to be #team UHBW*	Strategic Initiative	Our People Strategy Year 3	People Committee	PC
	Corporate Project	Medical Workforce Programme	*People Committee*	*PC*
	Breakthrough objective	Delivering the pro equity promise	People Committee	PC
Timely Care *Timely access to care for all*	Strategic Initiative	Communication Strategy Year 2	Executive Committee	EC
	Corporate Project	Proactive Hospital	Quality Outcomes Committee	QOC
	Corporate Project	Improving Theatres Efficiency and Productivity	Quality Outcomes Committee	QOC
	Corporate Project	Improving Outpatients Efficiency and Productivity	Quality Outcomes Committee	QOC
	Breakthrough objective	Ready for Discharge	Quality Outcomes Committee	QOC
Innovate and Improve *Unlocking our potential*	Strategic Initiative	Patient First Deployment Year 3	People Committee	PC
	Strategic Initiative	UHBW Digital Strategy Year 1	Finance, Digital and Estates Committee	FDEC
	Corporate Project	Fire Safety Programme	Finance, Digital and Estates Committee	FDEC
	Breakthrough objective	Consistency in undertaking weekly fire evacuation checks in every division and department	Finance, Digital and Estates Committee	FDEC
Our Resources *Using our resources wisely*	Corporate Project	Delivering Financial and Productivity Improvement	Finance, Digital and Estates Committee	FDEC
	Corporate Project	Digital procurement, stores and materials management	Finance, Digital and Estates Committee	FDEC
	Breakthrough objective	Delivering recurrent savings	Finance, Digital and Estates Committee	FDEC

Status Key	Project Status				Turning the dial: how much improvement is being made since the project baseline						Other	
	✓	Project timeline on track	✗	Project timeline off track	Green text	Metric is on target or moving positively towards trajectory	Red text	Metric is off target or moving negatively from trajectory	Black text	Project not in measurement phase	IQPR	Detailed information included in UHBW Integrated Performance and Quality Report

Author: Melanie Jeffries, Continuous Improvement Programme Manager. Date report finalised: 26/06/24

Experience of Care - *Exceptional patient experience*

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 a consistently outstanding experience for ALL our patients as reported by them and as recognised by our staff

Vision Metrics	**Starting position**	**Latest position**	**Turning the dial** (Baseline to latest position)
≥98% of inpatients and maternity will rate their care as good or above	• **91.5%** of inpatient and maternity stays rate their care as good or above in 2022/23	• **88.9%** of inpatient and maternity stays rate their care as good or above in 2024/25 (April 2024) Note: Data may change as postal surveys still to arrive	**1.6% point reduction**
Feedback is representative of the patients we care for	• 2024/25 baselines in development, will be available for September report	Working commencing to improve in 2024/25	Metric to be defined once project commences
Top 10% of non-specialist acute trusts: Staff would recommend this organisation for treatment of a friend or relative'	• **71.1%** in 2022 staff survey (National result) • **8% points** from top decile (79.1% - 92.5%) in 2022	• **74.2%** in 2023 staff (National result) • **6.2% points** from top decile (80.4% - 94%) in 2023	• **3.1% point increase** • **2.2% point improvement**
Top 10% of non specialist acute Trusts for overall patient experience based on the national patient survey results	• Inpatients 2022 34th out of 133 Trusts (within top 30%) • Maternity (2023) - 27th out of 121 Trusts (within top 30%) • Children and Young People (2020) - 6th out of 125 Trusts (top 10%)	• 2023 National Inpatient survey publication date will be Autumn 2024 • 2024 Maternity survey publication date will be Autumn 2024 Q4 2024/2025 • 2024 Children and Young People publication date will be Quarter 4 2024/25	**Await data in Autumn 2024**

Strategic Priority Projects	**Goal**	**Starting Position**	**Latest Position**	**Turning the dial** (Baseline to latest position)	**Key Progress**	**Project Status**	**Next Actions**
Strategic Initiative **Experience of Care strategy Delivery Year one** Assurance: QOC	Year 1 deliverables goals and metrics will be added for September report				• Experience of care strategy published and communicated in June 2024	✓	• Mobilise year 1 deliverables, and agree which to include in the strategic priorities reports to SLT and Board report
Breakthrough objective **Experience of care through better communication** Assurance: QOC	By March 2025 we will have increased the proportion of inpatients who rate their overall experience of care as good or better by focusing on improving communication with patients and between staff.	: Composite Communication score out of 100 - rolling 3 month average 2023/24 –**84** Note: This metric was developed in 2023.	83.1 Composite Communication score out of 100 - rolling 3 month average Target - 88 (Year to date in May 2024)	**Below target for 13 months**	• Continued bespoke Patient Feedback Hub training and support • Participating Divisions undertaking data analysis to develop countermeasures • National 'What Matters To You' (WMTY) day held on 6th June with participation from across UHBW • Evaluation of the impact of WMTY commenced at Weston	✓	• Report to be produced for Experience of Care Group at Divisional / Ward level tracking communication experience metrics across Trust. • Presentation to Weston Grand Round as next step for medical staff engagement • presentation to Weston Grand Round as next step for medical staff engagement • A3 thinking session 1 workshop for Medicine wards

Patient Safety - *Excellent care, every time*

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 reduce avoidable patient harm events and further develop a "no blame" and "just culture."

Vision Metric: Annual incremental improvements in patient safety culture questions in NHS staff survey to be within 1% of the best

Patient safety culture questions	Starting position	Latest position	Turning the dial (Baseline to latest position)
• not seen any errors/near misses/incidents that could have hurt staff/patients/service users	• Data not available	• Data not available	Data not available
• staff involved in error/near miss/incident treated fairly	• **5.9% points** from Best staff survey organisation (67.7%)	• **3.9% points** from Best staff survey organisation (69.3%)	**2% point improvement**
• organisation encourages us to report errors, near misses or incidents	• **1.4% points** from Best staff survey organisation (90.8%)	• **2.5% points** from Best staff survey organisation (92.2%)	**1.1% point deterioration**
• organisation ensure errors/near misses/incidents do not repeat	• **7.7% points** from Best staff survey organisation (75.9%)	• **7.1% points** from Best staff survey organisation (77.2%)	**0.6% point improvement**
• feedback given on changes made following errors/near misses/incidents	• **8.4% points** from Best staff survey organisation (69.1%)	• **7.4% points** 'from Best staff survey organisation (71%)	**1% point improvement**

	Strategic Priority Projects	Goal	Starting Position	Latest Position	Turning the dial (Baseline to latest position)	Key Progress	Project Status	Next Actions
Strategic Initiative	**Clinical Strategy Year 1** Assurance: QOC	To produce a single document that describes the clinical strategy for UHBW, recognisable to clinical teams and aligned with other strategic development work	No single clinical strategy for UHBW	Development of draft priorities	Clinical strategy programme in place and progressing	• Draft goals shared with key stakeholders • Drafting of content underway with aim to share with key stakeholders over July/August • Alignment with Experience of care strategy	✓	• Complete draft of narrative and test with key stakeholder • Complete final draft • Design and publication completed • Publish UHBW Clinical Strategy in Quarter 3 of 2024/25.
		Phase 1: Implement Single Managed Service for Pathfinder specialities and (TBC) additional specialties during 2024-25.	**0** Single Managed Services New metric	**2** pathfinder specialties commenced	**0** single managed services	• Development of Joint Clinical Strategy document for publication • Development of single managed services models of delivery underway in two Pathfinder services • Work to develop a Hospital Group Operating model commenced	✓	• Development of high level implementation plan for phases one to three of joint clinical strategy
		To have produced a Full Business Case to complete the Healthy Weston Phase 2 and 3 developments	Outline Business Case for full model of care originally approved ICB Board May 2022	Full business case developed for Phase 2	Business case produced	• Full business case finalised	✓	• Business case is going to Integrated Care Board on the 4th July then to Acute Health Care Improvement Group for approval in principle on the 15th July
Important Corporate	**Implementing Careflow Medicines Management** Assurance: FDEC	Improve patient care and reduce the risk to patients relating to the prescription of medicines through implementation of an electronic prescribing module within the Careflow PAS for use within the inpatient hospital bed base	Paper based prescriptions, with the exception of chemotherapy	Go live date to be decided at Executive Board in June	Monitor % of areas live once deployment commences	• Pre-Admit functionality installed, tested and signed off. • Completed install of CareFlow Integration Engine (CIE) upgrade in Live system. • Completed clinician user acceptance testing with participation and assurance from all divisions (Basic Functionality)	✗	• Technical Readiness (system installed fully for use) • Complete Assurance review (critical issues identified) • Continue engagement and demonstrations with stakeholders. • Sign off all training materials and upload eLearning to Kallidus in preparation for release to staff
	Delivering our Deteriorating Patient Programme IQPR Assurance: QOC	Increase effective and timely recognition, escalation and response of potentially deteriorating patients, including the recognition of sepsis by March 2025.	Note: Automated data is not available for all patients. A monthly manual audit of 100 patient notes is completed, proportionally divided across Divisions Inpatients -**10%** of 174 inpatients audited in 2023/24 had UHBW Sepsis pathway used appropriately Emergency Department -**53%** of 149 patients audited in 2023/24 had UHBW Sepsis pathway used appropriately		Latest audit data not yet available	• Project goals and deliverables refreshed for 2024/25 • Preparation for dissemination of updated NICE Sepsis 2024 guidance • New approach to manual audit process trialled, but needs to be revised	✓	• Dissemination of updated NICE sepsis guidance to all adult clinical areas in July/August 2024 • Progress discussions to ascertain if for partially automated data can extracted from vitals -to widen the pool patients being audit

Our People - *Proud to be #team UHBW*

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.

Vision Metric	**Starting position**	**Latest position**	**Turning the dial** (Baseline to latest position)
We will be in the top 10% of NHS organisations for staff recommending us as a place to work, a 5% improvement year on year.	• **60.1%** in 2022 staff survey (National result) • **10.2%** points from top decile (70.3% - 78.1%) in 2022	• **67.4%** in 2023 staff survey (National result) • **4.7%** points from top decile (72.1% - 82.9%) in 2023	• **7.3% point increase** • **5.5% point improvement**

	Strategic Priority Projects	Goal	Starting Position	Latest Position	Turning the dial (Baseline to latest position)	Key Progress	Project Status	Next Actions
Strategic Initiative	**Our People Strategy Year 3** Assurance: PC	Meet our stability index target of 85% by the end of March 2025	All staff **83.9%** April 2024	All staff **84.97%** May 2024	**0.8% point increase**	• Carried forward from last year with a focus on unregistered clinical posts	✓	• Develop A3 to scrutinise the data- tri-angulation of turnover, recruitment pipeline into high turnover areas,
		Develop new career pathways - Admin & Clerical, Health care scientists and Pharmacy	**2** career pathways	**2** career pathways	No shift since last report	• Admin and clerical group focussing on pathway development	✓	• Continue to develop pathways
		75% of staff have attended Leading Together training by the end of March 2025.	**0%** as new course (April 2023)	**65%** of leaders have completed (May 2024)	**65% point increase**	• Divisional compliance ranges between 55-76% • Compliance on the fast-track programme is 66% and is 64% on the full-route • 99% of managers have completed the self-assessment.	✓	• Leadership, Management and Coaching team have planned workshops and interventions to reach the target by end of July. • Self-assessment being removed as an option for new managers by August • Do Not Attends will be monitored as part of the Learner dashboard
		Achieve price cap compliance and eradicate off framework agency usage from 1 July 2024 and specialist rate cap by October 2024	To measured from July 2024		**New project**	• Discussions taken place with NHS England to assure on steps being taken to remove framework usage	✓	• Work to continue to remove off framework usage • Confirm plans for removal of specialist rate usage by 1 October 2024
		Deliver excellent Health & Safety governance and systems including responses to the British Safety Council 8 audit recommendations.	**0/8** Audit recommendations complete	**0/8** Audit recommendations complete as project new for 2024/25	**New project**	• Detailed plan against each recommendation created • Action plan to address risks of travel/ transport/pedestrians for Alfred Parade. • Training sessions for stress management commenced in April 2024.	✓	• Progress plan to move info/documents to SharePoint, to improve completion of Risk Assessments • Risk review for RIDDOR compliance, given reduced compliance
Important Corporate	**Medical Workforce Programme** Assurance: PC	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.	% of required specialties using all the new digital workforce systems	% of required specialties using all the new digital workforce systems	**New metrics in development**	• E-Job Plan link to payroll went live on 1st May. 24% of consultants have current job planned signed off • 75% of specialties are using Locum's Nest • 64% departments using healthroster for leave and absence management	✓	• Hold 3 x half day training sessions covering Healthroster, Locum's Nest and Loop to ensure departments are informed and trained. • Complete Guardian of Safeworking department tagging
			Reduction of medical workforce spend metric to be agreed		**New project**	• Master vendor on board and prepared for the rate reduction programme • On track for 3/4 off framework doctors moving to framework agencies.	✓	• Regional rate card should be agreed by July. Immediate implementation for short term agency. • Agree flight path for the longer term agency posts
			0 medical workforce funded retention strategy		**New project**	• Locally Employed Drs (LED) Career Pathway task and finish group established • Data analysis of LED workforce numbers initial cut and high level analysis	✓	• Task and finish group with leads from all clinical staff groups to discuss options for development of sustainable workforce plan for General Internal Medicine and Acute Medicine
Breakthrough objective	**Delivering the Pro Equity promise** Assurance: PC	New strategic priority project, in the development phase. Goal and metrics to be added for September report				• Project charter in development, which will detail the goal and the metrics to be used	✓	• Complete project charter

Timely Care - *Timely access to care for all*

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

Vision Metric		Starting position	Latest position	Turning the dial (Baseline to latest position)
IQPR	A 10% year on year improvement in ambulance handover times as a measure of improved patient flow through our hospital	**April – May 2023 cumulative position:** • **26.5%** of ambulance handovers within15 minutes • **58.9%** of ambulance handovers within 30 minutes	**April – May 2024 cumulative position:** • **23.5%** of ambulance handovers within15 minutes • **61.5%** of ambulance handovers within 30 minutes	**Handovers within 15 minutes:** • **10% point improvement not sustained for last 2 months** Note comparison is now 24/25 to 23/24 **Handovers within 30 minutes:** • **10% point improvement not sustained for last 2 months** Note: comparison is now 24/25 to 23/24

	Strategic Priority Projects	Goal	Starting Position	Latest Position	Turning the dial (Baseline to latest position)	Key Progress	Project Status	Next Actions
Strategic Initiative	**Communication Strategy Year 1** Assurance: EC	UHBW will have a high performing communication function. There will be a clear UHBW brand, channels and platforms in place which are fit for purpose, measurable and support opportunity for two-way engagement	Refreshed Communication strategy approved in October 2022.	17/25* key milestones to deliver Branding, Intranet, Website, Channels and functions complete *corrected denominator	**68% of key milestones complete**	• Intranet replacement project commenced. • Full-hearted care launched. • New internal communications channels launched (phase 1).	✓	• Intranet Discovery (including staff listening events) to inform site design. • Full-hearted care roll out and embed. • Phase 2 channel implementation begins.
Important Corporate	**Proactive Hospital** IQPR Assurance: QOC	Demonstrable reduction in delays to timely patient care by March 2025	**8.7**% patients spent over 12 hours in an Emergency Department 2022/23	**4%** patients spent over 12 hours in an Emergency Department vs 2% target 2024/25	**4.7% point reduction**	• 24/7 Discharge lounge improvement project completed and evaluation underway • Standardised Wardview boards live in Medicine with other Divisions to follow across June. • Emergency Department to CT scan project commenced	✓	• Preparation for Interprofessional standards rollout • Commence community referrals being directly accepted by Frailty Same Day Emergency clinic • ED speciality referrals project to agree priorities
	Improving Theatres Efficiency and Productivity Assurance: QOC	To optimise theatre capped touchtime utilisation to 85%. To improve scheduling processes to reduce early finishes and pre-assessment to provide sufficient numbers of patients available to list.	**71.2%** capped touch time utilisation (April 2023)	**74.9%** capped touch time utilisation (May 2024) Target -85%	**3.7% point increase**	• BI theatre dashboard now provides analysis of opportunity for additional activity within current funded sessions. • Bristol Dental Hospital a 3% improvement since March, with June currently showing a further 6% increase. • Utilisation for Bristol Royal Hospital for Children at its highest level since 2019 for both April (78%) and May (75%).	✓	• Agree improvement trajectories and plans with divisions & specialities to achieve the 4% utilisation increase required by NHSE • Formalise new clinical working group to review and implement GIRFT guidance for theatre flow and surgical discharge. • Implement key improvement actions in Bristol Eye Hospital, Bristol Dental Hospital, South Bristol Community Hospital and Dermatology
	Improving Outpatients Efficiency and Productivity Assurance: QOC	To optimise outpatients utilisation focussing on reducing Did Not Attends and cancellations in key specialities. Contribute to a reduction in outpatient backlogs enabling patients to receive more timely care by March 2024.	• **7.1%** Did Not Attend rate in 2022/23 • **11.5%** patient cancellation rate in 2022/23	• **6.3%** Did Not Attend (5% stretch target) in 2024/25 • **12.4%** patient cancellation rate (10% target) in 2024/25	**Did Not Attend rate:** **0.8% point reduction** **Patient Cancellation rate:** **0.9% point increase**	• Roll out of DrDoctor digital letters to all Bristol adult Specialties ,in March 2024, 54% of patients notified accessed their letters digitally. • DrDoctor rescheduling successfully rolled out to 1st phase specialities • DrDoctor two-way messaging re-testing in progress with pilot speciality	✓	• Engage high impact specialities with the NHSE GIRFT guidance and checklist for reducing DNA,s and deployment of supporting DrDoctor functions. • Develop delivery plan for DrDoctor patient led booking • Safeguarding review of processes to support DrDoctor letters for under 16's.
Breakthrough objective	**Ready for Discharge** IQPR Assurance: QOC	Revised goal in June 2024: To bring the median discharge time forwards 2 hours (13:30 -13:50) by March 2025	Median discharge time in 2023/24 - **15:38**	Median discharge time in 2024/25 – **15:48**	**10 min increase**	• Golden patient discharge work shown improvement on pilot wards, staff training video to with senior clinical and medical engagement produced • Digital discharge checklist went live in April and in the first month overall compliance reached 20%. • Rollout of Proactive Board Round (PBR) clinical note in June, including recording of no criteria to reside status	✓	• Work with Every Minute Matters (EMM) Consultant Clinical Lead to develop communication materials and plans for improved awareness of EMM among doctors. • Develop a plan to rollout Golden Patient across BRI and Weston • Monitor compliance and embed the PBR clinical note on all adult inpatient wards.

Innovate and Improve – *Unlocking our potential*

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.

		Starting position	Latest position	Turning the dial (Baseline to latest position
Vision Metric	A 2% improvement year on year in staff reporting they are able to make improvements	• **55%** in 2022 staff survey (National result) • **7.1% points** from top decile (62.1% - 69.1%) in 2022	• **59.6%** in 2023 staff survey (National result) • **3.2%** points from top decile (62.8% - 67.8%) in 2023	• **4.6% point improvement** • **3.9% point improvement**

Strategic Priority Projects		Goal	Starting Position	Latest Position	Turning the dial (Baseline to latest position)	Key Progress	Project Status	Next Actions
Strategic Initiative	**Patient First Deployment Year 3** Assurance: PC	Develop and deploy the Patient First tools, processes, routines, behaviours and support in order to: • deploy the Patient First Management Operating System into the divisions • by March 25 deploy Patient First for Teams training to 24 teams • continue to develop capability through A3 thinking projects – 38 projects completed (cumulative 23/24 and 24/25)	Metric revised for 24/25 deliverables: **9** Patient First for Teams training **27** A3 thinking Improvement projects underway or completed (April 2024)	**13** Patient First for Teams training **33** A3 thinking improvement projects underway or completed (June 2024)	**4 teams increase** **6 project increase**	• Catchball completed • Divisional Strategy Deployment reviews commenced with specialised services • Medicine Division commence preparation and planning for the full management operating system deployment • Amended approach to Patient First for Teams training to increase capacity to 48 teams per year	✓	• Commence Divisional Strategy Deployment reviews with Weston, Diagnostics and Therapies, Weston, Estates and Facilities • 2nd division to commence full management operating system deployment • Patient First for Teams training roll out plan to be developed with divisional triumvates
Strategic Initiative	**UHBW Digital Strategy Year 1 Deliverables** Assurance: FDEC	Year 1 deliverables goals and metrics to be added for September report				The Digital Delivery plan for 24/25 was approved at the Digital Hospital Programme Board yesterday and will be presented at CPSG next week.	✓	Define Year 1 deliverables goals and metrics
Mission Critical	**Fire Safety Programme** Assurance: FDEC	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	**0%** clinical building fire strategies and risk assessment	**100%** clinical building fire strategies and risk assessment vs target 100% by end of April 2024	**100% done (Awaiting final documents)**	• Fire Strategies (FS) completed for all initial clinical buildings • Fire Risk Assessment (FRA) surveys completed for all initial clinical buildings • Recruitment of fire safety advisers in progress. • Prioritised fire evacuation exercise matrix completed.	✓	• Annual review of St.Michael's Hospital FRA to be undertaken. • Phase 2 buildings requiring FS's and FRA's identified and programme to be developed with external fire engineers • Completion of Priority Risk Matrix across all initial buildings; divisional engagement to commence. • Newly reform Fire Safety Committee with divisional representation and co-chair Deputy Chief Nurse.
Breakthrough objective	**Consistency in undertaking weekly fire evacuation checks in every division and department** Assurance: FDEC	Weekly fire evacuation checks are undertaken for every clinic, department and ward across our Trust.	**Under 10%** evacuation reporting (October 2023)	**48%** of expected evacuation reports completed (May 2024)	**38% point improvement**	• Apollo 35 ward evacuation simulation – walk and talk training exercise with staff completed. • Bi-weekly NICU evacuation and fire safety meetings held • Continuing fire warden recruitment and training undertaken across Bristol and Weston sites.	✗	• Monthly summary report to be developed for Divisions to highlight areas reporting/not-reporting, number of fire wardens per location plus highlight risk identified within divisions from the fire warden reports. • PICU and A607 simulation – walk and talk training evacuation exercise with staff scheduled.

Our Resources – *Using our resources wisely*

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 eliminate the underlying deficit within the timeline set out within the System Medium Term Financial Plan. And to then move towards achieving a 1% income and expenditure surplus, creating a recurrent source of funding for strategic investment.

Vision Metric

	Starting position	Latest position	Turning the dial (Baseline to latest position)
To eliminate the underlying deficit within the timeline set out within the System Medium Term Financial Plan. IQPR	Breakeven plan for 2024/25	**6.3 million** year to date (YTD) deficit compared with YTD plan of breakeven at end of Month 2	**6.3 million adverse to plan**
We will treat more patients with elective care needs, exceeding 2019/20 activity levels. IQPR	The approved plan equates to 8% growth on 19/20 levels supporting more patients to be treated.	Position end of month 2:	

2024/25 approved plan Year to Date	
Day cases	£9,798,100
Elective inpatients	£12,084,469
Outpatient	£11,056,292
Total	**£32,938,860**

2024/25 Actual Delivery Year to Date	
Day cases	£9,781,905
Elective inpatients	£10,056,168
Outpatient	£10,461,909
Total	**£30,299,982**

Day cases	-£16,194 adverse to plan
Elective inpatients	-£2,028,301 adverse to plan
Outpatient	-£594,383 adverse to plan
Total	-£2,638,878 adverse to plan

Strategic Priority Projects	Goal	Starting Position	Latest Position	Turning the dial (Baseline to latest position)	Key Progress	Project Status	Next Actions
Mission Critical **Driving Productivity and Financial Improvement** Assurance: FDEC	New strategic priority project, in the development phase. Goal and metrics to be added for September report					✓	Project charter to be developed, which will detail the goal and the metrics to be used
Important Corporate **Digital procurement, Stores and materials management** Assurance: FDEC	Transform the digital capability of the trust to provide better procurement controls, visibility of stock and to deliver value from all of our spend	Existing Procurement System has to be replaced, impacting ability to use current Managed Inventory System (MIS)	Digital Procurement System: • Phase 1 strategic sourcing live • Phase 2 guide buying sourcing in progress • MIS build and integration plans underway	**Metrics to be monitor impact of new system in development and to be monitored once system is live**	• Townhall with demonstration to 730+ people across UHBW and NBT held to socialise the change. • Phase 2 – Guided buying – design complete, build underway, training and user assurance planning underway, go live date unchanged as late August. • MIS End user communication commenced– Monthly newsletter	✓	• Phase 2 design – build work to be completed including interfaces to finance systems and new UHBW Managed Inventory System. • Unit, integration, and user acceptance testing to be completed, preparation for user acceptance testing which starts in July. • Monthly face to face engagement including roadshows.
Breakthrough objective **Value and Waste – Recurrent Cost Improvement**	New strategic priority project, in the development phase. Goal and metrics to be added for September report				• Proposed approach developed and presented to Productivity and Financial Improvement group	✓	• Project charter to be developed, which will detail the goal and the metrics to be • Mobilise implementation approach

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9 July 2024

Report Title	**Carbon Reduction Plan**
Report Author	**Ned Maynard, Head of Sustainability**
Executive Lead	**Neil Kemsley, Chief Financial Officer**

1. Purpose

The Board is asked to approve the Trust's Carbon Reduction Plan (CRP) to allow for publication on its website. It is a requirement of Procurement Policy Note 06/21 that Carbon Reduction Plans are Board approved and publicly available.

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

The Trust is increasingly being asked to provide data and evidence of our carbon reduction commitments and activities in the work it bids for.

A common requirement for public sector bids is the provision of a Carbon Reduction Plan that is compliant with the requirements set out in Procurement Policy Note (PPN) 06/21.

The provision of a compliant CRP is a pass/fail criterion in the evaluation of tenders.

The Trust has therefore produced a CRP for Board approval and publication on its website.

The Plan confirms our Green Plan commitment to be net zero carbon by 2030.

It contains a subset of carbon data that is already published as part of the Annual Report and Accounts which the Board approved last month.

It also summarises the high level actions the Trust has already undertaken to reduce its carbon emissions and highlights the future work it plans to undertake.

Having a CRP that meets the PPN 06/21 requirements will ensure that the Trust passes this criteria for any future bids.

The CRP will need to be updated and re-published every year to remain compliant.

3. Strategic Alignment

The CRP aligns to the 'Making the most of all our resources' strategic improvement priority.

It also links to the ICS Capital Prioritisation allocation. £3mn has been allocated for carbon reduction projects across the system this financial year.

4. Risks and Opportunities

There is a risk that the Trust may not be able to deliver the carbon reduction actions outlined in the plan and achieve net zero. Specifically, the risks include:

1. Lack of finances to deliver the required low carbon investment across the system.

2. Currently there is no preferred solution for replacement of the gas-fired CHP engines. The CHP will need to be replaced to achieve net zero in our scope 1 emissions. The CHP engines generate low-cost electricity for the Trust, removing the CHP will result in increased costs to the electricity budget but will lower the risk from future emission taxation. 3. Insufficient mechanisms and engagement to influence decision making on procurement and supply chain, impacting on our ability to reduce the largest part of our footprint (scope 3 emissions).
5. Recommendation
This report is for **approval.** The Board is asked to approve the Carbon Reduction Plan for publishing on our website.
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**

N/A	

UHBW Carbon Reduction Plan

Publication date: July 2024

Commitment to achieving Net Zero

UHBW are committed to achieving Net Zero emissions by 2030 across its scope 1, 2 and 3 emissions.

Baseline Emissions Footprint

Baseline emissions are a record of the greenhouse gases that have been produced in the past and were produced prior to the introduction of any strategies to reduce emissions. Baseline emissions are therefore a reference point against which emissions reduction can be measured.

Baseline Year: 2019/20	
Additional Details relating to baseline emissions calculations	
In April 2020, University Hospitals Bristol NHS Foundation Trust and Weston Area Health NHS Trust merged to form University Hospitals Bristol and Weston NHS Foundation Trust. 2019/20 has been chosen as the baseline to match the baseline of the rest of the Bristol, North Somerset and South Gloucestershire Integrated Care System (ICS). All partners within the ICS are working towards to the same net zero carbon target. The Trust aligns its reporting boundaries and accounting methodologies with those of NHS England. As an NHS Trust, our scope 1 emissions include those emitted from the use of anaesthetic gases. Scope 3 data includes a cradle-gate analysis carbon footprint calculation of our supply chain to produce the emissions from our purchased goods and services. We are therefore unable to separate from this the specific emissions that come from upstream transport and distribution but they are included within the purchased goods and services data listed below. The Trust does not sell or transport any products. Therefore, the downstream transport and distribution emission category is not relevant to us. Business travel emissions were not calculated until 2022/23. The data for this scope 3 subset is therefore from 2022/23 not 2019/20. Our business travel emissions for public transport and flights are calculated based on cost. We recognise that this is not best practice but have no other means at present to calculate these emissions.	
Emissions	**Total (tCO2e)**
Scope 1	12,772
Scope 2	6,684
Scope 3 including purchased goods and services, waste, business travel, employee commuting	117,187
Total Emissions	136,643

Current Emissions Reporting

Please see notes in the baseline year for data coverage.	
Reporting Year: 2023/24	
Emissions	**Total (CO2e)**

Scope 1	19,470
Scope 2	1,228
Scope 3 including purchased goods and services, waste, business travel and employee commuting	141, 688
Total Emissions	162,386

Emissions Reduction Targets

The Trust has set a net zero carbon emissions target by 2030 across its scope 1, 2 and 3 sources. This equates to a 90% reduction in emissions over this time.

This target is published as part of our Green Plan which can be accessed from the following link.

BNSSG-ICS-Green-Plan-2022.pdf (england.nhs.uk)

The Green Plan outlines the initiatives, projects and activities we will deliver towards to reach our net zero target.

Carbon Reduction Projects

Completed Carbon Reduction Initiatives

The following environmental management measures and carbon reduction projects have been implemented since our baseline year. These measures will be in effect when performing the contract.

- Upgraded the software and control hardware on the building management system and combined heat and power unit to give greater functionality and a broader range of hardware connectivity, allowing for greater control, zoning and improved data.
- Begun to install volatile gas capture technology for anaesthetic medicines.
- Begun to convert to low-temperature hot water systems and replace steam boilers.
- Updated the procurement process and creating new tools to help stakeholders manage the sustainability impact of the procurement process, embedding the new NHS England net zero commitment requirement into the procurement documents, templates and sign-off process. The net zero commitment ensures all NHS suppliers over the PCR threshold have a publicly available, approved commitment to meet net zero by 2050 of earlier.
- Every tender has a minimum of 10% of the award criteria for social value.
- Carried out waste audits and training to ensure that the correct bins are in place to aid segregation, reducing the amount of waste that is over treated.
- We have agreed clinical waste collections to avoid peak times.
- Introduced a cycle to work scheme open for applications all year round and for an increased value of £4k.
- Bespoke, personal travel plans for staff on their cleaner and active travel options are available.
- Improvements made to our free to use staff, patient and visitor shuttle bus service.
- An owned fleet made up of 50% electric vehicles.

In the future we hope to implement further measures such as;

- Replace all domestic sized boilers with heat pumps.
- Fully remove all nitrous oxide manifolds from our estate.
- Install volatile gas capture technology on 100% of our anaesthetic machines.
- Install more solar PV on site.
- Continued optimisation of the CHP at both Bristol and Weston to recover as much heat as possible from the system.
- Create an ICS wide waste management policy in accordance with revised HTM 07-01 and the NHS Clinical Waste Management Strategy.
- Fully transition our entire owned fleet to electric vehicles.
- Embed sustainable and active travel options in the recruitment process for new staff.

Declaration and Sign Off

This Carbon Reduction Plan has been completed in accordance with PPN06/21 and associated guidance and reporting standard for Carbon Reduction Plans.

Emissions have been reported and recorded in accordance with the published reporting standard for Carbon Reduction Plans and GHG Reporting Protocol corporate standard[1] and uses the appropriate Government emission conversion factors for greenhouse gas company reporting[2].

Scope 1 and scope 3 emissions have been reported in accordance with SECR requirements. Scope 3 emissions have been reported in accordance with the published reporting standard for Carbon Reductin Plans and the Corporate value Chain scope 3 standard[3].

This Carbon Reduction Plan has been reviewed and signed off by the board of directors.

Signed on behalf of UHBW;

Date

[1] Corporate Standard | GHG Protocol
[2] Government conversion factors for company reporting of greenhouse gas emissions - GOV.UK (www.gov.uk)
[3] Government conversion factors for company reporting of greenhouse gas emissions - GOV.UK (www.gov.uk)

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Director held in Public on 9 July 2024

Reporting Committee	**Quality and Outcomes Committee – May 2024 meeting**
Chaired By	**Marc Griffiths – Non-Executive Director (standing in for Sue Balcombe)**
Executive Lead	**Deirdre Fowler – Chief Nurse**

For Information

The Infected Blood Inquiry report, which had been the subject of recent media attention, was discussed by the Committee. Published on Monday 20th May 2024, it had not been identified as an imminent strategic risk in the Trust's current practice. The report related to blood products in the 1970s and 1980s, with some Bristol cases being referenced in its content. The Trust had produced a statement to apologise for the experience of any patients affected. Psychological support would be provided from the Bristol site from September 2024 onwards, and the committee was assured that NHS England (NHSE) had agreed to fund this service. Until this service's launch affected patients would be directed to the Patient Advice and Liaison Service (PALS). The Trust's whistleblowing mechanisms were also discussed as part of this item.

The meeting received the Quarter 4 Infection Prevention Control Report, and it was noted that this would be Martin William's last report as Director of Infection Prevention and Control (DIPC). On behalf of the committee Marc Griffiths thanked Martin for the work he had undertaken in this role and for the valued contribution he had made to the work of the committee.

The Committee received the following reports for information and discussion:

- Monthly Nurse Safe Staffing Report
- Quarter 4 Thematic Patient Safety Report
- Quarter 4 VTE update
- Maternity Spotlight Report
- Integrated Quality & Performance Report

For Board Awareness, Action or Response

The committee considered the Care Quality Commission (CQC) Paediatric Audiology Letter of Concern. This open letter to all NHS Trusts had been received in April 2024 and requested Trust's to provide assurance in respect of the safety, quality, and accessibility of children's hearing services. It was noted that concerns had originally been raised nationally in 2021 about delayed diagnosis or missed treatment of children with hearing loss, which had led to a wider review of paediatric audiology services across the NHS.

It was noted that:

University Hospitals Bristol and Weston NHS Foundation Trust

- The Paediatric Audiology team at UHBW was fully engaged in continuous quality improvement and had been for many years.
- The team had been working towards the Improving Quality in Physiological Sciences (IQIPS) accreditation standards for 5+ years.
- The process of IQIPS accreditation was a significant challenge both in terms of finance and staffing resources.
- A comprehensive NHSE desktop review of the service had been undertaken in 2023.

It was reported UHBW's Paediatric Audiology service was not currently IQIPS accredited but the service had carried out a gap analysis of the IQIPS standards. In respect of how long it would take the service to gain accreditation, the department had assessed that they would need resource to cover the cost of the accreditation and would also need clinical (paediatric audiologist) time to progress through the accreditation process, and to maintain accreditation. This cost was predicted to be roughly £45,000 per annum.

One of the questions from the CQC related to the number and severity of incidents. In the last five years, there has been one incident recorded, documented in September 2020 (minor harm).

During the ensuing discussion the committee was asked to consider if it had received sufficient assurance in respect of the Paediatric Audiology service in the planned response to the CQC (as outlined in the report) or whether this required further scrutiny by the Trust Board. Attention was brought to the report's appendices which directly responded to the CQC's request for assurance about quality and safety. All Directors present indicated that the report's content and gap analysis had provided the necessary assurance had been provided, and that the report did not require further escalation, but that it should be highlighted to the Board in the Chair's report for visibility.

Key Decisions and Actions
N/A
Additional Chair Comments
None

Date of next meeting:	**Tuesday 24 June 2024**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9 July 2024

Report Title	**Bi-Annual review of Safe Staffing for Nursing, Midwifery and Allied Health Professionals**
Report Author	**Sarah Dodds Deputy Chief Nurse** **Andy Landon Senior Nurse - Clinical Informatics** **Sarah Windfeld – Director of Midwifery** **Vimal Sriram – Director of Allied Health Professionals.** **Valentino Oriolo – Advanced Practitioner Lead** **Deirdre Fowler – Chief Nurse and Midwife**
Executive Lead	**Professor Deirdre Fowler – Chief Nurse and Midwife**

1. Purpose

The purpose of the paper is to provide assurance to the Trust Board that wards and departments have been safely staffed in line with the National Quality Board guidance and Developing Workforce standards. It makes recommendations for maintaining a sustainable nursing, midwifery, and allied health professional workforce through a triangulation of professional judgement and professional evidenced based acuity tools.

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

Key points to note from the report: -

- The adult fill rates have now consistently been above 95%. Bristol Children's Hospital for Children (BRHC) fill rates have however remained slightly below this level at 93%. This does show an improvement over the last 6 months. The night HCSW fill rate remains above 100%, this is to ensure vulnerable patients are kept safe with enhanced care observation.

- All in-patient area fill rates are based on the funded beds and do not include the additional boarding beds within a ward or escalation beds, when in use these beds are an additional workload for staff.

- The vacancy level for band 5 staff has now reduced to 4.8% (90.1 WTE) in March 2024 with approximately 150 new starters awaiting OSCE and PIN's.

- The Registered Nurse Turnover rate continues a downward trend (from 13.4% down to 11.3%) due to the successful recruitment of Internationally Educated Nurses (IEN's), Newly Qualified Nurses (NQN's) and the impact of the Trust wide focus on retention initiatives.

- Care hours per patient day (CHPPD) is a measure of actual nursing resource deployment and the registered nurse (RN) CHPPD and total CHPPD are included in the metric tables. Trust wide RN CHPPD has remained within the

range 6.5 – 6.8. UHBW benchmarks well against peers in the model hospital dashboard and is in the highest national quartile for CHPPD.

- The level of red flag reporting remains low as more roster gaps are covered due to reduced vacancy levels or from temporary staffing assignments. The low staffing incident reports over the past 6 months is also on a downward trend compared to the period March to September 2023.

- NICE Midwifery red flags are now included below and will be reported each month through the Safe Staffing Report as per the CQC improvement recommendations.

- The current AHP staffing turnover has reduced and is at 12.9%. Vacancies within the specialties and professional groups vary with problem areas in diagnostic radiography and occupational therapy reflecting national areas of difficulty in recruitment.

3. Strategic Alignment

Patient Safety, Experience of Care, Our People, Making the Most of all Resources

4. Risks and Opportunities

For all staff groups

The risks have all been reduced due to the improved vacancy and turnover positions sustained over the past 6 months.

Risk Number	Details	Risk Level	Score
737	Risk that the Trust is unable to recruit sufficient numbers of substantive staff – all staff groups.	Strategic Risk Register	8 (↓12)
2694	Risk that the Trust is unable to retain members of the substantive workforce.	Strategic Risk Register	8 (↓12)
5477	Risk that nurse staffing levels will not be met.	Strategic Risk Register	9 (↓12)

5. Recommendation

This report is for Information

- Continue the approach outlined using the Safer Nursing Care Tool (SNCT) assessments to underpin nursing establishment on all in-patient wards, both adults and children and ED's acknowledging this is a process that will evolve over time after each assessment.
- Following the last Annual safe staffing review and operational planning for 24/25 the funded increases in staffing have been agreed in:

- **BRHC Emergency Department**
- **BRHC Paediatric Intensive Care unit**
- **BRHC theatres**
- **Trust Wide Palliative Care services**
- **D603 (Adult Oncology) Increase to night duty staffing.**
- **Funding for the Vascular access nurse at Weston**

- Note that the **5.6 WTE HCSW for D601 (Teenage and Young adults with Cancer unit)** remains substantively unfunded**.** Quality and Equality Impact assessment completed with assurances of appropriate mitigation.

- Note that the **Weston ED** continues to have staffing in post for the ED observation unit and the Rapid Assessment and Treatment service which is unfunded.

- Note the changes being made within the **Division on Medicine** based on the SNCT results and professional judgement that has **enabled movement of funding within the Division** to improve patient experience for care of the elderly and patients requiring enhanced care.

- Note the **CQC Requirement for Maternity safe staffing** and the actions in place to achieve this.

6. History of the paper

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

Executive Committee	26th June 2024

Report on Nurse (RN's), Midwifery (RM's) and Allied Health Professionals (AHP's) Staffing Levels UHBW (October 2023 – March 2024).

Context

Following publication of the Francis Report 2013[1] and the subsequent "Hard Truths" (2014)[2] document, NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery and care staff levels. These include:

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

The RCN workforce Standards (2021)[3] report have been reviewed and compliance continues to improve with actions in place to support best practice.

Contents

There are 3 specific strategic nurse, midwifery and AHP staffing risks graded as high risk held on the corporate risk register as below. The risks have all been reduced due to the improved vacancy and turnover positions sustained over the past 6 months.

For all staff groups

Risk Number	Details	Risk Level	Score
737	Risk that the Trust is unable to recruit sufficient numbers of substantive staff – all staff groups.	Strategic Risk Register	8 (↓12)
2694	Risk that the Trust is unable to retain members of the substantive workforce.	Strategic Risk Register	8 (↓12)
5477	Risk that nurse staffing levels will not be met.	Strategic Risk Register	9 (↓12)

For Midwives

Risk 988: - This risk has been reduced as the number of transfers out or inability to admit neonates has decreased due to improved vacancy levels, however some NICU cots remain closed due to the inability to safely staff cots all the time.

[1] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK (www.gov.uk)
[2] NHS England » Guidance issued on Hard Truths commitments regarding the publishing of staffing data
[3] Nursing Workforce Standards | Professional Development | Royal College of Nursing (rcn.org.uk)

Risk Number	Details		Risk Level	Score
33	Risk that inadequate nursing levels in line with BAPM standards 2011 will affect neonatal outcomes		Departmental	15
988	Risk that neonates are transferred out to alternative NICU units due to lack of cot capacity		Departmental	9
3623	Risk that extreme pre-term babies will have a sub-optimal outcome due to inability to deliver in a tertiary centre		Departmental	8

For AHPs

Risk Number	Details	Risk Level	Score
737	Risk that the Trust is unable to recruit sufficient numbers of substantive staff	Strategic Risk Register	8 (↓12)
2694	Risk that Trust is unable to retain members of the substantive workforce	Strategic Risk Register	8 (↓12)

- The report highlights the work being undertaken to mitigate the above risks.

1. Nursing Report

Trust Metrics overview

The previous 6 months Trust level staffing metrics are contained within Table 1, the Divisional summary tables can be found in the appendices.

Key points to note: -

- The adult fill rates have now consistently been above 95%. Bristol Royal Hospital for Children (BRHC) fill rates have however remained slightly below this level at 93%. This does show an improvement over the last 6 months. The night HCSW fill rate remains above 100%, this is to ensure vulnerable patients are kept safe with enhanced care observation.

- All in-patient area fill rates are based on the funded beds and do not include the additional boarding beds within a ward and escalation beds, when in use these beds are an additional workload for staff.

- The vacancy level for band 5 staff has now reduced to 4.8% (90.1 WTE) in March 2024 with approximately 150 new starters awaiting OSCE and PIN's.

- The Registered Nurse Turnover rate continues a downward trend (from 13.4% down to 11.3%) due to the successful recruitment of Internationally Educated Nurses (IEN's), Newly Qualified Nurses (NQN's) and the impact of the Trust wide focus on retention initiatives.

- Care hours per patient day (CHPPD) is a measure of actual nursing resource deployment and the registered nurse (RN) CHPPD and total CHPPD are included in the metric tables. Trust wide RN CHPPD has remained within the range 6.5 – 6.8. UHBW benchmarks well against peers in the model hospital dashboard and is in the highest national quartile for CHPPD.

- The level of red flag reporting remains low as more roster gaps are covered due to reduced vacancy levels or from temporary staffing assignments. The low staffing incident reports over the past 6 months is also on a downward trend compared to the period March to September 2023.

- NICE Midwifery red flags are now included below and will be reported each month through the Safe Staffing Report as per the CQC Improvement recommendations.

Table 1 - Trust Metrics

Trust Overview Measure	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
Registered Nurse Fill Rate - Day	93%	98%	99%	99%	97%	98%	
Registered Nurse Fill Rate - Night	96%	99%	101%	100%	98%	99%	
Unregistered Nurse Fill Rate - Day	97%	95%	104%	103%	107%	104%	
Unregistered Nurse Fill Rate - Night	111%	112%	111%	115%	115%	116%	
All Staff Fill Rate - Overall	97%	100%	102%	102%	102%	102%	
Registered Care Hours per Patient Day	6.4	6.5	6.8	6.6	6.5	6.7	
Total Care Hours per Patient Day	10.2	10.3	10.7	10.5	10.3	10.6	
Supervisory Ward Sister %	79%	80%	74%	79%	82%	76%	
Sickness (Rostering KPI)	7.5%	7.1%	8.1%	7.6%	5.4%	5.7%	
Registered Nurse Band 5 Turnover Rate	13.4%	12.5%	12.1%	11.8%	11.5%	11.3%	
Unregistered Nurse Band 2/3 Turnover Rate	16.7%	16.6%	17.1%	16.9%	16.7%	16.4%	
Registered Nurse Band 5 Vacancy WTE	160.0	134.2	110.0	98.0	94.3	90.1	
Unregistered Nurse Band 2/3 Vacancy WTE	156.1	170.4	113.9	99.5	97.0	88.6	
% Agency staff used to support substantive staff	5%	4%	4%	3%	4%	4%	
% Bank staff used to support substantive staff	17%	17%	16%	17%	18%	20%	
Nursing Lower than expected Staffing Incidents - In patient Wards	72	37	54	27	29	39	
Midwifery Lower than expected Staffing Incidents	7	5	5	4	7	23	
Nursing Red Flag Reported incidents - In patient Wards	9	5	16	8	7	10	
Midwifery Red Flag Reported Incidents	3	1	2	3	1	5	

*Midwifery lower than expected staffing incidents and red flags increase in March 2024 in line with change in NICE Midwifery red flag reporting

Safer Nursing Care Tool 2023

- The Trust has completed 4 cycles of the Safer Nursing Care Tool (SNCT) assessments using the available Adult, Children and Young Person and Emergency Department tools. After the annual staffing reviews and with professional judgement analysis, the results of these audits have supported changes in nursing establishments over the last 12 months.

- A revised adult tool was published in October 2023, this new version has been expanded to include the care for one-to-one Enhanced Care Requirements (ECO) assignments and for patients requiring a two-to-one or more staffing level to ensure both patients and staff are kept safe.

- A detailed training programme based on the national NHS England requirements is being delivered to all key adult-based staff in preparation for the SNCT audits during July 2024, November 2024 and February 2025. The data obtained from November onwards will support the Trust staffing reviews.

- The Children's and Emergency Department tools are unchanged and will continue to be undertaken in July and February each year as standard.

Update to the Key areas requiring a change to the establishments from the November 2023 report:

- The **Medicine Division reviewed their establishments** based on the July 2023 SNCT audits and following a detailed professional judgement process a small reduction of Band 2 and Band 5s in some wards was undertaken. This **enabled movement of funding within the Division** to improve patient experience for care of the elderly and patients requiring enhanced care.

- The **overnight staffing for D603** (Adult Oncology) has now been fully funded.

- **The BRHC Intensive Care Department (PICU)** nursing establishment is being increased with funding agreed to meet the Paediatric Critical Care Society (PCCS) standards and equates to an additional 7.74 WTE nurses plus 4 WTE Clinical Skills facilitators to staff 18 beds all year round. This includes a 26% headroom factor (allowing for 15% annual leave, 5% essential training, 5% sickness and 1% special leave) as recommended by the PCCS standards.

- Following a full review against the Association for Perioperative Practice (AfPP) guidelines the funding for the planned increase of 12.66 WTE has been agreed **for the BRHC's theatre department**.

- The Funding has now been agreed for a fully staffed 5-day per week **Trust wide Palliative care team**, with recruitment for the nursing roles underway.

The Emergency Department Safer Nursing Care Tool (SNCT)

- **The BRHC ED** increase in funding for nurse staffing has been agreed, this will increase the substantive WTE by 20 WTE, this will continue to be monitored through the ongoing SNCT audits.

