University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday, 10 September 2024 from 13:15 to 16:30 in the Bordeaux Room, City Hall, College Green, Bristol

AGENDA

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS
Preliminary Business				
1.	Apologies for Absence	Information	Chair	13.15 25 mins
2.	Declarations of Interest	Information	Chair	
3.	Patient Story	Information	Patient and Public Involvement Lead	
4.	Minutes of the Last Meeting- **Tuesday, 9 July 2024**	Approval	Chair	
5.	Matters Arising and Action Log	Approval	Chair	
6.	Questions from the Public	Information	Chair	
Strategic				
7.	Chief Executive's Report	Information	Hospital Managing Director UHBW	13.40 10 mins
8.	Chair's Report	Information	Chair	13.50 10 mins
9.	Patient First Strategic Priority Update Report	Information	Executive Managing Director, Weston General Hospital	14.00 20 mins
10.	Board Assurance Framework	Information	Director of Corporate Governance	14.20 10 mins
Quality and Performance				
11.	Quality and Outcomes Committee – Chair's Report	Information	Chair of the Quality and Outcomes Committee	14.30 10 mins
12.	Maternity Assurance Report	Information	Chief Nurse and Midwife	14.40 10 mins

We are
supportive
respectful
innovative
collaborative.
We are UHBW.

University Hospitals Bristol and Weston NHS Foundation Trust

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS
13.	Learning from Deaths: a. Quarter 1 Report b. 2023/2024 Annual Report	Information	Interim Chief Medical Officer	14.50 15 mins
BREAK – 15.05 TO 15.15				
14.	Integrated Quality and Performance Report	Information	Interim Chief Medical Officer	15.15 10 mins
Financial Performance				
15.	Finance, Digital & Estates Committee Chair's Report	Information	Chair of the Finance, Digital & Estates Committee	15.25 10 mins
16.	Monthly Finance Report	Information	Chief Financial Officer	15.35 10 mins
Estates and Infrastructure				
17.	Green Plan Annual Report 2023-24	Information	Chief Financial Officer	15.45 10 mins
People Management				
18.	People Committee Chair's Report	Information	Chair of the People Committee	15.55 10 mins
Governance				
19.	Acute Provider Collaborative Board Closure	Information	Director of Corporate Governance	16.05 10 mins
20.	Audit Committee Chair's Report	Information	Chair of the Audit Committee	16.15 10 mins
21.	Register of Seals	Information	Director of Corporate Governance	16.25 5 mins
22.	Governors' Log of Communications	Information	Director of Corporate Governance	
Concluding Business				

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NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS
23.	Any Other Urgent Business – *Verbal Update*	Information	Chair	16.30
24.	Date and time of next meeting • **Tuesday, 12 November 2024**	Information	Chair	

Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 2024		
Report Title:	What Matters to Me – a Patient Story		
Report Author:	Tony Watkin – Patient and Public Involvement Lead		
Report Sponsor:	Deirdre Fowler – Chief Nurse and Midwife		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			Yes
	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.		

Key Points to Note *(Including any previous decisions taken)*

This patient story is set in the context of the role our Spiritual and Pastoral Care team has in supporting patients at the end of their lives. It is a story about forgiveness and one which helps us understand how, by knowing, understanding and supporting our patients' needs, we can deliver kind and compassionate care at a personal and spiritual level in a way that meets their wishes.

This is a very personal story which will blend elements from across our Experience of Care Strategy whilst offering a reflection on the impact and aspirations of our Spiritual and Pastoral Care team. It complements a staff story previously shared at private board in March 2024 and helps illustrate the holistic impact of Chaplaincy on our people and communities.

The story will be shared by Rob Morgan, Chaplaincy Team Leader.

By way of additional context, the Board approved the Trust's Experience of Care Strategy 2024-2029 "My Hospitals Know and Understand Me" in May 2024. The strategy Delivery Plan includes milestones across three years to deliver a skilled Chaplaincy service that is increasingly inclusive to all, enriching the experience of our patients and staff by providing a visible compassionate presence within our organisation. Click here to view the strategy document.

In November, the Board story will focus on the importance of accessible information and communication, in particular the role of Translating and Interpreting services in providing equitable care.

Strategic Alignment	
This work aligns to the True North Experience of Care strategic priority.	
Risks and Opportunities	
None.	
Recommendation	
This report is for **INFORMATION.** The Board is asked to **NOTE** the report **.**	
History of the paper (details of where paper has <u>previously</u> been received)	
[Name of Committee/Group/Board] **None.**	[Insert Date paper was received] **Not applicable.**
Appendices:	**None.**

University Hospitals Bristol and Weston NHS Foundation Trust

BOARD OF DIRECTORS (IN PUBLIC)

Minutes of the meeting held on Tuesday, 9 July 2024 at 13.45 – 16.45 in St James' Court, Canon Street, Bristol

Present

Board Members

Name	Job Title/Position
Ingrid Barker	Trust Chair
Martin Sykes	Non-Executive Director
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
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

Sonah Paton	Founder and Managing Director for Black Mothers Matter (for Item 3: Patient Story)
Laura Lewinson	Diversity and Inclusion Lead Midwife
Emily Judd	Corporate Governance Manager (minutes)
Rachel Liebling	Consultant for Obstetrics and Gynaecology
Sophie Mann	Modern Matron Midwifery
Mark Pender	Head of Corporate Governance
Tony Watkin	Patient and Public Involvement Lead (for Item 3: Patient Story)
Sarah Windfeld	Divisional Director of Nursing
John Wintle	Resilience Manager Emergency Planning

The Chair opened the Meeting at 13.45

Minute Ref.	*Item*	*Actions*
01/07/24	**Welcome and Apologies for Absence**	
	Ingrid Barker, Joint Chair, welcomed members of the Board to her first Trust Board meeting in public since taking on the role of Joint Chair of University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and North Bristol NHS Trust (NBT). Ingrid informed attendees that the meeting would be recorded and published on the Trust's YouTube account for public access following the meeting. Furthermore, Ingrid 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: • Anne Tutt, Non-Executive Director; • Susan Hamilton, Associate Non-Executive Director. Ingrid informed the Board that questions had been received from a member of the public that related to Lloyds Pharmacy, located within the Bristol Royal Infirmary Hospital entrance. Ingrid confirmed that answers had been provided to the questioner, to Board members, and to members of the public that were in attendance at the meeting. The questions and responses are attached to the minutes under Appendix I.	
02/07/24	**Declarations of Interest**	
	There were no new declarations of interest relevant to the meeting to note.	
03/07/24	**Patient Story**	
	Tony Watkin, Patient Experience Involvement Lead, introduced Sonah, the founder and Director of "Black Mothers Matter". Sonah drew on the experiences of black mothers and reflected on the wider social experience within maternity care services. Sonah highlighted what mattered to black mothers, where progress locally had been recognised (including current work to address equity at UHBW) and where an additional focus could bring most impact. Sonah provided examples of her own experience to the Board, where her first child was born pre-term after Sonah went into spontaneous labour at 28 weeks. Sonah acknowledged the exceptional care she received in the Neonatal Intensive Care Unit (NICU) but noted how the NHS Chaplaincy Programme within the hospital did not once acknowledge her throughout her ten-week stay, despite visiting all other patients' bedsides voluntarily. Sonah referenced other upsetting experiences during her hospital stay, such as her donated breastmilk being taken, but Sonah not being featured to appear on the social media pages for the milk bank meaning her breastmilk was not utilised. Ingrid thanked Sonah for her powerful story and opened the meeting to questions from the Trust Board. Sue Balcombe, Non-Executive Director, thanked Sonah for sharing her experience and for providing insight into the inequitable maternity outcomes faced by black mothers receiving healthcare with the NHS. Sue queried whether healthcare and support for black mothers had progressed since Sonah's experience and Sonah felt that the care received within NICU had shifted, however it was still apparent that black mothers were not reflected on the social media pages for the milk bank. Deirdre Fowler, Chief Nurse and Midwife highlighted an ongoing project called "Reframe" with UHBW's Medical Illustrations team, NHS England, and the University of the West of England (UWE). The Reframe project would seek to address the current deficiency in diverse healthcare images by creating a comprehensive digital library of photographs that could be used, both in healthcare education and in practice, to accurately show how different conditions can present in various ways among a diverse group of patients. Marc Griffiths, Non-Executive Director, asked Sonah whether she knew how well UWE was connected with Black Mothers Matter and whether the university could do more to help. Sonah said the team at Black Mothers Matter had visited the university to talk to the midwifery students, and Deirdre	

Minute Ref.	*Item*	*Actions*
	added that two UWE lecturers were on the Black Maternity Matters supportive collaborative, along with Deirdre, Maria Kane, Chief Executive for North Bristol NHS Trust (NBT), and Steve Hams, Chief Nursing Officer for NBT. Sonah explained how Black Maternity Matters provided an anti-racism education and training programme, examining a range of topics including unconscious bias and the role of the individual in perpetuating unsafe systems for the care for black women. The Board were keen to hear from the maternity team about their experiences of Black Maternity Matters and Sarah Windfeld, Divisional Director of Nursing, commented that more could be done within the organisation to recruit a more diverse workforce to reflect the people the Trust served. In terms of training for maternity staff, Laura Lewinson, Diversity and Inclusion Lead Midwife, said maternity teams had received training specifically on caring for black mothers and the team had visited UWE to teach students about perinatal bias. The Black Mothers Matter group also ran free community events for black mothers. Stuart Walker, Interim Chief Executive thanked Sonah for the insight into how the organisation provided maternity care for its black patients and recognised that the disparity of care was not fair. Stuart asked Laura if there was anything further the Board could do to support the work and Laura responded that continued support from the Board was welcome and had helped to shape improvements for black women. Ingrid noted the lived experiences and health inequalities experienced by the women UHBW was serving and assured Sonah that the Board would take this story away to consider how it could learn from these experiences and apply it to other areas within the hospital. Deirdre referred to a Ted Talk that Sonah was preparing which she would circulate to the Board once available. **RESOLVED that the Patient Story be received and noted for information**.	
04/07/24	**Minutes of the Last Meeting – Tuesday 14th May 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 14th May 2024. **RESOLVED that the minutes of the meeting of the University Hospitals Bristol and Weston NHS Foundation Trust Board held in public on Tuesday 14th May 2024 be approved as a true and accurate.**	
05/07/24	**Matters Arising and Action Log**	
	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.*** This item would come to the September meeting of the Board. **Action ongoing.** **19/03/24:** ***Director of Corporate Governance to amend the Modern Slavery and Human Trafficking Statement 2023/24 to include social care.*** The Modern Slavery and Human Trafficking Statement 2023/24 had been updated and published on the Trust's website. **Action closed**.	

Minute Ref.	*Item*	*Actions*
	RESOLVED that the updates against the action log be noted.	
06/07/24	**Chief Executive's Report**	
	Stuart Walker, Interim Chief Executive, provided a verbal update on the following key issues: • **Industrial action** – The Trust was managing ongoing industrial action and continued to support colleagues regardless of whether they participated in the industrial action. It was hoped that discussions with the new Government would reach some form of resolution. • **National Letter –** All NHS Trusts had received a letter flagging the importance of delivering high-quality care for Emergency Department patients, even in the most pressurised environments. The letter referred to the two-year recovery plan from the Covid-19 pandemic. The Trust was checking all its processes against the two-year plan which would be reported to the Quality and Outcomes Committee, and a system process was being undertaken for all partners to form a trajectory. • **General Election 2024** – Stuart congratulated MPs within the Bristol area on being elected in the recent general election, and noted that meetings would be organised with local MPs including Carla Denyer for for Bristol Central. • **Common Ambition Team** – Stuart informed the Board that he had visited the Common Ambition Team at Pablo's Barber Shop in East Bristol. He reminded the Board of this community-based service that sought to provide support to African and Caribbean heritage communities in Bristol to reduce HIV diagnosis, stigma and generally improve sexual health. In response to a query from Martin Sykes, Non-Executive Director, it was confirmed that Weston General Hospital would be included in the overall response to the letter received on patient care. **RESOLVED that the Chief Executive's report be received and noted for information**.	
07/07/24	**Joint Chair's Report**	
	Ingrid Barker, Joint Chair, introduced the Joint Chair activity report and described her activity with both Trusts since starting in June 2024. Ingrid had connected with Trust colleagues by visiting numerous areas of both Trusts. Ingrid had also met with system partners and attended an Integrated Care Partnership Meeting. **RESOLVED that the Joint Chair's activity report be received and noted for information**.	
08/07/24	**Patient First Strategic Priority Projects Update**	
	Paula Clarke, Executive Managing Director for Weston General Hospital, introduced the first quarterly update report on the Patient First strategic priority projects for 2024/25. Paula explained that the report provided an assessment of the progress with project timelines and milestones being on or off track and assessed delivery of project targets against trajectory. Paula	

Minute Ref.	*Item*	*Actions*
	advised that metrics are continually reviewed to ensure we are addressing the actions that will make the most difference. She provided an example of the ready for discharge metric which has changed to now focus on bringing the median discharge time forwards by 2 hours by March 2025 and she described the cultural change that would be necessary to deliver this approach. Paula outlined the assessment made in June 2024 and 6 of the True North metrics were red, 2 of the 20 strategic priority project timelines were red and 5 of the strategic priorities were in development. Emma Wood, Chief People Officer, updated the Board on the breakthrough objective "Delivering the Pro Equity promise" which would positively impact on the whole organisation. Emma noted that the first draft would be presented to the People Committee. Arabel Bailey, Non-Executive Director recognised how everyone in the organisation had a part to play in the Patient First approach and queried what progress had been made around the breakthrough objectives relating to fire evacuation and Implementing Careflow Medicines Management. Neil Kemsley, Chief Financial Officer said he would take an action to bring a progress report on the Patient First breakthrough objective relating to Fire Evacuation to the Finance, Digital and Estates Committee. **Action – Neil Kemsley to bring a progress report on the Patient First breakthrough objective relating to Fire Evacuation to the Finance, Digital and Estates Committee.** In terms of Careflow Medicines Management, Becky Maxwell, Interim Chief Medical Officer, reported that the project had been delayed to November to ensure all assurances for successful implementation were in place. Marc Griffiths, Non-Executive Director commended the teams involved for achieving 100% in fire safety. **RESOLVED that the Patient First Strategic Priority Projects Update be received and noted for information.**	Chief Financial Officer
09/07/24	**Carbon Reduction Plan**	
	Neil Kemsley, Chief Financial Officer provided an update on the Trust's Carbon Reduction Plan which followed on from discussions held at May's Board meeting. Neil noted that the Annual Sustainability update was due to come to the Board in September which would provide the latest updates and provide the option to test the realism of achieving the Trust's Green Plan commitment to be net zero carbon by 2030. Neil explained that the Board was being asked to approve the Trust's Carbon Reduction Plan to allow for publication as part of a requirement of Procurement Policy Note 06/21 that Carbon Reduction Plans were Board approved and publicly available. Rosie Benneyworth, Non-Executive Director, noted the link between environmental sustainability and patient safety health outcomes and asked whether a quality and safety group had been established within the Trust to explore this. Neil confirmed that the BNSSG Green Plan had considered a clinical voice and would consider examples such as carbon emissions associated with the hospital's supply chain. Neil noted that UHBW's response and actions would align to the system-wide Green Plan. Annabel Bailey had read the system-wide Green Plan which she considered to be ambitious and asked whether a progress update could be provided to the Board. Neil said the plan could be provided to the Board and noted that the Interim Director of	

Minute Ref.	*Item*	*Actions*
	Procurement would be talking about the supply chain in more detail to the Finance, Digital and Estates Committee in September. Rosie asked from a Trust level perspective, whether there was enough focus on clinical outcomes for patient safety, such a pre-filled syringes and Neil responded that this information was available and would align to the system-wide Green Plan. Linda Kennedy, Non-Executive Director asked whether the objectives within the report could be split out to demonstrate what the objective was trying to achieve, and the progress made against that objective. Neil said he would provide the last report to Linda which would support the progress and confirmed that he would add updates into the September report. **Action – Neil Kemsley to provide the previous sustainability report to Linda Kennedy and update the next report to provide a table of objectives and progress made.** Marc Griffiths, Non-Executive Director reported that he had been approached by Trust staff about the idea of an apprenticeship for the Green Plan programme of work which he felt was a positive direction of travel for the Trust. Roy Shubhabrata, Non-Executive Director, highlighted a small typo that should be changed ahead of publication. Ingrid summarised that the Carbon Reduction Plan was hugely important in light of the Trust's role as an anchor institution and noted that the Trust had a duty to improve the environment for the region it served. Ingrid asked Board members to approve the Carbon Reduction Plan, and there were no dissenting voices. **RESOLVED that the Carbon Reduction Plan be approved.**	Chief Financial Officer
10/07/24	**Quality and Outcomes Committee – Chair's Report**	
	Marc Griffiths, Non-Executive Director, introduced the Quality and Outcomes Committee Chair's Report from May's meeting which he had chaired in Sue Balcombe's absence. Key points from the report included: • The Committee considered the Care Quality Commission (CQC) Paediatric Audiology Letter of Concern which all NHS Trusts had received. It was noted that the report highlighted the Trust's response to the letter. Sue Balcombe, Non-Executive Director and Chair of the Quality and Outcomes Committee introduced the Chair's Report from June's meeting. Key points from the report included: • The Committee approved the Annual Quality Account. • The Committee agreed to close the Trust's Quality Strategy as the Clinical Strategy was now in place. • The Quarter One Care Quality Commission (CQC) composite action plan was received, and it was noted that additional actions had been added following the recent inspections of Theatres and Maternity. The Committee approved the closure of 10 actions leaving around 40 open.	

Minute Ref.	*Item*	*Actions*
	Arabel Bailey, Non-Executive Director queried the difference in Safer Staffing fill rates within the report, compared to the Six-Monthly Nurse Staffing Report. Deirdre Fowler, Chief Nurse and Midwife explained that the Six-Monthly Nurse Staffing Report had been reported until the end of March 2024, whereas the report sent to the Committee was a monthly update. **RESOLVED that the Quality and Outcomes Committee Chair's Reports for May and June 2024 be received and noted for information.**	
11/07/24	**Six-Monthly Nurse Staffing Report**	
	Deirdre Fowler, Chief Nurse and Midwife introduced the Six-Monthly Nurse Staffing Report which was to provide assurance to the Trust Board that wards and departments had been safely staffed in line with the National Quality Board guidance and Developing Workforce standards. Key updates included: • For the six-month period covered by the report, the adult fill rates had been consistently above 95%. Bristol Children's Hospital for Children (BRHC) fill rates had remained slightly below this level at 93%. • The vacancy level for Band 5 nursing staff had reduced to 4.8% (90.1 WTE) and there was one Band 5 vacancy, which was a huge improvement on the previous position. • The Registered Nurse Turnover rate continued 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 Trustwide focus on retention initiatives. Deirdre noted by comparison that at the end of 2022, the turnover rate was reported at 19%. • The current Allied Health Professions (AHP) staffing turnover had reduced to 12.9%. Deirdre noted that vacancies within the specialties and professional groups varied with problem areas in Diagnostic Radiography and Occupational Therapy, reflecting national areas of difficulty in recruitment. Regular reports would continue to the People Committee in this area. • Improvement had been seen in safe staffing due to funding increases for certain areas. There were two areas that were substantively unfunded but being covered by other areas. Rosie Benneyworth, Non-Executive Director thanked Deirdre for the positive report and asked about Advance Practitioner roles due to national discussions around introducing a new workforce model. Deirdre said work was ongoing to support individuals aligning to a five-year strategy that aimed to improve their career opportunities. **RESOLVED that the Six-Monthly Nurse Staffing Report be received and noted for information.**	
12/07/24	**Integrated Quality and 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 included:	

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	• In terms of planned care in June 2024, performance had exceeded expectations. • Cancer performance against the Faster Diagnosis Standard was performing above the target. • In terms of Diagnostics, improvements had been 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 had dropped to 78.2% and improvement plans were in place. • Work was underway to develop a demand and capacity modelling tool to support No Criteria To Reside (NCTR) and bed occupancy within the hospitals due to a continued high rate of bed occupancy of 103% coupled with high non-elective demand impacting on non-elective services. In response to a query from Rosie Benneyworth relating to planning for winter pressures and bed occupancy rates, Jane described the improvements that had already been seen at Weston General Hospital over the last year, and noted the importance of the Trust focussing on key areas that would support a step change, which were Patient Discharge and No Criteria To Reside. Sue Balcombe, Non-Executive Director, noted that at a recent system-wide quality meeting there had been good discussion about developing a system response and commitment to improving No Criteria To Reside. The Board agreed that the system needed to work together and it was suggested that this should be discuss in detail at future board development discussions. Deirdre Fowler, Chief Nurse and Midwife, and Rebecca Maxwell, Interim Chief Medical Officer highlighted the key points around quality and safety which included: • The Trust had recorded 10 cases of Clostridium Difficile in May and 24 during the year to date. The Patient First methodology was being used to explore the reasons behind this. It was noted that this was a national challenge in terms of new strains of Clostridium Difficile and their resistance to treatment, and the overall response to new cases would be investigated, such as isolating patients more quickly. • Both the Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) were in NHS Digital's "as expected" category and the Mortality Surveillance Group would continue to monitor performance in this area. Emma Wood, Chief People Officer & Deputy Chief Executive, highlighted key points around people which included: • Work to grow bank usage and reduce agency staff would remain a priority to ensure the Trust received the full value from the nursing establishment. The Board celebrated that there was only one Band 5 Nurse vacancy open. **RESOLVED that the Integrated Quality and Performance Report be received and noted for information**.	
13/07/24	**Medical Appraisal and Revalidation Board Report**	

Minute Ref.	*Item*	*Actions*
	Rebecca Maxwell, Interim Chief Medical Officer, introduced the report to demonstrate compliance with regulations and key national guidance related to appraisal and revalidation for 2023/2024. Rebecca noted that since the last report, a new interim medical team had been put in place and a new Medical and Dental Appraisal and Revalidation Lead had been welcomed. The overall appraisal and revalidation compliance for the last year continued in a positive direction and was beginning to align with North Bristol NHS Trust, including sending REV 6 notifications for doctors that had not completed an appraisal in year, and discussing support mechanisms for these doctors with internal teams on a monthly basis. Ingrid summarised that it had been a positive year and asked the Trust Board to approve the report prior to submission to NHS England. There were no opposing voices. **RESOLVED that the Medical Appraisal and Revalidation Board Report be approved for submission to NHS England**.	
14/07/24	**Learning From Deaths Quarterly Report – Q4**	
	Rebecca Maxwell, Interim Chief Medical Officer, introduced the Learning from Deaths Quarterly Quarter 4 Report to describe the structures of the learning from deaths programme across the Trust and progress made by the workstream between 1st January 2024 – 31st March 2024. Key updates included: • A new national Medical Examiner service would become statutory on 9 September 2024 where at that point it would not be possible to register a death without Medical Examiner scrutiny and would see a new reporting format. In terms of the Trust, all adult deaths were already scrutinised by the Medical Examiner, and it was expected that deaths in the Children's division would also reach this point by September. • There had been a spike in deaths during Quarter 4 for patients with learning disabilities, which the team had investigated and identified no care concerns, however learning points had been identified. • It was noted that the data for the Children's division was not been available for this report. • 43% of the Quarter 4 Medican Examiner referrals of concern were for patients in Weston General Hospital which had been investigated and fell in line proportionally with the other divisions. It was also noted that since the last report this figure had decreased, and positive feedback had been received from the Medical Examiner for Weston's reports. Rosie Benneyworth, Non-Executive Director, asked how learning was shared for deaths after discharge from hospital and Rebecca confirmed that this data would be captured from September under the changes to the governance framework and noted that currently community partners shared data so that concerns could be followed up within the system. **RESOLVED that the Learning from Deaths Quarterly Report be received and noted for information**.	
15/07/24	**Finance, Digital & Estates Committee – Chair's Report**	

Minute Ref.	*Item*	*Actions*
	Martin Sykes, Non-Executive Director and Chair of the Finance, Digital & Estates Committee updated the Board on the last meetings held in May 2024. Key points included: • The Committee was 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 Committee received a detailed report on the events leading to the power outage in May and the initial findings of the subsequent investigations. The Committee had commended the teams involved for going above and beyond their duties to resolve the issues. Emma Wood, Chief People Officer asked whether the use of electronic systems, such as DrDoctor for patient appointments since the covid pandemic, was being captured. Neil Darvill, Chief Digital Officer said the amount of video consultations was being captured within the system, however the data was unknown for telephone consultations. Neil noted that this was transformational work and virtual consultations would support the Trust's Green Plan ambitions. Marc Griffiths, Non-Executive Director asked how different languages were taken into account and whether this had created any challenges. Neil Darvill said the system provided translation convertors for system users. Deirdre Fowler, Chief Nurse and Midwife asked whether a digital service was best for the Trust's patients and Neil said he was not aware of many patient concerns since the digital system was introduced and noted that approximately 70% of the system's population would welcome a digital interface. The Board considered the need to better understand the data and digital safety issues and Deirdre confirmed that a report would be presented to the Quality and Outcomes Committee. **RESOLVED that the Finance, Digital and Estates Committee Chair's Report be received and noted for information**.	
16/07/24	**Monthly Finance Report**	
	Neil Kemsley, Chief Financial Officer, informed the Board of the Trust's overall financial performance from 1st April 2024 to 31st May 2024 (month 2). Key points included: • The Trust's net income and expenditure position at the end of May was a deficit of £6.3m which was a cause for concern. The main drivers for this deficit related to a Cost Improvement Programme (CIP) shortfall of £2.4m, a shortfall in elective recovery funding of £2.6m and £1.3m on other issues such a pay. • The month 3 forecast was a deficit of £8.4m, which included costs associated with industrial action. • Recovery actions were outlined within the finance report which the organisation needed to stay committed to. It was noted that the in-year position would be transparent due to the phased approach of the recovery plan.	

Minute Ref.	Item	Actions
	• The two divisions causing the majority of the deficit were Women's and Children's and Surgery and an escalation framework agreed at Integrated Care Board level had not only been applied to these areas, but to all divisions. • The Trust's cash position remained at circa £90m which was broadly on target. • Additional capital had been allocated at system-level and the Trust had received an additional £8m. • The Cost Improvement Programme was outlined to the Board, and it was noted that divisional plans represented 38% of the Trust plans and aimed to over-deliver on savings to balance out the forecast shortfall on savings delivery. The corporate workstreams would be driving most of the planned savings requirements. Rosie Benneyworth, Non-Executive Director asked whether the Trust recorded costs for safety failures, such as increased length of stay and medication errors. Neil said that he would look at this work. Stuart Walker, Interim Chief Executive noted that the organisation needed to see a shift from month 4 which he thought could occur from the information provided. Stuart noted that this position would achieve system support. In response to a query from Ingrid relating to the system position, Neil confirmed that the system had committed to a break-even plan and areas such as No Criteria to Reside would be difficult to resolve without system support, however divisional savings were in the Trust's control to improve. Stuart added that the system's response to issues such as No Criteria to Reside would be critical. **RESOLVED that the Monthly Finance Report be received and noted for information**.	
17/07/24	**People Committee - Chair's Report**	
	Linda Kennedy, Chair of the People Committee introduced the last Chair's Report that was written by Bernard Galton, the previous Committee Chair who had since left the Trust. Linda noted her thanks to Bernard for the handover of the People Committee and went on to note the key updates from the last meeting which included: • The Committee received an update on the delivery of Leadership Management and Coaching training programme and it was reported that compliance was up to 62% and could now be accessed via a new SharePoint site. • The Wellbeing Bi-annual report was approved with a forward look at 2024 priorities. • The Equality, Diversity and Inclusions Bi-annual report was approved. • The Committee received an update on the status of vaccination of staff within the Trust and that it would align to the system-wide approach. • A further update would be presented to the Committee on Locum Doctors.	

Minute Ref.	*Item*	*Actions*
	• The Committee discussed the implementation of the Communications Strategy which would provide a clear message on how the two organisations, UHBW and NBT, would be working together. Deirdre Fowler, Chief Nurse and Midwife requested that the Board continued to monitor the vaccination of staff within the Trust to avoid this impacting on sickness levels and maintaining safety, as well as the financial gain. Emma Wood, Chief People Officer added that Occupational Health had received funding to support the recording the vaccination status of staff. In response to a query from Marc Griffiths, Non-Executive Director, Emma reported that work had been ongoing as part of a national request to transfer doctors onto on-framework agreements. **RESOLVED that the People Committee Chair's Report be received and noted for information**.	
18/07/24	**Freedom to Speak Up 6-Monthly Report**	
	Eric Sanders, Director of Corporate Governance introduced the Freedom to Speak Up (F2SU) 6-Monthly Update. Key points included: • The national context of whistleblowing in the NHS was addressed where staff described the fear of speaking up. It was however noted that within the Trust 68% of staff that took part in the staff survey felt safe in raising concerns. • In 2023/34, 95 concerns were reported, compared to 109 in the previous financial year. • Of the staff completing the staff survey, 55% felt the organisation would address their concerns. • It was noted that more work needed to be done to promote speaking up so that colleagues could see and feel noticeable change. • Looking forward, key areas to address included improving policies and procedures, recruiting an equitable workforce and equipping managers with the skills required to address concerns and poor behaviour. The team would explore the use of new communication tools within the Trust to share and tell F2SU stories. • A new FTSU strategy had been drafted which considered what the service could deliver over the next 2 years and how the service could work as part of a hospital group model. • Eric noted his thanks to the Deputy Freedom to Speak Up Guardians and the FTSU Champions across the organisation for promoting this work and for listening to staff. • The Board was asked to note the contents of the Annual Report for 2023/24 and Eric asked what more the Board could do in response to the report. Ingrid noted the importance of the FTSU service and advised that the Board needed more time to discuss the report whilst considering the cultural journey of the organisation. It was agreed for the report to be reviewed and discussed again at the next People Committee with a Board discussion added to the agenda for September's Board Development Day.	Director of Corporate Governance

Minute Ref.	*Item*	*Actions*
	Action – Director of Corporate Governance to add a discussion on Freedom to Speak Up on the next agenda for the Board Development Day in September. **RESOLVED that the Freedom to Speak Up 6-Monthly Report be received and noted for information**.	
19/07/24	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report**	
	John Wintle Resilience Manager Emergency Planning introduced the Emergency Preparedness, Resilience and Response (EPRR) Annual Report for January 2023 - May 2024. Key points included: • The Trust was rated substantially compliant to the EPRR core standards in the NHS England annual assurance process for 2023, which was an improved position from the previous year. • The Trust had developed a newly created plan to manage the impact of patients presenting with potential or actual high consequence infectious diseases. • The shelter and evacuation plan had been refreshed and validated by running 2 exercises with the Integrated Care System to include cross divisional input. • A new Business Continuity Management System had been implemented. • The report provided an outline of other emergency incidents and disruptive events as a consequence of industrial action, with learning and lessons identified to improve the Trust's response. In response to a query from Rosie Benneyworth, Non-Executive Director, John confirmed that cyber security was covered under the Trust's Data Security Toolkit. As part of this, an exercise was being planned to test the disaster recovery process. John also noted that some clinical staff had attended a cyber security workshop. Neil Darvill, Chief Digital Officer acknowledged that some disruptive events could impact third party suppliers which might be out of the Trust's control to resolve. **RESOLVED that the Emergency Preparedness, Resilience and Response (EPRR) Annual Report be received and noted for information**.	
20/07/24	**Audit Committee - Chair's Report**	
	The Board acknowledged that the last 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. **RESOLVED that the Audit Committee Chair's Report be received and noted for information.**	
21/07/24	**Well-Led Action Plan Update**	
	Eric Sanders, Director of Corporate Governance introduced the Well-Led Action Plan which outlined progress made since the Board received the Well-Led report in March 2024. The Board heard that good progress had 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	

Minute Ref.	*Item*	*Actions*
	performance reporting from Quarter 2. Eric noted that the Committees would receive the new principal risks at their meetings in July, with the new risks being presented to the Board every six months. In response to a query from Sue Balcombe, Non-Executive Director, relating to KLOE 3 and the Board's oversight of clinical activity at a system level in primary and mental health care, Eric agreed to reflect on the response to ensure it was accurately captured by thinking about what the Board's role would be. **Action – Director of Corporate Governance to consider the response to KLOE 3 to include engagement and oversight at a Board level on clinical activity at a system level in primary and mental health care.** **RESOLVED that the Well-Led Action Plan Update be received and noted for information.**	Director of Corporate Governance
22/07/24	**Register of Seals**	
	Eric Sanders, Director of Corporate Governance, presented the Register of Seals for the information of the Board and highlighted that since the previous report, seven sealings had taken place. **RESOLVED that the Register of Seals be received and noted for information.**	
23/07/24	**Governors' Log of Communications**	
	Eric Sanders, Director of Corporate Governance, presented the Governors' Log of Communications for the information of the Board and highlighted that since the previous report three questions had been added to the log, and two questions had been answered on the log. **RESOLVED that the Governor's Log of Communications be received and noted for information**.	
24/07/24	**Any Other Urgent Business**	
	There were no items of urgent business for discussion.	
25/07/24	**Date of Next Meeting:** Tuesday 10th September 2024, City Hall Bristol	

Appendix I – Question from Member of the Public

Outsourced Outpatient Dispensary Services for University Hospitals Bristol and Weston NHS Foundation Trust: LloydsPharmacy HealthCare Services Ltd

1. ***On 6/6/24 the average waiting time publicised on screen was 2 hours 42 minutes at the BRI outpatient pharmacy operated by Lloyd's. What is the contractual KPI for average waiting time for dispensing prescriptions?***

The Key Performance Indicator (KPI) for turnaround times for patients waiting to collect a prescription from the Lloyds store on both the Weston and Bristol sites of UHBW is 98% or higher patients wait less than 30 minutes.

In addition to patients waiting for prescriptions, Lloyds also dispense other prescription categories these being patients collecting the following day, and prescriptions to be delivered to a community store or a patient's home address. Unfortunately, on the day the screen on the Bristol Royal Infirmary (BRI) site displayed a waiting time of 2 hours and 42 minutes, the time included all prescription categories. Patients waiting for a prescription would be prioritised with other prescription categories taking longer to process. This has since been rectified, and the screen now displays the average turnaround time for a patient waiting for a prescription based on the pervious hour period.

On 6th June, the average (mean) time for patients waiting for prescriptions on BRI site was recorded as 48 minutes, which is higher than what is required by UHBW. However, the Trust have been working hard with Lloyds to further improve this metric. The majority of days since 17th June have seen 100% patients waiting for prescriptions receive them in under 20 minutes. During this same period, over 99% of prescriptions have been processed in under 30 minutes, with a consistent average of under 20 minutes waiting time.

2. ***Where the BRI outpatient pharmacy operated by Lloyd's has not met a KPI, what action has the Board taken?***

The Services Contract was awarded to LloydsPharmacy HealthCare Services Ltd to commence on 1st April 2024 and despite careful planning, there have been some unforeseen challenges to address. It was recognised early on that improvement was required to ensure the patient experience through the hospital was sufficient to meet the needs of their care.

Daily performance monitoring meetings chaired by the Divisional Director for Diagnostics and Therapies were implemented in May, with members including UHBW Director of Pharmacy, Senior Clinical and Operational staff from both UHBW Pharmacy and Lloyds.

In addition, a weekly executive oversight meeting was implemented, and chaired by UHBW Chief Operating Officer, with representation from the Divisional Director for Diagnostics and Therapies, UHBW Director of Pharmacy, Chief Executive Officer for Lloyds Pharmacy HealthCare Services, Lloyds Chief Pharmacist and other senior members of their national/regional team. Collective actions were agreed and implemented that has resulted in a significant improvement in performance now meeting KPIs. There is an action plan co-created by UHBW and Lloyds which will continue to be worked through to ensure the service performance improvements are maintained and sustained.

3. ***Is the Board assured that the service delivered at BRI outpatient pharmacy operated by Lloyd's is performing to a sufficient standard?***

Yes. Since 17th June 2024, the performance from Lloyds in relation to patients waiting for prescriptions has remained consistent, and this will continue to be monitored through twice weekly oversight meetings and monthly KPI/Contract meetings. NB There will remain a robust approach for rapid escalation should the regular meeting cycle or other reporting indicate a performance decline.

University Hospitals Bristol and Weston NHS Foundation Trust

Public Trust Board of Directors Meeting on Tuesday, 10 September 2024
Action Log

Outstanding actions from the meeting held in July 2024					
No.	**Minute reference**	**Detail of action required**	**Executive Lead**	**Due Date**	**Action Update**
1.	**08/07/24**	Patient First: Chief Financial Officer to bring a progress report on the Patient First breakthrough objective relating to Fire Evacuation to the Finance, Digital and Estates Committee.	Chief Financial Officer	September 2024	**Suggest action is closed** This item has been added to the agenda for September's meeting of the Finance, Digital and Estates Committee.
2.	**09/07/24**	Annual Sustainability Report: Chief Financial Officer to provide the previous sustainability report to Linda Kennedy and update the next report to provide a table of objectives and progress made.	Chief Financial Officer	September 2024	**Suggest action is closed** The report has been sent to Linda Kennedy and September's report updated to provide a table of objectives and progress made.
3.	**18/07/24**	Director of Corporate Governance to add a discussion on Freedom to Speak Up on the next agenda for the Board Development Day in September.	Director of Corporate Governance	September 2024	**Suggest action is closed** This item was on the agenda for September's Board Development Day.
4.	**21/07/24**	Well-Led Review: Director of Corporate Governance to consider the response to KLOE 3 to include engagement and oversight at a Board level on clinical activity at a system level in primary and mental health care.	Director of Corporate Governance	September 2024	**Suggest action is closed** The action plan has been amended following feedback from the Board. The plan now includes ensuring updates from ICB and system meetings is included in reports to the Board, primarily the Chair and CEO reports, and updates from Committee Chairs who also attend ICB committees. Relevant information will also be provided by Executive Directors in their updates via the Integrated Quality and Performance Report or standalone reports to the Board.

5.	**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	**Suggest action is closed** This item was on the agenda for September's meeting of the Board.
Closed actions from the meeting held in July 2024					
1.	**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	**Action closed** The Modern Slavery and Human Trafficking Statement 2023/24 has been updated and published in the Trust's website.

Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10 September 2024		
Report Title:	Chief Executive Report		
Report Author:	Executive Director		
Report Sponsor:	Maria Kane, Joint Chief Executive		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events, and key staff appointments.		

Key Points to Note *(Including any previous decisions taken)*

The report seeks to highlight key issues not covered in other reports in the Board pack and which the Board should be aware of. These are structured into four sections:

- National Topics of Interest
- Integrated Care System Update
- Strategy and Culture
- Operational Delivery
- Engagement & Service Visits

Strategic Alignment

This report highlights work that aligns with the Trust's strategic priorities.

Risks and Opportunities

The risks associated with this report include:

- The potential impact of strikes on the availability of services and quality of care delivery.

Recommendation

This report is for Information. The Trust Board is asked to note the contents of this report.

History of the paper (details of where paper has <u>previously</u> been received)

N/A	
Appendices:	N/A

Background

This report sets out briefing information for Board members on national and local topics of interest.

National Topics of Interest

NHS Leadership Event 3 September 2024

I attended the NHS Leadership event on Tuesday 3 September in London. The event is one of two face to face meetings held each year and are led by Amanda Pritchard, NHS England CEO and other members of the national executive team.

The meeting provided updates from NHS England and included discussions about current high level priorities for 2024/25 which included winter planning, continued elective recovery and delivery of financial plans. Both nationally and at a local level, these are key focus areas for the NHS. Additionally, there was a session on the 10-year plan and the three strategic shifts which are:

- Shifting care aware from hospitals in the community
- Health promotion and prevention
- Better use of technology and data.

NHS Pay Award

On 29 July, the government announced the 2024/25 pay award, applying an uplift of 5.5% to Agenda for Change (AfC) staff, and 6% to consultants, doctors in training (who will receive an additional uplift of £1,000), SAS doctors and salaried dentists. The pay award is back-dated to 1 April 2024, and the national ESR system is currently being updated to reflect this. It is not yet confirmed when colleagues will receive these arrears, but it will be no earlier than October's payroll.

Notably, the AfC pay scales have reintroduced intermediate step points in bands 8a-9, having previously been removed in 2018. This means that colleagues in these bands are able to see a pay step increase after two years in post rather than five. This is now consistent with other bands, and resolves a significant barrier to recruitment and retention.

The Royal College of Nursing are consulting members on whether to accept the AfC pay award, with the vote closing on 16 September. Unison similarly are consulting until 5 September, and have recommended the deal to members.

The government has also agreed terms with the British Medical Association (BMA) on terms for a two year pay deal which would increase 23/24 pay by 4%. With the existing pay increase of an average of 9% for 23/24, and the 24/25 pay award of 6% + £1,000 noted above, the total increase for the two years would be an average of 22%.

The BMA has recommended the deal in a referendum of its members, with the vote result expected on 16 September.

Civil Unrest

There have been a number of instances of serious community unrest across the country which has been driven by misinformation in the wake of the Southport attacks last month. In Bristol

there was significant violence which took place on 3 August by groups affiliated with the far-right. Further far-right action was expected on other days but up to the time of writing has failed to materialise in the face of a very large, non-violent anti-racist counter protest and an effective police response.

Our messaging to staff over the past couple of weeks has been to condemn the recent racism and xenophobia. The Trust is extremely proud of the diversity of our organisation, and we do not accept any form of discrimination or race hatred.

Engagement & Service Visits

- I joined the UHBW Executive Managing Director for Weston at Weston General Hospital earlier this month for a site visit and orientation.
- I joined the Chair on a visit to the Genomics Lab team who are based in the Pathology building at Southmead. This provided an opportunity to look at processing of the genetic testing work which is carried out on behalf of our system.
- Ingrid Barker and I also took part in an introduction meeting with the Chair of the Bristol Health and Wellbeing Board – Councillor Stephen Williams.
- I met with the respective chairs from the JUC at both North Bristol and UHBW. This was the first joint meeting and combined briefing, and the aim is to continue this on a quarterly basis. Meetings with individual Chairs, as well as regular attendance at our Partnership Forum will also continue to ensure that organisation specific conversations can be had.
- Ingrid Barker and I were invited to join the Healthwatch England Chair David Croisdale-Appleby OBE, on his recent visit to the local Healthwatch Hub based in Bristol city centre. They were joined by Georgie Bigg, Healthwatch BNSG Chair and Vicky Marriott, CEO and welcomed David to the area.

Integrated Care System Update

GP Collective Action

A non-statutory ballot by the General Practtitioners Committee of the British Medical Association ran between 17th and 29th July 2024, with the majority of members voting to take collaborative action. The ballot was held in response to the proposed incoming changes to the GP contract. The collective action will comprise of ten potential actions, with GP contractors and partners being able to choose which of these actions to take, this being a work to contract, rather than a breach of contract at this time. The action is not time limited and is anticipated to continue until such time as the contractual disputes have been resolved. For BNSSG, the Local Medical Council intend to meet with General Practice Contractors on 10th September 2024, to agree which actions will be implemented as a system. System Partners continue to work the implications of this action and ensure mitigations are in place.

University of Bristol Masterclass

I was invited to deliver an Enterprise Masterclass at the University of Bristol on 2 September 2024 as part of their staff and student development programme. Maria spoke about Collaborating with the NHS and the future of healthcare, sharing details of her career, the challenges of agility and innovation in a large organisation, the effects AI and digital are having on healthcare, and practical advice on how academics can collaborate with the NHS.

Strategy and Culture

Group Model Update

The initial face to face sessions with our new Strategic Partner, Teneo have taken place this month. The first meeting was at our Joint Executive Group where the focus was to consider the work and role of that meeting, an approach to designing the operating model and a focus on the case for change. The meeting was well attended and there was a keen and creative approach.

The Board-to-Board meeting also took place this month and again saw a well-attended meeting with full engagement from both parties. The focus for this session included a getting to know each other section, as well as updates from the Joint Clinical Strategy and Corporate services work. Our Teneo partners helped to facilitate the day by working in small mixed groups. They focused the discussion on different group models and their likely benefits.

Board members also spent some time discussing their respective organisational approach to improving equality, diversity, and inclusion and exploring what it means to be an anti-racist organisation. Both Boards confirmed their commitment to leading UHBW and NBT to become truly anti-racist organisations.

Collaborative Bank pilot with UHBW

The pilot for a new Collaborative Bank service with our colleagues at NBT has just been launched. The bank which is initially for Band 5 general nurses means that colleagues will benefit from more flexibility to work shifts across both our trusts and receive one payslip for all their bank work. This provides opportunities for our staff to gain further experience and expertise by working across both organisations with differing specialities.

Gold Defence Employer Recognition Scheme Award

We are delighted to announce the Ministry of Defence have awarded UHBW Gold status under their employer recognition scheme. This recognises the support the Trust offers serving personnel, reservists and veterans from meeting their health care needs, offering time off for colleagues to serve, new career opportunities and in house learning and education programmes.

Operational Delivery

UHBW's performance against key measures has continued to improve during 2024/25. Provisional reporting for August reflects that ongoing improvement across urgent and emergency care; current August performance 80% bringing the year-to-date performance to 76%. Of note, 98.4% of patients spent less than 12 hours in ED during August. This is the strongest performance against these two measures since July 2023 and is testament to the increased focus on ED performance improvement across all sites. Patients on an elective care referral to treatment backlog have notably reduced during the year and ongoing progress continues to be made in the elimination of 65 and 78 week waits. Performance against the three core cancer standards have also continued to improve since April 2024, with all three standards now exceeding national targets.

Recommendation
The Board is asked to note the report.

Maria Kane
Joint Chief Executive

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 2024		
Report Title:	Joint Chair Activity Report		
Report Author:	Ingrid Barker, Joint Chair		
Report Sponsor:	Ingrid Barker, Joint Chair		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	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.		
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.			
Strategic Alignment			
This report highlights work that aligns with the Trust's strategic priorities.			
Risks and Opportunities			
N/A			
Recommendation			
This report is for Information. The Board is requested to note the contents of this report.			
History of the paper (details of where paper has <u>previously</u> been received)			
N/A			
Appendices:	N/A		

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. Background

The Trust Board receives a report from the Joint Chair to each meeting of the Board, detailing relevant engagements she has undertaken and important changes or issues affecting NBT (and UHBW) and the external environment during the previous month.

3. Appointment of the Joint Chief Executive

Appointing the Joint Chief Executive across North Bristol Trust and University Hospitals Bristol and Weston Foundation Trust was the highest early priority for me as the new Joint Chair and I am delighted that Maria Kane's appointment has now been announced. This is a significant step forward in the move to form a Hospital Group between the two organisations. Maria's extensive experience as a Chief Executive and her track record in bringing about strategic change in partnership with others will be of huge benefit to us.

I would like to thank those colleagues and partners who played a part in this successful recruitment process. I know the Board will want to join me in congratulating Maria who took up the role on 29th July.

4. Connecting with our Trust Colleagues at University Hospitals Bristol and Weston NHS Foundation Trust (UHBW):

I undertook a variety of visits during July and August 2024, in continuation of my planned induction programme, including:

- Visit to Bristol Haematology and Oncology Centre with Rachel Protheroe, Clinical Chair, Owen Ainsley, Divisional Director, Jamie Cargill, Director of Nursing and Sophie Baugh, Deputy Divisional Director, Division of Specialised Services
- Visit to Neonatal Intensive Care Unit with Andy Jeanes, Director of Facilities and Estates
- Visit to Research and Development with Fergus Caskey and Diana Benton, Head of Research and Innovation
- Visit to St. Michael's Hospital with Martin Gargan, Clinical Chair, and Fiona Jones, Divisional Director, Division of Women's and Children's
- Visit to Laboratories and Radiology with Rachel Bennett, Clinical Chair, and Jenny Keeble, Divisional Director, Division of Diagnostics and Therapies
- Visit to Digital Services with Neil Darvill, Joint Chief Digital Information Officer, NBT and UHBW
- Introduction Meeting with Clare Haley, Workplace Wellbeing Manager
- Introduction Meeting with the Patient Safety Team and Anne Reader, Associate Director of Quality and Patient Safety
- Meeting with UHBW Safeguarding Team with Sue Bourne, Director of Safeguarding, UHBW and NBT
- Introduction meeting with Staff Side

- Introduction to Patient First with Cathy Caple, Deputy Director of Innovation and Mel Jeffries, Continuous Improvement Programme Manager
- Induction meetings with Executive Directors and Non-Executive Directors.
- Meet with Valerie Clarke, Programme Director, Acute Provider Collaborative
- Introduction meeting with Dr Sadie Thomas-Unsworth, Consultant Clinical Psychologist and Joint Head of Psychological Health Services
- Introduction meeting/visit with Care of Elderly Consultants, UHBW, Division of Medicine
- Monthly meeting with Non-Executive Directors
- Monthly meeting with Vice-Chair

5. Connecting with our Trust Colleagues at North Bristol NHS Trust (NBT):

I undertook a variety of visits during July 2024, in continuation of my planned induction programme, including:

- I met with the Estates and Facilities teams with Tony Hudgell, Director of Operational Estates and Facilities, Matt Chick, Deputy Director of Estates and Facilities, Paul Jenkins, Associate Director of Estates and Facilities, Andy Kettle, Head of SOFT FM, Jeannette Baker, Senior FM Manager, Lisa Broderick, Senior Duty Manager for Domestics, Sharon Fortune, Senior Ops Manager, Craig Tolley, Head of Capital Projects.
- Meeting with Hilary Sawyer, Freedom To Speak Up Lead.
- Meeting with Sue Bourne, Joint Director of Safeguarding, Ashley Windebank-Brooks, Head of Patient Safety, Emily Ayling, Patient Experience and Complaints Team, Paul Cresswell, Director of Quality Governance.
- Meeting with Fiona King, Union Representative and Shawn Fleming, Union Representative.
- IM&T walkaround, meeting a variety of staff hosted by Kath Kaboutian, Deputy Chief Digital Information Officer.
- Induction meetings with Executive Directors and Non-Executive Directors.

I also undertook a variety of visits during August 2024, including:

- A visit to Therapies with Liz-Varian Peacock, Divisional Director of Nursing for CCS, Lynsey Francey, Dietitian Manager, Catherine Hamilton, Head of Speech and Language Therapy.
- Meeting with Helen Gilbert, Director of Improvement provided an introduction and training on Patient First methodology.
- The Allotment Gala in support of a Sustainability event.
- Meeting with Hazel O'Dowd, Consultant Clinical Psychologist for Staff.
- I commenced NED Briefings
- Meeting with Elaine Watson, Genetics Operations Manager, Maggie Williams, Christopher Wragg and Laura Yarram-Smith, Healthcare Scientist(s), Ian Berry, Principal Scientist.
- Meeting with Joanna Smithers, General Manager and Sarah McClelland, Stroke Consultant for Stroke and Thrombectomy services.

6. Communications

The communications teams from both Trusts have been very helpful in making the above visits visible to our colleagues and to governors. For NBT this has been through a weekly 'round up' as part of 'Maria's Midweek Message' and for UHBW this has been through its platform Viva Connect and a newsletter to Governors. I would like to thank both teams for their support in this.

7. Connecting with our Partner

I undertook further introduction meetings with partners during August as follows:

- Ruth Hughes, Chief Executive Officer & Julia Ross, Chair, One Care.
- Introduction meeting with Steve West, Vice-Chancellor, University of the West of England.
- Introduction meeting with Caroline Bell, CQC Operations Manager
- Introduction meeting with Evelyn Walsh, Vice-Chancellor, University of Bristol, and Chrissie Thirlwell (Head of Bristol Medical School)
- Introduction meeting with Christina Gray, Director of Communities and Public Health, Bristol City Council
- Introduction meeting with CEO of VOSCUR, Rebecca Mear
- Monthly meeting with Chair BNSSG ICB, Jeff Farrar
- Introduction meeting with Claire Young, MP for Thornbury and Yate
- Introduction meeting with Councillor Stephen Williams
- David Smallacombe, CEO and Alethea Mizen, Deputy CEO for Care and Support West.
- Georgie Bigg, Chair, Vicky Marriott, CEO, David Croisdale-Appleby OBE, Healthwatch England Chair and Maria Kane, Joint CEO.
- Helene Gibson, RGM Specialist Community Public Health Nurse for SMS Pathway and treating Tabacco.

8. National and Regional Engagement

- Regular one to one 'touch points' with Elizabeth O'Mahony, NHS England Regional Director
- Meeting with Sir Ron Kerr, Chair of NHS Providers
- One to one meetings with four fellow 'Group' Joint Chairs to share experience and insight
- Attendance at the NHS Confederation National Chairs' group meeting.

9. Summary and Recommendations

The Trust Board is asked to note the content of this report.

Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 2024		
Report Title:	Strategic Priorities		
Report Author:	Melanie Jeffries. Continuous Improvement Programme Manager		
Report Sponsor:	Paula Clarke. Executive Managing Director		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			✓
	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)		

Key Points to Note *(Including any previous decisions taken)*

This is the last report in this format. Going forwards it will be integrated into the revised Integrated Quality and Performance Report.

Appendix 1 summarises the progress in delivery of the 22 Patient First strategic priority projects for 2024/25, for which there are 39 deliverable outputs. 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 August 2024 the following assessment has been made:

- 7 of the 21 True North vision metrics are red
- 3 of the 39 strategic priority project delivery timelines are red
- 3 of the 39 strategic priority projects deliverables have red target metrics, and 11 metrics are in development or being revised

It is noted which projects align to the IQPR and all projects are tracked through the monthly Senior Leadership Team Strategy Deployment Review.

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

Risks and Opportunities

The strategic priority projects help to mitigate the key risks highlighted in the Board Assurance Framework

Recommendation		
This report is for **Information** Board is asked to note the content of the report		
History of the paper (details of where paper has <u>previously</u> been received)		
Report is based on the content of update reports given at Senior Leadership team Strategy Deployment Review meetings		Reports from July and August meetings
Appendices:	Appendix 1: Strategic Priority Projects 2024/25: Progress report for Public Board September 2024	

Appendix 1: Strategic Priority Projects 2024/25: Progress report for Public Board September 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
	Corporate Project	Mental Health across UHBW	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
	Corporate Project	Implementation of Martha's Rule	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	Waste Reduction	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

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 (3 month rolling average)	• **91.5%** of inpatient and maternity stays rate their care as good or above in 2022/23	**90.2%** of inpatient and maternity stays rate their care as good or above in 2024/25 year to date -July 2024 Note: Data may change as postal surveys still to arrive	**1.3% point reduction** (0.3% increase since May report)
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
Annual metric: 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 • **8% points** from top decile (79.1% - 92.5%) in 2022	• **74.2%** in 2023 staff survey • **6.2% points** from top decile (80.4% - 94%) in 2023	• **3.1% point increase** • **2.2% point increase**
Annual metric: 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 **(26%)** • Maternity (2023) - **27th** out of 121 Trusts **(22%)** • Children and Young People (2020) - **6th** out of 125 Trusts **(5%)**	• 2023 Inpatient survey –**26th** out of 131 Trusts **(20%)** • 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	**Inpatient Survey: 6% point increase**

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	5% year on year increase in patients asked about their communication needs at first point of contact	**21.08%** 2023/24	**20.54%** 2024/25 Year to date	**0.54% decrease**	Accessible Information Standard essential to role training launched with patient-led intro video	✓	Launch audit to understand if, how and when clinical services ask patients about their communication needs
		2% year on year increase in the combined fill rate (Face to face / remote) for interpreting bookings.	Baseline being calculated	Metric in development for November report		Contract awarded for new spoken Language interpreting provider (Word360) starting in Oct/Nov 2024	✓	• Commence Internal booking process improvement • Award non-spoken language contract
		Undertaking a minimum of 4 community outreach events per year aligned to the Core20Plus5 health inequality areas	0 events held	**3** events held	**3 events**	Community outreach event held with Deaf and hard of hearing community, Somali Women and South Bristol community	✓	Outreach events for Cancer Improvement Collaborative project, and Somali women regarding children dental health (Core20plus5)
		25% year on year growth in the number of Expert by Experience participants	**56** participants March 2024	**58** participants August 2024	**2 participant increase**	Baseline of experts by experience active in Trust groups and committees	✓	• Launch Participation Community • Identify opportunities to embed new Expert by Experience roles in Trust groups, committees and programmes
		Achieve a 2% year on year increase in patients who said they were involved in decisions about their care and treatment	**71%** 2023/24	**72.57%** 2024/25 Year to date	**1.57% increase**	• Learning report collated from national What Matters To You (WMTY) day • 28 wards using WMTY	✓	Continue to roll out WMTY to inpatient wards and share/embed learning via Experience
Important	**Mental Health across UHBW**	To have a robust infrastructure to support the mental health care of patients, ensuring the safety of patients and staff by March 2025.	Metric in development for November report			Project charter written and project prioritised as Important corporate project	✓	• Establish project structure and resource • Complete gap analysis of current provision across all sites
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**	**83.4** composite communication score out of 100 - rolling 3 month average Target - 88 (Year to date in July 2024)	**0.6% decrease** compared to starting position 0.3% increase since July report	• Medicine, Weston and Specialised Service Division undertaking improvement work • Example of improvements implemented include using a communication checklist on admission to ward, and focus on improvement experience of discharge • Training for medical staff on how to access Patient Feedback Hub	✓	• Agreed wards to continue the improvement work underway to understand the specific problems to be address in their areas • Gather pace in delivery of improvement ideas

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 metrics

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)
• 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 completed and reviewed at Clinical Strategy Programme Group (CSPG) and Executive Committee. • Testing with stakeholders commenced with close date of end of August, and delivery plan under development with Divisions.	✓	•Development days with Board and Governors to review stakeholder feedback and finalise content •Finalise document and design. Approval through Public Board (November)
		Implement Single Managed Service (SMS)for eight specialities in 2024-25.	**0** Single Managed Services	**2** pathfinder specialties commenced	**0** single managed services	• Liaison Psychiatry and Safeguarding have formally initiated their programme to become Single Managed Services • Scoping in Trauma & Orthopaedics (T&O) ahead of planned initiation in Quarter 3, and initial discussions on scoping approach for Acute Medicine have commenced.	✓	•Develop the approach to corporate enablers for the Joint clinical strategy •Initiation of T&O, Acute Medicine and Haematology as Single Managed Services •Development of preferred future SMS model for Cardiology, Liaison Psychiatry and Safeguarding
		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 ready for approval	• Confirm scope to progress phased implementation in 24/25 within UHBW delivery plan • Progress plans to mature integration and cross site delivery in key medical services	✓	•Approval of business case in principle through Integrated Care Board (ICB) Acute Health & Care Improvement Group •Plans to progress cross site delivery and UHBW integration moving forward – cardiology, respiratory focus.
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 agreed	Monitor % of areas live once deployment commences	• Drug build completed in test environment excluding Maternity • Functional/Technical testing commenced, • Superuser eLearning launched • Hardware/device audit completed for all areas	✗	•Clinical safety workshops to commence from 27th August. •Development of go live support plans •Finalise and approve clinical risk management plan
	Delivering our Deteriorating Patient Programme IOPR Assurance: QOC	Increase effective and timely recognition, escalation and response of potentially deteriorating patients, including the recognition of sepsis by March 2025.	2023/24 UHBW Sepsis pathway used appropriately •**10%** of 174 inpatients •**53%** of 149 Emergency Department patients (manual notes audit)	Latest audit data will be available in September 2024		• Evaluation of Recognising, Escalating and Responding to the Deteriorating Patient (Adult) eLearning completed. • Development of implementation delivery plan for Sepsis NICE 2024 Guidance	✓	•Finalise Recognition, Treatment, and Management of Sepsis (adults) Standard Operating Procedure to support implementation of update NICE guidance. •Progress data collection and diagnostics for Escalation and Response A3 thinking
	Implementation of Martha's Rule Assurance: QOC	To have an accessible and inclusive system across UHBW and NBT for patients, families, carers and advocates to access a 24/7 rapid review from a critical care outreach team To have a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily.	Metric in development			• Project charter written and project prioritised as Important corporate project	✓	•Establish project structure and resource

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)
Annual metric: 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 • **10.2%** points from top decile (70.3% - 78.1%) in 2022	• **67.4%** in 2023 staff survey • **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 - unregistered clinical posts	Unregistered nursing and midwifery - **66.7%** April 2024	Unregistered nursing and midwifery- **74.3%** July 2024	**7.6%-point increase**	• Work underway to refresh data to remove staff who leave to undertake nursing apprenticeships/nurse training	✓	• Divisions reporting progress and plans for improvement via Divisional Strategy Deployment Reviews
		Develop new career pathways - Admin & Clerical, Health care scientists and Pharmacy	**2** career pathways	**2** career pathways	Pathways scheduled for delivery in quarter 4	• Task and finish group for Admin and Clerical pathways progressing work	✓	• Review first draft of pharmacy career pathway in September • Commence work on Healthcare Scientist career pathway
		75% of staff have attended Leading Together: Compassionate and Inclusive leadership training by the end of March 2025	**0%** as new course (April 2023)	**70.1%** of leaders have completed (August 2024)	**70.1% point increase**	• Diagnostics and Therapies, Trust Services and Weston Division have reached 75% or above compliance	✓	• Divisions reporting progress and plans to achieve compliance via Divisional Strategy Deployment Reviews
		Achieve price cap compliance and eradicate off framework agency usage from 1 July 2024 and specialist rate cap by October 2024 ***Medical agency update included in medical workforce programme below****	**Nursing and Midwifery 2023/24** • Off framework: Average 160 shifts per month • Framework All agency above capped rate	**Nursing and Midwifery 2024/25** Year to Date • Off framework: Average 15 per month • Framework: Agreed capped rate with agency providers	• **145 shift decrease in off framework shifts** • **Achieved price cap for framework agency**	• Southwest rate card agreement • Phased reduction until October 2024 agreed for specialist areas • Chief Nurse Office/ Strategic on call approval required for non-framework agency shifts • Off framework use reduced further in July and August to < 5 shifts per month.	✓	• Deliver phased reduction plan for specialist areas • Implementation of Collaborative Bank with North Bristol Trust for Band 5 Nurses. • Increase the use of mental health support workers
		Deliver excellent Health & Safety governance and systems including responses to the British Safety Council 8 audit recommendations.	Develop metric to demonstrate progress against the 10 objectives			• Department stress audit completed, and discussions regarding 2 new areas • Stress management standards project plan in place	✓	• Development of central index for departmental risk assessments • Estate officer asbestos training scheduled for Sept 2024
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. • Systems Delivery and Associated Policies • Reducing Short Term Agency • Funded Medical long-term plan	Implement 4 digital systems: Ejobs plans sign off, Healthroster for leave and absence management, Locum's Nest and Loop	• Ejobs plans signed off: 25% • Healthroster: 66% • Locum's Nest: 82% • Loop: 0%	• **Ejobs plan: 25% increase** • **Healthroster: 66% increase** • **Locum's Nest: 82% increase**	• Training sessions for Loop planned • Emergency Department self-rostering trial	✓	• Loop go live • Evaluate Emergency Department self rostering trial • Remaining specialities go live using Locum's Nest
			Metric in development			• Southwest rate card agreed for external agency (with phased introduction for high-risk areas) • All non-framework agency bookings now on framework and all agency locums mapped to a cost reduction plan	✓	• Sign off escalation process • Agree go live date and inform agencies • Review each external agency doctor to determine which agency cap category they come under and then calculate the phasing of implementation and savings.
			0 medical workforce funded retention strategy	Diagnostic phase underway	Not applicable at present	• Locally employed doctors career pathway outline drafted • Acute Medicine (Bristol and Weston) workshop completed as part of A3 thinking	✓	Workshop to scope content and pathways required for future medical workforce pipeline and training
	Delivering the Pro Equity promise Assurance: PC	To establish our Pro-Equity approach. Pro-Equity is inclusion in everything we do and embracing full hearted care to eliminate disparities in experience by March 2025.	Metric in development			• 10 Anti-Racism workshops have been scheduled. • 5 are closed sessions for ethnically minoritised colleagues only, 5 are open to all staff.	✓	• Complete the sexual safety listening events and hold a workshop to develop next steps to support further work • Divisions develop action plans related to Workforce Race Equality Survey and Workforce Disability Equality Survey data

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 IQPR	**Starting position**	**Latest position**	**Turning the dial** (Baseline to latest position)
A 10% year on year improvement in ambulance handover times as a measure of improved patient flow through our hospital	**April – July 2023 cumulative position:** • **35.6%** of ambulance handovers within15 minutes • **68.3%** of ambulance handovers within 30 minutes	**April – July 2024 cumulative position:** • **33.8%** of ambulance handovers within15 minutes • **70.4%** of ambulance handovers within 30 minutes	**Handovers within 15 minutes: -1.8% decrease** **Handovers within 30 minutes: 2% improvement** 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.	23/29 key milestones to deliver Branding, Intranet, Website, Channels and functions complete	**79% of key milestones complete**	• New brand launched, hosted workshops for key teams and began series of engagement sessions for leadership teams. • Viva Engage has approximately 12,500 active users and over 50 communities. • New newsletter and operational update launched	✓	• Embed brand internally with publication of tools and templates for all colleagues • Appoint website supplier. • Finalise and approve social media and media policies and comms incident plan.
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	**3.5%** patients spent over 12 hours in an Emergency Department vs 2% target 2024/25 year to date position – July 2024	**5.2% point reduction**	• Emergency Department (ED) specialty referrals project commenced • Alignment of internal professional standards project due to recently published Getting It Right First Time (GIRFT) Principles for Acute Patient Care.	✓	• Weston Wardview board rollout • Delivery of Same Dat Emergency Clinic Boost plans • Establish project team for ED speciality referrals • Complete Value Stream mapping for ED to CT scan pathway
Important Corporate	**Improving Theatres Efficiency and Productivity** Assurance: QOC	To optimise theatre capped touch time 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)	**79.9%** capped touch time utilisation (July 2024) Target -85%	**8.7% point increase**	• Fixed term Theatre Improvement Practitioners recruited who will lead on the new GIRFT guidance for theatre flow and booking & scheduling operational workstreams. • On target to meet NHSE target of 4% improvement in capped utilisation and currently exceeding our trajectory.	✓	• Implement & embed theatre report specifically for surgeons to encourage engagement and awareness of trust and national performance expectations • Continued focus on Bristol Dental Hospital & South Bristol Community Hospital to maintain and increase utilisation.
Important Corporate	**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	• **6.2%** Did Not Attend (5% stretch target) in 2024/25 • **12.2%** patient cancellation rate (10% target) in 2024/25	**Did Not Attend rate: 0.9%-point reduction** **Patient Cancellation rate: 0.7% point increase**	• 3,331 appointments successfully changed using DrDoctor rescheduling function available in 14 specialities. • DrDoctor two-way messaging re-testing in progress with pilot specialities	✓	• Roll out DrDoctor rescheduling to further specialities • Develop delivery plan for DrDoctor patient led booking • Finalise ClearPrint and EasyRead read letter packs with patient focus groups and develop deployment plan to specialities.
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 **15:30** *corrected time	Median discharge time in 2024/25 **15:30**	No shift	• Golden Patient – discharge before 10:00 rollout extended to additional Medicine and Surgery Division wards • Home First Timely Discharge Simulation Video to share best practice for timely and complex discharge. • Home First community live on Viva Engage to share information, thoughts and ideas to facilitate timely discharge.	✓	• Ongoing improvement of proactive board rounds, including use of improved reporting • Golden Patient rollout to Weston wards • Home First F1/ F2 doctors training in September • Four Medicine Division Wards undertaking A3 thinking projects to identify discharge improvements

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.