- **The BRI ED** reviewed the skill mix and have piloted a senior nurse to minimize crowding and maintain safety across the department. This has been a successful cost neutral change with a notable improvement in patient experience and flow out of the ED.

- **Weston ED** identified staffing increases were not funded through the operational planning review.

    - These posts remain a cost pressure for Weston: 5.2 WTE RN and 5.2 WTE HCSW for the ED Observation Unit, 5.2 WTE RN for a Rapid Assessment and Treatment Team and 1 x HCSW to support ED flow across the busiest period 12.00 – 00.00.

- Additional funding was obtained for the expansion of the **vascular access team to cover Weston Hospital** providing a fully supported service across both sites.

- **D601 Teenage and Young Adult Cancer Unit**. An additional 5.6 WTE HCSW required to support changes in acuity and dependency, following a Quality and Equality Impact Assessment, the mitigation is in place but is currently unfunded.

The Advanced Practitioner Role in UHBW.

- UHBW is recognised as a leading employer and an innovator of advanced practitioner (AP) services. Since 2021, it has grown from approximately 40 trainees and 19 qualified APs to 54 trainees and 39 qualified AP across 12 specialties. UHBW has shown a clear intention in the investment of the AP role and the surrounding governance and clinical supervision for these roles.

- The past 3 years has seen UHBW establish a trust wide approach to the training and introduction of AP services. Across BNSSG, UHBW has the greatest diversity of multiprofessional trainees, has established Divisional AP Leads with a clear vision for the next 5 years, outlined in both UHBW 3-year AP Strategy and UHBW 5-year Workforce Plan.

- A clear clinical career pathway has now been defined along the continuum of the scope of practice, from novice to enhanced and advanced practitioner and ultimately consultant practitioner. To this effect, UHBW is standardising nomenclature of role descriptor to provide clarity and professional identity to members of the multi-disciplinary team, the patients and carers who use our services and members of the public.

2. Midwifery Report

Introduction

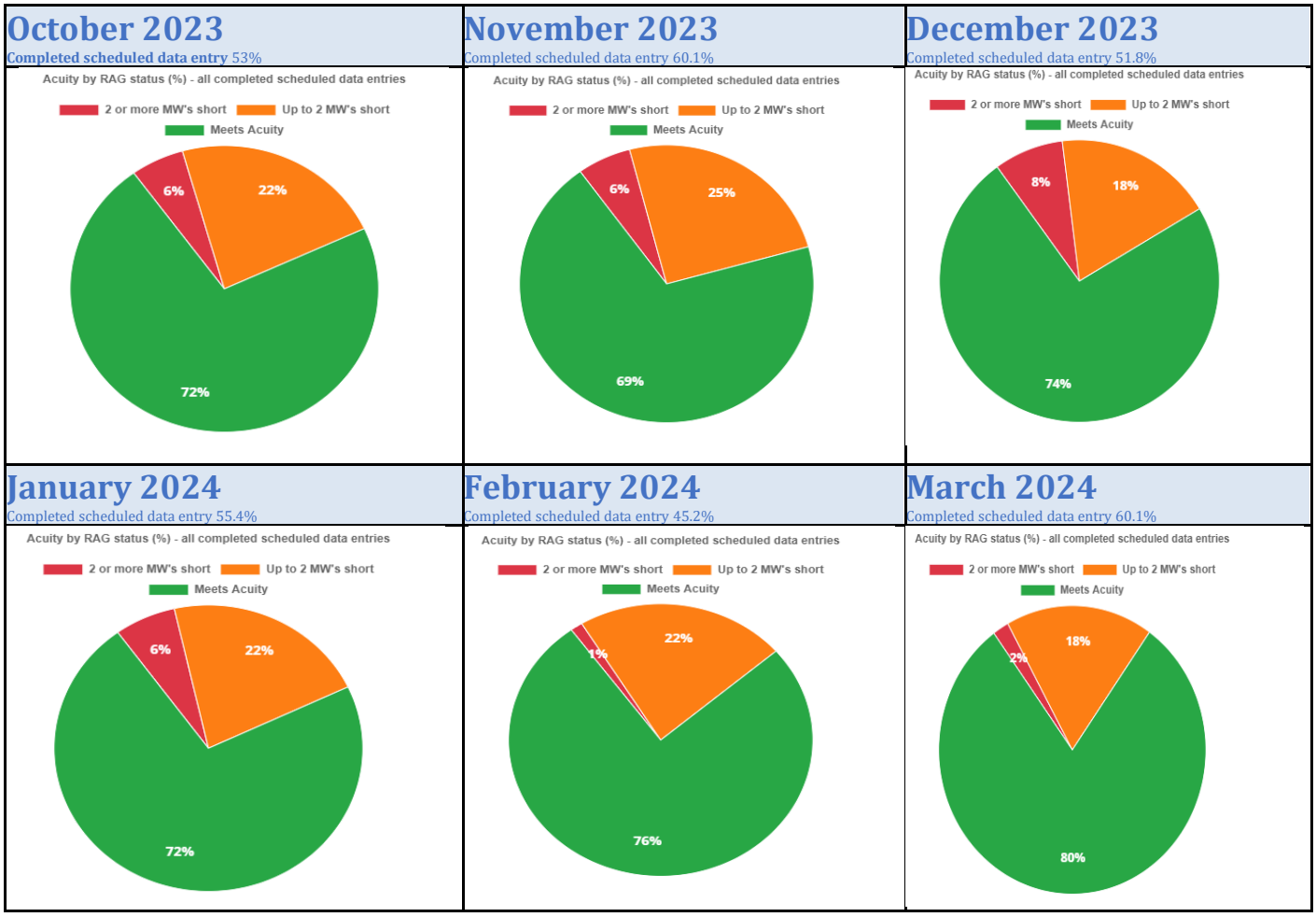
This section of the report details the specific requirements and actions taken by Midwifery Services to ensure that all mothers and babies are given quality care in a safe and secure environment.

The Trust continues to review its services against the landmark publications of the Ockendon Reports in December 2020 and March 2022 to assure the Trust that the Midwifery services are responding appropriately to the recommendations outlined in these two reports. A full Birthrate plus workforce assessment was undertaken in June 2022 with the next formal review planned for 2025/2026.

Between October 2023 and March 2024 staffing in both Maternity and Neonatal Intensive Care Unit (NICU) has been challenging due to the level of sickness and the number of vacancies within the teams, but the flexibility of the workforce and joint working between midwifery and the neonatal unit has maintained safe staffing in these areas.

In midwifery the hospital on-call midwife and the on-call community midwives have been used in periods of high acuity and/or activity to support staffing shortfall with the midwifery on-call manager available for support. There are twice daily flow meetings held between maternity, gynaecology, and neonatology each day with the 'flow midwife monitoring activity and the movement of staff during the week. The data recorded in the Birthrate Plus tool informs the flow midwife of hotspots on the day.

Birth rate Plus acuity tool. *Table 2*



The Birth rate Plus acuity tool is used on the delivery suite to help manage the midwifery staffing and trigger escalation. The data compliance for October 23 - March 24 shows an improvement on the preceding 6 months from 20 - 40% completed compliance to 50-60% completed compliance. This increased compliance is expected to continue to improve as the tool is embedded in the Central Delivery Suite. The percentage of times the service was green has also improved over the six-month period.

Recruitment

There has been a successful level of recruitment into Midwifery services over the past 6 months with 10.26 WTE vacancies recruited into with staff commencing in April. Midwifery continues to hold regular recruitment open days with the aim to recruit to turn over.

The department have received on going funding from the Local Maternity and Neonatal System (LMNS) for the recruitment and retention midwife who works alongside the Divisional recruitment and retention lead. This role actively ensures exit interviews are encouraged and leads on the wellbeing initiatives for staff.

Within the neonatal service there were 3.5 WTE Band 5 and 2.5 WTE Band 6 vacancies at the end of March 2024. Safe staffing has been managed by the closure of cots and the use of bank incentives however by September 2024 the NICU expects to be recruited to turnover.

The Division welcomed the extension of the funding for the bereavement team by the LMNS providing essential support for both maternity and neonatal patients/carers.

Staffing and CQC.

The Maternity service was inspected in December 2023 by the CQC and was rated as 'Good' overall, with one requirement and one recommendation made for Safe Staffing.

CQC Requirement	Regulation	Findings	Action
That 'red flag' midwifery staffing incidents are monitored effectively, including delays to induction of labour, in line with national guidance.	Regulation 18 (1)	The service did not effectively monitor maternity 'red flag' staffing incidents in line with NICE guideline 4 'Safe midwifery staffing for maternity settings'... Managers did not monitor and compare maternity red flag incidents in the six nursing and midwifery staffing reports to trust board in line with national guidelines	1) Ensure all managers monitor and compare maternity red flags. 2) Report on Midwifery red flags in the Monthly safe staffing report highlighting any action.

Red flags including delayed inductions are monitored through the PQSM (Perinatal Quality and Safety Maternity Matrix) and daily flow meetings. Red flags as per NICE guidelines were added in July 2023 on the Datix system. Red flags and themes of staffing issues are monitored monthly through the individual area governance groups and at the hospital Women's Governance Group and escalated as necessary to the Divisional Quality Assurance Committee.

Staffing is monitored daily at flow meetings and staff are moved to manage any risks, including use of the on-call midwife. As a result of the CQC visit all staff were reminded to record any staffing related safety incidents or where mitigations have been required when reporting unsafe staffing incidents on Datix including the use of NICE red flags.

As a result of the above actions, there has been an increase in red flag reporting over the previous months. See below Table 3

Table 3 – Midwifery red flag reporting

		2023			2024			Grand Total
		Sep	Oct	Dec	Jan	Feb	Mar	
Central Delivery Suite - Ward 77(StMH)								
Midwifery Red Flag 1:1 Care		1	1	1	1		1	**5**
Midwifery Red Flags: Delay of 30 minutes presentation to triage					1		1	**2**
Midwifery Red Flags: Delayed Time Critical Activity				1	1	1	1	**4**
Midwifery Led Unit (StMH)								
Midwifery Red Flag 1:1 Care								
Ward 73 (Maternity) StMH								
Midwifery Red Flags: Delayed Time Critical Activity		1	1				2	**4**
Ward 76 - Transitional Care (StMH)								
Midwifery Red Flags: Delayed Time Critical Activity			1					**1**
Grand Total		**2**	**3**	**2**	**3**	**1**	**5**	**16**

The recommendation from the CQC for staffing was to ensure there are enough midwifery staff to provide a full range of maternity choices including use of the midwifery-led unit (MLU). The CQC noted that "Midwifery staffing levels impacted on the availability of the midwifery led unit'.

The midwifery led unit was staffed from the 11 midwives assigned to Central Delivery Suite (CDS) with two midwives covering the midwifery led unit if there was a woman wanting to use the facility. Staffing gaps due to sickness and vacancy has impacted on CDS' ability to support women to give birth on the MLU within a specific shift. However, this has been sustained whenever possible by moving staff from other areas and by using the on-call midwife overnight or at weekends without compromising the overall safety of the service.

Following recent recruitment in March 2024 the CDS is now able to allocate and name two midwifery staff members per shift to support any woman fitting the criteria and opting for MLU birth. There has been a 75 % increase in births in the MLU following this change.

Continuity of carer teams

The service has maintained the 4 continuity of carer midwifery teams, mainly present in areas of high deprivation and ethnic diverse population. In addition, funding has been received from the LMNS for enhanced maternity support workers to reach out to vulnerable women and facilitate earlier engagement into the Maternity service. 33.45% of women giving birth at UHBW In March 2024 were receiving care from a continuity midwifery team.

3. Allied Health Professionals (AHP's) report

The Trust employs nine professional groups as allied health professionals (AHP) and range across all divisions in the Trust with: -

- 867 (730.79 WTE) AHPs registered with the Health and Care Professionals Council (Bands 5-8D)

- 125 (100.65 WTE) support workers and assistants (Bands 2-4)

Apart from national guidance for stroke and critical care (adults and paediatrics), there is no tool for deciding safe staffing levels for AHPs within inpatient settings, with staffing levels generally determined by demand-capacity and patient/non-patient related activity data.

The current AHP staffing turnover has reduced and is at 12.9%. Vacancies within the specialties and professional groups vary with problem areas in diagnostic radiography and occupational therapy reflecting national areas of difficulty in recruitment.

Recruitment and Retention:

We are continuing to implement plans set out in the Director of AHPs recruitment and retention plan (presented to the People Committee in September 2023). As part of the progress in that plan:

- A second joint recruitment exercise across UHBW, North Bristol Trust (NBT) and Sirona for band 5 occupational therapists and physiotherapists resulted in offering

posts for nine occupational therapists and eight physiotherapists. Plans to over recruit to diagnostic radiographers and adult therapies have been submitted to help ease the need for multiple recruitment rounds.

- After a successful consultation exercise in Weston diagnostic radiography the CT scan facility has now moved to a 24/7 service (from an on-call service) in line with ambitions set out in the Healthy Weston 2 plan. The Trust have also re-started hosting pre-registration students in the Weston site as the recently recruited cohort of international radiographers have settled in and are working to their competencies.

- The Trust has been successful in securing funding from NHS England Southwest to provide enhanced support to the internationally educated AHPs in partnership with NBT and Sirona.

- UHBW is also increasing the offer of pre-registration apprenticeships into the professions of Occupational Therapy, Physiotherapy, Dietetics, Diagnostic and Therapeutic Radiography.

- Ongoing work to recruit to Advanced Practitioner roles continues with the successful appointments of a Consultant Practitioner in Adult Therapies (critical care) and Consultant Practitioner – radiotherapy (Prostate Cancer) this year.

- An integrated (nursing, midwifery and AHP) preceptorship programme for newly registered practitioners commenced this year and all disciplines are reviewing the competencies for support workers (bands 2-4) to align them to the national framework.

- Exploratory work has commenced to move AHP staff onto the e-Job planning process to support improved role clarity and transparency across all the AHP disciplines.

4. Assurance statement and summary.

The Trust continues to closely monitor staffing levels and comply with the recommendations outlined in the Developing Workforce Safeguards guidance (2018). The SNCT cycles completed over the past 12 months support the nursing establishment setting process using a recognised evidence-based approach. Noting the staffing information detailed in this report, alongside the robust escalation and mitigation of short- and long-term staffing shortfalls. **The conclusion is that professional judgement indicates that the Trust has in place sufficient processes and oversight of its staffing arrangements to ensure safe staffing is prioritised as part of its routine activities, whilst also supporting development for both the registered and non-registered Nursing and Midwifery workforce and the AHP staff.**

The last 6 months have seen significant improvement with recruitment overall as more Internationally educated nurses fully joined the nursing workforce. Many adult areas are now recruited to turnover.

Safe staffing has been supported with nurse bank incentives which have provided an increase in the bank fill rate and enabled a sustained reduction of off framework agency use. The significant improvement in the vacancies and effects of the retention programmes has ensured that the Trust is well prepared for any risks which may occur through the agency cap rate reduction.

Pressure on the front door service has continued over this 6-month period requiring the regular opening of extra capacity areas and supporting the ED queues in the adult ED departments. Increasingly this is now being staffed by substantive or bank staff instead of agency staff.

The turnover position in the BRHC has shown an improving trend, from 16.9% in October 2023 to 13.5% in March 2024. The overall vacancy level within BRHC has fluctuated over the months however there is a strong recruitment pipeline to support the Division over the next 6 months.

5. Recommendations for Trust Board

The Trust Board is offered assurance of detailed monthly monitoring and reporting to the Quality and Outcomes committee which provides fill rates by wards, red flag reporting and detailed analysis and review of all the safe staffing incidents reported, along with triangulation of impact on patient quality outcomes and staff experience.

The Trust Board is asked to note the following:

- Continue the approach outlined using the Safer Nursing Care Tool (SNCT) assessments to underpin nursing establishment on all in-patient wards, both adults and children and ED's acknowledging this is a process that will evolve over time after each assessment. Recommended uplifts of staffing will also be subject to scrutiny and support via the annual operational planning round.

- Following the last Annual safe staffing review and operational planning the funded increases in staffing have been agreed in:

    - **Bristol Royal Hospital for Children's Emergency Department**
    - **BRHC Paediatric Intensive Care unit**
    - **BRHC theatres**
    - **Trust Wide Palliative Care services**
    - **D603 (Adult Oncology) Increase to night duty staffing.**
    - **Funding for the Vascular access nurse at Weston**

- Note that the **5.6 WTE HCSW for D601 (Teenage and Young adults with Cancer unit)** is in place but remains substantively unfunded**.**

- Note that the **Weston ED** continues to have staffing in post for the ED observation unit and the Rapid Assessment and Treatment service which is unfunded.

- Note the changes being made within the **Division on Medicine** based on the SNCT results and professional judgement that has **enabled movement of funding within the Division** to improve patient experience for care of the elderly and patients requiring enhanced care.

- Note the **CQC Requirement for Maternity safe staffing** and the actions in place to achieve this.

- Support the continued evaluation work required to review the budgetary impact of the increasing level of training required in specialist areas. National recommendations would suggest a 1% - 4% increase to support Critical Care, ED's and Maternity areas where the level of specialist training is greater.

Appendix 1 – Divisional Grids and key Issues.

Medicine – Additional Key Issues.

- The Key issue for medicine has been the Increased numbers of patients being admitted under medicine who have a primary or secondary mental health diagnosis. This has resulted in an increase in ECO and RMN use.

- Medicine is now recruited to turnover and this is reflected with the reduction in agency usage over the 6th month period.

Division - Medicine Measure	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
Registered Nurse Fill Rate - Day	98%	100%	107%	104%	100%	97%	
Registered Nurse Fill Rate - Night	104%	104%	112%	104%	100%	104%	
Unregistered Nurse Fill Rate - Day	102%	93%	102%	100%	101%	98%	
Unregistered Nurse Fill Rate - Night	118%	108%	114%	112%	111%	106%	
All Staff Fill Rate - Overall	105%	101%	108%	105%	103%	101%	
Registered Care Hours per Patient Day	5.3	5.3	5.6	5.3	5.4	5.5	
Total Care Hours per Patient Day	11.2	10.9	11.5	10.8	10.8	11.1	
Supervisory Ward Sister %	70%	68%	73%	74%	78%	74%	
Sickness	6.3%	7.2%	8.5%	7.8%	5.6%	6.7%	
Registered Nurse Band 5 % Turnover Rate	13.6%	12.9%	11.2%	10.0%	9.0%	8.0%	
Unregistered Nurse Band 2/3 Turnover Rate	15.6%	15.0%	14.1%	15.5%	16.3%	18.4%	
Registered Nurse Band 5 Vacancy WTE	34.6	23.53	14.5	-3.1	-9.3	-8.3	
Unregistered Nurse Band 2/3 Vacancy WTE	64.2	58.6	45.2	34.7	34.4	32.2	
% Agency staff used to support substantive staff	7%	4%	5%	3%	5%	2%	
% Bank staff used to support substantive staff	28%	26%	24%	24%	27%	29%	
Lower than expected Staffing Incidents	8	9	9	5	10	9	
Red Flag Reported incidents	0	1	1	0	0	1	

Specialised Services: - Additional Key Issues.

Appendix 1 – Divisional Grids and key Issues.

- Funding for 5.2 WTE Patient Education Facilitators roles (PEFs) and 0.5 WTE Education Lead Nurse to enhance the specialist educational provision in the Division has been agreed.
- Fill rates for Health Care support workers (HCSW) were significantly increased over the past 6 months due to increased complex patients on several wards requiring prolonged enhanced care observation and the unfunded HCSW cover for D601 as highlighted within the main report.

Division - Specialised Services Measure	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
Registered Nurse Fill Rate - Day	89%	94%	93%	94%	90%	91%	
Registered Nurse Fill Rate - Night	91%	96%	93%	96%	93%	93%	
Unregistered Nurse Fill Rate - Day	114%	108%	116%	126%	125%	121%	
Unregistered Nurse Fill Rate - Night	131%	132%	139%	149%	147%	170%	
All Staff Fill Rate - Overall	97%	100%	97%	105%	102%	104%	
Registered Care Hours per Patient Day	7.3	7.7	8	7.8	7.2	7.3	
Total Care Hours per Patient Day	10	10.3	11	10.9	10.2	10.5	
Supervisory Ward Sister %	81%	73%	68%	75%	78%	79%	
Sickness	7.6%	6.9%	7.6%	7.1%	6.0%	7.6%	
Registered Nurse Band 5 Turnover Rate	14.4%	14.5%	13.8%	13.8%	14.6%	14.7%	
Unregistered Nurse Band 2/3 Turnover Rate	15.8%	13.4%	13.9%	13.9%	13.1%	13.6%	
Registered Nurse Band 5 Vacancy WTE	42.5	37.4	44.8	43.7	47.3	43.7	
Unregistered Nurse Band 2/3 Vacancy WTE	21.7	27.3	10.4	10.8	10.0	7.6	
% Agency staff used to support substantive staff	3%	3%	2%	3%	2%	2%	
% Bank staff used to support substantive staff	18%	18%	19%	19%	20%	22%	
Lower than expected Staffing Incidents	2	2	4	5	2	9	
Red Flag Reported incidents	1	0	1	3	2	3	

Appendix 1 – Divisional Grids and key Issues.

Surgery: - Additional Key Issues

- The Division had opened additional beds in ITU as part of expansion coupled with the continued support of the ECMO service.

Division - Surgery Measure	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
Registered Nurse Fill Rate - Day	101%	108%	110%	111%	104%	114%	
Registered Nurse Fill Rate - Night	104%	112%	113%	114%	108%	118%	
Unregistered Nurse Fill Rate - Day	85%	76%	96%	87%	93%	92%	
Unregistered Nurse Fill Rate - Night	97%	106%	106%	106%	103%	104%	
All Staff Fill Rate - Overall	98%	102%	107%	106%	103%	110%	
Registered Care Hours per Patient Day	8.6	7.9	8.2	8.4	7.7	8	
Total Care Hours per Patient Day	13.3	11.9	12.5	12.6	11.6	12	
Supervisory Ward Sister %	87%	95%	74%	85%	86%	71%	
Sickness	6.8%	6.7%	7.2%	7.5%	6.7%	6.4%	
Registered Nurse Band 5 Turnover Rate	12.8%	11.3%	11.3%	11.6%	10.6%	10.3%	
Unregistered Nurse Band 2/3 Turnover Rate	18.8%	18.3%	18.8%	19.7%	20.7%	20.7%	
Registered Nurse Band 5 Vacancy WTE	54.6	39.6	17.2	10.0	5.0	1.6	
Unregistered Nurse Band 2/3 Vacancy WTE	36.2	36.3	29.7	26.0	25.1	35.0	
% Agency staff used to support substantive staff	4%	2%	2%	2%	3%	4%	
% Bank staff used to support substantive staff	15%	17%	17%	18%	18%	19%	
Lower than expected Staffing Incidents	7	3	1	2	2	3	
Red Flag Reported incidents	2	0	0	1	1	1	

Appendix 1 – Divisional Grids and key Issues.

Childrens: - Additional Key Issues

- There is ongoing development work to see how mental health patients' acuity can be captured on Apollo due to the high level of staffing requirements.
- Caterpillar with the summer/winter split of staffing and Daisy which showed as having a surplus will be reviewed again following the July SNCT audit.
- The level of agency usage in the Division remains high compared to other divisions, this will reduce over the summer as the vacancy levels decrease in line with the increased IEN recruitment.
- The introduction of SafeCare at staffing meetings has helped with managing staffing across the whole site in line with acuity needs.

Division - Childrens Measure	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
Registered Nurse Fill Rate - Day	89%	95%	98%	94%	96%	92%	
Registered Nurse Fill Rate - Night	91%	95%	97%	92%	95%	91%	
Unregistered Nurse Fill Rate - Day	89%	102%	103%	97%	108%	96%	
Unregistered Nurse Fill Rate - Night	76%	85%	85%	102%	98%	101%	
All Staff Fill Rate - Overall	89%	95%	97%	94%	97%	93%	
Registered Care Hours per Patient Day	11.6	11.4	12.3	12.3	12.1	11.6	
Total Care Hours per Patient Day	14.1	13.9	15.1	15	14.8	14.2	
Supervisory Ward Sister %	71%	78%	76%	80%	84%	72%	
Sickness	6.6%	5.6%	7.0%	6.7%	4.2%	5.5%	
Registered Nurse Band 5 Turnover Rate	16.9%	15.8%	15.3%	13.4%	14.3%	13.5%	
Unregistered Nurse Band 2/3 Turnover Rate	16.5%	19.1%	19.6%	18.1%	16.8%	16.1%	
Registered Nurse Band 5 Vacancy WTE	35.5	41.3	38.6	47.0	42.6	45.9	
Unregistered Nurse Band 2/3 Vacancy WTE	-13.8	8.3	-13.4	-16.0	-16.7	-14.0	
% Agency staff used to support substantive staff	9%	9%	8%	5%	8%	7%	
% Bank staff used to support substantive staff	8%	9%	8%	11%	11%	12%	
Lower than expected Staffing Incidents	21	7	24	4	3	3	
Red Flag Reported incidents	1	0	3	0	0	0	

Appendix 1 – Divisional Grids and key Issues.

Women's: - Additional Key Issues

- Please see main report.
- Midwifery red flag reports are for the CDS, MLU and Ward 73 and Ward 76
- Nursing red flag reports are for NICU and Ward 78.

Division - Womens in Patient Wards Measure	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
Registered Nurse Fill Rate - Day	91%	88%	93%	99%	98%	101%	
Registered Nurse Fill Rate - Night	92%	90%	93%	97%	95%	94%	
Unregistered Nurse Fill Rate - Day	84%	91%	93%	103%	99%	94%	
Unregistered Nurse Fill Rate - Night	93%	91%	92%	98%	96%	82%	
All Staff Fill Rate - Overall	90%	90%	94%	98%	97%	96%	
Registered Care Hours per Patient Day	8.6	8.7	8.9	8.5	8.7	9	
Total Care Hours per Patient Day	11	11.1	11.3	10.9	11.1	11.4	
Supervisory Ward Sister %	100%	100%	100%	100%	100%	100%	
Sickness	8.2%	5.8%	5.4%	6.0%	3.6%	4.3%	
Registered Midwife Band 6 Turnover Rate	13.0%	13.3%	12.4%	12.5%	12.6%	11.1%	
Registered Nurse Band 5 Turnover Rate	13.6%	12.9%	13.6%	14.3%	13.1%	14.5%	
Unregistered Midwife/Nurse Band 2/3 Turnover Rate	16.5%	19.1%	19.6%	18.1%	16.8%	16.1%	
Registered RM and RN Band 6 Vacancy WTE *	41.0	42.8	44.0	40.9	42.0	39.18	
Registered Nurse Band 5 Vacancy WTE	-0.1	-3.9	-4.4	-0.4	-4.3	-2.7	
Unregistered Midwife/Nurse Band 2/3 Vacancy WTE	1.7	2.9	4.3	6.6	6.8	3.4	
% Agency staff used to support substantive staff	0%	0%	0%	1%	0%	0%	
% Bank staff used to support substantive staff	11%	8%	8%	10%	12%	11%	
Midwifery Lower than expected Staffing Incidents	7	5	5	4	7	23	
Nursing Lower than expected Staffing Incidents	14	7	6	4	4	10	
Midwifery Red Flag Reported Incidents	3	1	2	3	1	5	
Nursing Red Flag Reported incidents	5	0	2	2	1	2	
* Band 6 Vacancy Level includes all womens services							

Appendix 1 – Divisional Grids and key Issues.

Weston: - Additional Key Issues

- There has been a notable increase in acuity on Berrow Ward (Respiratory) of SNCT level 2 patients requiring NIV BiPAP/ CPAP for acute respiratory support. When the number of Level 2 patients rises an additional RN has been required day and night increasing the nurse patient ratio to 1:5.6.

Division - Weston Measure	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
Registered Nurse Fill Rate - Day	90%	98%	93%	90%	90%	95%	
Registered Nurse Fill Rate - Night	93%	98%	97%	97%	100%	98%	
Unregistered Nurse Fill Rate - Day	100%	106%	107%	106%	115%	115%	
Unregistered Nurse Fill Rate - Night	124%	129%	119%	121%	129%	132%	
All Staff Fill Rate - Overall	100%	106%	103%	102%	107%	108%	
Registered Care Hours per Patient Day	5.6	5.7	6.5	5.4	5.5	5.7	
Total Care Hours per Patient Day	9.4	9.4	10.2	9.1	9.4	9.8	
Supervisory Ward Sister %	82%	82%	69%	75%	82%	74%	
Sickness	7.9%	7.6%	9.5%	8.1%	4.9%	5.3%	
Registered Nurse Band 5 Turnover Rate	7.6%	7.5%	7.5%	9.0%	8.4%	9.2%	
Unregistered Nurse Band 2/3 Turnover Rate	16.6%	16.3%	18.3%	16.7%	15.3%	13.2%	
Registered Nurse Band 5 Vacancy WTE	5.5	8.3	5.2	5.8	11.4	7.0	
Unregistered Nurse Band 2/3 Vacancy WTE	45.2	34.8	38.2	36.8	35.8	23.8	
% Agency staff used to support substantive staff	1%	2%	2%	3%	2%	3%	
% Bank staff used to support substantive staff	24%	21%	20%	19%	20%	20%	
Lower than expected Staffing Incidents	20	9	11	7	8	13	
Red Flag Reported incidents	7	4	7	2	3	4	

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9th July 2024

Report Title	**Integrated Quality and Performance Report**
Report Author	**David Markwick, Director of Performance** **James Rabbitts, Head of Performance Reporting** **Anne Reader/Julie Crawford, Head/Deputy Head of Quality (Patient Safety)** **Alex Nestor, Deputy Director of Workforce Development** **Laura Brown, Head of HR Information Services (HRIS)** **Kate Herrick, Head of Finance**
Executive Lead	**Overview and Access – Jane Farrell, Chief Operating Officer** **Quality – Deirdre Fowler, Chief Nurse/Stuart Walker, Medical Director** **Workforce – Emma Wood, Director of People** **Finance – Neil Kemsley, Director of Finance**

1. Purpose
To provide an overview of the Trust's performance on quality, access and workforce standards.
2. Key points to note *(Including any previous decisions taken)*
Please refer to Executive Summary.
3. Strategic Alignment
This report aligns to the objectives in the domains of "Quality and Safety", "Our People", "Timely Care" and "Financial Performance".
4. Risks and Opportunities
Risks are listed in the report against each performance area and in a summary.
5. Recommendation
This report is for **Information**
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**
Quality and Outcomes Committee – 25 June 2024

University Hospitals Bristol and Weston NHS Foundation Trust

Integrated Quality and Performance Report

Month of Publication: June 2024
Data up to: May 2024

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

INTRODUCTION

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

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

EXECUTIVE SUMMARY

Quality and Safety

The Summary Hospital Mortality Indicator for UHBW for the 12 months February 2023 to January 2024 was 92.9 and in NHS Digital's "as expected" category. This is below the overall national peer group of English NHS trusts of 100.

HSMR within CHKS for UHBW solely for the month of February 2024 was 88.1, meaning there were 15 fewer observed deaths (111) than the statistically calculated expected number of deaths (126). Single monthly figures for HSMR are monitored in UHBW as an "early warning system" and are not valid for wider interpretation in isolation. The HSMR for the 12 months to February 2024 for UHBW was 90.4, below the National Peer figure of 92.2.

The Trust saw ten cases of Clostridium difficile in May these were apportioned as eight hospital onset hospital acquired (HOHA) and two community onset hospital acquired (COHA). Year to date shows as 24 in total (20 HOHA and four COHA). Year to date shows as 24 in total (20 HOHA and 4 COHA), the 2024/5 case limit target is awaited from NHSE. Clostridium Difficile reviews from this month have now been streamlined in line with patient safety incident response (PSIRF) and will be recorded as a Careflow clinical note to assure accessibility for clinical teams and the Infection, Prevention and Control team as part of the patients record.

The Trust has had no reportable cases of MRSA for May 2024. Year to date the trust has currently no cases attributed.

The Medicine division in May 2024 have successfully undertaken a division wide drive to increase Venous Thrombo Embolism (VTE) risk assessment completion compliance , despite this work compliance remains below target within the organisation. Recent audit has demonstrated that VTE prophylaxis is being correctly prescribed and the incidence of Hospital acquired VTE remains low. Work has been successfully completed on the mandatory function within the digital Comprehensive Medication Management system (CMM) for Venous Thrombo Embolism (VTE) Risk Assessment prior to the system launch across the organisation. The Trust wide VTE policy has been updated and will be submitted for approval via Patient Safety Group.

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

EXECUTIVE SUMMARY

Our People

Vacancy increased to 2.4% (295.9 FTE) from 0.5% (58.8 FTE) the previous month. The increase is largely due to an increase in recorded funded FTE and this is common in the first two months of the new financial year as budgets are in the process of being set for 24/25. Recruitment focus:

- Adverts for the Student Nursing Associate (SNA), Registered Nurse Degree Apprenticeship (RNDA) and Accelerated Registered Nurse Degree Apprenticeship (ARNDA) closed and have been shortlisted. Three assessment centres for these apprenticeship programs are scheduled for June.
- The Trust has launched a social media campaign for the recruitment of ten newly qualified radiographers, with interviews taking place in June.
- Efforts continue to support the implementation of Healthy Weston 2, including a targeted recruitment campaign to attract candidates to the Weston site. Additionally, a social media campaign was launched to promote Weston-Super-Mare as a desirable place to live and work.

Turnover increased to 11.7% from 11.4% the previous month. Work continues to improve retention within the Equality, Diversity and Inclusion and Wellbeing Strategic Frameworks, as well as the Engagement Strategic Action Plan, based on Staff Survey priorities. Activity against these plans are monitored in People Committee. The annual recognising success awards took place on Friday 17th May with three hundred colleagues attending to celebrate the shortlisted nominees, winners of the awards and colleagues celebrating career milestones of 30/40/50 years.

Sickness absence reduced to 4.1% compared with 4.3% in the previous month. 'Viva Engage' was launched in May with the creation of a workplace wellbeing community to keep colleagues of all disciplines updated on the offer. The People Committee signed-off the 2024-25 collaborative workplace wellbeing action plan on 23 May. This comprises 28 milestones to improve workforce wellbeing aligned to the People Strategy.

Appraisal compliance increased to 78.7% compared with 78.6% in the previous month. Appraisal is one of the key areas of focus for the OD team in response to the Staff Survey findings. Phase one of the appraisal programme of work has concluded and includes a shorter more flexible appraisal form.

Statutory and Mandatory training shows a decrease of 0.3%, from 90.8% to the current figure of 90.5%. There were very slight decreases for 9 of the 11 core skills titles.

Agency usage is 0.9%, on target and reduced by 4.5 FTE on the previous month. It remains a priority focus area as reflected in the Patient First Corporate Projects. Bank usage is on target at 7.3%, usage increased slightly by 17.5 FTE. The Bank team continues to work closely with the Acute Provider Collaborative to consider a Collaborative Bank.

Integrated Quality and Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

EXECUTIVE SUMMARY

Timely Care

A continued high rate of bed occupancy in May (BRI: 104.9% and Weston 99.1%) coupled with high non-elective demand has continued to impact non-elective services, although progress has been noted against a number of performance measures.

Planned Care - At the end of May 2024, no patients were waiting over 104 weeks, and the Trust continues to maintain zero 104-week Referral To Treatment (RTT) breaches, with no patient waiting longer than 104 weeks since February 2023.

Significant progress has been made in reducing the number of patients waiting over 78 weeks in the last 18 months, reducing to 22 patients at the end of May 2024. The sustained improvement noted during this time reflects the continued impact of Divisional recovery plans and the number of patients waiting 78+ weeks is now limited to a small number of specialties (Dental, 3; Ophthalmology (Cornea Graft), 18; Paediatric Urology, 1).

In line with the NHS England (NHSE) 2024/25 Operational Planning ambition, the Trust have forecast that there will be no patients waiting longer than 65 weeks for treatment by the end of September 2024. In agreement with NHSE this target excludes patients waiting for cornea graft surgery who are delayed due to national issues with the supply of sufficient graft material. From a challenged position last year, significant progress has been made and the Trust remain on track to deliver against the 65 week wait recovery trajectory.

Cancer - The Trust continues to comply with the Faster Diagnosis Standard and is already performing above the NHSE target of 77%, set as part of the Operational Planning Guidance for 2024/25, reporting 77% for April 2024. The 62-day referral to treatment standard performed above NHSE's 70% target for a fifth consecutive month in April (73.2%), and performance against the 31-day decision to treat to treatment standard remained greater than 90% although below the compliance threshold of 96% due to the continued impact of clearing backlogs caused by industrial action. The Trust expects to continue to improve against each of the three cancer standards during 2024/25.

Diagnostics - Improvements were made throughout 2023/24 and, at the end of March 2024, 81.9% of patients were waiting six weeks or less for a diagnostic test, against a trajectory of 83.3%. During the first two months of 2024/25, performance has dropped to 78.2% and improvement plans are in place or being formalised for those modalities that have predictably been challenged during Q1 , including Echocardiography, Audiology adults, Sleep Services, and Endoscopy.

....continued over page

Integrated Quality and Performance Report

Reporting Month: May 2024

EXECUTIVE SUMMARY

Timely Care (continued)

Emergency Department (ED) - During May, 68% of attendances spent less than 4 hours in an ED, from arrival to discharge or admission, compared to 68.5% in April, 69.1% in March, 63.4% in February. A continued focus on ED 4-hour performance has continued from March into April and May and, when combined with the performance uplift of 6.1% (the proportionate allocation from system type 3 performance) the Trust achieved 74.1% performance in May.

The number of patients spending 12 hours or more in ED during May was reported as 3.94% (4.1% in April), which is an improvement following a period of deterioration during Q3. It should be noted that performance against this measure has improved from the same period last year (5.05% May 2023) and the Trust continues to progress actions to deliver and sustain the NHSE target (2%). High bed occupancy levels continue to impact timely flow across all sites.

Ambulance Handovers - The proportion of ambulance handovers within 15 minutes has reduced in May (30.8%) compared to April (32.7%) and March (34.4%) following a period of sustained improvement since December (26.3%) following a predictable deterioration between July (51.4%) and October (20.6%) due to the impacts of the constrained flow (i.e. more NEL admissions coming in and increased bed occupancy), particularly noticeable on the BRI site. Following an improved position in April (68.1%), performance has similarly dropped in May (67.0%) for ambulance handovers within 30 minutes, when compared with January (62.3%).

No Criteria to Reside - During May, the average daily number of patients in hospital with no criteria to reside (NCtR) was 153, a slight decrease from April (158) and March (157). Work is underway to review the focus of the Discharge to Assess Transformation Programme to identify key schemes for 2024/25 - the system NCTR ambition of 15%, alongside a bed occupancy of 92% has been agreed, and now individual acute site targets are being set.

Integrated Quality & Performance Report

Reporting Month: May 2024

EXECUTIVE SUMMARY (continued)

Financial Position

The position at the end of May is a net deficit of £6,322k against a breakeven plan, £3,722k worse than the previous month. Significant variances in the year-to-date position include: the value of elective income behind plan by £2,600k and a shortfall on savings delivery of £2,355k.

In May the Trust has spent £146k on costs associated with Internationally Educated Nurses (IENs). Pay expenditure at the end of April is c£800k lower than plan, although higher than planned medical staffing and nursing costs continue to cause concern across some divisions.

Agency expenditure in month is £1,276k, compared with £1,573k in April. Bank expenditure in month is £5,829k, compared with £5,711k in April.

Total operating income is below plan by £1,227k, mainly due to other operating income.

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

SUMMARY SCORECARD – FINANCIAL YEAR 2024/25

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

			Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Infection Control: C.Diff Cases (Hospital Attributable)	Risks: 800 and 4651	Actual	14	10	-	-	-	-	-	-	-	-	-	-
		Trajectory	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3	7.3
Infection Control: MRSA Cases (Hospital Onset)	Risks: 800 and 4651	Actual	0	0	-	-	-	-	-	-	-	-	-	-
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Fracture NOF: Theatre Within 36 Hours		Actual	63.4%	40.7%	-	-	-	-	-	-	-	-	-	-
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Fracture NOF: Geriatrician Review Within 72 Hours		Actual	85.4%	92.6%	-	-	-	-	-	-	-	-	-	-
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
VTE Risk Assessment	Risk: 720	Actual	77.1%	75.3%	-	-	-	-	-	-	-	-	-	-
		Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Workforce: Agency Usage	Risk: 674	Actual	1.0%	0.9%	-	-	-	-	-	-	-	-	-	-
		Trajectory	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
Workforce: Turnover	Risk: 2694	Actual	11.5%	11.7%	-	-	-	-	-	-	-	-	-	-
		Trajectory	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%
Workforce: Staff Sickness		Actual	4.3%	4.1%	-	-	-	-	-	-	-	-	-	-
		Trajectory	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Workforce: Staff Vacancy	Risk: 737	Actual	0.5%	2.4%	-	-	-	-	-	-	-	-	-	-
		Trajectory	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%

			Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Summary Hospital Level Mortality Indicator (SHMI)		Actual	92.1	92.9										
		Trajectory	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Integrated Quality & Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

SUMMARY SCORECARD – FINANCIAL YEAR 2024/25

DOMAIN: "Timely Care"

			Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Referral To Treatment 65+ Weeks	Risk: 801	Actual	246	232	-	-	-	-	-	-	-	-	-	-
		Trajectory	236	220	148	79	16	0	0	0	0	0	0	0
Referral To Treatment 52+ Weeks	Risk: 801	Actual	2,344	2,347	-	-	-	-	-	-	-	-	-	-
		Trajectory	2,179	2,114	2,049	1,917	1,785	1,653	1,521	1,389	1,257	1,125	993	862
Cancer 28 Day Faster Diagnosis Standard	Risk: 801	Actual	77.0%											
		Trajectory	75%	75%	75%	77%	77%	77%	77%	77%	77%	77%	77%	77%
Cancer Treated Within 62 Days	Risk: 801	Actual	73.2%											
		Trajectory	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Diagnostics: Percentage Waiting Under 6 Weeks	Risk: 801	Actual	78.9%	78.2%	-	-	-	-	-	-	-	-	-	-
		Trajectory	85.8%	87.3%	88.1%	89.3%	89.4%	90.4%	91.1%	92.2%	92.8%	93.7%	94.6%	95.2%
Emergency Department: Percentage Spending Under 4 Hours in ED	Risks: 910 and 4700	Actual	68.5%	68.0%	-	-	-	-	-	-	-	-	-	-
		Trajectory	68.5%	69.0%	69.8%	70.5%	71.5%	71.8%	71.8%	71.8%	71.8%	71.8%	71.8%	71.8%
Emergency Department: Percentage Spending Over 12 Hours in ED	Risks: 910 and 4700	Actual	4.1%	3.9%	-	-	-	-	-	-	-	-	-	-
		Trajectory	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Emergency Department: Handovers Under 15 Minutes	Risks: 910 and 4700	Actual	32.7%	30.8%	-	-	-	-	-	-	-	-	-	-
		Trajectory	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%
Emergency Department: Handovers Under 30 Minutes	Risks: 910 and 4700	Actual	68.1%	67.0%	-	-	-	-	-	-	-	-	-	-
		Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Every Minute Matters: Timely Discharges (12 Noon)	Risk: 423	Actual	15.8%	15.8%	-	-	-	-	-	-	-	-	-	-
		Trajectory	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%
Every Minute Matters: Discharge Lounge Use (BRI and Weston)	Risk: 423	Actual	27.4%	27.0%	-	-	-	-	-	-	-	-	-	-
		Trajectory												
Every Minute Matters: No Criteria To Reside Average Beds Occupied	Risk: 423	Actual	158	156	-	-	-	-	-	-	-	-	-	-
		Trajectory												

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Final Quarter 4 Position

CORPORATE RISKS

ID	Corporate Risks, Projected Mitigation	2023/24 Q2	2023/24 Q3		2023/24 Q4	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4	2026/27	2027/28
2244	Long waits for Outpatient follow-up appointments	20	20	↔	20			4							
910	Patients in ED do not receive timely and effective	16	16	↑	20		6								
6744	Patients attending with Stroke will not receive			↔	20		3								
972	Compliance with Regulatory Reform (Fire Safety)	16	16	↔	16										4
2264	Delays in commencing induction of labour	16	16	↔	16			4							
1035	Insufficient access to critical care beds	16	16	↔	16			4							
588	Patient deterioration is not identified and responded	15	15	↔	15			5							
856	Emotional and mental health needs of children and	15	15	↔	15			8							
292	Trust is impacted by a cyber incident	15	15	↔	15										
6691	Medicines are not stored securely	15	15	↔	15			6							
1595	Mental health patients in Adult ED for prolonged	12	12	↔	12		8!								
422	Patients and staff experience violence and	12	12	↔	12		6								
674	Use of agencies not complaint with national pricing	12	12	↔	12							4			
1598	Patients suffer harm or injury from preventable falls	12	12	↔	12			9!							
2639	Staff compliance with annual appraisals	12	12	↔	12	6									
2695	Establish and maintain robust governance	12	12	↔	12			8							
5520	Health inequalities exacerbated for patients on	12	12	↔	12				6						
2614	Patients being cared for in extra capacity locations	8	8	↑	10		6								
5477	Nurse staffing levels will not be met	15	12	↓	9	6									
793	Colleagues experience work-related stress	12	12	↓	9!*										
6502	Industrial action impact's ability to maintain patient	9	9	↔	9			5							
921	Staff compliance with Essential Training	9	9	↔	9			6							
720	VTE prevention and management	8	8	↔	8			4							

KEY

* Risk has met the target score

! Target score is above tolerance

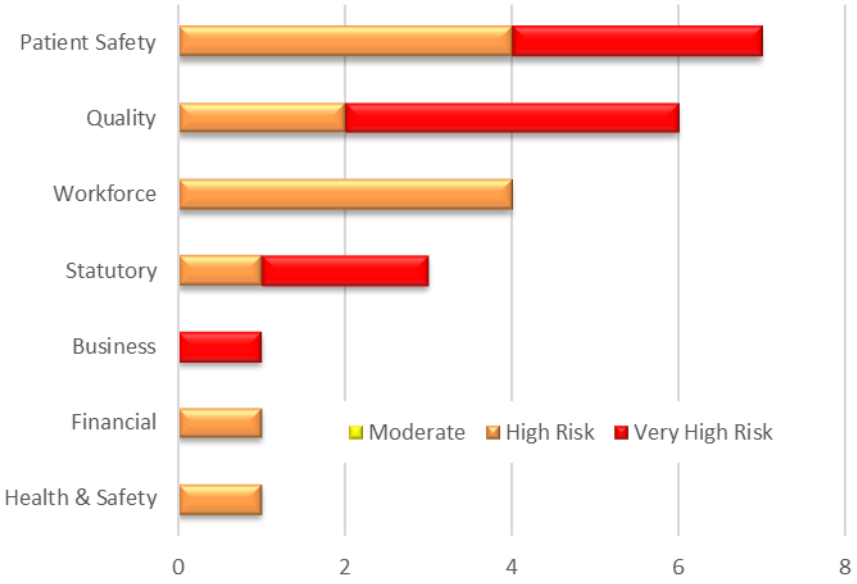
☐ Target scores are outlined in black

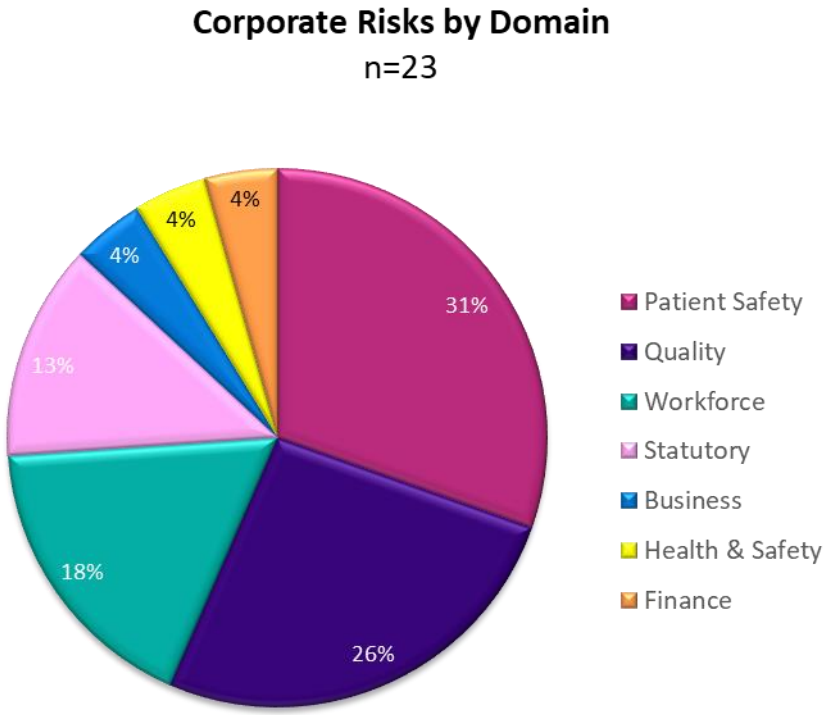
Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Final Quarter 4 Position

CORPORATE RISKS





Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: January 2024

STANDARD	QUALITY AND SAFETY: MORTALITY - SHMI (Summary Hospital-level Mortality Indicator)
Background:	Mortality indicators are used as alerts to identify something that needs closer investigation. This indicator is published nationally by NHS Digital and is six months in arrears. This data is now provided by NHS Digital as a single figure from UHBW. SHMI is derived from statistical calculations of the number of patients expected to die based on their clinical risk factors compared with the number of patients who actually died. There is no target. A SHMI of 100 indicates these two numbers are equal, but there is a national statistically acceptable range calculated by NHS Digital and a SHMI that falls within this range is "as expected".
Performance:	The Summary Hospital Mortality Indicator for UHBW for the 12 months February 2023 to January 2024 was 92.9 and in NHS Digital's "as expected" category.
National Data:	UHBW's total is below the overall national peer group of English NHS trusts of 100.
Actions:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to diagnosis group level if required and investigating any identified alerts.

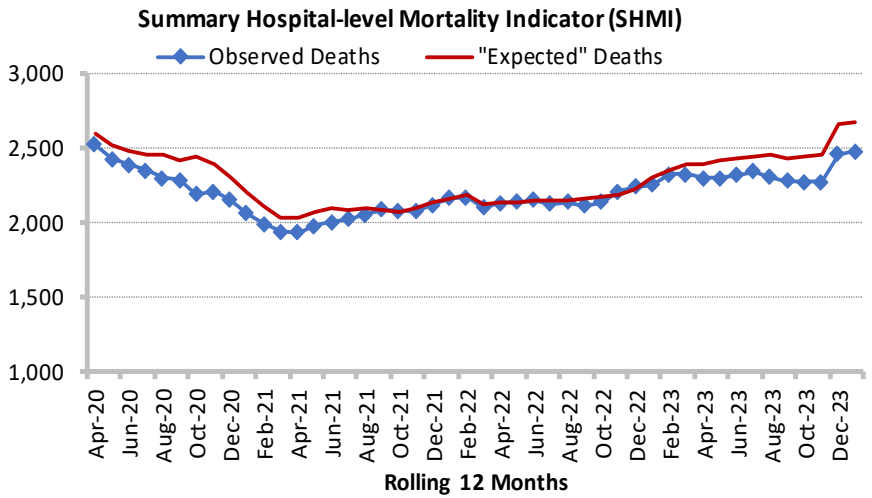
Rolling 12 Months To:	Observed Deaths	"Expected" Deaths	SHMI
Jan-23	2,255	2,300	98.0
Feb-23	2,325	2,350	98.9
Mar-23	2,325	2,385	97.5
Apr-23	2,295	2,395	95.8
May-23	2,300	2,420	95.0
Jun-23	2,320	2,435	95.3
Jul-23	2,340	2,440	95.9
Aug-23	2,305	2,455	93.9
Sep-23	2,280	2,425	94.0
Oct-23	2,270	2,440	93.0
Nov-23	2,270	2,455	92.5
Dec-23	2,455	2,665	92.1
Jan-24	2,480	2,670	92.9

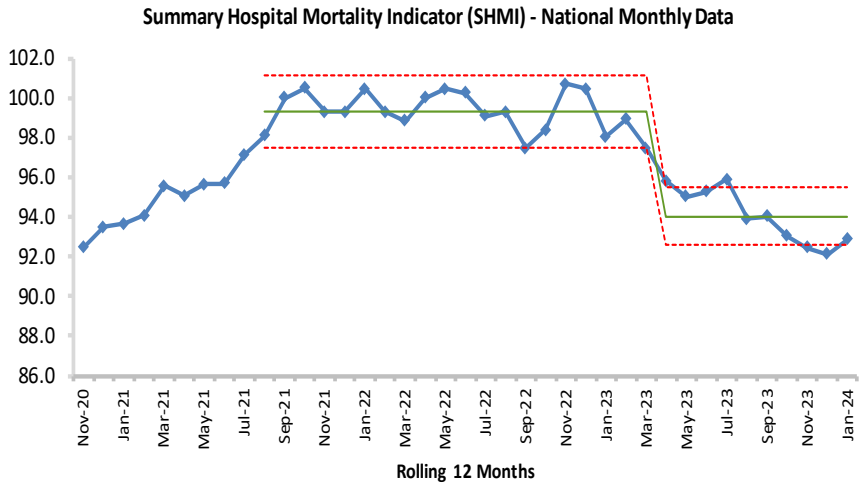
Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: January 2024

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





Integrated Quality & Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: February 2024

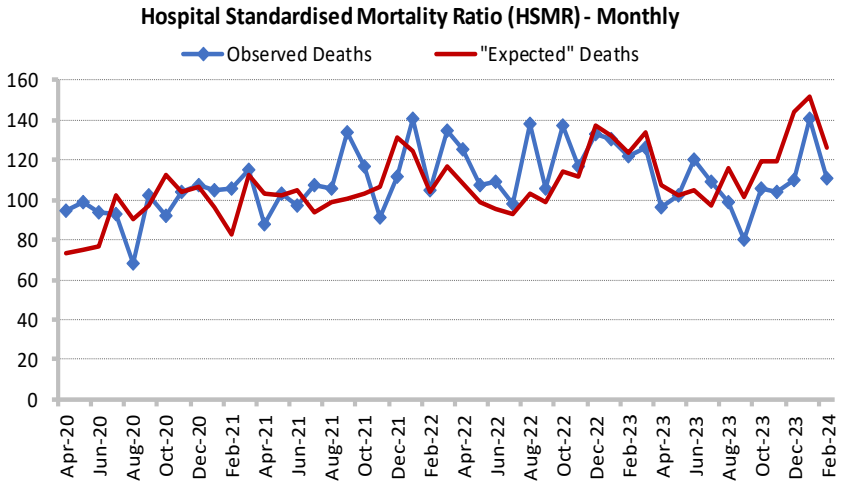
STANDARD	QUALITY AND SAFETY: MORTALITY - HSMR (Hospital Standardised Mortality Ratio)
Background:	Reported HSMR is from CHKS (Capita Health Knowledge System) and is subject to annual rebasing. HSMR data published by the Dr Foster unit is rebased more frequently so figures will be different, although our position relative to other Trusts will be the same. Single monthly figures for HSMR are monitored in UHBW as an "early warning system" and are not valid for wider interpretation in isolation.
Performance:	HSMR within CHKS for UHBW solely for the month of February 2024 was 88.1, meaning there were 15 fewer observed deaths (111) than the statistically calculated expected number of deaths (126). Single monthly figures for HSMR are monitored in UHBW as an "early warning system" and are not valid for wider interpretation in isolation.
National Data:	The HSMR for the 12 months to February 2024 for UHBW was 90.4, below the National Peer figure of 92.2.
Actions:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to diagnosis group level if required and investigating any identified alerts.

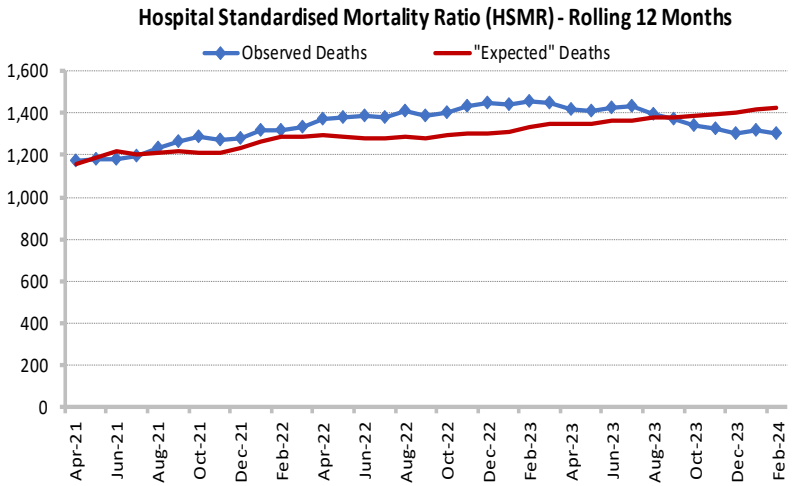
Month	Observed Deaths	"Expected" Deaths	HSMR
Feb-23	122	124.0	98.4
Mar-23	126	134.0	94.0
Apr-23	96	107.0	89.7
May-23	102	102.0	100.0
Jun-23	120	105.0	114.3
Jul-23	109	97.0	112.4
Aug-23	99	116.0	85.3
Sep-23	80	101.0	79.2
Oct-23	106	119.0	89.1
Nov-23	104	119.0	87.4
Dec-23	110	144.0	76.4
Jan-24	141	152.0	92.8
Feb-24	111	126.0	88.1

Integrated Quality & Performance Report

Reporting Month: February 2024

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





Integrated Quality & Performance Report

Reporting Month: May 2024

STANDARD	QUALITY AND SAFETY: INFECTION CONTROL– C.DIFFICILE AND MRSA
Background:	For this section there are two infections reported: C.difficile and methicillin-resistant Staphylococcus aureus (MRSA). Infections are reported in two different categories for infections associated with hospital care: 1. Hospital Onset – Healthcare Associated (HOHA). Patient is an inpatient in an acute trust and has 3 or more days between admission and a positive specimen. 2. Community Onset – Healthcare Associated (COHA). Patient returns a positive specimen within 28 days of discharge from an elective or emergency hospital admission. For C.difficile, two measures are reported: HOHA and COHA. For MRSA it is the HOHA cases only. The limit of C.difficile cases for 2023/24 as set by NHS England was 88. This limit will give a maximum monthly number of approximately 7.3 cases. Please note the NHSE limited for 2024/25 have not yet been circulated. The Trust has been advised these are likely after the July election. For MRSA the expectation is to have zero cases.
Performance:	**C.Difficile:** The Trust saw 10 cases of Clostridium difficile in May these were apportioned as 8 HOHA and 2 COHA. Year to date shows as 24 in total (20 HOHA and 4 COHA). There are several potential contributory factors for increased risk of Clostridioides Difficile infection, the most important ones being antibiotic prescribing and appropriate standards of cleanliness including commodes and toilet areas. **MRSA:** The trust has had no reportable cases of MRSA for May 2024. Year to date the trust has currently no cases attributed.
National Data:	See next page.
Actions:	**C.Difficile** • The short life task finish focusing on C.Diff is progressing and has identifying areas for improvement in the patients care pathways with key actions for improvement be agreed including prompt assessment and isolation of patients with diarrhoea. The lead for this work is a Deputy Director of Nursing. • Clostridium Difficile reviews from this month have now been streamlined in line with patient safety incident response (PSIRF) and will be recorded as a Careflow clinical note to assure accessibility for clinical teams and the Infection, Prevention and Control team as part of the patients record. • The Operational Infection Control Group continues to scrutinise the cleaning standards audited with Divisions with the monthly audits is being refined to reflect the focus on clinical cleaning standards including commodes and how the data is presented to support improvement in practice in the clinical areas. • A new electronic Infection Prevention and Control (IPC) cleaning request is being rolled out which will be available for staff to request additional cleaning following the discharge of a patient with a known infection. *....continued over page*

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

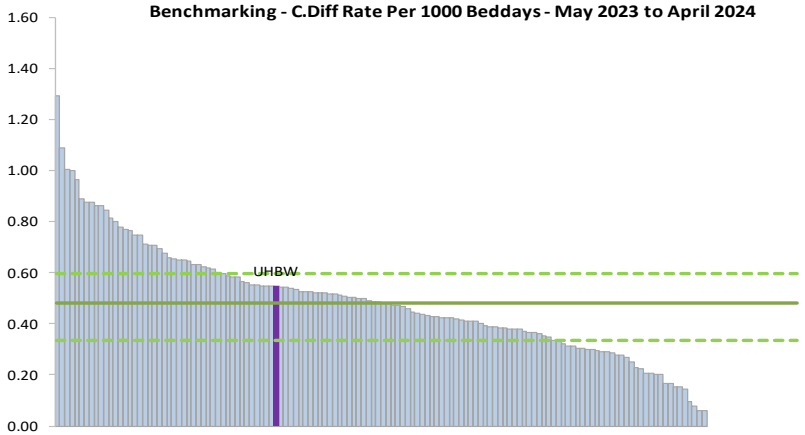
STANDARD	QUALITY AND SAFETY: INFECTION CONTROL– C.DIFFICILE AND MRSA
Actions (continued):	**MRSA** • The ongoing Quality Improvement project for cannulation in BRI and Weston Emergency Departments continues. • The MRSA short life quality improvement working group is progressing. Strategies for improvement have been identified based on the data set from the post infection reviews of cases and quality improvement solutions are being developed. This group is chaired by a Divisional Director of Nursing (DDoN) with cross divisional support, Infection Prevention and Control and Microbiology. A key element is decolonisation of those patients who have MRSA on their skin with the care pathway being streamlined and updated. Training to be delivered. Audit data (from the AMaT system) for PVC line is also being scrutinised to improve how the data set can help clinical teams.
Risks:	800: Risk that Trust operations are negatively impacted by (COVID-19) pandemic 4651: Risk that Covid -19 is transmitted between patients and staff within the Trust

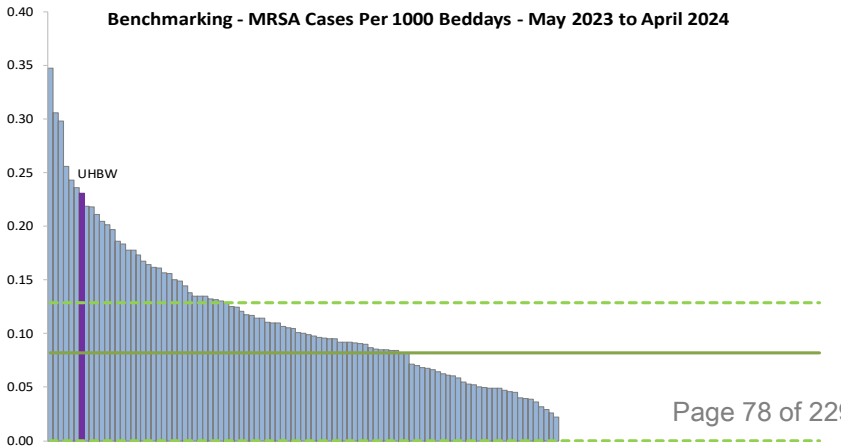
C.Difficile

	May-24		2024/2025		2023/2024	
	HOHA	COHA	HOHA	COHA	HOHA	COHA
Medicine	1	0	6	0	25	7
Specialised Services	5	1	6	2	12	8
Surgery	0	0	0	0	4	1
Weston	1	1	4	2	27	9
Women's and Children's	1	0	4	0	12	2
Other	0	0	0	0	0	3
UHBW TOTAL	**8**	**2**	**20**	**4**	**80**	**31**

MRSA

	May-24	2024/2025	2023/2024
Medicine	0	0	2
Specialised Services	0	0	0
Surgery	0	0	3
Weston	0	0	3
Women's and Children's	0	0	1
Other	0	0	0
UHBW TOTAL	**0**	**0**	**9**



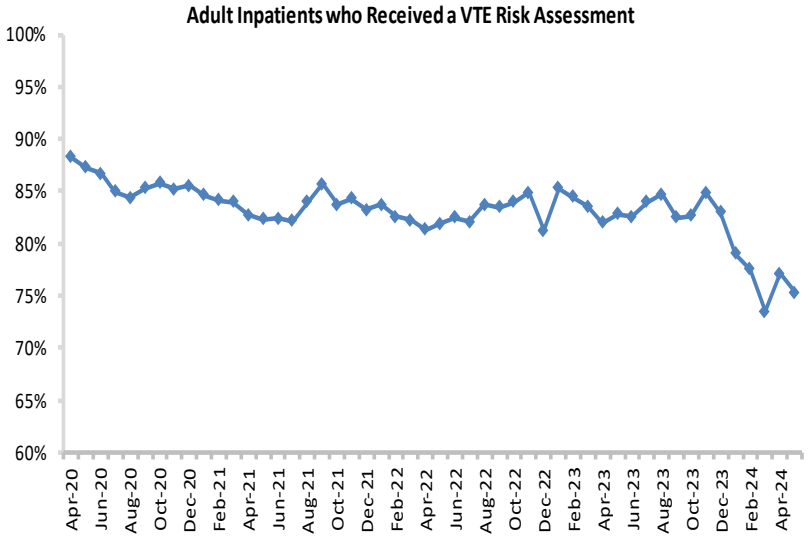


Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

STANDARD	QUALITY AND SAFETY: VENOUS THROMBOEMBOLISM (VTE) RISK ASSESSMENT
Background:	Venous Thromboembolism (VTE) is a significant cause of mortality and disability in England. At least two-thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and the administration of appropriate thromboprophylaxis. The expectation for UHBW was to achieve 95% compliance, with an amber threshold to 90%.
Performance:	VTE performance remains largely unchanged and well below the 95% standard. This is despite a real push within the division of medicine over two weeks in May which saw divisional performance increase over that time period. Local auditing is more encouraging, a pilot audit demonstrated that despite a risk assessment not being completed the majority of patients had the correct VTE prophylaxis prescribed. The number of HAVTE remains low with no SI reported.
Actions:	• Work has been completed on the mandatory function within Comprehensive medication management system (CMM) for VTE Risk Assessment and wards agreed. • The Trustwide VTE policy has been updated and will be submitted for approval via Patient Safety Group. • Message of the month re VTE risk assessments circulated in June. • Work continues on a series of teaching videos regarding VTE Risk assessments.
Risks:	Corporate Risk 720: Risk that VTE risk assessments are not completed



Division	SubDivision	Number Risk Assessed	Total Patients	Percentage Risk Assessed
Diagnostics and Therapies	Radiology	29	29	100.0%
Diagnostics and Therapies Total		**29**	**29**	**100.0%**
Medicine	Medicine	3,333	4,851	68.7%
Medicine Total		**3,333**	**4,851**	**68.7%**
Specialised Services	BHOC	2,702	2,818	95.9%
	Cardiac	321	537	59.8%
	Clinical Genetics	1	1	100.0%
Specialised Services Total		**3,024**	**3,356**	**90.1%**
Surgery	Anaesthetics	28	33	84.8%
	Dental Services	97	176	55.1%
	ENT & Thoracics	221	440	50.2%
	GI Surgery	1,084	1,646	65.9%
	Ophthalmology	299	309	96.8%
	Trauma & Orthopaedics	179	425	42.1%
Surgery Total		**1,908**	**3,029**	**63.0%**
Women's and Children's	Women's Services	1,435	1,652	86.9%
Women's and Children's Total		**1,435**	**1,652**	**86.9%**
Grand Total		**9,729**	**12,917**	**75.3%**

Integrated Quality & Performance Report

Reporting Month: May 2024

STANDARD	QUALITY AND SAFETY: FRACTURE NECK OF FEMUR (#NOF)
Background:	Fractured neck of femur best practice comprises eight elements, all of which need to be provided within relevant time scales to demonstrate care provided to individual patients has met best practice standards. Two of the eight individual criteria are monitored in this report: time to theatre within 36 hours and ortho-geriatrician review within 72 hours. Both standards have a target of 90%.
Performance:	In May, there were 54 patients eligible for the Best Practice Tariff (BPT): 27 in Bristol and 27 in Weston. For the 36 hour time to surgery standard, 33/54 patients (61%) achieved the standard. For the 72-hour time to Ortho-geriatric assessment, 51/54 patients (94%) achieved the standard. 32/53 (59%) achieved BPT. At Bristol sites 27 patients were eligible for Best Practice Tariff in May 2024: 11/27 (41%) patients had surgery in 36 hours 25/27 (93%) patients had an Ortho- geriatric review within 72 hours of admission 11/27 (41%) Predicted BPT for May 2024 At Weston General Hospital 27 patients were eligible for Best Practice Tariff in May 2024. 22/27 - 81% had surgery within 36hrs of admission 26/27 - 96% had an Ortho-geriatrician assessment within 72hrs of admission 21/27 - 78% achieved all the markers required for BPT
Actions:	Bristol: • Theatre capacity being actively monitored and prioritised on a weekly basis across all specialties. • Poor results discussed in Trauma & Orthopaedic Governance & Silver trauma steering group meeting so ideas for improvement could be discussed. • Actively re-patriating patients to Weston to avoid breaches. • Trauma Standard Operating Procedure (SOP) signed off to allow the allocation of a “Golden Patient", enabling a prompt start. • Restart of automatic send. Weston: • Surgery breaches are minimised by utilising elective and emergency (CEPOD) lists where possible.
Risks:	924: Risk that there is a delay in hip fracture patients accessing surgery within 36 hours of admission. 1834: Risk of failure to achieve best practice tariff and good quality care for patients with #NOF

Integrated Quality & Performance Report

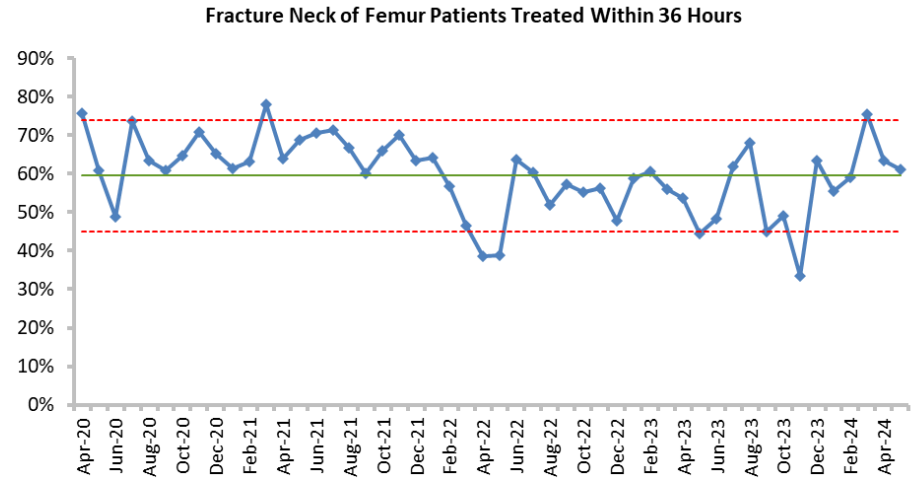
NHS University Hospitals Bristol and Weston NHS Foundation Trust

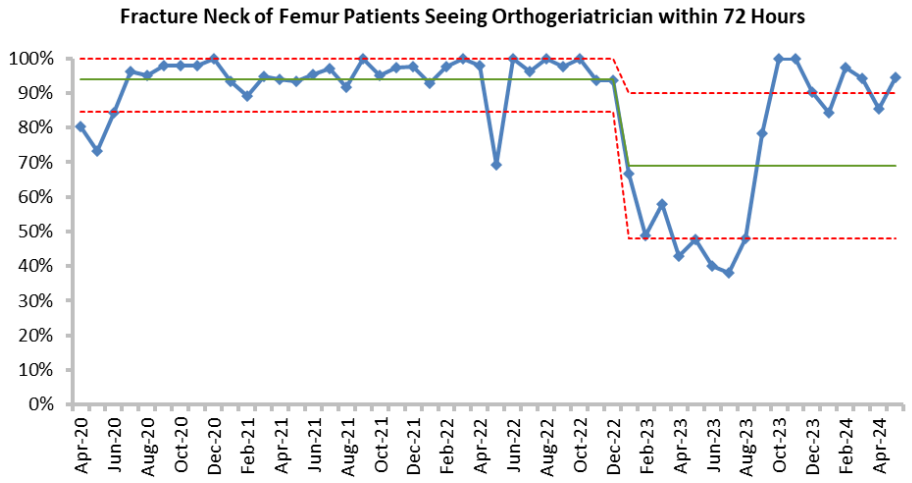
Reporting Month: May 2024

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

May-24

		36 Hours		72 Hours	
	Total Patients	Seen In Target	Percentage	Seen In Target	Percentage
Bristol	27	11	41%	25	93%
Weston	27	22	81%	26	96%
TOTAL	**54**	**33**	**61.1%**	**51**	**94.4%**





Integrated Quality & Performance Report

Reporting Month: March 2024

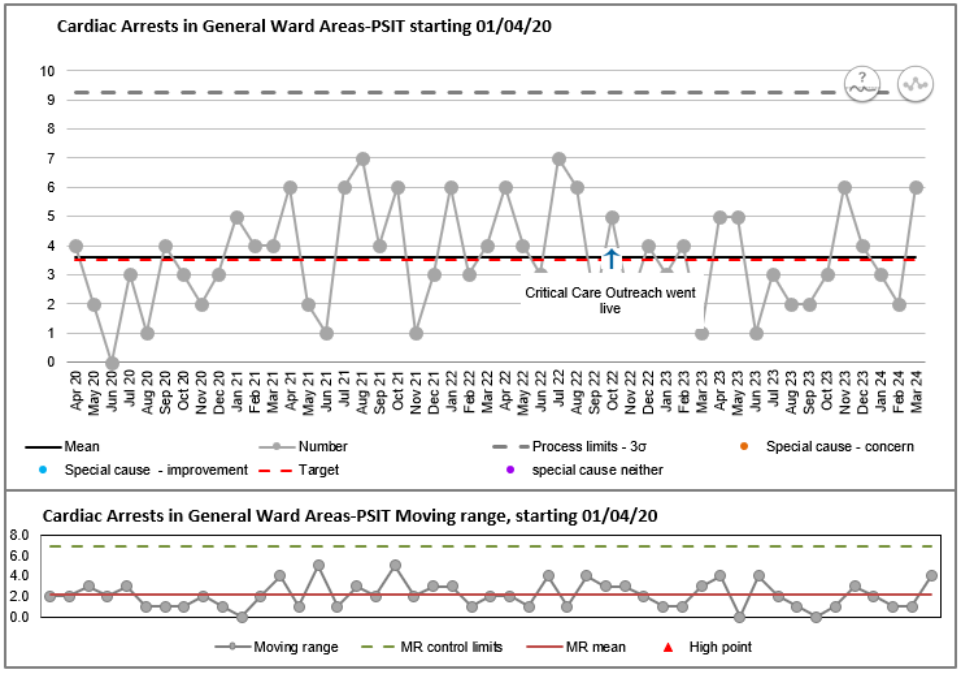
STANDARD	QUALITY AND SAFETY: DETERIORATING PATIENT
Background:	Delayed recognition and response to patient deterioration is nationally recognised as one of the significant causes of avoidable harm. This is a long-term improvement programme (to March 2025) with several workstreams reported in more detail as part of the Patient First Deteriorating Patient corporate project. In 2023/24 the Deteriorating Patient Programme focussed on improving educational resources for adult clinical staff, embedding the Bristol Adult Critical Care Outreach Team, deployment of MOEWS in non-obstetric areas, commencing the standardisation of ReSPECT processes, and analysed data collected to inform the next priorities for improvement. April 23 - March 24 audit data (600 patients from across adult inpatient ward settings) demonstrated that 35% of patients were escalated in the expected timeframe, and 27% were reviewed within the expected timeframe based on their NEWS2 score (as per RCP/UHBW standards). As a result of data analysis, escalation, and response are the agreed priorities for 24/25. The Trust also needs to respond to two new high priority national requirements (2024 NICE Sepsis Clinical Guidelines, and implementation of Martha's Rule); as a result, Sepsis is also an agreed priority for 24/25 and is the primary focus of the programme. The implementation of Martha's Rule is an interdependent project under Patient Safety/Patient First Project.
Performance:	The performance measures for the deteriorating patient programme 23-24 are reportable up to March 2024. The number of cardiac arrests in general ward areas was one of the proxy outcomes measures for the deteriorating patient programme. This relates to adult in-patients in general wards. In March 2024 there were six cardiac arrests; the mean average for the year 23-24 is 3.5 cardiac arrests PCM with a range of 1 – 6. Unplanned ITU admissions (of adult inpatients) was the second of the proxy outcome measures for the deteriorating patient programme, 2023 – 2024, and showed only patients with a NEWS2 score of ≥5; these patients were sampled because this audit aimed to measure and identify improvements in the clinical outcomes for patients who deteriorated prior to being admitted to ITU. The figure for March 2024 is 14; the mean for the year is 14.8 unplanned ITU admissions per month, with a range of 10 – 20. The graph for unplanned ITU admissions CQUIN data (Commissioning for Quality and Innovation data) measured the percentage of adult patients who had an unplanned ITU admission had documented escalation and response within a certain time. Data for February 2024 is 31 per cent and for March 2024 is 36 per cent; the mean average for the year 23-24 was 29.2 per cent, with a range of 8 – 50 per cent. Data relating to the agreed 24/25 priorities (Sepsis, Escalation and Response) will be reportable from July 2024 onwards (data up to May 2024).

Integrated Quality & Performance Report

Reporting Month: March 2024

STANDARD	QUALITY AND SAFETY: DETERIORATING PATIENT (continued)

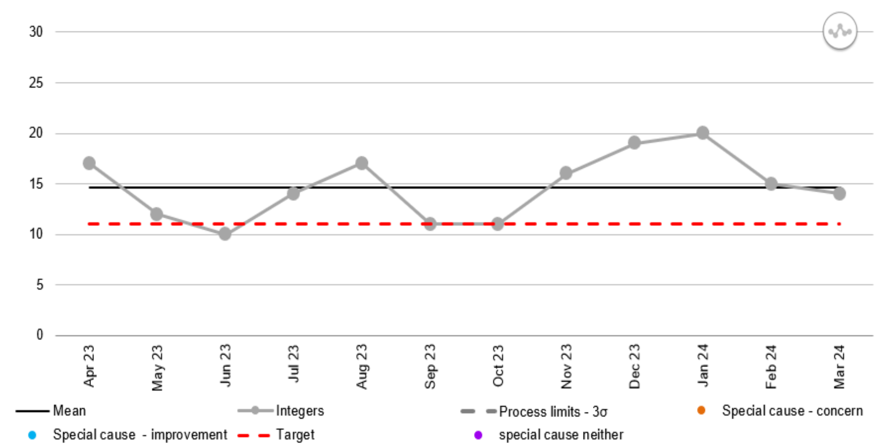
National Data:	**N/A**
Actions:	• Options appraisal for Sepsis NICE guidance completed; recommendation of two phased approach to implementation approved at CQG. Development of Sepsis implementation delivery plan underway. • Evaluation of Recognising, Escalating and Responding to the Deteriorating Patient (Adult) eLearning undertaken; analysis of results will be used to inform amendments to eLearning, and be incorporated into improvement priorities moving forward. • Evaluation of the impact of MOEWS in non-obstetric settings commenced (audit). • A3's commenced data collection and diagnostics) on Escalation and Response.



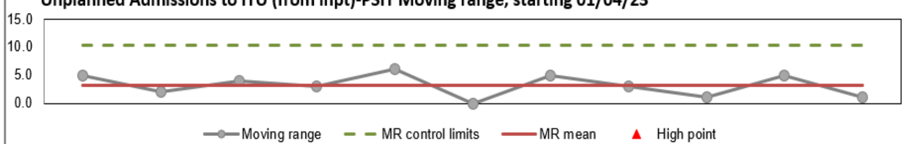
Reporting Month: March 2024

STANDARD QUALITY AND SAFETY: DETERIORATING PATIENT

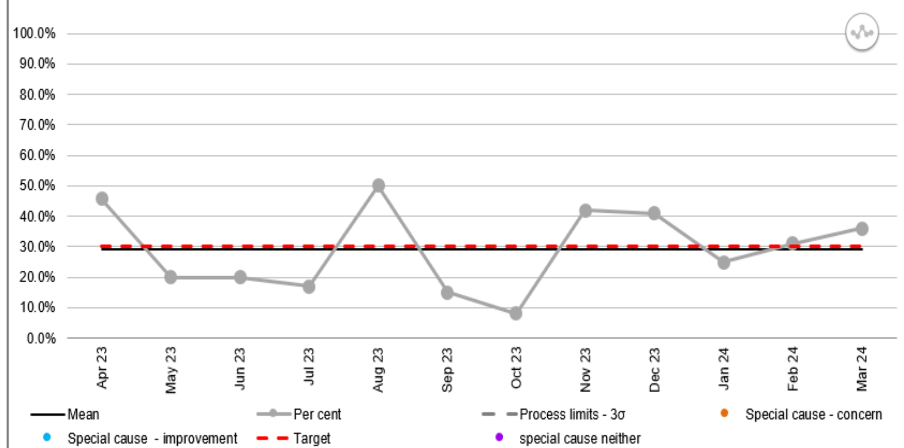
Unplanned Admissions to ITU (from inpt)-PSIT starting 01/04/23



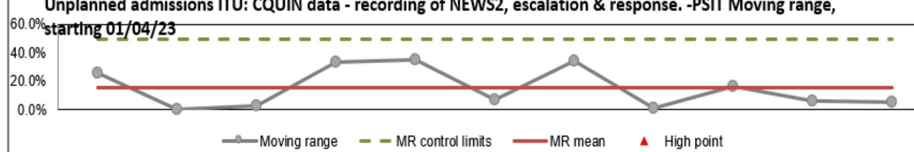
Unplanned Admissions to ITU (from inpt)-PSIT Moving range, starting 01/04/23



Unplanned admissions ITU: CQUIN data - recording of NEWS2, escalation & response. -PSIT starting 01/04/23



Unplanned admissions ITU: CQUIN data - recording of NEWS2, escalation & response. -PSIT Moving range, starting 01/04/23



Integrated Quality & Performance Report

Reporting Month: May 2024

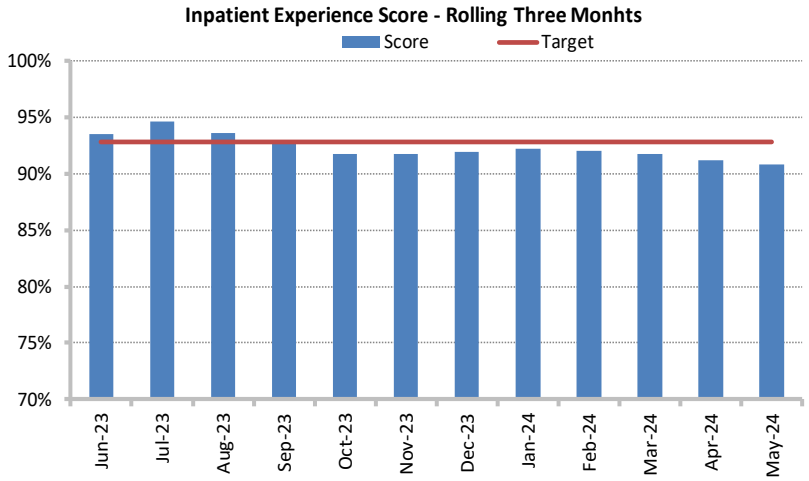
STANDARD	QUALITY AND SAFETY: PATIENT EXPERIENCE
Background:	The Inpatient and Outpatient Experience Score metric is based on the survey question 'Overall, how was your experience of our service?'. The score is based on the percentage of patients who responded to the monthly survey who rated their care as good or very good in the overall experience question. The target for this metric is for 98% of patients to rate their care as a good or above (via the monthly surveys) by the end of 2027/28 financial year against the baseline position for 2022/23. A five year trajectory has been agreed to reach the target. The current year target (2024/25) for inpatients and maternity services to achieve a score of 94.1% or higher, for outpatients the target is 97.5%. The communication experience metric is a composite indicator of 16 questions in the monthly inpatient survey that focuses on communication-related aspects of care. The target is a score of 88%. This metric has been developed to monitor the Patient First Experience of Care breakthrough objective. The metric includes questions on how well we involve patients in decisions about their care, how clearly we communicate with patients and keep them informed on what will happen next in their care, whether we treat patients with kindness and understanding and respect and dignity. These metrics are the Patient First True North metrics for the Experience of Care priority. Divisional level metrics are reported quarterly through the Experience of Care Group (EoCG) and Quality and Outcomes Committee (QOC). Patient First methodology will drive the programme of work required to turn the dial to reach the target for inpatients and maternity and therefore at this relatively early stage in the roll-out, we may expect to see initial under-performance.
Performance:	The rolling 3-month average inpatient experience to May 2024 was 90.8% (April score was 91.2%). Metric is below target for 2024/2025. The rolling 3-month average for outpatient experience to May 2024 was 96.7% (April score was 97.4%). Metric is just below target for 2024/2025. The rolling 3-month average for the inpatient communication metric experience to May 2024 was 82.9% (April score was 83.1%). Metric is below target for 2024/2025.
Actions:	• 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 experience. • A new communication experience metric has been produced and ward-level analysis was shared with Divisions in January 2024 to support conversations on where to focus improvement efforts. • To date, Medicine and Specialised Services have selected this as a priority area via Catch-ball and there is a focus on improving communication experience at Weston General Hospital.

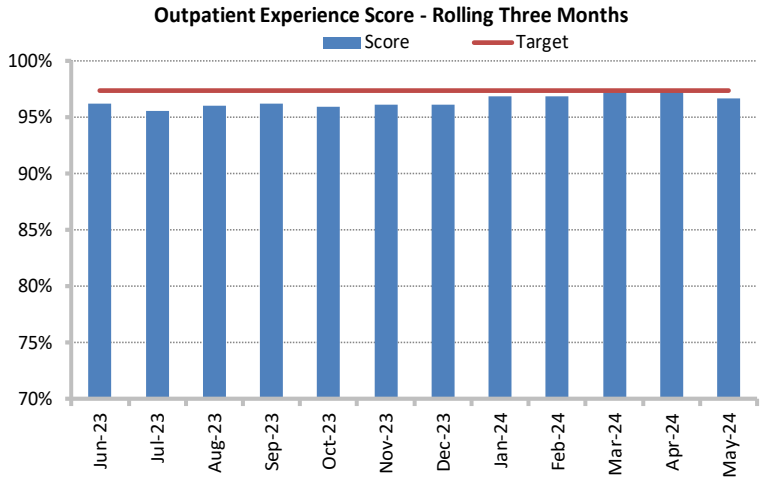
Integrated Quality & Performance Report

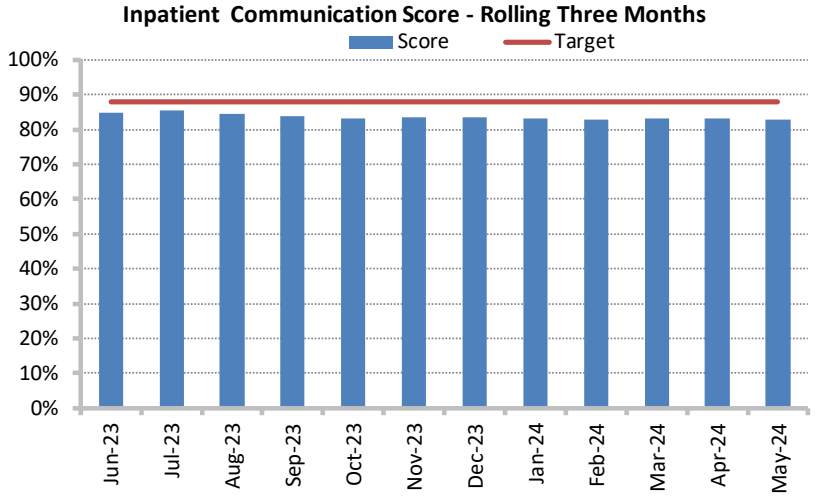
University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

STANDARD QUALITY AND SAFETY: PATIENT EXPERIENCE (continued)





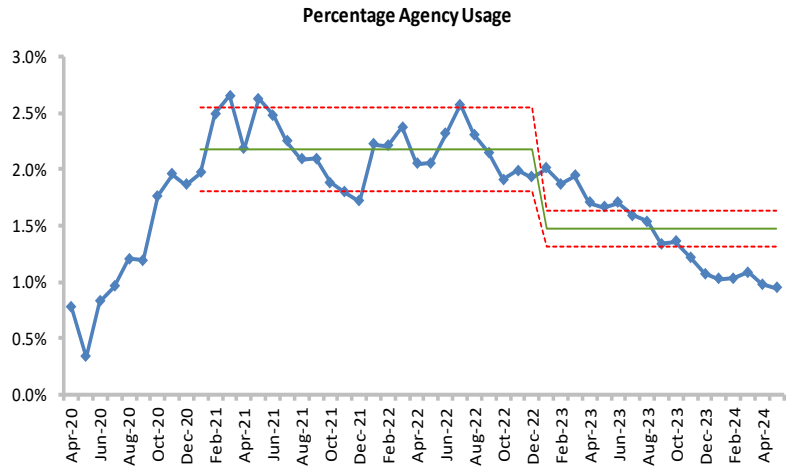


Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

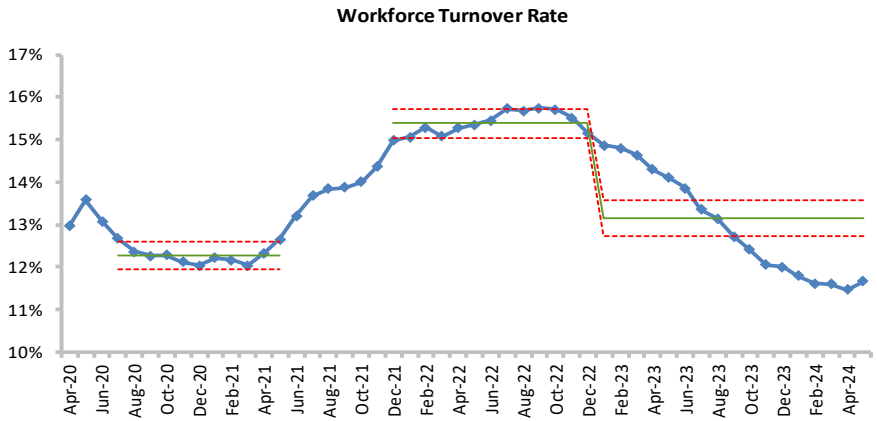
STANDARD	OUR PEOPLE: WORKFORCE AGENCY USAGE
Performance:	Agency usage reduced by 4.5 FTE to 0.9% (122.8 FTE). There were increases within two divisions. The largest divisional increase was seen within Women's and Children's, where usage increased to 47.3 FTE from 38.8 FTE in the previous month. There were reductions within four divisions. The largest divisional reduction was seen within Surgery, where usage reduced to 20.0 FTE from 28.3 FTE in the previous month.
Actions:	• A total of 37 new starters joined the Bank in May, including 13 re-appointments. • 13 agency registered nurse workers were successful during interview in May and are in process of moving across to the Bank, some of these are from high-cost agencies. • The UHBW Bank team continues to work closely with the Acute Provider Collaborative to consider a Collaborative Bank. • System work continues at regional level to drive the supply off framework nursing agency, adhering to cap compliance and working hard to reduce off framework usage by the NHSE mandated deadline of 1st July. • The Trust continues to encourage "block bookings" to reduce the use of last minute, non-framework reliance. In Medicine and Weston, this has been reduced to only one framework Mental health registered nurse per shift. • Active recruitment continues to substantive medical roles in the Weston Division to drive down the demand for high-cost agency usage. This is in addition to a focused piece of work to stop non-framework agency usage for medics across the Trust.
Risks:	Corporate Risk 674: Risk that use of agencies who are non-compliant with national pricing caps does not reduce



Integrated Quality & Performance Report

Reporting Month: May 2024

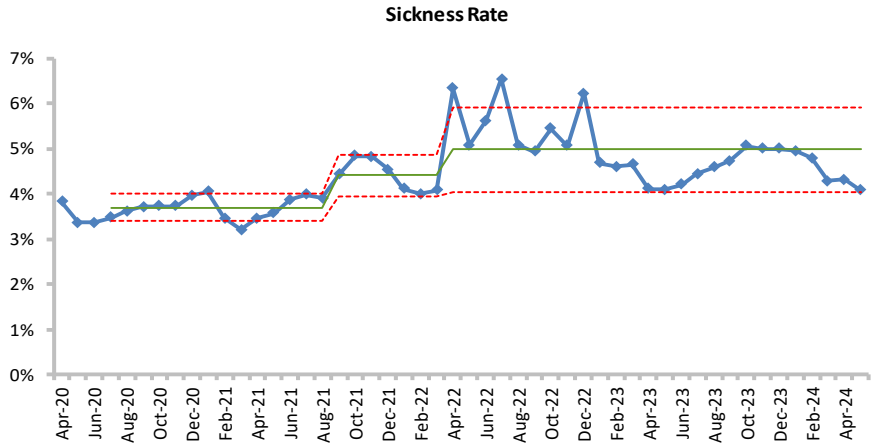
STANDARD	OUR PEOPLE: WORKFORCE STAFF TURNOVER
Performance:	Turnover for the 12-month period increased to 11.7% compared with 11.5% the previous month (updated figures). Three divisions saw reductions whilst five divisions saw increases in comparison to the previous month. The largest divisional reduction was seen within Facilities and Estates, where turnover reduced by 0.4 percentage points to 13.5% compared with 13.9% the previous month. The largest divisional increase was seen within Weston General Hospital, where turnover increased by 0.6 percentage points to 12.0% compared with 11.4% the previous month.
Actions:	• Staff Survey 2023: May Culture and People Group enabled peer to peer sharing of divisional Culture and People plans from the HRBP Team, highlighting divisional priorities and opportunities for collaborative working. Engagement governance agreed for the year ahead with quarterly review meetings. • Recognition: The annual recognising success awards took place on Friday 17th May 2023, with three hundred colleagues attending to celebrate the shortlisted nominees, winners of the awards and colleagues celebrating career milestones of 30/40/50 years, as well as divisionally nominated guests. This was followed by our UHBW Celebration week which included videos, pictures, and each of the 1428 nominated colleagues receiving congratulation cards from the Chief Executive. • People Strategy milestones: There are robust plans in place to improve retention within the EDI and Wellbeing Strategic Framework's, as well as the Engagement Strategic Action Plan, based on Staff Survey priorities. Activity against these plans are monitored in People Committee. • Work is commencing as part of the HR Services A3 thinking project on improvements to onboarding processes and general support to provide increased support and guidance to our new starters with the aim improving staff experience in addition to induction and local induction. Part of this will include more signposting and information for managers in supporting their new starters.
Risk:	Strategic Risk 2694: Risk that Trust is unable to retain members of the substantive workforce



Integrated Quality & Performance Report

Reporting Month: May 2024

STANDARD	OUR PEOPLE: WORKFORCE STAFF SICKNESS
Performance:	Sickness absence reduced to 4.1% compared with 4.3% in the previous month, based on updated figures for both months. This figure is now combined with Covid Related absence. There were reductions within six divisions, one divisional increase and one division where the absence rate remained static, compared with the previous month. The largest divisional reduction was seen in Medicine, where sickness reduced by 1.05 percentage points to 4.01%, compared to 5.06% in the previous month. The only divisional increase was seen in Diagnostics and Therapies, where sickness increased by 0.3 percentage points to 3.6%, compared to 3.3% in the previous month.
Actions:	• Staff Survey 2023: May Culture and People Group enabled peer to peer sharing of divisional Culture and People plans from the HRBP Team, highlighting divisional priorities and opportunities for collaborative working. Engagement governance agreed for the year ahead with quarterly review meetings. • Recognition: The annual recognising success awards took place on Friday 17th May 2023, with three hundred colleagues attending to celebrate the shortlisted nominees, winners of the awards and colleagues celebrating career milestones of 30/40/50 years, as well as divisionally nominated guests. This was followed by our UHBW Celebration week which included videos, pictures, and each of the 1428 nominated colleagues receiving congratulation cards from the Chief Executive. • People Strategy milestones: There are robust plans in place to improve retention within the EDI and Wellbeing Strategic Framework's, as well as the Engagement Strategic Action Plan, based on Staff Survey priorities. Activity against these plans are monitored in People Committee. • Work is commencing as part of the HR Services A3 thinking project on improvements to onboarding processes and general support to provide increased support and guidance to our new starters with the aim improving staff experience in addition to induction and local induction. Part of this will include more signposting and information for managers in supporting their new starters.