Vision Metric	Starting position	Latest position	Turning the dial (Baseline to latest position
Annual metric: A 2% improvement year on year in staff reporting they are able to make improvements	• **55%** in 2022 staff survey • **7.1% points** from top decile (62.1% - 69.1%) in 2022	• **59.6%** in 2023 staff survey • **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)
			9 Patient First for Teams training
			27 A3 thinking Improvement projects (underway or completed)
			April 2024
				13 Patient First for Teams training
				46 A3 thinking improvement projects (underway or completed)
				July 2024
					4 teams increase
					19 project increase in 2024/25
						• Six Divisions have commenced Divisional Strategy Deployment reviews with Executive team
						• Introduction workshop for deploying full management operating system completed with Estates and Facilities
						• Patient First for teams training revised to increase number of teams that can be trained to 42 a year
						• Preparation for Medicine Division launch of the full operating system
							✓	• Patient First for Teams cohort one graduation
								• Commence Patient First for Teams cohort two
								• Develop and establish new ways of working in the Medicine Division:
								  • Driver meetings and scorecards
								  • Leader standard work
								  • Visual Management

Strategic Initiative	**UHBW Digital Strategy Year 1 Deliverables** Assurance: FDEC	**Progress six strategic objectives:** • Infrastructure: Deliver solid, future-proofed secure foundations • Digital systems: Our corporate and clinical information will be consolidated into core digital systems • Health records: Removing reliance on paper • Business Intelligence: Optimise and transform our services • Governance and assurance: Agree digital priorities for our Trust • Digital Services: A redesigned digital service: forging a strong partnership between the new team and the Trust	To be developed			• Undertake site survey and infrastructure preparation work • Development of system optimisation plan for approval in sept 2024 • Annual digital delivery plan approved • Regular update reports provided to Digital Hospital programme board	✓	• Complete site survey and infrastructure preparation work • Develop Strategic Outline case • Commence delivery of system optimisation plan once approved • Prepare for Scan on Demand in Bristol Haematology and Oncology Centre in Quarter 4 • Complete Power BI readiness review by end of quarter 3 • Development of process to manage/triage all new digital requests, including request for changes to existing systems • Single Digital Leadership team across UHBW and North Bristol Trust by end of Sept
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	**New metric being developed** as 100% of clinical building fire strategies and risk assessment completed	New metric being developed	New metric being developed	• Clinical Project Lead appointed for fire improvement programme. • Head of Compliance of Estates appointed to improve fire compliance – statutory and mandatory planned and preventative maintenance. • Survey of all fire evacuation routes and final exit doors commenced and remedial actions started • NICU evacuation aid evaluation - to replace or improve the existing provision.	✓	• 2024/25 programme for review of existing building specific fire risk assessments plus remaining buildings being developed with OFR (external fire engineers). • Authorised Engineer (Fire) annual fire audit to take place in September. • On-going housekeeping and firestopping in plantrooms • Develop processes for integration of fire improvement requirements with Capital Projects teams
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)	Data being revised	Data being revised	• Fire Warden weekly checklist amended and simplified – awaiting feedback from fire wardens.. • Fire warden recruitment continuing and training undertaken across both Bristol and Weston sites. • On-site follow-up sessions carried out by fire trainers with fire wardens on their own wards.	✗	• Fire Evacuation Floor Plans – external provider supporting the production of up-to-date floor plans for wards/dept./clinic • Review process for responding and completing actions related to information provided by fire wardens • Revise methodology to measure evacuation check compliance to enable Divisions to understand where improvement is required.

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	**7.738 million** year to date (YTD) deficit compared with YTD plan of breakeven at end of month 4	**7.738 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	£20,067,528
Elective inpatients	£23,483,302
Outpatient	£22,364,348
Total	**£65,915,178**

2024/25 Actual Delivery Year to Date	
Day cases	£19,668,651
Elective inpatients	£20,358,499
Outpatient	£22,912,757
Total	**£62,939,906**

Day cases	**-£398,877 adverse to plan**
Elective inpatients	**-£3,124,803 adverse to plan**
Outpatient	**£548,409**
Total	**-£2,975,272 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	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)	Delayed implementation to Procurement and Managed Inventory system replacement	None	**Digital procurement** • Strategic Sourcing complete. • Guided buying design complete. • Full go live support model in place consisting of onsite and central helpdesk functions. **MIS Replacement** • Training commenced • Full inventory test data uploaded to test environment.	✗	**Digital procurement** • system integration testing and supplier enablement to be completed • Go live support teams to be trained. • Monthly face to face engagement including roadshows. **MIS Replacement** • Complete training • Complete and sign off end to end testing, and User Acceptance Testing • Go live
Breakthrough objective	**Waste Reduction**	To reduce waste in our processes by March 2025	Recurrent cost improvement related metric to be agreed			• Proposed approach approved by Productivity and Finance Improvement groups • Training session completed with Finance Service improvement team • Pilot session completed with ward managers from Medicine Division	✓	• Complete next pilot training session with nominated attendees • Complete waste walk with attendees of pilot training sessions. Aim to complete one idea for waste removal in each area using improvement methodology. • Finance service improvement team to support methodology for how waste reduction converts to cost improvement

Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 2024		
Report Title:	UHBW Board Assurance Framework - Q1 2024/25		
Report Author:	Sarah Wright, Head of Risk Management & Information Governance		
Report Sponsor:	Maria Kane, Joint Chief Executive		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	The Trust's Board Assurance Framework (BAF) Risk Report serves as a pivotal document guiding governance and oversight around the Trust's inherent principal risks. Through the BAF, the board is sighted on risks that may impact on its ability to achieve Strategic priorities. The BAF aligns principal risks to corporate operational risks, assurance received by the Board and the Patient First Strategic Initiatives Corporate Projects and Breakthrough objectives.		

Key Points to Note *(Including any previous decisions taken)*

- Risk 1. Quality - A substantial portion of linked quality risks in clinical divisions stems from the management of medical devices and equipment. A major concern is the replacement of aging equipment, which may fail and impact the delivery of care.
- Risk 2. Workforce - A number of corporate risks have been reassessed and reduced.
- Risk 3. Financial - Current controls noted as 'Inadequate'.
- Risk 4. Estate Infrastructure - Current controls noted as 'Inadequate'.
- Risk 5. Fire Safety - Current controls noted as 'Inadequate'.
- Risk 6. Capacity & Performance – Risk 901 to be replaced with an assessment of all ED's
- Risk 7. Digital & Cyber - Current controls noted as 'Inadequate'.
- Risk 8. Change Management – No associated corporate risks.
- Risk 9. System Working - This risk was agreed to be closed, system working is mitigation for performance and capacity and any gaps in controls would be noted in risk 6.
- Risk 10. Emergency Planning – 1 associated corporate risk.
- 67 Linked Corporate Risks.
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Strategic Alignment

Each principal risk has been assessed against its impact to affect the achievement of the Trusts 'Patient First' Strategic Priorities.

Risks and Opportunities	
As noted in the paper.	
Recommendation	
This report is for **Information** The Board is asked to note the quarter one position.	
History of the paper (details of where paper has <u>previously</u> been received)	
Executive Directors Meeting	26/06/24
Senior Leadership Team	17/07/24
Audit Committee	16/07/24
People Committee	18/07/24
Finance & Digital Committee	23/07/24
Quality and Outcome Committee	23/07/24
Appendices:	Appendix A - Board Assurance Framework

Impact on Delivery of Patient First Strategic Priorities	Experience of Care of Care	Patient Safety	Our People	Timely Care	Improve Together	Our Resources
Goal	We will be in the top 10% of NHS organisations for providing a consistently outstanding experience	A significant reduction in patient harm events	We will improve the employment experience of all our colleagues to retain our valuable people	Eliminate delays in patient care	To be in the top decile for staff stating they can easily make improvement in their area of work	To eliminate underlying deficit within the timeline within the System Medium Financial Plan
Risk 1. Quality	High	High	High	High	Low	Moderate
Risk 2. Workforce	High	High	High	High	Low	Moderate
Risk 3. Financial	High	Moderate	Moderate	Moderate	Low	High
Risk 4. Estate Infrastructure	High	High	High	High	Low	Moderate
Risk 5. Fire Safety	Low	Moderate	Moderate	Low	Low	High
Risk 6. Capacity & Performance	High	High	Moderate	High	Low	High
Risk 7. Digital & Cybersecurity	Moderate	High	Moderate	Moderate	Moderate	High
Risk 8. Change Management	Low	Low	High	Low	High	Moderate
Risk 9. System Working						
Risk 10. Emergency Planning	Moderate	High	High	High	Low	Low

Linked Corporate Risks	High Risks	Very High Risk	Total	Movement
Risk 1. Quality	12	8	20	↑
Risk 2. Workforce	4	0	4	↓
Risk 3. Financial	2	2	4	↔
Risk 4. Estate Infrastructure	1	5	6	↓
Risk 5. Fire Safety	6	3	9	↔
Risk 6. Capacity & Performance	6	6	12	↓
Risk 7. Digital & Cybersecurity	6	5	11	↑
Risk 8. Change Management	0	0	0	↔
Risk 9. System Working	0	0	0	↔
Risk 10. Emergency Planning	1	0	1	↔
Total	**38**	**29**	**67**	**↓**

Board Assurance Framework		Impact on Delivery of Strategic Priority					
Risk 1	**Quality** (Patient Safety, Patient Experience, Clinical Effectiveness)	Experience of Care	Patient Safety	Our People	Timely Care	Improve Together	Our Resources
Executive Leads	**Chief Nurse & Chief Medical Officer**	High	High	High	High	Low	Moderate
Board Committee	**Quality & Outcomes Committee**	**Operational Lead**	**Associate Directors of Quality**		**Executive Sub-Group**	**Clinical Quality Group**	

Principal Risk Description

Failure to uphold high standards of care and clinical safety within the Trust may compromise patient well-being and result in a range of adverse consequences. These could include an increased incidence of errors leading to patient harm, an increase in health inequalities, higher rates of hospital-acquired infections, prolonged recovery times, avoidable complications, and in severe cases, permanent harm.

Suboptimal patient outcomes may also result in decreased patient satisfaction, impacting staff retention rates and the overall reputation of the Trust within the community as well as leading to legal liabilities, and financial repercussions for the Trust.

Root Causes & Contributory Factors

- Resource Constraints
- Organisational Culture
- Lack of Standardiation
- Insufficient investment in infrastructure
- Failure to address systemic issues
- Lack of robust digital infrastructure and processes
- Staffing Issues
- Communication Breakdowns
- Ineffective feedback mechanisms

Sources of Assurance

External – Third Line of Defence

- Clinical Accreditation Programme
- Deep dive reports into services
- Safe Staffing Reports
- Complaint and patient experience reports
- Pulse surveys and staff survey reports
- FTSU feedback reports
- Maternity assurance reports
- IQPR – performance metrics
- CQC Reports

Existing Controls

Adequate

- Staff Training and Education Programs
- Policies and Guidelines
- Clinical Audits
- Patient Safety Initiatives
- Incident reporting
- Communication channels
- Patient Feedback and Engagement
- Resource Allocation

Gaps in Controls

- Insufficient Training uptake
- Limited staffing availability
- Lack of robust digital infrastructure and processes
- Lack of robust BI function
- Compliance Issues
- Failure to act on results
- Inadequate Feedback Mechanisms
- Limited Data Analysis and Learning

Patient First Projects to Mitigate

1. **Strategic Initiative** - Experience of Care Strategy
    - Ensure representative patient feedback
    - Access to interpreting services
2. **Breakthrough Objective** - Improve communication with patients
3. **Strategic Initiative** – UHBW Clinical Strategy, incorporating:
    - Joint Clinical Strategy
    - Healthy Weston phase 2
    - UHBW Elective Strategy
4. **Critical Corporate Project** – Careflow Medicines Management
5. **Important Corporate Project -** Deteriorating Patient Programme

Corporate Risks

6744	Patients attending with Stroke will not receive specialist treatment	↔	20
6634	Adults & children safeguarding activity may not be met	↔	16
6635	Requirements of Mental Capacity Act may not be met	↔	16
2264	Delays in commencing induction of labour	↔	16
588	Patient deterioration is not recognised and responded to	↔	15
856	Emotional & mental health needs of C&YP may not be met	↔	15
6691	That medicines are not stored securely	↔	15
5615	Failure to provide interpreting support when needed	↔	15
5942	Failure to record patients communication requirements	↔	12
6013	Methicillin Resistant Staphylococcus aureus bacteraemia's	↔	12
418	Routine radiology reports are not signed off/ acknowledged timely	↑	12
528	Patients suffer harm or injury from preventable pressure damage	↔	12
1598	patients suffer harm or injury from preventable falls	↔	12
1702	Communication needs of patients with disability or sensory impairment	↔	12
2042	DNA policy is not followed for 16 and 17 year olds	↔	12
2680	Complainants experience a delay in receiving a call back	↔	12
3452	Patient Safety Improvement Programme aims are not met	↔	12
3763	Compliance with CQC Regulations	↔	12
4711	Patients suffer harm or injury from preventable arterial thrombus	↔	12
5269	That AKI care is not in line with national guidance	↔	12

Risk Appetite and Tolerance

Appetite -The Trust Board of Directors is averse to any risks that could compromise patient safety, patient safety is our utmost priority, and we maintain a strong aversion to risks that could jeopardise it. However, we recognise that in certain situations, accepting a measured level of short-term risk can be in the best interests of our patients and service users. This willingness allows us to prioritise patient experience and clinical effectiveness, ultimately leading to long-term rewards and benefits that enhance the overall quality of care we provide.

In line with this commitment, we actively support innovation and embrace opportunities for improvement. We understand that innovation can bring about positive advancements in healthcare delivery, technology, and treatment options. Our risk appetite extends to fostering a culture of innovation and exploring new ideas, processes, and technologies that have the potential to transform patient care.

Tolerance - 6
The Trust expects any individual risk that may impact on the safety of patients, staff or public or the quality of our services and patient experience, with a current assessment of 6 or above to be actively mitigated to a more tolerable level.

Current Position

- Risk 418 - Routine radiology reports are not signed off/ acknowledged timely increased from 9 to 12.
  A cross divisional Task Group is reviewing risks associated with reporting results and have agreed that the management of these risks will be more effective if there is separate focus on Radiology and Pathology reports, as well as reporting of routine results and reporting of incidental findings.

- A substantial portion of linked quality risks in clinical divisions stems from the management of medical devices and equipment. A major concern is the replacement of aging equipment, which may fail and impact the delivery of care.

Board Assurance Framework		Impact on Delivery of Strategic Priority					
Risk 2	Workforce	Experience of Care	Patient Safety	Our People	Timely Care	Improve Together	Our Resources
Executive Leads	Chief People Officer	High	High	High	High	Low	Moderate
Board Committee	People Committee	Operational Lead	Deputy Chief People Officer		Executive Sub Group	People Learning & Development Group	

Principal Risk Description

There is a risk that our colleagues employment experience is not consistently excellent, and the Trust is unable to develop, engage and empower colleagues.

This may lead to poor retention and difficulty in attracting new staff, exacerbating the shortage of appropriately skilled and experienced professionals and increasing the cost of temporary staffing.

This situation could increase workloads, create skill gaps, decrease staff motivation, reduce a sense of belonging and ultimately impact the quality of care and patient outcomes.

Root Causes & Contributory Factors

- Increasing demand for services along with budget constraints
- Retention and Recruitment challenges and shortages of specialists nationally
- Fixed reward structure (AFC)
- Tempory staffing costs and market forces
- Insufficient training provision
- Workload and work related stress
- Dr rotation allocation
- Capacity of HEI's and FE's to develop workforce plan
- Inconsistent culture and experience across staff groups
- Pipeline, leadtimes and funding for developing the workforce
- Industrial action

Sources of Assurance

- Compliance with standards related to staffing levels and safety
- Routine monitoring and reporting on performance metrics
- Deliverables of People Strategy reported to PLDG & People Commitee
- People themed audits as part of the ASW Assurance annual planning
- CQC reports contain feedback on workforce
- Annual site visits from HEI's of sudent experiences and placements
- Workforce planning annual submission
- British Safety Council Audit and Safer Learning Environmental Charter
- NHSE Quality visits to Education
- Freedom to Speak up process and reports
- National Violence and Aggression Prevention Standards

External Audit – Third Line of Defence

Existing Controls

- The People Strategy
- Workforce planning
- Funded Nurse Retention Programme
- Workforce information Reports
- Reports in IQPR
- Job planning and E-Rostering
- Guardian of safe working reports
- Education Strategy
- Safer staffing report
- High cost agency and temporary spend working groups

Adequate

Gaps in Controls

- Pro-equity and Anti Racism statement is in development
- Understanding the productivity of our workforce
- Ability to forecast future threats to local supply of workforce e.g Elective Hub **(action required unknown until workforce plan is finalised)**
- Current workforce plan for medical roles needs to be refreshed to include hard to fill posts, alternative roles, options for reducing high cost agency and locums and international pipeline
- Long term workforce plan financial and student allocations are unknown **(action required unknown until national letter is received**)

Patient First Projects to Mitigate

1. **Strategic initiative** - People Strategy
   - Reduction in agency spend
   - Meet stability index of 85%
   - Compliance with LMC offer at 75%
   - Deliver H&S governance and systems
   - Develop 3 new career pathways for A&C, HCS and Pharmacy
2. **Important Corporate Project** - Medical Workforce programme
3. **Breakthrough objective -** Delivering the pro-equity promise

Corporate Risks

422	Violence and Aggressive behavious towards staff and Patients	↔	12
2639	Staff not receiving an annual appraisal	↔	12
7324	Inadequate Health & Safety provision	↔	12

Risk Appetite and Tolerance

Appetite - The Trust Board of Directors understand that innovation can bring about workforce risks, and we are prepared to accept them when they are a direct result of our pursuit of innovation. We recognise that embracing innovation can lead to improved recruitment and retention of talented staff and create developmental opportunities for our workforce.

Our commitment extends beyond UHBW, as we actively collaborate with partner organisations to foster value and opportunities across current and future services through system-wide partnerships. By working together as a system partner, we aim to leverage collective expertise, resources, and innovations to enhance the quality of care and drive positive outcomes for our patients.

Tolerance - 8
The Trust expects any individual workforce related risk with a current assessment of 8 or above to be actively mitigated to a more tolerable level.

Current Position

- The patient first projects will seek to mitigate the risks and gaps in control. We await confirmation from external sources to mitigate some gaps. Project charters are being prepared for the patient first objectives and A3 thinking planned to agree which actions should be prioritised in the next 12 – 18 months.

Changes to risk assessments:

- Risk 7259 - Failure to develop the Trust's leaders has reduced from 12 to 6
- Risk 737 - Recruit of substantive staff has reduced from 12 to 8
- Risk 5524 - Compliance with the Immigration Act has reduced from 12 to 8
- Risk 4835 - Numbers of Investigating Officers has reduced from 12 to 2
- Risk 5633 - Roster and job planning cannot support New Ways of working is being reassessed with a view to reducing from 12 to 9.
- Risk 5775 – lack of accommodation for new starters in Bristol reduced from 12 to 9.

Board Assurance Framework		Impact on Delivery of Strategic Priority					
Risk 3	Financial	Experience of Care	Patient Safety	Our People	Timely Care	Improve Together	Our Resources
Executive Leads	Chief Financial Officer	High	Moderate	Moderate	Moderate	Low	High
Board Committee	Finance, Digital & Estates Committee	Operational Lead	Director of Operational Finance		Executive Sub Group	Productivity and Financial Improvement Group	

Principal Risk Description

Failure to overcome financial constraints and achieve fiscal balance caused by inability to meet elective activity targets, productivity targets, cost improvement targets and/or manage cost pressures.

The resultant budget deficits can then lead to service reductions and compromised patient access and care, as well as negative impacts on reputation, stakeholder trust and an ability to invest to mitigate other operational risks.

The likely consequences are additional headcount controls and recruitment constraints, a loss of autonomy in decision-making with greater System and Regulator oversight and reduced financial scope for investing in the future.

Root Causes & Contributory Factors

- Insufficient revenue funding from the ICB and Specialised Commissioners
- Insufficient CDEL and/or cash for capital investment
- Underlying financial challenge
- Increasing demand, with fixed and/or limited growth funding
- Workforce supply challenges, with premium costs or contained capacity
- Operational inefficiencies and negative productivity
- Estate configuration, condition and infrastructure maintenance
- Political priorities
- Macro-economic conditions
- Technological advancements
- Public expectations

Sources of Assurance

- Monthly reporting to Board, Finance Committee, SLT, ICB and NHSE.
- Monthly reporting of CIP/ERF at PFIG (with ICB/NHSE review)
- Intenal and External Audit submissions to Audit Committee
- Report from Local counter fraud service
- Capital plan monitoring at Trust Capital Group and Capital Progam Steering Group.
- ICB review through BNSSG Performance and Recovery Board and BNSSG Finance, Estates & Digital Committee.

External – Third Line of Defence

Existing Controls

- Budget Planning and Oversight
- Regular financial reporting at divisional and Trust level, through internal and external routes.
- ICB and Trust level escalation frameworks
- Divisional Performance Management
- Investment Prioritisation
- Stakeholder Engagement
- Continuous Improvement Initiatives
- Financial Forecasting and Scenario Planning
- Local counter fraud service

Inadequate

Gaps in Controls

- Failure to achieve CIP targets on a recurring basis
- Overspending on pay budgets due to over-establishment and premium workforce costs
- Negative productivity (as measured by NHSE) and linking elective recovery investment (of more inputs) with elective activity delivery
- Review of previous investments to ensure benefits realised

Patient First Projects to Mitigate

1. **Strategic Initiave** - Digital Strategy and Joint Estates Strategy
2. **Mission Critical** Corporate Project - Driving Productivity and Financial Improvement – being developed at present.
3. **Important Corporate Service Project** - Centralised stores and materials management
4. **Important Corporate Service Project** - Theatre productivity, outpatient productivity, funded retention, reducing premium workforce, ready for discharge.
5. **Breakthrough objective -** Savings identified on a recurring basis.

Corporate Risks

416	The Trust fails to fund the Trust's Strategic Capital Programme	↔	20
5645	the Trust fails to achieve its stated Clean Air Hospital Framework	↔	15
6594	Changes to specialised commissioning structures impacts income	↔	12
5375	That the Trust doesn't deliver the in-year financial plan	↔	12

Risk Appetite and Tolerance

Appetite - The Trust Board of Directors recognise the importance of balancing financial considerations with patient safety and the quality of care. While we acknowledge the need to manage costs effectively, our focus extends beyond financial factors alone. We are prepared to accept a certain level of financial risk when necessary to mitigate risks to patient safety or uphold the quality of care. We prioritise the implementation of appropriate controls to ensure responsible financial management. Our decision-making process encompasses a comprehensive understanding of value for money, where cost is an important consideration but not the sole determinant. We remain committed to making decisions that optimise patient outcomes, taking into account a holistic perspective that encompasses both financial prudence and the provision of high-quality care.

Tolerance - 9
The Trust expects any individual risk that may impact on the Trust's finances with a current assessment of 9 or above to be actively mitigated to a more tolerable level.

Current Position

- Reducing premium workforce costs: success in reducing nursing agency usage now needs to extend to challenge premium medical workforce spend.
- New breakthrough objective, focused on recurring savings identification and delivery, to include organisational wide appeal to reduce waste.
- In the light of Month 2 financial position, action 5375 will need to be reviewed and the score increased to reflect likelihood of a deficit position during the course of this financial year.
- Trust has chosen to apply the Escalation Framework to two clinical divisions at this stage. Wider roll-out expected in next few weeks based on internal feedback to apply even-handedly across whole Trust.

Board Assurance Framework		Impact on Delivery of Strategic Priority					
Risk 4	Estate Infrastructure	Experience of Care	Patient Safety	Our People	Timely Care	Improve Together	Our Resources
Executive Leads	Chief Finance Officer	High	High	High	High	Low	Moderate
Board Committee	Finance, Digital & Estates Committee	Operational Lead	Director of Estates & Facilities		Executive Sub Group	Strategic Estates Development Prog. Board	

Principal Risk Description

Any failure to prioritise infrastructure upgrades for modernisation or maintenance of the estate infrastructure or its key equipment can have far-reaching consequences. It leads to the deterioration of facilities, posing safety hazards, operational inefficiencies and non-compliance with regulations (e.g. Fire RRO, HTMs for ventilation etc).

Outdated or poorly maintained infrastructure can result in malfunctions and structural deficiencies, increasing the risk of accidents and injuries for both patients and staff. These issues contribute to poor patient experience, longer wait times and disruptions in service delivery.

Additionally, the environment can impact staff morale, leading to frustration, burnout, and increased staff turnover.

Root Causes & Contributory Factors

- Aging Infrastructure
- Deferred Maintenance
- Inadequate Funding
- Lack of Strategic Planning
- Regulatory Compliance Issues
- Environmental Factors
- Technological Obsolescence
- Budgetary Constraints
- Staffing Shortages

Sources of Assurance

- Internal Audit reports from ASW Assurance
- Premisis Assurance Model
- External Audits
- Regulatory Inspections
- Third-Party Assessments
- Quality Assurance Programs
- Benchmarking Studies
- Certification Programs
- Performance Reviews

Internal Audit – Third Line of Defence

Existing Controls

- Preventive Maintenance Programs
- Asset Management Systems
- Compliance Audits
- Risk Assessments
- Training and Development
- Emergency Preparedness Plans
- Technology Integration
- Sustainability Initiatives
- Collaboration and Partnerships

Inadequate

Gaps in Controls

- Resource Allocation
- Data and Information Management
- Workforce Skills and Training
- Risk Management Practices
- Technology Integration
- Collaboration and Communication
- Condition Survey
- Full Asset Registers
- Compliant Planned Prevantative Maintance (PPM) Porgramme

Patient First Projects to Mitigate

1. **Strategic initiative** - Joint Estates strategy
    - Develop interim plan

Corporate Risks

3472	That the Trust fails to deliver the ICS Green Plan		20
5540	The Trust infrastructure is inadequate for extreme weather		16
7130	The Trust is unable to fund the strategic estate programme		16
7131	That we cannot deliver the Strateigic capital estate development		16
6112	That the Estates backlog maintenance will not be adequately		15
2642	Inability to modernise the estate due to restricted access to areas		12

Risk Appetite and Tolerance

Appetite - The Trust Board of Directors prioritise compliance with regulatory requirements and uphold a cautious approach. Whilst we strive to ensure adherence to all applicable regulations, we also recognise that certain circumstances may pose regulatory challenges. In such cases, we are willing to accept the possibility of regulatory scrutiny while maintaining the confidence that we can successfully defend our actions.

We commit to taking all reasonable measures to ensure our practices align with regulatory standards. Our focus remains on proactive compliance, while acknowledging the potential for occasional regulatory challenges and preparing ourselves to address them effectively.

Tolerance – 8/9
The Trust expects any individual risk with the potential to impact upon on our statutory obligations, regulatory compliance, assessments and inspections with a current assessment of 8 or environmental risks of 9 or above to be actively mitigated to a more tolerable level.

Current Position

- The patient first projects will seek to mitigate the risks and gaps in control. Project charters has been produced for Estates Compliance and project charter for Capital Projects delivery is pending completion.

Changes to risk

- Risk 3472 - ICS Green Plan – Risk score review meeting 4th July.
- Risk 4427 - That the Estate Building is not fit for purpose has been closed.
- Risk 5114 - That the Trusts Car Parks are not managed in compliance with HTM has been closed.
- Risk 6125 - Confined Space – Risk is an operational risk for Estates.

Board Assurance Framework		Impact on Delivery of Strategic Priority					
Risk 5	Fire Safety Compliance	Experience of Care	Patient Safety	Our People	Timely Care	Improve Together	Our Resources
Executive Leads	Chief Finance Officer	Low	Moderate	Moderate	Moderate	Low	High
Board Committee	Finance, Digital & Estates Committee	Operational Lead	Director of Estates & Facilities		Executive Sub-Group	Strategic Estates Development Prog. Board	

Principal Risk Description

Fire safety within the NHS is paramount due to the unique environment and critical nature of healthcare facilities.

The Trust has a statutory duty to build robust data management systems for fire safety.

While stringent regulations and protocols are in place to mitigate fire risks, there are inherent challenges and complexities that must be addressed to ensure the safety of patients, staff, and visitors.

Root Causes & Contributory Factors

- Aging Infrastructure
- Complex estate
- Insufficient historical investment
- Fire safety culture
- Lack of specialist knowledge
- Lack of data management and record keeping
- Inadequate project management
- Insufficient decant space to complete major work
- Limited access to clinical areas to complete work
- Lack of curiosity following prior fire incidents
- Asbestos containing buildings delay intrusive fire surveys and related work
- Building Safety Act, and related secondary legislation, increased the fire safety duties that the Trust is required to manage.

Sources of Assurance

- Internal Audit reports from ASW Assurance
- Annual report from Authorised Officer
- Premisis Assurance Model
- Compliance reports
- External fire engineers

Internal Audit – Third Line of Defence

Existing Controls

- Fire Improvement Group
- Building Fire Strategies (FS) and Building Fire Risk Assessments (FRA)
- Fire Evacuation Plans and equipment
- Fire detection and suppression systems
- Investment in expanding Fire Safety Team
- Dedicated fire improvement project team
- Intrusive surveys following reciept of FS/FRA's
- Planned Preventaive Maintance (PPM) Programme
- Fire safety training inc. evacuation
- Fire wardens
- Compliance with HTM 05-01 - Managing healthcare fire safety

Inadequate

Gaps in Controls

- Building Fire Strategies and Fire Risk Assessments incomplete
- Evacuation Plans incomplete and fire evacuation routes compromised
- Fire detection and suppression systems inadequate
- Emergency lighting inadequate
- Fire warden coverage and data inadequate
- Capacity to undertake identified fire improvement work
- Staff fire safety training compliance
- Incomplete Asset Register of fire safety systems
- Non-complaint Planned Preventaive Maintance (PPM) Programme
- Competency of Estates tradestaff to inspect and repair fire doors
- Inadequate storage, goods, beds and equipment management

Patient First Projects to Mitigate

1. **Mission Critical corporate project -** Fire Safety Programme.
2. **Breakthrough Objective -** Consistency in undertaking weekly fire evacuation checks in every division and department.

Corporate Risks

972	Non-Compliance with Regulatory Reform Order 2005	↔	20
3827	Incomplete Risk Assessments for plant rooms	↔	20
3830	Incomplete fire compartmentation	↔	20
3826	Departmental Risk Assessments by non-competent persons	↔	12
4823	BEH theatres have inadequate compartmentation	↔	12
5564	WGH fire doors do not meet current certification standards	↔	12
6085	StMH wet riser is not sufficient for firefighting needs BS9990:201	↔	12
6136	Lack of building specific fire strategies to inform improvement plans	↔	12
6202	Fire alarm cause & effect is not programmed correctly	↔	12

Risk Appetite and Tolerance

Appetite -The Trust Board of Directors prioritise compliance with regulatory requirements and uphold a cautious approach. Whilst we strive to ensure adherence to all applicable regulations, we also recognise that certain circumstances may pose regulatory challenges. In such cases, we are willing to accept the possibility of regulatory scrutiny while maintaining the confidence that we can successfully defend our actions. We commit to taking all reasonable measures to ensure our practices align with regulatory standards. Our focus remains on proactive compliance, while acknowledging the potential for occasional regulatory challenges and preparing ourselves to address them effectively.

Tolerance – 8
The Trust expects any individual risk with the potential to impact upon on our statutory obligations, regulatory compliance, assessments and inspections with a current assessment of 8 or above to be actively mitigated to a more tolerable level.

Current Position

- The corporate risk register for fire requires review to reflect the current risk position that has been identified in the fire strategies and fire risk assessments plus the subsequent intrusive survey data.
- Trust will hold significant fire risk for an extend period due to the anticipated time required to bring fire safety infrastructure up to compliant standard.
- Potential for impact on Timely Care and Patient Safety if intrusive surveys and/or fire risk assessment highlight areas that currently present a risk to life in the event of a fire.

Board Assurance Framework		Impact on Delivery of Strategic Priority					
Risk 6	Capacity & Performance	Experience of Care	Patient Safety	Our People	Timely Care	Improve Together	Our Resources
Executive Leads	Chief Operating Officer	High	High	Moderate	High	Low	High
Board Committee	Quality & Outcomes Committee	Operational Lead	Deputy COO's & Performance Director		Executive Sub-Group	Planning & Delivery Group	

Principal Risk Description

When demand surpasses available resources in healthcare settings, it results in overcrowding, care delays, and staff stress. Patients endure prolonged wait times, risking worsened conditions, while overcrowded conditions heighten infection spread. Stretched resources raise error risks, compromising patient safety. Failing to meet goals leads to extended wait times, poor experiences, safety risks, and potential outsourcing.

These issues decrease productivity and quality service delivery, exacerbating health inequalities.

Root Causes & Contributory Factors

- Poor coordination between different parts of the healthcare system can lead to inefficiencies and duplications.
- Limited access to primary care
- Capacity of social care to support complex discharge.
- A growing and aging population increases the prevalence of chronic conditions and the need for healthcare services.
- Sudden surges in demand due to outbreaks, such as COVID-19, can overwhelm healthcare systems.
- Limited bed capacity and space in emergency departments and wards.
- Patients with no criteria to reside.

Sources of Assurance

- IQPR Reports to Trust Board and sub-committees
- True North Timely Care Quality Report
- ASW Data Quality Framework Audit

Internal Audit– Third Line of Defence

Existing Controls

- Bed management
- Same Day Emergency Care Departments (SDEC)
- Extra capacity locations identified
- Discharge planning
- Telemedicine
- NHS@Home
- System working

Adequate

Gaps in Controls

- Ability to measure productivity
- Ability to staff extra capacity locations
- Ability to discharge ina timely manner
- Inability to ring fence critical care beds for elctive procedures due to emergency admissions

Patient First Projects to Mitigate

1. **Strategic Initiative** - Patient First Deployment
2. **Mission Critical Corporate Project** – Proactive Hospital
3. **Important Corporate Services Project** - Improving Outpatients Productivity and Efficiency
4. **Important Corporate Services Project** - Improving theatres productivity and efficiency
5. **Breakthrough Objective** – Ready for discharge

Corporate Risks

423	That demand for inpatient admission exceeds available bed capacity	↔	20
910	That patients in BRI ED do not receive timely and effective care	↔	20
2244	Long waits for Outpatient follow-up appointments	↔	20
1035	That there are Insuffient numbers of critical care beds	↔	16
6782	Non-compliance with the 28 day Faster Diagnosis cancer standard	↔	16
6320	That there is inadequate Clinical Site Management resource	↔	15
5779	@Home service will be limited due to lack of dedicated service base	↔	12
5532	Non-compliance with the 31 day cancer standard	↔	12
801	That elements of the NHS Oversight Framework are not met	↔	12
5520	That health inequalities are exacerbated for patients on waiting lists	↔	12
7182	Non-compliance with routine elective treatment within 65 weeks	↔	12

Risk Appetite and Tolerance

Appetite - The Trust Board of Directors is averse to any risks that could compromise patient safety, patient safety is our utmost priority, and we maintain a strong aversion to risks that could jeopardise it. However, we recognise that in certain situations, accepting a measured level of short-term risk can be in the best interests of our patients and service users. This willingness allows us to prioritise patient experience and clinical effectiveness, ultimately leading to long-term rewards and benefits that enhance the overall quality of care we provide.

Tolerance - 6
The Trust expects any individual quality or safety related risk with a current assessment of 6 or above to be actively mitigated to a more tolerable level.

Current Position

- Risk 6784 - That cancer services have poor quality performance data, reduced from 15 to 12 as the probability has reduced.
- Risk 5534 - Non-compliance with waiting >62 days on a GP suspected cancer pathway is exceeded, has been closed as the standard has been retired.
- Risk 5531 - Non-compliance with the 62-day RTT Cancer standard, reduced from 20 to 8 as the risk has been reframed against the interim 70% standard (valid for 2024/25) instead of the statutory 85% standard.

Board Assurance Framework		Impact on Delivery of Strategic Priority					
Risk 7	Digital & Cybersecurity	Experience of Care	Patient Safety	Our People	Timely Care	Improve Together	Our Resources
Executive Leads	Chief Digital Information Officer	Moderate	High	Moderate	Moderate	Moderate	High
Board Committee	Finance, Digital & Estate Committee	Operational Lead	Deputy Chief Digital Information Officer		Executive Sub-Group	Digital Hospital Programme Board	

Principal Risk Description

Inadequate digital maturity, oversite and coordination will lead to an insecure and unstable digital infrastructure of siloed incomplete data.

This can result in successful cyber-attack, data breaches, privacy violations, regulatory action, financial losses, and damage to reputation, as well as inadequacies in service delivery, poor user experience, compromised patient safety and confidence in the Trust.

Root Causes & Contributory Factors

- Insufficient and piecemeal Investment in Digital Infrastructure creates variety which causes challenges with maintenance, future proofing, performance management, and keeping pace with new cyber security standards. A lot of the network is at or near end of life.
- Amount of Shadow IT makes it difficult to coordinate use of digital systems, consolidate information and assure that the whole digital estate is secure.
- Insufficient investment in and prioritisation of replacing end of life software leads to reliance on unsupported software
- BI capability is hindered by data silos and a continued reliance on paper records and poor data quality.
- Capacity for digital transformation spread too thinly due to lack of prioritisation and control by Trust leadership

Sources of Assurance

- HIMSS Infrastructure Adoption Model Assessment has scored our digital infrstructure capability at 4 out of 7. Our hospital group partner, NBT ar on course to achieve a score of 7 in 2026.
- DSPT Self-Assessment and Audit Report – 2024 assessmnet due for submission in June.
- Internal Audit has recently reviewed the Trust's Information Security Policies, Cyber-Security Action Plan, and Business Continuity Plans in the Trust's digital supply chain
- Annual IT Health Check - Planned for completion in July 2024
- Digital Maturity Assessment
- HIMSS Electronic Medical Record Adoption Model

External Audit – Third Line of Defence

Existing Controls

- Information Security Policies Compliance
- Disaster recovery/virtualisation/backup in place
- End user devices updated after 5 years use
- CareFlow Clinical workspace brings together patient information from multiple systems
- Connecting brings together data from primary care, GP practices, secondary and community care providers
- Clinical Risk Management System for Digital Systems
- Digital Hospital Programme Board and its supporting bodies
- DS Business Board
- New Request Process for changes to or introduction of Digital systems

Inadequate

Gaps in Controls

- Infrastructure unfit to enable joint working with NBT as set out in Joint Clinical Strategy (JCS)
- Insufficient alignment of Core IT Systems with NBT to support JCS aims
- Information Asset Register is incomplete making it impossible to confirm full compliance with Information Security Policies
- Most shadow IT and some DS systems are not compliant with clinical risk management system
- 33 Servers running unsupported operating systems
- Contract management of digital systems is limited
- BI reporting is not user friendly or advanced enough
- No Data quality function.

Patient First Projects to Mitigate

1. **Strategic initiative** – Digital Strategy Year 1 delivery plan

Corporate Risks

7051	Risk That Homegrown Solutions bespoke limits future development	↑	16
7034	That the Trust has unsupported server operating systems in use	↔	15
291	Trust IT infrastructure does not meet the needs of a Digital hospital	↔	15
292	Risk that the Trust is impacted by a cyber incident	↔	15
6299	That patients may not have migrated from Millenium to Medway	↔	15
1374	Risk that obsolete network components are not replaced	↑	12
6431	Inability to upload patient data from Careflow Connect to EPR	↔	12
3115	That clinical decision making may be based upon incomplete	↔	12
5190	Non-compliance with NHSD Standard DCB0160 on clinical risk	↔	12
6129	That inappropriate access to systems is undetected	↔	12
526	Risk that staff are non-compliant with IG Training	↔	12

Risk Appetite and Tolerance

Appetite The purpose of a Risk Appetite Statement is to articulate what risks the Trust is willing or unwilling to take in order to achieve its objectives, it's how we describe the Trust's 'attitude' to change and innovation and communicate how willing we are to encourage risk taking.
In order to achieve its objectives Trusts may have to adopt a more innovative approach to delivery overtime and therefore a more open risk appetite. See the Trusts Risk Management Policy for the Risk appetite matrix.
Tolerance The Trust expects any individual safety or quality related risk with a current assessment of 6 or above to be actively mitigated to a more tolerable level, likewise with any workforce, statutory or reputation risk of 8 and Business, finance, and environmental risks of 9.

Current Position

- 7 risks have been identified regarding challenges with using patient lists in CareFlow to ensure all appropriate patients are invited to followup. Digital Safety Steering Group has asked for improvements to followup management to be included in this year's service optimisation programme
- The CMM readiness assessment shows that the project is at risk of not being ready for Go-live. The extra time required to complete the drugs build has limited time available to complete subsequant workstreams.
- DHPB have been asked for support to define exit plans for all unsupported server operating systems. A proposal is being prepared to address security implications of reliance on out of support Microsoft Office Software.

Board Assurance Framework		Impact on Delivery of Strategic Priority					
Risk 8	Change Management	Experience of Care	Patient Safety	Our People	Timely Care	Improve Together	Our Resources
Executive Leads	Executive Managing Director	Low	Low	High	Low	High	Moderate
Board Committee	People Committee, Quality & Outcomes Committee	Operational Lead	Deputy Director of Improvement & Innovation		Executive Sub Group	Executive Patient First Steering Group	

Principal Risk Description

Inadequate planning and delivery of the process, scale and pace of change can lead to overwhelmed staff, decreased morale, increased staff turnover, increased errors, and ultimately, failed improvement initiatives, wasting resources, impeding progress in delivering the Trust's strategy and reduced influence as a leader in our local systems.

Root Causes & Contributory Factors

- Lack of clearly articulated purpose of the change and the outcome and benefits to be achieved
- Lack of application of processes and tools for undertaking change management
- Complex organisational governance processes being a barrier to change
- Lack of communication and engagement with stakeholders
- Insufficient training and support for staff
- Lack of engagement and co-design of staff in the change
- Poor experience of previous changes leading to resistance to further change
- (Potentially perceived) limited resources – time, people, finance, space, equipment
- Inadequate resolution of stakeholder conflicts

Internal Audit – Third Line of Defence

- Regular reporting on Board priorities for improvement and change
- Policies and procedures
- Audit and assurance reviews
- Balanced scorecard Performance metrics (IQPR)
- Staff feedback mechanisms
- Training and competency assessments
- Risk registers
- Benchmarking and peer comparisons
- Scenario planning

Existing Controls

- Patient First continuous improvement methodology and management opertaing system
- Change and project/programme management tools, processes and templates
- Project and programme management approaches and governance
- Effective communication channels
- Stakeholder engagement
- Training, and development programmes in leadership, continuous improvement, change management
- Coaching, mentoring and support to staff
- Staff Well-being Initiatives
- Performance monitoring and feedback mechanisms
- Risk management processes
- Resource allocation and planning

Adequate

Gaps in Controls

- Capacity of staff to attend training for improvement and to undertake change
- Capability across all staff to effectively undertake change projects and programmes using Patient First continuous improvement methodology, and Change and project/programme management tools
- Continuous Improvement team capacity to deliver staff training at pace Consistent leadership for change

Patient First Projects to Mitigate

The Patient First approach directly mitigates this risk:

- Focus on smaller number of improvement projects at corporate, division, specialty and team levels to enable focus of improvement resource and accelerate pace of change
- Systems, processes and tools for change projects with focus on purpose and root cause understanding
- Dedicated Continuous Improvement team providing training, coaching and support to teams undertaking improvement
- Trustwide training programmes in leadership, management and coaching, and leadership for change aligned to the Patient First approach

Corporate Risks

	None		

Risk Appetite and Tolerance

Appetite - The Trust has an open risk appetite for change management risks, acknowledging that innovation and transformation are essential for improving healthcare services. This balanced approach ensures that while the Trust is open to embracing necessary changes, it also supports the Trusts cautious stance to protecting patient safety, ensuring the provision of quality services, and maintaining financial stability.

Tolerance - The Trust expects any individual safety or quality related risk with a current assessment of 6 or above to be actively mitigated to a more tolerable level, likewise with any workforce, statutory or reputation risk of 8 and Business, finance and environmental risks of 9.

Current Position

- Deployment of Patient First is proceeding in line with the agreed timeline.
- Delivery of strategic priorities are reported to Trust Board and into Committees.

Board Assurance Framework		Impact on Delivery of Strategic Priority					
Risk 10	Emergency Planning	Experience of Care	Patient Safety	Our People	Timely Care	Improve Together	Our Resources
Executive Leads	Chief Operating Officer	Moderate	High	High	High	Low	Low
Board Committee	Quality & Outcomes Committee	Operational Lead	Deputy Chief Operating Officer		Executive Sub-Group	Planning & Delivery Group	

Principal Risk Description	Root Causes & Contributory Factors	Sources of Assurance	
Failure to plan for emergency scenarios as well as black swan events (cyber incidents, pandemics etc.) and ensure robust business continuity arrangements can result in operational disruptions, financial losses, compromised patient care, and reputational damage, as well as legal and regulatory penalties.	• National security risk assessement (NRSA) identifies the threat of malicious attack to the population of the UK and its territories. This includes the threat to critcal infrasturcture from cyber attack. • Avon and Somerset community risk register identiifes the risk to the local population from threats and hazards such as those due to local infrastructure locations such as industry, the use of hazardous materials in manufacturing industry, the impacts of incindets affecting transport networks such as rail, air and road. Pandemic disease outbreaks, flooding, adverse severe weather, malicious threats are included. This risk regsiter informs the local health resilience partnership and organisational EPRR workplan.	• EPRR Annual Report. • NHSE EPRR Core standards compliance report. • Data Security Protection Toolkit compliance report. • ASW Assurance Business Continuity audit.	Audit – Third Line of Defence

Existing Controls		Gaps in Controls	Patient First Projects to Mitigate
• Trust Accountable Emergency Officer (AEO) is the Chief Operating Officer, supported by Deputy Chief Operating Officer for urgent care, flow and discharge as the senior responsible officer (SRO) for Emergency Preparedness, Resilience and Response (EPRR). • EPRR policy identifies the roles and responsibilities. • EPRR workplan with cross divisional and corporate representation. • Business Continuity Management System (BCMS) aligned to the international standard for Business Continuity. • BC Plans in place across the trust at service level plans are reviewed annually and after an incident. • Incident response plan in place providing the response framework to an incident that results in casualties requiring emergency hospital attendance and treatment to save life and reduce harm. • Digital services disaster recovery plan. • Compliance with BC elements of the DSPT.	Adequate	• The trust was rated substantialy compliant at 98% (fully compliant in 61 out of 62 core standards) in the 2023 NHS England Core standards for EPRR assurance process. The trust was partialy compliant on 1 core standard “lockdown plans”. The Bristol hospital sites had a lockdown plan in place, the gap was for a lockdown plan for the Weston hospital site at the time of the assurance process being completed . This has since been completed by the trust security team and is now in place.	

Corporate Risks – 1			
5787	That there is severe disruption to supplies of non-pay consumables	↔	12

Risk Appetite and Tolerance	Current Position
Appetite - The purpose of a Risk Appetite Statement is to articulate what risks the Trust is willing or unwilling to take in order to achieve its objectives, it’s how we describe the Trust’s ‘attitude’ to change and innovation and communicate how willing we are to encourage risk taking. In order to achieve its objectives Trusts may have to adopt a more innovative approach to delivery over time and therefore a more open risk appetite. See the Trusts Risk Management Policy for the Risk appetite matrix. **Tolerance -** The Trust expects any individual safety or quality related risk with a current assessment of 6 or above to be actively mitigated to a more tolerable level, likewise with any workforce, statutory or reputation risk of 8 and Business, finance and environmental risks of 9.	• Risk 5787 - UHBW continues to see supply disruption to many of the consumables it purchases as part of its day to day activity. Supply disruption notifications continue to be sent to the Trust by BWPC as and when they receive them. Clinical teams then work with BWPC to source appropriate alternative products for services to use.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board of Directors in Public on Tuesday 10th September 2024

Reporting Committee	**Quality and Outcomes Committee – 23/07/2024**
Chaired By	**Sue Balcombe – Non-Executive Director**
Executive Lead	**Deirdre Fowler – Chief Nurse and Midwife**

For Information

The committee was briefed on current strategic issues to include positive feedback following the visit from Dr Henrietta Hughes, The Patient Safety Commissioner noting in particular the good levels of staff engagement and positive feedback. The Trust was also congratulated on the work programme to integrate Human Factors within core clinical practice. Three Executive Directors have been invited to join the National Safety Forum.

The funding of the Adult Inherited Metabolic Disease (IMD) service was escalated to QWOC as it has not been picked up by the specialist commissioners as elsewhere in the country leading to a cost pressure. This has been escalated to NHSE.

The Committee received an update on The Cleft Service Review Action Plan. It was noted that good progress has been made since April 2023 with all patients contacted, enhanced network support now in place to include outpatient hubs in Gloucester, Exeter, Plymouth and Truro. This has resulted in no further breaches since June 2023 and a significant reduction in the waiting list. Securing theatre capacity remains a significant constraint with a capital expansion plan for paediatric theatres under consideration in August 2024.

The Safer Staffing report demonstrated a fill rate of 105% with a further reduction in band 5 turnover. Staffing in NICU remains one of the key areas for monitoring.

The committee received the first quarterly Patient First Report for Timely Care and its four underpinning projects. It was noted that under Proactive Hospital – the Trust had achieved a 10% improvement in ambulance handovers with SDEC's in particular making a positive impact. There was also some improvement in our internal processes for No Criteria to Reside with system oversight also improving. Theatre Utilisation continues to improve with more work underway to improve productivity in peripheral sites. The continued roll out of the patient portal means that 65% of patients are now accessing their OPD appointments digitally. There remain a small number of clinics with higher levels of DNA's than expected.

This month's Maternity report advised that the Birthrate + acuity tool for maternity was released in July 2024 and was demonstrating an increase in the number of complex cases with a corresponding impact on staffing levels. The Maternity Spotlight report highlighted the focussed work underway to reduce the numbers of incidents of post-partum haemorrhage which is now having a positive impact.

University Hospitals Bristol and Weston NHS Foundation Trust

The committee received a report detailing the progress being made in managing the VTE pathway. Good levels of assurance were being received regarding prescribing appropriately using the manual audit process but the roll out of electronic prescribing remains the key outstanding issue. The Quarter One Legal Report was received, and the large number of inquests noted. The breadth of legal advice and high levels of support provided to the clinical teams by the service was commended. In terms of performance, it was noted that bed occupancy remains high with the number of patients identified as meeting No Criteria to Reside virtually static at 155. Good progress was particularly noted in the 78-week, Cancer Faster Diagnosis, ED four hour and ambulance handover pathway targets. Rates of C.Difficile remain under close observation.
For Board Awareness, Action or Response
The new Board Assurance Framework was received. It was agreed that the risk pertaining to the management of medical devices would be explored in more detail at the next meeting.
Key Decisions and Actions
N/A
Additional Chair Comments
None

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

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 2024		
Report Title:	Maternity and Neonatal Safety Report Quarter 1 2024/24		
Report Author:	Sarah Windfeld, Director of Midwifery and Nursing Jo Mockler, Quality and Patient Safety Manager		
Report Sponsor:	Deirdre Fowler, Chief Nurse and Midwife		
Purpose of the report:	**Approval**	**Discussion**	**Information**
		✓	✓
	This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the Board of Directors of present or emerging safety concerns. The information within the report reflects actions and progress in line with Ockenden and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).		

Key Points to Note *(Including any previous decisions taken)*

This is the new style quarterly maternity and neonatal safety report for Quarter 1 2024/25

Strategic Alignment

This report forms part of the divisional reporting requirement which supports the delivery of safer maternity care. This reflects the Trusts priority of Patient Safety within the Patient First True North Strategy.

Risks and Opportunities

Risks associated with CNST:
7493 - Risk that the trust will not achieve CNST MIS Year 6 safety standards (9)

Safety action 1:
7322 - Risk that the trust perinatal pathology service will be significantly disrupted due to the current staffing model (20)
7157 - Risk that there is a delay in families receiving the Perinatal Mortality Review Report following the review of their care (4)

Safety action 4:
7247 - Risk that BAPM standards will not be met if there are not enough Qualified in Speciality (QIS) nurses (20)

Safety action 5:
5716 - Risk that maternity services will be unable to provide continuity of carer pathway due to insufficient midwives (12)

Safety Action 8:
1048 - Risk that level 3 safeguarding training targets are not met (12)
6923 - Risk that patient safety will be compromised if mandatory essential training is no compliant (9)
7562 - Risk that NICU will not have enough up to date nurses trained in neonatal resuscitation (8)

Recommendation

This report is for **Information & Assurance**

This report has been produced to inform/update the Board and to allow discussion where required.

History of the paper (details of where paper has previously been received)

Appendices:	*Appendix 1: Issues and Actions from Perinatal Mortality Reviews Q1* *Appendix 2: ATAIN Report (Q4 2023/24 and Q1 2024/25)* *Appendix 3: Maternity Incidents (Moderate harm or above Q1)* *Appendix 4: Perinatal Quality Surveillance Matrix - June 2024* *Appendix 5: Triangulation Report Q1*

Maternity and Neonatal Safety Report Quarter 1 2024/25

1. Purpose

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the Board of Directors of present or emerging safety concerns. The information within the report reflects actions and progress in line with Ockenden and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

2. Perinatal Mortality

2.1. Perinatal Mortality Rate

The following graphs demonstrate how University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) are performing against the national ambition.

There was 1stillbirths in Q1, see table 1 for additional details.

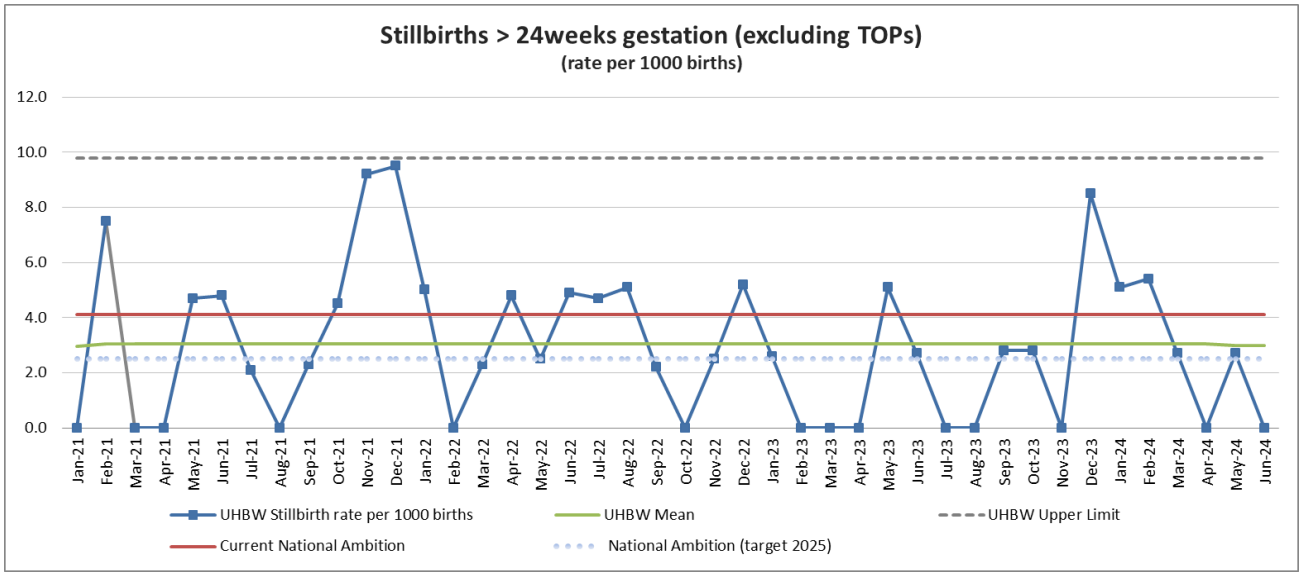


Figure 1.UHBW Trust Stillbirth rate per 1000 births

There were 4 neonatal deaths reported in Q1, see table 1 for additional details.

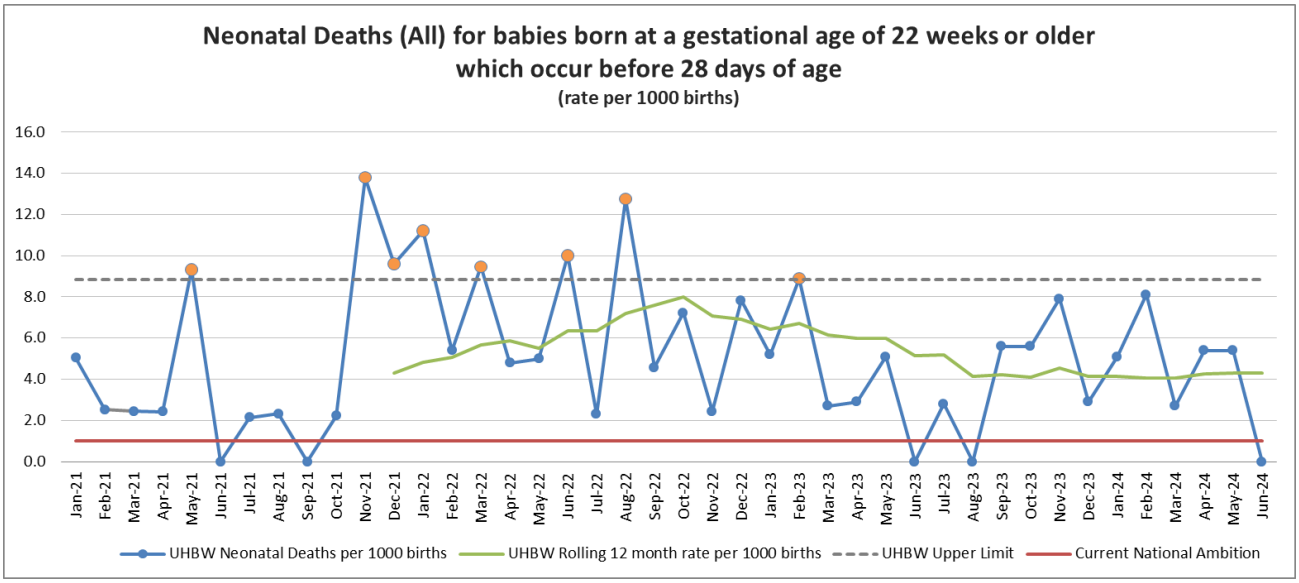


Figure 2.UHBW Trust Neonatal Deaths rate per 1000 births

2.2. Perinatal Mortality Summary for Quarter 1 2024/25

			April 2024	May 2024	June 2024	Total Q1 2024/25
Late fetal losses	22 weeks to 23+6 weeks		0	0	0	0
Stillbirths	24 weeks to 36+6 weeks		0	1	0	1
	>37 weeks		0	0	0	0
Neonatal Deaths	**Early**	**Inborn** (babies born at UHBW)	0	0	0	0
		Outborn (babies transferred to UHBW following birth for neonatal care)	1	0	0	1
	Late	**Inborn** (babies born at UHBW)	1	1	0	2
		Outborn (babies transferred to UHBW following birth for neonatal care)	0	1	0	1

Table 1. Perinatal Mortality Summary Quarter 1 2024/25

2.3. Perinatal Mortality Review Tool (PMRT) real time data monitoring tool

All perinatal deaths within the Trust have been reported using the PMRT tool since its launch in 2017. PMRT reporting is a requirement of Safety Standard 1 of the NHSR Maternity Incentive Scheme Year 6.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-UK (MBRRACE-UK) collects data on perinatal deaths which fall into one of the following criteria:

- **Late fetal losses** – the baby is delivered between 22 weeks+0 days and 23 weeks+6 days of gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred
- **Stillbirths** – the baby is delivered from 24 weeks+0 days gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth
- **Terminations of pregnancy** – Any late fetal loss, stillbirth or neonatal death resulting from a termination of pregnancy should be notified.

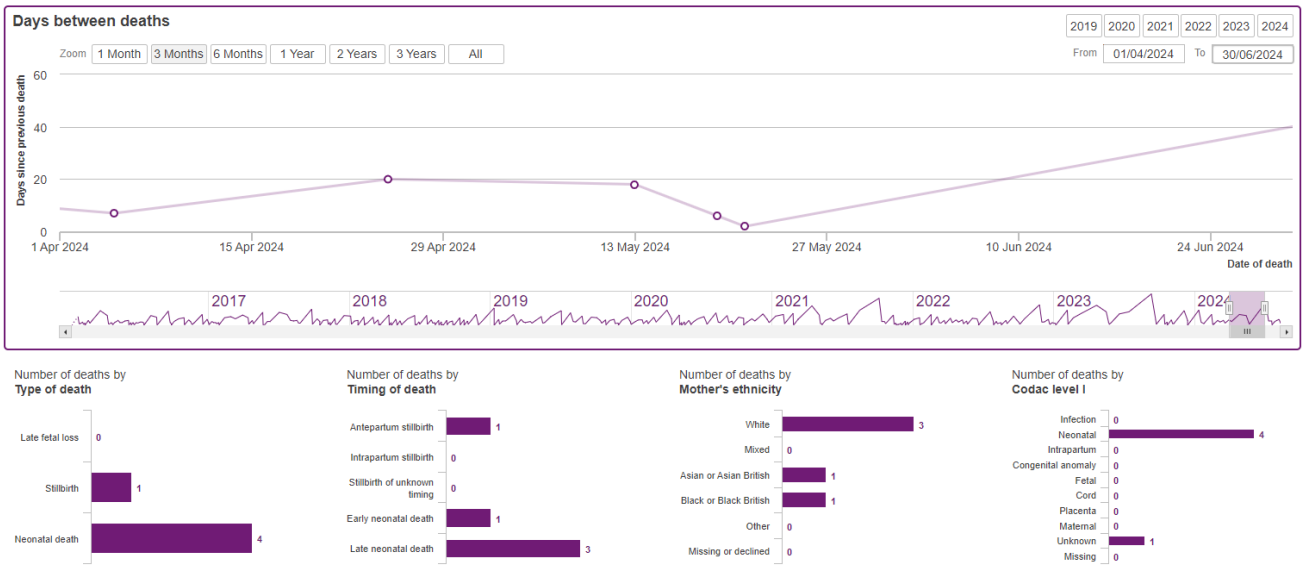


Figure 3.PMRT 'Deaths within your Organisation' Report (01/04/2024 to 30/06/2024)

2.4. Learning from PMRT Reviews

Appendix 1 provides an update on the actions identified via the multidisciplinary PMRT review panel for cases reviewed during Q1 (2024/24).

2.5. PMRT Key Performance Indicators (MIS Year 6)

MIS Safety Action 1*: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?*

	Requirement	Compliance Status
1.1	Have all eligible perinatal deaths from 8 December 2023 onward been notified to MBRRACE-UK within seven working days?	Fully Compliant
1.2	For at least 95% of all deaths of babies who died in your Trust (UHBW) from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Fully Compliant
1.3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 December 2023 been started within two months of each death? This includes deaths after homebirths where care was provided by your Trust	Fully Compliant
1.4	Were 60% of the reports published within 6 months of death?	Fully Compliant
1.5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews and consequent action plans.	Fully Compliant
1.6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Fully Compliant

Table 2. PMRT Key Performance Indicators Quarter 1 2024/25

3. Maternity and Newborn Safety Investigation (MNSI) Programme and Maternity Serious Incidents

3.1. Background

The Maternity and Newborn Safety Investigation (MNSI) Programme (previously known as the Healthcare Safety Investigation Branch (HSIB)) undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions, 2018) taken from Each Baby Counts and MBRRACE-UK.

MNSI provide independent investigations which meet one of the following defined criteria:

- All term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:
  - Intrapartum stillbirth
  - Early neonatal death

- Baby born with a potential severe brain injury diagnosed in the first seven days of life

- Maternal Death: when a mother dies whilst pregnant or within 42 days of the end of their pregnancy

3.2. MNSI Referrals and Investigation Progress Update

There were 5 cases which met the initial criteria for referral to MNSI during Q1.

Two cases have proceeded to investigation from April 2024:

- 1 x HIE Referral - proceeded due to family concerns (baby's MRI investigations were reported as normal)
- 1 x Early Neonatal Death - Baby transferred to NICU following delivery from NBT, MNSI have now reallocated this case to NBT, although staff from UHBW will be asked to contribute to the investigation

One case has proceeded to investigation from May 2024:

- 1 x HIE Referral - Baby admitted to Bristol Children's Hospital by air ambulance following neonatal collapse at home. MNSI have now reallocated this case to GLOU, although staff from PICU will be asked to contribute to the investigation

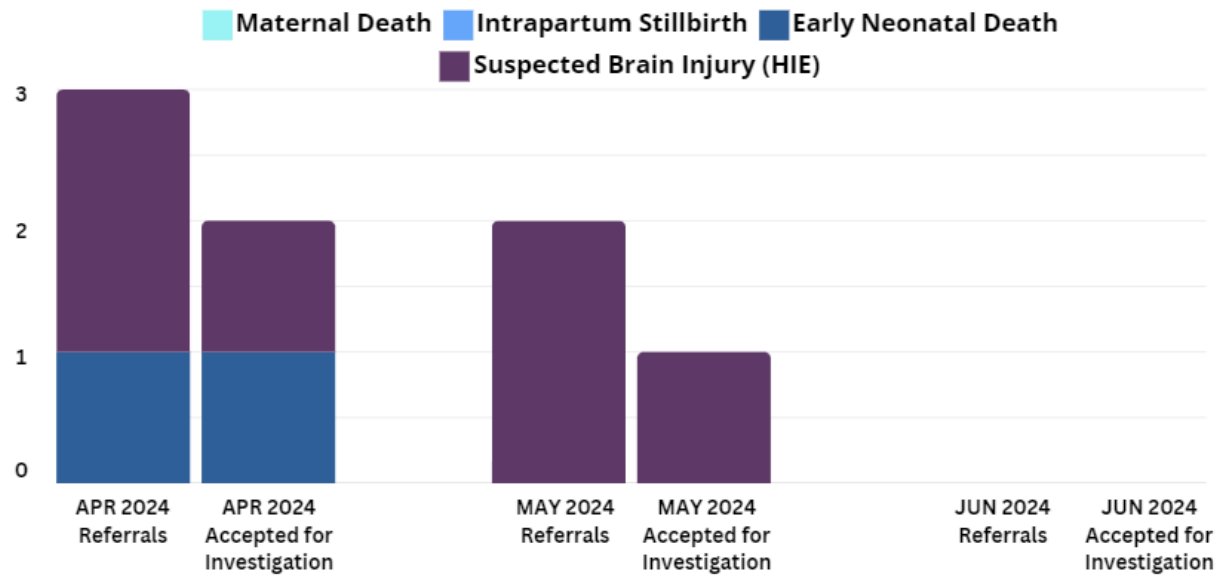


Figure 4.MNSI Referrals and Cases accepted for Investigation (01/04/2024 to 30/06/2024)

No MNSI reports returned in Q1.

3.3 Maternity and Newborn Safety Investigations (MNSI) and NHS Resolution's Early Notification (EN) Scheme Key Performance Indicators (MIS Year 6)

MIS Safety Action 10*: Have you reported 100% of qualifying cases to MNSI and to NHS Resolution's Early Notification (EN) Scheme?*

	Requirement	Compliance Status
10.1	Have your reported 100% of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024?	Fully Compliant
10.2	Have you reported 100% of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024?	Fully Compliant
10.3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme?	Fully Compliant
10.4	Has there been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 in respect of the duty of candour?	Fully Compliant
10.5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI / EN incidents and numbers reported to MNSI and NHS Resolution?	Fully Compliant
10.6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Fully Compliant
10.7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Fully Compliant
10.8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Fully Compliant

Table 3. MNSI / ENS Key Performance Indicators Quarter 1 2024/25

4. Avoidable Term Admissions to NICU (ATAIN)

The ATAIN framework was launched by NHS Improvement in 2018, with aims to reduce term admissions into Neonatal units to below 5% of births per month (for babies born at 37 weeks or above) in order to avoid unnecessary separation of the mother and baby.

Each case of an unanticipated admission to NICU at term is reviewed by a multidisciplinary team with learning disseminated to the wider team with actions to improve care allocated and monitored via the appropriate governance pathways.