Integrated Quality & Performance Report

Reporting Month: May 2024

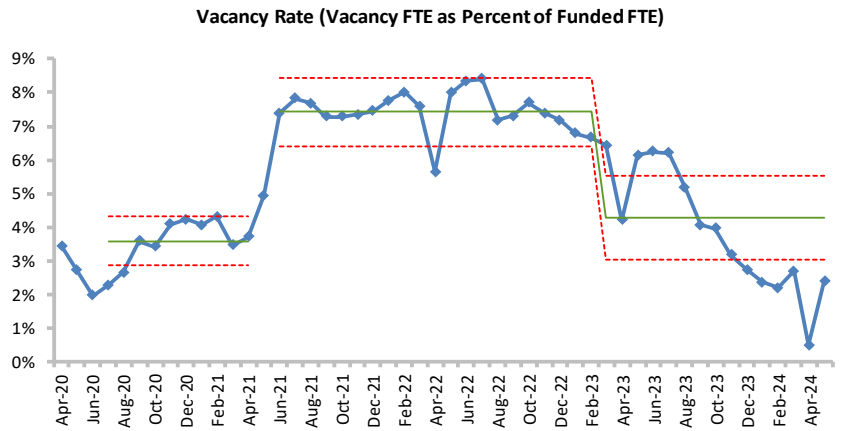
STANDARD	OUR PEOPLE: WORKFORCE STAFF VACANCY
Performance:	Overall vacancies increased to 2.4% (295.9 FTE) compared to 0.5% (58.8 FTE) in the previous month. The largest divisional increase was seen in Specialised Services where vacancies increased to 44.4 FTE from -18.8 FTE in the previous month. The largest divisional reduction was seen in Facilities and Estates where the division reduced to 68.0 FTE, compared with having a vacancy of 76.3 FTE the previous month. The largest staff group reduction was seen in Ancillary staff, where the staff group reduced to 77.4 FTE, compared with having a vacancy of 83.5 FTE the previous month. The largest staff group increase was seen in Nursing staff, where the staff group increased to 8.7 FTE from -104.2 FTE the previous month. Consultant vacancy has increased to 42.8 FTE (5.3%) from 30.4 FTE (3.8%) in the previous month. Unregistered nursing vacancies can be broken down as follows: <table><tr><th>Band</th><th>Vacancy</th></tr><tr><td>AfC Band 2</td><td>13.7 FTE</td></tr><tr><td>AfC Band 3</td><td>30.0 FTE</td></tr><tr><td>AfC Band 4</td><td>-103.0 FTE</td></tr></table> The band 4 over establishment is due to the large number of newly qualified nursing staff awaiting their NMC PINs. Once these staff become fully qualified and have received their PIN, this should reduce the band 4 over establishment, reduce the registered nursing vacancy position, and increase the unregistered nursing vacancy position, which is a much more accurate reflection of the nursing vacancy position.
Actions:	• Worked commenced to organise two open days for the Neonatal and Paediatric Intensive Care Units due to take place in June. • Planning commenced for a summer campaign to promote a wide range of nursing roles within the Bristol Royal Hospital for Children (BRHC). The campaign is due to go live over July and August. • Adverts for the Student Nursing Associate (SNA), Registered Nurse Degree Apprenticeship (RNDA) and Accelerated Registered Nurse Degree Apprenticeship (ARNDA) closed and were shortlisted. Three assessment centres for these apprenticeship programs are scheduled for June. • 26 substantive Healthcare Support Workers (HCSW) started in the Trust during the month of May and another 18 were offered. • Eight substantive Allied Health Professionals (AHPs) and 13 substantive Healthcare Scientists joined the Diagnostics and Therapies division. • The Trust launched a social media campaign for the recruitment of ten newly qualified radiographers, with interviews taking place throughout June. • The new Adult Therapies recruitment video was finalised in May and a promotional campaign has been planned to be launched in June. This will support the promotion of the Adult Therapies Service in hopes to attract more applicants to the historically hard-to-fill roles such as Occupational Therapists and Speech and Language Therapists. *...continued over page*

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

STANDARD	OUR PEOPLE: WORKFORCE STAFF VACANCY
Actions (continued):	• In May, two substantive ED consultants and one substantive Surgery consultant were offered positions at the Weston site. • In May, one non-consultant grade doctor in Surgery and one non-consultant grade doctor in Medicine were offered positions at Weston. Two non-consultant grade doctors have been cleared to start in Weston Medicine in June. • Efforts continued to support the implementation of Healthy Weston 2, including a targeted recruitment campaign to attract candidates to the Weston site. Additionally, a social media campaign was launched to promote Weston-super-Mare as a desirable place to live and work. Results to follow. • Work has begun on organising a Consultant Recruitment Information evening to promote our vacancies and attract talent to the Trust. A targeted social media campaign went live on LinkedIn, along with a promotion on the British Medical Journal website, to ensure the right audience for the event is reached.
Risks:	Strategic Risk 737: Risk that the Trust is unable to recruit sufficient numbers of substantive staff



Integrated Quality and Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

STANDARD	REFERRAL TO TREATMENT (RTT) LONG WAITS
Performance:	At the end of May: • 2,347 patients were waiting 52+ weeks against the 2024/25 Operating Plan trajectory of 2,114. • 232 patients were waiting 65+ weeks against the 2024/25 Operating Plan trajectory of 220. • 22 patients were waiting 78+ weeks. • 0 patients were waiting 104+ weeks. For 2024/25 the Operating Plan shows elimination of 65+ week waits by September and a reduction of 52+ week waits to 862 by end of March 2025.
National Data:	For April 2024, across all of England, 4.1% of the waiting list was waiting over 52 weeks. UHBW's performance was 3.9% (2,344 patients) which places UHBW as the 62nd highest Trust out of 157 Trusts that reported RTT wait times.
Actions:	• At the end of May 2024, there were no patients waiting over 104+ weeks. This is a sustained position, with February 2023 being the last time a patient was reported waiting 104 weeks or longer. • The Trust continues to work towards the elimination of any patient waiting longer than 78 weeks and plans developed with clinical divisions are being enacted to achieve this ambition. At the end of May, the Trust reported 22 patients who have waited 78 weeks or longer: 3 patients in dental services, 18 cornea graft patients and 1 paediatric urology patient. • From the end of June 2024, it is forecast that there will be no patients waiting longer than 78 weeks, with the potential exception of patients awaiting cornea graft material. Due to a previously reported national shortage of cornea graft material, the Trust are unable to date these patients until the national supply issue is resolved. The Trust is expecting to receive further cornea graft material in June to commence treating the longest waiting patients and have advised NHS England the numbers of patients who remain waiting for graft material. • As part of the 2024/25 Annual Planning Process (APP), clinical divisions have developed plans to move towards the national ambition of no patient waiting longer than 65 weeks by end of September 2024. The number of patients waiting in excess of 65 weeks at the end of May was 232 against the trajectory of 220 which is an improvement on the April position when 246 patients were waiting 65 weeks or longer. • Dental services have additional Independent Sector capacity under contractual agreements with both Nuffield and Spire to support their recovery in cleft services and the service are using KPI Health as an insourcing provider for paediatric dental clinics and extractions which commenced January 2023, with schedules being provided each month. • The Trust has established insourcing arrangements for outpatient services in paediatric dentistry, paediatric oral surgery, oral medicine, orthodontics and maxillo facial and the dental service have recruited an additional orthodontics consultant and a paediatric cleft locum to increase the capacity within these services. Within dental services there continues to be a gap in the number of paediatric dentistry consultants, equating to 1.1 WTE. The dental management team are continuing to work with the UHBW Talent Team and have re-advertised for a paediatric dentistry consultant with a closing date of 15th April 2024 however this was unsuccessfully recruited to for a third time. The dental team are now recruiting a middle grade to fill some of the gap. *...continued over page*

Integrated Quality and Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

STANDARD	REFERRAL TO TREATMENT (RTT) LONG WAITS
Actions (continued):	• The Trust continues to bolster additional capacity through other insourcing providers and waiting list initiatives. • Where patients are too complex for transferring outside of the organisation for treatment under mutual aid arrangements, theatre schedules are under review via a theatre improvement programme to ensure that suitable capacity is available for the longest waiting patients. This continues to be a challenge due to the high volume of cancer cases, inpatient capacity, critical care capacity and staff shortages. • The Trust's Paediatric services are working with University Hospitals Plymouth (UHP) to repatriate paediatric patients who live within the UHP catchment area to Plymouth for treatment assuming that they are clinically appropriate and choose to transfer their care. UHP's paediatric theatre fully opened in January 2024 with a launch event on 15th May 2024 and a plan is pending approval with the relevant Integrated Care Board to re-open the Directory of Service (DoS) on the e-referral system to ensure that paediatric patients are referred to UHP in the first instance from 1st July 2024. Monthly meetings are underway with UHP to agree suitable patients to transfer with seven patients currently under review for transfer by UHP (2 paediatric plastic patients and 5 paediatric ENT) and additional further patients are being reviewed with clinical involvement to deem suitability for transfer. Patients who are too complex and/or are currently under follow-up care at the Bristol Children's Hospital will be transferred to UHBW following initial triage at UHP.
Risk:	Corporate Risk 801: Risk that the six oversight themes within the NHS Oversight Framework for 2023/24 are not met

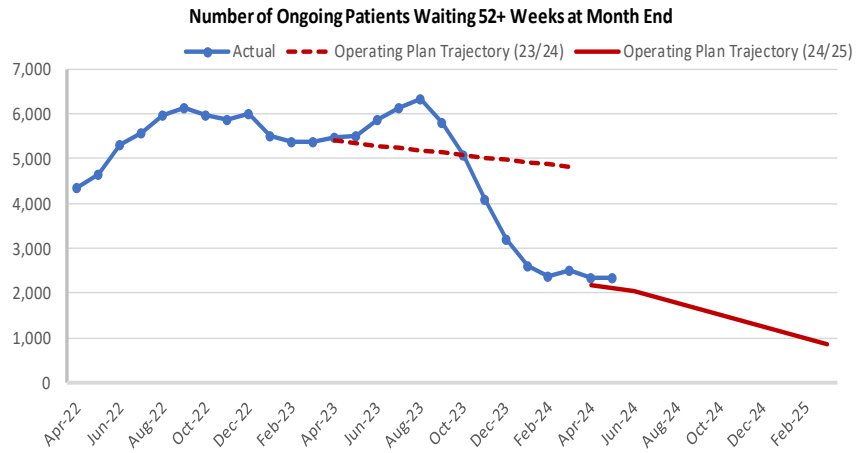
Integrated Quality and Performance Report

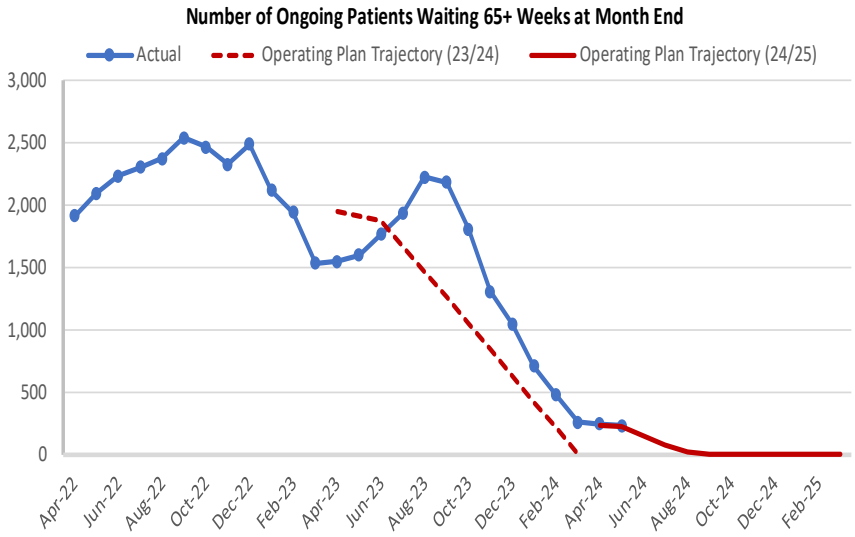
University Hospitals Bristol and Weston NHS Foundation Trust

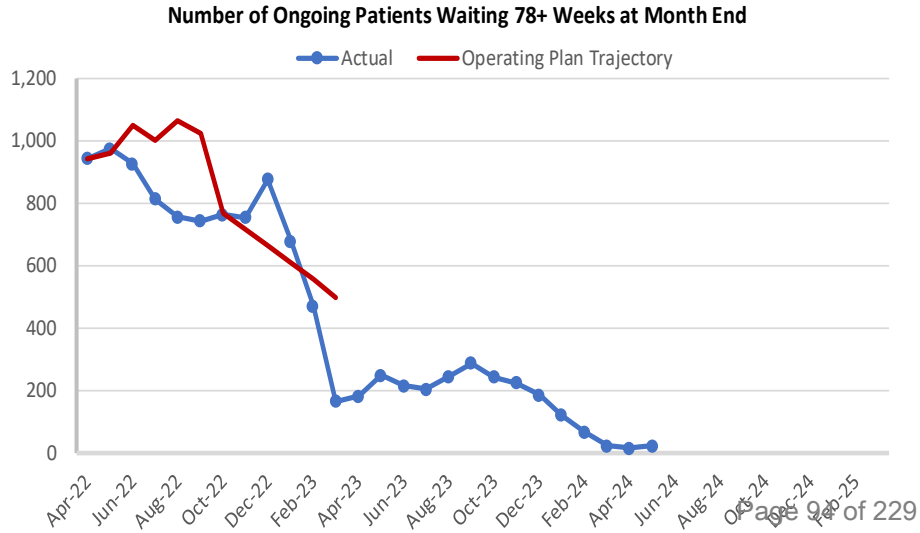
Reporting Month: May 2024

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

	May-24		
	52+ Weeks	65+ Weeks	78+ Weeks
Diagnostics and Therapies	31	0	0
Medicine	211	5	0
Specialised Services	142	4	0
Surgery	1,456	160	21
Women's and Children's	507	63	1
Other	0	0	0
UHBW TOTAL	**2,347**	**232**	**22**







Integrated Quality and Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2024

STANDARD	CANCER WAITING TIMES
Performance:	All three cancer standards are reported a month in arrears. The "Faster Diagnosis Standard" (FDS) measures time from receipt of a suspected cancer referral from a GP or screening programme to the date the patient is given a cancer diagnosis, or told cancer is excluded, or has a decision to treat for a possible cancer. In 2023/24, this time should not have exceeded 28 days for a minimum of 75% of patients. The NHS ambition is to deliver this for a minimum of 77% of patients by March 2025 and then 80% by March 2026. UHBW's operating plan trajectory for 2024/25 was set at 75% in Quarter 1 and 77% in Quarters 2, 3 and 4. Performance in April was compliant at 77.0%. The 62 Day Standard reports number of patients treated within 62 days of starting a suspected cancer pathway. The national constitutional standard is 85% and UHBW's operating plan trajectory for 2024/25 was set at 70% each month. For April, 73.2% of patients were treated within 62 days. The 31 Day Standard reports number of patients treated within 31 days of the decision to treat. For April, 93.1% of patients were treated within 31 days. The national constitutional standard is 96%.
National Data:	National data for patients treated within 62 days of starting a suspected cancer pathway is shown on the next page.
Actions:	The Trust continues to comply with the Faster Diagnosis Standard, including with the 77% increased target for 24/25 financial year. The 62-day referral to treatment standard performed above NHSE's interim target for a fifth consecutive month, and performance against the 31-day decision to treat to treatment standard remained greater than 90% although below the compliance threshold of 96% due to the continued impact of clearing the backlog in thoracic surgery caused by industrial action. The thoracic surgery backlog has been cleared at the end of May 2024. The actions to sustain and further improve this performance include; increasing operating theatre capacity through the new elective centre (from April 2025), expansion of the gynaecological cancer one-stop assessment clinics and continued rigorous waiting list management.
Risk	Corporate Risk 801: Risk that the six oversight themes within the NHS Oversight Framework for 2023/24 are not met

	Apr-24		
	Within Target	**Total Patients**	**% Achievement**
28 Day Faster Diagnosis	1,401	1,819	77.0%
31 Day Standard	770	827	93.1%
62 Day Standard	182	249	73.2%

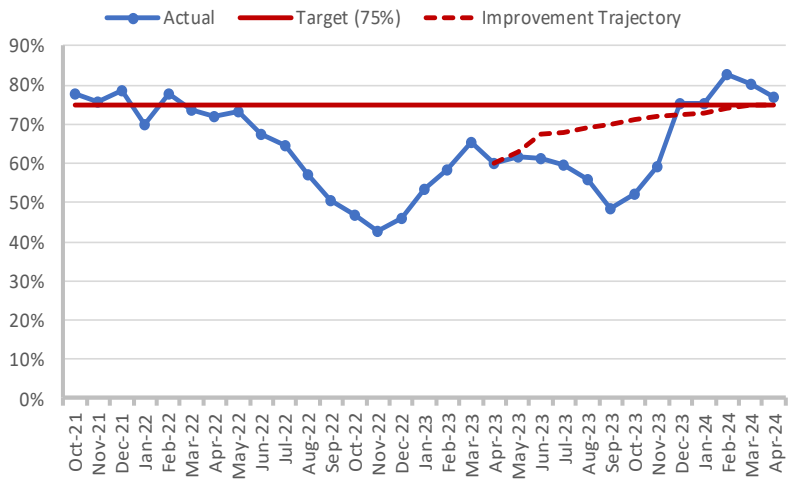
Integrated Quality and Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

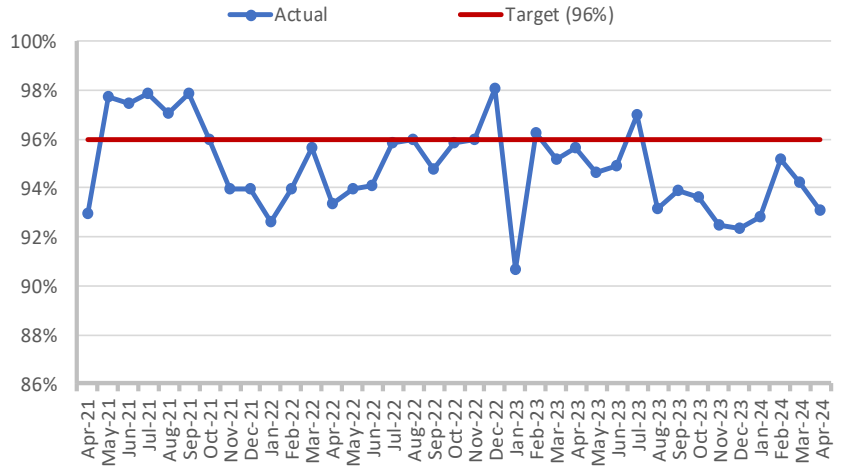
Reporting Month: April 2024

STANDARD CANCER WAITING TIMES

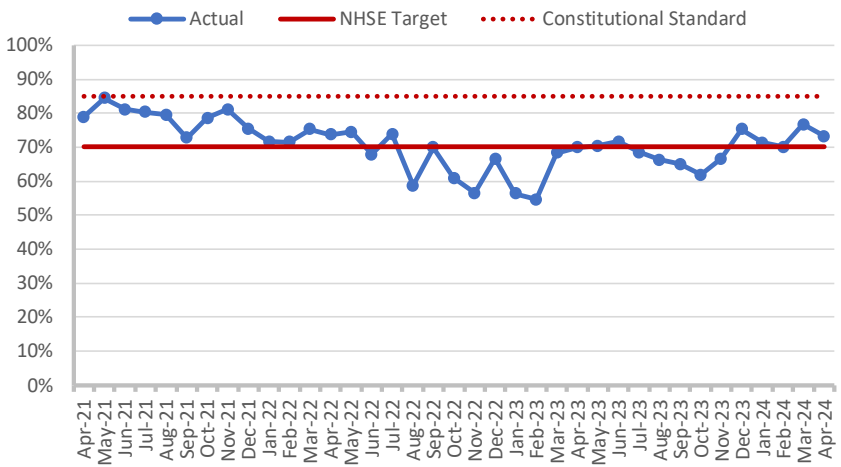
28 Day Cancer Faster Diagnosis Standard



31 Day Diagnosis to Treatment



62 Day Referral To Treatment

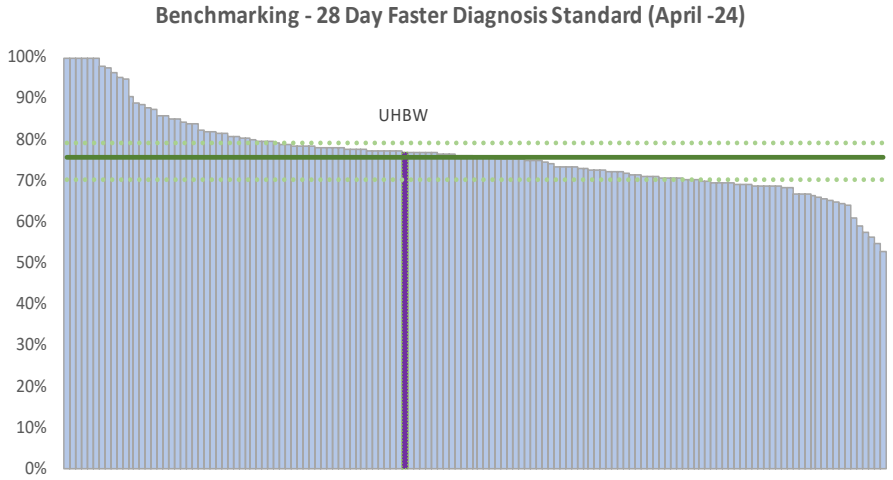


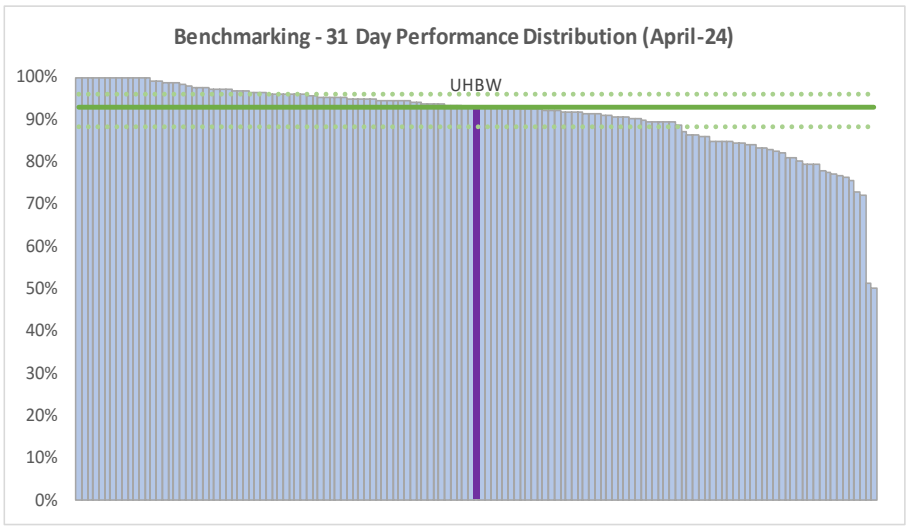
Integrated Quality and Performance Report

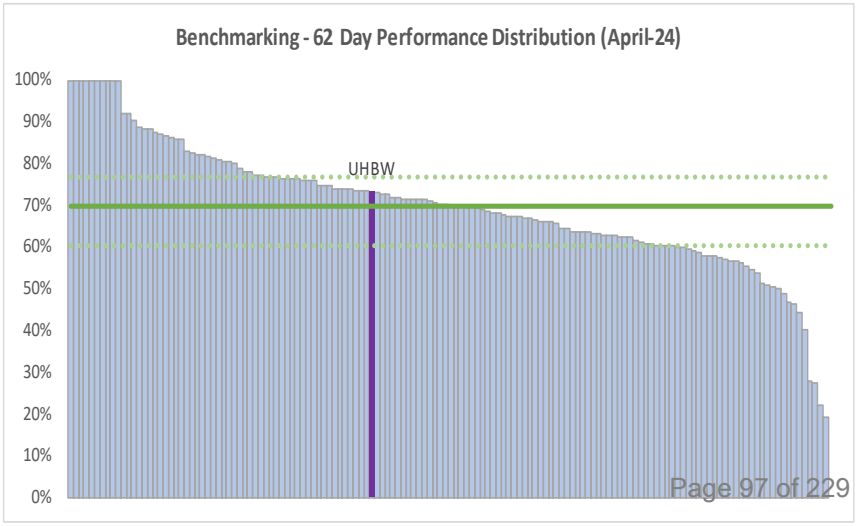
NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2024

STANDARD	CANCER WAITING TIMES







Integrated Quality and Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

STANDARD	DIAGNOSTIC WAITING TIMES
Performance:	The ambition set as part of the Trust's operational planning submission for 2024/25 is that 87.3% of patients will be waiting under six weeks by end of May 2024. The Trust achieved 78.2% for May. The constitutional standard is to achieve 95% and the 2024/25 operating plan submission shows recovery to 95% by March 2025. Trusts are also focussing on reducing long wait volumes, for patients waiting 13+ and 26+ weeks. As at the end of May: • 770 patients were waiting 13+ weeks. This is 4.8% of the total waiting list. • 113 patients were waiting 26+ weeks. This is 0.7% of the total waiting list. Note there were no required national trajectories for these long wait measures in 2024/25.
National Data:	For April 2024, the England total was 76.1% of the waiting list under six weeks. UHBW's performance was 78.9% which places UHBW 69th of 156 Trusts that reported diagnostic wait times.
Action/Plan:	• At the end of May, diagnostic performance against the six week wait standard was reported as 78.2% against the operational planning trajectory of 87.3%. Considerable efforts have been made to improve performance, and despite the progress made in several modalities, improvement in diagnostic performance was not achieved in May 2024. • Notably, 11 modalities/ sub-modalities maintained or improved from April 2024 performance, five sub-modalities/ modalities achieved more than 85% under six weeks, a further nine sub-modalities/ modalities achieved more than 99% under six weeks. • Reducing and eliminating diagnostic long waiters is a priority and the number of patients waiting more than 26 weeks reduced to 113 by the end of May. Patients waiting more than 13 weeks increased to 770 from 622, however this deterioration is attributed to challenges and recovery actions associated with Sleep Studies. • 19 sub-modalities improved or maintained performance for reducing long waiters in May 2024 and 13 sub-modalities reported zero patients waiting more than 13 weeks. Despite the improvements being made, challenges do remain in Paediatrics MRI, Endoscopy and Ultrasound as these modalities are highly specialist and cannot be outsourced. There are also challenges in Audiology adults and Sleep Studies but plans and actions are in place to recover. Diagnostic capacity throughout 23/24 and year to date has been challenged by sickness in the workforce, further cancellations caused by industrial action (IA) and prioritisation of more clinically urgent patients. • Although challenges remain (particularly within the paediatric service), ultrasound performance improved during May 2024 and the service continues to utilise outsourcing and insourcing to Independent Sector provider and further improvement is expected. • Echocardiography performance has also improved, despite the service experiencing a sustained increase in urgent and inpatient demand which affects elective capacity and recovery. The service is utilising core capacity across all sites to reduce waits and it should be noted that expected additional Community Diagnostic Centre (CDC) capacity was delayed, impacting the recovery plans. • Audiology adults performance has been challenged, and although long waiters increased slightly, the percentage under six weeks improved in May 2024. Recovery plans are in place and improvement to the national target is expected by Q3 24/25 with the use of different types of additional capacity to supplement the core capacity which has been maintained. *...continued over page*

Integrated Quality and Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

STANDARD	DIAGNOSTIC WAITING TIMES
Action/Plan (continued):	• Endoscopy (adults) performance against the six-week standard improved in May 2024, although the number of patients waiting over 13 weeks did not reduce and patients waiting more than 26 weeks were the same as the previous month. The risks associated with performance include the impact of IA, ongoing complex patients queries, challenges in certain staffing groups, and complex patients requiring their procedures under general anaesthetic (GA) or other capacity which is limited and prioritised for the most clinically urgent patients. • Performance and long waiters in Sleep Studies continues to be a challenge to diagnostic performance within the Trust, this modality has had the most significant impact on diagnostic performance in May 2024. Improvement is expected in coming months as the service continues to use significant additional capacity to improve waiting times for patients and, despite the reported performance, improvements are materialising following the extensive and sustained actions being taken. The position is expected to recover by Q3 2024/25 and is being monitored closely. • Previous industrial action has significantly impacted diagnostic performance as the unrealised capacity generally cannot be recouped – pushing out recovery timelines. Industrial action in June and July 2024 is anticipated to have further impact to diagnostic performance, but plans are in place to reduce the impact as far as possible. Staff sickness and capacity constraints in highly specialist sub-modalities, particularly for patients requiring their procedures under GA, also significantly impact diagnostic performance improvement. • Modality-level diagnostic trajectories and plans for 24/25 are being finalised across the organisation and the Trust continues to utilise transferred capacity and outsourcing to the independent sector which are also integral to the 24/25 diagnostic recovery plans.
Risk:	Corporate Risk 801: Risk that the six oversight themes within the NHS Oversight Framework for 2023/24 are not met

End of May 2024

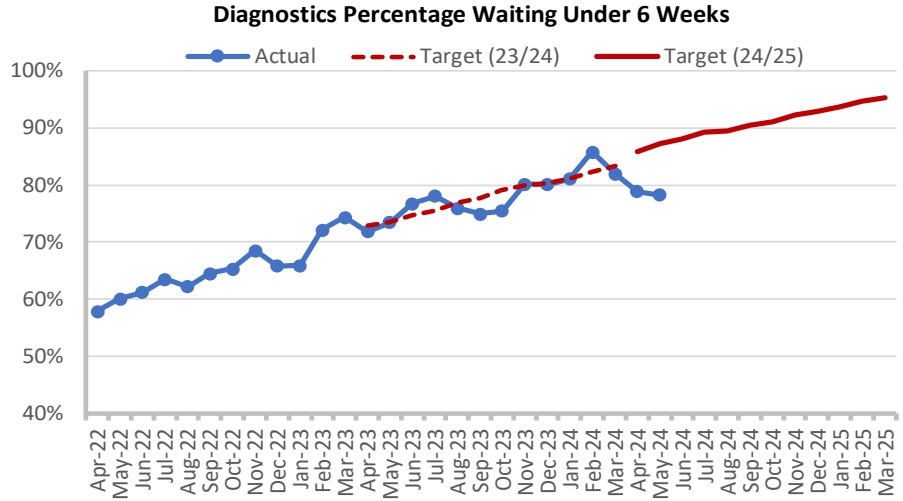
Modality	Total On List	Under 6 Weeks		13+ Weeks		26+ Weeks	
		Number	Percentage	Number	Percentage	Number	Percentage
Audiology Assessments	1,486	247	83%	57	4%	1	0%
Colonoscopy	474	172	64%	70	15%	3	1%
Computed Tomography (CT)	2,441	311	87%	25	1%	2	0%
DEXA Scan	423	82	81%	3	1%	0	0%
Echocardiography	2,179	734	66%	29	1%	0	0%
Flexi Sigmoidoscopy	148	42	72%	12	8%	1	1%
Gastroscopy	479	175	63%	54	11%	3	1%
Magnetic Resonance Imaging (MRI)	2,812	438	84%	144	5%	14	0%
Neurophysiology	273	11	96%	0	0%	0	0%
Non-obstetric Ultrasound	5,058	991	80%	122	2%	2	0%
Sleep Studies	356	309	13%	254	71%	87	24%
Other	0	0		0		0	
UHBW TOTAL	**16,129**	**3,512**	**78.2%**	**770**	**4.8%**	**113**	**0.7%**

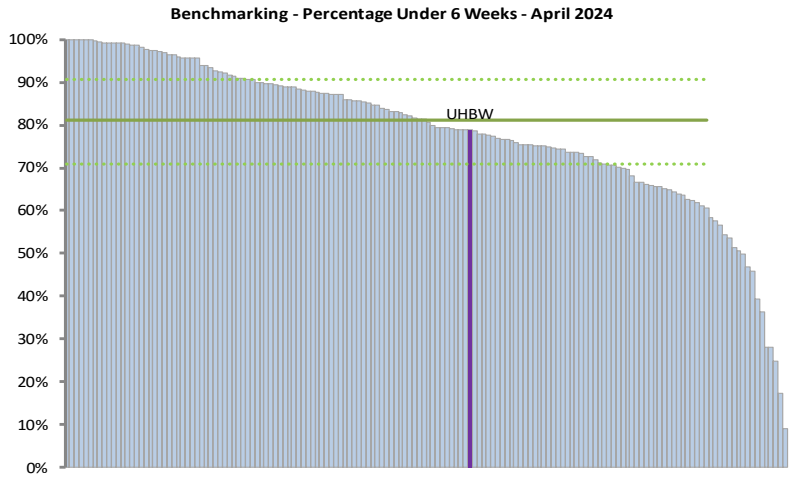
Integrated Quality and Performance Report

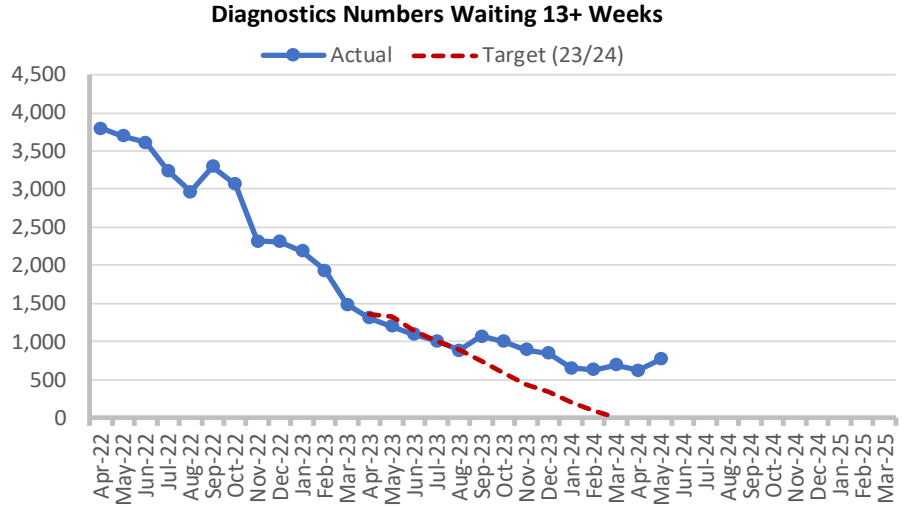
NHS University Hospitals Bristol and Weston NHS Foundation Trust

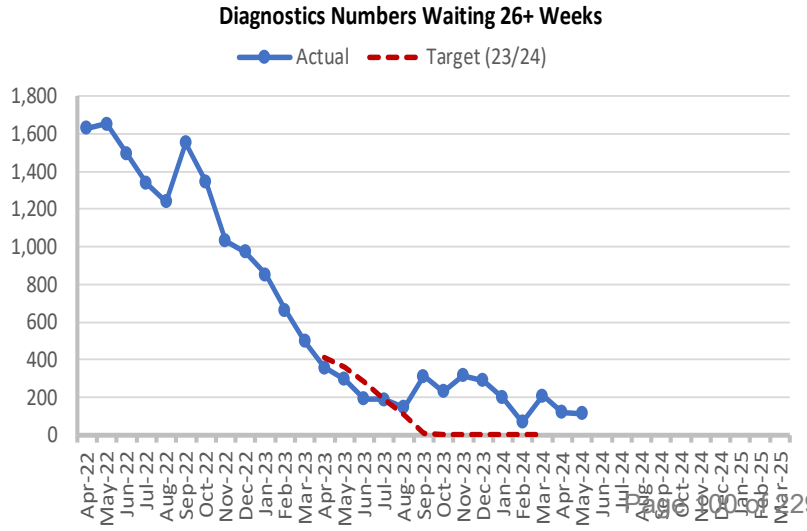
Reporting Month: May 2024

STANDARD **DIAGNOSTIC WAITING TIMES**









Integrated Quality and Performance Report

Reporting Month: May 2024

STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS & WAITS IN A&E FROM ARRIVAL TO DISCHARGE, ADMISSION OR TRANSFER
Performance	**Waits in ED from arrival to discharge, admission or transfer** The total time spent in the emergency department (ED) measures from arrival time to discharge/admission time. There are two standards reported: • The "4 Hour Standard". This is the standard that has been reported in previous years and had a constitutional standard of 95%. For 2024/25, systems are required to return performance to 78% by March 2025, i.e. 78% of ED attendances should spend less than 4 hours in ED. UHBW is required to deliver 71.8% by March 2025 to contribute to the 78% system target. • The "12 Hour Standard". This standard was introduced in 2023/24 and reports the proportion of patients attending ED who wait more than 12 hours from arrival to discharge, admission or transfer. This has an operational standard of no more than 2%. Note: both standards apply to all four emergency departments in the Trust. During May, 68.01% of patients attending ED spent less than 4 hours in an emergency department from arrival to discharge or admission. This is below the operational planning trajectory of 69.0% for May. The May performance for the "12 Hour Standard" shows an improvement to 3.9%, compared to 4.11% in April, with 721 patients spending more than 12 hours in ED out of a total of 18,504 attendances. **Attendances** • BRI attendances were 67,146 in May (average 231 per day), which is a 1.1% increase on the daily attendance figure seen in April and a 3.9% increase from May 2023 which averaged 222 attendances per day. • Children's Hospital attendances were 4,184 in April (average 135 per day). This represents a 7% increase from the 126 attendances per day in April and a 1.0% increase from May 2023 which averaged 134 attendances per day. • Weston Hospital attendances were 4,763 in May (average 154 per day). This is a 2.7% increase from the 150 attendances per day in April and a 9.0% increase from May 2023 which averaged 141 attendances per day. • Eye Hospital attendances were 2,411 in May (78 per day), which is a 1.1% increase from the 77 attendances per day in April and an 4.1% increase from May 2023 which averaged 75 attendances per day. **12 Hour Trolley Waits** This metric relates to patients who are admitted from ED, and measures from the Decision To Admit (DTA) time to the Admission Time. During May, there were 321 12 Hour Trolley Waits, compared to 350 in April. **Ambulance Handovers** Following handover between ambulance and ED the ambulance crew should be ready to accept new calls within 15 minutes. The two metrics reported are the number and percentage of handovers that are completed within 15 or 30 minutes. The current improvement targets are that 65% of handovers should be completed within 15 minutes and 95% within 30 minutes. Of the 3,985 ambulance handovers in May: • 1,227 ambulance handovers were within 15 minutes which was 30.8% of all handovers. • 2,668 ambulance handovers were within 30 minutes which was 67.0% of all handovers.

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University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E
National Data:	Ambulance Handovers: There are 19 hospitals in the South-West that the Ambulance Service reported data for April 2024, overall percentage of handovers under 15 minutes was 23.7% across these hospitals. The Children's Hospital ranked first (best performing) with 67% of handovers under 15 minutes, Weston was 5th highest at 29% and BRI was 8th highest at 24%. ED 4 Hours: For Quarter 4 across all Type 1 Emergency Departments in England, 57.7% of patients were seen within 4 hours. UHBW was at 61.5%. The upper quartile was 63.0% (i.e. 25% of Emergency Departments achieved 63.0% or above in Quarter 4).
Actions:	**Bristol Royal Infirmary (BRI)** • The Emergency Department sees an ongoing growth in attendances with an average of 231 patients per day seen in May, an increase from 228 per day in April. • During May, 4-hour performance improved to 52.7% up slightly from 52.0% the previous month. • 5.3% of attendances had a 12+ hour length of stay in the department, up from 4.8% in April. • 953 hours were lost to ambulance handover delays at BRI ED in May which equates to an average of 30.7 hours per day; compared to April when 912 hours were lost (an average of 30.4 hours per day). • The Proactive Hospital team are supporting with a review of the ED to Radiology pathway with a focus on reducing CT diagnostic turnaround times, in addition to ongoing work with Diagnostics & Therapies division to improve blood result turnaround times. • The Department have also established a Patient First team to deliver improvements. • The key aim for the next month is to run an 'ED Perfect Week' to trial a new Rapid Assessment and Triage (RAT) process and improve Ambulance Service handovers, to reduce the number of hours lost to ambulance handovers. **Weston General Hospital (WGH)** • Emergency Department attendances increased in May to an average of 154 per day, from an average of 150 per day in April. • Overall attendances in April and May 2024 were 13% higher than in April and May 2023 and an analysis is currently being carried out to understand the drivers behind this increase. • Admissions to the bed base remained stable at an average of 31 patients per day, compared with 30 in April and 31 in March. • ED 4-hour performance improved to 69% in May with improvements in flow across the hospital. • A focus on structured huddles with the ED team to improve four-hour performance is taking place in June. • Attendances in the Acute Medicine HOT (emergency) clinic increased to 40 in May, from 26 in March and 28 in April and a review of the clinic location and timings is underway to further increase activity. Patients discharged home from the Acute Medical Unit also increased to 29%, from 26% in April. • Length of stay in the Older Persons Assessment Unit increased slightly in May to 2.0 days (from 1.9 in April). A review of flow through the Care of the Elderly bed base is being carried out by the Care of the Elderly team. • Two new ED consultants have been recruited meaning the department is now fully established regarding medical staff. Page 102 of 229 *...continued over page*

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STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E
Actions (continued):	**Bristol Royal Hospital for Children (BRHC):** May 2024 saw 4,184 attendances (average of 135 per day), which is relatively similar to the attendances when comparing to May 2023 (4,144), but an increase on the 3,784 attendances recorded in April 2024 (average of 126 per day). ED 4-hour performance in May was 78.6% which is a decrease on the 86.7% achieved in April, and also very close to May 2023 (78.4%). There were 17 x 12hour breaches in May, which is an increase on the 4 recorded in April 2024 but a significant decrease against the 54 recorded in May 2023. **Same Day Emergency Care (SDEC):** The development of the SDEC offer across the Trust aims to redirect clinically appropriate patients away from Emergency Departments to support patient flow, reduce waiting times and minimise unnecessary admissions. **Surgical SDEC – BRI:** Attendance during May shows the service seeing 455 patients, this is the highest number since March 2023 when 377 patients were seen. April had also seen the highest percentage of patients discharged home at 82.1%, which dropped slightly in May to 79.1%. Length of stay data is undergoing review and so has not been presented this month. The number of reattendances in ED following an SDEC visit had dropped to their lowest point in Quarter 4 2023/24, but this increased in April to 45 reattendances before dropping again in May to 39 patients. The average wait in ED before a Surgical SDEC visit continues to remain below the 4-hour target. Key aims: • Review of space within the Trust to support expansion is ongoing and this includes an options appraisal of potential sites for the Surgical SDEC – Clinical lead walkaround has now taken place. • Opportunities to further enhance orientation of Advanced Practitioners continue to be explored with the newly appointed Clinical Leads. • Discussion of expected patients and notes audits findings to take place the results of which will guide next actions. • Improvement team support now allocated which will support progression of the creation of a Surgical SDEC discharge summary. • Separation of the service from the Surgical and Trauma Assessment Unit (STAU) continues with associated documentation currently under review. *…continued over page*

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Reporting Month: May 2024

STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E
Actions (continued):	**Medical SDEC - BRI:** • Medical SDEC continues to deliver a 70-hour weekday and 24-hour weekend service, compliant with standard. • SDEC saw 727 patients in May 2024, a 2% increase compared to April (712). • The service saw 9% of front door attendances and 22% of patients on the medical take; the admission rate reduced slightly to 25% (26% in April) and the average length of stay in SDEC reduced to 4 hours 35 minutes from 4 hours 50 minutes in April. • The service continues to work on increasing the number of direct referrals from the Ambulance Service into SDEC and in May received 57 direct referrals, of which 12% were admitted. **Weston SDEC**: • In May there were 769 attendances at SDEC, an average of 25 per day, remaining stable from April (24 attendances per day). • 422 of the attendances were from the Emergency Department (ED), which was 9% of May's total ED attendances, this is a drop from 10% in April and 12% in March. The ED and SDEC teams have reviewed handover and referral processes in May to increase SDEC activity from ED. • Work is ongoing to develop a model for frailty SDEC, working in conjunction with the Geriatric Emergency Medicine Service (GEMS) service. • Work on the new urgent care facility at Weston is expected to start in June 2024, including development of a new SDEC facility.
Risks:	Corporate Risk 910: Risk that patients in ED do not receive timely and effective care 4700: Risk that a patient may deteriorate whilst being held in the ambulance bay

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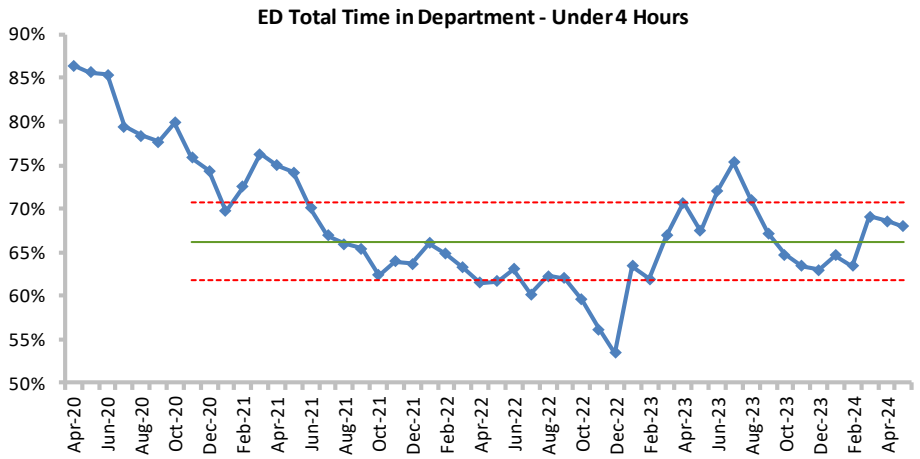
NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

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

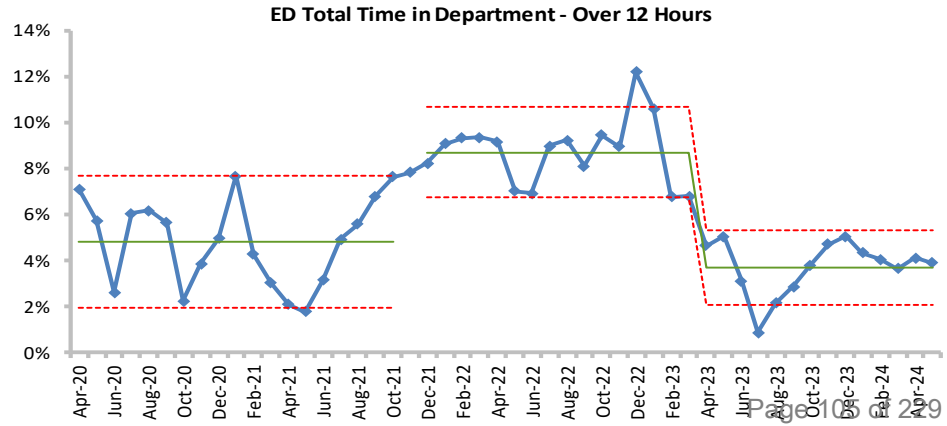
Patients Who Spend Under 4 Hours In ED (Arrival to Discharge/Admission)

4 Hour Performance	May-24	2024/25	2023/24
Bristol Royal Infirmary	52.72%	52.34%	54.19%
Bristol Children's Hospital	78.59%	82.43%	75.64%
Bristol Eye Hospital	93.12%	94.04%	95.74%
Weston General Hospital	68.97%	67%	65.86%
UHBW TOTAL	**68.01%**	**68.27%**	**67.58%**



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

12 Hour Performance	May-24	2024/25	2023/24
Bristol Royal Infirmary	5.3%	5%	5%
Bristol Children's Hospital	0.4%	0.3%	1.5%
Bristol Eye Hospital	0%	0%	0%
Weston General Hospital	6.9%	7.7%	5.7%
UHBW TOTAL	**3.9%**	**4%**	**3.7%**



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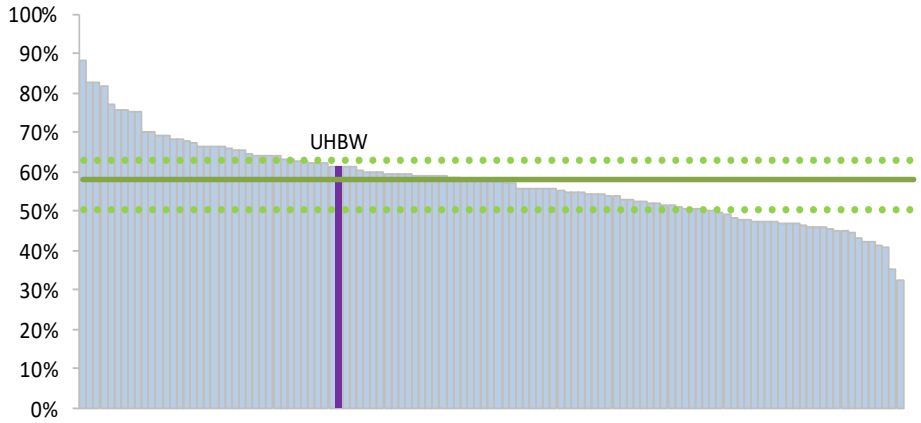
University Hospitals Bristol and Weston NHS Foundation Trust

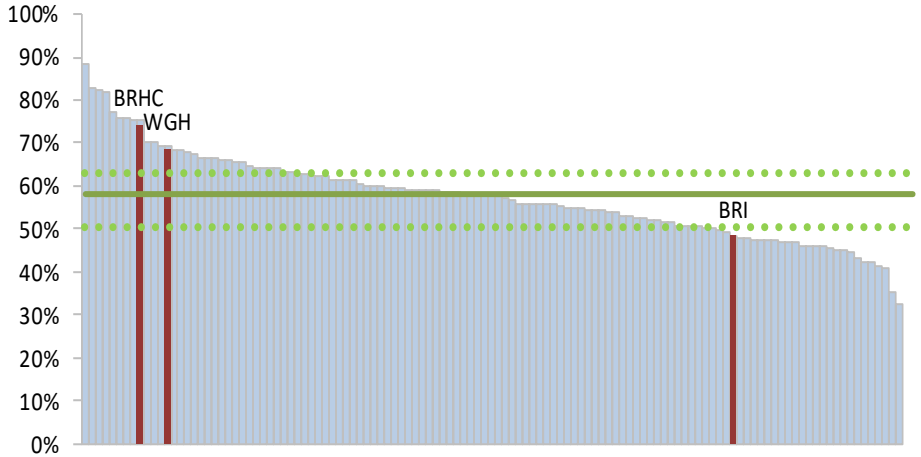
Reporting Month: Quarter 4

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

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



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



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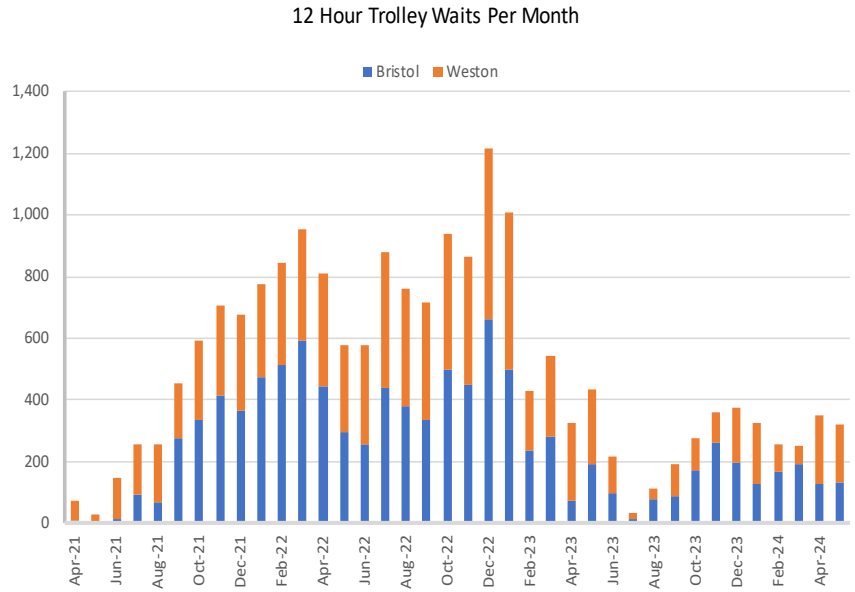
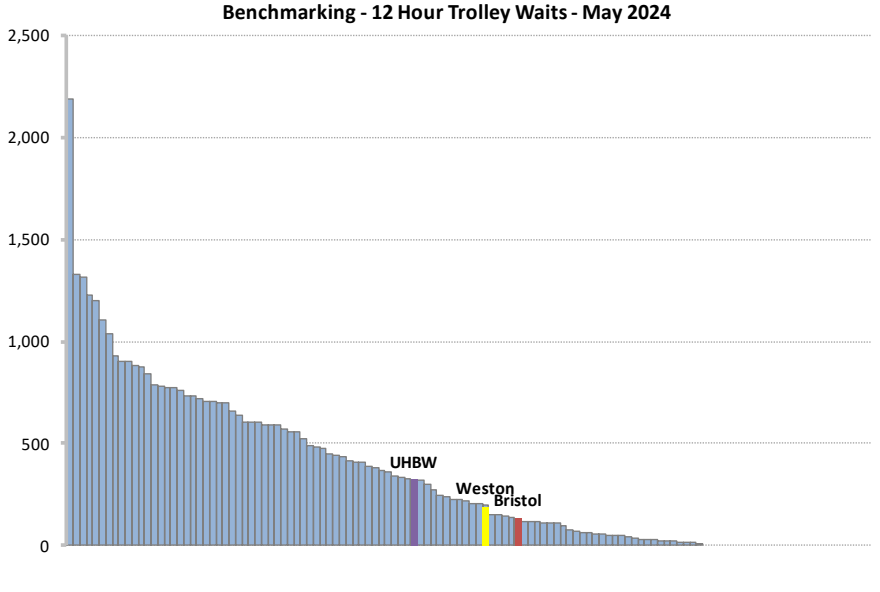
STANDARD **EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E**

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

	2022/2023												2023/2024												2024/2025	
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Bristol	443	297	257	437	379	334	496	449	659	500	235	278	74	192	95	11	79	89	172	259	195	125	164	189	129	131
Weston	366	282	319	441	379	383	445	413	558	506	192	267	250	243	119	23	33	104	104	102	181	202	91	60	221	190
UHBW	**809**	**579**	**576**	**878**	**758**	**717**	**941**	**862**	**1217**	**1006**	**427**	**545**	**324**	**435**	**214**	**34**	**112**	**193**	**276**	**361**	**376**	**327**	**255**	**249**	**350**	**321**





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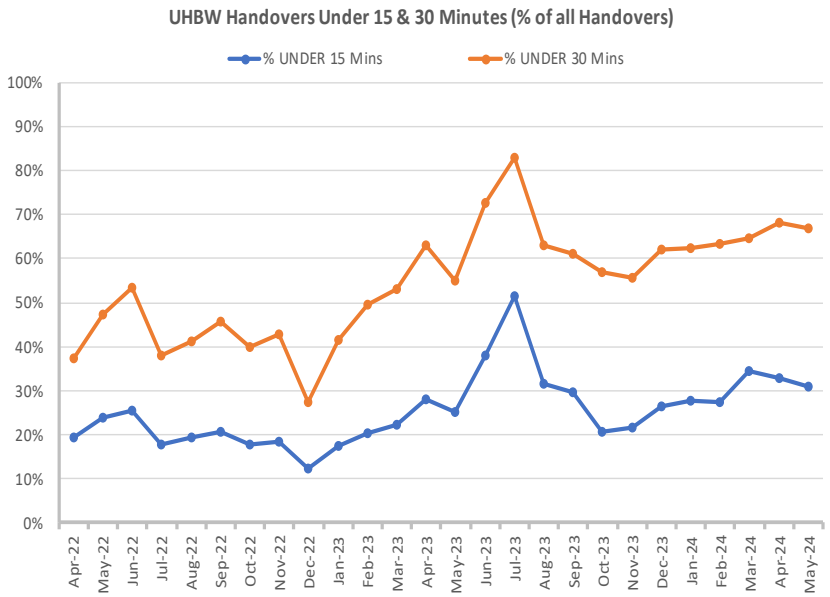
University Hospitals Bristol and Weston NHS Foundation Trust

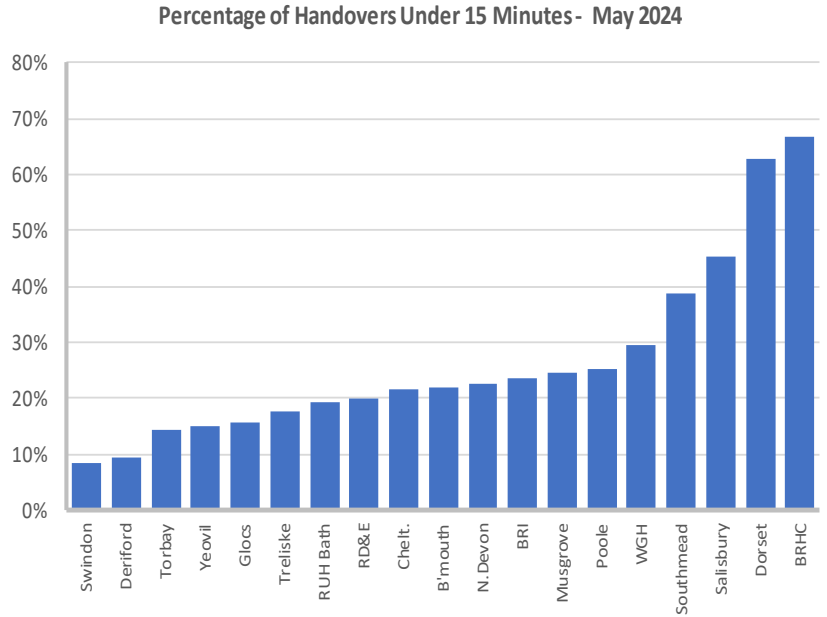
Reporting Month: May 2024

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

Ambulance Handovers

May-24							
	Total Handovers	Under 15 Mins	% Under 15 Mins	Under 30 Mins	% Under 30 Mins	Average Handover Time (Minutes)	Total Hours Above 15 Mins
Bristol Royal Infirmary	2,478	587	23.7%	1,435	57.9%	38.4	1,005
Bristol Children's Hospital	522	349	66.9%	470	90.0%	17.5	45
Weston General Hospital	985	291	29.5%	763	77.5%	27.4	221
UHBW Total	**3,985**	**1,227**	**30.8%**	**2,668**	**67.0%**	**33.0**	**1,271**





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University Hospitals Bristol and Weston NHS Foundation Trust

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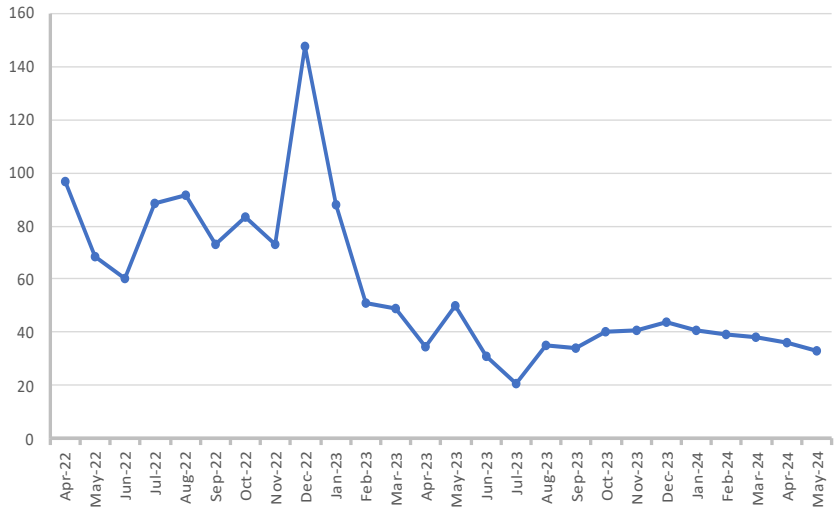
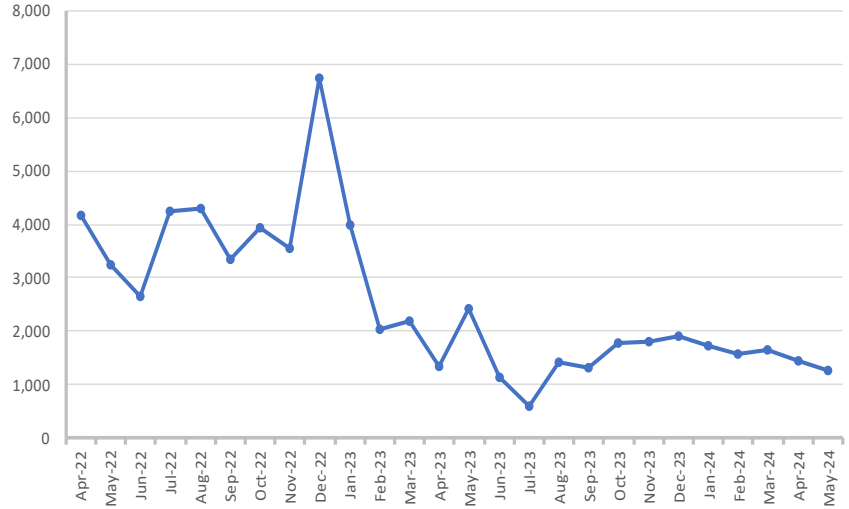
STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E

Ambulance Handovers (continued)

Average Handover Time (Minutes)



Hours Lost: Handovers over 15 Minutes



Integrated Quality and Performance Report

Reporting Month: May 2024

STANDARD	EVERY MINUTE MATTERS
Background:	The Every Minute Matters (EMM) programme has four work streams. **1. Implementation of the SAFER bundle – including Estimated Date of Discharge EDD:** A bundle of principles that advocates best practice in optimising flow. It includes early senior review, flow of patients from admission units to downstream wards before 10am, timely discharges and daily review of all patients with a length of stay greater than seven days. **2. Proactive Board Rounds:** Focuses on implementing daily board rounds with a consistent structure that proactively progresses adult patients towards safe, timely discharge through effective multidisciplinary collaboration. **3. Criteria to Reside - Using the MCAP tool:** Comprises 11 nationally defined criteria to ensure patients who require acute care are in the most appropriate bed. The criteria identify where patients no longer require acute care and can be discharged safely to their home or within the community. MCAP is the digital system that determines whether a patient is in the right bed for their care, whether there is a delay in their pathway, and what their next care location should be. **4. Optimising use of the Discharge / Transition Lounge:** Optimising the use of the discharge lounge so that it is embedded as a routine part of the inpatient pathway - freeing acute beds early for new unplanned admissions and elective activity.
Performance:	1. Percentage of patients with a “timely discharge” (before 12 noon). May had 15.8% discharged before 12 noon (no change from March). The SAFER bundle standard is to achieve 33%, though the Trust are reviewing this as there is no longer evidence that this produces a "best in class" outcome. Using the Patient First methodology, the focus is on timely discharge to identify actions which will bring the discharge curve forwards. 2. Percentage of patients discharged via the BRI or Weston Discharge Lounges. In May 27.0% of eligible discharges went through the Weston or BRI Discharge Lounges, compared to 27.4% in April. This was 793 patients, averaging 37.8 patients per working day (excluding bank holidays). a. BRI achieved 27.1%, with 576 patients. This averages to 27.4 patients per working day (excluding bank holidays). b. Weston achieved 26.8% with 217 patients. This averages to 10.3 patients per working day (excluding bank holidays). 3. At the end of May there were 138 No Criteria To Reside (NCTR) patients in hospital: 83 in Bristol and 55 in Weston. 4. During May, 4,824 bed days were consumed by NCTR patients (1 bed day = 1 patient in bed at 12midnight). This gives a daily average number of patients with no criteria reside of 156 (69 at Weston and 86 at Bristol). This is equivalent to saying 156 beds, on average, were occupied each day by NCTR patients. For May, the NCTR bed days occupied 17.8% of the total occupied bed days.

Integrated Quality and Performance Report

Reporting Month: May 2024

STANDARD	EVERY MINUTE MATTERS
Actions:	**Timely Discharge** **Key priorities for Every Minute Matters (EMM) programme include:** • **Proactive Board Rounds:** updated SOP signed off and available on MyStaff app. Adult inpatient wards should be following the principles in their morning board rounds. Initial work is underway to review how Surgery wards covered by multiple specialities can implement the principles of the proactive board round. • **Criteria to Reside (CtR) reporting:** A new reporting process went live on 10th June. Initial compliance in completing CtR information is good; additional work needed to ensure that this is integrated in the Proactive Board Rounds across all areas. Reporting is in place to monitor compliance, for use in flow meetings and for other teams that support flow and discharge. • **Wardview rationalisation and governance:** A standardised version of Wardview has been reviewed and agreed with all divisions. Information from the Proactive Board Round (PBR)clinical note now pulls through live to Medicine ward boards with other divisions to follow from 1st July and a governance group has been set-up with representation from all divisions. A solution is still required for Weston wards as they do not currently have access to Wardview and are therefore duplicating some tasks. **Proactive Hospital Improvement Coach supported work:** • **Discharge Lounge improvement:** now moved to BAU with Discharge Lounge improvement group in place and reporting to Every Minute Matters programme group • **Discharge checklist:** now BAU. Survey to be conducted for feedback on new process. • **BRI ED to CT pathway review:** project group set up and process mapping underway • **Interprofessional standards:** standards have been agreed with positive feedback from staff. Communications and launch plans are underway with a scheduled launch date of 9th September • **Specialty pathways review**: set up of project group under-way

Integrated Quality and Performance Report

Reporting Month: May 2024

STANDARD	EVERY MINUTE MATTERS
Actions (continued):	**No Criteria To Reside (NCTR) and Transfer of Care Hub (ToCH)** **No Criteria To Reside (NCTR) and Transfer of Care Hub (ToCH)** Applying the methodology of continuous improvement, the Transfer of Care Hubs are working on a number of core principles which align with the Every Minute Matters principle of respecting patients' time. This includes actions to reduce the number of people waiting in hospital for onward care, and the number of days they are delayed for: • Reduction in NCTR length of stay (particularly for the longest waiting patients), through weekly multi-disciplinary team (MDT) escalation reviews. • Sirona recruitment ongoing at WGH, with Sirona still to establish a 7-day working model • North Somerset Council have gaps but recruitment is underway • Voluntary Sector supporting at both Transfer of Care Hubs A significant focus on the Transfer of Care Hubs is on transformation and improvement, with the following initiatives underway: • D2A are working with external consultancy Whole Systems Partnerships (WSP) to develop a demand and capacity modelling tool. Having achieved a 25% reduction is LOS against LGA baseline 21/22, saving 128 beds across the BNSSG acute bed base. Using this modelling tool, a new baseline is being calculated. • 73 less community beds in use between March 23 and March 24 • Significant shift away from nursing care home to more Home First options • Increased flow in P1 pathway for patients going home requiring care • Developing an action plan to reduce internal delays across both sites • Working with health and social care partners to agree process measures to support a reduction in Length of Stay and shift towards Home First model. • Improving the timeliness of referral to community providers via same day submission (Baseline:38% May Audit: 74%) • Streamlining the Bristol, North Somerset and South Gloucestershire (BNSSG) process of referral to community providers, including a trusted assessment for home care • Working with partners to improve efficiencies in processes to reduce length of stay
Risks:	Strategic Risk 423: Risk that demand for inpatient admission exceeds available bed capacity. 6874: Risk that ways of working are not changed ToCH partners will operate in silo impeding the team's ability to discharge patients.

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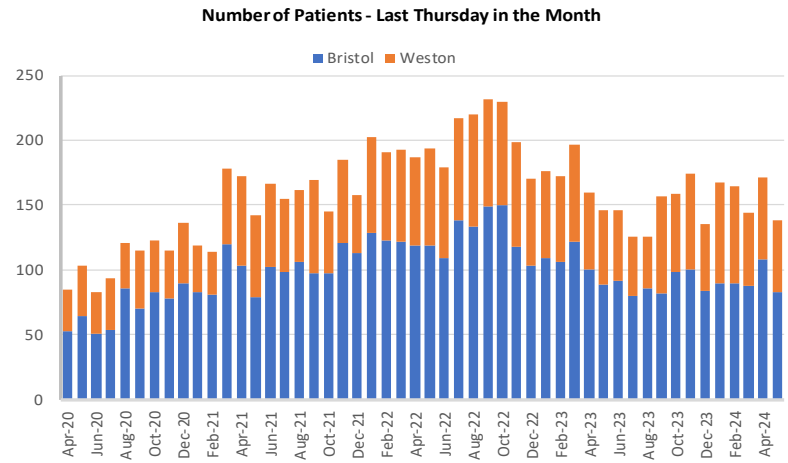
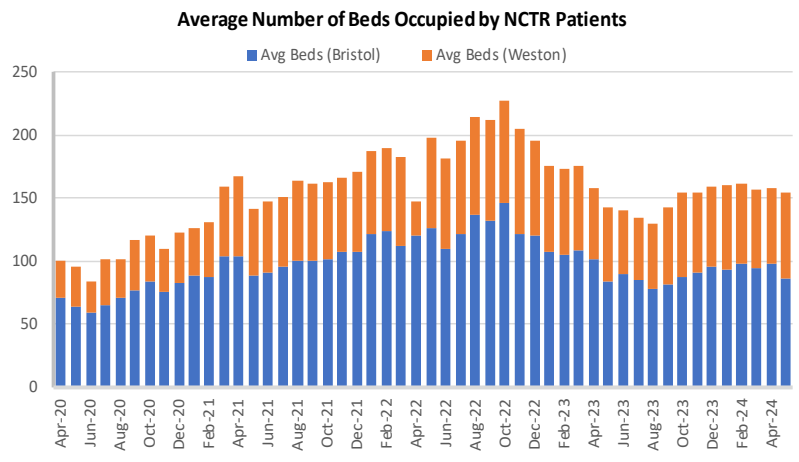
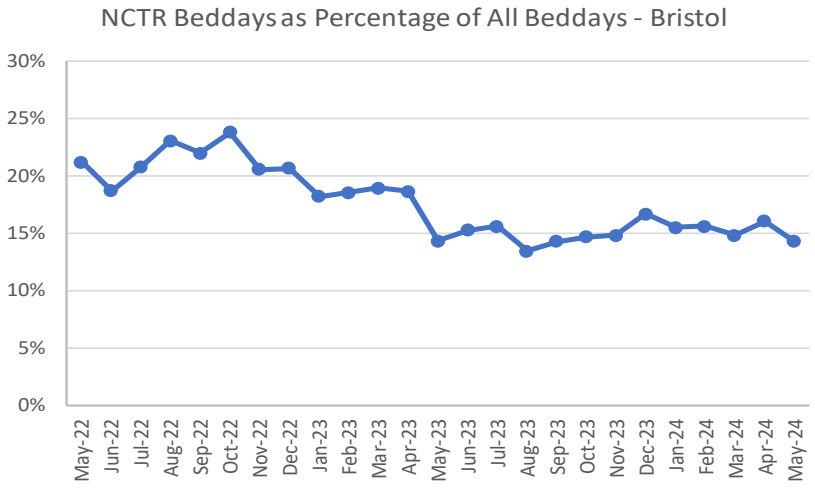
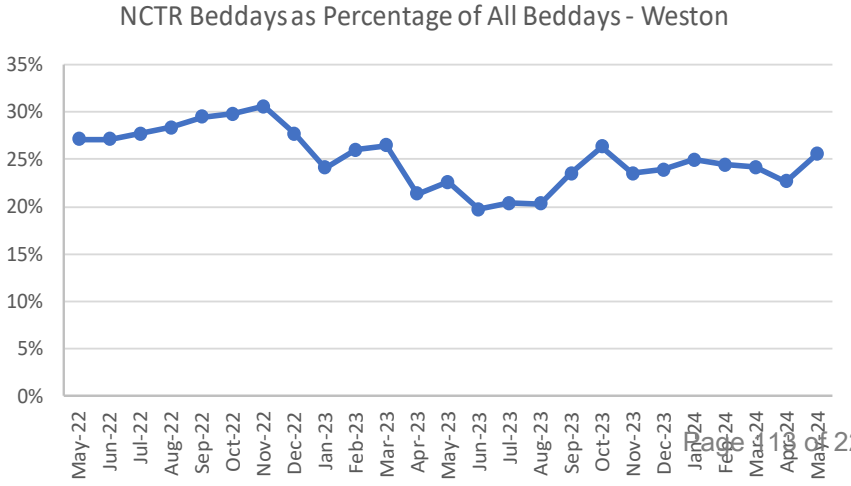
Reporting Month: May 2024

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









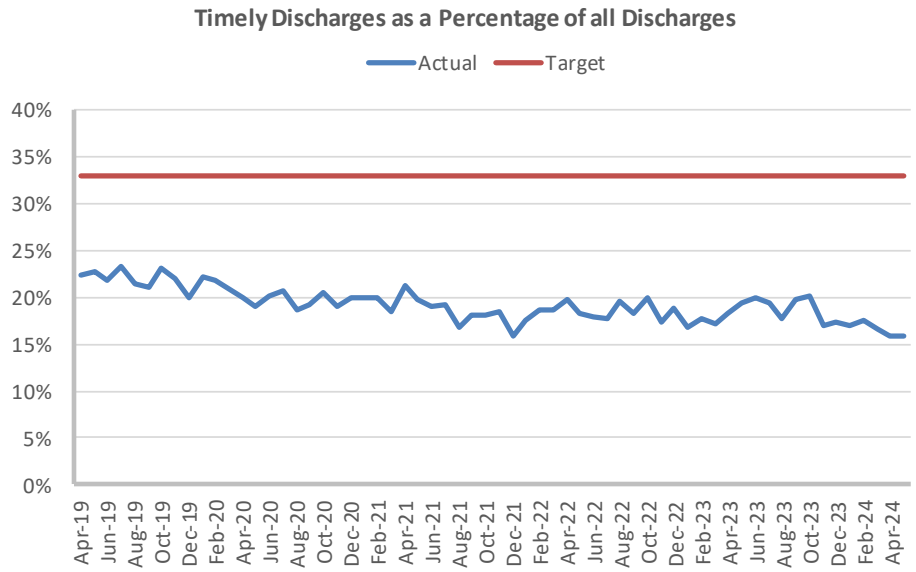
Integrated Quality and Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

STANDARD **EVERY MINUTE MATTERS - TIMELY DISCHARGE**

Timely Discharge (Before 12 Noon)



Summary of High Volume Specialties - May 2024

	Total Discharges	% Before Noon
Cardiac Surgery	106	13.2%
Cardiology	304	14.5%
Clinical Oncology	82	4.9%
Colorectal Surgery	125	4.8%
ENT	90	12.2%
Gastroenterology	120	14.2%
General Medicine	653	18.7%
General Surgery	232	13.4%
Geriatric Medicine	272	29.0%
Gynaecology	152	16.4%
Ophthalmology	77	31.2%
Paediatric Surgery	81	22.2%
Paediatrics	214	17.3%
Thoracic Medicine	162	14.2%
Trauma & Orthopaedics	237	19.8%
Upper GI Surgery	36	16.7%
UHBW TOTAL	**4,040**	**15.8%**

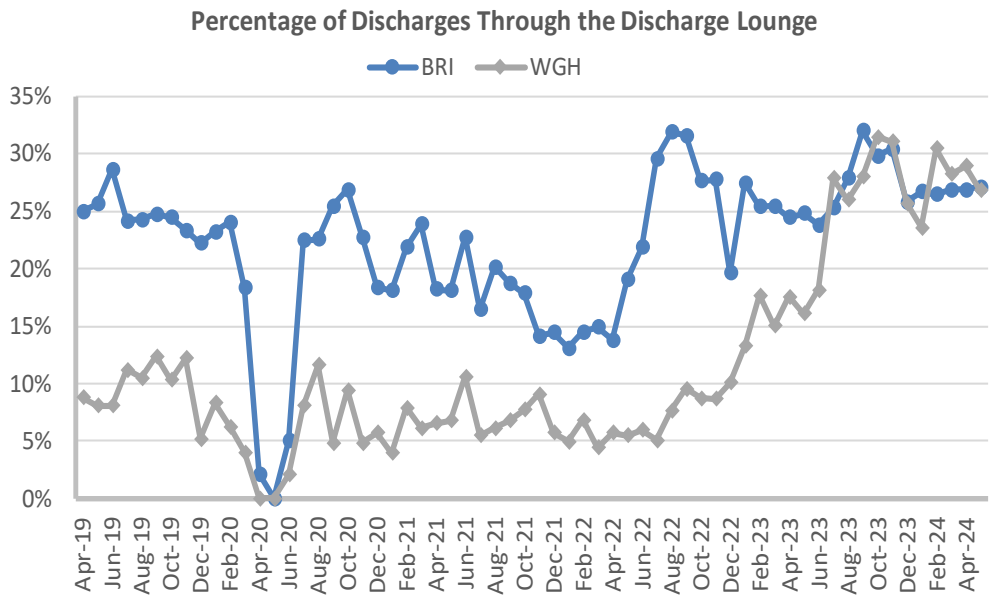
Integrated Quality and Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

STANDARD **EVERY MINUTE MATTERS - TIMELY DISCHARGE**

Discharge Lounge Use Summary



Summary of High Volume Specialties - May 2024

	BRI	WGH	TOTAL
Accident & Emergency	11.4%	2.4%	9.5%
Cardiac Surgery	68.1%	-	68.1%
Cardiology	50.9%	42.1%	50.3%
Colorectal Surgery	15.9%	38.5%	18.3%
ENT	7.9%	-	7.9%
Gastroenterology	17.5%	21.2%	19.8%
General Medicine	28.2%	26.7%	27.5%
General Surgery	12.4%	28.8%	18.1%
Geriatric Medicine	40.6%	34.3%	39.0%
Hepatobiliary and Pancreatic Surgery	31.0%	-	31.0%
Maxillo Facial Surgery	8.9%	-	8.9%
Thoracic Medicine	16.7%	13.0%	15.5%
Thoracic Surgery	13.5%	-	13.5%
Trauma & Orthopaedics	23.0%	41.2%	30.8%
Upper GI Surgery	17.4%	27.3%	20.6%
UHBW TOTAL	**27.1%**	**26.8%**	**27.0%**

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NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

2024/25 YTD Income & Expenditure Position	• Net I&E deficit of £6,322k against a breakeven plan (excluding technical items). • Total operating income is £1,227k adverse to plan due to lower than planned income from activities (£424k) and other operating income (£803k). • Total operating expenditure is £5,745k adverse to plan due to higher than planned non-pay costs at £6,447k and lower than planned pay expenditure at £806k. Depreciation and financing costs are marginally favourable to plan, mainly due to interest receivable.
Key Financial Issues	• *Recurrent savings delivery below plan* – YTD CIP delivery is £4,210k or 64% of plan, of which recurrent savings are £2,753k, 42% of plan. • *Delivery of elective activity below plan* – elective activity must be delivered in line with plan. At M2, the cumulative YTD value of elective activity is £2.6m behind plan, a deterioration of £1.3m in May. A continuation of the YTD performance could result in a total loss of income of up to £15.6m and may result in the Trust failing to meet the financial plan. • *Corporate mitigations not delivered in full* – non-recurrent mitigations of £1,164k were delivered at the end of May. • *Failure to deliver the financial plan* – failure to deliver the actions and therefore the financial plan of break-even will constitute a breach of this statutory duty and will result in regulatory intervention.
Strategic Risks	• 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.

Integrated Quality and Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

Trust Year to Date Financial Position

	Month 2			YTD		
	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's
Income from Patient Care Activities	91,077	91,793	716	181,249	180,825	(424)
Other Operating Income	9,886	8,137	(1,749)	19,772	18,969	(803)
Total Operating Income	**100,963**	**99,929**	**(1,034)**	**201,021**	**199,794**	**(1,227)**
Employee Expenses	(59,618)	(56,780)	2,838	(119,236)	(118,430)	806
Other Operating Expenses	(36,463)	(42,213)	(5,750)	(72,437)	(78,884)	(6,447)
Depreciation (owned & leased)	(3,789)	(3,848)	(59)	(7,162)	(7,266)	(104)
Total Operating Expenditure	**(99,870)**	**(102,841)**	**(2,971)**	**(198,835)**	**(204,580)**	**(5,745)**
PDC	(1,210)	(1,208)	2	(2,420)	(2,417)	3
Interest Payable	(247)	(234)	13	(494)	(465)	29
Interest Receivable	292	456	164	584	937	353
Net Surplus/(Deficit) inc technicals	**(72)**	**(3,899)**	**(3,827)**	**(144)**	**(6,731)**	**(6,587)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	72	178	106	144	409	265
Net Surplus/(Deficit) exc technicals	**0**	**(3,721)**	**(3,721)**	**0**	**(6,322)**	**(6,322)**

Key Facts:

- The position at the end of May is a net deficit of £6,322k against a breakeven plan, £3,722k worse than the previous month.
- Significant variances in the year-to-date position include: the value of elective income behind plan by £2,600k and a shortfall on savings delivery of £2,355k.
- In May the Trust has spent £146k on costs associated with Internationally Educated Nurses (IENs).
- Pay expenditure at the end of April is c£800k lower than plan, although higher than planned medical staffing and nursing costs continue to cause concern across some divisions.
- Agency expenditure in month is £1,276k, compared with £1,573k in April. Bank expenditure in month is £5,829k, compared with £5,711k in April.
- Total operating income is below plan by £1,227k, mainly due to other operating income.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9 July 2024

Report Title	A framework of quality assurance for responsible officers and revalidation. Annex D – annual board report and statement of compliance
Report Author	Dr Helen Rees
Executive Lead	Dr Rebecca Thorpe

1. Purpose
To demonstrate compliance with regulations and key national guidance related to appraisal and revalidation - appraisal year 2023/2024
2. Key points to note *(Including any previous decisions taken)*
Overall appraisal and revalidation at UHBW has continued in a positive direction, though continued work pressure and the junior doctor industrial action have all impacted on the ability to improve the appraisal rate further. All actions from the previous board report have been completed. We now have a new Interim CMO Team in place and a new Medical and Dental Appraisal & Revalidation Lead in post since Oct 2023. The team continues to work hard to optimise and streamline processes to ensure governance is robust and our appraiser team are up to date and supported. Overall conclusion: Overall a good year for revalidation and appraisal, with compliance and revalidation recommendations in line with other similar sized organisations.
3. Strategic Alignment
n/a
4. Risks and Opportunities
None
5. Recommendation
This report is for **Information.** The board is asked to approve this report which provides assurance regarding appraisal and revalidation activity at UHBW prior to submission to NHSE
6. History of the paper. Last presented:

Meeting of the Board of Directors in Public	**July 2023**

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2024

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team of UHBW can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

> **Action from last year**: The Deputy RO is stepping down from the post in October 2023 and therefore a handover to the new deputy needs to take place prior to this date. A successor has been identified and this is in action.
>
> **Comments:**
> Dr Anne Frampton stepped down as Deputy RO and Deputy Medical Director for revalidation and appraisal as planned in October 2023 and Dr Rebecca Thorpe was appointed as Deputy Medical Director for Professional Standards and Revalidation and Deputy RO.
> Professor Stuart Walker temporarily stepped down as RO having been appointed as Interim Chief Executive Officer, Dr Rebecca-Anne Maxwell now holds the Responsible Officer (RO) role as Interim Chief Medical Officer (CMO).
> Dr Helen Rees started in the newly created post of Revalidation and Appraisal Lead in October 2023.
>
> **Action for next year:** Update interim roles as above

2. The designated body provides sufficient funds, capacity, and other resources for the responsible officer to carry out the responsibilities of the role.

> **Yes**
>
> **Action from last year:** Ensure actions are completed and that the number of appraisers within the organisation is maintained and appropriately remunerated for the role.
>
> **Comments:** All actions have been completed, but work will continue to maintain the improvements in appraisal rates within dental teams and the recruitment of new appraisers. Work has continued with divisions and HR around approaches to appraisers and job planning.
>
> **Action for next year:** Continue working with HR and Divisions around approaches to appraisers and job planning. Explore potential for more shared appraisers with North Bristol Trust and continue working with divisions around job planning for appraisers.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Continue to maintain lists.

Comments: As the online appraisal toolkit automatically links to the GMC we ensure visibility of all connected doctors. Regular review of the list of prescribed connections is undertaken to ensure it remains up to date, however challenges remain around the high turnover of staff bank doctors.

Action for next year: Continue to maintain lists.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Review and update the Medical Appraisal and Revalidation policy before year end 23/24

Comments: Action completed. The revised policy was approved and live from Autumn 2023, next due for a full revision in July 2026

Action for next year: Review Medical Appraisal and Revalidation Policy for minor amendments should local changes to the online portfolio occur.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Complete any outstanding actions on the plan

Comments: All actions that were in progress on the plan are now completed, including the appraiser capacity review, and the creation of the new post of Medical Appraisal Lead and a successful appointment made.

Action for next year: Consider a future peer review with NBT.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Continue

Comments: Yes. All doctors have access to Fourteen Fish and an appraiser, as well as supporting material, to ensure they are aware of their requirements. Provision is also included within Fourteen Fish to appraise at UHBW and maintain a connection with another Trust and to use the facility of this portfolio for their revalidation. They are all contacted on an individual basis by the Appraisal Lead and an individualised plan is made for each depending on their own circumstances.

For Clinical Fellows compliance is good, and we have visibility of locum and bank doctors though as noted above these doctors remain the most challenging group to identify.

Action for next year: Continue to actively ensure that all Clinical fellows and bank/locum doctors are designated a supervisor within 3 months of starting within the trust

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Nil

Comments: All appraisals are all reviewed prior to revalidation to ensure full scope of practice is covered and there is an additional check built into the appraisal system to require doctors to declare if they undertake private practice.

In addition, there is close liaison with local private sector providers to ensure appropriate information transfer. There is a regular complaints feed into the appraisal process and a regular feed of low-level concerns at divisional level.

The new appraisal formal and the QA process has highlighted the need for robust summaries as not all information is now uploaded to portfolios. The new change to the appraisal template for 2022/3 was welcomed as this provides a better balance of information and verbal reflection and support appraisers better in providing a balanced summary of the meeting. Feedback from doctors is that they prefer the new format and find it less onerous to complete.

Regular appraiser updates sessions are offered to support the appraisers, discuss challenging encounter, provide peer support and also to identify issues in the appraiser processes

Action for next year: Nil

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue to ensure an appropriate action plan is put in place for non-engaging doctors which are discussed at our internal Responsible Officer Approval Group meeting, and where no other reason for

not undertaking appraisal has been identified, agree issuing of REV 6 notifications.

Comments: Where a doctor has not completed an appraisal in year (other than approved missed appraisals) the appraisal date is bought forward to the beginning of the next year to ensure that the length of time between appraisals is minimised. As an organisation we always try to work with them locally and have continued our efforts to engage our medical workforce with support from our GMC ELA. In May 2024, after applying our escalation process, we have now commenced sending REV 6 notifications. These doctors are discussed at our monthly ROAG meeting.

These doctors are discussed at our internal ROAG meeting and an appropriate action plan put in place

Action for next year: Continue this process

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Review the Appraisal and Revalidation policy

Comments: completed and approved July 2023

Action for next year: nil

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Continue to ensure that appraisal capacity is maintained

Comments: This will continue to be reviewed. Timing of appraisals is an issue monitored by the team and a system is in place to regularly review overdue appraisals and escalate rapidly and appropriately from local level to trust-wide level.

Action for next year: Continue to ensure that appraisal capacity is maintained

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Action from last year: To respond to feedback from appraisers to continue to refine and develop the content to meet their needs, and continue to develop this process

Comments: The appraiser update schedule for the last year has been significantly impacted by Industrial Action periods which have meant several have had to be cancelled. We would usually aim to hold 6-8 annual events across both sites or online to ensure access for appraisers from both organisations. A record of attendance of these events is maintained, and access to material discussed at the events is made available to all appraisers on the workspace on the ensure access for appraisers from both organisations. Topics included feedback from the GMC, updates from NHSE and signposting for Wellbeing and Support

We work to ensure these updates are useful and a supportive and a way to share challenges around appraisal and develop ways to improve as a team.

Action for next year: Continue to develop this process.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Continue to develop and refine this process

Comments: the QA process continues and has also been picked up through the peer review process. There remains ongoing training with appraisers to ensure high quality appraisal outputs and feedback is in place.

Action for next year: Continue to develop and refine this process

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as of 31 March 2024	1204
Total number of appraisals undertaken between 1 April 2023 and 31 March 2023	984
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	220
Total number of agreed exceptions	67

Section 3 – Recommendations to the GMC

0. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None

Comments:

147 doctors came under notice for revalidation in 2023/24

107 positive revalidation recommendations were made

40 doctors were deferred; 39 due to insufficient appraisal activity; 1 doctor is currently under investigation and on hold.

Our deferral rate appeared to have increased this year and there was a combination of reasons for agreed deferral with many doctors experiencing periods of time off for sickness family reasons or sabbaticals.

There were an increased number of incomplete appraisals with no specific reason given. We are aware of the pressure that our doctors are under with the impact of industrial action, increased waiting lists and intensity of workload, so have previously resisted utilising the GMC REV6 warning notices around non engagement.

We have issued no REV6 notices for the 2023/24 year, and with changes to the appraisal and revalidation team we are committed to increased rigor in this area.

Action for next year: Work with our GMC liaison officer to issue REV6 non-engagement notices.

1. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the

recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: No other actions identified

Comments: All doctors are contacted a minimum of 6 and then 4 months prior to revalidation to outline any remaining requirements and a plan to ensure they are met. In addition, the trust Appraisal Lead will scan all doctors up to a year in advance of revalidation to pick up any who are looking as if they may fall short of requirements. Doctors in whom a deferral may be made are all contacted and given an explanation and a plan to work to ensure revalidation is not deferred on a second occasion.

All doctors are contacted as soon as the recommendation for revalidation has been made to make them aware.

Action for next year: Nil

Section 4 – Medical governance

0. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Nil

Comments: UHBW has an active patient safety, audit and effectiveness culture overseen by the Quality team at the Trust. The work of this team is outlined in the UHBW Quality Strategy

Action for next year: None identified

1. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None

Comments: Recommendations for revalidation are based on the triangulation of information from appraisal, complaints and reports from clinical chairs regarding soft concerns. Currently UHBW has no method of automatically providing audit, GIRFT or other data directly to doctors for

their appraisals and they are expected to access this information themselves.

Action for next year: Nil identified

2. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Nil additional

Comments: The ROAG group continues to meet monthly and has a range of cases on the list spanning FTP/ local investigation/ grievance, appraisal and revalidation concerns

Action for next year: Nil additional

3. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Action from last year: None

Comments: Last year we undertook an EDI audit looking at the characteristics of our appraisers in comparison to our medical cohort as well as our deferrals and FtP referrals. This data was reassuring in that we did not identify any major areas of concern, though will need monitoring. The report is attached as an appendix to this board report. (Appendix C)

Other Measurement and Key performance indicators comprise:

- The number of Speaking Up concerns raised.

The outline of all concerns will be recorded, and outcomes monitored by the Board and People Committee to identify any key themes or issues patterns/similarities so as to maintain a safe learning culture within the Trust.

• National staff survey indicators relating to staff feeling secure about raising concerns about unsafe clinical practice and having confidence in the organisation to address the concern

Action for next year: Consider regular EDI audit every 3-5 years for assurance.

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

4. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Action from last year: None

Comments: Yes, all new starters have an MPIT TOI form completed and uploaded onto the appraisal system. Exceptions are doctors who transfer from HEE where the ARCP outcome is used for this process. Any concerns are flagged to the DMD directly.

There are regular triangulation meetings with NBT and the Spire and Nuffield hospitals to ensure relevant information can be shared between organisations.

Any doctor moving from UHBW where there is a concern is discussed directly with the new RO as well as submitting an MPIT form

Action for next year: No additional actions identified

5. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: none

Comments: The Trust has a strong equality and diversity ethos and policies covering bias and discrimination

Action for next year: nil identified

Section 5 – Employment Checks

0. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: None

Comments: This action is completed by the HR team. A request from the Spire private hospital for this information to support emergency placement of doctors in 2020 allowed us to review the robustness of this process. Information was available for all doctors attached to UHBW as requested by the Spire.

Action for next year: Nil identified

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

Overall appraisal and revalidation at UHBW has continued in a positive direction since the end of the covid 19 pandemic though continued work pressure and the junior doctor industrial action have all impacted on the ability to improve the appraisal rate further. All of the actions from the previous board report have been completed

In terms of staffing we now have a new interim executive team in place and a new revalidation & appraisal lead in post since Oct 2023. The team continues to work hard to optimise and streamline processes to ensure governance is robust and our appraiser team are up to date and supported.

Overall conclusion: Overall a good year for revalidation and appraisal, with compliance and revalidation recommendations in line with other similar sized organisations.

Section 7 – Statement of Compliance:

The executive management team of UHBW has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: **University Hospitals Bristol & Weston, NHS Foundation Trust**

Name**: Dr Rebecca Thorpe**

Signed: 

Role: **Deputy Medical Director & Deputy Responsible Officer**

Date**: 24.6.24**

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This publication can be made available in a number of other formats on request.

Publication reference: PR1844

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9 July 2024

Report Title	**Learning from Deaths Quarter 4 Report**
Report Author	**Karin Bradley**
Executive Lead	**Rebecca Maxwell, Interim Chief Medical Officer**

1. Report Summary

The report describes the structures of the learning from deaths programme across the Trust and progress made by the workstream in Quarter Four of 2023/2024, 1st January 2024 – 31st March 2024.

The number of ME referrals and SRJs requested are included in section 3.0.

2. Key points to note

(Including decisions taken)

ALL adult deaths at UHBW were scrutinised by the Medical Examiner service for the period 1st January – 31st March 2023/24

Key points
- Appointment of new Mortality Surveillance Group Chair, Karin Bradley (Interim AMD). Rebecca Thorpe taken up DMD role from the late March 2024.

- Aortic Dissection thematic review: previously reported to CQG in Q3 LFD report as complete with no concerns. Additional clarification and case review later requested by lead Medical Examiner. Further supplementary reviews/responses provided assurance on all points and thematic review now complete with no concerns identified.

- Evidence of a spike in deaths in Q4 for patients with learning disabilities but no care concerns identified – assurance provided through UHBW LD and Autism report (attached as Appendix 1).

- Medical Examiner service will become statutory on 9th September 2024. At that point it will not be possible to register a death (acute and community) without ME scrutiny. No significant concerns for UHBW – ME service already covering nearly 100% of acute UHBW deaths – simply some discussions required to align child death and ME processes.

- SJRs requiring a medical review as well as a specialist review, such as learning disabilities or mental health, have been streamlined into a single sequential document to improve clinical accuracy and reduce the risk of two separate documents potentially drawing differing conclusions.

The group is asked to note and approve the report.

3. Risks

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

The risks associated with this report include:
The Division (Medicine) with the greatest workload under Learning from Deaths policy is currently without a mortality lead.

University Hospitals Bristol and Weston NHS Foundation Trust

4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is presented for **Information.**	
5. History of the paper **Please include details of where paper has previously been received.**	
Clinical Quality Group	**May 2024**

We are supportive respectful innovative collaborative. We are UHBW.

1.0 Introduction

This paper will set out the progress and report on the results of the Trust's 'Learning from Deaths' programme in the final quarter of 2023/24.

This report has been prepared for information.

2.0 Progress this Quarter

Rebecca Thorpe has recently stepped down as Chair of Mortality Surveillance Group (MSG) to take up a new role as deputy Medical Director. Our new Mortality Lead, Karin Bradley, has commenced in post as Interim Associate Medical Director for Patient Safety from 12 March 2024; with previous roles as Trust Clinical Audit Lead and a Medical Examiner she brings relevant knowledge to the group.

The lead ME raised a concern around a cluster of 3 deaths in non-operated aortic dissections in late 2023/early 2024. These were promptly investigated by the Division and the rationale for not proceeding with surgery was described in detail in a thematic review (previously shared as an appendix to the Q3 report). The lead ME subsequently requested clarification regarding: a) decisions not to operate based on a predicted survival scoring system and b) timeliness of senior/consultant review out of hours. In addition, further assurance was requested around the care of two additional aortic dissection patients who died despite operative intervention. The cases and questions were considered by a multiprofessional panel of senior cardiac specialists and assurance was provided, to the lead MEs satisfaction, on all points.