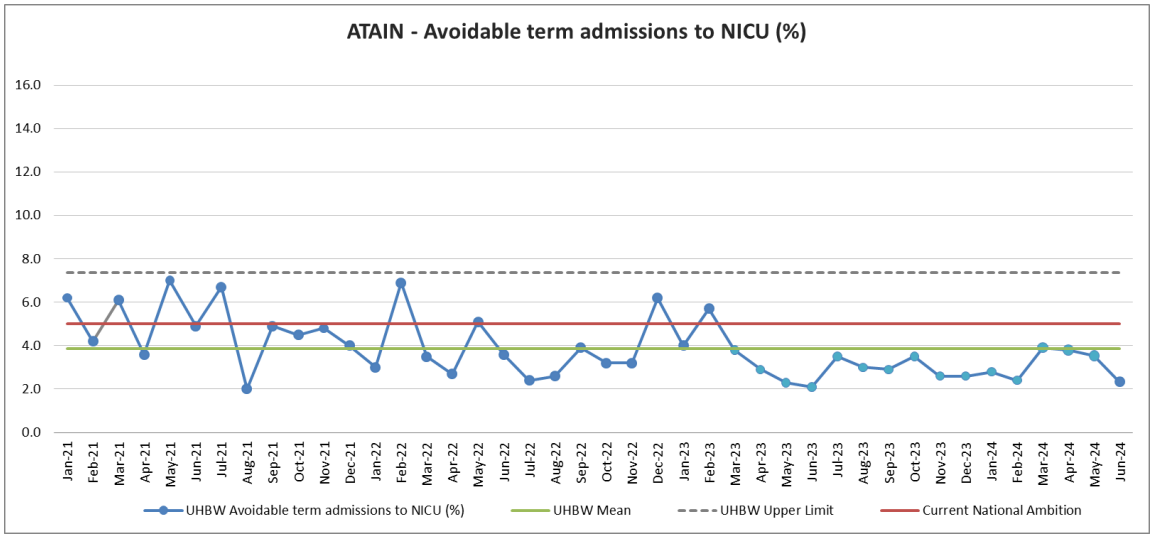


Figure 5.Avoidable Term Admission Rate to NICU (%)

See Appendix 2 for Q4 2023/4 and Q1 2024/24 ATAIN Report.

5. Coroner Regulation 28 Made Directly to Trust

Not applicable.

6. Maternity Serious Incidents

There were 17 moderate harm events reported during Q4. Of these, one incident has been accepted for a PSII.

Appendix 3 provides additional information regarding these incidents.

7. Continuity of Care

7.1. Background

Maternity transformation sets out to support the implementation of The National Maternity Review (Better Births (2016), the NHS Long-Term Plan (2019) and the national Maternity Transformation Plan.

7.2. Progress to Date

UHBW currently has 4 dedicated continuity of carer teams; these are strategically located to target vulnerable/at risk groups and those from Ethnic minority groups.

Approximately a third of all women accessing maternity care at UHBW will be cared for by a continuity of care team.

	APR 24	MAY 24	JUN 24
Continuity of Carer (Percentage of Women booked for maternity care within a continuity team)	33.9%	30.9%	34.3%

8. Ockenden Update

The Trust is not required to submit evidence of compliance, although this is monitored at speciality level and is included in the monthly Perinatal Quality Surveillance Matrix.

See Appendix 4 for June's PQSM Report.

9. Training Compliance

Sharing of local maternal and neonatal outcomes from serious incidents, near misses and never events are incorporated into training, and disseminated to staff in a variety of formats including: staff safety briefings, the patient safety 'Close Encounter' newsletter, the patient safety SharePoint page, case review posters and quality and safety whiteboards displayed in clinical areas.

Training compliance monitored at speciality level and is reported monthly within the Perinatal Quality Surveillance Matrix.

Current challenges regarding compliance levels for Newborn Life Support (NLS) training amongst Neonatal Nurses has been escalated to the Neonatal training team and a recovery plan is now in situ.

See table 4 for additional details.

Training	Target	Local Threshold			Apr-24	May-24	Jun-24	Year to date average	Trend	SPC		Comment	Countermeasure / Action
		G	A	R						Variation	Assurance		
Training compliance fetal wellbeing day - Obstetric doctors (ALL)	MIS Y6 90%	≥90%		≤80%	68%	81%	87%	67%		H	F		
Training compliance fetal wellbeing day - Midwives (ALL)	MIS Y6 90%	≥90%		≤80%	94%	92%	91%	84%		H	?		
Training compliance in maternity emergencies and multi-professional training - Obstetric doctors (ALL)	MIS Y6 90%	≥90%		≤80%	77%	85%	90%	79%		H	?		
Training compliance in maternity emergencies and multi-professional training (includes NBLS) - Midwives (ALL)	MIS Y6 90%	≥90%		≤80%	90%	87%	90%	90%			?		
Training compliance in maternity emergencies and multi-professional training - Anaesthetists (ALL)	MIS Y6 70%	≥70%		≤60%	77%	77%	74%	76%			?		
Training compliance in maternity emergencies and multi-professional training - Maternity care assistants - ALL	MIS Y6 90%	≥90%		≤80%	89%	84%	86%	84%		H	?	..	
Training compliance annual local NBLS - NICU Doctors (ALL)	MIS Y6 90%	≥90%		≤80%	97%	97%	91%	97%		L	P		
Training compliance annual local NBLS NICU ANNPs (ALL)	MIS Y6 90%	≥90%		≤80%		95%	95%					More consistent reporting required in order to calculate SPC - bi-monthly reporting moving forward	
Training compliance annual local NBLS NICU Nurses (Band 5 and above)	MIS Y6 90%	≥90%		≤80%		67%	67%					More consistent reporting required in order to calculate SPC - bi-monthly reporting moving forward	Discussed at NICU Governance June 2024 - RISK added to Risk register

10. Board Level Safety Champion Walk Arounds

The Board Safety Champions undertook walk arounds across Maternity Services: 24th April 2024, 24th May 2024 and 26th June 2024.

Actions from these walk arounds are monitored via local governance groups with oversight via the Maternity and Neonatal Safety Champions meeting.

11. NHS Resolution Maternity Incentive Scheme

The Maternity Incentive Scheme (MIS) was developed in 2017. The scheme is designed to support safer maternity and perinatal care by driving compliance with ten 'safety actions'. The safety actions are updated annually by a collaborative advisory group, consisting of representatives from NHS Resolution, NHS England, The Royal College of Obstetricians and Gynaecologists (RCOG, the Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), the Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity Newborn Safety Investigation Programme (MNSI).

The Clinical Negligence Scheme for Trusts released their Ten Safety Standards for Year 6 on the 2nd of April 2024. A GAP analysis of Year 6's standards has been undertaken and work is now underway to ensure full compliance is met. Progress with these standards is monitored through regular reviews with the LMNS, and progress is reported on in the monthly Perinatal Quality Surveillance Matrix.

12. Safe Maternity Staffing

From May 2024 maternity staffing metrics have been included within the Perinatal Quality Surveillance Matrix.

Within neonatal services achieving the required establishment of 70% Neonatal Qualified In Speciality (QIS) trained nurses remains challenging. An A3 project to address this is planned to be undertaken by the NICU Matron and Deputy Director of Midwifery. It is anticipated that this will be shared with the Quality Outcomes Committee in due course.

13. Complaints / Compliments / Patient Advice and Liaison Service (PALS)

Oversight of complaints, compliments and PALS interactions is held by the Women's Patient Experience Group. Bi-monthly meetings are also held between the quality and patient safety team and the legal team.

Reviews of individual complaints are managed locally and learning disseminated when required via staff safety briefings, the patient safety 'Close Encounter' newsletter or the patient safety SharePoint page.

A monthly overview of complaints/compliments received is captured within the monthly Perinatal Quality Surveillance Matrix.

14. Triangulation Report

NHS Resolution (NHSR) have advised that the revised Obstetric Scorecard has been delayed, it is anticipated that this will now be released during September.

The Q1 Triangulation report has therefore been compiled using the current version of this.

See Appendix 5 for Q1s triangulation report.

15. Risk Register

All open risks (score 12 or >) within Maternity and Neonates are listed below:

ID	Domain	Monitoring Group	Title	Rating (current)
7322	Quality	Divisional Governance Group Womens	Risk that the trust perinatal pathology service will be significantly disrupted due to the current staffing model	20
7247	Workforce	NICU Governance Committee	Risk that BAPM standards will not be met if there are not enough Qualified in Speciality (QIS) nurses	20
2264	Patient Safety	Divisional Governance Group Womens	Risk that delays in commencing induction of labour increases perinatal morbidity and mortality	16
7540	Patient Safety	CDS Governance	Risk that women and/or babies may suffer harm because the parents decline to engage in maternity care when in labour at home	15
7283	Quality	Divisional Governance Group Womens	Risk that patient safety investigations may be hindered by the quality of data and documentation recorded within BadgerNet	15
6830	Patient Safety	CDS Governance	Risk that the lack of pulse oximetry on CTG Machines makes it difficult to monitor maternal pulse against fetal pulse	15
6906	Patient Safety	CDS Governance	Risk that fetal heart monitoring may be delayed due to equipment unavailability as the CTG fleet exceed recommended lifespan	15
33	Patient Safety	Divisional Governance Group Womens	Risk that inadequate nursing levels in line with BAPM standards 2011 will affect neonatal outcomes	15
757	Workforce	Divisional Governance Group Womens	Risk that the level of midwifery vacancies may impact on the quality and safety of the service	12
1048	Quality	Women and Children's Quality Assurance Committee	Risk that level 3 safeguarding training targets are not met	12
1162	Patient Safety	Divisional Governance Group Womens	Risk that a poor outcome for mother and/or baby due to staffing levels if opening a 2nd emergency obstetric theatre out of hours	12
3232	Quality	Post Natal Working Party	Risk that newborn babies will not receive their screen in a timely manner.	12
3643	Quality	Antenatal Working Party	Risk that patient care will be compromised if remote IT access is not improved to provide a reliable	12

			accessible secure system	
4422	Business	Women and Children's Quality Assurance Committee	Risk that W&C Division will be unable to fully deliver against access targets and backlog recovery plans	12
4471	Workforce	NICU Governance Committee	Risk that a shortfall in AHP provision on NICU leads to reduced early intervention, poor longterm prognosis & patient experience	12
4628	Quality	Divisional Risk Management Group (D&T)	Risk that babies will come to harm if we are unable to fully implement the USS requirements for SBLV3	12
4825	Patient Safety	Antenatal Working Party	Risk that pregnant women are not seen during their pregnancy by the correct or any consultant	12
5288	Patient Safety	Divisional Governance Group Womens	Risk that not having an allocated triage area and system may result in a delay treating patients	12
5716	Workforce	Divisional Governance Group Womens	Risk that maternity services will be unable to provide continuity of carer pathway due to insufficient midwives	12
6277	Workforce	Pharmacy Managers Group	Risk that patients may be harmed as a result of medication errors due to the workload of the NICU pharmacist	12
6329	Patient Safety	Women and Children's Quality Assurance Committee	Risk that NICU will not be able to accept referrals due to lack of capacity caused by delays in patient flow to the BRHC	12
6466	Patient Safety	CDS Governance	Risk that inability to provide theatre staff for a 2nd emergency list at STMH between 5.30-9pm may result in harm to a patient	12
7222	Patient Safety	NICU Governance Committee	Risk that babies will come to harm due to lack of available nCPAP machines in NICU	12

16. Recommendation

This report has been produced to inform/update the Board and to allow discussion where required.

Issue's/ Action's from Perinatal Mortality Review's - Q1 (April 24 - June 24)

PMRT gradings:
Grading of care of the mother and baby up to the point of birth of the baby. 1.
Grading of care of the baby from birth up to the death of the baby. 2.
Grading of care of the mother following the death of her baby. 3.
The review group concluded that there were no issues with care identified from birth up the point that the baby died A -
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

PMRT Ref No.	Intrauterine Death (IUD) or Neonatal Death (NND)	Datix No.	Date Discussed	PMRT Grading	Issues/ Actions?	Issue (generated by PMRT)	Issue Explaination	Categorisation of Issue	Sub-Category of Issue	Action Description	Categorisation of Action	Sub-Category of Action	Datix Action No.	Target Date	Datix Action Completion	Effectiveness Audit or additional action required? If yes, add as action to Datix and put Action number here	Audit / additional action Follow up
91548	IUD	244201	17/04/2024	1=A 3=B	Issue/ Action	Custom	Mother was unable to access her maternity notes through the Badgernotes app.	Patient	Digital Services	Reminder to midwives to offer hand held notes to women who are unable to access Badgernotes app. This includes midwives that work in areas other than Community where a short booking may be performed following a transfer for fetal medicine care for example.	Documentation	Communication - Family	93684	01/07/2024			
91294	IUD	242502	17/04/2024	1=B 3=A	Issue/ No Action	This mother's progress in labour was not monitored on a partogram	Observations were performed and recorded, however not recorded on a partogram likely due to multiple tasks being performed during a precipitate (quick) labour.	Omission	Clinical assessment								
87895	NND	220711	17/04/2024	2=A (Neonatal care only, outborn RUH)	Issue/ No Action	It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	Documentation issue - Reminder given to staff	Documentation	Bereavement								
90025 (Twin 2's is 89856)	NND	233844	17/04/2024	2=B (Neonatal care only, outborn Glos)	Issue/ No Action	The thermal management of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate	Due to the unexpected nature of Edwards delivery- being born down a toilet, it would have been difficult to regain a normothermic temperature upon admission to the neonatal unit. Having a temperature of 36.0 degrees on admission to the neonatal unit shows that the neonatal team were able to rewarm Edward fairly quickly. To remind staff about continuing to use mattress temperature as well as humidity/ incubator temp to help maintain warmth.	Enviroment	Equipment								
91906	IUD	246407	03/05/2024	1=C 3=B	Issue/ No Action	This mother booked late. Did this affect her care?	Mother was of unknown gestation when first presented, however a dating ultrasound scan was arranged for before the booking appointment. The earliest available appointment was made once mother had made contact with maternity services.	Enviroment	Clinical appointmnets								
						This mother's progress in labour was not monitored on a partogram	Patient care prioritised over partogram documentation. Staff are regularly reminded to ensure cotemporaneous documentation and to write in retrospect when needed.	Omission	Clinical documentation								
						This mother's pain was not managed appropriately during labour	Anaesethist was made aware that Hafiza wanted a PCA. Midwives made sure Hafiza was clinically ready for PCA. Labour progressed quickly and PCA was not ready in time for delivery. Other analgesia was provided.	Staffing	Analgesia								
						This mother had poor/no English and family members were used as interpreters during her labour and birth	Family member had an excellent understanding and was used to translate during the intrapartum period, however for more complex conversations a translator was used e.g. before going to theatre.	Staffing	Translation								
					Issue/ Action	This mother was assessed as high risk and in need of aspirin but aspirin was not prescribed. This mother had a previous baby which was growth restricted/small for gestational age and her antenatal care was not appropriate given this history.	Mother was unsure of the birthweight of her first baby, however she did highlight that she thought the baby was very small. The booking midwife highlighted that Mother needed growth scans based on this information, however she did not recognise this as a risk factor on the Aspirin risk assessment or commence her on aspirin which would have been indicated at this time.	Omission	Risk assessmnet	A previous small baby should be recognised as a risk factor on the aspirin risk assessment and aspirin prescribed where needed. Reminder to staff to be given the close encounters newsletter. Additionally, to discuss with the informatics midwives if the Badgernet system can be used to automatically pull through a previous small birth weight to the aspirin risk assessment.	Quality assurance	Risk assessmnet	93686 and 92903	31/05/2024 and 1/7/24	Completed 30/05/2024 and 6/6/24	Yes - 93689	

						This mother and/or baby did not have further postnatal investigations despite the investigations being requested	Postnatal blood tests had to be repeated as they were initially incorrectly labelled. Mother was prescribed antibiotics in view of a suspected urinary tract infection however mid-stream urine (MSU) sample was never processed by lab as it was sent in the wrong bottle and not repeated.	Misinterpretation	Investigations	Postnatal investigations were not labelled/ sent in the correct way. Reminder to staff in the close encounters newsletter.	Training	Investigations	92903	01/07/2024	06/06/2024		
91939	IUD	246651	03/05/2024	1=B 3=A	Issue/ No Action	NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	No documented evidence of CO testing at booking. Regular reminders to staff to do CO testing at booking regardless of smoking status.	Omission	Clinical assessment								
						This mother had poor/no English and family members were used as interpreters on occasions during her antenatal care	Telephone interpreters used at almost every appointment and interaction (documented well) however a couple of documented occasions of daughter translating.	Omission	Translation								
						Estimated fetal weights from scans had not been plotted on a chart	It has been recognised that consistent plotting of efw on the intergrowth chart is not being done. Not considered to be causal. However being considered as part of a wider data quality issue since launch of BadgnerNet. The implications of this not being used needs to be explored further.	Omission	Clinical documentation								
						This mother had poor/no English and language line was used to interpret during her labour and birth	Lack of face to face interpreters is a known risk on the trust risk register. This is being reviewed on a quarterly basis and actions are being put in place to improve the service across the trust.	Staffing	Translation								
					Issue/ Action	This mother was assessed as high risk and in need of aspirin but aspirin was not prescribed	The birthweight of the woman's previous babies was documented as unknown at booking and therefore didn't trigger the need for aspirin. However it is documented at an obstetric review that all her previous babies were under 2kg which would make them small for gestational age. It has been identified that there is a potential theme of women being incorrectly classified as low risk for aspirin. The QPS team will undertake an audit to identify the scope of this issue and whether there are any system changes that can be made.	Omission	Medications	It has been identified that there is a potential theme of women being incorrectly classified as low risk for aspirin. The QPS team will undertake an audit to identify the scope of this issue and whether there are any system changes that can be made.	Quality assurance	Medications	93692 (linked with 93689)	01/10/2024			
						This mother has a history of pregnancy induced hypertension and her antenatal care was not appropriate given this history	On the booking notes it is documented that the woman didn't have a previous hypertensive disorder in pregnancy, however at an obstetric review it is documented that she has previous pregnancy induced hypertension. There is no documentation that she was commenced on aspirin. It has been identified that there is a potential theme of women being incorrectly classified as low risk for aspirin. The QPS team will undertake an audit to identify the scope of this issue and whether there are any system changes that can be made.	Misinterpretation	Risk assessmnet		Quality assurance	Risk assessmnet					
92428	IUD	249455	03/05/2024	1=A 3=A	No Issue												
92227	IUD	248593	15/05/2024	1=A 3=A	Issue/ No Action	This mother's progress in labour was not monitored on a partogram	Reminder to staff that partogram completion should still be used alongside HDU chart.	Omission	Clinical documentation								
92461	IUD	249917	15/05/2024	1=B 3=A	Issue/ No Action	NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	Booking form shows that a 'CO was not available'. This is unlikely as there are multiple monitors available in each base. Audit monitors this and low compliance is addressed with the relevant staff. This is not relevant to the outcome in this case. Carbon monoxide monitoring was performed at 24 weeks of pregnancy and showed a normal/ low reading of 3ppm.	Omission	Clinical assessment								
						This mother had poor/no English and an interpreter was not used on every occasion when she was seen for her antenatal care	Mother has some understanding of English. A translator was not available during the FTCS otherwise whether a translator was offered or not is not documented.	Staffing	Translation								
						This mother had poor/no English and arrangements other than an interpreter were made during her labour and birth	Mother has some understanding of English. She declined the use of an interpreter prior to induction of labour. It is unclear whether an interpreter was re-offered in labour.	Patient	Translation								

					Issue/ Action	Following the antenatal admission with abdominal pain, antibiotics to treat a suspected urinary tract infection were given however a mid stream urine (MSU) sample was not sent to the lab for testing. Similarly, a speculum examination was performed in view of the abdominal pain however a high vaginal swab (HVS) was not sent to the lab for testing.	If a women presents with urinary tract infection symptoms, a mid stream urine sample should be sent (regardless of dipstick result). If a women is having a speculum examination, a high vaginal swab should be performed with consent and sent to the lab.	Omission	Investigations	Reminder on CDS safety briefing and in close encounters newsletter: If a women presents with urinary tract infection symptoms, a mid stream urine sample should be sent (regardless of dipstick result). If a women is having a speculum examination, a high vaginal swab should be performed with consent and sent to the lab.	Training	Clinical assessment	93697	01/08/2024			
91953	NND	246808	15/05/2024	1= 2= 3= (awaiting PM results to determine grading of care)	No Issue												
89615	NND	231256	15/05/2024	2=A (Neonatal care only, outborn NBT)	No Issue												
90268	NND	235378	19/06/2024	2=B (Neonatal care only, outborn Cornwall)	Issue/ No Action	The opportunity to take their baby home was not offered to the parents as this was logistically too complicated to organise	Mum did not drive and took a train home as no family could come and collect her.	Patient	Bereavement								
92720	NND	251954/ 251763	19/06/2024	1= B 2= A 3= A	Issue/ No Action	The baby was cold on arrival in the neonatal unit	Prolonged resus/stabilisation meaning delay in taking patient to nicu	Clinical assessment	Neonatal care								
						The opportunity to discuss post mortem with the parents prior to their baby's death as part of end of life care was not taken	It was not felt to be appropriate given the difficult and challenging situation given mum's poor health since the birth	Omission	Communication - Family								
						The opportunity to take their baby home was not offered to the parents	Mother still an inpatient in hospital for a further 4 days or so after patient had died. Parents not keen to see 'dead body' after they said there goodbyes.	Omission	Communication - Family								
					Issue/ Action	Custom	There was no listed Next of Kin details for this mother and therefore it was difficult to contact the family member during the obstetric emergency.	Omission	Clinical documentation	Reminder to all staff that it is everybody's responsibility to ensure that Careflow Live is updated with Next of Kin details at all appointments and admissions. Reminder distributed via email, safety briefing board, and at team meetings.	Quality assurance	Clinical documentation	91998	01/05/2024	Completed 15/4/24	yes - 94590 (Discuss with EB r.e. can NoK be mandatory on Badgernet? Ongoing report can be pulled from Badgernet and complience is low.)	
						Custom	No referral to bereavement team in view of 8 previous losses or wellbeing team antenatally.	Omission	Bereavement	Reminder that women who experienced a previous loss can be referred to Snowdrop bereavement team for support. Reminder to be shared at community team meeting.	Quality assurance	Clinical oversight	94477	01/08/2024			

University Hospitals Bristol and Weston NHS Foundation Trust

Report Title	**CNST Maternity Incentive Scheme (MIS) Safety Action 3: Avoiding Term Admissions into Neonatal Units (ATAIN) Report – January to June 2024 Update**
Report Author	**Sneha Basude, Rachna Bahl, Marina John, Katie Hunt**
Executive Lead	**Deirdre Fowler Chief Nurse and Midwife**

1. Purpose

This report provides the trust board with oversight regarding the rates of admission of babies over 37 weeks' gestation into the neonatal unit (NNU). This report includes admission data for 1st of January to 30th of June 2024.

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

This is the CNST Maternity Incentive Scheme (MIS) Report for Safety Action 3, January to June 2024.

As identified within the CNST standards, oversight and review of all admissions to the NNU of babies equal to or greater than 37weeks must be completed by both the maternity and neonatal teams.

3. Strategic Alignment

This report forms part of the divisional reporting requirement which supports the delivery of safer maternity care. This reflects the Trusts priority of Patient Safety within the Patient First True North Strategy.

4. Risks and Opportunities

Oversight of term admissions to the NNU allows the opportunity to identify recurrent trends/themes, which in turn provides an opportunity to implement system changes and reduce patient harm.

5. Recommendation

This report is for Information and Assurance

Board is asked to note this report for information and assurance.

6. History of the Paper

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

CNST Maternity Incentive Scheme (MIS) Safety Action 3: Avoiding Term Admissions into Neonatal Units (ATAIN) Report

1. Purpose

This report provides the trust board with oversight regarding the rates of admission of babies over 37 weeks' gestation into the neonatal unit (NNU). This report includes admission data for January to June 2024.

2. Context/Background

ATAIN has been set up to reduce harm leading to avoidable admission of full-term babies into neonatal units by understanding preventable causes. A central aim of the work is to prevent the separation of a mother and baby.

The work aligns with national priorities including the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030.

This report is a standing agenda item as per the recommendations set out in the Maternity Incentive Scheme (MIS) and the NHS England report.

3. Avoiding Term Admissions into Neonatal Units (ATAIN)

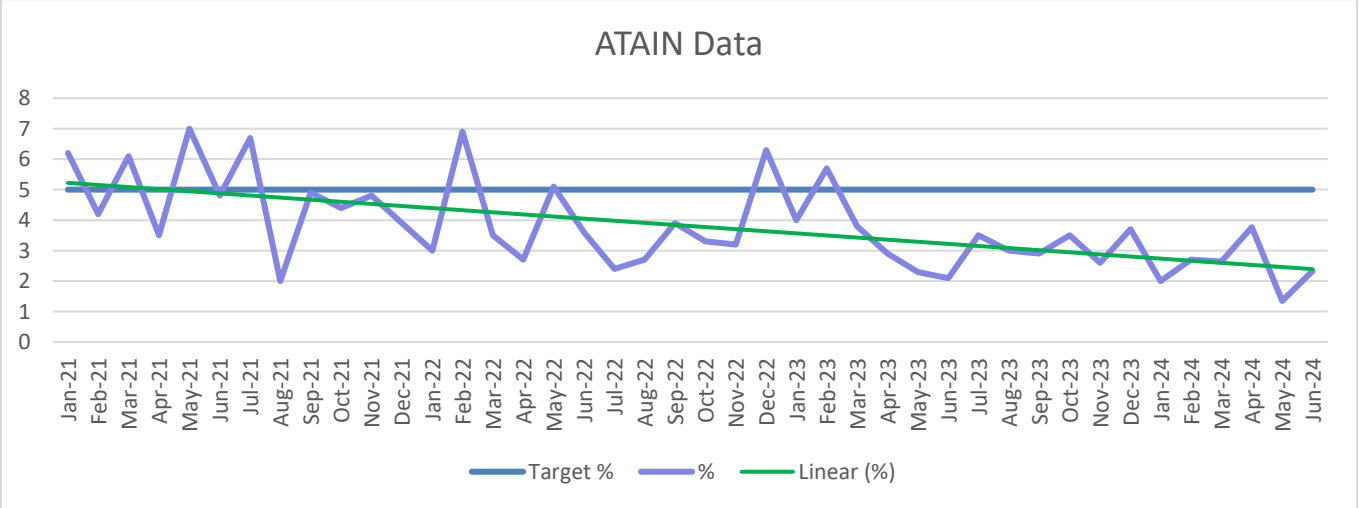


Figure 1: Steady decline in avoidable term neonatal admission rates to NNU- Data from Jan 2021 to June 2024

For all unplanned admissions to a neonatal unit for medical care at term a thorough clinical review is undertaken by the maternity and neonatal services. Planned admissions such as those for congenital abnormalities would be excluded from this data.

The Graph above shows the rate of term neonatal admissions in UHBW since 2021, showing steady decline over time (Figure 1). This rate is expected to be fewer than 5%. The ATAIN rate over the period covered in this report (January to June 2024) was 2.77%.

4. Reasons for admission

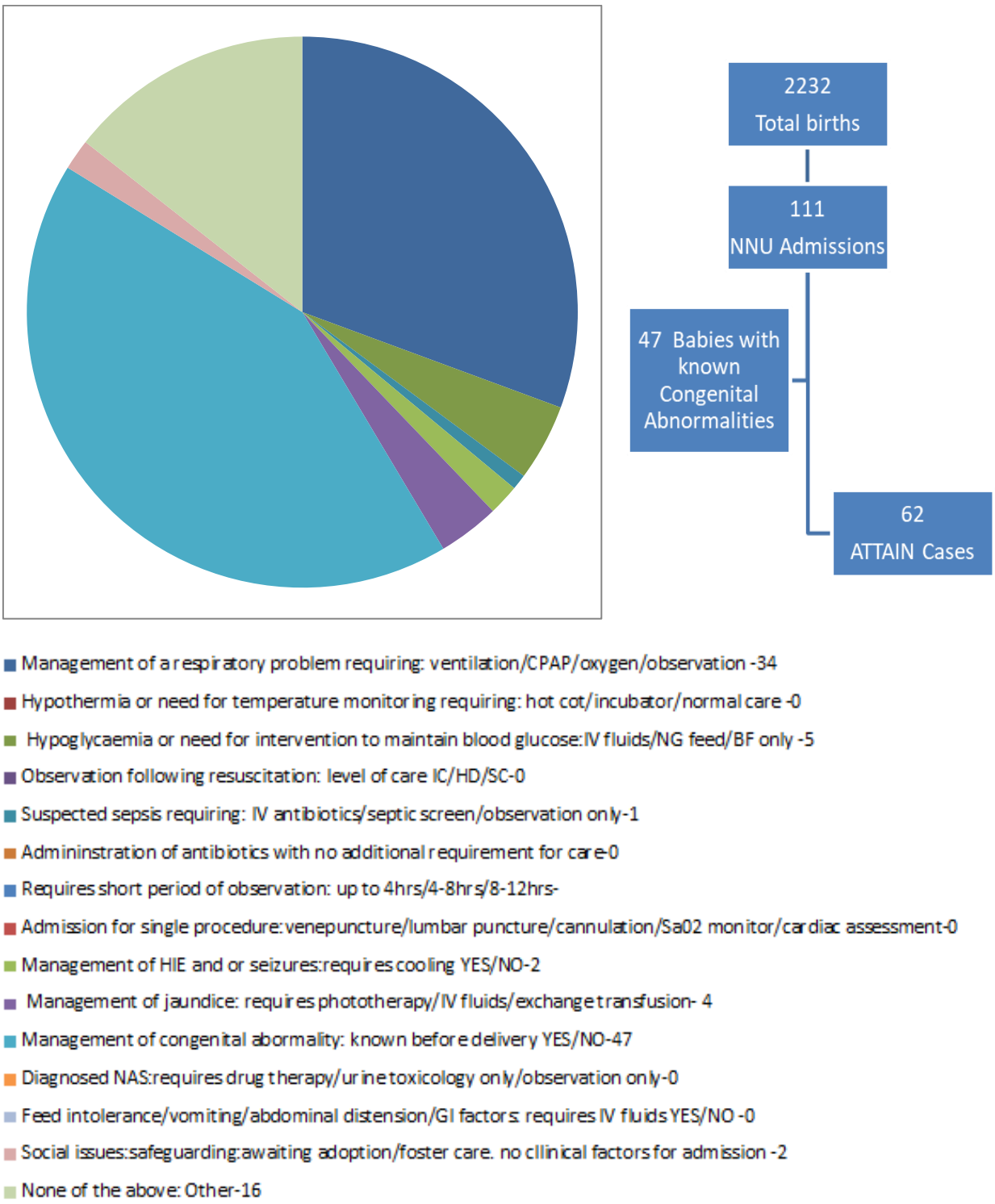


Figure 2: Reasons for term NNU admissions from January to June 2024

The most common reason for neonatal admission was congenital anomalies in 47 babies and respiratory distress in 34 babies was the second commonest over the six months. 'Other' causes contributed to the third highest reason for NNU admission, the details of the causes within this group can be seen below (Figure3)

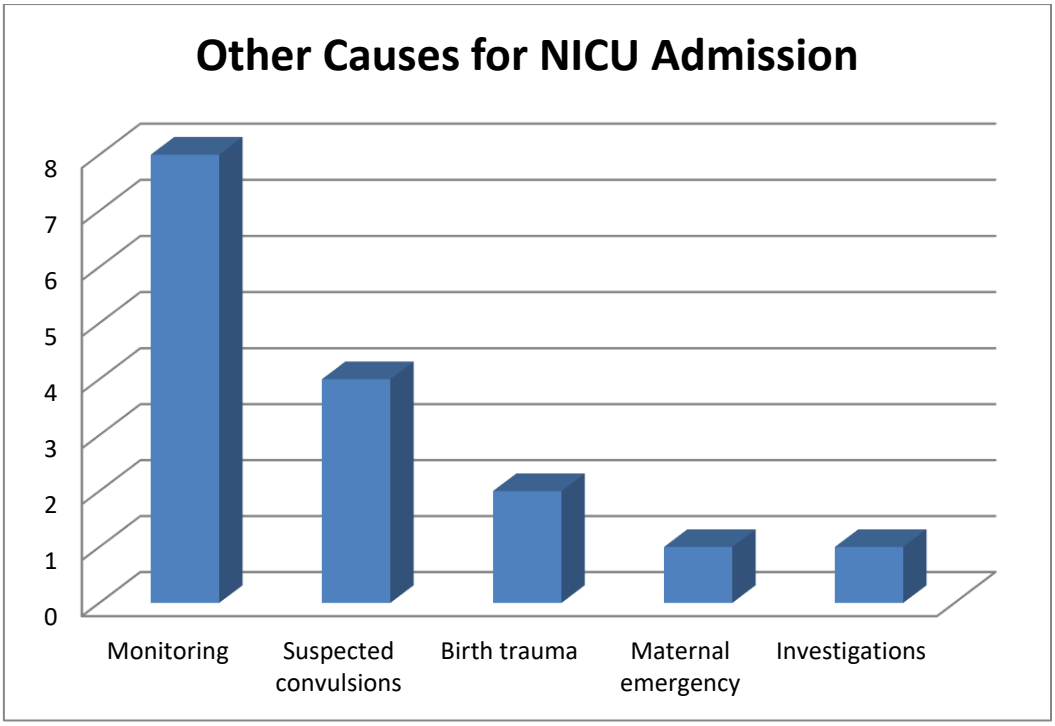


Figure 3: 'Other' reasons for NNU admission

Monitoring of babies on neonatal unit was the largest group. Monitoring was undertaken for various reasons such as hyponatremia secondary to maternal hyponatremia, failed pulse oximetry, cleft palate with absent gag reflex to name a few. There were 2 birth trauma related incidents which are being reviewed in morbidity meetings and training provided around impacted fetal head at birth.

5. Neonatal admissions by Ethnicity and IMD

Figure 4 and 5 Show the admission to neonatal unit by ethnicity and Indices of Multiple Deprivation during the six months covered by the report. However the information was missing or documented as 'other' for nine of these cases which could potentially skew the data.

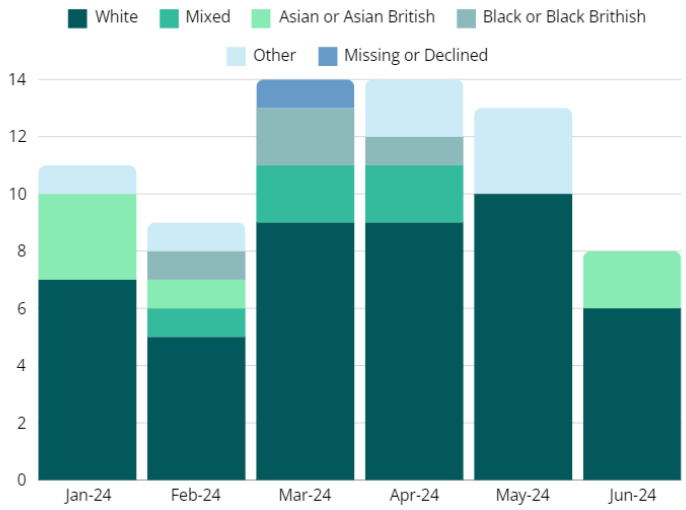


Figure 4: ATAIN Admissions by Ethnicity: 6 Month Overview

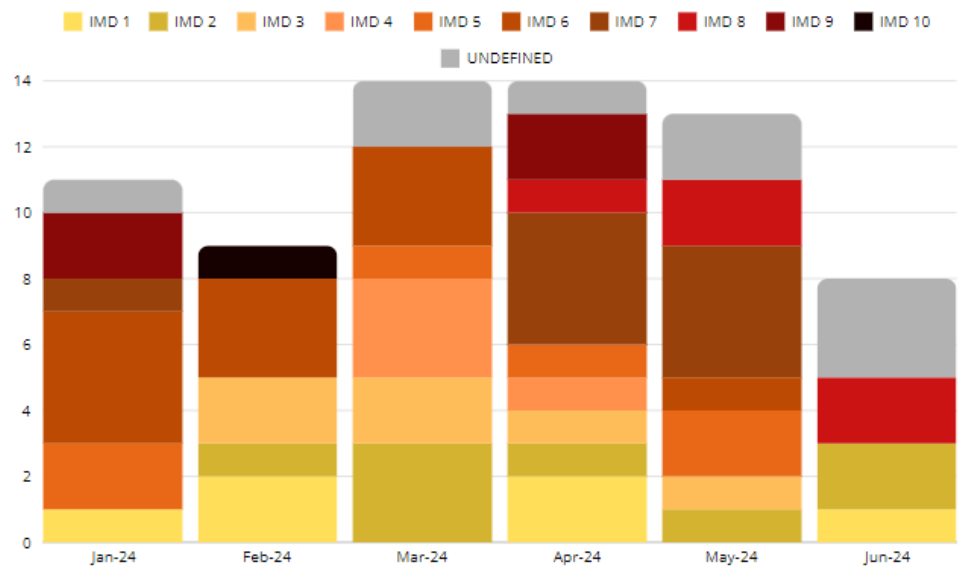


Figure 5: ATAIN Admissions by Maternal IMD: 6 Month Overview

6. Suspected Hypoxic ischemic encephalopathy (HIE) /Therapeutic Cooling

There were 6 babies with suspected Hypoxic ischemic encephalopathy (HIE). None of these met the Maternity and Newborn Safety Investigations (MNSI, formerly HSIB) criteria. One baby had MRI due to increased tone which was normal. Two babies received therapeutic hypothermia, both with normal brain MRI. 4 babies were admitted with suspected convulsions- 2 had normal MRI, 2 had normal CFM and did not qualify for MRI.

1. Impacted Fetal Head (IFH) at the time of birth - Seizures – phenobarbitone – Normal MRI
2. Admitted from home- mother on sertraline- seizure activity- Normal CFM, EEG. MRI- Occipital Peri-ventricular Nodular Heterotopia
3. Admitted to NICU with sepsis, abnormal movements- Normal CFM, Cong pneumonia
4. IFH- abnormal neurology – Normal CFM- settled spontaneously

7. Respiratory problems

Admission for respiratory support was noted to be the commonest potentially modifiable indication. We reviewed the timing and duration of respiratory support needed by each neonate to assess if this respiratory support could be delivered on CDS to avoid separation of neonates from their mothers. To this effect there was evidence of monitoring of babies on delivery suite to reduce unnecessary Neonatal unit admission. For the 18 babies where the respiratory distress occurred soon after birth and the data were available, the median duration of CPAP support prior to admission was 50 minutes (Inter quartile range: 40-60 minutes).

8. Actions and oversight

SITE/ GOV.Team	ACTIONS
Community	Complete feeding assessment on day 3-5
CDS	AVB- review of case with 6 pulls
	Take paired cord bloods for cord pH if concerns re fetal monitoring or baby born in poor condition
	Improve awareness to ensure NO OXYTOCIN for augmentation in multips with out complete senior obstetric review
	Sending Kleihauer for concealed abruption- lab rejects sample automatically for Rh +ve women
	No oxytocin for augmentation in multips until senior obstetric review
	Communicate with staff on CDS re: emergency resuscitation documentation on Badgernet
	STOP oxytocin if hyperstimulation
	Neonatal Head care bundle for traumatic births Explore role of Ultrasound to confirm fetal head position if planning trial in theatre and CTG abnormal
Postnatal ward	neonatal jaundice on P/N ward- if bilifash above normal- escalate
CDS + Postnatal	Baby should have septic screen if mother becomes septic within 24 hours of giving birth
NICU and postnatal	System review of hyperbilirubinaemia care and management followed by Jaundice awareness week Review management of babies admitted for monitoring to investigate if these babies can be managed on postnatal ward with enhanced observations
IT	If an alert can be added when the SBR data entered

9. Recommendations

This report is for information and assurance.

Maternity Incidents (Moderate Harm or above) Quarter 1 (April 2024 to June 2024)

APRIL

Datix	Date of Incident	Incident	Outcome / Learning / Actions
251683	03/04/2024	Infusion Injury (Extravasation)	**Manager Review completed** Patient aware of psychological support services if required
252465	09/04/2024	Major Haemorrhage and ruptured uterus, ICU admission	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC completed as part of the QPS review process Presented at RIRM, for **MDT review** within joint maternity and gynaecology morbidity and mortality forum
253805	25/04/2024	Neonatal Death	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC to be completed as part of the PMRT process Bereavement support being provided by the Snowdrop team Referral for psychological services completed **MNSI Investigation**
254398 /254196	25/04/2024	ICU Admission & Bowel Perforation following caesarean section	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC completed as part of the QPS review process Accepted for **PSII**

MAY

256032	17/05/2024	Spontaneous onset of labour (booked for an elective Caesarean) Cat 3 Caesarean, significant PPH (4138mls) with unplanned hysterectomy	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC to be completed as part of the QPS review process For **MDT review** within the maternity morbidity and mortality forum
256095	15/05/2024	Antenatal Stillbirth IUD confirmed at 32+1 weeks	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC to be completed as part of the PMRT process Bereavement support being provided by the Snowdrop team Referral for psychological services completed
254398	25/04/2024	Emergency Caesarean for fetal wellbeing Post-operative Illius with conservative manangement Subseqent bowel perforation / ICU admission	**Meets criteria for PSIRF Learing Response:** Verbal DOC completed, written DOC to be completed in conjuction with Surgical Services Joint RIR Meeting held with Surgical Services Accepted for **Trust PSII** (investigation due to commence July 2024) Referral for psychological services completed Initial patient debrief meeting arranged for 15/07/2024
256003	17/05/2024	Shoulder Dystocia (forceps delivery) Baby born with broken arm	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC completed as part of the QPS review process For **MDT review** within the maternity morbidity and mortality forum
254469	01/05/2024	Shoulder Dystocia (forceps delivery) 3a perineal tear & 2700ml PPH	For care review within PPH forum and follow up by the Perinatal Pelvic Health Specialist Physiotherapy Team Psychological support being provided by the Wellbeing team

255929	16/05/2024	KIWI Delivery 2nd degree perineal tear and 2996ml PPH	For care review within the PPH forum QPS follow-up to be completed 6 weeks post-delivery due to reporting of moderate psychological harm
254823	05/05/2024	Baby received the wrong mother's breast milk	Manager Review in progress QPS follow-up to be completed 6 weeks post-incident due to reporting of moderate psychological harm

JUNE

257541	01/06/2024	Post partum haemorhage (2 Litres)	Patient follow-up with CMW - Psychological harm downgraded to Low
260197	02/06/2024	ICU Admission - Acute Fatty Liver of Pregnancy / HELLP Overlap Syndrome	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC completed as part of the QPS review process For **MDT review** within the maternity morbidity and mortality forum
259500	22/06/2024	Domestic violence incident between patient and partner	No further QPS action required - patient has sufficient psychological support in place
260118	24/06/2024	Management of abnormal blood results	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC completed as part of the PMRT process **For MDT review** within the maternity morbidity and mortality forum
261092	25/06/2024	Possible postnatal diagnosis of Trisomy 21	Level of pychological harm to be verified
260240	29/06/2024	Antenatal Stillbirth at 30+5	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC to be completed as part of the PMRT process Bereavement support being provided by the Snowdrop team Referral for psychological services completed

University Hospitals Bristol and Weston NHS Foundation Trust

Perinatal Quality Surveillance (PQSM)

June 2024

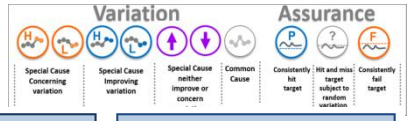
UHBW Maternity

Inspected and rated Good

CareQuality Commission

Maternity Workforce & Acuity

Public Board



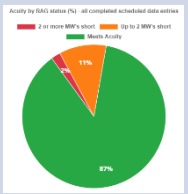
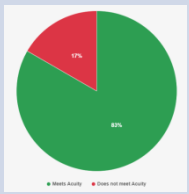
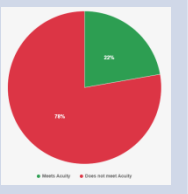
Safe - Maternity Workforce	Target	Local Threshold G	A	R	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Year to date average	Trend	SPC Variation	SPC Assurance	Comment	Countermeasure / Action
One to one care in labour (as a percentage)* excludes BBAs	SBLV3 100%	100%		≤99%	100%	100%	100%	100%	99.5%	100.0%	99.8%				May 24 1 x precipitous labour - delivered on ward 73	
Compliance with supernumerary status for labour ward coordinator	SBLV3 100%	100%		≤99%	100%	100%	100%	100%	100%	100%	100%					
Number of times maternity unit attempted to divert or on divert	Local	0		≥2	1	1	0	0	0	0	0.3					
Number of obstetric consultant non-attendance to 'must attend' clinical situations	Local	0		≥2	0	0	0	0	0	0	0.0					
Consultant Led MDT ward rounds on CDS day	SBLV3 100%	100%		≤90%	100%	100%	100%	100%	100%	100%	100%					
Consultant Led MDT ward rounds on CDS evening/night	SBLV3 100%	100%		≤90%	74.2%	86.2%	100%	100%	100%	100%	89.0%					
Percentage of 'staff meets acuity' - CDS	Birthrate+ 100%	≥90%		≤70%	72%	76%	80%	81%	90%	87%	78.0%				On going challenges with recording data within allocated time window when acuity in the unit is high	
Confidence factor in Birthrate+ (data recording on CDS)	Birthrate+ 60%	≥55%		≤45%	55.4%	45.2%	60.1%	57.1%	57.1%	56.0%	49.4%					
Percentage of 'staff meets acuity' - Ward 73	Birthrate+ 100%	≥90%		≤70%						83%					Birthrate+ Acuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC	
Confidence factor in Birthrate+ (data recording on Ward 73)	Birthrate+ 60%	≥55%		≤45%						15%					Birthrate+ Acuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC	
Percentage of 'staff meets acuity' - Ward 76	Birthrate+ 100%	≥90%		≤70%						22%					Birthrate+ Acuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC	
Confidence factor in Birthrate+ (data recording on Ward 76)	Birthrate+ 60%	≥55%		≤45%						7.5%					Birthrate+ Acuity Tool for Ward areas released July 2024 insuffient historic data to calculate SPC	

Birthrate Plus®

Capture of intrapartum (CDS) data is required 6 times during a 24 hour period (00:30, 04:00, 08:00, 12:00, 16:00 & 20:00), there is an hour's window for entering data: 30 mins before and 30 mins after the scheduled time.

Capture of ward data is required 4 times during a 24 hour period (02:00, 08:00, 14:00 and 20:00) ,there is a window for data entry 30 minutes before the scheduled entry time and 60 minutes afterwards.

Data entered outside of the time window may still be recorded by will not contribute to the overall compliance calculation.

Central Delivery Suite (CDS)	Antenatal & Postnatal Inpatients (Ward 73)	Transitional Care (Ward 76)
		

Is the standard of care being delivered?

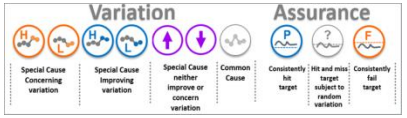
- **No episodes where the supernumerary status of the CDS coordinator was not maintained**

What are the top contributing factors to over/under achievement?

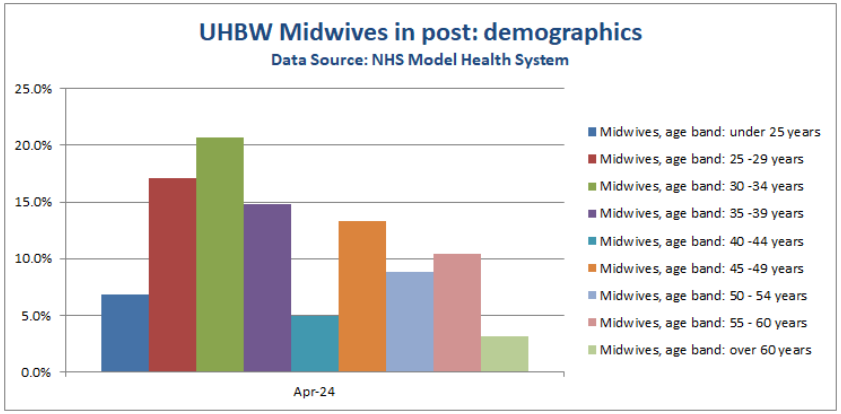
- **Increased complexity of individual cases continues to impact of 'staffing meet acuity' data for CDS**

Maternity Workforce & Acuity

Public Board



Safe - Maternity Workforce	Target	Local Threshold G	A	R	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Year to date average	Trend	SPC Variation	SPC Assurance	Comment	Countermeasure / Action
Band 5/6/7 Midwifery Vacancy Rate (inclusive of maternity leave) WTEs	197.78 WTE 100%	≤5		≥10	14.38	14.02	10.26	6.30	7.30	8.57	14.56		L	F	Current vacancy rate of 8.57 wte, with 15.5 wte in onboarding process	Action not currently required
Obstetric Consultant Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3					0	0					New data set insuffient historic data to calculate SPC	
Obstetric Registrar Vacancy Rate (inclusive of maternity leave)WTEs		≤1		≥3					0.9	0.9					New data set insuffient historic data to calculate SPC	
Obstetric SHO Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3					-1.2	-1.2					New data set insuffient historic data to calculate SPC	
Midwifery Shift Fill Rate (%) - acute services* day		≥97.5%		≤95%					96.5%	90.6%					New data set insuffient historic data to calculate SPC	
Midwifery Shift Fill Rate (%) - acute services* night		≥97.5%		≤95%					89.6%	88.8%					New data set insuffient historic data to calculate SPC	
Obstetric Shift Fill Rate - acute services* day		≥97.5%		≤95%					100%	100%					New data set insuffient historic data to calculate SPC	*June 2024 - Staffing gaps in junior rota due to industrial action covered by Consultant body acting down 1 x SR Night shift uncovered
Obstetric Shift Fill Rate - acute services* night		≥97.5%		≤95%					100%	99%					New data set insuffient historic data to calculate SPC	
Anaesthetic (Obstetric) Shift Fill Rate (%) - acute services* day		≥97.5%		≤95%					98.7%	100%					New data set insuffient historic data to calculate SPC	*June 2024 - Staffing gaps in junior rota due to industrial action covered by Consultant body acting down *Short-term sickness in junior rota covered by trainee colleagues
Anaesthetic (Obstetric) Shift Fill Rate (%) - acute services* night		≥97.5%		≤95%					100%	100%					New data set insuffient historic data to calculate SPC	



Vacancies currently open for applications (as of 05/07/2024)

Staff Nurse - Maternity — Band 5
University Hospitals Bristol and Weston NHS Foundation Trust, Bristol
Speciality: Nursing - Maternity
Salary: £28,407 - £34,581 pa pro rata

Treating Tobacco Dependency Advisor - Maternity Community — Band 4
University Hospitals Bristol and Weston NHS Foundation Trust, Bristol
Speciality: Community Maternity Services
Salary: £25,147 - £27,596 pa pro-rata

Early Pregnancy Nurse/ Midwife — Band 6
University Hospitals Bristol and Weston NHS Foundation Trust, Bristol
Speciality: Early Pregnancy
Salary: £35,392 - £42,618 pro rata

Band 7 Rotational Midwife — Band 7
University Hospitals Bristol and Weston NHS Foundation Trust, Bristol
Speciality: Midwifery
Salary: £43,742 - £50,056 pa pro rata

Midwifery Staff currently in the on-boarding process:

Band 6 – 1.64 wte
Band 5 – 13.96 wte

June 2024

Midwifery Maternity Rate:

8.42 wte

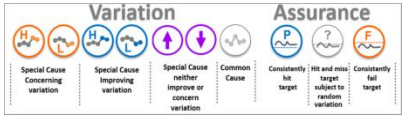
NICE Red Flags, as identified within: Safe midwifery staffing for maternity settings, NG14 published 27/02/2015

NICE Red Flags (as identified within 'Safe midwifery staffing for maternity settings, NG14, published 27/02/2015)

	Data Source	Reliability of Data	Rationalle for current reliability assessment	Mar-24	Apr-24	May-24	Jun-24
Delayed or cancelled time-critical activity	Datix/ BadgerNet	Variable	Cat 1 and Cat 2 CS delays captured in BadgerNet. All other delayed or cancelled time-critical activities rely of Datix submission by clinical staff	11	19	22	19
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	Datix	Variable	Relies on Datix submission by clinical staff	1	0	0	0
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	Datix	Variable	Relies on Datix submission by clinical staff	11	12	5	3
Delay of more than 30 minutes in providing pain relief	Datix	Variable	Relies on Datix submission by clinical staff	2	0	0	2
Delay of 30 minutes or more between presentation and triage	BadgerNet	Good	Data extracted from BadgerNet	19.3% (89 attendances)	10.5% (51 attendances)	10.8% (50 attendances)	10.4% (47 attendances)
Full clinical examination not carried out when presenting in labour	BadgerNet	Good	Data extracted from BadgerNet	37.7% (139 assessments not completed/partially completed)	36.7% (133 assessments not completed/partially completed)	27.8% (101 assessments not completed/partially completed)	28.8% 97 assessments not completed/partially completed
Delay of 2 hours or more between admission for induction and beginning of process	BadgerNet	Good	Data extracted from BadgerNet	79.8% (95 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle)	79.5% (101 admissions for IOL experienced a delay of 2 hours or more from admission to time of first cycle)	Data Pending	Data Pending
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	Datix/ BadgerNet	Variable	SEPIS trigger data extracted directly from BadgerNet. Recognition of abnormal urine output relies of Datix submission by clinical staff	8	12	6	6
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	BadgerNet	Good	Data extracted from BadgerNet	0	0	1	0

Neonatal Workforce & Acuity

Public Board



Safe - Neonatal Workforce	Target	Local Threshold G	A	R	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Year to date average	Trend	SPC Variation	SPC Assurance	Comment	Countermeasure / Action
Number of NICU consultant non-attendance to 'must attend' clinical situations	Local	0		≥2	0	0	0	1	0	0	0.08				APR 24 1 x late attendance - bleep failure	
Band 5/6/7 Neonatal Nursing Vacancy Rate (inclusive of maternity leave) WTEs		≤5		≥10					6.98	8.51					New data set insuffient historic data to calculate SPC	
Neonatal Nurse Qualified in Speciality establishment rate	BAPM 70%	≥70%		≤60%	60.7%	60.7%	52%	52%	49%	49%	55.1%					A3 Project relating to QIS Staffing to be undertaken by NICU Matron and Deputy Director of Midwifery and Nursing
Neonatal Consultant Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3					0	0					New data set insuffient historic data to calculate SPC	
Neonatal Registrar Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3					0.1	0.1					New data set insuffient historic data to calculate SPC	
Neonatal SHO Vacancy Rate (inclusive of maternity leave) WTEs		≤1		≥3					0.9	0.9					New data set insuffient historic data to calculate SPC	
Neonatal Nursing Fill Rate (%) - acute services* day using BAPM acuity tool		≥97.5%		≤95%					102.7%	92.9%					New data set insuffient historic data to calculate SPC	
Neonatal Nursing Fill Rate (%) - acute services* night using BAPM acuity tool		≥97.5%		≤95%					104.2%	101.5%					New data set insuffient historic data to calculate SPC	
Neonatal Nursing QIS Fill Rate (%) - acute services* day using BAPM acuity tool		≥70%		≤60%					61.9%	53.0%					New data set insuffient historic data to calculate SPC	A3 Project relating to QIS Staffing to be undertaken by NICU Matron and Deputy Director of Midwifery and Nursing
Neonatal Nursing QIS Fill Rate (%) - acute services* night using BAPM acuity tool		≥70%		≤60%					62.5%	54.6%					New data set insuffient historic data to calculate SPC	A3 Project relating to QIS Staffing to be undertaken by NICU Matron and Deputy Director of Midwifery and Nursing
Neonatal (Medical) Shift Fill Rate (%) - acute services* day		≥97.5%		≤95%						87.8%					New data set insuffient historic data to calculate SPC	Absence due to acute sickness, long-term sickness and industrial action. Tier 2: 6 uncovered shifts Tier 1: 8 uncovered shifts. All shifts including those depleted met minimum staffing requirements.
Neonatal (Medical) Shift Fill Rate (%) - acute services* Night		≥97.5%		≤95%						97%					New data set insuffient historic data to calculate SPC	

SONAR Workforce

	Staffing (Funded)	Vacancy Rate	June Uncovered Shifts
Nursing Tier	12 WTE	0.07 WTE	4 (3%)
Middle Tier	12 WTE	2.1 WTE	19 (16%)
Consultant			0 (0%)

Neonatal Nursing Staff currently in the on-boarding process:

Band 6 –
Band 5 –

May 2024

Neonatal Nursing Maternity Rate:

wte

Vacancies currently open for applications (as of 18/06/2024)

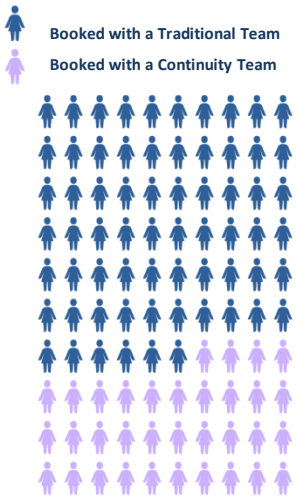
Registered Nurse - Neonatal Intensive Care - Band 5 — NHS AfC: Band 5

North Bristol NHS Trust, Bristol
Speciality: Neonatal Intensive Care
Salary: £28,407 - £34,581 pa

Maternity Metrics: June

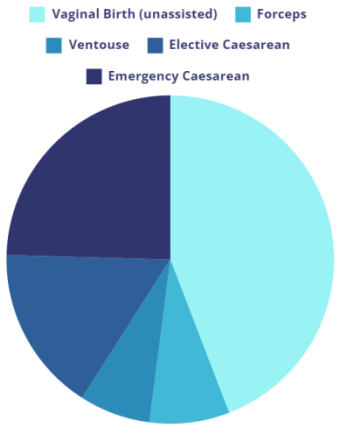
Public Board

Percentage of Women booked with a Continuity Team (%)



Mode of Birth

340 Registerable Babies born during June 2024



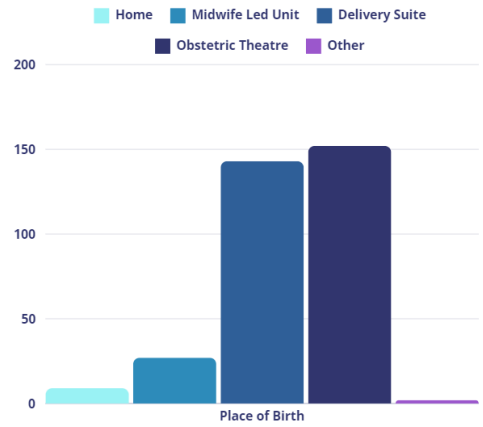
Induction of Labour Rate

36%

VBAC

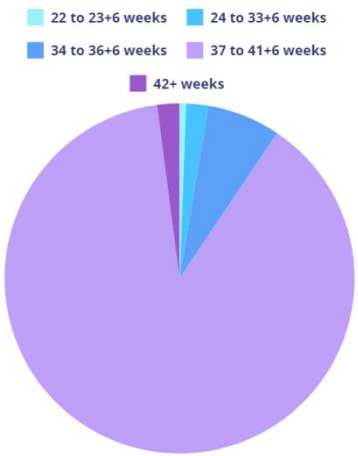
9.8%

Location of Birth



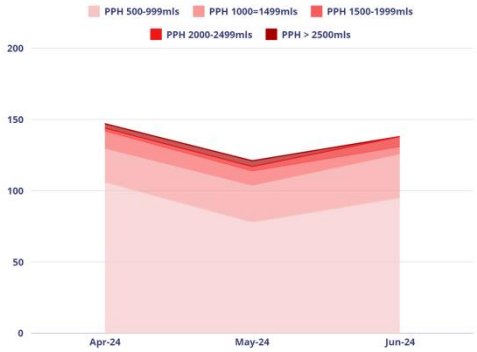
Gestation at Delivery

340 Registerable Babies born during June 2024

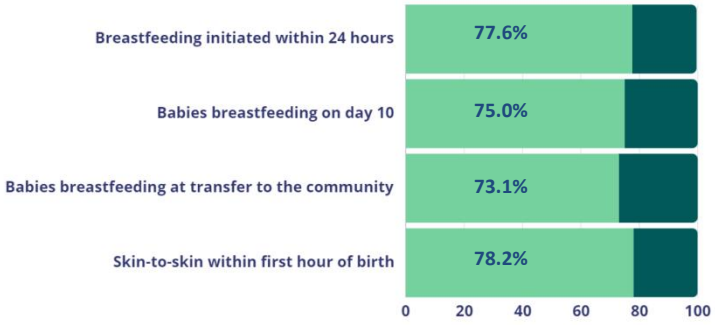


Postpartum Haemorrhage (PPH)

(Count of women)



Infant Feeding & skin to skin (%)



Shoulder Dystocia's (% of vaginal births)

2.5%

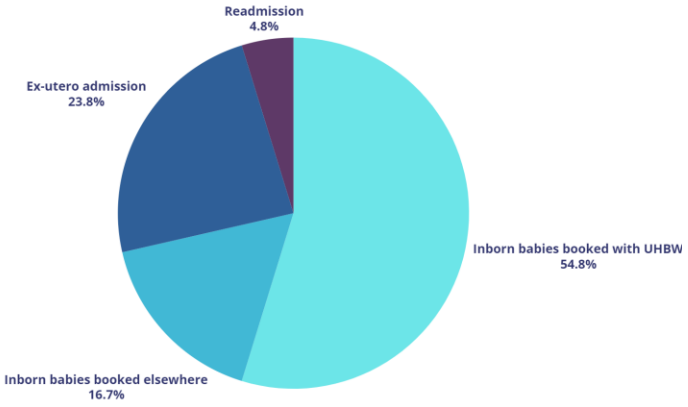
% of women commencing vaginal birth sustaining a 3rd/4th degree tear

3.5%

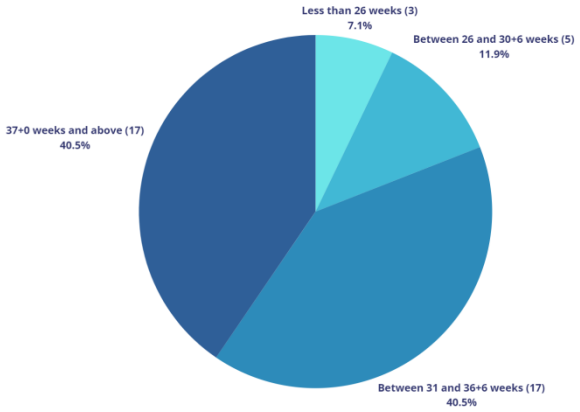
Neonatal Metrics: June

NICU Admission by Source

42 Babies Admitted to NICU in June



NICU Admission by Gestation



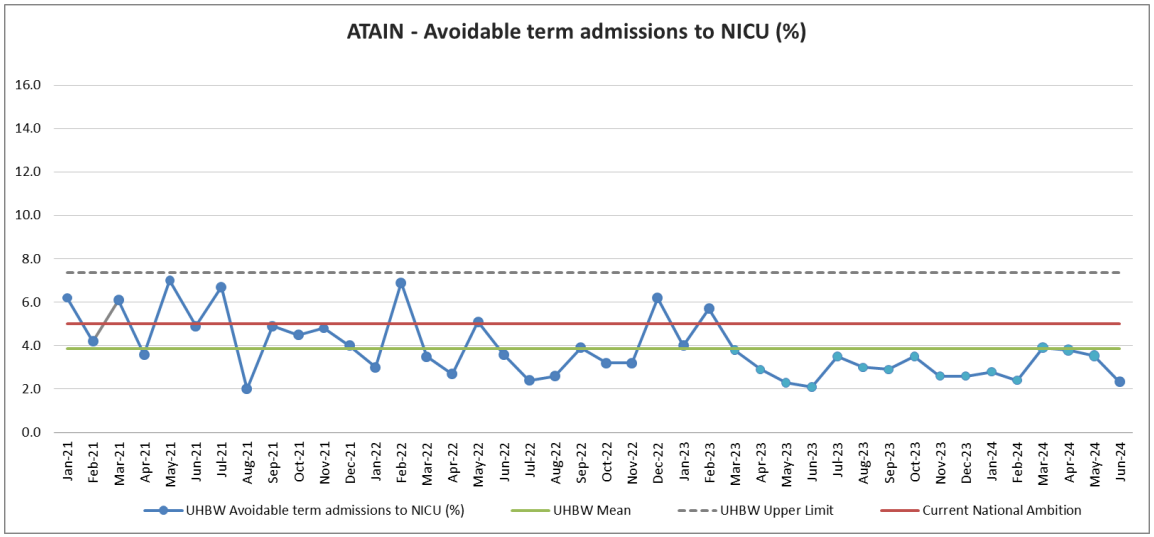
Neonatal Commissioned Cot Summary

Intensive Care (IC) Cots	= 15
High Dependency (HD) Cots	= 8
Special Care (SC) Cots	= 8
Transitional Care (TC) Cots	= 16

June Cot Occupancy Rates

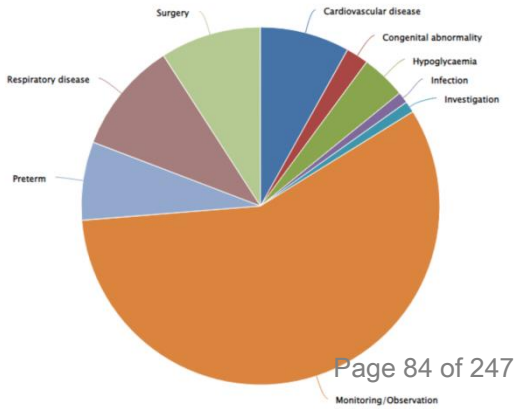
Intensive Care Cots	= 74.2%
High Dependency Cots	= 81.1%
Special Care Cots	= 62.9%
Transitional Care	= 23.2%

Avoidable Term Admission Rate in NICU (ATAIN)



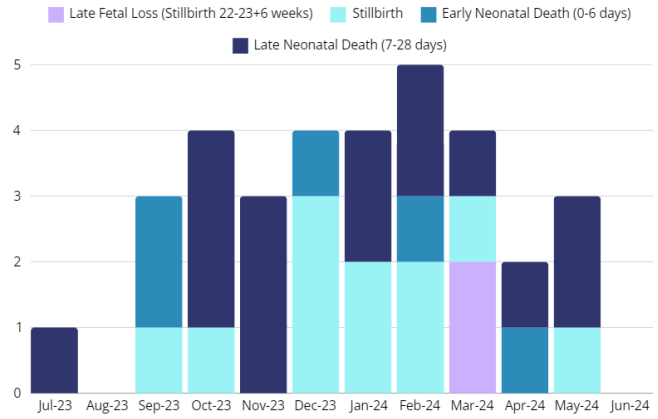
NNU* Principle reason for first admission

***NNU includes babies requiring neonatal care admitted to either NICU, Transitional Care or the Postnatal Ward**



UHBH Perinatal Mortality

Stillbirths and Neonatal Deaths

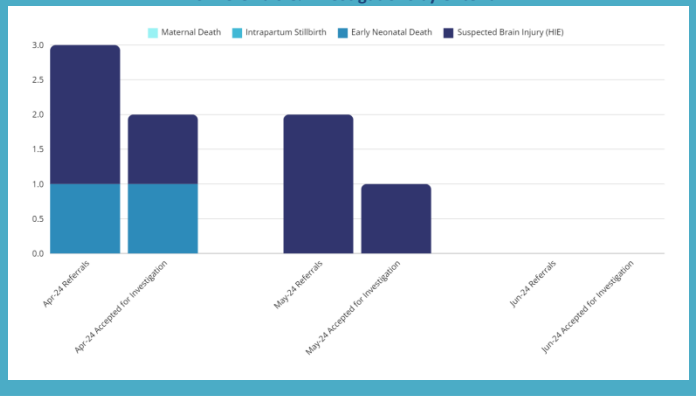


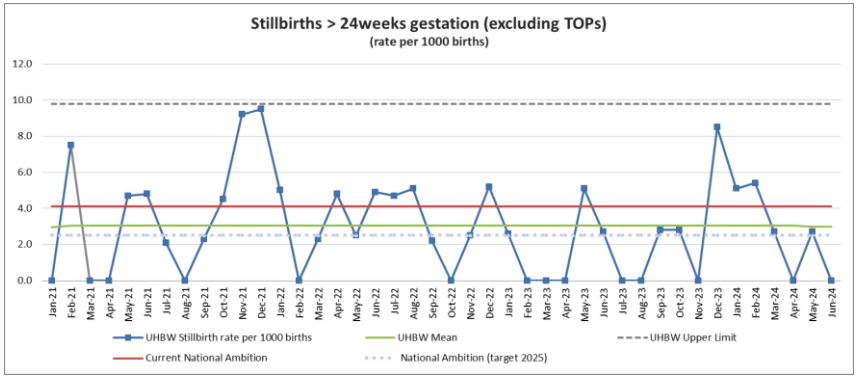
Maternity and Newborn Safety Investigations (MNSI)

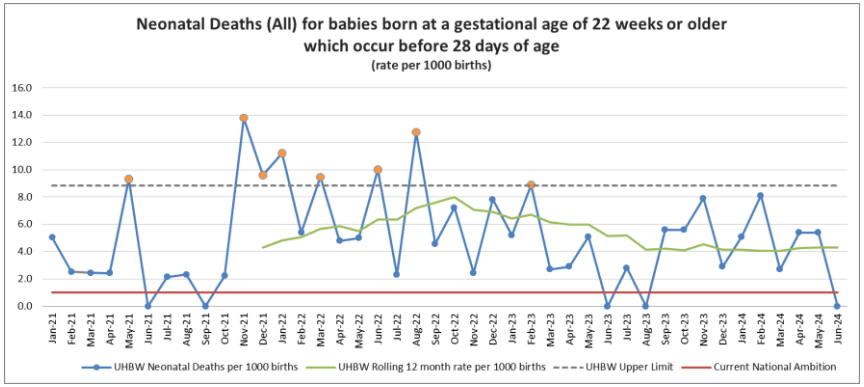
The Maternity and Newborn Safety Investigations (MNSI) programme investigates certain cases of:

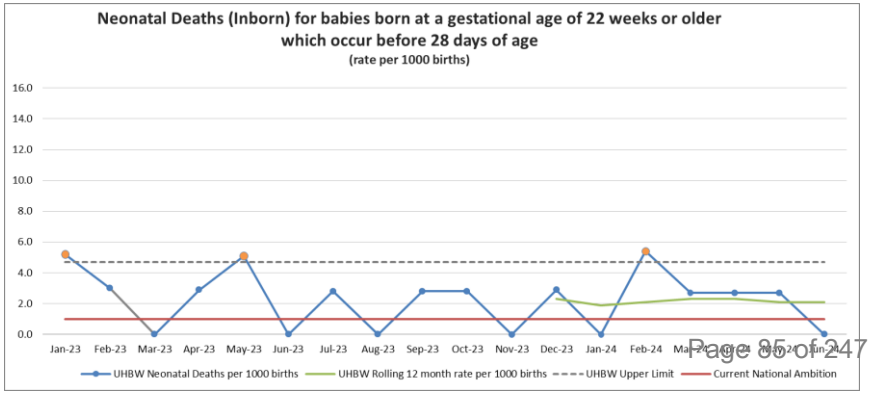
- Early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour in England
- maternal deaths in England

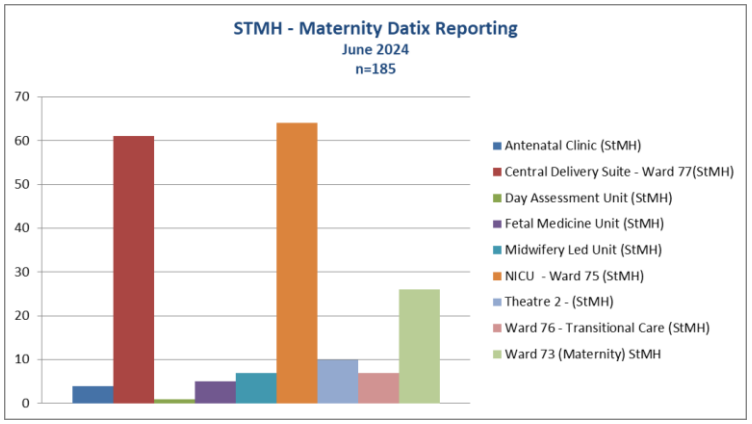
MNSI Referrals & Investigations by Criteria

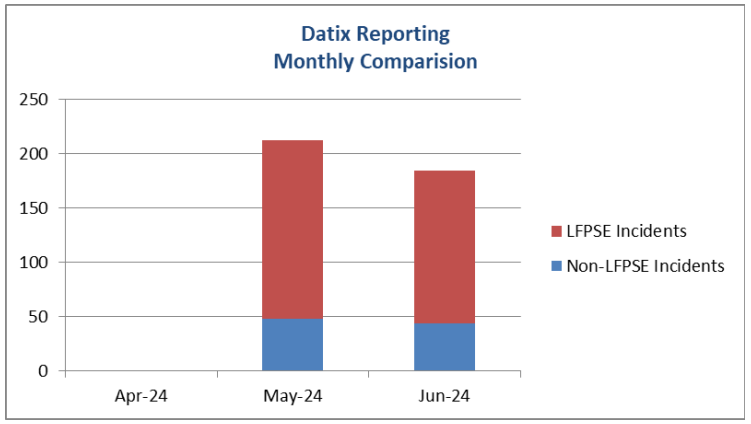












CQC Action Required:
The service must ensure incidents are reviewed in a timely manner.
Regulation 17 (2) (b)

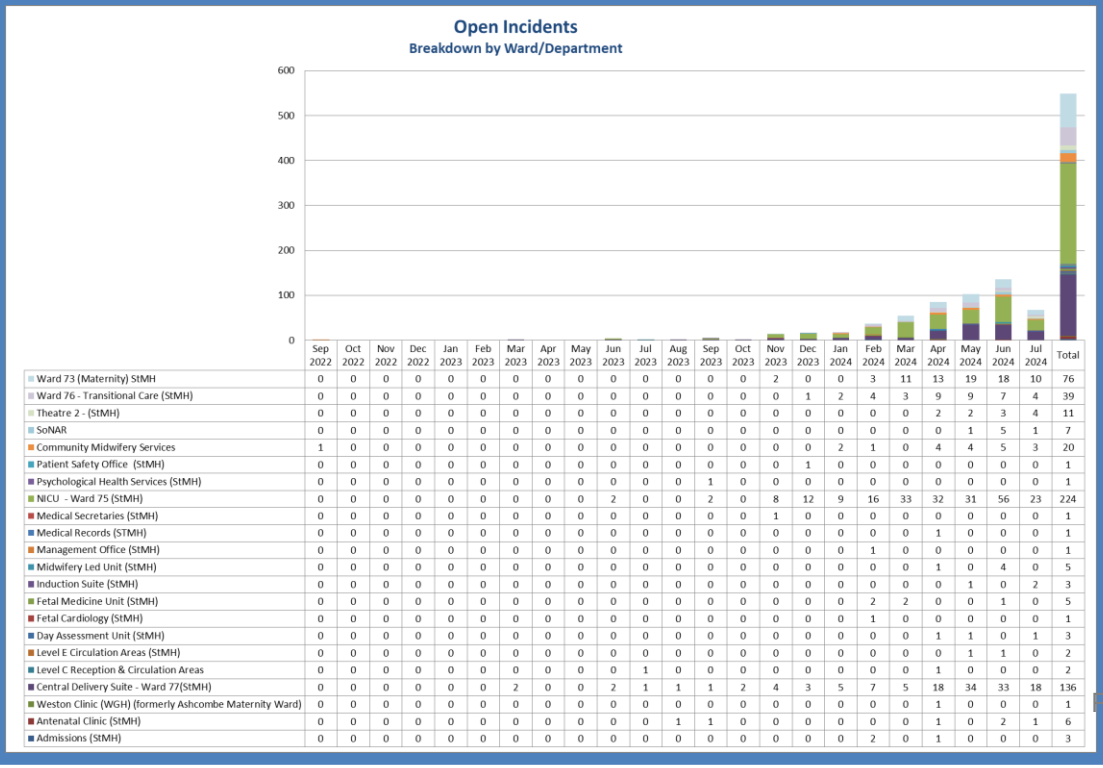
Steady progress, although slower than desirable being made.