SJRs requiring a medical review as well as a specialist review, such as learning disabilities or mental health, have been streamlined into a single sequential document to improve clinical accuracy and reduce the risk of two separate documents drawing differing conclusions.

The Medical Examiner service will become statutory on 9th September 2024. At that point it will not be possible to register a death (acute and community) without formal ME scrutiny. This raises no significant concerns for UHBW as the ME service is already scrutinising close to 100% of acute UHBW deaths; some discussions still required to align child death and ME processes.

Following on from negative feedback last year, the nurse Practice Education Facilitator based in Weston collaboratively devised an EOL study day which is being delivered every 2 months (captured 55 attendees in 2022 and 115 in 2023). It includes sessions on recognising dying, breaking bad news, palliative care, care of an adult body after death and a tour of the mortuary to demystify processes – staff report feeling more confident, competent and empathic. Improvement in care has been indicated by the reduction in of referrals received for this theme and a rise in positive feedback complimenting care.

Rachel Bradley is now on secondment as Clinical Lead for Every Minute Matters which leaves the Division with the greatest workload (Medicine) without a Mortality Lead. Clare Holmes the newly appointed Clinical Chair and Sally Wilson, quality and safety lead are working to support the programme and are seeking to appoint a replacement lead within the Division.

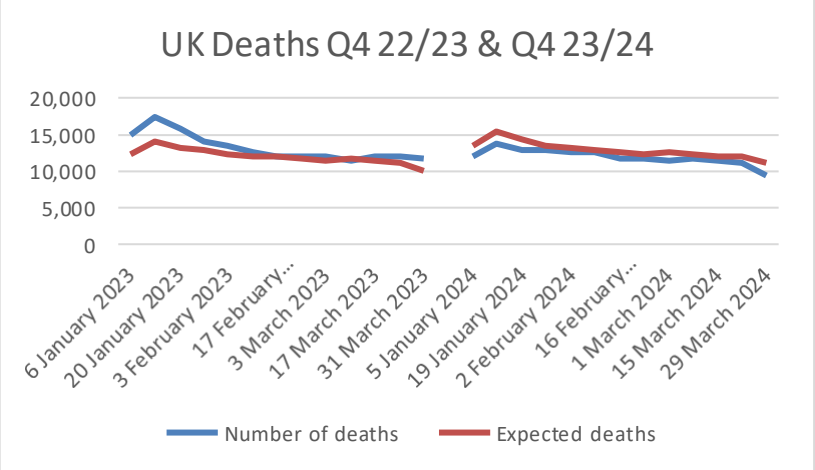
Other actions to note:
- All Mortality Leads now have NHS Spine access to patient records – previously this was restricted and access to records closed following a patient's death.
- Yasmin Ismail, Specialised Services Lead, led a teaching session for Medical Examiners to access cardiac notes held on digital systems. This was very well received.

- LEDER have encountered delays to accessing patient notes since requesting these be exported and emailed (previously LEDER reviewers visited the Trust). They are now in direct contact with Medical Records managers to streamline the process and reduce delays.
- The annual report for Learning Disability was shared at MSG
- The collaborative programme with NBT reviewing and improving and further aligning mortality processes and learning from deaths has been initiated.
- This report summarises Learning from Deaths for adult patients but, to note, MSG reviewed the latest (2021) annual report on Child Deaths from BRCH, presented by Dr Nik Sargeant. This report is submitted separately to CQG but MSG noted that BRCH benchmarked nationally as expected given its clinical services and geographical location.

3.0 Figures for total deaths, medical examiner referrals, and mortality reviews for all UHBW sites

Divisional in-hospital adult mortality:
Overall the number of in-hospital deaths has fallen slightly in Q4 23-24 in comparison with Q4 22-23 in line with the national trend (Fig 1).

Fig 1. Office for national statistics www.ons.gov.uk



In terms of how these are distributed across the Trust, an increase is recorded in deaths in Specialised Services (from 11.7% to 15.6% of total UHBW deaths across the two Q4 periods) against a drop in Medicine Division deaths (from 76.3% to 73%). Deaths in the Division of Surgery were stable at ~11% of total UHBW deaths. MCCD Causes 1 and 2 will be interrogated for the annual report.

	Q4 2022-23	Q4 2023-24
Total deaths	**528**	**511**
Medicine	403	373
Specialised Services	62	80
Surgery	63	58
Other	0	0
Referrals from ME Office	**50**	**69**
Referrals meeting SJR criteria	**7**	**31**

Note: Totals for deaths by trust and division are taken from a BI report on Careflow and hospital sites are not differentiated.

Totals for referrals are taken from a separate report generated manually from referrals emailed from the Medical Examiners Office – this report does contain data differentiating between sites and a breakdown is provided in section 3.1.

3.1 Medical Examiner Referrals and SJR themes

In Q4 the number of ME referrals represented 13.5% of the total UHBW deaths. This represents a significant increase from only 9.5% referred in Q4 22-23. However, further analysis reveals that the number of ME referrals across Q1-Q4 in 22-23 varied between 8% and 14% (of total UHBW deaths) and in 23-24 the range has been not dissimilar between 10% and 13%.

In Q4 22-23 only 14% of the ME office referrals were judged to meet SJR criteria as compared to 45% of those in Q4 23-24.

Referrals by site and category

ME referrals by site		Positive feedback	Queries and concerns	SJRs	Learning disability & autism	Mental Health	SJRs for Care or treatment concerns
Bristol Royal Infirmary	30	0	30	14	10	1	3
Bristol Heart Institute	5	0	5	3	0	0	3
Bristol Haematology and Oncology Centre	2	1	1	1	0	1	0
Weston General Hospital	32	5	27	13	3	1	9
UH Bristol and Weston Trust	**69**	**6**	**63**	**31**	**13**	**3**	**15**

43% of the Q4 UHBW ME referrals of concern were for patients on the Weston site.

Deaths for patients with learning disabilities were stable over Quarters 1-3 during 2023 (6,6 and 5 deaths respectively) but a spike of 13 has occurred in Q4. The deaths were not obviously related to winter related illness but were from varied causes including sepsis, aspiration pneumonia, cancer and cardiac causes. The LD and Autism UHBW report (attached as Appendix 1) provides good assurance around care for these patients and highlights good communication and documentation with patients and families. Areas for improvement include the opportunity to use the Abbey pain tool more frequently and an ongoing need for healthcare professionals to appreciate that learning disability rather than learning difficulty is the correct terminology.

Process selected after ME referral *Note that referrals can be subject to more than one process*	**#**
Feedback to ward /specialty/ clinical area (inc. EOL)	36
Structured Judgement Review	31
Patient Support and Complaints Team	1
Thematic review – Med EOL **12** /Aortic Dissection **1**	13
Datix (for previously unrecognised incident)	0
Report to other organisation (1 RUH 1 NBT)	2
No action required	1

ME referral theme Number is greater than total number of referrals as >1 theme for some patients	**#**
Communication	17
Statutory Category - Learning disability/Autism/Mental Health	16
Treatment /care issue	9
Nursing issue	9
EOL care issue	8
Room / space issue	8
Positive feedback	6
Other provider issue	3
Failed discharge	2
Documentation	1
Medication issue	0

Examples of positive feedback via ME team

"Everything was amazing - the team in A&E were absolutely brilliant and got x through very quickly. All the staff in hospital were absolutely amazing. The care was second to none, first class and I couldn't have asked for better. Lovely, lovely people!" - sent on via GREATIX

Nurses were impeccable in their care for xxxx and the rest of the family - could not fault them Care received from staff on Kewstoke ward was exceptional, especially care given by nurse Duncan Jennings - Amazing care given by Duncan which the family are extremely grateful for.

Care - Wife is a nurse and bereavement officer, very very good, especially the staff on Kewstoke Ward, excellent in how they related to xxxxx and also how they dealt with the family too

The feedback from the NOK was that the care was amazing and from some of the best medical minds in the world.

Examples of family concerns raised by ME team

'The only issues were getting to the hospital, parking and then finding his way around the hospital and it not being very clear signage. The NOK then missed the death of his father by minutes due to not being able to find where he was going and the lifts being out of use or too busy."

NOK feedback - mixed messages from different members of the team at EOL - consistent messaging around likely prognosis may have helped family prioritise spending time with xxxx.

NOK concerns re. communication - lack of updates and support over the weekend when mother's condition had changed (no longer talking or moving) and no one able to explain why.

"NOK concerns - The night before John died, his daughter-in-law spoke to him on the phone and his breathing sounded bad, very rattley, and he was hearing voices in his head. She fed this back to the nurse on the phone who reassured Donna not to worry, saying he was just a bit unsettled. Donna now wishes she'd gone with her gut instincts and come in that evening. When the family arrived in the morning Xxxx was now unconscious and died later that day.

Xxxx remained out on the ward, but the family would have appreciated a side room for EOL - greater privacy for Xxxx and for the family, but she appreciates that the side rooms are often needed to isolate infective

patients. But otherwise care was fantastic and the nurses on when John died were brilliant and really looked after them too."

Son said that the care form nursing staff and the doctors was very good - they were very thoughtful, very kind and caring. The family appreciated the time they were allowed to spend on the ward and the explanations given - really helpful.

Only one negative: at EOL, Janet was on a ward with other patients and it got quite noisy at times: his mum was in a bed next to a patient with (?) mental health issues / dementia who was shouting out a lot of unpleasant things. They understand the capacity issues, but did say that a side room would have been very much appreciated to give them and mum more privacy. But not a complaint - overall he couldn't fault the care.

NOK concerns re. palliation delay (weekend admission). Left in A&E for 2 days without seeing a doctor after the initial review. He was hallucinating and agitated and struggling all of Saturday night. NOK came back in on Sunday and sat with him all day until he was moved to MAU. Lots of shouting and waving of arms. It wasn't until 4pm on the Monday that he was seen by a consultant, Dr Allain - absolutely wonderful doctor who took control of the situation, explained things and made him comfortable. As soon as he was given the morphine and haloperidol, he became calmer and more settled. Daughter feels, given how quickly he responded to the medications, he could have been settled earlier with the decision to palliate made sooner. Otherwise happy with care overall.

NOK concerns: 1. Delay in decision to palliate - Ongoing investigations and intervention even after significant and prolonged deterioration over several days and then clearly dying. Very distressing for NOK to witness who felt the deterioration was torturing him. / 2. Communication - language barriers (? a consultant): NOK had difficulty understanding what the doctor was telling her. / 3. Care concern: Pt. admitted with back issues that were being investigated, yet early on he was left in a chair for 8 hours - couldn't sit up, was found slumped and in distress.

3.2 Structured Judgement Reviews (SJRs)

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A total of 31 SJRs were requested representing 6% of all deaths for this quarter. Once the 16 mandatory SJR category deaths are removed, this reduces to 3% of all Q4 deaths having triggered an SJR due to potential care concerns.

Division	SJRs	Mandatory category	Treatment issue
Specialised Services	5	1 LD, 1MH	3
Surgery	6	3 LD	3
Medicine	20	9LD, 2MH	9
Total	**31**	**13 LD 3MH**	**15**

Note: Not all SJRs are triggered by Medical Examiner referrals. Clinicians and the Learning Disability Team initiate SJRs for the BNSSG LEDER as standard for all patient deaths they are aware of that meet the criteria

4.0 SJR Scores

Avoidability of death scores

Definitions - avoidability of death

1 *Definitely avoidable*
2 *Strong evidence of avoidability*
3 *Probably avoidable, more than 50:50*
4 *Possibly avoidable but unlikely, less than 50:50*
5 *Slight evidence of avoidability*
6 *Definitely unavoidable*

All deaths for this quarter were rated **4** or above for avoidability.

Phase of care scores
Key to Care scores: 1=Very Poor, 2=Poor Care, 3=Adequate, 4=Good Care, 5=Excellent
Low Phase of cares scores

The majority of SJR cores were rated 4 and above, but one patient was assigned scores of 2 for both 'overall care' and the 'ongoing care' section. A second review was completed by the Trust Mortality Lead, under the LFD policy, and some uncertainty regarding the wording of the MCCD was identifed (omission of a traumatic fractured neck of femur). This led to a delayed HMC referral and full DOC was discharged by the Trust Mortality Lead through a telephone call with the patient's family and a subsequent letter. An RIR was also progressed (Datix previously reported).

All other SJR ratings for phases of care and for overall care were scored at 3 or above.

5.0 Thematic Reviews

Aortic dissections: commissioned and completed. Assurance provided.

End of Life review: End of Life Group leads now have access to Mortality Surveillance Group information feeds, including Medical Examiner Referrals, to independently monitor issues in palliative care.

Transport of emergency cases between sites: Transfer check list previously in use at Bristol site spread to Weston site. UHBW Transport SOP updated to reflect increased operational pressures on SWASFT and to include alternative emergency transport option such as Retrieve (regional critical care transport service) and UHBW ambulance transport service. Targeted education for specific groups such as Weston clinical teams, critical care and anaesthesia. Trust-wide safety bulletin circulated.

6.0 Risks

Rachel Bradley is now on secondment as Clinical Lead for Every Minute Matters which leaves the Division with the greatest workload (Medicine) without a Mortality Lead. Clare Holmes the newly appointed Clinical Chair and Sally Wilson, quality and safety lead are working to support the programme and are seeking to appoint a replacement lead within the Division.

7.0 Conclusions and Future work

The Board is asked to note this report.

Appendix 1:

UHBW LEARNING DISABILITY AND AUTISM DEATHS 2023 - 24 MORTALITY SURVEILLANCE GROUP

Deb Parsons, Interim Strategic Lead- Adult Learning Disability and/or Autism Services

Introduction

In 2019 the national Learning from Deaths Mortality Review team (LeDeR) have stated that 'People with a learning disability have higher rates of morbidity and mortality than the general population and die prematurely' LeDeR found that 42% of deaths of people with a learning disability were avoidable (LeDeR, 2023).

This report provides an overview of deaths that have occurred within UHBW for our learning disabled population or those who are autistic.

Background

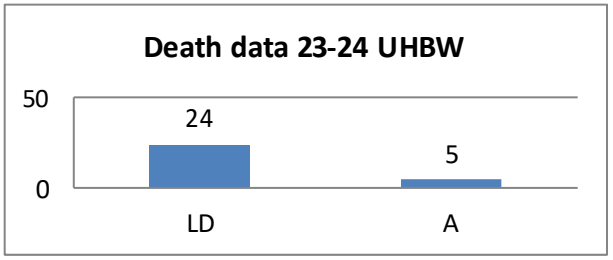
The 2022 Learning Disabilities Mortality Review (LeDeR) found the median age at death was 63 for adults with a learning disability. This is significantly less than the median age of death of 82 for men and 86 for women in the general population. This means the difference in median age at death between adults with a learning disability and the general population is 19 years for men and 23 years for women.

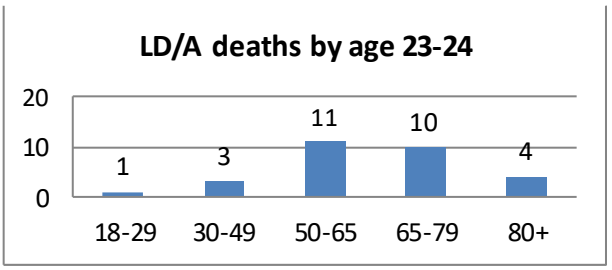
During 2023 BNSSG LeDeR recorded 75 deaths, 50 of which occurred in hospitals. UHBW reported 29 deaths.

Findings

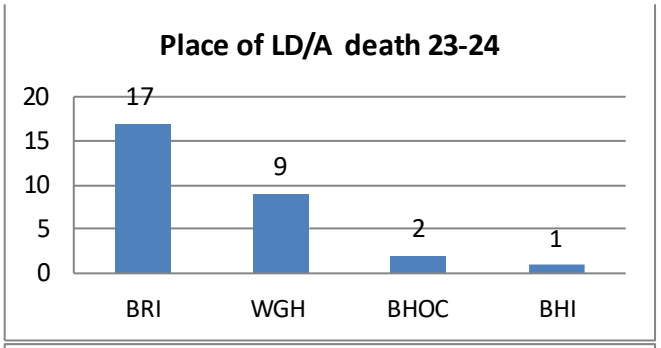
The majority of deaths were learning disability related as opposed to Autism, this reflects the national picture and BNSSG. There was nil specific found with our autistic patients relating to cause of death, although 2 patients had mental health involvement.

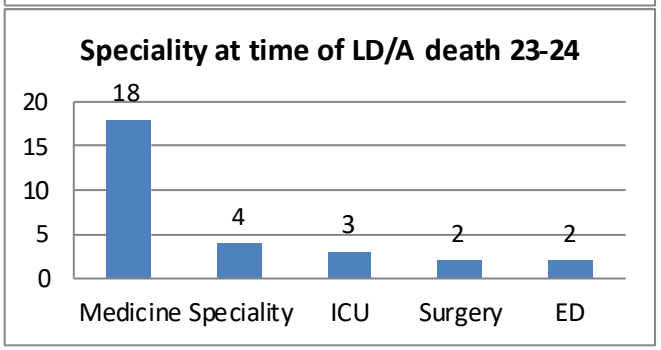
The national median age at death is 63 years, BNSSG note the median age of death to be 68 years, North Bristol Trust notes their median age of LD/A deaths to be 64 years. UHBW median age is 65 years, men dominating the number of deaths at 66%.





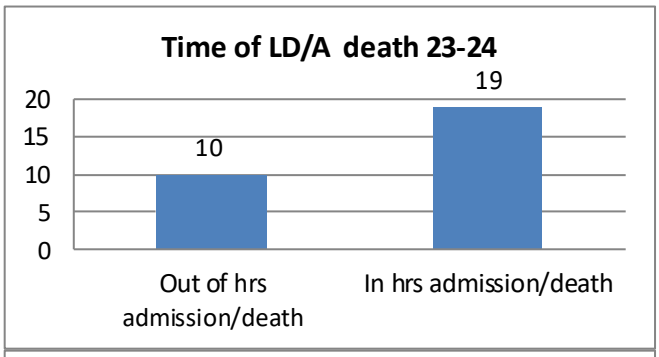
BRI is noted as having the majority of deaths which is understandable in the context of the UHBW landscape, with Medicine being the dominant speciality. Weston General Hospital; a small division has supported 31% of all learning disability deaths. Weston super Mare in particular has a high number of learning disability specific care homes and service users are well known to the LD/A team based at WGH.

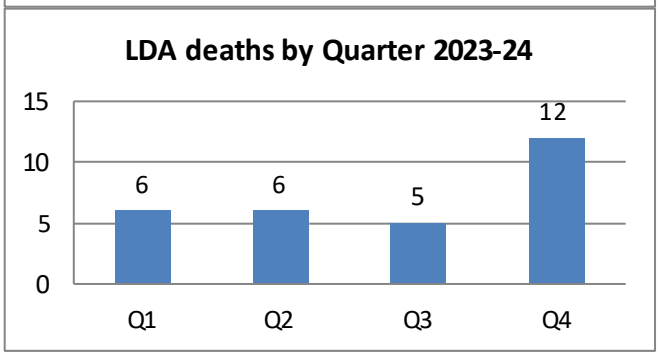




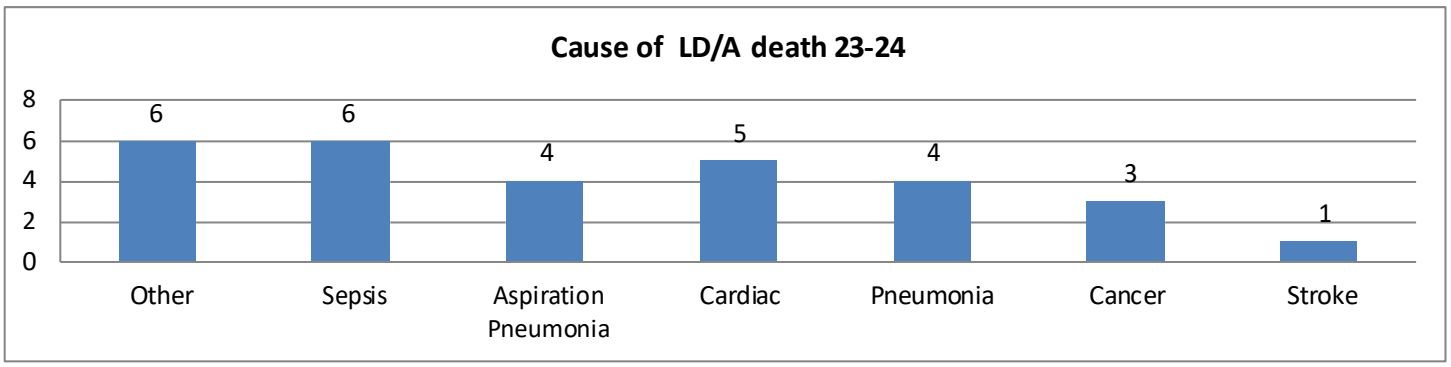
The 2 Emergency Department deaths were both in BRI and out of hours and both had aspiration pneumonia. Both patients had a respect form. Excellent care was noted in both SJR's.

19 of the deaths occurred within working hours and all 19 patients were seen by the LDA team. Deaths occurred steadily over Q1-3 during 2023 and then a spike of 12 occurred in Q4, the causes of these deaths were not related to winter related illness or disease.





Cause of death was mixed; Sepsis, Cardiac and Other were out top 3 causes (other included brain injury and bowel related illness amongst others)



North Bristol Trust's top cause of death was aspiration pneumonia; it was discussed at their LD/A steering group if this group of patients were admitted with aspiration pneumonia or developed it after admission.

UHBW had 4 cases of aspiration pneumonia each were reviewed; 2 deaths were admitted to our ED and deceased less than 24 hours later. Both were admitted with aspiration pneumonia. One patient had been discharged from BRI ED the day before, having attended with breathing difficulties, they had a ReSPECT form in place that detailed avoid further hospital admissions and to comfort eat and drink as able, they remained in BRI for more than 2 months. The final case was likely admitted with aspiration pneumonia, they had an NG placed and referral to SALT within 24 hrs, they deceased 3 days later.

The Learning Disability and/or Autism SJR template has been adapted to capture 1) good practice and 2) what could have been better, in line with the National Mortality Care Record (NMCR).

Good practice:

- communication with family,
- end of life care and care planning,
- Reasonable adjustments,
- use of IMCA and best interest process,
- intervention of the PCT,
- Involvement of LD team

What could have been better:

- poor pain control,
- delay in prescribing analgesia,
- Little evidence of the Abby Pain tool being used.
- Not always a learning disability team referral,
- life possibly prolonged by investigations,
- L Difficulty used instead of Learning Disability.

Conclusion:

23 of the 29 deaths reviewed by the Learning Disability team were scored 6 on the NMCR – definitely not avoidable. 4 deaths are yet to be reviewed. One case scored 2, which is being investigated using the Patient Safety Incident Response Framework and will be a coroner case. During the reviews the communication that clinicians had with family or those close to the patient was noted as very good and very well recorded. The learning disability team although not always referred to, had seen all patients that had deceased within working hours. Learning points must be for improved pain control for our learning disabled patients, who very often do not have a voice to raise a concern or may be too poorly to understand when to. The Abbey pain tool is underused and could be of great benefit to this cohort of patients. Learning difficulty is still being used by a wide range of professionals instead of learning disability, this is an incorrect diagnoses.

A reminder that the learning disability team are here to support and offer expert advice to clinicians and health care practitioners during the patient pathway, they work a 7 day rota and will advise on reasonable adjustments.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board held in Public 9 July 2024

Reporting Committee	**Finance Digital and Estates Committee – May 20224 meeting**
Chaired By	**Martin Sykes, Non-Executive Director**
Executive Lead	**Neil Kemsley, Chief Financial Officer and Neil Darvill, Joint Chief Digital Information Officer**

For Information

Finance

The Month 1 finance report was reviewed by the committee, acknowledging that with the overlap with annual accounts production Month 1 is inevitably 'draft'.

The position showed a £2.6m deficit against plan, with a shortfall of £1.3m on savings and a similar shortfall on activity income. Capital investments and cash were both close to plan.

The committee were informed that the Trust Productivity and Financial Improvement Group (PFIG) would be getting to grips with the savings programme in Q1 and were pleased to note that a risk-share on 'no criteria to reside' had been reached with commissioners.

Notwithstanding the strengthened governance arrangements for savings delivery, it was clear that CIP delivery remains a key risk for the Trust.

Digital

The Committee received the Digital Services Annual Plan and noted the key projects that would be undertaken over the coming year.

New processes for requesting digital projects had been introduced by the Digital Hospital Programme Board to avoid 'mission creep'. The revised governance was endorsed by the committee.

Progress against key projects including Medicines Management was noted, with user acceptance testing being underway.

The Committee were updated on the progress of the 'DrDoctor' patient portal project involving patient communication, scheduling and consultation. Since go-live the portal had been used to send 80,000 letters, host 26,000 video consultations and had piloted a self-service solution for patients to manage appointments.

The key digital risks were reviewed.

University Hospitals Bristol and Weston NHS Foundation Trust

Estates

The committee received a detailed report on the events leading to the significant power outage experience on 3/5/24 and the initial findings of the subsequent investigations.

It was clear that the Estates team and Trust business continuity arrangements had operated well although there were some lessons to be learned, for example around communication and availability of parts.

The committee offered thanks to the many individuals who had contributed to resolving the complex issues on the day.

The Estates team were unable to assure the committee that such an event could not happen again but given the age and complexity of the estate mitigations were being strengthened where possible (for example through adding additional generator plug-ins)

For Board Awareness, Action or Response
Savings delivery remains a key financial risk, with all clinical and corporate areas needing to deliver to plan.
Key Decisions and Actions
Nothing to report.
Additional Chair Comments

Date of next meeting:	23rd July 2024

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9 July 2024

Report Title	**Month 2 Trust Finance Performance Report**
Report Author	**Jeremy Spearing, Director of Operational Finance**
Executive Lead	**Neil Kemsley, Chief Financial Officer**

1. Purpose

To inform the Trust Board of the Trust's overall financial performance from 1st April 2024 to 31st May 2024 (month 2).

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

The Trust's net income and expenditure position at the end of May is a deficit of £6.3m against a break-even plan. The adverse position against plan is primarily due to the shortfall on the delivery of savings and elective activity not achieving planned levels.

The Trust delivered savings of £4.2m, £2.4m behind plan. The forecast for recurrent savings delivery is £18.8m against a plan of £41.2m.

The value of elective activity for outpatient, day case and inpatient delivery points fell further behind plan in May, deteriorating by £1.3m to £2.6m behind plan year to date.

The Trust delivered capital investment of £4.0m year to date, £1.2m behind plan.

The Trust's cash position was £87.4m as at the 31st May 2024, broadly in line with plan.

In response to the Trust's deficit, the following actions will be undertaken:

- Confirm application of Escalation Framework across whole Trust from early July;
- Ensure the consistent application of 'Grip and Control' measures across UHBW and NBT;
- Divisions, Corporate Services and Corporate Workstreams to ensure recurrent CIP schemes are set out by 2nd August that fully recover the YTD shortfall and deliver the 2024/25 efficiency requirement of £41.2m;
- Delivery of the elective activity volume per the Trust's 2024/25 Operating Plan necessary to secure the planned Elective Recovery Funding (ERF) and support the delivery of the Trust's break-even financial plan. Forecast trajectories back to plan are required from the COO Team, working with divisions, by the end of July;
- Agreed route to deliver the Trust's non-recurrent corporate mitigations of £14m, by 2nd August;
- Recovery actions implemented in any areas where workforce costs exceed funded levels; and
- Delivery of the 2024/25 monthly capital plan. Forecast outturn trajectories are required from Divisions in July.

3. Strategic Alignment
This report is directly linked to the Patient First objective of 'Making the most of our resources'. Achieving break-even ensures our cash balances are maintained and therefore we can continue to support the Trust's strategic ambitions subject to securing CDEL cover.
4. Risks and Opportunities
416 – Risk that the Trust fails to fund the strategic capital programme. Unchanged risk score of 20 (very high). 5375 – Risk that the Trust does not deliver the in-year financial plan. Unchanged risk score of 12 (high) pending completion of the quarter 1 Forecast Outturn in July.
5. Recommendation
This report is for **Information**. The Board is asked to note the Trust's financial performance for the period.
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**
N/A

University Hospitals Bristol and Weston NHS Foundation Trust

Trust Finance Performance Report

Reporting Month: May 2024

Executive Summary

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

2024/25 YTD Income & Expenditure Position	• Net I&E deficit of £6,322k against a breakeven plan (excluding technical items). • Total operating income is £1,227k adverse to plan due to lower than planned income from activities (£424k) and other operating income (£803k). • Total operating expenditure is £5,745k adverse to plan due to higher than planned non-pay costs at £6,447k and lower than planned pay expenditure at £806k. Depreciation and financing costs combined are marginally favourable to plan, mainly due to interest receivable.
Key Financial Issues	• *Recurrent savings delivery below plan* – YTD CIP delivery is £4,210k, £2,355k behind plan at 64% of plan. Recurrent savings are £2,753k, 42% of plan. • *Delivery of elective activity below plan* – elective activity must be delivered in line with plan. At M2, the cumulative YTD value of elective activity is £2.6m behind plan, a deterioration of £1.3m in May. A continuation of the YTD performance could result in a total loss of income of up to £15.6m and may result in the Trust failing to meet the financial plan. • *Corporate mitigations not delivered in full* – non-recurrent mitigations of £1,164k were delivered at the end of May. • *Failure to deliver the financial plan* – failure to deliver the actions and therefore the financial plan of break-even will constitute a breach of this statutory duty and will result in regulatory intervention.
Strategic Risks	• 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.

SPORT

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: May 2024

Successes

- Delivery of capital investment of £1.4m in May.
- The Trust's cash position remains strong at £87.4m broadly in line with plan.
- Delivery of elective day case activity is on plan.
- BPPC continues at 90% for invoices paid by value and 89% paid by volume within 30 days.
- Submission of the Trust's 2024/25 financial plan to NHSE on 2nd May 2024 in accordance with the national timetable.
- Additional system "incentive" CDEL of c£11m allocated to BNSSG system for submitting a breakeven financial plan.

Priorities

- Confirm application of Escalation Framework across whole Trust from early July.
- Ensure consistent application of 'Grip and Control' measures across UHBW and NBT.
- Divisions, Corporate Services and Corporate Workstreams to ensure recurrent CIP schemes are set out by 2nd August that fully recover the YTD shortfall and deliver the 2024/25 efficiency requirement of £41.2m.
- Delivery of the elective activity volume per the Trust's 2024/25 Operating Plan necessary to secure the planned Elective Recovery Funding (ERF) and support the delivery of the Trust's break-even financial plan. Forecast trajectories back to plan are required from the COO Team, working with divisions, by the end of July.
- Agreed route to deliver the Trust's non-recurrent corporate mitigations of £14m, by 2nd August.
- Recovery actions implemented in any areas where establishment/ workforce costs exceed funded levels.
- Delivery of the 2024/25 monthly capital plan. Forecast trajectories are required from Divisions in July.

Opportunities

- Agree with System partners, the Trust's share of the additional system "incentive" CDEL.
- Securing system CDEL brokerage of up to £3m.
- Re-casting of the 2024/25 elective activity plan including productivity opportunities to ensure forecast delivery of the elective recovery requirement for break-even.
- Securing the financial benefits of fully established nursing and midwifery ward areas through further reductions in temporary bank and agency expenditure.

Risks & Threats

- Insufficient reduction in "No Criteria To Reside" patients therefore displacing bed capacity and the Trust's ability to deliver the elective activity plan.
- Workforce supply challenges in hard to fill vacant posts such as theatre nursing, junior doctors together with ongoing bed constraints continues to impact on the Trust's ability to manage emergency demand and deliver the planned elective activity.
- Under-delivery on the Trust's savings requirement will result in a significant deterioration in the Trust's deficit.
- Under-delivery against the Trust's elective inpatient activity plan will result in a significant deterioration in the Trust's deficit.
- The significantly reduced CDEL for 2024/25 is likely to constrain the Trust's strategic capital plans over the next three to five financial years.

Income & Expenditure Summary

May 2024

Trust Year to Date Financial Position

	Month 2			YTD		
	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's	Plan £000's	Actual £000's	Variance Favourable/ (Adverse) £000's
Income from Patient Care Activities	91,077	91,793	716	181,249	180,825	(424)
Other Operating Income	9,886	8,137	(1,749)	19,772	18,969	(803)
Total Operating Income	**100,963**	**99,929**	**(1,034)**	**201,021**	**199,794**	**(1,227)**
Employee Expenses	(59,618)	(56,780)	2,838	(119,236)	(118,430)	806
Other Operating Expenses	(36,463)	(42,213)	(5,750)	(72,437)	(78,884)	(6,447)
Depreciation (owned & leased)	(3,789)	(3,848)	(59)	(7,162)	(7,266)	(104)
Total Operating Expenditure	**(99,870)**	**(102,841)**	**(2,971)**	**(198,835)**	**(204,580)**	**(5,745)**
PDC	(1,210)	(1,208)	2	(2,420)	(2,417)	3
Interest Payable	(247)	(234)	13	(494)	(465)	29
Interest Receivable	292	456	164	584	937	353
Net Surplus/(Deficit) inc technicals	**(72)**	**(3,899)**	**(3,827)**	**(144)**	**(6,731)**	**(6,587)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	72	178	106	144	409	265
Net Surplus/(Deficit) exc technicals	**0**	**(3,721)**	**(3,721)**	**0**	**(6,322)**	**(6,322)**

Key Facts:

- The deficit in May was £3,721k against a plan of break-even. The cumulative YTD position at the end of May is a net deficit of £6,322k against a breakeven plan. The Trust is therefore £6,322k adverse to plan. The cumulative YTD net deficit is c3% of total operating income.
- Significant variances in the year-to-date position include: the value of elective income behind plan by £2,600k and a shortfall on savings delivery of £2,355k.
- In May the Trust has spent £146k on costs associated with Internationally Educated Nurses (IENs).
- YTD pay expenditure at the end of May is £806k lower than plan, although higher than planned medical staffing and nursing costs continue to cause concern across some divisions with increasing pay costs in total across substantive, bank and agency staff.
- Agency expenditure in month is £1,276k, compared with £1,573k in April. However, bank expenditure continues the upward trend in month at £5,829k, compared with £5,711k in April.
- Total operating income is below plan by £1,227k, mainly due to the shortfall in ERF offset by higher than planned pass-through payments.

Savings – Cost Improvement Programme

NHS University Hospitals Bristol and Weston NHS Foundation Trust

May 2024

Division	2023/24 Recurrent shortfall	2024/25 Target (2%)	2024/25 Original Target	Year To Date – April to May					Forecast Outturn				
				Current Plan	Recurring	Non-Recurring	Total	Variance Fav / (Adv)	Current Plan	Recurring	Non-Recurring	Total	Variance Fav / (Adv)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Diagnostics & Therapies	543	1,741	2,284	371	100	72	172	(199)	2,284	868	335	1,203	(1,081)
Medicine	416	2,180	2,596	515	521	-	521	7	4,008	4,277	-	4,277	269
Specialised Services	(377)	2,095	1,718	259	128	78	206	(53)	1,718	977	417	1,394	(324)
Surgery	1,285	3,411	4,696	726	368	-	368	(358)	4,696	2,365	28	2,393	(2,304)
Weston	(156)	1,045	889	148	128	-	128	(19)	889	772	-	772	(117)
Women's & Children's	397	3,316	3,713	695	691	-	691	(4)	4,260	4,294	-	4,294	33
Estates & Facilities	194	1,097	1,292	170	33	9	42	(127)	1,292	543	98	641	(650)
Finance	(0)	226	225	63	63	-	63	-	379	379	-	379	-
HR	(0)	274	273	45	32	9	42	(4)	273	224	56	280	7
Digital Services	566	428	994	172	1	122	123	(49)	994	6	694	700	(294)
Trust HQ	417	517	935	156	20	-	20	(136)	935	121	-	121	(814)
Corporate	-	10,385	10,385	1,912	-	1,167	1,167	(745)	11,472	-	7,000	7,000	(4,472)
			-										
Divisional Sub Totals	**3,286**	**26,714**	**30,000**	**5,232**	**2,087**	**1,457**	**3,543**	**(1,688)**	**33,200**	**14,825**	**8,629**	**23,454**	**(9,746)**
Urgent & Emergency Care	**-**	**9,400**	**9,400**	**667**	**667**	**-**	**667**	**-**	**4,000**	**4,000**	**-**	**4,000**	**-**
Elective Recovery	**-**	**-**	**-**	**667**	**-**	**-**	**-**	**(667)**	**4,000**	**-**	**-**	**-**	**(4,000)**
Grand Totals	**3,286**	**36,114**	**39,400**	**6,565**	**2,753**	**1,457**	**4,210**	**(2,355)**	**41,200**	**18,825**	**8,629**	**27,454**	**(13,746)**

Key Points:

- The Trust's 2024/25 savings plan is £41,200k. This includes £8,000k attributable to Urgent & Emergency Care (UEC) investments delivery bed reductions and reduced insourcing and outsourcing costs of elective recovery.
- The Divisional plans represent 38% of the Trust plans. Corporate workstreams are driving the majority of the planned savings requirement.
- As at month 2, the Trust is reporting total savings of £4,210k against a plan of £6,565k, a shortfall in delivery of £2,355k. The Trust is forecasting savings of £27,454k against the savings plans of £41,200k, a savings delivery shortfall of £13,746k.
- The full year effect forecast outturn at month 2 is £22,355k, a shortfall of £17,045k.
- The performance of the corporate workstreams supporting the Divisional plans require an urgent and step change in delivery to recover the YTD and forecast shortfall on savings delivery.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on 9 July 2024

Reporting Committee	**People Committee – 23 May 2024**
Chaired By	**Bernard Galton**
Executive Lead	**Emma Wood - CPO and Deputy Chief Executive.**

For Information

The agenda included the following items:

- An update on the delivery of Leadership Management and Coaching with a forward look at the delivery against the strategic milestones with a discussion on costs and risks.
- The Wellbeing Bi -annual report for information and approval with a forward look at 2024 priorities.
- An update on the status of vaccination of staff within UHBW and how the uptake maybe improved.
- Discussion and assurance on the implementation of the Trust wide communications strategy
- EDI Bi- Annual report for approval
- Guardian of Safe Working Hours Q4 report
- KPI report for discussion with a deep dive report on work force performance in Estates and Facilities.

For Board Awareness, Action, or Response

Many of the Agenda items focussed on activity in the previous financial year and were for approval prior to going to the Board for sign off. The Committee noted the excellent progress that has been made on wellbeing and EDI although, as ever, there is more to be done especially around the role and visibility of staff networks.
It was also felt that our anti racist policy should be publicised to ensure staff are more aware of it.
The take up of vaccines is potentially a cause for concern in term of patient safety. This may benefit from a System wide approach to have a concerted campaign to improve vaccination numbers next winter.
The number of Locum doctors at Weston remains very high and it was asked that a further update be brought to the next meeting.

Key Decisions and Actions

There was another excellent presentation from Emma Mooney outlining the progress that has been made on implementing the new Communications Strategy. Staff reaction to date is positive but full implementation will take time and uptake and understanding will need to be carefully evaluated.

Additional Chair Comments

Update from ICB Committee

Nothing significant to report

Date of next meeting:	**18 July 2024**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on 9 July 2024

Report Title	**Freedom to Speak Up Annual Report 2023/24**
Report Author	**Eric Sanders, Freedom to Speak Up Guardian** **Kate Hanlon, Deputy Freedom to Speak Up Guardian** **Zakira Takolia, Interim Freedom to Speak Up Guardian**
Executive Lead	**Emma Wood, Chief People Officer**

1. Purpose

To present the annual Freedom to Speak Up Report to the Board for assurance.

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

- The wider internal and external political and social factors (cost of living, industrial action, financial pressures facing all NHS Trusts) is impacting the culture within this Trust (some colleagues report moral distress, fatigue due to work pressures and reports of poor behaviours).
- Our NHS Staff Survey results (completed by 53% of colleagues) highlight that although 68% colleagues feel safe in raising concerns only 55% felt the organisation would address them**.**
- There is greater awareness and visibility of the FTSU service. This has been achieved through attendance at corporate induction, training for teams and departments, and coordinated walkabouts.
- The feedback from those who have accessed the FTSU service report confidence in the service and the guardian.
- Greater scrutiny has been applied in collecting data, especially around protected characteristics.
- There is still work to be done on learning from concerns so that colleagues speaking up can see and feel noticeable change.

3. Strategic Alignment

This report seeks to flag key issues for the Board in relation to the development of the culture of UHBW, which will support the achievement of the Trust's strategy.

4. Risks and Opportunities

The main risks and opportunities associated with this report include:

- Not being able to evidence learning and change from concerns will undermine confidence in speaking up and the FTSU service.

5. Recommendation

This report is for **Information**

The Board is asked to note the contents of the Annual Report for 2023/24 and discuss the actions it should now take in response.

6. History of the paper

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

N/A

UHBW Freedom to Speak Up Annual Report 2023/24

1. Purpose

1.1 To present the annual Freedom to Speak Up (FTSU) Report to the Board for assurance.

2. Introduction

2.1 Below is anonymous feedback from a member of staff who raised a concern via the FTSU Guardian in 2023/34:

"Only by speaking up can we bring about change, but I hope real change in behaviour happens, rather than just tick boxing." (December 2023)

The feedback reflects what staff have reported in the annual NHS Staff Survey and to the FTSU Guardian. The quote is a reminder to the Board around the challenges in delivering and building confidence around speaking up.

In the words of Sir Robert Francis:

"The NHS is blessed with staff who want to do the best for their patients. They want to be able to raise their concerns about things they are worried may be going wrong, free of fear that they may be badly treated when they do so, and confident that effective action will be taken. This can be a difficult and a brave thing to do, even in a well-run organisation or department, but will be extremely challenging when raising concerns is not welcomed".[1]

2.2 The implementation of FTSU Guardians across England was just one of the recommendations which arose from Sir Robert Francis's 'Freedom to Speak Up Review' published in 2015. This followed the 2013 report of the Mid Staffordshire NHS Foundation Trust public inquiry. Since its inception in 2016, the FTSU Guardian service has become firmly embedded within UHBW. The service encourages all workers at UHBW – whether substantive, agency, bank, students, or volunteers, to raise concerns, report any issues and share ideas relating to patient safety and workplace practises among other themes. By adopting an open culture, we can provide a positive working environment for all our colleagues and ensure safe care for our patients.

3. National context

3.1 As reported last year, wider societal challenges (including the cost-of-living crisis, the crisis in adult social care, and pressures to address operational performance) continue to place enormous pressure on NHS staff and services.

3.2 In the11 years since the Mid Staffordshire public inquiry report was published, we have seen recurrent organisational catastrophes across the NHS, for example infant deaths at the neonatal unit of the Countess of Chester Hospital; staff reporting bullying and toxic culture at University Hospitals Birmingham; poor maternity care reported by families at Nottingham University NHS Trust, and maternity failings at Shrewsbury and Telford Hospital NHS Trust to name just a few.

3.3 At the time of writing this report Sir Robert Langstaff has published the Infected Blood Inquiry report. In his report, Sir Robert recommends a 'culture change' in the NHS to prevent any 'cover-ups', and for NHS Trusts to acknowledge when mistakes have been made. He argues individual managers should be held to account if there is a failure to

[1] Francis, Sir R (2015) *Freedom to Speak Up – An Independent Review into Creating an Open and Honest Culture in the NHS,* The Report (freedomtospeakup.org.uk) *(Francis, 2015, p.* 4)

take action. A 'culture of defensiveness, lack of openness, failure to be forthcoming and being dismissive of concerns' can be addressed by 'making leaders accountable for how the culture operates in their part of the system, and for the way in which it involves patients.'

3.4 On 21 May 2024, Dr Jayne Chidgey-Clark (National Guardian for Freedom to Speak Up) and Miley Sibley (Founder, Patient Experience Library) gave evidence to the Health and Social Care Committee in the House of Commons. Both described the fear and futility reported by staff around speaking up in the NHS which is hindering patient safety and delays in patient safety issues being investigated.[2]

3.5 A Bill to establish an 'Office of the Whistleblower' to protect whistleblowers and whistleblowing is currently going through Parliament and will repeal the Public Interest Disclosure Act 1998. The delayed Bill aims to provide greater confidence and legal protection to whistleblowers.

4. Context for UHBW

4.1 In 2023/34, 95 concerns were reported to the FTSU Guardian at UHBW, compared to 109 in the previous financial year.

4.2 Although concerns raised by staff working in the Weston division had started to stabilise, this year's data shows the highest number of concerns coming from Weston (28%) followed by the division of Surgery (21%) and Trust Services (19%). Comparative numbers are provided for previous financial years.

Division	**Number of concerns in 23-24 financial year**	**22-23**	**21-22**	**20-21**	**Head count (including bank staff) April 2024**
Diagnostics and Therapies	4	5	6	6	1,676
Estates and Facilities	8	13	8	6	1,239
Medicine	6	14	10	7	1,786
Specialised Services	4	8	5	9	1,449
Surgery	20	12	11	10	2,611
Trust Services	18	21	13	9	3,904
Weston	27	21	39	56	1,147
Women's and Children's	8	15	10	9	2,723
Total	**95**	**109**	**102**	**112**	**16,535**

4.3 The increase in the number of concerns relating to the Weston division can be explained in part due to changes made in theatres during Q3. Colleagues reported bullying, a top-down approach in driving change, consultation viewed as a tick box exercise and changes to the service resulting in inequity, especially for female colleagues. The increase in the number of concerns from the division of Surgery is not linked to any one area/department or team.

[2] Parliamentlive.tv - Health and Social Care Committee

4.4 In terms of staff groups speaking up, the chart below shows the breakdown for UHBW below. In line with previous years, administrative and clerical staff are the predominant group raising concerns via FTSU, followed by registered nurses and midwives.

4.5 The National Guardian's Office (NGO) annual report for 2022/23 revealed that, nationally, registered nurses and midwives accounted for the biggest portion of cases raised with FTSU Guardians (30%), while administration and clerical staff accounted for the second largest portion of cases (20%). The NGO reflected that the proportion of cases raised with FTSU Guardians by these groups is similar to the share of the workforce they involve.[3]

4.6 Clearly there is work here to continue to explore why other staff groups are not using the FTSU service or using it less frequently. It is important to note however that Guardians are only one route for speaking up and these staff groups also have other routes to speak up within the Trust.

Profession	Number of concerns	% of overall concerns
Allied Health Professionals	2	2%
Medical and dental	3	3%
Nursing and Midwifery registered	24	25%
Administrative and clerical	29	31%
Additional professional scientific and technical	7	7%
Additional clinical services	12	13%
Estates and ancillary	7	7%
Healthcare scientists	0	0
Students	4	4%
Not known	5	5%
Other	2	2%

4.7 The annual NHS staff survey contains questions on the NHS People Promise theme of 'we each have a voice that counts', and specifically four questions which reflect how staff feel about raising concerns in their organisation. The results for UHBW show a relatively stable picture with results largely in line with previous years and above the average scores for other benchmarked acute and acute and community Trusts. However, there remains work to be done to ensure we continue to improve these scores – the focus of which is outlined in the section below around areas for improvement.

[3] 202223-Annual-Data-Report.pdf (nationalguardian.org.uk)

Staff Survey questions related to raising concerns (% agreeing / strongly agreeing with the following statements):	2020	2021	2022	2023	Average for acute and acute and community Trusts
I would feel secure raising concerns about unsafe clinical practice	73.72%	75.88%	73.12%	72.29%	70.24%
I am confident that the organisation would address my concern	63.67%	60.32%	57.88%	59.15%	55.90%
I feel safe to speak up about anything that concerns me in this organisation	69.71%	66.76%	65.84%	68.41%	60.89%
If I spoke up about something that concerned me I am confident my organisation would address my concern	Not asked in 2020	53.52%	50.96%	55.53%	48.65%

4.8 Since 2022/23, the themes of cases reported to the NGO fall into four categories: patient safety/quality, worker safety or wellbeing, inappropriate attitudes and behaviours and bullying or harassment. Last financial year, the NGO reported the highest number of concerns is within the 'inappropriate attitudes and behaviours' category (30%) followed by worker safety and wellbeing (27%).