The QPS team continues to offer support to Datix / Incident handlers to ensure timely review and closing of incidents.

Current Hotspots:

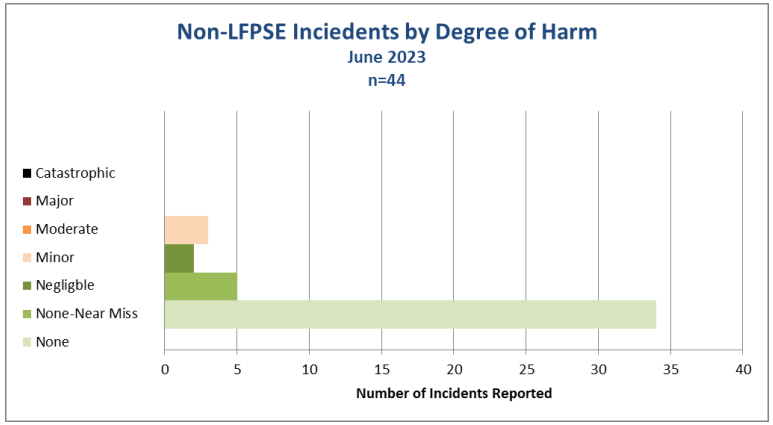
- NICU
- Central Delivery Suite
- Ward 73

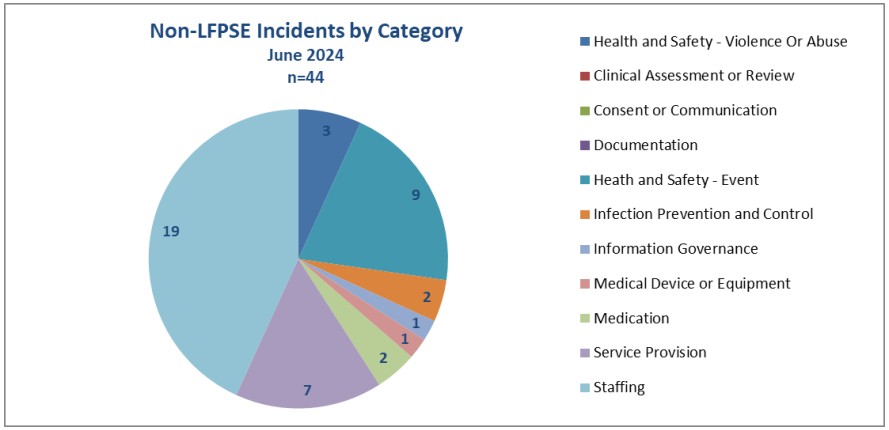
Acuity within these area's continues to impact timely review and closure of Datix / incidents.



	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Total
Ward 73 (Maternity) StMH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	3	11	13	19	18	10	76
Ward 76 - Transitional Care (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	4	3	9	9	7	4	39
Theatre 2 - (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	3	4	11
SoNAR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	5	1	7
Community Midwifery Services	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	4	4	5	3	20
Patient Safety Office (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Psychological Health Services (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
NICU - Ward 75 (StMH)	0	0	0	0	0	0	0	0	0	2	0	0	2	0	8	12	9	16	33	32	31	56	23	224
Medical Secretaries (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Medical Records (STMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Management Office (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Midwifery Led Unit (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	4	0	5
Induction Suite (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2	3
Fetal Medicine Unit (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	0	0	1	0	5
Fetal Cardiology (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Day Assessment Unit (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	3
Level E Circulation Areas (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	2
Level C Reception & Circulation Areas	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	2
Central Delivery Suite - Ward 77(StMH)	0	0	0	0	0	0	2	0	0	2	1	1	1	2	4	3	5	7	5	18	34	33	18	136
Weston Clinic (WGH) (formerly Ashcombe Maternity Ward)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Antenatal Clinic (StMH)	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	0	2	1	6
Admissions (StMH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1	0	0	0	3

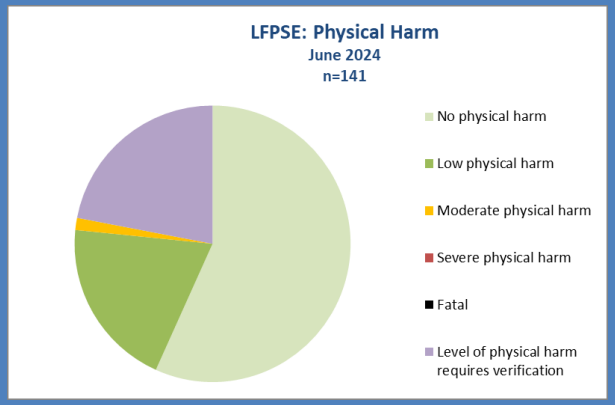
A total of 185 Datix were reported in June 2024, these consisted of 44 non-LFPSE incidents and 141 LFPSE incidents



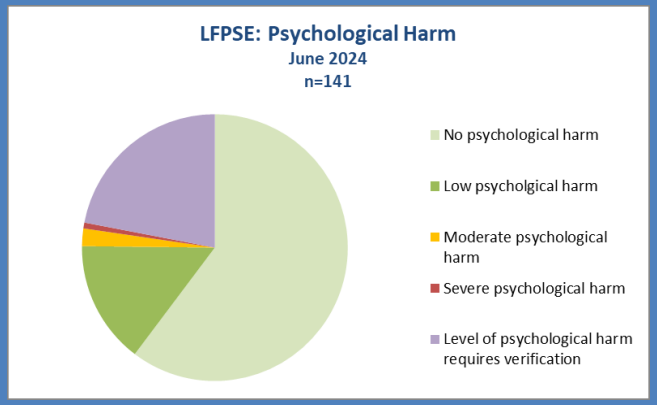


Learning from Patient Safety Events (LFPSE)

141 incidents met the LFPSE criteria in June.
Each incident is categorised by Physical and Psychological harm. The breakdown of these is as follows:



- No physical harm (n=80)
- Low physical harm (n=28)
- Moderate physical harm (n=2)



- No psychological harm (n= 85)
- Low psychological harm (n=21)
- Moderate psychological harm (n=3)
- Severe psychological harm (n=1)

New Cases Reported in June 2024

Datix	Date of Incident	Harm	Incident	Outcome / Learning / Actions	MNSI Reference (If applicable)
257541	01/06/2024	Low physical harm Moderate psychological harm	Post partum haemorhage (2 Litres)	Level of pychological harm to be verified - Community Midwife requested to follow-up with patient	N/A
260197	02/06/2024	Moderate physical harm No psychological harm	ICU Admission - Acute Fatty Liver of Pregnancy / HELLP Overlap Syndrome	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC completed as part of the QPS review process For **MDT review** within the maternity morbidity and mortality forum	N/A
259500	22/06/2024	No physical harm Moderate psychological harm	Domestic violence incident between patient and partner	No further QPS action required - patient has sufficient psychological support in place	N/A
260118	24/06/2024	Moderate physical harm Low psychological harm	Management of abnormal blood results	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC completed as part of the PMRT process For MDT review within the maternity morbidity and mortality forum	N/A
261092	25/06/2024	No physical harm Moderate psychological harm	Possible postnatal diagnosis of Trisomy 21	Level of pychological harm to be verified	N/A
260240	29/06/2024	No physical harm Severe psychological harm	Anenatal Stillbirth at 30+5	**Meets criteria for PSIRF Learning Response:** Verbal DOC completed, written DOC to be completed as part of the PMRT process Bereavement support being provided by the Snowdrop team Referral for psychological services completed	N/A

Ongoing MNSI Investigations / PSIIs

Datix	Date of Incident	Harm	Incident	Outcome / Learning / Actions	MNSI Reference (If applicable)
253795	24/04/2024	Low physical harm No psychological harm	Unexpected NICU admission for therapeutic cooling MRI Normal	Ongoing MNSI Investigation at family's request	MI-037344
253805	25/04/2024	Outcome - Death	Early Neonatal Death Baby born in Southmead, transferred for specialised neonatal care	Ongoing MNSI Investigation	MI-037345
No Datix Submitted	26/05/2024		(HEMS) admission to PICU (BCH) following postnatal collapse at home of a baby born at Gloucester MRI - Evidence of Hypoxic Ischaemic Enchelopathy (HIE)	Ongoing MNSI Investigation (referred by Gloucester)	MI-037464

Closed Cases June 2024

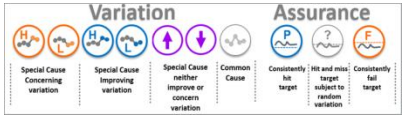
Datix	Date of Incident	Harm	Incident	Outcome / Learning / Actions	MNSI Reference (If applicable)
235378	04/11/2023	**Grading of Care:** Antental and Intrapartum Care N/A (Royal Cornwall Hospital) Care after birth = B Care after neonatal death = A	Neonatal Death (Outborn)	**PMRT Multidisciplinary review held 19/06/2024** Actions: None Identified for UHBW	N/A
251954	05/04/2024	**Grading of Care:** Care up until birth = B Care after birth = A Care after neonatal death = A	Neonatal Death (Inborn)	**PMRT Multidisciplinary review held 19/06/2024** Actions: 1. Safety Briefing to remind staff and admin team to check and record patient Next of Kin Information 2. Reminder to Community teams that women can be refered to the Snowdrop team if they have experienced a previous late fetal loss	N/A
242300	08/01/2024	**Moderate**	Bladder Injury at LSCS	**Case review at Maternity Morbidity and Mortality Meeting held 14/06/2024** Actions: None Identified	N/A
244201	24/01/2024	**Minor**	Intrauterine Death at 27 weeks gestation known fetal growth restriction and placentalmegaly	**Case review at Maternity Morbidity and Mortality Meeting held 14/06/2024** Actions: 1. Reminder to midwifery staff to offer handheld maternity notes if a mother is unable to access the BadgerNet app	N/A

Maternity Safety Support Programme:

N/A

Coroner's regulation 28:

N/A



Training	Target	Local Threshold			Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Year to date average	Trend	SPC		Comment	Countermeasure / Action
		G	A	R									Variation	Assurance		
Training compliance fetal wellbeing day - Obstetric doctors (ALL)	MIS Y6 90%	≥90%		≤80%	69%	70%	70%	68%	81%	87%	63%		H	F		
Training compliance fetal wellbeing day - Midwives (ALL)	MIS Y6 90%	≥90%		≤80%	90%	89%	93%	94%	92%	91%	81%		H	?		
Training compliance in maternity emergencies and multi-professional training - Obstetric doctors (ALL)	MIS Y6 90%	≥90%		≤80%	78%	75%	80%	77%	85%	90%	75%			?		
Training compliance in maternity emergencies and multi-professional training (includes NBLS) - Midwives (ALL)	MIS Y6 90%	≥90%		≤80%	91%	79%	85%	90%	87%	90%	90%			?		
Training compliance in maternity emergencies and multi-professional training - Anaesthetists (ALL)	MIS Y6 70%	≥70%		≤60%	92%	92%	92%	77%	77%	74%	76%			?		
Training compliance in maternity emergencies and multi-professional training - Maternity care assistants - ALL	MIS Y6 90%	≥90%		≤80%	89%	91%	91%	89%	84%	86%	82%		H	?		
Training compliance annual local NBLS - NICU Doctors (ALL)	MIS Y6 90%	≥90%		≤80%	100%	100%	97%	97%	97%	97%	98%			P		
Training compliance annual local NBLS NICU ANNPs (ALL)	MIS Y6 90%	≥90%		≤80%					95%	95%					More consistent reporting required in order to calculate SPC - bi-monthly reporting moving forward	
Training compliance annual local NBLS NICU Nurses (Band 5 and above)	MIS Y6 90%	≥90%		≤80%					67%	67%					More consistent reporting required in order to calculate SPC - bi-monthly reporting moving forward	Discussed at NICU Governance June 2024 - RISK added to Risk register

Awaiting Safeguarding Training Data

Friends and Family Test

June 2024

FFT score												
	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Antenatal community	100%	100.0%	100%	100%	100%	100%	100%	97%	100%	98%	100%	100%
Birth	99%	100.0%	96%	100%	98%	100%	100%	94%	97%	97%	95%	100%
Postnatal ward	96%	100.0%	98%	96%	99%	100%	100%	99%	100%	92%	95%	91%
Postnatal community	98%	100.0%	100%	100%	100%	100%	100%	100%	100%	98%	100%	97%
Total	**98%**	**100.0%**	**98%**	**99%**	**99%**	**100%**	**100%**	**97%**	**99%**	**97%**	**97%**	**97%**

FFT response rate												
	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Antenatal community	2%	12%	9%	10%	5%	10%	13%	23%	11%	36%	4%	8%
Birth	24%	4%	15%	15%	27%	8%	6%	24%	8%	10%	6%	5%
Postnatal ward	7%	4%	16%	14%	25%	7%	6%	22%	8%	7%	5%	3%
Postnatal community	24%	19%	12%	8%	10%	8%	9%	11%	6%	17%	6%	12%
Total	**15%**	**9%**	**13%**	**12%**	**18%**	**8%**	**8%**	**20%**	**8%**	**14%**	**6%**	**7%**

Safety Champions

June 2024 walk around - NICU

Key Points Raised (staff):

- Staffing challenges, particularly QIS ratio
- Recruitment to QIS role – banded differently in some Trusts
- Staff wellbeing, demands of the role

Key Points Raised (families):

- All families expressed gratitude and appreciation for the staff
- All felt well supported, involved in decision making, and providing care for their babies
- Amazing support offered by the Infant feeding team
- All thankful for the provision of accommodation (Cots for Tots)
- Awareness of staffing challenges and demands on all the team
- Discussed network challenges and having to wait for a cot in UHBW – delaying their baby's treatment

Maternity and Neonatal Voices Partnership (MNVP)

Neonatal MNVP recruited (shared role with Taunton) – now in post
Appointed two MNVPs for UHBW – start dates to be confirmed

MNVP Programme Lead out for advert

Compliments & Complaints

Formal Complaints	**7**	**Compliments Received**	**5**
Informal Complaints	**2**	**PALS enquires**	**2**

Divisional Complaint themes:

- Unhappy with clinical decision making
- Staff attitude
- Unhappy with communication
- Incorrect documentation
- Service not provided
- Unhappy with safeguarding referral
- Care environment for complex patients

Compliance with National Directives: Maternity (and Perinatal) Incentive Scheme – Year 6

MIS Safety Actions	Compliance with MIS Actions Year 5	Progress with MIS Actions Year 6
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?		
Can you demonstrate an effective system of clinical workforce planning to the required standard?		
Can you demonstrate an effective system of midwifery workforce planning to the required standard?		
Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version 3?		
Listen to women, parents and families using maternity and neonatal services and coproduce services with users.		
Can you evidence the required elements of local training plans and 'in-house', one day multi professional training?		
Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?		
Have you reported 100% of qualifying cases to MNSI and to NHS Resolutions Early Notification (EN) Scheme?		

The Maternity Incentive Scheme (MIS) was developed in 2017. The scheme is designed to support safer maternity and perinatal care by driving compliance with ten 'safety actions'. The safety actions are updated annually by a collaborative advisory group, consisting of representatives from NHS Resolution, NHS England, The Royal College of Obstetricians and Gynaecologists (RCOG, the Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), the Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity Newborn Safety Investigation Programme (MNSI).

MIS Year 6 Progress Update:

- Revised safety actions released 2nd April 2024
- GAP analysis now completed
- Transitional Care QI Project identified - project TOR to be agreed

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

Compliance with National Directives: Three Year Delivery Plan

Three Year Delivery Plan - Theme Summary			Workstream tracker				
Last updated: 20/03/2024	Total no. of Trust Responsibilities	Total no. of workstreams	Not started (late)	Planned	In progress (on schedule	In progress (off schedule)	Complete
Theme 1, objective 1	4	9	0	5	2	0	1
Theme 1, objective 2	9	12	0	2	4	0	6
Theme 1, objective 3	2	3	0	2	1	0	0
Theme 1 TOTAL	**15**	**24**	**0**	**9**	**7**	**0**	**7**
Theme 2, objective 4	7	8	0	2	2	0	4
Theme 2, objective 5	17	19	1	3	8	1	5
Theme 2, objective 6	4	4	0	0	3	0	1
Theme 2 TOTAL	**28**	**31**	**1**	**5**	**13**	**1**	**10**
Theme 3, objective 7	6	7	0	2	2	0	3
Theme 3, objective 8	12	17	1	4	4	0	7
Theme 3, objective 9	7	7	0	2	3	0	2
Theme 3 TOTAL	**25**	**31**	**1**	**8**	**9**	**0**	**12**
Theme 4, objective 10	7	9	0	4	4	0	1
Theme 4, objective 11	5	6	0	1	1	0	4
Theme 4, objective 12	2	3	0	1	1	0	1
Theme 4, TOTAL	**14**	**18**	**0**	**6**	**6**	**0**	**6**
TOTAL	**82**	**104**	**2**	**28**	**35**	**1**	**35**

Key	
Grey	Already BAU/Being met through existing workstream/complete
Green	In progress (on schedule)
Amber	In progress (off schedule)
Red	Not being met or in any existing plans/ not started
Yellow	Planned

Compliance with National Directives: Three Year Delivery Plan

By exception:

Theme	Deliverable	Comments
2.5.1	To work with Educational Institutions to deliver QIS training in region	New national QIS standards to be released in October 2024 which may require a complete overhaul of the UWE course. We are unable to commit to the high level of support required for the UWE course from January as we have no education lead for NICU (post vacant). For 2024 we have been placing our RNs on the Birmingham course. A regional /ODN solution would be helpful as is a challenge beyond out service.
2.5.6	Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce. Continuation from Ockenden action, Work to increase strong pool of system wide candidates	Bridges programme on offer by Trust (6 x managers supporting Bridges coaching (Cohort 4). To promote cohort 5 - numbers need improvement), but continue scoping to see what else can be done to strengthen this – requires a system response?
3.8.4	How do we **act** alongside maternity and neonatal leaders on outcomes data, staff and MNVP feedback, audits, incident investigations and complaints as well as learning from where things have gone well.	We have strong evidence for the governance etc around how this information is managed and reviewed but less robust evidence for how we **act** on this. It is occurring but we haven't gathered the robust evidence yet.

Compliance with National Directives: Ockenden

IEA	Number of Assurance Questions	N/A for UHBW or National Actions	Red	Amber	Green	Blue	Completed and evidenced	% of Compliance
1. Workforce Planning and Sustainability	11	1	0	0	0	0	10	100
2. Safe Staffing	10	2	0	0	0	1	7	88
3. Escalation and Accountability	5	0	0	0	0	0	5	100
4. Clinical Governance and Leadership	7	1	0	0	0	0	6	100
5. Incident Investigations and Complaints	7	0	0	0	0	2	5	71
6. Learning from Maternal Deaths	3	2	0	0	0	0	1	100
7. Multidisciplinary Training	9	0	0	0	0	0	9	100
8. Complex Antenatal Care	5	0	0	0	1	0	4	80
9. Pre-term Birth	4	1	0	0	0	0	3	100
10. Labour and Birth	6	0	0	1	0	0	5	83
11. Obstetric Anaesthesia	5	2	0	0	0	0	3	100
12. Postnatal Care	4	0	0	0	0	0	4	100
13. Bereavement Care	4	0	0	1	0	0	3	75
14. Neonatal Care	8	3	0	1	0	0	4	80
15. Supporting Families	3	0	0	1	0	0	2	67
TOTAL	91	12	0	4	1	3	71	90

	N/A for UHBW or National Action
	Immediate remedial action required to progress
	Action required for successful delivery of this activity
	Activity on target
	Completed activity (evidence sign off required)
	Completed activity (evidence signed off)

Next Steps for Progression:

- IEA10 – Installation of centralised CTG monitoring
- IEA13 – Creation of new ‘ Bereavement Champion’ role to support 7 day bereavement support
- IEA14 – Neonatal Staffing action plan review scheduled
- IEA15 – Improving accessibility to psychological services to ensure equitability for all patients/families

NHSR Scorecard (Obstetrics)

CNST claims received with an incident date between 01/04/2013 and 31/03/2023 (correct at: 30/06/2023)
The trust has received a total of 58 Obstetric claims. These account for 12% of all CNST claims received and equates to 51% of the total value of all CNST claims received

Top 5 injuries by volume:	Top 5 injuries by value:
Psychiatric/psychological damage (9)	Hypoxia (5)
Unnecessary pain (6)	Brain damage (4)
Fatality (5)	Psychiatric/psychological damage (9)
Hypoxia (5)	Fracture (1)
Incontinence (4)	Incontinence (4)
Top 5 causes by volume:	**Top 5 causes by value:**
Fail / delay treatment (16)	Fail / delay treatment (16)
Fail to monitor 2nd stage of labour (6)	Fail to monitor 2nd stage of labour (6)
Fail antenatal screening (5)	Birth defects (1)
Inadequate care (3)	Fail to respond to abnormal FHR (3)
Fail to respond to abnormal FHR (3)	Not specified (1)

Formal Complaints Themes Q1 24-25 (received: 14)

- Lack of specialist service available at weekend (1)
- GDPR / Data Breech (1)
- Communication – clinical (2)
- Communication – staff attitude (2)
- Clinical care (6)
- Birth experience (1)

Incidents Q1 24-25

- Moderate Harm (or above) Datix (17)
- MNSI Accepted Referrals (3)
- ICU Admissions (3)
- Shoulder dystocia (20)
- PPH greater than 1.5 litres (27)
- 3rd / 4th degree tears (30)

Patient Safety Triangulation 2024-25, Q1 Legal, Complaints & Incidents

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Themes Q1 24-25

- Delay in recognition of deteriorating fetal wellbeing and escalation in the 2nd stage of labour (links with previous claims and incidents)
- Inadequate fluid balance management in labour leading to maternal and neonatal hyponatraemia
- Delay in utilising the 2nd obstetric theatre out of hours
- MEOWS charts not completed / not acted upon (links with previous claims and incidents)

Learning Q1 24-25

- PPH Forum reinstated to review current PPH rates and identify area's for improvement in the prediction and management of PPH. Positive fall in Significant PPHs seen.

Action Plans Q1 24-25

Not started	In progress	Completed

To ensure all staff are familiar with the current NLS algorithm, including increasing pressures during IPPV if no response		
To ensure all staff are aware of the limitations of single parameters in diagnosing unsuccessful endotracheal intubation. To ensure staff are aware of the neonatal difficult airway algorithm		
The NICU unit to invest in a video laryngoscope assist with intubation. In particular this will enhance confidence of ETT placement and allow easy visualisation by multiple team members. Roll out of training on video laryngoscope (VL)		

Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 2024		
Report Title:	Q1 Learning from Deaths Report 2024-2025		
Report Author:	Karin Bradley – Interim Associate Medical Director		
Report Sponsor:	Rebecca Maxwell – Interim Chief Medical Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			√
	To update Board on UHBW Learning from Deaths process Q1 24-25.		

Key Points to Note *(Including any previous decisions taken)*

8.7% increase in deaths at UHBW in Q1 24/25 as compared to Q1 23/24 (national picture in England shows stability/marginal decrease).

Medical Examiner (ME) referrals into UHBW rose to 15.5% (highest rate since 22/23). Proportion of ME referrals triggering an SJR also continues to rise; now 44% (17% in 22/23, 34% in 23/24). Rise in mandatory categories greater than rise in potential care concern category. Also organisational change in 2023 to include HMC (His Majesties Coroner) and patient safety cases within SJR portfolio following PSIRF introduction. Latter will increase numbers of SJRs for care concerns.

Annual LfD 23/24 report highlighted that number of SJRs triggered for potential care concerns higher in Weston in-patients (3.2%) as compared to BRI (1.3%), adjusted for number of deaths. Numerous caveats (detailed in report) meant data required further tracking and consideration. Q1 24/25 data reveals that the rates of SJRs triggered for care concerns have increased on both sites (now 5% of all deaths in Weston and 2.6% in the BRI). The discrepancy between the sites has marginally reduced. Overall numbers small so caution with interpreting data.

ME referral numbers and the volume of SJRs requested for care concerns across UHBW warrant ongoing monitoring. Neither an ME referral nor an SJR being triggered for a potential care concern are valid outcome metrics of quality of care. SJRs completed for Q1 show predominantly good scores. It is also important to note that tracking of SJRs at UHBW is not currently supported by robust digital processes and requires considerable manual input to monitor and analyse, making it vulnerable to error.

Assurance provided to lead ME regarding management of two cases with intractable seizures.

Comms issued clarifying restricted access to ME documents on Evolve and also around changes to follow from the statutory ME ‘go-live’ date on 9th September 2024.

‘Confirmation/Verification & checklist Following the Death of an Adult Patient’ document amended to prevent accidental draft referrals to HMC (several cases noted and addressed).

Strategic Alignment

Patient Safety
Risks and Opportunities
Failure to recruit to mortality lead post in Division of Medicine. Division with greatest number of deaths (as predicted). Risk to LfD programme. Informal feedback suggests workload exceeds time allocated. Ongoing monitoring of trends in ME referral rates into UHBW and of SJRs triggered for care concerns required, including tracking of the latter by Division/ geographical site. Ongoing work required to align PSIRF/LfD processes.
Recommendation
This report is for **Information**
History of the paper (details of where paper has <u>previously</u> been received)

Clinical Quality Group	September 2024
Appendices:	Report attached separately

LEARNING FROM DEATHS REPORT Q1 24/25

INTRODUCTION

Authors
- **Karin Bradley – Interim Associate Medical Director, UHBW Mortality Lead**
- **Dawn Shorten, CMO Mortality Administrator**

Circulation
- **Divisional/Site Mortality and Patient Safety Leads (to share at M&Ms)**
- **Divisional Senior Tris (to share at Divisional Boards)**
- **Upwards reporting via CQG and Public Board**

This report provides an update on the UHBW Learning from Deaths (LfD) process for Q1 2024/25.

This report covers learning from adult deaths across the Trust. A separate annual Child Death Review (CDR) report is shared through W&C governance and the Trust Mortality Surveillance Group. Maternity and peri-natal deaths are also reported separately and are collated on an annual MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) report.

PROGRESS THIS QUARTER

From Q1 24/25, all LfD reports will be circulated to Divisional mortality and patient safety leads along with Clinical Chairs with a request to share the report at Divisional/Departmental M&Ms and Divisional Boards (following feedback re insufficient sight of information by clinical staff).

Trust comms issued in May 2024 to clarify rationale for restricted access for UHBW staff to Medical Examiner (ME) records on Evolve. National ME position is that their scrutiny and documentation should not be accessed by clinical teams as there have been examples where the information has been misinterpreted and used to provide inappropriate assurance around quality of care. Local ME team appreciate that the information may be useful to inform learning and a generic email contact for BNSSG ME team circulated if clinical teams have a strong rationale for wishing to seek permission to view the documents for a specific case.

It was identified that on several occasions draft HMC (His Majesties Coroner) referrals were completed for patients on Careflow by clinical staff when no referral was indicated. Following a death, the discussion between the responsible clinician and ME will identify if an HMC referral is indicated and the final step to referral is issued from the ME office. Those patients who had draft referrals completed in error were not ever referred to HMC, but it did cause confusion for clinical and patient safety staff who later reviewed the cases. It was identified that the UHBW ‘Confirmation/Verification & checklist Following the Death of an Adult Patient’ provided helpful instructions on how to complete an HMC referral which occasionally led ward staff to believe that it was routinely required. The wording was amended to clarify that confirmation was required from the clinically responsible consultant before commencing a referral to HMC.

Work is ongoing with IT support to amend the SJR templates to: remove a historically redundant section on hip fractures; to link the medical, mental health and learning disability elements of the SJR, to provide clarity on authorship of each section; to include confirmation on geographical site as well as Division (supporting easier analysis of Weston site data) and to provide a section to record formal date of sign off through Mortality Surveillance Group.

In May 2024, a meeting was held between UHBW legal, patient safety and two coroners (including the lead coroner) in Avon to discuss the rising number of inquests and the changing landscape of documentation available from UHBW since the introduction of PSIRF. A similar meeting with the Somerset coroner is planned for September 2024.

The Lead ME raised a possible concern around two patients admitted to UHBW within a 12-month period with seizures that were not clinically controllable. Assurance was provided, to the Lead MEs satisfaction, that appropriate investigations and management had taken place. No further action was required.

It is recognised that PSIRF and LfD processes are not yet aligned at UHBW, and benchmarking has confirmed that this is a national problem. Work is ongoing to streamline workflows to limit the risk of duplication or overlap. The central Patient Safety Team and Inquest Core Group are sighted on the challenges. In particular, discussions are ongoing regarding the appropriateness of completing SJRs for patients referred to His Majesties Coroner. To not complete SJRs in this context would align UHBW with NBT.

Work is ongoing to clarify and progress the 2020 UHBW-NBT Mortality Funding agreement (signing of which was impacted by the pandemic) and align the associated mortality improvement work.

Comms has been issued across UHBW ahead of the ME service statutory 'go-live' date of 9th September 2024 to alert staff to the associated process changes. For UHBW this represents minor changes: new format death certificate (MCCD) paperwork, removal of cremation forms, doctor completing MCCD only has to have met deceased in their lifetime and not in preceding 28 days and final alignment of child death processes with ME scrutiny. From 9th September, it will not be possible to register a death (in any hospital or community setting) without ME review.

UHBW MORTALITY FIGURES, ME REFERRALS AND SJRs

Death rates for England Q1 23/24 and Q1 24/25 (Office for National Statistics)

	Q1 (23/24)	Q1 (24/25)
April	41,966	46,052
May	44,608	44,131
June	43,842	39,807
Total	**130,416**	**129,990**

The national data shows a stable/marginal decrease in the death rate in England between Q1 23/24 and Q1 24/25.

UHBW in-patient deaths Q1 23/24 vs Q1 24/25

Site	Division	Q1 (23/24)	Q1 (24/25)
BHOC	Medicine	0	0
	Sp Sv	28	19
BRCH	Died in ED	1	1
	Surgery	0	0
	W&C	9	6
BRI	Died in ED	19	20
	Medicine	169	199
	Sp Sv	48	48
	Surgery	28	40
	W&C	1	0
St Michael's	W&C (paeds)	5	5
	W&C (adult)	4	0
Weston	Died in ED	8	13
	Medicine	120	126
	Sp Sv	1	0
	Surgery	20	20
Total		461	497
Total adult deaths		**446**	**485**

N.B. Adult in-patient deaths in Women's are typically treated under gynae-oncology and hence are often captured in Specialised Services data.

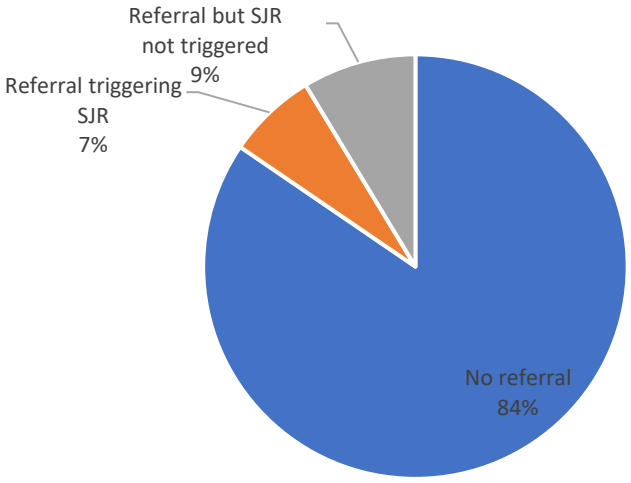
The table above includes child death figures, but the remainder of the report excludes these and deals with data for adult deaths only.

Slightly against the national trend, deaths at UHBW have shown a small (8.7%) increase in Q1 24/25 as compared to Q1 23/24. The increase is seen for adult medical and surgical patients.

ME referrals and SJRs triggered Q1 23/24 and 24/25

	Q1 23/24	Q1 24/25
Total deaths	**446**	**485**
Referrals from ME Office	**44**	**75**
Referrals meeting SJR criteria	**7**	**33**
Referred for a Learning Disability and Autism SJR	5	8
Referred for a Mental Health SJR	1	8
Referred for both a Mental Health and LD&A SJR	1	1
Total mandatory category reviews	**6**	**17**
SJRs referred for only treatment/care concerns	**2**	**16**

Chart shows ME referrals as % of all adult in-patient deaths



Of the 485 adult deaths at UHBW in Q1, 75 (15.5%) were referred. The ME referral rate into UHBW was 19% on average in 22/23 and 13% on average in 23/24. Looking at the quarterly data for 23/24, the referral rates have ranged 8%-14%. The current data, therefore, represents the highest recorded referral rate since 22/23 and is in keeping with the trend noted in the 23/24 annual report.

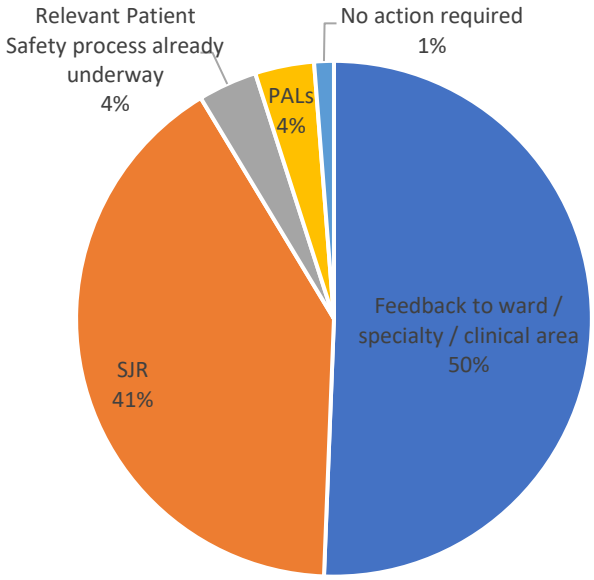
Of the 75 referrals passed to the Medical Director Team, 33 (44% of referrals or 6.8% of deaths overall) met the criteria for an SJR. The same data for the year 23/24 was 34% of referrals or 4.5% of deaths and so SJR numbers continue to increase. Of the 33 SJRs in Q1, 17 (52%) fell under mandatory reporting categories; learning disability & autism (8), mental health (8) and both (1). The remaining 16 (48% of all SJRs) were triggered solely for treatment/care concerns. .

As highlighted in the 23/24 annual LfD report, the indications at UHBW for an SJR have expanded since the introduction of PSIRF and there continues to be a (national) rise in mandatory category SJRs. Careful monitoring of these trends is required.

Of the 75 Medical Examiner referrals, 41 were assessed as requiring clinical team or area feedback. These were highlighted to appropriate senior staff with a request for sharing the learning as appropriate. Of these 41 triaged for clinical feedback, 4 were complimentary of the care given. In this situation, thanks and commendations were sent to the individuals or teams from senior staff.

Process	#
Feedback to ward /specialty/ clinical area	**41**
Structured Judgement Review	**33**
Thematic review	**0**
Relevant Patient Safety process already underway	**3**
Patient Advice and Liaison Service (PALs)	**3**
Report to other organisation	**0**
No Action required	**1**
Total: Note: referrals may be subject to more than one process	**81**

Chart shows % of ME referrals assigned to each process

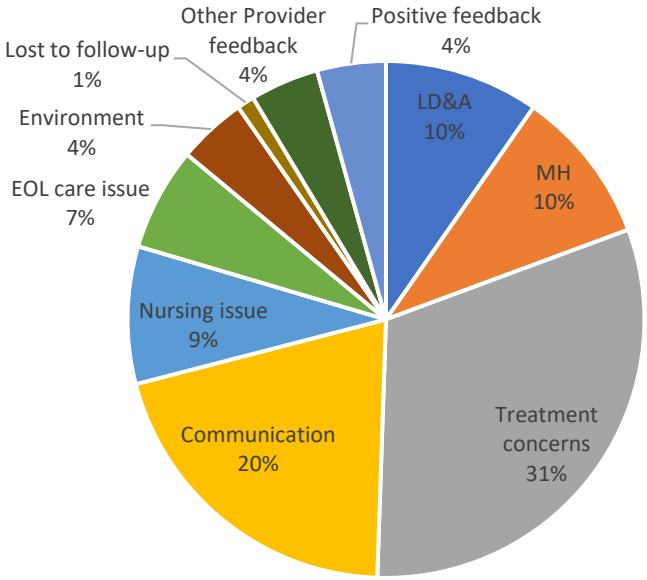


Any comments shared within the organization are progressed within those areas by senior staff, and confirmation and assurance regarding follow-up actions and shared learning is sought by the Medical Director's office.

ME referrals – themes

Learning Disability & Autism	**9**
Mental Health	**9**
Treatment concerns	**29**
Communication	**19**
Nursing issue	**8**
EOL care issue	**6**
Documentation	**0**
Environment	**4**
Safeguarding issue	**0**
Lost to follow-up	**1**
Failed discharge	**0**
Other Provider feedback	**4**
Positive feedback	**4**

Note: referrals can be for more than one theme



Once the detail of the feedback was reviewed, the commonest themes were communication and treatment concerns.

Examples of feedback from bereaved (as shared with UHBW from ME team):

Care - staff very nice, did what they could, problem with staff being stretched - X required pain relief , asked staff was not forthcoming - so eventually rang son X to get him to ask staff.

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

Family were rung 12.00 at night, didn't get to phone in time – no message was left and just stated private number - so they were unaware how bad X was. Previously, Doctors were heard discussing X on the telephone on the ward but did not update the family when they attended his bed for attention to dressings etc.

NOK concerns re. communication / lack of consultant contact to discuss EOL decisions to help address NOK concerns and manage expectations. Exacerbated by lack of continuity of care (many staff involved).

Communication with staff was very poor - lack of continuity of care, nursing staff not willing/able to give updates, ignoring the family when they were on the ward. NOK said they "felt invisible".

NOK concerns: frequent ward moves at EOLC with NOK not kept informed - disruptive & traumatic both for X and family. Compounded delirium. Better communication needed around why being moved and ensuring timely updates for family.

Family feel palliative approach prioritising X's comfort could have been started sooner. No replies to calls and emails from consultant. Happy with care, but feel palliation could have been started sooner had they been able to speak to consultant.

EOL care brilliant - very dignified

SJRs for care concerns by Division/geographical site

Site	Division	Deaths Q1 (24/25)	SJRs for care concerns only
BHOC	Medicine	0	0
	Sp Sv	19	0
BRI	Died in ED	20	0
	Medicine	199	7
	Sp Sv	48	0
	Surgery	40	1
	W&C	0	0
Weston	Died in ED	13	0
	Medicine	126	7
	Sp Sv	0	0
	Surgery	20	1
Total		**485**	**16**

Q1 24/25

	Weston	BRI
SJRs triggered for care concerns	8	8
Total deaths	159	307
SJRs triggered for care concerns as a % of total deaths	**5%**	**2.6%**
Bed base	279	400
Approximate % of bed base occupied by 'medical' in-patients	~75%	~61%

The annual 23/24 report highlighted that Weston (3.2%) triggered more than double the rate of ME referrals leading to SJRs for care concerns as compared to the BRI (1.3%). The significant caveats around interpreting that data are detailed in that report. In Q1 24/25, SJRs triggered for care concerns have increased on both sites, the discrepancy between the sites has marginally reduced. The overall numbers of SJRs and deaths is small as compared to the annual cummulative data.

ME referral numbers and the volume of SJRs requested for care concerns warrant ongoing monitoring. **Importantly though, neither an ME referral nor an SJR being triggered for a potential care concern are valid outcome metrics of quality of care. They are merely triggers for additional reflection (see SJR scoring outcomes below). It is also important to note that tracking of SJRs across UHBW is not currently supported by robust digital processes and requires considerable manual input to monitor and analyse and is therefore vulnerable to errors.**

SJR Scoring

Key to Care scores: 1=Very Poor, 2=Poor Care, 3=Adequate, 4=Good Care, 5=Excellent

Of the SJRs in Q1, where scoring is complete, most reviews assessed **overall care** as good (4 and above). One SJR received a score of 3 due to possible delayed cardiac investigations prior to presenting with an out of hospital cardiac arrest (acute presentation – no care concerns). This has been fed into patient safety processes to be appropriately considered.

Avoidability of death ratings:

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 SJRs for Q1, where scoring has been completed, had an **avoidability rating** of 4 or above.

THEMATIC REVIEWS

There are currently no active thematic reviews triggered through mortality processes.

RISKS

The Divisional mortality lead post in Medicine has been vacant since April 2024, resulting in delays in completing SJRs and in delivering learning back into the Division. It is the Division with the greatest number of deaths (as predicted from case-mix and bed-base) in the organisation. The post remains unfilled and informal feedback suggests that the workload is too great for the time assigned.

Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 2024		
Report Title:	Annual Learning from Deaths Report 2023-2024		
Report Author:	Karin Bradley – Interim Associate Medical Director		
Report Sponsor:	Rebecca Maxwell – Interim Chief Medical Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			√
	To update Board on UHBW Learning from Deaths process 23-24.		

Key Points to Note *(Including any previous decisions taken)*

Summary Hospital-Level Mortality Indicator (SHMI) for UHBW for the 12 months was 91.6, within the NHS Digital 'as expected' category.

Nationally (and at UHBW) total deaths were lower in 23-24 than in 22-23. Medical Examiner (ME) referrals into UHBW also fell from 19% of all deaths to 13%. However, proportion of ME referrals triggering an SJR rose from 17% in 22/23 to 34% in 23/24. Likely this relates mostly to a UHBW (and national) rise in deaths in patients with mandatory SJR requirements plus an organisational change in April 2023 to include HMC and patient safety cases within SJR portfolio following the introduction of PSIRF. However, data needs to be watched to ensure no real/sustained increase in care concerns.

New data analysis approach: data now presented by both geographical site and Division.

Number of SJRs triggered for potential care concerns higher in Weston in-patients (3.2%) as compared to BRI (1.3%), adjusted for number of deaths. Numerous caveats (detailed in report) and data requires further tracking and consideration.

Neither an ME referral nor an SJR being triggered for a potential care concern are valid outcome metrics of quality of care. SJRs completed show predominantly good scores. Also,tracking of SJRs across UHBW not currently supported by robust digital processes and requires considerable manual input to monitor and analyse and is therefore vulnerable to errors. Priority to address.

Excellent improvement in completion of timely SJRs in Weston following appointment of mortality lead at the start of this 23-24 annual cycle.

Weston chest drain SOP approved and in use (triggered by ME concerns).

Successful completion of thematic reviews in EOL care, transport of emergency cases between sites and following a cluster of aortic dissection deaths.

Strategic Alignment

Patient Safety	
Risks and Opportunities	
Recruitment to mortality lead post in Division of Medicine a priority to deliver LfD model effectively (unsuccessful recruitment to date). Ongoing tracking of ME referrals and number of SJRs triggered (both mandatory and for possible care concerns) per division and geographical site important to identify any trends. Opportunity moving forwards (pending CQG approval) to submit annual LfD report at end Q4 instead of submitting Q4 report and then a delayed annual report.	
Recommendation	
This report is for **Information**	
History of the paper (details of where paper has <u>previously</u> been received)	
Clinical Quality Group	September 2024
Appendices:	Report attached separately

University Hospitals Bristol and Weston NHS Foundation Trust

LEARNING FROM DEATHS

2023/24 ANNUAL REPORT

Authors
- **Karin Bradley, Trust Mortality Lead from 12 March 2024**
- **Rebecca Thorpe, Trust Mortality Lead until 12 March 2024**
- **Dawn Shorten, CMO Mortality Administrator**

This report covers the Learning from Deaths for the year 2023/24.

This report will cover data relating to the programme, the programme group structure and governance processes and will analyse themes that have emerged in the year.

This report covers learning from adult deaths across the Trust. A separate annual Child Death Review (CDR) report is shared through W&C governance and the Trust Mortality Surveillance Group. Maternity and peri-natal deaths are also reported separately and are collated on an annual MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) report.

During 2023/24 all UHBW in-hospital adult deaths were scrutinised by a Medical Examiner.

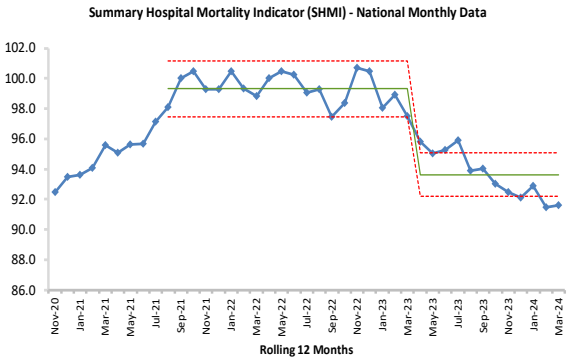
Contents **page**

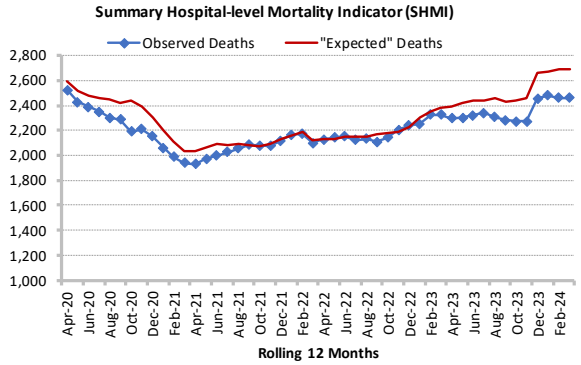
UHBW MORTALITY FIGURES AND BENCHMARKING ANALYSES

Trust-level adult mortality 2023-24

National benchmarking of UHBW mortality rates is undertaken in the Quality Intelligence Group.

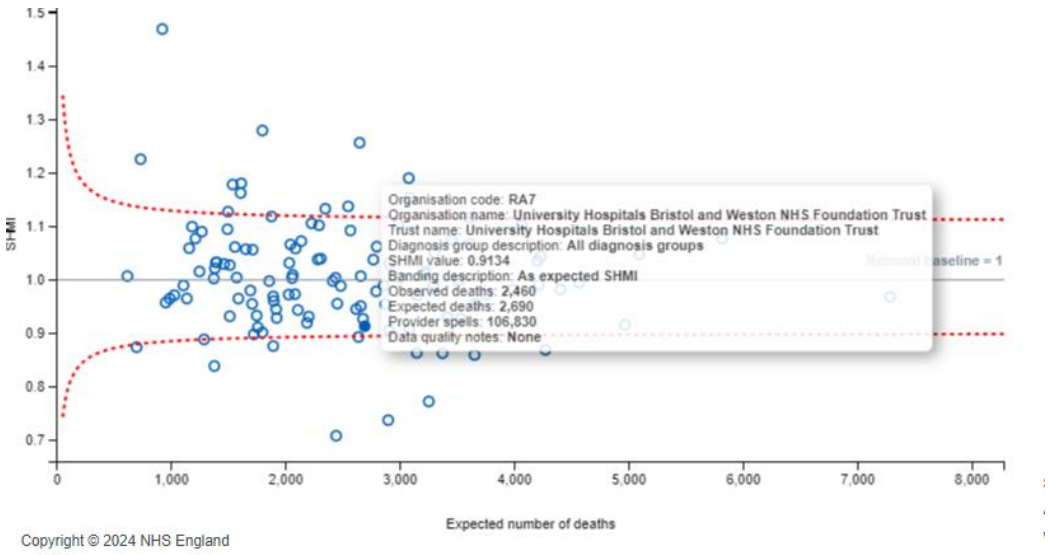
The Summary Hospital-level Mortality Indicator (SHMI) indicators are published monthly by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average figures for England, taking into account the characteristics of the patients treated there. There is no target. A SHMI of 100 indicates that the two figures are equal, but there is a national statistically acceptable range calculated by NHS Digital and a SHMI that falls within this range is reported as being 'as expected'.





The SHMI for UHBW for the 12 months April 2023 to March 2024 was 91.6, within NHS Digital's 'as expected' category.

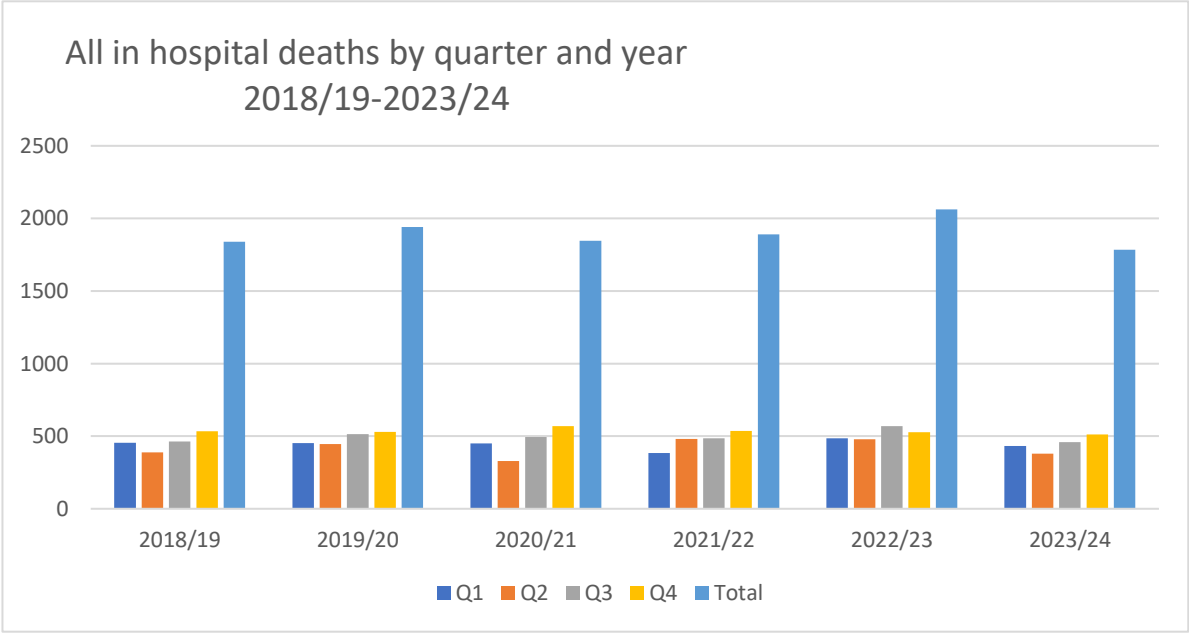
Rolling 12 Months To:	Observed Deaths	"Expected" Deaths	SHMI
Mar-23	2,325	2,385	97.5
Apr-23	2,295	2,395	95.8
May-23	2,300	2,420	95.0
Jun-23	2,320	2,435	95.3
Jul-23	2,340	2,440	95.9
Aug-23	2,305	2,455	93.9
Sep-23	2,280	2,425	94.0
Oct-23	2,270	2,440	93.0
Nov-23	2,270	2,455	92.5
Dec-23	2,455	2,665	92.1
Jan-24	2,480	2,670	92.9
Feb-24	2,460	2,690	91.4
Mar-24	2,460	2,685	91.6



The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to diagnosis group level if required, and investigating any identified alerts.

UHBW adult in-patient deaths 2023-24

Overall numbers for in-hospital deaths were 13.5% lower this year than for the preceding year. As forecast nationally, there were fewer deaths this year reflecting a national trend towards pre-pandemic levels.



UHBW in hospital adult deaths per quarter by division for 22/23

Division	Q1	Q2	Q3	Q4	Total
Medicine	338	342	421	403	**1504**
Surgery	68	60	73	63	**264**
SpSv	80	77	75	62	**294**
W&C		1			**1**
Total	**486**	**479**	**570**	**528**	**2063**

N.B.: In 22-23, Weston site data was fully integrated into UHBW clinical divisional data. Of note, adult in-patient deaths in Women's are typically treated under gynae-oncology and hence are often captured in Specialised Services data.

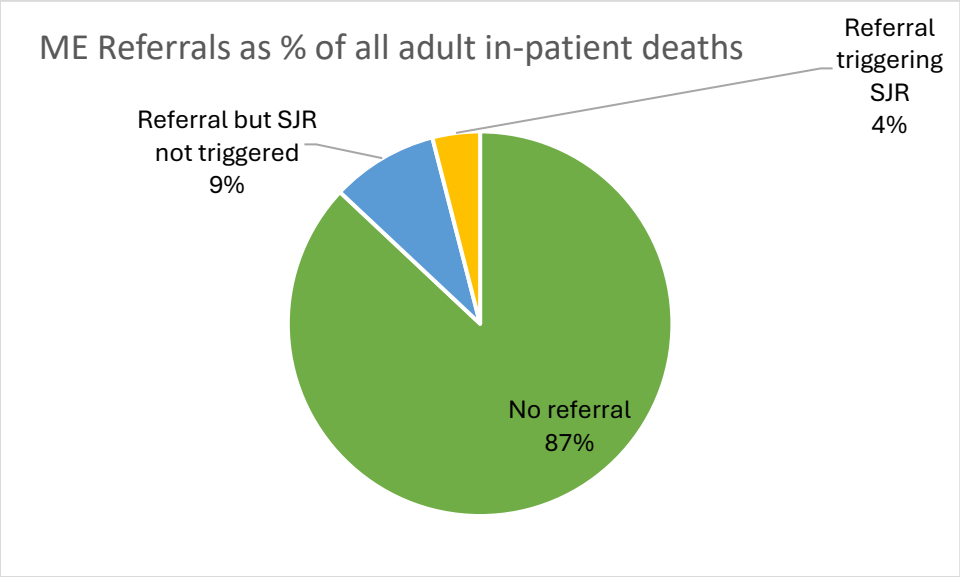
UHBW in hospital deaths per quarter for 23/24

Site	Division	Q1	Q2	Q3	Q4	Total
BHOC	Medicine	0	1	0	0	**1**
	Sp Sv	28	19	30	17	**94**
BRCH	Died in ED	1	0	1	6	**8**
	Surgery	0	0	1	0	**1**
	W&C	9	12	11	8	**40**
BRI	Died in ED	19	10	15	16	**60**
	Medicine	169	150	189	193	**701**
	Sp Sv	48	44	45	61	**198**
	Surgery	28	32	35	52	**147**
	W&C	1	0	0	0	**1**
St Michael's	W&C (paeds)	5	4	4	4	**17**
	W&C (adult)	4	0	1	0	**5**
Weston	Died in ED	8	4	9	12	**33**
	Medicine	120	107	117	151	**495**
	Sp Sv	1	0	1	0	**2**
	Surgery	20	14	24	12	**70**
Total		461	397	483	532	1873
Total adult deaths		**446**	**381**	**466**	**514**	**1807**

N.B.: Data for 23-24 has now been split by geographical site and division to provide a more informative picture. This is the first time using this data analysis methodology (extracted from Careflow) and may not be directly comparable to 22/23 method (previous manual scrutiny of Careflow data has revealed occasional omissions and/or duplication). Adult in-patient deaths in Women's are typically treated under gynae-oncology and hence are often captured in Specialised Services data.

The table above includes child death figures, but the remainder of the report excludes these and deals with data for adult deaths only.

100% of all UHBW adult deaths were scrutinised by a Medical Examiner (ME). MEs send feedback from their reviews and from the deceased's family - positive and negative - to the Medical Directorate on a weekly basis. This feedback is shared with relevant clinical teams. Referrals which highlight potential serious concerns around care are shared with the appropriate Divisional Mortality Lead, in order to arrange a Structured Judgement Review (SJR). The SJRs are then formally reviewed and approved at Mortality Surveillance Group (process commenced in 23-24).



ME referrals and SJRs triggered 23/24

2023/24	Q1	Q2	Q3	Q4	All
Total deaths	**446**	**381**	**466**	**514**	**1807**
Referrals from ME Office	**44**	**49**	**62**	**69**	**243**
Referrals meeting SJR criteria	**7**	**28**	**16**	**31**	**82**
Referred for a Learning Disability and Autism SJR	5	5	5	11	26
Referred for a Mental Health SJR	1	8	1	4	14
Referred for both a Mental Health and LD&A SJR	1	0	0	1	2
Total mandatory category reviews	**6**	**13**	**6**	**16**	**40**
SJRs referred for only treatment/care concerns	**2**	**15**	**5**	**20**	**42**

Of the 1807 adult deaths at UHBW, 243 (13%) were flagged by the MEs. This represents a 6% reduction in ME referrals as compared to 2022/23. Referrals are reviewed and triaged by the Medical Director Team so that each case can be taken forward though the most appropriate process. The triage process is described below in governance and processes. The ME scrutiny is intended to improve the quality of death certification, to ensure appropriate direction of deaths to His Majesties Coroner, to improve the experience of bereaved relatives (including by raising any concerns to a doctor not involved in the care of the deceased) and to support the NHS to learn and improve the overall quality of care delivered.

Of the 243 referrals passed to the Medical Director Team, 82 (34% of referrals or 4.5% of deaths overall) met the criteria for an SJR. The SJR is an NHSE approved process developed by the Royal College of Physicians for conducting reviews in treatment/care as part of the Learning from Deaths process. Of these 82 SJRs, 40 (48%) fell under mandatory reporting categories; learning disability & autism (26) and mental health (14). The remaining 42 (51% of all SJRs) were triggered solely for treatment/care concerns.

Historically, SJRs were not requested for patients referred to HMC or for whom patient safety processes were triggered under the Serious Incident Framework. This changed in April 2023 as the new Patient Safety Investigation and Review Framework (PSIRF) moved away from detailed written

incident reports and hence the SJR has increased in significance as a source of narrative in cases where the patient has died. There has also been a rise in the number of mandatory SJR category deaths (reflected nationally) from 18 in 22/23 to 40 in 23/24. These two factors likely significantly contribute to the increased number of ME referrals leading to SJRs. In 23/24 there were 82 SJRs (representing 34% of total ME referrals) as compared to 49 SJRs in 22/23 (representing 17% of ME referrals). Selecting which ME referrals trigger an SJR is slightly subjective, outside the mandatory categories, but it is not felt that this factor was relevant during this period. This data does, however, need to be watched as, despite a fall in overall mortality and a reduction in ME referrals into UHBW, the number of ME referrals that then trigger an SJR has risen. Future trends will help confirm if there is any real sustained increase in concerns around care delivered. To note, the 23/24 annual BNSSG Medical Examiner report (Appendix 1) quotes a referral rate to trust governance of 14% for UHBW and 11% for NBT.

ME referrals – governance processes and outcomes

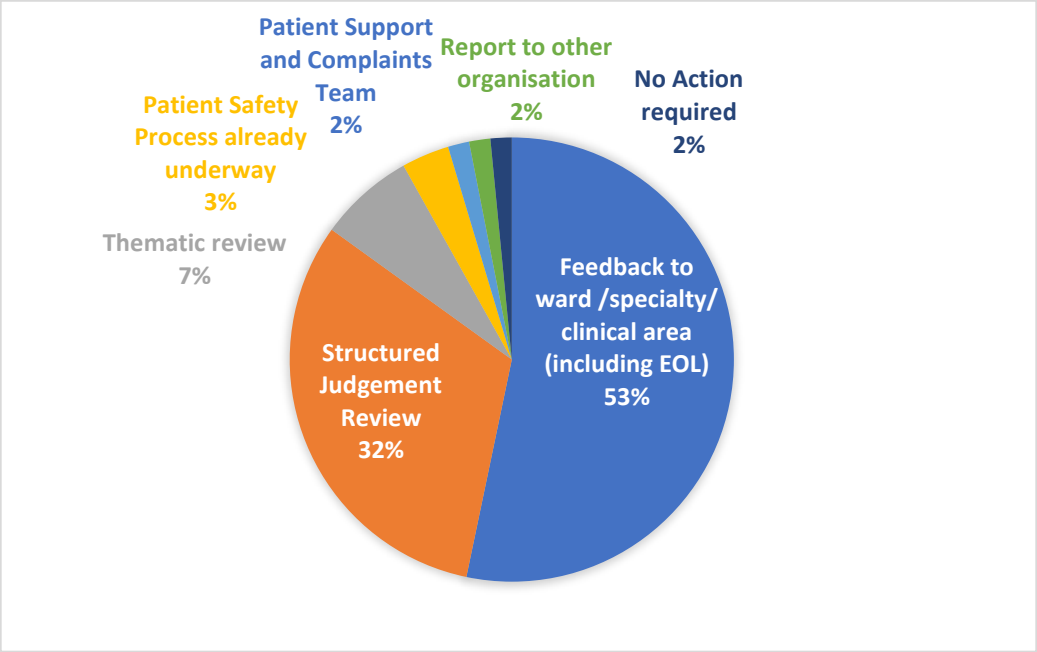
Referrals are sent to the Medical Directors team and are triaged to an appropriate onward process.

If the referral does not meet the threshold for an SJR, the feedback will be passed to a senior member of staff in the relevant clinical area or team. The route for sharing this information is considered on a case-by-case basis to ensure that the feedback is shared in a way that supports learning and doesn't compromise staff well-being. Those referrals noted as having engaged the patient support and complaints process will already be subject to a Divisional investigation process and response. Some recurring issues noted by the Medical Director team may be selected as appropriate for a thematic review. Very rarely, further action on feedback will not be indicated.

Of the 243 Medical Examiner referrals, 138 were assessed as requiring clinical team or area feedback. These were highlighted to appropriate senior staff with a request for sharing the learning as appropriate. Of these 138 triaged for clinical feedback, 21 were complimentary of the care given. In this situation, thanks and commendations were sent to the individuals or teams from senior staff.

Process	**#**
Feedback to ward /specialty/ clinical area (including EOL)	**138**
Structured Judgement Review	**82**
Thematic review	**18**
Patient Safety Process already underway	**9**
Patient Support and Complaints Team	**4**
Report to other organisation	**4**
No Action required	**4**
Total: Note: referrals may be subject to more than one process	**259**

Chart shows % of ME referrals assigned to each process

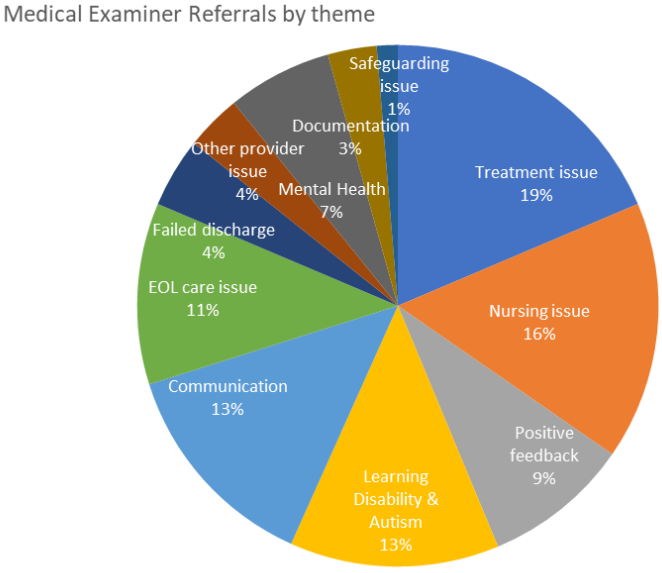


Any comments shared within the organization are progressed within those areas by senior staff, and confirmation and assurance regarding follow-up actions and shared learning is sought by the Medical Director's office.

ME referrals – themes

Treatment issue	***43***
Nursing issue	***37***
Positive feedback	***21***
Learning Disability	***26***
Communication	***31***
EOL care issue	***26***
Failed discharge	***10***
Other provider issue	***8***
Mental Health	***14***
Documentation	***7***
Safeguarding issue	***3***

Note: referrals can be for more than one theme



Once the detail of the feedback was reviewed, the commonest themes were **communication** and **end-of-life (EOL) care**.

Communication issues included difficult conversations that could have been handled more sensitively, sharing printed information around EOL processes, managing families' expectations realistically, and problems reaching staff by telephone from outside the trust.

Lack of privacy on the ward (particularly over the busy winter period), distress caused by disruptive patients and concerns around sufficient pain relief were significant elements of the feedback regarding EOL in-patient care.

"*NOK - daughter - perplexed at EOL care - was not explained to her and her family the process and why it is done - no fluids etc. X googled to get information but then spoke with a nurse who did explain very well - if this nurse had been available at the beginning of EOL would have been less stressful"*

"NOK concerns re. communication: lack of continuity of care leading to mixed messages from doctors, difficulty getting answers and nursing staff not being fully appraised."

In Weston, it was decided to offer a series of Practice Education Facilitator training sessions focusing on care at the end of life. The aim was to upskill nurses regarding how best to share information with patients and relatives and the adjustments in care indicated at end of life pathway. A reduction in the number of referrals critical of Weston end-of-life nursing was noted after this training, and positive comments received. A similar programme has now been implemented on the Bristol site.

March '24
"*Care - lovely, amazing care, looked after him very well, nurses outstanding on cheddar ward*"

" Very very good, especially the staff on Kewstoke ward, excellent in how they related to XXXX and also how they dealt with the family too"

" Nurses were impeccable in their care for XXX and the rest of the family - could not fault them"

STRUCTURED JUDGEMENT REVIEWS

	SpSv	Surgery	Medicine	**Total**	LD&A	MH	Both LD&A and MH	**Mandatory SJR totals**	**SJRs for treatment concerns**
BHI	8		1	**9**			0		**9**
BHOC	3			**3**	1	2	0	**3**	**0**
BRI	2	13	26	**41**	17	10	1	**27**	**14**
WGH		2	27	**29**	8	2	1	**10**	**19**
Div Totals	**13**	**15**	**54**	**82**	**26**	**14**	**2**	**40**	**42**

2023/24

	Weston	BRI
SJRs triggered for care concerns	19	14
Total deaths	600	1107
SJRs triggered for care concerns as a % of total deaths	**3.2%**	**1.3%**
Bed base	279	400
Approximate % of bed base occupied by 'medical' in-patients	~75%	~61%

The highest number of deaths, ME referrals and SJRs occur in medical in-patients, as would be expected**.**

In 2023-24, Weston had 19 SJRs triggered for treatment concerns out of 600 deaths (3.2%). The BRI site had 14 SJRs for treatment concerns with 1107 recorded deaths (1.3%). This would suggest that in 23/24, Weston triggered more than double the rate of ME referrals that lead to SJRs for care concerns as compared to the BRI (adjusted for death rate).

There are caveats to making direct comparisons from the data. For example, selection bias cannot be completely excluded and nor can the possiblity that the 23/24 data is anomalous since we have no historical comparator (due to new data extraction methods). Also, crucially, an SJR triggered for a possible care concern does not equate to there being a proven care concern (see SJR scoring section below). In fact, in the majority of cases, significant care concerns were excluded.

On the Weston site ~75% of the beds contain medical in-patients (with a recognised higher SJR rate), as opposed to ~61% being 'medical' on the BRI site. Further tracking and analysis of the Weston data is planned, acknowledging that greater challenges might be predicted in a coastal community with an elderly demographic and where the central area features in the 1% most deprived wards in England in several indices of deprivation (Ministry of Housing, communities and Local Government 2019. It is worthy of note that in Q4 23/24, Weston received more positive ME feedback than the whole of the rest of the organisation and may be on a progressively positive trajectory and so further tracking of the data is indicated.

As outlined above, neither an ME referral nor an SJR being triggered for a potential care concern are valid outcome metrics of quality of care. They are merely triggers for additional reflection (see SJR scoring outcomes below).
It is also important to note that tracking of SJRs across UHBW is not currently supported by robust digital processes and requires considerable manual input to monitor and analyse and is therefore vulnerable to errors.

SJR Scoring

Key to Care scores: 1=Very Poor, 2=Poor Care, 3=Adequate, 4=Good Care, 5=Excellent

Of the 82 cases referred for SJR, the majority of reviews assessed **overall care** as good (4 and above) with prompt reviews and treatment. Those rated as adequate still fell within the accepted parameters of appropriate care.

SJRs were requested for four cases via the patient safety team in order to ensure comprehensive oversight of the patient journey. These were all subsequently scored 2 ('poor care') in the overall care category. They had been referred following RIRs for incidents that had been reported on Datix and investigated via patient safety processes. *Note: Under previous parameters these would not have been selected as requiring an SJR and would have only been reported via patient safety processes.*

Avoidability ratings:
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 but one SJR had an **avoidability rating** of 4 and above i.e. highly unlikely to be unavoidable.

One SJR was assigned a score of 2 in this category i.e. more than a 50:50% chance of the patient's death being caused due to a problem in care. All other phases of care for this patient were rated as having been good or adequate.

This case is the subject of ongoing discussions as it has highlighted a risk of potential duplication and inefficiency where LfD and PSIRF processes overlap. It also raises the risk of subtly different interpretations in complex cases, especially where cases are reviewed by clinicians with differing relevant specialist expertise. In a situation where external scrutiny of internal documents may be required, the SJR template does not lend itself to a narrative that is considerate to the bereaved and the avoidability scoring is subjective and may be open to criticism if an expert in the relevant sub-specialist area later reviews the case.

Discussions are ongoing regarding the appropriateness of completing SJRs for patients referred to His Majesties Coroner. To not complete SJRs in this context would align UHBW with NBT who currently do not and who do not plan to do so. Wider discussions with NBT and national peer trusts are also being explored to understand how trusts are managing to align LfD and PSIRF processes.

THEMATIC REVIEWS

Thematic reviews/learning from 2023-24 have included:

1. **EOL thematic review (12 patients)**
   Focus on access to palliative care out of hours and communication at EOL. The wider issues around out of hours provision is well understood, and funding has now been secured to expand this service. Additional actions from the thematic review include linking the EOL steering group to MSG information feeds to support monitoring of issues in palliative care.

2. **Transport of emergency cases between sites, including NBT**
   Concerns identified included: clinical decision making and EOL planning prior to transfer, availability of transfer services and the impact of lack of theatre access in Weston overnight. Outcomes included a check-list shared from Bristol to Weston, an updated transport SOP to

reflect increased operational pressures on SWASFT and to include alternative options (e.g. Retrieve) plus targeted education for specific relevant staff groups and a trust-wide safety bulletin. Also linked to emergency surgery at Weston T&F group.

3. **Aortic dissection thematic review (5 patients)**
   A cluster of 3 deaths in unoperated aortic dissection patients in late 23/early 24 was raised as a concern via the ME team. A thematic review completed by Specialised Services and presented at MSG identified no care concerns and it was shared with the lead ME. Following discussion at MSG, the scope was later widened to include two additional aortic dissection patients who had died despite operative intervention. All 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.

THEMES (MORTALITY LEAD FEEDBACK, DIVISIONAL OR CLINICAL AREA INFORMATION)

Learning Disability and Autism - LEDER Reviews

Of the 28 deaths reviewed by the Learning Disability team in 2023/4 the majority were scored by reviewers at 6 definitely not avoidable on the NMCRR template. Only one case has raised concerns around medical care which is the case under review with the legal team(already noted in this report) for a patient safety incident due for inquest.

During the reviews the communication that clinicians had with family or those close to the patient was noted as 'very good' and were 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.
- 'The term 'Learning difficulty' is still being used by a wide range of professionals instead of learning disability, this is an incorrect diagnosis.

The learning disability team encourage Drs to contact them 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.

A safety bulletin was issued in June this year by the Associate Medical Director to clarify that Learning Disability must be stated and that it is a diagnosis distinct from Learning Difficulty, it was noted that funding for this service depends on correct coding. **Debra Parsons, Lead LD Nurse July 2024.**

End of Life steering group

The End-of-Life steering group meets quarterly and is attended by Divisional, Corporate and Lay representatives with an end-of-life story presented at each meeting for sharing and learning. The focus for improvement is managed through a workplan which is aligned to the national end of life framework and informed by feedback received by the group in the form of incident recording, complaints, and medical examiner feedback. Objectives have included development of an end-of-life care volunteer service, education and specialist palliative care provision. With the recognition of the risk and significant pressures of capacity upon the specialist team, substantive funding has been

secured to provide a robust 5-day service. There is an on-call specialist palliative care consultant available at the weekend. Funding has been acquired to develop an adult end of life care practice education facilitator team to provide training and education and support practice across the Trust. The Trust are participating in the national audit of care at the end of life (NACEL), a comparative audit of the quality and outcomes of care experienced by the dying person and those important to them.
Julia Hardwick 7th July 2024

Medicine Division

There has been no mortality lead within the Division since April 2024. The post was advertised but no expressions of interest were received. Informal feedback highlights that the workload for mortality in medicine exceeds the 0.5PA assigned to the post. Mortality referrals are currently being shared with the Clinical Chair as an interim measure, but this is unsustainable, results in delays and risks safe oversight of processes through MSG. The themes prevalent in the division in 23-24 include escalation and response, delay to senior decision making, timely pain management and readmission within 3 days of discharge.

Specialised Services Division

The division delivered the required analyses (see thematic reviews) to provide robust assurance around the management of a cluster of 5 cases of aortic dissection. They also delivered a well-received training session to MEs on accessing cardiology in-patient electronic medical records.

Surgery Division

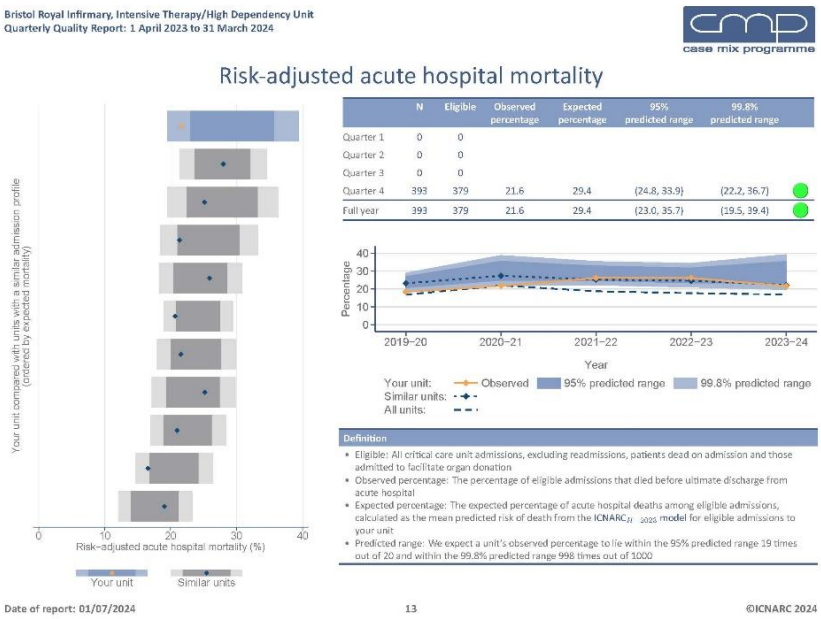
The main theme from this year has been the transfer of patients from Weston for emergency surgery (see thematic reviews).

Intensive Care Medicine

The department conducts highly detailed and robust M&M meetings and has an action log for any issues arising in care. Themes arising are listed below:

- PE Thrombectomy
- Management of Adult congenital heart disease
- Inter-hospital transfers of non-ICU patients at risk of deterioration
- Isolated decision making in WGH
- Discussion of chemotherapy on the ICU
- Trauma Patients in WGH
- ICU admission timelines
- Posterior circulation stroke
- Cardiogenic Shock
- Escalations from different areas of ICU
- Use of Midazolam for peri- procedural sedation

ICNARC (Intensive Care National Audit and Research Centre) data for the UHBW BRI Unit shows the risk adjusted acute hospital mortality to be significantly lower than expected



Weston General Hospital Site

Excellent reduction in backlog of SJRs. SOP for chest drain insertion at Weston approved (triggered by ME concerns). In Q2 23/24 LfD report, it was noted that an analysis completed by the Weston mortality lead for the previous 12 months had identified that there were the same number of ME referrals for the Weston site as for the whole of the rest of the organisation. The metric of SJRs requested for likely care concerns (adjusted for number of deaths) is newly explored in this report and warrants further tracking and consideration, whilst acknowledging that it is not a marker for quality of care.

Appendix 1

BNSSG Medical Examiners Report

April 2023- March 2024

Dr. David Crossley

Lead Medical Examiner for BNSSG

June 2024

Contents

Introduction

On behalf of the medical examiner (ME) service for Bristol, North Somerset and South Gloucestershire (BNSSG), I am delighted to provide our fourth annual report.

The national medical examiner system is a key component of the Department of Health and Social Care's "Death Certification Reform Programme for England and Wales". It also forms part of the NHS Patient Safety Strategy and the NHS Long Term Plan in England, and is a key element of the quality and patient safety agenda in Wales. The BNSSG service is one of 128 medical examiner offices, the largest in the South-West, and one of the largest in England.

We are considered "business as usual" in terms of the scrutiny of deaths at University Hospitals Bristol and Weston NHS Trust (where only child deaths remain to be fully integrated into the ME service), and the North Bristol NHS Trust, (where all deaths are covered), ensuring the three key components of the medical examiner service are met:

1. Improving the experience of bereaved relatives through better communication around the death certification process, and including their views of the care of their loved ones.
2. Ensuring the Medical Certificate of Cause of Death (MCCD) is accurate.
3. Liaising with His Majesty's Coroner to ensure appropriate referrals are made.

The main focus of the service nationally is to enable all bereaved people to benefit from independent scrutiny of non-coronial deaths, provide a forum to include *their views* about the care of their loved ones - be it good or bad, and to support the NHS and beyond to learn from this scrutiny to improve the quality of care. We are currently rolling our service out to the community.

Regards,

Dr David Crossley, Lead Medical Examiner for BNSSG

About the Medical Examiner Service in BNSSG

Implementation of the ME service began in England and Wales in 2019 with the appointment of the national medical examiner and recruitment of national and regional teams. There then followed a period of building up the required staffing.

Our service was established in May 2020. It was developed in the footprint of the (at that time) putative Integrated Care System, rather than the conventional individual Trust model. An additional hurdle was to do this during the Covid-19 pandemic. The team now consists of 8.4 whole time equivalent medical examiner officers (MEO's, nine persons), and 28 sessions (2.8 whole time equivalents) of medical examiners (ME's, 17 persons). These figures include the lead MEO and lead ME roles, and will ensure the team is able to scrutinise the approximately 8500 expected deaths that occur each year in BNSSG.

Following a ministerial statement in April 2024, the date for the statutory medical examiner system is now fixed as the 9th of September 2024. From this date, in law, all non-coronial deaths in England and Wales will require scrutiny by an ME service prior to their registration.

Any concerns or themes identified by the ME service are shared with the Trusts governance department(s), and they in turn report back actions both proposed and taken. The role of the lead ME is to report onwards to the national ME (following discussion with the responsible Medial Director) where actions or escalations taken are thought inadequate or insufficient.

Additionally, we interact with the new "Mortality Improvement Programme" providing data (where appropriate).

Performance Statistics

During this year in England and Wales there were over 500,000 deaths, of which around 8500 occurred in BNSSG. Of these deaths, 3917 occurred in the two acute Trusts, and the remainder in the community.

Appropriate signposting of cases to His Majesty's Coroner (HMC) is an important part of the medical examiner service. In BNSSG, during this year our rate of coronial referral was 18%, a figure that has been consistent for our service over the last 4 years. Nationally around 36% of deaths are referred to HMC, but this includes community deaths, so a comparison is hard to make at this time.

The referral rate to Trust governance for further investigation was 10.9% of cases scrutinised at NBT (227 referrals out of 2083 deaths), and 14% of cases scrutinised at UHBW (257 referrals out of 1834 deaths). This gives an average rate of referral of 12.3% for our service, in the context of a national expectation for governance referral of 10-15%. Of note there are two different systems for capture of this data at the two Trusts. Work is ongoing between the Trusts (via the aforementioned Mortality Improvement Programme) to standardise mechanisms, so at present conclusions should not be drawn from these raw figures.

For this year, the average time from death to completion of the required paperwork was 3.6 days. The requirement in law for registration is 5 days (despite a national average for this figure of 7 days), taking no account of weekends or bank holidays. Our response time means that the majority of our bereaved relatives should be able to register within the appropriate timeframe. The 5-day legal standard was broken during just 4 weeks of the year at NBT, and 6 weeks at UHBW.

We maintained a timely service throughout all the Junior Doctors strikes to date – there being no significant change in the timings (above) to finalise the required paperwork from the ME service.

Changes when the service becomes statutory

- The main area of development this year has been the aforementioned community rollout – in preparation for the statutory service. Our community service runs from an office on the Frenchay site of NBT

- We have used three local general practices as “pilot sites” to test our processes over a period of nine months

- All communication and record keeping for the community service is on the “EMIS” system

- Changes associated with the statutory system include:

  -The “28-day rule” will be abolished, and a Qualified Attending Practitioner (QAP) who has “attended in life” will be adequate/appropriate to complete a Medical Certificate of the Cause of Death (MCCD).

  -The ME (or practically the ME service) will be the individual legally responsible for passing (or “finalising”) the MCCD to the Registry Office.

  -The Registry Office will no longer refer to HMC for issues with the appropriate nature of the MCCD re the cause of death, as this will be the sole responsibility of the ME service.

- A new MCCD, which will include:
  -the ME’s name,
  -the patient’s ethnicity (if stated),
  -if it is a maternal death,
  -a “1d” to give an additional line for entry,
  -medical device or implant to be confirmed,
  -an ME MCCD to be completed at HMC request to avoid non-registered deaths (when a QAP not available in a reasonable timeframe).

Where next?

A national ME case management system will be developed, complimented by a digital MCCD for England and Wales with which it will integrate (pilots are currently running in Wales). However, there will always be a paper option available for “IT issues”.

We consider that we are well positioned to manage the transfer to the statutory service on the 9th September 2024.

dc june 2024

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Trust Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 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 Quality (Patient Safety) Alex Nestor, Deputy Director of Workforce Development Laura Brown, Head of HR Information Services (HRIS) Kate Herrick, Head of Finance		
Report Sponsor:	Overview and Access – Jane Farrell, Chief Operating Officer Quality – Deirdre Fowler, Chief Nurse and Midwife and Rebecca Maxwell, Interim Chief Medical Officer Workforce – Emma Wood, Chief People Officer Finance – Neil Kemsley, Chief Financial Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			Yes
	To provide an overview of the Trust's performance on quality, access and workforce standards.		
Key Points to Note *(Including any previous decisions taken)*			
Please refer to Executive Summary			
Strategic Alignment			
This report aligns to the objectives in the domains of "Quality and Safety", "Our People", "Timely Care" and "Financial Performance".			
Risks and Opportunities			
Risks are listed in the report against each performance area and in a summary.			
Recommendation			
This report is for Information.			
History of the paper (details of where paper has <u>previously</u> been received)			
N/A			
Appendices:	None.		

University Hospitals Bristol and Weston NHS Foundation Trust

Integrated Quality and Performance Report

Month of Publication: August 2024
Data up to: July 2024

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 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: July 2024

EXECUTIVE SUMMARY

Quality and Safety

The Summary Hospital Mortality Indicator for UHBW for the 12 months April 2023 to March 2024 was 91.7 and in NHS Digital's "as expected" category. This is below the overall national peer group of English NHS trusts of 100.

The trust saw thirteen cases of Clostridium difficile (c.diff) for July and these were apportioned as 6 Hospital Onset and 7 Community Onset. Year to date shows as 51 in total (31 Hospital Onset and 20 Community Onset). During the diagnostic phase of the c.diff quality improvement group, an audit of all ward sluices has identified issues regarding the number of macerators that are out of action for protracted periods of time and the sluices needing to be generally upgraded to allow for effective cleaning.

July saw no additional cases of MRSA bacteraemia, year to date the trust has currently one case thus far attributed.

Overall, the Trust remains below the level of compliance for Venous Thromboembolism (VTE) risk assessment, but improvement has been seen in some areas notably Weston site. Monthly auditing of VTE risk assessments has commenced and was undertaken in 119 patients across the organisation in July, this demonstrated 100% compliance with prescribing of medication where a risk assessment had been undertaken and 94% compliance with mechanical prophylaxis. Where patients had not had a risk assessment completed (53 of the 119 patients) all except four had either had anticoagulation for VTE prophylaxis prescribed, or no prescription because they were already on anticoagulation medication.

In July, there were 59 patients eligible for the Best Practice Tariff (BPT) for Fracture Neck of Femur patients: 29 in Bristol and 30 in Weston. For the 36-hour time to surgery standard, 35/59 patients (59%) achieved the standard. For the 72-hour time to Ortho-geriatric assessment, 51/59 patients (86%) achieved the standard. 28/59 (47%) achieved all elements of the Best Practice Tariff.

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

EXECUTIVE SUMMARY

Our People

Vacancy overall vacancies increased to 4.1% compared to 3.3% (407.7 FTE) in the previous month.

Turnover reduced to 11.5% compared to 11.7% in June.

Stability index increased to 85.8% compared to 85.4% the previous month which reflects the retention of staff and the new joiners to UHBW in 2023/24 completing their first year of service.

Sickness absence increased to 4.4% from 4.0% in June. The workforce report details the actions taking place including steps to improve access to workplace adjustments and improved experiences of the management of long-term health conditions within the workplace.

Appraisal overall appraisal compliance increased to 78.7% compared to 78.4% in the previous month. The engagement programme is explained in the accompanying workforce report, and Phase 2 is now in progress.

Statutory and Mandatory training the overall rate for the Core Skills titles has decreased by 0.6% to 90.4%, which can be attributed to the change in update refresher period of 3 to 2 years for Moving & Handling Level 2. Rates for 8 of the individual core skills titles have increased; rates for Fire Safety, Infection Prevention and Control and Moving & Handling have all decreased

Leadership training Leadership training compliance increased to 68.4% from 67.0% in the previous month.

Agency usage remains static at 0.8% against a target of 1% maximum. Usage reduced by 11.8 FTE on the previous month. It remains a priority focus area as reflected in the Patient First Corporate Projects, with increased focus on reducing medical usage.

Bank usage increased to 6.9% and remains below but close to the target of 7.0%. For context, the bank target has been set at a minimum level for the last 2 years because bank usage has been identified as a key enabler to the delivery of agency reductions. As agency reductions are achieved and sustained, bank reductions should be viewed as a desirable. The bank and agency metrics must be considered together.

Integrated Quality and Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

EXECUTIVE SUMMARY

Timely Care

Bed occupancy remains high in July (BRI: 103.3% and Weston 95.5%) which, when coupled with high non-elective demand, has continued to impact non-elective services, although good progress has been noted against a number of performance measures.

Planned Care - At the end of July 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, decreasing to eight patients at the end of July 2024. The sustained improvement noted over the last 19 months demonstrates the continued impact of divisional recovery plans and the number of patients waiting 78+ weeks is now limited to seven patients awaiting cornea graft surgery and one Paediatric Neurosurgery patient. As per NHSE guidance, Cornea Graft breaches are monitored but excluded from planning assumptions.

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, whilst the number of patients waiting at the end of July 2024 is greater than had been forecast, the Trust remain confident that 65-week waits will be eliminated by the end of September, with the exception of a marginal drift in Dental. On 22nd August, the trust declared to NHS England that the planning assumptions have been compromised by an unplanned drift in Paediatric Oral & complex Orthodontic services. Increases in demand combined with unplanned workforce losses has generated a forecast of 86 breaches for September. Work is in train to confirm when full elimination will be secured.

As part of the 24/25 Operational Planning round NHSE requested the trust exclude Cornea Graft from planning assumptions given Cornea Graft nationally was compromised due to 'national supply issues' out-with the trusts control. Formal written confirmation was received. 35 Cornea Graft breaches are currently forecast for September. There is capacity to treat but access to graft material is still pending.

Cancer - The Trust continues to comply with the Faster Diagnosis Standard and is consistently performing above the NHSE target of 77%, set as part of the Operational Planning Guidance for 2024/25, reporting 78.6% for June 2024, the fifth consecutive month that performance has exceeded 77% . The 62-day referral to treatment standard performed above NHSE's 70% target for a seventh consecutive month in June (79.5%), and performance against the 31-day decision to treat to treatment standard surpassed the national target of 96%, reporting 96.2% for June 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.

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Integrated Quality and Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

EXECUTIVE SUMMARY

Timely Care (continued)

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 three months of 2024/25, performance had dropped but has started to improve in July, reporting 81.8%, up from 78.4% in June.

Urgent Emergency Care

Emergency Department (ED) - During July, 69.5% of attendances spent less than 4 hours in an ED, from arrival to discharge or admission, which is the highest performing month since August 2023 . A continued focus on ED 4-hour performance has continued from March into Q1 and, when combined with the performance uplift of 6.6% (the proportionate allocation from system type 3 performance in July), the Trust achieved 76.1% in July.

The number of patients spending 12 hours or more in ED during July was reported as 2.4% (3.4% in June, 3.94% in May and 4.1% in April), which is also the best performance since August 2023 and a continued improvement following a period of deterioration during Q3. The Trust continues to progress actions to deliver and sustain the NHSE target (2%), noting that high bed occupancy levels continue to impact timely flow across all sites.

Ambulance Handovers - The proportion of ambulance handovers within 15 minutes has improved again during July (36.9%) compared to June (35%) and May (30.8%) continuing a period of sustained improvement since December which had followed a predictable deterioration between July and October (20.6%) due to the impacts of the constrained flow which was particularly notable on the BRI site (i.e. more NEL admissions coming in and increased bed occupancy). Similarly, performance for ambulance handovers within 30 minutes has reported an improved position in July (74.8%) compared with June (71.7%) and May (67.0%). Performance against both ambulance handover standards is the highest reported position since July 2023.

No Criteria to Reside - During July, the average daily number of patients in hospital with no criteria to reside (NCtR) was 168, an increase from previous months (June, 155; May, 156), although the associated bed days are lower representing increased throughput . 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, with individual acute site targets set of 11% BRI and 19% WGH.

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

EXECUTIVE SUMMARY

Financial Position

In July, the Trust delivered a £625k surplus against a plan of break-even. The cumulative Year To Date position at the end of July is a net deficit of £7,738k (£8,363k at Quarter 1) against a breakeven plan. The Trust is therefore £7,738k (£8,363k at Quarter 1) adverse to plan. The cumulative Year To Date net deficit is c2% of total operating income.

Significant variances in the year-to-date position include: the value of elective income behind plan by £3,000k, a shortfall on savings delivery of £5,789k, £1,072k costs associated with industrial action and £1,100k of pay pressures relating to nursing and medical staff.

At the end of July, the Trust has spent £435k on costs associated with Internationally Educated Nurses (IENs).

Year To Date pay expenditure at the end of July is £3,466k higher than plan as higher than planned medical staffing and nursing costs continue to cause concern across some divisions with continuing high pay costs in total across substantive, bank and agency staff.

Agency expenditure in month is £1,186k, compared with £1,003k in June. Bank expenditure reduced in month to £4,994k, from £5,122k in June.

Total operating income is below plan by £1,629k, mainly due to the shortfall in Elective Recovery Fund (ERF) offset by higher than planned pass-through payments.

The financial position of the clinical divisions, excluding industrial action, shows a deterioration of £2,650k in July, to a Year To Date overspend against budget of £12,132k or 3.9%. The most significant variances to budget in percentage and absolute terms are in: Surgery (£3,589k or 5.4%); and Women's & Children's (£5,178k or 7.0%).

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 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	14	13	-	-	-	-	-	-	-	-
		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	1	0	-	-	-	-	-	-	-	-
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Fracture NOF: Theatre Within 36 Hours		Actual	63.4%	61.1%	26.5%	48.3%	-	-	-	-	-	-	-	-
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Fracture NOF: Geriatrician Review Within 72 Hours		Actual	85.4%	94.4%	100.0%	100.0%	-	-	-	-	-	-	-	-
		Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
VTE Risk Assessment	Risk: 720	Actual	77.1%	75.3%	75.3%	76.7%	-	-	-	-	-	-	-	-
		Trajectory	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Workforce: Agency Usage	Risk: 674	Actual	1.0%	0.9%	0.8%	0.7%	-	-	-	-	-	-	-	-
		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%	11.8%	11.5%	-	-	-	-	-	-	-	-
		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%	4.0%	4.1%	4.4%	-	-	-	-	-	-	-	-
		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%	3.3%	4.1%	-	-	-	-	-	-	-	-
		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	91.4	91.6								
		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: July 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	237	184	-	-	-	-	-	-	-	-
		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	2,365	2,051	-	-	-	-	-	-	-	-
		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%	80.1%	78.6%									
		Trajectory	75%	75%	75%	77%	77%	77%	77%	77%	77%	77%	77%	77%
Cancer Treated Within 62 Days	Risk: 801	Actual	73.2%	74.5%	79.5%									
		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%	78.4%	81.1%	-	-	-	-	-	-	-	-
		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%	69.3%	69.5%	-	-	-	-	-	-	-	-
		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%	3.4%	2.4%	-	-	-	-	-	-	-	-
		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%	35.0%	36.9%	-	-	-	-	-	-	-	-
		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%	71.7%	74.8%	-	-	-	-	-	-	-	-
		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%	16.3%	17.2%	-	-	-	-	-	-	-	-
		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%	25.3%	28.3%	-	-	-	-	-	-	-	-
		Trajectory												
Every Minute Matters: No Criteria To Reside Average Beds Occupied	Risk: 423	Actual	158	156	155	168	-	-	-	-	-	-	-	-
		Trajectory												

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: March 2024

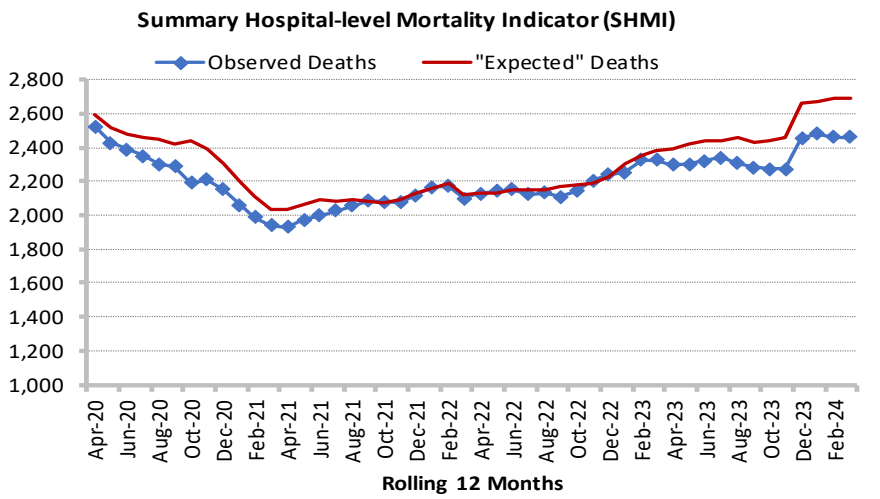
STANDARD	QUALITY AND SAFETY: MORTALITY - SHMI (Summary Hospital-level Mortality Indicator)
Background:	Mortality indicators are used as alerts to identify something that needs closer investigation. This indicator is published nationally by NHS Digital and is six months in arrears. This data is now provided 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 April 2023 to March 2024 was 91.6 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.
Risks:	No risk in current Board Assurance Framework.

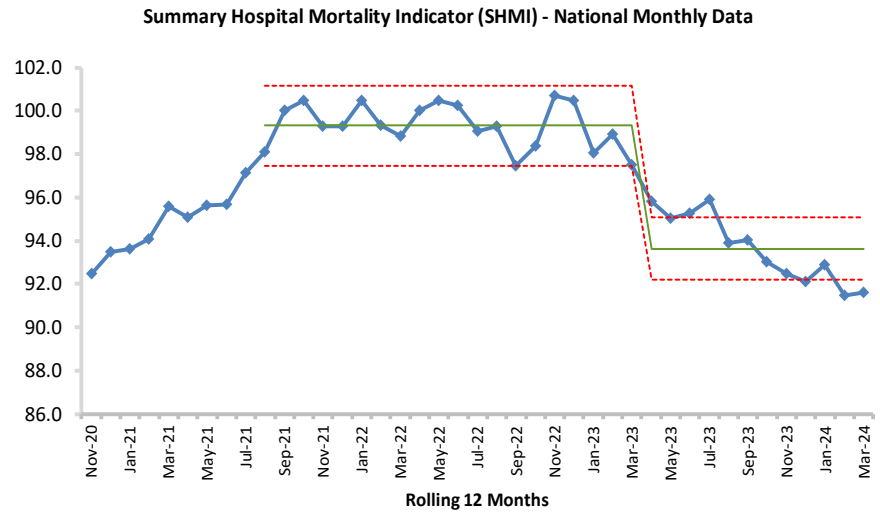
Rolling 12 Months To:	Observed Deaths	"Expected" Deaths	SHMI
Mar-23	2,325	2,385	97.5
Apr-23	2,295	2,395	95.8
May-23	2,300	2,420	95.0
Jun-23	2,320	2,435	95.3
Jul-23	2,340	2,440	95.9
Aug-23	2,305	2,455	93.9
Sep-23	2,280	2,425	94.0
Oct-23	2,270	2,440	93.0
Nov-23	2,270	2,455	92.5
Dec-23	2,455	2,665	92.1
Jan-24	2,480	2,670	92.9
Feb-24	2,460	2,690	91.4
Mar-24	2,460	2,685	91.6

Integrated Quality & Performance Report

Reporting Month: March 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: April 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 April 2024 was 85.0, meaning there were 19 fewer observed deaths (108) than the statistically calculated expected number of deaths (127). 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 April 2024 for UHBW was 89.6, below the National Peer figure of 91.2.
National Data:	The HSMR for the 12 months to February 2024 for UHBW was 88.3, below the National Peer figure of 91.9.
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.
Risks:	No risk in current Board Assurance Framework.

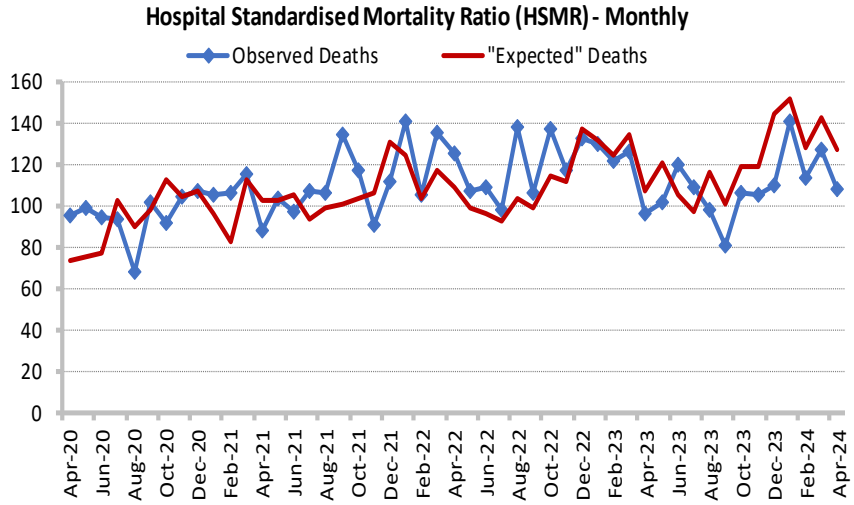
Month	Observed Deaths	"Expected" Deaths	HSMR
Apr-23	96	107.0	89.7
May-23	102	121.0	84.3
Jun-23	120	105.0	114.3
Jul-23	109	97.0	112.4
Aug-23	98	116.0	84.5
Sep-23	81	101.0	80.2
Oct-23	106	119.0	89.1
Nov-23	105	119.0	88.2
Dec-23	110	144.0	76.4
Jan-24	141	152.0	92.8
Feb-24	113	128.0	88.3
Mar-24	127	143.0	88.8
Apr-24	108	127.0	85.0

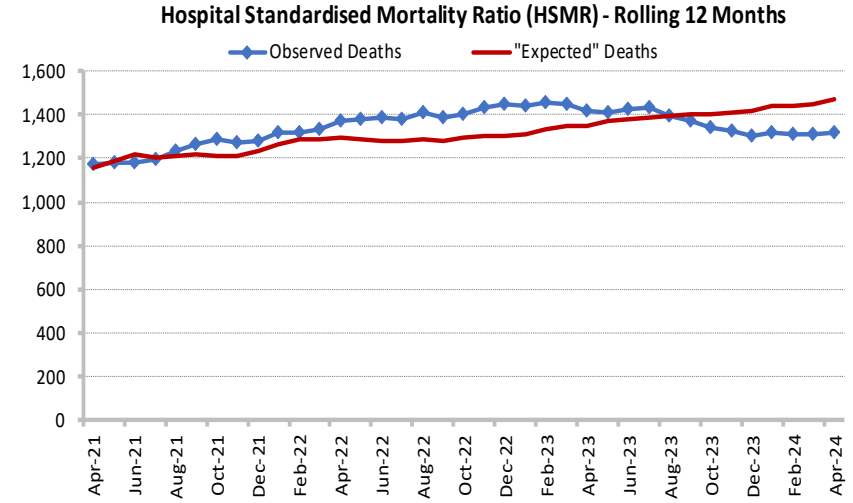
Integrated Quality & Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: April 2024

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





Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 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 is 88. This limit will give a maximum monthly number of approximately 7.3 cases. For MRSA the expectation is to have zero cases.
Performance:	**C.Difficile:** The Trust saw 13 cases of Clostridium difficile for July these were apportioned as 6 HOHA and 7 COHA. Year to date shows as 51 in total (31 HOHA and 20 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. During the diagnostic phase of the c.diff quality improvement group, an audit of all ward sluices has identified issues regarding the number of macerators that are out of action for protracted periods of time and the sluices needing to be generally upgraded to allow for effective cleaning. **MRSA:** No additional cases of MRSA bacteraemia were reported in July 2024, year to date the Trust has currently one case thus far attributed.
National Data:	See next page.
Actions:	**C.Difficile** • The C.Diff quality improvement group chaired by the Director of Nursing for Weston General Hospital, with the support of the transformation team and Infection Prevention & Control are collaborating on the cross Divisional working group for C Diff. The diagnostic phase is coming to a close. There are some areas for improvement in terms of actions for clinical care delivery but also in relation to the Estates. **MRSA** • The MRSA quality improvement group chaired by the Director of Nursing for Surgery, with the support of the transformation team and Infection Prevention & Control, as a collaborative in a cross Divisional working group for MRSA Quality Improvement (QI) is in progress. The diagnostic phase is coming to a close, some Just Do It 'quick wins' have been identified to be delivered.
Risks:	Corporate Risk 6013 - Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia's (12)

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

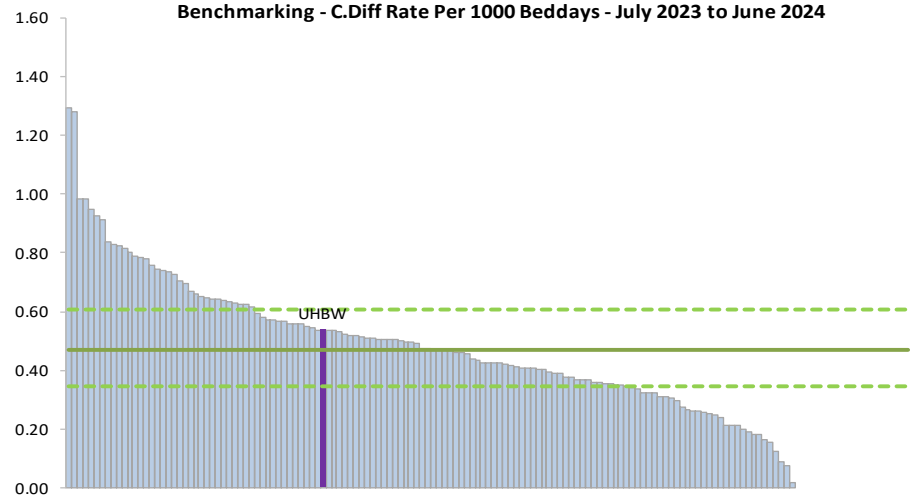
STANDARD **QUALITY AND SAFETY: INFECTION CONTROL– C.DIFFICILE AND MRSA**

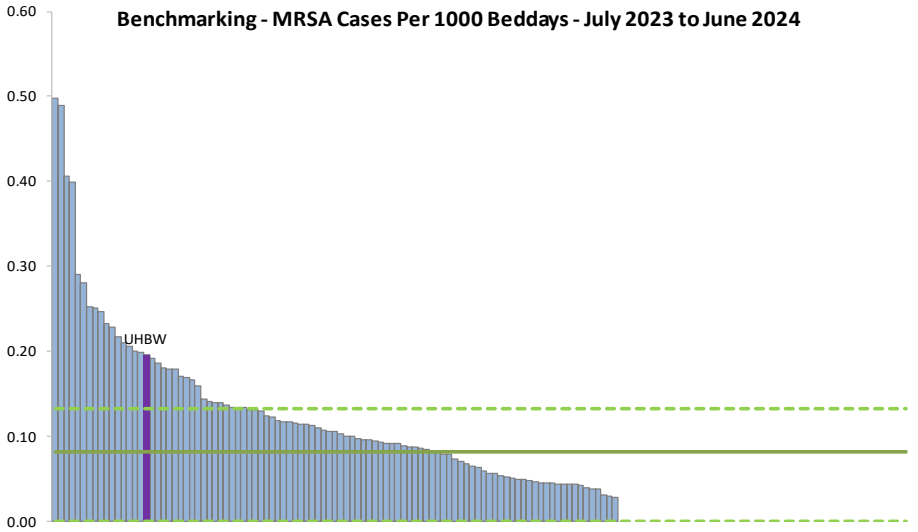
C.Difficile

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

MRSA

	Jul-24	2024/2025	2023/2024
Medicine	0	1	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**	**1**	**9**



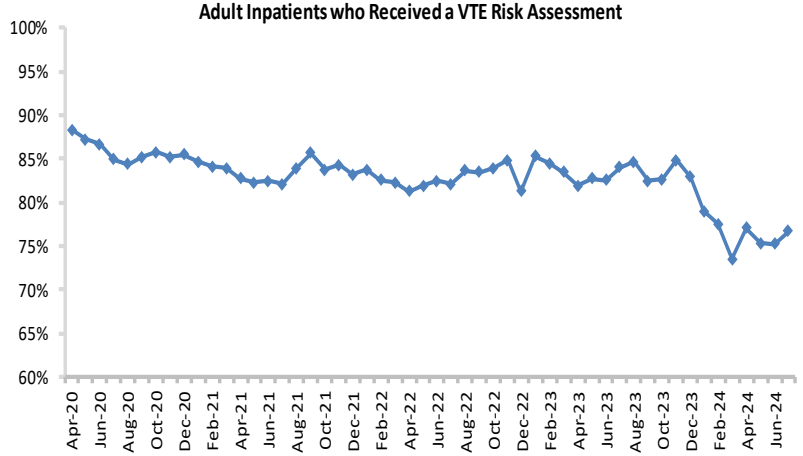


Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 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:	• Overall, the Trust remains below the level of compliance, but improvement has been seen in some areas notably Weston site. • Monthly auditing of VTE risk assessments has commenced and was undertaken in 119 patients across the organisation in July. • This demonstrated 100% compliance with prescribing of medication where a risk assessment had been undertaken and 94% compliance with mechanical prophylaxis. • Where patients had not had a risk assessment completed (53 of the 119 patients) all except four had either had anticoagulation for VTE prophylaxis prescribed, or no prescription because they were already on anticoagulation medication. Whilst this does not entirely mitigate the lack of formal documented electronic RA in these patients, it indicates that VTE prophylaxis is being completed even when the RA has not been documented on the electronic system.
Actions:	Key actions taken this month at VTE steering group include: • Audit reports shared with ward teams • Educational material in the process of being updated for induction
Risks:	Corporate Risk 4711 - Patients suffer harm or injury from preventable arterial thrombus (12) VTE (8)



Division	SubDivision	Number Risk Assessed	Total Patients	Percentage Risk Assessed
Diagnostics and Therapies	Radiology	30	30	100.0%
Diagnostics and Therapies Total		**30**	**30**	**100.0%**
Medicine	Medicine	3,427	4,906	69.9%
Medicine Total		**3,427**	**4,906**	**69.9%**
Specialised Services	BHOC	2,840	2,981	95.3%
	Cardiac	321	546	58.8%
Specialised Services Total		**3,161**	**3,527**	**89.6%**
Surgery	Anaesthetics	23	26	88.5%
	Dental Services	106	194	54.6%
	ENT & Thoracics	196	388	50.5%
	GI Surgery	1,298	1,886	68.8%
	Ophthalmology	338	349	96.8%
	Trauma & Orthopaedics	148	371	39.9%
Surgery Total		**2,109**	**3,214**	**65.6%**
Women's and Children's	Women's Services	1,577	1,764	89.4%
Women's and Children's Total		**1,577**	**1,764**	**89.4%**
Grand Total		**10,304**	**13,441**	**76.7%**

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 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 July, there were 59 patients eligible for the Best Practice Tariff (BPT): 29 in Bristol and 30 in Weston. For the 36-hour time to surgery standard, 35/59 patients (59%) achieved the standard. For the 72-hour time to Ortho-geriatric assessment, 51/59 patients (86%) achieved the standard. 28/59 (47%) achieved BPT. In July, 29 patients were eligible for the Best Practice tariff (BPT) at the Bristol Royal Infirmary sites. • 14/29 - 48% achieved surgery within 36hrs of admission • 29/29 - 100% patients had an ortho-geri assessment within 72hrs of admission • Overall, care for 14/29- 48% achieved all the targets necessary for BPT. In July, 30 patients were eligible for BPT at Weston General Hospital • 21/30 patients 70% received surgery within 36hrs of admission • 22/30 77% received an ortho-geri assessment within 72hrs of admission • Overall, 14/30 53% met all the criteria necessary 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 groups 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: • Seven patients missed ortho-geriatrician assessment/target due to sick leave of the sole person responsible for this role. Longstanding issue is that there is no backup cover for sickness or annual leave. • Additional six patients breached the time to surgery target because of medical issues and required optimisation, awaiting MRI scan for confirmation of diagnosis and lack of theatre space. Weston does not have a designated weekend trauma list (shared with general surgery) and no afternoon trauma lists on Tues and Thursday afternoons. • One patient did not receive a post-operative delirium screen. Reasons unknown
Risks:	No risk in current Board Assurance Framework.

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

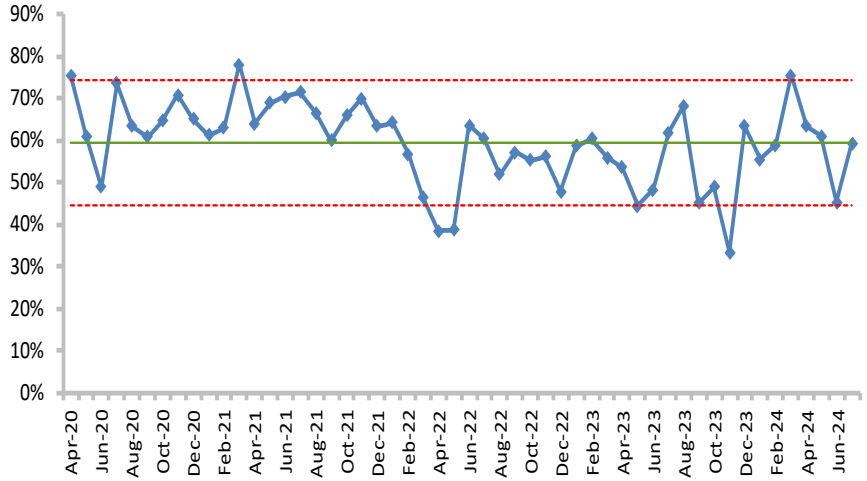
Reporting Month: July 2024

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

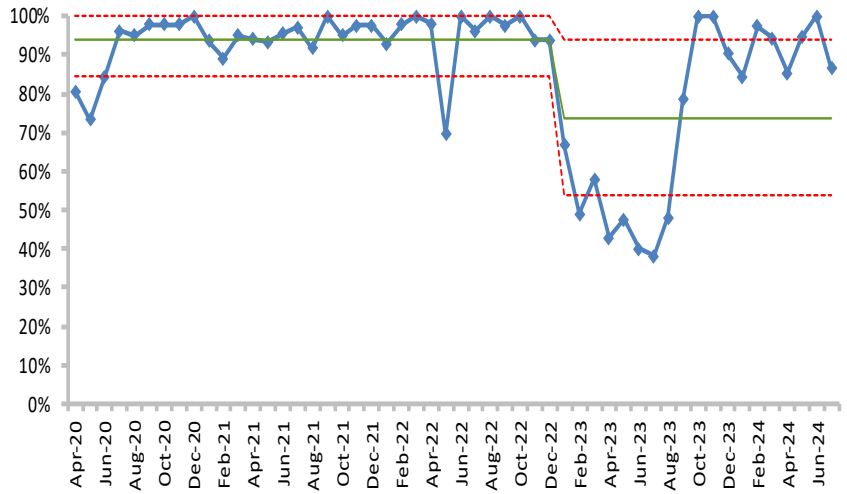
Jul-24

		36 Hours		72 Hours		Best Practive Tariff	
	Total Patients	Seen In Target	Percentage	Seen In Target	Percentage	Achieved All Elements	Percentage
Bristol	29	14	48.3%	29	100.0%	14	48.3%
Weston	30	21	70.0%	22	73.3%	14	46.7%
TOTAL	**59**	**35**	**59.3%**	**51**	**86.4%**	**28**	**47.5%**

Fracture Neck of Femur Patients Treated Within 36 Hours



Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours



Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 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 with several workstreams reported in more detail as part of the Patient First Deteriorating Patient corporate project. The goal of the project is to increase effective and timely recognition, escalation, and response of potentially deteriorating patients, including the recognition of sepsis by March 2025. The formal implementation of the 2024 NICE Sepsis (adult) Guidance occurred end of July 2024, with the introduction of the new Sepsis Screening Tool and Pathway. As a result, the revised metrics are as follows: • % Patients screened appropriately using the paper sepsis pathway • % Patients treated appropriately for sepsis
Performance:	Data for the two metrics will be reported in October 2024, with baseline data from May 2024.
National Data:	N/A
Actions:	
Risks:	Corporate Risk 589 - Patient deterioration is not recognised and responded to (15)

Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

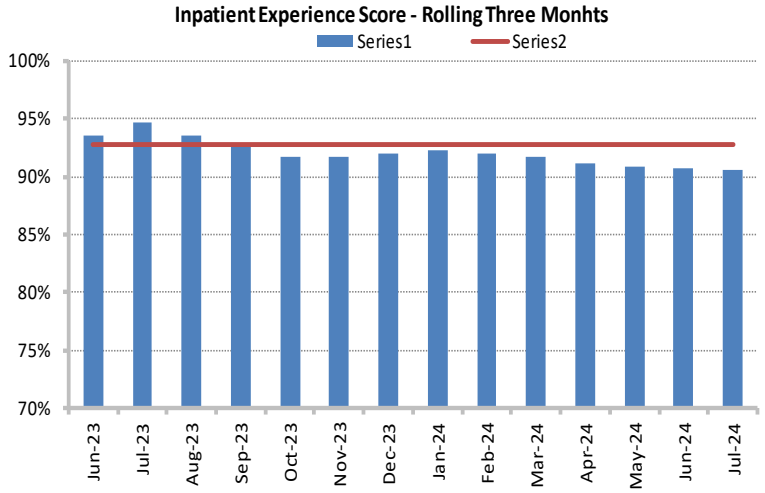
STANDARD	QUALITY AND SAFETY: PATIENT EXPERIENCE
Background:	The Inpatient and Outpatient Experience Score metric is based on the survey question 'Overall, how was your experience of our service?'. The score is based on the percentage of patients who responded to the monthly survey who rated their care 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 July 2024 was 90.9% (June score was 91.1%). Metric is below target for 2024/2025. • The rolling 3-month average for outpatient experience to July 2024 was 96.8% (June score was 96.6%). Metric is just below target for 2024/2025. • The rolling 3-month average for the inpatient communication metric experience to July 2024 was 83.3% (June score was 83.3%). 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. The communication experience metric has been developed to support conversations on where to focus improvement efforts. Medicine and Specialised Services (who selected this as a priority area via Catch-ball) are developing counter measures that will drive improvement in participating wards as well as identifying quick win opportunities to improve experience of care. There is also a focus on improving communication experience at Weston General Hospital who have led the What Matters To You conversation tool roll-out.
Risks:	No risk in current Board Assurance Framework.

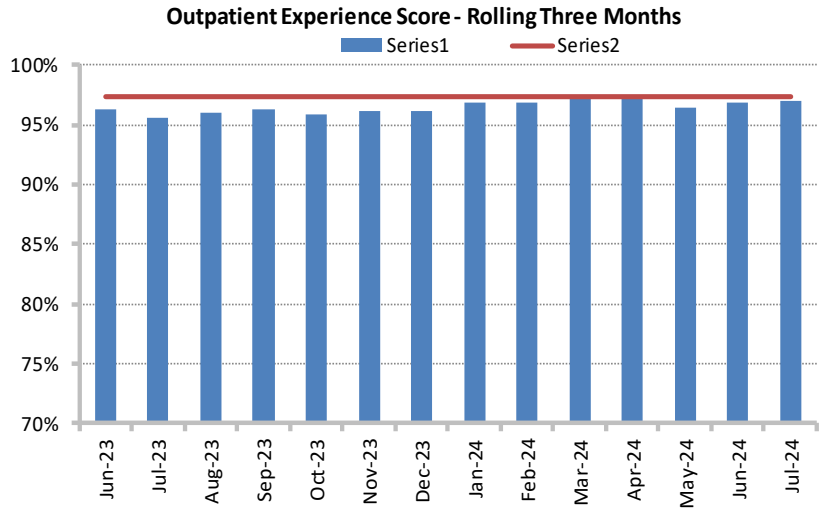
Integrated Quality & Performance Report

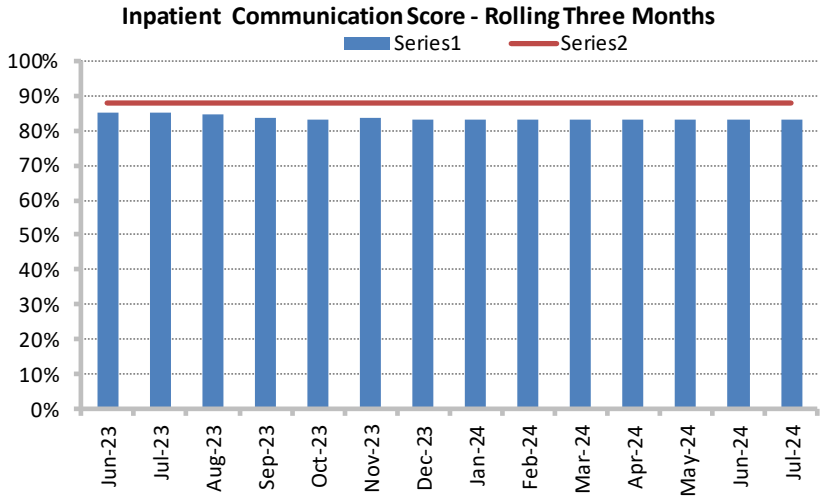
University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

STANDARD **QUALITY AND SAFETY: PATIENT EXPERIENCE (continued)**





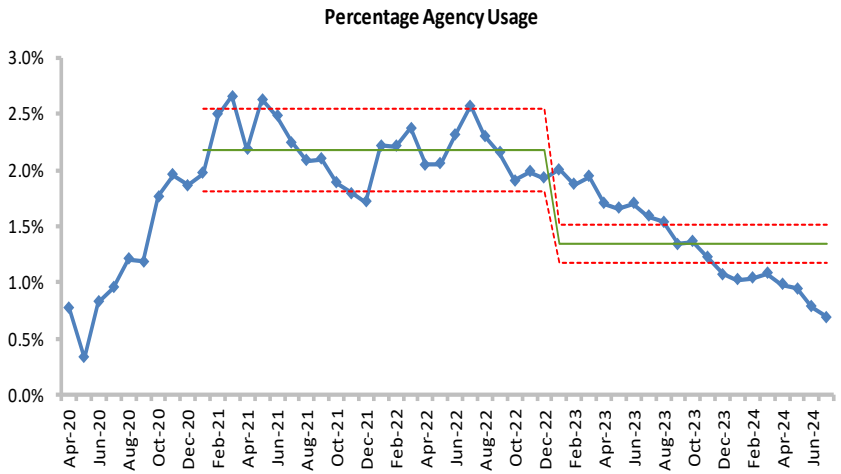


Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

STANDARD	OUR PEOPLE: WORKFORCE AGENCY USAGE
Performance:	Agency usage reduced by 11.8 full time equivalents (fte) to 101.3 fte which was 0.8%. There were increases within two divisions. The largest divisional increase was seen within Medicine, where usage increased to 21.9 FTE from 20.2 FTE in the previous month. There were reductions within four divisions. The largest divisional reduction was seen within Surgery, where usage reduced to 5.7 FTE from 9.7 FTE in the previous month.
Actions:	• 31 Bank Senior Healthcare Support Worker (HCSW) started in the Trust during the month of July and another 21 were offered. • The Bank continues to work closely with the Acute Provider Collaborative to deliver a Collaborative Bank between North Bristol Trust and UHBW which is due to go live on 21st August. • System work continues to drive the supply of lower cost framework nursing agency supply with a renewed focus on developing a plan to deliver cap compliant agency supply. • The Trust Bank has launched the Allocate Loop app, which will enable staff to see availability of shifts and book onto them in a more accessible way increasing Bank fill and reducing agency reliance. • Agency reliance continues to decrease following the launch of the second agency rate reduction and the introduction of tighter scrutiny over agency approval. • Ongoing work continues to encourage the UHBW Bank as the employer of choice for temporary workers. • The Trust continues to encourage block bookings to reduce the use of last minute, non-framework reliance. • Active recruitment continues to substantive medical roles in the Weston Division to drive down the demand for high-cost agency usage.
Risks:	No risk in current Board Assurance Framework.



Integrated Quality & Performance Report

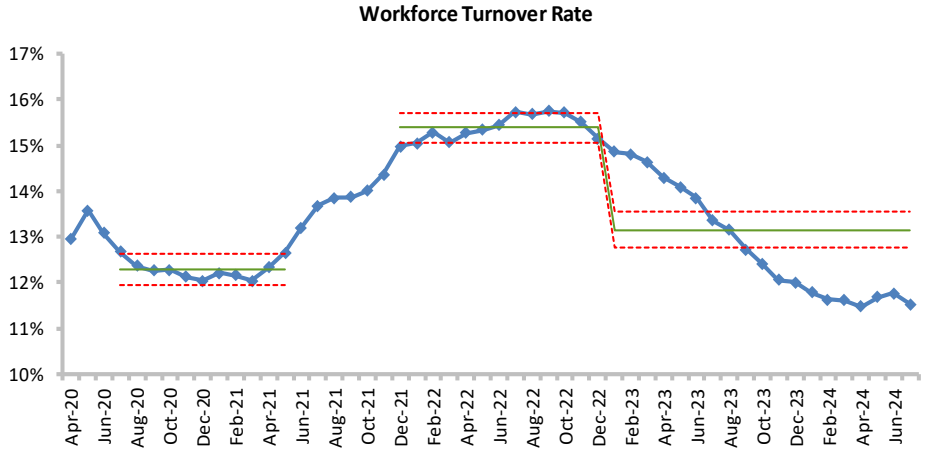
NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

STANDARD	OUR PEOPLE: WORKFORCE STAFF TURNOVER
Performance:	Turnover for the 12-month period reduced to 11.5% compared with 11.8% the previous month (updated figures). • Five divisions saw reductions whilst three divisions saw increases in comparison to the previous month. The largest divisional reduction was seen within Facilities and Estates, where turnover reduced by 0.78 percentage points to 13.86% compared with 14.64% the previous month. The largest divisional increase was seen within Trust Services, where turnover increased by 0.5 percentage points to 10.5% compared with 10.0% the previous month. • Four staff groups saw a reduction, and four staff groups saw an increase, in comparison to the previous month. Admin and Clerical remained static. The largest staff group reduction was seen within Estates and Ancillary, where turnover reduced by 0.66 percentage points to 15.59% compared with 16.24% the previous month. The largest staff group increase was seen within Medical and Dental, where turnover increased by 0.4 percentage points to 3.6% compared with 3.2% the previous month. • Turnover rate for Band 5 nurses in July is 10.9% (compared with 11.2% for June).
Actions:	• **IEN Nurse Retention:** From January 2024, the first UHBW cohorts of Internationally Educated Nursing Recruits will reach three years' service with UHBW. This will mean that they reach the end of their repayment clause in their contracts and will need to renew their visas. HR Services are working closely with the IEN pastoral care team and the Resourcing Team to ensure that the visa renewal process runs smoothly, and that information is provided ahead of the usual deadlines to reassure and retain this staff group. Where the launch of the new leavers survey has been successfully implemented, work is now commencing to review the consistency of face-to-face leavers conversations throughout the trust and how to best make use of the information provided. • **Quarter 2 Pulse Survey:** The survey closed 31st July with the highest response rate to date of over 1300 colleagues providing feedback. The measures from the feedback on engagement, patient safety, wellbeing questions on workplace fatigue, and awareness and impact of Respecting Everyone will be shared through appropriate governance and relevant stakeholders. • **People Strategy milestones:** There are robust plans in place to improve retention within the EDI and Wellbeing Strategic Frameworks, as well as the Engagement Strategic Action Plan, based on Staff Survey priorities. Activity against these plans is monitored in People Committee.
Risk:	No risk in current Board Assurance Framework.

Integrated Quality & Performance Report

Reporting Month: July 2024

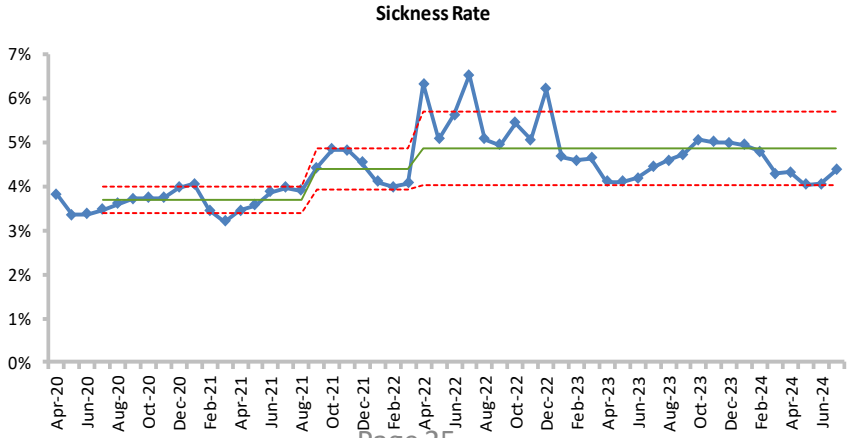


Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

STANDARD	OUR PEOPLE: WORKFORCE STAFF SICKNESS
Performance:	Sickness absence increased to 4.4% compared with 4.1% the previous month, based on updated figures for both months. This figure is combined with Covid Related absence. • There were reductions within two divisions and six divisional increases, compared with the previous month. The largest divisional reduction was seen in Surgery, where sickness reduced by 0.1 percentage points to 4.4%, compared to 4.5% in the previous month. The largest divisional increase was seen in Trust Services, where sickness increased by 0.97 percentage points to 4.14%, compared to 3.17% in the previous month. • There were reductions within one staff group, increases in the seven staff groups, and one staff group remained unchanged compared with the previous month. The only staff group reduction was seen within Additional Clinical Services, reducing by 0.2 percentage points to 4.4% from 4.6% in the previous month. • The largest staff group increase was within Healthcare Scientists, increasing by 1.0 percentage points to 3.5% from 2.5% the previous month.
Actions:	• A Menopause café was held on 4thJuly for colleagues to learn about cholesterol during menopause and to connect with other colleagues with lived experience. • An event to support the wellbeing of Internationally Educated Nurses was held on 5th July. • Sisters and Ward Managers from W&C Division received an overview of workplace wellbeing provision to equip them to better support the needs of colleagues. • North Somerset Healthy Workplaces team organised a webinar entitled 'Oral health in the workplace' to help employers support the wider wellbeing of colleagues. • The Psychological Health Service team collaborated with the Workplace Wellbeing team on 16th July to provide in-person information and signposting to colleagues working within Kewstoke, Draycott & Uphill Wards, held within the Wellbeing Hub, Weston.
Risks:	No risk in current Board Assurance Framework.



Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

STANDARD	OUR PEOPLE: WORKFORCE STAFF VACANCY
Performance:	Overall vacancies increased to 4.1% (506.0 FTE) compared to 3.3% (407.7 FTE) in the previous month. The largest divisional increase was seen in Diagnostics and Therapies where the division increased to 96.1 FTE, compared with having a vacancy of 28.7 FTE the previous month. There has been a funding FTE increase of 84.1 FTE compared to the previous month. The only divisional reduction was seen in Surgery where the division reduced to 163.3 FTE, compared with having a vacancy of 164.3 FTE the previous month. The only staff group reduction was seen in Medical staff, where the staff group reduced to 51.5 FTE from 56.7 FTE the previous month The largest staff group increase was seen in Allied Health / Scientific Professions, where the staff group increased to 135.7 FTE from 70.1 FTE the previous month. There has been a funding FTE increase of 82.4 FTE compared to the previous month. Consultant vacancy has reduced to 41.6 FTE (5.1%) from 43.6 FTE (5.4%) in the previous month. Unregistered nursing vacancies can be broken down as follows; Band / Vacancy AfC Band 2 / 27.3 FTE AfC Band 3 / 69.2 FTE AfC Band 4 / -40.4 FTE
Actions:	• An Open Day event was held on July 16th for Theatres. Eight attended and interviewed on the day. Four were appointable with more candidates in reserve to be interviewed. • Newly Qualified Midwives vacancies both for students who have and have not had placements with the Trust have now gone live. Conversations for the open day for these candidates have begun with a date in September. • An Assessment Centre for Student Nursing Associates (SNAs) filled the last three places. A Registered Nurse Degree Apprenticeship (RNDA) assessment was held in July to fill our last place. The total places offered for October 2024 cohort for registered nurse degree apprenticeships is 20 RNDA (four year) 15 ARNDA (two year) and 10 SNA places. • 14 substantive Healthcare Support Workers (HCSW) started in the Trust during the month of July and another 19 were offered. • 22 substantive Allied Health Professionals (AHPs) and 14 substantive Healthcare Scientists joined the Diagnostics and Therapies division. • The Trust began work on the Pharmacy career pathway which lays out three different detailed careers paths including: Pharmacy Assistants, Pharmacy Technicians and Pharmacists. The first draft is due to be reviewed and signed off by end of Quarter 3. • The Trust initiated a project to reduce the costs of using external agencies across AHP's and Healthcare Scientists. The Talent team and Bank are working collaboratively to create a solution and cut down on significant costs. The project is at the initial investigation stage.

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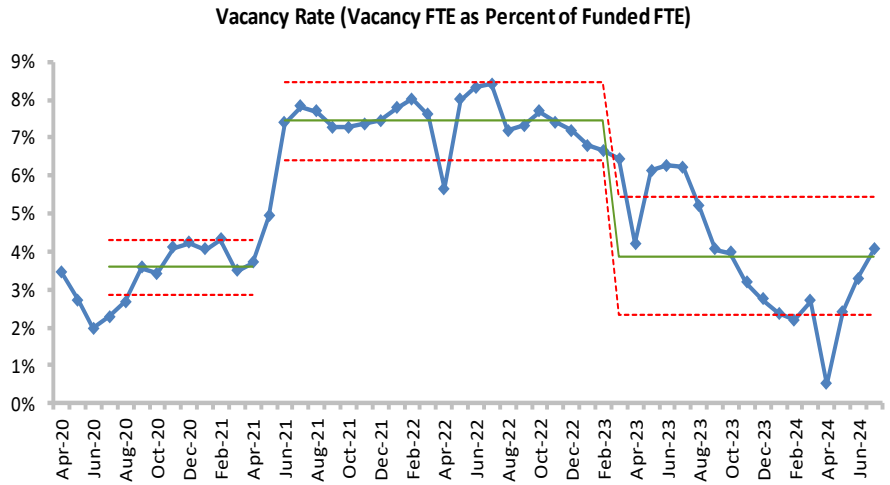
Integrated Quality & Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

STANDARD	OUR PEOPLE: WORKFORCE STAFF VACANCY
Actions (continued):	• Four non-consultant grade doctors started in the Weston site. Five non-consultant grade doctors have been cleared to start in Weston Medicine in August. • Four non-consultant grade doctors in Medicine and one non-consultant grade doctor in Surgery were offered positions at Weston. • One consultant grade doctor in Emergency Medicine and one consultant grade doctor in general Medicine were offered positions in Weston. • The "Dial a job" campaign targeting consultants is due to go live in August. Results to follow. • Substantive interviews for a Acute Medicine Consultant on the Weston site is scheduled to go ahead in August. • Throughout the month the Trust ran the first "Get to know" campaign where a specific department is highlighted and promoted across the Trusts social media sites. This was launched as a pilot and dependant on feedback, this will be re-created regularly targeting areas across the Trust that have difficulty recruiting. • The Trust launched a campaign to celebrate South Asian Heritage Month (18th July – 17th August). The Trust interviewed and shared personal stories from staff members to highlight and celebrate the South Asian community at UHBW.
Risks:	No risk in current Board Assurance Framework.



Integrated Quality and Performance Report

Reporting Month: July 2024

STANDARD	REFERRAL TO TREATMENT (RTT) LONG WAITS
Performance:	At the end of July: • 2,051 patients were waiting 52+ weeks against the 2024/25 Operating Plan trajectory of 1,994. • 184 patients were waiting 65+ weeks against the 2024/25 Operating Plan trajectory of 79 • 8 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 June 2024, across all of England, 4.1% of the waiting list was waiting over 52 weeks. UHBW's performance was 4.0% (2,365 patients) which places UHBW as the 59th highest Trust out of 156 Trusts that reported RTT wait times.
Actions:	• At the end of July 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 July, the Trust reported eight patients who have waited 78 weeks or longer: seven of who are cornea graft patients and one Paediatric Neurosurgery patient. • From the end of July 2024, the Trust had forecast that there would 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 and did not receive sufficient cornea graft material from the national ocular tissue team to clear the remaining seven patients in July. The one additional breach relates to a paediatric neurosurgery patient where treatment was postponed due to a broken (o-arm) imaging device. The Trust are in the process of seeking a loan machine pending receipt of the new machine and are working with finance and procurement colleagues to support this purchase. • 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 July was 184 against the trajectory of 79 which is an improvement on the June position when 237 patients were waiting 65 weeks or longer. • On 22nd August, the trust declared to NHS England that the planning assumptions for the elimination of 65 week breaches by end of September had been compromised by an unplanned drift in Paediatric Oral & complex Orthodontic services. Increases in demand combined with unplanned workforce losses has generated a forecast of 86 breaches for September. Work is in train to confirm when full elimination will be secured. In addition, 35 cornea graft breaches are forecast. There is capacity to treat but access to graft material still pending. As per NHSE guidance, Cornea Graft breaches are monitored but excluded from planning assumptions. *...continued over page*

Integrated Quality and Performance Report

Reporting Month: July 2024

STANDARD	REFERRAL TO TREATMENT (RTT) LONG WAITS
Actions (continued):	• 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 1.4 WTE. The service has tried, unsuccessfully on three occasions, to recruit a substantive consultant in paediatric dentistry. Additional paediatric sessions have been provided to mitigate the activity gap, and the service is seeking to advertise for a fourth time in the autumn to coincide with the completion of the current specialist registrar training round. • Dental services also 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 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. A meeting took place on the 16th July with Devon ICB, BNSSG ICB and UHBW colleagues to agree the activity volumes relating to the repatriation of patients from Bristol to Plymouth so that appropriate contracting methods can be formalised. UHBW are reviewing patients against the criteria provided by UHP to identify patients who are suitable for transfer and as of end of July, one Paediatric ENT patient agreed to be transfer with a further three patients identified as suitable.
Risk:	Corporate Risk 7182 - Non-compliance with routine elective treatment within 65 weeks (12)

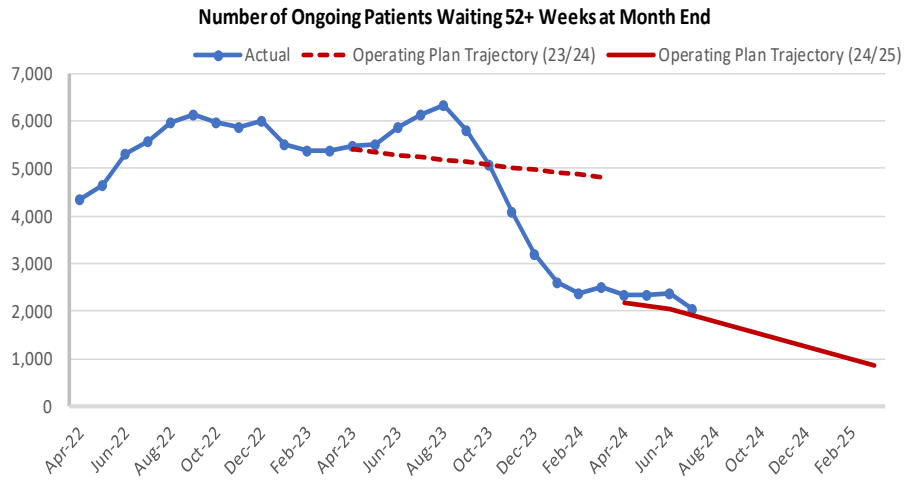
Integrated Quality and Performance Report

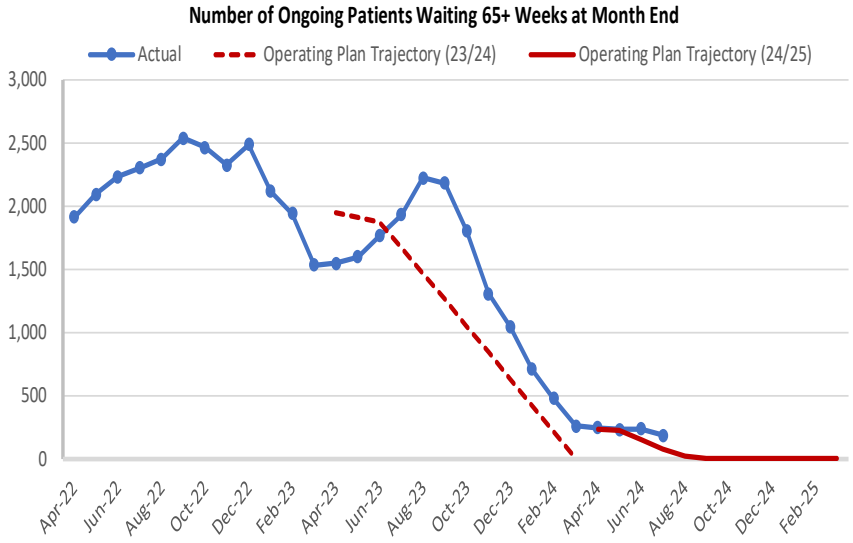
University Hospitals Bristol and Weston NHS Foundation Trust

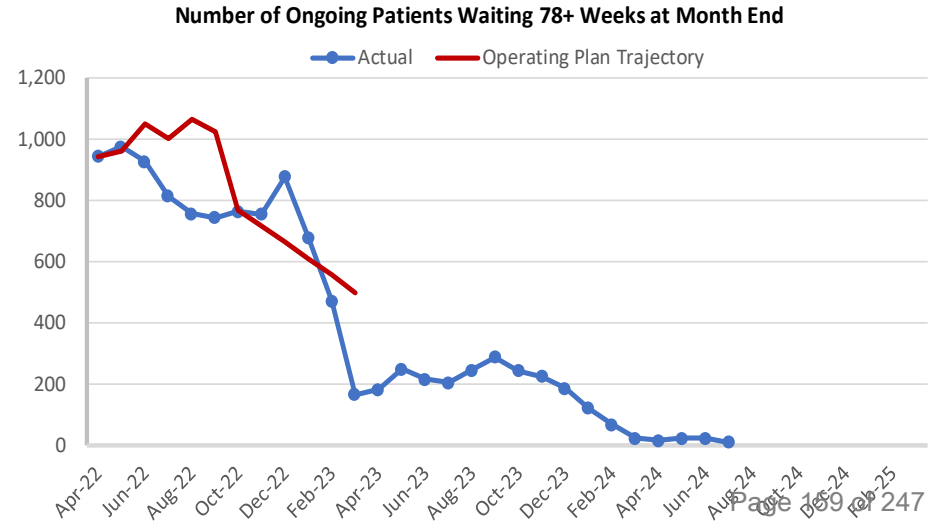
Reporting Month: July 2024

STANDARD REFERRAL TO TREATMENT (RTT) LONG WAITS

	Jul-24		
	52+ Weeks	65+ Weeks	78+ Weeks
Diagnostics and Therapies	29	0	0
Medicine	209	1	0
Specialised Services	140	6	0
Surgery	1,215	147	7
Women's and Children's	458	30	1
Other	0	0	0
UHBW TOTAL	**2,051**	**184**	**8**







Integrated Quality and Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: June 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 June was compliant at 78.6% 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 June, 79.5% 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 June, 96.2% 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 seventh consecutive month with an ongoing improvement trend, and performance against the 31-day decision to treat to treatment standard sustains compliance. 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 6782 - Non-compliance with the 28 day Faster Diagnosis cancer standard (16) Corporate Risk 5532 - Non-compliance with the 31 day cancer standard (12)

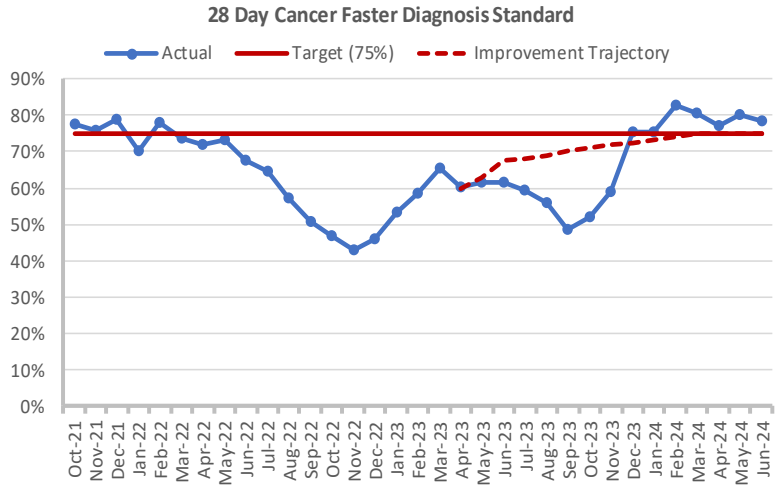
	Jun-24		
	Within Target	**Total Patients**	**% Achievement**
28 Day Faster Diagnosis	1,527	1,943	78.6%
31 Day Standard	734	763	96.2%
62 Day Standard	165	208	79.5%

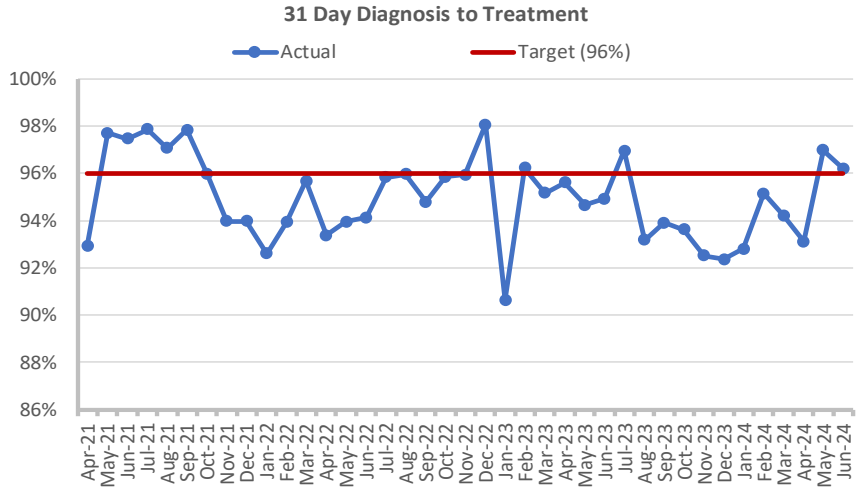
Integrated Quality and Performance Report

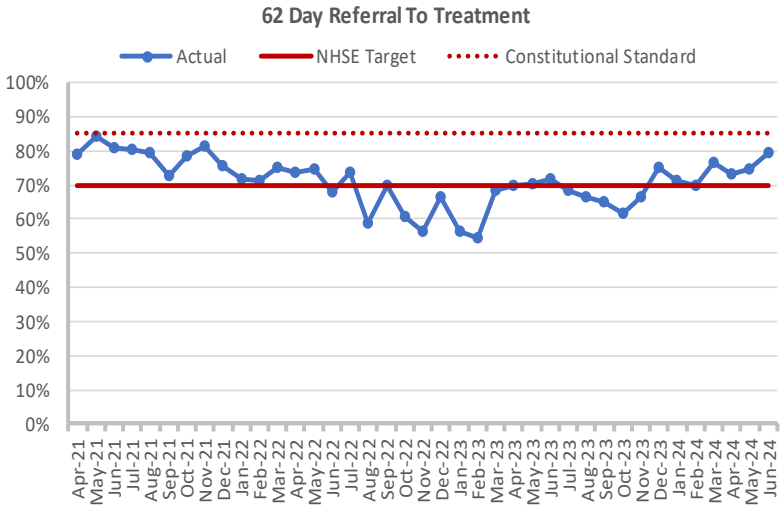
University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: June 2024

STANDARD	CANCER WAITING TIMES





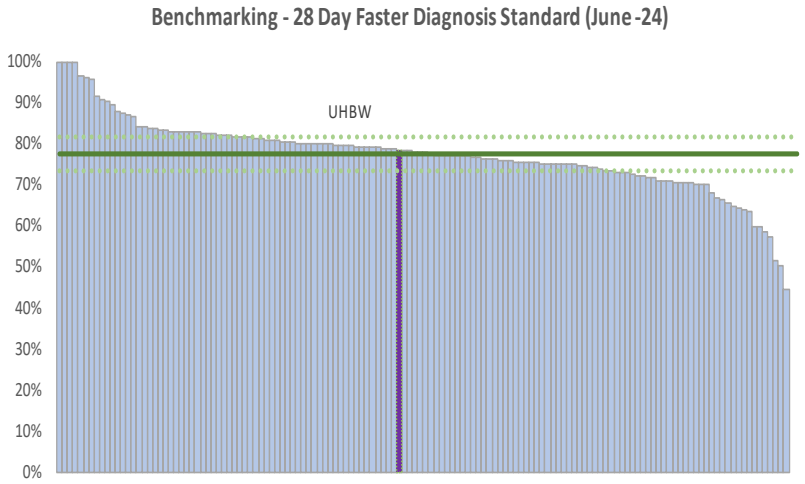


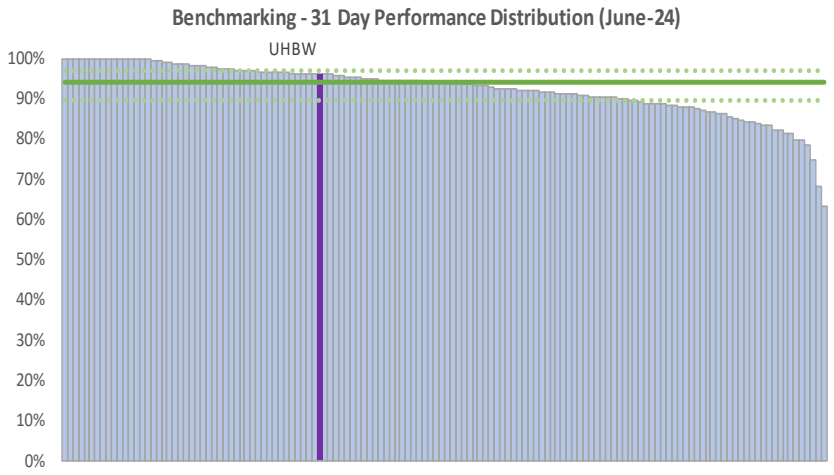
Integrated Quality and Performance Report

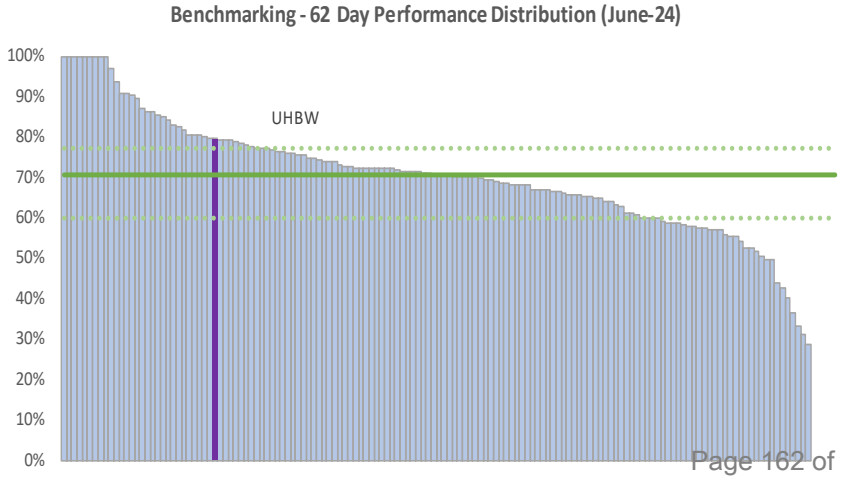
NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: June 2024

STANDARD	CANCER WAITING TIMES







Integrated Quality and Performance Report

Reporting Month: July 2024

STANDARD	DIAGNOSTIC WAITING TIMES
Performance:	The ambition set as part of the Trust's operational planning submission for 2024/25 is that 89.3% of patients will be waiting under six weeks by end of July 2024. The Trust achieved 81.1% for July 2024. 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 July: • 489 patients were waiting 13+ weeks. This is 3.0% of the total waiting list. • 30 patients were waiting 26+ weeks. This is 0.2% of the total waiting list. Note there were no required national trajectories for these long wait measures in 2024/25.
National Data:	For June 2024, the England total was 76.2% of the waiting list under six weeks. UHBW's performance was 78.4% which places UHBW 68th of 157 Trusts that reported diagnostic wait times.
Action/Plan:	• At the end of July, diagnostic performance against the six week wait standard was reported as 81.1% against the operational planning trajectory of 89.3%. Considerable efforts have been made to improve performance and both the percentage of patients waiting less than six weeks and patients waiting over 13 weeks have improved. • 18 sub-modalities achieved more than 85% of patients under six weeks, 11 of these achieved at least 95% under six weeks, with seven sub-modalities achieving more than 99% under weeks. Overall, the majority of DM01 modalities improved against the six week standard, including Echo which improved by 4.5%, Non-obstetric ultrasound improving by 3.7% in both adult and paediatric services, and Dexa improving by 9.1%. Sleep Studies also improved by 19.9%. • Reducing and eliminating diagnostic long waiters is a priority and the number of patients waiting more than 26 weeks reduced to 30 by the end of July and patients waiting more than 13 weeks reduced from 761 in June to 489 in July. Overall, 16 sub-modalities maintained or improved to zero patients waiting over 13 weeks with a further six sub-modalities reporting less than five patients waiting more than 13 weeks. • Improvements in performance are being noted, but 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, Echocardiography and Sleep Studies but plans and actions are in place to recover, and these are yielding good results so far with further recovery in these services expected over next six months. • Audiology (adults) performance remains challenged. 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. • The deterioration in MRI performance is attributed to the adults Cardiac MRI service, where there is an increasing level of demand. The service is reviewing all possible actions to support recovery, however additional capacity needed for recovery is also very specialised adding an additional layer of complexity to the recovery plans. • Echocardiography performance continues to improve, 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. *...continued over page*

Integrated Quality and Performance Report

Reporting Month: July 2024

STANDARD	DIAGNOSTIC WAITING TIMES
Action/Plan (continued):	• Performance and long waiters in Sleep Studies is improving well, and further improvements are expected in this modality. The service continues to use significant additional capacity to improve waiting times for patients and extensive actions continue to be undertaken to improve this service. The position is expected to recover during Q3 2024/25 and is being monitored closely. • Endoscopy (adults) performance against the six-week standard improved in July along with a reduction in patients waiting over 13 weeks. Actions are in place and further improvement is expected over the next few months and the service are anticipating the clearance of long waiters over 13 weeks by Q3 24/25. The risks associated with performance remain but are being mitigated as far as possible. Risks include ongoing complex patients queries, challenges in certain staffing groups, and complex patients requiring capacity which is limited and prioritised for the most clinically urgent patients. • Diagnostic capacity year to date has been challenged by sickness and other workforce challenges and the prioritisation of more clinically urgent patients. Previous industrial action has significantly impacted diagnostic performance as the unrealised capacity generally cannot be recouped, pushing out recovery timelines. Capacity constraints in highly specialist sub-modalities, particularly for patients requiring their procedures under general anaesthetic, also significantly impacts diagnostic performance improvement. • Modality-level diagnostic trajectories and plans for 24/25 are agreed across the organisation and the Trust continues to utilise insourcing and transferred capacity and outsourcing to the independent sector which are all integral to the 24/25 diagnostic recovery plans.
Risk:	n/a

End of July 2024

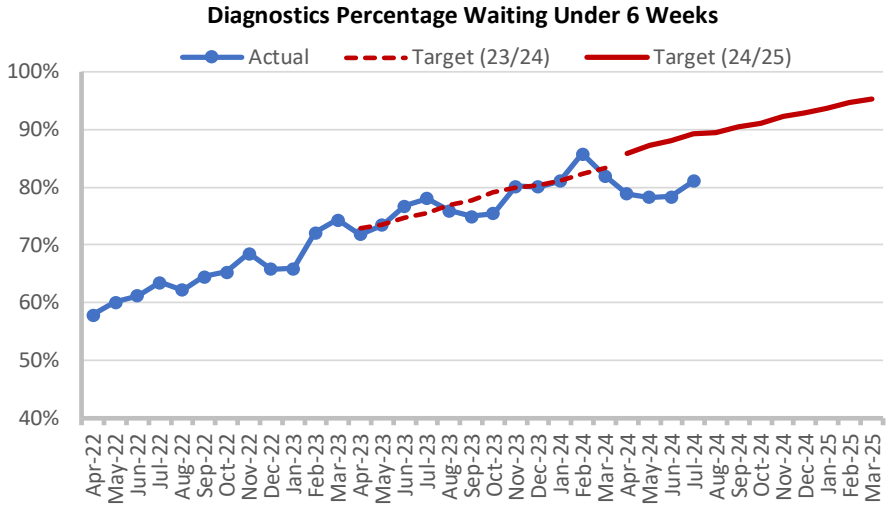
Modality	Total On List	Under 6 Weeks		13+ Weeks		26+ Weeks	
		Number	Percentage	Number	Percentage	Number	Percentage
Audiology Assessments	1,002	258	74%	16	2%	5	0%
Colonoscopy	529	172	67%	71	13%	9	2%
Computed Tomography (CT)	2,968	298	90%	39	1%	1	0%
DEXA Scan	381	12	97%	3	1%	0	0%
Echocardiography	1,743	410	76%	1	0%	0	0%
Flexi Sigmoidoscopy	166	49	70%	13	8%	0	0%
Gastroscopy	400	134	67%	54	14%	4	1%
Magnetic Resonance Imaging (MRI)	3,387	553	84%	154	5%	2	0%
Neurophysiology	290	22	92%	0	0%	0	0%
Non-obstetric Ultrasound	4,782	901	81%	66	1%	0	0%
Sleep Studies	484	239	51%	72	15%	9	2%
Other	0	0		0		0	
UHBW TOTAL	**16,132**	**3,048**	**81.1%**	**489**	**3.0%**	**30**	**0.2%**

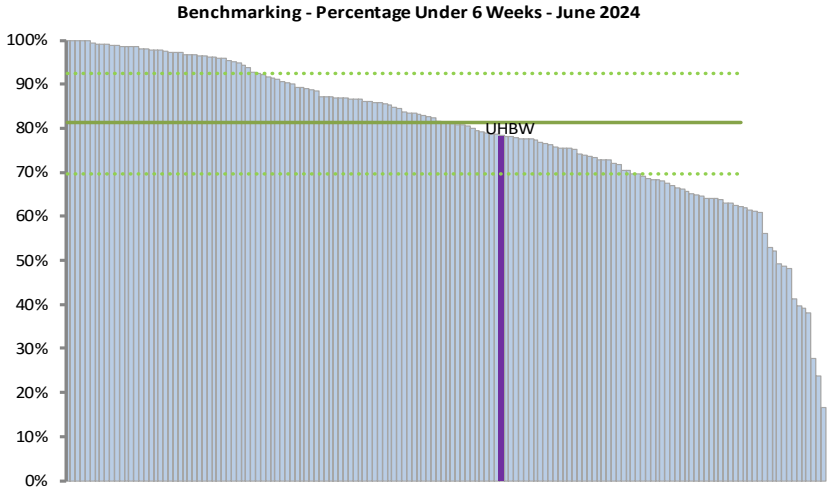
Integrated Quality and Performance Report

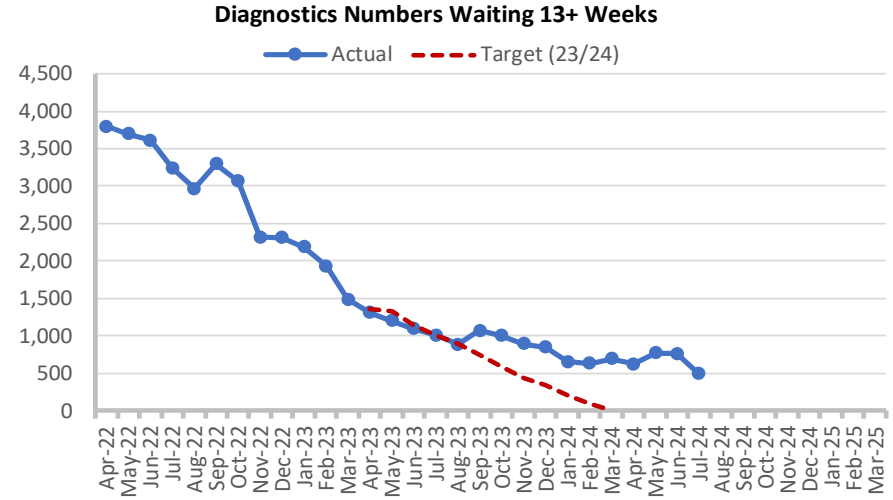
University Hospitals Bristol and Weston NHS Foundation Trust

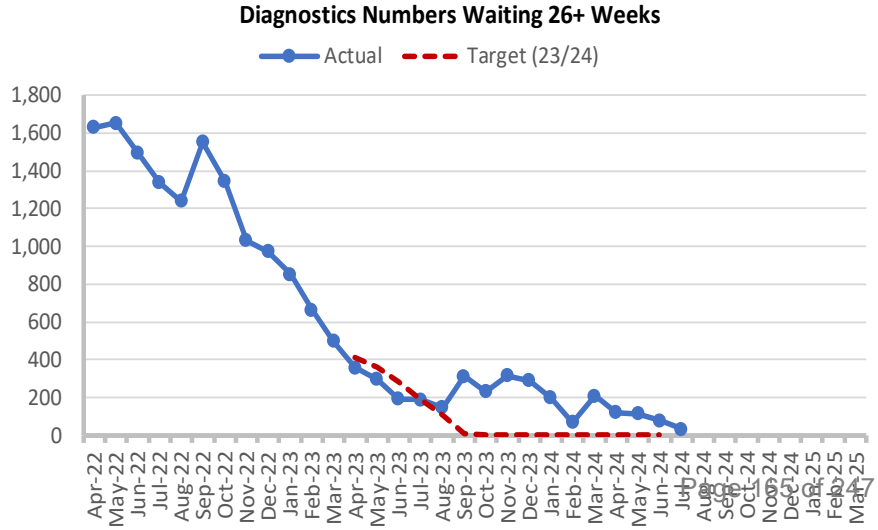
Reporting Month: July 2024

STANDARD **DIAGNOSTIC WAITING TIMES**









Integrated Quality and Performance Report

Reporting Month: July 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 July, 69.5% of patients attending ED spent less than 4 hours in an emergency department from arrival to discharge or admission, which is the best performance against this standard since August 2023, although slightly below the operational planning trajectory of 70.5%. The July performance for the "12 Hour Standard" shows an improvement to 2.4%, compared to 3.4% in June and is also the best performance since August 2023, with 423 patients spending more than 12 hours in ED out of a total of 17,504 attendances. **Attendances** • BRI attendances were 6,718 in July (average 217 per day), which is the same as the daily attendance figure seen in June and a 6.4% increase from July 2023 which averaged 204 attendances a day. • Children's Hospital attendances were 3,656 in July (average 118 per day). This represents a 10.0% decrease from the 131 attendances per day in June but a 7.7% increase from July 2023 which averaged 109 attendances a day. • Weston Hospital attendances were 4,791 in June (average 155 per day). This is a 0.8% decrease from the 156 attendances per day in June and a 13.1% increase from July 2023 which averaged 137 attendances per day. • Eye Hospital attendances were 2,339 in July (75 per day), which is a 4.1% increase from the 72.5 attendances per day in June and a 4.8% increase from July 2023 which averaged 72.0 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 July, there were 146 12 Hour Trolley Waits, compared to 230 in June. This is the best performance since August 2023 when the Trust reported 112. **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 3,926 ambulance handovers in July: • 1,448 ambulance handovers were within 15 minutes which was 36.9% of all handovers. • 2,935 ambulance handovers were within 30 minutes which was 74.8% of all handovers.

Integrated Quality and Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 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 July 2024, overall percentage of handovers under 15 minutes was 25.1% across these hospitals. The Children's Hospital ranked first (best performing) with 69.1% of handovers under 15 minutes, BRI was 5th highest at 33.2% and Weston was 7th highest at 29.9%. ED 4 Hours: For Quarter 1 across all Type 1 Emergency Departments in England, 60.2% of patients were seen within 4 hours. UHBW was at 64.7%. The upper quartile was 67.3% (i.e. 25% of Emergency Departments achieved 67.3% or above in Quarter 1).
Actions:	**Bristol Royal Infirmary (BRI)** • Daily ED attendances to BRI Emergency Department in July were down slightly from June and the reduction is primarily due to lower Fast Flow and Majors attendances in month and an increase in specialty patients. • Overall, 4-hour performance at the BRI site was 53.4% in July. ED performance (patients not admitted to a specialty) was 63.9% in July (up from 62.5% in June) • 3.1% of patients waited 12 hours in the department in July, a reduction from 4.9% in June with some improvements in flow across the hospital contributing to a reduction in 12-hour trolley breaches. • 726 hours were lost to ambulance handover delays in July which equates to an average of 23.5 hours per day; compared to June when 743 hours were lost (an average of 24.7 hours per day). ED to launch a perfect week with SWAST and senior ED nurse team in September to focus on handovers and XCAD sign off. • There will be a continued reduction in ED SDEC provision from 1st July for 12 weeks due to ED consultant capacity. • The Proactive Hospital Team, ED, Radiology and Portering Leads have completed a process map of current ED to CT pathway. The next step is to gather data and to observe the actual process on the shopfloor (GEMBA). GEMBA dates to be arranged for September 24. Focus to improve CT diagnostic turnaround times and eliminate duplication. • The key aim is to review training required for the Patient Flow Co-ordinator role to embed processes and expectations of the 'Flow Out Patient Flow Coordinator (PFC)' in Majors. ED leadership team is to visit Weston ED on 11 September to observe Weston ED Tracker role. • Developing ideas on an Admin & Clerical 4hr flow co-ordinator pilot to manage patient wait times in the department to reduce length of stay in ED and avoid 4-hour and 12-hour breaches. Escalating any challenges to Senior Leads in ED/Divisional Silvers. **Weston General Hospital (WGH)** • Emergency Department attendances remained stable in July at 155 per day (156 in June) • ED 4-hour was at 70% in July (71% in June) with improvements in flow across the hospital. • Performance against the 12-hour standard improved to 4% (from 5% in June) • Ambulance handover remained stable at 29% under 15 minutes with a total of 228 hours of lost time (7.35 hours per day). • A review of handovers process and times taken to transfer patients from ED to assessment units will take place in August. Currently it can take up to an hour to transfer a patient from ED once the bed is ready on the ward. Teams will work towards achieving this in 30 minutes. *…continued over page*

Integrated Quality and Performance Report

Reporting Month: July 2024

STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E
Actions (continued):	**Weston General Hospital (WGH) (continued)** • Length of stay in the Older Persons Assessment Unit decreased in June to 1.7 days (from 2.0 in May). Improvements in flow through the care of the elderly bed base to the downstream wards have supported with this. • Length of stay on AMU remained stable at 1.5 days with an increase in the utilisation of the hot clinic to 87%.. The percentage of people discharged home from AMU increased to 93 patients in July (87 in June) **Bristol Royal Hospital for Children (BRHC):** July 2024 saw a total of 3,656 attendances to the Children's Emergency Department (CED), with an average of 118 attendances per day. This daily figure is down slightly from June 2024 where the average daily attendance was 131 (3,930 overall). Figures from July 2023 show that there were 3,390 (109 average per day) attendances in the previous year, this is an attendance increase of 7.85% which is above the level of attendance increase that we would expect, year on year. ED 4-Hour performance in July 2024 was 82.87%, which is an improvement on June 2024 performance of 81.98%. There were 7 x 12-Hour breaches in July 2024, this is down from 26 x 12-Hour breaches in June 2024. July 2023 recorded a total of 5 x 12-Hour breaches. Key aims are to focus on 12-hour breaches and continue winter planning. **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:** Review of data since June 2023 has shown a consistent upward trend of the number of attendances into the service with Quarter 1 averaging around 389. However, there has been a slight drop in July with 354 attendances. April saw the highest percentage of patients discharged home at 82.1%, which dropped slightly in May and June siting at 78.91% and 79.03% respectively. July saw a positive rise to 81.36%. Length of Stay data has now been stabilised on the dashboard and reflects an average of 7.73 hours in July. This is a drop from the previous two months with June sitting at an average of 8.61 and May 8.51. The average length of stay in ED for SDEC patients sat notably under the 4 hour target at 2.98 hours in July. *…continued over page*

Integrated Quality and Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

STANDARD	EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E
Actions (continued):	**Weston SDEC**: • In July there were 786 attendances at SDEC, an average of 25 per day, remaining stable from June (26 attendances per day). • 460 of the attendances were from the Emergency Department (ED), which was 10% of June's total ED attendances. • Surgical SDEC activity remained stable at 206 attendances in July (205 in June). • Missed SDEC opportunity underway to identify any additional pathways that could be managed via SDEC • 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 started in June 2024, including development of a new SDEC facility. **Medical SDEC - BRI:** • Medical SDEC continues to deliver a 70-hour weekday and 24-hour weekend service, compliant with standard. • SDEC saw 621 patients in July, up from 611 in June. • There has been a significant increase in activity seen in SDEC over the last two years. On average SDEC saw 739 patients each month in 2023/24, an increase of 38% from an average of 535 patients each month in 2022/23. For months 1-4 of 2024/25 the SDEC is averaging 668 attendances per month. (Apr: 712, May: 727, June: 611, July: 621). • The service saw 9% of front door attendances and 25% of patients on the medical take; the admission rate increased to 30% (22% in June) and the average length of stay in SDEC increased to 4 hours 30 minutes in July from 4 hours 15 minutes in June. • The service continues to work on increasing the number of direct referrals from community into SDEC and in July received 50 direct referrals (+13 from June). Key aims: • Review of inappropriate activity within SDEC - transfer infusions back out of SDEC to increase weekend capacity • Increase direct referrals from the community – consider local implementation of Consultant Connect telemedicine system to better facilitate referral pathways • Review pilot of practitioner-led SDEC on weekends • Ensure all medically expected patients are seen via SDEC or direct to an assessment unit to reduce pressure in ED footprint
Risks:	Corporate Risk 910 - That patients in BRI ED do not receive timely and effective care (20)

Integrated Quality and Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

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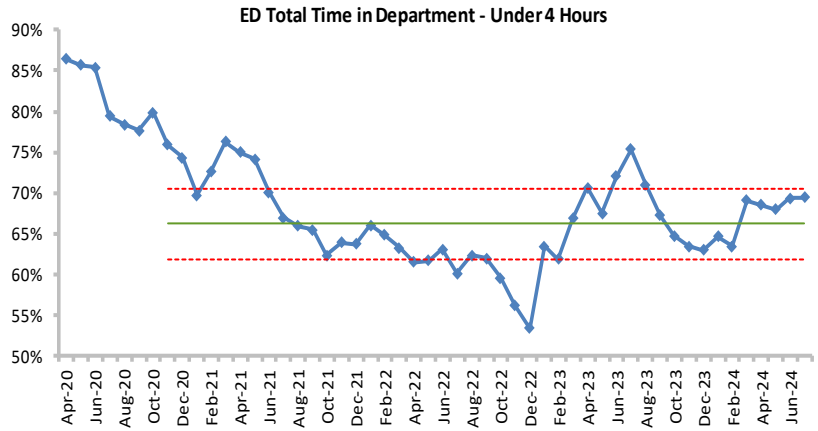
STANDARD **EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E**

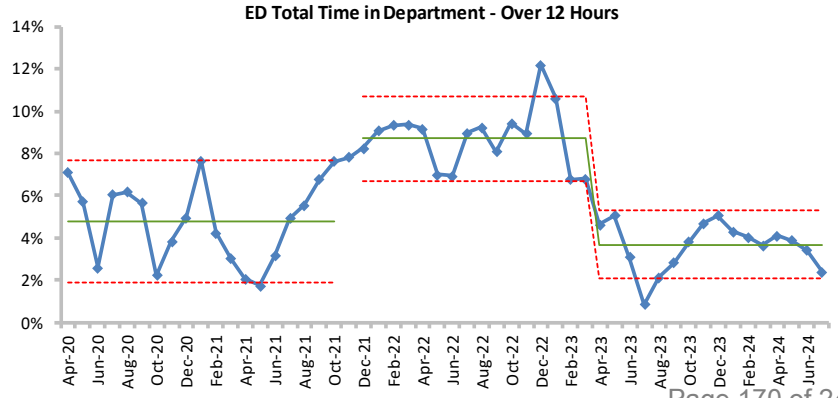
Patients Who Spend Under 4 Hours In ED (Arrival to Discharge/Admission)

4 Hour Performance	Jul-24	2024/25	2023/24
Bristol Royal Infirmary	53.4%	52.4%	54.2%
Bristol Children's Hospital	82.7%	82.4%	75.6%
Bristol Eye Hospital	94.3%	94.6%	95.7%
Weston General Hospital	69.9%	68.8%	65.9%
UHBW TOTAL	**69.5%**	**68.8%**	**67.6%**



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

12 Hour Performance	Jul-24	2024/25	2023/24
Bristol Royal Infirmary	3.1%	4.5%	5.0%
Bristol Children's Hospital	0.2%	0.3%	1.5%
Bristol Eye Hospital	0.0%	0.0%	0.0%
Weston General Hospital	4.3%	6.2%	5.7%
UHBW TOTAL	**2.4%**	**3.5%**	**3.7%**



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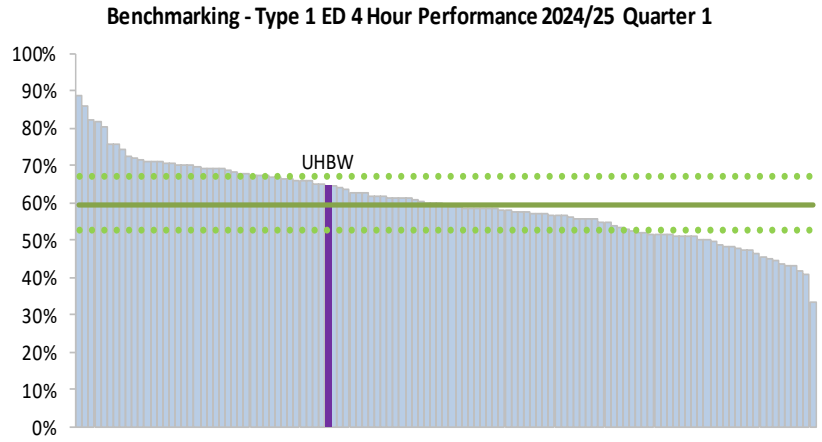
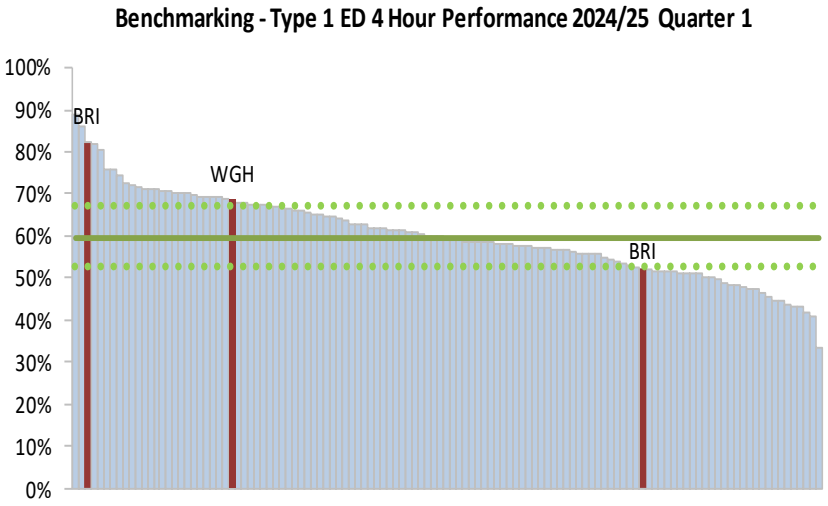
University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: Quarter 1

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





Integrated Quality and Performance Report

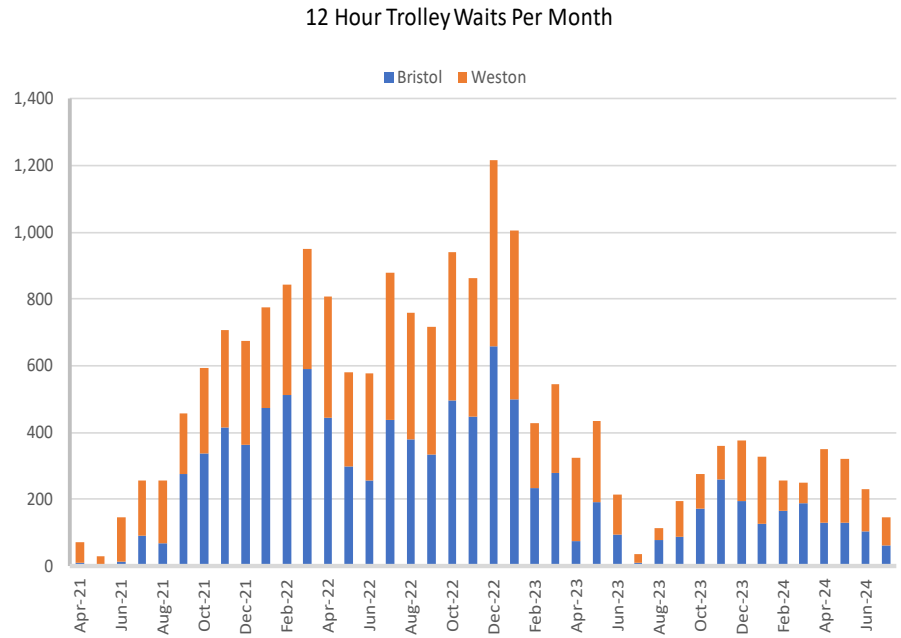
NHS University Hospitals Bristol and Weston NHS Foundation Trust

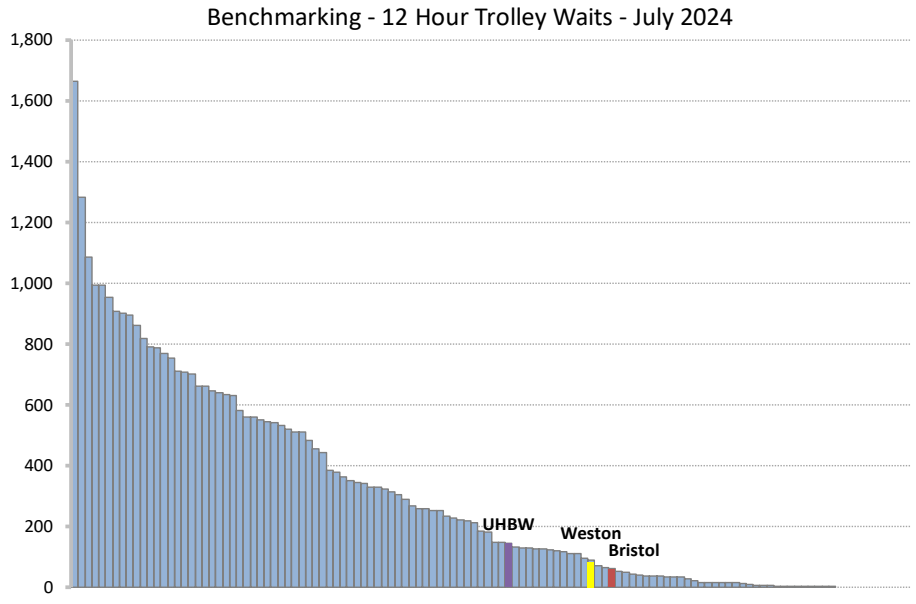
Reporting Month: July 2024

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	Jun	Jul
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	104	61
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	126	85
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**	**230**	**146**





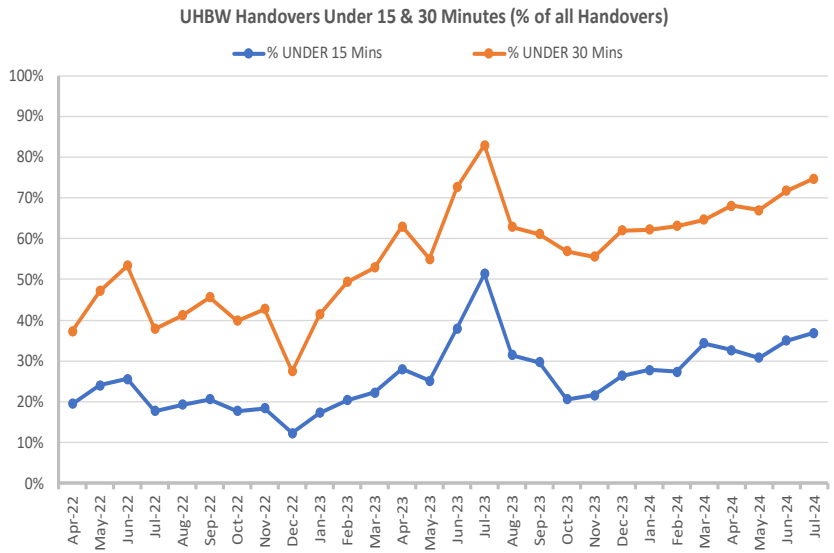
Integrated Quality and Performance Report

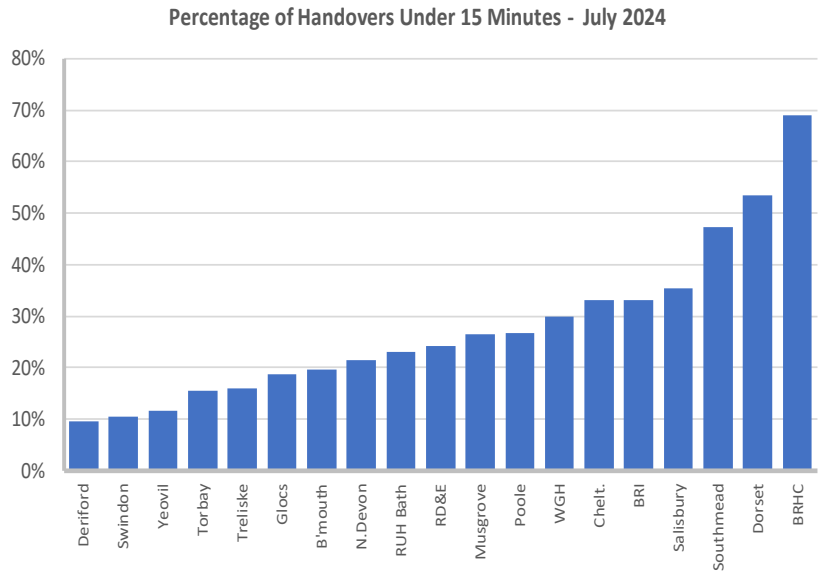
Reporting Month: July 2024

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

Ambulance Handovers

Jul-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	2,464	821	33.3%	1,759	71.4%	30.8	703
Bristol Children's Hospital	485	335	69.1%	447	92.2%	15.6	28
Weston General Hospital	977	292	29.9%	729	74.6%	28.0	229
UHBW Total	**3,926**	**1,448**	**36.9%**	**2,935**	**74.8%**	**28.2**	**960**





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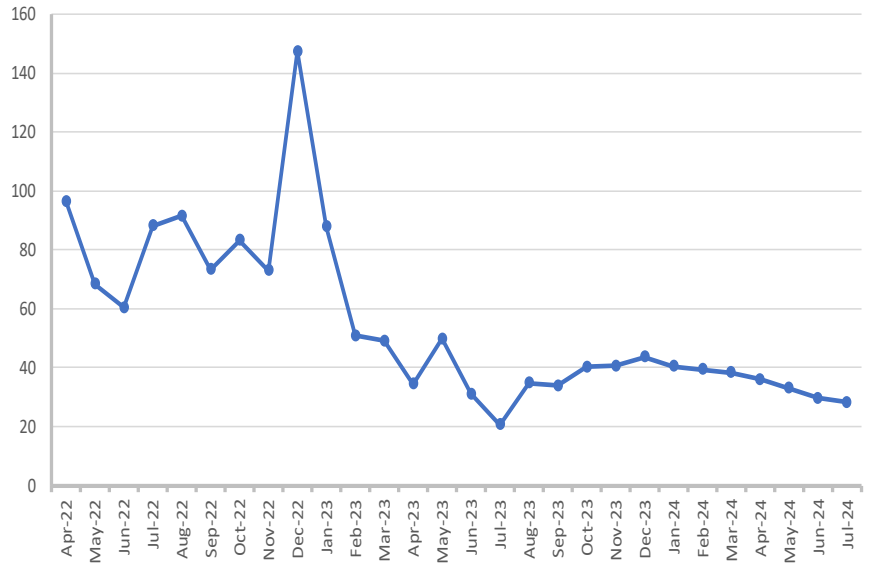
University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

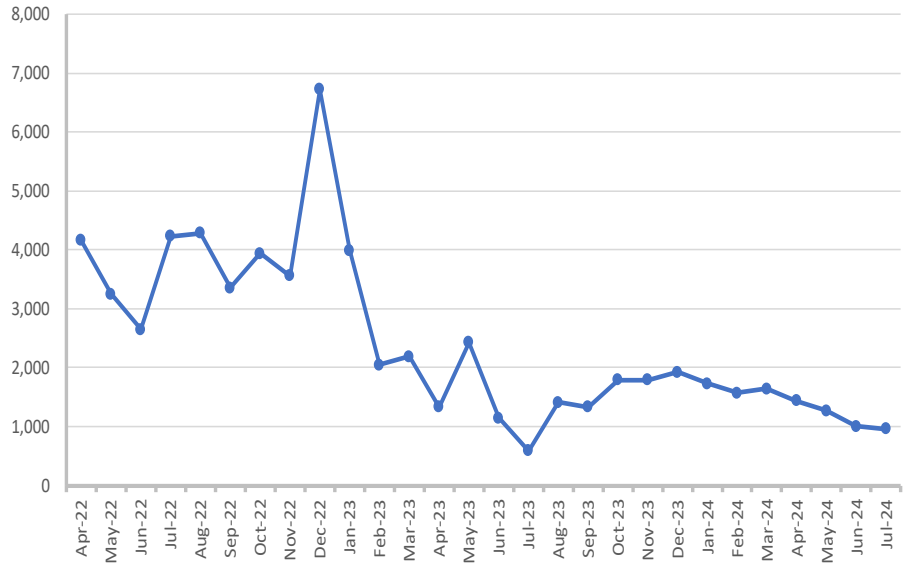
STANDARD **EMERGENCY DEPARTMENT – AMBULANCE HANDOVERS AND WAITS IN A&E**

Ambulance Handovers (continued)

Average Handover Time (Minutes)



Hours Lost: Handovers over 15 Minutes



Integrated Quality and Performance Report

Reporting Month: July 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). July had 17.2% discharged before 12 noon (+0.9% when compared to June). 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 July 28.3% of eligible discharges went through the Weston or BRI Discharge Lounges, compared to 25.3% in June. This was 840 patients, averaging 36.5 patients per working day (excluding bank holidays). a. BRI achieved 29.1%, with 616 patients. This averages to 26.8 patients per working day (excluding bank holidays). b. Weston achieved 26.2% with 224 patients. This averages to 9.7 patients per working day (excluding bank holidays). 3. At the end of July there were 172 No Criteria To Reside (NCTR) patients in hospital: 98 in Bristol and 74 in Weston. 4. During July, 5,193 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 168 (65 at Weston and 103 at Bristol). This is equivalent to saying 168 beds, on average, were occupied each day by NCTR patients. For July, the NCTR bed days occupied 19.4% of the total occupied bed days.

Integrated Quality and Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 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:** the new reporting process in place from 10th June is now well established, with good levels of reporting compliance. Work continues to integrate the reporting into the morning proactive board rounds and avoid duplication of tasks for ward staff. • **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. Technical issues with wardview at Weston have been resolved and an SBAR to ensure to agree rollout timings (and any support needed) will be discussed at the Digital Hospital Programme Board shortly. • **Every Minute Matters team:** The Every Minute Matters Clinical Lead left in June, with their replacement taking up the post on 2nd September 2024. **Proactive Hospital Improvement Coach supported work:** • **Discharge checklist:** feedback on the new process is largely positive, however there has been a dip in compliance since launch. Divisions have been asked to review compliance in their areas and report any concerns or improvements needed via the Every Minute Matters programme group • **BRI ED to CT pathway review:** project group set up and process mapping underway. • **Interprofessional standards:** work to date is under review in the context of recently issued GIRFT guidelines 'Principles for Acute Patient Care'. Recent meeting discussions have suggested that this work should proceed after the Specialty review and ED/Radiology pathways projects to help ensure the right foundations are in place, and that it is correctly aligned with the GIRFT Principles for Acute Patient Care. • **Specialty pathways review**: Divisional leads are not yet in place to support this work. Further request through Divisions underway. • **ED/Radiology pathways**: process mapping is now complete with value stream mapping underway. This will be aligned with the Acute Patient Care Principles focussed on diagnostics turnaround times for UEC areas.

Integrated Quality and Performance Report

Reporting Month: July 2024

STANDARD	EVERY MINUTE MATTERS
Actions (continued):	**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 establishing a 7-day working model • North Somerset Council to resource a 5 day model in the Weston Hub from September • Voluntary Sector continuing support at both Transfer of Care Hubs with training, education and awareness roll-out plans scheduled A significant focus on the Transfer of Care Hubs is on transformation and improvement, with the following initiatives underway: • The number of bed days associated with longest 10 patients remaining in hospital who no longer require acute care has decreased from 1,063 in January 2024 to 455 in July 2024. Efforts ongoing to sustain and further reduce NCTR bed days. • Bristol City Council have reduced the time it has taken to complete a Care Act Assessment from 5.5 days to 2.2 days (60% reduction). System discussions underway to routinely report process measures supporting the Transfer of Care Hub KPI's • Discharge To Assess (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 based upon 22/23. Work continues to set performance trajectories to reduce LOS. • The Trust continues to prioritise improving timely discharges to support the reduction in Length of Stay. Pathway 0 timely discharge is the highest it's been since April 2023 – 18%. Pathway 1 -3 timely discharges 47%. Focussed improvement work ongoing on our "Golden Patient" wards – Pilot extended to 7 wards. • Significant shift away from nursing care home to more Home First options • Partnering with NHS@Home service across both sites to set up processes to avoid cancellations, increase early supported discharge and reduce likelihood of readmission by linking D2A pathways with NHS@Home to meet patients needs at home before considering hospital admission. • 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%, June Audit: BRI:72%, WGH: 34%). Action plan to be created to improve Weston performance. Alongside a robust mechanism to record monthly performance and set performance trajectories. • Pathway 1 direct referral pilot ongoing - reviewing opportunities to streamline referrals to community services to promote Home First and reduce delays within hospital.
Risks:	n/a

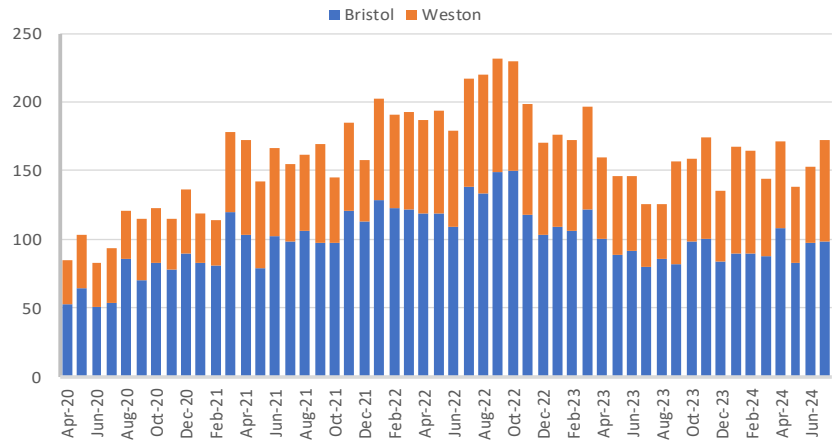
Integrated Quality and Performance Report

University Hospitals Bristol and Weston NHS Foundation Trust

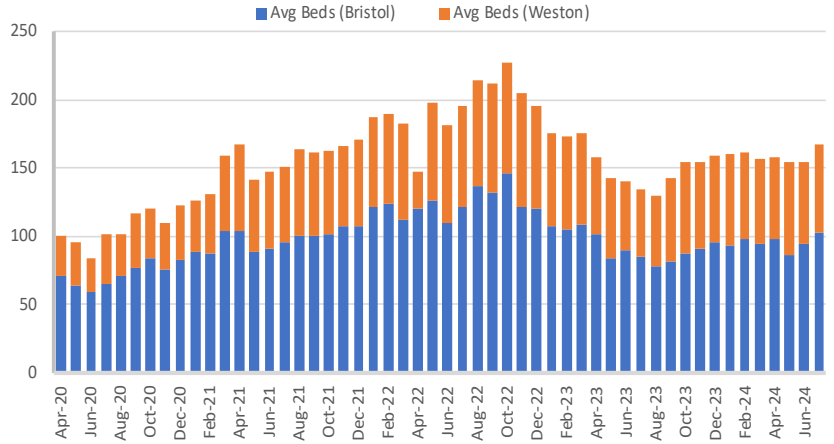
Reporting Month: July 2024

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

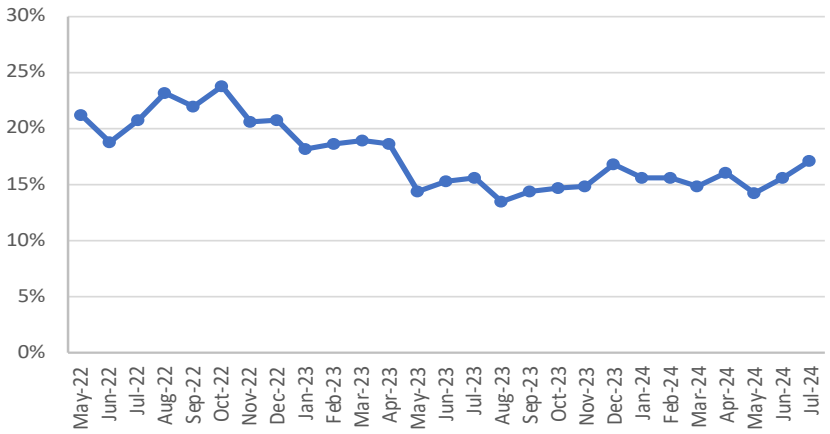
Number of Patients - Last Thursday in the Month



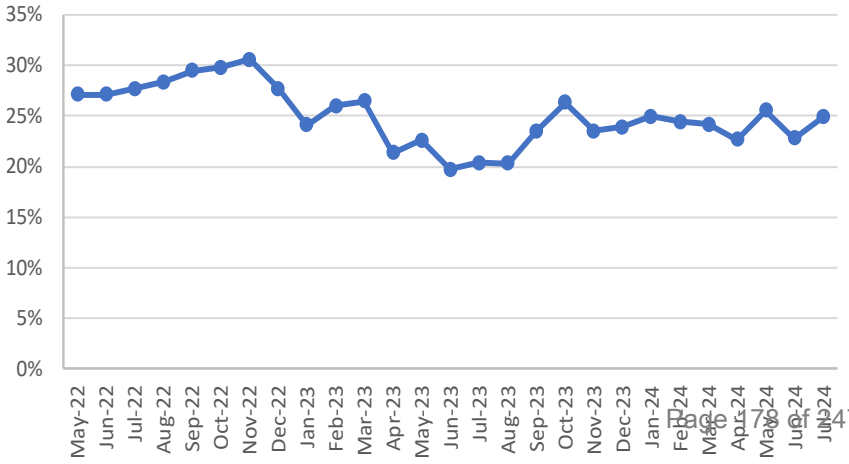
Average Number of Beds Occupied by NCTR Patients



NCTR Beddays as Percentage of All Beddays - Bristol



NCTR Beddays as Percentage of All Beddays - Weston



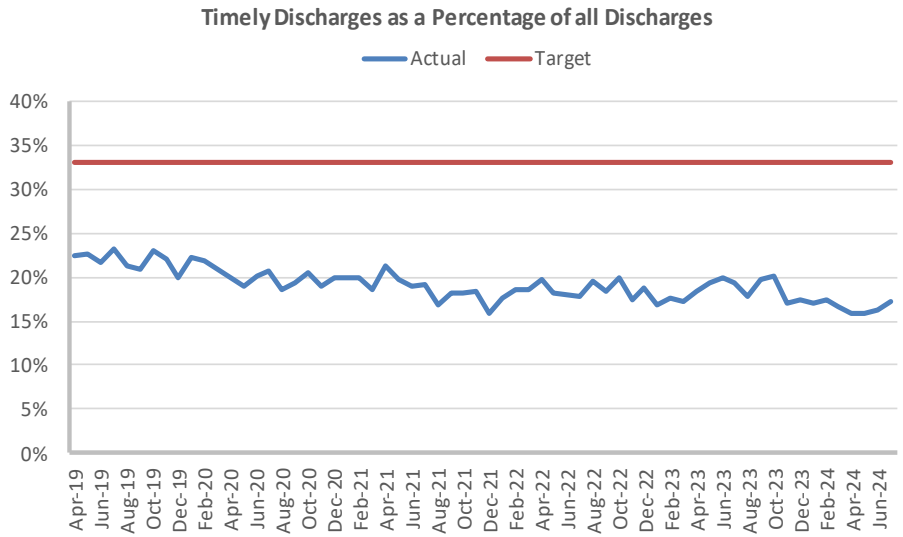
Integrated Quality and Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

STANDARD **EVERY MINUTE MATTERS - TIMELY DISCHARGE**

Timely Discharge (Before 12 Noon)



Summary of High Volume Specialties - July 2024

	Total Discharges	% Before Noon
Cardiac Surgery	117	12.8%
Cardiology	316	15.2%
Clinical Oncology	80	7.5%
Colorectal Surgery	98	17.3%
ENT	87	12.6%
Gastroenterology	128	15.6%
General Medicine	631	21.1%
General Surgery	257	11.7%
Geriatric Medicine	273	28.6%
Gynaecology	162	16.0%
Ophthalmology	87	51.7%
Paediatric Surgery	87	14.9%
Paediatrics	183	11.5%
Thoracic Medicine	176	14.2%
Trauma & Orthopaedics	198	24.2%
Upper GI Surgery	51	17.6%
UHBW TOTAL	**4,028**	**17.2%**

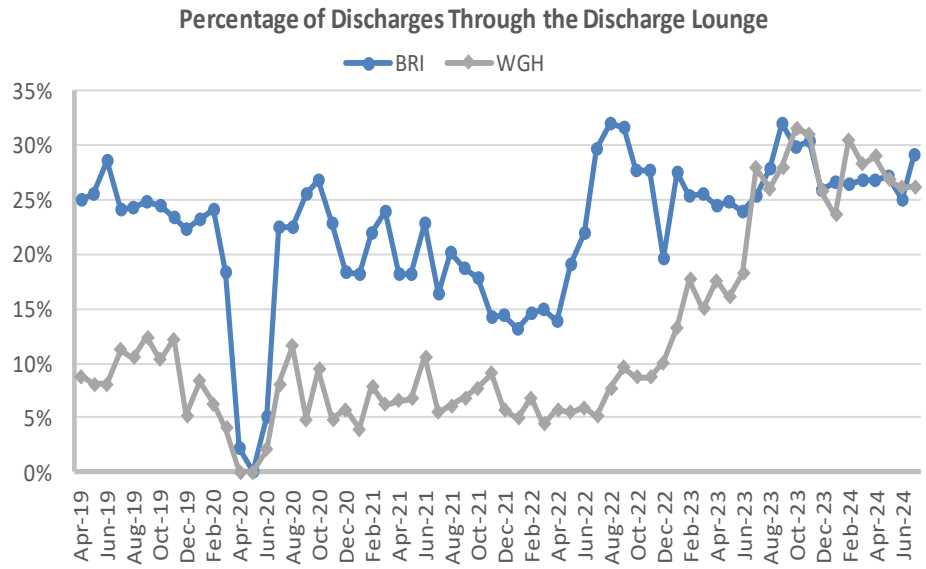
Integrated Quality and Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

STANDARD **EVERY MINUTE MATTERS - TIMELY DISCHARGE**

Discharge Lounge Use Summary



Summary of High Volume Specialties - July 2024

	BRI	WGH	TOTAL
Accident & Emergency	7.5%	0.0%	5.5%
Cardiac Surgery	79.7%	-	79.7%
Cardiology	46.9%	25.0%	45.5%
Colorectal Surgery	25.0%	21.1%	24.2%
ENT	14.1%	-	14.1%
Gastroenterology	23.0%	37.5%	29.4%
General Medicine	26.1%	28.4%	27.5%
General Surgery	8.4%	33.3%	14.2%
Geriatric Medicine	40.7%	30.2%	38.7%
Hepatobiliary and Pancreatic Surgery	40.0%	-	40.0%
Maxillo Facial Surgery	7.0%	-	7.0%
Thoracic Medicine	20.3%	7.4%	16.3%
Thoracic Surgery	35.1%	-	35.1%
Trauma & Orthopaedics	24.3%	48.8%	34.4%
Upper GI Surgery	43.2%	25.0%	38.8%
UHBW TOTAL	**29.1%**	**26.2%**	**28.3%**

Integrated Quality and Performance Report

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

2024/25 YTD Income & Expenditure Position	• **Net I&E deficit of £7,738k against a breakeven plan (excluding technical items).** • **Total operating income is £1,629k adverse to plan due to lower than planned income from activities (£2,489k) offset by other operating income (£860k).** • **Total operating expenditure is £7,361k adverse to plan due to higher than planned non-pay costs at £2,660k and higher than planned pay expenditure at £3,466k. Depreciation and financing costs combined are £475k behind plan.**
Key Financial Issues	• ***Recurrent savings delivery below plan*** **– YTD CIP delivery is £7,493k, behind plan by £5,789k or 44%. Recurrent savings are £4,243k, 32% of plan.** • ***Delivery of elective activity below plan*** **– elective activity must be delivered in line with plan. The cumulative YTD value of elective activity is £3.0m behind plan, a deterioration of £1.0m in July. A continuation of the YTD performance could result in a total loss of income of up to £9.0m and may result in the Trust failing to meet the financial plan.** • ***Corporate mitigations not delivered in full*** **– non-recurrent mitigations are on track to deliver in full.** • ***Failure to deliver the financial plan*** **– failure to deliver the savings and ERF requirement and therefore the financial plan of break-even will constitute a breach of this statutory duty and will result in regulatory intervention.**
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: July 2024

Trust Year to Date Financial Position

	Month 4			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	91,805	89,694	(2,111)	362,824	360,335	(2,489)
Other Operating Income	9,886	12,386	2,500	39,544	40,404	860
Total Operating Income	**101,691**	**102,080**	**389**	**402,368**	**400,739**	**(1,629)**
Employee Expenses	(59,618)	(61,976)	(2,358)	(238,472)	(241,938)	(3,466)
Other Operating Expenses	(37,585)	(35,300)	2,285	(146,010)	(149,754)	(3,744)
Depreciation (owned & leased)	(3,395)	(3,413)	(18)	(13,514)	(13,664)	(150)
Total Operating Expenditure	**(100,598)**	**(100,690)**	**(92)**	**(397,996)**	**(405,357)**	**(7,361)**
PDC	(1,210)	(1,208)	2	(4,840)	(4,833)	7
Interest Payable	(247)	(148)	99	(988)	(917)	71
Interest Receivable	292	451	159	1,168	1,849	681
Net Surplus/(Deficit) inc technicals	**(72)**	**485**	**557**	**(288)**	**(8,519)**	**(8,231)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	72	140	68	288	781	493
Net Surplus/(Deficit) exc technicals	**0**	**625**	**625**	**0**	**(7,738)**	**(7,738)**

Key Facts:

- In July, the Trust delivered a £625k surplus against a plan of break-even. The cumulative YTD position at the end of July is a net deficit of £7,738k (£8,363k at Q1) against a breakeven plan. The Trust is therefore £7,738k (£8,363k at Q1) adverse to plan. The cumulative YTD net deficit is c2% of total operating income.
- Significant variances in the year-to-date position include: the value of elective income behind plan by £3,000k, a shortfall on savings delivery of £5,789k, £1,072k costs associated with industrial action and £1,100k of pay pressures relating to nursing and medical staff.
- At the end of July, the Trust has spent £435k on costs associated with Internationally Educated Nurses (IENs).
- YTD pay expenditure at the end of July is £3,466k higher than plan as higher than planned medical staffing and nursing costs continue to cause concern across some divisions with continuing high pay costs in total across substantive, bank and agency staff.
- Agency expenditure in month is £1,186k, compared with £1,003k in June. Bank expenditure reduced in month to £4,994k, from £5,122k in June.
- Total operating income is below plan by £1,629k, mainly due to the shortfall in ERF offset by higher than planned pass-through payments.
- The financial position of the clinical divisions, excluding industrial action, shows a deterioration of £2,650k in July, to a YTD overspend against budget of £12,132k or 3.9%.
- The most significant variances to budget in percentage and absolute terms are in: Surgery (£3,589k or 5.4%); and Women's & Children's (£5,178k or 7.0%).