4.9 Looking at the themes of concerns raised at UHBW, 20% relate to inappropriate attitudes or behaviours, followed by worker safety and wellbeing (16%). The highest category of concerns is 'policies, procedures and processes' (25%). Examples here from the past year include concerns around fairness and transparency in recruitment, alongside unresolved pay issues and problems with paperwork around visas for international staff.

4.10 It is frustrating to hear repeated concerns around recruitment despite the introduction of guidance for recruitment managers in 2022 – which outlines the correct process to follow to ensure fairness and transparency. Where recruitment managers are not adhering to the guidance, trust and confidence is eroded, alongside the environment in which colleagues feel safe to raise issues or concerns directly with their managers.

4.11 These themes, alongside concerns regarding the condition of the estate and shortage of space for staff parking, present challenges to the organisation and will inevitably influence staff behaviour, clinical performance, and ultimately patient safety.

4.12 Failure to demonstrate that learning is taking place is just one of the barriers to speaking up. Fear and futility are two of the key barriers to speaking up across the NHS as evidenced by the NGO in June 2023[4]. Futility in speaking up links directly to the NHS Staff Survey score around confidence that the organisation will address concerns raised (55.5% of respondents at UHBW in 2023). To better understand whether some of the barriers to speaking up are pertinent to an individual's protected characteristics, the FTSU Guardian has started to collect this data.

5. Summary of highlights

There have been several positive changes from a FTSU perspective:

5.1 Current compliance against mandatory speak up training as of March 2024 was 87.7%. The highest compliance fell under nursing and midwifery and admin and clerical staff.

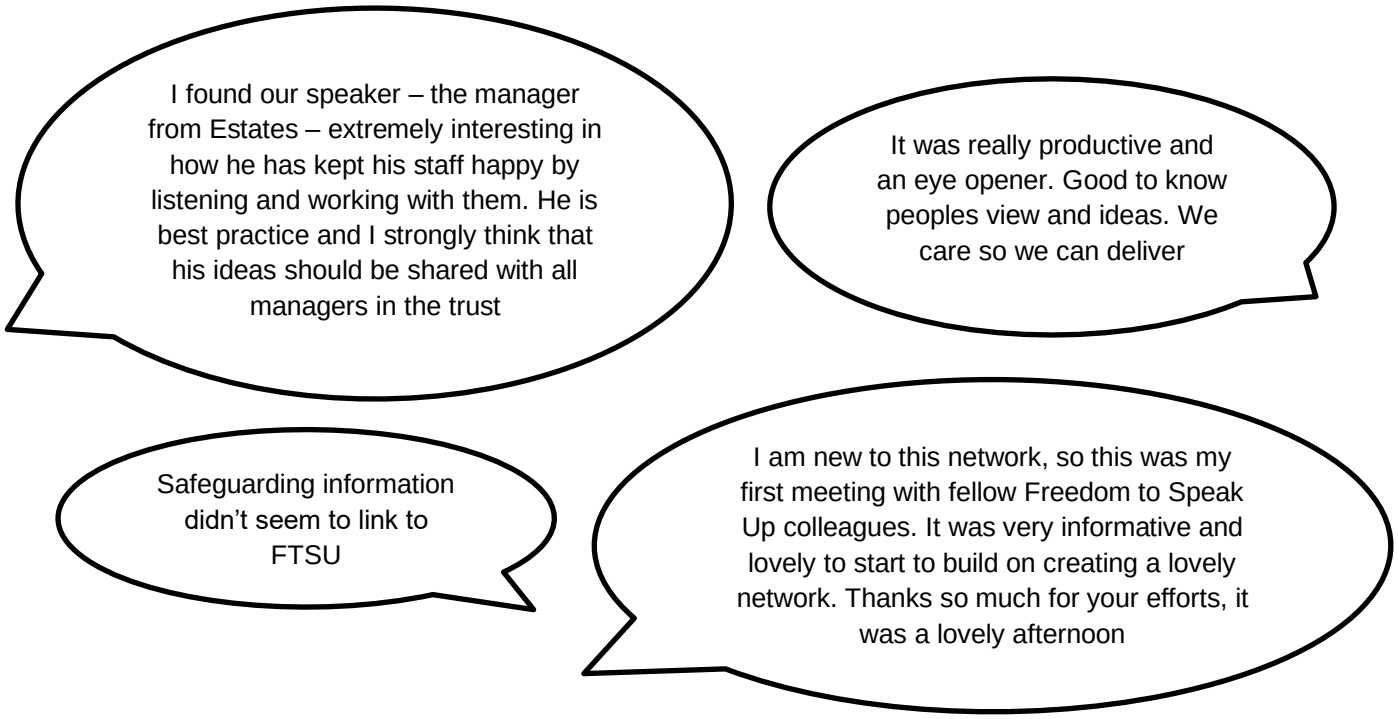
[4] Fear-and-Futility-NHS-Staff-Survey-1.pdf (nationalguardian.org.uk)

This may help to explain why greater reporting of concerns comes from this profession. The lowest compliance for all divisions falls under medical and dental staff.

5.2 The community of FTSU champions, who support the FTSU Guardians in their work, continues to develop and grow. There is a total of 80 champions. A buddying scheme has been identified to support all new champions. Ongoing efforts are being made to ensure visibility and access to a champion is available as widely as possible.

5.3 Colleagues have fed back that there is greater visibility of FTSU champions and Guardians. The Guardian regularly attends corporate induction, department meetings and walkabouts.

5.4 The first reflection and learning event for FTSU champions took place on 6 March 2024. On the back of the positive feedback, the event will be held biannually. Some of the feedback is noted below:



5.5 In response to the initial feedback around safeguarding (which is noted above) the materials for FTSU champion training were modified and included case studies. The training was delivered in partnership with the safeguarding lead.

5.6 The FTSU Guardians continue to work collaboratively with regional/system partners. As part of sharing good practice, the FTSU Guardian and three FTSU champions attended the South Western Ambulance Service CPR (creating positive relationship) programme. The programme was in response to significant concerns raised by student paramedics around power imbalance and inappropriate sexual behaviour. In response to the concerns raised and the feedback they received SWAST commissioned training which would encourage a safe speak up culture and providing tools and skills to safely challenge when witnessing poor behaviour. The FTSU Guardian has included and applied some of the learning in the training for all new champions.

5.7 As part of a collaborative piece of work with the University of the West of England (UWE) the FTSU Guardian along with other NHS providers in the South West have examined the reporting mechanism between healthcare organisations and education providers. Guidance posters on 'The role of the Freedom to Speak Up Guardians in supporting

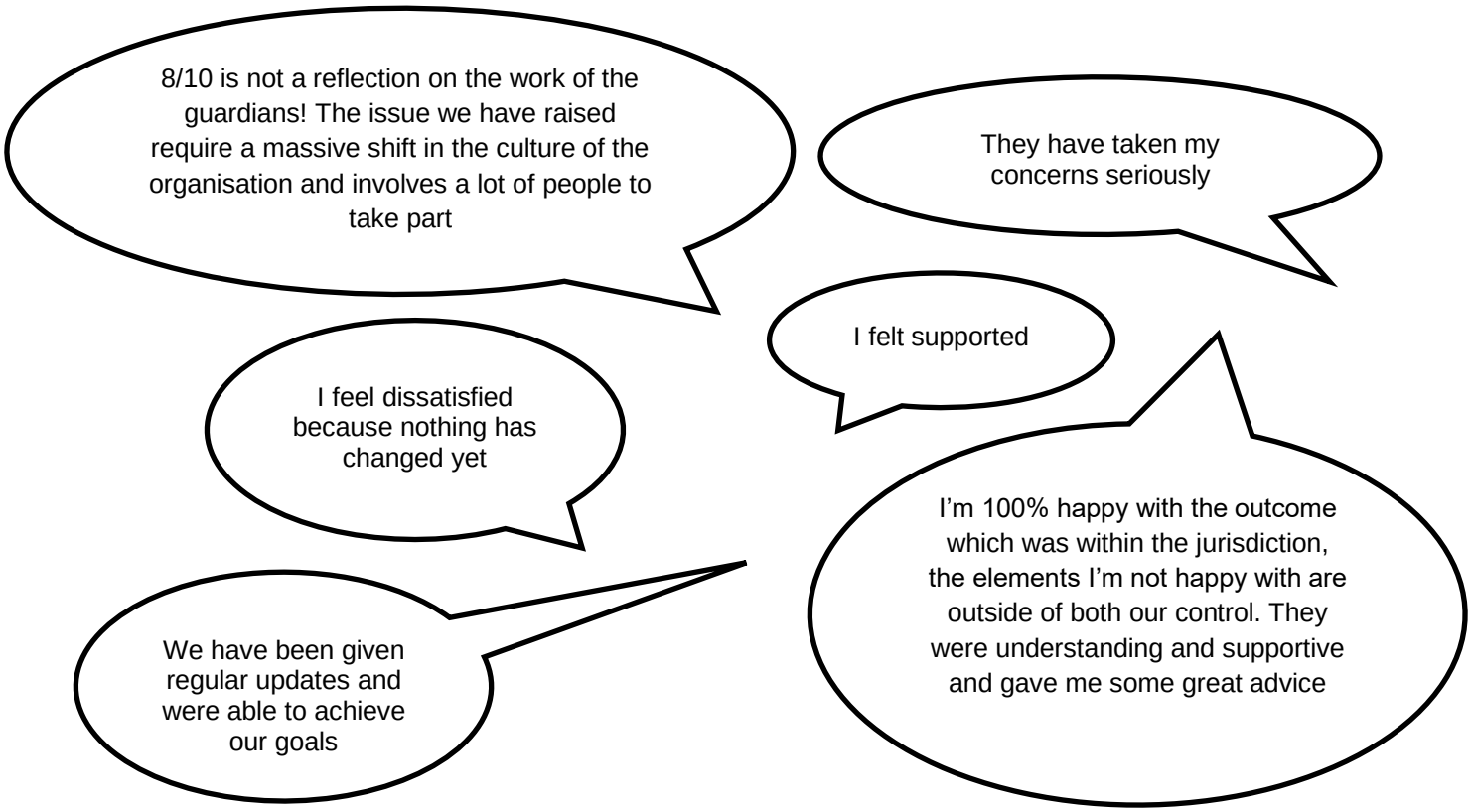
students' and UWE information posters has been disseminated to all students on placement within a healthcare setting.

5.8 Protected characteristics are now being captured in all areas of work completed by the FTSU Guardian.

6. FTSU user feedback

6.1 For all closed concern cases colleagues are given the opportunity to complete a short, anonymous feedback survey. 24 responses were collected. In response to the question: “Did you feel that your concerns were taken seriously?” 23 responded yes. In answer to the question: “Do you feel you have suffered in any way as a result of speaking up?”, three said yes, two didn’t wish to say and 19 said no.

6.2 Below are examples of some of the qualitative comments received:



7. Areas for improvement

7.1 Along with areas already described above, some concerns have failed to be resolved to the satisfaction of the individual/s who raised the concern because meaningful feedback has not been provided, or they have experienced significant delays as the concerns have become stuck in a process, or they do not always experience or see changes to their working environment. This erodes confidence that speaking up can make a difference.

7.2 Where change is not seen or felt, and poor behaviour is not held to account, this further adds to the sense of futility in speaking up and a lack of confidence that speaking up can deliver change.

7.3 Colleagues report discrimination being experienced on the grounds of sex, race and age. Failure to demonstrate learning to staff where discrimination concerns are raised, as with other concerns, erode confidence in speaking up. In the well-led domain of the CQC single assessment framework relating to Freedom to Speak Up is the statement: 'When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on.' By not learning we cannot prevent the same thing from happening again. At present it is not possible to extrapolate data that shows whether harassment or bullying is related to a protected characteristic. This will be collected from June 2024.

7.4 We will continue to try to enhance the diversity of the FTSU champion network to ensure balanced representation. Data which shows a comparison of the network membership to the UHBW workforce shows gaps in terms of representation in ethnicity (13% of champions are BAME compared to 25% of the workforce); age (22% of champions are under the age of 35 compared to 40% of the workforce) and by pay band (13% of champions are band 2 or 3 compared to 28% of the workforce, and we have low representation from the medical and dental workforce).

7.5 A common theme reported is around a disconnect with leaders. Colleagues report not feeling that they matter (some staff describing themselves as the invisible disposable workforce). It is suggested that enhanced visibility of senior leaders needs to be prioritised to show what good role modelling looks like and that all our colleagues matter.

7.6 The Leadership and Management Development Programme and the Respecting Everyone framework which was launched in 2023 is becoming embedded within the Trust. Colleagues report having had sight of the policy and its purpose. However, some have reported that the Respecting Everyone policy is being applied and used as a mechanism to prevent accountability when poor behaviour is reported. A Best Practice Group, including representation from across the organisation (Patient Safety, HR, FTSU, Staff Side, staff networks) will be in place from July 2024 to provide oversight of the delivery of the formal processes included within this policy.

7.7 The mandatory 'Compassionate and Inclusive Leader training' was launched at the end of April 2023. At the end of March 2024, 39% (750 managers) have completed the training. The challenges for the Trust are to both increase compliance and understand what impact it has on driving culture change.

8. Forward look 2024/25

8.1 A refreshed FTSU strategy has been drafted and shared with various stakeholders for feedback. This looks at what the FTSU service could deliver in the 12-24 months ahead. It will also consider how the service moves forward under a hospital group model. The resources required to deliver the strategy need to be confirmed before the strategy is discussed with the People Committee and presented to the Board.

8.2 Work has evolved in collaboration with colleagues across the Trust to understand and triangulate data about the health of teams across UHBW. This should help to pinpoint where more support/intervention is required and ensure a consistent, proactive approach to team development.

8.3 We will explore the use of new communication tools in the Trust (VivaEngage) to share and tell stories to help forge connection, empathy, learning and provides an opportunity to understand different perspectives.

9. Recommendations

9.1 The Board is asked to note the contents of the Annual Report for 2023/24 and discuss any actions it should now take in response.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9 July 2024

Report Title	**EPRR assurance for activity 2023- May 2024**
Report Author	**John Wintle, EPRR Manager**
Executive Lead	**Jane Farrell, Chief Operating Officer**

1. Purpose

This report is to give assurance by outlining activity over the period 2023-May 2024, that the Trust is meeting its statutory civil protection duties and contractual conditions of service in relation to Emergency Preparedness, Resilience and Response (EPRR).

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

The Trust was rated substantially compliant to the EPRR core standards in the NHS England annual assurance process for 2023. This is a return to previous years compliance position following a drop for 2021-2022 to partially compliant due to the impact of the global pandemic and responding to infrastructure related incidents. Gaps in business continuity (BC) plans across the organisation have been addressed through the implementation and embedding of the business continuity management system and the use of divisional declarations of assurance signed off at divisional management board level.

The report lists a summary of key risks for EPRR as well as the training and exercising undertaken over the time period, whilst concurrently responding to the disruption of industrial action.

3. Strategic Alignment

The strategic aim and the core principles of emergency planning align with "patient first" patient safety domain- Saving life and reducing harm in civil emergencies.

4. Risks and Opportunities

The risks associated with this report include:

- 199 =4 (moderate). Risk that incidents at massed gatherings event could cause disruption to Trust operational services
- 210 = 6 (moderate) Risk to Trust business and operations as a result of adverse weather conditions e.g., ice and snow
- 800 =9 (High) Risk that Trust operations are negatively impacted by (COVID-19) pandemic
- 1909 =9 (moderate) Risk that the Trust is unable to respond to major or business continuity incidents
- 2031=3 (moderate) Risk that contaminated patient self-presenting to one of the Trusts emergency departments is not identified
- 2453 = 4 (moderate) Risk that outdated major incident plans would not deliver a coordinated network response to a major incident

5. Recommendation	
This report is for information and assurance, the board are asked to note the current position of substantial compliance to the NHS England Core standards for EPRR.	
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**	
[Name of Committee/Group/Board]	[Insert Date paper was received]

Title:	Emergency Preparedness Resilience and Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V1.0 Final

Emergency Preparedness, Resilience and Response

Annual Report 2024

Prepared by: **John Wintle,** EPRR Manager

Presented by: **Emilie Perry,** Deputy Chief Operating Officer

Executive Summary

University Hospitals Bristol and Weston NHS Foundation Trust (the Trust) needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect the safe and effective operation of services. These could be anything from severe weather to an infectious disease outbreak or a major transport accident.

Under the Civil Contingencies Act (2004) (CCA), NHS organisations must show that they can effectively respond to emergencies and business continuity incidents while maintaining critical services to patients. This work is referred to in the health service as Emergency Preparedness, Resilience and Response (EPRR).

The Civil Contingencies Act 2004 places a number of statutory duties on NHS organisations which are classed as either Category 1 or Category 2 responders.

Category 1 responders are those organisations at the core of an emergency response. As a Category 1 responder, the Trust is required to prepare for emergencies in line with its responsibilities under the following:

- The Civil Contingencies Act 2004,
- The Health and Care Act, 2022 and
- NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) 2022.

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The NHS Core Standards for EPRR cover ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

Title:	Emergency Preparedness Resilience and Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V1.0 Final

In addition to the civil protection duties of the CCA 2004, the Trust must ensure it is compliant with Service Condition 30 of the NHS Standard contract for Emergency Preparedness, Resilience and Response as outlined below:

- Comply with EPRR Guidance if and when applicable.
- Identify and have in place an Accountable Emergency Officer.
- Notify the Co-ordinating Commissioner as soon as reasonably practicable and in any event no later than 5 Operational Days following:
    a) The activation of its Incident Response Plan and/or Business Continuity Plan or.
    b) any risk or any actual disruption to Commissioner Requested Service (CRS) or Essential Services.
- Provide whatever support and assistance may reasonably be required by the Commissioners and/or NHS England and/or the UK Health Security Agency in response to any national, regional or local public health emergency or incident

Part of the Trust is positioned centrally in what is known as a 'Core' city. This position places an even greater emphasis on there being robust up to date emergency plans in place. This report outlines the position of the Trust in relation to Emergency Preparedness, Resilience and Response and how the Trust will meet the duties set out in legislation and associated guidance, as well as any other issues identified by way of risk assessments and identified capabilities.

The Trust was rated substantially compliant to the EPRR core standards in the annual assurance process for 2023 an improved position from the previous year from a position of partial compliance.

There was a negative impact on progressing business continuity planning for non-staffing related disruption due to responding to the protracted and repeated rounds of industrial action.

2022 Strategic priorities progress

Theme	Action	Progress update
NHS England Assurance process	Improve from the EPRR core standards "partially compliant" rating of 86% to "Substantially compliant" for 2023.	The Trust was rated as "Substantially compliant" to the core Standards with acknowledgment of the work that has been done to achieve this position.

Title:	Emergency Preparedness Resilience and Response (EPRR) Annual Report
Owner:	Chief Operating Officer & Accountable Emergency Officer
Version:	V1.0 Final

Training	Continuing to ensure delivery of training in the emergency departments for the on-going CBRN training programme. Design and deliver a Trust wide business continuity training programme to support Trust preparedness and resilience	CBRN response and capability training has continued, with the annual CBRN Assurance audit carried out by SWASFT on behalf of NHS England identifying no non-compliances to the core standards. Business continuity response training has been delivered throughout 2023 including a joint exercise with ICS Partners. Live responses to incidents have acted as training vehicles and superseded the need for a full training programme for 2023.
System working	Support to develop a system wide mass countermeasure distribution plan, taking learning from mass vaccinations centres set up from Covid19 response.	This action was on hold throughout 2023 due to the response required to mitigate and minimise risks of the disruption from industrial action and the ongoing operational pressure in recovery of the health economy.
Shaping the future	Embed EPRR into the development of the new “Integrated care system” (ICS) to shape future local, regional and national preparedness actions.	The UHBW EPRR Manager was deputy chair of the local health resilience partnership business management group (tactical planning group) until Nov 2023. Key workstreams within the ICS included Fuel disruption and national power outage planning. System wide shelter and evacuation exercises, and VIP/ dignitary multiagency exercises.

EPRR Strategic plan for next 2 years

The EPRR manager undertook a gap analysis in 2022 to establish the strategic direction for UHBW EPRR in light of the changed health landscape both regionally and nationally in response to the health and care act, 2022. The newly formed Integrated Care Boards and Integrated care systems alongside the move to a regional approach from NHS England also influenced this review. The table below outlines the outcome and progress of this activity noting that phase 3 (the longer-term plan) is well underway.

Phase activity	Outcome

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Phase 1(July – November 2022): Assess position in new heath landscape. Complete	Understand UNBW's EPRR position against the following the strategic drivers: • CCA 2004 • NHS England EPRR Core standards, 2022 audit • Recovery from Covid to include lessons embedded (local and national) • NHS long term plan ICS/ICB • NHS England Southwest EPRR Strategy and move to regional Health resilience partnerships • ASW EPRR Audit (External Audit) • UHBW Divisional declarations of preparedness as part of Audit • Integration of Weston hospital into UHBW divisional management structure • Revised training needs analysis against national minimum occupational standards for EPRR and relevant guidance.
Phase 2 (Nov -Dec 2022): Identify strategic priorities Complete	• Requirement to implement a robust Business Continuity Management System • Develop Training and exercising Programme • Revise On-call arrangements post Weston hospital integration • NHS England Core Standards
Phase 3: (2023-2025). On Track	Embed actions and manage change for success of strategic priorities • Business Continuity Management System in place • Robust On-call arrangements across Hospital management teams in place and iterative. This includes the NHS England Minimum occupational standards for on-call incident leads being embedded. • Iterative Training and Exercise programme based on training needs assessment. • Move away from the pure focus of the core standards towards a holistic Emergency Planning Management system (EPMS). This incorporates the EPRR core standards as an element along with other key performance indicators - commencing spring 2024
Phase 4: Maintain and review	• NHS EPRR Annual assurance process • Annual Internal audit as part of BCMS • Peer review ICS Partners of UHBW EPMS.

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Further actions required to Risk 1909 - Risk that the Trust is unable to respond to major or business continuity incidents.

The work of Business continuity Planning has been an affected aspect of EPRR work due to protracted rounds of industrial action affecting the supply of staff to mitigate operational pressures taking them away from business-as-usual activities. The Business continuity management system embedded into the organisation includes annual audits of BC (Business Continuity) plans and divisional management board assurance and oversight of gaps.

Actions underway to resolve = Divisional management boards are holding the action plans to progress gaps within their division, and this is presented at Business continuity planning group meetings (a trust internal cross divisional group).

Conclusion

For the period of Jan 2023- May 2024 the EPRR Business continuity workplan was impacted by industrial action, as responding to these regular disruptive incidents prevented in depth planning for the consequences of other types of disruption such as loss of premises, process or procedures and critical infrastructure including power. The agility of the EPRR unit converted this protracted challenge into an opportunity to train and exercise key staff in the management of business continuity incidents and for the familiarisation of the role, purpose and layout of incident control centres and the principles of incident command and control.

The NHS England EPRR core Standards position improved from the previous year's "partial compliance" to "sustainability compliant" by:

- capitalising on the training opportunities from industrial action
- Completion of the High Consequence Infectious Disease plan
- Revising the Shelter and Evacuation plan and validating through exercises
- Embedding the new business continuity management system

The Integrated Care System provides an opportunity to create more collaborative system plans to support the response to incidents and emergencies in a cohesive way taking greater account of the local nuances including the specialist services delivered by individual organisations or shared services across the patch.

The Trust EPRR Unit is working to establish a more holistic approach to emergency planning that incorporates the NHS England Core standards as one element and not the whole element of the EPRR workplan. The Core standards are the minimum standards for EPRR for any NHS funded organisation and therefore UHBW's EPRR Unit are looking beyond this with the development of an Emergency Planning Management System (EPMS). The EPMS will identify key performance indicators taken from national guidance alongside real worked examples of recognised good practice across the EPRR community to inform the EPRR workplan in tandem with our Acute collaborative provider partners at NBT.

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Acronyms and Definitions

Acronym	Definition
AEO	Accountable Emergency Officer – at UH Bristol and Weston this is the Chief Operating Officer
BCMS	Business Continuity Management System
BCPG	Business Continuity Planning Group *(Internal Group)*
CBRN	Chemical, Biological, Radiological and Nuclear
EPRR	Emergency Preparedness, Resilience and Response
IRPG	Incident Response Planning Group *(Internal Group)*
ICS/ICB	Integrated care system / Integrated care board
ISO 22301	International Standardisation Organisation *(the International Standard for Business Continuity Management)*
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
NED	Non-Executive Director
OCMF	On Call Managers Forum *(Internal Group)*
SWASFT	Southwestern Ambulance Service NHS Foundation Trust

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1. Introduction

1.1 Purpose

This report outlines the Trust's EPRR activities during the period Jan 2023 to May 2024 that relate to the requirements of the Civil Contingencies Act (CCA) 2004, its associated regulations, statutory and non-statutory guidance.

The report is presented to the Trust Board in line with the national requirements of the NHS England Core Standards for Emergency Preparedness, Resilience and Response.

1.2 Background

The CCA, 2004 sets out a single framework for civil protection in the United Kingdom. It provides a statutory framework for civil protection at a local level and divides local responders into two categories depending on the extent of their involvement in civil protection work and places a set of duties on each.

Category 1 responders are those organisations at the core of emergency response. Acute Trusts are identified as Category 1 responders and are subject to the full set of civil protection duties.

UHBW is therefore required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning,
- Put in place emergency plans,
- Put in place business continuity plans,
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency,
- Share information with other local responders to enhance co-ordination,
- Co-operate with other local responders to enhance co-ordination and efficiency.

In addition to the civil protection duties of the CCA 2004, the Trust must ensure it is compliant with Service Condition 30 of the NHS standard contract for Emergency Preparedness, Resilience and Response as outlined below:

- Comply with EPRR guidance if and when applicable.
- Identify and have in place an Accountable Emergency Officer.
- Notify the Co-ordinating Commissioner as soon as reasonably practicable and in any event no later than 5 operational days following:
  a) The activation of its Incident Response Plan and/or Business Continuity Plan or.
  b) any risk or any actual disruption to Commissioner Requested Service (CRS) or Essential Services.

As a Category 1 responder UHBW is required to prepare for emergencies in line with its responsibilities under:

- The Health and Care Act, 2022, and

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- NHS England Core Standards for Emergency Preparedness Resilience and Response 2022.

The NHS England Core Standards for Emergency Preparedness, Resilience and Response are the minimum standards which NHS organisations and providers of NHS funded care must meet. **(Appendix 1).**

The NHS Core Standards for EPRR cover ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

1.3 National and local Context

For the NHS nationally and locally the crucial issues that required managing and that impacted recovery of services from the impacts of the global pandemic and delivery of care was industrial action. The below table outlines the dates and staffing groups that took part in industrial action that affected UHBW. For each period of disruption extensive mitigations planning were undertaken by core teams of staff across all sites and divisions. EPRR Command and control structures were used for the periods of disruptions as part of incident management to ensure strong leadership was in place to manage any patent safety issues and that action to manage safety issues could be undertaken as responsive as possible.

Dates	**Staff groups / Union**
*15/12/2022	Royal College of Nursing (RCN)
*20/12/2022	RCN
*21/12/2022	GMB, Unison, Unite - Ambulance
*28/12/2022	GMB- Ambulance
11/01/2023	Unison, GMB -Ambulance
18-19/01/2023	RCN
23-24/01/2023	Unison- Ambulance
26/01/2023	Chartered Society of Physiotherapists (CSP)

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06-07/02/2023	RCN, GMB / Unite - Ambulance
20/02/2023	GMB, Unite - Ambulance
13-16/03/2023	BMA (British Medical Association) Junior Drs, Hospital Consultants and Specialists Association (HCAS), British Dental Association (BDA)
11-15/04/2023	BMA Junior Drs, HCSA, BDA
30/04/2023- 01/05/2023	RCN
14-17/06/2023	BMA Junior Drs
13-18/07/2023	BMA Junior Drs
20-21/07/2023	BMA Consultants, BDA
25-27/07/2023	Society of Radiographers (SOR)
11-15/08/2023	BMA
24-26/082023	BMA
19-23/09/2023	BMA Consultants and BMA Junior Drs
02-05/10/2023	BMA Consultants and BMA Junior Drs, HCSA, BDA
03-04-/10/2023	SOR
20-23/12/2023	BMA Junior Drs, BDA
03-09/01/2024	BMA Junior Drs, HCSA
24-29/02/2024	BMA Junior Drs, HCSA

*Included in order provide context on the impacts of planning for disruption and the recovery period affecting normal service delivery

1.4 Progress on Strategic priorities from 2022

Theme	Action	Progress update
NHS England Assurance process	Improve from the EPRR core standards “partially compliant” rating of 86% to “Substantially compliant” for 2023.	The Trust was rated as “Substantially compliant” to the core Standards with acknowledgment of the work that has been done to achieve this position.

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Training	Continuing to ensure delivery of training in the emergency departments for the on-going CBRN training programme. Design and deliver a Trust wide business continuity training programme to support Trust preparedness and resilience	CBRN response and capability training has continued, with the annual CBRN Assurance audit carried out by SWASFT on behalf of NHS England identifying no non-compliances to the core standards. Business continuity response training has been delivered throughout 2023 including a joint exercise with ICS Partners. Live responses to incidents have acted as training vehicles and superseded the need for a full training programme for 2023.
System working	Support to develop a system wide mass countermeasure distribution plan, taking learning from mass vaccinations centres set up from Covid19 response.	This action was on hold throughout 2023 due to the response required to mitigate and minimise risks of the disruption from industrial action and the ongoing operational pressure in recovery of the health economy.
Shaping the future	Embed EPRR into the development of the new “Integrated care system” (ICS) to shape future local, regional and national preparedness actions.	The UHBW EPRR Manager was deputy chair of the local health resilience partnership business management group (tactical planning group) until Nov 2023. Key workstreams within the ICS included Fuel disruption and national power outage planning. System wide shelter and evacuation exercises, and VIP/ dignitary multiagency exercises.

2. Governance and Assurance

EPRR within the Trust is overseen by the Chief Operating Officer (COO) who acts as the Accountable Emergency Officer (AEO), The Trust has in place a senior responsible officer (SRO) for EPRR, this role is undertaken by the Deputy Chief Operating Officer. The SRO deputises at the strategic level in the local health resilience partnership (LHRP) in the absence of the AEO.

There is an EPRR Manager at 1.0 WTE 8a who is supported by an EPRR Officer at band 5 1.0 WTE, reporting to the Deputy Chief Operating Officer for Urgent and Emergency care.

The EPRR workplan is presented to the internal operational management group “Operational Delivery Group” (ODG) which is a cross divisional group that meets weekly. Under ODG are two substantive EPRR working groups chaired by the EPRR Manager. These are the Incident Response Planning Group (IRPG) and the Business Continuity Planning Group (BCPG). The work of both groups was impacted by industrial action response planning, which required an all-staff reaction.

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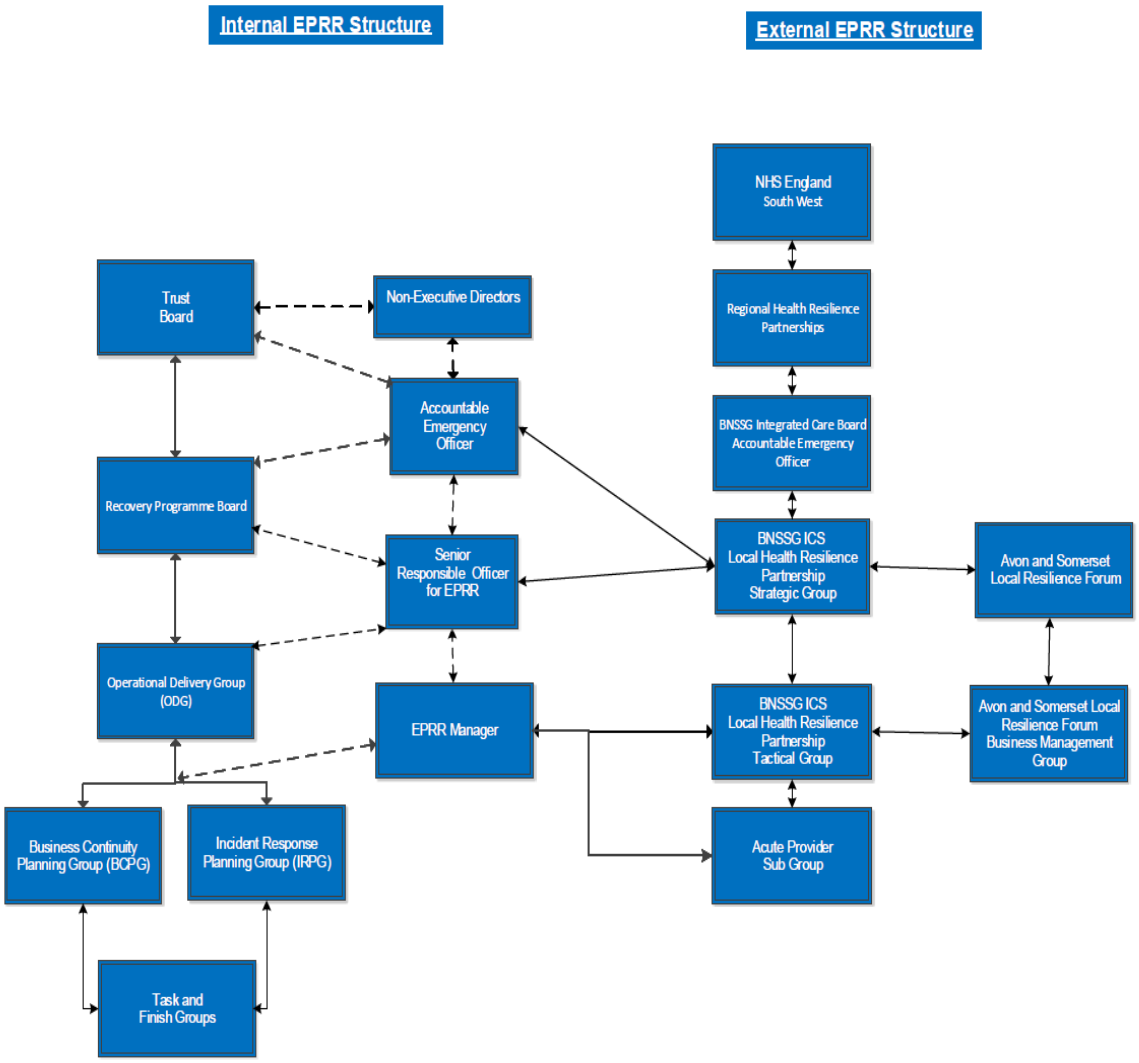
The diagram below represents the internal and external Emergency Planning, Resilience and Response governance structure and the link with external partners through the LHRP.



In the 2023 NHS England EPRR Core Standards review the Trust was deemed to be **Substantially compliant.** This was an improved position from the previous year's **partially compliant** position**.** The actions undertaken to improve this position by the Trust EPRR Unit included: -

- development of the trust evacuation and shelter plan,
- delivery of the High consequence infectious disease plan with associated training,
- Implementation and embedding of the business continuity management system,
- Improving the training and exercise process with a revised training needs analysis.

(See **Appendix 2** for UHBW outcomes and **Appendix 3** for BNSSG ICS assurance outcomes).

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2.1 Strategic plan 2022-2025 progress

The EPRR manager undertook a gap analysis in 2022 to establish the strategic direction for UHBW EPRR in light of the changed health landscape both regionally and nationally in response to the health and care act, 2022. The newly formed Integrated Care Boards and Integrated care systems alongside the move to a regional approach from NHS England also influenced this review. The table below outlines the outcome and progress of this activity noting that phase 3 (the longer-term plan) is well underway.

Phase activity	Outcome
Phase 1(July – November 2022): Assess position in new heath landscape. Complete	Understand UNBW's EPRR position against the following the strategic drivers: • CCA 2004 • NHS England EPRR Core standards, 2022 audit • Recovery from Covid to include lessons embedded (local and national) • NHS long term plan ICS/ICB • NHS England Southwest EPRR Strategy and move to regional Health resilience partnerships • ASW EPRR Audit (External Audit) • UHBW Divisional declarations of preparedness as part of Audit • Integration of Weston hospital into UHBW divisional management structure • Revised training needs analysis against national minimum occupational standards for EPRR and relevant guidance.
Phase 2 (Nov -Dec 2022): Identify strategic priorities Complete	• Requirement to implement a robust Business Continuity Management System • Develop Training and exercising Programme • Revise On-call arrangements post Weston hospital integration • NHS England Core Standards
Phase 3: (2023-2025). On Track	Embed actions and manage change for success of strategic priorities • Business Continuity Management System in place • Robust On-call arrangements across Hospital management teams in place and iterative. This includes the NHS England Minimum occupational standards for on-call incident leads being embedded. • Iterative Training and Exercise programme based on training needs assessment. • Move away from the pure focus of the core standards towards a holistic Emergency Planning Management system (EPMS). This

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	incorporates the EPRR core standards as an element along with other key performance indicators - commencing spring 2024
Phase 4: Maintain and review	• NHS EPRR Annual assurance process • Annual Internal audit as part of BCMS • Peer review ICS Partners of UHBW EPMS.

3. Risk Assessment

This section details how the Trust is complying with the duty to undertake risk assessments for the purpose of informing contingency planning activities.

3.1 Community Risk Register

University Hospitals Bristol and Weston NHS Foundation Trust contributes to the development and maintenance of the Avon and Somerset Community Risk Register (CRR) through the BNSSG Local Health Resilience Partnership (Tactical Group) where, amongst other areas, health related risks to the community are reviewed and updated and taken into the Avon and Somerset local resilience forum for multiagency review.

3.2 Trust Risk Register

EPRR risks are recorded on the Trust risk register. Risks assessed as scoring 12 or above are reviewed by the Trust Risk Management Group and Trust Board.

ID	Title	Description	Rating (inherent)	Controls in place	Adequacy of controls	Rating (current)	Rating (Target)
199	Risk that incidents at Massed Gatherings event could cause disruption to Trust operational services	If an incident occurred at massed gathering events in Bristol E.g., St Paul's Carnival, Bristol Balloon, Ashton Court, Maritime Festival, Bristol Half Marathon Then this could cause severe pressure on operational services Resulting in a major incident declaration impacting on the Trusts ability to operate normally	4= Moderate Risk	1. The Trust has in place Incident Response and Mass Casualty plans; these plans are exercised annually in line with the requirements of the Civil Contingencies Act 2004. 2. The Trusts EPRR unit receives notifications from the Safety advisory group of Bristol city council, south Gloucestershire and North Somerset council on planned events and the mitigations that will be in place.	Adequate	4 = Moderate Risk	4 = Moderate Risk

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				3. The Trust exercised the Mass casualty incident response plan November 2023 as part of an EMERGO exercise led by the Emergency Planning manager as part of a 3-year exercise cycle. 4. NHS England exercise completed March 9th, 2023, to test trauma network response			
210	Risk to Trust business and operations as a result of adverse weather conditions	If climate change continues to affect weather, Then there may be an increase in adverse weather (including ice, snow, flooding, Heat). Resulting in disruption to travel networks and infrastructure and potential increase of slips and falls and may impact negatively on the ability of staff and patients to travel to site, or the health and safety and welfare of staff and patients in heat wave weather.	9= High Risk	Internal resources for gritting roads and paths within all sites. Relationship with Community Pay Back teams to provide additional gritting and snow clearance., Monitoring weather reports from the MET Office to flag any deterioration in weather and trigger severe weather plan (as appropriate), emergency access to Multiagency Logistics cell that includes 4x4 capability to for the purposes of saving life in times of adverse weather, The trust has a severe weather plan in place. Estates are reviewing the current Planned Preventative Maintenance schedules, to ensure all roofs are covered and at the right frequency. Climate adaption planning is included through NHS estates and sustainability teams to reduce trust impacts on climate and mitigate against heat weather.	Adequate	6 = Moderate Risk	6 = Moderate Risk
800	Risk that Trust operations are negatively	If there is a national pandemic influenza outbreak (including any	25 = Very	The Trust has a comprehensive Pandemic Influenza plan that was	Adequate	9= High Risk	9 = High Risk

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	impacted by (COVID-19) pandemic	Novel Respiratory Disease such as COVID-19), Then there may be a significant increase in staff sickness rates at a time when activity is likely to increase and time pressures increase. a loss of available beds capacity due to introduction of social distancing measures and specific patient pathways based on infection status as opposed to Clinical presentation requirements. Resulting in the Trust being under severe pressure and operationally disrupted.		developed in consultation with UKHSA (United Kingdom Health Security Agency), other local health providers and internally the DIPC. This was utilised for covid-19. A management group will be activated to oversee the response reporting to recovery programme board with a number of sub-groups managing specific workstreams. Divisional leads will be appointed to coordinate divisional planning and cascade information to staff. TOR for group attached. An incident log will be maintained and can be reported on for assurance purposes.			
1909	Risk that the Trust is unable to adequately respond to major incidents	If there are extreme bed pressures in an extended period of a major or catastrophic internal or external incident, then the Trusts business continuity response may be hampered resulting in delay to normal operations	16 =Very High Risk	1. Trust has a business continuity management system in place to ensure effective and up to date business continuity plans to deliver a coordinated and timely response in place across most of the organisation. 2. Winter planning work 3. Up to date and effective incident response plans 4. the cross divisional group "Operational Delivery Group" (ODG) meets fortnightly and bridges the gap between OPEL 4 and a business continuity or critical incident to maintain patient flow over "Winter period" and high OPEL levels 5. ODG remains a capability that can be stepped up more frequently when de-escalation from an incident	Requires further action (see section 3.2)	9= High Risk	4 = Moderate Risk

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				related to operational pressure to prevent rebound into a critical incident. 6. Full Capacity protocol in place to ensure full use of all boarding capacity at Bristol 7. Operational Escalation plans in place across front door and critical care services			
2031	Risk that contaminated patient self-presenting to one of the Trusts Emergency Departments is not identified	If Patent(s) self-presenting to Weston or the Adult or Children's Emergency Departments In Bristol are contaminated by an unknown substance (either chemical, biological, radiological or nuclear from a malicious incident or an industrial accident) and if the patient is not identified and decontaminated then they pose an increased risk to themselves as well as the other staff and patients within the department resulting in patient harm, staff harm and disruption to normal operations	5 = Moderate Risk	The trust has a Chemical, Biological, Radiological and Nuclear (CBRN) response plan which covers the Adult and Children's ED (Emergency Department) in Bristol with a separate plan for the Weston site to account for the geographical and Estate differences. Key elements covered in these are: - Actions on identification and isolation of a potentially contaminated patient(s) - Contact details to access specialist advice - PPE (Personal Protective Equipment) for staff - Decontamination protocols including wet and dry decontamination processes - Quarterly training and maintenance for specialist CBRN kit -UHBW linked are in with SWASFT for a protective suit train the trainer programme 2022	Adequate	3 = Low Risk	3 = Low Risk

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2453	Risk that outdated major incident plans would not deliver a coordinated network response to a major incident	If a large-scale incident were to happen, then there is the risk of a lack of coordination across these networks if capacity was stretched beyond individual Trusts ability to respond. Whilst the Trust, and other neighbouring Trusts, have major incident plans the equivalent plans for the trauma, critical care and burns network are not up to date. Resulting in significant impact to trauma, critical care and burns services and delayed treatment.	9 = High Risk	The Trust is working with networks to inform local planning as well as supporting the networks develop and update their plans. Work includes support to a Burns network Emergo exercise, developing the mass casualty distribution plan with Severn trauma network and support to the critical care network in development of their plans.	Adequate	4 = Moderate Risk	4 = Moderate Risk

3.2 Risk 1909 - Risk that the Trust is unable to respond to major or business continuity incidents further actions required.

The frequency of triggering Business continuity incidents or critical incidents due to operational pressures has decreased along with the frequency of periods of extended escalation decreasing the likelihood from possible to unlikely. Existing plans revision are ongoing and cyclical as part of a robust business continuity management system to reflect changes in estate along with quality impact assessment to support release and re-deployment of staffing resources.

The work of Business continuity Planning has been an affected aspect of EPRR work due to protracted rounds of industrial action affecting the supply of staff to mitigate operational pressures taking them away from business-as-usual activities. The Business continuity management system imbedded into the organisation includes annual audits of BC (Business Continuity) plans and divisional management board assurance and oversight of gaps. Actions underway to resolve = Divisional management boards are holding the action plans to progress gaps within their division, and this is presented at Business continuity planning group meetings (a trust internal cross divisional group).

4. Maintaining Plans

This section details the activities undertaken to develop and maintain arrangements for responding to incidents. Planning activities are ongoing, informed by identifying risks as per the above risk register and the guidance available from NHS England.

4.1 Shelter and evacuation

The Trust Shelter and evacuation plan was revised to include new guidance from NHS England to include the requirement that patient's requiring additional support during shelter and/or evacuation events should have their needs predetermined and documented as part of general care planning. The plan was iterated and validated in two separate ICS exercises "Exercise Exodus" and "Exercise Displaced" with cross

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divisional input as part of task and finish groups. These exercises also acted as training in the plan for key staff involved in an incident response including on call teams for command and control.

4.2 Severe cold weather plan

The severe cold weather plan was revised to ensure that it was aligned to new guidance from the Met office and the joint UKHSA/ NHS England strategy for managing health in periods of extreme cold weather.

4.3 High Consequence infectious diseases

The Trust developed a newly created plan to manage the impact of patients presenting with potential or actual high consequence infectious diseases.

In the UK, a high consequence infectious disease (HCID) is defined by the UKHSA according to the following criteria:

- An acute infectious disease
- typically has a high case-fatality rate
- may not have effective prophylaxis or treatment
- is often difficult to recognise and detect rapidly
- has the ability to spread in the community and within healthcare settings
- requires an enhanced individual, population and system response to ensure it is managed effectively, efficiently and safely

The development of the plan combined the expertise of the trust Infection prevention and control team, estates and facilities, nursing and clinical staff, microbiology and virology teams amongst others. Teams participated in patient pathway walkthroughs to identify and mitigate issues from initial presentation, identification, infection containment and clinical investigations and treatments including onward transfer to designated HCID Centres in England.

4.4 Escalation plan

The Adults inpatient escalation plan is reviewed at least six monthly with the latest version of the plan reflecting further increased escalation capacity at Weston hospital. This included further mitigations to allow the use of all available space from work already undertaken in 2022 and reflects the fluidity of patient flow and the actions required to reduce ambulance handover times including actions that were needed to respond to sustained operational pressure and increased numbers of patients attending with respiratory illness.

4.5 Incident Response Plan

The Trust responded to a local incident at Hinkley point C by activating the incident response plan and declaring “Major incident- Standby “. This acted as a communications test as well as an opportunity to ensure that the new initial process added to the response from previous learning was clear and understood. This early process involves the rapid co-location and communication of the incident to operational teams, Emergency department staff and strategic and tactical incident leads. This innovative approach supported rapid decision making from shared situational

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awareness and enable a proportionate response to the incident in which the trust received no casualties.

The plan had a full review in Dec 2023 after a trust wide exercise in Nov 2023 to include the need for greater detail on mass casualty arrangements for the Trust's pre-determined response, and revised action cards.

5. Business and Service Continuity Planning

This section details the Trust's activities to develop, maintain and embed arrangements to ensure the continuity of service provision during an emergency or other disruption.

The standard for Business Continuity that has been adopted worldwide is known as ISO22301. NHS Specific supporting guidance was revised in 2023 to supplement the principles of the international standard.

Over the course of 2023-May 2024 there has been a continued focus on ensuring plans are updated to adhere to this standard, as well as being fit for operational use at the service delivery level.

The Business continuity management system implemented in 2023 includes divisional management boards making a declaration of preparedness that incorporates oversight of any gaps and holding the action plans to mitigate being reported into the Business continuity planning group. This is part of the annual BC audit cycle and is an ongoing process to ensure that divisional boards are sighted on their areas of risk and can accountably govern these accordingly.

6. Training and Exercising

The guidance set out by NHS England stipulates that exercises must be carried out and provides a time frame for the type and frequency of exercises. See table 1 below:

Exercise type	Minimum Frequency	Undertaken
Communications exercise	6 monthly	Not required as completed in live incidents
Tabletop	12 monthly	July 2023 "Exercise Displaced"
Live play	3 yearly	Completed in Nov 2023
Command Post	3 Yearly	2022-2023 Industrial action response

Table 1: EPRR exercises and frequency (Adapted from NHS England, 2022)

The response to industrial action since December 2022 has fulfilled the command post and tabletop requirements where the Trust had in place command and control structures and an incident co-ordination centre at both Weston Hospital and Bristol.