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board held in Public on 10 September 2024

Reporting Committee	**Finance, Digital & Estates Committee – July 2024**
Chaired By	**Arabel Bailey, Non-Executive Director (deputising for Martin Sykes)**
Executive Lead	**Neil Kemsley, Chief Financial Officer**

For Information

1. The committee received the Trust Financial Performance report for Month 3 (June 2024) and it was reported that there was a net deficit of £8.4 million in the Trust's actual net income and expenditure against a break even plan. The net deficit had increased by £2 million in June 2024. At a system level there was a £19.2 million deficit against a £5.8 million deficit plan. Non-Executive Directors questioned what was being to done to recover the shortfall, and the importance of sticking to the original plan was stressed. There is a collective focus on ensuring that there is no further deterioration in month 4 and the commitment remained to deliver break-even by the end of the year.

2. As part of the Digital Update report it was reported that the CareFlow Medicines Management (CMM) project, which was due to go live in July, would have to be delayed. Quality assurance processes were being carried out, with the Divisions assisting with software testing and process mapping. This was a substantial task, which had resulted in the Vitals and CareFlow EPR upgrades being removed from the project plan for 2024 because of technical and resource conflicts with CMM. The committee recognised the benefits this project would bring across the Trust, and also the transformation effort required to deliver it.

3. The committee reviewed the new Board Assurance Framework (BAF) in relation to the elements that related to the responsibilities of the committee, namely the financial, estate infrastructure, fire safety and digital / cyber risks. The revised format was praised by committee members as providing greater clarity on the Trust's principal risks.

4. An update on strategic estates development was provided which outlined the current status of feasibility studies which were started in 2023/2024 and the planned next steps for 2024/2025 strategic funding prioritisation. The report also described the ongoing work to support the development of an ICS infrastructure strategy, including the agreed top five acute strategic capital priorities. The important and positive progress, particularly the collaborative work with NBT, in influencing the ICB about major schemes, was noted by the committee.

For Board Awareness, Action or Response

5. The Committee discussed capital spending, and it was reported that the Trust has overprogrammed capital spend by approximately 23% for 2024/25 to ensure the full allocation was spent, as has been achieved in previous years. It was

University Hospitals Bristol and Weston NHS Foundation Trust

agreed that a detailed report on capital forward planning would come to the October Finance, Digital and Estates Committee meeting.
Key Decisions and Actions
6. The Committee considered the draft strategic outline case for the Enterprise Network Replacement Programme and provided feedback on its contents. It was noted that this would come back for further consideration to the September meeting of the committee.
Additional Chair Comments
7. It is great to see continuing improvements in the papers coming to the committee (particularly the Digital Services report and the BAF). These provide much clearer information and give a better basis for discussion. It is also good to see elements of the approved Digital Strategy progressing; in this case, the SOC for the Network Replacement Programme.
Update from ICB Committee
N/A

Date of next meeting:	**24 September 2024**

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 2024		
Report Title:	Trust Finance Performance Report		
Report Author:	Jeremy Spearing, Director of Operational Finance		
Report Sponsor:	Neil Kemsley, Chief Financial Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			Yes
	To inform the Trust Board of the Trust's overall financial performance from 1st April 2024 to 31st July 2024 (month 4).		

Key Points to Note *(Including any previous decisions taken)*

The Trust's net income and expenditure position at the end of July is a deficit of £7.7m against a break-even plan. This position includes unfunded costs of £1.1m in relation to industrial action. The adverse position against plan of £7.7m is primarily due to the shortfall on the delivery of savings and elective inpatient activity not achieving planned levels.

The Trust delivered savings of £7.5m, £5.8m behind plan. The forecast for recurrent savings delivery is £26.8m against a plan of £41.2m.

The value of elective activity for outpatient, day case and inpatient delivery points fell further behind plan in July, deteriorating by £1.0m to £3.0m behind plan year to date.

The Trust delivered capital investment of £7.4m year to date.

The Trust's cash position was £90.8m as at the 31st July 2024, £3.7m higher than plan.

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

- Responding to the NHSE requirement in relation to the incoming audit of workforce controls and headcount growth benefits realisation assessment;
- Agreement of Division and Corporate Services Control Totals by the end of September, following a review of M5 Forecast Outturns (FOTs);
- Production of the Trust's Financial Recovery Plan (FRP) and FOT scenarios including the potential response to Phase 2 of the Systems FOT change protocol;
- Recovery actions agreed and implemented in any areas where substantive workforce costs exceed funded levels, excluding areas of accepted over-establishment, such as escalation capacity;
- Divisions, Corporate Services and Corporate Workstreams to ensure recurrent CIP schemes are set out by 2nd September that fully recover the year to date shortfall and deliver the 2024/25 efficiency requirement of £41.2m. Commission further external support with CIP delivery;
- 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; and
- Agreed route to deliver the Trust's non-recurrent corporate mitigations of £15m including further potential income opportunities.

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.	
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 month 5 FOT in September.	
Recommendation	
This report is for **Information.** The Board is asked to note the Trust's financial performance for the period.	
History of the paper (details of where paper has <u>previously</u> been received)	
[Name of Committee/Group/Board] N/A	[Insert Date paper was received] N/A
Appendices:	N/A

University Hospitals Bristol and Weston NHS Foundation Trust

Trust Finance Performance Report

Reporting Month: July 2024

Executive Summary

University Hospitals Bristol and Weston NHS Foundation Trust

Reporting Month: July 2024

2024/25 YTD Income & Expenditure Position	• Net I&E deficit of £7,738k against a breakeven plan (excluding technical items). This position includes unfunded costs of £1,072k in relation to industrial action. NHSE are indicating this will not be treated as a financial performance failure against the break-even plan. • Total operating income is £1,629k adverse to plan due to lower than planned income from activities (£2,489k) offset by other operating income (£860k). • Total operating expenditure is £7,361k adverse to plan due to higher than planned non-pay costs at £2,660k and higher than planned pay expenditure at £3,466k. Depreciation and financing costs combined are £475k behind plan.
Key Financial Issues	• *Recurrent savings delivery below plan* – YTD CIP delivery is £7,493k, behind plan by £5,789k or 44%. Recurrent savings are £4,243k, 32% of plan. • *Delivery of elective activity below plan* – elective activity must be delivered in line with plan. The cumulative YTD value of elective activity is £3.0m behind plan, a deterioration of £1.0m in July. A continuation of the YTD performance could result in a total loss of income of up to £9.0m and may result in the Trust failing to meet the financial plan. • *Corporate mitigations not delivered in full* – non-recurrent mitigations are on track to deliver in full. • *Failure to deliver the financial plan* – failure to deliver the savings and ERF requirement and therefore the financial plan of break-even will constitute a breach of this statutory duty and will result in regulatory intervention.
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: July 2024

Successes

- Delivery of capital investment of £1.7m in July, £7.4m YTD.
- The Trust's cash position remains strong at £90.8m, £3.7m ahead of plan.
- BPPC performance remains good at 91% for invoices paid within 30 days by value and 89% for invoices paid by volume.
- Increase in the Trust's CDEL by £8.8m as "incentive" CDEL from NHSE as a result of the BNSSG System submitting a break-even 2024/25 financial plan in May.
- Implementation of the Trust's new invoice approval system.
- Re-casting of the 2024/25 elective activity plan including productivity opportunities to support delivery of the elective recovery requirement for break-even.
- The Trust's productivity as measured by NHSE is in line with plan at the end of July.

Priorities

- Responding to the NHSE requirement in relation to the incoming audit of workforce controls and headcount growth benefits realisation assessment.
- Agreement of Division and Corporate Services Control Totals by the end of September, following a review of M5 FOTs.
- Production of the Trust's Financial Recovery Plan (FRP) and FOT scenarios including the potential response to Phase 2 of the Systems Forecast Outturn change protocol.
- Recovery actions agreed and implemented in any areas where substantive workforce costs exceed funded levels, excluding areas of accepted over-establishment, such as escalation capacity.
- Divisions, Corporate Services and Corporate Workstreams to ensure recurrent CIP schemes are set out by 2nd September that fully recover the YTD shortfall and deliver the 2024/25 efficiency requirement of £41.2m. Commission further external support with CIP delivery.
- 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.
- Agreed route to deliver the Trust's non-recurrent corporate mitigations of £15m including further potential income opportunities.

Opportunities

- Further discussions with NHSE in relation to Weston CDEL settlement.
- Securing the financial and non-financial benefits of fully established nursing and midwifery ward areas through further reductions in temporary bank and agency expenditure.
- Implementation of additional workforce cost controls, including the imposition of targeted pauses in recruitment to reduce the Trust's rate of pay expenditure.
- Executive agreement to additional Divisional support as requested by Divisions necessary to secure improvement in CIP delivery.

Risks & Threats

- Insufficient reduction in "No Criteria To Reside" patients therefore, displacing the Trust's ability to deliver the elective activity plan and/or remove escalation capacity and ward costs.
- 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 and failure of the approved break-even plan.
- Under-delivery against the Trust's elective inpatient activity plan could 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

July 2024

Trust Year to Date Financial Position

	Month 4			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	91,805	89,694	(2,111)	362,824	360,335	(2,489)
Other Operating Income	9,886	12,386	2,500	39,544	40,404	860
Total Operating Income	**101,691**	**102,080**	**389**	**402,368**	**400,739**	**(1,629)**
Employee Expenses	(59,618)	(61,976)	(2,358)	(238,472)	(241,938)	(3,466)
Other Operating Expenses	(37,585)	(35,300)	2,285	(146,010)	(149,754)	(3,744)
Depreciation (owned & leased)	(3,395)	(3,413)	(18)	(13,514)	(13,664)	(150)
Total Operating Expenditure	**(100,598)**	**(100,690)**	**(92)**	**(397,996)**	**(405,357)**	**(7,361)**
PDC	(1,210)	(1,208)	2	(4,840)	(4,833)	7
Interest Payable	(247)	(148)	99	(988)	(917)	71
Interest Receivable	292	451	159	1,168	1,849	681
Net Surplus/(Deficit) inc technicals	**(72)**	**485**	**557**	**(288)**	**(8,519)**	**(8,231)**
Remove Capital Donations, Grants, and Donated Asset Depreciation	72	140	68	288	781	493
Net Surplus/(Deficit) exc technicals	**0**	**625**	**625**	**0**	**(7,738)**	**(7,738)**

Clinical Divisions YTD Financial Position – Variance to Budget

Division	M4 YTD Variance Favourable/(Adverse) £000's	M3 YTD Variance Favourable/(Adverse) £000's	(Increase) / Decrease in Variance £000's	M4 YTD Variance exc. Industrial Action Favourable/(Adverse) £000's	M4 YTD Variance exc. Industrial Action as % of Budget
Diagnostics & Therapies	(1,111)	(547)	(564)	(1,104)	-3.2%
Medicine	(809)	(809)	0	(525)	-1.0%
Specialised Services	(710)	(986)	276	(610)	-1.0%
Surgery	(3,589)	(3,214)	(375)	(3,393)	-5.2%
Weston	(735)	(445)	(290)	(461)	-2.5%
Women's & Children's	(5,178)	(3,481)	(1,697)	(4,886)	-6.7%
Clinical Divisions Total	**(12,132)**	**(9,482)**	**(2,650)**	**(10,979)**	**-3.6%**
Estates & Facilities	(182)	(303)	121	(163)	-0.8%
Total	**(12,314)**	**(9,785)**	**(2,529)**	**(11,142)**	**-3.4%**

Key Facts:

- In July, the Trust delivered a £625k surplus against a plan of break-even. The cumulative YTD position at the end of July is a net deficit of £7,738k (£8,363k at Q1) against a breakeven plan. The Trust is therefore £7,738k (£8,363k at Q1) adverse to plan. The cumulative YTD net deficit is c2% of total operating income.
- Significant variances in the year-to-date position include: the value of elective income behind plan by £3,000k, a shortfall on savings delivery of £5,789k, £1,072k costs associated with industrial action and £1,100k of pay pressures relating to nursing and medical staff.
- At the end of July, the Trust has spent £435k on costs associated with Internationally Educated Nurses (IENs).
- YTD pay expenditure at the end of July is £3,466k higher than plan as higher than planned medical staffing and nursing costs continue to cause concern across some divisions with continuing high pay costs in total across substantive, bank and agency staff.
- Agency expenditure in month is £1,186k, compared with £1,003k in June. Bank expenditure reduced in month to £4,994k, from £5,122k in June.
- Total operating income is below plan by £1,629k, mainly due to the shortfall in ERF offset by higher than planned pass-through payments.
- The financial position of the clinical divisions, excluding industrial action, shows a deterioration of £2,650k in July, to a YTD overspend against budget of £12,132k or 3.9%.
- The most significant variances to budget in percentage and absolute terms are in: Surgery (£3,589k or 5.4%); and Women's & Children's (£5,178k or 7.0%).

Savings – Cost Improvement Programme

NHS University Hospitals Bristol and Weston NHS Foundation Trust

July 2024

Division	2024/25 Programme			Progress to Date					Forecast Outturn					Full Year Forecast Outurn	Full Year Forecast Outurn Variance
				2024/25 Programme					2024/25 Programme						
					<-------- Actual -------->			Variance	Current Year				Variance		
	2023/24 Recurrent shortfall*	2024/25 Target (2%)	2024/25 Total Target	Current Plan	Recurring	Non-Recurring	Total	Fav / (Adv)	Current Plan	Recurring	Non-Recurring	Total	Fav / (Adv)	Total	Fav / (Adv)
Financial Performance	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Diagnostics & Therapies	543	1,741	2,284	746	237	124	361	(385)	2,284	868	365	1,234	(1,050)	1,148	(1,136)
Medicine	416	2,180	2,596	1,079	1,077	-	1,077	(2)	4,008	4,017	-	4,017	9	5,398	2,802
Specialised Services	(377)	2,095	1,718	527	343	129	472	(55)	1,718	1,132	385	1,516	(202)	1,397	(322)
Surgery	1,285	3,411	4,696	1,481	708	-	708	(772)	4,696	2,267	28	2,295	(2,401)	2,670	(2,026)
Weston	(156)	1,045	889	303	240	-	240	(64)	889	719	-	719	(171)	773	(116)
Women's & Children's	397	3,316	3,713	1,400	1,397	-	1,397	(3)	4,260	4,235	-	4,235	(26)	5,411	1,698
Estates & Facilities	194	1,097	1,292	382	46	383	429	47	1,292	441	714	1,155	(136)	946	(346)
Finance	(0)	226	225	126	101	-	101	(25)	379	304	-	304	(75)	304	78
HR	(0)	274	273	91	51	19	69	(21)	273	159	56	215	(58)	163	(110)
Digital Services	566	428	994	343	2	243	245	(98)	994	6	694	700	(294)	6	(988)
Trust HQ	417	517	935	312	40	18	59	(253)	935	121	55	176	(759)	121	(814)
Corporate	-	10,385	10,385	3,824	-	2,333	2,333	(1,490)	11,472	4,500	7,000	11,500	28	4,500	(5,885)
			-												
Divisional Sub Totals	**3,286**	**26,714**	**30,000**	**10,615**	**4,243**	**3,249**	**7,493**	**(3,122)**	**33,200**	**18,769**	**9,297**	**28,066**	**(5,134)**	**22,835**	**(7,165)**
Urgent & Emergency Care	-	**9,400**	**9,400**	**1,333**	-	-	-	**(1,333)**	**4,000**	**4,000**	-	**4,000**	-	**4,000**	**(5,400)**
Elective Recovery	-	-	-	**1,333**	-	-	-	**(1,333)**	**4,000**	**4,000**	-	**4,000**	-	**4,000**	**4,000**
Grand Totals	**3,286**	**36,114**	**39,400**	**13,282**	**4,243**	**3,249**	**7,493**	**(5,789)**	**41,200**	**26,769**	**9,297**	**36,066**	**(5,134)**	**30,835**	**(8,565)**

Key Points:

- The Trust's 2024/25 savings plan is £41,200k. This includes £8,000k attributable to Urgent & Emergency Care (UEC) investments delivering bed reductions and reduced insourcing and outsourcing costs of elective recovery.
- The Divisional plans represent 50% of the Trust's plans. Corporate workstreams are driving a significant proportion of the planned savings.
- As at month 4, the Trust is reporting total savings of £7,493k against a plan of £13,282k, a shortfall in delivery of £5,789k. The Trust is forecasting savings of £36,066k against the savings plans of £41,200k, a savings delivery shortfall of £5,134k.
- The full year effect forecast outturn at month 4 is £30,835k, a shortfall of £8,565k.
- The performance of the corporate workstreams supporting the Divisional plans require an urgent step change in delivery to recover the YTD and forecast shortfall on savings delivery. The Trust's Productivity & Financial Improvement Group (PFIG) will need to ensure traction is secured and delivery improves.

Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 2024		
Report Title:	UHBW Board Green Plan Annual Report for 2023-24		
Report Author:	Report - Samuel Willitts, Head of Sustainability for the BNSSG ICS UHBW Coversheet – Ned Maynard, UHBW Head of Sustainability		
Report Sponsor:	Neil Kemsley, Chief Financial Officer for UHBW		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			x
	Scheduled annual update to the board on UHBW's progress towards delivering the ICS Green Plan and where focus is needed going forward.		

Key Points to Note *(Including any previous decisions taken)*

The ICS Green Plan annual update is attached and sets out the future planning and deliverables across the system and gives for the first time a collective and cohesive approach to our pledge of achieving net zero by 2030. Below is a summary of the specific areas UHBW need to address in the coming years.

Net Zero (Direct Emissions)

This area is dominated by UHBW's use of gas for heating and hot water which means we ultimately need to de-gas the estate. The first step to de-gassing is to lower our heat temperatures which is very complicated in an aged estate like ours, but the UHBW Energy Team are working hard to progress a plan to how we will address lower temperatures. We will be requesting monies as previously stated to begin feasibility studies and capital works to lower our temperatures in 2024/25 with a view to ultimately making our gas-fired Combined Heat & Power engines redundant.

Procurement (Indirect Emissions)

This area is dominated by medical equipment, medical consumables and pharmaceuticals. The UHBW Sustainability Team has interacted with the medicine's optimisation workstream over the past year and awareness of the impact of indirect emissions is improving with work ongoing to address real reductions. Some significant progress has been made in the past year, particularly on anaesthetic gas capture and nitrous oxide manifold shutdowns. Future work here will revolve around establishing a functional workstream via the Green Plan Implementation Group to drive emission reductions across a broader range of medicines areas.

Waste

Over the past 4 years the UHBW Waste Team has been working with BWPC to procure innovative new waste contracts which will allow us to divert 100% of our waste from landfill. There have been some delays and extensions to this process, but we are working hard with BWPC colleagues to get a go live date in the next quarter, so we can realise the environmental and financial cost benefits.

Clean Air

UHBW are working to bring down air pollution levels around the Bristol site to match the background ambient pollution of the wider city. This year we had shorelines installed so ambulances in the A&E queue can plug in and switch off their engines while waiting. We also hosted a Clean Air Day campaign to promote better travel alternatives. In 2022 Bristol introduced a Clean Air Zone which has lowered overall ambient pollution levels in the city, and the BRI site mean pollution levels are now broadly aligned to the wider city ambient for NO_2 and PM 2.5. However, this mean hides some poorly performing areas including Alfred Parade and the Ambulance Bay which have remained at elevated levels of pollution since 2023. We have already begun a system-wide transport optimisation project to reduce vehicle movements between sites which should reduce air pollution and transport costs. We will also conduct a piece of work to establish what can feasibly be done to further lower air pollution on Alfred Parade and the Ambulance Bay to reach city ambient levels.

Communications & Engagement

UHBW have come to the end of our app-based engagement platform called Greener Together so are reviewing how to take this forward. This workstream is led by NBT who will be making recommendations to the Green Plan Steering Group on the preferred way forward in the coming months.

Note

- To support ongoing monitoring and assurance, a UHBW internal audit is currently planned, looking at the Trust's own elements in the delivery of the ICS Green Plan. See Appendix 1 for the terms of reference for the audit.

Strategic Alignment

Each NHS Trust is required to have a Green Plan and monitor progress against it. The Green Plan stream of work most closely aligns with the true north strategic objective of 'making the most of our resources'.

Risks and Opportunities

There are financial and reputational risks associated with not meeting the objectives of the ICS Green Plan. See Datix Risk ID 3472

Recommendation

This report is for **Information**

The board is asked to note that:

- Net Zero (Direct Emissions) – A financial investment and delivery plan is required for the human resource, feasibility and capital work for lowering temperatures.

- Procurement (Indirect Emissions) - We need to expand existing medicines optimisation work and identify a pipeline of future net zero opportunities within pharmaceuticals etc. This will be done via the Green Plan Steering Group and Green Plan Implementation Group structure.

- Waste - The new waste contracts need to be expedited to enable delivery of the strategic waste objectives.

History of the paper (details of where paper has <u>previously</u> been received)	
BNSSG Directors of Finance Meeting BNSSG Green Plan Steering Group BNSSG ICB Board Meeting	14th June 2024 30th July 2024 5th Sept 2024
Appendices:	Appendix 1, Green Plan Internal Audit Terms of Reference

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

Report title:

UHBW Board Green Plan Annual Report for 2023-24

1. Background

ICS partners across the system have been working to embed our ambitious sustainability goals and create a governance structure and delivery plan that sees us working together to achieve our immediate and future goals. This year has seen the publication of the ICS revised Green Plan, setting out our sustainability commitments and outcomes and confirming our aim to be a leader in delivering sustainable healthcare for our region. All ICS partners have signed up to the Green Plan, aligning our efforts and amplifying our action and outcomes. The ICS has also developed a delivery plan to drive implementation and monitor progress against the Green Plan commitments.

The Green Plan sets out three clear outcomes that we are working towards;

1. Net zero carbon by 2030 across scope 1, 2 and 3 emissions sources.
2. Improve the environment by reducing waste, improving air quality and restoring biodiversity.
3. Create a BNSSG wide movement to support a culture change amongst, staff, citizens and businesses.

Further development in the granularity of the delivery plan sets what our actions will achieve against these outcomes and identifies the gaps we need to focus on.

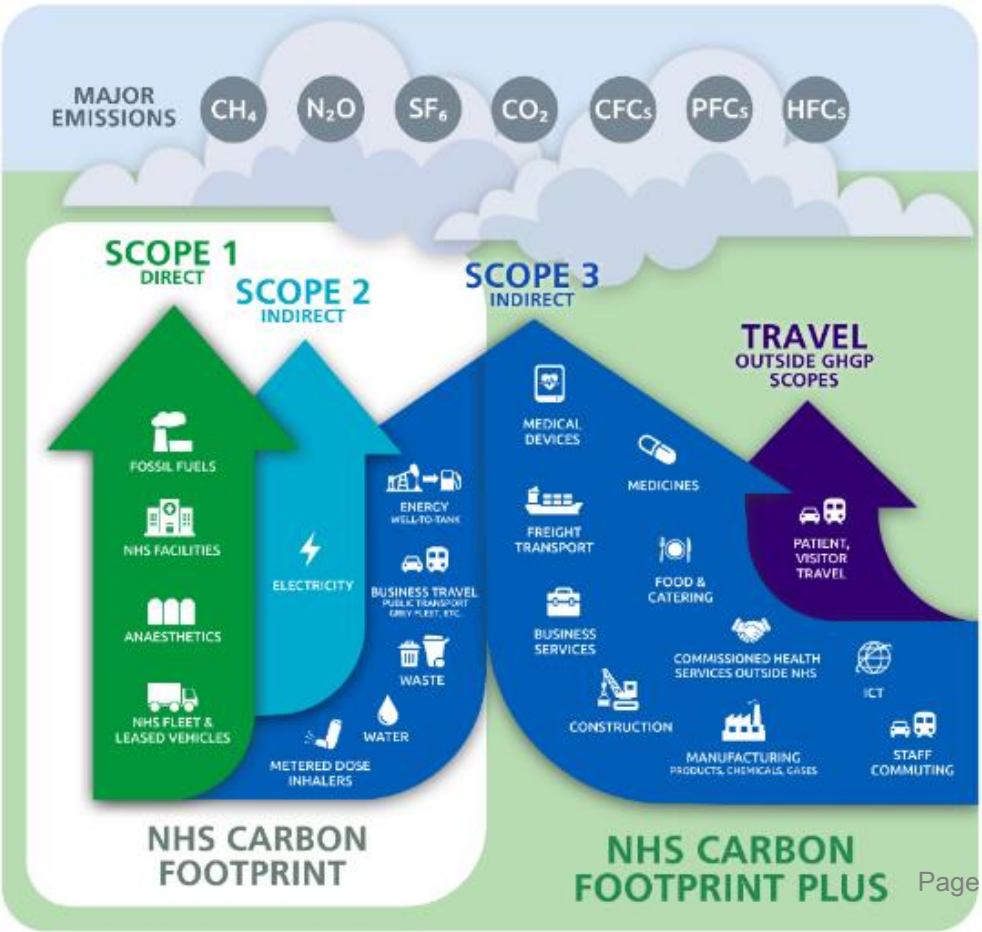


Figure 1 Scope 1, 2 and 3 emissions

This year, North Bristol and University Hospitals Bristol and Weston have worked together as one sustainability team along with colleagues from Sirona and Avon and Wiltshire Mental Health Partnership to achieve the Healthier Together Integrated Care System Green Plan objectives to mitigate the harmful impacts climate change will have on the health, wellbeing and livelihoods of the Bristol, North Somerset and South Gloucestershire population for generations to come. Achieving net zero, addressing the ecological emergency and building resilience to climate change through delivering our Green Plan will be crucial to delivering the best care for our patients now and in the future.

Throughout the year, our staff have reduced the environmental impact of their services whilst improving patient experience. Through conversations with our patients, we have learnt that reducing the carbon footprint of our services is important to them and their long-term health. We believe the way we deliver care to our patients should not harmfully impact the health of future populations and their ability to access outstanding levels of care.

This year we have refined our Green Plan Delivery Plan and prioritised projects for the future that will deliver the greatest carbon reduction and make best use of our resources. The Green Plan is delivered through six workstreams which are led by subject matter experts from each ICS organisation. The workstreams report into the Green Plan Implementation Group which reports into the Green Plan Steering Group of with ICS Executive Directors sustainability leads as members. Next year we hope to further embed net zero into organisation processes and spread the innovation at North Bristol Trust (NBT) such as carbon pricing, carbon budgets and headline objectives for divisions that can be monitored in Divisional Performance Reviews.

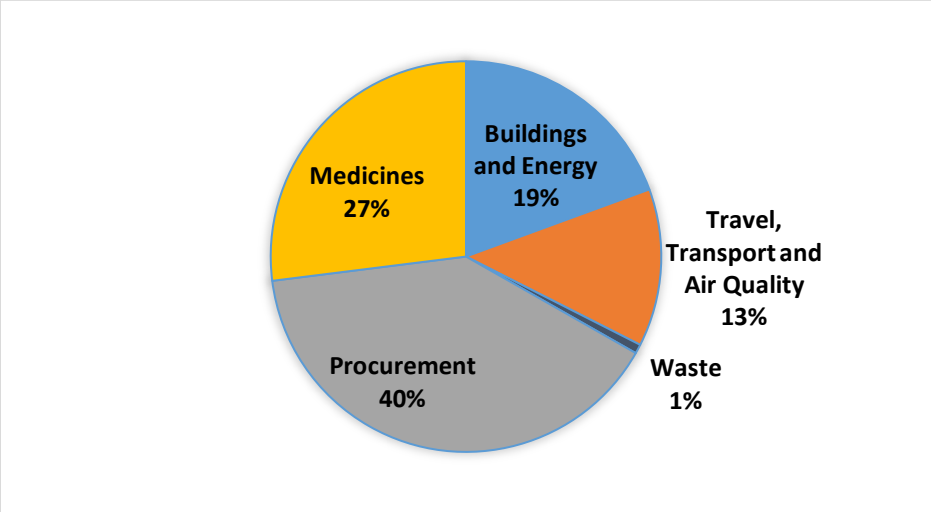


Figure 2 percentage of carbon emissions by workstream

An essential element for achieving net zero will be to reduce the demand on high cost and high carbon hospital services; realising the co benefits of prevention in improving the health of our population whilst reducing carbon and costs.

2. Net Zero Carbon by 2030

The carbon reduction trajectory towards net zero of the main delivery plan workstreams is set out below. Our Delivery plan (appendix 1) provides the detail of the carbon reductions that would be delivered by achieving the targets we have identified in our workstreams. To achieve net zero following the Science Based Targets Initiative approach we must reduce

our emissions by 90% to 39,514 tonnes CO_2e. The remaining 10% is to be addressed by offset schemes - investing in projects that result in permanent carbon removal and storage to counterbalance the residual 10% of emissions that cannot be eliminated.

Current actions will deliver carbon reduction of 257k tonnes CO_2e, but this assumes there is capital funding available to decarbonise our buildings and energy. The gap remaining from our current delivery plan is 98k tonnes CO_2e for which we will need to identify further actions and funding. Without funding for buildings and energy decarbonisation the gap increases to 143k tonnes CO_2e.

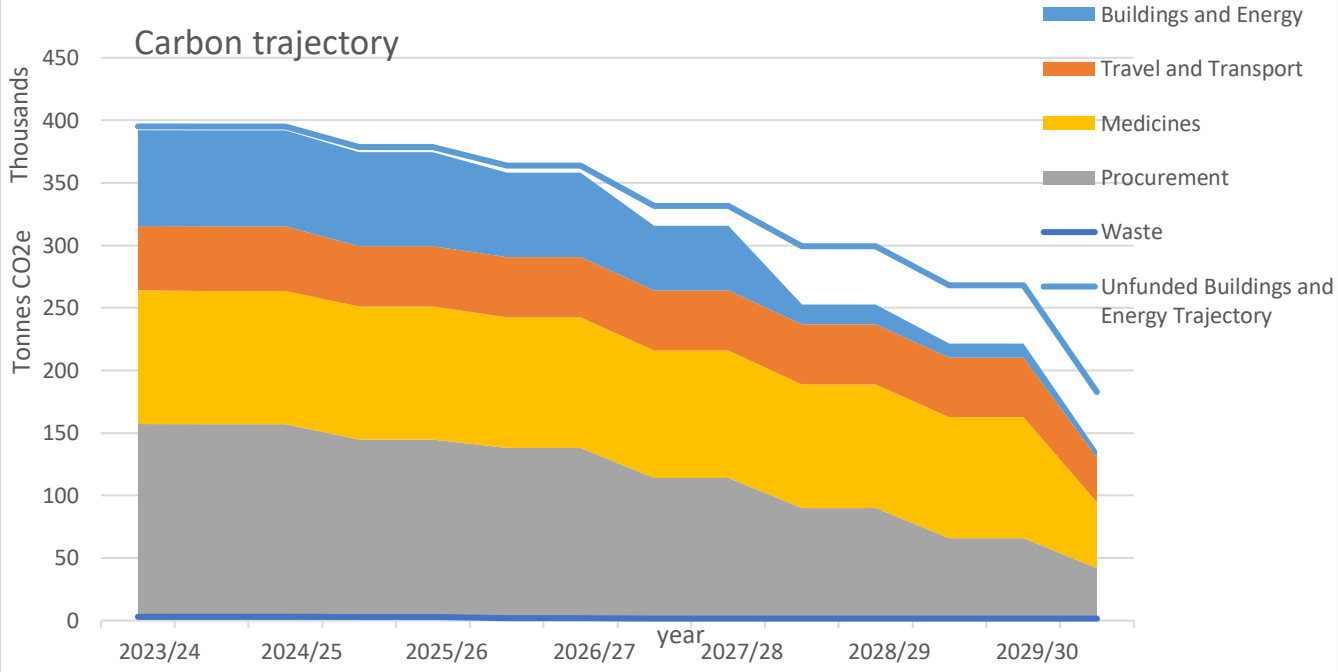


Figure 3 Carbon trajectory with current identified actions

	Tonnes CO_2e	Variance from carbon trajectory to meet target 90% emissions reduction (unfunded)	Carbon footprint goal 10% offset for net zero carbon
Current carbon footprint	395,140		
Carbon reduction required to meet NZC by 2030 (@90%)	Minus 355,626	0	39,514
Scenario 1 - Delivery Plan actions to achieve goal (assuming energy decarbonisation funded)	Minus 257,353	98,273	39,514
Scenario 2 - Delivery Plan actions to achieve goal assuming no funding available)	Minus 212,387	143,239	39,514

We have identified routes to net zero for our buildings and energy, and waste which are areas under our direct control but subject to achieving funding. Transport reductions are less in our control and dependent on working with partners across the ICP. Similarly, a substantial amount of our procurement is dependent on national approaches such as supplier carbon reduction plans and we are more limited in where we can influence them. Medicines requires further identification of reduction opportunities in reducing medicines

waste and targeting high impact areas such as inhalers, but as with wider procurement achieving net zero will be reliant on improving population health to reduce demand for pharmaceuticals and medical equipment.

Our delivery plan (appendix1) sets out the detailed deliverables against the targets for each workstream area and by organisation. We have added RAG rated progress updates against targets and expected carbon reduction trajectories.

Our ICS carbon footprint includes the emissions of:

Integrated Care Board:

- NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)

Healthcare Providers:

- Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)
- General Practice providers
- North Bristol NHS Trust (NBT)
- Sirona care and health (Sirona)
- Southwestern Ambulance Service NHS Foundation Trust (SWASFT)
- University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)

The carbon footprint includes scopes 1, 2 and 3 as described above. Annual data for 2023/24 across all scopes is only available for the Acute hospital Trusts. However most of our carbon footprint is associated with the acute sector so we are able to use this a representative of our system.

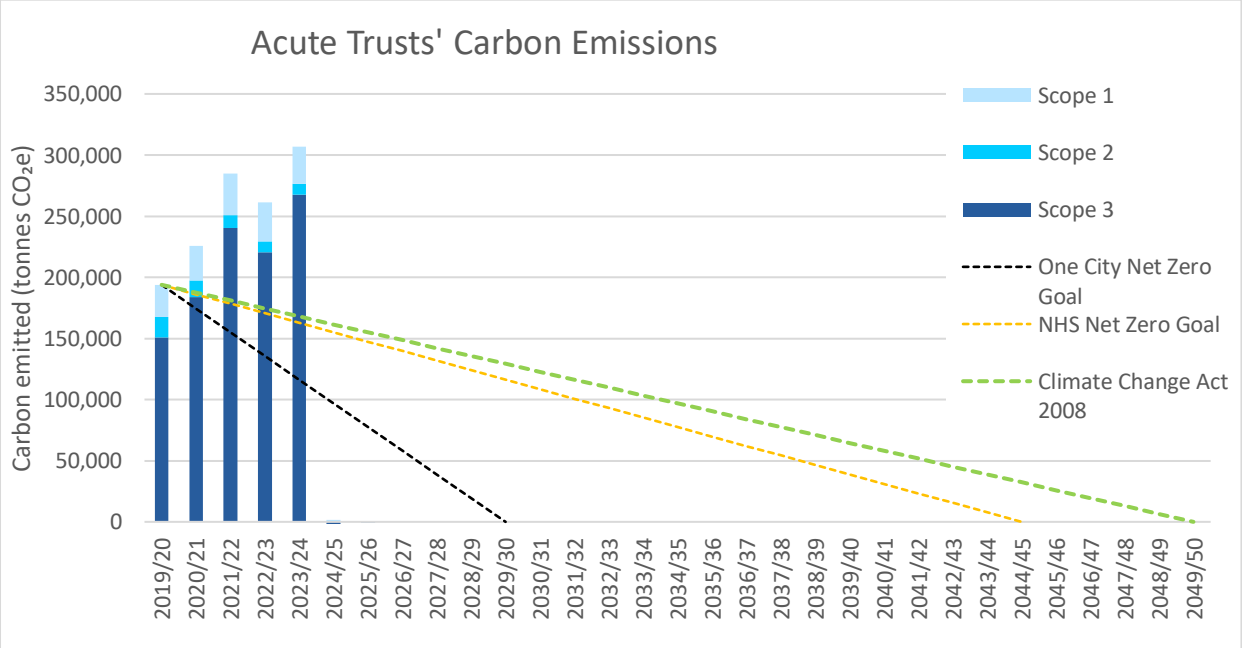


Figure 4 North Bristol and University Hospitals Bristol and Weston NHS Trusts' total carbon emissions for financial years 2019/20 to 2023/24 compared with the carbon emissions trajectory required to achieve net zero carbon by 2030 as well as the trajectories to achieve the NHS Carbon Footprint Plus goal and the Climate Change Act 2008 target.

Our current approach to calculating our procurement carbon footprint is based on spend. This spend-based approach is flawed as it doesn't reflect where we are reducing carbon in our supply chain. The procurement footprint is particularly distorted by the increased spend during covid and high inflation.

Despite the emissions we have most control for, energy, water and waste showing an overall 4% carbon reduction in 2023-24 compared with 2022-23 We have seen a 21% growth impact from increased spend driven by inflation and activity (including investment in buildings and diagnostic equipment).

The carbon emissions reported in the table below cover the two acute hospital trusts that we have 2023/24 annual data for.

Emissions Source	Unit	2021/22 Actual	2022/23 Actual	2023/24 Target	2023/24 Actual
Scope 1 (direct emissions)	tCO_2e	34,341	31,876	14,202	30,348
Scope 2 (indirect emissions from electricity)	tCO_2e	10,162	8,913	3,971	8,985
Scope 3 (indirect emissions)	tCO_2e	240,542	220,295	98,147	267,469
Total	**tCO_2e**	**285,044**	**261,083**	**116,320**	**306,801**
Energy					
Gas consumption	kWh	154,181,076	143,401,024		137,405,280
Oil Consumption	Litres	2,020,495	743,682		623,595
Electricity Consumption	kWh	47,861,589	46,091,982		43,390,423
Supply Chain					
Purchased goods and services (including upstream transport and distribution)	tCO_2e	186,226	177,616		224,120
Travel and Transport					
Trust owned Fleet	tCO_2e	358	352		411
Employee Commuting	tCO_2e	7,596	7,785		7,836
Waste					
Total Waste	Tonnes	6,350	6,564		6,679
	tCO_2e	2,767	2,739		2,522
Water					
Water volume	m3	692,744	625,348		618,789
Water volume and wastewater	tCO_2e	282	251		264

Figure 5 Acute Trusts carbon emissions

As of July 2024, we have 5 years and 5 months left to achieve net zero carbon goal to avoid the worst impacts of climate change hitting our health system. The figure below shows the future carbon taxation cost of our carbon footprint and how that reduces with our carbon reduction trajectory. This takes our delivery plan carbon reduction trajectory on the ICS carbon footprint from NHS England data and we have applied Treasury guidance to show the abatement cost of carbon for our system.

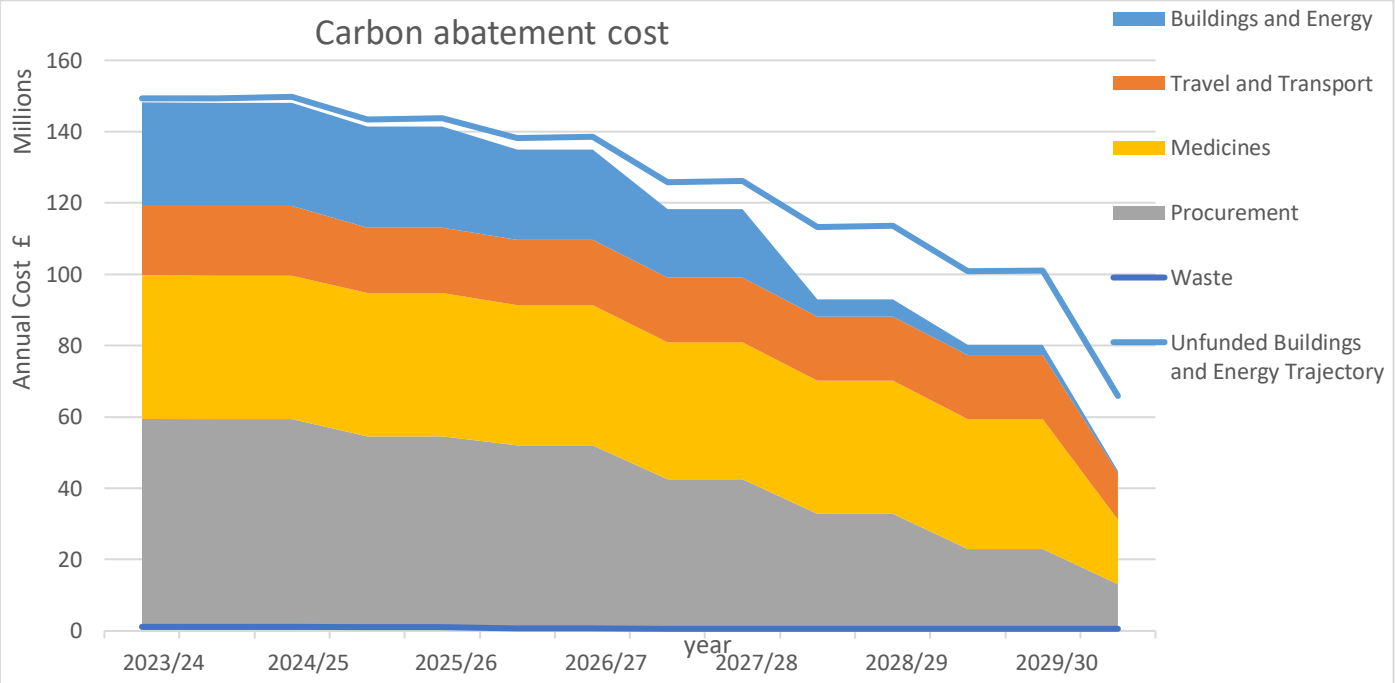


Figure 6 Carbon abatement cost for ICS carbon trajectory

A summary of progress with the main workstreams is set out in the sections below.

2.1 Progress

System wide collaboration on sustainability has been driven by the ICB, this has been clearly exhibited in developing the system capital prioritisation process. The ICS has recognised the importance of net zero by embedding it in this process and committing 10% of system capital in 2024/25 to a decarbonisation fund which partners can bid for and is overseen by the Green Plan Steering Group.

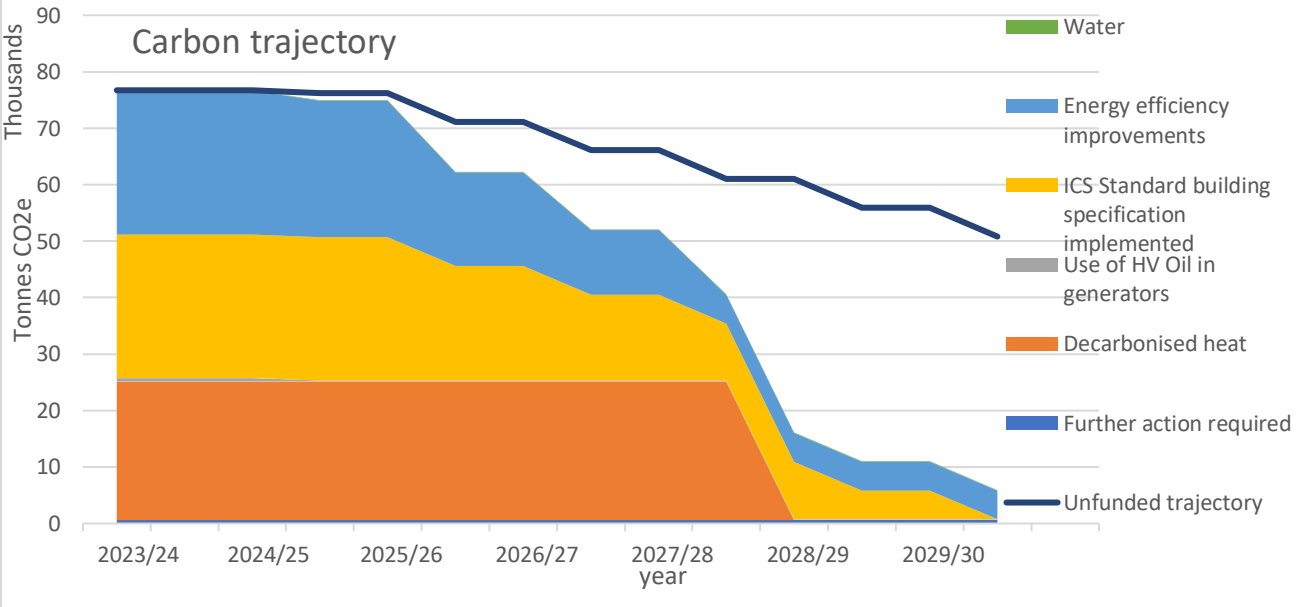
The ICS has incorporated a Sustainability Impact Assessment and carbon cost calculator into its project management gateway process ensuring net zero economic impact and social value are considered.

The ICS has embedded sustainability into the system strategic planning process with the Joint Forward Plan development requiring all areas to include how their plans contribute to the Green Plan. Net zero is a crucial inclusion in the emerging ICS infrastructure strategy.

The following section provides a summary of the progress made in our main workstreams giving further detail of the carbon trajectory for each workstream's key target actions from the delivery plan. The progress made against these actions and the focus for the future

2.1.1 Buildings and Energy

To sustainably achieve net zero carbon emissions by 2030, our energy consumption will need to substantially reduce and remove fossil fuels use. All new building or refurbishment projects will need be designed for zero or low carbon heating, solar PV panels, LED lighting etc). Our priority is to decarbonise our heating systems across the estate, following the direction taken by NHS England. The estimated cost to decarbonise our buildings and energy is £196m. The graph below shows the effect on the carbon trajectory if external funding is not found for estate decarbonisation. This represents a significant risk to the system as capital allocations are not sufficient to meet decarbonisation costs.



Target	Progress	RAG
Decarbonised heat solutions installed by 2028	• System capital decarbonisation funding has unlocked access to grant funding by supporting the match funding requirements. NBT has secured £7.3 million of Salix Public Sector Decarbonisation Scheme (PSDS) Phase 3c grant funding to decarbonise the heating in the Pathology and Learning and Research energy centre. This scheme has the potential to reduce carbon by up to 1,188, tCO_2e. • UHBW has been awarded £234K Salix grant funding to decarbonise the heating in residences, this was also supported by system capital match funding. • NBT's first PSDS Phase 3a project to install heat pumps to the retained estate and deliver energy efficiency measures	

	is now complete, having successfully received £4.4m of grant funding. This scheme has the potential to reduce carbon by up to 904 $ktCO_2e$. • Installed heat pumps in 6 NBT buildings reducing gas demand by 16% • Delivery of the detailed RIBA stage 3 designs for decarbonising heating systems across NBT, backed by another successful bid for £438k of Salix funding under the Low Carbon Skills Fund (LCSF) Phase 4, is complete. This will help shape the future requirements of the Trust and its decarbonisation journey. • AWP's new Learning Disability and Autism Centre will be completed in June 2025. This will be the first building in the Trust to have heating and hot water supplied solely from an air source heat pump system. There will be no gas boilers installed in the building, and so will avoid creating gas related carbon emissions.	
Implement energy efficiency measures for Carbon footprint reduction 80% by 2028, Net zero by 2030	• UHBW has focused on upgrading the software and control hardware on the building management system and combined heat and power unit. The software upgrade will give greater functionality and a broader range of hardware connectivity, allowing for greater control, zoning and improved data. This data allows for the analysis of performance and opportunities for increased efficiency to be identified. • AWP invested £135k into upgrading the lighting at 8 sites to energy efficient LED lighting, saving 48 tonnes of CO2e. We have engaged with NHS property services to encourage the installation of energy efficiency improvements including LED lighting to Primary Care and community health properties they are responsible for. • In Primary Care we have completed energy surveys and green plan progress reports in 25 GP surgeries to give surgeries the information to enable action in reducing their carbon footprints and reducing energy costs. Analysis of surveys will also give us an overview of the common actions that may be suitable for collective purchasing. Further individual surveys are needed to complete audits for all practices • NBT have installed 500kW of solar panels, double glazing in Elgar building and LED lighting in the Brunel building	
Off balance sheet energy decarbonisation funding model approved by 2026	• Discussion started with stakeholders including City Leap to identify potential solutions and lobbying routes for compliant funding model for decarbonisation that enables 3rd party funding	

Switch from diesel to HVO for backup heat and power by 2025	• AWP and NBT have now replaced the diesel fuel used in standby electricity generators with HVO fuel (Hydro treated vegetable oil). HVO is synthesised from animal fats and vegetable oils, which makes it a much cleaner burning fuel. It is 30% cleaner than diesel, and produced from 100% sustainable and renewable sources including waste fats and vegetable oils. The generator engines also run more efficiently and are less noisy when they use HVO fuel. • UHBW due to convert this year.	

Future focus

Our priority will be decarbonising our heating systems. This is particularly challenging as it is a significant financial cost and often a complex process to achieve this for our buildings. The system decarbonisation capital £3m has been successful in leveraging grant funding. However, we know this will not be sufficient funding (£196m) to meet our targets so to achieve this crucial funding we must pursue a compliant funding model for decarbonisation that enables 3rd party off balance sheet funding.

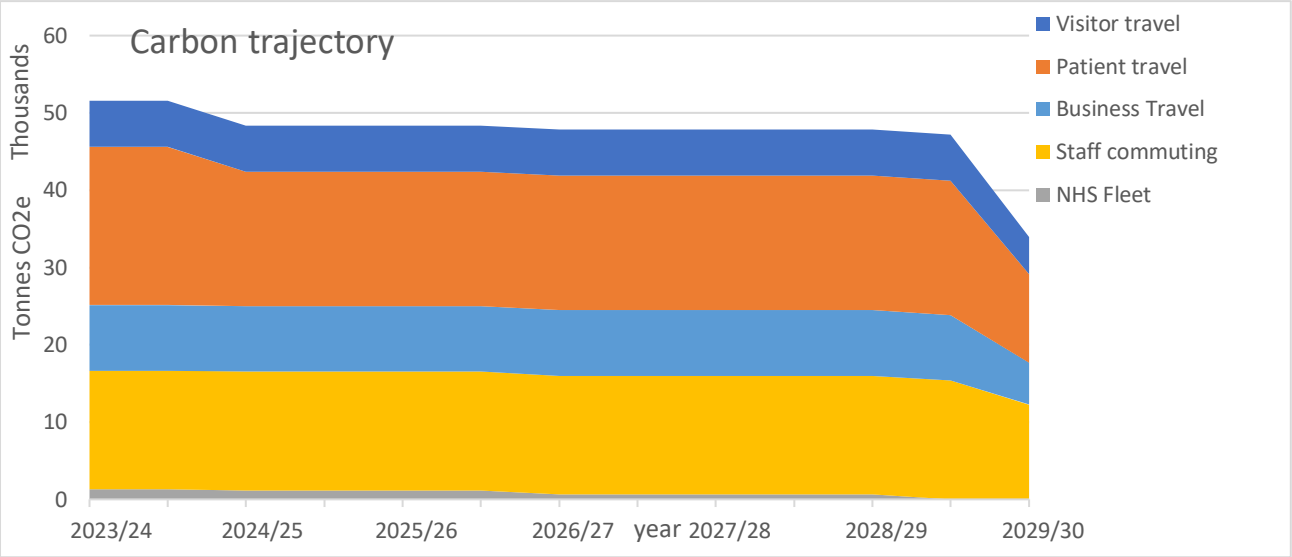
A strategy for future electrical capacity is a focus as new facilities such as the Elective Centre and heat pumps come on stream and mark a shift away from gas to electricity.

The NHS Net Zero Building Standard which was published in February 2023, will further drive reductions in carbon for all new major investments in healthcare buildings. We are developing a BNSSG ICS standard specification which includes applying the net zero building principles across all construction.

The identified actions will achieve net zero without requiring us to identify further actions, however this is subject to us achieving a compliant off balance sheet 3rd party funding model which is the most important focus for future delivery of our energy and building decarbonisation to avoid increasing the gap to net zero by a further 44966 tCO_2e.

2.2.1 Travel, Transport and Air Quality

Carbon emissions from transport are the fourth largest emissions source from our carbon footprint. Emissions from transport also cause significant air pollution. Air pollution is the biggest environmental threat to health in the UK, with between 28,000 and 36,000 deaths a year attributed to long-term exposure. There is strong evidence that air pollution causes the development of coronary heart disease, stroke, respiratory disease and lung cancer, and exacerbates asthma. As a health and care system we have a moral duty to significantly reduce the carbon emissions and air pollution we are causing with the large amount of vehicle journeys undertaken by our staff, patients, visitors and supply chain each year.



Target	Progress	RAG
100% of fleet vehicles are ULEV (or Euro 6) by March 2024. All new vehicles owned and leased by NHS will be ZEV from 2027 (excluding ambulances)	• Sirona are the first organisation in the ICS to have successfully changed its fleet to all electric vehicles. UHBW now has 50% of its fleet as electric vehicles. • NBT has partnered with the West of England Combined Authority to take part in the Urban Freight Trial to swap NBT Logistics Team's diesel van for an electric cargo bike. Estimates suggest the trial could save 1,060 kg CO2e and £5,200 per annum. • AWP In 2023, installed wiring for a new dual socket 7KW Electric Vehicle (EV) charging point at the Blackberry Hill site. The intention is to install more EV charging points across organisations to ensure we have a sufficient EV charging network by 2026.	
Travel emissions measurement for staff and patients in place by March 2024. Organisation specific sustainable travel plan by June 2024	• Despite national active travel funding being severely reduced in 2023-24, both Acute Trusts have maintained their staff bike loan scheme, introduced a new cycle to work scheme, Ultra Low Emission Vehicle Salary Sacrifice Scheme (78 at NBT this year), pool car service (25 NHS@home staff) and Doctor Bike sessions where staff can have their bike checked over for safety and any minor works carried out free of charge. AWP and UHBW have made improvements to secure cycle parking.	
Air quality is improved at each site to at least ambient levels by March 2027	• UHBW has seen an improvement in the air quality in and around the central Bristol located sites. Outside the Bristol Royal Infirmary and Children's Hospital, nitrogen dioxide is down by around 20%. This improvement is a result of the implementation of the Bristol Clean Air Zone. This reduction can be seen in the ambient air quality levels of the roads directly outside the Bristol	

	Royal Infirmary but also in the monitoring equipment across the hospital site. However, the ambulance bay and Alfred Parade, the main delivery road on the central Bristol site, are still areas of poor air quality, exceeding World Health Organisation nitrogen dioxide limits during the day. • Action has been taken to improve the air quality impact of the supply chain through the contracts let that result in many deliveries and vehicle movements on sites. Mean air quality levels around Bristol Royal Infirmary can be over 30% higher for nitrogen dioxide during busy delivery periods over quiet periods. This is being addressed through the social value criteria that apply to all tenders. Including 'improving air quality' as an outcome in relevant tenders has resulted in commitments being made from suppliers to reduce delivery frequency, optimise route planning and plans to introduce low and zero emission vehicles. • Both Hospital Trusts have added air quality monitoring on their sites to improve the data and identify improvement opportunities • AWP sharing public air quality monitoring on their website	

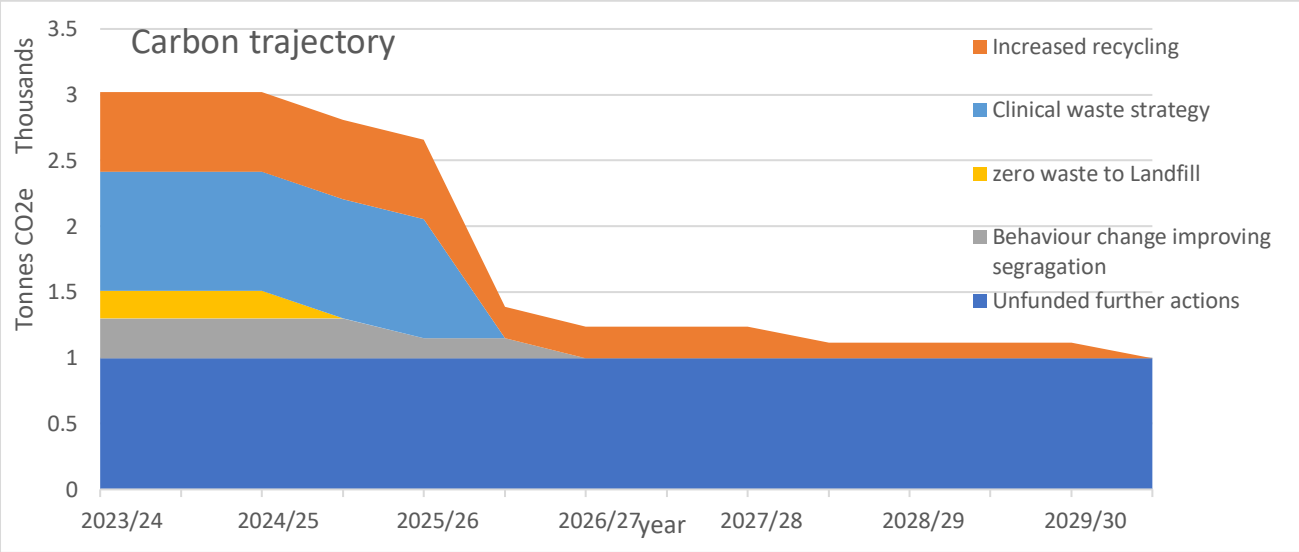
Future focus

A key focus for the ICS-wide Travel, Transport and Air Quality workstream, to decarbonise travel and transport across the ICS will be undertaking a major fleet optimisation study designed to identify and remove unnecessary, replicated journeys by vehicles from NBT, UHBW, Sirona and AWP.

- Barriers to overcome in implementing ZEV are range anxiety, vehicle charging on site and at home, availability of suitable vehicle types and the capital funding required.
- Staff and patient travel emissions are currently not recorded or only estimated from surveys. We will look to widen UHBW's calculated approach.
- Adding the use of local authority air quality monitoring will enable all ICS sites to be tracked.
- The remaining gap to net zero of 28760 tCO_2e reflects the challenges of transport which are a much wider problem that no single organisation can solve on its own therefore an essential focus will be building on the partnerships that have already been established to ensure the health benefits are realised as part of future transport strategies. The health system as trusted voice must play a leadership role in amplifying the health benefits of partner organisations messages around active travel and air pollution.

2.2.2 Waste

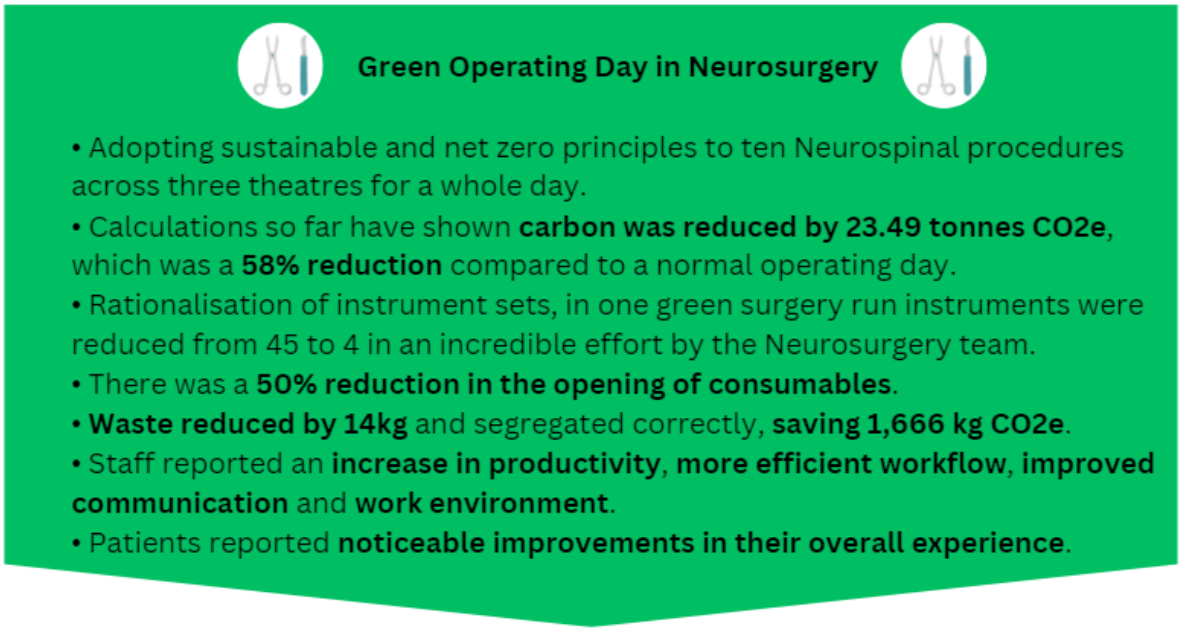
The impacts of healthcare waste on our environment are particularly high given the large volumes of single use and contaminated waste produced and high carbon methods of disposal. High carbon and high-cost waste disposal solutions go hand in hand. Seeking more sustainable solutions therefore has the joint benefit of reducing carbon and cost. Reducing waste is not just about disposal but tackling unnecessary consumption and working with suppliers to develop circular economy approaches to minimise waste generated.



Target	Progress	RAG
Waste Contract in place by April 2024 Zero waste to landfill by March 2025	• New waste contracts have been delayed. The Trusts launched a joint tender for Sustainable Waste Management services, with a focus on and commitment to environmental protection, carbon reduction and the circular economy. The tender dedicated 20% of its quality award criteria to these requirements in addition to a further 10% for social value. The immediate impacts will be to eliminate waste to landfill and to carbon footprint the service. • The project adopted the EcoQUIP Plus innovation procurement methodology, taking the project team through the process of needs identification, through market engagement and the adoption of pro-innovation tendering and contracting approaches. We will be applying the learning to the sustainability challenges of procurement more widely. Further information on the EcoQuip Plus innovation procurement methodology and the project, can be found in the case study report. • 30,000 masks were donated for reuse, avoiding 5 tonnes of CO2e	

	• 356 mattresses were donated for reuse, avoiding 3 tonnes of CO2e and saving £13.6k	
Recycling weight: 60% of all waste reused or recycled by March 2026, 80% by 2028, 100% by 2030	• With a focus on the waste hierarchy at AWP and UHBW recycling rates have increased from 36% to 41%. • Warpit system for reuse of equipment across NBT an UHBW has enabled cost saving of £342k and tCO2e	
Deliver plan to achieve a 20:20:60 split across clinical waste sent for incineration, alternative treatment and offensive waste treatment by 2025	• The Trusts have been working jointly on waste to make progress towards the NHS Clinical Waste Strategy target • Reduced clinical waste sent for high temperature incineration by 396 tonnes being segregated as non-infectious saving 426 tonnes CO2e • Progress is dependent on waste contracts being in place	

NBT have one particularly successful waste and consumption project shown below which was made possible by a very determined Neurosurgery team who challenged themselves to do things differently.



Future focus

The key barrier is getting the new waste contracts in place so we will be able to work with contractors on reducing waste, increasing recycling, achieving clinical waste ration. We will focus on reducing single use plastics through audits to identify items to work with our supply chain reducing usage.

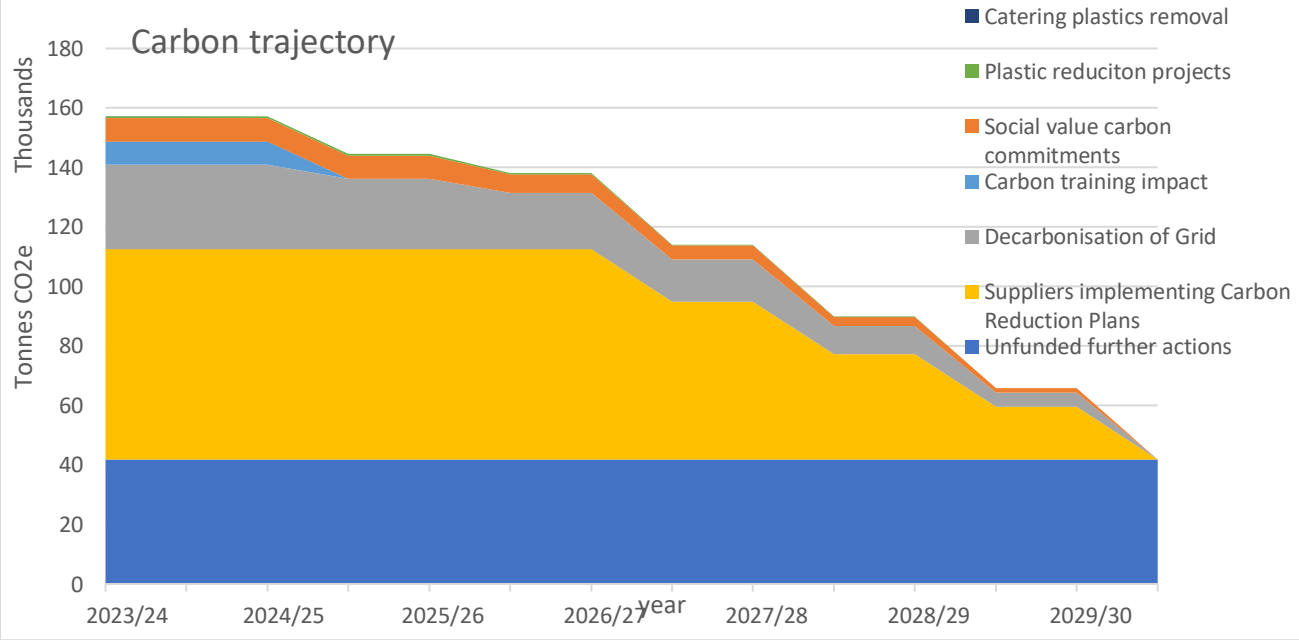
The next step is extending and standardising waste monitoring and practices across all organisations.

An important focus will be to engage and support staff to identify and implement further projects like the green operating day to reduce consumption and waste.

Delivering the actions identified will be sufficient to achieve our net zero target but delivery is dependent on waste contracts being in place to enable us to work with suppliers to achieve the targets.

2.2.3 Procurement

Scope 3 procurement emissions are the largest source of carbon emissions, with purchased goods and services making up over 60% of the total footprint. This is also our greatest opportunity to use our spend as a positive influence to realise economic, social and environmental benefits.



Target	Progress	RAG
Plan for robust carbon measurement - carbon measurement in new procurement system Sept 2024,	• The procurement emissions data is presented in this report, but it is important to recognise that the current spend-based methodology does not reflect our carbon performance, nor is it in line with best practice calculation methods. We continue to review alternatives calculation methodologies but have yet to identify a suitable solution to cover the scale and variety that	

targeted approach to non-spend based measurement of suppliers	exists within our supply chain. Bristol and Weston Purchasing Consortium (BWPC) is seeking to improve our data as internal systems are upgraded. • AWP and Sirona have engaged a contractor CO2Analysis to provide a carbon footprint of their supply chains.	
Process implemented ensuring suppliers have carbon reductions plans for all tenders from April 2024	• BWPC have been focused on the design of a new procurement system which is going live in summer 2024. The new system will allow suppliers to upload their Carbon Reduction Plans in line with Procurement Policy Notice (PPN) 06/21 which the NHS adopted in 2024. BWPC has also been busy complying with the Modern Slavery Act, delivering modern slavery training to all procurement staff and gaining Trust Board approval for their Modern Slavery Statement which will be published in 2024	
All tenders include minimum 10% social value weighting by March 2022 and embedded in contract management March 2024	• Social value weighting included in all tenders but not embedded in contract management • We have created a social value question bank tool that can be used to select the most relevant and proportionate question to ask on net zero amongst other social value outcomes. The sustainability team have also provided advice and been directly involved in the procurement process for some high-risk tenders, creating the sustainability requirements, evaluation criteria and contract management mechanisms for these. • The Sustainability Team has played an advisory role in the implementation of PPN 06/20 with social value being incorporated into seven tenders during the year. In September 2023, the Sustainability Team launched the new Sustainability Impact Assessment (SIA) with an embedded carbon cost calculator which has been embedded in the NBT's business case process and the ICB's Gateway Process. The SIA has been shared with the rest of the system along with other NHS organisations, ICSs and NHS England as a pioneering approach to integrate sustainability into business cases and decision making.	

Future focus

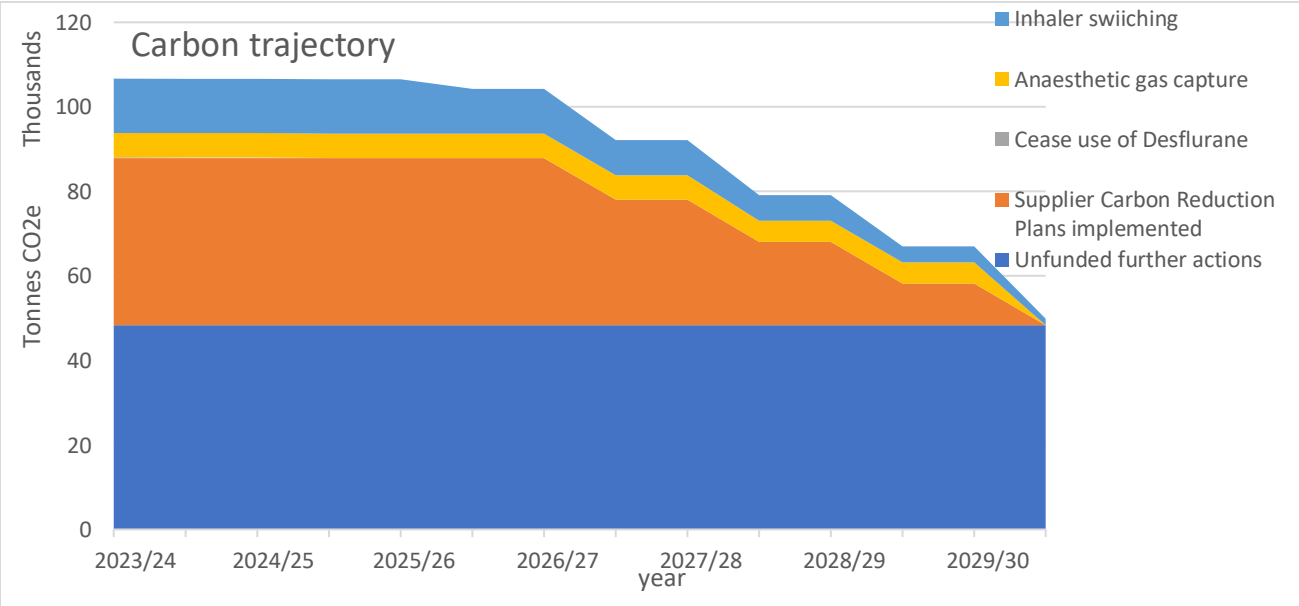
We will continue updating the procurement process and creating new tools to help stakeholders manage the sustainability impact of the procurement process. Our focus will also continue on embedding the NHS England net zero commitment requirement for suppliers' carbon reduction plans into the procurement documents, templates and sign-off process. These national approaches are expected to deliver a 45% reduction by 2030. There is still a significant gap of 26106 tonnes CO_2e of unfunded further actions which will

be required to reduce emissions by 90% to achieve net zero. Our approach to reducing this gap includes:

- In 2024-25, Category Managers will undertake a risk assessment of their categories to identify supply chain risks and opportunities to integrate into tenders and will work with NHS Supply Chain and the Sustainability Team to implement carbon and waste reduction projects.
- Developing a non-spend based approach to measuring our supply chain emissions to drive progress with reducing procurement related emissions
- Engage with suppliers to seek reductions in emissions in the supply chain
- Support for the transition to a circular economy (this is an economic system aimed at eliminating waste and the continual use of resources) while identifying opportunities for enhancing social value (e.g. skills and training, employment opportunities for disadvantaged groups and others). This particularly key to reducing single use plastics.
- Procurement processes including a weighting for local suppliers to support a low carbon procurement system. This also helps to ensure resilience of supply which is an important consideration especially when dealing with pressures similar to the recent Covid-19 pandemic.

2.2.4 Medicines

Medicines make up 20% of our carbon footprint and 40% of our total procurement emissions. Many inhalers for asthma use propellants that have a high impact. Anaesthetics also have a significant greenhouse gas impact many times higher than carbon dioxide.



Target	Progress	RAG
Inhaler switching - Achieve SABA MDI use to be 75% low carbon, Preventer use to be 70% lower carbon and 30% v high carbon as per NHSBSA respiratory carbon dashboard by 2025.	• 60% of Primary Care carbon footprint consists of the medicines they prescribe including meter dose inhalers. Initiatives in some GP surgeries to improve asthma control and optimise inhaler prescribing are helping reduce the climate impact of their medicines' footprint. • No central funded respiratory project for coordination in 24/25. Awaiting NICE guidance that will support switching	
Suppliers carbon reductions plans 100% of new medicines contracts have supplier carbon reduction plan as tendered and awarded from April 2024	• Pharmaceuticals excluded from social value requirements by NHSE. However, they are required to provide a carbon reduction plan and complete an Evergreen assessment every year • Medicines optimisation - some initiatives in reducing wastage of medicines and avoiding patients taking unnecessary medicines reducing the impact of medicines on the environment.	
Reduce carbon footprint from anaesthetic gases as far as possible in order to reduce abatement cost to get to net zero by 2030. Decommission Desflurane by 2024 in line with NHSE mandate	• Staff led approaches by Anaesthetists have been very successful in driving reductions and eliminating the use of the highest impact anaesthetic gases. • Nitrous oxide destruction unit requirements have been identified. However, very high costs exceed benefits so need to consider alternative approaches • Ceased use of Desflurane • Manifolds being decommissioned where possible	

Future focus

Reduce the environmental impact of medicines and medical devices on towards net zero by:

- Ensuring delivery of decarbonising anaesthetic gases
- Promoting use of lower carbon inhalers where clinically appropriate
- Reduce carbon impact of overprescribing by reducing inappropriate prescribing through greater use of Structured Medication Reviews
- Driving more effective medicines waste management
- Closing the unfunded remaining gap in achieving net zero requires Identifying a pipeline of future opportunities for greener alternatives and reviewing highest carbon impact medicines where possible

3. Sustainable Healthcare

3.1 Sustainable healthcare – Anchor in the community

Realising the economic, social and environmental benefits of being an anchor in the community and achieving sustainable healthcare is dependent on us building on being anchor organisations to becoming an anchor system.

A key strategic approach to our system achieving sustainable healthcare and our net zero target is to keep people well and out of hospital. We need to bend the curve on the predicted rise in demand for high-cost and high carbon, reactive and hospital-based care and focus on prevention. That means supporting people to take care of their health and wellbeing, intervening early and keeping people healthy at home for as long as possible, focussing investment on primary and community services. Avoiding carbon intensive hospitals for issues that could have been prevented in primary care or managed better in the community.

We can't afford to build more carbon intensive hospitals as way to deal with increasing system demands, we need to do things differently – this includes:

- Supporting our staff and working with partners
- Using our buildings and spaces
- Engaging our staff to lead change in our organisations and communities
- Building resilience to climate change

Target	Progress
Sustainability Impact Assessment (SIA) with carbon costing included in all business cases SIA in use across the system by September 2024	• Implemented for NBT business cases and ICB gateway process. • Shared with ICS organisations, needs organisations' Exec sponsor to support.
Schedule of carbon inset schemes by July 2024	• Decarbonisation capital prioritisation has identified carbon saving inset schemes. Insetting for other business cases not agreed.
Biodiversity value included in sustainability impact assessment by May 2024 and in business cases July 2024	• Included in NBT business case SIA. Dependent on roll out of SIA to other organisations

10,000 new trees planted across our footprint by 2025	• Tree planting priority mapping for NHS sites. Coordinated delivery requires resource
Reduce anti-depressant prescriptions where appropriate by increasing Green Social Prescribing offer	• Green social prescribing project has received £328,000 from Treasury and NHSE to extend work during 2024/25. Commitment to recurrent funding required.
Climate adaptation - Risk assessments show organisations are resilient to effects of climate change by March 2027	• Adaptation action plan and risk assessments not started

3.2 Supporting our Staff and Partnership working

Supporting staff to move to sustainable models of care within our services has improved patient experience and staff productivity by creating more efficient ways of working and using fewer resources to deliver outstanding care. We need to embed sustainability in our ways of working by expanding use of tools such as our Sustainability Impact Assessment to support decision making to ensure we realise economic, social and environmental benefits as we improve how and where we deliver our services.

Supporting our staff through NBT's Quality Improvement programme, 10 sustainable models of care have been identified throughout 2023-24, Through the nurse's preceptorship programme and the Patient First approach we will identify and support more sustainable models of care than ever in 2024-25. NBT's Infection Control Team have been pivotal in driving sustainable models of care this year through their membership of the Infection Prevention Society's Sustainability Special Interest Group.

To become a sustainable health system we must ensure prevention and healthy lifestyles promotion is the first line in all clinical guidance and by promote community based approaches including resources such as the 'Healthier with Nature' directory of projects to ensure we have suitable places to refer patients including, exercise programmes and community groups. The advantage of many of these VCSE resources is that they often have multiple benefits (helping mental and physical health and adding social value) This 5 min video from Bristol Health Partners of a VCSE group demonstrates the benefits.

Our primary care CATCH programme is seeking to drive outcomes and benefits of working with and supporting the VCSE sector.

Primary care and VCSE Alliance CATCH programme
(communities acting together for climate and health)

We have launched the CATCH programme who's focus is to help communities become healthier, happier, and more connected with greater access to physical activity, green space, and nutritious food, fostering lifestyles which prevent disease, rather than causing it. Healthier communities need less healthcare which has a high carbon footprint so the programme will also reduce the carbon footprint of communities, helping them move towards net zero.

The strength of this programme is the collaboration between the VCSE sector and Primary care. General Practices are anchor institutions in their local community, with 90% of healthcare being delivered in primary care. Most of the population will have contact with Primary care every year which makes it well placed to help develop healthier communities. The VCSE sector is embedded in the local community and has knowledge of what is needed and wanted. Joint working using the VCSE sector's local knowledge and expertise and Primary Care's health skills will help drive forward positive change exponentially.

The climate crisis is a health crisis, and it will impact those with the least, the most. The climate disparity in experiencing the impacts and disparity in available resources for mitigation and adaptation will only widen existing health inequalities. The CATCH programme will tackle this by helping more individuals and groups who face inequalities and poverty take action to shape healthier, lower carbon communities with higher quality but lower carbon healthcare.

Healthier Together 2040

In 2024 our system has started a long- term project to implement the system strategy published in 2023 by focusing on the population cohorts expected to experience the poorest health in 2040.

As we look to 2040, national and local evidence is showing that people are likely to live increasingly in poor health, with multiple health needs and that over the next 15 years this is not going to improve without focused action. The working age population is growing at a significantly slower rate than the number of people expected to require support, many buildings are not fit for purpose and there are increasingly fewer resources. In addition there are inequalities built into our how our system works which we need to tackle to improve health and reduce how long people live with poor health.

By focusing on groups of people and all the health, wellbeing and social needs surrounding them, we can bring people together to organise and deliver health and care differently. This will fundamentally move to new sustainable care models wrapped around people in their communities and shifting resource to tackle the key drivers influencing current and future health needs.

We know we can't solve the complex systemic challenges we face on our own and that it is essential we work with others to overcome them. In 2023-24, we have strengthened our existing partnerships with local organisations through our membership of the West of

England Nature Partnership, North Bristol Sus Com, the SDG Alliance, Bristol Green Capital Partnership, SHINE HIT, No Cold Homes Steering Group, the One City Environment Board, One City Transport Board and Bristol Advisory Committee on Climate Change. We have continued our involvement with our Local Authorities including public health, WECA's Climate action panel and Future Transport Zone programme.

We have also continued to work with local organisations such as Leigh Court Farm, the Sustainable Development Trust, Forestry England and Natural England to improve staff and patient access to green space on our estates.

3.3 Using buildings and Spaces to Support Communities

The large footprint of the health estate grants us responsibility to support local biodiversity and pioneer nature recovery programmes within our local areas. Through our estate we can also increase access to nature for our staff, patients and local residents.

Supporting biodiversity is essential to achieving sustainable healthcare. We have recognised this by adding biodiversity to our sustainability impact assessment to embed the value of biodiversity in our decision making. This is currently in use in NBT business cases and the ICB gateway process but needs to be adopted across the system.

Mental Health sites
AWP as a mental health Trust, have recognised the importance of using green spaces to improve physical and mental health for their patients and service users. They have established green spaces at several sites including Fromeside and Callington Road.

Fromeside's Malago Centre (occupational therapy) have an occupational therapy led therapeutic garden running sessions which range from sensory to fitness and strength promotion. The garden contains beds of various heights to accommodate physical health challenges and is used to grow food for the Rivers café (onsite vocational training café); flowers for cutting; and an ornamental garden for beauty and sensory work. The herb garden, as well as other food grown in the garden, is used for cooking sessions with service users which help promote healthy eating, nature connection and build additional movement into the day.

At the Callington Road inpatient site, the occupational therapists based at the Coppice and Woodside buildings run groups which utilise the garden areas of wards as well as running an allotment.

Many teams also run walking groups and help service users connect with nature and horticulture activities as part of their recovery plans across the AWP map including Green Gym, volunteering with wildlife trusts, attending walking groups

Acute sites
In 2023-24 NBT patients continued to use green spaces to support their recovery through social prescribing sessions held in our HITU eco therapy garden, Elgar House and our Southmead Allotment. Last summer we hosted Natural England's Nature Conference and invited local organisations and regional NHS Trusts to view our green estate and discuss the NHS' role in nature recovery.

The acute hospital Trusts have recently been successful in securing a £193k joint bid to fund a Green Spaces Co-Ordinator which will identify and address barriers to accessing green space and social prescribing. The funding will also embed green social prescribing into the existing Arts on Referral programme and support a pilot of a new green social prescribing programme for patients with chronic pain, cancer or respiratory conditions. The funding will also cover improvements to the HITU eco therapy garden.

System wide sites - Healthier with Nature
BNSSG hosts one of just seven national test and learn sites across England for Green Social prescribing. Our local programme branded as Healthier with Nature was originally funded in 2021 and has just received £328,000 from Treasury and NHSE to extend work during 2024/25. Sirona host the programme which is considered a national leader in this field with BNSSG hosting ministerial visits and national board meetings in recognition of our work.

To date over 4,000 patients, mainly from primary care have accessed nature-based interventions to improve their health outcomes. However, during 2024 a number of different patient cohorts have been included in pilot work including support around hospital discharge, frequent callers to the ambulance service and work with our mental health trust AWP. Work is also developing with our ambulance service SWASFT to better support frequent callers. The aim is to both provide better personalised care for patients but also show a measurable reduction in service usage with the related financial and environmental benefits.

In addition to work to improve patient outcomes the programme looks to support nature recovery on NHS Estates by boosting biodiversity both in hospital settings and primary care estates. This improves spaces for nature but also patient care and staff wellbeing.

Healthier with Nature has been a real success story for BNSSG but still has no long-term recurrent funding and as such is likely to have significantly reduced capacity after April 2025 unless some revenue funding can be found to support in the longer term. There is a risk that a work stream for which BNSSG is considered a regional and national leader will be diluted.

3.4 Staff Engagement

Our staff are our greatest asset in delivering sustainable healthcare. From keeping the population healthy to making procurement decisions of what products to buy our staff are fundamental to achieving our Green Plan objectives. As shown in the green operating day case study staff led change is crucial to us moving to sustainable models of care and realising the environmental, social and financial benefits. Staff awareness and engagement in sustainability is essential to meet our responsibility to show leadership in all our interactions with our communities. Staff are also crucial in modelling the behaviours and providing the health perspective on climate change to support the culture change required in our society.

In 2023-24, the ICS Communications and Engagement workstream launched several Net Zero for Health campaigns to acknowledge the importance of achieving net zero to create a safe and healthy future for our patients.

Target	Progress
10% of staff by 2025 actively engaged Increase number of Green Champions by 5% per year	• This year NBT and UHBW celebrate the two-year anniversary of their joint sustainability staff engagement scheme, Greener Together, which has so far seen 568 staff members sign up and 18,575 actions being taken • NBT also introduced its first ever Sustainability Staff Award which was awarded to Dr Emma Carver for her unwavering dedication to embedding sustainability within the Emergency Department. • 11246 engagements with staff • Current engagement scheme reviewed • Completed system Communications programme of engagement activities
Increase in number of staff reporting increased awareness of Climate & Ecological emergency and report having made practical changes (in workplace and outside)	• 13 lunch and learn sustainability webinars • Visited 12 teams • 35 face to face events • AWP the CEAG Group is the main forum for raising awareness of sustainability and taking forward ideas from staff members, which will help to reduce carbon emissions and reduce costs
10 GP surgeries active on green impact for health toolkit by October 2024	• The Bristol & Bath Greener Practice group meets monthly to share learning and develop projects with the aim of making our local primary care systems as environmentally friendly as possible. improve uptake of the Green Impact for Health toolkit, which is hosted by the RCGP and is open to all GPs to reduce their carbon footprint. The toolkit is a series of actions which can be ticked off to achieve points. These accumulate towards bronze, silver, gold and carbon awards. Actions are in the clinical, managerial and admin arenas. The group provides peer support by discussing different areas of the toolkit in meetings and sharing ideas and solutions between practices. • £20k CATCH programme launched
Training - Sustainability e-learning promoted and completed by 20% of staff by 2025	• E-learning mandatory at ICB other organisations to consider • The development of a sustainability impact assessment with carbon calculator at NBT is a key tool being provided to enable better decision making by staff. The tool has been integrated by the ICB into its gateway process. Further embedding use across the system will support staff integrating sustainability into their ways of working

Engagement is important for recruitment and retention of staff. With demand for staff exceeding supply, one of the ways in which healthcare can stand out is through its sustainability efforts. The simple act of prioritising environmental issues can be an effective way to increase employee engagement and attract staff.

This is particularly the case in providing what the new generation of employees are looking for in employers. By 2025, it is projected that Generation Z will make up 27% of the workforce, with Millennials making up the vast majority of the remainder. When it comes to recruitment, aligning with Gen Z and Millennial values is going to be key.

- A study by global analytics firm Gallup found that 71% of workers consider a company's environmental record when deciding on an employer.
- A Deloitte report found nearly two in five (37% of Gen Zs and 36% of Millennials) say they have rejected a job based on their personal ethics. Nearly 40% of Millennials have accepted one job offer over another because that company was sustainable.
- According to the Deloitte report, those who are satisfied with their employers' societal and environmental impact are more likely to want to stay with their employer for more than five years.

3.4 Resilience to climate impacts

We are already seeing impacts of climate breakdown including increased extreme weather events such as heat waves and flooding. These impacts adversely affect most those least able to cope exacerbating health inequalities. Whilst our focus has been on mitigating climate change it is essential that we build resilience in our organisations and our communities to ensure we are able to continue to deliver our services and minimise the impacts on our communities.

We have a system-wide climate adaptation strategy and have engaged with some groups such as emergency planning but will need to work with partners across the ICP to develop the actions to deliver our target that risk assessments show our organisations are resilient to effects of climate change by March 2027

4. Recommendations

- Achievement of the carbon trajectory is dependent on revenue and capital investment being provided to support actions. The cost is principally related to actions to reduce carbon from our energy and buildings

- Lobbying will be required for a compliant 3rd party off balance sheet funding solution to deliver £196m of energy decarbonisation projects

- To follow success at NBT and ICB, we should introduce the use of Sustainability Impact Assessment into business cases and decision making

- The new waste contracts need to be expedited to enable delivery of the strategic waste objectives

- We need to develop partnerships to optimise transport across our system and improve travel options in our region
- We need to expand existing medicines optimisation work and identify a pipeline of future net zero opportunities
- We need to develop a non-spend based measure of supply chain carbon footprint
- We need to embed national requirements for carbon reduction plans and social value into procurement processes
- Focusing investment on primary and community services could support people to take care of their health, intervening early and keeping people healthy at home and out of high carbon healthcare for as long as possible

5. Financial resource implications

The high-level financial implication is shown in Figure1 as the carbon abatement cost of carbon emissions £150m per annum. Decarbonisation costs identified for NBT, UHBW and NBT in the ICS capital prioritisation process total £196m. Detail of costs for delivering against targets where these have been identified are shown in the delivery plan Appendix 1.

A key target is to enable sufficient finance is to lobby for a compliant off balance sheet funding model for energy decarbonisation that enables 3rd party funding that is approved by CFOs, Auditors, Treasury and ONS.

6. Legal implications

On 1 July 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Care Act 2022. This places duties on NHS England, and all trusts, foundation trusts, and integrated care boards to contribute towards statutory emissions and environmental targets.

The Act requires commissioners and providers of NHS services specifically to address the net zero emissions targets. It also covers measures to adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act.

Trusts and integrated care boards (ICBs) will meet this new duty through the delivery of their localised Green Plans, and every Trust and ICB in the country now having a board-level lead.

7. Risk implications

Risk	Mitigations
Engagement – risk that the Green plan will fail to become fully embedded across the breadth of our activities.	• Delivery of communications & engagement strategy • Approval by ICS organisation Boards • Role of ICS Steering Group to oversee alignment

Financial – Risk that we are unable to meet the outcomes of the plan due to financial constraints in terms of capital investment and revenue implications and being able to access off balance sheet 3rd party funding	• Access to national funding such as Public Sector Decarbonisation Funds • Early strategic planning at a system level to understand total financial need & prioritisation of resources to highest impact areas • Lobbying for off balance sheet 3rd party funding solution • Recognise the financial savings that are possible through operating more sustainably • Accounting for the contribution to non-financial outcomes (e.g. population health) that can be achieved by operating sustainably
Reputational – Risk that our reputation is impacted if we are unable to meet the outcomes set out in this plan	• Green Plan Steering Group to maintain close focus on key deliverables • Maintain an honest dialogue with staff & citizens about what is achievable and any barriers to delivery that are outside of our control (e.g. supply chain, decarbonisation of national grid)
Elements of delivery beyond our control – Risk that we are unable to deliver against significant elements of the plan due to elements of the plan that are outside of our direct control (e.g. supply chain, national grid decarbonisation)	• Early and robust engagement with supply chains • Use collective pressure through regional and national bodies
Competing priorities – risk that the pressures such as elective recovery, and establishment of new models of care impact on delivery and relative priority of this plan	• Ensure that the sustainability outcomes are central to our ICS strategic aims • Continue to recognise that operating sustainably is a key part of the solutions to our biggest challenges, not an afterthought • Role of executive leaders to maintain the priority of this programme.
Adapting to climate change – Risk to health of our population and delivery of services if we fail to adapt to climate change	• Ensure adaptation plans and risk assessments are completed • Ensuring adaptation is considered alongside mitigation of climate change

8. How does this reduce health inequalities

Health inequalities and climate change are both systemic issues the determinants and impacts of health and climate change are interconnected. Climate change impacts exacerbate health inequalities. But there are health co-benefits of mitigating climate change including through cleaner air, healthier diets and physical activity.

The main contributing factors to disability/poor health	Alignment to green plan ambitions
Musculoskeletal disease	Active travel & green social prescribing
Cardiovascular disease and stroke	Active travel, nutrition, preventative models of care
Respiratory diseases including COPD	Targeting air pollution
Depression and mental health problems	Green social prescribing

Cancers and particularly lung cancer	Targeting air pollution, healthy lifestyle choices
Alcohol and drug misuse	Green social prescribing

Making a significant improvement in the health and wellbeing of our population will mean:

- Addressing the major health threats of cardiovascular/cerebrovascular, respiratory, mental health, musculoskeletal diseases and cancer.
- Addressing the gross inequalities in our system by deprivation and between groups, such as those with learning disabilities and serious mental health issues.

As one of our key system objectives, a sustainable approach to health and care delivery, will be part of addressing the wider determinants of health outcomes

9. How does this impact on Equality and Diversity?

The EIA produced for the Green Plan has identified there are potential positive and negative impacts on protected characteristics Age, Disability and Race groups
Age and Disability

Positive - upskilling workforce

Negative –some key actions, particularly related to active travel, may not be suitable for elderly people or those with certain disabilities. Risk of staff feeling excluded from action plans.

Race

Positive – the themes outlined in the ICS Green Plan are inclusive of all races and the Plan will harness the cultural diversity of our staff and patients to deliver innovative solutions to reduce our impact.

Negative – Sustainability is practiced in unique ways across various cultures and therefore the ICS Green Plan could risk alienating staff and patients.

10. Consultation and Communication including Public Involvement

An ICS Green Plan communications and engagement group has been established that is developing a comprehensive communications strategy and plan.

There has been no public involvement in the writing of this paper. However existing evidence from the public and feedback on the Green Plan has been used.

Appendices

Appendix 1 Green Plan Delivery Plan

Glossary of terms and abbreviations

Net zero	Achieving a zero level of carbon emissions based on reduction and offsetting. This follows the Science based targets initiative definition of reducing carbon emissions from our baseline of 2019/20 by at least 90% and offsetting the remaining emissions.
Adaptation	Adaptation is actions to adjust to climate change, and the extreme weather that it makes increasingly likely. This includes making homes more resilient to extreme heat and cold weather, and adapting our landscapes to better cope with flooding or drought events, for example.
Anchor institution	Refers to large, typically non-profit, public-sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities.
Carbon footprint	Carbon footprint refers to emissions that are associated with the consumption spending of UK or England's residents on goods and services, wherever in the world these emissions arise along the supply chain, and those that are directly generated by UK or England's households through private motoring and burning fuel to heat homes.
Circular economy	Circular economy is an economic system aimed at eliminating waste and the continual use of resources while identifying opportunities for enhancing social value (e.g. skills and training, employment opportunities for disadvantaged groups and others).

Climate Emergency	A situation in which urgent action is required to reduce or halt climate change and avoid potentially irreversible environmental damage resulting from it
Ecological Emergency	A recognition that nature is declining globally at rates unprecedented in human history - and the rate of species extinctions is accelerating, with grave impacts on people around the world now likely.
Healthier Together Integrated Care System:	A statutory partnership of health & care organisations formed to realise our shared ambitions to improve the health and wellbeing of the people of Bristol, North Somerset, and South Gloucestershire.
Net-zero carbon	A person, company or country is net-zero carbon if they balance the carbon dioxide they release into the atmosphere through their everyday activities with the amount they absorb or remove from the atmosphere. Overall no carbon dioxide is added to the atmosphere. There are two main ways to achieve net zero: reducing emissions and removing carbon dioxide from the atmosphere, through technologies that actively take in carbon dioxide or by enhancing natural removal methods - by planting trees, for example. These methods can be used in combination. Net zero is the UK government's target for at least a 100% reduction of net greenhouse gas emissions (compared with 1990 levels) in the UK by 2050.
Sustainable Development:	Sustainable development aims to ensure the basic needs and quality of life for everyone are met, now and for future generations. Sustainable Development promotes the reduction of carbon emissions, the efficient use of finite resources, recognises the importance of protecting our natural environment, and preparing our communities for climate change (extreme weather events and increased risk of disease) by promoting health and wellbeing through healthy lifestyle choices to ensure a strong, healthy and resilient community now and for future generations

Internal Audit Terms of Reference

Client	University Hospitals Bristol and Weston NHS Foundation Trust
Project	Environmental Sustainability
Prepared by (Lead Auditor)	Chipo Makore- Senior Audit and Assurance Specialist
Agreed by (Senior Audit and Assurance Manager)	Marina Willis, Senior Audit and Assurance Manager
Date Issued to Client	22/7/2024

Background Information

As part of the 2024/25 Audit and Assurance Plan, as agreed by the Audit Committee, we will undertake a review of the Trust's approach to Environmental Sustainability with a specific focus on the Trust's progress regarding the BNNSG Green Plan.

The Green Plan 2022–2025 by BNSSG Healthier Together is a strategic initiative that focuses on sustainability within the Bristol, North Somerset, and South Gloucestershire Integrated Care System (ICS). As an ICS, BNSSG has put sustainability at the core of its aims and objectives. This plan sets out the commitments it made to deliver 3 key outcomes for its population:

Improve the environment: To improve the overall environmental impact and sustainability of its services, especially the damaging local impacts of air pollution. This will create a cleaner, safer, more ecologically resilient environment, locally and globally, including restoring biodiversity as much as possible.

Net zero carbon: The Group particularly recognises the pressing urgency to address its carbon footprint and will reduce the impact of its services on the environment by achieving net zero carbon across all emissions scopes by 2030.

Generate a BNSSG-wide movement: The Group's sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment whilst building resilience in its communities.

Audit Scope, Objectives and Approach

The overarching objective of our review is to provide assurance that UHBW is progressing in line with the BNSSG Green Plan. More specifically, we will review how UHBW is progressing their contribution to the plans and projects for the following workstreams:

1. Net zero carbon
2. Sustainable procurement
3. Sustainable waste management for both clinical and non-clinical waste
4. Travel, Transport and clean air
5. Communications and engagement.

We will also review and confirm that UHBW has:

- Appropriate governance arrangements in place to oversee/monitor the Trust's progress towards the UHBW elements of the BNSSG Green Plan objectives.
- Appropriate policies and procedures in place to support the UHBW elements of the Green Plan.

Resources, Timing and Reporting Arrangements

We will be in regular contact during the audit so that issues arising during the course of the audit can be discussed with the staff concerned. Timescales will be agreed with the managers concerned in respect of the

implementation of any recommendations made in the report. Draft and final reports will be distributed as shown below to allow for effective consultation and response to the contents.

AUDIT COMPLETION			AUDIT PROGRESS & REPORTING	
Lead Auditor	Chipo Makore		**Key Contacts/ Report Recipients**	**Draft/Final report?**
Audit Supervisor	Marina Willis		Andy Jeanes, Director of Facilities and Estates	Both
Planned Start date (fieldwork)	July/August 2024		Neil Kemsley, Chief Financial Officer	Both
			Matthew James, Associate Director of Estates	Both
			Martin Sykes, Chair of Finance and Digital and Estates Committee	Final
			Trust Secretariat	Final
			KPMG, External Auditor	Final

Confidentiality and Security of Data

All information related to clients is held securely and will not be shared with other organisations without the permission of the organisation concerned. This report will be issued under strict confidentiality and, whilst it is accepted that issues raised may well need to be discussed with the organisation's officers not shown on the distribution list, the report itself must not be copied / circulated / disclosed to anyone outside of the organisation without prior approval from the Director of Audit and Assurance Services.

ASW Assurance, Office Address/Contact Details:

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Trust Headquarters
Marlborough Street
Bristol
BS1 3NU

Marina Willis, Senior Audit and Assurance Manager
Email: marina.willis@nhs.net

Chipo Makore, Senior Audit and Assurance Specialist
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University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the People Committee on 18 July 2024 in St James Court, Bristol

Reporting Committee	**People Committee**
Chaired By	**Linda Kennedy, Non-Executive Director**
Executive Lead	**Emma Wood Deputy CEO and Chief People Officer**

For Information

The People Strategy comprises four key pillars of **Growing for the Future, New Ways of Working, Inclusion and Belonging and Looking After Our People**. Focus in this meeting was on Inclusion and Belonging.

Growing for the Future

The new Patient First Programmes relating to 'Develop the medical workforce strategy and reduce medical agency spend' and were shared. It was evident to the committee these programmes would assist to mitigate risks and progress the work programmes linked to the papers received.

New Ways of Working

There were no items from the People Strategy work programme for this meeting.

Inclusion and Belonging

There was an update on 'Delivering the Pro Equity promise' and we received the Equality report, an update of violence and aggression and the Respecting Everyone approach.

The equality report provided an overview of the Trusts performance in the following areas: Gender Pay Gap (GPG), Workplace Race Equality Standard (WRES) and Workplace Disability Equality Standard (WDES). The reports highlighted that of the 20 WRES and WDES metrics measured 8 were RAG rated red. The reports highlight the issues the Trust has with Ableism which show that our practices, procedures and culture are creating barriers for disabled colleagues.

Positively the Trust has improved upon 6 WRES indicators evidencing the prioritisation of race issues in the last year.

The data sets were explored in detail alongside the Patient First Breakthrough Objective 'Delivering our Pro Equity Promise' and the committee were assured of the work programmes led corporately and divisionally aimed at resolving the metrics RAG rated as Red (least improved or worsened). These programmes are defined as 'interpersonal actions' (how we treat each other and 'institutional actions' (our policies, practices and procedures). The Red RAG rated metrics are highlighted below:

University Hospitals Bristol and Weston NHS Foundation Trust

WRES (2 Red RAG rated)

- The gap in the likelihood of white colleagues being appointed from shortlisting compared to ethnically minoritised colleagues has increased and the gap is still large. White candidates are 1.92 times more likely to be appointed than Ethnically Minoritised candidates from shortlist. 20.3% of Ethnically Minoritised Colleagues compared to 39.1% of white colleagues (18.2pp gap). This gap is prevalent in all divisions.
- Ethnically Minoritised colleagues are 1.59 times more likely to enter the formal disciplinary progress than white colleagues. The proportion of Ethnically Minoritised colleagues entering the formal disciplinary process has increased from 2022 to 2023. The Respecting Everyone paper presented described how the Trust has commenced a programme to deliver improvements in this metric and the committee were assured of this progress and noted the need for strategic patience in turning some dials.

WDES (6 Red RAG rated) summarised as follows

- Disabled colleagues feel much less valued than non-disabled colleagues and this gap is increasing. 39.5% of Disabled Colleagues compared to 50.1% of non-disabled colleagues
- The gap in experience of harassment, bullying or abuse for Disabled Colleagues compared to non-disabled colleagues is high, with large gaps in all divisions;
    - 11.9% of Disabled Colleagues experiencing harassment, bullying or abuse from managers compared to 6.5% of non-disabled colleagues
    - 25.0% of Disabled Colleagues experiencing harassment, bullying or abuse from other colleagues compared to 14.5% of non-disabled colleagues
    - 29.5% of Disabled Colleagues experiencing harassment, bullying or abuse from patients/service users compared to 21.0% of non-disabled colleagues

Respecting Everyone

An update on the Respecting Everyone (Just and Learning Culture) approach was shared for information. In summary, the committee heard that the number of Employee Relations cases overall had decreased, along with the time taken to resolve them. However, the case complexity and seriousness had increased. This correlated with the intent for UHBW to tackle legacy cases of behaviour which is inconsistent with our pro-equity approach.

The data also correlated with the findings in the WRES that a disproportionately high level of ethnic minoritised colleagues were subject to disciplinary action. The data indicated that the new Respecting Everyone approach was making headway. Since the launch of the new approach, the proportion of cases being dealt with informally had increased.

Work is continuing to support managers with the new approach; and action is being taken to address the gaps in experience felt by those colleagues in minoritised groups, including training on pro-equity approaches and closed case reflections and reviews in the HR Services and HR Business Partner Teams.

Looking after our People

We have received a number of annual reports for assurance including the annual health and safety report and the Guardian of Safe Working report.

There were no new risks or issues relating to the Guardian of Safe Working report and good compliance with contract provisions remains in place with no exception reports from Weston General Hospital. The issues relating to the use of locums and rota management was explored and the committee assured these items are part of the scope of the 'Develop the medical workforce strategy and reduce medical agency spend' corporate project.

Health and Safety (H&S) Report

The committee received the H&S report and noted good improvements. These included the reduction of clinical sharps incidents alongside the introduction of a 'safer' hypodermic across Bristol sites, the reduction of manual handling incidents by 23% from previous year and reduction of late reports made to enforcing authority under RIDDOR legislation

In the next year improvements will be sought to improve the capacity of the H&S team to mitigate the risk held that this team has inadequate resources to meet the needs of the Trust (7324). The team will also seek to deliver the 8 recommendations of the British Safety Council audit also a key delivery of the People Strategy year 3 milestones.

Violence and aggression (V&A)

The Committee received an update paper on our compliance against the national V&A standard and current programmes of work to reduce V&A. Progress aims to mitigate the risk relating to V&A behaviour towards staff and patients (422). Key data headlines:

- The Trust has met 26 of the 27 standards. There is one remaining red indicator relating to health and safety assessments. The standard requires a central depository for risk assessments which is not currently available within our Datix system.
- There has been a slight decrease of reported verbal aggression and physical assaults with an increase of just 2 incidents in the last quarter.
- The committee recognised the innovation in managing V&A in ward A522 a care of the elderly ward at the BRI where an activity coordinator has identified ways to divert some poor behaviour with a 'crafty cafe'.

The link between papers and the delivery of the People Strategy was evident throughout the meeting.

For Board Awareness, Action or Response

Gender Pay Gap (GPG)

The GPG reports the median and mean pay gaps. The mean average takes into account the absolute salary values of all staff, and the median takes the actual value of the salary in the middle of the range. By controlling for the effect of a relatively small number of the highest earners, the median can be expected to offer a more accurate average of relative pay levels across the organisation.

- UHBW's Mean Gender Pay Gap for 2024 is 15.11% a modest reduction from last year (16.20%) The gender gap in mean hourly rate is largely attributable to the difference in gender profile across roles in the organisation. A greater proportion of male employees in the Trust occupy senior or medical roles. Female employees make up a disproportionate amount of nursing roles in particular, lowering the mean hourly earnings in comparison.
- The Median Gender Pay gap is 3.19% in favour of male employees which reflects the larger proportion of males in senior clinical roles and the large proportion of females in nursing professions. The reported figures show a favourable trend in comparison with the 2023 report from 4.34% the lowest rate since 2020/21. This is a testament to the robust pay controls in place at the organisation, minimising the use of individual management allowances, recruitment and retention premia (RRPs), or any other irregular changes to earnings.

Operational Key Performance Indicator (KPI) report

The committee received the KPI report and were assured that most targets are green and triangulate with the data provided to the Board in the IQPR.

The Surgery HR Business Partner presented their report and was able to describe how the Division is progressing its people agenda through their Workforce committee and People and Culture Plans. The committee were assured that there is firm connectivity with the corporate teams and divisional plans to deliver upon the Patient First programmes and the People Strategy milestones.

Key Decisions and Actions

The committee supported the programmes of work to address inequalities in the Trust namely Delivering our Pro Equity Promise, the EDI action plan and Respecting everyone work programme.

The committee agreed to support the review of H&S resources to mitigate risk 7324.

University Hospitals Bristol and Weston NHS Foundation Trust

ICB Committee or Relevant System Updates
At the ICB Committee meeting there were general updates from the other People Committee chairs in the system. There was nothing particular of note, other than reassurance that we are all working to broadly the same agenda. There was a presentation on the Workforce KPI's, including some of the controls around nursing and medical agency spend, which is aligned to the work we are already doing in UHBW, so we are fully involved with it.
Commentary
The committee look forward to receiving updates on the 'medical workforce strategy and reduce medical agency spend' programme and how these will deliver benefits to the Trust and patients. Our next committee will focus on updates relating to the People Strategy Pillar 'New ways of working' with a focus on our education, learning and development delivery and strategic workforce planning.

Date of next meeting:	**26 September 2024**

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Public Trust Board		
Date of Meeting:	10 September 2024		
Report Title:	Acute Provider Collaborative Arrangements		
Report Author:	Xavier Bell, Director of Corporate Governance, NBT Eric Sanders, Director of Corporate Governance, UHBW Paula Clarke, Executive Managing Director (WGH), UHBW		
Report Sponsor:	Ingrid Barker, Joint Chair		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		
	This report sets out proposed changes to the governance of the NBT and UHBW Acute Provider Collaborative taking into account the ongoing development of a Hospital Group operating model and governance arrangements.		

Key Points to Note *(Including any previous decisions taken)*

It is proposed that the Acute Provider Collaborative Board (APCB), a joint committee between NBT and UHBW, is stood down with effect from September 2024.

The APCB was created prior to the decision of both organisations' Boards to pursue the creation of a Hospital Group model. Following the creation of the Joint Clinical Strategy, the appointment of a Joint Chair and Joint Chief Executive, a regularly meeting Joint Executive Group, and the appointment of a strategic partner to support the Hospital Group development, the role of the APCB in setting and overseeing shared strategic direction is no longer relevant.

The ongoing work associated with developing the Hospital Group, including the ongoing delivery of the Joint Clinical Strategy, will be via the Joint Executive Group, reporting into both organisations' Boards via the Joint Chief Executive (Accountable Officer). This will be supported by a smaller group (provisionally referred to as the "Strategic Minds" group) which will include the Joint Chair and Joint Chief Executive, to provide a regular drumbeat of input and oversight to the work of JEG and the strategic partner. Both Boards will be directly engaged in the development of the Hospital Group via regular Board-to-Board meetings, until such time as the longer-term Hospital Group operating model and governance is agreed.

Strategic Alignment

This paper and the proposals that it contains are aligned with delivering the organisations' Joint Clinical Strategy.

Risks and Opportunities

The proposal to stand down the APCB presents an opportunity to simplify existing governance structures and ensures that all members of both Boards are equally involved in the development of the Hospital Group operating model and governance, rather than a smaller sub-set making up the APCB.

Recommendation

This report is for **Approval**.

It is recommended that the Board:

- Stand down its joint Acute Provider Collaborative Board with NBT, and

• Note that the ongoing work associated with developing the Hospital Group, including the ongoing delivery of the Joint Clinical Strategy, will be via the Joint Executive Group, reporting into both organisations' Boards via the Joint Chief Executive (Accountable Officer).	
History of the paper (details of where paper has <u>previously</u> been received)	
N/A	N/A
Appendices:	Appendix 1: APCB Terms of Reference (v0.91)

1. Purpose

1.1 This report sets out proposed changes to the governance of the NBT and UHBW Acute Provider Collaborative taking into account the ongoing development of a Hospital Group operating model and governance arrangements.

2. Background

2.1 The Acute Provider Collaborative Board (APCB) was established as a joint committee in 2021 following the national requirement that all providers be a member of a provider collaborative. The terms of reference of the APCB (attached) were expanded in early 2024 to reflect the Joint Clinical Strategy and the signing of the Memorandum of Understanding (MOU) associated with the Hospital Group model.

2.2 In March 2024 the organisations established a Joint Executive Group (JEG) as a sub-group of the APCB, meeting approximately every six weeks, supported by a smaller weekly Strategic Oversight Group (SOG) led by the Chief Executive(s) and now the Joint Chief Executive setting direction for the JEG meetings. The core purpose of JEG is to operate as a Programme Board to enable implementation of our strategic intent to establish a Hospital Group, working in accordance with the principles and behaviours set out in our MOU and to drive and support delivery of the joint clinical strategy and associated clinical and corporate workstreams.

2.3 In March, the Trusts appointed a Joint Chair and in July they appointed a Joint Chief Executive, further cementing their shared leadership and decision-making ability. A strategic partner was appointed in August to support development of the Hospital Group model.

3. Proposed governance changes

3.1 Having this robust Executive governance in place has highlighted the need to review and simplify the governance structures that are overseeing Hospital Group development and collaborative work. There is also a desire for the strategic partner, Teneo, to work with all members of both Boards in developing the Hospital Group model, meaning that the quarterly APCB is no longer relevant as a forum for overseeing this work.

3.2 It is therefore proposed that as this work progresses:

- The APCB is stood down as a joint committee,
- The JEG is reconstituted as a management meeting of the Joint Chief Executive (Accountable Officer),

- updates on the Group development work and progress of the Joint Clinical Strategy are brough directly to both Boards via the Joint Chief Executive/Executive Teams. These reports will be aligned into a single, consistent format.
- Regular Board-to-Board meetings will be scheduled in the intermittent month between formal Board meetings to ensure all Board members are fully engaged in the Hospital Group model development.
- A small “Strategic Minds” group will be constituted, made up of the Joint Chair, Joint Chief Executive with other members to be determined. This group will meet regularly and will provide a regular drumbeat of input and oversight to the work of JEG and the strategic partner.

These proposed changes ensures that at this key stage in beginning to design our Group model, all Board members are included and engaged, rather than a subset of Executives and NEDs as is the case with the APCB.

3.3 These arrangements are also expected to be transitional in nature and will ultimately be replaced by whichever Hospital Group operating model and governance is developed and approved by both Boards over the coming months.

3.4 For information, the NHSE requirement to join at least one provider collaborative from July 2022 is defined as “partnership arrangements that bring together two or more trusts to maximise economies of scale and improve care for their local populations”. Our Group development partnership arrangements will fulfil this requirement, taking us a step further in collaboration from our initial Acute Provider Collaborative approach. Further consideration is needed to develop our communication and engagement on describing our Group collaboration.

4. Recommendations

4.1 This report is for **Approval**.

4.2 It is recommended that the Board:

- Stand down its Acute Provider Collaborative Board (joint committee with NBT), and
- Note that the ongoing work associated with developing the Hospital Group, including the ongoing delivery of the Joint Clinical Strategy, will be via the Joint Executive Group with regular input from the “Strategic Minds” group, reporting into both organisations’ Boards via the Joint Chief Executive (Accountable Officer).

Acute Provider Collaboration Board
Terms of Reference

Version Tracking				
Version	Date	Revision Description	Editor	Approval Status
0.1	03/08/2021	First draft	Xavier Bell	Draft
0.2	16/08/2021	Amendments following comments from PC	Charlotte Devereaux	Draft
0.3	17/08/2021	Amendments following comments from ES	Charlotte Devereaux	Draft
0.4	18/08/2021	Amendments following comments from ES and PC	Charlotte Devereaux	Draft
0.5	01/09/2021	Amendments following NBT August Trust Board	Xavier Bell	Draft
0.6	09/09/2021	Amendments to decision-making authority	Xavier Bell and Eric Sanders	Draft
0.7	07/07/2022	Amendments to membership and meeting frequency	Xavier Bell and Eric Sanders	Draft
0.8	21/07/2022	Update to para 3.1 to recognise the Health and Care Act had received royal assent	Xavier Bell and Eric Sanders	Draft
0.9	20/03/2024	Updated following approval of the Joint Clinical Strategy and Memorandum of Understanding	Eric Sanders and Xavier Bell	Approved

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1. Constitution

1.1. The Boards of Directors (the Boards) of University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust have resolved to establish an Acute Provider Collaboration Board (the APC Board), which will be a joint committee of the two organisations.

1.2. The APC Board has no executive powers other than those derived from its membership (i.e., the powers of Executive Directors) or those specifically delegated in these Terms of Reference.

2. Authority and Accountability

2.1. Members of the APC Board remain accountable to the Boards of Directors of their respective Trusts.

2.2. The APC Board is authorised by the Boards to investigate any activity within its terms of reference.

2.3. The APC Board is authorised to seek any information it requires from any officer of the Trusts via their respective Chief Executive. All officers are directed to co-operate with any request made by the APC Board via their respective Chief Executive.

2.4. The APC Board may obtain whatever professional advice it requires[1], and may require Directors or other officers to attend meetings.

2.5. The APC Board may delegate specific decisions to a sub-group. . This includes delegation to any Executive-led programmes or task and finish groups. Where the APC Board intends to delegate authority, this will be reported to the Boards of Directors for approval. The sub-group must include members of the APC Board but may also include other individuals from either organisation who are not APC Board members.

[1] The APC Board may, from time to time, contract specialists to advise and support the discharge of these terms of reference. This shall be funded by both Trusts subject to APC Board approval.

For legal advice, this shall be subject to consultation with the Directors of Corporate Governance.

3. Purpose

3.1. The purpose of the APC Board is:

3.1.1. to provide strategic leadership and direction for the Acute Provider Collaboration,
3.1.2. to provide Non-Executive and Executive oversight to the Acute Provider Collaboration,
3.1.3. to oversee delivery of the Joint Clinical Strategy including the clinical and corporate workstreams
3.1.4. to ensure adherence to the Memorandum of Understanding, and in particular the principals and behaviours described
3.1.5. to oversee the development of a Hospital Group Model for approval by both Boards of Directors.

3.1.6. to consider the resource requirements for the phases of the development of the Group Model and make recommendations to the Trusts as required.

3.1.7. to be the point of escalation for any issues or significant risks that the programmes cannot mitigate,

.

3.1.8. To provide a forum for sharing each organisations' Patient First Programme, allowing discussion and strategic alignment where appropriate,
3.1.9. to provide regular updates to each Board of Directors on the progress of the Acute Provider Collaboration.

3.2 The APC Board shall role model the expected behaviours of the partnership as described in the Memorandum of Understanding.

4. Sub-Groups

4.1. In accordance with these Terms of Reference, the APC Board has agreed that a Joint Executive Group (JEG) will be convened to support delivery of the stated purpose of the Board. The JEG will provide direct management of the programme workstreams.

4.2. The JEG will report to the APC Board at each meeting and will present its Terms of Reference to the APC Board for approval.

4.3. The JEG will be supported by a Strategic Oversight Group, comprising the Chief Executives and their Deputies, which will provide strategic oversight and coordination of the plans to develop the Group Model.

5. Membership

5.1. The following shall be members of the Board:

5.1.1. Trust Chairs [2] (or the Trusts' Joint Chair, once appointed)
5.1.2. Chief Executives [2] (or the Trusts' Joint Chief Executive, once appointed)
5.1.3. Chief Operating Officers [2]
5.1.4. Chief Medical Officer [2]
5.1.5. Non-executive Directors [2], NBT
5.1.6. Non-executive Directors [2], UHBW

5.2. The APC Board will be co-chaired by the two Trust Chairs. The co-chairs will alternate taking the lead until the appointment of the Joint Chair.

5.3. In the absence of both Trust Chairs, the remaining members present for the Acute Provider Collaboration Board shall elect one of the other non-executive Director members to chair the Acute Provider Collaboration Board.

5.4. If a member is unable to attend, whenever possible, apologies should be sent to the secretary of the Board at least five [5] working days in advance of the meeting. A deputy will be invited to attend the meeting if a member is unable to attend. It is important deputies are chosen to reflect the areas of expertise brought by the core members.

5.5. ***Quorum***

5.5.1. The quorum necessary for the transaction of business shall be three [3] members from each Trust, of whom two [2] must be non-executive Director/Trust Chair, and one [1] must be an Executive Director.

5.5.2. A duly convened meeting of the APC Board at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the APC Board.

5.5.3. Deputies and other attendees do not count towards the quorum.

5.6. ***Secretariat Services***

5.6.1. The Directors of Corporate Governance will provide secretariat services to the APC Board.
5.6.2. This shall include the provision of a secretary to the APC Board and such other services as are required from time to time.
5.6.3. The secretary to the Board will be provided by the organisation hosting the meeting.

6. Attendance

6.1. Other officers and external advisers may be invited to attend for all or part of any meeting as and when appropriate and where no conflict of interest exists.
6.2. The Executive Leads agreed for the Clinical and Corporate Workstreams will be required to attend regularly (as set out on the approved forward-workplan) to provide updates to the Committee.
6.3. The Directors of Corporate Governance from the respective Trust's will be expected to attend the meeting to provide governance advice.

7. Meetings

7.1. Meetings of the APC Board shall be conducted in accordance with the following provisions:

7.2. ***Frequency of meetings***

7.2.1. The APC Board shall meet four [4] times per year and at such other times as the Co-Chairs of the APC Board shall require as advised by the secretary.

7.3. ***Notice of meetings***

7.3.1. Meetings of the APC Board shall be called by the secretary of the APC Board at the request of the co-chairs.

7.3.2. Unless otherwise agreed, a notice of each meeting confirming the venue, time, and date, together with an agenda of items to be discussed, shall be made available to each member of the APC Board and any other person required to attend no later than five [5] working days before the date of the meeting.

7.3.3. Supporting papers shall be made available to APC Board members and to other attendees as appropriate no later than five [5] working days before the date of the meeting.

7.4. ***Minutes of meetings***

7.4.1. The secretary shall minute the proceedings and resolutions of meetings of the APC Board, including the names of those present and those in attendance.

7.4.2. Draft Minutes of meetings shall be made available promptly to all members of the APC Board and, once agreed, to all other members of the Boards of Directors[2].

[2] Unless a conflict of interest exists.

7.5. ***Public Access and Confidentiality***

7.5.1. There is nothing within the Constitution of the University Hospitals Bristol and Weston NHS Foundation Trust Constitution, which requires the meetings of this APC Board to be held in public or to allow public access. Personal information shall be subject to the provisions of the Data Protection Act 2018; other information shall remain subject to the Freedom of Information Act 2000.

7.5.2. All members and attendees shall have due regard to the confidentiality of any discussions relating either to identifiable individuals or to commercially confidential information.

8. Reporting

8.1. The Co-Chairs of the APC Board shall report formally to their respective Board of Directors on all proceedings and matters within the duties and responsibilities of the APC Board.

8.2. The minutes of Acute Provider Collaboration Committees meetings shall be formally recorded and submitted to the Board of Directors according to the Boards' Annual Reporting Cycles.

8.3. The Chairs of the Acute Provider Collaboration Committees shall make whatever recommendations to his Board of Directors he deems appropriate on any area within the Acute Provider Collaboration Committees remit where disclosure, action or improvement is needed.

9. Monitoring and Review

9.1. The Co-Chairs of the Acute Provider Collaboration Board shall, at least once a year, lead a review of the performance, constitution, and terms of reference of the APC Board to ensure it is operating at maximum effectiveness and make any recommendations for change of the Terms of Reference to the Boards of Directors for agreement.

9.2. The Acute Provider Collaboration Board will review the Memorandum of Understanding (MoU) annually and make recommendations to their respective Boards on any changes.

University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Board held in Public on 10 September 2024

Reporting Committee	**Audit Committee – July 2024**
Chaired By	**Anne Tutt, Non-Executive Director**
Executive Lead	**Neil Kemsley, Chief Financial Officer**

For Information

1. The committee reviewed the new Board Assurance Framework (BAF) for quarter 1, and members commented on how impressed they were with the development of this piece of work and noted that this was an iterative process that would develop over time. In the report's next iteration, a risk analysis from the Patient Safety Group would appear in the corporate risks box. Executive Committee sub-groups were now receiving quarterly detailed reports containing detailed reviews of risk mitigations and the current position in relation to divisional risks. The BAF report contained the headlines for the Board to focus on. However, if committees were not assured by the BAF and divisional reports, they could instruct deep dives to provide more assurance. Some valuable ideas on how to gain intelligence to highlight key areas of focus were discussed by the committee.

2. The committee received an update on the Trust's information governance arrangements and an update on progress against the Data Security and Protection Toolkit. It was reported that the rust's recently published Data Protection and Security Toolkit (DSPT) had identified gaps in evidence, and this was being looked at by the Information Governance team. Non-Executive Directors requested assurance around this issue and it was confirmed that lessons had been learned, which included a much earlier self-assessment against the DSPT to identify gaps sooner so these could be addressed in a timely manner. The committee also discussed the 53% compliance rate for subject access requests and it was noted that the process was being reviewed.

3. The committee reviewed the following internal audit review reports:

   - Risk Management (part 2) - The assurance opinion was satisfactory for overall risk management and board assurance framework arrangements.
   - Locum's Nest Payments - The assurance opinion was satisfactory overall.
   - DSPT (Data Protection and Security Toolkit) - The assurance opinion was satisfactory overall.
   - Right to Work Checks - The assurance opinion was satisfactory overall.
   - Data Quality Framework - The assurance opinion was satisfactory overall.
   - Financial Planning/CIP - The assurance opinion was satisfactory overall.
   - Fire Evacuation Arrangements - The assurance opinion was limited assurance. The Trust had provided a robust action plan in response to the recommendations, but the committee felt it required more assurance on the resources available, timeliness, and demonstration that progress was being made in this area.

University Hospitals Bristol and Weston NHS Foundation Trust

- Cyber Security - The assurance opinion was limited assurance, and a management response was awaited. The assurance opinion was of concern to the committee, and it was confirmed that this area fell within the remit of the Finance, Digital and Estates Committee which could undertake a deep dive and could then report back to the Audit Committee. The Director of Corporate Governance agreed to re-examine the governance process for audit reports that sat between two committees.

4. The Committee received and reviewed the following reports:

- Policies and Procedures / Standard Operating Procedures Update
- Counter Fraud Progress Report
- Review of Losses and Special Payments
- Review of Single Tender Actions

For Board Awareness, Action or Response

5. It was reported that NHS England (NHSE) had mandated an audit of workforce controls to be completed by 30 September 2024. The prescribed scope of the audit was extensive and included vacancy control, review of establishment governance, compliance with sickness absence, leave and overtime policies, use of bank and agency staff, rostering, high-cost locum exit arrangements, and a review of salary overpayments. It was estimated that this would take 40 to 50 internal audit days which were not included in current audit plan. It was agreed that the Head of Internal Audit would work with the Director of Corporate Governance and the Executive Directors to look at the current plan, deprioritise existing audit days in favour of the new audit, and to use those days along with contingency days to progress this additional audit.

Key Decisions and Actions

6. The Committee discussed the number of outstanding actions from recommendations arising from internal audit reviews and asked for updates on long standing overdue actions at its next meeting.

7. The Director of Audit & Assurance Services was asked to work with the Director of Corporate Governance and the Executive Team to look at the current audit plan, deprioritise existing audit days in favour of the new audit, and to use those days along with contingency days to progress the workforce audit mandated by NHSE.

Additional Chair Comments

8. I would like to highlight the number of Audit recommendations from the previous financial year that are still showing as in progress, and I will ensure the Audit Committee remains sighted on any further slippages in closing these recommendations.

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Update from ICB Committee	
N/A	
Date of next meeting:	**31 October 2024**

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Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 2024		
Report Title:	Register of Seals		
Report Author:	Mark Pender, Head of Corporate Governance		
Report Sponsor:	Eric Sanders, Director of Corporate Governance		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	This report provides a summary of the applications of the Trust Seal made since the previous report in July 2024**.**		

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.

Two sealings have taken place since the last report, as per the attached list.

Strategic Alignment

N/A

Risks and Opportunities

N/A

Recommendation

This report is for **Information**

The Board is asked to note the Register of Seals report.

History of the paper (details of where paper has <u>previously</u> been received)

N/A

Appendices:	Summary of the applications of the Trust Seal

University Hospitals Bristol and Weston NHS Foundation Trust

Register of Seals

July 2024 to September 2024

Reference Number	Document	Date Signed	Authorised Signatory 1	Authorised Signatory 2	Witness
901	Intermediate Building contract for refurbishment and alterations to the Cardiovascular Research Unit between UHBW and Speller Metcalfe Malvern Ltd.	05/08/24	Neil Kemsley	Stuart Walker	Mark Pender
902	Works to meet the cooling and power demands of Server Rack, Level 8, IT Services Server Room between UHBW and T. Clarke Contracting Ltd.	05/08/24	Neil Kemsley	Stuart Walker	Mark Pender

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Board of Directors in PUBLIC		
Date of Meeting:	Tuesday 10th September 2024		
Report Title:	Governors' Log of Communications		
Report Author:	Mark Pender, Head of Corporate Governance		
Report Sponsor:	Eric Sanders, Director of Corporate Governance		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	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.		

Key Points to Note *(Including any previous decisions taken)*

Since the previous Board of Directors meeting held in public on 09 July 2024:

- No questions have been added to the log.
- Two questions have been answered on the log.
- There are no outstanding questions on the log.

Strategic Alignment

N/A

Risks and Opportunities

N/A

Recommendation

This report is for **Information**

The Trust Board is asked to note the updates to the Governors Log.

History of the paper (details of where paper has <u>previously</u> been received)

Quality Focus Group	05 September 2024

Appendices:	Appendix 1 – Governors Log

governors log september 2024

Governors questions reference number	Coverage start date	Governor Name	Governor Constituency	Description	Executive Lead	Coverage end date	Response	Status
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	Funding for Continuing Health Care (CHC) care packages stays in place when people are admitted to hospital. Where admissions are expected to be short, the CHC team would not look to reduce/amend etc the package, particularly where people have bespoke care teams that work with them. Where CHC team know that an admission may be lengthy, they may look to agree a reduced price (retainer) to pay the provider to keep the care team live for when the person eventually is discharged. If a person's needs are more generic and they are expected to be admitted for a length time, the CHC team may serve notice on the package, knowing that a new care package can be stood up quickly as the person's discharge date draws closer. For people with LD/Autism needs, particularly around communication, the CHC team would support carers that are knowledgeable about the person following them into hospital to support.	Closed
297	25/06/2024	Ben Argo		Please can you provide an update on the Reasonable Adjustments Digital Flag implementation compliance of UHBW's systems? The second phase was due to be completed by 30 June and it would be good to know if this implementation has gone ahead.	Chief Information Digital Officer	22/08/2024	This action remains open. All digital and IT resource is currently allocated to the implementation of a significant new Trust-wide digital system – Careflow Medicine Management. We will review resource again in Q3 and provide an update on the Careflow EPR alerts project to the Digital Hospital Programme Board which is currently scheduled to take place on 12th September 2024.	Closed