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Below is a summary of EPRR training and exercising which has taken place over 2023-2024.

6.1 Integrated care system evacuation and shelter exercises

South Bristol Community hospital evacuation – "Exercise Exodus"

UHBW Staff Participated in an exercise at South Bristol Community Hospital based on the scenario of a fire and loss of power to the site. The aim of the exercise was to examine the BNSSG (ICS) response to the whole site evacuation of a hospital care facility. However, it was also used as vehicle to understand gaps in the UHBW evacuation and shelter plan. This exercise informed the first iteration and development of the Trustwide shelter and evacuation plan.

The objectives were:

- Test ICS arrangements for a response to mass evacuation including:
  - Displaced people
  - Social care demand surge
  - Triage, tracking and transportation of affected persons
- Validate Sirona's care and heath's evacuation and shelter plans
- Evaluate interface of Sirona and UHBW, specifically:
  - Alignment of evacuation and shelter arrangements
  - Opportunities for interoperable efficiencies

Exercise outcomes:

UHBW and Sirona emergency planning, estates, facilities and operational colleagues worked collaboratively on harmonising existing emergency procedures and developing robust local communication and incident co-ordination arrangements at South Bristol Community Hospital.

Shelter arrangements for a complete site evacuation of SBCH (South Bristol Community Hospital) were explored in detail and formalised via MOUs/SOPs.

ICS level co-ordination of an entire site healthcare facility evacuation and shelter incident should be managed in line with the principles of personal evacuation plans and a plan be developed which should consider:

- Service users immediate and short-term medication requirements
- Formal discharge, handover of care and care act assessment requirements
- Specific management of IPC (Infection Prevention and Control) related issues in the case of a concurrent outbreak within an affected healthcare facility (evacuated or receiving)
- Transportation requirements, demand, supply and prioritisation including need to request standing up of the LRF Logistics Cell
- Consider integration with and/or alignment to local authority processes to reduce duplication of efforts
- Criteria for escalation to NHS Level 3 Incident
- Processes for management during the out of hours periods, particularly weekends and bank holidays

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- A process for the identification, escalation and agreement of ownership of the management of risks related to evacuation and shelter.

BNSSG ICS Hospital Evacuation exercise – "Exercise Displaced"

UHBW staff participated in the BNSSG ICS "exercise displaced" designed to Provide an exercise scenario to allow individual organisations to test their own Evacuation and Shelter and Incident Response Plans in relation to an evacuation of a hospital

The objectives were:

- Demonstrate the BNSSG ICS command and control arrangements by holding an ICS system escalation call in response to an evacuation of a hospital in the BNSSG area
- Review the key points from Exercise Exodus (LHRP exercise, Jan 2023, South Bristol Hospital Evacuation) to address the learning captured and to inform the development of an ICS level response plan
- Introduce to colleagues the capability of the Explosive Ordinance Disposal (EOD) and the support that they can offer.
- Identify the work required to develop an ICS Evacuation and Shelter response plan

The following outcomes from the exercise were subsequently taken into the organisation and were used to inform the final version of the UHBW Shelter and evacuation plan: -

No	Gap / Identified Action
1	NHSE guidance needs an action card to inform some of the early decision-making process
2	Need list of pre-identified evacuation points to ensure mutual aid processes are in place.
3	NBT (North Bristol Trust) – Switchboard would be affected. This is a real pinch point with no clear solution. Numbers could be diverted, but there would be issues with cancelling appointments etc.
4	Concern re agency staff only running some units overnight. Need to consider function of OOH team
5	SWAST major incident cascade does not always include BNSSG ICB, even though it is in the policy. This needs to be remedied.
6	Transport Cell – who would lead and facilitate? This needs discussion with SWAST who did not attend the exercise
7	Dispersal map for evacuated patients needed once there is capacity. This needs to include all levels of patients and evacuation definitions discussed – i.e. reverse triage to avoid confusion.
8	Concerns on high number of critical care patients to evacuate (numbers noted in escalation call). A 200m exclusion zone will make it difficult to get ambulances near the hospital so a plan is needed.
9	Need to link with regional team re Level 3 incident, patient dispersal, network

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	support. A plan is required for this with NHSE, Network Leads (Critical Care, Paediatric, Trauma, Burns), ICB
10	ICS Evacuation & Shelter Plan with Action Cards, in hours and OOH escalation process, Agenda's, cell structure and links to Avon & Somerset Local Resilience Forum (LRF). All templates to be included including Health Major Incident levels to aid understanding.
11	Emergency Care Act Assessments are in place with Local Authorities with a process in place. Handover of care required from NHS partners.
12	Risks – identification as part of system calls. JESIP (Joint Emergency Services Interoperability Programme) template

6.2 Acute providers Business continuity exercise

The EPRR Units of both UHBW and NBT joined forces to design and delivery a collaborative business continuity exercises for acute trusts.

The aim of exercise was to Validate the business continuity plans for the radiology services at both NBT and UHBW. To achieve this, the exercise had 5 objectives:

- Exercise Key Staff
- Explore the plan and process for the loss of the premises providing a radiology service.
- Identify mutual aid capabilities
- Identify interdependencies
- Ratify recovery time objectives and maximum tolerable period of disruption

The exercise took the format of a virtual tabletop exercise held over MS Teams with the emergency planning manager leading facilitated discussion. Scenarios were used with a series of injects in response to escalating levels of disruption

- Due to extenuating circumstances on the day, there was no representation from NBT, therefore the exercise was delivered as a UHBW only event.

The table below highlights the learning identified from the participants attending the exercise and contributes to personal learning objectives:

Learning summary	Key Takeaways
1. Understanding Service Disruptions	Participants gained insights into handling service disruptions and recognized the importance of clear action plans.
2. Enhanced Training and Clarity	Participants learned about the need for better training and clarity, especially in dealing with emergency scenarios.
3. User-Friendly Business Continuity Plan	Realization that the business continuity plan should be more user-friendly and tailored specifically for radiology.
4. Clear Escalation Process	Understanding the significance of having a clear escalation diagram within the radiology plan.
5. Action Plan for Radiology Disruptions	Recognizing the need for a user-friendly action plan in case of radiology service disruptions, including image burning.

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6. Additional Monitors for Service Continuity	Addressing the importance of extra monitors in radiology to maintain service continuity during disruptions.
7. Contingency for Image Transfer	Discussing the contingency of burning scans to a disc/CD-ROM for transfer to receiving organizations during disruptions.

The exercise report was shared with partners at NBT which provided an opportunity for NBT to delivery heir exercise and cross reference the shared learning

6.3 Escalation plan and winter operational business continuity

The aim of the exercise was to prepare the organisation for increasing pressure in the health and social care system against predictable operational challenges for the winter period. To achieve this the exercise had 5 objectives:

- Support divisions and services to review and identify any additional available inpatient capacity
- To explore extraordinary response arrangements that are required to maintain a safe organisation during significant operational pressure
- To explore the sustainability of mitigating actions to identified risks
- To act as a training vehicle for operational and tactical decision makers within UHBW
- Identify opportunities to ensure a safe balance of inpatient admissions against discharges to prevent overcrowding at the front door whilst continuing to manage patient safety throughout the period

The outputs from the session were used to inform the revised adults inpatient escalation plan and support the development of the “full capacity protocol” which is designed to support mitigation against ambulances queuing at the front door.

6.4 Trust Mass casualty exercise

This exercise was designed and delivered to test and validate the revised Major incident response plan and the mass casualty distribution plan for the region. Attendees were UHBW staff with strategic and tactical incident leads based in a separate incident coordination centre.

The objectives were:

- To test University Hospitals Bristol and Weston (UHBW) NHS Foundation Trust’s Major Incident Plan in response to a mass casualty event receiving 172 Adult casualties and 96 paediatric casualties in the first 4 hours of a major incident occurring inside of office hours.
- To test processes and patient flow through Emergency Department / Theatres / ICU /Trauma and Orthopaedics / for both Adult and children’s pathways.
- To involve Support Services in the response and identifying interdependencies
- To make staff aware of local major incident procedures
- To enable teamwork and leadership skills in an emergency response
- To provide staff with an opportunity to train on the processes and flow in a safe learning environment.
- To support validation of the revised action cards.

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The scenario required multiple tactical group meetings to ensure regular updates to the incident coordination team from key areas of the hospital. Staff were supported in each area by an exercise facilitator with regular reference to existing action cards to support development and iteration of the overarching plan.

Post the event action cards were reviewed by divisional leads and updated. The next step is to finalise the mass casualty aspect of the major incident suite of plans to include additional capacity identified to surge into to support releasing any potential ambulances that may be queuing at our sites prior to an incident occurring. Ambulances would require immediate release in the event of a major incident so that they can attend the scene of the incident requiring a temporary surge into areas not routinely used to support patient flow.

7. Warning and Informing

As a category one responder under the Civil Contingencies Act 2004 the Trust has a “duty, in partnership with others to warn and inform the public of emergencies”.

The Trust Communications Team continues to work in partnership with NHS England and the ICB to inform and warn the public when circumstances warrant it. The Communications Team issue messages either directly or in collaboration with the ICB and UK Health Security Agency (previously Public Health England) and are part of a local network of NHS Communications Teams. In the event of a major incident NHS England would ensure communications are coordinated and will link into the Trust communications department.

8. Cooperation

This section details how the Trust engages with local EPRR planning groups.

8.1 BNSSG Local Health Resilience Partnership (LHRP)

The Local Health Resilience Partnership, chaired by the ICB, brings together all NHS organisations to ensure coordinated and joined up planning across BNSSG. There are separate LHRP’s for Bath, Swindon and Wiltshire (BSW) and for Somerset. Between these 3 LHRP’s at least 1 ICB will attend the Avon and Somerset LRF and represent all of health in the area.

There is a strategic group that meets quarterly and is attended by the Accountable Emergency Officers (AEO) from all organisations in the BNSSG area. The Chief Operating Officer is the UHBW Accountable Emergency Officer (AEO) supported by the Deputy Chief Operating Officer. This group defines the strategic direction, the priorities and actively monitors the progress of the Tactical Planning Group.

8.2 Local Health Resilience Partnership Sub-groups

There are normally several LHRP subgroups and task and finish groups; membership of these groups is dependent on the area of focus of the group.

8.3 Local Resilience Forum (LRF)

The LRF is a statutory planning group attended by Category 1, 2 and uncategorised responders in Avon and Somerset, as defined by the Civil Contingencies Act 2004. Health is normally represented by the ICB, which acts in the interests of all providers. This group also informs some of the planning activity undertaken by the BNSSG LHRP.

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9. Recent Major or Significant Events

The Trust has experienced the following emergency incidents and disruptive events whilst responding concurrently to the disruption throughout the year as a consequence of industrial action.

Title	Date
BC Incident – water supply disruption BRI (Bristol Royal Infirmary)	14 January 2023
Major incident standby – Hinkley Point C Bus crash	17 January 2023
BC Incident -Unity Digital services	January 2023
BC Incident - Careflow EPR (Electronic Patient Record) digital service outage	7 March 2023
Amber heat health alert	9-12 June 2023
BC Incident -water mains burst St Michaels Hill	20 June 2023
BC Incident -water mains burst Eugene Street	23 June 2023
BC Incident- Digital clinical systems Trustwide	9 August 2023
BC Incident- Digital clinical systems Trustwide	30 August 2023
Amber heat health alert	5-10 September 2023
BC Incident-WGH CT Scanner Outage	18-21 December 2023
Critical Incident – Power outage across Bristol sites	3-4 May 2024

Debriefs have been undertaken as part of the EPRR policy with learning and lessons identified being used to improve the Trust's response.

10. Conclusions

For the period of Jan 2023- May 2024 the EPRR Business continuity workplan was impacted by industrial action, as responding to these regular disruptive incidents prevented in depth planning for the consequences of other types of disruption such as loss of premises, process or procedures and critical infrastructure including power. The agility of the EPRR unit converted this protracted challenge into an opportunity to train and exercise key staff in the management of business continuity incidents and for the familiarisation of the role, purpose and layout of incident control centres and the principles of incident command and control.

The NHS England EPRR core Standards position improved from the previous year's "partial compliance" to "sustainability compliant" by :

- capitalising on the training opportunities from industrial action
- Completion of the High Consequence Infectious Disease plan
- Revising the Shelter and Evacuation plan and validating through exercises
- Embedding the new business continuity management system

The Integrated Care System provides an opportunity to create more

collaborative system plans to support the response to incidents and emergencies in a cohesive way taking greater account of the local nuances including the specialist services delivered by individual organisations or shared services across the patch.

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The Trust EPRR Unit is working to establish a more holistic approach to emergency planning that incorporates the NHS England Core standards as one element and not the whole element of the EPRR workplan. The Core standards are the minimum standards for EPRR for any NHS funded organisation and therefore UHBW's EPRR Unit are looking beyond this with the development of an Emergency Planning Management System (EPMS). The EPMS will identify key performance indicators taken from national guidance alongside real worked examples of recognised good practice across the EPRR community to inform the EPRR workplan in tandem with our Acute collaborative provider partners at NBT.

Classification: Official

Publication reference: PAR1609_i

NHS core standards for emergency preparedness, resilience and response guidance

Version 6.0, 29 July 2022

Contents

1. Purpose

The purpose of the NHS core standards for EPRR is to:

- enable health agencies across the country to share a common approach to EPRR
- allow co-ordination of EPRR activities according to the organisation's size and scope
- provide a consistent and cohesive framework for EPRR activities
- inform the organisation's annual EPRR work programme.

2. Relevant legislation and guidance

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England.

Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.

3. Relevant legislation and guidance

The NHS England Board has a statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. This is provided through the EPRR annual assurance process and assurance report. This report is submitted to the Department of Health and Social Care and the Secretary of State for Health and Social Care.

As the NHS core standards for EPRR provide a common reference point for all organisations, they are the basis of the EPRR annual assurance process.

Providers and commissioners of NHS-funded services complete an assurance self-assessment based on these core standards. This assurance process is led nationally and regionally by NHS England and locally by integrated care boards.

4. NHS core standards EPRR

The NHS core standards for EPRR cover 10 domains:

1. governance
2. duty to risk assess
3. duty to maintain plans
4. command and control
5. training and exercising
6. response
7. warning and informing
8. co-operation
9. business continuity
10. chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

The applicability of each domain and core standard depends on the organisation's function and statutory requirements. Where organisations provide services across multiple organisation types, all the standards in all the applicable organisation types will apply; for example, an NHS111 service provider that also provides urgent treatment services (community) is required to comply with all the standards applicable to NHS111 services **and** community service providers.

An 11th domain is only applicable to NHS ambulance trusts and covers the 'interoperable capabilities' they must have in place.

4.1 Governance

An EPRR policy or statement of intent outlining the organisation's commitment to deliver EPRR must be in place. This statement should be supported by an annual EPRR work programme to ensure all NHS core standards for EPRR are delivered.

Organisations must have an appointed accountable emergency officer (AEO) who is a board-level director and responsible for EPRR in their organisation. Following a national review of non-executive director (NED) champions, the requirement for a non-executive board member to support the AEO has been removed, recognising

that the responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met.

The AEO must provide reports to the public board on EPRR activity no less frequently than annually and must publicly state its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.

Organisations that do not have a public board must instead publicly state their readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements.

4.2 Duty to risk assess

Organisations should have provision in place to regularly assess the risks to the population they serve. This process should consider the community and national risk registers.

A supporting risk management system must be in place to ensure a robust method of reporting, recording, monitoring, communicating and escalating EPRR risks internally and externally with partners.

4.3 Duty to maintain plans

Appropriate and up-to-date plans must set out how the organisation plans for, responds to and recovers from major incidents, critical incidents and business continuity incidents. These should be developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.

4.4 Command and control

A robust and dedicated EPRR on-call mechanism should be in place to receive notifications relating to EPRR. This facility should be 24 hours a day, seven days a week, and provide the ability to respond or escalate notifications to executive level.

Personnel performing the on-call function should be appropriately trained in major incident response.

4.5 Training and exercising

EPRR training should be carried out in line with a training needs analysis to ensure staff are competent in their role.

Arrangements must be exercised through, as a minimum, a:

- communications exercise every six months
- tabletop exercise once a year
- live exercise every three years
- command post exercise every three years.

4.6 Response

Staff trained in incident response should be available to respond to incidents from within an incident co-ordination centre (ICC). This includes having processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings. These arrangements should also include an alternative ICC, should the primary location be affected by the incident itself or be unavailable at the time of response.

4.7 Warning and informing

EPRR and communications planning activity should be co-ordinated to ensure communications align with organisational requirements during an incident. This includes ensuring access to trained communications support for senior leaders during an incident.

Communications plans should be tested alongside incident plans to support communication with partners and stakeholders, and warning and informing public and staff when responding to major incidents, critical incidents and business continuity incidents.

Organisations should also have appropriate media and social media strategies to enable communication with the public. This should include identification of, and access to, trained media spokespeople who can represent the organisation.

4.8 Co-operation

Arrangements should be in place to share appropriate information with stakeholders. This includes participation in local health resilience partnerships (LHRPs) and with local resilience forums (LRFs) and other multiagency planning forums to demonstrate engagement and co-operation with other responders.

4.9 Business continuity

Organisations must set out their intention and methods of undertaking business continuity in a policy and/or business continuity management system (BCMS).

The BCMS is part of the overall management system that establishes, implements, operates, monitors, reviews and improves business continuity.

The system allows organisations to identify prioritised/critical activities by undertaking a business impact analysis (BIA). In addition, it contributes to ensuring an organisation has business continuity plans in place to respond to business continuity incidents.

Each organisation should have in place a process to measure the effectiveness of the BCMS and take corrective action where necessary.

The BCMS should be in line with the International Standards for Organisations (ISO) 22301.

4.10 Chemical, biological, radiological, nuclear (CBRN) and hazardous materials (HAZMAT)

Acute, specialist, mental health and community healthcare providers are required to have planning arrangements in place for the management of CBRN incidents. NHS ambulance trusts also share this requirement and their specific responsibilities in relation to CBRN are set out in ‘interoperable capabilities’.

4.11 Interoperable capabilities

NHS ambulance trusts in England are required to maintain a set of specialist capabilities. These capabilities are nationally specified under the NHS England EPRR Framework.

These capabilities are interoperable between services. They must be maintained according to strict national standards to ensure they can be combined safely to provide an effective national response to certain types of incidents.

The interoperable capabilities include:

- hazardous area response teams (HART)
- marauding terrorist firearms attack (MTFA)
- chemical biological radiological nuclear (CBRN)
- mass casualty vehicles (MCV)
- command and control
- joint emergency services interoperability principles (JESIP).

5. Climate adaptation planning

Under the adaptation reporting powers of the Climate Change Act, the Greener NHS programme has been invited by the Department for Environment, Food and Rural Affairs to produce the health and care adaptation reports on behalf of the sector.

The third health and care adaptation report includes the recommendation for adaptation planning to be considered for inclusion in the latest revision of the EPRR core standards to increase systematic scrutiny.

This has been reflected across several existing relevant domains and standards including:

- the consideration of reasonable worst-case scenario and extreme events for adverse weather as a core component of community risk registers
- adverse weather arrangements should be reflective of climate change risk assessments and cognisant of extreme events
- climate change adaption planning to be considered as a longer-term impact on an organisation as part of a business continuity policy statement.

As with all the core standards, it will be important for EPRR leads to engage with relevant local leads for the Greener NHS programme or climate adaptation planning, not only to seek local assurance of these relevant areas, but also to align longer-term planning arrangements.

6. Equality and health inequalities

In complying with the core standards for EPRR, organisations must ensure all EPRR arrangements and planning consider the needs of people with protected characteristics and vulnerable groups, particularly with regard to: access to information, services and premises; increased risk based on health factors; safeguarding implications; and the management of restoration of services.

Equality and health inequalities impact assessments (EHIAs) are tools that can be used to assess the impact of arrangements and plans on the communities and populations the organisation serves.

The use of EHIAs, and any subsequent recommendations made as a result of EHIAs, will assist organisations in developing EPRR plans and arrangements that improve the care and safety, health and wellbeing of all patients, staff, visitors and populations from protected characteristic groups. Their use contributes to the assurances that NHS organisations are meeting their legal duties around equalities and health inequalities under the Equality Act 2010 and the Health and Social Care Act 2012.

7. Reviews and updates

The NHS core standards for EPRR are subject to an annual review. This review includes minor amendments and updates according to recent learning and changes in legislation and/or guidance.

A full review of the core standards occurs every three years, involving consultation with a working group. This was last conducted in 2022. The working group for the 2022 review consisted of representatives from a variety of NHS organisations and independent providers of NHS services from across the country, including commissioners, acute, specialist, mental health, community, patient transport and NHS111 service providers.

Any amendments/recommendations to future NHS core standards for EPRR can be directed to: england.eprr@nhs.net

Contact us
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This publication can be made available in a number of alternative formats on request.

Bristol, North Somerset and South Gloucestershire Integrated Care Board

UHBW – Core Standards Assurance Confirm and Challenge Meeting

Date: 29.09.2023
Time: 13.30pm-14.30pm
Location: MS Teams

Item No.	Agenda Item
1	**Welcome and Apologies** **Organisation** / **Name(s)** **Chair** – Lisa Manson **BNSSG Support (Note Taker)** – Jack Robison **UHBW** – John Wintle; Lucy Parsons; Jane Farrell **BNSSG ICB** – Janette Midda; Caroline Dawe Lisa Manson welcomed the group.
2	**Provider view of progress made since 2021/22 and positive achievements (brief discussion)** John Wintle noted that UHBW have significantly improved their position and have delivered more of the core standards as a baseline. Lockdown plan is being written by UHBW's security manager to make them site specific and then testing of. This should be completed by the end of year 2023. It is believed this would bring UHBW to 100% compliance. John is confident that the EPRR standards are largely rooted in practice due to regular response to incidents and Industrial Action. Divisional assessments have highlighted gaps for divisions to view and BC culture is now firmly embedded. There is now a BC management system in place. Lucy Parsons noted that BC management teams are meeting monthly rather than quarterly, this is working well. Staff and divisions are more familiar with the language of BC incidents now which is helping. During IA Divisions took increased accountability for BC which has enabled the EPRR team to focus on outstanding workstreams enabling compliance to be higher. EPRR assurance has confirmed this.

Item No.	Agenda Item
	BC management system shows how BC will be delivered and contains the correct governance. Every service has a BC plan to move forwards. Diagnostics and therapies audit will be available in December. They have an action plan which is signed off by the management board. They will continue to meet monthly to address the gaps. Communications plan for major incident is now in place. This is included in the evidence bundle. This document includes a media strategy and particular roles for the comms team. Shelter and evacuation plan is an interim plan. This was used in Exercise Displaced. UHBW is exploring the use of a mass notification system. Digital technology team has invested in these areas. Task and Finish group is making progress on these plans. Lisa Manson noted this is positive progress overall. Lucy Parsons noted that the High Consequence Infectious Disease (HCID) plan is a good plan. It is iterative and describes every step if a patient arrives with a HCID. Children's hospital plan will continue to be worked on. Consideration has been given to a scenario with a family being present. There is a negative pressure space in BRI where more than one person can be treated. A300 would be used for pregnant women with a HCID.
3	**Detailed review of self-assessment,** **Core Standards** Janette Midda noted that the countermeasures standard was met, which is why lockdown is the only item to be addressed (as noted in section 2 of these notes). **Deep Dive** 2 ambers in Training Needs Analysis and the minimum percentage of people to complete training (for strategic and tactical staff). This is going to be addressed through the year.
4	**Review of work programme to include areas of partial / non-compliance for 2023/24 and key priorities**

Item No.	Agenda Item
	Industrial Action has essentially been a BC exercise once per month. Training and Exercising is going to be a priority, and to keep staff members engaged.
5	**Programme for training & exercising** Lockdown plan will be completed by the end of November. This will be tested in July 2024 as part of a CBRN exercise. In terms of help, command and control training needs to be system focussed and with joined up exercises. Delivering loggist training takes place across the BNSSG patch. Training is offered to system partners. Have explored getting loggist training included in job roles, but there are challenges associated with this.
6	**Examples of good practice and innovation** HCID – This has been offered to NBT. Sirona would be welcome to utilise this as well. Screening questions are good practice. Felt that UHBW displays good system working as BAU. Mass Casualty – UHBW and NBT are heavily involved in this.
7	**Contribution to LHRP** LHRP BMG - Acknowledged thanks to John for his role as co-chair of LHRP BMG for a year. There is concern around how support for EPRR function is maintained in organisations. Lucy noted that work with on-call managers could help with this. On-call managers have a growing skillset.
8	**AOB** Impact of Industrial Action, and being approached as an exercise opportunity, has been productive. Lisa Manson noted that an impressive amount of work has been conducted for this.

Item No.	Agenda Item
	Thanks was given to Janette Midda's support.
9	**Summary and next steps** UHBW have improved in terms of compliance to the core standards. **98%**

NHS England South West

Our Reference: BNSSG/NOV23

To: Caroline Dawe, Deputy Director
Performance and Delivery, NHS BNSSG ICB

Copy: Janette Midda, EPRR Manager and
Jack Robison, EPRR Officer

Sent by email

Keith Grimmett
NHS England
Head of EPRR

Tel: 07783 816496
Email: k.grimmett@nhs.net

08 November 2023

Dear Caroline,

Emergency Preparedness, Resilience and Response (EPRR) annual assurance outcome for 2023/24.

Thank you for preparing and submitting your self-assessment, supporting evidence and your engagement prior to and during the review meeting held on October 30th, 2023. This letter summarises the outcome of this year's process, capturing any agreed actions.

ICB Outcome Summary

Organisation	2021	2022	2023
NHS BNSSG ICB	Full	Substantial	**Full**

Your agreed organisational compliance level for 2023 is Full, with the assessment showing full compliance against 100% of applicable standards (47 of 47). See annex 1 for descriptors.

Throughout the 2023 process and as summarised during the confirm and challenge session, you demonstrated comprehensive EPRR and Business Continuity Management Systems alongside recognition of the need for continual review and further development opportunities.

Deep Dive review

The focus of the deep dive for 2023 was EPRR Responder Training. Whilst these additional standards are subject to the same assessment processes as the 47 Core Standards, they are not included directly in your overall outcome scoring.

Your agreed organisational compliance level for the deep dive review is Full, with the assessment showing full compliance against 100% of the standards (10 of 10). See annex 1 for descriptors.

Advisories

NHSE provided comments against several fully compliant standards to support maintenance, general development and to achieve good practice. These comments are broadly termed 'advisories' and apply to the following standards.

Core Standard:

- 2: EPRR Policy
- 6: Continuous Improvement

The detailed narrative outlining suggested actions for standards with advisory comments has been discussed with your EPRR leads. A plan to support these actions should now be developed and form part of the 2024 Core Standards monitoring and support programme beginning in January.

BNSSG System Outcome Summary

You provided a full and concise overview of the approach you have used to undertake the EPRR Core Standards confirm and challenge process for 2023, demonstrating a close working relationship with your providers.

NHSE South-West did not have any observations or advisories to raise in relation to the confirm and challenge process you adopted to assess your providers and acknowledge the high level of support provided to them by your EPRR practitioners. With regards to your partially compliant providers, we noted that progress had been made and that the areas requiring improvement were different to those identified in 2022.

Organisation	2021	2022	2023
AWP	Full	Full	Full
NBT	Substantial	Substantial	Substantial
Severnside (Brisdoc)	Full	Full	Substantial
Sirona	Substantial	Partial	Partial
UHBW	Substantial	Partial	Substantial

Additionally, you confirmed that providers operating in BNSSG but covering multiple geographies are assessed by an agreed lead ICB. You confirmed you were engaged in that process for input and have been sighted on both the submission and the outcome as outlined below.

Organisation	2021	2022	2023
Severnside (PPG)	Full	Substantial	Full
SWASFT	Full	Full	Full

Next Steps

The outcome of this assurance review will be included in the annual EPRR Regional assurance summary letter which is reviewed and endorsed by NHSE South West's Senior Leadership Team before being presented to the NHSE National Team for wider scrutiny.

New ways of working were trialled for 2023 to complete the EPRR annual assurance process, NHSE will now conduct a regional review to capture successes and challenges. We welcome your local reflections on this and will provide feedback via your EPRR practitioners.

If you would like to discuss any elements of the confirm and challenge process and/or the contents of this letter, please do not hesitate to contact me directly.

Finally, thank you again for the hard work put into this year's assurance process while contending with significant system pressures, issues and incidents.

Yours Sincerely,

Keith Grimmett
Head of EPRR
NHS England South West

Annex 1: Compliance Levels

Organisational rating	Criteria
Full compliance	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliance	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public – 9 July 2024

Reporting Committee	**Audit Committee – June 2024 Meeting**
Chaired By	**Martin Sykes, Non-Executive Director**
Executive Lead	**Neil Kemsley, Chief Financial Officer**

This meeting was dedicated exclusively to end of year business, specifically reviewing the Trust's draft annual accounts and annual report for 2023/24 prior to their submission to the Trust Board for approval. The Head of Internal Audit Opinion for 2023/2024 was also received, which provided significant assurance on the assurance on the work undertaken during 2023/2024.

The Audit Committee recommended the annual accounts and annual report for 2023/24 to the Trust Board for approval.

The annual accounts and annual report were subsequently approved by the Board of Directors at ita meeting held in private on 11 June 2024.

Date of next meeting:	**16 July 2024**

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors on Tuesday 9 July 2024

Report Title	**Well-Led Review Action Plan Update**
Report Author	**Eric Sanders, Director of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Purpose

To present an update on the Well Led Review action plan for the Board's consideration.

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

The Board received the Well-led Review report to its meeting in March 2024, alongside an action plan to address the recommendations made by DCO Partners. The Board accepted the action plan and requested quarterly updates on progress.

Updates against the actions, including the priority areas relating to strategy, risk and performance reporting, are included in the appendix.

Good progress has been made against all actions including the launch of the new Trust Brand and Strategy, a revised approach to risk reporting and oversight, particularly relating to the principal risks to the Trust, and a revised approach to performance reporting.

The Board's Committees will have first sight of the new principal risks to the Trust at their meetings in July, with the new risks being presented to the Board every six months.

A revised performance report is also under development and will be ready by the end of Q2.

The Board should also note progress against the action relating to complaints handling, and cross refer to the most recent Quality and Outcomes Committee meeting where a fuller update on the actions to improve the complaints position were shared and discussed.

3. Strategic Alignment

The review is a key tool in assessing how well governed the Trust is, which supports delivery of the Trust strategy.

4. Risks and Opportunities

There is a risk that the Trust has "blind spots" and therefore does not identify and recognise merging risks or issues which could impact on the delivery of its objectives. This review will help assess how self-aware the Board and organisation is.

The review also presents an opportunity to identify any areas for improvement or development which will support the journey of continuous improvement by the Trust.

5. Recommendation	
This report is for **Information**. The Board is asked to consider and note the progress against actions.	
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**	
N/A	N

University Hospitals Bristol and Weston NHS Foundation Trust

Well-led Review – Action Plan – Update as at June 2024

Please note: Priority areas as agreed by the Bord are highlighted in Bold.

Recommendation	Accept?	Response	June 2024 Update	Lead	Due Date
KLOE 1					
A. The Board should reflect on the nature of when and where it deliberates on its future – a regulatory inspection will insist on full access and the Board needs to become comfortable with debating issues in front of others.	Yes (Already in place)	The Chair will continue to consider the appropriateness of observers depending upon the agenda and the business the Board needs to undertake.	N/A	Chair	N/A
B. The impact of the uncertainty over strategy is having an impact on the "day job". The Board must ensure that sufficient leadership resources are maintained to run day to day activity, ensuring that not everyone focuses on the future. See also Recommendations 1-9 in Appendix A	Yes	This forms part of our planning for the resourcing of the development of the group model plus in setting our leadership team's annual objectives and priorities	In progress	Interim CEO	TBC as part of the APC work

University Hospitals Bristol and Weston NHS Foundation Trust

Recommendation	Accept?	Response	June 2024 Update	Lead	Due Date
KLOE 2					
C. The Board needs to redouble its efforts on strategy and tie together all the various strands to form a coherent picture. This picture then needs to be communicated to staff at all levels – cultural improvements will be hampered without this leadership.	**Yes**	**Strategic narrative to be developed and shared with the Board.** **Revised strategic narrative to be communicated to staff**	**Our strategic narrative has been developed and shared with the Board.** **A difference that matters – encompassing our new vision, mission and purpose has been agreed, and is being rolled out aligned to launching full-hearted care and new communications channels. A clear visual strategy on a page has been developed and a visual alignment of this and our strategic priorities/divisional priorities are under development and will roll out in the summer.** **Clinical strategy delayed to ensure alignment achieved with Joint Clinical Strategy and messaging around Group Development. Engagement across the Clinical Divisions is strong.**	**Director of Business Development and Improvement and Director of Communications**	~~**31 March 2024**~~ **30 Sept 2024**

University Hospitals Bristol and Weston NHS Foundation Trust

Recommendation	Accept?	Response	June 2024 Update	Lead	Due Date
D. The Board needs to decide its approach to public consultation over strategy, developing themes now and not waiting for challenges to arise. This will require investment in time and resources and is extremely complex.	**Yes**	**Reminder of the legal requirement for public consultation to be shared with the Board.**	**N/A**	**Director of Corporate Governance**	**Completed**
E. The Trust should reassess its stakeholder maps as a matter of urgency and seek appropriate legal advice early.	Yes (Already in place)	Stakeholder management included in our Communications Strategy and due for renewed focus in 2025. Currently managed on a programme-by-programme basis.	Comprehensive stakeholder mapping will be one of the areas of focus as part of the Group Development work over the coming months.	Director of Communications	N/A
KLOE 3					
F. The Board needs to develop a parallel focus on developing those areas of clinical activity which impact on population health, namely primary care and mental health. The reasons why these areas lag behind have been well explained but their importance is in danger of being underestimated by the	Yes (Already in place)	This is in place as follows and no further action planned: • Active roles in the health and care improvement groups for mental health and improving the lives of people in our communities. • Participation and board membership in locality partnerships across Bristol,	N/A	Director of Business Development and Improvement	N/A

University Hospitals Bristol and Weston NHS Foundation Trust

Recommendation	Accept?	Response	June 2024 Update	Lead	Due Date
Trust, and collaborative work needs to commence soon.		South Gloucester and North Somerset • Health and Wellbeing Board members in North Somerset and Bristol (North Bristol Trust is member in S Glos) • Workstreams actively developing improvements in mental health provision/liaison across the acute sector • Development work underway with primary care • Health inequality leadership through CNO and well established health equity and inclusion group • Development work underway with Sirona Care and Health (local provider of community services) and Social Services – relationship building within senior leadership teams (exec to exec and with divisional leadership teams) plus operational delivery work through transfer of care hubs, Healthy Weston			

University Hospitals Bristol and Weston NHS Foundation Trust

Recommendation	Accept?	Response	June 2024 Update	Lead	Due Date
		and urgent and emergency care schemes (e.g. NHS@Home)			
G. Learning from Serious Incidents needs to be more specific. Divisional leadership needs to provide assurance that it has a grip on this important area and use IQPR data to develop conclusions that can be shared more widely across the Trust. The Quality Committee should then use these conclusions to inform its own deep dives.	Yes (Already in place)	The sharing of learning between divisions and corporate teams occurs at Clinical Quality Group which was not observed by DCO. Deep Dives at QOC are risk based not speciality based and are now aligned with the new PSIRF framework.	N/A	Chief Nurse and Midwife	N/A
H. The Complaints process will need an overhaul soon, with emphasis on speed and quality of response, and the backlog should be reported regularly to the Board. See also Recommendation 10 in Appendix A	Yes	Complaint process currently being reviewed with material changes to process and personnel underway. Initial efficiencies made to complaints process have been further supplemented with process mapping support from the Continuous Improvement Team which will be concluded in March. New format for response letters and investigation reports will be implemented for 1st April. Web portal will replace external email	Complaints handling process efficiencies have been implemented and are being embedded. New format for response letters and investigation reports implemented in April as planned. Caseworker backlog reduced from 310 (previous update) to 227 as at 21/6/24 = 27% improvement. An administrative backlog has re-	Chief Nurse and Midwife	~~April 2024~~ September 2024

University Hospitals Bristol and Weston NHS Foundation Trust

Recommendation	Accept?	Response	June 2024 Update	Lead	Due Date
		address to focus information received in enquiries – implementation also to be completed by 1st April. Administration backlog has been removed. Caseworker backlog currently holding steady at around 310 cases whilst process improvements are implemented.	emerged since the last update; 126 enquiries (of all types – not all complaints) are waiting to be logged on Datix as at 21/6/24, however all cases have been triaged, i.e. we know what we have received and have prioritised enquiries accordingly. Pace of recovery is being significantly hampered by high staff sickness absence levels in PALS & Complaints Team. Agreement secured to create two new full-time posts (B5, B4) to strength team capacity and resilience. Short-term bank and agency support engaged to maintain progress.		
KLOE 4					
I. Once the Weston integration is considered complete, the issue of the site Managing Director role will need to be debated and place in the context of either further site Managing Director appointments across the rest of	Yes	To be considered as part of the developing Group model which will need to consider site leadership.	In progress.	Interim Chief Executive	TBC as part of the APC work

University Hospitals Bristol and Weston NHS Foundation Trust

Recommendation	Accept?	Response	June 2024 Update	Lead	Due Date
the Trust or a reversion to the full COO role fully covering all sites. See also Recommendations 11-13 in Appendix A					
KLOE 5					
J. There are some significant risks facing the Trust which the Board urgently needs to identify and then classify. We felt that these included Estate Condition (particularly Fire Safety and IT development). This in turn should generate an investment programme to mitigate risks effectively. The risk profile should be prioritised on the basis of patient and staff safety and not Trust reputation or threat of legal challenge.	**Yes**	**Risk management refresh to be undertaken which will consider the process of identification, evaluation, escalation, and de-escalation of risk. A revised set of principal risks has been developed following a Board workshop held on 31 January 2024 and subsequently refined through a Board level Task & Finish Group.** **This revised picture of risk to then inform business planning and investment for 2024/25.**	**Following a Board workshop on January 31, 2024, and subsequent refinements by a Board-level Task & Finish Group, a revised set of principal risks has been developed. Additionally, we have established a new board assurance framework and reporting process. This updated risk profile will support business planning and investment decisions.** **Completed – most significant patient and staff safety risks have been addressed through revenue and capital prioritisation processes as part of the 24/25 planning round. Active risk assessment and EQIA processes will continue**	**Director of Corporate Governance** **Director of Business Development and Improvement**	**~~April 2024~~** **September 2024** **April 2024**

Recommendation	Accept?	Response	June 2024 Update	Lead	Due Date
			into 25/26 planning so as to ensure items not funded and/or newly raised issues have visibility and further opportunity to be resolved.		
K. The Board should review both its BAF and Corporate risk register to ensure greater coherence	Yes		As above for recommendation J		
L. The Board should conduct another Risk Appetite exercise and ensure that this matches its revised risk picture See also Recommendations 14-16 in Appendix A	Yes	The Board will consider if its Risk appetite statements need to be refreshed and will consider how to use the statements more effectively to drive action decision making. This is being led by a Board level Task & Finish Group.	The Trust's risk appetite statements are reviewed annually. This year, the statements have been updated and aligned with the revised principal risks and principal BAF risks. This alignment will enhance the effectiveness of our statements in supporting decision-making. This initiative is being led by the Board-level Task & Finish Group.	Director of Corporate Governance	~~April 2024~~ September 2024
	KLOE 6				
M. The performance picture given to the Board is overly complex and needs simplification in terms of volume of data and relevance.	Yes	Review of performance reporting alongside Patient First reporting to be presented to the Board for consideration.	The outcome of the review of performance reporting alongside Patient First reporting was presented to the Board for consideration and	Chief Operating Officer	~~April 2024~~ September 2024

University Hospitals Bristol and Weston NHS Foundation Trust

Recommendation	Accept?	Response	June 2024 Update	Lead	Due Date
			approval given to proceed. The revised integrated performance report incorporating Patient First will be developed over Q1 and Q2, with the aim of being operational in Q3. The production of the current IQPR (2 versions) will cease at that point.		
N. The Board should ask for urgent progression of the complaints backlog.	Yes		See response to Recommendation H		
O. The risks inherent with the Trust's own IT/Digital capability, and its ability to integrate services with other providers need further attention from the Board. See also Recommendation 17 in Appendix A	Yes	To be included in the Digital Strategy.	Completed. Digital Strategy approved by the Board.	Joint Chief Digital Information Officer	March 2024
KLOE 7					
P. The Board needs to develop a communications strategy to engage all stakeholders effectively and early on the	Yes (Already in place)	Communications Strategy in place alongside a communications plan for APC work. The plans will evolve as the programme evolves.	N/A	Director of Communications	N/A

Recommendation	Accept?	Response	June 2024 Update	Lead	Due Date
significant changes that are proposed for the future.					
Q. The Board needs to consider the wider clinical partnerships in Primary and Mental Health and Community services as part of its current strategic planning (see also KLOE 3 above).	Yes		See response to Recommendation F		
R. The Trust needs to redouble its efforts in communicating progress, or lack of it, to staff in terms of investment in facilities and equipment. See also Recommendations 18-19 in Appendix A	Yes	Communications need to distinguish between action to address issues with existing estate versus developments of a more strategic nature. Also requires building awareness of changes in regime that require ICB level decisions around allocations and priorities. Communications, through appropriate channels, to be issued by March 2024 with quarterly updates for existing estate and bi-annual for strategic thereafter.	The capital plan for 2024/25 has been further revised in Q1, following the confirmation of an increase in our capital limit of c£8m. This is largely driven by the change in the national financial regime that rewards Systems that have been able to commit to break-even revenue plans in this financial year. In early July we will communicate our plans for capital investment across the organisation and will include detail of those elements that will tackle infrastructure issues in respect of estate and digital. This will also include detail on	Chief Financial Officer	~~31 March 2024~~ September 2024

University Hospitals Bristol and Weston NHS Foundation Trust

Recommendation	Accept?	Response	June 2024 Update	Lead	Due Date
			spend already committed in the early part of the financial year. At a System level work further work is planned over the next couple of months with regard to the longer term ICS level Estates Strategy. This will include, for the first time, an agreed set of priorities for the Acute Sector within the ICS. It is expected that this will be finalised by early Autumn and can therefore be used to inform the next update to the wider organisation, with those communications to be co-ordinated with NBT.		
KLOE 8					
S. Innovation is happening in some notable pockets but its profile across the Trust is far too low. The Board needs to be an active sponsor of innovation, understanding the Trust's position and promoting learning across the Trust, and most importantly, it needs a narrative.	Yes	This is in place as follows and no further action planned. Clinical Lead for Continuous Improvement is beginning to scope out an innovation strategy framework engaging with NBT and wider system partners and stakeholders eg Health Innovation WoE	N/A	Chief Medical Officer	N/A

University Hospitals Bristol and Weston NHS Foundation Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 9 July 2024

Report Title	**Register of Seals Report**
Report Author	**Mark Pender, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Purpose
This report provides a summary of the applications of the Trust Seal made since the previous report in March 2024**.**
2. **Key points to note** *(Including any previous decisions taken)*
Standing Orders for the Trust Board of Directors stipulate that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the person who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust Seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing. Seven sealings have taken place since the last report, as per the attached list.
3. Strategic Alignment
N/A
4. Risks and Opportunities
N/A
5. Recommendation
This report is for **Information** The Board is asked to note the Register of Seals report.
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**
N/A

University Hospitals Bristol and Weston NHS Foundation Trust

Register of Seals

March 2024 to July 2024

Reference Number	Document	Date Signed	Authorised Signatory 1	Authorised Signatory 2	Witness
894	Renewal of lease by reference to an existing lease relating to Suite 5A, 3rd Floor, Whitefriars, Lewins Mead, Bristol between Topland Mercury Ltd and UHBW	12/03/24	Stuart Walker	Neil Kemsley	Mark Pender
895	Supplemental lease of Unit 4, Level 2, BRI Welcome Centre, between UHBW and Boots UK Ltd	12/03/24	Stuart Walker	Neil Kemsley	Mark Pender
896	Sonar / Watch / Retrieve fit out at 350 Quadrant Industrial Estate, Bradley Stoke, BS32 4QA. Contract document between UHBW and K.P. Witton & Sons Ltd	24/04/24	Emma Wood	Neil Kemsley	Mark Pender
897	TR1 Surrender of part of ground floor of St James Court, Bristol BS1 3HL between Jubb Consulting Engineers Ltd and UHBW	24/04/24	Emma Wood	Neil Kemsley	Mark Pender
898	Lease of part of 1st and 3rd floors of the Bristol Dental Hospital and 3rd floor of the Wellcome Building at Lower Maudlin Street between Bristol University and UHBW	08/05/24	Emma Wood	Paula Clarke	Rachel Hartles
899	Weston General Hospital Somatom Drive CT between Siemens Healthcare Ltd and UHBW	02/07/24	Stuart Walker	Emma Wood	Mark Pender
900	Renewal of lease for 9C Whitefriars between Topland Mercury Ltd and UHBW	02/07/24	Stuart Walker	Emma Wood	Mark Pender

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 09 July 2024

Report Title	**Governors' Log of Communications**
Report Author	**Mark Pender, Head of Corporate Governance**
Executive Lead	**Eric Sanders, Director of Corporate Governance**

1. Purpose
The purpose of this report is to provide the Board of Directors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous meeting. The Governors' Log of Communications is a means of channelling communications between the governors and the officers of the Trust.
2. Key points to note *(Including any previous decisions taken)*
Since the previous Board of Directors meeting held in public on 14 May 2024: • Three questions have been added to the log around Continuing Health Care, Pharmacy and Microsoft Legacy Licences. • Two questions have been answered on the log. • There is one question outstanding a response but is not yet overdue.
3. Strategic Alignment
N/A
4. Risks and Opportunities
None
5. Recommendation
This report is for Information
6. History of the paper **Please include details of where paper has <u>previously</u> been received.**
N/A

Governors Log July 2024

Governors questions reference number	Coverage start date	Governor Name	Governor Constituency	Description	Executive Lead	Coverage end date	Response	Status
294	21/05/2024	Ben Argo		The Finance, Digital and Estates Committee report from March 2024 noted 'a particular issue around legacy Microsoft licenses'. Given that end of life software will no longer receive security updates, and purchasing extended support is often very costly, I wanted to ask whether this was picked up during the rollout of Microsoft 365 last year; and seek assurances that this will continue to receive appropriate scrutiny going forward.	Chief Information Digital Officer	18/06/2024	The Microsoft 365 licencing issues are being reviewed currently and an options appraisal is being prepared for the next Digital Hospital Programme Board (DHPB) which aims to mitigate the risks that have been identified. I will be happy to share the paper and the outcome of the discussions after DHPB	Closed
295	29/05/2024	John Rose		What provision is in the contract with Lloyds Pharmacy to get prescriptions to patients who cannot collect their prescriptions at UHBW? It has been reported that Lloyds Pharmacy may use a courier service to deliver patient prescriptions, which can take up to 8 days to be delivered. When Boots Pharmacy held the contract with UHBW, a patient could request to collect a UHBW written prescription at their nearest Boots chemist in 24hours, and it is my understanding that Lloyds are unable to offer this service.	Chief Operating Officer	25/06/2024	Lloyds Pharmacy Healthcare Services have a formal partnership with Day Lewis Pharmacy to use their Community Pharmacy's as a collection point, similar to the model previously employed with Boots. There are 8 Day Lewis Pharmacy stores in the community that patients can nominate to collect their medication from. The service specification for Lloyds to provide medication for delivery either to a patients home or a Day Lewis Pharmacy for collection is 3 working days from Lloyds receiving the prescription. Currently waiting times sit above this expectation, but Lloyds are working with the Trust to recover this position and sustainably deliver a 3 working day turnaround. This is an enhanced service for patients in Weston who before 1st April 2024 were not able to collect their medication in the community. Lloyds and UHBW are monitoring if additional collection points are needed within the BNSSG area.	Closed
296	25/06/2024	Ben Argo		I wish to seek assurance that there are robust plans covering finance, resources, and contingency measures for when people receiving Continuing Health Care (CHC) are admitted as inpatients to our hospitals, and the Trust is instructed to temporarily assume responsibility for the person's care needs.	Chief Financial Officer	23/07/2024		Assigned to Executive Lead